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

PERSONNEL AND
READINESS

AUG 13 2020

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

Dear Mr. Chairman:

The Department's response to Senate Report 116-236, pages 237-238, accompanying S. 4049, the National Defense Authorization Act for Fiscal Year 2021, is enclosed. The committee requests the Secretary of Defense provide a report on the TRICARE managed care support contract structure.

Based on a thorough review of the contract structure, the Department of Defense intends to pursue TRICARE programmatic revisions and a TRICARE managed care support contract acquisition strategy. This approach will expand on the existing two-region structure by implementing demonstrations permitting the Department to test the efficacy of offering beneficiaries access to multiple networks in the same geographic area. It also involves implementing other pilots and demonstrations to test the feasibility of a wide range of innovations in health care and incentives for the TRICARE managed care support contractors.

This approach is designed to achieve the Department's objectives of improved readiness, increased beneficiary choice, quality-based payments, and industry business standards. Further, it initially relies on demonstrations as vehicles for testing innovations to allow time to shape necessary statutory, regulatory, or policy changes. The approach provides flexibility to consider a separate administrative contract to address the high cost of eligibility, enrollment, and encounter data. Finally, it integrates the new TRICARE program with other efforts shaping the right-sizing of military medical treatment facilities and modernization of the Military Health System.

Thank you for your continued strong support of our Service members, civilian workforce, and families.

Sincerely,

//SIGNED//
Matthew P. Donovan
US Under Secretary of Defense for P&R

Enclosure:
As stated

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WASHINGTON, D.C. 20301-4000

PERSONNEL AND READINESS

AUG 13 2020

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

Dear Senator Reed:

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Report to the Committee on Armed Services of the Senate

Senate Report 116-236, Pages 237-238, Accompanying S. 4049, the National Defense Authorization Act for Fiscal Year 2021

TRICARE Managed Care Support Contract Structure

August 2020

The estimated cost of this report or study for the Department of Defense is approximately $3,350 for the 2020 Fiscal Year. This includes $500 in expenses and $2,850 in DoD labor.
Generated on 2020Jul22 RefID: 2-EFE52FE

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EXECUTIVE SUMMARY

This report is in response to Senate Report 116-236, pages 237-238, accompanying S. 4049, the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2021, which requests a report on "TRICARE managed care support contract structure." This committee report raised questions regarding the continuation of the current two-region model into the next generation of TRICARE contracts (T-5). Specifically, the committee asked whether this approach comports with prior legislative direction regarding TRICARE contract structure (including direction to increase competition and beneficiary choice). The report urged the Secretary of Defense to ensure that the T-5 contract structure departs from the current two-region design to a multiple region construct with multiple contracts as well as multiple provider networks.

REPORT CONTENTS

The subject report requests that the Secretary of Defense "...review the legislative reforms enacted over the past several years and report to the committee on how the acquisition strategy for the next set of TRICARE managed care support contracts incorporates those reforms in a manner that increases competition and beneficiary choice. This report should be provided to the committee prior to the release of any T-5 Request for Proposal."

BACKGROUND

The NDAA for FY 2017 (Public Law 114-328) directed the implementation of sweeping reforms for TRICARE and the Military Health System (MHS), including specific reforms regarding the "acquisition of [TRICARE] contracts." Specifically, section 705(c) directed the Secretary to ensure that managed care support (MCS) contracts under the TRICARE program incorporate a strategy to improve access to health care, improve health outcomes and health care quality, enhance the beneficiary's experience of care, and lower per capita health care costs. This section also directed that local, regional, and national health plans should have an opportunity to participate in the competition for TRICARE MCS contracts, and that the strategy should incentivize the "incorporation of innovative ideas and solutions into managed care support contracts through the use of teaming agreements, subcontracts, and other contracting mechanisms that can be used to develop and continuously refresh high-performing networks of health care providers at the national, regional, and local level."

To comply with all applicable legislative direction and guidance, and to ensure alignment with the MHS vision and goals, the Defense Health Agency (DHA) explored multiple business/contracting models and conducted extensive market research prior to developing the T-5 acquisition strategy. DHA's T-5 acquisition strategy approach, primary objectives, process and rationale are discussed below.

