BILLIN

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

[Docket ID: DOD-2019-HA-0056]

RIN 0720-AB73

TRICARE; Reimbursement of Ambulatory Surgery Centers and Outpatient Services Provided in Cancer and Children's Hospitals

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

ACTION: Final rule.

SUMMARY: The DoD is amending TRICARE reimbursement of ambulatory surgery centers (ASCs) and outpatient services provided in Cancer and Children's Hospitals (CCHs). These amendments are in accordance with the TRICARE statute that requires TRICARE's payment methodologies for institutional care be determined, to the extent practicable, in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under Medicare. In accordance with this requirement, TRICARE finalizes the adoption of Medicare's payment methodology for ASCs, and adoption of Medicare's payment methodology for outpatient services provided in CCHs as set forth in this final rule.

DATES: This rule is effective 180 October 1, 2023.

FOR FURTHER INFORMATION CONTACT: Jahanbakhsh Badshah, Defense Health Agency, 303-676-3881.

SUPPLEMENTARY INFORMATION:

I. Discussion of Public Comments and Changes

On Friday, November 29, 2019 (84 FR 65718-65727), the Department of Defense published a proposed rule titled "TRICARE; Reimbursement of Ambulatory Surgery Centers and Outpatient Services Provided in Cancer and Children's Hospitals" for a 60-day public comment period. Eleven public comments were received. This section responds to those public comments.

1. General Comments on Reimbursement, Access to Care, and Difference in Beneficiary Population for Ambulatory Surgery Centers (ASCs)

Comment: Several commenters expressed concern that this change in reimbursement methods and rates might lead to access to care issues because providers might opt out of providing services because the Medicare rate is lower than the previously paid TRICARE rates. One commenter urged the Defense Health Agency (DHA) to "take a more granular examination of changes in reimbursement that will occur as the result of the proposed alignment and take steps to ensure that any procedures that are being performed in significant volume in ASCs do not experience a reduction in reimbursement." Another commenter recommended that DHA should not adopt the Medicare ASC fee schedule (FS) because Medicare patients have different needs from those seen under TRICARE. The commenter requested DHA to consider differences in procedure types performed on TRICARE patients, in part because this commenter found that their TRICARE patients "tend to undergo Orthopedic and ENT surgeries at a much higher rate than our Medicare patients do."

Response: We appreciate the commenters' concerns regarding the potential impact of adopting Medicare's ASC FS in the TRICARE program. As discussed in the notice of proposed rulemaking, we are adopting the Medicare ASC system because, first, TRICARE is statutorily obligated to reimburse like Medicare where practicable, second, the current TRICARE ASC system is based primarily on Medicare's retired ASC reimbursement system, and finally, the

TRICARE rates are difficult to update and in some cases anomalous. The Medicare ASC rates, which TRICARE is adopting, are based on assessments made each year by the Centers for Medicare and Medicaid Services (CMS) of the appropriate level of reimbursement for ASCs. In contrast to adopting a system that CMS will update each year for the appropriate level of reimbursement for each ASC surgery, over one-half of the procedures under the current TRICARE ASC system have rates and groups based on assignments made prior to 2001. DHA has found that TRICARE's current patchwork system can produce reimbursement anomalies, particularly in comparison to Medicare's ASC rates and Outpatient Prospective Payment System (OPPS) rates. For example, we compared the January 2020 TRICARE ASC rates with Medicare ASC rates for 40 high-volume, higher-cost procedures and found that for one-fifth of the cases, the Medicare ASC rate is more than 40 percent higher than the current TRICARE ASC rate and that in only one quarter of the cases are the Medicare ASC rates within 10 percent of the TRICARE rates. In two cases, the TRICARE ASC rate is even greater than the OPPS rate, which is anomalous. These anomalies would be corrected using the Medicare ASC rates.

We agree with the commenter that it is important to look at the impact of proposed reimbursement changes for high-volume codes. DHA did this type of analysis prior to publishing the notice of proposed rulemaking and we have now used data from 2019 to examine the impact of reimbursement changes on high-volume ASC procedures as suggested by the commenter. We selected all TRICARE ASC procedures with 660 or more claims in the January-June 2019 period plus any other procedures that were among the highest 10 in terms of TRICARE ASC allowed amounts in 2019. The combined group of 40 high-volume, high-cost surgical procedures accounted for over 71 percent of all TRICARE ASC surgery claims and 63 percent of all TRICARE ASC allowed amounts in the January-June 2019 period.

We found that the maximum allowable Medicare ASC rates in January 2020 were higher than the current TRICARE ASC rates for almost half (43 percent) of the 40 high-volume, high cost procedures, including 3 of the 6 highest-volume TRICARE ASC surgeries. We also found

that the Medicare rates for an additional one-eighth of the 40 procedures had Medicare ASC rates that were only slightly less (0 to 9 percent) than the current TRICARE ASC rates. On average, the Medicare rates for the 40 high-volume, high-cost procedures were 14 percent lower than the January 2020 TRICARE ASC rates. Thus, we were re-assured that for over half of the high-volume, high-cost procedures, the Medicare rates will represent either an increase or a small decrease compared with the TRICARE ASC rates.

We disagree with the commenter that DHA should ensure that *none* of the high-volume procedures experience a reduction in reimbursement rates. Even though there will be an overall reduction in TRICARE reimbursement rates, many codes will have higher rates and the benefits of adopting an updated, internally-consistent reimbursement system outweigh the disadvantages of reduced rates for some ASC surgeries. In addition, it is not practical for DHA to have TRICARE pay different amounts for procedures in ASCs compared to Medicare solely because a procedure is common.

We also disagree with the comment that Medicare ASC rates are not appropriate for TRICARE patients because the patients have different needs. First, the TRICARE population is generally younger and healthier on average than Medicare patients. Second, DHA has already adopted the use of the Medicare OPPS and the Medicare Physician Fee Schedule, with Medicare rates, and Medicare's ASC FS rates are simply a hybrid of those two systems' rates. Furthermore, many of the procedures that DHA has added to the TRICARE ASC FS in the last few years were priced based on the Medicare ASC FS rate. Fourth, there is nothing unique about freestanding ASCs that make Medicare rates inappropriate due to beneficiary characteristics compared to those payment systems. Fifth, we have no evidence that the Medicare ASC rates are too low because TRICARE beneficiaries generally do not require more costly care than Medicare beneficiaries. Sixth, the fact that a procedure is more common in one population than another does not, in itself, argue for different payment rates because procedures are billed by specific Common Procedural Terminology (CPT) code. As the commenter suggested, we did

examine the change in maximum reimbursement rates for ear nose and throat (audiology and respiratory) surgeries and orthopedic (musculoskeletal) surgeries. We found that almost one-quarter of the 40 high-volume, high-cost TRICARE surgical procedures are ENT or orthopedic and that the maximum TRICARE reimbursement rate would decrease by 6 percent for ENT surgeries and by 4 percent for orthopedic surgeries. In comparison, the rates would decrease by an average of 14 percent for all 40 surgeries. Thus, our analysis of the high-volume, high-cost procedures for TRICARE ASC patients indicates that although the mix of TRICARE and Medicare ASC surgeries is different, the types of surgeries identified by the commenter as being more common among the non-Medicare population will have modest reductions and smaller reductions than for other procedures. For all these reasons, DHA concludes that adopting the Medicare ASC rates is appropriate for TRICARE patients.

2. Non-opioid Pain Management in ASCs

Comment: One commenter requested that DHA evaluate including non-opioid pain management medications in the list of covered ancillary services for ASC reimbursement, as Medicare did in 2019.

Response: DHA intends to adopt Medicare's ASC FS rules, payment rates, and addenda, including their list of ancillary procedures allowed to be paid outside the packaged procedure rate (Addendum BB, ASC Covered Ancillary Services). Currently, as finalized in the CY 2021 OPPS/ASC final rule (86 FR 63484) , Medicare has approved four such substances including Exparel (*C9290; Injection, bupivacaine liposome, 1 mg*), Omidria (*J1097*; *Phenylephrine 10.16 mg/ml and ketorolac 2.88 mg/ml ophthalmic irrigation solution, 1 ml*), Zynrelef (*C9088*; *Instillation, bupivacaine and meloxicam, 1 mg/0.03 mg*), and Xaracoll (*C9089*; *Bupivacaine, collagen-matrix implant, 1 mg*). These codes can be found in Addendum BB of the Medicare ASC FS rule files, with a payment rate given.

