buildings. The United States Department of the Treasury (Treasury) awards Section 1602 funds to State housing credit agencies in an amount equal to their low-income housing grant election amount which may not exceed a portion of the States' low-income housing tax credit ceiling for 2009.

Section 1602(d) of the Act requires that State housing credit agencies return to the Treasury funds not used to make subawards before January 1, 2011. The Terms and Conditions promulgated by the Treasury to govern the program require that any funds not disbursed before January 1, 2011, be returned to the Treasury. Upon further consideration Treasury has determined that this requirement is overly restrictive and may preclude funding of otherwise eligible projects that may not reach final completion by the end of 2010. This rule therefore changes this requirement. Under this rule set forth at 31 CFR part 32, State housing credit agencies are required to return to the Treasury any funds not used to make subawards by December 31, 2010. However, once a subaward has been made, a State can continue to disburse funds for the subaward through December 31, 2011, provided the project is at least 30 percent complete by the end of 2010.

II. Procedural Analyses

Administrative Procedures Act

This rule is being issued without prior public notice and comment because under 5 U.S.C. 553(b) and (d)(3) good cause exists to determine that prior notice and comment rulemaking is unnecessary and contrary to the public interest. The policy being implemented through this rule impacts procedural requirements imposed on State housing credit agencies that receive funds from the Federal government under Section 1602 and does not adversely affect the rights of the public. Additionally, delay in the effective date of this rule is contrary to the public interest because without clarity regarding the time period within which State housing credit agencies may disburse funds under the program, State housing credit agencies are unable to make decisions regarding which projects to fund thereby delaying the construction or rehabilitation of low-income housing.

Request for Comment on Plain Language

Executive Order 12866 requires each agency in the Executive branch to write regulations that are simple and easy to understand. We invite comment on how to make the interim rule clearer. For example, you may wish to discuss: (1) Whether we have organized the material to suit your needs; (2) whether the requirements of the rules are clear; or (3) whether there is something else we could do to make these rules easier to understand.

Regulatory Planning and Review

The rule is a ''significant regulatory action'' as defined in Executive Order 12866. Accordingly, the rule has been reviewed by the Office of Management and Budget.

Regulatory Flexibility Act Analysis

Because no notice of rulemaking is required, the provisions of the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) do not apply.

List of Subjects in 31 CFR Part 32

Low-income housing tax credits.

■ For the reasons set forth in the preamble, we add 31 CFR Part 32 to read as follows:

PART 32—PAYMENTS IN LIEU OF LOW INCOME HOUSING TAX CREDITS

Sec.

32.1. Timing of disbursements.

Authority: Public Law 111–5.

§ 32.1 Timing of disbursements.

(a) State housing credit agencies that receive funds under section 1602 of Division B of the American Recovery and Reinvestment Tax Act of 2009 must make subawards to subawardees to finance the construction or acquisition and rehabilitation of low-income housing no later than December 31, 2010. Any funds that are not used to make subawards by December 31, 2010, must be returned to the Treasury by January 1, 2011.

(b) The requirement in subsection (a) above does not prevent State housing credit agencies from continuing to disburse funds to subawardees after December 31, 2010 provided:

(1) A subaward has been made to the subawardee on or before December 31, 2010;

(2) The subawardee has, by the close of 2010, paid or incurred at least 30 percent of the subawardee's total adjusted basis in land and depreciable property that is reasonably expected to be part of the low-income housing project; and

(3) Any funds not disbursed to the subawardee by December 31, 2011, must be returned to the Treasury by January 1, 2012.

Dated: August 19, 2009.

Gary Grippo,

Acting Fiscal Assistant Secretary.

[FR Doc. E9–20903 Filed 8–28–09; 8:45 am]

BILLING CODE 4810–25–P

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

[DoD–2008–HA–0007; RIN 0720–AB21]

TRICARE; Reimbursement of Critical Access Hospitals (CAHs)

AGENCY: Office of the Secretary, Department of Defense.

ACTION: Final rule.

SUMMARY: This rule implements the statutory provisions that TRICARE payment methods for institutional care be determined to the extent practicable in accordance with the same reimbursement rules as those that apply to payments to providers of services of the same type under Medicare. This final rule implements a reimbursement methodology similar to that furnished to Medicare beneficiaries for services provided by critical access hospitals (CAHs).

