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

PERSONNEL AND
READINESS

NOV 29 2022

The Honorable Jack Reed
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The Department's response to House Report 117–118, page 186, accompanying H.R. 4350, the National Defense Authorization Act for Fiscal Year 2022, which requests a report on TRICARE reimbursement for care in critical access hospitals, is enclosed.

This report includes information stemming from review of current TRICARE reimbursements for all critical access hospitals near military installations. It also includes: a geographic review and comparison of reimbursement rates for all other hospitals participating in TRICARE; a review and identification of health care providers currently receiving rates less than current comparable Medicaid rates for TRICARE services; and a review of the impact of health care provider closures on military access to health care and readiness. In addition, the report identifies critical access hospitals or rural access hospitals that currently receive less than Medicaid rate for a portion of TRICARE services provided.

Thank you for your continued support for the health and well-being of our Service members, veterans, and their families. I am sending a similar letter to the House Armed Services Committee.

Sincerely,

Gilbert R. Cisneros, Jr.

Enclosure:
As stated

cc:
The Honorable James M. Inhofe
Ranking Member

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

PERSONNEL AND
READINESS

NOV 29 2022

The Honorable Adam Smith
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The Department's response to House Report 117–118, page 186, accompanying H.R. 4350, the National Defense Authorization Act for Fiscal Year 2022, which requests a report on TRICARE reimbursement for care in critical access hospitals, is enclosed.

This report includes information stemming from review of current TRICARE reimbursements for all critical access hospitals near military installations. It also includes: a geographic review and comparison of reimbursement rates for all other hospitals participating in TRICARE; a review and identification of health care providers currently receiving rates less than current comparable Medicaid rates for TRICARE services; and a review of the impact of health care provider closures on military access to health care and readiness. In addition, the report identifies critical access hospitals or rural access hospitals that currently receive less than Medicaid rate for a portion of TRICARE services provided.

Thank you for your continued support for the health and well-being of our Service members, veterans, and their families. I am sending a similar letter to the Senate Armed Services Committee.

Sincerely,

Gilbert R. Cisneros, Jr.

Enclosure:
As stated

cc:
The Honorable Mike D. Rogers
Ranking Member

Report to Congressional Armed Services Committees

In Response to House Report 117–118, Page 186, Accompanying H.R. 4350, the National Defense Authorization Act for Fiscal Year 2022, "TRICARE Reimbursement of Critical Access Hospitals"

November 2022

Preparation of this study/report cost the Department of Defense a total of approximately $3,181 for the 2022 Fiscal Year. This includes $0.00 in expenses and $3,181 in DoD labor

RefID:

Table of Contents

INTRODUCTION

This report is in response to House Report 117–118, page 186, accompanying H.R. 4350 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2022 regarding the impact of inadequate TRICARE reimbursement for care in critical access hospitals (CAHs).

BACKGROUND

House Report 117-118 requests the Secretary of Defense to submit a report to the Committees on Armed Services of the Senate and the House of Representatives by February 1, 2022. The report includes information on the following:

1) Review of current TRICARE reimbursements for all CAHs near military installations;

2) Geographic review and comparison of reimbursement rates for all other hospitals participating in TRICARE;

3) Review and identification of health care providers currently receiving rates less than current comparable Medicaid rates for TRICARE services; and

4) Review of the impact of health care provider closures on military access to health care and readiness, including CAHs or Rural Access Hospitals that currently receive less than Medicaid rate for a portion of TRICARE services provided.

DISCUSSION

1) *Review of current TRICARE reimbursements for all CAHs nearby military installations.*

CAHs are small hospitals that provide limited inpatient and outpatient hospital services primarily in rural areas. Excluding distinct part unit services, TRICARE reimburses CAHs for 101 percent of each CAH's costs, which is the method that Medicare also uses to pay CAHs for both inpatient and outpatient care (see Exhibit 1). This method of payment was established by TRICARE in the CAH Reimbursement Final Rule on August 31, 2009, (74 FR 44752). Reimbursing a CAH at 101 percent of its costs is more generous than the methods that TRICARE uses to reimburse inpatient and outpatient care at other types of hospitals: TRICARE reimburses Sole Community Hospitals (SCHs) for 100 percent of their inpatient costs, and for outpatient care, TRICARE reimburses both SCHs and acute care hospitals (ACHs) using the TRICARE Outpatient Prospective Payment System (OPPS) which uses OPPS reimbursement rates established by Medicare.[1, 2]

[1] TRICARE has a small number of OPPS rates which differ from Medicare's rates due to TRICARE's coverage of services for its unique population.
[2] SCHs also receive additional payment from TRICARE for maternity deliveries.

Exhibit 1

Comparison of TRICARE ACH Reimbursement Methods

Exhibit 1 Comparison of TRICARE Acute Care Hospital Reimbursement Methods		
	Inpatient	**Outpatient**
CAHs	101% of hospital-specific IP costs	101% of hospital-specific OP costs
SCHs	100% of hospital-specific IP costs	OPPS, lab, and PT fee schedules
ACHs	TRICARE DRGs	OPPS, lab, and PT fee schedules

Note: Rates for Long Term Care Hospitals, Inpatient Rehabilitation Facilities, and Children's Hospitals were excluded because the types of care they provide differ substantially from the care provided by CAHs. Maryland ACHs are also excluded.

CAHs play a small but important role for TRICARE beneficiaries: in FY 2020 a total of 720 CAHs had inpatient TRICARE admissions and an additional 402 CAHs had only TRICARE outpatient services. In total, CAHs provided 3,300 inpatient admissions and 3.1 million (M) outpatient services for TRICARE patients.[3] CAHs accounted for about 1.3 percent of TRICARE inpatient admissions and 6.6 percent of the total number of TRICARE outpatient department services. For the 1,122 CAHs with TRICARE patients in FY 2020, the Defense Health Agency (DHA) spent $30M for inpatient admissions and $128M for hospital outpatient services for a total of $158M.

We identified 55 CAHs within a 40-mile radius of a military base (including Coast Guard facilities). Forty of the 55 provided inpatient services to TRICARE beneficiaries. Even though the 55 represent only 5 percent of the total number of CAHs serving TRICARE patients, these 55 hospitals provided over $61M of the $158M in TRICARE CAH payments in FY 2020. Appendix A provides a listing of all 55 CAHs. As expected, the 55 CAHs within 40 miles of a military base provide both inpatient and outpatient care for active duty Service members (ADSMs), in addition to other TRICARE beneficiaries. About 12 percent of the TRICARE inpatient admissions and almost 30 percent of the TRICARE emergency room (ER) visits at the 55 CAHs near military installations were provided to ADSMs.

