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SOLE COMMUNITY HOSPITALS

Early Indications Show That TRICARE's Revised Reimbursement Rules Have Not Affected Access to Care

GAO-15-402

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GAO Highlights

Highlights of GAO-15-402, a report to congressional committees

Why GAO Did This Study

DOD offered health care to about 9.6 million eligible beneficiaries through TRICARE, which provides care through military treatment facilities and civilian providers. Because DOD determined that its approach for reimbursing SCHs (459 in 2014) based on their billed charges was inconsistent with TRICARE's governing statute to reimburse civilian providers in a manner similar to Medicare, it implemented revised rules in January 2014.

House Report 113-446, which accompanied the National Defense Authorization Act for Fiscal Year 2015, included a provision for GAO to review issues related to the changes in TRICARE's reimbursement rules for SCHs. In this report, GAO examines (1) how TRICARE's revised reimbursement rules for SCHs compare to Medicare's reimbursement rules for these hospitals, and (2) the extent to which TRICARE's revised reimbursement rules for SCHs may have affected access to these facilities by servicemembers and their dependents. GAO reviewed federal laws and regulations as well as TRICARE and Medicare's rules for reimbursing SCHs. GAO analyzed fiscal year 2013 TRICARE claims data on SCH admissions and reimbursement amounts, and Medicare data on SCH net patient revenue and total discharges. GAO interviewed 10 SCHs with the highest number of TRICARE admissions or reimbursement amounts about access issues. GAO also interviewed officials from DOD and national health care associations and military beneficiary coalition groups.

View GAO-15-402. For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

What GAO Found

TRICARE's revised reimbursement rules for Sole Community Hospitals (SCHs), which provide health care in rural areas or where similar hospitals do not exist under certain criteria, approximate those for Medicare's. Specifically, both programs reimburse SCHs using the greater of either a cost-based amount or the allowed amount under a diagnostic-related-group-based payment system, although each program takes a different approach in implementing these methods. Each program also provides for reimbursement adjustments under specific circumstances. In order to minimize sudden significant reductions in SCHs' TRICARE reimbursements, the revised rules include a transition period during which an eligible SCH is reimbursed using a cost-based ratio that is reduced annually until it matches the SCH's Medicare cost-to-charge ratio, which is calculated by the Centers for Medicare & Medicaid Services for each hospital. Under TRICARE's revised rules for SCHs, this cost-to-charge ratio will be multiplied by the hospitals' billed charges to determine their reimbursement amounts. Most SCHs—about 74 percent—qualified for a transition to their Medicare cost-to-charge ratios.

Because most SCHs have just completed the first year of a multi-year transition, it is too early to determine the full effect of the revised reimbursement rules, including any impact on TRICARE beneficiaries' access to care at these hospitals. Nonetheless, early indications show that TRICARE beneficiaries have not experienced problems accessing inpatient care at these facilities. Specifically, Defense Health Agency (DHA) officials reported that they do not think access to inpatient care at SCHs will be an issue because hospitals that participate in the Medicare program are required to participate in the TRICARE program and serve its beneficiaries. Although some of them were not familiar with this requirement, officials from the 10 SCHs GAO interviewed with the highest number of TRICARE admissions, the highest reimbursement amounts, or both, stated that they provide care to all patients, including TRICARE beneficiaries. DHA officials also said that they track access issues pertaining to inpatient care at SCHs through concerns or complaints, and as of February 2015, they had not received any access complaints. They noted that they are still looking at ways to measure changes in access to care at these facilities and will likely focus on the 44 SCHs that had 100 or more TRICARE admissions. In addition, other stakeholders, including representatives of national health care associations and military beneficiary coalition groups, said that they are not aware of TRICARE beneficiaries having difficulty accessing care at SCHs. Moreover, in its analysis of available Medicare data for these facilities (427 of 459 SCHs), GAO found that overall TRICARE reimbursements for SCHs averaged less than 1 percent of SCHs' net patient revenue, with TRICARE beneficiaries making up just over 1 percent of their total discharges for fiscal year 2013. As a result, the impact of TRICARE's revised reimbursement rules may likely be small for most SCHs.

GAO provided a draft of this report to the Department of Defense (DOD) for comment. DOD responded that it agreed with the report's findings and provided technical comments, which we incorporated as appropriate.

Contents

Abbreviations

ADD	active duty dependents
ADSM	active duty servicemembers
BRAC	Base Realignment and Closure
CMS	Centers for Medicare & Medicaid Services
DHA	Defense Health Agency
DOD	Department of Defense
DRG	diagnosis-related group
FY	fiscal year
IPPS	inpatient prospective payment system
SCH	sole community hospitals

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Congressional Committees

The Department of Defense (DOD) offered health care coverage to about 9.6 million eligible beneficiaries through TRICARE, its regionally structured health care program, in fiscal year 2013.[1] Although TRICARE provides some care directly through military treatment facilities, civilian health care providers, including physicians and hospitals, are also used to augment the direct care system when needed.

By law, TRICARE—administered by DOD's Defense Health Agency (DHA)[2]—must, to the extent practicable, reimburse civilian providers in a manner similar to Medicare.[3] TRICARE pays for most inpatient hospital care under a diagnosis-related group (DRG) inpatient prospective payment system (IPPS) similar to Medicare's.[4] Until recently, TRICARE exempted sole community hospitals (SCH)—which provide health care in rural areas or where like hospitals do not exist under certain criteria—

[1]TRICARE-eligible beneficiaries include active duty personnel and their dependents, medically eligible Reserve and National Guard personnel and their dependents, and retirees and their dependents and survivors.

[2]Prior to October 1, 2013, the TRICARE Management Activity, an entity within DOD, was responsible for overseeing the TRICARE program. In response to increasing pressure on its budgetary resources, DOD established the Defense Health Agency on October 1, 2013, to assume management responsibility of numerous functions of its medical health system, including the former TRICARE Management Activity, which was terminated on that date. For additional information, see GAO, *Defense Health Care Reform: Additional Implementation Details Would Increase Transparency of DOD's Plans and Enhance Accountability,* GAO-14-49 (Washington, D.C: Nov. 6, 2013).

