



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 145
6010.55-M
JANUARY 18, 2012**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE REIMBURSEMENT MANUAL (TRM), AUGUST 2002**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: FISCAL YEAR (FY) 2012 CRITICAL ACCESS HOSPITAL (CAH) COST-TO-CHARGE RATIO (CCR) CAPS AND INPATIENT MENTAL HEALTH PER DIEM SYSTEM DEFLATOR FACTOR (DF)

CONREQ: 15709

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change provides the annual update to the CAH inpatient and outpatient CCR caps, and updates the mental health per diem system DF for FY 2012 to 3.5077.

EFFECTIVE DATES: October 1, 2011 - FY 2012 inpatient mental health per diem system DF.
December 1, 2011- CAH CCR caps.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

Ann N. Fazzini

**Ann N. Fazzini
Chief, Medical Benefits and
Reimbursement Branch**

**ATTACHMENT(S): 7 PAGE(S)
DISTRIBUTION: 6010.55-M**

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rate is determined. The actual amounts of each regional per diem that will apply in any federal fiscal year shall be published in the **Federal Register**. For FY 2007, Medicare has determined a market basket and subsequent update factor specific to psychiatric facilities.

FISCAL YEAR	UPDATE FACTOR	FISCAL YEAR	UPDATE FACTOR
1992	4.7%	2003	3.5%
1993	4.2%	2004	3.4%
1994	4.3%	2005	3.3%
1995	3.7%	2006	3.8%
1996	0%	2007	3.4%
1997	0%	2008	3.4%
1998	0%	2009	3.2%
1999	2.4%	2010	2.1%
2000	2.9%	2011	2.6%
2001	3.4%	2012	3.0%
2002	3.3%		

F. Higher Volume Hospitals and Units.

1. Higher Volume of TRICARE Mental Health Discharges During the Base Period.

a. Any hospital or unit that had an annual rate of 25 or more TRICARE mental health discharges during the period July 1, 1987 through May 31, 1988, shall be considered a higher volume hospital or unit during federal FY 1989 and all subsequent fiscal years.

b. All other hospitals and units covered by the TRICARE/CHAMPUS inpatient mental health per diem payment system shall be considered lower volume hospitals and units.

2. Higher Volume of TRICARE Mental Health Discharges in Subsequent Fiscal Years and Hospital-Specific Per Diem Calculation.

a. In any federal fiscal year in which a hospital or unit not previously classified as a higher volume hospital or unit has 25 or more TRICARE mental health discharges, that hospital or unit shall be considered to be a higher volume hospital or unit during the next federal fiscal year and all subsequent fiscal years.

b. The hospital-specific per diem amount shall be calculated in accordance with the above provisions, except that the base period average daily charge shall be deemed to be the hospital's or unit's average daily charge in the year in which the hospital or unit had 25 or more TRICARE mental health discharges, adjusted by the percentage change in average daily charges for all higher volume hospitals and units between the year in which the hospital or unit had 25 or more TRICARE mental health discharges and the base period. The base period amount, however, can not exceed the cap described in this section. Once a

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statistically valid rate is established based on a year in which the hospital or unit had at least 25 mental health discharges, it becomes the basis for all future rates. The number of mental health discharges thereafter have no bearing on the hospital-specific per diem.

(1) The TRICARE contractor shall be requested at least annually to submit to the TMA Office of Medical Benefits and Reimbursement Systems within 30 days of the request a listing of high volume providers that qualified as high volume during the most recent government fiscal year. Periodically, additional information may be requested by TMA concerning high volume providers. This requested information will be used in the calculation of the Deflator Factor (DF).

(2) Percent of change and DF.

FOR 12 MONTHS ENDED:	PERCENT OF CHANGE	DF
September 30, 1992	85.81%	1.8581
September 30, 1993	94.48%	1.9448
September 30, 1994	106.94%	2.0694
September 30, 1995	117.20%	2.1720
September 30, 1996	123.83%	2.2383
September 30, 1997	126.20%	2.2620
September 30, 1998	116.93%	2.1693
September 30, 1999	129.19%	2.2919
September 30, 2000	128.82%	2.2882
September 30, 2001	131.83%	2.3183
September 30, 2002	141.57%	2.4157
September 30, 2003	159.90%	2.5990
September 30, 2004	171.39%	2.7139
September 30, 2005	185.93%	2.8593
September 30, 2006	200.58%	2.9724
September 30, 2007	205.85%	2.9785
September 30, 2008	233.63%	3.3363
September 30, 2009	246.31%	3.4631
September 30, 2010	234.40%	3.3440
September 30, 2011	250.77%	3.5077

3. New Hospitals and Units.

a. The inpatient mental health per diem payment system has a special retrospective payment provision for new hospitals and units. A new hospital is one which meets the Medicare requirements under Tax Equity and Fiscal Responsibility Act (TEFRA) rules. Such hospitals qualify for the Medicare exemption from the rate of increase ceiling