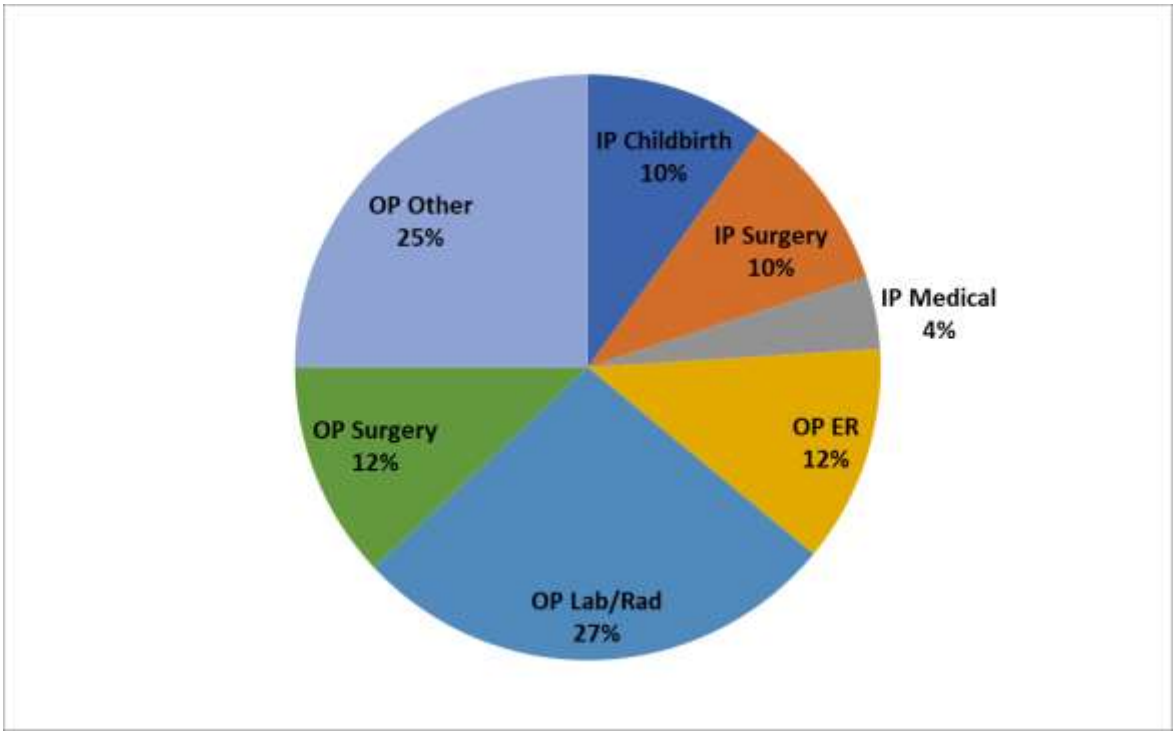
About one-quarter of TRICARE payments to the 55 CAHs near military installations were for inpatient services (see Figure 1). About two-thirds of the admissions to the 55 CAHs

[3] This counts the number of unique line items for separate outpatient services, not claims.

were for deliveries and care of newborns, although these services accounted for only about 10 percent of payments. Outpatient laboratory and radiology (Lab/Rad) service payments accounted for just over one-quarter of all TRICARE payments to the 55 CAHs and outpatient ER services and outpatient surgeries each accounted for another 12 percent of payments.

Figure 1

TRICARE Payments to CAHs Near Military Installations in FY 2020



Eight of the 55 CAHs located near military installations accounted for 65 percent of all TRICARE payments to CAHs. These eight "high-volume" CAHs are located in two eastern States and five western States (see Figure 2 and Appendix B for additional information on these eight CAHs). The other 47 CAHs that are located near military bases are scattered across 24 States. These high-volume CAHs are a particularly important subset of CAHs because they provide more care for ADSMs than the other 47 CAHs located near military bases combined. The eight high-volume CAHs account for five-sixths of the TRICARE allowed amounts for ADSM inpatient and outpatient care at the 55 CAHs. In addition, three of the eight high-volume CAHs had over 150 childbirth admissions in FY 2020 (the large CAHs in Alaska, Idaho, and Washington).

2) *A geographic review and comparison of reimbursement rates for all other hospitals participating in TRICARE.*

TRICARE reimburses CAHs for 101 percent of each CAH's costs. When an inpatient or outpatient claim is submitted by a CAH, the TRICARE managed care support contractor multiplies the billed charge on the claim by a hospital-specific "cost-to-charge ratio" (CCR).

These ratios are calculated from the Medicare cost report filed annually by each CAH with the Centers for Medicare and Medicaid Services (CMS).[4] Similarly, SCH inpatient reimbursement also uses hospital-specific CCRs to calculate payment. In comparison, TRICARE reimburses ACHs for inpatient care using TRICARE's Diagnosis-Related Group (DRG)-based prospective payment system (PPS). The TRICARE DRG reimburses hospitals a prospectively-set amount for each discharge based on patient diagnosis and the procedures performed during the inpatient stay.[5]

We compared TRICARE CAH reimbursement rates with the TRICARE reimbursement rates at two other types of hospitals: SCHs, which, like CAHs, are primarily located in rural areas; and ACHs.[6] Because the mix of services provided at CAHs differs from the services at ACHs, we compared TRICARE reimbursement levels for 13 of the most common types of CAH inpatient admissions and for 10 of the most common types of outpatient services at CAHs.[7]

TRICARE paid CAHs more than it paid SCHs or ACHs in FY 2020 for those 13 specific types of inpatient admissions at CAHs (see Appendix C for detailed information on the 13 types of admissions). The median ratio of TRICARE CAH payments to SCH payments for these 13 common admission types was 1.48, which indicates that TRICARE paid CAHs 48 percent more than SCHs for the same exact DRGs.[8] For all 13 types of admissions, TRICARE paid CAHs at least 14 percent more than it paid SCHs for the same exact DRGs. TRICARE CAH reimbursement is even more generous when compared to TRICARE reimbursement at ACHs that are not SCHs: the median ratio of the TRICARE CAH payment to ACH payment for these 13 common admission types was 2.26, which indicates that CAHs were paid 126 percent more by TRICARE than non-SCH ACHs. For all 13 types of inpatient admissions, TRICARE reimbursement for CAHs was at least 59 percent more than TRICARE reimbursement for ACHs. Figure 3 shows the relative levels of average TRICARE reimbursement amounts for three of the most common childbirth, medical, and surgical TRICARE DRGs, including vaginal delivery (DRG 807), esophagitis (DRG 392), and major hip/knee replacement (DRG 470). This figure illustrates that CAHs are reimbursed substantially more than SCHs or ACHs by TRICARE.

[4] Separate inpatient and outpatient CCRs are calculated for each hospital and used by the TRICARE Managed Care Support Contractors to reimburse CAH claims.

[5] The TRICARE PPS is modeled on the Medicare Inpatient Prospective Payment System, but TRICARE has additional diagnosis-related groups and its own payment weights to reflect the unique characteristics of the TRICARE population.

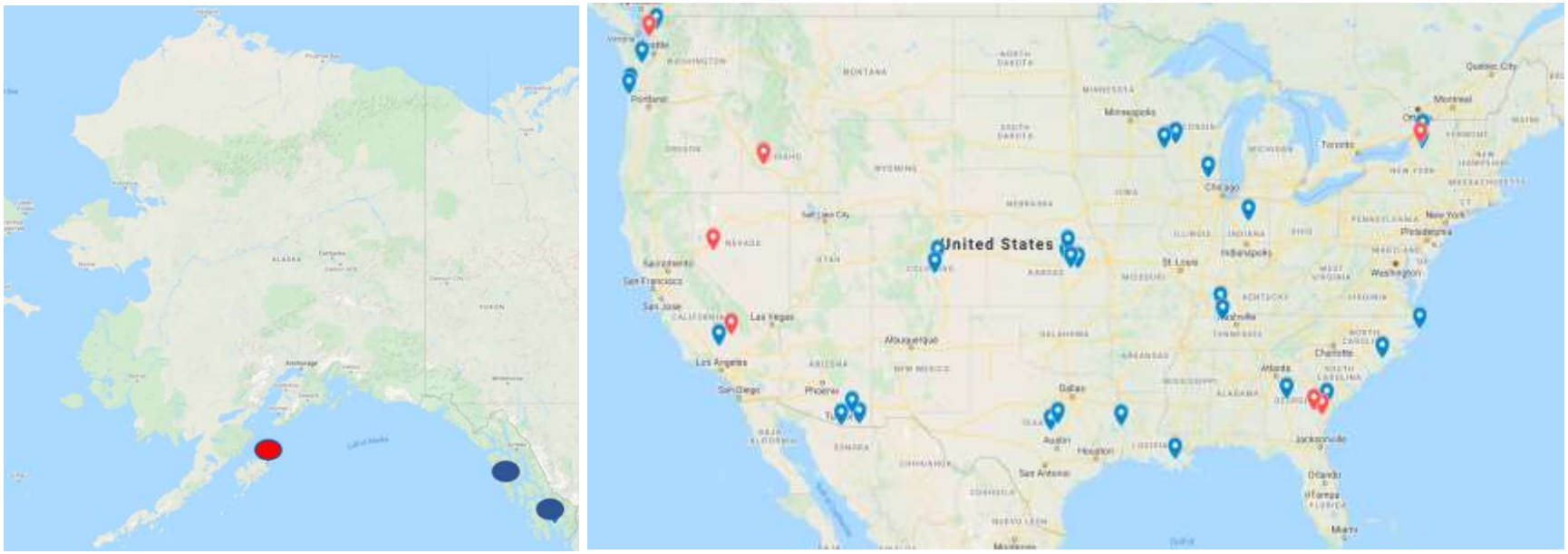
[6] We excluded Children's Hospitals from the comparison because they receive special (higher) TRICARE reimbursement rates than ACHs, and because they provide specialty care for infants and children which is not offered by CAHs. We also excluded Maryland hospitals as they have a special state-regulated hospital payment system which exempts them from other TRICARE (and Medicare) payment schemes.

