THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

FEB 05 2007

The Honorable Carl Levin
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510-6050

Dear Mr. Chairman:

This letter forwards the final reply to the request in House Report 109-95 that the Secretary of Defense prepare a study on the TRICARE payment rates for physician services. Specifically, the Secretary was asked to provide a report on the process for establishing physician reimbursement rates and the adequacy of current reimbursement rates for physicians in all three TRICARE Regions.

The attached report both summarizes the findings of analysis that was conducted, and provides sufficient detail for discussion of the adequacy of TRICARE payment rates and services. There were concerns that TRICARE rates may not be adequate and may be causing providers not to accept additional TRICARE patients. These concerns have been explained and resolved through actions taken by the TRICARE Management Activity (TMA).

In summary, this review and analysis concludes with good news that TRICARE physician rates, at least in most areas, are adequate to attract physicians who have shown a willingness to accept new TRICARE patients. I am certain that current Department of Defense regulations and policy, along with the actions taken by TMA completely support adequate access to care in our TRICARE regions.

Thank you for your continued support of the Military Health System.

Sincerely,

William Winkenwerder, Jr., MD

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member

TRICARE MANAGEMENT ACTIVITY REPORT TO CONGRESS ON TRICARE'S PHYSICIAN REIMBURSEMENT RATES AND THEIR ADEQUACY

Prepared in response to House Report 109-95

In House Report 109-95 to the DoD Appropriations Act for FY06, the Military Quality of Life and Veterans Affairs Subcommittee asked the Assistant Secretary of Defense for Health Affairs (ASD(HA)) to report on the process for establishing physician reimbursement rates and the adequacy of current reimbursement rates for physicians in all three TRICARE Regions in order to address concerns about the adequacy of TRICARE's physician payment rates. In response, the TRICARE Management Activity (TMA) has prepared the following report.

SUMMARY

The TMA's research indicates that physicians are generally as willing to accept new TRICARE patients as new private patients, even though private insurers most often pay more than TRICARE. New survey data specific to TRICARE Standard in 29 select locations indicate that a lower percentage of physicians are willing to accept new TRICARE patients than new Medicare patients. This occurs even though TRICARE physician payment rates are equal to Medicare rates for over 99 percent of services. Whereas physicians are reluctant to take new TRICARE/Medicare patients, the decisions are based as much on other issues; such as, business practices, as due to TRICARE's payment rates.

TRICARE physician payment rates are lower than commercial rates. However, they are nearly equal for office visits and higher for some other services, such as mental health visits. Even with these lower rates, TRICARE Standard physicians who see

TRICARE patients overwhelmingly accept the CHAMPUS Maximum Allowable Cost (CMAC) as payment in full, even when they could balance bill beneficiaries. Based on these measures, TRICARE's physician payment rates are adequate to attract providers, at least in most locations. In certain geographic areas where it may be more difficult for beneficiaries to obtain adequate access to physicians and reimbursement appears to be the driving factor, TRICARE exercises its authority to increase the payment rate to improve access.

PROCESS FOR ESTABLISHING TRICARE PHYSICIAN REIMBURSEMENT RATES

TRICARE's reimbursement of physicians is based upon the methodology used by Medicare. 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 that apply to Medicare providers. In 1986, a statutory provision was enacted requiring hospitals participating in Medicare to also participate in CHAMPUS. 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.

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 this linkage to Medicare payment amounts.

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. TRICARE physician payment levels were gradually aligned with Medicare's rates over several years, and special provisions were built into the process to stop reducing payments if access to care was threatened. Over 99 percent of physician CMAC rates are now at the same level as Medicare; fewer than 1 percent are higher than Medicare because their gradual transition to the Medicare level is not yet complete. To protect access for maternity/delivery services, TMA has set the CMACs for these services at a higher level than Medicare.

The maximum amount that will be paid to a physician in a given location for a given CPT code is the CHAMPUS Maximum Allowable Charge, or CMAC. The CMACs used to reimburse physicians are established in two broad steps:

- first, a national CMAC is established for a CPT code; and
- second, the national CMAC is then adjusted to a local level.

In some circumstances, there are "waivers" that modify the CMACs.

