

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8-I-14

Subject: Modernizing TRICARE Payment Policies  
(Resolution 108-A-14)

Presented by: Jack McIntyre, MD, Chair

Referred to: Reference Committee J  
(Melissa J. Garretson, MD, Chair)

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1 At the 2014 Annual Meeting, the House of Delegates referred Resolution 108, “Modernizing  
2 TRICARE Payment Policies.” The resolution was sponsored by the Virginia, West Virginia,  
3 Kentucky, South Carolina, Maryland and California Delegations, and asked that the American  
4 Medical Association (AMA):

5  
6 help to insure the continued access of our nation’s military dependents and retirees to the  
7 services of civilian physicians by actively pursuing the modernization of TRICARE policies to  
8 reflect standard fair payment policies to physicians, specifically with regard to: a) accepting the  
9 “incident to” Medicare model for payment for mid-level provider services, if under the general  
10 supervision of a physician, b) paying for treatment of mental health conditions, regardless of  
11 the specialty of the treating physician, and c) covering the copayment of a Medicare patient  
12 who receives transition of care services (CPT 99495, 99496) by a physician.

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14 Reference committee testimony on this item reflected support for efforts to improve access to  
15 services through TRICARE and the need for more information regarding the specific TRICARE  
16 payment policies cited in the resolution. There was support for referral of Resolution 108-A-14,  
17 and it was assigned to the Council for a report back at the 2014 Interim Meeting.

18  
19 **BACKGROUND**

20  
21 TRICARE provides health insurance benefits to 9.6 million active and retired military personnel  
22 and their dependents. The program is operated by the Department of Defense and administered by  
23 three regional contractors in the United States and an overseas contractor. Contractors work with  
24 TRICARE’s West, North and South Regional Offices to purchase services from civilian providers  
25 and to coordinate medical services provided by civilian providers with services provided in military  
26 treatment facilities. TRICARE contractors are selected through a competitive bidding process, and  
27 are responsible for establishing TRICARE provider networks, providing information and customer  
28 service to beneficiaries and providers, and providing administrative support services, such as  
29 enrollment and claims processing.

30  
31 TRICARE offers three main coverage options: TRICARE Prime, TRICARE Standard and  
32 TRICARE Extra. Active military and reserve members are required to enroll in TRICARE Prime;  
33 other beneficiaries can participate in any of the three programs. TRICARE Prime enrollees receive  
34 most of their care directly from military treatment facilities, although some care may be provided  
35 by network civilian providers. TRICARE Extra and TRICARE Standard offer a wider range of  
36 provider choice, with cost-sharing based on whether patients receive care from network civilian

1 providers (TRICARE Extra) or non-network providers (TRICARE Standard). TRICARE Extra and  
 2 TRICARE Standard beneficiaries may also receive care from military treatment facilities.

3  
 4 Maintaining access to civilian providers under TRICARE has been a concern since the program  
 5 was created in 1995. As noted, beneficiaries enrolled in the TRICARE Prime program receive the  
 6 majority of their care from military treatment facilities, and rely less on civilian providers.  
 7 However, beneficiaries who access care through the TRICARE Extra or Standard programs have  
 8 consistently reported problems finding civilian providers who will accept TRICARE patients. A  
 9 2013 study issued by the United States Government Accountability Office (GAO) reported that  
 10 nearly one in three beneficiaries had difficulty finding a civilian provider. The most common  
 11 reason cited was that the practice did not accept TRICARE insurance. Among the reasons  
 12 providers cited for not accepting TRICARE patients were lack of awareness about the program,  
 13 reimbursement concerns and a negative perception of TRICARE as an insurer.<sup>1</sup>

