THE ASSISTANT SECRETARY OF DEFENSE

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HEALTH AFFAIRS

SEP 1 2006

The Honorable John W. Warner
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 109-89 that the Secretary of Defense prepare a study on the TRICARE payment rates for obstetrics/gynecology, pediatrics, and mental health services. Specifically, the Secretary was asked to provide a study that compares the TRICARE rates for these services to other federal health programs in at least two TRICARE regions.

The attached report both summarizes the findings of the work and analysis that was done, and also provides sufficient detail for further background and discussion of the TRICARE payment rates for these services compared to the payment rates of other federal health programs. There were some concerns that lower TRICARE rates could cause problems maintaining networks, hence, causing access to care issues. These concerns have been fully explained and resolved through actions taken by the TRICARE Management Activity (TMA) as discussed in this report.

In summary, this in-depth review and analysis concludes with good news that TRICARE rates compare favorably to other federal programs. Specifically, the review found that TRICARE payment rates for Obstetrics/Gynecology, Pediatrics and Mental Health services almost always exceed rates established by Medicaid. Because of the importance of provider access to maternity services, during 2005, the Department thoroughly reviewed the rates for delivery services. There were states in which Medicaid rates were higher than TRICARE. Based on this news, DoD created a special payment waiver in May 2006 that raised the rates for maternity/delivery services to the higher Medicaid level. We will continue to closely monitor rates for all TRICARE services to ensure access for needed healthcare by our beneficiaries. I am certain that current Department of Defense regulation and policy, and the actions taken by TMA completely support adequate access to care within the TRICARE regions.

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

Sincerely,

William Winkenwerder, Jr., MD

Enclosure:
As stated

cc:
The Honorable Carl Levin
Ranking Member

Report to Congress

TRICARE's Payment Rates for OB/GYN, Pediatrics and Mental Health Services

REPORT ON TRICARE'S PAYMENT RATES FOR OB/GYN, PEDIATRICS,

AND MENTAL HEALTH SERVICES

Prepared in response to House Report 109-89

INTRODUCTION

In recent years, there have been concerns about potential problems that TRICARE beneficiaries may have in getting access to professional providers. These concerns have centered on two problems:

- First, are there a sufficient number of network providers in areas where TRICARE Prime is offered? If not, what are the reasons that providers are unwilling to join the network? Is the problem the level of physician reimbursement? What could be done to increase the number of network physicians?
- Second, in areas where beneficiaries do not have access to network providers, are there a sufficient number of professional providers willing to see TRICARE Standard beneficiaries? Is the level of physician reimbursement a problem?

The Department's interest in these two issues stems from its interest in ensuring that TRICARE beneficiaries have access to high quality health care. To ensure high quality health care, the Department believes that having a beneficiary enrolled in a managed care network with a primary care physician (often referred to as a Primary Care Manager, or PCM) will increase continuity of care and will contribute to the quality of care; consequently, the Department wants to have its beneficiaries enrolled in managed care networks where this enrollment is feasible and when beneficiaries find it desirable. If TRICARE beneficiaries decide to enroll in TRICARE Prime, the Department wants to ensure that they can get timely appointments with primary care physicians and that they get any required specialty care in a timely manner. The Department also wants to ensure that enrolled beneficiaries do not have to travel long distances to see their primary care physicians or for specialty referrals.

Recognizing that not all TRICARE beneficiaries want to enroll in TRICARE Prime and that it is not feasible to establish managed care networks which meet the Department's access standards (distance and timeliness standards for a full complement of primary care and specialty providers) in some areas, the Department has a second goal: to ensure that its beneficiaries who do not enroll in available managed care networks or who live in areas where managed care networks are not available have the ability to see physicians who will not charge them exorbitant amounts for their care. By law, the Department has set limits on the amounts that physicians can bill beneficiaries: physicians are allowed to charge up to 115 percent of the TRICARE payment limit, which is commonly referred to as the CMAC, or CHAMPUS Maximum Allowable Charge. However, the Department is concerned that some physicians will not allow beneficiaries to make appointments because they believe that 115 percent of the CMAC amount is insufficient payment or because they are concerned about slow claims payments. In these cases, beneficiaries must travel long distances to find a provider who will accept TRICARE patients , and for providers who do not accept the CMAC, the patient must pay the physician's entire bill out of pocket and file a claim for reimbursement. This is a particular concern in areas where beneficiaries do not have access to a military treatment facility (MTF) or where a managed care network is not available.

In recent years there have been increasing concerns about whether the TRICARE physician payment rates are adequate to attract physicians to join TRICARE networks or to see TRICARE Standard patients. These concerns have been prompted by decreases in CMAC rates for some services. Even though the number of TRICARE beneficiaries who have enrolled in TRICARE Prime (with its low copayments for physician visits) is at an all-time high and the level of balance billing for TRICARE Standard patients is at an all-time low, the Department continues to monitor potential access problems. The Department monitors potential access problems and has developed mechanisms to increase physician payment rates when it is necessary.

