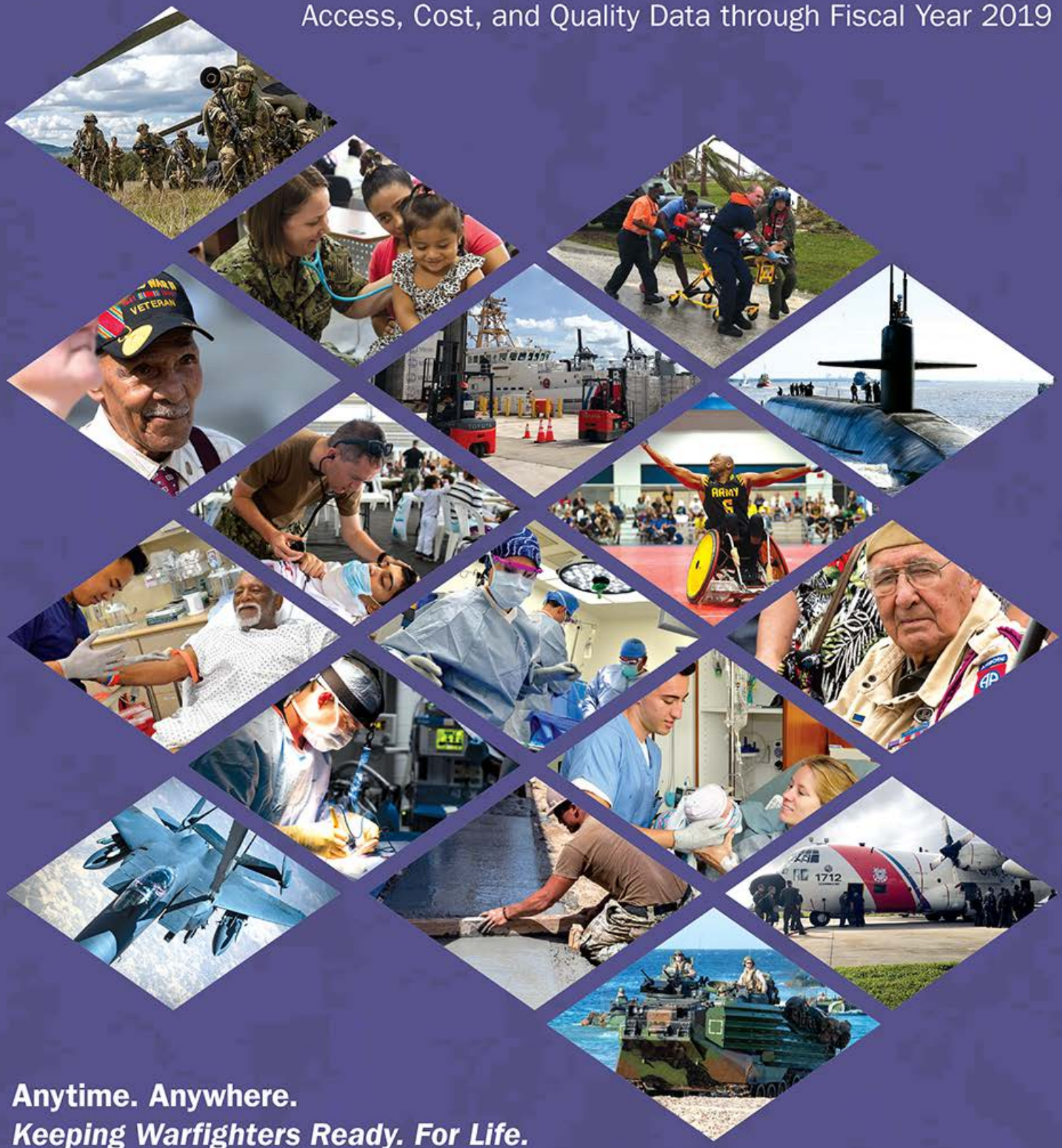
Evaluation of the TRICARE Program:

Fiscal Year 2020 Report to Congress

Access, Cost, and Quality Data through Fiscal Year 2019



Anytime. Anywhere.

Keeping Warfighters Ready. For Life.

23rd Annual

TRICARE Evaluation Report and Data

Evaluation of the TRICARE Program:

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Access, Cost, and Quality Data through Fiscal Year 2019

FEBRUARY 29, 2020

The *Evaluation of the TRICARE Program: Fiscal Year 2019 Report to Congress* is provided by the Defense Health Agency (DHA), Analytics and Evaluation Division, in the Office of the Assistant Secretary of Defense for 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 – Paratroopers with 503rd Infantry Regiment sprint off a Boeing CH-47 Chinook during training at Vojarna Josip Jovic Airbase, Udbina, Croatia, during exercise Immediate Response. (May 2019)

B – A Navy doctor assigned to hospital ship USNS Comfort (T-AH 20) examines a patient at a temporary medical treatment site as part of an international effort to relieve pressure on medical systems strained by an increase in Venezuelan migrants. (August 2019)

C – Coast Guard personnel help medevac a patient in the Bahamas during Hurricane Dorian, supporting the hurricane response efforts of the Bahamian National Emergency Management Agency and the Royal Bahamian Defense Force. (September 2019)

D – A World War II Veteran is a guest of honor at a ceremony at the National World War II Memorial, Washington, D.C., to commemorate the 75th anniversary of D-Day and Operation Overlord. (June 2019)

E – Coast Guard cutters at Coast Guard Sector Miami onload hurricane relief supplies to take to the Bahamas. (September 2019)

F – The Ohio-class ballistic-missile submarine USS Tennessee (SSBN 734) gold crew returns to its homeport at Naval Submarine Base Kings Bay, Georgia, following a strategic deterrence patrol. (January 2019)

G – A Navy pediatric neurologist assigned to the hospital ship USNS Comfort (T-AH 20) listens to the breathing of a 19-year-old man suffering from a traumatic brain injury at a temporary medical treatment site in Santa Marta, Colombia. (August 2019)

H – A Team Army athlete attempts a fingertip catch during a rugby prelim for the 2019 Department of Defense Warrior Games in Tampa, Fla. (June 2019)

I – A Navy corpsman participating in Navy Medicine's Hospital Corpsman Trauma Training works with a patient at UF Health Jacksonville. (August 2019)

J – A surgical technician at Naval Hospital Jacksonville retrieves instruments for surgeons during a laparoscopy. (June 2019)

K – A Veteran of the 82nd Airborne, 508th Regiment, Easy Company, poses for a photo during a ceremony held in honor of all airborne troops and flight crew that served on D-Day in Picauville, France. He dropped from midnight skies into Normany with the objective of overtaking an enemy stronghold. (June 2019)

L – A surgical doctor assigned to Navy Fleet Surgical Team Seven operates on a patient aboard the amphibious assault ship USS Wasp (LHD 1), the flagship of the Wasp Amphibous Ready Group. (June 2019)

M – A hospitalman apprentice assigned to Naval Hospital Camp Pendleton's labor and delivery ward hands a mother her newborn baby. (May 2019)

N – An F-15E Strike Eagle conducts aerial refueling with a KC-10 Extender from the 908th Expeditionary Air Refueling Squadron within U.S. Central Command's area of responsibility. (July 2019)

O – A Navy builder assigned to Naval Mobile Construction Battalion ONE levels wet concrete during construction of a new school for the indigenous Wayuu people of Colombia, as part of Southern Partnership Station 2019. (August 2019)

P – Coast Guard air crews and health service technicians are briefed at Coast Guard Air Station Clearwater before a C-130 flight to Andros Island in preparation for Hurricane Dorian response. (September 2019)

Q – Amphibious assault vehicles attached to 3rd Battalion, 5th Marine Regiment Landing Team, approach a beach in Jordan after departing amphibious dock landing ship USS Harpers Ferry (LSD 49). (August 2019)

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

CONTENTS

BETTER CARE *(CONT.)*

BETTER HEALTH

LOWER COST

APPENDIX

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

I am pleased to provide Congress with the Department of Defense (DoD) *Evaluation of the TRICARE Program* report, as required per section 717 of the National Defense Authorization Act (NDAA) for fiscal year (FY) 1996 (Public Law 104-106). This report provides an assessment of the Military Health System (MHS) overall performance in providing full-spectrum health care services to our 9.6 million Service member, retiree, and family member beneficiaries—representing a $49 billion FY 2020 Unified Medical Program (UMP) critical for the warfighters and patients we serve.

This report comes at a time of significant organizational reform across the MHS. As we forge a new way of doing business, we redouble our commitment to build an improved system of military health that delivers on our readiness mission to ensure troops are fit to fight, medical professionals are ready to support them in training and on the battlefield, and our patients are receiving the highest quality care possible.

The MHS is laser-focused on three key areas of organizational reform: consolidated management of the direct care and purchased care systems; a reinvigorated focus on readiness within the direct care system; and optimizing the size and composition of the military medical force, including the recruitment, education and training, and sustainment of skills to deliver on our readiness mission.

The MHS reform efforts underway will improve the quality of care and access to services for our patients, and better integrate the direct and purchased care systems. Standardization will lead to improved safety and familiar business practices which will allow patients to more easily manage their health care.

Our patients have already benefitted from recent TRICARE enhancements—including new TRICARE contracts for care provided through civilian networks; a successful rollout of two TRICARE Open Seasons; the new TRICARE Select benefit; expanded access to preventive care, urgent care, and mental health services; the option for retirees to purchase dental coverage; and eligibility for vision coverage for most beneficiaries through the Federal Employees Dental and Vision Insurance Program (FEDVIP). And in line with the National Defense Strategy, military medicine continues to engage with other federal agencies, the private sector, international institutions, and partner nations to better serve our providers and patients.

The sweeping organizational changes underway represent a historic opportunity for the MHS to better support the warfighter and care for the patient. To date, we have built a system that has achieved the highest battlefield survival rates in history, provided world-class health care for millions of beneficiaries, remained at the global forefront of cutting-edge research and development, and built the strongest and most extensive arsenal of military medical combat support capabilities on the planet. It is our highest priority to provide the best possible health care to the courageous Service members who defend our nation, to retirees, and to the families who depend on us. We will continue to deliver on this promise.

—Thomas McCaffery

EXECUTIVE SUMMARY: KEY FINDINGS FOR FY 2020

Evaluation of the TRICARE Program: Report to Congress

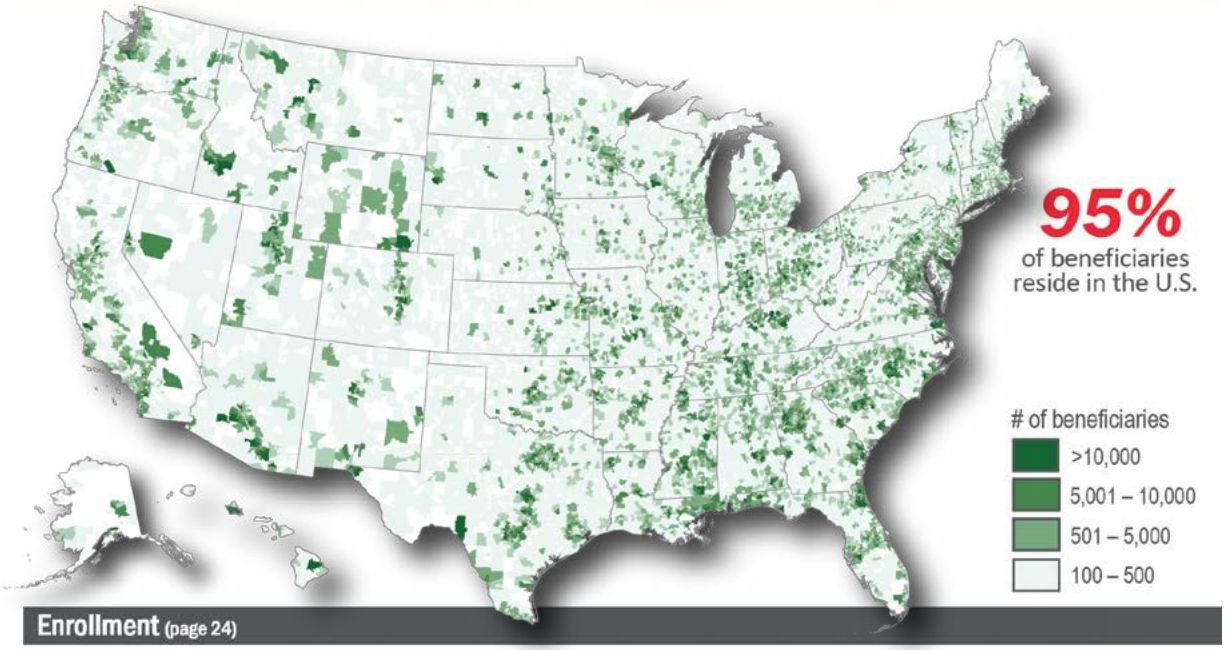
Executive Summary: Key Findings for FY 2020 (Data for FYs 2017–2019)

The DHA, a Combat Support Agency, leads the MHS integrated system of readiness and health to deliver:

The Quadruple Aim

Improved **Readiness** | *Better* **Care** | *Better* **Health** | *Lower* **Cost**

Beneficiary Population (page 29)



Enrollment (page 24)

Prime Enrolled:
4.8 million beneficiaries

- **3,461,000** Prime: MTF PCM
- **1,194,000** Prime: Network PCM
- ↑ **111,000** USFHP
- ↓ **11,000** TYA Prime

Select Enrolled/Non-Enrolled:
2.1 million beneficiaries

- ↓ **1,679,000** TRICARE Select
- ↑ **392,000** TRS
- ↑ **183,000** Direct Care Only
- ↓ **27,000** TRICARE Plus
- ↑ **27,000** TYA Select
- ↑ **10,000** TRR

Medicare-Eligible:
2.5 million beneficiaries

- ↑ **2,092,000** TFL
- ↓ **186,000** TRICARE Plus
- ↓ **91,000** Direct Care Only
- ↓ **42,000** USFHP
- **31,000** Prime: MTF PCM
- **31,000** Prime: Network PCM
- ↓ **3,000** Other

Numbers rounded to the nearest thousand; ↑ Increase from FY 2018; ↓ Decrease from FY 2018

Readiness (pages 49–50)

Active	Reserve	Dental
87%	85%	94%
Strategic Goal: 85%	Strategic Goal: 85%	Strategic Goal: 95%

Perinatal Care Measures (pages 119–120)

	MTFs	National
Health Care–Associated Blood Stream Infections	0.0%	1.0%
Elective Delivery	1.1%	1.7%
Cesarean Section	19.2%	25.7%
Exclusive Breastfeeding	71.3%	49.2%
Antenatal Steroids	98.5%	95.7%

Pharmacy (page 173)

$861 million
Retail Pharmacy Refunds

Surgical Safety (page 98)

40% decrease in number of Wrong-Site Surgery Reportable Events

Hospital Ratings (page 147)

Direct care scores improved by 4.8 percentage points from FY 2016

EXECUTIVE SUMMARY: KEY FINDINGS FOR FY 2020 *(CONT.)*

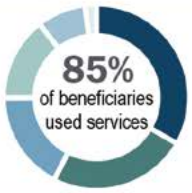
Budget (page 21)

FY 2019 Expenditures → FY 2020 Budget

$50.6 B → $49.2 B

Beneficiary Categories (page 23)

- 33% Retirees and Family Members <65
- 24% Retirees and Family Members ≥65
- 17% Active Duty Family Members
- 15% Active Duty
- 9% Guard/Reserve Family Members
- 2% Guard/Reserve Members



Utilization & Expenditures (pages 33, 36, 37, 41, 47)

	PURCHASED CARE		DIRECT CARE	
	Utilization	Expenditures	Utilization	Expenditures
Inpatient Dispositions	369,600 <1% decrease	$3,794 M 2% increase	195,000 5% decrease	$2,073 M 3% decrease
Outpatient Encounters	37.1 million 2% increase	$8,680 M 7% increase	38.3 million 2% decrease	$8,027 M 2% increase
Pharmacy Scripts	22.6 million <1% increase	$1,934 M 4% decrease	43.7 million <1% decrease	$1,518 M 9% increase
Expenditures Total		$14,408 M 4% increase		$11,618 M 2% increase

TRICARE Network Providers (pages 160–161)

21% increase in **Prime network** providers since FY 2015

11% increase in **total network** providers since FY 2015

of behavioral health providers accept TRICARE

Hospital Ratings (page 145)

Direct care ratings improved in all product lines

- **Medical**: 75% → 76% (FY 2017 → FY 2019)
- **Surgical**: 77% → 79% (FY 2017 → FY 2019)
- **Obstetric**: 65% → 68% (FY 2017 → FY 2019)

HEDIS Scores and Star Ratings (page 117)

30-Day Mental Health Follow-Up

81% FY 2016 → 78% FY 2018

Low Back Pain Imaging

76% FY 2016 → 80% FY 2019 ★★★

Well Child: 6 or More Visits

84% FY 2016 → 86% FY 2019 ★★★

Urgent Access (pages 66, 70–72)

The direct care system met future appointment goals of **less than 7 days (6.5 days) in FY 2019**

Network urgent care usage by MTF enrollees **increased almost 51%** while emergency department visits remained similar to FY 2018

– **56% of beneficiaries enrolled in secure messaging** in FY 2019
– **Over 80%** of patient messages were responded to within one business day

Access Ratings (pages 75, 92)

Overall network leakage of MTF enrollees' primary care needs **increased** from 9.9% in FY 2018 to **11.3%** in FY 2019

66–79% of MTF users in FY 2019 reported they could get care when needed, an average **2% decrease** from FY 2018

EXECUTIVE SUMMARY: KEY FINDINGS FOR FY 2020 *(CONT.)*

MHS Worldwide Summary

- The $49.2 billion Unified Medical Program (UMP) presented in the FY 2020 President's Budget, including estimated outlays from the Medicare-Eligible Retiree Health Care Fund (MERHCF), is 3 percent lower than the $50.6 billion in actual expenditures in FY 2019 and is 7 percent of total FY 2020 estimated Department of Defense (DoD) outlays (ref. pages 33–34).
- In FY 2019, 9.6 million beneficiaries were eligible for DoD medical care. Of those, almost 4.9 million (51 percent) were enrolled in TRICARE Prime (including TRICARE Young Adult [TYA] Prime and Uniformed Services Family Health Plan [USFHP]) (ref. pages 23, 30).
- TYA enrollment increased to over 37,000 beneficiaries under age 26 in FY 2019, from almost 36,500 in FY 2018, with most enrolled in the TRICARE Select benefit (72 percent) (ref. page 159).
- There were almost 391,000 covered lives in the premium-based TRICARE Reserve Select (TRS) in 146,500 plans, while Retired Reserve members and their families in TRICARE Retired Reserve (TRR) reached just over 3,800 plans and almost 10,500 covered lives (ref. pages 155–156).

MHS Workload and Cost Trends[1,2]

- The percentage of beneficiaries using Military Health System (MHS) services remained constant between FY 2017 and FY 2019, at 86 percent (ref. page 31).
- Excluding TRICARE for Life (TFL), total MHS workload (direct and purchased care combined) fell from FY 2017 to FY 2019 for inpatient care (7 percent) and prescription drugs (5 percent) but remained unchanged for outpatient care (ref. pages 36, 37, 41).
- From FY 2017 to FY 2019, direct care workload decreased for inpatient care (13 percent) and outpatient care (8 percent) but remained unchanged for prescription drugs. Over the same period, total direct care costs fell by 3 percent (ref. pages 36, 37, 41, 47).
- Excluding TFL, purchased care workload declined for inpatient care (4 percent) and prescription drugs (14 percent) but rose for outpatient care (5 percent). Overall, purchased care costs rose by 7 percent (ref. pages 36, 37, 41, 47).
- The purchased care portion of total MHS health care expenditures rose from 53 percent in FY 2017 to 55 percent in FY 2019 (ref. page 47).
- In FY 2019, out-of-pocket costs for MHS beneficiary families under age 65 were between $6,500 and $7,100 lower than those for their civilian counterparts, while out-of-pocket costs for MHS senior families were $3,200 lower (ref. pages 191, 193, 196).

Lower Cost

- MHS estimated savings include $861 million in retail pharmacy refunds in FY 2019 and $149 million in Program Integrity (PI) activities in calendar year (CY) 2018 (ref. page 173).

Improved Readiness

- **Force Health Protection:** At the end of FY 2019, the overall medical readiness of the Total Force was at 86 percent, with the Active Component at 87 percent and the Reserve Component at 85 percent, both equaling or exceeding the strategic goal of 85 percent. Dental readiness, at 94 percent, was just under 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 49–52).

Better Care

- **Access to Care:** Patient-Centered Medical Home (PCMH) primary care administrative measures indicate that, in FY 2019, military treatment facility (MTF) enrollees saw their primary care provider 57 percent of the time and a PCMH team member 83 percent of the time. Days to third next 24-hour or acute appointments (1.21 days) did not meet the one-day goal, but continued to be shorter than the minimum seven-day standard for future appointments. Network urgent care usage increased from 13 visits per 100 enrollees in FY 2018 to 18 visits per 100 enrollees in FY 2019, consistent with the enhanced benefit. Beneficiary enrollment in and MTF responsiveness to secure messaging increased in FY 2019. The Joint Outpatient Experience Survey (JOES) survey shows 76 to 81 percent of MTF users in FY 2019 reported they could get care when needed. Administrative data shows that 89 percent of non-Active Duty enrollees had at least one primary care visit in FY 2019; 81 percent of those using purchased care had at least one visit during that year (ref. pages 65–66, 71–73, 81, 88).
- **Hospital Quality of Care:** MTFs and MHS civilian network hospital performance perinatal quality measures are comparable to The Joint Commission® (TJC) hospital benchmarks. MHS civilian network hospitals and inpatient MTFs are required to maintain accreditation by a recognized external accreditation organization to demonstrate compliance with national standards of care (ref. pages 119–121).
- **Outpatient Care:** MTF Healthcare Effectiveness Data and Information Set (HEDIS®) rates exceed the national standards at the 90th percentile for treatment of children with upper respiratory infection, and surpass the national 75th percentile for cervical cancer screening, colorectal cancer screening, low back pain imaging, and treating children with pharyngitis. Based on only claims data, purchased care is in the 50th percentile for colorectal cancer screening (ref. pages 113–116).
- **Beneficiary Ratings of Inpatient Care—Overall Hospital Rating:** Direct care has shown improved patient hospital ratings from FY 2017 to FY 2019, meeting or exceeding the national Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) benchmark average in the medical and surgical product lines, with three MTFs at the 90th percentile and ten MTFs at the 75th percentile. Although ratings continue to improve in the obstetric product line, they remain below the HCAHPS benchmark (ref. pages 145–146).
- **Patient Safety:** The MHS direct care system has been focusing on reducing Wrong-Site Surgery Reportable Event (WSS RE) education and leadership engagement, with a goal of zero events. There was a reduction in REs from FY 2018 (45) to FY 2019 (27) (ref. page 98).
- **MHS Provider Trends:** The number of TRICARE network providers increased by 22 percent from FY 2015 to FY 2019. The total number of participating providers increased by 11 percent over the same time period (ref. page 160).
- **Access for TRICARE Select Users:** Results from the third year of the congressionally mandated four-year survey (2017–2020) of civilian providers and MHS non-enrolled beneficiaries shows eight of 10 physicians accept new TRICARE Select patients, a higher acceptance rate than reported for behavioral health providers (ref. page 161).

[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.

[2] The DoD's new electronic health record (EHR), MHS GENESIS, was deployed at four initial fielding sites in FYs 2017–2018 and at four additional sites at the end of FY 2019. Any inpatient and outpatient workload performed at those facilities (and at clinics that report data to those facilities) from the deployment dates onward have not yet been fully captured in the MHS administrative data, and will result in reported workload being lower than the actuals, especially in FY 2018.

MHS PURPOSE, MISSION, VISION, AND STRATEGY

The Military Health System (MHS) provides the Department of Defense (DoD) and the military with a ready medical and medically ready force that simultaneously improves the health of all those entrusted to our care. The MHS supports the Secretary's three goals by increasing the readiness of the deployable force, strengthening partnerships with industry, and reforming business processes to streamline management and administration of military treatment facilities (MTFs).

The MHS maintains integrated medical teams that deliver health services to America's military, anytime and anywhere, all supported by a uniformed sustaining base, a robust health plan, medical evacuation capabilities, and MTFs. 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 full range of military operations is contingent on the ability to create and sustain a healthy, fit, and medically ready force. To do so, we partner with industry and academia as well as other federal agencies and allies to research, innovate, educate, and train. An agile, responsive capacity for research, innovation, and development is essential to achieve improvements on the battlefield.

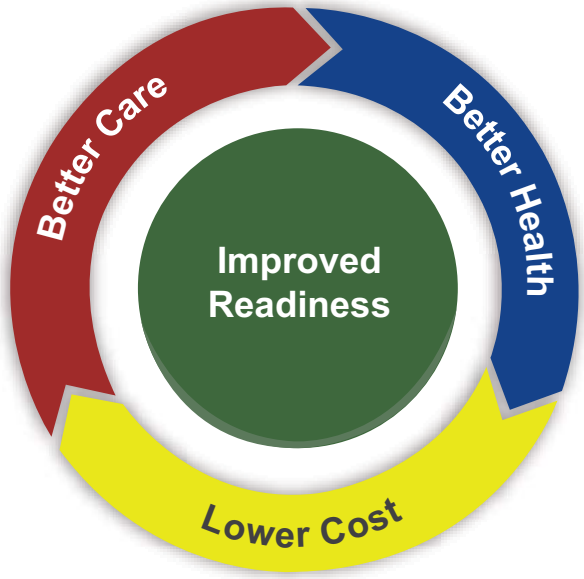
The MHS is one of the world's only global health systems, capable of rapid deployment to austere environments. We realize that we must reform legacy processes and continue to integrate in order to meet the challenges of the ever-evolving nature of war while reducing costs to the American taxpayer.

MHS QUADRUPLE AIM—STRATEGIC DIRECTION AND PRIORITIES

Since 2009, the MHS Quadruple Aim has served as the enduring framework to align the priorities of the Army, Navy, Air Force, and Defense Health Agency (DHA) to improve readiness, better care, better health, and lower costs.

- **Improved Readiness:** Readiness means ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health services at a moment's notice in support of the full range of military operations, on the battlefield or during 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, maintain, and restore the health of the fighting force as well as all entrusted to our care. 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 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 unnecessary variation. As the industry moves 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. We are becoming more agile in our decision making and are implementing longer-term opportunities to improve the value of health services for all we serve.

MHS QUADRUPLE AIM



DHA VISION AND MISSION FOR FYs 2019–2020

Vision: Unified and Ready…

Mission: As a Combat Support Agency, the DHA leads the MHS integration of readiness and health to deliver the Quadruple Aim: Improved Readiness, Better Care, Better Health, and Lower Cost.

The Quadruple Aim—Improved 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 improved readiness of the nation's fighting force.
- Fourth, ***the DHA delivers globally integrated health solutions to Combat Forces.*** 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.

–Ronald J. Place
LTG, MC, USA
Director, Defense Health Agency

DHA VISION AND MISSION FOR FYs 2019–2020 *(CONT.)*

Office of the Under Secretary of Defense for Personnel and Readiness Intent

The Office of the Under Secretary of Defense for Personnel and Readiness (OUSD[P&R]) supports the Secretary of Defense (SECDEF) and the National Defense Strategy lines of effort to build a more lethal force, strengthen alliances, and reform the Department for greater performance and affordability. Committed to developing policies, plans, and programs to support the All-Volunteer Force, OUSD(P&R) oversees military health reform efforts and force health protection, to take care of the Department's most valuable resource: our people. By generating efficiencies in the delivery of high-quality health care, OUSD(P&R) will advance the Department's Reform Management Group (RMG) initiative to bring business reform to the DoD.

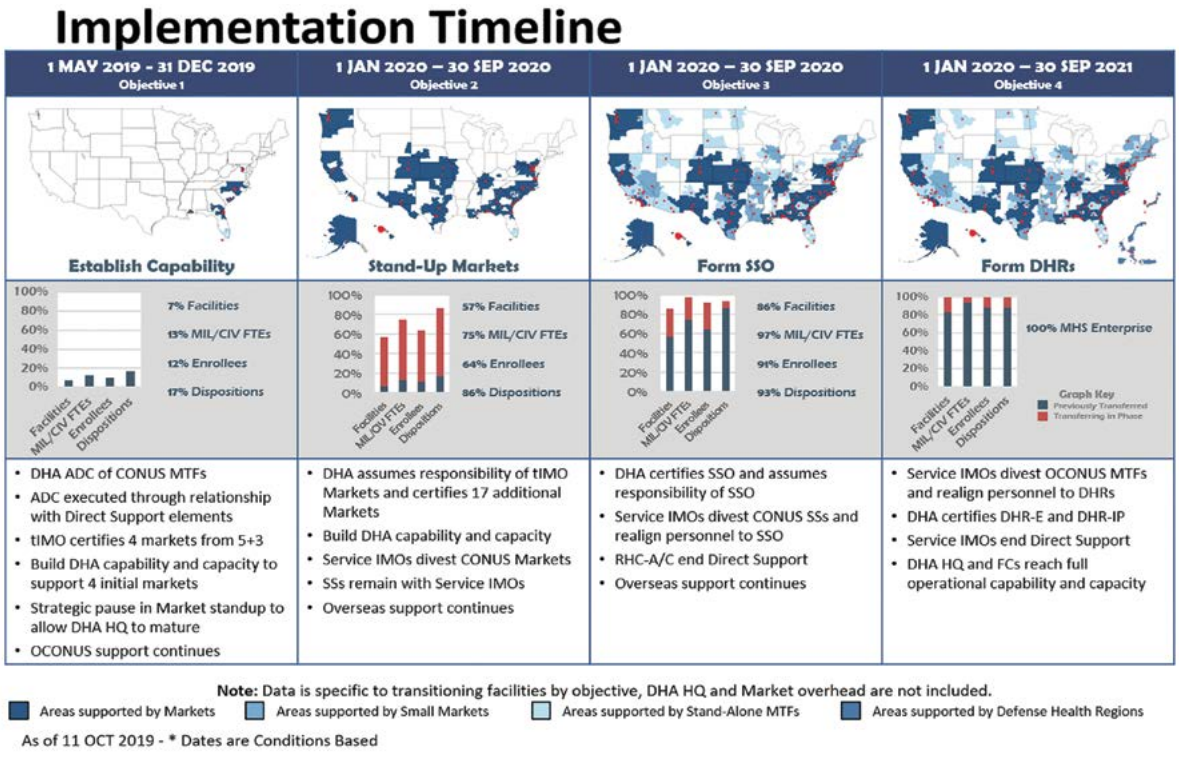
Office of the Assistant Secretary of Defense for Health Affairs Intent

The intent of the Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA]) is to support an integrated system of readiness and health. The Department's phased deployment plan executes congressional guidance set forth in Title VII of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2017, as amended by NDAA FY 2019, and seeks to eliminate separate silos of military health and integrate military health care under the DHA, consistent with the direction provided by the SECDEF. The OASD(HA) supports the DHA's implementation plan for transitioning authority, direction, and control (ADC) and management of MTFs from the military departments to DHA.

DHA Director's Intent and the MHS Transformation

The DHA's priority effort is continued implementation of the provisions of NDAA FY 2017, section 702, as modified by NDAA FY 2019, from May 1, 2019, through September 30, 2021, shown below in the implementation timeline. In October 2019, the DHA undertook administration and management of all MTFs within the contiguous United States (CONUS). The DHA will initially oversee these facilities through a direct-support relationship with the Services. The DHA is establishing a market-based structure that will provide administrative services to the hospitals and clinics in that region. The MHS Market Construct is explained on page 15. In Objective 2, the DHA will stand up 21 direct reporting markets. These markets, where nearly two-thirds of patient encounters occur, will be centered on large medical centers, establishing centers of excellence for specialty care that meet the needs of beneficiaries across their market region. In Objective 3, the DHA will establish the 16 small markets and 66 stand-alone MTFs that will report to a Small-Market and Stand-Alone Organization (SSO). The small markets will be focused on providing ambulatory and some specialty and inpatient care across their region. In Objective 4, the DHA will establish two Defense Health Regions outside the contiguous United States (OCONUS): one for Europe and one for the Pacific.

Phased Implementation of NDAA FY 2017, Section 702



Phased Implementation of NDAA FY 2017, Section 702 *(cont.)*

MHS Market Construct Overview

Designing an integrated health system that improves the delivery and coordination of health services, drives value for beneficiaries, and enhances medical readiness

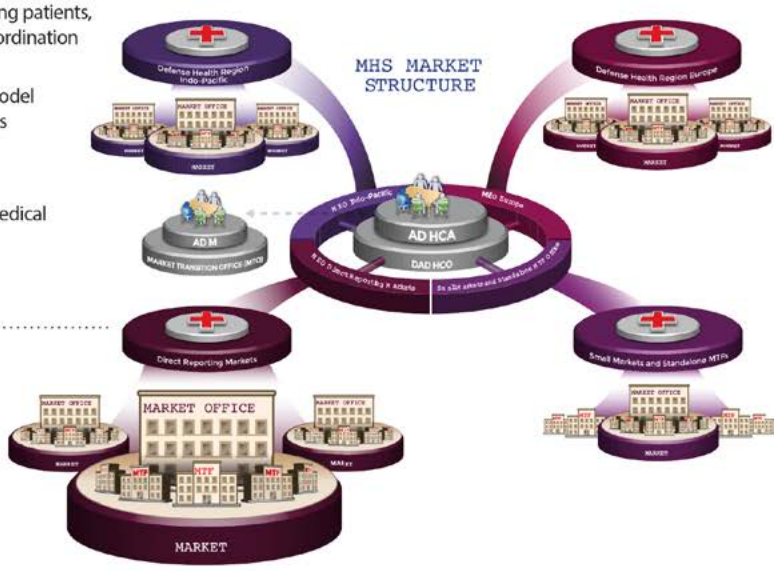
DHA Defense Health Agency

At the center of this organizational design is the health care Market. A Market is a group of MTFs in a geographic area that operate as a system, sharing patients, providers, functions, and budgets across facilities to improve the coordination and delivery of health care services.

This market construct stand up is a criteria-based and data driven model that expands on the existing eMSM concept in order to drive process standardization, reduce variability, and generate efficiencies.

A Market will:

- Provide centralized, day-to-day management and support to all medical facilities and centers of excellence within the market
- Place readiness support at the heart of its responsibilities
- Ensure the clinical competency of all of its health care providers



Market Benefits

READINESS

The market construct provides opportunities to optimize patient care while increasing maintenance of readiness related skillsets for providers and care teams

PATIENT EXPERIENCE

The demand for specialties across the Market offers opportunity for aligning healthcare demand and supply; standardized market initiatives provide greater consistency and convenience

STAFF EXPERIENCE

Administrative functions are centralized across the Market, enabling staff to engage in enhanced skill development

RESOURCES

Resourcing (i.e., funding, personnel, space) is optimized within the market, creating flexibility for MTFs to launch broader initiatives with greater reach

RESOURCES

Market Information | Transition MilSuite Site | DHA Launchpad

Core Market Functions

Each Market will execute centralized functions in support of MTFs, working to increase efficiency and standardization while maximizing great outcomes. The functions will fall into the four main buckets below.

CLINICAL

1. Functions that support the delivery of patient care
2. Clinical functions include Clinical Operations, Clinical Integration, Patient Administration, Healthcare Optimization, and Patient Safety & Quality

ADMINISTRATIVE

1. Functions that support operations of the market and MTFs in support of patient care
2. Administrative functions include Facilities, Logistics, Acquisitions, Financial Management & Comptroller, Personnel, Administration & Management, and Information Technology

EXECUTIVE SUPPORT

1. Functions that enable the execution of other functions by providing necessary knowledge, planning, and tools
2. Executive Support functions include Plans & Operations, Communications, Education & Training, and Special Staff

ANALYTICS

1. Functions that support the development, management, and review of strategy and performance goals
2. Analytics functions include Analysis & Evaluation and Strategy

Our Definition of Success

GREAT OUTCOMES

Our most important outcome is a medically ready force

READY MEDICAL FORCE

Our MTFs sustain team-based currency and proficiency enabling a ready medical force

SATISFIED PATIENTS

Our patients feel fortunate for MHS care that helps them achieve their goals

FULFILLED STAFF

Our staff feel joy and purpose working in the MHS

MHS PERFORMANCE MANAGEMENT

Performance Management System

The Under Secretary of Defense for Personnel and Readiness (USD[P&R]) simplified MHS governance on October 1, 2018, to coincide with the beginning of the system transformation directed by Congress in the NDAA for FY 2017. MHS governance was reorganized into four oversight councils covering specific policy domains—readiness, health, resource management, and health informatics. Each council is chaired by a Deputy Assistant Secretary of Defense, and co-chaired with the Joint Staff Surgeon for the readiness council. As a major change from past business practices, the MHS no longer requires full consensus from MHS components at the oversight councils; the Assistant Secretary of Defense for Health Affairs (ASD[HA]) retains the authority to make decisions where disagreement between the DHA and Services exists. Above the level of the oversight councils, the Senior Military Medical Advisory Committee and MHS Executive Review continue to adjudicate issues that require a department-wide response or decision.

Concurrent to standing up the new governance system, the OASD(HA) began building a new strategy derived from the National Defense Strategy to improve performance across the MHS, spanning the medically ready and ready medical force, population health, and efficient use of resources. The new strategy accounts for the transition of MTFs to the DHA, new paradigms in provider or institutional payment methods, as well as the ever-evolving nature of conflict, humanitarian assistance, and war.

The MHS core measures for FY 2019 largely carry over from FY 2018 and continue to focus on the MHS Quadruple Aim of Improved Readiness, Better Care, Better Health, and Lower Cost. These measures are used to drive improvement at all levels. Metrics selected from the core set underpin MHS guidance at multiple levels of the organization by measuring performance improvement at the MTFs and markets through the Quadruple Aim Performance Plan (QPP); tracking progress made by the RMG led by the DoD Chief Management Officer; and monitoring system risk during the transition of ADC of MTFs to the DHA.

MHS FY 2019 CORE MEASURES

QUAD AIM	MEASURE NAME	STATUS	QPP CRITICAL INITIATIVES	RMG	NDAA TRANSITION
IMPROVED READINESS	Individual Medical Readiness (IMR)	Currently Used	●	●	●
	Percent of Providers Meeting Knowledge, Skills, and Abilities (KSAs) for General Surgery	Partially Deployed	●	●	
	Percent of Providers Meeting KSAs for Orthopedic Surgery	Partially Deployed	●	●	
	Deployment-Limiting Medical/Dental Condition	Partially Deployed	●	●	
	Capacity to Provide Health Services for Validated RFFs ISO Conventional Force Requirements	In Development	●	●	●
	Percent of Fill Against Authorized Billets	To Be Determined	●	●	
	Defense Readiness Reporting System (DRRS) (Service)	In Development			●
BETTER CARE	Risk-Adjusted Mortality (Standardized Mortality Ratio)	Currently Used		●	
	NSQIP All Cases Morbidity	Currently Used			
	NSQIP All Cases Mortality	Currently Used			
	Inpatient: Recommend Hospital (Patient Satisfaction with Care)	Currently Used		●	●
	Catheter-Associated Urinary Tract Infection (CAUTI) Standardized Infection Ratio (SIR)	Currently Used			
	Central Line–Associated Blood Stream Infection (CLABSI) SIR	Currently Used	●	●	●
	Wrong-Site Surgery (WSS)	Currently Used	●		●
	Unintended Retained Foreign Object (URFO)	Currently Used	●		●
	Diabetes A1c Testing	Currently Used	●		
	Low Back Pain	Currently Used	●		
	Children with Pharyngitis	Currently Used	●		
	Breast Cancer Screening	Currently Used			
	Cervical Cancer Screening	Currently Used			
	Colon Cancer Screening	Currently Used			
	7-Day Mental Health (MH) Follow-Up	Currently Used			
	All-Cause Readmissions	Currently Used			
	Primary Cesarean Section (AHRQ IQI 33)	Currently Used			
	Post-Partum Hemorrhage	Currently Used			
	Unexpected Newborn Complications	Currently Used			
	Well-Child Visits	Currently Used			
	Primary Care Manager (PCM) Continuity	Currently Used			
	Potentially Recapturable Primary Care Leakage to the Network	Currently Used		●	●
	Ambulatory Specialty Care Leakage	Currently Used			
	Third Next Available Future Appointments	Currently Used	●		●
	Third Next Available 24-Hour Appointments	Currently Used	●	●	●
	Specialty Care: Average Days from Referral to Booking	Currently Used	●		
	Specialty Care: Average Days from Booking to Appointment	Currently Used	●		
	Secure Messaging Enrollment	Currently Used	●		
	Secure Messaging Response Within One Business Day	Currently Used			
	Outpatient Provider Communications Composite	Currently Used			
	Getting Care When Needed	Currently Used	●	●	●
	Active Duty Access for Primary Care	Currently Used	●	●	●
	Active Duty Access for Specialty Care	Currently Used	●	●	●
	Base/Operating Commander Assessment of Health Services Support	Prototype Approved	●	●	
	Integrated Disability Evaluation System (Cycle Time)	Currently Used			●
	Residency Review Committee (ACGME) Pass Rate	Currently Used			●
	The Joint Commission® (TJC) (Accreditation)	Currently Used			●
	College of American Pathologists (CAP)	Currently Used			●
BETTER HEALTH	Health-Related Quality of Life (HRQOL)	Currently Used	●	●	
	Obesity Prevalence in Adults	Currently Used	●	●	
	Obesity Prevalence in Children	Currently Used	●	●	
	Overweight Prevalence in Adults	Currently Used	●	●	
	Overweight Prevalence in Children	Currently Used	●	●	
	Smoking Cessation	Currently Used	●		
	Tobacco Use Rate	Currently Used	●	●	
LOWER COST	Per Member Per Month (PMPM)	Currently Used		●	●
	Total Purchased Care Cost	Currently Used			
	Private-Sector Care Cost	Currently Used			●
	Total Empanelment	Currently Used			
	Pharmacy Percent Retail Spend	Currently Used			
	Active Duty: Specialty Care Provider Efficiency	Currently Used	●	●	
	Operating Room Utilization	In Development			
	PCM Empanelment	Currently Used			
	Savings from Enterprise Shared Services and Reform Initiatives	Currently Used		●	
	Average Daily Patient Load	Currently Used			●
	Intensive Care Unit (ICU) Bed Days	Currently Used			●

Note: RFF=Request For Forces; ISO=In Support Of; NSQIP=National Surgical Quality Improvement Program; AHRQ=Agency for Healthcare Research and Quality; IQI=Inpatient Quality Indicator; ACGME=Accreditation Council for Graduate Medical Education.

MHS PERFORMANCE MANAGEMENT *(CONT.)*

Performance Management System *(cont.)*

The MHS has different dashboards for different purposes and audiences, as shown below:

DIFFERENT DASHBOARDS FOR DIFFERENT PURPOSES (FY 2019 DASHBOARDS)

MHS Core Dashboard

Critical Initiative Measures Dashboard

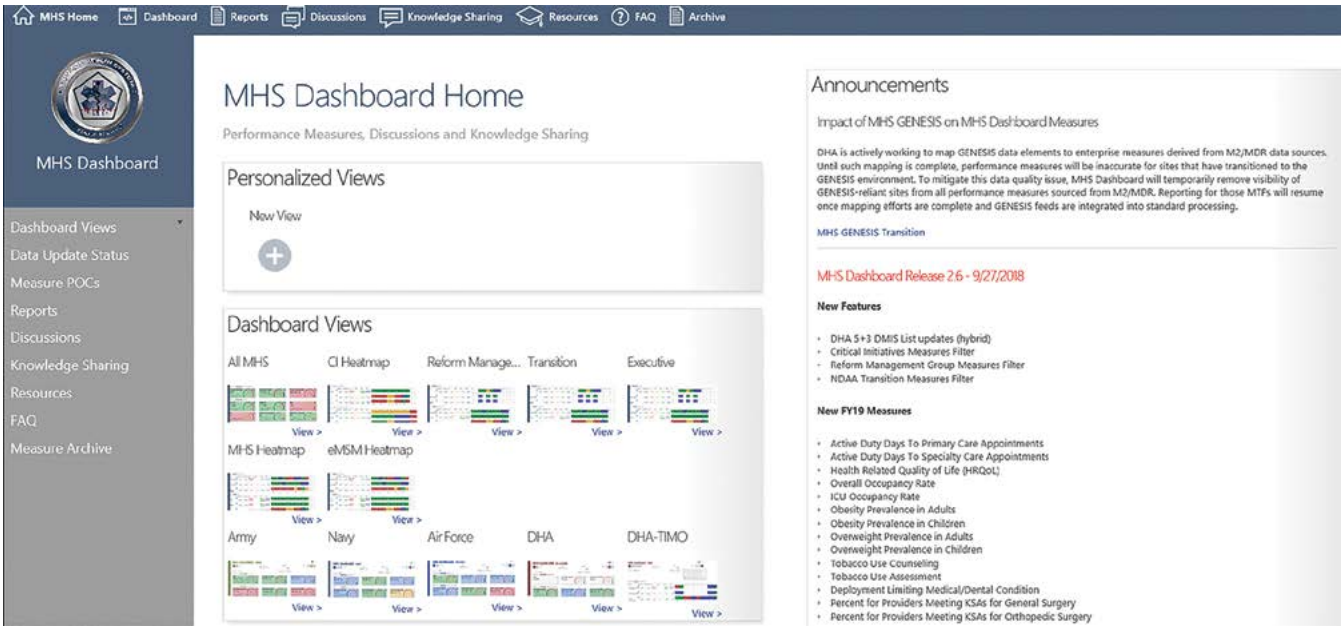
RMG Measures Dashboard

Transition Measures Dashboard

MHS Core Dashboard	Critical Initiative Measures Dashboard	RMG Measures Dashboard	Transition Measures Dashboard
63 measures	29 measures	24 measures	22 measures
Initial measures approved Dec. 2014	Available October 1, 2018	Available October 1, 2018	Available October 1, 2018
Reviewed by work groups, components, and MHS governance	Utilized for development of QPPs	Requested by the RMG	Developed in response to NDAA FY 2017 section 702
Represents core measures aligned to the Quadruple Aim and as a result of the MHS Review and includes the measures from the three dashboards displayed to the right	Represents the current priority focus areas for the DHA, as identified by VADM Bono's 7 Critical Initiatives for FY 2019	Enables the RMG insight into measures they have identified as key to enterprise performance	Provides leadership a framework to manage risk to enterprise performance during the MHS transformation

The MHS Performance Dashboard

The MHS Performance Dashboard is available to all Common Access Card (CAC) 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 (where applicable).



MHS PERFORMANCE MANAGEMENT *(CONT.)*

Performance Management System *(cont.)*

QPP Critical Initiatives Dashboard

Below is an example of the Process Improvement Dashboard, which is reviewed on a monthly basis at various levels within the MHS:

Readiness/Medically Ready Force

Measure	Data As Of	Next Refresh	Red	Yellow	Green	Blue	MHS	AIR FORCE	ARMY	NAVY	DHA	MCSC
IMR	9/2019	1/2020	<75%	≥75%	≥85%	≥90%	Current — Prior —	Current 86.1% Prior 86.8%	Current 86.6% Prior 87.8%	Current 88.6% Prior 90.2%	Current — Prior —	Current — Prior —
Deployment-Limiting Medical/Dental Condition												
Percent Meeting KSAs for General Surgery												
Percent Meeting KSAs for Orthopedic Surgery												

Better Health/Improve Well-Being

Measure	Data As Of	Next Refresh	Red	Yellow	Green	Blue	MHS	AIR FORCE	ARMY	NAVY	DHA	MCSC
HRQOL	9/2019	10/2020	—	—	—	—	Current 90.1% Prior 90.2%	Current 90.0% Prior 92.4%	Current 89.8% Prior 88.4%	Current 88.6% Prior 90.9%	Current 86.5% Prior 93.6%	Current — Prior —
Obesity in Adults Lower is better	9/2019	2/2020	—	—	—	—	Current 33.2% Prior 33.2%	Current 32.6% Prior 32.4%	Current 34.5% Prior 34.6%	Current 32.1% Prior 32.3%	Current 33.3% Prior 33.4%	Current — Prior —
Obesity in Children Lower is better	9/2019	2/2020	—	—	—	—	Current 4.7% Prior 4.6%	Current 4.0% Prior 3.9%	Current 5.1% Prior 5.1%	Current 4.7% Prior 4.6%	Current 5.0% Prior 4.8%	Current — Prior —
Overweight in Adults Lower is better	9/2019	2/2020	—	—	—	—	Current 39.1% Prior 39.1%	Current 38.7% Prior 38.7%	Current 39.0% Prior 39.0%	Current 39.6% Prior 39.5%	Current 39.1% Prior 39.2%	Current — Prior —
Overweight in Children Lower is better	9/2019	2/2020	—	—	—	—	Current 6.8% Prior 6.7%	Current 6.4% Prior 6.3%	Current 7.1% Prior 6.9%	Current 6.9% Prior 6.7%	Current 7.1% Prior 7.0%	Current — Prior —
Tobacco Counseling	9/2019	12/2019	—	—	—	—	Current 21.5% Prior 22.3%	Current 15.2% Prior 16.1%	Current 27.9% Prior 29.1%	Current 17.4% Prior 18.3%	Current 21.1% Prior 21.5%	Current — Prior —
Tobacco Use	9/2019	12/2019	—	—	—	—	Current 22.5% Prior 22.4%	Current 19.1% Prior 19.0%	Current 28.2% Prior 25.2%	Current 24.7% Prior 24.7%	Current 17.8% Prior 17.8%	Current — Prior —

Better Care/Improve Safety

Measure	Data As Of	Next Refresh	Red	Yellow	Green	Blue	MHS	AIR FORCE	ARMY	NAVY	DHA	MCSC
CLABSI – SIR Lower is better	6/2019	1/2020	Statistically Significantly >1	—	Statistically no different than 1 (Predicted)	Statistically Significantly <1	Current 1.004 Prior 0.825	Current 0 Prior —	Current 1.222 Prior 1.109	Current 0.749 Prior 0.675	Current 0.797 Prior 0	Current — Prior —
WSS Lower is better	9/2019	1/2020	Current qtr ≥3 qtr avg	Current qtr <3 qtr avg	0 events in current qtr	0 events for 3 qtrs	Current 9 Prior 3	Current 2 Prior 0	Current 3 Prior 2	Current 2 Prior 1	Current 2 Prior 0	Current — Prior —
URFO Lower is better	9/2019	1/2020	Current qtr ≥3 qtr avg	Current qtr <3 qtr avg	0 events in current qtr	0 events for 3 qtrs	Current 5 Prior 5	Current 3 Prior 3	Current 1 Prior 1	Current — Prior 0	Current 1 Prior 0	Current — Prior —

Better Care/Improve Condition-Based Quality Care

Measure	Data As Of	Next Refresh	Red	Yellow	Green	Blue	MHS	AIR FORCE	ARMY	NAVY	DHA	MCSC
Diabetes A1c Testing	9/2019	12/2019	<91.61%	≥91.61%	≥93.43%	≥94.89%	Current 91.87% Prior 91.68%	Current 91.69% Prior 91.15%	Current 92.02% Prior 92.01%	Current 92.15% Prior 91.89%	Current 91.57% Prior 91.92%	Current 76.44% Prior 76.33%
Low Back Pain	9/2019	12/2019	<76.51%	≥76.51%	≥80.51%	≥83.92%	Current 82.58% Prior 82.60%	Current 82.80% Prior 82.93%	Current 81.68% Prior 81.54%	Current 84.22% Prior 84.24%	Current 81.33% Prior 81.55%	Current 79.23% Prior 100.00%
Children w/ Pharyngitis	9/2019	12/2019	<88.89%	≥88.89%	≥92.32%	≥94.88%	Current 93.63% Prior 93.53%	Current 93.41% Prior 93.38%	Current 92.87% Prior 92.91%	Current 94.42% Prior 94.17%	Current 95.31% Prior 94.77%	Current 79.57% Prior 100.00%

Better Care/Improve Comprehensive Primary Care

Measure	Data As Of	Next Refresh	Red	Yellow	Green	Blue	MHS	AIR FORCE	ARMY	NAVY	DHA	MCSC
24-Hour Appts Lower is better	10/2019	1/2020	>1.5 Days	≤1.5 Days	≤1 Day	≤0.83 Days	Current 1.31 Prior 1.41	Current 1.66 Prior 1.79	Current 1.36 Prior 1.46	Current 0.87 Prior 0.96	Current 1.37 Prior 1.45	Current — Prior —
Future Appts Lower is better	10/2019	1/2020	>8 Days	≤8 Days	≤7 Days	≤2.3 Days	Current 6.77 Prior 6.94	Current 7.60 Prior 8.17	Current 6.68 Prior 6.68	Current 5.18 Prior 5.16	Current 7.29 Prior 7.44	Current — Prior —

Better Care/Optimize & Standardize Access

Measure	Data As Of	Next Refresh	Red	Yellow	Green	Blue	MHS	AIR FORCE	ARMY	NAVY	DHA	MCSC
Secure Messaging Enrollment	10/2019	1/2020	<37.00%	≥37.00%	≥50.00%	≥75.00%	Current 57.60% Prior 56.90%	Current 58.72% Prior 58.44%	Current 52.06% Prior 51.09%	Current 66.34% Prior 65.41%	Current 55.23% Prior 54.55%	Current — Prior —
Getting Care When Needed	6/2019	2/2020	<81.20%	≥81.20%	≥84.40%	≥87.20%	Current 78.56% Prior 79.54%	Current 78.58% Prior 79.54%	Current 78.41% Prior 79.72%	Current 79.31% Prior 79.73%	Current 77.71% Prior 78.54%	Current — Prior —
Specialty: Referral to Book Lower is better	8/2019	12/2019	>4 Days	≤4 Days	≤3 Days	≤1 Day	Current 4.26 Prior 4.01	Current 4.98 Prior 4.50	Current 3.91 Prior 3.65	Current 3.80 Prior 3.62	Current 5.37 Prior 5.16	Current — Prior —
Specialty: Booked to Appt Lower is better	8/2019	12/2019	>24 Days	≤24 Days	≤15 Days	≤7.5 Days	Current 15.77 Prior 15.90	Current 17.12 Prior 17.68	Current 15.28 Prior 15.46	Current 15.48 Prior 15.38	Current 16.28 Prior 16.33	Current — Prior —
AD: Days to Primary Care Lower is better	9/2019	12/2019	>1.5 Days	≤1.5 Days	≤1 Day	≤0.83 Days	Current 0.70 Prior 0.64	Current — Prior —	Current — Prior —	Current — Prior —	Current — Prior —	Current — Prior —
AD: Days to Specialty Care Lower is better	9/2019	12/2019	>24 Days	≤24 Days	≤15 Days	≤7.5 Days	Current 12.69 Prior 12.45	Current — Prior —	Current — Prior —	Current — Prior —	Current — Prior —	Current — Prior —

Lower Cost/Improve Stewardship

Measure	Data As Of	Next Refresh	Red	Yellow	Green	Blue	MHS	AIR FORCE	ARMY	NAVY	DHA	MCSC
AD: Specialty Provider Efficiency	6/2019	1/2020	<61%	≥61%	<79%	≥79%	Current 30% Prior 32%	Current 28% Prior 29%	Current 41% Prior 37%	Current 27% Prior 31%	Current 22% Prior 30%	Current — Prior —

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

CLINICAL QUALITY MANAGEMENT IN THE MHS *(CONT.)*

Accreditation and Compliance: Program to Address Compliance with Standards *(cont.)*

TOP 5 TJC AMBULATORY STANDARDS CITED BY CHAPTER IN MTF SURVEYS, CYs 2014–2018

CY 2014	CY 2015	CY 2016	CY 2017	CY 2018
Medication Management	Environment of Care	Environment of Care	Environment of Care	Environment of Care
Environment of Care	Medication Management	Medication Management	Medication Management	Infection Prevention and Control
Leadership	Leadership	Infection Prevention and Control	Infection Prevention and Control	Medication Management
National Patient Safety Goals	Infection Prevention and Control	Provision of Care, Treatment, and Services	Provision of Care, Treatment, and Services	Provision of Care, Treatment, and Services
Human Resources	National Patient Safety Goals	National Patient Safety Goals	Record of Care, Treatment, and Services	Leadership

TOP 5 TJC HOSPITAL STANDARDS CITED BY CHAPTER IN MTF SURVEYS, CYs 2014–2018

CY 2014	CY 2015	CY 2016	CY 2017	CY 2018
Environment of Care	Environment of Care	Life Safety	Environment of Care	Environment of Care
Infection Prevention and Control	Life Safety	Environment of Care	Life Safety	Life Safety
Life Safety	Infection Prevention and Control	Provision of Care, Treatment, and Services	Provision of Care, Treatment, and Services	Provision of Care, Treatment, and Services
Provision of Care, Treatment, and Services	Provision of Care, Treatment, and Services	Infection Prevention and Control	Infection Prevention and Control	Infection Prevention and Control
Medication Management	Medication Management	Medication Management	Medication Management	Medication Management

Source: DHA/Medical Affairs/CSD, 12/10/2019

Health care accreditation surveys provide valuable feedback on the extent to which MTFs are compliant with applicable accreditation standards, National Patient Safety Goals, and participation requirements. The AC Program requires that MTFs are assessed for health care accreditation through an on-site survey process at least every three years.

Reports generated from on-site accreditation survey activities identify noncompliant standards and requirements for improvement, and require documented completion of action plans within prescribed time frames to demonstrate successful compliance with standards.

To drive transparency, accountability, standardization, prevention, and improvement, the AC Program, in collaboration with the Services, recently led the establishment of a health care accreditation survey data repository for all survey findings for MTFs over the past five years. The repository serves as a tool to share information between facilities, monitor for patterns or trends, and identify systemwide improvement opportunities. As shown in the tables on this page, the top five hospital and ambulatory findings provide areas for a focused analysis to identify common themes for improvement activities as well as continuous compliance monitoring.

The AC Program procedures require all MTFs to continuously assess and maintain compliance with accreditation standards, policy mandates, and regulatory requirements. An annual self-assessment of all the accreditation standards must be conducted, documented, and submitted to DHA by the MTF staff. Continuous compliance with health care accreditation standards contributes to the maintenance of safe, quality patient care, and improved performance.

In addition to the survey process for accreditation, TJC requires accredited hospitals to submit national clinical quality measures data to TJC on a quarterly basis. Each inpatient MTF selects the measures for data submission. Trained abstractors collect data centrally and report to the MTFs for analysis and improvement as indicated. As an example, the perinatal care measures are included in the WICC quality measures section of this report (see pages 119–120).

Clinical Laboratory Services Accreditation

Regulatory Compliance

Standards for the regulatory compliance of clinical laboratories in the MHS are established by DoDI and DoD Manual (DoDM) 6440.02, titled *Clinical Laboratory Improvement Program (CLIP),* and *Clinical Laboratory Improvement Program (CLIP) Procedures*, respectively, dated May 29, 2014. The CLIP conditions and standards are federal laboratory/Clinical Laboratory Improvement Amendments (CLIA) comparable. Memorandum of Understanding (MOU) 15-46, between the DoD and the Department of Health and Human Services (DHHS), recognizes that certain unique mission requirements exist within the DoD that are not found within the civilian sector and authorizes the establishment of comparable, but not necessarily identical, CLIA regulations within the DoD. This MOU is current for a six-year period beginning January 14, 2015. The regulatory compliance of clinical laboratories in the MHS is, in part, evaluated

MHS PERFORMANCE MANAGEMENT *(CONT.)*

Purchased Care Performance Management *(cont.)*

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

TRICARE HEALTH PLAN ENTERPRISE SUPPORT ACTIVITY—PURCHASED CARE DASHBOARD

Strategic Alignment	Measure	Thresholds				Benchmark Date	Current Managed Care Support Contractor (MCSC) Performance	PURCHASED CARE COMPONENT PERFORMANCE						As of	Uniformed Services Family Health Plan Designated Providers (DP)						
								Managed Care Support Contractor (MCSC)		TRICARE Overseas Program (TOP)											
Quad Aim	HEDIS Measures	RED <50th %ile	YELLOW ≥50th %ile	GREEN >75th %ile	BLUE >90th %ile			East	West	Overseas	TOP 13 (Eurasia Africa)	TOP 14 (Pacific)	TOP 15 (TLAC)		Brighton Marine	Christus Health	Johns Hopkins	Martin's Point	PacMed	St. Vincent's	As of
Improved Readiness	(M1) Medical capability reports provided to Combatant Commands upon request	<90.00		≥90.00	100					100				11/2019							
	(M2) Are Combatant Commands satisfied with the quality of the reports?	<90.00		≥90.00	100					100				11/2019							
	(M1) % of patients moved from theater by TOP contractor when deferred by U.S. Transportation Command	<90.00		≥90.00	100					100				11/2019							
	(M2) % of patient movement requests where a "go/no go" decision was provided to the unit within 90 minutes	<90.00		≥90.00	100					83.00				11/2019							
Better Care	Diabetes: Annual A1c Testing	<91.61	≥91.61	≥93.40	≥94.90	10/2019	76.33	76.65	75.40		62.16	28.57	68.75	8/2019	92.53	88.69	93.19	94.54	92.00	83.00	8/2018
	30-Day Mental Health Follow-Up	<73.48	≥73.48	>80.11	>86.05		64.39							8/2016	74.47	22.22	66.40	61.74	47.10	50.00	8/2018
	Imaging for Low Back Pain	<76.51	≥76.51	≥80.51	≥83.92	10/2019	70.14				70.14			8/2019	78.43	65.38	77.48	70.19	73.60	72.00	8/2018
	Children with Pharyngitis	<88.89	≥88.89	≥92.32	≥94.88	10/2019	79.45				79.45			8/2019	97.01	79.41	92.03	91.34	79.70	92.00	8/2018
	Children with Upper Respiratory Infection	RET	RET	RET	RET		RET							RET	97.01	68.18	93.90	91.46	94.82	94.00	
	Access & Satisfaction Measures			Bench-mark			MCSC PERFORMANCE	East	West				TOP		Brighton Marine	Christus Health	Johns Hopkins	Martin's Point	PacMed	St. Vincent's	
	Inpatient: Recommend Hospital			71.00			73.00	72.00	77.00				N/A	FY 2015							
	Satisfaction: Getting Care When Needed			86.00			84.00	83.00	84.00				67.00	FY 2015	94.00	no data	90.90	94.28	89.50	94.20	8/2018
	Overall Satisfaction with Health Care (Outpatient)						88.00	89.00	87.00				N/A	FY 2015	90.70	no data	86.30	90.60	87.00	95.90	8/2018
	Provider Communication	<85.00	≥85.00	≥88.00	≥91.00	6/2019	86.60	86.90	85.70					3/2019	96.30	94.60	96.30	97.62	96.90	95.50	8/2018
	Care Coordination						70.70	71.40	68.70					3/2019	91.60	84.30	89.40	90.76	91.60	87.70	8/2018
	Beneficiary Satisfaction w/Online Enrollment Services																				
	ATC Days to Specialty Care (Prime Enrolled)	<70.00	70.00	80.00	90.00		71.80	74.90	61.40					Jan–Mar 2019							
	Active Duty Dental Care Access	<95.00		95.00	99.00		99.80							Jul–Sep 2019							
	Referrals to Non-Network				<4.00		1.90	2.30	0.30					Jul–Sep 2019							
	Hospital Compare Measures			National Rate	Good Perfor-mance		MCSC + DP PERFORMANCE	East	West				TOP		Brighton Marine	Christus Health	Johns Hopkins	Martin's Point	PacMed	St. Vincent's	
	MHS Composite			96.80			97.00	97.50	96.90				N/A	Apr 2014–Mar 2015							
	Perinatal Care: Elective Delivery			3.00			3.00	2.90	2.90				N/A	Apr 2014–Mar 2015							
	CLABSI ICU and Wards SIR (O/E Ratio)	SIR>1		SIR=1	SIR<1		0.55	0.55	0.52				N/A								
	CAUTI ICU and Wards SIR (O/E Ratio)	SIR>1		SIR=1	SIR<1		0.56	0.60	0.57				N/A	Apr 2014–Mar 2015							
	PSI 90: % Better or at National Benchmark	PSI 90>1		PSI 90=1	PSI 90<1		0.94	0.92	0.93				N/A	Jul 2012–Jun 2014							
	7-Day Mental Health Follow-Up	<47.17	≥47.17	≥57.27	≥64.46	10/2019	41.02	39.83	42.59		82.50	50.00	73.33	12/2018	44.68	16.67	45.60	40.87	29.40	N/R	8/2018
	Well-Child Visits	<82.57	≥82.57	≥87.39	≥90.41		82.69	86.19	82.37		49.12	27.59	65.52	8/2019		35.67	55.76	52.15	73.17	57.00	8/2018
Better Health	**Breast Cancer Screening**	<72.61	≥72.61	≥77.40	≥81.04	10/2019	69.48	70.42	67.63				62.92	8/2016	82.49	70.12	79.15	81.72	74.80	64.00	8/2018
	Colorectal Cancer Screening	<63.92	≥63.92	≥70.83	≥76.01	10/2019	68.96	72.68	64.65				60.55	8/2016	82.50	51.34	77.62	81.62	71.40	58.00	8/2018
	Cervical Cancer Screening	<75.16	≥75.16	≥79.02	≥82.48	6/2019	68.01	70.13	67.00				70.86	8/2016	85.38	53.04	80.78	76.24	67.80	68.00	8/2018
	Well-Child Visits in the First 15 Months	<82.57	≥82.57	≥87.39	≥90.41	10/2019	82.69	86.19	82.37				47.13	8/2019	85.96	63.64	61.85	75.00	71.43	62.00	8/2018
Lower Cost							MCSC	East	West				TOP		Brighton Marine	Christus Health	Johns Hopkins	Martin's Point	PacMed	St. Vincent's	
	Per Member Per Month	>3.20 yearly growth		>0–3.20 yearly growth	<0 yearly growth		1.10	0.90	–0.20					3/2019							
	Private-Sector Care Cost	>3.21	≤3.21	≤3.20	≤0		–1.30	–1.60	0.50					3/2019							

Note: TLAC=TRICARE Latin America & Canada; ATC=Access to Care; O/E Ratio=Observed to Expected Mortality; PSI=Patient Safety Indicators.

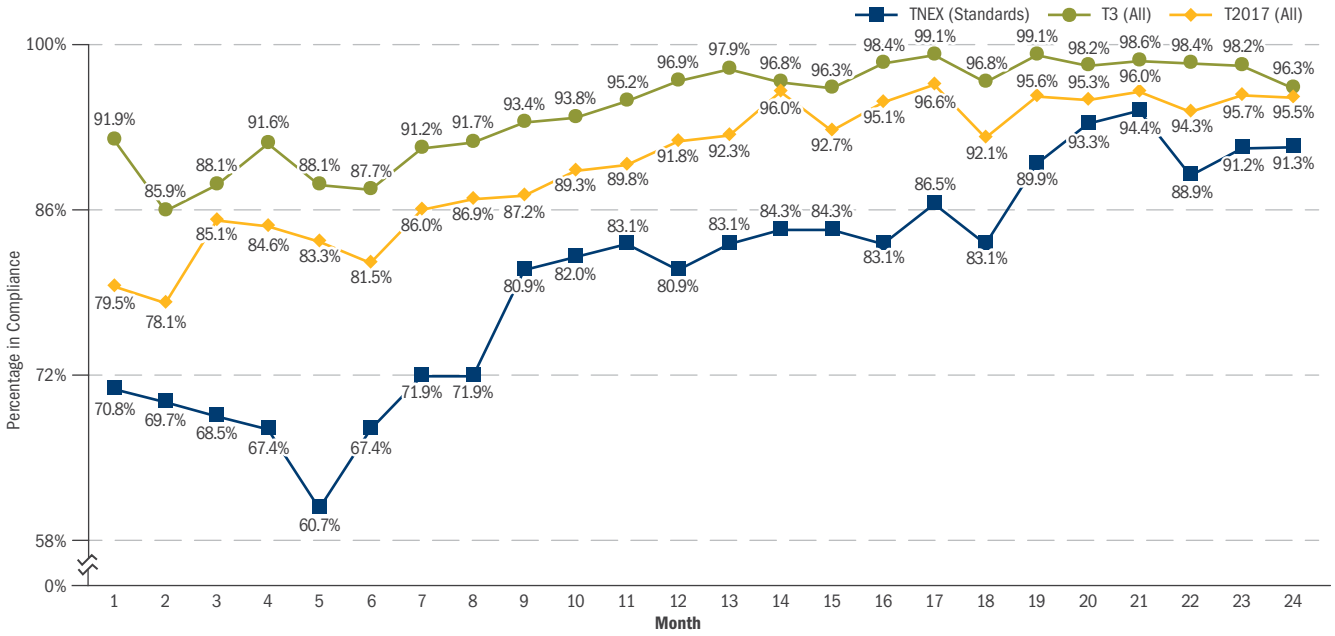
MHS PERFORMANCE MANAGEMENT *(CONT.)*

Purchased Care Performance Management *(cont.)*

The new TRICARE (T2017) contracts transitioned and started health care delivery on January 1, 2018. In comparing T2017 contract performance with the two previous generations of TRICARE contracts (T3 and TNEX) during the first nine months of performance, after some initial challenges, T2017 had compliance similar to T3 across more than 20 contract requirements in seven critical areas.

However, there have been several T2017 performance issues. The managed care support contractor (MCSC) for the West Region, Health Net, faced a shortage of primary care providers and specialists across multiple regional areas. In addition, the provider directory was found to be correct for only 25 percent of providers in the West Region. In the East Region, Humana Military faced difficulties processing timely and accurate claims.

PERCENTAGE OF CONTRACTS IN COMPLIANCE, OPTION PERIODS 1 AND 2



Source: Requirements from the Contract Quality Assurance Plan

In FY 2019, DHA continued three demonstrations/pilots to adhere to NDAA FY 2016, section 726 and NDAA FY 2017, sections 701(h), 704(a), and 705(a) requirements focused on value-based care. These projects were Network Requirements and Standards for Urgent Care Centers, Medication Adherence, and the Performance-Based Maternity Payment (P-BMP) program. Additionally, DHA completed a demonstration project launched in FY 2016 for Lower Extremity Joint Replacement or Reattachment (LEJR) in the Tampa Bay market area. The Network Requirements and Standards for Urgent Care Centers pilot began in December 2017 and was implemented nationwide. The goal of this project was to improve access to and quality of care in urgent care (UC) center services in both MTFs and TRICARE preferred provider networks. It included removing referral requirements for network UC, extending hours at MTF UC, and requiring network UC facilities to comply with several clinical practice guidelines (CPGs). The Medication Adherence demonstration, launched in February 2018, was designed to reduce or eliminate copays for high-value drugs to encourage patient adherence to these medications. This program is expected to impact approximately 136,000 users per quarter with a copay savings for users of approximately $4.9 million per year.

DHA has developed metrics related to desired clinical outcomes that are associated with these high-value drugs. Lastly, the P-BMP program began on April 1, 2018, encouraging beneficiaries to utilize high-value, high-quality facilities for maternity care, in line with Leapfrog Group quality metrics. In October 2018, this program was expanded to incorporate quality incentive payments to providers that exceed national benchmarks for maternity care quality. These efforts are ongoing. Further, DHA is in the process of developing new value-based incentive programs for hospital value-based purchasing, home health value-based purchasing, and modifications to reimbursement for physician-administered drugs. Several beneficiary incentive programs are under review consistent with NDAA FY 2017, section 729. TRICARE also developed an accountable care organization (ACO) demonstration in the Atlanta area, which allows beneficiaries to enroll into a high-value plan offered by Kaiser Permanente. These projects will offer DHA the opportunity to test value-based payment models and incorporate innovative ideas and solutions into managed care support contracts under the TRICARE program. They will also inform efforts to implement significant reforms and improvements into the next generation T5 TRICARE managed care support contracts.

WHAT IS TRICARE?

TRICARE is the worldwide Department of Defense (DoD) health care program serving 9.6 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 (tricare.mil). As a major component of the Military Health System (MHS; health.mil), TRICARE brings together the military hospitals and clinics worldwide (often referred to as "direct care," usually in military medical treatment facilities [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.

The TRICARE program offers beneficiaries a range of health plans as follows:

- **TRICARE Prime** is an enrollment-based plan comparable to health maintenance organization (HMO) plans. Each enrollee is assigned a primary care manager (PCM), a health care provider 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 Select.
- **TRICARE Select** is an enrollment-based, self-managed preferred provider organization (PPO) plan that features access to both network and non-network TRICARE-authorized providers with no referrals required for coverage.
- **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), available for purchase by Selected Reserve members and family members, and family members of Active Duty members
    - Continued Health Care Benefit Program (CHCBP), which provides a Consolidated Omnibus Budget Reconciliation Act–like continuation benefit
    - Federal Employees Dental and Vision Insurance for Program (FEDVIP) offers dental insurance for purchase by retirees and vision insurance for purchase by most TRICARE plan enrollees
  - **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 and Department of 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 private sector chiropractic care is authorized)
    - Clinical and educational services demonstration programs (e.g., chiropractic care, autism services, and the accountable care organization [ACO])

HOW TRICARE IS ADMINISTERED

TRICARE consists of both care in the direct care system and in the purchased care sector through managed care support contracts and the TRICARE health care benefit.

The direct care system consists of medical centers, hospitals, and ambulatory clinics located worldwide. Effective October 25, 2019, the Defense Health Agency (DHA) is responsible for the administration, direction, and control (ADC) of MTFs in fulfillment of the National Defense Authorization Act (NDAA) for fiscal year (FY) 2017, section 702. One of the goals of the NDAA FY 2017, section 702 was to eliminate variance in processes in order to eliminate unnecessary overhead and support the MHS's Quadruple Aim. DHA will direct and administer the direct care system by establishing standard DHA guidance, reporting relationships, and implementing a market construct. Markets consist of one or more MTFs, which will be under a single authority reporting to DHA, and which will allow better utilization of medical assets in support of a ready

HOW TRICARE IS ADMINISTERED *(CONT.)*

medical force and a medically ready force. Direct care market offices worldwide are responsible for successfully executing established performance plans and DHA guidance.

From the purchased care perspective, TRICARE is administered by the DHA on a regional basis. The Managed Care Support Program (MCSP) section within the purchased care delivery branch provides government oversight of two regional managed care support contracts: Humana Military in the East Region and Health Net Federal Services for the West Region. These managed care support contractors (MCSCs) provide private sector health care services to TRICARE enrollees located within the United States. DHA's TRICARE Overseas Program (TOP) section provides government oversight of the overseas contractor, International SOS.

Both MCSP and TOP are responsible for managing purchased care operations for their respective areas of responsibilities and for coordinating with the MTFs for medical services available through civilian providers. The MCSP and TOP offices perform the following:

- Administer and manage the purchased care contracts in the United States and overseas
- Support the optimization of MTF markets, both small and large
- Support the Combatant Commands in delivery of health care in remote locations and during natural disasters when military assets are not available

NEW BENEFITS AND PROGRAMS IN FY 2019 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 Program and Benefits Evolution over the Years in the Appendix).

Contracts and Organizational Change

Assistant Secretary of Defense for Health Affairs Formally Sworn Into Office

Thomas McCaffery, a former civilian health care executive, was formally sworn into office on August 28, 2019, having served as the Principal Deputy Assistant Secretary of Defense for Health Affairs since August 2017. As assistant secretary, McCaffery is responsible for executing the Defense Health Program (DHP), including providing health care to 9.6 million Service members, retirees, and their families through the TRICARE health benefit, at both MTFs and through civilian networks.

DHA Welcomes New Director

Army Lt. Gen. Ronald Place became the third director of the DHA on September 3, 2019. He succeeded Navy Vice Adm. Raquel Bono, who retired after 36 years of service and had been the DHA director since 2015. Place led the Program Management Office as it established, implemented, and oversaw some of the most sweeping organizational changes in military medicine in decades driven by NDAA FY 2017 reforms.