[7] The 13 types of admissions are among the most common 25 admissions at CAHs and include 7 of the top 10 types of TRICARE CAH admissions. The 10 types of outpatient services are among the 35 most common services at CAHs and include 6 of the top 10 TRICARE CAH services.

[8] Allowed amounts include the impact of any discounts that are offered by providers. We found that very few CAHs offer discounts while most SCHs and ACHs offer discounts to the allowed amount at these hospitals.

Figure 2

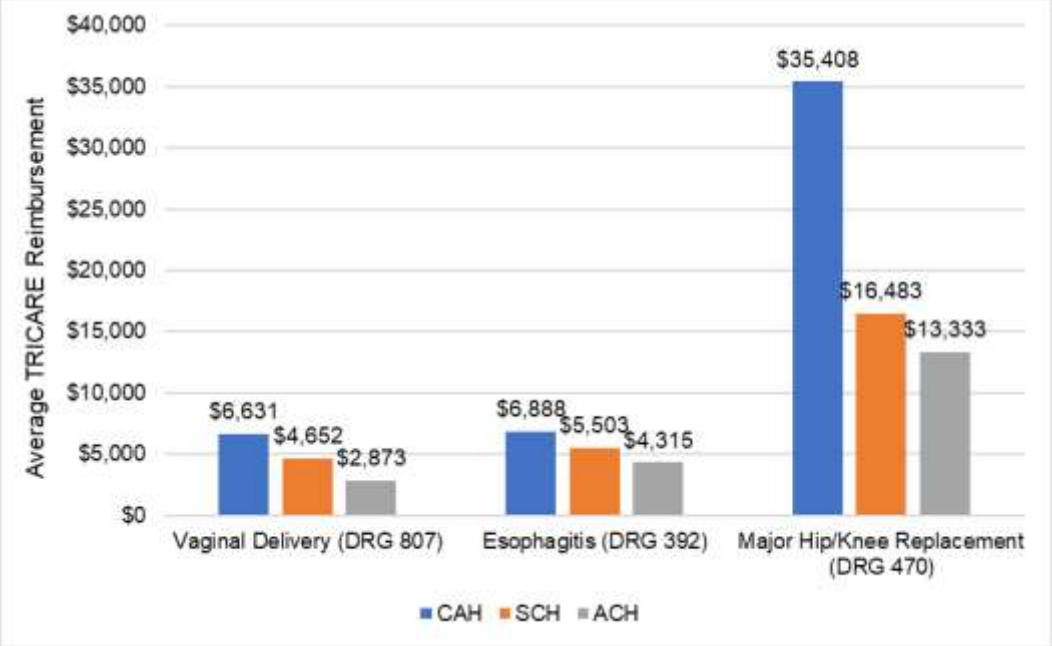
CAHs Near Military Bases with TRICARE Admissions in FY 2020



Note: CAH hospitals in RED include the eight high-volume CAHs with the highest number of TRICARE admissions. Other TRICARE inpatient CAHs are represented in BLUE. CAHs that provide only outpatient care are not shown.

Figure 3

Average TRICARE Reimbursement Rates for Inpatient Admissions at CAHs Are Much Higher Than at SCHs or ACHs

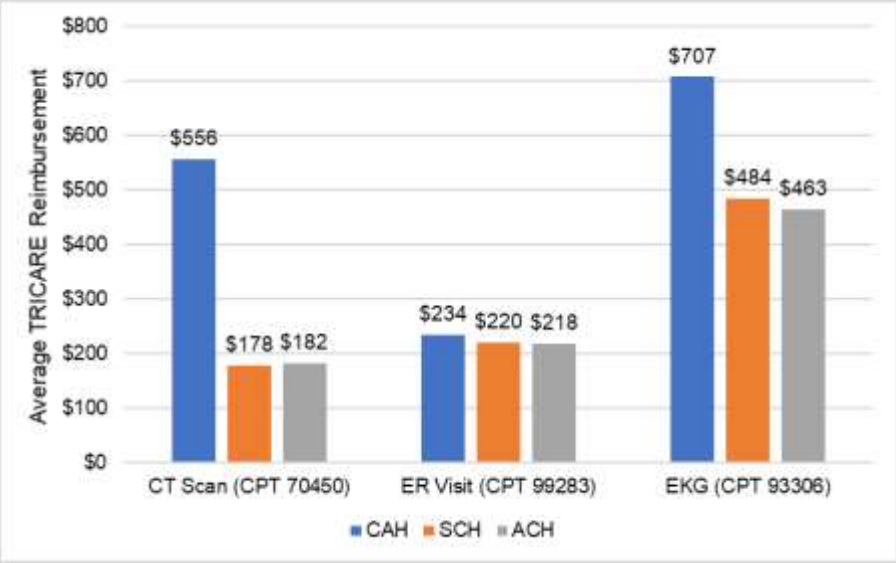


For hospital *outpatient* services, the relationship between the level of TRICARE payments at CAHs and ACHs is more variable. We focused on 10 common outpatient services (including ER visits) provided at TRICARE hospitals and found that the average TRICARE payments were much higher at CAHs for seven of the 10 common services we examined, similar for the two ER visits, and lower for the colonoscopy (see Appendix D for detailed information on the 10 common services examined). It is noteworthy that for radiology and lab services (which account for over one-third of all CAH outpatient payments), the TRICARE CAH payments are three to five times higher at CAHs than they are at SCHs and ACHs. Additionally, CAH payments for the common medical and physical therapy services we reviewed are about 50 percent higher than at SCHs or ACHs. The median ratios of CAH payments to SCH and ACH payments were 1.48 and 1.51, indicating that CAHs were paid about 50 percent more than SCHs or ACHs for these common types of outpatient services. Figure 4 provides examples of the higher TRICARE reimbursement levels at CAHs for three common CAH outpatient services.[9]

[9] Currently TRICARE has a special reimbursement method for outpatient services at Children's and Cancer hospitals, which provides higher payment than at ACHs. DHA has published a Notice of Proposed Rulemaking that would modify this reimbursement methodology. We did not include them in our comparison in this report because these hospitals serve special populations and because TRICARE's reimbursement methods are assumed to change.

Figure 4

Average TRICARE Reimbursement Rates for Hospital Outpatient Services at CAHs Are Much Higher Than at SCHs or ACHs



We also conducted a ***geographic review*** of CAH reimbursements by TRICARE in FY 2020 and found that:

- CAHs located in rural areas (about 85 percent of TRICARE CAH claims are from rural CAHs) receive an average of about 15 percent more per admission from TRICARE than urban CAHs.

- CAHs in the West Census region have the highest TRICARE payments per discharge and those in the South have the lowest average. Payments in the West are about 15 percent higher than the national average (see Figure 5).

- In all Census regions, CAHs are paid more per discharge by TRICARE than SCHs or ACHs. For one of the two most common TRICARE CAH discharges (DRG 807 for a vaginal delivery), TRICARE CAHs received at least 50 percent more than SCHs and ACHs in each region.

- TRICARE payments vary substantially within regions and within States because TRICARE reimburses each CAH based on 101 percent of its own costs. Therefore, States with higher-cost CAHs have higher TRICARE payments. In the West Census region, for example, we identified six States with a sufficient number of discharges for DRG 807 (vaginal delivery) to allow comparisons across the region. The variation in payments between States illustrated in Figure 6 shows that TRICARE payments were over three times higher in Alaska than in Nevada in FY 2020. We also found that in each State the average CAH payments per discharge were at least 25 percent higher than the average for SCHs and ACHs.