The Congress has also been concerned about whether TRICARE's physician payment rates are adequate. House Report 109-89 to the National Defense Authorization Act for FY06 states that the Armed Services Committees of the House and Senate are

> "concerned that the CHAMPUS Maximum Allowable Charge (CMAC) for obstetrics, gynecology, pediatrics and mental health remain fair and equitable. CMAC rates are based upon Medicare rates; however, Medicare does not have a robust experience particularly in the areas of pediatrics and obstetrics or in traumatic stress related mental health. While there is a process to address differences in experience between TRICARE and Medicare, there is growing concern that the reimbursement rates need to be reviewed. The committee is concerned that if significant inequity exists, access to these services may decrease. In particular, children's hospitals provide services to military children with the most complex illnesses and treatment needs and availability of adult and family oriented mental health services are critical to the success of the Department of Defense post-deployment support programs. Therefore, the committee directs the Secretary of Defense to conduct a study that compares the CMAC rates for obstetrics, gynecology, pediatrics and mental health to other federal health programs in at least two TRICARE regions. The committee directs the Secretary to submit this report by March 31, 2006, to the Senate Committee on Armed Services and the House Committee on Armed Services."

TRICARE PROFESSIONAL PROVIDER REIMBURSEMENT AND ACCESS TO PROFESSIONAL SERVICES

Background

By law, TRICARE's reimbursement of professional providers is based upon the methodology used by Medicare. The relationship of DoD payment levels to Medicare's for professional health care services is central to the ongoing success of TRICARE because payment levels have significant effects on DoD's ability to implement managed care programs, to assure beneficiary access to the full spectrum of health services, and to do these things cost-effectively.

It is appropriate that Medicare serve as the model for establishment of payment rates for TRICARE because 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 adapt 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. To a practicable extent, DoD was directed to pay hospitals using the same reimbursement rules that applied 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 (now called the Government Accountability 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 in 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 the linkage to Medicare payment amounts.

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 DoD's beneficiaries, and enabled aggressive implementation of the CHAMPUS Diagnosis Related Group (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 were gradually brought into harmony with Medicare's rates over several years, and special provisions were built into the process to stop reducing payments if access 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.

The amounts paid for health care services in TRICARE are governed by either the payment rules described below 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.

How CMAC Rates Are Set

The maximum amount that will be paid to a physician in a given location for a given Current Procedural Terminology (CPT) code is referred to as the CMAC. The CMAC is established in two broad steps. First, a national CMAC is established for a CPT code. This CMAC is almost always equal to the Medicare national fee schedule amount for that CPT code. 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 to 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. Updates in the Medicare fees since 1997 have meant that most of these codes are set to the current Medicare fee as the higher price, but there are still some codes where the 1997 Medicare fee was higher than its current one, and that 1997 rate is the CMAC.[1, 2]

In a second step, the national CMAC is then adjusted to a local level. After the "national" CMAC level has been determined, it is adjusted to one of the 89 TRICARE geographic localities to represent local cost factors in relationship to national averages. The TRICARE localities are defined with the same geographic boundaries as the Medicare localities.[3] For physician services, a national CMAC is adjusted through use of the Medicare geographic practice cost indices (GPCIs) and the Medicare Relative Value Units (RVUs), in the same way that Medicare does. For physician services, there are three different GPCIs: one GPCI for the cost of physician "work", one for practice expenses, and one for malpractice insurance. These three GPCIs correspond to the three different RVU components set by Centers for Medicare and Medicaid Services (CMS) for each CPT code which are summed to obtain the total RVUs for a CPT code. For each CPT code, a geographic adjustor to the national CMAC is created by multiplying each GPCI by the proportion of RVUs its corresponding component represents out of the total RVUs.[4] Local CMACs are then created for each locality and each CPT code by multiplying the national CMACs by these CPT- and locality-specific

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1 Maternity CPT codes set at the 1997 Medicare fee level because it was higher than the current one are: 59012, 59020-59051, 59120, 59135, 59140, 59320-59350, 59409-59414, 59514, 59515, 59612, 59614, 59620, 59622, 59812, 59840, 59850, 59851, and 59855-59866.

2 As discussed below, in order to ensure adequate access to maternity/delivery services for TRICARE beneficiaries, in May 2006 the Department increased the maternity/delivery CMACs in 11 states so that the CMACs would be equal to the Medicaid payment rates in these states.

