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Honorable J. Dennis Hastert  
Speaker of the House of Representatives  
Washington, DC 20515

Dear Mr. Speaker:

The enclosed report is submitted as required by Section 716 of the National Defense Authorization Act for Fiscal Year 2000. The report details the results of two reviews specific to the TRICARE program.

The first review contains an assessment of whether the reimbursement requirements described in this section will result in utilization by TRICARE of best industry practices, to include an assessment of the costs of implementing these requirements. The review also provides a discussion of TRICARE payment policies and how those policies have influenced provider participation and beneficiary access to care. The Department has monitored closely the participation rates by type of service for different geographic areas. Although access problems persist in certain geographic locations, the number of states with low rates of participation has declined dramatically. Section 716 increased flexibility in our reimbursement provisions and further enhances the Department's ability to respond to local market conditions.

The second review assesses the effects of moving the methodology for charges billed to third party payers for beneficiary care in military treatment facilities (MTFs) from reasonable cost to reasonable charge. This review provides a background on the Third Party Collection Program and addresses potential cost. This change in the direct care billing methodology will affect MTF business practices as well as information system requirements. However, these changes are necessary in order to align our business practices with the civilian industry standards.

Thank you for your continued interest in the Military Health System.

Sincerely,

William Winkenwerder, Jr., MD

Enclosure:  
As stated

# Report to Congress



## Report on TRICARE Reimbursement of Professional Providers

Required by: FY00 National Defense Authorization Act, Section 716

# REPORT TO CONGRESS ON TRICARE REIMBURSEMENT OF PROFESSIONAL PROVIDERS

## Introduction

The Fiscal Year 2000 Defense Authorization Act, Section 716, added a new Section 1097b to Title 10, United States Code, which modifies the reimbursement provisions for TRICARE providers. This Section gives DoD the authority to reimburse network health care providers under the TRICARE program at rates higher than the reimbursement rates otherwise authorized for TRICARE Prime providers. This authority can be exercised if the Secretary determines that application of the higher rates is necessary in order to ensure the availability of an adequate number of qualified network health care providers.

The Act limits the higher reimbursement rate to the lesser of the following two amounts:

1. The amount equal to the local fee-for-service charge for the service in the service area in which the service is provided as determined by the Secretary based on one or more of the following payment rates:
  - (a) Usual, customary, and reasonable.
  - (b) The Health Care Financing Administration's Resource Based Relative Value Scale.
  - (c) Negotiated fee schedules.
  - (d) Global fees.
  - (e) Sliding scale individual fee allowances.
2. The amount equal to 115 percent of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) maximum allowable charge (CMAC) for the service.

The Act also required the Department of Defense (DoD) to provide a Report to Congress assessing the effects of the implementation of the requirements and authorities set forth above. The Act indicated that the report should assess the cost of the implementation of such requirements and authorities as well as whether the implementation of any such requirements and authorities will result in the utilization by TRICARE of the best industry practices with respect to these matters.

Coincident with the development of the report to Congress, DoD has published a notice of proposed rulemaking regarding improvements in access to services in TRICARE. The rulemaking implements the new Section 1097b provisions related to reimbursement of network providers, as well as provides increased flexibility to increase payments where needed to assure access for TRICARE beneficiaries.

## **Background on TRICARE and CHAMPUS Payments to Providers**

The relationship of DoD payment levels to Medicare's for institutional and professional health care services is central to the ongoing success of TRICARE. Payment levels have significant effects on DoD's ability to implement an integrated health service delivery program, to assure beneficiary access to the full spectrum of health services and to do these cost-effectively.

It is appropriate that Medicare serve as the model for establishment of payment rates for TRICARE. Medicare is by far the largest payer for health services in the country, and as such its payment methodologies are carefully developed by the Executive Branch and the Congress, and subject to intense scrutiny by the public and by providers of health services. When payment rate policy was established by the Congress and the Executive Branch in the 1980s and early 1990s, CHAMPUS, being structurally similar to Medicare, and a considerably smaller program, neither attracted nor warranted the same degree of attention in development of reimbursement methods. Thus, Congress followed the prudent course of directing DoD to adopt or adapt Medicare payment approaches when appropriate.

Legislative initiatives to link DoD and Medicare payment rates for health care began in the early 1980s, with the initial focus on institutional services. DoD was directed to pay hospitals to the extent practicable using the same reimbursement rules as apply to Medicare providers. In 1986, a statutory provision was enacted requiring hospitals participating in Medicare to also participate in CHAMPUS. On the basis of these authorities, a Diagnosis Related Group-Based Payment System was implemented for CHAMPUS in 1987, modeled largely on the Medicare Prospective Payment System that had been implemented in 1983.

