

**DEPARTMENT OF DEFENSE****Office of the Secretary****DoD Medicare-Eligible Retiree Health Care Board of Actuaries; Notice of Federal Advisory Committee Meeting****AGENCY:** DoD.**ACTION:** Meeting notice.

**SUMMARY:** The Department of Defense is publishing this notice to announce a meeting of the DoD Medicare-Eligible Retiree Health Care Board of Actuaries. This meeting will be open to the public.

**DATES:** Friday, July 31, 2015, from 10:00 a.m. to 12:00 p.m.

**ADDRESSES:** 4800 Mark Center Drive, Conference Room 18, Level B1, Alexandria, VA 22350.

**FOR FURTHER INFORMATION CONTACT:**

Kathleen Ludwig at the Defense Human Resource Activity, DoD Office of the Actuary, 4800 Mark Center Drive, STE 05E22, Alexandria, VA 22350-7000. Phone: 571-372-1993. Email: [Kathleen.A.Ludwig.civ@mail.mil](mailto:Kathleen.A.Ludwig.civ@mail.mil).

**SUPPLEMENTARY INFORMATION:** This meeting is being held under the provisions of the Federal Advisory Committee Act of 1972 (5 U.S.C., Appendix, as amended), the Government in the Sunshine Act of 1976 (5 U.S.C. 552b, as amended), and 41 CFR 102-3.150.

Purpose of the Meeting: The purpose of the meeting is to execute the provisions of 10 U.S.C. chapter 56 (10 U.S.C. 1114 *et seq.*). The Board shall review DoD actuarial methods and assumptions to be used in the valuation of benefits under DoD retiree health care programs for Medicare-eligible beneficiaries.

**Agenda**

## 1. Meeting Objective

Approve actuarial assumptions and methods needed for calculating:

- i. FY 2017 per capita full-time and part-time normal cost amounts
- ii. September 30, 2014, unfunded liability (UFL)
- iii. October 1, 2015, Treasury UFL amortization and normal cost payments
2. Trust Fund Update
3. Medicare-Eligible Retiree Health Care Fund Update
4. September 30, 2013, Actuarial Valuation Results
5. September 30, 2014, Actuarial Valuation Proposals
6. Decisions

Actuarial assumptions and methods needed for calculating:

- a. FY 2017 per capita full-time and part-time normal cost amounts

- b. September 30, 2014, unfunded liability (UFL)

- c. October 1, 2015, Treasury UFL amortization and normal cost payments

Public's Accessibility to the Meeting: Pursuant to 5 U.S.C. 552b and 41 CFR 102-3.140 through 102-3.165 and the availability of space, this meeting is open to the public. Seating is on a first come basis. The Mark Center is an annex of the Pentagon. Those without a valid DoD Common Access Card must contact Kathleen Ludwig at 571-372-1993 no later than June 30, 2015. Failure to make the necessary arrangements will result in building access being denied. It is strongly recommended that attendees plan to arrive at the Mark Center at least 30 minutes prior to the start of the meeting.

Pursuant to 41 CFR 102-3.105(j) and 102-3.140, and section 10(a)(3) of the Federal Advisory Committee Act of 1972, the public or interested organizations may submit written comments to the Board about its mission and topics pertaining to this public meeting.

Committee's Designated Federal Officer or Point of Contact: Persons desiring to attend the DoD Medicare-Eligible Retiree Health Care Board of Actuaries meeting or make an oral presentation or submit a written statement for consideration at the meeting, must notify Kathleen Ludwig at (571) 372-1993, or [Kathleen.A.Ludwig.civ@mail.mil](mailto:Kathleen.A.Ludwig.civ@mail.mil), by June 30, 2015.

Dated: February 6, 2015.

**Aaron Siegel,**

*Alternate OSD Federal Register Liaison Officer, Department of Defense.*

[FR Doc. 2015-02872 Filed 2-11-15; 8:45 am]

**BILLING CODE 5001-06-P**

**DEPARTMENT OF DEFENSE****Office of the Secretary****TRICARE; Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); Fiscal Year 2015 Diagnosis Related Group (DRG) Updates****AGENCY:** Office of the Secretary, DoD.**ACTION:** Notice of DRG revised rates.