DISCUSSION

The DHA is designing the TRICARE Program and the next generation of TRICARE MCS contracts (T-5) to provide the best readiness of the military at the best price in an integrated system that is responsive to beneficiary experience of care. Experience of care includes access, availability, best outcomes, high-performing networks and value-based incentives to providers and health plans. The re-designed TRICARE Program and the T-5 contracts will implement and deliver policies and approaches that enhance readiness as a priority, incorporate industry standards to the maximum extent practicable, and incentivize the provision of high value care through integrated direct care and private sector networks, to the end of improving quality and access while containing cost.

Our strategy is to improve beneficiary choice and allow more contractors to compete for TRICARE business, which we believe is responsive to the committee's concerns. Because of the legal issues described below, and because the Department desires to test any new program delivery/contracting model before rolling it out program wide, we will be pursuing this strategy in phases. From the start of T-5, we plan to implement an innovative demonstration that will require the MCS contractors to partner with plans within each region (on a localized basis) to test the multiple contract and multiple provider network concept and to identify an optimal configuration. This demonstration will require education of beneficiaries on new options, assessment of the cost structure and other requirements of the innovations to ensure they improve care, quality, and access, and analysis and evaluation to understand what could work. In addition, during performance of the T-5 contracts, DHA also plans to implement a separate demonstration to test another multiple contract and multiple provider network approach. Under this demonstration, DHA would competitively award limited local or market-based contracts in each region directly to healthcare organizations, including plans or providers, under alternative payment and high-value network arrangements, which would deliver healthcare to beneficiaries on a localized basis. These contractors would operate in the same geographic space as the existing MCS contractors. In order to reach this end state and execute the demonstration, DHA will first need to compete a separate contract (external to the T-5 MCS contracts) to satisfy the unique administrative needs of TRICARE in areas such as eligibility, enrollment, and encounter data. We believe this approach, which will allow local and regional contracted health care plans and providers to focus solely on delivering health care services rather than these back-office activities unique to TRICARE, will lead to more plans and providers competing for TRICARE business. If the demonstrations are successful, the Department would utilize the rulemaking process (and, if necessary, request legislative changes) to implement the concepts program wide.

The primary goals of the re-design of the TRICARE Program and contracts are to:

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

2. Place beneficiary choice at the center of the program by requiring contractors to empower them with information on cost, quality and access. The program and

contracts will offer expanded enrollment choices for beneficiaries that include information on cost and choice of provider.

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

4. Move the contract to industry business standards.

These goals may be mapped to the Department's established high level requirements planned for T-5 and their corresponding subsections in section 705 of the NDAA for FY 2017:

Table 1. Healthcare Reforms and Innovations to Increase Competition and Beneficiary Choice

Goals	T-5 Innovation	Section 705(c)(5)
1	Enhance Readiness by Managing the TRICARE Prime Benefit	B, G
1,2	Integrated Care: Co-located Direct and Purchased Care	B
1,2,4	MHS Genesis utilization and Enhance Data Transparency	B
1,2	Referrals	H
1,2	Market and/or MTF on-site Support	B
1,2	Beneficiary Choice	A, G
1,2,3	Beneficiary Incentives	E, F, I
1,2,3	High and Low-Value care	D
1,2,3,4	Alternative Payment Methods	D, F, I
1,2	Expanded use of Telehealth	C
1,2	Centers of Excellence	A, B
4	Length of Contract	A

LEGAL ISSUES

Key to several of the section 705 requirements is the use of multiple contract and multiple provider networks. From the beginning of the TRICARE program, the Department has interpreted and implemented the law (through rulemaking) to effect a single network concept on the basis that such an approach/concept is the most efficient, effective, and feasible means of delivering the TRICARE program to beneficiaries while complying with the "uniform program" mandate at 10 U.S.C. § 1071 and the definitions of "network" and "out-of-network" set forth in 10 U.S.C. § 1075. The Department has designed and implemented all other programmatic requirements and elements (e.g., point-of-service care, referrals, cost shares) around this single network concept. Some of the most evident marks of the single network interpretation and implementation are found at 32 CFR Part 199.17 in its discussion of beneficiary access to network and non-network providers, TRICARE enrollment procedures, TRICARE Prime referrals, the obligations of network providers, and the freedom of choice of Select beneficiaries

to see any authorized providers. Because the single network concept is assumed and ingrained throughout the entire implementation of the TRICARE program at 32 CFR Part 199, it is not currently administratively feasible for the Department to utilize multiple contract and provider networks under the TRICARE Program except under demonstration authority.