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applicable to new hospitals which are DRG-exempt psychiatric hospitals. Any new hospital or unit that becomes a higher volume hospital or unit may additionally, upon application to the appropriate contractor, receive a retrospective adjustment. The retrospective adjustment shall be calculated so that the hospital or unit receives the same government share payments it would have received had it been designated a higher volume hospital or unit for the federal fiscal year in which it first had 25 or more TRICARE mental health discharges. This provision also applies to the preceding fiscal year (if it had any TRICARE patients during the preceding fiscal year). A retrospective payment shall be required if payments were originally made at a lower regional per diem. This payment will be the result of an adjustment based upon each claim processed during the retrospective period for which an adjustment is needed, and will be subject to the claims processing standards.

b. By definition, a new hospital is an institution that has operated as the type of facility (or the equivalent thereof) for which it is certified in the Medicare and or TRICARE programs under the present and previous ownership for less than 3 full years. A change in ownership in itself does not constitute a new hospital.

c. Such new hospitals must agree not to bill beneficiaries for any additional cost-share beyond that determined initially based on the regional rate.

4. Request for a Review of Higher or Lower Volume Classification. Any hospital or unit which TMA improperly fails to classify as a higher or lower volume hospital or unit may apply to the appropriate contractor for such a classification. The hospital or unit shall have the burden of proof.

G. Payment for Hospital Based Professional Services.

1. Lower Volume Hospitals and Units. Lower volume hospitals and units may not bill separately for hospital based professional services; payment for those services is included in the per diems.

2. Higher Volume Hospitals and Units. Higher volume hospitals and units, whether they billed separately for hospital based professional services or included those services in the hospital's or unit's charges, shall continue the practice in effect during the period July 1, 1987 to May 31, 1988 (or other data base period used for calculating the hospital's or unit's per diem), except that any such hospital or unit may change its prior practice (and obtain an appropriate revision in its per diem) by providing to the appropriate contractor notice of its request to change its billing procedures for hospital-based professional services.

H. Leave Days.

1. No Payment. The government shall not pay (including holding charges) for days where the patient is absent on leave (including therapeutic absences) from the specialty psychiatric hospital or unit. The hospital must identify these days when claiming reimbursement.

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2. Does not Constitute a Discharge/Do not Count Toward Day Limit. The government shall not count a patient's departure for a leave of absence as a discharge in determining whether a facility should be classified as a higher volume hospital.

I. Exemptions from the TRICARE Inpatient Mental Health Per Diem Payment System.

1. Providers Subject to the DRG-Based Payment System. Providers of inpatient care which are neither psychiatric hospitals nor psychiatric units as described earlier, or which otherwise qualify under that discussion, are exempt from the inpatient mental health per diem payment system.

2. Services Which Group into Mental Health DRG. Admissions to psychiatric hospitals and units for operating room procedures involving a principal diagnosis of mental illness (services which group into DRG 424 prior to October 1, 2008, or services which group into DRG 876 on or after October 1, 2008) are exempt from the per diem payment system. They will be reimbursed on the basis of billed charges.

3. Non-Mental Health Procedures. Admissions for non-mental health procedures that group into non-mental health DRG, in specialty psychiatric hospitals and units are exempt from the per diem payment system. They will be reimbursed on the basis of billed charges.

4. Sole Community Hospital (SCH). Any hospital which has qualified for special treatment under the Medicare Prospective Payment System (PPS) as a SCH and has not given up that classification is exempt. For additional information on SCHs, refer to [Chapter 14, Section 1](#).

5. Hospital Outside the 50 United States, the District of Columbia, or Puerto Rico. A hospital is exempt if it is not located in one of the 50 United States, the District of Columbia, or Puerto Rico.

6. Billed charges and set rates. The allowable costs for authorized care in all hospitals not subject to the DRG-based payment system or the inpatient mental health per diem payment system shall be determined on the basis of billed charges or set rates.

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improved road is any road that is maintained by a local, state, or federal government entity and is available for use by the general public. An improved road includes the paved surface up to the front entrance of the CAH and the front entrance of the garage.

NOTE: CAHs that are not exempt from the allowable charge methodology may not report condition code B2.

C. Reasonable Cost Methodology. Reasonable cost is based on the actual cost of providing services and excluding any costs, that are unnecessary in the efficient delivery of services covered by the program.

1. TMA shall calculate an overall inpatient CCR and overall outpatient CCR, obtained from data on the hospital's most recently filed Medicare cost report as of July 1 of each year.

2. The inpatient and outpatient CCRs are calculated using Medicare charges, e.g., Medicare costs for outpatient services are derived by multiplying an overall hospital outpatient CCR (by department or cost center) by Medicare charges in the same category.

3. The following methods are used by TMA to calculate the CCRs for CAHs. The worksheet and column references are to the CMS Form 2552-96 (Cost Report for Electronic Filing of Hospitals).

Inpatient CCRs

Numerator Medicare costs were defined as Worksheet D-1, Part II, line 49 MINUS (worksheet D, Part III, Column 8, sum of lines 25-30 PLUS Worksheet D, Part IV, line 101).

Denominator Medicare charges were defined as Worksheet D-4, Column 2, sum of lines 25-30 and 103.

