American Hospital Association

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June 4, 2008

S. Ward Casscells, M.D.
Assistant Secretary of Defense for Health Affairs
Department of Defense
1160 Defense Pentagon
Washington, DC 20301-1160

RE: DoD-2008-HA-0007; 0720-AB21, TRICARE; Reimbursement of Critical Access Hospitals (CAHs); Proposed Rule (Vol. 73, No. 87), May 5, 2008

Dear Dr. Casscells:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Department of Defense (DoD) proposed rule regarding TRICARE reimbursement of critical access hospitals (CAHs).

Under 10 U.S.C. 1079(j)(2), TRICARE is required to reimburse hospitals using the same methodology as Medicare, to the extent practicable. TRICARE currently reimburses CAHs through the TRICARE diagnosis-related groups for inpatient hospital care, and based on billed charges for facility charges for outpatient care. In contrast, Medicare generally reimburses CAHs on the basis of 101 percent of their allowable and reasonable costs for both inpatient and outpatient care.

In the proposed rule, DoD states that until now it has been unable to reimburse hospitals using Medicare's reimbursement methodology because the department did not have access to hospital-specific cost data. However, Medicare recently indicated that it will provide TRICARE with these data. Therefore, DoD proposes that TRICARE adopt Medicare's reimbursement methodology for CAH inpatient and outpatient care.

As stated above, Medicare reimburses CAHs 101 percent of their allowable and reasonable costs. This reimbursement is not subject to Medicare's "lesser of cost or charges" reasonable-cost principle. While DoD proposes to adopt this same methodology, the department actually adopts the "lesser of cost or charges" reasonable-cost principle, stating that it will reimburse CAHs at the lesser of the billed charge or 101 percent of reasonable costs. For some CAHs, this

discrepancy may not have any effect. However, for other CAHs, it will have considerable consequences, as their billed charges may be up to 25 percent less than their costs. Under DoD's proposal, these CAHs will be reimbursed 25 percent less than their costs, which will have a devastating effect on their ability to provide critical patient care. **To comply with the statutory requirement regarding hospital reimbursement, we urge the Secretary to adopt Medicare's exact methodology for determining CAH reimbursement for inpatient and outpatient care.** Medicare's methodology is familiar to CAHs, is effective and has been refined over many years – we encourage DoD to utilize this known, tested approach.

In addition, the proposed rule fails to address several other critical aspects of Medicare's CAH reimbursement methodology, such as interim payments and cost settlement. Currently, Medicare makes interim payments to CAHs during a fiscal year based on costs estimated from a prior year's cost report. After a fiscal year ends, Medicare reaches a "settlement" with CAHs to align payments 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 guarantee that CAHs are reimbursed in a timely manner at the appropriate level. Without such mechanisms, these hospitals will endure a significant amount of uncertainty about whether they will be able to cover their costs, jeopardizing their ability to provide quality patient care. **We urge the Secretary to make interim payments to and reach cost settlement with CAHs, and to do so in the same manner as Medicare.**

If you have any questions, please feel free to contact me or Joanna Hiatt, senior associate director for policy, at (202) 626-2340 or jhiatt@aha.org.

Sincerely,

Rick Pollack
Executive Vice President