3. Annual Update Factor Used for ASCs

Comment: One commenter suggested that DHA should update the Medicare ASC rates for inflation using the hospital market basket update factor for CY 2023, not the CPI-U.

Response: We agree with the commenter that DHA should use the hospital market basket adjusted for productivity update factor for CY 2023, which aligns with Medicare and is practicable to adopt under the TRICARE program. The TRICARE updates will match the method that CMS uses each year to update the Medicare ASC rates. Therefore, we have revised the rule accordingly.

4. Beneficiary Copayment and Cost-share Amounts for ASCs

Comment: One commenter indicated that the proposed rule did not describe cost-sharing for ASC care under the new reimbursement methodology.

Response: TRICARE's cost sharing structure varies by type of service (IP vs OP), type of beneficiary (active duty dependent versus retiree), and by type of enrollment (Prime vs. Select). The cost sharing for ASC care has been established by regulation and the cost sharing structure for ASC care will not be affected by TRICARE's adoption of the Medicare ASC rates. Most active duty family members in Prime pay no cost sharing for ASC care and those enrolled to Select generally pay $25 per surgery. Most retirees and their family members in Prime pay $67 per surgery (in 2022) and most Select enrollees pay 20 percent of the allowed amount for in-network ASC care and 25 percent of the allowed amount for out-of-network ASC care. Given that there will be a reduction in TRICARE allowed amounts under the Medicare ASC rates, most TRICARE retirees enrolled in Select will see reduced cost sharing, another benefit of adopting the new ASC system.

5. Maintain Current Exclusion of CCHs from OPPS

Comment: One commenter stated that the adoption of OPPS reimbursement for CCHs will have an undesirable financial impact on their Children's hospital and other Children's Hospitals that serve large TRICARE populations. Their concerns include that Medicare payments have been historically below cost, and that changes to the TRICARE fee structure,

when combined with Medicare's rates, pose a significant threat to their ability to service military families. The suggestions ranged from continuing to reimburse Children's Hospitals at billed charges or "grandfathering" certain facilities that are in close proximity to military bases that treat a disproportionate share of TRICARE beneficiaries.

Response: DHA agrees that some children's hospitals will have reduced TRICARE payments due to the rule's provisions although DHA's analysis also indicates that some children's hospitals will see large increases in their TRICARE payments.

The proposed rule contained a provision for a General Temporary Military Contingency Payment Adjustment (GTMCPA) which will allow children's hospitals and cancer hospitals that meet certain criteria to receive additional payments for services which will be paid under OPPS. The criteria will not be based on criteria similar to those specified under TRICARE's OPPS for GTMCPAs. These criteria, which have been tailored for CCHs, will include: (1) 10 percent or more of the hospital's revenue is from TRICARE for care of ADSMs/ADDs; (2) the hospital having 10,000 or more TRICARE visits that would fall under the OPPS payment system for ADSMs/ADDs annually; and (3) the hospital being deemed as essential for TRICARE operations. Hospitals that meet these criteria will be eligible to receive up to 115 percent of the hospital's costs for OPPS services. These provisions can be implemented for children's hospitals without jeopardizing access for TRICARE beneficiaries, because of the ability of children's hospitals to apply for a GTMCPA.

6. Transition Period for ASCs

Comment: Several commenters remarked that the lack of a transition period between the current TRICARE ASC reimbursement and the adoption of the Medicare rates may mean that there would be an immediate access to care effect, exacerbated by the abrupt change in fees. One commenter suggested a three year transition period, to allow ASCs time to adjust to the new rates. Another commenter suggested that without a transition, some beneficiaries would be

forced to use higher-cost options, such as hospital outpatient departments, which would reduce DHA's expected savings from adopting the new ASC rates.

Response: DHA is adopting the new ASC reimbursement system to be consistent with Medicare's, as required by statute, which states that TRICARE institutional service payments shall be determined to the extent practicable in accordance with the same reimbursement rules as apply under Medicare. DHA has concluded that it is practicable for TRICARE to adopt Medicare's ASC rates. DHA is not adopting the Medicare ASC rates in order to reduce TRICARE costs. DHA recognizes that there will be both increases and decreases in TRICARE maximum allowed amounts using the Medicare ASC rates. Although DHA expects a decrease in total TRICARE payments for ASCs, DHA also expects that these savings would be reduced if TRICARE beneficiaries increase their use of hospital outpatient departments (HOPDs).

As noted in the proposed rule, DHA considered a transition period but decided against one because the overall impact of the new system is small (for the 40 high-volume, high-cost procedures a reduction of 14 percent) and because there are many ASC procedures that will have rate increases under the new Medicare ASC system (over 40 percent of the high-volume surgeries). In addition, DHA has reviewed carefully Medicare Payment Advisory Committee (MedPAC's) most recent assessment of Medicare's ASC rates. The March 2022 MedPAC report to Congress found that there has been growth in the number of ASCs and that the number of Medicare beneficiaries using ASCs had increased from 2015 to 2019, which MedPAC states are both indicators of adequate access to ASCs. MedPAC also found in its March 2022 report that ASCs had adequate access to capital. As a result, MedPAC concluded that access to ASCs was adequate and that indicators of payment adequacy for ASCs were positive. Given that TRICARE will be adopting the Medicare ASC rates, DHA finds MedPAC's conclusions to be particularly relevant to issues of access and payment adequacy.

DHA also notes that even if some ASCs denied access to TRICARE beneficiaries for some surgeries, TRICARE beneficiaries would be largely protected from access problems because these patients could have their surgeries performed in HOPDs.

One commenter argued that a transition period would allow ASCs a chance to budget for the rate decreases and potential revenue loss. However, since rates will be decreased by a modest amount (14 percent for the 40 high-volume, high-cost surgeries) and because TRICARE beneficiaries are typically a small percentage of ASCs total revenue, as evidenced by the fact that 2019 TRICARE payments to ASCs (approximately $250 M) were less than 5 percent of the 2019 Medicare payments to ASCs ($5.2B), we have determined that a transition is not warranted. The TRICARE updates will match the method that CMS uses each year to update the Medicare ASC rates. In addition, as noted above, the rates for almost half the high-volume ASC surgeries will increase under the Medicare ASC rates. A transition would mean that the full rate increases would not go into effect for a number of years.

7. Exemption of Common Procedural Terminology (CPT) Code 41899 for ASCs

Comment: Several commenters suggested that DHA should maintain CPT code 41899 (unlisted dentoalveolar structures) in the TRICARE ASC fee schedule, even though it is not payable under Medicare's ASC fee schedule. Commenters added that dental procedures are commonly performed on TRICARE beneficiaries and areneeded for TRICARE's pediatric population with special needs, who may require anesthesia when undergoing dental procedures. One commenter expressed concerns that removing CPT code 41899 from the TRICARE ASC fee schedule will result in TRICARE beneficiaries losing access to this code, without providing any explanation.

Response: While DHA intends to adopt Medicare's ASC payment rules, to the extent practicable, we do recognize that in the case of dental care, an exception may be required, as Section 702 of the John Warner National Defense Authorization Act (NDAA) for Fiscal Year 2007 provides that, institutional and anesthesia services may be covered for both hospital and in-

out surgery settings related to dental care for pediatric and certain other patients. Generally, Medicare does not pay for unlisted procedure codes in a freestanding ASC according to 42 CFR 416.166(c), because CMS must ensure that procedures allowed in an ASC are not a safety risk and that a patient would not typically be required to stay overnight or have active medical monitoring. However, we recognize that CPT 41899 is commonly utilized to bill for the facility fees associated with dental care for pediatric and certain other patients, who may require anesthesia during dental procedures. We agree that CPT 41899 is appropriate in an ASC setting and we have added this exception to the ASC list of covered surgical procedures, in accordance with Section 702 of NDAA for Fiscal Year 2007. For covered dental services as defined in § 199.4 of this part , this rule will permit reimbursement for the ASC facility fee for dental procedures that are excluded from Medicare's ASC list, such as CPT 41899 (including subsequent codes, if renumbered or renamed). The TRICARE payment for such covered dental procedures without an ASC rate would be based on the same rate under the TRICARE OPPS. DHA will not maintain a separate ASC list to accommodate this exception; instead the TRICARE contractors will be instructed to reimburse the procedure code at the OPPS rate. This approach ensures access in freestanding facilities while implementing a practicable solution to accommodate the needs of our younger population.

