

Modernization of the TRICARE Benefit

November 5, 2020



President's Memo



DEFENSE
HEALTH
BOARD

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE HEALTH AFFAIRS

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MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

SUBJECT: Modernization of the TRICARE Benefit

The Defense Health Board (DHB) is pleased to submit its report on the Modernization of the TRICARE Benefit. This review summarizes a DHB-recommended set of criteria for evaluating vendor proposals for the next managed care TRICARE support contract.

On July 24, 2020 the Assistant Secretary of Defense for Health Affairs (ASD(HA)) directed the Defense Health Board (DHB) to provide recommendations to the DoD for criteria to assess and prioritize commercial health care innovations for the TRICARE program. In this request, the ASD(HA) asked the DHB to provide advice on how the DoD might develop and implement health care innovations as part of a shift toward value-based health care in TRICARE. The ASD(HA) stressed that the DHB's recommendations should consider the needs of beneficiaries in rural, remote, and isolated areas as directed by Congress in the National Defense Authorization Act for Fiscal Year 2017, Section 705.

The TRICARE Health Plan Working Group reviewed legislation that defines the TRICARE program, the current and historical benefit structure, the process for amending the program, and innovative health care practices. The Working Group received briefings from, and consulted with, subject matter experts in government and the civilian health care industry.

The TRICARE Health Plan Working Group presented its report to the DHB on November 5, 2020. Following public deliberation, the innovation criteria were unanimously approved.

On behalf of the Board, I appreciate the opportunity to provide the Department with this independent review and hope that it furthers the DoD's mission to maintain force and family readiness through the TRICARE program.

A handwritten signature in black ink that reads "Jeremy Lazarus, M.D." The signature is written in a cursive, flowing style.

Jeremy Lazarus, M.D.
President, Defense Health Board

Attachment:
As stated

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Executive Summary

TRICARE, the Department of Defense's (DoD) health care service program, complements and supplements the military's direct care system with a network of civilian providers to serve 9.6 million beneficiaries, including Active Duty Service Members (ADSM), retirees, and their dependents. Established in 1993, TRICARE traces its roots to programs established by legislation in the 1950s and 1960s for the DoD's health care system to accommodate the increasing population of military retirees and dependents following World War II and the Korean War. Today's TRICARE enables integrated health care across military treatment facilities (MTF), or "direct care," and networks of civilian providers, or "purchased care." Civilian managed care support contractors (MCSC) help to deliver the TRICARE benefit in purchased care worldwide through multi-year contracts. The DoD updates these contracts periodically to reflect changes in the military's medical requirements and support the Military Health System's (MHS) effort to provide quality health care to beneficiaries.

Despite these updates, TRICARE lags behind civilian and other government health plans in terms of innovation. On July 24, 2020, the Assistant Secretary of Defense for Health Affairs (ASD(HA)) directed the Defense Health Board (DHB) to provide recommendations to the DoD for criteria to assess and prioritize commercial health care innovations for the TRICARE program. In this request, the ASD(HA) asked the DHB to advise how the DoD might develop and implement health care innovations as part of a shift toward value-based health care in TRICARE. The ASD(HA) stressed that the DHB's recommendations consider beneficiaries' needs in rural, remote, and isolated areas directed by Congress in the National Defense Authorization Act for Fiscal Year 2017, Section 705.

The DHB adopted a series of Foundational Principles to guide the development of their criteria. First, care should be patient- and family-centric, incorporating shared decision-making and prevention-oriented care throughout the care continuum. Collaborative team-based care, incorporating physicians and multidisciplinary team members, is the optimal model of care. Next, outcome measurement is essential to inform the effectiveness of any program within TRICARE and should occur at multiple points across the care continuum. Additionally, payment and benefit incentives must align to reward providers for good outcomes and incentivize beneficiaries to seek quality care. Finally, transparency of the quality, outcome, and cost of health care is essential for all stakeholders including beneficiaries, providers, policy-makers, and MHS and DoD leadership.

With these principles in mind, the DHB developed the following innovation criteria that it recommends the DoD use to evaluate bidding TRICARE vendors. These criteria include:

- A proposed innovation's potential impact on the MHS's Quadruple Aim of Improved Readiness, Better Health, Better Care, and Lower Cost
- The level of evidence that the vendor can produce for their success in implementing the proposed innovation
- The ease of implementing a proposed innovation by asking if the innovation requires the DoD to design an innovation de novo

- The amount of rulemaking or legislative effort required for the DoD to incorporate a proposed innovation into the TRICARE program
- The vendor’s ability and demonstrated competence to track and regularly report program outcomes, particularly outcomes beyond the standard Healthcare Effectiveness Data and Information Set (HEDIS®) measures such as Patient-Reported Outcome Measures and condition-specific measures by individual providers
- The ability of TRICARE to manage and monitor the innovation through regular reports from the vendor and the level of ongoing project management for the innovation
- Whether the innovation addresses any of the specific elements that NDAA 2017 or other statutory requirements that the DoD is obligated to implement

In this report, the DHB used these criteria to frame its evaluation and prioritization of the proposed innovations. The DHB advises Defense Health Agency (DHA) vendor evaluators not to use a simplistic scoring method, particularly not one in which evaluators weigh each innovation criterion equally and in which they weigh innovations equally with other vendor proposal criteria. The DHB believes that the DHA should give increased weight to vendor proposals with innovations that are likely to have the most significant overall impact on the Quadruple Aim and bring TRICARE closer to a value-based program.



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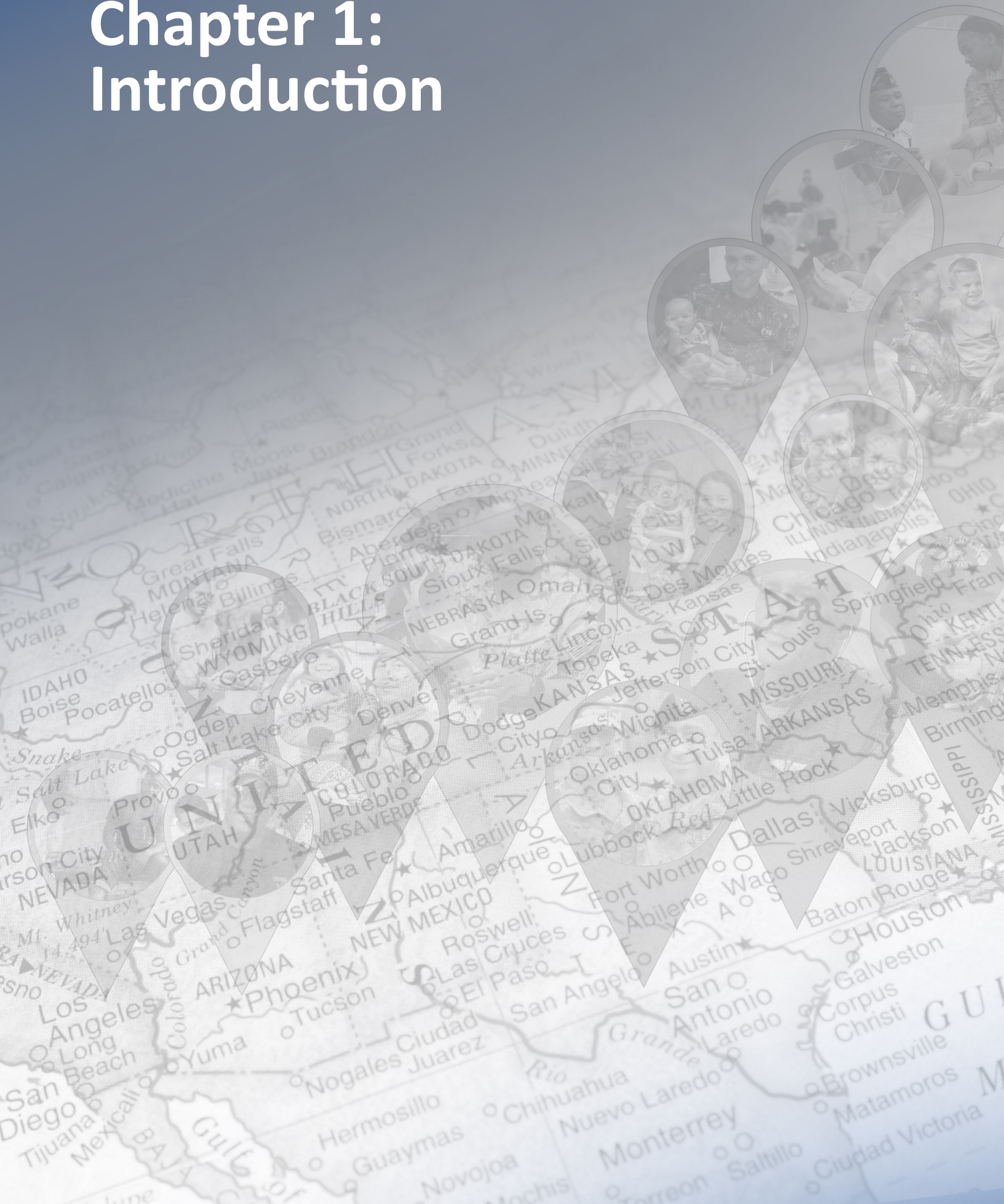
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Chapter 1: Introduction



On July 24, 2020, the Assistant Secretary of Defense for Health Affairs (ASD(HA)) directed the Defense Health Board (DHB) to provide recommendations to the Department of Defense (DoD) for criteria to assess and prioritize commercial health care innovations to the TRICARE program. In this request, the ASD(HA) asked the DHB to advise how the DoD might develop and implement health care innovations as part of a shift toward value-based health care in TRICARE. The DHB recommends the DoD apply the criteria described in this report to evaluate health care innovations included in bids for upcoming TRICARE contracts. In this report, the DHB selects innovations that would contribute substantially to moving the TRICARE program toward a value-based health care system based on applying the recommended evaluation criteria and the DHB's professional experience. The DHB recommends that TRICARE create a comprehensive health care strategy with the greatest likelihood of achieving the Military Health System (MHS) Quadruple Aim of *increased readiness through better care, better health, and lower cost* of health care services.

This report outlines the DHB's recommended criteria for the Defense Health Agency (DHA) to consider when assessing and prioritizing TRICARE health care innovations. These criteria include:

- Demonstrated effectiveness and potential impact on the Quadruple Aim
- Likelihood of tracking and reporting outcomes
- Ease of implementation
- Ease of managing and monitoring through data-gathering from vendors and beneficiaries
- Compliance with DoD and TRICARE statutory and regulatory requirements

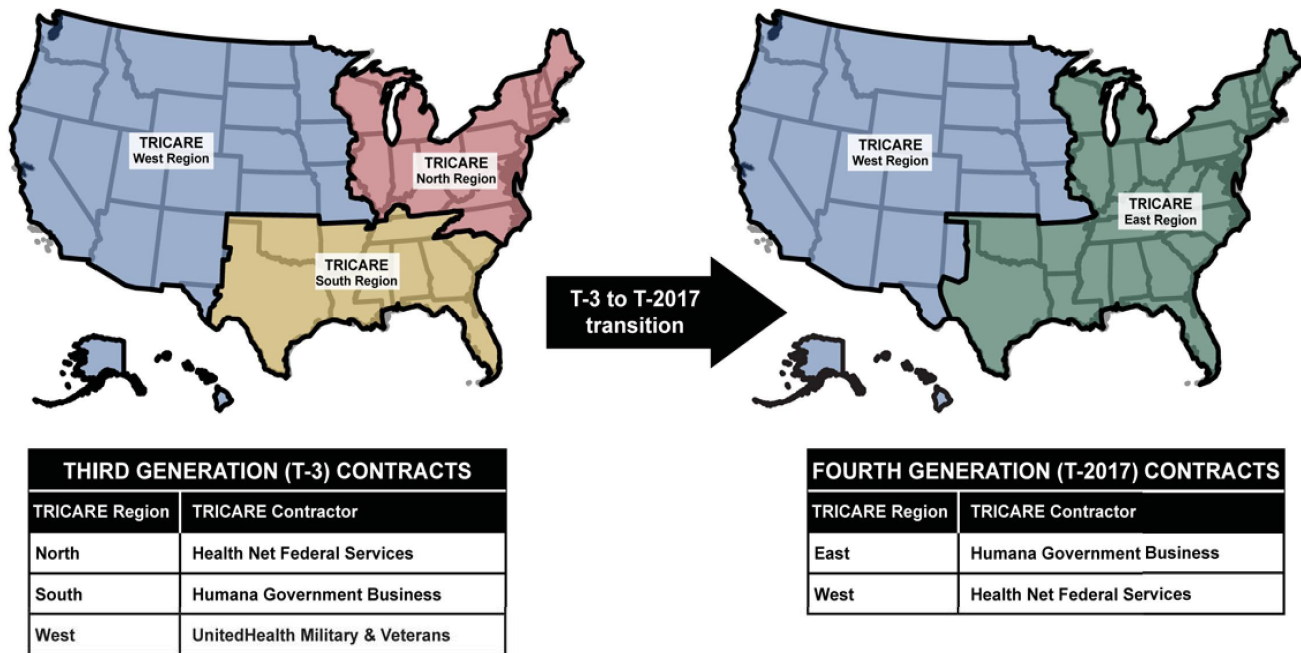
TRICARE Background

TRICARE is the DoD program that implements the health care benefit provided to Service members, retirees, and their families. Managed by the DHA under the ASD(HA), it complements and supplements the military's direct care system with civilian providers' network. As of 2020, the program serves 9.6 million beneficiaries, including Active Duty Service Members (ADSM), retirees, and their dependents. ADSMs are eligible for TRICARE after 30 days of service.¹

Today's TRICARE evolved through multiple legislative actions designed to improve health care services delivery to DoD beneficiaries. ADSMs, retirees, and their families all received care at Military Treatment Facilities (MTF) prior to the introduction of TRICARE. The size of this population grew significantly after World War II and the Korean War, which challenged the MTFs' ability to provide care to all beneficiaries. Congress passed the Dependents Medical Care Act of 1956 to better manage the health care of military retirees and dependents. Along with the Military Medical Benefits Amendments of 1966, this legislation allowed the DoD to outsource health care services for military retirees and military dependents to civilian health practitioners.² The program, originally called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), provided these health care services.

In response to increasing usage and rising medical costs, the DoD proposed a set of reforms, the CHAMPUS Reform Initiative, to move this health care services program to a managed care system. Congress endorsed these reforms in the 1987 National Defense Authorization Act (NDAA), one in a series of annually passed United States federal laws that authorize the DoD budget and allowable expenditures. The NDAA 1987 specified that the DoD should conduct a demonstration of this reformed system to “determine if managed health care can significantly improve upon CHAMPUS by increasing access to care while containing costs.”³ This demonstration showed the utility of delegating health care and administrative services to an outside contractor and provided the groundwork for the current TRICARE program.³ The DoD began implementing a nationwide managed care program called TRICARE in 1993, awarding managed care support contracts (MCSC) to administrative organizations to coordinate the program. TRICARE divided the United States into 12 health care regions and awarded MCSCs in each region. In 2003, TRICARE consolidated the 12 regions into three. In 2016, TRICARE reduced the number of regions to two (Figure 1). Each MCSC iteration has introduced reforms to the TRICARE program to improve health care services to Service members, retirees, and their families and adapt to the military’s changing health needs.

