Hospital Reimbursement - TRICARE DRG-Based Payment System (New Technology Add-On Payments (NTAPs))

Issue Date: January 8, 2021
Authority: 32 CFR 199.14(a)(1)(iii)(E)

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 NTAPs, and how are they reimbursed?

3.0 NTAP OVERVIEW

3.1 NTAPs are special payments that are offered because new medical services and new technologies are not yet included in the calculation of standardized DRG rates. By law and regulation, Medicare has established a reimbursement methodology to more appropriately pay for the costs of new medical services and technologies under the hospital Inpatient Prospective Payment System (IPPS). As a part of this methodology, Centers for Medicare & Medicaid Services (CMS) clinical experts evaluate applications for new technologies that may raise the cost of care to the extent that it merits additional payment beyond the base DRG payment.

3.2 CMS uses criteria set forth in regulation regarding the newness, clinical benefit, and cost of a new technology to determine which treatments will receive an NTAP. That is, CMS determines the newness based upon the delay in projected market entry; clinical benefits considerations require that the technology substantially improve the diagnosis or treatment of patients; and cost considerations require the applicant to provide data showing that the technology is expensive relative to the cost of the entire case based upon set statistical cost deviations.

3.3 To qualify for the NTAPs, a specific technology will be "new" according to CMS regulations, specifically §412.87(b)(2). The statutory provision allows for special payment treatment for new technologies until they are incorporated into the DRG, which takes between two and three years. Once they are incorporated into the DRG, they are no longer considered NTAPs.

4.0 POLICY

In accordance with Title 10, United States Code (USC), Section 1079(i)(2), the amount to be paid to hospitals, Skilled Nursing Facilities (SNFs), and other institutional providers under the TRICARE program, "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." This statutory authority has been implemented through an Interim Final Rule (IFR) with Request for Comment, published in the Federal Register on September 3, 2020, amending the TRICARE regulation by adding 32 Code of Federal Regulations (CFR) 32 CFR 199.14(a)(1)(iii)(E)*(5)* to allow adoption of Medicare NTAP payment adjustments to TRICARE DRG reimbursements. Under the amended TRICARE regulation, any Medicare approved NTAP reimbursement of hospitals subject to the Medicare program as required under 42 CFR 412.88 will be adopted or adopted as modified for TRICARE unless the Assistant Secretary of Defense for Health Affairs (ASD(HA)) determines that it is not practicable for TRICARE to adopt the Medicare NTAP. The Director, Defense Health Agency will issue necessary guidance regarding any Medicare NTAP not adopted by the ASD(HA) or any modification of a Medicare NTAP deemed necessary for adoption by TRICARE.

4.1 Payment Method

4.1.1 NTAP payment adjustments apply for discharges on or after January 1, 2020.

4.1.2 The contractor shall reimburse hospitals subject to NTAPs using the list of NTAPs and reimbursement rules in the current Fiscal Year (FY) IPPS Final Rule Home Page found on the CMS website. The reimbursement amounts in the current FY IPPS Final rule represent the maximum add-on payment that will be provided for each NTAP.

4.1.3 The contractor shall determine each procedure code eligible for an NTAP payment according to 42 CFR 412.87, which provides the reference to the most recent **Federal Register** with a list of approved NTAPs and the procedure codes used to identify use of the technology. Each year in the IPPS Final Rule, the list of NTAPs is updated by CMS.

4.1.3.1 The contractor shall maintain a list of procedure codes eligible for NTAP payments.

4.1.3.2 The contractor shall update the list of procedure codes eligible for NTAPs within ten business days of publication by CMS.

4.1.4 The contractor shall also determine the maximum NTAP payment amount for each technology according to 42 CFR 412.87, which provides the reference to the most recent **Federal Register** with the maximum payment for each approved NTAP. Each year the maximum NTAP payment amounts are updated by CMS.

4.1.4.1 The contractor shall maintain a list of the maximum NTAP payment amounts for each technology.

4.1.4.2 The contractor shall update the list of the maximum NTAP payment amounts for each technology within ten business days of publication by CMS.

4.1.5 The contractor shall apply the separate NTAP payment using the appropriate formula from the IPPS Final Rule and as documented in 42 CFR 412.88. The contractor shall calculate for each eligible NTAP on a claim, case the appropriate NTAP payment, where the payment rate is equal to the lesser of:

- The designated percentage of the amount by which the total covered costs of the case exceed the Medicare Severity (MS)-DRG payment, as determined by CMS, as published in the current FY IPPS Final rule, or

- The maximum NTAP payment amount for the specific technology, as determined by CMS.

The resulting NTAP amount shall then be reimbursed in addition to the TRICARE DRG payment amount.

4.2 The contractor shall monitor the CMS FY IPPS website and adopt other updates (e.g., in the case that Medicare issues a correction or mid-year update) to the list of NTAPs, the designated percentage of the amount by which the total covered costs of the case exceed the MS-DRG payment, and maximum payment amounts within ten business days of publication by CMS.

5.0 EXCLUSIONS

5.1 Hospitals excluded from IPPS.

5.2 Hospitals that are located in the state of Maryland participate in the CMS Maryland All-Payer Model, and thus do not receive NTAPs.

5.3 Other hospitals excluded from the CMS IPPS, (see Section 4, paragraph 3.3).

6.0 EFFECTIVE DATE

January 1, 2020.

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