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

PERSONNEL AND
READINESS

JAN 11 2018

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

Dear Mr. Chairman:

The enclosed report is in response to section 726 of the National Defense Authorization Act for Fiscal Year 2016 (Public Law 114-92), which requests the Department to provide an annual report to the congressional defense committees on a value-based demonstration in the purchased care component of the TRICARE program.

The Defense Health Agency (DHA) commenced a value-based demonstration for Lower Extremity Joint Replacement and Reattachment (LEJR) surgeries and post-operative care in the Tampa-St. Petersburg, Florida market on May 23, 2016. This demonstration was designed to test whether value-based incentives are effective tools for improving health care quality, enhancing the beneficiary experience of care, and reducing the rate of increase in health care spending over time.

Seven demonstration hospitals and six cohort (control group) hospitals in the Tampa-St. Petersburg market are currently participating in this initiative. Demonstration hospitals may earn financial incentives, in the form of gain-sharing payments, if they successfully reduce LEJR episode costs, while simultaneously achieving and maintaining a satisfactory health care composite quality score. Beginning in Demonstration Year Two, hospitals may also incur loss-sharing penalties if actual episode costs exceed the target episode price. Hospitals that do not achieve and maintain a satisfactory quality score are ineligible for financial incentives, regardless of financial performance. This approach ensures that hospitals do not sacrifice health care quality in order to lower overall costs.

To date, data analysis has been conducted on 53 total episodes of care (surgery plus 90 days post-operative care). Although additional LEJR surgeries have occurred since the demonstration started, the episode-based design of the project plus normal claims lag time means that cost data cannot be evaluated until approximately 240 days from the activating event (LEJR surgery). Due to the relatively small number of completed LEJR episodes to date, and the delay in obtaining full-cost data for completed episodes, it would be premature to draw any conclusions about the effectiveness of the demonstration; more data is needed. However, based on the information that is currently available, four of the seven demonstration hospitals are delivering care where the total episode cost is lower than the target episode price. Three out of the four hospitals have achieved and maintained a satisfactory composite quality score, which was based on Centers for Medicare and Medicaid Services (CMS) analysis published in April

2017. Since this was the first year that CMS produced these performance ratings, it is not possible to draw any conclusions about quality performance trends at this time. However, if these cost and performance trends hold through the end of Demonstration Year One, three of the seven demonstration hospitals will be eligible for five percent gain-sharing incentive payments. The remaining four hospitals will be ineligible for gain sharing because they failed to meet the quality standards and actual episode costs exceeded the target. The DHA will continue to evaluate this demonstration and provide reports to the congressional defense committees through the life of the demonstration (December 2019).

Thank you for your interest in the health and well-being of our Service members, veterans, and their families. A similar letter has been sent to the other congressional defense committees.

Sincerely,

Robert L. Wilkie

Robert L. Wilkie

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

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

PERSONNEL AND
READINESS

JAN 11 2018

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

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Robert L. Wilkie

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Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member

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

PERSONNEL AND
READINESS

JAN 11 2018

The Honorable Thad Cochran
Chairman
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

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Sincerely,

Robert L. Wilkie

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Enclosure:
As stated

cc:
The Honorable Patrick J. Leahy
Vice Chairman

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

PERSONNEL AND
READINESS

JAN 11 2016

The Honorable Rodney P. Frelinghuysen
Chairman
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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Sincerely,

Robert L. Wilkie

Enclosure:
As stated

cc:
The Honorable Nita M. Lowey
Ranking Member

Report to Congressional Defense Committees on

Pilot Program on Incentive Programs to Improve Health Care Provided Under the TRICARE Program

In Response to: Section 726 of the National Defense Authorization Act for Fiscal Year 2016 (Public Law 114-92)

The estimated cost of this report or study for the Department of Defense (DoD) is approximately $3,290.00 for the 2017 Fiscal Year. This includes $50.00 in expenses and $3,240.00 in DoD labor. Generated on August 29, 2017 RefID: 8-FDE349D

REPORT TO CONGRESSIONAL DEFENSE COMMITTEES

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Pilot Program on Incentive Programs to Improve Health Care Provided Under the TRICARE Program

1) Executive Summary:

This report summarizes the Department of Defense's (DoD) efforts to date regarding the value-based demonstration, which was implemented on March 23, 2016, consistent with section 726 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2016 (Public Law 114-92). Since that date, the Defense Health Agency (DHA) has been conducting the Lower Extremity Joint Replacement or Reattachment (LEJR) demonstration in the Tampa-St. Petersburg, Florida market, using a modified version of the Comprehensive Care Joint Replacement (CJR) program which was implemented by the Centers for Medicare and Medicaid Services (CMS) in April 2016.

2) Background:

Section 726 of the NDAA for FY 2016 required a demonstration project to determine whether value-based payment incentives could effectively reduce the rate in increase of health care spending, improve health care quality, and enhance the beneficiary experience of care in the TRICARE program. Pursuant to that section, the DoD is required to submit interim reports to the congressional defense committees prior to each year's anniversary of the enactment of the Act (November 25, 2015), and no less frequently than once each year thereafter until the termination of the pilot program.