14  
 15 RESOLUTION 108-A-14

16  
 17 Resolution 108-A-14 identified several specific payment policies that have the potential to lead to  
 18 access problems for TRICARE patients. In particular, Resolution 108-A-14 noted that TRICARE  
 19 limits its payment for services rendered by mid-level providers to 85 percent of the allowable  
 20 charge for the service, regardless of whether the provider is delivering services as part of a  
 21 physician-led team. Medicare and other payers have policies that allow practices to bill at the  
 22 physician rate for a service provided by qualified non-physician providers if certain conditions are  
 23 met related to the supervising physician’s involvement with the patient and with the provider. For  
 24 example, Medicare’s “incident to” billing rules allow payment under the physician fee schedule for  
 25 services provided by a non-physician provider as long as the services are related to treatment for a  
 26 condition originally identified by a personal interaction between the patient and the physician, and  
 27 the physician is present in the facility when the follow up care is being provided.<sup>2</sup> TRICARE does  
 28 not appear to have a mechanism that recognizes the contribution of mid-level providers in a team-  
 29 based care delivery model, and requires that a physician be present for at least a portion of the  
 30 patient encounter in order to bill at 100 percent of the allowable charge for the service.

31  
 32 A second issue highlighted in Resolution 108-A-14 relates to TRICARE coverage for mental health  
 33 services provided by primary care physicians. According to the resolution and follow-up  
 34 correspondence from the Virginia Delegation, some TRICARE regions are denying claims for  
 35 services rendered by primary care physicians for certain common mental health conditions. Current  
 36 TRICARE policies allow enrollees access to eight outpatient behavioral health care visits without  
 37 the need for referrals or prior authorizations, and TRICARE advises that a primary care provider  
 38 can “provide an initial assessment and possibly treatment” for non-emergency mental health  
 39 services.<sup>3</sup> Nevertheless, some enrollees have reported that some claims for mental health services  
 40 are being denied, and that the TRICARE regional authority has indicated the denials are because  
 41 primary care providers are not authorized to provide mental health services. Supplemental  
 42 information provided by the Virginia delegation indicates that this problem had previously been  
 43 addressed and resolved by TRICARE, but has recently re-emerged, and is effectively limiting  
 44 patient access to mental health services.

45  
 46 A third issue raised in Resolution 108-A-14 is TRICARE’s policy that excludes coverage for  
 47 Medicare copayments for transition of care services received by for TRICARE for Life  
 48 (TRICARE’s supplemental coverage for Medicare-eligible beneficiaries) enrollees. In 2013,  
 49 Medicare authorized payment for transitional care management services (CPT codes 99495 and  
 50 99496) provided to patients following a discharge from a hospital or skilled nursing facility. The  
 51 care management codes cover services such as time spent discussing a care plan, connecting

1 patients to community services, and monitoring adherence to treatment plans and the need for  
 2 follow up treating or treatment. Paying for these services helps support physicians in their efforts to  
 3 participate in new care delivery models that emphasize care coordination and facilitate  
 4 improvements in the overall quality of health care. Current TRICARE policy excludes payment for  
 5 these services, and TRICARE will not pay a Medicare copayment for services billed to Medicare.  
 6 This policy is inconsistent with health care delivery trends and evidence that suggests that  
 7 improved transition care management can help improve patient outcomes and reduce hospital  
 8 readmissions.

9  
 10 Finally, Resolution 108-A-14 raises concerns about inconsistent immunization coverage under  
 11 TRICARE. TRICARE policy is to cover vaccines that have been recommended and adopted by the  
 12 Advisory Committee on Immunization Practices (ACIP),<sup>4</sup> however supplemental information from  
 13 the Virginia Delegation indicates that beneficiaries and physicians are receiving conflicting  
 14 information about the coverage of certain vaccinations. In particular, some patients and physicians  
 15 have been advised that TRICARE covers Zostavax when administered to patients between ages 50  
 16 and 59, only to experience claim denials because TRICARE only covers the vaccine for people age  
 17 60 and over. This appears to be an error on the part of TRICARE representatives. TRICARE policy  
 18 explicitly states that it covers the shingles vaccine Zostavax only for beneficiaries age 60 and older.  
 19 This is consistent with ACIP guidelines. Although the Food and Drug Administration approved the  
 20 use of Zostavax for patients ages 50 to 59 in 2011, ACIP decided against updating its  
 21 recommendations, and continues to recommend the vaccine only for patients over age 60.<sup>5</sup>  
 22 Coverage of the Tdap (tetanus toxoid, reduced diphtheria toxoid and acellular pertussis) vaccine  
 23 also appears to be a source of confusion. Although ACIP guidelines recommend the Tdap vaccine  
 24 for adults under certain conditions (e.g., health care personnel, exposure to young children),<sup>6</sup> it is  
 25 unclear whether TRICARE offers coverage for adults. Confusion and inaccurate or incomplete  
 26 information regarding vaccine coverage can leave patients and physicians with unanticipated  
 27 financial burdens that could ultimately result in access issues for TRICARE patients.