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

4 The arithmetic formula for this (where TRVU = total RVUs, WRVU= work RVUs, PERVU= practice expense RVU, MRVU = malpractice RVU, WGPCI = work GPCI, etc.) would be: geographic ADJUSTOR = [WGPCI x (WRVU/TRVU)] + [PEGPCI x (PERVU/TRVU)] + [MGPCI x (MRVU/TRVU)] Just like Medicare, this is done separately for codes which have both a facility and nonfacility rate, as the proportion of RVUs for overhead varies between the two rates.

geographic adjustors. The result is that the TRICARE CMAC for a CPT code in a location is almost always equal to the Medicare payment level for that code in that locality.

GAO's 1998 Review of CMAC Methodology

The Congress has had concerns about the adequacy of TRICARE's physician payment rates and requested that the GAO study how they were established and whether they were appropriately set. In February 1998, the GAO 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, the GAO reviewed the establishment of CMACs and contracted with actuaries to evaluate the methodology's compliance with statutory requirements; compared Medicare and CMAC rates; interviewed physicians and beneficiary advocacy groups in four locations; and interviewed TRICARE administrators and staff from TRICARE contractors.

The 1998 GAO study found that the CMAC methodology was sound, and that DoD was saving about $770 million annually as a result of CMACs. The GAO also found that:

- CMAC rates were generally consistent with Medicare's rates.
- Physician concerns focused on network discounts off 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.

The GAO suggested that DoD do a better job informing physicians about payment rates, and informing beneficiaries about balance billing limitations. As a result, TRICARE payment rates are now available on the Internet, and the Explanation of Benefits for each claim describes the applicable balance billing limit. Revisions to TRICARE's claims payment timeliness requirements have addressed many concerns about slow payments.

GAO's 2001 Review of Whether CMACs Should Be Increased

In response to further concerns about TRICARE's payment rates, the Congress asked the GAO to study whether increases in professional payment rates would be beneficial. In 2001, the GAO submitted a report which analyzed the utility of increasing TRICARE reimbursement rates. The GAO report concluded that,

> "Changing the TRICARE reimbursement rate nationally to the 70th percentile of billed charges would be costly, inflationary, and largely unnecessary. . . Moreover, an across-the-board increase is unnecessary at this time because the vast majority of military beneficiaries are obtaining the care they need through military physicians and civilian physicians who accept TRICARE's reimbursement rates."[5]

However, the GAO report noted that access is impaired in some remote and rural areas. The GAO looked closely at Alaska where reimbursement rates had been increased sharply by 28 percent by the Department. The GAO found that this large increase in reimbursement rates in Alaska was not effective. Specifically, the GAO concluded that:

> "Although DoD's across-the-board rate increase in one locality has not improved access to care, pressure remains for further increases. However, DoD must be judicious about using such rate increases because they will be costly. Problems with access to care are infrequent and primarily related to specialty care, yet across-the-board increases would raise rates for all types of physicians. Rate increases, targeted to localities where access to care is severely impaired, may improve access to care, but other problems such as the scarcity of physicians and transportation difficulties are likely to remain. Responding to physician demands to pay based on billed charges–a practice DoD abandoned in 1992 when its health care costs were spiraling upward–would not only increase current program costs but also has the potential to further inflate government outlays, as physicians would likely raise rates over time, pushing TRICARE rates higher."

CMAC Locality Waivers

In order to allow the Department to address TRICARE payment rate issues in localities where access was a problem, Congress gave the Department the ability to adjust CMACs in certain circumstances. Section 716 of the National Defense Authorization Act for FY 2000 extended new flexibility to the Secretary of Defense to increase TRICARE reimbursement rates

if necessary to ensure the availability of an adequate number of qualified providers in the preferred provider network. Section 757 of the Strom Thurmond National Defense Authorization Act for FY 2001 extended new flexibility to the Secretary of Defense to increase TRICARE reimbursement rates in areas where access to health care services is severely impaired. Section 757 also gave the Department guidance on determining whether access was severely impaired. This included consideration of "the number of providers in a locality who provide the 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."

The Department published a regulation in September 2001 implementing Section 716 and Section 757 authority. The regulation allows two types of waivers. First, it allows locality waivers. Under this type of waiver, the Department can apply higher rates to all similar services in a locality (e.g., all maternity rates) or to define a new locality for application of the higher payment rates (e.g., higher payment rates in a county). The regulation allows higher CMAC prices to be based on a variety of flexible methods to address access problems (e.g., local prevailing charges, other government rates, etc.). Most waiver requests have been quite narrow and have been targeted to apply only to services where access is severely impaired; this ensures that the Department does not pay higher rates to providers for services without severe access impairments. For example, some waivers have affected a limited range of CPT codes for only one particular specialty in one zip code.

The second type of waiver allows the Department to increase payment rates for network providers. For these CMAC waivers, the CMAC can be increased up to 15 percent over the standard CMAC level for network providers only. These waivers typically allow the Managed

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[5] U.S. GAO, "Defense Health Care: Across-the-Board Physician Rate Increase Would be Costly and Unnecessary" (GAO-01-620, May 24, 2001.)