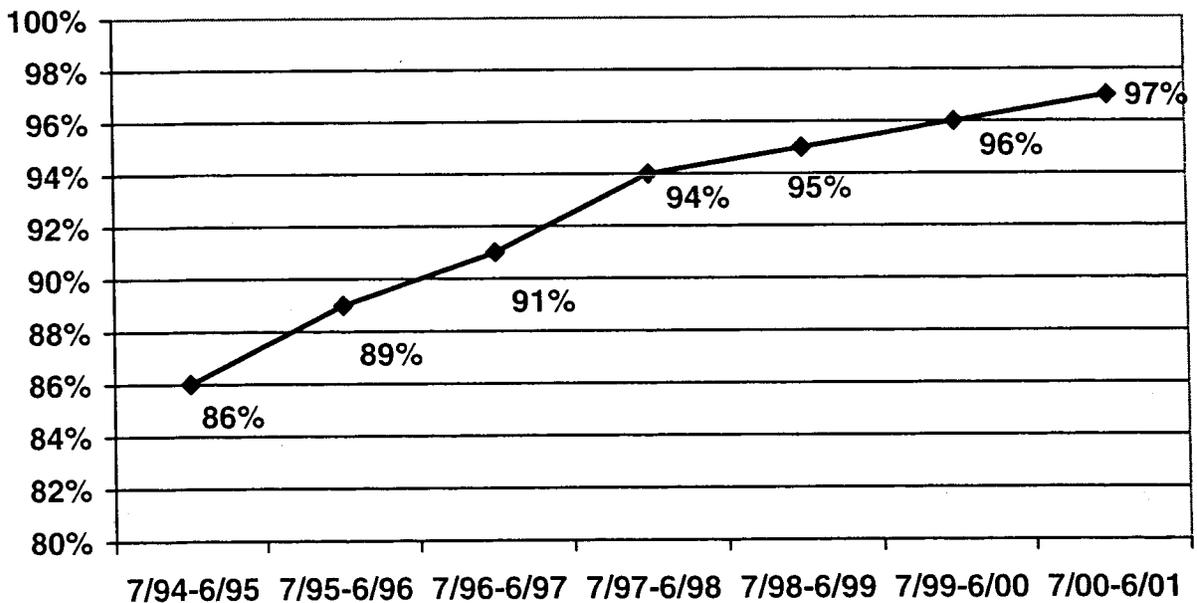
Similar initiatives have linked DoD's payment levels for professional services to Medicare. Based on General Accounting Office recommendations, Congress in 1988 directed that growth in CHAMPUS prevailing charges be limited through application of the Medicare Economic Index, which had been used since 1972 as a limit on growth in Medicare physician payments. Beginning in 1991, Congress directed that CHAMPUS payments be analyzed to identify overpriced procedures, and gradually to bring payment levels for those procedures into line with payments under Medicare. TRICARE payment limits are called CMACs (CHAMPUS Maximum Allowable Charges).

In 1992, Medicare implemented the Medicare Fee Schedule, and began basing payment limits on the relative resource requirements of procedures, rather than on historical charges submitted by providers. In keeping with statutory direction, Medicare

Fee Schedule amounts have become the target payment amounts for TRICARE. The National Defense Authorization Act for Fiscal Year 1996 codified the linkage to Medicare payment amounts.

A key principle of DoD's activity in reimbursement design has been the protection of access to services. The statutory linkage of hospital participation in CHAMPUS to Medicare participation provided ample protection for DoD's beneficiaries, and enabled aggressive implementation of the CHAMPUS DRG-Based Payment System, which saved taxpayers (and beneficiaries) hundreds of millions of dollars per year. Lacking similar protections for physician services, DoD had to proceed more cautiously: payment levels have been gradually brought into harmony with Medicare's rates over several years, and special provisions are built into the process to stop reducing payments if access was threatened. In a 1996 Report to Congress, DoD reviewed acceptance of its payment rates, and found that 86% of the time, physicians accepted the CMAC as payment in full; 14% of services were subject to balance billing. More recently, this has increased to 97% acceptance, with only three percent of civilian services subject to balance billing (see Figure 1). For the small proportion of claims that are subject to balance billing, providers are prohibited from collecting more than 115% of the CMAC rate, just as in Medicare.

