



**American Hospital
Association**

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August 31, 2011

Jonathan Woodson, M.D.
Assistant Secretary of Defense for Health Affairs
Director, TRICARE Management Activity
Department of Defense
1160 Defense Pentagon
Washington, DC 20301-1160

RE: DoD-2010-HA-0072; 0720-AB41, TRICARE; Reimbursement of Sole Community Hospitals and Adjustment to Reimbursement of Critical Access Hospitals; Proposed Rule (Vol. 76, No. 128), July 5, 2011

Dear Dr. Woodson:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our nearly 42,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Department of Defense's (DoD) proposed rule regarding TRICARE reimbursement of sole community hospitals (SCHs).

Under Title 10 of the United States Code §1079(j)(2), TRICARE is required to reimburse hospitals using the same methodology as Medicare, to the extent practicable. TRICARE currently reimburses SCHs in one of two ways: billed charges less a negotiated discount for network hospitals and billed charges for non-network hospitals. In contrast, Medicare reimburses SCHs the higher of the diagnosis-related group (DRG) payment or a hospital-specific rate based on historical costs per discharge from fiscal year (FY) 1982, 1987, 1996 or 2006. DoD states that the current TRICARE method results in reimbursing SCHs substantially more than Medicare for equivalent inpatient care and, thus, a change is needed to conform to the statute.

In the proposed rule, DoD states that reimbursing SCHs using Medicare's method is not practicable. It states that while TRICARE can calculate the aggregate DRG reimbursement for all TRICARE discharges by a SCH during a year, using the Medicare cost per discharge would not be appropriate. Differences in the TRICARE and Medicare beneficiary case mix render the Medicare hospital-specific rate not directly applicable for TRICARE purposes. **The AHA agrees with this conclusion.**



Instead, DoD proposes to pay a SCH the higher of the DRG amount for all of its TRICARE discharges or an amount equal to the SCH's specific cost-to-charge ratio (CCR) multiplied by the hospital's billed charges for TRICARE services. This will be accomplished through a year-end reconciliation.

We are concerned about DoD's proposal because it does not specify which CCR it plans to use to adjust SCHs' billed charges. Using a Medicare CCR is not appropriate – differences in the TRICARE beneficiary populations and their associated services render the Medicare CCR not directly applicable for TRICARE purposes. The same problem exists if using an overall CCR. In addition, it would be administratively difficult, as well as burdensome to hospitals, to calculate a TRICARE-specific CCR. **Therefore, we have developed an alternative approach, detailed below, for TRICARE payment to SCHs. We urge DoD to adopt this approach rather than the one it has proposed.**

Our alternative approach has two parts. **The first part modifies DoD's proposed approach by using an adjusted Medicare CCR as the basis for determining payments, which will more accurately reflect the TRICARE beneficiary population and its costs.** Specifically, a FY 2010 report to Congress evaluating TRICARE indicates that 10 DRGs account for more than 40 percent of TRICARE inpatient discharges.¹ These DRGs are identified in Table 1 below.

Table 1: Top 10 TRICARE Inpatient DRGs by Volume

DRG	391	373	371	630	143	372	544	359	370	288	Total
Volume	74,354	65,709	24,780	22,052	11,579	11,331	10,585	10,218	7,846	6,216	244,670

Of these 10 DRGs, six are labor/delivery and newborn DRGs (DRGs 391, 373, 371, 630, 372 and 370). These six DRGs account for 84.2 percent of the volume of the top 10 TRICARE inpatient DRGs.

These data can, in turn, be utilized to estimate the percentage of all TRICARE inpatient discharges related to labor, delivery and the care of newborns. Specifically, since 84.2 percent of 40 percent of TRICARE inpatient discharges are related to labor, delivery and the care of newborns, at least 34 percent ($0.842 \times 0.40 = 0.337$) of TRICARE inpatient discharges are for these services. In contrast, 2009 data from the National Inpatient Survey show that less than 20 percent of total discharges nationwide are for these same services.² This further demonstrates the unique nature of services furnished by hospitals to TRICARE beneficiaries, which is not accounted for if using overall or Medicare CCRs to determine TRICARE costs.

Given the significant portion of TRICARE discharges related to labor, delivery and the care of newborns, we examined the CCRs for the labor/delivery and nursery cost centers, as well as their

¹ TRICARE Management Activity, Health Program Analysis and Evaluation Directorate, in the Office of the Assistant Secretary of Defense (Health Affairs) (OASD/HA). "Evaluation of the TRICARE Program Fiscal Year 2010 Report to Congress." February 28, 2010.