In the past two years, Place has served in several DHA leadership roles, including the National Capital Region Medical Directorate (NCRMD), MHS transitional Intermediate Management Organization (tIMO), and later as the interim assistant director for health care administration, a key position that will eventually have oversight over all military hospitals and clinics.

DHA Assumes ADC for all MTFs in the United States and Puerto Rico

The Deputy Secretary of Defense directed ADC of all MTFs and dental treatment facilities (DTFs) in the fifty United States and Puerto Rico transfer from the military departments to the DHA effective October 25, 2019: "The management of these MTFs and DTFs during FY 2020 will be executed through direct support agreements currently in effect between the DHA and each military department and will ensure that operation of the MHS continues in an efficient and effective manner during the transition of capability and resources from the military departments to the DHA." Important objectives of the transition include:

- **Centralized ADC** of all MTFs formerly reporting to the individual Services to support consistent and standardized policies and procedures.
- **Establishment of Health Care Markets.** The DHA will stand up 21 large markets during the transition period to manage MTFs in local areas.

NEW BENEFITS AND PROGRAMS IN FY 2019 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

- **Establishment of a Small-Market and Stand-Alone Organization (SSO)** for stateside military hospitals and clinics not aligned to a large market. This office will provide managerial and clinical oversight.
- **Establishment of Defense Health Regions Overseas.** The transition period for standing up Defense Health Regions in Europe and the Indo-Pacific begins in 2020. All MTFs overseas would then report to their respective DHA regional offices.

Once complete in 2021, the MHS will operate as one system with the unifying missions to improve readiness for our medical professionals and deliver better care for patients and better health outcomes for all DoD beneficiaries.

TRICARE Retiree Dental Program (TRDP) Replaced with FEDVIP on January 1, 2019

In a change to the benefits for retirees, TRDP ended on December 31, 2018, and was replaced with FEDVIP, which is administered by the U.S. Office of Personnel Management (OPM). Now, FEDVIP dental coverage is available for purchase by TRICARE beneficiaries who previously qualified for TRDP. They may choose a dental plan from among the 10 dental carriers participating in FEDVIP dental.

The Federal Benefits Open Season ran concurrently with the TRICARE Open Season. Coverage went into effect January 1, 2019. Messages have been sent via postcards, newsletters, e-mails, and phone calls to inform beneficiaries of these changes. Beneficiaries have been directed to OPM phone numbers and Benefeds.com for more information and to enroll.

TRICARE Beneficiaries May Qualify to Purchase Vision Coverage Through FEDVIP

Most beneficiaries in a TRICARE health plan may also enroll in a FEDVIP vision plan. They may choose a vision plan from among the five vision carriers participating in FEDVIP vision. FEDVIP vison plans provide comprehensive vision coverage, including routine eye exams and contacts or glasses.

Retirees, retiree family members, and Active Duty family members (ADFMs) who are enrolled in a TRICARE health plan may qualify to purchase FEDVIP vision coverage during the annual Federal Benefits Open Season in the fall each year.

DoD, VA Launch Joint Office to Make Decisions on Health Record Interoperability

Leaders from the DoD and VA committed to the creation of an office to oversee the interoperability of electronic health records (EHRs) between the two as they roll out new, modernized systems. The DoD and VA agreed to the creation of the Federal Electronic Health Record Modernization (FEHRM) program management office in March 2019.

MHS GENESIS Goes Live at Four New Sites, Effective September 7, 2019

MHS GENESIS is the new electronic health care record of the MHS. Once fully deployed, it will provide a standardized, advanced EHR to support the application of standardized workflows, integrated health care delivery, and data standards for the improved and secure electronic exchange of medical and dental patient data across the continuum of care, from point of injury to the MTF.

MHS GENESIS utilizes the same software under development by the VA for that agency's new EHR system, and will be interoperable by default. When fully deployed, information between the two health care systems will be passed securely, conveniently, and easily, helping to ensure a warm handoff of Service members into the VA system of care.

TRICARE Program Changes in 2019

During Calendar Year 2019:

- **TRICARE extended the open enrollment window to December 31, 2018.** Beneficiaries could enroll in or change their TRICARE Prime or TRICARE Select plan through December 31, 2018, for coverage starting on January 1, 2019. They could also change the type of enrollment, like switching from individual to family coverage.
- **Starting on January 1, 2019, TRICARE beneficiaries** will only be able to enroll or make changes to TRICARE Prime or TRICARE Select plans during the annual fall TRICARE Open Season or within 90 days after a qualifying life event (QLE).
- **Retiring Service members now have up to a year to decide whether to stay with TRICARE Prime or choose TRICARE Select for their family's health coverage after they leave military service.** The health care selection period for retirement—one of eight TRICARE-recognized QLEs—is now 365 days rather than the 90-day window for all other QLEs.

NEW BENEFITS AND PROGRAMS IN FY 2019 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

- **TRICARE Select expanded the TRICARE network** by requiring MCSCs to ensure that at least 85 percent of TRICARE Select enrollees have ready access to network providers.
- **Reinforced standards of access to care for Prime enrollees**. Consistent with law, Prime enrollees are assured of more timely MTF appointments. Prime beneficiaries also have expanded access to urgent care (UC) without the need for a referral from their PCM.
- **An annual open season enrollment** (November–December 2019) when beneficiaries were free to change or enroll into TRICARE Prime or TRICARE Select for coverage effective January 1, 2020.
- **Rules for QLEs were refined** that permit beneficiaries to change TRICARE health plans outside open season starting in 2019.

Atlanta Pilot Program Supports Value-Based TRICARE Prime Option

TRICARE Prime beneficiaries in the Atlanta region will be able to choose Kaiser Permanente as a health care option in 2020. Humana Military, the company that administers TRICARE's East Region, has partnered with Kaiser Permanente on a three-year pilot to provide TRICARE Prime to eligible residents within 40 miles of Atlanta. The new agreement, which will run through 2023, could be the first of several similar arrangements as the DHA explores new ways to provide "value-based care," defined as a health system that pays providers based on performance, quality, and value, as opposed to volume. Under the NDAA FY 2017, the Pentagon was required to assess using value-based care within TRICARE and report the results to Congress.

TRICARE Receives High Marks from Blue Star Families Military Lifestyle Survey

Among the top findings were feedback about TRICARE, the military's health program. Two-thirds (66 percent) of military family respondents ranked health care benefits as the second top reason for staying in the military following the retirement benefit (71 percent).

Although the vast majority (81 percent) of military family respondents were satisfied with the cost share of military health care, the quality of providers (73 percent), and the quality of care (78 percent), they were least satisfied with the ease of access and timeliness of care (65 percent).

DoD Proposes Rule That Would Allow the Secretary of Defense (SECDEF) to Impose Civil Monetary Penalties (CMPs)

This proposed rule establishes a program within the DoD to impose CMPs for certain unlawful conduct in the TRICARE program. To the extent applicable, the proposed rule would adopt the Department of Health and Human Services (DHHS) well-established CMP rules and procedures. This would enable both TRICARE and TRICARE providers to rely upon Medicare precedents and guidance issued by the DHHS Office of Inspector General regarding conduct that implicates the CMP law. The program to impose CMPs in the TRICARE program would be called the Military Health Care Fraud and Abuse Prevention Program.

New Procedure Codes for Applied Behavior Analysis (ABA) Provider Services Under the TRICARE Comprehensive Autism Care Demonstration (ACD), Effective January 1, 2019

The ACD covers ABA services for all eligible TRICARE beneficiaries diagnosed with autism spectrum disorder. Behavior analysis is based on the science of learning and behavior. The goal of ABA services is to increase behaviors that are helpful and decrease behaviors that are harmful or affect learning.

Current procedural terminology (CPT) codes are the U.S. standard for how health care professionals document and report medical, surgical, radiology, laboratory, anesthesiology, and evaluation and management services. CPT codes are used by all providers, payers, and facilities. Updating these codes is expected to improve the provider claims process and bring the ACD more in line with the TRICARE basic benefit.

TRICARE Announces Changes to Coverage Regarding Breastfeeding Supplies and Services

The policy changes, announced April 9, 2019, now clarify the specific types of breast pumps and supplies covered. The updated policy also added coverage for two additional breastfeeding supplies. TRICARE continues to cover breast pumps, breast pump supplies, and breastfeeding counseling at no cost for new and adoptive mothers.

NEW BENEFITS AND PROGRAMS IN FY 2019 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

TRICARE Policy Change Allows Children with Terminal Illnesses Covered by TRICARE to Receive Both Treatment and End-of-Life Care

Prompted by the NDAA FY 2018, the new policy allows military dependents under 21 to receive both medical treatment for their terminal illness, such as medication, radiation, or surgeries; and care that falls under the umbrella of "hospice," which includes pain relief and symptom control. Under previous law and policy, a patient could only receive one or the other.

Quadruple Aim: Improved Readiness

DHA Releases Latest Version of the Military Acute Concussion Evaluation 2 (MACE2)

The MACE2 is for use by all medically trained personnel who treat Service members with suspected traumatic brain injury (TBI). This includes medics, corpsmen, and other health care providers.

The Defense and Veterans Brain Injury Center (DVBIC), the DHA's Research and Development Directorate's TBI center of excellence, developed the MACE2 from the 2012 version of MACE. The MACE2 combines state-of-the-science advances in concussion care and feedback from military end users. The result is a more thorough tool to evaluate and document concussions in Service members and Veterans.

DHA Director Signs Policy Memorandum to Set Out Guidelines Around Managing Problematic Substance Use by DoD Personnel

The policy will be in effect for 10 years. The policy outlines the requirements to provide educational materials and the opportunity for evaluation and treatment to any Service member or DoD employee who has problematic substance use issues. It requires coordinated treatment and referral services with other military programs serving populations at high risk for problematic substance use, such as programs for child and spouse maltreatment, exceptional family member programs, and hospital medical and surgical services.

TRICARE Provides Health Care Support Following Hurricanes and Floods

Following hurricane and flooding events in 2019, TRICARE put into place emergency procedures for impacted beneficiaries. Emergency prescription refill procedures or referral waivers were in effect for varying periods in California, Iowa, Nebraska, and Virginia as follows:

- February 28–March 18, 2019: California (emergency prescription refills)
- March 18–April 1, 2019: Iowa and Nebraska (emergency prescription refills)
- September–October 2019: Virginia (emergency prescription refills and referral waivers)

Air Force Introduces New Medical Model to Restore the Overall Readiness of Our Military

Under the new Air Force Medical Reform model, dedicated provider care teams will be aligned to an Operational Medical Readiness Squadron primarily focused on proactively treating Active Duty Airmen and improving their availability to support the warfighting mission. Care for non-Active Duty patients, primarily the families of Service members and military retirees, will be handled by separate provider teams aligned to a Health Care Operations Squadron.

Quadruple Aim: Better Care

DVBIC Releases Clinical Recommendations for Cognitive Rehab Following Mild to Moderate TBI

Recommendations build on the 2016 VA/DoD CPGs on concussion and mild TBI. While there has been new research on cognitive rehabilitation over the past few years, clinical practice varies widely in the MHS and throughout the VA.

To diminish this variation, DVBIC established subject matter expert (SME) work groups from the DoD, VA, civilian health care, and academia; nearly 40 experts were involved. Drawing on both published literature and their own expertise, the working group developed a consensus opinion in August 2017 that helped shape how the specific recommendations were developed. The new DVBIC recommendations provide resources to enable consistent care delivery across the MHS, Veterans Health Administration (VHA), and civilian providers.

Cognitive rehabilitation focuses on improving thinking and communication skills such as attention, problem solving, planning, and memory. More generally, it provides strategies to target cognitive difficulties in daily life.

NEW BENEFITS AND PROGRAMS IN FY 2019 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

Joint Base San Antonio, Texas, Air Force and Army Medical Researchers Developing Smartphone App to Connect Providers Downrange with On-Call Ophthalmologists

The smartphone application, called FOXTROT, which stands for "forward operating base expert telemedicine resource utilizing mobile application for trauma," will bring specialty eye care much closer to the point of injury. Specifically, it will allow providers downrange to conduct eye exams and assist with diagnosis and the management of eye injuries.

Ten Army Medical Professionals to Participate in New Program Designed to Sustain Battlefield Medicine Skills by Training at Two of Nation's Civilian Teaching Hospitals

The program, called Army Military-Civilian Trauma Team Training (AMCT3), is a two- to three-year program at Cooper University Health Care in Camden, N.J., and Oregon Health and Sciences University in Portland, Ore. The goal of the program is to advance military trauma operational readiness for deployment around the globe by partnering with high-volume civilian trauma centers to gain critical teamwork and technical trauma skills.

Quadruple Aim: Better Health

TRICARE Publishes Article Highlighting Benefits Available to Prevent and Treat Heart Disease

TRICARE covers cardiovascular disease screenings, including blood pressure and cholesterol checks. For men aged 65 to 75 who have ever smoked, TRICARE covers a one-time abdominal aortic aneurysm screening to screen for cardiovascular disease.

During a health promotion and disease prevention exam, TRICARE also covers Type 2 diabetes screening for those who have high blood pressure and adults between the ages of 40 and 70 who are overweight or obese. Getting preventive screenings now could save your life tomorrow.

Quadruple Aim: Lower Cost

TRICARE Annual Cost Increases

The DHA adjusted TRICARE costs on January 1, 2019. Rate changes were based on factors such as the annual cost of living adjustment or average costs of covered services. To make costs more predictable for enrollees, the DHA introduced more copayments for in-network care under the new TRICARE Select program.

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

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

Increases to TRICARE Pharmacy Copayments

Effective January 1, 2020, a 90-day supply of generic drugs received through the program's mail-order pharmacy increased from $7 to $10. Copays on brand-name drugs received through the mail went from $24 to $29.

Generic drug prescriptions filled at retail pharmacies will see the cost rise from $11 to $13 for a 30-day supply, while the same supply of brand-name medications will increase from $28 to $33. Prescriptions filled on base will continue to be free.

BENEFICIARY TRENDS AND DEMOGRAPHICS

System Characteristics

TRICARE FACTS AND FIGURES—PROJECTED FOR FY 2020

	PROJECTED FOR FY 2020[a]	FY 2019 (AS PROJECTED LAST YEAR)
Total Beneficiaries	**9.6 million worldwide[b]**	9.5 million worldwide[b]
MILITARY FACILITIES—DIRECT CARE SYSTEM[c]		
Inpatient Hospitals and Medical Centers	**50 (37 in U.S.)**	51 (37 in U.S.)
Ambulatory Care and Occupational Health Clinics	**425 (372 in U.S.)**	424 (373 in U.S.)
Dental Clinics	**246 (203 in U.S.)**	248 (204 in U.S.)
Veterinary Facilities	**251 (206 in U.S.)**	251 (206 in U.S.)
Military Health System (MHS) Defense Health Program–Funded Personnel	**138,283**	144,217
Military	**77,739**	82,256
	28,824 Officers	30,796 Officers
	48,915 Enlisted	51,460 Enlisted
Civilian (including Foreign National)	**60,544**	61,639
CIVILIAN RESOURCES—PURCHASED CARE SYSTEM[d]		
Network Primary Care, Behavioral Health, and Specialty Care Providers (i.e., individual, not institutional, providers)	**548,297**	799,600
Network Behavioral Health Providers (shown separately, but included in above)	**97,727**	78,660
TRICARE Network Acute Care Hospitals	**4,372**	3,309
Behavioral Health Facilities	**1,612**	1,310
Contracted (Network) Retail Pharmacies	**56,696**	56,810
Contracted Worldwide Pharmacy Home Delivery Vendor	**1**	1
TRICARE Dental Program (TDP) (for Active Duty families, Reserve members and their families)	**Over 1.8 million covered lives in 769,000 contracts**	Over 1.8 million covered lives in 767,000 contracts
TDP Network Dentists	**Over 73,000 total dentists, including: 60,000 general dentists over 14,000 specialty dentists**	Over 75,000 total dentists, including: 61,000 general dentists over 14,000 specialty dentists
Total Projected FY 2020 Unified Medical Program (UMP) (including Projected Trust Fund Receipts)	**$49.20 billion[e]**	**$53.67 billion[e]**
Projected Receipts from MERHCF Trust Fund	**$7.53 billion**	**$10.65 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) 2020 is 9,584,000, rounded to 9.6 million, and is based on the DoD Comptroller's Budget End Strength, the DoD Actuary's forecast of retiree populations and the historical counts of family members per sponsor from the Defense Manpower Data Center (DMDC).

[c] Military treatment facility (MTF) clinic count includes occupational health, community-based, embedded behavioral health, Active Duty troop, centers of excellence, 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)/Analytics and Evaluation Division, 2/6/2020.

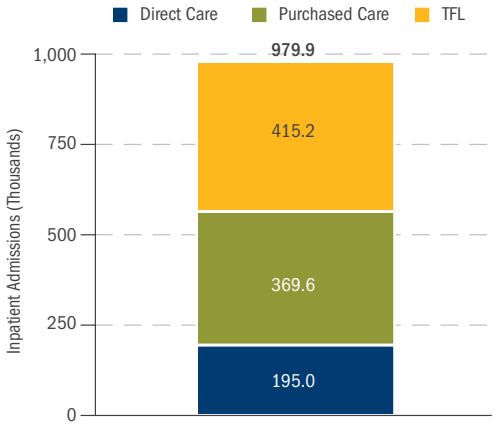
[d] As reported by the managed care support contractors (MCSCs) for contracted network provider and hospital data (2/10/2020), and by TRICARE Dental Office, Health Plan Execution and Operations for dental provider data (12/30/2019).

[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"). Budget and expense data from DHA/Resources & Management Directorate, 1/24/2020.

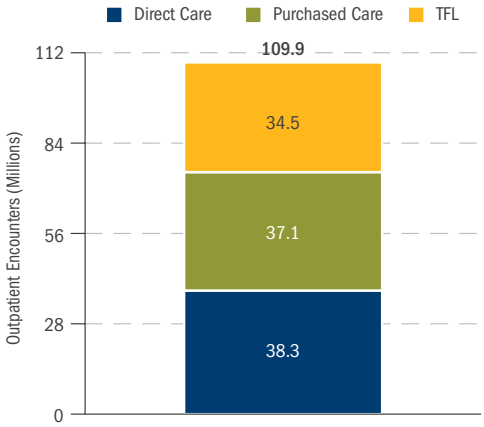
BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

FY 2019 TRICARE Workload and Population Summary

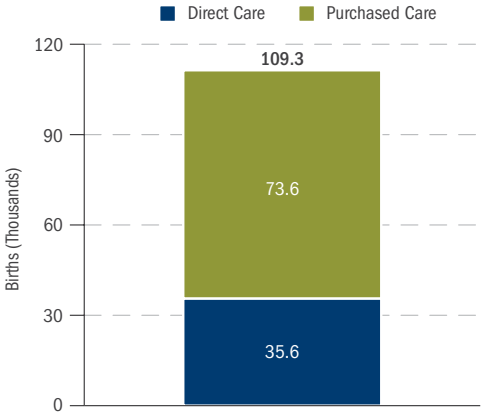
INPATIENT ADMISSIONS[a]



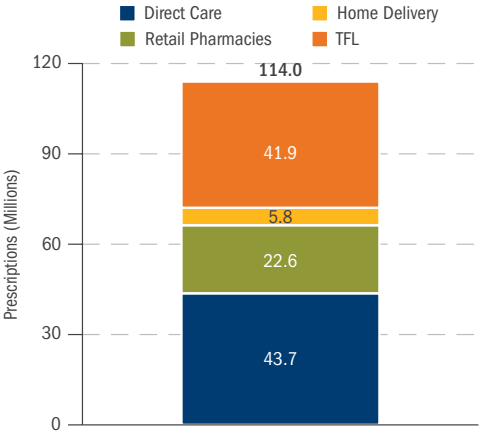
OUTPATIENT ENCOUNTERS[a]



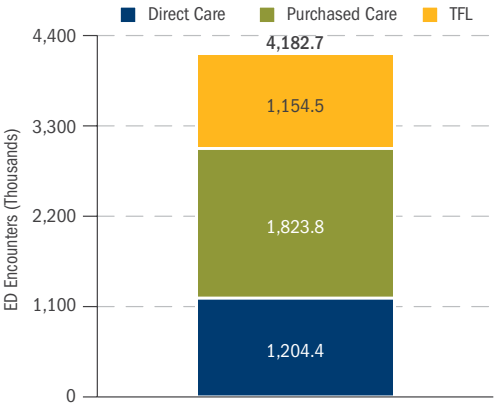
BIRTHS[a]



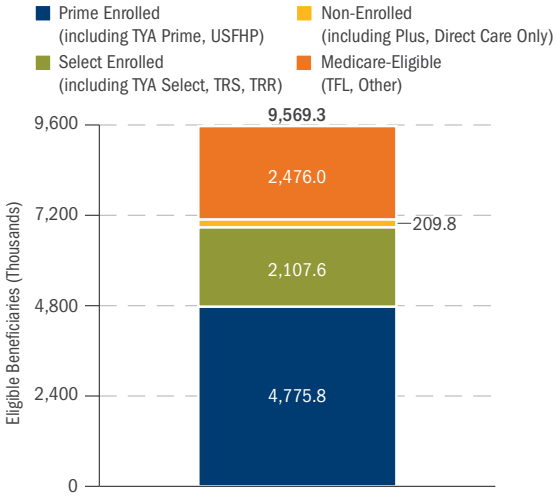
PRESCRIPTIONS[a]



EMERGENCY DEPARTMENT (ED) ENCOUNTERS[a]



ELIGIBLE BENEFICIARIES



Sources: MHS administrative data, 1/13/2020, and Defense Enrollment Eligibility Reporting System (DEERS), 12/9/2019

[a] Excludes Uniformed Services Family Health Plan (USFHP) because MHS administrative data used in this report have no USFHP utilization information.

Notes:

– TFL=TRICARE for Life; TRR=TRICARE Retired Reserve; TRS=TRICARE Reserve Select; TYA=TRICARE Young Adult.

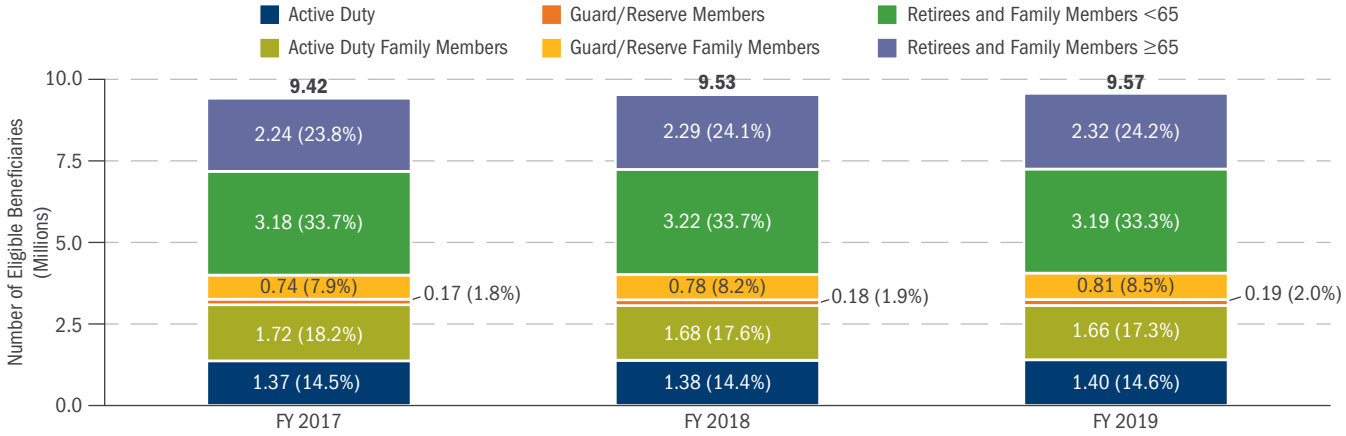
– Numbers may not sum to bar totals due to rounding.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Number of Eligible and Enrolled Beneficiaries Between FY 2017 and FY 2019

The number of beneficiaries eligible for DoD medical care (including TRR, TRS, and TYA) increased from 9.4 million[1] in FY 2017 to 9.6 million in FY 2019. Although the number of Active Duty members increased slightly, the number of Active Duty family members (ADFMs) fell by 3 percent. The number of retirees and family members (RETFMs) under age 65 remained flat, but the number of RETFMs aged 65 and over increased by 3 percent.

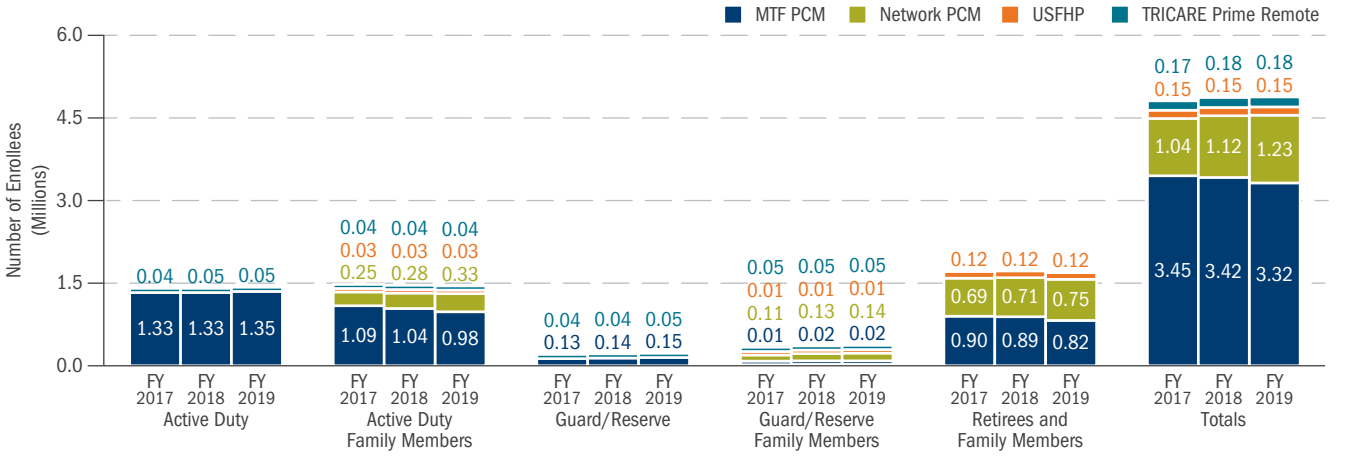
TRENDS IN THE END-YEAR NUMBER OF ELIGIBLE BENEFICIARIES BY BENEFICIARY GROUP, FYs 2017–2019



Note: The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere. Also, 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.

- ADFMs experienced a decline in Prime enrollment with an MTF primary care manager (PCM) but an increase in Prime enrollment with a network PCM. Prime enrollment by Guard/Reserve members and their families increased slightly.
- The trend in RETFM Prime enrollments was similar to that of ADFMs, with the number of beneficiaries with an MTF PCM decreasing and the number with a network PCM increasing. In FY 2019, however, most RETFMs (52 percent) were still enrolled with an MTF PCM.
- TRICARE Prime Remote (TPR) and USFHP enrollment remained about the same from FY 2017 to FY 2019.

TRENDS IN THE END-YEAR NUMBER OF ENROLLED BENEFICIARIES BY BENEFICIARY GROUP, FYs 2017–2019



Source: DEERS, 12/18/2019

[1] This number should not be confused with the one displayed under TRICARE Facts and Figures on page 21. The population figure on page 21 is a projected FY 2020 total, whereas the population reported on this page is the actual for the end of FY 2019.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Beneficiary Plan Choice by Age Group and Beneficiary Category

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

PLAN CHOICE BY AGE GROUP, END OF FY 2019

PLAN TYPE	0–17	18–24	25–44	45–64	≥65	TOTAL[a]
Prime Enrolled	1,289,813	915,381	1,531,665	1,031,412	7,561	4,775,832
Prime: MTF PCM	800,765	777,462	1,297,217	584,056	1,557	3,461,057
Prime: Network PCM	454,717	121,988	214,408	401,601	933	1,193,647
USFHP	34,331	8,022	17,440	45,755	5,071	110,619
TYA Prime	0	7,909	2,600	0	0	10,509
Select Enrolled	650,010	223,495	494,135	761,769	5,035	2,134,444
TRICARE Select	488,770	165,810	312,236	708,112	3,999	1,678,927
TRS	152,987	32,879	173,441	32,384	21	391,712
TYA Select	5,620	1,516	3,014	15,665	1,015	26,830
TRICARE Plus	0	22,024	4,634	0	0	26,658
TRR	2,633	1,266	810	5,608	0	10,317
Non-Enrolled	33,558	32,851	44,226	50,996	21,346	182,977
Direct Care Only	33,558	32,851	44,226	50,996	21,346	182,977
Medicare-Eligible	24	876	35,714	151,053	2,288,342	2,476,009
TFL	5	479	17,536	84,536	1,989,844	2,092,400
TRICARE Plus[b]	0	5	146	842	184,806	185,799
Direct Care Only	3	36	4,508	12,895	73,192	90,634
USFHP	0	11	346	1,702	39,879	41,938
Prime: MTF PCM	6	144	6,004	24,988	11	31,153
Prime: Network PCM	6	130	6,287	25,028	18	31,469
Other	4	71	887	1,062	592	2,616
Total	**1,973,405**	**1,172,603**	**2,105,740**	**1,995,230**	**2,322,284**	**9,569,262**

Source: DEERS, 12/18/2019

[a] The totals in the right-hand column of the above table 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, 182,913 with TRICARE Plus also have TFL. These numbers are not included in the TFL row.

- About 30 percent of USFHP enrollees are seniors (aged 65 and older), and about 20 percent are children (aged 0–17).
- The vast majority of those aged 65 and above are enrolled in Medicare Part B and are covered by 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 MTFs.
- Medicare-eligible beneficiaries under age 65 have a choice between TRICARE Prime (including the USFHP) and TFL. About 57 percent choose TFL and 43 percent choose Prime.
- Beneficiaries aged 45–64 had the lowest TRICARE Prime enrollment rate, at 56 percent. Enrollment rates for the other age groups were 65 percent for 0–17, 78 percent for 18–24, and 74 percent for 25–44. Beneficiaries aged 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 2019

PLAN TYPE	AD	ADFM	GR	GRFM	IGR	IGRFM	OTH	RET	RETFM	SRV	TOTAL[a]
Prime Enrolled	1,396,858	1,379,301	192,877	199,619	6,462	13,541	2,265	559,842	987,991	37,076	4,775,832
Prime: MTF PCM	1,396,858	1,016,859	192,877	61,623	2,755	3,978	1,151	293,901	475,073	15,982	3,461,057
Prime: Network PCM	0	334,859	0	130,806	3,512	9,029	1,042	237,864	458,008	18,527	1,193,647
USFHP	0	26,586	0	7,030	195	533	71	28,077	45,790	2,337	110,619
TYA Prime	0	997	0	160	0	1	1	0	9,120	230	10,509
Select Enrolled	0	264,894	0	94,195	175,351	293,156	15,153	420,756	808,708	62,231	2,134,444
TRICARE Select	0	261,302	0	93,130	29,842	46,484	14,856	407,431	764,936	60,946	1,678,927
TRS	0	1	0	168	145,508	245,718	253	18	44	2	391,712
TYA Select	0	1,725	0	129	1	7	5	9,555	14,845	563	26,830
TRICARE Plus	0	1,866	0	768	0	947	7	0	22,351	719	26,658
TRR	0	0	0	0	0	0	32	3,752	6,532	1	10,317
Non-Enrolled	0	17,584	0	3,675	17,203	2,948	17,504	39,446	76,544	8,073	182,977
Direct Care Only	0	17,584	0	3,675	17,203	2,948	17,504	39,446	76,544	8,073	182,977
Medicare-Eligible	0	2,390	0	718	160	975	2,040	1,195,451	775,800	498,475	2,476,009
TFL	0	0	0	0	0	0	1,765	991,143	659,588	439,904	2,092,400
TRICARE Plus[b]	0	364	0	45	0	0	28	94,488	59,852	31,022	185,799
Direct Care Only	0	1,484	0	298	6	27	177	51,568	20,918	16,156	90,634
USFHP	0	0	0	0	0	0	31	20,581	13,549	7,777	41,938
Prime: MTF PCM	0	0	0	0	0	0	9	18,536	10,779	1,829	31,153
Prime: Network PCM	0	0	0	0	0	0	16	19,006	10,807	1,640	31,469
Other	0	542	0	375	154	948	14	129	307	147	2,616
Total	**1,396,858**	**1,664,169**	**192,877**	**298,207**	**199,176**	**310,620**	**36,962**	**2,215,495**	**2,649,043**	**605,855**	**9,569,262**

Source: DEERS, 12/18/2019

[a] The totals in the right-hand column of the above table 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, 182,913 with TRICARE Plus also have TFL. These numbers are not included in the TFL row.

AD = Active Duty
ADFM = Active Duty Family Members
GR = Guard/Reserve
GRFM = Guard/Reserve Family Members
IGR = Inactive Guard/Reserve
IGRFM = Inactive Guard/Reserve Family Members
OTH = Other
RET = Retirees
RETFM = Retiree Family Members
SRV = Survivors

- Only 3 percent of non-Medicare-eligible beneficiaries are not enrolled in any TRICARE plan (i.e., they use space-available care at MTFs or other health insurance (OHI).
- 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 28 percent in FY 2019.
- Almost 80 percent of beneficiaries enrolled in the USFHP are retirees and family members (including survivors), 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.)*

Trends in Plan Choice

PLAN CHOICE AND PERCENTAGE OF TOTAL ENROLLMENT, END OF FYs 2017–2019

PLAN TYPE	FY 2017		FY 2018		FY 2019	
	POPULATION	% OF TOTAL	POPULATION	% OF TOTAL	POPULATION	% OF TOTAL
Prime Enrolled	4,701,960	49.9%	4,768,800	50.0%	4,775,832	49.9%
Prime: MTF PCM	3,578,114	38.0%	3,560,392	37.4%	3,461,057	36.2%
Prime: Network PCM	1,007,714	10.7%	1,087,891	11.4%	1,193,647	12.5%
USFHP	99,050	1.1%	106,865	1.1%	110,619	1.2%
TYA Prime	17,082	0.2%	13,652	0.1%	10,509	0.1%
Select Enrolled	2,252,604	23.9%	2,142,750	22.5%	2,134,444	22.3%
TRICARE Standard/Extra/Select[a]	1,806,829	19.2%	1,705,083	17.9%	1,678,927	17.5%
TRS	385,723	4.1%	377,146	4.0%	391,712	4.1%
TYA Standard/Select[b]	29,223	0.3%	28,247	0.3%	26,830	0.3%
TRICARE Plus	22,383	0.2%	22,882	0.2%	26,658	0.3%
TRR	8,446	0.1%	9,392	0.1%	10,317	0.1%
Non-Enrolled	54,359	0.6%	165,298	1.7%	182,977	1.9%
Direct Care Only	54,359	0.6%	165,298	1.7%	182,977	1.9%
Medicare-Eligible	2,410,083	25.6%	2,454,984	25.8%	2,476,009	25.9%
TFL	2,045,963	21.7%	2,068,919	21.7%	2,092,400	21.9%
TRICARE Plus	183,544	1.9%	188,074	2.0%	185,799	1.9%
Direct Care Only	65,462	0.7%	90,595	1.0%	90,634	0.9%
USFHP	48,590	0.5%	42,708	0.4%	41,938	0.4%
Prime: MTF PCM	34,614	0.4%	32,148	0.3%	31,153	0.3%
Prime: Network PCM	29,560	0.3%	29,609	0.3%	31,469	0.3%
Other	2,350	0.0%	2,931	0.0%	2,616	0.0%
Total	**9,419,006**		**9,531,832**		**9,569,262**	

Source: DEERS, 12/18/2019

[a] TRICARE Standard/Extra in FY 2017; TRICARE Select in FYs 2018–2019

[b] TRICARE Young Adult Standard in FY 2017; TRICARE Young Adult Select in FYs 2018–2019

- As a percentage of the total eligible population, the number of Prime-enrolled beneficiaries remained the same from FY 2017 to FY 2019. However, the number with an MTF PCM decreased, whereas the number with a network PCM increased.
- As a percentage of the total eligible population, the number of beneficiaries with TRICARE Standard/Extra/Select plans declined from FY 2017 to FY 2019. Over the same time period, the percentage of beneficiaries with direct care only increased by roughly the same number of percentage points lost by TRICARE Standard/Extra/Select. Because percentage changes in all other plans were negligible, this suggests that the beneficiaries leaving TRICARE Standard/Extra/Select are choosing direct care only.
- After a year of grace in CY 2018, the open season model went into full effect for coverage in CY 2019. TRICARE hosted its first annual open season November through December 2018. Beneficiaries could no longer change their TRICARE coverage outside open season unless they had a TRICARE-recognized qualifying life event (QLE).
- Since most beneficiaries who switched from TRICARE Select to direct care only in 2019 were retirees and family members (not shown), these may be the so-called “TRICARE ghosts” who do not use their TRICARE benefit other than through space-available care at MTFs.

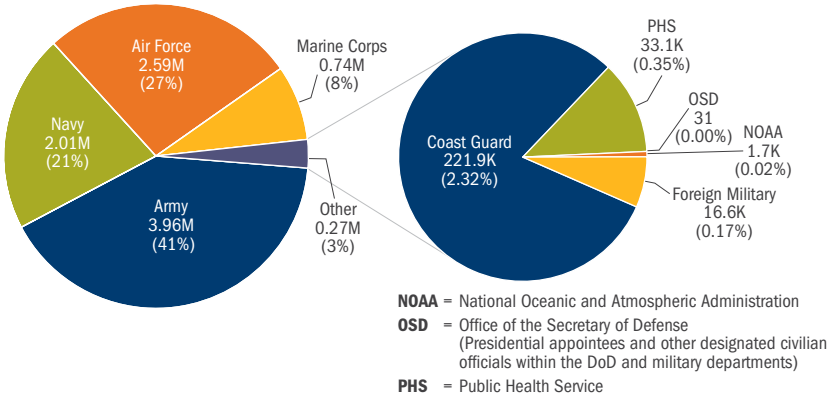
BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Eligible Beneficiaries in FY 2019

- There were a total of 9.57 million beneficiaries eligible for some form of DoD health care benefits at the end of FY 2019. 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.
- Retirees and their family members (including survivors) constitute the largest percentage of the eligible beneficiary population (57 percent). The U.S. MHS population is presented at the state level on page 32, 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.

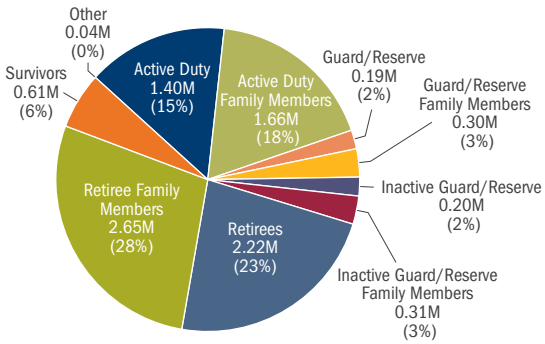
WORLDWIDE BENEFICIARIES ELIGIBLE FOR DoD HEALTH CARE BENEFITS, END OF FY 2019

BY SERVICE BRANCH



NOAA = National Oceanic and Atmospheric Administration
OSD = Office of the Secretary of Defense (Presidential appointees and other designated civilian officials within the DoD and military departments)
PHS = Public Health Service

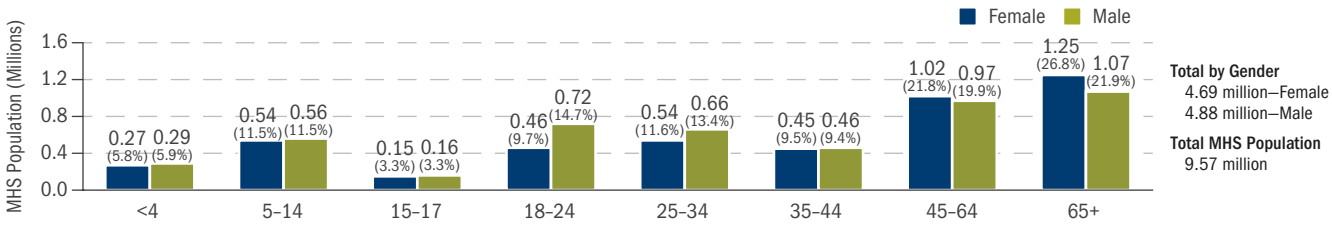
BY BENEFICIARY CATEGORY



TOTAL: 9.57 Million

Source: DEERS, 12/18/2019

MHS POPULATION BY AGE GROUP AND GENDER, END OF FY 2019



Source: FY 2019 actuals from DEERS as of 12/18/2019

PROJECTED END-YEAR MHS POPULATIONS (MILLIONS) BY BENEFICIARY CATEGORY, FYs 2020–2027

BENEFICIARY CATEGORY	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027
Active Duty	1.40	1.41	1.41	1.42	1.42	1.42	1.42	1.42
Active Duty Family Members	1.67	1.68	1.68	1.69	1.69	1.70	1.70	1.70
Guard/Reserve	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20
Guard/Reserve Family Members	0.31	0.31	0.31	0.32	0.32	0.31	0.31	0.31
Inactive Guard/Reserve	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20
Inactive Guard/Reserve Family Members	0.31	0.31	0.31	0.31	0.31	0.31	0.31	0.31
Retirees	2.22	2.23	2.23	2.24	2.25	2.25	2.25	2.25
Retiree Family Members	2.65	2.66	2.66	2.66	2.66	2.66	2.66	2.65
Survivors	0.60	0.60	0.60	0.60	0.60	0.60	0.61	0.61
Other	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04
Total	**9.59**	**9.64**	**9.65**	**9.67**	**9.69**	**9.69**	**9.69**	**9.69**

Source: DHA Projection of Eligible Population (PEP) as of 1/10/2020

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Locations of MTFs (Hospitals and Ambulatory Care Clinics) at the End of FY 2019

The map on the following page shows the geographic dispersion of the 9 million beneficiaries eligible for the TRICARE benefit residing within the United States (95 percent of the 9.6 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 Prime Service Area (PSA). PSAs are geographic areas in which the TRICARE 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 Base Realignment and Closure (BRAC) process (BRAC PSAs), and by designated providers through the USFHP as of October 1, 2013. The overlay of MTF PSAs and BRAC PSAs on the map shows the eligible beneficiary population.

MHS ELIGIBLE BENEFICIARY PROXIMITY TO MTFs, END OF FY 2019[a]

BENEFICIARY GROUP[b]	POPULATION TOTAL	POPULATION IN PSAs	% IN PSAs	% IN MTF SERVICE AREAS
Active Duty and Their Families	2,765,703	2,647,639	95.7%	93.0%
Guard/Reserve and Their Families[c]	982,850	668,961	68.1%	54.1%
Retirees, Their Families, Survivors, and Other Eligibles	5,315,760	4,031,638	75.8%	63.9%
Total MHS Eligibles, U.S.	9,064,313	7,348,238	81.1%	71.7%
MHS Eligibles, Overseas	511,194			
Total MHS Eligibles, Worldwide	9,575,507			

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, population as of 9/30/2019

Notes:

[a] Eligible MHS beneficiary data from the MHS Data Repository (MDR) DEERS, as of 9/30/2019. Residential ZIP code was used as the location for all beneficiaries.

[b] Location information determined by DHA Catchment Area Directory database, September 2019.

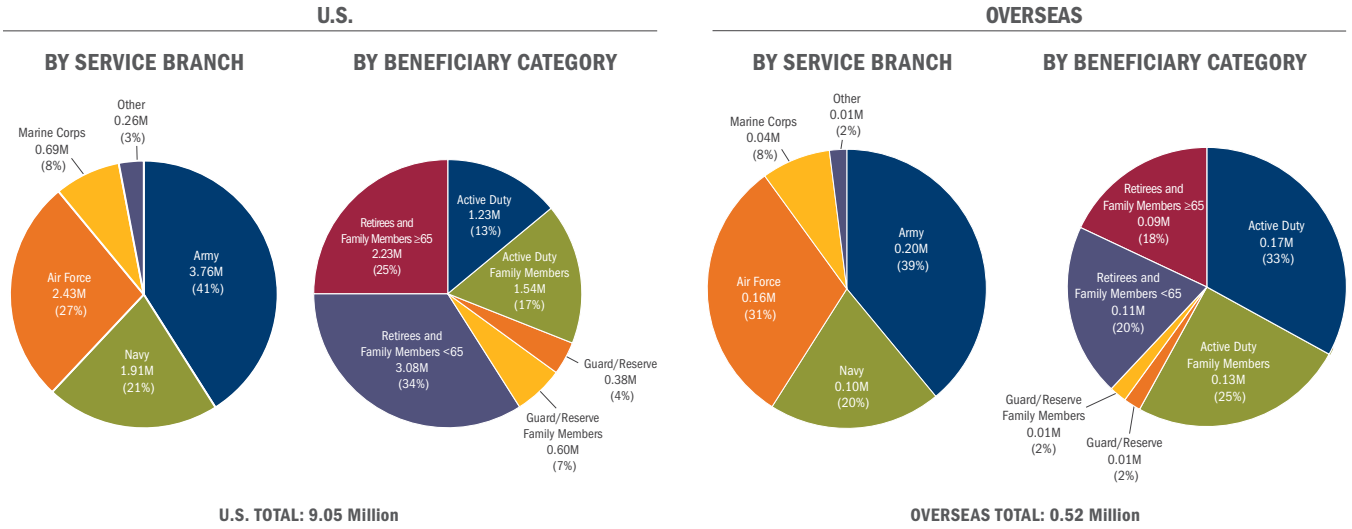
[c] TRICARE medically eligible Guard/Reserve beneficiaries, including those who have enrolled in TRS, TRR, or TYA (does not include all Select Reserve).

Definitions:

– PSAs are based on ZIP codes in which MCSCs must offer the TRICARE Prime benefit.

– MTF Service Areas are defined by ZIP code centroids that are within a 40-mile radius of an active MTF (inpatient or outpatient), subject to overlap rules, barriers, and other policy overrides.

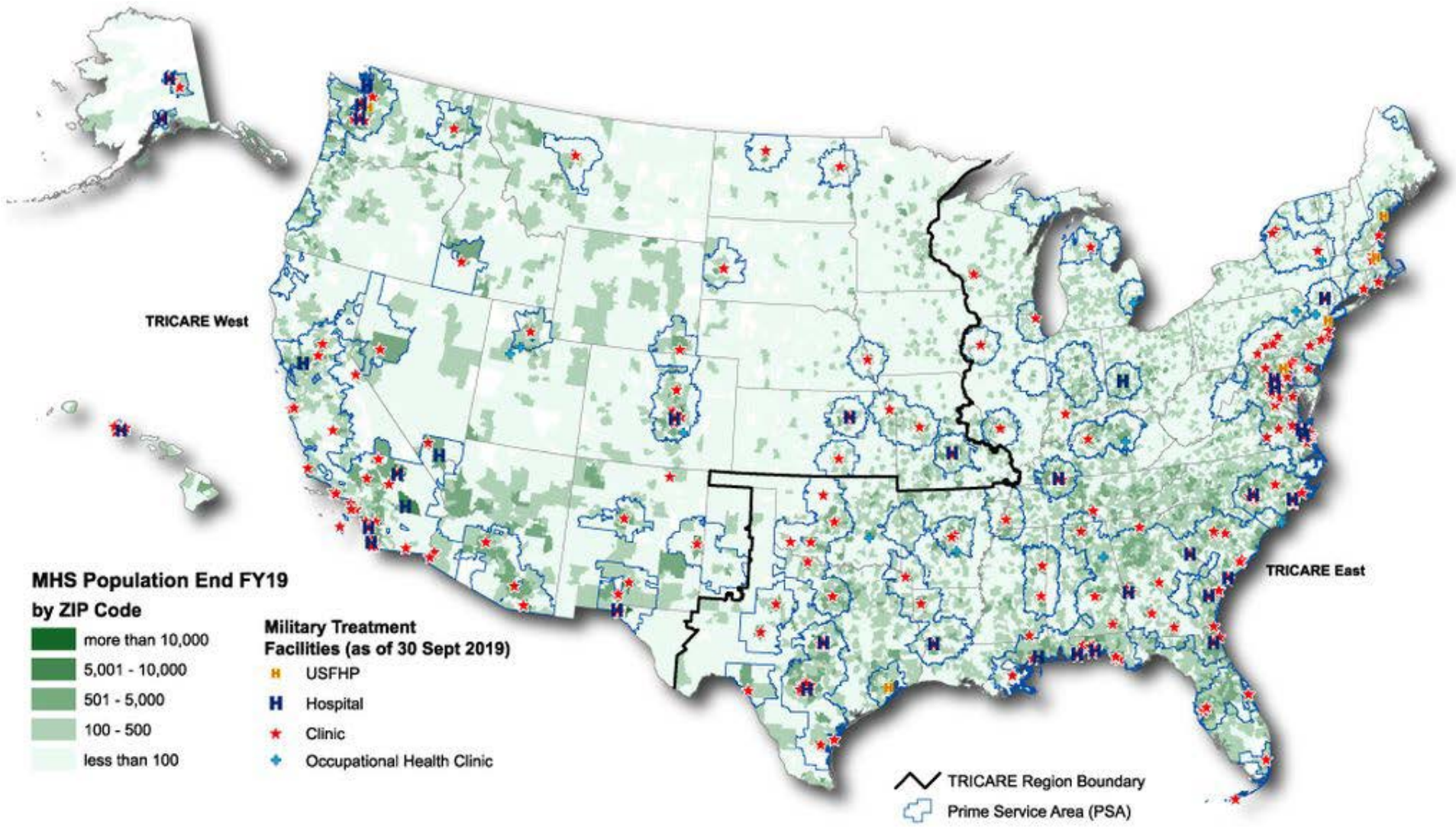
BENEFICIARIES ELIGIBLE FOR DoD HEALTH CARE BENEFITS, END OF FY 2019



Source: DEERS, 12/18/2019

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

MHS POPULATION DISTRIBUTION IN THE U.S. RELATIVE TO MTFs, END OF FY 2019



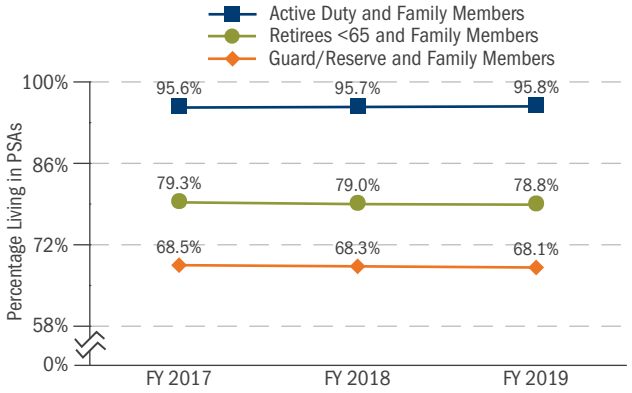
Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, population as of 9/30/2019
Note: For in-depth market area maps, visit https://info.health.mil/staff/analytics/decsupmp/gismaps (a DoD-issued Common Access Card [CAC] is required for access).

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

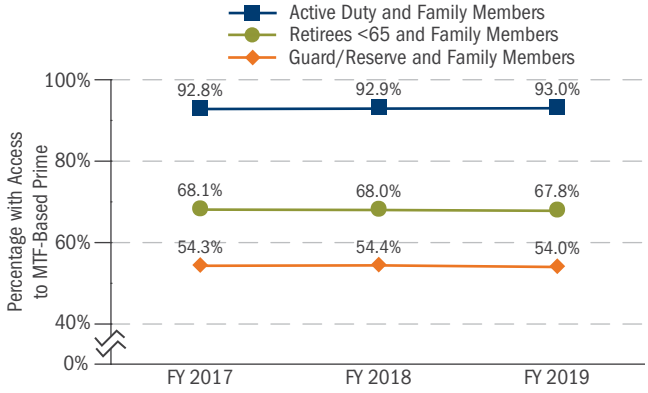
Beneficiary Access to Prime

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 last remark below the table on page 28 for the definition of an MTF Service Area).

TREND IN ELIGIBLE POPULATION LIVING IN PSAs, FYs 2017–2019



TREND IN ELIGIBLE POPULATION WITH ACCESS TO MTF-BASED PRIME, FYs 2017–2019



- Between FY 2017 and FY 2019, the percentage of Active Duty and family members living in PSAs increased slightly. The percentage of the other beneficiary groups living in PSAs decreased slightly.
- As determined by residence in an MTF PSA, access to MTF-based Prime increased slightly from FY 2017 to FY 2019 for Active Duty and family members and decreased slightly for other 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.

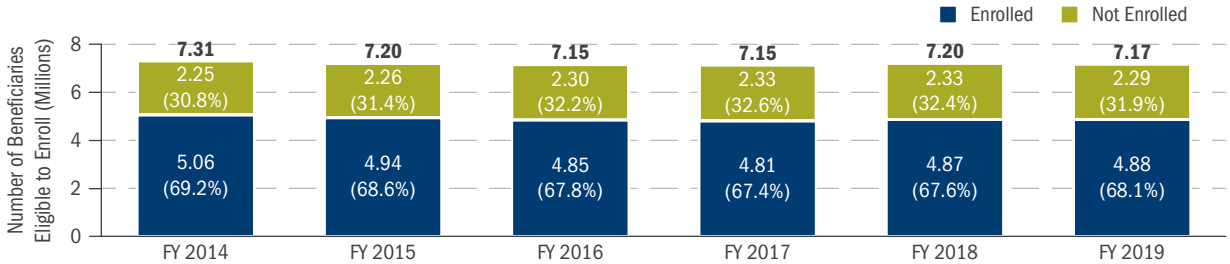
Eligibility and Enrollment in TRICARE Prime

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 aged 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 Prime, TPR (including Overseas), TYA Prime, and the USFHP are included in the enrollment counts below. Beneficiaries enrolled in all other plans (including TRICARE Plus, TRS, TYA Standard and Select, and TRR) and non-enrolled beneficiaries (direct care only) are included in the non-Prime-enrolled counts.

- The number of beneficiaries enrolled in TRICARE Prime had been continuously dropping from FY 2014 to FY 2017, but rebounded slightly in FY 2018 and remained flat in FY 2019. As a percentage of the beneficiary population, TRICARE Prime enrollment had been dropping from FY 2014 to FY 2017, due to a drop in Active Duty end-strength and a reduction in the number of locations designated as PSAs. The percentage started to climb slightly in FY 2018 and again in FY 2019.
- By the end of FY 2019, about 68 percent of all eligible beneficiaries were enrolled (4.88 million enrolled of the 7.17 million eligible to enroll).

HISTORICAL END-YEAR PRIME ENROLLMENT NUMBERS, FYs 2014–2019



Source: DEERS, 12/18/2019

Note: Numbers may not sum to bar totals due to rounding. Detailed MHS enrollment data by state can be found on page 32.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

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

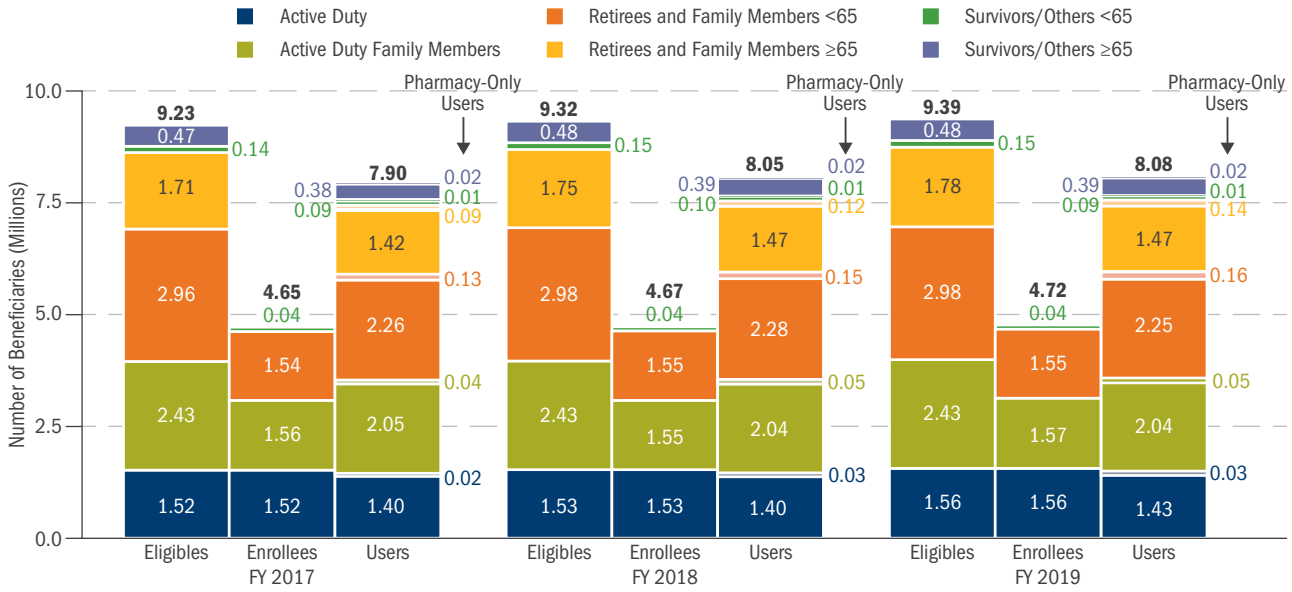
This section compares the number of users of MHS services with the numbers of eligibles and enrollees. Because beneficiaries eligible for any part of the year can be users, average (rather than end-year) beneficiary counts were used for all calculations.

The average numbers of eligibles and TRICARE Prime enrollees by beneficiary category[1] from FY 2017 to FY 2019 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 (including Guard/Reserve) and eligible family members increased by 1 percent between FY 2017 and FY 2019. The number of RETFMs under age 65 remained about the same, while the number of RETFMs age 65 and older increased by 4 percent. The number of survivors and others (SRV/OTHs) increased by 6 percent for those under age 65 and by 2 percent for those age 65 and older.
- The percentage of ADFMs enrolled in TRICARE Prime remained constant at about 64 percent from FY 2017 to FY 2019. 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 remained constant at around 27 percent.
- The overall user rate remained about the same between FY 2017 and FY 2019 at about 86 percent. The user rate for RETFMs aged 65 and older increased by two percentage points from 89 percent to 91 percent (including pharmacy-only users), whereas the user rates for the other beneficiary groups varied by less than one percentage point.
- 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 under age 65 (a much smaller beneficiary group) because some RETFMs had OHI.

AVERAGE NUMBERS OF ELIGIBLES, ENROLLEES, AND USERS BY BENEFICIARY CATEGORY, FYs 2017–2019



Sources: DEERS and MHS administrative data, 12/18/2019

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

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

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	80,863	1,381	21,725	24,745	4,889	8,733	60,092
AL	210,552	9,575	13,327	23,934	18,204	32,457	87,922
AR	85,346	5,305	6,200	8,551	5,047	9,049	28,847
AZ	212,736	8,664	24,167	29,771	16,926	29,451	100,315
CA	786,351	23,293	171,846	154,398	42,272	80,600	449,116
CO	248,951	10,515	43,955	47,125	18,932	34,825	144,837
CT	48,706	2,464	8,827	7,568	2,072	3,498	21,965
DC	22,394	669	11,913	3,159	820	889	16,781
DE	34,259	1,685	4,644	5,123	2,691	4,214	16,672
FL	721,541	25,821	74,509	91,106	62,163	102,851	330,629
GA	441,080	14,951	76,231	76,759	38,070	67,032	258,092
HI	151,662	1,941	45,280	49,151	5,353	9,252	109,036
IA	47,258	5,078	2,777	3,969	775	1,449	8,970
ID	55,350	4,307	4,862	6,599	3,048	5,565	20,074
IL	151,700	8,979	27,903	19,314	8,798	15,691	71,706
IN	95,531	9,864	5,066	8,607	4,177	8,288	26,138
KS	121,398	5,774	24,722	26,641	6,449	12,664	70,476
KY	145,091	6,287	37,464	22,459	7,861	13,994	81,778
LA	124,076	7,394	20,420	21,179	6,949	12,778	61,326
MA	70,356	6,013	7,289	7,789	6,286	9,376	30,740
MD	247,133	7,677	40,606	48,146	28,748	42,940	160,440
ME	39,493	2,339	1,814	3,520	7,447	10,580	23,361
MI	102,010	6,941	5,187	7,878	3,641	6,404	23,110
MN	71,846	9,458	4,724	4,818	124	771	10,437
MO	158,368	12,324	21,197	20,557	8,432	15,621	65,807
MS	116,241	5,540	17,365	14,570	6,282	10,855	49,072
MT	37,031	2,265	4,377	4,676	944	1,829	11,826
NC	512,207	12,801	109,046	105,621	28,206	50,103	292,976
ND	32,761	2,590	8,330	7,547	1,235	2,109	19,221
NE	61,757	4,753	7,671	9,168	3,955	7,089	27,883
NH	31,099	2,100	2,217	2,514	4,782	6,818	16,331
NJ	87,028	4,883	13,696	15,434	5,131	8,963	43,224
NM	83,554	2,068	13,965	14,428	5,931	10,268	44,592
NV	107,664	3,826	13,273	15,425	8,575	14,267	51,540
NY	177,471	7,301	31,634	30,636	9,708	17,237	89,215
OH	171,899	13,260	13,101	16,458	7,422	13,653	50,634
OK	156,075	7,130	26,428	23,354	10,950	20,477	81,209
OR	69,676	3,276	3,793	4,766	796	1,932	11,287
PA	163,767	10,510	8,764	12,770	7,734	13,282	42,550
RI	24,574	1,184	4,453	3,915	1,531	2,463	12,362
SC	251,202	10,707	44,291	33,313	16,969	29,242	123,815
SD	35,809	4,764	4,703	5,221	1,409	2,449	13,782
TN	201,392	11,258	6,561	27,381	11,479	21,140	66,561
TX	917,172	36,231	137,223	149,727	79,761	149,543	516,254
UT	79,413	8,840	7,800	11,799	4,614	9,786	33,999
VA	749,322	15,780	139,305	146,019	57,301	92,397	435,022
VT	13,154	1,190	940	1,316	1,350	1,939	5,545
WA	348,284	8,766	65,006	69,260	27,944	48,128	210,338
WI	76,342	7,113	4,704	5,742	1,088	2,089	13,623
WV	37,507	2,381	2,960	2,213	995	1,595	7,763
WY	24,273	1,429	4,204	4,448	1,265	2,175	12,092
Subtotal	**9,040,725**	**390,645**	**1,402,465**	**1,460,587**	**617,531**	**1,080,800**	**4,561,383**
Overseas	**528,537**	**2,824**	**187,270**	**118,333**	**434**	**12,972**	**319,009**
Total	**9,569,262**	**393,469**	**1,589,735**	**1,578,920**	**617,965**	**1,093,772**	**4,880,392**

Source: MHS administrative data systems, as of 12/18/2019 for end of FY 2019

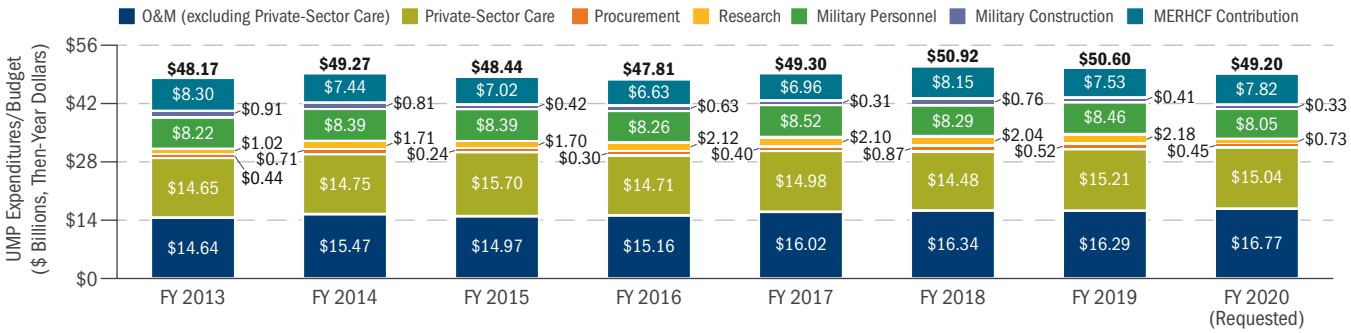
Note: "Prime Enrolled" includes Prime (MTF and network PCMs), TRICARE Prime Remote (and Overseas equivalent), TYA Prime, and USFHP; and excludes members in TRICARE Select, TYA Select, TRS, TRR, TRICARE Plus, and TFL.

UNIFIED MEDICAL PROGRAM FUNDING

The Defense Department's FY 2020 budget request for current and future healthcare services was $49.20 billion. In nominal terms, this is about 3 percent lower than the FY 2019 $50.60 billion in actual expenditures.

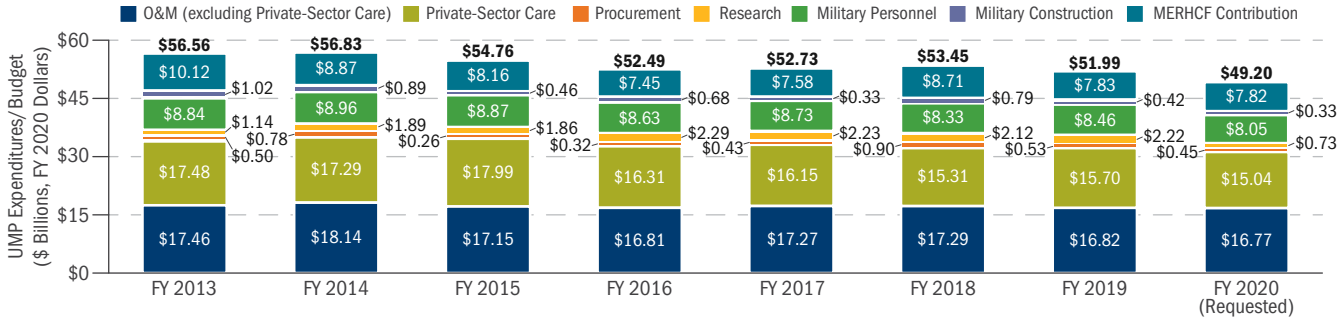
The budget request has three components. First is the direct appropriation to DHP, which includes operations and maintenance (O&M), procurement, and research, development, test, and evaluation (RDT&E) funding totaling $33.0 billion (down from $34.2 billion in FY 2019). The second is comprised of transfers from DoD, including military personnel and military construction, totaling $8.4 billion (down from $8.9 billion in FY 2019). The third component is the DoD contribution to the MERHCF Trust Fund, 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 DoD Office of the Actuary determines how much funding should be set aside to pay the package of future benefits promised to those currently on Active Duty. These funds are paid into the MERHCF out of DoD personnel accounts. The FY 2020 contribution has been set at $7.8 billion.

UMP FUNDING AND TRUST FUND CONTRIBUTIONS ($ BILLIONS) IN THEN-YEAR DOLLARS, FYs 2013–2020



When we convert to constant FY 2020 dollars, the FY 2020 $49.20 billion request is about 5 percent less than the real FY 2019 actual expenditures, and about $7.4 billion (13 percent) less than the real FY 2013 expenditures.

UMP FUNDING AND TRUST FUND CONTRIBUTIONS ($ BILLIONS) IN CONSTANT 2020 DOLLARS, FYS 2013–2020



Source: UMP cost and budget estimates, DHA/Resources and Management Directorate (J-8)/Budget and Execution Division, 2/25/2020

Notes:

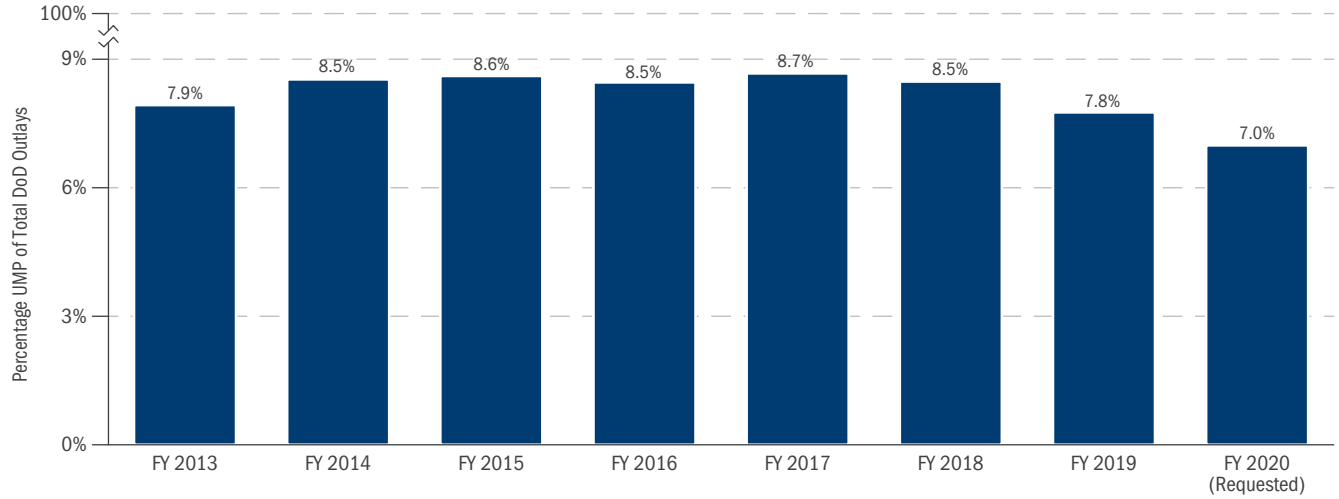
– FYs 2013–2019 reflect Comptroller Information System Actual execution; FY 2020 reflects the President's Budget request.
– Source of data for deflators (military personnel, DHP, procurement, RDT&E, and military construction) is Table 5-5, DoD deflators—TOA, National Defense Budget Estimates for FY 2020 (Green Book).
– MERHCF deflator computed using a combination of military personnel (5 percent) and DHP factors (95 percent).
– FY 2013 includes $966.022 million in Overseas Contingency Operations (OCO) supplemental funding for O&M; reflects reductions for sequestration, NDAA sections 3001, 3004, and 8123.
– FY 2014 includes $715.484 million for OCO.
– FY 2015 includes $344.645 million for OCO.
– FY 2016 includes $285.032 million for OCO.
– FY 2017 includes $332.603 million for OCO.
– FY 2018 includes $405.856 million for OCO.
– FY 2019 includes $349.422 million for OCO.
– FY 2020 estimate includes $347.746 million OCO supplemental funding request for O&M.

UNIFIED MEDICAL PROGRAM FUNDING *(CONT.)*

UMP Share of Defense Budget

The UMP funding share of total DoD expenditures has declined for three consecutive years and is below FY 2013 levels.

UMP EXPENDITURES AS A PERCENTAGE OF TOTAL DoD OUTLAYS, FYs 2013–2020

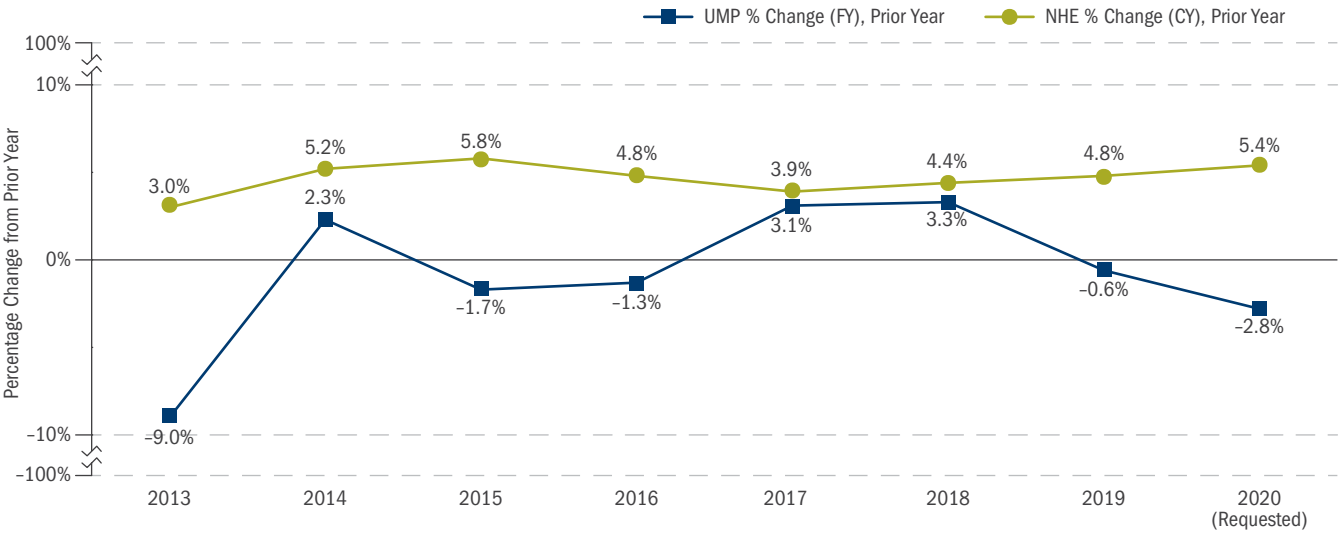


Source: UMP cost and budget estimates, DHA/Resources and Management Directorate (J-8)/Budget and Execution Division, 2/25/2020
Note: Percentages are estimates of total DoD outlays reflected in the FY 2020 President's Budget.

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 contributions) has fluctuated from a high of 3.3 percent in FY 2018, to a low of negative 9 percent in FY 2013. Growth in the UMP has been essentially zero since FY 2011 (not shown). By comparison, the NHE series compiled by the Centers for Medicare & Medicaid Services (CMS) has been growing at about 4.6 percent per year over the same period.

COMPARISON OF CHANGE IN ANNUAL UMP (FY) AND NHE (CY) ESTIMATED EXPENDITURES OVER TIME, 2013–2020



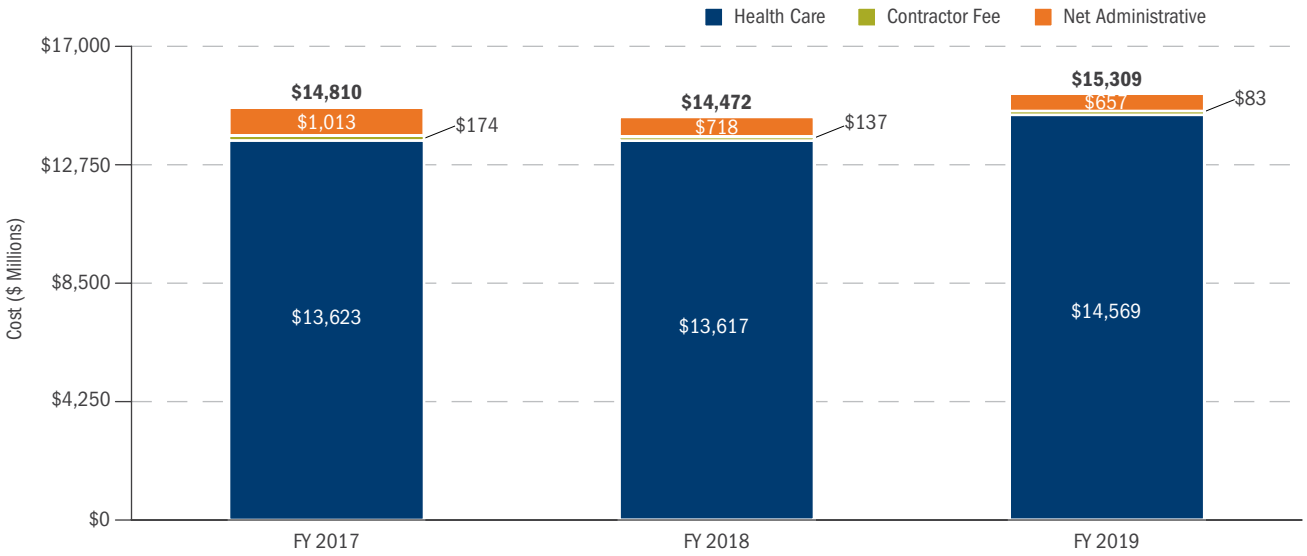
Sources: UMP cost and budget estimates, DHA/Resources and Management Directorate (J-8)/Budget and Execution Division, 2/25/2020, using NHE data from CMS, Office of the Actuary, NHE Projections 2018–2027, Table 2, National Health Expenditure Amounts and Annual Percent Change by Type of Expenditure: Calendar Years 2011–2027; http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html
Note: DoD UMP data are in fiscal years; CMS NHE data are in calendar 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]

- Private-sector care (PSC) costs decreased from $14,810 million in FY 2017 to $14,472 million (2 percent) in FY 2018, but then increased to $15,309 million (6 percent) in FY 2019.
- On January 1, 2018, DHA began collecting Prime enrollment fees that were previously held by the contractors to offset their administrative costs. DHA collected $234 million in Prime enrollment fees during the nine months of FY 2018 that the new T2017 contract was in effect and $307 million in FY 2019. Net of Prime enrollment fees, PSC administrative costs decreased by 29 percent in FY 2018 and by another 8 percent in FY 2019.
- Excluding contractor fees, net administrative expenses decreased from 7 percent of total PSC costs in FY 2017 ($1,013 million of $14,636 million) to 4 percent in FY 2019 ($657 million of $15,226 million). Including contractor fees (in both administrative and total costs), net administrative expenses decreased from 8 percent of total PSC costs in FY 2017 ($1,187 million of $14,810 million) to 5 percent in FY 2019 ($740 million of $15,309 million).
- Contractor fees declined by 52 percent between FY 2017 and FY 2019, due in part to lower incentive payments earned for obtaining discounts from hospitals and provider groups.

