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MB&RS

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CHANGE 119
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REMOVE PAGE(S)	INSERT PAGE(S)
CHAPTER 2	
Section 1, pages 7 through 12	Section 1, pages 7 through 12
CHAPTER 6	
Table of Contents, pages 1 and 2	Table of Contents, pages 1 and 2
Section 7, pages 1 and 2	Section 7, pages 1 and 2
Section 8, pages 11 through 14	Section 8, pages 11 through 14
Addendum B (FY 2013), page 1	★ ★ ★ ★ ★ ★
★ ★ ★ ★ ★ ★	Addendum B (FY 2016), page 1
Addendum C (FY 2013), pages 1 through 26	★ ★ ★ ★ ★ ★
★ ★ ★ ★ ★ ★	Addendum C (FY 2016), page 1
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pages 1 and 2	pages 1 and 2

SUMMARY OF CHANGES

CHAPTER 2

1. Section 1. This change updates the Daily Hospital Charges for Active Duty Family Members for Fiscal Year 2016. EFFECTIVE DATE: 10/01/15.

CHAPTER 6

2. Section 7. This change updates the Cost-to-Charge Ratio for Adjusted Standardized Amounts (ASAs) for FY 2016. EFFECTIVE DATE: 10/01/15.

3. Section 8. This change updates the Cost-to-Charge Ratio for admissions, The National Operating Std Cost Share of Total Costs, TRICARE fixed loss cost-outlier, Children's Cost-to-Charge Ratio, and the Children's Marginal Cost Factor for FY 2016. EFFECTIVE DATE: 10/01/15.

4. Addendum B (FY 2013). This change removes the Cost-to-Charge Ratio for Adjusted Standardized Amounts for FY 2013. EFFECTIVE DATE: 10/01/15.

5. Addendum B (FY 2016). This change adds the Cost-to-Charge Ratio for Adjusted Standardized Amounts for FY 2016. EFFECTIVE DATE: 10/01/15.

6. Addendum C (FY 2013). This change removes the Diagnosis Related Groups (DRGs), DRG Relative Weights, Arithmetic and Geometric Mean Lengths-Of-Stay (LOS), and Short-Stay Outlier Thresholds for FY 2013. EFFECTIVE DATE: 10/01/15.

7. Addendum C (FY 2016). This change adds the DRGs, DRG Relative Weights, Arithmetic and Geometric Mean LOS and Short-Stay Outlier Thresholds, for FY 2016. EFFECTIVE DATE: 10/01/15.

FIGURE 2.1-1 UNIFORMED SERVICES HOSPITAL DAILY CHARGE AMOUNTS

PERIOD	DAILY CHARGE
October 1, 2009 - September 30, 2010 (for ADFMs not enrolled in Prime)	$16.30
October 1, 2010 - September 30, 2011 (for ADFMs not enrolled in Prime)	$16.85
October 1, 2011 - September 30, 2012 (for ADFMs not enrolled in Prime)	$17.05
October 1, 2012 - September 30, 2013 (for ADFMs not enrolled in Prime)	$17.35
October 1, 2013 - September 30, 2014 (for ADFMs not enrolled in Prime)	$17.65
October 1, 2014 - September 30, 2015 (for ADFMs not enrolled in Prime)	$17.80
October 1, 2015 - September 30, 2016 (for ADFMs not enrolled in Prime)	$18.00
Use the daily charge (per diem rate) in effect for each day of the stay to calculate a cost-share for a stay which spans periods.	

1.3.3.2.2 Other Beneficiaries: For services exempt from the DRG-based payment system and the mental health per diem payment system and services provided by institutions other than hospitals (i.e., Residential Treatment Centers (RTCs)), the cost-share shall be 25% of the allowable charges.

1.3.3.3 Cost-Shares: Maternity

1.3.3.3.1 Determination. Maternity care cost-share shall be determined as follows:

1.3.3.3.1.1 Inpatient cost-share formula applies to maternity care ending in childbirth in, or on the way to, a hospital inpatient childbirth unit, and for maternity care ending in a non-birth outcome not otherwise excluded.