**SUMMARY:** This notice describes the changes made to the TRICARE DRG-based payment system in order to conform to changes made to the Medicare Prospective Payment System (PPS). It also provides the updated fixed loss cost outlier threshold, cost-to-

charge ratios, and the data necessary to update the FY 2015 rates.

**DATES: Effective Dates:** The rates, weights, and Medicare PPS changes which affect the TRICARE DRG-based payment system contained in this notice are effective for discharges occurring on or after October 1, 2014.

**ADDRESSES:** Defense Health Agency, TRICARE, Medical Benefits and Reimbursement Office, 16401 East Centretech Parkway, Aurora, CO 80011-9066.

**FOR FURTHER INFORMATION CONTACT:**

Amber L. Butterfield, Medical Benefits and Reimbursement Office, TRICARE, telephone (303) 676-3565.

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

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

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

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

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

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

**A. DRG Classifications**

Under both the Medicare PPS and the TRICARE DRG-based payment system, cases are classified into the appropriate DRG by a Grouper program. The Grouper classifies each case into a DRG on the basis of the diagnosis and procedure codes and demographic

information (that is, sex, age, and discharge status). The Grouper used for the TRICARE DRG-based payment system is the same as the current Medicare Grouper with two modifications. The TRICARE system has replaced Medicare DRG 435 with two age-based DRGs (900 and 901), and has implemented thirty-four (34) neonatal DRGs in place of Medicare DRGs 385 through 390. For admissions occurring on or after October 1, 2001, DRG 435 has been replaced by DRG 523. The TRICARE system has replaced DRG 523 with the two age-based DRGs (900 and 901). For admissions occurring on or after October 1, 1995, the CHAMPUS Grouper hierarchy logic was changed so the age split (age <29 days) and assignments to Major Diagnostic Category (MDC) 15 occur before assignment of the pre-MDC DRGs. This resulted in all neonate tracheostomies and organ transplants to be grouped to MDC 15 and not to DRGs 480–483 or 495. For admissions occurring on or after October 1, 1998, the CHAMPUS Grouper hierarchy logic was changed to move DRG 103 to the pre-MDC DRGs and to assign patients to pre-MDC DRGs 480, 103, and 495 before assignment to MDC 15 DRGs and the neonatal DRGs. For admissions occurring on or after October 1, 2001, DRGs 512 and 513 were added to the pre-MDC DRGs, between DRGs 480 and 103 in the TRICARE Grouper hierarchy logic. For admissions occurring on or after October 1, 2004, DRG 483 was deleted and replaced with DRGs 541 and 542, splitting the assignment of cases on the basis of the performance of a major operating room procedure. The description for DRG 480 was changed to “Liver Transplant and/or Intestinal Transplant”, and the description for DRG 103 was changed to “Heart/Heart Lung Transplant or Implant of Heart Assist System”. For FY 2007, CMS implemented classification changes, including surgical hierarchy changes. The TRICARE Grouper incorporated all changes made to the Medicare Grouper, with the exception of the pre-surgical hierarchy changes, which will remain the same as FY 2006. For FY 2008, Medicare implemented their Medicare-Severity DRG (MS-DRG) based payment system. TRICARE, however, continued with the Centers for Medicare and Medicaid Services DRG-based (CMS-DRG) payment system for FY 2008. For FY 2009, the TRICARE/CHAMPUS DRG-based payment system shall be modeled on the MS-DRG system, with the following modifications.

The MS-DRG system consolidated the 43 pediatric CMS DRGs that were

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

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

For FY10, there are no additional or deleted DRGs.

For FY 11, the added DRGs and deleted DRGs are the same as those included in CMS’ final rule published on August 16, 2010 (75 FR 50041–50677). That is, DRG 009 is deleted; DRGs 014 and 015 are being added.

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

For FY 2013 there are no new, revised, or deleted DRGs.

For FY 2014 there are no new, revised, or deleted DRGs.