[3]Medicare is a federal insurance program that pays for covered health services for most persons 65 years of age and older and for most permanently disabled individuals under the age of 65. Part A of the program, the Hospital Insurance program, covers hospital, post-hospital, and hospice services. According to 10 U.S.C. § 1079(j)(2), the amount to be paid to hospitals under TRICARE "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 [Medicare]."

[4]Medicare reimburses acute care hospitals for inpatient services under its IPPS, which involves payments on a per-discharge or per-case basis. Under Medicare, discharges are assigned to a DRG, a classification system that groups similar clinical conditions (diagnoses) and the procedures furnished by the hospital during the stay. Under the IPPS, hospitals are paid a predetermined amount for each Medicare patient, based on the patient's diagnosis and treatment, and on certain characteristics of the hospital.

from reimbursement under its DRG-based payment system. Under Medicare, SCHs qualified for special payment provisions that were based on historical hospital costs and other factors.[5] However, because these hospital-specific costs were unavailable to DOD, the department did not implement Medicare's special payment provisions for SCHs and has generally been reimbursing SCHs based on their billed charges.[6]

DHA determined that continuing to reimburse SCHs on the basis of their billed charges was fiscally imprudent and inconsistent with TRICARE's governing statute, and, as a result, it implemented revised reimbursement rules in January 2014 that are designed to more closely align with Medicare's payment provisions for SCHs. DHA estimated that the new reimbursement rules will result in a cost savings of more than $590 million through fiscal year 2017.

However, there have been congressional questions about the potential effect of these reimbursement changes on TRICARE beneficiaries' access to inpatient care at SCHs, which we are defining as their ability to obtain care at these facilities. House Report 113-446, which accompanied the National Defense Authorization Act for Fiscal Year 2015, included a provision for GAO to review issues related to the changes in TRICARE's reimbursement rules for SCHs. In this report, we examine (1) how TRICARE's revised reimbursement rules for SCHs compare to Medicare's reimbursement rules for these hospitals, and (2) the extent to which TRICARE's revised reimbursement rules for SCHs may have affected access to these facilities by servicemembers and their dependents.

To determine how TRICARE's revised reimbursement rules for SCHs compare to Medicare's reimbursement rules for these hospitals, we reviewed relevant federal laws and regulations as well as TRICARE's and

[5]In response to concerns about the financial condition of rural hospitals, Congress modified the Medicare payment system in 1983 to increase payments to these hospitals by establishing special payment provisions that allow for payments based on historical costs, adjustments for treating a disproportionate share of low-income patients, and additional payments for significant volume decreases—defined as more than a 5 percent decrease in total inpatient discharges as compared to the immediately preceding cost reporting period.

[6]TRICARE network providers may be reimbursed less than billed charges if they agree to a negotiated discount off of their billed charges.

Medicare's rules for reimbursing hospitals for inpatient care. We also interviewed DHA officials about the revised rules for reimbursing SCHs and their implementation of these rules. In addition, we analyzed data on the reimbursement rates for SCHs and reviewed DHA's cost savings estimate. We determined that the data were sufficiently reliable for the purposes of this report based on information from DHA officials about the procedures in place to ensure its quality and completeness.

To determine the extent to which TRICARE's revised reimbursement rules for SCHs may have affected beneficiaries' access to care at these facilities, we obtained fiscal year 2013 TRICARE claims data on the number of admissions and reimbursement amounts for each of the 459 hospitals that were designated as SCHs in 2014.[7] We used these data to assess the frequency of TRICARE admissions to identify TRICARE beneficiaries' utilization of inpatient care at these facilities. We also used these data to select 10 SCHs that had the highest number of TRICARE admissions, the highest reimbursement amounts, or both, and we interviewed officials at those SCHs about the change in TRICARE reimbursement rules and any resulting effect on access to care.[8] (See appendix I for our selection methodology and a list of these facilities.) We determined that the TRICARE claims data were sufficiently reliable for the purposes of this report based on information from DHA officials about the procedures in place to ensure the quality and completeness of these data. We also analyzed the proximity of SCHs with 100 or more TRICARE admissions in fiscal year 2013 (44 of 459 SCHs) to military hospitals and clinics to determine military beneficiaries' potential reliance on these SCHs as a source of inpatient care.[9] We also obtained fiscal year 2013 data on net patient revenue, total number of discharges, and the number of hospital beds for 427 of the 459 SCHs using the

[7]Nine of the 459 SCHs had not been designated as SCHs in fiscal year 2013. We reported the number of SCHs during calendar year 2014 because the revised rules were implemented January 1, 2014.

[8]The SCHs we selected ranged in size from 162 beds to 753 beds, and included regional medical centers.

[9]We determined whether an SCH was within 40 miles of a military treatment facility by calculating the distance between the central point of the zip codes of the SCH and military treatment facilities. Under TRICARE, the Assistant Secretary of Defense for Health Affairs defines a Prime Service Area as a set of 5-digit zip codes, usually within an approximate 40-mile radius of a military treatment facility. DHA requires its TRICARE contractors to establish networks of civilian providers within these areas.

Healthcare Cost Report Information System.[10] We determined that the Healthcare Cost Report Information System data were sufficiently reliable for the purposes of this report based on information about the procedures in place to ensure the quality and completeness of these data.

Furthermore, we contacted officials at selected military hospitals located within 40 miles of some of the highest-volume SCHs we identified about their reliance on the SCHs, as well as any effects the revised rules have had on beneficiaries' access to care at these facilities.[11] We also contacted each of the military services to determine whether an SCH was located near a military hospital that had closed or no longer offered inpatient care since 2012, and we interviewed officials at these locations to assess beneficiaries' reliance on these SCHs and whether their access had been impaired.[12] We interviewed officials from DHA, the three TRICARE Regional Offices (North, South, and West), and the three regional TRICARE managed care support contractors (UnitedHealthcare Military & Veterans Services, Humana Military Healthcare Services, and Health Net Federal Services) about changes in the reimbursement rules, the effect of the changes on SCHs, and the effect on TRICARE beneficiaries' access to care at these facilities.[13] We also interviewed DHA officials about their plans to monitor access to care at sole community hospitals. Finally, we interviewed officials from the following national health care associations and military beneficiary coalition groups—American Hospital Association's Section for Small or Rural Hospitals, National Rural Health Association, Military Officers Association of America, and the National Military Family Association—to obtain their insights about these issues from the perspective of those who would potentially be affected by the revised reimbursement rules.

