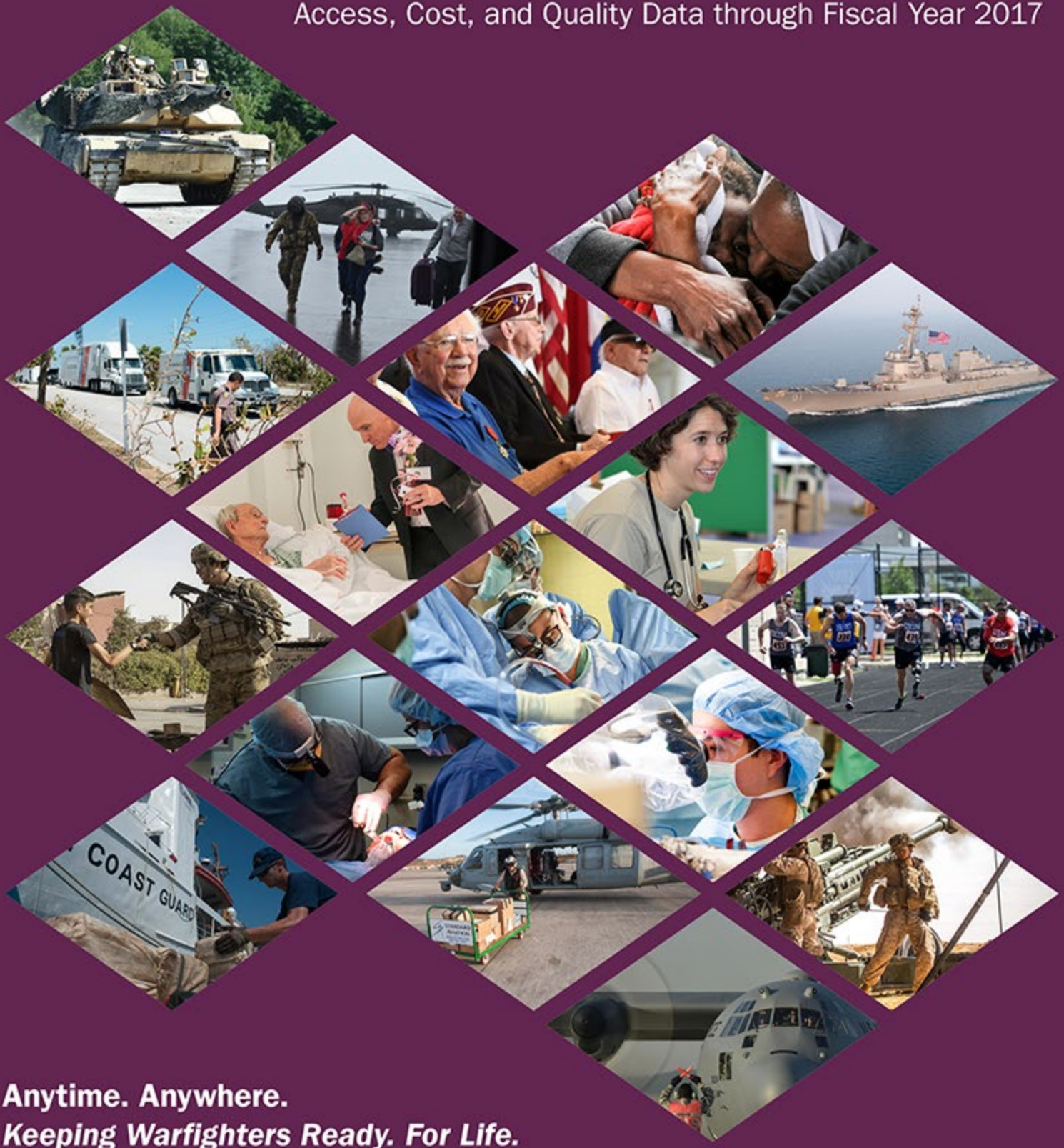
Evaluation of the TRICARE Program:

Fiscal Year 2018 Report to Congress

Access, Cost, and Quality Data through Fiscal Year 2017



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21st Annual
TRICARE Evaluation Report and Data

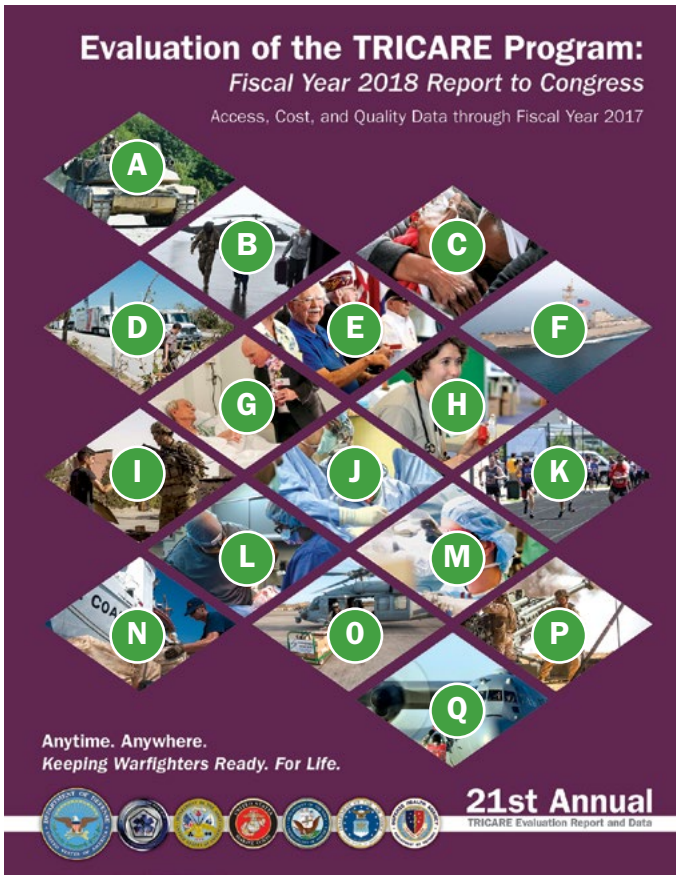
Evaluation of the TRICARE Program:

Fiscal Year 2018 Report to Congress

Access, Cost, and Quality Data through Fiscal Year 2017

February 28, 2018

The *Evaluation of the TRICARE Program: Fiscal Year 2018 Report to Congress* is provided by the Defense Health Agency (DHA), Decision Support Division, in the Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]). Once the Report has been sent to Congress, an interactive digital version with enhanced functionality and searchability will be available at: http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program.



Front cover photo descriptions:

A – U.S. Soldiers conduct a Combined Arms Live Fire Exercise with M1A2 Abrams tanks at the 7th Army Training Command's Grafenwoehr Training Area, Germany. (July 2017)

B – A Louisiana National Guardsman leads personnel bringing critically needed medical supplies after Hurricane Harvey devastated southeast Texas. (August 2017)

C – A woman cuddles a child in the cabin of an HH-60 Pave Hawk helicopter after the family was pulled up from flood waters in Texas. (August 2017)

D – A Florida state trooper helps escort a convoy of Coast Guard communication trucks to Sector Key West near Marathon, Florida. (September 2017)

E – World War II Veterans attend a French Legion of Honor presentation ceremony aboard the amphibious landing dock ship USS New York during the 27th annual Fleet Week Port Everglades. (May 2017)

F – The Arleigh Burke-class guided missile destroyer USS Pinckney transits the U.S. 5th Fleet area of operations in support of maritime security operations. (September 2017)

G – Inpatient Veterans at William Beaumont Army Medical Center (WBAMC) received a special visitor in recognition of National Salute to Veteran Patients Week. (February 2017)

H – A pediatrician with the 21st Medical Operations Squadron advises the mother of a patient on the use of an inhaler with the assistance of a local volunteer in Azua, Dominican Republic. (March 2017)

I – A paratrooper assigned to the 82nd Airborne Division, 2nd Brigade Combat Team shakes the hand of a young boy while patrolling to support Operation Inherent Resolve in Mosul, Iraq. (July 2017)

J – A team of U.S. Army medical personnel from Brooke Army Medical Center participates in a training exercise in Hospital Escuela and Hospital Maria in Tegucigalpa, Honduras. (July 2017)

K – Soldiers compete in the 100-meter track event. (July 2017)

L – A Naval Officer performs oral surgery on Logistics Specialist Seaman Victor Colon in the dental office aboard the aircraft carrier Harry S. Truman. (September 2017)

M – An Army Officer uses a microscope during a microvascular transplant as part of WBAMC's Reconstructive Microsurgery Program. (April 2017)

N – A Coast Guard Cutter Diligence Crewmember stacks bales of cocaine that the Coast Guard Cutter Tahoma interdicted in the Caribbean. (September 2017)

O – An Aircrewman unloads emergency supplies as part of first response efforts to the U.S. Virgin Islands in the wake of Hurricane Irma. (September 2017)

P – U.S. Marines with the 11th Marine Expeditionary Unit fire an M777 Howitzer during a fire mission in northern Syria as part of Operation Inherent Resolve. (March 2017)

Q – A Staff Sergeant marshals a C-130 Hercules aircraft during Exercise Saber Guardian 17 at Bezmer Air Base, Bulgaria. (July 2017)

Photos used throughout this report are courtesy of U.S. Army, www.navy.mil, www.usmc.mil, and www.af.mil.

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A MESSAGE FROM THOMAS McCAFFERY, ACTING ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

I'm honored to provide you with the Department's 2018 Evaluation of the TRICARE Program.

The Military Health System (MHS) has embraced transparency, and this report—along with our online resources at www.health.mil—are a testament to the continued building of a rich, informative repository for our leaders, our beneficiaries, our elected leaders, and the American public.

This comprehensive report looks across the spectrum of health services we deliver and arrange for our 9.4 million beneficiaries, and provides all Americans with an assessment of our performance.

Our online portal displays accreditation, access, quality, safety, and associated policy guidance across the MHS, and down to the military treatment facility (MTF) level. This year, we have collaborated with the Centers for Medicare & Medicaid Services (CMS) allowing our patients to view MHS MTF performance on the CMS Hospital Compare website (https://www.medicare.gov/hospitalcompare/search.html).

Our Department's $54 billion FY 2018 Unified Medical Program (UMP) represents about 9 percent of the total Department of Defense (DoD) outlays. For the last several years, the DoD has successfully kept health care costs within projections. Overall costs were moderated in FY 2017 by almost $900 million collected in pharmacy retail refunds and retroactive collections, about $300 million in program integrity (anti-fraud/abuse) claims recoveries and recaptured payments, and by encouraging the use of the less-costly pharmacy home delivery program as well as generic drugs.

I am excited about leading the MHS at a time of historical reform in how we manage and oversee military medicine. The 2017 National Defense Authorization Act established a number of significant changes to both our benefit and our organizational structure, with the explicit goals of further improving readiness, access, quality, and of wisely managing our costs.

We are guided in our efforts by the strategic direction delivered by Secretary Mattis: RESTORE military readiness as we build a more lethal force; STRENGTHEN alliances and attract new partners; and BRING business reforms to the DoD. The MHS has responsibilities within each of these lines of effort.

I have included in this year's report an article in the *Journal of the American Medical Association*, authored by our senior MHS leaders. This article outlines how our MHS strategy is aligned to meet our national security objectives and the intent of Congress by focusing on readiness; creating an integrated enterprise to provide a common, high-quality experience for our patients; and eliminating redundancies.

I have been privileged to witness this system up close since I joined the Department in August 2017.

The MHS continues to have a profound effect in supporting our Service members, allies, and friends around the world. In far-flung and austere locations, our medical team provides life-saving services to those in harm's way. And they provide indispensable support to those suffering from catastrophic events and humanitarian crises.

Representing the DoD at the Global Health Security Agenda ministerial meeting in Kampala, Uganda, I was energized to hear our partners in the United Kingdom, Finland, and Uganda speak to the defense sector's unique skills and experiences in helping support international efforts and respond to life-threatening outbreaks. I was able to see firsthand the U.S. government's powerful ability to help build host-nation capacity to combat threats from infectious diseases. It is a strategic capability that enhances security cooperation around the world, as well as protecting our own Service members and U.S. citizens from the consequences of a disease outbreak.

Here at home—whether in our large medical centers or smaller clinics—I have been equally moved by the excellent and compassionate care provided to our extended military family.

This report captures our performance in great detail, and also highlights where we can make further improvements in our system of care. An interactive digital version with enhanced functionality and searchability will be available at: https://health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program.

I am grateful for the service and sacrifice of our military and civilian members of the MHS, for the advocacy and guidance of our partners in Military and Veterans Services Organizations, and the unrelenting support of our leaders in the Department and Congress in providing the resources and strategic guidance we need. I look forward to working closely with all of our stakeholders in building on our impressive legacy in the coming year.

—Thomas McCaffery

MHS PURPOSE, MISSION, VISION, AND STRATEGY

The Department of Defense (DoD) relies on the Military Health System (MHS) to provide a ready medical and medically ready force. The MHS maintains integrated medical teams to deliver health services in support of America's military—anytime, anywhere. We are ready to go into harm's way to meet our national security and military challenges, at home or abroad, and remain committed to becoming a world leader in quality, safety, education, training, research, and technology.

Our capability to provide a continuum of health services across the range of military operations is contingent upon the ability to create and sustain a healthy, fit, and protected force. Key elements of research and innovation, medical education and training, and a uniformed sustaining base and platforms are interdependent and cannot exist alone. A responsive capacity for research, innovation, and development is essential to achieve improvements in operational care and medical evacuation.

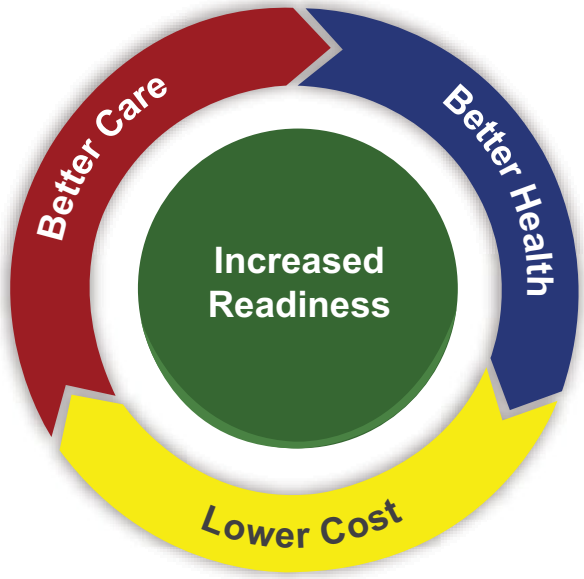
The MHS is a global system capable of delivering quality health services to members of the military. Working as an integrated enterprise, the MHS delivers a ready medical and medically ready force to the Combatant Commanders. In everything we do, we adhere to common aims essential for accomplishing our mission and achieving our vision.

MHS QUADRUPLE AIM—STRATEGIC DIRECTION AND PRIORITIES

Since 2009, the MHS Quadruple Aim has served as the strategic framework to align priorities of the Army, Navy, Air Force, and Defense Health Agency (DHA). The Quadruple Aim guides the Department to increase readiness, and deliver better care, better health, and lower cost.

- **Increased Readiness:** Readiness means ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver supportive health services anytime and anywhere in support of the full range of military operations, including on the battlefield or disaster response and humanitarian aid missions.
- **Better Care**: We are proud of our track record and recent improvements, but there is always more to accomplish. We continue to advance health care that is safe, timely, effective, efficient, equitable, and patient- and family-centered.
- **Better Health:** Our goal is to improve and maintain the health of the Warfighter and all beneficiaries of TRICARE. Doing so reduces the frequency of visits to our military hospitals and clinics by keeping the people we serve healthy. We are making the transformation from health care to health by reducing the generators of disease and injury, encouraging healthy behaviors, increasing health resilience, and decreasing the likelihood of illness through focused prevention.
- **Lower Cost:** To lower costs, we increase value by focusing on quality, eliminating waste, and reducing unwarranted variation. In the move toward value-based health care, we begin to consider the total cost of care over time, not just the cost of care at a single point in time. There are both near-term opportunities to become more agile in our decision making and longer-term opportunities to change the trajectory of cost growth by building value and improving the health of all we serve.

MHS QUADRUPLE AIM



DHA VISION AND MISSION FOR FY 2018

Vision: Unified and Ready

Mission: The DHA, a Combat Support Agency, leads the MHS integrated system of readiness and health to deliver the Quadruple Aim: Increased Readiness, Better Care, Better Health, and Lower Cost.

The Quadruple Aim—Increased Readiness, Better Care, Better Health, and Lower Cost—serves as the strategic framework for the MHS. As a joint, integrated Combat Support Agency, the DHA is charged by Congress to deliver these aims by enabling the Army, Navy, and Air Force to provide a medically ready force and a ready medical force to the Combatant Commands. To ensure the Quadruple Aim is achieved, the DHA has developed four strategic goals:

- First, ***the DHA empowers and cares for its people.*** The workforce is the foundation of our health system. Without our people, we cannot achieve success. We know that a person who finds fulfillment in the work they do will be more invested in the larger mission. Empowering the people who design, manage, and deliver the health system will ultimately lead to higher-quality and better-value health care to improve the overall well-being and readiness of our military.
- Second, ***the DHA optimizes operations across the MHS*** to improve health services and medical readiness. By centralizing management of joint, enterprise health services and streamlining operations to become more effective and agile, the DHA serves as an enabling force to lay the groundwork for a truly integrated and cost-effective system of readiness and health. Such efficiencies are critical to the DoD's ongoing reform efforts and will ensure the long-term viability of the MHS.
- Third, ***the DHA***, in partnership with the beneficiaries of the military health care system, ***co-creates optimal outcomes for health, well-being, and readiness.*** Nobody understands the needs of our beneficiaries better than the patients themselves. To optimally respond to global trends in health care and the needs of our patients, the DHA strives to bring patients and experts into the decision-making process. This strengthens the partnership between patient and provider and ensures the best overall health outcomes and increased readiness of the nation's fighting force.
- Fourth, ***the DHA delivers solutions to Combatant Commands.*** Those entrusted to lead our nation's military need a ready force, as well as agile and adaptive solutions to challenges with integrated health care and readiness. The DHA sees readiness as its top priority and is committed to delivering joint functions and activities to enable the rapid adoption of proven practices, reduce unwanted variation, and improve coordination of joint health care for the Warfighter.

By working continuously to achieve these four strategic goals in support of the Quadruple Aim, the DHA affirms its unwavering commitment to our beneficiaries, joint health care team, and Combatant Commands across the globe.

–Raquel "Rocky" Bono
VADM, MC, USN
Director, Defense Health Agency

TRANSFORMING THE MILITARY HEALTH SYSTEM

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Smith DJ, Bono RC, Slinger BJ. Transforming the Military Health System. JAMA. 2017; 318(24):2427-2428. doi:10.1001/jama.2017.16718. https://jamanetwork.com/journals/jama/fullarticle/2663037

VIEWPOINT

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The Military Health System (MHS) is one of the largest health systems in the United States, delivering health services to 9.4 million eligible patients in nearly 700 military hospitals and clinics around the world as well as through the TRICARE health plan.[1] The TRICARE health plan provides care to all members of the Uniformed Forces,[2] their families, and retirees, rendering TRICARE the fourth largest health plan in the United States. However, military health services are currently managed by 4 separate entities: Army, Navy, Air Force, and the Defense Health Agency (DHA), creating opportunities for variation and inefficiency. The MHS falls under the Department of Defense and is distinct from the Veterans Health Administration, which provides care to the majority of veterans and to veterans ineligible for TRICARE.[3]

The National Defense Authorization Act for Fiscal Year 2017[4] directs changes to existing management structures, enabling the MHS to collectively transform into an integrated system of readiness and health. The law provides a set of interdependent and nested initiatives to optimize delivery of the Quadruple Aim of improved readiness, better health, better care, and lower cost.

The Military Health System (MHS) is one of the largest health systems in the United States, delivering health services to 9.4 million eligible patients in nearly 700 military hospitals and clinics around the world

With so many provisions in the law related to reform, it is important to maintain sight of the larger strategic imperative. In its entirety, the law drives several overarching health care goals: to ensure trained and ready military medical personnel, to deliver an improved health care experience to beneficiaries, and to perform both functions as one efficient enterprise. This Viewpoint describes the strategic logic of a transformation that Sen John McCain (R, Arizona) stated was the "Most sweeping overhaul of the [MHS] in a generation."[5]

Transforming the Military Health System

Centralized administration of military hospitals and clinics (ie, military medical treatment facilities [MTFs]) under the authority of the new law affords the MHS an opportunity to focus on readiness, provide a common, high-quality experience for patients, and eliminate redundancies. Today, the Army, Navy, Air Force, and DHA deliver health services independently with varying degrees of integration. Working as a single integrated enterprise, the MHS intends to focus on value expected and defined by the beneficiaries, improve the experience of each patient, and modernize the TRICARE health plan. The Department of Defense plans to transform the MHS through 5 lines of effort.

First, a clear, measurable definition of the medical readiness for which the health system is responsible for delivering is necessary. The MHS requires a common vernacular to determine whether the system meets the medical requirements of the military's joint operational plans.[6] This begins by specifying the types of combat casualty care disciplines (eg, emergency medicine, trauma surgery, critical care), calculating the number of personnel needed to fill operational medical force requirements, and then determining the appropriate means to acquire and sustain these capabilities.

A major effort is under way to define the knowledge, skills, and abilities (KSAs) required by military medical personnel for deployment to a combat zone or in support of humanitarian crises. The military surgical community developed its expeditionary KSAs first; follow-on efforts to develop KSAs for other clinical disciplines are ongoing. KSAs are linked to procedure codes, which provide the MHS with a powerful tool to correlate the relationship between the workload of health care personnel and their military medical readiness while informing decisions for training and skills maintenance.

Second, with clinical readiness more clearly defined, the MHS plans to optimize MTFs as training platforms for the ready medical force. This includes determining which MTFs will be designated as medical centers and primary training platforms for critical wartime specialties with level I or II trauma capability, serving as the foundation of military graduate medical education. At MTFs that provide such readiness training, the law expands care to veterans and civilians to increase KSAs. Other MTFs will be designated as hospitals or ambulatory care centers based on readiness need as well as the availability of local civilian care. Concurrently, the Department of Defense will review graduate medical education programs to ensure appropriate alignment with operational readiness requirements.

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The new law provides opportunities for partnerships with civilian academic medical centers and trauma teaching hospitals to provide greater exposure to patients with complex, critical injuries. High-performance military-civilian integrated markets should improve access, care, outcomes, and experience for patients while simultaneously improving military medical skills. Given the imperative of sustaining a trained and ready combat casualty care team, the DHA will oversee the Joint Trauma System and develop a Joint Trauma Education and Training Directorate, both focused on standardizing care, translating research, and creating clinical practice guidelines applicable to both combat injuries and domestic mass casualty care.

Third, plans for centralization of health care administration will focus on standardization of health care delivery and readiness support. At present, each service branch and DHA administer MTFs with relative independence under the guidance of governance councils, creating a loosely integrated direct care system with degrees of duplication and variation. Under the new law, the DHA becomes responsible for the administration of all MTFs with respect to budgetary matters, information technology, health care administration and management, administrative policy and procedure, as well as other matters determined by the Secretary of Defense. The service branches, supported by the DHA, will ensure the readiness of the military medical force based on future mission requirements. These changes could drive functional and clinical integration to create savings through found efficiencies across the enterprise. To build accountability, common performance standards for MTF leaders will be developed for readiness, quality, access, outcomes, and safety.

Fourth, the Department of Defense plans to improve the patient experience so that each MTF is the first choice for beneficiaries where available and appropriate. A standardized system for scheduling appointments should enable timely access to care, while access to urgent care and expanded primary care services will be better aligned to civilian health care practices. For instance, wait times in pharmacies will be displayed, unifying focus on optimizing wait times for any service and identifying drivers for additional efficiencies. Expanding telehealth can bring a synchronous care to patients where they live when they need it.

The integrated MHS plans to focus on measurement of health outcomes, quality of care, and safety. Enterprise core quality metrics will be adopted to ensure that performance is assessed relative to national measures and benchmarks, eliminating undesired variability and improving quality through evidence-based best practices. Advisory committees of military personnel, patients, and family members plan to co-create the future integrated system of readiness and health alongside the MHS, adding insights that improve the experience of care from the patients' perspectives.

Fifth, the new law directs the DHA to modernize the TRICARE health plan. Two comprehensive options will be offered: a managed care plan (TRICARE Prime) and a preferred provider network (TRICARE Select). A strategy for value in development rewards quality, safety, experience, and outcomes rather than volume and intensity through value-based pilots and demonstration projects that target savings and value creation through patient-defined and clinical outcomes.

The new law catalyzes integration, creating a common experience for patients and driving improvement across the system.[7] The DHA will go a step further than most health systems are able, integrating care purchased from the civilian market and that which the military provides to create a ready medical force. The transformation of the MHS plans to create this new model that could elevate military health services and inform national health care standards.

Summary

Maintaining readiness and medical skills is the primary mission of the MHS and will always take highest priority. Moreover, the MHS has important professional and statutory obligations to active duty personnel, their families, and military retirees to receive the highest-quality care and achieve the best health outcomes possible, in the most efficient way. The National Defense Authorization Act for Fiscal Year 2017 is a welcome prescription for transformation. The provisions of the law work together, ensuring that a trained, ready health team fully supports military personnel and the military service branches, improve the patient experience, and enable the MHS to act as one enterprise.

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Conflict of Interest Disclosures: All authors have completed and submitted the ICMUE Form for Disclosure of Potential Conflicts of Interest and none were reported.

[1] Defense Health Agency. *Evaluation of the TRICARE Program Fiscal Year 2017 Report to Congress*. Washington, D.C.: U.S. Dept of Defense, 2017.https://health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program

[2] Organization and General Military Powers, 10 USC §101(a). https://www.gpo.gov/fdsys/pkg/USCODE-2011-title10/pdf/USCODE-2011-title10-subtitleA-partI.pdf.

[3] Health benefits. U.S. Department of Veterans Affairs website. https://www.va.gov/HEALTHBENEFITS/apply/veterans.asp. Accessed 11/7/2017.

[4] National Defense Authorization Act for FY 2017, Pub L 114-328, Title VII, 12/23/2016.

[5] McCain, J. Remarks by Senate Armed Services Committee Chairman John McCain on the National Defense Authorization Act for FY 17. Washington, D.C.: Brookings Institution, 5/26/2016. https://www.mccain.senate.gov/public/index.cfm/2016/5/remarks-by-sasc-chairman-john-mccain-on-the-national-defense-authorization-act-for-fy17.

[6] Report of the Military Compensation and Retirement Modernization Commission: Final Report. Washington, D.C.: U.S. Military Compensation and Retirement Modernization Commission, 1/29/2015. https://www.ngaus.org/sites/default/files/MCRMC%202015_0.pdf.

[7] Berwick, D.M., Nolan, T.W., Whittington, J. The Triple Aim: Care, Health, and Cost. Opinion Viewpoint E2. *Health Affairs* 2008, 27(3), 759–69.

EXECUTIVE SUMMARY: KEY FINDINGS FOR FY 2018

MHS Worldwide Summary

- The $53.64 billion Unified Medical Program (UMP) presented in the FY 2018 President's Budget, including estimated outlays from the Medicare-Eligible Retiree Health Care Fund (MERHCF), is 3 percent higher than the $52.21 billion in actual expenditures in FY 2017 and is 9 percent of total FY 2018 estimated Department of Defense (DoD) outlays (ref. pages 27–28).
- The number of beneficiaries eligible for DoD medical care remained at approximately 9.4 million between FY 2015 and FY 2017, while the number of Prime-enrolled beneficiaries has decreased annually since 2011, falling to 4.8 million in FY 2017, consistent with the decrease in Active Duty and their family members (ref. pages 18, 24).
- TRICARE Young Adult (TYA) enrollment increased to just under 40,000 beneficiaries under age 26 in FY 2017, from just over 38,000 in FY 2016. Prime enrollment was 43 percent of the total (ref. page 148).
- TRICARE Reserve Select (TRS) enrollment increased in FY 2017 to over 145,000 plans and almost 386,000 covered lives, while retired Reservists and their families in TRICARE Retired Reserve (TRR) reached just over 3,000 plans and 8,100 covered lives (ref. pages 144–147).

MHS Workload and Cost Trends[1]

- The percentage of beneficiaries using Military Health System (MHS) services remained about the same between FY 2015 and FY 2017, at between 85 and 86 percent (ref. page 25).
- Excluding TRICARE for Life (TFL), total MHS workload (direct and purchased care combined) fell from FY 2015 to FY 2017 for inpatient care (–3 percent) and prescription drugs (–2 percent). Total outpatient workload increased by 1 percent (ref. pages 30, 31, 34).
- From FY 2015 to FY 2017, direct care workload decreased for inpatient care (–6 percent) and prescription drugs (–1 percent), but increased by 2 percent for outpatient care. Over the same period, direct care costs rose by 5 percent (ref. pages 30, 31, 34, 40).
- Excluding TFL, purchased care workload fell for inpatient care (–2 percent), outpatient care (less than 1 percent), and prescription drugs (–4 percent). Overall, purchased care costs decreased by 8 percent, due largely to the resolution of fraudulent compound drug prices at the end of FY 2015 (ref. pages 30, 31, 34, 40).
- The purchased care portion of total MHS health care expenditures decreased from 55 percent in FY 2015 to 52 percent in FY 2017 (ref. page 40).
- In FY 2017, out-of-pocket costs for MHS beneficiary families under age 65 were between $5,700 and $7,200 lower than those for their civilian counterparts, while out-of-pocket costs for MHS senior families were $3,100 lower (ref. pages 177, 179, 182).

Lower Cost

- MHS estimated savings include nearly $850 million in retail pharmacy refunds in FY 2017 and $105 million in Program Integrity (PI) activities in calendar year 2016 (ref. page 159).

Increased Readiness

- **Force Health Protection:** At the end of FY 2017, the overall medical readiness of the total force was at 87 percent, with the Active Component at 88 percent and the Reserve Component at 85 percent, all equaling or exceeding the strategic goal of 85 percent. Dental readiness, at 96 percent, exceeded the MHS goal of 95 percent. The MHS surgical community is leading the way in identifying and enumerating critical clinical readiness skill sets (ref. pages 43–46).

Better Care

- **Access to Care:** In FY 2017, 84 percent of Prime enrollees reported at least one outpatient visit, comparable to the civilian HMO benchmark, while administrative data reflect 82 percent of non-Active Duty enrollees had at least one recorded primary care visit and 40 percent had five or more visits. Patient-Centered Medical Home (PCMH) primary care administrative measures indicate military treatment facility (MTF) enrollees saw their primary care provider 59 percent of the time, and a PCMH team member 92 percent of the time; days to third next 24-hour or acute appointments declined to 0.93 days (sooner than one day), and continued to meet the seven-day standard for future appointments. Beneficiary enrollment in and usage of secure messaging continued to increase in FY 2017. Dispositions and bed-days per 1,000 enrollees continued to improve, decreasing 26 and 27 percent, respectively, from FY 2012. The new standardized DHA/Service survey of beneficiary outpatient experience shows strong and stable ratings of access to care at 83 percent (ref. pages 58–61, 63, 72).
- **Hospital Quality of Care:** MTFs and MHS-supporting civilian hospitals report results are comparable to many Joint Commission national hospital quality measures and consistent with the national Joint Commission benchmarks in the perinatal care measures (ref. pages 104–106).
- **Outpatient Care:** MTF HEDIS® rates exceed the national standards at the 90th percentile for colorectal cancer screening, mental health follow-up visits post hospitalization, and treatment of children with upper respiratory infection, and surpass the national 75th percentile for cervical cancer screenings, low back pain, well-child visits, and treating children for pharyngitis (ref. pages 101–103, 112).
- **Beneficiary Ratings of Inpatient Care:**
  - **Overall Hospital Rating:** Direct care has shown improved patient hospital ratings from FY 2015–2017, with Service meeting or exceeding the national Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) benchmark in the medical and surgical product lines. While ratings continue to improve in the obstetric product line for all Services and purchased care, they remain below the HCAHPS benchmark.
  - **Beneficiary Recommendation of Hospital:** MHS beneficiary ratings for both direct and purchased care are above the HCAHPS benchmark in the medical and surgical product line, while Service and purchased care ratings are close to or above the national HCAHPS benchmark in FY 2017 for the obstetric product line (ref. pages 128, 133).
- **Patient Safety:** The MHS direct care system has been focusing on reducing Wrong-Site Surgery Sentinel Events (WSS SEs) through the development and dissemination of prevention tool kits, educational webinars, leadership engagement and direct MTF coaching. Compared to FY 2016, FY 2017 saw a 32 percent reduction in WSS SEs (ref. page 84).
- **MHS Provider Trends:** The number of TRICARE network providers increased by 21 percent from FY 2013 to FY 2017. The total number of participating providers increased by 9 percent over the same time period (ref. page 149).
- **Access for TRICARE Standard/Extra Users:** Results from the first year of the congressionally mandated four-year survey (2017–2020) of civilian providers and MHS non-enrolled beneficiaries shows 8 of 10 physicians accept new TRICARE Standard patients, a higher acceptance rate than reported for behavioral health providers (ref. page 150).

[1] All workload trends in this section refer to intensity-weighted measures of utilization (relative weighted products [RWPs] for inpatient, relative value units [RVUs] for outpatient, and days supply for prescription drugs). These measures are defined on the referenced pages.

WHAT IS TRICARE?

TRICARE is the worldwide Department of Defense (DoD) health care program serving 9.4 million Service members (Active and Guard/Reserve) on Active Duty (greater than 30 days) and their families; as well as retirees, their families, survivors, and certain former spouses (https://www.tricare.mil). As a major component of the Military Health System (MHS; www.health.mil), TRICARE brings together the military hospitals and clinics worldwide (often referred to as "direct care," usually in military treatment facilities, or MTFs) with network and non-network TRICARE-authorized civilian health care professionals, institutions, pharmacies, and suppliers (often referred to as "purchased care") to provide access to the full array of high-quality health care services while maintaining the capability to support military operations.

During FY 2017, in addition to providing care from MTFs where available, TRICARE offered beneficiaries a family of health plans, based on the following primary options:

- **TRICARE Prime** is comparable to health maintenance organization (HMO) benefits offered in many areas. Each enrollee chooses or is assigned a primary care manager (PCM), a health care professional who is responsible for helping the patient manage his or her care, promoting preventive health services (e.g., routine exams and immunizations), and arranging for specialty provider services as indicated. TRICARE Prime access standards apply to the travel time to reach a primary care or specialty care provider, waiting times to get an appointment, and waiting times in doctors' offices. TRICARE Prime's point-of-service (POS) option permits enrollees to obtain care from TRICARE-authorized providers other than the assigned PCM without a referral, but with deductibles and cost shares significantly higher than those under TRICARE Standard.
- **TRICARE Standard** is the non-network benefit, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), open to all eligible DoD beneficiaries, except Service members on Active Duty. An annual deductible (individual or family) and cost shares are required.
- **TRICARE Extra** is the network benefit for beneficiaries eligible for TRICARE Standard. When non-enrolled beneficiaries obtain services from TRICARE network professionals, hospitals, and suppliers, they pay the same deductible as TRICARE Standard; however, TRICARE Extra cost shares are reduced by 5 percent. TRICARE network providers file claims for the beneficiary.
  - As noted earlier in this report, TRICARE Standard and Extra were replaced by TRICARE Select, an enrollment-based plan, effective January 1, 2018.
- **TRICARE for Life (TFL)** is Medicare wraparound coverage for TRICARE-eligible beneficiaries who have Medicare as their primary health care coverage. In most instances, Medicare pays first, then TRICARE pays second.
- **Other plans and programs:** Some beneficiaries may qualify for other benefit options depending on their location, Active/Reserve status, and/or other factors. Some examples are:
  - **Premium-based health plans**, including:
    - TRICARE Young Adult (TYA), available for purchase by qualified dependents up to the age of 26
    - TRICARE Reserve Select (TRS), available for purchase by qualified Selected Reserve members
    - TRICARE Retired Reserve (TRR), available for purchase by qualified Retired Reserve members
    - TRICARE Dental Program (TDP) and the TRICARE Retiree Dental Program (TRDP)
    - Continued Health Care Benefit Program (CHCBP), which provides a Consolidated Omnibus Budget Reconciliation Act–like continuation benefit
  - **Other major benefits and plans**, including:
    - The Transitional Assistance Management Program (TAMP), which provides 180 days of premium-free continued access to the TRICARE benefit after release from Active Duty for certain Active Component members separating from Active Duty and Reserve Component members who have served more than 30 consecutive days in support of a Contingency Operation
    - Dental benefits (military dental treatment facilities and claims management for Active Duty using civilian dental services)
    - Pharmacy benefits in MTFs, via TRICARE retail network pharmacies, and through the TRICARE Pharmacy Home Delivery program (formerly called TRICARE Mail Order Pharmacy)
    - Overseas purchased care and claims processing services
  - **Supplemental programs**, including:
    - TRICARE Prime Remote (TPR) in the United States and overseas, DoD-Veterans Affairs (VA) sharing arrangements, and joint services
    - Uniformed Services Family Health Plan (USFHP), which provides the full TRICARE Prime benefit, including pharmacy (under capitated payment) to non-Active Duty MHS enrollees at six statutorily specified locations: Washington, Texas, Maine, Massachusetts, Maryland, and New York
    - Chiropractic care, limited to Service members (on Active Duty) at certain MTFs only (no purchased chiropractic care)
    - Clinical and educational services demonstration programs (e.g., chiropractic care, autism services, and the Acute Care Demonstration Pilot)

HOW TRICARE IS ADMINISTERED

TRICARE is administered on a regional basis, previously with three regional contractors in the United States (to be consolidated to two beginning January 1, 2018) and an overseas contractor working with their TRICARE Regional Offices (TROs) to manage purchased care operations and coordinate medical services available through civilian providers with the MTFs. The TROs do the following:

- Provide oversight of regional operations and health plan administration
- Manage the contracts with regional contractors
- Support MTF Commanders
- Develop business plans for areas not served by MTFs (e.g., remote areas)

NEW BENEFITS AND PROGRAMS IN FY 2017 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT

The MHS continues to meet the challenge of providing the world's finest combat medicine and aeromedical evacuation, while supporting the TRICARE benefit to DoD beneficiaries at home and abroad. Since its inception in 1995, TRICARE continues to offer an increasingly comprehensive health care plan to Uniformed Services members, retirees, and their families. Even as the MHS aggressively works to sustain the TRICARE program through good fiscal stewardship, it also refines and enhances the benefits and programs in a manner consistent with the industry standard of care, best practices, and statutes to meet the changing health care needs of its beneficiaries (see TRICARE Benefits over the Years in the Appendix).

Contracts and Organizational Change

The Defense Health Agency (DHA) Will Take Over Responsibility of the DoD HIV/AIDS Prevention Program's (DHAPP) from Navy Medicine

Established in 2001, the DHAPP helps contain the global health threat posed by the HIV pandemic, with a mission to assist foreign militaries with developing HIV control programs in support of global health security and DoD security cooperation efforts. Historically, the Navy managed the DHAPP due to the command's expertise in HIV research and development of effective prevention and intervention programs for the U.S. military. In 2014 the DoD approved the realignment of all medical executive agent organizations under DHA's leadership. DHA oversight will streamline interagency collaboration for DHAPP. The transition in responsibility from Navy to DHA will be completed in late August.

TROs Reduced from Three to Two to Manage New Support Contracts

Beginning January 1, 2018, the TRICARE North and South Regions will combine to form TRICARE East, while TRICARE West will remain mostly unchanged. The new East Region contract was awarded to Humana Government Business, Inc., and the West Region contract to Health Net Federal Services, LLC. The contracts will be a cost-plus-fixed-fee contract with a nine-month base period (transition-in) and five one-year option periods for health care delivery, plus a transition-out period, with the vast majority of the spending passed through to the thousands of private-sector health care providers who take part in the TRICARE system. In advance of this award, the regional offices of TRICARE North and South Regions had already been consolidated into a single region—TRICARE East.

Both the Government Accountability Office (GAO) and the Court of Federal Claims Upheld DHA Contract Awards

In November 2016, the GAO upheld the DHA contract awards to Humana Government Business, Inc., to provide managed care support to the East Region, and Health Net Federal Services, LLC, in the West Region. In June 2017, the Court of Federal Claims also rejected several bid protests. In the newly created East Region, the total potential contract value is estimated at $40.5 billion. For the West Region, it is approximately $17.7 billion.

Bridge Contract

The DHA awarded Humana Military a one-year, $3.80 billion "bridge" contract to extend the company's health care delivery services under the TRICARE Health Benefits program through March 31, 2018. The contract extension ensures uninterrupted care delivery throughout the South Region until DHA implements the follow-on T-2017 TRICARE managed support contracts.

Last year, DHA awarded contracts worth up to $58 billion for Humana and Health Net to respectively provide TRICARE support services in the East and West Regions.

MHS Deployment of New Electronic Health Record—MHS Genesis

MHS GENESIS provides a single, integrated medical and dental record for inpatient and outpatient encounters across the MHS. It will support the availability of electronic health records for more than 9.4 million DoD beneficiaries worldwide.

The department chose a "high-performing, off-the-shelf commercial system" to take advantage of the progress that civilian health organizations have made in health information technology. That progress coupled with an eye on the unique elements of our military—from readiness and cybersecurity requirements to the culture in military health care—will make MHS GENESIS like no other electronic health record.

Initial operating capability (IOC) brought MHS GENESIS to four MTFs and their child sites, all in Washington state. Sites launching GENESIS in FY 2017 included the 92nd Medical Group, Fairchild Air Force Base on February 7, Naval Hospital Oak Harbor on July 15, and Naval Hospital Bremerton on September 23. Army Medical Center Madigan joined the other three IOC sites on October 21 in early FY 2018.

Three of the four IOC sites—Oak Harbor, Bremerton, and Madigan (which oversees the Air Force's 62nd Medical Squadron Clinic at Joint Base Lewis-McChord)—are members of the Puget Sound market, which includes Army, Navy, and Air Force facilities and

NEW BENEFITS AND PROGRAMS IN FY 2017 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

provides care to more than 288,500 beneficiaries in the region.

The DoD Healthcare Management System Modernization contract was awarded to Leidos, Inc., for $4.3 billion in the summer of 2015. Fielding to IOC sites took place throughout 2017. With IOC complete, deployment at future sites is expected to begin after a thorough review through 2018. Fielding to all MHS garrison sites is expected to be completed by 2022.

The MHS Announced It Has improved Its Transparency Website

The MHS has put military hospital and clinic quality, safety, and patient satisfaction information online for years, but not always in ways that could be easily found or understood. Recently, the agency re-examined the site and improved its design to make it more user friendly.

The website improvements include the following changes:

- Each military hospital and clinic now has a page where patients can see all the data in one place.
- Users can find a U.S. hospital or clinic by ZIP code search and find any hospital or clinic that reports data, including those overseas, through a name search.
- Users can compare up to three nearby hospitals or clinics on one custom report.
- MHS data managers now have a system that lets them update performance measures. They can also add new measures.

Users can visit the site directly, or go to the main landing page of the health.mil website and click a link to the MHS Transparency pages. Individual military hospital and clinic websites will also link to the transparency site from their web pages.

The TRICARE Pharmacy Program Network Has Expanded to Include Walgreens

Effective December 1, 2016, Walgreens became part of the TRICARE Pharmacy program network. This addition coincides with CVS, including those inside Target stores, being dropped from the network. Ninety-eight percent of TRICARE beneficiaries live within five miles of a network store. Express Scripts contacted patients with specialty medications to assist in transferring the prescriptions, and preventing coverage gaps.

Annual Patient Consent Required for Automatic TRICARE Pharmacy Home Delivery Refills of Maintenance Medications through Express Scripts

Effective September 1, 2017, Express Scripts requires an annual patient consent in order to continue automatic refills of maintenance medications for those enrolled in TRICARE Pharmacy Home Delivery. Beneficiaries were contacted in advance of the prescription refill expiring, to ask if they would like to continue with auto refills and whether they wanted their doctor contacted for the prescription renewal. If Express Scripts did not receive consent within 10 days of reaching out to the beneficiary, the medication was removed from the auto refill program.

TRICARE Program Changes in 2018

In fulfillment of section 701 of the 2017 National Defense Authorization Act, the DoD implemented the most sweeping changes to the TRICARE benefit structure since TRICARE was established in 1995. Contract management adjusted to synchronize these changes with the DoD's transition to the TRICARE 2017 contracts and regional oversight. The TRICARE changes expand beneficiary choice, improve access to network providers, modernize beneficiary cost-sharing, and enhance administrative efficiency.

Effective January 1, 2018

- **TRICARE Select replaced TRICARE Standard and TRICARE Extra**. Named by Congress "TRICARE Select," this single plan features an enrollment requirement for purchased care with non-network and network care.
- **All TRICARE beneficiaries in December 2017 were enrolled in their TRICARE plan effective January 1, 2018.** TRICARE Prime enrollees remained in TRICARE Prime, while TRICARE Standard and Extra beneficiaries were automatically enrolled into TRICARE Select.
- **No referral or authorization is needed for TRICARE Select enrollees** to obtain care from any TRICARE-authorized provider.
- **Fixed-fee copayments** apply for most network care in TRICARE Select after the annual deductible is met. Enrollees will welcome the simplicity and predictability of copayments, and providers will find it more attractive to participate in the TRICARE network.
- **TRICARE has expanded coverage** of preventive care services, treatment of obesity, high-value care, and telehealth. There is no cost for preventive services from network providers.
- **Non-enrolled beneficiaries** may receive care only at a military clinic or hospital on a space-available basis; non-enrollment means no coverage for civilian care. Beneficiaries need to be sure they are enrolled in TRICARE Prime or TRICARE Select if they want coverage for civilian care (see bullet below about grace period.)

NEW BENEFITS AND PROGRAMS IN FY 2017 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

During Calendar Year 2018

- **2018 is a transition year with a grace period for enrollment.** This first year is treated as a transition year, so beneficiaries can adjust to the new enrollment rules. Beneficiaries are permitted to make coverage changes from the beginning of the year through the first open season, which will be offered in fall 2018. For those eligible to enroll in TRICARE Prime or TRICARE Select, but do not, TRICARE will cost share on an initial episode of care and then will notify them of the opportunity to enroll in TRICARE Prime or TRICARE Select, as desired.
- **TRICARE Select expands the TRICARE Network** by requiring the managed care support contractors (MCSCs) to ensure at least 85 percent of TRICARE Select enrollees have ready access to network providers.
- **Standards of access to care for Prime enrollees will be reinforced.** Consistent with legislation, Prime enrollees will be assured of more timely MTF appointments and more access to care without the need for referrals. Prime beneficiaries will also have expanded access to urgent care without the need for a referral from their PCM.
- **All these changes will occur while preserving benefits for Active Duty dependents and TFL beneficiaries.**
- **An annual open enrollment period (November–December 2018) will be established**, when beneficiaries are free to change or enroll in TRICARE Prime or TRICARE Select for coverage effective January 1, 2019.
- **Rules for qualifying life events will be established** that permit beneficiaries to change TRICARE health plans outside open season starting in 2019.
- **These program changes also restructure and reinforce authority to update TRICARE Prime retiree copayments, which have not changed since 1995.**

Quadruple Aim: Readiness

The 2017 Seasonal Influenza Vaccination Program

An interim procedures memorandum from August 3, 2017, provided guidance for the 2017 seasonal influenza vaccination program. This policy stated that all Active Duty and Reserve Component personnel (excluding Individual Ready Reserve and Retired Reserve) will be vaccinated against influenza. The DHA tracks, collects, and analyzes the immunization data, and confirmed vaccine compromises, in coordination with the DoD Components, with the Surgeons General monitoring compliance data.

HELP for Forward Deployed Providers

The 7227th Medical Support Unit at Landstuhl Regional Medical Center became the first Army unit in Europe to use the HELP system on April 24, 2017, with the support of Navy Medicine East in Portsmouth, Virginia. HELP is a web-based Navy program designed to treat sailors deployed on ships. The system stores patient information, such as X-rays and treatment records, which specialists anywhere in the world can access to advise less-experienced medical personnel on how to treat patients. Doing so can, in many cases, allow patients to remain where they are rather than being medically evacuated elsewhere for treatment. Previously, trying to coordinate providers in different locations could be challenging. HELP has saved approximately $100,000 a month in transportation costs since that time. Other units have begun using it as well, including Ramstein Air Base and Walter Reed National Military Medical Center (WRNMMC).

Disaster Support

Emergency Procedures Following Floods and Wildfires

Following the extensive flooding and wildfires in 2017, TRICARE put into place emergency prescription refill procedures and waived the referral requirement. These special processes affected parts of Texas, Louisiana, California, Washington, Georgia, Florida, Puerto Rico, and the U.S. Virgin Islands, as follows:

- September 7–16, 2017: California and Washington (emergency prescription refills and waivers for referrals)
- August 25–September 15, 2017: Louisiana and Texas
- September 7–17, 2017: Georgia, Florida, Puerto Rico, and the U.S. Virgin Islands

Air Force Trauma Support to Wounded from Las Vegas Shooting

Four general surgeons and three resident surgeons from Nellis Air Force Base, Nevada, treated patients after the largest single-shooter massacre in American history on October 1, 2017.

The surgeons, assigned to the 99th Medical Group, responded to the University Medical Center of Southern Nevada to help treat more than 100 patients with surgical procedures and end-of-life care. The hospital is Nevada's only Level I trauma center.

Humanitarian Relief

A huge airborne relief mission—using C-130s, including Air National Guard flights, and helicopters following the

NEW BENEFITS AND PROGRAMS IN FY 2017 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

fixed-wing flights—was sent to the Florida Keys to help people impacted by the devastation caused when the eye of Hurricane Irma, a massive Category 4 storm, blasted through the Lower Keys.

Quadruple Aim: Better Care

TRICARE Covering Annual Preventive Office Visits for All Prime Beneficiaries Six Years of Age and Older

Children under six are already covered by existing well-child coverage. Effective January 1, 2017, TRICARE began covering annual preventive office visits for all other Prime beneficiaries as well. The new, covered services also include free genetic counseling by a TRICARE-authorized provider, and stool DNA testing (e.g., Cologuard™) once every three years starting at age 50 for those who have an average risk of colon cancer.

TRICARE Expands Coverage for Treatment of Congestive Heart Failure

As of October 2016, congestive heart failure became a covered diagnosis under the TRICARE cardiac rehabilitation benefit. Providers of cardiac rehabilitation services must be TRICARE-authorized hospitals or freestanding cardiac rehabilitation facilities. All cardiac rehabilitation services must be ordered by a physician.

Madigan Army Medical Center Recognized for the Excellent Care Provided in Its Sleep Service Clinic

The American Academy of Sleep Medicine (AASM) awarded accreditation last fall to Madigan Army Medical Center. Obtaining the AASM accreditation makes Madigan one of four MTFs with this designation in the Army. The sleep service cares for about 5 percent of all Service members on Joint Base Lewis-McChord, and, because of volume, only sees Active Duty patients. The clinic offers assessments, education, sleep monitoring devices, and behavioral health therapists.

TRICARE Expanded Coverage to Include Non-Active Duty Family Members in Two Areas

Effective early December 2016, coverage was expanded to include the care and treatment of beneficiaries requiring an auditory osseo-integrated implant, a prosthetic device implanted in the skull to transmit sounds to the inner ear. Additionally, it now covers the services and supplies needed to diagnose and treat urinary system illness, such as urinary tract infections or cancer, or injury of the urinary system, such as from blunt force or sports injuries.

The DHA Reported Significant Advances in Identifying Bacteria That Can Resist Current Antibiotics

The Centers for Disease Control and Prevention (CDC) concern over infections and deaths from antibiotic-resistant bacteria along with a 2014 presidential executive order prompted the MHS to expand efforts in this area. Enhanced surveillance, improved stewardship of antibiotics, and the development of new diagnostic tests and treatments were among the steps taken by the military, with international efforts in mind and shared with the larger scientific community. As a result, the Multidrug Resistant Organism Repository and Surveillance Network (MRSN) at Walter Reed Army Institute of Research (WRAIR) was the first to discover a gene from a human patient within the U.S. that is resistant even to a last-resort antibiotic, such as Colistin. In addition, researchers learned more about methicillin-resistant Staphylococcus aureus (MRSA) and *E. coli*, and can provide rapid assistance with potential outbreak situations. Although originally designed to service Army medicine, all MTFs around the world are now collecting and sending resistant bacteria to MRSN, allowing the organization to provide direct information back to clinicians caring for patients, with a turnaround time in days rather than weeks as in the past. It also allows for analyses on the causes of antibiotic resistance and means of transmission.

The Extension for Applied Behavior Analysis (ABA) Providers to Get Necessary Certifications Has Ended

The DHA requires providers who deliver ABA services under the TRICARE Autism Care Demonstration be certified and have Basic Life Support certification before they see TRICARE patients. Effective January 1, 2017, claims submitted for services by providers who were not certified were no longer accepted. With concern that uninterrupted care be provided to children receiving ABA services, the original deadlines were extended to allow more than ample time for providers to meet these basic standards.

New Clinic at Landstuhl Regional Medical Center (LRMC) Is Making It Easier for Active Duty Service Members and Their Families to Get Medical Appointments, While Also Significantly Expanding the Pool of Patients Eligible for Care at the Hospital

LRMC, the U.S. military's largest hospital overseas, stood up the Enhanced Access Clinic in May, open to TRICARE and non-TRICARE beneficiaries (including DoD civilian families, who in the past typically had to seek care in the German health system). The Enhanced Access Clinic offers an array of medical services, and patients can be seen for routine exams, acute illnesses, counseling, and disease prevention (among other services), or get referrals for more specialized treatment at the hospital.

NEW BENEFITS AND PROGRAMS IN FY 2017 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

Brooke Army Medical Center (BAMC) Surgeons Performed Their First Above-the-Elbow Arm Replant on a 22-Year-Old Trauma Patient Last Year

The patient's arm was severed in a car wreck. San Antonio firefighters administered a life-saving tourniquet, packed the arm in ice, and brought her to BAMC, one of two Level I trauma centers in San Antonio. The surgical team reconnected or grafted the various nerves, taking skin and veins from her legs and muscle from her back to successfully splice everything back together. After recovery, the patient is thriving. This was one of only 82 above-elbow replantations performed worldwide since the first one in the 1960s. Trauma cases such as this are vital to military preparedness of providers deployed to worldwide combat zones.

Walter Reed National Military Medical Center (WRNMMC) Is Providing Heart Patients a Newly Approved Leadless Pacemaker

Approved by the Food and Drug Administration (FDA) in early 2016, physicians at WRNMMC implanted the first leadless pacemaker in November 2016, and have since implanted more of the devices than any other single institution in the area. Unlike traditional pacemakers, these new devices are significantly smaller, and with no leads or wires, can make direct contact with heart tissue, taking less energy to pace the heart. The body tends to form a capsule over the new pacemakers, reducing the infection rate. Complications are about half that of traditional pacemakers, and require less recovery time, usually just a week after surgery. Though currently only approved for use in the right ventricle (10–20 percent of patients), the next generation could service multiple chambers.

Fort Belvoir Community Hospital's Surgeons Performed the First Small Incision Lenticule Extraction (SMILE) Procedure in the DoD, the Latest Advancement in Laser Eye Surgery

Recently approved by the FDA, the procedure was performed at Belvoir Hospital in March 2017. The surgery, lasting 15–20 minutes, uses a very fast and short pulsed femtosecond laser to create a thin disc within the cornea, which is then removed through a cut on the corneal surface. The cornea quickly reshapes to correct nearsightedness, and with visual recovery accelerated, both eyes can be treated in the same session. Performed internationally since 2011, FDA approval now allows for use in the U.S. as well. The SMILE procedure is currently available for research purposes at only three locations, Belvoir Hospital, San Diego Naval Medical Center, and Wilford Hall in San Antonio. The goal of this research effort is achieving the most precise correction without a loss to military task performance.

New Procedure at William Beaumont Army Medical Center (WBAMC) Is Opening Doors for Patients with Severe Reconstructive Needs

The launch of the state-of-the-art Reconstructive Microsurgery Program at WBAMC has brought the latest in groundbreaking reconstructive surgery to beneficiaries with severe reconstructive needs, such as from cancer or trauma. The surgery requires removal of a body part on its own blood supply, completely separating all the tiny arteries and veins, and reconnecting them again under a microscope. The technique of microsurgery with free-flap procedures began in the mid-20th century with toes and hands, and has expanded focus from trauma to treatment of cancer with function and aesthetic restoration, now encompassing cases from breast reconstruction to extremely complex full-face transplants. To improve chances for success, WBAMC uses a multidisciplinary approach; as of early 2017, the program had completed four successful transplants, with more scheduled.

The DHA Announced a Three-Year Renewal of the Non-FDA-Approved Laboratory Developed Tests (LDTs) Demonstration Project, Which Began in September 2014

Hospitals and labs, including those run by the military, can create and use these tests without seeking the FDA's approval. The demonstration, begun in September 2014, allows TRICARE to evaluate non-FDA-approved LDTs to determine if they meet TRICARE's requirements for safety and effectiveness, and allows those that do to be covered as a benefit under the demonstration. More than 100 tests have been given the green light, including those for diagnosing cancers as well as blood or clotting disorders, genetic diseases or syndromes, and neurological conditions. The MHS uses the Laboratory Joint Working Group, a body of clinical and lab experts from all Services, to prioritize and evaluate tests based on reliable evidence of proven medical effectiveness as well as TRICARE's rules involving rare diseases. Final approval of the group's recommendations is granted by the Director of the DHA. During the next three years, the DHA will continue to evaluate the LDT examination and recommendation process for an ever-expanding pool of non-FDA-approved LDTs, including tests for cancer risk, diagnosis and treatment, blood and clotting disorders, a variety of genetic diseases and syndromes, and neurological conditions. The results of the evaluation will support future regulatory revisions and provide an assessment of the potential improvement of the quality of health care services for beneficiaries who would not otherwise have access to these safe and effective tests.

NEW BENEFITS AND PROGRAMS IN FY 2017 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

On September 3, 2016 TRICARE Expanded Mental Health and Substance Use Disorder (SUD) Services, Adding Intensive Outpatient Programs and Expanding Options for Opioid Treatment

In addition to other improvements, this expansion improves access to care and increases opportunities for mental health and SUD treatment. It also makes it easier for beneficiaries to access the right level of care for their health and wellness needs. These new services round out existing TRICARE-covered treatments, including:

- Emergency and non-emergency inpatient hospitalization
- Psychiatric residential treatment center care for children
- Inpatient/residential SUD care
- Partial hospitalization
- Outpatient and office-based mental health and treatment

Other changes are:

- **Increased Substance Use Disorder Treatment Options.** Improvements to SUD options include opioid treatment programs and office-based opioid treatment. Office visits with qualified TRICARE-authorized providers may include coverage of medications for opioid addiction.
- **Reduced Limitations on Number of Treatments.** TRICARE reduced limitations for receiving mental health and SUD services. There are no limits for the number of times beneficiaries can get SUD treatment, smoking cessation counseling, and outpatient treatment per week. In addition, TRICARE removed the requirement for authorization after the eighth outpatient mental health visit.
- **Lower Copayments and Cost Shares.** Lower copayments and cost shares continue from last year. Since October 2016, non-Active Duty dependent beneficiaries, retirees, family members, and survivors began paying generally lower copayments and cost shares for mental health and SUD care. One example is the cost per mental health and SUD outpatient office-based visit, now reduced from $25 to $12. See the full list of updated mental health copayments and cost shares on the TRICARE website.
- **New TRICARE-Authorized Institutional Provider Options.** For mental health and SUD treatment providers, becoming TRICARE-authorized is now a more streamlined process for providers and facilities. This means more options for TRICARE beneficiaries.

The changes remove unique certification requirements to become consistent with industry standards. In the coming months, new mental health and SUD institutional provider options, such as intensive outpatient programs, will be available. Networks are being developed now.

Warriors Heart

Warriors Heart is now a certified TRICARE Provider, and the first private treatment center in the U.S. solely dedicated to healing warriors (military, veterans, law enforcement, firefighters, and first responders) dealing with chemical dependency and other co-occurring psychological disorders.

Co-occurring psychological disorders treated include posttraumatic stress disorder (PTSD), moral grief/injury, depression, anxiety, and others. It offers a unique peer-to-peer residential treatment. The program focuses on a "holistic," healing approach to the mind, body, and spirit.

Birth Simulator

The David Grant United States Air Force Medical Center (DGMC) debuted a state-of-the-art birth simulator that will enhance the obstetric (OB) capabilities of its nurses, providers, and technicians.

Providers and staff at DGMC's Maternal Child Flight, part of the 60th Inpatient Squadron, will now use the Complicated OB Emergency Simulator, or COES. The COES is an improved training platform that will enhance the quality of analysis and feedback available from training sessions.

One of the main capabilities of the new COES is the data reporting and tracking system, with data automatically sent to the Air Force Medical Operations Agency and the DHA so evaluators get real-time updates on which providers are doing what tasks, as well as an immediate after action report. The new system helps providers and staff achieve the overall goal to increase patient safety while standardizing clinical processes.

The COES also comes with an infant and birthing simulator, which allows scenario-based training for newborn conditions/characteristics, such as respiratory failure and the amount of pressure being applied when providing care.

NEW BENEFITS AND PROGRAMS IN FY 2017 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

Quadruple Aim: Better Health

Protecting Military Children from Traumatic Brain Injury (TBI)

TBI is caused by an external force, such as blows to the head or being shaken violently. Concussion (or mild TBI) is the most common—though sometimes most difficult-to-diagnose—type. The leading cause of TBI is falls. TRICARE suggested that beneficiaries can help prevent TBI in children by using car seats properly, using helmets for bike riding and other sports, and installing baby gates in homes with toddlers.

When accidents do occur, though, TRICARE offers TBI treatment through a robust rehabilitation benefit that includes occupational therapy, physical therapy, speech therapy, and behavioral health services.

The 5210 Healthy Military Children Campaign

The DoD launched the 5210 Healthy Military Children campaign, a collaboration between the DoD's Office for Military Community and Family Policy and the Clearinghouse for Military Family Readiness at Penn State University.

This campaign provides some valuable tools in the battle against childhood obesity. The program encourages children to get five or more servings of fruits and vegetables a day; fewer than two hours of recreational time in front of a TV, tablet, portable video game, or computer screen; one hour of exercise each day; and zero sugary drinks. Officials are promoting education efforts where military families live, work, and play: doctor's offices, recreation centers, and schools on base. The value of the program may not become apparent right away, as long-term drops in obesity may take years to realize, but the program is seen as an investment in the future of today's children. As a side benefit, the healthy habits ingrained in the children also show up in their moms and dads.

Quadruple Aim: Lower Cost

TRICARE Provides a Convenient Online Summary of Beneficiary Premiums and Cost Shares

For a complete list of current premiums and cost shares, see www.tricare.mil/Costs/HealthPlanCosts.aspx and click on the "Costs and Fees Sheet" link to access the PDF.

The National Defense Authorization Act (NDAA) for FY 2017 Included a Demonstration of Value-Based Insurance Design (VBID) in the TRICARE Program

The bill calls for a pilot demonstrating the feasibility of incorporating VBID no later than January 1, 2018. VBID prioritizes the medications and services that are of highest priority to the consumer, and represents an effort to shift the health care system from a fee-for-service system with high copays and deductibles to one with clinical consideration of the needs and health conditions of individuals. One of the core tenets of VBID is clinical nuance, which recognizes two things: (1) medical services differ in the amount of health produced; and (2) the clinical benefit derived from a medical service depends on who is using it, who is delivering the service, and where it is being delivered. Clinical nuance sets cost sharing to encourage the use of high-value providers and services (such as a first-degree relative of a colon cancer sufferer getting screened for colorectal cancer), and to discourage the use of low-value providers and services (such as a 30-year-old with no family history of colon cancer receiving that same colorectal cancer screening).

The pilot of VBID will involve military individuals and families who are enrolled in the TRICARE program. The NDAA states the TRICARE program will provide high-quality medications and providers to covered beneficiaries while reducing the price of care.

The pilot will assess how implementing VBID concepts impacts adherence to medication, quality measures, health outcomes, and patient experience. The

NEW BENEFITS AND PROGRAMS IN FY 2017 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

demonstration was available in only seven states in 2017 (Arizona, Iowa, Indiana, Massachusetts, Oregon, Pennsylvania, and Tennessee) with three additional states (Alabama, Michigan, and Texas) being added in 2018.

In the first year, plans can offer varied benefit design for enrollees who fall into certain clinical categories: diabetes, congestive heart failure, chronic obstructive pulmonary disease, past stroke, hypertension, coronary artery disease, and mood disorders. In 2018, the demonstration will expand to include dementia and rheumatoid arthritis.

TRICARE Payments Adjusted for Home Medical Equipment

Rates for home medical equipment were reduced by Medicare in the second half of 2016. However, a subsequent resolution, the 21st Century Cares Act, required Medicare to retroactively delay a second round of reimbursement cuts in rural (non-bid) areas from July 1, 2016, to January 1, 2017, allowing providers to recoup a portion of six months' worth of payments. As its reimbursement rates are tied to Medicare reimbursement rates by law and current network agreements, TRICARE followed suit, allowing providers to resubmit claims adjudicated under the reduced rates to the MCSCs in these regions for reprocessing.

Monthly TRICARE Dental Premiums for Active Duty Families as Well as National Guard and Reserve Members and Their Families Dropped across All Categories

Beginning May 1, 2017, the TRICARE Dental Program moved from MetLife to United Concordia, bringing reductions in monthly premiums, several benefit improvements, and a renewed focus on education and prevention. The changes push premiums below 2015 levels across all categories, while moving all the family and family-plus-sponsor rates to about $9 below 2014 rates. The new contract also includes an increase to the annual maximum benefit from $1,300 to $1,500 and a change that makes sealants free instead of carrying a 20 percent copay. Additionally, children in families who have purchased the dental program and who are enrolled in Defense Enrollment Eligibility Reporting System (DEERS) will automatically be added to their family's plan when they turn one year old, rather than at age four. Troops and families must sign up for coverage by enrolling online or calling the TRICARE dental contractor. Military retirees are not affected by the change, and Active Duty members do not use the TRICARE Dental Program.

MONTHLY TRICARE DENTAL PREMIUMS

	SPONSOR ONLY		SINGLE DEPENDENT		FAMILY		SPONSOR AND FAMILY	
	Prior to May 2017	As of May 1, 2017	Prior to May 2017	As of May 1, 2017	Prior to May 2017	As of May 1, 2017	Prior to May 2017	As of May 1, 2017
Active Duty Families	n/a	n/a	$11.68	$11.10	$34.68	$28.87	n/a	n/a
Selected Reserve and IRR (Mobilization Only)	$11.68	$11.10	$29.19	$27.76	$87.59	$72.18	$99.27	$83.28
IRR (Non-Mobilization)	$29.19	$27.76	$29.19	$27.76	$87.59	$72.18	$116.78	$99.94

Note: The monthly premium depends on the sponsor's military status (Active Duty, Selected Reserve, or Individual Ready Reserve [IRR]) and type of enrollment:
– Sponsor only
– Single dependent—one family member; doesn't include sponsor
– Family—more than one family member; doesn't include sponsor
– Sponsor and family

NEW BENEFITS AND PROGRAMS IN FY 2017 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

Coverage Changes

The Defense and Veterans Brain Injury Center (DVBIC) Recently Added TBI Network Sites at Fort Gordon, Georgia; Fort Drum, New York; and at the South Texas Veterans Health Care System in San Antonio

Each location also provides added benefits, enabling DVBIC to help patients more effectively. San Antonio, Texas, offers access to the VA poly-trauma system of care services and allows research from patients as to what treatments are most effective. Fort Drum, New York, makes it easier for providers in the northeast to learn about new treatments, rather than having to travel all over New England or to WRNMMC. Ft. Gordon, Georgia, operates an outpatient program for a significant number of patients with persistent brain injury, allowing DVBIC staff to learn about more efficiently targeted care and reducing wait times. DVBIC brings its knowledge to each of these locations so providers will not have to hunt down new information on their own.

The Department of Defense and the Veterans Administration Launched a Historic Partnership as It Opened the First Joint VA-DoD Clinic

The Major General William H. Gourley Clinic VA-DoD Outpatient Clinic opened its doors to military Veterans of the Monterey Peninsula military community, along with the family medicine and pediatrics TRICARE Prime patients of the DoD.

The clinic design is a collaboration between VA's health care system and the Army's PCMH model, which will put patients first and allow providers to influence them to make great decisions on their health and wellness.

The California Medical Detachment from the Presidio of Monterey, a subordinate unit of Madigan Army Medical Center, will begin pediatrics and family medicine care in the facility alongside their VA teammates. These Army clinics are targeting an enrolled population of 4,200.

The pediatric clinic will provide care to the Presidio of Monterey pediatric population with primary needs ranging from acute visits to well visits, such as sports physicals, immunizations, and overseas screenings.

The family medicine clinic will provide care for all adult dependents from the main clinic on Presidio of Monterey. Each patient will partner with a team of health care providers to receive improved access, coordinated services, and better continuity of care.

The joint facility will also feature an on-site pharmacy, laboratory, X-ray capabilities, and will leverage cutting-edge technology to provide telehealth from specialists at Madigan.

The technology and merging of care models from two medical systems is leading the way forward for DoD health care and VA medicine.

The newly opened Major General William H. Gourley VA-DoD Outpatient Clinic in Marina treated its first patients. (August 2017)

BENEFICIARY TRENDS AND DEMOGRAPHICS

System Characteristics

TRICARE FACTS AND FIGURES—PROJECTED FOR FY 2018

	PROJECTED FOR FY 2018[a]	FY 2017 (AS PROJECTED LAST YEAR)
Total Beneficiaries	**9.4 million worldwide[b]**	9.4 million worldwide
MILITARY FACILITIES—DIRECT CARE SYSTEM[c]		
Inpatient Hospitals and Medical Centers	**51 (38 in U.S.)**	54 (41 in U.S.)
Ambulatory Care and Occupational Health Clinics	**381 (329 in U.S.)**	377 (312 in U.S.)
Dental Clinics	**247 (200 in U.S.)**	250 (202 in U.S.)
Veterinary Facilities	**251 (206 in U.S.)**	251 (206 in U.S.)
Military Health System (MHS) Defense Health Program–Funded Personnel	**144,217**	147,165
Military	**82,562**	84,167
	30,938 Officers	31,444 Officers
	51,624 Enlisted	52,723 Enlisted
Civilian	**61,655**	62,998
CIVILIAN RESOURCES—PURCHASED CARE SYSTEM[d]		
Network Primary Care, Behavioral Health, and Specialty Care Providers (i.e., individual, not institutional, providers)	**604,279**	570,507
Network Behavioral Health Providers (shown separately, but included in above)	**84,029**	83,701
TRICARE Network Acute Care Hospitals	**3,664**	3,777
Behavioral Health Facilities	**833**	812
Contracted (Network) Retail Pharmacies	**58,427**	58,312
Contracted Worldwide Pharmacy Home Delivery Vendor	**1**	1
TRICARE Dental Program (TDP) (for Active Duty families, Reservists and their families)	**Over 1.8 million covered lives in 767,000 contracts**	Almost 1.8 million covered lives in over 764,000 contracts
TDP Network Dentists	**Over 76,000 total dentists including: almost 62,000 general dentists over 14,000 specialty dentists**	Over 99,000 total dentists including: 79,000 general dentists 20,000 specialists
TRICARE Retiree Dental Program (for retired Uniformed Services members and their families)	**Over 1.6 million covered lives in over 721,000 contracts**	Over 1.56 million covered lives in almost 793,000 contracts
Total Projected FY 2018 Unified Medical Program (UMP) (Including Projected Trust Fund Receipts)	**$53.64 billion[e]**	**$52.55 billion**
Projected Receipts from MERHCF Trust Fund	**$10.38 billion**	**$10.27 billion**

[a] Unless specified otherwise, this report presents budgetary, utilization, and cost data for the Defense Health Program (DHP)/UMP only, not those related to deployment or funded by the "Line" of the Services.

[b] Department of Defense (DoD) health care beneficiary population projected for mid–fiscal year (FY) 2018 is 9,420,000, rounded to 9.4 million, and is based on Director, Defense Health Agency (DHA) Memo dated October 28, 2017, "Estimate of Beneficiaries Eligible for Health Care in Fiscal Year 2018."

[c] Military treatment facility (MTF) data include 13 Occupational Health Clinics, Active Duty troop and centers of excellence clinics, and joint DoD-VA clinics, and excludes leased/contracted facilities and Aid Stations; MTF counts are consistent with DHA/Resources & Management (J-1/J-8)/Budget and Execution and Programming Divisions. Source: DHA/Strategy, Plans and Functional Integration (J-5)/Decision Support Division, 11/7/2017.

[d] As reported by TRICARE Regional Offices (TROs) for contracted network provider and hospital data (10/26/2017), and by TRICARE Dental Office, Health Plan Execution and Operations for dental provider data (10/31/2017).

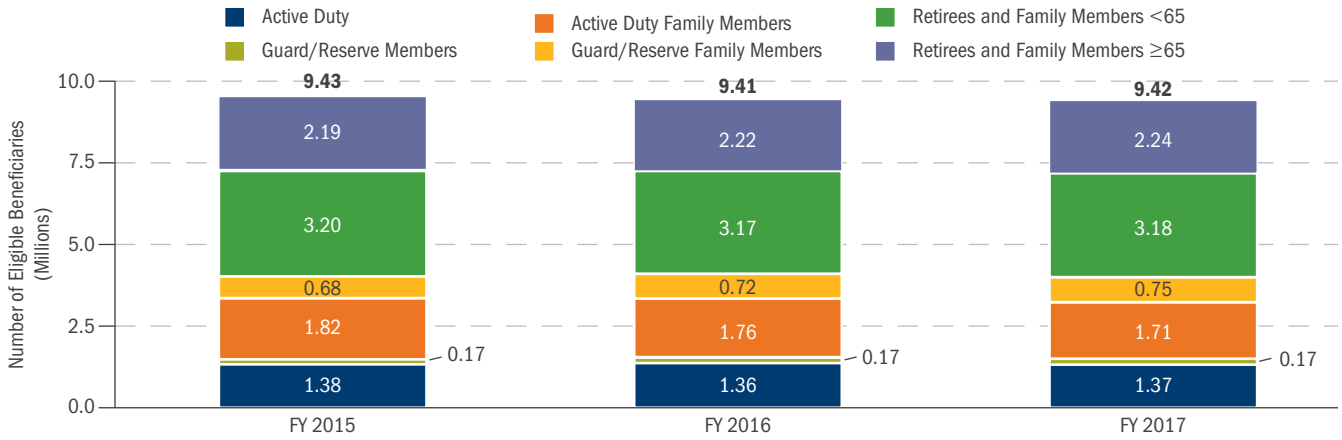
[e] UMP presented here includes direct and private-sector care funding, military personnel, military construction, and the Medicare-Eligible Retiree Health Care Fund (MERHCF) ("Accrual Fund"). Change in reporting for FY 2017: presenting actual and projected MERHCF receipts from the Trust Fund instead of DoD Normal Cost Contribution. Budget and expense data from DHA/Resources & Management Directorate, 11/8/2017.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Number of Eligible and Enrolled Beneficiaries between FY 2015 and FY 2017

The number of beneficiaries eligible for DoD medical care (including TRICARE Reserve Select [TRS], TRICARE Young Adult [TYA], and TRICARE Retired Reserve [TRR]) remained at about 9.4 million[1] between FY 2015 and FY 2017. Declines in the numbers of Active Duty, their family members, and retirees and family members under age 65 were largely offset by increases in inactive Guard/Reserve and their family members[2] with TRS and retirees and family members age 65 and above.

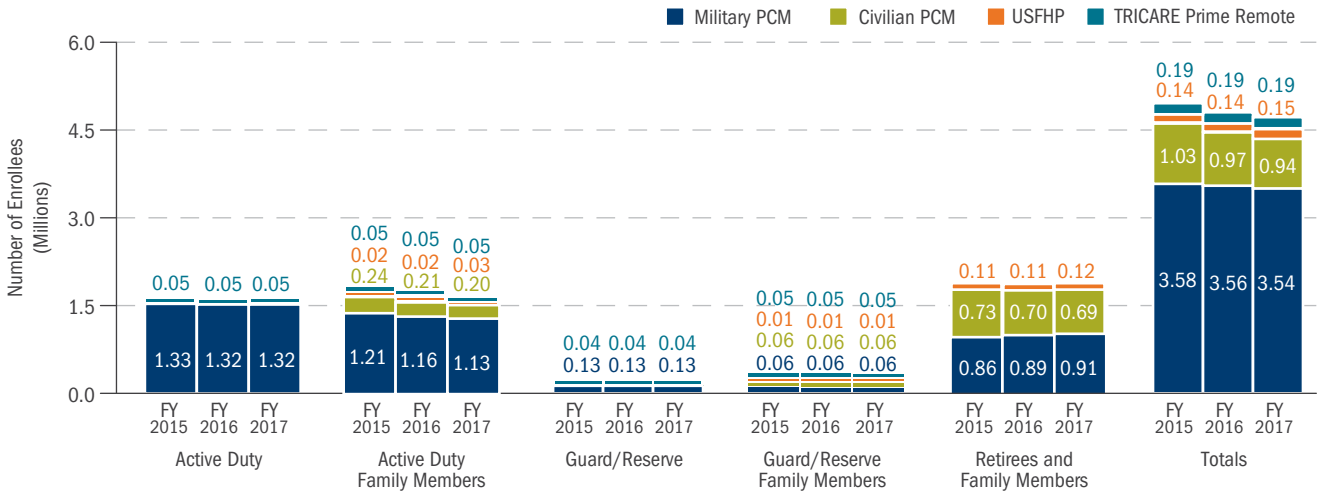
TRENDS IN THE END-YEAR NUMBER OF ELIGIBLE BENEFICIARIES BY BENEFICIARY GROUP, FYs 2015–2017



Source: Defense Enrollment Eligibility Reporting System (DEERS), 1/4/2018
Note: The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere.

- Declines in Prime enrollment (for both a military and a civilian primary care manager [PCM]) are due primarily to corresponding declines in the Active Duty and Guard/Reserve populations and their family members.
- Retirees and family members continue to shift their enrollments from civilian to military PCMs.
- TRICARE Prime Remote (TPR) and Uniformed Services Family Health Plan (USFHP) enrollment remained about the same from FY 2015 to FY 2017.

TRENDS IN THE END-YEAR NUMBER OF ENROLLED BENEFICIARIES BY BENEFICIARY GROUP, FYs 2015–2017



Source: DEERS, 1/4/2018

[1] This number should not be confused with the one displayed under TRICARE Facts and Figures on page 17. The population figure on page 17 is a projected FY 2018 total, whereas the population reported on this page is the actual for the end of FY 2017.

[2] Both inactive Guard/Reserve members and their families are included under Guard/Reserve Family Members because their benefits are similar to those of family members.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Beneficiary Plan Choice by Age Group and Beneficiary Category

Although Prime and Standard/Extra are the primary choices for most TRICARE beneficiaries, several other options are available to those who do not qualify for those benefits. Plan choice varied by age group and beneficiary category.

PLAN CHOICE BY AGE GROUP, END OF FY 2017

PLAN TYPE	0–17	18–24	25–44	45–64	≥65	TOTAL[a]
Prime Enrolled	1,278,726	881,319	1,493,814	1,049,500	2,296	4,705,655
Prime	1,247,377	860,721	1,473,694	1,005,722	1,940	4,589,454
USFHP	31,349	7,698	15,910	43,778	356	99,091
TYA Prime	0	12,900	4,210	0	0	17,110
Non-Enrolled	673,324	265,287	515,557	832,418	19,428	2,306,014
Standard/Extra	516,442	207,503	327,833	772,410	4,268	1,828,456
TRS	148,466	32,831	171,992	32,471	16	385,776
Direct Care Only	31	3,997	7,529	5,971	14,144	31,672
Plus	6,278	1,671	3,425	16,902	995	29,271
TYA Standard	0	18,242	4,153	0	0	22,395
TRR	2,107	1,043	625	4,664	5	8,444
Medicare-Eligible	39	1,076	33,697	147,477	2,222,185	2,404,474
TFL	9	596	18,183	87,674	1,937,042	2,043,504
Plus[b]	0	4	120	1,204	181,096	182,424
Direct Care Only	1	12	315	6,695	57,342	64,365
Prime	24	404	14,022	48,781	369	63,600
USFHP	1	20	412	2,226	45,887	48,546
Other/Unknown	4	40	645	897	449	2,035
Total	**1,952,089**	**1,147,682**	**2,043,068**	**2,029,395**	**2,243,909**	**9,416,143**

Source: DEERS, 1/4/2018

[a] The totals in the right-hand columns of the above tables may differ slightly from ones shown in other sections of this report. Reasons for differences may include different data pull dates, end-year vs. average populations, and different data sources.

[b] Among Medicare eligibles, 179,003 with TRICARE Plus also have TFL. These numbers are not included in the TFL row.

- About one-third of USFHP enrollees are seniors (age ≥65), and one-fifth are children (age 0–17).
- The vast majority of those age 65 and above are enrolled in Medicare Part B and are covered by TRICARE for Life (TFL) as their supplemental plan. About 8 percent of seniors covered by TFL are also enrolled in TRICARE Plus, the primary care–only plan available at selected military treatment facilities (MTFs).
- Beneficiaries aged 45–64 had the lowest TRICARE Prime enrollment rate, at 56 percent. Enrollment rates for the other age groups were 66 percent for 0–17, 77 percent for 18–24, and 74 percent for 25–44. Beneficiaries age 65 and older predominantly use TFL.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Beneficiary Plan Choice by Age Group and Beneficiary Category *(cont.)*

PLAN CHOICE BY BENEFICIARY CATEGORY, END OF FY 2017

PLAN TYPE	AD/GRD	ADFM/GRDFM[a]	RET/RETFM <65	RET/RETFM ≥65[b]	TOTAL[c]
Prime Enrolled	1,540,502	1,571,775	1,591,443	1,935	4,705,655
Prime	1,540,502	1,537,979	1,509,394	1,579	4,589,454
USFHP	0	31,967	66,768	356	99,091
TYA Prime	0	1,829	15,281	0	17,110
Non-Enrolled	0	878,692	1,409,322	18,000	2,306,014
Standard/Extra	0	471,496	1,352,720	4,240	1,828,456
TRS	0	384,784	991	1	385,776
Direct Care Only	0	16,844	1,679	13,149	31,672
Plus	0	2,448	26,218	605	29,271
TYA Standard	0	3,115	19,280	0	22,395
TRR	0	5	8,434	5	8,444
Medicare-Eligible	0	8,175	176,768	2,219,531	2,404,474
TFL	0	2,674	105,274	1,935,556	2,043,504
Plus[d]	0	540	1,204	180,680	182,424
Direct Care Only	0	0	7,023	57,342	64,365
Prime	0	3,347	60,207	46	63,600
USFHP	0	91	2,583	45,872	48,546
Other/Unknown	0	1,523	477	35	2,035
Total	**1,540,502**	**2,458,642**	**3,177,533**	**2,239,466**	**9,416,143**

Source: DEERS, 1/4/2018

[a] Inactive Guard/Reserve and their family members eligible for TRICARE are included in the ADFM/Guard/Reserves and Family Members (GRDFM) group.

[b] This column total does not match the "≥65" total in the top table because the latter includes a small number of ADFMs age 65 and older.

[c] The totals in the right-hand columns of the above tables may differ slightly from ones shown in other sections of this report. Reasons for differences may include different data pull dates, end-year vs. average populations, and different data sources.

[d] Among Medicare eligibles, 179,003 with TRICARE Plus also have TFL. These numbers are not included in the TFL row.

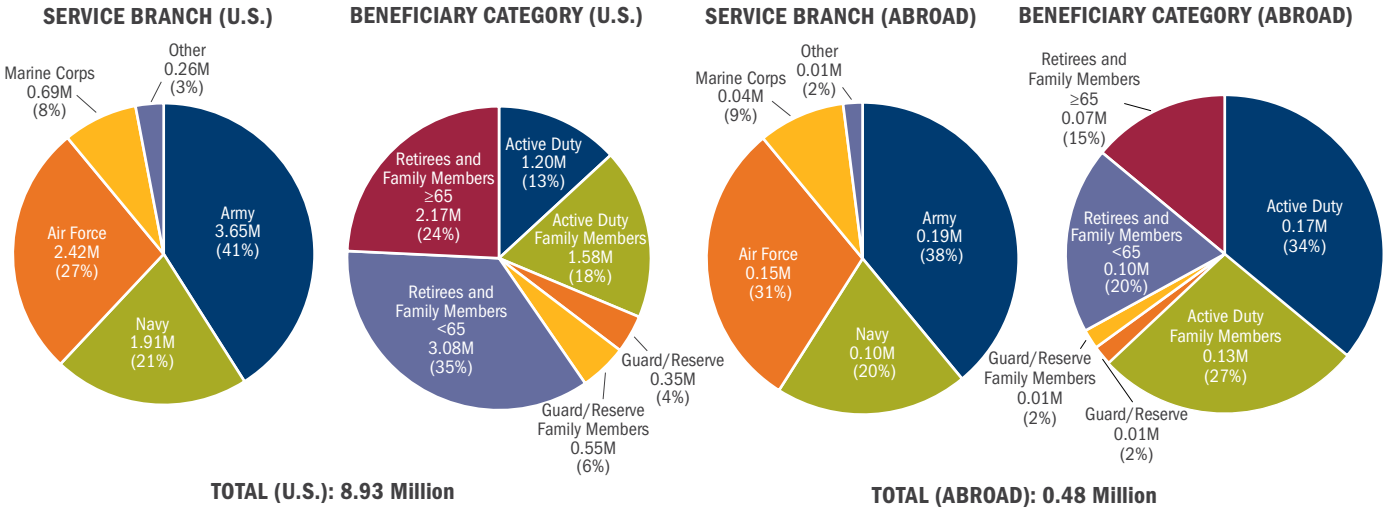
- Only 1 percent of retirees and family members (RETFMs) under the age of 65 are enrolled in plans other than Prime or Standard/Extra (including USFHP, TYA Prime, and Standard).
- Sixteen percent of ADFM/GRDFMs are enrolled in plans other than Prime or Standard/Extra. The vast majority are inactive Guard/Reserves and family members enrolled in TRS.
- The large majority of beneficiaries enrolled in TYA are children of retirees under the age of 65 (most Active Duty members are not old enough to have children in the requisite age group). TYA Prime enrollment has declined from 58 percent of total TYA enrollment in FY 2015 to 41 percent in FY 2017.
- About 80 percent of beneficiaries enrolled in the USFHP are RETFMs, most of whom are under age 65. The USFHP is available at only six sites nationwide, so enrollment is low relative to Prime.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Eligible Beneficiaries in FY 2017

- Of the 9.42 million eligible beneficiaries at the end of FY 2017, 8.93 million (95 percent) were stationed or resided in the United States (U.S.), and 0.48 million were stationed or resided abroad. The Army has the most beneficiaries eligible for Uniformed Services health care benefits, followed (in order) by the Air Force, Navy, Marine Corps, and other Uniformed Services (Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration). Although the proportions are different, the Service rankings (in terms of eligible beneficiaries) are the same abroad as they are in the U.S.
- Whereas retirees and their family members constitute the largest percentage of the eligible population (59 percent) in the U.S., Active Duty personnel (including Guard/Reserve Component [RC] members on Active Duty for at least 30 days) and their family members make up the largest percentage (65 percent) of the eligible population abroad. The U.S. MHS population is presented at the state level on page 26, reflecting those enrolled in the Prime benefit and the total population, enrolled and non-enrolled.
- Mirroring trends in the civilian population, the MHS is confronted with an aging beneficiary population.

BENEFICIARIES ELIGIBLE FOR DoD HEALTH CARE BENEFITS, END OF FY 2017

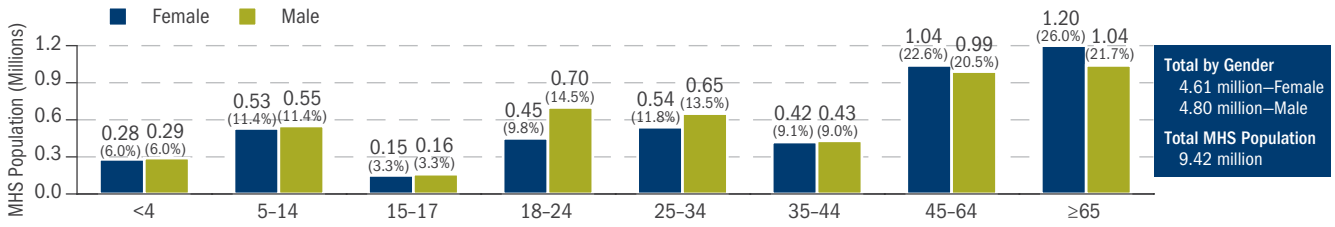


TOTAL (U.S.): 8.93 Million

TOTAL (ABROAD): 0.48 Million

Source: DEERS, 1/4/2018
Note: Percentages may not sum to 100 percent due to rounding.

MHS POPULATION BY AGE GROUP AND GENDER, END OF FY 2017



Source: FY 2017 actuals from DEERS as of 1/4/2018

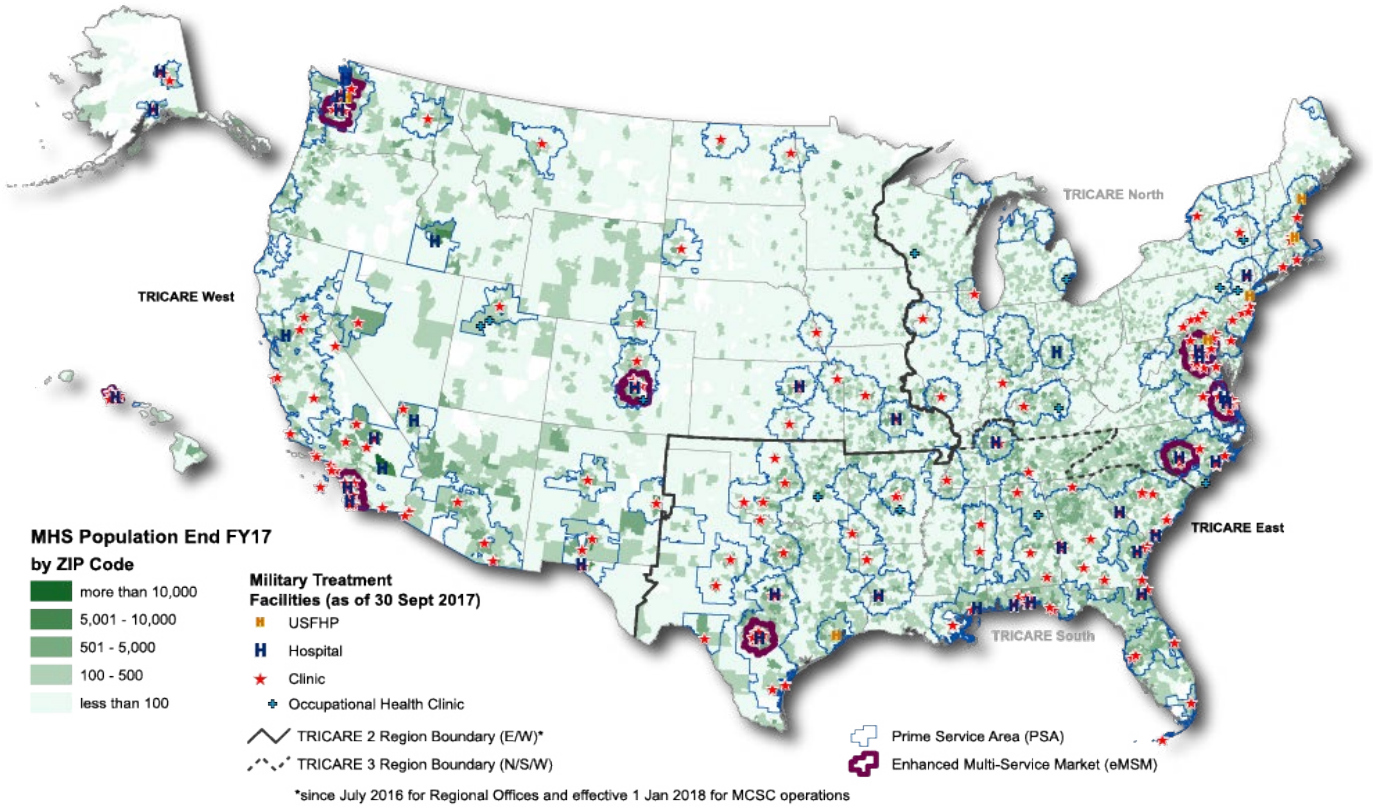
PROJECTED END-YEAR MHS POPULATIONS (MILLIONS) BY BENEFICIARY CATEGORY, FYs 2018–2025

BENEFICIARY CATEGORY	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025
Active Duty	1.37	1.38	1.38	1.38	1.38	1.38	1.38	1.38
Active Duty Family Members	1.71	1.72	1.72	1.72	1.72	1.72	1.72	1.72
Guard/Reserve	0.18	0.18	0.18	0.18	0.18	0.18	0.18	0.18
Guard/Reserve Family Members	0.28	0.28	0.28	0.28	0.28	0.28	0.28	0.28
Inactive Guard/Reserve	0.18	0.18	0.18	0.18	0.18	0.18	0.18	0.18
Inactive Guard/Reserve Family Members	0.29	0.29	0.29	0.29	0.29	0.29	0.29	0.29
Retirees	2.21	2.22	2.22	2.23	2.23	2.24	2.25	2.25
Retiree Family Members	2.57	2.57	2.57	2.58	2.58	2.58	2.59	2.58
Survivors	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60
Other	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05
Total	**9.43**	**9.46**	**9.47**	**9.49**	**9.50**	**9.51**	**9.52**	**9.52**

Source: FYs 2018–2025 estimates from DHA Projections of Eligible Population (PEP) model as of 10/26/2016

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

MHS POPULATION DISTRIBUTION IN THE U.S. RELATIVE TO MTFs, END OF FY 2017



MHS ELIGIBLE BENEFICIARY PROXIMITY TO MILITARY TREATMENT FACILITIES, END OF FY 2017[a]

BENEFICIARY GROUP[b]	POPULATION TOTAL (FY 2017)	POPULATION IN PSAs	% IN PSAs	% IN CATCHMENTS	% IN PRISMs	% IN MTF SERVICE AREAS	% IN eMSMs
Active Duty and Their Families	2,779,159	2,658,887	95.7%	67.2%	88.8%	93.0%	38.0%
Guard/Reserves and Their Families[c]	903,546	619,068	68.5%	22.3%	39.4%	54.4%	12.6%
Retirees, Their Families, Survivors, and Other Eligibles	5,256,779	4,012,181	76.3%	34.0%	50.3%	64.2%	19.5%
Total MHS Eligibles, U.S.	8,939,484	7,290,136	81.5%	43.2%	61.2%	72.2%	24.6%
MHS Eligibles, Overseas	473,789						
Total MHS Eligibles, Worldwide	9,413,273						
VETERANS HEALTH ADMINISTRATION PRIORITY BENEFICIARIES	**POPULATION TOTAL (FY 2015)**	**POPULATION IN PSAs**	**% IN PSAs**	**% IN CATCHMENTS**	**% IN PRISMs**	**% IN MTF SERVICE AREAS**	**% IN eMSMs**
Eligible Veterans without TRICARE Eligibility	7,308,883	4,322,618	59.1%	14.9%	24.0%	42.6%	6.5%
Dual TRICARE-Eligible and VHA-Eligible Veterans	1,453,905	1,086,187	74.7%	32.2%	49.1%	62.4%	17.5%
Total VHA Priority Veterans U.S.	8,762,788	5,408,805	61.7%	17.8%	28.2%	45.9%	8.3%
VHA Veterans Overseas	203,134						
Total VHA Worldwide	8,965,922						

Sources: DHA/SP&FI (J-5)/Decision Support, 12/12/2017; population as of 9/30/2017, pulled 12/12/2017; and Veteran's Health Administration (VHA) population as of 9/30/2015, provided 11/18/2015

Notes:

[a] Eligible MHS beneficiary data from the MHS Data Repository (MDR) DEERS, effective 9/30/2017. Residential zip code was used as the location for all beneficiaries.

[b] Location information determined by DHA Catchment Area Directory database, September 2017.

[c] TRICARE medically eligible Guard/Reserve beneficiaries, including those who have enrolled in TRS, TRR, or TYA; does not include all Select Reserve.

Definitions:

– Catchment Area: Includes ZIP codes in the 40-mile circle around an inpatient MTF, subject to overlap rules, barriers, and other policy overrides.

– Provider Requirement Integrated Specialty Model (PRISM) Area: Includes ZIP codes in the 20-mile circle around an active MTF (inpatient or outpatient), subject to overlap rules, barriers, and other policy overrides.

– MTF Service Area: Includes ZIP codes in the 40-mile circle around an active MTF (inpatient or outpatient), subject to overlap rules, barriers, and other policy overrides.

– Prime Service Areas (PSAs) are those in effect in 2017, defined as the 40-mile area around existing MTFs, as well as previously closed MTFs (Base Realignment and Closure [BRAC] sites).

– Enhanced multi-Service market (eMSM) areas used here are the six eMSMs used in the MHS strategy and market management (National Capital Region, Hawaii, Puget Sound, Colorado Springs, San Antonio, and Tidewater), as well as two densely populated multiple-market areas in San Diego and Fort Bragg.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

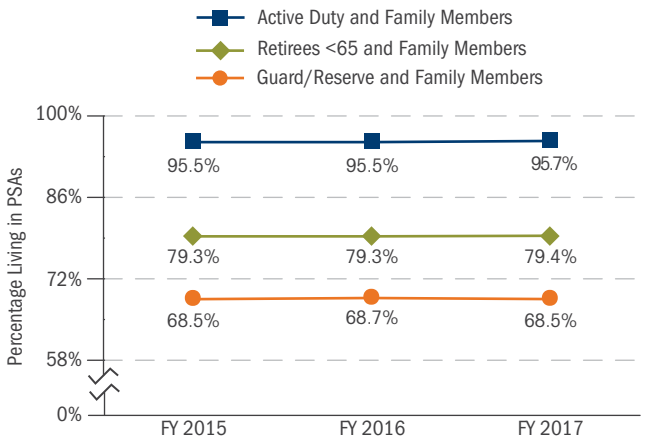
Locations of MTFs (Hospitals and Ambulatory Care Clinics) at the End of FY 2017

The map on the previous page shows the geographic dispersion of the almost 9 million beneficiaries eligible for the TRICARE benefit residing within the United States (95 percent of the 9.4 million eligible beneficiaries described on the previous pages). An overlay of the major DoD MTFs (medical centers and community hospitals, as well as medical clinics) reflects the extent to which the MHS population has access to TRICARE Prime. A beneficiary is considered to have access to Prime if he or she resides within a PSA. PSAs are geographic areas in which the TRICARE managed care support contractors (MCSCs) offer the TRICARE Prime benefit through established networks of providers. TRICARE Prime is available at MTFs, in areas around most MTFs ("MTF PSAs"), in areas where an MTF was eliminated in the BRAC process ("BRAC PSAs"), and by designated providers through the USFHP as of October 1, 2013. The overlay of MTF and BRAC PSAs on the map on the previous page shows the eligible beneficiary population.

