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

PERSONNEL AND
READINESS

JAN 31 2018

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

Dear Mr. Chairman:

The enclosed report is in response to section 701(h)(3) and section 705(d) of the National Defense Authorization Act for Fiscal Year 2017 (Public Law 114-328), which require the Department of Defense to provide a report to the Committees on Armed Services of the Senate and House of Representatives on a value-based pilot in the purchased care component of the TRICARE program and the Department's implementation plan and contract modification efforts with respect to these programs.

The Defense Health Agency is currently engaged in the design and implementation of six distinct value-based pilots and initiatives, which will be modified into the TRICARE 2017 Managed Care Support Contracts over the next 6 to 18 months. Pilot features include copayment or cost share reductions as well as exemptions of certain services from deductible requirements. At least four value-based pilots are projected to be implemented in 2018: the first commencing on January 1, the second on April 1, and two pilots commencing no later than July 1. We anticipate contract modifications and associated contract data requirements lists to be issued 2-4 months prior to a pilot implementation.

A similar letter is being sent to the Chairman of the Committee on Armed Services of the Senate. Thank you for your interest in the health and well-being of our Service members, veterans, and their families.

Sincerely,

Robert L. Wilkie

Robert L. Wilkie

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

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

PERSONNEL AND
READINESS

JAN 31 2018

The Honorable John McCain
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

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Sincerely,

Robert L. Wilkie

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member

# Report to the Armed Services Committees on

# Pilot Program on Incorporation of Value-Based Health Care in Purchased Care Component of TRICARE Program

**Section 701(h)(3)**
**National Defense Authorization Act for Fiscal Year 2017 (Public Law 114-328)**

**The estimated cost of the report for the Department of Defense (DoD) is approximately $3,300. This includes $100 in expense and $3,200 in DoD labor. Generated on 01 Jun 2017 and 01 Aug 2018**
**RefID: 9-38036EF and 3-6E596F7**

# AND

# Implementation Plan – Value-Based Incentives Under

**Section 705(d)**
**National Defense Authorization Act for Fiscal Year 2017 (Public Law 114-328)**

**The estimated cost of this report or study for the DoD is approximately $5,190.00 for the 2017 Fiscal Year. This includes $50.00 in expenses and $5,140.00 in DoD labor. Generated on June 29, 2017**
**RefID: 3-6E596F7**

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# Report on Pilot Program on Incorporation of Value-Based Health Care in Purchased Care Component of TRICARE Program

# AND

# Report on Implementation Plan – Value-Based Incentives/Managed Care Support Contract Strategy for TRICARE

## EXECUTIVE SUMMARY

This report is in response to section 701(h)(3) of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2017 (Public Law 114–328), regarding the pilot program on incorporation of value-based health care in the purchased care component of the TRICARE program and section 705(d) of the NDAA for FY 2017 (Public Law 114-328), regarding the Department's implementation plan and contract modification efforts with respect to TRICARE value-based incentive programs associated with section 705(a).

The Defense Health Agency (DHA) is currently engaged in the design and implementation of six distinct value-based pilots and initiatives, which will be modified into the TRICARE 2017 (T-2017) Managed Care Support Contracts (MCSCs) over the next 6 to 18 months. Some features of the pilots include co-payment or cost share reductions, as well as exemptions of certain services from deductible requirements. At least four value-based pilots are projected to be implemented in 2018: the first commencing on February 1, the second on April 1, and two pilots commencing no later than July 1. The Department of Defense (DoD) anticipates contract modifications and associated contract data requirements lists to be issued 2-4 months prior to a pilot implementation. Additionally, the DHA is exploring the opportunity to establish markets where the MCSCs assume more risk for the cost and quality of care provided.

The DoD believes these incentive programs will enable the Military Health System (MHS) to achieve greater value for the warfighter and the military family. The DoD will support the DHA's approach of transitioning from the standard fee-for-service (FFS) payment model to a new value-based/quality driven purchasing reimbursement model with three lines of effort that include: (1) alternative payment models which utilize provider incentives to reward high-value care; (2) value-based insurance design strategies which focus on changing beneficiary behavior to improve outcomes; and (3) high-value network design which is built to continuously develop and improve flexible networks of high-value providers.