In summary, TRICARE CAH reimbursement rates are more generous than TRICARE's payments to SCHs and ACHs for both hospital inpatient and outpatient services. This was true for all Census regions. TRICARE CAH payments do vary by region, State, and within States because the payment is based on 101 percent of each hospital's own costs, as reported by the hospital to CMS.

Figure 5

TRICARE CAH Payments Per Discharge Vary by Census Region (For DRG 807 - Vaginal Delivery)

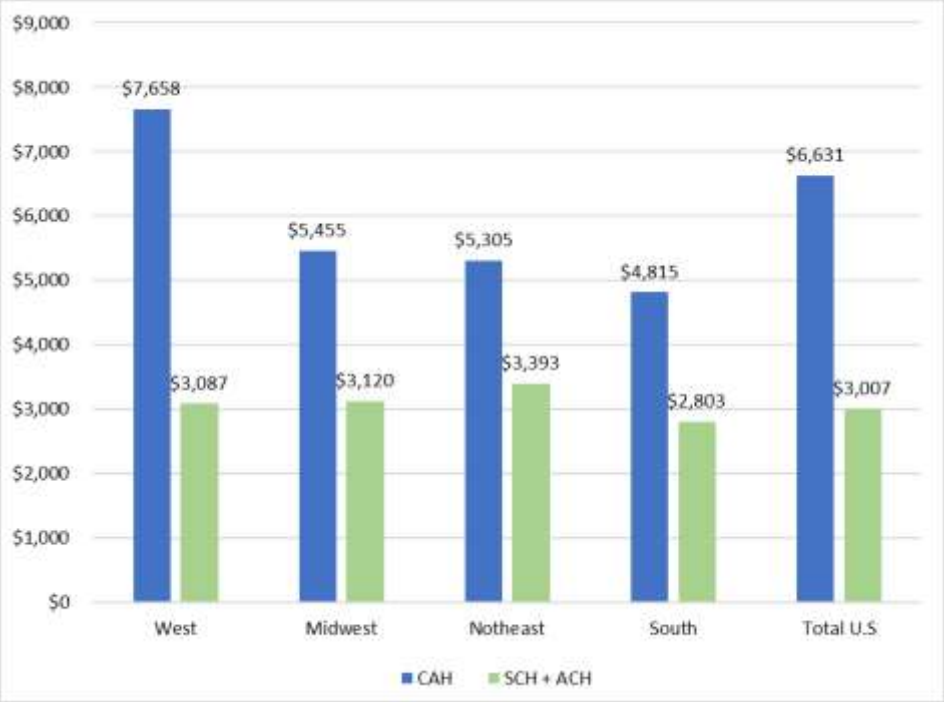
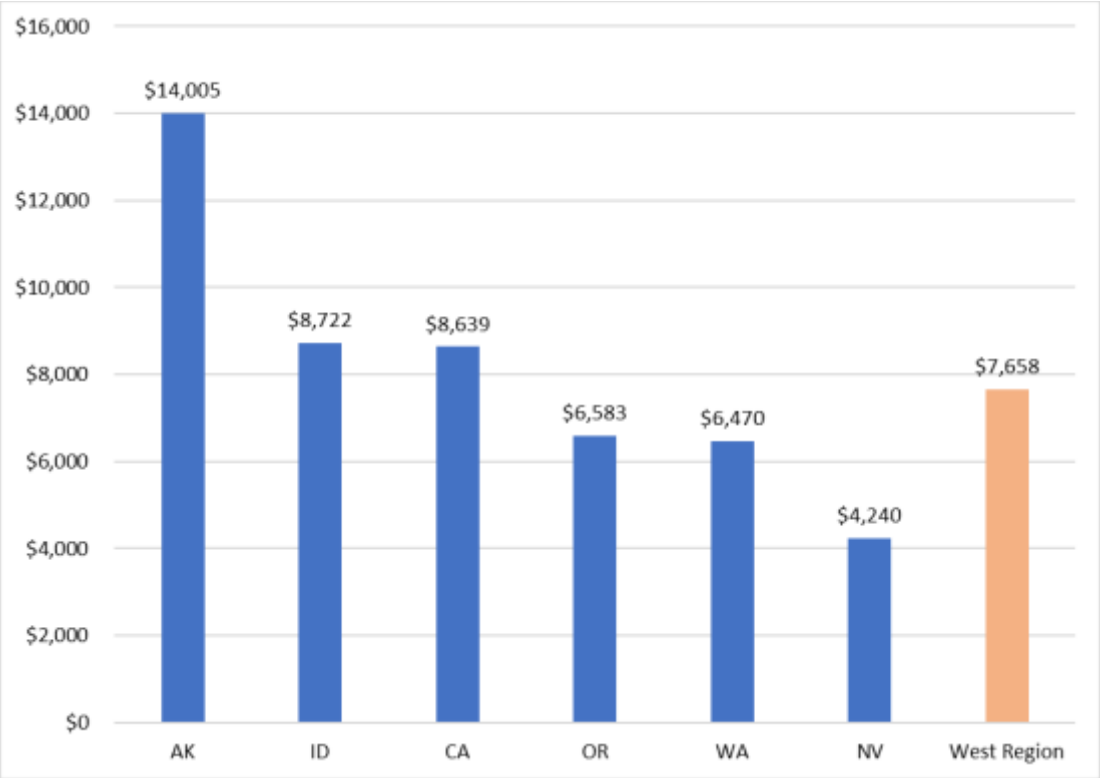


Figure 6

TRICARE CAH Payments Per Discharge Vary Substantially by State (For DRG 807 – Vaginal Delivery)



3) *A review and identification of health care providers currently receiving rates less than current comparable Medicaid rates for TRICARE services.*

Congress is interested in whether CAHs receive lower reimbursement from TRICARE than Medicaid. Each State Medicaid program establishes its own method of reimbursement for inpatient care. For example, one State may use a cost-based approach for reimbursement, while a neighboring State uses a PPS for reimbursement. To compare Medicaid reimbursement of outpatient acute care with TRICARE reimbursement rates for CAHs, we obtained data from each of the seven States with high-volume TRICARE CAH services and found that none of the seven Medicaid programs reimburse ACHs at a higher rate than TRICARE (101 percent of costs).

Medicaid Inpatient CAH Reimbursement

Medicaid programs often reimburse inpatient services at CAHs differently than they reimburse inpatient acute care providers. We identified the seven States with the most TRICARE CAH admissions in FY 2020, which include Alaska, California, Georgia, Idaho,

Washington, Nevada, and New York.[10] We then identified how each of these State Medicaid programs reimburse CAHs:

- Idaho's Medicaid program reimburses CAHs based on 101 percent of costs;
- Washington's Medicaid program reimburses CAHs using a hospital-specific weighted CCR;
- New York, Nevada, and Alaska Medicaid programs reimburse CAHs using a hospital-specific per-diem;
- California's Medicaid program uses the All Patients Refined Diagnosis Related Groups (APR-DRG) PPS, and Georgia's Medicaid program uses the TRICARE DRG but calculates their own Medicaid-specific weights and hospital specific standardized base amounts.

For California Medicaid, because its APR-DRG system operates differently than the TRICARE payment for CAHs, it is possible that some of the payments made by California Medicaid could be higher than TRICARE. On average, based on TRICARE data, it appears that TRICARE's CAH payments are greater than or equal to California Medicaid's CAH payments.