Note 1: Inpatient cost-share formula applies to prenatal and postnatal care provided in the office of a civilian physician or certified nurse-midwife in connection with maternity care ending in childbirth or termination of pregnancy in, or on the way to, a Military Treatment Facility (MTF) inpatient childbirth unit. ADFMs pay a per diem charge (or a $25.00 minimum charge) for an admission and there is no separate cost-share for them for separately billed professional charges or prenatal or postnatal care.

1.3.3.3.1.2 Ambulatory surgery cost-share formula applies to maternity care ending in childbirth in, or on the way to, a birthing center to which the beneficiary is admitted, and from which the beneficiary has received prenatal care, or a hospital-based outpatient birthing room.

1.3.3.3.1.3 Outpatient cost-share formula applies to maternity care which terminates in a planned childbirth at home.

1.3.3.3.1.4 Otherwise covered medical services and supplies directly related to "complications of pregnancy", as defined in the Regulation, will be cost-shared on the same basis as the related maternity care for a period not to exceed 42 days following termination of the pregnancy and thereafter cost-shared on the basis of the inpatient or outpatient status of the beneficiary when medically necessary services and supplies are received.

1.3.3.3.2 Otherwise authorized services and supplies related to maternity care, including maternity related prescription drugs, shall be cost-shared on the same basis as the termination of pregnancy.

1.3.3.3.3 Claims for **pregnancy testing** are cost-shared on an outpatient basis when the delivery is on an inpatient basis.

1.3.3.3.4 Where the beneficiary delivers in a **professional office birthing suite** located in the office of a physician or certified nurse-midwife (which is not otherwise a TRICARE-approved birthing center) the delivery is to be adjudicated as an at-home birth.

1.3.3.3.5 Claims for **prescription drugs** provided on an outpatient basis during the maternity episode but not directly related to the maternity care are cost-shared on an outpatient basis.

1.3.3.3.6 Newborn cost-share. Effective for all inpatient admissions occurring on or after October 1, 1987, separate claims must be submitted for the mother and newborn. The cost-share for inpatient claims for services rendered to a beneficiary newborn is determined as follows:

1.3.3.3.6.1 In a DRG hospital:

1.3.3.3.6.1.1 Same newborn date of birth and date of admission:

- For ADFMs, there will be no cost-share during the period the newborn is deemed enrolled in Prime.
- For newborn family members of other than active duty members, unless the newborn is deemed enrolled in Prime, the cost-share will be the lower of the number of hospital days minus three multiplied by the per diem amount, OR 25% of the total billed charges (less duplicates and DRG non-reimbursables such as hospital-based professional charges).

1.3.3.3.6.1.2 Different newborn date of birth and date of admission:

- For ADFMs, there will be no cost-share during the period the newborn is deemed enrolled in Prime.
- For all other beneficiaries, the cost-share is applied to all days in the inpatient stay unless the newborn is deemed enrolled in Prime.

1.3.3.3.6.2 In DRG exempt hospital:

1.3.3.3.6.2.1 Same newborn date of birth and date of admission:

- For ADFMs, there will be no cost-share during the period the newborn is deemed enrolled in Prime.
- For family members of other than active duty members, the cost-share will be calculated based on 25% of the total allowed charges unless the newborn is deemed enrolled in Prime.

1.3.3.3.6.2.2 Different newborn date of birth and date of admission:

- For ADFMs, there will be no cost-share during the period the newborn is deemed enrolled in Prime.
- For family members of other than active duty members, the cost-share will be calculated based on 25% of the total allowed charges unless the newborn is deemed enrolled in Prime.

1.3.3.3.7 Maternity Related Care. Medically necessary treatment rendered to a pregnant woman for a non-obstetrical medical, anatomical, or physiological illness or condition shall be cost-shared as a part of the maternity episode when:

- The treatment is otherwise allowable as a benefit; and,
- Delay of the treatment until after the conclusion of the pregnancy is medically contraindicated; and,
- The illness or condition is, or increases the likelihood of, a threat to the life of the mother; or,
- The illness or condition will cause, or increase the likelihood of, a stillbirth or newborn injury or illness; or,
- The usual course of treatment must be altered or modified to minimize a defined risk of newborn injury or illness.