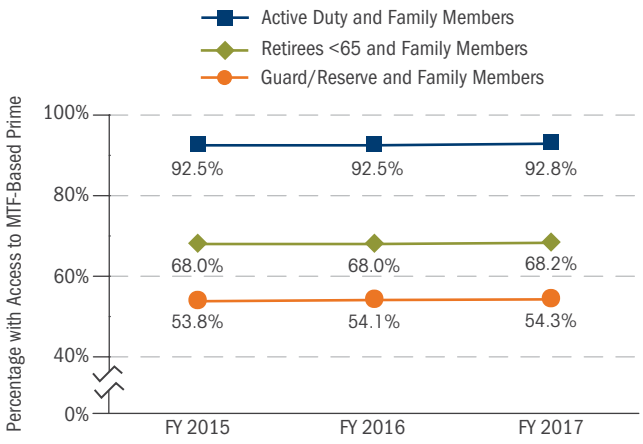
Beneficiary Access to Prime

The left chart below shows the percentage of beneficiaries living in PSAs (defined only in the U.S.). The right chart below shows the percentage of the eligible population in the U.S. with access to MTF-based Prime. The latter is defined as the percentage living in both a PSA and an MTF Service Area (see the notes to the right of the map on the previous page for the definition of an MTF Service Area).

TREND IN ELIGIBLE POPULATION LIVING IN PSAs, FYs 2015–2017



TREND IN ELIGIBLE POPULATION WITH ACCESS TO MTF-BASED PRIME, FYs 2015–2017



Source: DEERS, 1/4/2018

- Between FY 2015 and FY 2017, the percentage living in PSAs has remained about the same for all beneficiary groups.
- As determined by residence in an MTF PSA, access to MTF-based Prime increased slightly from FY 2015 to FY 2017 for all beneficiary groups.
- As expected, Active Duty and their families have the highest level of access to MTF-based Prime, whereas Guard/Reserve members and their families have the lowest. Retirees, some of whom move to locations near an MTF to gain access to care in military facilities, fall in between.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

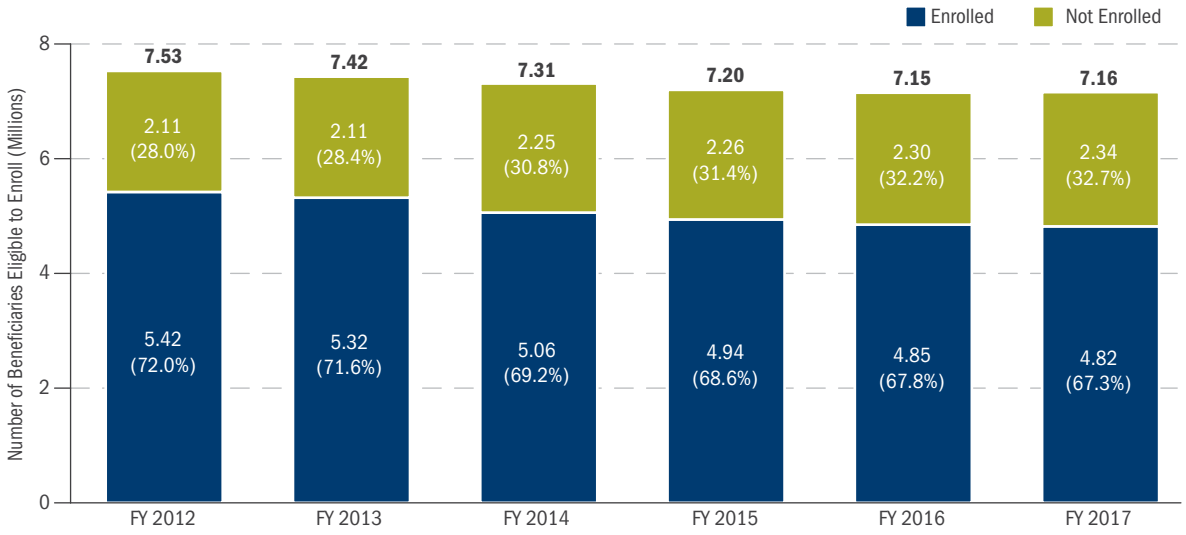
Eligibility and Enrollment in TRICARE Prime

Eligibility for and enrollment in TRICARE Prime was determined from DEERS. For the purpose of this report, all Active Duty personnel are considered to be enrolled. The eligibility counts exclude most beneficiaries age 65 and older, but include beneficiaries living in remote areas where Prime may not be available. The enrollment rates displayed below may, therefore, be somewhat understated.

Beneficiaries enrolled in TPR (including Global Remote), TYA Prime, and the USFHP are included in the enrollment counts below. Beneficiaries enrolled in TRICARE Plus (a primary care enrollment program offered at selected MTFs), TRS, TYA Standard, and TRR are excluded from the enrollment counts below; they are included in the non-enrolled counts.

- The number of beneficiaries enrolled in TRICARE Prime has continued to drop since FY 2012. As a percentage of the beneficiary population, TRICARE Prime enrollment remained level from FY 2012 to FY 2013 but dropped significantly in FY 2014, due to a drop in Active Duty end-strength and a reduction in the number of locations designated as PSAs.
- By the end of FY 2017, about 67 percent of all eligible beneficiaries were enrolled (4.82 million enrolled of the 7.16 million eligible to enroll).

HISTORICAL END-YEAR ENROLLMENT NUMBERS, FYs 2012–2017



Source: DEERS, 1/4/2018
Note: Numbers may not sum to bar totals due to rounding. Detailed MHS enrollment data by state can be found on page 26.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Recent Three-Year Trend in Eligibles, Enrollees, and Users

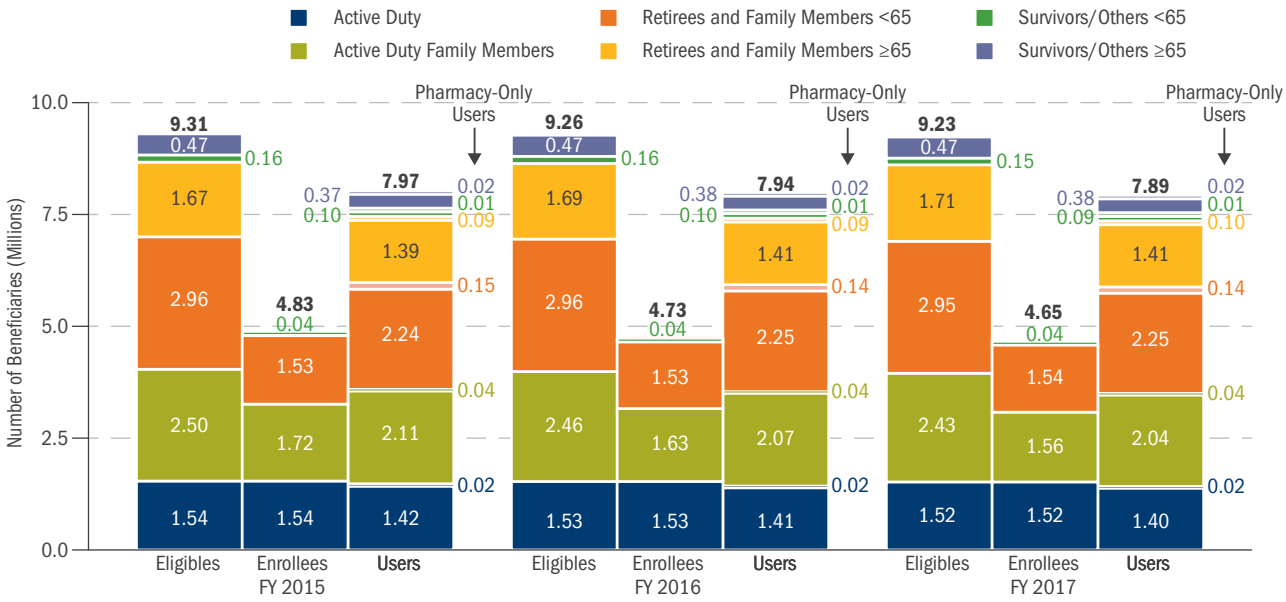
This section compares the number of users of MHS services with the numbers of eligibles and enrollees. Because beneficiaries eligible for any part of the year can be users, average (rather than end-year) beneficiary counts were used for all calculations.

The average numbers of eligibles and TRICARE Prime enrollees by beneficiary category[1] from FY 2015 to FY 2017 were determined from DEERS data. The eligible counts include all beneficiaries eligible for some form of the military health care benefit and, therefore, include those who may not be eligible to enroll in Prime. TRICARE Plus and Reserve Select enrollees are not included in the enrollment counts. USFHP enrollees are excluded from both the eligible and enrollment counts because information about users of that plan was not available.

Two types of users are defined in this section: (1) users of inpatient or outpatient care, regardless of pharmacy utilization; and (2) users of pharmacy only. No distinction is made here between users of direct and purchased care. The union of the two types of users is equal to the number of beneficiaries who had any MHS utilization.

- The number of Active Duty and eligible family members declined by 2 percent between FY 2015 and FY 2017. The number of RETFMs under age 65 remained about the same, while the number of RETFMs age 65 and older increased by 2 percent. The number of survivors and others (SRV/OTHs), both under and over age 65, remained about the same.
- The percentage of ADFMs enrolled in TRICARE Prime declined from 69 percent in FY 2015 to 64 percent in FY 2017. The percentage of RETFMs under age 65 enrolled in Prime remained constant at 52 percent and the percentage of SRV/OTHs under age 65 enrolled in Prime increased from 26 to 28 percent over the same time interval.
- The overall user rate remained about the same between FY 2015 and FY 2017 at about 86 percent. The user rates changed only slightly for each beneficiary group, varying by less than half a percentage point between FY 2015 and FY 2017.
- RETFMs under age 65 constituted the greatest number of MHS users, but had the second lowest user rate. Their MHS user rate was lower than all but SRV/OTHs (a much smaller beneficiary group) because some RETFMs had other health insurance (OHI).

AVERAGE NUMBERS OF ELIGIBLES, ENROLLEES, AND USERS BY BENEFICIARY CATEGORY, FYs 2015–2017



Sources: DEERS and MHS administrative data, 1/4/2018

[1] Inactive Guard/Reserves and their family members are grouped with ADFMs because their TRICARE benefits are similar.

Note: Numbers may not sum to bar totals due to rounding. The bar totals reflect the average number of eligibles and enrollees, not the end-year numbers displayed in previous charts, to account for beneficiaries who were eligible or enrolled for only part of a year.

MHS POPULATION: ENROLLEES AND TOTAL POPULATION BY STATE

STATE	TOTAL POPULATION	TRS ENROLLED	PRIME ENROLLED				
			ACTIVE DUTY AND GUARD/RESERVE ON ACTIVE DUTY	DEPENDENTS OF ACTIVE DUTY AND GUARD/RESERVE ON ACTIVE DUTY	RETIRED	RETIRED FAMILY MEMBERS/ OTHERS	TOTAL
AK	82,241	1,310	22,165	25,590	5,170	8,778	61,703
AL	208,039	8,659	13,548	23,623	18,536	31,207	86,914
AR	86,608	4,666	6,732	8,753	5,239	9,148	29,872
AZ	204,609	8,724	21,861	27,101	17,520	28,762	95,244
CA	791,788	23,134	165,407	148,662	46,028	84,358	444,455
CO	247,330	8,995	43,008	48,117	20,295	35,213	146,633
CT	48,858	2,180	9,128	7,620	2,038	3,215	22,001
DC	22,274	660	11,796	2,943	830	824	16,393
DE	33,311	1,737	4,364	4,646	2,783	4,024	15,817
FL	707,226	23,288	70,859	89,978	64,079	101,292	326,208
GA	432,548	15,061	72,151	75,833	39,968	66,371	254,323
HI	155,818	2,079	47,598	50,813	5,725	9,260	113,396
IA	46,213	4,935	2,196	3,864	824	1,835	8,719
ID	52,483	4,084	4,584	6,461	3,116	5,172	19,333
IL	149,679	9,137	26,105	18,097	9,472	15,620	69,294
IN	91,684	9,621	4,510	7,136	4,149	7,539	23,334
KS	123,497	5,477	25,557	28,060	6,637	12,168	72,422
KY	142,423	6,445	36,091	21,460	8,123	13,827	79,501
LA	125,242	7,665	19,981	21,995	7,395	12,967	62,338
MA	69,699	5,903	6,666	7,251	6,346	9,071	29,334
MD	245,922	7,137	40,377	47,660	29,630	42,230	159,897
ME	39,128	2,514	1,641	3,510	7,548	10,385	23,084
MI	99,128	6,932	5,127	7,661	3,563	5,974	22,325
MN	67,707	10,827	4,024	4,798	164	316	9,302
MO	156,791	10,997	21,671	19,920	8,747	15,427	65,765
MS	110,465	7,313	15,807	13,740	6,666	11,068	47,281
MT	35,614	2,491	4,286	4,817	1,017	1,671	11,791
NC	504,169	13,919	104,808	106,095	28,368	47,908	287,179
ND	33,200	2,271	8,649	7,940	1,364	2,127	20,080
NE	61,768	4,499	7,613	9,512	4,280	7,216	28,621
NH	31,006	1,905	2,221	2,315	4,836	6,731	16,103
NJ	83,716	5,460	11,922	13,390	5,174	8,406	38,892
NM	83,800	2,041	13,567	15,145	6,480	10,242	45,434
NV	104,790	3,666	12,502	15,272	9,022	14,185	50,981
NY	177,785	7,279	33,154	29,980	9,509	15,869	88,512
OH	166,777	12,429	12,532	15,940	7,676	13,182	49,330
OK	156,710	6,067	26,100	23,312	11,427	20,481	81,320
OR	67,128	3,849	3,523	5,022	957	1,584	11,086
PA	162,619	10,294	8,556	11,698	7,710	12,571	40,535
RI	24,478	1,181	4,400	3,881	1,576	2,308	12,165
SC	246,312	10,422	43,966	31,890	17,712	28,894	122,462
SD	34,773	4,686	4,471	5,153	1,565	2,494	13,683
TN	196,689	12,166	5,627	28,948	11,843	20,387	66,805
TX	891,385	35,202	130,757	147,200	81,453	143,608	503,018
UT	76,137	9,463	7,273	11,259	4,664	8,922	32,118
VA	745,255	14,254	132,356	145,087	60,406	91,972	429,821
VT	13,405	1,159	893	1,240	1,268	2,055	5,456
WA	349,527	9,113	63,931	71,304	29,527	48,458	213,220
WI	73,096	7,637	3,902	5,616	1,115	2,004	12,637
WV	35,804	2,560	2,210	2,156	964	1,443	6,773
WY	23,488	1,418	3,787	4,236	1,332	2,234	11,589
Subtotal	**8,920,142**	**384,911**	**1,355,960**	**1,443,700**	**641,836**	**1,063,003**	**4,504,499**
Overseas	**496,001**	**3,057**	**184,052**	**119,475**	**492**	**8,580**	**312,599**
Total	**9,416,143**	**387,968**	**1,540,012**	**1,563,175**	**642,328**	**1,071,583**	**4,817,098**

Source: MHS administrative data systems, as of 1/4/2018 for end of FY 2017

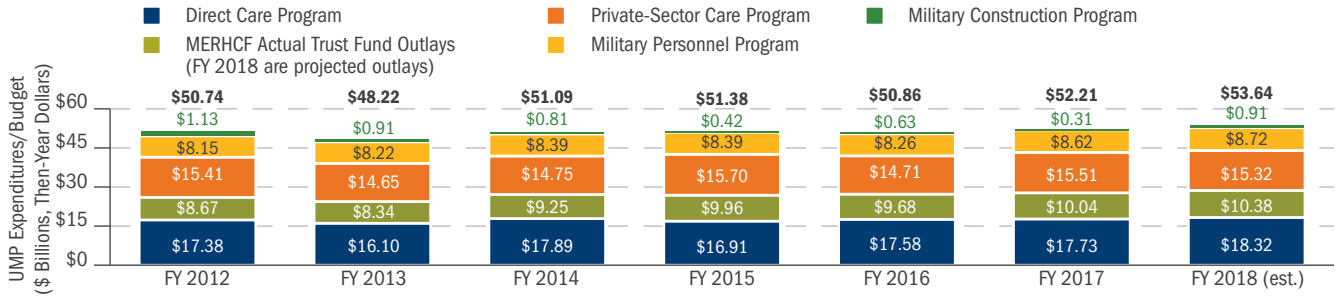
Note: "Prime Enrolled" includes Prime (military and civilian PCMs), TRICARE Prime Remote (and Overseas equivalent), TYA Prime, and USFHP; and excludes members in TFL, TRICARE Plus, TYA Standard, and TRS.

UMP FUNDING

The UMP, estimated at $53.64 billion for FY 2018 in the FY 2018 President's Budget, is almost 3 percent higher than the FY 2017 $52.21 billion in actual expenditures (unadjusted, then-year dollars). The UMP displayed here includes the actual Trust Fund outlays from the MERHCF, or the "Accrual Fund". This fund (effective October 1, 2002) pays the cost of DoD health care programs (both direct and purchased care) for Medicare-eligible retirees, retiree family members, and survivors. The majority of Accrual Fund payments for health care provided to Medicare-eligible beneficiaries are for purchased care, pharmacy, and outpatient care.

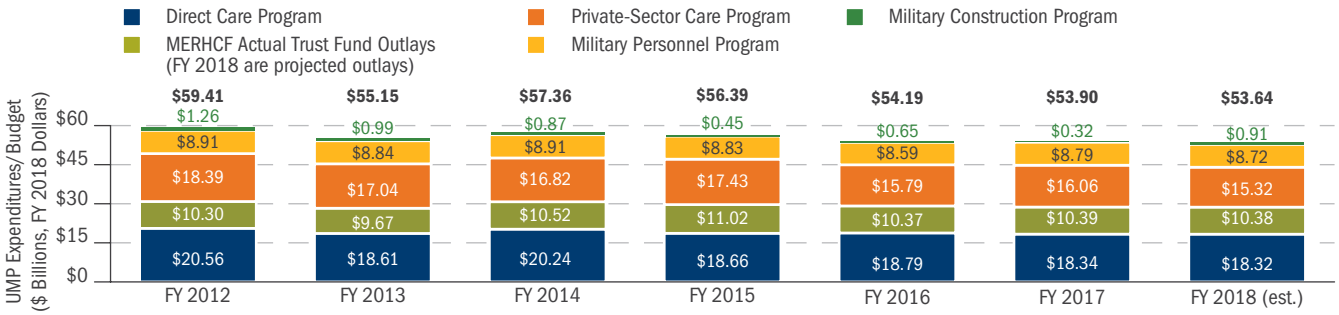
At $18.32 billion estimated for FY 2018, direct care expenditures represent the largest sector of the UMP (34 percent), followed by the private sector program ($15.32 billion, almost 29 percent). Outlays from the Trust Fund have increased from $8.67 billion in FY 2012 to $10.38 billion estimated for FY 2018.

UMP FUNDING AND TRUST FUND OUTLAYS ($ BILLIONS) IN UNADJUSTED, THEN-YEAR DOLLARS, FYs 2012–2018 (EST.)



As shown in the chart below, in constant FY 2018 dollar funding, when actual expenditures or projected funding are adjusted for inflation as estimated by the Department, the FY 2018 $53.64 billion estimated budget in purchasing value is currently programmed to be slightly less than the $53.90 billion adjusted FY 2017 actual expenditures and $5.8 billion (almost 10 percent) less than the peak in FY 2012 of $59.41 billion (in FY 2018 dollars).

UMP FUNDING AND TRUST FUND OUTLAYS ($ BILLIONS) IN CONSTANT FY 2018 DOLLARS, FYs 2012–2018 (EST.)



Source: Cost and budget estimates, DHA/Resources and Management Directorate (J-1/J-8)/DHP Programming, 11/8/2017

Notes:

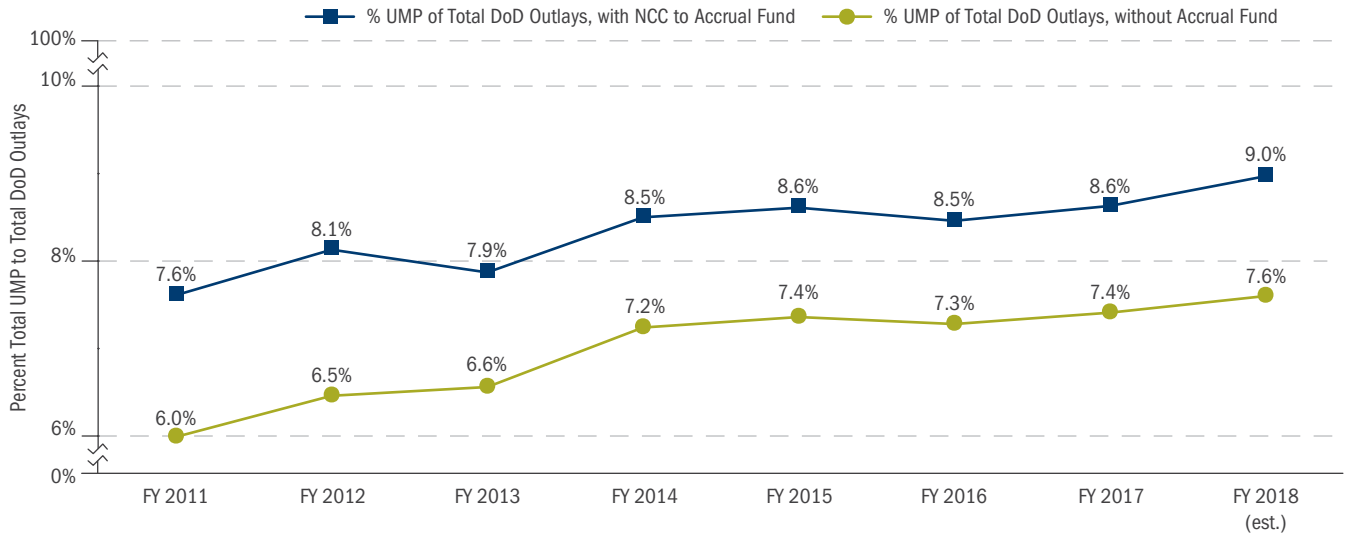
- FYs 2012–2016 reflect Comptroller Information System actual execution.
- Source of data for deflators (MILPERS; DHP; Procurement; Research, Development, Test, and Evaluation [RDT&E]; and MILCON) is Table 5-5, Department of Defense Deflators—TOA, National Defense Budget Estimates for FY 2017 (Green Book).
- FY 2012 includes $1.2 billion OCO supplemental funding for Operations and Maintenance (O&M) and reductions for Department of Defense efficiency initiatives. FY 2012 OCO includes $452 million in private sector, $765 million in direct care.
- FY 2013 includes $966.022 million in OCO supplemental funding for O&M; reflects reductions for sequestration, NDAA sections 3001, 3004, and 8123.
- FY 2014 includes $715.484 million in OCO supplemental funding for O&M, as well as congressional additions and statutory reductions as reflected in Public Law 113-76.
- FY 2015 includes $300.531 million in OCO supplemental funding for O&M, as well as congressional additions and statutory reductions as reflected in Public Law 113-64.
- FY 2016 includes $272.704 million in OCO supplemental funding for O&M, as well as congressional additions and statutory reductions as reflected in Public Law 114-113.
- FY 2017 reflects the amended request of $334.311 million in OCO funding after amended request was not considered.
- FY 2018 reflects the FY 2018 President's Budget, including an OCO request of $395.805 million.

UMP FUNDING *(CONT.)*

UMP Share of Defense Budget

UMP expenditures as a percentage of total DoD expenditures (outlays, which include DoD normal cost contributions to the MERHCF in both the UMP and DoD expenditures) have gradually increased from 7.6 percent in FY 2011 to 9 percent estimated for FY 2018 (with Accrual Fund), or from 6 percent to 7.6 percent (without Accrual Fund).

UMP EXPENDITURES AS A PERCENTAGE OF TOTAL DOD OUTLAYS, FYs 2011–2018 (EST.)

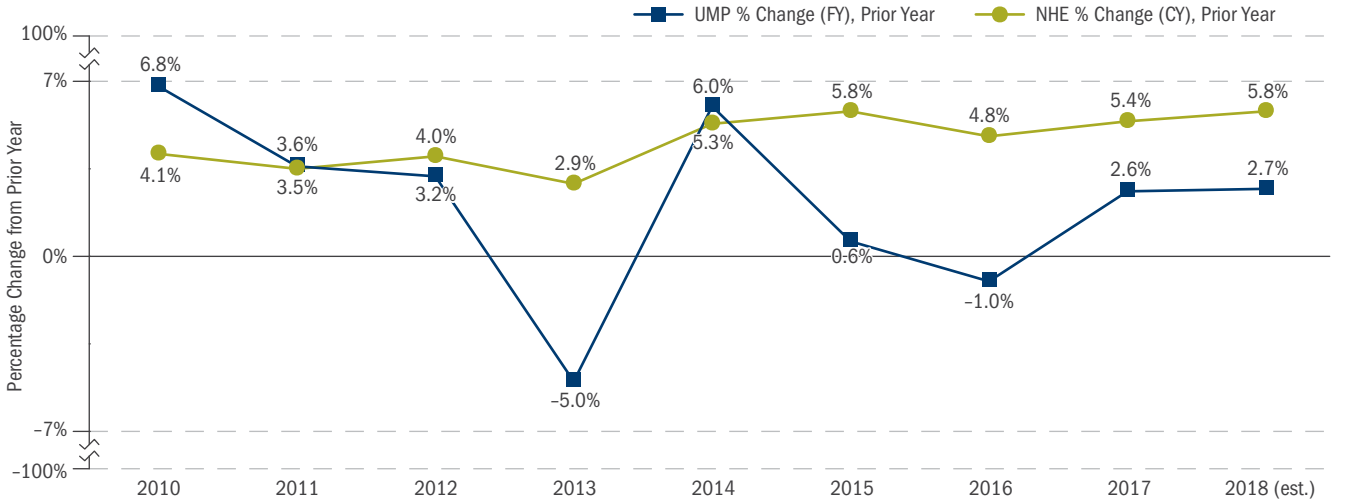


Source: UMP cost and budget estimates, DHA/Resources and Management Directorate (J-1/J-8)/DHP Programming, 11/8/2017
Note: Percentages are estimates of total DoD outlays reflected in the FY 2018 President's Budget.

Comparison of UMP and National Health Expenditures (NHE) Over Time

As shown in the chart below, the annual rate of growth in the UMP (in then-year dollars—including Trust Fund Outlays) has fluctuated from a high of 6.8 percent in FY 2010, to a low of –5 percent in FY 2013, and was below 3 percent the last four fiscal years. In comparison, the Centers for Medicare & Medicaid Services (CMS) estimates that annual percentage changes in NHE have fluctuated by between 3 and 6 percent since calendar year (CY) 2008 (not shown), with expenditures projected to reach an estimated $3.75 trillion in CY 2018 (ref. source notes below).

COMPARISON OF CHANGE IN ANNUAL UMP (FY) AND NHE (CY) ESTIMATED EXPENDITURES OVER TIME, 2010–2018 (EST.)



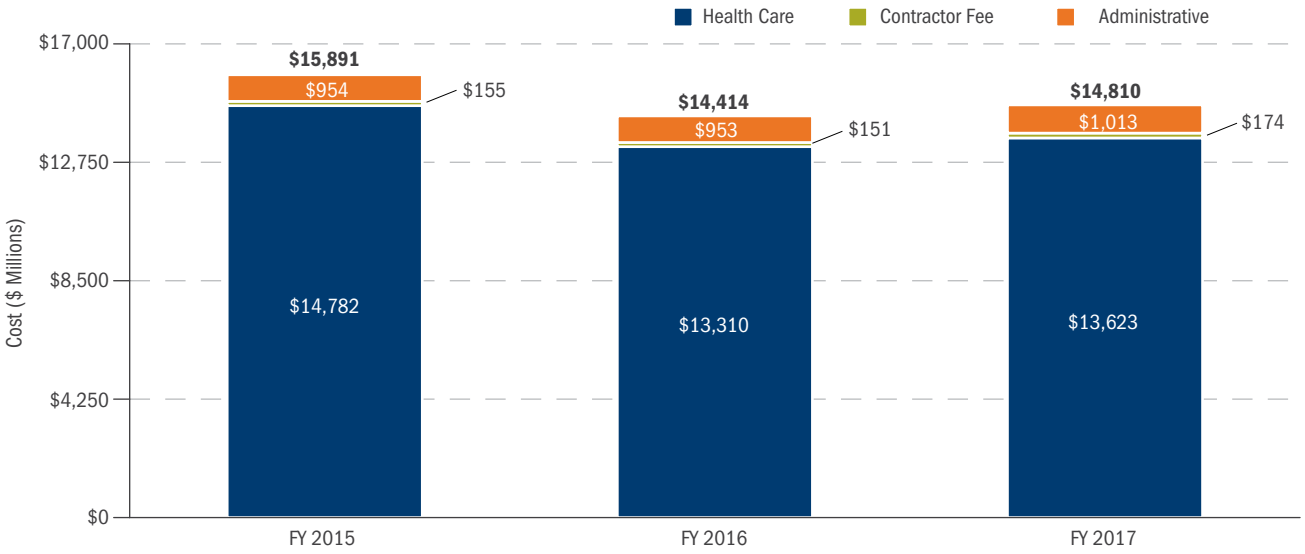
Sources: UMP cost and budget estimates, DHA/Resources and Management Directorate (J-1/J-8)/DHP Programming, 11/8/2017; DHA (J-5)/Decision Support using CMS, Office of the Actuary, Table 2, National Health Expenditure Amounts and Annual Percent Change by Type of Expenditure: Calendar Years 2009–2025. NHE Projections 2016–2025—table modified 2/14/2017, accessed 11/13/2017. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html
Note: CMS data are in calendar years, and DoD's UMP data are in fiscal years.

PRIVATE-SECTOR CARE ADMINISTRATIVE COSTS

The Private-Sector Care Budget Activity Group (PSC BAG) includes underwritten health, pharmacy, Active Duty supplemental, dental, and overseas care; the USFHP; funds received and executed for OCO; and other miscellaneous expenses. It excludes costs for non-DoD beneficiaries and MERHCF expenses. The totals in the chart below differ from the PSC BAG because the former exclude settlements paid for in prior years, undefinitized change-order costs, and certain DoD internal/overhead costs, but include funds authorized and executed under the DHP carry-over authority.[1]

- Total private-sector care costs decreased from $15,891 million in FY 2015 to $14,810 million in FY 2017, but the high cost in FY 2015 was due to runaway compound drug prices, which have subsequently been brought under control. From FY 2016 to FY 2017, total private-sector care costs increased by 3 percent.
- After declining by 10 percent from FY 2015 to FY 2016 (again due to runaway compound drug prices in FY 2015), private-sector health care costs rose by 2 percent in FY 2017.
- After remaining about the same from FY 2015 to FY 2016, administrative costs increased by 6 percent in FY 2017.
- Excluding contractor fees, administrative expenses increased from 6 percent of total private-sector care costs in FY 2015 ($954 million of $15,736 million) to 7 percent in FY 2017 ($1,013 million of $14,636 million). Including contractor fees (in both administrative and total costs), administrative expenses increased from 7 percent of total private-sector care costs in FY 2015 ($1,109 million of $15,891 million) to 8 percent in FY 2017 ($1,187 million of $14,810 million).
- After declining slightly from FY 2015 to FY 2016, contractor fees rose by 15 percent in FY 2017, due in part to an increase in contractor incentive payments for obtaining deeper discounts from hospitals and provider groups.

TRENDS IN PRIVATE-SECTOR CARE COSTS, FYs 2015–2017



Source: DHA/R&M (J-1/J-8)/CRM (Administrative Costs), 11/3/2017

[1] DHA has congressional authority to carry over 1 percent of its O&M funding into the following year. The amount carried forward from the prior-year appropriation was $307 million in FY 2015. There was no funding carried over in FYs 2016 and 2017.

MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE)

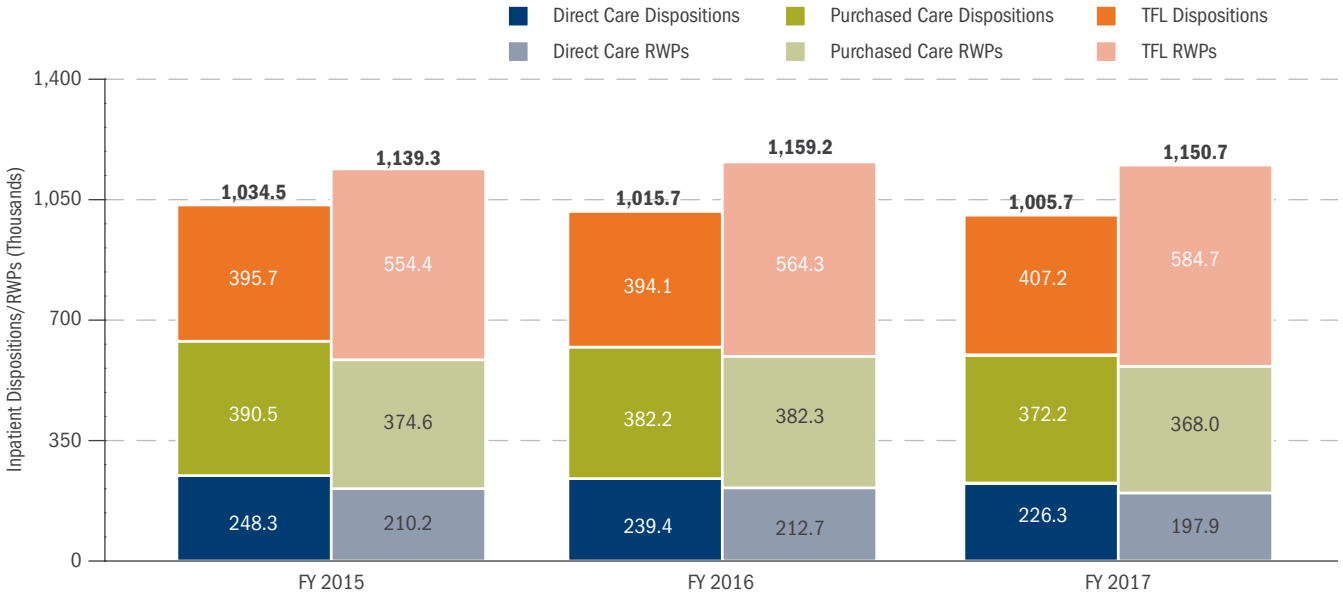
MHS Inpatient Workload

Total MHS inpatient workload is measured two ways: as the number of inpatient dispositions and as the number of relative weighted products (RWPs), excluding observation stays. The latter measure, relevant only for acute care hospitals, reflects the relative resources consumed by a single hospitalization as compared with the average of those consumed by all hospitalizations. It gives greater weight to procedures that are more complex and involve greater lengths of stay.

Total inpatient dispositions (direct and purchased care combined) declined by 6 percent and total RWPs declined by 3 percent between FY 2015 and FY 2017,[1] excluding the effect of TFL.

- Direct care inpatient dispositions decreased by 9 percent and RWPs by 6 percent over the past three years.
- Excluding TFL workload, purchased care inpatient dispositions decreased by 5 percent, while RWPs decreased by 2 percent between FY 2015 and FY 2017.
- Including TFL workload,[2] purchased care dispositions decreased by 1 percent, while RWPs increased by 3 percent between FY 2015 and FY 2017.
- Although not shown, about 7 percent of direct care inpatient workload (dispositions) was performed abroad in FY 2017. Purchased care and TFL inpatient workload performed abroad accounted for about 2 percent of the worldwide total.

TRENDS IN MHS INPATIENT WORKLOAD, FYs 2015–2017



Source: MHS administrative data, 1/22/2018

[1] The DoD's new electronic health record, MHS GENESIS, was deployed at three MTFs in FY 2017: 92nd Medical Group, Fairchild Air Force Base, in February; Naval Hospital Oak Harbor in July; and Naval Hospital Bremerton in September. Any workload performed at those facilities (and at clinics that report data to those facilities) from the deployment dates onward has not yet been captured in the MHS administrative data. However, the effect of the conversion on total MHS inpatient workload in FY 2017 is expected to be very small because the three MHS GENESIS facilities accounted for only 1 percent of the MHS inpatient total in all of FY 2016, and the workload from two of those facilities was missing for only the last three months of FY 2017. If workload from those facilities (plus any other facilities to which MHS GENESIS is deployed in the future) continues to be missing from the MHS administrative data throughout all or most of FY 2018, the future impact could be considerably larger.

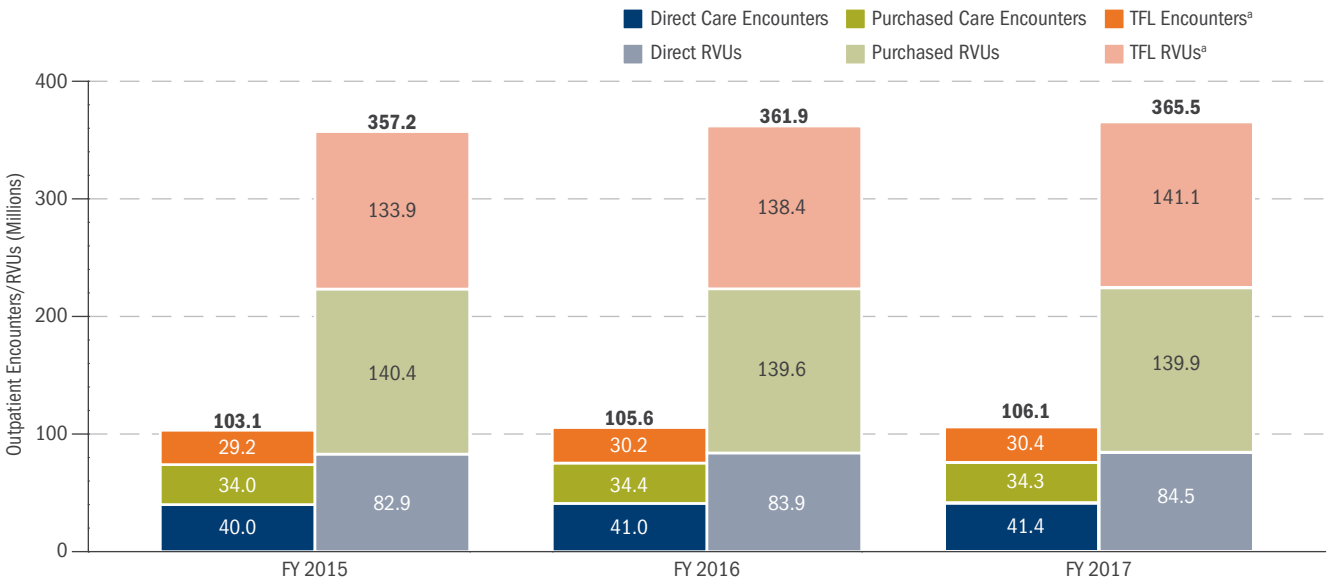
[2] Although TFL claims are not technically MHS workload (i.e., the MHS does not deliver the care, it just acts as second payer to Medicare), it would give an incomplete picture of the services provided by the MHS if they were not considered.

MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE) *(CONT.)*

MHS Outpatient Workload

Total MHS outpatient workload is measured two ways: as the number of encounters (outpatient visits and ambulatory procedures) and as the number of relative value units (RVUs). Because encounters do not appear on purchased care claims, they are calculated using a DHA-developed algorithm.[1] RVUs reflect the relative resources consumed by a single encounter compared with the average of those consumed by all encounters. In FY 2016, some enhancements were made to the RVU measure that resulted in a slightly lower direct care RVU total and a substantially higher purchased care RVU total. The changes were retrofitted to earlier years of data so that RVUs are measured consistently over time. See the appendix for a more detailed description of the RVU measure.

TRENDS IN MHS OUTPATIENT WORKLOAD, FYs 2015–2017



Source: MHS administrative data, 1/22/2018

[a] Purchased care only

- Total outpatient encounters (direct and purchased care combined) increased by 2 percent, while RVUs increased by less than 1 percent between FY 2015 and FY 2017,[2] excluding the effect of TFL.
- Direct care outpatient encounters increased by 4 percent and RVUs by 2 percent over the past three years.
- Excluding TFL workload, purchased care outpatient encounters increased by 1 percent while RVUs remained the same. Including TFL workload, encounters increased by 3 percent and RVUs by 2 percent.
- Although not shown, about 8 percent of direct care outpatient workload (encounters) was performed abroad. Purchased care and TFL outpatient workload performed abroad accounted for less than 1 percent of the worldwide total.

[1] In FY 2017, DHA improved the algorithm used to calculate encounters, resulting in slightly higher totals than shown in previous reports.

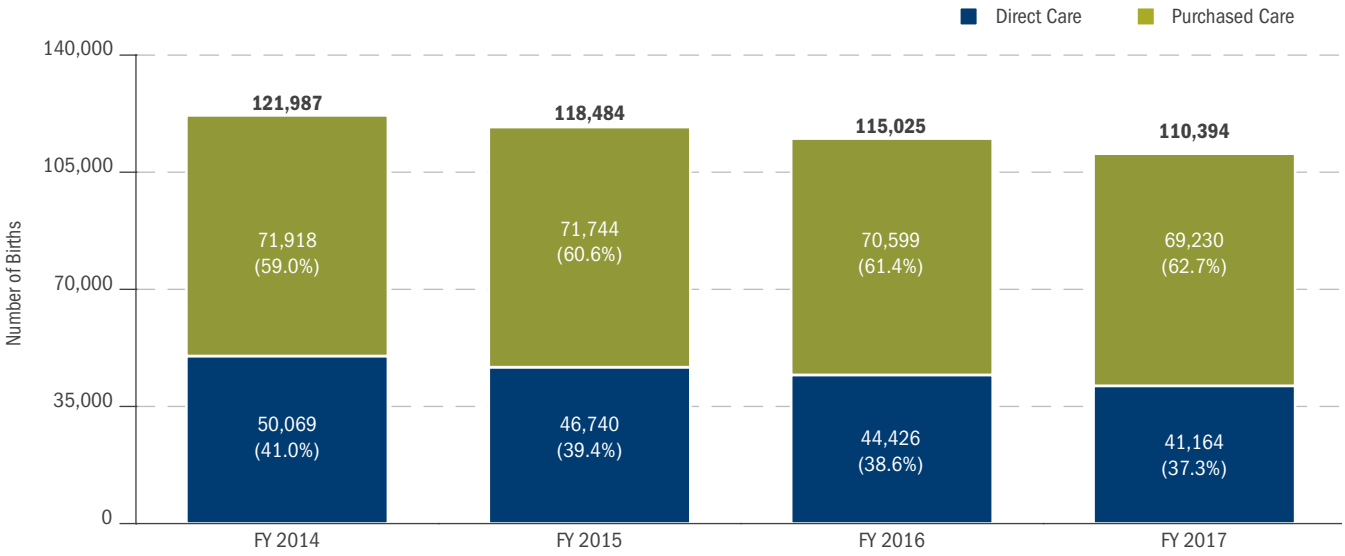
[2] The DoD's new electronic health record, MHS GENESIS, was deployed at three MTFs in FY 2017: 92nd Medical Group, Fairchild Air Force Base, in February; Naval Hospital Oak Harbor in July; and Naval Hospital Bremerton in September. Any workload performed at those facilities (and at clinics that report data to those facilities) from the deployment dates onward has not yet been captured in the MHS administrative data. However, the effect of the conversion on total MHS outpatient workload in FY 2017 is expected to be very small because the three MHS GENESIS facilities accounted for less than 2 percent of the MHS outpatient total in all of FY 2016, and the workload from two of those facilities was missing for only the last three months of FY 2017. If workload from those facilities (plus any other facilities to which MHS GENESIS is deployed in the future) continues to be missing from the MHS administrative data throughout all or most of FY 2018, the future impact could be considerably larger.

MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE) *(CONT.)*

MTF Market Share for Childbirths

A 2011–2012 DHA survey of MTF obstetric (OB) patients measured satisfaction with various aspects of their care. Moderate correlations were found between some survey satisfaction levels and MTF market shares for childbirths (i.e., the percentage of total OB workload [direct plus purchased] performed in direct care facilities). MTF OB market shares in the U.S. ranged from 7 percent to 88 percent. From the chart below, overall MTF OB market share decreased from 41 percent to 37 percent between FY 2014 and FY 2017, but that is likely due to the reduction in Active Duty end-strength and the consequent reduction in the number of ADFMs. There is nothing to suggest that the reduction in MTF market share is a result of declining satisfaction with MTF OB care. On the contrary, the latest results from the TRICARE Inpatient Satisfaction Survey (TRISS) show improving satisfaction with OB care at MTFs (see page 128).

TRENDS IN MTF MARKET SHARE FOR CHILDBIRTHS, FYs 2014–2017



Source: MHS administrative data, 1/22/2018

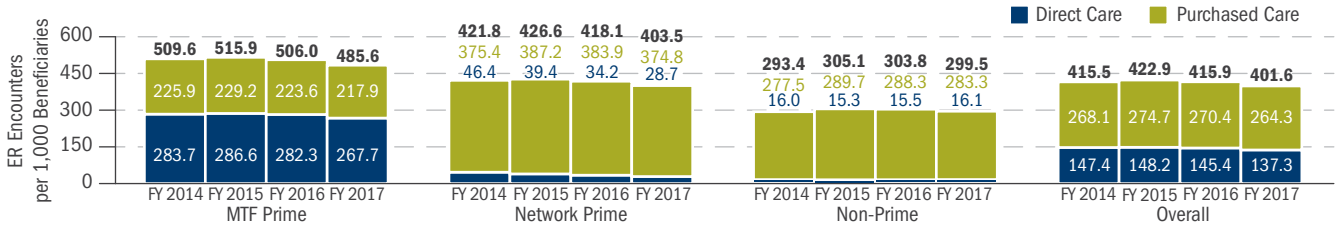
MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE) *(CONT.)*

Emergency Room Utilization

Emergency room (ER) utilization is sometimes used as an indirect measure of access to care, particularly for Prime enrollees. Using data from the National Health Interview Survey, the National Center for Health Statistics reports that almost 80 percent of civilians who use the ER do so because of lack of access to other providers.[1] Although not equivalent, it is reasonable to ask whether a similar situation occurs in the MHS, in particular whether Prime enrollees make excessive use of ERs as a source of care because they cannot get timely access to their PCMs under the normal appointment process. To provide a preliminary evaluation of this issue, direct and purchased care ER utilization rates were compared across three enrollment groups: MTF enrollees, network enrollees, and non-enrollees. The rate for each enrollment group was calculated by dividing ER encounters[2] by the average population in that group. The rates were then adjusted to reflect the age/sex distribution of the overall MHS population. To avoid biasing the comparisons, seniors were excluded from the calculations because they are almost exclusively non-enrollees.

- ER utilization per capita declined for Prime enrollees from FY 2014 to FY 2017 (5 percent for both MTF and network Prime enrollees). The rate for non-Prime enrollees increased by 2 percent over the same time period.
- In FY 2017, MTF Prime enrollees had an ER utilization rate 20 percent higher than that of network Prime enrollees and 62 percent higher than that of non-enrollees. Network Prime enrollees had an ER utilization rate 35 percent higher than that of non-enrollees.
- For MTF Prime enrollees, 45 percent of ER encounters were in purchased care facilities (not necessarily in-network).
- Children under five years old had the highest ER utilization rate for all enrollment groups (not shown).
- The FY 2017 rate of 402 encounters per 1,000 beneficiaries is 9 percent lower than the civilian rate of 444 per 1,000 reported in CY 2014, the most recent year for which data are available.[3]

ER UTILIZATION BY ENROLLMENT STATUS AND SOURCE OF CARE (ENCOUNTERS PER 1,000 BENEFICIARIES), FYs 2014–2017

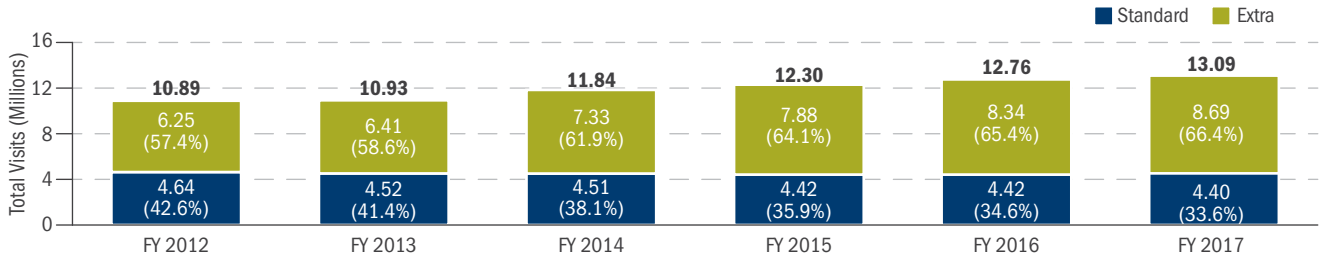


Source: MHS administrative data, 1/22/2018

Extra vs. Standard Non-Prime Visits

For beneficiaries not enrolled in Prime, the ratio of Extra to Standard visits has been steadily increasing. In FY 2008, Extra visits accounted for only 46 percent of all non-Prime visits. By FY 2009, the number of Extra visits exceeded the number of Standard visits for the first time (51 percent). In FY 2017, 66 percent of all non-Prime visits were to Extra providers. One reason for the increasing use of Extra providers is the expansion of the TRICARE provider network (see page 149).

TRENDS IN EXTRA VS. STANDARD VISITS, FYs 2012–2017



Source: MHS administrative data, 1/22/2018

[1] Gindi, R. M., et al., "Emergency Room Use Among Adults Aged 18–64: Early Release of Estimates from the National Health Interview Survey, January–June 2011," National Center for Health Statistics, May 2012, http://www.cdc.gov/nchs/nhis/releases.htm.

[2] ER encounters were calculated using an enhanced methodology in this year's report. This resulted in lower ER counts than shown in previous years' reports.

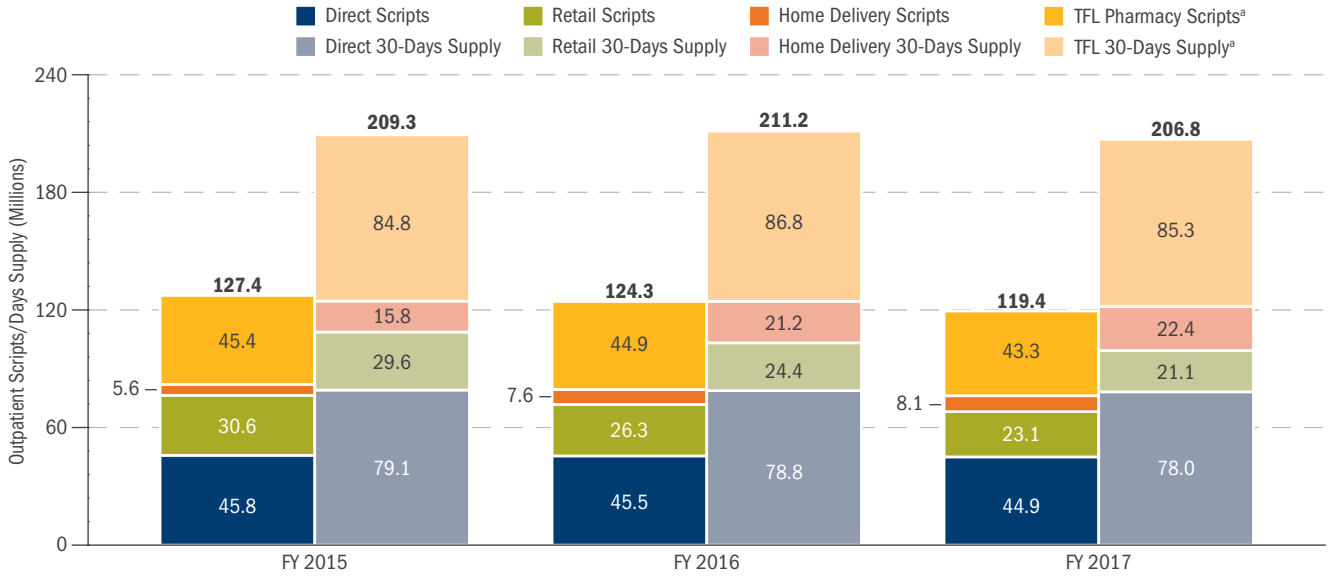
[3] Centers for Disease Control and Prevention (CDC), "National Hospital Ambulatory Medical Care Survey: 2014 Emergency Department Summary Tables," Table 1, https://www.cdc.gov/nchs/data/nhamcs/web_tables/2014_ed_web_tables.pdf. The civilian ER rate reported on this page is somewhat lower than the rate reported by the CDC because we adjust the rate for the age/sex distribution of the military population.

MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE) *(CONT.)*

MHS Prescription Drug Workload

TRICARE beneficiaries can fill prescription medications at MTF pharmacies through home delivery (mail order), at TRICARE retail network pharmacies, and at non-network pharmacies. Total outpatient prescription workload is measured two ways: as the number of prescriptions and as the number of days supply (in 30-day increments). Total prescription drug workload (all sources combined) decreased between FY 2015 and FY 2017 (prescriptions by 7 percent and days supply by 2 percent), excluding the effect of TFL purchased care pharmacy usage.

TRENDS IN MHS PRESCRIPTION WORKLOAD, FYs 2015–2017



Source: MHS administrative data, 1/22/2018

[a] Home delivery workload for TFL-eligible beneficiaries is included in the TFL total.

- Direct care prescriptions decreased by 2 percent and days supply by 1 percent between FY 2015 and FY 2017.
- Purchased care prescriptions (retail and home delivery combined) decreased by 14 percent while days supply decreased by 4 percent from FY 2015 to FY 2017, excluding TFL utilization. Including TFL utilization, purchased care prescriptions decreased by 9 percent and days supply decreased by 1 percent. The discrepancy in trends between purchased care prescription counts and days supply is due to increased beneficiary utilization of home delivery services, which are dispensed for up to a 90-day supply.
- Although not shown, about 6 percent of direct care prescriptions were issued abroad. Purchased care prescriptions issued abroad accounted for 3 percent of the worldwide total.

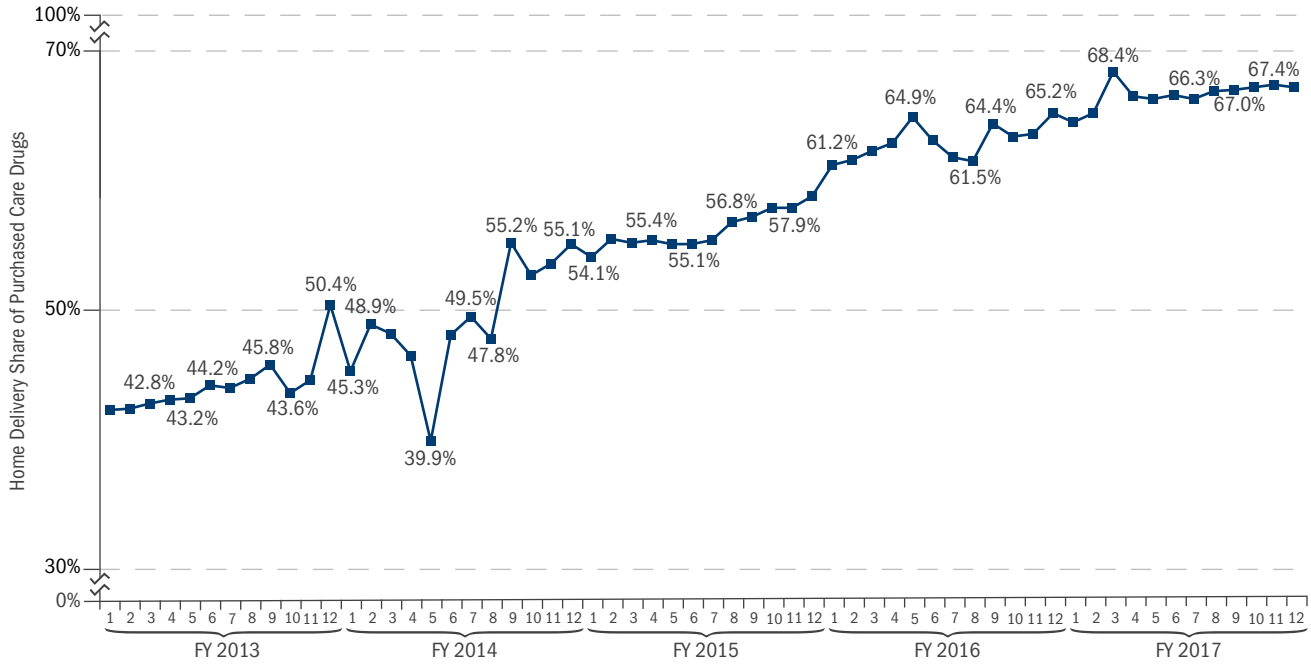
MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE) *(CONT.)*

MHS Prescription Drug Workload *(cont.)*

Home delivery of prescription medications offers benefits to both the DoD and its beneficiaries. The DoD negotiates home delivery prescription prices that are considerably lower than those for retail drugs—$20 for a 90-day home delivery supply versus $24 for a 30-day retail pharmacy supply. In November 2009, the DoD consolidated its pharmacy services under a single contract (called TPharm) and launched an intensive campaign to educate beneficiaries on the benefits of home delivery services. As an additional incentive for beneficiaries to use home delivery services, effective October 1, 2011, TRICARE eliminated home delivery beneficiary copayments for generic drugs while at the same time increasing retail pharmacy copayments. Furthermore, the NDAA for FY 2013 mandated that the DoD implement a five-year pilot program requiring TFL beneficiaries to obtain all refill prescriptions for select non-generic maintenance medications from the TRICARE home delivery program or MTF pharmacies. The pilot program went into effect on February 14, 2014. The NDAA for FY 2015 ended the pilot program on September 30, 2015, and expanded the program to all non-Active Duty beneficiaries beginning October 1, 2015.

The home delivery share of total purchased care utilization has been on the rise since the DoD changed the copayment structure for retail/home delivery drugs at the beginning of FY 2012. Since that time, retail drug copayments have further increased relative to home delivery. As a result, the home delivery share of purchased care pharmacy utilization (as measured by days supply) has increased almost linearly, from 44 percent at the end of FY 2013 to 67 percent at the end of FY 2017.

TREND IN HOME DELIVERY UTILIZATION (DAYS SUPPLY) AS A SHARE OF TOTAL PURCHASED CARE UTILIZATION, FYs 2013–2017[b]



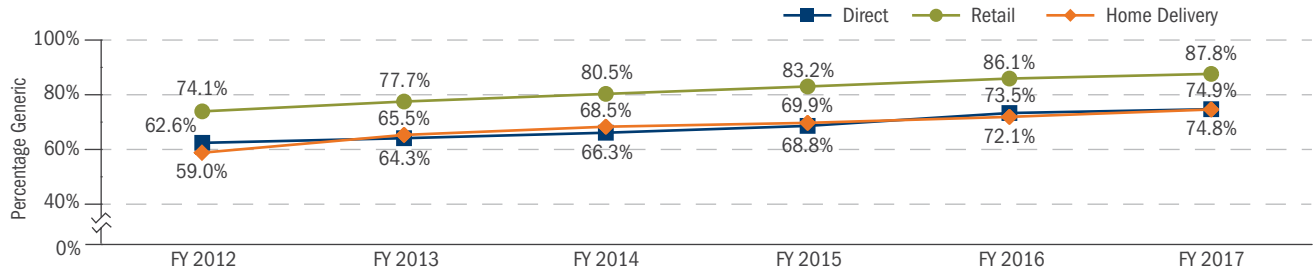
Source: MHS administrative data, 1/22/2018

[b] The large and sudden dip in February 2014 was due to a computer system problem in Express Scripts' auto-refill program, which resulted in a reduced volume of home delivery prescriptions.

COST SAVINGS EFFORTS IN DRUG DISPENSING

- The rate of generic drug dispensing has been increasing for all sources: direct, retail, and home delivery. Home delivery pharmacies have seen the greatest increase, from 59 percent in FY 2012 to 75 percent in FY 2017. However, retail pharmacies dispensed the highest percentage of generic drugs in FY 2017 (88 percent).
- The retail generic drug dispensing rate in FY 2017 was about the same as that of the private sector (89 percent).[1] However, the direct care rate (75 percent) was well below that of the private sector.[2]
- The average cost to the DoD for a 30-day supply of a brand versus generic drug in FY 2017 was $67 versus $15 for direct care, $291 (net of manufacturer refunds) versus $15 for retail pharmacies, and $114 versus $21 for home delivery (costs are not adjusted for differences in drug types between brand and generic). Therefore, all other factors being equal, the trend toward greater generic drug dispensing is likely to lower DoD costs for prescription drugs.

TRENDS IN GENERIC DRUG DISPENSING, FYs 2012–2017

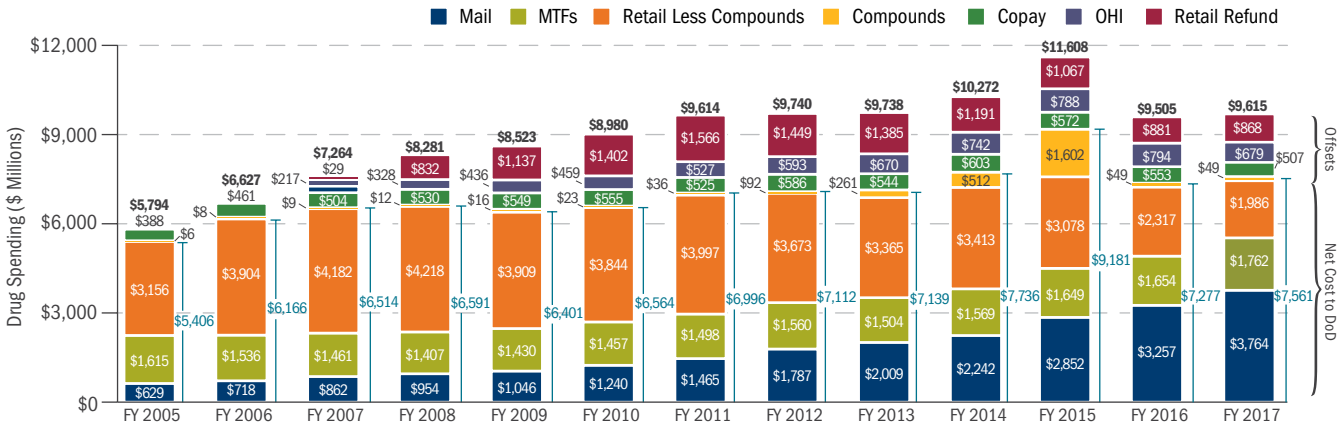


Source: MHS administrative data, 1/22/2018

The NDAA for FY 2008 mandated that the TRICARE retail pharmacy program be treated as an element of the DoD and, as such, be subject to the same pricing standards as other federal agencies. As a result, beginning in FY 2008, drug manufacturers began providing refunds to the DoD on most brand-name retail drugs.

- Although total drug costs have consistently increased over the past decade, retail drug refunds have stemmed the increase in the cost to the DoD. In FY 2017, the refunds are estimated to have saved the DoD $868 million. After rising an average of only 2.7 percent per year from FY 2008 to FY 2014, net DoD costs rose by 19 percent in FY 2015 alone, driven largely by a threefold increase in expenditures for compound drugs. Once the DoD got compound drug prices under control, net DoD costs fell by 21 percent in FY 2016 and then rose by 4 percent in FY 2017, but to a level still 2 percent below that of FY 2014.

MHS OUTPATIENT DRUG SPENDING, FYs 2005–2017



Sources: Pharmacy Data Transaction Service (PDTS) Data Warehouse; DHA Pharmacy Operations Division (refunds) as of 12/6/2017

Notes: Net cost to the DoD represents total prescription expenditures minus copays, coverage by OHI, and retail refunds invoiced. It does not include an MHS-derived dispensing fee as in the charts on pages 40–41. Mail Order dispensing fees are included; however, other retail/mail contract costs and MTF cost of dispensing are not included. Retail refunds are reported on an accrual rather than a cash basis, corresponding to the original prescription claim data and updated refund adjustments. Retail compound spending, broken out separately, is not adjusted for any recoveries or settlements with compound pharmacies outside of claims reversals.

[1] Association for Accessible Medicines, "Generic Drug Access and Savings in the U.S.," 2017, https://accessiblemeds.org/sites/default/files/2017-07/2017-AAM-Access-Savings-Report-2017-web2.pdf.

[2] The direct care generic dispensing rate may be lower than in the private sector because the MHS can frequently buy a branded drug at a lower cost, either under contract or at federal pricing, than the generic drug (this occurs during the 180-day exclusivity period when there is only one generic drug competing against the branded drug). This is not the case for most commercial plans. The MHS is also forbidden by law to purchase generic drugs from countries that do not comply with the requirements established by the Trade Agreements Act.

COST SAVINGS EFFORTS IN DRUG DISPENSING *(CONT.)*

DoD/VA Pharmacy Contracting Initiatives

The Departments continued to maximize efficiencies through joint efforts when possible. National contracts are at an all-time high with 186 existing contracts, of which 58 were new in FY 2016. There are currently 17 joint contracts pending at the National Acquisition Center and 12 pending at the Defense Logistics Agency. The DoD/VA pharmacy team identified 41 commonly used pharmaceutical products and manufacturers for potential joint contracting action and continue to seek new joint contracting opportunities where practicable. In FY 2016, the VA spent $526 million on joint national contracts, and the DoD spent $195 million. Over the same time period, VA joint national contract prime vendor purchases represented 8.86 percent of total prime vendor purchases; DoD purchases represented 4.03 percent, an increase from 3.8 percent over the previous year.

PREVENTING PRESCRIPTION OPIOID ABUSE BY MILITARY SERVICE MEMBERS

Because of increasing abuse of opioids in the civilian sector, Congress, in the NDAA for FY 2017, requested that the Secretary of Defense submit a report on DoD efforts to prevent, educate, and treat prescription opioid drug abuse by military Service members.

Opioids are natural or synthetic chemicals that reduce feelings of pain. Common prescription opioid pain relievers include hydrocodone (e.g., Vicodin), oxycodone (e.g., OxyContin), oxymorphone (e.g., Opana), methadone, and fentanyl. Opioids are generally safe when taken as prescribed for a short time, but regular use can produce dependence, and misuse can lead to fatal overdose. Misuse occurs when opioids are taken in a manner or dose other than prescribed; used by someone other than the prescription holder, even if for a legitimate medical complaint such as pain; or when taken to feel euphoric (i.e., to get high).

Service members have been prescribed pain medication at a significantly increased rate since 2001. One study found that chronic pain and prescription opioid use rates in the military—specifically in Service members returning from Afghanistan—were estimated to be 44 percent and 15 percent, respectively; these percentages are higher than in the general population.

Data suggest that the DoD's extensive efforts in prevention, education, and treatment are countering opioid misuse in Service members. Although Service members are prescribed opioid medications at a higher rate than the general population, prescription drug misuse in the military is low and declining.

In addition, the DoD is continuing efforts to develop more effective means for preventing overdose deaths, including pain management education and training, drug monitoring programs and robust early detection, improved emergency interventions for opiate overdose, and the availability of military crisis and peer support lines—as well as education and guidance for health care providers.

Source: House Report 114–537, Page 174, accompanying H.R. 4909, the National Defense Authorization Act for Fiscal Year 2017, Report on Prescription Opioid Abuse and Effect on Readiness, 10/29/2017

SPECIALTY DRUG COST TRENDS

Specialty drugs are prescription medications that often require special handling, administration, or monitoring. Although the cost of specialty drugs is high, some represent significant advances in therapy and may be offset by decreases in future medical costs.

Although the definition of a specialty drug varies across insurers, the DoD has adopted the following guidelines in order to designate a medication as a specialty drug: (1) the cost is greater than or equal to $500 per dose or greater than or equal to $6,000 per year; (2) it has a difficult or unusual process of delivery; (3) it requires patient management beyond traditional dispensing practices; or (4) as defined by the DoD.

In FY 2017, specialty drugs accounted for approximately 1 percent of total MHS prescription drug utilization (30-day equivalents), but 30 percent of total spending.

By total FY 2017 spending, the top five specialty classes, as defined by the Pharmacy & Therapeutics (P&T) Committee, are oncological agents, targeted immunological biologics (TIBs), multiple sclerosis agents, antiretroviral agents, and pulmonary arterial hypertension agents. The DoD P&T committee continually monitors specialty pharmaceutical utilization.

TOP 20 SPECIALTY CLASSES ($ MILLIONS), AS DEFINED BY P&T COMMITTEE, FYs 2015–2017

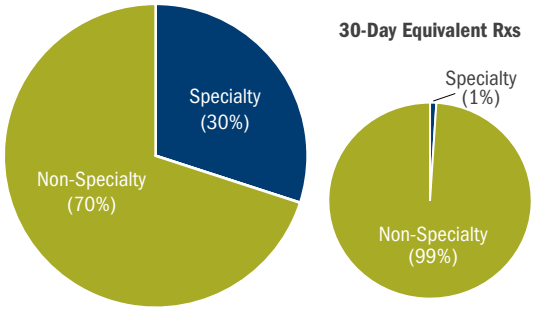
FY 2017 RANK	SPECIALTY CLASS	FY 2015	FY 2016	FY 2017	FYs 2016–2017 % CHANGE[a]
1	ONCOLOGICAL AGENTS	$455	$536	$631	18%
2	TIBs	$296	$308	$349	13%
3	MULTIPLE SCLEROSIS AGENTS	$216	$193	$197	2%
4	ANTIRETROVIRALS	$88	$102	$113	11%
5	PULMONARY ARTERIAL HYPERTENSION	$69	$76	$86	12%
6	ANTIHEMOPHILIC FACTORS	$89	$69	$76	11%
7	PULMONARY-1 AGENTS	$24	$48	$65	36%
8	ENDOCRINE AGENTS MISCELLANEOUS	$53	$58	$62	7%
9	NEUROLOGICAL AGENTS MISCELLANEOUS	$29	$43	$58	35%
10	HEPATITIS C AGENTS	$191	$86	$44	–48%
11	CORTICOSTEROIDS (IMMUNE MODULATORS)	$40	$35	$35	–2%
12	OSTEOPOROSIS AGENTS	$26	$27	$35	30%
13	ATTENTION DEFICIT HYPERACTIVITY DISORDER (WAKEFULNESS PROMOTING AGENTS)	$23	$24	$25	6%
14	GROWTH STIMULATING AGENTS	$29	$26	$25	–4%
15	OPHTHALMIC AGENTS MISCELLANEOUS	$23	$22	$24	8%
16	EXCLUDED FROM THE PHARMACY BENEFIT	$21	$20	$22	7%
17	RESPIRATORY AGENTS MISCELLANEOUS	$17	$20	$21	1%
18	ANTICOAGULANTS	$34	$26	$20	–24%
19	ANTISERA	$18	$17	$19	14%
20	WHITE BLOOD CELL STIMULANTS	$19	$19	$17	–6%

Source: Pharmacy Data Transaction Service (PDTS) Data Warehouse, 12/11/2017
Note: FY 2016 Q4 Specialty Agent Reporting List applied to all data; total costs adjusted for retail refunds (FY 2016 Q3 refund per unit applied to FY 2016 Q4 data), MTF PV cost per unit, Mail PV cost per unit.
[a] The percentage changes are based on the original unrounded numbers.

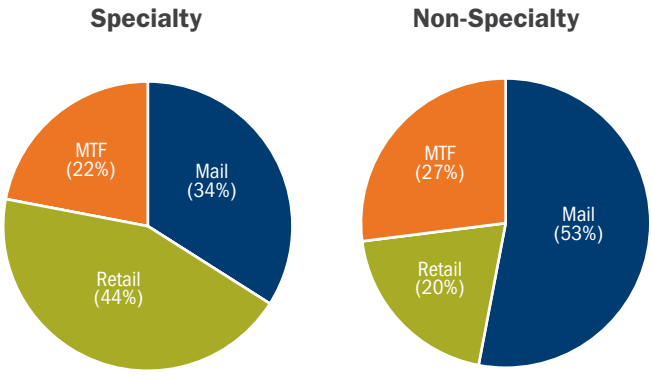
SPECIALTY DRUG COST TRENDS *(CONT.)*

MHS SPENDING: SPECIALTY VS. NON-SPECIALTY DRUG SPENDING (EXCLUDING COMPOUNDS, OHI, PAPER CLAIMS)

FY 2017 TOTAL SPENDING



FY 2017 TOTAL SPENDING BY POINT OF SERVICE



Source: Pharmacy Data Transaction Service (PDTS) Data Warehouse, 12/11/2017

TOTAL ESTIMATED SPENDING ($ MILLIONS) BY QUARTER, FYs 2014–2017

	FY 2014				FY 2015				FY 2016				FY 2017			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Non-Specialty	$1,335	$1,335	$1,399	$1,364	$1,368	$1,430	$1,355	$1,350	$1,262	$1,319	$1,110	$1,156	$1,213	$1,312	$1,305	$1,198
Specialty	$332	$372	$413	$425	$465	$488	$482	$491	$470	$494	$484	$490	$489	$547	$554	$561
Percentage Specialty[a]	19.9%	21.8%	22.8%	23.8%	25.4%	25.4%	26.2%	26.7%	27.1%	27.2%	30.4%	29.8%	28.7%	29.4%	29.8%	31.9%

Source: As of 12/11/2017; FYs 2013 and 2014 based on FY 2014 Q4 Specialty Agent Reporting List; FY 2015 on FY 2015 Q4 list; FY 2016 on FY 2016 Q4 list; totals adjusted for retail refunds (FY 2016 Q3 refund per unit applied to FY 2016 Q4 data), copays, and against PV cost per unit for MTF and mail

[a] "Percentage Specialty" excludes compounds, paper claims, and OHI.

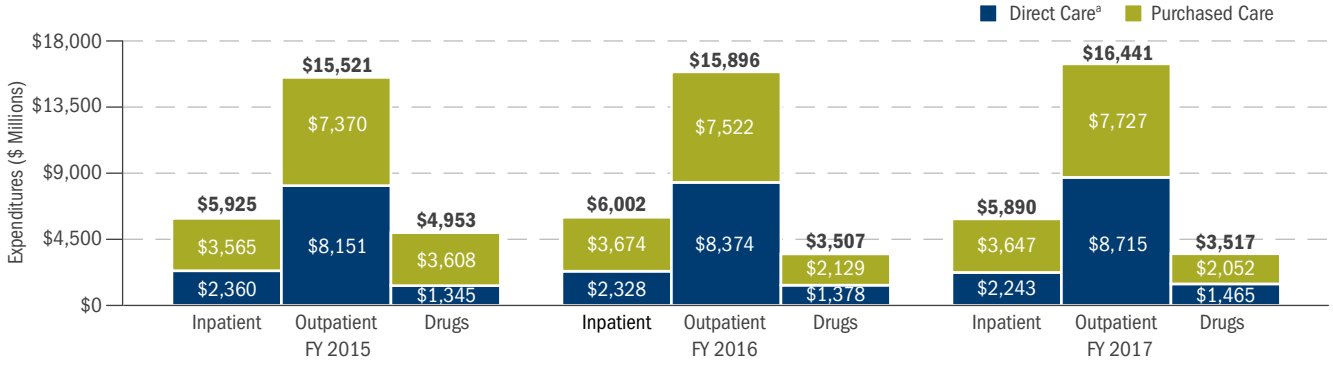
- Specialty spending continues to increase as a percentage of total drug expenditure, while accounting for a very small amount of total use. In FY 2017, specialty drugs accounted for 30 percent of total pharmacy spend, but only about 1 percent of total utilization (by 30-day equivalent prescriptions), a substantial increase compared to five years ago (the percentage was about 19 percent in FY 2013).
- Specialty spending also continues to increase in terms of total expenditures, with an 11 percent increase for FY 2017 versus FY 2016. By comparison, total spending for non-specialty agents increased by only about 4 percent in FY 2017. Much of the increase in specialty spend for FY 2017 comes from two classes: oncological agents and TIBs. Compared with FY 2016, total FY 2017 spending for oncological agents increased by 18 percent and for TIBs by 13 percent. Both classes are marked by rapid introduction of new agents and new mechanisms of action, expanding indications for established agents, and overall high unit costs.
- As a potential cost-saving effort, the Services are able to leverage DHA-generated reports to identify and recapture high-cost specialty medications from retail and benefit from more advantageous pharmaceutical pricing at MTFs.
- The DoD P&T Committee considers the clinical- and cost-effectiveness of reviewed specialty agents with the end goal of selecting safe, efficacious, and cost-effective treatments for beneficiaries.

MHS COST TRENDS

Net of MERHCF costs, total DoD expenditures for health care decreased by 2 percent between FY 2015 and FY 2017. Inpatient expenses decreased by 1 percent, outpatient expenses increased by 6 percent, and prescription drug expenses decreased by 29 percent. The latter decline is largely an anomaly because many compound drug claims in FY 2015 were found to be fraudulent, thereby driving up total prescription drug costs in that year and making subsequent year expenses appear to be dramatically lower.

- The share of DoD expenditures for outpatient care relative to total expenditures for inpatient and outpatient care increased from 72 percent in FY 2015 to 74 percent in FY 2017. For example, in FY 2017, DoD expenses for inpatient and outpatient care totaled $22,331 million, of which $16,441 million were for outpatient care, for a ratio of $16,441/$22,331 = 74 percent.
- In addition to the compound drug anomaly noted above, the 2015 NDAA required beneficiaries to move selected maintenance medication refills out of retail to either home delivery or MTF pharmacies. This helped to further reduce prescription drug costs. Purchased care drug costs shown below have been reduced by manufacturer refunds for retail name brand drugs accrued to the years in which the drugs were dispensed.
- In FY 2017, the DoD spent $2.79 on outpatient care for every $1 spent on inpatient care.

TRENDS IN DoD EXPENDITURES FOR HEALTH CARE (EXCLUDING MERHCF), FYs 2015–2017



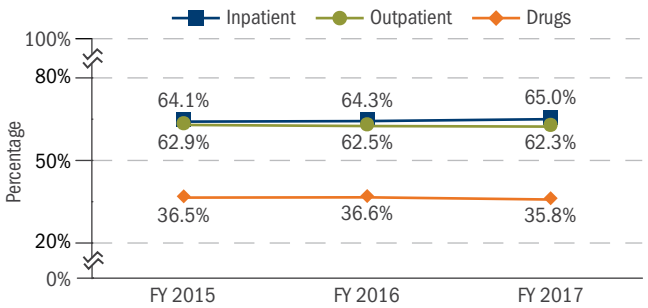
Source: MHS administrative data, 1/22/2018

[a] Direct care prescription costs include an MHS-derived dispensing fee.

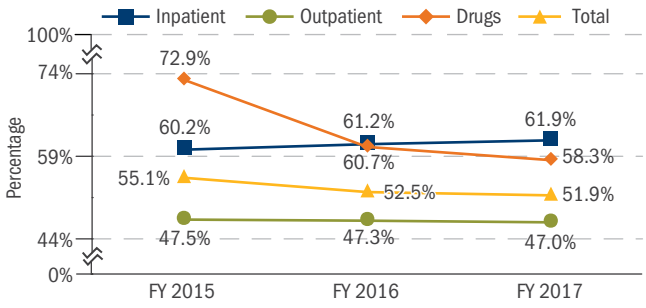
Note: Numbers may not sum to bar totals due to rounding.

- The purchased care share of total inpatient utilization increased slightly from FY 2015 to FY 2017 while the purchased care share of total outpatient and prescription drug utilization each dropped slightly over the same time period.
- The purchased care share of total MHS costs dropped by 3 percentage points between FY 2015 and FY 2017. The purchased care share of total drug costs dropped by 15 percentage points (note again the compound drug anomaly in FY 2015), the purchased care share of total inpatient costs increased by almost two percentage points, and the share of total outpatient costs dropped by less than one percentage point.

TRENDS IN PURCHASED CARE UTILIZATION[a] AS PERCENTAGE OF MHS TOTAL BY TYPE OF SERVICE, FYs 2015–2017



TRENDS IN PURCHASED CARE COST AS PERCENTAGE OF MHS TOTAL BY TYPE OF SERVICE, FYs 2015–2017



Source: MHS administrative data, 1/22/2018

[a] Utilization is measured as RWPs for inpatient care (acute care hospitals only), RVUs for outpatient care, and days supply for prescription drugs. Purchased care drugs include both retail and home delivery.

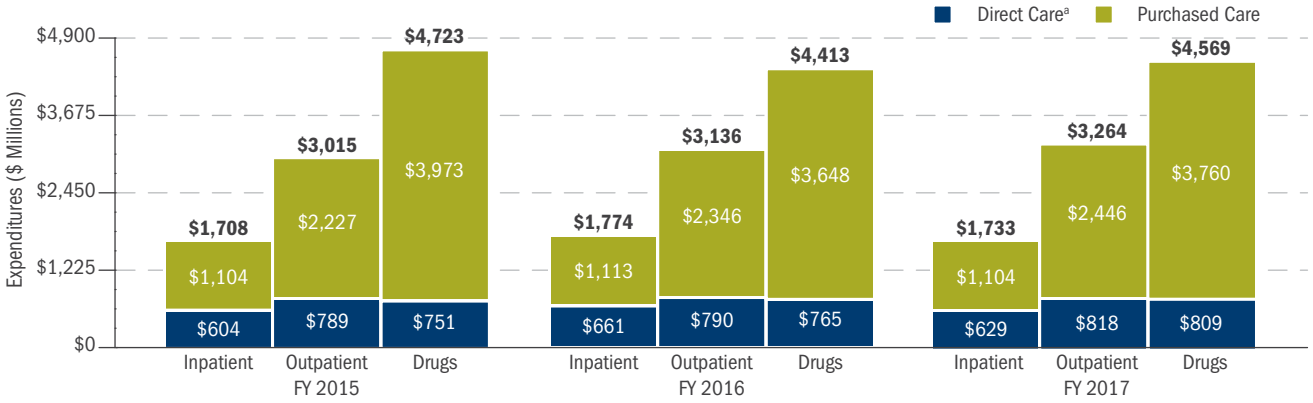
MHS COST TRENDS *(CONT.)*

MERHCF Expenditures for Medicare-Eligible Beneficiaries

The MERHCF covers Medicare-eligible retirees, retiree family members, and survivors only, regardless of age or Part B enrollment status. The MERHCF is not identical to TFL, which covers Medicare-eligible non-Active Duty beneficiaries enrolled in Part B. For example, the MERHCF covers MTF care and USFHP costs, whereas TFL does not. Total MERHCF expenditures fell from $9,447 million in FY 2015 to $9,323 in FY 2016[1] (1 percent) but climbed to $9,566 in FY 2017, including manufacturer refunds on retail prescription drugs. The percentage of TFL-eligible beneficiaries who filed at least one claim remained at about 83 percent.

- Total DoD direct care expenses for MERHCF-eligible beneficiaries increased by 5 percent from FY 2015 to FY 2017. Inpatient and outpatient costs each grew by 4 percent, while prescription drug costs increased by 8 percent.
- From FY 2015 to FY 2017, TRICARE Plus enrollees accounted for 73 percent of DoD direct care inpatient and outpatient expenditures on behalf of MERHCF-eligible beneficiaries.
- Including prescription drugs, TRICARE Plus enrollees accounted for 59 percent of total DoD direct care expenditures on behalf of MERHCF-eligible beneficiaries from FY 2015 to FY 2017.
- Total purchased care MERHCF expenditures remained about the same from FY 2015 to FY 2017. Inpatient expenditures remained the same, outpatient expenditures increased by 10 percent, and prescription drug expenditures declined by 5 percent.[1]

MERHCF EXPENDITURES BY TYPE OF SERVICE, FYs 2015–2017



Source: MHS administrative data, 1/22/2018

[a] Direct care prescription costs include an MHS-derived dispensing fee.

[1] The decline from FY 2015 to FY 2016 is an anomaly because many compound drug claims in FY 2015 were found to be fraudulent, thereby driving up total prescription drug costs. The issue was corrected in late FY 2015.

MEDICAL READINESS OF THE FORCE

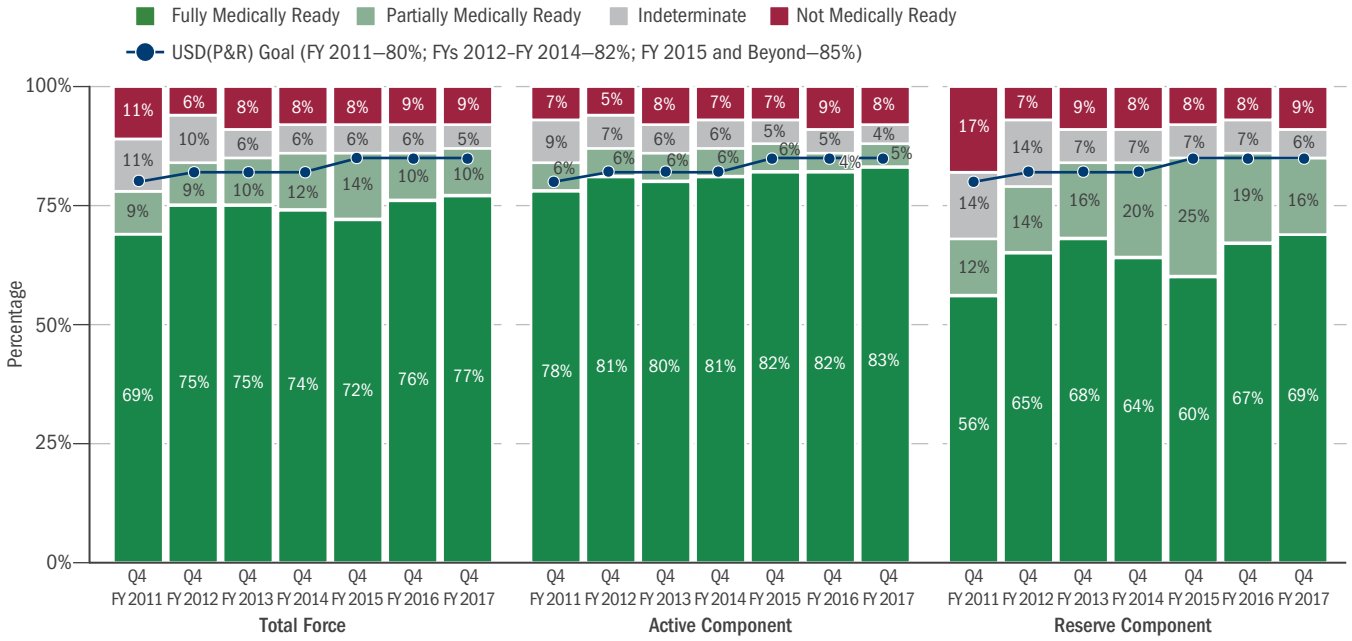
The Department of Defense (DoD) Individual Medical Readiness (IMR) program assesses the medical readiness of an individual Service member or larger cohort (e.g., unit or Service component) against established readiness requirements and metrics of key elements to determine medical deployability in support of military operations. The DoD began tracking IMR status in 2003 to help ensure that Service members, both Active Component (AC) and Reserve Component (RC), were medically ready to deploy when required. The six requirements tracked per DoD Instruction 6025.19 "Individual Medical Readiness (IMR)" include: Satisfactory Dental Health, Completion of Periodic Health Assessments, Free of Deployment-Limiting Medical Conditions, Current Immunization Status, Completion of Required Medical Readiness Laboratory Tests, and Possession of Required Individual Medical Equipment.

The IMR chart below shows that by the end of fiscal year (FY) 2017, the Total Force medical readiness, at 87 percent, surpassed the Under Secretary of Defense for Personnel and Readiness (USD[P&R]) goal of 85 percent, with the AC at 88 percent, and the RC at 85 percent (these percentages are shown as the sum of the percentages in the dark and light green sections). The overall medical readiness of the Total Force since FY 2011 has increased by nine percentage points (from 78 percent in FY 2011 to 87 percent in FY 2017), and, separately, the AC has increased by four percentage points (from 84 percent to 88 percent), and the RC by 17 percentage points (from 68 percent to 85 percent).

As Total Force medical readiness has improved, the USD(P&R) medical readiness goal has increased, from 80 percent in FY 2011, to 82 percent from FY 2012 to FY 2014, to 85 percent in FY 2015 to present. The Total Force and, separately, the AC and RC have met the higher USD(P&R) goal since it was last increased in FY 2015. Increasing the medical readiness goal above 85 percent is currently under consideration by USD(P&R).

The IMR status is a component of the Military Health System (MHS) Partnership for Improvement (P4I) dashboard and is monitored by the Surgeons General and the Office of the Assistant Secretary of Defense (Health Affairs), in the Quarterly Metrics Review and Analysis Forum.

OVERALL INDIVIDUAL MEDICAL READINESS STATUS (ALL COMPONENTS NOT DEPLOYED), FY 2011 Q4 TO FY 2017 Q4



Source: Defense Health Agency (DHA), Healthcare Operations Directorate, Public Health Division, 10/26/2017
Note: Percentages may not sum to 100 percent due to rounding.

HEALTHY, FIT, AND PROTECTED FORCE

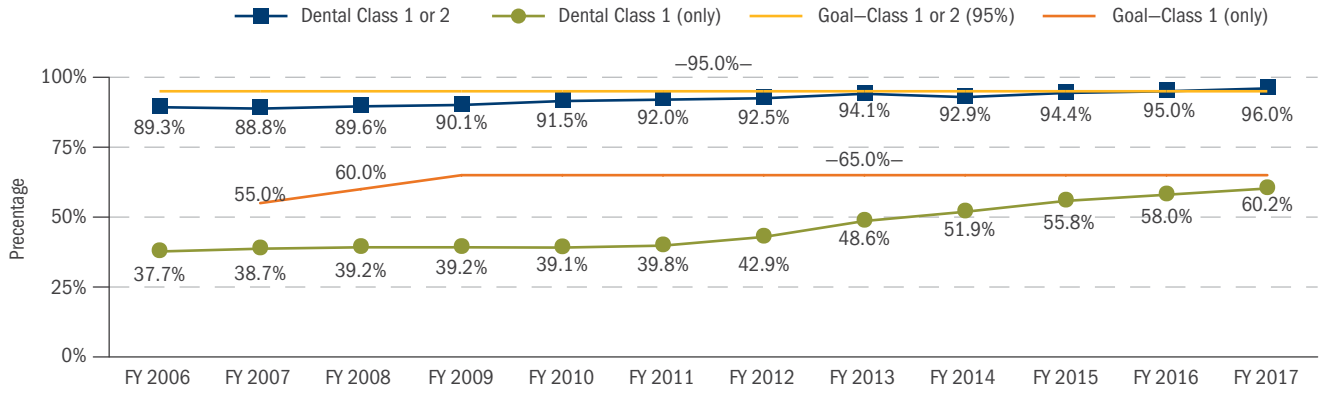
Key among the measures of performance related to providing an efficient and effective deployable medical capability and offering force medical readiness are those related to how well we (1) maintain the worldwide deployment capability of our Service members, as in dental readiness and immunization rates presented below; and (2) measure the success of benefits programs designed to support the RC forces and their families, such as TRICARE Retired Reserve (TRR) and TRICARE Reserve Select (TRS), presented in the Better Care section.

DENTAL READINESS

The MHS Dental Corps Chiefs established in 1996 the goal of maintaining at least 95 percent of all Active Duty personnel in Dental Class 1 or 2. Patients in Dental Class 1 or 2 have a current dental examination, and do not require dental treatment (Class 1), or require non-urgent dental treatment, or re-evaluation for oral conditions that are unlikely to result in dental emergencies within 12 months (Class 2—see note below chart). This goal also provides a measure of Active Duty access to necessary dental services.

- Overall MHS dental readiness in the combined Classes 1 and 2 remains high. Following a generally steady annual increase since FY 2007, the combined Classes 1 and 2 percentage rose again in FY 2017 to 96 percent, up from 95 percent in FY 2016, exceeding the long-standing MHS goal of 95 percent.
- The rate for Active Duty personnel in Dental Class 1 has risen steadily since 2010 (39.1 percent), most recently increasing from 58 percent in FY 2016 to 60 percent in FY 2017—or five percentage points short of the MHS goal of 65 percent. The MHS goal of 65 percent was increased in FY 2009 from the 55 percent goal established in FY 2007.

ACTIVE DUTY DENTAL READINESS: PERCENT CLASS 1 OR 2, FYs 2006–2017



Source: The Services' Dental Corps–DoD Dental Readiness Classifications, 10/30/2017

Definitions:

– Dental Class 1 (Dental Health or Wellness): Patients with a current dental examination who do not require dental treatment or re-evaluation. Class 1 patients are worldwide deployable.

– Dental Class 2: Patients with a current dental examination who require non-urgent dental treatment or re-evaluation for oral conditions that are unlikely to result in dental emergencies within 12 months. Patients in Dental Class 2 are worldwide deployable.

MAINTENANCE OF EXPEDITIONARY CURRENCY AND COMPETENCY: THE CLINICAL READINESS PROJECT

The primary responsibility of the military expeditionary surgeon is to provide life-saving and limb-preserving surgical care at the leading edge of the surgical continuum of care. The goal of this care is to optimize the potential for favorable outcomes as patients move along the evacuation chain from point of injury to rehabilitation. The wars in Afghanistan and Iraq became the imperative for combat surgeon preparation and the engine of sustainment, but as major kinetic operations have decreased, the surgical services of the MHS are approaching an interwar period. During this period of reduced need for combat surgical care, the retention of the hard-won combat casualty care skill set (knowledge, skills, and abilities [KSAs]) has become more difficult to sustain, as shown in the graph on the following page. **The current approach to training, refinement, and retention of expeditionary surgeon clinical readiness does not optimally ensure maintenance of critical wartime combat casualty care skills across the MHS.** Further exacerbating the problem is that elective surgical practice is increasingly focused on minimally invasive laparoscopic, endoscopic, or endovascular techniques and surgical subspecialty care. This problem has been recognized in current and past analysis as well as published literature (see table on the following page).

Maintenance of a clinical readiness skill set requires both currency and competency in the expeditionary environment and surgical practice at home in support of direct beneficiary care. The components of competency are well defined and focus on knowledge, technical skill, judgment (grounded in both knowledge and proficiency), and professionalism. Several efforts have been made to address this shortfall and elements of these competencies with some success; however, a data-driven comprehensive approach for the entire MHS has yet to be realized. To build on these initial efforts, the surgical community has developed a program that addresses currency and competency for the expeditionary general surgeon using a scalable methodology that provides a baseline of surgeon interoperability for all Services and mission sets. This approach uses the knowledge gained over the past decade of conflict (clinical practice guidelines, relevant published literature, and expeditionary case logs) to produce a program to quantify and measure the perpetual currency and competency of the expeditionary general surgeon by focusing on four elements:

1. Periodic assessment of knowledge and abilities aligned with a relevant curriculum
2. Pre-deployment assessment of procedural skills
3. Appropriate remediation, when necessary, focused on areas of need by the above assessments
4. Development of a measurable “readiness” value of pre-deployment practice

This approach addresses all of the key elements of currency and competency: cognitive knowledge by providing a curriculum and assessing retention; judgment through that base of knowledge; professionalism by defining a distinct program for military surgeons linked to the Joint Trauma System/DoD Trauma Enterprise; direct assessment of key surgical skills needed in the expeditionary environment; currency via a system that allows for periodic updates as new practices evolve; and a quantifiable measure of the readiness contribution of surgical practice in direct beneficiary care. This program provides an evidence-based methodology that can be applied to assurance of baseline currency and competency of the entire expeditionary and combat casualty care team. This also informs sustainment of currency and competency through direct practice by prioritization of high readiness-value beneficiary care that may be augmented by partnerships with civilian health systems. This underpins a strategy for assurance of combat casualty care team readiness by guiding difficult decisions in an increasingly resource-constrained MHS.

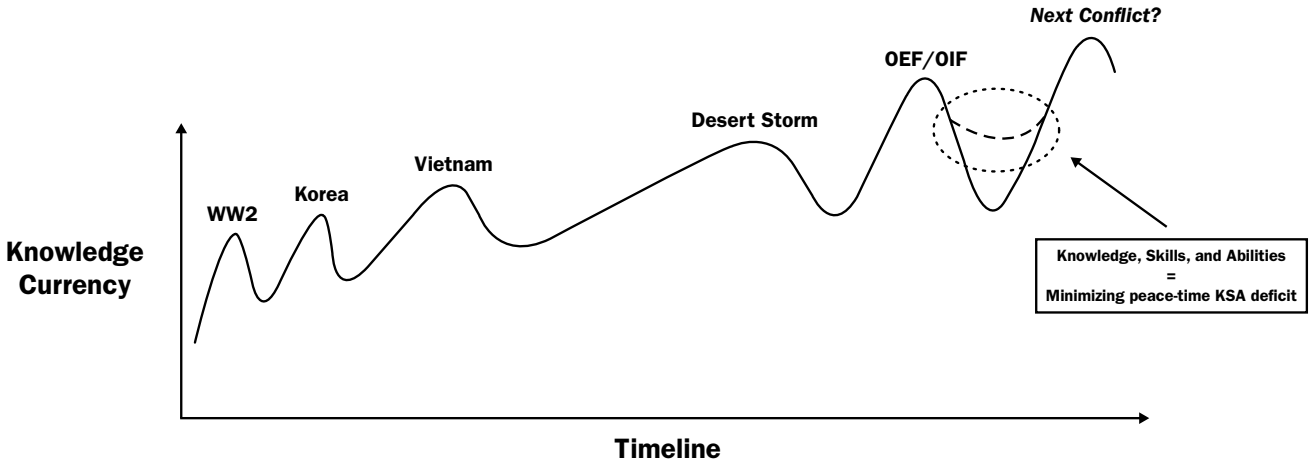
This process developed for the military’s general surgery community has been expanded to the rest of the combat casualty care team (orthopedic surgery, anesthesia, critical care, and emergency medicine) and a proof of concept is underway to assess the tools and concepts for using KSAs at the treatment-facility level to manage clinical readiness.

