TRICARE Transformation
August 7, 2020

Vision: An Integrated System of Readiness & Health

The Military Health System (MHS) is a unique and indispensable element of our national security, and the Defense Health Agency vision is for an Integrated System of Readiness & Health that gives 1) Great Outcomes, 2) A Ready Medical Force, 3) Satisfied Patients, and 4) Fulfilled Staff. MHS is designed to ensure service members are medically ready to deploy anywhere in the world on a moment's notice, and provide a well-trained medical team that can deliver the full spectrum of health services (from prevention to combat casualty care and recovery) to our military force. This unique readiness mission distinguishes the Military Health System from any other health system in the country, and is its principal purpose for existing.

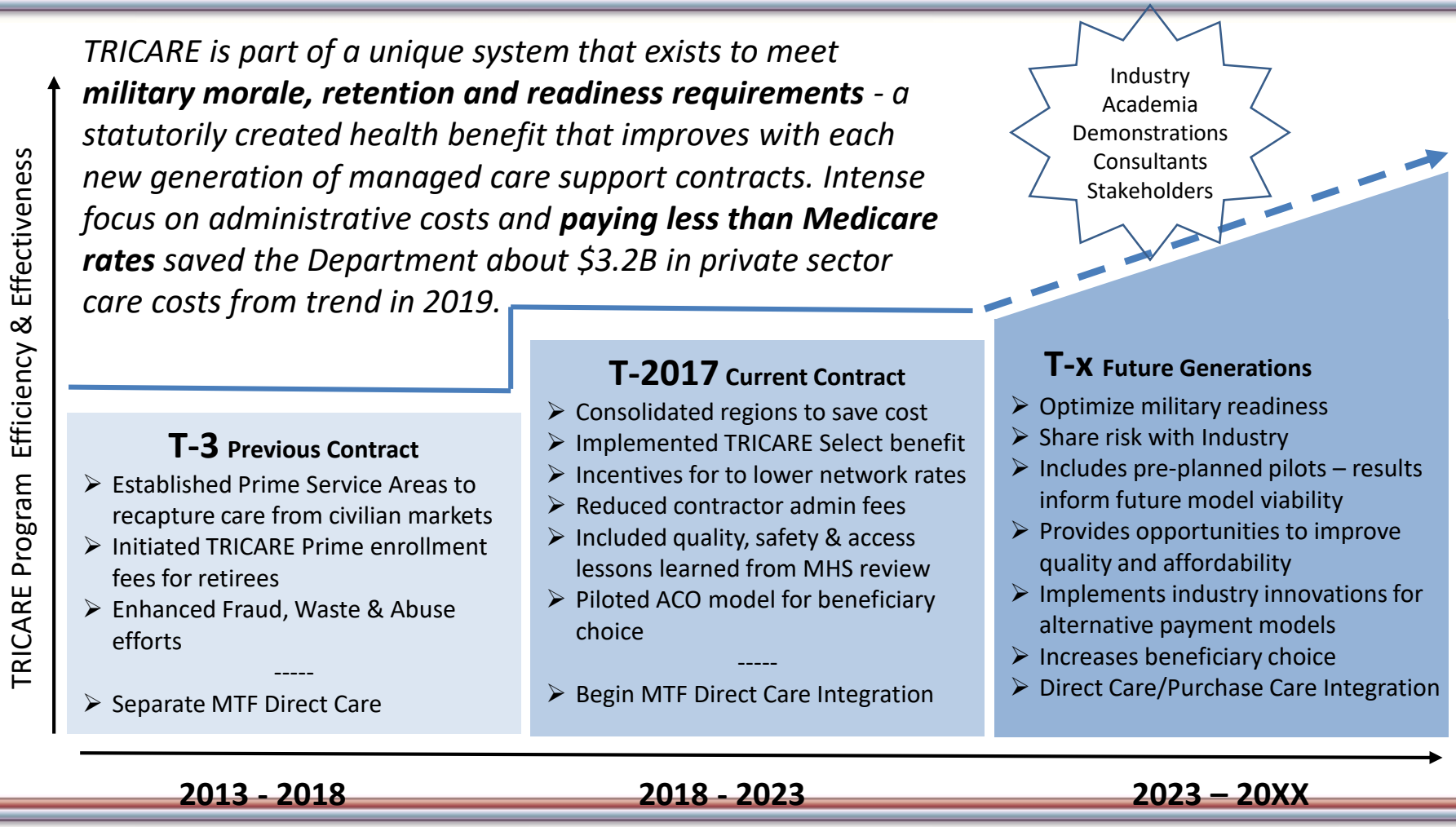
Along with its readiness responsibilities, the MHS manages a health benefit for over 9 million beneficiaries. DoD's health benefit also serves as a compelling recruitment and retention tool. Given the challenging mission of the Armed Forces, the objective remains to offer one of the most comprehensive health benefits at low out-of-pocket costs for its globally-distributed population.