1.3.3.4 Cost-Shares: DRG-Based Payment System

1.3.3.4.1 General

These special cost-sharing procedures apply only to claims paid under the DRG-based payment system.

1.3.3.4.2 TRICARE Standard

1.3.3.4.2.1 Cost-shares for ADFMs.

1.3.3.4.2.1.1 Except in the case of mental health services, ADFMs or their sponsors are responsible for the payment of the first $25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider, or the amount the beneficiary or sponsor would have been charged had the inpatient care been provided in a Uniformed Service hospital, whichever is greater.

1.3.3.4.2.1.2 Effective for care on or after October 1, 1995, the inpatient cost-sharing for mental health services is $20 per day for each day of the inpatient admission.

1.3.3.4.2.2 Cost-shares for beneficiaries other than ADFMs.

1.3.3.4.2.2.1 The cost-share will be the lesser of:

1.3.3.4.2.2.1.1 An amount based on a single, specific per diem amount which will not vary regardless of the DRG involved. The following is the DRG inpatient TRICARE Standard cost-sharing per diems for beneficiaries other than ADFMs.

- For FY 2005, the daily rate is $512.
- For FY 2006, the daily rate is $535.
- For FY 2007, the daily rate is capped at the FY 2006 level of $535, per Section 704 of NDAA FY 2007.
- For FYs 2008, 2009, 2010, and 2011, the daily rate is $535.
- For FY 2012, the daily rate is $708.
- For FY 2013, the daily rate is $698.
- For FY 2014, the daily rate is $744.
- For FY 2015, the daily rate is $764.
- For FY 2016, the daily rate is posted to the DHA web site at http://health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement.

1.3.3.4.2.2.1.1.1 The per diem amount will be calculated as follows:

- Determine the total allowable DRG-based amounts for services subject to the DRG-based payment system and for beneficiaries other than ADFMs during the same database period used for determining the DRG weights and rates.
- Add in the allowance for Capital and Direct Medical Education (CAP/DME) which have been paid to hospitals during the same database period used for determining the DRG weights and rates.
- Divide this amount by the total number of patient days for these beneficiaries. This amount will be the average cost per day for these beneficiaries.
- Multiply this amount by 0.25. In this way total cost-sharing amounts will continue to be 25% of the allowable amount.
- Determine any cost-sharing amounts which exceed 25% of the billed charge (see paragraph 1.3.3.4.2.2.1.2) and divide this amount by the total number of patient days in paragraph 1.3.3.4.2.2.1.1). Add this amount to

the amount in paragraph 1.3.3.4.2.2.1.1. This is the per diem cost-share to be used for these beneficiaries.

1.3.3.4.2.2.1.1.2 The per diem amount will be required for each actual day of the beneficiary's hospital stay which the DRG-based payment covers except for the day of discharge. When the payment ends on a specific day because eligibility ends on either a long-stay or short-stay outlier day, the last day of eligibility is to be counted for determining the per diem cost-sharing amount. For claims involving a same-day discharge which qualify as an inpatient stay (e.g., the patient was admitted with the expectation of a stay of several days, but died the same day) the cost-share is to be based on a one-day stay. (The number of hospital days must contain one day in this situation.) Where long-stay outlier days are subsequently determined to be not medically necessary by a Peer Review Organization (PRO), no cost-share will be required for those days, since payment for such days will be the beneficiary's responsibility entirely.

1.3.3.4.2.2.1.2 Twenty-five percent (25%) of the billed charge. The billed charge to be used includes all inpatient institutional line items billed by the hospital minus any duplicate charges and any charges which can be billed separately (e.g., hospital-based professional services, outpatient services, etc.). The net billed charges for the cost-share computation include comfort and convenience items.

1.3.3.4.2.2.2 Under no circumstances can the cost-share exceed the DRG-based amount.

1.3.3.4.2.2.3 Where the dates of service span different fiscal years, the per diem cost-share amount for each year is to be applied to the appropriate days of the stay.

1.3.3.4.3 TRICARE Extra

1.3.3.4.3.1 Cost-shares for ADFMs. The cost-sharing provisions for ADFMs are the same as those for TRICARE Standard.

1.3.3.4.3.2 Cost-shares for beneficiaries other than ADFMs. The cost-sharing provisions for beneficiaries other than ADFMs is the same as those for TRICARE Standard, except the per diem copayment is $250.