**Figure 1**



**TRICARE National Physician Participation Rates**

Over 98% of physician CMAC rates are now at the same level as Medicare, and fewer than two percent are higher than Medicare because their gradual transition to the Medicare level is not yet complete (about 0.5% are higher due to special policies for maternity services). Historically, owing to the strict wording of the Appropriations Act provision on physician payment reform, DoD did not have broad discretion to raise payments for services reimbursed at rates below the Medicare level. Although these services (about 60 out of the 7,200 service types reimbursed) represented less than 0.2% of DoD spending for health services (roughly \$14 million out of \$10 billion), it was important that this issue be addressed. The Department issued a final regulation in September 1998 to provide that in these few cases in which the CMAC rate was less than the Medicare rate, the CMAC rate would be increased to the Medicare level. Implementation was in the February 1, 1999 update of payment rates.

In February 1998, the General Accounting Office (GAO) issued a report, "Defense Health Care: Reimbursement Rates Appropriately Set; Other Problems Concern Physicians" (GAO/HEHS-98-80). In conducting the study from March 1997 to January 1998, GAO reviewed the establishment of CMACs and contracted with actuaries to evaluate the methodology's compliance with statutory requirements; compared Medicare and CMAC rates; interviewed physicians and beneficiary advocacy groups in four locations; and interviewed TRICARE administrators and staff from TRICARE contractors. The GAO found that the CMAC methodology was sound, and that DoD saves about \$770 million annually as a result of CMACs.

The GAO also found that:

- CMAC rates were generally consistent with Medicare's rates.
- Physician concerns focused on network discounts off CMACs, rather than on the acceptability of CMACs themselves. Local market factors were found to be the principal determinants of whether physicians would accept discounts off CMACs.
- Physicians also expressed concerns about administrative hassles and slow claims payments.

GAO suggested that DoD do a better job of informing physicians about payment rates, and informing beneficiaries about balance billing limitations. Payment rates are now available on the Internet, and the Explanation of Benefits for each claim describes the applicable balance billing limit. Revisions to claims payment timeliness requirements have addressed many concerns about slow payments. Physicians' concerns about timely claims payments have been addressed in other recent program improvements.

The amounts paid for health care services in TRICARE are governed by either the payment rules described above or on the basis of discounts from those rates. Each regional at-risk TRICARE contractor is required to establish a network of providers where the TRICARE Prime (HMO-type) option is offered, and the contractor attempts to negotiate reduced payment amounts with providers who join the network. Beneficiaries who enroll in TRICARE Prime use the network for most civilian health care services; beneficiaries who do not enroll retain their freedom to use any civilian provider under TRICARE Standard, but can take advantage of the discounted network under TRICARE Extra. DoD thus achieves efficiencies for itself and its beneficiaries while preserving freedom of choice of provider for those who do not wish to use the managed care options of TRICARE.

The evolution of DoD reimbursement reforms over the past 15 years has complemented DoD's managed care initiatives; one could not have proceeded without the other. Continued attention to beneficiary access and satisfaction issues will enable DoD to continue to assure high quality services for military families and retirees.

### **Access to Care Issues**

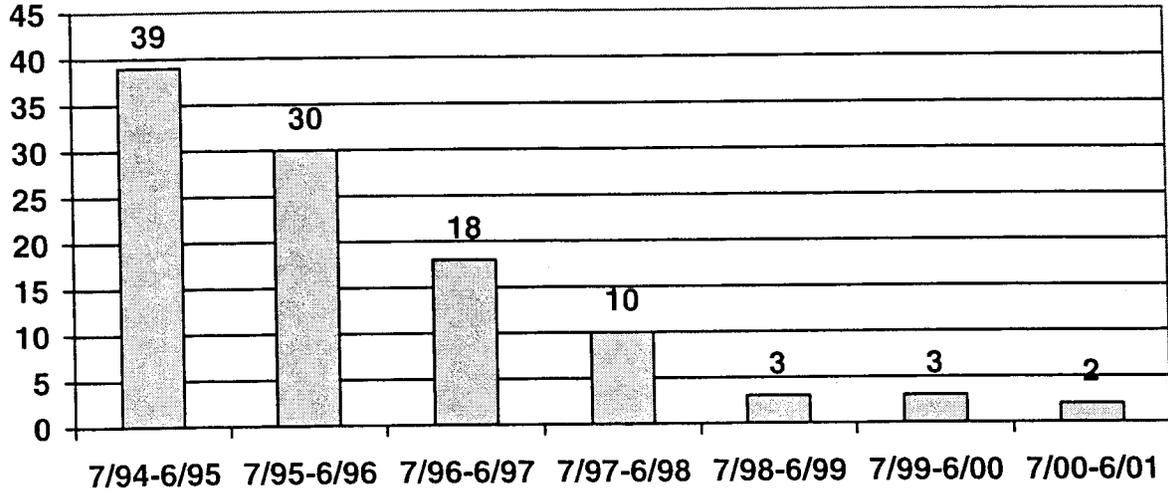
As measured by acceptability of payment rates, access to professional services in TRICARE is at its highest level in history. Over 96% of the time, providers accept the TRICARE payment amount as full payment, and do not balance bill the beneficiary. This high rate of acceptance has been achieved despite ongoing reductions in payment amounts over the past several years.