II. Summary of Changes from Proposed Rule

In this final rule, after consideration of public comments, we are revising our proposed rule and adopting the method that CMS uses each year to update the Medicare ASC reimbursement rates to update the TRICARE ASC payment system, instead of specifying a specific method, such as consumer price index for all urban consumers (CPI-U). We are also revising the criteria for CCHs to apply for the GTMCPA. Clarifications have been made regarding DHA's intention to reimburse like Medicare, where practicable.

We are making changes to the ASC provider participation agreement, adding a new "hold harmless" provision under § 199.6(b)(4)(x)(B)(*1*)(*ii*) and (*iii*) that will prohibit ASC facilities

from billing TRICARE beneficiaries for non-covered procedures, unless the beneficiary agreed in advance in writing to pay for the services. The advanced notice would inform TRICARE beneficiaries about potential costs prior to receiving services, which will protect beneficiaries from unintended liability. Incorporating the "hold harmless" provision is appropriate because providers have a responsibility of knowing whether specific services or items are covered, as required by § 199.6(a). Providers seeking authorized provider status and payment from the Federal Government through programs such as TRICARE have a responsibility to familiarize themselves with, and comply with program requirements. Therefore, the provider should be held financially responsible for failing to properly inform TRICARE beneficiaries about patient costs before services are rendered. While the ASC facility charges would be denied, the professional charges for the non-ASC procedure or service could potentially be reimbursed.

Corrections have been made to the regulations text at § 199.14(a)(6)(ii) to reflect the current version of the regulation, because the proposed rule used an older version. Therefore, we are only revising the current version of § 199.14(a)(6)(ii)(A) to specifically include CCHs as being added to the OPPS controlled reimbursements, as they have been excluded to date.; we are revising § 199.14(a)(6)(ii)(E) to specifically exclude CCHs from the any Temporary Transitional Payment Adjustments (TTPAs) under § 199.14(a)(6)(ii)(E)(*1*) and (*2*); we are revising § 199.14(a)(6)(ii)(E)(*3*) to specifically name the additional available military contingency payment adjustment as a "general temporary military contingency payment adjustment (GTMCPA)" to further distinguish it from the TTPAs, and have added specific criteria for CCHs to qualify for GTMCPA; and, we are inserting a new § 199.14(a)(6)(ii))(E)(*4*) which provides CCHs with annual hold-harmless adjustments to OPPS payments. Finally, we have permitted a limited exception to allow payment for covered dental care by revising § 199.14(d) to address how

covered dental procedures will be reimbursed in the absence of a Medicare ASC payment rate. All other aspects of the proposed rule remained the same.

III. Executive Summary

A. Purpose of the Final Rule

The purpose of this rule is to finalize TRICARE regulation modifications necessary to implement for Ambulatory Surgery Centers (ASC) and Cancer and Children's Hospitals (CCHs) the statutory requirement that payments for TRICARE institutional services "shall be determined to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under [Medicare]." Although Medicare's reimbursement methods for ASC and CCHs are different, it is prudent to finalize adopting both the Medicare ASC system and the Outpatient Prospective Payment System (OPPS) with hold-harmless adjustments (meaning the provider is not reimbursed less than their costs) for CCHs simultaneously to align with our statutory requirement to reimburse like Medicare at the same time. This rule sets forth the regulatory modifications necessary to implement TRICARE reimbursement methodologies similar to those applicable to Medicare beneficiaries for outpatient services rendered in ASCs and cancer and children's hospitals.

1. TRICARE is adopting the Medicare reimbursement methodology for ASCs. Currently, TRICARE reimburses surgical services performed in TRICARE authorized ambulatory surgery settings (i.e., freestanding ASCs and other TRICARE providers exempt from the TRICARE OPPS reimbursement methodology including cancer and children's hospitals) institutional facility costs on the basis of prospectively determined amounts, in accordance with 32 Code of Federal Regulations (CFR) 199.14(d). The current system was modeled after Medicare's previous ASC reimbursement system. TRICARE's current reimbursement system for services provided in these ambulatory surgery settings is based on Medicare's retired system, and is difficult to update. Adoption of Medicare's ASC reimbursement system will bring TRICARE reimbursement for ambulatory surgery care into alignment with the statutory

requirement that payment methods for institutional care be, to the extent practicable, in accordance with the same reimbursement rules used by Medicare.

2. TRICARE is adopting the Medicare payment methodology for outpatient services provided in CCHs. In a final rule, published December 10, 2008, (73 FR 74945-74966), TRICARE adopted Medicare's payment methodology for outpatient hospital services–the Outpatient Prospective Payment System (OPPS). Under Medicare, CCHs were held harmless and were paid the full amount of the decrease they experienced (as prior to OPPS the hospital had been paid 100 percent of their costs) after the implementation of OPPS, under section 1833(t) (7) of the Social Security Act. These payments are transitional outpatient payments (TOPs). Because of the complexity and because of the administrative burden/expense of calculating and maintaining the TOPs, TRICARE opted to totally exempt CCHs from OPPS initially. The agency is now revisiting the exemption of CCHs from OPPS. In this final rule, TRICARE is adopting the Medicare methodology for reimbursement of outpatient facility services (including ambulatory surgery) rendered in a cancer or children's hospital, with modifications to address the administrative burden and complexity. The DHA now has the capability, and it is feasible, to adopt these reimbursement provisions with a modification that the hold-harmless provisions will be calculated and paid annually, rather than in monthly interim payments.

B. Summary of the Major Provisions of the Final Rule

1. *Adopting Medicare's Ambulatory Surgical Center Reimbursement System for TRICARE Authorized Ambulatory Surgery Centers.* Per Title 10 United States Code (U.S.C.), section 1079(i) (2), TRICARE's payment methods for institutional care shall be determined, to the extent practicable, in accordance with the same reimbursement rules used by Medicare. Under this final rule, TRICARE will reimburse ASCs for ambulatory surgical services using a method similar to Medicare's ASC reimbursement methodology. Under the TRICARE ASC

reimbursement method, payment for a TRICARE patient will be made at the lower of the billed charge or the Medicare-determined ASC payment rate with applicable TRICARE cost-sharing provisions. The TRICARE ASC reimbursement method would include payment for all facility services associated with the surgical procedure that are included in the payment methodology by Medicare, but would exclude certain services also excluded by Medicare under the ASC reimbursement methodology (e.g., certain ancillary services and implantable devices with pass-through status).

2. *Adopting Medicare's Outpatient Prospective Payment System (OPPS) for Cancer and Children's Hospitals.* In a final rule, dated December 10, 2008 (73 FR 74945-74966), TRICARE adopted Medicare's payment methodology for outpatient hospital services–the outpatient prospective payment system (OPPS). Under Medicare, CCHs were held harmless and were paid the full amount of the decrease they experienced after the implementation of OPPS, under section 1833(t) (7) of the Social Security Act. These payments are transitional outpatient payments (TOPs). Because of the complexity and because of the administrative burden/expense of calculating and maintaining the TOPs, TRICARE opted to totally exempt CCHs from the TRICARE OPPS reimbursement methodology initially.

Ten years after the implementation of OPPS, the agency is now revisiting the exemption of cancer and children's hospitals from OPPS. This final rule with comment period finalizes the adoption of the Medicare methodology for reimbursement of outpatient facility services rendered in a cancer or children's hospital, with modifications to address the administrative burden and complexity that initially led the agency to exclude these facilities from OPPS. DHA now has the capability, and it is feasible, to adopt Medicare's reimbursement provisions with two modifications: (1) that the hold-harmless provisions will be calculated annually, rather than in monthly interim payments; and (2) that the agency will use the hospital's cost-to-charge ratio (CCR) rather than the payment-to-cost ratio. With adoption of OPPS for cancer and children's

hospitals, these institutions will no longer be considered TRICARE ambulatory surgery sites for application of the TRICARE ASC reimbursement methodology.

