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

PERSONNEL AND READINESS

MAR 0 3 2021

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

Dear Mr. Chairman:

The enclosed report is in response to section 729 of the National Defense Authorization for Fiscal Year 2017 (Public Law 114-328), Improvement of Health Outcomes and Control of Costs of Health Care Under TRICARE Program Through Programs to Involve Covered Beneficiaries.

The three initiatives outlined in this report are designed to meet the intent of section 729, which requires that the Defense Health Agency (DHA) establish: (1) a Medical Intervention Incentive Program; (2) a Healthy Lifestyle Intervention Incentive Program; and (3) a Healthy Lifestyle Maintenance program. The DHA's implementation of these three initiatives supports both section 729 reform and the Military Health System's vision of increasing value to the warfighter and military family. These programs were, or will be, modified into the current TRICARE contracts and will be considered as requirements in the next generation of TRICARE contracts, if they are determined to be successful (as evaluated against the criteria established when the programs were developed). In addition to these demonstrations, the DHA will continue to explore other value-based initiatives that could add value to the TRICARE Program and shift risk to the Managed Care Support Contractors.

Thank you for your continued strong support of the health and well-being of our Service members, veterans and families. I am sending a similar letter to the House Armed Services Committee.

Sincerely,

//SIGNED//

Virginia S. Penrod
Acting

Enclosure:
As stated

cc:
The Honorable James M. Inhofe
Ranking Member

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

PERSONNEL AND READINESS

MAR 03 2021

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

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Sincerely,

//SIGNED//

Virginia S. Penrod
Acting

Enclosure:
As stated

cc:
The Honorable Mike D. Rogers
Ranking Member

Report to Congress

In Response To: Section 729 of the National Defense Authorization Act for Fiscal Year 2017 (Public Law 114-328) on Improvement of Health Outcomes and Control of Costs of Health Care Under TRICARE Program Through Programs to Involve Covered Beneficiaries

January 2021

Preparation of this study/report cost the Department of Defense a total of approximately $3,200.00 for the 2020 Fiscal Year. This includes $0.00 in expenses and $3,200.00 in DoD labor

RefID:

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1) Introduction:

This report is in response to section 729 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2017 (Public Law 114-328) on the Department of Defense's (DoD) initiatives to improve health outcomes and control of costs of health care under the TRICARE program through programs to involve covered beneficiaries. Due to the complexity and timelines of designing and implementing such programs, DoD did not have sufficient information to submit a final report on January 1, 2020; therefore in 2020 DoD submitted an interim report.

The NDAA for FY 2017, section 729, required the Defense Health Agency (DHA) to establish three programs:

1. Medical Intervention Incentive Program
2. Lifestyle Intervention Incentive Program
3. Healthy Lifestyle Maintenance Incentive Program

The DHA is engaged in the design and implementation of four value-based pilots, demonstrations, and initiatives related to the requirements in Section 729, which we modified into the TRICARE 2017 (T-2017) contracts and are under consideration for inclusion in the TRICARE Fifth Generation (T5) of Managed Care Support Contracts. The DHA has partially completed implementation of Section 729, and continues to work to fully enact the provisions of this law.

2) Background:

The NDAA for FY 2017, sections 701(h), 704(a), 705(a), and 729 (a) (b) and (c) required DoD to execute programs in support of value-based care. Section 729 required DoD to implement programs that apply the concept of providing incentives to encourage beneficiaries to participate in medical intervention and lifestyle programs. The legislation directed the DoD to implement programs which would improve health, reduce cost, and prevent, or lessen, chronic diseases such as diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, and hypertension.

Financial incentives to encourage healthy behaviors have been employed in a variety of areas across the health care industry, ranging from promoting more healthful eating and physical activity, to smoking cessation and weight loss. The use of incentives to improve health hinges on the concept that people tend to discount the importance of future outcomes (e.g., avoiding a heart attack or stroke in 20 years) relative to the importance of present-day events (e.g., enjoying a bacon cheeseburger). By incentivizing individuals for healthy behaviors in real time, it is theorized that this future discounting effect can be lessened, enhancing or even creating

motivation to change.[1]

Non-communicable diseases such as type 2 diabetes and coronary heart disease are a leading cause of death and disability around the world.[2] These diseases often are the consequence of unhealthful lifestyle habits such as lack of exercise or frequent consumption of alcohol and tobacco. Unfortunately, health-damaging habits are notoriously hard to break because they tend to persist despite people's firm intentions to change their behaviors. On the basis of this knowledge, DHA was tasked with developing new types of health programs that aim to disrupt unhealthy lifestyle choices in order to inculcate new, healthful habits through the use of incentives.

