

required. If FDA determines a categorical exclusion does not apply, we will request an environmental assessment and make it available for public inspection.

Dated: November 25, 2019.

Lowell J. Schiller,

Principal Associate Commissioner for Policy.

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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: Proposed rule.

SUMMARY: The Department of Defense, Defense Health Agency, is proposing to amend its reimbursement of ambulatory surgery centers (ASC) and outpatient services provided in Cancer and Children's Hospitals (CCHs). Proposed revisions are in accordance with the TRICARE Statute that requires TRICARE's payment methods for institutional care be determined, to the extent practicable, in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under Medicare. In accordance with this requirement, TRICARE proposes to adopt Medicare's payment methodology for ASC, and adopt Medicare's payment methodology for outpatient services provided in CCHs.

DATES: Written comments received at the address indicated below by January 28, 2020 will be accepted.

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

- *Federal Rulemaking Portal:* www.regulations.gov. Follow the instructions for submitting comments.
- *Mail:* Department of Defense, Office of the Chief Management Officer, Directorate for Oversight and Compliance, 4800 Mark Center Drive, Mailbox #24, Suite 08D09, Alexandria, VA 22350–1700.

Instructions: All submissions received must include the agency name and

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

FOR FURTHER INFORMATION CONTACT: Elan Green, Defense Health Agency, 303–676–3907.

SUPPLEMENTARY INFORMATION:

I. Executive Summary

A. Purpose of the Proposed Rule

The purpose of this rule is to propose 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 propose adopting both the Medicare ASC system and to adopt 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 proposed 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 proposes 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 Title 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 proposes to adopt 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% 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 proposed rule, we propose that TRICARE adopt 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 Defense Health Agency (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 annually, rather than in monthly interim payments.

B. Summary of the Major Provisions of the Proposed 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.), 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 proposed rule, TRICARE will reimburse ASCs for ambulatory surgical services using a method similar to Medicare's ASC reimbursement methodology. Under the proposed 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 rule proposes TRICARE adopt 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. The agency 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 propose no transition period for the implementation of the ASC reimbursement system. Historically transitions are done to protect providers from payments below their costs. However, in this case, while revenues would decrease for some providers, payment would not be made below the provider's costs. Some providers may see dramatic increases 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 propose no transition for cancer and children's hospitals, with the rationale that providers will be held harmless under this proposed reimbursement system. 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.

C. Costs and Benefits

Although it is unlikely that this rule will be effective before calendar year 2020, the overall economic impact of the rule is estimated based on an analysis of expected outcomes had the rule been implemented during calendar year 2018. Such analysis may be used to provide a reasonable estimate of future economic impact.

The overall economic impact of this rule is a net increase of approximately \$14 million in allowed amounts to providers for those surgical services currently listed in the TRICARE ASC list if the rule had been implemented during calendar year 2018.

The economic impact of the proposal to adopt Medicare's payment methodology for ASCs is anticipated to result in total cost-savings to the DoD of approximately \$40 million for Calendar Year (CY) 2018. This increase in savings is made up of decreased payments of

approximately \$54 million in CY 2018 for bundled and device codes that are not being reimbursed separately under Medicare's ASC reimbursement system. However, the cost-savings are partially offset by increased payments to ASCs of approximately \$14 million in CY 2018 for surgical services that are currently reimbursed using TRICARE's existing ASC reimbursement system.

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 \$12 million per year if implemented in 2018.

We estimate that the effects of the provisions that would be implemented by this proposed rule would have an impact of increased cost-savings to the DoD of approximately \$52 million, including \$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 TRICARE proposes to adopt.

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, TRICARE proposes 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 also propose 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. Like Medicare, we propose the ASC system will not reimburse for the 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 reimbursement systems, including the CHAMPUS Maximum Allowable Charge (CMAC), Durable Medical Equipment Prosthetics Orthotics and Supplies (DMEPOS) Fee Schedule and the Ambulance Fee Schedule. We propose that surgical procedures that are also offered in physicians' offices, and that the Centers for Medicare and Medicaid Services (CMS) classifies as "office-based," will be reimbursed the lower of the ASC rate or the non-facility practice expense relative value unit (RVU) amount of the CMAC. 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), we propose the ASC will be reimbursed as though the service was performed in a physician's office utilizing TRICARE's CMAC methodology, with no additional payment for facility charges.