TRENDS IN PRIVATE-SECTOR CARE COSTS, FYs 2017–2019



Source: DHA/R&M (J-1/J-8)/CRM (Administrative Costs), 12/5/2019

[1] DHA has congressional authority to carry over 1 percent of its O&M funding into the following year. There was no funding carried over in FY 2017. The amount carried forward from the prior-year appropriation was $200 million in FY 2018 and $315 million in FY 2019.

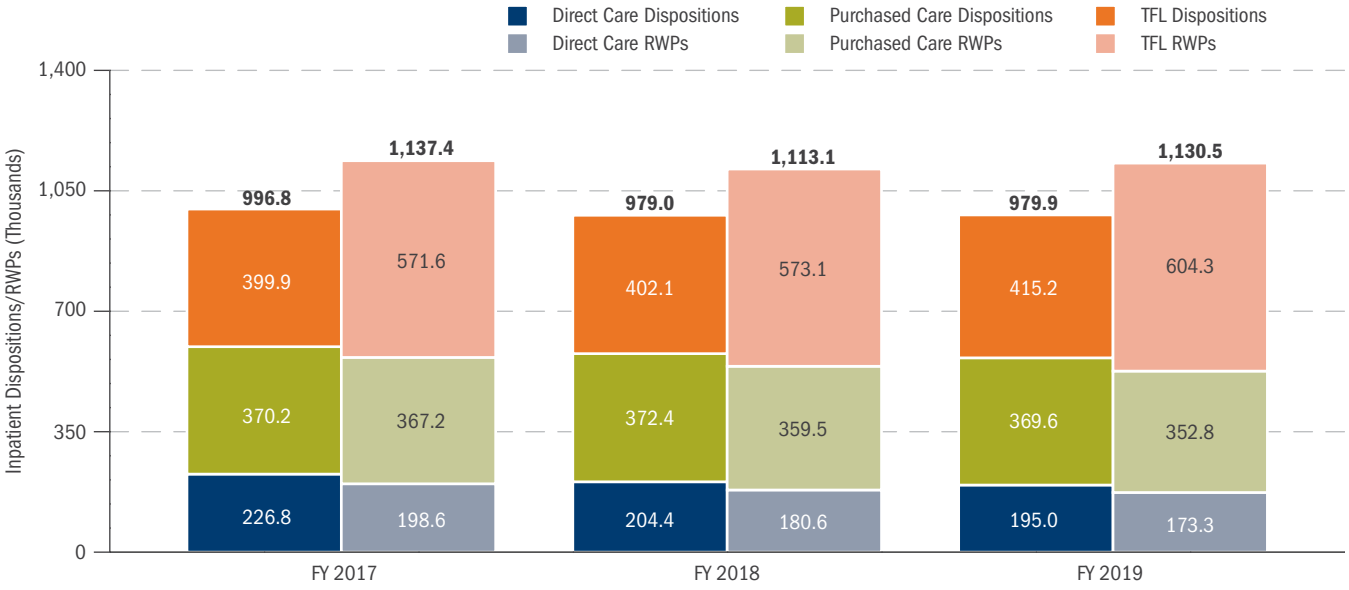
MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE)

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 5 percent and total RWPs by 7 percent between FY 2017 and FY 2019, excluding the effect of TFL.
- Direct care inpatient dispositions decreased by 14 percent and RWPs by 13 percent over the past three years.[1]
- Excluding TFL workload, purchased care inpatient dispositions remained about the same, while RWPs decreased by 4 percent between FY 2017 and FY 2019.
- Including TFL workload,[2] both purchased care dispositions and RWPs increased by 2 percent between FY 2017 and FY 2019.
- Although not shown, about 7 percent of direct care inpatient workload (dispositions) was performed abroad in FY 2019. Purchased care and TFL inpatient workload performed abroad accounted for about 2 percent of the worldwide total.

TRENDS IN MHS INPATIENT WORKLOAD, FYs 2017–2019



Source: MHS administrative data, 1/13/2020

[1] The DoD's new electronic health record (EHR), MHS GENESIS, was deployed at four initial fielding sites in 2017: 92nd Medical Group, Fairchild Air Force Base, in February; Naval Hospital (NH) Oak Harbor in July; NH Bremerton in September; and Madigan Army Medical Center (AMC) in October (FY 2018). In September 2019, the DoD deployed MHS GENESIS to four additional locations: 60th Medical Group, Travis Air Force Base; Army Dental Clinic Presidio of Monterey; Naval Air Station Lemoore; and 366th Medical Group, Mountain Home Air Force Base. Of those eight sites, only four offer inpatient care. Any inpatient workload performed at those facilities from the deployment dates onward has not yet been fully captured in the MHS administrative data. Considering all direct care facilities except the MHS GENESIS sites, total inpatient workload decreased by 7 percent between FY 2017 and FY 2019. The MHS GENESIS hospitals contributed an additional 7 percent to the decrease in total direct care inpatient workload, resulting in the 14 percent decrease across the three years reported above.

[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 included.

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

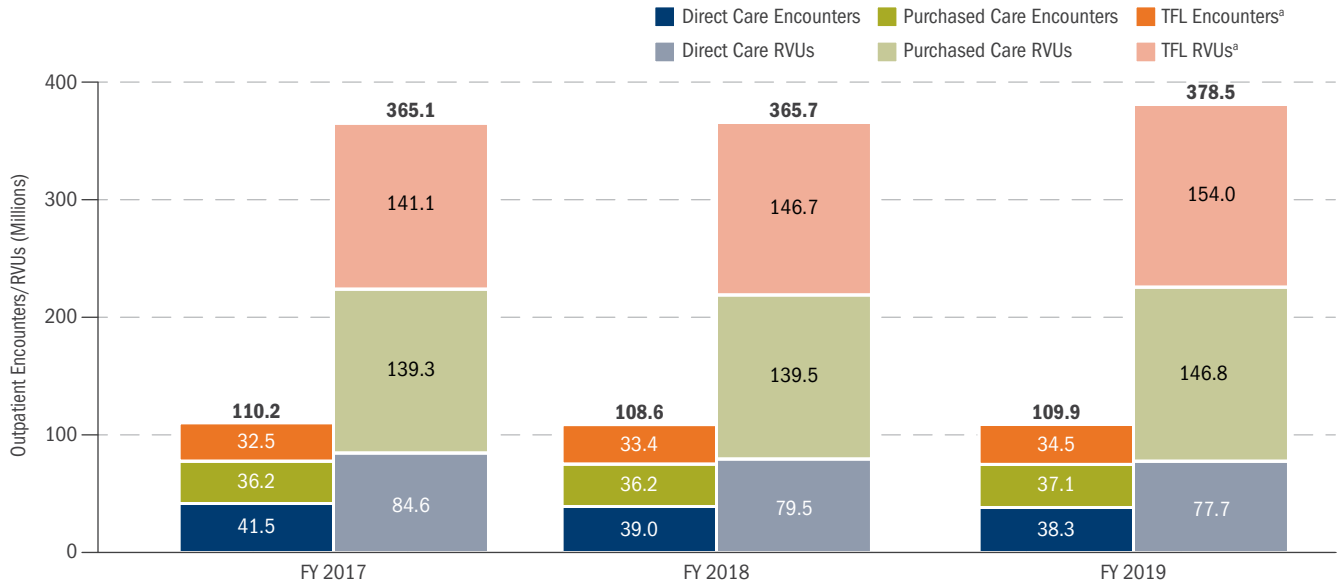
MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE) *(CONT.)*

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. RVUs reflect the relative resources consumed by a single encounter compared with the average of those consumed by all encounters. See the Appendix for a more detailed description of the RVU measure.

- Total outpatient encounters (direct and purchased care combined) decreased by 3 percent, while RVUs remained unchanged between FY 2017 and FY 2019,[1] excluding the effect of TFL.
- Direct care outpatient encounters and RVUs each decreased by 8 percent over the past three years.
- Excluding TFL workload, purchased care outpatient encounters increased by 3 percent while RVUs increased by 5 percent. Including TFL workload, encounters increased by 4 percent and RVUs increased by 7 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.

TRENDS IN MHS OUTPATIENT WORKLOAD, FYs 2017–2019



Source: MHS administrative data, 1/13/2020

[a] Purchased care only

[1] The DoD's new EHR, MHS GENESIS, was deployed at four initial fielding sites in 2017: 92nd Medical Group, Fairchild Air Force Base, in February; NH Oak Harbor in July; NH Bremerton in September; and Madigan AMC in October (FY 2018). In September 2019, the DoD deployed MHS GENESIS to four additional locations: 60th Medical Group, Travis Air Force Base; Army Dental Clinic Presidio of Monterey; Naval Air Station Lemoore; and 366th Medical Group, Mountain Home Air Force Base. Any outpatient workload performed at those facilities (and at clinics that report data to those facilities) from the deployment dates onward has not yet been fully captured in the MHS administrative data. Considering all direct care facilities except the MHS GENESIS sites, total outpatient workload decreased by 3 percent between FY 2017 and FY 2019. The MHS GENESIS facilities contributed an additional 5 percent to the decrease in total direct care outpatient workload, resulting in the 8 percent decrease across the three years reported above.

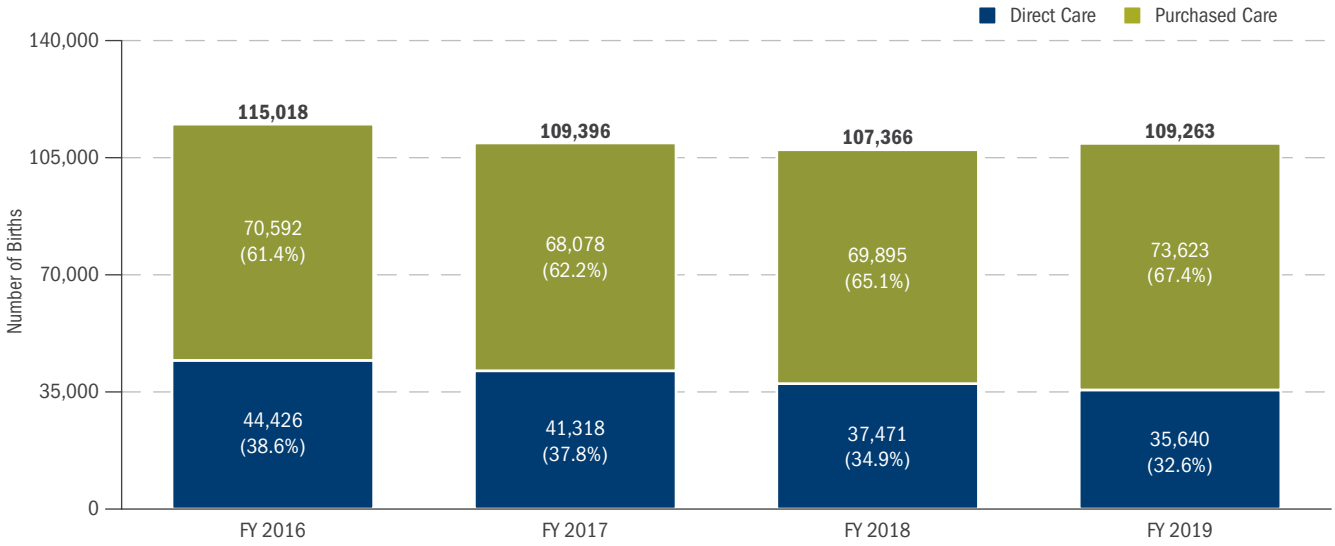
Note: Numbers may not sum to bar totals due to rounding.

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

MTF Market Share for Childbirths

Overall MTF obstetric (OB) market share decreased from 39 percent to 33 percent between FY 2016 and FY 2019. This trend is likely due, at least in part, to the migration of Prime enrollees from an MTF to a network PCM (see the table on page 26) and the downsizing of five MTF hospitals to clinics during that time period. In FY 2019, individual MTF shares in the U.S. ranged from 17 percent to 98 percent.

TRENDS IN MTF MARKET SHARE FOR CHILDBIRTHS, FYs 2016–2019



Source: MHS administrative data, 1/13/2020

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

Urgent Care (UC) Utilization

The NDAA FY 2016 required the DoD to implement a UC pilot program that eliminated the requirement for a referral or prior authorization for up to two UC visits per year. UC is defined as care needed for a non-emergency illness or injury requiring treatment within 24 hours. The pilot program was implemented in the contiguous United States, Alaska, and Hawaii beginning May 23, 2016, and included the use of a nurse advice line (NAL) to guide enrollees to the most appropriate level of health care. The purpose of the pilot program was to determine whether relaxing the restrictions on the use of UC improved beneficiary access to care while decreasing the inappropriate use of expensive emergency department (ED) care. The pilot program was terminated as of January 1, 2018; the UC benefit was incorporated into the basic TRICARE program and expanded to allow unlimited self-referred UC visits for the covered beneficiary population.

- UC encounters increased by 78 percent from FY 2017 to FY 2019, while RVUs increased by 88 percent.
- The government share of the cost for UC increased by about $60 million (89 percent) from FY 2017 to FY 2019.

TRENDS IN UC UTILIZATION, FYs 2017–2019

	ENCOUNTERS	RVUs	GOVERNMENT COST
FY 2017	774,411	1,941,742	$65,941,984
FY 2018	1,050,990	2,704,034	$92,848,449
FY 2019	1,379,400	3,657,588	$124,510,301

Source: MHS administrative data, 1/13/2020

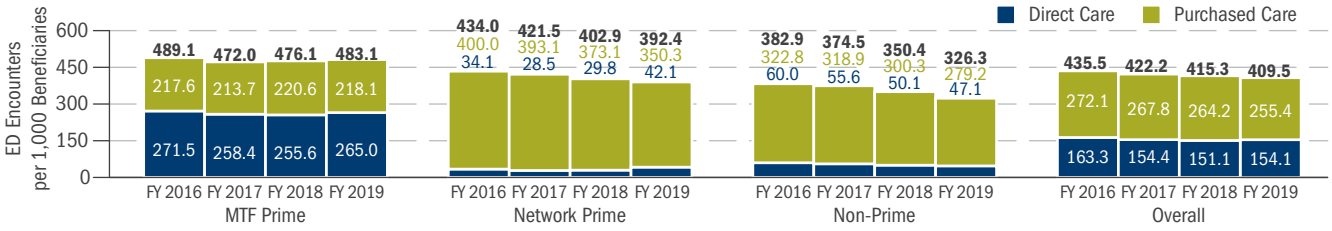
MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE) *(CONT.)*

ED Utilization

ED 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 (NCHS) reports that almost 80 percent of civilians who use the ED 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 EDs 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 ED 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 ED encounters 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.

- ED utilization per capita declined for Prime enrollees from FY 2016 to FY 2019 (1 percent for MTF enrollees and 10 percent for network enrollees). The rate for non-Prime enrollees declined by 15 percent over the same time period. One possible reason for the decline is increased access to urgent care by TRICARE beneficiaries (see page 39).
- In FY 2019, MTF Prime enrollees had an ED utilization rate 23 percent higher than that of network Prime enrollees and 48 percent higher than that of non-enrollees. Network Prime enrollees had an ED utilization rate 20 percent higher than that of non-enrollees.
- For MTF Prime enrollees, 45 percent of ED encounters were in purchased care facilities (not necessarily in-network) in FY 2019.
- Children under five years old had the highest ED utilization rate for all enrollment groups (not shown).
- The FY 2019 rate of 410 encounters per 1,000 beneficiaries is 9 percent lower than the civilian rate of 451 per 1,000 reported in CY 2016, the most recent year for which data are available.[2]

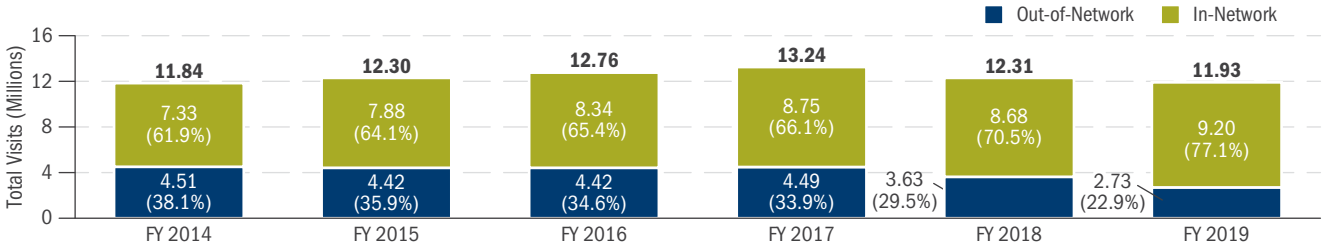
ED UTILIZATION BY ENROLLMENT STATUS AND SOURCE OF CARE (ENCOUNTERS PER 1,000 BENEFICIARIES), FYs 2016–2019



Out-of-Network vs. In-Network Non-Prime Visits

For beneficiaries not enrolled in Prime, the ratio of in-network to out-of-network visits has been steadily increasing. In FY 2008, in-network visits accounted for only 46 percent of all non-Prime visits. By FY 2009, the number of in-network visits exceeded the number of out-of-network visits for the first time (51 percent). In FY 2019, 77 percent of all non-Prime visits were to in-network providers. One reason for the increasing use of in-network providers is the expansion of the TRICARE provider network (see page 160).

TRENDS IN OUT-OF-NETWORK VS. IN-NETWORK VISITS, FYs 2014–2019



Source: MHS administrative data, 1/13/2020

[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," NCHS, May 2012, https://www.cdc.gov/nchs/data/nhis/earlyrelease/emergency_room_use_january-june_2011.pdf.

[2] Centers for Disease Control and Prevention (CDC), "National Hospital Ambulatory Medical Care Survey: 2016 Emergency Department Summary Tables," Table 2, https://www.cdc.gov/nchs/data/nhamcs/web_tables/2016_ed_web_tables.pdf. The civilian ED 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.

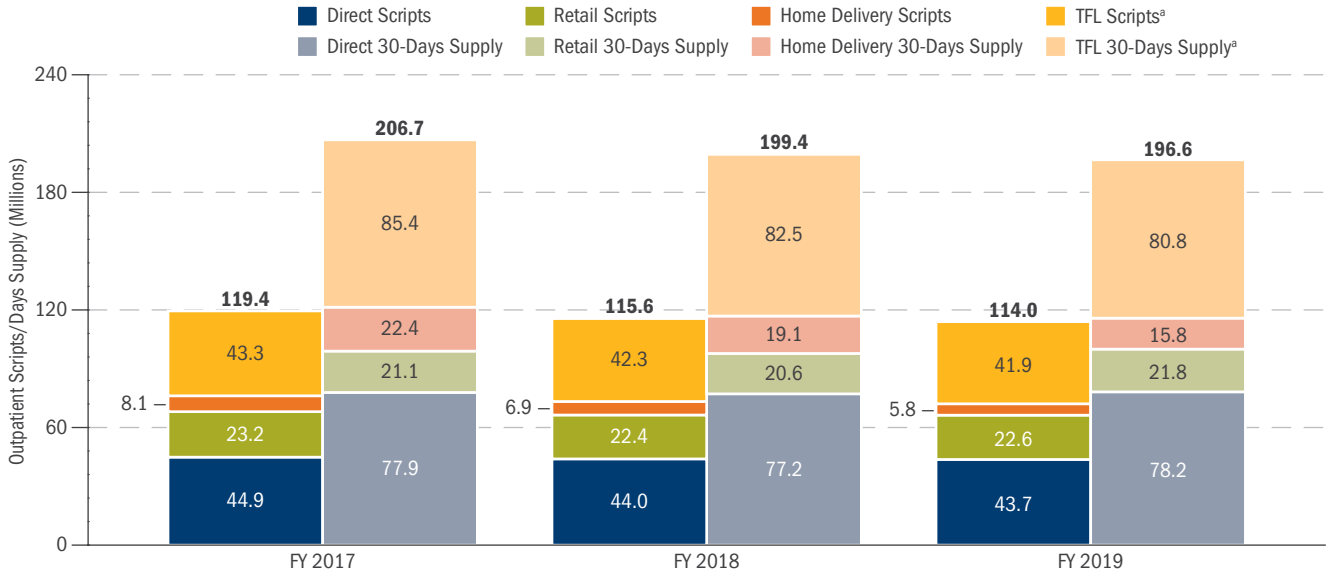
Note: Numbers may not sum to bar totals due to rounding.

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 2017 and FY 2019 (prescriptions and days supply each fell by 5 percent), excluding the effect of TFL purchased care pharmacy usage.

TRENDS IN MHS PRESCRIPTION WORKLOAD, FYs 2017–2019



Source: MHS administrative data, 1/13/2020

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

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

- Direct care prescriptions decreased by 3 percent, while days supply remained constant between FY 2017 and FY 2019.
- Purchased care prescriptions (retail and home delivery combined) decreased by 9 percent and days supply by 14 percent from FY 2017 to FY 2019, excluding TFL utilization. Including TFL utilization, purchased care prescriptions decreased by 6 percent and days supply by 8 percent.
- 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.)*

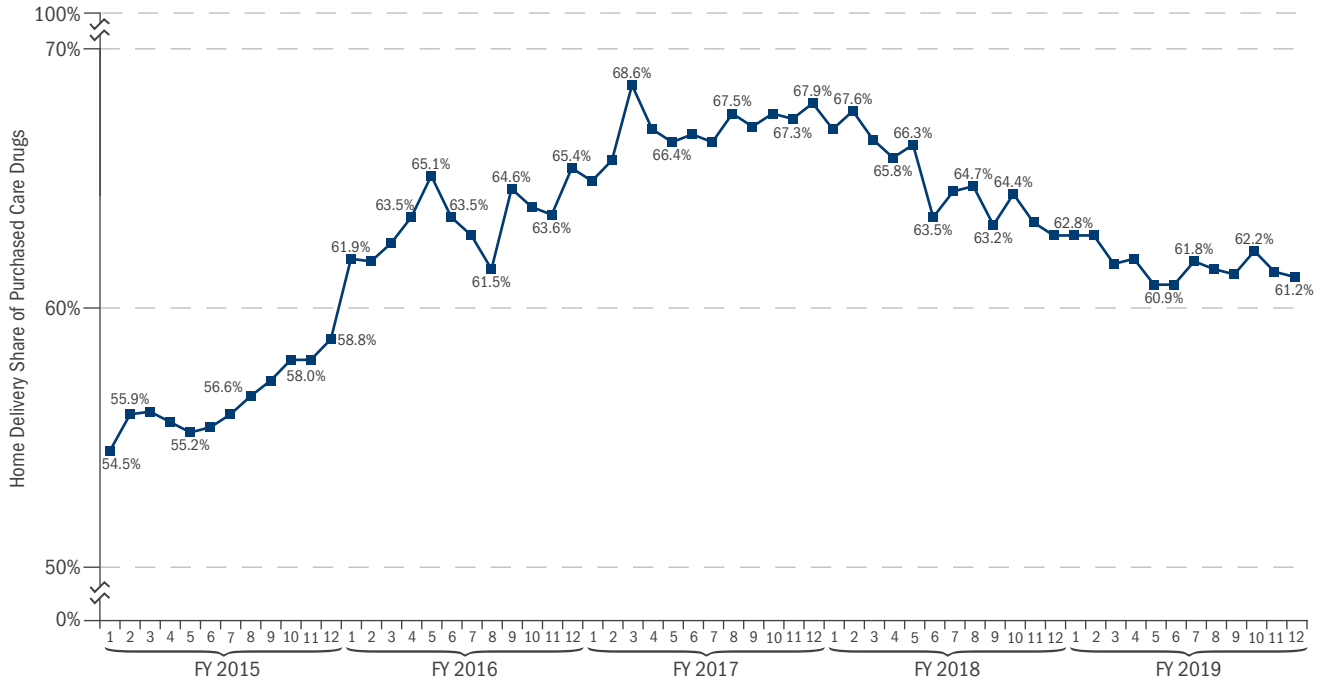
MHS Prescription Drug Workload *(cont.)*

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. As an 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. Since that time, copayments have increased every year for both home delivery and retail drugs.

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 nongeneric 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 had been on the rise since the DoD changed the copayment structure for retail/home delivery drugs at the beginning of FY 2012. From FY 2015 to FY 2017, the home delivery share of purchased care pharmacy utilization (as measured by days supply) increased from 56 percent to 67 percent. However, in FY 2018 the home delivery copayment for a 90-day supply of generic formulary drugs rose from $0 to $7, which reduced the disparity in copayments between home delivery and retail drugs. This likely contributed to the decreased home delivery share of total purchased care utilization seen in FY 2018 (65 percent) and continuing into FY 2019 (62 percent).

TREND IN HOME DELIVERY UTILIZATION (DAYS SUPPLY) AS A SHARE OF TOTAL PURCHASED CARE UTILIZATION, FYs 2015–2019

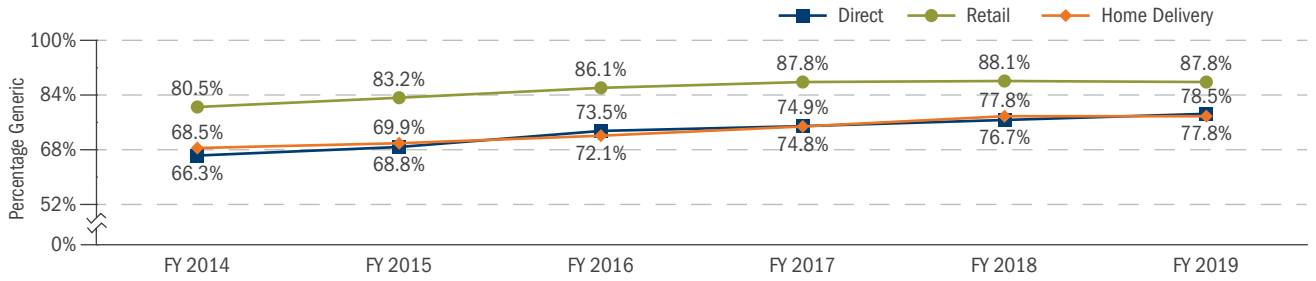


Source: MHS administrative data, 1/13/2020

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 69 percent in FY 2014 to 78 percent in FY 2019. However, retail pharmacies dispensed the highest percentage of generic drugs in FY 2019 (88 percent).
- The retail generic drug dispensing rate in FY 2019 was about the same as that of the private sector (90 percent).[1] However, the direct care rate (79 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 2019 was $83 versus $17 for direct care, $370 (net of manufacturer refunds) versus $12 for retail pharmacies, and $148 versus $15 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 2014–2019

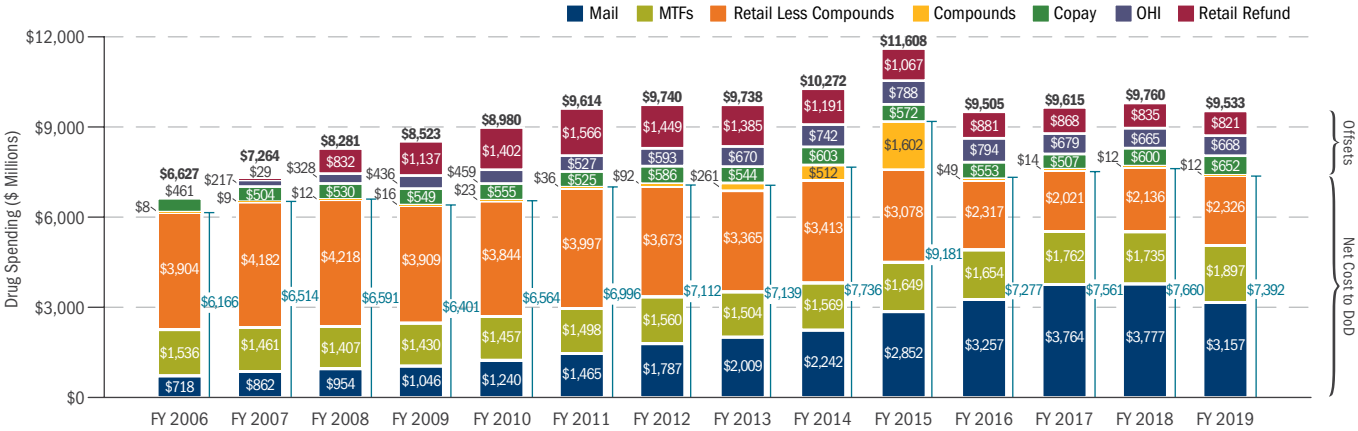


Source: MHS administrative data, 1/13/2020

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 2019, the refunds are estimated to have saved the DoD $821 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 have remained relatively constant since then.

MHS OUTPATIENT DRUG SPENDING, FYs 2006–2019



Sources: Pharmacy Data Transaction Service (PDTS) Data Warehouse; DHA Pharmacy Operations Division (refunds) as of 12/17/2019

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 47–48. 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 Savings in the U.S.," 2019, https://accessiblemeds.org/sites/default/files/2019-12/AAM-2019-Generic-Biosimilar-Access-Savings-US-One-Pager.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. In addition, the MHS has a higher fraction of brand-name maintenance drugs. As per NDAA FY 2016, these drugs must be dispensed at the MTF or home delivery point of service.

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 191 existing contracts, of which 47 were new in FY 2019. There are currently 14 joint contracts pending at the National Acquisition Center and 30 pending at the Defense Logistics Agency. The DoD/VA pharmacy team identified 34 commonly used pharmaceutical products and manufacturers for potential joint contracting action and continue to seek new joint contracting opportunities where practicable. In FY 2019, the VA spent $449 million on joint national contracts, and the DoD spent $203 million. Over the same time period, DoD joint national contract prime vendor (PV) purchases represented 3.8 percent of the DoD's total PV purchases.

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) cost is greater than or equal to $500 per dose or greater than or equal to $6,000 per year; (2) has difficult or unusual process of delivery; (3) requires patient management beyond traditional dispensing practices; or (4) as defined by DoD.

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

TOP 20 SPECIALTY CLASSES ($ MILLIONS), AS DEFINED BY P&T COMMITTEE, FYs 2017–2019

FY 2019 RANK	SPECIALTY CLASS	FY 2017	FY 2018	FY 2019	FYs 2018–2019 % CHANGE[a]
1	Oncological	$633	$758	$891	18%
2	Targeted Immunomod Biologics	$349	$418	$529	26%
3	Multiple Sclerosis	$197	$195	$181	–7%
4	Antiretrovirals	$113	$127	$137	8%
5	Pulmonary Arterial Hypertension	$86	$97	$119	22%
6	Corticosteroid-Immune Modulators	$48	$65	$75	15%
7	Antihemophilic Factors	$76	$73	$68	–7%
8	Pulmonary-1 (e.g., nintedanib, pirfenidone)	$65	$58	$60	3%
9	Cystic Fibrosis	$29	$42	$54	30%
10	Endocrine Misc (e.g., cinacalcet, deferasirox)	$43	$47	$51	8%
11	Sleep Disorders	$26	$28	$50	79%
12	Antisera (immune globulins)	$19	$25	$48	91%
13	Hematological	$36	$39	$44	11%
14	Metabolic Misc (e.g., asfotase alfa, sapropterin)	$20	$27	$36	33%
15	Osteoporosis	$35	$38	$36	–7%
16	Neurological Misc (e.g., botulinum toxin, VMAT2s)	$58	$25	$33	34%
17	Gastrointestinal-2	$11	$16	$22	41%
18	Cardiovascular Misc	$11	$16	$21	31%
19	Respiratory Misc	$22	$21	$20	–4%
20	Immunological Misc	$18	$16	$20	23%

Source: PDTS Data Warehouse, 10/23/2019

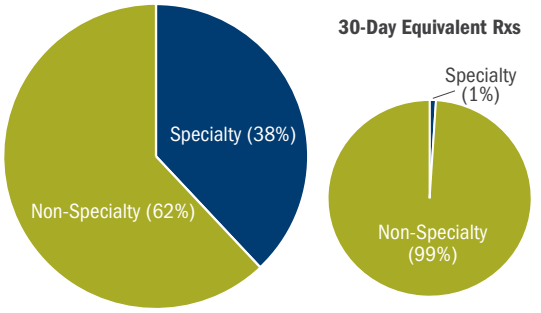
[a] The percentage changes are based on the original unrounded numbers.

Note: FY 2019 Q4 Specialty Agent Reporting List applied to all data; total costs adjusted for retail refunds (FY 2019 Q3 refund per unit applied to FY 2019 Q4 data), MTF PV cost per unit, home delivery PV cost per unit.

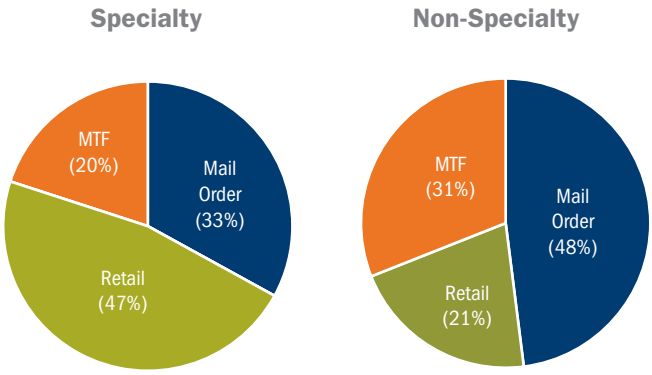
SPECIALTY DRUG COST TRENDS *(CONT.)*

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

FY 2019 TOTAL SPENDING



FY 2019 TOTAL SPENDING BY POINT OF SERVICE



Source: PDTS Data Warehouse, 10/23/2019

TOTAL ESTIMATED SPENDING ($ MILLIONS) BY QUARTER, FYs 2016–2019

	FY 2016				FY 2017				FY 2018				FY 2019			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Non-Specialty	$1,262	$1,319	$1,110	$1,156	$1,152	$1,245	$1,237	$1,149	$1,084	$1,090	$1,087	$1,061	$1,058	$1,126	$1,130	$1,128
Specialty	$470	$494	$484	$490	$488	$545	$551	$550	$551	$592	$596	$621	$612	$665	$685	$729
Percentage Specialty[a]	27.1%	27.2%	30.4%	29.8%	29.8%	30.4%	30.8%	32.4%	33.7%	35.2%	35.4%	36.9%	36.7%	37.1%	37.7%	39.3%

Source: As of 10/23/2019; based on Specialty Agent Reporting List for applicable quarters; totals adjusted for retail refunds (FY 2019 Q3 refund per unit applied to FY 2019 Q4 data), copays, and against PV cost per unit for MTF and home delivery drugs.

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

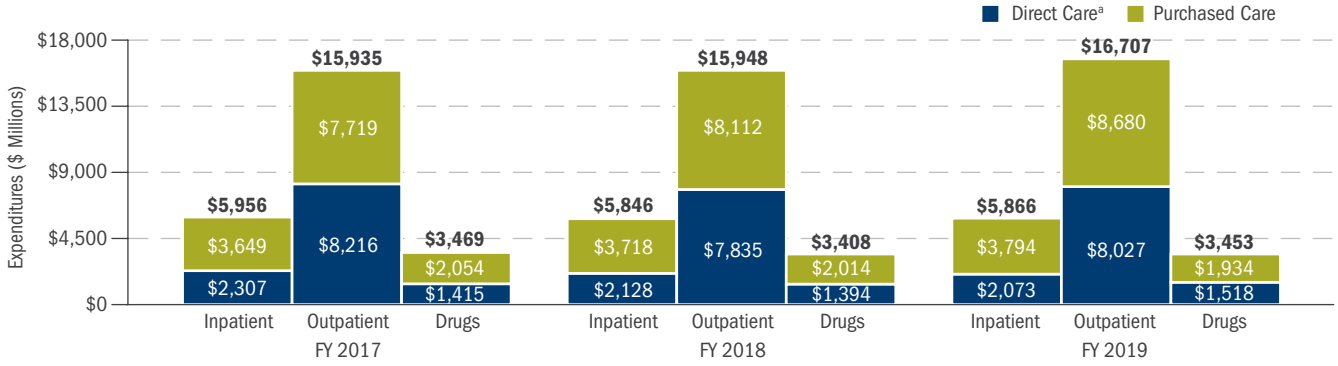
- In FY 2019, specialty drugs accounted for less than 1 percent of total MHS prescription drug utilization (30-day equivalents), but for 38 percent of total spending.
- As a percentage of total drug costs, specialty drug costs continued to increase from FY 2013 to FY 2019. A large proportion of specialty spend comes from retail prescriptions, reflecting the limited distribution mechanisms in place for many of these agents. This limits availability at mail order and MTFs, which are generally lower cost points of service.
- The highest spend specialty class, oncological agents, accounted for about $891 million in drug spend in FY 2019, up from $758 million in FY 2018. The top five oncological subclasses (by total FY 2019 spend) were multiple myeloma ($255 million), breast cancer ($100 million), renal cell carcinoma ($73 million), CYP-17 inhibitors ($59 million), and second-generation antiandrogens ($57 million). Other subclasses and unclassified oncological agents accounted for another $347 million.
- 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. The committee reviews new drugs shortly after U.S. Food and Drug Administration (FDA) approval, including all new specialty agents.

MHS COST TRENDS

Net of MERHCF costs, total DoD expenditures for health care increased by 3 percent between FY 2017 and FY 2019. Inpatient expenses decreased by 2 percent, outpatient expenses increased by 5 percent, and prescription drug expenses remained about the same.

- The share of DoD expenditures for outpatient care relative to total expenditures for inpatient and outpatient care increased slightly from 73 percent to 74 percent from FY 2017 to FY 2019. For example, in FY 2019, DoD expenses for inpatient and outpatient care totaled $22,573 million, of which $16,707 million were for outpatient care, for a ratio of $16,707/$22,573 = 74 percent.
- NDAA FY 2015 required beneficiaries to move selected maintenance medication refills out of retail to either home delivery or MTF pharmacies. This helped to reduce prescription drug costs. Purchased care drug costs shown below have been reduced by manufacturer refunds for retail brand-name drugs accrued to the years in which the drugs were dispensed.
- In FY 2019, the DoD spent $2.85 on outpatient care for every $1 spent on inpatient care.

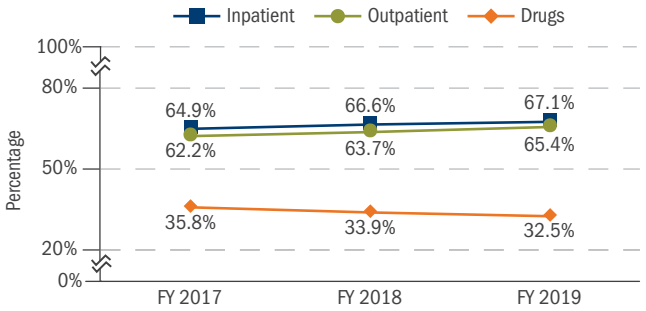
TRENDS IN DoD EXPENDITURES FOR HEALTH CARE (EXCLUDING MERHCF), FYs 2017–2019



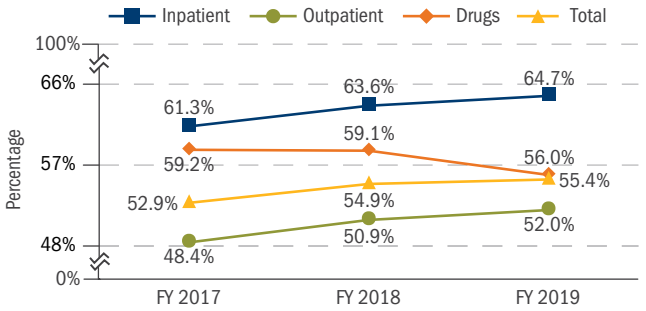
[a] Direct care prescription costs include an MHS-derived dispensing fee.
Note: Numbers may not sum to bar totals due to rounding.

- The purchased care shares of total inpatient and total outpatient utilization each increased from FY 2017 to FY 2019 while the purchased care share of total prescription drug utilization dropped over the same time period.
- The purchased care share of total MHS costs increased by two percentage points between FY 2017 and FY 2019. The purchased care share of total inpatient costs increased by three percentage points, the purchased care share of total outpatient costs increased by about four percentage points, and the share of total prescription drug costs decreased by three percentage points.

TRENDS IN PURCHASED CARE UTILIZATION[a] AS PERCENTAGE OF MHS TOTAL BY TYPE OF SERVICE, FYs 2017–2019



TRENDS IN PURCHASED CARE COST AS PERCENTAGE OF MHS TOTAL BY TYPE OF SERVICE, FYs 2017–2019



Source: MHS administrative data, 1/13/2020

[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.

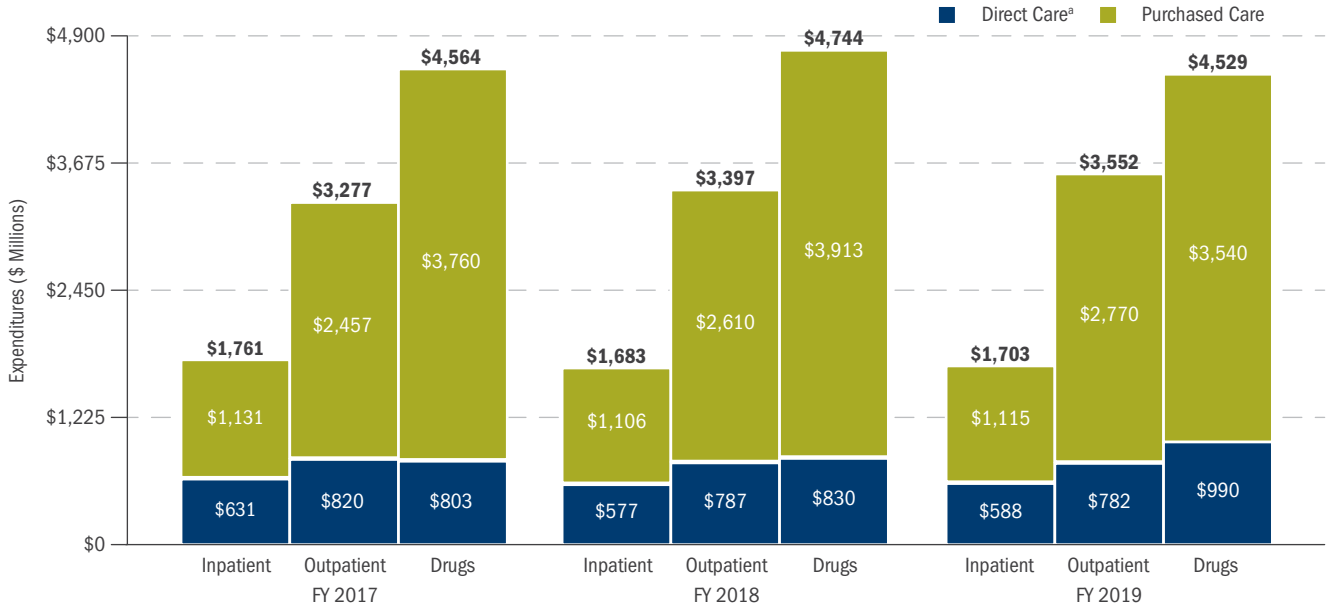
MHS COST TRENDS *(CONT.)*

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 increased from $9,602 million in FY 2017 to $9,784 million in FY 2019 (2 percent), 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 2017 to FY 2019. Inpatient costs fell by 7 percent and outpatient costs fell by 5 percent, but prescription drug costs increased by 23 percent.
- In FY 2017, TRICARE Plus enrollees accounted for 74 percent of DoD direct care inpatient and outpatient expenditures on behalf of MERHCF-eligible beneficiaries. That percentage dropped to 72 percent by FY 2019 (not shown).
- Including prescription drugs, TRICARE Plus enrollees accounted for 59 percent of total DoD direct care expenditures on behalf of MERHCF-eligible beneficiaries in FY 2017. That percentage dropped to 56 percent by FY 2019 (not shown).
- Total purchased care MERHCF expenditures increased by 1 percent from FY 2017 to FY 2019. Inpatient expenditures declined by 1 percent, outpatient expenditures increased by 13 percent, and prescription drug expenditures decreased by 6 percent.

MERHCF EXPENDITURES BY TYPE OF SERVICE, FYs 2017–2019



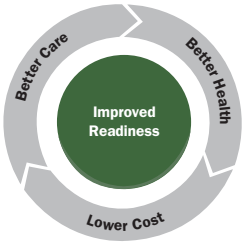
Source: MHS administrative data, 1/13/2020

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

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

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.

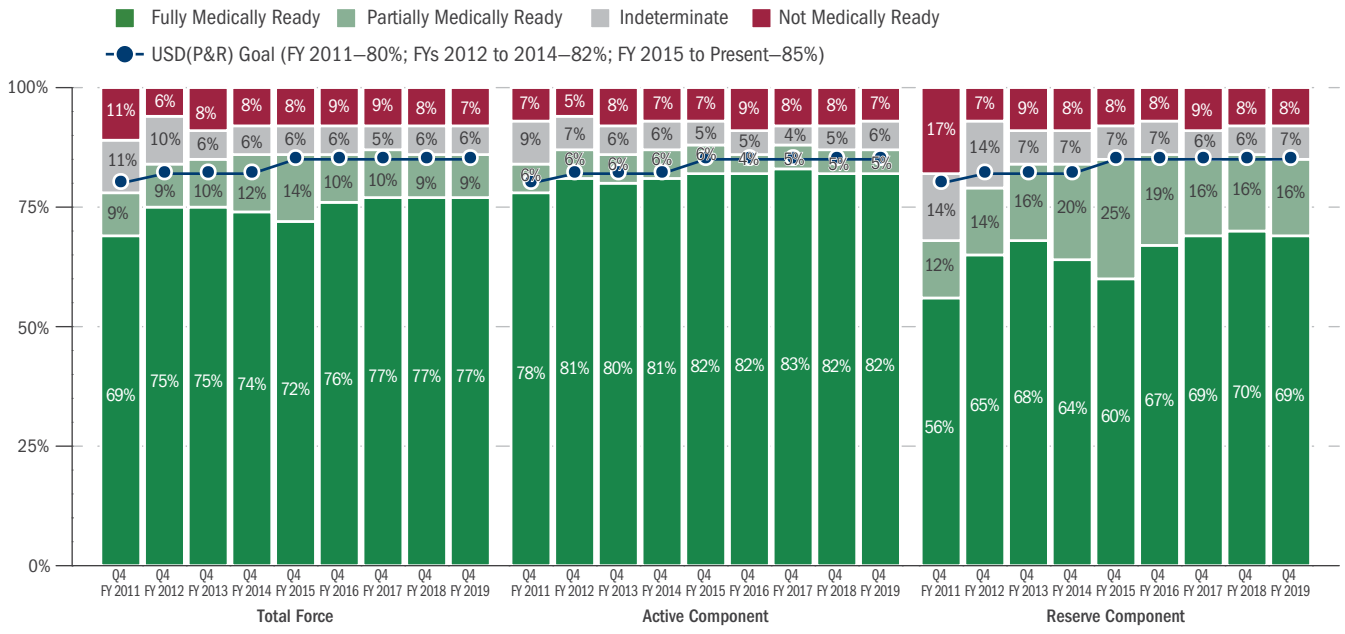


The IMR chart below shows that by the end of fiscal year (FY) 2019, the Total Force medical readiness, at 86 percent, surpassed the Office of the Under Secretary of Defense for Personnel and Readiness (OUSD[P&R]) goal of 85 percent, with the AC at 87 percent, and the RC at 85 percent (these percentages 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 eight percentage points (from 78 percent in FY 2011 to 86 percent in FY 2019), and, separately, the AC has increased by three percentage points (from 84 percent to 87 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 OUSD(P&R) goal since it was last increased in FY 2015. Increasing the medical readiness goal above 85 percent to 90 percent is currently being pursued by the OUSD(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 for Health Affairs (OASD[HA]), in the Quarterly Metrics Review and Analysis Forum.

OVERALL INDIVIDUAL MEDICAL READINESS STATUS (ALL COMPONENTS NOT DEPLOYED), FY 2011 Q4 TO FY 2019 Q4



Source: Defense Health Agency (DHA), Public Health Division, 10/29/2019
Note: Percentages may not sum to 100 percent due to rounding.

HEALTHY, FIT, AND PROTECTED FORCE

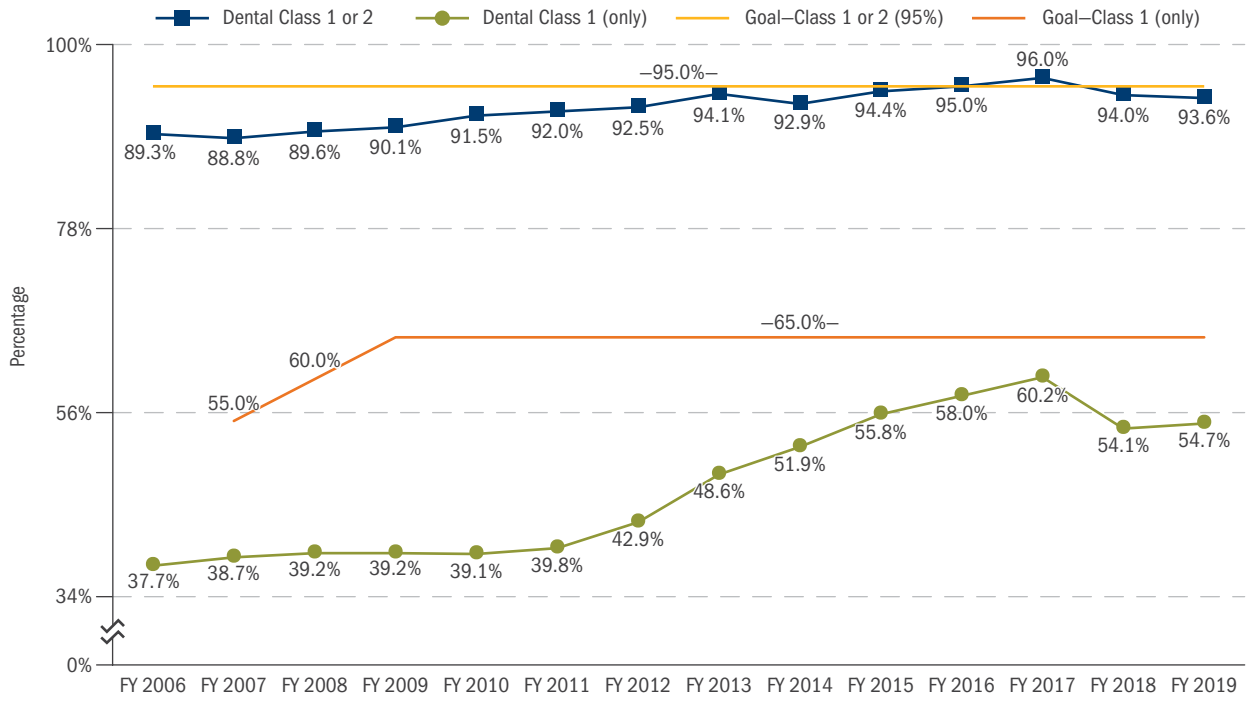
Key among the measures of performance related to providing an efficient and effective deployable medical capability and offering force medical readiness are those related to how well we (1) maintain the worldwide deployment capability of our Service members, as in dental readiness and immunization rates 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 reevaluation for oral conditions that are unlikely to result in dental emergencies within 12 months (Class 2—see definitions 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 fell in FY 2018 to just under 94 percent and remained there in FY 2019, down from 96 percent in FY 2017, falling short of the long-standing MHS goal of 95 percent.
- The rate for Active Duty personnel in Dental Class 1 had risen steadily since FY 2010 (39.1 percent), but fell from 60.2 percent in FY 2017 to 54.1 percent in FY 2018, remaining there in FY 2019—more than ten percentage points short of the MHS goal. 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 2006–2019



Source: The Services' Dental Corps–DoD Dental Readiness Classifications, 12/11/2019

Definitions:

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

– Dental Class 2: Patients with a current dental examination who require non-urgent dental treatment or reevaluation 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 MHS is unique in that it must provide expertise in stateside hospitals as well as across the globe in support of military operations. The MHS sustains the clinical readiness of its providers through routine medical practice, particularly in military treatment facilities (MTFs). The key to the military mission is identifying which aspects of care are relevant to "readiness" and ensuring that military providers are proficient in those areas. While there are many components that comprise "readiness," the basis of the DoD's expeditionary medical systems rests on individual clinical proficiency. The Clinical Readiness Project provides an innovative approach to measuring, evaluating, and sustaining individual clinical proficiency, with a focus on the Combat Casualty Care Team (CCCT), shown in Figure 1, although the process can be applied generally.

FIGURE 1. CCCT+ SPECIALTIES

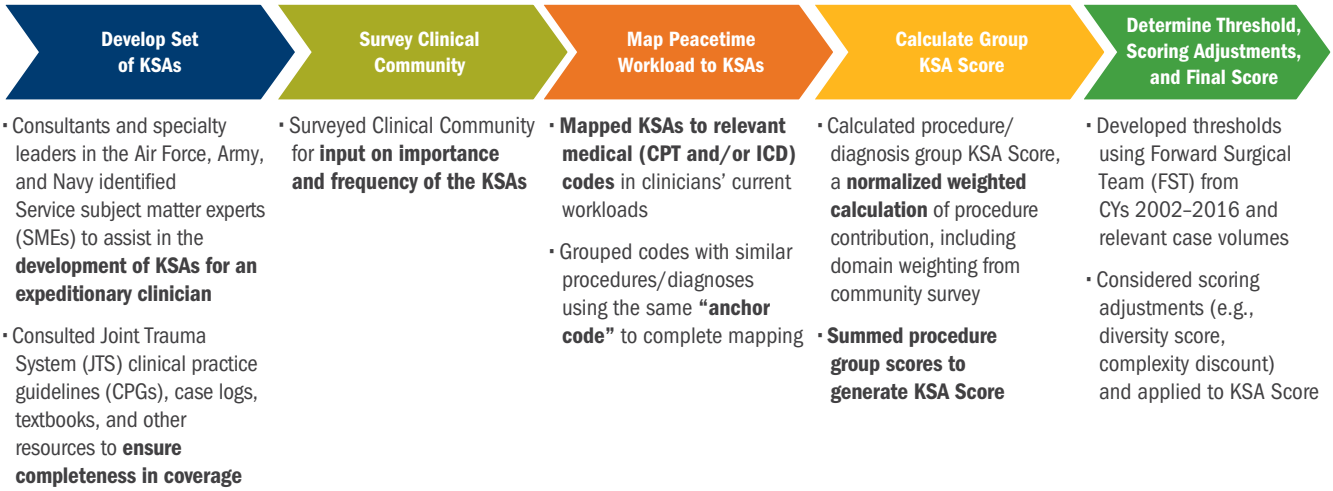
1	General Surgery (and Colorectal)	9	Ophthalmology
2	Orthopedic Surgery	10	Cardiothoracic (CT) Surgery
3	Critical Care	11	Vascular Surgery
4	Emergency Medicine	12	Plastic Surgery
5	Anesthesiology (and Certified Registered Nurse Anesthetists)	13	Urology
6	Emergency Department (ED) Nursing	14	Oral Maxillofacial (OMFS)
7	Critical Care Nursing	15	Otorhinolaryngology (ENT)
8	Trauma Surgery	16	Neurosurgery

Clinical Currency

Knowledge, skills, and abilities (KSAs) comprise the specialty-specific skill set used by an expeditionary clinician, reflecting both clinical currency and competency. The Clinical Readiness Project is based on a continuous cycle (clinical readiness life cycle) of clinical currency through periodic knowledge assessment, clinical practice (KSA metric), and skills assessment. KSAs create the ability to assess the wartime medical readiness value derived from each clinician's peacetime workload, as well as provide detailed descriptions of the knowledge and skills needed in the expeditionary environment. KSAs are developed using a standardized process, shown in Figure 2.

To date, over 5,000 individual KSAs have been developed for 11 of the 16 CCCT+ specialties. From this the clinical currency measure and threshold have been developed for six of the CCCT+ specialties, with the remaining specialties currently in various stages of development.

FIGURE 2. KSA DEVELOPMENT PROCESS



Knowledge Assessment

The knowledge assessment and associated multimedia curriculum is a standard measure to determine the individual's cognitive capabilities tied to medical readiness for the joint force. To assure the validity and reliability of knowledge assessment measures, the program implemented a rigorous process for test development. The test development process for general surgery and its subspecialties was done in partnership with the American College of Surgeons (ACS) and resulted in a knowledge exam that encompasses eight subdomains

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

of expertise deemed necessary to assure the readiness of expeditionary surgeons. This highly reliable, dual version 200 question test was administered to 113 Active Duty military surgeons with a mean score of 72 percent and high psychometric integrity. The assessment identified knowledge gaps in relevant domains and also differentiated between learner experience and specialty. Coupled with an aligned multimedia curriculum found on the ACS website, this effort provides a data-driven process for identifying and addressing readiness knowledge gaps prior to deployment. Periodic knowledge assessments every three years will help identify areas of knowledge decay and inform ongoing training refreshment intervals. Similar knowledge assessments are currently being developed for trauma surgery, critical care, anesthesiology, and orthopedic surgery with the other CCCT+ specialties to follow.

Skills Assessment

A third, and final, piece for determining clinician readiness in a standardized and measurable format is the technical skills assessment. A performance assessment of procedural abilities and technical skills includes key measures for determining individual medical readiness capabilities for the joint force. To measure and assess technical skills, the program is examining integration in procedural contexts as part of the Advanced Surgical Skills for Exposure in Trauma (ASSET) Plus course. The ASSET Plus course provides an excellent model of applied trauma surgical care in a simulated context, using perfused cadavers. It is designed to facilitate one-on-one training of participants in trauma surgery by expert expeditionary trauma surgeons and is intended to be delivered either every two years or in a pre-deployment window. Performance assessment in this context encompasses three components: (1) procedural knowledge; (2) technical skills; and (3) procedural integration (knowledge and skills). Procedural knowledge is assessed pre- and post-training to evaluate the relative impacts of course activities on individual cognitive and decision-making capabilities in trauma care. Technical skills are assessed using formative assessment instrumentation to measure discrete surgical tasks while performing 28 trauma procedures with procedural guidance from teaching faculty. Finally, procedural integration of knowledge and skills is assessed using summative assessment instrumentation to measure procedural knowledge, decision making, and technical skills while performing 20 procedures without guidance.

The precision of both the procedural integration and technical skills assessment instruments are sufficiently rigorous to identify variance within individual procedural performance (performance in some procedures was not equivalent to others for a single individual), and procedural performance across individuals (performance on one procedure varied between individuals). Preliminary data are also able to differentiate between subspecialty trained surgeon performance in areas where overlap occurs in trauma care (e.g., vascular subspecialists outperform others in vessel exposure and control procedures). This approach is scalable, cost effective, and, with future expansion, will allow the ability to predict performance capabilities for surgeons as a component of the clinical readiness life cycle.

Implementation of KSA Metric

A successful proof of concept was performed to assess the applicability and feasibility of the KSA metric methodology to a representative sample of facilities within the MHS. The proof of concept was performed by providing the KSA metric, methodology, and utilization to the general surgical and orthopedic Clinical Community at six Tri-Service MTFs varied with respect to capability and capacity. Walter Reed National Military Medical Center, Fort Belvoir Community Hospital, William Beaumont Army Medical Center, Naval Hospital Camp Pendleton, 96th Medical Group (Eglin Air Force Base), and David Grant USAF Medical Center (Travis Air Force Base) participated in the proof of concept. A dedicated site visit was performed at each MTF with a team to present the KSA dashboard tools that include direct care, network purchased care, and surgeon workload, as well as metrics for management. Metrics for management included operational parameters such as operating room utilization, percentage of military surgeons meeting the Medical Group Management Association (MGMA) benchmark, patient access to care, workload capture, surgeon caseload, average surgeon diversity and KSA score, as well as quality metrics. Each facility received step-by-step instructions on how to navigate the readiness dashboard, management trial overview, outline for continuous improvement, and the strategic imperative and significance with respect to a medically ready force. KSA performance was reviewed and analyzed quarterly. As a result, the KSA metric has been distributed systemwide through online dashboards, and incorporated into the DHA's Quadruple Aim Performance Plan (QPP). A key finding of the effort was the loss of significant readiness generating clinical cases to the purchased care network that now can be targeted for recovery at MTFs to support clinical readiness.

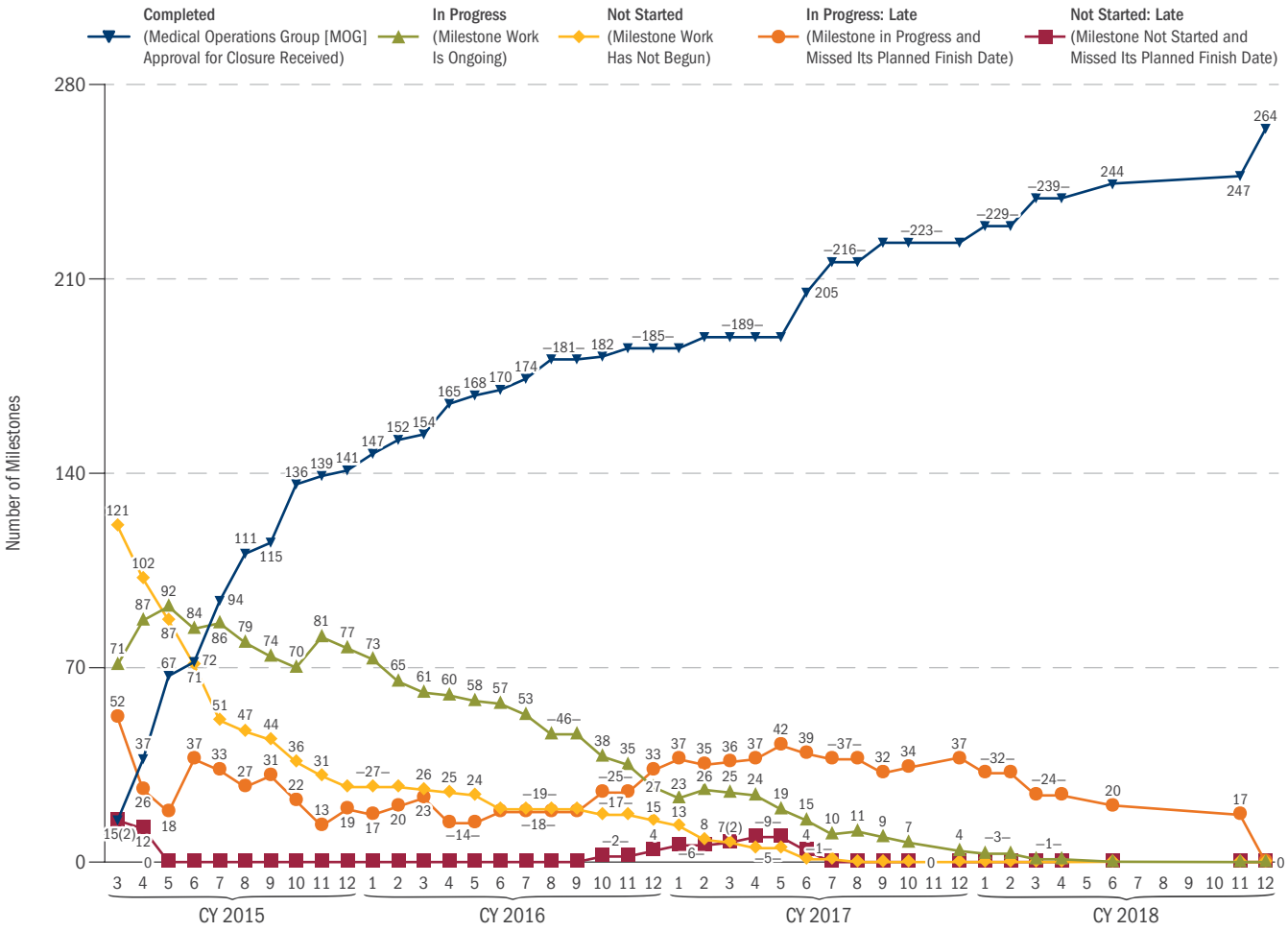
Since the completion of the proof of concept, additional Clinician Readiness Dashboards for emergency medicine, critical care, and trauma surgery have been made available on the Common Access Card (CAC)-enabled CarePoint site. Several MTFs have ongoing QPP initiatives to improve their KSA scores for these initial specialties, and both general surgery and orthopedic surgery KSAs are tracked as part of the MHS core measures.

ACCESS, QUALITY, SAFETY, AND PATIENT ENGAGEMENT

MHS Review—Status Update

The Secretary of Defense (SECDEF) directed a review of the Military Health System (MHS) in 2014, focused on safety, quality of care, and access to care. To fully address all the recommendations from the MHS review, 41 action plans were developed. As of November 18, 2019, all 41 action plans, comprising 264 milestones, have been closed. While milestones may have been fulfilled and warrant action plan closure, sustained advances will be met through individual action plan capstone summaries. These summaries are being developed to assign and ensure recommendations are incorporated into standard and enduring work. To date, 12 of the completed capstone summaries have been approved by MHS leadership. The remaining capstone summaries are in various stages of development and approval with scheduled completion by the second quarter of 2020.

MILESTONE STATUS TREND, CYs 2015–2018



Source: DHA/Medical Affairs/CSD, 1/2/2020

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

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

High Reliability Organization Journey

As a result of the MHS review and subsequent findings, the SECDEF directed the MHS to adopt the practices and principles of high reliability organizations (HROs) as the framework to improve the quality of health care delivered. To meet the charge, the MHS developed the high reliability operating model (HROM), a visual representation of organizational relationships within the MHS that supports the Quadruple Aim of Improved Readiness, Better Care, Better Health, and Lower Cost is depicted below. Throughout FY 2019, the DHA and Services advanced and supported the HROM through the MHS Clinical Communities, strategically aligning quality improvement initiatives with the QPP process.

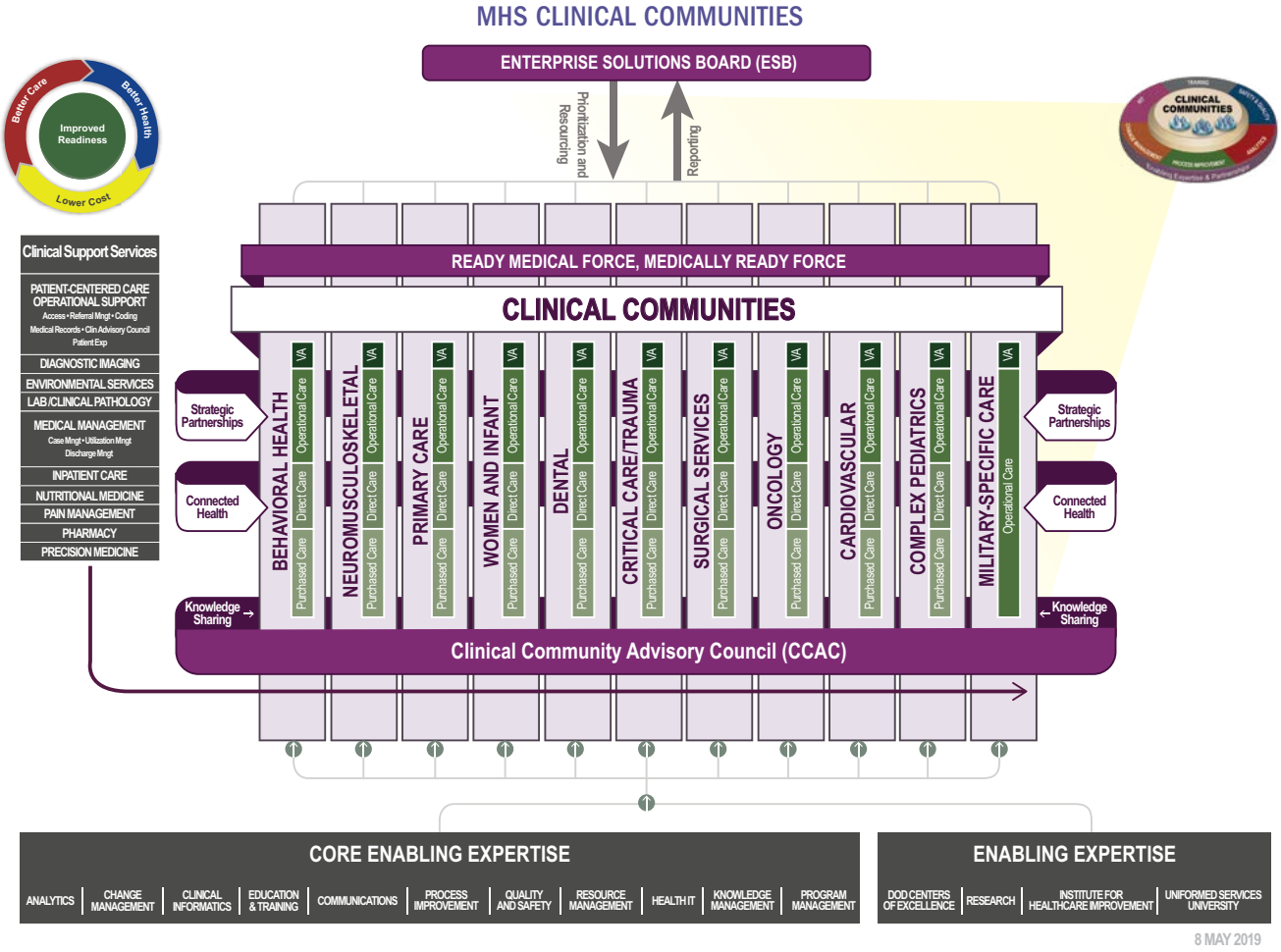
MHS INTEGRATED HEALTH CARE DELIVERY SYSTEM HROM

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

High Reliability Organization Journey *(cont.)*

MHS Clinical Communities

The MHS Clinical Communities are a key driver promoting HRO and continuous process improvement (CPI) in health care delivery across the MHS. Clinical Communities are networks of MHS providers who work to optimize health care delivery for every patient across the MHS. In May 2019, the MHS stood up its remaining six Clinical Communities, following the initial proof of concept period for the first five communities. As seen in the visual representation below, the MHS Clinical Communities now include: Behavioral Health, Neuromusculoskeletal, Primary Care, Women and Infant, Dental, Critical Care/Trauma, Surgical Services, Oncology, Cardiovascular, Complex Pediatrics, and Military-Specific Care. In FY 2019, these communities were actively supported by Clinical Support Services and Enabling Expertise to drive enterprise-wide clinical quality improvement (CQI).



High Reliability Organization Journey *(cont.)*

Also in FY 2019, the Clinical Communities successfully launched care pathways at pilot locations in MTFs within the contiguous United States (CONUS). Care pathways approach care from the patient's perspective and guide a patient with a specific condition through each step of the care experience. Providers use the pathway to ensure that all patients receive consistent, high-quality care aligned to best practices. The following are just a few initiatives underway (additional Clinical Community accomplishments and associated measurements can be found on pages 113–126).

- **Behavioral Health:** The MHS Behavioral Health Clinical Community (BHCC) implemented an enterprise-wide means to assess posttraumatic stress disorder (PTSD) and major depressive disorder outcomes using the Behavioral Health Data Portal (BHDP). The BHDP enables collection and analysis of self-reported patient data that inform MHS behavioral health care improvements. With consistent and comprehensive use of BHDP, the MHS can reliably monitor patient self-reported behavioral health outcomes. The BHCC is piloting use of the BHDP with transitioned DHA MTFs with a goal to increase BHDP adoption and use, and to ultimately improve analysis of behavioral health outcomes.
- **Neuromusculoskeletal:** The MHS Neuromusculoskeletal Clinical Community (NMSKCC) partnered with the Traumatic Brain Injury Advisory Committee (TAC) to pilot the clinical pathway to improve treatment outcomes for patients with acute concussion. This care pathway pilot will enable modernization of the standard assessment protocol for patients who sustain concussion or mild traumatic brain injuries (TBIs) and ultimately to reduce chronic concussion-related symptoms that may be avoidable if they are appropriately identified earlier in the clinical course. Timely follow-up and access to care are among the focused improvement targets to improve outcomes and progressive return to activity for our Active Duty Service members (ADSMs).
- **Primary Care:** The MHS Primary Care Clinical Community (PCCC) developed and launched the Stepped Care Model for Pain, an evidence-based process for improving assessment and treatment of acute and chronic pain in primary care. The goal of this pathway is to achieve enhanced delivery of nonpharmacological pain treatment and improve opioid prescribing practices. To ensure successful rollout of the pathway, the PCCC implementation team is providing training, data feedback, and ongoing support to all MHS primary care clinics and pain champions.
- **Women and Infant:** The MHS Women and Infant Clinical Community (WICC) launched the Induction of Labor (IOL) care pathway at Naval Medical Center San Diego. The IOL care pathway is designed to widely standardize the evidence-based approach to the induction of labor shown to decrease maternal infections, length of time from admission to delivery, postpartum hemorrhage (PPH) rate, and cesarean section rate. Following implementation, Naval Medical Center San Diego saw statistically significant improvement in two outcomes: (1) a decrease in unplanned neonatal intensive care unit (NICU) admissions; and (2) a decrease in the rate of chorioamnionitis infections related to labor. By July 2019, more than 80 percent of the hospital's providers were using the pathway.

  The WICC also continues work to improve outcomes related to PPH through DHA policy publication and is developing an implementation plan for the Alliance for Innovation on Maternal Health (AIM) PPH Bundle. The goal of the bundle is to decrease morbidity associated with hemorrhage by standardizing obstetric hemorrhage supplies, equipment, and protocols. This bundle is an expansion of the Navy Medicine Obstetric Hemorrhage Bundle, which decreased peripartum hysterectomies, intensive care unit (ICU) admissions, blood product transfusions, and maternal sentinel events (SEs).

These improvement efforts support and drive the MHS transition by standardizing the best care approaches across the system and leading initiatives to support the Quadruple Aim. The MHS Clinical Communities are vital to ensuring a consistent level of excellence in patient care at every MTF.

In FY 2019, to evaluate MTF performance in key clinical areas, the DHA incorporated Clinical Community metrics into the requirements of the FY 2021 cycle of the QPP. Four Clinical Communities (Behavioral Health, Neuromusculoskeletal, Primary Care, and Women and Infant) identified top CQI requirements in the planning of FY 2021 QPP supplemental guidance. The QPP is the process by which the DHA identifies and resources improvement priorities across the system. The QPP also serves as a guide for evaluating provider performance and enhancing accountability. MHS Clinical Communities inform DHA resourcing decisions by analyzing current gaps in care delivery and targeting high-impact and high-risk areas for improvement. Their insights inform the DHA's annual strategy development that aligns resources to DHA leaders' top objectives. Clinical Communities are supported in the review of FY 2020 QPP plans and continue to evaluate a subset of the QPP plans to learn what improvements at the MTF level should be incorporated into the next fiscal year's enterprise-wide strategy, resourcing, and performance assessments. To further promote a learning environment, performance gaps identified in one year are considered for incorporation into the strategic guidance and QPP critical initiatives for the subsequent year.