3) NDAA Requirements:

Specifically, the NDAA for FY 2017, section 729, required the Department to establish three separate programs:

1. ***Medical Intervention Incentive Program***, Section 729 (a): (1) In general—the Secretary of Defense shall establish a program to incentivize covered beneficiaries to participate in medical intervention programs established by the Secretary, such as comprehensive disease management programs, that may include lowering fees for enrollment in the TRICARE program by a certain percentage or lowering copayment and cost-share amounts for health care services during a particular year for covered beneficiaries with chronic diseases or conditions described in paragraph (2) who met participation milestones, as determined by the Secretary, in the previous year in such medical intervention programs. (2) Chronic diseases or conditions described. Chronic diseases or conditions described in this paragraph may include diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, coronary artery disease, mood disorders, obesity, and such other diseases or conditions as the Secretary determines appropriate.

2. ***Lifestyle Intervention Incentive Program***, Section 729 (b): the Secretary shall establish a program to incentivize lifestyle interventions for covered beneficiaries, such as smoking cessation and weight reduction, that may include lowering fees for enrollment in the TRICARE program by a certain percentage or lowering copayment and cost share amounts for health care services during a particular year for covered beneficiaries who met participation milestones, as determined by the Secretary, in the previous year with respect to such lifestyle interventions, such as quitting smoking or achieving a lower body mass index by a certain percentage.

3. ***Healthy Lifestyle Maintenance Incentive Program***, Section 729 (c): the Secretary shall establish a program to incentivize the maintenance of a healthy lifestyle among covered beneficiaries, such as exercise and weight maintenance, that may include lowering fees

[1] Roberto, Christina A, and Ichiro Kawachi. *Behavioral Economics and Public Health.* Oxford University Press, 2015.
[2] Roberto, Christina A, and Ichiro Kawachi. *Behavioral Economics and Public Health.* Oxford University Press, 2015.

for enrollment in the TRICARE program by a certain percentage or lowering copayment and cost-share amounts for health care services during a particular year for covered beneficiaries who met participation milestones, as determined by the Secretary, in the previous year with respect to the maintenance of a healthy lifestyle, such as maintaining smoking cessation or maintaining a normal body mass index.

Further, the statute which required this report, section 729 (d) of the NDAA for FY 2017 (Public Law 114–328) states: (1) In General. — Not later than January 1, 2020, the Secretary shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report on the implementation of the programs established under subsections (a), (b), and (c). (2) Elements.—the report required by paragraph (1) shall include the following: (A) A detailed description of the programs implemented under subsections (a), (b), and (c). (B) An assessment of the impact of such programs on— (i) improving health outcomes for covered beneficiaries; and (ii) lowering per capita health care costs for the Department of Defense.

4) Discussion:

To meet the requirements of section 729 of the NDAA for FY 2017, DHA has implemented two of the four value-based initiatives, a third initiative launched in January 2021 and the fourth is under review. These initiatives are: 1) a Medication Adherence Pilot; 2) an Accountable Care Organization (ACO) Demonstration with Kaiser Permanente in the Atlanta, Georgia market area; 3) a Physical Therapy for Low-back Pain Demonstration; and 4) a Diabetes Prevention Program.

1. ***Medication Adherence Pilot***. The Medication Adherence Pilot supports the requirement to establish a **medical intervention incentive program** focused on specific chronic diseases; however, incentives are not based on when patients met participation milestones in the prior year. The intent of this pilot is to determine whether reducing or eliminating copayments will result in increased compliance with medication regimens for diabetes and high cholesterol, thereby resulting in better care management, slowing the progression of disease, and resulting in fewer hospitalizations and other complications. Copayments are reduced for Lantus Pens (to treat diabetes) and eliminated for Rosuvastatin (generic cholesterol medicine) at both retail and mail order pharmacies. This pilot began on February 1, 2018, and will conclude on January 31, 2023.