[10]Data for the other 32 SCHs were not available at the time of our review.

[11]We contacted officials from Naval Hospital Beaufort (South Carolina) and Naval Hospital Camp Lejeune (North Carolina) about these issues.

[12]No military hospitals closed during this time frame, but two Naval hospitals—Naval Hospital Lemoore (California) and Naval Hospital Oak Harbor (Washington)—eliminated all or most of their inpatient services.

[13]Managed care support contractors are private sector companies that DOD contracts with to develop and maintain civilian provider networks and provide other services, such as specialty care referrals, enrollment, medical case management, claims processing, and customer service.

We conducted this performance audit from October 2014 to April 2015 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Under TRICARE, beneficiaries may obtain health care through either the direct care system of military treatment facilities or the purchased care system of civilian providers and hospitals, including SCHs. SCHs were exempted from TRICARE's reimbursement rules for hospitals until revised rules were implemented in January 2014.

Sole Community Hospitals

SCHs serve communities that rely on them for inpatient care, and they include hospitals and regional medical centers ranging in size from 9 to 598 beds.[14] The intent of the SCH designation is to maintain access to needed health services for Medicare beneficiaries by providing financial assistance to hospitals that are geographically isolated. A hospital may generally qualify for SCH status by showing that because of factors such as isolated location, weather conditions, travel conditions, or absence of other like hospitals, it is the sole source of inpatient hospital services reasonably available in a geographic area.

In 2014, 459 hospitals were designated as SCHs under the Medicare program. A hospital that qualifies as an SCH under the Centers for Medicare & Medicaid Services's (CMS) Medicare regulations is also considered an SCH under TRICARE. Specifically, a hospital paid under the Medicare Acute Care Hospital IPPS is eligible for classification as an SCH if it meets one of the following criteria established by CMS:

[14]This information is based on fiscal year 2013 data from the Healthcare Cost Report Information System.

- The hospital is at least 35 miles from other like hospitals;[15]
- The hospital is rural, between 25 and 35 miles from other like hospitals, and meets one of the following criteria:
  - No more than 25 percent of hospital inpatients or no more than 25 percent of the Medicare inpatients in the hospital's service area are admitted to other like hospitals within a 35-mile radius of the hospital or, if larger, within its service area;[16]
  - The hospital has fewer than 50 beds and would meet the 25 percent criterion except that some beneficiaries or residents were forced to seek specialized care outside of the service area due to the unavailability of necessary specialty services at the hospital; or
  - Because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each 2 out of 3 years.
- The hospital is rural and located between 15 and 25 miles from other like hospitals, but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each of 2 out of 3 years; or
- The hospital is rural and because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

TRICARE Networks and Access-to-Care Standards

Under the TRICARE program, beneficiaries can obtain care either from providers at military treatment facilities or from civilian providers. DHA contracts with three regional managed care support contractors to develop networks of civilian providers in their respective regions, including SCHs, to serve TRICARE beneficiaries in geographic areas

[15]A like hospital (1) furnishes short-term, acute care; (2) is paid under the Medicare Acute Care Hospital IPPS; (3) is not designated as a critical access hospital; and (4) is not paid under any other Medicare PPS. Critical access hospitals are limited-service rural facilities that meet certain distance criteria or have been designated as necessary providers, offer 24-hour emergency care, have no more than 25 inpatient beds, and have no more than 96-hour average lengths of stay.

[16]A hospital's service area is the area from which it draws at least 75 percent of its inpatients during the most recent 12-month cost reporting period ending before it applies for SCH classification.

called Prime Service Areas.[17] Prime Service Areas are geographically defined by a set of 5-digit zip codes, usually within an approximate 40-mile radius of a military treatment facility.[18] These civilian provider networks are required to meet specific access standards for certain types of TRICARE beneficiaries, such as travel times or wait times for appointments.[19] However, these access standards do not apply to inpatient care.

TRICARE's Reimbursement Rules for Hospitals

Since 1987, DHA has reimbursed hospitals for claims using the agency's DRG-based payment system, which was modeled after Medicare's system.[20] Under this system, claims are priced using an annual standard amount and a weighted value for each DRG. For example, in fiscal year 2014, the TRICARE annual standard amount was approximately $5,500.00. Payment weights are assigned to each DRG based on the average resources used to treat patients. For example, in fiscal year 2014, a lung transplant had a weight of 8.6099, which would be multiplied by the annual standard payment amount ($5,500.00) for a reimbursement of $47,354.45. TRICARE's DRG-based payment system differs from Medicare's DRG-based payment system in that each program has different annual standard amounts and different DRG weights due to differences in the characteristics of their beneficiary populations. For example, Medicare's population, which is generally older and less healthy

[17]Network providers are providers who have contractual relationships with the TRICARE managed care support contractors to provide care at negotiated rates. TRICARE beneficiaries may also obtain care from a nonnetwork provider, which may require a higher cost share.

[18]The managed care support contracts also require the contractors to develop civilian provider networks at all Base Realignment and Closure (BRAC) sites, which are military installations that have been closed or realigned as a result of decisions made by the Commission on Base Realignment and Closure.

[19]Under TRICARE, beneficiaries may choose among three basic options—TRICARE Prime (a managed care option), TRICARE Extra (a preferred provider organization option), and TRICARE Standard (a fee-for-service option). The TRICARE Prime option has five access-to-care standards for outpatient services that address the following: (1) travel time, (2) appointment wait time, (3) availability and accessibility of emergency services, (4) composition of network specialists, and (5) office wait time. See 32 C.F.R. § 199.17(p)(5). However, the access standards do not apply to beneficiaries using options other than TRICARE Prime, such as TRICARE Standard or Extra.