For the MHS, maintaining an active clinical practice allows the military medical team to maintain its clinical skills in support of readiness. DoD has long recognized, however, that its direct care system of medical centers, hospitals and clinics cannot provide all the health care that beneficiaries need in all locations in which we operate. The TRICARE Health Plan is designed to offer beneficiaries a choice of health plans that (a) best support the readiness mission; (b) integrate care for beneficiaries who elect to use both military and civilian providers, (c) provide high value care through access to high quality providers; and (d) efficiently deliver a complex health benefit while sustaining TRICARE as a powerful tool for retention.

In future TRICARE contracts, to achieve the vision outlined above, the DHA is redesigning how it administers TRICARE by creating a "market-based" approach – with networks tailored to the specific requirements of each MTF platform, and local leaders empowered to move resources in support of the MHS mission. This strategy requires sensitivity to rapidly-changing operational requirements, an orientation to ensure high-value, and a system that is centered around and responsive to the patient.

TRICARE Contract Evolution

- Evolution of a basic entitlement program over three decades
- Leverages best practices successfully implemented in other plans
- Partnership with Congress and key stakeholders
- Deliberate improvement approaches



Fee For Service → **Value Based Contracts**

Objectives - TRICARE Fifth Generation (T-5)

1.  Optimize the readiness of the military force and the Knowledge, Skills and Abilities of personnel in the military health system

2.  Place beneficiary choice at the center of the program empowered by information on cost, quality and access

3.  Use Alternative Payment Methods and other means to change from volume-based payments to quality based payments

4.  Move the contract toward industry business standards

Industry Innovations

Healthcare Innovation Examples
Virtual Value Providers: Assess and assign special status to specific in-network providers for certain procedures based on high quality + affordable cost
Centers of Excellence (Standard): High quality/outcomes provider designation for better care quality
Standard Telehealth: Allow synchronous and asynchronous telehealth; care at home, virtual monitoring teams
Targeted Utilization Review: Focused review on specific cases, based on criteria, for heightened attention
Automatic Authorizations: “Gold card” - high value providers: authorization not required for referral
Care Collaboration: Facilitate eConsults and reduce specialist referral rates
Care Management: Require standard care management for care coordination, referral management, provider shaping
Provider Recognition: Provider performance measured and shared, care improves when access to information is present
Wellness Pilots: Replacing the current “following year” reduced copay, co-insurance, enrollment fee design (will require statutory change)
Advanced Primary Care (APC): Encourage team-based medical home: patient-centered, longitudinal, coordinated
ATC Standards: Standard 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