DATES: *Effective Date:* This rule is effective December 1, 2009.

FOR FURTHER INFORMATION CONTACT: Ms. Martha M. Maxey, TRICARE Management Activity, Medical Benefits and Reimbursement Branch, telephone (303) 676–3627.

SUPPLEMENTARY INFORMATION:

I. Introduction and Background

Hospitals are authorized TRICARE institutional providers under 10 U.S. Code 1079(j)(2) and (4). Under 10 U.S.C. 1079(j)(2), the amount to be paid to hospitals, skilled nursing facilities (SNFs), and other institutional providers under TRICARE, ''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.'' Under 32 CFR 199.14(a)(1)(ii)(D)(1) through (9) it specifically lists those hospitals that are exempt from the DRG-based payment system. CAHs are not listed as exempt, thereby making them subject to the DRG-based payment system. CAHs are not listed as excluded, because at the time this regulatory provision was written, CAHs were not a recognized entity.

Legislation enacted as part of the Balanced Budget Act (BBA) of 1997

authorized states to establish State Medicare Rural Hospital Flexibility Programs, under which certain facilities participating in Medicare could become CAHs. CAHs represent a separate provider type with their own Medicare conditions of participation as well as a separate payment method of 101 percent of reasonable costs. Since that time, a number of hospitals have taken the necessary steps to be designated as CAHs by the Centers for Medicare & Medicaid Services (CMS). The statutory authority requires TRICARE to apply the same reimbursement rules as apply to payments to providers of services of the same type under Medicare to the extent practicable. Therefore, if practicable, TRICARE has the requirement through the publication of a proposed and final rule to exempt critical access hospitals from the DRG-based payment system and adopt a reimbursement method similar to Medicare principles for these hospitals.

Currently under TRICARE, with the exception of Alaska, CAHs are subject to the TRICARE DRG-based payment system for inpatient care. For outpatient care, CAHs are reimbursed based on billed charges for facility charges. In Alaska, under a demonstration project, CAHs are reimbursed the lesser of the billed charge or 101 percent of reasonable costs for inpatient and outpatient care. The 101 percent of reasonable costs is calculated by multiplying the billed charge of each claim by the hospital's cost-to-charge (CCR) ratio, and then adding 1 percent to that amount. Based on the above statutory mandate, TRICARE is proposing to adopt this same reimbursement methodology for all CAHs, with one substantive change. TRICARE will not apply the ''lesser of cost or charges'' provision. We found approximately 15 percent of CAHs have inpatient CCRs of 1.0 or more and 2 percent have outpatient CCRs greater than 1.0. In order to reimburse the vast majority of hospitals 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.

II. Public Comments

The TRICARE Reimbursement of CAHs proposed rule (73 FR 17271) was published on May 5, 2008, providing a 30-day public comment period. Five timely items of correspondence were received containing multiple comments on the proposed rule which resulted in one substantive change in TRICARE's reasonable cost methodology, (i.e., removal of the lesser of cost or charges provision).

Following is a summary of the public comments and our responses:

Comment: Several commenters requested DoD adopt the exact Medicare CAH payment methodology of 101 percent of their allowable and reasonable costs, not being subject to the ''lesser of cost or charges'' reasonable-cost principle. To comply with the statutory requirement regarding hospital reimbursement, these commenters urge the Secretary to adopt Medicare's exact methodology for determining CAH reimbursement for inpatient and outpatient care.

Response: Based on the comments received, TRICARE is removing the ''lesser of cost or charges'' provision from its final rule. We found that approximately 15 percent of CAHs have inpatient CCRs of 1.0 or more but that only 2 percent of CAHs have outpatient CCRs greater than 1.0. In order to reimburse the vast majority of hospitals 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 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 FY09, this calculation resulted in an inpatient CCR cap of 2.12 and outpatient CCR cap of 1.23; these will be re-calculated each year with the CCR update. Thus, for FY09, TRICARE will pay the lesser of 2.12 × billed charges or 101 percent of costs (using the hospital's CCR and billed charges) for inpatient services and the lesser of 1.23 × billed charges or 101 percent of costs for outpatient services. We believe this approach captures the bulk of CAHs' costs.

