



PERSONNEL AND  
READINESS

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

18 FEB 2020

The Honorable James M. Inhofe  
Chairman  
Committee on Armed Services  
United States Senate  
Washington, DC 20510

Dear Mr. Chairman:

The enclosed report is in response to section 726 of the National Defense Authorization Act for Fiscal Year 2016 (Public Law 114-92), which requires the Department of Defense to provide a report to Congress on a value-based demonstration in the purchased care component of the TRICARE program.

The Defense Health Agency (DHA) commenced a value-based demonstration for Lower Extremity Joint Replacement and Reattachment surgeries and post-operative care in the Tampa-St. Petersburg, Florida, market on May 23, 2016. The 3-year demonstration was designed to test whether value-based incentives are effective tools for improving health care quality and reducing the rate of increase in health care spending over time.

Due to the low number of overall episodes, DHA was not able to ascertain with certainty the effect of this demonstration on cost or quality trends. However, DHA did obtain useful information regarding the administrative requirements of implementing a value-based purchasing program. Value-based purchasing programs are new to TRICARE and require additional administrative processes and procedures to ensure effective implementation. The lessons learned from this demonstration project will inform DHA's efforts to establish standard operating procedures in implementing alternative provider reimbursement methodologies in support of value based care.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families. I am sending identical letters to the other congressional defense committees.

Sincerely,

A handwritten signature in black ink, appearing to read "Matthew P. Donovan".

Matthew P. Donovan  
Performing the Duties of the Under Secretary of  
Defense for Personnel and Readiness

Enclosure:  
As stated



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

18 FEB 2020

Dear Senator Reed:

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

Dear Mr. Chairman:

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The Honorable William M. "Mac" Thornberry  
Ranking Member  
Committee on Armed Services  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Thornberry:

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The Honorable Richard C. Shelby  
Chairman  
Committee on Appropriations  
United States Senate  
Washington, DC 20510

18 FEB 2020

Dear Mr. Chairman:

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The Honorable Patrick J. Leahy  
Vice Chairman  
Committee on Appropriations  
United States Senate  
Washington, DC 20510

Dear Senator Leahy:

The enclosed report is in response to section 726 of the National Defense Authorization Act for Fiscal Year 2016 (Public Law 114-92), which requires the Department of Defense to provide a report to Congress on a value-based demonstration in the purchased care component of the TRICARE program.

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The Honorable Nita M. Lowey  
Chairwoman  
Committee on Appropriations  
U.S. House of Representatives  
Washington, DC 20515

Dear Madam Chairwoman:

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The Honorable Kay Granger  
Ranking Member  
Committee on Appropriations  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Granger:

The enclosed report is in response to section 726 of the National Defense Authorization Act for Fiscal Year 2016 (Public Law 114-92), which requires the Department of Defense to provide a report to Congress on a value-based demonstration in the purchased care component of the TRICARE program.

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## **Report to Congressional Defense Committees**



### **Pilot Program on Incentive Programs to Improve Health Care Provided under the TRICARE Program**

**In Response to: Section 726 of the National Defense Authorization  
Act  
for Fiscal Year 2016 (Public Law 114-92)**

**The estimated cost of this report or study for the Department of Defense (DoD) is approximately \$3,200.00. This includes \$0.00 for expenses and \$3,200.00 in DoD labor.**

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# **Pilot Program on Incentive Programs to Improve Health Care Provided Under the TRICARE Program**

## **1) Executive Summary:**

This final report summarizes the Department of Defense's (DoD) efforts to-date regarding a value-based demonstration, which was implemented on May 23, 2016, consistent with section 726 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2016 (Public Law 114-92). The Defense Health Agency (DHA) conducted the Lower Extremity Joint Replacement or Reattachment (LEJR) demonstration in the Tampa-St. Petersburg, Florida market, using a modified version of the Comprehensive Care for Joint Replacement (CJR) program—a Centers for Medicare & Medicaid Services (CMS) value-based model implemented in April 2016. This report provides the final results of the demonstration for LEJR surgeries spanning from May 2016 through June 2018. Preliminary data from years one and two of the demonstration suggest that total episode costs for LEJR surgeries at demonstration hospitals are higher than those at cohort hospitals (an average of \$21,509.00 vs. \$19,375.00, respectively). Due to the low number of episodes, it is not possible to draw any cost savings or quality-of-care conclusions. Data from year three (the final year) of the demonstration is currently pending. Despite the lack of data for year three, DHA is filing this final report, as we do not anticipate the data from year three to modify these findings. However, as a result of these findings, DHA will put forth new processes and procedures to ensure all current and future value-based demonstrations are effectively and accurately implemented.