Sources:

– Rehrig, et al. Critical Wartime Surgical Skills Retention in the U.S. Military Health Care System, 9/6/2013
– Edwards M.J., Edwards K.D., White C, Shepps C, Shackelford S. Saving the Military Surgeon: Maintaining Critical Clinical Skills in a Changing Military and Medical Environment. *Journal of the American College of Surgeons* 2016, 222(6), 1258–64.
– Schwab C.W. Winds of War: Enhancing Civilian and Military Partnerships to Assure Readiness: White Paper. *Journal of the American College of Surgeons* 2015, 221(2), 235–54. doi: 10.1016/j.jamcollsur, 4/14/2015.
– Antevil J.L. et al. A New Reality: Critical Skills Retention and Readiness for Military Trauma Surgery. *International Review of the Armed Forces Medical Services* 2016, 89(1), 53–63.

MAINTENANCE OF EXPEDITIONARY CURRENCY AND COMPETENCY: THE CLINICAL READINESS PROJECT *(CONT.)*

EVOLUTION OF KNOWLEDGE SKILL CURRENCY ACROSS CONFLICTS



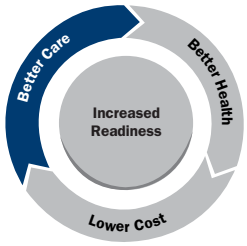
SHORTFALLS IN CURRENT KNOWLEDGE AND SKILLS MAINTENANCE

REPORT	SHORTFALL	REFERENCE
National Academies of Sciences, Engineering, and Medicine Zero Preventable Deaths	Inconsistent in the deployment of true trauma expertise.	Section S-3
	No core set of standards for the acquisition and maintenance of trauma care skills.	Section 5-2
	Several military and civilian courses are available for development and maintenance of combat casualty care skills. However, course attendance requirements, and in some cases content, are variable.	Section 5-21
	To eliminate preventable mortality and morbidity at the start of and throughout future conflicts, comprehensive trauma training, education, and sustainment programs throughout the DoD are needed for battlefield critical physicians, nurses, medics, administrators, and other allied health professionals who comprise military trauma teams.	Section 5-26 (Recommendation)
Bureau of Medicine and Surgery SSG Critical Skills Sustainment	*We recognize, however, the discordance between the skills we train for in peacetime against the requirement in war.*	Page i
	Identifying approaches to remain proficient in critical skills is a challenge for Navy medicine.	Page iii
U.S. Army Medical Command Operation Order 17-17	Pre-deployment training surveys, observations, insights, and lessons (OIL) indicate that clinical-specific pre-deployment training provided to deploying personnel does not consistently and/or adequately prepare individuals to quickly assume their medical duties while deployed.	Page 1
DoD Trauma Enterprise CBA	Currently there is no standard surgical preparation for military surgeons being deployed.	American College of Surgeons, "Military Health System Partnership Prioritizes Surgeon Readiness and Trauma Systems"
	No standard exists for clinical currency.	Defense Health Care Reform, Government Accountability Office (GAO), September 2016

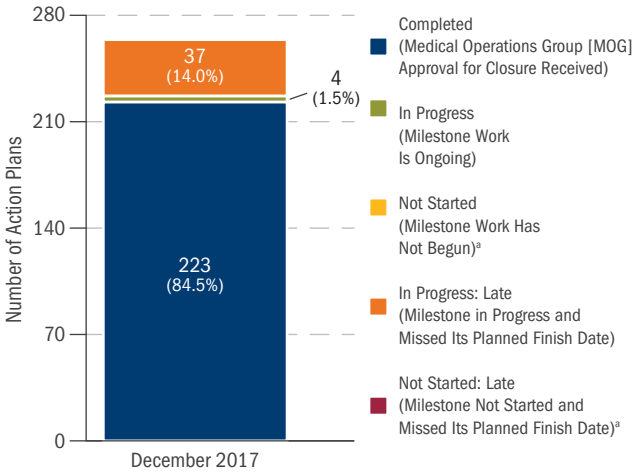
BETTER CARE: ACCESS, QUALITY, SAFETY, AND PATIENT ENGAGEMENT

MHS Review

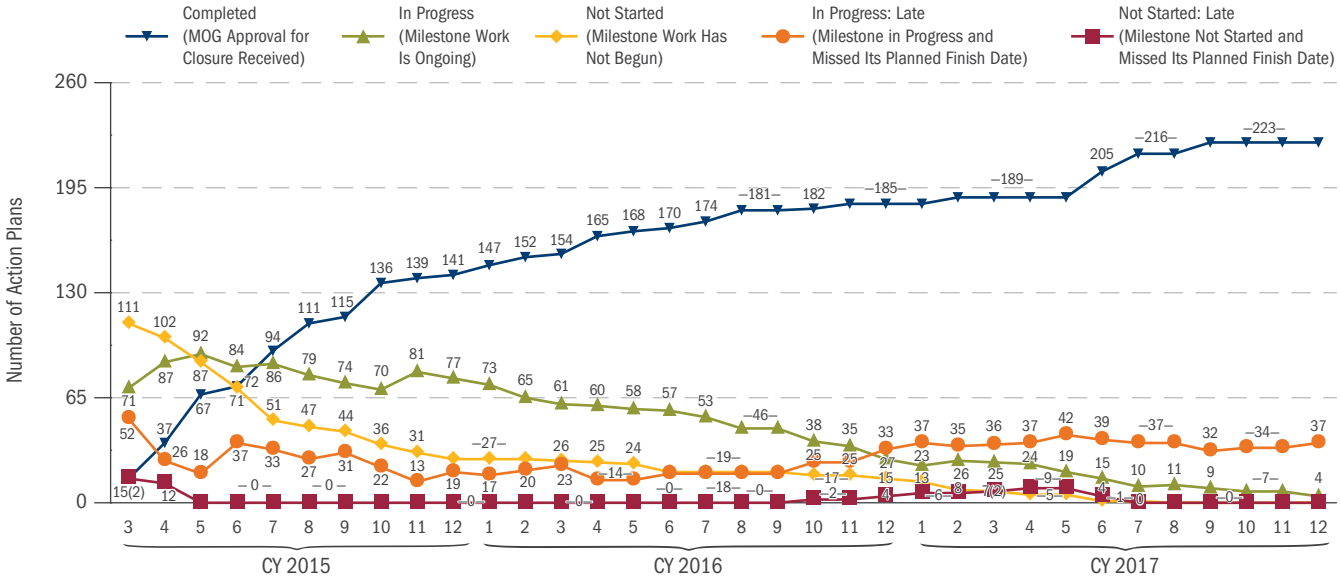
The Secretary of Defense (SECDEF) directed a comprehensive review of the Military Health System (MHS) in 2014. Based on the six overarching recommendations of this review, the SECDEF directed the MHS, in an October 2014 memo, to address compliance with access to care standards, performance monitoring and improvement for quality and patient safety, transparency of MHS data through public reporting, and a means to engage patients for input on health care service delivery. In addition, the SECDEF directed the MHS to establish a plan to become a High Reliability Organization (HRO). Per the *Evaluation of the TRICARE Program: FY 2017 Report to Congress*, which includes individual component reports, the MHS met these directives through establishment of a performance management system, known as the Partnership for Improvement (P4I); public reporting of MHS direct care data at www.health.mil; and through some of the requirements coincidentally mandated by the fiscal year (FY) 2016 and FY 2017 National Defense Authorization Acts. To fully address all the recommendations from the MHS review, 41 action plans were developed for a comprehensive approach (as noted on page 35 of last year's report). To date, 27 of these 41 action plans have been closed, several are near closure, and the remainder are being reassessed for feasibility for closure in the near term, while strategies for project or program management are developed for the long term. As action plans close, capstone summaries are actively being developed to ensure the original intent of recommendations in the MHS review were indeed met or are documented in handoff to appropriate work groups under the MHS HRO Operating Model.



CURRENT MILESTONE STATUSES, DECEMBER 2017



MILESTONE STATUS TREND, CYs 2015–2017



[a] Zero action plans

For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

BETTER CARE: ACCESS, QUALITY, SAFETY, AND PATIENT ENGAGEMENT *(CONT.)*

HRO Journey

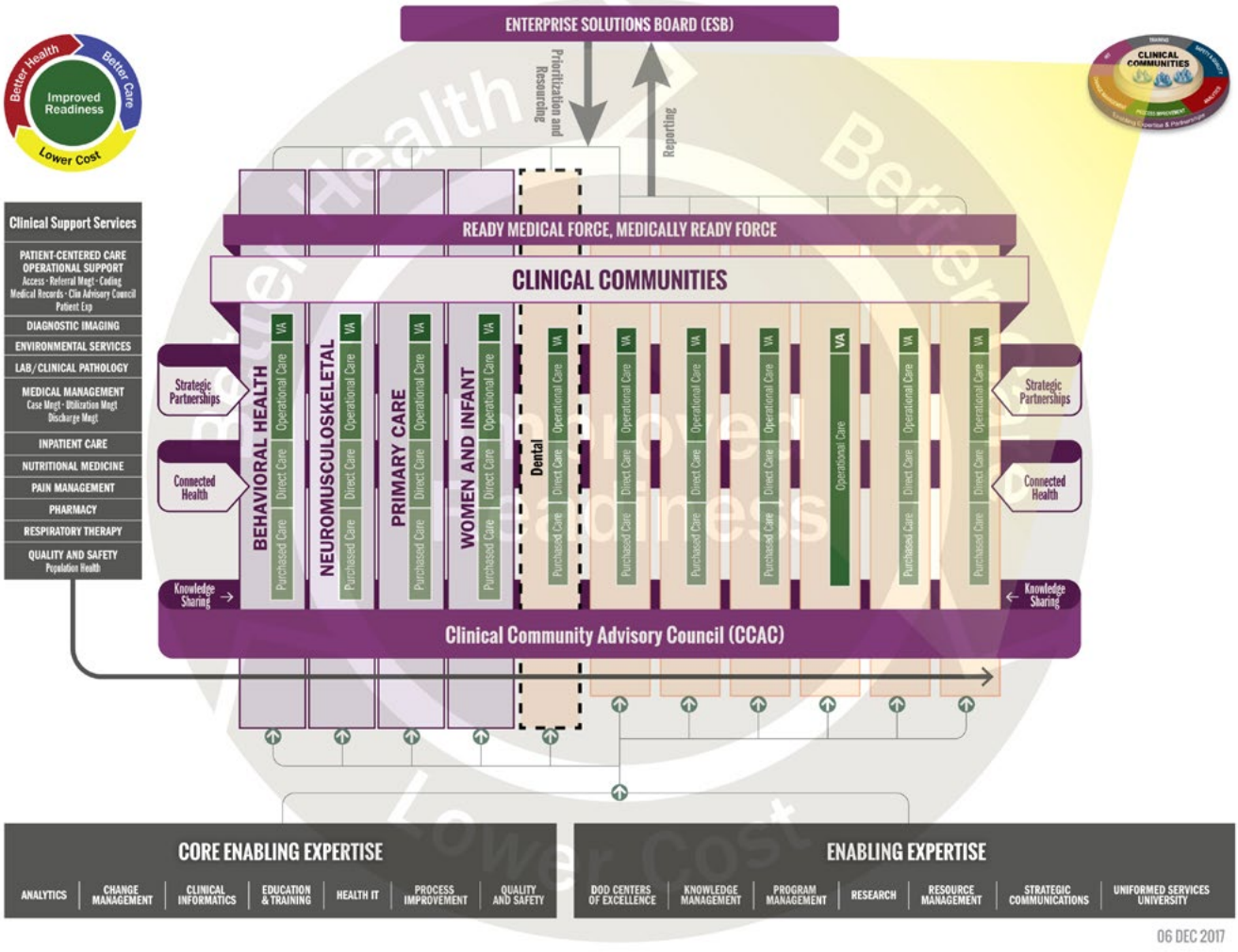
As a result of the MHS review and subsequent findings, the SECDEF directed the MHS to adopt the principles of HROs as the framework to improve the quality of health care provided. To develop a viable HRO Operating Model for the MHS, HRO practices from leading high-performing civilian health care organizations and health care systems were adapted to accommodate the unique aspects of military medicine. The HRO Operating Model outlined in this document is guided by priorities of the MHS Quadruple Aim, the HRO Domains of Change, and HRO Principles, and supports many of the requirements within the National Defense Authorization Act (NDAA) for FY 2017.

MHS INTEGRATED HEALTH CARE DELIVERY SYSTEM HRO OPERATING MODEL

BETTER CARE: ACCESS, QUALITY, SAFETY, AND PATIENT ENGAGEMENT *(CONT.)*

The HRO Operating Model is intended to enable frontline clinicians to drive enterprise-wide performance improvements in readiness and health, to empower enterprise-level Clinical Communities to create conditions for high reliability at the point of care, and to establish MHS standards and clinical outcomes for which it is accountable. The HRO construct provides a Tri-Service approach to clinical problems, and prioritizes readiness and high-risk and high-volume interrelated care processes centered on patients' experience of accessing and receiving care. The model will enable the HRO transformation by:

- **Enhancing quality, safety, and patient experience:** Will leverage the existing enterprise risk management infrastructure and resources to advance patient safety and clinical quality with the goal of achieving zero preventable harm.
- **Providing clinical direction:** Will operationalize Tri-Service Clinical Communities composed of stakeholders representing each level of the enterprise organized around specific patient-centered clinical processes, working together to identify and address relevant issues within the associated patient population. This model promotes collaboration to drive improvements in care from the bottom up rather than being pushed from the top down.
- **Facilitating leadership development:** The High Reliability Coordination Board (HRCB) redefined the MOG governance piece and fostered expansion of the membership role across the enterprise. In addition, HRCB and MOG support continuous learning opportunities for leadership development.
- **Driving high reliability standards and process improvement:** Will establish measures that integrate clinical and business processes for improved outcomes and experience, and recommend performance improvement initiatives that will benefit the entire enterprise.
- **Driving transparency:** Will share lessons learned through transparent performance measurement and data analysis, encouraging collaborative, patient-centered solutions.
- **Alignment:** Will align the clinical and business personnel needed to drive change.
- **Readiness:** Will focus on readiness and population health to ensure optimal delivery of care from the right providers to the right patients.



Summary of Key Data Responding to Section 713, NDAA 2016

This report has been expanded to address the 2014 SECDEF–directed MHS review and subsequent October 1, 2014 Secretary's Action Plan with corrective strategies. This report also responds to data required in section 713 of NDAA 2016, with data in this section presented at the MHS level, and web references showing assessment of data and performance at the MTF and Service levels.

In response to section 713 of NDAA 2016:

1. Reporting to the National Practitioner Data Bank (NPDB):

- **NPDB:** In FY 2017, 103 practitioners providing health care in military treatment facilities (MTFs) worldwide were reported to the NPDB (reported by the Services to the Department of Defense (DoD) Risk Management Committee). The activities that gave rise to the reports include the following: paid tort claims (malpractice claims), adverse privilege actions, government administrative actions, Active Duty death cases, adverse practice actions, judgments or convictions, and Active Duty disability cases. As noted in last year's report (FY 2017, page 36), 129 practitioners were reported in FY 2016 (ref. page 88).

2. With respect to each military MTF, an assessment of:

- **The current accreditation status, including recommendations for corrective action. Accreditation Status of MTFs:** DoD Instruction 6025.13 requires all MTFs, as well as hospitals and other facilities used by managed care support contractors (MCSCs), to meet or exceed the standards of appropriate external accrediting bodies. Military hospitals and clinics are accredited by several external, independent health care quality and accreditation organizations. All fixed DoD military hospitals and ambulatory clinics are accredited by The Joint Commission (TJC). An independent, not-for-profit organization, TJC accredits and certifies more than 21,000 health care organizations and programs in the United States. TJC accreditation and certification are recognized nationwide as symbols of quality that reflect an organization's commitment to meeting health care performance standards. Accredited organizations, including DoD inpatient and free-standing ambulatory clinics, can be found on TJC's website at: http://www.qualitycheck.org/consumer/searchQCR.aspx. All other clinics are subordinate to MTF hospitals and are included in the facility TJC accreditation. As a result of the MHS review and HRO task force, and in response to section 712 of NDAA 2016, MTF-specific hospital and clinic accreditation status, accreditation organization (TJC or Accreditation Association for Ambulatory Health Care), survey dates, and requirements for improvement to meet full accreditation are displayed at the Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]) public-facing web portal www.health.mil/AccreditationandPolicy. This transparency is consistent with standardized management across an enterprise journeying toward an HRO, and supports the section 713 requirements (ref. pages 90–92).
- **Any policies or procedures implemented during the year by the Secretary of the military department concerned, designed to improve patient safety, quality of care, and access to care.** A consolidated summary of relevant Health Affairs and Service policies is provided at www.health.mil/AccreditationandPolicy, and they are also provided in their associated subject areas related to access, patient safety, and quality of care at www.health.mil.
- **Data on surgical and maternity care outcomes during the year.** MHS-level data were presented in the FY 2017 report (pages 111–112), and again presented in the following pages. MTF-level data over time are publicly presented at www.health.mil in the "Health Outcomes" section, showing at each relevant MTF the number of deliveries, percentage of deliveries to full term, and complications related to surgery (the latter compared to American College of Surgeons' National Surgical Quality Improvement Program [NSQIP] participant rates). The MHS initiated participation in the American College of Surgeons (ACS) NSQIP to validate the quality of surgical care and identify opportunities to enhance surgical outcomes. The ACS NSQIP evaluates outcome measures associated with surgical mortality and morbidity, and is a nationally benchmarked, clinical, risk-adjusted, and outcomes-based program. The MHS 90-day Review included a recommendation to expand participation in ACS NSQIP to include all inpatient MTFs. During FY 2017, the number of MTFs participating in NSQIP significantly increased to 43 hospitals (ref. pages 98–100 and 104–107).
- **Data on access and appointment wait times during the year.** MHS-level appointment and other access to care data were presented in last year's report (pages 89–108), including access to care for children, and family members with autism spectrum disorder. Updated results are presented again this year (see "Access to Outpatient Care in

- the MHS" section beginning on page 57). Variation in performance across MTFs is presented using box and whisker charts and MTF-level data over time are publicly available at www.health.mil in the "Transparency" section, showing more detailed results for primary care manager (PCM) continuity, access to acute and primary care appointments, and patient engagement and self-reported access to care data, including MHS-established standards for each measure (ref. pages 58–78).
- **Data on patient safety, quality of care, and access to care, as compared with standards established by the DoD.** In addition to the MHS-level data presented in this report, and the individual MTF-level data presented in the www.health.mil public-facing website, the MHS performance management system (P4I) also presents data at the MTF level. P4I users can aggregate the data to higher levels relevant for leadership review at each level (e.g., the MTF level for local commanders and their subject matter expert [SME] staff, or the Service Intermediate Command level [Army's Regional Health Command-C or Navy Medicine-East]), or the multi-Service market area level, all the way to the Service and MHS levels. These data are routinely monitored and assessed by the Service staff and their MTF leadership, as well as in relevant Tri-Service working groups for assessment of policies or processes of high-performing MTFs that might be shared across the Services and/or standardized across the MHS. Measures have established expected targets of performance based on relevant and applicable civilian standards where relevant (e.g., comparing MHS results of the outcomes measure of complications related to surgery compared to the NSQIP-participating hospitals in the nation, or MHS beneficiary ratings of their willingness to recommend a hospital to others compared to the Hospital Consumer Assessment of Healthcare Providers and Systems [HCAHPS] 50th percentile). Where there are no relevant external benchmarks or standards, the MHS uses either legislated standards (such as appointment availability) or targets based on improvement from prior year results (such as patient reports of their ability to get care when needed). Data are presented on the www.health.mil public-facing website to help our beneficiaries and constituency understand their health care capability in their local areas (ref. "Better Care" section, from pages 47–151).

To the extent that information in this report contains medical quality assurance data or other information, it has been reported in the aggregate to comply with the requirements of 10 U.S.C. 1102.

MHS Data Transparency

The MHS has published on its publicly available website data that the Secretary considers appropriate to assess patient safety, quality of care, patient satisfaction and health outcomes for health care provided under the TRICARE program at each military treatment facility.

MHS has put military hospital and clinic quality, safety, and patient satisfaction information online for years, but not always in ways that could be easily found or understood. Recently, the agency re-examined the site and improved its design to make it more user friendly.

The website improvements include:

- Each military hospital and clinic now has a page where patients can see all the data in one place.
- Users can find a U.S. hospital or clinic by ZIP code search and find any hospital or clinic that reports data, including those overseas, through a name search.
- Users can compare up to three nearby hospitals or clinics on one custom report.
- MHS data managers now have a system that lets them update performance measures. They can also add new measures. Users can visit the site directly, or go to the main landing page of the health.mil website and click a link to the MHS Transparency pages. Individual military hospital and clinic websites will also link to the transparency site from their web pages.

The performance measure information at www.health.mil/transparency is provided with descriptions in plain language that provide the context needed to make the information not just available, but also understandable to patients and the general public whenever possible. The MHS Transparency Initiatives Group (TIG) works closely with other governance bodies to evaluate and make recommendations to DoD leadership on additional data that may provide patients and the general public a better understanding of the MHS performance. This ongoing evaluation by the TIG includes systemwide and facility-level volume data that can be provided with the contextual information needed to make the information useful to patients and the general public.

The following pages present five screen shots of the health.mil/transparency pages, in the sequence a site visitor should follow to identify the MTFs of interest, and the specific measures desired. Figure 6 shows how the MHS data are noted on the Centers for Medicare & Medicaid Services Hospital Compare website.

MHS Data Transparency *(cont.)*

FIGURE 1. VISIT WWW.HEALTH.MIL

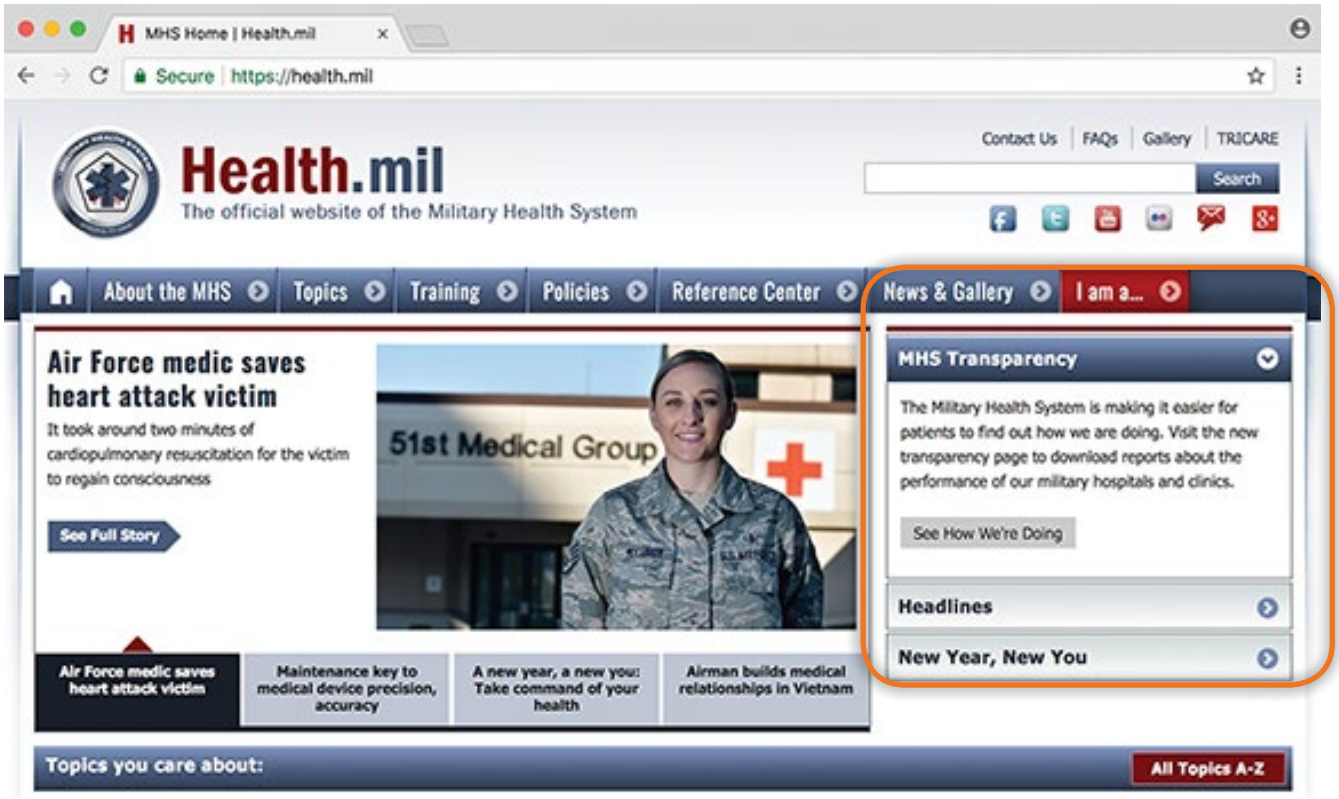
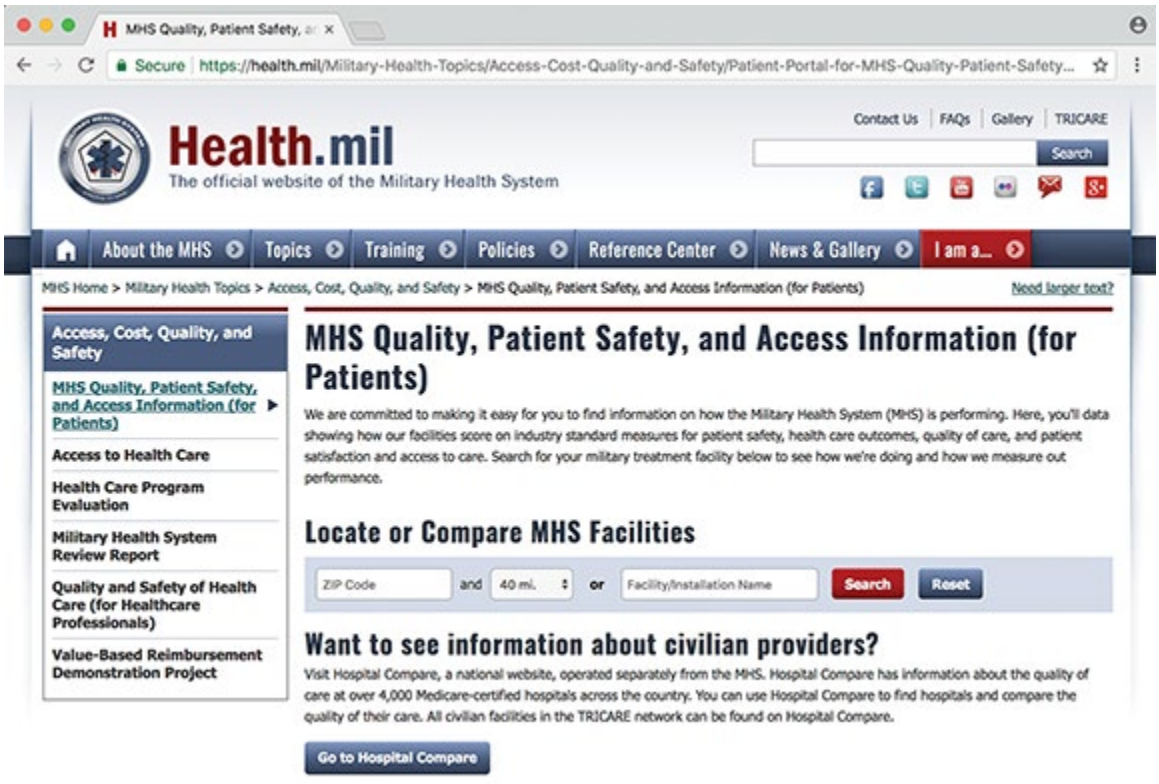


FIGURE 2. TYPE IN ZIP CODE AND RANGE OF MILES TO GET LISTING OF MTFS



MHS Data Transparency *(cont.)*

FIGURE 3. CLICK ON UP TO THREE MTF BOXES TO OBTAIN COMPARATIVE DATA

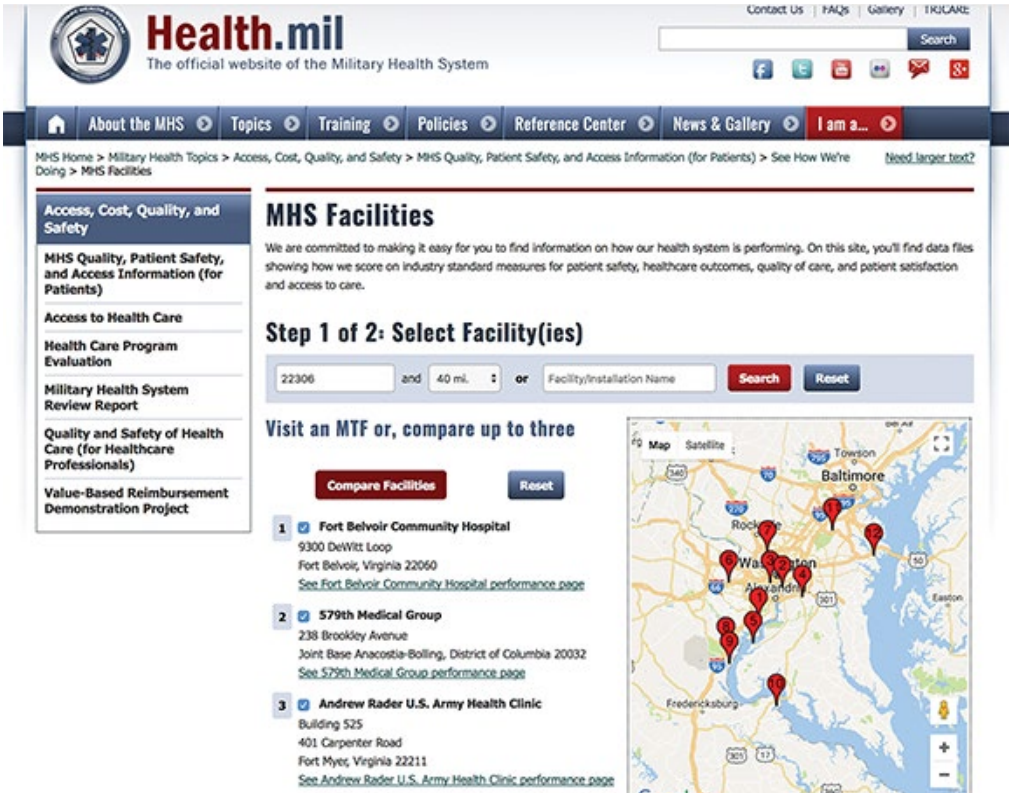


FIGURE 4. SELECT MEASURES, E.G., ACCESS TO ACUTE CARE APPOINTMENTS UNDER PATIENT SATISFACTION/ACCESS

MHS Data Transparency *(cont.)*

FIGURE 5. THE MHS IS COLLABORATING WITH CMS TO POST MTF HOSPITAL RESULTS ON THE HOSPITAL COMPARE WEBSITE

Access to Acute Care Appointments

Seeing your provider in a timely manner is important to you—and to us. Our goal is for you get the right level of care, at the right time, by the right provider.

What we measure

Graph: AF-C-579TH MED GRP-JB ANACOSTIA-BOLLING and FORT BELVOIR COMMUNITY HOSPITAL

Average Days Until Third Next Available Appointment Within 24 Hours

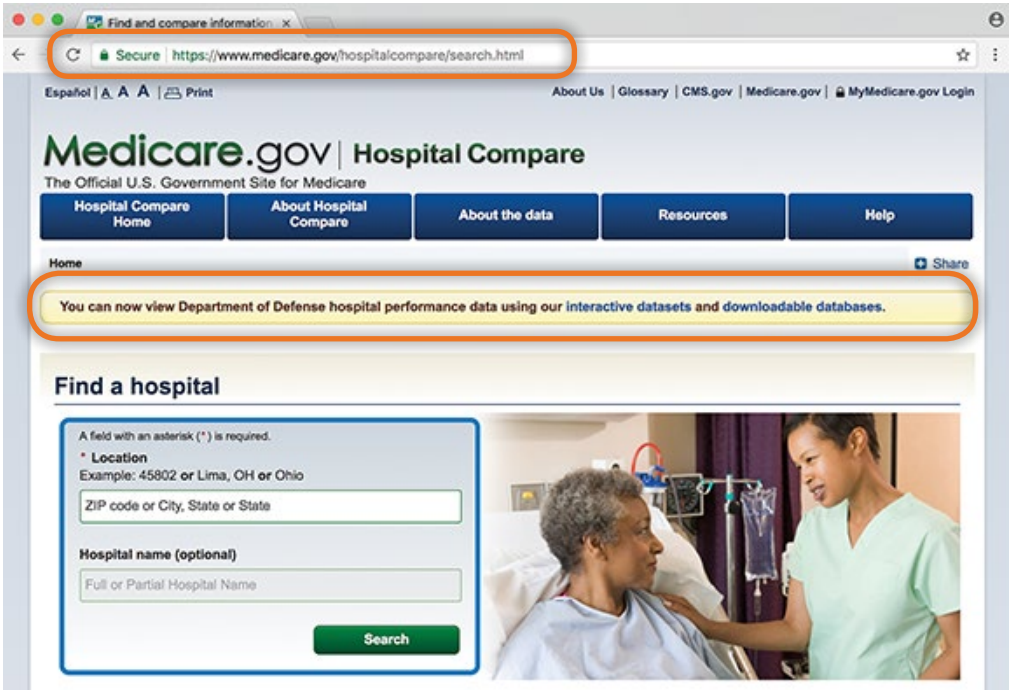
Table: AF-C-579TH MED GRP-JB ANACOSTIA-BOLLING and AHC ANDREW RADER-MYER-HENDERSON and FORT BELVOIR COMMUNITY HOSPITAL

Average Days Until Third Next Available Appointment Within 24 Hours

Military Treatment Facility	2016-Jul	2016-Aug	2016-Sep	2016-Oct	2016-Nov	2016-Dec	2017-Jan	2017-Feb	2017-Mar	2017-Apr	2017-May
AF-C-579TH MED GRP-JB ANACOSTIA-BOLLING	2.88	2.32	2.46	1.92	3.05	2.49	2.94	2.2	2.04	2.11	2.37
AHC ANDREW RADER-MYER-HENDERSON	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND	ND
FORT BELVOIR COMMUNITY HOSPITAL	0.6	0.75	1.13	0.63	0.69	0.62	0.8	1.2	1.07	0.65	0.5

- Data on inpatient results reported by the Centers for Medicare & Medicaid Services (CMS). The TRICARE Inpatient Satisfaction Survey (TRISS) results and Timely and Effective Care results are now publicly posted by CMS on the Hospital Compare website: www.medicare.gov/hospitalcompare. The results on this website provide official comparisons of military hospitals to civilian hospitals. An example would include the average length of time from arrival in the emergency room (ER) to ER departure. Patient experience survey results also include star ratings—a type of scorecard for hospitals.

FIGURE 6. IN THE INTERIM, CMS HAS AGREED TO POST THE NOTICE OF MHS CURRENT DATA ON THEIR WEBSITE



BETTER CARE: ACCESS, QUALITY, SAFETY, AND PATIENT ENGAGEMENT *(CONT.)*

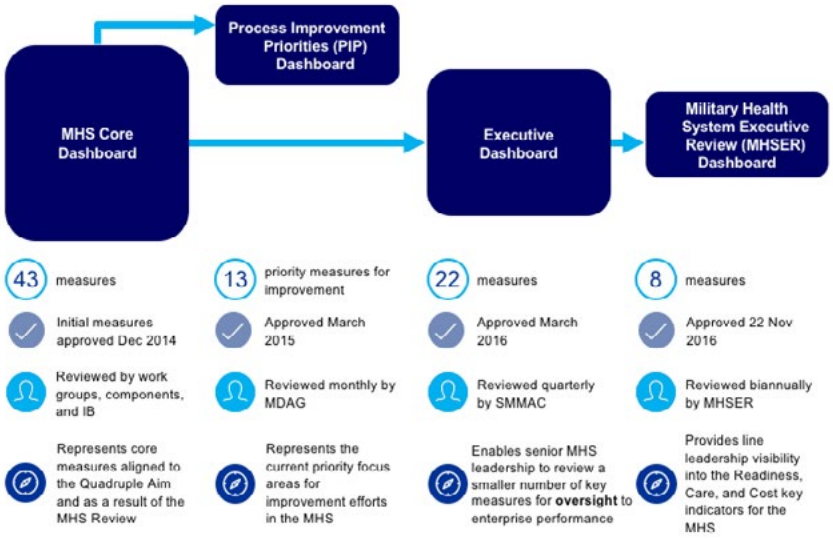
Performance Management System

Performance data for direct care are presented to and monitored quarterly by the Assistant Secretary of Defense for Health Affairs, the Service Surgeons General, and the director of the Defense Health Agency (DHA). If specific corrective action plans are recommended, SMEs must report back to leadership. On a monthly basis, the Medical Deputies Action Group, comprised of the Principal Deputy Assistant Secretary of Defense for Health Affairs, the Service Deputy Surgeons General, and the Deputy Director of the DHA, review detailed performance data in the three Process Improvement Priority areas: Achieve Zero Patient Harm, Improve Condition-Based Quality Care, and Improve Access. The SME advisory boards, such as the Tri-Service Patient-Centered Medical Home (PCMH) Advisory Board, analyze performance management system data on a monthly basis and identify performance outliers for Service action. The Tri-Service SME boards further explore reasons for challenges and opportunities for improvement by analyzing core measure driver metrics affecting core measure performance.

The Services subsequently monitor performance of subordinate MTFs and identify reasons for and opportunities to resolve some MTFs' low performance on core measures. MTFs are expected to monitor and address core performance as well as support driver measure performance on an ongoing basis.

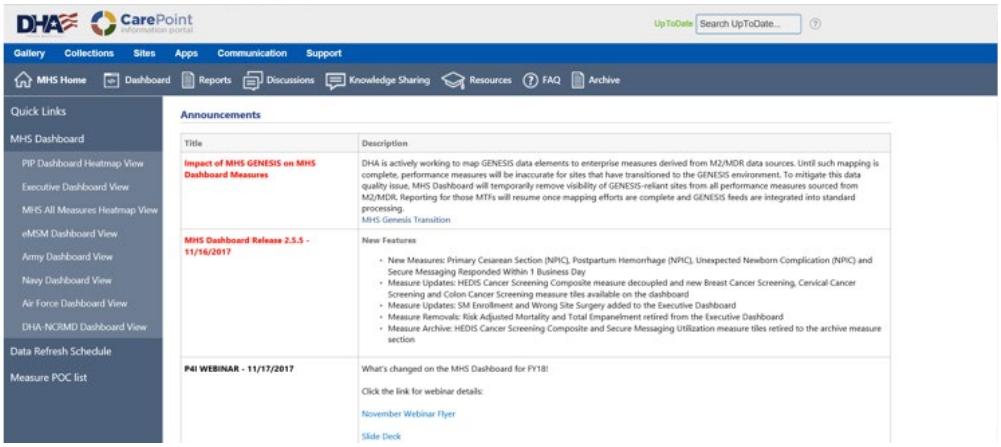
MHS leaders have approved a data source, a calculation methodology, a SME, and performance goals for each of the MHS core performance measures. The MHS has different dashboards for different purposes and audiences, as shown in the graphic below:

DIFFERENT DASHBOARDS FOR DIFFERENT PURPOSES (NEW FOR FY 2018)



The MHS Performance Dashboard

The MHS Performance Dashboard is available to all Common Access Card holders on the DHA CarePoint Platform. Overall MHS data are presented for each measure compared to thresholds. Data can be further selected for each Service or purchased care (for the measures available and in common with direct care) and the Enhanced multi-Service markets (eMSMs).



BETTER CARE: ACCESS, QUALITY, SAFETY, AND PATIENT ENGAGEMENT *(CONT.)*

Performance Management System *(cont.)*

MHS DASHBOARD

The Purchased Care Dashboard was developed by the TRICARE Health Plan (THP) Enterprise Support Activity Workgroup (WG) to provide a method for determining the value of the services provided by THP to the Services and to our beneficiaries and other stakeholders. The goal was to identify and track important, actionable measures that directly impact each component of the Quadruple Aim. Thus the first four measures focus primarily on quality, the next four on beneficiary experience, Active Duty dental care on readiness, and the last two on cost of care/efficiency.

KEY	
﹀	Decrease in current value from prior
﹀	Increase in current value from prior
>	No change in current value from prior
Trend	The number of data periods corresponding to the performance trend direction

To the highest degree possible, measures were also selected to be benchmarked against civilian data, show performance in both adult and pediatric populations, and allow comparison with the direct care system. Several are also included on the P4I Dashboard. The total number of measures was based on ensuring a sufficiently broad approach to allow evaluation of all aspects of the Quadruple Aim while also limiting the number to that which could be reasonably managed. All of the measures were agreed upon by the Services and DHA.

The Purchased Care Dashboard is used by the WG to monitor the performance of the THP with the goal of continuous improvement. The WG reviews the entire dashboard on a quarterly basis and recommends actions for improvement as needed. Data are updated constantly and can also be discussed as they are received. The dashboard will be shared internally within THP and DHA to guide improvement efforts and to improve transparency. In addition, the dashboard is a "living" tool. The WG may add or remove measures based on sustained high performance or areas of concern that are identified in the future.

ACCESS TO MHS CARE

Access to Outpatient Care in the MHS

The direct care system has continued improving access to care performance and reducing variance among MTFs, particularly in primary care. Direct care system efforts gained momentum after the SECDEF-directed 2014 MHS review of quality, safety, and access through robust Tri-Service governance, development of standard processes, and implementation of an MHS performance management system. The direct care system continued optimizing several initiatives to ensure a consistent patient experience among MTFs, including a PCMH model of primary care at all MTFs; use of standard referral and clinical practice guidelines in the Tri-Service Workflow (TSWF) templates in the MHS electronic health record; and implementation of enhanced access initiatives, including secure messaging, online appointing with text and e-mail reminders and access to beneficiaries' own personal health history, and the nurse advice line (NAL). The FY 2017 NDAA directed additional patient-centered enhancements throughout the direct care system. The FY 2017 NDAA section 704 directed MTFs to further enhance access to urgent care by expanding operating hours in MTF PCMHs and by implementing additional MTF urgent care clinics (UCCs) at locations where sufficient patient demand existed to justify operating costs. The FY 2017 NDAA section 709 also directed the MHS to implement standard appointing processes and procedures and to develop productivity standards on the expected number of patient encounters for each health care provider. The direct care system is currently implementing standard appointing and procedures to improve access, enhance patient experience, and eliminate variance among MTFs. Standard processes and procedures include the optimization of the PCMH model of primary care; simplified appointing to reduce template complexity and improve access; the use of standard referral and clinical practice guidelines in the TSWF templates in the MHS electronic health record; implementation of enhanced access initiatives, including team-based care, embedded specialists, and walk-in clinics for common acute conditions; and standard First Call Resolution processes in both primary and specialty care to ensure beneficiaries' needs are met the first time they call for an appointment. The MHS also established productivity standards on the expected number of encounters per provider to meet the congressional intent of the 2017 NDAA section 709.

Starting in FY 2017, the direct care system also began leveraging leading practices from industry and high-performing MTFs to begin improving access in specialty care. The direct care system is measuring compliance with First Call Resolution policies using the MHS's first measure of unmet demand. Continued efforts are also underway in specialty care to streamline the appointment referral process with a goal for patients to receive a specialty appointment before they leave the MTF or within 48 hours. Finally, the MHS continues the plan directed by the 2016 NDAA section 730 report to Congress to implement initiatives to improve performance, enhance patient experience, and reduce variance.

The Tri-Service PCMH Advisory Board and Clinical Community evaluates changes in appointment performance across the MHS each month by following a number of measures, a subset of which are reported in the performance management system, or Partnership for Patients (PfP), and associated MHS Dashboard. These measures are monitored and presented through MHS governance to the Surgeons General and Assistant Secretary of Defense (Health Affairs) in the quarterly review and analysis in the Senior Military Medical Advisory Council. SMEs evaluate progress on every measure, relative to past performance and to stated targets for reduced variability per MHS review, and present these select measures through SME working groups (Patient Access and Patient Satisfaction) and governance, and report them in the MHS Dashboard at the MTF level and higher, with quarterly reporting to the Surgeons General in the review and analyses. The access working group also identifies outliers (all using interquartile range [IQR]) each month and remand to the Services for action.

ACCESS TO MHS CARE *(CONT.)*

Access to Outpatient Care in the MHS *(cont.)*

The following summarizes key Tri-Service initiatives that were accomplished by the direct care system in FY 2017 and are underway for FY 2018.

TRI-SERVICE INITIATIVES, FYs 2017–2018

FY 2017	FY 2018
Develop MHS's First Measurement of Unmet Patient Demand	Implement 2017 NDAA Section 704 Expanded Hours and UCCs
Implement New Specialty Appointing and Referral Policy	Implement 2017 NDAA Section 704 Integrated Healthcare Systems
Implement MHS's First Specialty Care Access Measures	Implement 2017 NDAA Section 709 Standard Appointing Processes
Develop Standard Tri-Service Access and Customer Service Curriculum	Implement 2017 NDAA Section 709 Provider Productivity Standards
Develop Strategy to Optimize Telehealth Capabilities	Implement MTF Access Dashboards
Implement Evidence-Based Workflows in Primary Care	Implement New MHS GENESIS in Waves
Implement the TRICARE Online (TOL) Mobile Application	Deploy NAL Globally
Implement Blue Button Access for Children Under Age 12 for Patients	Implement Patient and Family Partnership Councils at each MTF

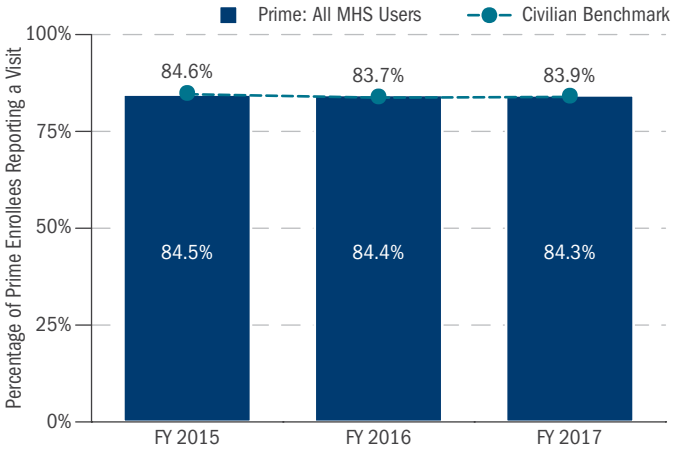
Beginning with the FY 2016 report, the following sections address many aspects of MHS access to care, modified in response to the current legislation.

Measures of Availability and Ease of Access

Access to MHS care is measured in multiple ways: by survey, asking beneficiaries about their experience in obtaining needed care or an appointment; by examining institutionally recorded data indicating whether appointments were offered within certain access standards; or by administrative data recording the number of successful visits to providers over time. In addition to face-to-face visits by walk-in or appointment, provider access can be enhanced for both provider and patient through sometimes more convenient means, including the telephone or secure e-mail.

- **Self-Reported Access:** The ability to see a doctor reflects one measure of successful access to the health care system. Prime enrollees were asked whether they had at least one outpatient visit during the past year. As shown in the chart (at right), access to and use of outpatient services remain high among Prime enrollees (with either a military or civilian PCM), with over 84 percent reporting at least one visit in FY 2017. This rate has been stable since FY 2015, following a marked decrease from almost 88 percent in FY 2014 (shown in last year's report). MHS results remain statistically comparable to the civilian benchmark of almost 84 percent. Actual administrative data demonstrate 88 percent of direct care system enrollees had at least one primary care encounter in FY 2017.

TRENDS IN PRIME ENROLLEES HAVING AT LEAST ONE OUTPATIENT VISIT DURING THE YEAR, FYs 2015–2017



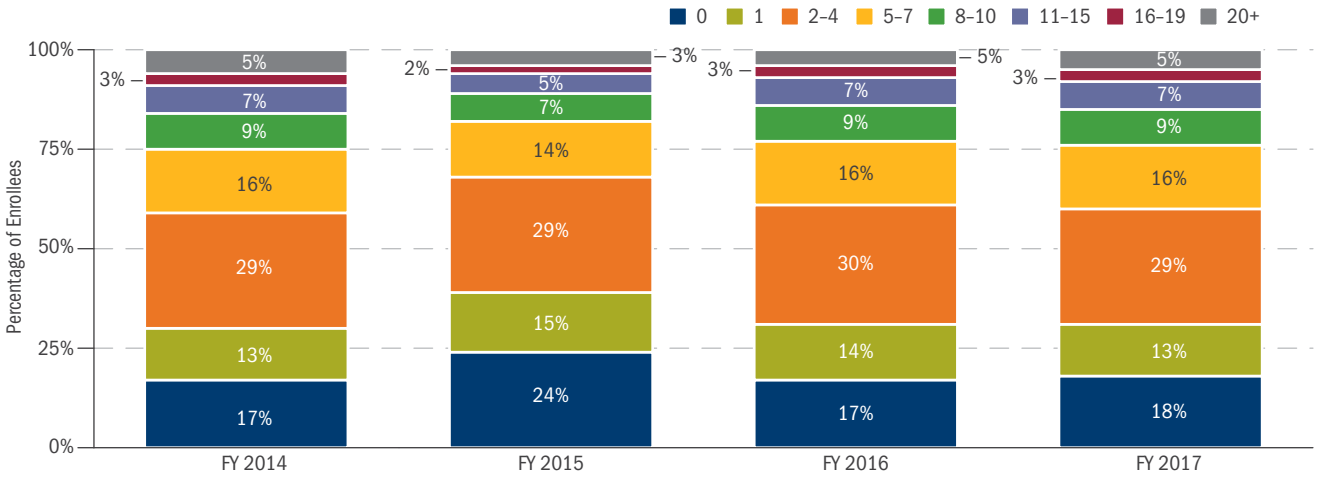
Note: DoD data were derived from the FYs 2015–2017 Health Care Survey of DoD Beneficiaries (HCSDB), as of 11/13/2017, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the National Committee for Quality Assurance (NCQA) by commercial plans. Benchmarks used in 2015 come from NCQA's 2013 data, while the benchmarks used in 2016 and 2017 come from NCQA's 2015 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

ACCESS TO MHS CARE *(CONT.)*

Measures of Availability and Ease of Access *(cont.)*

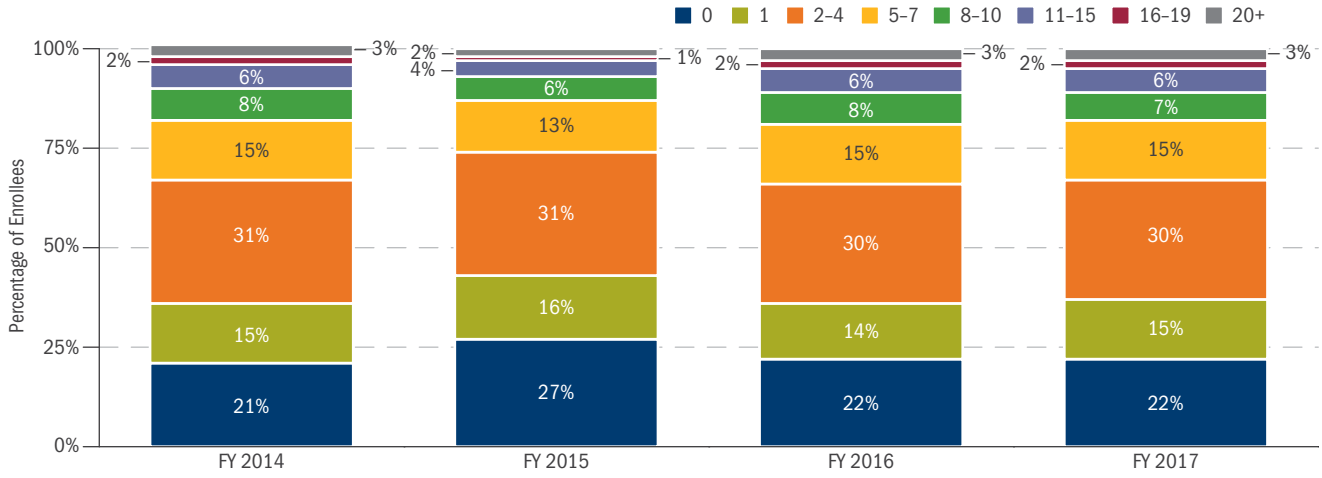
- **Direct Care Enrollee Access:** Based on administrative utilization data shown in the chart below, 82 percent of all non-Active Duty MTF enrollees under age 65 had at least one recorded outpatient visit for primary care reasons in FY 2017 (i.e., 18 percent did not have at least one visit). This access has been relatively stable since 2014, except for a decrease to 76 percent in FY 2015. While 42 percent had between one and four visits in FY 2017, 19 percent had eight to 19 visits, and 5 percent had 20 or more visits. When Active Duty personnel are included in the data, the percentage of all Prime under age 65 who had at least one primary care visit increased to 83 percent (not shown).

PERCENTAGE OF MTF NON-ACTIVE DUTY <65 BY NUMBER OF ANNUAL VISITS FOR PRIMARY CARE (ANY VENUE), FYs 2014–2017



- **Purchased Care Enrollee Access:** Based on administrative claims utilization data, the chart below shows 78 percent of all non-Active Duty MCSC Network Prime enrollees under age 65 had at least one recorded outpatient visit for primary care reasons in FY 2017 (i.e., 22 percent had no visits). While 45 percent had between one and four visits in FY 2017, 18 percent had eight or more visits, and 3 percent had 20 or more visits. When Active Duty personnel are included in the data, the percent of all Prime under age 65 who had at least one primary care visit remained at 78 percent (not shown).

PERCENTAGE OF MCSC/NETWORK NON-ACTIVE DUTY <65 BY NUMBER OF ANNUAL VISITS FOR PRIMARY CARE (ANY VENUE), FYs 2014–2017



Source: MHS Administrative Data Systems (M2), DHA/Ops (J-3)/PCMH, 11/27/2017

Note: The term "primary care visits" in this calculation includes all outpatient encounters related to primary care reported in the medical record, including scheduled episodes of repetitive care such as embedded physical therapy, prenatal care, and behavioral health.

Patient-Centered Medical Home (PCMH) Primary Care

The direct care system has implemented the PCMH model of value-based primary care at all MTFs. The direct care system's long-standing PCMH strategies remain: proactively addressing current and future health care needs and focusing on prevention; use of evidence-based medicine to increase the value of health care by improving outcomes cost-effectively; engaging with beneficiaries to identify and achieve their health care goals; optimizing access to care by offering face-to-face and virtual appointments; enhancing access and experience by offering secure messaging; and partnering with other clinicians and health care settings to better coordinate care. Direct care PCMHs continue to employ processes to ensure each routine, follow-up, or urgent medical appointment is focused on prevention and future medical needs. For example, if a patient is seen for an acute medical need, the PCMH also addresses needed preventive services, renews medications, and meets as many of the patient's other medical needs as possible during the same visit. In support of medical readiness, the Uniformed Services continue to implement operational medical homes through the Marine-Centered, Soldier-Centered, Fleet-Centered, and Submarine-Centered Medical Home programs.

PCM and PCMH Team Continuity

The PCM–patient relationship remains the driving force to improve quality and better health outcomes for MTF-enrolled beneficiaries because it leads to higher quality; more integrated/coordinated care; a more proactive, preventive focus on health; and lower unnecessary health care utilization and reduced health care costs. In the direct care system, high PCM continuity may be correlated with higher patient satisfaction with access to care, and appears related to better access to care performance and reduced unnecessary inpatient utilization by enrollees, based on MTF administrative appointment tracking (consolidated in the TRICARE Operations Center). Despite the value of PCM continuity, the direct care system must balance PCM continuity with access to care requirements, especially for acute medical needs. Recent efforts to expand virtual appointing in MTFs to allow PCMs to leverage telehealth capabilities to provide care to their established patients are expected to improve PCM continuity in the future.

- In FY 2017, enrollees saw their own PCMs during primary care visits 59 percent of the time, and 92 percent of the time from their own PCM or a fellow PCMH team provider. Median PCM continuity was 59 percent, and performance variance among individual MTFs continued to be low, with an IQR of 10 percent. A recent assessment by the DoD Inspector General's office, following up on the MHS review of quality, safety, and access, demonstrated fewer outliers in FY 2017 compared to FY 2014; all MTF outliers reported in FY 2014 were no longer outliers in FY 2017.

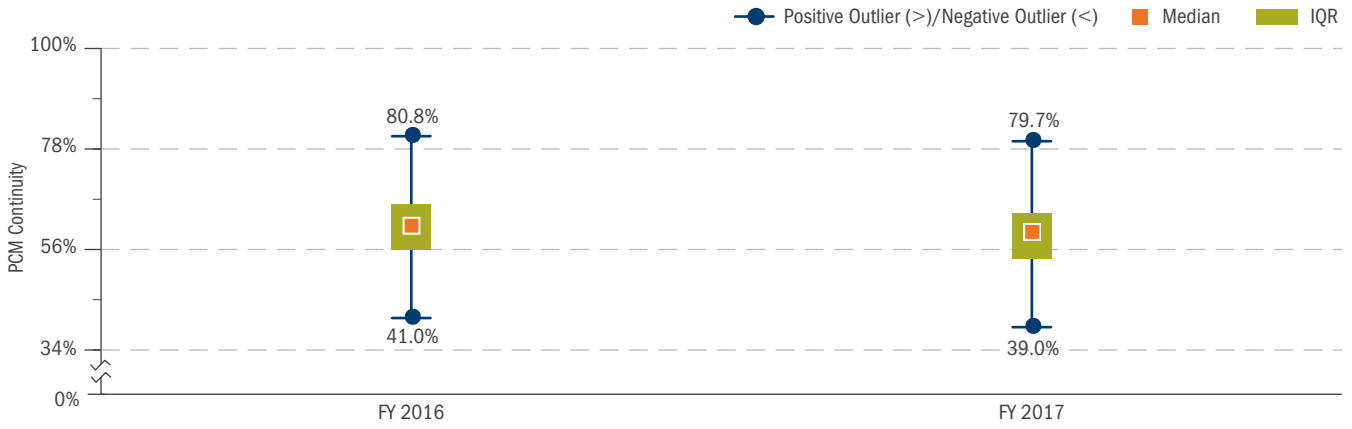
PCM AND PCMH TEAM CONTINUITY, FYs 2012–2017

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
PCM Continuity	55%	58%	60%	60%	60%	59%
PCMH Team Continuity	86%	90%	91%	91%	92%	92%

PCM CONTINUITY, FYs 2016–2017

	FY 2016	FY 2017
Median	61%	60%
Q3	66%	64%
Q1	56%	54%
IQR	10%	10%
Positive Outlier (>)	80.8%	79.7%
Negative Outlier (<)	41.0%	39.0%

PCM CONTINUITY, FYs 2016–2017



Source: MHS Administrative Data Systems (M2), DHA/Ops (J-3)/PCMH Tri-Service Primary Care PCMH Advisory Board, 11/24/2017

ACCESS TO MHS CARE *(CONT.)*

Patient-Centered Medical Home (PCMH) Primary Care *(cont.)*

Average Number of Days to 24-Hour and Future Appointments in Primary Care

The direct care system prospectively measures access to primary care by evaluating the average number of days to the third next available 24-hour or acute appointment and third next available future appointment against the MHS goals of 1.0 and 7.0 days, respectively. Prospective measurement of access to care is considered a more sensitive and accurate measure of access compared with retrospective analysis of when the appointment was booked. In FY 2017, the direct care system governance modified the measurement methodology slightly to increase accuracy. Third next 24-hour and future appointment methodology changes were: to count only appointments with PCMH PCMs; to eliminate federal holidays from the calculation; and to weight clinics by the number of scheduled appointments. Because of this approved methodology change, only FY 2016 and FY 2017 data are provided below, with revised data applied to FY 2016.

In FY 2017, the direct care system performed better on Third Next 24-Hour Appointment than the goal of 1.0 days or less for the first time, achieving an annual average of 0.93 days and median performance of 0.92 days. The FY 2017 mean and median appointment performance improved by 8 percent and 9 percent, respectively, compared to FY 2016. The direct care system also performed better than the future appointment goal of 7.0 days or fewer, achieving an annual average of 5.53 days and median performance of 5.39 days. FY 2017 future mean and median appointment performance improved by over 5 percent and 7 percent, respectively, compared with FY 2016.

BETTER CARE

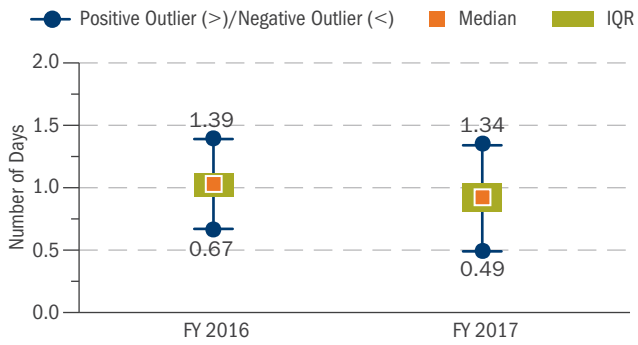
AVERAGE NUMBER OF DAYS TO 24-HOUR AND FUTURE APPOINTMENTS IN PRIMARY CARE, FYs 2016–2017

	MHS GOALS	FY 2016	FY 2017
Avg # of Days to Third Next 24-Hour Appointment	1	1.01	0.93
Avg # of Days to Third Next Future Appointment	7	5.82	5.53

DAYS TO THIRD NEXT AVAILABLE 24-HOUR APPOINTMENT, FYs 2016–2017

	FY 2016	FY 2017
Median	1.00	0.91
Q3	1.12	1.03
Q1	0.94	0.82
IQR	0.18	0.22
Positive Outlier (>)	1.39	1.34
Negative Outlier (<)	0.67	0.49

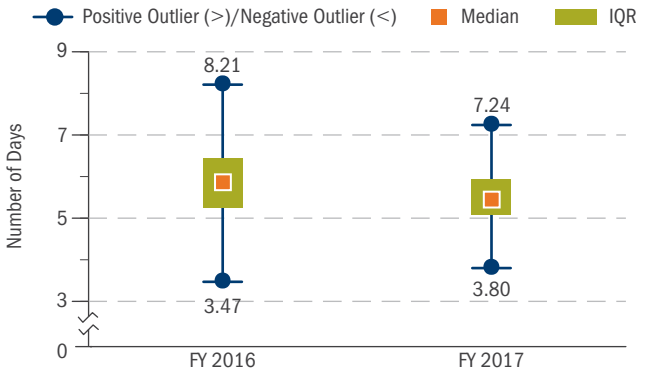
DAYS TO THIRD NEXT AVAILABLE 24-HOUR APPOINTMENT, FYs 2016–2017



DAYS TO THIRD NEXT AVAILABLE FUTURE APPOINTMENT, FYs 2016–2017

	FY 2016	FY 2017
Median	5.82	5.21
Q3	6.44	5.95
Q1	5.25	5.09
IQR	1.19	0.86
Positive Outlier (>)	8.21	7.24
Negative Outlier (<)	3.47	3.80

DAYS TO THIRD NEXT AVAILABLE FUTURE APPOINTMENT, FYs 2016–2017



Source: MHS Administrative Data Systems (M2), DHA/Ops (J-3)/PCMH Tri-Service Primary Care PCMH Advisory Board, 11/24/2017

Patient-Centered Medical Home (PCMH) Primary Care *(cont.)*

Sources of Primary Care Appointing

The direct care system offers multiple options for scheduling primary care appointments in MTFs. In September 2017, 93 percent of primary care appointments were scheduled by the MTF through appointment centers or directly by primary care clinics. The percent of appointments scheduled by patients using the TOL Patient Portal increased from almost 4 percent in September 2016 to over 5 percent in September 2017. The direct care system is expanding efforts to publicize appointing capabilities in the TOL Patient Portal and deployed a mobile TOL application in FY 2017. Slightly less than 2 percent of appointments are arranged via a secure message between patients and health care teams, and approximately 0.17 percent of appointments are scheduled by the centralized NAL for patients needing an MTF PCMH appointment within 24 hours or fewer.

PRIMARY CARE APPOINTMENT BOOKING SOURCES, SEPTEMBER 2016 AND 2017

	SEPTEMBER 2016 PERCENT BOOKED	SEPTEMBER 2017 PERCENT BOOKED
MTF Appointment Center/Clinic Booked	94.30%	93.01%
TRICARE Online Patient Portal	3.85%	5.16%
Arranged on Secure Messaging	1.70%	1.66%
NAL Booked	0.15%	0.17%
Total Booked	100.00%	100.00%

Source: MHS Administrative Data (M2); Tri-Service Primary Care PCMH Advisory Board, DHA/Ops (J-3)/PCMH, 11/24/2017

Access to Integrated Specialists in the PCMH

The most common conditions in the direct care enrollee population, excluding pregnancy, remain related to behavioral health; musculoskeletal issues; and miscellaneous conditions such as hypertension, hyperlipidemia, obesity, and diabetes. To improve access and outcomes for beneficiaries affected by these conditions, the direct care system continues to optimize the use and integration of embedded specialists in PCMHs by providing more continuous, comprehensive care in the primary care setting and facilitating coordinated care. Currently, over 80 percent of PCMHs serving adult enrollees have embedded behavioral health specialists who provide treatment for mental health and behavioral health issues. Directly embedding behavioral health providers ensures the embedded specialists are able to work closely in partnership with the patient, PCM, and PCMH team; moreover, because the specialties are co-located, it helps destigmatize the care received. The Uniformed Services University for the Health Sciences determined that being seen by a behavioral health specialist embedded in a PCMH results in a statistically significant improvement in mental health status. PCMH clinical pathways are being optimized by incorporating multidisciplinary specialties for behavioral health–related issues prevalent in the MTF Prime population, including alcohol misuse, anxiety, depression, diabetes, obesity, chronic pain, sleep problems, and tobacco use. The MHS is also implementing embedded clinical pharmacists in PCMHs. An FY 2016 independent analysis demonstrated that the use of embedded clinical pharmacists resulted in a statistically significant improvement in diabetes, hypertension, and hyperlipidemia outcomes. Finally, the MHS is implementing physical therapists in PCMHs to address highly prevalent musculoskeletal issues, such as low back pain. Where implemented, embedded physical therapists continue to achieve improved outcomes and reduced MTF enrollee purchased care costs.

ACCESS TO MHS CARE *(CONT.)*

Patient-Centered Medical Home (PCMH) Primary Care *(cont.)*

Dispositions and Bed-Days per 1,000 MTF Enrollees

By focusing on prevention, proactive care coordination, and improving outcomes for common conditions, direct care system PCMHs focus on reducing the incidence of dispositions (admissions) and bed-days per 1,000 MTF enrollees. PCMH teams continue efforts to reduce the number of times MTF enrollees are admitted to hospitals and medical centers in both the direct and purchased care sectors, and the length of time they spend as inpatients if they are admitted, which is measured by bed-days (number of dispositions multiplied by the length of stay). The dispositions per 1,000 MTF enrollees averaged 15.82 in FY 2017, a reduction of 2 percent compared to FY 2016 and 26 percent compared to FY 2012. Variance among MTFs decreased 29 percent since FY 2016. The number of bed-days per 1,000 MTF enrollees decreased to 48.76, a reduction of 4 percent compared to FY 2016 and 27 percent compared to FY 2012. Variance among MTFs decreased 10 percent since FY 2016. During this same period, the average length of stay decreased 1 percent (not shown). The top five reasons for admissions were for childbirth and musculoskeletal, circulatory, digestive, and respiratory conditions.

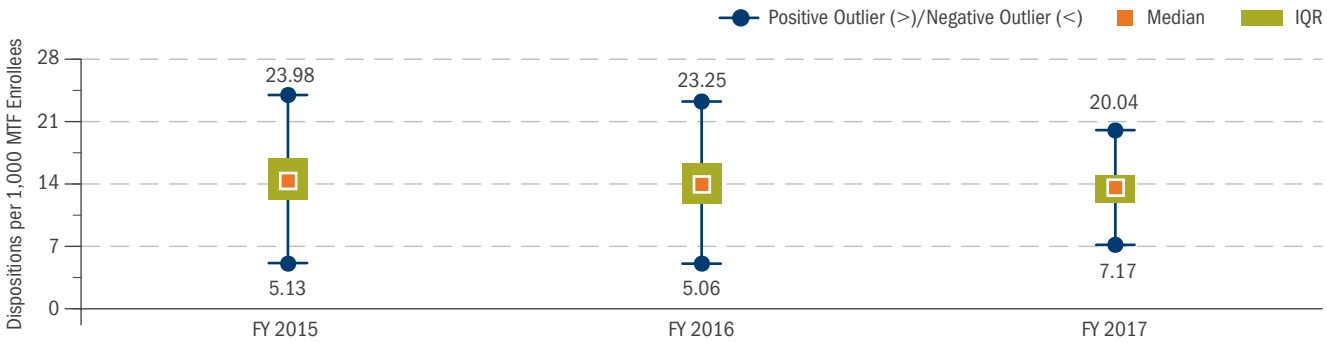
DISPOSITIONS AND BED-DAYS PER 1,000 MTF ENROLLEES, FYs 2012–2017

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Dispositions per 1,000 MTF Enrollees	21.24	19.17	17.29	16.56	16.12	15.72
Bed-Days per 1,000 MTF Enrollees	66.51	60.07	53.72	50.67	50.62	48.81

DISPOSITIONS PER 1,000 MTF ENROLLEES, FYs 2015–2017

	FY 2015	FY 2016	FY 2017
Median	13.48	13.12	13.12
Q3	16.91	16.43	15.21
Q1	12.20	11.88	12.00
IQR	4.71	4.55	3.22
Positive Outlier (>)	23.98	23.25	20.04
Negative Outlier (<)	5.13	5.06	7.17

DISPOSITIONS PER 1,000 MTF ENROLLEES, FYs 2015–2017



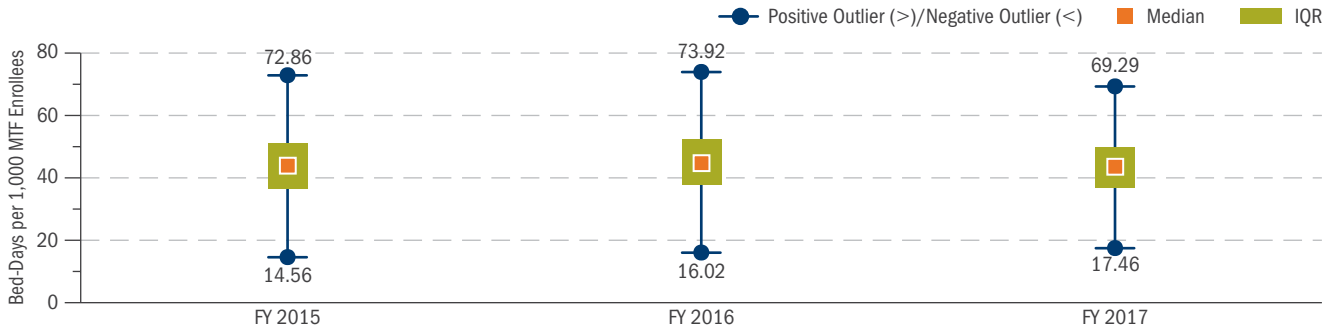
Source: MHS Administrative Systems (M2); DHA/Ops (J-3)/PCMH Tri-Service Primary Care PCMH Advisory Board, 12/8/2017

Patient-Centered Medical Home (PCMH) Primary Care *(cont.)*

BED-DAYS PER 1,000 MTF ENROLLEES, FYs 2015–2017

	FY 2015	FY 2016	FY 2017
Median	43.10	43.00	42.74
Q3	51.00	52.21	49.86
Q1	36.42	37.74	36.90
IQR	14.58	14.47	12.96
Positive Outlier (>)	72.86	73.92	69.29
Negative Outlier (<)	14.56	16.02	17.46

BED-DAYS PER 1,000 MTF ENROLLEES, FYs 2015–2017



Source: MHS Administrative Systems (M2); DHA/Ops (J-3)/PCMH Tri-Service Primary Care PCMH Advisory Board, 12/8/2017

Recapturable ER Visits in the Private Sector per 100 MTF Enrollees

The direct care system continues to make remarkable progress in reducing the number of primary care–recapturable ER visits to the private sector. ER visits for primary care reasons are a small percentage of all ER visits, and are defined by the Tri-Service Emergency Medicine consultants and industry as Evaluation and Management Codes 99281 and 99282.[1] Efforts to reduce ER visits include better access to 24-hour care in PCMHs, walk-in clinics for common acute conditions, the use of PCMH team members to meet patients' needs, and the use of the NAL and secure messaging.

- As shown in the table below, as of April 30, 2017, the average number of primary care network ER visits per 100 MTF enrollees for primary care reasons decreased 31.5 percent compared with the FY 2012 average. The improvement rate in declining network ER visits remains unchanged since the recent Urgent Care Demonstration. Due to the direct care system's efforts to provide more continuous care overall in the MTF, network ER visits for all reasons, including true emergencies, declined 2.4 percent over the same period. In total, network ER visits for primary care reasons represent 3.5 percent of all direct care system enrollee ER visits; the remaining 96.5 percent of network ER visits are due to conditions for which an ER is the appropriate health care setting.

AVERAGE NETWORK ER VISITS PER 100 MTF ENROLLEES, FY 2012–APRIL 30, 2017

	AVERAGE NETWORK ER VISITS PER 100 MTF ENROLLEES (INCLUDING TRUE EMERGENCIES)	AVERAGE NETWORK ER VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS
FY 2012	20.98	1.06
FY 2013	20.62	0.90
FY 2014	20.67	0.80
FY 2015	20.95	0.79
FY 2016	20.38	0.74
FY 2017 (through April)	20.48	0.72
Improvement since 2012	–2.4%	–31.5%

NETWORK ER VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS, FYs 2015–2017

	FY 2015	FY 2016	FY 2017
Q3	1.07	1.02	1.02
Q1	0.21	0.21	0.22
IQR	0.86	0.80	0.81
Positive Outlier (>)	2.36	2.22	2.23
Negative Outlier (<)	1.08	0.99	0.99

Source: MHS Administrative Systems (M2); DHA/Ops (J-3)/PCMH Tri-Service Primary Care PCMH Advisory Board, 11/24/2017

[1] Tri-Service ER Consultants' guidance and the National Patient-Centered Primary Care/Agency for Healthcare Research and Quality (AHRQ) (how they count primary care sensitive ER visits).

Percentage of Enrollees Registered to Use Secure Messaging

The direct care system offers enhanced access to care through the use of a commercially available secure messaging system. In FY 2017, the direct care system continued efforts to deploy secure messaging in specialty care. Secure messaging allows MTF enrollees to communicate directly with their PCMs and PCMH teams to ask questions about their health or medical tests and to arrange referrals or appointments. As of the end of FY 2017, over 1.6 million MTF enrollees (MTF Prime and TRICARE Plus seniors) were registered in secure messaging, or 48.6 percent of all enrollees, approaching the goal of 50 percent or more. The median performance among MTFs was 50 percent, achieving the MHS goal. Although not shown in the table (at right), analysis of the primary reasons patients initiate messages include: asking a medical question (55 percent), arranging appointments (15 percent), or renewing medications (14 percent).

PERCENTAGE OF MTF ENROLLEES REGISTERED IN SECURE MESSAGING, FYs 2015–2017

	FY 2015	FY 2016	FY 2017
Average	39%	44%	49%
Median	42%	47%	50%
Negative Outlier (<)	2%	11%	11%
Maximum Performance	82%	95%	98%
Q1	31%	36%	39%
Q3	50%	53%	58%
IQR	19%	17%	19%

Source: MHS Administrative Data Systems (M2), DHA/Ops (J-3)/PCMH Tri-Service Primary Care PCMH Advisory Board, 11/24/2017

Percentage of Patient-Initiated Messages Responded to within One Business Day

In FY 2017, the direct care system approved a new performance measure to evaluate the percent of secure messages sent by beneficiaries responded to by the health care team within one business day. The previous goal was 72 hours, or three business days, which mirrors the industry average. The FY 2017 average through July 2017 was 77.5 percent of messages responded to within one business day. Secondary to the 2017 NDAA section 709, standard MTF processes include those requiring all providers to utilize secure message and to respond to patients.

ACCESS TO MHS CARE *(CONT.)*

Nurse Advice Line (NAL)

The MHS NAL continues to provide valuable, quality, and convenient nurse triage and care coordination services to our MHS beneficiaries 24 hours a day, seven days a week, directing over half a million callers per year to the most clinically appropriate level of care. Since implementation in late FY 2014, the NAL has provided access to registered nurses who address health concerns, offer self-care advice, and answer general health questions to more than 1.8 million callers. The NAL receives approximately 1,500 calls per day and potentially saves 12 lives per day by recommending or activating emergency procedures and assisting callers in crisis. In FY 2017, NAL calls from Active Duty Service members (ADSMs) made up 17 percent of total calls. The NAL also assisted close to 102,000 concerned mothers or fathers of children under the age of two years old, which made up 18 percent of total FY 2017 NAL encounters.

The NAL is fully integrated with the MTF PCMH primary care clinics, as MTF enrollees make up 89 percent of all NAL calls. If the RN determines the beneficiary needs to be seen within 24 hours, the NAL staff can schedule MTF primary care appointments, warm transfer the beneficiary directly to his or her MTF via telephone, provide information about MTF urgent care (UC) and ER Fast Track options, and/or generate civilian UC referrals in the electronic health record. PCMH primary care teams have access to NAL encounter information through an NAL web portal; teams use NAL data to conduct appropriate follow-up with their patients and coordinate care, if clinically indicated. The NAL web portal also includes performance data, which allow PCMH teams to monitor utilization and adjust future appointing templates to accommodate changes in demand.

The direct care system analyzed over 900,000 NAL encounters from MTF enrollees in FY 2016 and FY 2017. The NAL RN collects the beneficiary's pre-intent—what the caller would have done—if they had not called the NAL. This is compared to the NAL RN's advice for care. The NAL Program Management Office provides these data to a third-party vendor, who pulls the purchased care claims and MTF encounter data from the MHS Mart (M2) to determine what the beneficiary actually did 24 hours after they called the NAL (see below chart). This comparison demonstrates the NAL's ability to safely and cost-effectively direct patients to the most clinically appropriate level of care. Overall, 36 percent of beneficiaries would have gone to a TRICARE-authorized civilian ER, and 26 percent would have gone to a TRICARE-authorized civilian UCC; however, 24 hours after MTF enrollees called the NAL, only 13 percent actually went to a civilian ER and 20 percent went to a civilian UCC. The majority, 67 percent, either received care in their MTF or chose to administer self-care. As of September 30, 2017, 0.17 percent of all primary care appointments were scheduled by the NAL.

NAL CALLER INFORMATION, FY 2015–JUNE 2017

NAL DISPOSITION	CALLER'S PRE-INTENT	NURSE ADVICE	CALLER'S ACTION WITHIN 24 HOURS
Purchased Care ER	36%	11%	13%
Purchased Care UC	26%	25%	20%
Direct Care MTF	20%	25%	37%
Self-Care	7%	31%	30%
Other	11%	9%	0%

Source: NAL Program and MHS Administrative Data (M2/MDR); DHA/Ops (J-3)/PCMH Tri-Service Primary Care PCMH Advisory Board, 11/24/2017
Note: Data from DHA/J3/Health Service Delivery Branch/NAL Program Management Office, NAL web reporting repository and M2; data reflect October 2015 to June 2017.

ACCESS TO MHS CARE *(CONT.)*

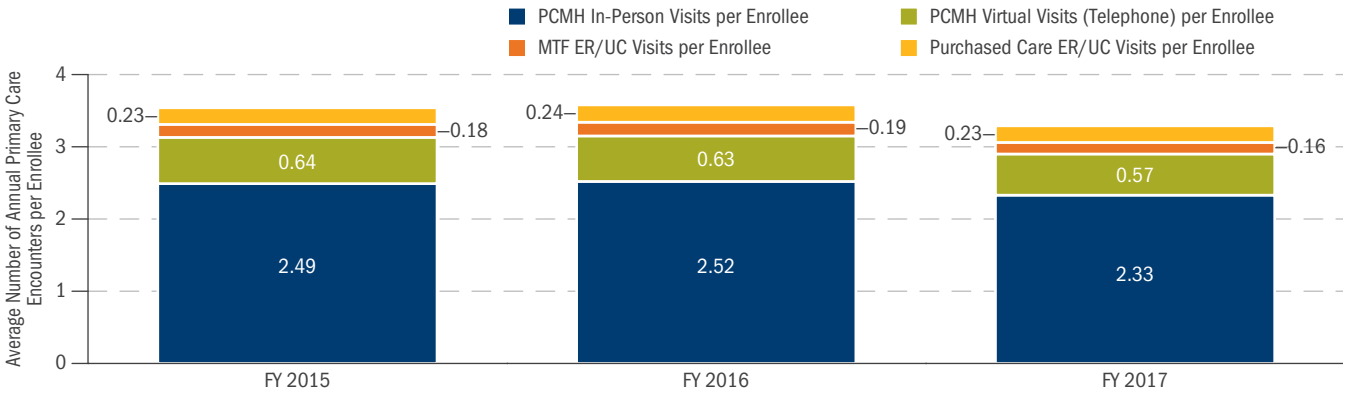
Primary Care Utilization and Market Share

The average annual number of direct care system enrollees' primary care visits decreased slightly from 3.58 in FY 2016 to 3.28 in FY 2017 through August 31, 2017. The direct care system captures over 93 percent of its enrollees' primary care visits, with most visits occurring in the patient's own PCMH clinic. In FY 2017, 6.95 percent of direct care system enrollee visits occurred in network UC or ERs. Of note, almost 18 percent of total direct care system primary care visits were delivered via telephone in FY 2017; in future years, MTF PCMHs will leverage additional telehealth capabilities and transition some of these telephone visits to virtual video visits. In FY 2017, median performance increased slightly, while the IQR decreased slightly.

PRIMARY CARE UTILIZATION AND MARKET SHARE, FYs 2012–2017

FISCAL YEAR	PCMH IN-PERSON VISITS PER ENROLLEE	PCMH VIRTUAL VISITS (TELEPHONE) PER ENROLLEE	MTF ER/UC VISITS PER ENROLLEE	PURCHASED CARE ER/UC VISITS PER ENROLLEE	TOTAL ANNUAL PRIMARY CARE ENCOUNTERS PER ENROLLEE	PERCENT NETWORK LEAKAGE
FY 2012	2.54	0.49	0.18	0.23	3.44	6.67%
FY 2013	2.55	0.54	0.17	0.23	3.49	6.59%
FY 2014	2.52	0.57	0.16	0.22	3.47	6.38%
FY 2015	2.49	0.64	0.18	0.23	3.54	6.58%
FY 2016	2.52	0.63	0.19	0.24	3.58	6.66%
FY 2017	2.33	0.57	0.16	0.23	3.28	6.95%

AVERAGE NUMBER OF ANNUAL PRIMARY CARE ENCOUNTERS PER ENROLLEE, FYs 2015–2017



AVERAGE NUMBER OF ANNUAL DIRECT CARE ENROLLEE VISITS FOR PRIMARY CARE, FYs 2015–2017

	FY 2015	FY 2016	FY 2017
Median	7.6	7.7	8.7
Q1	4.2	4.7	5.3
Q2	11.3	11.8	11.8
IQR	7.0	7.1	6.5

Source: MHS Administrative Data Systems (M2), DHA/Ops (J-3)/PCMH Tri-Service Primary Care PCMH Advisory Board, 11/24/2017

ACCESS TO MHS CARE *(CONT.)*

Specialty Care Access

In FY 2017, the MHS began monitoring specialty care performance for several reasons: most purchased care costs for direct care system enrollees are due to costs associated with deferrals to the purchased care network for needed specialty care; patient feedback indicated improvements were required; and specialty care workload helps ensure a ready medical force and clinical currency for direct care system specialty providers. In FY 2017, the MHS codified standards for appointing beneficiaries to specialty care in the DHA-Interim Procedures Memorandum (DHA-IPM) 17-002 on Specialty Care Referral Accountability and Business Rules, dated January 18, 2017. To measure compliance with the policy, two new specialty care measures were implemented: time from specialty consult to appointment booking, and time from appointment booking to the patient's appointment. Together, these two measures reflect how long it takes to be seen for a specialty appointment from the patient's perspective, yet both must be managed by the MTF.

Average Number of Days from Consult to Booking

The average number of days from consult to booking measures how long it takes for the patient to obtain a scheduled appointment date and time after receiving a referral from a primary care or other provider. Survey and qualitative data demonstrate a longer wait to obtain a scheduled appointment is a source of patient dissatisfaction and also delays needed care. DHA-IPM 17-002 identified standard processes to expedite the time from consult to appointment booking. The goal is for beneficiaries to be scheduled for a specialty care appointment within two days or fewer. Currently, the direct care system is not meeting the goal, but has improved 5 percent since FY 2016— although variance among MTFs has increased 60 percent. In FY 2017, the highly standardized specialty mental health product line performed the best; dermatology performed the worst. In FY 2018, MHS specialty care leaders will refine this measure to also demonstrate the percent of referrals scheduled within two days.

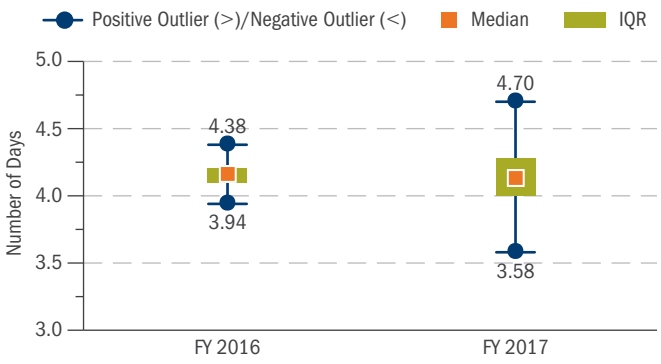
AVERAGE NUMBER OF DAYS FROM ORDERED TO MTF BOOKED, FYs 2016–2017

	FY 2016	FY 2017
Days from Ordered to MTF Booked	4.16	4.16

DAYS FROM ORDERED TO MTF BOOKED, FYs 2016–2017

	FY 2016	FY 2017
Median	4.14	4.09
Q3	4.21	4.28
Q1	4.10	4.00
IQR	0.11	0.28
Positive Outlier (>)	4.38	4.70
Negative Outlier (<)	3.94	3.58

DAYS FROM ORDERED TO MTF BOOKED, FYs 2016–2017



Source: MHS Administrative Data Systems (M2), DHA/Ops (J-3)/PCMH Tri-Service Primary Care PCMH Advisory Board, 11/24/2017

ACCESS TO MHS CARE *(CONT.)*

Specialty Care Access *(cont.)*

Average Number of Days from Booking to Appointment

The average number of days from booking to appointment measures how long the patient waits for a scheduled appointment from the time the appointment was scheduled. Survey and qualitative data demonstrate a longer wait for specialty appointments is a source of patient dissatisfaction and also delays needed care. Standard processes to meet the congressional intent of 2017 NDAA section 709 requirements are designed to increase the number of available specialty care appointments, standardize appointment templates, and increase direct care system specialty care capacity. The goal is for beneficiaries to have a specialty care appointment within 16 days of being scheduled for the appointment. Currently, the direct care system is not meeting the goal, but has improved 5 percent since FY 2016; however, variance among MTFs increased 141 percent during this period. In FY 2017, the highly standardized specialty mental health product line performed the best; dermatology performed the worst.

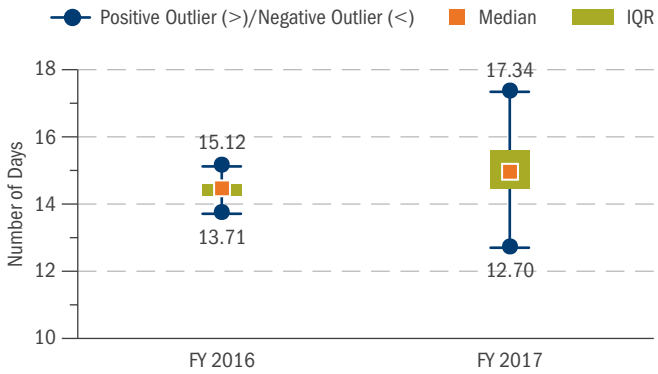
AVERAGE NUMBER OF DAYS FROM MTF BOOKED TO MTF APPOINTMENT, FYs 2016–2017

	FY 2016	FY 2017
Days from MTF Booked to MTF Appt	13.91	14.50

DAYS FROM MTF BOOKED TO MTF APPOINTMENT, FYs 2016–2017

	FY 2016	FY 2017
Median	14.46	14.73
Q3	14.59	15.60
Q1	14.24	14.44
IQR	0.35	1.16
Positive Outlier (>)	15.12	17.34
Negative Outlier (<)	13.71	12.70

DAYS FROM MTF BOOKED TO MTF APPOINTMENT, FYs 2016–2017



Source: MHS Administrative Data Systems (M2), DHA/Ops (J-3)/PCMH Tri-Service Primary Care PCMH Advisory Board, 11/24/2017

BETTER CARE

ACCESS TO MHS CARE *(CONT.)*

Patient-Centered, Self-Reported Measures

In addition to tracking patient access to care using administrative and provider-centric data, including patient self-reported information will provide a more complete assessment of the performance of the health care system from the patient user's perspective. There are a number of methods for evaluating the patient's experience: face-to-face encounters, complaint and suggestion programs, focus groups, and surveys. Within surveys, patients can be asked about their experience following a specific event and time, as in event-based surveys after an outpatient visit or discharge from a hospital.

The goal of MHS outpatient surveys is to monitor and report on the experience and satisfaction of MHS beneficiaries who have received outpatient care in an MTF or civilian provider office. The Army, Navy, and Air Force have, for a number of years, fielded individual outpatient Service satisfaction surveys: the Army Provider Level Satisfaction Survey (APLSS), the Navy Patient Satisfaction Survey (PSS), and the Air Force Service Delivery Assessment (SDA). Service surveys focused on MTF care within each Service and provided extensive detailed data for each MTF, for clinics within MTFs, and down to the individual providers. Service surveys provided transparency across a Service's MTFs and allowed providers to understand beneficiary perceptions of the care they provided. As noted in the FY 2016 and FY 2017 annual reports, because of differences in Service and DHA outpatient surveys, MHS leadership agreed to create a standardized outpatient survey using a standardized instrument, sampling methodology, analysis, and reporting.

The Services transitioned to Joint Outpatient Experience Survey (JOES) from their respective surveys during the third and fourth fiscal quarters of FY 2016. Service survey results through FY 2016 cannot be compared across Services, only within (e.g., at the MTF and intermediate command level). FY 2016 Q3 and Q4 results reflect a mixture of Service and JOES data as each Service transitioned during the quarter: Navy began using the JOES survey in May 2016, the NCR began between May and June 2016, Army began in June 2016, and Air Force began in September 2016. Survey transitions were staggered to avoid overlapping survey contracts and to allow each Service to close out its survey and contract in an orderly fashion, without duplicating effort. In order to show trends in survey results over time, this year's report reflects results from the Service surveys through FY 2016, as well as the JOES results for all Services beginning in FY 2017 Q1.

The TRICARE Outpatient Satisfaction Survey (TROSS) has been fielded by the DHA (and its predecessor, the TRICARE Management Activity), for a number of years as well, but was designed to measure MHS system performance from the patient's perspective, including the perspective of MHS beneficiaries using purchased care. TROSS, fielded monthly to a sample of patients using either direct or purchased care provider offices, was based on the AHRQ CAHPS Clinician and Group questionnaire (CAHPS® C&G), allowing MHS comparison to civilian benchmarks, as well as MHS beneficiary ratings across direct and purchased care venues, and among Service MTFs. Following updated guidelines from the AHRQ CAHPS® C&G, TROSS transitioned in May 2016 as a companion survey with JOES, and was renamed the Joint Outpatient Experience Survey-CAHPS (JOES-C). The JOES-C similarly allows comparison of MHS results to civilian benchmarks, direct and purchased care venues, and among Service MTFs. Both JOES-C and TROSS include MHS-specific questions that measure some aspects of the experience of care used in other DHA surveys (JOES, HCSDB). Results from the MHS population survey, the Health Care Survey of DoD Beneficiaries (HCSDB), are also included in the results that follow, where appropriate, as a comparison against outpatient surveys that are administered following care. The HCSDB, based on the CAHPS Plan survey, is administered quarterly to a sample of the 9.4 million members of the eligible MHS population, irrespective of where they might have received care, and uses a 12-month recall period for most questions (i.e., "In the last 12 months..."). As such, the focus of the HCSDB and CAHPS Plan surveys is the performance of the health plan over time from beneficiary's perspective, while the focus of the JOES-C/TROSS CAHPS® C&G–based survey is about health care received over the past six months following a specific outpatient visit. The comparison of these surveys provides a more comprehensive understanding of the experiences of beneficiaries, regardless of the survey that they are completing or the care that they may or may not have received. Additional results on the HCSDB can be found on page 78.

ACCESS TO MHS CARE *(CONT.)*

Patient-Centered, Self-Reported Measures *(cont.)*

In support of state and federal statutes, the MHS respects and upholds the privacy right of adolescents to protect teen confidentiality for specific services—particularly reproductive and sexual health, mental health, and drug and alcohol treatment. Adolescents may schedule their own appointments and receive their own test results and provider messages. Protecting adolescent confidentiality for these services encourages teens to seek treatment for conditions that they may want to keep private from parents. Nothing in these statutes prevents teens from involving parents in health care decision making. In the results provided on the following pages, the MHS did not survey individuals younger than 18 years of age using TRISS, JOES-C, or HCSDB. The MHS protected the privacy rights of adolescents when administering the JOES survey by only sending a survey to Service members, responding to a child's care for children ages 0–10. The following patient-centered, self-reported results are based on the ages included in the sample.

The HIPAA Privacy Rule and Adolescents[1]

In August 2002, a new federal rule took effect that protects the privacy of individuals' health information and medical records. The rule, which is based on requirements contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), provides important protections for minors, along with a significant acknowledgment of state and federal laws combined with the judgment of health care providers. In each of the circumstances below, the parent is not the personal representative of the minor and does not automatically have the right of access to health information specific to the situation, unless the minor requests that the parent act as the personal representative and have access.

A minor is considered "the individual" who can exercise rights under the rule in one of three circumstances:

1. The minor has the right to consent to health care and has consented, such as when a minor has consented to treatment of emergencies, general health, contraception, pregnancy, HIV or other STDs, substance abuse, or mental health.
2. The minor may legally receive care without parental consent when a minor has requested and received court approval to have an abortion without parental consent or notification.
3. A parent has agreed to confidentiality between the health care provider and the minor.

[1] Adapted from https://www.guttmacher.org/journals/psrh/2004/hipaa-privacy-rule-and-adolescents-legal-questions-and-clinical-challenges

ACCESS TO MHS CARE *(CONT.)*

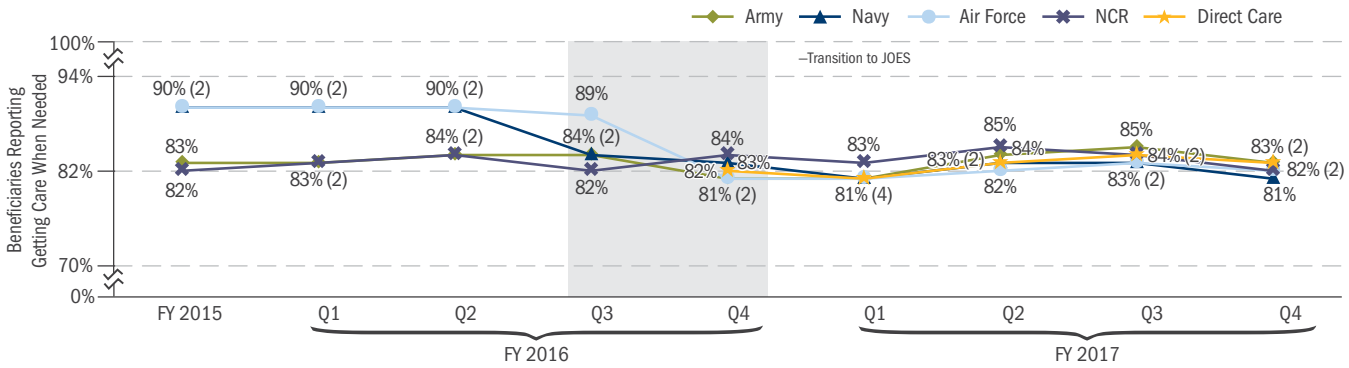
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care

Ratings of Getting Care When Needed

The following chart presents data on one specific measure of access used in all MHS outpatient surveys over the past three years, combining the prior Service-only surveys for all of FY 2015 and most of FY 2016, and the transition to JOES at the end of FY 2016 through each quarter in FY 2017. That is, the measure of Getting Care When Needed was developed as a common question and response item across all outpatient service and DHA surveys for a number of years: APLSS, PSS, SDA, TROSS, JOES, and JOES-C.

- FY 2015 and early FY 2016 display relatively consistent results for each Service, with Navy scores at 90 percent, Air Force results ranging from 89 to 90 percent, Army results ranging from 83 to 84 percent, and NCR results ranging from 82 to 84 percent.
- Prior to FY 2017, comparison of Getting Care When Needed results was not appropriate between the Services using Service-specific surveys. With the introduction of JOES in the second half of FY 2016, Service results are now comparable and have clearly converged. The results for each Service range from 81 to 85 percent, with higher ratings in FY 2017 Q2 and Q3.

SERVICE SURVEYS/JOES GETTING CARE WHEN NEEDED, FY 2015–FY 2017 Q4



Source: DHA/SP&FI (J-5)/Decision Support, analyzing TROSS, APLSS, PSS, SDA, and JOES, compiled 11/27/2017

Notes:

– Sites that migrated to MHS GENESIS were not sampled after migration.