[20]In 1983, CMS implemented an IPPS for acute care hospitals using DRG-based payments.

than TRICARE's population, may require more resources and may require longer inpatient lengths of stay. Also, some services, notably obstetric and pediatric services, are nearly absent from Medicare, but are a much larger component of TRICARE's services.

SCHs were exempted from DHA's DRG-based payment system because they had special payment provisions under Medicare that allowed for payments based on historical costs as well as certain types of adjustments, such as additional payments for significant volume decreases defined as a more than 5 percent decrease in total inpatient discharges as compared to the immediately preceding cost reporting period. Instead, DHA generally reimbursed SCHs based on their billed charges for inpatient care provided to TRICARE beneficiaries. However, distinctions were made among providers based on network status. Specifically, nonnetwork SCHs were reimbursed for their billed charges, and network hospitals were reimbursed based on their billed charges less any discounts that they negotiated with the managed care support contractors.

TRICARE's Revised Reimbursement Rules for SCHs Approximate Those for Medicare

Under its revised reimbursement rules for SCHs, DHA's methodology for TRICARE approximates the rules for Medicare for these hospitals. Specifically, both programs reimburse SCHs using the greater of either a cost-based amount or the allowed amount under a DRG-based payment system. However, each program takes a different approach in implementing these methods.

Medicare reimburses each SCH based on which of the following methods yields the greatest aggregate payment for that hospital: (1) the updated hospital-specific rate based on cost per discharge from fiscal year 1982, (2) the updated hospital-specific rate based on cost per discharge from fiscal year 1987, (3) the updated hospital-specific rate based on cost per discharge from fiscal year 1996, (4) the updated hospital-specific rate based on cost per discharge from fiscal year 2006, or (5) the IPPS hospital-specific DRG rate payment.[21] Medicare's reimbursement rules also include payment adjustments that SCHs may receive under special

[21]The IPPS provides incentives for hospitals to operate efficiently by paying a predetermined standard amount for an entire inpatient episode of a given type rather than the actual costs incurred in providing the care.

programs or circumstances, such as adjustments to SCHs that experience significant volume decreases.

Beginning January 1, 2014, TRICARE began reimbursing SCHs based upon the greater of (1) the SCH's Medicare cost-to-charge ratio, or (2) TRICARE's DRG-based payment system. The Medicare cost-to-charge ratio that TRICARE uses is calculated for each hospital by CMS and is distinct from the historical hospital-specific rates based on the cost per discharge that Medicare uses to reimburse SCHs. Under TRICARE's revised rules for SCHs, the cost-to-charge ratio will be multiplied by each hospital's billed charges to determine its reimbursement amount. Also, at the end of each year, DHA calculates the aggregate amount that each SCH would have been reimbursed under TRICARE's DRG-based payment system, which it uses to reimburse other hospitals that provide inpatient care to TRICARE beneficiaries. If an SCH's aggregate reimbursement would have been more under this system than it would have using the Medicare cost-to-charge ratio, DHA pays the SCH the difference. TRICARE's revised reimbursement rules also include payment adjustments that SCHs may receive under special circumstances, although the specific TRICARE adjustments differ from those available under Medicare. For example, effective with the revised reimbursement rules, SCHs may qualify for a General Temporary Military Contingency Payment Adjustment if they meet certain criteria, including serving a disproportionate share of active duty servicemembers and their dependents—10 percent or more of the SCH's total admissions.[22] At the time of our review, DHA officials did not have an estimate of the number of SCHs that would qualify for this adjustment.

Under TRICARE's revised rules, some SCHs—which were previously reimbursed at up to 100 percent of their billed charges—will eventually be reimbursed at 30 to 50 percent of their billed charges. In order to minimize sudden significant reimbursement reductions on SCHs, DHA's revised rules include a transition period to the new reimbursement levels for most SCHs. Eligible SCHs are reimbursed using an individually

[22]The criteria to receive a General Temporary Military Contingency Payment Adjustment are: (1) the hospital serves a disproportionate share of active duty servicemembers (ADSM) and active duty dependents (ADD), i.e., 10 percent or more of the SCH's total admissions are for ADSMs and ADDs; (2) the hospital is a TRICARE network hospital; (3) the hospital's actual costs for inpatient services exceed TRICARE payments or other extraordinary economic circumstance exists; and (4) without the adjustment, DOD's ability to meet military contingency mission requirements will be significantly compromised.

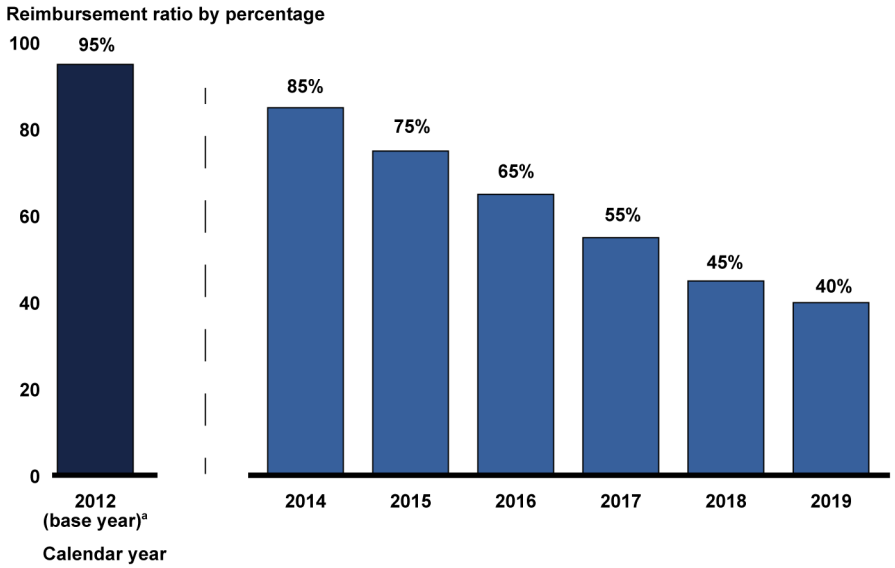
derived base-year ratio that is reduced annually until it matches the SCH's Medicare cost-to-charge ratio that CMS has calculated for each hospital. For each hospital designated as an SCH during fiscal year 2012, DHA calculated a base-year ratio of their allowed-to-billed charges using fiscal year 2012 TRICARE claims data. Based on these calculations, each SCH fell into one of two categories: (1) SCHs with base-year ratios higher than their Medicare cost-to-charge ratios, or (2) SCHs with base-year ratios lower than, or equal to, their Medicare cost-to-charge ratios.