## **2) Background:**

Section 726(d)(1) of the NDAA for FY 2016 required the implementation of a program to determine whether value-based payment incentives could effectively reduce the rate in increase of health care spending and improve health care quality. The DoD was required to submit a final report to the congressional defense committees by September 30, 2019.

The LEJR demonstration was designed to encourage hospitals, physicians, and post-acute care providers to work collaboratively on an “episode of care” basis to improve health care quality and optimize coordination of services from the initial hospitalization through the recovery period. The demonstration was designed to aggregate payments for LEJR surgeries without major complications or comorbidities (Diagnosis Related Group 470) and 90 days of related post-operative care at certain hospitals in the Tampa-St. Petersburg market, and to reward hospitals that lower costs while maintaining satisfactory quality. Seven demonstration hospitals were identified, along with a “control group” cohort consisting of all other hospitals in the Tampa market, and target episode prices were calculated for each demonstration hospital based on historical TRICARE claims data. Target episode prices were adjusted annually for inflation and to reflect changes in the rate blend over time (hospital-specific vs. market-wide prices).

In demonstration years one and two, the blended rate for the target episode price was based on two-thirds hospital-specific data and one-third market-wide data. In demonstration year three, the target episode price was based on one-third hospital-specific data and two-thirds market-wide data. To ensure fair cost comparisons between hospitals, adjustments were also

made for Indirect Medical Education costs and extreme cost outliers (i.e., episodes with a total cost higher than two Standard Deviations [SDs] above the Tampa-wide average were truncated at the two-SD threshold).

Beginning in demonstration year one (episodes starting on or after May 23, 2016, and ending by September 30, 2017), hospitals were eligible for gain-sharing payments if they achieved and maintained a satisfactory quality performance rating and if actual episode costs were lower than the target episode price. This approach ensured that hospitals did not sacrifice health care quality in order to lower overall costs. Quality performance ratings were derived from the CMS composite quality score for their CJR program. The CMS composite quality score is a hospital-level summary quality score reflecting performance and improvement on the quality measures adopted for CMS's CJR model (Total Hip Arthroplasty/Total Knee Arthroplasty) complications measure and the Hospital Consumer Assessment of Healthcare Providers and Systems patient experience survey measure. Hospital-level incentives (in the form of gain-sharing payments) were based on total TRICARE allowable charges for LEJR surgeries in comparison to the target episode price for each hospital. Gain-sharing payments in demonstration years one and two were equal to five percent of the total cost-savings for a particular demonstration hospital during the applicable year. This amount increased to 10 percent in demonstration year three. Hospitals would also incur loss-sharing penalties if actual episode costs exceed the target episode price. Loss sharing was 0 percent in demonstration year one, 5 percent in demonstration year two, and 10 percent in demonstration year three.

### **3) Discussion:**

Historically, approximately 100 TRICARE beneficiaries received LEJR surgery in the Tampa-St. Petersburg, Florida market annually. During the first 2 years of the demonstration (LEJR admissions from May 2016 through June 2018), there were 227 LEJR admissions in the demonstration and cohort hospitals (129 and 98, respectively). Additional admissions occurred in year three; however, the nature of this episode-based demonstration (hospital admission plus 90 days of post-operative care, plus claims submission and processing time) creates a significant lag time before all data are available. Therefore, data from the third demonstration year are not yet available.

Based on LEJR episodes with post-operative claims ending by September 30, 2018, total episode costs for LEJR surgeries at demonstration hospitals were higher than those at cohort hospitals (average of \$21,509.00 vs. \$19,375.00, respectively). See Figure 1.