– JOES results displayed above begin in FY 2016 Q3 for Navy and NCR; JOES results for Air Force, Army, and Direct Care begin in FY 2016 Q4. The following time periods are the first available month of data for each of the Services: Navy—May 2016, NCR—June 2016, Army—July 2016, Air Force—September 2016.

– Prior to JOES, the Service-specific survey results above were not reported as weighted. JOES results displayed above are weighted to represent the composition of the MHS population.

– "Getting Care When Needed" is posed in each survey as an agreement to the following statement: "In general, I am able to see my provider when needed." The five-point scale for this question ranges from "Strongly Disagree" to "Strongly Agree." The results provided above are for those beneficiaries who reported either "Somewhat Agree" or "Strongly Agree."

– For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care *(cont.)*

Extent of Change in Variability in Patient Ratings Over Time

In addition to striving to improve overall patient ratings of their access to care, as reflected in the previous trend chart (e.g., improve the average/mean or median of ratings), the MHS also strives to reduce the variability in ratings, such as reducing the number of low ratings. Identifying MTFs with generally low ratings can be the first step in identifying and changing variability in the underlying care and patient management processes.

Description of Box and Whisker Plots and Coefficient of Variation with Patient-Centered, Self-Reported Surveys

Box Plots: Box and whisker plots are used in this report to illustrate the distribution of scores over time. Parent facility scores were weighted to represent the composition of the MHS population. These weighted scores were sorted from highest to lowest, and parent facilities in the top 25 percent are shown at the top by the whiskers and open circles. Parent facilities in the bottom 25 percent are, conversely, shown in the bottom of the graph. The IQR is a measure of variation and represents the middle 50 percent of scores. The upper whisker extends to 1.5*IQR + 75th percentile and the lower whisker extends to 1.5*IQR – 25th percentile. For the purpose of the analyses in this report, "outliers" are defined as those scores that are beyond 1.5*IQR + 75th percentile or 1.5*IQR – 25th percentile, and are represented by open circles.

Facility satisfaction scores were scaled by the number of respondents to each question to reduce the ability of facilities with low numbers of respondents to have an overstated influence on the outcomes of analyses and resultant influence on conclusions.

Coefficient of Variation: The coefficient of variation (CV) refers to a statistical measure of the distribution of data points in a series around the mean and is calculated as the ratio of the standard deviation to the mean. The CV aims to describe the dispersion of the variable in a way that does not depend on the variable's measurement unit, and therefore allows comparison of data variability across questions with differing means. The CV is a helpful statistic in comparing the degree of variation from one data series to another even when the means are considerably different from each other. Since the CV is a function of the standard deviation and the mean, the cases where this value would decrease include instances where either there is little change in standard deviation and an increase in the mean, or a decrease in the standard deviation and little change in the mean. The higher the CV, the greater the dispersion in the variable.

JOES Getting Care When Needed—Variability Over Time

- The table on the following page displays the extent to which the measure of Getting Care When Needed changed over time in terms of improvement (increasing mean or median), or decreased dispersion (reduced range or IQR).
- From FY 2017 Q1 to FY 2017 Q4, Army, Air Force, and Navy improved in terms of the median ratings. With the introduction of JOES, these median results are very similar with each Service and by quarter, and these results are fully comparable.
- Dispersion, in terms of the range between the lowest- and highest-performing MTFs, increased overall from FY 2017 Q1 to FY 2017 Q4 for Army and Air Force, and decreased for Navy. The number of negative outliers increased from two in FY 2017 Q1 to five in FY 2017 Q4. The IQR increased from FY 2017 Q1 to FY 2017 Q4 for Army, Air Force, and Navy. Dispersion, measured by changes to the CV, is also included following the box and whisker plots.

ACCESS TO MHS CARE *(CONT.)*

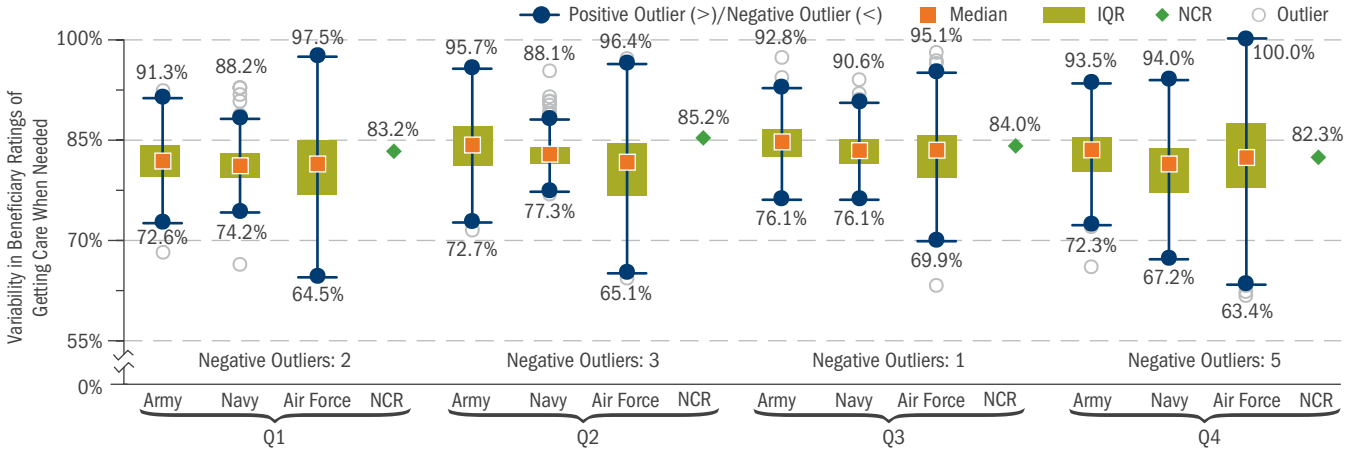
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care *(cont.)*

VARIABILITY IN SERVICE SURVEYS/JOES: GETTING CARE WHEN NEEDED, FY 2017

	FY 2017 Q1	FY 2017 Q2	FY 2017 Q3	FY 2017 Q4	FY 2017 Q1–Q4 % POINT CHANGE
ARMY					
Mean	81.3%	83.8%	84.5%	83.1%	1.8
Median	81.2%	83.9%	84.8%	83.7%	2.5
75th Percentile (Q3)	84.3%	87.1%	86.6%	85.5%	1.2
25th Percentile (Q1)	79.6%	81.3%	82.4%	80.2%	0.6
IQR	4.7%	5.7%	4.2%	5.3%	0.6
Positive Outlier (>)	91.3%	95.7%	92.8%	93.5%	2.1
Negative Outlier (<)	72.6%	72.7%	76.1%	72.3%	–0.4
Maximum	92.2%	92.4%	97.1%	92.7%	0.5
Minimum	68.0%	71.3%	77.3%	65.8%	–2.2
Range	24.2%	21.1%	19.8%	26.9%	2.7
NAVY					
Mean	81.5%	83.2%	83.3%	81.4%	–0.1
Median	80.6%	82.8%	83.1%	82.6%	2.0
75th Percentile (Q3)	83.0%	84.1%	85.2%	83.9%	0.9
25th Percentile (Q1)	79.4%	81.3%	81.5%	77.2%	–2.2
IQR	3.5%	2.7%	3.6%	6.7%	3.2
Positive Outlier (>)	88.2%	88.1%	90.6%	94.0%	5.7
Negative Outlier (<)	74.2%	77.3%	76.1%	67.2%	–7.0
Maximum	92.6%	95.1%	93.8%	92.9%	0.3
Minimum	66.2%	76.7%	77.5%	73.4%	7.2
Range	26.5%	18.4%	16.3%	19.5%	–7.0
AIR FORCE					
Mean	81.4%	81.7%	83.1%	82.6%	1.2
Median	81.8%	83.1%	85.0%	83.3%	1.5
75th Percentile (Q3)	85.1%	84.6%	85.7%	87.6%	2.5
25th Percentile (Q1)	76.9%	76.8%	79.4%	77.9%	1.0
IQR	8.3%	7.8%	6.3%	9.7%	1.4
Positive Outlier (>)	97.5%	96.4%	95.1%	100.0%	2.5
Negative Outlier (<)	64.5%	65.1%	69.9%	63.4%	–1.1
Maximum	95.7%	97.0%	97.9%	98.8%	3.1
Minimum	69.7%	64.1%	63.0%	61.5%	–8.2
Range	26.0%	32.8%	34.9%	37.3%	11.3
NCR					
Mean	83.2%	85.2%	84.0%	82.3%	–0.9

Source: DHA/SP&FI (J-5)/Decision Support, JOES, weighted data, compiled 12/5/2017. Parent facilities are scaled to account for the number of responses and those reporting fewer than 30 responses were excluded from analyses. Sites that migrated to MHS GENESIS were not sampled after migration.

VARIABILITY IN BENEFICIARY RATINGS: GETTING CARE WHEN NEEDED, FY 2017



Source: DHA/SP&FI (J-5)/Decision Support, JOES, weighted data, compiled 12/5/2017

Notes:

– The box shows interquartile range (25th–75th percentiles) with median highlighted.

– Length of whiskers are at 1.5 times the interquartile range, and may or may not include the minimum or maximum values. MTFs outside the "whiskers" are identified as outliers.

– Facilities are scaled to account for the number of responses, and those reporting fewer than 30 responses were excluded from analyses.

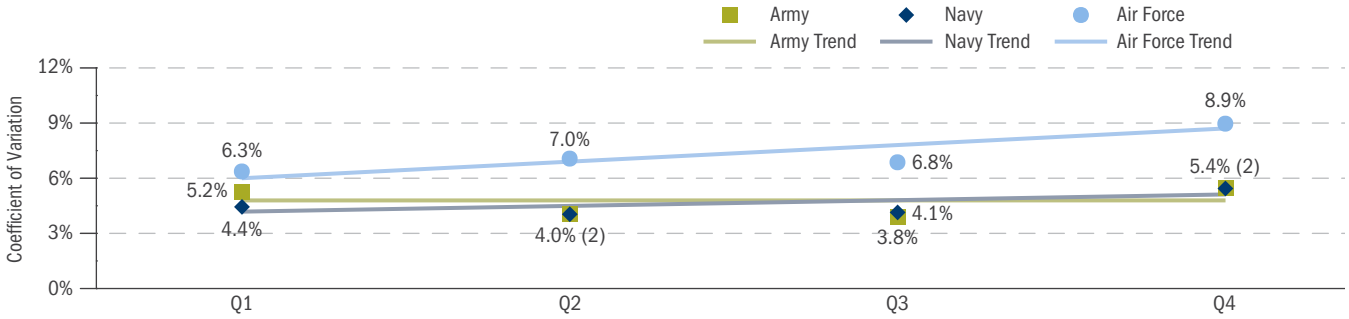
– Parent facilities Fort Belvoir and Walter Reed compose the NCR category, which is represented by a scaled average.

ACCESS TO MHS CARE *(CONT.)*

Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care *(cont.)*

- The following graph shows the CV for the JOES measure Getting Care When Needed. Similar to the results described previously for the range and IQR, the CV is increasing for Air Force and Navy.
- The dispersion of scores at the parent facility level has remained relatively flat over time for Army. This does not mean that scores for each parent facility did not change, nor does it mean that the CV did not change from one quarter to the next. It does indicate, however, that there is not much of an increasing or decreasing trend for the dispersion of Army parent facility scores over time (as measured by the CV).

RELATIVE DISPERSION IN GETTING CARE WHEN NEEDED, FY 2017



Source: DHA/SP&FI (J-5)/Decision Support, JOES, weighted data, 12/5/2017
For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

ACCESS TO MHS CARE *(CONT.)*

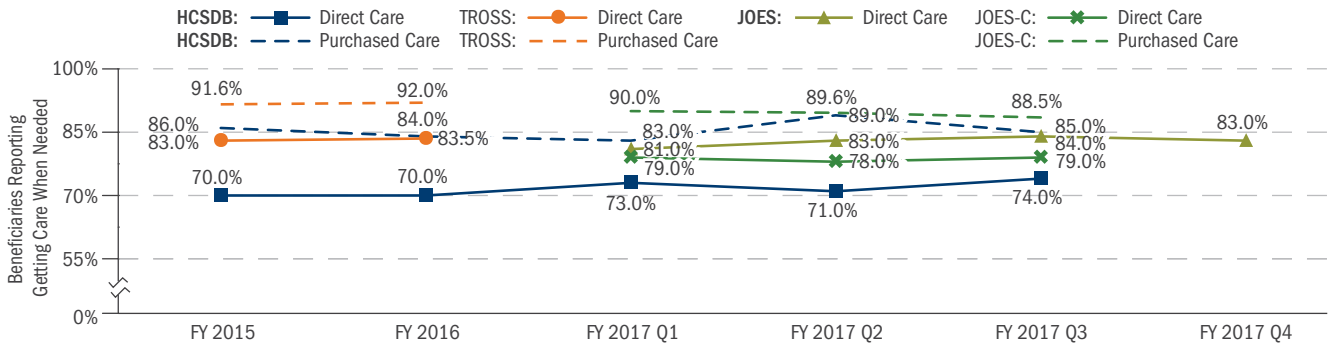
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care *(cont.)*

Comparison of Multiple Surveys—Getting Care When Needed

In addition to each of the Service Surveys and JOES, the population-based HCSDB, TROSS, and JOES-C also report results for the measure of Getting Care When Needed. Including this same measure in each survey provides important information about the differences between surveys and the beneficiaries who answer them. A description of the differences between each of the surveys can be found on page 70.

- Beneficiaries who utilize or are assigned to purchased care report greater access to their provider than those who utilize or are assigned to direct care, regardless of time period. The differences between purchased care and direct care results range by approximately 10 to 20 percent.
- Beneficiaries who completed JOES-C and TROSS reported greater access than beneficiaries who completed HCSDB, over time, for direct care and purchased care. This may be because beneficiaries who complete TROSS and JOES-C are beneficiaries who have already received care, while those who complete the HCSDB may not have received care.
- Trends for Getting Care When Needed are mixed by survey. Results for TROSS from FY 2015 to FY 2016 improved, while those for HCSDB declined. Quarterly results in FY 2017 have been mixed for HCSDB, JOES, and JOES-C direct care; access for JOES-C purchased care has decreased from FY 2017 Q1 to Q3.

HCSDB, TROSS, JOES, AND JOES-C RATINGS OF GETTING CARE WHEN NEEDED, FY 2015–FY 2017 Q4



Source: DHA/SP&FI (J-5)/Decision Support, HCSDB, TROSS, JOE), and JOES-C, 12/5/2017.

Notes:

– Health Care Survey of DoD Beneficiaries, TRICARE Outpatient Satisfaction Survey (TROSS), Joint Outpatient Experience Survey (JOES), and Joint Outpatient Experience Survey-CAHPS (JOES-C) results provided above. Sites that migrated to MHS GENESIS were not sampled after migration.

– Results for each survey above are weighted to appropriately represent the composition of the MHS population.

– TROSS results for FY 2016 continue from October 2015 to May 2016 for direct care, and from October 2015 to April 2016 for purchased care. Although JOES-C began subsequent to the termination of TROSS, the JOES-C survey instrument changed in August 2016; trending for this question is not recommended from FY 2016 to FY 2017 Q1.

– Results for HCSDB are for Prime enrollees only. "HCSDB purchased care" is defined as those who are assigned to an MCSC. "Getting Care When Needed" is posed in each survey as an agreement to the following statement: "In general, I am able to see my provider when needed." The five-point scale for this question ranges from "Strongly Disagree" to "Strongly Agree." The results provided above are for those beneficiaries who reported either "Somewhat Agree" or "Strongly Agree."

– Sites that migrated to MHS GENESIS in FY 2017 were not sampled after migration.

ACCESS TO MHS CARE *(CONT.)*

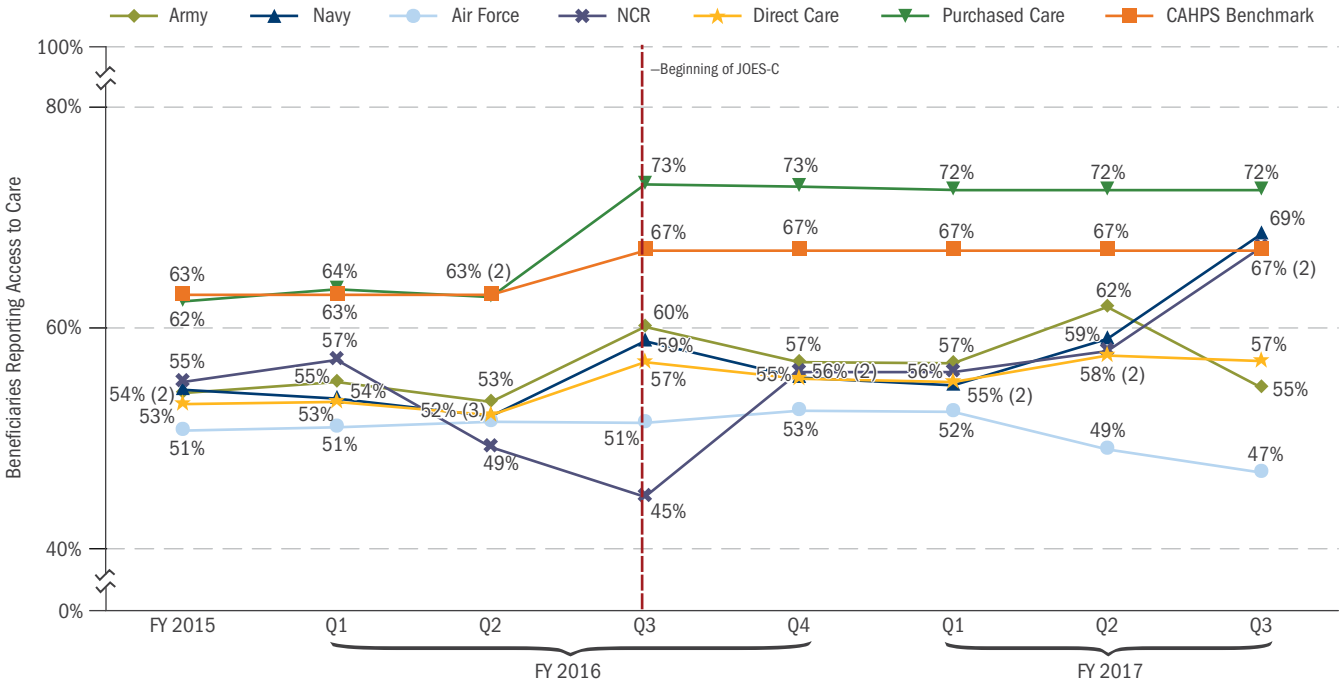
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care *(cont.)*

TROSS/JOES-C Access to Care Composite

The Access to Care composite differs from Getting Care When Needed, not only because it is based on guidelines from AHRQ C&G, but also because there are multiple questions that are included in the results, and the reference ("look-back") period is six months compared to 24–48 hours for JOES. Component questions that are part of the Access to Care composite include whether the patient was able to be seen for routine and urgent appointments and if the patient received an answer to a question within an appropriate time.

- The Access to Care composite ratings for beneficiaries receiving outpatient care at civilian facilities are higher than for those receiving care from MTFs. Ratings for Access to Care remained fairly stable under TROSS, with the exception of NCR.
- With the introduction of JOES-C in FY 2016 Q3, purchased care has risen above the CAHPS benchmark along with NCR and Navy in FY 2017 Q3. Air Force has experienced a decrease in ratings from FY 2017 Q1 to FY 2017 Q3, and Army has seen mixed results from FY 2016 Q3 to FY 2017 Q3. Results in each of the Services have contributed to fairly stable ratings in direct care from FY 2016 Q3 to FY 2017 Q3. Army, Air Force, and direct care overall remained below the benchmark since the introduction of JOES-C.

TROSS/JOES-C ACCESS TO CARE COMPOSITE, FY 2015–FY 2017 Q3



Source: DHA/SP&FI (J-5)/Decision Support, compiled 12/5/2017

Notes:

– Weighted results are provided above from the TRICARE Outpatient Satisfaction Survey (TROSS) (October 2014–March 2016) and the Joint Outpatient Experience Survey-CAHPS (JOES-C) (direct care—June 2016–present; purchased care—May 2016–present).

– Results displayed above were weighted to represent the composition of the MHS population.

– Sites that migrated to MHS GENESIS were not sampled after migration.

– Benchmarks are the CAHPS 50th percentiles from the 2014 Adult 12-Month Survey 2.0 with/without PCMH items, 2015 Adult 12/6-Month Survey 2.0 with/without PCMH items, 2015 Adult Survey 3.0, and the 2016 Adult 6-Month Survey 3.0 with/without PCMH items.

ACCESS TO MHS CARE *(CONT.)*

Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care *(cont.)*

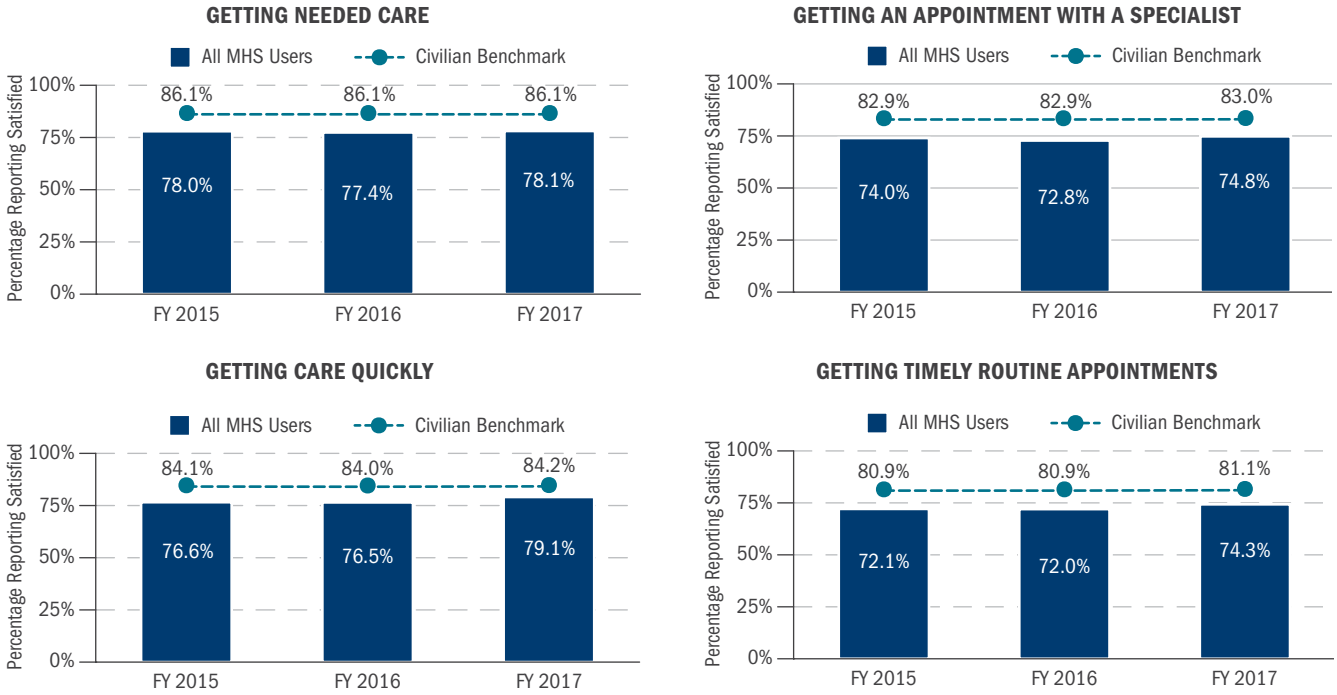
Instead of focusing on a specific health care event to assess patient experience with care, population surveys are designed to sample populations based on the demographics being considered (e.g., a survey of all ADSMs about their health behaviors, or a survey of all MHS beneficiaries to assess their use of preventive services and access to primary and specialty care), as in the case of the DHA Health Care Survey of DoD Beneficiaries (HCSDB). The next two pages of charts are based on beneficiary ratings of their care experiences in the prior 12 months, and not based on a particular visit or hospital stay.

Availability and Ease of Obtaining Care

Availability and ease of obtaining care can be characterized by the ability of beneficiaries to obtain the care they need when they need it. Two major measures of access within the CAHPS survey—Getting Needed Care and Getting Care Quickly—address these issues. Getting Needed Care has a submeasure: problems getting an appointment with specialists. Getting Care Quickly also has a submeasure: waiting for a routine visit.

- Overall MHS beneficiary ratings for Getting Needed Care and Getting an Appointment with a Specialist were unchanged between FY 2015 and FY 2017. Ratings for Getting Timely Routine Appointments and Getting Care Quickly increased from FY 2015 to FY 2017. Civilian benchmarks for all four access measures remained stable over the same time period.
- MHS beneficiary satisfaction with all four access measures was lower than the comparable civilian benchmarks in each year between FY 2015 and FY 2017.

TRENDS IN MEASURES OF ACCESS FOR ALL MHS BENEFICIARIES (ALL SOURCES OF CARE), FYs 2015–2017



Note: DoD data were derived from the FYs 2015–2017 HCSDB, as of 11/13/2017, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used in 2015 come from NCQA's 2013 data, while the benchmarks used in 2016 and 2017 come from NCQA's 2015 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

ACCESS TO MHS CARE *(CONT.)*

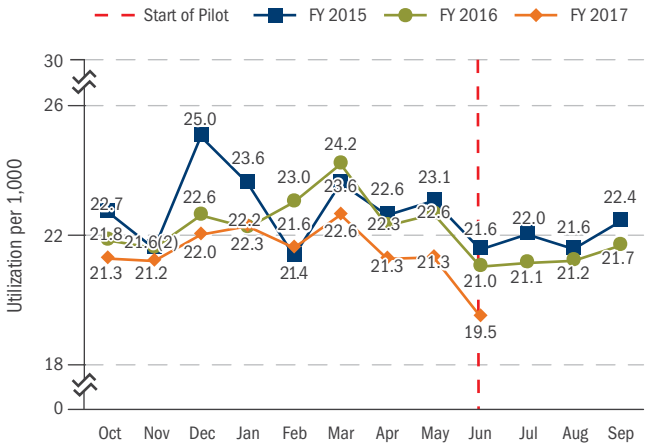
Urgent Care Pilot

Section 725(c)(1) of the NDAA for FY 2016 (Public Law 114-92) required the implementation of a pilot program to allow TRICARE Prime beneficiaries visits to network UCC without preauthorization. The pilot program began on May 23, 2016. Previously, a TRICARE Prime beneficiary had to obtain a referral from their PCM to visit a network UCC, a referral was not required for a visit to an ER. Because of this policy, many beneficiaries visited the more costly ER in lieu of a UCC, despite exhibiting symptoms that could be appropriately addressed at the UCC. The pilot is structured to encourage beneficiaries to obtain care in the setting most appropriate to their condition, while easing an administrative burden of the preauthorization requirement for up to two UCC visits annually. The pilot is examining utilization patterns, impacts on cost of care, and beneficiary satisfaction.

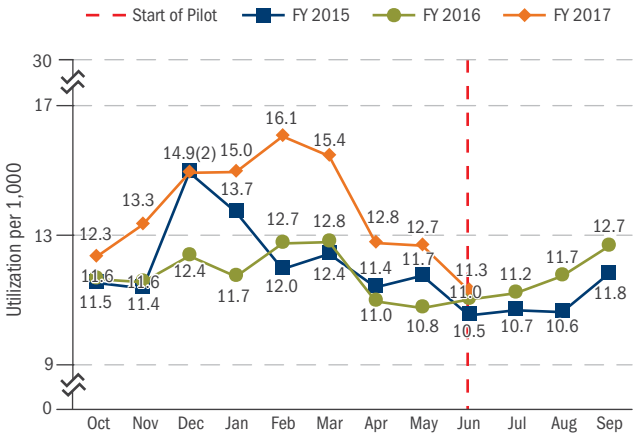
ER and UCC Utilization and Cost per Beneficiary

Network UCC and ER statistics have been monitored for TRICARE Prime beneficiaries across FY 2015, FY 2016, and FY 2017 (October through June). Comparing June 2016 to June 2017, UCC utilization has increased by 3 percent and cost per beneficiary has decreased by 1 percent, while ER utilization has decreased by 7 percent and cost per beneficiary has decreased by 5 percent.

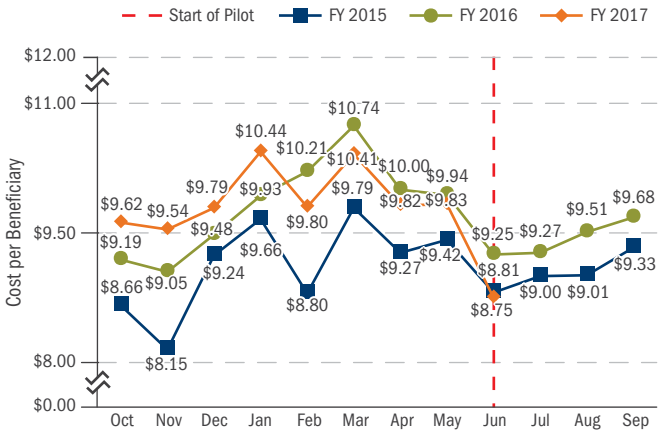
EMERGENCY CARE UTILIZATION, FYs 2015–2017



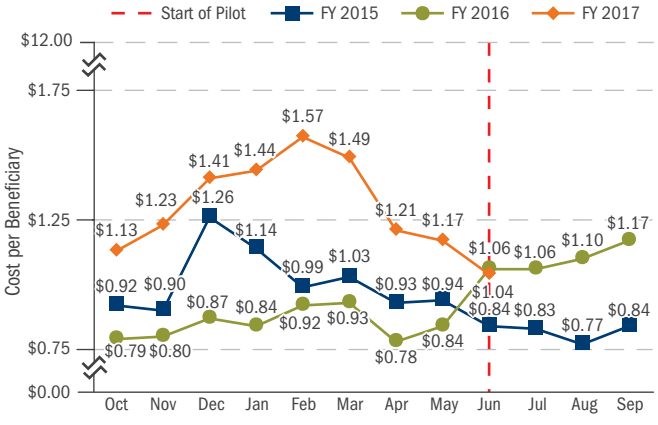
URGENT CARE UTILIZATION, FYs 2015–2017



EMERGENCY CARE COST, FYs 2015–2017



URGENT CARE COST, FYs 2015–2017



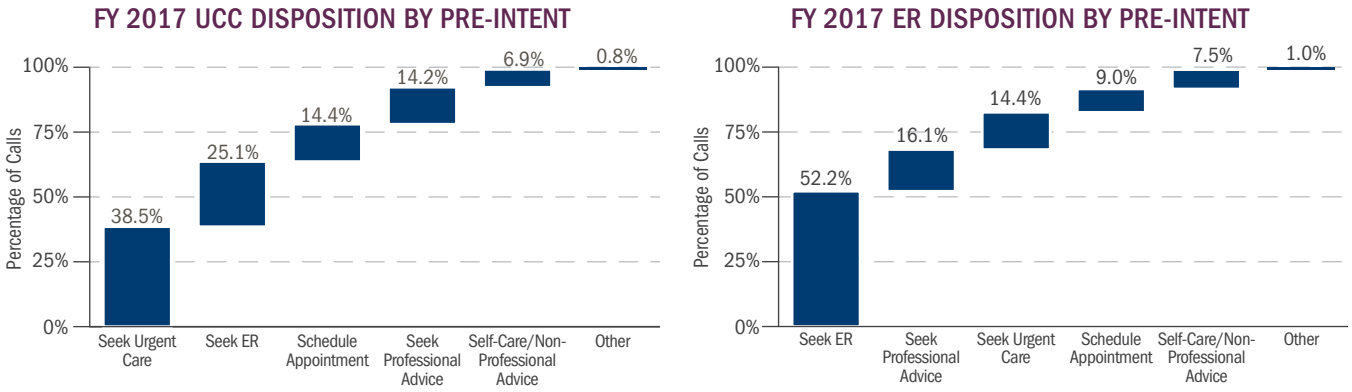
Notes:
– M2, TED-NI, MTF Prime = Enrollment Site Military Service = A, F, N, P; MCSC Prime = Enrollment Site Millitary Service = M.
– Excludes Active Duty members and Guard/Reserve on Active Duty (Beneficiary Category ≠ ACT, GRD).
– ASV Group = Prime only.

ACCESS TO MHS CARE *(CONT.)*

Urgent Care Pilot *(cont.)*

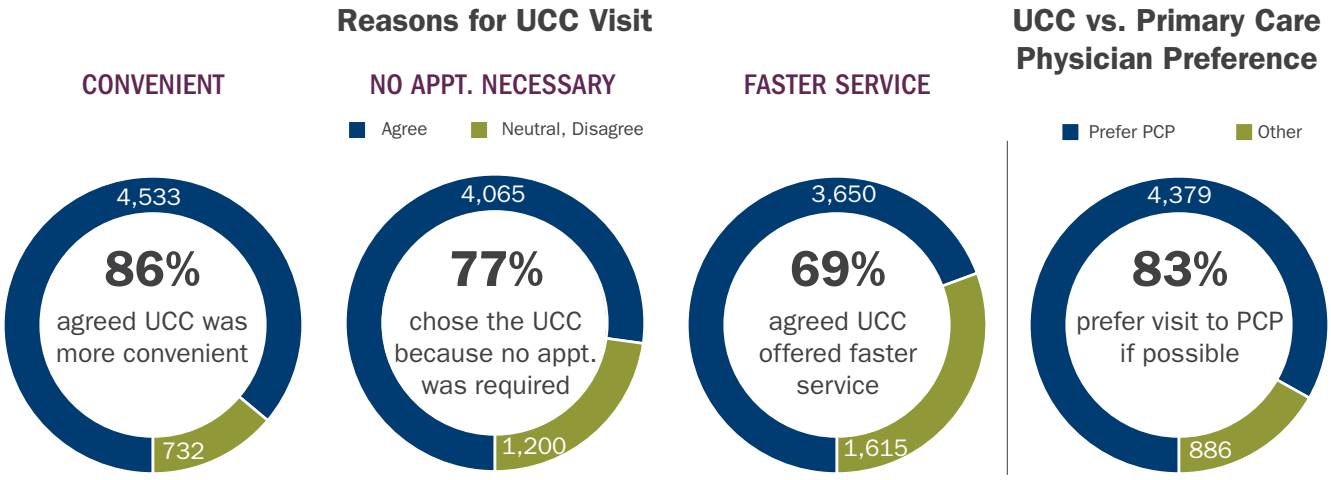
Nurse Advice Line

The NAL is used to guide and encourage enrollees into appropriate levels of health care utilization. Since the implementation of the UCC pilot, NAL survey data suggest that the NAL is successful at directing patients to the appropriate level of care. Of beneficiaries who received care in a UCC, 46 percent called the NAL prior to their visit. In FY 2017, 25 percent of patients who called the NAL and were seen in a network UCC had initially intended to seek treatment at an ER, and 14 percent of patients who called the NAL and were seen in a network ER had initially intended to seek care at a UCC.



Urgent Care Survey Results[1]

Additionally, as shown in the trend charts on the next page, patient satisfaction survey results of beneficiaries who received care in a network UCC indicate that beneficiaries are generally satisfied with this new benefit. Patient satisfaction has consistently remained above 90 percent since July 2016, while benefit awareness steadily increased from 33.6 percent in July 2016 to 46.9 percent in July 2017. Survey responses also reveal that UCCs are chosen based on convenience factors: 86 percent of respondents chose to visit the UCC because it had convenient hours, 77 percent chose the UCC because no appointment was required, and 69 percent agreed that the UCC offered faster service than other sources of care.

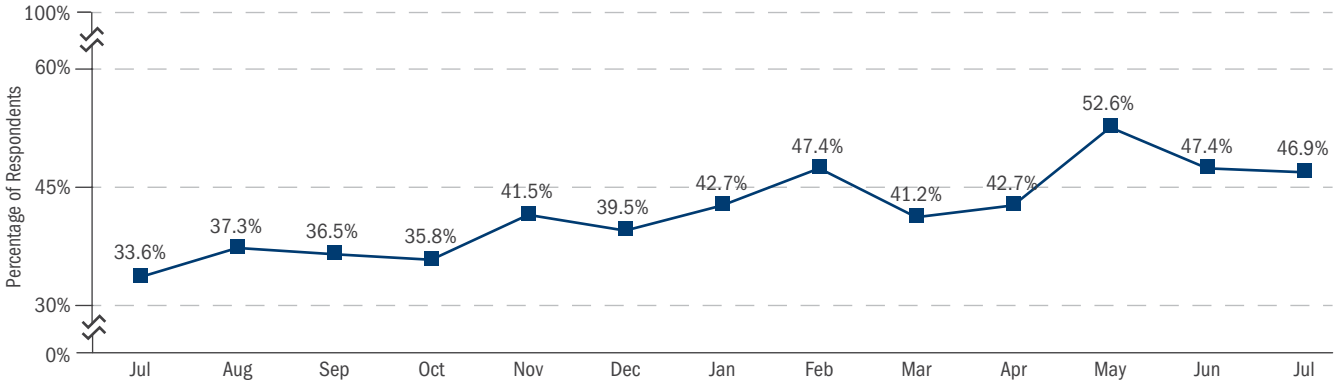


Source: DHA/SP&FI (J-5)/Decision Support, 11/6/2017
[1] N= 5,265 TRICARE Prime enrollee (MTFs and purchased care) responses from July 2016 to July 2017.

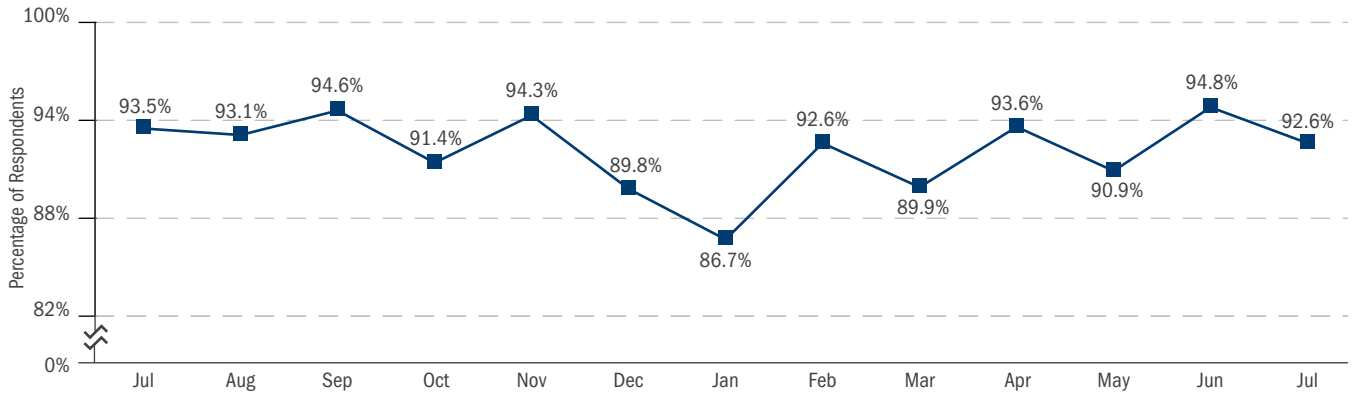
ACCESS TO MHS CARE *(CONT.)*

Urgent Care Pilot *(cont.)*

BENEFIT AWARENESS, JULY 2016–JULY 2017



PATIENT SATISFACTION, JULY 2016–JULY 2017



BETTER CARE

Medical Management

Improving the health and quality of life for MHS beneficiaries living with chronic conditions is an ongoing effort. To support identification and engagement with this population, the MHS is working proactively to identify beneficiaries within a dedicated MHS Population Health Portal (MHSPHP).

The registries are created by using direct care and purchased care information, and enhanced using the Johns Hopkins Adjusted Clinical Groups® (ACG®) System. The MHSPHP registries stratify beneficiaries with select chronic conditions by identifying morbidity patterns, which can then be used by MTF disease management staff to target specific high-risk populations for interventions.

MHS Case Management Program Development

The MHS case management (CM) program has made improvements in documentation and coordination with MTF primary care teams. Specifically, these improvements include the development of dedicated adult and pediatric TSWF forms, which support standardized, enterprise-wide documentation and allow clinical case managers to comprehensively initiate, monitor, and document CM needs and services for all beneficiary categories in need of complex care management in the MTF.

Traditionally, CM program requirements have been developed and executed through Service-specific policy. This has resulted in varied approaches in both the delivery and outcomes of CM implementation. Recognizing inefficiencies in implementation and fragmentation of care, the need to standardize CM documentation across the MHS was identified. There is also a requirement to make clinical CM documentation readily available to the members of the patient's health care team. To achieve these objectives, the medical management team collaborated with a Tri-Service group of CM subject matter experts, who in turn coordinated with the TSWF team, to develop MHS-wide CM adult and pediatric TSWF forms. Implementation of these forms supports standardized CM documentation and facilitates communication and coordination of necessary resources to improve the quality of care and patient outcomes across the MHS. In addition, dedicated MHS policy was published in July 2017 to support ubiquitous use of the CM TSWF within the direct care system.

QUALITY OF MHS CARE

The MHS maintains active and effective organizational structures, management emphasis, and program activities to ensure quality in health care throughout the system. DoDI 6025.13 identifies the components of clinical quality management as patient safety, risk management, credentials and clinical privileging, quality assurance, and clinical performance measurement and improvement. The directive requires MTF participation in the DoD Patient Safety Program (PSP) to identify and report actual and potential problems in medical systems and processes and to implement effective actions to improve patient safety and health care quality throughout the MHS. MTFs are required to implement active risk management systems and programs to reduce liability associated with actual or alleged medical malpractice. All fixed MTFs, as well as hospitals and other facilities used by MCSCs, are required to meet or exceed the standards of appropriate external accrediting bodies. Individual provider credentials and qualifications are carefully evaluated before allowing involvement in patient care. Every MTF maintains a performance measurement system for clinical quality to confirm quality-of-care outcomes and identify opportunities for improvement. Combined, these components provide the MHS with a strong clinical quality management infrastructure to support the provision of high-quality care to our beneficiaries.

Programs to Prevent Harm

The mission of the DoD PSP is to promote a culture of safe, high-quality patient care to end preventable patient harm by engaging, educating, and equipping patient-care teams to put evidence-based safe practices in place across the organization. In the MHS direct care system, the DoD PSP regularly monitors, measures, and identifies trends in patient safety data and safety event reports, which are leveraged to prioritize areas of focus for patient safety improvement in collaboration with the Services. The DoD PSP then develops targeted tools and solutions, disseminates them to frontline care teams, and evaluates their impact for continuous improvement.

The comprehensive May 2014 MHS review reinvigorated the organization's commitment to the delivery of safe, high-quality health care with the adoption of high-reliability principles to reduce variability and improve performance. The DoD PSP, in collaboration with Service leadership, is integral to this effort in its continued support for advancing a culture of a safe health care system and establishing data-driven, standardized processes to promote safe and reliable care for every patient, every time.

Assessing Data to Identify Patient Safety Needs

Reporting patient safety events is a component in the MHS effort to achieve high reliability, continuously improve, and provide the safest patient care possible. The reporting of patient safety events, including those that did not reach the patient (i.e., near-miss events), allows the DoD PSP to analyze the sequence of events that potentially lead to an error, identify trends in patient harm across the MHS direct care system, and share lessons learned to prevent future harm events reaching the patient. The Patient Safety Reporting (PSR) system is a standardized, anonymous, voluntary web-based reporting system that was implemented across the MHS direct care system in FY 2011 to capture patient safety events.

MHS leadership has directed MTF commanders and staff to report all patient safety events reaching the patient, and encourages the reporting of near misses to the greatest extent possible. The table below compares FY 2014 to FY 2017 PSR, stratified by harm classification. In FY 2017, a total of 99,670 patient safety event reports were submitted from our direct care system, which included 55 hospitals, 373 ambulatory clinics, 251 dental clinics, and the operational environment, representing a 6 percent decrease from FY 2016 to FY 2017. Near-miss safety events accounted for 51 percent of all patient safety events reported in FY 2017, which decreased by almost 13 percent from 57,875 in FY 2016. The number of harm events decreased slightly from 10,037 in FY 2016 to 9,865 in FY 2017 (almost 2 percent).

PATIENT SAFETY EVENTS REPORTING, FYs 2014–2017

HARM GROUP	FY 2014		FY 2015		FY 2016		FY 2017	
	#	%	#	%	#	%	#	%
Harm	7,613	9%	9,162	9%	10,037	9%	9,865	10%
No Harm	37,286	42%	34,565	35%	38,227	36%	39,363	39%
Near Miss	44,275	50%	53,644	55%	57,875	55%	50,442	51%
Total	**89,174**	**100%**	**97,371**	**100%**	**106,139**	**100%**	**99,670**	**100%**

Source: DHA/OPS (J-3)/ CSD, 11/25/17

QUALITY OF MHS CARE *(CONT.)*

Programs to Prevent Harm *(cont.)*

Another way that the DoD looks at safety is through the reporting of sentinel events (SEs). The DoD has mandated the reporting of all SEs, which are defined as a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following: death, permanent harm, or severe temporary harm. The most commonly reported SEs are shown in the table below. This table includes SEs that are reportable to TJC, and both medical (non-dental) and dental events.

- **Wrong-Site Surgery (WSS):** WSS is a preventable SE involving surgeries on the wrong site, wrong side, wrong person, or wrong procedure in the direct care system. The MHS goal for WSS events is zero events. In FY 2017, the MHS saw a 32 percent reduction from FY 2016 in the number of reported WSS SEs. Efforts to prevent WSS include developing and disseminating prevention tool kits, continuous and focused communication to leadership, direct MTF coaching to implement stronger corrective actions after an event, and sustained deployment of universal protocols.
- **Delay in Treatment:** Delay-in-treatment events can be serious SEs that result in patient death or serious injury associated with a missed diagnosis; misdiagnoses; delays in diagnosis; and failure to follow up on or communicate laboratory, pathology, or radiology test results. In FY 2017, there was a 19 percent decrease in the number of reported delay-in-treatment events. To prevent these events, the Services are implementing various measures, including establishing a group dedicated to looking at and preventing delays in treatment.
- **Unintended Retained Foreign Object (URFO):** An URFO event that occurs after an invasive medical or surgical procedure is an SE that causes patient harm and significantly increases the cost of patient care. The MHS goal for URFO SEs is zero events. The MHS measures URFO SEs by looking at the reported number of events involving an URFO that result in no harm (event reached patient, but no harm was evident), harm, or death in the direct care system. In FY 2017, the number of reported URFO SEs increased 39 percent over FY 2016. To combat the occurrence of these events, the Services continue to monitor the conduction of time-outs, participate in the Institute for Healthcare Improvement (IHI) surgical collaborative, and have disseminated an URFO prevention guidebook.
- **Intraoperative SEs:** Intraoperative SEs include serious events that occur during a surgery or procedure, or immediately post-operative or post-procedure. The MHS measures these events by looking at any event that results in death, permanent harm, or severe temporary harm during or after a surgery or procedure. There was a 40 percent decrease in reported intraoperative events from FY 2016 to FY 2017. To further prevent these events, the Services have implemented several improvement initiatives, including reporting all intraoperative events to a dedicated surgical perioperative safety subgroup and enforcing a 60-second pause before all surgeries.
- **Maternal SEs:** Maternal SEs include events during pregnancy (after 20 weeks gestation) and the postpartum period (up to 42 days) related to pregnancy. Maternal SEs could include adverse outcomes, delay in treatment, WSS, URFOs, and/or other events that impact the health and outcome of pregnancies.

SENTINEL EVENTS REPORTING, FYs 2014–2017

EVENT TYPE	FY 2014	FY 2015	FY 2016	FY 2017	TOTAL
	#	#	#	#	#
WSS: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedures	41	33	38	26	**138**
Delay in Treatment: Lab, Path, Radiology, Referral, Treatment Order	18	19	27	22	**86**
URFO	18	24	18	25	**85**
Intraoperative or Immediate Post-Op/Post-Procedure or Surgery	13	18	25	15	**71**
Maternal (≥ 20 Week Gestational Age–42 Days Postpartum): Hemorrhage, Hysterectomy	2	21	30	8	**61**

Source: DHA/OPS (J-3)/ CSD, 11/25/17

QUALITY OF MHS CARE *(CONT.)*

Programs to Prevent Harm *(cont.)*

The DoD also continues to focus on health care–associated infections (HAIs). Central line-associated bloodstream infections (CLABSIs) and catheter-associated urinary tract infections (CAUTIs) are HAIs that occur after placement of a central line or catheter, respectively. These infections are associated with increased morbidity, mortality, health care costs, and length of stay per the Centers for Disease Control and Prevention (CDC); however, they can be prevented when recommended infection control measures are followed. There are five specific intensive care unit (ICU) types and four specific ward types within the MHS that are required to report to CDC's National Healthcare Safety Network: the medical, pediatric medical/surgical, medical/surgical, surgical, and trauma ICUs; and the labor and delivery, medical, medical/surgical, and surgical wards.

- The most reliable way to track CLABSIs and CAUTIs is through the use of the standardized infection ratio. This measure compares the number of infections (CLABSI and CAUTI) that occurred in MHS direct care with the number of infections that were predicted in these settings by a statistical model that adjusts for patient characteristics that may increase the risk of infection. These methods were developed by the CDC and are the current benchmarks used for performance comparisons by Medicare.
- As shown in the table below (where lower than one is better than the national benchmark), the MHS has had sustained good performance for both CAUTIs and CLABSIs. For CAUTIs, the excellent performance seen in the past two years has led to the event being tracked less frequently at an MHS level, allowing leadership to focus on other, more pressing safety issues. To combat the occurrence of these infections, MHS facilities are focusing on monitoring best practice techniques such as hand hygiene and standard precautions, focusing on catheter insertion only for appropriate indications, using aseptic technique and sterile equipment, disseminating focused reviews on HAIs, and spreading best practices through the use of tool kits and guidebooks.

HEALTH CARE–ASSOCIATED INFECTIONS, FY 2014 Q1–FY 2017 Q3, STANDARDIZED INFECTION RATIO

	2014 Q1	2014 Q2	2014 Q3	2014 Q4	2015 Q1	2015 Q2	2015 Q3	2015 Q4	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3
CLABSIs	0.4	0.8	0.9	1.0	0.5	1.1	1.4	1.0	1.5	0.5	1.4	1.3	1.0	0.8	0.8
CAUTIs	0.0	0.5	0.8	0.9	0.1	0.5	0.2	0.8	0.2	0.3	0.2	0.2	0.3	0.8	0.9

Source: DHA/OPS (J-3)/CSD, 11/25/2017
Notes:
– The standardized infection ratio (SIR) is a CDC National Healthcare Safety Network measure for tracking HAIs over time at a national, state, or facility level. The SIR compares the actual number of HAIs at each hospital to the predicted number of infections. The predicted number is an estimate based on national baseline data, and it is risk adjusted. Risk adjustment takes into account that some hospitals treat sicker patients than others. Lower than 1.0 is better than the national average.
– FY 2017 Q4 is unavailable due to a three- to four-month data lag.

In addition to capturing patient safety events reported through PSR, the DoD PSP receives root cause analyses (RCAs), which are required from MTFs for every SE that occurs within a facility. Services can also voluntarily submit "internal" RCAs for safety events that are not regarded as sentinel, but for which an RCA would still be beneficial by promoting learning and system improvements. In total, 135 RCAs and 49 internal RCAs were received in FY 2017, representing a 4 percent and 6 percent decrease over FY 2016, respectively. For each RCA received, the DoD PSP reviews the strength of corrective actions (CAs) and submits a review back to the Service. Through this process, the DoD PSP guides MTFs to implement strong CAs that are more likely to prevent a similar event from happening again. In FY 2017, the percentage of RCAs that included higher strength CAs increased by 13 percent over 2016.

Finally, in FY 2017, the DoD implemented several initiatives aimed at sharing lessons learned between Services and MTFs. One such effort is the SERCA (Sentinel Event and Root Cause Analysis) Tool. This tool allows users with access to view SE and PSR reporting for their own facilities and others across the MHS, and access all CAs implemented for safety events across the DoD. This is the first time MTFs have had real-time visibility into what others in the DoD are doing to prevent events and improve safety, and will allow individual facilities to view and utilize the strongest CAs developed at other locations.

Programs to Prevent Harm *(cont.)*

MHS Patient Safety Culture

Approximately every three years, the DoD PSP administers the MHS Patient Safety Culture Survey, which is adapted from the nationally recognized Hospital Survey on Patient Safety Culture developed by the AHRQ, and designed to assess staff perceptions of patient safety across 12 dimensions within the MTF. The survey is fielded in the MHS direct care system across all hospitals, clinics, and dental facilities. In the 2016 survey, there was an approximate 42 percent response rate, which was down one percentage point since the last administration of the survey in 2011. Perceptions of teamwork within units and supervisors' promotion of patient safety remained high, while significant positive increases were seen in staff comfort with reporting events, providing feedback, and communicating openly about errors. There remain a few areas of opportunity for improvement, specifically in patient hand-offs and decreasing staff workload and fatigue.

Evolving a safety culture MHS-wide is a long-term journey that necessitates a continuous improvement approach, including ongoing culture assessments and improvement actions based on data, lessons learned, and emerging safety science knowledge. Using results from survey feedback, plan development is underway to further improve patient safety efforts by methodically investigating the causes of the gaps in the staffing dimension of safety culture. This plan will include input from the Services and contain: (1) a review of evidence and data on staffing-related patient safety risks and on measurement tools and techniques; (2) a baseline assessment aimed at identifying the causal factors; (3) a design of evidence-based improvement strategies; (4) plans for implementation, impact evaluation, sustainment, and ongoing improvement; (5) change in management principles and techniques; and (6) the identification of additional resource requirements. Since safety culture is a local phenomenon, the methods and measures will be applied at the local level. Fostering a strong culture of safety within the MTFs remains an essential element to achieving high reliability within the MHS.

Programs to Prevent Harm *(cont.)*

Targeted Solutions to Engage, Educate, and Equip

The DoD PSP continued its work in 2017 to identify and refine competencies related to patient safety, quality, and process improvement (PS/Q/PI) to support the MHS in its transformation to an HRO. Working with the MHS High Reliability Coordination Board, the DoD PSP is expanding on previous work by adding competencies related to risk management and performance monitoring into its analysis and identifying how learning resources used by the Services and NCR support these as well as the original PS/Q/PI competencies.

In addition to refining competencies, the DoD PSP offers an array of resources and solutions to target contributing factors to patient safety events in the MHS, such as breakdowns in staff-to-staff communication. Included in these resources is Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS®), an evidence-based, teamwork development system designed to improve health care team communication techniques and produce teams that optimize the use of information, people, and resources to achieve the best clinical outcomes. The DoD PSP supports the Services by helping TeamSTEPPS® Service coordinators by hosting the annual TeamSTEPPS® DoD conference session to share leading practices, providing infrastructure to obtain continuing education, offering one-on-one team coaching, and evaluating the system's effectiveness. Throughout the MHS direct care system, over 65,000 MHS staff members (calendar year [CY] 2010 to September 2017) have recorded being trained in TeamSTEPPS® principles.

Further training is offered for Patient Safety Managers (PSMs) through the Patient Safety Professional Course (PSPC)—a week-long course hosted four times a year to provide new PSMs with standardized knowledge, skills, and tools to implement patient safety initiatives at their facility. The PSPC offers an award-winning, state-of-the-art learning system with a pre-work module, five days of face-to-face training, post-training virtual coaching, and opportunities for continued development through a PSM Ongoing Learning Certificate. The PSPC curriculum is updated to integrate HRO principles and foundational knowledge within the course content, and keep attendees trained on the latest innovative health care information and resources. Before attending the course, trainees reported an average confidence level of 25 percent across all aspects of their role; after course completion, this increased to 81 percent. As part of the PSPC, the DoD PSP provides individual coaching to PSMs at three, six, and 12 months post-course to further build confidence and competencies as they grow within their new role. Nearly 100 percent of those surveyed at the 12-month coaching session express high confidence in their abilities as PSMs.

The DoD PSP also undertakes actions to develop educational tools and resources to engage leadership and patient safety champions in advancing quality and patient safety. These products equip MTF staff with information on leading practices and resources to facilitate large-scale change. Following the development and dissemination of the Leadership Engagement Toolkit and strategies, the Army, Navy, and Air Force focused on implementation of the Daily Safety Briefing. PSP coaches worked with six Army MTFs to ensure successful implementation and helped identify measurements of effectiveness. PSP also distributed more than 207,000 pieces of education materials—including badge cards, brochures, posters, pocket guides, training DVDs, etc.—designed to help advance their improvement initiatives.

Education and shared knowledge are further promoted through the development and release of key resources, such as "Eliminating WSS and Procedure Events: A Guidebook for Inpatient and Ambulatory Facilities," designed to provide the Services and MTF leaders and staff with a resource for identifying, understanding, and implementing nationally and internally recognized leading practices to help eliminate WSS incidences. In 2017, the PSAC published three Focused Review publications, one on ambulatory care and two on HAIs, as well as the CY 2016 Patient Safety Annual Summary, which is a retrospective annual review of MHS direct care patient safety trends for CY 2016 in comparison with CYs 2015, 2014, and 2013. These publications act as a catalyst for transparency, sharing success stories and areas of improvement to focus on, and aid in understanding the complex care network that contributes to quality and safety in the MHS.

Programs to Address Risk—Risk Management

The focus of health care risk management programs is to promote safe and effective patient care, maintain a safe working environment, and protect financial resources using structured analytical processes. The MHS risk management program supports the MHS strategy for managing systemic risks. Oversight of the risk management process in the MHS is the responsibility of the Risk Management Work Group (RMWG). This governance body is directed by the DoDI 6025.13 and the DoDM 6025.13, and is the primary body for oversight of risk management processes and reporting of malpractice and adverse privileging actions to the NPDB. The work group provides a forum to discuss relevant risk management topics, share clinical lessons learned from risk management events within the MHS, identify variance in health care delivery, and promote uniform Tri-Service implementation of risk management processes.

Reporting to the NPDB. In FY 2017, 103 practitioners providing health care in MTFs worldwide were reported to the NPDB (reported by the Services to the MHS RMWG). The activities that gave rise to the reports include the following: paid tort claims (malpractice claims), adverse privilege actions, government administrative actions, Active Duty death cases, adverse practice actions, judgments or convictions, and Active Duty disability cases. As noted in last year's report (page 36), 129 practitioners were reported in FY 2016.

Joint Centralized Credentialing and Quality Assurance System

The Joint Centralized Credentialing and Quality Assurance System (JCCQAS) is a web-based application that will integrate DoD and Department of Veterans Affairs Healthcare Administration (VHA) credentialing organizations to create a joint global application. These joint processes and collaboration will standardize the collection of common data points and encourage increased collaboration through the pursuit of common goals. This integrated information system will expedite the credentialing processes at all facilities that share provider resources within the VHA and DoD by bridging the information gap and eliminating duplication in the verification of credentials for health care providers who are assigned to multiple facilities. JCCQAS benefits include:

- Submitting a single application for multiple facilities.
- Sharing of credentialing information across departments, which increases provider quality and patient safety.
- Supporting data integrity and autonomy between the two departments while allowing for sharing.
- Utilizing the same system to enable further standardization of processes between the departments.
- Supporting department custody of data while allowing for sharing in a well-defined, role-based, computable format.
- Allowing for electronic workflow for review, routing, and approval of provider credentials.

FY 2017 JCCQAS Accomplishments

- Completion of the identification, decomposition, and acceptance criteria for 44 high-level VA requirements and functions that exist today in the VA legacy credentialing system, but does not exist in the DoD legacy system.
- Collaboration with VA and DoD SMEs to develop common business rules and practices to streamline the credentialing process.
- Completion of 12 of 13 planned Agile Sprint development cycles and 11 of 13 functionality demonstrations to VA and DoD stakeholders and system users.
- Completion of data modeling and data migration activities for both VA and DoD legacy systems.

JCCQAS is on track for implementation to over 500,000 current health care providers and system users in FY 2018. Once implemented, it will merge over 13 million documents and one million credentialing records into a single, secure database.

Programs to Address Risk—Risk Management *(cont.)*

Health Care Resolutions Program

The Health Care Resolutions Program supports high reliability by ensuring that the MHS has a cadre of trained personnel available on a 24/7/365 basis to provide guidance and support to Service leadership, medical centers, hospitals, clinics, and deployed locations to manage disclosure of adverse or unanticipated medical or dental events.

To promote a culture of high reliability, the program facilitates and provides interventions that emphasize organizational transparency through full disclosure of unanticipated or adverse clinical events and restores trust and healing through conflict resolution and timely open dialogue.

Health Care Resolutions coordinates and facilitates the discussion between the patient and/or patient and family with a representative from Quality Assurance to ensure that their perspective is brought forward and is included in the review of their care when the patient or family has requested this opportunity. Additionally, Health Care Resolutions notifies the patient/family in advance that results of Quality Assurance reviews may not be released to them in accordance with federal law. Health Care Resolutions facilitates an opportunity for dialogue with patients and involved providers for purposes of disclosure of all facts related to the patient's care if that did not occur and a claim has not yet been filed. The opportunity to have input into Quality Assurance processes is not influenced in any way by a patient having retained legal counsel or having filed a claim for compensation. Legal counsel is not included in the discussions with Health Care Resolutions, Quality Assurance representatives, or providers.

Peer Support Program

Peer Support is a program to encourage provider discussions with a trained peer to decrease the detrimental emotional effects experienced after adverse clinical outcomes, reduce provider self-harm, and lower provider attrition from military medicine. Supporting providers is already a component of Health Care Resolutions, since these specialists engage with providers and patients at the time of service delivery when there are adverse events, but more is needed.

Health care providers who are involved in an unanticipated, adverse patient event, medical error, or a patient-related injury often feel personally responsible for the outcome. Many feel they have failed the patient, second-guessing their clinical skills and knowledge base. Participation in a blame-free discussion with a qualified peer may help promote clinician healing and recovery from what is sometimes called "the second victim" experience. Data suggest that 90 percent of providers do not feel adequately supported by their respective organizations when adverse medical events occur. It is also known that half of all clinicians will be involved in a serious adverse event at least once during their career.

Military medicine is committed to becoming a high-reliability enterprise, and there is an established correlation between high reliability and providers' recovery as second victims. Evidence shows that supported providers begin to recover from adverse events and tend to report them earlier and more frequently. Improved provider recovery has been demonstrated to reduce medical errors; improve quality of care; increase productivity; and foster good will, trust, and appreciation.

QUALITY OF MHS CARE *(CONT.)*

MHS Quality Assurance

The care provided in the MHS is based on nationally recognized standards for health care organizations. Accreditation and certification by external organizations provide the MHS with valuable information to validate compliance with standards and to identify opportunities for improvement.

MTF-specific hospital and clinic accreditation status, accreditation organization (TJC or AAAHC), survey dates, and requirements for improvement to meet full accreditation are displayed at the OASD(HA) public-facing web portal www.health.mil/AccreditationandPolicy. This transparency is consistent with standardized management across an enterprise journeying toward an HRO, and supports the section 713 requirements.

MTF Accreditation

All fixed MTFs are accredited by TJC using the standards relevant to the care provide at the facility. For example, a TJC survey team for an inpatient MTF with ambulatory care clinics and a behavioral health unit would include surveyors with expertise in the standards for hospitals and ambulatory and behavior health Address Risk accreditation. The chapters in TJC accreditation manuals contain standards for patient-focused functions and organization functions.

CHAPTERS IN TJC ACCREDITATION

HOSPITAL CHAPTERS	AMBULATORY CHAPTERS	BEHAVIORAL HEALTH CHAPTERS
Management of the Environment of Care	Environment of Care	Care, Treatment, and Services
Emergency Management	Emergency Management	Emergency Management
Human Resources	Human Resources	Environment of Care, Treatment, or Services
Infection Prevention and Control	Infection Prevention and Control	Human Resources Management
Management of Information	Information Management	Infection Prevention and Control
Leadership	Leadership	Information Management
Life Safety	Life Safety	Leadership
Medical Staff	Medication Management	Life Safety
Medication Management	Provision of Care	Medication Management
Nursing	Performance Improvement	Performance Improvement
Performance Improvement	Record of Care, Treatment, and Services	Record of Care
Provision of Care, Treatment, and Services	Rights and Responsibilities of the Individual	Rights of the Individual
Record of Care, Treatment, and Services	Transplant Safety	Waived Testing
Rights and Responsibilities of the Individual	Waived Testing	

Source: DHA/OPS (J-3)/Clinical Support Division, 12/18/2017

TJC conducts an on-site survey every three years. The purpose of the survey is to assess the extent of the MTF's compliance with applicable TJC standards, National Patient Safety Goals (NPSGs), and Accreditation Participation Requirements.

The MTF receives a report at the end of the on-site survey identifying any standards that were scored noncompliant, and thus require improvement. The MTFs have 60 days to provide documentation to TJC demonstrating successful execution of an improvement plan and compliance with the standards.

The MHS is nearing completion of a data repository with all TJC accreditation findings for MTFs over the past three years as a tool to share information between facilities, monitor for patterns or trends, and identify systemwide improvement opportunities. As shown in the chart on the next page, the Top five hospital and ambulatory findings provide areas for a focused review to identify common themes for improvement activities as well as continuous compliance monitoring.

MHS Quality Assurance *(cont.)*

TOP 5 JOINT COMMISSION AMBULATORY STANDARDS CITED IN MTF SURVEYS, CYs 2014–2016

CY 2014	CY 2015	CY 2016
Medication Management	Environment of Care	Environment of Care
Environment of Care	Medication Management	Medication Management
Leadership	Leadership	Infection Prevention and Control
NPSGs	Infection Prevention and Control	Provision of Care, Treatment, and Services
Human Resources	National Patient Safety Goals	NPSGs

TOP 5 JOINT COMMISSION HOSPITAL STANDARDS CITED IN MTF SURVEYS, CYs 2014–2016

CY 2014	CY 2015	CY 2016
Environment of Care	Environment of Care	Life Safety
Infection Prevention and Control	Life Safety	Environment of Care
Life Safety	Infection Prevention and Control	Provision of Care, Treatment, and Services
Provision of Care, Treatment, and Services	Provision of Care, Treatment, and Services	Infection Prevention and Control
Medication Management	Medication Management	Medication Management

Source: DHA/OPS (J-3)/Clinical Support Division, 12/18/2017

TJC accreditation requirements include the completion of an annual self-assessment as a means to continually evaluate compliance with standards between surveys and implement improvements as indicated. Continuous compliance with TJC standards contributes to the maintenance of safe, quality patient care, and improved performance.

In addition to the survey process for accreditation, TJC requires hospitals to submit National Quality Measures Clearinghouse data on a quarterly basis. Each MTF selects the measures for data submission. Data are collected centrally by trained abstractors and reported to the MTFs for analysis and improvement as indicated. The perinatal care (PC) measures are included in the women and infant quality measures section of this report (see page 104).

Laboratory Services Accreditation

Standards for regulatory compliance of clinical laboratories in the MHS are established by DoD Manual 6440.02, dated May 29, 2014, and titled *Clinical Laboratory Improvement Program (CLIP) Procedures*. These standards are federal lab/Clinical Laboratory Improvement Act (CLIA) comparable, but modified to meet unique aspects of DoD missions. The performance of clinical laboratories in the MHS is, in part, evaluated through deemed agencies, such as the College of American Pathologists (CAP), the Commission on Laboratory Accreditation (COLA), TJC, American Society for Histocompatibility and Immunogenetics (ASHI), American Association for Laboratory Accreditation (A2LA), as well as through self-inspections.

The Joint-Service Center for Laboratory Medicine Services (CLMS) provides regulatory oversight for all DoD laboratories and provides reports to Health Care Operations and the Service Surgeons General when requested. The office also manages a DoD contract with the Clinical Laboratory Standards Institute, providing access to all necessary clinical laboratory standards for management and operation of laboratories.

All MTF-based clinical laboratories are accredited by CAP. Non-MTF laboratories are inspected by CAP or the other agencies/methods listed above. Accreditation inspections are unannounced for the vast majority, and on a two-year cycle.

More MHS laboratories are accredited by recognized national lab organizations than similar civilian laboratories. The DoD CLIP manual requires all laboratories to perform proficiency testing for all laboratory tests, to include those in the waived complexity category. Also, the MHS has stricter policy standards than civilian laboratories in the oversight of waived testing laboratories and exceeds national benchmarks. CLIP requires accreditation inspections of all laboratories with waived or provider-performed microscopy (PPM) certificates. CMS does not require this for their waived or PPM labs, nor does it require proficiency testing.

In FY 2017, 100 percent of all MHS clinical laboratories and blood banks attained national accreditation. One hundred eight Army laboratories were inspected and attained an average accreditation score of 99.51 percent and a proficiency testing score of 97.96 percent; 84 Air Force laboratories achieved an average accreditation score of 99.43 percent and a proficiency testing score of 98.13 percent; and 106 Navy laboratories were inspected with an average accreditation score of 99.48 percent and a proficiency testing score of 98.31 percent. Overall, the Service laboratories compared favorably to the national averages of 99.24 percent for inspection accreditation score and average proficiency scores of 98.09 percent. An area identified for improvement is documentation of competency assessment. An estimated 25 percent of DoD laboratories were cited for partial compliance. The DoD deficiency rate for this requirement is lower than the average for all laboratories inspected by the CAP.

QUALITY OF MHS CARE *(CONT.)*

MHS Quality Assurance *(cont.)*

In 2017, the CAP, a CMS-approved accreditation authority, awarded the Joint Pathology Center (JPC) accreditation for the International Organization for Standardization (ISO) 15189 standard under the CAP 15189SM Accreditation Program. The accreditation is based on the ISO 15189 standard for laboratories' technical competence, management, and continual improvement. It focuses on improved patient safety and risk reduction, outlining standards for quality, and competence particular to medical laboratories. CAP 15189SM is a voluntary, non-regulatory accreditation to the ISO 15189:2012 standard. The program does not replace the CAP's CLIA-based Laboratory Accreditation Program, but complements CAP accreditation and other quality systems. The program optimizes processes to improve patient care, strengthens quality standards while reducing institutional errors and risks, and controls costs. CAP 15189SM is an educational program that offers a highly disciplined approach to implementing and sustaining change. This ISO 15189 accreditation and achievement by the JPC is not only a first for the DoD, but also, as of this publication, a first for the entire federal government. There are only 34 labs in the U.S. with the ISO 15189 designation, and only 44 in the world.

Blood Bank Services Accreditation

Blood Bank Services in the MTFs are surveyed by external organizations based on the services provided. For MTFs with blood collection operations, U.S. Food and Drug Administration (FDA) registration and standards compliance demonstrated through an inspection process is required, as well as AABB (formerly known as the American Association of Blood Banks) inspection. If the MTF has blood transfusion operations, CAP and AABB are mandated. Additionally, Blood Bank Services are assessed under relevant TJC standards during the survey process and annual self-assessments.

Continuous compliance with standards is monitored by the Services Program Officer through quality assurance audits. MTFs conduct internal audits to track performance on an ongoing basis. The Transfusion Service and Donor Centers actively evaluate performance by evaluating compliance with established processes and procedures. Complaints are investigated, root causes identified, and improvements implemented. Performance monitoring and continuous improvement are key to quality assurance in Blood Bank Services.

Programs to Improve Performance

Robust performance improvement occurs across the MHS. The PfP, participation in the NSQIP, execution of the TeamSTEPPS program, and enterprise-wide deployment of the PCMH are all examples of enterprise improvement activities that involve the MHS working toward a common goal. Additional programs demonstrating the MHS's ongoing commitment to performance improvement include performance improvement priorities, learning partnerships, and the annual improvement awards.

Partnership for Improvement—Performance Improvement Priorities

In March 2015, leadership chose four process improvement priorities (PIPs) for focused improvement: (1) improve quality outcomes for condition-based care, (2) reduce patient harm, (3) improve access, and (4) increase direct care primary care capacity. There are nine measures from the MHS Core Dashboard associated with the four areas.

MHS CARE DASHBOARD PIP MEASURES

CLABSIs
URFO
Diabetes Composite · HbA1c Testing · HbA1c Control
Acute Condition Composite · Treatment of Upper Respiratory Infection in Children · Treatment of Pharyngitis in Children · Use of Imaging for Acute Low Back Pain
Average Number of Days to Third Next Available 24-Hour Appointment
Average Number of Days to Third Next Available Future Appointment
Percent of Direct Care Enrollees in Secure Messaging
Satisfaction with Getting Care When Needed
Total Empanelment

These areas are reviewed on a monthly basis with the Principal Deputy Assistant Secretary of Defense for Health Affairs and Service Deputy Surgeons General to enhance knowledge sharing with regard to process improvement efforts. In June 2016, leadership set a target date of June 2017 for "going to green" on the PIP measures. If already "green" on a particular measure, a 30 percent reduction for "amber" or "red" MTFs is expected. Setting this additional threshold further illustrates our leaders' commitment to reducing variance and not being satisfied with just getting to "green."

QUALITY OF MHS CARE *(CONT.)*

Programs to Improve Performance *(cont.)*

PERFORMANCE OVERVIEW JUNE 2017

Comparison of Performance as of June 2016 and June 2017:

- The table below shows two performance values for each PIP: (1) the performance reported at the June 29, 2016, R&A, and (2) the performance in the same reporting month but one year later, for review of improvement today at the June 29, 2017, R&A.
- Measures are colored according to threshold met.

OVERALL MEASURES GREEN OR BLUE

	AS OF JUNE 2016	AS OF JUNE 2017
MHS	2	4
Army	1	3
Air Force	5	4
Navy	6	7
DHA-NCR	2	5

PERFORMANCE COMPARISON JUNE 2016 VS. JUNE 2017

MEASURE	DATA AS OF		MHS		AIR FORCE		ARMY		NAVY		DHA-NCRMD	
	JUN 2016	JUN 2017	JUN 2016	JUN 2017	JUN 2016	JUN 2017	JUN 2016	JUN 2017	JUN 2016	JUN 2017	JUN 2016	JUN 2017
CLABSI[a]	Dec 2015	Dec 2016	3.2	3.5	3.8	3.4	2.6	3.4	3.7	3.7	2.7	4.0
URFO	Mar 2016	Mar 2017	8	6	0	0	4	5	3	1	1	0
HEDIS Diabetes Composite[b]	Feb 2016	Feb 2017	75%	80%	80%	83%	66%	73%	81%	86%	77%	67%
Acute Conditions Composite[b]	Feb 2016	Feb 2017	68%	80%	83%	87%	41%	65%	91%	99%	69%	95%
Avg No. of Days to Third Next Available Future Appt	Apr 2016	Apr 2017	6.42	5.59	6.84	6.81	6.05	4.92	5.62	4.06	9.39	8.18
Avg No. of Days to Third Next Available 24-Hour Appt	Apr 2016	Apr 2017	1.32	1.14	1.68	1.54	1.24	0.86	0.85	0.83	1.33	2.45
Percent of Direct Care Enrollees in Secure Messaging	Apr 2016	Apr 2017	42.14%	46.72%	45.19%	49.46%	34.46%	39.19%	49.77%	53.83%	47.70%	54.58%
Satisfaction With Getting Care When Needed[c]	N/A	Mar 2017	N/A	83%	N/A	82%	N/A	84%	N/A	83%	N/A	85%
Total Empanelment	Mar 2016	Mar 2017	–0.4%	–0.4%	–0.5%	–0.6%	–0.8%	–0.8%	0.1%	0.2%	0.5%	0.1%

[a] Previous June 2016 reported incident number for CLABSI; this reporting of June 2016 reflects new methodology using points.

[b] MHS Performance for HEDIS Diabetes and Acute measures reflects Direct Care only (removed MCSC from performance); measure reported using treatment DMIS.

[c] MHS transitioned to JOES December 2016; threshold to be established and performance reported at the start of FY 2018.

QUALITY OF MHS CARE *(CONT.)*

Programs to Improve Performance *(cont.)*

MHS PERFORMANCE OVERVIEW: HOW THE MHS HAS PROGRESSED, DECEMBER 2017

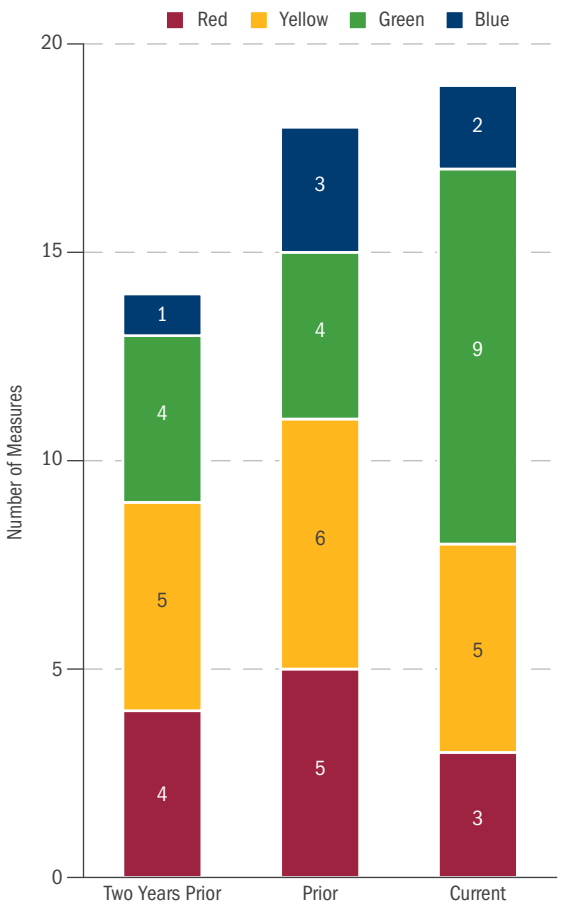
The table shows performance values for each current Executive Dashboard measure at the MHS level as reported on CarePoint: "Current" is performance reported today, "Prior" is performance reported for the same time period in 2016, and "Two Years Prior" is performance reported for the same time period in 2015. Measures that were not displayed on the Executive Dashboard or did not report data in the previous performance years are indicated. **PIP measures are in bold.**

Summary of Performance Since 2015

Of the 22 current measures, 19 measures have MHS level performance. Examination of these measures over time highlights:

- Improvement on 79 percent of measures (15/19).
- Movement to lower performance threshold on 16 percent of measures (3/19).
- Achieved "green" or "blue" on 58 percent of measures (11/19).

PERFORMANCE BREAKDOWN



PERFORMANCE OVERVIEW, 2015–2017

MEASURE	CURRENT PERIOD	PRIOR PERIOD	TWO YEARS PRIOR PERIOD	CHANGE
IMR	–	–	–	Not Reported at MHS Level
F.R. Surgery Capacity	–	–	–	
Humanitarian Assistance	–	–	–	
Recommend Hospital	76.49%	75.43%	75.0%	▲
CLABSI*	0.806	1.437	1.399	▲
WSS* (PIP as of FY 2018)	7	10	9	▼
URFO*	7	2	5	▲
Diabetes A1c Testing	92.56%	91.31%	91.33%	▲
Low Back Pain	81.55%	78.42%	See Note	▲
Children with Pharyngitis	90.74%	84.34%	See Note	▲
7-Day Mental Health	77.91%	75.97%	74.56%	▲
Avg No. of Days to Third Next Available 24-Hour Appt*	0.92	1.05	1.16	▼
Avg No. of Days to Third Next Available Future Appt*	5.71	5.64	5.79	▼
Primary Care Leakage (Recap)*	6.38%	6.67%	6.71%	▲
PCM Continuity	57.42%	58.4%	59.9%	▼
Secure Messaging Enrollment	49.55%	45.28%	39.66%	▲
Satisfaction with Getting Care When Needed	82.49%	81.43% (Dec 2016)	–	▲
Specialty Care: Referral to Book*	3.92	4.1	–	▲
Specialty Care: Booked to Appointment*	14.72	14.26	–	▼
PMPM*	0.98%	4.34%	10.6%	▲
Pharmacy Percent Retail*	23.4%	27.5%	34.3%	▲
AD: Specialty Provider Efficiency (PIP as of FY 2018)	44%	46%	43%	▲

Source: CarePoint https://carepoint.health.mil, as of 12/12/2017
Note: Measure changed from enrollment DMIS to treatment DMIS; cannot compare 2015.
* Indicates lower performance is better.
** JOES Implementation

Programs to Improve Performance *(cont.)*

IHI Collaborative

The MHS established a strategic partnership with the IHI designed to drive systemwide transformation. Access to Care and Surgical Quality were the two areas of focus for the initial Learning Partnerships. The change ideas introduced in the partnerships are widely regarded as industry-standard best practice. Several of the change concepts that underpinned the curricula were already written into MHS policy. The Learning Partnership sought to support teams in building those recommended processes into their daily work and increasing reliability of best practices.

Access to Care and Surgical Quality Learning Partnerships

The MHS Access to Care Learning Partnership (ACLP) has been a 12-month effort engaging 23 teams from MTFs across the MHS to work on reducing delays and improving access to care. The partnership was sponsored by the MHS Tri-Service Patient-Centered Care Integrated Board (TSPCCIB). The partnership provided a rich learning experience for MTF teams, IHI faculty, and staff. Teams built improvement capability by applying improvement science at the front line to address delays in access to care in their MTFs. Using rapid-cycle testing, teams tested and adapted industry-standard access and efficiency principles to their local context.

The MHS Surgical Quality Learning Partnership (SQLP) has been a 12-month effort engaging 22 teams from MTFs across the MHS to work on different aspects of surgical quality. Sponsored by the MHS Surgical Quality Consortium (SQC), the partnership has been a robust learning experience for all teams as well as the IHI faculty and programmatic team. Teams learned about frontline improvement by working in their own MTFs on topics that have great value to them, including surgical site infections, venous thromboembolism, efficiency, pain management, and urinary tract infections.

The Learning Partnerships arm the involved clinical staff and leaders with improvement skills and introduce the MHS to a scalable execution strategy by which to cultivate everyday improvers across the enterprise. This engagement provided an opportunity to build an understanding of the resources and contexts in the MHS that encouraged frontline teams armed with improvement science to identify and improve in their clinical settings.

Programs to Improve Performance *(cont.)*

MHS Advancement toward High Reliability in Healthcare Awards

The MHS encourages and engages field members to share performance improvement activities through an annual awards process. The concept was conceived as a way to raise awareness, reward successful efforts, inspire organizations, and communicate success throughout the MHS. The Advancement toward High Reliability in Healthcare Awards identify those who have shown innovation and commitment to the development of systems and processes focused on the needs of the patient, eliminating preventable harm, and enhancing the integration of nationally recognized standards of care. There were a total of 95 submissions received for the 2017 awards program: 48 for Healthcare Quality and Safety, 32 for Improved Access, and 15 for Patient Engagement. The Healthcare Quality and Patient Safety Award had nine award winners, the Improved Access Award had eight award winners across five categories, and the Patient Engagement award had five winners across two categories. Winners were recognized at the 2017 Association of Military Surgeons of the United States Conference. Webinars to share these successful practices provide an opportunity for across system learning.

Below is a short summary of the winning Healthcare Quality and Patient Safety Award submissions:

- **Naval Hospital Camp Pendleton, Cervical Cancer Screening Optimization:** The objective of this process improvement project was to increase the Cervical Cancer Screening HEDIS performance measure from the 10th to the 75th percentile of one clinic by January 1, 2017. The clinic also sought to increase its ranking among the 13 Naval Hospital Camp Pendleton clinics from 13th out of 13 to sixth out of 13. By January 1, 2017, the San Onofre clinic reached the 75th percentile—and shortly thereafter surpassed the 90th percentile due to the new improvements.
- **99th Medical Group, Nellis Air Force Base, Enhanced Recovery Program:** The program's objective was to reduce surgical site infections and improve surgical outcomes using modified Duke University protocols for colorectal surgical cases and components of the ACS Enhanced Recovery After Surgery (ERAS) practices. The NSQIP Surgical Clinical Review and NSQIP Surgical Champion coordinated an expanded effort and constructed a hybrid plan for improvement, standing up a multidisciplinary team to implement new standardized surgical processes. The MTF is now rated as an exemplary performer and is in the top 10 percent, or first decile, for SSIs for all NSQIP enrolled sites.
- **Walter Reed National Military Medical Center, High-Value, Cost-Conscious Care: Optimizing the Electronic Medical Record to Reduce Laboratory Overutilization:** The overall goal of this initiative was to sustainably improve delivery of high-value health care to the patient population, and promote a culture of cost consciousness among providers. The primary outcome was number of labs/IPBD in a two-month period compared to prior years, with a secondary outcome of associated cost reductions. Between 2014 and 2017, the number of labs/IBPD in a two-month study period decreased from 4.99 to 3.26 (IRR 0.65, 95 percent CI 0.64–0.67; p = 0.001), due to cumulative effects of the three serial Essentris interventions. This overall reduction of 34.6 percent corresponds to estimated cost savings of up to $1.25 million.
- **Fort Belvoir Community Hospital, Improve Sterile Instrument and Process Handling:** The goal of the project was to improve sterile instrument and process handling to reduce defects within the sterilization process. Multiple interventions were implemented to focus on improved training and preparation, and help to achieve an improved sigma quality level of 3.35. This represents 98.5 percent of the process goal.
- **David Grant Medical Center, Implementation of an Enhanced Recovery after Surgery Program to Reduce Surgical Complications:** The focus of this project was to address persistently high rates of surgical readmissions. The team designed a multi-phase, multidisciplinary program, tailoring elements of a robust ERAS program to focus on the highest-volume surgeries performed at the MTF. The result based on an on-demand report for 2017 shows a reoperation rate of 2.07 percent (CI 1.4–2.8, OR 0.89), and a readmission rate of 5.19 percent (CI 4.06–6.46, OR 1.09).
- **Brian Allgood Army Community Hospital (ACH), Increase HEDIS Low Back Pain (LBP) Imaging Compliance at MEDDAC-K:** For this project, a team consisting of a Population Health Nurse, physician champion, and radiology worked together using the A3 8-Step Practical Problem-Solving Method to measure, determine root causes, develop solutions, and implement solutions—solutions that were incorporated by Brian Allgood ACH to achieve 85.43 percent compliance by March 2017, a total change of 8.45 percent.
- **USAMEDDAC Ft. Stewart/Hunter Army Airfield, Winn ACH Clinical Improvement of LBP:** For this improvement project, a team was formed to assess the

Programs to Improve Performance *(cont.)*

- Veterans Affairs/DoD Low Back Pain Clinical Practice Guideline against current practice using focused review. The team identified gaps in provider knowledge regarding treatment of LBP and inappropriate use of imaging. By July 2015, baseline performance was in the 10th percentile and steadily increased to the 90th percentile. From this, a standard operating procedure was developed for LBP imaging. Based on the success of this initiative, physical therapy was embedded within two other satellite clinics.
- **Health Net Federal Services LLC, Improving Colorectal Cancer (CRC) Screening by Mailing Fecal Immunochemical Testing (FIT) Home Screening Kits to Beneficiaries:** The objective of this effort was to impact the overall CRC screening rate in the civilian TRICARE Prime North population. Health Net sent evidence-based FIT kits to beneficiaries due for screenings, which were easily returnable by mail to a lab for processing. Participation was robust in all three years, with an average 21.3 percent participation, which compared favorably to the vendor's database average of 10–15 percent. The team successfully delivered three iterations of this evidence-based prevention intervention to a large TRICARE population, which resulted in robust participation levels and noteworthy improvements in CRC screening rates.
- **Naval Hospital Pensacola, Improve HEDIS Antidepressant Medication Management (AMM):** To increase the quality of AMM, a proactive standardized process was initiated and implemented over nine months, with a goal to achieve the 90th HEDIS percentile for both phases of AMM. Over 16 months, this standardized process increased medication adherence from 50th to 90th HEDIS percentile in the acute phase and from 25th to 90th HEDIS percentile in the continuation phase of treatment. The improvement was sustained over the following nine months once the goal was achieved.

2017 QUALITY AND PATIENT SAFETY AWARD WINNERS

MILITARY TREATMENT FACILITY/TRICARE REGIONAL OFFICE	AWARD-WINNING INITIATIVE
Naval Hospital Camp Pendleton	Cervical Cancer Screening Optimization
99th Medical Group, Nellis Air Force Base	Enhanced Recovery Program
Walter Reed National Military Medical Center	High-Value, Cost-Conscious Care: Optimizing the Electronic Medical Record to Reduce Laboratory Overutilization
Fort Belvoir Community Hospital	Improve Sterile Instrument and Process Handling
David Grant Medical Center	Implementation of an Enhanced Recovery after Surgery Program to Reduce Surgical Complications
Brian Allgood ACH	Increase HEDIS Low Back Pain Imaging Compliance at MEDDAC-K
USAMEDDAC Ft. Stewart/Hunter Army Airfield	Winn Army Community Hospital Clinical Improvement of Low Back Pain
Health Net Federal Services LLC	Improving Colorectal Cancer Screening by Mailing Fecal Immunochemical Testing (FIT) Home Screening Kits to Beneficiaries
Naval Hospital Pensacola	Improve HEDIS Antidepressant Medication Management

Source: DHA/OPS (J-3)/CSD, 11/25/2017

QUALITY OF MHS CARE *(CONT.)*

Focused Quality Initiatives

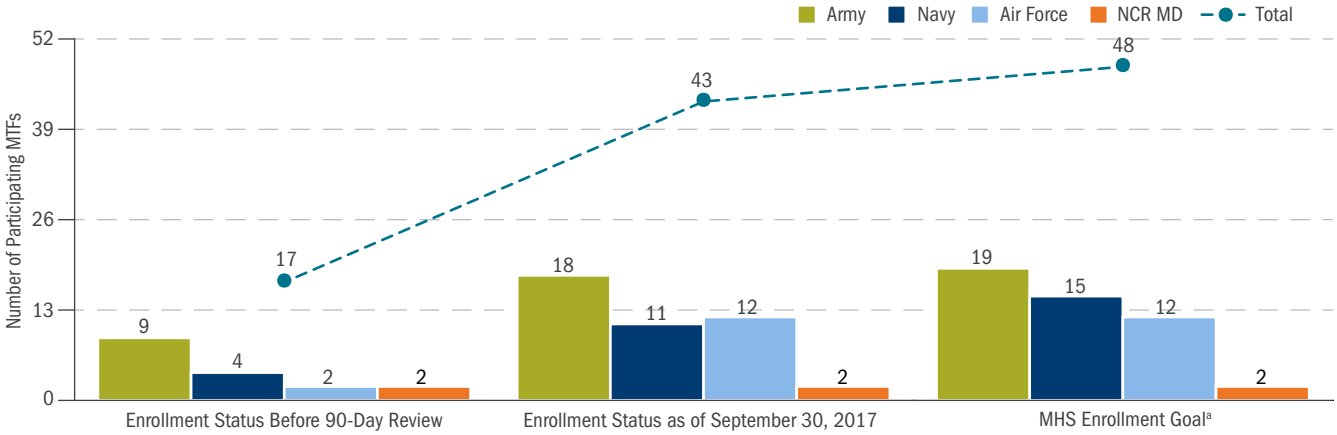
Surgical Services Initiatives

The quality of surgical care provided in the MHS has traditionally been monitored through a series of nationally recognized process measures identified as Surgical Quality Improvement Project (SQIP) measures. The measures included the timing of antibiotic administration and discontinuation, antibiotic selection, appropriate hair removal for surgical site, and treatment orders to prevent venous thromboembolism. As noted in the *FY 2017 Evaluation of the TRICARE Program* report, several measures displayed were scheduled for retirement. The SQIP measures were included in the list of retired measures. This is due to the high level of performance for the SQIP measures across the nation and the shift to increase the utilization of outcomes measures. The MHS has decided to maximize MTF participation in the ACS NSQIP to enhance the monitoring of surgical outcomes.

NSQIP Quality Outcomes

The MHS monitors surgical outcomes through the morbidity and mortality data from the ACS NSQIP. DHA Procedural Instruction 6025.01 outlines the MHS plan for NSQIP expansion to include identification of key roles, responsibilities and requirements for management, and oversight of MTFs participating in NSQIP. DoD participation in NSQIP has successfully expanded from the initial 17 MTFs to 43 MTFs with an expansion goal of 48, which includes all MTFs eligible to participate in the ACS NSQIP (as shown in the graph below).

CURRENT MHS NSQIP ENROLLMENT STATUS (UPDATED SEPTEMBER 30, 2017)



Source: DHA/OPS (J-3)/Clinical Support Division, 12/18/2017

[a] MHS Enrollment Status: 94 percent of MTFs are now enrolled in NSQIP.

◆ **MHS NSQIP Key Expansion Progress to Date:**

- Complete ACS NSQIP webinar: 100 percent completed
- Engage surgeon champions: 100 percent completed
- Hire SCRs: approximately 94 percent of SCRs hired
- Complete SCR training: approximately 90 percent completed
- Submit NSQIP enrollment applications: approximately 90 percent completed
- Develop DHA NSQIP procedural instruction: signed, published, and disseminated

QUALITY OF MHS CARE *(CONT.)*

Focused Quality Initiatives *(cont.)*

Legacy NSQIP sites (participating prior to 2016) have all demonstrated improved outcomes in morbidity and mortality. The 2016 morbidity data indicated that all MTFs met the expected performance level, including five MTFs that exceeded the expected performance level based on risk-adjusted analysis of the data. This is the highest number of MTFs exceeding the expected performance level for morbidity since the initiation of the NSQIP in the MHS. The 2016 mortality data indicated all MTFs met the expected performance level, including two MTFs that exceeded the expected performance level. The overall mortality performance levels for 2015 and 2016 are consistent.

MTF MORTALITY AND MORBIDITY PERFORMANCE, CYs 2014–2016

			CY 2014		CY 2015		CY 2016	
			MORTALITY	MORBIDITY	MORTALITY	MORBIDITY	MORTALITY	MORBIDITY
MEDICAL CENTERS	Army	MTF 1		★				★
		MTF 2						
		MTF 3		★	★	★		★
		MTF 4						
		MTF 5					★	
		MTF 6						
		MTF 7		★				
		MTF 8						
	Navy	MTF 1						
		MTF 2						
	Air Force	MTF 1	★		★	★	★	
		MTF 2						★
	NCR	MTF 1						★
COMMUNITY HOSPITALS	Army	MTF 1						
	Navy	MTF 1		★				
		MTF 2						
		MTF 3				★		★
	NCR	MTF 1						

★ Exceeds Standards Meets Standards
Needs Improvement Data Unavailable

Source: DHA/OPS (J-3)/Clinical Support Division, 12/18/2017

MTFs' NSQIP All Cases morbidity data over time are publicly displayed at https://health.mil/transparency in the "Select Facility" searchable database under the "Complications Related to Surgery" section. The information shows risk-adjusted surgical complication rates compared to rates from the over 680 NSQIP-participating hospitals in the U.S. MHS leadership has approved expansion of publicly available data to include NSQIP All Cases mortality data. The data from each NSQIP-participating MTF's semi-annual report is shared among all Service Headquarters Quality Leads and MTF NSQIP personnel to support the transfer of best practice information between high- and low-performing sites.

Focused Quality Initiatives *(cont.)*

ACS NSQIP CY 2016 Meritorious Status Award

The ACS Meritorious Award is bestowed upon top-performing hospitals for the quality of the surgical care provided based on the 2016 all-cases, risk-adjusted models and evaluated results for eight outcome areas: mortality, cardiac, pneumonia, unplanned intubation, ventilator >48 hours, renal failure, urinary tract infection, and surgical site infections. Also, to be eligible, a hospital could not have failed an ACS audit, or be a negative statistical outlier for any of the eight outcomes. The MTFs listed below were recognized by the ACS as NSQIP "Meritorious" hospitals based on their composite quality scores for care provided during CY 2016:

ACS NSQIP
CY 2016 MERITORIOUS STATUS AWARD

- Keesler Medical Center
- David Grant Medical Center (second year in a row)
- Brooke Army Medical Center

These sites are among 68 facilities representing the top 10 percent of all ACS NSQIP-participating hospitals worldwide in 2016.

Pediatric Surgical Population

The National Surgical Quality Improvement data will be expanded to include three MTFs with the largest pediatric surgical populations. Those facilities include San Antonio Military Medical Center, Portsmouth Naval Medical Center, and San Diego Naval Medical Center. It is anticipated the data collection will begin in 2018.

Surgical Care Performance Improvement

As indicated on the previous page, the ACS NSQIP is the cornerstone for MHS surgical quality improvement. Through its expanded partnership with the ACS, the MHS has identified the need to better develop and support surgical-quality champions, case reviewers, and teams. The DoD NSQIP Collaborative is committed to enterprise-wide learning, sharing successful practice and capitalizing on improvement opportunities. The NSQIP Steering Panel, MHS Surgical Quality Consortium, various MHS surgical collaborative groups, and surgical-quality and safety SMEs from each of the Services meet on a regular basis. The Steering Panel has organized efforts through the DoD NSQIP working group, and is investigating improved data visualization strategies to make demonstration of performance and trends more accessible to the surgical teams.

The MHS has also developed strategic partnerships to strengthen institutional knowledge and expand opportunities to network with nationally recognized leaders in surgical-quality care. Through the MHS Strategic Partnership with American College of Surgeons (MHSSPACS), ACS leadership and Service surgical-quality experts discuss surgical-quality improvement data, innovations, and leading practices and have established the Surgical Consultative Site Visit Program. Three MTFs were visited in the past fiscal year with plans for eight additional MTFs in the coming fiscal year.

The surgical-quality program has evolved from focusing on data collection to evaluating clinical care and improving performance, and maximizing return on investment. The dedication of the NSQIP leaders and surgical staff at the MTFs, as well as involvement in strategic partnerships as mentioned above, have positively impacted the outcomes of care for surgical patients.

QUALITY OF MHS CARE *(CONT.)*

Focused Quality Initiatives *(cont.)*

Primary Care Services

Primary care provided in the MHS is evidence-based practice. The MHS PCMH practice model provides the essential structure to establish standard processes and procedures; integrate and coordinate care; and develop the cohesive team of health care professionals required to provide consistent, safe, quality care. The MHS has developed a variety of tools to support the PCMH teams in meeting the care needs of beneficiaries.