Most SCHs fell into the first category with base-year ratios higher than their Medicare cost-to-charge ratios (339 or 74 percent), which qualified them for a transition period.[23] For these SCHs, their base-year ratios are reduced annually based on their network participation status, and their modified ratios are multiplied by their billed charges beginning January 1, 2014. Specifically, a nonnetwork SCH has no more than a 15 percentage point reduction each year, while a network SCH has no more than a 10 percentage point reduction as its reimbursement level declines to its respective Medicare cost-to-charge ratio.[24] The length of the transition period differs for each SCH and is determined by the difference between its base-year ratio and its Medicare cost-to-charge ratio, and its network status. Figure 1 shows an example of the transition for a network SCH with a 95 percent base-year ratio that is transitioning to a Medicare cost-to-charge ratio of 40 percent. As a network provider, the SCH's base-year ratio would be reduced by 10 percentage points to 85 percent during the first year of implementation of the revised rules and would continue to be reduced until its reimbursement ratio matches the SCH's Medicare ratio 5 years later.

[23]Twenty of the 339 SCHs with base-year ratios higher than their Medicare cost-to-charge ratios are also being reimbursed at their Medicare ratios during the first year of the transition because their modified ratios are equal to their Medicare ratios.

[24]If a nonnetwork SCH that qualified for the transition to its Medicare cost-to-charge ratio subsequently becomes a network provider, the annual modification to its reimbursement ratio would be reduced to 10 percentage points.

Figure 1: Example of a Network Sole Community Hospital's Transition from Its Base-Year Ratio to Its Medicare Cost-to-Charge Ratio



Source: Defense Health Agency. | GAO-15-402

[a]Base-year ratios are based on fiscal year 2012 TRICARE claims.

Twenty-four percent (111 of 459) of the hospitals that were designated as SCHs during fiscal year 2012 with base-year ratios less than or equal to their Medicare cost-to-charge ratios did not qualify for a transition period because either their reimbursement increased to their Medicare cost-to-charge ratio, or they continued to be reimbursed at their Medicare cost-to-charge ratio. Similarly, about 2 percent (9 of 459) of the hospitals that were not designated as SCH in fiscal year 2012 also did not qualify for a transition period. Instead, these SCHs are now reimbursed using their Medicare cost-to-charge ratio in accordance with TRICARE's revised reimbursement rules.

Once an SCH reaches its Medicare cost-to-charge ratio, TRICARE reimburses labor, delivery, and nursery care services at 130 percent of this ratio. This rule is based on DHA's assessment that Medicare's ratio

does not accurately reflect the costs for these services.[25] According to TRICARE's fiscal year 2013 claims data, 120 SCHs (approximately 30 percent of all SCHs) were already reimbursed using rates that were at or below their Medicare cost-to-charge ratios.

Early Indications Show That Access to Care Has Not Been Affected by TRICARE's Revised Reimbursement Rules for SCHs

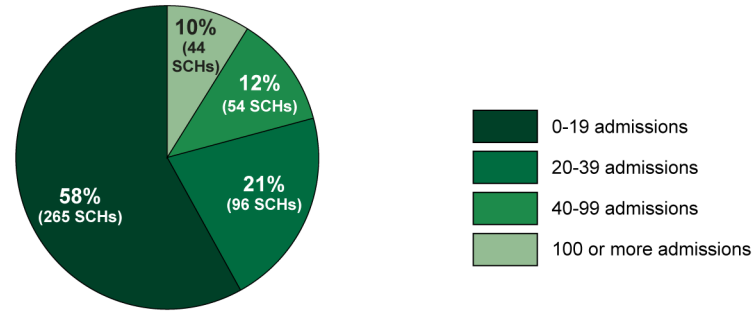
Because most SCHs have just completed the first year of a multi-year transition, it is too early to determine the full effect of the revised reimbursement rules on SCHs, including any effect on TRICARE beneficiaries' ability to obtain care at these hospitals. Nonetheless, early indications show that TRICARE beneficiaries have not experienced problems accessing inpatient care at these facilities.

For fiscal year 2013, we found that overall TRICARE reimbursements for SCHs averaged less than 1 percent of their net patient revenue, with TRICARE beneficiaries making up just over 1 percent of their total discharges.[26] We also found that the majority of SCHs—58 percent (265 of 459)—had fewer than 20 TRICARE admissions during this time while 10 percent (44 of 459) had 100 or more TRICARE admissions. As a result, the impact of TRICARE's revised reimbursement rules may likely be small for most SCHs. Figure 2 illustrates a breakdown of the 459 SCHs by their fiscal year 2013 TRICARE admissions.

[25]TRICARE's SCH reimbursement rule for labor, delivery, and nursery care services is not applicable to all pediatric inpatient services. A DHA official told us that most pediatric inpatient costs include room and board, lab, drug, radiology and other costs, which are typically applicable to both adults and children. In addition, comments received on the proposed and final rule were specifically related to reimbursement for labor, delivery and nursery care in SCHs.

[26]Net patient revenue and total discharge information is based on data from the Healthcare Cost Report Information System and includes data for 427 of the 459 SCHs, some of which had no TRICARE admissions during fiscal year 2013. TRICARE reimbursements are defined as TRICARE allowed amounts, which differ from TRICARE government costs that exclude beneficiary cost sharing.