Figure 1. TRICARE Map of Consolidated Regions⁴



Accessing Care

TRICARE beneficiaries receive health care services through a network of MTFs and civilian health care facilities and providers. “Direct care” refers to health care services provided at MTFs, and “purchased care” services are those provided by TRICARE-authorized health professionals and partner institutions.¹ MCSCs administer the purchased care component of the TRICARE program in partnership with civilian health care providers. The TRICARE purchased care system currently consists of two regions, with Humana Military and Health Net establishing East and West regions’ provider networks, respectively (Figure 1). The MCSCs

manage contractual agreements with network providers and certify non-network providers. Network providers must⁵:

- Agree to provide care to TRICARE beneficiaries at a negotiated rate
- Accept the beneficiaries' copayment or cost-share as payment in full
- File claims with TRICARE for the remaining amount

Providers that choose not to become a network provider may still provide services to TRICARE beneficiaries but must “agree to file claims for beneficiaries, to accept payment directly from TRICARE and to accept the TRICARE allowable charge as payment in full for their services.”⁵

TRICARE Contracts

TRICARE contracts are agreements between MCSCs and the DoD that coordinate beneficiaries' access to MTFs and civilian health care providers. Through these purchased care contracts, community-based providers receive payment for providing health care services to TRICARE beneficiaries. Changes between the contracts reflect changes in the military's medical requirements and support the MHS's effort to provide quality health care to ADSMs, military retirees, and their dependents. The “T-3” contract, in effect from 2013 - 2018, established Prime Service Areas or geographic areas near MTFs to allow for greater recapture of beneficiaries from private markets. The current contract, “T-2017,” in effect from 2018 – 2023, consolidated TRICARE regions from three to two. The consolidation reduced administrative costs and gave beneficiaries a greater choice in where they received care. It also introduced incentives for lower provider network rates, stating, “the contractor must meet a required discount rate on care provided by network providers.”⁴

The next contract, referred to as “T-5,” aims to increase military readiness by increasing opportunities to strengthen the competence of MHS personnel, improve the quality of care, and lower costs.⁶ In the design of this upcoming contract, the DHA has emphasized increased modernization by adopting civilian industry standards in health care and administration. For example, the DHA wants to use value-based payment structures in which providers are paid for complete patient treatments, often contingent on health outcomes rather than the number of procedures they perform.⁷ Pre-planned pilots will inform the viability of the innovations introduced in the T-5 contract.

National Defense Authorization Act for Fiscal Year 2017

The NDAA 2017 specifically addresses the upcoming T-5 TRICARE contract and lays out a series of changes to the TRICARE benefit. Title XII “Health Care Provisions,” subtitle A “Reform of TRICARE

“The T-5 contract will be more evolutionary than revolutionary.”

CAPT Edward Simmer, TRICARE Health Plan

and Military Health System,” subsection 705, requires the Secretary of Defense to conduct a new competition of medical support contracts, excluding overseas medical support contracts. Subsection 705(c) (5) requires the DoD to include the following nine elements into the contract⁸:

- Provider Networks: Maximum flexibility in network design and development
- Medical Management: Integrated medical management between military medical treatment facilities and TRICARE network providers
- Telehealth: Maximum use of telehealth services to provide real-time communications between patients and health care providers and remote patient monitoring
- Value-Based Methodologies: Use of value-based reimbursement methods that transfer financial risk to health care services and medical support contractors
- Financial Incentives: The use of financial incentives for contractors and health care providers to benefit from reductions in medical spend when care is optimized and to potentially share in the risk of higher costs when care is not optimized
- Prevention and Wellness Incentives: Use of prevention and wellness incentives to encourage beneficiaries to improve their health, utilize wellness services, and seek care from high-value providers
- Beneficiary Enrollment: A streamlined enrollment process and timely assignment of primary care managers
- Referrals: Elimination of the requirement to seek the authorization of referrals for specialty care services
- Medical and Lifestyle Incentives: The use of incentives to encourage particular beneficiaries to engage in medical and lifestyle intervention programs

This section of NDAA 2017 also allows the DoD to use existing value-based incentive designs from TRICARE MCSCs, Centers for Medicaid and Medicare Services, or other federal entities when designing the program. In addition to the elements listed in Section 705(c)(5), Section 705(c)(6) highlighted the need for the DoD to consider how to deliver the proposed guidelines to rural, remote, and isolated areas. These four elements specifically direct the DoD to:

- Assess the unique characteristics of providing health care services in Alaska, Hawaii, Indian Health Service, and other rural areas of the contiguous 48 states
- Consider the challenges inherent in developing robust networks of health care providers in these locations
- Develop a provider reimbursement rate structure in those locations that ensure timely access, high quality primary and specialty care, improvement in beneficiaries’ health outcomes, and enhanced experience for beneficiaries
- Ensure that managed care support contracts under the TRICARE program will establish provider networks that provide timely access to care and deliver high-quality care, better health outcomes, and better experience of care for beneficiaries

A 2020 report by the United States Government Accountability Office found that of the 13 elements outlined in Section 705, the DoD had partially implemented six in the T-2017 contract. The report

concluded that “while DHA has taken steps to begin implementing some of these elements...it has not developed implementation plans with time frames and specific actions needed to guide its efforts” to improve the TRICARE program as recommended by Congress in NDAA 2017.⁴ Specifically, the DoD may fall short of achieving the 13 program improvements “related to access to care, health outcomes, quality of care, beneficiaries’ experience, and cost efficiency.”⁴

The six elements the DoD has partially implemented are⁴:

- **Provider Networks**: To address this element, the DHA established an Accountable Care Organization (ACO) demonstration through Kaiser Permanente in Atlanta, Georgia. This demonstration will inform the design of provider networks in the T-5 contract.
- **Medical Management**: A system-wide pilot is underway for the TRICARE Select Patient Navigator program. This program assists beneficiaries in understanding their benefits and navigating the direct and purchased care systems.
- **Telehealth**: DHA has expanded and standardized telehealth services’ capabilities, including the number of locations where beneficiaries may receive telehealth services. Providers receive reimbursement at the same rate and in the same manner whether they provide telehealth or in-person services.
- **Value-Based Methodologies**: DHA began its Performance-Based Maternity Payments Pilot in San Diego, California in April 2018. This pilot seeks to improve health outcomes for mothers and babies through an emphasis on maternity care quality. DHA plans to implement value-based reimbursement methodologies in other settings to transfer financial risk to managed care support contractors.
- **Prevention and Wellness Incentives**: DHA officials cited the Performance-Based Maternity Payments Pilot, which incentivizes beneficiaries to seek care from high-performing maternity care providers, as a prevention and wellness incentive. The DHB does not view this pilot as a prevention and wellness initiative as traditionally known in civilian health care plans. DHA officials will continue to address these requirements in the T-5 contract.
- **Beneficiary Enrollment**: The Beneficiary Web Enrollment allows beneficiaries the ability to enroll themselves in TRICARE plans and make changes to their Primary Care Manager.

This specific statutory mandate should enable the new, fully operational DHA with expanded capability to make and execute arrangements to integrate the MTFs with the network and ensure a medically ready force more effectively than in prior TRICARE contracts.

TRICARE Pilots and Demonstrations

Statutory authority defines the functions and covered benefits of the TRICARE program. TRICARE does not cover unproven or experimental benefits or those specifically excluded by law or policy. Before introducing a new benefit to the TRICARE program, TRICARE must have evidence that the benefit is safe, effective, and representative of the standard for good health care in the United States. Statutory requirements mandate that TRICARE consider peer-reviewed medical literature, technology assessments, and published positions of national medical policy organizations before developing a

new policy to introduce the benefit into the program.⁹ TRICARE has the authority to conduct pilot programs and demonstration projects to test whether a considered benefit should be included in the program. Section 1092, Chapter 55, Title 10 of the United States Code grants TRICARE the authority to “enter into contracts with public or private organizations to conduct these pilot studies and demonstrations.”¹⁰

Pilots and demonstrations differ. Pilot programs have existing legislative authorization specific to the pilot’s topic and inherent permission to adopt the benefit, if successful, as part of TRICARE. Demonstrations also test whether a benefit is effective in the TRICARE environment, but they do not have the existing legislative authority to be incorporated into TRICARE. A legislative change is required before a successful demonstration is adopted within TRICARE. The legislative process is extensive, which causes extensive delay before an innovation, tested in a demonstration or pilot, can become a covered benefit.

TRICARE introduced a range of pilots and demonstrations to support innovations to the program’s T-5 contract and future innovations. These provide evidence about program innovations and inform policy to include them as future covered TRICARE benefits. The pilots and demonstrations include:

- Pilot to Redirect Uniformed Services Beneficiaries Identified for Inpatient Admission at Civilian Emergency Departments (ED) for Admission to Designated MTFs/Enhanced Multi-Service Markets (eMSM): This pilot assessed the partnership between MCSCs, network EDs, and inpatient MTFs in providing emergency care to Service members. This pilot established processes within civilian network facilities to promote transferring medically stable TRICARE beneficiaries from civilian EDs to an inpatient MTF or eMSM for treatment. A multi-service market is a geographic area “where at least two medical hospitals or clinics from different services have overlapping service areas.” Six multi-service markets are considered “enhanced” due to their overall size, medical mission, and graduate medical education capacity.¹¹ This pilot promoted participation in the Direct Care system and medical readiness of MTFs and academic medical programs.¹⁰ The pilot began July 25, 2016.
- Bundled Payments for Lower Extremity Joint Replacement (LEJR) Demonstration: Launched on April 1, 2016, DHA initiated the LEJR demonstration to assess the impact of bundled payments on the outcome and cost of clinical care. The goal was to improve and sustain excellence in care and coordination and to test whether value-driven incentives contain increases in health care spending.¹² The demonstration’s design came from the Centers of Medicare and Medicaid Services’ (CMS) Comprehensive Care for Joint Replacement Model (CJR), created to promote better and more efficient care for beneficiaries undergoing LEJR surgery. In the CJR model, hospitals, physicians, and other care providers work together to coordinate care from patient intake through recovery. Participating facilities were responsible for all costs for each patient’s entire “episode of care,” or the admission period up to 90 days after discharge. Called a “bundled episode,” this included all health care services paid under Medicare Part A and B. The demonstration concluded in June

2019. A February 2020 report to Congressional Defense Committees stated the results of the demonstration did not provide positive or negative evidence in support of this demonstration, largely due to low enrollment.¹³

- **ACO Demonstration:** This demonstration examines the use of financial incentives for contracted health care providers and aims to show whether value-based payments support the MHS Quadruple Aim. In partnership with Kaiser Permanente in Atlanta, Georgia, the DHA tests how financial incentives improve health outcomes, beneficiary experience, and lower per capita costs to the DoD.¹⁰ The Kaiser Permanente model of coordinated care promotes beneficiary involvement in wellness and prevention programs and gives beneficiaries access to the Kaiser Permanente network of health care providers across the metro Atlanta area.¹⁴ This demonstration began on January 1, 2020 and will terminate on December 31, 2022 with a goal of enrolling 10,000 beneficiaries.
- **Home Health Value-Based Purchasing (HHVBP):** This demonstration, scheduled to run from January 1, 2020 until December 31, 2022 tests the adoption of a value-based initiative based on a Centers for Medicare and Medicaid Services' program in which CMS determines a payment adjustment up to the maximum percentage based on the Home Health Agency's Total Performance Score. The result incentivizes quality improvements and encourages efficiency. The program tests the HHVBP model that provides incentives for better quality care, studies new measures for appropriateness in a home health setting, and enhances the public reporting process. The demonstration will provide evidence for the feasibility of incorporating the HHVBP model into TRICARE and will help the DoD determine if such a model will improve quality of care and result in long-term cost savings.¹⁵
- **Medication Adherence Pilot:** This pilot's purpose is to demonstrate the feasibility of reducing copayments for high-value medications to improve health outcomes through improved patient medication adherence. Under this pilot, TRICARE will reduce or eliminate co-pays for a selection of prescription medications for the management of certain chronic conditions, including diabetes.¹⁰ TRICARE will credit the amount of the reduced co-pay to the participants' deductible/catastrophic cap.¹⁶ The pilot began February 1, 2018 and will terminate December 31, 2022.¹³
- **Performance-Based Maternity Payments Pilot:** This pilot is a value-based initiative that seeks to improve mothers' and babies' health outcomes by emphasizing maternity care quality in the TRICARE networks. The Leapfrog Group, a nonprofit organization established to drive improvements in health care quality and safety, conducts an annual hospital survey and compares reported hospital performance against nationally recognized benchmarks for five maternity care measures: early elective deliveries, Cesarean sections, episiotomies, maternity care processes, and high-risk deliveries. Participating hospitals in The Leapfrog Group's survey are eligible for annual incentive payments. The DHA designed this pilot to facilitate dialogue with maternity care providers leading to better health outcomes and beneficiary satisfaction.¹⁰ This pilot began April 1, 2018 and will end December 31, 2022.¹³

- **Pilot Program on Health Care Assistance System:** The TRICARE Select Patient Navigator program introduces a personalized health care experience for certain TRICARE Select enrollees. Eligible participants have two or more complex medical conditions like asthma, cancer, depression, diabetes, and heart disease. Beneficiaries who have claims of over \$100,000 per year are also eligible. In this program, patients connect with a nurse who will help connect the patient with health care providers, schedule appointments, and are available to answer health or benefit questions.¹⁷ The DoD awarded a contract for this pilot on December 27, 2019 and the contractor began recruiting beneficiaries to participate in the program in April 2020.
- **Comprehensive Autism Care Demonstration (ACD):** The Comprehensive ACD aims to determine the feasibility of increasing access and delivery of Applied Behavior Analysis (ABA) services under TRICARE. TRICARE will analyze the quality, efficiency, convenience, and cost effectiveness of ABA services not currently covered by the TRICARE medical benefit to determine appropriateness and value of services for beneficiaries diagnosed with Autism Spectrum Disorder. The demonstration aims to maximize access to ABA services while ensuring the highest level of quality and appropriateness of services for beneficiaries.¹⁰ The pilot began on July 25, 2014 and is currently scheduled to last until December 31, 2023.
- **Lab Developed Tests (LDT) Demonstration:** This demonstration evaluated the potential utilization and clinical utility of non-FDA approved LDTs within the TRICARE population. It also extended prenatal Cystic Fibrosis carrier screening “when provided in accordance with the most current American College of Obstetricians and Gynecologists guidelines in order to allow the DoD to establish whether there is a benefit to offering such testing to TRICARE beneficiaries.”¹⁰ This demonstration ran from January 1, 2013 until July 25, 2020. The results of this demonstration are not yet available.