3. *Transition Period.* When implementing the ASC fee schedule, Medicare included a four-year transition which blended the payment rates of the old methodology with the new for those procedures that were paid under both methods. We evaluated the feasibility of including a similar transition, where, the TRICARE-allowed amount would be 75 percent of the old rate and 25 percent of the new rate in year one; 50 percent of the old rate and 50 percent of the new rate in year two; and 25 percent of the old rate and 75 percent of the new rate in year three. In the fourth year the rate would be 100 percent of the new rate. However, many of the services reimbursed under TRICARE's current ASC reimbursement methodology have lower rates under Medicare, so providers would have to wait for higher reimbursements under the new system. Therefore, we are finalizing a no transition period for the implementation of the ASC reimbursement system. Some providers may see substantialincreases in reimbursement, and a transition period would not be beneficial for these providers. Additionally, because alternative locations are available for these services (e.g., Hospital Outpatient Departments), concerns regarding access to care are unfounded.

Similarly, we are finalizing no transition period for cancer and children's hospitals, with the rationale that providers will be held harmless under this reimbursement system. CCHs will receive, at a minimum, one hundred percent of their costs, or the OPPS payment, whichever is higher. Because many CCH providers will receive payment increases, a transition period would not be beneficial for them.

C. Costs and Benefits

Although this rule will be effective near fiscal year 2024, the overall economic impact of the rule is estimated based on an analysis of expected outcomes had the rule been implemented

during calendar year (CY) 2021. Such analysis may be used to provide a reasonable estimate of future economic impact.

The economic impact of adopting Medicare's payment methodology for ASCs is anticipated to result in total cost-savings to the DoD of approximately $ 10 million for CY 2021.

The economic impact of the proposal to adopt OPPS for CCHs, including the hold harmless provisions will be reduced payments to these providers of approximately $35 million per year if implemented in 2021.

We estimate that the effects of the provisions that would be implemented by this final rule would have an impact of increased cost-savings to the DoD of approximately $45 million, offset by an estimate $1.5 million in administrative costs to implement these changes.

II. Introduction and Background

1. TRICARE ASC PPS Reimbursement

A. Reimbursement

Medicare replaced their previous ASC system on January 1, 2008. Medicare's reimbursement system for ASCs uses OPPS relative payment rates as a guide. OPPS rates are reduced by a factor to account for the fact that ASCs have lower overhead costs than hospitals. In 2012, Medicare's ASC rates averaged 61 percent of the OPPS rates paid to acute care hospitals for surgical procedures. Under Medicare, ASCs are paid the lesser of the billed charge or the standard ASC reimbursement rate, a method which we are finalizing under the TRICARE program.

Under Medicare, the standard payment rate for ASC covered surgical procedures is calculated as the product of the ASC conversion factor and the ASC relative payment weight for each separately payable procedure or service. Payments are then geographically adjusted using wage-index values. Payments may also be adjusted for multiple surgical procedures or when surgical procedures are started and then discontinued.

Like Medicare, we are finalizing our approach to make a single payment to ASCs for covered procedures, which includes the facility services furnished in connection with the covered procedure (e.g., nursing services, certain drugs, surgical dressings, and administrative services). We are also finalizing our approach to separately reimburse for ancillary services that are integral to a covered service (e.g., drugs and biologicals that are separately paid under OPPS; radiology services that are separately paid under OPPS; brachytherapy services; implantable devices with OPPS pass-through status; and corneal tissue acquisition), similar to Medicare. The TRICARE ASC payment system will not reimburse for services of individual professional providers, Durable Medical Equipment (DME), non-implantable prosthetics, ambulance services, or independent laboratory services. These services will be reimbursed using other payment systems, which include the CMAC, Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) Fee Schedule and the Ambulance Fee Schedule. If there is no payment rate under the ASC reimbursement system for services that are medical in nature (such as office visits and diagnostic tests), the ASC will be reimbursed as though services were furnished in a physician's office utilizing the TRICARE CMAC methodology, with no additional payment for facility charges.

B. Definition and requirements for Ambulatory Surgery Centers

This regulatory action finalizes a definition for ASCs, which will mirror Medicare's, with exceptions made for TRICARE's pediatric patients. Medicare defines an ASC as, "a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients"; in this action we are finalizing our proposal to adopt a definition at 32 CFR 199.2 that defines ASCs as those that meet the definition of an ASC under 42 CFR 416.2, including the requirement that they must participate in Medicare as ASCs per 42 CFR 416.25, with exceptions for ASCs that do not have an agreement with Medicare due to the specialty populations they serve. Medicare also requires the provider to have an agreement with CMS; we are finalizing as proposed that in lieu of separate certification by TRICARE, the ASC will simply provide

evidence of a valid agreement with Medicare. While the terms of the agreement with Medicare will not apply to TRICARE, only those providers with an agreement with Medicare (or those providers that meet certain exceptions as noted below), are eligible for reimbursement for ambulatory surgery services provided in ASCs. We are finalizing our approach to accept Medicare's determination of a facility as an ASC. If the facility meets the definition of an ASC at 42 CFR 416.2 and has an agreement with Medicare as an ASC, they will be considered a TRICARE authorized ASC and subject to all requirements for authorized institutional provider status under 32 CFR 199.6. ASCs must also enter into a participation agreement with TRICARE, to ensure that the ASC accepts the TRICARE reimbursement rate, and meets all other conditions of coverage. Additionally, due to the differences between the TRICARE and Medicare populations, there may be ASCs that specifically serve pediatric populations. As such, these ASCs may not routinely enter into agreements with Medicare. Therefore, we are finalizing the proposal to allow certain pediatric ASCs without a valid Medicare participation agreement to be eligible for reimbursement under TRICARE's ASC system, when such facilities are accredited by the Joint Commission, the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), or other accrediting body as authorized by the Director, DHA and published in the implementing instructions. Additionally, the ASC must enter into a participation agreement with TRICARE to receive reimbursement for covered services provided to TRICARE beneficiaries. This provision will not negatively affect access to care, as ambulatory surgery services are also available in hospital outpatient departments. The flexibility offered to pediatric specialty ASCs is sufficient to serve the unique needs of our patient population, while still ensuring the program complies with the requirements of 10 U.S.C. 1079(i). TRICARE-authorized pediatric ASCs will be subject to the same reimbursement system as finalized in this regulatory action.

Section 32 CFR 199.6(b)(4)(x)(B)(*1*) currently includes specific requirements for ambulatory surgery centers. With this regulatory action, we are changing the regulations text at §

199.6(b)(4)(x)(B)(*1*) to state that ASCs participating in Medicare meet all program requirements to be an authorized TRICARE provider. However, for ASCs that do not participate in Medicare (due to the specialized nature of the patients they treat, i.e., pediatric patients) but are otherwise accredited by an accrediting body as approved by the Director, DHA, must continue to meet all the requirements stated. All ASCs must also enter into participation agreements with TRICARE.

C. Ambulatory Surgical Center Services List

Medicare identifies and maintains a list of surgical procedures that may be performed in an ASC. This list is updated at least annually by Medicare. The ASC list of covered procedures indicates those procedures which are covered and paid for if performed in the ASC setting. The ASC list is comprised of those surgical procedures that CMS has determined do not pose a significant safety risk and are not expected to require an overnight stay following the surgical procedure. Procedures on the Medicare Hospital Outpatient Prospective Payment System (HOPPS) inpatient-only list (42 CFR 419.22(n)) are not eligible for designation and coverage as ASC surgical procedures. Procedures that are reported utilizing unlisted category I Current Procedural Technology® codes are also excluded from the ASC list. TRICARE is adopting the Medicare ASC List, in its entirety, including any updates made by Medicare to the list in the future, without any deviations (except for certain covered dental procedures) from the ASC List, as maintained and updated by CMS. No separate TRICARE ASC list would be maintained; the TRICARE program would rely upon CMS's determinations regarding those procedures determined to be appropriate in an ASC setting. The maintenance of a separate ASC List for TRICARE is unnecessary as adoption of Medicare's list is practicable, and maintenance of a separate list would be extremely complex for the agency and providers to review, maintain, and update. We invited comments on this approach, especially from facilities that specialize in care for young adult, pediatric, and other specialized populations not routinely covered by Medicare. We reviewed procedures that would commonly be performed on pediatric patients and found that these were generally included on the Medicare ASC list. These procedures included:

adenoidectomy; myringotomy; nasal endoscopy; tonsillectomy; circumcision; inguinal and umbilical hernia repair; eye muscle repair; syndactyly repair; and hypospadias repair. Fowler-Stephens Orchiopexy is not listed on Medicare's ASC list, but is priced in OPPS.