Care Support Contractor to pay network providers in certain specialties more than the CMAC rate; this allows some providers to join the network or to remain in the network.

As of mid-2006, the Department has approved 12 of these locality-specific CMAC waivers; about one-half were for network providers only, and the remainder for all providers of the specific services in shortage.

CMAC Waivers for Maternity/Delivery Services

In response to provider complaints and Congressional hearings in the Fall of 2005, the Department conducted a thorough analysis comparing the TRICARE CMACs for maternity services to Medicaid rates for such services in each state. Adequate access to maternity services is of great importance to TRICARE given the demographics of the TRICARE beneficiary population, and proper prenatal and maternity care is critical for high-quality health care and outcomes. Such services are also of importance to state Medicaid programs because of their beneficiaries' characteristics. Physicians who are board-certified in obstetrics are in short supply in some geographic areas and this specialty has high malpractice insurance rates. These high practice costs combined with specialty shortages lead to providers who can often be selective in their patient practice or insurance participation, as they already have practices with little excess capacity.

Although Medicaid programs are often the lowest payer in any geographic area due to budgetary issues, and often extremely low in relation to Medicare, many states have established much higher Medicaid payment rates for maternity/delivery services in order to maintain proper access and help improve birth outcomes. In these states, the Medicaid maternity/delivery rates can sometimes be higher than the rates calculated from the Medicare formula. As a consequence, the Medicaid rates can exceed the TRICARE CMACs (which are largely based on the Medicare rates).

The Department's research found that in March 2006 there were approximately 11 states in which the Medicaid rates for delivery services were higher than the TRICARE rates. [6] Based on this study, DoD created a special CMAC waiver in May 2006 that raised the CMACs for maternity/delivery CPT codes to the Medicaid level in any state in which the payment rates were below Medicaid, in order to maintain reasonable access to such services. Each year, the TRICARE Management Activity (TMA) will compare the Medicaid maternity/delivery rates with the TRICARE CMACs and ensure that the CMACs are equal to or exceed the Medicaid maternity/delivery payment rates.

COMPARISON OF CMACS TO PAYMENTS IN OTHER FEDERAL HEALTH PROGRAMS

The adequacy of TRICARE's payments to physicians is an important concern because of its effect on access. There are anecdotal concerns that the TRICARE CMACs do not adequately reimburse physicians, causing an unwillingness among some physicians to accept TRICARE patients. House Report 109-89 requested that the Department compare the CMAC rates for certain services (pediatrics, mental health, and obstetrics/gynecology) to the rates paid by other federal health programs. The major federal health programs (other than TRICARE) are Medicare, the Department of Veterans Affairs (VA), and Medicaid (Medicaid is a federal-state program). As discussed above, the Medicare and TRICARE payment rates are equal for over 99 percent of the CPT codes. The VA also uses the Medicare rates if patients receive care outside VA facilities.[7] As a consequence, the TRICARE and VA rates for physician services are also equivalent.

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[6] Kennell and Associates, "Analysis of TRICARE Payment Rates for Maternity/Delivery Services, Evaluation and Management Services, and Pediatric Immunizations," March 30, 2006.

[7] The Alaska VA fee schedule has higher fees than Medicare for many codes. This special fee schedule was the result of a provision in PL 106-117 (Veterans Millennium Health Care and Benefits Act) of November 1999 which mandated a special report on non-VA physician fees in Alaska. There

There are significant differences between the TRICARE CMACs and Medicaid physician payment rates. The similarities and differences between these rates are discussed below by type of service.

Comparison with Medicaid Payment Rates

House Report 109-89 requested a comparison of payment rates for obstetrics, gynecology, pediatrics, and mental health services. We compared the payment rates between Medicaid and TRICARE by examining the payment rates for specific CPT codes.[8] To make the comparison manageable we selected a number of CPT codes for each type of care. Specifically, we identified 14 maternity/delivery services, 5 mental health codes, and 14 pediatric codes for this comparison. These 33 CPT codes account for a very large share of TRICARE expenditures for maternity/delivery services, mental health services, and pediatric services (as discussed below). They are also the codes with the highest number of TRICARE purchased care services for these types of care:

- Included in the 14 maternity/delivery codes are the 6 codes that are used for deliveries (CPT 59400, 59409, and 59410 are for vaginal deliveries; CPT 59510, 59514, and 59515 are for caesarean section deliveries). These 6 codes account for almost 90 percent of all TRICARE civilian maternity/delivery expenditures.
- The mental health service codes represent the five CPT codes with the highest number of purchased care services. They represent a psychiatric diagnostic interview (CPT 90801), individual psychotherapy (CPT 90806 and 90807), family therapy (CPT 90847) and pharmacological management (CPT 90862). These five codes account for 90 percent of all TRICARE professional mental health services.

