UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

NOV 13 2023

The Honorable Mike D. Rogers
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The Department's response to House Report 117–397, pages 207-208, accompanying H.R. 7900, the National Defense Authorization Act for Fiscal Year 2023, "TRICARE Dialysis Reimbursement," is enclosed.

Outpatient dialysis services need to be provided on a regularly scheduled basis to maintain the life of a person with End Stage Renal Disease (ESRD). ESRD patients become eligible for Medicare coverage after 120 days of dialysis treatment, regardless of age, at which point the Centers for Medicare and Medicaid Services (CMS) often becomes the primary payer of these services. This report shows how reimbursement rates differ between the Department of Defense, and the Department of Veterans Affairs, the Federal Employees Health Benefits Program, CMS, and leading insurance companies as primary payers for dialysis. Also included is a discussion of how TRICARE dialysis reimbursement rates have changed pursuant to recently published regulations.

Thank you for your continued strong support for the health and well-being of our Service members, veterans, and their families.

Sincerely,

[redacted]

Ashish S. Vazirani
Acting

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

Report to the Committee on Armed Services of the House of Representatives

TRICARE Dialysis Reimbursement

November 2023

Preparation of this study/report cost the Department of Defense a total of approximately $3,300.00 for the 2023 Fiscal Year. This includes $3,300.00 in DoD labor.
Generated On: Sept 1, 2023 RefID: 7-F16221C

Introduction

This report is in response to the House Report 117–379, pages 207-208, accompanying H.R. 7900, the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2023, which requests a report to the Committee on Armed Services of the House of Representatives on the state of dialysis reimbursement rates under TRICARE in comparison to other Federal program payers.

Background

Dialysis services are TRICARE covered services available to treat beneficiaries with End Stage Renal Disease (ESRD). ESRD is diagnosed when kidney failure is deemed permanent and will require a regular course of dialysis or a kidney transplant for the remainder of the patient's life. An estimated 786,000 Americans are currently living with ESRD.[1] Dialysis removes waste products and excess accumulated water, and balances certain electrolytes in the blood of a person whose kidneys are not functioning properly. Hemodialysis, sometimes referred to as simply "dialysis," is the mode of treatment for the large majority of ESRD patients. Blood is continuously cycled out of the body and through the dialysis circuit before returning to the patient's bloodstream via the same method of access. This treatment generally needs to be performed for several hours, three times per week, though individual prescriptions can vary slightly. Dialysis can take place in an inpatient or outpatient medical facility, or in the patient's home with appropriate training and assistance. Some patients also have the option of peritoneal dialysis, in which treatment fluid is held in the abdomen and drained regularly. This care does not require designated time spent at a dialysis facility after appropriate training is completed but is less common.

Since 1972, ESRD has been listed as a qualifying condition for Medicare. After 120 days of dialysis treatment, all TRICARE beneficiaries become eligible for Medicare coverage regardless of age, making TRICARE (or any other health plan) the secondary payer at this point if they choose to sign up for Medicare.

Discussion

Previously, the TRICARE program, under the Department of Defense (DoD), classified freestanding (non-hospital) ESRD facilities as Corporate Services Providers (CSP) and reimbursed using a fee-for-service methodology for covered professional services/supplies only, meaning institutional charges, such as general staff nursing or equipment use, were not paid. An interim final rule was published in the Federal Register (88 FR 1992) and became effective on January 12, 2023, permanently adjusting how the DoD reimburses for dialysis services. That rule is currently in the process of being implemented.

With this rule, no new TRICARE CSP participation agreements are accepted for coverage of ESRD, and all current TRICARE CSP participation agreements from freestanding ESRD facilities terminated. Only ESRD services furnished by hospital-based ESRD facilities and TRICARE authorized freestanding ESRD facilities qualify as TRICARE covered services.