The DoD and VA clinical practice guideline (CPG) collaboration has established a rigorous systematic review of medical evidence to help primary care providers and health care teams deliver consistent high-quality health care to beneficiaries. CPGs are developed by multidisciplinary clinical experts and are based on unbiased clinical research studies and literature reviews. Twenty-four CPGs have been developed and updated to provide practitioners with information and tool kits to support evidence-based practice. The DoD/VA CPGs are available at https://www.qmo.amedd.army.mil. To enhance the availability and utilization of the information in the CPGs, the TSWF team embedded CPG information into the electronic medical record. The goal was to incorporate the CPGs into the clinician's workflow to ensure ease of use. Information on assessment, diagnosis, and recommendations for treatment were literally placed at the providers' fingertips.

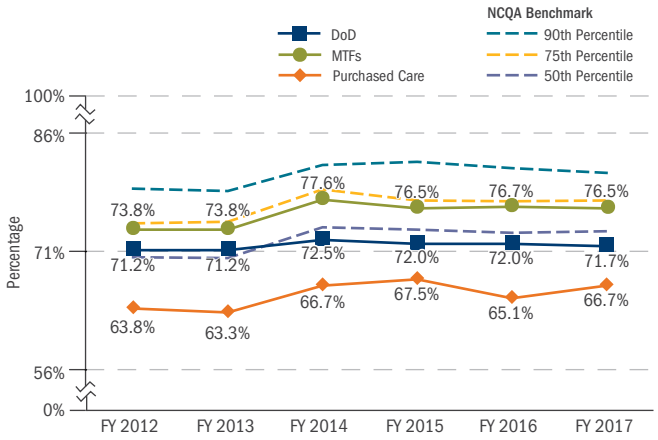
Additionally, the MHS monitors the performance of primary care services by using a variety of nationally recognized quality measures. The NCQA HEDIS includes primary care–focused health plan measures with methodologies. HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. MHS data can be compared with the NCQA annual benchmark results. The MHS Population Health Portal CarePoint application provides the MHS with the measure methodology, as well as the data at system, Service, region, clinic, and provider level. The HEDIS methodologies used by CarePoint to calculate HEDIS measures have been reviewed annually by an NCQA HEDIS auditor to validate that the Portal methodology is appropriately implemented.

MHS leadership, from MTF staff through the respective Services, to DHA and senior Surgeon General and OASD(HA) leadership, routinely monitor HEDIS performance at all levels of the MHS. HEDIS performance measures are included in the MHS performance management system known as the Partnership for Improvement, or P4I. The measures are presented in the dynamically linked MHS Dashboard at the MTF level and aggregated to Service Intermediate Commands, Services, and the MHS as a whole. MHS leadership formally reviews and assesses select measures on a quarterly basis, including HEDIS, with discussion on Service efforts to improve performance and encouraging increased MTF compliance with measures.

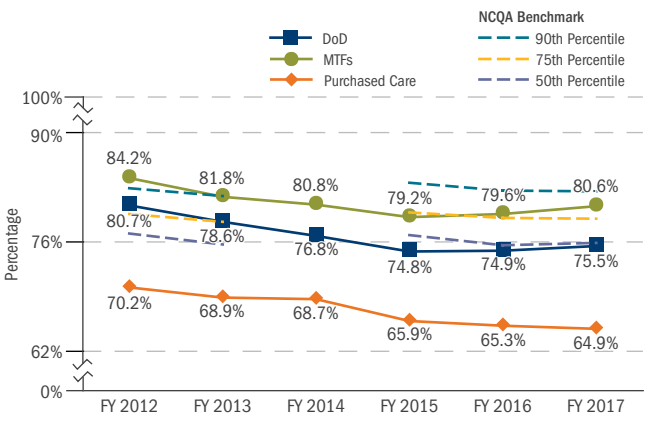
Adult HEDIS Measures

- **Breast and Cervical Cancer Screening:** HEDIS measure focused on cancer screening for early detection and treatment to maximize the potential for a cure. Direct care has reached the NCQA 75th percentile for cervical cancer screening. At the 50th percentile for breast cancer screening, direct care is within one percentage point of reaching the 75th percentile. Purchase care improved performance on breast cancer screening in FY 2017 but decreased slightly on cervical cancer screening. Initiatives to streamline appointments, engage patients, and to optimize technology are underway to continue to improve compliance with these important clinical service screenings.

BREAST CANCER SCREENING, FYs 2012–2017



CERVICAL CANCER SCREENING, FYs 2012–2017

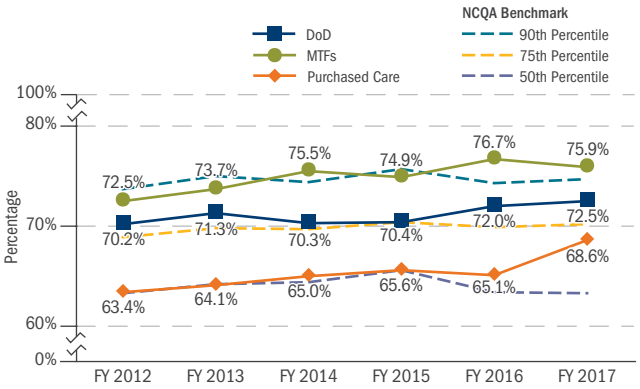


Source: DHA/OPS (J-3)/Clinical Support Division, 12/18/2017

QUALITY OF MHS CARE *(CONT.)*

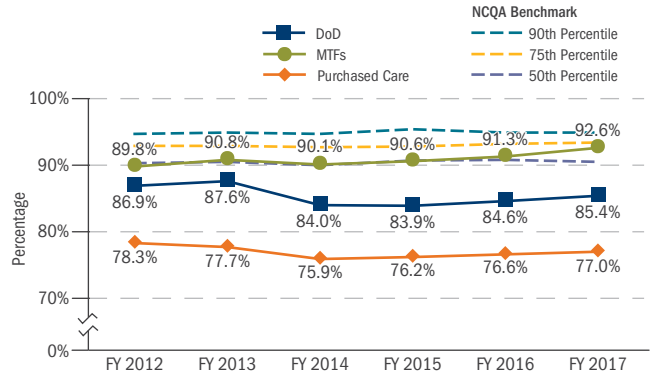
Focused Quality Initiatives *(cont.)*

COLORECTAL CANCER SCREENING, FYs 2012–2017



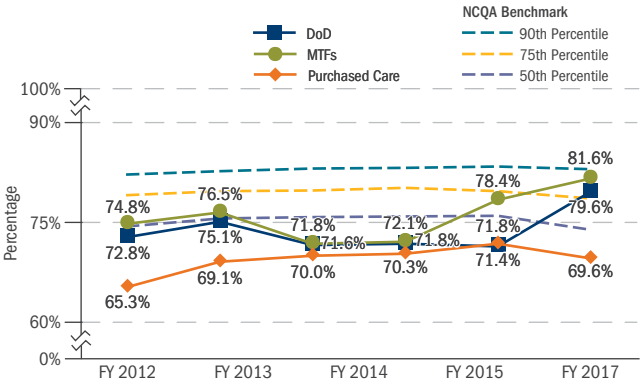
- **Colorectal Cancer Screening:** HEDIS measure focused on detecting colorectal cancer as well as screening for premalignant polyps to prevent cancer. MHS direct and purchased care rates have improved in colorectal cancer screening. MHS direct care MTF rates are consistent with the NCQA 90th percentile in FYs 2016 and 2017; purchased care rates are consistent with the NCQA 50th percentile.

DIABETES HbA1c SCREENING, FYs 2012–2017



- **Diabetes HbA1c Screening:** HEDIS measure focused on annual testing to help healthcare providers with care for the common and serious chronic disease of diabetes. This measure was included in the MHS FY 2017 Performance Improvement Priorities (PIPs). The MHS continues to work to improve the management of diabetic patients. The FY 2017 rate of performance for direct care facilities is consistent with the NCQA 50th percentile and is less than one percentage point from the 75th percentile.

LOW BACK PAIN IMAGING, FYs 2012–2017



- **Low Back Pain Imaging:** HEDIS measure focused on overuse of imaging for acute LBP. This measure was included in the MHS FY 2017 PIPs. MHS has integrated the DoD-VA LBP CPG into the electronic medical record to support providers with improvement initiatives. An LBP campaign is in progress. Performance reporting capabilities were developed for each level of care, MTF, Provider Team, and Individual Provider to support feedback. The FY 2017 rate of performance for direct care facilities is consistent with the NCQA 75th percentile, while the purchased care provider performance decreased from the previous year.

Source: DHA/OPS (J-3)/Clinical Support Division, 12/18/2017

QUALITY OF MHS CARE *(CONT.)*

Focused Quality Initiatives *(cont.)*

The MHS has performed well compared with national HEDIS benchmarks, obtaining the national 90th percentile benchmarks on two measures (with 5 stars shown below: screening for chlamydia and controlling diabetes with HbA1c under 7), and the 75th percentile for seven measures (with 4 stars shown: following up on mental health stays within seven and 30 days; pediatric measures of managing well-child visits of six or more and children with upper respiratory infection; and PCMH measures including colorectal cancer screening, low back pain imaging, and controlling diabetes with HbA1c under 8%). The MHS improved on nine of 14 measures from 2016 to 2017, and performed at the 75th percentile on three of the five measures that did not statistically improve.

MHS HEDIS BENCHMARK PERFORMANCE, JUNE 2014–JUNE 2017

HEDIS MEASURES	2014	2015	2016	2017	2014 TO 2015 CHANGE	2015 TO 2016 CHANGE	2016 TO 2017 CHANGE	HEDIS BENCHMARK STATUS (2017)
Mental Health								
Follow-Up Mental Health: 30 Days	78.10%	78.86%	81.08%	80.90%	0.76%	2.22%	–0.18%	★★★★
Follow-Up Mental Health: 7 Days	62.41%	64.01%	68.03%	69.03%	1.60%	4.01%	1.01%	★★★★
Pediatric								
Well Child: 6 or More Visits	80.85%	83.09%	84.09%	87.09%	2.24%	1.01%	2.99%	★★★★
Children with Pharyngitis	76.04%	73.04%	74.91%	79.31%	–3.00%	1.87%	4.41%	★★
Children with Upper Respiratory Infection	89.07%	90.48%	91.32%	93.32%	1.42%	0.84%	2.00%	★★★★
PCMH								
Breast Cancer Screening	72.65%	72.27%	72.08%	71.59%	–0.38%	–0.19%	–0.49%	★★
Cervical Cancer Screening	77.13%	74.38%	74.73%	75.24%	–2.75%	0.35%	0.51%	★★
Colorectal Cancer Screening	70.64%	70.91%	71.81%	73.27%	0.27%	0.91%	1.46%	★★★★
Chlamydia Screening	58.33%	62.36%	64.43%	65.41%	4.03%	2.07%	0.97%	★★★★★
Low Back Pain Imaging	71.49%	71.38%	76.36%	78.70%	–0.11%	4.98%	2.34%	★★★★
Diabetes Screening	84.24%	83.68%	84.30%	84.94%	–0.57%	0.62%	0.65%	★
Diabetes <7	50.21%	48.52%	48.33%	46.82%	–1.69%	–0.18%	–1.51%	★★★★★
Diabetes <8	68.10%	67.69%	67.87%	66.90%	–0.40%	0.17%	–0.96%	★★★★
Diabetes ≤9	76.71%	76.77%	77.31%	76.70%	0.06%	0.54%	–0.61%	★★★

Source: MHS Population Health Portal, June 2017
Notes:
– 2014: Rates for June 2014; 2015: Rates for June 2015; 2016: Rates for June 2016; 2017: Rates for June 2017
– Statistical Testing: Two-sample Z test; Green or Red: statistically significant at p=0.05 level
– HEDIS Benchmark Status
  • 1 star: Below 25th percentile
  • 2 stars: Between 25th and 49th percentile
  • 3 stars: Between 50th and 74th percentile
  • 4 stars: Between 75th and 89th percentile
  • 5 stars: At or above 90th percentile

QUALITY OF MHS CARE *(CONT.)*

Focused Quality Initiatives *(cont.)*

Women, Newborn, and Infant Initiatives

The Women and Infant Clinical Community (WICC) oversees and reviews the data and clinical outcomes related to women's health issues, specifically perinatal (maternity) and infant (birth to one year of age) care. The PCMH model supports general wellness metrics for women's health (breast and cervical cancer screening), in addition to the clinical care of pediatric beneficiaries above the age of one year. Collaboratively, WICC and PCMH scope the care for all women and children in the MHS. WICC is the continuation of the work done by the Perinatal Advisory Working Group in the decrease of postpartum hemorrhage and standardization of assessment, treatment, and outcomes for this complication. Specialty communities support condition-specific and medical complexities, linking all beneficiaries into a continuum of care.

Perinatal Care Measures

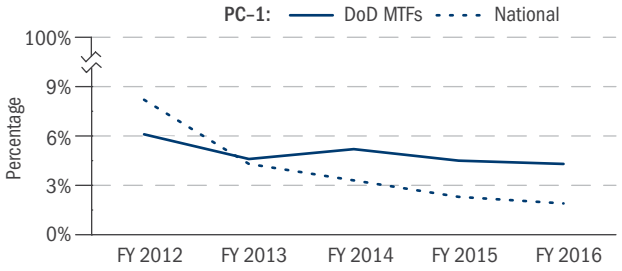
The MHS utilizes nationally recognized measures to continually monitor perinatal care provided across the system. The perinatal care (PC) measures are endorsed by the National Quality Forum. The collection and submission of quality measures data to TJC are required to meet accreditation requirements.

- **Elective Delivery:** This measure (PC-01) focuses on improving the health and outcomes of infants and mothers by avoiding non-medically indicated early elective births (before 39 weeks gestation). DoD MTF rates have continued to decrease over the past three years.

PC–1 ELECTIVE DELIVERY[a]

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
DoD MTFs	6.1%	4.6%	5.2%	4.5%	4.3%
National[a]	8.2%	4.3%	3.3%	2.3%	1.9%

DoD HOSPITAL QUALITY MEASURE: ELECTIVE DELIVERY PC–1, FYs 2012–2016[a]



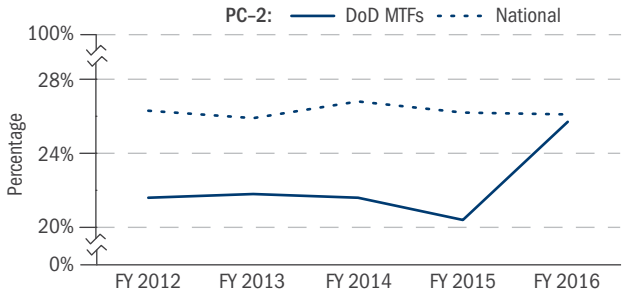
- **Cesarean Rates:** This measure (PC-02) focuses on safe and appropriate opportunities to prevent overuse of cesarean delivery to reduce risk and increase safety for mothers and infants. DoD MTF rates continue to be below the national rates (lower is better).

PC–2 CESAREAN SECTION[a]

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
DoD MTFs	21.6%	21.8%	21.6%	20.4%	25.7%
National[a]	26.3%	25.9%	26.8%	26.2%	26.1%

[a] Lower rates are better.

DoD HOSPITAL QUALITY MEASURE: CESAREAN SECTION PC–2, FYs 2012–2016[a]

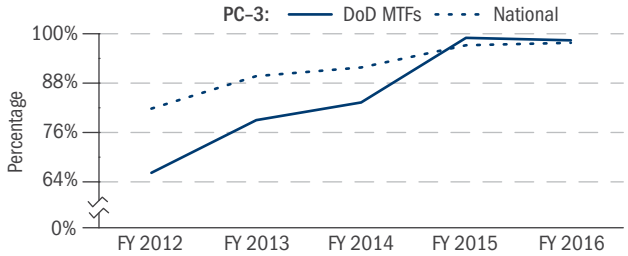


- **Antenatal Steroids:** This measure (PC-03) focuses on providing patients at risk of preterm delivery (≥24 and <34 weeks gestation) with steroids prior to delivering preterm newborns. DoD MTF rates for the past two years are consistent with the national rate.

PC–3 ANTENATAL STEROIDS

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
DoD MTFs	66.2%	79.0%	83.3%	99.0%	98.4%
National	81.8%	89.7%	91.8%	97.2%	97.8%

DOD HOSPITAL QUALITY MEASURE: PERINATAL CARE, ANTENATAL STEROIDS PC–3, FYs 2012–2016



Source: DHA/OPS (J-3)/Clinical Support Division, 12/18/2017

Focused Quality Initiatives *(cont.)*

- **Newborn Bloodstream Infections:** This measure (PC-04) focuses on monitoring health care–associated infections in newborns to identify opportunities for improvement. The DoD, like all health care organizations, strives to eliminate health care–associated infections. The DoD MTF rate has been at or below the national rate for the past three years.

PC–4 HEALTH CARE–ASSOCIATED BLOODSTREAM INFECTIONS IN NEWBORNS[a]

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
DoD MTFs	9.5%	4.1%	0.9%	1.7%	1.2%
National[a]	ND	2.5%	3.2%	2.4%	1.1%

[a] Lower rates are better.

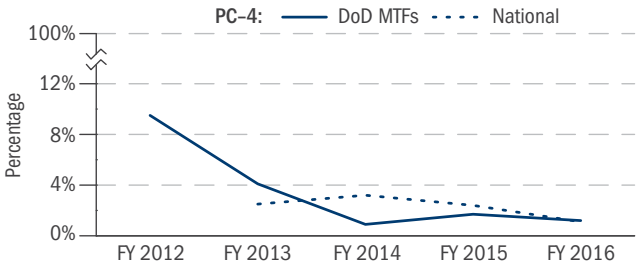
- **Breastfeeding:** This measure (PC-05) focuses on exclusive breastfeeding for newborns during entire hospitalization. The benefits of breastfeeding an infant, especially in the days after birth, are internationally recognized. DoD MTF performance on this measure significantly surpasses the national rate, and has continued to incrementally improve each of the past six years (higher is better).

PC–5 EXCLUSIVE BREASTFEEDING

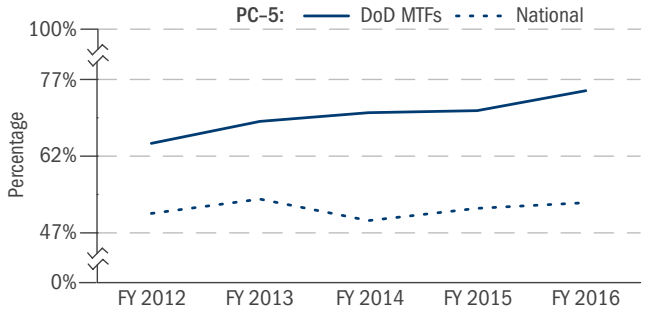
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
DoD MTFs	64.5%	68.8%	70.5%	70.9%	74.8%
National	50.8%	53.6%	49.4%	51.8%	52.9%

Source: DHA/OPS (J-3)/Clinical Support Division, 12/18/2017

DoD HOSPITAL QUALITY MEASURE: HEALTH CARE–ASSOCIATED BLOODSTREAM INFECTIONS IN NEWBORNS PC–4, FYs 2012–2016[a]



DoD HOSPITAL QUALITY MEASURE: EXCLUSIVE BREASTFEEDING PC–5, FYs 2012–2016



Additional data for perinatal metrics are provided through a contract with the vendor National Perinatal Information Center (NPIC), which serves as an analytic service to provide MTF-, Service-, and MHS-level data on over 100 metrics for the direct care component. Purchased care component data are expected to be available in CY 2018. NPIC data demonstrate over a 35 percent decrease in the postpartum hemorrhage rate from the initiative started in 2015. A CY 2017 high-priority topic has been the initiation of a clinical care path for decreasing variation in care of women receiving oxytocin, an Institute for Safe Medication Practices high-alert medication, during labor and delivery. Standardization of assessment, treatment, and outcomes of this care path is anticipated to potentially decrease cesarean section, postpartum hemorrhage, and non-reassuring fetal heart tracings, leading to healthier mothers and infants. The journey to decrease unnecessary variation in clinical practice will continue for years to come. Additionally, the NPIC data reveal an increase in the number of postpartum and infant (inborn) readmissions to delivery hospitals in the MTFs. The MHS data system allows for complete tracking of our beneficiaries as they are readmitted, providing a more accurate database of readmissions than is possible in the NPIC member facilities databases. It is expected that due to this more complete capture of data, the MTF-based readmissions will remain elevated, but a deep dive into both causes and conditions that are most commonly found is underway. This review of readmissions is an extension of the MHS 90-day review of overall MTF adult readmission work through Project RED (Re-Engineered Discharge) for the perinatal population. Initial data show readmissions are higher for women with caesarian sections and for infants with higher jaundice levels. Both of these are consistent

QUALITY OF MHS CARE *(CONT.)*

Focused Quality Initiatives *(cont.)*

with the reasons for readmission in the NPIC member populations. Data reported by NPIC to the MTFs provide a quarterly listing of specific conditions that warrant a deep dive at the MTF level to understand complex diagnosis. These deep dives are recommended for all patients who have postpartum hemorrhage, shoulder dystocia, birth trauma (composite or Patient Safety Indicators [PSI] 17), and/or a severe maternal mortality event.

The data below reflect the excellent work done by the MHS in attaining and maintaining standards of clinical outcomes on five metrics: postpartum hemorrhage, shoulder dystocia, shoulder dystocia linked with birth trauma, and low-risk caesarian sections. Areas for continued work include readmissions, both maternal and infant, and birth injury/trauma. Outliers are MTFs with two most recent reported quarters (2016 Q3 and Q4) two standard deviations above the NPIC benchmark.

NATIONAL PERINATAL INFORMATION CENTER COMPARATIVE DATA ALL SERVICES COMBINED, CY 2016 Q1–Q4

	CY 2016 (Q1)		CY 2016 (Q2)		CY 2016 (Q3)		CY 2016 (Q4)	
Total Deliveries	10,204		10,417		11,510		10,147	
Maternal Outcome Measures	MTF Level Rate		MTF Level Rate		MTF Level Rate		MTF Level Rate	
Inpatient Quality Indicator (IQI) 33 Low-Risk Cesarean Birth Rate	16.1%	●	14.2%	●	14.9%	●	See footer[a]	
Postpartum Hemorrhage Rate	2.4%	●	3.2%	●	3.2%	●	2.9%	●
Shoulder Dystocia Rate	2.0%	●	3.4%	●	2.3%	●	2.2%	●
Maternal Readmit Rate to Delivery Hospital	1.0%	●	1.3%	●	1.3%	●	1.3%	●
Total Neonates	10,899		10,906		12,147		10,931	
Neonatal Outcome Measures	MTF Level Rate		MTF Level Rate		MTF Level Rate		MTF Level Rate	
PSI 17 Birth Trauma Rate	0.6%	●	0.8%	●	0.8%	●	See footer[a]	
Total Birth Trauma Rate (Composite)	3.9%	●	4.2%	●	3.8%	●	3.6%	●
Inborn Readmit Rate to Birth Hospital	3.4%	●	3.1%	●	3.5%	●	4.1%	●
Inborn Mortality ≥2,000 Grams	0.0%	●	0.0%	●	0.0%	●	0.0%	●

NUMBER OF MTF NPIC MEASURE OUTLIERS, 2016 Q3–Q4

NPIC MEASURE OUTLIER	ARMY	NAVY	AIR FORCE	NCR
Birth Injury/Trauma Composite	2	0	1	0
Maternal Readmission to Delivery Facility	1	1	0	0
Newborn (Inborn) Readmission to Delivery Facility	10	8	3	2

Source: DHA/OPS (J-3)/Clinical Support Division, 12/18/2017

[a] Pending NPIC calculation (coming soon).

GREEN indicates the MTF level average rate is **two standard deviations above** the NPIC/Quality Analytic Services (QAS) rate.

RED indicates the MTF level average rate is significantly **above or below two standard deviations** of the NPIC/QAS rate.

MTF Level and NPIC/QAS Database Rates for AHRQ measures IQI 33 and PSI 17 are the sum of all numerators/sum of all denominators (case level rates). For all other measures, the MTF level and NPIC/QAS database rates are the sum of all individual MTF/hospital rates (including those with 0 percent), divided by the number of MTFs/hospitals in the analysis (unweighted average).

The **Perinatal Center Database rate** is an unweighted average from all NPIC/QAS civilian hospitals in the database.

IQI 33 (AHRQ): Number of cesarean deliveries, reported without a hysterotomy procedure, among cases meeting the inclusion and exclusion rules for the denominator; a more comprehensive measure of primary caesarian sections than TJC Perinatal Agency for Healthcare Research and Quality Care-01, which looks at primary cesareans for first baby only.

Shoulder Dystocia (AHRQ): Coded condition during delivery; shoulder dystocia is a specific case of obstructed labor whereby after the delivery of the head, the anterior shoulder of the infant cannot pass below, or requires significant manipulation to pass below, the pubic symphysis; may or may not result in injury.

Postpartum Hemorrhage (based on American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance standardized definition): Postpartum hemorrhage is divided into two categories: (1) immediate (within first 24 hours after birth) and (2) delayed (after 24 hours postpartum). Hemorrhage is defined as a blood loss of more than 1,000 mL after a delivery.

Birth Injury/Trauma: Two metrics: (1) complete measure of birth trauma/injury is based on ICD-10 codes for birth trauma in any diagnosis field of injury or trauma to a newborn that requires increased length of stay, increased use of resources or consultation post discharge, specific diagnosis, and three miscellaneous categories; (2) discharges among cases meeting the inclusion and exclusion rules for the denominator with ICD-10 codes. A subset of total birth trauma, fewer diagnoses, and fewer miscellaneous categories (PSI 17 from AHRQ).

Maternal Readmission to Delivery Facility: Occurs within 42 days of delivery; related to delivery process.

Newborn (Inborn) Readmission to Delivery Facility: Readmission of infant born in facility to same facility within 30 days of birth.

Focused Quality Initiatives *(cont.)*

State Vaccine Programs

Section 719 of the NDAA FY 2017 language added authority to reimburse State Vaccine Programs (SVPs) for vaccines provided to TRICARE-covered beneficiaries. The DHA director has authorized an implementation plan with the process TRICARE will follow to reimburse SVPs. DHA is taking a two-phased approach: Phase 1 is the temporary, interim process to provide payments to SVPs for arrearages from December 23, 2010 on. Phase 2 is the permanent, ongoing process with contract modification to the MCSCs.

Medical Nutrition Therapy

Section 714 of the NDAA FY 2017 confirmed long-standing nutritional therapy policy and added new benefits, including low-protein modified foods for the treatment of inborn errors of metabolism such as phenylketonuria and homocystinuria. Additionally, the TRICARE program added coverage for: (1) outpatient services and supplies necessary to administer a ketogenic diet for the treatment of seizures that are refractory to anti-seizure medication; (2) medical nutritional therapy/counseling when medically necessary; and (3) the services of Registered Dietitian Nutritionists providing medical nutritional therapy/counseling for medically authorized covered services.

Behavioral Health Service Initiatives

Availability of Mental Health Providers for Active Duty Members and Families. Given the tremendous growth in DoD mental health (MH) staffing since early FY 2002, the current level of MH resourcing continues to be adequate to serve all Active Duty and eligible Reserve Component (RC) members and their families, as well as retirees and their dependents. In April 2016, the GAO completed an audit to assess the availability and accessibility of MH care for Service members in the MHS. The GAO found that the MHS makes a variety of inpatient and outpatient MH care services available to ADSMs and eligible RC members domestically and overseas.

This care is typically available through MTFs and clinics (direct care), and is supplemented by care provided through networks of civilian providers (purchased care). In FY 2016, the DoD provided 78 percent of 2.9 million outpatient MH services through direct care and 64 percent of 0.2 million inpatient MH bed-days through purchased care for our Active Duty and eligible RC Service members. To deliver MH care, the military Services use a range of strategies, including telehealth, embedding MH providers within units, and integrating MH providers in primary care.

Since 9/11, with the support of Congress, the DoD has increased the outlays for MH care by an 8.2 percent compounded annual rate from FY 2002 through FY 2016.

Approximately 17 percent of Active Duty used MH outpatient services in FY 2016. In addition, care is embedded into both primary care clinics and fighting units. The number of MH providers in the MHS has increased by 42 percent, from 6,548 in FY 2009 to 9,273 by the end of FY 2017. Further, TRICARE network assets have been bolstered to better serve Reservists, dependents, and retirees, with a total of 84,029 MH providers available in the purchased care network.

Additionally, on September 2, 2016, the DoD published the *Final Rule: TRICARE; Mental Health and Substance Use Disorder Treatment*, which contained comprehensive revisions to the TRICARE regulation to reduce administrative barriers to accessing MH benefit coverage and to improve access to substance use disorder (SUD) treatment for all TRICARE beneficiaries. This is consistent with current standards of practice and principles of MH parity, which require that MH benefits be on par with medical benefits. The Final Rule greatly expanded the continuum of MH and SUD treatment services covered under TRICARE, to include: coverage of intensive outpatient programs and outpatient venues for medication-assisted treatment for opioid use disorder (e.g., buprenorphine prescribed in Office-Based Opioid Treatment [OBOT] and methadone prescribed in Opioid Treatment Programs [OTP]), and elimination of quantitative limitations on care and coverage of MH treatment for the diagnosis of gender dysphoria. The Final Rule also simplified previous requirements to become a TRICARE-authorized MH and SUD institutional provider (e.g., partial hospitalization programs, residential treatment centers, SUD rehabilitation facilities, and psychiatric hospitals). These changes promote expansion of the MH/SUD network while simultaneously maintaining the quality of MH/SUD services. The expanded benefit is relatively new and is currently maturing in network development and beneficiary usage. The DHA will provide an assessment of the change in utilization or network size in next year's report.

A pilot to deliver Telemental Health (TMH) services to a patient's location (e.g., home) was initiated with two US Family Health Plan (USFHP) Designated Providers on June 1, 2016. The purpose of this pilot was to assess if web-based audio/video conferencing technologies could be used to deliver safe, effective, and quality MH care in the patient's home for those who needed medically

Focused Quality Initiatives *(cont.)*

necessary MH care, and determine whether the use of TMH care at the patient's location could:

- Enhance access for beneficiaries;
- Shorten wait times for appointments;
- In the case of child psychotherapy services, provide an opportunity to observe child behavior and parent-child interaction in the home environment and facilitate participation of both parents in the treatment process; and
- Serve as a viable alternative to delivery of MH care in a traditional clinic setting.

This pilot was terminated in July 2017, at which time the TRICARE Policy Manual chapter on telemedicine was modified to allow care to be delivered to a patient's home via telemedicine. Preliminary findings from the pilot suggest overall satisfaction with TMH services by both patients and providers. Effectiveness of TMH versus in-person care is still being evaluated.

Access to MHS Care and Services for Active Duty and Non-Active Duty Family Members with Autism Spectrum Disorder

In response to section 714 of the NDAA 2013, this section of the report builds on the previous reports by extending the evaluation of the TRICARE program in addressing dependents of members on Active Duty with severe disabilities and chronic health care needs.

Applied behavior analysis (ABA) is one of many TRICARE-covered services to treat autism spectrum disorder (ASD). Other services include, but are not limited to, speech therapy, occupational therapy, physical therapy, medications, and psychotherapy.

In June 2014, TRICARE published the Comprehensive Autism Care Demonstration (ACD) Notice in the *Federal Register* upon the approval of the Office of Management and Budget, and in compliance with the regulations that govern TRICARE demonstrations. Based on limited demonstration authority, in July 2014, the ACD was merged into a single program from three previous programs with no annual caps of government cost shares in an attempt to strike a balance that maximizes access while ensuring the highest level of quality care for our beneficiaries. This consolidated demonstration will ensure consistent ABA coverage for all TRICARE beneficiaries—including Active Duty family members (ADFMs) and non-ADFMs diagnosed with ASD. ABA services are not limited by the beneficiary's age, the dollar amount spent, or the number of services provided. The most recent full-year fiscal data available, FY 2016, show the total ABA services program expenditures were $232 million. ABA services are not provided at MTFs, but rather through the ACD in the purchased care system. The ACD, which began on July 25, 2014, will run through December 31, 2023.

As evidenced in our previous reports and the information in the table on the following page, participation in the ACD by beneficiaries and ABA providers is growing. By the end of FY 2016, 13,399 beneficiaries participating in the ACD had filed claims (see table). While not shown, this number is expected to grow to approximately 15,000 in FY 2017.

In summation, the DoD has implemented a robust ABA benefit that serves all eligible TRICARE beneficiaries. Unlike many civilian insurance plans, the TRICARE benefit has no limits on medically necessary hours of ABA care or cost per beneficiary. Although our contractors deserve credit for their recruitment efforts to continually build the network, another factor contributing to the success is that the TRICARE benefit is one of the best in the nation. That is especially true since ABA providers never have to collect a copayment, deductible, or any other payment from Active Duty families, who have 100 percent coverage. Retirees have nominal out-of-pocket costs and are protected by the catastrophic cap.

Focused Quality Initiatives *(cont.)*

HISTORICAL NUMBER OF COMBINED TRICARE ADFM AND NON-ADFM ABA PROGRAM USERS

(BASED ON MDR DATA AS OF AUGUST 1, 2017)

	NUMBER OF USERS				% GROWTH IN USERS FROM PRIOR YEAR			
	ECHO AND TUTOR PILOT PROGRAMS[a]	TRICARE BASIC ABA	NEW AUTISM CARE DEMO	TOTAL UNIQUE USERS	ECHO AND TUTOR PILOT PROGRAMS[a]	TRICARE BASIC ABA	NEW AUTISM CARE DEMO	TOTAL UNIQUE USERS
	BY SIX-MONTH INCREMENTS							
FY 2012 First Six Months	5,317	50	–	5,342	–	–	–	–
FY 2012 Second Six Months	6,064	192	–	6,140	–	–	–	–
FY 2013 First Six Months	6,184	1,834	–	6,958	16%	3,568%	–	30%
FY 2013 Second Six Months	5,943	3,020	–	7,838	-2%	1,473%	–	28%
FY 2014 First Six Months	6,010	3,699	–	8,219	-3%	102%	–	18%
FY 2014 Second Six Months	6,583	4,774	14	9,410	11%	58%	–	20%
FY 2015 First Six Months	5,350	3,287	8,938	9,774	-11%	-11%	–	19%
FY 2015 Second Six Months	179	2,361	10,732	10,771	-97%	-51%	76,557%	14%
FY 2016 First Six Months	353	–	10,875	10,944	-93%	-100%	22%	12%
FY 2016 Second Six Months	543	–	11,715	11,821	203%	-100%	9%	10%
FY 2017 First Six Months	528	–	11,469	11,567	50%	–	5%	6%
	BY FISCAL YEARS							
FY 2011	5,140	9	–	5,149	–	–	–	–
FY 2012	6,465	221	–	6,686	26%	2,356%	–	30%
FY 2013	7,215	3,526	–	8,743	12%	1,495%	–	31%
FY 2014	7,561	5,848	14	10,462	5%	66%	–	20%
FY 2015	5,416	3,287	11,461	12,166	-28%	-44%	–	16%
FY 2016	695	–	13,290	13,399	-87%	-100%	–	10%

Source: DHA/TRICARE Health Plan (J-10)/Execution Ops, 11/3/2017

[a] After January 1, 2015, Extended Care Health Option (ECHO) non-Tutor program non-ABA benefits, such as durable equipment and respite care for beneficiaries diagnosed with ASD, continue to be available.

QUALITY OF MHS CARE *(CONT.)*

Focused Quality Initiatives *(cont.)*

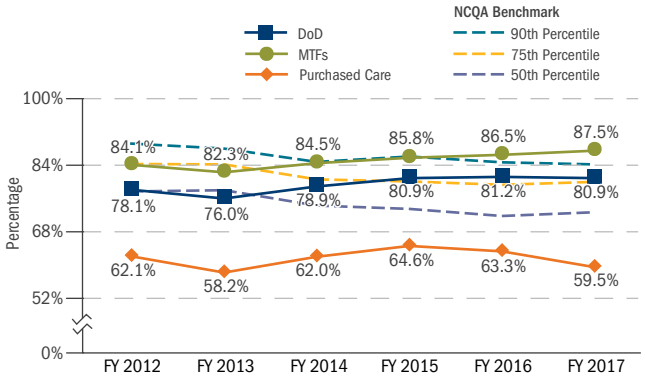
Child and Adolescent MH and SUD Treatment

The Final Rule changes, implemented in 2017, are especially important to the pediatric population, as they expanded the array of TRICARE-authorized MH/SUD providers across the full continuum of care in alignment with the civilian behavioral health care industry. These changes also brought MH and SUD benefits into increased alignment with the Affordable Care Act. The goal of these changes was to continue to modernize access, safety, and quality health care options to strengthen our families' resilience.

Comprehensive child and adolescent MH/SUD services across the continuum of care ensure that the children of military members have access to the full array of medically/psychologically necessary MH/SUD services required for individual and family MH, and Service-member readiness. For children/adolescents, the continuum of care includes MH/SUD outpatient services, intensive outpatient programs, partial hospitalization programs, MH residential treatment centers, SUD rehabilitation facilities, and acute inpatient MH and SUD hospital services. Child/adolescent MH/SUD services are offered in both purchased care (PC) and direct care (DC).

TRICARE has a robust MH/SUD provider network across the continuum of MH/SUD care to meet the needs of the approximately 2.25 million pediatric beneficiaries.

MENTAL HEALTH FOLLOW-UP, FYs 2012–2017



Source: DHA/OPS (J-3)/Clinical Support Division, 12/18/2017

In FY 2016, 10,798 pediatric beneficiaries received inpatient MH/SUD treatment, 1,706 received psychiatric residential treatment center care, and 59 received SUD rehabilitation facility care. Over 30,000 providers delivered MH and SUD outpatient treatment to over 40,000 pediatric beneficiaries in DC and PC. 68,994 pediatric beneficiaries received 578,005 psychotropic medication prescriptions under the pharmacy benefit. This does not include pediatric beneficiaries who received care from developmental pediatricians or neurologists for the diagnosis and treatment of a developmental disorder or those diagnosed with ASD who received applied behavior analysis under the ACD, which is discussed separately.

The Final Rule added new MH/SUD benefits under TRICARE to include: MH and SUD intensive outpatient programs, medication-assisted treatments for the treatment of opioid dependence (buprenorphine [suboxone] prescribed in the OBOT setting and methadone prescribed in an OTP setting). Additionally, the requirements for partial hospitalization programs, child and adolescent psychiatric residential treatment centers and SUD rehabilitation facilities were streamlined to reduce administrative requirements to attract more providers to join the TRICARE network. Information on these efforts to expand the network should become available in FY 2019.

- **Mental Health Follow-Up:** This HEDIS measure examines 30-day mental health follow-up care in the MHS DC and PC systems. DC includes all participating MTFs as a group. PC includes the regional MCSC networks, the Designated Provider/USFHPs, and overseas networks participating. The MHS continues to focus its efforts on seamless transitions of MH care in both DC and PC.

QUALITY OF MHS CARE *(CONT.)*

Focused Quality Initiatives *(cont.)*

Pediatrics—Health Care and Related Support for Children in TRICARE

The MHS continues to advance programs, discussions, and decision making for the pediatric population in the areas of quality, safety, access, and satisfaction, with data reporting to represent this unique population. The DHA, along with Service leader partners, continues to engage internal and external stakeholders to facilitate collaboration and increase transparency in this journey. For the past two years, the DHA has presented to organizations inside and outside the federal government, engaging specifically with pediatric advocacy groups to discuss updates of pediatric benefits, pilots, demonstrations, innovations, and metrics. DHA pilots that began in 2016 have been evaluated and based on their impact to all beneficiaries, including the pediatric population, to improve access to care in the least restrictive environment. The TRICARE basic programs will be expanded to include UC visits without referrals and availability of virtual phone visits and TMH visits. Additionally, the NAL has provided invaluable support and increased access to care for families, now expanded to worldwide services. The NAL reports that 25 percent of calls are related to care for children between birth and two years of age.

Sweeping revisions published under the Final Rule revise TRICARE's MH and SUD benefit to achieve MH parity and improve MH care and access for children and families. These (over 90) TRICARE manual changes authorize TRICARE's adult and pediatric beneficiaries to receive MH and SUD treatment at an appropriate level of care in proximity to their communities. These changes enable treatment to progress for both MH and SUD without the historic limits on number of visits or hospitalizations for these complex conditions. The goals of these changes are to continue to update access, safety, and quality health options to strengthen our families' resilience. This benefit is further explained on the preceding page.

The metrics that constitute the quality measurement of pediatric health care and child health within the MHS continues to be evaluated and expanded. CY 2017 began with multiple engagements with federal child health leaders from CMS, AHRQ, CDC, Health Resource Service Agency, Maternal Child Health Branch, Substance Abuse and Mental Health Service Agency, military Services (Army, Navy, Air Force) pediatric leads, Defense Health, and Health Affairs staff. The resulting dashboard is a result of identifying areas within MHS pediatric care that should be addressed by quality measures with comprehensive measurement domains. The metrics are to be based on domains and health system needs. Measures are chosen to accurately reflect how the MHS is monitoring pediatric care and identifying opportunities for improvement in timely, efficient, and equitable patient- and family-centered pediatric care for both direct and purchased care components. The domains included in performance measure selection and prioritization, all of which are factors in delivering relevant, meaningful, and understandable information, are: importance to health; improvement; stakeholders; scientific acceptability for validity and reliability; feasibility of available, retrievable, reliable, and unbiased data; and data collection and usability cost. The pediatric metrics and dashboard will be iterative and continue to evolve based on assessment of value and feasibility of metrics.

MHS PEDIATRIC DASHBOARD (INITIAL DISPLAY)

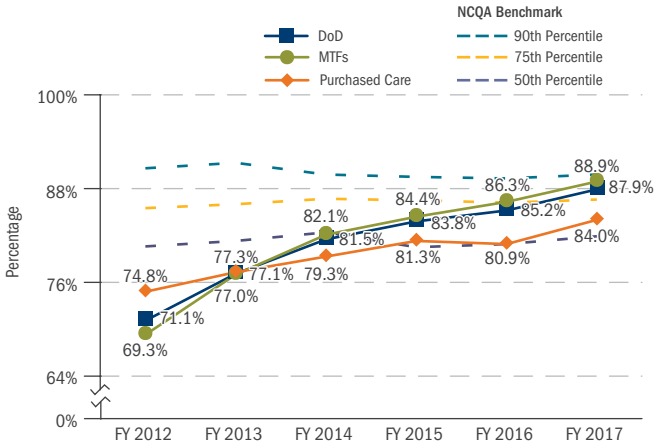
Average Number of Days to Third Next Appointment (Primary Care)
Pediatric and Neonatal CLABSIs
Appropriate Treatment for Children with Upper Respiratory Infection
Appropriate Testing for Children with Pharyngitis
Childhood Immunizations
Immunizations for Adolescents
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
Adolescent Well-Care Visits Ages 12–21
Neonatal Mortality Rate
Composite Measure for Specialty Referral To Care Time
Attention-Deficit/Hyperactivity Disorder Follow-Up Care

Source: DHA/OPS (J-3)/Clinical Support Division, 12/18/2017

QUALITY OF MHS CARE *(CONT.)*

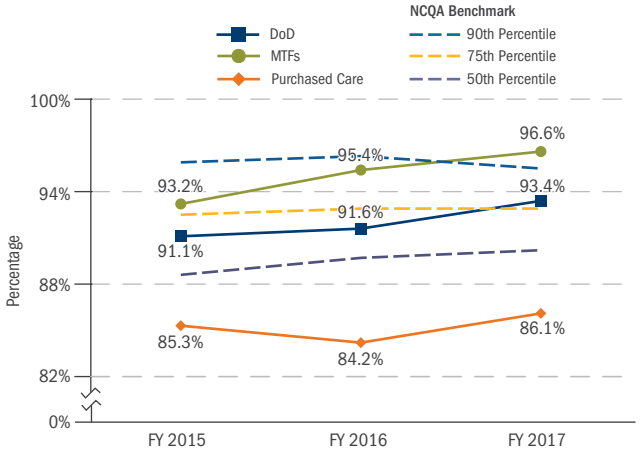
Focused Quality Initiatives *(cont.)*

WELL-CHILD VISITS, FYs 2012–2017



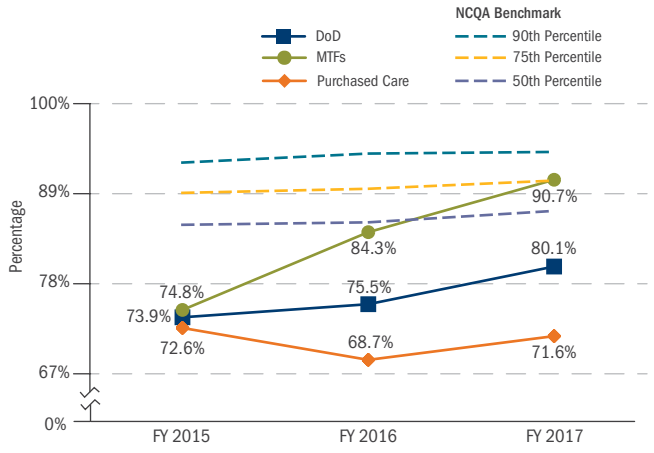
- **Well-Child Visits:** HEDIS measures focused on the adequacy of well-child care for infants. The MHS continues to demonstrate improvement in this measure, which focuses on children having six visits within the first 15 months of life. Direct care facilities exceeded the NCQA 75th percentile in FY 2017 and are near the 90th percentile. The purchased care providers are in the 50th percentile.

CHILDREN WITH UPPER RESPIRATORY INFECTION, FYs 2015–2017



- **Children With Upper Respiratory Infection:** HEDIS measure focused on the prevalence of inappropriate antibiotic prescribing and increasing awareness of the importance of antibiotic stewardship to prevent antibiotic resistance. This measure was included in the MHS FY 2017 PIPs. The rate of performance for direct care facilities reached the NCQA 90th percentile. The purchased care provider performance improved from the previous year.

CHILDREN WITH PHARYNGITIS, FYs 2015–2017



- **Children With Pharyngitis:** HEDIS measure focused on appropriate use of antibiotics based on laboratory data. Pharyngitis diagnosis can be easily and objectively validated through administration of a group A strep test at the point of care. Validation of the diagnosis prevents unnecessary use of antibiotics. This measure was included in the MHS FY 2017 PIPs. Direct care facilities obtained the NCQA 75th percentile for FY 2017. The purchased care provider performance improved from the previous year.

Source: DHA/OPS (J-3)/Clinical Support Division, 12/18/2017

QUALITY OF MHS CARE *(CONT.)*

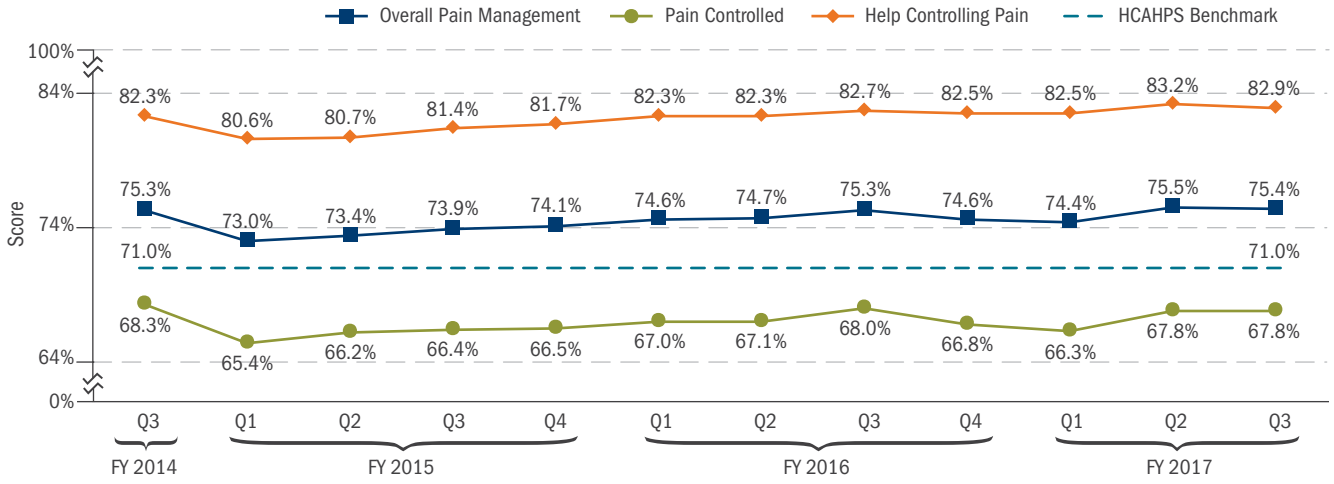
Pain Management in the MHS

During FY 2017, the MHS continued to mature pain management capabilities and resources, optimize pain management policy and clinical care, and field innovative education and training products and clinical tools across the enterprise, including:

- Continued implementation of the Stepped Care Model of Pain Management (SCMPM), developed by the VHA, to ensure the appropriate level of pain care is available and delivered to patients throughout the continuum of acute and chronic pain. Service-specific implementation of the SCMPM began in 2015. For more information on the model, see https://www.ncbi.nlm.nih.gov/pubmed/27006068.
- Expansion of Pain Telehealth integration in primary care in the NCR through both direct care visits and provider webinar case-based education.
- Deployment of the Pain Assessment Screening Tool and Outcome Registry (PASTOR), which integrates the National Institutes of Health (NIH) Patient Reported Outcomes Measurement Information System (PROMIS) into a pain registry and clinical decision-making tool for DoD providers.
- Continued execution of the Joint Pain Education Project (JPEP), a standardized DoD and VA pain management curriculum with supplemental pain videos for widespread use in education and training programs. Completed in 2016, JPEP activities for FY 2017 shifted to a deliberate review of JPEP content based on feedback from users and updates required to address emerging guidelines and medical evidence.
- Collaborative research with VA and NIH to examine non-pharmacological treatments for complex pain syndromes experienced by military populations.
- Publication of the VA/DoD CPGs for the Management of Opioid Therapy for Chronic Pain in February 2017 and clinical tools to support decision making and effective use of prescription medications, as well as compliance with the 2016 CDC Guideline for Prescribing Opioids for Chronic Pain.
- Implementation of the Chronic Opioid Therapy Safety (COTS) form for the TSWF in AHLTA (Armed Forces Health Longitudinal Technology Application), with plans to integrate the COTS functionality into MHS GENESIS to provide clinicians a standardized format for documenting items critical to understanding and managing patients with pain appropriately.

Through pursuing a range of clinical, data, and research solutions, the DoD continues to excel on national benchmarks of patient ratings of their experience with inpatient pain management. As part of the annual Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, overall patient pain management in the MHS is assessed by patient self-report following discharge from a hospital on two questions: (1) "During this hospital stay, how often was your pain well controlled?" (Pain Controlled question); and (2) "During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?" (Help Controlling Pain question). Patients are asked to respond by selecting one of the options—"never," "sometimes," "usually," or "always"—to the pain management questions. The percentages shown below are based on patients who selected the most positive response option, "always," to the survey questions. Using a composite of these two questions, the chart below depicts inpatient satisfaction from FY 2014 Q3 to FY 2017 Q3. Overall pain management performance has remained above the national benchmark of 71 percent. The results for the Pain Controlled question have remained over 65 percent, while those of the Help Controlling Pain question have remained over 80 percent.

INPATIENT USER RATINGS OF PAIN MANAGEMENT IN MILITARY HOSPITALS, FY 2014 Q3–FY 2017 Q3



Source: DHA/OPS(J-3)/CSD, 10/30/2017

QUALITY OF MHS CARE *(CONT.)*

Patient Ratings—Experience of Care and Service

Beneficiary Ratings of Experience and Satisfaction with Key Aspects of TRICARE

Patient experience is important because it is a unique indicator of health facility performance in the critical areas of safety, access, and quality of care. For instance, there is a growing body of evidence that shows that better patient experiences are closely related to patients adhering to preventive measures and treatment protocols, better patient safety within hospitals, less need to seek further treatment after an encounter, better quality of care from hospital staff, and overall better patient outcomes, including both medical and surgical care.

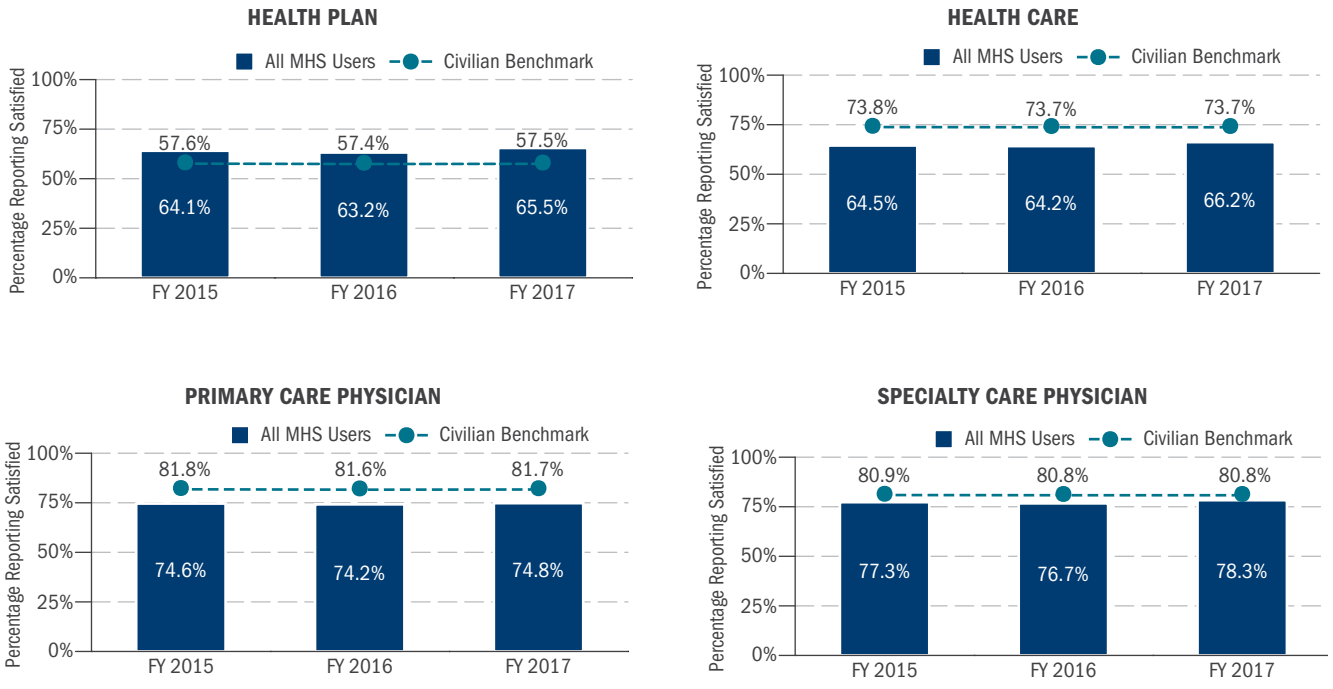
In this section, MHS beneficiaries in the U.S. who have used TRICARE are compared with the civilian benchmark with respect to ratings of (1) the health plan in general; (2) health care; (3) their personal physician; and (4) specialty care. Health plan ratings depend on access to care and how the plan handles various service aspects such as claims, referrals, and customer complaints.

Beneficiary Ratings of Their Health Plan through Population-Based Surveys

The population-based HCSDSB is based on the CAHPS plan, and is used to routinely assess MHS beneficiary experience with health care, whether in the direct or purchased systems, or with other health insurance (OHI). Unlike JOES or JOES-C, which follow an outpatient visit, or the TRISS, which follows a discharge from a hospital, the HCSDB is based on a sample of all MHS-eligible beneficiaries worldwide. Results from the HCSDB can be compared to civilian health plans, providing a good benchmark for MHS performance measurement. Results of the HCSDB for the past three years on key aspects of a health plan are presented below.

- MHS beneficiary satisfaction with both their health plan and health care quality increased from FY 2015 to FY 2017. The civilian benchmarks for all four health plan aspects remained steady over the same time period.
- MHS beneficiary satisfaction with the health plan exceeded that of the civilian benchmark in each year between FY 2015 and FY 2017. However, MHS beneficiary satisfaction with health care quality and with primary and specialty care physicians was lower than the comparable civilian benchmarks.

TRENDS IN SATISFACTION RATINGS OF KEY HEALTH PLAN ASPECTS, FYs 2015–2017



Note: DoD data were derived from the FYs 2015–2017 HCSDB, as of 11/13/2017, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS health plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used in 2015 come from NCQA's 2013 data, while the benchmarks used in 2016 and 2017 come from NCQA's 2015 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

QUALITY OF MHS CARE *(CONT.)*

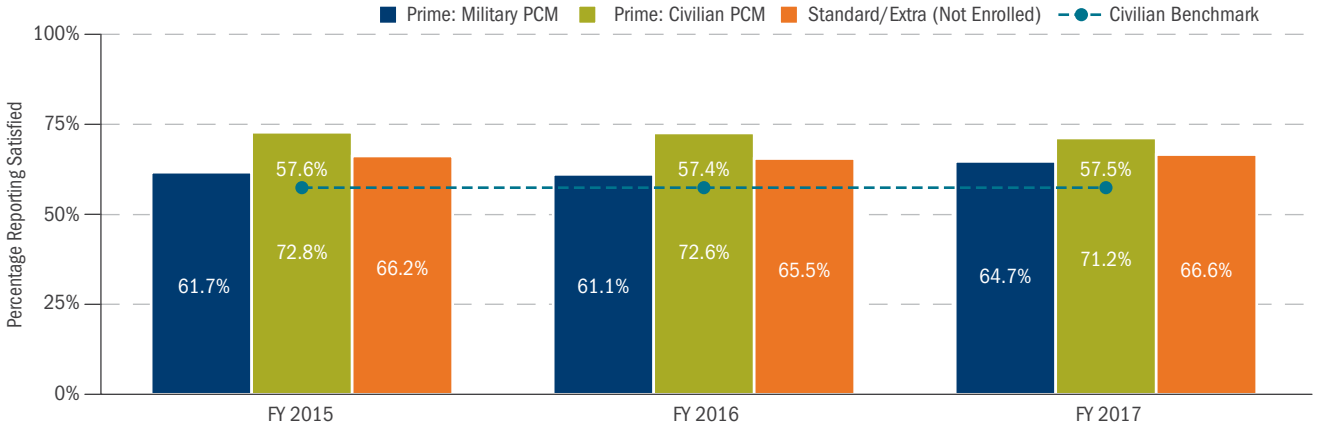
Patient Ratings—Experience of Care and Service *(cont.)*

Beneficiary Ratings of Their Health Plan Based on Enrollment Status

DoD health care beneficiaries can participate in TRICARE in two ways: by enrolling in the Prime option or by not enrolling and using the traditional indemnity option for seeing participating providers (Standard) or network providers (Extra). Satisfaction levels with one's health plan across the TRICARE options are compared with commercial plan counterparts.

- Satisfaction with the TRICARE health plan increased from FY 2015 to FY 2017 for Prime enrollees with a military PCM and remained stable for those with a civilian PCM and for non-enrollees.
- For each year between FY 2015 and FY 2017, all MHS enrollment groups reported higher levels of satisfaction with their health plan than did their civilian counterparts.

TRENDS IN SATISFACTION WITH THE HEALTH PLAN BY ENROLLMENT STATUS, FYs 2015–2017

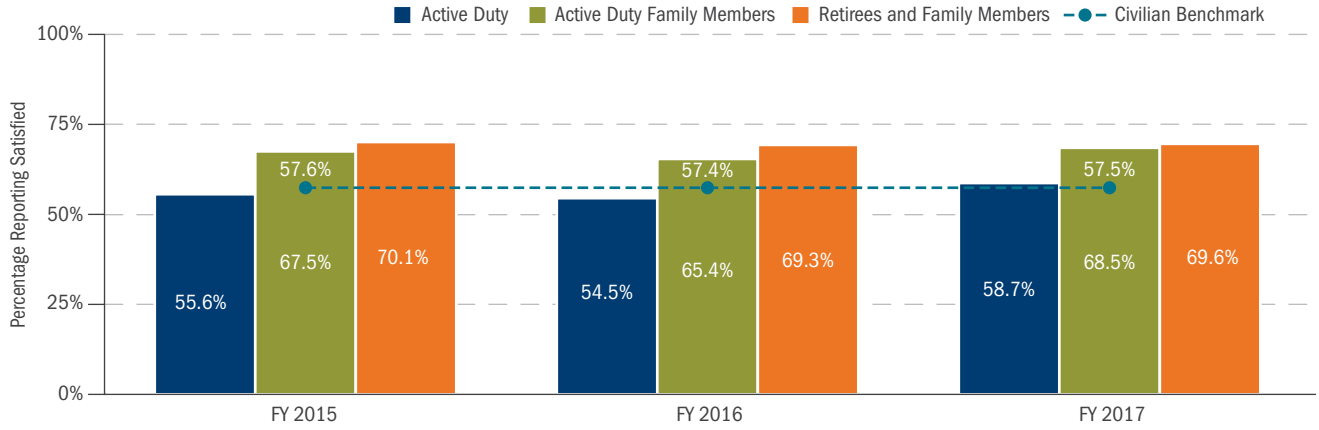


Beneficiary Ratings of Their Health Plan Based On Beneficiary Category

Satisfaction levels of different beneficiary categories are examined to identify any diverging trends among groups.

- Satisfaction with the TRICARE health plan increased from FY 2015 to FY 2017 for Active Duty but remained stable for ADFMs and retirees and family members.
- Active Duty satisfaction was lower than the civilian benchmark in FY 2016. However, satisfaction levels for ADFMs and non-enrollees were higher than the civilian benchmarks in each year from FY 2014 to FY 2016.

TRENDS IN SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY, FYs 2015–2017



Note: DoD data were derived from the FYs 2015–2017 HCSDB, as of 11/13/2017, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS health plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used in 2015 come from NCQA's 2013 data, while the benchmarks used in 2016 and 2017 come from NCQA's 2015 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

QUALITY OF MHS CARE *(CONT.)*

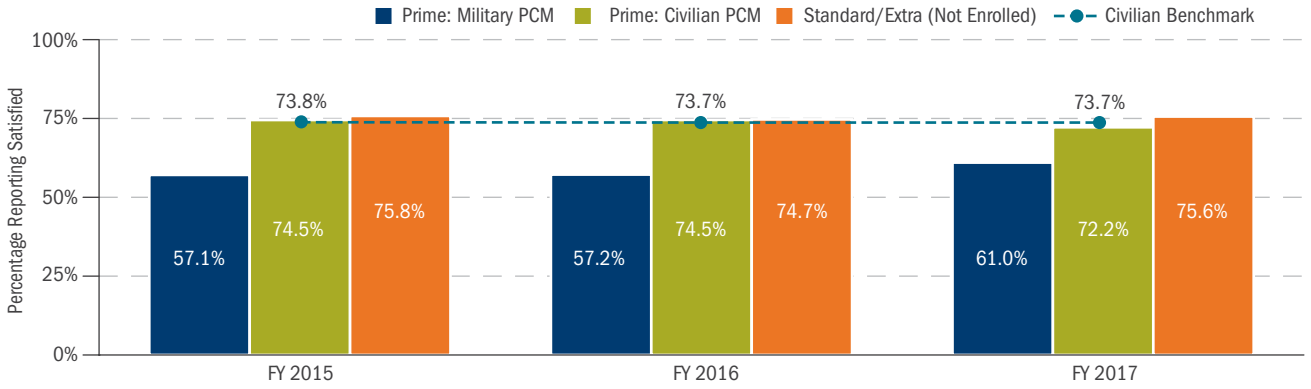
Patient Ratings—Experience of Care and Service *(cont.)*

Beneficiary Ratings of Satisfaction with Health Care Based on Enrollment or Beneficiary Category

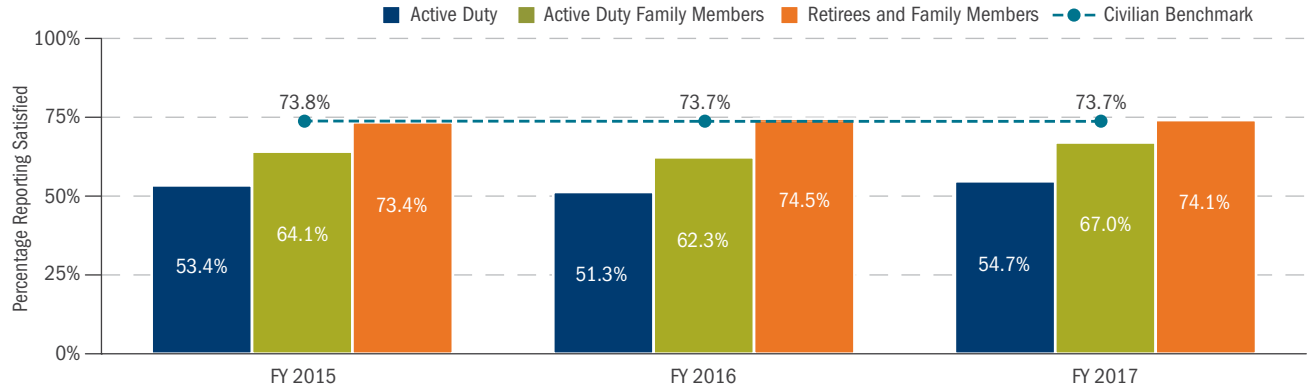
Similar to satisfaction with the TRICARE health plan, satisfaction levels with the health care received differ by beneficiary category and enrollment status.

- Satisfaction with health care for enrolled beneficiaries with military PCMs increased from FY 2015 to FY 2017. Satisfaction remained stable for both those with a civilian PCM and non-enrolled beneficiaries.
- In FY 2017, satisfaction with health care for beneficiaries with a military PCM were lower than the civilian benchmark. Satisfaction levels for the other enrollment groups equaled the civilian benchmarks.
- In FY 2017, the satisfaction levels of Active Duty and ADFMs were lower than the corresponding civilian benchmark. The satisfaction level for retirees and family members equaled the civilian benchmark.
- Satisfaction with health care increased for Active Duty and ADFMs between FY 2015 and FY 2017. Satisfaction levels remained stable for retirees and families.

TRENDS IN SATISFACTION WITH TRICARE HEALTH CARE BY ENROLLMENT STATUS, FYs 2015–2017



TRENDS IN SATISFACTION WITH TRICARE HEALTH CARE BY BENEFICIARY CATEGORY, FYs 2015–2017



Note: DoD data were derived from the FYs 2015–2017 HCSDB, as of 11/13/2017, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS health plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used in 2015 come from NCQA's 2013 data, while the benchmarks used in 2016 and 2017 come from NCQA's 2015 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

QUALITY OF MHS CARE *(CONT.)*

Patient Ratings—Experience of Care and Service *(cont.)*

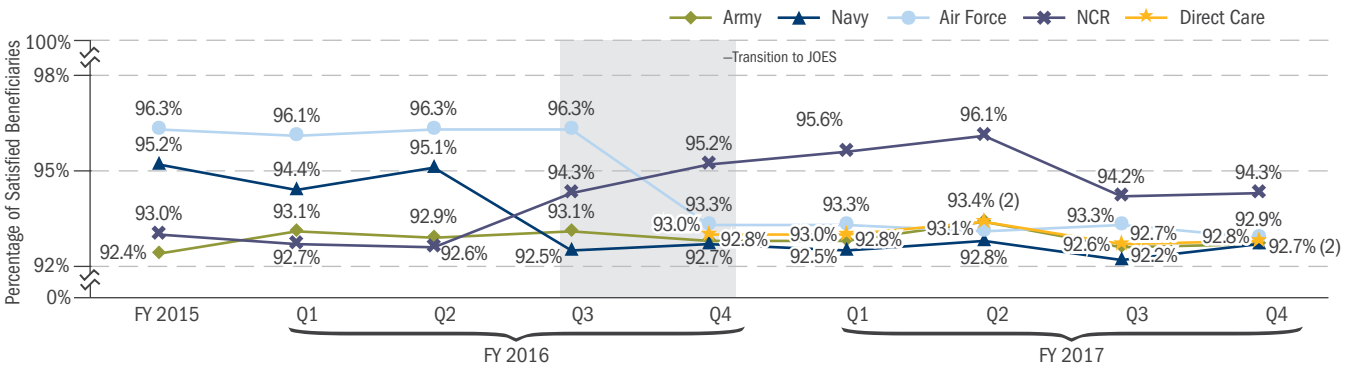
Beneficiary Ratings of Satisfaction with Care Following Outpatient Treatment

As of FY 2017, the JOES and the JOES-C measure various aspects of the patient experience with MHS care. Some aspects that the beneficiary reports on include: his/her experience with the pharmacy, laboratory, or radiology department (JOES); the communication of the receptionists and providers (JOES, JOES-C); how care was received (JOES); and if the provider knew and communicated information about the beneficiary's medical history and prescription medicines (JOES, JOES-C). During and prior to FY 2016, similar aspects were captured in Service-specific surveys and in TROSS. Additional description on the transition from the Service-specific surveys and TROSS to JOES and JOES-C can be found under "Access to Care: Patient-Centered, Self-Reported Measures" on page 70.

An important question in each of these surveys is how the beneficiary feels about his/her episode of care in general. The question asks for the beneficiary's agreement with the following statement: "Overall, I am satisfied with the health care I received on this visit." Drivers of satisfaction, or what may lead a beneficiary to respond favorably or negatively to this question, are shown starting on page 139.

Rating of Satisfaction with Care: Results for Satisfaction with Care were very distinct by service, based on Service surveys occurring in FY 2015 and FY 2016. With the transition to JOES during FY 2016 Q3–Q4, there was a convergence of scores for Air Force, Army, and Navy around 93 percent. NCR results were elevated above the Services from FY 2016 Q4 to FY 2017 Q2, with a slight convergence occurring in FY 2017 Q3. Overall, the direct care score is very high, indicating that the vast majority of beneficiaries who responded were satisfied with the care that they received.

SERVICE SURVEYS/JOES SATISFACTION WITH CARE, FY 2015–FY 2017 Q4



Source: DHA/SP&FI (J-5)/Decision Support, analyzing Service, JOES and JOES-C data, 12/5/2017; TROSS, APLSS, PSS, SDA, and JOES.

Notes:

– JOES results displayed above begin in FY 2016 Q3 for Navy and NCR; JOES results for Air Force, Army, and direct care begin in FY 2016 Q4. The following time periods are the first available month of data for each of the Services: Navy—May 2016, NCR—June 2016, Army—July 2016, Air Force—September 2016. Sites that migrated to MHS GENESIS were not sampled after migration.

– Prior to JOES, the Service-specific survey results above were unweighted. JOES results displayed above are weighted to represent the composition of the MHS population.

– "Satisfaction with Care" is worded in JOES as: "Overall, I am satisfied with the health care I received on this visit." Wording in TROSS is very similar: "Overall, how satisfied are you with the health care you received?" The five-point scale response for this question ranges from "Strongly Disagree" to "Strongly Agree". The results provided above are for those beneficiaries who reported either "Somewhat Agree" or "Strongly Agree".

– For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

QUALITY OF MHS CARE *(CONT.)*

Patient Ratings—Experience of Care and Service *(cont.)*

JOES Satisfaction with Care—Variability Over Time

The box and whisker plot on the following page is a visual representation of the table below. Additional detail on all of the components of the box and whisker plot, as well as the CV, can be found on page 73.

- The table below displays the extent to which the ratings of satisfaction with care changed over time in terms of improvement (increasing mean or median) or decreased dispersion (reduced range or IQR).
- From FY 2017 Q1 to FY 2017 Q4, Army, Air Force, and Navy worsened in terms of the median ratings. Mean ratings were similar to the median, with the exception that Navy did not worsen over the four-quarter period. The degree that the mean and median worsened over time did not exceed 2 percent. These median ratings are very similar with each Service and by quarter, with the introduction of JOES, and these results are fully comparable.
- Dispersion, in terms of the range between the lowest- and highest-performing MTFs, increased overall from FY 2017 Q1 to FY 2017 Q4 for Army, Air Force, and Navy; the same is true for the IQR. The number of negative outliers increased from 11 in FY 2017 Q1 to 12 in FY 2017 Q4. Dispersion, measured by changes to the CV, is also included following the box and whisker plots.

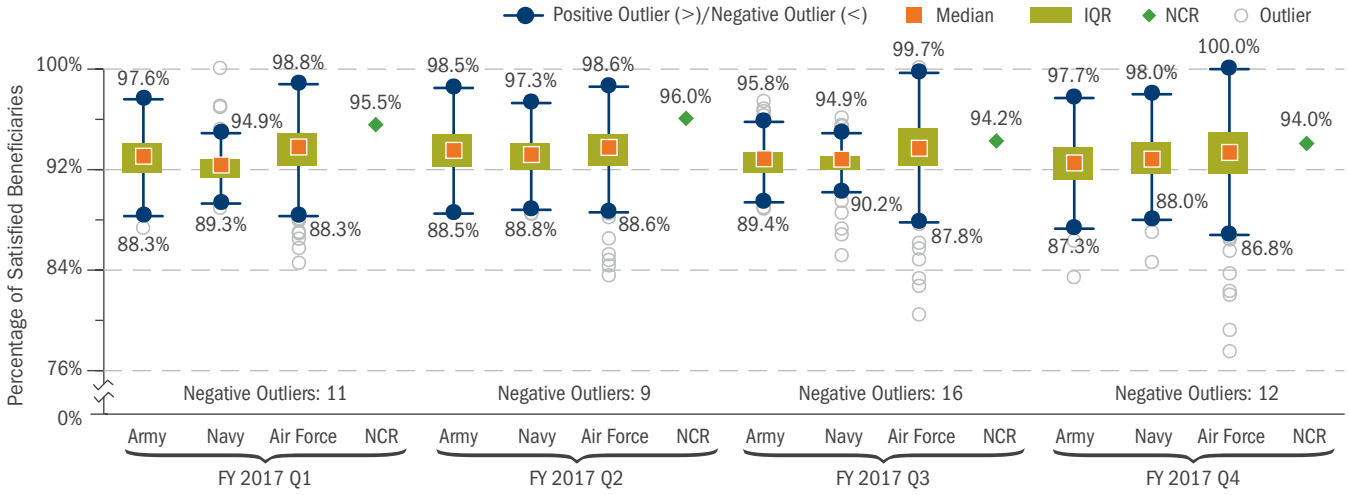
VARIABILITY IN JOES RATINGS: SATISFACTION WITH CARE, FY 2017 Q1–Q4

	FY 2017 Q1	FY 2017 Q2	FY 2017 Q3	FY 2017 Q4	FY 2017 Q1–Q4 % POINT CHANGE
ARMY					
Mean	92.9%	93.6%	92.7%	92.6%	–0.2
Median	93.0%	93.3%	93.1%	92.3%	–0.7
75th Percentile (Q3)	94.1%	94.8%	93.4%	93.8%	–0.3
25th Percentile (Q1)	91.8%	92.3%	91.8%	91.2%	–0.6
IQR	2.3%	2.5%	1.6%	2.6%	0.3
Positive Outlier (>)	97.6%	98.5%	95.8%	97.7%	0.1
Negative Outlier (<)	88.3%	88.5%	89.4%	87.3%	–1.0
Maximum	96.2%	96.2%	97.3%	97.5%	1.3
Minimum	87.2%	90.0%	88.8%	83.3%	–3.9
Range	9.0%	6.2%	8.6%	14.2%	5.2
NAVY					
Mean	92.5%	93.0%	92.3%	92.7%	0.2
Median	92.6%	93.2%	93.1%	92.2%	–0.4
75th Percentile (Q3)	92.8%	94.1%	93.1%	94.2%	1.4
25th Percentile (Q1)	91.4%	92.0%	92.0%	91.7%	0.3
IQR	1.4%	2.1%	1.2%	2.5%	1.1
Positive Outlier (>)	94.9%	97.3%	94.9%	98.0%	3.1
Negative Outlier (<)	89.3%	88.8%	90.2%	88.0%	–1.3
Maximum	100.0%	97.3%	96.0%	97.8%	–2.2
Minimum	88.8%	88.3%	85.0%	84.5%	–4.3
Range	11.1%	9.0%	11.0%	13.3%	2.2
AIR FORCE					
Mean	93.4%	93.3%	93.3%	93.0%	–0.4
Median	94.0%	93.8%	93.3%	93.0%	–1.0
75th Percentile (Q3)	94.9%	94.8%	95.3%	95.0%	0.1
25th Percentile (Q1)	92.3%	92.3%	92.3%	91.7%	–0.6
IQR	2.6%	2.5%	3.0%	3.3%	0.7
Positive Outlier (>)	98.8%	98.6%	99.7%	100.0%	1.1
Negative Outlier (<)	88.3%	88.6%	87.8%	86.8%	–1.6
Maximum	98.7%	98.4%	100.0%	100.0%	1.3
Minimum	84.4%	83.4%	80.3%	77.4%	–7.0
Range	14.2%	15.0%	19.7%	22.6%	8.4
NCR					
Mean	95.5%	96.0%	94.2%	94.0%	–1.5

Source: DHA/SP&FI (J-5)/Decision Support, JOES, weighted data, compiled 12/5/2017
Notes:
– Parent facilities were scaled to account for the number of responses, and those reporting fewer than 30 responses were excluded from analyses.
– Sites that migrated to MHS GENESIS were not sampled after migration.

Patient Ratings—Experience of Care and Service *(cont.)*

DESCRIPTION OF DATA BY FISCAL YEAR AND QUARTER: JOES SATISFACTION WITH CARE, FY 2017 Q1–Q4

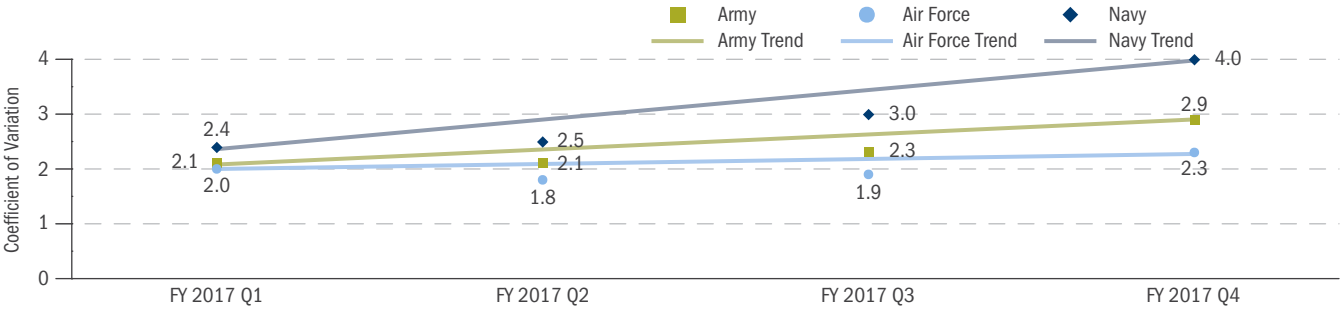


Source: DHA/SP&FI (J-5)/Decision Support, JOES, weighted data, compiled 12/5/2017
Notes:
– The box shows interquartile range (25th–75th percentiles) with median highlighted.
– Length of whiskers are at 1.5 times the interquartile range, and may or may not include the minimum or maximum values. MTFs outside the "whiskers" are identified as outliers.
– Parent facilities were scaled to account for the number of responses, and those reporting fewer than 30 responses were excluded from analyses.
– Parent facilities Fort Belvoir and Walter Reed compose the NCR category, which is represented by a scaled average.

The CV is used to understand dispersion in terms of the standard deviation and the mean. Additional information about the coefficient of variation can be found on page 73.

The following graph shows the CV for the JOES measure Satisfaction with Care. Similar to the results described previously for the range and IQR, the CV is increasing for Air Force, Army, and Navy. Changes to the IQR are similar to changes to the CV over time.

RELATIVE DISPERSION BY FISCAL YEAR AND QUARTER: JOES SATISFACTION WITH CARE, FY 2017 Q1–Q4



Source: DHA/SP&FI (J-5)/Decision Support, JOES, weighted data, compiled 12/5/2017
Notes:
– Sites that migrated to MHS GENESIS were not sampled after migration.
– Parent facilities were scaled to account for the number of responses, and those reporting fewer than 30 responses were excluded from analyses.

QUALITY OF MHS CARE *(CONT.)*

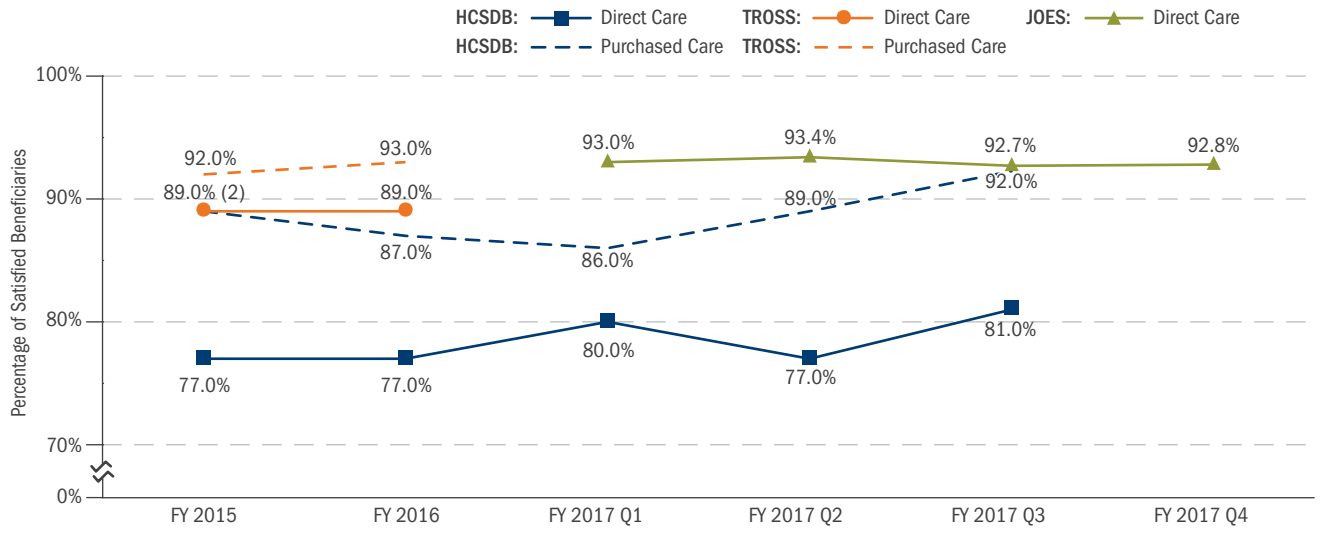
Patient Ratings—Experience of Care and Service *(cont.)*

DHA Surveys—Satisfaction with Care

In addition to each of the Service surveys and JOES, the population-based HCSDB and TROSS also report results for the Satisfaction with Care measure. Including this same question in each survey provides important information about the differences between surveys and the beneficiaries who answer them. A description of the differences between each of the surveys can be found on page 70.

- Beneficiaries who utilize or are assigned to purchased care report greater satisfaction with care than those who utilize or are assigned to direct care, regardless of time period. The differences between purchased care and direct care results range by approximately 5 percent to 15 percent.
- Beneficiaries completing TROSS reported greater satisfaction than beneficiaries completing HCSDB, over time, for direct care and purchased care. This may be because beneficiaries who complete TROSS and JOES-C are beneficiaries who have already received care, while those who complete the HCSDB may not have received care.
- Trends for Satisfaction with Care are mixed by survey. Results for TROSS from FY 2015 to FY 2016 improved marginally; HCSDB purchased care declined, while direct care remained the same. Quarterly results in FY 2017 have improved for HCSDB purchased care, and have been mixed for JOES and HCSDB direct care.

HCSDB, TROSS, AND JOES SATISFACTION WITH CARE, FY 2015–FY 2017 Q4



Source: DHA/SP&FI (J-5)/Decision Support, 12/5/2017, HCSDB, TROSS, and JOES, compiled 12/5/2017

Notes:

– Results for each survey above are weighted to appropriately represent the composition of the MHS population.

– TROSS results for FY 2016 continue from October 2015 to May 2016 for direct care, and from October 2015 to April 2016 for purchased care.

– Results for HCSDB are for Prime enrollees only. "HCSDB Purchased Care" is defined as those who are assigned to an MCSC. "Satisfaction With Care" is worded very similarly in each survey as the following statement: "Overall, I am satisfied with the health care I received on this visit."
The five-point scale response for this question ranges from "Strongly Disagree" to "Strongly Agree." The results provided above are for those beneficiaries who reported either "Somewhat Agree" or "Strongly Agree."

– Sites that migrated to MHS GENESIS were not sampled after migration.

QUALITY OF MHS CARE *(CONT.)*

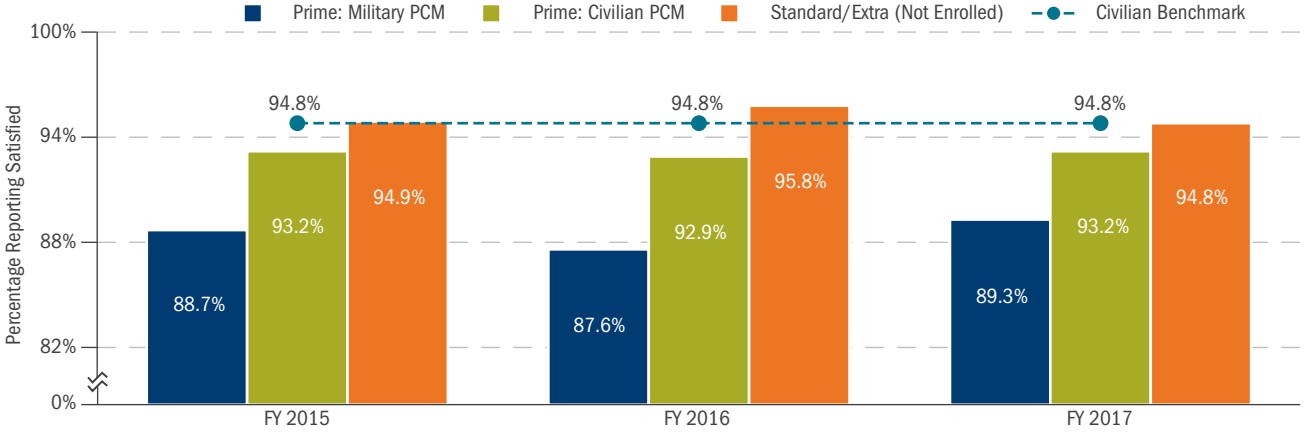
Patient Ratings—Experience of Care and Service *(cont.)*

Satisfaction with Doctors' Communication

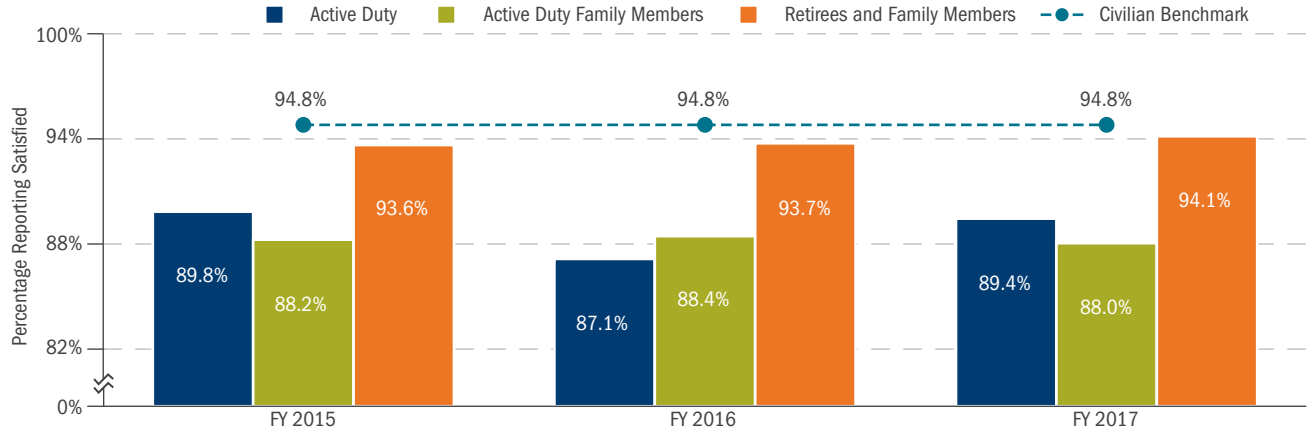
Communication between doctors and patients is an important factor in beneficiaries' satisfaction and their ability to obtain appropriate care. The following charts present beneficiary-reported perceptions of how well their doctor communicates with them.

- Overall Prime enrollee (military and civilian PCMs combined) satisfaction levels with their doctors' communication remained stable between FY 2015 and FY 2017. Satisfaction levels for those with a civilian PCM were higher than for those with a military PCM. Over the same period, non-enrollee satisfaction levels remained stable. In FY 2017, satisfaction ratings for Prime enrollees were lower than the civilian benchmark, while non-enrollee satisfaction equaled the civilian benchmark.
- The levels of satisfaction with doctors' communication remained stable for all beneficiary groups.
- In FY 2017, satisfaction with doctors' communication was lower than the civilian benchmark for all beneficiary groups.

TRENDS IN SATISFACTION WITH DOCTORS' COMMUNICATION BY ENROLLMENT STATUS, FYs 2015–2017



TRENDS IN SATISFACTION WITH DOCTORS' COMMUNICATION BY BENEFICIARY CATEGORY, FYs 2015–2017



Note: DoD data were derived from the FYs 2015–2017 HCSDB, as of 11/13/2017, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS health plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used in 2015 come from NCQA's 2013 data, while the benchmarks used in 2016 and 2017 come from NCQA's 2015 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

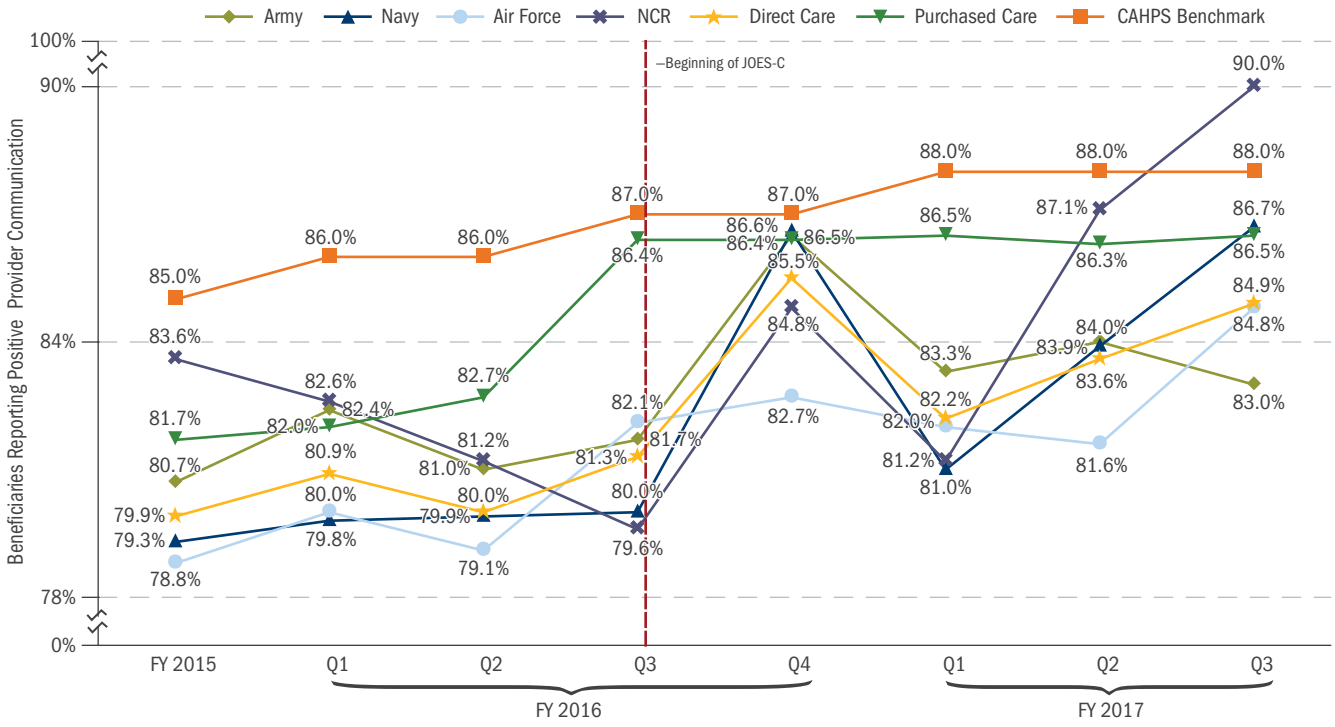
QUALITY OF MHS CARE *(CONT.)*

Patient Ratings—Experience of Care and Service *(cont.)*

As provided on page 139 in Drivers of Patient Experience Ratings, communication between the beneficiary and the provider is the leading driver of the overall satisfaction of the patient with the visit in outpatient care. Both TROSS and JOES-C measure this communication from the beneficiary's perspective. Some of the questions in these surveys include: if the provider was understandable, if the provider listened, if the provider was respectful, and if the provider spent enough time with the patient. The results of these questions make up the score for the composite measure Provider Communication. These results can be ranked to nationally representative civilian and military benchmarks, and can be compared across all levels of the MHS.

- Between FY 2015 and FY 2016 Q3, results were mixed during the TROSS, except for results for NCR, which steadily decreased.
- JOES-C was introduced in June 2016 for direct care and May 2016 for purchased care. Results on a quarterly level for JOES-C have continued to be mixed, but NCR did rise above the civilian and military benchmark in FY 2017 Q3. The trajectory for Air Force and Navy was also favorable during FY 2017 Q3.

TROSS/JOES-C PROVIDER COMMUNICATION COMPOSITE, FY 2015–FY 2017 Q3



Source: DHA/SP&FI (J-5)/Decision Support, 12/5/2017, TROSS (October 2015–March 2016) and JOES-C (direct care June 2016–June 2017; purchased care May 2016–June 2017), compiled 11/22/2017.

Note: Benchmarks are the CAHPS 50th percentiles from the 2014 Adult 12-Month Survey 2.0 with/without PCMH items, 2015 Adult 12/6-Month Survey 2.0 with/without PCMH items, 2015 Adult Survey 3.0, and the 2016 Adult 6-Month Survey 3.0 with/without PCMH items.

QUALITY OF MHS CARE *(CONT.)*

Patient Ratings—Experience of Care and Service *(cont.)*

The box and whisker plot on the following page is a visual representation of the table below. Additional detail on all of the components of the box and whisker plot, as well as the CV, can be found on page 73.

- The table below displays the extent to which the provider communication composite changed over time in terms of improvement (increasing mean or median) or decreased dispersion (reduced range or IQR).
- From FY 2016 Q3–Q4 to FY 2017 Q3–Q4, the median score for Air Force and Navy increased, while the median score decreased for Army. During FY 2017 Q3–Q4, the median score for Navy rose above the CAHPS benchmark.
- Dispersion, in terms of the range between the lowest- and highest-performing MTFs increased overall from FY 2016 Q3–Q4 to FY 2017 Q3–Q4 for Army and Air Force, and decreased for Navy. The number of negative outliers decreased from three in FY 2016 Q3–Q4 to two in FY 2017 Q3–Q4. Dispersion, measured by changes to the IQR and CV, are also included in the box and whisker plot on the following page.

JOES-C: PROVIDER COMMUNICATION COMPOSITE, FY 2016 Q3–Q4 TO FY 2017 Q3–Q4

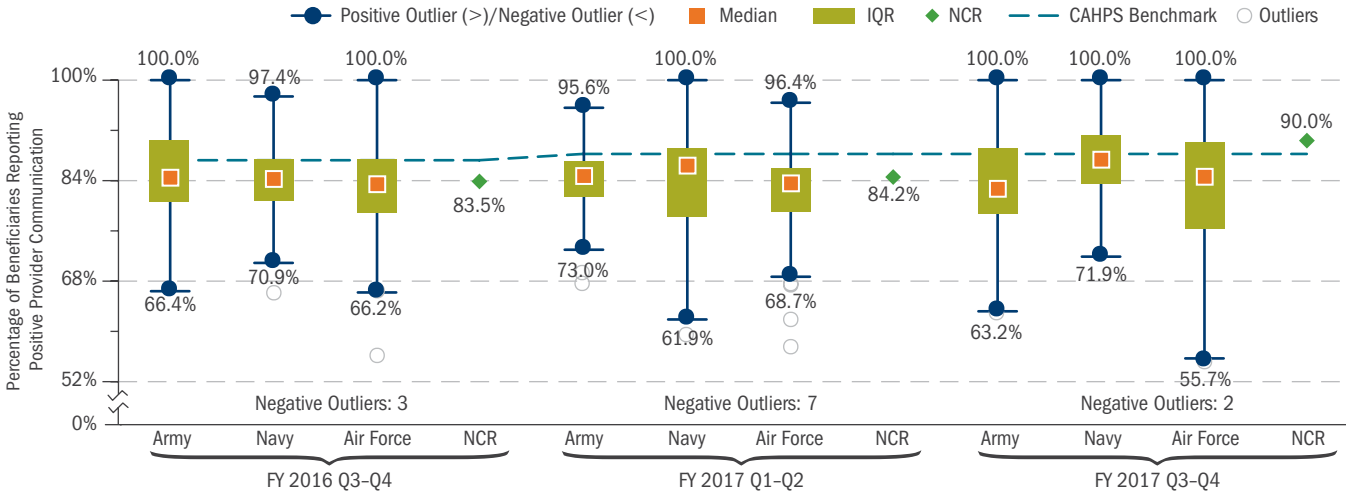
	FY 2016 Q3–Q4	FY 2017 Q1–Q2	FY 2017 Q3–Q4	FY 2016 Q3–Q4 TO FY 2017 Q3–Q4 % POINT CHANGE
ARMY				
Mean	85.1%	83.6%	83.5%	-1.5
Median	86.4%	85.0%	84.3%	-2.1
75th Percentile (Q3)	90.4%	87.1%	89.1%	-1.3
25th Percentile (Q1)	80.8%	81.5%	78.7%	-2.0
IQR	9.6%	5.7%	10.4%	0.8
Positive Outlier (>)	100.0%	95.6%	100.0%	0.0
Negative Outlier (<)	66.4%	73.0%	63.2%	-3.2
Maximum	94.5%	95.4%	95.9%	1.4
Minimum	67.8%	67.4%	62.7%	-5.1
Range	26.7%	28.0%	33.2%	6.5
NAVY				
Mean	84.0%	82.7%	88.5%	4.5
Median	83.9%	85.2%	89.5%	5.6
75th Percentile (Q3)	87.4%	89.1%	91.3%	3.8
25th Percentile (Q1)	80.8%	78.2%	83.5%	2.7
IQR	6.6%	10.9%	7.8%	1.2
Positive Outlier (>)	97.4%	100.0%	100.0%	2.6
Negative Outlier (<)	70.9%	61.9%	71.9%	1.0
Maximum	97.3%	98.1%	97.7%	0.5
Minimum	65.9%	59.2%	78.6%	12.7
Range	31.4%	38.9%	19.1%	-12.3
AIR FORCE				
Mean	82.6%	81.8%	82.3%	-0.4
Median	83.5%	82.3%	84.8%	1.3
75th Percentile (Q3)	87.4%	86.0%	90.2%	2.8
25th Percentile (Q1)	78.9%	79.1%	76.4%	-2.5
IQR	8.5%	6.9%	13.8%	5.3
Positive Outlier (>)	100.0%	96.4%	100.0%	0.0
Negative Outlier (<)	66.2%	68.7%	55.7%	-10.5
Maximum	93.1%	92.5%	98.8%	5.8
Minimum	55.9%	57.3%	54.9%	-1.0
Range	37.2%	35.2%	43.9%	6.8
NCR				
Mean	83.5%	84.2%	90.0%	6.5

Source: DHA/SP&FI (J-5)/Decision Support, JOES-C, weighted data, compiled 12/5/2017
Notes:
– FY 2016 Q3 results include June 2016 only, with the initiation of JOES-C; FY 2017 Q4 results include July 2017 only.
– Parent facilities were scaled to account for the number of responses and those reporting fewer than 30 responses were excluded from analyses.
– Sites that migrated to MHS GENESIS were not sampled after migration.