T-5 Innovations and the Quadruple Aim

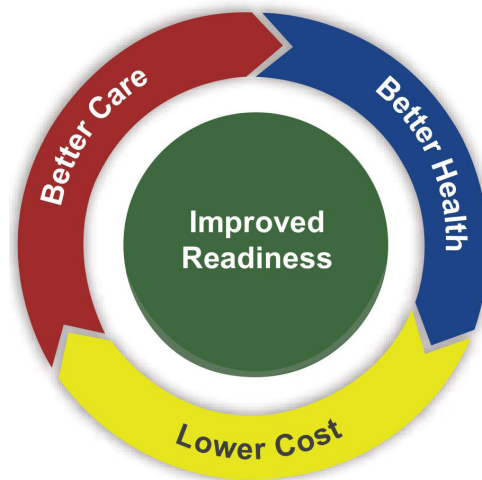
Consistent with the 13 elements set forth by NDAA 2017, the DHA established four goals to guide the implementation of the T-5 contract:

- Optimize the readiness of the military force and the Knowledge, Skills, and Abilities (KSA) of personnel in the MHS
- Place beneficiary choice at the center of the program, with decision making empowered by information on cost, quality, and access
- Provide high-value care with measurable outcomes through Alternative Payment Methods to change from volume-based payments to quality-based payments
- Move the contract process toward industry best practices by enabling the industry to communicate with the DHA using commercial processes and methods for enrollment, eligibility, and encounter processing and adopting commercial standards for claims payment

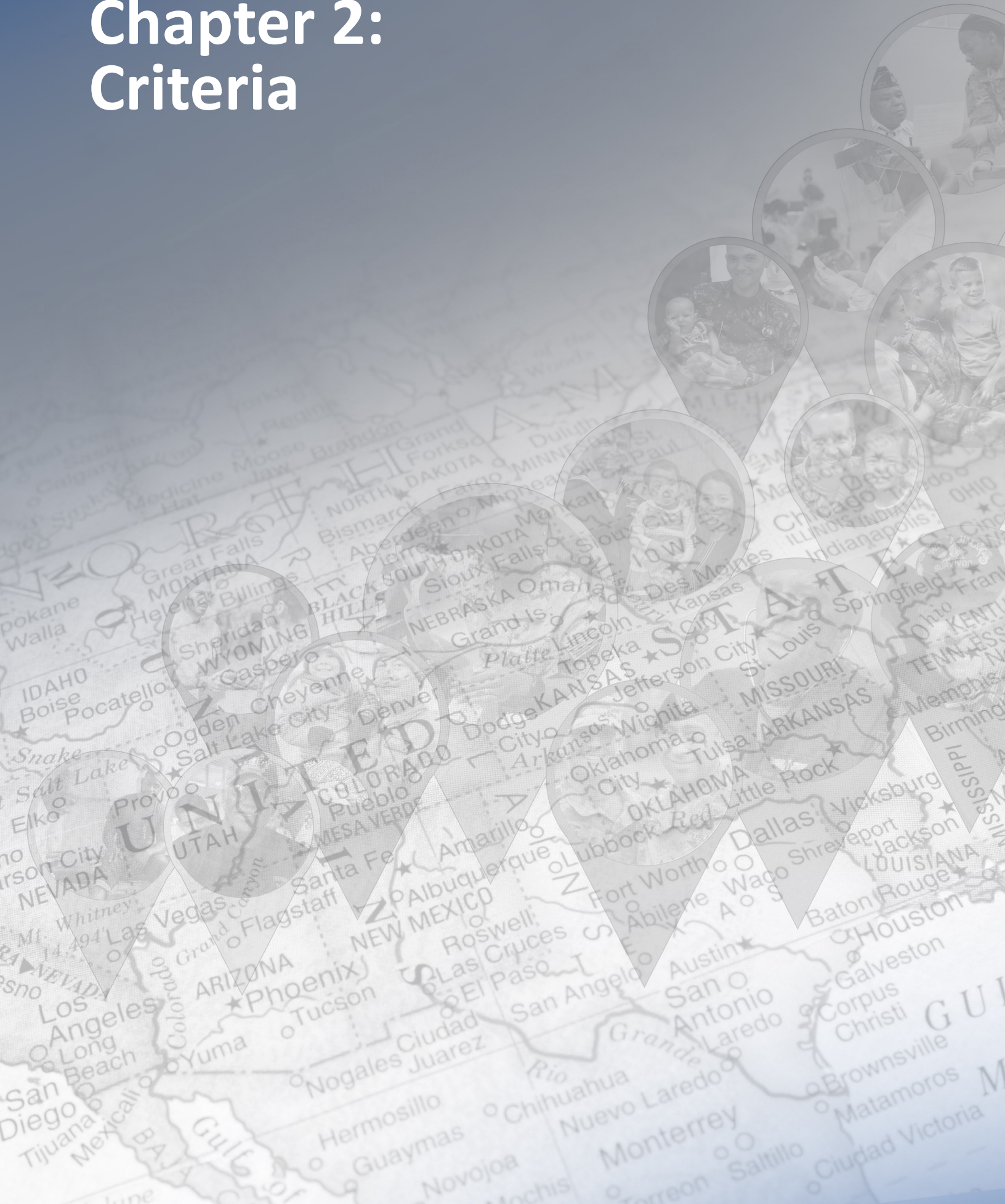
The T-5 contract aims to meet these four goals and with the 13 elements required by Congress in NDAA 2017 through the health care innovations. The private industry has implemented some of these innovations. Demonstrations of their application in the TRICARE environment will inform future iterations of these innovations in TRICARE. Given limited time and resources for demonstrations to generate evidence of an innovation’s effectiveness and appropriateness for TRICARE, the DHA must carefully consider which innovations it selects to include in the T-5 contract.

The DoD should use the MHS Quadruple Aim (Figure 2) to guide the innovations’ selection and implementation and assess an innovation’s impact. The Quadruple Aim – increased readiness, better care, better health, and lower cost – represents the overarching goals of the MHS. All TRICARE activities should have a demonstrable impact on at least one aspect of the Quadruple Aim. This report will establish criteria, based on the Quadruple Aim, for the DoD to use to evaluate any health care innovation and assess its feasibility for implementation, a potential benefit to beneficiaries, and an impact on the goals of the MHS and TRICARE.

Figure 2. MHS Quadruple Aim



Chapter 2: Criteria



Foundational Principles

The DHB used several Foundational Principles to guide its development of criteria to assess and prioritize proposed health care innovations. These principles guide the design of a data-driven, value-based system that promotes readiness and improves health outcomes for all TRICARE beneficiaries:

- Care should be patient- and family-centric, prevention-oriented and incorporate shared decision-making across the entire care continuum. Prevention includes primary prevention to prevent a disease, secondary prevention to detect a disease early and prevent it from getting worse, and tertiary prevention from improving the quality of life and reducing the symptoms of a disease.
- Collaborative and team-based care, incorporating not only physicians, but also multidisciplinary team members (nurses, advanced practice providers, behavioral/mental health professionals, physical/rehabilitation therapists, nutritionists, psychologists, social workers, case managers, and other allied health practitioners) represents the optimal model of care.
- Outcomes measurement is essential and should occur regularly at multiple points across the care continuum to drive process and care improvement. Measures should include Patient-Reported Outcomes. Regular reporting and monitoring of outcomes throughout the contract is necessary for timely responsiveness to DOD needs and improvements in beneficiary health and readiness.
- Payment should be outcomes contingent, rewarding providers for good outcomes and penalizing them for inadequate ones. Programs should engage providers in learning and improving through transparent performance data and feedback. Benefit design should provide beneficiaries with incentives to seek high quality and evidence-based care. These are essential qualities of Value-Based Insurance Design (VBID). Administrative policies and processes must work in concert with payment model design to direct beneficiaries to high-performing providers and away from low-value care.
- Transparency of the quality, outcomes, and cost of health care is essential for all stakeholders – beneficiaries, providers, policymakers, comptrollers, vendors, military leaders, and Congress.
- Better and lower-cost health will occur when systems embrace the full cycle, from conception to evaluation, leverage care enabling technology in meaningful ways, and share best practices.

Innovation Assessment Criteria

The DHB recommends the following criteria to assess and prioritize health care innovations. Considerations include the extent to which the innovation impacts the Quadruple Aim, the level of evidence for the innovation's success, the level of difficulty in implementing the innovation within TRICARE, and the vendor's

ability to track outcomes and manage the innovation. The DoD must also consider whether the innovation contributes to the goals required by legislation.

1. Potential Impact on the Quadruple Aim

The Quadruple Aim's four components form the framework on which the DHA aims to build a value-based care system that supports the military's medical readiness. Through the Quadruple Aim, the DHA increases readiness by providing better care and better health at a lower cost.

An innovation's ability to positively impact readiness by supporting a "medically ready force and a ready medical force" must be a central criterion when evaluating potential programs. The willingness and ability to support the fully operational DHA's defined necessary military ready force's competencies and KSAs through relationships with health care systems within that contractor's geographic area should be a critical evaluation criterion for the T-5 contract as outlined in the NDAA. The DoD should judge innovations by whether they positively support the ability of ADSMs to be physically and mentally ready to serve, mobilize, and deploy. Furthermore, innovations should equally support the readiness of Active Duty Family Members (ADFM), particularly when ADSMs mobilize or deploy.

Many of the innovations can produce *better care* by having the right team deliver the right care or procedure for the right patient at the right time. The DoD should judge vendors by their proven effectiveness in achieving this outcome and request evidence about such "right care" during the T-5 solicitation. The vendor should be responsible for avoiding low-value care and improper care, and be able to track and report the incidence of low value or improper care. Regular reports and dashboards should include metrics to track *better care* outcomes.

Better health is another component of the Quadruple Aim. Optimal lifestyle habits are the most important contributor to *better health*, defined at the simplest level for the TRICARE beneficiary as to how well and how long one lives. The DoD should judge vendors and innovations in this area on their ability to engage beneficiaries in successfully understanding and improving healthy behaviors, such as greater use of a plant-based diet, regular exercise, tobacco abstinence, reduction or elimination of unhealthy alcohol and substance abuse, maintenance of a healthy weight, restorative sleep, stress reduction/mindfulness/resilience, and social connection.

The DoD should assess an innovation's impact on *lower cost* including cost reduction and cost avoidance. Most of the innovations discussed in this report have a history of a positive Return on Investment (ROI), specifically reducing medical and pharmacy costs or total medical care costs. Some innovations should already be standard parts of health plan operations (e.g., Centers of Excellence (COE) networks) and therefore, not require additional spending to produce that desired savings. The total benefit cost (positive and negative) to the TRICARE beneficiary is an additional consideration. An innovation cannot result in a net cost increase to the TRICARE beneficiary, but it can decrease cost. The DoD should judge vendors and innovations in this area on their ability to demonstrate *lower cost*. When a vendor presents innovations

as “buy-ups,” (provided at an additional optional cost), the expected ROI and its methodology should be defined and monitored. Contracts need to include Performance Guarantees with fees at-risk. Regular outcomes reporting (engagement, outcomes, cost savings, and ROI, etc.) is essential. If a buy-up is not achieving the intended outcome, the contract should stipulate that TRICARE can terminate the innovation and payment.

The DoD must also assess the potential to positively affect cost, access, and experience of care and weigh the trade-offs that will inevitably need to be made to obtain the best outcome.

2. Demonstrated Success

The strongest evidence for an innovation’s effectiveness, and in turn, its applicability to the TRICARE program, would be demonstrated, peer-reviewed evidence obtained in multiple settings. Randomized Controlled Clinical Trials (RCT) are the gold standard. The DHB, however, is aware that this level of evidence is rarely available for health care delivery innovations. In the absence of RCTs, TRICARE evaluators should consider evidence in decreasing hierarchy of scientific evidence: Meta-analyses, non-randomized controlled trials, cohort studies, case series, case studies. Innovations that have never been demonstrated in a real-world setting have the lowest level of evidence for DoD adoption for TRICARE.

The DoD should consider the level of success that submitting vendors have had in implementing the high-priority innovations and the evidence available to support the adoption of the innovation in TRICARE. Vendors should provide evidence, especially the outcomes of their programs from prior deployment, to inform the DoD’s selection for the T-5 contract. Evaluators can categorize innovations by the strength of evidence shown that they will have the intended impact when applied to the TRICARE beneficiaries.

Innovations not evaluated through RCTs or real-world case studies can still serve an important role in TRICARE’s evolution and should be considered for inclusion in future demonstrations or contracts. The DoD may also leverage eminence, or the opinions of experts and leaders in health care administration and health systems research, to assess innovations that may have value for TRICARE but have little evidence base to date. It is also essential to consider the options that future technological advances may enable, and what steps the DoD can take now to lay the groundwork for such innovations when they become available.

3. Ease of Implementation

Innovations with evidence of success across multiple settings or populations demonstrate the greatest feasibility for adoption. Many innovations will already be part of the vendors’ present-day operations and system of care (Centers of Excellence, use of Artificial Intelligence, and validated automatic authorizations) and, therefore, be relatively easy to implement. Innovations successfully implemented by the MCSC vendor in other populations or locations can serve as a TRICARE model and the DoD should judge these favorably. Innovations that require de novo design are less desirable. New demonstrations may be a way to test de

novo innovation implementations during the T-5 contract, enabling the DoD to evaluate them for inclusion in future TRICARE contracts.

Since any major benefit change to TRICARE requires legislation, another dimension of an innovation's ease of implementing is whether it requires policy changes before it can be included in TRICARE. The short and intermediate term feasibility of an innovation to the TRICARE program depends heavily on the authority required to implement it. There are three levels of authority, which correspond to increasing difficulty, time, and uncertainty in implementing the TRICARE contract.

- **DHA Demonstration Authority:** The Assistant Secretary of Defense for Health Affairs can authorize studies and demonstration projects to trial test innovations that may improve quality, efficiency, convenience, or cost effectiveness. Demonstrations need to be limited in scale, scope, and duration and must work within the current legislatively defined TRICARE benefit. However, they can include alternative payment models, cost-sharing by beneficiaries, innovative approaches to delivery and financing of health and medical services, alternative approaches to reimbursement, and prepayment for medical care provided to maintain the health of a defined population. The DHA can update the TRICARE Operations Manual with the demonstration details without the need for writing or re-writing of DoD regulations; however, the Assistant Secretary of Defense for Health Affairs must provide notice of the demonstration in the Federal Register. Permanent implementation of successful demonstrations requires changes to statute and/or federal regulations where not consistent with current law and/or regulations.
- **Rule and Regulation-Making Authority:** Innovations affecting the TRICARE benefit that are not consistent with current regulations require changes within the Code of Federal Regulations. Regulation change follows a 'notice-and-comment' rulemaking process. Agencies must inform the public of the proposed changes, perform internal reviews, and allow time for public comment. Full notice and comment rulemaking can take upwards of 24 months to complete.
- **Legislative authority:** Congress passes legislation that establishes requirements for the TRICARE benefit, beneficiary cost sharing, and the inter-relationship of the medical, dental, and pharmacy benefits. When innovations or changes in the Military Health System require legislative change, political considerations, competing priorities, and the need for legislative support add significant uncertainty to the adoption and timeline of such innovations.

The DoD should evaluate the authority needed to implement a proposed TRICARE innovation. While innovations that leverage benefit design and contribution, scope of services (e.g., integration of pharmacy), price negotiating authority, and alternative payment models require significant effort and investment of time, they nevertheless also promise the most significant positive impact to the goals of the Quadruple Aim.

4. Outcomes Measurement

When evaluating proposals from vendors for a TRICARE MCSC, the DoD should strongly consider a vendor's capability to track and regularly report program outcomes. Outcomes measurement is a significant contributor to learning and accountability in a value-based health care system. The DoD should look beyond the standard HEDIS® measures, particularly to incorporate Patient-Reported Outcome Measures and condition-specific measures by individual providers. The vendor should clearly define and report the measures and metrics of its program. The DoD should judge vendors' ability to report positive outcomes with data assessing an innovation's impact on the Quadruple Aim. Such data may include:

- Cost/benefit analyses
- Timely access to needed care by patients across the program
- Patient-Reported Outcomes specific to the condition treated
- Sharing of health information across providers and integration of health information into a variety of providers and settings in the program
- Improvements over time of health and function (as opposed to disease) indicators including rates of healthy behaviors and functional assessments (BMI, nutrition, physical activity, stress/resilience, substance use/abuse for tobacco and alcohol, self-reported health status and Patient Health Questionnaire-assessed functionality)
- Preventable and manageable chronic disease (e.g., diabetes, asthma/COPD, hypertension, renal failure) and disease-specific mortality rates

The DoD should track measures of the health and medical readiness of ADSMs and ADFMs, and the readiness of the medical force, to avoid having the TRICARE contract negatively affect readiness.