   Results show that since the pilot began in February of 2018, over $1.70M in prescriptions have been dispensed that were eligible for copayment reductions or eliminations. Of this, $20.9M has been applied to the catastrophic cap for patients using these medications (through the reduction or elimination of copayments) as directed by Congress. By the end of the third quarter for FY 2020, data revealed that 65,913 patients benefitted from the copayment reduction or elimination provided by this pilot. Of note, an interim analysis of the Medication Adherence Pilot reveals little to no difference in adherence rates among Rosuvastatin and its alternatives, nor the Lantus Pen and its alternatives. Further, no link between health outcomes and adherence to these medication could be established. Analysis of this pilot will continue.

2. ***Accountable Care Organization Demonstration.*** The ACO Demonstration, in partnership with Humana Government Business (HGB) and Kaiser Permanente (KP), services the Atlanta, GA market area. The HGB/KP ACO Demonstration was published in the Federal Register on August 16, 2019, and initiated with modification to the HGB contract on September 30, 2019. Enrollment in the HGB/KP demonstration was offered to TRICARE Prime and Select members in the Atlanta Prime Service Area during the 2019 Open Enrollment Season. Health care delivery began January 1, 2020, and will continue through December 31, 2023. As of September 2020, beneficiary enrollment in the ACO Demonstration was 1,779.

   The intent of this demonstration is to determine if greater levels of beneficiary satisfaction, cost containment, efficiency, and effectiveness can be reached using a capitation model. To incentivize beneficiaries to enroll in the ACO Demonstration, applicable annual TRICARE enrollment fees will be waived for the first year in which they enroll. This ACO Demonstration addresses all three areas of Section 729 **(medical intervention, lifestyle intervention, and lifestyle maintenance programs)** by offering a wellness rewards program, an assortment of wellness and healthy lifestyle tools, as well as a wide variety of discounts and no-cost resources to make maintaining wellness easier. For example, the beneficiary wellness incentive program, provided at no cost to the government, encourages beneficiaries to participate in wellness activities in order to receive incentive cards that they may use for cost-sharing, such as copays, prescription eyeglasses or contact lenses, or other Internal Revenue Service-qualified medical expenses. To date, 28 incentive cards have been issued, with another 70 expected to be issued by the end of October.

   The ACO demonstration incorporates other unique features including a risk sharing model and a quality incentive. The financial risk sharing model limits the DHA's financial liability for these covered beneficiaries. Finally, KP can potentially earn quality financial incentives for exceeding certain specific quality metric benchmarks established by DHA. This project serves as a potential model to integrate an ACO under a Managed Care Support Contractor. The demonstration is also designed to compare health care outcomes of geographically overlapping populations; one enrolled to HGB and one enrolled to KP.

3. ***Physical Therapy for Low-back Pain Demonstration***. The DHA published a Federal Register Notice on Tuesday, June 30, 2020, to establish a demonstration that will waive cost-sharing for up to three physical therapy (PT) visits for patients with a primary diagnosis of low back pain (acute, subacute, and chronic low back pain) in 10 demonstration states: Arizona, California, Colorado, Florida, Georgia, Kentucky, North Carolina, Ohio, Tennessee, and Virginia. This demonstration would specifically address section 729(a) (l) **(a medical intervention incentive program)**. By waiving copayments or cost-shares for physical therapy, patients will be incentivized to try PT before advancing to other methods to treat pain. This demonstration began January 1, 2021, and will terminate December 31, 2023. The purpose of this demonstration is to encourage the uptake of physical therapy services in lieu of lower-value care for the treatment and management of acute, sub-acute, and chronic low back pain. Low back pain is a

common condition that adversely impacts medical readiness for Active Duty Service Members and results in high costs for TRICARE beneficiaries and DHA. Use of low-value services increases health care costs, and patients who receive low-value, inappropriate care for low back pain may experience worse outcomes than patients who receive high-value, more conservative measures such as physical therapy. Through this approach to care for low back pain, DHA hopes to reduce use of low-value care items such as opioid drugs, injectable steroid drugs, an unnecessary surgery, and to potentially stop some patients from transitioning to chronic pain from acute or subacute pain.