## NDAA REQUIREMENTS

Section 701(h)(3) of the NDAA for FY 2017 (Public Law 114–328), provides that "not later than January 1, 2018, the Secretary of Defense shall carry out a pilot program to demonstrate and assess the feasibility of incorporating value-based health care methodology in the purchased care component of the TRICARE program by reducing co-payments or cost shares

for targeted populations of covered beneficiaries in the receipt of high-value medications and services and the use of high-value providers under such purchased care component, including by exempting certain services from deductible requirements."

Section 705(d) of the NDAA for FY 2017 (Public Law 114-328), requires the DoD to "not later than 60 days before the date on which the Secretary of Defense first modifies a contract awarded under chapter 55 of title 10, United States Code, to implement a value-based incentive program under sub-section (a), or the managed care support contract acquisition strategy under subsection (c), the Secretary shall submit to the Committees on Armed Services of the Senate and House of Representatives a report on any implementation plan of the Secretary with respect to such value-based incentive program or managed care support contract acquisition strategy."

## BACKGROUND

Under a traditional FFS reimbursement model, health care providers receive payments based on the volume of care they provide; regardless of the quality of the care or impact on the patient's health. This model can fragment the delivery of health care and inadvertently reward providers for providing low value tests, services, or procedures that are not correlated with positive health outcomes. Value-Based Health Care seeks to reward value over volume, with value generally being expressed in terms of improved health outcomes, enhanced experience of care for the patient, and reduced health care costs over time. Emphasis is given to transparency, accountability, standardized performance measurement, and "clinical nuance" – recognizing medical services vary in the amount of actual health they produce, and payments on how well a particular service, procedure, or medication helped keep patients healthy or returned them to a higher state of health.

The current TRICARE program already incorporates multiple value-based aspects. For example, many preventive services are provided without cost to TRICARE beneficiaries, regardless of the beneficiaries' plan (e.g., colorectal, breast, cervical or prostate cancer screening, and immunizations). The TRICARE Pharmacy program incorporates value-based principles to ensure that beneficiaries have access to high-value medications to manage their chronic medical conditions (at low or no cost), while assigning higher out-of-pocket costs for drugs offering less value in terms of clinical outcome or cost-effectiveness.

The TRICARE-2017 (T-2017) generation of TRICARE contracts incorporates multiple quality and value-based requirements, including a requirement for the MCSCs to operate a Clinical Quality Management Program (CQMP). The CQMP contains Quality Improvement Projects, which are activities designed to achieve measurable improvements in processes and outcomes of care. Next are Clinical Quality Studies; these are an assessment conducted for the purpose of improving patient care through peer analysis, intervention, resolution of the problem, and follow-up. Finally, CQMPs can include the review and investigation of potential and verified quality issues (deviation from acceptable standards of practice), and other quality-based initiatives. These are all examples of the MHS's ongoing efforts to replace a FFS approach to payments based on value, not volume. Demonstrated maturity of the TRICARE quality model will provide a sound foundation for aligning health care quality outcomes with future value-based projects.

Finally, in the area of value-based incentive programs, the DHA is currently engaged in the design and implementation of six distinct value-based pilots and initiatives, which will be modified into the T-2017 MCSC over the next six to 18 months. These pilots include:

1. *Medication Adherence Pilot (sections 701 and 705):* The pilot is approved for implementation nationwide on February 1, 2018, and is designed to promote adherence to medication regimens for targeted populations of covered beneficiaries by reducing or eliminating co-pays for preferred diabetes and cardiovascular agents and crediting the amount towards the deductible/catastrophic cap. If successful, this pilot can be expected to improve health outcomes and enhance beneficiary experience of care by reducing or eliminating any financial barriers to medication adherence.