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is no special VA fee schedule in any other state, although individual VA Medical Centers may negotiate contracts for non-VA care at the local level.

[8] This allows an "apples-to-apples" comparison and ensures that the different mix of services used by different populations does not cloud the results.

- The 14 pediatric codes represent the highest-volume CPT codes for professional services provided by pediatricians. They include a mix of office visits, inpatient visits, and preventive services, and immunizations. These 14 codes account for approximately two-thirds of the professional services performed by pediatricians in TRICARE.

For each of these 33 codes we obtained data from each state's Medicaid program. We were able to obtain data on the Medicaid rates being used to pay providers in March and April 2006 for 47 of the 50 states. Tennessee and Delaware do not have fee-for-service Medicaid programs, and we were unable to obtain Medicaid payment rate data from Rhode Island or the District of Columbia. We also obtained data on the CMAC for each of these 33 codes in each state.[9]

Comparisons for Maternity/Delivery Services

As discussed above, we examined 14 maternity/delivery codes. For purposes of comparing Medicaid rates with the CMACs, this report focuses on CPT 59400, the "global" vaginal delivery code which covers prenatal visits, the delivery, and postpartum visits. About 60 percent of all TRICARE deliveries in the civilian sector are paid under this code. In the 10 states in which the Medicaid program does not pay for CPT 59400, we examined CPT 59409 (the code for a vaginal delivery only). Two other states do not pay for CPT 59400 or 59409, but do pay for CPT 59410 (the code for the vaginal delivery and postpartum visits). In these two cases we examined CPT 59410.

We found that 11 of the 47 states for which we were able to obtain data in March and April 2006 had Medicaid rates for deliveries that were higher than the TRICARE rates. As of

[9] In comparing the state Medicaid rates to the TRICARE CMAC we selected the lowest CMAC in any state that had more than one payment locality (most states have one payment locality; there are 89 TRICARE payment localities in the U.S.). We also used the Medicaid rate and the TRICARE CMAC for a physician-office visit (TRICARE and most Medicaid programs pay lower rates to physicians who work in a facility).

May 1, 2006, the TRICARE CMACs for maternity/delivery services were increased in the 11 states in which the Medicaid rates had been higher for these services.[10] As a result, as of May 1, 2006, the TRICARE CMACs for maternity/delivery services are equal to or greater than the Medicaid rates in all states.

In general, we found that the TRICARE CMACs for maternity/delivery services are significantly higher than the Medicaid rates in most states. As of May 1, 2006, for 12 states, the TRICARE CMAC is equal to the Medicaid rate. In 35 of the 47 states, the TRICARE CMAC exceeds the level of Medicaid reimbursement. Furthermore, in 28 of the 47 states, the TRICARE CMAC exceeds the Medicaid payment rate by 10 percent or more. [11] In 18 states, the TRICARE CMAC is 25 percent or more higher than the Medicaid rate.

Table 1

Ratio of the Medicaid Rate to the TRICARE CMAC for Deliveries, May 2006

Ratio	# of States
1.0	12
0.90 – 0.99	7
0.80 – 0.89	10
0.70 – 0.79	11
<0.70	7
No Information	4
	51

Note: Values in this table based upon CPT 59400, 59409, or 59410. A ratio less than 1.0 indicates that the CMAC is higher than the Medicaid payment rate.

We also found that the ratio of the Medicaid payment rate to the CMAC for CPT 59400 is a very good predictor of the ratio for the other five delivery CPT codes and for most of the other maternity/delivery services we examined. For example, in Arizona, the Medicaid payment rate and the TRICARE CMACs are equal for all 14 of the maternity delivery codes we examined.

[10] In one state the Medicaid payment rate and the TRICARE CMAC were equal.

Other states also have similar Medicaid/CMAC ratios for the 14 maternity delivery codes.[12] Thus, we believe that the conclusions reached using CPT 59400 apply generally to all maternity/delivery services.

We also compared Medicaid payment rates and the TRICARE CMACs for the three most common gynecology codes. We found that the TRICARE CMACs exceed the Medicaid payment rates for gynecology services in all but a few states (Alaska, Wyoming, and Maryland).

Comparisons for Mental Health Services

To compare the TRICARE mental health CMACs with Medicaid payment rates we focused on the most common mental health code, CPT 90806, which is defined by the American Medical Association (AMA) as individual psychotherapy in an outpatient or office setting for 45 to 50 minutes face-to-face with the patient. This one code accounts for 50 percent of all TRICARE mental health visits. The services in CPT 90806 are performed by psychiatrists, psychologists, and other mental health professionals. We also examined two other services done commonly by all three types of mental health professionals and which together account for about one-quarter of all TRICARE mental health visits: CPT 90801 (psychiatric diagnostic interview) and CPT 90847 (family psychotherapy).