How the National CMACs are Established for Physicians

Each year, the national CMAC is set directly to the Medicare national physician fee schedule amount if the TRICARE CMAC has already reached the Medicare level. For the one percent of CMACs which exceed the Medicare fee level, the previous year's CMAC is reduced by the lesser of 15 percent or the amount necessary to reach the Medicare physician fee amount. For new CPT codes without any prior history, the CMAC is set directly to the Medicare fee.

If there is no Medicare fee level for a CPT code and TRICARE reimburses that service, the CMAC amount is set at the TRICARE prevailing charge level. The prevailing charge is the 80th percentile of current billed charges across a provider class (physician or nonphysician) for a specific CPT code, using all national claims over the prior year's time period (between July 1st and June 30th). The one exception to using Medicare fees as the direct basis for the national CMAC rate is for maternity services (CPT codes in the range of 59000-59999). Due to some large cuts in the Medicare fees for these services in 1998 and the importance of maintaining access to these services for the TRICARE beneficiary population, TMA established a policy that the CMAC must be set at the higher of the current Medicare fee or the 1997 Medicare fee. 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.

Medicare does not have a true "fee schedule" for many non-physicians and does not cover many of the types of providers that TRICARE does. Usually, Medicare pays non-

physicians at a certain percentage of the physician fee amount, by specific specialty. TRICARE does not have CMACs for each specialty, but pays at 75 percent of the physician amount for mental health CPT codes for providers other than physicians or psychologists, and at 85 percent of the physician CMAC for non-physicians for all other codes, except maternity services. This is very similar to Medicare's policies which pay by provider specialty only (Medicare pays 75 percent for its mental health non-physician practitioners, and 85 percent to physician assistants or nurse practitioners).

Adjustment of the National CMACs to Locality-specific CMACs

After the "national" CMAC level has been determined, it is adjusted to one of 89 TRICARE geographic localities, which are defined with the same geographic boundaries as Medicare localities.[1] For physician services, a national CMAC is adjusted through use of the Medicare geographic practice cost indices (GPCIs) and the Medicare relative value units, in the same way that Medicare does.

CMAC Waivers

In order to address TRICARE payment rate issues in localities where access was a problem, Section 757 of the FY 2001 Defense Authorization Act extended new flexibility to the Secretary of Defense to increase TRICARE reimbursement rates. Section 757 indicated that reimbursement rates could be increased if access was severely impaired. This included consideration of "the number of providers in a locality who provide the

[1] TRICARE does have two different Alaska localities (Anchorage metro area, and the rest of the state), although Medicare only has one statewide locality.

services, the number of such providers who are CHAMPUS participating providers, the number of covered beneficiaries under CHAMPUS in the locality, the availability of military providers in the location or a nearby location, and any other factors determined to be relevant by the Secretary." This authority was implemented in September 2001. As of mid-2006, 12 CMAC waivers have been approved; about one-half were for network providers only, and the remainder were locality waivers affecting all providers in an area.

ADEQUACY OF CURRENT TRICARE PHYSICIAN REIMBURSEMENT RATES

MedPAC, the organization that advises the Congress on Medicare reimbursement policies, uses a variety of indirect measures to examine the adequacy of physician payment. TMA examined TRICARE's payment adequacy in four of the ways that are also used by MedPAC:

1. Physicians' willingness to accept new patients
2. Timeliness of beneficiaries access to care
3. Physicians willing to accept the CMAC as payment in full for their services
4. TRICARE rates compared to commercial rates

1. Physicians' willingness to accept new patients

During the past two years, TMA has conducted surveys of physician offices in a number of localities about the willingness of these physicians to take new TRICARE patients. In 2005, the Department conducted a "dual mode" mail and phone survey of physician offices in 20 states as well as in 29 locations in the U.S, covering all 3 TRICARE Regions.

TMA found that among the physicians whose practices were open to new patients, about 81 percent were willing to take new TRICARE patients, compared to 97 percent for Medicare according to a study by the Center for Studying Health System Changes. [2] However, the samples of physician offices used in these studies are quite different. While the Center uses a nationally representative survey of physician offices, the TRICARE survey of 29 locations is not meant to be nationally representative. Seventeen of the 29 local sites were selected purposively because of beneficiary concerns about poor access for TRICARE Standard in these 17 areas. As a result of the differences in the samples, it is unclear whether the difference in the rate of acceptance of new TRICARE patients (81 percent) should be regarded as being significantly different than the percentage of physicians accepting new Medicare patients (97 percent). The difference could be due to differences in the programs or because of the different samples.