Outpatient CCRs

Numerator Outpatient costs were taken from Worksheet D, Part V, line 104, the sum of Columns 6, 7, 8, and 9.

Denominator Total outpatient charges were taken from the same Worksheet D, Part V, line 104, sum of Columns 2, 3, 4, and 5 for the same breakdowns.

4. To reimburse the vast majority of CAHs for all their costs in an administratively feasible manner, TRICARE will identify CCRs that are outliers using the method used by Medicare to identify outliers in its Outpatient Prospective Payment System (OPPS) reimbursement methods. Specifically, Medicare classifies CCR outliers as values that fall outside of three standard deviations from the geometric mean. Applying this method to the CAH data, those limits will be considered the threshold limits on the CCR for reimbursement purposes. For Fiscal Year (FY) 2010, this calculation resulted in an inpatient CCR cap of 2.31 and outpatient CCR cap of 1.26. For FY 2011, the inpatient CCR cap is 2.57 and the outpatient CCR cap is 1.31. **For FY 2012, the inpatient CCR cap is 2.46 and the outpatient CCR cap is 1.32.** Thus, for FY 2012, TRICARE will pay the lesser of 2.46 multiplied by the billed charges or 101% of costs (using the hospital's CCR and billed charges) for inpatient services and the

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lesser of 1.32 multiplied by the billed charges or 101% of costs for outpatient services. Following is the two step comparison of costs.

STEP 1: Inpatient, pay the lesser of:

FY cap x billed charges (minus non-covered charges) OR
1.01 x (hospital-specific CCR x billed charges (minus non-covered charges))

STEP 2: Outpatient, pay the lesser of:

FY cap x billed charges OR
1.01 x (hospital-specific CCR x billed charges)

5. TMA shall provide a list of CAHs to the Managed Care Support Contractors (MCSCs) with their corresponding inpatient and outpatient CCRs by November 1 each year. The CCRs shall be updated on an annual basis using the second quarter CMS Hospital Cost Report Information System (HCRIS) data. The updated CCRs shall be effective as of December 1 of each respective year, with the first update occurring December 1, 2009.

6. TMA shall also provide the MCSCs the State median inpatient and outpatient CAH CCRs to use when a hospital specific CCR is not available.

D. CAH Listing.

1. TMA will maintain the CAH listing on the TMA's web site at <http://www.tricare.mil/hospitalclassification/>, and will update the list on a quarterly basis and will notify the contractors by e-mail when the list is updated.

2. For payment purposes for those facilities that were listed on both the CAH and SCH lists prior to June 1, 2006, the contractors shall use the implementation date of June 1, 2006, as the effective date for reimbursing CAHs under the DRG-based payment system. The June 1, 2006, effective date is for admissions on or after June 1, 2006. For admissions prior to June 1, 2006, if a facility was listed on both the CAH and SCH lists, the SCH list took precedence over the CAH list. The contractors shall not initiate recoupment action for any claims paid billed charges where the CAH was also on the SCH list, prior to the June 1, 2006, effective date. For admissions on or after December 1, 2009, CAHs are reimbursed under the reasonable cost method.

3. The effective date on the CAH list is the date supplied by CMS upon which the facility began receiving reimbursement from Medicare as a CAH, however, if a facility was listed on both the CAH and SCH lists prior to June 1, 2006, the effective date for TRICARE DRG reimbursement is June 1, 2006. For admissions on or after December 1, 2009, CAHs are reimbursed under the reasonable cost method.

4. After June 1, 2006, if a CAH is added or dropped off of the list from the previous update, the quarterly revision date of the current listing shall be listed as the facility's effective or termination date, respectively.

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5. If the contractor receives documentation from a CAH indicating their status is different than what is on the CAH listing on TMA's web site, the contractor shall send the information to TMA, Medical Benefits & Reimbursement Branch (MB&RB) to update the listings on the web.

E. CAHs participating in the demonstration in the state of Alaska, from July 1, 2007 through November 30, 2009, are exempt from the DRG-based payment system and are subject to the payment rates under the TRICARE Demonstration Project. For information on the demonstration, refer to the TRICARE Operations Manual (TOM), [Chapter 20, Section 8](#).

F. Prior to December 1, 2009, the contractor's shall update their institutional provider files to include CAH's and their Indirect Medical Education (IDME) factors, if applicable, as the CMS Inpatient Provider Specific File used to update the annual DRG Provider File does not contain CAH information.

G. Billing and Coding Requirements.

1. The contractors shall use type of institution 91 for CAHs.
2. CAHs shall utilize bill type 11X for inpatient services.
3. CAHs shall utilize bill type 85X for all outpatient services including services approved as Ambulatory Surgery Center (ASC) services.
4. CAHs shall utilize bill type 12X for ancillary/ambulance services.
5. CAHs shall utilize bill type 14X for non-patient diagnostic services.
6. CAHs shall use bill type 18X for swing bed services.

H. Beneficiary Liability. Applicable TRICARE deductible and cost-sharing provisions apply to CAH inpatient and outpatient services.

V. EFFECTIVE DATE

Implementation of the CAH reasonable cost methodology is effective for admissions and outpatient services occurring on or after December 1, 2009.

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