We found that the Medicaid mental health payment rates are lower than the TRICARE CMACs in all but a handful of states (see Table 2). For CPT 90806, which is the most common TRICARE mental health code, the Medicaid rates are higher than the TRICARE rates in only two states: Alaska and Arkansas (the Medicaid rate is 8 percent higher in Alaska and 4 percent higher in Arkansas). We also found that the Medicaid payment rates and the CMACs for CPT 90806 are equal in three other states: Oklahoma, Arizona, and Wyoming. The TRICARE CMACs are more than 10 percent higher than the Medicaid rates in 34 of the 43 states for which

[11] Details for each state can be found in Kennell and Associates, "Analysis of TRICARE Payment Rates for Maternity/Delivery, Mental Health, and Pediatric Services", May 17, 2006.

we were able to obtain data on CPT 90806. [13] In 27 states, the CMAC is 25 percent or more higher than the Medicaid payment rate.

Because of concerns about access of TRICARE beneficiaries to psychiatrists, we also compared the CMAC and Medicaid payment rates for two codes that are done more commonly by psychiatrists and other physicians and less commonly by psychologists and other mental health professionals. These codes are CPT 90807 and CPT 90862; together, these two CPT codes account for almost 20 percent of TRICARE's mental health visits. CPT 90807 is identical to CPT 90806 except that it also includes medical evaluation and management services (which includes drug management). CPT 90862 is for pharmacological management, including prescription drugs, with no more than minimal medical psychotherapy. Some states pay relatively higher rates in their Medicaid programs for CPT 90807. We found that the Medicaid rates exceed the CMAC for CPT 90807 in four states (Alaska, Arkansas, Nebraska, and Minnesota) and are equal in three others (Oklahoma, Arizona, and Wyoming).[14] However, as we found for CPT 90806, the TRICARE CMACs are more than 10 percent higher than the Medicaid rates for this code in all but 12 of the 43 states for which we were able to obtain comparisons. In 26 states, the CMAC is 25 percent or more higher than the state's Medicaid payment rate for this code.

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[12] For example, in New Mexico, the ratio of the Medicaid payment to the CMAC for CPT 59400 is 0.81. For the other 5 delivery codes, the ratios range from 0.76 to 0.86. For the other 8 maternity/delivery codes we examined, the ratios range from 0.67 to 0.87.

[13] Some state Medicaid programs do not establish a payment rate for CPT 90806.

[14] In these four states the Medicaid rates exceed the CMAC by 8-16 percent.

Table 2

Ratio of the Medicaid Rate to the TRICARE CMAC For Psychotherapy, May 2006

Ratio	Number of States	
	CPT 90806	CPT 90807
>1.0	2	4
0.90 – 1.0	8	8
0.80 – 0.89	7	5
0.70 – 0.79	6	9
<0.70	21	17
No information	7	8
	51	51

Note: CPT 90806 and 90807 are the most common psychotherapy codes in TRICARE. CPT 90807 is used commonly by psychiatrists; CPT 90806 is used by psychiatrists and other mental health professionals. A ratio below 1.0 indicates that the TRICARE CMAC is higher than the Medicaid payment rate.

We found that the ratio of the Medicaid payments to the CMAC in a given state was fairly similar for all five of the mental health CPT codes examined in this report. For example, in South Carolina, the ratio of the Medicaid payment to the CMAC was 0.80 for all five codes, while in North Carolina it was 0.95 for all five codes, and in North Dakota it was 0.90 for all five codes.

Comparisons for Pediatric Services

The most common code billed by pediatricians is CPT 99213, which is defined by the AMA as a mid-level office visit for an established patient. We examined this code and 13 other high-volume professional services codes used by pediatricians to compare the level of payments between Medicaid and TRICARE.

We found that in 42 of the 47 states for which we obtained Medicaid data, the CMACs are higher than the Medicaid rates for CPT 99213 (see Table 3). We found that the five states

in which the Medicaid rates are equal to or exceed the TRICARE CMAC for CPT 99213 have Medicaid rates that are at most 8 percent higher than the CMAC.[15] In 38 of the 47 states for which we were able to obtain data, the TRICARE CMAC exceeds the Medicaid rate by 10 percent or more for CPT 99213. Furthermore, in 30 states, the CMAC is 25 percent or more higher than the Medicaid payment rate.

Table 3

Ratio of the Medicaid Rate to the TRICARE CMAC for Evaluation and Management Services (CPT 99213), May 2006

Ratio	# of States
≥1.0	5
0.90 – 0.99	4
0.80 – 0.89	8
0.70 – 0.79	10
<0.70	20
No Information	4
	51

Note: A ratio below 1.0 indicates that the TRICARE CMAC is higher than the Medicaid payment rate.