The Medicaid and CHIP (Children's Health Insurance Program) Payment and Access Commission (MACPAC), the organization that advises Congress on Medicaid reimbursement, conducted a comprehensive review of Medicaid inpatient reimbursement policies (including CAH, ACH, and SCH reimbursement) in each State in 2018 and found that there was only one State where Medicaid payments were higher than TRICARE. While not one of the seven States with a high-volume TRICARE CAH, we found that the Medicaid program in Maine reimburses CAHs for 109 percent of costs for inpatient admissions, which is higher than TRICARE.[11] To our knowledge, there are no other Medicaid programs that reimburse inpatient care at CAHs at a higher rate than TRICARE.[12]

Medicaid Outpatient CAH Reimbursement

For outpatient services, we found that only one of the seven State Medicaid programs we focused on, Alaska, reimburses some CAHs at a higher rate than TRICARE. Each year, the Alaska Medicaid program establishes an outpatient reimbursement rate percentage for each CAH. We compared the FY 2022 Alaska Medicaid CAH percentage to the TRICARE CAH outpatient CCRs and found that four Alaska CAHs had higher Medicaid outpatient reimbursement rates than TRICARE. For example, Alaska Medicaid reimburses outpatient

[10] These seven States accounted for 40 percent of all TRICARE CAH admissions.
[11] There are 10 CAHs in Maine which had TRICARE admissions in FY 2020. None had more than 10 TRICARE admissions and none had over $50,000 in TRICARE allowed amounts for inpatient care.
[12] MACPAC, State Medicaid Payment Policies for Inpatient Hospital Services, December 2018. https://www.macpac.gov/publication/macpac-inpatient-hospital-payment-landscapes/

services at Providence Kodiak Island Medical Center for 44 percent of its billed charges, compared to TRICARE's reimbursement of 38 percent of charges in FY 2022. Providence Seward Medical Center, Providence Valdez Medical Center, and Wrangell Medical Center were also paid more for outpatient services by Alaska Medicaid than TRICARE. However, we found that TRICARE reimburses CAHs more for outpatient services than Alaska Medicaid at five other Alaska CAHs.

Similarly, to their review of inpatient services discussed earlier, MACPAC performed a review of outpatient service reimbursement for all State Medicaid programs in 2016 and found that there was only one State that has higher outpatient rates for CAHs than TRICARE.[13] We found that Maine's Medicaid program reimburses CAH outpatient services at 109 percent of costs, which is higher than TRICARE. In our review of Medicaid CAH outpatient reimbursement, we found no other State in which Medicaid reimburses outpatient care at CAHs at a higher rate than TRICARE.

Medicaid Non-CAH Acute Care Reimbursement

In addition to reviewing how Medicaid programs reimburse CAHs, we also analyzed whether any Medicaid programs reimburse inpatient care at other non-CAH ACHs more than TRICARE reimburses CAHs in each State. Focusing on the seven States with large TRICARE CAHs, we first identified how each State reimburses inpatient services at non-CAH ACHs and found that:

- Idaho, Washington, California, and New York Medicaid programs all use the APR-DRG PPS;
- Georgia's Medicaid program uses the TRICARE DRGs with their own weights and adjusted standardized amounts; and
- Alaska and Nevada both reimburse other inpatient care using a provider specific per-diem.

We reviewed MACPAC's findings for 2018 and also reviewed the Medicaid websites for each of the seven States and contacted each program to determine whether the non-CAH Medicaid reimbursement rates were higher than TRICARE's reimbursement rates for CAHs. We found that one Medicaid program, Idaho, reimburses some types of inpatient care at non-CAH ACHs at higher rates than TRICARE. In July 2021, Idaho Medicaid implemented its APR-DRG system with a goal of reimbursing Idaho hospitals for 91.7 percent of their inpatient costs, which is less than TRICARE's 101 percent. However, the Idaho Medicaid program increases payments for inpatient obstetric services by 35 percent and normal newborn births by

[13] MACPAC, State Medicaid Payment Policies for Outpatient Hospital Services.

55 percent.[14] We estimate that Idaho's Medicaid program pays ACHs roughly 25 percent to 45 percent more than TRICARE reimburses Idaho CAHs for obstetric and newborn services, depending on severity of the case.[15]

We also analyzed Medicaid inpatient acute care rates in California, New York, Washington, Nevada, Alaska, and Georgia and found that all six State Medicaid programs have lower inpatient acute care reimbursement rates than TRICARE. In addition, we found that none of the seven States have higher Medicaid outpatient payment rates for non-CAHs than TRICARE reimbursement for outpatient CAH care.

4) *Review of the impact of health care provider closures on military access to health care and readiness*

Congress is interested in the impact of all rural hospital closures, not just CAH closures, on TRICARE readiness and access to care, particularly for rural hospitals that receive lower reimbursements from TRICARE than they receive from Medicaid. We first identified all rural ACHs during the FY 2016-2021 period that had closed completely or that had closed their inpatient services and converted to an outpatient facility. We focused on those that were located within 40 miles of a military base (including Coast Guard) and identified 15 hospitals near military bases that had either completely closed or that had closed their inpatient services and converted to an outpatient facility.[16] We also identified six other rural hospitals that had closed and that were not located near a military base but had TRICARE allowed amounts for outpatient services of $150,000 or more for TRICARE beneficiaries during the FY 2016-2020 period and included these rural hospitals in our analysis.[17] About half of the 21 rural hospital closures that met these criteria were CAHs (nine), two were SCHs, and the other 10 were ACHs.

Of the 21 rural hospitals that stopped providing inpatient services at some point during the FY 2016-2021 period, only six had 15 or more TRICARE inpatient admissions in a year (roughly one admission per month, see Exhibit 2). St. Luke's Cushing Hospital, which was reimbursed under TRICARE's DRG system and not as a CAH, had the highest number of TRICARE admissions. Only two of the closures with 15 or more TRICARE admissions in any year were CAHs (Community HealthCare System-St. Marys and Sitka Community Hospital).

---

[14] Idaho adjusts the 3M national APR-DRG weights by a factor of 1.46. This is designed to achieve reimbursement of 91.7 percent of costs. The additional adjustments for obstetrics and normal newborns are made after the initial 1.46 adjustment.

[15] The Idaho Medicaid program also increases the payments for inpatient mental health care admissions at ACHs by 60 percent above the APR-DRG level. However, Idaho exempts most psychiatric hospitals from its APR-DRG system. Most TRICARE mental health admissions are at psychiatric hospitals, not ACHs; Idaho reimburses all psychiatric hospitals (i.e., referred to as Institutes of Mental Disease by the Idaho Medicaid program) at 91 percent of costs, which we calculated to be less than what would be paid using the TRICARE per diem for psychiatric hospitals.

[16] We used a listing of rural hospital closures developed by the Sheps Center at the University of North Carolina and then identified the subset of hospitals that were within 40 miles of a military base.

[17] The six hospitals we added were Community Health Care System-St Marys in St. Marys, KS; Adventist Health Feather River in Paradise, CA; Shands Lake Shore RMC in Lake City, FL; Shands Live Oak RMC in Live Oak, FL; Chillicothe Hospital in Chillicothe, TX; and Little River Healthcare Rockdale Hospital in Rockdale, TX.

Of these 21 hospitals, only three are located in States that have Medicaid programs that might pay more than TRICARE for certain types of inpatient care (one in Alaska and two in California).

In examining the impact of rural hospital closures on ***readiness***, we focused on care for ADSMs as a key consideration for readiness (see Exhibit 3). We found that there was only one closure with more than three ADSM admissions in a year, which was the closure in 2020 of St. Luke's Cushing Hospital in Leavenworth, Kansas. In FY 2016, St. Luke's Cushing had 21 ADSM admissions (15 medical and 6 surgical admissions), but the number of ADSM admissions decreased from 21 in FY 2016 to 18 in FY 2017, 11 in FY 2018, and 4 in FY 2019, before its closure in FY 2020. Although the hospital closed in FY 2020, another hospital in Leavenworth, Kansas, had a substantial increase in TRICARE outpatient services after FY 2019 and there are four other hospitals located within 25 miles.

