CHILDREN'S HOSPITAL ASSOCIATION

600 13TH ST., NW, SUITE 500
WASHINGTON, DC 20005
p | 202-753-5500
f | 202-347-5147

16011 COLLEGE BLVD., SUITE 250
LENEXA, KS 66219
p | 913-262-1436
f | 913-262-1575

WWW.CHILDRENSHOSPITALS.ORG

July 21, 2023

Dr. Lester Martinez-Lopez
Assistant Secretary of Defense for Health Affairs
1200 Defense, Pentagon Room 3E1070
Washington, DC 20301

Lieutenant General Telita Crosland, USA
Director, Defense Health Agency
Department of Defense
7700 Arlington Blvd
Falls Church VA 22024

Dear Dr. Martinez-Lopez and General Crosland:

On behalf of the children's hospitals that care for children in military-connected families in the United States, we are writing to seek a delay in the implementation of the final rule, *TRICARE; Reimbursement of Ambulatory Surgery Centers and Outpatient Services Provided in Cancer and Children's Hospitals*. We are committed to working in partnership with the Department of Defense (DoD) and the Defense Health Agency (DHA) to ensure that the 2.4 million children in military and veteran families[1] have access to appropriate, timely and high-quality specialized pediatric services. Therefore, we ask for sufficient time to address the technical and operational challenges of the rule's reimbursement methodology changes and its potential impact on our ability to continue to provide essential services to military families in our communities. **At a minimum, we ask that the rule's effective date be delayed until at least the time that the new T-5 Tricare Managed Care Support contract goes into effect.**

Children's hospitals serve an essential function in ensuring that children in military-connected families, including children with medical complexity who are covered by TRICARE, have access to needed pediatric health care services. Military families face certain stressors—deployment, reintegration, frequent relocation, and life in remote locations, among others—which can impact their overall health and well-being. As a result, children covered by TRICARE are more likely to have special health care needs and to have a behavioral health diagnosis compared to children with other insurance types.[2] These children rely on the highly specialized pediatric care that can only be found at children's hospitals.

We appreciate that TRICARE has exempted independent children's hospitals from the Medicare Outpatient Prospective Payment System (OPPS) since 2008 and, instead, maintained the reimbursement methodology for children's hospitals that was in effect prior to the adoption of OPPS. As you know, children's hospitals' experience with the Medicare payment system is limited to their care for children with End-Stage Renal Disease who account for, on average, less than 1% of their payor mix. Furthermore, children's hospitals' contracts with commercial payers typically do not rely on Medicare payment methodologies given Medicare's adult focus. The OPPS exemption has meant that military children continue to have timely access to needed specialty and subspecialty care without unnecessary barriers stemming from the imposition of adult-focused Medicare policies on child-focused providers.

Children's hospitals will need more time to analyze the implications for their individual institutions and make the requisite system changes to allow them to comply with OPPS. Most children's hospitals do not have software and systems set up or their staff trained to conduct computations under Medicare OPPS given their extremely limited Medicare and commercial business that utilize OPPS for pediatrics. At the same time, they are facing the operational challenges of modifying claims and other complex processes in preparation for the upcoming transition to the T-5 Tricare Managed Care Support contract, while continuing to have workforce shortages coming out of the recent surge in childhood respiratory illnesses, like respiratory syncytial virus (RSV) and ongoing pediatric mental health crisis.

In addition, children's hospitals' finance experts need more time and information to accurately determine the specific economic impacts of these changes. Absent sufficient time for technological and administrative adaptations and financial

modeling, it is not possible for children's hospital finance experts to accurately determine and plan for the specific administrative and financial impact of these changes. Furthermore, allowing time for a comprehensive analysis can help forestall any unintended negative impacts on children's access to care that could result from moving too quickly to implement this substantial policy change. For example, the majority of children's hospitals' patients are covered by Medicaid and it is not uncommon for children's hospitals to have high rates of undercompensated care, which could exacerbate any potential financial impacts from the changes in this rule. Hospitals that may experience financial losses under the rule will also need time to develop mitigation strategies to prevent undue barriers to military-connected children's access to needed care.

To that end and to support the financial modeling necessary to fully understand impact, we respectfully ask for additional information regarding the underlying assumptions and methods that were used in the DoD's fiscal impact analysis, including:

- Clarification of the data sources used to conduct the analysis and more detail on the analytical approach used to determine fiscal impact.
- An impact analysis for each outpatient service category (e.g., emergency department, surgical, outpatient clinics) that will be subject to the new methodology.
- Clarification of whether drugs, implantables and other related pediatric therapeutics are subject to the new methodology. If they are, can DoD provide its analysis of the financial impact of those items, particularly high-cost drugs?

The rule states that the economic impact for children's hospitals would have been $35 million if the rule had been implemented in 2021. However, the rule does not provide sufficient information about how that impact is determined. Absent more detailed cost analysis information, children's hospitals are not able to conduct in-depth or exact modeling to determine the specific financial impact on their institutions and possible mitigation strategies to avoid negative implications for children's health. Regardless, the loss of a total of $35 million in payments to the independent children's hospitals that serve the most vulnerable children in military families is particularly problematic given they continue to face significant challenges with the ongoing youth mental health crisis and workforce, drug and supply shortages.

In conclusion, we urge DoD to delay the implementation of this rule and work with the nation's children's hospitals, particularly those that have higher TRICARE volumes, to further evaluate whether this reimbursement change is, in fact, practicable given children's hospitals' extremely low Medicare volumes and the resulting challenges the rule's changes present. We look forward to working with you to address our questions and concerns.

Thank you for your continued efforts and interest in collaborating with us to ensure that children in military families have timely access to the lifesaving and specialized pediatric care that children's hospitals provide. If you have any questions, please contact Jan Kaplan at the Children's Hospital Association at jan.kaplan@childrenshospitals.org or 202-753-5384.

Sincerely,

Aimee C. Ossman

Aimee Ossman
Vice President, Policy
Children's Hospital Association