2. *Performance-Based Maternity Payments (P-BMP) Pilot (sections 701 and 705):* The pilot is approved for implementation nationwide on April 1, 2018, and will provide incentives (both monetary and non-monetary) to hospitals that achieve and maintain excellence in maternity care quality. MCSCs will be incentivized to improve network quality over time and promote greater transparency regarding maternity care quality at participating purchased care sector hospitals helping beneficiaries better understand the risks and benefits associated with specific maternity care. If successful, this pilot can be expected to improve health outcomes, reduce unnecessary services and enhance beneficiary experience of care by providing clear, easy-to-understand maternity care quality ratings.

3. *Pre-Surgical Decision Support Pilot (section 729—info only, not required to be reported):* The pilot will commence on July 1, 2018, in select markets in the West region, and will prepare beneficiaries to better navigate the surgical decision process and facilitate shared decision making between beneficiaries and their providers. If successful, this pilot should result in immediate reductions in surgical costs and overall medical costs, increased beneficiary satisfaction, improved health literacy rates, and better clinical outcomes with lower lengths of stay, fewer hospital admissions and re-admissions.

4. *High-Value Primary Care Provider (High-Value PCP) Pilot (sections 701 and 705):* The pilot will commence nationwide on July 1, 2018, and will promote better health outcomes with incentives for primary care providers who exceed certain quality thresholds, as well as incentives for beneficiaries who engage with them (through reduced cost-shares/co-payments and/or enrollment fees). If successful, this pilot will improve health outcomes and decrease costs since beneficiaries who are not effectively managed in the primary care setting may not receive appropriate medical intervention until their disease state deteriorates, leading to increased emergency room visits, unnecessary hospitalizations, and poor health outcomes. It will also have the benefit of increasing consistency of standards for primary care across both direct and purchased care.

5. *Diabetes Prevention Program (section 729—info only, not required to be reported):* The program will most likely commence in targeted markets in the West region on July 1 and will focus on the pre-diabetic population (possible expansion to include

hypertension and hyperlipidemia), providing a targeted online curriculum/educational resources and assistance in identifying and achieving healthy lifestyle choices to prevent progression into diabetes, and access to health coaches. Beneficiaries who meet participation milestones and maintain their progress over time will receive reduced TRICARE enrollment fees in the following year. If successful, this program will prevent or delay the progression of chronic diseases and improve health outcomes.

6. *Obesity/Weight Management Program (section 729—info only, not required to be reported):* This program will commence most likely commence in targeted markets nation-wide on July 1, and will establish healthy weight loss/weight management participation milestones and offer beneficiary incentives (in the form of reduced TRICARE enrollment fees) for making progress towards achieving a healthy Body Mass Index. If successful, this program will help overweight and obese children and adults to achieve long term physical health improvements, healthy lifestyle habits, thus reducing healthcare cost and improving quality of life.

**DISCUSSION**

The MHS vision of achieving greater value for the warfighter and the military family is enabled by an aggressive shift to value-based care. In support of that vision and as part of MHS reform directed in the NDAA for FY 2017, the DHA is pursuing an approach of transitioning from the standard FFS payment model to a new value-based/quality driven purchasing reimbursement model with three lines of effort that include: (1) alternative payment models which utilize provider incentives to reward high-value care; (2) value-based insurance design strategies which focus on changing beneficiary behavior to improve outcomes; and (3) a high-value network design which is built to continuously develop and improve flexible networks of high-value providers.

The six value-based pilots and initiatives that are currently being developed are in alignment with the DHA's goals and will span all three lines of effort to achieve the MHS objectives for value-based purchasing. These actions should provide the Department with a comprehensive, rigorous evaluation of the feasibility of incorporating value-based health care in the purchased care component of the TRICARE program. The DHA will use successful aspects of these pilots in the direct care system where applicable. The DHA is also meeting regularly with the MCSCs to explore additional value based initiatives including the application of bundled payments and opportunities around financial risk sharing. The DHA will continue to explore these and other value-based opportunities via a continuous process of identifying, prioritizing, testing, evaluating, and ultimately scaling the most successful initiatives that will add value to the TRICARE program.