DoD is concerned that the very high acceptance rate for TRICARE payments to professional providers may mask local access problems. When the CMAC payment approach was implemented in 1992, national payment levels were adjusted to reflect local economic conditions in over two hundred "localities" following the Medicare program's technique for recognizing local variations. (This replaced the historical approach taken for CHAMPUS, which based payments on statewide patterns). Since that time, the number of localities has been reduced to fewer than ninety, with the introduction of more and more statewide payment localities for Medicare, and hence for TRICARE.

The number of states with low rates of provider participation has also dropped significantly in recent years. In the July 1994 – June 1995 period, the national TRICARE physician participation rate (for all physician services) was approximately 86%. At that time, 39 states had participation rates below that average level of 86%. As Figure 2 indicates, there are currently only two states in which participation rates are below 86%. Thus, the likelihood that a TRICARE beneficiary will be balance billed has declined dramatically.

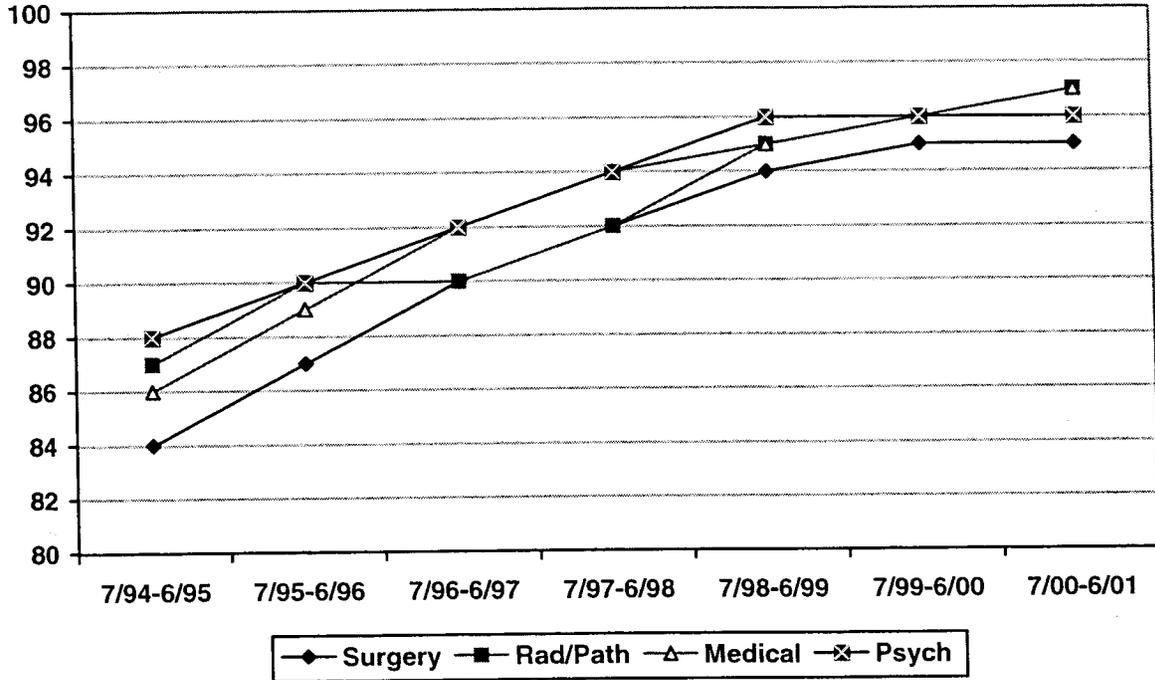
**Figure 2**

**Number of States With Physician Participation Rates of 85% or Less**



DoD has also monitored closely the participation rates for certain types of care. Participation rates have increased for all four major types of service (medical, surgical, radiology/pathology, and mental health) since the 1994-95 period (see Figure 3). In the 1994-1995 period, none of these four types of services had participation rates above 88% on a national average basis. In contrast, by the 2000-2001 period, the national average physician participation rate for all four types of services had increased to 95% or more. Thus, for all major types of services, the likelihood of a TRICARE beneficiary being subject to balance billing is only about 1 in 20 on a national average basis.