4. ***Diabetes Prevention Program.*** The DoD is evaluating a Diabetes Prevention Program (DPP), in partnership with Health Net Federal Services (Health Net). Health Net has an existing DPP, which is being considered for adoption by the DoD at this time. If adopted, this program will meet NDAA section 729 (a), (b) and (c) requirements by addressing a chronic disease (diabetes) with a structured medical, lifestyle intervention and maintenance program. The DPP emphasizes weight reduction, and encourages the maintenance of a healthy lifestyle at no cost to the beneficiary. The National Diabetes Prevention Program is a Centers for Disease Control and Prevention (CDC) recognized lifestyle change program on which the Health Net program is based.

   One goal of the DPP is prevention of type 2 diabetes in individuals with an indication of pre-diabetes through weight loss. The program consists of nine core sessions over the course of 12 months. The sessions can be in-person or virtual. These sessions provide strategies for long-term dietary change and increased physical activity. After the core sessions are complete, the DPP offers 12 months of follow up sessions to help participants maintain healthy behaviors.

   The Centers for Medicare & Medicaid Services (CMS) implemented a similar DPP nationwide in the Medicare population in 2018.[3] The CMS Office of the Actuary projects Medicare's DPP will save Medicare $182M between 2018 and 2027.[4] Medicare initially tested DPP through a Center for Medicare and Medicaid Innovation model. This model provided reimbursement to the YMCA for teaching the diabetes prevention curriculum to Medicare beneficiaries. After the CMS Office of the Actuary certified that the model reduced costs and improved beneficiary health outcomes, CMS expanded the model nationwide. Under the model and the current nationwide program, there are no out of pocket costs for beneficiaries to participate. As a condition of payment, diabetes coaches must be CDC certified. Organizations offering the curriculum have the option of providing the program in person or virtually. DHA continues to evaluate the DPP for possible inclusion in the TRICARE benefit and anticipates the evaluation to be completed in early 2021.

While the programs listed above meet the intent and spirit of section 729, they do not

[3] CMS, "Medicare Diabetes Prevention Program Expanded Model," https://innovation.cms.gov/innovation-models/medicare-diabetes-prevention-program.
[4] CMS, "CY 2018 Outpatient Prospective Payment System Final Rule – Regulatory Impact Analysis," https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.

reward participants for outcomes achieved in a *prior year*. Research in behavioral economics has shown the timing of incentives appears to affect behavior change.[5] Immediate incentives have proven to be more effective in participants maintaining a wellness program than those paid out in the future.[6] Therefore, the time between the occurrence of the desired behavior and incentive payout should be minimized.[7] Further, there are significant administrative barriers to providing incentives a year after participation achievements are met, for example, tracking weight loss and applying cost-sharing reductions requires significant administrative expense, especially when done across plan years. Because the research shows that immediate rewards are more likely to be successful, and due to the administrative barriers in implementing the language as it is currently written, DHA has proposed a legislative amendment to eliminate the requirement for patients to achieve milestones for a year prior to receiving an incentive in order to provide flexibility to adopt additional evidence-based programs.

These four programs do not constitute DHA's full scope of work on value-based care. DHA has considered, implemented, developed, or is in the process of evaluating, 20 value-based initiatives (including the four detailed in this report) for the private sector care component of the TRICARE Program. Five of these 20 initiatives have been implemented, two are complete, and three are underway. These initiatives are reflected in the tables below. Initiatives in **bold** reflect those related to section 729.

Initiative	**Status**	**Highlighted Results**
Bundled Payments for Lower Extremity Joint Replacement	Concluded. Final year of data expected this Fall 2020	No reduced cost or improved quality identified.
Network Requirements and Standards for Urgent Care Centers	Permanent change as of January 1, 2018	No net cost savings.
Medication Adherence Pilot	In process; February 1, 2018-December 31, 2023	No impact on medication adherence to-date.
Performance-Based Maternity Payments Pilot	In process; April 1, 2018-March 31, 2021	Approx. 12 percent of the participating hospitals were eligible for an incentive payment in the first year.
Accountable Care Demonstration	In process; January 1, 2020 - December 31, 2023	None yet available.