**REPORT ELEMENTS**

**Section 701(h)(3) of the NDAA for FY 2017 (Public Law 114–328) / Pilot Program on Incorporation of Value-Based Health Care in Purchased Care Component of TRICARE Program**

A. List of Each High-Value Medication and Service

1. *Medication Adherence Pilot:* This pilot encourages medication adherence by reducing or eliminating co-payments for select high-value medications that treat hyperlipidemia and diabetes. Active Duty and Active Duty Family Member Prime beneficiaries have a zero dollar co-pay on all medications. The two medications with reduced or eliminated co-payments are:

   a. Lantus Pens for Diabetes

   b. Rosuvastatin/generic Crestor for Hyperlipidemia

   *High-Value Primary Care Provider (High-Value PCP) Pilot:* This pilot encourages and rewards excellence in the primary care setting by establishing incentives for both beneficiaries and High-Value PCPs for beneficiaries with chronic diseases and other complex medical conditions. The High Value-PCP pilot is a preliminary and initial step and is necessary to identify the specific chronic conditions with the providers directly applicable to section 701(h)(3). These chronic conditions includes "diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, coronary artery disease, mood disorders, and such other diseases or conditions as the Secretary considers appropriate." Beneficiaries receiving care from one of these High-Value PCPs will have their cost-shares and/or co-payments reduced or eliminated. The High-Value PCPs will be eligible to receive additional provider payments or a reduction or elimination of their TRICARE network discount as long as the provider continues to meet appropriate benchmarks. The High-Value PCP cannot be implemented earlier than July 1, 2018, due to the full commitment of Defense Manpower Data Center resources to implement TRICARE Select and T-2017 changes.

2. *Performance-Based Maternity Payment Pilot:* This pilot provides network incentives for high quality care, while promoting greater transparency regarding maternity quality at participating purchased care sector hospitals to lower delivery related complications. The pilot will also incentivize the MCSCs to improve network quality over time, while simultaneously promoting greater transparency regarding maternity quality at participating purchased care sector hospitals, which will help beneficiaries understand the risks and benefits associated with specific delivery choices and facilitate meaningful dialogue with their OB providers. If successful, this pilot can be expected to improve health outcomes, reduce unnecessary services such as early elective deliveries which lack medical necessity, and enhance beneficiary experience of care by providing clear, easy-to-understand maternity care quality ratings.

Quality measures will include:

1. Early elective deliveries
2. C-sections
3. Episiotomies
4. Maternity care processes;
5. High-risk deliveries (very low birth weight babies; at least 50 deliveries per year).

B. Co-payments and Cost Shares

1. Medication Adherence Pilot

   a. Lantus Pens for Diabetes: The current co-payment for the selected brand agent (Lantus) is $20 at the mail order pharmacy and $24 at retail pharmacies. The pilot will eliminate the mail order co-payment and reduce the retail co-payment to $10. The selected brand-name medications will have Uniform Formulary Tier-1 co-payment applicable at the point of service.

   b. Rosuvastatin/generic Crestor for Hyperlipidemia: The current co-payment for the selected generic agent (Rosuvastatin) for hyperlipidemia at retail point of service is $10, but will be eliminated in the pilot. The selected generic medications will be $0 at both Retail and Mail Order points of service.

2. High-Value PCP

   a. Beneficiaries will have their cost share or co-payment either eliminated or reduced. Exact details are to be determined.

   b. Providers will be eligible to receive additional payments for performance. Exact details to be determined.

   c. The specific list of chronic conditions is in development and will include "diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, coronary artery disease, mood disorders, and such other diseases or conditions as the Secretary considers appropriate."

3. Performance-Based Maternity Payments

   a. No change in cost shares or co-payments for beneficiaries. Benefit comes from the program itself.

C. Communications Plan

1. The Communications Plan in development in order to notify beneficiaries of any changes. This may include, but is not limited to, beneficiaries receiving notification via mail of enrollment status and changes to the pilot. The expected cost is over

$400,000 and includes informing beneficiaries of the pilot start date, as well as discontinuation at the end of the five-year pilot.