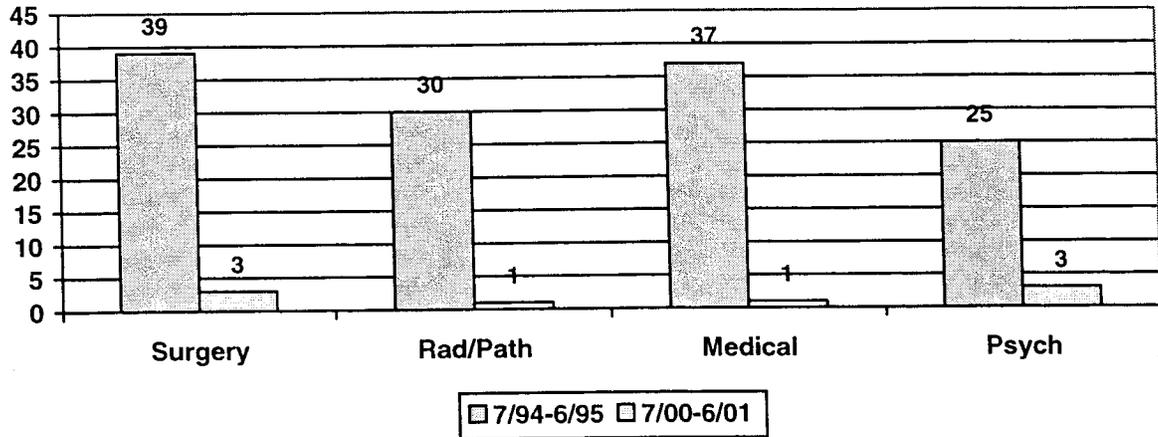
**Figure 3**  
**Physician Participation Rates by Type of Service**



DoD has also monitored closely participation rates by type of service for different geographic areas. The number of states with low rates of participation for these four major types of care has also declined dramatically (see Figure 4). In the 1994-1995 period, more than one-half of all states had participation rates of 85% or less for each of the four major types of services. Six years later, only eight states have a participation rate of 85% or less for any one of the four major types of physician services. This is quite an accomplishment for DoD beneficiaries.

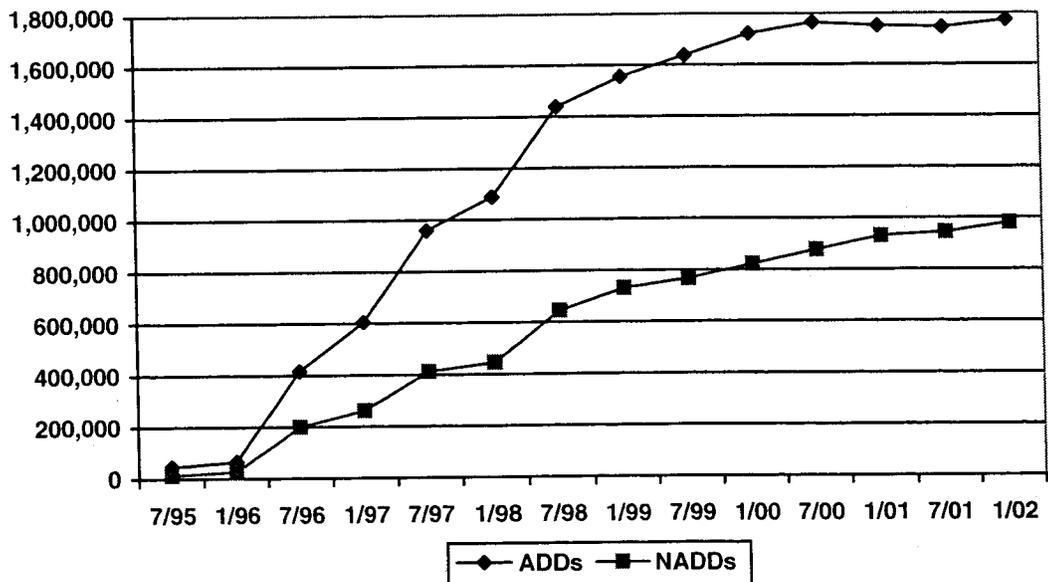
Figure 4

Number of States With Physician Participation Rates of 85 Percent or Less, by Type of Service