5. Ease of Management and Monitoring

Another criterion to consider is the ability of TRICARE to manage and monitor the innovation through periodic reporting. The DoD should also consider the level of ongoing project management required for the innovation. This consideration includes assessing the effort required by the DoD to assure the vendor has satisfactorily implemented and managed the innovations. The DoD also needs to assess whether the information will require additional input from beneficiaries to measure satisfaction and identify care management needs. Ideally, the DoD should be able to monitor the innovations with minimal additional DoD-administered surveys. Regular data-driven reporting and dashboards to track outcomes and key processes must be part of the proposals and implementation. Easier collection of beneficiary feedback on health behaviors and functionality (which does not currently reside in claims information) should be possible in T-5 due to the advent of new technologies, personal devices, and monitoring capabilities. The DoD should seek to align data, reports, and dashboards currently used for MTFs and MHS with data, reports, and dashboards for TRICARE.

6. Compliance with Statutory Requirements

As outlined in the Background section of this report, NDAA 2017 and other legislation establish specific statutory requirements for the DoD to execute. The Department should consider whether any potential future innovation addresses any specific elements that NDAA 2017 or other statutory requirements the DoD is obligated to implement. Assessments of future innovations should also consider whether the proposed innovation includes a specific period for complying with the requirements and specific actions that address the mandated changes.

Application of Criteria to Proposed T-5 Innovations

Each innovation in the tasking's Terms of Reference is described in Appendix B. The DHB chose to group these innovations into three categories:

- Innovations in Network Design: Innovations in network design include and highlight providers that have demonstrated an ability to achieve better outcomes and health at a lower cost. These innovations will inform and incentivize beneficiaries to use better performing providers.
- System-wide Innovations: These programs overlay the network to help patients achieve better quality and the system to incur a lower cost. These programs are generally nurse and other allied health staff-based and not physician or provider-based.
- Innovations to Basic Health Plan Operations: These components of a health plan must be in place for the system to function well. They are not particularly groundbreaking innovations but are necessary for the system to function efficiently and conveniently for beneficiaries. Examples of these are Centralized Enrollment or Transition Assistance.

As the DHB evaluated the innovations, it recognized significant overlap across several of them. For the upcoming T-5 contract, the DHB prioritized innovations that will significantly impact on the Quadruple Aim outcomes, have evidence of their utility, and are feasible to implement with little rulemaking. Artificial Intelligence (AI) can improve health outcomes by enhancing the ability of providers to provide better care through reduced medical complications and provide lower costs by increasing efficiency of the health care system if implemented effectively and without bias. The DHB also discussed innovations with future promise but that require rulemaking for future generations of the TRICARE program. The DHB encourages using the proposed criteria to assess any future TRICARE innovation or evaluate existing components of TRICARE. The DHB advises TRICARE evaluators not to use a simplistic scoring method, particularly not one in which evaluators weigh all innovations equally. TRICARE evaluators should weigh evaluation criteria in a way that prioritizes innovations that optimize impact on the Quadruple Aim. The highest impact proposals will likely incorporate many of these innovations as a cohesive whole and should be preferred.

Network Design Innovations

Network design refers to the selection criteria for the inclusion of providers and models of care in the health care network.

Accountable Care Organizations

Accountable Care Organizations (ACO) are groups of health care providers and facilities that form a network to provide high-quality care to their patients. In evaluating a proposed ACO benefit, the DHB recommends the DoD evaluate how the ACO will affect the readiness of the uniformed services through better access to care and reduced recovery time. Excellent performance for these two factors will enhance Force readiness.

The DHB views ACOs as a critical innovation with great potential for delivering Quadruple Aim benefits to beneficiaries and the DoD. Systems of integrated, accountable care can demonstrate better care at lower cost. The TRICARE beneficiary cost should be the same or lower through an ACO than from alternative care strategies. The DoD should also evaluate ACOs in their ability to collect, report, and improve standardized outcomes, including Patient-Reported Outcomes, the indicators of better care. In addition, ACOs should reduce lost duty, work, or school time for all beneficiaries. ACOs should promote better health by tracking basic measures on prevention and wellness. Vendors should also have specific processes in place to provide care for complex conditions (e.g., autism, organ transplants) outside of the ACO, possibly at a Center of Excellence (another innovation, discussed next in the report).

The DoD should ensure that the vendor proposing an ACO for the TRICARE program has demonstrated responsiveness to purchaser's needs in the past with evidence that they have met the users' needs. The DoD should judge ACO proposals by their willingness and ability to accommodate the DoD's and DHA's requirements for clinical experience and training for military providers in essential KSAs.

The DHB views ACOs as a relatively easy to implement innovation with high benefit to beneficiaries. Vendors, especially those with existing ACOs that they propose to include in the TRICARE program, should bear the burden of monitoring and managing them. The DoD monitors the ACO's performance through regular metric reporting to ensure the ACOs and vendors meet the high-quality and low-cost goals. Overall, the DHB places a high priority on ACOs in combination with other value-based care innovations such as Centers of Excellence.

Centers of Excellence

The DHB recommends Centers of Excellence (COEs) as part of a value-based health care strategy for the TRICARE program in addition to, or embedded within, ACOs. COEs are hospitals, physician groups, or health systems that specialize in specific procedures and treatments. These COEs are leaders in quality, safety, and outcomes for their specialty area. COEs promote better care by having experienced multidisciplinary teams

treat patients over complete cycles of care and extensive measurement of outcomes, reduced treatment variability, and low incidence of inappropriate care. COEs lower costs through reduced downtime for beneficiaries and lower incidence of medical complications.

The DoD should judge COE proposals by their willingness to integrate with military health care providers and MTFs to assure continued readiness of the medical force. The DoD should also assess whether the condition being treated by a COE is of sufficiently high volume among TRICARE beneficiaries to make a measurable difference in one or more aspect of the Quadruple Aim. For example, a high score for a vendor that offers a COE that affects only a small proportion of the beneficiary population will not contribute much to achieving the Quadruple Aim.

Evaluators should assess whether a vendor has established criteria to evaluate whether treatment by the COE is appropriate (e.g., mandatory second opinion for appropriateness of intervention). For example, referring a patient with back pain to an excellent spine surgery COE may not be appropriate if physical therapy or weight loss and exercise can alleviate the back pain and for whom a risky spine surgery is not likely to be effective. COEs for conditions such as back pain is preferable to COEs for a procedure such as laminectomy so that a patient has the benefit of the full range of treatment options.

The DHB recommends that evaluators view COEs and sites with external body accreditations more favorably than those that do not. They also recommend that the DoD consider vendors that partner with or express a willingness to integrate with existing TRICARE providers favorably.

The DHB recommends the DHA implement a COE demonstration that mirrors private sector COE programs to gather data on its effectiveness in the TRICARE environment.¹⁸ In this type of innovation, the health care plan also pays for the transportation and lodging of the patient and family member (or another caregiver) to access a COE.

At-Risk Centers of Excellence

At-Risk COEs are an advanced version of COE in which the providers take the risk for the cost and outcomes of the care they deliver. Risk-bearing entities, especially with both positive and negative incentives, tend to have lower costs and better outcomes. Being at risk often fosters deeper collaboration amongst the providers who work together to avoid losses. The DHB encourages the use of At-Risk COEs as a promising innovation, enhancing COEs' contribution to the Quadruple Aim through lower costs and delivering better care, as measured by better health outcomes.

Advanced Primary Care

Advanced Primary Care (APC) places the patient and family at the center of care, focusing on health outcomes rather than care volume. Patients can access same-day care, communicate after hours with the

provider team, and receive highly coordinated care when they need specialists' services. The DHB views Advanced Primary Care as an innovation that offers many potential benefits to beneficiaries such as more patient-centered care, better access, better care coordination, and better outcomes. The vendor should demonstrate the effectiveness of its included APCs by reporting on access, outcomes, and cost. The DHB recommends that the DHA and TRICARE promote the Advanced Primary Care model in MTFs.

Care Collaboration

Care Collaboration is the integration of care among providers across the care continuum, integrating activities such as virtual consults between primary care providers and specialists (sometimes formalized as "e-Consults"), effective sharing of health information, and enhanced communication among the members of the multi-disciplinary care team and with the patient and family. These activities also include integrating behavioral health with the medical care teams, using technology for home monitoring, soliciting patient-reported outcomes, synchronous and asynchronous communication between patients and providers without the need for in-person office visits. The DoD should judge Care Collaboration proposals by their scope and demonstration of effective implementation. Advanced Care Collaboration can lead to better outcomes through avoided errors and gaps in care due to increased communication across the care team.

Clinically Integrated Networks

A Clinically Integrated Network (CIN) is a group of independent providers that come together to create a high-quality, low cost set of services intended to benefit beneficiaries. The DHB views CINs as less well-developed and impactful innovations than ACOs and COEs since the providers remain independent and not integrated into an organization with accountability. However, the DHB has seen some CINs bring substantial benefits to rural areas by linking rural providers to a central provider organization with strong specialty expertise that may be lacking in the rural environment. Academic medical centers could serve as such a central hub for a network of decentralized and independent providers in rural areas with their specialty expertise. The DHB recognizes that although they may not have a large impact on the overall Quadruple Aim, high quality medical care in rural areas is a necessary and critical part of the 13 elements specified in the NDAA 2017. When done successfully, CINs coordinate care across the network, and bring medical expertise to beneficiaries in areas with low access to knowledgeable specialized care and diagnostics. CINs can also promote Electronic Health Record (EHR) interoperability, clinical to clinical consults, access to clinical practice guidelines between facilities, and telehealth using various technologies.

Virtual Value Providers

Virtual Value Provider Networks are subsets of network providers, identified through robust data analytics, who in their approach to patients and generally conservative use of diagnostic testing and specialty referral provide high value care. The vendor should be able to inform and proactively promote to ("steer")

beneficiaries the value of these high value providers through transparent, easy to understand data sharing, communication, incentives, and referral management. The DHB recognizes that there are few financial levers that TRICARE can employ with its beneficiaries (at least as compared to current commercial beneficiaries). However, the DoD should consider beneficiary levers that are “value-based” in nature (i.e., that the beneficiary is incentivized to select the higher value rather than the lower value service or provider). Transparency of data is necessary for beneficiaries to know which providers are higher values. TRICARE and TRICARE vendors should measure quality of care at the condition level rather than at the hospital, provider system, or MTF level. The vendor should outline the specific parameters by which they will evaluate providers and determine value.

System-Wide Innovations

System-wide innovations are programs that target patients directly to educate, motivate, and support patients in adhering to evidence-based care guidelines, self-care, and healthy behaviors.

Advanced Care Management

Advanced Care Management (ACM) encompasses care coordination, chronic condition care management, case management, and medication therapy management. The DoD needs to carefully vet proposals to ensure the vendor has demonstrated success in using data analytics and predictive modeling to identify the beneficiaries with high risk or complex medical conditions in need of medical support and care coordination. Specifically, the vendor should show that their ACM program impacts patient understanding, shared decision-making, and adherence. Regular patient monitoring, particularly to detect declines in physical or mental status, and the delivery of proactive interventions should produce improved health and satisfaction. Vendors should also demonstrate how they have leveraged technology in case management and its impact on outcomes. Finally, the DoD should assess the vendor’s record of addressing the root causes of poor health, including health behaviors and socio-cultural influences that are the major contributors to chronic disease. The DoD should rate vendors highly if they can link patients’ needs with local programs and communities to promote healthy behaviors. The vendor should demonstrate superior cost savings, clinical outcomes, and better health using their ACM programs, contributing to a positive ROI.

Wellness Programs

Wellness Programs seek to engage beneficiaries in a deeper understanding of the multiple factors contributing to the health and a sense of well-being, leading to positive changes in the beneficiary’s lifestyle. The DHB recommends that when TRICARE evaluators assess a vendor’s wellness offering, they review their record of success in engaging beneficiaries, the quality of programs or partnerships addressing lifestyle changes, the improved health of those engaging, and the ROI (medical and pharmacy costs) or Value on Investment (inclusion of total employer productivity costs increasingly measured by leading employers) of the program. Also, wellness programs should have evidence of a socio-cultural foundation in that they align culturally with beneficiaries and incorporate local providers.

Disease Management

Disease Management programs are generally remote, nurse case manager telephonic models to address certain chronic diseases. The DHB finds that disease management programs narrowly focused on only one disease, rather than on the whole person with multiple co-morbidities in the context of their family and social needs, to be of limited or negative ROI. Instead, the DoD should view support programs that emphasize the whole person with a multidisciplinary team as preferable to Disease Management programs.

Innovations to Basic Health Plan Operations

The DHB considers innovations in this category to be administrative functions of a health plan that should be a standard part of any vendor's current or near-term operational capability.

Access to Care Standards

Access to Care Standards are necessary to ensure timely care for both better care and increased medical readiness of the force. Access to Care Standards are particularly important to support rural health care delivery. More important than the Standards is a vendor's demonstrated ability to provide care within these standards and their ability to meet TRICARE's access standards as well. The DHB expects the use of telehealth technologies can support better access (again, particularly for rural beneficiaries) relative to previous TRICARE contracts.

Automatic Authorizations

The DHB does not consider Automatic Authorizations (removing the need for health plan approvals for designated procedures and/or providers) to be a particularly innovative practice. However, it should be a part of how a vendor decreases the overall cost to TRICARE, increases provider acceptance of the TRICARE vendor contract, and improves convenience for beneficiaries. The DoD should consider the robustness of the vendor's technology to improve the automatic authorization process and better identify which referrals require additional oversight. Providers and procedures can be given an exemption from authorizations due to evidence in previous data and ongoing guideline or benchmark adherence.

Central Enrollment

Central Enrollment is an innovation that can support care for the highly mobile TRICARE beneficiary population. The DHB encourages the DoD to prioritize selecting vendors that have proven they can assure a smooth transition between providers and locations to prevent inconvenient and dangerous gaps in care when patients move between health networks. The DoD should assure that when beneficiaries switch from one vendor to another, (particularly in the event of mobilization or change-of-duty station) both vendors will proactively assure the transition of care in the months before and month after the transition.

Vendors should utilize a Continuity of Care Record to facilitate patient records transfer across providers and networks. The DHB believes that this feature will contribute to increased readiness of ADSMs, retirees, and dependents by avoiding the issues that can arise when a person requires care soon after moving.

Provider Recognition and Reward

The DHB recognizes that Provider Recognition (awarding “gold stars” or ribbons to high performing providers) and Provider Reward (bonus payments to providers in addition to payment for care) by themselves are of limited value in contributing to the Quadruple Aim. Historically, incentives have been too low to produce meaningful outcome improvements. Provider Recognition and Reward has been most effective when they incorporate externally transparent comparisons, condition-specific outcome measures, and comparison of providers against both best practice benchmarks and peers.

Telehealth and Digital Health

The DHB views telehealth and digital health as “care enabling” and “force-multiplying” technologies and vital components of a health system that contributes greatly to the Quadruple Aim. Telehealth and digital health should be integral parts throughout the continuum of care. TRICARE should promote innovative applications of these technologies such as remote home monitoring and digital self-monitoring for selected chronic conditions across the network in the T-5 contract and beyond. In today’s health care world, telehealth has become vital to the delivery of everyday care in addition to specialized care. These technologies are especially important in providing care to beneficiaries in rural areas.