For FY 2015 the added, deleted and revised DRGs are the same as those included in the CMS’ final rule published on August 22, 2014, (79 FR 49853–50536), with the exception of endovascular cardiac valve replacement for which CMS added DRGs 266/267. The TRICARE Grouper already has DRGs 266/267 assigned to a pediatric procedure therefore TRICARE added DRGs 317/318, respectively, for endovascular cardiac valve replacement.

#### *B. Wage Index and Medicare Geographic Classification Review Board Guidelines*

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

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

TRICARE is adopting CMS’ percentage of labor related share of the standardized amount. For wage index values greater than 1.0, the labor related portion of the Adjusted Standardized Amount (ASA) shall continue to equal 69.6 percent. For wage index values less than or equal to 1.0 the labor related portion of the ASA shall continue to equal 62 percent.

#### *D. Hospital Market Basket*

TRICARE will update the adjusted standardized amounts according to the final updated hospital market basket used for the Medicare PPS for all hospitals subject to the TRICARE DRG-based payment system according to CMS’ August 22, 2014, final rule. For FY 2015, the market basket is 2.9 percent. Note: Medicare’s FY 2015 market basket index adjusts according to hospitals’ compliance with quality data and electronic health record meaningful use submissions. These adjustments do not apply to the TRICARE Program.

#### *E. Outlier Payments*

Since TRICARE does not include capital payments in our DRG-based payments (TRICARE reimburses hospitals for their capital costs as reported annually to the contractor on a pass through basis), we will use the fixed loss cost outlier threshold calculated by CMS for paying cost outliers in the absence of capital prospective payments. For FY 2015, the TRICARE fixed loss cost outlier threshold is based on the sum of the applicable DRG-based payment rate plus any amounts payable for Indirect Medical Education (IME) plus a fixed dollar amount. Thus, for FY 2015, in order for a case to qualify for cost outlier payments, the costs must exceed the TRICARE DRG base payment rate (wage adjusted) for the DRG plus the IME payment (if applicable) plus \$22,705 (wage adjusted). The marginal cost factor for cost outliers continues to be 80 percent.

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

The FY 2015 TRICARE National Operating Standard Cost as a Share of Total Costs (NOSCASTC) used in calculating the cost outlier threshold is 0.922. TRICARE uses the same methodology as CMS for calculating the NOSCASTC; however, the variables are different because TRICARE uses national cost to charge ratios while CMS uses hospital specific cost to charge ratios.

### G. Indirect Medical Education (IDME) Adjustment

Passage of the Medical Modernization Act of 2003 modified the formula multipliers to be used in the calculation of IDME adjustment factor. Since the IDME formula used by TRICARE does not include disproportionate share hospitals (DSHs), the variables in the formula are different than Medicare's, however; the percentage reductions that will be applied to Medicare's formula will also be applied to the TRICARE IDME formula. The multiplier for the IDME adjustment factor for TRICARE for FY 2015 is 1.02.

### H. Cost to Charge Ratio

TRICARE uses a national Medicare cost-to-charge ratio (CCR). For FY 2015, the Medicare CCR used for the TRICARE DRG-based payment system for acute care hospitals and neonates will be 0.2726. This is based on a weighted average of the hospital-specific Medicare CCRs (weighted by the number of Medicare discharges) after excluding hospitals not subject to the TRICARE DRG system (Sole Community Hospitals, Indian Health Service hospitals, and hospitals in Maryland). The Medicare CCR is used to calculate cost outlier payments, except for children's hospitals. The Medicare CCR has been increased by a factor of 1.0065 to include an additional allowance for bad debt. The 1.0065 factor reflects the provisions of the Middle Class Tax Relief and Job Creation Act of 2012. For children's hospital cost outliers, the CCR used is 0.2939.

### I. Pricing of Claims

The final rule published on May 21, 2014, (79 FR 29085–29088) set forth all final claims with discharge dates of October 1, 2014, or later and reimbursed under the TRICARE DRG-Based payment system, are to be priced using the rules, weights and rates in effect on as of the date of discharge. Prior to this, all final claims were priced using the rules, weights and rates in effect as of the date of admission.