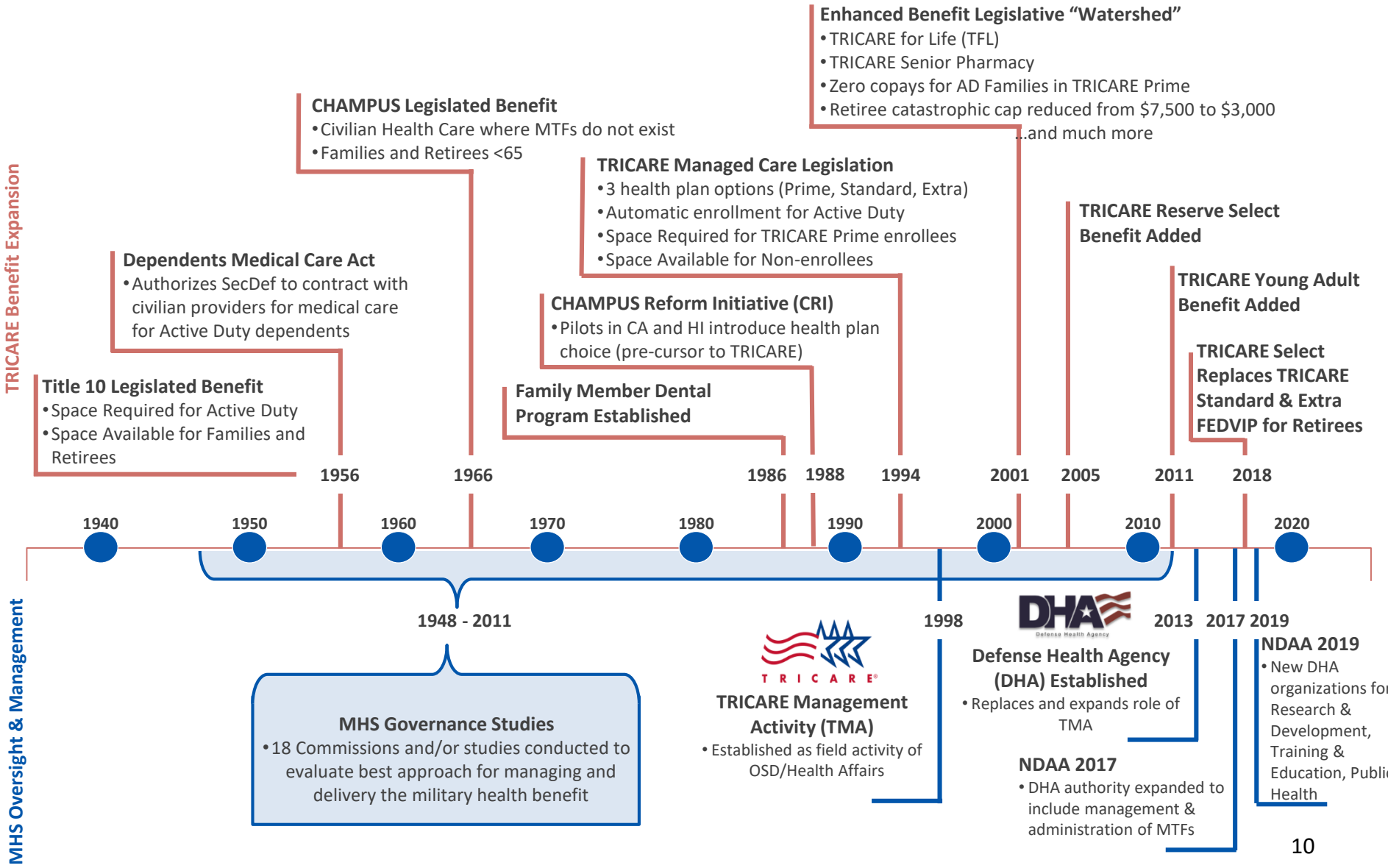
Advanced Industry Innovations

Best-Practice Innovation Examples
Accountable Care Organizations: Assess and assign special status to sub-groups of providers and APC based on "high-value" = high quality + affordable cost; AND incent beneficiaries and health plans to use ACO providers
Clinically Integrated Networks: Networks of providers that band together to improve care quality and lower costs, using clinical, data, and financial integration that measure and manage performance
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 (may wish to share savings)
Optimize Telehealth: Synchronous and asynchronous telehealth; care at home, virtual monitoring teams, maximize digital solutions (e.g. all qualified providers); Beneficiary and provider financial incentives for utilization
Utilization Management: Focused review on specific cases, based on criteria, using financial incentives
Artificial Intelligence: identify areas where authorization not economical, should automate
Advanced Care Management: Advanced care management & care coordination, require MCSC provider incentives for interoperability and Artificial Intelligence care management tools, referral management, provider shaping. Target high cost, high utilization, complex needs beneficiaries for DM - esp. chronic 5 conditions and cancer; Advanced predictive risk identification and stratification tools (with SDOH). Breadth and depth expands in COA 2 because at risk.
Provider Reward: Provider performance measured and managed, financial gain from reducing total cost of care
Wellness and Disease Management Pilots: Utilize best-in-class program design and financial incentives to enable patient behavior change, replacing the current "following year" reduced copay, co-insurance, enrollment fee design (will require statutory change)