The results of the TRICARE survey do reveal a very important finding: the percentage of physicians who are willing to accept new TRICARE patients varies significantly among markets. In the 29 locations sampled by TRICARE, the percentage of physicians willing to accept at least some new patients varied from 66 percent to 94 percent. The percentage of these physicians accepting at least some new patients who said

[2] The physicians were selected randomly in each location. Richard R. Bannick, "TRICARE Standard Survey: Civilian Physician Acceptance of New Patients Under TRICARE Standard", Presented to the TRICARE Beneficiary Panel, March 8, 2006.

they would accept new TRICARE patients ranged from 60 – 96 percent.[3] This variation indicates that the TRICARE program (and its rates) are adequate in many markets but may be inadequate in others.

The TRICARE survey of physician offices is also valuable because it asked physicians why they did not accept new TRICARE patients. The two most frequently cited reasons were: 1) "Dr. is not available" (because the practices were too busy, had a limited practice, or was not accepting more TRICARE patients) cited by 29 percent of the offices that said they did not accept new TRICARE patients; and 2) "reimbursement" issues (low reimbursement and length of time for claims to be paid) which was cited by 24 percent of the offices not accepting new TRICARE patients. Other reasons included "inconvenience", "specialty not covered", and "never heard of TRICARE".

2. Timeliness of beneficiary access to care

TRICARE surveys its beneficiaries about whether they have to wait longer than they wanted for physician appointments. In 2005, the Health Care Survey of DoD Beneficiaries found that about 60 percent of TRICARE beneficiaries were able to obtain care within a timeframe acceptable to them, compared to 74 percent for Medicare and 67 percent for commercial insurance [4]. TRICARE has found that most access problems

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[3] In 5 of the 29 markets, the percentage of physicians who said they would accept new TRICARE patients ranged from 60 – 70 percent (this is among physicians taking at least some new patients). All 5 of these markets were ones selected purposively because they were thought to be ones in which TRICARE beneficiaries had access problems.

[4] MedPAC, "Report to the Congress: Medicare Payment Policy", March 2006.

occur in rural areas and areas where there are few physicians. Most of the CMAC waiver requests that have been approved have been in these areas.

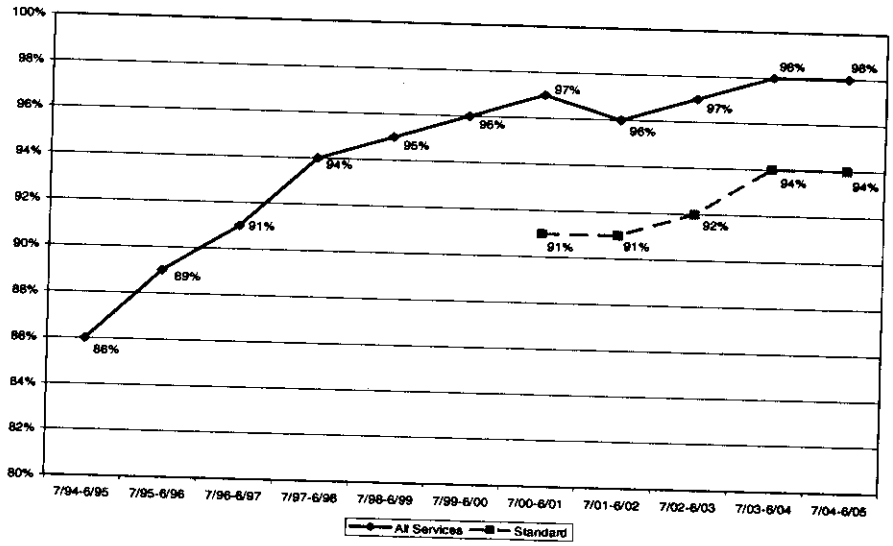
3. Physicians' willingness to accept the CMAC as payment in full

The willingness of physicians to accept the CMAC as payment in full is thus another gauge of the adequacy of TRICARE payments. Participating physicians accept the CMAC as payment in full for services covered by TRICARE and are not allowed to balance bill. Non-network physicians are allowed to balance bill, that is charge TRICARE patients 15 percent more than the CMAC.