1.3.3.4.4 TRICARE Prime

There is no cost-share for ADFMs. For beneficiaries other than ADFMs, the cost-sharing provision is the first $25 of the allowable institutional costs incurred with each covered inpatient admission to a hospital or other authorized institutional provider, or a per diem rate of $11, whichever is greater.

1.3.3.4.5 Maternity Services

See paragraph 1.3.3.3, for the cost-sharing provisions for maternity services.

1.3.3.5 Cost-Shares: Inpatient Mental Health Per Diem Payment System

1.3.3.5.1 General. These special cost-sharing procedures apply only to claims paid under the inpatient mental health per diem payment system. For inpatient claims exempt from this system,

the procedures in paragraph 1.3.3.2 or 1.3.3.4 are to be followed.

1.3.3.5.2 Cost-shares for ADFMs. Effective for care on or after October 1, 1995, the inpatient cost-sharing for mental health services is $20 per day for each day of the inpatient admission. This $20 per day cost-sharing amount applies to admissions to any hospital for mental health services, any RTC, any Substance Use Disorder Rehabilitation Facility (SUDRF), and any PHP providing mental health or substance use disorder rehabilitation services. For Prime ADFMs care provided on or after April 1, 2001, cost-share is $0 per day. See Addendum A for further information.

1.3.3.5.3 Cost-shares for beneficiaries other than ADFMs.

1.3.3.5.3.1 Higher volume hospitals and units. With respect to care paid for on the basis of a hospital specific per diem, the cost-share shall be 25% of the hospital specific per diem amount.

1.3.3.5.3.2 Lower volume hospitals and units. For care paid for on the basis of a regional per diem, the cost-share shall be the lower of paragraph 1.3.3.5.3.2.1 or paragraph 1.3.3.5.3.2.2:

1.3.3.5.3.2.1 A fixed daily amount multiplied by the number of covered days. The fixed daily amount shall be 25% of the per diem adjusted so that total beneficiary cost-shares will equal 25% of total payments under the inpatient mental health per diem payment system. This fixed daily amount shall be updated annually and published in the **Federal Register** along with the per diems published pursuant to Chapter 7, Section 1. This fixed daily amount will also be furnished to contractors by DHA. The following fixed daily amounts are effective for services rendered on or after October 1 of each fiscal year.

- Fiscal Year 2000 - $144 per day.
- Fiscal Year 2001 - $149 per day.
- Fiscal Year 2002 - $154 per day.
- Fiscal Year 2003 - $159 per day.
- Fiscal Year 2004 - $164 per day.
- Fiscal Year 2005 - $169 per day.
- Fiscal Year 2006 - $175 per day.
- Fiscal Year 2007 - $181 per day.
- Fiscal Year 2008 - $187 per day.
- Fiscal Year 2009 - $193 per day.
- Fiscal Year 2010 - $197 per day.
- Fiscal Year 2011 - $202 per day.
- Fiscal Year 2012 - $208 per day.
- Fiscal Year 2013 - $213 per day.
- Fiscal Year 2014 - $218 per day.
- Fiscal Year 2015 - $224 per day.
- Fiscal Year 2016 - $229 per day.

1.3.3.5.3.2.2 Twenty-five percent (25%) of the hospital's billed charges (less any duplicates).

1.3.3.5.4 Claim which spans a period in which two separate per diems exist. A claim subject to the inpatient mental health per diem payment system which spans a period in which two separate per diems exist shall have the cost-share computed on the actual per diem in effect for each day of care.