Figure 2: TRICARE Admissions for the 459 Sole Community Hospitals (SCH) for Fiscal Year 2013



Source: Defense Health Agency. | GAO-15-402

Note: In 2014, 459 hospitals had been designated as SCHs. Nine of the 459 hospitals had not been designated as SCHs in fiscal year 2013. Due to rounding, the percentages total more than 100.

DHA officials reported that they do not think access to inpatient care at SCHs will be an issue because hospitals that participate in the Medicare program are required to participate in the TRICARE program and serve its beneficiaries.[27] Officials from the 10 SCHs we identified as having the highest number of TRICARE admissions, the highest reimbursement amounts, or both, told us that they provide care to all patients, including TRICARE beneficiaries—although some of them were not familiar with this requirement. TRICARE reimbursement for these SCHs ranged from about 2 to 12 percent of their net patient revenue, and TRICARE beneficiaries accounted for about 1 to 27 percent of their total discharges. See table 1 for TRICARE percentages of net patient revenue and total discharges for each of these SCHs.

[27]42 U.S.C. § 1395cc(a)(1)(J) and (a)(1)(L). This requirement applies to inpatient services furnished to beneficiaries admitted on or after January 1, 1987. 42 C.F.R. § 489.25.

Table 1: TRICARE Percentages of Total Discharges and Net Patient Revenues of Sole Community Hospitals (SCH) with the Highest Number of TRICARE Admissions or Reimbursements in Fiscal Year 2013

Sole community hospital	Number of hospital beds	TRICARE admissions as a percentage of total SCH discharges	TRICARE reimbursements as a percentage of SCH net patient revenue
Onslow Memorial Hospital, North Carolina	162	23.1	12.0
Samaritan Medical Center, New York	165	27.8	4.8
Carolina East Medical Center, North Carolina	289	11.2	4.3
New Hanover Medical Center, North Carolina	598	0.9	3.5
Beaufort Memorial Hospital, South Carolina	167	14.6	5.2
Benefis Healthcare, Montana	228	8.5	3.2
Trinity Health - St Joseph, North Dakota	202	9.0	1.9
Cheyenne Regional Medical Center West, Wyoming	170	9.3	4.5
United Regional - Eleventh Street Campus, Texas	269	5.5	4.6
Rapid City Regional Hospital, South Dakota	339	3.8	2.1

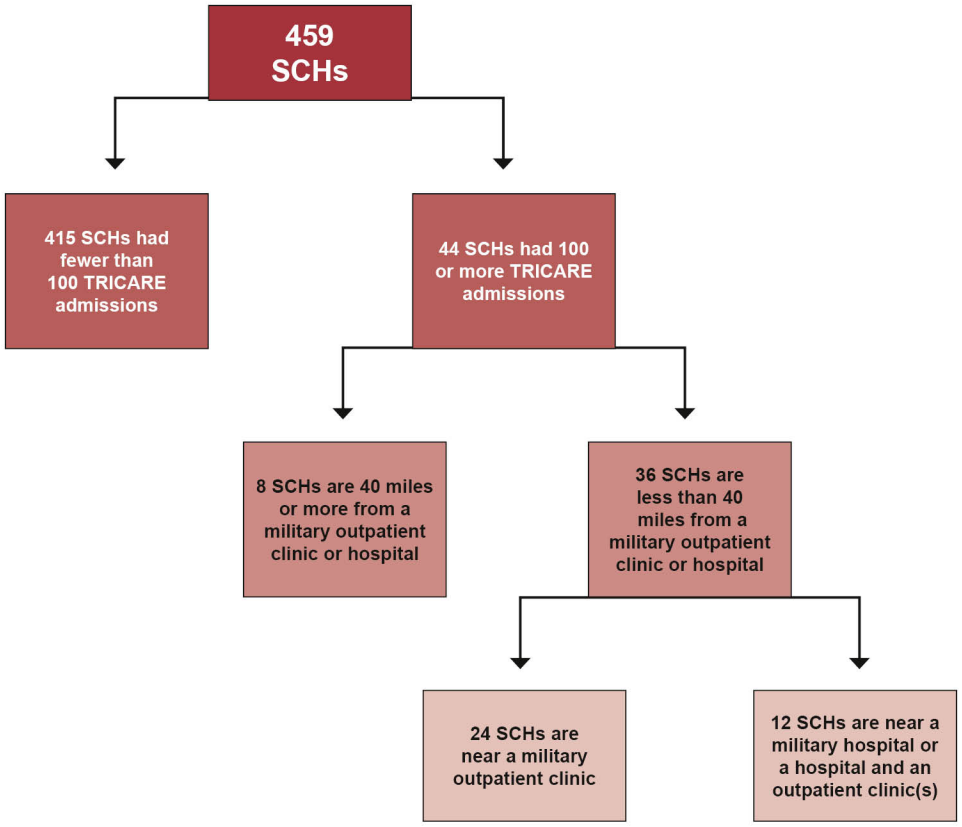
Source: Defense Health Agency and Healthcare Cost Report Information System. | GAO-15-402

However, TRICARE beneficiaries' access to care at SCHs could be affected if these hospitals reduced or eliminated their inpatient services. The SCH officials we spoke with told us that they had not reduced the inpatient services available at their hospitals as a result of TRICARE's revised reimbursement rules. However, officials at two SCHs did express concerns about future difficulties maintaining their current level of operations as they face further reductions in reimbursements not only from TRICARE, but also from other sources, such as Medicare and Medicaid. These officials said that they are concerned about their facilities' long-term survival. Given the current environment of decreasing reimbursements, some SCHs we interviewed reported taking proactive steps, such as eliminating equipment maintenance contracts, to help offset the reimbursement reductions. Officials from one facility we interviewed told us that they are considering an option to partner with another SCH as a way to increase efficiency.