QUALITY OF MHS CARE *(CONT.)*

Patient Ratings—Experience of Care and Service *(cont.)*

DESCRIPTION OF DATA BY FISCAL YEAR AND QUARTER: JOES-C PROVIDER COMMUNICATION, FY 2016 Q3–Q4 TO FY 2017 Q3–Q4



Source: DHA/SP&FI (J-5)/Decision Support, Joint Outpatient Experience Survey-CAHPS (JOES-C), weighted data, compiled 12/5/2017

Notes:

– FY 2016 Q3 results include June 2016 data only, with the initiation of JOES-C; FY 2017 Q4 results include July 2017 data only.
– Sites that migrated to MHS GENESIS were not sampled after migration.
– The box shows interquartile range (25th–75th percentiles) with median highlighted.
– Length of whiskers are at 1.5 times the interquartile range, and may or may not include the minimum or maximum values. MTFs outside the "whiskers" are identified as outliers.
– Facilities are scaled to account for the number of responses, and those reporting fewer than 30 responses were excluded from analyses.
– Parent facilities Fort Belvoir and Walter Reed compose the NCR category, which is represented by a scaled average.
– CAHPS benchmarks are the 50th percentile value from the 2016 Adult 6-month Survey 3.0 with/without PCMH items.

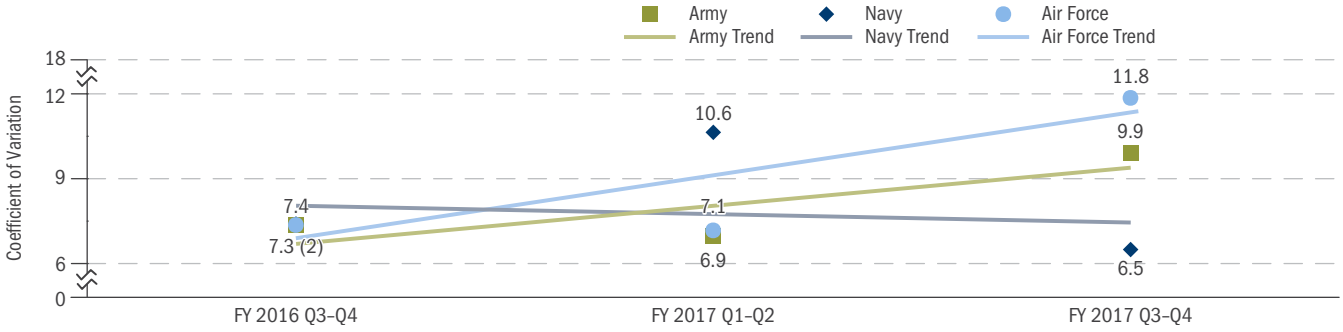
QUALITY OF MHS CARE *(CONT.)*

Patient Ratings—Experience of Care and Service *(cont.)*

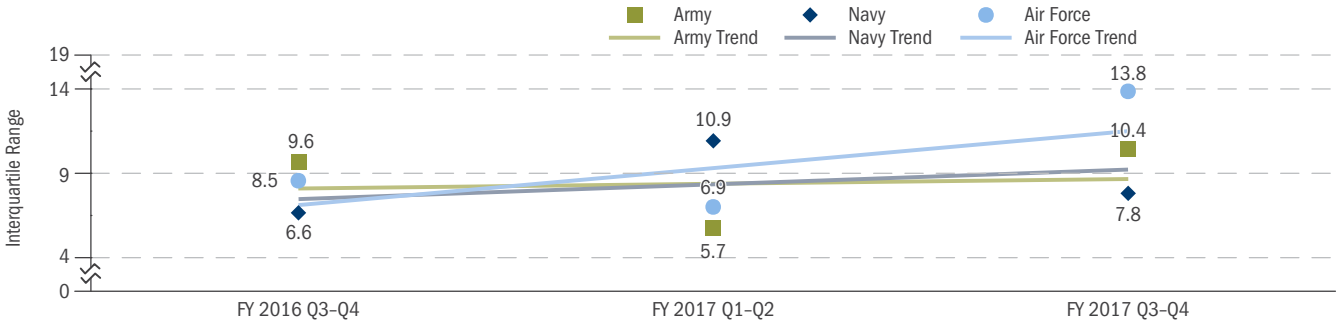
The CV is used to understand dispersion in terms of the standard deviation and the mean. Additional information about the CV can be found on page 73. A trend for the IQR is also included to measure dispersion in terms of the percentiles.

- The following graph shows the CV for the JOES-C measure Provider Communication. The CV is increasing for Army and Air Force, similar to results for the range; the CV is relatively flat for Navy.
- A graph for the IQR follows the results for the CV. Trends for the IQR are similar to those of the CV.
- There are several Air Force facilities that have few responses to JOES-C within a four- to six-month period. These facilities are more likely to have very high scores or very low scores, which can affect the range. Results for the IQR and CV are more robust to extreme values. As Air Force results for both the CV and IQR are increasing, this indicates that the dispersion is increasing in terms of both the mean/standard deviation and percentiles, respectively.

RELATIVE DISPERSION BY FISCAL YEAR AND QUARTER: JOES-C PROVIDER COMMUNICATION, FY 2016 Q3–Q4 TO FY 2017 Q3–Q4



VARIABILITY BY FISCAL YEAR AND QUARTER: JOES-C PROVIDER COMMUNICATION, FY 2016 Q3–Q4 TO FY 2017 Q3–Q4



Source: DHA/SP&FI (J-5)/Decision Support, JOES-C, weighted data, compiled 12/5/2017

Notes:

– FY 2016 Q3 results include June 2016 data only, with the initiation of JOES-C; FY 2017 Q4 results include July 2017 data only.

– Sites that migrated to MHS GENESIS were not sampled after migration.

– Parent facilities were scaled to account for the number of responses, and those reporting fewer than 30 responses were excluded from analyses.

QUALITY OF MHS CARE *(CONT.)*

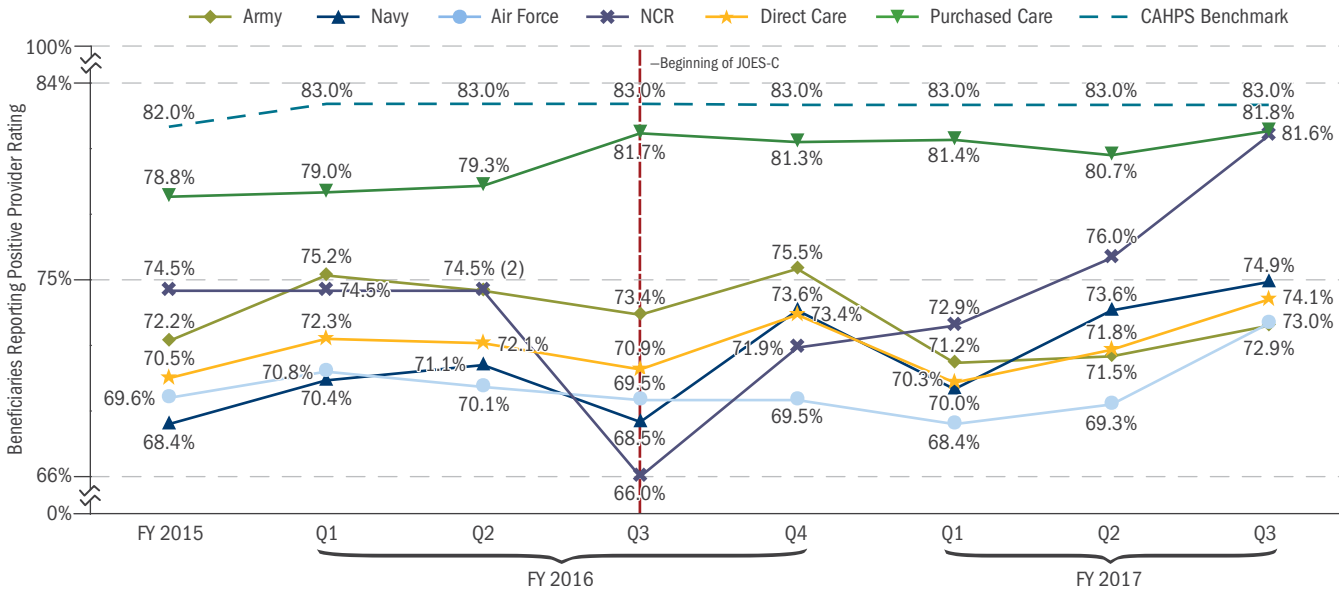
Patient Ratings—Experience of Care and Service *(cont.)*

Beneficiary Ratings of Provider Following Outpatient Treatment Using CAHPS Surveys

Beneficiaries are also asked to provide an overall rating for their provider, based on a scale from 0 (worst provider possible) to 10 (best provider possible). The percent of beneficiaries that score their provider as a 9 or 10 is provided in the following graph. The results to this question are comparable to civilian results, and the civilian 50th percentile score is used as the CAHPS benchmark provided below.

- Ratings of provider results were captured by TROSS from FY 2015 to FY 2016 Q2. Ratings for each Service were fairly stable under the TROSS, with purchased care scores above direct care results. JOES-C results began in FY 2016 Q3. Ratings under JOES-C were similar to results of the CAHPS Provider Communication composite. NCR results increased from FY 2016 Q4 to FY 2017 Q3, and were close to the CAHPS benchmark as of FY 2017 Q3. Trends for direct care and all Services increased from FY 2017 Q2 to FY 2017 Q3.

TROSS/JOES-C RATING OF PROVIDER, FY 2015–FY 2017 Q3



Source: DHA/SP&FI (J-5)/Decision Support, 12/5/2017, TROSS (October 2015–March 2016) and JOES-C (direct care June 2016–June 2017; purchased care May 2016–June 2017), compiled 12/5/2017

Notes:

- Results displayed above were weighted to represent the composition of the MHS population.
- Sites that migrated to MHS GENESIS were not sampled after migration.
- Benchmarks are the 50th percentiles from the CAHPS 2014 and 2015 Adult 12/6-Month Survey 2.0 with/without PCMH items, 2015 Adult Survey 3.0, and the 2016 Adult 6-Month Survey 3.0 with/without PCMH items.

Patient Ratings—Experience of Care and Service *(cont.)*

Beneficiary Ratings of Care Following Inpatient Treatment

TRICARE Inpatient Satisfaction Survey (TRISS). The purpose of the OASD(HA)/DHA TRISS is to monitor and report on the perceptions and experiences of MHS beneficiaries who have been admitted to MTF and civilian hospitals. The survey instrument incorporates the questions developed by the AHRQ and CMS for the HCAHPS initiative. The HCAHPS protocols for sampling, data collection, and coding can be found in the HCAHPS Quality Assurance Guidelines manual on the official HCAHPS website, www.hcahpsonline.org. The TRISS study follows the HCAHPS protocols developed by the CMS and is endorsed by the National Quality Forum.

The goal of the HCAHPS initiative is to measure uniformly and report publicly on inpatient care experiences through the use of a standardized survey instrument and data collection methodology. The information derived from the survey can provide feedback to providers and patients, valuable insight for internal quality improvement initiatives, and an assessment of the impact of changes in operating procedures.

Comparison of these data with the results from previous surveys, as well as comparisons to civilian benchmark data, enable the DoD to measure progress in meeting its goals and objectives of high-quality health care. The TRISS compares care across all Services and across venues (i.e., direct MTF-based care and private-sector/purchased care) including inpatient surgical, medical, and obstetric care. In 2014, new methodological changes and HCAHPS requirements were implemented that resulted in higher response rates. The survey covers a number of domains, including:

- Overall rating of hospital and recommendation of hospital to others;
- Nursing care (care, respect, listening, and explanations);
- Physician care (care, respect, listening, and explanations);
- Communication (with nurses and doctors, and regarding medications);
- Responsiveness of staff;
- Pain control;
- Hospital environment (cleanliness and quietness); and
- Post-discharge (such as written directions for post-discharge care).

The following pages will provide specific results on the global satisfaction measures of overall hospital rating and recommendation of hospital to others.

Results provided below are produced by the DHA J-5 Decision Support Division and do not represent official HCAHPS results. Official HCAHPS results are published on the Hospital Compare website (https://www.medicare.gov/hospitalcompare).

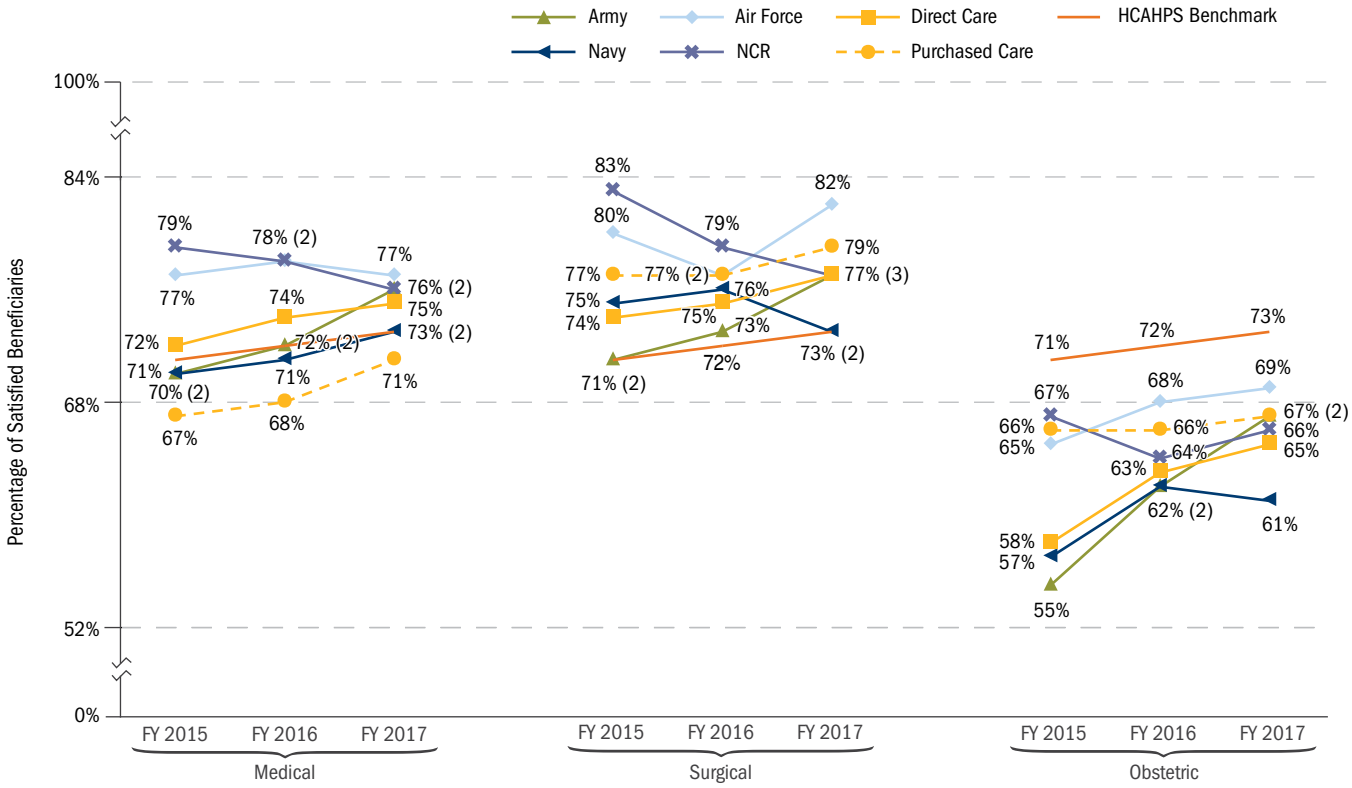
Overall Hospital Rating. Overall, direct care has improved patient satisfaction over time in each inpatient product line from FY 2015 to FY 2017 Q3. The strong upward trend in the Army's obstetric product line has continued to be the leading driver in direct care's obstetric results in FY 2017. Each of the Services met or exceeded the national HCAHPS benchmark in FY 2017 in the medical and surgical product lines. Although the obstetric product line results for all Services and purchased care are below the HCAHPS benchmark, direct care and purchased care results continue upward.

QUALITY OF MHS CARE *(CONT.)*

Patient Ratings—Experience of Care and Service *(cont.)*

Overall, direct care has improved patient satisfaction over time in each inpatient product line from FY 2015 to FY 2017 Q3. The strong upward trend in the Army's obstetric product line has continued to be the leading driver in direct care's obstetric results in FY 2017. Each of the Services has met or exceeded the national HCAHPS benchmark in FY 2017 in the medical and surgical product lines. The obstetric product line results for all Services and purchased care was below the HCAHPS benchmark, but direct care and purchased care continued upward.

TRISS OVERALL HOSPITAL RATING TRENDS, FYs 2015–2017



Source: DHA/SP&FI (J-5)/Decision Support, 12/5/2017, TRISS, weighted data.

Notes:

– FY 2017 includes results from FY 2017 Q1–Q3 for direct care and the Services; FY 2017 includes results from FY 2017 Q1–Q2 for purchased care.

– HCAHPS benchmarks are the U.S. scores from the October 2015, Octobert 2016, and July 2017 HCAHPS Public Reports. More information about these scores can be found at: http://hcahpsonline.org/en/summary-analyses/

– For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

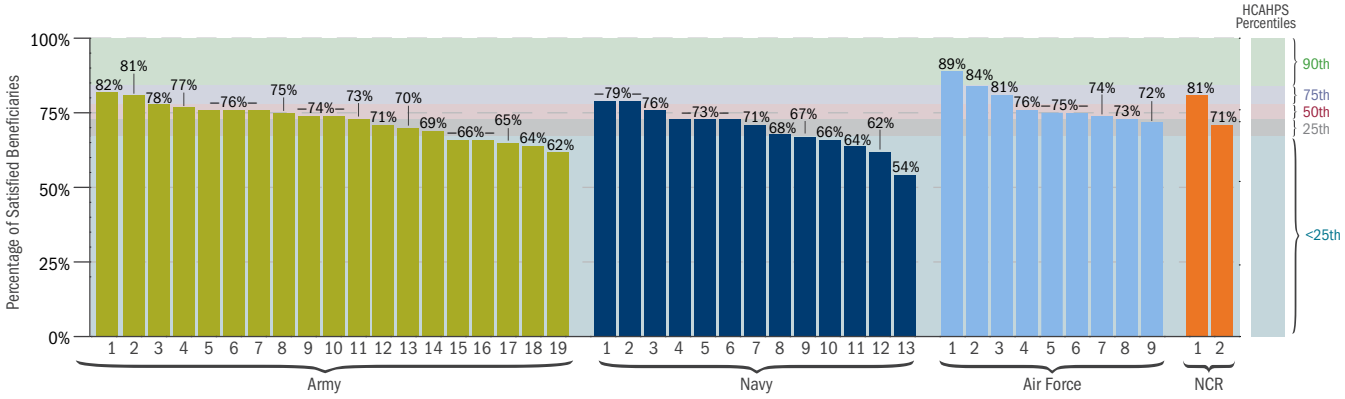
QUALITY OF MHS CARE *(CONT.)*

Patient Ratings—Experience of Care and Service *(cont.)*

The facilities in both TRISS histogram charts have been de-identified within their respective Service. The de-identified labels (e.g., Army 1, Army 2, etc.) in Overall Hospital Ratings correspond with the same facilities in the Recommend Hospital histogram chart on page 134.

The chart below shows the distribution for Overall Hospital Ratings of direct care inpatient facilities, and how they compared with the national HCAHPS percentiles. The facilities with ratings in the HCAHPS 90th percentile were AF-H-31st MEDGRP-Aviano and AF-MC-81st MEDGRP-Keesler. Seven facilities had ratings in the HCAHPS 75th percentile; 17 facilities had ratings in the HCAHPS 50th percentile. The remaining facilities were below the HCAHPS 50th percentile.

TRISS OVERALL HOSPITAL RATING: DIRECT CARE, FY 2017



Source: DHA/SP&FI (J-5)/Decision Support, 12/5/2017, TRISS, weighted data, compiled 11/10/2017
Notes:
– Facilities that have fewer than 30 responses do not have a score displayed above.
– The increments of the above percentiles were set at <25th, 25th, 50th, 75th, and 90th. Percentiles are based on nationally representative civilian and military facility scores (October 2017 Public Report: January 2016 to December 2016 discharges). More information about these percentiles can be found at: http://hcahpsonline.org/en/summary-analyses/

QUALITY OF MHS CARE *(CONT.)*

Patient Ratings—Experience of Care and Service *(cont.)*

The box and whisker plot is a visual representation of the following table. Additional detail on all of the components of the box and whisker plot, as well as the CV, can be found on page 73.

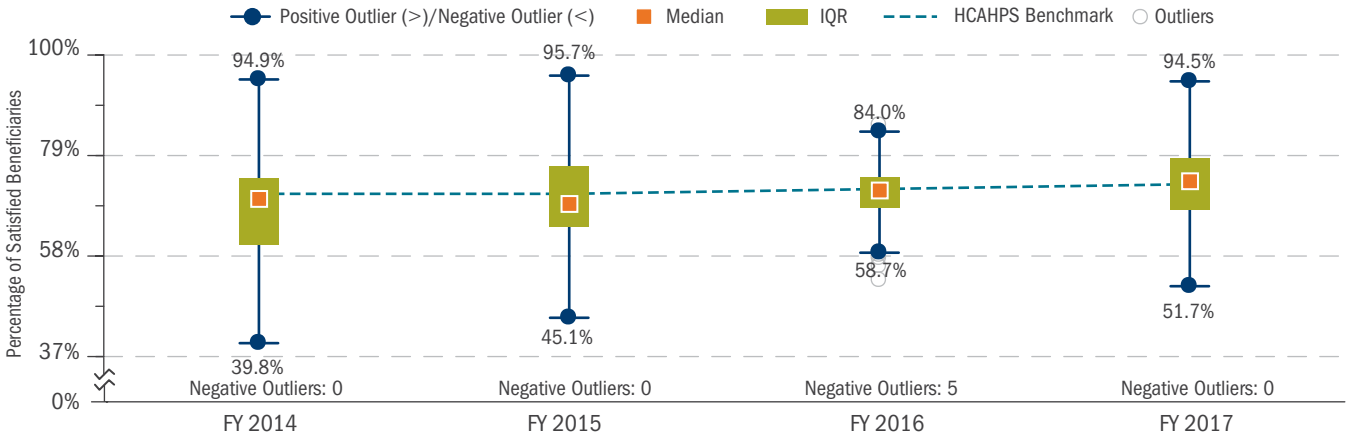
- The table below displays the extent to which the measure of Overall Hospital Rating changed over time in terms of improvement (increasing mean or median) or decreased dispersion (reduced range or IQR).
- From FY 2014 to FY 2017, direct care improved by approximately 5 percent in terms of the median and mean ratings—a substantial change over time for an HCAHPS-based survey.
- Dispersion also decreased in terms of the range and IQR from FY 2014 to FY 2017; the changes were approximately 3 percent from from FY 2014 to FY 2017. Negative outliers were only present during FY 2016 partly due to the tight IQR of that fiscal year. Dispersion, measured by changes to the CV, is also included following the box and whisker plots.

TRISS OVERALL HOSPITAL RATING: DIRECT CARE, FYs 2014–2017

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2014–FY 2017 % POINT CHANGE
Mean	68.0%	69.2%	71.4%	73.3%	5.3
Median	69.3%	68.4%	71.6%	73.9%	4.7
75th Percentile (Q3)	74.2%	76.7%	74.5%	78.4%	4.2
25th Percentile (Q1)	60.4%	64.1%	68.2%	67.7%	7.3
IQR	13.8%	12.7%	6.3%	10.7%	-3.1
Positive Outlier (>)	94.9%	95.7%	84.0%	94.5%	-0.4
Negative Outlier (<)	39.8%	45.1%	58.7%	51.7%	11.9
Maximum	84.3%	83.7%	85.2%	89.1%	4.8
Minimum	46.0%	50.3%	52.8%	54.0%	8.0
Range	38.3%	33.4%	32.4%	35.1%	-3.3

Source: DHA/SP&FI (J-5)/Decision Support, TRISS, weighted data, compiled 12/5/2017
– Inpatient facilities were scaled to account for the number of responses and those reporting fewer than 30 responses were excluded from analyses.
– FY 2017 includes results from FY 2017 Q1–Q3 for direct care.

VARIABILITY IN TRISS OVERALL HOSPITAL RATINGS: DIRECT CARE, FYs 2014–2017



Source: DHA/SP&FI (J-5)/Decision Support, TRISS, weighted data, compiled 12/5/2017
Notes:
– FY 2017 includes Q1–Q3 for direct care and purchased care results.
– Results for FY 2014 Q4 are unavailable and not included in the results.
– The box shows interquartile range (25th–75th percentiles) with median highlighted.
– Length of whiskers are at 1.5 times the interquartile range, and may or may not include the minimum or maximum values. MTFs outside the "whiskers" are identified as outliers.
– Facilities are scaled to account for the number of responses, and those reporting fewer than 30 responses were excluded from analyses.

QUALITY OF MHS CARE *(CONT.)*

Patient Ratings—Experience of Care and Service *(cont.)*

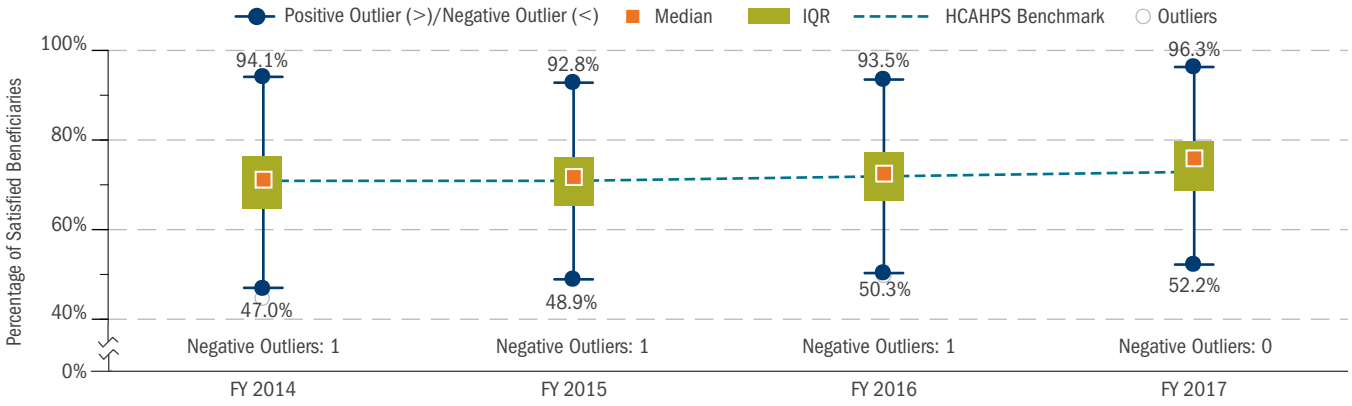
- From FY 2014 to FY 2017, purchased care improved by 3 percent in terms of the median and mean ratings.
- Dispersion decreased in terms of the range from FY 2014 to FY 2017 by approximately 6 percent. The number of negative outliers decreased from one in FY 2014 to zero in FY 2017. The interquartile range changed by less than 1 percent (decrease) over the time period.

TRISS OVERALL HOSPITAL RATING: PURCHASED CARE, FYs 2014–2017

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2014–FY 2017 % POINT CHANGE
Mean	70.4%	70.6%	72.0%	73.6%	3.2
Median	71.4%	71.7%	72.7%	74.8%	3.4
75th Percentile (Q3)	76.5%	76.3%	77.3%	79.8%	3.3
25th Percentile (Q1)	64.7%	65.4%	66.5%	68.7%	4.0
IQR	11.8%	11.0%	10.8%	11.0%	–0.8
Positive Outlier (>)	94.1%	92.8%	93.5%	96.3%	2.2
Negative Outlier (<)	47.0%	48.9%	50.3%	52.2%	5.2
Maximum	87.6%	85.7%	88.7%	88.6%	1.0
Minimum	44.6%	48.7%	49.6%	52.1%	7.5
Range	43.0%	37.0%	39.1%	36.5%	–6.5

Source: DHA/SP&FI (J-5)/Decision Support, TRISS, weighted data, compiled 12/5/2017
Notes:
– Inpatient facilities were scaled to account for the number of responses, and those reporting fewer than 30 responses were excluded from analyses.
– FY 2017 includes results from FY 2017 Q1–Q3 for purchased care.

VARIABILITY IN TRISS OVERALL HOSPITAL RATINGS: PURCHASED CARE, FYs 2014–2017



Source: DHA/SP&FI (J-5)/Decision Support, TRISS, weighted data, compiled 12/5/2017
Notes:
– FY 2017 includes Q1–Q3 for direct care and purchased care results.
– Results for FY 2014 Q4 are unavailable and not included in the results.
– The box shows interquartile range (25th–75th percentiles) with median highlighted.
– Length of whiskers are at 1.5 times the interquartile range, and may or may not include the minimum or maximum values. MTFs outside the "whiskers" are identified as outliers.
– Facilities are scaled to account for the number of responses, and those reporting fewer than 30 responses were excluded from analyses.

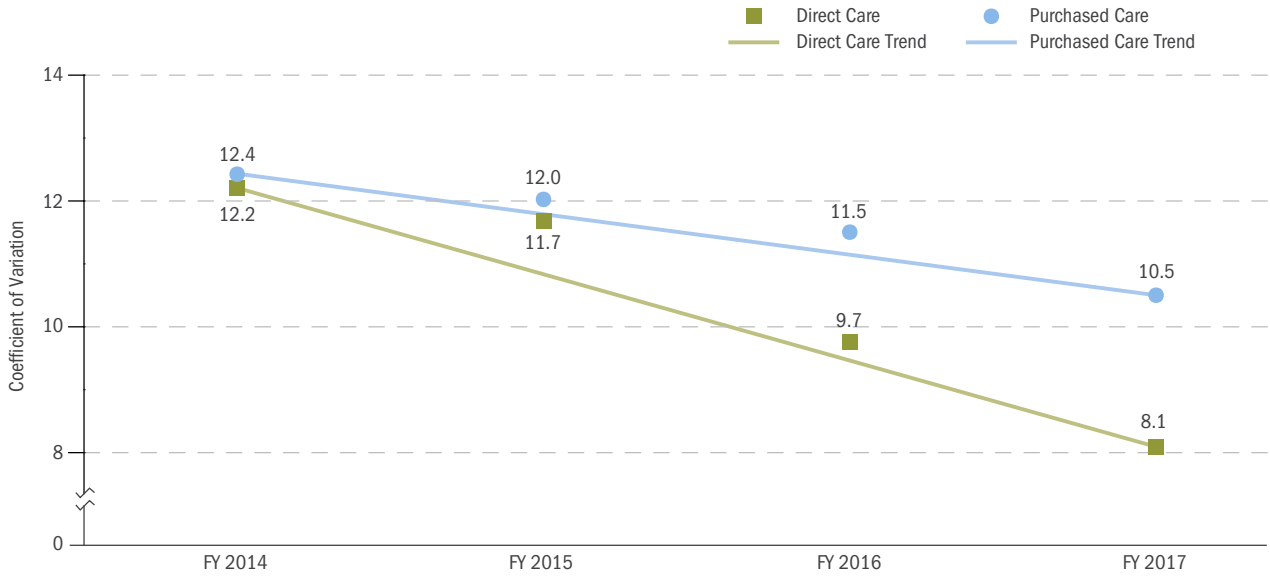
QUALITY OF MHS CARE *(CONT.)*

Patient Ratings—Experience of Care and Service *(cont.)*

The CV is used to understand dispersion in terms of the standard deviation and the mean. Additional information about the CV can be found on page 73.

- The following graph shows the CV for the TRISS measure Overall Hospital Rating. Similar to the results described previously for the range, the CV is decreasing substantially for direct care and less substantially for purchased care.

RELATIVE DISPERSION IN TRISS OVERALL HOSPITAL RATINGS, FYs 2014–2017



Source: DHA/SP&FI (J-5)/Decision Support, TRISS, weighted data, compiled 12/5/2017
Notes:
– FY 2017 includes fiscal quarters 1–3 for direct care and purchased care results.
– Results for FY 2014 Q4 are unavailable and not included in the results.
– Facilities are scaled to account for the number of responses, and those reporting fewer than 30 responses were excluded from analyses.

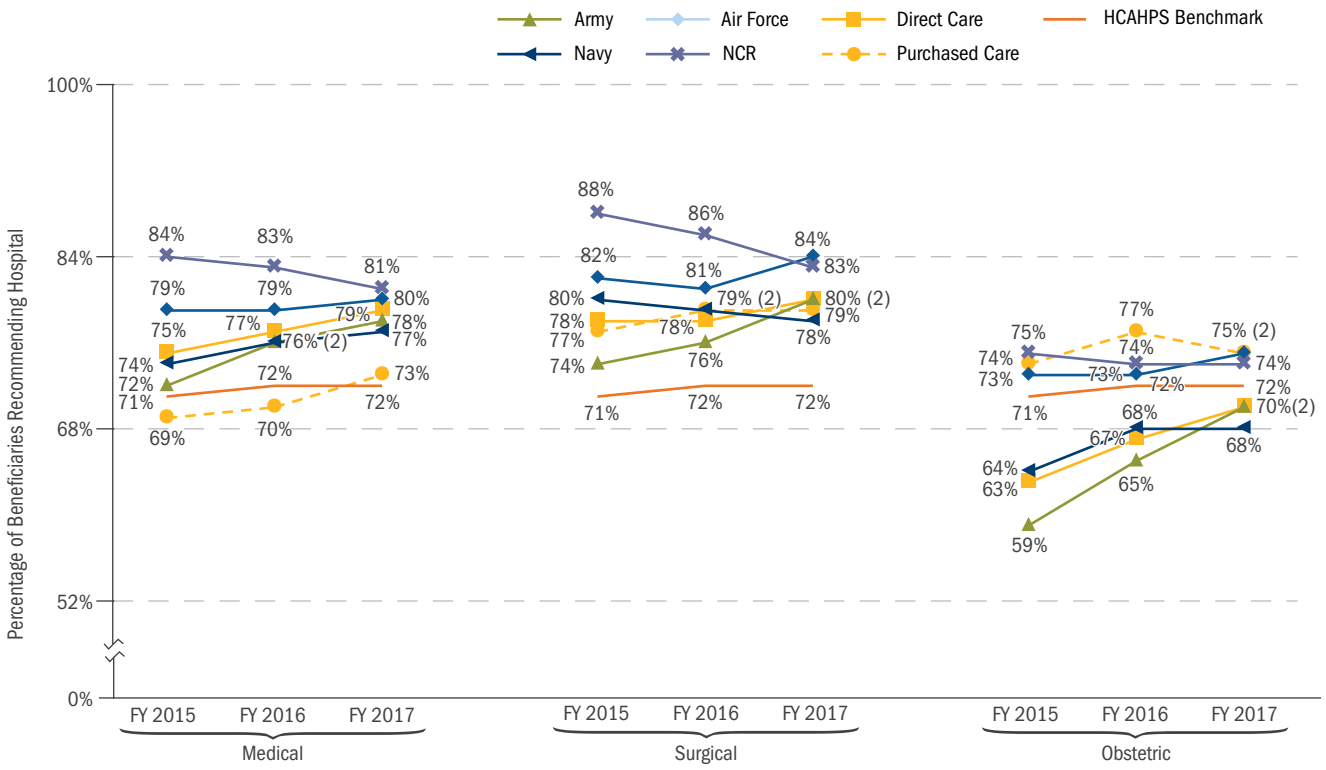
QUALITY OF MHS CARE *(CONT.)*

Patient Ratings—Experience of Care and Service *(cont.)*

Beneficiary Recommendation of Hospital Following Inpatient Treatment

Results for Recommend Hospital are similar, but more elevated, to those seen with Overall Hospital Rating. As of FY 2017, ratings for each Service and purchased care are above the HCAHPS benchmark in the medical and surgical product lines. Results for the obstetric product line places each Service and purchased care close to or above the national HCAHPS benchmark in FY 2017. Although trends for the NCR have decreased for each product line during the observed time period, the NCR continues to be among the leaders of patient experience. Conversely, trends for Army continue to improve for each product line from FY 2015 to FY 2017.

TRISS RECOMMEND HOSPITAL TRENDS, FYs 2015–2017



Source: DHA/SP&FI (J-5)/Decision Support, TRISS results, compiled 12/7/2017
Note:
– Weighted results from the TRISS.
– FY 2017 includes results from FY 2017 Q1–Q3 for direct care and the Services.
– HCAHPS benchmarks are U.S. scores from the October 2015, October 2016, and July 2017 HCAHPS Public Reports. More information about these scores can be found at: http://hcahpsonline.org/en/summary-analyses/
– For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

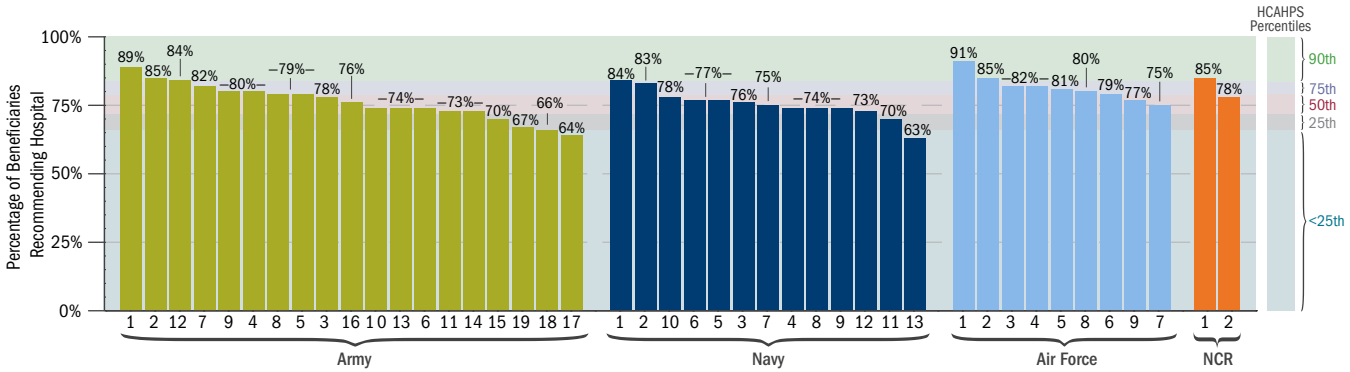
BETTER CARE

QUALITY OF MHS CARE *(CONT.)*

Patient Ratings—Experience of Care and Service *(cont.)*

The chart below shows the distribution for Recommend Hospital of direct care inpatient facilities, and how they compared with the national HCAHPS percentiles. Seven facilities had ratings that reached the HCAHPS 90th percentile: three Army, one Navy, two Air Force, and one NCR. Eleven facilities had ratings in the HCAHPS 75th percentile; nineteen facilities had ratings in the HCAPS 50th percentile. The remaining facilities were below the HCAHPS 50th percentile.

TRISS RECOMMEND HOSPITAL: DIRECT CARE, FY 2017



Source: DHA/SP&FI (J-5)/Decision Support, TRISS, weighted data, compiled 12/7/2017

Note:

– FY 2017 includes results from FY 2017 Q1–Q3 for direct care and the Services.

– Facilities that have fewer than 30 responses do not have a score displayed above.

– The increment of the above percentiles was set at <25th, 25th, 50th, 75th, and 90th. Percentiles are based on nationally representative civilian and military facility scores (October 2017 Public Report: January 2016–December 2016 discharges). More information about these percentiles can be found at: http://hcahpsonline.org/en/summary-analyses/

QUALITY OF MHS CARE *(CONT.)*

Patient Ratings—Experience of Care and Service *(cont.)*

The box and whisker plot below is a visual representation of the following table. Additional detail on all of the components of the box and whisker plot, as well as the CV, can be found on page 73.

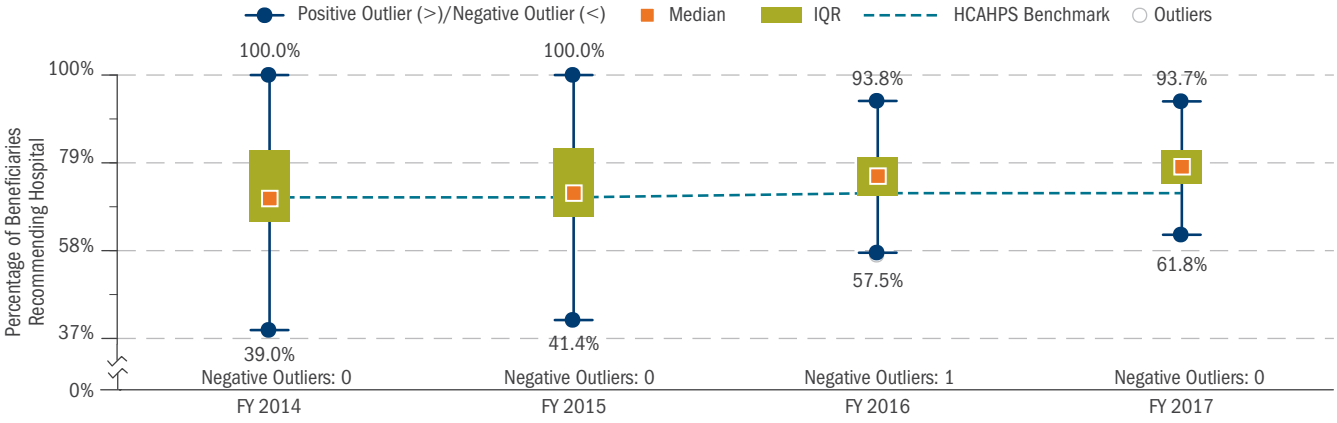
- The table below displays the extent to which the ratings of Recommend Hospital changed over time in terms of improvement (increasing mean or median) or decreased dispersion (reduced range or IQR).
- From FY 2014 to FY 2017, direct care improved by over 5 percent in terms of the median and mean ratings—a substantial change over time for an HCAHPS-based survey.
- Dispersion decreased in terms of the range and IQR from FY 2014 to FY 2017; the changes were over 7 percent from FY 2014 to FY 2017. There was only one negative outlier present in FY 2016 during the four-year time period. Dispersion, measured by changes to the CV, is also included following the box and whisker plots.

TRISS RECOMMEND HOSPITAL: DIRECT CARE, FYs 2014–2017

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2014–FY 2017 % POINT CHANGE
Mean	72.1%	72.6%	75.1%	77.3%	5.2
Median	71.5%	73.0%	75.3%	77.8%	6.4
75th Percentile (Q3)	81.9%	82.3%	80.2%	81.7%	-0.2
25th Percentile (Q1)	64.7%	65.9%	71.1%	73.8%	9.0
IQR	17.2%	16.4%	9.1%	8.0%	-9.2
Positive Outlier (>)	100.0%	100.0%	93.8%	93.7%	-6.3
Negative Outlier (<)	39.0%	41.4%	57.5%	61.8%	22.8
Maximum	87.5%	89.8%	89.7%	90.6%	3.1
Minimum	52.1%	55.2%	56.8%	63.0%	10.9
Range	35.4%	34.6%	32.9%	27.6%	-7.8

Source: DHA/SP&FI (J-5)/Decision Support, TRISS, weighted data, compiled 12/5/2017
Notes:
– Inpatient facilities were scaled to account for the number of responses, and those reporting fewer than 30 responses were excluded from analyses.
– FY 2017 includes results from FY 2017 Q1–Q3 for direct care.

VARIABILITY IN TRISS RECOMMEND HOSPITAL: DIRECT CARE, FYs 2014–2017



Source: DHA/SP&FI (J-5)/Decision Support, TRISS, weighted data, compiled 12/5/2017
Notes:
– FY 2017 includes Q1–Q3 for direct care and purchased care results.
– Results for FY 2014 Q4 are unavailable and not included in the results.
– The box shows interquartile range (25th–75th percentiles) with median highlighted.
– Length of whiskers are at 1.5 times the interquartile range, and may or may not include the minimum or maximum values. MTFs outside the "whiskers" are identified as outliers.
– Facilities are scaled to account for the number of responses, and those reporting fewer than 30 responses were excluded from analyses.

BETTER CARE

QUALITY OF MHS CARE *(CONT.)*

Patient Ratings—Experience of Care and Service *(cont.)*

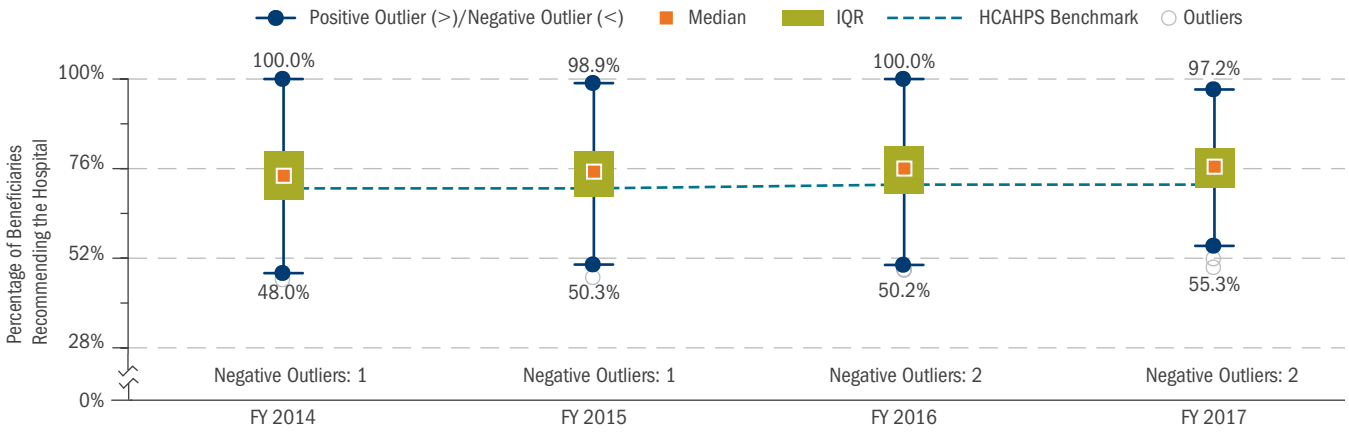
- From FY 2014 to FY 2017, purchased care improved by approximately 2 percent in terms of the median and mean ratings.
- Dispersion also decreased in terms of the range and IQR from FY 2014 to FY 2017 by approximately 3 percent. The number of negative outliers increased from one in FY 2014 to two in FY 2017. Dispersion, measured by changes to the IQR and CV, are also included in the box and whisker plot below.

TRISS RECOMMEND HOSPITAL: PURCHASED CARE, FYs 2014–2017

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2014–FY 2017 % POINT CHANGE
Mean	73.3%	73.6%	75.2%	75.7%	2.4
Median	72.9%	75.0%	76.5%	75.7%	2.7
75th Percentile (Q3)	80.7%	80.7%	81.9%	81.5%	0.8
25th Percentile (Q1)	67.6%	68.5%	69.2%	71.0%	3.4
IQR	13.1%	12.1%	12.7%	10.5%	–2.6
Positive Outlier (>)	100.0%	98.9%	100.0%	97.2%	–2.8
Negative Outlier (<)	48.0%	50.3%	50.2%	55.3%	7.3
Maximum	89.2%	89.0%	92.3%	91.3%	2.1
Minimum	45.6%	46.2%	48.2%	51.2%	5.6
Range	43.6%	42.8%	44.1%	40.1%	–3.5

Source: DHA/SP&FI (J-5)/Decision Support, TRISS, weighted data, compiled 12/5/2017
– Inpatient facilities were scaled to account for the number of responses, and those reporting fewer than 30 responses were excluded from analyses.
– FY 2017 includes results from FY 2017 Q1–Q3 for purchased care.

VARIABILITY IN TRISS RECOMMEND HOSPITAL: PURCHASED CARE, FYs 2014–2017



Source: DHA/SP&FI (J-5)/Decision Support, TRISS, weighted data, compiled 12/5/2017
Notes:
– FY 2017 includes fiscal Q1–Q3 for direct care and purchased care results.
– Results for FY 2014 Q4 are unavailable and not included in the results.
– The box shows interquartile range (25th to 75th percentiles) with median highlighted.
– Length of whiskers are at 1.5 times the interquartile range, and may or may not include the minimum or maximum values. MTFs outside the "whiskers" are identified as outliers.
– Facilities are scaled to account for the number of responses and those reporting fewer than 30 responses were excluded from analyses.

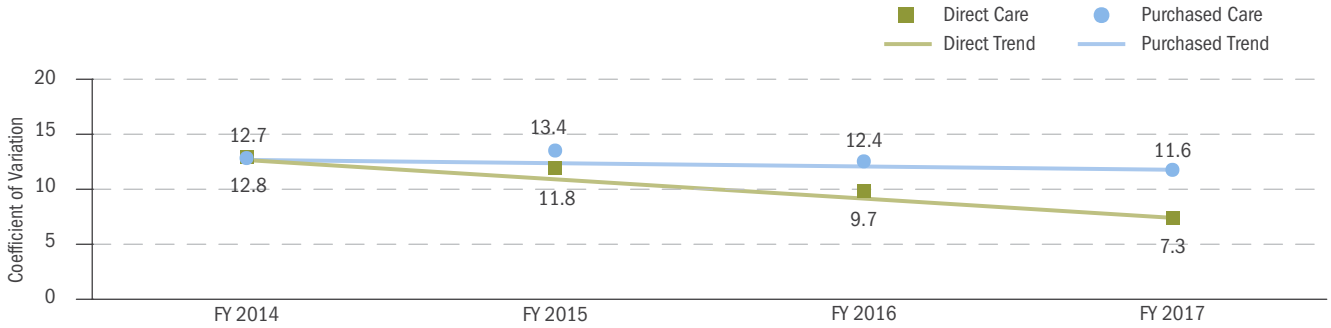
QUALITY OF MHS CARE *(CONT.)*

Patient Ratings—Experience of Care and Service *(cont.)*

The CV is used to understand dispersion in terms of the standard deviation and the mean. Additional information about the CV can be found on page 73.

- The following graph shows the CV for the TRISS measure Recommendation of Hospital. Similar to the results described previously for the range and IQR, the CV is decreasing substantially for direct care and less substantially for purchased care.

RELATIVE DISPERSION IN TRISS RECOMMEND HOSPITAL RATINGS, FYs 2014–2017



Source: DHA/SP&FI (J-5)/Decision Support, TRISS, weighted data, compiled 12/5/2017
Notes:
– FY 2017 includes fiscal Q1–Q3 for direct care and purchased care results.
– Results for FY 2014 Q4 are unavailable and not included in the results.
– Facilities are scaled to account for the number of responses, and those reporting fewer than 30 responses were excluded from analyses.

QUALITY OF MHS CARE *(CONT.)*

Patient Ratings—Experience of Care and Service *(cont.)*

Patient Experience Star Ratings—Inpatient Facilities

Star ratings are used by CMS to provide grades for facilities on broad levels, which include patient experience. The summary star rating for patient experience takes into account all of the domains referenced on page 127, which include Overall Hospital Rating and Recommend Hospital as components. Official star ratings for CY 2016, including for military hospitals in the United States, are posted on CMS's website at www.medicare.gov/hospitalcompare. The MHS calculates star ratings similarly to the method used by CMS with the most recently available civilian benchmarks, and these results are published on the TRISS reporting website.

The MHS performs very well as measured by star ratings from FY 2016 Q4 to FY 2017 Q3. Three stars can be considered an "average" patient experience, so most of the MHS facilities are performing above average.

PATIENT EXPERIENCE STAR RATINGS, FY 2016 Q4–FY 2017 Q3

★★★★★	★★★★	★★★
6 FACILITIES (LISTED BELOW)	30 FACILITIES	4 FACILITIES
	★★★★★	
81st Medical Group, Keesler	Keller ACH, West Point	Landstuhl Regional Medical Center
88th Medical Group, Wright-Patterson	Brian Allgood ACH, Seoul	Naval Hospital Pensacola

Source: DHA/SP&FI (J-5)/Decision Support, TRISS, weighted data, compiled 12/5/2017

Note: One hundred responses to TRISS within the year were required to receive a summary star rating.

Patient Ratings—Experience of Care and Service *(cont.)*

Drivers of Patient Experience Ratings

Results of patient surveys have become increasingly important in measuring health plan performance and in directing action to improve the beneficiary experience and quality of services provided. The goal of any patient survey is to assess the patient's perception of the provided health care. Patient surveys are intended to assess the patient's perception of the interpersonal contacts made during the interaction and delivery of health care services and are an invaluable tool for improving communication and engaging patients in their care. Knowing whether the patient's overall experience or rated level of satisfaction was positive or negative can have serious impact, and the only way to take advantage of this knowledge is to address the information raised by the survey results. Results have continued to gain in importance as a measure of health plan performance and in directing action to improve the beneficiary experience and health service quality.

Three key beneficiary surveys measure self-reported access to and satisfaction with MHS direct and purchased care experiences:

- TRISS—event-based after a discharge from a hospital (based on HCAHPS);
- JOES-C—event-based following an outpatient visit, asking about care received in the preceding six months (based on CAHPS C&G); and
- HCSDB—population-based quarterly survey sampling MHS-eligible beneficiaries who may use the MHS or their own health insurance, asking about care received in the preceding 12 months (based on CAHPS Plan).

Results from these three surveys for FYs 2016 and 2017 (using all data available at the time of analysis) were modeled to identify key drivers of satisfaction. Drivers of satisfaction for all surveys of the direct care system were determined by examining the effects of composite scores on outcome variables. The models controlled for all composites and patient demographic variables, including beneficiary category, gender, Service, health status, and region. The statistical significance and effect size of odds ratios were used to rank drivers of satisfaction.

The table below shows that beneficiary satisfaction with health care provided in MTFs was driven by communication between patients and providers, getting care when needed, getting care quickly, use of information to coordinate care, and cleanliness of the patient room/bathroom. Results suggest that improving communication between beneficiaries and health care providers, ensuring patient room/bathroom cleanliness, and providing care at the right time and location have the potential to influence a patient's health care experience and hospital satisfaction.

TOP THREE DRIVERS OF SATISFACTION BY SURVEY: DIRECT CARE, FYs 2016–2017

FISCAL YEAR	RANKING	TRISS DIRECT CARE MHS RATING OF HOSPITAL	JOES-C DIRECT CARE MHS SATISFACTION WITH HEALTH CARE	HCSDB DIRECT CARE U.S. SATISFACTION WITH HEALTH CARE
FY 2016	#1	Communication with Nurses	Getting Timely Appointments, Care, and Information	Communication with Doctors
	#2	Communication with Doctors	How Well Providers Communicate with Patients	Getting Needed Care
	#3	Cleanliness of Room/Bathroom	Helpful, Courteous, and Respectful Office Staff	Getting Care Quickly
FY 2017	#1	Communication with Nurses	Getting Timely Appointments, Care, and Information	Communication with Doctors
	#2	Communication with Doctors	How Well Providers Communicate with Patients	Getting Needed Care
	#3	Cleanliness of Room/Bathroom	Providers' Use of Information to Coordinate Patient Care	Getting Care Quickly

Source: DHA/SP&FI (J-5)/Decision Support, TRISS results, compiled 12/7/2017, JOES-C, and HCSDB, FYs 2016–2017 (Q1–Q3 only for TRISS and JOES-C), compiled 11/14/2017
Notes:
– Composite measure generation followed guidelines established by the AHRQ.
– TRISS followed HCAHPS composite construction found at: http://www.hcahpsonline.org/
– JOES-C followed CG-CAHPS version 3.0 guidelines detailed at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/cg/about/cg_3-0_overview.pdf
– HCSDB followed CAHPS guidelines provided at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/hp/about/measures_hp50_2109.pdf

Patient Ratings—Experience of Care and Service *(cont.)*

Drivers of Patient Experience Ratings—JOES

In addition to the TRISS, JOES-C, and HCSDB, the MHS also fields the JOES that combined and standardized previously established methods used by the Army, Navy, Air Force, and DHA/NCR to learn about beneficiary health care experiences. The JOES aims to more efficiently gather beneficiary health care experiences so that the information obtained can better inform improvement measures within and across the Services.

Respondent data from the JOES for FYs 2016 and 2017 (using all data available at the time of analysis) were modeled to identify key drivers of a patient's satisfaction with health care and their ability to receive care when they felt it was necessary. Drivers for these two types of patient experience for the direct care system were determined by analyzing the effect of individual aspects of the patient care experience on outcome variables. The models assessed the ease of making an appointment for care, the helpfulness and courteousness of both staff and providers, whether or not a provider knew the patient's medical history and reviewed current and/or new medications, as well as whether the provider team considered the patient's values and opinions when devising a care plan. Results took into account the patient demographic variables, including beneficiary category, gender, Service, health status, and region. The statistical significance and effect size of odds ratios were used to rank drivers of satisfaction and the experience of being able to get care when needed.

The table below shows that overall satisfaction with health care and the experience of obtaining care when needed in MTFs was driven by ease of the appointment making process, the provider explaining things in a clear and understandable way, the helpfulness and courtesy of clerks and receptionists, and the provider knowing the patient's medical history. Results suggest that improving communication between patients and their providers and ensuring staff members take the necessary time getting patients seen by providers have the potential to positively influence a patient health care experience.

TOP THREE DRIVERS OF PATIENT EXPERIENCE FROM JOES: DIRECT CARE, FYs 2016–2017

FISCAL YEAR	RANKING	SATISFACTION WITH HEALTH CARE	ABILITY TO GET CARE WHEN NEEDED
FY 2016	#1	Provider Explained Things in a Way That Was Easy to Understand	Ease of Making the Appointment
	#2	Able to Get Care When Needed	Provider Knew Important Medical History
	#3	Provider Knew Important Medical History	Helpfulness of Clerks and Receptionists
FY 2017	#1	Provider Explained Things in a Way That Was Easy to Understand	Ease of Making the Appointment
	#2	Provider Knew Important Medical History	Provider Knew Important Medical History
	#3	Able to Get Care When Needed	Helpfulness of Clerks and Receptionists

Source: DHA/SP&FI (J-5)/Decision Support, JOES results, FYs 2016–2017, compiled 11/27/2017

QUALITY OF MHS CARE *(CONT.)*

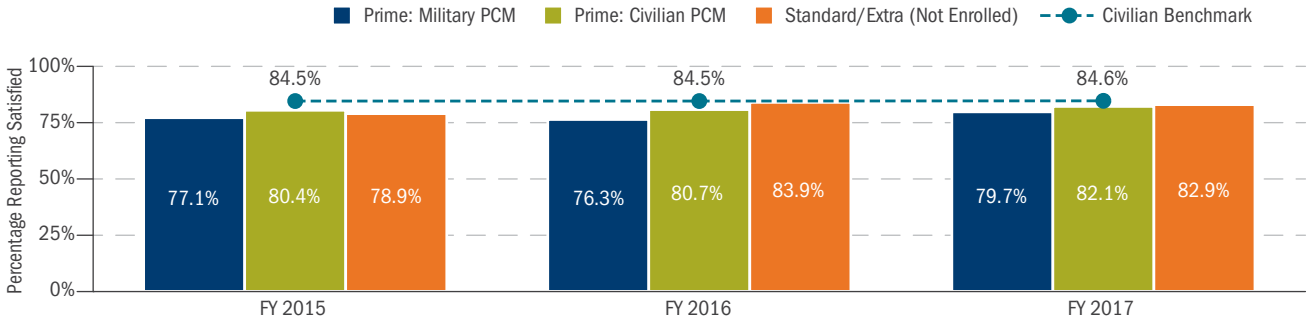
Patient Ratings—Experience of Care and Service *(cont.)*

Satisfaction with Customer Service

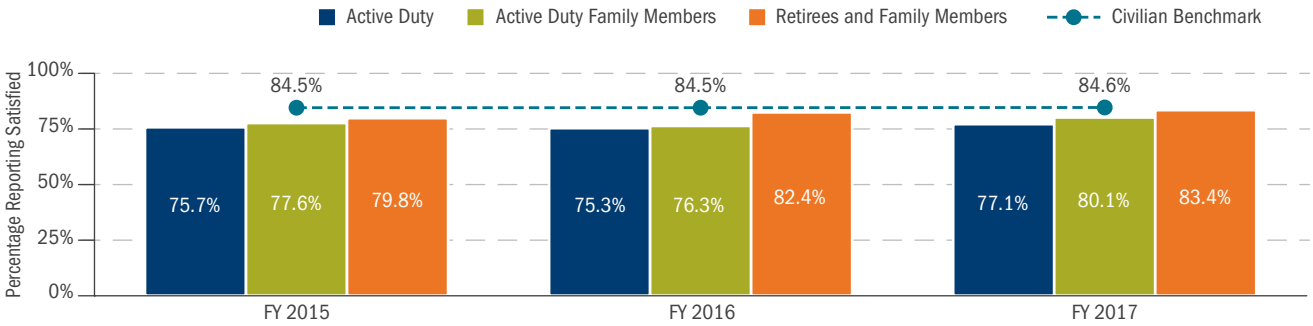
Access to and understanding written materials about one's health plan are important determinants of overall satisfaction with the plan.

- MHS beneficiary satisfaction with customer service in terms of understanding written material, getting customer assistance, and dealing with paperwork increased for Prime enrollees with a military PCM from FY 2015 to FY 2017. The civilian benchmark remained steady over the same time period.
- In FY 2017, satisfaction for Prime enrollees with either a military or civilian PCM was lower than the civilian benchmark.
- Satisfaction levels for all beneficiary groups held steady from FY 2015 to FY 2017. The civilian benchmark also held steady over the same period.
- For each year between FY 2015 and FY 2017, satisfaction levels for Active Duty and ADFMs were lower than the civilian benchmark. Except for FY 2015, satisfaction of retirees and family members was equal to the civilian benchmark.

TRENDS IN RESPONSIVE CUSTOMER SERVICE: COMPOSITE MEASURE OF FINDINGS (UNDERSTANDING WRITTEN MATERIAL, GETTING CUSTOMER ASSISTANCE, AND DEALING WITH PAPERWORK) BY ENROLLMENT STATUS, FYs 2015–2017



TRENDS IN RESPONSIVE CUSTOMER SERVICE: COMPOSITE MEASURE OF FINDINGS (UNDERSTANDING WRITTEN MATERIAL, GETTING CUSTOMER ASSISTANCE, AND DEALING WITH PAPERWORK) BY BENEFICIARY CATEGORY, FYs 2015–2017



Note: DoD data were derived from the FYs 2015–2017 HCSDB, as of 11/13/2017, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used in 2015 come from NCQA's 2013 data, while the benchmarks used in 2016 and 2017 come from NCQA's 2015 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

QUALITY OF MHS CARE *(CONT.)*

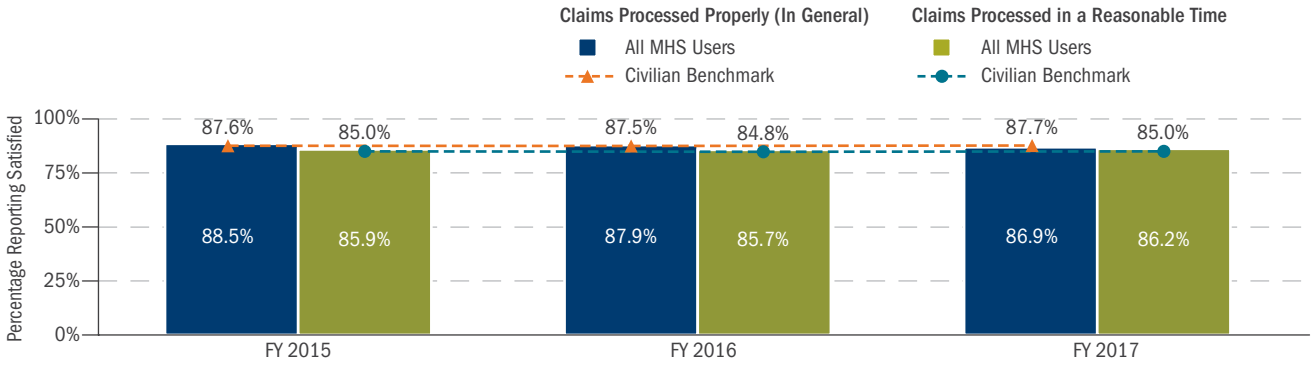
Patient Ratings—Experience of Care and Service *(cont.)*

Both beneficiaries and their providers have an interest in the promptness and accuracy of claims processing and payment. The MHS monitors the performance of TRICARE claims processing through surveys of beneficiary perceptions and administrative tracking.

Beneficiary Perceptions of Claims Filing Process

- Satisfaction with claims being processed properly and with processing speed remained stable from FY 2015 to FY 2017. The civilian benchmarks also remained stable over the same period.
- MHS satisfaction levels with both the accuracy and the speed of claims processing were equal to the civilian benchmarks from FY 2015 to FY 2017.

TRENDS IN SELF-REPORTED ASPECTS OF CLAIMS PROCESSING (ALL SOURCES OF CARE), FYs 2015–2017



Note: DoD data were derived from the FYs 2015–2017 HCSDB, as of 11/13/2017, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used in 2015 come from NCQA's 2013 data, while the benchmarks used in 2016 and 2017 come from NCQA's 2015 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

Trends in Claims Filing Process

TRICARE monitors claims processing to ensure compliance with contractual requirements and to ensure our participating providers are paid on a timely basis. Claims processing for purchased care comprises three intervals: claims submission, claims processing, and transmission acceptance.

- **Claims Submission:** The claims submission interval is the time from the patient's last date of care to the date that the treating provider files a claim for payment with the Purchased Care Processing Contractor.
- **Claims Processing:** The Purchased Care Processing Contractor adjudicates the claim and sends a TRICARE Encounter Data (TED) record to DHA requesting payment. Claims processing includes the time needed for the Purchased Care Processing Contractor to ensure the TED records pass all TRICARE validation edits (services are "Accepted").
- **Transmission Acceptance:** The transmission acceptance interval is the time between when DHA takes an "Accepted" TED record and when it identifies the appropriate program cost fund for payment. The accept date is defined as the "Last Update Date" in the TED record by current contracts. Contracts between DHA and MCSCs require that TED records be received by 10 AM Eastern time for DHA to accept the same day; otherwise, the cutoff moves the TED "Accepted" record to the next day.

Patient Ratings—Experience of Care and Service *(cont.)*

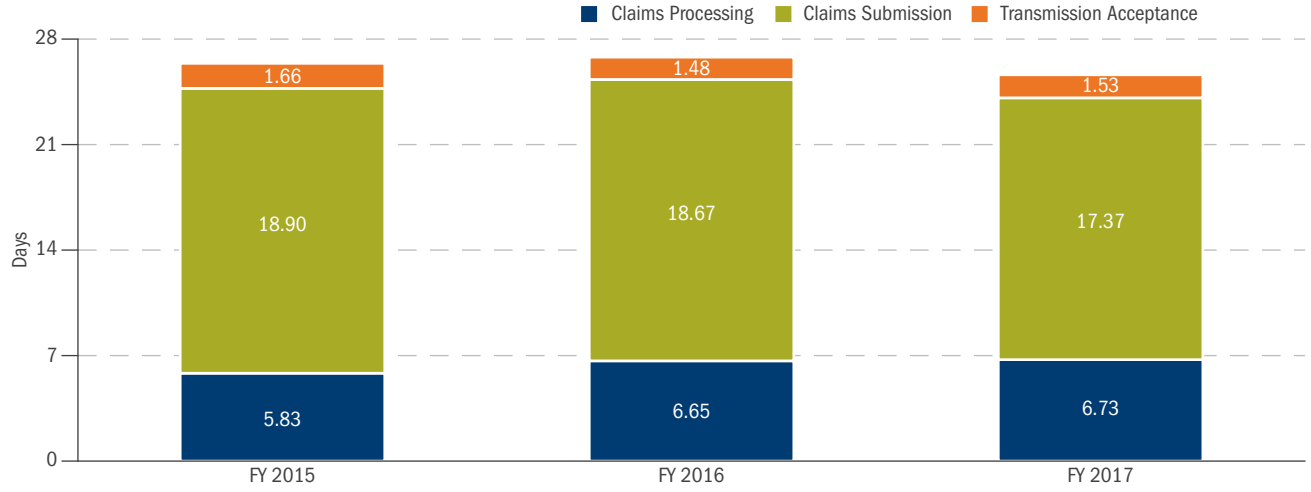
DHA pays MCSCs within seven days of the later of "Transmission Receive Date" or "Last Update Date," in compliance with contractual language. The graph below shows that TRICARE payments met time requirements, complying with Managed Care Support Contracts.

The below graph excludes paper claims and claims from OHI, pharmacy, TRICARE Dual Eligible Fiscal Intermediary Contract, and TRICARE Overseas Program contracts. There was a continuing trend of a slight decrease in overall claims processing times across all contract regions during FY 2017, with the slight Claim Processing time increases offset by a larger drop in Claims Submission time.

The lengthiest portion of claims processing is consistently Claims Submission—the time it takes for the treating provider to submit claims. Since institutional claims are less than 5 percent of the total claims, the Claims Submission time is not affected by institutional claims.

The chart below shows results of analysis of claims counts of 38.1 million, 38.8 million, and 39.8 million for FY 2015, FY 2016, and FY 2017, respectively. The most recent fiscal year is a 1 million claim increase from the previous, and a slight decline can be seen from the FY 2015 and FY 2016 previous annual measurements due to canceled claims and an ongoing OHI discovery process.

AVERAGE INTERVAL (DAYS) FOR CLAIMS PROCESSING, FYs 2015–2017



Source: DHA/SP&FI (J-5)/Decision Support, MHS Administrative data, 11/20/2017

OTHER PLANS AND PROGRAMS

Additional benefit options may be available to beneficiaries depending on location, Active/Reserve status, and/or other factors. These supplemental plans and programs can enhance existing benefits or are a blend of the Prime and Standard/Extra options with some limitations.

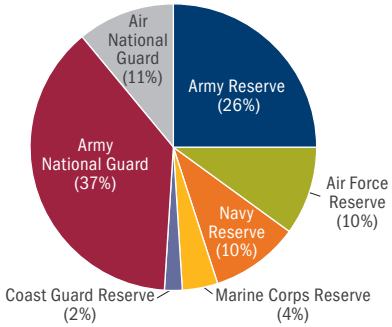
TRICARE Benefits for the Reserve Component

TRICARE offers a broad array of benefits coverage for RC members who qualify and their eligible family members pre-deployment, during deployment, post-deployment, and into retirement.

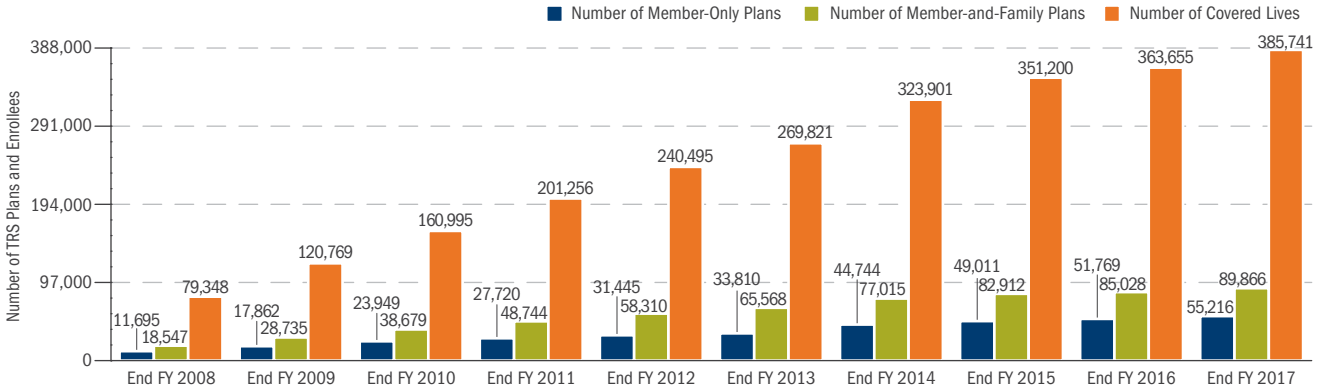
TRICARE Reserve Select (TRS). The premium-based TRS health plan offers comprehensive TRICARE Standard and Extra coverage for purchase by qualified members of the Selected Reserve. TRS grew to over 145,000 plans with nearly 386,000 covered lives by the end of FY 2017. The chart below shows TRS enrollment growth since the NDAA FY 2007 enacted current member qualifications, effective October 1, 2007.

- As shown in the pie chart at right, Army National Guard and Army Reserve combined constitute 63 percent of the 385,741 TRS covered lives.

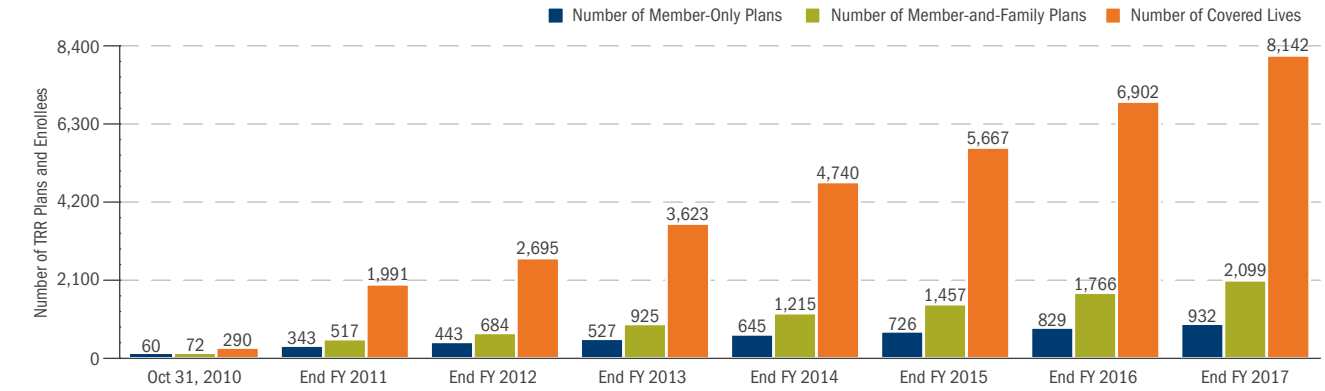
TRICARE RESERVE SELECT: POPULATION BY COMPONENT (385,741 SPONSORS AND FAMILY MEMBERS AS OF SEPTEMBER 2017)



TRENDS IN RESERVE COMPONENT ENROLLMENT IN TRS, SEPTEMBER 2008–SEPTEMBER 2017



TRENDS IN ENROLLMENT IN TRICARE RETIRED RESERVE, OCTOBER 2010–SEPTEMBER 2017



Source: Defense Manpower Data Center (DMDC)/ Defense Enrollment Eligibility Reporting System (DEERS) Medical Policy Report, 10/17/2017

TRICARE Benefits for the Reserve Component *(cont.)*

TRICARE Retired Reserve (TRR). Coverage under the TRR premium-based health plan began on October 1, 2010 (NDAA for FY 2010, section 705 and encoded at 10 U.S.C. 1076e). The law allows qualified members of the Retired Reserve to purchase full-cost, premium-based coverage under TRR until they reach age 60, when they receive premium-free TRICARE coverage for themselves as retirees and their eligible family members.

Although coverage under TRR is similar to TRS, it differs in the cost contribution. Unlike TRS, where the Department and member share in the cost of the premium, TRR members pay the full cost of the premium. Premiums are calculated annually for both.

Linear enrollment growth continues: by the end of FY 2017, over 8,100 retired Reservists and their families were covered by TRR in 3,031 member-only and member-and-family plans.

TRS and TRR Premiums. As of December 1, 2017, purchasing coverage will be done through mainstream Beneficiary Web Enrollment and the previous Reserve Component Purchase TRICARE Application will be retired.

On January 1, 2018, a new TRICARE Select cost sharing structure began for TRS and TRR, though unlike TRICARE Prime/Select, there will be no grandfathering. Premiums are derived from actual prior year costs, and will change for CY 2018 as follows:

MONTHLY PREMIUMS FOR TRS AND TRR, CYs 2017–2018

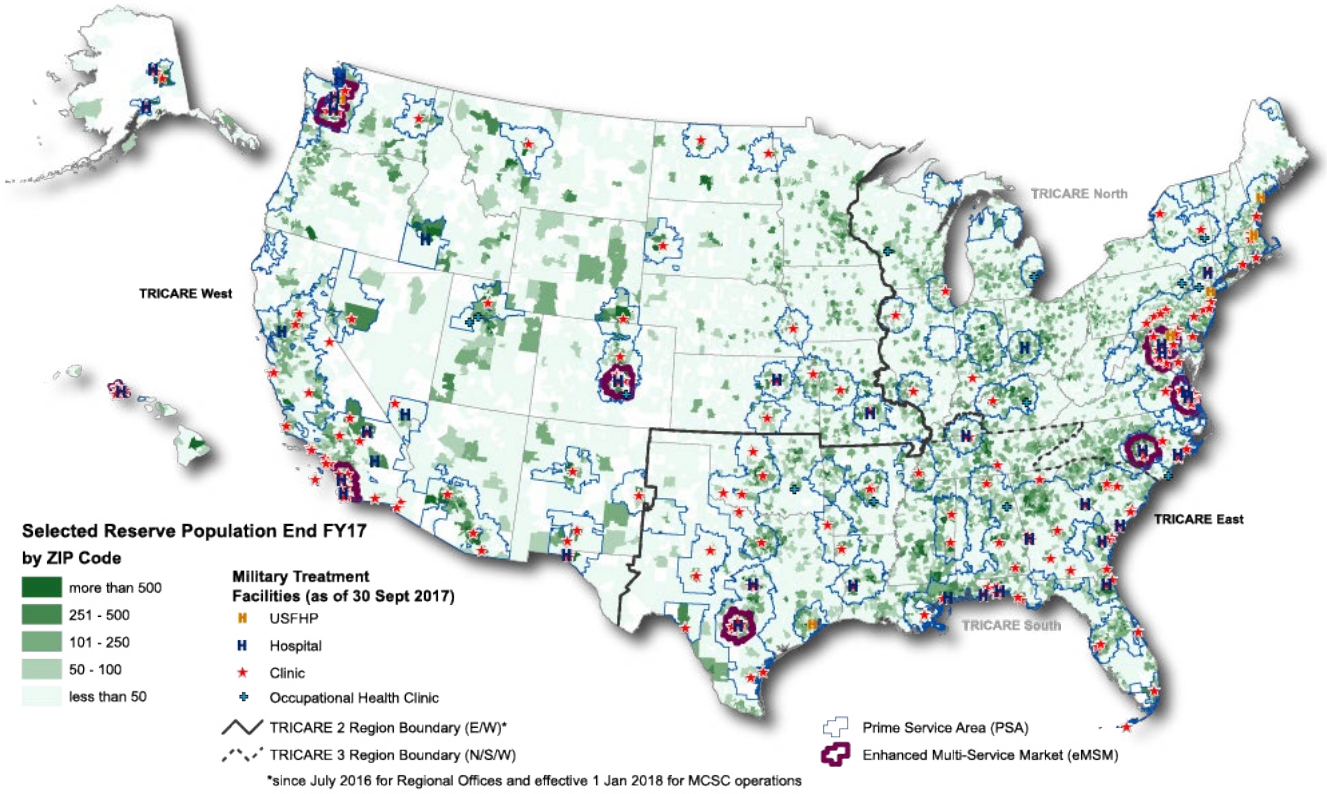
TYPE OF COVERAGE	CY 2017 MONTHLY	CY 2018 MONTHLY	% CHANGE
TRS Member Only	$47.82	$46.09	–3.8%
TRS Member and Family	$217.51	$221.38	1.8%
TRR Member Only	$402.81	$431.35	7.1%
TRR Member and Family	$1,013.36	$1,038.31	2.5%

Source: TRS data from http://tricare.mil/Costs/HealthPlanCosts/TRS.aspx, TRR data from http://tricare.mil/Costs/HealthPlanCosts/TRR.aspx, accessed 10/19/2017

OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Benefits for the Reserve Component *(cont.)*

SELECTED RESERVE POPULATION IN THE U.S. RELATIVE TO MTF, PRIME, AND NON-PRIME SERVICE AREAS, FY 2017



COMPARISON OF SELECTED RESERVE AND ACTIVE DUTY SPONSORS AND FAMILY MEMBER PROXIMITY TO MTFs AND NETWORK PROVIDERS IN THE U.S. (SEPTEMBER 30, 2017)

BENEFICIARY GROUP	POPULATION TOTAL (FY 2017)	POPULATION IN PSAs	% IN PSAs	POPULATION IN CATCHMENTS	% IN CATCHMENTS	POPULATION IN PRISMs	% IN PRISMs	POPULATION IN MTF SERVICE AREAS	% IN MTF SERVICE AREAS	POPULATION IN MULTI-SERVICE MARKET AREAS	% IN MULTI-SERVICE MARKET AREAS
Active Duty and Their Families	2,779,159	2,658,887	95.7%	1,867,879	67.2%	2,468,068	88.8%	2,584,560	93.0%	1,055,234	38.0%
Selected Reservists and Their Families	1,955,050	1,339,432	68.5%	449,415	23.0%	739,167	37.8%	1,065,165	54.5%	238,864	12.2%

Sources: DHA/SP&FI (J-5)/Decision Support for population and geospatial representation, 12/12/2017, and DHA/R&M (J-1/J-8) Facilities for MTF designations
Population Data: Selected Reserve and family member data provided by Office of the Deputy Assistant Secretary of Defense (ODASD)/Military Personnel Policy (MPP) RCCPDS and DEERS database extract as of 9/30/2017, provided 12/7/2017; Active Duty and their families from MHS Data Repository (MDR) DEERS extract as of 9/30/2017, provided 12/11/2017.

Notes:

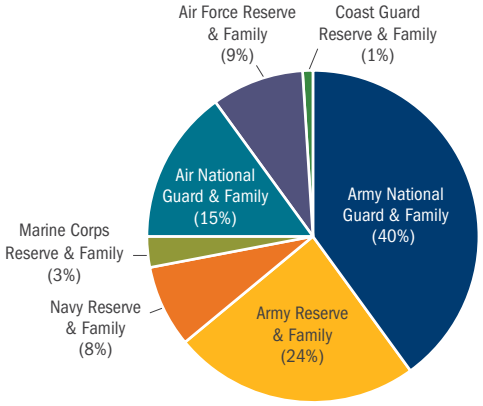
– Percentages are rounded to the nearest whole number.
– MTF Service Areas are 40-mile circles around inpatient and outpatient MTFs, rounded to include all complete and partial ZIP codes, subject to overlap rules, barriers, and other policy overrides.
– Prime Service Areas are MTF Service Areas and similar geographies around closed MTFs (Base Realignment and Closure [BRAC] Prime Service Areas), effective 9/30/2017.
– Multi-Service market areas are the six enhanced multi-Service market (eMSM) areas used in the MHS strategy and metrics calculations (i.e., National Capital Region, Puget Sound, Colorado Springs, San Antonio, Tidewater, and Hawaii areas) and two densely populated multiple-market areas in San Diego and Fort Bragg.

OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Benefits for the Reserve Component *(cont.)*

- As of September 30, 2017, there were more than 2 million Selected Reserve Service members and their families (2,077,243), of which 814,959 were sponsors and 1,262,284 were family members.
- The map on page 146 depicts where Selected Reservists and their family members reside in the U.S. relative to the direct care MTFs, and also to all areas where TRICARE Prime networks are available. As shown in the accompanying table, by September 30, 2017, 68.5 percent of Selected Reservists and their family members (96 percent for Active Duty and their family members) in the U.S. live within the area covered by the TRICARE network (PSAs). Slightly more than half (54.5 percent) of this population resides near a clinic or inpatient MTF, compared with 93 percent of Active Duty and their family members.
- As shown below, almost two-thirds (64 percent) of the worldwide Selected Reserve population of 2 million sponsors and their family members are Army National Guard (40 percent) and Army Reserve (24 percent), similar to the 63 percent enrolled in TRICARE Reserve Select.

SELECTED RESERVE POPULATION (2,077,243): SPONSORS AND FAMILY MEMBERS BY SERVICE (SEPTEMBER 2017)



Source: ODASD (MPP), as of 12/7/2017

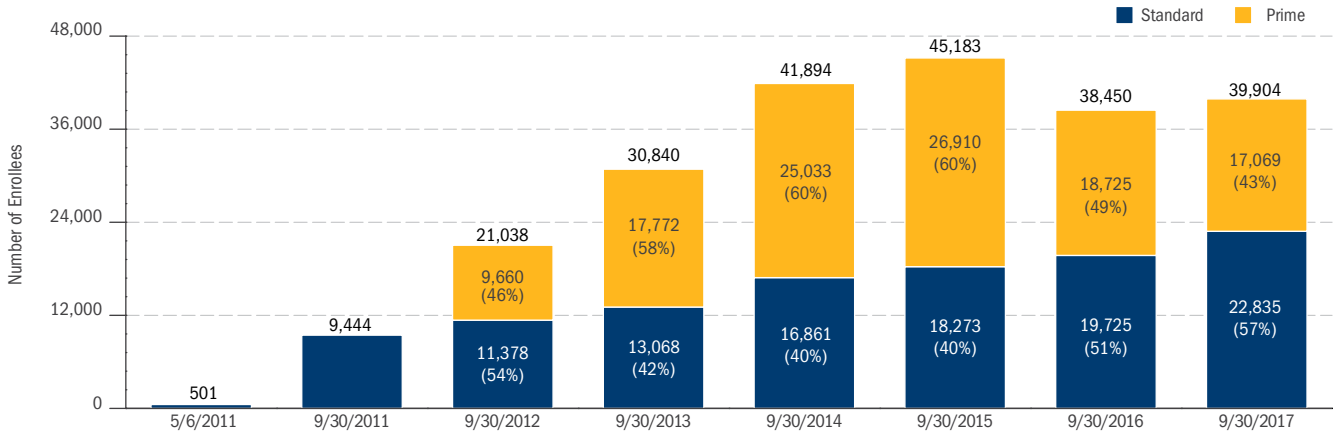
OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Young Adult

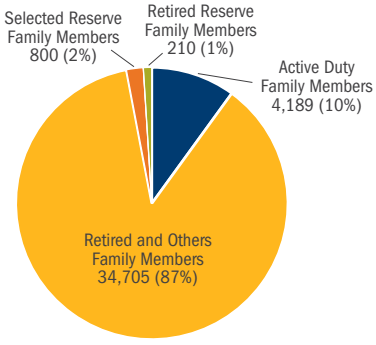
The TRICARE Young Adult (TYA) program is a premium-based TRICARE plan coverage available for purchase by qualified adult-age dependents who lose eligibility for TRICARE due to age. TYA extends specific TRICARE health care coverage options based on where the adult-age dependent lives and the sponsor's status, and can provide coverage up to the age of 26 if not otherwise qualified. TYA is an umbrella plan that offers Prime and Standard coverage across all TRICARE plans (Prime, TRICARE Prime Remote [TPR] ADFM, Prime Overseas, Prime Overseas Remote, Standard, Standard Overseas, TRR, TRS, and USFHP). TYA Standard plans began in May 2011 and expanded to TYA Prime plans in January 2012. Monthly premiums are established to actuarially cover the full cost of the coverage. When purchased, TYA meets the minimum essential coverage requirements of the Patient Protection and Affordable Care Act.

- As shown in the chart below, enrollment rose from just over 38,000 in FY 2016 to just under 40,000 in FY 2017. Prime enrollment accounted for 43 percent of total TYA enrollment.
- As shown in the accompanying pie chart, most TYA enrolled (90 percent) are family members of those who are not Active Duty (e.g., dependents of retirees and others).
- Based on actual prior year costs, TYA monthly premiums will increase from $319 to $324 per month for Prime and from $216 to $225 per month for Standard in CY 2018 (table below; see http://tricare.mil/Costs/HealthPlanCosts/TYA.aspx [accessed 1/3/2018]).

TRENDS IN TYA ENROLLMENT SINCE INCEPTION (MAY 2011–SEPTEMBER 2017)



TYA ENROLLMENT BY SPONSOR CAREER STATUS, AS OF SEPTEMBER 30, 2017



MONTHLY TYA PREMIUMS, CYs 2016–2018

	CY 2016	CY 2017	CY 2018
Prime	$306	$319	$324
Standard	$228	$216	$225

Source: DHA/SP&FI (J-5)/Decision Support Division, 11/3/2017

OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Provider Participation

The National Provider Identifier (NPI) is a unique identification number issued to health care providers in the U.S. by CMS. All HIPAA-covered individual health care providers and organizations must obtain an NPI for use in all HIPAA standard transactions. In this report, providers are counted using the NPI. The number of TRICARE-participating providers was determined by the number of unique providers filing TRICARE (excluding TFL) claims.[1] Providers were counted in terms of full-time equivalent (FTE) units (1/12 of a provider for each month the provider saw at least one MHS beneficiary). The total number of participating providers has been rising steadily for more than a decade. The trend is due exclusively to an increase in the number of network providers; the number of Standard providers has actually slightly declined. Since FY 2013, the number of network primary care providers has increased at a higher rate (26 percent) than that of specialists (15 percent), and the total number of participating primary care providers has increased at a higher rate (13 percent) than that of total participating specialists (5 percent).[2]

- Between FY 2013 and FY 2017, the South Region saw the largest increase in the total number of TRICARE providers (14 percent), while the West Region saw an increase of 8 percent and the North Region an increase of 7 percent.
- The West Region saw the largest increase in the number of network providers (22 percent), followed by the North Region at 21 percent and the South Region at 18 percent.
- The total number of TRICARE providers decreased by 12 percent in PSAs and increased by 103 percent in non-PSAs (not shown). This pattern is not due to any fundamental shift in where providers practice, but rather to the reduction in the number of PSAs in FY 2014.
- The number of network providers decreased by 3 percent in PSAs and increased by 161 percent in non-PSAs, also due to the reduction in the number of PSAs in FY 2014.
- In FY 2017, 68 percent of all network providers and 65 percent of all participating providers were in PSAs.

TRENDS IN NETWORK AND TOTAL PARTICIPATING PROVIDER FTEs, FYs 2013–2017[a]

Source: MHS administrative data, 2/21/2018

Notes: The source for the provider counts shown above was the TRICARE purchased care claims data for each of the years shown, in which a provider was counted if he or she was listed as a TRICARE-participating provider. The claims also explicitly identify network providers. Numbers may not sum to bar totals due to rounding.

[a] Network providers are TRICARE-authorized providers who have a signed agreement with the regional contractors to provide care at a negotiated rate. Participating providers include network providers and those non-network providers who have agreed to file claims for beneficiaries, to accept payment directly from TRICARE, and to accept the TRICARE allowable charge, less any applicable cost shares paid by beneficiaries, as payment in full for their services.

[b] Numbers may not sum to regional totals due to rounding.

[c] The West Region includes Alaska.

[1] Providers include physicians, physician assistants, nurse practitioners, and select other health professionals. Providers of support services (e.g., nurses, laboratory technicians) were not counted.

[2] Primary care providers were defined as general practice, family practice, internal medicine, obstetrics/gynecology, pediatrics, physician's assistant, nurse practitioner, and clinic or other group practice.

OTHER PLANS AND PROGRAMS *(CONT.)*

Civilian Provider Acceptance of, and Beneficiary Access to, TRICARE Standard and Extra

The DoD has completed the first year of a congressionally mandated four-year survey (2017–2020) of civilian providers and MHS non-enrolled beneficiaries, designed to determine civilian provider acceptance of, and beneficiary access to, the TRICARE Standard benefit option. This survey complies with the requirements of NDAA 2015, section 712 (Public Law 113-291). This four-year survey is required as a follow-on to two previous four-year surveys completed from 2008 to 2011 (section 711, NDAA 2008 Public Law 110-181) and 2012 to 2015 (section 721, NDAA FY 2012, Public Law 112-81). The survey is licensed by the Office of Management and Budget (provider survey) and Washington Headquarters Service (beneficiary survey), and has been reviewed by the GAO as required by the guiding legislation.

- **Provider survey results and key points after the first year:**
  - About six of 10 providers overall (57 percent of physicians and nonphysician behavioral health providers) and eight of 10 physicians (77 percent) accept new TRICARE Standard patients if they accept new patients of any insurance. These acceptance rates are statistically similar to the 2012–2015 benchmark survey for physicians (76 percent), and lower for all providers (59 percent). However, results are likely to change, up or down, as the survey progresses through the years and results accumulate as more locations and providers are surveyed.
  - Almost nine of 10 providers (85 percent) and over nine of 10 physicians (94 percent) are aware of the TRICARE program in general (greater than the 2012–2015 and 2008–2011 benchmarks, respectively, 84 and 82 percent for all providers and 93 and 91 percent for physicians).
  - Similar to the 2008–2011 benchmark survey, behavioral health providers (including psychiatrists, psychologists, and nonphysician providers) report lower rates than physicians for awareness (77 percent) and acceptance (36 percent), pulling down the all-provider acceptance rates.
  - Primary care and specialist physicians report similar rates of awareness, both of which exceed the 2012–2015 benchmark.
  - Providers in non-PSAs report greater awareness and acceptance of new TRICARE Standard and Medicare patients than do PSA providers.
- **Beneficiary survey results and key points after the first year:**
  - Compared with the civilian benchmark, MHS non-enrolled beneficiaries eligible for Standard/Extra rate their care experience and access to care higher than or comparable to the civilian benchmark (higher for two of four global measures; higher for one of four access measures; equal for the remaining). This is the same regardless of whether we separate beneficiaries by PSA/non-PSA or analyze all beneficiaries together.
  - Comparing PSAs to non-PSAs, there are no significant differences between beneficiaries residing in PSAs and non-PSAs with regard to global or access measures.
- Provider and beneficiary results vary among PSAs, non-PSAs, and Health Service Areas, offering opportunities for improvement in some local areas, such as the boroughs of New York City and the Tacoma/Bremerton area of Washington.

Even as the DHA reports the 2017 results of this study, section 701 of NDAA FY 2017 establishes the new enrollment-based TRICARE Select benefits program, and terminates the non-enrolled Standard program effective January 1, 2018. This survey may be useful in supporting evaluation of the effectiveness of TRICARE Select as it is unveiled and matures in 2018 and beyond.

OTHER PLANS AND PROGRAMS *(CONT.)*

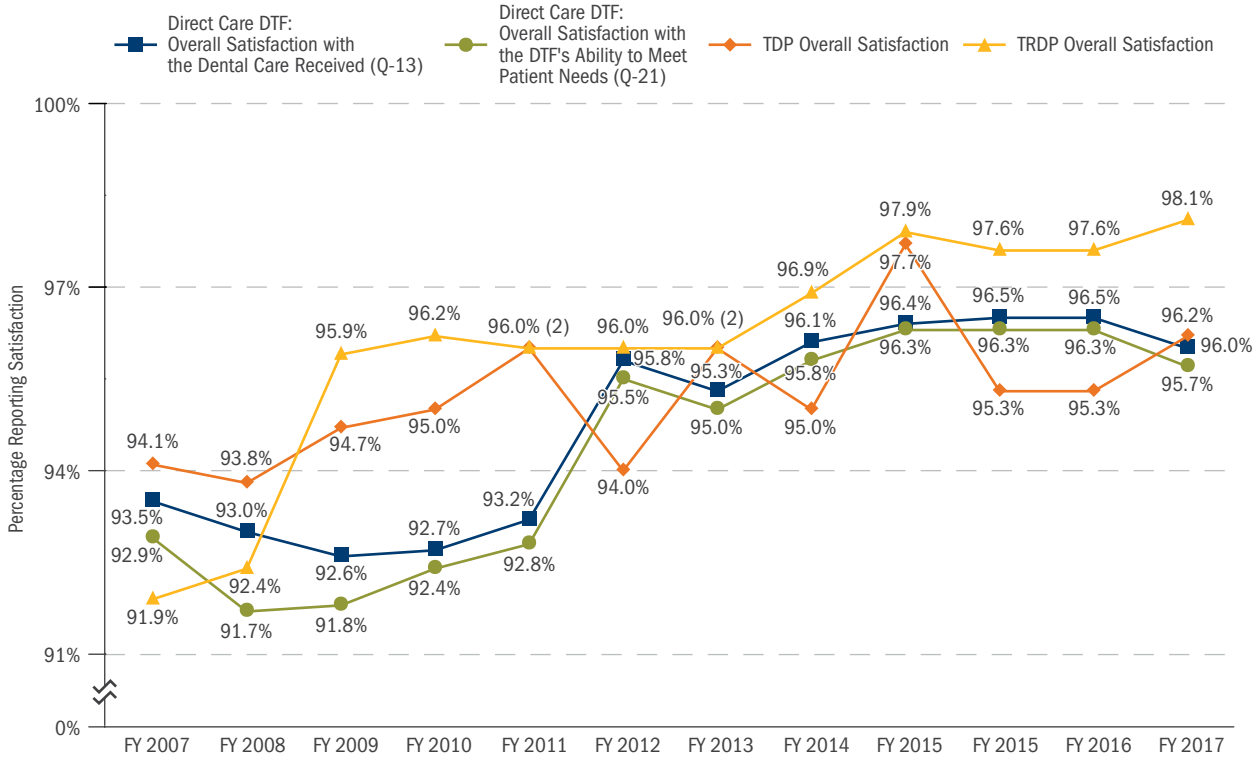
TRICARE Dental Programs Customer Satisfaction

The overall TRICARE dental benefit is composed of several delivery programs serving the MHS beneficiary population. Consistent with other benefit programs, beneficiary satisfaction is routinely measured for each of these important dental programs.