If an ASC provides a surgical service not listed as covered on Medicare's ASC list, except for certain dental procedures, we are finalizing our proposal to deny the ASC facility charges, similar to Medicare. However, related professional services may be reimbursed utilizing TRICARE's allowable charge methodology. TRICARE finalizes the adoption of the Medicare requirement that facility charges may be reimbursed for only those services on the "ASC List." We are confident that there will be no access to care concerns with this approach, as surgical care continues to be available in hospital outpatient departments, and in inpatient settings, as appropriate. However, we are allowing an exception to this list for dental procedures covered under § 199.4 of this part, as Section 702 of the NDAA for Fiscal Year 2007 provides that, institutional and anesthesia services may be covered for both hospital and in-out surgery settings related to dental care for pediatric and certain other patients. In the case that a dental procedure is performed and the procedure is not listed as covered on Medicare's ASC list (e.g., CPT Code 41899), the TRICARE contractors may make payment for that procedure at the OPPS rate. For example, CPT 41899 under OPPS is currently assigned to ambulatory payment classification (APC) 5161, which has a CY 2022 base-rate of $216; therefore, TRICARE's payment in an ASC setting would also be $216.

D. Services Included in the ASC Payment

We are finalizing as proposed that, like Medicare, the following items currently fall within the scope of ASC facility services. Future modifications made by Medicare to the services included in the ASC payment will be adopted by TRICARE in the implementing instructions. ASCs must incorporate charges for packaged services into the charges reported for the separately payable services with which they are provided to ensure appropriate payment.

Covered ASC facility services include:

(1) Nursing, technician, and related services;

(2) Use of the facility where the surgical procedures are performed;

(3) Any laboratory testing performed under a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver;

(4) Drugs and biologicals for which separate payment is not allowed under the hospital outpatient prospective payment system (OPPS);

(5) Medical and surgical supplies not on pass-through status under subpart G of 42 CFR part 419;

(6) Equipment;

(7) Surgical dressings;

(8) Implanted prosthetic devices, including intraocular lenses (IOLs), and related accessories and supplies not on pass-through status under subpart G of 42 CFR part 419;

(9) Implanted DME and related accessories and supplies not on pass-through status under subpart G of 42 CFR part 419;

(10) Splints and casts and related devices;

(11) Radiology services for which separate payment is not allowed under the OPPS, and other diagnostic tests or interpretive services that are integral to a surgical procedure;

(12) Administrative, recordkeeping and housekeeping items and services;

(13) Materials, including supplies and equipment for the administration and monitoring of anesthesia; and

(14) Supervision of the services of an anesthetist by the operating surgeon.

CMS may make further changes and refinements to the items included within the ASC reimbursement system. TRICARE will adopt all future modifications and refinements to this system made by CMS, unless found to be impracticable, as approved by the Director, DHA.

E. Covered Ancillary Items and Services

We are finalizing our approach to allow separate payment for covered ancillary items and services that are integral to a covered surgical procedure, consistent with Medicare. CMS defines these services at 42 CFR 416.61.

CMS may make further changes and refinements to the ancillary services that are paid separately within this reimbursement system. TRICARE will adopt all future modifications and refinements to this system made by CMS, unless found to be impracticable, as approved by the Director, DHA.

F. Surgical Dressings, Supplies, Splints, Casts, Appliances, and Equipment

We are finalizing our approach that the TRICARE payment for surgical dressings, supplies, splints, casts, appliances, and equipment (e.g., gowns, masks) will mirror Medicare's payment. Currently, these items are included in the payment for the surgical procedure. TRICARE will adopt all future modifications and refinements to the payment for these supplies and equipment provided in ASCs, as made by CMS, unless found to be impracticable, as approved by the Director, DHA.

G. Drugs and Biologicals

ASC facility payment for a surgical procedure includes payment for drugs and biologicals that are usually not self-administered and that are considered to be packaged into the payment for the surgical procedure under OPPS. Similar to Medicare, we are finalizing our approach to allow separate payment to ASCs for drugs and biologicals that are furnished integral to an ASC covered surgical procedure and that are separately payable under OPPS, as defined by Medicare. TRICARE will adopt all future modifications and refinements to the payment for drugs and biologicals provided in ASCs, as made by CMS, unless found to be impracticable, as approved by the Director, DHA.

H. Diagnostic and Therapeutic Items

Simple diagnostic tests that are generally included in facility charges may be considered facility services (e.g., urinalysis, hematocrit levels). Diagnostic tests performed by the ASC other than those generally included in the facility's charge are not covered by this reimbursement system. ASCs with laboratories certified as independent laboratories under Medicare may bill for tests, or alternatively, the ASC may make arrangements with an independent laboratory or other laboratory to perform the diagnostic tests it requires prior to surgery. Payment for these diagnostic and therapeutic items will be made under the existing provisions of 32 CFR 199.14. TRICARE will adopt all future modifications and refinements to the payment for diagnostic and therapeutic items provided in ASCs, as made by CMS, unless found to be impracticable, as approved by the Director, DHA.

I. Blood and Blood Products

We are finalizing our approach that these items will be considered a facility service and no separate reimbursement will be made, similar to Medicare. TRICARE will adopt all future modifications and refinements to the payment for these blood and blood products provided in ASCs, as made by CMS, unless found to be impracticable, as approved by the Director, DHA.

J. Anesthesia

We are finalizing as proposed that anesthetic agents that are not paid separately under OPPS, as well as materials necessary for administration will be included in the facility payment. TRICARE will adopt all future modifications and refinements to the payment for anesthesia provided in ASCs, as made by CMS, unless found to be impracticable, as approved by the Director, DHA.

K. Implantable Durable Medical Equipment

We are finalizing our approach that the payment for implantable DME will be included in the payment for the covered surgical procedure, with the exception of OPPS pass-through devices which are paid separately. TRICARE will adopt all future modifications and refinements to the

payment for implanted DME provided in ASCs, as made by CMS, unless found to be impracticable, as approved by the Director, DHA.

L. Intraocular Lenses (IOL) and New Technology IOLs (NTIOL)

This final rule finalizes the adoption of Medicare's payment provisions for IOLs and NTIOLs provided during or subsequent to cataract surgery in ASCs. As such, the payment for IOLs will be included in the ASC payment for the associated surgical procedure, except for NTIOLs designated by Medicare, and covered by TRICARE. NTIOLs may be subject to a payment adjustment, as determined by Medicare, and adopted by TRICARE. TRICARE will adopt all future modifications and refinements to the payment for IOLs and NTIOLs provided in ASCs, as made by CMS, unless found to be impracticable, as approved by the Director, DHA.

M. Payment for ASC Facility Services

We are finalizing our approach to make a single payment to ASCs for covered procedures, which will include the facility services furnished in connection with the covered procedure (e.g., nursing services, certain drugs, surgical dressings, and administrative services), when the services are rendered by a provider described in the finalized definition of an ASC in 32 CFR 199.2. This payment will be the lower of the ASC payment rate or the billed charge. We are finalizing our approach to adopt the Medicare ASC payment rates, without making any TRICARE-specific adjustments or modifications to Medicare rates.

We are finalizing our approach to allow separate payment for ancillary services that are integral to a covered service (e.g., drugs and biologicals that are separately paid under OPPS; radiology services that are separately paid under OPPS; brachytherapy services; implantable devices with OPPS pass-through status; and corneal tissue acquisition). Like OPPS, payment under this system will not include reimbursement for services of individual professional providers, DME, non-implantable prosthetics, ambulance services, or independent laboratory services. These services will be reimbursed using other payment systems like the Medicare

Physician Fee Schedule (similar to CHAMPUS Maximum Allowable Charges, or CMAC), DMEPOS Fee Schedule, and the Ambulance Fee Schedule.

We are also finalizing our proposal that covered ancillary services (including OPPS pass-through devices) that are contractor-priced under Medicare's ASC reimbursement system will be priced under TRICARE utilizing the allowable charge methodology for procedures paid outside of the OPPS under 32 CFR 199.14(j)(1).