B. Definition and Requirements for Ambulatory Surgery Centers

This regulatory action proposes 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 propose 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 by 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 propose that in lieu of separate certification by TRICARE, the ASC simply provide evidence that there is 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 propose 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, we propose that they will be considered an authorized ASC under TRICARE 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. These ASCs may not routinely enter into agreements with Medicare. We propose that these facilities may also be reimbursed under this proposed system, but they must be accredited by the Joint Commission, the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC), or have other accreditation as authorized by the Director, DHA and published in the implementing instructions. Additionally, these facilities must also enter into participation agreements with TRICARE in order to receive reimbursement under the program. Facilities that do not participate under Medicare, or are otherwise accredited, and do not have participation agreements with TRICARE as noted above, shall not be TRICARE authorized providers and will not receive reimbursement for ambulatory surgery services. We do not believe that this requirement will have any impact on access to care, as ambulatory surgery services are also available in hospital outpatient departments. We believe that 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). These TRICARE-certified pediatric ASCs will be subject to the same reimbursement system as proposed in this regulatory action.

Title 32 CFR 199.6(b)(4)(x)(B)(1) currently includes specific requirements for ambulatory surgery centers. With this regulatory action, we propose to modify those requirements to state that ASCs that participate in Medicare meet all program requirements to be an authorized TRICARE provider; and, that those (due to the specialized nature of the patients they treat, *i.e.*, pediatric patients) ASCs that do not participate in Medicare 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 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 proposes to adopt the Medicare ASC List, in its entirety, including any updates made by Medicare to the list in the future. We also propose no deviations or exceptions 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. We believe 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 invite 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 hospital outpatient settings (OPPS).

If an ASC provides a surgical service that is not on this list, TRICARE proposes that the facility charges will be denied, similar to Medicare. However, related professional services may be reimbursed utilizing TRICARE's allowable charge methodology. TRICARE proposes to adopt the

Medicare requirement that facility charges may be reimbursed for only those services on the “ASC List.” We believe 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.

D. Services Included in the ASC Payment

This regulatory action proposes 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 propose that separate payment will be allowed for covered ancillary items and services that are integral to a covered surgical procedure, similar to 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 propose that TRICARE's 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. TRICARE proposes, similar to Medicare, to make 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 propose these items are 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 propose 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 propose payment for implantable DME will be included in the payment of 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)

TRICARE proposes to adopt Medicare's provisions for payments of IOLs and NTIOLs provided during or subsequent to cataract surgery in ASCs. We propose that payment for the IOL is 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 propose 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 proposed definition of an ASC in 32 CFR 199.2. This payment will be the lower of the ASC payment rate or the billed charge. TRICARE proposes to adopt the Medicare ASC payment rates. We propose no TRICARE-specific adjustments or modifications to the Medicare rates.

We propose to pay separately 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, we propose that payments under this system do not include reimbursement for the services of individual professional providers, DME, non-implantable prosthetics, ambulance services, or independent laboratory services. These services will be reimbursed using other reimbursement systems like the Medicare Physician Fee Schedule (similar to CHAMPUS Maximum Allowable Charges, or CMAC), DMEPOS Fee Schedule, and the Ambulance Fee Schedule.

We propose that the small number of 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 actual 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 actual 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 propose that 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 propose to adopt 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

Medicare makes an annual adjustment of the payment rates for inflation based on CPI-U. We propose to adopt the annual adjustments, as well as any interim adjustments to the ASC payment rates, as made by Medicare. TRICARE will publish the annual rates and related files to the TRICARE website, and may refer contractors to the appropriate Medicare files, when available.