One important reason for these increases in participation is the increase in use of network providers by beneficiaries, which has been driven, in part, by the increase in Prime enrollment. Currently, about 85% of active duty dependents and over 30% of retirees under age 65 and their dependents are enrolled in Prime. The growth in Prime enrollment has been dramatic (see Figure 5). As TRICARE Prime enrollment continues to increase, one would expect to see improvements in participation rates, but because these rates are so high already, future increases will be modest.

Figure 5  
TRICARE Prime Enrollment Trends for ADDs and NADDs



Access problems persist in some locations. In late 1999, DoD undertook a redefinition of one statewide locality – for Alaska – in recognition of significant differences in acceptability of TRICARE payment rates in Anchorage compared to the rest of the state. Overall, CMACs are accepted as full payment about 93% of the time in Alaska, but the vast majority of services are provided in Anchorage, so that severe access problems elsewhere were hidden. In an effort to increase acceptability of payment rates outside of Anchorage, DoD created a new locality, for all of Alaska except Anchorage, and, for the new locality, waived reductions in payment amounts taken since inception of the CMAC payment approach in 1992. The resulting payment levels are about 28% higher than they would be otherwise. In 2002, this 28% rate increase was extended to the Anchorage area for all but mental health services (which had almost complete CMAC acceptance by local providers) in recognition of unique local market conditions which were felt to be noticeably affecting the supply of civilian health care services to TRICARE beneficiaries. Some of the factors were low supply of many specialists, an uncompetitive physician market, geographic isolation from the rest of the U.S., unusually high Medicaid and private insurer rates, and a projected need for more civilian providers due to deployments of military providers.

### **TRICARE Prime Preferred Provider Network Adequacy Issues**

TRICARE Managed Care Support (MCS) contractors are responsible for providing an adequate network of qualified providers in all areas of TRICARE regions as designated under the terms of their contracts with the Government. The network must include a complement of civilian professional providers adequate to ensure access to care for TRICARE Prime and Extra beneficiaries. In determining if a network is adequate, the network must include an appropriate mix of primary care and specialists to satisfy demand and to meet the standards established for appointment/waiting time and travel distance for patient access to primary, specialty or emergency care.

Today, the number of providers in the TRICARE network varies across the country – for example, the number of specialists per 1,000 enrollees ranges from as low as 16 to as high as 84. This variation may arise from the availability of military providers, which reduces the need for an extensive civilian network. It may also reflect real problems in network sufficiency, and regional averages may mask further problems at local levels.

While TRICARE Prime Preferred Provider networks are generally considered adequate, there are isolated geographical areas outside major metropolitan areas and within states with limited population bases in which network development may be hindered due to allowable TRICARE payments being lower than rates used by competitive commercial health care insurance or other governmental programs. Because CMACs are based on Medicare-prescribed payment localities, and generally are

consistent with Medicare reimbursement rates, Congress has authorized the Secretary of Defense to allow higher payments, with certain limitations, when determined necessary to ensure adequacy of TRICARE networks.

### **New Authority**

In response to potential concerns about network payment rates, the Fiscal Year 2000 Authorization Act allows DoD to establish higher payment rates for services than would otherwise be allowable. The amount of reimbursement for a health care service would be limited to the lesser of (1) an amount equal to the local fee-for-service charge in the area where the service is provided or (2) 115% of the otherwise allowable TRICARE rate for the service. DoD has discretion in exercising this authority. The Department believes at this time that the higher rate would be authorized only if all reasonable efforts have been exhausted in attempting to create an adequate network and if it is cost-effective and appropriate to pay the higher rate to ensure an appropriate mix of primary care and specialists in the network.