2. Medication Adherence Pilot: Beneficiaries will receive information regarding the pilot, the two medications below and the reduction and/or elimination in co-payments.

    a. Lantus Pens for diabetes

    b. Rosuvastatin (generic Crestor) for hyperlipidemia

3. The list of High-Value PCPs will be identified as high value in the MCSC provider directory. The Communication Plan will be created once the pilot is more fully developed. The DHA intends to begin educating the beneficiaries and providers as early as January 1, 2018, as details become available in preparation to go live at a future date.

4. Performance-Based Maternity Payments: The MCSCs will determine the best way to communicate this "high-risk delivery hospital" status in the provider directory, taking care to ensure that the meaning is clear to beneficiaries and cannot be confused with other hospital quality ratings (such as those that are available on the Hospital Compare website).

D. Description of Contract Modifications

1. Medication Adherence: The costs to support this pilot include technical changes to the TRICARE Pharmacy Contractor's adjudication system to achieve adjustments to the Catastrophic Cap and Deductible Database, as well as Contract Data Requirements List reporting.

2. High-Value PCP: To be determined as the pilot develops.

3. Performance-Based Maternity Payment: Contract changes identify all hospitals with "Value," "High Value," or "High-Risk Delivery" quality designations at the start of the pilot. At a minimum, data elements will include provider or hospital name and identification number, address, and quality designation categories. In addition, Subsequent submissions will provide the information requested in the first submission, adjusted for the current year's Leapfrog Group quality ratings. In addition, subsequent submissions will provide an analysis of maternity claims data and calculations for hospital-level and MCSC incentives as described in the contract reference.

Based on the DHA's timeline for these value-based pilot implementations, the DoD anticipates the first contract modifications and associated contract data requirements lists to be issued 2-4 months prior to pilot implementation. Accordingly, the first contract modifications implementing the Medication Adherence Pilot were issued with an implementation date of February 1, 2018. The P-BMP pilot contract modifications will be issued no later than February 1, 2018, with an implementation date of April 1, 2018. Additional contract modifications will occurred when necessary for the High-Value Primary Care Provider pilot. All contract modifications will include requirements for the MCSCs to analyze and report on their effectiveness in meeting the stated goals for cost, quality, health outcomes, and beneficiary experience of care.

## CONCLUSION

DHA's implementation of the six value-based pilots and initiatives support both NDAA for FY 2017 reform and the MHS's vision of increasing value to the warfighter and military family. These incentive programs will be modified into the T-2017 contracts over the next six to 18 months with contract modifications and associated contract data requirements lists to be issued 2-4 months prior to pilot implementation. In addition to these six initiatives, the DHA will continue to explore other value-based initiatives that could add value to the TRICARE program and shift risk to the MCSCs. Moreover, the DHA will develop and implement an overarching strategy for ensuring that the TRICARE MCSCs (both current and future) improve access to health care, health outcomes, quality of health care, enhance the experience of covered beneficiaries, and lower per capita costs to the DoD and otherwise satisfy the requirements of both section 701(h)(3) and section 705(c) of the NDAA for FY 2017. The DHA is also working to ensure value based care efforts are integrated with direct care efforts and pilots in the United States Family Health Plan sites while appropriately sharing risk. Although the DHA's overarching value-based/contracting strategy is evolving, the Department is confident that these value-based pilots will facilitate transformation of the TRICARE program from a volume-based to a value-based paradigm over time in a manner consistent with the terms of the forthcoming strategy.

The pilots outlined in this report will provide an opportunity for the DHA to have an avenue for beneficiaries to engage in healthy lifestyle behavior change/intervention programs that are designed to prevent and/or delay the progression of chronic conditions and improve health outcomes. The pilots are designed to eliminate financial barriers and reinforce medication compliance, by removing co-pay/cost shares to select medications, and provide incentives to both beneficiaries and providers that emphasize prevention and wellness from high value providers.