[1] https://www.niddk.nih.gov/health-information/health-statistics/kidney-disease

Perhaps most importantly, freestanding facilities, that are Medicare-certified ESRD facilities, providing outpatient dialysis services may be considered TRICARE-authorized institutional providers allowing their reimbursement for institutional charges rather than individually billable medical services only. Additionally, with this institutional designation, dialysis facilities will be reimbursed by TRICARE in a grouped, all-inclusive method that better reflects Medicare's ESRD Prospective Payment System (PPS) and brings ESRD reimbursement in alignment with the statutory requirements to reimburse like Medicare when practicable. The new TRICARE ESRD reimbursement for freestanding ESRD facilities is effective for all covered services received on or after January 12, 2023. To allow managed care support contractors adequate time to make systems changes, implementation may result in adjustments to claims processed early in Calendar Year 2023. Because this change is awaiting contractor implementation, reference will be made in this report to the prior methodology as the previous system, while the recently adopted methodology will be referred to as the current TRICARE reimbursement of dialysis services.

Centers for Medicare and Medicaid Services (CMS)

The Medicare program under CMS uses their own ESRD PPS. As the most common primary payer for dialysis services, since ESRD confers Medicare eligibility, Medicare has the most developed system for evaluation and adjustment of total rates per treatment, including on both the by-case patient level (age, Body Mass Index, certain comorbidities) and facility level (rurality, number of treatments provided per year, location-specific wage). Medicare may even further adjust payment for pediatric patients, patients with treatment costs exceeding a certain threshold, or in response to a facility's quality assessment results. Updated reimbursement rates and bundle inclusions are set in an annual report from Medicare.

Medicare Advantage plans tend to reimburse slightly more than traditional Medicare, depending on whether a dialysis center is in or out-of-network. Again, the basic Medicare methodology is used, and payments differ after the first 120 days of treatment. During the initial period, in-network providers receive a median amount of $301 per treatment, while out-of-network providers receive $232 for the same services.

Although the new TRICARE methodology does not exactly reflect that of Medicare, the change brings the program in line with other government payers in that rates are a program-appropriate variation of Medicare base rates. TRICARE rates will include fewer individualized adjustments; the small number of beneficiaries for which TRICARE remains the primary payer make it impracticable to adopt Medicare's PPS in full.

Though it is difficult to provide an exact value for reimbursement per treatment, by payer, due to the variety of adjustment variables, all identified government payers refer to base rates set by Medicare. After implementation of the new system for TRICARE dialysis reimbursement, rates will match or slightly exceed those of Medicare.

DoD

The TRICARE Program covers ESRD services, hemodialysis, and other dialysis services and supplies. As stated above, the DoD has adopted a new methodology modeled after Medicare where dialysis is reimbursed at a single, flat, per-session rate which includes facility use, general nursing services, laboratory services, pharmaceuticals not separately billable, and all other supplies. This matches the generally accepted "bundled" form of dialysis payment. Each year, TRICARE is the primary payer for between 500 and 600 eligible patients. Under the previous fee-for-service system, TRICARE pays an average of $119 for professional services and an additional $125 for supplementary drugs, tests, and supplies, for a total of $244 per session. Under the new bundled system, DoD will reimburse dialysis facilities $377 per session for the first 120 days of outpatient dialysis provided to ESRD patients. As reflected in the formula below, this is equal to the Medicare base rate for the same package of supplies and services multiplied by the Medicare age adjustment factor for individuals aged 60-69 years (the age range of the most TRICARE ESRD patients) and further multiplied by the Medicare adjustment factor for the initial onset period where it is presumed treatment will cost the facility more to evaluate, stabilize, and customize treatment to the patient.

(Medicare Base Rate) x (60-69 year age factor) x (initial onset factor) = DoD Rate

($265.57) x (7%) x (32.7%) = $377.08

After the initial 120-day period, if DoD is still the primary payer, facilities will no longer be reimbursed the additional percentage to compensate for costs associated with new patients. The age adjustment will remain. This is consistent with Medicare practices. This puts the continuous DoD base rate at $284.16 per session. While these are Medicare adjustment rates at the time of publication, if Medicare modifies this adjustment factor in subsequent years DoD will utilize the updated factors.