The DoD should assess how vendors applied lessons learned from the rapid expansion of telehealth and digital health due to the coronavirus disease 2019 pandemic to incorporate them into their standard services. The DHB advises that TRICARE should not view telehealth services as part of a fee-for-service model. Rather, the DHB encourages TRICARE to include telehealth as part of a value-based care strategy with movement toward embedding this service within a bundled or global payment.

The DoD should rate vendors on how they currently use telehealth and digital health and how they plan to strategically expand their use. This expansion includes the use of digital health for remote patient monitoring, feedback, and treatment. The DHB encourages TRICARE to adopt telehealth and digital health solutions that expand their ability to provide treatment for beneficiaries in their homes to the extent possible.

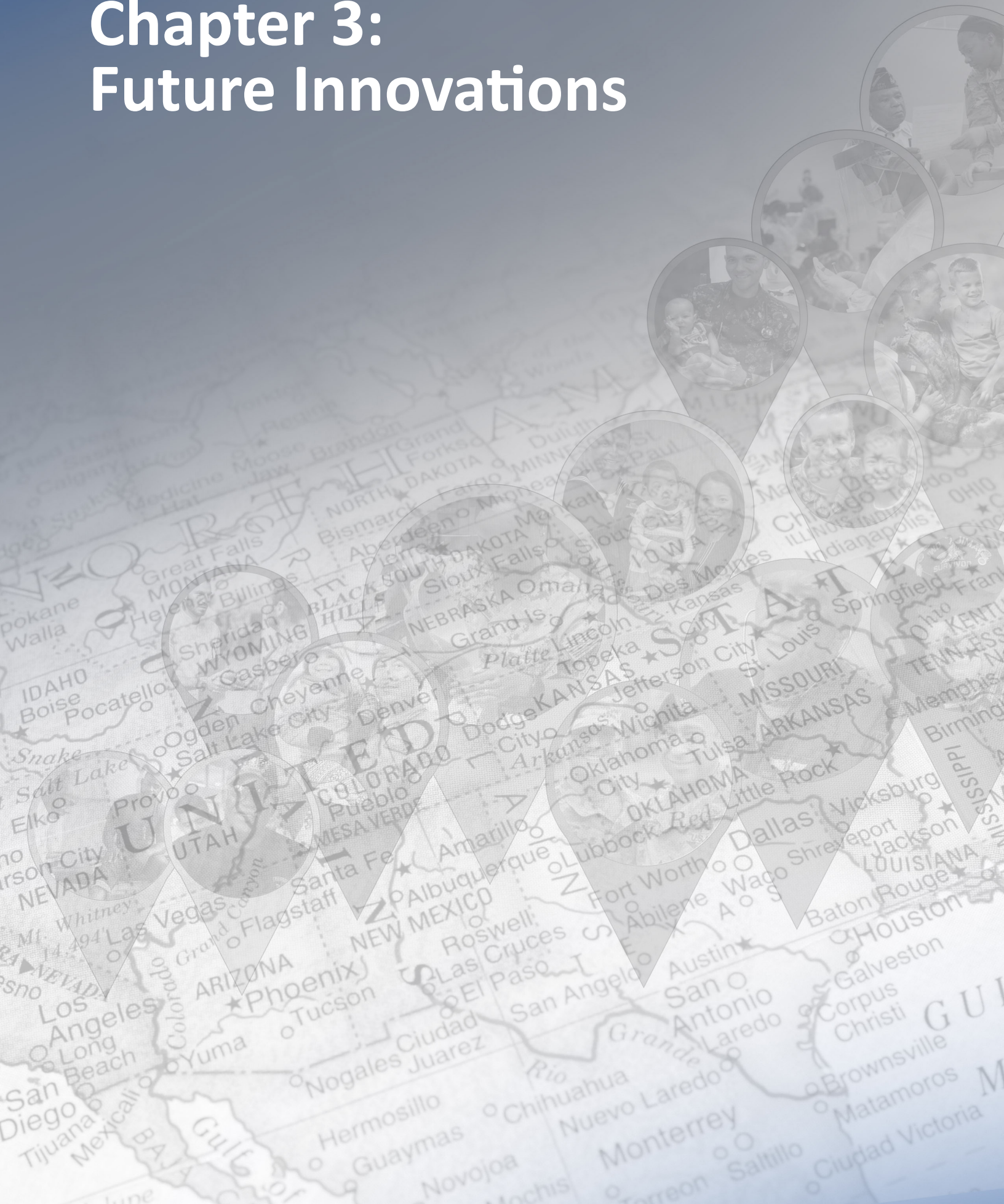
Utilization Management

The DHB views Utilization Management (UM) – applying criteria to assess appropriateness of services - as a practice that can reduce wasteful variation and inappropriate use of services. Similar to the other innovations categorized as system-wide innovations, the DHB expects that vendors should already be

conducting UM activities such as prior authorization, concurrent review, and retrospective review and using data analytics to identify positive and negative outliers. TRICARE should greatly expand the scope of UM to reflect randomized audits of costly, interventional treatments to assess whether an intervention was medically appropriate. Such audits can be especially helpful in “hotspots,” providers characterized by unusually high incidences of costly, interventional treatments. TRICARE can also use audits to question high volumes of low value medical services by individual vendors. Vendors should move positive outliers (those who show consistently good adherence to guidelines) to “automatic authorization.” Vendors should notify those that are negative outliers, apply corrective action, and remove them from the network if the outlier pattern of care continues.

To evaluate vendors’ proposals, the DoD should consider the extent to which the vendor has a systematic approach to identify, address, and reduce low-value and inappropriate visits, tests, services, and procedures among providers in their networks.

Chapter 3: Future Innovations



In addition to the criteria for evaluation outlined in the previous chapter, the DHB recommends that the DoD proactively explore the following innovations and emerging trends that will help TRICARE move faster and more effectively to a value-based health system:

1. Data Availability and Transparency

TRICARE currently lacks granular program data on health, wellness, and readiness. Future contracts should include data collection requirements that tie closely to the Quadruple Aim as applied to Service members, retirees, and their families. DoD should seek to align data, reports, and dashboards currently in use for MTFs and the MHS with data, reports, and dashboards for TRICARE. For all desired data elements, vendors in concert with TRICARE leadership can collect, extract, and if necessary, customize data from the program's activities. TRICARE should measure how program data tracks on or compares to past performance. Detailed Per Member Per Month cost data is an example of data that TRICARE can utilize to measure outcomes and make program decisions. In addition, TRICARE and the DoD should be prepared to distribute and share results from any pilots and demonstrations. The reach and structure of the DoD allows them to conduct health care research with the potential to have a significant impact on health care delivery across the United States. Additionally, the DHB recommends that DoD make anonymized TRICARE data available to health care researchers.

2. Beneficiary Cost Structure Flexibility to Enable Value-Based Benefit Design

TRICARE beneficiaries currently experience both a low and fixed total cost relative to the vast majority of health plans. While retaining this relative advantage to honor the sacrifices of military members and retirees, DOD should consider introducing a more flexible cost structure which could accelerate offering more impactful value-based benefit designs. This structure should include a range of co-payment and maximum out-of-pocket limits. TRICARE should consider introducing account-based plans with value-based incentives as options including a Health Savings Account to beneficiaries before they become Medicare-eligible at age 65; implement a value-based benefit design by not paying providers for low value care; and promote value-based care by imposing higher co-payments for beneficiaries that do not use COEs.

3. Provider Payment Reform

Related to a change in the cost structure of the TRICARE program, the DHB recommends moving TRICARE toward Alternative Payment Models (APM) to reimburse outcomes of care rather than volume of care. One example of APM is a bundled payment system. Research shows that bundled payments may lower spending without sacrificing quality.¹⁹ Bundled payments discourage unnecessary care by paying for expected costs of care based on a patient's condition

or type of procedure.²⁰ This type of payment model incentivizes efficiency in care, team-based care, integration across the patient’s treatment cycle, and accountability for patient outcomes. Additional APMs include capitation, shared-risk, and shared-saving.

4. Integration with Pharmacy and Dental Benefit

Separate statutory authorities currently cover the TRICARE dental, medical, and pharmaceutical benefits. TRICARE should explore the creation and potential impact of creating a unified and integrated benefit to improve beneficiary convenience and reduce costs in future versions of the program. Large employers and leading health systems increasingly measure “total cost of care” (including all medical, pharmacy, and to a lesser degree dental costs) to accelerate innovation in care delivery and achieve maximal cost savings. Amending the TRICARE program in this way is a lengthy process that may require conducting a demonstration. However, as the proof of total cost of care for both provider payment and employer-based purchasing models grows, there may be sufficient evidence for the DOD to move in this direction without conducting a demonstration. The TRICARE program will also be better able to realize the benefits of the emerging fields of pharmacogenetics and precision medicine when the pharmaceutical benefit aligns more closely with the medical benefit.

5. Artificial Intelligence

TRICARE should promote the use of advanced data and analytics (e.g., intelligent automation, AI, and machine learning) across the program and explore these innovations as used in the private sector to determine how best to apply them. For example, the DoD should conduct pilots and demonstrations that test the effectiveness of AI and other advanced analytical tools in as many areas of the TRICARE program as possible to prepare to implement them in future contracts. Participation in AI-consortia with the adoption of standards will help ensure the appropriate application of AI within TRICARE. The DoD should assess the use of AI in TRICARE to be sure it does not embed biases that exacerbate health disparities.

6. Intensive Lifestyle Disease Reversal Programs

The DoD should include Intensive Lifestyle Disease Reversal (ILDR) programs to the TRICARE benefit. ILDR is based on three decades of research that support the intensive use of health behaviors to treat and reverse common diseases such as cardiovascular disease, diabetes, multiple inflammatory conditions, and certain cancers.²¹ ILDR programs promote plant-based nutrition, physical activity, and stress management to improve health. The DHB recommends looking to the experience of large, self-insured employers that are deploying these programs in onsite clinics and community settings for employees and their spouses. These programs can reduce health care utilization,

medications, and improve productivity within weeks or months when offered to populations with multiple chronic diseases and related medications. TRICARE should study the use of ILDR programs in the TRICARE environment as the epidemic of life-shortening and costly lifestyle-related diseases continue to increase.

7. Rapid Cycle Innovation with Demonstrations and Pilots

The DoD should expand existing pilots and demonstrations that focus on medical conditions that have a high impact on the Quadruple Aim. The DoD should apply a rapid cycle improvement process to their demonstrations and pilots to inform their effectiveness in the TRICARE environment, develop best practices, and lay the groundwork for inclusion in future TRICARE contracts. The DoD should consider using an Agile approach to implementation, evaluation, and subsequent modifications or termination of the project based on that evidence.

The DHB used the criteria outlined in Chapter 2 of this report to frame its evaluation and prioritization of the proposed innovations. The DHB advises DHA vendor evaluators not to use a simplistic scoring method, particularly not one in which evaluators weigh each innovation criterion equally and in which they weigh innovations equally with other vendor proposal criteria. The DHB believes that the DHA should give increased weight to vendor proposals with innovations that are likely to have the greatest overall impact on the Quadruple Aim and bring TRICARE closer to a value-based program.

Appendix A: References

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Appendix B: Terms of Reference



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

JUL 24 2020

HEALTH AFFAIRS

MEMORANDUM FOR PRESIDENT, DEFENSE HEALTH BOARD

SUBJECT: Request for Defense Health Board Review, Modernization of the TRICARE Benefit

Pursuant to the attached Terms of Reference (TOR) on “Modernization of the TRICARE Benefit”, I direct that the Defense Health Board (“the Board”) provide recommendations to help customize value-and quality-based health care innovations to meet the unique needs of Department of Defense (DoD) beneficiaries and assist with their inclusion in TRICARE support contracts. Specifically, the Board should develop criteria to assess and prioritize health care innovations and advise how the DoD might best develop and implement the innovations within TRICARE.

The TOR for this review provides a detailed description and scope of the tasking. The point of contact for this action is CAPT Gregory Gorman. He may be reached at (703) 275-6060, or gregory.h.gorman.mil@mail.mil. Thank you for your support and commitment to optimizing the health and force-readiness of the military.

A handwritten signature in blue ink, appearing to read "Tom McCaffery".

Tom McCaffery

Attachment:
As stated

cc:
Group Federal Officer
Advisory Committee Management Officer
Defense Health Board Designated Federal Officer

Defense Health Board
Modernization of the TRICARE Benefit
TERMS OF REFERENCE

These terms of reference (TOR) establish the objectives for an independent review to help customize value- and quality-based health care innovations to meet the unique needs of Department of Defense (DoD) beneficiaries and assist with their inclusion in TRICARE support contracts.

Mission Statement: The mission of the Defense Health Board (“the Board”) is to provide independent advice and recommendations to maximize the safety and quality of, as well as access to, health care for members of the Armed Forces and other DoD health care beneficiaries.

Issue Statement: The Military Health System (MHS) is a unique federal health care system with a critical mission: ensuring that America’s military personnel are healthy, maintaining a ready medical force in support of operational forces around the world, and delivering a medical benefit to approximately 9.5 million beneficiaries¹ including 1.3 active-duty Service members. TRICARE is comprised of a network of 51 military hospitals and 424 military medical clinics (“Direct Care”), supplemented by programs to enable beneficiaries to seek care in the private sector (“Purchased Care”). Purchased Care is delivered through a suite of contracts including the TRICARE Managed Care Support contracts (MCSC); one for each of two regions in the United States, along with a separate overseas contract, and a statute-based carve-out of 6 designated health providers that provide care at the sites of former US Public Health Service locations.¹

Congress has an enduring interest in TRICARE as the health system for the nation’s military, dependents, and retirees, legislating periodic changes through National Defense Authorization Acts (NDAAs). The fundamental health plan design is built on a fee-for-service model with defined entitlements to manage TRICARE Prime and TRICARE Select health plans. Section 705² of the NDAA for Fiscal Year (FY) 2017 required DoD to incorporate 13 elements into the TRICARE contracts, including: leading best practices in value-based health care, improved benefits design, health plan management, technology, disease management, telehealth, and use of incentives to promote positive health outcomes. Section 705(c)(6) specifies special attention to health plan management in rural, remote, and isolated areas.

Leading health care systems, including those reimbursed by the Centers for Medicare & Medicaid Services, are moving towards alternative payment models that value healthcare outcomes over quantity of services provided. These payment models include bundling, capitation, accountable care organizations, and clinically integrated networks. When linked to quality outcomes, these value-based care models spur innovation for improved care at more affordable prices. The MHS has developed alternative payment models for some services, such as bundling of pregnancy and peripartum services and the Autism Demonstration Project. The MHS also initiated a medication adherence pilot and an accountable care demonstration in the metropolitan Atlanta area. There are opportunities to expand these and other alternative payment models, incentives, health technology, and other value-based health care innovations

in line with NDAA FY 2017 in support of the MHS Quadruple Aim of increased readiness, better care, better health, and lower cost.

The Defense Health Agency (DHA) has partially implemented 6 of the 13 elements specified in the FY 2017 NDAA.³ For the current and next TRICARE contract, DHA is considering expanding innovations, to include multiple new pilots and demonstrations. To meet the statutory, fiduciary, and moral obligations to MHS stakeholders and beneficiaries, a deliberate effort to identify and review commercial innovations through the lens of the unique TRICARE program could assist with better tailoring pilots and demonstrations to the needs and interests of TRICARE beneficiaries and help meet the Quadruple Aim.

Objectives and Scope:

The Board should develop criteria to assess and prioritize the following commercial health care innovations and provide advice and recommendations on how DoD might best develop and implement them within TRICARE. At a minimum, criteria should consider statutory requirements and magnitude of impact on the MHS Quadruple Aim. This may include an overall value-based healthcare vision that combines some or all of these innovations into a concerted strategy with optimal impact on readiness, cost, quality and access.