The LEJR demonstration is designed to encourage hospitals, physicians, and post-acute care providers to work together on an "episode of care" basis to improve health care quality and optimize coordination of services from the initial hospitalization through the recovery period. The pilot aggregates payments for LEJR surgeries without major complications or comorbidities (Diagnosis Related Group 470) and 90 days of related post-operative care at certain hospitals in the Tampa-St. Petersburg, Florida market and rewards hospitals that can lower costs while maintaining high quality. Seven demonstration hospitals have been identified, along with a "control group" cohort consisting of all other hospitals in the Tampa market, and target episode prices have been calculated for each demonstration hospital based on historical TRICARE claims data. Target episode prices are adjusted annually for inflation and also to reflect changes in the rate blend over time (hospital-specific vs. market-wide prices). In Demonstration Years One and Two, the blended rate for the target episode price is based on two-thirds hospital-specific data and one-third market-wide data. In Demonstration Year Three, the target episode price will be based on one-third hospital-specific data and two-thirds market-wide data. To ensure fair cost comparisons between hospitals, adjustments are also made for Indirect Medical Education costs and extreme cost outliers (i.e., episodes with a total cost higher than 2 Standard Deviations (SD) above the Tampa-wide average are truncated at the 2 SD threshold).

Beginning in Demonstration Year One (May 23, 2016, through September 30, 2017), hospitals are eligible for gain-sharing payments if they achieve and maintain a favorable quality performance rating and if actual episode costs are lower than the target episode price. This

approach ensures that hospitals do not sacrifice health care quality in order to lower overall costs. Quality performance ratings are derived from the CMS composite quality score for their CJR program. The CMS composite quality score is a hospital-level summary quality score reflecting performance and improvement on the quality measures adopted for Medicare's CJR model (Total Hip Arthroplasty/Total Knee Arthroplasty) complications measure and the Hospital Consumer Assessment of Healthcare Providers and Systems patient experience survey measure. Hospital-level incentives (in the form of gain-sharing payments) are based on total TRICARE allowable charges for LEJR surgeries in comparison to the target episode price for each hospital. Gain-sharing payments in Demonstration Years One and Two will be equal to five percent of the total-cost savings for a particular demonstration hospital during the applicable year. This amount increases to 10 percent in Demonstration Year Three. Hospitals may also incur loss-sharing penalties if actual episode costs exceed the target episode price. Loss sharing is zero percent in Demonstration Year One, five percent in Demonstration Year Two, and 10 percent in Demonstration Year Three.

3) <u>Discussion</u>:

Historically, approximately 100 TRICARE beneficiaries receive LEJR surgery in the Tampa-St. Petersburg, Florida market annually. During the first six months of the demonstration (May 23, 2016, through November 30, 2016), there were 53 LEJR admissions in the demonstration and cohort hospitals (30 and 23, respectively). Additional admissions have occurred since that time; however, the nature of this episode-based demonstration (hospital admission plus 90 days of post-operative care, plus claims submission and processing time) creates a significant lag time before all data are available. TRICARE providers are subject to a one-year timely filing rule for claims, but, most claims are submitted more quickly and TRICARE claims processing is faster than industry averages. For this demonstration, the DHA is anticipating an average of two to three months for claims runout, and an additional 30-45 days for TRICARE Encounter Data receipt, plus an additional 15 days for the data to be visible in enterprise data systems. This means that demonstration cost data cannot be evaluated until approximately 240 days from the activating event (LEJR surgery).

Based on LEJR admissions through November 30, 2016, total episode costs for LEJR surgeries at demonstration hospitals are higher than those at cohort hospitals (average of $20,688.00 vs. $18,903.00, respectively). However, it should be noted that the demonstration hospitals ran comparatively higher trends prior to the demonstration. Also, there was significant volatility in the annual cost trends, both for the demonstration and cohort hospitals, in the years preceding the demonstration (based on an analysis performed by Kennell & Associates for FYs 2013, 2014, and 2015). Prior to the introduction of the LEJR demonstration, annual cost trends for demonstration hospitals went up by 9 percent and then down by 5 percent, while cohort hospitals went up by 6 percent and then down by 12 percent. Finally, the number of completed episodes to date is still quite low, and, therefore, average costs per episode can be swayed by one or two admissions in comparison to the overall total. For these reasons, it would be premature to draw conclusions about the impact of the LEJR demonstration on cost trends.

Based on the information that is currently available, four of the seven demonstration hospitals are delivering care where the total episode cost is lower that the target episode price. Three out of the four hospitals have achieved and maintained a satisfactory composite quality score, which was based on CMS analysis published in April 2017. Since this was the first year that CMS produced these performance ratings, it is not possible to draw any conclusions about quality performance trends at this time. However, if these cost and performance trends hold through the end of Demonstration Year One, three of the seven demonstration hospitals will be eligible for five percent gain-sharing incentive payments. The remaining four hospitals will be ineligible for gain sharing because they failed to meet the quality standards and actual episode costs exceeded the target.

4) <u>Conclusions</u>:

The number of admissions for the first six months of the LEJR demonstration is still low (30 demonstration hospital admissions and 23 cohort hospital admissions through November 30, 2016). Therefore, average costs per episode in either group can be swayed by a change of a few more or less readmissions in the demonstration period relative to the historical year. It is difficult to confidently reconcile pre-demonstration differences in the cost trends because there was great volatility in the annual cost trends in the years preceding the demonstration, both for the demo hospitals (up 9 percent and then down 5 percent) and the cohort hospitals (up 6 percent and then down 12 percent). It is also not possible to draw conclusions about quality performance trends at this time, since CMS did not publish CJR composite quality scores before April 2017 (retrospective to April 2016). Finally, since this is an episode-based demonstration, cost evaluations include the activating event (surgery) plus 90 days of post-operative care, and demonstration cost data cannot be evaluated until approximately 240 days from the activating event. Given all of the above, the DHA concludes that it is too soon to draw any conclusions about whether or not there is any initial cost or quality impact from the demonstration; additional data is needed. The DHA will continue to monitor demonstration cost trends on a quarterly basis and as the total pool of completed episodes expands over time, more definitive analysis and evaluation will be possible.