Some items are paid the same amount in ASCs as they are paid under OPPS. These items include drugs and biologicals paid separately under OPPS when they are integral to covered surgical procedures and brachytherapy sources where prospective rates are available. Corneal tissue acquisition payment is based on acquisition cost or invoice.

The actual payment to ASCs requires a comparison between billed charges and the ASC payment rate for each separately payable procedure and service. Reimbursement is based on the lower of the ASC payment rate or the billed charge. Ancillary services should be billed on the same claim as the related ASC procedure. Should Medicare modify this process in the future, TRICARE will adopt all modifications, unless deemed to be impracticable, as approved by the Director, DHA.

N. Wage Adjustments and Labor Share

We are finalizing as proposed that the labor related adjustments to the ASC payment rates will be based on Medicare's methodology, currently the Core-Based Statistical Area methodology. The adjustment for geographic wage variation will be made based on a 50 percent labor share, subject to change by CMS. There is no adjustment for geographic wage differences for: corneal tissue acquisition; drugs and devices with pass-through status under OPPS; brachytherapy sources; payment adjustment for NTIOLs; and separately payable drugs and biologicals. We are adopting this methodology, as well as any future refinements or adjustments made by Medicare to the labor-related share, the items and services subject to wage adjustments,

and the methodology by which wage adjustments are made, unless determined to be impracticable by the Director, DHA.

O. Annual Adjustments

Since CY 2012, Medicare has applied an annual update to ASC payments based on the CPI-U reduced by the productivity adjustment. The proposed rule planned to adopt these annual updates. However, effective for CY 2019 through CY 2023, Medicare adopted the hospital market basket update reduced by the productivity adjustment to update ASC payments. DHA will adopt the update factors used in the Medicare ASC rates each year.

P. Payment for Terminated Procedures

This final rule with comment period finalizes the adoption of Medicare's payment provisions for terminated procedures, as well as the adoption of all future refinements and adjustments. Currently, this process is as follows:

1. Payment will be denied when an ASC submits a claim for a procedure that is terminated before the patient is taken into the treatment or operating room.
2. Payment will be made at 50 percent of the rate if a surgical procedure is terminated due to the onset of medical complications after the patient has been prepared for surgery and taken to the operating room but before anesthesia has been induced or the procedure initiated.
3. Full payment will be made for a surgical procedure if a medical complication arises which causes the procedure to be terminated after anesthesia has been induced or the procedure initiated.

Q. Payment for Multiple Procedures

We are finalizing the adoption of Medicare's payment provisions for multiple procedures, as well as the adoption of all future refinements and adjustments. When multiple procedures are performed in the same operative session that are subject to the multiple procedure discount, 100 percent of the highest paying surgical procedure on the claim is paid, plus 50 percent of the

applicable payment rates for the other ASC covered surgical services. In determining the ranking of the procedures for the discounting, the lower of the billed charge or the ASC payment amount will be used.

R. Offset for Payment for Pass-through Devices

The ASC payment may be reduced for certain procedures when provided in conjunction with a specific pass-through device. We are finalizing our proposal to adopt this methodology, and accept the code pairs as assigned and updated by CMS, as well as any other future refinements or adjustments to this methodology.

S. Payment for Devices Furnished with no Cost or Full or Partial Credit

Reduced payments are made for certain procedures when a specified device is furnished without cost or for which either a partial or full credit is received (e.g., device recall). We are finalizing as proposed to adopt this methodology as well as any other future refinements or adjustments to this methodology.

T. Payment for Non-ASC Services

ASCs may furnish and be paid under alternate established reimbursement methodologies for services not considered ASC facility services. For example, ASCs may be reimbursed the CMAC rate for a physician office visit; facility charges are not allowed. If there is no ASC payment for services that are medical in nature (such as office visits and diagnostic tests), the ASC is reimbursed as though the service was performed in a physician's office, with no additional payment for facility charges. Surgical services that do not have an established reimbursement rate under this system may not be reimbursed in an ASC setting.

U. Transitions

We are finalizing as proposed, no transition period, since many providers will see increases in payments under this reimbursement methodology.

V. ASC Quality Report Program and Value Based Purchasing

Medicare utilizes the ASC Quality Reporting program (ASCQR), under which ASCs must submit data on quality measures to receive the full payment update each year. ASCs that do not submit the required data have their payment update reduced by 2 percent. Performance on these measures does not impact ASC payments. For 2016, the measures included:

- ASC-1 Patient Burn
- ASC-2 Patient Fall
- ASC-3 Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant
- ASC-4 Hospital Transfer/Admission
- ASC-5 Prophylactic Intravenous (IV) Antibiotic Timing
- ASC-6 Safe Surgery Checklist Use
- ASC-7 ASC Facility Volume Data on Selected ASC Surgical Procedures
- ASC-8 Influenza Vaccination Coverage among Healthcare Personnel

Medicare contracts with outside entities to collect this quality data. Because the TRICARE program represents a small fraction of the ASC services rendered as a whole, we are finalizing our proposal to provide the full ASC update to all ASCs, regardless of whether they report quality data. Collecting information regarding which ASCs report quality data and which do not, and building that information into the reimbursement system in a timely manner will be impracticable for the program. However, TRICARE may utilize this data, which is publicly reported at data.medicare.gov, for future initiatives related to reimbursement for ASCs. The ASCQR may lead to a value based purchasing (VBP) program for ASCs in the future; however, there were no specific proposals in Medicare's most recent ASC final rule (2016). TRICARE will adopt reimbursement modifications to the ASC reimbursement system related to VBP, if determined to be practicable by the Director, DHA. Such changes will be incorporated into the implementing instructions, as appropriate.

2. Adopt Medicare's Payment Methodology for Outpatient Services Provided in Cancer and Children's Hospitals

A. Reimbursement

This final rule implements the adoption of Medicare's reimbursement methodology for outpatient services rendered in cancer and children's hospitals, with modifications made due to the administrative complexity of the Medicare system, as well as finalizes a combined OPPS and cost-reimbursement system. We are finalizing as proposed to pay these hospitals under TRICARE's existing OPPS, and then reimburse the hospitals the higher of the OPPS payment or one hundred percent of the hospital-specific costs for those same services, based on the hospital-specific outpatient cost to charge ratio (CCR), through an annual adjustment. We are also finalizing as proposed to change the regulations text at § 32 CFR 199.14(a)(6) to include cancer and children's hospitals as providers subject to OPPS, and will further describe how these providers will be held harmless under the finalized methodology.

B. Hospitals Subject to this Proposed Reimbursement System

We are finalizing our proposal that cancer and children's hospitals that were specifically excluded in TRICARE's OPPS final rule at 73 FR 74945, and are currently held harmless from OPPS under Medicare, will be subject to the provisions of this final rule.

C. Transitional Outpatient Payments

While Medicare provides reimbursement through TOPs for the difference between OPPS and hospital-specific costs on a monthly basis, we are finalizing our approach to make these payments on an annual basis. This approach reduces the administrative complexity of the system and makes the system practicable to adopt for TRICARE's comparatively smaller beneficiary population. A precedent can be found in TRICARE's implementation of the reimbursement system for SCHs; the TRICARE contractors perform a year-end comparison of the primary methodology with the Diagnosis Related Group (DRG)-based payment methodology, and

provide reimbursement where the DRG-based payment amount would have been higher than the primary methodology.

Additionally, Medicare holds CCHs harmless by calculating their pre-Balanced Budget Act (BBA) amount. The pre-BBA amount is an estimate of what the provider would have been paid during the CY for the same services under the Medicare system that was in effect prior to OPPS. This amount is calculated by multiplying the provider's payment-to-cost ratio (PCR), based on the provider's base year cost report (generally CY 1996), times the reasonable costs the provider incurred during a calendar year to furnish the services that were paid under the OPPS. However, we are finalizing as proposed to simply hold the hospital harmless based on their costs; with costs defined as the product of multiplying the hospital's total charges for covered OPPS services for a twelve-month period by the hospital-specific outpatient CCR. This modification still holds the hospital harmless and ensures payment at costs, and is also practicable to adopt for TRICARE's comparatively smaller beneficiary population, and addresses issues of administrative complexity which led the agency to exempt CCHs in the original implementation of OPPS. Additionally, for cancer hospitals, Medicare has adopted an additional adjustment, mandated by the Patient Protection and Affordable Care Act (PPACA), which applied an additional payment adjustment to account for higher costs incurred by cancer hospitals. Because TRICARE is not subject to the PPACA and due to the administrative complexity of the calculation, we are not adopting this additional adjustment to adjust for the average payment-to-cost ratio for cancer hospitals.