TRICARE beneficiaries' demand for inpatient care at SCHs also may be affected by the availability of inpatient care from their respective military installation. We found that 24 of the 44 SCHs we identified as having 100 or more TRICARE admissions in fiscal year 2013—about half—were within 40 miles of a military installation that only had an outpatient clinic. (See appendix II for a list of the 44 SCHs and their proximity to military hospitals and clinics). As a result, servicemembers and their dependents in those locations may be more reliant on a nearby SCH for their inpatient

care. We found that TRICARE inpatient admissions for these 24 facilities ranged from 101 to 2,178 in fiscal year 2013, and 6 of them were among the 10 SCHs that we interviewed because they had the highest number of TRICARE admissions, the highest reimbursement amounts, or both. Officials from these 6 SCHs told us that nearby TRICARE beneficiaries tend to rely on their facilities for certain types of inpatient services, such as labor and delivery. See figure 3 for additional information about SCHs with 100 or more TRICARE admissions and their proximity to military hospitals and clinics.

Figure 3: Proximity to Military Hospitals and Outpatient Clinics for Sole Community Hospitals (SCH) with 100 or More TRICARE Admissions in Fiscal Year 2013



Source: Defense Health Agency. | GAO-15-402

Note: In 2014, 459 hospitals had been designated as SCHs. Nine of the 459 hospitals had not been designated as SCHs in fiscal year 2013.

We also found that 12 of the 44 SCHs with 100 or more admissions were located fewer than 40 miles from a military hospital. TRICARE admissions for these facilities ranged from 117 to 2,364 in fiscal year 2013. Three of these SCHs—which are located near Naval hospitals in North Carolina and South Carolina—were among the 10 SCHs with the highest number of TRICARE admissions or the highest numbers of both admissions and reimbursement that we interviewed. An official with Naval Hospital Camp Lejeune (North Carolina) told us the hospital relies on local SCHs because it is either unable to meet their beneficiaries' demand for certain services, such as obstetric care, or because the SCHs offer services not available at the Naval hospital, such as some cardiac care. Naval Hospital Beaufort (South Carolina) provides limited inpatient services, and according to an official there, most of that hospital's beneficiaries obtain inpatient care at the local SCH, including intensive care, all pediatric care, maternity and newborn care, and certain types of specialty care not provided at the Naval hospital (neurology, cardiology, and gastroenterology).

We also interviewed officials at two additional military hospitals—Naval Hospital Lemoore (California) and Naval Hospital Oak Harbor (Washington)—that had eliminated all or most of their inpatient care and were within 40 miles of an SCH. These officials told us that they rely more on other hospitals that are closer to their installations than the SCHs. For example, an official with Naval Hospital Lemoore told us that Lemoore currently has a resource sharing agreement with another hospital, which is closer to them than the nearby SCH. This agreement allows military providers with privileges to deliver babies for TRICARE beneficiaries at that facility. Officials from Naval Hospital Oak Harbor told us that their hospital tends to utilize three smaller facilities closer to it than the SCH depending on the type of service needed.

DHA and managed care support contractor officials told us that they have not heard of concerns or issues with beneficiary access at SCHs resulting from the revised reimbursement rules. DHA officials reported that they do not think access to inpatient care at SCHs will be an issue because hospitals that participate in the Medicare program are required to participate in the TRICARE program and serve its beneficiaries.[28] DHA officials told us they track access issues pertaining to inpatient care at

[28]42 U.S.C. § 1395cc(a)(1)(J) and (a)(1)(L); 42 C.F.R. § 489.25.

SCHs through concerns or complaints communicated to them through the TRICARE Regional Offices or directly from beneficiaries. As of February 2015, these officials told us they have not received any such complaints. They noted that they are looking at ways to measure changes in access to care at these facilities, possibly by comparing the number of discharges from one year to the next. Although their plans are under development, officials stated that they will likely focus on the 44 SCHs that had 100 or more TRICARE admissions. Officials from DHA's TRICARE Regional Offices and the managed care support contractors also told us that they have not received complaints or heard of issues from beneficiaries about their ability to access inpatient care at SCHs.[29] In addition, officials from national health care associations and military beneficiary coalition groups that we spoke with also reported that they have not heard any concerns about access to care at SCHs resulting from TRICARE's revised reimbursement rules.

Agency Comments

We provided a draft of this report to DOD for comment. DOD responded that it agreed with the report's findings, and its comments are reprinted in appendix III. DOD also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the Secretary of Defense and appropriate congressional committees. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

[29]Officials with the managed care support contractors told us that 4 SCHs, with a collective total of 27 TRICARE admissions in fiscal year 2013, left the TRICARE network prior to the implementation of the revised rules, although they did not attribute the change specifically to the rules.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report are listed in appendix IV.

Debra A. Draper
Director, Health Care

List of Committees

The Honorable John McCain
Chairman
Committee on Armed Services
United States Senate

The Honorable Jack Reed
Ranking Member
Committee on Armed Services
United States Senate

The Honorable Mac Thornberry
Chairman
Committee on Armed Services
House of Representatives

The Honorable Adam Smith
Ranking Member
Committee on Armed Services
House of Representatives

Appendix I: Methodology for Selecting Sole Community Hospitals Based on Fiscal Year 2013 TRICARE Claims Data

We obtained TRICARE claims data on the number of admissions and reimbursement amounts for each sole community hospital (SCH) for fiscal year 2013. We used these data to select the eight SCHs with the highest number of TRICARE admissions and the eight SCHs with the highest reimbursement amounts. Due to overlap, the number of unique SCHs we selected totaled 10. We interviewed officials at those hospitals about the change in TRICARE reimbursement rules and any resulting effect on access to care.