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 29 **AMA POLICY AND ADVOCACY**

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 31 The Department of Defense is aware of access concerns associated with the TRICARE program  
 32 and supports ongoing efforts, through the Defense Health Agency and the TRICARE Regional  
 33 Offices, to monitor and address these issues. TRICARE is required to conduct an annual survey to  
 34 evaluate access to care issues, focusing particular attention on geographic areas that have been  
 35 identified by beneficiary and provider representatives as having significant access to care problems.  
 36 As part of these efforts, TRICARE representatives contact the AMA on an annual basis to solicit  
 37 input about areas that should be included in the survey. The AMA provides this input based on  
 38 responses to emails sent to state medical associations and national medical specialty societies  
 39 explicitly requesting information that can be shared with TRICARE. In recent years the AMA has  
 40 received only a limited number of responses from the Federation regarding specific TRICARE  
 41 access concerns.

42  
 43 As a result of Resolution 108-A-14 and follow up information submitted by the Virginia  
 44 Delegation, the AMA has initiated conversations with TRICARE regarding the coverage policies  
 45 and practices highlighted in the resolution. The AMA alerted TRICARE to these issues in August  
 46 2014, prior to the release of the 2014 TRICARE survey. At the time this report was written, it was  
 47 anticipated that the AMA would be meeting with TRICARE representatives in November 2014, to  
 48 discuss the results of TRICARE's annual access survey, and to further discuss the specific payment  
 49 policies and implementation issues raised in Resolution 108-A-14.

1 Council on Medical Service Report 2-I-08, "Acceptance of TRICARE Health Insurance,"  
2 examined TRICARE contracting and physician payment issues and patient access to care. Policy  
3 D-40.991, established with the adoption of the report, encourages state medical associations and  
4 national medical specialty societies to educate their members regarding TRICARE, including  
5 changes and improvements made to its operation, contracting processes and mechanisms for  
6 dispute resolution. It also encourages TRICARE to improve its physician education programs,  
7 including those focused on non-network physicians, to facilitate increased civilian physician  
8 participation and improved coordination of care and transfer of clinical information in the program;  
9 continue and strengthen efforts to recruit and retain mental health and addiction service providers  
10 in TRICARE networks, which should include providing adequate reimbursement for mental health  
11 and addiction services; implement significant increases in physician payment rates to ensure all  
12 TRICARE beneficiaries, including service members and their families, have adequate access to and  
13 choice of physicians; and increase payments for routine childhood immunizations.

14  
15 **DISCUSSION**

16  
17 The AMA is committed to ensuring access to care for active duty service members and retirees and  
18 their families through the TRICARE program. The availability of civilian physicians willing to  
19 accept TRICARE patients is critical to the success of the program, and the Council encourages all  
20 physicians to consider accepting TRICARE insurance. It should be noted that in most cases  
21 physicians may participate in TRICARE regardless of whether they participate in the Medicare  
22 program or are accepting new Medicare patients, although Medicare participation is generally  
23 required for authorization as an in-network provider. Policy D-40.991 supports broad AMA  
24 advocacy efforts to help ensure TRICARE patients have access to physicians. Continuing efforts to  
25 modernize TRICARE's payment policies will help ensure that physicians can afford to participate  
26 fully in the program and continue to provide care for military personnel and their dependents.