P. Payment for Terminated Procedures

TRICARE proposes adopting the same methodology for payment of terminated procedures as Medicare, as well as adopting 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

TRICARE proposes adopting the same methodology for payment of multiple procedures as Medicare, as well as adopting all future refinements and adjustments. When multiple procedures are performed in the same operative session that are subject to the multiple procedure discount, 100% of the highest paying surgical procedure on the claim is paid, plus 50% of the applicable payment rates for the other ASC covered surgical services. The CMS OPPS/ASC annual final rules specify the surgical procedures subject to multiple discounting, which TRICARE proposes to adopt. 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. TRICARE proposes 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). TRICARE proposes 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. Surgical procedures that are offered in physicians' offices, and that CMS classifies as "office-based" are reimbursed the lower of the ASC rate or the non-facility practice expense RVU amount of the CMAC. 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

TRICARE proposes no transition, since many providers will see increases in payments from adoption of this proposed 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%. 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 propose 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

We propose to adopt 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. We propose a combined OPPOS and cost-reimbursement system. We propose to pay these hospitals under TRICARE's existing OPPOS, and then reimburse the hospitals the higher of the OPPOS 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 propose to modify 32 CFR 199.14(a)(6) to include cancer and children's hospitals as providers subject to OPPOS, and will further describe how these providers will be held harmless under the proposed methodology.

B. Hospitals Subject to This Proposed Reimbursement System

We propose that those cancer and children's hospitals that were specifically excluded in TRICARE's OPPOS final rule at 73 FR 74945, and are those cancer and children's hospitals currently held harmless from OPPOS by Medicare, will be subject to the provisions of this proposed rule.

C. Transitional Outpatient Payments

While Medicare provides reimbursement through TOPs for the difference between OPPOS and hospital-specific costs on a monthly basis, we propose 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 OPPOS. 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 OPPOS. TRICARE, however, proposes 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 OPPOS 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 OPPOS. 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. TRICARE is not subject to the PPACA, and proposes to not adopt this additional adjustment to adjust for the average payment-to-cost ratio for cancer hospitals, due to the administrative complexity of the calculation.

For cancer and children's hospitals, the annual process is proposed to be as follows:

Step One: Identify the costs of the hospital by multiplying the total billed charges for OPPOS 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 OPPOS than their costs. If the result of Step 2 (OPPOS 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

TRICARE proposes no transition, since 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 calculated and issued in the same manner as those that are made currently under TRICARE's OPPTS.

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

Executive Order 12866, Executive Order 13563, and Executive Order 13771

A. Overall Impact

DoD has examined the impacts of this proposed rule as required by Executive Orders (E.O.s) 12866 (September 1993, Regulatory Planning and Review), 13563 (January 18, 2011, Improving Regulation and Regulatory Review), and 13771 (January 30, 2017, Reducing Regulation and Controlling Regulatory Costs); the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354); the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4); and the Congressional Review Act (5 U.S.C. 804(2)).

1. Executive Order 12866, Executive Order 13563, and Executive Order 13771

Executive Orders 12866 (Regulatory Planning and Review) and 13563 (Improving Regulation and Regulatory Review) 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.

Executive Order 13771 (Reducing Regulation and Controlling Regulatory Costs) directs agencies to reduce regulation and control regulatory costs and provides that “for every one new regulation issued, at least two prior regulations be identified for elimination, and that the cost of planned regulations be prudently managed and controlled through a budgeting process.” This proposed rule is not expected to be subject to the requirements of this Executive Order because it is not significant under Executive Order 12866.

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

Under the Congressional Review Act, a major rule may not take effect until at least 60 days after submission to Congress of a report regarding the rule. A major rule is one that would have an annual effect on the economy of \$100 million or more or have certain other impacts. This Notice of Proposed Rule Making is 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. Most hospitals are considered to be small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) identification of a small business (having revenues of \$34.5 million or less in any one year). For purposes of the RFA, we have determined that the majority of ASCs and CCHs would be considered small entities according to the SBA size standards. Individuals and States are not included in the definition of a small entity. Therefore, this proposed 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 proposed rule will not mandate any requirements for State, local, or tribal governments or the private sector.

5. Paperwork Reduction Act

This rule will not impose significant additional information collection requirements on the public under the Paperwork Reduction Act of 1995 (44 U.S.C. 3502–3511). Existing information collection requirements of the TRICARE and Medicare programs will be utilized. We do not anticipate any increased costs to hospitals because of paperwork, billing, or software requirements since we are 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 E.O. 13132, and it does not contain policies that have federalism implications that would have substantial direct effects on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of Government. Therefore, consultation with State and local officials is not required.

B. 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 OPPTS 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 OPPTS, respectively. Currently, only Maryland hospitals operate under such a waiver.