Table 3 focuses on one code: CPT 99213, the most common visit code used by pediatricians. We found that in a given state the ratio of the Medicaid payment rate to the CMAC was quite similar for the 14 pediatric codes we examined. For example, in Oregon, the ratio of the Medicaid payment rate to the CMAC was equal to 0.72 for CPT 99213. The ratios for all the other 13 codes ranged from 0.71 – 0.78, a very tight distribution. Similarly, in South Carolina, the ratios of the Medicaid payment to the CMAC varied between 0.73 and 0.80 (with a

[15] We also found that these five states also have high Medicaid rates for maternity/delivery care (Alaska, Oklahoma, Wyoming, Connecticut and Arizona) and for mental health care (Oklahoma, Alaska, Arizona, and Wyoming have Medicaid rates that are equal to or higher than the TRICARE CMACs).

ratio of 0.80 for CPT 99213). Thus, we believe that the findings for CPT 99213 are indicative of the findings for the other key pediatric codes.

Payment for Pediatric Vaccines/Immunizations

Some pediatricians have been concerned about TRICARE's payment level for a few pediatric immunizations. TRICARE reimburses providers for pediatric vaccines differently than it reimburses providers for professional services. Reimbursement for the vaccine itself (as billed under CPT codes 90476-90749) is payment for a manufactured product, rather than a professional service, and the payment for these codes is only for the vaccine itself. Professional services related to administering the vaccine are usually included in the payment for the other services performed during the visit.[16] Separate payment for vaccine administration alone is allowed under some circumstances, and this code is one of the five highest-volume CPT codes for which TRICARE reimburses pediatricians. The current 2006 CMAC rate for CPT code 90471 (one immunization administration) is $18.57, which is higher than any state's Medicaid program.

Even though TRICARE pays more than any Medicaid program for vaccine administration, some pediatricians are concerned about how much they are paid for the vaccine itself. TRICARE payments for pediatric vaccines cannot be compared to Medicaid payments because pediatric vaccines are typically supplied free-of-charge to pediatricians by states and/or the Centers for Disease Control and Prevention's (CDC's) Vaccines for Children (VFC) program. The VFC program provides free vaccines to enrolled public and private providers for recommended immunizations for children who are Medicaid-eligible, uninsured, on Medicaid, American Indian/Alaska Native, or underinsured by having insurance which does not cover routine immunizations. When a pediatrician receives VFC products free, he or she is usually paid an administration fee by most Medicaid programs which generally ranges between $3 and

[16] Such as the services included in payment for CPT 99213, the most common routine office visit code.

$10, with most states paying between $4-$6 for CPT code 90471 (TRICARE's CMAC is $18.57).

TRICARE's payment amounts for vaccines have changed in recent years. In April 2003, TRICARE adopted the Medicare rates for injectable drugs/biologicals and vaccines, which were set at 95 percent of the Average Wholesale Price or AWP.[17] In January 2005, Medicare moved to setting allowed amounts at 106 percent of the ASP (average sales price) for injectable drugs. The change to reimbursement under the ASP system was mandated by the 2003 Medicare Modernization Act. To calculate the ASP, Medicare receives data from the manufacturer regarding all sales of that drug in the United States over some time period. Prices for most vaccines and injectable drugs are set at 106 percent of the ASP, although by law, the three vaccines covered routinely for Medicare patients (pneumonia, influenza, and hepatitis B for patients at special risk) under Part B are still priced at 95 percent of the AWP. Other vaccines listed in the Medicare injectable drug pricing files have prices at 106 percent of ASP.[18] Medicare can adjust a particular ASP if they find that it is higher than the widely available market price for a drug. These rates are national and are not adjusted by locality, as manufacturers' list prices are national, suppliers sell nationally, and local factors do not appreciably affect cost. For codes that are not listed in the Medicare pricing files, the TRICARE contractors are instructed to pay based on 95 percent of AWP.

In March 2006 the Department compared the estimated private sector costs, AWP, and ASP pricing levels for the top volume vaccine codes. This study found that pediatric vaccines and injectable drugs generally appear to have reasonable CMAC reimbursement rates when

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[17] The AWP is essentially a "list price" given by the manufacturer, and there have been several studies showing that AWP lends itself to manipulation by manufacturers, as well as considerable overpayments by Medicare in comparison to what it actually costs healthcare providers to obtain injectable drugs.