### J. Updated Rates and Weights

The updated rates and weights are accessible through the Internet at <http://www.tricare.mil/drgrates>. The implementing regulations for the TRICARE/CHAMPUS DRG-based payment system are in 32 CFR part 199.

Dated: February 6, 2015.

Aaron Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

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## DEPARTMENT OF DEFENSE

### Office of the Secretary

#### TRICARE, Formerly Known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); Fiscal Year 2015 Mental Health Rate Updates

**AGENCY:** Department of Defense.

**ACTION:** Notice of updated mental health rates for Fiscal Year 2015.

**SUMMARY:** This notice provides the updated regional per-diem rates for low-volume mental health providers; the update factor for hospital-specific per-diems; the updated cap per-diem for high-volume providers; the beneficiary per-diem cost-share amount for low-volume providers; and the updated per-diem rates for both full-day and half-day TRICARE Partial Hospitalization Programs for Fiscal Year 2015.

**DATES: Effective Date:** The Fiscal Year 2015 rates contained in this notice are effective for services on or after October 1, 2014.

**ADDRESSES:** Defense Health Agency (DHA), Medical Benefits and Reimbursement Branch, 16401 East Centretech Parkway, Aurora, CO 80011–9066.

**FOR FURTHER INFORMATION CONTACT:** Elan Green, Medical Benefits and Reimbursement Office, DHA, telephone (303) 676–3907.

**SUPPLEMENTARY INFORMATION:** The final rule published in the **Federal Register** (FR) on September 6, 1988 (53 FR 34285) set forth reimbursement changes that were effective for all inpatient hospital admissions in psychiatric hospitals and exempt psychiatric units occurring on or after January 1, 1989. The final rule published in the **Federal Register** on July 1, 1993 (58 FR 35400) set forth maximum per-diem rates for all partial hospitalization admissions on or after September 29, 1993. Included in these final rules were provisions for updating reimbursement rates for each federal Fiscal Year. As stated in the final rules, each per-diem shall be updated by the Medicare update factor for hospitals and units exempt from the Medicare

Prospective Payment System (*i.e.*, this is the same update factor used for the inpatient prospective payment system). For Fiscal Year 2015, the market basket rate is 2.9 percent. This year, Medicare applied two reductions to its market basket amount: (1) A 0.5 percent reduction for economy-wide productivity required by section 3401(a) of the Patient Protection and Affordable Care Act (PPACA) which amended section 1886(b)(3)(B) of the Social Security Act, and (2) a 0.2 percent point adjustment as required by section 1886(b)(3)(B)(xii) of the Act as added and amended by sections 3401 and 10319(a) of the PPACA. These two reductions do not apply to TRICARE. Hospitals and units with hospital-specific rates (hospitals and units with high TRICARE volume) and regional-specific rates for psychiatric hospitals and units with low TRICARE volume will have their TRICARE rates for Fiscal Year 2015 updated by 2.9 percent.

Partial hospitalization rates for full-day programs also will be updated by 2.9 percent for Fiscal Year 2015. Partial hospitalization rates for programs of less than 6 hours (with a minimum of three hours) will be paid a per diem rate of 75 percent of the rate for a full-day program.

The cap amount for high-volume hospitals and units also will be updated by the 2.9 percent for Fiscal Year 2015.

The beneficiary cost share for low-volume hospitals and units also will be updated by the 2.9 percent for Fiscal Year 2015.

Per 32 CFR 199.14, the same area wage indexes used for the CHAMPUS Diagnosis-Related Group (DRG)-based payment system shall be applied to the wage portion of the applicable regional per-diem for each day of the admission. The wage portion shall be the same as that used for the CHAMPUS DRG-based payment system. For wage index values greater than 1.0, the wage portion of the regional rate subject to the area wage adjustment is 69.6 percent for Fiscal Year 2015. For wage index values less than or equal to 1.0, the wage portion of the regional rate subject to the area wage adjustment is 62.0 percent.

Additionally, 32 CFR 199.14 requires that hospital specific and regional per-diems shall be updated by the Medicare update factor for hospitals and units exempt from the Medicare prospective payment system.

The following reflect an update of 2.9 percent for Fiscal Year 2015.