C. Analysis of the Impact of Policy Changes on Payment for ASC 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

Under the method discussed in this proposed rule, TRICARE's ASC payments would increase to certain providers by approximately \$14 million. This is due to an increase in payments for surgical services that are paid under TRICARE's current ASC reimbursement methodology of approximately \$23 million, with a decrease in payments for surgical services that are currently reimbursed outside TRICARE's current ASC reimbursement system of approximately \$9 million. The overall impact represents an approximate 25-percent increase to ASCs for surgical services. For many procedures, the reimbursement amounts will increase by more than 25 percent. However, these increases will be offset by the fact that some procedures and devices that are currently paid separately will be bundled under this proposed reimbursement system.

This rule proposes 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. Alternatively, we considered permitting exceptions to the Medicare ASC list, however, such a process would require the creation and maintenance of an entirely separate list by TRICARE. This approach was not adopted because, first, this approach would be impracticable and complex; and second, covered services continue to be available in either hospital outpatient settings, or inpatient settings. 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 2016 Report To Congress: Medicare Payment Policy", indicates that Medicare payments to ASCs are adequate. 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 2015, TRICARE would have spent approximately \$250 million on ASC services. In contrast, ASCs received over \$3.8 billion in Medicare payments and beneficiaries' cost sharing in 2014 (2015 data unavailable in the 2016 MedPAC report). 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 2016 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 proposed rule, TRICARE's payments to CCHs would decrease by approximately \$12 million. The estimated costs savings are relatively low, because the current allowed-to-billed ratio is so similar to the proposed system that major savings are unlikely. Our analysis has shown that the impact on specific hospitals varied widely, although the aggregate impact was small. Of the 25 CCHs with the highest allowed amounts in 2015, seven hospitals would have their payments reduced by more than 15 percent, and 11 hospitals would have their payments increased by more than 15 percent.

An alternative to this payment approach would be to reimburse CCHs on the basis of their costs, rather than pay utilizing OPPS and comparing utilizing OPPS, and making annual adjustments. In other words, we evaluated using a process in reverse to the one described in this proposed rule. Under the alternative approach, TRICARE would have paid the hospital at its costs (billed charges multiplied by the CCR), and then performing a comparison to what would have been paid under OPPS annually, and making

annual adjustments if needed. Although this would result in fewer end-year adjustments, it would be administratively complex to adjust all claims utilizing OPPS at the end of the year. Additionally, this approach is inconsistent with the statutory obligation to pay like Medicare. Therefore, this approach was not adopted because TRICARE is statutorily obligated to pay like Medicare where practicable. It is practicable to adopt OPPS for these institutional providers, with annual hold harmless provisions.

We also propose no transition. 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 proposed to be amended as follows:

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

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

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

■ 2. Amend § 199.2(b) by adding, in alphabetical order, the definitions of "Ambulatory Surgery Center", "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.

* * * * *

Cancer hospital. A specialty hospital that is classified by CMS as a Cancer

Hospital 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 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) 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 § 199.16(e).

(ii) ASCs must demonstrate they have a valid participation agreement with Medicare, except as provided under paragraph (b)(4)(x)(B)(1)(v) of this section. ASCs must also enter into a participation agreement with TRICARE in order to be considered an authorized TRICARE provider.

(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 under § 199.6(a)(8)(i)(A) in order to be an authorized TRICARE provider.

■ 4. Section 199.14 is amended by revising paragraphs (a)(6)(ii)(A) and (B); and (d) to read as follows:

§ 199.14 Provider reimbursement methods.

(a) * * *

(6) * * *

(ii) *Outpatient services subject to OPPS.* Outpatient services provided in hospitals subject to Medicare OPPS as specified in 42 CFR 413.65 and 42 CFR 419.20, to include cancer and children's hospitals, will be paid in accordance with the provisions outlined in sections 1833(t) of the Social Security Act and its implementing Medicare regulation (42 CFR part 419) subject to exceptions as authorized by § 199.14(a)(5)(ii). Under the provisions of this section, CHAMPUS will recognize to the extent practicable, in accordance with 10 U.S.C. 1079(i)(2), Medicare's OPPS reimbursement methodology to include specific coding requirements, ambulatory payment classifications (APCs), nationally established APC amounts and associated adjustments (e.g., discounting for multiple surgery procedures, wage adjustments for variations in labor-related costs across geographical regions and outlier calculations). While CHAMPUS intends to remain as true as possible to Medicare's basic OPPS methodology, there will be some deviations required to accommodate CHAMPUS' unique benefit structure and beneficiary population as authorized under the provisions of 10 U.S.C. 1079(i)(2). Cancer and children's hospitals will be paid on the basis of OPPS, but consistent with Medicare, payments shall be adjusted so that these providers receive 100 percent of their costs. Adjustments shall be made on an annual basis. Within 180 days of the end of the OPPS year (OPPS Year is defined as April 1 through March 30), DHA shall 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.