High Reliability Organization Journey *(cont.)*

HRO Integrated Product Team

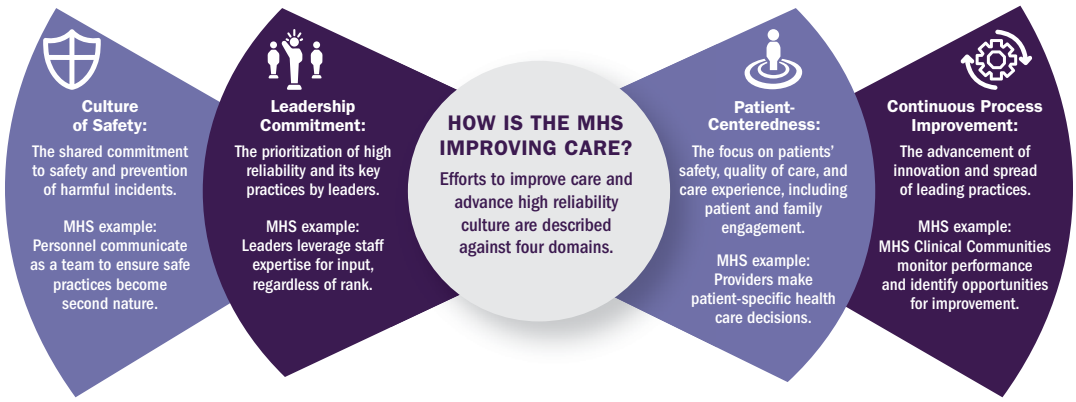
As the Services and DHA continue to work together to drive process improvement through the work of the Clinical Communities, they also collaborate to develop an enterprise-wide change plan for the advancement of HRO across the other domains of change: Culture of Safety, Leadership Commitment, and Patient-Centeredness. During FY 2019, the HRO Integrated Product Team (IPT), a group of safety, quality, and improvement representatives from across the DHA and the Services, led the prioritization and alignment of HRO across the MHS. In follow-up to Action Plan (AP) 1 of the 2014 MHS review, the HRO IPT finalized the AP 1 Narrative Summary in FY 2019 to highlight enduring work that is required to unify Service-specific improvements, spread the implementation of HRO culture and practices across the MHS, and promote MHS HRO transformation.

The AP 1 narrative contains a strategy for advancing high reliability across the entire MHS, which includes year-one MHS HRO priorities, enduring work for subsequent years, key HRO practices from leading U.S. health care organizations and Service HRO practitioners, and identification of MHS HRO domains of change and HRO principles.

Year-One MHS HRO Priorities:

1. Establish HRO senior executive oversight governance
2. Establish a standard organizational structure that aligns high reliability functions from headquarters, markets, and MTFs
3. Implement leader engagement strategies/practices
4. Develop an HRO assessment strategy and tools for the MHS aligned to the domains of change
5. Establish an organizational structure that focuses on patient/family experience at headquarters, market, and MTF levels
6. Establish a formal recognition program for highly reliable behaviors and activities to be acknowledged at headquarters, market, and MTF levels
7. Develop and implement an approach to standardize Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS®) principles across the system to enhance communication and promote safety culture
8. Understand and address contributing factors to staff burnout/well-being in the military environment
9. Develop, standardize, integrate, and mature change management capabilities and CPI across the DHA
10. Leverage the HROM, MHS Clinical Communities, and CPI to implement standardized, evidence-based safety practices, including processes, training, equipment, and use of technology such as the electronic health record (EHR)

REVISED MHS HRO DOMAINS OF CHANGE



HRO PRINCIPLES

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

MHS Data Transparency

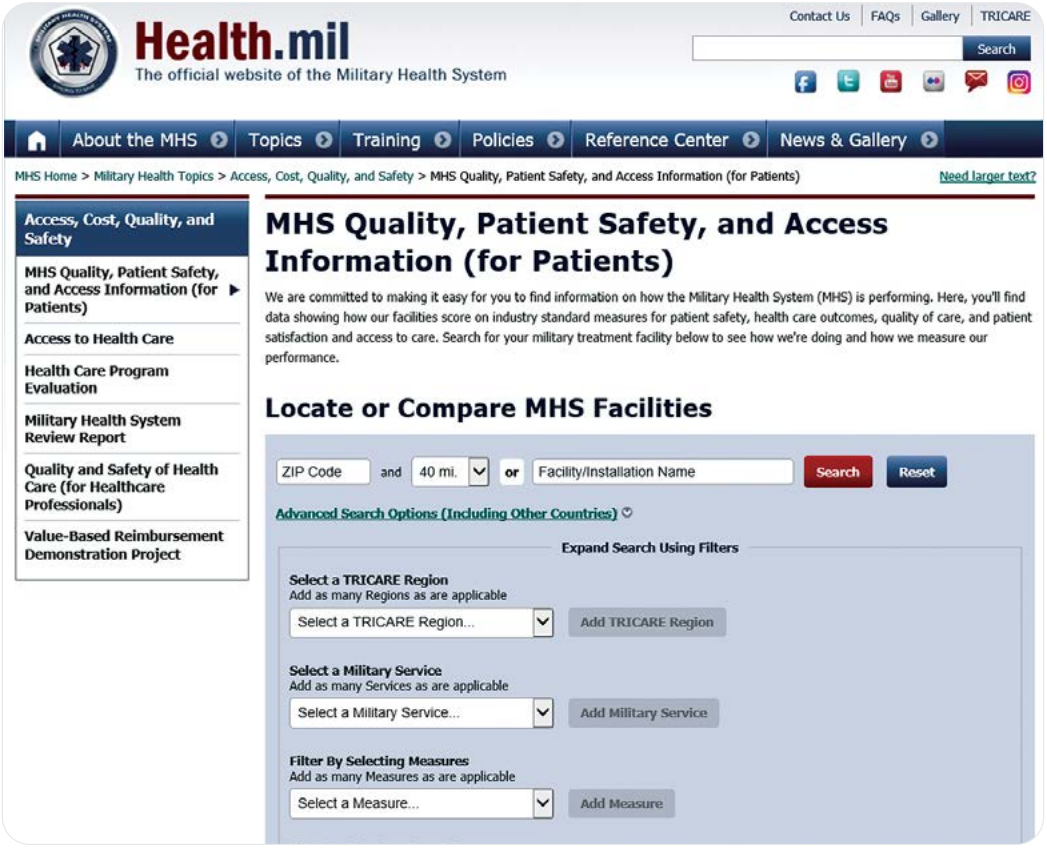
Since the 2014 MHS review, NDAA FY 2016 requirement to report MTF-level clinical quality data, and NDAA FY 2017, section 728 requirement to use Core Quality Measures Collaborative (CQMC) common measure sets, MHS transparency efforts have continued to evolve.

Leapfrog: The MHS continues to focus on clinical quality, safety, and transparency, putting the power of knowledge into the hands of the patient through participation in the Leapfrog Group's Hospital Survey. This past year, the DHA announced its new partnership with the Leapfrog Group, a national not-for-profit organization with the mission to trigger giant leaps forward in the safety, quality, and affordability of U.S. health care by using transparency to support informed health care decisions and promote high-value care. The DHA became the first federal agency to participate in the Leapfrog Group's Hospital Survey when five pilot inpatient MTFs submitted survey data in November of 2019. These facilities are now publicly reported on the Leapfrog website (www.leapfroggroup.org), allowing comparison of standard clinical quality and patient safety measures across both direct and purchased care. This new partnership will provide visibility for Service members on the patient care level and safety that is provided at each MTF, empowering our Service members and their families to make the best decisions for their health care.

Health.mil: The health.mil website is designed for patients to assess how the facilities at which they receive care are performing in terms of quality, safety, and access. Patient safety reports two types of data to the website: DoD REs and infection metrics (CLABSI and CAUTI). The website follows 10 U.S.C. §1102 data rules, and as such, many data at the MTF level on this website are redacted. In 2019, DoD PSP and the Transparency Initiative Group (TIG) focused on a group display refresh across CLABSI/CAUTI and JPSR.

The Tri-Service Transparency Initiative Group (TIG) and Clinical Quality Management Clinical Measurement Program maintain responsibility for public reporting efforts of MHS measures on the health.mil/transparency website. The TIG continues to review and iterate on the approach and display of publicly reported information, to include enhancements in search functionality, improved accreditation reporting, and development of plain language measure descriptions to facilitate end user value. The MHS publication of data and patient information on patient safety, quality of care, patient experience and satisfaction, and health outcomes is available on www.health.mil/transparency. Web page examples are shown below.

VISIT HEALTH.MIL/TRANSPARENCY



MHS Data Transparency *(cont.)*

Summary of Key Data Responding to NDAA FY 2017, Section 728 for incorporating CQMC core measures, MHS reporting on the Centers for Medicare & Medicaid Services (CMS) Hospital Compare website, and a framework for evolving MHS transparency:

- Public reporting of CQMC measures continues in prescribed phases as measures are developed and complete the approval process.
  - Phase 1 is complete with 13 measures relating to accountable care organizations (ACOs), patient-centered medical homes (PCMHs), primary care, obstetrics and gynecology, and pediatrics.
  - Phase 2 measures for cardiovascular and HIV/hepatitis C have completed Clinical Quality Management Clinical Measurement Work Group (CMWG) and subject matter expert (SME) review. Phase 2 measures are in data query and abstraction phases of development.
  - Phase 3 measures for gastroenterology, oncology, and orthopedics are being readied through CMWG, SME, and initial technical development review.

In response to section 713 of NDAA 2016:

1. Reporting to the National Practitioner Data Bank (NPDB). This is reported in the Health Care Risk Management section under Clinical Quality Management of this report (ref. page 105).

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

- **The current accreditation status, including recommendations for corrective action.** Accredited organizations, including Department of Defense (DoD) inpatient and freestanding ambulatory clinic MTFs, can be found on The Joint Commission (TJC) website at www.qualitycheck.org. Other associated clinics subordinate to one of these MTFs are included in the respective facility TJC accreditation. Additionally, MTF-specific hospital and clinic accreditation status, accreditation organization, completed survey dates, and requirements for improvement to meet full accreditation are found in the downloadable report at www.health.mil/AccreditationStatus (ref. pages 106–108).
- **Policies or procedures concerned with or designed to improve patient safety, quality of care, and access to care that were implemented during the year by the SECDEF include:** A consolidated summary of relevant Health Affairs and Service policies is provided at www.health.mil/AccreditationStatus. The DHA is currently in the process of developing and publishing publications to supersede both DoD and Service level policies (where appropriate) in support of management and administration of MTFs in accordance with NDAA FY 2017, section 702. Relevant Health Affairs, DHA, and Service policies can be found in their associated subject areas related to access, patient safety, and quality of care at www.health.mil (ref. pages 77, 95).
- **Data on surgical and maternity care outcomes during the year.** MHS-level data are presented in this report (ref. pages 119–121 and 127–130). MTF-level data over time are publicly presented at www.health.mil/transparency.
- **Data on access and appointment wait times at the MTF level.** MHS-level data are presented in this report (ref. pages 63–67), including MHS-wide and MTF-specific analysis of variability. MTF-level data over time are reported on www.health.mil/transparency.
- **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, the individual MTF-level data are presented in the www.health.mil/transparency public-facing website.
- **Data on patient experience and satisfaction.** MTF-level data are presented in the www.health.mil public-facing website and on the CMS Hospital Compare website.

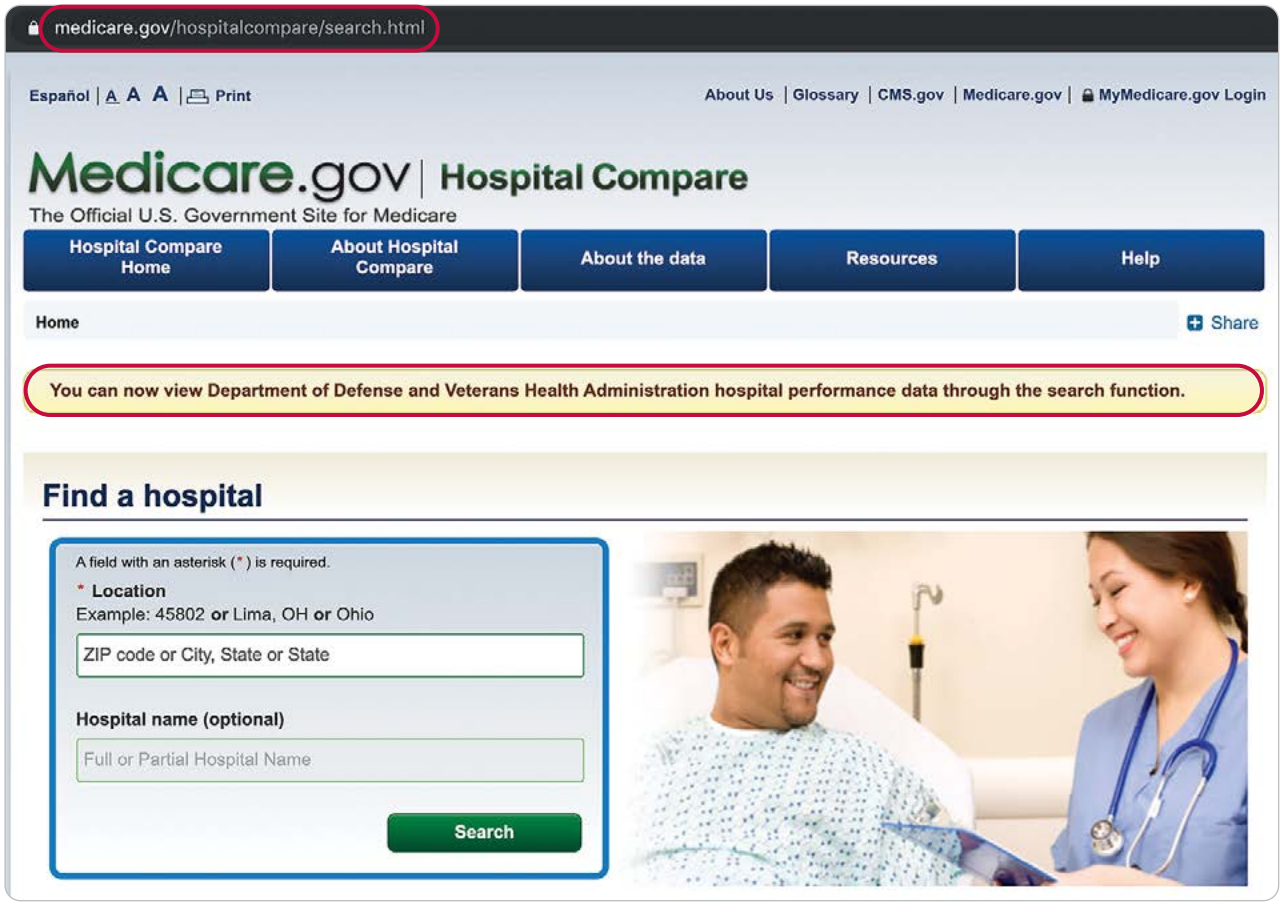
To the extent that information in this report contains medical quality assurance data or other information, it has been reported in the aggregate to comply with the requirements of 10 U.S.C. §1102 and the DHA Procedures Manual (DHA-PM) 6025.13.

MHS Data Transparency *(cont.)*

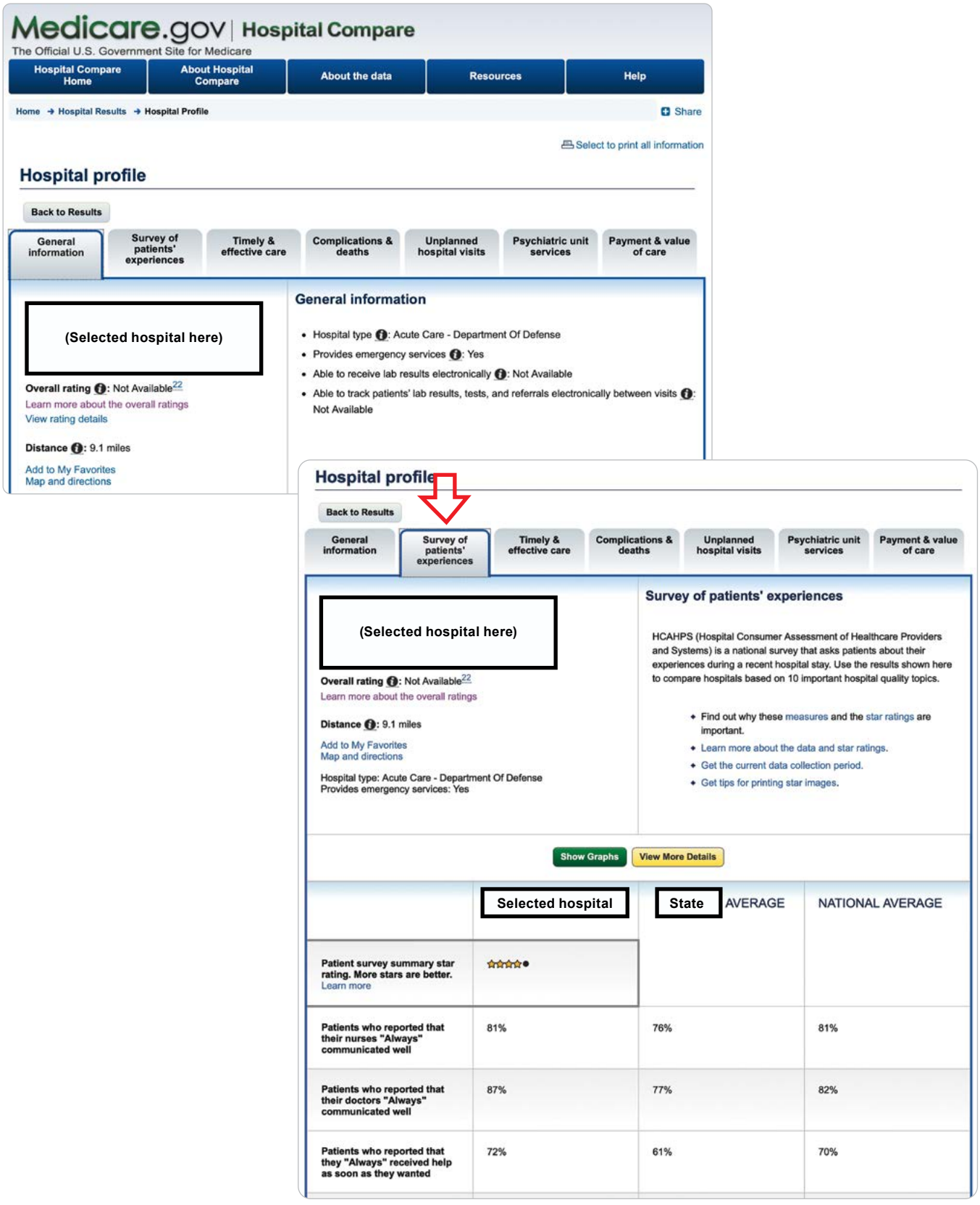
MHS Transparency on Hospital Compare

The MHS provides patient experience and timely and effective care measurement data to CMS for public reporting on Hospital Compare. Hospital Compare is a consumer-oriented website providing information on how well hospitals perform on quality measures, with more than 4,000 U.S. hospitals participating. The information on Hospital Compare helps patients make decisions about where to get health care and encourages hospitals to improve the quality of care they provide. The TRICARE Inpatient Satisfaction Survey (TRISS) and Timely and Effective Care results are now publicly posted on Hospital Compare for all military hospitals in the United States. TRISS is based on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and is administered following inpatient discharge to assess the patient's perceptions of staff communication/responsiveness, facility cleanliness/quietness, provision of discharge information, and whether they would recommend the hospital. Timely and Effective Care measures are process of care measures that show the percentage of hospitals that gave treatments for certain conditions/procedures, how quickly hospitals treat patients with certain emergencies, and how well hospitals perform in offering and providing preventive services. An example of these measures would include average time for an EKG in the emergency department and patient experience with staff responsiveness. MHS is developing a plan to expand reporting of measures on Hospital Compare. MTFs can be searched by ZIP code or hospital name and compared to civilian facilities in the same location.

THE MHS COLLABORATES WITH CMS TO POST MTF HOSPITAL RESULTS ON THE HOSPITAL COMPARE WEBSITE



MHS Data Transparency *(cont.)*

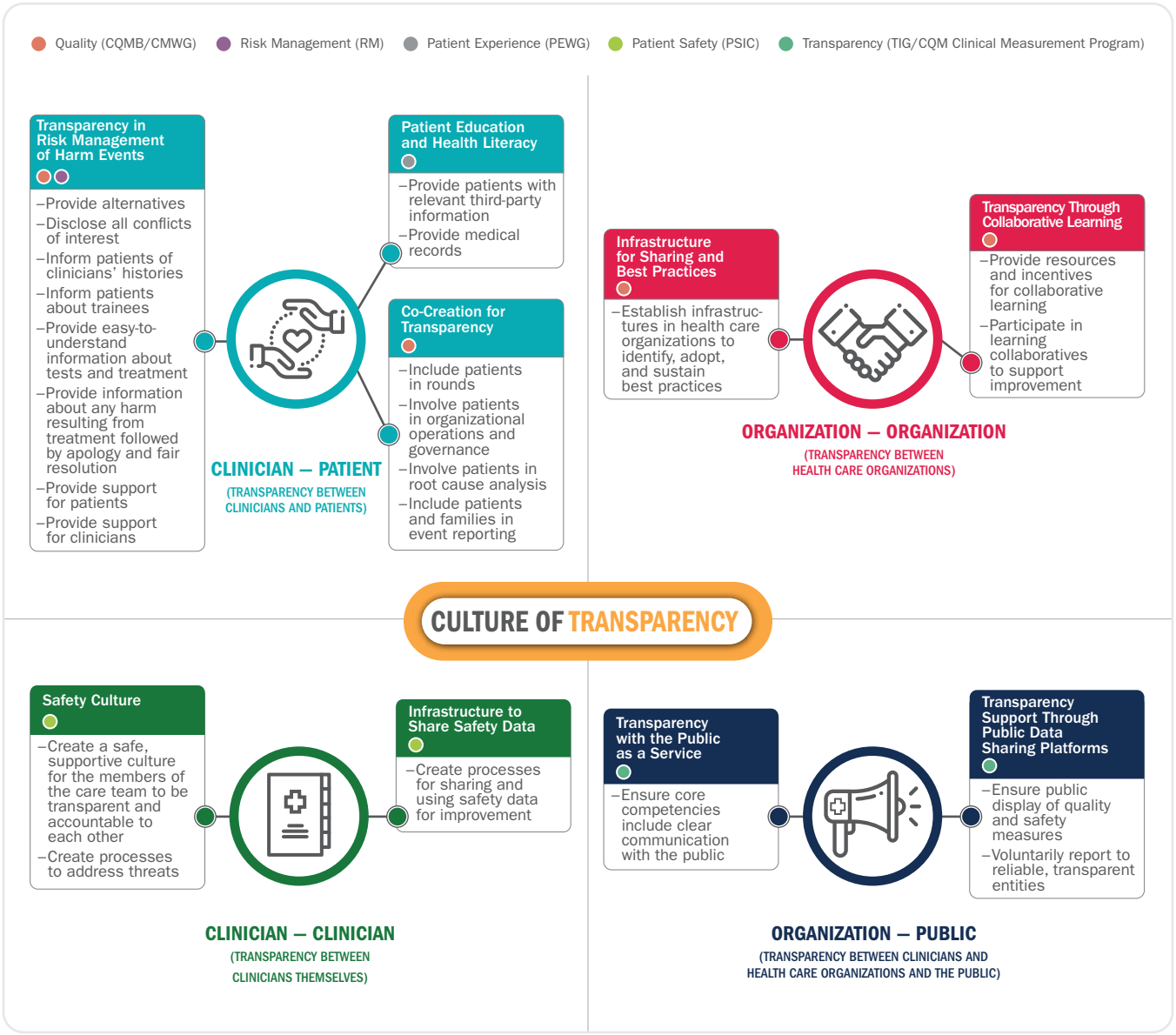


ACCESS, QUALITY, SAFETY, AND PATIENT ENGAGEMENT *(CONT.)*

MHS Transparency Framework

The MHS has established a framework to foster the culture of transparency throughout the organization. The framework addresses the four domains of transparency as identified by the National Patient Safety Foundation (transparency between clinician and patient; transparency between health care organizations; transparency between clinicians themselves; and transparency between clinicians and health care organizations and the public) and integrates the domains in work groups, programs, and activities across the organization.

MHS TRANSPARENCY FRAMEWORK



ACCESS TO MHS CARE

Access to Outpatient Care in the MHS

Access to the direct care component of MHS care is measured in multiple ways: by examining centralized, institutionally recorded data indicating whether appointments were offered within certain access standards; by administrative data recording the number of successful visits to providers over time; and by survey, asking beneficiaries about their experiences in obtaining needed care or an appointment. In addition to face-to-face visits, provider access is enhanced for both provider and patient through clinically appropriate and sometimes more convenient means, including telephone or secure e-mail. Access to civilian providers is monitored through surveys based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), allowing the DHA to compare access across MTFs, across purchased and direct care, and for comparison to national CAHPS-based benchmarks.

In the last year, the direct care system has continued improving access to care performance and reducing variance among MTFs. Direct care system access to care efforts gained momentum after the SECDEF-directed 2014 MHS review of quality, safety, and access through robust Tri-Service collaboration, development of standard processes, and implementation of an MHS performance management system.

In FY 2020, the direct care system continued optimization efforts to enhance patient experience and eliminate unwarranted variance among MTFs. The direct care system improved access, particularly in primary care, by implementing standard appointing and capacity processes codified in DHA policy to meet requirements in the NDAA for FY 2017. The NDAA FY 2017, section 704 directed MTFs to improve access to urgent care (UC) by expanding operating hours in MTF PCMHs, implementing additional MTF UC clinics at locations where sufficient patient demand existed to justify operating costs, and integrating the nurse advice line (NAL) UC and appointing processes. The NDAA FY 2017, 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 in both primary and specialty care. The direct care system is currently implementing standard appointing and procedures to improve access, increase direct care system capacity, enhance patient experience, and eliminate variance among MTFs. Standard processes and procedures include: (1) optimization of the PCMH model of primary care; (2) simplified appointing to reduce template complexity and improve access; (3) use of standard screening tools and clinical practice guidelines (CPGs) in the Tri-Service Workflow templates in the MHS EHR; (4) implementation of enhanced access initiatives, including team-based care, integrated specialists, and nurse-run walk-in clinics for common acute conditions; (5) 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; and (6) use of DHA-developed centralized data and standard tools to better match appointment supply to patient demand by day of week and hour of day. The MHS also established productivity standards on the expected number of encounters per provider to meet the congressional intent of the NDAA FY 2017, section 709. Finally, the MHS has established standard primary care empanelment goals per provider and MTF to optimize direct care system capacity and provide a basis for primary care staff resource allocation across the direct care system based on patient demand.

Although most progress to date has been in primary care, in FY 2018, the direct care system began specialty care access and capacity optimization efforts, based on leading practices from industry and high-performing MTFs. Continued efforts are also underway in specialty care to centralize and streamline specialty appointing and referral review processes, with a goal of patients receiving a specialty appointment before they leave the MTF or within two business days following the decision to accept the referral in the MTF or defer to the TRICARE network.

The Patient Centered Care Operations Board (PCCOB), which is organized under the flag-level Enterprise Solutions Board (ESB), evaluates changes in access and other performance across the MHS and identifies MTFs not meeting standards or goals, which would then be addressed by the Services or DHA. On a quarterly basis, the PCCOB reports measures of compliance to the ESB on MHS primary and specialty care core performance as well as measures of compliance with DHA policies on appointing, access, patient experience, and expanded hours. MHS core measures are monitored and presented through MHS governance to the Surgeons General and Assistant Secretary of Defense for Health Affairs in the quarterly review and analysis (R&A) in the Senior Military Medical Advisory Council. SMEs evaluate performance and variance among MTFs on every measure, relative to past performance and compared to MHS goals. Performance is reported on the MHS Dashboard, with quarterly reporting to the Surgeons General in the R&As.

ACCESS TO MHS CARE *(CONT.)*

Patient-Centered Medical Home Primary Care

The direct care system has implemented the Patient-Centered Medical Home (PCMH) model of value-based primary care at all MTFs. The direct care system's long-standing PCMH strategies remain: (1) optimizing processes to support primary care manager (PCM) continuity; (2) proactively addressing current and future health care needs and focusing on prevention; (3) use of evidence-based medicine to increase the value of health care by improving outcomes cost-effectively; (4) engaging with beneficiaries to identify and achieve their health care goals; (5) ensuring a medically ready force; (6) optimizing access to care by offering face-to-face and virtual appointments; (7) use of team-based and integrated care to meet patient demand; (8) enhancing access and experience by offering secure messaging, the NAL, and the TRICARE Online (TOL) and MHS GENESIS Patient Portals; and (9) partnering with other clinicians and health care settings to better coordinate and integrate comprehensive care.

MTF PCMHs 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.

ACCESS TO MHS CARE *(CONT.)*

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

PCM and PCMH Team Continuity

The PCM-patient relationship remains the driving force to improve access and quality, and deliver better health outcomes for MTF-enrolled beneficiaries. This leads to more integrated/coordinated care, a more proactive, preventive focus on health, lower unnecessary health care utilization, higher satisfaction, and reduced health care costs. In the direct care system, data demonstrate that 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 centralized appointing. Despite the value of PCM continuity, the direct care system must balance PCM continuity with access to care requirements, especially for acute medical needs; however, the MHS views even acute care appointments as an opportunity to address wellness by considering a holistic view of the patient's current and future medical needs.

Description of Box and Whisker Plots

Box and whisker plots are used in this report to illustrate the distribution of scores over time. Results represent the composition of the MHS population using care. These 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 interquartile range (IQR) is a measure of variation and represents the middle 50 percent of scores. The upper whisker extends to the maximum value; the lower whisker extends to the minimum value.

- As shown in the tables, in FY 2019, enrollees saw their own PCM during primary care visits approximately as frequently as prior years. PCMH team continuity, however, had a reduction in FY 2019 to 83 percent. FY 2019 variability for PCM and PCMH team continuity, measured by the IQR, increased by 2 percentage points compared to the year prior. MTFs are to maximize continuity of care by optimizing provider availability, templating appointments 180 days in advance, expanding clinic hours, and maintaining adequate team size (DHA-Interim Procedures Memorandum [DHA-IPM] 18-001).

PCM AND PCMH TEAM CONTINUITY, FYs 2012–2019

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
PCM Continuity	55%	58%	60%	60%	60%	59%	57%	57%
PCMH Team Continuity	86%	90%	91%	91%	92%	92%	92%	83%

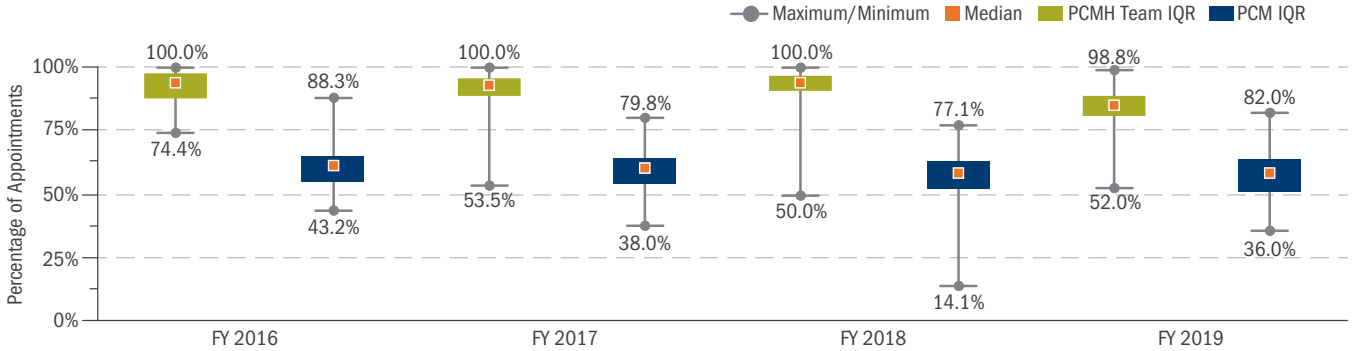
PCM CONTINUITY, FYs 2016–2019

	FY 2016	FY 2017	FY 2018	FY 2019
Median	61.3%	60.0%	58.4%	58.4%
75th Percentile (Q3)	66.0%	64.7%	64.2%	65.3%
25th Percentile (Q1)	56.0%	54.7%	52.7%	52.0%
IQR	10.0%	10.0%	11.5%	13.3%
Maximum	88.3%	79.8%	77.1%	82.0%
Minimum	43.2%	38.0%	14.1%	36.0%

PCMH TEAM CONTINUITY, FYs 2016–2019

	FY 2016	FY 2017	FY 2018	FY 2019
Median	93.6%	93.2%	94.2%	84.8%
75th Percentile (Q3)	98.7%	96.3%	97.5%	89.6%
25th Percentile (Q1)	89.0%	89.7%	91.2%	81.3%
IQR	9.6%	6.6%	6.3%	8.3%
Maximum	100.0%	100.0%	100.0%	98.8%
Minimum	74.4%	53.5%	50.0%	52.0%

PCM AND PCMH TEAM CONTINUITY, FYs 2016–2019



Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 11/5/2019

Notes:

– Parent facility scores were used to describe variability in the results above.

– Data includes MHS GENESIS sites beginning August 2019.

ACCESS TO MHS CARE *(CONT.)*

Patient-Centered Medical Home 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. Measuring third next for a prospective measurement of access to care is considered a more sensitive and accurate measure of access than retrospective analysis of when the appointment was booked. In FY 2017, the direct care system 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 data from FY 2016 and later are provided below, with revised data applied to FY 2016.

In FY 2019, there was an increase in the average number of days to third next available 24-hour (1.21 days) and future (6.45 days) appointments, with much of the increase beginning in May 2019 (not displayed). This has resulted in performance above the one-day standard for third next available 24-hour appointments, and increased variability (IQR) of performance among parent facilities in FY 2019. Performance for future appointments increased to 6.45 days, but remained below the seven-day standard in FY 2019.

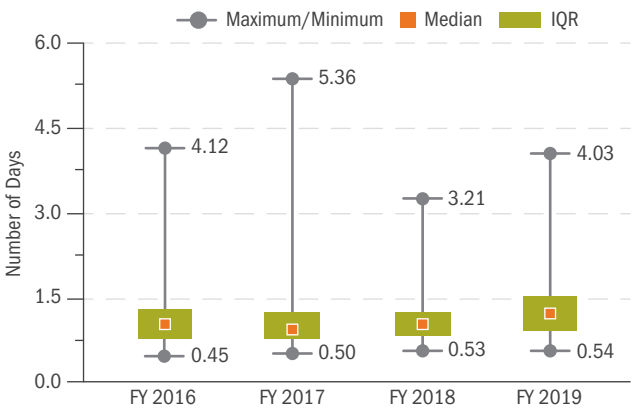
AVERAGE NUMBER OF DAYS TO 24-HOUR AND FUTURE APPOINTMENTS IN PRIMARY CARE, FYs 2016–2019

	FY 2016	FY 2017	FY 2018	FY 2019
Avg # of Days to Third Next 24-Hour Appointment	1.01	0.93	1.00	1.21
Avg # of Days to Third Next Future Appointment	5.82	5.49	5.90	6.45

DAYS TO THIRD NEXT AVAILABLE 24-HOUR APPOINTMENT, FYs 2016–2019

	FY 2016	FY 2017	FY 2018	FY 2019
Median	1.02	0.92	1.01	1.21
75th Percentile (Q3)	1.28	1.25	1.25	1.55
25th Percentile (Q1)	0.79	0.75	0.83	0.90
IQR	0.50	0.50	0.42	0.65
Maximum	4.12	5.36	3.21	4.03
Minimum	0.45	0.50	0.53	0.54

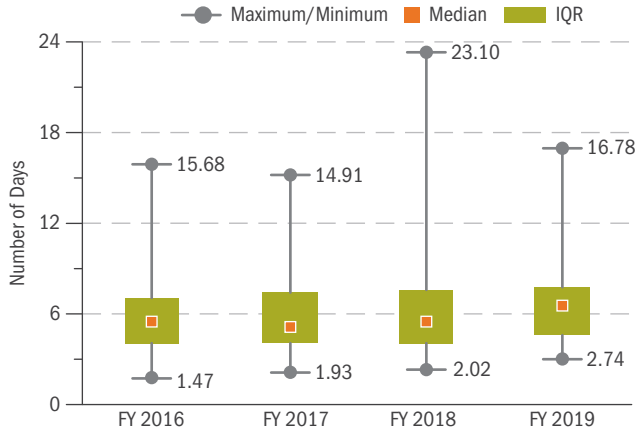
DAYS TO THIRD NEXT AVAILABLE 24-HOUR APPOINTMENT, FYs 2016–2019



DAYS TO THIRD NEXT AVAILABLE FUTURE APPOINTMENT, FYs 2016–2019

	FY 2016	FY 2017	FY 2018	FY 2019
Median	5.32	4.82	5.25	6.23
75th Percentile (Q3)	7.09	7.34	7.56	7.67
25th Percentile (Q1)	3.97	4.05	4.07	4.51
IQR	3.12	3.29	3.48	3.16
Maximum	15.68	14.91	23.10	16.78
Minimum	1.47	1.93	2.02	2.74

DAYS TO THIRD NEXT AVAILABLE FUTURE APPOINTMENT, FYs 2016–2019



Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 10/15/2019

Notes:

– Parent facility scores were used to describe variability in the results above.

– Data excludes MHS GENESIS results.

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

TOL Patient Portal Automatic Appointment Reminders

The TOL Patient Portal added the capability to allow beneficiaries to select the option of receiving reminders of upcoming MTF primary or specialty appointments by text message and/or e-mail. Once the beneficiary provides a preferred telephone number and/or e-mail address, the beneficiary receives several reminders of each upcoming appointment, regardless of whether the appointment was scheduled on TOL, by calling an appointment center, or in person. The appointment reminders are sent at least one week in advance, three days in advance, one day in advance, and then several hours in advance, depending how far in advance the appointment was scheduled. Each reminder notifies the beneficiary of the appointment date, time, provider, clinic, and MTF; the reminders also provide information on how to cancel the appointment, if necessary. In FY 2019, the MHS continued educating beneficiaries about the capability to set text and e-mail reminders in the TOL Patient Portal. During the fourth quarter of FY 2019, TOL sent an average of 315,452 e-mail and 198,628 text appointment reminders per week.

Access to Integrated Specialists in the PCMH

The most common conditions in the direct care enrollee population, excluding pregnancy, are behavioral health–related, musculoskeletal issues, and miscellaneous conditions such as hypertension, hyperlipidemia, obesity, and diabetes. To improve access and outcomes for the beneficiaries affected by these conditions, the direct care system continues optimizing the use and integration of specialists in PCMHs to provide more continuous, comprehensive care in the primary care setting and to facilitate coordinated care. Currently, the majority of PCMHs serving adult enrollees have integrated behavioral health specialists who provide treatment for mental health and behavioral health issues. Directly integrating behavioral health providers ensures that the integrated specialists are able to work closely in partnership with the patient, PCM, and PCMH team; moreover, because the specialties share a location, it helps to destigmatize the care received. The Uniformed Services University for the Health Sciences determined that being seen by a behavioral health specialist integrated 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 integrated clinical pharmacists in PCMHs. A FY 2016 independent analysis demonstrated that the use of integrated clinical pharmacists resulted in a statistically significant improvement in diabetes, hypertension, and hyperlipidemia outcomes. Finally, the MHS is implementing integrated physical therapists in PCMHs to address highly prevalent musculoskeletal issues, such as low back pain. Where implemented, integrated physical therapists continue to achieve improved outcomes and reduced MTF enrollee purchased care costs.

ACCESS TO MHS CARE *(CONT.)*

Patient-Centered Medical Home 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, MTF 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 [LOS]. The average monthly disposition count per 1,000 MTF enrollees was 5.18 in FY 2019 (based on Q1–Q3 data), an undesired increase above the elevated rate in FY 2018. The increase in inpatient dispositions in FY 2019 appears to be associated with increased network emergency department (ED) utilization by MTF enrollees. The IQR or variance among MTFs in both dispositions and average monthly bed-days per 1,000 MTF enrollees increased in FY 2019. The top five reasons for admissions remain: childbirth, musculoskeletal, circulatory, digestive, and respiratory conditions.

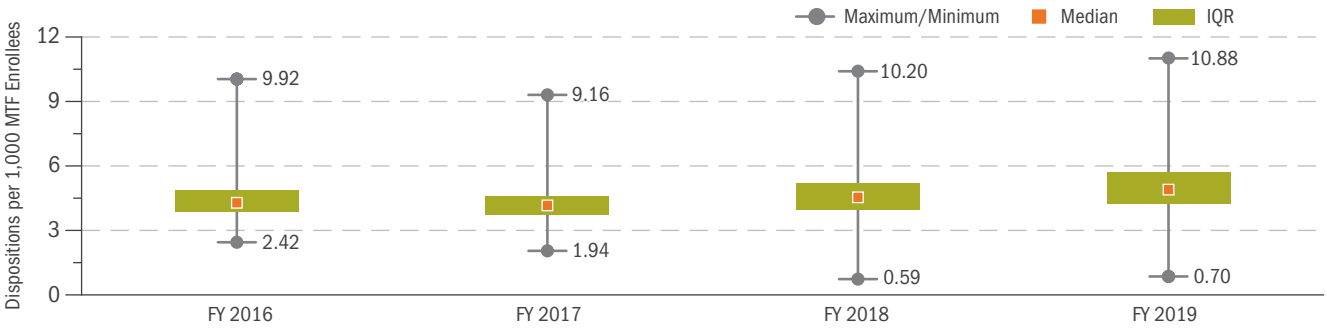
AVERAGE MONTHLY DISPOSITIONS AND BED-DAYS PER 1,000 MTF ENROLLEES, FYs 2016–2019

	FY 2016	FY 2017	FY 2018	FY 2019
Average Monthly Dispositions per 1,000 MTF Enrollees	4.83	4.67	4.92	5.18
Average Monthly Bed-Days per 1,000 MTF Enrollees	15.19	14.63	15.62	16.73

AVERAGE MONTHLY DISPOSITIONS PER 1,000 MTF ENROLLEES, FYs 2016–2019

	FY 2016	FY 2017	FY 2018	FY 2019
Median	4.21	4.10	4.53	4.89
75th Percentile (Q3)	4.84	4.61	5.17	5.63
25th Percentile (Q1)	3.79	3.65	4.00	4.18
IQR	1.05	0.96	1.16	1.44
Maximum	9.92	9.16	10.20	10.88
Minimum	2.42	1.94	0.59	0.70

AVERAGE MONTHLY DISPOSITIONS PER 1,000 MTF ENROLLEES, FYs 2016–2019



Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 11/5/2019
Notes:
– Parent facility scores were used to describe variability in the results above.
– Months with fewer than 50 enrollees for a given parent facility were removed from the analysis.
– FY 2019 average monthly dispositions were based on FY 2019 Q1–Q3 data.
– Data exclude MHS GENESIS sites.

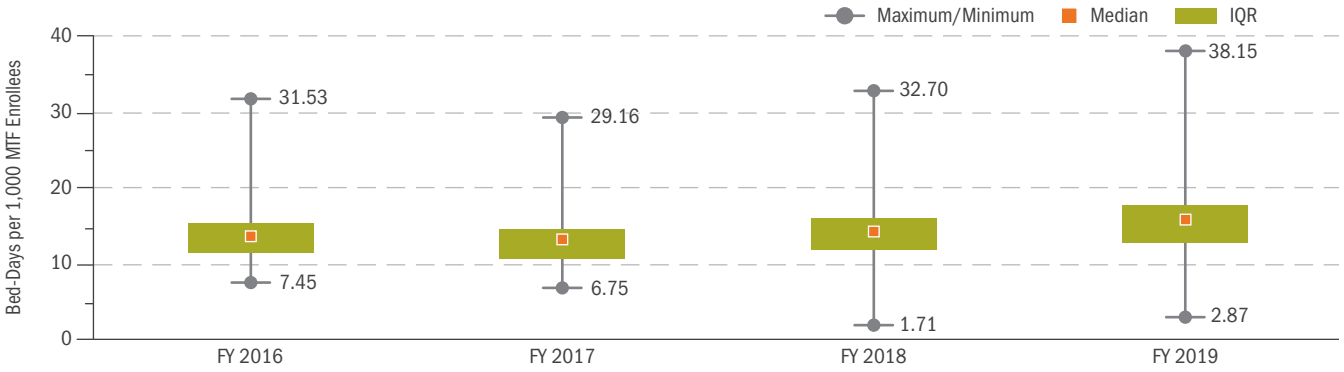
ACCESS TO MHS CARE *(CONT.)*

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

AVERAGE MONTHLY BED-DAYS PER 1,000 MTF ENROLLEES, FYs 2016–2019

	FY 2016	FY 2017	FY 2018	FY 2019
Median	13.56	13.18	14.32	16.10
75th Percentile (Q3)	15.79	14.89	16.54	17.98
25th Percentile (Q1)	11.75	11.11	12.18	13.12
IQR	4.04	3.77	4.37	4.86
Maximum	31.53	29.16	32.70	38.15
Minimum	7.45	6.75	1.71	2.87

AVERAGE MONTHLY BED-DAYS PER 1,000 MTF ENROLLEES, FYs 2016–2019



Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 11/5/2019

Notes:

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– Months with fewer than 50 enrollees for a given parent facility were removed from the analysis.
– FY 2019 average monthly dispositions were based on FY 2019 Q1-Q3 data.
– Data excludes MHS GENESIS sites.

ACCESS TO MHS CARE *(CONT.)*

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

Recapturable ED Visits in the Private Sector per 100 MTF Enrollees

The rate of network ED visits was consistent in FY 2019 compared to previous fiscal years, with approximately 18 visits per 100 MTF enrollees per year. ED visits for primary care reasons are a small percentage of all ED visits and are defined by the Tri-Service Emergency Medicine consultants and industry as evaluation and management codes 99281 and 99282. The rate of network ED visits for primary care reasons decreased in FY 2019 to 0.61 visits per 100 MTF enrollees, slightly lower than the FY 2018 value of 0.64. MTF efforts to reduce ED visits include better access to 24-hour care in PCMH, walk-in clinics for common acute conditions, PCMH team-based care to meet patients' needs, and the use of the NAL and secure messaging.

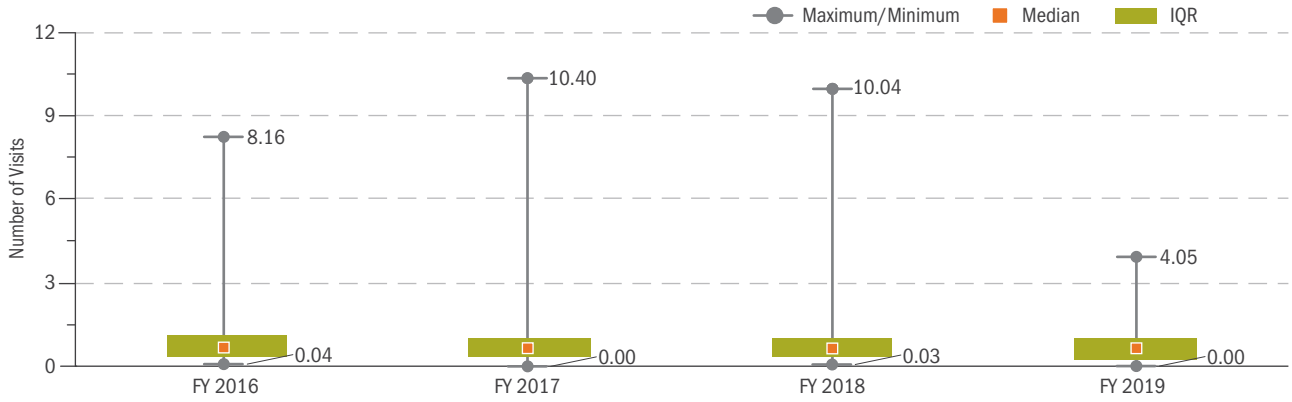
AVERAGE NETWORK ED VISITS PER 100 MTF ENROLLEES, FYs 2016–2019

	AVERAGE NETWORK ED VISITS PER 100 MTF ENROLLEES (INCLUDING TRUE EMERGENCIES)	AVERAGE NETWORK ED VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS
FY 2016	18.14	0.65
FY 2017	17.66	0.62
FY 2018	18.11	0.64
FY 2019	18.10	0.61

NETWORK ED VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS, FYs 2016–2019

	FY 2016	FY 2017	FY 2018	FY 2019
Median	0.59	0.54	0.54	0.56
75th Percentile (Q3)	1.08	1.02	1.00	0.99
25th Percentile (Q1)	0.32	0.30	0.31	0.27
IQR	0.76	0.72	0.69	0.72
Maximum	8.16	10.40	10.04	4.05
Minimum	0.04	0.00	0.03	0.00

NETWORK ED VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS, FYs 2016–2019



Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 11/5/2019

Notes:

– Parent facility scores were used to describe variability in the results above.
– Months with fewer than 50 enrollees for a given parent facility were removed from the analysis.
– ED visits were projected based on 2019 averages to account for visits during August–September 2019.
– Data exclude MHS GENESIS sites.

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

Network Urgent Care (UC) Visits per 100 Enrollees

As shown in the table below, the rate of network UC visits by MTF enrollees has continued to increase in FY 2019 compared to previous years, timed with the change to allow unlimited network UC visits. However, since the change to allow unlimited network UC visits, recapturable network ED visits have not decreased, resulting in a net cost increase to the MHS. The majority of network UC visits were for upper respiratory illness. That most network UC visits are for upper respiratory illnesses or colds is consistent with industry results that unlimited self-referred UC visits increase demand for care for self-limiting or low-acuity issues, beyond that which occurred in a given population previously. The DHA developed a UC demand dashboard on the CarePoint Information Portal that provides data by patient age, beneficiary category, ZIP code, and diagnosis reason, and recommends either MTF expanded hours or implementation of an MTF or market-based UC clinic to meet demand, if sufficient demand exists to justify the expense. In FY 2020, the MHS will continue to evaluate this data and recommend additional expanded hours or direct care UCs to increase convenience for enrolled beneficiaries and optimize direct care resources.

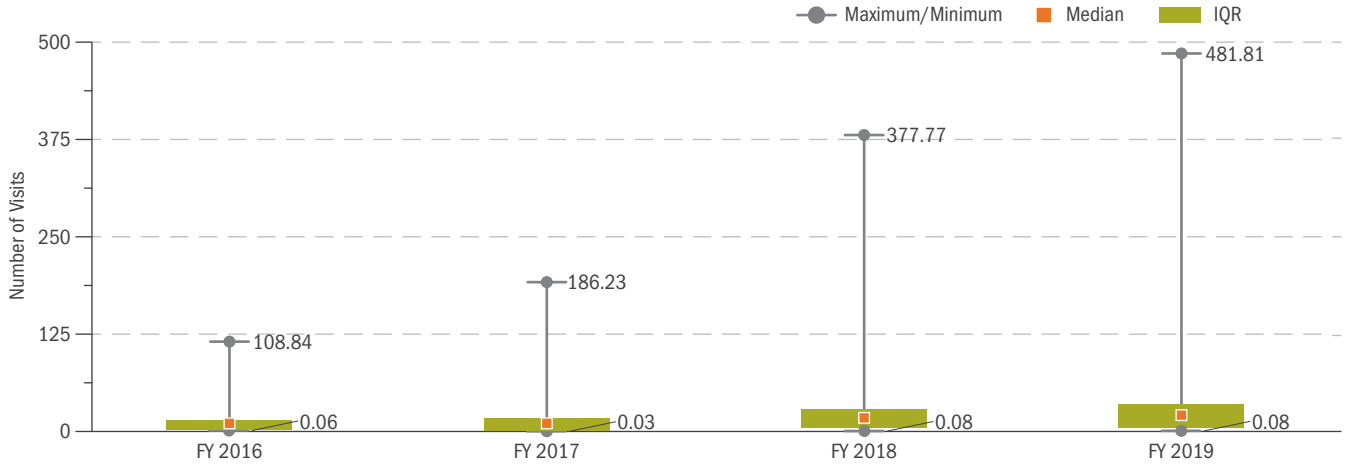
AVERAGE NETWORK UC VISITS PER 100 MTF ENROLLEES, FYs 2016–2019

	AVERAGE NETWORK UC VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS
FY 2016	7.08
FY 2017	8.07
FY 2018	13.03
FY 2019	18.17

NETWORK UC VISITS PER 100 MTF ENROLLEES, FYs 2016–2019

	FY 2016	FY 2017	FY 2018	FY 2019
Median	4.44	4.84	10.05	15.17
75th Percentile (Q3)	11.50	14.97	25.39	35.22
25th Percentile (Q1)	1.67	1.80	2.42	3.20
IQR	9.83	13.18	22.97	32.02
Maximum	108.84	186.23	377.77	481.81
Minimum	0.06	0.03	0.08	0.08

NETWORK UC VISITS PER 100 MTF ENROLLEES, FYs 2016–2019



Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 11/5/2019

Notes:

– Parent facility scores were used to describe variability in the results above.
– Months with fewer than 50 enrollees for a given parent facility were removed from the analysis.
– UC visits were projected based on 2019 averages to account for visits during August–September 2019.
– Data exclude MHS GENESIS sites.

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

Secure Messaging

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 2019, 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 care teams to ask questions about their health or medical tests and to arrange referrals or appointments. The proportion of beneficiaries registered to use secure messaging at parent facilities has increased with each fiscal year, with an average of 56 percent of beneficiaries registered to use secure messaging for FY 2019. The MHS prioritized enrollment in secure messaging starting in FY 2017. Analysis of the primary reasons that patients initiate messages include: asking a medical question (57 percent), arranging appointments/referrals (21 percent), or renewing medications (14 percent).

Percentage of Patient-Initiated Secure Messages Responded to Within One Business Day: In order to improve the patient experience, satisfaction with secure messaging, and the likelihood of patients to use secure messaging again to meet health care needs in the future, the MHS also prioritized responding to secure messages within one business day. In FY 2019, on average, over 80 percent of messages were responded to within one business day. In FY 2018, the DHA implemented a secure messaging performance dashboard tool on the CarePoint Information Portal. The dashboard provides information to MTFs on performance and response time down to the provider level. The secure messaging performance dashboard identifies to MTF leadership the providers who are not using or answering secure messages within the required time frame.

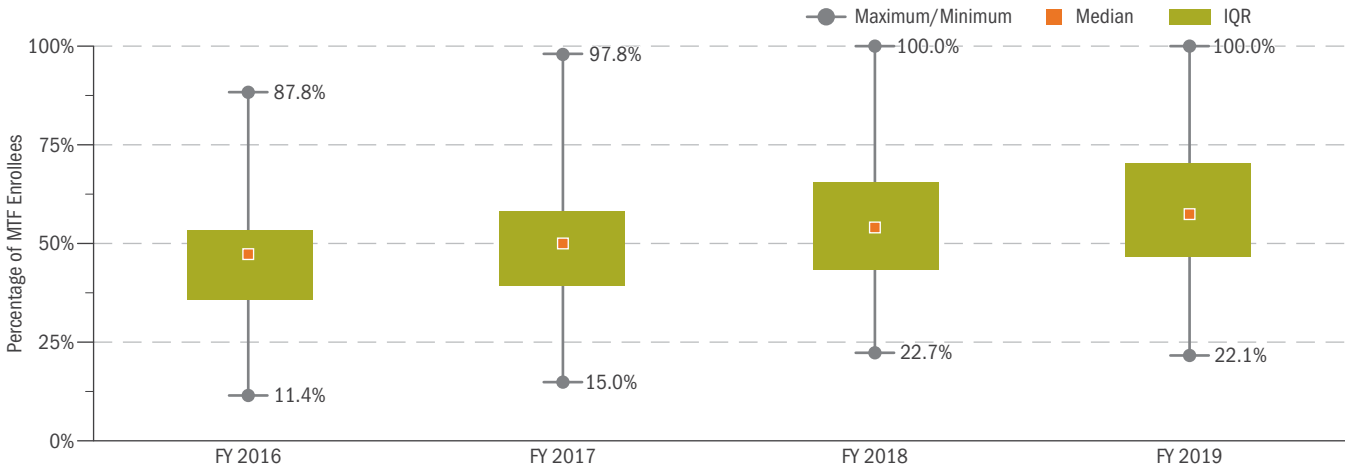
ACCESS TO MHS CARE *(CONT.)*

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

PERCENTAGE OF MTF ENROLLEES REGISTERED TO USE SECURE MESSAGING, FYs 2016–2019

	FY 2016	FY 2017	FY 2018	FY 2019
Median	46.7%	49.6%	53.6%	56.5%
75th Percentile (Q3)	53.2%	58.4%	65.6%	70.4%
25th Percentile (Q1)	36.2%	39.0%	43.4%	46.4%
IQR	17.0%	19.4%	22.2%	24.0%
Maximum	87.8%	97.8%	100.0%	100.0%
Minimum	11.4%	15.0%	22.7%	22.1%

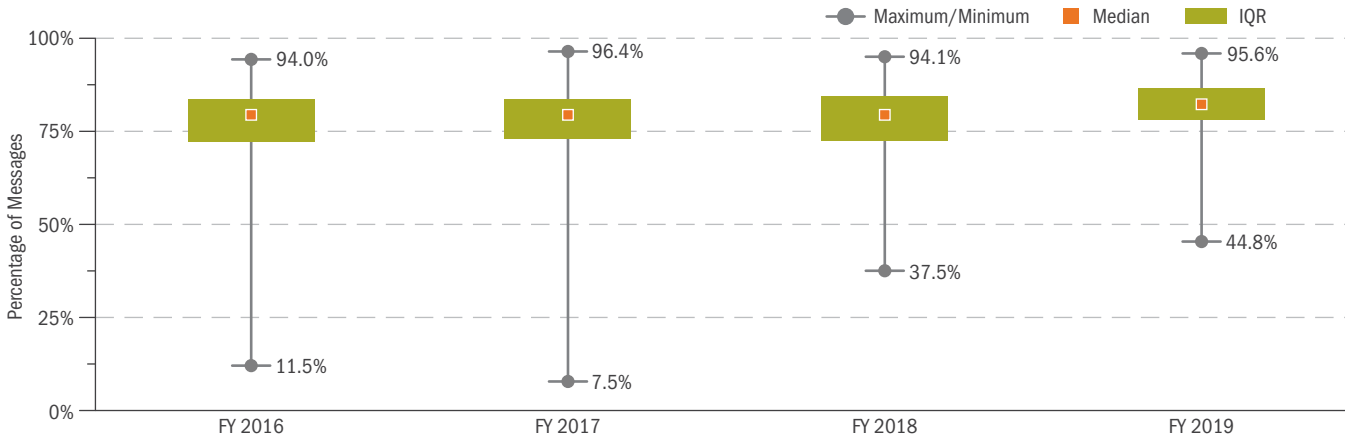
PERCENTAGE OF MTF ENROLLEES REGISTERED TO USE SECURE MESSAGING, FYs 2016–2019



PERCENTAGE OF SECURE MESSAGES RESPONDED TO WITHIN ONE BUSINESS DAY, FYs 2016–2019

	FY 2016	FY 2017	FY 2018	FY 2019
Median	78.7%	78.7%	79.1%	82.2%
75th Percentile (Q3)	83.6%	83.6%	84.1%	86.7%
25th Percentile (Q1)	72.1%	73.1%	72.6%	77.9%
IQR	11.5%	10.5%	11.5%	8.8%
Maximum	94.0%	96.4%	94.1%	95.6%
Minimum	11.5%	7.5%	37.5%	44.8%

PERCENTAGE OF SECURE MESSAGES RESPONDED TO WITHIN ONE BUSINESS DAY, FYs 2016–2019



Source: MHS administrative data; DHA/HCO/Healthcare Optimization Division, 11/12/2019
Notes:
– Parent facility scores were used to describe variability in the results above.
– Data exclude MHS GENESIS sites.

Nurse Advice Line

The MHS Nurse Advice Line (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 (RNs) who address health concerns, offer self-care advice, and answer general health questions. The NAL receives approximately 1,200 to 1,500 calls per day and potentially saves 15 lives per day by recommending or activating emergency procedures and assisting callers in crisis.

The NAL falls under the DHA PCMH program organizationally and is fully integrated with the MTF PCMH primary care clinics to support enhanced access strategies. MTF enrollees make up 85 percent of all NAL calls. If the RN determines that the beneficiary needs to be seen within 24 hours, the NAL staff can search the NAL Management System for MTF walk-in capabilities, schedule MTF PCMH appointments, warm transfer the beneficiary directly to his or her PCMH via telephone, provide information about MTF UC and ED Fast Track options, and/or generate civilian UC referrals in the EHR for Active Duty personnel. PCMH teams have access to NAL encounter information through the NAL Management System; teams use NAL data to conduct appropriate follow-up with their patients and coordinate care, if clinically indicated. The NAL Management System also includes performance data, which allow PCMH teams to monitor utilization and adjust future appointing templates to accommodate changes in demand.

In FY 2018, the NAL was expanded globally to provide a consistent source of clinical advice to all TRICARE beneficiaries residing or traveling in the United States and for patients enrolled or who receive care in MTFs located in Europe, Asia, Cuba, and in the Pacific Region. The new Global NAL includes several enhancements implemented based on beneficiary feedback: parents or caregivers may call the NAL and obtain advice without the minor child being present; RNs engage in more bidirectional discussion with the caller to assess symptoms and provide self-care advice; beneficiaries use an automatic beneficiary verification process, which allows them to connect more quickly with an RN rather than speaking to a beneficiary verification clerk first; and the Global NAL sends beneficiaries a written record of the advice given using e-mail following the call. Finally, beneficiaries are able to contact the Global NAL to obtain advice via text or video chat rather than just by telephone.

In FY 2019, the NAL piloted telemedicine visits with a contractor-provided virtual physician in place of a face-to-face visit at a network UC center. The six-month pilot included beneficiaries enrolled to an MTF in the National Capital Region (NCR) enhanced multi-Service market (eMSM). The purpose was to assess the demand for virtual visits, beneficiary and PCMH team satisfaction, and telemedicine problem resolution. Preliminary findings revealed that 67 percent of eligible beneficiaries accepted a virtual visit, and such visits resulted in high patient satisfaction: 87 percent of beneficiaries were satisfied with the virtual physician visit, would recommend the service to others, and would use it again.

The MHS analyzes NAL performance by comparing the beneficiary's pre-intent—what the caller states he/she would have done if they did not call the NAL—to the NAL RN's advice for care. The NAL provides this data to a third-party vendor, who pulls the purchased care claims and MTF encounter data from the MHS Management Analysis and Reporting Tool (MHS Mart or M2) to determine what the beneficiary actually did 24 hours after they called the NAL. This comparison demonstrates the NAL's ability to safely and cost-effectively direct patients to the most clinically appropriate level of care.

The percentage of NAL callers who intended to seek care in a network ED was nearly cut in half. The NAL recaptured nearly 30 percent of care back to the MTF, while 45 percent of callers did not seek follow-on care and instead used self-care advice provided by the RN. Patient satisfaction with the NAL remains over 92 percent, based on responses from a sample of beneficiaries who are surveyed by the DHA following the call.

NAL CALLER INFORMATION FOR MTF ENROLLEES, FYs 2014–2019 (THROUGH MARCH 2019)

NAL DISPOSITION	CALLER'S PRE-INTENT	NURSE ADVICE	CALLER'S ACTION WITHIN 24 HOURS
Network ED	26%	12%	14%
Network UC	20%	22%	15%
MTF Care	18%	23%	26%
Self-Care	6%	25%	45%
General Health and Other Miscellaneous Questions	30%	18%	0%
Total	100%	100%	100%

Source: NAL Program and administrative data (M2/MDR): DHA/HCO/Healthcare Optimization Division, 10/17/2019

Primary Care Utilization, Patient-Centered Medical Home Market Share, and Network Leakage

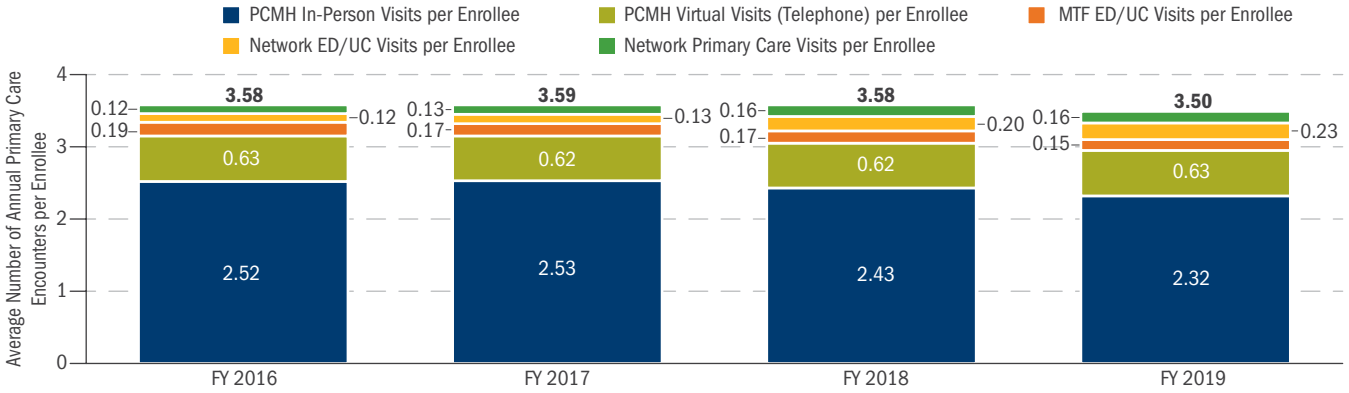
The average annual number of direct care system enrollees' primary care visits decreased slightly (2 percent) from 3.58 in FY 2018 to 3.50 in FY 2019. The MTF Patient-Centered Medical Home (PCMH) market share of empaneled beneficiaries' primary care needs decreased from 85 percent in FY 2018 to 84 percent in FY 2019. During this same period, the number of MTF enrollees' combined in-person and virtual PCMH visits decreased 3 percent, MTF ED/UC visits decreased 13 percent, and the number of network ED and UC visits increased 19 percent—a continuing increase resulting from the benefit change allowing unlimited self-referred network UC visits for non-Active Duty enrollees. As a result, overall network leakage of MTF enrollees' primary care needs increased from 9.9 percent in FY 2018 to 11.3 percent in FY 2019. Results vary by Service.

A major goal of the MHS's PCMH program is to reduce unnecessary health care utilization by maximizing PCM ability to meet beneficiary health care needs during each visit and by using team-based care to better meet beneficiary health care needs outside of in-person or telephone visits with the beneficiary's PCM. Any ED care referenced below was for low-acuity needs occurring Monday through Saturday (excluding federal holidays)—this is care that could be resolved by PCMHs. In FY 2019, the IQR or variance among MTFs increased 24 percent (similar to the IQR in FY 2017) and the median decreased 10 percent. In FY 2020, the MHS PCMHs will continue efforts to reduce unnecessary health care utilization and capture a greater proportion of MTF enrollees' primary care needs in the PCMH.

PRIMARY CARE UTILIZATION, PCMH MARKET SHARE, AND NETWORK LEAKAGE OF ENROLLEES' PRIMARY CARE NEEDS, FYs 2016–2019

	PCMH IN-PERSON VISITS PER ENROLLEE	PCMH VIRTUAL VISITS (TELEPHONE) PER ENROLLEE	MTF ED/UC VISITS PER ENROLLEE	NETWORK ED/UC VISITS PER ENROLLEE	NETWORK PRIMARY CARE VISITS PER ENROLLEE	TOTAL ANNUAL PRIMARY CARE VISITS PER ENROLLEE	PERCENT PCMH MARKET SHARE	PERCENT NETWORK PRIMARY CARE LEAKAGE
FY 2016	2.52	0.63	0.19	0.12	0.12	3.58	88.0%	6.8%
FY 2017	2.53	0.62	0.17	0.13	0.13	3.59	87.9%	7.2%
FY 2018	2.43	0.62	0.17	0.20	0.16	3.58	85.3%	9.9%
FY 2019	2.32	0.63	0.15	0.23	0.16	3.50	84.4%	11.3%

AVERAGE NUMBER OF ANNUAL PRIMARY CARE ENCOUNTERS PER ENROLLEE, FYs 2016–2019



Source: MHS administrative data; DHA/HCO/Healthcare Optimization Division, 11/20/2019

Notes:

– Data exclude MHS GENESIS sites, and only include Prime, Plus, and Reliant enrollments.

– September 2019 data was not included in FY 2019 rates.

Primary Care Utilization, Patient-Centered Medical Home Market Share, and Network Leakage *(cont.)*

AVERAGE NUMBER OF ANNUAL MTF ENROLLEE VISITS FOR PRIMARY CARE OVERALL, FYs 2016–2019

	FY 2016	FY 2017	FY 2018	FY 2019
Median	3.57	3.58	3.46	3.12
75th Percentile (Q3)	4.09	4.10	3.92	3.69
25th Percentile (Q1)	3.20	3.20	3.20	2.79
IQR	0.88	0.89	0.72	0.90
Maximum	5.94	5.62	5.49	5.43
Minimum	2.15	1.20	1.95	1.67

AVERAGE NUMBER OF ANNUAL MTF ENROLLEE VISITS FOR PRIMARY CARE OVERALL, FYs 2016–2019

Source: MHS administrative data; DHA/HCO/Healthcare Optimization Division, 11/20/2019
Notes:
– Results exclude MHS GENESIS sites, and only include Prime, Plus, and Reliant enrollments.
– September 2019 data was not included in FY 2019 results.

ACCESS TO MHS CARE *(CONT.)*

Improvement Tools

In FY 2019, the MHS continued expanding the centralized performance report capabilities in the DART on the CarePoint Information Portal to provide additional tools for MTFs to adjust supply to meet beneficiary demand. In FY 2019, the DART will also include new reports to measure MTF compliance with DHA policies on expanded hours and standardized appointing. Additional dashboards are available on the CarePoint Information Portal. In FY 2019, the tools below will be expanded to report and predict unexpected events, including missed appointments and cancellations by beneficiary age and category and by type of care. Finally, all tools will be expanded to show specialty care and inpatient data to support market optimization efforts.

Template Optimization Tool

The Template Optimization Tool provides information on scheduled appointments and appointment utilization by day of week and hour of day, compares scheduled appointments to beneficiary demand signals, and finally, recommends template changes to better meet patient demand.

Build or Buy Tool on CarePoint

MTFs expanded PCMH operating hours based on standard criteria including patient demand and readiness needs, as required by DHA policy. The MHS will continue to expand operating hours and/or implement additional market UC services where there is sufficient demand or local readiness requirements to justify expense. To support these efforts, the DHA implemented a Build or Buy dashboard on the CarePoint Information Portal to identify network ED and UC visits and costs in markets compared to MTF locations, ZIP codes in which beneficiaries reside, and estimated drive times. The Build or Buy dashboard recommends additional locations for either PCMH expanded hours or potential new MTF-owned UC clinics.

ACCESS TO MHS CARE *(CONT.)*

Specialty Care Access

In FY 2019, the MHS continued monitoring specialty care performance for several reasons: most purchased care costs for MTF enrollees are due to specialty deferrals to purchased care; patient feedback indicated dissatisfaction with the decentralized specialty care processes and variance among MTFs; and capturing specialty care workload delivered in the MTF enhances clinical currency and a ready medical force, which includes both providers and clinical support staff. In FY 2018, the MHS codified specialty care standards in the DHA-IPM 18-001 on standard appointing processes and productivity. To measure compliance with the policy, enhance patient experience, and eliminate unwarranted variance among MTFs, 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, from the patient's perspective, how long it takes to be seen for a specialty appointment. DHA-IPM 18-001 identifies standard MTF and market processes to improve both measures.

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 18-001 identified standard processes to centralize referral review and appointing at the MTF or market level compared to existing decentralized and time-consuming processes in which each specialty clinic reviewed referrals and scheduled appointments. As stated in DHA-IPM 18-001, MTFs are required to implement processes to ensure that the MTF decides to accept or defer the referral to the network within 24 hours and subsequently to schedule the beneficiary's appointment within two business days; the MHS goal is for the entire process to be accomplished in three business days or fewer. Currently, the MHS is not meeting the goal (time elapsed is still above four days on average) and not all MTFs are in compliance with DHA-IPM 18-001. In FY 2020, the MHS will emphasize implementation of centralized specialty care referral review and appointing, and further streamline the specialty referral process to eliminate unnecessary administrative burden or delays from the patient perspective.

AVERAGE NUMBER OF DAYS FROM ORDERED TO MTF BOOKED, FYs 2017–2019

	FY 2017	FY 2018	FY 2019
Days from Ordered to MTF Booked	4.15	4.15	4.10

AVERAGE NUMBER OF DAYS FROM ORDERED TO MTF BOOKED, FYs 2017–2019

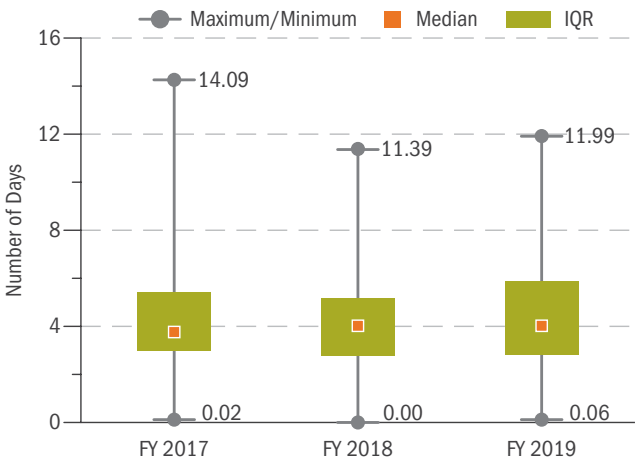
	FY 2017	FY 2018	FY 2019
Median	3.84	4.01	4.04
75th Percentile (Q3)	5.31	5.14	5.85
25th Percentile (Q1)	2.97	2.80	2.85
IQR	2.35	2.35	3.00
Maximum	14.09	11.39	11.99
Minimum	0.02	0.00	0.06

Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 11/13/2019

Notes:

– Parent facility scores were used to describe variability in the results above.
– Data exclude MHS GENESIS sites.
– FY 2019 results include fiscal quarters Q1–Q3.
– Results include referrals filled up to seven months after referral issuance.

AVERAGE NUMBER OF DAYS FROM ORDERED TO MTF BOOKED, FYs 2017–2019



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. DHA-IPM 18-001 identifies standard processes and specialty provider productivity requirements in order to increase the number of available specialty care appointments, standardize appointment templates, and optimize direct care system specialty care capacity. The goal is for beneficiaries to have a specialty care appointment within 15 days of being scheduled for the appointment. Currently, the direct care system is not meeting the goal, with more than 16 days elapsing on average before the appointment occurs. In FY 2020, the MHS will further emphasize implementation of standard processes in specialty care to enhance patient experience, eliminate unwarranted variance, and expand MTF specialty care capacity to optimize direct care system resources and support specialty providers' clinical currency needs.