Chapter 6

Diagnostic Related Groups (DRGs)

Section/Addendum	Subject/Addendum Title
1	Hospital Reimbursement - TRICARE DRG-Based Payment System (General)
2	Hospital Reimbursement - TRICARE DRG-Based Payment System (General Description Of System)
3	Hospital Reimbursement - TRICARE DRG-Based Payment System (Basis Of Payment)
4	Hospital Reimbursement - TRICARE DRG-Based Payment System (Applicability Of The DRG System)
5	Hospital Reimbursement - TRICARE DRG-Based Payment System (Determination Of Payment Amounts)
6	Hospital Reimbursement - TRICARE DRG-Based Payment System (DRG Weighting Factors)
7	Hospital Reimbursement - TRICARE DRG-Based Payment System (Adjusted Standardized Amounts (ASAs))
8	Hospital Reimbursement - TRICARE DRG-Based Payment System (Adjustments To Payment Amounts)
9	Hospital Reimbursement - TRICARE DRG-Based Payment System (Information Provided By TMA)
10	Hospital Reimbursement - TRICARE DRG-Based Payment System (Charges To Beneficiaries)
A	Health Benefit Program Agreement
B (FY 2014)	TRICARE Adjusted Standardized Amounts (ASAs) - FY 2014 Figure 6.B.2014-1 69.6% Labor Share/30.4% Non-Labor Share If Wage Index Greater Than 1 Figure 6.B.2014-2 62% Labor Share/38% Non-Labor Share If Wage Index Less Than Or Equal To 1
B (FY 2015)	TRICARE Adjusted Standardized Amounts (ASAs) - FY 2015 Figure 6.B.2015-1 69.6% Labor Share/30.4% Non-Labor Share If Wage Index Greater Than 1 Figure 6.B.2015-2 62% Labor Share/38% Non-Labor Share If Wage Index Less Than Or Equal To 1
B (FY 2016)	TRICARE Adjusted Standardized Amounts (ASAs) - FY 2016
C (FY 2014)	Diagnosis Related Groups (DRGs), DRG Relative Weights, Arithmetic And Geometric Mean Lengths-Of-Stay (LOS), And Short-Stay Outlier Thresholds - FY 2014

Section/Addendum	Subject/Addendum Title
C (FY 2015)	Diagnosis Related Groups (DRGs), DRG Relative Weights, Arithmetic And Geometric Mean Lengths-Of-Stay (LOS), And Short-Stay Outlier Thresholds - FY 2015
C (FY 2016)	Diagnosis Related Groups (DRGs), DRG Relative Weights, Arithmetic And Geometric Mean Lengths-Of-Stay (LOS), And Short-Stay Outlier Thresholds - FY 2016

Chapter 6 Section 7

Hospital Reimbursement - TRICARE DRG-Based Payment System (Adjusted Standardized Amounts (ASAs))

Issue Date: October 8, 1987
Authority: 32 CFR 199.14(a)(1)

1.0 APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the Defense Health Agency (DHA) and specifically included in the network provider agreement.

2.0 ISSUE

What are the Adjusted Standardized Amounts (ASAs) under the TRICARE Diagnosis Related Group (DRG)-based payment system, and how are they used and calculated?

3.0 POLICY

3.1 General

The ASA represents the adjusted average operating cost for treating all TRICARE beneficiaries in all DRGs during the database period. During Fiscal Year (FY) 1988 the TRICARE DRG-based payment system used two ASAs--one for urban areas and one for rural areas. Beginning in FY 1989 (admissions on or after October 1, 1988), three ASAs are used--one for large urban areas, one for other urban areas, and one for rural areas. Effective October 1, 1994, rural hospitals will receive the same payment rate as other urban hospitals. Effective April 1, through September 30, 2003, and November 1, 2003 forward, hospitals located in other areas shall receive the same ASA payment rate as large urban hospitals.

3.2 Calculation Of The ASA

The following procedures will be followed in calculating the TRICARE ASA.

3.2.1 Apply the Cost-to-Charge Ratio (CCR). In this step each charge is reduced to a representative cost by using the Medicare CCR. Effective FY 2014, the CCR is 0.2778. Effective FY 2015, the CCR is 0.2726. Effective FY 2016, the CCR is 0.2631.

3.2.2 Increase for Bad Debts. The base standardized amount will be increased by 0.01 in order to reimburse hospitals for bad debt expenses attributable to TRICARE beneficiaries. The base standardized amount will be increased by 0.0060 for FY 2000, 0.0055 for FY 2001, and through July

14, 2001, and by 0.0070 as of July 15, 2001 through FY 2012. Effective FY 2013, the base standardized amount will be increased by 0.0065.