Back-up

TRICARE BENEFIT CHANGES

Since 1995, There Have Been Significant Expansions in DoD Health Benefits



Evolution of the MCSCs

Contract	TRICARE Legacy Contracts	TRICARE Next Generation (T-NEX)	TRICARE Third Generation (T-3)	TRICARE T-2017
Regions				
Total Contract Period	1994-2004	2004-2009	2009-2017	2017-2022
MCSCs	• Region 1 - Sierra Military Health Services • Regions 2 & 5 - Anthem Alliance for Health, Inc (contract was later novated to Humana Military Healthcare Services, Inc.) • Regions 3 & 4 - Humana Military Healthcare Services, Inc. • Region 6 - Foundation Health Federal Service, Inc. • Regions 7 & 8 - TriWest Health Care Alliance, Inc. • Regions 9, 10, & 12 Foundation Health Federal Services, Inc. • Region 11 - Foundation Health Federal Services, Inc.	• North Region - Health Net Federal Service • South Region - Humana Military Health Services, Inc. • West Region - TriWest Healthcare Alliance, Inc.	• North Region - Health Net Federal Service • South Region - Humana Military • West Region - United Healthcare	• East Region - Humana Military • West Region - Health Net Federal Service
Highlights	• 7 contracts • Included at-risk elements, contractors were paid fixed price for health care costs based on a large number of variables – including the estimated number of beneficiaries in the contract region, the estimated participation of beneficiaries in each of the three options, inflation, expected beneficiary utilization of MTFs, and the contractor's ability to manage health care utilization.	• 3 contracts • Consolidated the 12 regions into 3 regions. One contract awarded for each region. • Carved out stand-alone contracts for the fiscal intermediary services for dual eligible Medicare/TRICARE beneficiaries (now known as the TRICARE Medicare Eligible Program) and the administration of the TRICARE Pharmacy Program. • Included a combination of fixed-price lined items (for administration costs on a fixed price per eligible beneficiary) with incentive provisions for specific objective measures of customer service and an award fee incentive based on subjective measures of customer satisfaction, and cost-reimbursement with incentive fee line items for health care costs.	• 3 contracts • Retained and refined the fixed price with incentive provisions in administration of the contract (i.e., for customer service and customer satisfaction) by adding performance incentives for the contractor to achieve a high level of clinical quality and to encourage greater submission of electronic claims. • The most significant change to the contracts was the implementation of a cost-reimbursement with fixed fee construct for risk sharing. • Included several health care cost performance incentives to encourage the contractors to pursue savings in those areas where they had some control over costs.	• 2 contracts • Reduced the number of MCS regions from 3 to 2. • Largely followed the path set by the T-3 contracts, in terms of the contract requirements, risk-sharing construct, and contract incentive structure—with the exception that the T-2017 contracts dropped the customer satisfaction award fee incentive arrangement. • Employed a per-member/per-month line item to capture all contractor costs associated with building and managing provider networks, managing referrals, engaging in medical management activities, providing customer service, processing claims, and otherwise managing all of the details associated with delivering the TRICARE program and benefit to beneficiaries.

T-5 Framework

Environmental Assumptions

- **Direct care system – overall – will become smaller**; an already high proportion of purchased care to direct care (60 – 40%) expect to grow even more
- **Beneficiary population will not appreciably change** (but contracts can be scaled upward in event of large mobilization)
- **Partnerships with the VA and integrated delivery networks will increase** – to support both readiness requirements and beneficiary care delivery
- **Beneficiary enrollment fees and cost-sharing will likely not change** significantly in next several years to drive different behavior in plan choice (none for active duty families; modest for retirees)
  - Choices will need to be driven by high value care and/ or supply-driven decisions
  - Will use demonstration authority to evaluate effect of cost-sharing changes on choices

Requirements to Achieve T-5 Vision

- **Assistance with managing expectations** of Stakeholders on extending the time period until next start of healthcare under new contract
- **Time**, will need at least 2 years beyond the last period of performance of the T-2017 contract to make regulatory/statutory changes
- **Partner with experts** who have expertise with commercial health plan implementation
- **Additional resources** to manage, structure and execute new acquisition strategies

Current TRICARE Pilots and Demonstrations

Pilot/Demonstration	Status
1. Pilot to Redirect Uniformed Services Beneficiaries Identified For Inpatient Admission At Civilian Emergency Departments (EDs) For Admission To Designated Military Treatment Facilities (MTFs)/Enhanced Multi-Service Markets (eMSMs)	Completed
2. Bundled Payments for Lower Extremity Joint Replacement (LEJR) Demonstration	Completed
3. Accountable Care Organization (ACO) Demonstration	Active
4. Home Health Value-Based Purchasing (HHVBP)	Active
5. Medication Adherence Pilot	Active
6. Performance-Based Maternity Payments Pilot	Active
7. Pilot Program on Health Care Assistance System (FY18 NDAA, Sec 731)	Active
8. Enhance Experience of Care for Beneficiaries in Naples and Sigonella	Active
9. Comprehensive Autism Care Demonstration (ACD)	Active
10. Lab Developed Tests (LDT) Demonstration	Active

- Fifteen (15) pilot projects are currently in development, pre-decisional
- Eight (8) potential pilot projects under internal review for development

Questions?