For cancer and children's hospitals, we are finalizing the annual process as follows:

Step One: Identify the costs of the hospital by multiplying the total billed charges for OPPS services on claims paid during the 12-month period by the most-recent hospital-specific outpatient CCR.

Step Two: Add together total TRICARE payments, cost-shares, and deductibles applied for all Ambulatory Payment Classifications (APCs), as well as outlier payments and transitional pass-through payments for drugs, biologicals and/or devices for those same claims paid during the year as those in Step One. If the result of Step 2 is greater than Step 1, no payment is warranted because the hospital was reimbursed more from OPPS than their costs. If the result of Step 2 (OPPS payments) is less than Step 1 (hospital's costs), the hospital will be issued a payment equal to 100% of the difference between the hospital's costs and actual payments.

Adjustments may be made in subsequent years for claims not processed to completion. The implementing instructions will contain the full instructions for calculation and payment of hold-harmless payments.

D. Transitions

We are finalizing as proposed, no transition period, as providers will be held harmless. Generally transitions are performed when providers may be exposed to payments that are below their costs; however, through the annual adjustments, providers are assured that they will receive reimbursements for their costs.

E. General Temporary Military Contingency Payment Adjustments (GTMCPA)

Under this system, at the discretion of the Director, DHA, CCHs may be eligible for GTMCPAs that will ensure network adequacy during military contingency operations, in accordance with the implementing instructions issued by the Director, DHA. These GTMCPAs will be issued in the same manner as those that are made currently under TRICARE's OPPS.

The criteria for applying for the GTMCPA, which have been tailored for CCHs, will include: (1) 10 percent or more of the hospital's revenue is from TRICARE for care of ADSMs/ADDs; (2) having 10,000 or more TRICARE visits that would fall under the OPPS payment system for ADSMs/ADDs annually; and (3) being deemed as essential for TRICARE

operations. Hospitals that meet these criteria will be eligible to receive up to 115 percent of the hospital's costs for OPPS services.

III. Regulatory Analyses for ASCs, Cancer, and Children's Hospitals

Executive Order 12866 and Executive Order 13563

A. Overall Impact

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

1. Executive Order 12866 and Executive Order 13563

Executive Orders 12866 and 13563 direct agencies to assess the 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). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This rule has been designated as a "not significant" regulatory action, and not economically significant, under section 3(f) of Executive Order 12866. Accordingly, the rule has not been reviewed by the Office of Management and Budget (OMB) under the requirements of these Executive Orders.

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 not a major rule under the Congressional Review Act.

3. Regulatory Flexibility Act (RFA)

The RFA requires agencies to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. For purposes of the RFA, hospitals are considered to be small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) identification of a small business (having revenues of $41.5 million or less in any one year). Likewise, the vast majority of ASCs are considered small businesses according to the SBA's size standards of having total revenues of $16.5 million or less in any one year. For purposes of the RFA, we have determined that 70 percent of ASCs would be considered small entities according to the SBA size standards. We have also determined that 100 percent of CCHs would be considered small entities under the RFA definition because they qualify as a nonprofit organization or governmental jurisdiction, even though almost all have revenues above the $41.5 million SBA size standard. Therefore, the Assistant Secretary of Defense for Health Affairs certifies this final rule would have a significant impact on a substantial number of small entities. The Regulatory Flexibility Analysis is included in the preamble of this rule.

4. Unfunded Mandates

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any one year of $100 million in 1995 dollars, updated annually for inflation. Currently, that threshold level is approximately $140 million. This final rule will not mandate any requirements for State, local, or tribal governments or the private sector.

5. Paperwork Reduction Act

This rule will not impose significant additional information collection requirements on the public under the Paperwork Reduction Act of 1995 (44 U.S.C. 3502-3511). Existing information collection requirements of the TRICARE and Medicare programs will be utilized. We do not anticipate any increased costs to hospitals because of paperwork, billing, or software

requirements since we are adopting Medicare's methodologies with which the ASCs and hospitals are already familiar.

6. Executive Order 13132, "Federalism"

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

7. Executive Order 13175, "Consultation and Coordination with Indian Tribal Governments"

It has been determined that this rule does not have a substantial effect on Indian tribal governments. This rule does not impose substantial direct compliance costs on one or more Indian tribes, preempt tribal law, or effect the distribution of power and responsibilities between the federal government and Indian tribes.

B. Entities Included in and Excluded from the Proposed Reimbursement Methodologies

The TRICARE ASC reimbursement system encompasses all ASCs that meet Medicare's definition of an ASC with a Medicare agreement, and those ASCs that due to the nature of the population they serve (i.e., pediatric patients) do not have a Medicare agreement but are otherwise accredited by an accrediting body as approved by the Director, DHA. The TRICARE OPPS reimbursement system encompasses all Medicare-classified cancer and children's hospitals that are also authorized for TRICARE except for hospitals in States that are paid by Medicare and TRICARE under a waiver that exempts them from Medicare's or TRICARE's OPPS, respectively. Currently, only Maryland hospitals operate under such a waiver.

C. Analysis of the Impact of Policy Changes on Payment for ASCs and CCHS, and Alternatives Considered

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

1. Alternatives Considered for the reimbursement of ASCs

This final rule with comment period finalizes paying ASCs on the basis of the Medicare ASC fee schedule, with no exceptions to the list of procedures considered appropriate by Medicare to be performed in an ASC. This approach was adopted because TRICARE is statutorily obligated to pay like Medicare where practicable. Medicare covers approximately 3,400 procedures under the ASC payment system. The ASC list is comprised of those surgical procedures that CMS has determined do not pose a significant safety risk and are not expected to require an overnight stay following the surgical procedure. We anticipate no impact to access to care by adopting Medicare's approach.

We have also determined that no transition period is necessary. First, as we have noted earlier, historically transitions are done to protect providers from payments below their costs. However, in this case, while revenues would decrease for some providers, some providers may see increases in reimbursement, and a transition period would not be beneficial for these providers. Second, because alternative locations are available for these services (Hospital Outpatient Departments), concerns regarding access to care are unfounded. Third, TRICARE payments to ASCs will be equal to Medicare's. The Medicare Payment Advisory Committee (MedPAC) is an independent congressional agency which advises the U.S. Congress on issues affecting the Medicare program. MedPAC's "March 2022 Report To Congress: Medicare Payment Policy", indicates that available indicators of payment adequacy for ASC services are generally positive. Fourth, the number of outpatient surgeries performed in ASCs under TRICARE is very small in comparison to Medicare and the industry. If TRICARE had the Medicare reimbursement system in place during CY 2019, TRICARE would have spent approximately $250 million on ASC services. In contrast, ASCs received over $5.2 billion in Medicare payments and beneficiaries' cost sharing in 2019. In aggregate, the TRICARE ASC

claims are a very small percentage of the industry's claims, so the change to reimbursement in the aggregate, is small. Finally, the 2022 MedPAC report determined that there was sufficient access to ASCs by Medicare beneficiaries, as evidenced by the continued growth and expansion of ASCs. Given that TRICARE ASC rates will be equal to Medicare ASC rates, we do not anticipate access problems for TRICARE beneficiaries.

2. Alternatives Considered for the Reimbursement of Cancer and Children's Hospitals

Under the method discussed in this final rule, TRICARE's payments to CCHs would decrease by approximately $35 million. Our analysis has shown that the expected impact on specific hospitals vary widely. Of the 35 CCHs with the highest allowed amounts in 2021, 14 hospitals would have their payments reduced by more than 15 percent, and six hospitals would have their payments increased by more than 15 percent. The median hospital in this group of 35 CCHs would have had its TRICARE reimbursement for the services covered by this rule reduced by two percent had the rule been implemented in 2021.

It is practicable to adopt OPPS for these institutional providers, with annual hold harmless provisions.

