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Federal Docket Management System Office
1160 Defense Pentagon
Washington, DC 20301–1160

Re: Docket DOD-2007-HA-0048; RIN 0720-AB19; Department of Defense; Hospital Outpatient Prospective Payment System; Delay of Effective Date and Additional Opportunity for Public Comment; (Federal Register 74, No. 24), February 6, 2009.

To Whom It Concerns:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 38,000 individual members, the American Hospital Association (AHA) thanks you for reopening the comment period for the final rule implementing the TRICARE hospital outpatient prospective payment system (OPPS). America's hospitals and health care systems have been responding with great pride to the growing needs of our nation's servicemen and women, and their families, especially as they restart and rebuild their lives following service in combat. However, we are concerned that the immediate and sharp reduction in payments under the OPPS will have a serious negative impact on hospitals and health care systems serving the TRICARE population, and could ultimately impact access to care and the health of local economies.

We strongly urge the Department of Defense (DoD) to reissue the final rule with changes that would implement the TRICARE OPPS in a manner that is budget neutral to the current TRICARE payment amount for hospital outpatient services. This would be consistent with the approach Medicare took when it put its OPPS into place. In subsequent years, payment rate reductions required to harmonize the TRICARE and Medicare OPPS payment systems should only occur through a gradual and meaningful transition policy.

In the final rule published in the December 10 *Federal Register*, DoD used 2007 claims data to estimate that hospital outpatient revenue will decline by $458 million in the first year of the transition to the TRICARE OPPS. According to DoD, these cuts would represent a 25 percent reduction from pre-OPPS levels for hospitals. However, these first-year cuts are a harbinger of even greater annual losses over the course of the three- to four-year transition period outlined in the final regulation. These cuts are unsustainable, especially in light of the precarious financial

situation hospitals are in as a result of the current economic environment. The financial impact will be especially devastating for hospitals in areas near military bases with large TRICARE populations, such as Hampton Roads, VA; San Antonio, TX; San Diego, CA; the District of Columbia and much of Florida and Georgia.

In addition, we are concerned that DoD's estimate of the financial losses to hospitals reported in the final rule has ballooned to nearly six times its original April estimate of $81 million per year, despite a modestly broader transition policy. This dramatic fluctuation is not adequately explained in the final rule and calls into question the reliability and validity of DoD's data and its economic impact methodology. Indeed, it is important to note that a rigorous, 2007 claims-based impact analysis conducted by industry demonstrates that the financial impact would, in fact, be well above DoD's estimate of 25 percent, reaching between 40 and 50 percent in the first year alone.

Federal law, at 10 USC (j)(2), mandates that DoD adopt a hospital OPPS that is consistent with Medicare rules. **We urge DoD to follow the precedent set by Medicare and, in the first year of its implementation, adopt the OPPS in a manner that is budget neutral to the current TRICARE payment amount for hospital outpatient services.** When Medicare implemented its OPPS, it did not cut hospital payments for services provided to seniors. Likewise, DoD should not cut hospital payments for military servicemen and women and their families.

As noted above, DoD's implementation of the OPPS is not budget neutral when compared to the total payments from the prior year's TRICARE outpatient payment system. This is inconsistent with the requirement in statute that DoD adopt the Medicare payment rules in implementing the OPPS. *The National Defense Authorization Act for Fiscal 2002* (P.L. 107-107 Section 707) amends the law at 10 U.S.C. 1079(j)(2) to state:

> The amount to be paid to a provider of services...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 title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). [Emphasis added.]

This provision originated from legislation H.R. 2586, Section 701. The Report of the Committee on Armed Services accompanying the House Bill (House Report No. 107-194 at 338) indicates:

> This section would implement reforms of TRICARE payment methods to bring consistency of payment methods to all TRICARE programs. The section would require the Secretary of Defense to base TRICARE program payment rates on payment rates used by the Medicare program, or similar rates ***based on Medicare payment methods.*** [Emphasis added.]