Overall, TRICARE physician participation rates are very high. In 2004-2005, for about 98 percent of all physician claims, physicians accepted the TRICARE CMAC as payment in full. TRICARE Standard physicians accepted the CMAC as payment in full for 94 percent of all Standard claims nationally in the July 2004 – June 2005 period. This rate is 3 percentage points higher than the rate observed in TRICARE Standard in the July 2000 – June 2001 and the July 2001– June 2002 periods.[5] This indicates that the vast majority of TRICARE physicians, both network and non-network, have either agreed to accept the CMAC levels as payment in full or have agreed to accept a payment level lower than the CMAC.

[5] Based upon a March 20, 2006 analysis by Kennell and Associates of TRICARE participation rates.

Figure 1
TRICARE Physician Participation Rates for All Services and TRICARE Standard Have Both Increased in Recent Years



Note: Based upon analysis of TRICARE physician claims data (purchased care)

Approximately 74 percent of TRICARE purchased care services are delivered by network physicians who agree to accept the CMAC or a discount off the CMAC and about 94 percent of the remaining TRICARE Standard physicians do not balance bill; therefore, only about 2 percent of TRICARE physician services involve any type of balance billing.[6] If TRICARE physicians thought that the TRICARE reimbursement rates were inadequate, a higher level of balance billing would be expected. The fact that most physicians are willing to take new TRICARE patients indicates that most physicians find the reimbursement levels adequate.

On a local basis, there is wide variation in the percentage of Standard claims that have balance billing. While the national average in 2004-2005 is 94 percent for assigned

[6] This is calculated as follows: (.74 + .94 (1-.74)) = .984.

claims, 13 of the 89 TRICARE payment localities had participation rates below 90 percent, with the lowest being 70 percent in Manhattan. This indicates that in some areas the TRICARE payment rates may be less adequate than in other areas.[7]

4. TRICARE rates compared to commercial rates

Another measure of payment adequacy is the relationship of TRICARE payment rates to the rates paid by private insurers. MedPAC commissioned Direct Research to analyze claims data from two large nationwide private insurers for the time period 1999 to 2004 and estimate average physician fees paid by private insurers and by Medicare. MedPAC found that Medicare physician fees (and therefore the TRICARE CMAC) were 83 percent of average private rates in 2004. However, the MedPAC data are national and may not represent all of the types of services that TRICARE beneficiaries use. [8]

The TRICARE physician payment rates average about 10-15 percent lower than commercial rates, although TRICARE physician payment rates are nearly equal for visits, but are less for procedures. The TRICARE study also found that there is a great deal of variation by local area, and within a local area there is a great deal of variation by type of service. TMA compared the TRICARE CMAC rates to private insurance rates in the 25 3-digit zip code areas in the U.S. with the highest level of TRICARE purchased care expenditures in FY 2005, for the CPT codes most frequently used by TRICARE

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[7] In 2004-05, the 5 areas with the lowest Standard participation rates had rates of 70-85 percent. These same 5 areas had Standard participation rates of 72-82 percent in the 2001-02 period. This indicates that the Standard participation rates in these areas are lower but stable.

[8] For example, TRICARE beneficiaries use significantly more pediatric care than Medicare beneficiaries.

beneficiaries (CPT 99213, a mid-level office visit by an established patient; CPT 59400, the most common maternity/delivery code; and CPT 90806, the most common mental health code). The TRICARE study indicated that the commercial payment for the office visit (CPT 99213) was about 5 percent higher than the TRICARE CMAC, payment for the maternity/delivery code (CPT 59400) was about 17 percent higher than the CMAC, and payment by private insurers was about 40 percent lower for the mental health code (CPT 90806) than for TRICARE.

An analysis conducted by the Center for Studying Health System Change found that there was little difference in access between localities in which Medicare (and consequently TRICARE) paid low amounts relative to commercial rates and those markets in which Medicare paid high rates relative to commercial rates. The study's authors note that there did not appear to be any access advantage for privately insured individuals in those markets in which the commercial insurers paid more than Medicare. In fact, the privately insured individuals had more access problems than the Medicare patients[9]. As a result, some analysts have concluded that higher payment rates are not the most important factor driving physicians to accept TRICARE/ Medicare patients.

[9] Trude, S. and P. Ginsburg, "An Update on Medicare Beneficiary Access to Physician Services", Center for Studying Health System Change, February 2005.