3.2.3 Update for Inflation. Each record in the database will be updated to FY 1988 using a factor equal to 1.07. Thereafter, any recalculation of the ASA will use an inflation factor equal to the hospital market basket index used by the Centers of Medicare and Medicaid Services (CMS) in their Prospective Payment System (PPS).

3.2.4 Preliminary Non-Teaching Standardized Amount. At this point Indirect Medical Education (IDME) costs have been removed through standardization in the weight methodology and direct medical education costs have been removed through the application of the Medicare CCR which does not include direct medical education costs. Therefore, a non-teaching standardized amount will be computed by dividing aggregate costs by the number of discharges in the database.

3.2.5 Preliminary Teaching Standardized Amounts. A separate standardized amount will be calculated for each teaching hospital to reimburse for IDME expenses. This will be done by multiplying the non-teaching standardized amount by 1.0 plus each hospital's IDME factor.

3.2.6 System Standardization. The preliminary standardized amounts will be further standardized using a factor which equals total DRG payments using the preliminary standardized amounts divided by the sum of all costs in the database (updated for inflation). To achieve standardization, each preliminary standardized amount will be divided by this factor. This step is necessary so that total DRG system outlays, given the same distribution among hospitals and diagnoses, are equal whether based on DRGs or on charges reduced to costs.

3.2.7 Labor-Related and Nonlabor-Related Portions of the ASA. The ASA shall be divided into labor-related and nonlabor-related portions according to the ratio of these amounts in the national ASA under the Medicare PPS. Since October 1, 1997, the labor-related portion of the ASA equals 71.1% and the non-labor portion equals 28.9%. Effective October 1, 2004, and subsequent years, for wage indexes less than or equal to 1.0 the labor related portion of the ASA shall equal 62%. Effective October 1, 2005, and subsequent years, for wage index values greater than 1.0, the labor related portion of the ASA shall equal 69.7%. Effective October 1, 2009 and subsequent years, for wage index values greater than 1.0, the labor related portion of the ASA shall equal 68.8% and the non-labor-related portion shall equal 31.2%. Effective October 1, 2013, and subsequent years, for wage index values greater than 1.0, the labor related portion of the ASA shall equal 69.6%, and the non-labor related portion shall equal 30.4%. For wage indexes less than or equal to 1.0 the labor-related portion for the ASA shall equal 62% and the non-labor-related portion shall equal 38%.

3.2.8 Updating the Standardized Amounts. For years subsequent to the initial year, the standardized amounts will be updated by the final published Medicare annual update factor, unless the standardized amounts are recalculated.

- END -

rounded down to the nearest whole number, and any stay equal to or less than the short-stay threshold will be considered a short-stay outlier.

- Short-stay outliers will be reimbursed at 200% of the per diem rate for the DRG for each covered day of the hospital stay, not to exceed the DRG amount. The per diem rate shall equal the wage-adjusted DRG amount divided by the arithmetic mean LOS for the DRG. The per diem rate is to be calculated before the DRG-based amount is adjusted for IDME. Cost outlier payments shall be paid on short stay outlier cases that qualify as a cost outlier.

- Any stay which qualifies as a short-stay outlier (a transfer cannot qualify as a short-stay outlier), even if payment is limited to the normal DRG amount, is to be considered and reported on the payment records as a short-stay outlier. This will ensure that outlier data is accurate and will prevent the beneficiary from paying an excessive cost-share in certain circumstances.

3.2.6.4 Cost Outliers

3.2.6.4.1 Any discharge which has standardized costs that exceed the thresholds outlined below, will be classified as a cost outlier.

3.2.6.4.1.1 For admissions occurring prior to October 1, 1997, the standardized costs will be calculated by first subtracting the noncovered charges, multiplying the total charges (less lines 7, N, and X) by the CCR and adjusting this amount for IDME costs by dividing the amount by one plus the hospital's IDME adjustment factor. For admissions occurring on or after October 1, 1997, the costs for IDME are no longer standardized.

3.2.6.4.1.2 Cost outliers will be reimbursed the DRG-based amount plus 80% effective October 1, 1994 of the standardized costs exceeding the threshold.