(A) Temporary transitional payment adjustments (TTPAs) will be in place for all hospitals, both network and non-network in order to buffer the initial decline in payments upon implementation of TRICARE's OPPS. For network hospitals, the temporary transitional payment adjustments (TTPAs) will cover a four-year period. The four-year transition will set higher payment percentages for the ten Ambulatory Payment Classification (APC) codes 604–609 and 613–616, with

reductions in each of the transition years. For non-network hospitals, the adjustments will cover a three year period, with reductions in each of the transition years. For network hospitals, under the TTPAs, the APC payment level for the five clinic visit APCs would be set at 175 percent of the Medicare APC level, while the five ER visit APCs would be increased by 200 percent in the first year of OPPS implementation. In the second year, the APC payment levels would be set at 150 percent of the Medicare APC level for clinic visits and 175 percent for ER APCs. In the third year, the APC visit amounts would be set at 130 percent of the Medicare APC level for clinic visits and 150 percent for ER APCs. In the fourth year, the APC visit amounts would be set at 115 percent of the Medicare APC level for clinic visits and 130 percent for ER APCs. In the fifth year, the TRICARE and Medicare payment levels for the 10 APC visit codes would be identical. For non-network hospitals, under the TTPAs, the APC payment level for the five clinic and ER visit APCs would be set at 140 percent of the Medicare APC level in the first year of OPPS implementation. In the second year, the APC payment levels would be set at 125 percent of the Medicare APC level for clinic and ER visits. In the third year, the APC visit amounts would be set at 110 percent of the Medicare APC level for clinic and ER visits. In the fourth year, the TRICARE and Medicare payment levels for the 10 APC visit codes would be identical.

(B) An additional temporary military contingency payment adjustment (TMCPA) 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 TMCPAs to OPPS payments shall be made only on the basis of a determination that it is impracticable to support military readiness or contingency operations by making OPPS payments in accordance with the same reimbursement rules implemented by Medicare. The criteria for adopting, modifying, and/or extending deviations and/or adjustments to OPPS payments shall be issued through CHAMPUS policies, instructions, procedures and guidelines as deemed appropriate by the Director, or a designee. TMCPAs may also be extended to non-network hospitals on a case-by-case basis for specific procedures where it is determined that

the procedures cannot be obtained timely enough from a network hospital. For such case-by-case extensions, “Temporary” might be less than three years at the discretion of the Director, or designee.

* * * * *

(d) *Payment of institutional facility costs for ambulatory surgery.* Surgical services provided in Ambulatory Surgery Centers (ASCs) as defined in § 199.2 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, as described in 42 CFR part 416 with the exception that TRICARE will implement no transitional payments. Payment for ambulatory surgery procedures is limited to those procedures that are reimbursed by Medicare in ASCs.

* * * * *

Dated: November 15, 2019.

Aaron T. Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 2019–25213 Filed 11–27–19; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 110

[Docket Number USCG–2019–0822]

Anchorage Grounds; Delaware Bay and Atlantic Ocean, Delaware

AGENCY: Coast Guard, DHS.

ACTION: Notice of inquiry; request for comments.

SUMMARY: The Coast Guard is considering amending its regulations to establish new anchorage grounds in the Delaware Bay and Atlantic Ocean. We are considering this action after receiving requests suggesting additional anchorage grounds are necessary to accommodate current and future vessel traffic, improve navigation safety, and because traditional anchorage areas may not be available due to planned or potential offshore wind energy development. We invite your comments

on whether we should initiate a rulemaking to amend our existing anchorage regulations based on this, or if the status quo should be maintained or other actions considered.