We note that the DHA cannot use its TRICARE MCS contracts as the vehicles for directly implementing changes to the TRICARE program (as implemented at 32 CFR Part 199). The MCS contracts do not create the TRICARE program. The contracts merely execute or deliver the program (and demonstration projects) as implemented by the Department. In order to implement programmatic changes,the Department must comply with the Administrative Procedure Act by providing the public with notice and an opportunity to comment on proposed changes, additions, etc. Only after fulfilling its rulemaking obligations can the Department call on its contractors to execute/deliver the now-revised programmatic requirements to beneficiaries. However, the Department may utilize its demonstration authority at 10 U.S.C. § 1092 to assess, on a limited basis, a new program requirement and the adaptations that would be required to make it work. As DHA moves forward with TRICARE reforms as directed by Congress and collaborates with industry on healthcare innovations, we plan to seek any necessary legislative relief and propose appropriate changes to the program through public notice and comment rulemaking.

T-5 DEVELOPMENT

The T-5 generation of contracts is also designed to address specific challenges related to contract design, performance issues, and "lessons learned" from current and previous contracts. During the development of the T-5 acquisition strategy, DHA considered different approaches to address historical contractor performance issues, foster innovation and adoption of industry best practices, and maximize return on DHA investment. In particular, the options of transformational change and immediate change were reviewed as described below.

- Transformational Change: This design starts with two MCS contractors that facilitate costly "back office" administrative functions (eligibility, enrollment, encounter data) while the Government shifts additional financial risk to these MCS contractors. The design will leverage demonstration authority to require the MCS contractors to partner with local and sub-regional health plans to test, on a limited basis, the efficacy of operating multiple contract and multiple networks within the framework and geography of their contracts. The other goal is to provide innovative and cost-effective industry best practices to improve beneficiary choice, competition, readiness, cost, quality and access. Other planned demonstrations include the use of Alternate Payment Models such as Accountable Care Organizations (ACOs), enhanced reporting of outcomes metrics, use of centers-of-excellence, increased use of telehealth, a focus on high-value care, and other innovations (see Table 1). The advantages of this approach include: stable "back office" platform without costly duplication of administrative functions, collection of evidence from innovation demonstrations and pilots on what works before the Department decides which

changes meet the requirement for innovative approaches expressed by Congress in section 705 of the NDAA for FY 2017. Disadvantages include temporary extension of current T-2017 contract to incorporate industry market research, and new pilots/demonstrations, higher cost due to additional demonstrations and pilots, and potential reduction in provider network discounts. Further, as noted above, in order to implement the multiple-network concept system-wide, the Department would need to seek legislative relief and substantially revise, through rulemaking, the TRICARE regulations at 32 CFR Part 199.

- Immediate Program-Wide Change: From the onset of the new contract period, the entire TRICARE program would change to organize around multiple regions which could have multiple MCS contractors in each region with multiple provider networks. The advantage of this approach is that it could allow greater beneficiary choice, greater competition among health plans to become MCS contractors, and the potential to offer different or supplemental benefits above the standard uniform benefit. Disadvantages include significant delay due to the need to seek legislative changes and conduct subsequent notice and comment rulemaking prior to Request for Proposal (RFP) release, potential reduction in beneficiary choice of provider, increased cost to deploy (eligibility, enrollment, and encounter setup alone is $50 million per MCS contractor), increased cost to administer both the standard benefit and multiple innovations that would be spawned, longer extension of the current T-2017 contract, and higher costs.

In developing the T-5 acquisition strategy, DHA also considered the unique nature of the MHS and the resulting challenges associated with all TRICARE acquisitions. TRICARE is a complicated program to build and administer and is founded on the principle that the program will be uniformly delivered and administered. The integration of readiness and health is unique to the military and is not a requirement in a fully commercial setting or for other government programs. With these factors in mind, DHA assessed through the phased transformational change approach, which DHA will test through demonstrations, that the efficacy of increasing competition and expanding beneficiary choice while building a cadre of subcontractors capable of competing for future contracts, provides the most realistic and executable path forward. The mentorship of alternative payment and high value network subcontractors by prime contractors ensures the accountability for readiness, cost, quality, and beneficiary experience outcomes. In addition, this approach will provide the necessary time to transition our large population of beneficiaries to a new TRICARE landscape where they will need to review and understand the implications of selection from multiple plan offerings.