AVERAGE NUMBER OF DAYS FROM MTF BOOKED TO MTF APPOINTMENT, FYs 2017–2019

	FY 2017	FY 2018	FY 2019
Days from MTF Booked to MTF Appt.	14.88	15.30	16.47

AVERAGE NUMBER OF DAYS FROM MTF BOOKED TO MTF APPOINTMENT, FYs 2017–2019

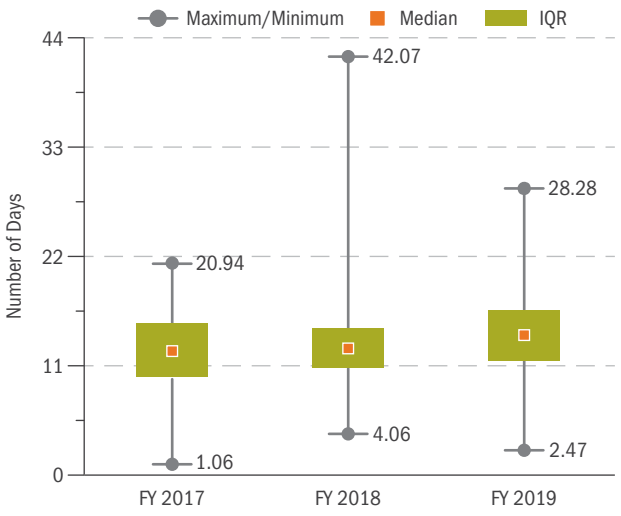
	FY 2017	FY 2018	FY 2019
Median	12.24	12.78	13.92
75th Percentile (Q3)	15.31	14.73	16.59
25th Percentile (Q1)	9.97	10.87	11.56
IQR	5.34	3.85	5.02
Maximum	20.94	42.07	28.28
Minimum	1.06	4.06	2.47

Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 11/13/2019

Notes:

– Parent facility scores were used to describe variability in the results above.
– Data exclude MHS GENESIS sites.
– FY 2019 results include fiscal quarters Q1–Q3.
– Results include referrals filled up to seven months after referral issuance.

AVERAGE NUMBER OF DAYS FROM MTF BOOKED TO MTF APPOINTMENT, FYs 2017–2019



Specialty Care Ambulatory Leakage

In FY 2019, the MHS had specialty care leakage consistent with previous years, at 13.5 percent. The MHS goal is to reduce this leakage to 10.7 percent. In FY 2020, the MHS will further analyze performance variance at each MTF and by product lines to identify reasons for and solutions to improve direct care system capacity.

AVERAGE AMBULATORY SPECIALTY CARE LEAKAGE, FYs 2014–2019

	ANNUAL AVERAGE
FY 2014	13.5%
FY 2015	13.2%
FY 2016	13.1%
FY 2017	13.5%
FY 2018	13.4%
FY 2019	13.5%

Source: MHS administrative data (M2); DHA/HCO/Healthcare Optimization Division, 1/27/2020

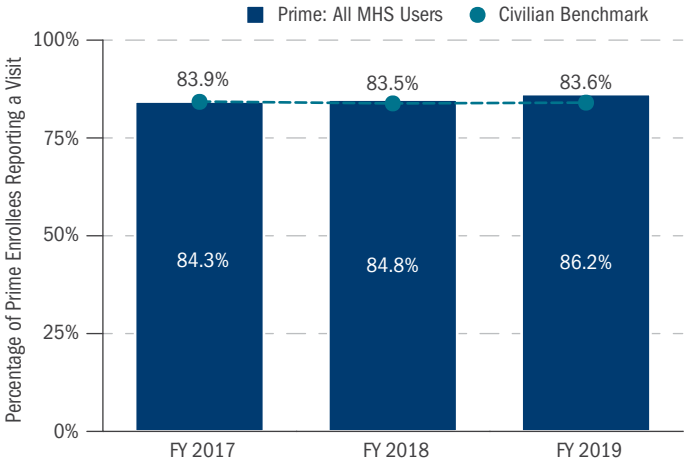
ACCESS TO MHS CARE *(CONT.)*

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, appointment reminder text messages, 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 an MTF or network PCM), with over 86 percent reporting at least one visit in FY 2019. MHS results remain statistically comparable to the civilian benchmark of almost 84 percent. Actual administrative data demonstrate 89 percent of direct care system (non-Active Duty) enrollees had at least one primary care encounter in FY 2019.

TRENDS IN PRIME ENROLLEES HAVING AT LEAST ONE OUTPATIENT VISIT DURING THE YEAR, FYs 2017–2019



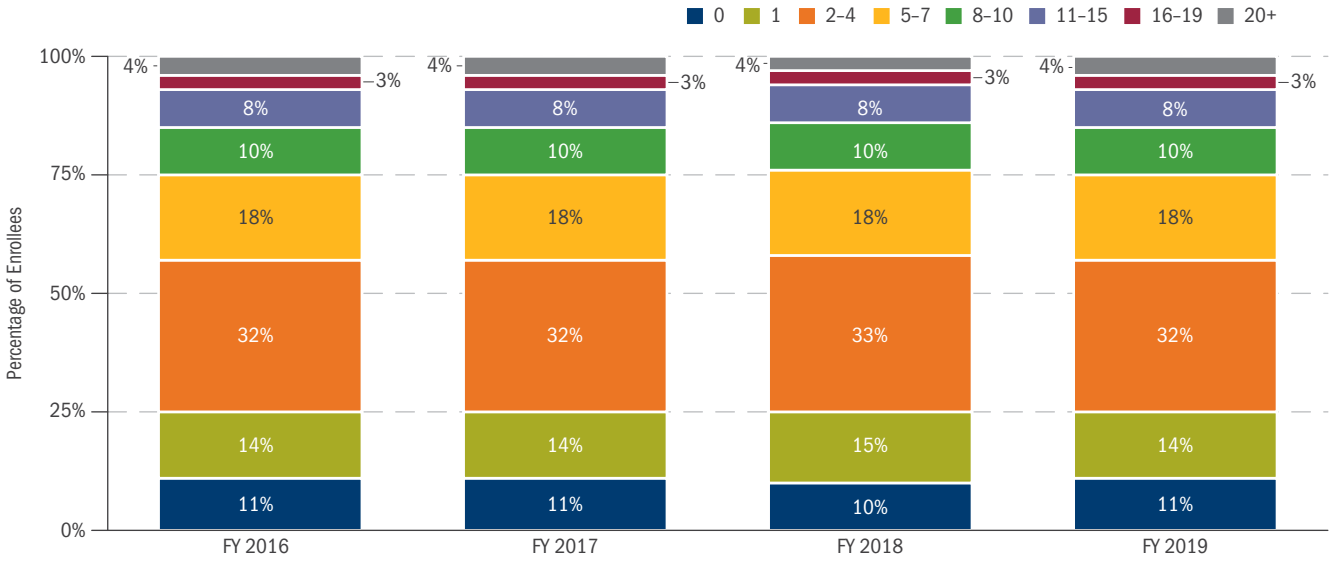
Note: Health Care Survey of DoD Beneficiaries (HCSDB) data were derived from the FYs 2017–2019 HCSDB, as of 11/15/2019, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) 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 National Committee for Quality Assurance (NCQA) by commercial plans. Benchmarks used in 2017 come from NCQA's 2015 data, while the benchmarks used in 2018 and 2019 come from NCQA's 2017 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.)*

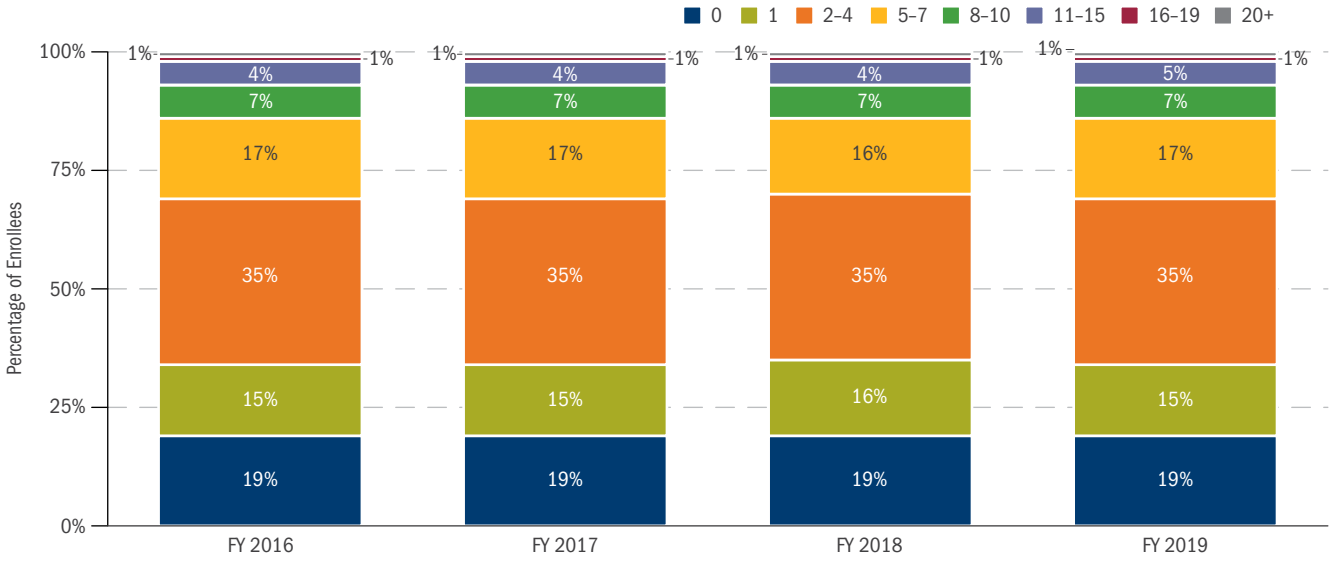
- **Direct Care Enrollee Access:** Based on administrative utilization data shown in the chart below, 89 percent of all non-Active Duty MTF enrollees under age 65 had at least one recorded outpatient visit for primary care reasons in FY 2019 (i.e., 11 percent did not have at least one visit). This access has been relatively stable since 2014. In FY 2019, 46 percent had between one and four visits, and 43 percent had five or more visits.

PERCENTAGE OF NON-ACTIVE DUTY ENROLLEES <65, BY NUMBER OF ANNUAL VISITS FOR MTF PRIMARY CARE (ANY VENUE), FYs 2016–2019



- **Purchased Care Enrollee Access:** Based on administrative claims utilization data, the chart below shows that 81 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 2019 (i.e., 19 percent had no visits). 50 percent of non-Active Duty MCSC Network Prime enrollees had between one and four visits, and 31 percent had five or more visits in FY 2019.

PERCENTAGE OF NON-ACTIVE DUTY ENROLLEES <65, BY NUMBER OF ANNUAL VISITS FOR MCSC/NETWORK PRIMARY CARE (ANY VENUE), FYs 2016–2019



Source: MHS administrative data Systems (M2), DHA/SP&FI (J-5)/Analytics and Evaluation Division, 1/30/2020

Notes:

– 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.

– Percentages may not sum to 100 percent due to rounding.

ACCESS TO MHS CARE *(CONT.)*

Changing Health Plan

Beneficiaries may change their TRICARE health plan during the TRICARE Open Season each fall. After open season closes, beneficiaries are locked into their choice of health plan until the next annual fall open season unless they have a TRICARE-recognized qualifying life event (QLE), such as marriage, the birth of a child, or a change in sponsor status. If beneficiaries want to change plans for other reasons, such as a plan's cost or the availability of doctors in the network, they must wait until the annual open season.

Changing health plans, particularly primary coverage, is an area of interest to beneficiaries, health plan managers, and policymakers for several reasons. First, beneficiaries could disrupt their continuity of care if their usual doctor does not accept the new plan. Beneficiaries who change plans need to learn the features, policies, and rules of their newly chosen plan to ensure that they make well-informed decisions about their care. Health plan managers will therefore have to provide access to easily understandable information about plans. Finally, significant volume of plan changing could indicate that current plans are not meeting beneficiaries' needs; policymakers and health plan managers might have to reassess how plans can provide the best coverage to their beneficiaries.

This study, completed in 2019 and described on the following pages, uses administrative data from the Defense Enrollment Eligibility Reporting System (DEERS) and survey data from the first and second quarters of the 2019 HCSDB to assess the prevalence of and reasons for plan changing in TRICARE. To determine whether a beneficiary changed plans, we compared each first quarter survey respondent's 2018 DEERS enrollment with his or her DEERS enrollment as of March 1, 2019. Although DEERS does not include data on enrollment in civilian health plans, it enabled us to examine the rate of plan changing within TRICARE. We used 2019 HCSDB data to investigate the reasons that respondents changed plans.

ACCESS TO MHS CARE *(CONT.)*

Changing Health Plan *(cont.)*

Introduction

As of March 1, 2019, 6 percent of respondents had changed their TRICARE plan, according to administrative data (see first table below). Respondents enrolled in Select or entitled to TRICARE but not enrolled in a TRICARE plan in 2018 were significantly more likely than those enrolled in Prime in 2018 to have changed their plan in 2019 (9 percent of Select enrollees and 55 percent of those entitled to TRICARE but not enrolled, compared with 4 percent of Prime enrollees).[1]

PLAN ENROLLMENT AMONG SURVEY RESPONDENTS, BY 2018 PLAN

DEERS ENROLLMENT (2018)	CHANGED PLAN IN 2019
TRICARE Entitled, Not Enrolled	55% (149)[b]
TRICARE for Life (TFL)	N.R.
TRICARE Prime[a]	4% (239)
TRICARE Plus	N.R.
TRICARE Reserve Select	N.R.
TRICARE Select	9% (209)[b]
Uniformed Services Family Health Plan (USFHP)	N.R.
Overall	**6% (630)**

Sources: DEERS, July 1, 2018; FY 2019 Q1 HCSBD. N = 8,800. The response rate is 8.8 percent. The survey was fielded from October 5, 2018, to January 31, 2019.

[a] Includes both military and civilian providers.
[b] Significantly different from Prime ($p < 0.05$).
Notes:
– Numbers in parentheses indicate sample size.
– N.R. indicates not reported because of small sample size.

Of the beneficiaries who were entitled to TRICARE but not enrolled in 2018, 55 percent moved to a TRICARE plan in 2019 (see table above), with 63 percent of those enrolling in Prime (see table below). Also shown below, 37 percent of respondents who were enrolled in Prime in 2018 changed to Select in 2019; another quarter of them changed to TRICARE for Life (TFL). Likewise, 47 percent of respondents who were enrolled in Select in 2018 changed to TFL in 2019, and a quarter moved to Prime.

PLAN ENROLLMENT AMONG SURVEY RESPONDENTS, BY NEW PLAN IN 2019

DEERS ENROLLMENT (2018)	TRICARE ENTITLED, NON-TFL	TFL	TRICARE PRIME	TRICARE RESERVE SELECT	TRICARE SELECT
TRICARE Entitled, Non-TFL	–	N.R.	63% (90)	N.R.	11% (25)
TRICARE Prime	17% (39)	27% (70)	–	N.R.	37% (82)
TRICARE Select	6% (20)	47% (56)	23% (57)	11% (32)	–

Sources: DEERS, July 1, 2018, and March 1, 2019; FY 2019 Q1 HCSBD. N = 8,800. The response rate is 8.8 percent. The survey was fielded from October 5, 2018, to January 31, 2019.

Notes:
– Numbers in parentheses indicate sample size.
– N.R. indicates not reported because of small sample size.
– TRICARE Plus and USFHP not reported because of small sample size.

[1] Most respondents who were entitled to TRICARE but not enrolled in a TRICARE plan and changed plans in 2019 were Active Duty or Active Reservists. Most of these respondents changed their plan to Prime in 2019, indicating a lag between entering Active Duty status and being enrolled in Prime.

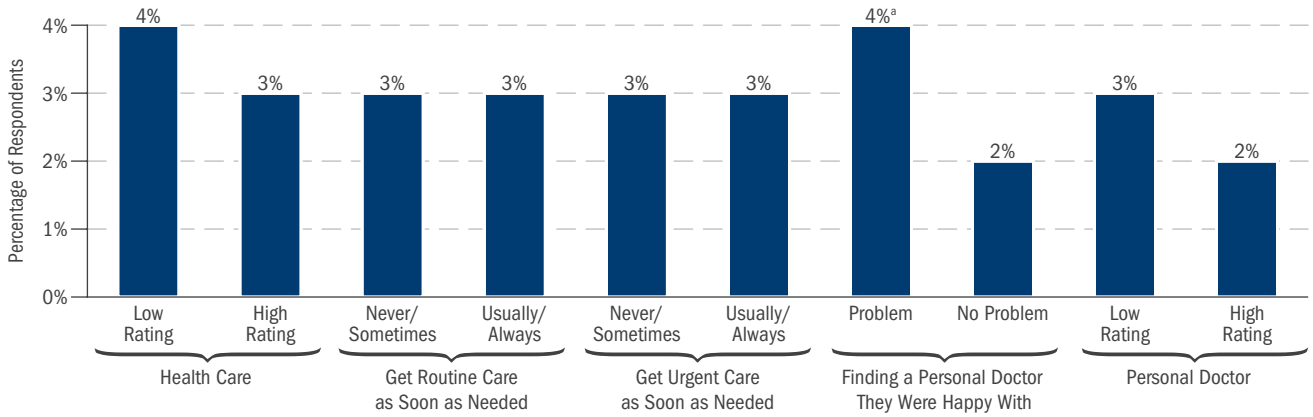
ACCESS TO MHS CARE *(CONT.)*

Changing Health Plan *(cont.)*

Reasons for Changing Plans

Respondents most commonly cited a QLE as the reason for changing health plans in 2019 (45 percent, not shown). Although QLEs are the most common reason for changing plans, other factors could also affect beneficiaries' decision, such as access to and satisfaction with care. We explored whether respondents who had a negative experience accessing care or were dissatisfied with their care were more likely to change health plans compared with those who had a positive experience or were satisfied with their care. Low ratings of health care or personal doctor were not associated with a higher likelihood of changing health plans. Similarly, those who had difficulty accessing routine and urgent care were as likely to change health plans as those who were usually or always able to access care. Respondents who said that they had either a big or small problem finding a personal doctor were more likely to change health plans than those who had no problem, although the difference was small (statistically significant difference of 4 percent versus 2 percent; see first figure below).

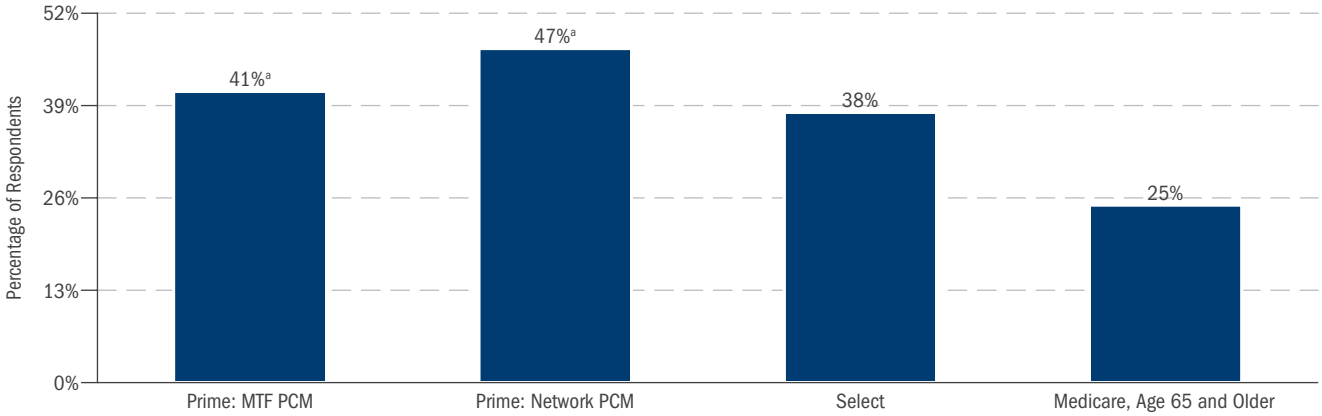
PERCENTAGE OF RESPONDENTS CHANGING PLANS, BY ACCESS TO AND RATINGS OF HEALTH CARE



Source: FY 2019 Q2 HCSDB. N = 9,280. The response rate was 9.2 percent. The survey was fielded from January 4, 2019, to March 29, 2019.
[a] Significantly different from No Problem Finding a Personal Doctor They Were Happy With ($p < 0.05$).

Overall, 35 percent of all respondents had difficulty finding a personal doctor they liked, regardless of whether they changed plans (not shown).[1] There were no significant differences by plan type in the percentage of enrollees who had difficulty finding a personal doctor (41 percent of Prime enrollees with an MTF primary care manager (PCM), 47 percent of Prime enrollees with a network PCM, and 38 percent of Select enrollees reported having difficulty, see figure below). The exception was Medicare enrollees aged 65 and older, who were less likely to have difficulty finding a personal doctor than those enrolled in Prime (either with an MTF or network PCM).

PERCENTAGE OF RESPONDENTS WHO HAD A PROBLEM FINDING A PERSONAL DOCTOR, BY PLAN TYPE



Source: FY 2019 Q2 HCSDB. N = 9,280. The response rate was 9.2 percent. The survey was fielded from January 4, 2019, to March 29, 2019.
[a] Significantly different from Medicare enrollees aged 65 and older ($p < 0.05$).
[1] This excludes Active Duty Service members, who largely are enrolled in Prime and have an MTF PCM.

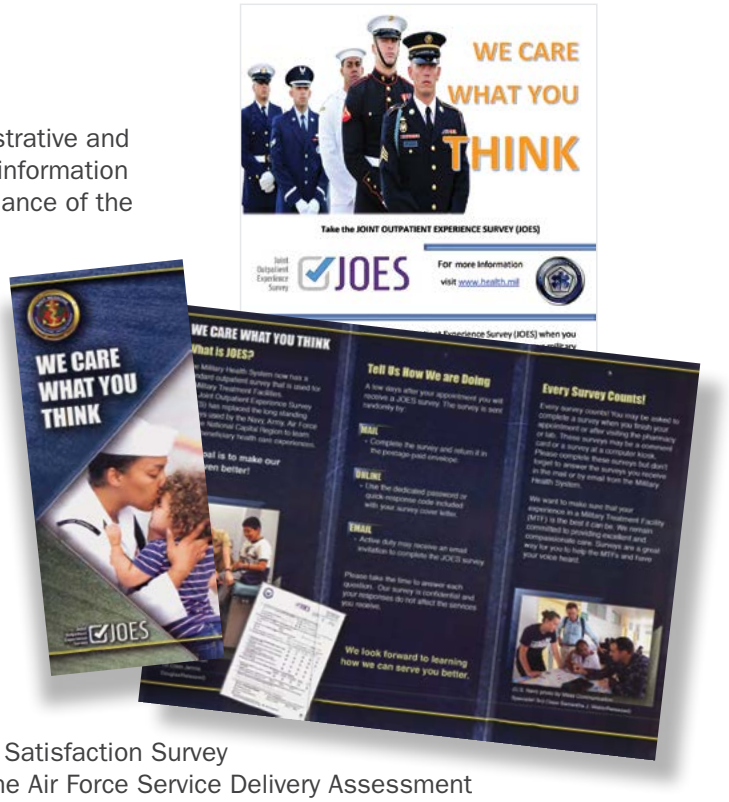
Changing Health Plan *(cont.)*

Conclusion and Next Steps

Overall, most survey respondents stayed in their current TRICARE plan in 2019, with only 6 percent changing their TRICARE enrollment. Among the respondents who changed TRICARE plans between 2018 and 2019, those enrolled in Select in 2018 were more likely to change plans than those enrolled in Prime. This higher rate of plan changing among Select enrollees might be related to the changes in the benefit introduced in 2018, but it is unlikely that Select beneficiaries were motivated to change because of dissatisfaction with Select. Almost half of Select enrollees who changed plans in 2019 moved to TFL, and the most common reason given by respondents for changing plans was a QLE. These findings suggest that Select enrollees were not changing plans because they were dissatisfied with Select but because they became eligible for Medicare.

Although most beneficiaries were changing plans because of a QLE, we found some evidence that difficulty finding a personal doctor was associated with a higher rate of plan changing. Difficulty finding a personal doctor is not exclusive to one plan. Prime enrollees with an MTF or network PCM, or Select enrollees, were equally likely to have this difficulty. The DHA might therefore consider assessing whether the plans available to beneficiaries enable them to easily find a doctor they like.

ACCESS TO MHS CARE *(CONT.)*



Patient-Centered, Self-Reported Measures

In addition to tracking patient access to care using administrative and provider-centric data, the inclusion of patient self-reported information provides a more complete user assessment of the performance of the health care system.

There are a number of methods for evaluating the patient's experience: face-to-face encounters, complaint and suggestion programs, focus groups, and surveys. Surveys can obtain patient experience data following a specific health care event, as in event-based surveys after an outpatient visit or discharge from a hospital. Patient experience is also assessed at the health plan or population level, to evaluate member experience over time.

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. FY 2019 marks the third complete year that the Joint Outpatient Experience Survey (JOES) has been fielded to replace the Army Provider Level Satisfaction Survey (APLSS), the Navy Patient Satisfaction Survey (PSS), and the Air Force Service Delivery Assessment (SDA). Almost 500,000 JOES surveys were returned during FY 2019, providing targeted areas for improvement in outpatient care at military facilities. As shown below, JOES results are comparable between each Service and have varied only minimally over time.

The Joint Outpatient Experience Survey-CAHPS (JOES-C) is a companion survey to the JOES, measuring outpatient care at military and civilian facilities. Beginning in FY 2016, the JOES-C is based on the Agency for Healthcare Research and Quality (AHRQ) CAHPS Clinician & Group Survey (CG-CAHPS), as was the predecessor to the JOES-C: the TRICARE Outpatient Satisfaction Survey (TROSS). This allows MHS comparison to civilian benchmarks, as well as MHS beneficiary ratings across direct and purchased care venues.

The JOES and JOES-C have improved in efficiency and representation, demonstrated through the collection of web-based surveys by ADSMs in FY 2019 in response to e-mailed invitations. More surveys are now being completed by Service members stationed overseas, providing invaluable feedback on their care. The results of the JOES and JOES-C measures are published to the JOES/JOES-C reporting website that allows users to examine the quality of care across the MHS. Additionally, some of these measures are routinely reported to senior MHS leadership as core measures on the MHS Dashboard, and are also reported publicly on the transparency website of health.mil. In this report, the JOES and JOES-C measures reported include Getting Care When Needed, Satisfaction with Care, Rating of Provider, Provider Communication composite, and Access to Care composite.

Results from the MHS population survey, the Health Care Survey of DoD Beneficiaries (HCSDB), are also included in the findings reported here, where appropriate, as a comparison against outpatient surveys that are administered following receipt of care. The HCSDB, based on the CAHPS Health Plan Survey, is administered quarterly to a sample of the approximately 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 Health Plan Survey is on the performance of the health plan over time from the beneficiary's perspective. The JOES-C/TROSS CG-CAHPS–based survey is focused on health care received over the past six months following a specific outpatient visit, while the JOES pertains solely to a specifically referenced 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 94.

ACCESS TO MHS CARE *(CONT.)*

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

Privacy of Adolescents

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 aged 0–10. The following patient-centered, self-reported results are based on the ages included in the sample.

The Health Insurance Portability and Accountability Act of 1996 (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 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.)*

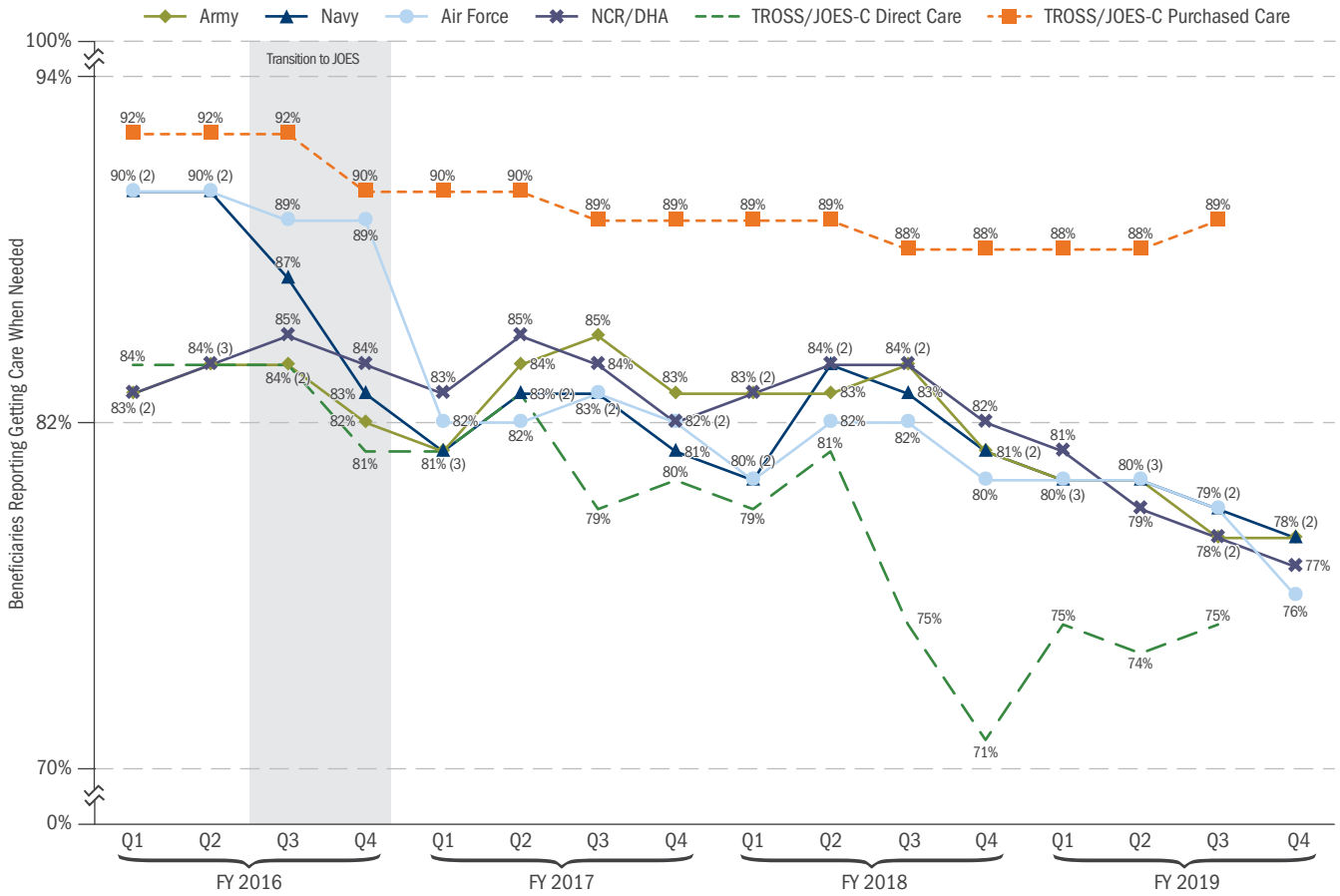
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care

Ratings of Getting Care When Needed

Historically, the measure of Getting Care When Needed has been a common question on the outpatient surveys across each of the Services (APLSS, PSS, SDA) and DHA (TROSS, JOES, JOES-C, HCSDB) since FY 2012. This question allows a patient to provide feedback on his or her ability to access care after care has been received. The following graph describes the effect of the transition to the JOES methodology and survey instrument for each Service.

- Prior to FY 2016, a 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.
- Scores for each Service have been largely consistent from FY 2017 to FY 2019; Air Force scores have ranged from 76 percent to 83 percent, Army scores from 77 percent to 85 percent, Navy scores from 77 percent to 83 percent, and NCR/DHA scores from 77 percent to 85 percent.
- All of the Services have seen a steady decrease in scores from FY 2017 to FY 2019.

SERVICE SURVEYS/JOES GETTING CARE WHEN NEEDED, FYs 2016–2019



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, analyzing APLSS, PSS, SDA, and JOES, compiled 10/25/2019

Notes:

– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 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 receiving care.

– "Getting Care When Needed" is assessed 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."

– The NCR category is represented by the FY 2016 Q1 through FY 2019 Q1 data points and is made up of parent facilities Fort Belvoir Community Hospital (FBCH) and Walter Reed National Military Medical Center (WRNMMC). Parent facilities FBCH, WRNMMC, 81st Medical Group at Keesler Air Force Base, Womack Army Medical Center, Naval Hospital Jacksonville, 4th Medical Group at Seymour Johnson Air Force Base, and 628th Medical Group at Joint Base Charleston compose the DHA category from FY 2019 Q2 through FY 2019 Q4.

– 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, with a focus on reducing the number of low ratings. Identifying MTFs with generally low ratings can be the first step in ascertaining and addressing discrepancies in care and patient management processes.

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 2018 Q1 & Q2 to FY 2019 Q3 & Q4, the median scores decreased for each Service. The means for Army, Navy, and NCR/DHA decreased for these quarters, while there was a slight increase for Air Force.
- Dispersion, in terms of the IQR, had an increase across Army, Navy, and Air Force between FY 2018 Q3 & Q4 and FY 2019 Q3 & Q4; the 75th percentile worsened along with the 25th percentile in these Services as well.
- From the beginning of JOES, the IQR, or the difference between the 75th and the 25th percentiles, has remained below 10 percent for all the Services.
- Dispersion, in terms of the range between the highest- and lowest-scoring parent facility, increased for Army, Navy, and Air Force.

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

VARIABILITY IN JOES GETTING CARE WHEN NEEDED, FYs 2018–2019

	FY 2018 Q1 & Q2	FY 2018 Q3 & Q4	FY 2019 Q1 & Q2	FY 2019 Q3 & Q4	% POINT CHANGE (FY 2018 Q1 & Q2 TO FY 2019 Q3 & Q4)
ARMY					
Service Score (Mean)	83.1%	82.3%	79.8%	78.8%	–4.3
Median	84.3%	82.5%	80.5%	78.9%	–5.4
75th Percentile	86.1%	86.1%	83.4%	82.3%	–3.8
25th Percentile	81.7%	79.7%	77.1%	76.4%	–5.2
IQR	4.4%	6.4%	6.3%	5.9%	1.5
Maximum	89.3%	92.3%	93.4%	85.3%	–4.0
Minimum	74.9%	74.3%	70.4%	57.7%	–17.2
Range	14.3%	18.0%	23.0%	27.5%	13.2
AIR FORCE					
Service Score (Mean)	81.1%	81.1%	79.5%	78.0%	–3.1
Median	82.6%	83.1%	81.0%	77.3%	–5.2
75th Percentile	87.3%	86.4%	85.7%	83.1%	–4.1
25th Percentile	78.7%	78.7%	75.7%	73.1%	–5.7
IQR	8.6%	7.6%	10.0%	10.1%	1.5
Maximum	97.7%	93.5%	100.0%	98.0%	0.3
Minimum	66.1%	58.7%	58.2%	58.4%	–7.7
Range	31.6%	34.8%	41.8%	39.6%	8.0
NAVY					
Service Score (Mean)	82.2%	81.9%	79.7%	79.1%	–3.1
Median	83.1%	83.3%	81.2%	80.7%	–2.5
75th Percentile	86.3%	86.2%	83.8%	84.6%	–1.7
25th Percentile	81.3%	80.5%	79.4%	76.9%	–4.4
IQR	5.0%	5.7%	4.4%	7.7%	2.7
Maximum	94.9%	91.6%	98.5%	90.7%	–4.2
Minimum	77.0%	77.0%	73.2%	69.9%	–7.1
Range	18.0%	14.6%	25.2%	20.8%	2.9
NCR/DHA					
Service Score (Mean)	83.9%	83.0%	79.2%	77.9%	–6.0

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES, weighted data, compiled 11/6/2019

Notes:

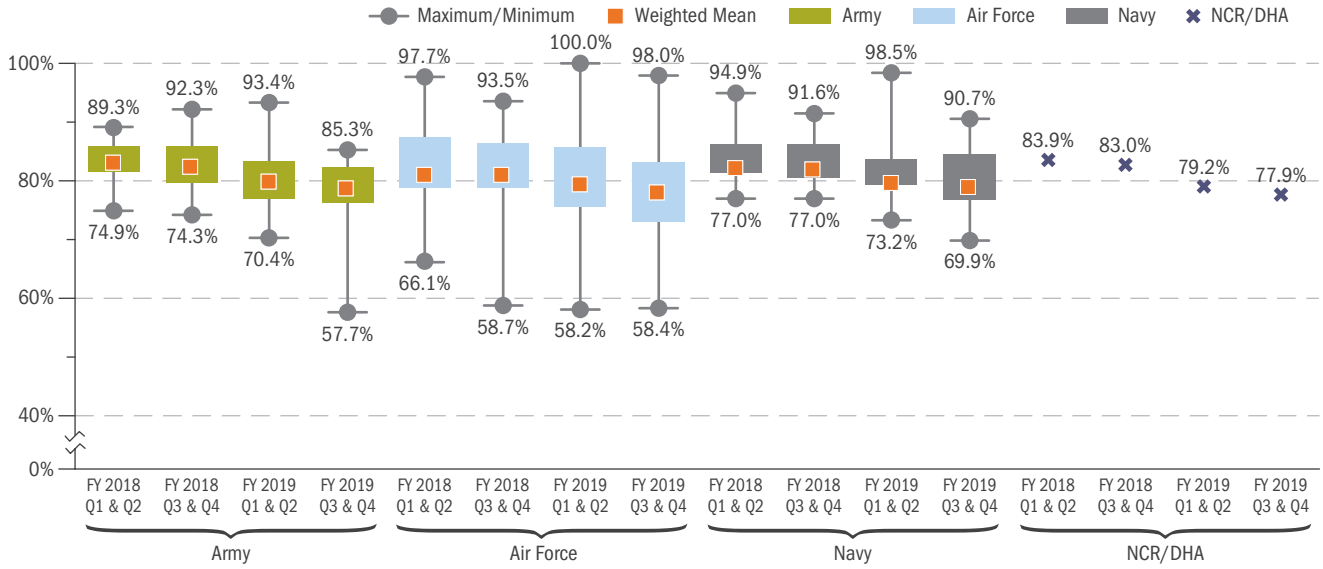
– Parent facility scores were used in the above table, and those reporting fewer than 10 responses in the time period were excluded from analyses.

– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration.

– Weighted means are shown for NCR/DHA. The NCR category is represented by the FY 2018 Q1 through FY 2019 Q1 data points and is made up of parent facilities FBCH and WRNMMC. Parent facilities FBCH, WRNMMC, 81st Medical Group at Keesler Air Force Base, Womack Army Medical Center, Naval Hospital Jacksonville, 4th Medical Group at Seymour Johnson Air Force Base, and 628th Medical Group at Joint Base Charleston compose the DHA category from FY 2019 Q2 through FY 2019 Q4.

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

VARIABILITY IN BENEFICIARY RATINGS: GETTING CARE WHEN NEEDED, FYs 2018–2019



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES, weighted data, compiled 11/6/2019

Notes:

– Parent facility scores were used above, and those reporting fewer than 10 responses in the time period were excluded from analyses.
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration.
– The box shows the IQR (25th to 75th percentiles) with the Service score (weighted mean) highlighted.
– Weighted means are shown for NCR/DHA. The NCR category is represented by the FY 2018 Q1 through FY 2019 Q1 data points and is made up of parent facilities FBCH and WRNMMC. Parent facilities FBCH, WRNMMC, 81st Medical Group at Keesler Air Force Base, Womack Army Medical Center, Naval Hospital Jacksonville, 4th Medical Group at Seymour Johnson Air Force Base, and 628th Medical Group at Joint Base Charleston compose the DHA category from FY 2019 Q2 through FY 2019 Q4.

ACCESS TO MHS CARE *(CONT.)*

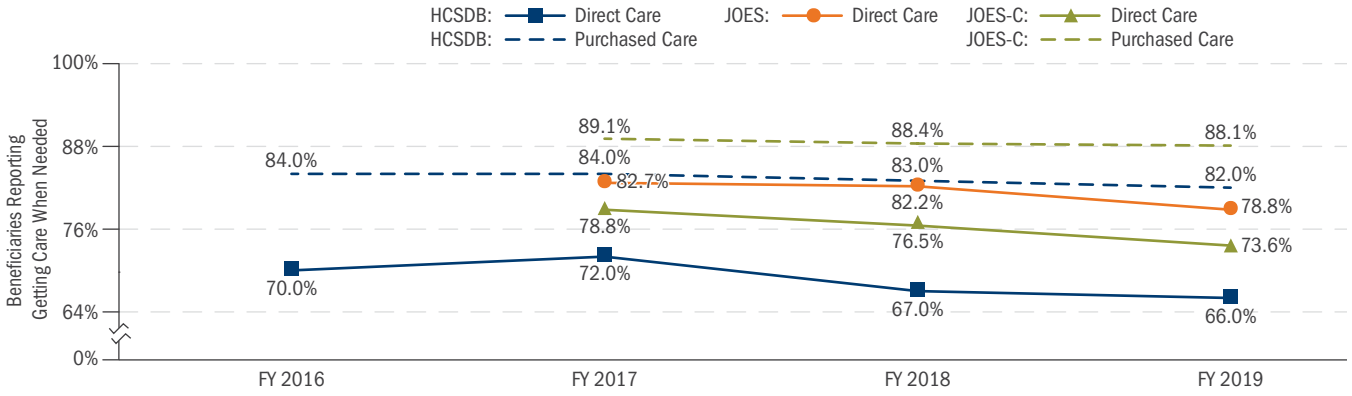
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care *(cont.)*

Comparison of Multiple Surveys—Getting Care When Needed

In addition to each of the Service surveys and JOES, JOES-C (and its predecessor, the TROSS), as well as the population-based HCSDB, also report results for the measure of Getting Care When Needed. Having this measure in each of the survey instruments provides important information about the differences between surveys and the beneficiaries who respond to them. A description of the differences between each of the surveys can be found on page 86.

- 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. For JOES-C, scores for purchased care are about 15 percentage points higher than those for direct care. Purchased care scores for HCSDB are 16 percentage points higher than their direct care counterpart scores in FY 2018 and FY 2019.
- Beneficiaries who completed JOES-C reported greater access than beneficiaries who completed HCSDB, over time, for direct care and purchased care. This may be because beneficiaries who complete JOES-C are beneficiaries who responded to a survey after having received care, while those who complete the HCSDB may not have received care or may not have received care as needed over the previous 12 months.
- Ratings of Getting Care When Needed have declined over time for respondents to the HCSDB direct and purchased care surveys, as well as for JOES. Ratings from beneficiaries completing the JOES-C survey decreased by 5 percent for direct care and may be leveling off for purchased care.

HCSDB, JOES, AND JOES-C RATINGS OF GETTING CARE WHEN NEEDED, FYs 2016–2019



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB, JOES, and JOES-C, weighted data, compiled 11/11/2019

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. 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 JOES-C FY 2019 direct care and purchased care include data from September 2018 to June 2019.
– 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 assessed 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 were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration, respective to the JOES and JOES-C surveys.
– HCSDB data were derived from the FYs 2017–2019 HCSDB, as of 11/1/2019, and adjusted for age and health status. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology.

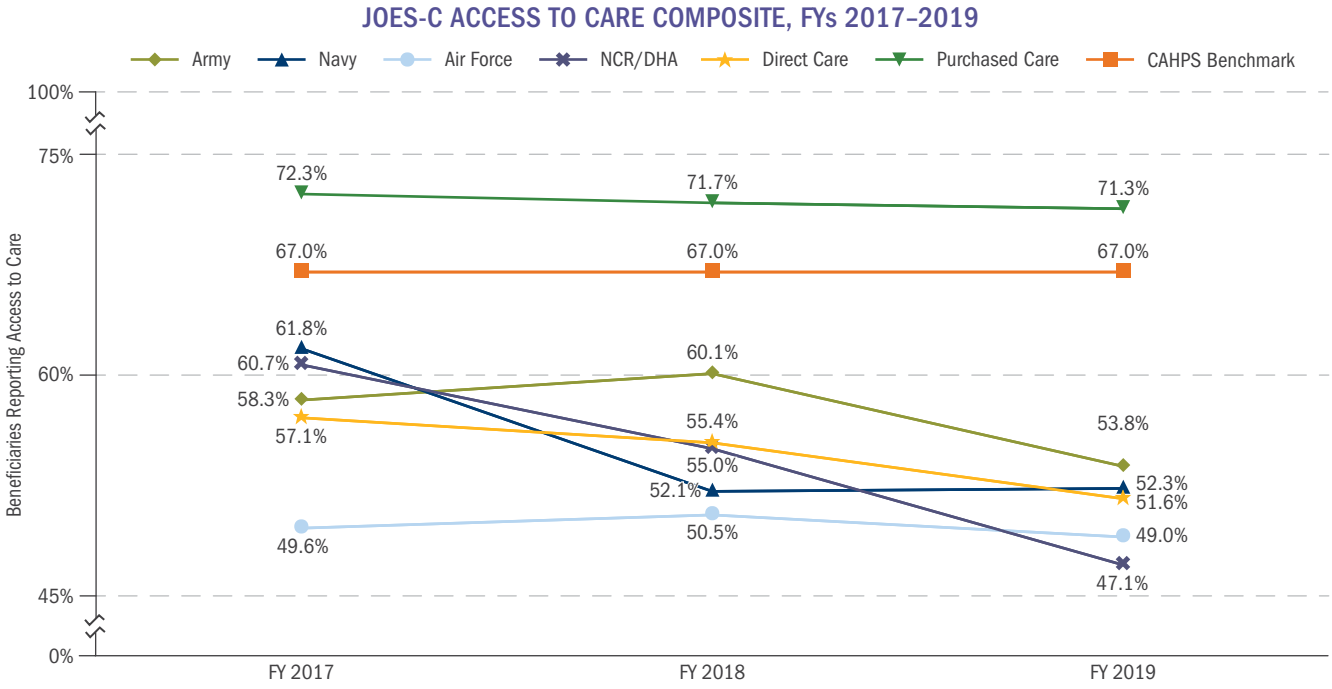
ACCESS TO MHS CARE *(CONT.)*

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

JOES-C Access to Care Composite

The Access to Care composite differs from the Getting Care When Needed measure, because it is based on guidelines from AHRQ's CG-CAHPS. Additionally, the Access to Care composite is calculated based on 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 (purchased care) are higher than for those receiving care from MTFs (direct care).
- With the introduction of JOES-C in FY 2016, overall scores for purchased care have decreased, yet they have remained above the CAHPS benchmark. Scores for all of the Services and direct care overall remain below the benchmark. From FY 2017 to FY 2019, there was a decrease in scores for each of the Services.



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES-C, weighted data, compiled 11/20/2019

Notes:

– JOES-C began fielding for encounters occurring in the following months: Direct Care=June 2016; Purchased Care=May 2016.
– Results displayed above were weighted to represent the composition of the MHS population receiving care.
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration.
– The NCR category is represented by the FY 2017 Q1 through FY 2019 Q1 data points and is made up of parent facilities FBCH and WRNMMC. Parent facilities FBCH, WRNMMC, 81st Medical Group at Keesler Air Force Base, Womack Army Medical Center, Naval Hospital Jacksonville, 4th Medical Group at Seymour Johnson Air Force Base, and 628th Medical Group at Joint Base Charleston compose the DHA category from FY 2019 Q2 through FY 2019 Q4.
– CAHPS benchmarks are the 50th percentiles from the respective 2016 and 2017 CG-CAHPS national civilian scores.

ACCESS TO MHS CARE *(CONT.)*

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

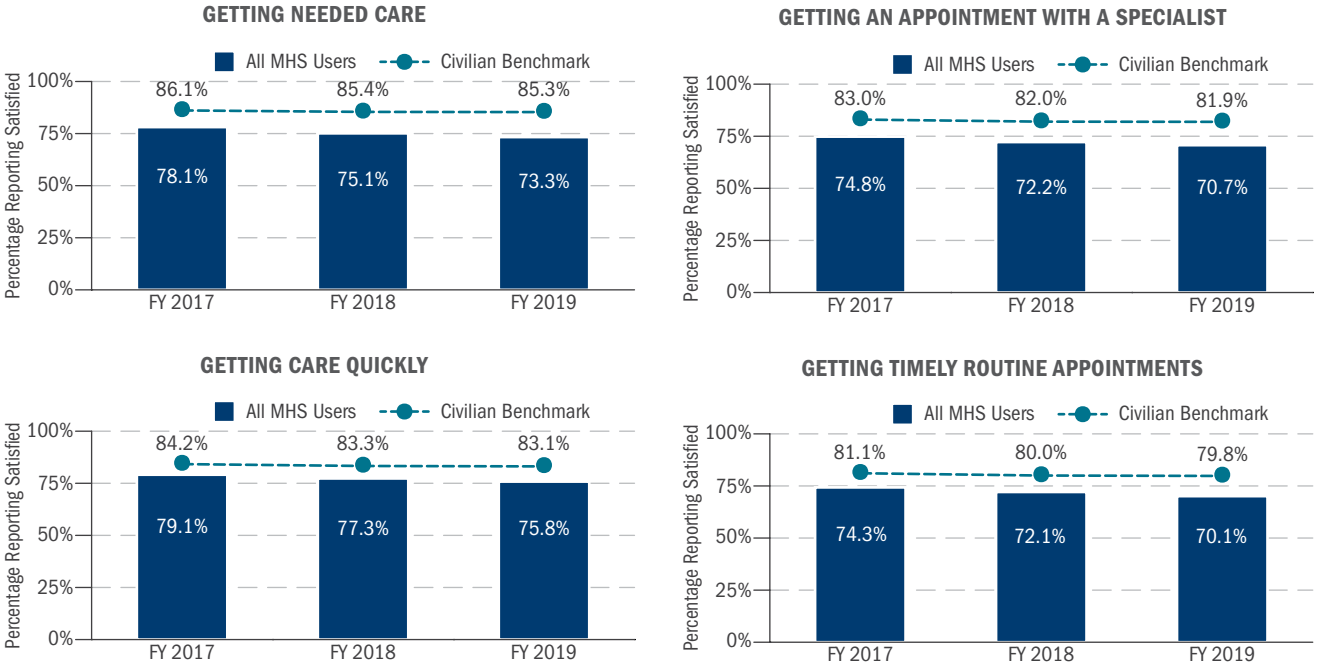
Instead of focusing on a specific health care event to assess patient experience with care, population surveys are designed to sample populations based on the demographics being considered (e.g., a survey of all ADSMs about their health behaviors, or a survey of all MHS beneficiaries to assess their use of preventive services and access to primary and specialty care), as in the case of the HCSDB. The following 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 all measures declined from FY 2017 to FY 2019. Civilian benchmarks for all four access measures fell slightly 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 2017 and FY 2019.

TRENDS IN MEASURES OF ACCESS FOR ALL MHS BENEFICIARIES (ALL SOURCES OF CARE), FYs 2017–2019



Note: HCSDB data were derived from the FYs 2017–2019 HCSDB, as of 11/1/2019, 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 2017 come from NCQA's 2015 data, while the benchmarks used in 2018 and 2019 come from NCQA's 2017 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.

CLINICAL QUALITY MANAGEMENT IN THE MHS

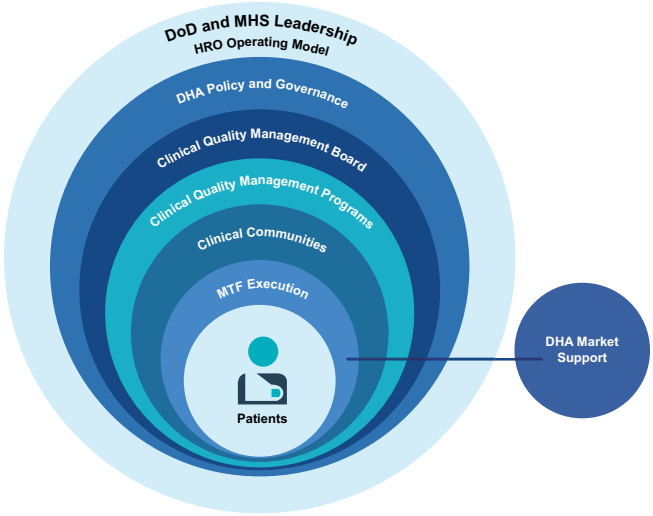
Clinical Quality Management Oversight

Through the MHS Quadruple Aim, the Clinical Quality Management (CQM) functional capability affirms its unwavering commitment to provide health care of the highest quality and value to all of our beneficiaries. The NDAAs for FYs 2017 and 2019 enacted significant TRICARE and MHS reforms including changes to the administration and management structure, collectively transforming the MHS into an integrated system of readiness and health. The prescribed changes enable the MHS to act as one enterprise delivering an improved experience. This opportunity provides the ability to unify quality improvement efforts through the elimination of unwarranted duplication and to reduce variation in execution through the application of a singular management authority.

In this work, CQM partners with the military departments and is fully committed to reach our shared vision of a better MHS. Our goal is to foster a culture of safety, collaboration, and high reliability that will accelerate the evolution of health care and the MHS. Leveraging the most advantageous practices of the Services and DHA, the requirements to fulfill this promise have been developed. Our vision is to unify CQM in the MHS through structure, process, and function to improve our readiness mission, while delivering world-class, efficient, and accessible health care for all of our beneficiaries. The future CQM operating environment will feature strong partnerships with stakeholders across the enterprise in order to responsively and effectively advance the DoD's operational and medical missions and to deliver on DHA priorities including great outcomes, a ready medical force, satisfied patients, and a fulfilled staff. This work is facilitated by the release of the DHA-PM 6025.13, "Clinical Quality Management in the Military Health System," which supersedes existing Service policy and unifies the MHS's approach to clinical quality under a singular organizational construct that provides a framework of interdependent programs integrated at each organizational level to objectively define, measure, assure, and improve the quality of care in the MHS. It is also furthered by ongoing work in support of the SECDEF-mandated MHS review and the MHS's journey toward high reliability, and includes regular assessments of health care safety culture across the MHS. Additionally, CQM is augmenting its assessment capability for the safety and quality of care in its purchased care network to further drive transparency, accountability, standardization, prevention, and improvement across both direct and purchased care environments.

The sections that follow provide additional detail on the MHS approach to CQM across key areas.

MHS GOVERNANCE OF CLINICAL QUALITY MANAGEMENT



Healthcare Resolutions Program

There are three primary components to the Healthcare Resolutions Program situated in large MTFs, with each assigned Special Assistant for Healthcare Resolutions having regional responsibilities. Healthcare Resolutions is a high reliability program that incorporates five core principles: preoccupation with failure, reluctance to simplify, sensitivity to operations, commitment to resilience, and deference to expertise. This is accomplished through its detailed fact-finding, consultation with experts, incorporation of involved patients and providers in facilitated dialogues, promotion of process improvement efforts with involved clinicians, assurance of full disclosure of the facts of care, and a resilience program for providers that has been extended to graduate medical education.

Healthcare Resolutions

Healthcare Resolutions is a 24/7/365 nonlegal venue to resolve complex health care issues following unanticipated/adverse outcomes of care or quality-of-care concerns starting at the time of service delivery at medical centers, hospitals, clinics, and/or operational medicine platforms. The program promotes organizational transparency and integrity with disclosure, recognition of system vulnerabilities, sharing of meaningful feedback between patients/families and providers, and an opportunity for both patient and provider input with a commitment to lessons learned following such events. Issues are addressed at the earliest opportunity, in a neutral setting, with equitable resolutions for patients, providers, and the organization. The program serves as a pivotal component of an HRO culture, encouraging a compassionate, collaborative, and integrated team response to clinical adverse events (AEs) without interference from legal or regulatory quality assurance processes. Arrangements may be made for patients to provide their perspective to quality assurance when they request such an opportunity, at which point it becomes a separate discussion. Healthcare Resolutions advises patients and families in advance that results of quality assurance reviews may not be released per federal regulations. Interventions in Healthcare Resolutions are preclaim discussions, as the filing of a claim transitions the process into a formal legal venue. There is no inclusion of organizational or patient legal counsel during any of the Healthcare Resolutions interventions. Healthcare Resolutions has been placed under an independent DHA Procedural Instruction (DHA-PI 6025.17), titled "Healthcare Resolutions, Disclosure, Clinical Conflict Management and Healthcare Provider Resiliency and Support in the Military Health System," signed in June 2019. Healthcare Resolutions has also been endorsed by the Under Secretary of Defense for Health Affairs in support of transparency and full disclosure following unanticipated or adverse medical events and is referenced in the revised DHA-PM.

Disclosure Training

Special Assistants for Healthcare Resolutions are responsible for promoting disclosure and a culture of transparency throughout the MHS following unanticipated/adverse outcomes of care, treatment, and services. Healthcare Resolutions provides disclosure training and real-time disclosure coaching for licensed independent practitioners who hold the disclosure responsibility, ensuring compliance with TJC disclosure standard, TJC patient-centered communication standard, American Medical Association Code of Ethics, DoD policy, and state apology laws, while respecting the boundaries of federal regulation (i.e., 10 U.S.C. §1102). The program is also responsible for drafting disclosure letters to notify a broad base of patients who may have been potentially harmed by noted discrepancies in care delivery, products that have been recalled, unsafe care-related practices such as instrument sterilization, or other issues of similar magnitude. Disclosure is promoted as a clinical dialogue and is not a legal venue. It also endorses the concept that patients will make future care decisions that are in their best interest when they have a more complete understanding of medical events that occurred during their previous care.

Peer Support

Healthcare Resolutions is involved with providers who are often second victims following adverse outcomes of care, knowing that the most devastating impact for providers is to feel responsible for causing harm, permanent injury, or death to a patient. Many feel that they have failed the patient and second-guess their clinical skills, knowledge base, and career choice. It is estimated that 90 percent of providers do not feel supported by organizations following adverse outcomes of care, yet at least 50 percent of all providers are expected to experience at least one serious AE during their careers. Rates of provider suicide and provider attrition continue to escalate. Peer Support Programs have been developed by Healthcare Resolutions to establish early involvement with providers following AEs. In cooperative partnerships with other organizational entities, these programs promote provider-

Healthcare Resolutions Program *(cont.)*

to-provider engagement following AEs, with an emphasis on emotional recovery and psychosocial support in a blame-free environment. Peer Support is separate from the event investigation and does not involve use of patient names, case analysis, review of medical records and documentation, or interference with quality assurance or legal processes. Peer Supporters are volunteer providers who receive training and coaching on the fundamentals of this critical intervention, as well as guidance regarding when formal clinical referrals should be sought. This initiative supports providers (staff providers, fellows, residents, interns), enhances provider recovery, contributes to quality-of-care improvements, allows providers to contribute to the event investigation, increases teamwork, enhances productivity, and reduces medical errors that are often associated with nonsupported providers. Peer Support is a critical component of military medicine's commitment to its providers and to firmly establishing itself as an HRO.

Patient Safety: Program to Prevent Harm

The mission of the DoD's Patient Safety Program (PSP) is to promote a culture of safe, high-quality patient care to end preventable patient harm. The DoD PSP strives to achieve this by establishing data-driven, standardized processes and engaging, educating, and equipping patient-care teams to institutionalize evidence-based practices. Through these efforts, the DoD PSP promotes safe and reliable care for every patient, every time, and supports providing a medically ready force and ready medical force to Combatant Commands in both peacetime and wartime. As the MHS continues its HRO journey, the DoD PSP aims to present an integrated picture of safety, utilizing available information from the entire organization. To accomplish this, the DoD PSP regularly monitors, measures, and identifies trends in patient safety data to prioritize areas of focus for improvement, providing enabling expertise to MHS Clinical Communities.

In collaboration with the Services and DHA former transitional Intermediate Management Organization (tIMO; active during this evaluation period but disestablished January 30, 2020), the DoD PSP focuses on three functional areas:

1. Eliminating harm through the identification, investigation, and mitigation of patient safety events;
2. Designing and identifying integrated solutions to engage, educate, and equip; and
3. Fostering a culture of safety.

These efforts are all key in continuously working to maintain and improve safety and high-quality patient care across MHS.

Eliminating Harm through the Identification, Investigation, and Mitigation of Patient Safety Events

Reporting patient safety events is a component of the MHS's effort to achieve high reliability, continuously improve, and provide the safest patient care possible. A patient safety event is defined as an incident or condition that could have resulted or did result in harm to the patient. A patient safety event can be but is not necessarily the result of a defective system or process design, a system or process breakdown, equipment failure or malfunction, or human error. Patient safety events include AEs, no-harm events, near-miss events, and unsafe/hazardous conditions. The identification, investigation, and mitigation of these 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, and share lessons learned to prevent future harm events from reaching the patient.

The MHS identifies, investigates, and mitigates patient safety events through several mechanisms and systems, including:

1. Joint Patient Safety Reporting, a self-reporting system that allows individuals to anonymously report all patient safety events;
2. DoD Reportable Events, the most severe events from across the organization;
3. Health care–associated infections (HAIs), which are tracked through the Centers for Disease Control and Prevention National Healthcare Safety Network; and
4. Global Trigger Tool, which measures AEs collected through a sampling methodology from patient records.

Patient Safety: Program to Prevent Harm *(cont.)*

1. Joint Patient Safety Reporting (JPSR)

The MHS directs MTF commanders and staff to report all patient safety events reaching the patient and to report near-miss events to the greatest extent possible through JPSR. JPSR is a standardized, anonymous, and voluntary web-based reporting system that was implemented in 2011 across the MHS to capture patient safety events. As a result, DoD PSP has seen increased collaboration on improvement efforts, knowledge exchange, and solutions. In FY 2019, a total of 93,219 patient safety reports were submitted from the direct care system. Near-miss JPSR events, which did not reach a patient, accounted for 54 percent of all JPSR events reported in FY 2019. Where feasible, the operational environment also reports patient safety events using the JPSR system.

The table below compares FY 2015 to FY 2019 patient safety reporting, stratified by degree of harm. Harm is defined as events that reach a patient and result in harm, including death; no harm is defined as events that reach a patient and do not result in harm; near miss is defined as events that do not reach a patient.

JOINT PATIENT SAFETY EVENTS REPORTED, FYs 2015–2019

HARM GROUP	FY 2015		FY 2016		FY 2017		FY 2018		FY 2019	
	#	%	#	%	#	%	#	%	#	%
Harm	9,170	9%	10,050	9%	10,519	10%	9,068	9%	8,284	9%
No Harm	34,601	35%	38,327	36%	40,927	39%	37,962	37%	34,478	37%
Near Miss	53,730	55%	57,967	55%	54,170	51%	55,082	54%	50,457	54%
Total	**97,501**	**100%**	**106,344**	**100%**	**105,616**	**100%**	**102,112**	**100%**	**93,219**	**100%**

Source: DHA/Medical Affairs/Clinical Support Division (CSD), 10/10/2019. Data reported as of 10/3/2019.

2. DoD Reportable Events (DoD REs)

DoD REs are an important part of patient safety. DoD REs are defined as any patient safety event resulting in death, permanent harm, or severe temporary harm, and include TJC SEs and National Quality Forum serious reportable events (NQF SREs). The most commonly reported medical and dental DoD REs reported to TJC are shown in the table below.

DoD REs REPORTED, FYs 2015–2019

EVENT TYPE	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
	#	#	#	#	#
Wrong-Site Surgery: Wrong Patient, Wrong Site, Wrong Procedure	33	38	27	45	27
Unintended Retained Foreign Object	24	18	25	27	14
Delay in Treatment: Lab, Path, Radiology, Referral, Treatment Order	19	25	19	27	8
Maternal (≥20 Week Gestational Age–42 Days Postpartum): Hemorrhage, Hysterectomy	21	28	9	12	4
Intraoperative or Immediate Post-Op/Post-Procedure or Surgery	16	25	13	11	<4[a]

Source: DHA/Medical Affairs/CSD, 10/10/2019. Data reported as of 10/3/2019.
[a] Contents confidential and privileged in accordance with 10 U.S.C. §1102.

- **Wrong-Site Surgery (WSS):** WSS is a preventable DoD RE involving surgeries on the wrong site, wrong side, wrong person, or wrong procedure in the system. The MHS goal for WSS is zero events. In FY 2019, the MHS saw a 40 percent decrease from FY 2018 in the number of reported WSS DoD REs (from 45 to 27). Efforts to prevent WSS include the development of concise incident analysis (CIA). Initially intended for dental WSS events, DoD PSP is developing and piloting the CIA methodology that may replace the comprehensive systematic analysis (CSA) process (in selected cases)—which itself replaced the root cause analysis (RCA) process—and facilitate quicker learning and development.
- **Unintended Retained Foreign Object (URFO):** An URFO event that occurs after an invasive medical or surgical procedure causes patient harm and significantly increases the cost of patient care. In FY 2019, the number of reported URFO DoD REs decreased 48 percent from FY 2018 (from 27 to 14). The MHS goal for URFOs is zero events.

Patient Safety: Program to Prevent Harm *(cont.)*

- **Delay in Treatment:** Delay in treatment events can be the result of a misdiagnosis, delay in diagnosis, or failure to follow up or communicate test results. These events can be serious DoD REs that ultimately result in serious harm or patient death. In FY 2019, there was a 70 percent decrease in the number of reported delay in treatment events (from 27 to eight). To bring greater awareness and leading practices for prevention in FY 2019, DHA published a focused review on delay in treatment. In addition, the DoD collaborated with the Department of Veterans Affairs (VA) National Center for Patient Safety (NCPS) in FYs 2018–2019 and did a deep-dive analysis on these events. This collaboration enabled MHS to learn from a greater number of errors and put in place solutions to proactively prevent the greatest number of delay in treatment events.
- **Maternal:** Maternal DoD REs include events where the mother receives more than four units of blood, is transferred to a higher level of care, or receives a hysterectomy due to hemorrhage. In FY 2019, there was a 67 percent decrease in the number of reported maternal DoD REs (from 12 to four). To address maternal events, the DoD PSP partners with the WICC to improve the safety of women and infants.
- **Intraoperative:** Intraoperative events include serious events that occur during a surgery or procedure, or immediately post-operative or post-procedure. There was a significant decrease in reported intraoperative events from FY 2018 to FY 2019. The decrease in reporting of these events is mainly due to clarification of the definition of these events through the publication of the CQM policy DHA-PM 6025.13, Volume 2. These events are now reported under a different event type.

Preventing Wrong-Site Surgery and URFOs – Service Example

Prevention Steps

The Air Force has made strong progress in reducing harm in their HRO journey by using effective strategies to minimize harm and drive to zero. Air Force Dental has been innovative, transparent, and diligent in CSA work to include reliable tooth marking, creating an interactive WSS prevention video, and publishing Dental Management Guides and weekly Dental Ops Summaries. In addition, the Air Force launched an operating room Safe Surgery Trainer gaming simulation, available for any MTF to enhance team communication using TeamSTEPPS® principles.

Preventing Surgical DoD REs – Service Example

Tourniquet Safety

The Army provides a great example of minimizing forgotten tourniquets and improving tourniquet safety. Numerous root causes for tourniquet-related events that are process- and material-related were found. The list of root causes was identified, and high reliability strategies were set in place for tourniquet safety, including standardizing procedures, standardizing placement, enhancing tourniquet visibility, and documenting tourniquet removal for accountability.

Improving CSA Quality – Service Example

Root Cause Analysis Event Support Engagement Team

The Army provides a great example of how CSAs can make an improvement on the services. The Root Cause Analysis Event Support Engagement Team (RESET) was established to study certain adverse patient safety events that occur in Army medical and dental treatment facilities worldwide. A RESET mission is deployed to collaborate with Army medical and dental staff in a detailed study of adverse patient safety events to discover process- and system-level vulnerabilities that made the event possible, identify strong actions to effectively mitigate future risk, and share lessons learned with MTFs across the enterprise. The purpose of a RESET mission is to promote culture change in Army Medicine guided by development of standardized processes, strong CA plans, and the spread of knowledge such that any best practices or lessons learned are shared to improve patient safety across the enterprise. Overall, an analysis of Army CSAs since FY 2016 has shown that RESET CSAs contained, on average, two additional strong or intermediate CAs compared to non-RESET CSAs conducted at the same facilities during the same time period.

In addition to capturing patient safety events through DoD REs, per policy, MTFs must submit a CSA for every DoD RE that occurs within their facility. In addition to mandatory completion, the Services/DHA former tIMO may also voluntarily elect to complete a CSA for events that do not meet the threshold of a DoD RE, representing an opportunity for learning and improvement for the MTF. In total, 133 CSAs were received in FY 2019, representing a 32 percent decrease from FY 2018 (not shown). For each CSA received, the DoD PSP reviews the strength of corrective actions (CAs) and submits a review back to the Service/DHA former tIMO. The DoD PSP's corrective rating system is based on the VA Action Hierarchy, which breaks down actions by strength based on likelihood of preventing the event from happening again. The actions can be strong, intermediate, or weak. Stronger actions focus on a system change and are not reliant on individual memory or vigilance. Through this process, the DoD PSP guides MTFs in implementing strong CAs that are more likely to prevent a similar event from happening again. In FY 2019, the percentage of CSAs that included at least one strong or intermediate CA decreased by 2.5 percent over FY 2018 (not shown).

Patient Safety: Program to Prevent Harm *(cont.)*

3. Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN)

The reduction and prevention of HAIs, improved antibiotic stewardship, and reduction of multidrug-resistant organisms (MDROs) remain as top priorities for the DoD PSP. To ensure standardization of reporting practices across the health care system, the MHS continues to participate in the CDC NHSN reporting system. NHSN participation directly aligns with the MHS goal of achieving zero harm, by allowing for the implementation of targeted process improvement initiatives based on standardized measures and benchmarks. The MHS continues to participate in the NHSN device-associated module, which includes submission of central line–associated blood stream infection (CLABSI) and catheter-associated urinary tract infection (CAUTI) data for all ICUs and wards. The standardized infection ratio (SIR) continues to serve as the primary source for benchmarking and comparison of internal data against national benchmarks.

The table below shows where the MHS performed in comparison to the national benchmark for both CAUTIs and CLABSIs. The MHS performed better than or the same as the national benchmark if the value shown is 1.0 or less.

HEALTH CARE–ASSOCIATED INFECTIONS, FY 2015 Q2–FY 2019 Q3, STANDARDIZED INFECTION RATIO

	2015 Q2	2015 Q3	2015 Q4	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1	2019 Q2	2019 Q3
CLABSIs	1.1	1.4	1.0	1.5	0.5	1.4	1.3	1.0	0.8	0.8	1.2	0.6	0.5	0.8	0.7	1.4	0.8	1.0
CAUTIs	1.2	1.4	0.9	0.7	0.8	1.3	1.3	1.3	1.0	0.9	1.1	0.9	0.8	0.5	0.8	0.4	0.4	0.5

Source: DHA/Medical Affairs/CSD, 10/10/2019.

Note: FY 2019 Q4 data is unavailable due to a three-month lag in data maturity. FY 2015 Q1 data is not included because the CDC used a different benchmark for calendar year (CY) 2014 and prior.

4. Global Trigger Tool (GTT)

In FY 2018, MHS completed the implementation of the GTT, which is based on the Institute for Healthcare Improvement (IHI) methodology. Voluntary reporting methods detect only a fraction of AEs that cause patient harm. However, GTT uses a standardized process shown to detect AEs not otherwise reported. It is a validated, objective, and consistent retrospective method for medical record review. The tool is used to determine and monitor rates of patient harm over time and supplements other reporting systems to help direct resources and monitor impact. Since the IHI methodology recommends a minimum of 12 months of data collection to determine a baseline, FY 2019 is the first year where GTT data is reportable. The table below shows GTT statistics from FY 2019 Q1 to FY 2019 Q3.

GLOBAL TRIGGER TOOL ADVERSE EVENTS, FY 2019 Q1–Q3

	2019 Q1	2019 Q2	2019 Q3
Adverse Events per 100 Admissions	7.1	7.9	7.0

Source: DHA/Medical Affairs/CSD, 11/4/2019.

Note: FY 2019 Q4 data is unavailable due to a four-month lag in data maturity.

Patient Safety: Program to Prevent Harm *(cont.)*

Design or Identify Integrated Solutions to Engage, Educate, and Equip

Through the MHS transformation, DoD PSP continued to work toward improved patient safety, quality, and process improvement. Over the course of the past year, DoD PSP has focused on engaging, educating, and equipping our MTFs and their leadership teams to improve patient safety. This focus includes collaboration with the Services and Clinical Communities to provide improved patient safety. Examples of patient safety solutions that engage, educate, and equip the field are described below.

Engage

The DoD PSP supports several efforts throughout the year to engage the enterprise. Several examples of how DoD PSP engages the organization are described below.

Patient Safety Awareness Week (PSAW): One example of how DoD PSP engages the organization is through PSAW. This week is a multi-organizational effort that serves as a national education campaign for promoting patient safety practices. The DoD PSP collaborates with external organizations including AHRQ and IHI on this awareness initiative. In FY 2019, PSAW efforts included hosting webinars on leading practices and efforts from across the organization; engaging our MTFs through daily activities such as quizzes; and providing PSAW kits such as posters, badges, and other patient safety–related materials. PSAW is a consistent way that DoD PSP reaches into all areas of the organization to promote and encourage the adoption of leading safety practices.

Clinical Communities: Clinical Communities improve patient safety and quality of care by engaging appropriate clinical experts, enabling process improvement, promoting collaboration, expanding knowledge sharing, setting the standard of care, and defining practice guidelines to bolster force readiness and support our clinicians and staff in delivering the best health outcomes for all our recipients of care. Navy led the way in the establishment of Clinical Communities, which are comprised of SMEs and stakeholders representing each level of the Navy Medicine enterprise, working together to identify and address relevant issues within the associated patient population. DHA replicated Navy's six Clinical Communities and the Navy Clinical Community model to stand up 12 DHA Tri-Service Clinical Communities. As the DHA Clinical Communities have been established in FY 2019, DoD PSP has engaged with these groups and has provided enabling expertise to the communities. For example, the PSP engaged with the WICC on January 1, 2019, when TJC's newly added element of performance (EP) for the National Patient Safety Goal (NPSG.01.01.01) took effect. The purpose of this engagement was to standardize newborn naming conventions across the enterprise. This also included developing a job aid and one-page communication, and recording a webinar on the naming changes.

Highly Reliable Communications – Service Example

Establishment of Leading Communication Practices

In an effort to move closer to becoming an HRO, the Army expanded on its foundation as part of its journey to mature as an HRO. In 2018, six leading communication practices were implemented to support the Army's foundational work with having leadership commitment to zero harm goals and establishment of a culture of safety. These six evidence-based leading practices have been shown to assist in the development of high performing teams. The practices include: 1) Leadership Daily Safety Briefs; 2) Safety Leadership Rounds; 3) Unit-Based Huddles; 4) Situation-Background-Assessment-Recommendation (SBAR) tool for handoff of critical patient information; 5) Surgical Team Briefs and Debriefs for each surgical case; and 6) Focus on a team time-out prior to surgery to ensure all safety checks are completed. One year later, Army medical and dental treatment facilities have reported a high level of success in initial implementation and use of these HRO tools.

Educate

DoD PSP has multiple evidence-based learning resources available to our Services and MTFs. The goal of these resources is to ensure leaders, providers, and staff are knowledgeable about new regulations, protocols, and technology related to patient safety. All are developed and designed to eliminate patient harm. To identify gaps in learning resources and opportunities for development, in FY 2019 the DoD PSP led a working group that used the curriculum framework development process and focused on the same framework in all six CQM programs. DoD PSP representatives narrowed the focus to patient safety professionals. This process began with developing a competency model and included a review of currently available learning resources and a needs analysis. Next, the representatives identified gaps in learning, and with the final step, began developing learning pathways for patient safety professionals. All information, to include gaps in learning and identifying learning pathways, is built into the FY 2020 Education and Training Strategic Plan.

Patient Safety: Program to Prevent Harm *(cont.)*

The DoD supports the Services/DHA former tIMO and MTF teams by providing infrastructure to obtain continuing education (CE) for multiple training courses, offering one-on-one team coaching, and evaluating the system's effectiveness. Throughout FY 2019, 7,064 MHS leaders, providers, and staff completed CE eligible training as reported through the Online Registration Center. Of those, 1,617 professionals completed all requirements and received CE credit from the accreditation partner, the Postgraduate Institute of Medicine (PIM). Our MHS staff completed training in a variety of areas, including:

- Patient Safety Professional Course (PSPC)
- TeamSTEPPS Train the Trainer 2.0
- TeamSTEPPS Train the Staff 2.0
- TeamSTEPPS Scenario-Based Train the Staff 2.0
- TeamSTEPPS Simulation-Based Train the Staff 2.0
- Military Health System Surgical Quality Consortium
- Preventing Dental Patient Safety Errors through Improved Identification and Reporting of Events

PSPC: A key learning resource in the patient safety inventory is the PSPC. Patient safety professionals obtain their initial training through the PSPC, which they complete within the first year of assuming their role in an MTF. It is a week-long course hosted four times a year and provides them with evidence-based 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 prework module, five days of face-to-face training, post-training virtual coaching, and opportunities for continued development through a Patient Safety Manager Ongoing Learning Certificate. The PSPC curriculum is regularly updated to integrate HRO principles and foundational knowledge within the course content, to reflect the MHS transition and policy changes, and to keep attendees trained on the latest innovative health care information and resources. The PSPC has had proven success in training patient safety professionals. For example, in FY 2019, before completing the course, 24 percent of the participating patient safety professionals highly or very highly believed they could apply MHS HRO guiding principles at their facility. After the course, the percentage increased to 73 percent.

