

DEPARTMENT OF DEFENSE**Office of the Secretary****32 CFR Part 199**

RIN 0720-AA58

TRICARE; Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); Payments for Professional Services in Low-Access Locations**AGENCY:** Office of the Secretary, DoD.**ACTION:** Proposed rule.

SUMMARY: This proposed rule implements section 716 of the National Defense Authorization Act for Fiscal Year 2000 which allows the Secretary of Defense to authorize higher provider reimbursement than normally allowable, with certain limitations, when necessary to ensure an adequate TRICARE Prime network of qualified providers. This proposed rule also describes additional actions which may be taken under section 731 of the National Defense Authorization Act for Fiscal Year 1996 when TRICARE beneficiaries face very severe limitations on access to needed health care services. In such instances, the Assistant Secretary of Defense (Health Affairs) may authorize higher TRICARE payments than would normally be allowable for professional services in a designated location.

DATES: Public comments must be received by July 31, 2000.

ADDRESSES: TRICARE Management Activity (TMA), Program Development Branch, Aurora, CO 80045-6900.

FOR FURTHER INFORMATION CONTACT: Steve Lillie, Office of the Assistant Secretary of Defense (Health Affairs)/TRICARE Management Activity, telephone (703) 681-3628.

SUPPLEMENTARY INFORMATION: Questions regarding payment of specific claims under the CHAMPUS allowable charge method should be addressed to the appropriate TRICARE/CHAMPUS contractor.

1. 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 our ability to implement managed care programs, to assure beneficiary access to the full spectrum of health services, and to do these things cost-effectively. This section reviews the background of the

linkage of TRICARE and CHAMPUS rates to Medicare.

It is appropriate that Medicare serve as the model for establishment of payment rates for TRICARE and CHAMPUS. 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 adopt 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 in accordance with the same reimbursement rules as apply to providers of services of the same type under Title XVIII of the Social Security Act" (Department of Defense Authorization Act, 1984 (Pub. L. 98-94, amending 10 U.S.C. 1079(j)(A)). 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. Regulatory provisions governing this and other TRICARE payments are at 32 CFR 199.14.

In adapting Medicare's payment approaches to TRICARE, it has been vital to recognize the differences in the programs and the populations they serve, and to accommodate those differences in the technical details of the payment methodologies. To illustrate, the services of children's hospitals as well as care for neonates were excluded from the initial implementation of the CHAMPUS DRG-Based Payment System. This was done out of concern that the DRG classification system and payment levels did not adequately distinguish the more complex and resource-intensive children's conditions. In consultation with children's hospital representatives, DoD developed a special additional factor (the "children's hospital differential") to use in the payment methodology so that children's hospital services were appropriately reimbursed. For neonatal services, DoD adopted an industry-developed approach to classify neonates by birthweight to more accurately reimburse their care. Thus, our approach was modeled on Medicare's but modified to reflect the special characteristics of the TRICARE population. Maintaining the special treatment of children's hospitals has required occasional policy changes. For example, recent changes to Medicare's payment of outlier cases have been adopted by TRICARE for most hospitals, but these changes have had an adverse impact on payments to children's hospitals for outlier cases. DoD is working with children's hospital representatives to fix the problem.

For some providers, such as residential treatment centers for children and adolescents, there is no Medicare coverage, and in these cases DoD has developed its own reimbursement approaches, working through the legislative and regulatory processes to find reasonable, cost-effective approaches to payment.

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 our 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, we reviewed acceptance of our payment rates, and found that 86 percent of the time, doctors accepted the CMAC as payment in full; 14 percent of services were subject to balance billing. More recently, this has increased to over 94 percent acceptance, with less than 6 percent of services subject to balance billing. For the small proportion of claims that are subject to balance billing, providers are prohibited from collecting more than 115 percent of the CMAC rate, just as in Medicare.

As of February 1999, over 90 percent of CMAC rates are at the same level as Medicare, and fewer than 10 percent are higher than Medicare, because their gradual transition to the Medicare level is not yet complete. 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 7,000 service types reimbursed) represent less than 0.2 percent of DoD spending for health services (roughly \$14 million out of \$10 billion), it was important that the 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 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, and interviewed physicians and beneficiary advocacy groups in four locations; and

- Interviewed TRICARE administrators and staff from TRICARE contractors.

GAO found that the CMAC methodology was sound, and that DoD saves about \$770 million annually as a result of CMACs. Rates were found to be generally consistent with Medicare's rates. Physician concerns focused on network discounts off to 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.)

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 us to continue to assure high quality services for our military families and retirees.