### **Potential Cost of Implementing This Authority**

Estimating the cost of the authority to pay increased amounts to network providers is difficult due to the uncertainties regarding the specific instances where this authority might be needed. However, one can make a rough estimate of the potential cost of exercising this authority under certain assumptions. An important assumption is determining the areas in which this authority is likely to be required. Ideally, one would need the Managed Care Support Contractor (MCSC) to provide evidence of any area in which it had been difficult to develop networks, or portions of the network. One would also need to know whether the MCSC had exhaustively attempted to create an adequate network. Because this type of information is not readily available, the Department has attempted to estimate the cost of implementing this authority using an alternative approach.

We have attempted to estimate the cost of implementing this authority based on the overall locality participation rates, DoD's experience with provider rate complaints in specific areas, and network access problems in rural states. We thus estimated potential individual network provider CMAC increases ranging from one percent of network provider costs for contract regions with low levels of participation/access problems (contract regions 3/4, 6, and 9/10/12) to two percent for regions with some isolated noted problems and/or localities with participation rates below 90% (regions 2/5, 11, PR) to five percent for regions where DoD has observed the most problems (regions 1 and 7/8). The estimated costs, by contract regions are shown in Figure 6.

The costs of exercising this authority include both the *direct costs* of increasing the network reimbursement rate up to 115% of the CMAC, as well as the *indirect costs* of having more beneficiaries use providers from the expanded network. This indirect effect includes not only the effect of assuming that some physicians who are now non-network providers will join the network, but also the costs of increasing the share of costs paid by the government for each service because of the reduced beneficiary cost sharing requirements. We estimate these indirect health care costs to be between \$1-2M per year. Thus, the total estimated costs of this authority would be about \$4 million per year (see Figure 6).

**Figure 6**

<b>Estimated FY03 Government Health Care Costs for Individual Network Provider 15% CMAC Increases</b>			
<b>Contract Region</b>	<b>Network Provider-specific Increases</b>	<b>Indirect Health Care Costs (utilization, copays)</b>	<b>Total Health Care Costs</b>
1	\$0.44M	\$0.2M	\$0.6M
2/5	\$0.51M	\$0.2M	\$0.7M
3/4	\$0.41M	\$0.2M	\$0.6M
6	\$0.17M	\$0.1M	\$0.3M
7/8	\$0.96M	\$0.5M	\$1.5M
9/10/12	\$0.17M	\$0.1M	\$0.3M
11	\$0.10M	\$0.1M	\$0.2M
PR	\$0.00M	\$0.0M	\$0.0M
<b>Total</b>	<b>\$2.8M</b>	<b>\$1.4M</b>	<b>\$4.2M</b>

### **Utilization of Best Industry Practices**

The new authority gives the Department increased flexibility in responding to local market conditions. This flexibility is a hallmark of the best practices used by private sector purchasers of care, who pay what is necessary in each market, but no more than that amount. We believe that the new authority will provide sufficient flexibility to solidify TRICARE networks where they are precarious, without increasing costs excessively. This is reflective of industry best practices.

Commercial health care plans face challenges similar to those faced by TRICARE: the establishment of a network of providers who can provide needed services in a timely, high-quality manner. TRICARE MCS contractors are responsible for providing an adequate network of qualified providers in all areas of TRICARE regions as designated under the terms of their contracts with the Government. The network must include a complement of civilian professional providers adequate to ensure access to care for

TRICARE Prime and Extra beneficiaries. In determining if a network is adequate, it is necessary for the network to include an appropriate mix of primary care and specialists to satisfy demand and to meet the standards established for appointment/waiting time and travel distance for patient access to primary, specialty or emergency care.

For professional services, the CMAC rate has served as the ceiling rate for TRICARE contractors in their efforts to secure an adequate network. By contrast, a key aspect of commercial practice is greater flexibility in pricing arrangements and payment levels – they can negotiate higher payments if necessary to assure coverage. Section 1097b(a), added by the National Defense Authorization Act for Fiscal Year 2000, provides statutory authority for higher reimbursement for professional providers than normally allowable when determined necessary to ensure an adequate TRICARE Prime network of qualified providers. Implementation of this Section, through amendment of 32 CFR 199.14(h), will provide enhanced flexibility in the development of TRICARE networks, consistent with commercial business practices.

Additional areas of best business reimbursement practices which could be reviewed, in line with the Fiscal Year 2000 Defense Authorization Act, are usual, customary, and reasonable payment levels, the Health Care Finance Administration's Resource Based Relative Value Scale, negotiated fee schedules, global fees, and sliding scale individual fee allowances. However, we will not remain in tune with the best practices of the private sector unless we review our actions periodically, and act to correct payments as market conditions change.