- **Virtual Value Providers:** Assess and assign special status to specific in-network providers for certain procedures based on high quality and affordable cost
- **Centers of Excellence (COE):** Designate high quality/outcomes providers for better care quality
- **Standard Telehealth:** Allow synchronous and asynchronous telehealth, care at home, and virtual monitoring teams
- **Optimized Telehealth:** In addition to standard telehealth, maximize digital solutions (e.g. all qualified providers); add beneficiary and provider financial incentives for utilization
- **Targeted Utilization Review:** Focused review on specific cases, based on criteria, for heightened attention, to change and improve provider practice patterns
- **Automatic Authorizations:** “Gold cards” for certain high value providers: authorization not required for referral
- **Care Collaboration:** Facilitate electronic Consults and reduce specialist referral rates
- **Care Management:** Require standard care management for care coordination, referral management, and provider shaping
- **Advanced Care Management:** In addition to standard Care Management, require MCSC provider incentives for interoperability and Artificial Intelligence (AI) care management tools (for predictive risk identification/stratification), referral management, and provider shaping. Target high cost, high utilization, complex needs beneficiaries such as those with diabetes mellitus and cancer.
- **Provider Recognition:** Provider performance measured and shared.
- **Provider Reward:** Provider performance measured and managed, with financial gains for providers who reduce total cost of care while improving outcomes.
- **Wellness Pilots:** Replacing the current “following year” reduced copay, co-insurance, and enrollment fee design.

- **Wellness and Disease Management Pilots:** In addition to Wellness Pilots, use best-in-class program design and financial incentives to enable patient behavior change.
- **Advanced Primary Care (APC):** Encourage team-based medical home: patient-centered, longitudinal, and coordinated.
- **Access to Care Standards:** Standardize measures for Access to Care across TRICARE Prime and TRICARE Select plans.
- **Central Enrollment:** Strategic roadmap that aligns an eligibility & enrollment timeline to regulatory & technology dependencies
- **Accountable Care Organizations (ACO):** Assess and assign special status to sub-groups of providers and APC based on “high-value” and incentivize beneficiaries and health plans to use ACO providers.
- **Clinically Integrated Networks:** Require to the maximum extent possible networks of providers that band together to improve care quality and lower costs, using clinical, data, and financial integration that measure and manage performance. They are usually high performance networks with integrated medical management that use value-based payments and other incentives inside the network to incentivize providers to practice high quality, cost effective care.
- **At-Risk Centers of Excellence:** High quality/outcomes provider groups with affordable cost by adding episode of care/bundled payment contracts – enables COEs to achieve cost savings which they may wish to share
- **Utilization Management:** Focused review on specific cases, based on criteria, for heightened attention, use financial incentives
- **Artificial Intelligence:** Use of AI for a variety of purposes to improve care, quality, and cost. For example, identify areas where prior authorization is not economical and should be automated, improve clinical stratification and identification to find patients needing interventions before they get sick, or network optimization within and between direct care and purchase care providers.
- And other innovations identified by the Board

Methodology:

1. The Board may conduct interviews and site visits as appropriate.
2. The Board may seek input from other sources with pertinent knowledge or experience.
3. In accordance with the November 26, 2018 Deputy Secretary of Defense memo, “Advisory Committee Management,” the Board shall receive full and timely cooperation of each OSD or DoD Component Head in providing analyses, briefings and other DoD information or data necessary for the fulfillment of its responsibilities as provided for by this TOR.

Compliance:

The Board will operate in conformity with and pursuant to the Federal Advisory Committee Act, the Government in the Sunshine Act, and other applicable federal statutes and regulations. Individual Board members do not have the authority to make decisions or recommendations on behalf of the Board, nor report directly to any federal representative. The members of the Board are subject to certain Federal ethics laws, including 18 U.S. Code §208, governing conflicts of

interest, and the Standards of Ethical Conduct regulations in 5 Code of Federal Regulations, Part 2635.

Deliverables:

The Board will complete its work by November 2020, and will deliberate on the report in a public forum. The Board will report to the Assistant Secretary of Defense for Health Affairs, who has been delegated the authority to evaluate the independent advice and recommendations received from the Board and, in consultation with the Under Secretary of Defense for Personnel and Readiness, identify actions or policy adjustments to be made by DoD in response. Progress updates will be provided at each Board meeting.

Required Support:

1. The Defense Health Board Support Division will provide any necessary research, analytical, administrative, and logistical support for the Board.
2. Funding for this review is included in the division's operating budget.

References:

1. Evaluation of the TRICARE Program: Fiscal Year 2020 Report to Congress (<https://health.mil/Reference-Center/Reports/2020/06/29/Evaluation-of-the-TRICARE-Program-Fiscal-Year-2020-Report-to-Congress>)
2. National Defense Authorization Act for Fiscal Year 2017. Pub L. 114-328, div. A, title VII, §705, 130 Stat. 2201-2206 (2016).
3. Government Accountability Office. Defense Health Care Plans Needed to Ensure Implementation of Required Elements for TRICARE's Managed Care Support Contracts. GAO-20-197, February 2020.

Appendix C: Methods

The DHB Support Division performed a comprehensive search and review of the TRICARE program's current and historical benefits structure, the process for amending the program, and innovative health care practices. Topics of research included legislation that governs TRICARE, the process by which TRICARE benefits may be modified, details about the innovations listed in the TOR, and recent or current TRICARE pilots and demonstrations.

The Working Group received briefings from experts within the Defense Health Agency (DHA) and civilian health care industry on the TRICARE program, the legislative authority required to change TRICARE benefits, the results and lessons learned from TRICARE pilots and demonstrations, and various healthcare innovations. These experts were identified through a review of current TRICARE leadership and partner civilian organizations participating in TRICARE pilots and demonstrations. The Working Group members also utilized their professional experience in health care management and innovation to develop criteria and apply it to the innovations.

The DHB Support Division used data condensation methods (e.g., categorizing, theming, indexing) to provide a framework for the Working Group members when drafting evaluation criteria. The framework was subsequently used to guide the Working Group's application of the prioritization criteria to the proposed innovations listed in the TOR. The Working Group Chair briefed the prioritization criteria to the DHB in an open forum, with discussion by DHB members and opportunity for input by the public.

Appendix D: Innovation Descriptions

These are general descriptions of the health care innovations under consideration by the DHA as presented at the TRICARE T-5 Industry Forum in September 2020. See Appendix E: TRICARE T-5 Industry Forum Slides for more information.

1. Accountable Care Organizations

Accountable Care Organizations are groups of health care providers and facilities that form a network to provide high-quality care to their patients. An integrated team of providers agrees to be “accountable” for the care of a given population and coordinates internally to achieve high-quality outcomes. ACOs utilize health outcome measures to identify high performing providers and streamline referrals to these provider teams to improve health outcomes of beneficiaries and lower costs by encouraging evidence-based practices to reduce complications. ACOs vary on the level of integration with pharmacy and community partners, and on the level of tolerance for beneficiary care provided outside of the ACO. Physician-led ACOs have a better record of cost reduction than hospital-led ACOs. In an ACO, the payment is at least partially dependent on documentation of cost savings and quality outcomes. The larger the percent of payment at risk, the better the performance tends to be.

2. Centers of Excellence

Centers of Excellence are hospitals or health systems that specialize in specific procedures and treatments. These COEs are quality, safety, and outcome leaders in their specialty areas, for example transplants, cancer treatment, joint replacement, and maternity care. The COE model provides wrap-around team-based care, involving multiple health professionals and extending care throughout a patient’s care cycle (e.g. pre-operative, post-operative, inpatient, outpatient, rehabilitative).

3. At-Risk Centers of Excellence

At-Risk COEs are COEs that accept episode of care and bundled payment contracts. The COEs accept the risk – or reward - if costs to achieve positive outcomes differ from the value of the bundled payment. At-risk COEs have a larger incentive for multidisciplinary collaboration throughout the continuum of care.

4. Advanced Primary Care

Advanced Primary Care is a method of care that places the patient and family at the center, which focuses on outcomes rather than volume. Patients can have same day appointments and access to the care team after hours. APC stratifies patients by risk with proactive outreach to be sure each patient is getting the needed care. It focuses on prevention, promotes care coordination for complex patients, and supports robust connections with community-based services through a multidisciplinary care team.

This care team works with a value-driven administrative infrastructure to enhance care optimized for patient satisfaction.²²

5. Care Collaboration

Care Collaboration refers to a broad set of activities facilitating coordination among providers across the care continuum, which may include virtual “curbside” consults between and among primary care and specialist providers (including behavioral health) via telehealth. Providers and the patient’s caregivers work together to ensure that the patient is following the treatment plan. This leads to better outcomes through avoided errors and gaps in care due to the increased communication across the care team.

6. Clinically Integrated Networks

A Clinically Integrated Network is a group of independent providers that come together to create a high quality, low cost set of services intended to benefit consumers. Providers use EHRs to share information and promote team-based care. Clinically Integrated Networks allow providers to practice independently but promote better outcomes due to increased access to data that informs them of best practices for treating patients in their area. Besides the benefit for providers, Clinically Integrated Networks allows patients to receive high quality, high-value care across the network. This is especially beneficial for patients in rural areas. TRICARE coverage through a clinically integrated health care delivery system has the potential to assure better access to care, improved outcomes, and reduced cost.

7. Access to Care Standards

Access to Care Standards provide benchmarks by time, distance, or drive time for primary and specialty care. They ensure that beneficiaries have access to needed high-value care that is available across the network regardless of where they live.

8. Virtual Value Providers

Virtual Value Provider Networks are subsets of network providers, identified through data analytics, who naturally provide high value care. Vendors, through preferential referrals, steer beneficiaries to providers within these virtual networks.

9. Advanced Care Management

The ACM model encompasses holistic patient and family-centric care coordination, chronic condition care management, case management, and medication therapy management. In this model, integrated data from multiple sources (claims, medications, behavioral health, employee assistance programs, etc.)

and predictive modeling identifies beneficiaries that require ACM and the level of medical support and coordination they need. With this information, a primary case manager uses a behavioral medical approach to provide integrated care coordination to beneficiaries with high risk and complex medical conditions. The ACM model promotes better care and better health through a collaborative care process between providers of different disciplines to provide holistic treatment for the patient. Shared decision-making and patient advocacy services reduce low value tests and procedures and promote higher value services and providers. It is a “whole-person” model of care management, rather than a narrow disease-specific focused program.

10. Wellness Programs

Wellness Programs engage the whole population of beneficiaries in activities to assess health risk and develop action plans to improve health through life-style changes. Successful programs often use behavioral economics and social gamification to motivate behavior change. Incentives may include coaching, digital trackers, and financial incentives to promote beneficiary engagement with the program.

11. Disease Management

Disease Management programs group patients with the same condition, such as asthma, diabetes, and heart disease and proactively reaches out to encourage adherence with the medication regime and evidence-based care. Disease Management aims to improve outcomes by enhancing patient knowledge and self-management.

12. Provider Recognition and Reward

A Provider Recognition and Reward program provides positive feedback to providers on the results of their care. Feedback may consist of public acknowledgment or financial incentives. This practice can promote quality improvement and cost effectiveness of medical care. Recognition and rewards should account for case-mix and medical complexity so that providers perceive the program as fair. The incentives can promote value-based care by motivating providers to avoid low-value care.

13. Automatic Authorizations

Automatic Authorization is a process that reduces the need for manual authorization for referrals. With Automatic Authorization, AI uses data to analyze provider quality, cost, outcomes, and referral patterns to determine whether the provider complies with the requirements. Providers can achieve lower costs through increased efficiency, lower personnel cost, and increased patient satisfaction due to reduced waiting time for a referral when they receive Automatic Authorizations. Automatic Authorization programs can overlay with Provider Recognition/Reward programs to allow high-value providers to refer patients without the need for authorization.

14. Central Enrollment

Central Enrollment enables timelier and more portable enrollment and eligibility for newly enrolled or transferring beneficiaries. These functions preserve beneficiary choice of provider based on their needs and, ideally, provides accurate provider directory information. Central enrollment allows providers to link family members in the system. This is especially useful for TRICARE beneficiaries who have unique mobility requirements as they move between service areas.

15. Telehealth and Digital Health

Telehealth uses synchronous and asynchronous communication technologies to provide health services. These services facilitate connection between patients and providers, support treatment adherence through automated messages and appointment reminders, and improve access to care for patients of limited mobility or in rural areas. The more-encompassing concept of Digital Health involves remote health monitoring, secure messaging, email, AI chat-bots for triage and diagnosis, as well as traditional telehealth technologies for patient care. Digital Health contributes to better outcomes by supporting multiple aspects of a patient's care experience. This allows beneficiaries to receive care from their homes rather than having to travel to a health care facility resulting in lower costs for the beneficiary.

16. Utilization Management

Utilization Management refers to a broad set of activities intended to monitor, measure, and manage use of clinical services to improve quality by reducing unnecessary care and lowering costs. UM aims to manage health care costs by assessing the appropriateness of a service before the beneficiary receives the service. It manages costs by balancing necessity of care, alternatives to care, and the cost of such care. UM also includes Targeted Utilization Review, a system that analyzes referrals, testing, hospitalization, and other indicators to identify and measure inappropriate care. UM identifies wasteful practices.

Appendix E: TRICARE T-5 Industry Forum Slides

Innovations under T-5

DHA has been mandated by Congress (through the National Defense Authorization Act of 2017) and the Government Accountability Office (GAO) in 2020 to initiate 9 specific reform elements to the TRICARE program to modernize services and maximize efficiencies and value (see sections 705, 718, 728 & 729).

In an effort to satisfy these reform expectations, the following innovations are under consideration and will be reviewed in the following slides:

Access to Care

ACO

Advanced Care Management (ACM)

Advanced Primary Care

Care Collaboration Tools

Centers of Excellence (COE)

Centralized Enrollment and Eligibility (CEE)

Clinically Integrated Networks

Provider Recognition & Reward

Targeted Utilization Management

Telehealth

Virtual Value Networks (VVN)

Wellness & Disease Management Incentives



Access to Care

Hypothesis: To support military medical readiness, service members must have access to high-value care in MTFs and Purchased Care (i.e., civilian) settings. The network must be comprehensive, large enough to support timely access to care, easy to navigate and seamlessly coordinated. New technologies and models of care delivery can improve access to care. Through access to high-value care, beneficiaries will experience better outcomes and lower costs.

Description:

- According to the Institute of Medicine, “Access is a shorthand term for a broad set of concerns that center on the degree to which individuals and groups are able to obtain needed services from the medical care system. Often because of difficulties in defining and measuring the concept, people equate access with insurance coverage or with having enough doctors and hospitals in the geographic area in which they live. But having insurance or nearby health care providers is no guarantee that people who need services will get them...”
- Access is “the timely use of personal health services to achieve the best possible health outcomes.” †
- Models including Advanced Primary Care and Telehealth improve access to care

Demonstrated Outcomes

Quality

- Use of National Committee for Quality Assurance standards to guide measurement for availability of providers
- Use of multiple metrics to measure Access to Care and support ongoing assessments of network adequacy
- New higher access provider models improve preventive and chronic care outcomes

Efficiency

- Network will be sufficient in number, mix and geographic distribution to provide the full scope of benefits for which all TRICARE beneficiaries are eligible

Convenience

- Beneficiaries have access to remote home monitoring capabilities, telemedicine, nurse visit and other modes of high-value accessible care
- Access to online provider directory and accessible 24/7
- Improved same/next day in-person access and telehealth access

Cost Effectiveness (Benchmark)

- Timely access to high quality primary care will reduce the need for urgent care and emergency care visits

† Institute of Medicine (US) Committee on Monitoring Access to Personal Health Care Services; Millman M, editor. Access to Health Care in America. Washington (DC): National Academies Press (US); 1993. Summary. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK235890/>



Accountable Care Organizations

Hypothesis: ACOs deliver integrated and coordinated care to beneficiaries by bringing together groups of high performing physicians, hospitals, and other providers who share financial and clinical responsibility for providing high-quality care aligned to financial incentives. Plan sponsors that offer ACOs may achieve high quality outcomes, lower cost of care and reduction of waste.