TeamSTEPPS: Teamwork failures are substantial contributors to 68 percent of patient harm events according to TJC, making them a major source of preventable medical errors. Developed by the DoD PSP in collaboration with AHRQ, TeamSTEPPS is 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. MTFs continue to provide opportunities for widespread training of team-based safe practices. The MTFs, with leadership actively engaged, are focusing on implementation and sustainment of the concepts, tools and strategies and the impact they may have on patients. In FY 2019, the DoD PSP led an effort to update the TeamSTEPPS Fundamentals curriculum and included key tools from the Air Force Medical Service Trusted Care initiative. As per the DHA-PM, TeamSTEPPS is identified as foundational to patient safety and is the MHS standard for maximally integrating teamwork principles into practice. The DoD PSP supports the MTFs with several adjuncts to learning, to include coaching, the TeamSTEPPS Teamwork Perceptions Questionnaire, badge cards, pocket guides, and tips and scenarios. The DoD PSP sponsors Active Duty and DoD civilian government employees to participate in the annual TeamSTEPPS conference, which includes a DoD breakout session. DoD participants discuss teamwork innovations and lessons learned at the DoD session as well as at the national conference sponsored by the American Hospital Association. Over the past year, DoD PSP equipped MTFs with 486 instructor guides and 595 leadership engagement tool kits for TeamSTEPPS.

High Reliability and Readiness – Service Example

Connecting High Reliability to Readiness

The Navy continues to move toward becoming an HRO through its Quality and Safety Leadership Academy (QSLA). The QSLA Cohort 5 brought together Navy Medicine leaders in support of quality, patient safety, and high reliability throughout the enterprise. In prior cohorts, the focus was to educate MTF Triads and Chief Medical Officers (CMOs). This cohort's purpose was to connect high reliability to readiness. In addition, Cohort 5 was designed to tailor to Navy Medicine's mission: support the readiness of the Operational Forces. In support of the mission, more than half of the Cohort 5 scholars consisted of Operations Forces medical personnel, and the leadership panel—previously represented by DHS Office of the CMO and regional CMOs—consisted of representation from the Medical Office of the Marine Corps and Fleet Forces.

Patient Safety: Program to Prevent Harm *(cont.)*

Equip

The DoD PSP provides several resources, including guidebooks, tool kits, and job aids to equip MTFs with the tools needed to improve patient safety. Two examples are shown below.

CLABSI: The MHS has made great strides in developing a formal infection prevention and control (IPC) structure, and efforts continue to be leveraged to drive progress through the DoD Infection Prevention and Control Working Group. Key deliverables and initiatives have focused on the development and systemwide implementation of evidence-based guidance for critical IPC processes. This includes the completion of a CLABSI tool kit, which is now integrated across all Services. The tool kit covers five key elements: 1) staff education, training, and engagement; 2) evaluation of procedural competence; 3) central line insertion and maintenance of procedures; 4) auditing of central line insertion, maintenance, and hand hygiene practices; and 5) leadership engagement and accountability.

Additionally, the organization boasts having established a standardized IPC competency model and continues to make progress in the standardization of formal training for infection preventionists.

MHS GENESIS and Patient Safety: The MHS is in the process of deploying the new EHR, MHS GENESIS. The DoD PSP engaged with the EHR team early in the deployment in FY 2019, resulting in the development and release of several materials, including a job aid, training deck, practice exercises, and communication materials that target patient safety professional transitioning to the new system. DoD PSP also participated in deployment training at the MHS GENESIS sites to educate around the appropriate and timely reporting and resolution of any patient safety issues that may arise due to EHR deployment.

Transparency

Transparency is key to patient safety improvement. The DoD PSP is making strides in increasing and improving the transparency of patient safety care and data for Service members and their families. Data transparency has been a big focus as DHA moves forward to stand up the markets and centralize the MTFs under a unified and centralized structure. MHS transparency efforts are described below and on pages 58 and 111.

Safety Event and Root Cause Analysis (SERCA): To share lessons learned and data from four data sources (JPSR, DoD REs, CDC NHSN, and GTT) between Services/DHA former tIMO and MTFs, the DoD has implemented the DHA SERCA tool. This tool allows designated users to view data for their own facilities and others across the MHS and access all CAs implemented for safety events across the DoD. This provides enhanced transparency, and MTFs have real-time visibility into what other facilities in the DoD are doing to prevent events and improve safety. The SERCA tool has over 500 active users and over 10,000 views since initial deployment in FY 2017.

MHS Patient Safety Culture Survey

Since 2005, the DoD PSP has administered the MHS Patient Safety Culture Survey approximately every three years across the MHS direct care system, and most recently in 2019. Adapted from the nationally recognized Surveys on Patient Safety Culture developed by AHRQ, the MHS Patient Safety Culture Survey is an anonymous, web-based self-reported questionnaire designed to assess staff perceptions of patient safety within their MTF work units. The survey assesses culture across several key dimensions, including leadership support, teamwork, staff empowerment, trust, and reporting and learning from errors. The DoD PSP administers the survey across all DoD hospitals, outpatient clinics, and dental facilities to all staff members, including Active Duty and Reserve personnel, contractors, government employees, and volunteers. The DoD PSP uses the data to define the current state of safety culture across the MHS, trend improvements over time, and identify opportunities for improvement.

The DoD PSP most recently administered the MHS Patient Safety Culture Survey from April 2019 to June 2019. For the 2019 survey, the DoD PSP added several new items to assess the role of staff burnout and resilience on safety culture and to further inform improvement strategies. The results from this survey are currently being analyzed, with results expected in early 2020. As with past culture survey iterations, the DoD PSP intends to provide MTFs with multiple resources, including a guidebook, learning webinars, and SME office hours, to help frontline staff members interpret their results and use them to advance their local safety culture toward high reliability.

Patient Safety: Program to Prevent Harm *(cont.)*

HRO Awards Program to Promote a Culture of Safety

The HRO Awards Program raises awareness, rewards successful efforts, inspires organizations, and communicates successes throughout the MHS. Ultimately, these awards support DoD on its journey to transform the MHS into an HRO. One quality of an HRO is a single-minded focus on identifying potential problems and high-risk situations before they lead to AEs. The PSP encourages and engages field members through the facilitation of the HRO Awards Program on a yearly basis. The award identifies 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. In 2019, there were a total of 101 submissions received for the awards program—the largest number of submissions ever received. By award discipline, these included 30 for Healthcare Quality, 33 for Patient Safety, 21 for Improved Access, and 17 for Patient Engagement. See below for the full breakdown of submissions across Army, Navy, Air Force, and the DHA former tIMO.

This year's award winners have been selected from various MTFs across the country. There were 10 winners selected for the Healthcare Quality Award and nine winners selected for the Patient Safety Award. In addition, several of the winning submissions are aligned with the Clinical Communities. Below is a short summary of the winning Healthcare Quality and Patient Safety Award submissions.

2019 HEALTHCARE QUALITY AND PATIENT SAFETY AWARD WINNERS

MILITARY TREATMENT FACILITY/ TRICARE REGIONAL OFFICE	AWARD-WINNING INITIATIVE
Naval Health Clinic Hawaii	Using HRO Principles to Improve Weight-Based Prescribing for Pediatric Patients
Naval Medical Center Portsmouth	Enhanced Recovery After Surgery – Establishment of an Institutional Protocol
96th Medical Group Eglin Air Force Base	Improvement of Surgical Outcomes through Implementation of ERAS Protocol
Naval Hospital Pensacola	Improving Accuracy and Speed of Urine Drug Testing in Opioid Therapy
Brooke Army Medical Center	Implementing Standardized Comprehensive Behavioral Health Screening in Military Primary Care Clinic
Brooke Army Medical Center	MRI TIA Protocol Order Change Reduces Cost and Redundant MR Angiographic Imaging: Preliminary Results
Brooke Army Medical Center	NICU Enteral Feeding Protocol: Impact on TPN and Central Line Days
Brooke Army Medical Center	Successful Implementation of an Antibiotic Audit and Feedback Program at a Tertiary Military Medical Center
Naval Medical Center Portsmouth	Sustainment and Standardization of PeriOP Surgical Quality Improvements to Support a Medically Ready Force
U.S. Naval Hospital Guantanamo Bay	Sterile Compounding Program Optimization
USCENTCOM Military Treatment Facilities	Infection Control Improvements in Deployed Medical Treatment Facilities
MEDDAC Bavaria	Improving Medication through Trending Near-Miss Errors
Naval Medical Center San Diego	Emergency Checklists – Improving Outcomes in Obstetric Emergencies
97th Medical Group Altus Air Force Base	Dental Readiness – Crossing Military Branch Barriers for Safe, Expedient, and Efficient Care
Naval Medical Center Portsmouth	Tissue Management Process
Keller Army Community Hospital	Pediatric Weight-Based Medication Dosing Errors
U.S. Naval Hospital Yokosuka	Blue Light Hazard Reduction Initiative Protects Patients and Staff
U.S. Naval Hospital Yokosuka	Master Privilege List Accuracy, Visibility, and Plasticity
Naval Medical Center Portsmouth	Short-Term Opiate Prescribing and Intraoperative Therapy

Total submissions received: 101

- **Healthcare Quality: 30**
  - Army: 7
  - Navy: 14
  - Air Force: 7
  - DHA former tIMO: 2
- **Patient Safety: 33**
  - Army: 12
  - Navy: 14
  - Air Force: 6
  - DHA former tIMO: 1
- **Improved Access: 21**
  - Army: 3
  - Navy: 13
  - Air Force: 4
  - DHA former tIMO: 1
- **Patient Engagement: 17**
  - Army: 4
  - Navy: 8
  - Air Force: 5
  - DHA former tIMO: 0

CLINICAL QUALITY MANAGEMENT IN THE MHS *(CONT.)*

Health Care Risk Management: Program to Address Risk

The focus of health care risk management is to promote safe and effective patient care, maintain a safe working environment, and protect financial resources using enterprise risk management and structured analytical processes.

The MHS Health Care Risk Management (HRM) Program promotes accountability, transparency, and standardization through support of the MHS strategy for managing clinical, operational, human capital, technical, and corporate compliance 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 Department of Defense Instruction (DoDI) 6025.13 and the DHA-PM 6025.13, and is the primary body for oversight of risk management processes and reporting to the NPDB paid malpractice tort claims, Active Duty death and disabilities associated with health care, adverse privileging actions, and administrative/criminal actions related to health care. The RMWG 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 implementation of health care risk management processes across the MHS.

Reporting to the NPDB. In FY 2019, 119 practitioners providing health care in MTFs worldwide were reported to the NPDB (reported by the Services to the MHS RMWG). As noted in last year's report (page 104), 113 practitioners were reported in FY 2018.

Credentialing and Privileging: Program to Assure Appropriate Credentials and Privileges

The Credentialing and Privileging (CP) Program serves as the foundation for quality and safe care by ensuring qualified and competent staff deliver care in a manner that is consistent with their education and training, and the scope of services approved by their organization. Through its activities and procedures, in close collaboration with the DHA HRM Program, the CP Program affirms DHA's commitment to drive increased transparency, accountability, and standardization. The CP Program details and manages the requirements for licensure, required credentials, and health care provider competency assessment. The CP Program supports the Privileging Authority and manages the privileging process, and liaises with HRM and other stakeholders to assure quality and safe care delivery in all health care settings and delivery modalities.

The CP executes primarily through the DoD's Centralized Credentialing and Quality Assurance System (CCQAS), which is a web-based application that serves as the single DoD global application for credentialing and privileging of MHS providers, and the DoD Joint Credentials Working Group purpose: to develop, promote, and provide oversight, direction, and guidance to improve the quality of the CP Program and manage CCQAS to serve and support the overall needs of the CP Program. Under the leadership of the CP Program and in collaboration with key stakeholders, the changes to the CCQAS system required to support the MHS transition are underway.

The DHA recently published the DHA-PM 6025.13 including Volume 4 defining procedures in the CP Program. Through the execution of the procedures defined in this volume, the CP Program will standardize credentialing and privileging processes throughout the DoD to gain efficiencies in provider sharing, as well as promote accountability. Similarly, the CP Program continues to collaborate closely with peers in the VA to increase the standardized and agile movement of providers between VA and DoD treatment facilities.

Accreditation and Compliance: Program to Address Compliance with Standards

MTF/TJC Accreditation, Top Five TJC Standards

The MHS is committed to the provision of safe, quality care to all beneficiaries. Utilization of health care industry standards to continually assess the care provided in the MHS serves as a foundation of CQM. The nationally recognized standards for health care organizations provide guidance for the development of policies and practices at MTFs. Civilian network health care facilities are contractually required to maintain accreditation by an approved accrediting organization. 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 is available publicly on the accreditation organization website, TJC Quality Check (www.qualitycheck.org). MTF survey completion dates and requirements for improvement to meet full accreditation are displayed at the Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA]) public-facing web portal, www.health.mil/AccreditationStatus. This transparency is consistent with standardized management across an enterprise journeying toward an HRO, and supports NDAA FY 2016, section 713 requirements.

DHA is establishing the DHA Accreditation and Compliance (AC) Program to manage and administer accreditation and compliance activities in MTFs formerly

CLINICAL QUALITY MANAGEMENT IN THE MHS *(CONT.)*

Accreditation and Compliance: Program to Address Compliance with Standards *(cont.)*

aligned with the Services. To establish the DHA AC Program, Service and DHA SMEs are working in close collaboration to develop program procedures based on the successes of the Service accreditation programs. The Services continue to support MTF accreditation activities during the development and staffing of the DHA AC Program.

MTF Accreditation

All fixed MTFs maintain health care accreditation by the authorized MHS direct care system health care accrediting organization (currently TJC) and use the standards relevant to the scope of care, treatment, and services provided. Accreditation survey teams consist of clinical, administrative, and facility specialty surveyors with expertise in application and assessment of the standards applicable to the facility. TJC standards assess both patient-focused functions and organizational functions; the most commonly utilized standards for MTF surveys are in the Comprehensive Accreditation Manuals for Hospitals, Ambulatory Care, Behavioral Health Care, and Home Care.

CHAPTERS IN TJC ACCREDITATION MANUALS

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

In the MHS, the largest number of health care accreditation surveys for 2018 were completed in MTFs providing ambulatory care, closely followed by hospital care and then behavioral health care. Only one MHS MTF participates in home care accreditation due to geographical location. As shown in the table below, 20 inpatient MTFs, 21 ambulatory care MTFs, and 17 behavioral health units underwent health care accreditation surveys in CY 2018 and all successfully achieved the outcome of fully accredited status.

MHS HEALTH CARE ACCREDITATION SURVEYS COMPLETED, BY TYPE AND YEAR

YEAR	HOSPITAL	AMBULATORY	BEHAVIORAL HEALTH	HOME CARE
2015	24	14	5	1
2016	17	35	10	0
2017	12	24	4	0
2018	20	21	17	1

Source: DHA/Medical Affairs/CSD, 12/23/2019

CLINICAL QUALITY MANAGEMENT IN THE MHS *(CONT.)*

Accreditation and Compliance: Program to Address Compliance with Standards *(cont.)*

TOP 5 TJC AMBULATORY STANDARDS CITED BY CHAPTER IN MTF SURVEYS, CYs 2014–2018

CY 2014	CY 2015	CY 2016	CY 2017	CY 2018
Medication Management	Environment of Care	Environment of Care	Environment of Care	Environment of Care
Environment of Care	Medication Management	Medication Management	Medication Management	Infection Prevention and Control
Leadership	Leadership	Infection Prevention and Control	Infection Prevention and Control	Medication Management
National Patient Safety Goals	Infection Prevention and Control	Provision of Care, Treatment, and Services	Provision of Care, Treatment, and Services	Provision of Care, Treatment, and Services
Human Resources	National Patient Safety Goals	National Patient Safety Goals	Record of Care, Treatment, and Services	Leadership

TOP 5 TJC HOSPITAL STANDARDS CITED BY CHAPTER IN MTF SURVEYS, CYs 2014–2018

CY 2014	CY 2015	CY 2016	CY 2017	CY 2018
Environment of Care	Environment of Care	Life Safety	Environment of Care	Environment of Care
Infection Prevention and Control	Life Safety	Environment of Care	Life Safety	Life Safety
Life Safety	Infection Prevention and Control	Provision of Care, Treatment, and Services	Provision of Care, Treatment, and Services	Provision of Care, Treatment, and Services
Provision of Care, Treatment, and Services	Provision of Care, Treatment, and Services	Infection Prevention and Control	Infection Prevention and Control	Infection Prevention and Control
Medication Management	Medication Management	Medication Management	Medication Management	Medication Management

Source: DHA/Medical Affairs/CSD, 12/10/2019

Health care accreditation surveys provide valuable feedback on the extent to which MTFs are compliant with applicable accreditation standards, National Patient Safety Goals, and participation requirements. The AC Program requires that MTFs are assessed for health care accreditation through an on-site survey process at least every three years.

Reports generated from on-site accreditation survey activities identify noncompliant standards and requirements for improvement, and require documented completion of action plans within prescribed time frames to demonstrate successful compliance with standards.

To drive transparency, accountability, standardization, prevention, and improvement, the AC Program, in collaboration with the Services, recently led the establishment of a health care accreditation survey data repository for all survey findings for MTFs over the past five years. The repository serves as a tool to share information between facilities, monitor for patterns or trends, and identify systemwide improvement opportunities. As shown in the tables on this page, the top five hospital and ambulatory findings provide areas for a focused analysis to identify common themes for improvement activities as well as continuous compliance monitoring.

The AC Program procedures require all MTFs to continuously assess and maintain compliance with accreditation standards, policy mandates, and regulatory requirements. An annual self-assessment of all the accreditation standards must be conducted, documented, and submitted to DHA by the MTF staff. Continuous compliance with health care accreditation standards contributes to the maintenance of safe, quality patient care, and improved performance.

In addition to the survey process for accreditation, TJC requires accredited hospitals to submit national clinical quality measures data to TJC on a quarterly basis. Each inpatient MTF selects the measures for data submission. Trained abstractors collect data centrally and report to the MTFs for analysis and improvement as indicated. As an example, the perinatal care measures are included in the WICC quality measures section of this report (see pages 119–120).

Clinical Laboratory Services Accreditation

Regulatory Compliance

Standards for the regulatory compliance of clinical laboratories in the MHS are established by DoDI and DoD Manual (DoDM) 6440.02, titled *Clinical Laboratory Improvement Program (CLIP),* and *Clinical Laboratory Improvement Program (CLIP) Procedures*, respectively, dated May 29, 2014. The CLIP conditions and standards are federal laboratory/Clinical Laboratory Improvement Amendments (CLIA) comparable. Memorandum of Understanding (MOU) 15-46, between the DoD and the Department of Health and Human Services (DHHS), recognizes that certain unique mission requirements exist within the DoD that are not found within the civilian sector and authorizes the establishment of comparable, but not necessarily identical, CLIA regulations within the DoD. This MOU is current for a six-year period beginning January 14, 2015. The regulatory compliance of clinical laboratories in the MHS is, in part, evaluated

CLINICAL QUALITY MANAGEMENT IN THE MHS *(CONT.)*

Accreditation and Compliance: Program to Address Compliance with Standards *(cont.)*

through inspections conducted by an accreditation organization that has been granted deeming authority by CMS's Division of Clinical Laboratory Improvement and Quality, such as the College of American Pathologists (CAP), Commission on Laboratory Accreditation (COLA), TJC, American Society for Histocompatibility and Immunogenetics, American Association for Laboratory Accreditation, as well as through periodic self-inspections.

The Joint-Service Center for Laboratory Medicine Services (CLMS), which was established in 1992, provides regulatory oversight for all DoD clinical laboratories and provides reports to the Deputy Assistant Director, Healthcare Operations, DHA, and the Services' Surgeons General, on a periodic basis and when requested. The office also manages a DoD contract with the Clinical and Laboratory Standards Institute, providing access to consensus-based standards regarding the management and operation of clinical laboratories.

All MTF-based clinical laboratories are accredited by CAP per requirements in the DoDI and DoDM. Non-MTF clinical laboratories are inspected by CAP or one of the other deemed accreditation organizations, or their regulatory compliance is assessed via an alternative inspection method as determined by CLMS. Accreditation inspections are unannounced for the majority of the clinical laboratories, and are conducted on a two-year (biennial) cycle.

The DoDM currently specifies key conditions that place more stringent requirements on DoD's clinical laboratories, such as requiring the performance of proficiency testing for all laboratory tests, to include those in the waived complexity category. The DoDM also requires accreditation inspections of DoD's clinical laboratories that operate under the authority of waived or provider-performed microscopy (PPM) certificates. At present, CMS does not require inspection of their waived- or PPM-certificate laboratories, nor does it require proficiency testing for tests conducted within those laboratories. The application of these more stringent requirements within the DoD means that more of the MHS's clinical laboratories are assessed and accredited for proficiency testing when compared to the U.S. civilian-sector clinical laboratories.

In FY 2019, CLMS concluded the process of reviewing the DoDM to assure the DoD's policies, conditions, and standards regarding clinical laboratory regulatory compliance were current and updated as compared to CLIA, as implemented by Title 42, Code of Federal Regulations, Part 493. The updated document will be reviewed by the Division of Clinical Laboratory Improvement and Quality at DHHS to ensure the CLIP standards and requirements are essentially equivalent to those in CLIA.

Accreditation Performance

In FY 2019, 100 percent of all MHS clinical laboratories on the cycle for inspection were reaccredited. Scores for accreditation and proficiency testing are summarized below.

MHS CLINICAL LABORATORY ACCREDITATION SCORES, BY SERVICE, FY 2019

SERVICE	# OF LABORATORIES INSPECTED	ACCREDITATION SCORE AVG.	PROFICIENCY TESTING SCORE
Army	58	99.34%	98.43%
Air Force	48	99.43%	98.28%
Navy	62	99.26%	97.20%

Source: DHA/Medical Affairs/CSD, 12/13/2019

Overall, the MHS's clinical laboratories outperformed the CAP average as it pertains to inspection accreditation rating, and are within 0.03 percent of the CAP average in proficiency testing scores. As in FY 2018, the top area identified for improvement during inspections was the documentation of staff's competency assessment.

Although the DoD deficiency rate for this requirement is lower than the average for all laboratories inspected by the CAP, CLMS has included a web-based application in its new contract with CAP for individual sites to utilize and improve documentation compliance with this standard.

CLINICAL QUALITY MANAGEMENT IN THE MHS *(CONT.)*

Blood Bank Services Accreditation

The regulatory compliance of Blood Bank Services in the MHS is, in part, evaluated through inspections conducted by an accreditation organization that has been granted deeming authority by CMS's Division of Clinical Laboratory Improvement and Quality. 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 and CAP. If the MTF has blood transfusion operations, the Transfusion Service is registered with the FDA, and inspections are performed based on the services provided. All MTFs that perform transfusion operations are mandated to be accredited by CAP and AABB, and inspections are performed based on the services provided. Additionally, Blood Bank Services are assessed under relevant TJC standards during the survey process and annual self-assessments.

Stringent quality oversight is conducted by the Service Blood Program Offices. MTF QA personnel also conduct internal audits to track performance on an ongoing basis and conduct annual training on Current Good Manufacturing Practices (cGMPs) to ensure each blood product is collected and manufactured in accordance with FDA regulations. Complaints are investigated, root causes identified, and improvements implemented. Performance monitoring and continuous improvement are key to quality assurance in Blood Bank Services.

As in FY 2019, 100 percent of the Armed Services Blood Program (ASBP) centers maintained FDA licensure and registrations, as well as AABB and CAP accreditations. The Transfusion Services at two Army MFTs met the requirements needed to help the MTFs obtain certification as Level One and Level Two Trauma Centers. The Armed Service Blood Program Division established a quality assurance section. The quality assurance section manager will create a portal for submission of all FDA, CAP and AABB inspections. The submitted inspection findings and or citations will provide an enterprise quality assessment of the Transfusion Service and Blood Donor Centers that will identify repeat non-conformance or citations. The quality assurance manager will provide guidance for corrective actions to be taken and continual process improvement. An Armed Service Blood Program Quality Plan will be created and published as a reference for the Services Blood Programs for implementation at Blood Donor Centers and Transfusion Services. The quality assurance manager will establish metrics to monitor overall quality assurance in the Transfusion Service and Blood Donor Centers.

CLINICAL QUALITY MANAGEMENT IN THE MHS *(CONT.)*

Clinical Measurement

The Clinical Measurement (CM) Program is an integral and integrating part of the CQM system. The goal of CM is to objectively define and measure the quality of care provided in the MHS. CM is composed of three distinct programs: internal assessment of the quality of health care delivered; participation in external quality assessment programs and partnerships with other federal partners and CQM organizations; and facilitation of MHS transparency efforts including Health.mil and Leapfrog Hospital Survey participation.

CM activities include internal assessment of quality care delivered, identification of improvement opportunities, and comparative analysis with benchmarks from professional organizations. In addition to using measures to assess the quality and safety of care delivered, CM is used to identify trends, serve as the basis of studies, and focus quality improvement efforts in performance plans across the health care delivery system. CM provides point-of-care providers, clinical support staff, and MHS leadership with the data and information needed to assess clinical quality processes, outcomes, patient perceptions, and organizational structure and systems.

Assessment of clinical quality is dependent on the utilization of a variety of external and internal CM sets. The use of nationally recognized consensus measures provides consistency of methodology and the potential for comparison with established benchmarks. Where no nationally recognized consensus measures exist, the MHS develops measures to support strategic priorities and the MHS Quadruple Aim, and to provide insight into a variety of care functions and settings. Additionally, evidence-based practice guidelines, such as those produced collaboratively by the VA and the DoD, provide critical input to guide clinical measurement.

The information gathered from measurement informs leaders and providers on the quality of care in the MHS. Analysis of measurement data provides insights on the level of clinical quality strategic goal attainment, alignment with organizational priorities, and effectiveness of CQM programs. CM data are displayed throughout the CQM section and in various other sections included in this report.

National (External) Clinical Quality Programs and Databases

On October 1, 2014, the Access, Quality of Care, and Patient Safety Memorandum was signed by the SECDEF. This memorandum directed the DHA to establish an MHS performance management system. The objective was to drive improvement throughout the enterprise for identified common executable goals and develop dashboard measures that address all areas covered by the MHS review. Participation in strategically selected national databases, such as the National Surgical Quality Improvement Program (NSQIP®), was identified as a means to significantly contribute to meeting this requirement.

The DoD's participation in national clinical quality programs provides powerful tools to systematically assemble large volumes of individual and population patient care data that are used to enhance health care quality, delivery of care, clinical decision support, and cost improvement initiatives. The databases extract data from multiple sources, providing a broader range of information and increasing the opportunities for greater performance improvement analysis and quality/safety measurements.

The DoD currently participates in 12 clinical quality programs and databases:

- American College of Surgeons (ACS) NSQIP Adult Program
- ACS NSQIP Pediatric Program
- ACS Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP)
- ACS Trauma Verification, Review, and Consultation (VRC) Program; and Trauma Quality Improvement Program (TQIP)
- Ambulatory Surgical Center Quality Reporting Program
- National Cardiovascular Data Registry (NCDR)
- American Society of Clinical Oncology (ASCO) Quality Oncology Practice Initiative
- National Perinatal Information Center (NPIC) Data Base
- NHSN
- Hospital Compare
- Targeted Solutions Tool
- TJC National Hospital Measure

This list is evolving and expanding as programs are selected based on their contributions to improving the quality and value of care for MHS beneficiaries.

As described throughout the CQM section, MHS clinical measurement results data are found on the following websites: Leapfrog (https://www.leapfroggroup.org); Hospital Compare (https://www.medicare.gov/hospitalcompare); Health.mil (https://health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Patient-Portal-for-MHS-Quality-Patient-Safety-and-Access-Information); and TJC Quality Check (https://www.qualitycheck.org/).

CLINICAL QUALITY MANAGEMENT IN THE MHS *(CONT.)*

Clinical Measurement *(cont.)*

Transparency

MHS transparency efforts are described in detail on page 58 in association with high reliability. The DHA became the first federal agency to participate in the Leapfrog Group's Hospital Survey in 2018 with Walter Reed National Military Medical Center participation and with multi-facility (Walter Reed National Military Medical Center, Womack Army Medical Center, Fort Belvoir Community Hospital, 81st Medical Group at Keesler Air Force Base, and Naval Hospital Jacksonville) participation in November 2019. Plans are being made for additional MTFs to begin participation in 2020–2021.

Clinical Quality Improvement

The DHA supports the MHS with a CQI program responsible for establishing an infrastructure to enable frontline staff to systematically identify, implement, and sustain data-driven and evidence-based quality improvement initiatives. The overarching goal of the CQI program is to ensure that quality improvement is strategically aligned to support an integrated system of readiness and health to optimize patient outcomes. The CQI program is supported by a dedicated clinical quality performance measurement system from the DHA Clinical Quality Measures program and the DHA performance management system to evaluate the quality of care outcomes to identify actionable improvement opportunities for the MHS.

The CQI program is a new function in CQM at DHA with three main objectives identified to provide oversight of CQI initiatives in collaboration with the Clinical Communities. First, the CQI program leverages CQM foundational elements to support strategic quality planning sessions aligned to the QPP. The CQI program organized the first quality planning session with review of existing performance data and MTF quality improvement projects to finalize top priorities from each Clinical Community that provided input to the FY 2021 QPP development. In addition, the CQI program will integrate existing programs for the VA/DoD Evidence-Based Practice Work Group (EBPWG) and CQI studies (CQIS) into the new structure supporting CQM as enabling expertise for the Clinical Communities. Both EBPWG and CQIS programs function at the DHA headquarters level with results of improvement studies and CPGs being shared with the MTFs through the market structure. Finally, in collaboration with all CQM programs, the CQI program is developing workforce competencies in CQM and a knowledge management (KM) capability to support the MHS as a learning organization.

In order to maximize value and reduce waste by aligning improvement priorities in support of the DHA strategy, the CQI program partnered with the Clinical Communities Advisory Council (CCAC) to provide oversight of MHS CQI initiatives and standardize health care practices across the MHS in support of the HRO journey.

The QPP is the enterprise-wide planning process that integrates capabilities in strategic planning, performance planning, financial operations, performance improvement, and decision-making. QPP supports alignment of the market and MTF activities to the Quadruple Aim of Improved Readiness, Better Care, Better Health, and Lower Cost. Improvement initiatives prior to the QPP used Service-specific guidance, which resulted in variances in performance and limited learning across the MHS. The new QPP process will achieve efficiencies by using DHA strategic priorities to determine resource decisions. The CQI program is currently supporting the evaluation of four different FY 2020 market QPP plans that were recommended for enterprise solution consideration. Further, the CQI program organized the prioritization of top quality improvement initiatives from the Clinical Communities, which ultimately provided input to the CQI requirements in the FY 2021 QPP. The CQI program developed the QPP supplemental guide and associated training to define requirements for performance targets in support of existing and pending policies that support Clinical Community initiatives.

Clinical Quality Improvement *(cont.)*

Empowering individuals to use evidence-based tools and improvement science to help identify improvement opportunities and promote data-driven improvement behaviors throughout the system is a foundational capability of the CQI program. The success of the MHS HRO journey requires a workforce equipped with core competencies in health care quality, patient safety, and quality improvement. The CQI program is establishing a training and education function to build improvement capability across the DHA that will enhance the development of sustained learning and improvement with a focus on CQM professionals.

In support of the MHS as a continuous learning system, the CQI program is responsible for the development of a CQM-specific KM capability to promote transparency and enable enterprise learning and accountability. To that end, the CQI program is creating a collaborative SharePoint website for communication and exchange of CQM activities. The DHA KM platform continues to evolve through adoption of best practices from all existing Service KM platforms with the goal of enabling MHS performance improvement professionals to engage with one another and share performance improvement best practices.

The MHS is also involved in conducting CQIS designed to validate and improve processes and outcomes of the care delivered to beneficiaries, to include the analysis and comparison of the performance of MHS direct care and purchased care with civilian national benchmarks, whenever available. The goal is to conduct two studies per fiscal year with proposed topics originating from data analysis, evolving evidence-based practice, and MHS Clinical Communities. The two FY 2018 quality improvement studies are as follows:

- **Patient Population with Opioid Overdose Events, FY 2016–FY 2017**

  This quality improvement study evaluated whether clinicians used risk reduction strategies in the 90 days following an index opioid-related overdose in FY 2015 and then determined the effectiveness of the strategies to prevent a second opioid-related overdose in the subsequent 12 months. Opioid risk reduction strategies in direct and purchased care were compared to guidance published in the VA/DoD Pain Management CPG. The results are pending at this time. Final data will be shared with all stakeholders including the Pharmacy Operations Division, CQM, and Pain Management Clinical Support Service, to identify and implement potential improvement opportunities.

- **Screening for Maternal Depression Among Direct Care Beneficiaries**

  Based on abstraction of FY 2017 maternal and pediatric records, this quality improvement study examined the frequency of screening for maternal depression during prenatal, postnatal, and pediatric visits to MTF health care providers; examined rates of referral to mental health (MH) specialists following a positive screen; and compared rates and patterns of screening and MH specialists as recommended in the VA/DoD Management of Pregnancy CPG and the American College of Obstetricians and Gynecologists (ACOG) guidelines. The results found a need to increase screenings at regularly timed intervals using the VA/DoD guidelines. All women with positive screening assessments were referred to MH specialists. Recommendations were presented to the WICC in November 2019 with pending implementation plan.

The CQI program will assume the DoD program management of the joint VA/DoD EBPWG, which is chartered through the Health Executive Committee (HEC) Professional Development Business Line reporting to the Joint Executive Committee. The EBPWG is responsible for using clinical and epidemiological evidence to improve the health of the population across the Veterans Health Administration (VHA) and MHS. This partnership facilitates the development of tool kits for clinicians and patients to promote continuous learning. In FY 2019, four CPGs were developed with accompanying video training modules, located on the VHA Employee Education System (EES) training platform for use by both DoD and VHA: hypertension; osteoarthritis of the hip and knee; dyslipidemia; overweight and obesity. VA/DoD CPGs consistently receive national recognition including the ECRI Institute's Guidelines Trust approval.

HIGH RELIABILITY OPERATING MODEL/CLINICAL COMMUNITIES

Primary Care Clinical Community

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.

VA and DoD 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. Multiple CPGs have been developed and updated to provide practitioners with information and tool kits to support evidence-based practice. VA/DoD CPGs are available at www.healthquality.va.gov/. To enhance its availability and use, CPG information is embedded into the EHR as clinical decision support. 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.

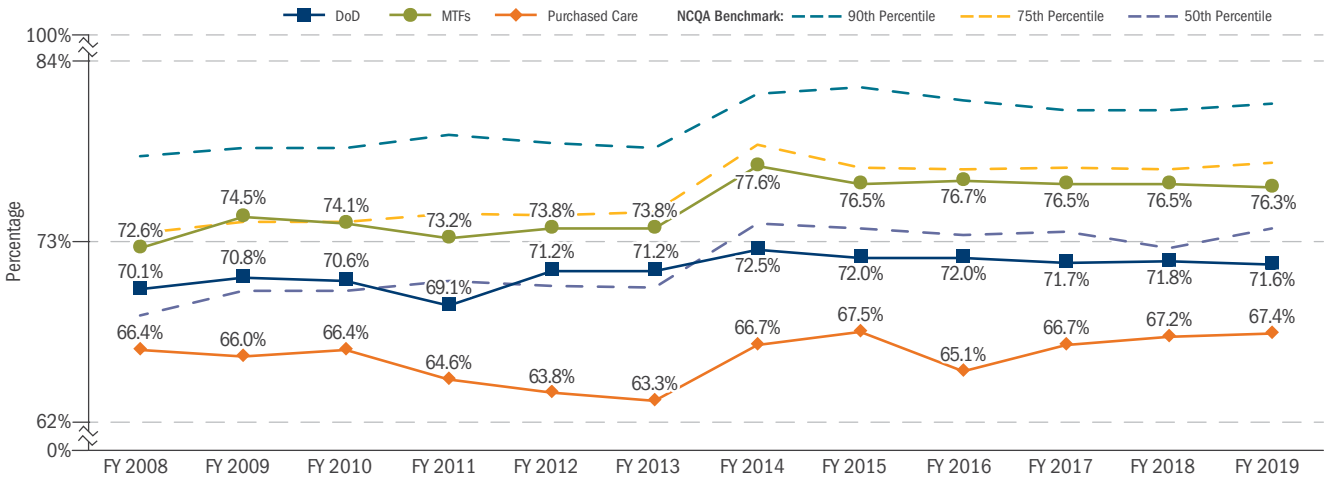
Additionally, the MHS monitors the performance of primary care services with a variety of nationally recognized quality measures. The NCQA Healthcare Effectiveness Data and Information Set (HEDIS) includes primary care–focused health plan measures with methodologies. HEDIS is a tool used by America's 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 measure methodology, as well as performance data at the system, Service, region, clinic, and provider level. The HEDIS methodologies used by CarePoint are reviewed annually by an NCQA HEDIS auditor for validation and certification.

MHS leadership, from MTF staff through the respective Services, to DHA and the Surgeons 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. 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 efforts to improve performance.

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. Breast cancer screening is at the NCQA 50th percentile and is within two percentage points of reaching the 75th percentile in direct care. Cervical cancer screening is at the 75th percentile for direct care. Purchased care improved performance on breast cancer and cervical cancer screening in FY 2019. Initiatives to streamline appointments, engage patients, and optimize technology are underway to continue to improve compliance with these important clinical service screenings. For cervical cancer screening, major measure specification changes in FY 2014 resulted in a break in previous benchmark applicability and is noted in the chart to follow.

BREAST CANCER SCREENING, FYs 2008–2019

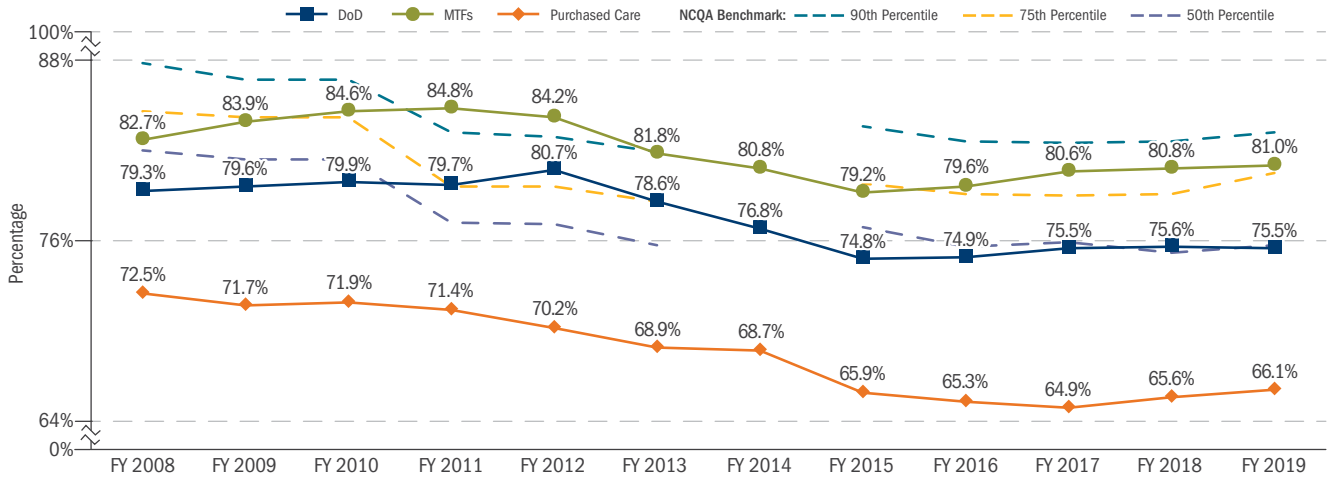


Source: DHA/Medical Affairs/CSD, 12/3/2019

HIGH RELIABILITY OPERATING MODEL/CLINICAL COMMUNITIES *(CONT.)*

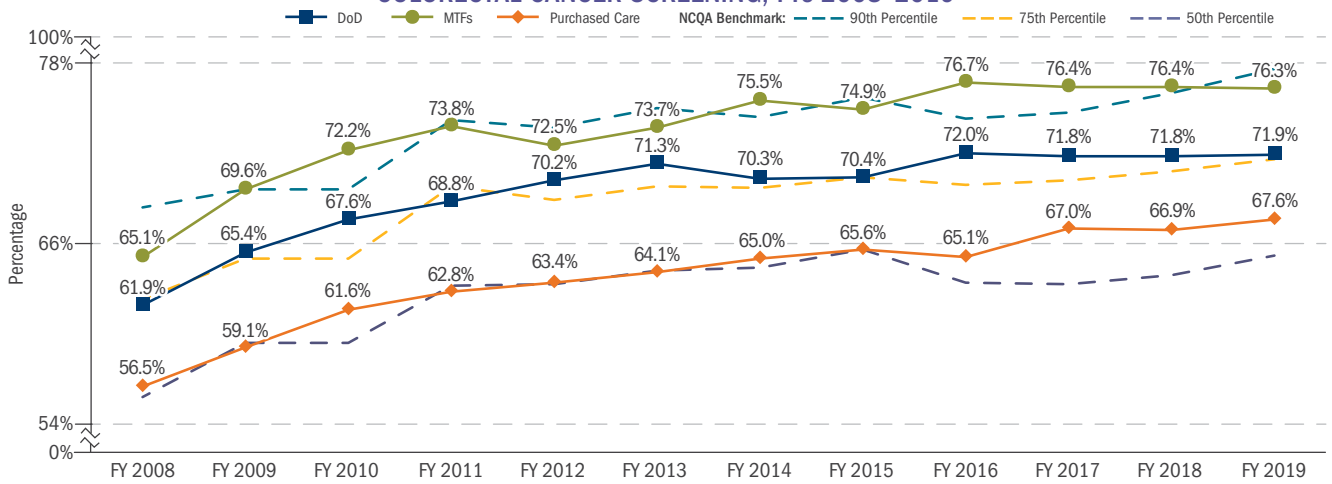
Primary Care Clinical Community *(cont.)*

CERVICAL CANCER SCREENING, FYs 2008–2019



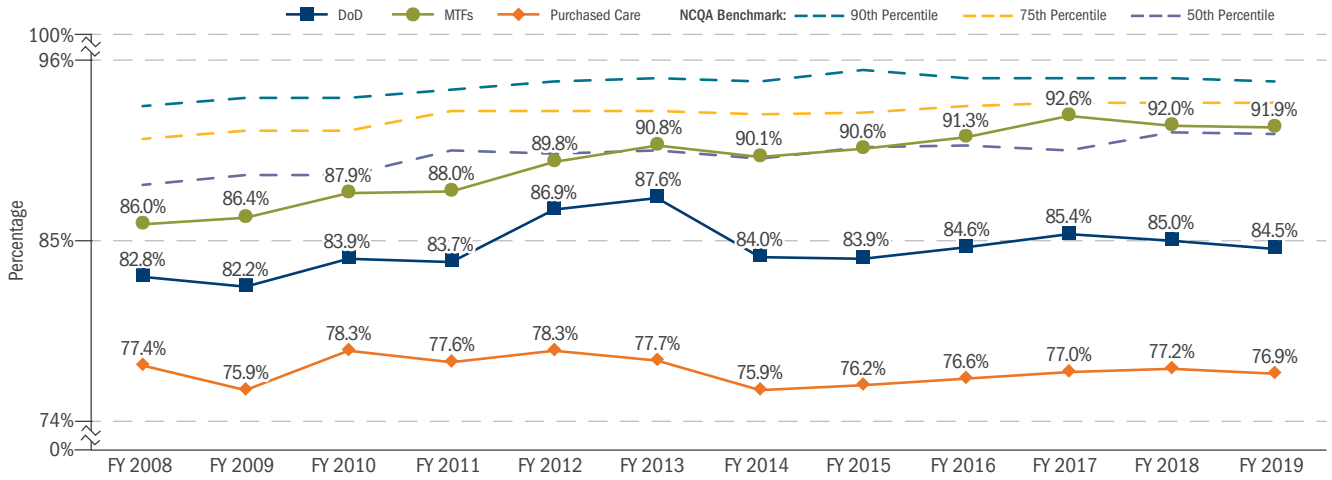
- **Colorectal Cancer Screening:** HEDIS measure focused on detecting colorectal cancer as well as screening for premalignant polyps to prevent cancer. MHS direct and purchased care rates have improved in colorectal cancer screening over time. MHS direct care MTF rates are 1.3 percentage points from the NCQA 90th percentile in FY 2019; purchased care rates are consistent with the NCQA 50th percentile.

COLORECTAL CANCER SCREENING, FYs 2008–2019



- **Diabetes HbA1c Screening:** HEDIS measure focused on annual testing to help health care providers with care for the common and serious chronic disease of diabetes. The MHS continues to work to improve the management of diabetic patients. The FY 2019 rate of performance for direct care facilities is consistent with the NCQA 50th percentile and is 1.5 percentage points from the 75th percentile.

DIABETES HbA1c SCREENING, FYs 2008–2019

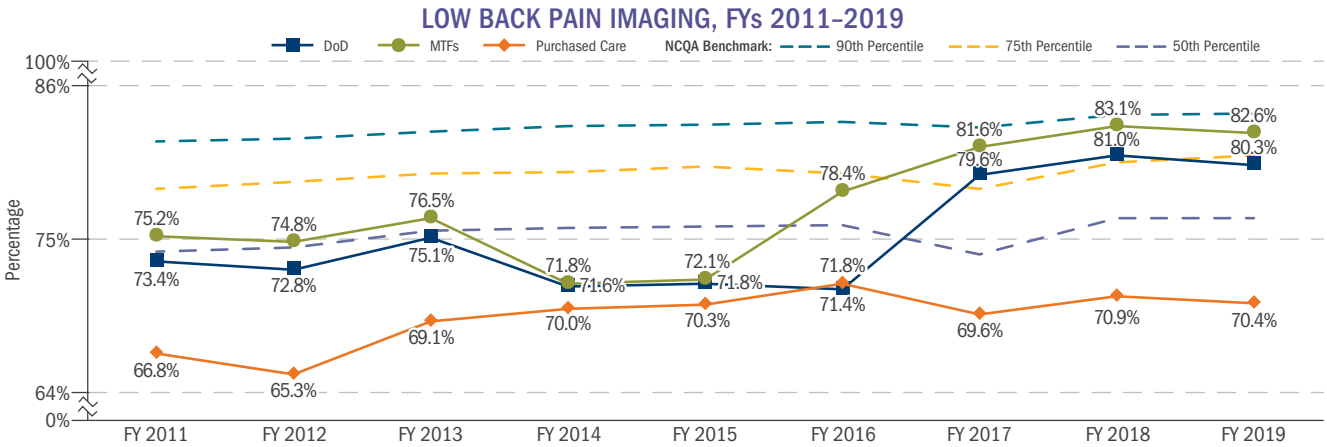


Source: DHA/Medical Affairs/CSD, 12/3/2019

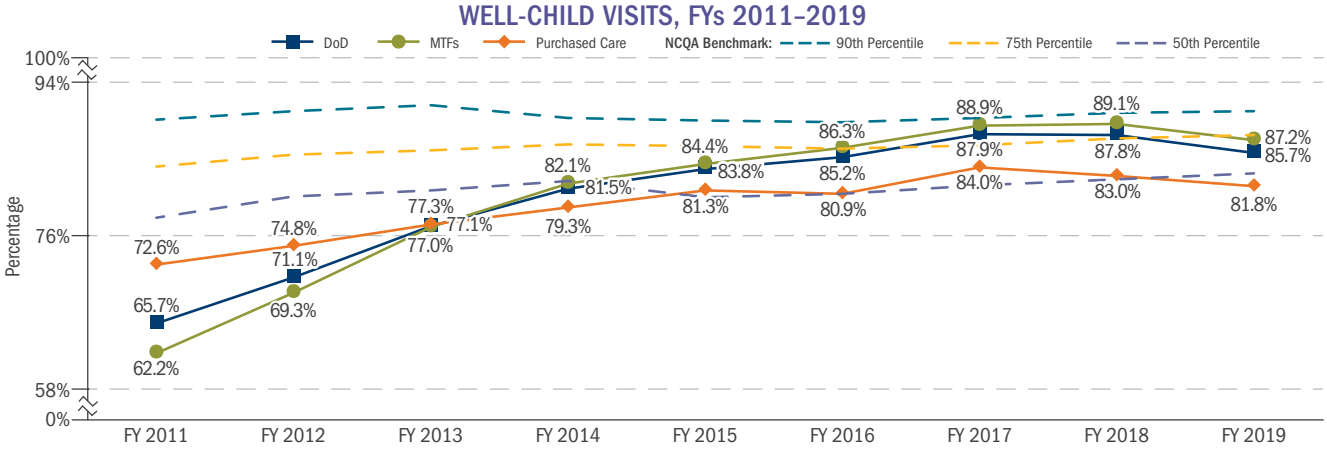
HIGH RELIABILITY OPERATING MODEL/CLINICAL COMMUNITIES *(CONT.)*

Primary Care Clinical Community *(cont.)*

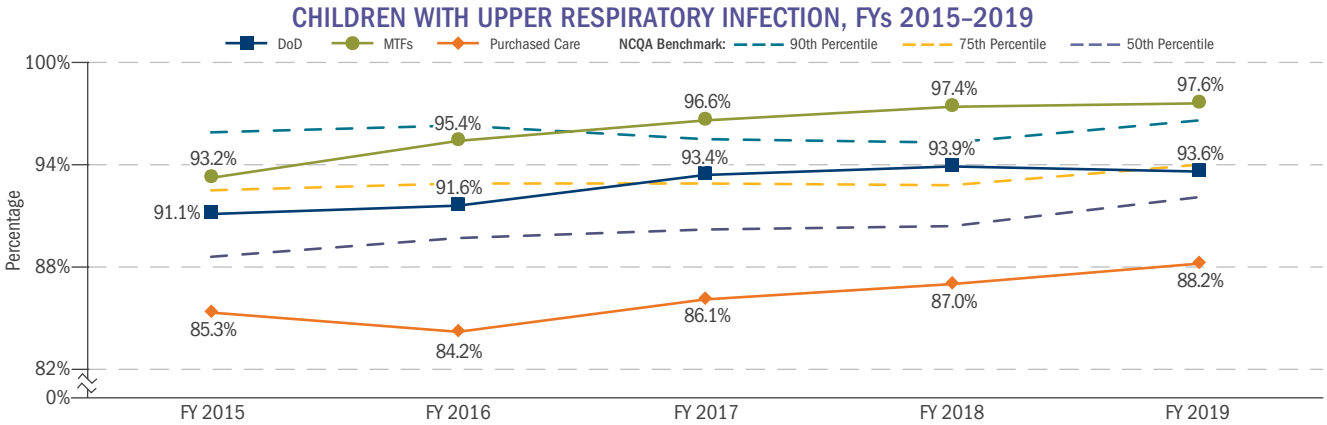
- **Low Back Pain Imaging:** HEDIS measure focused on overuse of imaging for acute low back pain. MHS has integrated the VA/DoD low back pain CPG into the EHR to support providers with improvement initiatives. Performance reporting capabilities were developed for each level of care, MTF, provider team, and individual provider to support feedback. The FY 2019 rate of performance for direct care facilities is consistent with the NCQA 75th percentile and is near the 90th percentile, while the purchased care provider performance saw a slight decrease from the previous year.



- **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 are in the NCQA 50th percentile in FY 2019 and are near the 75th percentile. The purchased care providers are near the 50th percentile.



- **Children With Upper Respiratory Infection:** HEDIS measure focused on the prevalence of inappropriate antibiotic prescribing and on increasing awareness of the importance of antibiotic stewardship to prevent antibiotic resistance. The rate of performance for direct care facilities in FY 2019 is within the NCQA 90th percentile. The purchased care provider performance improved from the previous year.

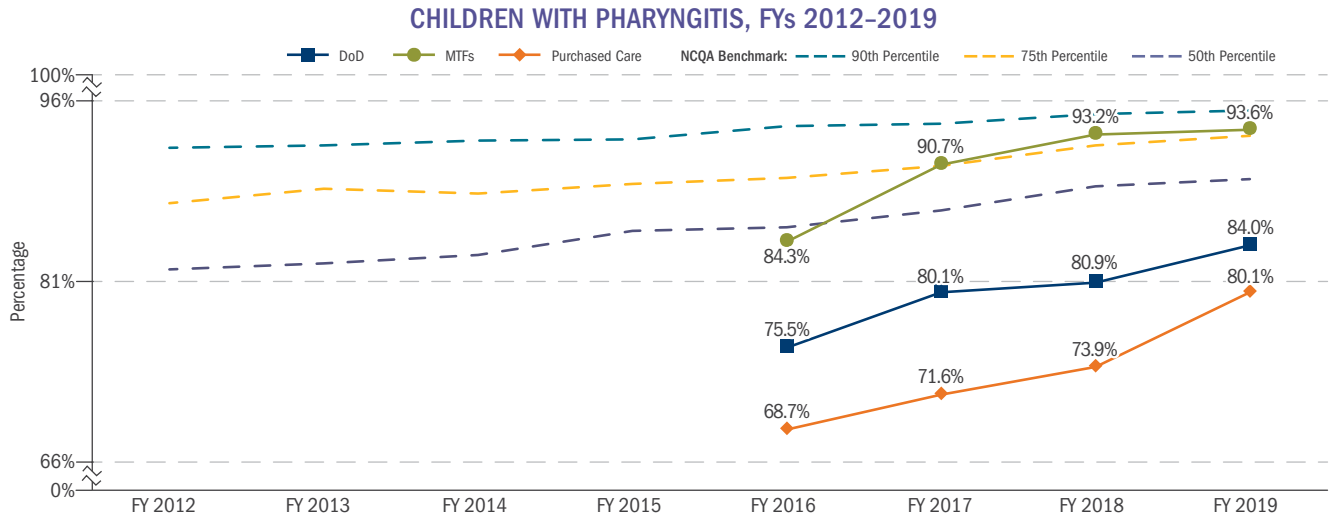


Source: DHA/Medical Affairs/CSD, 12/3/2019

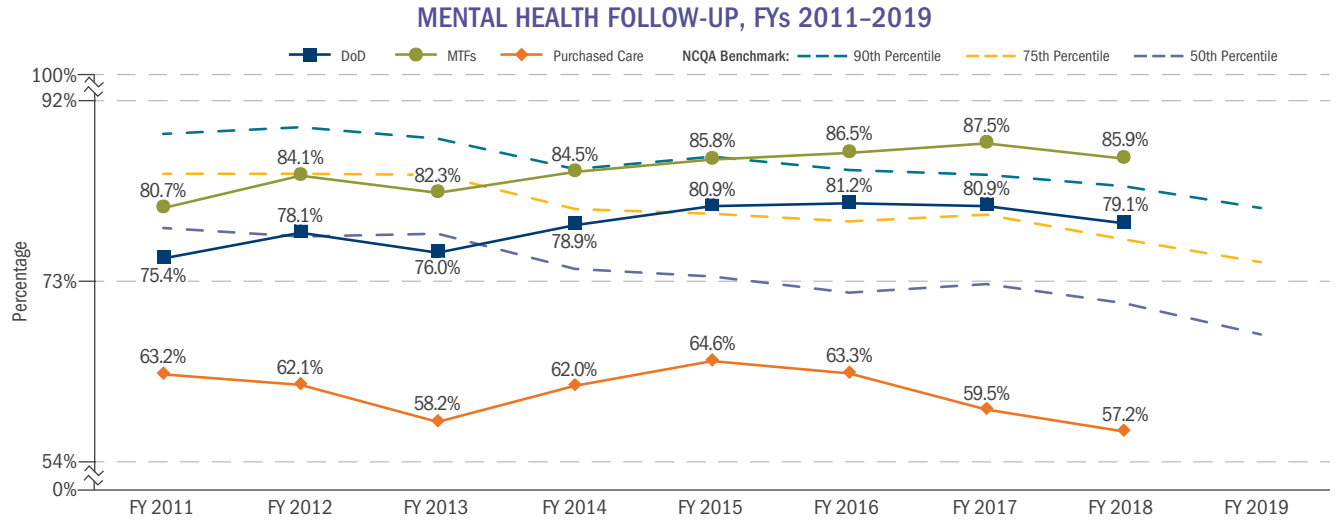
HIGH RELIABILITY OPERATING MODEL/CLINICAL COMMUNITIES *(CONT.)*

Primary Care Clinical Community *(cont.)*

- **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. The FY 2019 rate of performance for direct care facilities is consistent with the NCQA 75th percentile, while the purchased care provider performance improved substantially from the previous year. Rates for children with pharyngitis are available for previous years; however, prior to FY 2016, rates were aggregated based on MTF enrollment and not by treatment place of care. The chart below reflects the transition to place of care attribution for data reporting in FY 2016 and in subsequent years following the attribution change.



- **Mental Health Follow-Up:** This HEDIS measure examines 30-day MH follow-up care in the MHS MTF and purchased care venues. Due to changes in technical specifications resulting in code rewrites and validation issues, the 7- and 30-day MH follow-up data is not available for FY 2019. It is anticipated that this data will be available for future annual reports.



Source: DHA/Medical Affairs/CSD, 12/3/2019

HIGH RELIABILITY OPERATING MODEL/CLINICAL COMMUNITIES *(CONT.)*

Primary Care Clinical Community *(cont.)*

MHS performance on HEDIS measures, which includes direct and purchased care TRICARE Prime and TRICARE Plus enrolled beneficiaries, demonstrates an ongoing effort to improve the care provided across the system. Measures requiring laboratory results such as Diabetes A1c and Chlamydia Screening reflect direct care only, whereas claims is the source of data for purchased care measures.

MHS performed well compared with national HEDIS benchmarks, obtaining the national 90th percentile benchmarks for Diabetes A1c Level <7% and <8%, and the 75th percentile for Colorectal Cancer Screening, Chlamydia Screening, and Diabetes A1c Level ≤9%. The percentages in the MHS HEDIS Benchmark Performance table below for any given year differ from those in the Adult HEDIS Measures charts on the preceding pages as the calculations are based on different enrollee groups. Overall MHS performance shown below includes TRICARE Prime and Plus enrollees to facilities containing an Army, Navy, Air Force, or DHA facility service codes, along with TRICARE Prime enrollees to Defense Medical Information System Identifiers (DMIS IDs) associated with an MCSC, USFHP, or Coast Guard facility service code. Direct care, purchased care, and DoD performance calculations (pages 113–116) only include TRICARE Prime beneficiaries and do not include Coast Guard facilities.

MHS HEDIS BENCHMARK PERFORMANCE, JUNE 2014–JUNE 2019

HEDIS MEASURE	2014	2015	2016	2017	2018	2019	2014 TO 2015 CHANGE	2015 TO 2016 CHANGE	2016 TO 2017 CHANGE	2017 TO 2018 CHANGE	2018 TO 2019 CHANGE	HEDIS BENCHMARK STATUS (2019)
Mental Health												
Mental Health Follow-Up: 30 Days	78.10%	78.86%	81.08%	80.90%	77.68%	–	0.76	2.22	-0.18	-3.23	–	–
Mental Health Follow-Up: 7 Days	62.41%	64.01%	68.03%	69.03%	61.31%	–	1.60	4.01	1.01	-7.73	–	–
Pediatric												
Well-Child: 6 or More Visits	80.85%	83.09%	84.09%	87.09%	88.25%	85.95%	2.24	1.01	2.99	1.16	-2.30	★★★
Children with Pharyngitis	76.04%	73.04%	74.91%	79.31%	80.89%	83.76%	-3.00	1.87	4.41	1.57	2.87	★
Children with Upper Respiratory Infection	89.07%	90.48%	91.32 %	93.32 %	93.79%	93.64%	1.42	0.84	2.00	0.47	-0.15	★★★
PCMH												
Breast Cancer Screening	72.65%	72.27%	72.08%	71.59%	71.84%	71.70%	-0.38	-0.19	-0.49	0.24	-0.14	★★
Cervical Cancer Screening	77.13%	74.38%	74.73%	75.24%	75.32%	75.38%	-2.75	0.35	0.51	0.08	0.06	★★
Colorectal Cancer Screening	70.64%	70.91%	71.81%	73.27%	72.18 %	72.36%	0.27	0.91	1.46	-1.09	0.18	★★★★
Chlamydia Screening	58.33%	62.36%	64.43%	65.41%	65.68%	66.50%	4.03	2.07	0.97	0.27	0.82	★★★★
Low Back Pain Imaging	71.49%	71.38%	76.36%	78.70%	80.56%	80.48%	-0.11	4.98	2.34	1.86	-0.07	★★★
Diabetes Screening	84.24%	83.68%	84.30%	84.94%	85.31%	84.60%	-0.57	0.62	0.65	0.37	-0.71	★
Diabetes A1c Level <7%	50.21%	48.52%	48.33%	46.82%	47.29%	46.80%	-1.69	-0.18	-1.51	0.47	-0.49	★★★★★
Diabetes A1c Level <8%	68.10%	67.69%	67.87%	66.90%	67.75%	67.62%	-0.40	0.17	-0.96	0.84	-0.13	★★★★★
Diabetes A1c Level ≤9%	76.71%	76.77%	77.31%	76.70%	77.93%	77.21%	0.06	0.54	-0.61	1.22	-0.71	★★★★

Source: MHS Population Health Portal, June 2019

Notes:

– 2014=Rates for June 2014; 2015=Rates for June 2015; 2016=Rates for June 2016; 2017=Rates for June 2017; 2018=Rates for June 2018; 2019=Rates for June 2019.
– Rates include TRICARE Prime and TRICARE Plus enrollees to Army, Air Force, Navy, DHA, MCSCs, Coast Guard, and associated USFHP DMIS IDs.
– Rates for "Mental Health Follow-Up" 30- and 7-day rates for 2019 are currently unavailable due to ongoing methodological review and code validation.
– Statistical Testing: Two-sample Z test; Green or Red: statistically significant at p=0.05 level.
– 2017 and 2018 data exclude the MHS GENESIS initial operating capability (IOC) sites.
– Sites that have transitioned to MHS GENESIS use as of June 2019 were removed for 2017–2019.
– 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

Neuromusculoskeletal Clinical Community

The mission of the Neuromusculoskeletal Clinical Community (NMSKCC) is to optimize the neuromusculoskeletal health and readiness of the force by enabling efficient business practices and data-driven decisions to decrease clinical practice variation, improve outcomes, and ensure a high-quality, consistent patient experience. The NMSKCC provides leadership to the patient-centered, clinician-led neuromusculoskeletal networks that span all Service components, environments, and care-impacting areas from headquarters through MTFs. The NMSKCC is the MHS proponent for improving readiness through comprehensive neuromusculoskeletal, TBI, and amputation/extremity trauma care. Standardizing care of common conditions, such as low back pain and mild TBI or concussion, is a focus area for DHA's NMSKCC.

The NMSKCC, via the Traumatic Brain Injury Advisory Committee (TAC), developed the Acute Concussion Care Clinical Pathway in September 2018. The primary foci of the pathway are: (1) early identification, assessment, and management of acute concussion; (2) patient and provider education on screening procedures and tools; and (3) progressive return to activity. Referral to a National Intrepid Center of Excellence is also an option if further intervention is required. Early identification and treatment of concussions can prevent long-term negative consequences to cognitive, psychological, and physical functions. The Services' TBI leads and the Defense and Veterans Brain Injury Center worked to modernize an acute concussion screening tool (Military Acute Concussion Evaluation 2 [MACE2]) and updated the Concussion Management Tool (CMT). The MACE2 incorporates state-of-the-science advances in concussion evaluation, with particular focus on vestibular and oculomotor areas. The CMT is a revision of the previous concussion management algorithm to further drive modernized concussion management. Four pilot sites have been identified, with data collection planned from November 2019 to January 2020, prior to enterprise implementation later in 2020 or early 2021.

The NMSKCC is developing the musculoskeletal data portal (MDP) to collect and analyze patient outcomes. The MDP seeks to establish an enterprise-wide system for reliable collection of validated patient-reported outcome measures related to musculoskeletal conditions that have the greatest impact on readiness, disability, and well-being. Using the MDP in evidence-based medical care and analyzing patient-reported outcome data will help define the best care pathways for various musculoskeletal health conditions and allow for an assessment of the return on value (ROV) for specific elements of care.

The NMSKCC is also working to implement a Low Back Pain Clinical Pathway to decrease care variability and return Soldiers to duty faster. The pathway focuses on patient outcomes, in line with high reliability principles. The pathway seeks to facilitate early access to physical therapy, which has been shown to improve patient outcomes and reduce cost and additional utilization of health care resources. The pathway aims to improve pain management and the patient experience through the reduction of unnecessary imaging, opioid prescriptions, and pain-related disability. Pilot sites are currently being determined, with anticipated initial data collection in the first quarter of 2020.

HIGH RELIABILITY OPERATING MODEL/CLINICAL COMMUNITIES *(CONT.)*

Women and Infant Clinical Community

Women and Infant Initiatives

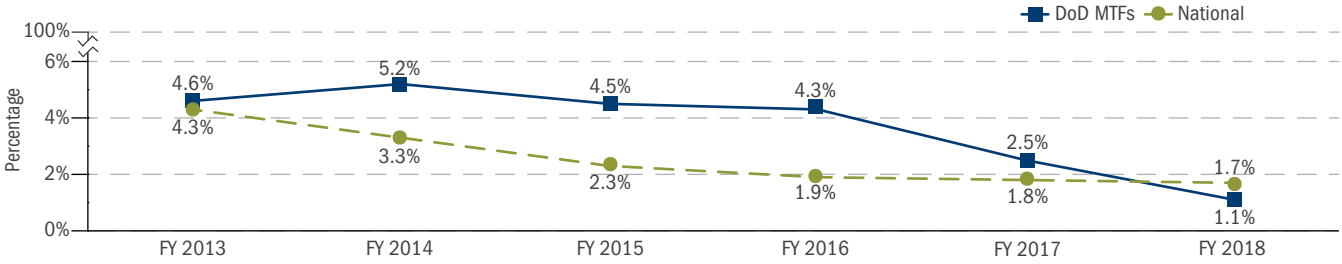
The Women and Infant Clinical Community (WICC) promotes readiness, process improvement, maximum value, and desired patient outcomes, while catalyzing innovation and eliminating preventable harm and waste. It is organized by readiness-critical or high-volume, high-risk, high-variability groups of interrelated processes related to the care of women and infants, and aligns related clinical specialty work. The WICC oversees and reviews data and clinical outcomes related to women's health issues, specifically perinatal (maternity) and infant (birth to one year of age) care. It was developed from the Perinatal Advisory Working Group (PAG), and is continuing PAG initiatives to decrease the severity and impact of PPH. The WICC, utilizing national collaboratives, has leveraged existing bundles to standardize the assessment, readiness, response, and treatment of multiple maternal and infant conditions to improve outcomes for families. The PCMH model tracks and reviews population health metrics of women's health (including breast and cervical cancer screenings), and pediatrics (well-child visits in the first 15 months of life). The WICC collaborates with other Clinical Communities to ensure that the metrics and care quality for all women and children are optimized, linking all beneficiaries into a complete continuum of care.

Perinatal Care Measures

Perinatal care is a high-volume specialty in the MHS. Nationally recognized measures are continually monitored at the enterprise, community, and MTF levels to assess the quality and safety of perinatal care provided across the system for both community-based and MTF-based care. A variety of the perinatal care measures used are endorsed by the NQF, TJC, and AHRQ. The collection and submission of perinatal quality measures data to TJC are required to meet accreditation requirements.

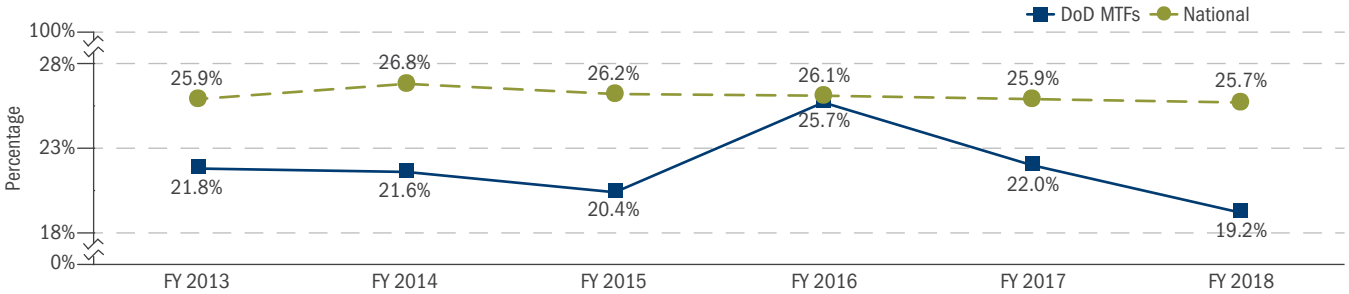
- **Elective Delivery:** This measure (PC-01) focuses on improving the health and outcomes of infants and mothers by avoiding nonmedically indicated early elective births (before 39 weeks gestation). Elective inductions result in more cesarean births, longer maternal LOS, and increased short-term neonatal morbidity. DoD MTF rates have continued to decrease over the past five years (lower is better).

DoD HOSPITAL QUALITY MEASURE: ELECTIVE DELIVERY PC-01, FYs 2013–2018



- **Cesarean Rates:** This measure (PC-02) focuses on safe and appropriate use of cesarean delivery for women who have not previously given birth and have a nulliparous, term (39 weeks), singleton, vertex cesarean delivery. The goal of the measure is to reduce risk and increase safety for mothers and infants. DoD MTF rates continue to decrease and be below the national rates (lower is better).

DoD HOSPITAL QUALITY MEASURE: CESAREAN SECTION PC-02, FYs 2013–2018



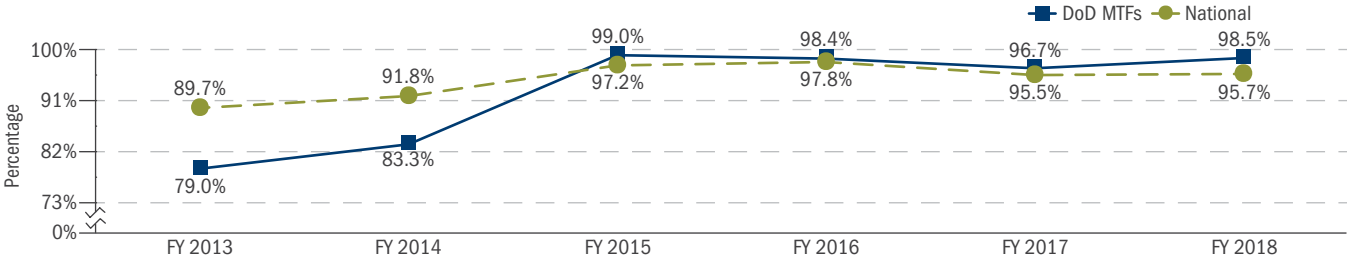
Sources: for DoD MTFs, DHA/Medical Affairs/CSD, 12/16/2019; for National, TJC/TJC Connect/Performance Measurement System Extranet Track (PET), 12/13/2019

HIGH RELIABILITY OPERATING MODEL/CLINICAL COMMUNITIES *(CONT.)*

Women and Infant Clinical Community *(cont.)*

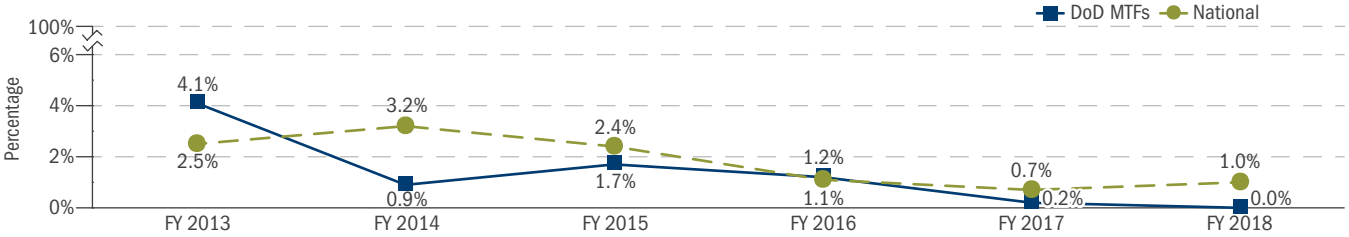
- **Antenatal Steroids:** This measure (PC-03) focuses on providing mothers at risk of preterm delivery (≥24 and <34 weeks gestation) with steroids prior to delivering preterm newborns. The steroids improve the lung function in premature infants. DoD MTF rates for the past four years are slightly better than the national rate (higher is better).

DoD HOSPITAL QUALITY MEASURE: ANTENATAL STEROIDS PC-03, FYs 2013–2018



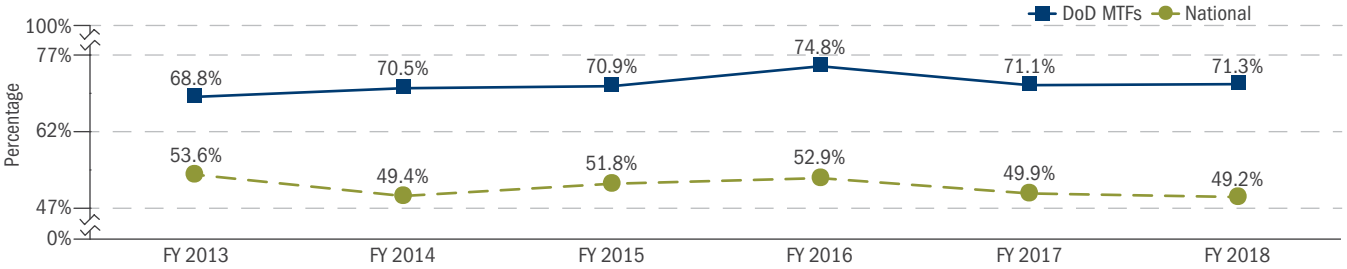
- **Newborn Bloodstream Infections:** This measure (PC-04) focuses on monitoring HAIs in newborns to identify opportunities for improvement. The DoD continually strives to eliminate HAIs through the use of evidence-based preventive measures. The DoD MTF rate has been at or below the national rate for the past two years (lower is better).

DoD HOSPITAL QUALITY MEASURE: HEALTH CARE–ASSOCIATED BLOODSTREAM INFECTIONS IN NEWBORNS PC-04, FYs 2013–2018



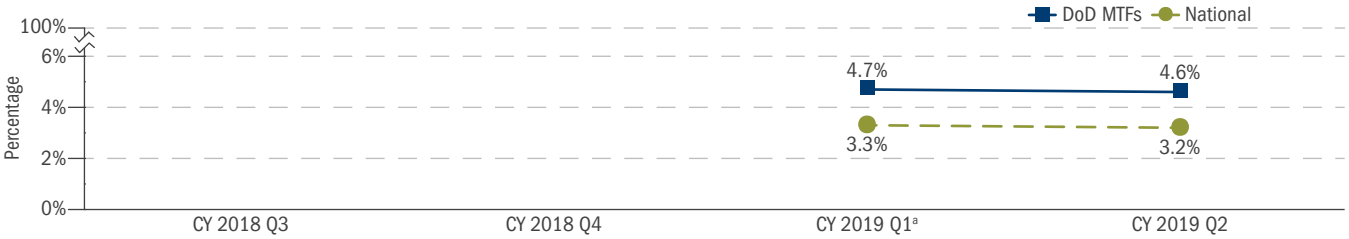
- **Breastfeeding:** This measure (PC-05) focuses on exclusive breastfeeding for newborns during the entire hospitalization. The World Health Organization and national leaders in pediatric and obstetric care note the benefits of breastfeeding an infant for the first six months of life. Early initiation of breastfeeding is critical for successful exclusive breastfeeding. DoD MTF performance on this measure continues to significantly surpass the national rate (higher is better).