[18] By law, Medicare only routinely covers the three types of vaccine mentioned (hep B, pneumonia and flu) for preventive reasons, although they would cover a specific vaccine required due to a medical event or condition, such as rabies vaccine. Medicare still lists prices in its files for most vaccines, including pediatric vaccines, even though they do not cover them, as they receive the data from manufacturers and can calculate an ASP.

derived from Medicare pricing.[19] However, it did appear that CPT code 90633, pediatric hepatitis A vaccine, was likely a case where the Medicare ASP pricing was low in comparison to reasonable costs to obtain the drug. As a result, TRICARE changed its pricing method to 95 percent of AWP in May 2006 for code 90633.

Summary

The TRICARE CMACs are equal to or exceed the Medicaid payment rates for maternity/delivery, mental health, and pediatric services in almost all states as of May 1, 2006. The CMACs exceed the level of Medicaid payments for the key maternity/delivery, mental health, and pediatric service codes in all the eight states that have the highest level of TRICARE payments for professional services (these eight states account for 50 percent of all TRICARE civilian professional service payments). In fact, Table 4 indicates that in many of these states, the CMACs are 50 percent or more higher than the Medicaid payment rates. On the other hand, there are five states that have higher Medicaid payment rates for mental health and pediatric services (Alaska, Arizona, Connecticut, Oklahoma, and Wyoming). For almost all the other states, the TRICARE CMACs for these services are higher than the Medicaid payment rates.

[19] Kennell and Associates, "Analysis of TRICARE Payment Rates for Maternity/Delivery Services, Evaluation and Management Services, and Pediatric Immunizations," March 30, 2006.

Table 4

Ratio of TRICARE CMACs to Medicaid Payment Rates in the Eight States with the Highest Level of TRICARE Professional Payments, May 2006

State	Ratio by Type of Service		
	Maternity/Delivery	Mental Health	Pediatric
Arizona	100%	100%	100%
California	150%	217%	227%
Florida	130%	189%	192%
Georgia	120%	NA	120%
North Carolina	105%	105%	105%
South Carolina	100%	125%	125%
Virginia	101%	145%	135%
Texas	149%	149%	167%

Note: These 8 states had the highest level of TRICARE professional expenditures in FY05. They account for 50 percent of all civilian professional expenditures. Maternity/delivery service ratios are based on CPT 59400; mental health on CPT 90806; pediatric codes on CPT 99213. A percentage above 100% indicates that TRICARE pays more than Medicaid in that state.

CONCLUSION

In recent years there have been increasing concerns about whether the TRICARE physician payment rates are adequate to attract physicians to join TRICARE networks or to see TRICARE Standard patients. Even though the number of TRICARE beneficiaries who have enrolled in TRICARE Prime (with its low copayments for physician visits) is at an all-time high and even though the level of balance billing for TRICARE Standard patients is at an all-time low, the Department continues to monitor potential access problems.

This study found that the TRICARE CMACs are equal to or exceed the Medicaid payment rates for maternity/delivery, mental health, and pediatric services in almost all states as of May 1, 2006. There are five states that have slightly higher Medicaid payment rates for some mental health and pediatric services. Because the Medicaid rates are only slightly higher than the CMACs and because the Department is not aware of access problems in these states, the Department does not believe that the CMACs need to be increased at this time. For all the other states, the TRICARE CMACs for these services are higher than the Medicaid payment

rates. The study found that in the eight states with the highest levels of TRICARE civilian professional expenditures, the CMACs equal or exceed the Medicaid payment rate for all three types of services.

The Department will continue to monitor the level of the CMACs in relation to the payment rates used by other Federal payers. When payment problems are causing access problems, one of the key tools the Department will use is the waiver authority granted by the Congress in Section 757 of FY 2001 Defense Authorization Act. The Final Rule published in September 2001 by the Department allows the Department to increase CMACs when it is necessary to prevent severe impairments to access. The Department has used this authority 12 times in recent years and will use it when necessary in the future. For example, the Department's research found that in March 2006 there were approximately 11 states in which the Medicaid rates for maternity/delivery services were higher than the TRICARE rates. Based on this finding, DoD created a special CMAC waiver in May 2006 that raised the CMACs for maternity/delivery CPT codes to the Medicaid level in any state in which the payment rates were below Medicaid, in order to maintain reasonable access to such services. Each year, TMA will compare the Medicaid maternity/delivery rates with the TRICARE CMACs and ensure that the CMACs are equal to or exceed the Medicaid maternity/delivery payment rates.

The Department will continue to use its CMAC waiver authority when appropriate. However, as the GAO's 2001 report noted, ". . . DoD must be judicious about using such rate increases because they will be costly. Problems with access to care are infrequent and primarily related to specialty care, yet across-the-board increases would raise rates for all types of physicians. Rate increases, targeted to localities where access to care is severely impaired, may improve access to care, but other problems such as the scarcity of physicians and transportation difficulties are likely to remain." However, when access problems are related to physician reimbursement, the Department will continue to use the CMAC waiver authority.