Comment: Several commenters state the proposed rule fails to address interim payments and cost settlement. Medicare may make interim payments to CAHs during a fiscal year based on costs generally estimated from a prior year's cost report. After a fiscal year ends, Medicare reaches a ''settlement'' with CAHs to align payment with actual costs, which may be higher or lower than estimated. If interim payments were lower than actual costs, Medicare pays the CAH the difference; if payments were higher, the CAH repays Medicare. Therefore, both interim payments and cost settlement help ensure that CAHs are reimbursed in a timely manner at the appropriate level. Without such mechanisms, hospitals could endure a significant amount of uncertainty about whether they will be able to cover their costs, which may affect their ability to provide quality patient care. These commenter's urge the Secretary to make interim payments to and reach cost settlement with CAHs and to do so in the same manner as Medicare.

Response: Since TRICARE is a relatively small payer, and hospitals do not file cost reports with TRICARE, it is not administratively feasible for TRICARE to issue interim payments or conduct retroactive cost settlements. TRICARE will be using historical data to pay claims, i.e., we are using FY 2006 cost report data to calculate CCRs to process and pay claims for services provided in 2009. We acknowledge the data is a few years old, and some hospitals will be paid a little more one year and a little less another year, but over time we believe that the payments will be roughly equal to the hospital's costs. TRICARE does not need to make interim payments because hospitals will be paid as each claim is processed (using the CCR approach). Due to varying fiscal year end dates, database development by CMS, etc., it is not possible to use more recent data.

We have analyzed the impact of the rule on CAHs that have a high percentage of their discharges for TRICARE patients. We examined all the CAHs that served TRICARE patients in October 2008–March 2009 period and found that 11 CAHs had 5 percent or more of their discharges from TRICARE. We then calculated the change in TRICARE payments that would occur due to this rule. We found that the impact was under $1,000 for two of these hospitals, indicating that the rule would have a significant impact on only 9 of the 11 hospitals. For these 9 hospitals, we calculated the change in TRICARE payments relative to estimated total hospital revenues and found that 3 would have had slight declines in overall hospital revenues due to the rule and that 6 would have had increases. The range of change in total hospital revenues was from −2.4 percent to +9.1 percent. The median change in total hospital revenues was estimated to be an increase of 2.9 percent and the average was an increase of 3.2 percent.

Comment: One commenter urges DoD to conduct a thorough review of the Alaska demonstration project—including contacting each of the twelve CAHs that are licensed in Alaska to discuss any difficulties experienced under the demonstration.

Response: The opportunity to provide comments on the proposed reimbursement methodology for CAHs, currently being tested in Alaska, was provided through the publication of the proposed rule. We did receive one item of correspondence from one of the Health Systems in Alaska and their comments are addressed in this final rule. In addition, over the course of the demonstration, we have been contacted by some of the CAHs participating in the demonstration and have worked with them directly to resolve any problems.

Comment: One commenter urged DoD to establish an election option regarding payment for outpatient services that is identical to established Medicare regulations found at 42 CFR Section 413.70(b)(3). The change would also align the TRICARE reimbursement methodology in the proposed rule with Medicare reimbursement principles as required under the statute.

Response: The statutory provision in 10 United States Code 1079(j)(2) states that TRICARE payment methods for institutional care shall be determined to the extent practicable in accordance with the same reimbursement rules as those that apply to payments to providers of services of the same type under Medicare. While it is practicable to adopt a similar payment methodology to Medicare's to pay CAHs 101 percent of reasonable costs, it is not practicable for TRICARE to implement an election option identical to Medicare due to the complexity of identifying what each hospital has elected and keeping up with the changes in the elections and implementing special claims processing procedures to accommodate these elections. TRICARE is not equipped to handle these types of elections.

Comment: One commenter states that while the policy should be automatically effective on a prospective basis, the Secretary should allow CAHs the option to request retroactive reimbursement for all previous years for which they were classified as CAHs.

Response: TRICARE does not have the regulatory authority to allow retroactive reimbursement prior to the effective date of the new reimbursement methodology for CAHs.

Comment: One commenter requests TRICARE clarify in the final rule how the CAH reimbursement methodology will be implemented. They state the proposed rule was not specific and left many questions unanswered such as:

- How will facility specific cost to charge ratios be computed?
- What data elements will be used from the Medicare cost report?
- How often will rates be determined?
- When will rates be updated?
- Will there be retroactive settlements if rates are changed mid-year after the filing of the prior year's Medicare cost report?
- Will there be retroactive settlements after the year's Medicare cost report is audited and final settled?
- Will there be any retroactive settlements or is the entire payment system prospective?