DoD HOSPITAL QUALITY MEASURE: EXCLUSIVE BREASTFEEDING PC-05, FYs 2013–2018



- **Unexpected Complications in Term Newborns:** This measure (PC-06), beginning January 1, 2019, focuses on complications that would prevent families from bringing home a healthy baby. This metric combines many potential complications to assess the health outcomes of term infants with no preexisting conditions, who represent over 90 percent of all births (lower is better).

DoD HOSPITAL QUALITY MEASURE: UNEXPECTED COMPLICATIONS IN TERM NEWBORNS PC-06, CY 2018 Q3–CY 2019 Q2



Sources: for DoD MTFs, DHA/Medical Affairs/CSD, 12/16/2019; for National, TJC/TJC Connect/PET, 12/13/2019

[a] As of CY 2019 Q1, rates are calculated using TJC Specifications Manual v2018B1, www.jointcommission.org.

HIGH RELIABILITY OPERATING MODEL/CLINICAL COMMUNITIES *(CONT.)*

Women and Infant Clinical Community *(cont.)*

Perinatal metrics are aggregated and analyzed through a contract with NPIC. NPIC provides benchmarks in the general obstetrical and neonatal populations where no national benchmarks are available. Analyses are provided quarterly to each of the 47 MTFs with obstetrical services, aggregated up to the Service and DHA enterprise level. The analyses reflect over 100 perinatal metrics for the direct care component. Purchased care component data are tracked by NPIC semiannually for community-based facilities that deliver care to 150 or more TRICARE beneficiaries. Purchased care data elements allow comparison of care quality and outcomes between MTF- and network-based care in regions and markets.

NATIONAL PERINATAL INFORMATION CENTER COMPARATIVE DATA ALL SERVICES COMBINED, CY 2018 Q3–CY 2019 Q2

	CY 2018 Q3			CY 2018 Q4			CY 2019 Q1			CY 2019 Q2		
Total Deliveries	9,574			8,906			8,611			8,068		
Maternal Outcome Measures	**MHS Avg**	**NPIC Avg**		**MHS Avg**	**NPIC Avg**		**MHS Avg**	**NPIC Avg**		**MHS Avg**	**NPIC Avg**	
Inpatient Quality Indicator (IQI) 33 Primary Cesarean Delivery Rate	12.8%	18.2%	●	14.1%	18.3%	●	14.5%	18.2%	●	13.4%	18.6%	●
Postpartum Hemorrhage (PPH) Rate	4.2%	4.5%	●	4.2%	4.7%	●	3.6%	4.6%	●	4.2%	4.4%	●
Severe Maternal Morbidity Overall Rate	1.9%	2.0%	●	2.2%	2.1%	●	2.1%	2.1%	●	2.3%	2.1%	●
Maternal Readmit Rate to Delivery Hospital	1.9%	1.3%	●	1.6%	1.1%	●	1.7%	1.2%	●	1.8%	1.3%	●
Total Neonates	10,001			9,459			9,086			8,508		
Neonatal Outcome Measures	**MHS Avg**	**NPIC Avg**		**MHS Avg**	**NPIC Avg**		**MHS Avg**	**NPIC Avg**		**MHS Avg**	**NPIC Avg**	
Total Unexpected Newborn Complications (UNC) Rate[a]	4.8%	3.2%	●	5.0%	3.2%	●						
Inborn Readmit Rate to Delivery Hospital	3.8%	1.0%	●	4.1%	1.1%	●	3.9%	1.3%	●	4.3%	0.9%	●
Inborn Mortality ≥2,000 Grams (Per 1,000 births)	0.0%	0.2%	●	0.2%	0.2%	●	0.2%	0.2%	●	0.1%	0.2%	●

[a] After CY 2018 Q4, no NPIC data are displayed as rates are currently calculated using TJC Specifications Manual v2018B1, www.jointcommission.org. CY 2019 Q1 and CY 2019 Q2 TJC Unexpected Complications in Term Newborns rates can be found on page 120.

Note: For all measures, lower rates/scores are better.

GREEN indicates the MHS average rate is better (equal to or lower) than the NPIC/Quality Analytic Service (QAS) rate.

RED indicates the MHS average rate is worse (higher) than the NPIC/QAS rate.

NUMBER OF MTF NPIC MEASURE OUTLIERS, CY 2019 Q1 & CY 2019 Q2

NPIC MEASURE OUTLIER	ARMY	NAVY	AIR FORCE	NCR
Severe Maternal Morbidity Overall Rate	0	0	0	0
Maternal Readmit Rate to Delivery Hospital	1	0	0	0
Inborn Readmit Rate to Delivery Hospital	5	5	4	2

Source: DHA/Medical Affairs/Clinical Support Division, 2/21/2020

RED indicates the number of Service-aligned MTFs that performed worse (higher) than the NPIC/QAS rate for the two consecutive quarters shown (CY 2019 Q1 and CY 2019 Q2).

MHS Average and NPIC/QAS Database Rates for IQI 33 are the sum of all numerators/sum of all denominators (case level rates). For all other measures, the MHS Average 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).

NPIC Average is an unweighted average from all NPIC/QAS civilian hospitals in the database.

IQI 33 (AHRQ): Overall rate of cesarean deliveries, regardless of the number of deliveries a woman has had; MHS continues to have lower rates of cesarean sections than the NPIC benchmark.

PPH (based on American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance standardized definition). The MHS average continues to be lower than the NPIC benchmark. The MHS continues to focus its attention on PPH and is actively working to implement the Alliance for Innovation on Maternal Health Patient Safety Bundle on Obstetric Hemorrhage at select MTFs. The MHS has added the metric of Severe Maternal Morbidity to align with national concerns in the multiple conditions that can impact a mother's health during pregnancy and delivery.

Maternal and Infant Readmission to Delivery Hospital: Occurs within 30–42 days of delivery; related to delivery process. Hypertension and jaundice are the most common causes for readmission nationwide. The most prominent readmission diagnosis is hypertension (40 percent) for mother and jaundice (43 percent) for newborn. The primary readmission diagnosis is consistent with NPIC, but the volume is higher in the MHS; likely related to readmissions to help families without local support or with a deployed spouse. Readmission work continues to be reviewed in collaboration with MHS's overall readmission project.

Inborn Mortality ≥2,000 Grams (per 1,000 births) remains lower than the benchmark for term (2,000 g) infants born in MTFs.

HIGH RELIABILITY OPERATING MODEL/CLINICAL COMMUNITIES *(CONT.)*

Behavioral Health Clinical Community

Developing the Behavioral Health HROM

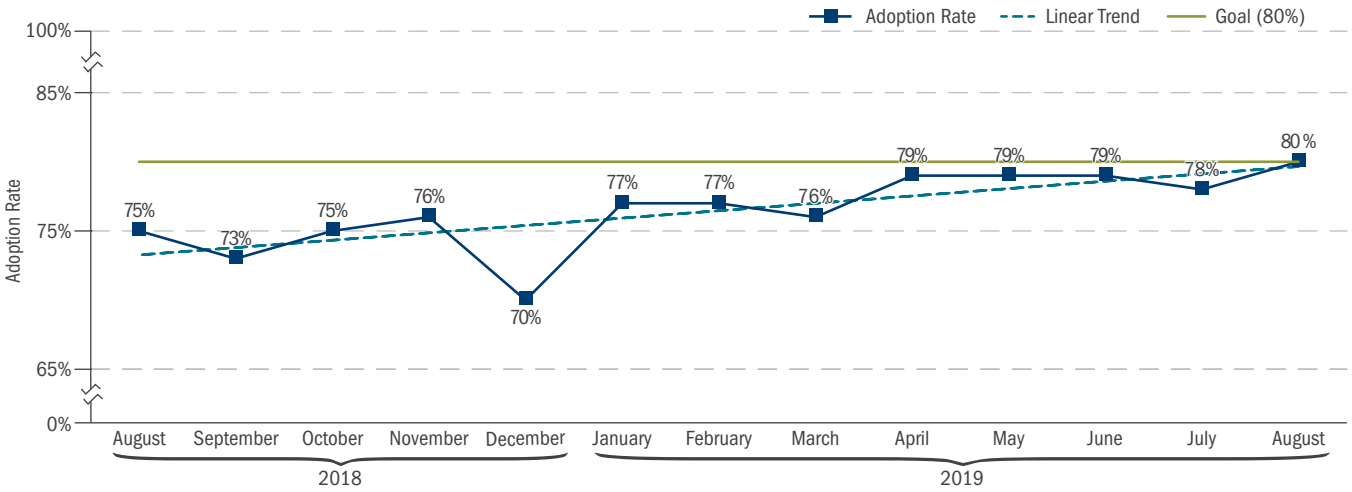
The Behavioral Health Clinical Community (BHCC) was chartered under DHA Healthcare Operations on November 8, 2017 and meets biweekly, with executive sessions including only core members in the off-weeks followed by backbriefs to the entire group. The BHCC Chair and other voting members are Directors of Psychological Health from Army, Air Force, Navy, and a representative from one of the markets under authority, direction, and control of the DHA; all are active in clinical practice. BHCC membership also consists of consulting members from other DoD stakeholder offices whose missions pertain to behavioral health. The fields of psychiatry, psychology, and social work are all represented within BHCC's membership to inform multidisciplinary decision-making.

To attain its objectives, BHCC established working relationships with persons and entities with the following types of enabling expertise: analytics, change management, clinical informatics, education and training, health information technology, process improvement, quality, and patient safety. Strategic partners include DoD Psychological Health Center of Excellence, Uniformed Services University, Military Operational Medicine Research Program, TRICARE, and VA.

Since its inception, BHCC has focused on standardizing MHS behavioral health policy and implementing programs to advance improved outcomes and safe, quality behavioral health care. Specifically, the following progress has been made:

1. **Behavioral Health Treatment and Outcomes Monitoring:** The NDAA FY 2016, section 729 and a 2013 Assistant Secretary of Defense Memorandum, "Military Treatment Facility Mental Health Clinical Outcomes Guidance," required the DoD to collect behavioral health treatment-specific outcome measurements, and assess behavioral health outcomes, variations, and barriers to VA/DoD CPGs. To meet these requirements, the DHA published DHA-PI 6490.02, "Behavioral Health Treatment and Outcomes Monitoring." DHA-PI 6490.02 sets outcomes monitoring requirements in specialty care behavioral health, substance use disorder (SUD), and primary care clinics at MTFs. The types of metrics required by DHA-PI 6490.02 for collection, reporting, and analysis include: structure (i.e., equipment and training compliance), process (i.e., treatment dosage rate, evidence-based treatment rates), and clinical outcome metrics (i.e., improvement and/or remission in major depressive disorder and PTSD.
2. **BHDP Implementation:** BHDP is an enterprise-wide web application that enables standardized behavioral health assessments and outcome tracking in behavioral health clinics. Use of BHDP allows for real-time graphing of outcomes measures for clinical care, consolidation of data from multiple sources into one clinician dashboard, and aggregation of data for meaningful program evaluation. Improving performance on the metrics for BHDP Adoption Rate, Behavioral Health Treatment Dosage Rate, and Positive Outcome Rate are DHA FY 2020 QPP initiatives. Enterprise-wide, the BHDP Adoption Rate trended upward in FY 2019 (see chart below), and BHCC efforts are underway to continue improving performance on this metric.

DoD BHDP ADOPTION RATE, AUGUST 2018–AUGUST 2019

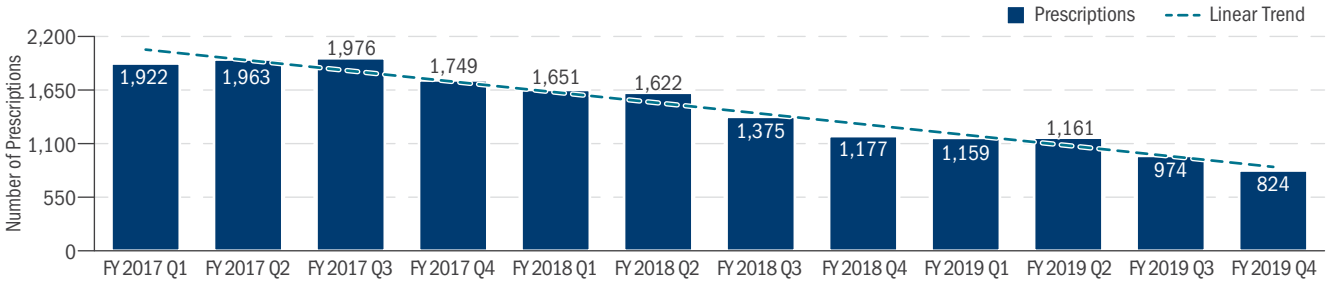


Source: DHA/Medical Affairs/CSD, 10/11/2019

Behavioral Health Clinical Community *(cont.)*

1. **PTSD Prescriber Tool:** NDAA FY 2017, section 745 required the DoD to implement a process to monitor MTF prescribing practices of pharmaceutical agents that are discouraged from use under the VA/DoD CPG for the Management of PTSD and Acute Stress Disorder, such as benzodiazepine (BZD). BHCC developed a PTSD Prescriber Profile that identifies, on a quarterly basis, individual providers who write a high number of BZD prescriptions to patients with PTSD. The overall number of BZD prescriptions written to patients with PTSD declined almost every quarter in FY 2018 and FY 2019, resulting in a reduction of more than 50 percent over this time period (see chart below).

NUMBER OF PRESCRIPTIONS FOR BZD TO BENEFICIARIES DIAGNOSED WITH PTSD, FYs 2017–2019



Source: DHA/Medical Affairs/CSD, 12/10/2019

Behavioral Health Update: Availability of MH and SUD Services for Eligible TRICARE Beneficiaries

Both direct and purchased care MH and SUD services continue to experience the benefit of the final rule "TRICARE; Mental Health and Substance Use Disorder Treatment," which was published on September 2, 2016. This final rule contained comprehensive revisions to the TRICARE regulation to reduce administrative barriers to accessing MH benefit coverage and to improve access to SUD treatment for all TRICARE beneficiaries. The expanded benefit continues to mature in network development and beneficiary usage. In FY 2018, partial hospitalization program (PHP) utilization remained fairly flat. However, MH intensive outpatient program (IOP) and residential treatment center (RTC) use increased sharply, with MH IOP encounters increasing nearly fourfold, and the number of RTC stays more than doubling.

Total MHS expenditures for MH and SUD care increased by approximately 1 percent from FY 2017 to FY 2018. In particular, three types of MH and SUD services had large changes in expenditures in FY 2018: autism care (primarily Applied Behavior Analysis [ABA] services) increased by 17 percent, pharmacy services decreased by 11 percent, and other types of MH and SUD services (i.e., IOPs, PHPs, RTCs, SUD rehabilitation facilities [SUDRFs], and opioid treatment programs [OTPs]) increased by 26 percent.

Similar to FY 2017, TRICARE beneficiaries had 8.2 million outpatient mental health visits, 70 percent of which occurred in purchased care and 30 percent of which occurred in the direct care system. Specific observations include:

- For inpatient MH services, approximately 78 percent of inpatient stays occurred in purchased care and 22 percent in direct care.
- Direct care inpatient services decreased by 1 percent while purchased care inpatient stays increased by 2 percent.
- Three beneficiary categories (ADSMs, Active Duty family members [ADFMs], and non-Active Duty dependents [NADDs]) had an increase in purchased care MH encounters, and NADDs had the largest increase for SUD encounters (16 percent). ADSM outpatient SUD encounters decreased by 13 percent.
- Thirty-three percent of all inpatient MH encounters were for a primary diagnosis of major depressive disorder.
- Both MH and SUD outpatient (non-autism) services had increases in expenditures (3 percent for MH and 13 percent for SUD).
- The seven most common outpatient MH diagnoses accounted for 80 percent of all MHS MH outpatient expenditures (autism accounted for 23 percent and PTSD accounted for 7 percent of total outpatient expenditures, ranking first and seventh, respectively).
- Alcohol-related disorders were one of the only conditions that were more commonly treated in direct care; ADSMs primarily used the direct care system for SUD treatment instead of other settings, such as SUDRFs and OTPs, which are only available in purchased care.
- OTP visits increased from 522 in FY 2017 to 882 in FY 2018 (a 69 percent increase) but still made up a very small share of SUD care. NADDs accounted for 76 percent of all OTP encounters.

Behavioral Health Clinical Community *(cont.)*

Pharmacy utilization is defined as MH medications, including drugs used for medication-assisted treatment (MAT). In FY 2018, pharmacy utilization was most common among NADDs, who were more likely to fill prescriptions at purchased care pharmacies. NADD purchased care scripts accounted for 77 percent of all MH prescriptions. In FY 2018, there was a 3 percent decrease in the number of prescriptions. Pharmacy utilization was more common among older populations, with 62 percent of prescriptions for adults filled by adults aged 45 and older. The most common therapeutic class of medications prescribed was anti-depressants.

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

In response to section 714 of the NDAA FY 2013, this section of the report builds on 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.

ABA services continue to be one of many TRICARE-covered services to treat ASD. Other services include, but are not limited to, speech and language therapy, occupational therapy, physical therapy, medications, and psychotherapy.

In June 2014, TRICARE published the Comprehensive Autism Care Demonstration (ACD) Notice in the Federal Register on the approval of the Office of Management and Budget, and in compliance with the regulations that govern TRICARE demonstration projects. Based on limited demonstration authority, in July 2014, the ACD consolidated the three previous ABA programs into a single program for eligible TRICARE beneficiaries. This consolidated demonstration ensures consistent ABA coverage for all TRICARE beneficiaries—including 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, and there are no annual caps of government cost shares. These changes attempt to strike a balance that maximizes access while ensuring care at the highest level of quality for our beneficiaries. An extension through December 31, 2023, for the demonstration was approved via a Federal Register Notice on December 11, 2017. The Notice stated that additional analysis and experience is required to determine the appropriate characterization of ABA services as a medical treatment, or other modality, under the TRICARE program coverage requirements. By extending the demonstration, the government is (1) gaining additional information about what services TRICARE beneficiaries are receiving under the ACD; (2) determining how to most effectively target services that will have the most benefit; (3) collecting more comprehensive outcomes data; and (4) gaining greater insight and understanding of the diagnosis of ASD in the TRICARE population.

The most recent full-year fiscal data available, FY 2018, show that all services for the diagnosis of ASD, including ABA services, had a total program expenditure of $383 million, with ABA services accounting for $313.7 million (82 percent of the total cost for ASD treatments). ABA services are not generally provided at MTFs, but rather through the ACD in the purchased care system. However, two installations, Fort Belvoir and Joint Base Lewis–McChord, have developed two distinct programs that function as a resource to those beneficiaries diagnosed with ASD, and their families, who are enrolled at the MTF. At Fort Belvoir Community Hospital, the Autism Resource Center provides a resource in which parents and caregivers can participate in monthly meetings where information from other clinics, TRICARE, public schools, local support resources, and other nonmedical services is offered. This program has expanded to two additional installations in FY 2018: Walter Reed National Military Medical Center and Naval Hospital Portsmouth. Additionally at Madigan Army Medical Center (AMC), the Center for Autism Resources, Education, and Services (CARES) program offers a multidisciplinary clinic as a resource of services and information for beneficiaries newly diagnosed with ASD and their families until services through the purchased care system become available.

As evidenced in our previous reports, participation in the ACD by beneficiaries and ABA providers is growing. By the end of FY 2018, 14,820 beneficiaries participating in the ACD had filed claims for ABA services. It is notable, however, that 50 percent of beneficiaries diagnosed with ASD receive ABA services through TRICARE. In many cases, these beneficiaries may be receiving other (non-ABA) services for ASD, services through their school, or may be functioning at a level that does not require ongoing services.

TRICARE has also started to measure outcomes for children enrolled in the ACD, to ensure they are receiving the maximum possible benefit from services, and to help guide future planning for ACD services in TRICARE. These measures include the Pervasive Developmental Disorder Behavior Inventory (PDDBI), administered every six months, and the Social Responsiveness Scale and Vineland Adaptive Behavior Scale, administered every two years. Preliminary results from the PDDBI, which should be interpreted with caution, as they are not controlled for demographic data or amount of services received, suggest that 15–20 percent of TRICARE beneficiaries in the ACD showed significant improvement in ASD symptoms; a similar number had significant worsening of their symptoms; and the rest showed little to no change after one year in the ACD.

Behavioral Health Clinical Community *(cont.)*

In summary, the DoD has implemented a robust benefit that serves all eligible TRICARE beneficiaries diagnosed with ASD. Unlike many civilian insurance plans, the TRICARE benefit has no limits on medically necessary hours of ABA services or cost per beneficiary. In addition, other services, such as occupational therapy and speech and language therapy, are available to beneficiaries with ASD. MCSCs continue to recruit new providers to expand the network, especially in areas with longer access to care times. The TRICARE benefit is one of the best in the nation, particularly considering that network 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 TRICARE's catastrophic coverage cap. The Department continues to review the ACD and make changes as needed to help ensure that our beneficiaries and their families receive the best evidence-based support to help our beneficiaries with ASD reach their maximum potential.

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 and SUD providers across the full continuum of care in alignment with civilian behavioral health treatment industry standards. The goal of these changes was to continue to modernize access, safety, and quality health care options to strengthen our families' resilience.

For children and adolescents, the continuum of care includes MH and SUD outpatient services, IOPs, PHPs, MH RTCs, SUDRFs, and acute inpatient MH and SUD hospital services. Child and adolescent MH and SUD services are offered in both direct care and purchased care settings.

TRICARE has a robust MH and SUD provider network across the continuum of MH and SUD care to meet the needs of approximately 2 million pediatric beneficiaries. Specific observations include:

- MHS MH and SUD costs for children increased by 10 percent in FY 2018, primarily driven by ASD expenditures.
- The most common diagnoses for children aged 1–4 were speech and language disorders; for ages 5–17, the most common diagnosis was ASD, followed closely by attention deficit hyperactivity disorder (ADHD) and reactions to severe stress and adjustment disorders; and the most common diagnosis for ages 18–21 were anxiety disorders and major depressive disorders.
- In FY 2018, over 55 percent of all inpatient MH stays for children were for ages 13–17.
- The number of outpatient MH encounters, excluding ASD, were fairly evenly distributed among the four age groups (23 percent for ages 1–4; 27 percent for ages 5–8; 20 percent for ages 9–12; and 22 percent for ages 13–17).
- Psychiatric RTC care is most common in the pediatric adolescent population, especially for ages 13–17. Adolescents aged 13–17 also had nearly 20 percent of the total IOP care and 18 percent of the total PHP MH encounters in FY 2018.
- SUD treatment is not common for beneficiaries under age 21 in the MHS. This age group accounted for approximately 5 percent of total encounters of SUD inpatient stays, and 2 percent for SUD outpatient care for all beneficiaries.
- Pharmacy prescriptions for pediatric beneficiaries totaled 12 percent of the total in FY 2018.

TRICARE provides a robust benefit for child and adolescent MH, and the TRICARE benefit changes implemented in 2017 have significantly improved access to high-quality services.

HIGH RELIABILITY OPERATING MODEL/CLINICAL COMMUNITIES *(CONT.)*

Dental Clinical Community

The MHS-level Dental Clinical Community (DCC) was established in October 2018 and enables frontline clinicians to drive MHS-wide performance improvements in readiness and health, empowers the DCC to create conditions for high reliability at the point of care (processes, standards, metrics), and holds the DCC accountable to MHS standards and clinical outcomes. This Clinical Community provides leadership to the patient-centered, clinician-led dental networks that span all Service components, environments, and care-impacting areas from the headquarters through MTFs. It is guided by the Quadruple Aim, HRO domains of change, and HRO principles, and is the primary mechanism for improving patient outcomes and embedding learning and safety culture about dental-related clinical practices across the MHS global integrated delivery system. The DCC pays particular attention to the patient's experience in navigating care throughout the spectrum of austere military operations, direct care, and purchased care.

The DCC milestones for FYs 2018 and 2019 include the following actions:

- The dental SMEs began teamwork relationships and have received monthly training in HRO models, key process analysis, and the MHS requirements submission portal.
- Clinical SME nominations by the military Services, NCR, and DHA were presented to the MHS ESB, and gained endorsement as voting and nonvoting members.
- A DCC governance charter, accepted by the CCAC, moved to the Deputy ESB (DESB) in December 2018, then to the ESB in January 2019. A DHA DCC Functional Champion was nominated for appointment recommended through the CCAC leadership and endorsement by the governance structure.
- A DCC operations plan, dental priorities, and dental process improvement plan are ongoing milestones in development for endorsement by MHS governance.

HIGH RELIABILITY OPERATING MODEL/CLINICAL COMMUNITIES *(CONT.)*

Ongoing Quality Initiatives: Surgical Services

Surgical Services across the system focus on providing quality surgical care to our beneficiaries. The MHS monitors the quality of surgical care through the ongoing assessment of process, outcome, and experience of care data. This data is used to focus improvement initiatives and drive desired outcomes.

NSQIP Quality Outcomes

The ACS NSQIP remains one of the most mature quality improvement programs utilized throughout the MHS in MTFs with inpatient surgery. It is the primary method to continuously monitor surgical outcomes through morbidity and mortality data. In February 2018, the MHS reached its NSQIP Adult Program expansion goal of 100 percent participation (48 MTFs). At the end of FY 2018, the total number of participating MTFs decreased to 46 with the transition of two hospitals to stand-alone ambulatory surgical centers. DoD NSQIP collaborates closely with the new DHA Surgical Services Clinical Community (S2C2) to provide surgical quality benchmarking with high-fidelity data and guidance on the development of standardized pathways for improvement of care in the MTFs.

HIGH RELIABILITY OPERATING MODEL/CLINICAL COMMUNITIES *(CONT.)*

Focused Quality Initiatives

The 2018 mortality data indicated that all MTFs reporting data met the expected performance level, including two facilities that exceeded the expected performance. The morbidity data indicated that of the 48 sites reporting data for CY 2018, 28 MTFs met expected performance levels while 11 were exemplary (results in the top quartile of hospitals). Nine MTFs were in the "needs improvement" category (results in the bottom quartile of hospitals). Falling in the "needs improvement" category rarely connotes a persistent deficiency unless recurrent on multiple reports, but it does enable the hospitals to recognize areas of potential concern and dive deeper to improve the quality of their surgical care (see table below).

MTF MORTALITY AND MORBIDITY PERFORMANCE, CYs 2014–2018

			CY 2014		CY 2015		CY 2016		CY 2017		CY 2018	
			MORTALITY	MORBIDITY	MORTALITY	MORBIDITY	MORTALITY	MORBIDITY	MORTALITY	MORBIDITY	MORTALITY	MORBIDITY
MEDICAL CENTERS	ARMY	AMC BAMC (SAN ANTONIO)					★					
		AMC DARNALL (HOOD)								★		★
		AMC EISENHOWER (GORDON)		★	★	★		★		★	★	★
		AMC LANDSTUHL (GERMANY)										★
		AMC MADIGAN (LEWIS)										
		AMC TRIPLER (SHAFTER)										
		AMC WILLIAM BEAUMONT (BLISS)		★								★
		AMC WOMACK (BRAGG)										
	NAVY	NMC PORTSMOUTH								★		★
		NMC SAN DIEGO										★
		NMC CAMP LEJEUNE										
	AIR FORCE	99th MED GROUP (NELLIS)						★				
		60th MED GROUP (TRAVIS)	★		★	★	★		★		★	
		88th MED GROUP (WRIGHT PATTERSON)					★					
		96th MED GROUP (EGLIN)										
		81st MED GROUP (KEESLER)						★				
	NCR	WALTER REED NMMC (BETHESDA)						★		★		★
COMMUNITY HOSPITALS	ARMY	ACH BASSETT (WAINWRIGHT)										
		ACH BAYNE-JONES (POLK)										
		ACH BLANCHFIELD (CAMPBELL)		★				★				
		ACH BRIAN ALLGOOD (SEOUL)										
		ACH EVANS (CARSON)								★		★
		ACH GENERAL LEONARD WOOD (WOOD)										
		ACH IRWIN (RILEY)								★		
		ACH KELLER (WEST POINT)										
		ACH MARTIN (BENNING)										
		ACH WEED (IRWIN)										
		ACH WINN (STEWART)										
	NAVY	NH BREMERTON										★
		NH CAMP PENDLETON										
		NH GUAM										
		NH GUANTANAMO BAY										
		NH JACKSONVILLE		★						★		★
		NH OKINAWA										
		NH PENSACOLA				★		★				
		NH TWENTYNINE PALMS										
		NH YOKOSUKA										
		NH SIGONELLA										
		NH NAPLES										
		NH ROTA										
	AIR FORCE	31st MED GROUP (AVIANO)										
		35th MED GROUP (MISAWA)										
		48th MED GROUP (RAF LAKENHEATH)										
		51st MED GROUP (OSAN)										
		633rd MED GROUP (JB LANGLEY-EUSTIS)										★
		673rd MED GROUP (JB ELMENDORF-RICHARDSON)										
		374th MED GROUP (YOKOTA)										
	NCR	FT BELVOIR COMMUNITY HOSP								★		

★ EXEMPLARY AS EXPECTED NEEDS IMPROVEMENT DATA UNAVAILABLE

Source: DHA/OPS Medical Affairs/CSD, 10/24/2019

Note: Data unavailable may be due to loss of Surgical Clinical Reviewer, site transitioned to ambulatory care, or in initial data collection.

HIGH RELIABILITY OPERATING MODEL/CLINICAL COMMUNITIES *(CONT.)*

Focused Quality Initiatives *(cont.)*

The most recent DoD collaborative report demonstrates that MHS surgical performance meets or exceeds most performance standards relative to the NSQIP population reference rate (722 hospitals across the United States currently participate in the ACS NSQIP Adult Program). According to the report, DoD collaborative performance was "exemplary" in 10 of 14 statistical models, exceeding expected performance even after adjustments for patient risk profiles. Three areas of "needs improvement" noted in the DoD collaborative report are All Cases Urinary Tract Infection (UTI), All Cases Return to Operating Room (ROR), and All Cases Readmission. The NSQIP Steering Panel is currently collaborating with the S2C2 to address these issues and develop strategies to improve performance.

DoD COLLABORATIVE JULY 2019 SUMMARY (SURGERY DATES JANUARY 1, 2018, TO DECEMBER 31, 2018)

MODEL NAME	COLLABORATIVE								NSQIP
	TOTAL CASES	OBSERVED EVENTS	OBSERVED RATE	ADJUSTED RATE[a]	95% LOWER CL	95% UPPER CL	OUTLIER[b]	ESTIMATED OR	POPULATION RATE
All Cases Mortality	41,093	53	0.13%	0.55%	0.39%	0.74%	Low	0.56	0.98%
All Cases Morbidity	41,093	995	2.42%	5.56%	5.23%	5.91%	Low	0.93	5.97%
All Cases Cardiac	41,093	35	0.09%	0.31%	0.19%	0.45%	Low	0.49	0.63%
All Cases Pneumonia	41,082	72	0.18%	0.55%	0.41%	0.72%	Low	0.59	0.94%
All Cases Unplanned Intubation	41,092	45	0.11%	0.41%	0.28%	0.56%	Low	0.60	0.68%
All Cases Ventilator >48 Hours	41,088	36	0.09%	0.37%	0.24%	0.54%	Low	0.53	0.70%
All Cases VTE	41,093	122	0.30%	0.63%	0.51%	0.75%	Low	0.78	0.80%
All Cases Renal Failure	41,086	37	0.09%	0.31%	0.21%	0.43%	Low	0.67	0.45%
All Cases UTI	41,037	273	0.67%	1.19%	1.07%	1.33%	High	1.14	1.05%
All Cases SSI	40,952	464	1.13%	2.28%	2.08%	2.50%		0.92	2.48%
All Cases Sepsis	41,029	90	0.22%	0.65%	0.51%	0.82%	Low	0.68	0.95%
All Cases C. Diff Colitis	41,093	32	0.08%	0.23%	0.15%	0.33%	Low	0.64	0.36%
All Cases ROR	41,093	612	1.49%	2.72%	2.53%	2.92%	High	1.17	2.34%
All Cases Readmission	41,093	1,080	2.63%	5.34%	5.05%	5.64%	High	1.08	4.98%

EXEMPLARY AS EXPECTED NEEDS IMPROVEMENT

Source: ACS NSQIP DoD Collaborative Report, released July 2019

[a] Adjusted Rate is the risk-adjusted smoothed rate.

[b] Outlier status is determined by the risk-adjusted smoothed rate confidence interval relative to the NSQIP population reference rate.

Note: "CL" means confidence limit, and "OR" means odds ratio.

Focused Quality Initiatives *(cont.)*

Surgical Quality Program Expansion

The MHS expanded its surgical quality improvement programs in 2018 to include the ACS NSQIP Pediatric Program, the ACS MBSAQIP, the ACS Trauma VRC Program, and the ACS TQIP.

The ACS NSQIP Pediatric Program is a multispecialty national database to measure pediatric surgical outcomes. The data are risk-adjusted and case-mix adjusted. There are currently 136 hospitals participating across the nation. Currently, Naval Medical Center Portsmouth is participating in the program and started data submission in May 2019. Plans are being developed to expand the program to other sites in 2020.

The ACS MBSAQIP provides a quality improvement program for patients suffering from severe obesity. Bariatric surgery is considered a low-volume, high-risk procedure and is one of the few foregut procedures currently available to surgeons that offer wartime surgical skill experience. There are 21 MTFs performing bariatric procedures on a regular basis. Four MTFs are currently participating in MBSAQIP, with 17 sites interested in MBSAQIP membership.

The ACS Trauma VRC Program was launched in 1987 to evaluate and validate resources at trauma centers. TQIP was established in 2009 by the ACS and provides risk-adjusted outcome measures for trauma patients. In January 2017, the ACS Committee on Trauma mandated that all trauma centers use a quality improvement program. Participation in TQIP will meet this requirement and assist the Joint Trauma System (JTS) Director with the directive to "develop evidence-based practice trauma care guidelines for clinical practice and program improvement processes" as directed by DoDI 6040.47 Joint Trauma System. There are currently 10 MTFs designated as or pursuing designation as trauma centers, with seven additional sites interested in pursuing trauma center designation.

Hospital enrollment in these programs depends on dedicated data abstractors trained to ensure data quality, but not all facilities that would qualify for participation have the available manpower to support participation.

ACS NSQIP CY 2018 Meritorious Award

The annual ACS Meritorious Award is presented to recognize top-performing hospitals for the quality of surgical care provided to their beneficiaries. There are two categories of meritorious hospitals recognized: the All Cases Meritorious List and the High Risk Meritorious List. The criteria for selection is based upon composite quality scores for surgical care provided in 2018 in eight All Cases outcome areas: mortality, cardiac (cardiac arrest and myocardial infarction), pneumonia, unplanned intubation, ventilator >48 hours, renal failure, UTI, and surgical site infection. The MTFs below were recognized by the ACS NSQIP as meritorious hospitals for 2018:

All Cases Meritorious List:

- Brooke Army Medical Center
- Dwight D. Eisenhower Army Medical Center
- William Beaumont Army Medical Center
- Evans Army Community Hospital
- 81st Medical Group (Keesler)
- Naval Medical Center San Diego
- Walter Reed National Military Medical Center

High Risk Meritorious List:

- Brooke Army Medical Center
- Dwight D. Eisenhower Army Medical Center
- 81st Medical Group (Keesler)
- Naval Medical Center San Diego
- Walter Reed National Military Medical Center

These sites are among the 88 facilities representing the top 10 percent of all NSQIP participating hospitals worldwide in 2018.

Surgical Care Performance

The ACS NSQIP continues to be a critical cornerstone for surgical quality improvement in the MHS. Implementation of NSQIP at all military inpatient surgical facilities has fostered the development of a formal quality collaborative. The DoD collaborative unites surgical SMEs across the enterprise with a single focus—surgical excellence. The collaborative assists with identifying enterprise trends, educating and building new quality leaders in program surgeon champions, and promoting collaboration with civilian experts. It also strengthens our culture of vigilance with surgical outcomes and providing quality surgical care across the MHS.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES

Medical Management

The DHA is dedicated to improving the health of all MHS beneficiaries. In support of this mission, ongoing collaboration to promote a fully integrated clinical and nonclinical evidence-based approach to improve care across all treatment settings is underway. These initiatives include collaboration with advisory boards, Clinical Communities, and VA; and enterprise-wide standardized clinical and business process workflows and documentation aimed to improve and complement care team communication and build the comprehensive coordination necessary to support beneficiary care requirements.

MHS medical management (MM) programs continue to influence program improvements through the recognition and execution of industry care management best practices and enhanced predictive analytics. Specifically, dedicated patient registries have been created using direct care and purchased care resource utilization. These registries are then analyzed against the Johns Hopkins Adjusted Clinical Groups® (ACG®) system. Registry information is then readily available to MTF MM teams on the MHS CarePoint site to promote proactive patient engagement, improve patient experience, and improve outcomes. Further, this evidence-based system is able to identify morbidity patterns, which can be leveraged by MTF MM representatives to target specific high-risk populations for dedicated engagement.

Traditionally, MM program requirements have been developed and executed through Service-specific policy. In alignment with the MHS, reform-dedicated policies to reduce variance and centralize MM program requirements are underway. These efforts will serve to promote enterprise-wide standardization, positive patient engagement through improved care management, continuity of care, and enhanced care team collaboration.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Pain Management

During FYs 2018 and 2019, MHS continued to mature the pain management capabilities and resources for our beneficiaries and health care workforce. Improved coordination and collaboration across the Services, DHA, and Uniformed Services University of the Health Sciences (USUHS) has resulted in several advances in pain management policy, clinical care, and fielding of innovative education, training products, and clinical tools, including:

- Continued implementation of the Defense and Veterans Pain Rating Scale (DVPRS), an innovative pain scale that was developed by the DoD to improve assessment of the impact of pain on a person's function and quality of life.
- Continued MHS implementation of the Stepped Care Model of Pain Management to ensure the appropriate level of pain care is available and delivered to patients throughout the continuum of acute and chronic pain.
- Continued implementation of pain-related CPGs, as well as continued identification of requirements for updated CPGs by using resources available through the Pain Management Clinical Support Service, Clinical Communities, and VA/DoD HEC Work Groups.
- Increasing pain telehealth integration in NCR primary care by both direct care visits and provider webinar case-based education.
- Continued primary care pain skills training offered annually by the NCR Pain Care Initiative.
- Expansion of pilot in-home telehealth visits to transitioning and rural service members and beneficiaries.
- Continued development and deployment of the Pain Assessment Screening Tool and Outcome Registry (PASTOR), the MHS pain outcomes registry and clinical decision-making tool. PASTOR is one of a growing number of use cases within the MHS Patient Reported Outcomes Clinical Record (PROCR) that leverage the National Institutes of Health (NIH) Patient Reported Outcomes Measurement Information System (PROMIS).
- Continued execution of the Joint Pain Education Project in disseminating a standardized VA/DoD pain management curriculum and supplemental pain videos for widespread use in education and training programs.
- Participation in research efforts offered by DoD, VA, and NIH to examine nonpharmacological treatments for acute and chronic pain, and also complex pain syndromes experienced by military populations.
- Conducting a pilot study in response to section 746 of the NDAA for FY 2017 to evaluate the feasibility and effectiveness of preventing diversion of opioid medications by dispensing opioids in locking cap vials, and providing education to patients and their family members, with particular consideration for adolescents.
- Conducted a study in response to section 735 of the NDAA for FY 2018 to evaluate the effectiveness of opioid prescriber safety training and assess the necessity for strengthened opioid prescribing initiatives in the MHS.
- Participation in the DHHS Pain Management Best Practices Inter-Agency Task Force.
- Drafting DHA-PI, "Acupuncture Practice in Medical Treatment Facilities," to establish DHA's guidance for implementing tiered acupuncture training, privileging providers in acupuncture, and supporting the clinical practice of acupuncture by designated clinical staff through the DoD Medicine Enterprise.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Preventing Opioid Misuse by Military Service Members

DHA-PI "Pain Management and Opioid Safety in the MHS," published June 8, 2018, establishes DHA's procedures to:

- Establish the MHS Stepped Care Model as the comprehensive standardized pain management model for MHS to provide consistent, quality, and safe care for patients experiencing pain, with an emphasis on nonpharmacological treatments;
- Educate patients in effective self-management of pain and injury rehabilitation;
- Educate clinicians regarding effective pain management and optimal opioid safety consistent with VA/DoD and CDC CPGs;
- Provide tools, including those through MHS GENESIS and legacy EHRs, to assist clinicians in evidence-based and patient-centered pain management; and,
- Conduct pain research to continuously improve the MHS approach to pain management.

The DHA-PI provides specific guidelines on opioid prescribing for MTF providers, consistent with VA/DoD CPGs, including: acquiring informed consent for patients who require opioids; prescribing less than a five-day supply of short-acting opioids for acute pain episodes and minor procedures in opioid-naïve patients; prescribing less than a 10-day supply of short-acting opioids for major procedures in opioid-naïve patients; providing medication assisted therapy for those with opioid use disorders; and providing naloxone (opioid reversal) for those at higher risk for overdose. It also provides guidance for the TRICARE health plan to partner with MCSCs to minimize inappropriate opioid prescribing and conduct value-based pilots of nonpharmacologic pain treatments.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient-Centered Care/Experience

Satisfaction with Provider

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.

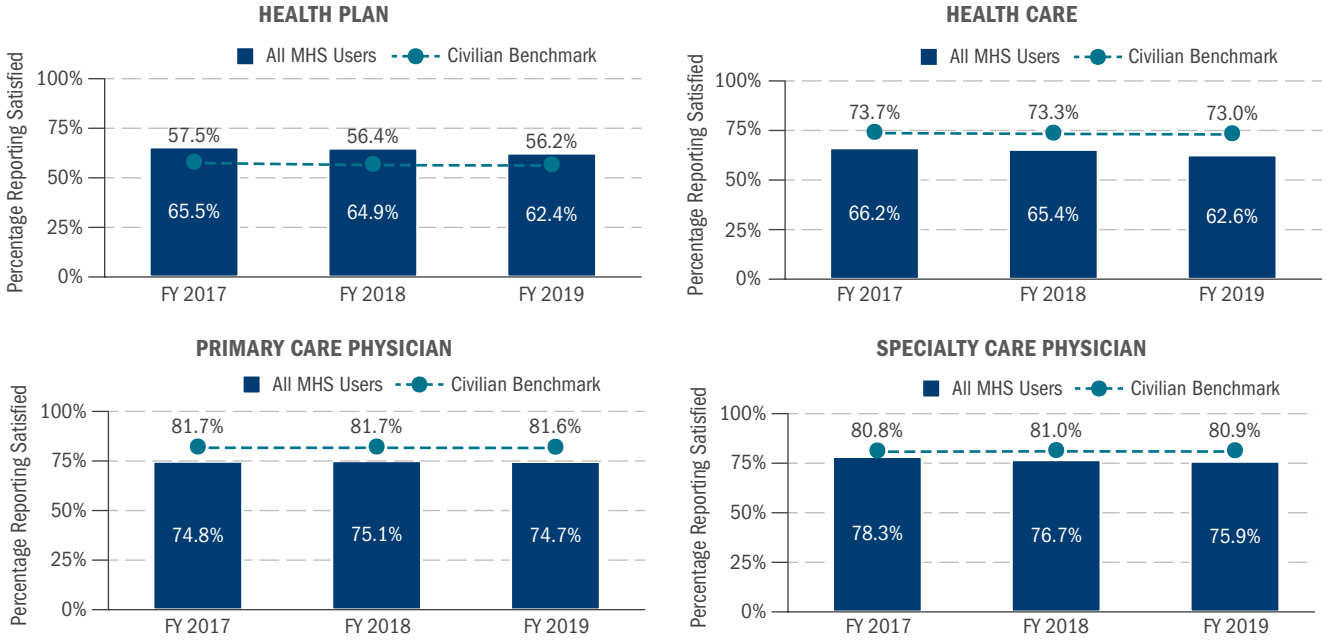
In this section, MHS beneficiaries in the U.S. who have used TRICARE are compared with the civilian benchmark with respect to ratings of (1) the health plan in general; (2) health care; (3) their personal physician; and (4) specialty care. Health plan ratings depend on access to care and how the plan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

Beneficiary Ratings of Their Health Plan through Population-Based Surveys

The population-based HCSDB is based on the CAHPS survey, and is used to routinely assess MHS beneficiary experience with health care, whether in the direct or purchased care 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 their health plan, health care, and specialty care decreased from FY 2017 to FY 2019; the civilian benchmark for health plans declined slightly as well. There were no significant trends for the remaining aspect of care.
- MHS beneficiary satisfaction with their health plan exceeded that of the civilian benchmark in each year between FY 2017 and FY 2019. 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 2017–2019



Note: HCSDB data were derived from the FYs 2017–2019 HCSDB, as of 11/1/2019, 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 2017 come from NCQA's 2015 data, while the benchmarks used in 2018 and 2019 come from NCQA's 2017 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.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

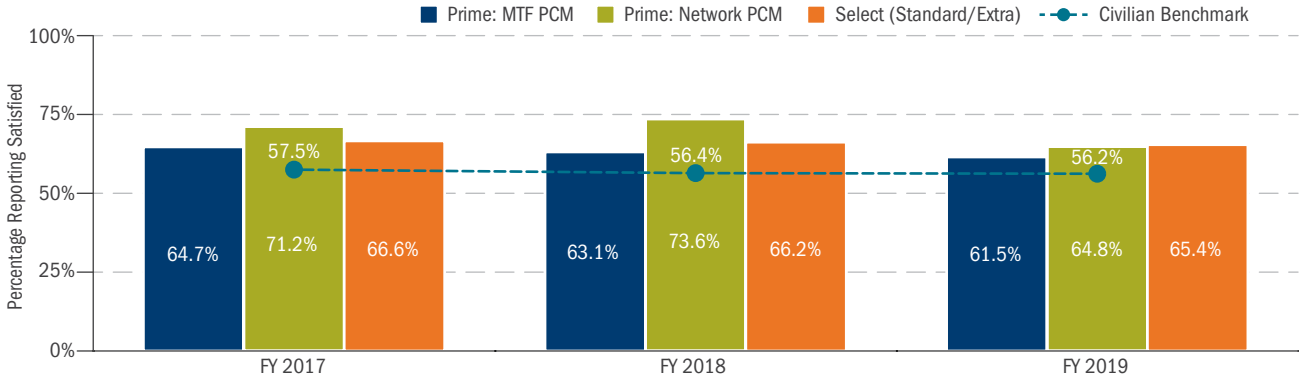
Patient-Centered Care/Experience *(cont.)*

Beneficiary Ratings of Their Health Plan Based on Enrollment Status

Most DoD health care beneficiaries participate in TRICARE in one of two ways: by enrolling in the Prime option or by using the traditional indemnity option for seeing participating or network providers (TRICARE Standard/Extra in FY 2017 or TRICARE Select in FYs 2018–2019). Satisfaction levels with one's health plan across the TRICARE options are compared with commercial plan counterparts.

- Satisfaction with the TRICARE health plan decreased from FY 2017 to FY 2019 for Prime enrollees with both an MTF and network PCM, and remained stable for non-enrollees.
- For each year between FY 2017 and FY 2019, 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 2017–2019

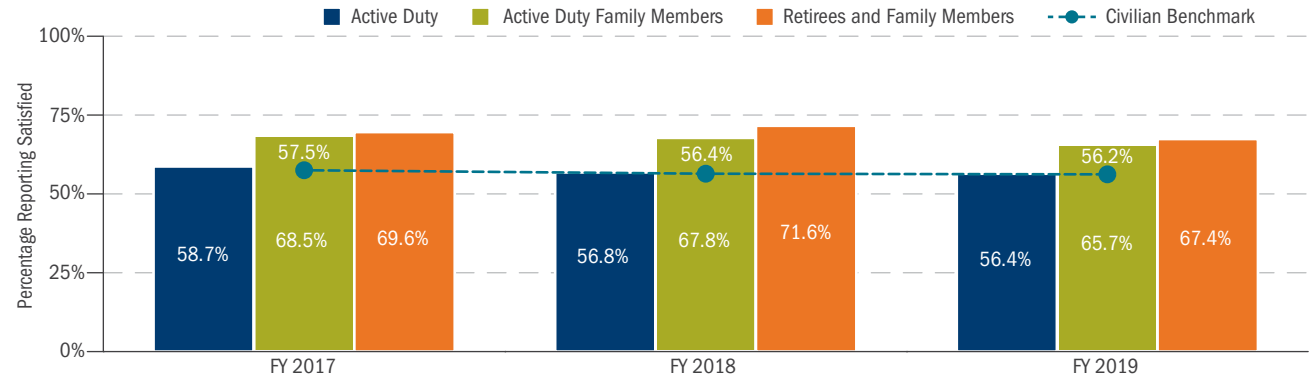


Beneficiary Ratings of Their Health Plan Based on Beneficiary Category

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

- Satisfaction with the TRICARE health plan declined slightly from FY 2017 to FY 2019 for all beneficiary groups. The corresponding civilian benchmark also declined slightly over the same time period.
- Active Duty satisfaction was nearly identical to the civilian benchmark for each year from FY 2017 to FY 2019. However, satisfaction levels for ADFMs and RETFMs were higher than the civilian benchmark in each year from FY 2017 to FY 2019.

TRENDS IN SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY, FYs 2017–2019



Note: HCSDB data were derived from the FYs 2017–2019 HCSDB, as of 11/1/2019, 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 2017 come from NCQA's 2015 data, while the benchmarks used in 2018 and 2019 come from NCQA's 2017 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.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

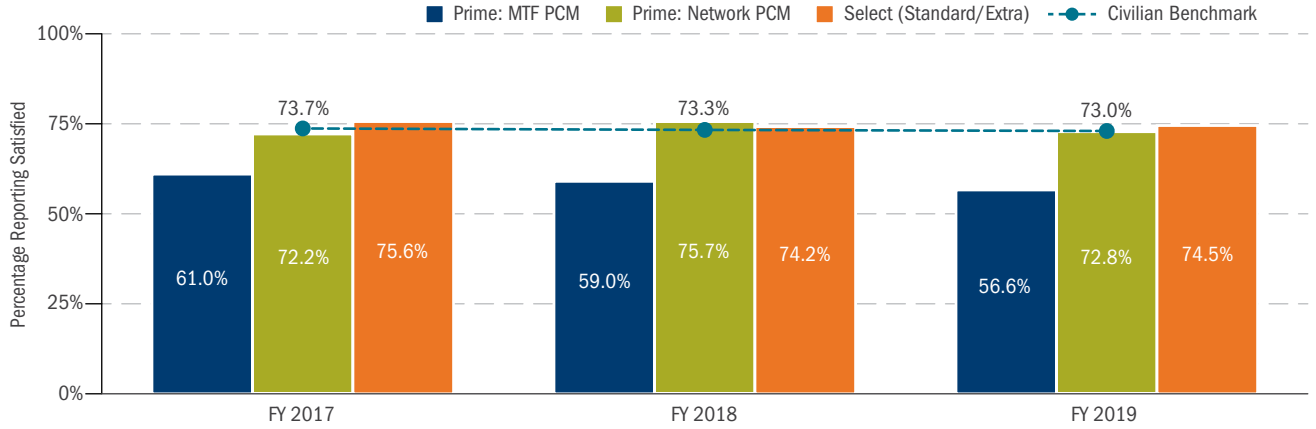
Patient-Centered Care/Experience *(cont.)*

Beneficiary Ratings of Satisfaction with Health Care by Enrollment Status and Beneficiary Category

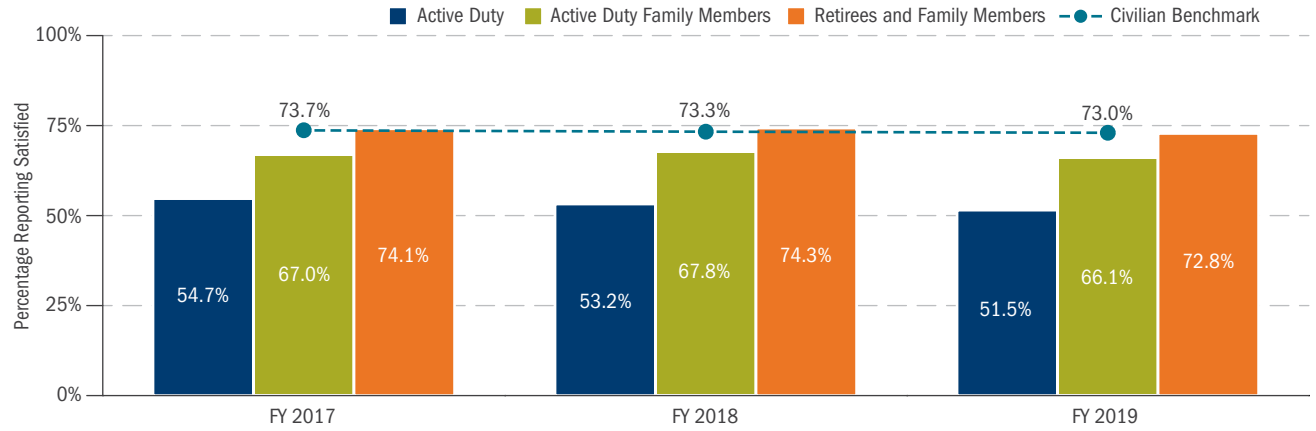
Similar to satisfaction with the TRICARE health plan, satisfaction levels with the health care received differ by beneficiary category and enrollment status.

- Beneficiary satisfaction with their health care remained stable between FY 2017 and FY 2019 for all enrollment groups except for beneficiaries with an MTF PCM. The civilian benchmark was also stable over the same time period.
- Satisfaction with health care for beneficiaries with an MTF PCM was significantly lower than the civilian benchmark in each year between FY 2017 and FY 2019. Satisfaction levels for the other enrollment groups were about the same as the civilian benchmark.
- Beneficiary satisfaction with their health care decreased for Active Duty between FY 2017 and FY 2019 but remained about the same for the other beneficiary groups. The civilian benchmark was stable over the same time period.
- Satisfaction with health care for Active Duty and ADFMs was well below the civilian benchmark for each year between FY 2017 and FY 2019. Satisfaction for RETFMs was about the same as the civilian benchmark.

TRENDS IN SATISFACTION WITH TRICARE HEALTH CARE BY ENROLLMENT STATUS, FYs 2017–2019



TRENDS IN SATISFACTION WITH TRICARE HEALTH CARE BY BENEFICIARY CATEGORY, FYs 2017–2019



Note: HCSDB data were derived from the FYs 2017–2019 HCSDB, as of 11/1/2019, 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 2017 come from NCQA's 2015 data, while the benchmarks used in 2018 and 2019 come from NCQA's 2017 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.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

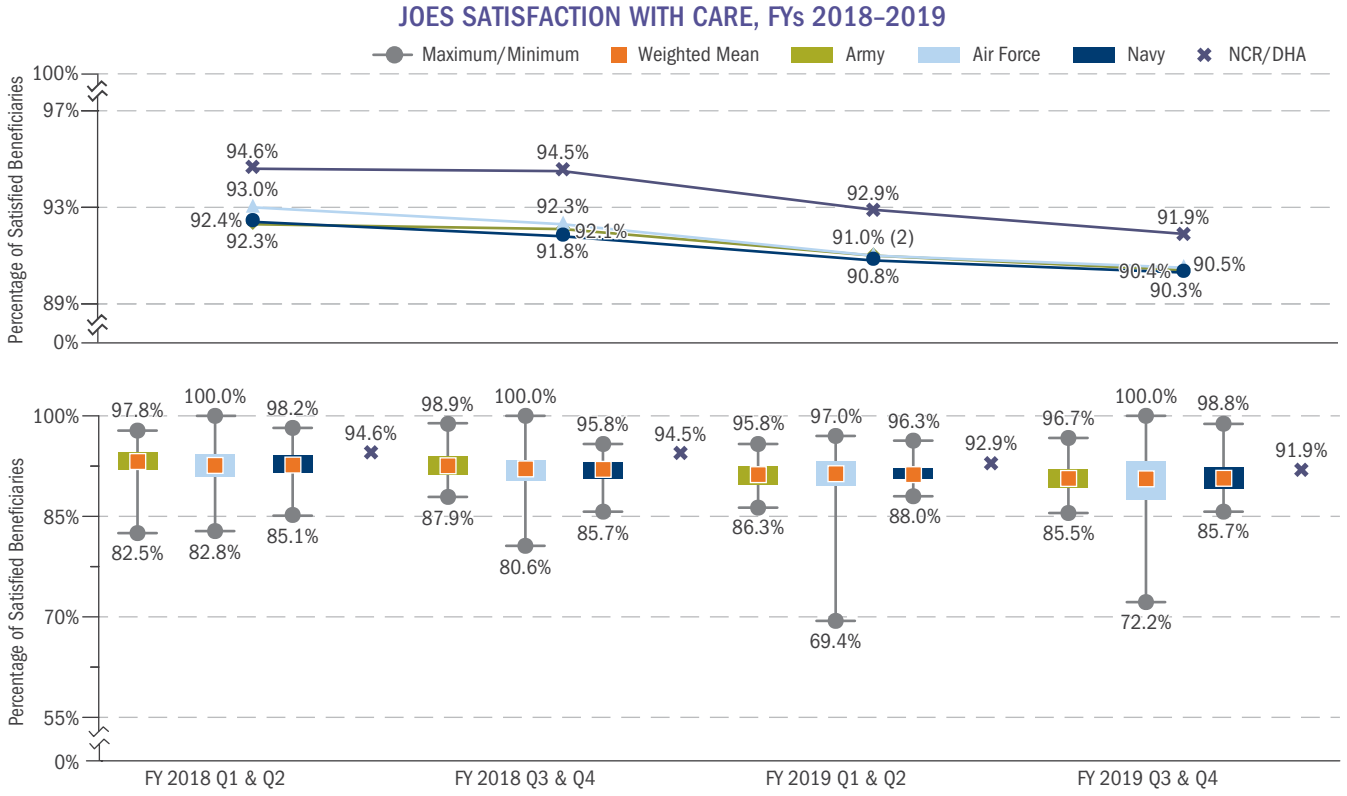
Patient-Centered Care/Experience *(cont.)*

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 factors reported on by the beneficiary include: his/her experience with the pharmacy, laboratory, or radiology department (JOES); the communication of 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 to JOES, and an example of the convergence of the results, can be found under "Patient-Centered, Self-Reported Measures" on page 86.

An important item in each of these surveys addresses how the beneficiary feels about his/her episode of care in general. The item 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 with care, or what may lead a beneficiary to respond favorably or negatively to this question, are shown starting on page 152.

Rating of Satisfaction with Care (JOES): The scores for each Service are tightly grouped together and above 90 percent—indicating that a large proportion of individuals are "Somewhat Satisfied" or "Very Satisfied" with the care that they received. Scores have trended slightly lower over time. As displayed with the box and whisker plot, there is limited dispersion of the parent facility scores—scores generally range between 80 percent and 100 percent. Air Force was the Service with the greatest dispersion, as indicated by the box plot. Additional description of the box and whisker plot creation can be found under "Patient-Centered Medical Home Primary Care" on page 65. JOES is not fielded to beneficiaries using purchased care, so purchased care results are not available for display below.



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES, weighted data, compiled 11/6/2019

Notes:

– Parent facility scores were used above, and those reporting fewer than 10 responses in the time period were excluded from analyses.
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration.
– The box shows the IQR (25th to 75th percentiles) with the Service score (weighted mean) highlighted.
– Weighted means are shown for NCR/DHA. The NCR category is represented by the FY 2018 Q1 through FY 2019 Q1 data points and is made up of parent facilities FBCH and WRNMMC. Parent facilities FBCH, WRNMMC, 81st Medical Group at Keesler Air Force Base, Womack Army Medical Center, Naval Hospital Jacksonville, 4th Medical Group at Seymour Johnson Air Force Base, and 628th Medical Group at Joint Base Charleston compose the DHA category from FY 2019 Q2 through FY 2019 Q4.
– For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient-Centered Care/Experience *(cont.)*

JOES Satisfaction with Care—Variability Over Time

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 2018 Q1 & Q2 to FY 2019 Q3 & Q4, Army, Air Force, and Navy worsened in terms of the mean and median ratings by approximately two to three percentage points, meaning that satisfaction slightly decreased.
- Dispersion, meaning variability of scores using the IQR, increased for Army, Air Force, and Navy. Changes for Army and Navy were less than one percentage point, but dispersion for Air Force increased by 2.3 percentage points.
- Dispersion, in terms of the range between the lowest- and highest-performing parent facilities, decreased overall from FY 2018 Q1 & Q2 to FY 2019 Q3 & Q4 for Army and Navy, while drastically increasing for Air Force, meaning variation in Air Force satisfaction scores increased.

VARIABILITY IN JOES RATINGS: SATISFACTION WITH CARE, FYs 2018–2019

	FY 2018 Q1 & Q2	FY 2018 Q3 & Q4	FY 2019 Q1 & Q2	FY 2019 Q3 & Q4	% POINT CHANGE (FY 2018 Q1 & Q2 TO FY 2019 Q3 & Q4)
ARMY					
Service Score (Mean)	93.0%	92.3%	91.0%	90.5%	–2.4
Median	93.3%	92.3%	91.0%	90.4%	–2.9
75th Percentile (Q3)	94.6%	93.9%	92.5%	92.0%	–2.6
25th Percentile (Q1)	92.0%	91.2%	89.7%	89.2%	–2.8
IQR	2.6%	2.7%	2.8%	2.8%	0.2
Maximum	97.8%	98.9%	95.8%	96.7%	–1.1
Minimum	82.5%	87.9%	86.3%	85.5%	3.1
Range	15.3%	11.1%	9.5%	11.2%	–4.1
AIR FORCE					
Service Score (Mean)	92.3%	92.1%	91.0%	90.5%	–1.9
Median	92.4%	91.9%	91.7%	90.4%	–2.0
75th Percentile (Q3)	94.3%	93.4%	93.2%	93.2%	–1.1
25th Percentile (Q1)	90.9%	90.4%	89.6%	87.5%	–3.4
IQR	3.4%	3.0%	3.6%	5.7%	2.3
Maximum	100.0%	100.0%	97.0%	100.0%	0.0
Minimum	82.8%	80.6%	69.4%	72.2%	–10.6
Range	17.2%	19.4%	27.5%	27.8%	10.6
NAVY					
Service Score (Mean)	92.4%	91.8%	90.8%	90.3%	–2.2
Median	92.7%	92.1%	91.3%	91.0%	–1.8
75th Percentile (Q3)	94.1%	93.1%	92.2%	92.4%	–1.6
25th Percentile (Q1)	91.5%	90.7%	90.6%	89.2%	–2.3
IQR	2.5%	2.4%	1.6%	3.2%	0.7
Maximum	98.2%	95.8%	96.3%	98.8%	0.5
Minimum	85.1%	85.7%	88.0%	85.7%	0.6
Range	13.1%	10.1%	8.3%	13.0%	–0.1
NCR/DHA					
Service Score (Mean)	94.6%	94.5%	92.9%	91.9%	–2.6

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES, weighted data, compiled 11/6/2019

Notes:

– Parent facility scores were used in the above table, and those reporting fewer than 10 responses in the time period were excluded from analyses.

– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration.

– Weighted means are shown for NCR/DHA. The NCR category is represented by the FY 2018 Q1 through FY 2019 Q1 data points and is made up of parent facilities FBCH and WRNMMC. Parent facilities FBCH, WRNMMC, 81st Medical Group at Keesler Air Force Base, Womack Army Medical Center, Naval Hospital Jacksonville, 4th Medical Group at Seymour Johnson Air Force Base, and 628th Medical Group at Joint Base Charleston compose the DHA category from FY 2019 Q2 through FY 2019 Q4.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

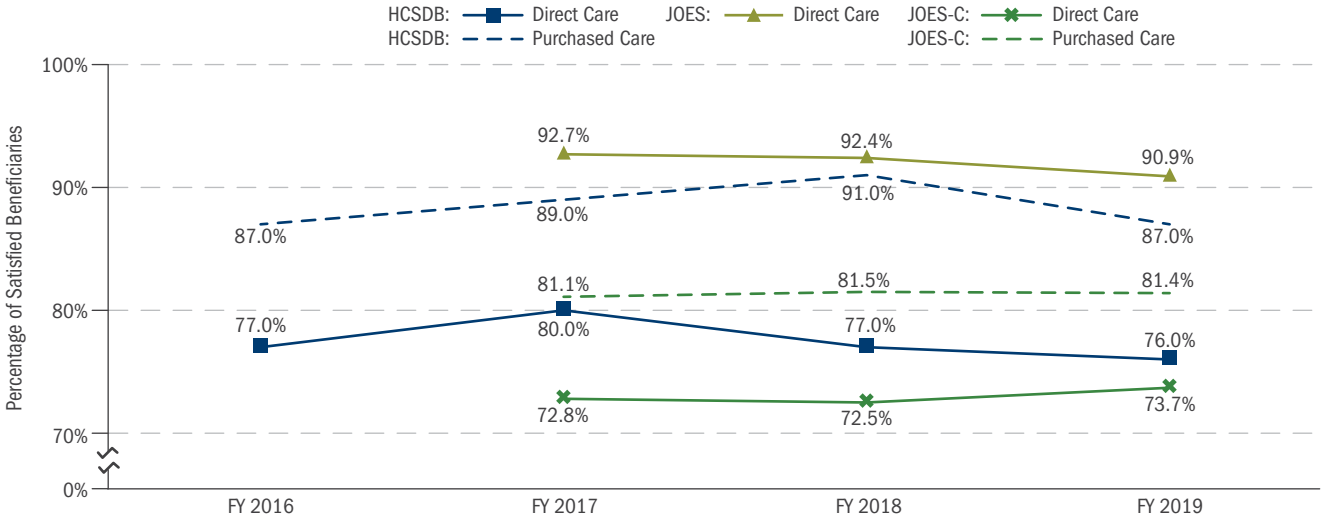
Patient-Centered Care/Experience *(cont.)*

DHA Surveys—Satisfaction with Care

In addition to each of the Service surveys and JOES, the JOES-C and population-based HCSDB surveys also report results for the Satisfaction with Care measure. Including this same item 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 86.

- From FY 2016 to FY 2019, beneficiaries using purchased care reported greater satisfaction with care than those using direct care, regardless of time period. The differences between purchased care and direct care results range from approximately 10 to 15 percent in FY 2019.
- Beneficiaries completing the HCSDB reported greater satisfaction than beneficiaries completing the JOES-C, over time, for direct care and purchased care.
- Trends for Satisfaction with Care are mixed by survey. HCSDB purchased care ratings improved through FY 2018, while direct care ratings varied but ended the same in FY 2018 as began in FY 2016. From FY 2017 to FY 2019, JOES-C direct care ratings improved slightly, while purchased care ratings remained stable. JOES ratings dipped slightly lower from FY 2017 to FY 2019 but remain above 90 percent.

HCSDB, JOES, AND JOES-C RATINGS OF SATISFACTION WITH CARE, FYs 2016–2019



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB, TROSS, JOES, and JOES-C, compiled 11/4/2019

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, but are not visualized. For FY 2016, the direct care score is 72.8% and the purchased care score is 81.4%.
– 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 sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration, respective to the JOES and JOES-C surveys.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

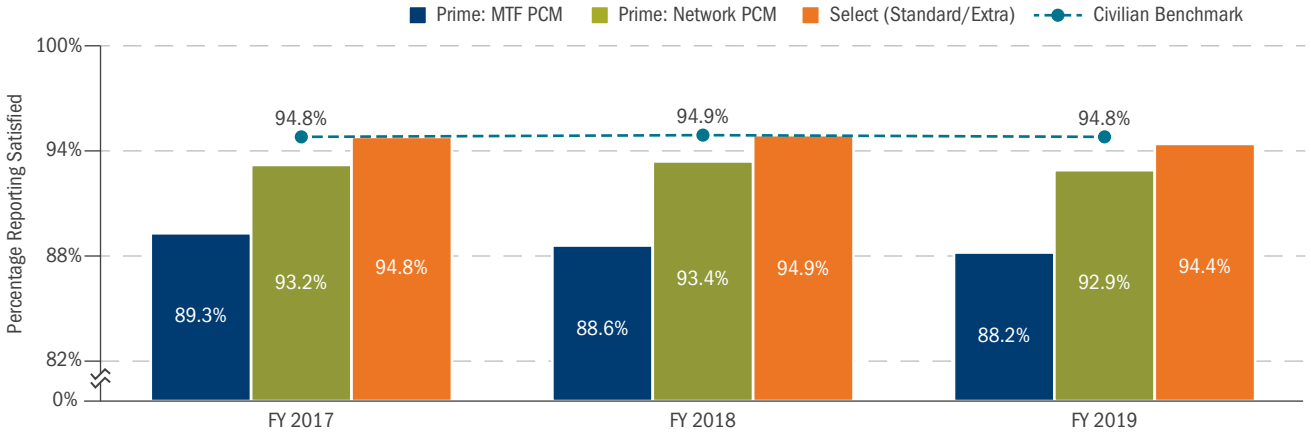
Patient-Centered Care/Experience *(cont.)*

Satisfaction with Doctors' Communication

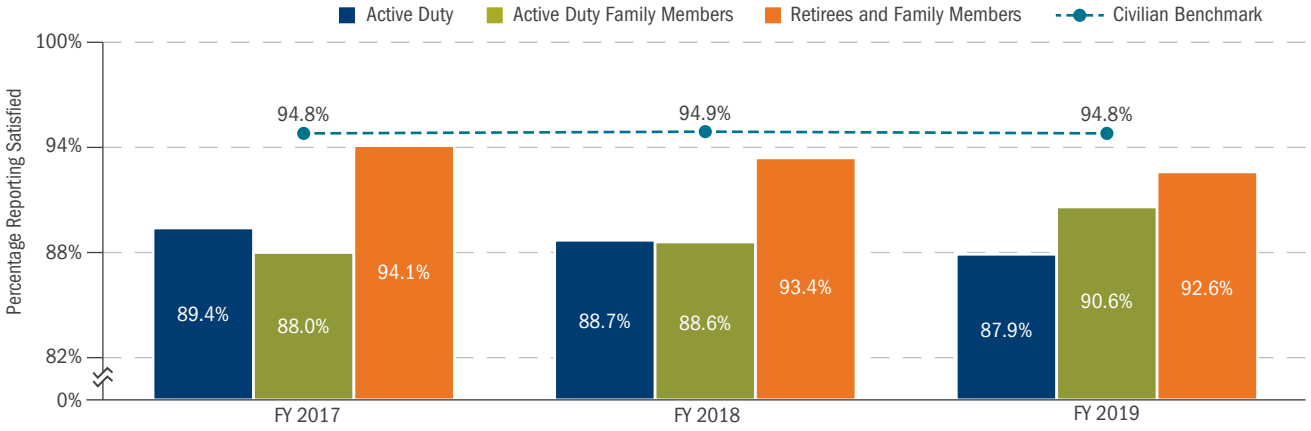
Communication between doctors and patients is an important factor in beneficiaries' satisfaction and their ability to obtain appropriate care. The following charts present beneficiary-reported perceptions of how well their doctor communicates with them.

- Beneficiary satisfaction with their doctors' communication remained stable between FY 2017 and FY 2019, regardless of their enrollment status. The civilian benchmark also remained stable over the same time period.
- Satisfaction reached parity with the civilian benchmark for each year between FY 2017 and FY 2019 except among Prime enrollees with an MTF PCM.
- Satisfaction with doctors' communication remained stable between FY 2017 and FY 2019 for all beneficiary groups except for ADFMs, who saw a modest increase. The civilian benchmark also remained stable over the same time period.
- Satisfaction with doctors' communication was lower than the civilian benchmark for all beneficiary groups in FY 2019.

TRENDS IN SATISFACTION WITH DOCTORS' COMMUNICATION BY ENROLLMENT STATUS, FYs 2017–2019



TRENDS IN SATISFACTION WITH DOCTORS' COMMUNICATION BY BENEFICIARY CATEGORY, FYs 2017–2019



Note: HCSDB data were derived from the FYs 2017–2019 HCSDB, as of 11/1/2019, 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 2017 come from NCQA's 2015 data, while the benchmarks used in 2018 and 2019 come from NCQA's 2017 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.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

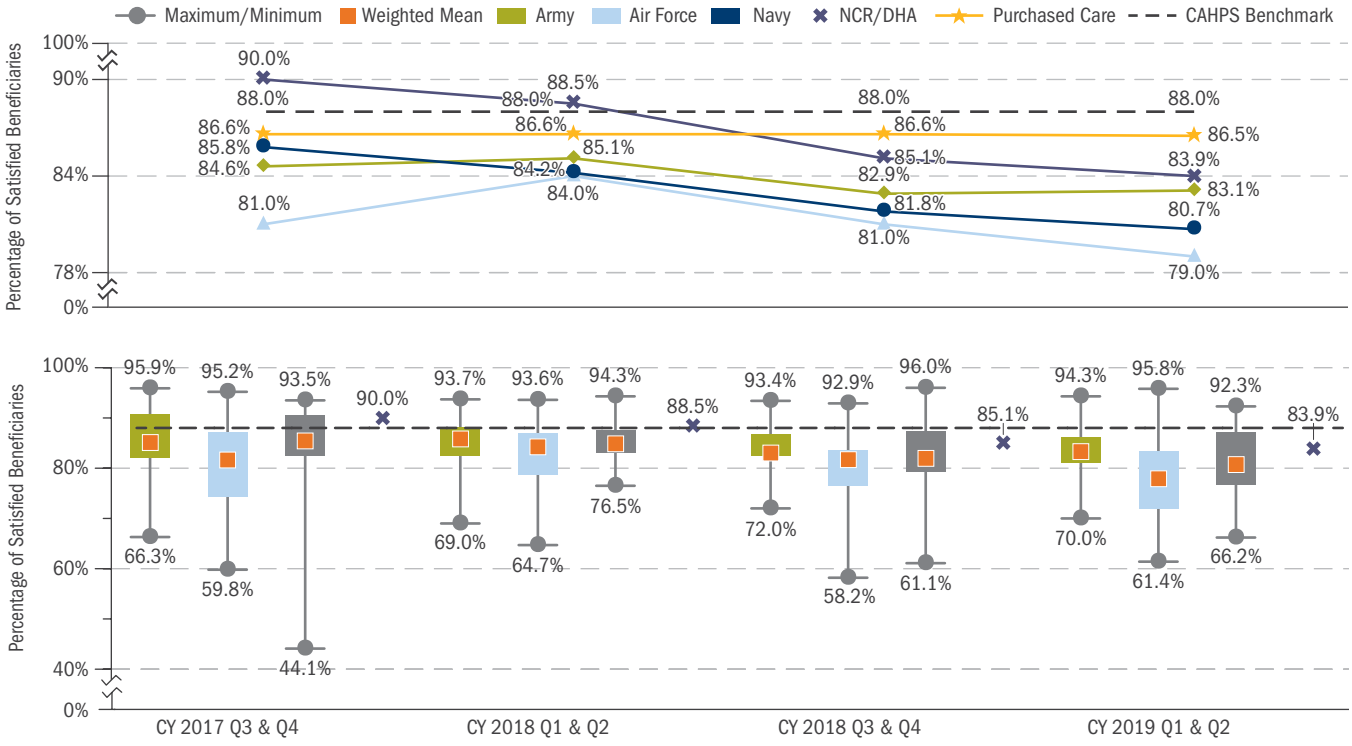
Patient-Centered Care/Experience *(cont.)*

Provider Communication

As detailed in "Drivers of Patient Experience Ratings" on pages 152–153, communication between the beneficiary and their provider is one of the leading drivers of overall patient satisfaction across care settings, in both outpatient and inpatient care, and is cross-validated by the three core surveys (JOES, JOES-C, and HCSDB). The TRISS, JOES-C, and HCSDB surveys measure provider communication (or doctor and nurse communication) from the beneficiary's perspective, and it remains vitally important to quality of care ratings. Some of the questions in these surveys ask: 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 Provider Communication composite measure. These results can be compared to nationally representative civilian and military benchmarks, and can be compared across all levels of the MHS.