Description:

- Beneficiary care is delivered by an integrated team of healthcare providers including physicians (primary and specialty), hospitals, and clinics who agree to be “accountable” for the quality, cost and overall care for a defined population.
- Can be executed directly between a health plan sponsor and health system or between a health plan (MCSC) and a health system
- Payment models are based on quality and cost outcomes and range from upside bonus payments only, upside and downside risk and full capitation.
- Next generation ACOs utilize data and analytics to identify high value providers within the sponsoring health system’s full network of providers. Historically, the focus has been creating networks of providers within one health system regardless of the provider performance.
- Continuous measurement and evaluation of the ACO is critical to determine its effectiveness using performance metrics that are consistent with CMS and other widely used ACO measures.

Demonstrated Outcomes

Quality

- Improved health outcomes delivered by a subset of high value providers with reduced complications, improved preventive care, improved patient reported outcomes and reduction of waste
- Leverages evidence-based medicine & population health by multidisciplinary care team

Efficiency

- Designed to retain “high value” providers and remove or assist “low value” providers
- Streamlined MTF referral process to an ACO improving medical readiness process

Convenience

- Provider network is defined for beneficiaries
- Beneficiaries incentivized to utilize providers within the ACO
- Improved referrals and access within the closed ACO provider system

Cost Effectiveness (Benchmark)

- Few ACOs are delivering consistent savings and most still have upside-only arrangements with the health plans[†]



[†] 2018 National Business Group on Health large employers' health care strategy and design survey.

Advanced Care Management

Hypothesis ACM supports care coordination, referral management and provider shaping and targets beneficiaries with high risk, high cost, high utilization and complex needs. Implementation of ACM demonstrates improved quality of care, decrease in total cost of care, higher beneficiary satisfaction and reduced waste.

Description

- ACM model encompasses care coordination, chronic/condition care management, case management, medication therapy management and integration with utilization management
- Process for predictive modeling data analysis to identify beneficiaries requiring ACM and required level of support, may include medical and/or social determinant data
- Multidisciplinary team utilizes an integrated behavioral medical approach; staff includes registered nurses, social workers, behavioral health clinicians, dietician, other clinical subject matter experts, clinical pharmacist, medical director, physical therapist etc.
- ACM systems allow for interoperability with existing Health Information Exchanges and can support direct provider-to-provider Electronic Health Record (EHR) information exchange
- ACM extends across the continuum of care (acute, subacute, long-term and home-based care) including medical and behavioral health settings
- Provider behavior can be positively influenced to be more consistent with value-based care principles through working more collaboratively with care managers in an advanced CM model

Demonstrated Outcomes

Quality

- Focus on high risk, complex beneficiaries and those with chronic diseases for at least 3-5% of high cost claimants
- Whole person approach to care
- Reduction in clinical complications
- Improved and sustained experience of care

Efficiency

- Improved readiness status/Return to Duty/Function
- Provides complex beneficiaries with whole person approach to care and seamless experience

Convenience

- Incorporates data from wearable and other remote monitoring devices (e.g. home blood pressure cuff) to monitor health status without having to go to a physical location for care
- Multimodal engagement strategies offered (e.g. text, email, chat)

Cost Effectiveness (Benchmark)

- Mercer Health Advantage ACM programs have demonstrated a > 2:1 Return on Investment (ROI); a recent analysis of the 2018 MHA Book of Business Performance demonstrated a \$375 per-employee-per-year savings, yielding a 2.7:1 ROI including program costs



Advanced Primary Care

Hypothesis Primary care is the most significant variable related to better health status, correlated with lower mortality and fewer deaths from high-cost conditions. Inclusion of community based Advanced Primary Care (APC) provider groups offering expanded services will demonstrate a reduced overall cost of care and improved clinical outcomes.

Description

- APC is a practice design that enhances patient access, focuses on prevention, promotes care coordination for complex patients, and supports robust connections with the medical neighborhood and community-based services through:
 - An integrated, multidisciplinary care team utilizing evidence-based medicine
 - An administrative infrastructure that supports value-driven care, population-based care payment, and integration of sponsor health and wellbeing ecosystem resources
 - Enhanced, patient-centric care options including: same/next-day/extended appointments, digital health tools, embedded telehealth, utilization of patient registries, collocation of behavioral health services, and management of life style risks
- Participating provider groups are identified based on clinical quality and financial performance, and the availability of embedded/collocated support services; Network APC coverage can be augmented by APC vendor groups operating at the local, regional and national level.
- Contracts can be structured with a combination of fee-for-service, capitation, and/or performance incentive payment for the management of the patient cohort.
- Providers are measured using risk-adjusted metrics for the care of their patient cohort, including: clinical, financial and beneficiary experience outcomes.

Demonstrated Outcomes

Quality

- Improves continuity of care with integrated, multidisciplinary team
- Improves prevention and clinical outcomes
- Reduces inappropriate care & waste

Efficiency

- Reduces utilization of emergency departments, hospitals, specialists, physical therapy, imaging and lab services[†]
- Streamlined specialist referral processes

Convenience

- Collocated, multidisciplinary team improves access
- On-demand digital health tools, embedded telehealth appointments
- Minimal waiting, longer visits

Cost Effectiveness (Benchmark)

- Multi-state APC vendor shown to reduce total cost of care by \$167 per member per month (PMPM)[†]
- Significant reduction in urgent care, Emergency Room, specialist and diagnostic services. Increase in primary care, pharmacy and behavioral health costs.



[†] Basu, S., Zhang, T., Gilmore, A., Datta, E. and Kim, E., 2020. Utilization and Cost of an Employer-Sponsored Comprehensive Primary Care Delivery Model. *JAMA Network Open*, 3(4), p.e203803.

Care Collaboration Tools (eConsults)

Hypothesis Increasing the ease of and access to provider-to-provider communications will speed diagnosis and treatment decisions, support primary care providers' ability to practice at the top of their license, reduce specialist referral rates therefore improve the quality and continuity of care and reduce cost. If DHA implemented care collaboration tools they would experience efficient, lower cost care and improved beneficiary satisfaction by reducing the reliance on referrals for in-person specialty visits and reducing wait times to receive specialist care

Description

- Care Collaboration tools refer to platforms and services that facilitate provider-to-provider virtual consultations (eConsults). eConsults are generally designed for primary care physicians (PCPs) seeking advice from specialists, they may be used between specialists as well.
- eConsults can be considered a form of Telehealth and can be implemented as a platform supporting multiple modalities of communication, or as a vendor provided service
- eConsults improve access to high value specialists, especially in underserved populations and rural areas
- eConsult platforms and EHR systems support machine-to-machine interoperability using healthcare EDI standards (e.g. HIPAA X12 transactions and Health Level 7® (HL7) Fast Healthcare Interoperability Resources® (FHIR) between MCSCs, network providers, the Direct Care System, and other authorized contractors

Demonstrated Outcomes

Quality

- Improved access to high value specialists & care quality
- Improve medical force readiness by increasing access to clinical subject matter experts
- PCPs report improved communication and sharing of knowledge with specialists compared to typical referral arrangements
- PCPs report that eConsult services remove approx. 50% of unnecessary specialist referrals; improve patient care in 80% of cases[†]

Efficiency

- eConsults allow for more timely provider to provider collaboration which may reduce the need for specialist care and/or fill network gaps
- Improves the specialist referral process, speeding return to warrior readiness

Convenience

- Reduced beneficiary wait time for specialist care

Cost Effectiveness (Benchmark)

- One eConsult vendor reports Return on Investments of >3:1 per customer and roughly \$500 savings per consult based on avoidance of specialist visits and/or avoidance of unnecessary services such as diagnostics/imaging

[†] Singh, J. et al, "Connecting PCPs to Specialists: Rubicon, MD Story as Narrated by Co-Founders," Credit Suisse, July 16, 2019



Centers of Excellence

Hypothesis COEs are hospitals and/or health systems that are recognized as having proven experience in specific treatment, procedures, and/or surgeries (e.g. transplant, cancer, joint replacement, cardiac surgery, bariatric surgery, and maternity care) and provide measurably higher quality care due to specialized expertise and resources. If DHA chooses and appropriately advises beneficiaries about their advantages, beneficiaries will use them and improve care.

Description

- Traditional COE models are built around procedures with high volume, high cost and highly variable outcomes while evolving COE models specialize in specific conditions such as diabetes, opioid use disorder and cancer and provide a collaborative model of care delivery; can be national and/or local but require equivalent quality standards
- Hard steerage (member incentive or disincentive) to COEs may reduce the beneficiary’s ability to choose but improves utilization of high quality, cost efficient care by in network providers. In the absence of hard steerage, COEs are a high quality, in network option for beneficiaries.
- A COE strategy can be achieved by one or more of the below designs:
 - Network option (with no risk): The COE is a high quality option within the existing MCSC network. Beneficiaries are not required to use the COE but are directed to the COE through education and referrals by the MCSC, particularly if care management is assisting the beneficiary with a condition that could be best treated at a COE
 - Beneficiary incentive: increase utilization from the network option through TRICARE plan design change to co-pay and/or co-insurance and/or offering a travel reimbursement
 - Fee-for-Service (FFS) Payment Arrangement: DHA may directly contract with a COE on a FFS basis or with a bundled payment for a defined episode of care that may or may not include a “warranty” based on specific outcomes; these warranties hold the provider clinically and financially responsible for treating specific poor outcomes within a defined time period
 - Value-Based Payment Arrangements with the COE: This puts the COE at risk in addition to, or in place of, beneficiary incentives added to the network option or a directly contracted option; helps achieve the best value (high quality, low cost) through adding contracted risk sharing mechanisms

Demonstrated Outcomes

Quality

- Quality of care will be high for a designated COE
- Avoidance of unnecessary procedures
- Reduced complications, shorter length of stay, superior clinical outcomes

Efficiency

- Reduced absenteeism and faster return to work

Convenience

- Beneficiaries select COE based on referral or proximity

Cost Effectiveness (Benchmark)

- National employer saved est. \$2.85M on joint replacements through bundled payment (\$2.5M) and avoided complications (\$300k) †
- Cost to the payer will vary depending on the financial arrangement



† Court E. How changing the way we pay for health care could save money and lives. MarketWatch website. <https://www.marketwatch.com/story/how-changing-the-way-we-pay-for-health-care-could-save-money-and-lives-2018-10-01>. Published October 2, 2018.

Centralized Enrollment and Eligibility (CEE)

Hypothesis CEE occurs when enrollment and eligibility administrative, technological and operational functions are carved out from the MCSCs. In this scenario, a single eligibility and enrollment vendor (EEV) provides advanced capabilities to manage all eligibility, enrollment and re-enrollment processes.

Description and Assumptions

- A single eligibility and enrollment vendor streamlines enrollment processes, improves the beneficiary experience, optimizes the implementation of new enrollment requirements over time and reduces a barrier to entry for new MCSC contractors.
- A MCSC-neutral eligibility and enrollment platform improves the beneficiary experience with innovative decision support tools and customer engagement technologies, including multi-channel contact center(call/chat/bot) supported by Artificial Intelligence.
- CEE Innovation will include a strategic and operational approach to ensure that the beneficiaries' eligibility and enrollment are not adversely affected during the transition.
- The EEV will serve as the "middle man" providing all enrollment-related information to the MCSC contractors, DMDC/DEERS, and any other participating entities, e.g. ACOs.
- The EEV will assume DMDC's role in maintaining/sharing data for the catastrophic cap and other health insurance information.

Demonstrated Outcomes:

Quality

- Streamlining the enrollment/eligibility processes eliminates barriers to access to care.
- This is evidenced by Colorado's PEAK® program (food stamps and medical assistance) reduction of call abandonment rate from 54% to 12% when the state implemented an advanced call center solution.

Efficiency

- Pilot programs in Michigan (food assistance and healthcare benefits) mobile application process resulted in a 77% reduction in time to apply (45 minutes to 10 minutes).
- Colorado's PEAK® chatbot allow agents to manage chats with 5 customers at the same time.

Convenience

- CEE systems ease disjointed and lengthy beneficiary enrollment processes.
- Improved beneficiary experience – one path leads to all answers.
- Multimodal engagement strategies (e.g. text, email, chat) powered by AI facilitate beneficiary support 24X7.

Cost Effectiveness (Benchmark)

- CEE systems exist in other government health insurance programs: Medicaid, the health insurance exchange marketplaces, and the Federal Employee Health Benefit Program.
- Colorado's PEAK®'s customer contact center solution resulted in reduction of call handling time from 12.5 minutes to 6 minutes.



Clinically Integrated Networks

Hypothesis A Clinically Integrated Network (CIN) is a select partnership of contractually linked but otherwise independent providers who allocate the right intensity of work to the most appropriately qualified provider for a given category of clinical issues or for a specific patient. A CIN promotes evidence-based care delivery with an emphasis on improved quality and outcomes, reduced waste and inefficiencies and lower costs.

Description

- This type of provider alignment is generally done at the hospital or health system level and focuses on specific service lines and usually consists of a group of otherwise unaffiliated hospitals, health systems and providers that come together to contract for a specific population
- The CIN can contract on behalf of all the providers for a particular population (e.g. chronically ill patients) on a risk or non-risk basis
- Provide additional opportunities for flexible, value-based financial arrangements and partnerships while allowing providers to maintain their independence
- CINs can engage in risk based arrangements with MCSCs; are more flexible than ACO arrangements because of the opportunity for variability in risk sharing and financial incentive arrangements
- Multi-disciplinary care teams within the CIN often identify select populations and/or conditions that are disproportionately expensive and could benefit from targeted approaches (e.g. chronically ill patients, patients with multiple diagnoses, specific surgery types and complexities)

Demonstrated Outcomes

<p>Quality</p> <ul style="list-style-type: none"> • Utilize proven protocols, measures, & evidence-based medicine to improve care & outcomes, control costs, demonstrate value to the market • Improved health outcomes delivered by a subset of high value providers with reduced complications, improved preventive care, improved patient reported outcomes and reduced waste 	<p>Efficiency</p> <ul style="list-style-type: none"> • Focus on high cost points (e.g. readmissions, gaps in care, leakage from CIN) • Monitor & exclude providers who do not meet established quality measures • Streamlined MTF referral process to an ACO improving medical readiness process 	<p>Convenience</p> <ul style="list-style-type: none"> • Enables providers to remain independent • Beneficiaries incentivized to utilize providers within the ACO • Improved referrals and access within the CIN provider system 	<p>Cost Effectiveness (Benchmark)</p> <ul style="list-style-type: none"> • Vanderbilt Health Affiliated Network achieved \$50 million in costs avoided for health plans, nearly \$20 million in shared savings to network clinicians and consistent cost savings and quality performance for five years running
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Provider Recognition & Reward

Hypothesis Understanding how providers practice is critical to ensuring quality care. Provider performance improves from meaningful performance measurement and individual feedback (recognition). When providers are rewarded based on that performance there is additional extrinsic incentive to perform well. If DHA implemented a provider recognition and reward program they could measure and improve quality and demonstrate cost effectiveness by motivating performance improvement.