A second concern for readiness is the ability for ADSMs to get outpatient care after a hospital has closed completely. We found that at the hospitals that were closing completely during the FY 2016-2021 period, there were very few ADSM ER visits at those hospitals prior to their closure, and the only two hospitals that provided a substantial number of outpatient services for ADSMs focused on outpatient surgeries (Doctors Hospital at Deer Creek in Leesville, Louisiana) and lab and radiology services (Little River Healthcare Rockdale in Rockdale, Texas), (see Exhibit 3). We do not believe that the closure of either hospital had a substantial impact on readiness; in the case of Doctors Hospital at Deer Creek, there already was another (larger) hospital located within one mile of it. Little River Healthcare Rockdale had over $128,000 in TRICARE allowed amounts for outpatient services for ADSMs in FY 2016, but almost 90 percent of the allowed amounts were for lab and radiology services which could be obtained from other nearby hospitals. Additionally, the number of ADSM lab tests and radiology services declined in the years before the hospital closed completely in 2018. Because there were other hospitals located nearby in Round Rock and Temple, Texas that offer outpatient services including radiology and clinical lab services, we think Rockdale's closure had a low impact on readiness.

Exhibit 2

Rural Hospital Closures in FY 2016-2021 With More Than 15 TRICARE Admissions in Any Year

Hospital (type)	Location	Type of Closure (year)	# of TRICARE Admissions		Closest Base (miles)
			Total	ADSM	
Adventist Health Feather River (ACH)	Paradise, CA	Complete (2018)	32	1	Beale AFB (48)
Doctor's Hospital at Deer Creek (ACH)	Leesville, LA	Complete (2019)	27	2	Ft. Polk (5)
Shands Lake Shore RMC (ACH)	Lake City, FL	Complete (2020)	24	10	NAS Jacksonville (56)
St Luke's Cushing (ACH)	Leavenworth, KS	Inpatient (2020)	133	21	Ft. Leavenworth (3)
CHCS-St Marys (CAH)	St Marys, KS	Inpatient (2021)	21	0	Ft. Riley (41)
Sitka Community Hospital (CAH)	Sitka, AK	Inpatient (2019)	30	3	USCG Sitka (1)

Notes: ACH is not an SCH or a CAH. Complete closure means that the hospital closed completely. Inpatient closure means the hospital no longer offers inpatient care but continues to offer outpatient care. Although categorized as a complete closure, Adventist Health opened an outpatient clinic in 2019.

Exhibit 3

Impact of Rural Hospital Closures During FY 2016-2021 Potentially Affecting Readiness

Complete Closures	Impact on ADSM IP Care	Impact on ADSM OP Care
Adventist Health Feather River	Only 1 ADSM admission in highest year	7 ADSM ER visits in highest year, new OP clinic opened in 2019
Doctors Hospital at Deer Creek	Only 2 ADSM admissions in highest year	No ER visits, but 58 ADSM OP surgeries in highest year
Shands Lake Shore RMC	No ADSM admissions	10 ADSM ER visits in highest year
Little River Rockdale	No ADSM admissions	1 ADSM ER visit, but 1,200 ADSM lab tests in highest year
IP Closures / Conversion to OP Only		
St. Luke's Cushing	21 ADSM admissions in highest year	N.A. - OP still open
Sitka	3 ADSM admissions in highest year	N.A. - OP still open

A third complete closure was Adventist Health Feather River in Paradise, California. This hospital was closed due to the Camp Fire wildfire in 2018. Adventist re-opened a clinic offering primary and specialty services in 2019 and plans to open a standalone emergency room. After the CAH closed in 2018, TRICARE patients were able to get care at two nearby hospitals (Enloe Medical Center and Oroville Hospital).

The fourth complete closure was at Shands Lake Shore Regional Medical Center (RMC), which had no inpatient admissions for ADSMs during the FY 2016-2021 period and 10 or fewer ER visits for ADSMs annually. This hospital closed in 2020 as another hospital in the same zip code (Lake City Medical Center) opened in the same year and is now providing outpatient care for ADSMs. Thus, we do not believe that these four complete closures, or the other inpatient closures, have had an impact on readiness.

To examine the impact of the rural hospital closures on access, we focused on the 10 hospitals that closed their inpatient services in the FY 2016-2021 period and that were located near a military base (see Appendix E).[18] We have already noted that the complete closures at Adventist Health Feather River, Doctors Hospital at Deer Creek, Shands Lake Shore RMC, and Little River Rockdale are unlikely to have had an effect on TRICARE access because there are

[18] None of the other rural hospitals that closed or converted to outpatient care only had more than five TRICARE admissions during the FY 2016-2020 period and most had no TRICARE admissions. None of the other rural hospitals that closed had TRICARE allowed amounts for outpatient services of more than $100,000 per year.

other hospitals nearby. Six other hospitals closed their inpatient services but maintained their outpatient services during the FY 2016-2020 period. In all six cases, it is unlikely that the inpatient service closures will have an impact on access of TRICARE beneficiaries to care because there are other nearby hospitals offering inpatient and outpatient care (in all six cases within 15 miles and in two cases within 5 miles of the closed inpatient-service). The Medicare Payment and Advisory Commission (MedPAC), the organization that advises Congress on Medicare reimbursement policies, studied rural hospital closures in FY 2019 and their impact on access to care (for Medicare beneficiaries) and reached a similar conclusion about the impact of rural hospital closures on access: MedPAC concluded that because few of the closures involved hospitals more than 35 miles away from the next nearest hospital, most patients would continue to have access to inpatient services in their area.[19] For the same reason, we believe that the closures of rural hospitals during the FY 2016-2021 period had negligible impacts on readiness and access to care for TRICARE beneficiaries.

CONCLUSION

After reviewing TRICARE's CAH reimbursement rates near military installations, conducting a geographic review of CAH reimbursement compared to all other hospitals participating in TRICARE, identifying health care providers receiving rates less than current comparable Medicaid rate for TRICARE services, and reviewing the impact of health care provider closures on military access to health care and readiness, the following summary is provided:

- TRICARE reimburses CAHs for 101 percent of their costs, both inpatient and outpatient, which is the method used by Medicare. This reimbursement is more generous than other methods that TRICARE uses for reimbursement of inpatient and outpatient care at other comparable types of hospitals.

- CAHs in rural areas comprised 85 percent of the total claims for all CAHs and average about 15 percent more reimbursement per admission from TRICARE than urban CAHs. CAHs in the West Census region have the highest TRICARE payments per discharge and those in the South have the lowest average, and payments in the West are about 15 percent higher than the national average. In all Census regions, CAHs are paid more per discharge by TRICARE than SCHs or ACHs.

- In a comparison of data on Medicaid reimbursement of outpatient and inpatient acute care with TRICARE reimbursement for CAHs (seven States with the highest level of TRICARE CAH expenditures), found that none of the seven Medicaid programs reimburse ACHs at a higher rate than TRICARE (101 percent of costs). We only identified one State, Maine, which reimbursed CAH inpatient and/or outpatient services at a higher rate than TRICARE (though TRICARE utilization of Maine CAHs was low).

[19] MedPAC, Report to the Congress: Medicare Payment Policy, March 2021, page 63.

- After reviewing data on rural hospital closures near a military base and the impact on access to care, the closures of rural hospitals during the FY 2016-2021 period had negligible impacts on readiness and access to care for TRICARE beneficiaries.