### **Financial Management, Third Party Collections**

The FY 2000 Authorization Act, Section 716, 1097b makes important improvements to the Third Party Collection program (TPCP) under 10 U.S.C. 1095, which allows military treatment facilities (MTFs) to collect from health care insurance carriers and other third party payers. The act replaces the term "cost" with "charge" and sets forth the method to use for computation of reasonable charges to include:

- (A) A method based on:
  - (1) Per diem rates
  - (2) All-inclusive rates for each visit
  - (3) Diagnosis-related groups
  - (4) Rates prescribed under regulations implementing sections 1079 and 1086 of this title; or
- (B) Any other method considered appropriate

Consistent with a 1997 amendment to the Department of Veterans Affairs' third party collection statute (38 U.S.C. 1729), this section would allow DoD facilities to bill third party payers based on reasonable charges. Reasonable charges would be

represented by the current payment rates under CHAMPUS, which uses diagnosis related groups (DRG)-based rates for inpatient care and CMAC (CHAMPUS Maximum Allowable Charge) rates for professional services. CHAMPUS DRG and CMAC rates are relatively comparable to military treatment facility costs. In addition to matching the congressional action for the VA program, another improvement this will permit is to allow MTFs, billing CMAC rates, to bill for outpatient care on the same medical procedure basis prevalent in the health insurance industry.

Coincident with the development of the report to Congress, DoD has published a notice of proposed rulemaking regarding rate methodology for the MTF reimbursable programs.

## **Background – Third Party Collections Program**

Third Party Collections is a program, which has been in place since FY 1987. Over the past few years, DoD has seen a decrease in its overall collections—funds that have been critical to the sustainment of numerous quality health care programs in the MTFs. One of the factors affecting reimbursement of claims is the unique rate methodology for outpatient services of MTFs compared to civilian health care practices.

### **Current Rates Methodology**

Currently the cost for inpatient services is a standardized amount determined by dividing the total costs of all inpatient care in all military treatment facilities by the total number of discharges. This produces a single national standard amount. Three standard amounts are calculated for large urban, other urban, and overseas. Using this applicable standardized amount, adjustments are made for area wage rates and indirect medical education, producing an adjusted standardized amount for each inpatient facility.

Outpatient visit rates are an all-inclusive rate determined by dividing the total cost of outpatient visits to a particular clinical specialty or subspecialty by the total number of visits. This rate includes all routine ancillary services. Separate rates are calculated for Ambulatory Procedure Visits as well as for ancillary services ordered by external providers.

### **Industry Best Practice**

Civilian industry practices for outpatient visits consist of itemized bills for outpatient claims processing. Charges are applied to Current Procedure Terminology (CPT). CPTs are created and maintained by the American Medical Association and consist of more than 7,000 codes used to report procedures and services. All third party payers accept CPT codes. While current claims produced by MTFs have CPTs, the claim is not itemized, or rather, an individual charge is not listed next to each CPT. Previous language directing DoD to set rates by cost limited the methodology used, as there existed no means by which the cost for each CPT could be obtained in the MTF settings.

This new law allows MTFs to adopt the rates and rate structure such as that currently used under CHAMPUS/TRICARE. The CHAMPUS/TRICARE payment rates for professional services are essentially the same as the Medicare fee schedule and are equal to significantly discounted rates by procedure code. As such, these rates are extremely competitive with the civilian sector pricing. Billing will conform to common methods used by the insurance industry, utilizing standard procedure codes, and will facilitate rate comparisons.

## **Potential Cost of Implementing This Authority**

Estimating the cost is speculative. There are three potential sources of cost in implementing a new rate methodology:

- 1) Calculation of the new rates
- 2) System changes for itemized billing
- 3) Training of coders/billers/providers on new coding requirements

The actual calculation of the new rates should be minimal, as the goal is to adopt the current CMAC rate structure published annually by DoD for network reimbursement of TRICARE patients. Current DoD information systems are not configured to capture and download the level of detail in clinical data required for itemized claims processing. An initial system evaluation has been performed and proposed System Change Requests drafted and submitted for consideration, although no development costs have yet been assigned. A change in data submission will accompany the system changes and will require training of providers, billing, and coding personnel. As the finalization of all the change requirements are not yet completed, it is difficult to assess the full extent of training needed by the facilities. The Department began implementation of outpatient itemized billing in the military treatment facilities on October 1, 2002. A rough estimate of the costs for these areas is \$10M. The approximation takes into account the number of systems and programs affected by such changes.