DATES: Your comments and related material must reach the Coast Guard on or before January 28, 2020.

ADDRESSES: You may submit comments identified by docket number USCG–2019–0822 using the Federal portal at <https://www.regulations.gov>. See the “Public Participation and Request for Comments” portion of the **SUPPLEMENTARY INFORMATION** section for further instructions on submitting comments.

FOR FURTHER INFORMATION CONTACT: If you have questions about this notice of inquiry, call or email Marine Science Technician Second Class (MST2) Thomas Welker, Sector Delaware Bay, U.S. Coast Guard; telephone (215) 271–4814, email Thomas.J.Welker@uscg.mil; or Mr. Jerry Barnes, Fifth Coast Guard District (dpw), U.S. Coast Guard; telephone (757) 398–6230, email Jerry.R.Barnes@uscg.mil.

SUPPLEMENTARY INFORMATION:

I. Table of Abbreviations

ACPARS Atlantic Coast Port Access Study
BOEM Bureau of Ocean Energy Management
CFR Code of Federal Regulations
FR Federal Register
OCS Outer Continental Shelf
WGS84 World Geodetic System 1984

II. Background and Purpose

The Coast Guard is considering amending its regulations to establish new anchorage grounds in the Delaware Bay and Atlantic Ocean. Our authority to establish anchorage grounds comes from 33 U.S.C. 471.

The Delaware Bay and River supports a diverse marine transportation system which includes the ports of Wilmington, DE; New Castle, DE; Philadelphia, PA; Camden-Gloucester City, NJ; and serves as an entry point for vessels bound for the port of Baltimore, MD, through the Chesapeake and Delaware Canal. Global trends in shipping indicate carriers continue to invest in larger vessels and these vessels are arriving at Delaware River ports. A river deepening project is nearing completion that will increase the Federal project depth from 40 to 45 feet from Philadelphia, PA, and Camden, NJ, to the mouth of the Delaware Bay. Large vessels bound for Delaware River ports often wait offshore at anchor in unregulated areas between the Eastern Directed Traffic area and Southeastern Directed Traffic Area, or in various places along the dredged

channel through the lower bay. Vessels anchor for a broad range of purposes including taking on stores, transferring of personnel, engaging in bunkering operations, or lightering. Designated anchorage grounds are available and regulations covering the use of these anchorages are set out in 33 CFR 110.157. These anchorage regulations were last revised in November 2016 to eliminate unusable anchorage grounds and provide additional usable grounds to support port demands and enhance navigation safety. See Final Rule published in the **Federal Register** on November 25, 2016 (81 FR 85157).

In 2016, the Coast Guard published a notice of its Atlantic Coast Port Access Route Study (ACPARS) (81 FR 13307, March 14, 2016) that analyzed the Atlantic Coast waters seaward of existing port approaches within the U.S. Exclusive Economic Zone and announced the report as final in 2017 (82 FR 16510, April 5, 2017). This multiyear study began in 2011, included public participation, and identified the navigation routes customarily followed by ships engaged in commerce between international and domestic U.S. ports. See <https://navcen.uscg.gov/?pageName=PARSReports>. During the study, the Coast Guard received comments from interested stakeholders addressing cumulative impacts of wind energy areas and potential conflicts with traditional navigation routes and uses of the waters. As wind energy areas are developed and distribution cables installed, vessel traffic may be displaced or funneled into smaller areas, and available anchorage areas may be decreased. This increased vessel density may cause the mixing of vessel types and speeds while also changing the geometry of interactions as vessels come within close range of each other. These changes may increase the risk of collision, loss of property, loss of life, and environmental damage. In the vicinity of the entrance to the Delaware Bay and River, the Coast Guard received requests from a Federal pilot and the Mariners’ Advisory Committee for the Delaware Bay and River to establish two new regulated anchorages in the Atlantic Ocean as potential wind energy leases would remove traditional unregulated anchorage areas from use.

In 2018, the Coast Guard held meetings with maritime stakeholders to discuss global shipping trends, wind energy areas and potential conflicts with traditional uses of the waters in the vicinity of the entrance to the Delaware Bay and River. Attendance included the Pilots’ Association for the Bay and River Delaware, the Mariners’ Advisory Committee for the Bay and River