II. Statutory Direction and Regulations

Title 10 U.S.C. section 1079(h) provides statutory authority for TRICARE payments to professional providers. Section 1079(h)(1) mandates that payments shall, to the extent practicable, equal Medicare payment

amounts. Section 1079(h)(2) permits exceptions, as determined to be necessary to assure that covered beneficiaries retain adequate access to health care services. Title 10 U.S.C. section 1097b(a) 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. Regulations providing for exceptions to normally allowed payment amounts are promulgated by the Secretary if Defense in consultation with the other administering Secretaries.

Regulations governing TRICARE payments to providers are in 32 CFR 199.14, with 32 CFR 199.14(h) addressing individual health care professional and other non-institutional health care providers.

III. 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 94 percent 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.

We are 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 one hundred, with the introduction of more and more statewide payment localities for Medicare, and hence for TRICARE.

In late 1999, DoD undertook a redemption 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 over 90 percent of the time in Alaska, but the vast majority of services are provided in Anchorage, so that severe access problems elsewhere are hidden. In an effort to increase acceptability of payment rates outside of Anchorage, DoD created a new locality, including 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. This was carried out under authority of 32 CFR 199.14(h)(1)(iv), which describes procedures for calculating CMAC levels for localities, including waiving reductions where access is threatened. The resulting payment levels are about 28 percent higher than they would be otherwise.

There is concern that even these dramatic steps, which use the full extent of DoD's current regulatory authority, may be insufficient in some locations. Accordingly, we are publishing this notice of proposed rulemaking, seeking public comment on possible additional actions to increase access to health care providers in locations where evidence shows that TRICARE beneficiaries lack access to needed health services.

IV. 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 designed under the terms of their contracts with the government. The network shall 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.

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 is 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.

V. Overview of the Rule

The proposed rule would add a new § 199.14(h)(1)(iv)(D), authorizing the establishing of higher payment rates for services than would otherwise be allowable, if it is determined that access to health care services is severely impaired. Payment rates could be established through addition of a percentage factor to an otherwise applicable payment amount, or by calculating a prevailing charge, or by using another governmental payment rate. Higher payment rates could be applied to all similar services performed in a locality, or a new locality could be defined for application of the higher payment rates.

The proposed rule would also add a new § 199.14(h)(1)(iv)(E), allowing the reimbursement of higher payment rates for services than would otherwise be allowable, if it is determined necessary to ensure adequate Preferred Provider networks. 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 per cent of the otherwise allowable TRICARE rate for the service. The higher rate will be authorized only if all reasonable efforts have been exhausted in attempting to create an adequate network and that it is cost-effective and appropriate to pay the higher rate to ensure an appropriate mix of primary care and specialists in the network.

VI. Issues of particular Interest Regarding the Special Locality-Based Exception to Applicable CMACs To Assure Adequate Beneficiary Access to Care

In addition to seeking public comments on the proposed approach, we particularly invite comment on the following issues:

1. *Nature of the relief from current payment levels.*—The proposed rule would authorize three approaches to increasing payment rates: (1) Addition of a percentage factor to the CMAC amount where access problems are so severe that other measures are insufficient; (2) reverting to the historical method of calculating the prevailing charge for a procedure, but using current billed charges to drive the calculation; or (3) using another

government payment rate (such as a state Medicaid program rate). Other approaches are possible, including simply paying of billed charges in a location, as is done currently in many overseas locations. Declaration of a location as “overseas” for purpose of an exemption from payment rules would require a statutory change, but we invite comment on the issue.

2. *Extent of availability of relief from payment levels.*—The proposed rule would make payment relief available for specific CPT codes in a location generally described by zip code(s). We invite comment on whether there are locations where access concerns are so pervasive that an authority to increase payment amounts for all services would be appropriate.

3. *Evidence needed to qualify a location for relief.*—The proposed rule would base determinations of severe access problems on the number of providers in the locality who provide the affected services, the number of such providers who are CHAMPUS Participating Providers, the number of CHAMPUS beneficiaries in the locality, availability (including reassignment) of military providers in the location or nearby, and other relevant factors. We invite comment on what factors should be considered to constitute reasonable evidence of severe access problems.

VII. Regulatory Procedures

Executive Order (EO) 12866 requires that a comprehensive regulatory impact analysis be performed on any economically significant regulatory action, defined as one which would result in an annual effect of \$100 million or more on the national economy or which would have other substantial impact.

The Regulatory Flexibility Act (RFA) requires that 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 is not a significant regulatory action under the provisions of Executive Order 12866, and it would not have a significant impact on a substantial number of small entities.

The proposed rule will not impose additional information collection requirements on the public under the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 55).

A discussion of the major issues received by public comments will be included with the issuance of the final rule, anticipated approximately 60 days after the end of the comment period.

List of Subjects in 32 CFR Part 199

Claims, Fraud, Healthcare, Health insurance, Individuals with disabilities, Military personnel.