Response: There are ongoing changes to the Medicare cost report; therefore, we think it is more appropriate to include the method for calculating the CCRs and the data elements used from the Medicare cost report in the Critical Access Hospital policy in Chapter 15, Section 1 of the TRICARE Reimbursement Manual (TRM). The TRM can be accessed at *http://manuals.tricare.osd.mil/*. The rates will be calculated and updated on a yearly basis. As stated above, TRICARE will not conduct any retroactive settlements.

Comment: Several commenters state that for many CAHs, their TRICARE patient volume is small enough that setting rates on a prospective basis updated once per year will be sufficient to ensure reasonable reimbursement. However, for those CAHs that have a higher TRICARE patient volume, they suggest a process be established where CAHs on their own initiative, may request a retroactive settlement after the end of a cost reporting period, by providing TRICARE with a copy of their Medicare cost report. A short computation form, similar to the current capital reimbursement form, could be developed to compute such a retroactive settlement.

Response: We agree with the commenter's first statement. In addition, we believe our revised approach on removing the ''lesser of cost or charges'' provision from the final rule will ease hospitals concerns about receiving reasonable reimbursement. As stated above, we have analyzed the impact of the rule on CAHs that have a high percentage of their discharges for TRICARE patients and for the period October 2008—March 2009 we found that 11 of approximately 1275 CAHs had 5 percent or more of their discharges from TRICARE. Of the 11, the impact was under $1,000 for two of the hospitals. For the remaining 9 hospitals, we calculated the change in TRICARE payments relative to estimated total hospital revenues and found that 3 would have had slight declines in overall hospital revenues due to the rule and that 6 would have had increases. The range of change in total hospital revenues was from −2.4 percent to +9.1 percent. The median change in total hospital revenues was estimated to be an increase of 2.9 percent and the average was an increase of 3.2 percent. As stated above, TRICARE will be using historical data to pay claims and over time we believe that the payments will reimburse the vast majority of hospitals for all their costs.

III. Regulatory Procedures

Executive Order 12866, ''Regulatory Planning and Review''

Section 801 of Title 5, U.S.C., and Executive Order (E.O.) 12866 requires certain regulatory assessments and procedures for any major rule or significant regulatory action, defined as one that would result in an annual effect of $100 million or more on the national economy or which would have other substantial impacts. It has been certified that this rule is not an economically significant rule; however, it is a regulatory action which has been reviewed by the Office of Management and Budget as required under the provisions of E.O. 12866.

Sec. 202, Public Law 104–4, ''Unfunded Mandates Reform Act''

It has been certified that this rule does not contain a Federal mandate that may result in the expenditure by State, local and tribal governments, in aggregate, or by the private sector, of $100 million or more in any one year.

Public Law 96–354, ''Regulatory Flexibility Act'' (5 U.S.C. 601)

The Regulatory Flexibility Act (RFA) requires each Federal agency prepare, and make available for public comment, a regulatory flexibility analysis when the agency issues a regulation which would have a significant impact on a substantial number of small entities. This rule will not significantly affect a substantial number of small entities.

Public Law 96–511, ''Paperwork Reduction Act'' (44 U.S.C. Chapter 35)

This rule will not impose any additional information collection requirements on the public under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3511). Existing information collection requirements of the TRICARE, cleared under OMB Control Number 0720–0013, and Medicare programs will be utilized.

Executive Order 13132, ''Federalism''

This rule has been examined for its impact under E.O. 13132. 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.

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 amended as follows:

PART 199—[AMENDED]

■ 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. In § 199.2, paragraph (b) is amended by adding a definition for ''CAHs'' in alphabetical order to read as follows:

§ 199.2 Definitions.

* * * * *

(b) * * *

CAHs. A small facility that provides limited inpatient and outpatient hospital services primarily in rural areas and meets the applicable requirements established by § 199.6(b)(4)(xvi).

* * * * *

■ 3. Section 199.6 is amended by adding new paragraph (b)(4)(xvi).

§ 199.6 TRICARE—authorized providers.