We are also finalizing as proposed, no transition period. CCHs will receive, at a minimum, one hundred percent of their costs, or the OPPS payment, whichever is higher. Historically, transitions are done to protect providers from payments below their costs. However, in this case, the providers will be held-harmless, so no transition is necessary.

List of Subjects in 32 CFR Part 199

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

Accordingly, 32 CFR part 199 is amended as follows:

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

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

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

2. Amend § 199.2 in paragraph (b) by adding in alphabetical order definitions for "Ambulatory Surgery Center (ASC)", "Cancer hospital", and "Children's hospital" to read as follows:

§ 199.2 Definitions.

* * * * *

(b) * * *

Ambulatory Surgery Center (ASC). Any distinct entity that is classified by the Centers for Medicare and Medicaid Services (CMS) as an Ambulatory Surgical Center (ASC) under 42 CFR part 416 and meets the applicable requirements established by § 199.6(b)(4)(x). Any ASC that would otherwise meet the CMS classification as an ASC but does not have a participation agreement with Medicare due to the nature of the patients they treat (e.g., pediatric) must meet the applicable requirements established by § 199.6(b)(4)(x) in order to be a TRICARE authorized ASC. All ASCs must also enter into participation agreements with TRICARE as required by § 199.6(b)(4)(x) in order to be an authorized TRICARE provider of ASC services. Additionally, ASCs are prohibited from billing TRICARE beneficiaries for procedures that are not included in Medicare's ASC list of procedures allowable for facility fee payment in an ASC setting, unless the beneficiary agreed in advance in writing to pay for the non-covered services, in accordance with the "hold harmless" provision under § 199.6(b)(4)(x)(B)(*1*)(*ii*) and (*iii*).

* * * * *

Cancer hospital. A specialty hospital that is classified by CMS as a Cancer Hospital as specified in 42 CFR 412.23 and meets the applicable requirements established by § 199.6(b)(4)(i).

* * * * *

Children's hospital. A specialty hospital that is classified by CMS as a Children's Hospital as specified in 42 CFR 412.23 and meets the applicable requirements established by § 199.6(b)(4)(i).

* * * * *

3. Amend § 199.6 by revising paragraph (b)(4)(x)(B)(*1*) to read as follows:

§ 199.6 TRICARE-authorized providers.

* * * * *

(b) * * *

(4) * * *

(x) * * *

(B) * * *

(*1*) *Ambulatory surgical centers* (*ASC)*. ASCs must meet all criteria for classification as an Ambulatory Surgical Center under 42 CFR part 416, as well as all of the requirements of this part, in order to be considered an authorized ASC under the TRICARE program. Care provided by an authorized TRICARE ASC may be cost-shared under the following circumstances:

(*i*) A childbirth procedure provided by a CHAMPUS-approved ASC shall not be cost-shared by CHAMPUS unless the surgical center is also a CHAMPUS-approved birthing center institutional provider as established by the birthing center provider certification requirement of this part, and then reimbursement of covered maternity care and childbirth services shall be subject to § 199.14(e).

(*ii*) ASCs must demonstrate they have a valid participation agreement with Medicare, except as provided under paragraph (b)(4)(x)(B)(*1*)(*i*) of this section. In addition, in order to be considered an authorized TRICARE provider, ASCs must accept the requirements for a participating provider under paragraph (a)(13) of this section and must also enter into a participation agreement with TRICARE which includes a specific "hold harmless" provision under which the facility will agree not to bill the patient for services not on the Medicare ASC

procedures list unless, the patient is advised in writing that the non-listed procedure is not covered by TRICARE and the patient agrees, in advance in writing, to be financially liable for the non-covered procedure.

(*iii*) ASCs that do not have an agreement with Medicare due to the nature of the patients they treat (*e.g*., pediatric patients) shall be accredited by the Joint Commission, the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), or such other accreditation as authorized by the Director, DHA and published in the implementing instructions. Additionally, these facilities must enter into participation agreements with TRICARE, including the hold harmless provisions under paragraph (b)(4)(x)(B)(*1*)(*ii*) of this section, and accept the requirements for a participating provider under paragraph (a)(13) of this section in order to be an authorized TRICARE provider.

* * * * *

4. Section 199.14 is amended by revising paragraphs (a)(6)(ii)(A), (a)(6)(ii)(E) introductory text, and (a)(6)(ii)(E)(*3*), adding paragraph (a)(6)(ii)(E)(*4*), and revising paragraph (d) to read as follows:

§ 199.14 Provider reimbursement methods.

(a) * * *

(6) * * *

(ii) * * *

(A) *General.* Outpatient services provided in hospitals subject to Medicare OPPS as specified in 42 CFR 413.65 and 42 CFR 419.20, to include cancer and children's hospitals, will be paid in accordance with the provisions outlined in sections 1833t of the Social Security Act and its implementing Medicare regulation (42 CFR part 419) subject to exceptions as authorized by this paragraph (a)(6)(ii).

* * * * *

(E) *Temporary transitional payment adjustments (TTPAs).* Temporary transitional payment adjustments will be in place for all hospitals, both network and non-network, except for cancer and children's hospitals, in order to buffer the initial decline in payments upon implementation of TRICARE's OPPS.

* * * * *

(*3*) An additional general temporary military contingency payment adjustment (GTMCPA) will also be available at the discretion of the Director, 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 GTMCPAs 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. For cancer and children's hospitals to qualify for the GTMCPA, they must meet the criteria in paragraphs (a)(6)(ii)(E)(*3*)(*i*) through (*iii*) of this section.: Cancer and children's hospitals that meet these criteria will be eligible to receive up to 115 percent of the hospital's costs for OPPS services. 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, or a designee. GTMCPAs 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 Director, or designee. The GTMCPA qualification criteria for cancer and children's hospitals follow:

(*i*) Have 10 percent or more of its revenue come from TRICARE for care of ADSMs and ADDs;

(*ii*) Have 10,000 or more of its TRICARE visits paid under the OPPS for ADSMs and ADDs annually; and

(*iii*) Be deemed as essential for TRICARE operations.

(*4*) *For cancer and children's hospitals*. There are no temporary transitional payment adjustments in place. Reimbursement will be on the basis of OPPS, however, payments shall be adjusted so that these providers receive 100 percent of their costs. Adjustments shall be made on an annual basis, and within 180 days of the end of the OPPS year (OPPS Year is defined as April 1 through March 30) DHA will calculate the hospital's costs, utilizing the hospital-specific outpatient cost-to-charge ratio (CCR). The costs shall be calculated by multiplying the hospital's billed charges for OPPS services by the CCR. If the hospital's costs, as calculated by DHA, exceeded the payment that had been made under OPPS, the hospital shall receive an annual payment adjustment so that the hospital receives 100% of their costs.

* * * * *

(d) *Payment of institutional facility costs for ambulatory surgery*. In general, TRICARE pays for 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 or CAHs, which are to be reimbursed in accordance with the provisions of paragraph (a)(6)(ii) or (iii) of this section. Surgical services provided in Ambulatory Surgery Centers (ASCs) as defined in § 199.2(b) will be paid in accordance with the provisions outlined in section 1833(t) of the Social Security Act and its implementing Medicare regulation (42 CFR part 416). TRICARE will recognize, to the extent practicable, in accordance with 10 U.S.C. 1079(i)(2), Medicare's ASC reimbursement methodology to include specific coding requirements, prospectively determined rates, discounts for multiple surgical procedures, the scope of ASC services, covered surgical procedures, and the basis of payment as described in 42 CFR part 416 with the exception that TRICARE will implement no transitional payments. Payments to ASCs for covered procedures and services

will be based on the lesser of the billed charge or the ASC payment rate. Payment for ambulatory surgery procedures is limited to those procedures that are reimbursed by Medicare in ASCs, with the exception of dental procedures that are covered by the TRICARE program, as described in § 199.4. In the absence of a Medicare ASC fee schedule rate, the payment for a covered dental procedure in ASCs will be based on the same rate under TRICARE's OPPS.

* * * * *

Dated: March 23, 2023.

Aaron T. Siegel,

Alternate OSD Federal Register Liaison Officer,

Department of Defense.

[FR Doc. 2023-06452 Filed: 4/3/2023 8:45 am; Publication Date: 4/4/2023]