Description

- In order to be effective, provider incentives and recognition are assessed at the individual level as well as the institutional or department level
- Performance measures must be actionable, within the provider's scope of care to be improved and timely enough to motivate improvement. Selected metrics should tie to the overall program quality strategy or program plan
- Providers are measured on a risk adjusted basis — not penalized for serving a sicker population
- Incentives may be implemented to drive high-value provider performance on key selected preventive care, chronic and acute care outcomes and wellness metrics
- Incentives, if implemented, will be both up and down side consistent with best practices as identified in the Centers for Medicare and Medicaid Services (CMS), CQMC and commercial provide incentives programs

Demonstrated Outcomes

Quality

- Increase in overall clinical quality performance
- Improved quality measures including Healthcare Effectiveness Data and Information Set (HEDIS), CMS Core measures CQMC and other national benchmarks scores
- Increase in beneficiary satisfaction and self-reports on health

Efficiency

- Decrease in low-value/wasted care once provider knows how they are performing compared to peers

Convenience

Cost Effectiveness (Benchmark)

- Reduction in total cost of care (e.g. reduced emergency department, urgent care, and specialist visits; pharmacy and areas of anticipated increased spend (mental health, primary care, medication adherence)
- Excellus BCBS and the Rochester Individual Practice Association (RIPA) collaborated on an incentive & reward program for RIPA's physician members; evaluation of the program found at least a 3:1 ROI for diabetes and heart disease patient populations †

† Incentives and Rewards Best Practices Primer: Lessons Learned from Early Pilots 5



Targeted Utilization Management

Hypothesis Employing a targeted Utilization Management (UM) design can foster a more collaborative approach to enhancing the efficiency and effectiveness of the healthcare system by targeting overuse, underuse and misuse of services. There exists providers who practice appropriate care and rarely have a prior authorization denied. Targeted UM eliminates the providers and procedures that are rarely denied and focuses on those that have frequent adverse determinations. Targeted UM results in increased efficiencies, reduced costs and waste, and improved provider satisfaction and willingness of beneficiaries to participate in TRICARE.

Description

- UM evaluates the medical necessity, appropriateness, and efficiency of the use of healthcare services, procedures, and facilities
- Targeted UM uses analytics to target review of high variability procedures and low value providers; removes the high value providers from the UM process
- Specific cases, levels of care, and provider types requiring heightened attention would benefit from focused review while UM review can be eliminated for other low cost or low denial rate services and specific high performing providers
- It may also include identification of “Gold Card” providers who are entitled to reduced or waived UM requirements based on high levels of performance
- Targeted UM results in a larger and probably higher quality networks which leads to high quality medically necessary care for beneficiaries

Demonstrated Outcomes

Quality

- Earlier and more effective referrals to Care Management (CM) opportunities
- Improved beneficiary safety
- Increased provider adherence to Evidence Based Medicine standards

Efficiency

- A targeted UM program includes reduced focus on low cost, low denial rate services to allow deeper review on highest value procedures and providers

Convenience

- Quicker turnaround times increases ease in patient scheduling

Cost Effectiveness (Benchmark)

- Financial impact: (cost savings, positive shifts in the distribution of spend)



Telehealth

Hypothesis As healthcare becomes increasingly virtual, DHA must continue to expand their telehealth offerings to continue capitalizing on their Telehealth program. Expanding Telehealth services improves fighting force readiness, cost of care, quality and access in rural and remote as well as more densely serviced areas.

Description

- Telehealth is a broad term that refers to a model of care in which digital communications services are utilized to provide care and health support at a distance. TH can include:
 - Clinical services provided at a distance, with a provider and the patient at separate locations
 - Newer models of telehealth offer longitudinal primary care and are more commonly embedded in the medical practice
 - Non-clinical services such as health education, coaching and administrative meetings
 - Remote monitoring using technology to gather patient data outside of the healthcare setting (e.g., remote diagnostics)
 - Triage and care support powered by data analytics and Artificial Intelligence (AI)
 - Provider-to-provider consultations ('curbside' consults/eConsults)
- TH can be synchronous (real-time) or asynchronous (store-and-forward), and use a variety of multi modal approaches and platforms (e.g., video, text, phone, chat, AI, augmented/virtual reality)
- TH will be utilized for the broadest feasible range of clinical services (behavioral, dermatology, radiology, many medical specialties, physical therapy, hospital-at-home, etc.)
- Equitable payments will be made for TH care encounters (types of services, Current Procedural Terminology [CPT] codes and locations)

Demonstrated Outcomes

Quality

- Intermountain Healthcare and Geisinger Health Plan use extensive TH capabilities to offer successful virtual chronic care management teams, reducing the number of specialist visits, improving medication adherence and lowering total cost of care
- Expands range of services otherwise not available in the local community

Efficiency

- 24/7 patient access to care
- Streamlines provider-to-provider communication to improve readiness, timeliness and quality of care decision-making

Convenience

- Improves access to care in remote locations especially to specialized medical services that may not otherwise be available in the community
- Expands timely access to medical care
- Enables individuals to avoid lengthy travel to see specialists, reduce wait times and unnecessary appointments

Cost Effectiveness (Benchmark)

- The cost of a virtual visit can be less the cost of an-person visit (note: during COVID, most health plans and CMS are paying in person and virtual visits at the same fee schedule)
- Impact of total cost of care is variable, but usually associated with a modest reduction in use of ER, urgent care and a low single digit savings



Virtual Value Networks

Hypothesis High value providers naturally exist in the market, but beneficiaries lack a structured way to identify those providers; plan sponsors that identify and steer members to these providers will achieve better outcomes.

Description:

- Virtual value networks comprise the subset of highest value providers within the network, identified using large cost and quality data sets covering a wide breadth of specialties and procedures across the entire country
- Independent vendors have developed tools to provide beneficiaries and plan sponsors 24/7 access to actionable, real time information with strong consumer interfaces that facilitate beneficiary choice of these preferred high value providers without disrupting the underlying MCSC networks. MCSCs are largely challenged to offer this service due to contractual limitations and more limited data sets.
- These tools are highly validated and replace the need for beneficiaries to use public search engines, family, and friends to identify medical providers
- The information can be utilized by the MTFs and beneficiary navigation services to develop high performance referral processes
- The VVN tool and information is available to all TRICARE beneficiaries (both being treated by the MTFs and purchased care providers)

Demonstrated Outcomes

Quality

- Steers away from bottom cohort of low quality providers
- Reduces inappropriate care and waste
- Reduces adverse clinical outcomes

Efficiency

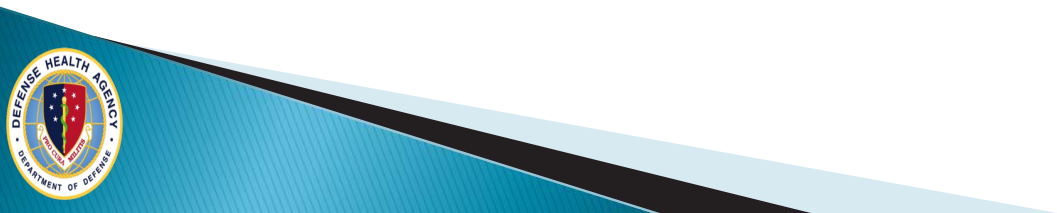
- Reduces beneficiary time to find high quality providers
- Streamlines MTF referral process

Convenience

- User friendly, mobile phone and computer based tools
- 24/7 access

Cost Effectiveness (Benchmark)

- 15-50% for appropriateness of care
- 10-40% for quality of care
- 10-25% total savings in costs of care



Wellness & Disease Management Incentives

Hypothesis A wellness program that has targeted interventions and timely incentives for completion of select healthy behaviors will be successful in aiding beneficiaries to make healthy choices and enact long-term behavior change. Moving from the premium reduction model to “in the moment” incentive, making it of significant value and repeatedly visible to the beneficiary will encourage higher rates of beneficiaries engagement and produce more favorable outcomes.

Description

- A comprehensive wellbeing program addresses a full spectrum of lifestyle and clinical chronic condition risks (e.g., smoking cessation, weight loss, exercise, weight management, sleep hygiene, stress, medication and therapy adherence, etc.) through a variety of program interaction modalities (coaching, digital apps, digital trackers, etc.)
- Successful programs offer financial and other types of incentives to increase program engagement rates and progress, capturing these engagement interactions to support and manage incentives awards
- Core behavioral design principles have been developed that identify incentives timing, sizing and communications methods associated with increased engagement and outcomes. Central to these principles is to make the incentive award as close to the time of the required activity as possible. The size, type and visibility of incentive are also key to being recognized as valuable to the recipient.
- A wellness program should also be supported by a technology solution which allows for integrated tracking of progress toward goals through self-report and encounter data that is easily accessed and available to the beneficiary and shared with the PCMH/Provider, MCSC and incentive distributor
- In order to have a successful program, the MCSC will outline an engagement plan that includes digital multichannel communication, techniques to employ personalized communication, and embedded marketing through touchpoints with PCMHs, Military Medical Treatment Facilities and MCSCs

Demonstrated Outcomes

Quality

- Incentives can drive program engagement and health improvement value resulting from program
- Improved Healthcare Effectiveness Data and Information Set, CMS Core measures or other recognized national clinical indicator scores to demonstrate changes in chronic condition, lifestyle risk, mental health and other relevant parameters

Efficiency

- Information sharing of self-identified lifestyle risks to providers and care managers
- Identification and referral to management programs (e.g. Disease Management)

Convenience

- Incentives are awarded/distributed soon after beneficiary completes action instead of the following year
- Program referrals are built into risk assessments and other data captured during the programs to connect beneficiaries with relevant resources

Cost Effectiveness (Benchmark)

- Evaluation of Johnson and Johnsons wellness program found an average annual per employee savings were \$565 in 2009, producing return on investment equal to a range of \$1.88-\$3.92 saved for every dollar spent on the program¹
- Although savings may be limited or diminished over time, large employers can see “Medical costs fall about \$3.27 for every dollar spent on wellness programs, and absentee day costs fall by about \$2.73 for every dollar spent”²

1. Henke RM, Goetzel RZ, McHugh J, Isaac F. Recent experience in health promotion at Johnson & Johnson: lower health spending, strong return on investment. *Health Aff(Millwood)*. 2011;30(3):490-499.
 2. Baicker, Katherine, et al. “Workplace Wellness Programs Can Generate Savings.” *Health Affairs*, 1 Feb. 2010, www.healthaffairs.org/doi/10.1377/hlthaff.2009.0626.



Appendix F: Meetings and Presentations

July 28, 2020: TRICARE Health Plan Working Group Meeting Video Teleconference

The Working Group met virtually and discussed the following: report outline, report timeline, report background material, and future briefings. There were no briefings at this meeting.

August 4, 2020: TRICARE Health Plan Working Group Meeting Video Teleconference

The Working Group met virtually and discussed report development, with particular emphasis given to developing scoring criteria. There were no briefings at this meeting.

August 11, 2020: TRICARE Health Plan Working Group Meeting Video Teleconference

The Working Group met virtually and received a brief on the legal considerations concerning TRICARE benefit from the DHA Office of General Counsel legal team.

The SMEs who briefed at the meeting:

- Mr. Mark Kogan, Associate Deputy General Counsel for Personnel and Health Policy
- Mr. Salvatore Maida, Acting General Counsel, DHA
- Mr. Robert Seaman, Associate General Counsel, DHA
- Mr. Erik Troff, Assistant General Counsel, DHA

August 18, 2020: TRICARE Health Plan Working Group Meeting Video Teleconference

The Working Group met virtually and received a brief on the Pacific Business Group on Health's efforts on health care innovations.

The SMEs who briefed at the meeting:

- Ms. Lauren Vela, Senior Director of Member Value, Pacific Business Group on Health
- Ms. Emma Hoo, Director, Pay for Value, Pacific Business Group on Health

August 25, 2020: TRICARE Health Plan Working Group Meeting Video Teleconference

The Working Group met virtually and received a brief from Dr. Jeffrey Dobro, Partner, Health and Benefits, Strategy Innovation of Mercer, on Mercer's expertise with health care innovations and their applicability to the TRICARE benefit.

September 1, 2020: TRICARE Health Plan Working Group Meeting Video Teleconference

The Working Group met virtually and discussed report development. There were no briefings at this meeting.

September 8, 2020: TRICARE Health Plan Working Group Meeting Video Teleconference

The Working Group met virtually and received a brief from Dr. A. Mark Fendrick, Director, Value-Based Insurance Design Center, University of Michigan, on the applicability of value-based insurance design to the TRICARE benefit.

September 15, 2020: TRICARE Health Plan Working Group Meeting Video Teleconference

The Working Group met virtually and discussed report development. There were no briefings at this meeting.

September 22, 2020: TRICARE Health Plan Working Group Meeting Video Teleconference

The Working Group met virtually and received a brief on vendor evaluation criteria for the next generation of TRICARE contracts from Mr. Joseph Mirrow, Chief, TRICARE Project Management Office.

September 29, 2020: TRICARE Health Plan Working Group Meeting Video Teleconference

The Working Group met virtually and discussed report development. There were no briefings at this meeting.

October 6, 2020: TRICARE Health Plan Working Group Meeting Video Teleconference

The Working Group met virtually and discussed report development. There were no briefings at this meeting.

October 13, 2020: TRICARE Health Plan Working Group Meeting Video Teleconference

The Working Group met virtually and discussed sections of the report. There were no briefings at this meeting.

October 20, 2020: TRICARE Health Plan Working Group Meeting Video Teleconference

The Working Group met virtually and discussed sections of the report. There were no briefings at this meeting.

October 27, 2020: TRICARE Health Plan Working Group Meeting Video Teleconference

The Working Group met virtually and discussed the report. There were no briefings at this meeting.

Appendix G: Glossary

ABA: Applied Behavior Analysis

ACD: Autism Care Demonstration

ACM: Advanced Care Management

ACO: Accountable Care Organization

ADFM: Active Duty Family Member

ADSM: Active Duty Service Member

AI: Artificial Intelligence

APC: Advanced Primary Care

APM: Alternative Payment Models

ASD(HA): Assistant Secretary of Defense for Health Affairs

CHAMPUS: Civilian Health and Medical Program of the Uniformed Services

CIN: Clinically Integrated Network

CJR: Comprehensive Care for Joint Replacement

CMS: Center for Medicare and Medicaid Services

COE: Center of Excellence

COPD: Chronic Obstructive Pulmonary Disease

CRI: CHAMPUS Reform Initiative

DHA: Defense Health Agency

DHB: Defense Health Board

DoD: Department of Defense

ED: Emergency Department

EHR: Electronic Health Record

eMSM: Enhanced Multi-Service Markets

FDA: Food and Drug Administration

HEDIS®: Healthcare Effectiveness Data and Information Set

HHVBP: Home Health Value-Based Purchasing

ILDR: Intensive Lifestyle Disease Reversal

KSA: Knowledge, Skills, and Abilities

LDT: Lab Developed Test

LEJR: Lower Extremity Joint Replacement

MCSC: Managed Care Support Contract/Contractor

MHS: Military Health System

MTF: Military Treatment Facility

NDAA: National Defense Authorization Act

RCT: Randomized Controlled Trials

ROI: Return on Investment

UM: Utilization Management

VBID: Value-Based Insurance Design