Accordingly, 32 CFR Part 199 is proposed to be 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. Section 199.14 is proposed to be amended by adding new paragraphs (h)(1)(iv)(D) and (E) to read as follows:

§ 199.14 Provider reimbursement methods.

* * * * *

- (h) * * *
(1) * * *
(iv) * * *

(D) Special locality-based exception to applicable CMACs to assure adequate beneficiary access to care. The Director, OCHAMPUS, or designee, may authorize establishment of higher payment rates for services than would otherwise be allowable under paragraph (h)(1) of this section, if the Director, or designee, determines that available evidence shows that access to health care services is severely impaired. For this purpose, such evidence may include consideration of the number of providers in the locality who provide the affected services, the number of such providers who are CHAMPUS Participating Providers, the number of CHAMPUS beneficiaries in the locality, availability (including reassignment) of military providers in the location or nearby, and other relevant factors. Providers or beneficiaries in a locality may submit to the Director, OCHAMPUS, or designee, a petition, together with appropriate documentation regarding relevant factors, for a determination that adequate access to health care services is severely impaired. The Director, OCHAMPUS, or designee, will consider and respond to all petitions. A decision to authorize a higher payment amount is subject to review and termination or modification by the Director at any time if circumstances change so that adequate access to health care services would no longer be severely impaired. A decision by the Director, or designee, to authorize, not authorize or terminate/modify authorization of higher payment amounts is not subject to the appeal and hearing procedures of § 199.10.

(1) Establishing the higher payment rate(s). When the Director, OCHAMPUS, or designee, determines that beneficiary access to health care services in a locality is severely impaired, the Director or designee may establish the higher payment rate(s) as he or she deems appropriate and cost-effective through one of the following methodologies to assure adequate access:

- (i) A percentage factor may be added to the otherwise applicable payment amount allowable under paragraph (h)(1) of this section;
(ii) A prevailing charge may be calculated, by applying the prevailing charge methodology of paragraph (h)(1)(ii) of this section to a specific locality; or
(iii) Another governmental payment rate may be adopted, for example, an applicable state Medicaid rate.

(2) Application of higher payment rates. Higher payment rates defined under paragraph (h)(1)(iv)(D) of this section may be applied to all similar services performed in a locality, or, if circumstances warrant, a new locality may be defined for application of the higher payment rates. Establishment of a new locality may be undertaken where access impairment is localized and not pervasive across the existing locality. Generally, establishment of a new locality will occur when the area is remote so that geographical characteristics and other factors (such as frequent and predominant climatic conditions, etc.) significantly impair egress/ingress, through normal means of civilian transportation, to health care services routinely available within the existing locality.

(E) Special Locality-Based Exception to Applicable CMACs to Ensure an Adequate TRICARE Prime Preferred Provider Network of Qualified Professional Providers. The Director, OCHAMPUS, or designee, may authorize any TRICARE managed care support contractor to reimburse health care providers participating in TRICARE Prime Preferred Provider Network a rate or rate(s) higher than would otherwise be allowable under paragraph (h)(1) of this section, if the Director, or designee, determines that available evidence shows that application of the higher rate(s) is necessary to ensure the availability of an adequate number and mix of qualified health care providers in a network in a specific locality. This authority may only be used to ensure adequate networks in those localities designated by the Director, or designee,

as requiring TRICARE Preferred Provider networks not in localities in which the managed care support contractor has voluntarily proposed to create TRICARE Preferred Provider networks. Appropriate evidence for this purpose, may include consideration of the number of available primary care and specialist providers in the network locality, availability (including reassignment) of military providers in the location or nearby, the appropriate mix of primary care and specialists needed to satisfy demand and meet appropriate patient access standards (appointment/waiting time, travel distance, etc.), what reasonable efforts have been made to create an adequate network, other cost-effective alternatives, and other relevant factors. The Director, OCHAMPUS, or designee, may establish procedures by which exceptions to applicable CMACs are requested and approved or denied under paragraph (h)(1)(iv)(E) of this section. A decision by the Director, or designee, to authorize or deny an exception is not subject to the appeal and hearing procedures of § 199.10. When the Director, OCHAMPUS, or designee, determines that it is necessary and cost-effective to approve a higher rate or rates in order to ensure the availability of an adequate number of qualified health care providers in a network in a specific locality, the higher rate may not exceed the lesser of the following:

(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 Director, OCHAMPUS, or designee, based on one or more of the following payment rates:

- (i) Usual, customary, and reasonable;
(ii) The Health Care finance administration's Resource Based Relative Value Scale;
(iii) Negotiated fee schedules;
(iv) Global fees; or
(v) Sliding scale individual fee allowances.

(2) The amount equal to 115 percent of the otherwise allowable charge under paragraph (h)(1) of the section for the service.

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Dated: May 23, 2000.

L.M. Bynum,

Alternate Federal Register Notice Liaison Officer, Department of Defense.

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