² <http://hcupnet.ahrq.gov/HCUPnet.jsp?Id=6650BB5E0DB8C179&Form=DispTab&GoTo=MAINSEL&JS=Y>

relationship to overall Medicare CCRs. Based on this analysis, we found that labor and delivery CCRs are 170 percent higher than overall CCRs on average, and nursery CCRs are 92 percent higher on average. The weighted variance, reflecting the distribution of services between labor/delivery and nursery, is 137.6 percent.

In the absence of a TRICARE-specific CCR, using a Medicare CCR that is adjusted based on the variance between overall CCRs and labor/delivery and newborn CCRs will more accurately account for TRICARE costs. Since at least 34 percent of TRICARE inpatient discharges are for these services and they have a CCR that is 137.6 percent higher than overall CCRs on average, an adjustment of 46.4 percent ($1.376 \times 0.337 = 0.464$) is appropriate. **Thus, we recommend that TRICARE use, as a basis for determining SCH payments, the Medicare CCR increased by 46.4 percent (or by multiplying the Medicare CCR by a factor 1.464).** This adjustment to the Medicare CCR allows TRICARE to move forward with its proposed approach while improving the accuracy of the CCR to derive TRICARE costs.

The second part of our approach entails using multiple base years. As described above, Medicare pays SCHs the higher of the DRG payment or a hospital-specific rate based on costs per discharge in FY 1982, 1987, 1996 or 2006. TRICARE reimbursement should likewise employ multiple base years and the same base years as Medicare. **Thus, the AHA urges DoD to modify its approach so that TRICARE payments will be equal to the highest of the SCH's CCRs from four base years (1982, 1987, 1996 and 2006) multiplied by the hospital's billed charges for services. The CCR should be adjusted to reflect TRICARE costs, as described above.**

The AHA strongly supports a transition period to give SCHs time to make adjustments to their operations in the face of pending cuts. DoD proposes a phase-in period for its approach with a maximum 15 percent per-year reduction in payments for non-network hospitals and a 10 percent per-year reduction for network hospitals. However, for a hospital with significant TRICARE volumes, a 10 percent reduction will result in a rapid decrease that will compromise the hospital's financial health and its ability to serve its community. In fact, under Medicare, Congress has specifically protected SCHs from this type of dramatic payment shift by requiring additional payments for hospitals that experience a 5 percent or greater decline in inpatient discharges in a particular year. **To more fully align its payment method with Medicare's, we urge DoD to limit per-year reductions in payments to 5 percent for all SCHs rather than the 10 and 15 percent proposed.**

We also urge DoD to incorporate into TRICARE reimbursement methodology the additional payment protections that Medicare affords SCHs. Specifically, TRICARE should adopt the additional payments, mentioned above, that are provided to SCHs that experience a significant decrease in volume in a particular cost reporting period provided for in section 1886(d)(5)(D)(ii) of the *Social Security Act* and Title 42 of the Code of Federal Regulations § 412.92(e). In addition, all other general Medicare payment adjustments should be incorporated, including the low-volume adjustment, geographic wage index reclassification and disproportionate share hospital payments.

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Finally, as noted above, TRICARE is statutorily required to reimburse hospitals using the same methodology as Medicare, to the extent practicable. TRICARE has previously implemented a revised payment methodology for critical access hospitals (CAH) to more closely approximate Medicare CAH reimbursement and is now proposing the same for SCHs. However, it has not addressed payments for hospitals with the Medicare designation of Medicare-dependent hospital (MDH).

Medicare MDH reimbursement is relatively similar to Medicare SCH reimbursement. MDHs are paid based on the higher of the DRG amount or their hospital-specific rate, although the applicable base years for MDHs are somewhat different – they are 1982, 1987 or 2002. In addition, whereas SCHs are paid 100 percent of the amount by which the hospital-specific rate exceeds the DRG amount, MDHs receive 75 percent of the difference. In both cases, if the DRG amount is higher than the hospital-specific rate, the DRG amount prevails.

We urge TRICARE to develop a MDH payment methodology comparable to the SCH methodology we have proposed above, but reflecting the slight difference in how Medicare reimburses MDHs.

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

Sincerely,

/s/

Rick Pollack
Executive Vice President