- **Military Dental Treatment Facilities (DTFs)** are responsible for the dental care of about 1.54 million ADSMs worldwide and eligible family members residing outside the continental U.S. (OCONUS). The Tri-Service Center for Oral Health Studies completed 105,944 surveys in FY 2017. Reports of overall satisfaction have remained at or just over 96 percent since FY 2014.
- The **TRICARE Dental Program (TDP)** composite overall average enrollee satisfaction declined slightly from FY 2015 (97.7 percent) to FY 2017 (96.2 percent). The TDP is a voluntary, premium-sharing dental insurance program available to eligible ADFMs, Selected Reserve and Individual Ready Reserve members, and their families. As of September 30, 2017, the TDP enrollment totaled 767,011 contracts, covering almost 2 million lives (1,822,638), 94 percent of which were in the U.S. The TDP network has 76,010 total dentists, a 23 percent decline from the 99,218 in FY 2016—of which 61,696 are general dentists and 14,314 are specialists. The United Concordia Companies, Inc. (UCCI) network consistently exceeds the contractual TDP access standards.
- The **TRICARE Retiree Dental Program (TRDP)** overall retired enrollee satisfaction rate rose from just under 98 percent in FYs 2015 and FY 2016 to just over 98 percent in FY 2017, after remaining steady at 96 percent from FY 2009 to FY 2013. The TRDP is a full premium insurance program open to retired Uniformed Services members and their families. TRDP enrollment at the end of FY 2017 was higher by 14 percent than in FY 2014, with over 1.6 million total covered lives in over 812,800 contracts in FY 2017, compared with about 1.4 million lives in nearly 721,700 contracts in FY 2014.

BETTER CARE

SATISFACTION WITH TRICARE DENTAL CARE: MILITARY AND CONTRACT SOURCES, FYs 2007–2017



Sources: TRICARE Dental Care Section, Health Plan Execution and Operations; Tri-Service Center for Oral Health Studies; and DoD Dental Patient Satisfaction Reporting website (Trending Reports), 10/30/2017

Note: The three dental satisfaction surveys (direct care, TDP, and TRDP) are displayed above for ease of reference, but are not directly comparable because they are based on different survey instruments and methodologies. For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

HEALTH PROMOTION AND DISEASE PREVENTION EFFORTS

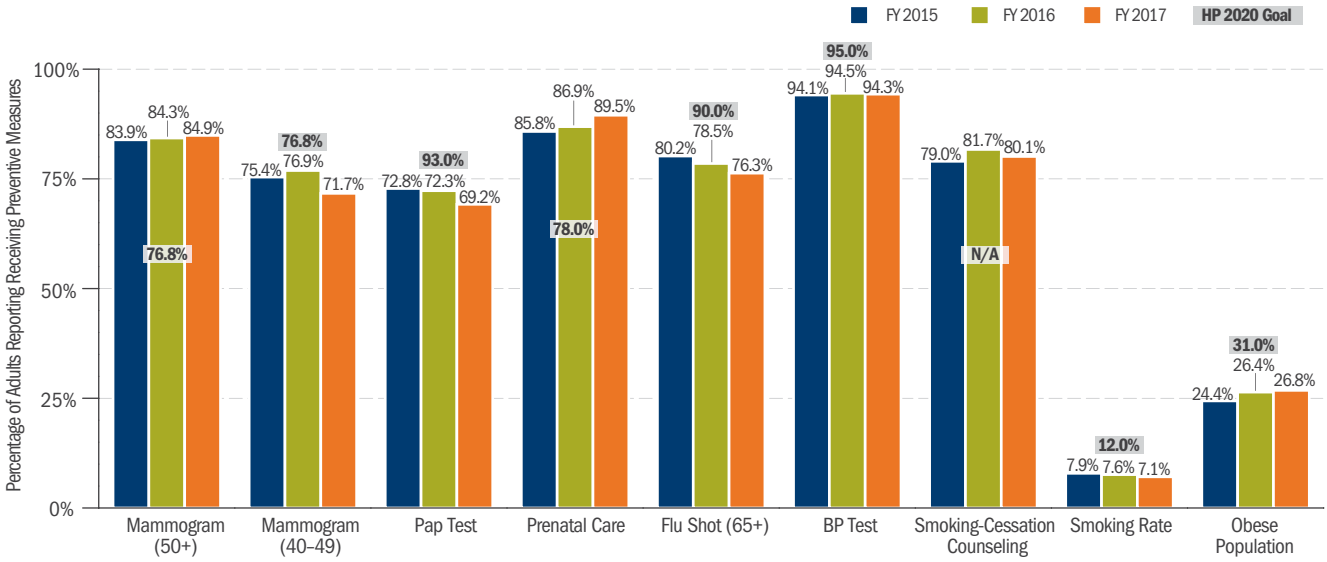
This section presents efforts toward meeting the Military Health System (MHS) aim of "Better Health," part of the Quadruple Aim, to include preventive care, population health, tobacco cessation, obesity, and condition management. This section also provides selected measures benchmarked to the Healthy People (HP) 2020 goals. The Healthy People 2020 goals are national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce those threats; these goals have been embraced by the Department of Defense (DoD).

The MHS strategic goals go beyond those for primary health and wellness. The graph on the following page reflects secondary prevention efforts via self-reported responses from all eligible MHS beneficiaries within the categories shown (e.g., all adult women for mammography, all adult pregnant women for prenatal care, etc.).

- The MHS has set as goals a subset of the health promotion and disease prevention objectives specified by the Department of Health and Human Services (DHHS) in HP 2020. Over the past three years, the MHS has exceeded targeted HP 2020 goals for providing mammograms (ages 50 and over) and prenatal care for women, as well as for rates of smoking and obesity (see notes on page 153).
- **Pap Test:** While exceeding the HP 2020 targets, the percentage of MHS female beneficiaries receiving Pap tests declined from just under 73 percent in fiscal year (FY) 2015 to just above 69 percent in FY 2017. In March 2012, the U.S. Preventive Services Task Force offered an updated "Final Recommendation Statement: Cervical Cancer Screening" (https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/cervical-cancer-screening), which may have contributed to the decline in Pap tests.
- **Tobacco Use:** The overall self-reported smoking rate among all MHS beneficiaries has declined for the past five years, decreasing from almost 15 percent in 2010 (not shown) to under 7 percent in FY 2017, five percentage points below the HP 2020 goal of 12 percent. Smoking-cessation counseling has increased slightly from 79 percent in FY 2015 to 81 percent in FY 2017.
- **Obesity:** The overall proportion of MHS beneficiaries identified as obese increased slightly from over 24 percent in FY 2015 to almost 27 percent in FY 2017. This is below the HP 2020 goal of almost 31 percent (revised from 34 percent in 2012, consistent with reporting from the National Health and Nutrition Examination Survey [NHANES]) and below the most recently identified U.S. population average of 35 percent (Centers for Disease Control and Prevention [CDC] National Center for Health Statistics, 2012; not shown). See additional charts on the following pages, which distinguish obesity rates by beneficiary category.

HEALTH PROMOTION AND DISEASE PREVENTION EFFORTS *(CONT.)*

TRENDS IN MEETING PREVENTIVE CARE STANDARDS, FYs 2015–2017



Source: DHA/SP&FI (J-5)/Decision Support Division, 2015–2017 Health Care Surveys of DoD Beneficiaries (HCSDB) http://www.tricare.mil/survey/hcsdbsurvey/home/z_reports.cfm, results provided 11/13/2017, the National Health and Nutrition Examination Survey (NHANES); CDC, National Center for Health Statistics (NCHS) http://www.healthypeople.gov/2020/Data/SearchResult.aspx?ztopicid=29&topic=Nutrition+and+Weight+Status&objective=NWS-9&anchor=141

Notes:
– Unlike the objective for all other categories, the objective for Smoking Rate and Obese Population is for actual rates to be below the HP 2020 goals.
– The goal for Prenatal Care was revised down from 90 percent in the HP 2010 goals to 77.6 percent in the HP 2020 goals.
– The goal for Obese Population was revised up from 15 percent in the HP 2010 goals to 30.5 percent in the HP 2020 goals (see http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx for more information).

MHS-TARGETED PREVENTIVE CARE MEASURES
Mammogram: Women aged 50 or older who had a mammogram in the past year; women aged 40–49 who had a mammogram in the past two years. **Pap Test:** All women who had a Pap test in the last three years. **Prenatal Care:** Women pregnant in the last year who received care in the first trimester. **Flu Shot:** People aged 65 and older who had a flu shot in the last 12 months. **Blood Pressure (BP) Test:** People who had a blood pressure check in the last two years and know the results. **Obese:** Obesity is defined as a body mass index (BMI) of 30 or above, which is calculated from self-reported data from the HCSDB. An individual's BMI is calculated using height and weight (BMI = 703 times weight in pounds, divided by height in inches squared). Although BMI is a risk measure, it does not measure actual body fat; as such, it provides a preliminary indicator of possible excess weight, which in turn provides a preliminary indicator of risk associated with excess weight. It should therefore be used in conjunction with other assessments of overall health and body fat. **Smoking-Cessation Counseling:** People advised to quit smoking in the last 12 months.

POPULATION HEALTH

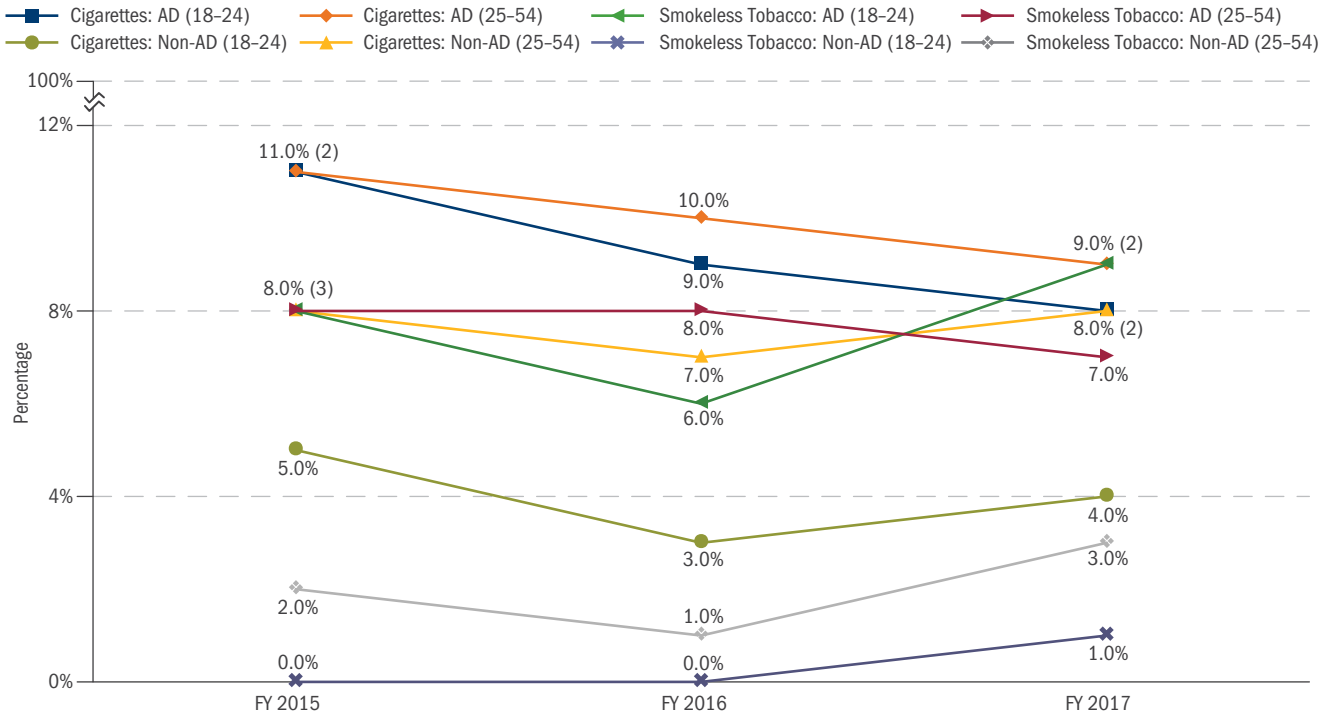
The MHS is dedicated to Population Health management and engagement. Although this concept is generally associated with managing the clinical risks associated with patients, the MHS has extended this concept to include helping the population manage their own health and creating an environment where the healthy choice is the easy choice. The MHS model continues to evolve to include strategies such as strengthening the connections between our military treatment facilities (MTFs) and Regional managed care support contractor (MCSC) engagement.

TOBACCO CESSATION

Tobacco continues to be the leading cause of preventable death, according to the CDC, and smoking rates in the military remain higher than desired. Military personnel who smoke experience reduced physical performance capability, impaired night vision, increased risk of respiratory illnesses and surgical complications, delayed wound healing, and accelerated age-related hearing loss. Furthermore, there are negative impacts on dental readiness, and long-term effects of tobacco use often include cancer, stroke, emphysema, and heart disease.

- Based on self-reported usage, cigarette smoking for Active Duty Service members (ADSMs) of all ages has continued to statistically decline over the past five years: from 16 percent in FY 2013, to 11 percent in FY 2015, to 9 percent in FY 2017 (not shown). This trend in lower Active Duty cigarette usage is most pronounced in the 18- to 24-year-old age range. Use of smokeless tobacco products by Active Duty and non-Active Duty remains lower, and has not changed from FY 2015 to FY 2017. Non-Active Duty appear to smoke cigarettes and use smokeless tobacco at lower rates than Active Duty. Active Duty and non-Active Duty rates are lower than the reported U.S. national average for smoking cigarettes (15.1 percent, reported in 2015), while the non-Active Duty smokeless tobacco rate is comparable to, or lower than, the national average (3.4 percent).

MHS CIGARETTE AND SMOKELESS TOBACCO USE RATES AMONG ACTIVE DUTY AND FAMILY MEMBERS, FYs 2015–2017

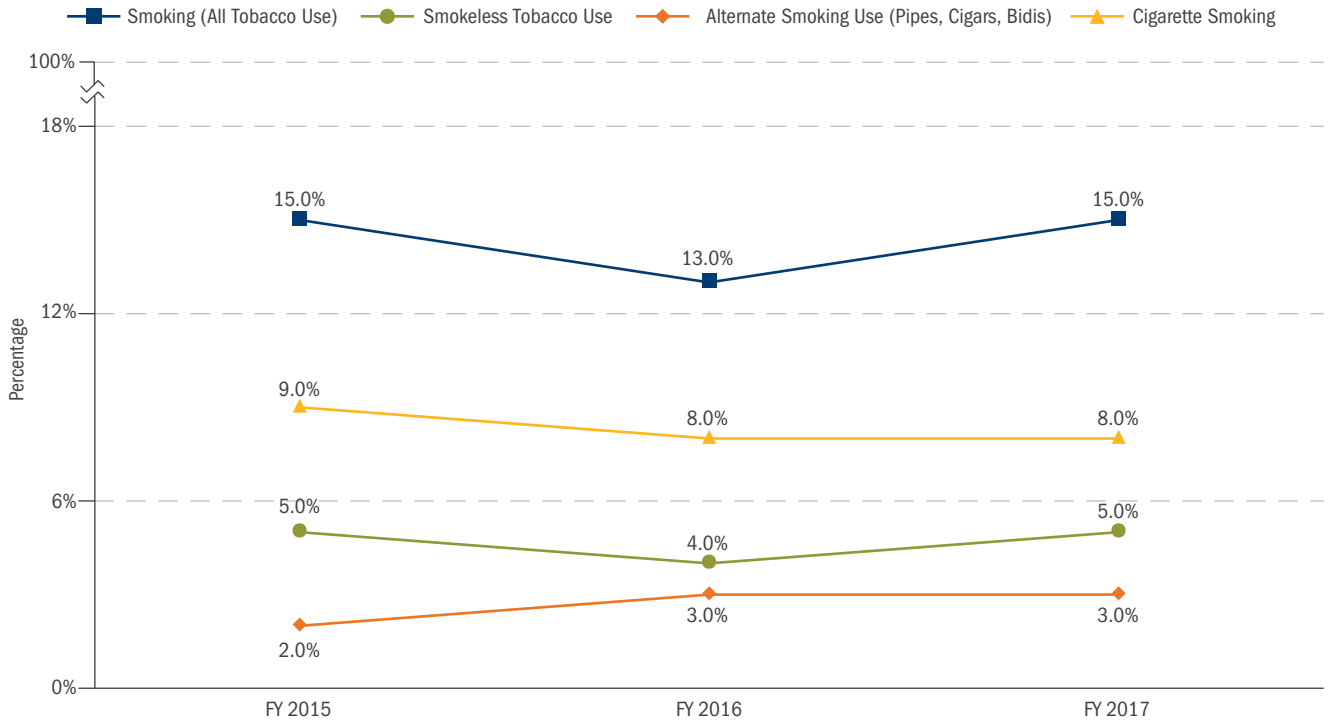


Source: DHA/SP&FI (J-5)/Decision Support Division, 2015–2017 HCSDB https://tricare.mil/survey/hcsdbsurvey/home/z_reports.cfm, results provided 11/28/2017
Notes:
– For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.
– Percentages are weighted for the probability of selection and nonresponse; variation in quarterly estimates may not be significant and should not be assumed as such without appropriate tests of significance.
– U.S. adult cigarette smoking rate of 15.1 percent from http://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/, accessed 11/28/2017
– U.S. adult smokeless tobacco rate of 3.4 percent in 2014 from http://www.cdc.gov/tobacco/data_statistics/fact_sheets/smokeless/use_us/index.htm, accessed 11/28/2017

TOBACCO CESSATION *(CONT.)*

- **MHS Prime Enrollee Use of Any Tobacco Products:** Although attention has historically been focused on cigarette smoking, the HCSDB has also been directed to assess the use of various tobacco products across MHS. The chart below presents the self-reported estimates of the prevalence of MHS Prime enrollees using different tobacco products (cigars, pipes, bidis, or kreteks). Prime enrollee use of tobacco in one form or another declined from 19 percent in FY 2013 to 15 percent in FY 2015 (shown on page 147 of last year's report), and, except for an estimated two-percentage-point dip in FY 2016, remained at 15 percent in FY 2017.
- Cigarette smoking, which is the most used form of tobacco among Prime enrollees, declined from 13 percent to 8 percent from FY 2013 to FY 2017 (but statistically has not changed over the past three years), while smokeless tobacco and alternate smoking use have remained unchanged from FY 2015 to FY 2017. Usage of various tobacco products shown in the chart is not mutually exclusive (e.g., a cigarette smoker may also report being a snuff user [smokeless tobacco] or a pipe smoker [alternate smoking tobacco]), and thus is not additive.

MHS PRIME ENROLLEE USE OF TOBACCO PRODUCTS, BY TYPE OF TOBACCO USE: CIGARETTES, ALTERNATE SMOKING TOBACCO, AND SMOKELESS TOBACCO, FYs 2015–2017



Source: DHA/SP&FI (J-5)/Decision Support Division, 2015–2017 HCSDB https://tricare.mil/survey/hcsdbsurvey/home/z_reports.cfm, results provided 11/28/2017
Notes:
– Smokeless tobacco may include dip, snuff, snuss, chew, etc., while alternate smoking tobacco may include cigars, pipes, hookahs, bidis, or kreteks.
– Percentages are weighted for the probability of selection and nonresponse; variation in quarterly estimates may not be significant and should not be assumed as such without appropriate tests of significance.

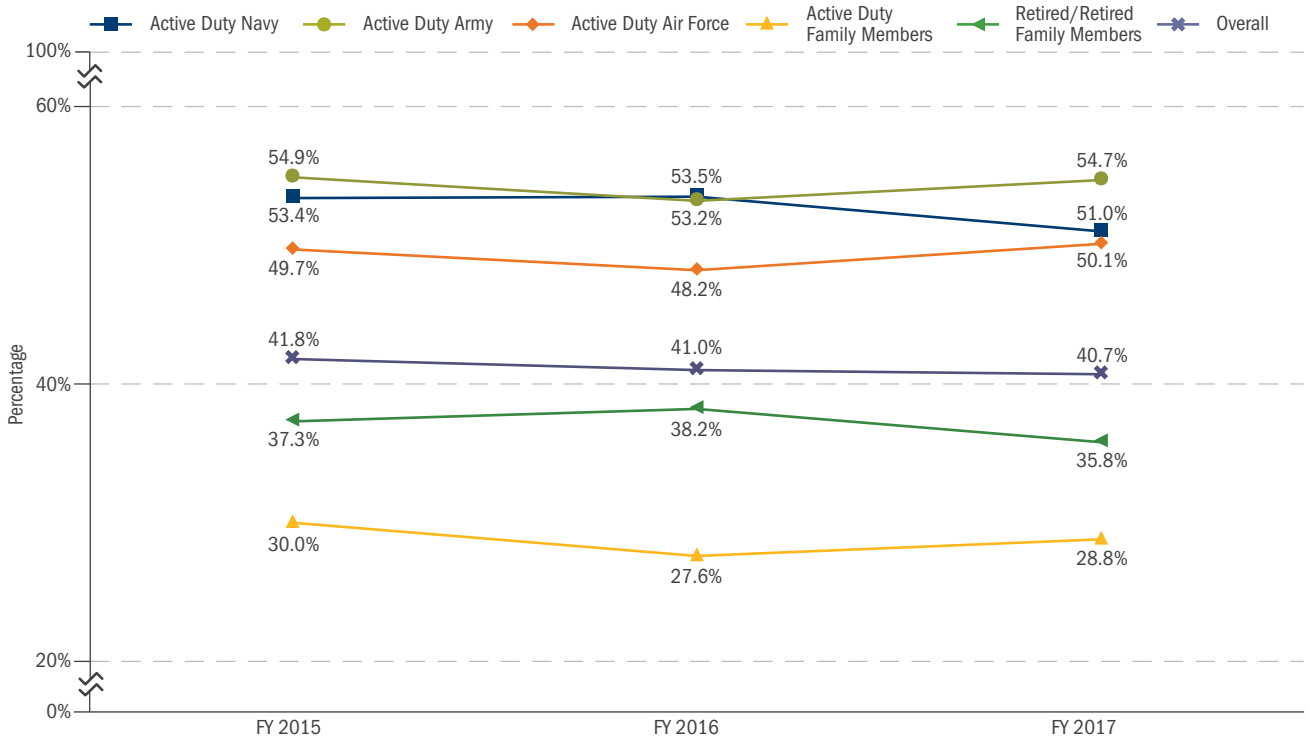
MHS ADULT OBESITY

This measure provides important information about the overall health of DoD beneficiaries for use by MHS leadership to help promote military initiatives that encourage exercise and healthy nutritional habits. These data can also shape the need for, and development of, medical interventions or modalities that are effective in maintaining healthy weights for all age groups.

The chart below displays the percentage of the population reporting in the HCSDB a height and weight that, when used in calculating BMI, result in a measurement of 30 or higher (30 is the threshold for obesity).

- As shown in the first chart below, almost 41 percent of all MHS beneficiaries were overweight in FY 2017, lower than the overall U.S. rate of 70.7 percent (CDC's NCHS 2013–2014). Active Duty family members (ADFMs), on average, have the lowest rate of being overweight (just under 29 percent), followed by the retired and their family members at almost 36 percent. Calculated BMI rates reflecting overweightness may not be reflective of Active Duty fitness without consideration of muscle mass, and may explain why Active Duty appear to have high prevalence rates of being overweight (between 50 and 55 percent) but low obesity rates (13 to 16 percent), as shown in the second chart.

MHS OVERWEIGHT RATE (BMI 25–29.9), FYs 2015–2017



Source: DHA/SP&FI (J-5)/Decision Support Division, 2015–2017 HCSDB https://tricare.mil/survey/hcsdbsurvey/home/z_reports.cfm, results provided 11/28/2017

Notes:

– BMI is defined as the individual's body weight divided by the square of his or her height. The formula universally used in medicine produces a unit of measure of kg/m^2. Because the HCSDB collects height and weight in inches and pounds, BMI is calculated as lb/in^2 x 703. A BMI of 18.5 to 25 may indicate optimal weight; a BMI lower than 18.5 suggests the person is underweight, while a number above 25 may indicate the person is overweight; a number of 30 or above suggests the person is obese (Division of Nutrition, Physical Activity and Obesity, National Center for Chronic Disease Prevention and Health Promotion, CDC).

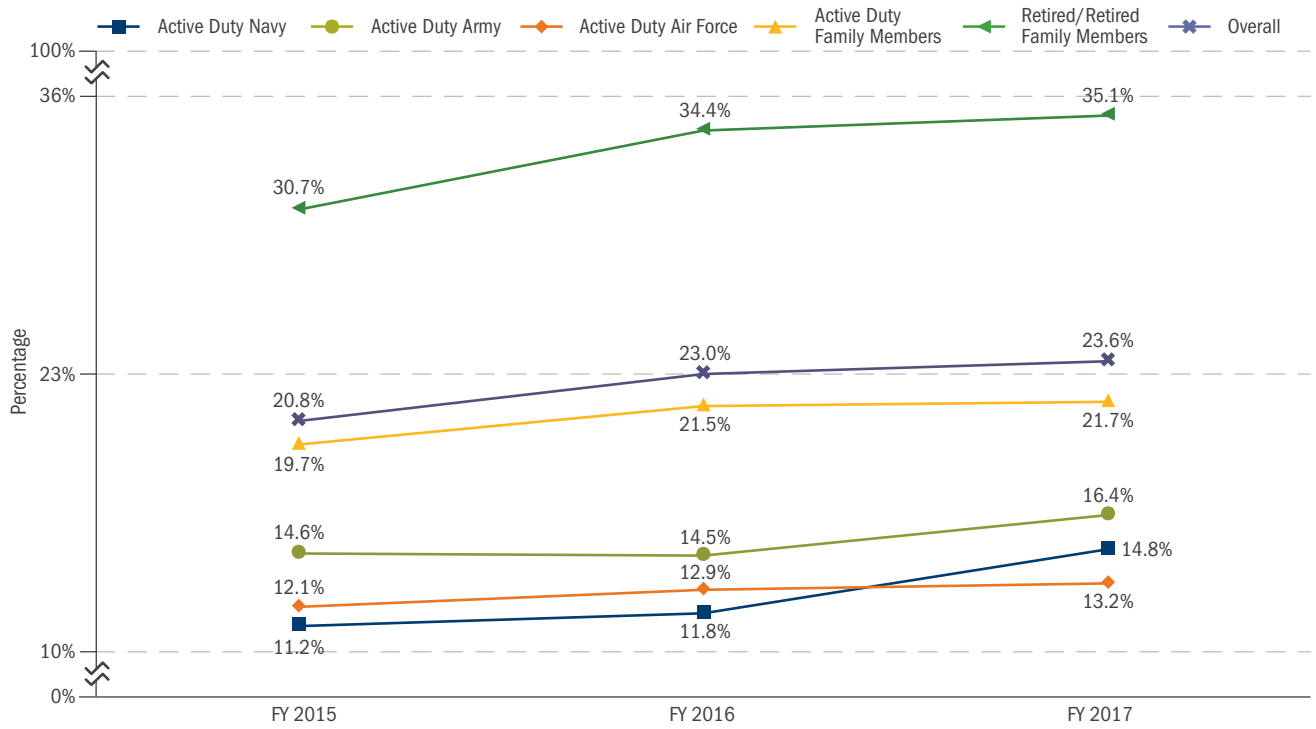
– Since the data are self-reported, they are subject to recall bias, while provider measurements are subject to instrument error (e.g., lack of calibration of weight scales) and inconsistency in recording (e.g., asking patient's height or weight versus measuring). Self-reported scores are adjusted for user characteristics that allow comparison with civilian benchmarks. No objective validation tool is used to verify accuracy of BMI results.

– CDC-reported obesity and overweight rates in U.S. adults: http://www.cdc.gov/nchs/fastats/obesity-overweight.htm, accessed 12/4/2017

- The second chart displays the prevalence of obesity in the MHS population (i.e., a calculated BMI of 30 or higher based on self-reported height and weight). Active Duty present the lowest rates (between 13 and 16 percent) in FY 2017. The overall MHS obesity rate in FY 2017 (almost 24 percent), as well as obesity rates for family members (22 percent) and the retired and their family members (35 percent), are lower than the U.S. average rate for adults aged 20 and over (38 percent) from 2013 to 2014. Overweight rates did not change appreciably from FY 2015 to FY 2017 (i.e., there was no statistically significant difference, although numerically the numbers appear different), while the obesity rate overall, and especially that of the retired and their family members, increased by about four percentage points.

MHS ADULT OBESITY *(CONT.)*

MHS OBESITY RATE (BMI 30 OR HIGHER), FYs 2015–2017



Source: DHA/SP&FI (J-5)/Decision Support Division, 2015–2017 HCSDB https://tricare.mil/survey/hcsdbsurvey/home/z_reports.cfm, results provided 11/28/2017

Notes:

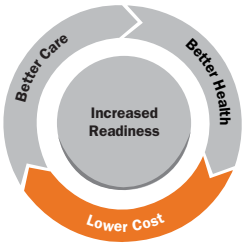
– BMI is defined as the individual's body weight divided by the square of his or her height. The formula universally used in medicine produces a unit of measure of kg/m^2. Because the HCSDB collects height and weight in inches and pounds, BMI is calculated as lb/in^2 x 703. A BMI of 18.5 to 25 may indicate optimal weight; a BMI lower than 18.5 suggests the person is underweight, while a number above 25 may indicate the person is overweight; a number of 30 or above suggests the person is obese (Division of Nutrition, Physical Activity and Obesity, National Center for Chronic Disease Prevention and Health Promotion, CDC).

– Since the data are self-reported, they are subject to recall bias, while provider measurements are subject to instrument error (e.g., lack of calibration of weight scales) and inconsistency in recording (e.g., asking patient's height or weight versus measuring). Self-reported scores are adjusted for user characteristics that allow comparison with civilian benchmarks. No objective validation tool is used to verify accuracy of BMI results.

– CDC-reported obesity and overweight rates in U.S. adults: http://www.cdc.gov/nchs/fastats/obesity-overweight.htm, accessed 12/4/2017

In an effort to capture objective administration data on obesity prevalence among the MHS population, an MHS guideline was developed to support the documentation of BMI with all direct care patient encounters. This documentation is intended to support the capture of information concerning the overall health of DoD beneficiaries for use by MHS leadership to help promote military initiatives that encourage exercise and healthy nutritional habits. These data can also shape the need for, and development of, medical interventions or modalities that are effective in maintaining healthy weights for all age groups.

SAVINGS AND RECOVERIES



Pharmacy Retail Refunds

The District Court's 2008 decision granted the Department of Defense (DoD) the authority to require refunds from drug manufacturers, a decision upheld by the U.S. Court of Appeals in 2013. Due to enhancements in the Retail Refund Calculation process and improvements in communication of eligible products among drug manufacturers, the Department of Veterans Affairs (VA), and the DoD, utilization data/refund recalculations were performed to ensure accuracy of the data reported to drug manufacturers, as well as refunds due to the DoD, since the inception of the U.S. Court of Appeal's Final Rule. Recalculations were conducted for calendar year (CY) 2009 Q3 through CY 2011 Q4 bill quarters during fiscal year (FY) 2013 and FY 2014.

There are two main drivers for the decline in rebates on retail drugs: (1) the implementation of the maintenance drugs benefit program produced the desired results in influencing beneficiaries to purchase maintenance drugs through mail order rather than retail pharmacies, and (2) many drugs included under the TRICARE Retail Refund Program have patents expiring and therefore are no longer included in the program.

PHARMACY RETAIL REFUNDS ($ MILLIONS), FYs 2013–2017

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Total Receivables	$1,491.06	$1,319.28	$1,068.04	$929.44	$850.71
Routine	$1,370.80	$1,280.96	$1,068.04	$929.44	$850.71
Additional from Recalculations (CY 2009 Q3–CY 2011 Q4)	$120.26	$38.32	–	–	–
Total Collections	$2,359.77	$1,496.25	$1,117.14	$982.73	$847.40

Source: DHA/R&M (J-1/J-8)/Contract Resource Management, 11/20/2017
Notes: Refund amounts are netted out of pharmacy costs provided within this report. The refunds in the table above are categorized in the FY they were validated and billed to the drug manufacturers.

Program Integrity Activities

The Defense Health Agency (DHA) Office of Program Integrity (PI) is responsible for health care antifraud to safeguard beneficiaries and protect benefit dollars. DHA PI develops and executes antifraud and abuse policies and procedures, provides oversight of contractor PI activities, coordinates investigative activities, develops cases for criminal prosecutions and civil litigations, and initiates administrative measures. Through a Memorandum of Understanding, DHA PI refers its fraud cases to the Defense Criminal Investigative Services. DHA PI also coordinates investigative activities with Military Criminal Investigative Offices, as well as other federal, state, and local agencies.

PROGRAM INTEGRITY RECOVERIES/COST AVOIDANCE ($ MILLIONS), CYs 2014–2016

	CY 2014	CY 2015	CY 2016
Total Recoveries	$21.6	$70.0	$104.9
Court-Ordered Fraud Judgments/ Settlements	$15.5	$61.2	$92.7
PI Contractor Administrative Recoupment/Offsets (Received)	$6.1	$8.8	$12.2
Total PI Contractors Cost Avoidance	$18.1	$34.2	$33.0
Contractor Prepayment Reviews	$17.7	$33.5	$31.9
Excluded Providers	$0.4	$0.7	$1.1

Source: DHA/R&M (J-1/J-8)/Contract Resource Management, 11/20/2017
Notes: TRICARE Program Integrity Operational Reports and Quarterly Fraud and Abuse Reports, CY 2013–CY 2016. CY 2016 data are latest reported as of 10/18/2017. Refund amounts are netted out of pharmacy costs provided within this report. The refunds in the table above are categorized in the FY they were validated and billed to the drug manufacturers.

Program Savings and Claim Recoveries

New reimbursement approaches are continually evaluated for potential savings to TRICARE. As new programs are established, savings are estimated and monitored.

Claim recoveries result from identified overpayments adjusted in TRICARE Encounter Data (TED), and the differences are recouped.

Recovery A—Post-Payment Duplicate Claim Recoveries: A post-payment duplicate claims system was developed by the DHA Healthcare Operations Directorate/TRICARE Health Plan Division for use by TRICARE purchased care contractors. The system was designed as a retrospective auditing tool and facilitates the identification of actual duplicate claim payments and the initiation and tracking of recoupments. The table below provides the historical recovery of duplicate claims payments. Duplicate claim recoveries are consistent with previous years.

RECOVERIES ($ MILLIONS), FYs 2015–2017

	FY 2015	FY 2016	FY 2017
Recovery A—Post-Payment Duplicate Claim Recoveries	$7.4	$6.8	$7.1

SAVINGS AND RECOVERIES *(CONT.)*

Recovery B—Improper Payment Recoveries: The DHA is vigilant in ensuring the accuracy of health care claims payment within the military health benefits program. The DHA has contracted with an external independent contractor (EIC) who is responsible for conducting post-payment accuracy reviews of TRICARE health benefit claims. The EIC is responsible for identifying improper payment made by TRICARE purchased care contractors as a result of contractor noncompliance with TRICARE policy, benefit, and/or reimbursement requirements.

OVERPAYMENTS RECAPTURED THROUGH PAYMENT RECAPTURE AUDITS ($ MILLIONS), FY 2016

PROGRAM OR ACTIVITY	ACTUAL OVERPAYMENT DOLLARS IDENTIFIED VIA RANDOM SAMPLES	TOTAL AMOUNT EXTRAPOLATED (ESTIMATED THROUGHOUT TOTAL OUTLAYS)	AMOUNT RECAPTURED[a] (ACTUAL REFUNDS)
Total	$6.1	$128.00	$285.59

Sources: DHA/R&M (J-1/J-8)/Trust Fund and Revenue Cycle Management Improper Payment Evaluation Branch, 11/20/2017: Operational Reports and Quarterly Fraud and Abuse Reports

[a] "Amount Recaptured" represents dollars paid back to the DHA throughout FY 2016. These refunds include overpayments identified in FY 2016 audits as well as refunds occurring in the course of routine claim adjustments (for claims initially paid in FY 2016 and other fiscal years). Refunds for Active Duty Dental Program (ADDP) claims are also included in "Amount Recaptured."

In addition to the EIC post-payment reviews, DHA requires TRICARE purchased care contractors to use industry best business practice when processing TRICARE claims. Contractors are required to use claims auditing software and develop prepayment initiatives that are manual and/or automated to avoid or prevent improper payments. The above table provides FY 2016 improper payment recoveries of health care as a result of the EIC compliance reviews and ongoing purchased care contractor efforts to identify and recover improper payments.

INPATIENT UTILIZATION RATES AND COSTS

TRICARE Inpatient Utilization Rates Compared with Civilian Benchmarks (U.S. Only)

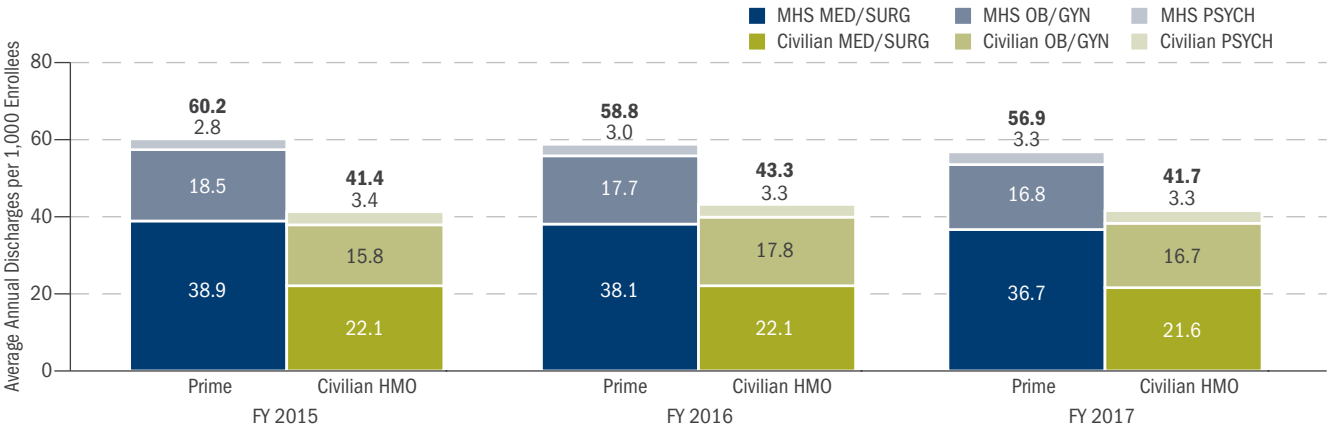
TRICARE Prime Enrollees

This section compares the inpatient utilization of TRICARE Prime enrollees with that of enrollees in civilian employer-sponsored health maintenance organization (HMO) plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. Inpatient utilization is measured as the total number of dispositions (i.e., the sum of direct and purchased care dispositions) because relative weighted products (RWPs) are not available in the civilian-sector data.

Dispositions are computed for three broad product lines—obstetrics/gynecology (OB/GYN), mental health (PSYCH), and other medical/surgical (MED/SURG)—and compared for acute care facilities only. The comparisons exclude beneficiaries age 65 and older because very few are covered by employer-sponsored plans. The Military Health System (MHS) data further exclude beneficiaries enrolled in the Uniformed Services Family Health Plan (USFHP) and TRICARE Plus.

- TRICARE Prime inpatient utilization rates declined by 5 percent between FY 2015 and FY 2017, while the civilian HMO rates increased by 1 percent. In FY 2017, the TRICARE Prime inpatient utilization rate (direct and purchased care combined) was 37 percent higher than the civilian HMO utilization rate (56.9 discharges per 1,000 Prime enrollees compared with 41.7 per 1,000 civilian HMO enrollees).
- In FY 2017, the TRICARE Prime inpatient utilization rate was 70 percent higher than the civilian HMO rate for MED/SURG procedures, 1 percent higher for OB/GYN procedures, and the same for PSYCH procedures.
- The average length of stay (LOS) for MHS Prime enrollees (direct and purchased care combined) increased slightly from 3.2 days in FY 2015 to 3.3 days in FY 2017, whereas the average LOS for civilian HMO enrollees remained about the same at 3.6 days. In FY 2017, the average LOS for MHS Prime enrollees was 9 percent lower than that of civilian HMO enrollees (not shown).

INPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK, FYs 2015–2017



Sources: MHS administrative data, 1/22/2018, and Truven Health Analytics Inc., MarketScan® Commercial Claims and Encounters (CCAE) database, 12/5/2017

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2017 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

– Numbers may not sum to bar totals due to rounding.

LOWER COST

INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

TRICARE Inpatient Utilization Rates Compared with Civilian Benchmarks (U.S. Only) *(Cont.)*

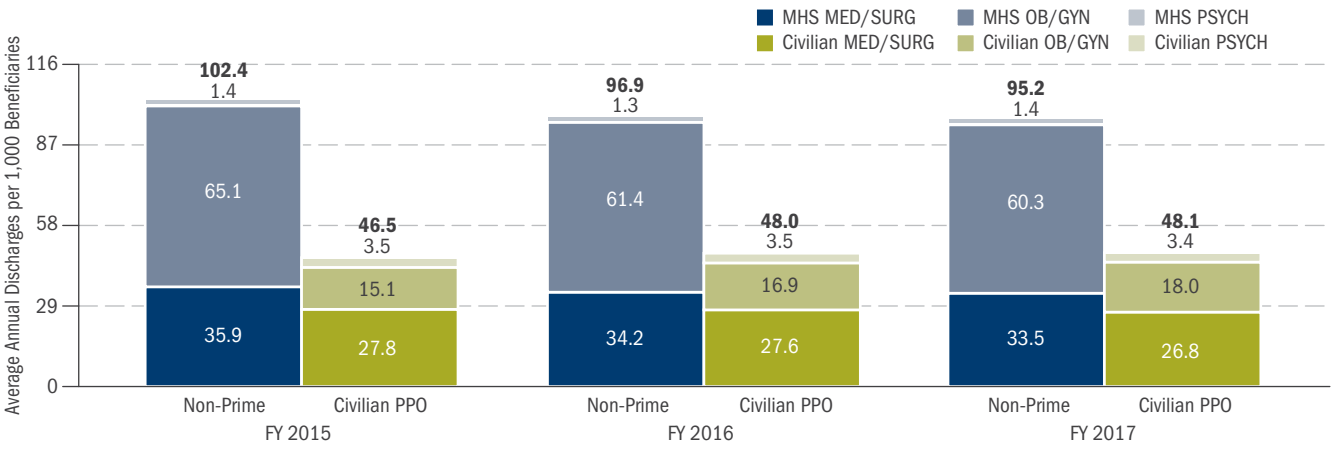
Non-Enrolled Beneficiaries

This section compares the inpatient utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored preferred provider organization (PPO) plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. Inpatient utilization is measured as the total number of dispositions (i.e., the sum of direct and purchased care dispositions) because RWPs are not available in the civilian-sector data.

Dispositions are computed for three broad product lines—OB/GYN, PSYCH, and other MED/SURG procedures—and compared for acute care facilities only. The comparisons exclude beneficiaries age 65 and older because very few are covered by employer-sponsored plans. To make the utilization rates of MHS and civilian beneficiaries more comparable, non-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Although most beneficiaries who fail to file a TRICARE claim have private health insurance, we estimate that about 17 percent do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable with the civilian rates, which also include non-users.

- Between FY 2015 and FY 2017, the TRICARE non-Prime utilization rate decreased by 7 percent, whereas the civilian PPO inpatient utilization rate increased by 4 percent. Despite trending in opposite directions, the TRICARE rate remains well above the civilian benchmark. In FY 2017, the inpatient utilization rate (direct and purchased care combined) for non-enrolled beneficiaries was almost double that of civilian PPO participants.
- By far the largest discrepancy in utilization rates between the MHS and the private sector is for OB/GYN procedures. From FY 2015 to FY 2017, the MHS OB/GYN disposition rate decreased by 7 percent, whereas it increased by 19 percent in the civilian sector. In FY 2017, the MHS non-Prime OB/GYN disposition rate was more than triple that of the corresponding civilian PPO rate.
- Of the three product lines considered in this report, only PSYCH procedures had lower utilization in the MHS than in the civilian sector.
- The average LOS for MHS non-enrolled beneficiaries (direct and purchased care combined) remained at about 3.5 days between FY 2015 and FY 2017, whereas the average LOS for civilian PPO participants declined slightly from 3.6 to 3.5 days. As a result, the average LOS for MHS non-Prime beneficiaries was 2 percent higher than that of civilian PPO participants in FY 2017 (not shown).

INPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK, FYs 2015–2017



Sources: MHS administrative data, 1/22/2018, and Truven Health Analytics Inc., MarketScan® CCAE database, 12/5/2017
Notes:
– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2017 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.
– Numbers may not sum to bar totals due to rounding.

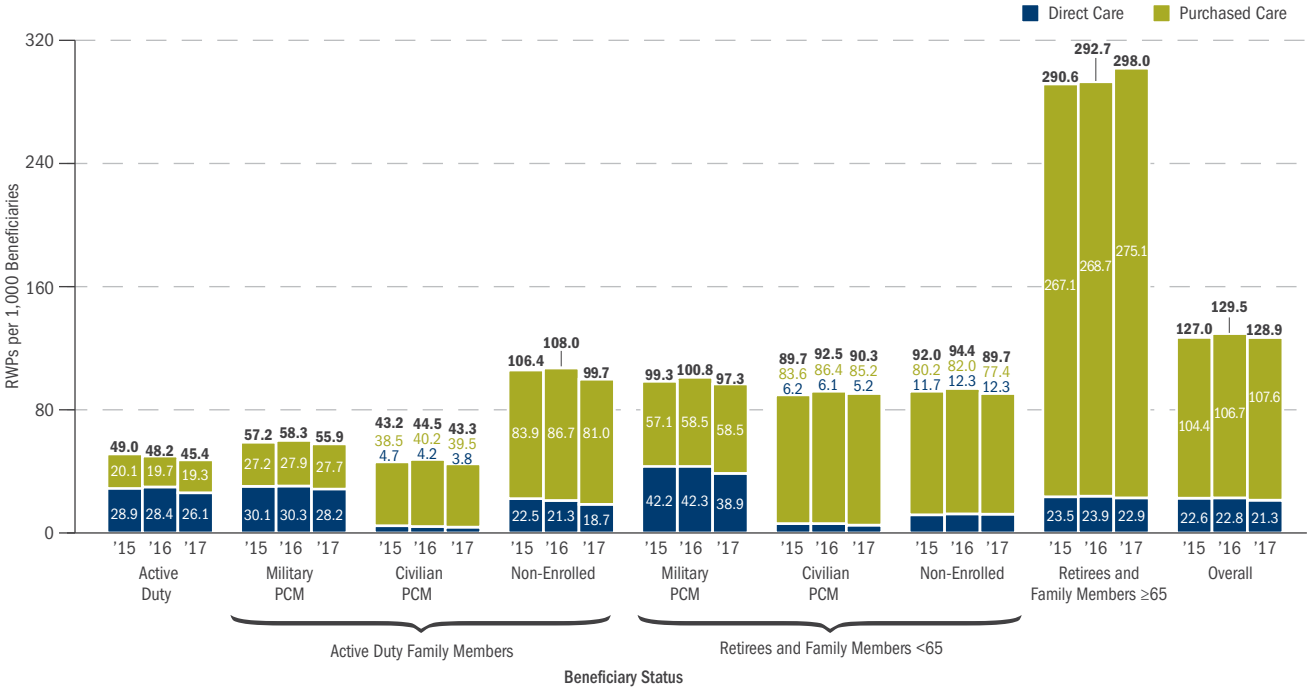
INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Inpatient Utilization Rates by Beneficiary Status (U.S. Only)

When breaking out inpatient utilization by beneficiary group, RWPs per capita more accurately reflect differences across beneficiary groups than do discharges per capita. MHS RWPs are based on the Medicare Severity Diagnosis Related Group (MS-DRG) system of classifying inpatient hospital cases under the Medicare Prospective Payment System and are relevant only for acute care hospitals.

- The overall (direct and purchased care combined) inpatient utilization rate (RWPs per 1,000 beneficiaries) increased by 2 percent from FY 2015 to FY 2017.
- Between FY 2015 and FY 2017, the direct care inpatient utilization rate decreased by 5 percent overall, due in part to the downsizing of four military hospitals to clinics over that time period. Beneficiaries with a civilian PCM experienced the largest declines (20 percent for Active Duty family members [ADFMs] and 16 percent for retirees and family members [RETFMs] under 65), but direct care utilization by those groups is relatively small. The only group with an increase in utilization was non-enrolled RETFMs under 65 (5 percent).
- The overall purchased acute care inpatient utilization rate increased by 3 percent. Non-enrolled beneficiaries (both ADFMs and RETFMs) experienced modest declines of 4 percent, whereas the remaining beneficiary groups experienced modest increases of 2–3 percent.
- Excluding Medicare-eligible beneficiaries (for whom Medicare is likely their primary source of care and TRICARE is second payer), the percentage of per capita inpatient workload performed in purchased care facilities remained at about 71 percent from FY 2015 to FY 2017.
- From FY 2015 to FY 2017, the percentage of per capita inpatient workload referred to the network on behalf of beneficiaries enrolled with a military primary care manager (PCM; including Active Duty personnel) rose from 49 to 52 percent.

AVERAGE ANNUAL INPATIENT RWPs PER 1,000 BENEFICIARIES, FYs 2015–2017



Source: MHS administrative data, 1/22/2018

Notes:

– Numbers may not sum to bar totals due to rounding.

– The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere.

LOWER COST

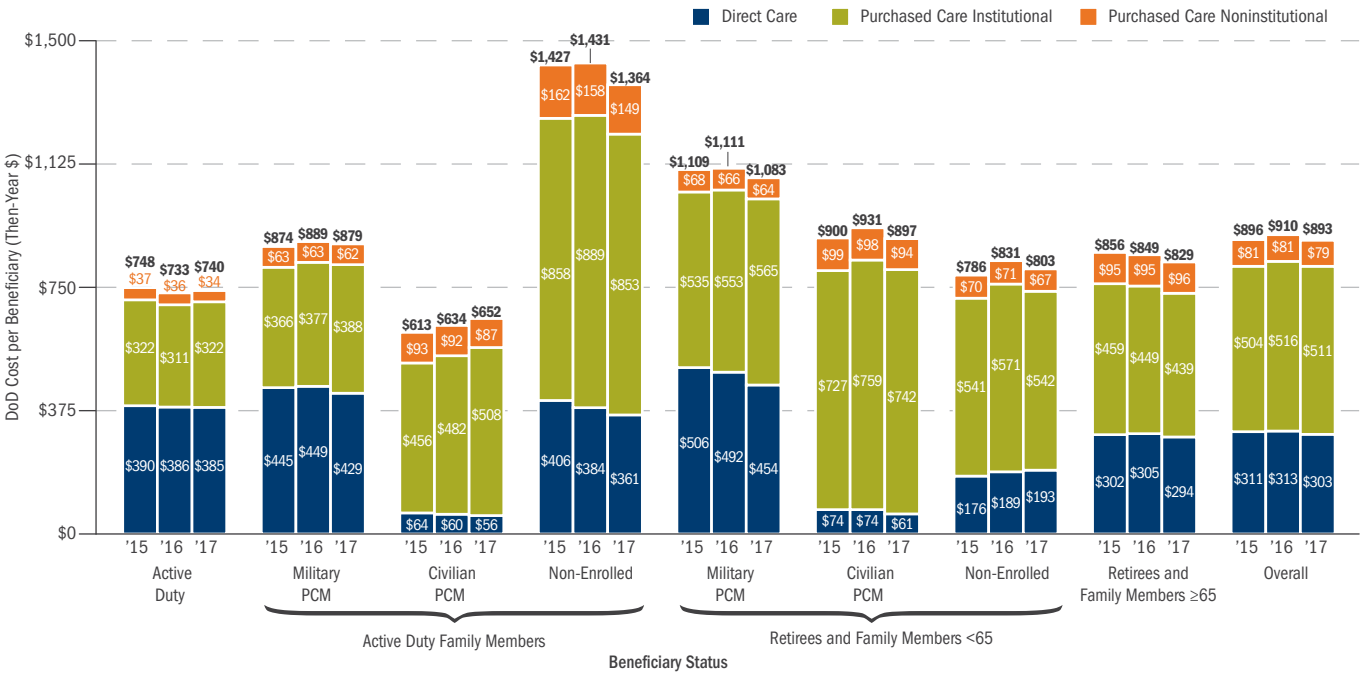
INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Inpatient Cost by Beneficiary Status (U.S. Only)

MHS costs for inpatient care include costs incurred in both acute and non-acute care facilities. They also include the cost of inpatient professional services (i.e., noninstitutional charges [e.g., physician, lab, anesthesia]) associated with a hospital stay. The overall MHS inpatient cost (in then-year dollars) per beneficiary (far-right columns below), including TRICARE for Life (TFL), remained about the same between FY 2015 and FY 2017.

- All beneficiary groups except ADFMs with a civilian PCM experienced modest changes (±0–4 percent) in total (direct plus purchased) per capita inpatient costs. ADFMs with a civilian PCM experienced a 6 percent increase.
- Direct care inpatient costs per capita decreased by 3 percent between FY 2015 and FY 2017. Purchased care inpatient costs (institutional plus noninstitutional) per capita increased by 1 percent over the same period.
- The direct care cost per RWP increased from $13,785 in FY 2015 to $14,196 in FY 2017 (3 percent).
- Exclusive of TFL, DoD purchased care cost (institutional plus noninstitutional) per RWP in acute care facilities increased from $7,354 in FY 2015 to $7,450 in FY 2017 (1 percent).
- The DoD purchased care cost per RWP is much lower than that for direct care partly because some beneficiaries (e.g., retirees) have substantial cost shares and may also have other health insurance (OHI). When beneficiaries have OHI, TRICARE becomes second payer, and the government pays a smaller share of the cost. If OHI claims are excluded, the DoD cost per RWP in acute care facilities increased slightly from $8,845 in FY 2015 to $8,873 in FY 2017, exclusive of TFL.
- Note: The reader should exercise caution when comparing the direct versus purchased care costs per RWP. The data on this page are unadjusted for differences in beneficiary mix, enrollment status, geographical location of care, etc. They represent DoD health care costs only, and specifically exclude beneficiary cost shares, administrative, and overhead expenses.

AVERAGE ANNUAL DoD INPATIENT COSTS PER BENEFICIARY, FYs 2015–2017



Source: MHS administrative data, 1/22/2018

Notes:

– Numbers may not sum to bar totals due to rounding.

– The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere.

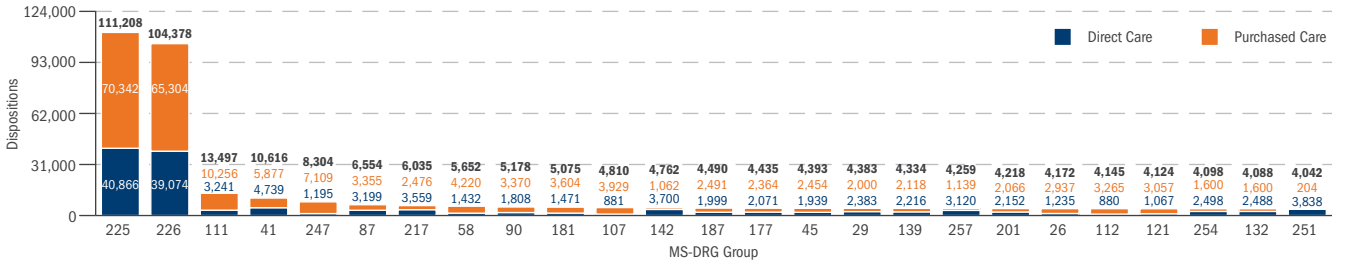
INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Leading Inpatient Diagnosis Groups (U.S. Only)

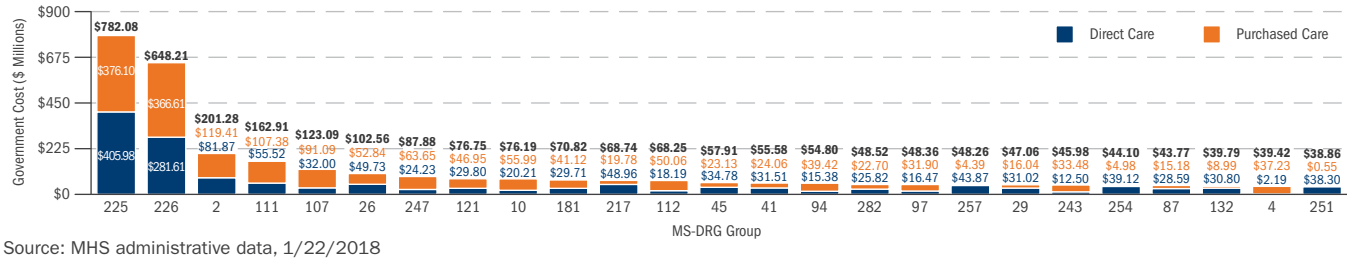
The MHS uses the MS-DRG system to classify acute care hospital inpatient cases into clinically related categories having similar treatment costs. For the purpose of this section, MS-DRGs exhibiting variations in complications and comorbidities were grouped into like categories[1] and numbered sequentially. The category numbers have no significance other than to identify the DRG groups on the horizontal axes in the charts below. See the Appendix for additional detail on the DRG grouping methodology.

The top 25 MS-DRG groups in terms of volume in FY 2017 accounted for 66 percent of all inpatient admissions (direct care and purchased care combined) in acute care hospitals. The leading MS-DRG groups in terms of cost in FY 2017 include both institutional and noninstitutional claims (i.e., they include hospital, attendant physician, drug, and ancillary service charges). The top 25 MS-DRG groups in terms of cost in FY 2017 accounted for 58 percent of total inpatient costs (direct and purchased care combined) in acute care hospitals. TFL admissions and observation stays are excluded from the calculations for both volume and cost.

LEADING INPATIENT DIAGNOSIS GROUPS BY VOLUME, FY 2017



LEADING INPATIENT DIAGNOSIS GROUPS BY COST, FY 2017



Source: MHS administrative data, 1/22/2018

MS-DRG Groups

2	ECMO (Extracorporeal Membrane Oxygenation) or Tracheostomy
4	Bone Marrow Transplant
10	Craniotomy
26	Major Small and Large Bowel Procedures
29	Appendectomy
41	Esophagitis, Gastroenteritis, and Miscellaneous Digestive Disorders
45	Cholecystectomy
58	Seizures and Headaches
87	Simple Pneumonia and Pleurisy
90	Bronchitis and Asthma
94	Cardiac Valve and Other Major Cardiothoracic Procedures
97	Coronary Bypass
107	Spinal Fusion Except Cervical
111	Major Joint Replacement or Reattachment of Lower Extremity
112	Cervical Spinal Fusion
121	Percutaneous Cardiovascular Procedures with Coronary Artery Stent
132	Heart Failure and Shock
139	Cardiac Arrhythmia and Conduction Disorders
142	Chest Pain
177	Cellulitis
181	O.R. Procedures for Obesity
187	Nutritional and Miscellaneous Metabolic Disorders
201	Kidney and Urinary Tract Infections
217	Uterine and Adnexal Procedures for Non-Malignancy
225	Pregnancy, Childbirth, and the Puerperium
226	Newborns and Other Neonates with Conditions Originating in Perinatal Period
243	Infectious and Parasitic Diseases with O.R. Procedure
247	Septicemia or Severe Sepsis
251	Neuroses Except Depressive
254	Psychoses
257	Alcohol/Drug Abuse or Dependence
282	Extensive O.R. Procedure Unrelated to Principle Diagnosis

- The top two procedures by volume are related to childbirth, accounting for 42 percent of all hospital admissions and 27 percent of total hospital costs (not just among the top 25).
- Procedures performed in private-sector acute care hospitals account for 61 percent of the total volume of the top 25 MS-DRG groups and 54 percent of the total cost.
- Admissions in direct care facilities exceed those in purchased care facilities for only nine of the top 25 MS-DRG groups. However, expenditures in direct care facilities exceed those in purchased care facilities for 11 of the top 25 MS-DRG groups.
- Surgical procedures for obesity rank 10th in both volume and cost among the top 25 MS-DRG groups. Thus, the obesity epidemic in the civilian sector appears to be mirrored to an extent in the DoD population as well.

[1] DRGs were grouped into like categories using a code set available on www.findacode.com/code-set.php?set=DRG, an online database of medical billing codes and information. The site lists surgical and medical DRGs within each Major Diagnostic Category (MDC) with headings above diagnostically related DRGs. In some cases (e.g., DRGs related to pregnancy and childbirth) the headings were further grouped into larger, descriptively similar categories. The headings were then sequentially numbered, providing the basis for the DRG grouping methodology.

Note: Numbers may not sum to bar totals due to rounding.

OUTPATIENT UTILIZATION RATES AND COSTS

TRICARE Outpatient Utilization Rates Compared with Civilian Benchmarks (U.S. Only)

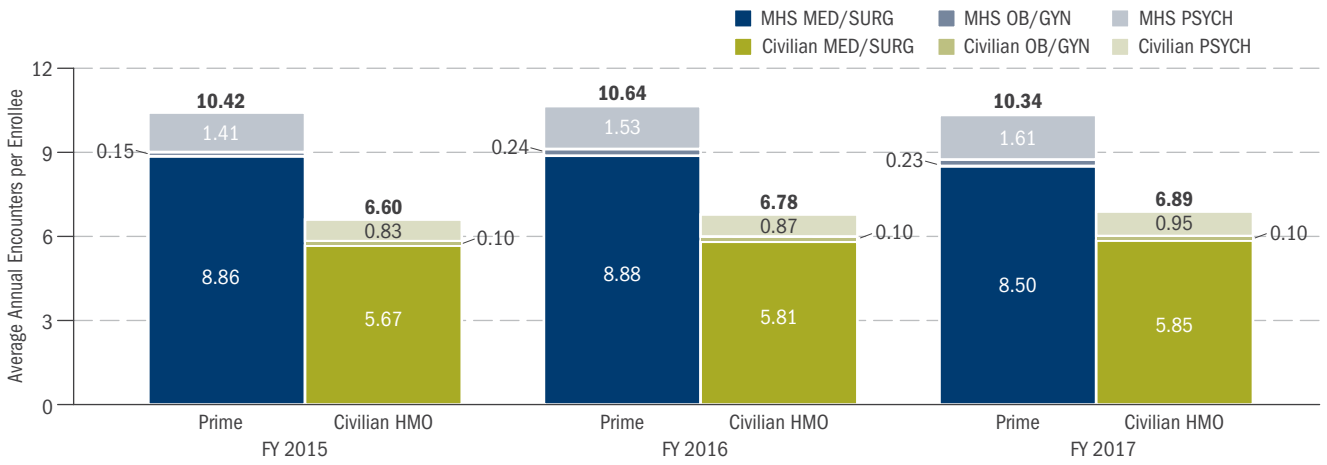
TRICARE Prime Enrollees

This section compares the outpatient utilization of TRICARE Prime enrollees with that of enrollees in civilian employer-sponsored HMO plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. Outpatient utilization is measured in terms of encounters because the civilian-sector data used in the comparisons do not contain a measure of relative value units (RVUs). However, there is no fixed definition for what constitutes a "face-to-face" encounter with a physician. TRICARE and the private sector may therefore use varying methodologies to calculate the number of encounters.

Encounters are computed for three broad product lines: OB/GYN, PSYCH, and other MED/SURG procedures. The comparisons are made for beneficiaries under age 65 only. The MHS data exclude beneficiaries enrolled in the USFHP and TRICARE Plus. Because telephone consults are routinely recorded in direct care data, but appear very infrequently in private-sector claims, they are also excluded from the direct care utilization computations.

- The overall TRICARE Prime outpatient utilization rate (direct and purchased care combined) decreased by 1 percent between FY 2015 and FY 2017. The civilian HMO outpatient utilization rate increased by 4 percent over the same period.
- In FY 2017, the overall Prime outpatient utilization rate was 50 percent higher than the civilian HMO rate.
- In FY 2017, the Prime outpatient utilization rate for MED/SURG procedures was 45 percent higher than the civilian HMO rate.
- The Prime outpatient utilization rate for OB/GYN procedures increased by 54 percent[1] between FY 2015 and FY 2016 (albeit from a low base rate). As a result, the Prime outpatient OB/GYN utilization rate was more than double that for civilian HMOs in FY 2017, but the disparity is due in part to how the direct care system records global procedures.[2]
- The Prime outpatient utilization rate for PSYCH procedures was 70 percent higher than the corresponding rate for civilian HMOs in FY 2017. This disparity, though based on relatively low MHS and civilian mental health utilization rates, may reflect the more stressful environment that many Active Duty Service members (ADSMs) and their families endure.

OUTPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK, FYs 2015–2017



Sources: MHS administrative data, 1/22/2018, and Truven Health Analytics Inc., MarketScan® CCAE database, 12/5/2017

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2017 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

[1] The large increase in OB/GYN encounters in FY 2016 is due almost exclusively to the conversion from the ICD-9-CM coding system to the more specific and detailed ICD-10-CM system.

[2] Outpatient encounters are not precisely comparable between the direct and private care sectors (including purchased care). In particular, services that are bundled in the private sector (such as newborn delivery, including prenatal and postnatal care) will not generate any outpatient encounters but will generate a record for each encounter in the direct care system. Because maternity care is a high-volume procedure, the disparity in utilization rates between the direct care and civilian systems will be exaggerated.

OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

TRICARE Outpatient Utilization Rates Compared with Civilian Benchmarks (U.S. Only) *(Cont.)*

Non-Enrolled Beneficiaries

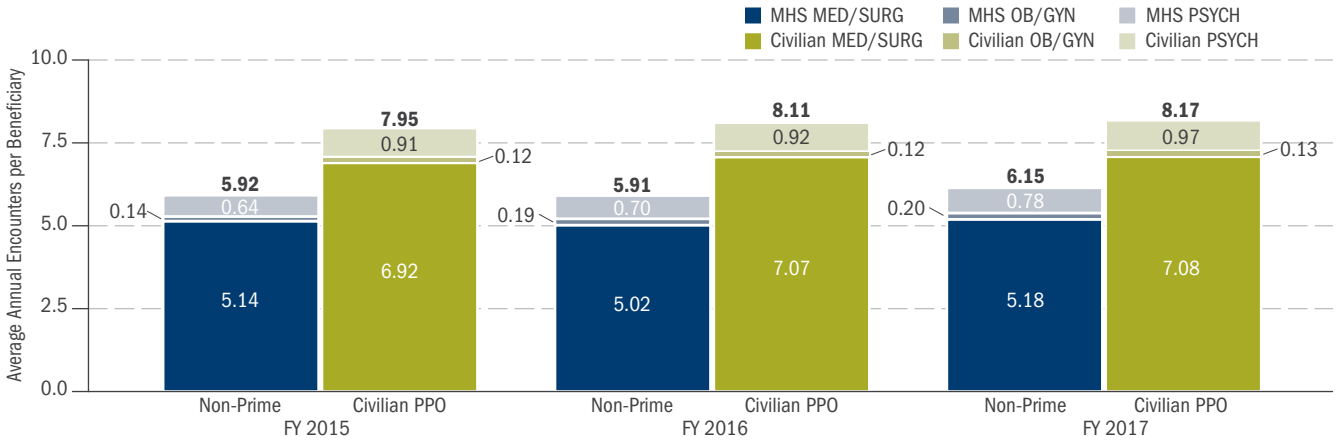
This section compares the outpatient utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored PPO plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. Outpatient utilization is measured in terms of encounters because the civilian-sector data used in the comparisons do not contain a measure of RVUs. However, there is no fixed definition for what constitutes a "face-to-face" encounter with a physician. TRICARE and the private sector may therefore use varying methodologies to calculate the number of encounters.

Encounters are computed for three broad product lines: OB/GYN, PSYCH, and other MED/SURG. The comparisons are made for beneficiaries under age 65 only. To make the utilization rates of MHS and civilian beneficiaries more comparable, non-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Because telephone consults are routinely recorded in direct care data, but appear very infrequently in private-sector claims, they are also excluded from the direct care utilization computations. Although most beneficiaries who fail to file a TRICARE claim have private health insurance, we estimate that about 17 percent do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable to the civilian rates, which also include non-users.

- The overall TRICARE non-Prime outpatient utilization rate (direct and purchased care combined) for non-enrolled beneficiaries increased by 4 percent between FY 2015 and FY 2017. The civilian PPO outpatient utilization rate increased by 3 percent over the same period.
- The overall TRICARE non-Prime (space-available and Standard/Extra) outpatient utilization rate remained well below the level observed for civilian PPOs. In FY 2017, TRICARE non-Prime outpatient utilization was 26 percent lower than in civilian PPOs.
- In FY 2017, the non-Prime outpatient utilization rate for MED/SURG procedures was 25 percent lower than the civilian PPO rate. MED/SURG procedures account for almost 90 percent of total outpatient utilization in both the military and private sectors.
- The non-Prime outpatient utilization rate for OB/GYN procedures increased by 37 percent between FY 2015 and FY 2017. As a result, the MHS OB/GYN rate was 56 percent higher than the rate for civilian PPO participants in FY 2017.[1]
- The PSYCH outpatient utilization rate of non-enrolled MHS beneficiaries increased by 22 percent from FY 2015 to FY 2017; the rate increased by 6 percent for civilian PPO participants. In FY 2017, the PSYCH outpatient utilization rate for non-enrolled beneficiaries was 19 percent below that of civilian PPO participants. The latter observation, together with the utilization exhibited by Prime enrollees, suggests that MHS beneficiaries in need of extensive PSYCH counseling (primarily ADSMs and their families) are more likely to enroll in Prime.

LOWER COST

OUTPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK, FYs 2015–2017



Sources: MHS administrative data, 1/22/2018, and Truven Health Analytics Inc., MarketScan® CCAE database, 12/5/2017
Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2017 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.
[1] The numbers on the chart are the same when rounded to two digits but are slightly different when not rounded.

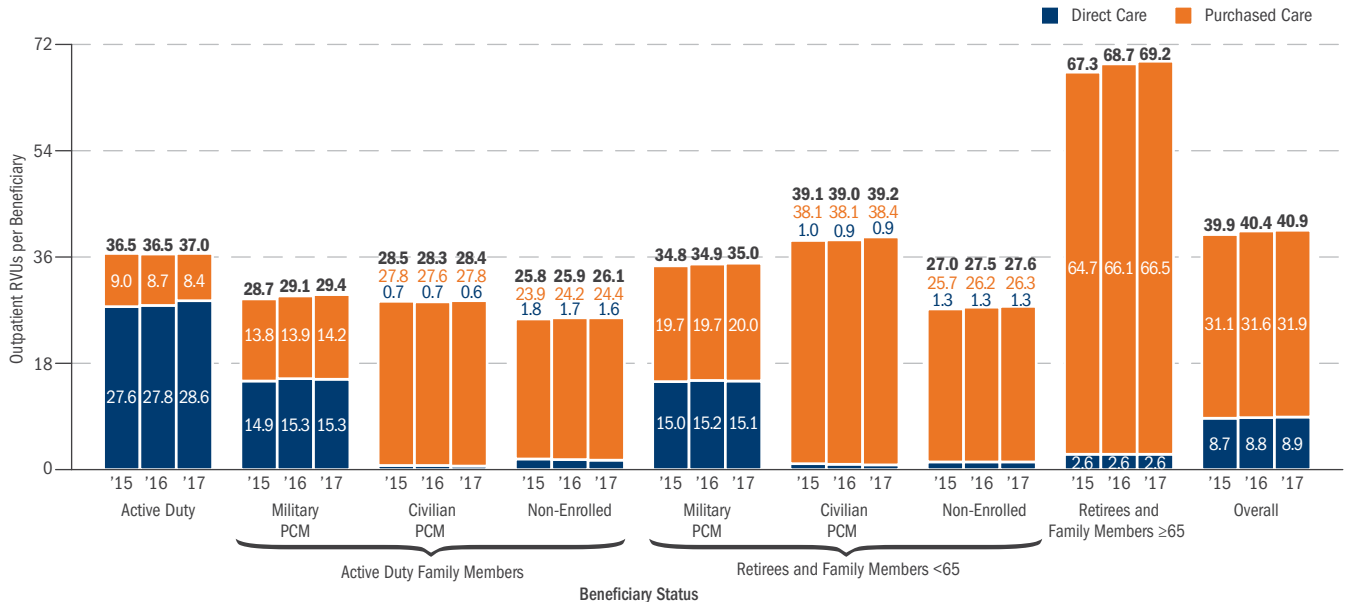
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Outpatient Utilization Rates by Beneficiary Status (U.S. Only)

When breaking out outpatient utilization by beneficiary group, RVUs per capita more accurately reflect differences across beneficiary groups than encounters per capita. The RVU measure used in this report is the sum of the Physician Work and Practice Expense RVUs (see the Appendix for a detailed description of the Physician Work and Practice Expense RVU measures). In FY 2016, some enhancements were made to the RVU measure that resulted in a slightly lower direct care RVU total and a substantially higher purchased care RVU total. The changes were retrofit to earlier years of data so that RVUs are measured consistently over time.

- Total per capita MHS utilization (direct plus purchased care) increased by 3 percent from FY 2015 to FY 2017.
- Overall direct care outpatient utilization increased by 3 percent from FY 2015 to FY 2017. While large percentage declines were experienced by ADFMs with a civilian PCM (14 percent), non-enrolled ADFMs (12 percent), and RETFMs under 65 with a civilian PCM (13 percent), their utilization of direct care is very low compared with other beneficiary groups. With the exception of non-enrolled RETFMs under 65 (no change), the remaining beneficiary groups experienced modest increases in utilization (1–4 percent).
- From FY 2015 to FY 2017, purchased care outpatient utilization increased by 3 percent overall. All beneficiary groups except Active Duty (6 percent decline) experienced modest increases in utilization (0–3 percent).
- The TFL outpatient utilization rate increased by 3 percent from FY 2015 to FY 2017.

AVERAGE ANNUAL OUTPATIENT RVUs PER BENEFICIARY, FYs 2015–2017



Source: MHS administrative data, 1/22/2018

Notes:

– Numbers may not sum to bar totals due to rounding.

– The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere.

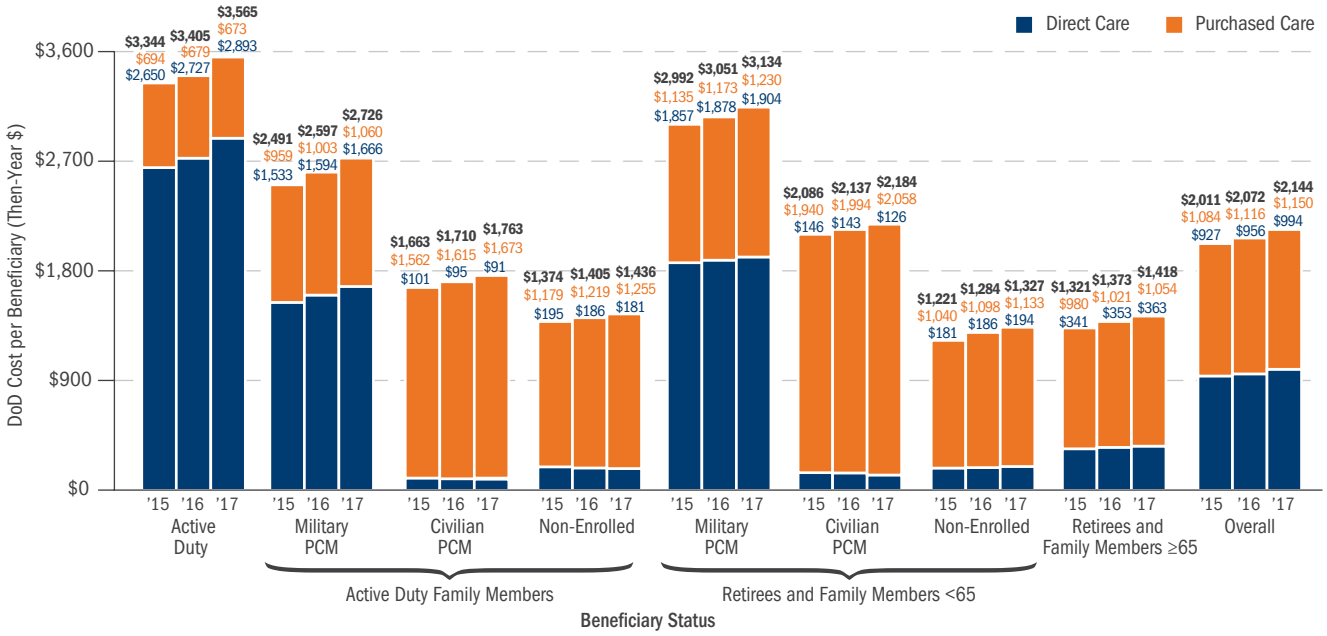
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Outpatient Costs by Beneficiary Status (U.S. Only)

Overall MHS outpatient costs (in then-year dollars) per beneficiary (far-right columns below), including TFL, increased by 7 percent from FY 2015 to FY 2017. This outpaced the rise in overall outpatient utilization (3 percent).

- The direct care cost per beneficiary increased by 7 percent overall from FY 2015 to FY 2017. Active Duty and ADFMs with a military PCM experienced the largest increases, both at 9 percent. Seniors and non-enrolled RETFMs under 65 experienced increases of 7 percent, whereas ADFMs and RETFMs under 65 with a civilian PCM experienced large percentage declines (10 and 14 percent, respectively).
- Excluding TFL, the per capita DoD purchased care outpatient cost increased for all beneficiary groups except Active Duty. Increases ranged from 7 percent for non-enrolled ADFMs to 11 percent for ADFMs with a military PCM.
- The TFL outpatient cost per beneficiary increased by 7 percent between FY 2015 and FY 2017.[1]

AVERAGE ANNUAL DoD OUTPATIENT COSTS PER BENEFICIARY, FYs 2015–2017



Source: MHS administrative data, 1/22/2018

Notes:

– Numbers may not sum to bar totals due to rounding.

– The "Retirees and family members" groups include survivors and others not explicitly identified elsewhere.

[1] The basis for this statement is the collection of stacked bars labeled "Retirees and Family Members ≥65." Although the vast majority of TFL-eligible beneficiaries are retirees and family members ≥65, there is a small number who are not.

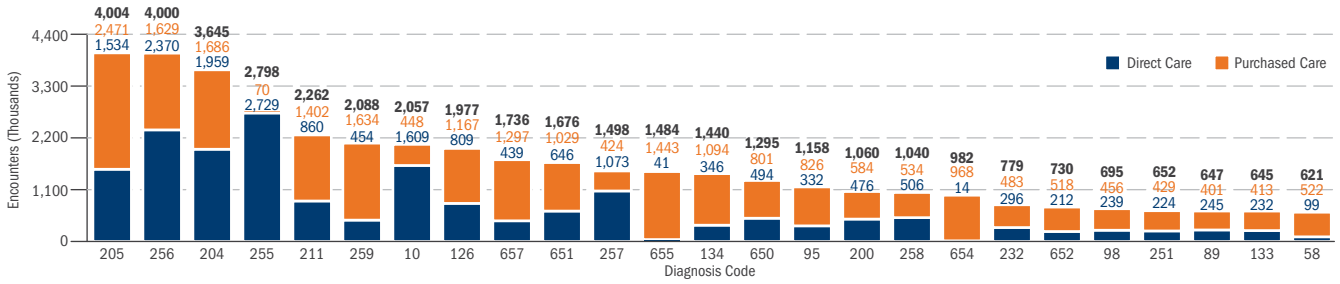
LOWER COST

OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

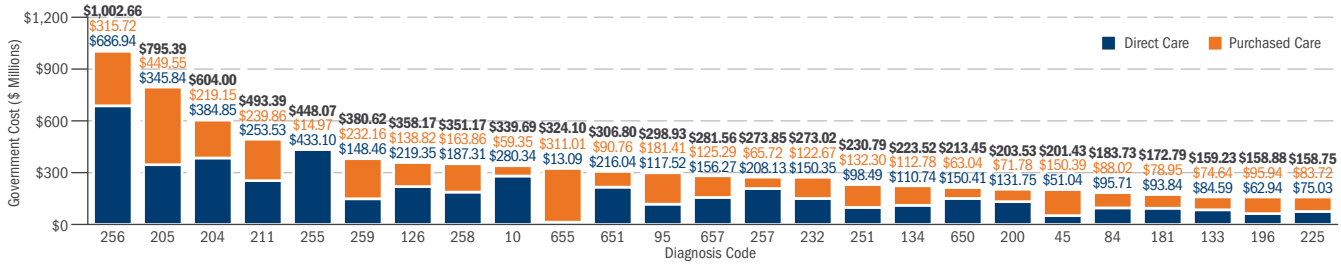
Leading Outpatient Diagnosis Groups (U.S. Only)

Leading outpatient diagnoses were determined by grouping ICD-10-CM primary diagnosis codes into like categories using the Clinical Classifications Software tool developed through a Federal-State-Industry partnership and sponsored by the Agency for Healthcare Research and Quality.[1] The top 25 outpatient diagnosis groups in FY 2017 accounted for 65 percent of all outpatient encounters (direct care and purchased care combined) and 54 percent of total outpatient costs.[2] Direct care drug expenses, which are included in outpatient costs in the direct care administrative data, are excluded from the cost totals in this section. TFL encounters and telephone consults are excluded from the calculations for both volume and cost.

LEADING OUTPATIENT DIAGNOSIS GROUPS BY VOLUME, FY 2017



LEADING OUTPATIENT DIAGNOSIS GROUPS BY COST, FY 2017



Source: MHS administrative data, 1/22/2018

Diagnosis Codes

10 Immunizations and Screening for Infectious Disease
45 Maintenance Chemotherapy; Radiotherapy
58 Other Nutritional, Endocrine, and Metabolic Disorders
84 Headache, Including Migraine
89 Blindness and Vision Defects
95 Other Nervous System Disorders
98 Essential Hypertension
126 Other Upper Respiratory Infections
133 Other Lower Respiratory Disease
134 Other Upper Respiratory Disease
181 Other Complications of Pregnancy and/or Delivery
196 Normal Pregnancy and/or Delivery
200 Other Skin Disorders
204 Other Non-Traumatic Joint Disorders
205 Spondylosis; Intervertebral Disc Disorders; Other Back Problems
211 Other Connective Tissue Disease
225 Joint Disorders and Dislocations; Trauma-Related
232 Sprains and Strains
251 Abdominal Pain
255 Administrative/Social Admission
256 Medical Examination/Evaluation
257 Other Aftercare
258 Other Screening for Suspected Conditions (Not Mental Disorders or Infectious Disease)
259 Residual Codes; Unclassified
650 Adjustment Disorders
651 Anxiety Disorders
652 Attention-Deficit, Conduct, and Disruptive Behavior Disorders
654 Developmental Disorders
655 Disorders Usually Diagnosed in Infancy, Childhood, or Adolescence
657 Mood Disorders

- The top six diagnostic groups in terms of volume are the same as those in terms of cost, albeit in different orders. The top three diagnosis groups by both volume and cost are general health examinations (adults and children), intervertebral disc disorders, and other non-traumatic joint disorders.
- Diagnoses treated in purchased care facilities account for 56 percent of the total volume of the top 25 diagnosis groups and 44 percent of the total cost.
- Encounters in direct care facilities exceed those in purchased care facilities for only five of the 25 top diagnosis groups. However, expenditures in direct care facilities exceed those in purchased care facilities for 16 of the top 25 diagnosis groups.

[1] The MHS began using the ICD-10-CM coding system for the first time in FY 2016. The analogous charts in reports prior to FY 2016 were based on the ICD-9-CM coding system.

[2] All costs were aggregated based on the primary diagnosis. Although some costs may be attributable to additional diagnoses on the record, there is no easy way to allocate the total cost to multiple diagnoses on the same record.

Note: Numbers may not sum to bar totals due to rounding.

PRESCRIPTION DRUG UTILIZATION RATES AND COSTS

TRICARE Prescription Drug Utilization Rates Compared with Civilian Benchmarks (U.S. Only)

Prescription utilization is difficult to quantify since prescriptions come in different forms (e.g., liquid or pills), quantities, and dosages. Moreover, home delivery and military treatment facility (MTF) prescriptions can be filled for up to a 90-day supply, whereas retail prescriptions are usually based on 30-day increments for copay purposes. Prescription counts from all sources (including civilian) were normalized by dividing the total days supply for each by 30 days.

Direct care pharmacy data differ from private-sector claims in that they include over-the-counter medications. To make the utilization rates of MHS and civilian beneficiaries more comparable, over-the-counter medications were backed out of the direct care data using factors provided by the DHA Pharmacy Operations Division.

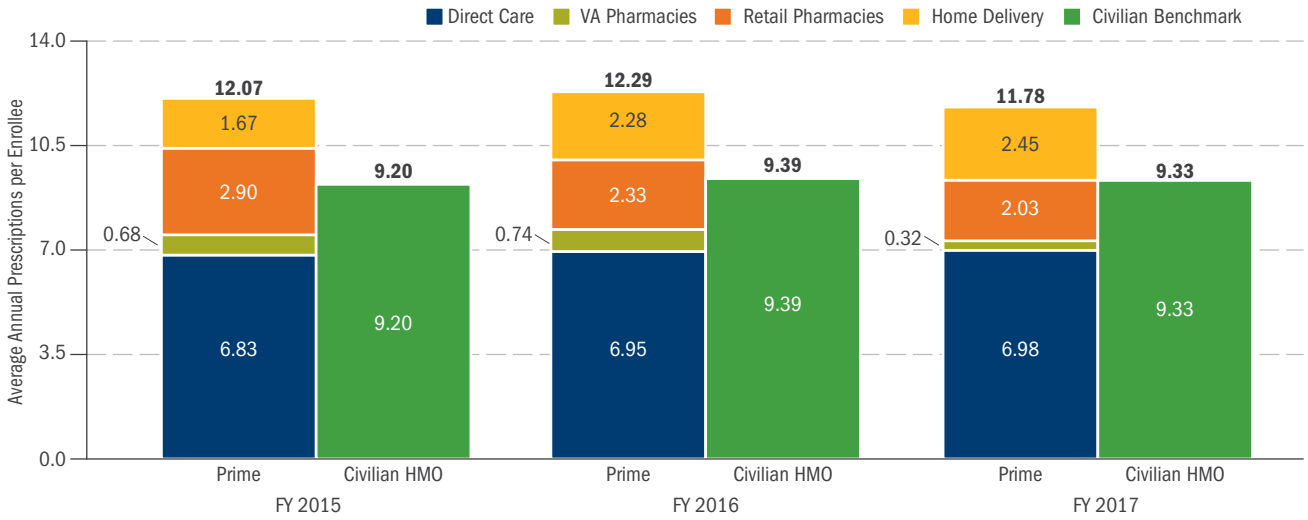
TRICARE Prime Enrollees

This section compares the outpatient prescription drug utilization of TRICARE Prime enrollees with that of enrollees in civilian employer-sponsored HMO plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. To give a more complete picture of total prescription drug utilization by TRICARE beneficiaries, prescriptions filled at VA pharmacies as part of a beneficiary's VA benefit (and paid for by VA) are included. Prescriptions filled at VA pharmacies under the TRICARE benefit have always been included with retail pharmacy prescriptions. Comparisons are made for beneficiaries under age 65 only. The MHS data exclude beneficiaries enrolled in the USFHP and TRICARE Plus.

- The overall prescription utilization rate (direct care, VA, and purchased care combined) for TRICARE Prime enrollees decreased by 2 percent between FY 2015 and FY 2017, while the civilian HMO benchmark rate rose by 1 percent. In FY 2017, the TRICARE Prime prescription utilization rate was 26 percent higher than the civilian HMO rate.
- Prescription utilization rates for Prime enrollees at DoD pharmacies rose by 2 percent between FY 2015 and FY 2017, whereas the utilization rate at retail pharmacies decreased by 30 percent (due largely to greater reliance on home delivery prescriptions).
- Although the number of prescriptions is small, prescription utilization rates for Prime enrollees at VA pharmacies declined by 53 percent between FY 2015 and FY 2017.[1]
- Home delivery prescription utilization has been on the upswing ever since the DoD began increasing the disparity in copayments between retail and home delivery drugs in FY 2012. Between FY 2015 and FY 2017, enrollee home delivery prescription utilization increased by 47 percent. In FY 2017, home delivery accounted for 55 percent of per capita purchased care prescription utilization by Prime enrollees (as measured by 30-day supply).

LOWER COST

PRESCRIPTION UTILIZATION RATES BY SOURCE OF CARE[a]: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK, FYs 2015–2017



Sources: MHS administrative data, 1/22/2018, and Truven Health Analytics Inc., MarketScan® CCAE database, 12/5/2017

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2017 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

[a] Source of care (direct, VA, retail, or home delivery) is based solely on where the prescriptions were filled, not on where the prescribing services were provided.

[1] A possible explanation for the precipitous drop in VA prescription utilization is the extension of the Veterans' Choice program in FY 2017. The Choice program allows veterans facing lengthy wait times at VA facilities or living more than 40 miles from the nearest VA facility to seek care in the private sector. A Choice program provider can issue a prescription for up to a 14-day supply of a National Formulary drug, which can be filled at any non-VA pharmacy and be reimbursed by VA.

PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT.)*

TRICARE Prescription Drug Utilization Rates Compared with Civilian Benchmarks U.S. Only *(Cont.)*

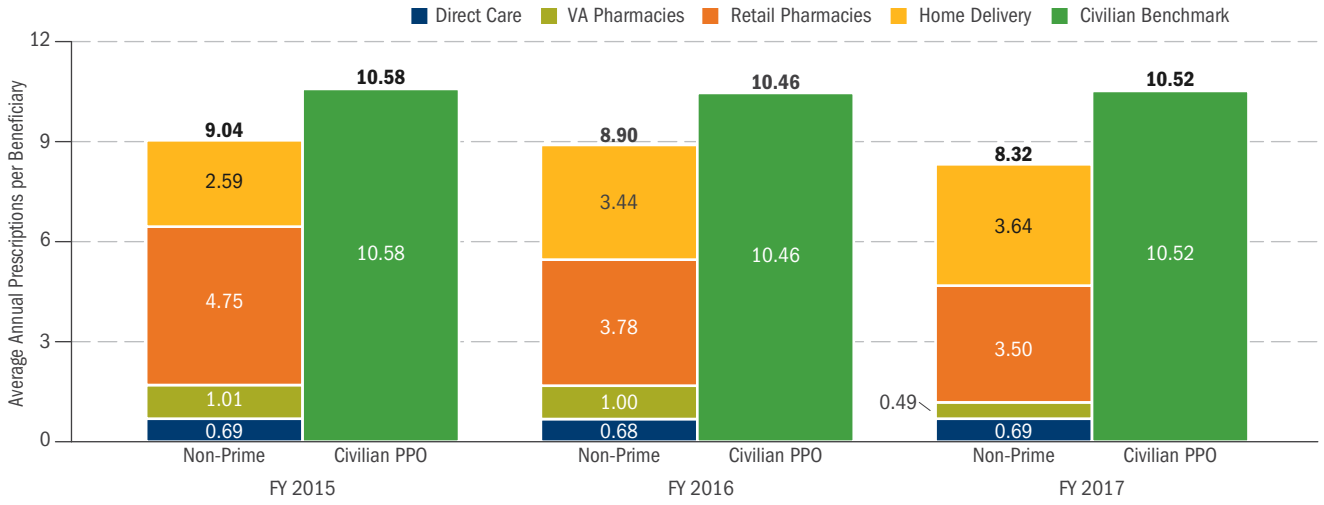
Non-Enrolled Beneficiaries

This section compares the outpatient prescription drug utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored PPO plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. To give a more complete picture of total prescription drug utilization by TRICARE beneficiaries, prescriptions filled at VA pharmacies as part of a beneficiary's VA benefit (and paid for by VA) are included. Prescriptions filled at VA pharmacies under the TRICARE benefit have always been included with retail pharmacy prescriptions. The comparisons are made for beneficiaries under age 65 only.

To make the utilization rates of MHS and civilian beneficiaries more comparable, non-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Although most beneficiaries who fail to file a TRICARE claim have private health insurance, we estimate that about 17 percent do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable to the civilian rates, which also include non-users.

- The overall prescription utilization rate (direct care, VA, and purchased care combined) for non-enrolled beneficiaries fell by 8 percent between FY 2015 and FY 2017. During the same period, the civilian PPO benchmark rate fell by 1 percent. In FY 2017, the TRICARE prescription utilization rate for non-enrollees was 21 percent lower than the civilian PPO rate.
- The direct care prescription utilization rate for non-enrolled beneficiaries remained the same from FY 2015 to FY 2017, whereas the utilization rate at retail pharmacies decreased by 26 percent (largely because of greater reliance on home delivery services).
- Prescription utilization rates for non-Prime enrollees at VA pharmacies decreased by 52 percent between FY 2015 and FY 2017.[1]
- Home delivery prescription utilization has been on the upswing ever since the DoD began increasing the disparity in copayments between retail and home delivery drugs in FY 2012. Non-enrollee home delivery prescription utilization increased by 41 percent from FY 2015 to FY 2017. In FY 2017, home delivery accounted for 51 percent of per capita purchased care prescription utilization by non-enrollees.

PRESCRIPTION UTILIZATION RATES BY SOURCE OF CARE[a]: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK, FYs 2015–2017



Sources: MHS administrative data, 1/22/2018, and Truven Health Analytics Inc., MarketScan® CCAE database, 12/5/2017

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2017 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

[a] Source of care (direct, VA, retail, or home delivery) is based solely on where the prescriptions were filled, not on where the prescribing services were provided.

[1] A possible explanation for the precipitous drop in VA prescription utilization is the extension of the Veterans' Choice program in FY 2017. The Choice program allows veterans facing lengthy wait times at VA facilities or living more than 40 miles from the nearest VA facility to seek care in the private sector. A Choice program provider can issue a prescription for up to a 14-day supply of a National Formulary drug, which can be filled at any non-VA pharmacy and be reimbursed by VA.

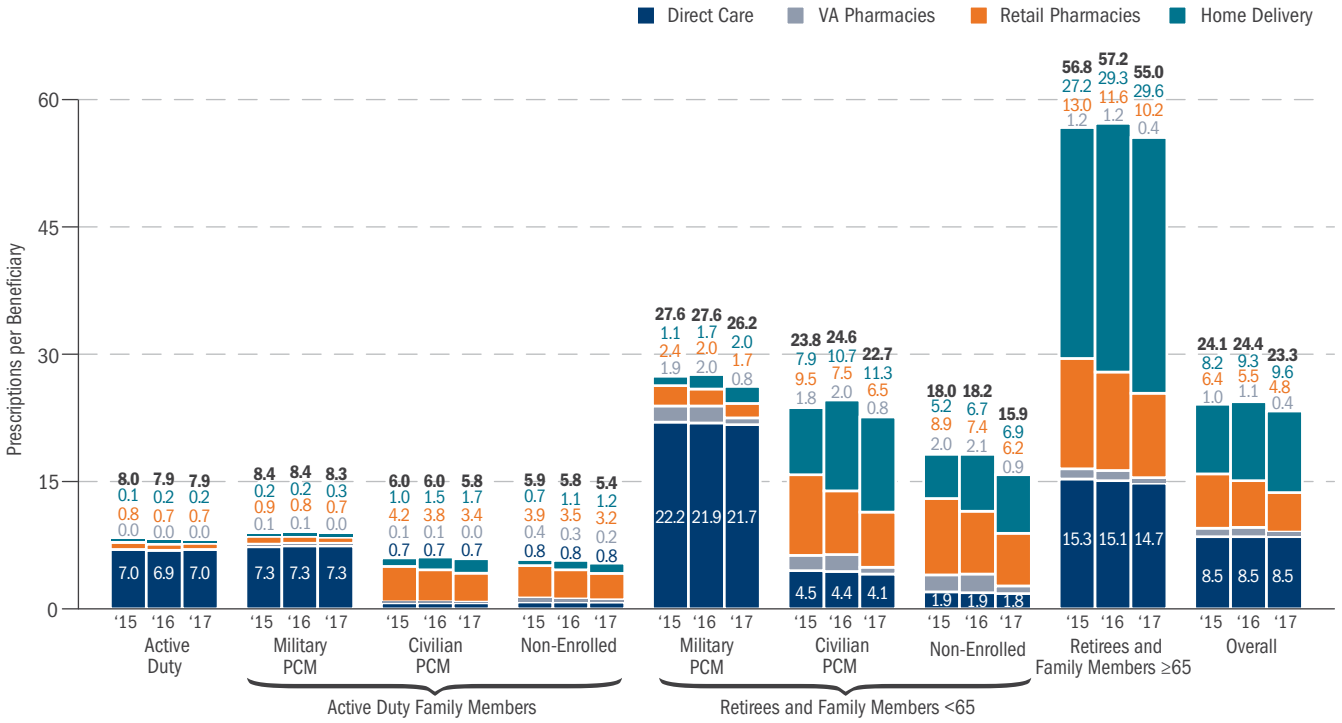
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT.)*

TRICARE Prescription Drug Utilization Rates by Beneficiary Status

Prescriptions include all initial and refill prescriptions filled at military pharmacies, VA pharmacies (for DoD/VA dual-eligible beneficiaries), retail pharmacies, and home delivery. VA prescriptions include those filled as part of a beneficiary's VA benefit and paid for by VA. Prescriptions filled at a VA pharmacy under the TRICARE benefit are included with retail pharmacy prescriptions. Prescription counts from all sources were normalized by dividing the total days supply for each by 30 days.