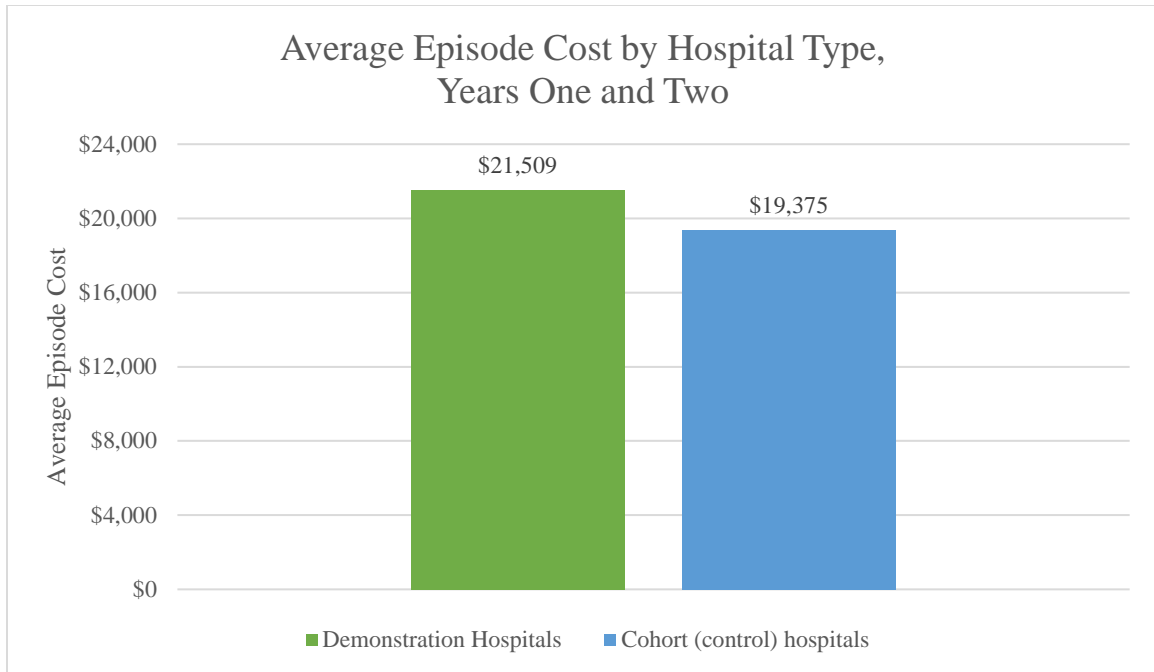


Figure 1

However, it should be noted the demonstration hospitals showed comparatively higher costs and trends prior to the demonstration. Additionally, there was significant volatility in the annual cost trends, both for the demonstration and cohort hospitals, in the years preceding the demonstration (for FYs 2013, 2014, and 2015). Prior to the introduction of the LEJR Demonstration, annual cost trends for demonstration hospitals increased by 9 percent in FY 2014 followed by a 5 percent decrease in FY 2015, while cohort hospitals went up by 6 percent in FY 2014 followed by a decrease of 12 percent in FY 2015. After the introduction of the LEJR Demonstration, annual cost trends for demonstration hospitals increased by four percent followed by another increase of three percent. Cohort hospitals saw an increase of three percent and then in year two, no change.

The number of completed episodes (hospital admission and 90-day post-discharge period) to date is still quite low, and, therefore, a few episodes could sway average costs per episode. For these reasons, we are unable to draw meaningful conclusions about the impact of the LEJR demonstration on cost trends.

Based on the information available for demonstration year two, four of the seven demonstration hospitals delivered care in which the total episode cost was lower than the target episode price. All four of these hospitals achieved and maintained a satisfactory composite quality score, which was based on CMS analysis published in June 2019. Therefore, in the second year, based on the cost and quality results, four of the seven demonstration hospitals were eligible for five percent gain-sharing incentive payments totaling \$2,511.00. The remaining three hospitals were subject to loss-sharing payments to DHA totaling \$2,223.00 because their actual episode costs exceeded the target episode price.