3.2.6.4.1.3 For admissions occurring on or after October 1, 1997, the following steps shall be followed when calculating cost outlier payments for all cases other than neonates and children's hospitals:

Standard Cost = (Billed Charges x CCR)

Outlier Payment = 80% of (Standard Cost - Threshold)

Total Payments = Outlier Payments + (DRG Base Rate x (1 + (IDME))

Note: Noncovered charges should continue to be subtracted from the billed charges prior to multiplying the billed charges by the CCR.

3.2.6.4.1.4 The CCR for admissions occurring on or after October 1, 2013, is 0.2778. The CCR for admissions occurring on or after October 1, 2014, is 0.2726. The CCR for admissions occurring on or after October 1, 2015, is 0.2631.

3.2.6.4.1.5 The National Operating Standard Cost as a Share of Total Costs (NOSCASTC) for calculating the cost-outlier threshold for FY 2014 is 0.920, for FY 2015 is 0.922, and for FY 2016 is 0.921.

3.2.6.4.2 For FY 2014, a TRICARE fixed loss cost-outlier threshold is set at $20,008. Effective October 1, 2013, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of $20,008 (also wage-adjusted).

3.2.6.4.3 For FY 2015, a TRICARE fixed loss cost-outlier threshold is set at $22,705. Effective October 1, 2014, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of $22,705 (also wage-adjusted).

3.2.6.4.4 For FY 2016, a TRICARE fixed loss cost-outlier threshold is set at $20,763. Effective October 1, 2015, the cost-outlier threshold shall be the DRG-based amount (wage-adjusted) plus the IDME payment, plus the flat rate of $20,763 (also wage-adjusted).

3.2.6.4.5 The cost-outlier threshold shall be calculated as follows:

{[Fixed Loss Threshold x ((Labor-Related Share x Applicable wage index) + Non-labor-related share) x NOSCASTC] + (DRG Base Payment (wage-adjusted) x (1 + IDME))}

Example: Using FY 1999 figures {[10,129 x ((0.7110 x Applicable wage index) + 0.2890) x 0.913] + (DRG Based Payment (wage-adjusted) x (1 + IDME))}

3.2.6.5 Burn Outliers

3.2.6.5.1 Burn outliers generally will be subject to the same outlier policies applicable to the TRICARE DRG-based payment system except as indicated below. For admissions prior to October 1, 1998, there are six DRGs related to burn cases. They are:

456 - Burns, transferred to another acute care facility
457 - Extensive burns w/o O.R. procedure
458 - Non-extensive burns with skin graft
459 - Non-extensive burns with wound debridement or other O.R. procedure
460 - Non-extensive burns w/o O.R. procedure
472 - Extensive burns with O.R. procedure

3.2.6.5.2 Effective for admissions on or after October 1, 1998, the above listed DRGs are no longer valid.

3.2.6.5.3 For admissions on or after October 1, 1998, there are eight DRGs related to burn cases. They are:

504 - Extensive 3rd degree burn w skin graft
505 - Extensive 3rd degree burn w/o skin graft
506 - Full thick burn w sk graft or inhal inj w cc or sig tr

507 - Full thick burn w sk graft or inhal inj w/o cc or sig tr
508 - Full thick burn w/o sk graft or inhal inj w cc or sig tr
509 - Full thick burn w/o sk graft or inhal inj w/o cc or sig tr
510 - Non-extensive burns w cc or significant trauma
511 - Non-extensive burns w/o cc or significant trauma

3.2.6.5.3.1 Effective October 1, 2008, and thereafter, the DRGs for these descriptions can be found at http://www.health.mil/rates.

3.2.6.5.3.2 For burn cases with admissions occurring prior to October 1, 1988, there are no special procedures. The marginal cost factor for outliers for all such cases will be 60%.

3.2.6.5.3.3 Burn cases which qualify as short-stay outliers, regardless of the date of admission, will be reimbursed according to the procedures for short-stay outliers.

3.2.6.5.3.4 Burn cases with admissions occurring on or after October 1, 1988, which qualify as cost outliers will be reimbursed using a marginal cost factor of 90%.