- The total (direct, VA, retail, and home delivery) number of prescriptions per beneficiary decreased by 6 percent from FY 2015 to FY 2017, exclusive of the TFL benefit. Including TFL, the total number of prescriptions decreased by 3 percent.
- The overall direct care prescription utilization rate declined by 1 percent between FY 2015 and FY 2017. Declines were experienced by all beneficiary groups except Active Duty and ADFMs with a military PCM (less than a 1 percent increase).
- After experiencing increases over the previous few years, average per capita prescription utilization through VA pharmacies dramatically decreased by 56 percent from FY 2015 to FY 2017.
- Average per capita prescription utilization through retail pharmacies decreased by 25 percent overall, primarily because of the congressionally mandated requirement for non-Active Duty beneficiaries to refill prescriptions for select non-generic maintenance medications at TRICARE home delivery or MTF pharmacies, effective October 1, 2015. Another contributor to the decline was the increase in copayments for retail drugs, which caused beneficiaries to migrate to home delivery for their maintenance drugs. Declines of between 18 percent (non-enrolled ADFMs) and 32 percent (RETFMs under 65 with a civilian PCM) occurred for every beneficiary group.
- Home delivery, which once accounted for only a small fraction of purchased care prescription drug utilization, grew by 17 percent between FY 2015 and FY 2017, to the point where it now accounts for 67 percent of total purchased care prescription drug utilization (as measured by 30-day supply) per capita. For beneficiaries under age 65, home delivery accounts for 51 percent of total purchased care prescription drug utilization, whereas for seniors it accounts for 74 percent.

AVERAGE ANNUAL PRESCRIPTION UTILIZATION PER BENEFICIARY, FYs 2015–2017



Source: MHS administrative data, 1/22/2018

Notes:

– Numbers may not sum to bar totals due to rounding.

– The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere.

LOWER COST

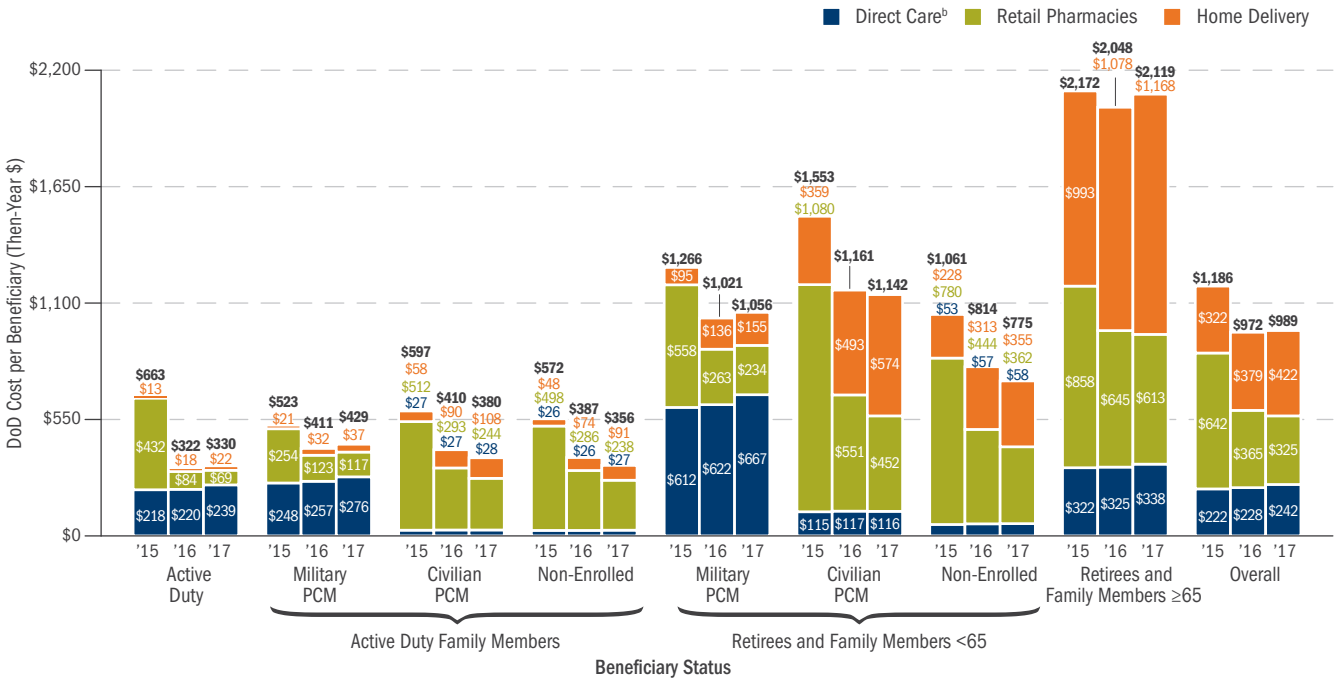
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT.)*

Prescription Drug Cost by Beneficiary Status

Although the drug refunds referenced on page 36 have slowed the overall growth of retail prescription drug costs, the refunds are not reflected in the chart below because they cannot be attributed to specific beneficiary groups. Exclusive of refunds, overall MHS prescription drug costs (in then-year dollars) per beneficiary (far-right columns below), including TFL, decreased by 17 percent from FY 2015 to FY 2017. The drop is due primarily to the MHS's efforts to contain previously out-of-control compound drug prices. The annual pharmacy cost for non-enrollees is diluted by the larger number of beneficiaries with OHI coverage where the DoD pays approximately 30 percent of their prescription coverage cost.

- Exclusive of TFL, per capita prescription drug costs fell by 29 percent between FY 2015 and FY 2017. Declines occurred for all beneficiary groups and ranged from 17 percent for RETFMs under 65 with a military PCM to 50 percent for Active Duty.
- Direct care costs per beneficiary increased by 9 percent, while retail pharmacy costs decreased by 60 percent excluding TFL and by 49 percent including TFL.
- Home delivery costs per beneficiary increased by 59 percent excluding TFL and by 31 percent including TFL. All ADFM enrollment groups experienced increases of over 75 percent. Home delivery costs per capita are increasing because of a shift away from retail pharmacy utilization to home delivery.

AVERAGE ANNUAL DoD PRESCRIPTION COSTS PER BENEFICIARY, FYs 2015–2017[a]



Source: MHS administrative data, 1/22/2018

Notes:

– Numbers may not sum to bar totals due to rounding.

– The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere.

[a] Excludes retail drug refunds.

[b] Direct care prescription costs include an MHS-derived dispensing fee.

BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65)

Out-of-pocket costs are computed for Active Duty and retiree families in the U.S. grouped by sponsor age: (1) under 65 and (2) 65 and older (seniors). Costs include deductibles and copayments for medical care and drugs, TRICARE enrollment fees, and insurance premiums. Costs are compared with those of civilian counterparts (i.e., civilian families with the same demographics as the typical MHS family). For beneficiaries under age 65, civilian counterparts are assumed to be covered by other employer-sponsored group health insurance (OHI).

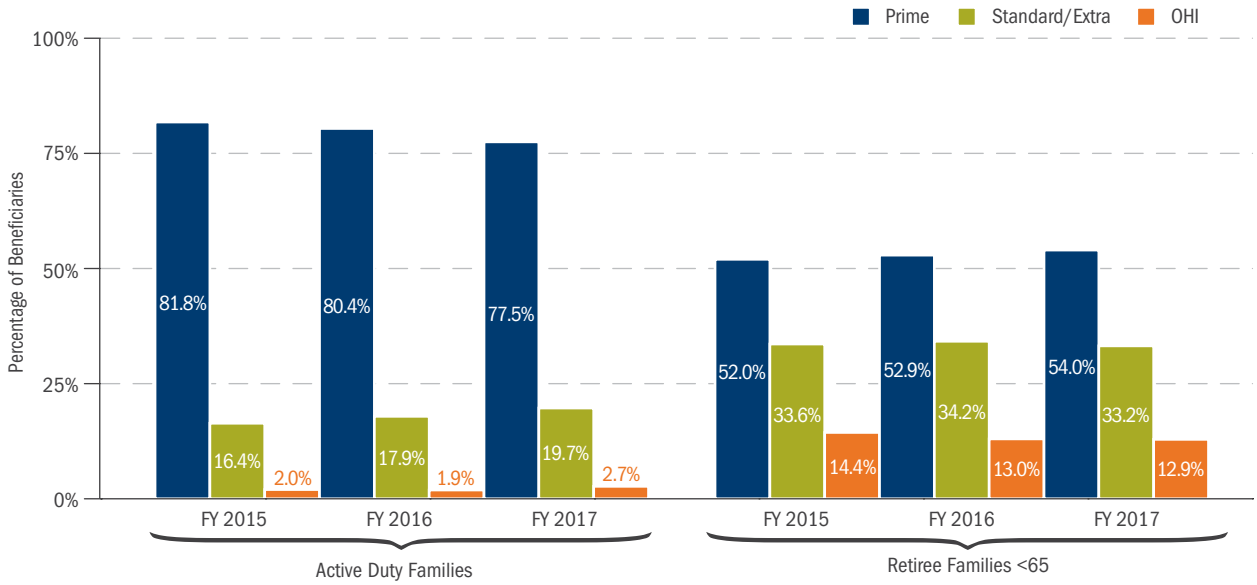
Health Insurance Coverage of MHS Beneficiaries Under Age 65

MHS beneficiaries have a choice of (1) TRICARE Prime, (2) TRICARE Standard/Extra, and (3) OHI. Many beneficiaries with OHI have no TRICARE utilization; however, some use TRICARE as a second payer.

Beneficiaries are grouped by their primary health plan:

- **TRICARE Prime:** Family enrolled in TRICARE Prime (including a small percentage who also have OHI coverage). In FY 2017, 77.5 percent of Active Duty families and 54.0 percent of retiree families were in this group.
- **TRICARE Standard/Extra:** Family not enrolled in TRICARE Prime and who do not have OHI coverage. In FY 2017, 19.7 percent of Active Duty families and 33.2 percent of retiree families were in this group.
- **OHI:** Family covered by OHI. In FY 2017, 2.7 percent of Active Duty families and 12.9 percent of retiree families were in this group.

HEALTH INSURANCE COVERAGE OF BENEFICIARIES UNDER AGE 65, FYs 2015–2017



Source: Insurance coverage in FYs 2015–2017 based on Defense Enrollment Eligibility Reporting System (DEERS) and Health Care Survey of DoD Beneficiaries (HCSDB) responses; as of 12/31/2017

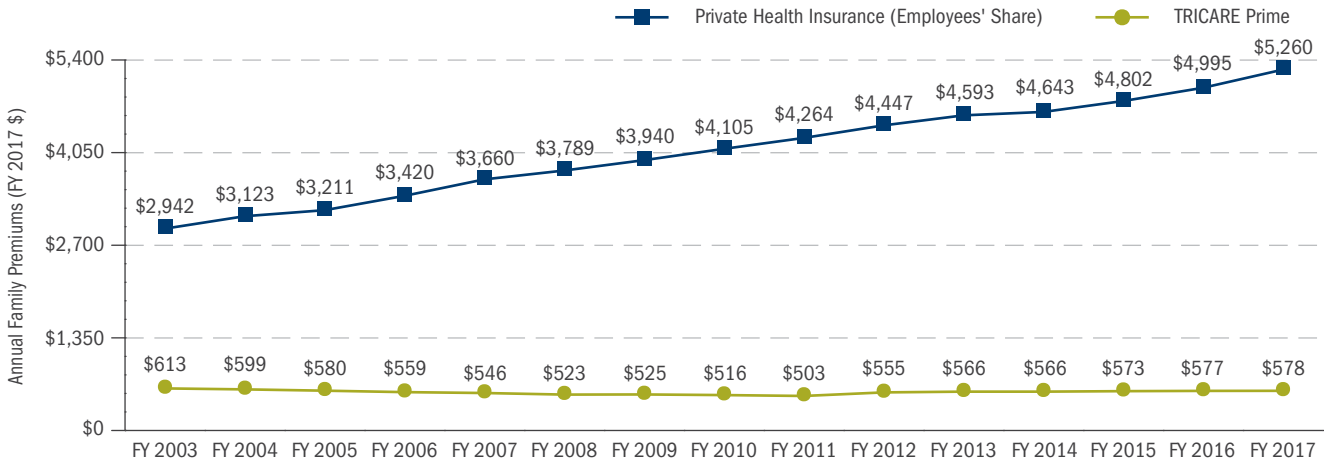
Note: The Prime group includes HCSDB respondents enrolled in Prime based on DEERS plus enrollees in the USFHP. The Standard/Extra group includes HCSDB respondents without OHI who are non-enrollees based on DEERS. The OHI group includes HCSDB respondents with private health insurance (i.e., Federal Employees Health Benefits Plan [FEHBP]), a civilian HMO such as Kaiser, or other civilian insurance such as Blue Cross. A small percentage of Prime enrollees are also covered by OHI; these beneficiaries are included in the Prime group. Percentages may not sum to 100 due to rounding.

BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Retirees and Family Members Under Age 65 Returning to the MHS

From FY 2003 to FY 2017, the average private health insurance family premium increased substantially, whereas the TRICARE Prime enrollment fee declined slightly. In FY 2017 dollars, private health insurance premiums increased by $2,318 (79 percent); the TRICARE Prime enrollment fee declined by $34 (–6 percent).

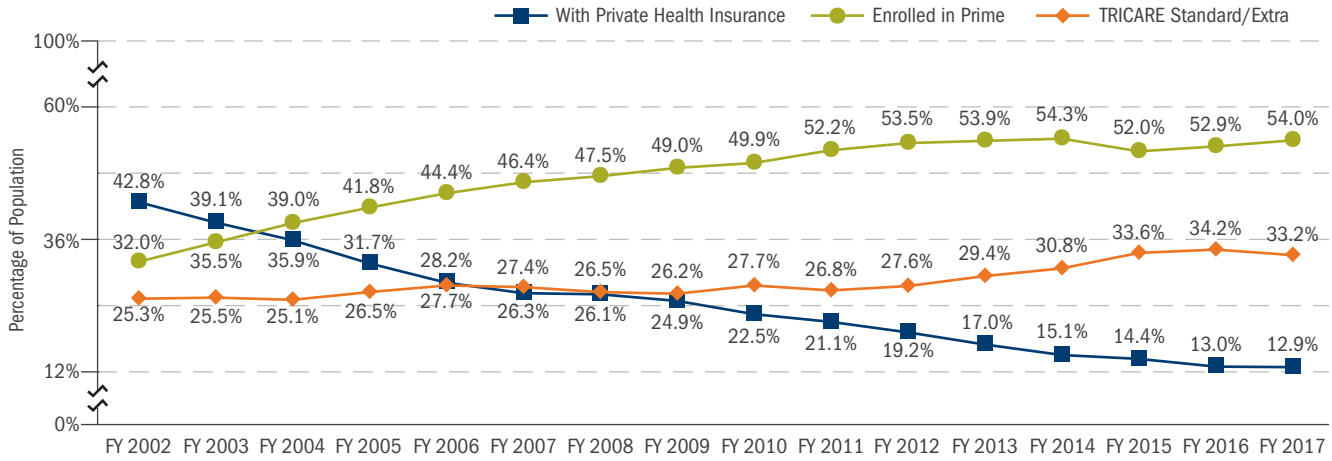
TRENDS IN PRIVATE INSURANCE PREMIUMS VS. TRICARE ENROLLMENT FEE, FYs 2003–2017



Sources: Employees' share of insurance premium for typical employer-sponsored family health plan in FYs 2003–2016 from the Insurance Component of the Medical Expenditure Panel Surveys (MEPS) 2002–2016; OHI premiums in FY 2017 forecasted by the Institute for Defense Analyses based on trends in premiums from Kaiser Family Foundation surveys; as of 12/31/2017

Between FY 2002 and FY 2017, 29.9 percent of retirees switched from private health insurance to TRICARE. Most switched because of an increasing disparity in premiums and out-of-pocket expenses; in the past few years, some lost coverage due to the recession.[1] As a result of declines in private insurance coverage, about 900,000 more retirees and family members under age 65 in the U.S. are now relying primarily on TRICARE instead of on private health insurance.

TRENDS IN RETIREE (<65) HEALTH INSURANCE COVERAGE, FYs 2002–2017



Sources: Insurance coverage in FYs 2002–2017 based on DEERS and HCSDB responses, as of 12/31/2017

Note: The Prime enrollment rates above include about 4 percent of retirees who also have private health insurance.

[1] For an analysis of retirees' switching from OHI to TRICARE, see Goldberg et al., "Demand for Health Insurance by Military Retirees," Institute for Defense Analyses (IDA) Document D-5098, May 2015, Alexandria, VA: IDA.

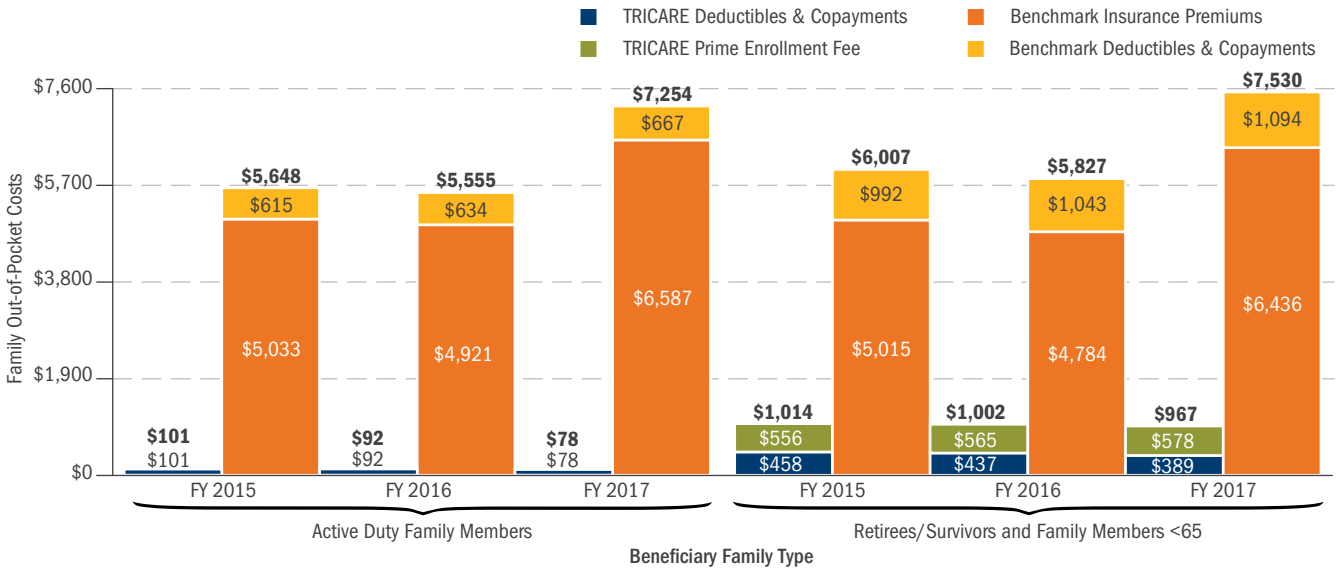
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Out-of-Pocket Costs for Families Enrolled in TRICARE Prime vs. Civilian HMO Counterparts

In FYs 2015–2017, civilian counterpart families had substantially higher out-of-pocket costs than TRICARE Prime enrollees.

- Civilian HMO counterparts paid more for insurance premiums, deductibles, and copayments.
- In FY 2017, costs for civilian counterparts were:
  - $7,200 more than those incurred by Active Duty families enrolled in Prime.
  - $6,600 more than those incurred by retiree families enrolled in Prime.

OUT-OF-POCKET COSTS FOR FAMILIES ENROLLED IN TRICARE PRIME VS. CIVILIAN HMO COUNTERPARTS, FYs 2015–2017



Sources: TRICARE beneficiary expenditures for deductibles and copayments in FYs 2015–2017 from MHS administrative data for all families enrolled in Prime without OHI payments; civilian benchmark expenditures for deductibles and copayments from the Household Component of the MEPS, actual MEPS in FY 2015 and projected MEPS in FYs 2016–2017; civilian benchmark insurance premiums in FYs 2015–2016 from the 2014–2016 Insurance Component of the MEPS; OHI premiums in FY 2017 forecasted by IDA based on trends in premiums from Kaiser Family Foundation surveys; as of 12/31/2017
Note: Estimates are for a demographically typical family. For Active Duty dependents, the family includes a spouse and 1.54 children, on average. For retirees, a family includes a sponsor, spouse, and 0.65 children.

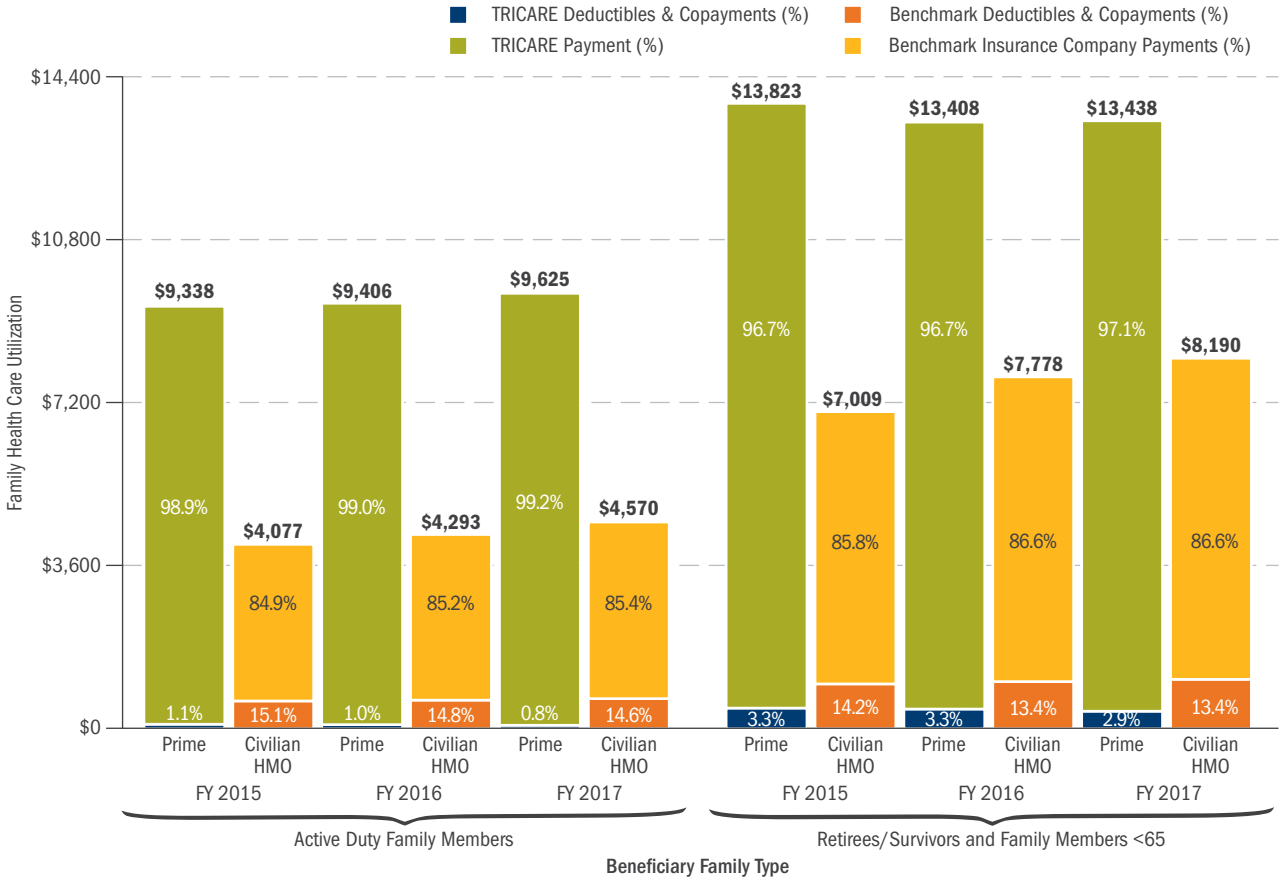
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Coinsurance and Health Care Utilization for Families Enrolled in TRICARE Prime vs. Civilian HMO Counterparts

Previous private-sector studies found that very low coinsurance rates increase health care utilization (dollar value of health care services).[1] In FYs 2015–2017, TRICARE Prime enrollees had negligible coinsurance rates (deductibles and copayments per dollar of utilization) and, not surprisingly, much higher utilization compared with civilian HMO counterpart families. Differences in coinsurance rates are a major reason for the higher utilization of health care services by Prime enrollees.

- In FYs 2015–2017, TRICARE Prime enrollees had coinsurance rates that were 10.1 to 14.0 percentage points below those of civilian HMO counterparts.
  - In FY 2017, the coinsurance rate for Active Duty families was 0.8 percent versus 14.6 percent for civilian counterparts (13.8 points lower).
  - In FY 2017, the coinsurance rate for retiree families was 2.9 percent versus 13.4 percent for civilian counterparts (10.5 points lower).
- In FYs 2015–2017, TRICARE Prime enrollees had substantially higher health care utilization than civilian HMO counterparts.
  - In FY 2017, Active Duty families consumed $9,600 of medical services versus $4,600 by civilian counterparts ($5,000 more).
  - In FY 2017, retiree families consumed $13,400 in medical services versus $8,200 by civilian counterparts ($5,200 more).

COINSURANCE AND HEALTH CARE UTILIZATION FOR FAMILIES ENROLLED IN TRICARE PRIME VS. CIVILIAN HMO COUNTERPARTS, FYs 2015–2017



Sources: TRICARE utilization expenditures by the MHS and beneficiaries in FYs 2015–2017 from MHS administrative data for all families enrolled in Prime without OHI payments for TRICARE utilization; civilian benchmark utilization payments by insurance companies and families from the Household Component of the MEPS, actual MEPS in FY 2015, and projected MEPS in FYs 2016–2017; as of 12/31/2017. Dual-eligible retirees obtain some care at the Department of Veterans Affairs (VA), which is not included in MHS administrative data. Using regression analyses, IDA estimated utilization at VA in FYs 2015–2017 for retirees enrolled in Prime and included these estimates in total utilization (e.g., $555 per retiree family in FY 2017).

[1] Newhouse, Joseph P., and Insurance Experiment Group. *Free for All? Lessons from the RAND Health Insurance Experiment. A RAND Study.* Cambridge, MA: Harvard University Press, 1993.

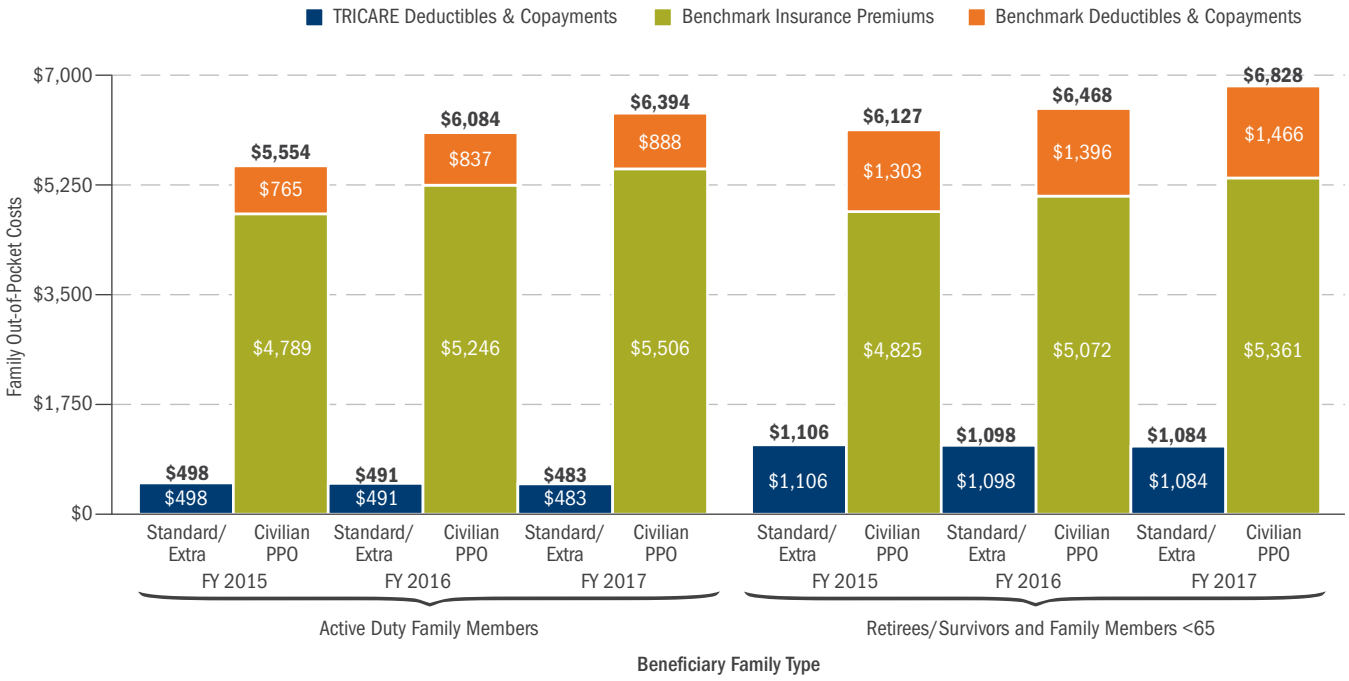
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Out-of-Pocket Costs for Families Who Rely on TRICARE Standard/Extra vs. Civilian PPO Counterparts

In FYs 2015–2017, civilian counterparts had much higher out-of-pocket costs than did TRICARE Standard/Extra users.

- In FYs 2015–2017, civilian PPO counterparts paid $5,000 to $5,900 more for insurance premiums, deductibles, and copayments.
- In FY 2017, costs for civilian counterparts were:
  - $5,900 more than those incurred by Active Duty families who relied on Standard/Extra.
  - $5,700 more than those incurred by retiree families who relied on Standard/Extra.

OUT-OF-POCKET COSTS FOR FAMILIES WHO RELY ON TRICARE STANDARD/EXTRA VS. CIVILIAN PPO COUNTERPARTS, FYs 2015–2017



Sources: TRICARE beneficiary expenditures for deductibles and copayments in FYs 2015–2017 from MHS administrative data for all Standard/Extra-reliant families without OHI payments for TRICARE utilization; civilian benchmark expenditures for deductibles and copayments from the Household Component of the MEPS, actual MEPS in FY 2015, and projected MEPS in FYs 2016–2017; civilian benchmark insurance premiums in FYs 2015–2016 from the 2014–2016 Insurance Component of the MEPS; OHI premiums in FY 2017 forecasted by IDA based on trends in premiums from Kaiser Family Foundation surveys; insurance coverage from HCSDB, FYs 2015–2017; as of 12/31/2017

LOWER COST

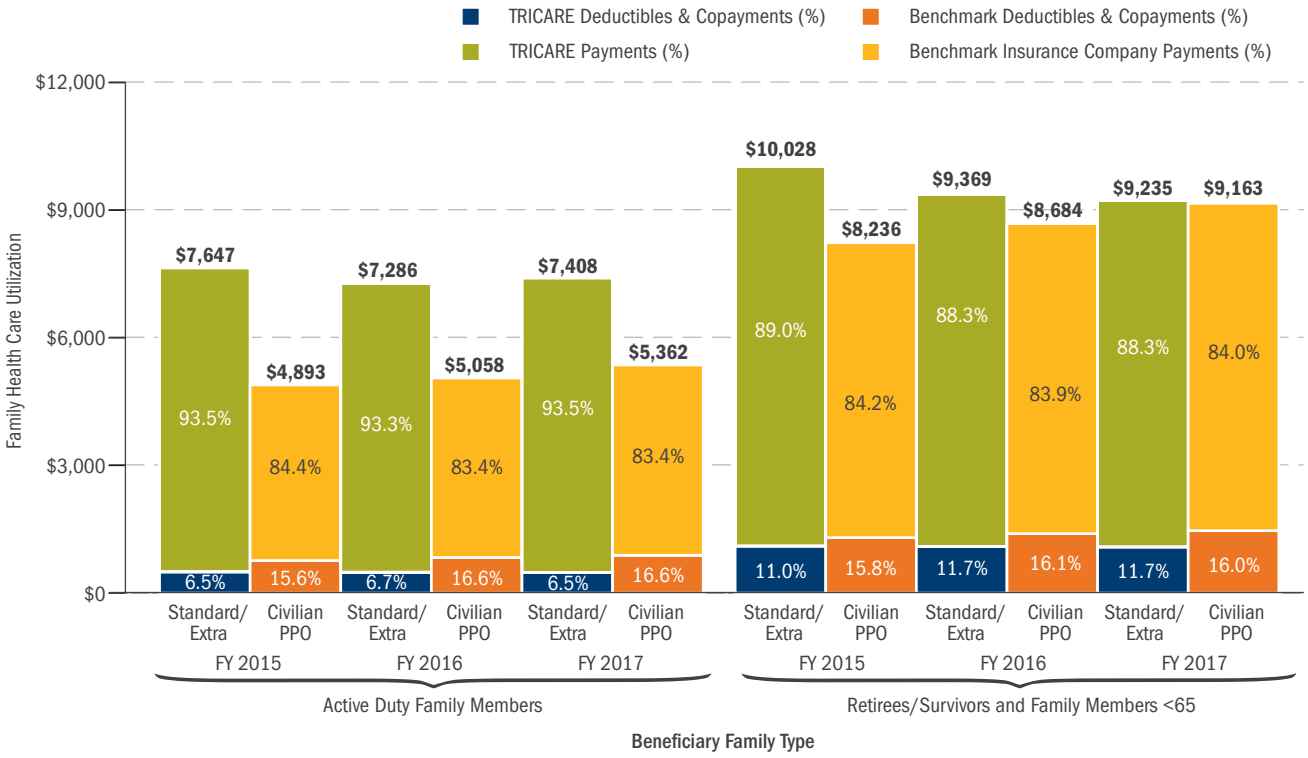
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Coinsurance and Health Care Utilization for Families Who Rely on TRICARE Standard/Extra vs. Civilian PPO Counterparts

Active Duty families who relied on TRICARE Standard/Extra had only slightly lower coinsurance rates (deductibles and copayments per dollar of utilization) and only slightly higher health care utilization (dollar value of health care services consumed) than civilian counterparts. For Retiree families, coinsurance rates and utilization were similar.

- In FY 2017 for Active Duty families:
  - Coinsurance rates were 6.5 versus 16.6 percent for civilian counterparts (10.1 points lower).
  - Health care utilization was $7,400 versus $5,400 for civilian counterparts ($2,000 more).
- In FY 2017 for retiree families:
  - Coinsurance rates were 11.7 versus 16.0 percent for civilian counterparts (just 4.3 points lower).
  - Health care utilization was $9,235 versus $9,163 for civilian counterparts (just $72 more).

COINSURANCE AND HEALTH CARE UTILIZATION FOR FAMILIES WHO RELY ON TRICARE STANDARD/EXTRA VS. CIVILIAN PPO COUNTERPARTS, FYs 2015–2017



Sources: TRICARE utilization payments by the MHS and beneficiaries in FYs 2015–2017 from MHS administrative data for all Standard/Extra-reliant families without OHI payments; civilian benchmark utilization payments by insurance companies and families from the Household Component of the MEPS, actual MEPS in FY 2015, and projected MEPS in FYs 2016–2017; as of 12/31/2017. Dual-eligible retirees obtain some care at VA, which is not included in MHS administrative data. Using regression analyses, IDA estimated utilization at VA in FYs 2015–2017 for retirees who relied on TRICARE Standard/Extra and included these estimates in total utilization (e.g., $415 per retiree family in FY 2017).

BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES)

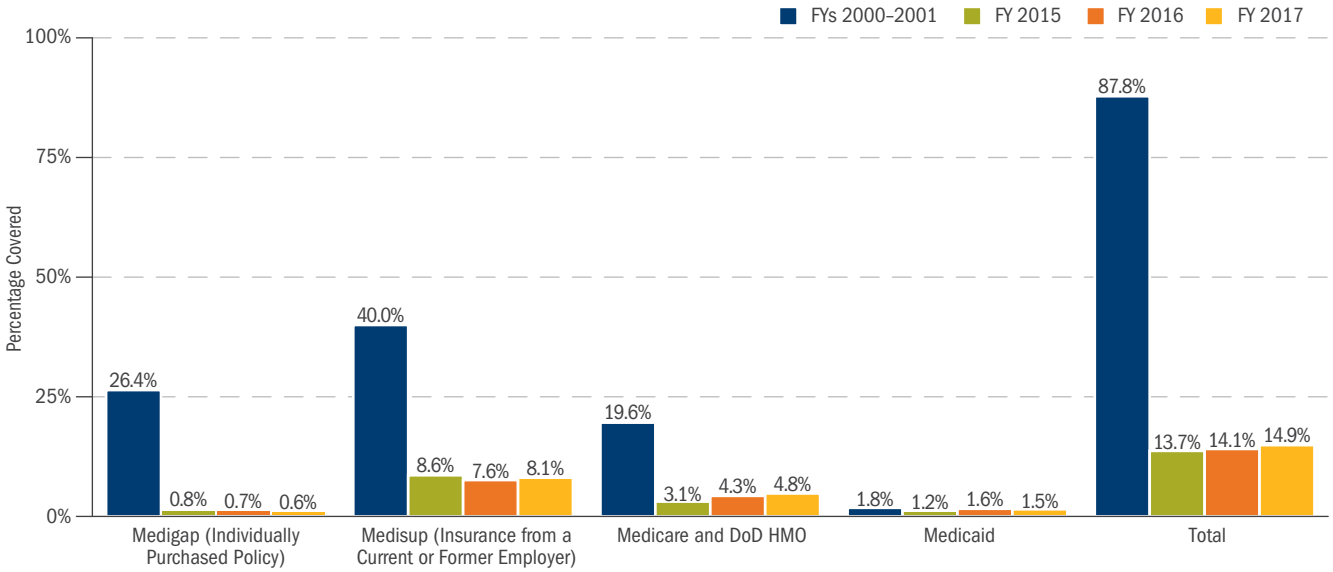
Out-of-pocket costs for retirees age 65 and older (seniors) and their families include deductibles and copayments for medical care and drugs, TRICARE enrollment fees, and insurance premiums. In April 2001, the DoD expanded drug benefits for seniors; on October 1, 2001, the DoD implemented the TFL program, which provides Medicare wraparound coverage (i.e., TRICARE acts as second payer to Medicare, minimizing beneficiary out-of-pocket expenses). For seniors, costs are compared with civilian counterparts enrolled in Medicare having pre-TFL supplemental insurance coverage.

Health Insurance Coverage of MHS Senior Beneficiaries Before and After TFL

Although Medicare provides coverage for medical services, there are substantial deductibles and copayments. Until FY 2001, most MHS seniors purchased some type of Medicare supplemental insurance (e.g., Medigap, Medisup).[1] A small number were active employees with employer-sponsored insurance or were covered by Medicaid. Because of the improved drug and TFL benefits, most MHS seniors dropped their supplemental insurance.

- Before TFL (FYs 2000–2001), 87.8 percent of MHS seniors had Medicare supplemental insurance or were covered by Medicaid. After TFL, the percentage of MHS seniors with supplemental insurance or Medicaid fell sharply. It was 14.9 percent in FY 2017.
- Why do 14.9 percent of all seniors still retain supplemental insurance, especially a Medisup policy, when they can use TFL for free? Some possible reasons are:
  - A lack of awareness of the TFL benefit.
  - A desire for dual coverage.
  - Higher family insurance costs if a spouse is not yet Medicare-eligible. Dropping a non-Medicare-eligible spouse from an employer-sponsored plan can result in higher family costs if the spouse must purchase a nonsubsidized individual policy.

MEDICARE SUPPLEMENTAL INSURANCE COVERAGE OF MHS SENIORS, FYs 2000–2001 TO FY 2017



Source: FYs 2000–2001 and FYs 2015–2017 HCSDB, as of 12/31/2017

[1] Medigap is an individually purchased policy that covers Medicare deductibles and copays. Medisup is group insurance from a current or former employer (or a union). It includes those with Medicare who are covered either by FEHBP, a civilian HMO such as Kaiser, or other civilian health insurance such as Blue Cross. Individually obtained HMO policies include Medicare Advantage, USFHP, and TRICARE Senior Prime (until December 2001). Almost all TRICARE seniors are covered by Medicare and are enrolled in Parts A and B; only 1.3 percent have just Part A. About 2 percent of TRICARE seniors are covered by government-sponsored Medicaid. About 1 percent of TRICARE seniors have OHI and are not covered by Medicare; these are excluded from the above figure; as of 12/31/2017.

LOWER COST

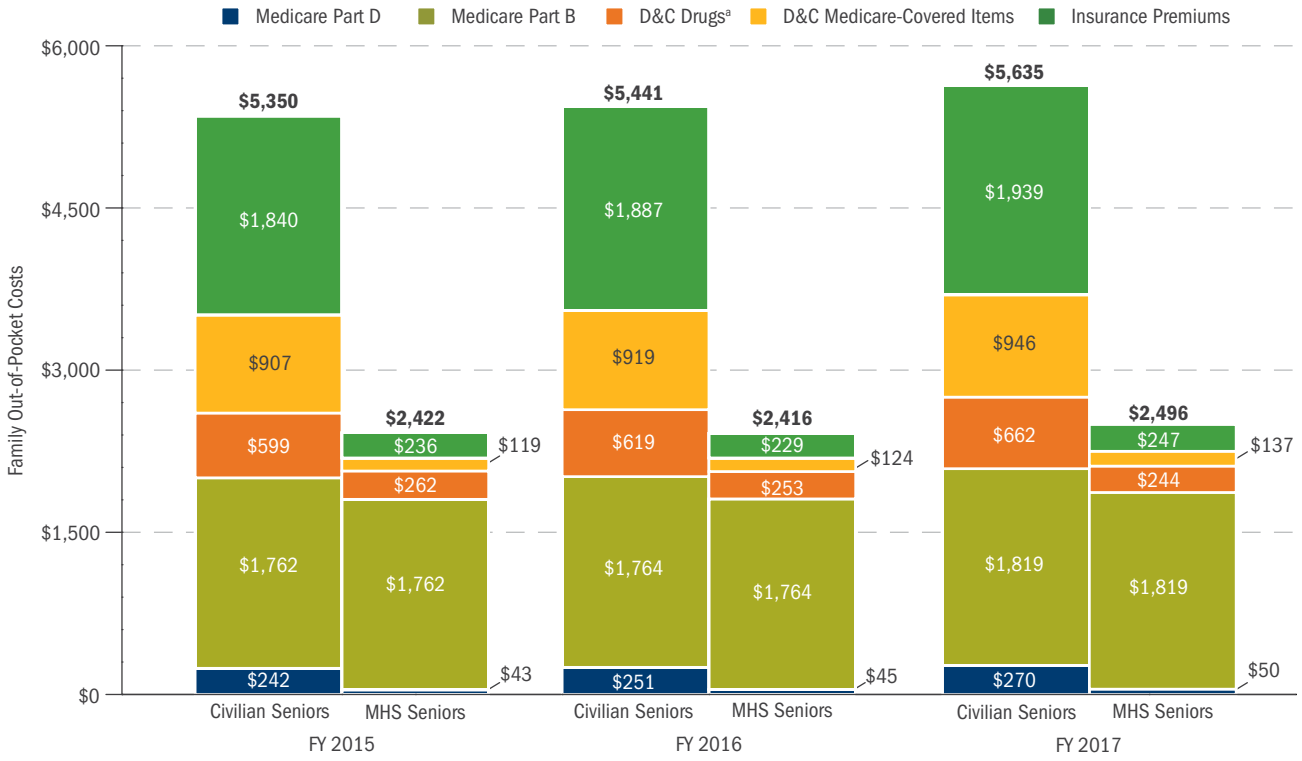
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT.)*

Out-of-Pocket Costs for MHS Senior Families Before and After TFL

About 87 percent of TRICARE senior families use MHS health care. TFL and added drug benefits have enabled MHS seniors to reduce their out-of-pocket costs for deductibles/copayments and supplemental insurance. The costs for a typical TRICARE senior family after TFL, including MHS users and non-users, are compared with those of civilian counterparts having the supplemental insurance coverage of TRICARE senior families before TFL in FYs 2000–2001.

- In FY 2017, out-of-pocket costs for MHS senior families were 56 percent less than those of their "before TFL" civilian counterparts.
- In FY 2017, MHS senior families saved about $3,100 as a result of TFL and added drug benefits.

OUT-OF-POCKET COSTS OF MHS SENIOR FAMILIES AFTER TFL VS. CIVILIAN COUNTERPARTS, FYs 2015–2017



Sources: TRICARE senior family deductibles and copayments for MHS users in FYs 2015–2017 from MHS administrative data on all TRICARE senior families. For MHS non-users and civilian benchmark senior families, deductibles and copayments by type of Medicare supplemental coverage from the Household Component of the MEPS, actual MEPS in FY 2015, and projected MEPS in FYs 2016–2017; Medicare Part B and Medicare HMO premiums in FYs 2015–2017 from the Centers for Medicare & Medicaid Services; Medigap premiums in FYs 2015–2017 from Weiss Research, Inc.; Medisup premiums in FYs 2015–2017 estimated from Towers Perrin Health Care Cost Surveys 2014–2017; Medicare Part D premiums in FYs 2015–2017 from Kaiser Family Foundation Surveys; Medicare supplemental insurance coverage, before and after TFL from HCSDB, FYs 2000–2001, 2015–2017; as of 12/31/2017.

Note: Estimates are for a demographically typical senior family. On average, this consists of 0.7 men and 0.7 women over the age of 65.

[a] "D&C" is deductibles and copayments.

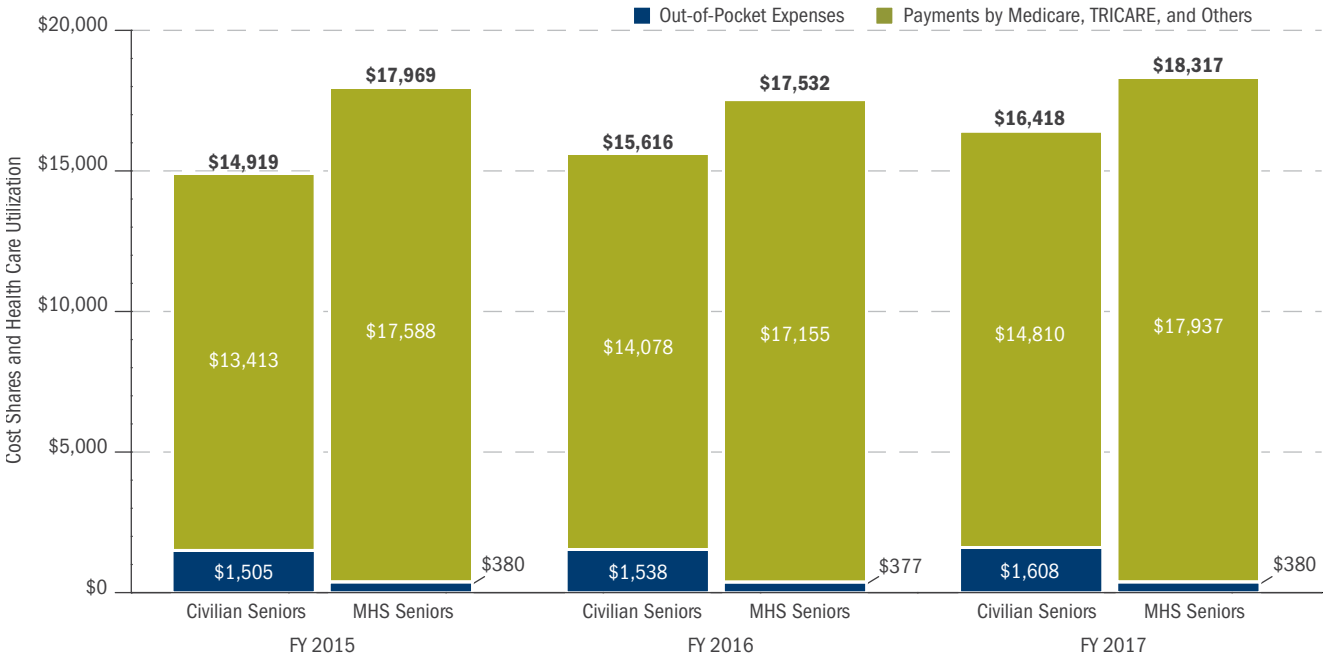
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT.)*

Coinsurance and Health Care Utilization for MHS vs. Civilian Senior Families

Medicare supplemental insurance lowers the coinsurance rate (deductibles and copayments per dollar of utilization), and previous studies have found that this leads to more health care services consumed by seniors.[1] TFL and added drug benefits substantially lowered coinsurance rates; not surprisingly, utilization is moderately higher for MHS seniors compared with "before TFL" civilian counterparts.

- TRICARE senior families have coinsurance rates below those of civilian counterparts.
  - In FY 2017, the coinsurance rate for civilian counterparts was 9.8 percent; for MHS seniors, 2.1 percent (7.7 percentage points lower).
- TRICARE senior families have relatively high health care utilization.
  - In FY 2017, MHS senior families consumed $1,900 more in medical services than their civilian counterparts (11.6 percent greater).

COINSURANCE AND HEALTH CARE UTILIZATION FOR SENIOR FAMILIES VS. CIVILIAN COUNTERPARTS, FYs 2015–2017



Sources: TRICARE senior family utilization, deductibles, and copayments for MHS users in FYs 2015–2017 from MHS administrative data. For MHS non-users and civilian benchmark senior families, utilization, deductibles, and copayments by type of Medicare supplemental coverage from the Household Component of the MEPS, actual MEPS in FY 2015, and projected MEPS in FYs 2016–2017; Medicare supplemental insurance coverage, before and after TFL, from HCSDB, FYs 2000–2001 and 2015–2017; as of 12/31/2017.

[1] Physician Payment Review Commission, "Private Secondary Insurance for Medicare Beneficiaries," in *Annual Report to Congress: Fiscal Year 1997* (Washington, D.C.: U.S. Government Printing Office, 1997), 27–28.

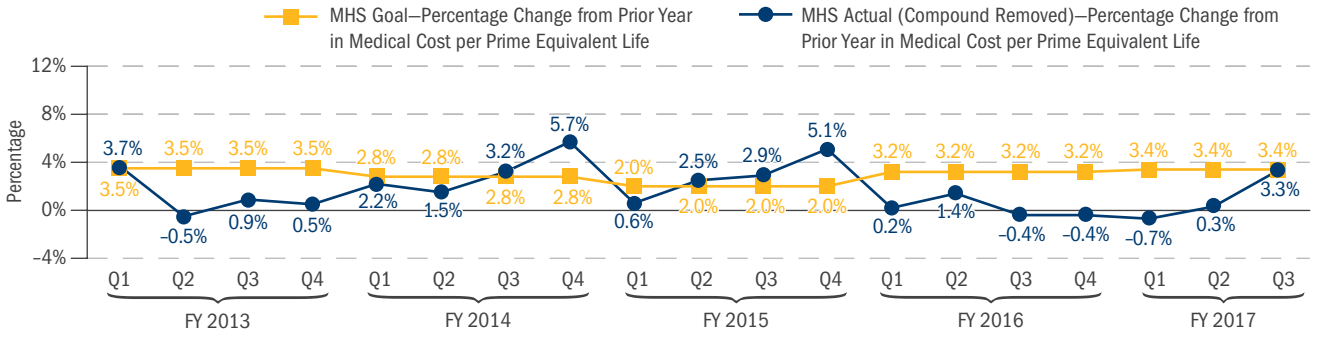
LOWER COST

SYSTEM PRODUCTIVITY: MHS MEDICAL COST PER PRIME ENROLLEE

The goal in using this financial and productivity metric is to support the Quadruple Aim of managing lowering costs. This metric focuses on per capita costs to examine the extent to which the MHS stays below a targeted annual rate of increase based on industry practice, including how well MHS manages the care for those individuals who have chosen to enroll in an HMO-type benefit provided by MTFs. Designed to capture aspects of three major management issues, this metric measures (1) how efficiently MTFs provide care, (2) how efficiently MTFs manage the demand of their enrollees, and (3) how well MTFs determine which care should occur internally versus which should be purchased externally from a managed care support contractor.

- During FY 2017, the DoD Components focused on improvements in provider productivity through improved access standards, MTF site visits, effective use of resources, capturing of inpatient RVUs, and optimization of referral management. Current provider productivity performance levels are the highest achieved, demonstrating improvement processes are starting to work. As productivity improves, review will be needed for overall ambulatory care utilization, but through the second quarter of FY 2017, the goal was achieved.
- Pharmacy compounded products were removed from all years, because the vast majority of compounded products in FY 2014 and FY 2015 were found to be fraudulent, and, if included, would unrealistically demonstrate dramatic decreases in growth rates for FY 2016. During FY 2016, pharmacy showed dramatic improvement due to the National Defense Authorization Act (NDAA) 2015 maintenance medication and operational changes. Under the NDAA 2015, maintenance medications were redirected from the retail pharmacy to either TRICARE Home Delivery or MTFs, which resulted in significant reduction in pharmacy costs to the government. Additionally, further reductions in overall pharmacy costs were achieved through the Pharmacy & Therapeutics Committee explicit formulary management and actionable Prime enrollee leakage reports for non-maintenance medication. The impact of these actions resulted in achievement of the goal through FY 2016.
- Through FY 2014, increases in purchased care outpatient costs were eased by DHA's implementation of the Outpatient Prospective Payment System (OPPS), beginning in May 2009 and completely phased in by May 2013, aligning TRICARE reimbursement with Medicare rates for hospital outpatient services. Pharmacy refunds continue to partially mitigate retail pharmacy costs—the highest-cost pharmacy venue. OPPS and refunds have provided short-term pricing decreases; however, as they have been phased in fully, pricing has stabilized and utilization has again become a cost driver, as reflected in increases beginning in FY 2014.
- The MHS continues to expand the Patient-Centered Medical Home (PCMH) strategy, a practice model in which a team of health care professionals, coordinated by a personal physician, works collaboratively to provide high levels of care, access, and communication; care coordination and integration; and care quality and safety. Care delivered in a PCMH is meant to produce better outcomes; reduce mortality, unnecessary emergency department visits, and preventable hospital admissions for patients with chronic diseases; lower overall utilization; and improve patient compliance with recommended care, resulting in lower spending for the same population.
- The MHS goal in percentage change in medical costs from the prior year is based on the annual national survey of nonfederal private and public employers with three or more workers, conducted by the Kaiser Family Foundation and the Health Research and Educational Trust. From this survey, the MHS rate is set, based on the average annual premiums for employer-sponsored health insurance for family coverage. For the FY 2013 to FY 2016 time period, the MHS goal was set at one percentage point below the survey. Starting in FY 2017, the goal is reverting back to the actual survey result.

PERCENTAGE CHANGE IN MEDICAL COST PER PRIME EQUIVALENT LIFE (FROM PRIOR YEAR), FYs 2013–2017



Source: Office of the Assistant Secretary of Defense for Health Affairs Health Resources Management and Policy, 11/7/2017, and MHS administrative data (M2: Standard Inpatient Data Record/Standard Ambulatory Data Record/Comprehensive Ambulatory/Professional Encounter Record/TRICARE Encounter data-institutional/TED-Noninstitutional, Pharmacy Data Transaction Service; Expense Assignment System IV. Enrollees are adjusted for health risk status. FY 2017 data are reported through FY 2017 Q3, and data from this quarter should be considered preliminary.

GENERAL METHOD

This report presents the overall performance of the TRICARE program with respect to the Military Health System (MHS) Quadruple Aim of increased readiness, better care, better health, and lower cost. MHS monitors various metrics to assess performance and, where possible, tries to compare MHS performance with relevant civilian health care performance. This report examines the effects of TRICARE on beneficiary utilization of inpatient, outpatient, and prescription services, as well as on MHS and beneficiary costs. Wherever feasible, the report contrasts various aspects of TRICARE and national health care trends. These include comparison of TRICARE utilization and cost measures with comparable civilian sector benchmarks derived from the MarketScan® Commercial Claims and Encounters (CCAE) database provided by Truven Health Analytics, an IBM Company, trended changes in medical costs based on the national survey of nonfederal health plans and public employers conducted by the Kaiser Family Foundation and the Health Research and Education Trust (HRET), and national patient survey results from the consortium of the Agency for Healthcare Research and Quality (AHRQ) and the Consumer Assessment of Health Providers and Systems (CAHPS).

Notes on Methodology

- Numbers in charts or text may not sum to the expressed totals due to rounding.
- Unless otherwise indicated, all years referenced are federal fiscal years (FYs; October 1–September 30).
- Unless otherwise indicated, all dollar amounts are expressed in then-year dollars for the fiscal year represented.
- All photographs in this document were obtained from websites accessible by the public. These photos have not been tampered with other than to mask an individual's name.
- Differences between MHS survey-based data and the civilian benchmark, or the MHS over time, were considered statistically significant if the significance level was less than or equal to 0.05.
- All workload and costs are estimated to completion based on separate factors derived from MHS administrative data for direct care and recent claims experience for purchased care.
- Data were current as of:
  - Surveys—HCSDB (11/13/2017); Service surveys: APLSS, PSS, and SDA, and TROSS/JOES and JOES-C (11/27/2017); and TRISS (12/5/2017) Surveys
  - Eligibility/enrollment data—1/4/2018
  - MHS workload/costs—1/22/2018
  - Website uniform resource locators—1/26/2018
- The Defense Health Agency (DHA) regularly updates its encounters and claims databases as more current data become available. It also periodically "retrofits" its databases as errors are discovered. The updates and retrofits can sometimes have significant impacts on the results reported in this and previous documents if they occur after the data collection cutoff date. The reader should keep this in mind when comparing this year's results with those from previous reports.

DATA SOURCES

Health Care Survey of DoD Beneficiaries (HCSDB)

The HCSDB was developed by the DHA and its predecessor, the TRICARE Management Activity, to fulfill the 1993 National Defense Authorization Act (NDAA) requirements and to provide a routine mechanism to assess TRICARE-eligible beneficiary access to and experience with the MHS or with alternate health plans. Conducted continuously since 1995, the HCSDB was designed to provide a comprehensive look at beneficiary opinions about their Department of Defense (DoD) health care benefits. The HCSDB provides information on a wide range of health care issues, such as beneficiaries' ease of access to health care, preventive care services, and healthy behaviors.

The worldwide, multiple-mode Adult HCSDB has been conducted on a quarterly basis (three fiscal year quarters: October, January, and April) since FY 2013, and reported quarterly on a publicly accessible website (https://tricare.mil/survey/hcsdbsurvey/home/z_reports.cfm). Mathematica Policy Research, Inc. has been the lead contractor providing independent analysis and assessment of the HCSDB and TRICARE Standard Survey results presented in this report.

The CAHPS is a nationally recognized set of standardized questions and reporting formats that has been used to collect and report meaningful and reliable information about the health care experiences of consumers. It was developed by a consortium of research institutions and sponsored by the AHRQ. It has been tested in the field and evaluated for validity and reliability. The questions and reporting formats have been tested to ensure that the answers can be compared across plans and demographic groups.

About three-fourths of HCSDB questions are closely modeled on the CAHPS Health Plan survey in wording, response choices, and sequencing. The other one-fourth of HCSDB questions are designed to obtain information unique to TRICARE benefits or operations, and to solicit information about healthy lifestyles or health promotion, often based on other nationally recognized health care survey questions (e.g., Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System, National Health Interview Survey, or the National Health and Nutrition Examination Survey). Supplemental questions are added on a quarterly basis to explore specific topics of interest, such as the acceptance and prevalence of preventive services, including colorectal cancer screening and annual influenza immunizations; availability of other non-DoD health insurance; and indications of posttraumatic stress in the overall MHS population.

Because the HCSDB uses CAHPS questions, TRICARE can be benchmarked to civilian managed care health plans reporting CAHPS Health Plan results. More information on CAHPS can be obtained at https://www.cahps.ahrq.gov.

The survey request is sent by postal mail to all beneficiaries and also by e-mail to Active Duty members, with responses accepted via web and, for a random sample of initial non-respondents, by postal mail. The HCSDB is fielded to a stratified random sample of beneficiaries. In order to calculate representative rates and means from their responses, sampling weights are used to account for different sampling rates and different response rates in different sample strata. Beginning with the FY 2006 report, weights were adjusted for factors such as age, sex, and rank that do not define strata, but make some beneficiaries more likely to respond than others. Because of the adjustment, rates calculated from the same data differ from past evaluation reports and are more representative of the population of TRICARE users.

The DHA HCSDB is sent to a random sample of all MHS-eligible users and non-users. Survey results are reported quarterly, with almost 29,000 respondents from about 300,000 beneficiaries sampled in FY 2017 (about a 12 percent raw response and over a 20 percent weighted response rate, up from a 10 percent raw response rate in FY 2016). Results can be estimated from the HCSDB for all beneficiary groups eligible for MHS benefits, whether they use direct care, purchased care, or other health insurance available to them, and are compared with benchmark results from a national sample of commercial civilian health plans administering the CAHPS Health Plan survey.

Results provided from HCSDB in FYs 2015 through FY 2017 were based on questions taken from the CAHPS Version 5.0. As CAHPS versions change, the HCSDB results will be compared to the like-CAHPS version results each year because changes in the questionnaires and changes in rates are only meaningful when compared with changes in the relevant benchmark. CAHPS Version 5.0 benchmark microdata were obtained from the National Committee for Quality Assurance (NCQA).

The National CAHPS Benchmarking Database collects CAHPS results voluntarily submitted by participating health plans and is funded by the AHRQ and administered by a contractor. The NCQA's

file also contains voluntarily submitted health plan survey results. Only health maintenance organization (HMO), preferred provider organization (PPO), and HMO/point-of-service (POS) plans from either source are used in the calculation of the benchmark scores. Both benchmarks and TRICARE results are adjusted for age and health status.

Differences between the MHS and civilian benchmark were considered significant at less than or equal to 0.05, using the normal approximation. The significance test for a change between years is based on the change in the MHS estimate minus the change in the benchmark, which is adjusted for age and health status to match the MHS. T-tests measure the probability that the difference between the change in the MHS estimate and the change in the benchmark occurred by chance.Tests are performed using a Z-test, and standard errors are calculated using SUDAAN to account for the complex stratified sample and unequal weights. If P is less than 0.05, the difference is significant.

Within the context of the HCSDB, Prime enrollees are defined as those enrolled at least six months.

TRICARE Inpatient Satisfaction Survey (TRISS)

The purpose of the Office of the Assistant Secretary of Defense (Health Affairs) TRISS is to monitor and report on the experience and satisfaction of MHS beneficiaries who have been admitted to military treatment facilities (MTFs) and civilian hospitals. The survey instrument incorporates the questions developed by the AHRQ and Centers for Medicare & Medicaid Services (CMS) for the Hospital CAHPS (HCAHPS®) initiative. The goal of the HCAHPS initiative is to measure uniformly and report publicly patient experiences with inpatient care through the use of a standardized survey instrument and data collection methodology. The information derived from the survey can be useful for internal quality improvement initiatives, to assess the impact of changes in policy, and to provide feedback to providers and patients.

The TRISS is a 43-item survey instrument with 21 questions asking how often or whether patients experienced a critical aspect of hospital care, rather than whether they were "satisfied" with their care, and 22 DoD-specific questions, including an open-ended question to solicit location-specific comments from our beneficiaries.

The TRISS questionnaire is sent to all (census) adult MTF inpatients worldwide between 48 hours and six weeks after discharge. The TRISS survey is also administered to a random sample of adult MHS inpatients discharged from civilian network/purchased care hospitals. The TRISS follows the HCAHPS protocols developed by the CMS. HCAHPS protocols for sampling, data collection, and coding can be found in the HCAHPS Quality Assurance Guidelines manual on the official HCAHPS website, http://www.hcahpsonline.org. The overall FY 2017 Q1–Q3 response rate for direct care was almost 38 percent and for purchased care was 42.5 percent.

TRICARE Outpatient Satisfaction Survey (TROSS) and Service Outpatient Surveys

This report presents beneficiary self-reported ratings of their outpatient experience from multiple sources, and, in so doing, offers different perspectives on how the MHS assesses the outpatient beneficiary experience. These outpatient surveys are the TRICARE Outpatient Satisfaction Survey (TROSS), the Army Provider Level Satisfaction Survey (APLSS), the Navy Patient Satisfaction Survey (PSS), and the Air Force Service Delivery Assessment (SDA).

- The DHA TROSS is sent to a randomized sample of MHS beneficiaries following their outpatient encounter in either direct or purchased care. Survey results are reported monthly, with about 115,000 responses from about 575,000 annually surveyed in FY 2015 (19 percent raw annual response rate). Metric scores are compared with benchmarks established by the CAHPS Clinician and Group Survey.
- The APLSS is sent to about 2.5 million beneficiaries annually who have had an outpatient visit at an Army MTF. Results are reported to Army medical leadership from the Surgeon General, down to the individual providers in the MTFs.
- The PSS is sent to about 1 million beneficiaries annually who have used Navy MTFs. Results are reported to the Bureau of Medicine and Surgery (BUMED) leadership from the Surgeon General, down to the individual providers in the MTFs.
- The SDA is a telephone-based survey, with about 600,000 beneficiaries called annually who have used Air Force MTFs. Results are reported from the Surgeon General through Air Force Medical Service leadership, down to the individual providers in the MTFs.

DATA SOURCES *(CONT.)*

The Joint Outpatient Experience Survey (JOES) combines and standardizes the long-standing Services outpatient surveys (Army APLSS, BUMED PSS, and Air Force SDA). JOES continues to focus on the beneficiary experience with care received in MTFs, and is centrally managed under the direction of Service and DHA survey leads. JOES results are reported centrally, and reported for each Service, multi-Service market area, and down to each MTF and provider. JOES also includes a separate monthly survey based on the DHA TROSS, called JOES-C (where "C" stands for CAHPS Clinician and Group Survey). JOES-C continues to focus on beneficiary experience in both direct and purchased care provider offices, allowing MHS to compare beneficiary results to the civilian benchmark results.

Quality

Military hospital inpatient quality measures were abstracted from clinical records by trained specialists and reported to The Joint Commission for national benchmarking. The data for direct care hospitals participating in the National Surgical Quality Improvement Program are abstracted by trained surgical case reviewers and submitted to the American College of Surgeons. The perinatal data are obtained from the electronic data system through an administrative data pull and are submitted to the National Perinatal Information Center to support comparison with other participating organizations from across the nation. The availability of data for MHS providers continues to increase through the MHS Population Health Portal in CarePoint, via a streamlined access process, registry development for population management, and improved data displays. The MHS Dashboard has been added to CarePoint and provides views for all measures and executive and improvement priorities. The CarePoint portal includes a discharge tool to ensure patients at high risk for readmission are identified during hospitalization. This facilitates continuity of care and provides caregivers with time for patient education and follow-up appointment scheduling to reduce the risk of readmissions.

Utilization and Costs

Data on MHS and beneficiary utilization and costs came from several sources. We obtained the health care experience of eligible beneficiaries by aggregating Standard Inpatient Data Records (SIDRs—MTF hospitalization records), Comprehensive Ambulatory/ Professional Encounter Records (CAPERs—MTF outpatient records), TRICARE Encounter Data (TED—purchased care claims information) for institutional and noninstitutional services, and Pharmacy Data Transaction Service (PDTS) claims within each beneficiary category.

Inpatient utilization was measured using dispositions (direct care)/admissions (purchased care) and Medical Severity Diagnosis Related Group (MS-DRG) relative weighted products (RWPs), the latter being a measure of the intensity of hospital services provided. Outpatient utilization for both direct and purchased care was measured using encounters and an MHS-derived measure of intensity called Enhanced Total Relative Value Units (RVUs). MHS uses several different RVU measures to reflect the relative costliness of the provider effort for a particular procedure or service. Enhanced Total RVUs were introduced by MHS in FY 2010 and subsequently revised in FY 2016 (in both cases, they were retroactively applied to earlier years) to account for units of service (e.g., 15-minute intervals of physical therapy) and better reflect the resources expended to produce an encounter. The word "Total" in the name reflects that it is the sum of Work RVUs and Practice Expense RVUs. Work RVUs measure the relative level of resources, skill, training, and intensity of services provided by a physician. Practice Expense RVUs account for nonphysician clinical labor (e.g., a nurse), medical supplies and equipment, administrative labor, and office overhead expenses. In the private sector, Malpractice RVUs are also part of the formula used to determine physician reimbursement rates, but since military physicians are not subject to malpractice claims, they are excluded from Total RVUs to make the direct and purchased care workload measures more comparable. For a more complete description of enhanced as well as other RVU measures, see https://www.milsuite.mil/video/watch/video/9653.

Costs recorded on TEDs were broken out by source of payment (DoD, beneficiary, or private insurer). Although SIDR and CAPER data indicate the enrollment status of beneficiaries, the Defense Enrollment Eligibility Reporting System (DEERS) enrollment file is considered to be more reliable. We therefore classified MTF discharges as Prime or space-available by matching the discharge dates to the DEERS enrollment file. Final data pulls used for this report were completed in January 2017, as referenced above.

The CCAE database contains the health care experience of several million individuals (annually) covered under a variety of health plans offered by large employers, including PPOs, POS plans, HMOs, and indemnity plans. The database links inpatient services and admissions, outpatient claims and encounters and, for most covered lives, outpatient pharmaceutical drug data and individual-level enrollment information.

DATA SOURCES *(CONT.)*

We tasked Truven Health Analytics Inc. to compute quarterly benchmarks for HMOs and PPOs, broken out by product line (MED/SURG, OB, PSYCH) and several sex/age group combinations. The quarterly breakout, available through the second quarter of FY 2017, allowed us to derive annual benchmarks by fiscal year and to estimate FY 2016 data to completion. Product lines were determined by aggregating Major Diagnostic Categories (MDCs) as follows: OB = MDC 14 (Pregnancy, Childbirth, and Puerperium) and MDC 15 (Newborns and Other Neonates with Conditions Originating in Perinatal Period), PSYCH = MDC 19 (Mental Diseases and Disorders) and MDC 20 (Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders), and MED/SURG = all other MDCs. The breakouts by gender and age group allowed us to apply DoD-specific population weights to the benchmarks and aggregate them to adjust for differences in DoD and civilian beneficiary populations. We excluded individuals age 65 and older from the calculations because most of them are covered by Medicare and Medigap policies rather than by a present or former employer's insurance plan.

DRG Grouping Methodology

In the section that displays the "Top 25" inpatient diagnosis groups, Diagnosis Related Groups (DRGs) are grouped into descriptively (but not necessarily clinically) similar categories using a code set available on http://www.findacode.com/code-set.php?set=DRG, an online database of medical billing codes and information. The site lists DRGs within each MDC, with headings above diagnostically related DRGs. These headings provide a broad description of the DRGs underneath and distinguish between medical and surgical DRGs, but do not distinguish among DRGs with different (or any) levels of complications and comorbidities. For the purposes of this report, the DRGs were too detailed and the MDCs too broad to provide the reader with a general sense of the most common inpatient diagnoses the MHS confronts; therefore, the headings were used as the basis for broadening the groupings in this report into descriptively related categories, without regard for whether they are medical or surgical, whether there are complications, or which parts of the body are affected. For example, the "ECMO or Tracheostomy" group includes DRGs 003, 004, 011, 012, and 013. The description for each of those DRGs includes the words "ECMO" or "Tracheostomy"—some with complications, some without; some for face, mouth, and neck; and some for other parts of the body. Once all the groups were formed, they were numbered sequentially following the order in which they were presented on the website. This resulted in a reduction from 818 DRGs to 284 DRG groups.

ABBREVIATIONS

ABA	applied behavior analysis | 11
ACD	Autism Care Demonstration | 11
ADFM	Active Duty family member | 11
ADSM	Active Duty Service member | 11
AHRQ	Agency for Healthcare Research and Quality | 64
APLSS	Army Provider Level Satisfaction Survey | 70
ASD	autism spectrum disorder | 50
BMI	body mass index | 154
BRAC	Base Realignment and Closure | 22
BUMED	Bureau of Medicine and Surgery | 46
CAHPS	Consumer Assessment of Healthcare Providers and Systems | 58
CAUTI	catheter-associated urinary tract infection | 85
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services | 7
CDC	Centers for Disease Control and Prevention | 11
CLABSI	central line-associated bloodstream infection | 85
CM	case management | 82
CMS	Centers for Medicare & Medicaid Services | 1
CY	calendar year | 6
CV	coefficient of variation | 73
DEERS	Defense Enrollment Eligibility Reporting System | 18
DHA	Defense Health Agency | 2
DHP	Defense Health Program | 17
DHHS	Department of Health and Human Services | 153
DMDC	Defense Manpower Data Center | 144
DoD	Department of Defense | 1
ECHO	Extended Care Health Option | 195
eMSM	enhanced multi-Service market | 22
ER	emergency room | 33
FDA	Food and Drug Administration | 12
FTE	full-time equivalent | 149
FY	fiscal year | 17
GAO	Government Accountability Office | 8
GRDFM	Guard/Reserves and Family Members | 18
HCAHPS	Hospital Consumer Assessment for Healthcare Providers and Systems | 6
HCSDB	Health Care Survey of DoD Beneficiaries | 58
HEDIS	Healthcare Effectiveness Data and Information Set | 6
HIPAA	Health Insurance Portability and Accountability Act | 71
HMO	Health Maintenance Organization | 7
HRO	High Reliability Organization | 47
HP	Healthy People | 153
IMR	Individual Medical Readiness | 43
IOC	initial operating capability | 8
IQR	interquartile range | 57
JOES	Joint Outpatient Experience Survey | 70
JOES-C	Joint Outpatient Experience Survey-CAHPS | 70
KSAs	knowledge, skills, and abilities | 4
MCSC	managed care support contractor | 10
MDR	MHS Data Repository | 22
MERHCF	Medicare-Eligible Retiree Health Care Fund | 6
MH	mental health | 107
MHS	Military Health System | 1
MHSPHP	MHS Population Health Portal | 82
MS-DRG	Medicare Severity Diagnosis Related Group | 163
MTF	military treatment facility | 1
NAL	nurse advice line | 57
NCQA	National Committee for Quality Assurance | 58
NCR	National Capital Region | 22
NCRMD	National Capital Region Medical Directorate | 93
NDAA	National Defense Authorization Act | 1
NHANES	National Health and Nutrition Examination Survey | 153
NHE	National Health Expenditures | 28
NPDB	National Practitioner Data Bank | 50
NPI	National Provider Identifier | 149
NPIC	National Perinatal Information Center | 105
NSQIP	National Surgical Quality Improvement Program | 50
OCONUS	outside the continental U.S. | 151
OHI	other health insurance | 25
O&M	Operations and Maintenance | 27
P4I	Partnership for Improvement | 43
P&T	Pharmacy & Therapeutics | 184
PC	perinatal care | 6
PCM	primary care manager | 7
PCMH	Patient-Centered Medical Home | 6
PDTS	Pharmacy Data Transaction Service | 36
PfP	Partnership for Patients | 57
PI	Program Integrity | 6
PIPs	Performance Improvement Priorities | 92
POS	point-of-service | 7
PPO	preferred provider organization | 162
PRISM	Provider Requirement Integrated Specialty Model | 22

ABBREVIATIONS *(CONT.)*

PSA	Prime Service Area | 22
PSM	Patient Safety Manager | 87
PSP	Patient Safety Program | 83
PSR	Patient Safety Reporting | 83
PSS	Navy Patient Satisfaction Survey | 70
RC	Reserve Component | 6
RCA	root cause analysis | 85
RETFMs	Retirees and Family Members | 18
RVUs	relative value units | 6
RWPs	relative weighted products | 6
SDA	Air Force Service Delivery Assessment | 70
SE	Sentinel Event | 6
SECDEF	Secretary of Defense | 47
SME	subject matter expert | 47
TAMP	Transitional Assistance Management Program | 7
TBI	traumatic brain injury | 14
TDP	TRICARE Dental Program | 7
TeamSTEPPS	Team Strategies and Tools to Enhance Performance and Patient Safety | 87
TED	TRICARE Encounter Data | 142
TFL	TRICARE for Life | 6
TJC	The Joint Commission | 50
TOL	TRICARE Online | 58
TPR	TRICARE Prime Remote | 7
TRDP	TRICARE Retiree Dental Program | 7
TRISS	TRICARE Inpatient Satisfaction Survey | 32
TRO	TRICARE Regional Office | 7
TROSS	TRICARE Outpatient Satisfaction Survey | 70
TRR	TRICARE Retired Reserve | 6
TRS	TRICARE Reserve Select | 6
TYA	TRICARE Young Adult | 6
UMP	Unified Medical Program | 1
URFO	unintended retained foreign object | 84
USFHP	Uniformed Services Family Health Plan | 7
USD(P&R)	Under Secretary of Defense for Personnel and Readiness | 43
VHA	Department of Veterans Affairs Healthcare Administration | 88
WRNMMC	Walter Reed National Military Medical Center | 10
WSS	Wrong-Site Surgery | 84

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS

1988-1995

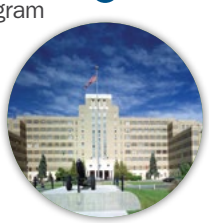
Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Era Leading to TRICARE

- Managed care demonstrations—mental health review, contracted provider arrangement for mental health, home health care/case management, catchment area management projects including the Tri-Service TRICARE Tidewater demonstration, the inaugural use of TRICARE branding
- CHAMPUS Reform Initiative demonstration contract for California and Hawaii offered CHAMPUS Prime, CHAMPUS Extra, and standard CHAMPUS (basis of later TRICARE triple option)

1993–1994

TRICARE Managed Care Legislation

- Administered under CHAMPUS fiscal intermediary contracts with oversight by the Office of CHAMPUS at Fitzsimmons Army Hospital installation in Aurora, CO
- Non-availability statements for civilian inpatient care in MTF catchment areas
- Program for Persons with Handicaps supplements basic program with non-medical benefits for Active Duty family members with serious disabilities
- Demonstration program to cover CHAMPUS Breast Cancer Treatment Clinical Trial; access to high-dose chemotherapy with stem-cell rescue; beginning of a partnership between CHAMPUS and the National Cancer Institute
- Added coverage of screening mammography and Papanicolaou (Pap) tests, added Certified Marriage and Family Therapists as TRICARE-authorized providers
- Added Continued Health Care Benefits Program for certain former DoD beneficiaries at full-cost premiums, providing beneficiaries with an option comparable to "COBRA" coverage to continue health care coverage for a limited period after leaving military service
- Reduced the catastrophic cap from $10,000 to $7,500 per year for retirees and their family members, capping their out-of-pocket expenses for any given fiscal year



1995

- Provided beneficiaries with greater choice, access to care, and coverage of preventive services through restructuring the MHS with publication of the TRICARE Final Rule (October 5, 1995; 60 FR 52078-52103) to implement managed care legislation of 1993
- TRICARE overlaid the CHAMPUS program established in 1966
- Established cost-neutral TRICARE triple option (TRICARE Prime, Extra and Standard)
- Started nationwide roll-out of managed care support contracts (seven contracts) across 12 regions, each headed by a lead agent (five Army, two Navy, four Air Force, one rotating)
- Built a TRICARE provider network to wrap around the MTFs

- Increased beneficiary access to pharmacy options by adding home delivery and retail pharmacy points of service as a result of Base Realignment and Consolidation (BRAC) commission
- Preventive services first offered exclusively under TRICARE Prime
- Reduced catastrophic cap for non-Active Duty enrollees from $7,500 to $3,000
- Expanded Active Duty Dental Benefit Plan begins

- Cancer Treatment Clinical Trial demonstration begins. Expanded beneficiary access to additional options for cancer treatment and through implementing a demonstration project Phase II and III Cancer Treatment Clinical Trials
  - Expanded coverage to all phase II and III cancer clinical trials sponsored by the National Cancer Institute (NCI)
  - Widened access to promising cancer therapies, and contributed to the NCI's efforts to further the science of cancer treatment
  - Eventually became a permanent TRICARE Basic benefit available to all beneficiaries

1996

- Requirement for outpatient Non-Availability Statement (NAS) dropped
- Increased beneficiary access to preventive services by expanding access in TRICARE Standard/Extra (expanded further in 1997 to be very similar to TRICARE Prime)
- TRICARE website is launched

1997

- National Mail Order Pharmacy program begins
- Improved access to services for families with a disabled family member through the implementation of the Program for Persons with Disabilities (PFPWD), simplifying the process and making access easier for families
- TRICARE Standard/Extra get comprehensive preventive benefits
- TRICARE Retiree Dental Program begins—full-cost premiums with no DoD subsidy

- TRICARE roll-out is complete with 11 regions operational (regions 7 and 8 consolidated)
- Increased beneficiary access to ancillary care, making it easier and cheaper by removing TRICARE Prime copayments for ancillary services (radiology, laboratory, and diagnostic testing) conducted as a result of an outpatient visit

1998

- TRICARE Senior Prime demonstration begins

1999

- Increased beneficiary access to more providers by adding Corporate Services Provider Class
  - Allowed provider groups and foundations to become TRICARE-authorized providers; the care rendered by these providers was previously not cost-shared
  - Included freestanding corporations or foundations that rendered professional ambulatory care (e.g., physical therapy), in-home care, or technical diagnostic procedures
- TRICARE Prime Remote benefit begins
- NAS are required for maternity care

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS *(CONT.)*

- Expansion of TRICARE Retiree Dental Program to dependents begins
- Reduced catastrophic cap for retirees, their family members, and survivors under TRICARE Standard/Extra from $7,500 to $3,000

2000

- The DoD waives charges for Active Duty Prime Remote family members through August 31, 2000
- Expanded TRICARE benefits to cover school physicals

2001

- TRICARE eliminates Prime copays for Active Duty family members
- TRICARE for Life (TFL) benefit begins, superseding TRICARE Senior Prime Demonstration. TFL is Medicare wraparound coverage for TRICARE beneficiaries who have Medicare Part A and Medicare Part B; TRICARE pays after Medicare and other health insurance for TRICARE-covered health care services.
- TRICARE Senior Pharmacy (TSRx) benefit begins, adding pharmacy benefits for retirees over 65 years of age who formerly lost all TRICARE benefits upon becoming eligible for Medicare at age 65
- TRICARE simplifies and reduces copay structure for prescription drugs
- Active Duty Service members get permanent chiropractic care benefit in MTFs
- TRICARE Prime travel benefit to reimburse travel expenses when a TRICARE Prime enrollee has to travel more than 100 miles for referred specialty care

- Improved beneficiary access to needed care by revising the Coverage Criteria for Transplants and Cardiac and Pulmonary Rehabilitation
  - Added coverage of heart-lung, single or double lung, and combined liver-kidney transplants
  - Added coverage of pulmonary rehabilitation
  - Enhanced access to life-saving treatments for seriously ill TRICARE beneficiaries
  - Expanded coverage for pulmonary rehabilitation services to additional diagnoses as determined by the Director or designee
- Demonstration that waived (a) NASs and (b) annual TRICARE Standard/Extra deductible for family of mobilized Reserve Component (RC) sponsor (extended five times until made permanent in 2008)
- Deployed PDTS—improving patient safety—an online, real-time worldwide prospective drug utilization review (clinical screening) against a patient's complete medication history for each new or refilled prescription; these clinical screenings identify potential medication issues, which are immediately resolved to ensure the patient receives safe and quality care

2002

- TRICARE Prime Remote for Active Duty Family Members (TPRADFM) benefit begins
- TRICARE Mail Order Pharmacy (TMOP) contract awarded (formerly managed by Defense Logistics Agency [DLA] as the National Mail Order Program)
- TRICARE Global Remote Overseas (TGRO) contract begins, providing cashless/claimless health care to overseas ADSMs/ADFMs assigned to Prime Remote locations

- Created Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC)—a discretionary program for beneficiaries with extraordinary medical or psychological conditions, providing coverage of care normally excluded by law or regulation, as long as the benefit was cost effective
- Created Custodial Care Transition Policy (CCTP) developed to cover new cases of custodial care for beneficiaries entitled to expanded benefits

2003

- TPRADFM is modified to allow family members residing in Prime Remote locations to remain enrolled when sponsors undergo Permanent Change of Station on unaccompanied tour
- Requirement for RC sponsor's activation orders for TRICARE Global Remote Overseas benefit begins

- Eliminated NAS requirement for TRICARE Standard, except for mental health
- TRICARE Retail Pharmacy contract (TRRx) awarded, carving the benefit out of the managed care support contracts into a single program

- Transitional Assistance Management Program (TAMP) coverage is temporarily extended to 180 days for all participants (made permanent in 2005)
- Early eligibility begins for RC members activated for more than 30 days in support of a contingency operation (made permanent in 2005)

2004

- TRICARE Regions and managed care support contracts consolidated to three (North, South, and West) from 11

2005

- Premium-based TRICARE Reserve Select (TRS) benefit begins for certain Reserve Component members
- Superseded the PFPWD with Extended Health Care Option/Home Health Care (ECHO/EHHC) program, including 16 hours of respite care per month
- Improved beneficiary access to needed medications and, in many cases, decreased beneficiary cost share, by implementing the DoD Pharmacy Uniform Formulary/three-tier cost-share system
- Implemented the Uniform Formulary three-tier copay, administered by the DoD Pharmacy & Therapeutics (P&T) committee under the Pharmacy Program

- Two premium tiers added to TRS so all members of the Selected Reserve can purchase coverage
- Gastric bypass, gastric stapling, or gastroplasty become covered benefits under TRICARE
- Family members are given a 30-day period to submit a TRICARE Prime enrollment form

2006

- Improved access to care for beneficiaries by adding transitional TRICARE survivor coverage for dependents whose sponsor dies on Active Duty (greater than 30 days)
- Expanded coverage to certain direct commission reserve officers awaiting Active Duty

2007

- Anesthesia and other costs for dental care for certain children and other beneficiaries are authorized
- Claims processing under TRICARE program and Medicare program is standardized
- Mental health screening and services for members of the Armed Forces are enhanced
- TRS is simplified—superseded three-tier TRS with a single 28 percent premium tier; opened to all Selected Reservists other than those eligible for, or enrolled in, Federal Employees Health Benefits (FEHB) program.

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS *(CONT.)*

- Mental health care program is included in definition of health care
- Implemented the Enhanced Access to Autism Care Demonstration through the ECHO for ADFMs
- Improved the care provided to Wounded Warriors by adding numerous benefits, including:
  - Expanded ECHO services to Service members with respite care added
  - Added retiree combat-related disability travel
  - Added transitional care for service-related conditions first identified during TAMP for RC members

2008

- Integrated disability evaluation system—ensured DoD disability ratings and VA disability ratings were established prior to medical retirement from Active Duty

2009

- Started Active Duty Dental Program (ADDP)
- Eased the potential burden on families with special needs by increasing the ECHO cap to $36,000 per year for certain services
- Increased access to care by expanding the TAMP program:
  - Separated Active Duty members who affiliate with the Selected Reserve
  - Members in receipt of a sole survivorship discharge
- Improved beneficiary access to behavioral health care by allowing a streamlined certification for Hospital-Based Psychiatric Partial Hospitalization Programs
- TRICARE Pharmacy manufacturer refunds are established (retroactive to January 2008)
- Outpatient Prospective Payment System (OPPS) is implemented
- Improved beneficiary access to vaccines by expanding coverage under pharmacy benefit for H1N1 at retail pharmacies at zero copay

2010

- TRICARE Overseas Program begins health care delivery
- Launched premium-based TRICARE Retired Reserve (TRR) program—TRICARE Standard/Extra coverage offered for purchase by Retired Reserve members (gray-area) for themselves and eligible family members
- Expanded ADDP to Reservists during TAMP

2011

- Launched premium-based TRICARE Young Adult (TYA)—TRICARE Standard/Extra coverage offered for purchase for certain beneficiaries up to age 26
- Increased access to support services by expanding the Autism Care Demonstration
- Increased access to needed treatment by expanding coverage of the available surgical options for morbid obesity
- TRICARE Pharmacy announces copay decreases for the home delivery option, coinciding with increases to copays for retail pharmacy purchases
- TRICARE Prime enrollment fee is adjusted and can now be collected annually (frozen for survivors and certain significantly injured or ill retirees)
- Increased beneficiary access to behavioral health services by adding Certified Mental Health Counselors as independent practitioners

2012

- Added coverage for off-label uses of devices if reliable evidence indicates it is safe, effective, and in accordance with nationally accepted standards of practice in the medical community
- Added assisted reproductive services for seriously or severely ill or injured service members

- Modified Over-the-Counter Demonstration Project to include Plan B One-Step (levonorgestrel) without prescription requirement
- Added coverage for abortions for rape or incest and brought coverage into conformance with existing federal statutory laws, including the Hyde Amendment, the Affordable Care Act, and President's Executive Order #13535 (March 24, 2010)
- Added coverage of hippotherapy under ECHO (horseback riding as a therapeutic or rehabilitative treatment)

2013

- Eliminated TRICARE Standard/Extra cost shares for authorized preventive services (always free of cost-sharing in TRICARE Prime)
- TYA expanded to offer TRICARE Prime coverage
- TRICARE revises compound drug coverage by adopting a more rigorous screening process to ensure they are safe and effective, and covered by TRICARE
- Decreased beneficiary cost by freezing TRICARE Prime enrollment fees at rate effective when first enrolled for Survivors of Active Duty deceased sponsors and medically retired members and dependents
- Reduction in Prime Services Areas (closed all PSAs not built around an MTF or BRAC site)
- TRS termination date delayed 180 days for Selected Reserve members involuntarily separated under honorable conditions
- Expanded Autism Care Demonstration to include retiree family members
- Restricted US Family Health Plan enrollment to beneficiaries (65 years and younger)
- Permanent authority to include certain OTC drugs under Uniform Formulary based on P&T recommendation

- Prime eligibility reinstated for some beneficiaries
- Launched Laboratory-Developed Test demonstration—authority to determine whether tests not yet approved by the FDA are safe and effective for use and thus eligible for TRICARE coverage
- TRICARE adds single-level cervical total disc replacement to list of covered procedures
- TRICARE increases access to mental health counselors
- The DoD expands available treatments for substance abuse
- TRICARE for Life (TFL) Pharmacy Pilot begins, requiring TFL beneficiaries living in the U.S. and the U.S. territories who use select maintenance medications to fill those prescriptions using TRICARE Pharmacy Home Delivery or a military pharmacy

2014

- TRICARE extends the Over-the-Counter demonstration, which permits beneficiaries to fill prescriptions for certain OTC drugs, from network pharmacies and through home delivery for free
- Certified Mental Health Counselors added as authorized TRICARE providers
- Day limits for inpatient mental health stays eliminated
- U.S.-based TRICARE Service Centers closed
- Expanded breast pump (and supplies) coverage to all TRICARE beneficiaries
- TRICARE extended coverage to same-sex spouses and their family members
- Clarified the Unfortunate Sequelae policy, ensuring that treatment of complications or medically necessary follow-on care that occurs subsequent to noncovered initial surgery/ treatment at an MTF is covered

2015

- TRICARE Prime access changed to allow beneficiaries to enroll in a region where their desired primary car manager (PCM) is located (cross-region enrollment)
- Launched fourth-generation pharmacy contract
- Added requirement for all beneficiaries (other than Service members) to receive maintenance drugs via mail-order or at MTFs only
- Awarded second-generation TRICARE Overseas Program contract
- Coverage of Transitional Care Management Services—includes services provided to beneficiaries with moderate or complex medical needs and who are transitioning from the inpatient setting to their community setting (e.g., home)

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS *(CONT.)*

2016

- Implemented first Value-Based Demonstration
  - The lower extremity joint replacement (LEJR) demonstration in the Tampa-St. Petersburg market has a direct linkage between quality and reimbursement
  - Better care coordination between the hospital and post-op care providers
- Comprehensive mental health parity—improved access at lower out-of-pocket expense
- Centralized approach for the MHS to support safe disposal of unwanted medications from patients
- Developed Medication Therapy Management Pilot
- DoD/VA Continuity of Care Drug List created for the purpose of including pharmaceutical agents critical for the treatment transition of Service members from the DoD to VA
- Added Advance Care Planning Services policy—provider reimbursement for end-of-life care beneficiary planning consultations, including the completion of Advance Directive documents
- Provided enhancements to preventive services and eliminated cost share/copays for some preventive services
- Comprehensive Autism Care Demonstration cost shares reduced for all applied behavior analysis services provided by authorized providers
- Added requirement for all beneficiaries (other than Service members) to get select brand name maintenance drugs through either TRICARE Pharmacy Home Delivery or from a military pharmacy
- Awarded TRICARE regional contracts, consolidating regions from three (North, South, and West) to two (East and West)
- Launched Urgent Care Pilot Program allowing non-ADSM Prime CONUS enrollees up to four network visits per year without referral or prior authorizations
- Expanded inpatient mental health hospital services coverage
- Over-the-counter drug coverage made permanent part of the TRICARE pharmacy benefit
- Slightly increased copays for prescription drugs at Home Delivery and retail network pharmacies
- Provisional coverage program introduced to provide coverage for emerging treatments and technologies
- Coverage additions under the TRICARE Basic Program
  - Surgery for femoroacetabular impingement (FAI)
  - Transcranial magnetic stimulation (TMS) for treatment of major depressive order and two-level cervical disc replacement
  - Nonsurgical treatment of gender dysphoria for all MHS beneficiaries; gender reassignment surgery only for Active Duty Service members
- U.S.-based pilot to encourage MHS beneficiaries seen in civilian emergency rooms (in designated markets) to voluntarily transfer to a participating MTF if an inpatient admission is needed and if determined safe for transfer
- Substance use disorder (SUD) Treatment Benefit revised to allow office-based opioid treatment by individual TRICARE-authorized physicians and add coverage of qualified opioid treatment programs as TRICARE authorized providers of SUD treatment for opioid use disorder.
- Health care delivery under second-generation TRICARE Overseas Program contract began September 1, 2016 (includes inpatient medical management of TOP Prime enrollees in civilian facilities and translation of medical documentation for all TOP Prime and Prime Remote beneficiaries)
- Implemented CHAMPUS Maximum Allowable Charges (CMAC) rates for professional services in all U.S. territories
- PSA definition changed to include newly created ZIP codes enclosed entirely within the existing PSA boundary

2017

- Initial deployment of MHS GENESIS to four MTFs and their child sites

The **Evaluation of the TRICARE Program: Fiscal Year 2018 Report to Congress** is provided by the Defense Health Agency, Decision Support Division, in the Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]). Once the Report has been sent to the Congress, an interactive digital version with enhanced functionality and searchability will be available at: http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program.

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M&RA = Manpower & Reserve Affairs
OPS = Operations
PCMH = Patient-Centered Medical Home
PHD = Public Health Division
R&M = Resources & Management
SP&FI = Strategy, Plans, and Functional Integration
THP = TRICARE Health Plan

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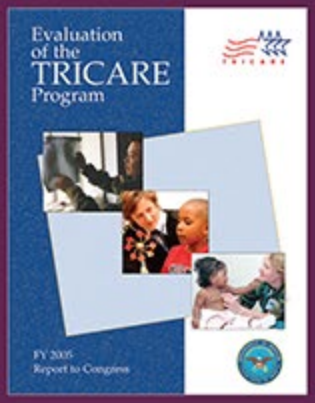

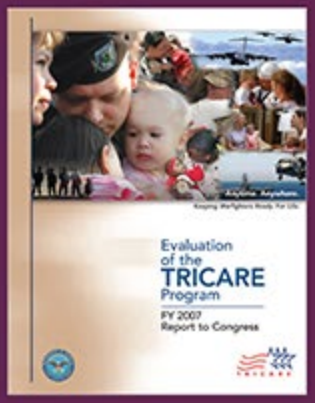

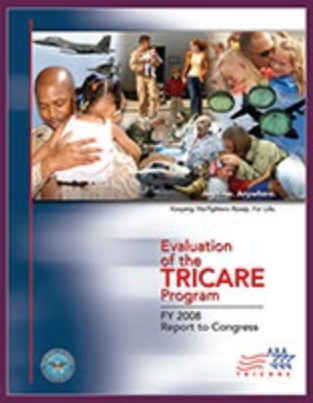

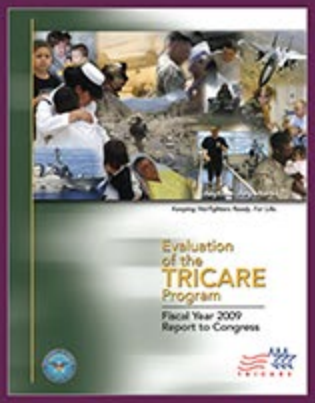

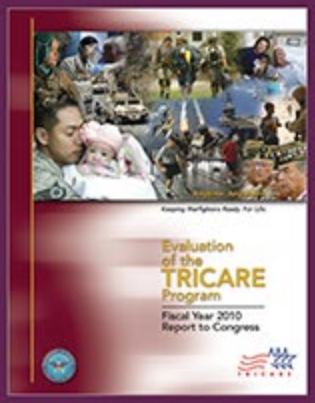

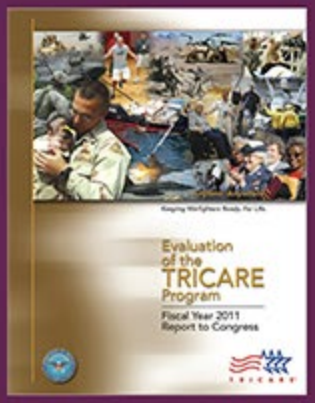

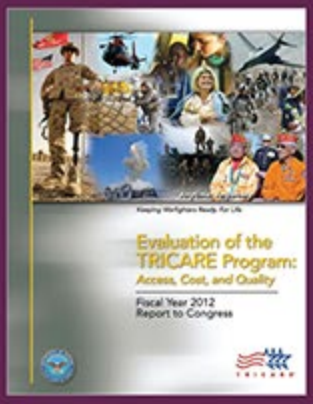

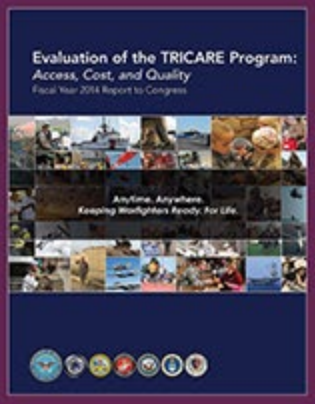

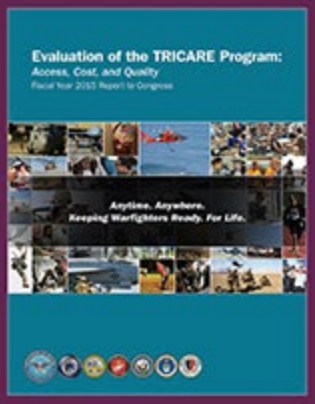

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