ACRONYMS

ACH – acute care hospital
ADSM – active duty Service member
AP-DRG – All Patients Refined Diagnosis Related Groups
CAH – critical access hospital
CCR – cost-to-charge ratio
CHIP – Children's Health Insurance Program
CMS – Centers for Medicare and Medicaid Services
DHA – Defense Health Agency
DRG – Diagnosis Related Group
ER –Emergency Room
FR – Federal Register
FY – Fiscal Year
MACPAC – Medicaid and CHIP (Children's Health Insurance Program) Payment and Access Commission
MedPAC – Medicare Payment and Advisory Commission
NDAA – National Defense Authorization Act
NPRM – Notice of Proposed Rulemaking
OCONUS – outside the continental United States
OHI – Other Health Insurance
OPPS – Outpatient Prospective Payment System
PPS – Prospective Payment System
RMC – Regional Medical Center
SCH – Sole Community Hospitals

Appendix A

55 TRICARE CAHs That Are Nearby Military Installations

#	Medicare ID	Provider Name	Nearest Base (miles)	City	State	Number of TRICARE Admissions	TRICARE Inpatient Allowed Amount	TRICARE Outpatient Allowed Amount
1	021306	PROVIDENCE KODIAK ISLAND MEDICAL CENTER	USCG Base Kodiak, 8 miles	KODIAK	AK	102	$1,395,126	$2,703,686
2	021311	KETCHIKAN MEDICAL CENTER	USCG Base Ketchikan, 1 mile	KETCHIKAN	AK	20	$191,827	$850,904
3	021314	MT EDGECUMBE HOSPITAL	USCG Sitka Air Station, 1 mile	SITKA	AK	27	$242,072	$897,082
4	031301	BENSON HOSPITAL	Fort Huachuca, 28 miles	BENSON	AZ	2	$16,452	$223,516
5	031312	COPPER QUEEN COMMUNITY HOSPITAL	Fort Huachuca, 26 miles	BISBEE	AZ	3	$10,988	$1,174,298
6	031313	HOLY CROSS HOSPITAL	Fort Huachuca, 10 miles	NOGALES	AZ	5	$23,122	$263,693
7	051301	ADVENTIST HEALTH TEHACHAPI VALLEY	Edwards AFB, 38 miles	TEHACHAPI	CA	8	$637,446	$492,209
8	051333	RIDGECREST REGIONAL HOSPITAL	Naval Air Weapons Station China Lake, 5 miles	RIDGECREST	CA	88	$787,778	$1,757,073
9	061326	UCHEALTH PIKES PEAK REGIONAL HOSPITAL	Peterson AFB, 23 miles	WOODLAND PARK	CO	12	$127,684	$789,693
10	061344	CENTURA HEALTH-ST THOMAS MORE	Fort Carson, 29 miles	CANON CITY	CO	1	$10,804	$550,519
11	111306	EFFINGHAM HEALTH SYSTEM	Hunter Army Airfield, 18 miles	SPRINGFIELD	GA	5	$41,874	$945,282
12	111310	MEDICAL CENTER OF PEACH COUNTY	Robins AFB, 10 miles	BYRON	GA	11	$38,645	$478,844
13	111323	OPTIM MEDICAL CENTER - TATTNAL	Fort Stewart, 36 miles	REIDSVILLE	GA	50	$4,251,408	$4,197,048
14	111326	SGMC LANIER CAMPUS	Moody AFB, 33 miles	LAKELAND	GA			$292,773
15	111335	LIBERTY REGIONAL MEDICAL CENTER	Fort Stewart, 9 miles	HINESVILLE	GA	60	$389,384	$1,871,560
16	121304	KAHUKU MEDICAL CENTER	Schofield Barracks, 14 miles	KAHUKU	HI			$30,784
17	131311	ST LUKE'S ELMORE MEDICAL CENTER	Mountain Home AFB, 14 miles	MOUNTAIN HOME	ID	176	$1,304,324	$3,591,971
18	141335	MERCY HARVARD HOSPITAL	Naval Station Great Lakes, 38 miles	HARVARD	IL			
19	151318	DUKES MEMORIAL HOSPITAL	Grissom Air Reserve Base, 10 miles	PERU	IN	5	$41,827	$717,087
20	171337	WAMEGO HEALTH CENTER	Fort Riley, 27 miles	WAMEGO	KS			
21	171340	HERINGTON HOSPITAL	Fort Riley, 29 miles	HERINGTON	KS	1	$14,912	$271,618
22	171371	CLAY COUNTY MEDICAL CENTER	Fort Riley, 25 miles	CLAY CENTER	KS	2	$1,931	$209,346
23	171379	MORRIS COUNTY HOSPITAL	Fort Riley, 34 miles	COUNCIL GROVE	KS	3	$11,802	$94,012
24	171381	MEMORIAL HOSPITAL	Fort Riley, 25 miles	ABILENE	KS	4	$21,475	$353,299
25	181304	TRIGG COUNTY HOSPITAL	Fort Campbell, 27 miles	CADIZ	KY	1	$1,084	$182,887
26	181322	CALDWELL MEDICAL CENTER	Fort Campbell, 40 miles	PRINCETON	KY			$76,392
27	191324	OCHSNER ST ANNE GENERAL HOSPITAL	NAS Joint Reserve Base New Orleans, 38 miles	RACELAND	LA	13	$50,208	$315,138
28	251322	LAIRD HOSPITAL INC	NAS Meridian, 29 miles	UNION	MS			$172,673
29	291313	BANNER CHURCHILL COMMUNITY HOSPITAL	NAS Fallon, 5 miles	FALLON	NV	115	$443,787	$1,326,974
30	331309	RIVER HOSPITAL CLINICS	Fort Drum, 19 miles	ALEXANDRIA BAY	NY			$1,056,994

Appendix A, Continued

#	Medicare ID	Provide Name	Nearest Base (miles)	City	State	Number of TRICARE Admissions	TRICARE Inpatient Allowed Amount	TRICARE Outpatient Allowed Amount
31	331315	GOUVERNEUR HOSPITAL	Fort Drum, 25 miles	GOUVERNEUR	NY	12	$74,766	$188,208
32	331317	LEWIS COUNTY GENERAL HOSPITAL	Fort Drum, 1 miles	LOWVILLE	NY	24	$162,575	$570,353
33	331318	CARTHAGE AREA HOSPITAL, INC	Fort Drum, 10 miles	CARTHAGE	NY	61	$285,923	$6,140,574
34	341307	PENDER MEMORIAL HOSPITAL	Marine Corps Air Station New River, 29 miles	BURGAW	NC	1	$2,719	$134,145
35	341324	THE OUTER BANKS HOSPITAL, INC	USCG Base Elizabeth City, 37 miles	NAGS HEAD	NC	28	$124,044	$489,512
36	361312	MERCY HEALTH - URBANA HOSPITAL	Wright-Patterson AFB, 25 miles	URBANA	OH			
37	381303	PROVIDENCE SEASIDE HOSPITAL	Coast Guard Sector Columbia River, 24 miles	SEASIDE	OR	5	$42,487	$240,880
38	381320	COLUMBIA MEMORIAL HOSPITAL	Coast Guard Sector Columbia River, 2 miles	ASTORIA	OR	45	$289,033	$1,249,713
39	421304	EDGEFIELD COUNTY HEALTHCARE	Fort Gordon, 27 miles	EDGEFIELD	SC			
40	431323	MONUMENT HEALTH CUSTER HOSPITAL	Ellsworth AFB, 36 miles	CUSTER	SD			$146,375
41	441311	TRISTAR ASHLAND CITY MEDICAL CENTER	Fort Campbell, 24 miles	ASHLAND CITY	TN			$224,400
42	441322	HOUSTON COUNTY COMMUNITY HOSPITAL	Fort Campbell, 23 miles	ERIN	TN	1	$3,165	$38,716
43	451323	ADVENTHEALTH ROLLINS BROOK	Fort Hood, 16 miles	LAMPASAS	TX	7	$169,106	$304,918
44	451361	SABINE COUNTY HOSPITAL	Fort Polk, 34 miles	HEMPHILL	TX	1	$6,715	$24,489
45	451365	ASCENSION SETON HIGHLAND LAKES	Fort Hood, 31 miles	BURNET	TX			$155,429
46	451379	CORYELL MEMORIAL HEALTHCARE	Fort Hood, 20 miles	GATESVILLE	TX	7	$153,091	$940,009
47	501304	SUMMIT PACIFIC MEDICAL CENTER	Fort Lewis, 30 miles	ELMA	WA			$124,872
48	501314	OCEAN BEACH HOSPITAL	Coast Guard Sector Columbia River, 12 miles	ILWACO	WA			$57,516
49	501319	ARBOR HEALTH MORTON HOSPITAL	Fort Lewis, 40 miles	MORTON	WA			$90,730
50	501329	PEACEHEALTH UNITED GENERAL MEDICAL	NAS Whidbey Island, 25 miles	SEDRO WOOLLEY	WA	2	$50,321	$413,088
51	501336	MASON GENERAL HOSPITAL & FAMILY	Fort Lewis, 16 miles	SHELTON	WA	18	$390,390	$502,953
52	501339	WHIDBEYHEALTH MEDICAL CENTER	NAS Whidbey Island, 7 miles	COUPEVILLE	WA	420	$2,790,973	$6,537,563
53	521305	MAYO CLINIC HLTH SYSTM FRANCIS	Fort McCoy, 7 miles	SPARTA	WI	7	$47,818	$0
54	521320	TOMAH MEMORIAL HOSPITAL	Fort McCoy, 9 miles	TOMAH	WI	46	$413,030	$905,639
55	521357	MERCY WALWORTH HOSPITAL & MEDICAL CENTER	Naval Station Great Lakes, 37 miles	LAKE GENEVA	WI	6	$16,503	$248,664
	Totals					**1,405**	**$15,078,618**	**$45,616,102**