It is important to note that other Government agencies with multiple contracts and multiple provider networks (e.g., the Center for Medicare & Medicaid Services) took considerable time to grow similar capabilities and do not have military readiness as an essential requirement. Their experience appears to show that innovations do not guarantee improvement in competition and beneficiary choice, and could potentially raise costs and will affect large numbers of beneficiaries system-wide.

The NDAA for FY 2017 was released after the award of the T-2017 contracts and, as noted above, some of the requirements in section 705 were not immediately implementable. However, as recognized by the Government Accountability Office in their report GAO-20-197, DHA has taken affirmative steps to modify the T-2017 contracts and to conduct demonstrations to meet certain section 705 requirements. Further, in order to encourage and stimulate industry involvement in this acquisition, the DHA has conducted extensive market research.

The Department believes the market research performed in anticipation of T-5 is unprecedented in the history of TRICARE in that it has been very open to receiving recommendations and providing opportunities to better understand the needs of the communities we serve. The Department will continue to interact with industry and conduct market research in order to meet the needs of all stakeholders. As a result of these market research efforts, multiple reforms and industry innovations/best practices have been identified and are being considered for implementation into the TRICARE Program and inclusion in T-5 (see Tables 2 and 3). The DHA will receive additional feedback from industry following the release of the draft RFP, which will provide the agency with valuable insight on the Government's proposed approach and draft requirements so that any issues can be addressed prior to the publication of the RFP.

TABLES

Table 2. Reforms and Industry Innovation Examples Under Consideration

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.
Access To Care (ATC) Standards: Standard measures for Access To CareATC across TRICARE Prime and TRICARE Select plans.
Central Enrollment: Strategic roadmap that aligns an eligibility & enrollment timeline to regulatory & technology dependencies.

Table 3. Best-Practice Innovation Examples Under Consideration

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: 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.
At-Risk Centers of Excellence: High quality/outcomes provider groups; WITH affordable cost by adding episode of care/bundled payment contracts – enables Centers of Excellence 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, for heightened attention, use financial incentives.
Advanced Care Management: Advanced care management & care coordination, require MCS contract provider incentives for interoperability and Artificial Intelligence care management tools, referral management, provider shaping. Target high cost, high utilization, complex needs beneficiaries for DM – especially chronic 5 conditions and cancer; advanced predictive risk identification and stratification tools (with social determinants of health). Breadth and depth expands in Course of Action 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).

CONCLUSION

Based on DHA's review of legislative reforms related to TRICARE contract structure, along with an in-depth analysis of change options, lessons learned, and market research, DHA intends to pursue TRICARE programmatic revisions and a T-5 acquisition strategy based on the phased transformational change option as discussed above. This approach will expand on the existing two-region structure by implementing demonstrations that will permit DHA to test the efficacy of offering beneficiaries access to multiple networks in the same geographic space. It will also involve the implementation of other pilots and demonstrations to test the feasibility of a wide range of innovations in health care, as well as incentives for the MCS contractors to provide innovative and cost-effective industry best practices intended to increase competition, beneficiary choice, quality, and access; improve readiness; and reduce costs. This approach is designed to achieve the Department's objectives of improved readiness, increased beneficiary choice, quality-based payments, and industry business standards. Further, because it initially leans on demonstrations as the vehicles for testing innovations, it also allows time to shape required statutory, regulatory, and policy changes if needed. This approach also provides flexibility to consider and implement a separate administrative contract to address the high cost of eligibility, enrollment, and encounter data and integrate the new TRICARE program with the other efforts that are shaping the right-sizing of military medical treatment facilities and modernization of the MHS.

DHA believes that this transformational approach will support innovation, beneficiary choice, market-based management strategies, and cost-effective industry best practices which will improve quality of care for TRICARE beneficiaries and maximize returns on DHA investment. The expansion of the current two-region model (via local and regional pilots, demonstrations, and subcontracts) will open the door for future increased competition and enable the Department to use an evidence-based approach and explore health care innovations to find what works and drive system performance improvement, while simultaneously minimizing risk and achieving health care delivery in the earliest possible timeframe.