(b) * * *

(4) * * *

(xvi) *CAHs.* CAHs must meet all conditions of participation under 42 CFR 485.601 through 485.645 in relation to TRICARE beneficiaries in order to receive payment under the TRICARE program. If a CAH provides inpatient psychiatric services or inpatient rehabilitation services in a distinct part unit, these distinct part units must meet the conditions of participation in 42 CFR 485.647, with the exception of being paid under the inpatient prospective payment system for psychiatric facilities as specified in 42 CFR 412.1(a)(2) or the inpatient prospective payment system for rehabilitation hospitals or rehabilitation units as specified in 42 CFR 412(a)(3).

* * * * *

■ 4. Section 199.14 is amended by:

■ a. Redesignating paragraphs (a)(3) through (a)(5) as (a)(4) through (a)(6), respectively;

■ b. Revising newly redesignated paragraph (a)(4) introductory text and the first sentence of paragraph (d)(1); and

■ c. Adding new paragraphs (a)(1)(ii)(D)(*10*), (a)(3), and (a)(6)(iii) and (iv).

The revisions and additions read as follows:

§ 199.14 Provider reimbursement methods.

(a) * * *

(1) * * *

(ii) * * *

(D) * * *

(*10*) *CAHs.* Effective December 1, 2009, any facility which has been designated and certified as a CAH as contained in 42 CFR Part 485.606 is exempt from the CHAMPUS DRG-based payment system.

* * * * *

(3) *Reimbursement for inpatient services provided by a CAH.* For admissions on or after December 1, 2009, inpatient services provided by a CAH, other than services provided in psychiatric and rehabilitation distinct part units, shall be reimbursed at 101 percent of reasonable cost. This does not include any costs of physician services or other professional services provided to CAH inpatients. Inpatient services provided in psychiatric distinct part units would be subject to the CHAMPUS mental health per diem payment system. Inpatient services provided in rehabilitation distinct part units would be subject to billed charges or set rates.

(4) *Billed charges and set rates.* The allowable costs for authorized care in all hospitals not subject to the CHAMPUS Diagnosis Related Group-based payment system, the CHAMPUS mental health per diem system, or the reasonable cost method for CAHs, shall be determined on the basis of billed charges or set rates. Under this procedure the allowable costs may not exceed the lower of:

* * * * *

(6) * * *

(iii) *Outpatient Services Subject to CAH Reasonable Cost Method.* For services on or after December 1, 2009, outpatient services provided by a CAH, shall be reimbursed at 101 percent of reasonable cost. This does not include any costs of physician services or other professional services provided to CAH outpatients.

(iv) *CAH Ambulance Services.* Effective for services provided on or after December 1, 2009, payment for ambulance services furnished by a CAH or an entity that is owned and operated by a CAH is the reasonable costs of the CAH or the entity in furnishing those services, but only if the CAH or the entity is the only provider or supplier of ambulance services located within a 35-mile drive of the CAH or the entity as specified under 42 CFR part 413.70(b)(5)(ii).

* * * * *

(d) * * *

(1) *In general.* CHAMPUS pays institutional facility costs for ambulatory surgery on the basis of prospectively determined amounts, as provided in this paragraph, with the exception of ambulatory surgery procedures performed in hospital outpatient departments or in CAHs, which are to be reimbursed in accordance with the provisions of paragraph (a)(6)(ii) or (a)(6)(iii) respectively, of this section. * * *

* * * * *

Dated: August 21, 2009.

Patricia L. Toppings,

OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. E9–20682 Filed 8–28–09; 8:45 am]

BILLING CODE 5001–06–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket No. USCG–2009–0646]

RIN 1625–AA00

Safety Zone; Upper Mississippi River, Mile 427.2 to 427.6, Keithsburg, IL

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing a temporary safety zone for all waters of the Upper Mississippi River, mile 427.2 to 427.6, extending the entire width of the river near Keithsburg, Illinois. This safety zone is needed to protect persons and vessels from safety hazards associated with a fireworks display occurring over a portion of the Upper Mississippi River. Entry into this zone is prohibited unless specifically authorized by the Captain of the Port Upper Mississippi River or a designated representative.

DATES: This rule is effective from 8 p.m. until 10:30 p.m. CDT on September 5, 2009.

ADDRESSES: Documents indicated in this preamble as being available in the