27  
28 Resolution 108-A-14 highlights specific TRICARE payment policies that may discourage  
29 physicians from serving TRICARE patients and compromise patient access to a full range of  
30 services that can help improve health and patient outcomes. In particular, TRICARE should be  
31 encouraged to modernize its payment policies so that they reflect and support trends in new, more  
32 effective models of care delivery, such as team based care and improved care coordination.  
33 TRICARE also needs to address inconsistencies in the implementation of its policies, particularly  
34 with respect to coverage of mental health and immunization services. As noted, the AMA has a  
35 strong working relationship with TRICARE, and annually raises specific concerns that are  
36 identified by state medical associations and national specialty medical societies. The AMA has  
37 already brought to the attention of TRICARE the issues raised in Resolution 108-A-14, and  
38 anticipates addressing these issues in more detail in the context of discussing the results of  
39 TRICARE's annual access survey later this year.

40  
41 The Council is encouraged that TRICARE leadership proactively approaches the AMA for input,  
42 and believes this relationship presents a valuable opportunity for physicians to communicate their  
43 concerns and suggestions for strengthening the TRICARE program. State medical associations and  
44 national medical specialty societies are strongly encouraged to respond to requests for information  
45 regarding specific concerns about the TRICARE program so that this information can be shared  
46 with TRICARE representatives.

47  
48 **RECOMMENDATIONS**

49  
50 The Council on Medical Service recommends that the following be adopted in lieu of Resolution  
51 108-A-14 and that the remainder of the report be filed:

- 1 1. That our American Medical Association (AMA) continue to encourage state medical  
2 associations and national medical specialty societies to respond to requests for information  
3 regarding potential TRICARE access issues so that this information can be shared with  
4 TRICARE representatives as they develop their annual access survey. (Directive to Take  
5 Action)  
6
- 7 2. That our AMA continue to advocate for changes in TRICARE payment policies that will  
8 remove barriers to physician participation and support new, more effective care delivery  
9 models, including:
  - 10 a. establishing a process to allow midlevel providers to receive 100 percent of the  
11 TRICARE allowable cost for services rendered while practicing as part of a physician-  
12 led health care team, consistent with state law, and
  - 13 b. paying for transitional care management services, including payment of copays for  
14 services provided to TRICARE for Life beneficiaries receiving primary coverage  
15 through Medicare. (New HOD Policy)  
16
- 17 3. That our AMA continue to advocate for improvements in the communication and  
18 implementation of TRICARE coverage policies to ensure continued patient access to  
19 necessary services, including:
  - 20 a. consistently approving full payment for services rendered for the diagnosis and  
21 treatment of common mental health conditions, regardless to the specialty of the  
22 treating physician, and
  - 23 b. clarifying policies with respect to coverage for age appropriate doses of vaccines that  
24 have been recommended and adopted by the Advisory Committee on Immunization  
25 Practices. (New HOD Policy)  
26
- 27 4. That our AMA reaffirm Policy D-40.991, "Acceptance of TRICARE Health Insurance."  
28 (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

## REFERENCES

<sup>1</sup> US Government Accountability Office. Defense Health Care. TRICARE Multiyear Surveys Indicate Problems with Access to Care for Nonenrolled Beneficiaries. April 2013. Available at:

<http://www.gao.gov/products/gao-13-364>

<sup>2</sup> Centers for Medicare and Medicaid Services. MLN Matters, "Incident to" Services, Number SE0441.

Available at: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0441.pdf>

<sup>3</sup> TRICARE Behavioral Health Services Fact Sheet. October 2013. Available at:

<http://tricare.mil/mentalhealth>

<sup>4</sup> <http://www.tricare.mil/vaccines>

<sup>5</sup> <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6044a5.htm>

<sup>6</sup> <http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/tdap-td.html>