Table 2: Sole Community Hospitals (SCH) with the Highest Number of TRICARE Admissions or Reimbursements in Fiscal Year (FY) 2013

Sole community hospital	State	FY 2013 TRICARE admissions	Top 8 rank by admissions	FY 2013 TRICARE reimbursements	Top 8 rank by reimbursements
Onslow Memorial Hospital	North Carolina	2,364	✓	$16,187,784	✓
Samaritan Medical Center	New York	2,178	✓	8,952,928	✓
Carolina East Medical Center	North Carolina	1,392	✓	12,702,501	✓
New Hanover Medical Center	North Carolina	1,386	✓	24,306,226	✓
Beaufort Memorial Hospital	South Carolina	1,162	✓	7,756,056	
Benefis Healthcare	Montana	934	✓	11,252,401	✓
Trinity Health - St Joseph	North Dakota	899	✓	6,956,710	
Cheyenne Regional Medical Center West	Wyoming	820	✓	11,462,996	✓
United Regional - Eleventh Street Campus	Texas	793		12,621,318	✓
Rapid City Regional Hospital	South Dakota	589		8,709,915	✓

Source: Defense Health Agency. | GAO-15-402

Appendix II: Sole Community Hospitals with More than 100 TRICARE Admissions, FY 2013, by Distance from a Military Facility

Sole community hospital (SCH)	State	Fiscal Year (FY) 2013 TRICARE admissions	SCH less than 40 miles from a military outpatient clinic(s)	SCH less than 40 miles from a military hospital(s)
8 SCHs that were 40 miles or more from a military outpatient clinic or hospital				
New Hanover Medical Center	North Carolina	1,386	—	—
DCH Regional Medical Center	Alabama	149	—	—
Dixie Regional Medical Center	Utah	120	—	—
Salina Regional Health Center	Kansas	116	—	—
Flagstaff Hospital	Arizona	103	—	—
Portneuf Medical Center	Idaho	103	—	—
St. Cloud Hospital	Minnesota	103	—	—
St. Peters Community Hospital	Montana	102	—	—
24 SCHs that were less than 40 miles from a military outpatient clinic				
Samaritan Medical Center	New York	2,178	✓	—
Benefis Healthcare	Montana	934	✓	—
Trinity Health - St Joseph	North Dakota	899	✓	—
Cheyenne Regional Medical Center West	Wyoming	820	✓	—
Yuma Regional Medical Center	Arizona	803	✓	—
Wayne Memorial Hospital	North Carolina	800	✓	—
United Regional - Eleventh Street Campus	Texas	793	✓	—
Western Missouri Medical Center	Missouri	670	✓	—
Rapid City Regional Hospital	South Dakota	589	✓	—
Sierra Vista Regional Health Center	Arizona	545	✓	—
Gerald Champion Memorial Hospital	New Mexico	510	✓	—
Altru Hospital	North Dakota	462	✓	—
Carthage Area Hospital	New York	326	✓	—
Jackson County Memorial Hospital	Oklahoma	305	✓	—
Rideout Memorial Hospital	California	292	✓	—
Key West Medical Center	Florida	249	✓	—
Val Verde Regional Medical Center	Texas	200	✓	—
Banner Churchill Community Hospital	Nevada	180	✓	—
Heartland Regional Medical Center	Missouri	169	✓	—
Southeast Georgia Health System - Brunswick	Georgia	152	✓	—
Munson Medical Center	Michigan	140	✓	—
Bothwell Regional Health Center	Missouri	104	✓	—
White County Medical Center	Arkansas	104	✓	—
Bay Area Hospital	Oregon	101	✓	—

Sole community hospital (SCH)	State	Fiscal Year (FY) 2013 TRICARE admissions	SCH less than 40 miles from a military outpatient clinic(s)	SCH less than 40 miles from a military hospital(s)
12 SCHs that were less than 40 miles from a military hospital or a hospital and an outpatient clinic				
Onslow Memorial Hospital	North Carolina	2,364	✓	✓
Carolina East Medical Center	North Carolina	1,392	✓	✓
Beaufort Memorial Hospital	South Carolina	1,162	✓	✓
Southeast Georgia Health System - Camden	Georgia	683	✓	✓
Carteret County General Hospital	North Carolina	530	✓	✓
Fairbanks Memorial Hospital	Alaska	365	✓	✓
Albemarle Hospital	North Carolina	226	✓	✓
Hi Desert Medical Center	California	190	—	✓
Mat Su Regional Medical Center	Alaska	160	✓	✓
Flagler Hospital	Florida	156	✓	✓
Phelps County Regional Medical Center	Missouri	129	✓	✓
PeaceHealth St. Joseph Medical Center	Washington	117	—	✓

Source: Defense Health Agency. | GAO-15-402

Note: We determined whether an SCH was within 40 miles of a military hospital or clinic by calculating the distance between the central point of the zip codes of the SCH and military treatment facilities.

Appendix III: Comments from the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MAR 2 0 2015

Ms. Debra Draper
Director, Health Care
U.S. Government Accountability Office
441 G Street, N.W.
Washington, DC 20548

Dear Ms. Draper:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) Draft Report, GAO-15-402, "SOLE COMMUNITY HOSPITALS: Early Indications Show that TRICARE's Revised Reimbursement Rules Have Not Affected Access to Care", dated February 27, 2015, (GAO Code 291242). Thank you for the opportunity to review the Draft Report and for your efforts reviewing this important subject. I agree with the draft report's findings and conclusion.

I am pleased that early indications demonstrate that implementation of the Sole Community Hospital (SCH) reimbursement system created no access to care issues. Rest assured that the DoD will continue to monitor and track access to care at SCHs.

My points of contact are (Functional) Ms. Ann Fazzini and Mr. Gunther Zimmerman. Ms. Fazzini may be reached at (303) 676-3803, or Ann.N.Fazzini.civ@mail.mil. Mr. Zimmerman may be reached at (703) 681-4360, or Gunther.J.Zimmerman.civ@mail.mil.

Sincerely,

Douglas J. Robb, DO, MPH
Lieutenant General, USAF, MC, CFS
Director

Appendix IV: GAO Contact and Staff Acknowledgments

GAO contact

Debra A. Draper, Director, (202) 512-7114 or draperd@gao.gov.

Staff Acknowledgments

In addition to the contact name above, Bonnie Anderson, Assistant Director; Jennie Apter; Jackie Hamilton; Natalie Herzog; Giselle Hicks; Sylvia Diaz Jones; and Eric Wedum made key contributions to this report.