[5] Parkinson, B., Meacock, R., Sutton, M. *et al.* Designing and using incentives to support recruitment and retention in clinical trials: a scoping review and a checklist for design. *Trials* 20, 624 (2019). https://doi.org/10.1186/s13063-019-3710-z
[6] Van Herck P, De Smedt D, Annemans L, Remmen R, Rosenthal MB, Sermeus W. Systematic review: Effects, design choices, and context of pay-for-performance in health care. BMC Health Serv Res. 2010;10:247
[7] Parkinson, B., Meacock, R., Sutton, M. *et al.* Designing and using incentives to support recruitment and retention in clinical trials: a scoping review and a checklist for design. *Trials* 20, 624 (2019). https://doi.org/10.1186/s13063-019-3710-z

Additionally, three of the remaining 15 value-based initiatives have been reviewed and approved for future implementation. These three initiatives are outlined in the table below.

Initiative	Status	Highlighted Results
Home Health Value-Based Purchasing	In Process; January 1, 2020 - December 31, 2022	None yet available.
Physical Therapy for Low Back Pain	Scheduled implementation for January 2021 - December 31, 2023	n/a
Hospital Value-Based Purchasing Program	Pending rule approval and publication	n/a

Of the remaining 12 initiatives, DHA has eight under review to determine the efficacy and feasibility of implementing these initiatives for the TRICARE program. One of these 12 initiatives, the Diabetes Prevention Program is in direct support of section 729 (a), (b) and (c). Lastly, DHA reviewed four initiatives that were not pursued for a variety of reasons such as cost, scalability, etc.

In addition, DHA has partnered with academia (Harvard Business School, The University of Michigan, and the Massachusetts Institute of Technology) to better understand how to transform TRICARE from volume-based care to value-based care, through value-based purchasing in such a way that optimizes force readiness. Lessons learned from these engagements will be considered for requirements in the T5 contracts.

5) Conclusion:

The four initiatives outlined in this report are designed to meet the intent of NDAA for FY 2017, Section 729, which required that the DHA establish: (1) a Medical Intervention Incentive Program; (2) a Healthy Lifestyle Intervention Incentive Program; and (3) a Healthy Lifestyle Maintenance program.

DHA's implementation of these four initiatives support both section 729 of the NDAA for FY 2017 reform and the MHS's vision of increasing value to the warfighter and military family. These programs were, or will be, modified into the T-2017 contracts and will be considered as requirements in the T5 contract, if they are determined to be successful (as evaluated against the criteria established when the programs were developed). In addition to these demonstrations, the DHA will continue to explore other value-based initiatives that could add value to the TRICARE Program and shift risk to the Managed Care Support Contractors.

6) Glossary:

A. Acronyms

CDC – Centers for Disease Control and Prevention
CMS – Centers for Medicaid and Medicare
COVID-19 – Coronavirus disease
DHA – Defense Health Agency
DoD – Department of Defense
DPP – Diabetes Prevention Program
FFS – Fee For Service
FY 2017 – Fiscal Year 2017
HGB – Humana Government Business
KP – Kaiser Permanente
MCSCs – Managed Care Support Contractors
MHS – Military Health System
NDAA – National Defense Authorization Act
P-BMP – Performance-Based Maternity Payments Pilot
PT – Physical Therapy
T5 – TRICARE Fifth Generation Contracts
T-2017 – TRICARE 2017 Contracts

B. Definitions

Accountable Care Organization – A group of health care providers who give coordinated high-quality care to beneficiaries, and shares financial and medical responsibility in hopes of limiting unnecessary spending.
Fee for Service – A payment method where health care providers are paid for each service performed.
Lantus Pens – Disposable insulin pen, used to treat diabetes.
Managed Care Support Contractor – Each TRICARE region has its own managed care support contractor who is responsible for administering the program in their region.
Preferred Provider Organization – A health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. The beneficiary pays less if they use a provider that belongs to the plan's network.[8]
Rosuvastatin – Generic cholesterol medicine.
T5 – The Fifth Generation of TRICARE contracts.
Value-based purchasing - Financial arrangements between payers, providers, and other health care entities designed to incentivize a change of behavior, increase the value of care provided to patients, and lower health care costs.
Section 729 – Section 729 of National Defense Authorization Act 2017.

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[8] U.S. Centers for Medicare & Medicaid Services. "Preferred Provider Organization (PPO)." *HealthCare.Gov,* U.S. Centers for Medicare & Medicaid Services, 2020, https://www.healthcare.gov/glossary/preferred-provider-organization-ppo/.