Another confounding factor was that the implementation and operation of this demonstration were complicated by the changeover in contractors for the region, as well as internal communications issues between DHA and the contractor. DHA has identified lessons-learned from these issues and will apply them to future value-based initiatives. Key lessons include: (1) enhanced oversight of contractors implementing these programs, especially during transitions; (2) improved succession planning; and (3) a need for ongoing and enhanced communication between the contractor and DHA regarding ongoing operations of the initiative.

#### **4) Conclusions:**

The DHA's design of this LEJR Value-based Demonstration supports both NDAA for FY 2016 requirements as well as the Military Health System's (MHS) vision of increasing the value of health care to the warfighter and military family.

The number of admissions for the first two years of the LEJR demonstration remained low (129 demonstration hospital admissions and 98 cohort hospital admissions through June 2018). Therefore, a few higher- or lower-cost episodes in the demonstration period relative to the historical year could sway average costs per episode in either group. It is also difficult to confidently assess differences in the hospitals' episode cost trends because of the volatility in the annual cost trends in the years preceding the demonstration, both for the demonstration hospitals (up 9 percent and then down 5 percent) and the cohort hospitals (up 6 percent and then down 12 percent). During the demonstration, costs for demonstration hospitals increased by four percent and then by three percent, while cohort hospitals increased by three percent and then in year two, no change (demonstration year one and year two, respectively). These results occurred naturally and were not driven by the LEJR demonstration.

The CMS CJR Model has had some success in reducing payments while maintaining quality of care. However, given the difference in episode volumes, population demographics, and issues with implementation, DHA did not achieve these same results. Further, due to the small sample sizes and volatility in pricing, DHA is not able to ascertain with certainty the effect of this demonstration on cost or quality trends. However, by conducting this demonstration, DHA obtained useful information regarding the administrative requirements of implementing a value-based purchasing program. Specific key lessons learned include: (1) enhancing contract oversight of these programs, especially during contract transitions; (2) improving succession planning processes; and (3) improving communication between the DHA and contractors responsible for implementation and operation of programs. Value-based purchasing programs are new and require additional processes and procedures to ensure effective implementation with providers. Given that each value-based purchasing model is unique, DHA will establish standard operating procedures to reflect this new way of reimbursing providers. DHA is currently administering or implementing six value-based purchasing programs. See Figure 2.

<b>NAME</b>	<b>OUTLINE</b>	<b>PROGRAM START/END DATE</b>
Medication Adherence Pilot	Promote adherence to medication regimens for targeted populations of covered beneficiaries	February 1, 2018 – December 31, 2022
Performance-Based Maternity Payments Pilot	Provide incentives to hospitals that achieve and maintain excellence in maternity care quality	April 1, 2018 – March 31, 2021
Network Requirements & Standards for Urgent Care Centers (UCC)	Improve access to UCC services in both military treatment facilities (MTFs) / Enhanced Multi-Service Markets (eMSMs) and TRICARE Preferred Provider Network when MTFs/eMSMs are unavailable or unable to provide such services	Implemented January 1, 2018  Permanent change, nationwide
Hospital Value-Based Purchasing	Nationwide initiative which will reward acute-care hospitals with incentive payments for the quality of care	Estimated implementation 2020
Home Health Value-Based Purchasing	Nationwide initiative to provide better care and patient outcomes at a lower cost. It will move home health agencies away from the traditional fee-for-service model to outcomes-based model	Estimated implementation 2020
Accountable Care Organization Demonstration	Help DHA assess whether value-driven incentives can reduce health care spending and improve health care quality for TRICARE beneficiaries	Implemented September 30, 2019. Start of health care delivery January 1, 2019

Figure 2

While results and data to-date for the LEJR demonstration do not support a finding of reduced costs or improved quality as a direct result of this demonstration, the benefit to the MHS is operational experience with value-based purchasing. These lessons are critically needed to strengthen the knowledge base and to inform future design of value-based purchasing programs that may reduce costs and improve the quality of care for patients.

DHA will draw from the lessons learned from the LEJR demonstration as it implements additional demonstrations. In addition to the LEJR demonstration, DHA is continuing exploration with value-based care to improve patient outcomes, align provider incentives, and manage health care spending.