Since Medicare often becomes primary payer after 120 days of dialysis treatment, TRICARE is generally responsible for the beneficiary's cost share of approximately $45 per treatment at this point. Approximately 90 percent of the dialysis treatments billed to DoD annually are as secondary payer.

The NDAA for FY 2023 requires this report include a description of how dialysis reimbursement rates differ between major payers, including the DoD, Department of Veterans Affairs (VA), Federal Employees Health Benefits Program (FEHBP), and Medicare. For these purposes, we will describe the dialysis reimbursement methods of each requested entity and provide a direct comparison of average rates per treatment with the predominant dialysis payer (Medicare).

Outpatient Dialysis Reimbursement to Freestanding Dialysis Facilities in Comparison with Medicare	
Payer	**Average Payment**
DoD Previous	Lower than Medicare
DoD Current	Equal to or exceeding Medicare
VA	Equal – slightly higher than Medicare
FEHBP	Equal – up to 2.5 times that of Medicare
Medicare Advantage	Slightly higher than Medicare
Private	4 times higher than Medicare

VA

The VA currently sets its reimbursement rates for non-VA providers in one of two ways: (1) Regional Community Care Network Contracts (similar to TRICARE's managed care contracts) will reimburse for dialysis at 100 percent of the Medicare level; or (2) National Community Care Network Contracts with two large chains of dialysis providers have negotiated rates. The reimbursement rates in the VA national contracts are reportedly slightly higher than those in regional contracts.

FEHBP

Each FEHBP plan has its own reimbursement policies for ESRD, and it appears the payment rates vary considerably by plan. As a general trend, plans without preferred provider organizations (PPOs) pay more than the Medicare rate, while plans with PPOs will negotiate for a rate closer to equal with Medicare. Some FEHBP-affiliated plans, such as Government Employees Health Associations and SAMBA, will reimburse dialysis and related charges at 200 percent of the set Medicare allowance. The National Association of Letter Carriers claims it provides 250 percent of the Medicare reimbursement rate. The MHBP (formerly the Mail Handlers Benefit Plan) has an allowance that is equal to Medicare's. Others still, such as the Blue Cross Blue Shield Federal Employees Plan use a fee-for-service system of individual billed changes more similar to TRICARE's previous process. It could not be determined how this total compared to Medicare rates.

Private Insurance Companies

Each private payer individually negotiates dialysis payments for ESRD patients during the first 3 to 4 months of treatment, so payments can range greatly. Since the outpatient dialysis market is largely made up of two for-profit organizations, private payers are highly sought after for providing a greater net profit. Private insurers with higher premiums, who are responsible for far fewer patients annually, can pay dialysis facilities an average of $1041 per session. Yet commercial insurance is the primary coverage for only 10.5 percent of dialysis patients. Revenue analysis has shown that when Government reimbursement rates decrease, private rates do as well, and in response so do facility operating costs, leaving total profits relatively unaltered.[2]

[2] Childers, C. P., Dworsky, J. Q., Kominski, G., & Maggard-Gibbons, M. (2019). A Comparison of Payments to a For-profit Dialysis Firm From Government and Commercial Insurers. JAMA internal medicine, 179(8), 1136–1138.

Conclusion

Reimbursement rates for dialysis services under the TRICARE program are comparable to other government payers. Other Government payers such as the VA and FEHBP also base their reimbursement rates on Medicare guidance. After the changes described in the Federal Register, TRICARE reimburses at rates even more closely reflecting Medicare's ESRD PPS and thereby match the industry standard for methodology. In general, private insurance reimbursement for dialysis is higher than Government payers; however, since ESRD patients qualify for Medicare after 120 days of treatment, Government rates are the primary reimbursement received by dialysis companies.