Appendix B

Eight CAHs Near Military Installations Accounted for Over 30% of All TRICARE CAH Admissions and Outpatient Services in FY20

Hospital Name	City	State	TRICARE Payments (millions)	Admissions	Outpatient Services	Nearby Military Base (miles)
Providence Kodiak Island RMC	Kodiak Island	AK	4.1	102	24,420	USCG Base Kodiak (8)
Ridgecrest Regional	Ridgecrest	CA	2.6	88	44,632	China Lake NAS (2)
Liberty RMC	Hinesville	GA	2.3	60	36,007	Fort Stewart (2)
Optim MC Tattnall	Reidsville	GA	8.5	50	11,295	Fort Stewart (36)
St Luke's Elmore	Mountain Home	ID	4.9	176	100,290	Mountain Home AFB (13)
Banner Churchill	Fallon	NV	1.8	115	44,915	NAS Fallon (6)
Carthage Area	Carthage	NY	6.4	61	184,803	Fort Drum (14)
Whidbey Island	Coupeville	WA	9.3	420	164,088	NAS Whidbey Island (13)
Subtotal			**39.9**	**1,072**	**610,450**	
47 Other CAHs Near Bases			21.8	333	378,911	
Subtotal for 55 CAHs			**61.7**	**1,405**	**989,361**	
All Other 1,067 CAHs			96.3	1,880	2,091,425	
Total, All 1,122 CAHs			**158.0**	**3,285**	**3,080,786**	

Note: TRICARE admissions and outpatient services include ADSMs, their spouses and dependents, and retirees and their dependents. Admissions and services paid by Other Health Insurance (OHI) are excluded. TRICARE payments reflect the sum of hospital inpatient and outpatient allowed amounts

Appendix C

Comparison of TRICARE Inpatient Acute Care Reimbursement Rates in FY20					
DRG Number - Type of Admissions	Average Allowed Amount			Ratio of CAH Average Allowed Amount to Average Allowed Amount at:	
Childbirth	CAH	SCH	ACH	SCH	ACH
773 - C-Section	$12,806	$8,645	$5,145	1.48	2.49
792 - Neonate, birthweight > 2,499 grams	$2,775	$2,279	$1,517	1.22	1.83
795 - Normal newborn	$2,146	$1,432	$872	1.50	2.46
806 - Vaginal delivery (w/complications)	$7,804	$5,267	$3,222	1.48	2.42
807 - Vaginal delivery (w/out complications)	$6,631	$4,652	$2,873	1.43	2.31
Medical					
392 - Esophagitis	$6,888	$5,503	$4,315	1.25	1.60
440 - Disorders of pancreas	$5,969	$5,217	$3,745	1.14	1.59
603 - Cellulitis	$6,384	$4,681	$3,781	1.36	1.69
641 - Misc. disorders of nutrition	$7,351	$4,772	$4,084	1.54	1.80
690 - Kidney/U.T.I.	$6,525	$4,738	$3,887	1.38	1.68
Surgical					
470 - Major hip/knee replacement	$35,408	$16,483	$13,333	2.15	2.66
473 - Cervical spinal fusion	$87,679	$15,018	$16,176	5.84	5.42
621 - O.R. procedure for obesity	$26,311	$11,994	$11,662	2.19	2.26
Median Ratio	N.A.	N.A.	N.A.	1.48	2.26

Note: ACH excludes CAHs, SCHs, and Children's Hospitals. Allowed amounts excludes claims with OHI, claims outside the continental United States (OCONUS) and claims at Maryland hospitals that do not participate in the TRICARE DRG.

Appendix D

Comparison of TRICARE Hospital Outpatient Reimbursement Rates in FY20					
	Average Allowed Amount			Ratio of CAH Average Allowed Amount to Average Allowed Amount at:	
Type of OP Service (CPT)	**CAH**	**SCH**	**ACH**	**SCH**	**ACH**
Radiology (CT) (70450)	$556	$178	$182	3.12	3.05
Radiology (MRI) (73721)	$840	$245	$242	3.43	3.47
Radiology (CT) (74177)	$1,272	$384	$369	3.31	3.45
Lab (80053)	$61	$11	$11	5.55	5.55
Medical (EKG) (93306)	$707	$484	$463	1.46	1.53
Medical (sleep study) (95810)	$1,274	$901	$868	1.41	1.47
PT (97110)	$45	$30	$30	1.50	1.50
ER visit (99283)	$234	$220	$218	1.06	1.07
ER visit (99284)	$370	$374	$364	0.99	1.02
Colonoscopy (45380)	$770	$928	$889	0.83	0.87
Median Ratio	N.A.	N.A.	N.A.	1.48	1.51

Note: ACHs excludes CAHs, SCHs, and Children's Hospitals. Allowed amounts excludes claims with OHI, claims OCONUS, and claims at Maryland hospitals that do not participate in the TRICARE DRG.

Appendix E

Impacts of Rural Hospital Closures on TRICARE Access

Hospital (type)	Type of Closure/Year	Pre-Closure TRICARE Admissions/OP Costs	Closest Base (miles)	Impact on Access
Shands Live Oak RMC (CAH) Live Oak, FL (32064)	Inpatient (2020)	10 IP admissions (2017) $371,000 OP (2018)	Moody AFB (48)	Low; 2 IP facilities within 25 miles and ER still open
Shands Starke RMC (CAH) Starke, FL (32091)	Inpatient (2020)	21 IP admissions (2017) $697,000 OP (2016)	NAS Jacksonville (36)	Low; 5 IP hospitals within 30 miles and ER still open
CHCS-St. Marys (CAH) St. Marys, KS (66521)	Inpatient (2021)	21 IP admissions (2018) $225,000 OP (2017)	Fort Riley (41)	Low; one IP hospital within 15 miles
Sitka Community (CAH) Sitka, AK (99835)	Inpatient (2019)	30 IP admissions (2019) $1.1 million OP (2021)	USCG Sitka (1)	Low; IP hospital 2 miles away
St. Luke's Cushing (PPS) Leavenworth, KS (66048)	Inpatient (2020)	133 IP admissions (2017) $2.8 million OP (2018)	Ft. Leavenworth (3)	Low; 5 IP hospitals within 25 miles, 1 within 3 miles
Chillicothe (CAH) Chillicothe, TX (79225)	Inpatient (2019)	No IP admissions <$1,000 OP	Altus AFB (3)	Low; little to no TRICARE use before IP closures and 3 IP hospitals within 15 miles
Little River Rockdale (CAH) Rockdale, TX (76567)	Complete (2018)	1 IP admission (2017) $1.2 million OP (2016)	Ft. Hood (55)	Low; 2 IP hospitals within 30 miles
Shands Lake Shore RMC (PPS) Lake Shore, FL (32055)	Complete (2020)	24 IP admissions (2017) $171,000 OP (2018)	NAS Jacksonville (56)	Low; another IP hospital within 5 miles
Doctors Hospital at Deer Creek (PPS) Leesville, LA (71446)	Complete (2019)	27 IP admissions (2017) $514,000 OP (2018)	Ft. Polk (8)	Low; Byrd Community Hospital within 1 mile
Adventist Feather River (PPS) Paradise, CA (95969)	Complete (2018)	32 IP admissions (2018) $479,000 OP (2018)	Beale AFB (48)	Low; Enloe hospital within 14 miles and Oroville hospital within 22 miles