3.2.6.5.3.5 For a burn outlier in a children's hospital, the appropriate children's hospital outlier threshold is to be used (see below), but the marginal cost factor is to be either 60% or 90% according to the criteria above.

3.2.6.6 Children's Hospital Outliers

The following special provisions apply to cost outliers.

3.2.6.6.1 The threshold shall be the same as that applied to other hospitals.

3.2.6.6.2 Effective October 1, 2013, the standardized costs are calculated using a CCR of 0.3012. Effective October 1, 2014, the standardized costs are calculated using a CCR of 0.2939. Effective October 1, 2015, the standardized costs are calculated using a CCR of 0.2840. (This is equivalent to the Medicare CCR increased to account for CAP/DME costs.)

3.2.6.6.3 The marginal cost factor shall be 80%.

3.2.6.6.4 For admissions occurring during FY 2014, the marginal cost factor shall be adjusted by 1.10. For admissions occurring during FY 2015, the marginal cost factor shall be adjusted by 1.18. The marginal cost factor for FY 2016 is posted to the DHA web site at http://health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement.

3.2.6.6.5 The NOSCASTC for calculating the cost-outlier threshold for FY 2012 is 0.919. The NOSCASTC for calculating the cost-outlier threshold for FY 2013 is 0.920. The NOSCASTC for calculating the cost-outlier threshold for FY 2014 is 0.920. The NOSCASTC for calculating the cost-outlier threshold for FY 2015 is 0.922. The NOSCASTC for calculating the cost-outlier threshold for FY 2015 is 0.921.

3.2.6.6.6 The following calculation shall be used in determining cost outlier payments for children's hospitals and neonates:

Step 1: Computation of Standardized Costs:

Billed Charges x CCR

(Non-covered charges shall be subtracted from the billed charges prior to multiplying the charges by the CCR.)

Step 2: Determination of Cost-Outlier Threshold:

{[Fixed Loss Threshold x ((Labor-Related Share x Applicable wage index) + Non-labor-related share) x NOSCASTC] + [DRG Based Payment (wage-adjusted) x (1 + IDME)]}

Step 3: Determination of Cost Outlier Payment

[{(Standardized costs - Cost-Outlier Threshold) x Marginal Cost Factor} x Adjustment Factor]

Step 4: Total Payments = Outlier Payments + [DRG Base Rate x (1 + IDME)]

3.2.6.7 Neonatal Outliers

Neonatal outliers in hospitals subject to the TRICARE DRG-based payment system (other than children's hospitals) shall be determined under the same rules applicable to children's hospitals, except that the standardized costs for cost outliers shall be calculated using the CCR of 0.64. Effective for admissions occurring on or after October 1, 2005, and subsequent years, the CCR used to calculate cost outliers for neonates in acute care hospitals shall be reduced to the same CCR used for all other acute care hospitals.

3.2.7 IDME adjustment

3.2.7.1 General

The DRG-based payments for any hospital which has a teaching program approved under Medicare Regulation Section 413.85, Title 42 CFR shall be adjusted to account for IDME costs. The adjustment factor used shall be the one in effect on the date of discharge (see below). The adjustment will be made by multiplying the total DRG-based amount by 1.0 plus a hospital-specific factor equal to:

$$1.04 \text{ X } \left[\left(1.0 + \frac{\text{number of interns + residents}}{\text{number of beds}} \right)^{.5795} - 1.0 \right]$$

- For admissions occurring during FYs 2008 and subsequent years, the same formula shall be used except the first number shall be 1.02.

TRICARE Adjusted Standardized Amounts (ASAs) - FY 2016

These amounts are posted to the Defense Health Agency (DHA) web site at http://health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement.

The FY 2016 cost-share per diem for beneficiaries other than dependents of active duty member are posted to the DHA web site at http://health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement.

- END -

Chapter 6 Addendum C (FY 2016)

Diagnosis Related Groups (DRGs), DRG Relative Weights, Arithmetic And Geometric Mean Lengths-Of-Stay (LOS), And Short-Stay Outlier Thresholds - FY 2016

Effective for admissions on or after October 1, 2015, the DRG weights and rates are posted to the Defense Health Agency (DHA) web site at http://health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement.

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