Nothing in this section or in its legislative history, as evidenced by this report language, indicates that the House of Representatives intended the provision to generate cost savings. Instead, the stated intention is to bring payment consistency and to align payment methods between Medicare

and TRICARE. The Senate version of the legislation contained a similar provision. In conference committee, the two provisions were reconciled with similar Congressional intent.

We believe that this consistency of payment methods mandated by Congress for TRICARE OPPS includes following Medicare's initial implementation process. *The Balanced Budget Act of* 1997 (BBA) required that Medicare implement an OPPS in 1999. Section 4523 of the BBA, which added 42 U.S.C. Section 1395l(t), set out the methodology for determining payments under the OPPS. This section required that the initial implementation of the OPPS for Medicare be budget neutral as compared to the prior system. That budget neutrality calculation is part of the methodology that was used to calculate the base payments rates under the Medicare OPPS.

As noted above, both the TRICARE OPPS' enabling legislation and its history indicate that Congress intended that TRICARE payment methods be determined using the Medicare reimbursement rules and methods. Because the Medicare methodology for calculating OPPS rates started with a base rate that was budget neutral, we believe that law requires DoD to do the same in determining TRICARE rates under OPPS. Therefore, the AHA recommends that the Secretary recalculate the base rates for the TRICARE OPPS in its first year of implementation in a manner that is budget neutral to the current TRICARE payment amount for hospital outpatient services, just as the Department of Health and Human Services did in establishing the base rates for the Medicare OPPS.

Moreover, given the significant changes in payment methodology engendered by the movement from the current TRICARE payment system to the OPPS, both in terms of the operational implementation challenges for DoD and its impact on health care providers, it makes sense to start with a system that does not also make drastic reductions in overall payments to providers. Implementing the new OPPS in a budget-neutral manner in its first year would allow DoD to work out any operational or policy issues without also having to focus on the impact of significant payment reductions for providers. In addition, a year of budget-neutral OPPS implementation would give DoD time to review its data and its economic impact methodology to address the multiple concerns that stakeholders have raised regarding its reliability and validity.

To the extent that DoD would then continue, in subsequent years, to harmonize TRICARE payment rates with the Medicare payment rules and rates for hospital outpatient services, we request that DoD institute a meaningful transition policy in order to alleviate the significant financial impact on hospitals and ensure access to outpatient hospital services for our nation's active-duty military service members, retirees and their families. Both TRICARE and Medicare historically have aided providers by incorporating a "phase-in" period during the transition from one reimbursement methodology to another. For example, DoD implemented a transition for physician payments – an annual 15 percent stop-loss to bring TRICARE physician payments in line with Medicare payments – that far exceeds what it has established in the TRICARE OPPS final rule for outpatient hospital services. As a result, the originally higher physician payment rates were gradually reduced over a period of several years until they were consistent with Medicare rates.

Similarly, the AHA recommends that DoD ease the transition to the TRICARE OPPS by limiting the annual amount by which reimbursement rates may fall in years following the initial budget-neutral implementation year. National payment rates under the OPPS are determined by multiplying the relative payment weights for each service by a dollar conversion factor. One simple way to implement gradual payment reductions would be to apply an adjustment to the OPPS conversion factor. Therefore, beginning in the second year of implementation of the TRICARE OPPS and continuing on an annual basis, DoD could gradually align the payment rates to the final TRICARE OPPS rates by reducing the OPPS conversion factor by a small amount – we suggest in the 5 to 10 percent range – until the final TRICARE OPPS payment rates are achieved. This will help assure that covered beneficiaries under TRICARE retain adequate access to hospital outpatient services.

Also, we urge DoD to put additional protections into place for hospitals that have a disproportionate share of TRICARE patients. DoD should provide this additional flexibility for such hospitals in order to ease their transition to OPPS or exempt them entirely from the OPPS system altogether.

Thank you for your consideration of our concerns and recommendations on this topic. If you have any questions, please feel free to contact me or Roslyne Schulman, the AHA's senior associate director for policy, at (202) 626-2273 or rschulman@aha.org.

Sincerely,

Rick Pollack
Executive Vice President