- JOES-C was introduced in June 2016 for direct care and May 2017 for purchased care. Results for NCR/DHA have declined since 2016 below the civilian CG-CAHPS benchmark and MHS target over the past four quarters. Results for Army and Air Force varied across time, but each ended CY 2019 Q2 approximately two percentage points lower, while Navy decreased more than five percentage points over the same period.
- There is a wide variation in the direct care scores, as reflected by the box and whisker plot (shown below). Parent facility scores have generally ranged from 60 percent to 100 percent for Army and Air Force, with greater variation in Navy scores, particularly for CY 2017 Q3 & Q4.

JOES-C PROVIDER COMMUNICATION, CY 2017 Q3 & Q4 TO CY 2019 Q1 & Q2



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES-C, weighted data, compiled 10/31/2019

Notes:

– Parent facility scores were used above, and those reporting fewer than 10 responses within the time period were excluded from analyses.

– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration.

– The box shows the IQR (25th to 75th percentiles) with the Service score (weighted mean) highlighted.

– Weighted means are shown for NCR/DHA. The NCR category is represented by the CY 2017 Q3 through CY 2018 Q4 data points and is made up of parent facilities FBCH and WRNMMC. Parent facilities FBCH, WRNMMC, 81st Medical Group at Keesler Air Force Base, Womack Army Medical Center, Naval Hospital Jacksonville, 4th Medical Group at Seymour Johnson Air Force Base, and 628th Medical Group at Joint Base Charleston compose the DHA category from CY 2019 Q1 through CY 2019 Q2.

– CAHPS benchmarks are the 50th percentiles from the respective 2016 and 2017 CG-CAHPS national civilian scores.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient-Centered Care/Experience *(cont.)*

Provider Communication

The table below displays the extent to which the ratings of the Provider Communication composite changed over time in terms of improvement (increasing mean or median) or decreased dispersion (reduced range or IQR).

- From CY 2017 Q3 & Q4 to CY 2019 Q1 & Q2, the median score and weighted mean for all Services decreased.
- Dispersion, in terms of the IQR, decreased for Army and Air Force while increasing for Navy. However, this decrease in dispersion for Air Force is partly due to the 75th percentile scores trending lower over time.
- Dispersion, in terms of the range between the lowest- and highest-performing parent facilities, decreased significantly from CY 2017 Q3 & Q4 to CY 2019 Q1 & Q2 for Navy while decreasing slightly for Army and Air Force. This was largely driven by improvements in the lowest-performing facilities for Navy.

JOES-C: PROVIDER COMMUNICATION COMPOSITE, CY 2017 Q3 & Q4 TO CY 2019 Q1 & Q2

	CY 2017 Q3 & Q4	CY 2018 Q1 & Q2	CY 2018 Q3 & Q4	CY 2019 Q1 & Q2	% POINT CHANGE (CY 2017 Q3 & Q4 TO CY 2019 Q1 & Q2)
ARMY					
Service Score (Mean)	84.6%	85.1%	82.9%	83.1%	–1.5
Median	87.6%	86.2%	82.8%	84.0%	–3.6
75th Percentile	90.7%	88.1%	86.7%	86.1%	–4.7
25th Percentile	82.1%	82.5%	79.5%	81.0%	–1.1
IQR	8.7%	5.6%	7.2%	5.1%	–3.5
Maximum	95.9%	93.7%	93.4%	94.3%	–1.6
Minimum	66.3%	69.0%	72.0%	70.0%	3.7
Range	29.6%	24.8%	21.4%	24.3%	–5.3
AIR FORCE					
Service Score (Mean)	81.4%	83.7%	81.3%	79.3%	–2.1
Median	81.3%	83.9%	80.2%	78.4%	–2.9
75th Percentile	87.1%	87.0%	83.5%	83.4%	–3.7
25th Percentile	74.2%	78.8%	76.5%	71.9%	–2.2
IQR	12.9%	8.2%	7.0%	11.5%	–1.4
Maximum	95.2%	93.6%	92.9%	95.8%	0.6
Minimum	59.8%	64.7%	58.2%	61.4%	1.6
Range	35.4%	28.9%	34.7%	34.4%	–1.0
NAVY					
Service Score (Mean)	85.8%	84.2%	81.8%	80.7%	–5.1
Median	85.3%	85.3%	83.3%	79.8%	–5.5
75th Percentile	90.6%	87.6%	87.3%	87.2%	–3.5
25th Percentile	82.5%	83.1%	79.3%	76.8%	–5.7
IQR	8.1%	4.5%	8.0%	10.4%	2.3
Maximum	93.5%	94.3%	96.0%	92.3%	–1.2
Minimum	44.1%	76.5%	61.1%	66.2%	22.1
Range	49.4%	17.8%	34.9%	26.1%	–23.3
NCR/DHA					
Service Score (Mean)	90.0%	88.5%	85.1%	83.9%	–6.1

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES-C, weighted data, compiled 10/31/2019

Notes:

– Parent facility scores were used in the above table, and those reporting fewer than 10 responses in the time period were excluded from analyses.

– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration.

– Weighted means are shown for NCR/DHA. The NCR category is represented by the CY 2017 Q3 through CY 2018 Q4 data points and is made up of parent facilities FBCH and WRNMMC. Parent facilities FBCH, WRNMMC, 81st Medical Group at Keesler Air Force Base, Womack Army Medical Center, Naval Hospital Jacksonville, 4th Medical Group at Seymour Johnson Air Force Base, and 628th Medical Group at Joint Base Charleston compose the DHA category from CY 2019 Q1 through CY 2019 Q2.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

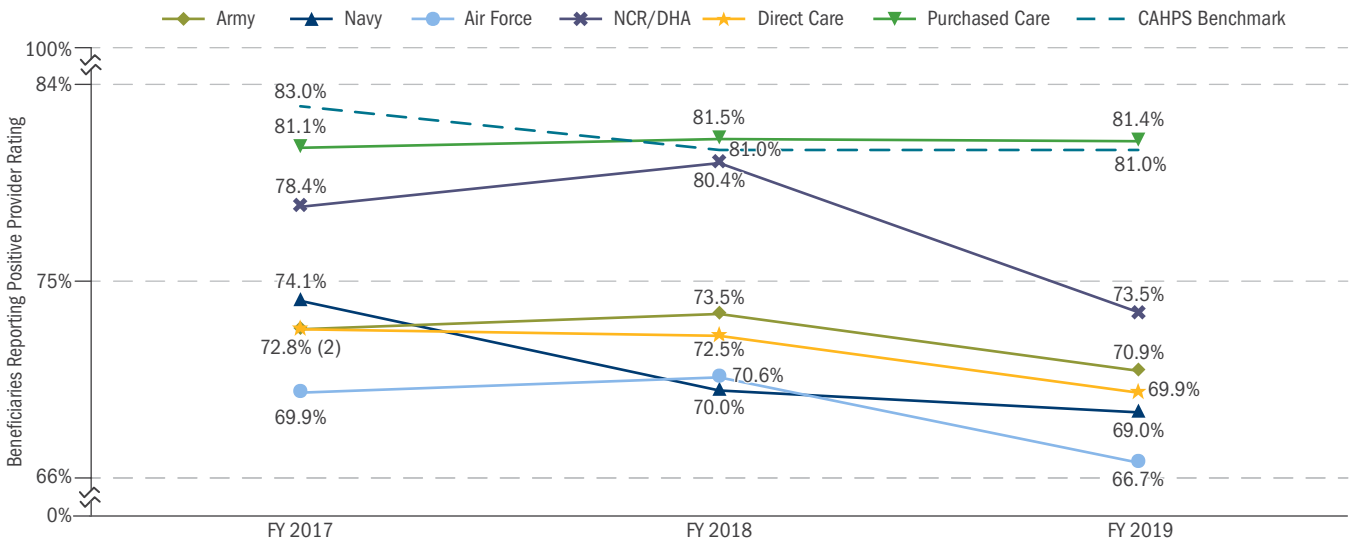
Patient-Centered Care/Experience *(cont.)*

Beneficiary Ratings of Provider Following Outpatient Treatment

In the JOES-C, beneficiaries are also asked to provide an overall rating for their provider, based on a scale from zero (worst provider possible) to 10 (best provider possible). The percentages of beneficiaries rating their provider a nine or 10 are 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.

- Provider ratings were captured by JOES-C from FY 2017 to FY 2019. The annual aggregated rating from FY 2017 to FY 2019 declined by approximately three and two percentage points for Air Force and Army, respectively. Provider ratings for NCR/DHA and Navy decreased by approximately five percentage points over this same period.
- Direct care scores declined about three percentage points between FY 2017 and FY 2019, while purchased care scores remained relatively steady.
- The graph shows that almost all of the Services are still below the national CAHPS 50th percentile as of FY 2019, with the exception sof the purchased care scores, which are similar to the benchmark.

JOES-C RATING OF PROVIDER, FYs 2017–2019



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES-C weighted data, compiled 10/15/2019

Notes:

– Results displayed above were weighted to represent the composition of the MHS population.
– CAHPS benchmarks are the 50th percentiles from the respective 2016 and 2017 CG-CAHPS national civilian scores.
– Results for JOES-C FY 2019 direct care and purchased care include data from September 2018 to June 2019.
– The NCR category is represented by the FY 2017 Q1 through FY 2019 Q1 data points and is made up of parent facilities FBCH and WRNMMC. Parent facilities FBCH, WRNMMC, 81st Medical Group at Keesler Air Force Base, Womack Army Medical Center, Naval Hospital Jacksonville, 4th Medical Group at Seymour Johnson Air Force Base, and 628th Medical Group at Joint Base Charleston compose the DHA category from FY 2019 Q2 through FY 2019 Q4.
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration.
– For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

Patient-Centered Care/Experience *(cont.)*

Beneficiary Ratings of Care Following Inpatient Treatment

TRISS: The purpose of the TRISS survey 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 AHRQ and CMS for the HCAHPS initiative. Additional information on HCAHPS, including the 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, as well as information on recent changes, star ratings, and other updates to publicly reported data such as that on the Hospital Compare website. The TRISS follows the HCAHPS protocols developed by CMS and endorsed by the NQF.

The goal of the HCAHPS initiative is to measure uniformly and report publicly on inpatient care experiences using 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. The TRISS continues to update and change as new HCAHPS requirements are tested and implemented, and these changes over time have resulted in more reliable measures and higher response rates. Data collected by the TRISS includes but is not limited to:

- 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;
- Communication about pain (recently updated);
- Hospital environment (cleanliness and quietness); and
- Post-discharge (such as written directions for post-discharge care).

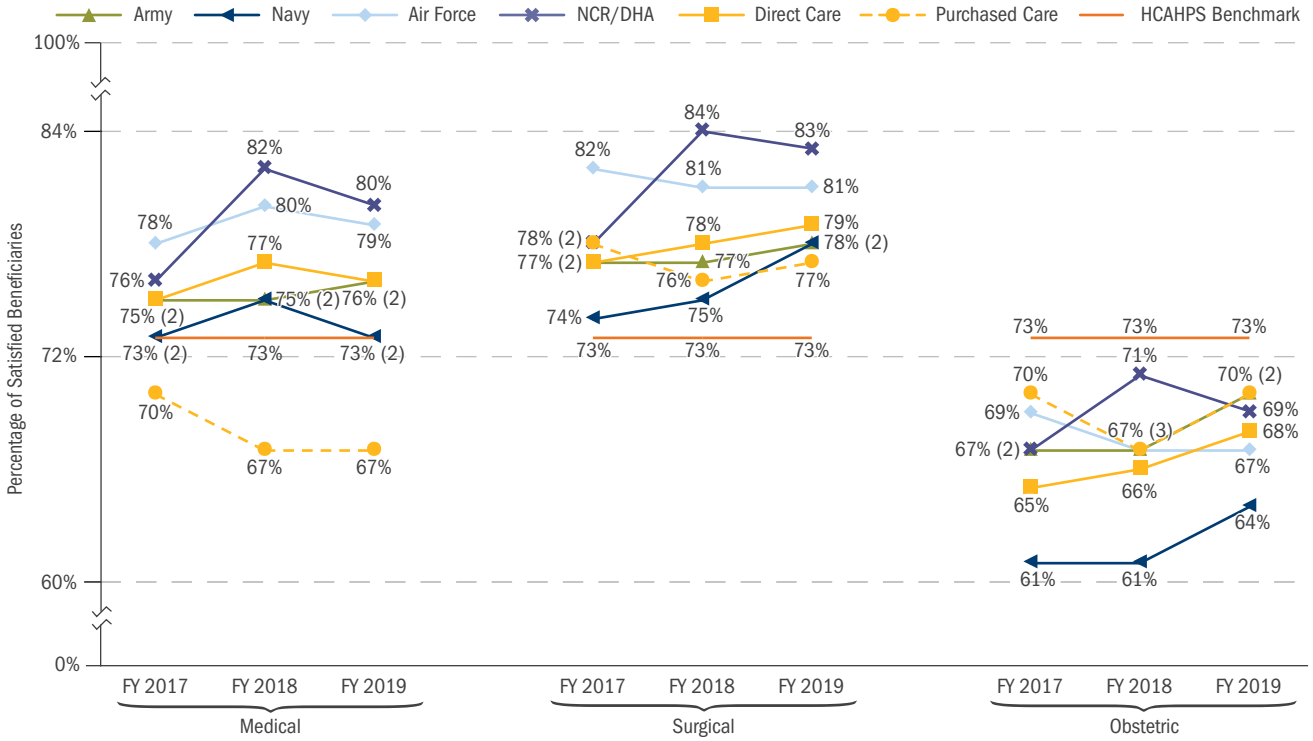
In the following sections, we detail specific findings focused primarily on two measures of patient experience: overall rating of the hospital and willingness to recommend the hospital to others. These results are produced by the DHA J-5 Analytics and Evaluation Division and do not represent official HCAHPS results. Official HCAHPS results are published on the Hospital Compare website (www.medicare.gov/hospitalcompare).

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient-Centered Care/Experience *(cont.)*

Overall Hospital Rating: Overall, direct care has improved patient satisfaction over time in each inpatient product line from FY 2017 to FY 2019. Each of the Services met or exceeded the national HCAHPS benchmark in FY 2019 in the medical and surgical product lines, with the surgical product line improving in FY 2019. Although the obstetric product line results for all Services and purchased care are below the HCAHPS benchmark, scores trended upward overall in FY 2019.

TRISS OVERALL HOSPITAL RATING TRENDS, FYs 2017–2019



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 11/20/2019

Notes:

– FY 2019 includes results from FY 2019 Q1–Q3 for direct care and the Services.

– HCAHPS benchmarks are the U.S. scores from the October 2017, October 2018, and July 2019 HCAHPS Public Reports. More information about these scores can be found at: https://www.hcahpsonline.org/en/summary-analyses/.

– The NCR category is represented by the FY 2017 Q1 through FY 2019 Q1 data points and is made up of parent facilities FBCH and WRNMMC. Parent facilities FBCH, WRNMMC, 81st Medical Group at Keesler Air Force Base, Womack Army Medical Center, Naval Hospital Jacksonville, 4th Medical Group at Seymour Johnson Air Force Base, and 628th Medical Group at Joint Base Charleston compose the DHA category from FY 2019 Q2 through FY 2019 Q4.

– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration.

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

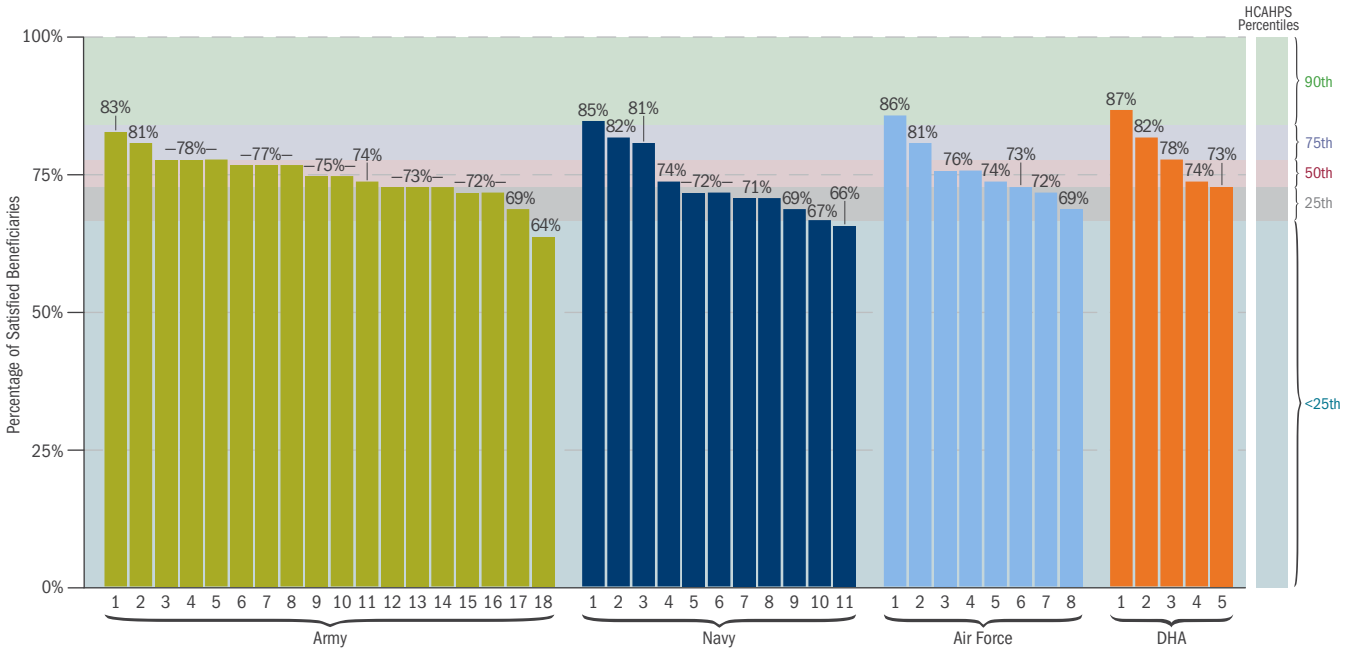
HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient-Centered Care/Experience *(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 149.

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 NH Guam, AF-MC-88th MEDGRP-Wright-Patterson, and AF-MC-81st MEDGRP-Keesler. Ten facilities had ratings in the HCAHPS 75th percentile; 16 facilities had ratings in the HCAHPS 50th percentile. The remaining facilities were below the HCAHPS 50th percentile.

TRISS OVERALL HOSPITAL RATING: DIRECT CARE, FY 2019



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 11/20/2019

Notes:

– FY 2019 includes results from FY 2019 Q1–Q3 for direct care and the Services.
– Facilities that have fewer than 25 responses do not have a score displayed above.
– Sites that migrated to MHS GENESIS were sampled in FY 2019 Q4 after migration.
– 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 (July 2019 Public Report: October 2017–September 2018 discharges). More information about these percentiles can be found at: https://www.hcahpsonline.org/en/summary-analyses/.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient-Centered Care/Experience *(cont.)*

The table below displays the extent to which the Overall Hospital Rating scores changed over time in terms of improvement (increasing mean or median) or decreased dispersion (reduced range or IQR).

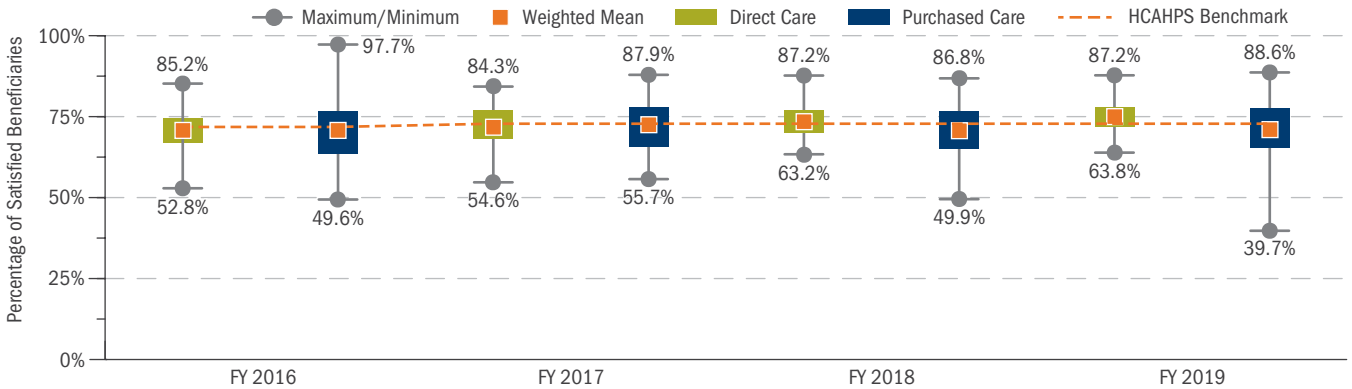
- From FY 2016 to FY 2019, direct care improved by approximately five and three percentage points in terms of the mean and median ratings, respectively.
- Dispersion of direct care decreased in terms of the range from FY 2016 to FY 2019; the range between the lowest- and highest-performing MTFs decreased by nine percentage points from FY 2016 to FY 2019.
- Dispersion of purchased care scores has changed minimally from FY 2016 to FY 2019—most changes were less than one percentage point over time. The IQR was lower for direct care than purchased care in FY 2019, indicating less dispersion of direct care scores than purchased care scores during the time period.

TRISS OVERALL HOSPITAL RATING: FYs 2016–2019

	FY 2016	FY 2017	FY 2018	FY 2019	% POINT CHANGE (FY 2016–FY 2019)
DIRECT CARE					
Weighted Mean	70.5%	72.5%	74.4%	75.3%	4.8
Median	71.6%	73.5%	74.3%	74.3%	2.7
75th Percentile (Q3)	74.5%	76.8%	76.9%	77.9%	3.4
25th Percentile (Q1)	67.0%	68.1%	70.0%	71.9%	4.9
IQR	7.5%	8.7%	6.8%	6.0%	–1.5
Maximum	85.2%	84.3%	87.2%	87.2%	2.0
Minimum	52.8%	54.6%	63.2%	63.8%	11.0
Range	32.4%	29.7%	24.0%	23.4%	–9.0
PURCHASED CARE					
Weighted Mean	71.4%	73.0%	70.8%	71.5%	0.1
Median	72.6%	72.3%	71.7%	71.9%	–0.7
75th Percentile (Q3)	77.8%	78.7%	76.8%	77.7%	–0.1
25th Percentile (Q1)	65.7%	67.0%	65.2%	65.5%	–0.2
IQR	12.1%	11.7%	11.5%	12.3%	0.2
Maximum	97.7%	87.9%	86.8%	88.6%	–9.1
Minimum	49.6%	55.7%	49.9%	39.7%	–9.9
Range	48.1%	32.3%	36.9%	49.0%	0.9

Notes:
– Inpatient facilities scores were used in the table above, and facilities reporting fewer than 25 respondents were excluded from analyses.
– FY 2019 includes results from FY 2019 Q1–Q3 for direct care and FY 2019 Q1–Q2 for purchased care.
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration.

VARIABILITY IN TRISS OVERALL HOSPITAL RATINGS, FYs 2016–2019



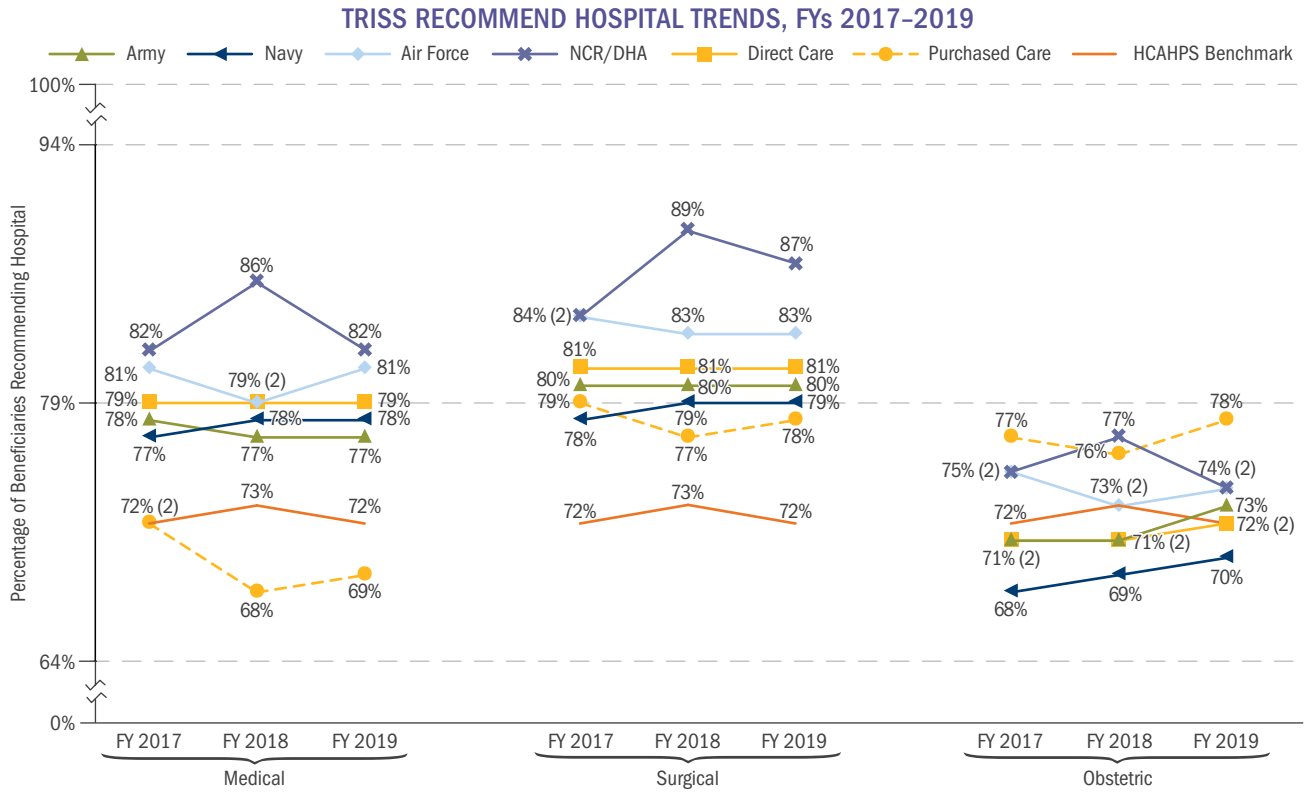
Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 11/20/2019
Notes:
– Inpatient facility scores were used above, and facilities reporting fewer than 25 responses in the time period were excluded from analyses.
– FY 2019 includes Q1–Q3 for direct care results and Q1–Q2 for purchased care results.
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration.
– The box shows the IQR (25th to 75th percentiles) with the direct care or purchased care score highlighted.
– HCAHPS benchmarks are U.S. scores from the October 2016 (72%), October 2017 (73%), October 2018 (73%), and July 2019 (73%) HCAHPS Public Reports. More information about these benchmarks can be found at: https://hcahpsonline.org/en/summary-analyses/.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient-Centered Care/Experience *(cont.)*

Beneficiary Recommendation of Hospital Following Inpatient Treatment

Results for Recommend Hospital follow similar trends to those for Overall Hospital Rating from FY 2017 to FY 2019. Both the medical and surgical product lines remain above the HCAHPS benchmarks with the exception of purchased care scores for the medical product line, which saw a decrease from FY 2017 to FY 2019. For the obstetric product line, purchased care, Air Force, and NCR/DHA scores remain steadily above the benchmark. NCR/DHA again demonstrates leadership in patient care ratings, with significant increases through FY 2018. While obstetric ratings also increased over time for Army, direct care, and Navy, they remain at or below the benchmark as of FY 2019.



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 11/20/2019

Notes:

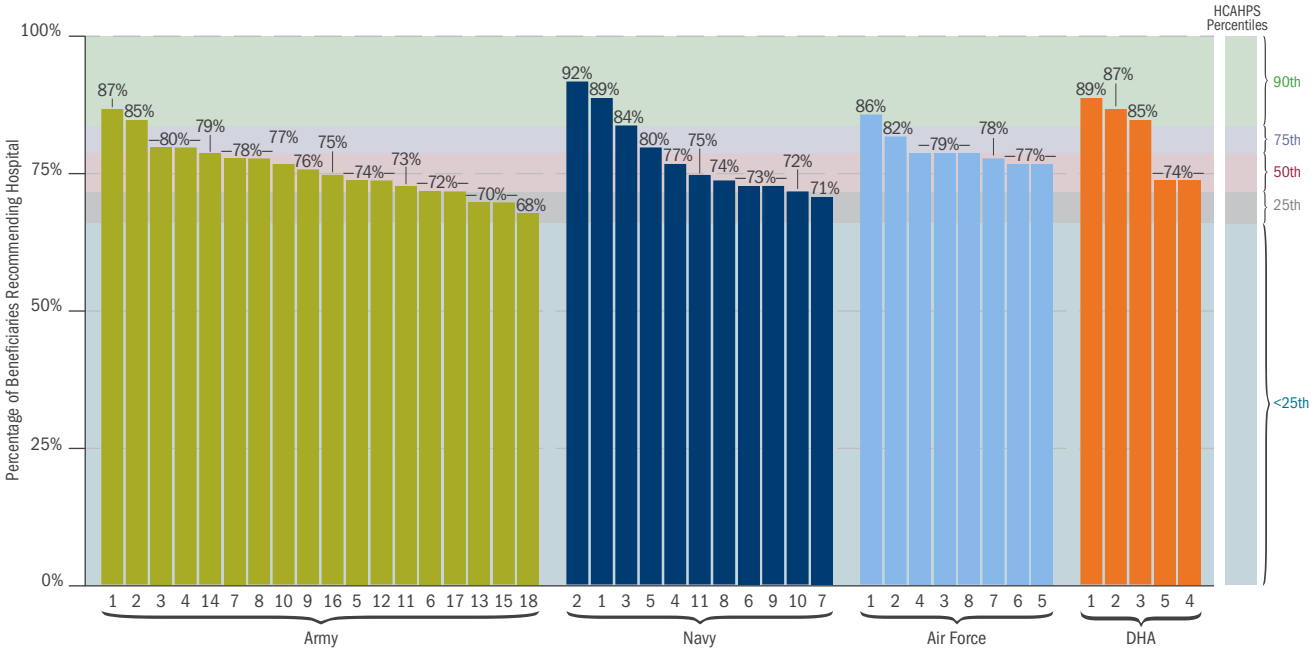
– FY 2019 includes results from FY 2019 Q1–Q3 for direct care and the Services.
– HCAHPS benchmarks are the U.S. scores from the October 2017, October 2018, and July 2019 HCAHPS Public Reports. More information about these scores can be found at: https://hcahpsonline.org/en/summary-analyses/.
– The NCR category is represented by the FY 2017 Q1 through FY 2019 Q1 data points and is made up of parent facilities FBCH and WRNMMC. Parent facilities FBCH, WRNMMC, 81st Medical Group at Keesler Air Force Base, Womack Army Medical Center, Naval Hospital Jacksonville, 4th Medical Group at Seymour Johnson Air Force Base, and 628th Medical Group at Joint Base Charleston compose the DHA category from FY 2019 Q2 through FY 2019 Q4.
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration.
– For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient-Centered Care/Experience *(cont.)*

The chart below shows the distribution for Recommend Hospital of direct care inpatient facilities, and how these ratings compared with the national HCAHPS percentiles. Nine facilities had ratings that reached the HCAHPS 90th percentile: two Army, three Navy, one Air Force, and three DHA. Eight facilities had ratings in the HCAHPS 75th percentile; 21 facilities had ratings in the HCAHPS 50th percentile. The remaining facilities were below the HCAHPS 50th percentile.

TRISS RECOMMEND HOSPITAL: DIRECT CARE, FY 2019



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 11/20/2019

Note:

- FY 2019 includes results from FY 2019 Q1–Q3 for direct care and the Services.
- Facilities that have fewer than 25 responses do not have a score displayed above.
- Sites that migrated to MHS GENESIS were sampled in FY 2019 Q4 after migration.
- 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 (July 2019 Public Report: October 2017–September 2018 discharges). More information about these percentiles can be found at: https://www.hcahpsonline.org/en/summary-analyses/.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient-Centered Care/Experience *(cont.)*

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).

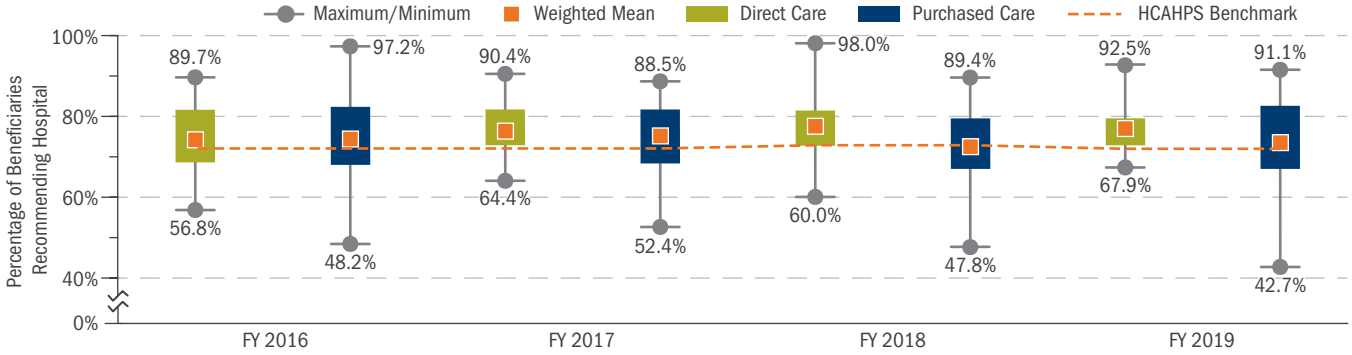
- From FY 2016 to FY 2019, direct care improved by four and two percentage points in terms of the mean and median ratings, respectively.
- The change in the IQR for direct care was greater than the change in the median and mean—there was a drop of two percentage points in the 75th percentile and an improvement of almost five percentage points in the 25th percentile.
- There was a decrease of eight percentage points in the range between the lowest- and highest-performing inpatient facilities for direct care.

TRISS RECOMMEND HOSPITAL RATING: FYs 2016–2019

	FY 2016	FY 2017	FY 2018	FY 2019	% POINT CHANGE (FY 2016–FY 2019)
DIRECT CARE					
Weighted Mean	74.3%	76.6%	77.8%	78.3%	4.0
Median	75.3%	77.7%	76.2%	77.4%	2.1
75th Percentile (Q3)	81.8%	81.8%	81.3%	79.9%	-1.9
25th Percentile (Q1)	68.8%	73.2%	73.0%	73.6%	4.8
IQR	13.0%	8.7%	8.4%	6.3%	-6.7
Maximum	89.7%	90.4%	98.0%	92.5%	2.8
Minimum	56.8%	64.4%	60.0%	67.9%	11.1
Range	32.9%	26.0%	37.9%	24.6%	-8.3
PURCHASED CARE					
Weighted Mean	74.6%	75.3%	73.4%	74.1%	-0.5
Median	75.8%	76.0%	73.9%	75.4%	-0.4
75th Percentile (Q3)	82.3%	81.6%	79.8%	82.9%	0.6
25th Percentile (Q1)	68.0%	68.9%	67.9%	67.6%	-0.4
IQR	14.3%	12.7%	11.8%	15.2%	0.9
Maximum	97.2%	88.5%	89.4%	91.1%	-6.1
Minimum	48.2%	52.4%	47.8%	42.7%	-5.5
Range	49.0%	36.1%	41.6%	48.4%	-0.6

Notes:
– Inpatient facility scores were used in the table above, and facilities reporting fewer than 25 respondents were excluded from analyses.
– FY 2019 includes results from FY 2019 Q1–Q3 for direct care and FY 2019 Q1–Q2 for purchased care.
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration.

VARIABILITY IN TRISS RECOMMEND HOSPITAL RATINGS, FYs 2016–2019



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 11/20/2019

Notes:
– Inpatient facility scores were used above, and facilities reporting fewer than 25 responses in the time period were excluded from analyses.
– FY 2019 includes results from FY 2019 Q1–Q3 for direct care and FY 2019 Q1–Q2 for purchased care.
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration.
– The box shows the IQR (25th to 75th percentiles) with the direct care or purchased care score highlighted.
– HCAHPS benchmarks are U.S. scores from the October 2016 (72%), October 2017 (72%), October 2018 (73%), and July 2019 (72%) HCAHPS Public Reports. More information about these benchmarks can be found at: https://hcahpsonline.org/en/summary-analyses/.

Patient-Centered Care/Experience *(cont.)*

Patient Experience Star Ratings—Inpatient Facilities

Star ratings are used by CMS to enable consumers to assess patients' experience of care across health care facilities. The summary star rating for patient experience takes into account all 10 publicly reported HCAHPS measures, referenced on page 144, including Overall Hospital Rating and Recommend Hospital as components. Official star ratings for CY 2017, including for military hospitals in the United States, are posted publicly on the CMS Hospital Compare website. The MHS calculates star ratings similarly to the method employed by CMS using the most recently available civilian benchmarks, and these results are published on the TRISS reporting website.

The MHS performed very well as measured by star ratings from FY 2018 Q4 to FY 2019 Q3. Three stars can be considered an "average" patient experience, so most of the MHS facilities are performing above average in terms of patient care, with 32 four-star-rated facilities and two facilities rated as five-star.

PATIENT EXPERIENCE STAR RATINGS, FY 2018 Q4–FY 2019 Q3

★★★★★	★★★★	★★★
2 FACILITIES	32 FACILITIES	4 FACILITIES

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 11/11/2019
Note: One hundred responses to TRISS within the year were required to receive a summary star rating.

Patient-Centered Care/Experience *(cont.)*

Drivers of Patient Experience Ratings

Results from patient surveys have become increasingly important in measuring health plan performance, directing action to improve the beneficiary experience, and improving the quality of services provided by health care facilities. Patient surveys provide key insights into the patient's perception of the health care they received, as well as the importance of different aspects of their care in determining their overall experience, satisfaction, and ratings of hospital facilities.

As stated previously, 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 health care plan rating (based on CG-CAHPS); 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 the CAHPS Health Plan Survey).

Results from these surveys for FY 2018 and FY 2019 (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 primarily by communication between patients and providers, and getting care when needed. In addition to the above, use of information to coordinate care and treatment by staff were also important to beneficiary satisfaction. Results suggest that improving communication between beneficiaries and health care providers, ensuring hospital cleanliness, and providing care at the right time and location have the potential to influence a patient's health care experience and hospital satisfaction ratings.

TOP THREE DRIVERS OF SATISFACTION BY SURVEY: DIRECT CARE, FYs 2018–2019

	RANKING	TRISS DIRECT CARE MHS RATING OF HOSPITAL	JOES-C DIRECT CARE MHS HEALTH CARE RATING	HCSDB DIRECT CARE U.S. SATISFACTION WITH HEALTH CARE
FY 2018	#1	Communication with Nurses	How Well Providers Communicate with Patients	Provider Communication
	#2	Communication with Doctors	Helpful, Courteous, and Respectful Office Staff	Getting Needed Care
	#3	Cleanliness of Hospital Environment	Providers' Use of Information to Coordinate Care	Treatment by Office Staff
FY 2019	#1	Communication with Nurses	How Well Providers Communicate with Patients	Provider Communication
	#2	Communication with Doctors	Helpful, Courteous, and Respectful Office Staff	Getting Needed Care
	#3	Cleanliness of Hospital Environment	Providers' Use of Information to Coordinate Care	Customer Service

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS results, compiled 10/18/2019, JOES-C results, compiled 10/14/2019, and HCSDB, FYs 2018–2019 (Q1–Q3 only for TRISS and JOES-C)

Notes:

– Composite measure generation followed guidelines established by AHRQ.
– TRISS followed HCAHPS composite construction found at: https://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

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient-Centered Care/Experience *(cont.)*

Drivers of Patient Experience Ratings—JOES

In addition to the TRISS, JOES-C, and HCSDB, the MHS also fields the JOES survey, which combined and standardized previous surveys used by the Army, Navy, Air Force, and NCR/DHA to learn about beneficiary health care experiences. The JOES aims to more efficiently gather beneficiary health care experiences so that the information obtained can be better utilized to improve care within and across the Services.

Respondent data from the JOES for FY 2018 and FY 2019 (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 provider. 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 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 overall satisfaction with health care and providers in MTFs was driven primarily by clear and understandable provider communication and the provider knowing the patient's medical history. Results suggest that treating patients with courtesy and respect, provider review of patient data before or during the exam, and ensuring an easy appointment scheduling process have the potential to positively influence health care experiences for patients.

TOP THREE DRIVERS OF SATISFACTION FROM JOES: DIRECT CARE, FYs 2018–2019

	RANKING	SATISFACTION WITH HEALTH CARE	SATISFACTION WITH PROVIDER
FY 2018	#1	Provider Explained Things in a Way That Was Easy to Understand	Provider Explained Things in a Way That Was Easy to Understand
	#2	Provider Knew Important Medical History	Provider Knew Important Medical History
	#3	Ease of Making the Appointment	Provider Treated Patient with Courtesy and Respect
FY 2019	#1	Provider Explained Things in a Way That Was Easy to Understand	Provider Explained Things in a Way That Was Easy to Understand
	#2	Provider Knew Important Medical History	Provider Knew Important Medical History
	#3	Provider Treated Patient with Courtesy and Respect	Provider Treated Patient with Courtesy and Respect

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES results, FYs 2018–2019, compiled 10/14/2019
Note: JOES questions continue to be updated over time; drivers analysis was based on the most recent survey questions.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

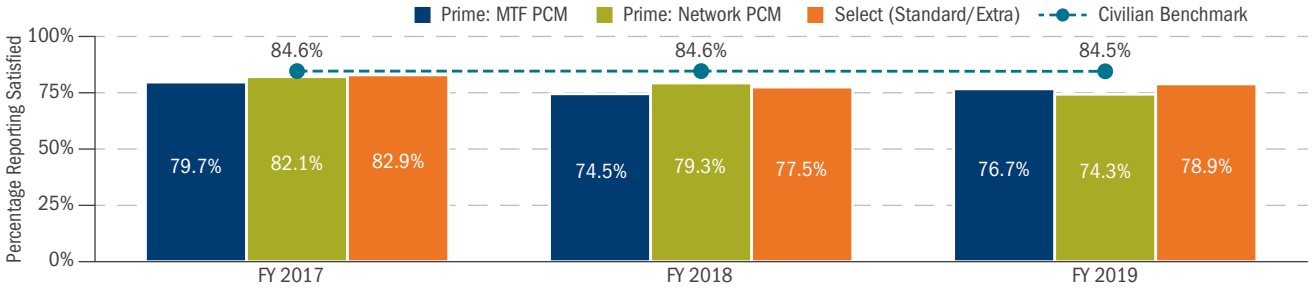
Patient-Centered Care/Experience *(cont.)*

Satisfaction with Customer Service

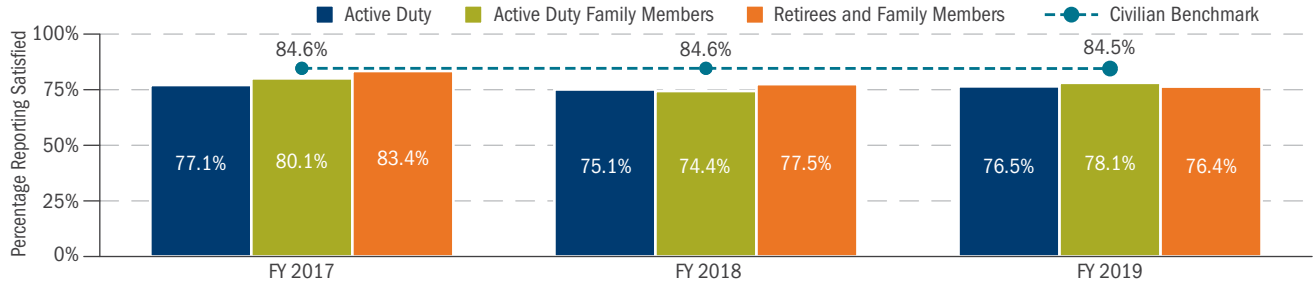
Most DoD health care beneficiaries participate in TRICARE in one of two ways: by enrolling in the Prime option or by using the traditional indemnity option for seeing participating or network providers (TRICARE Standard/Extra in FY 2017 or TRICARE Select in FYs 2018–2019). Access to and understanding 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 declined for Prime enrollees with both an MTF and network PCM as well as for non-enrolled beneficiaries from FY 2017 to FY 2019. The civilian benchmark remained steady over the same time period.
- Satisfaction with customer service for all enrollment groups was lower than the civilian benchmark in FY 2019.
- MHS beneficiary satisfaction with customer service remained stable for Active Duty and ADFMs, but declined significantly for RETFMs between FY 2017 and FY 2019. The civilian benchmark held steady over the same period.
- Satisfaction with customer service for all beneficiary groups was significantly lower than the civilian benchmark in FY 2019.

TRENDS IN RESPONSIVE CUSTOMER SERVICE: COMPOSITE MEASURE OF FINDINGS (UNDERSTANDING WRITTEN MATERIAL, GETTING CUSTOMER ASSISTANCE, AND DEALING WITH PAPERWORK) BY ENROLLMENT STATUS, FYs 2017–2019



TRENDS IN RESPONSIVE CUSTOMER SERVICE: COMPOSITE MEASURE OF FINDINGS (UNDERSTANDING WRITTEN MATERIAL, GETTING CUSTOMER ASSISTANCE, AND DEALING WITH PAPERWORK) BY BENEFICIARY CATEGORY, FYs 2017–2019



Note: HCSDB data were derived from the FYs 2017–2019 HCSDB, as of 11/1/2019, 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 2017 come from NCQA's 2015 data, while the benchmarks used in 2018 and 2019 come from NCQA's 2017 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.

OTHER PLANS AND PROGRAMS

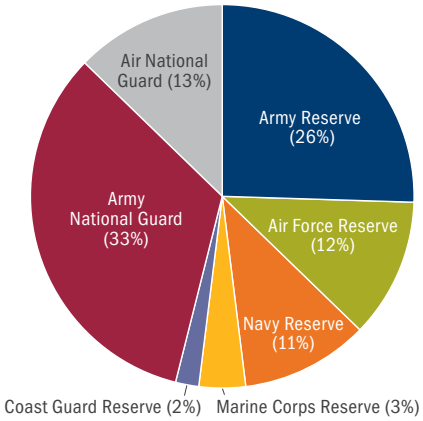
TRICARE Benefits for the Reserve Component

TRICARE offers a broad array of benefits coverage for Reserve Component (RC) members who qualify and their eligible family members pre-deployment, during deployment, post-deployment, and into retirement.

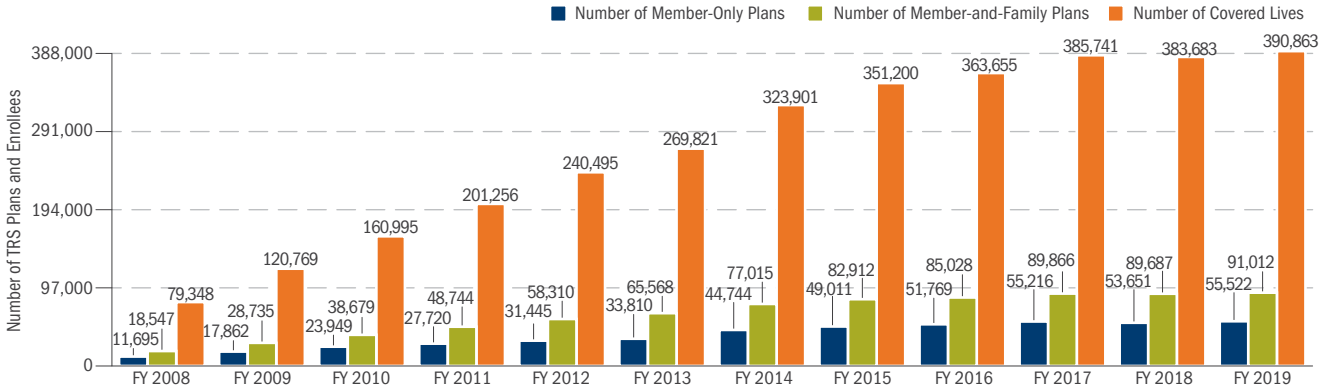
TRICARE Reserve Select (TRS). The premium-based TRS health plan features TRICARE Select coverage for purchase by qualified members of the Selected Reserve. TRS plateaued over the last three years at around 146,000 plans with nearly 391,000 covered lives by the end of FY 2019. The chart below shows TRS enrollment growth since October 1, 2007, when the NDAA FY 2007 enacted current TRS qualifications.

- As shown in the pie chart at right, Army National Guard and Army Reserve combined constitute 59 percent of the 394,636 TRS members.
- NDAA FY 2018, section 511, expanded early eligibility TRICARE (before activation) and Transitional Assistance Management Program (TAMP) coverage (upon deactivation) to include RC members activated for a preplanned mission (under authority of 10 U.S.C. §12304b).

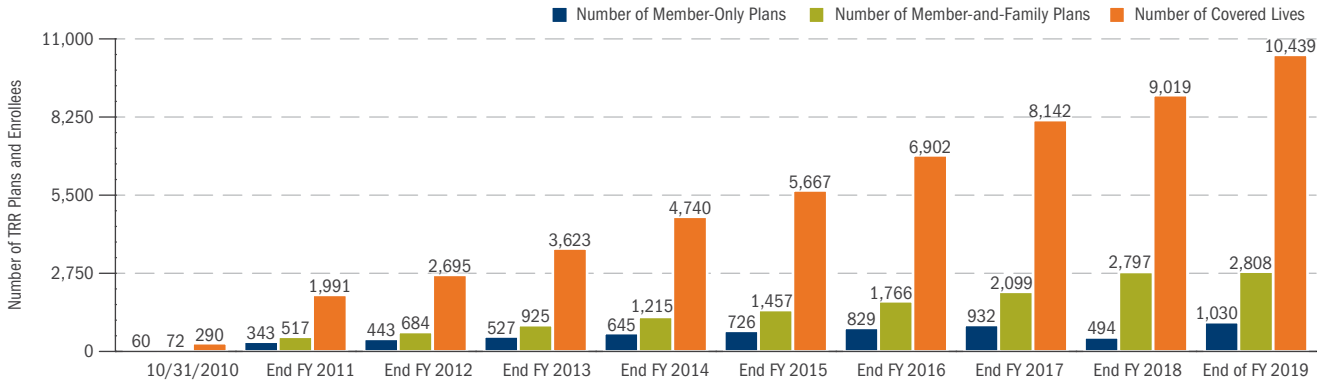
TRICARE RESERVE SELECT: POPULATION BY COMPONENT (394,636 SPONSORS AND FAMILY MEMBERS AS OF SEPTEMBER 2019)



TRENDS IN RC ENROLLMENT IN TRS, SEPTEMBER 2008–SEPTEMBER 2019



TRENDS IN ENROLLMENT IN TRR, OCTOBER 2010–SEPTEMBER 2019



Source: Defense Manpower Data Center (DMDC)/DEERS Medical Policy Report, September 2019

OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Benefits for the Reserve Component *(cont.)*

TRICARE Retired Reserve (TRR). Qualified members of the Retired Reserve may purchase full-cost, premium-based coverage under TRR until they reach age 60. Upon reaching age 60 and receiving retired pay, they and their eligible family members may enroll in an available TRICARE health plan for retirees.

TRR enrollment continued to grow in a linear fashion. By the end of FY 2019, TRR covered over 10,400 Retired Reserve members and their families in 3,838 member-only and member-and-family plans.

TRS and TRR Costs. Both TRS and TRR adopted the new TRICARE Select cost-sharing structure (Group B) on January 1, 2018.

TRR members pay the full cost of the premium unlike TRS, where the member's share of the premium is only 28 percent, with the Department absorbing the rest. Premiums are calculated annually for both TRS and TRR and are derived from actual prior year costs. Premium rates for CY 2020 are as follows:

MONTHLY PREMIUMS FOR TRS AND TRR, CYs 2019–2020

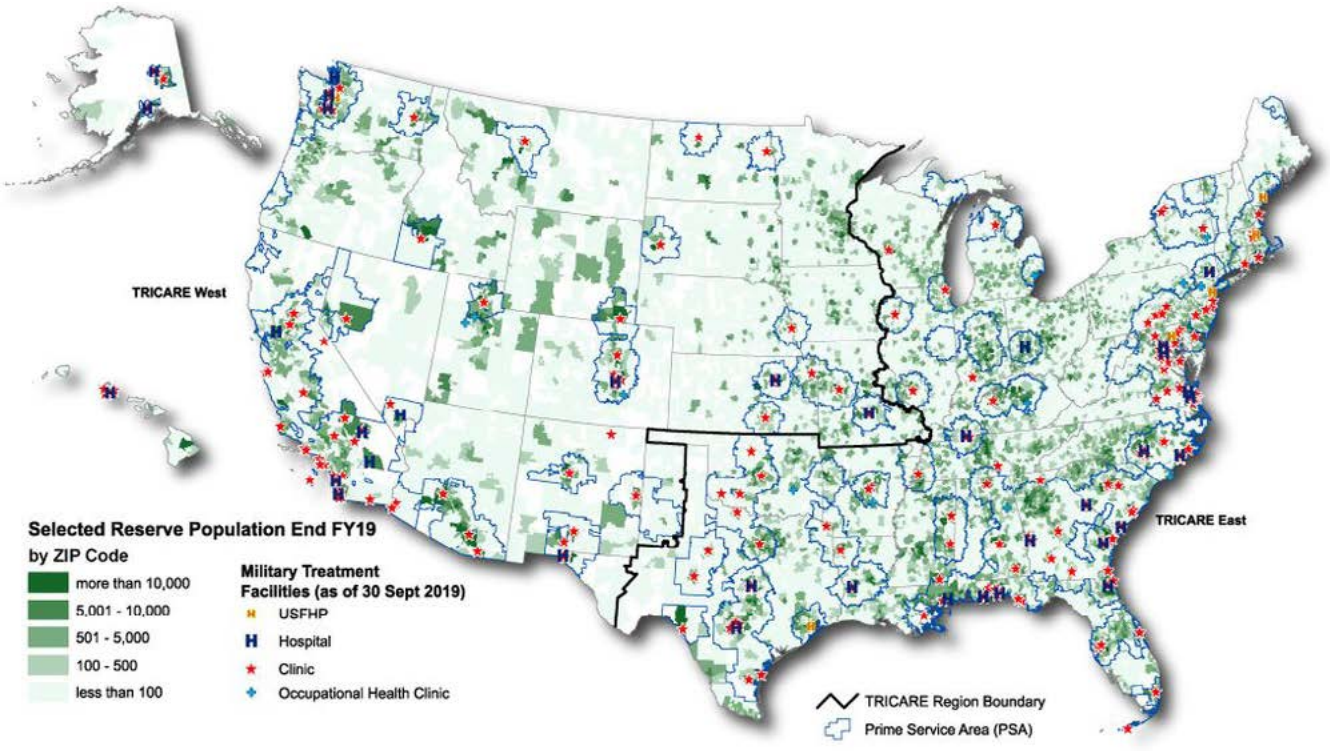
TYPE OF COVERAGE	CY 2019 MONTHLY	CY 2020 MONTHLY	% CHANGE
TRS Member Only	$42.83	$44.17	3.1%
TRS Member and Family	$218.01	$228.27	4.7%
TRR Member Only	$451.51	$444.37	–1.6%
TRR Member and Family	$1,083.40	$1,066.26	–1.6%

Source: TRS and TRR data from https://tricare.mil/Costs/Compare, accessed 1/2/2020

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, END OF FY 2019



COMPARISON OF SELECTED RESERVE AND ACTIVE DUTY SPONSORS AND FAMILY MEMBER PROXIMITY TO MTFs, END OF FY 2019[a]

BENEFICIARY GROUP[b]	POPULATION TOTAL	POPULATION IN PSAs	POPULATION IN MTF SERVICE AREAS	% IN MTF SERVICE AREAS
Active Duty and Their Families	2,765,703	2,647,639	2,572,722	93.0%
Selected Reserve and Their Families	1,928,632	1,317,726	1,053,522	54.6%

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, population as of 9/30/2019

Notes:

[a] Eligible MHS beneficiary data from the MHS Data Repository (MDR) DEERS, as of 9/30/2019. Residential ZIP code was used as the location for all beneficiaries.

[b] Location information determined by DHA Catchment Area Directory database, September 2019.

Definitions:

– PSAs are based on ZIP codes in which MCSCs must offer the TRICARE Prime benefit.

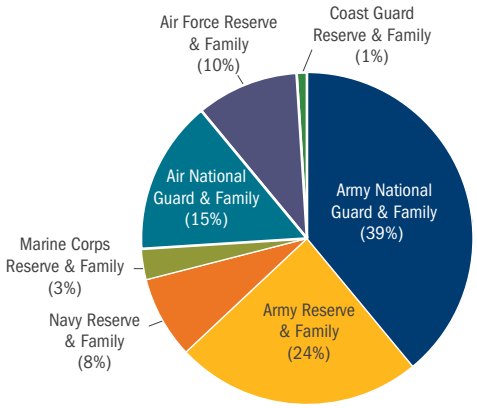
– MTF Service Area is defined by ZIP code (centroids), which are within a 40-mile radius of an active MTF (inpatient or outpatient), subject to overlap rules, barriers, and other policy overrides.

OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Benefits for the Reserve Component *(cont.)*

- As of September 30, 2019, there were more than 2 million Selected Reserve members and their families (2,051,638), of which 807,421 were sponsors and 1,244,217 were family members.
- Over 68 percent of Selected Reserve and their family members (almost 96 percent for Active Duty and their family members) in the U.S. lived in localities where TRICARE Prime was offered (see table on page 157). Slightly more than half (almost 55 percent) of this population lived near an MTF, compared with 93 percent of Active Duty and their family members.
- As shown in the pie chart, almost two-thirds (63 percent) of the worldwide Selected Reserve population of 2 million sponsors and their family members are Army National Guard (39 percent) and Army Reserve (24 percent).

SELECTED RESERVE POPULATION (2,051,638): SPONSORS AND FAMILY MEMBERS BY SERVICE (SEPTEMBER 2019)



Source: RC Common Personnel Data System (RCCPDS) and DEERS Database Extract as of 12/19/2019

TRS TAKE RATE

	TOTAL
Selected Reserve End Strength	**826,848**
Federal Employees Health Benefits Plan (FEHBP)	(113,121)
On Active Duty (AD)	(147,792)
On Early Identification or Early Eligibility (E-ID)	(12,599)
On TAMP	(59,678)
Adjusted TRS Eligible Population	**493,658**
Enrolled TRS Sponsors	126,980
Take Rate for Eligible Population	**25.72%**

Source: ODASD/MPP eligibility data as of 12/30/2014, provided 12/10/2015

Notes:

– Data in table are unchanged since being provided in the FY 2016 TRICARE Evaluation report (page 66); Office of Personnel Management (OPM) data unavailable for updating as of this writing.

– Selected Reserve end strength subcategories are mutually exclusive counts based on precedence of category (e.g., FEHBP, then AD, then E-ID, then TAMP). End of CY 2014 data are the latest available match results for the DoD-OPM match to identify RC members with FEHBP.

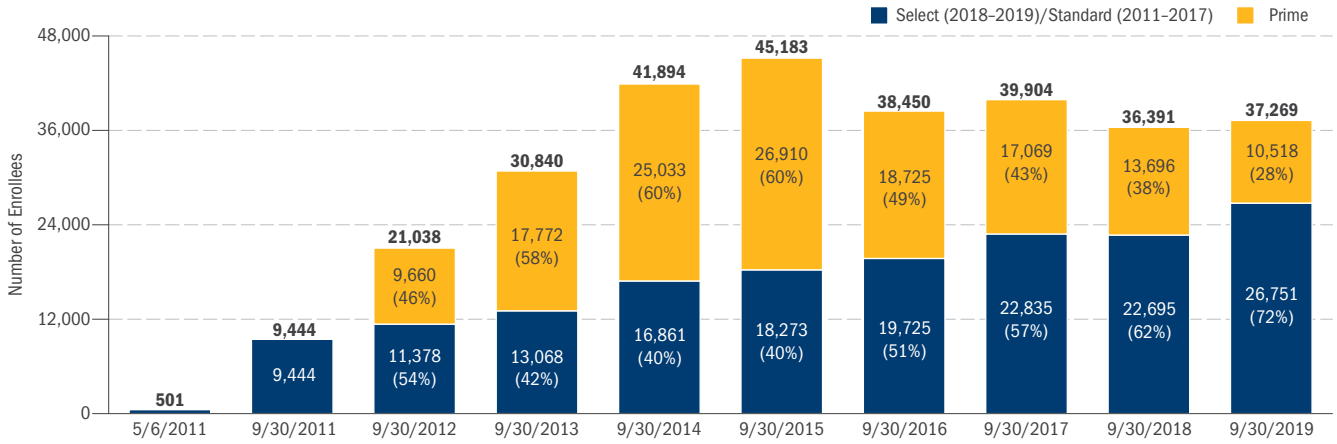
OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Young Adult

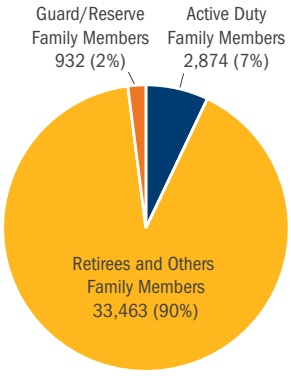
The TRICARE Young Adult (TYA) program is a premium-based TRICARE plan available for purchase by qualified adult-age children who lose eligibility for TRICARE due to age. TYA offers Prime and Select coverage across all TRICARE plans (Prime, Prime Remote ADFM, Prime Overseas, Prime Overseas Remote, Select, Select Overseas, TRR, TRS, and USFHP). Monthly premiums cover the full cost of the coverage with no government contribution. TYA meets the minimum essential coverage requirements of the Patient Protection and Affordable Care Act.

- As shown in the chart below, enrollment rose from over 36,000 in FY 2018 to over 37,000 in FY 2019. Enrollment in the TRICARE Select option accounted for 72 percent of total TYA enrollment.
- As shown in the accompanying pie chart, most TYA enrolled (92 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 increased for CY 2020 from $358 to $376 per month for Prime and from $214 to $228 per month for Select (table below; see tricare.mil/Costs/HealthPlanCosts/TYA).

TRENDS IN TYA ENROLLMENT SINCE INCEPTION (MAY 2011–SEPTEMBER 2019)



TYA ENROLLMENT BY SPONSOR CAREER STATUS, AS OF SEPTEMBER 30, 2019



MONTHLY TYA PREMIUMS, CYs 2016–2020

	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020
Prime	$306	$319	$324	$358	$376
Select (Standard)	$228	$216	$225	$214	$228

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, 1/7/2020
Note: Percentages may not sum to 100 percent due to rounding.

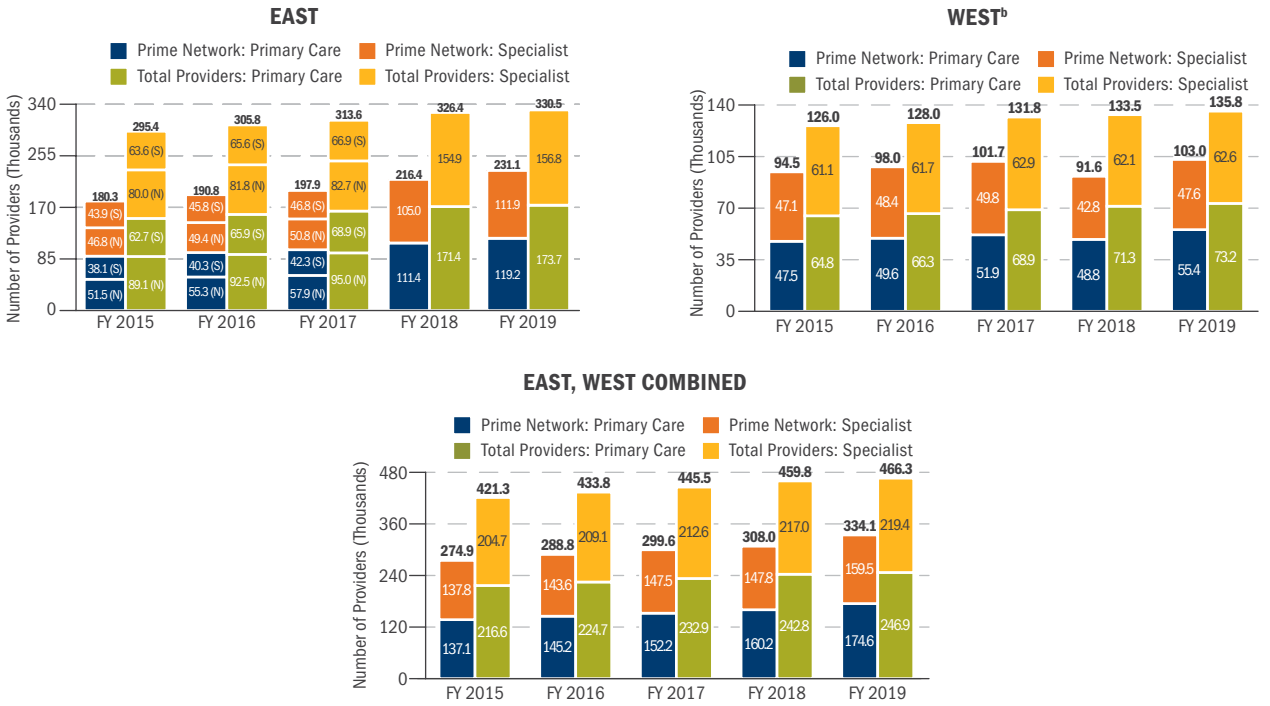
OTHER PLANS AND PROGRAMS *(CONT.)*

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 non-network providers has actually slightly declined. Since FY 2015, the number of network primary care providers has increased at a higher rate (27 percent) than that of specialists (16 percent), and the total number of participating primary care providers has increased at a higher rate (14 percent) than that of total participating specialists (7 percent).[2]

- Between FY 2015 and FY 2019, the East Region saw an increase of 12 percent in the total number of TRICARE providers (10 percent in the former North Region and 14 percent in the former South Region), while the West Region saw an increase of 8 percent.
- The East Region saw an increase of 28 percent in the total number of network providers (33 percent in the former North Region and 23 percent in the former South Region), while the West Region saw an increase of 9 percent.
- The total number of TRICARE providers increased by 11 percent in PSAs and by 10 percent in non-PSAs (not shown). Because the provider trends reported here begin in FY 2015, they are no longer affected by the reduction in the number of PSAs in FY 2014.
- The number of network providers increased by 19 percent in PSAs and by 27 percent in non-PSAs (not shown). These trends are also not affected by the reduction in the number of PSAs in FY 2014.
- In FY 2019, 67 percent of all network providers and 65 percent of all participating providers were in PSAs (not shown).

TRENDS IN NETWORK AND TOTAL PARTICIPATING PROVIDER FTEs, FYs 2015–2019[a]



Source: MHS administrative data, 12/16/2019

[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] The West Region includes Alaska.

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.

[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 assistant, nurse practitioner, and clinic or other group practice.

OTHER PLANS AND PROGRAMS *(CONT.)*

Civilian Provider Acceptance of, and Beneficiary Access to, TRICARE Select

The DoD has completed the first three years (2017–2019) 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 Select benefit option. This survey complies with the requirements of NDAA FY 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 (NDAA FY 2008, section 711, Public Law 110-181) and 2012 to 2015 (NDAA FY 2012, section 721, Public Law 112). 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 Government Accountability Office (GAO) as required by the guiding legislation.

- **Provider survey results and key points after the first three years:**
  - About six of 10 providers overall (55 percent of physicians and nonphysician behavioral health providers) and eight of 10 physicians (76 percent) accept new TRICARE Select 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).
  - Over eight of 10 providers (83 percent) and over nine of 10 physicians (93 percent) are aware of the TRICARE program in general (similar to the 2012–2015 benchmark, respectively, 84 percent for all providers and 93 percent for physicians).
  - Similar to the 2012–2015 and 2008–2011 benchmark surveys, behavioral health providers (including psychiatrists, psychologists, and nonphysician providers) report lower rates than physicians for awareness (75 percent) and acceptance (37 percent), pulling down the all-provider acceptance rates.
  - Primary care and specialist physicians report similar rates of awareness, while specialists report higher rates of acceptance. Both meet or exceed the 2012–2015 benchmark.
  - Providers in non-PSAs report greater awareness and acceptance of new TRICARE Select and Medicare patients than do PSA providers.
- **Beneficiary survey results and key points after the first three years:**
  - Compared with the civilian benchmark, MHS non-enrolled beneficiaries eligible for TRICARE Select rate their care experience and access to care higher than or comparable to the civilian benchmarks (higher for two of four global measures; higher for one of four access measures). This finding is the same regardless of whether we separate beneficiaries by PSA/non-PSA or analyze all beneficiaries together.
  - Beneficiaries in non-PSAs reported higher rates of getting care quickly and finding a personal doctor than those in PSAs. Other access measures did not differ significantly between PSAs and non-PSAs.
  - Provider and beneficiary results vary among PSAs, non-PSAs, and Health Service Areas, offering opportunities for improvement in some local areas for certain provider types (e.g., primary care in Portland and Eugene, Ore., or mental health care in the Bronx and Brooklyn, N.Y.).

During the time of this study, section 701 of NDAA FY 2017 replaced the non-enrolled TRICARE Standard program with the new enrollment-based TRICARE Select benefits program, effective January 1, 2018. Thus, these results combine experience of the new TRICARE Select program with the original TRICARE Standard program. This survey is useful in supporting evaluation of the effectiveness of TRICARE Select as it continues to mature.

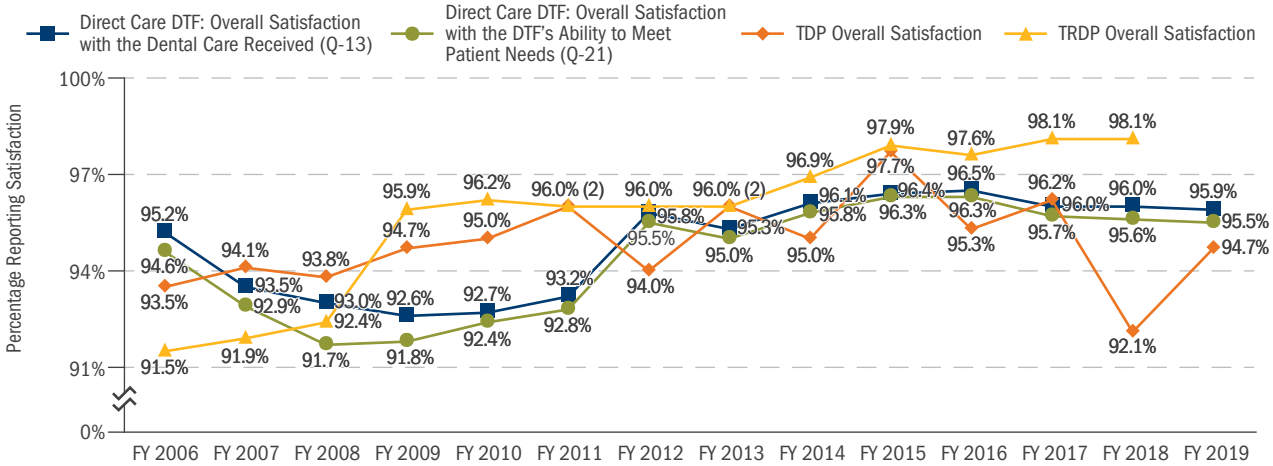
OTHER PLANS AND PROGRAMS *(CONT.)*

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 1.64 million ADSMs worldwide and eligible family members residing outside the contiguous United States (OCONUS). The Tri-Service Center for Oral Health Studies completed 131,059 surveys in FY 2019. Reports of overall satisfaction have remained at around 96 percent since FY 2014.
- The **TRICARE Dental Program (TDP)** composite overall average enrollee satisfaction rose from FY 2018 (92.1 percent) to FY 2019 (94.7 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, 2019, TDP enrollment totaled 769,165 contracts, covering almost 2 million lives (1,827,135), 94 percent of which were in the U.S. The TDP network has 73,085 total dentists, a decline from the 75,362 in FY 2018—of which 58,912 are general dentists and 14,173 are specialists.
- The **TRICARE Retiree Dental Program (TRDP)** overall retired enrollee satisfaction rate remained at just over 98 percent in FY 2018 (the final year of the program), after steadily climbing up over the past four years from 96 percent in FY 2013. The TRDP was a full premium insurance program open to retired Uniformed Services members and their families. TRDP enrollment at the end of FY 2018 was higher by 11 percent than in FY 2015, with over 1.6 million total covered lives in over 843,000 contracts in FY 2018, compared with just under 1.5 million lives in nearly 758,800 contracts in FY 2015.
  - NDAA FY 2017, section 715 (Public Law 114-328) directed the SECDEF to enter into an agreement with the Director of the U.S. Office of Personnel Management (OPM) to allow certain TRICARE-eligible individuals, such as certain retirees, surviving spouses and other dependents, to enroll in dental and vision benefits, and ADFMs to enroll in vision benefits offered under Federal Employees Dental and Vision Insurance Program (FEDVIP). DHA and OPM collaborated together to educate TRICARE beneficiaries about the termination of TRDP and the option to enroll in FEDVIP during the Federal Benefits Open Season from November 12 to December 10, 2018.
  - The TRDP to FEDVIP transition was completed in January 2019, and was the largest expansion of FEDVIP since its inception in 2007.
  - More than 3 million Uniformed Services retirees and their family members, formerly eligible for TRDP, chose FEDVIP dental and vision plans from a selection of 15 dental plan options and eight vision plan options. Approximately 639,437 (78 percent) of the 824,704 TRDP policy holders transitioned to FEDVIP in 2019. An additional 118,909 Uniformed Services eligible policy holders who were not previously enrolled in TRDP chose to enroll in FEDVIP dental plans.

SATISFACTION WITH TRICARE DENTAL CARE: MILITARY AND CONTRACT SOURCES, FYs 2006–2019



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), 12/11/2019

Notes:
– 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.

OTHER PLANS AND PROGRAMS *(CONT.)*

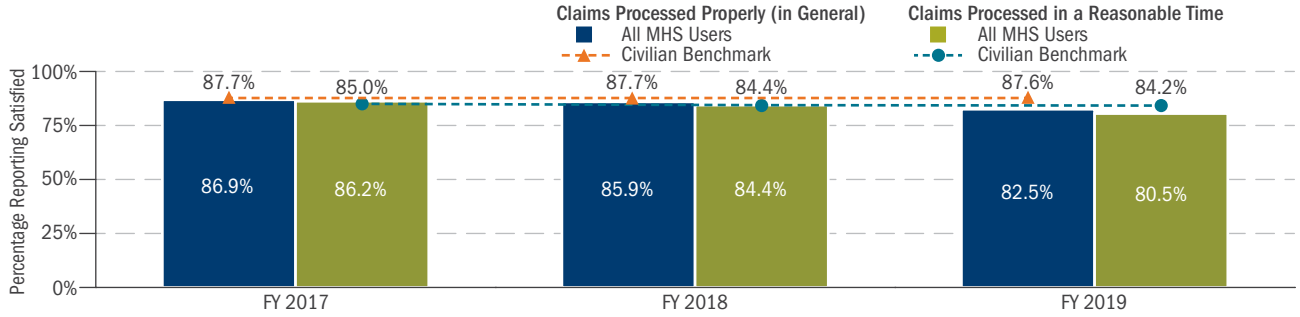
Customer Service, Claims Processing

Beneficiaries and their providers alike 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 both with claims being processed properly and with processing speed decreased from FY 2017 to FY 2019. The civilian benchmarks remained stable over the same time period.
- MHS satisfaction levels with both the accuracy and the speed of claims processing were lower than the civilian benchmarks for FY 2019.

TRENDS IN SELF-REPORTED ASPECTS OF CLAIMS PROCESSING (ALL SOURCES OF CARE), FYs 2017–2019



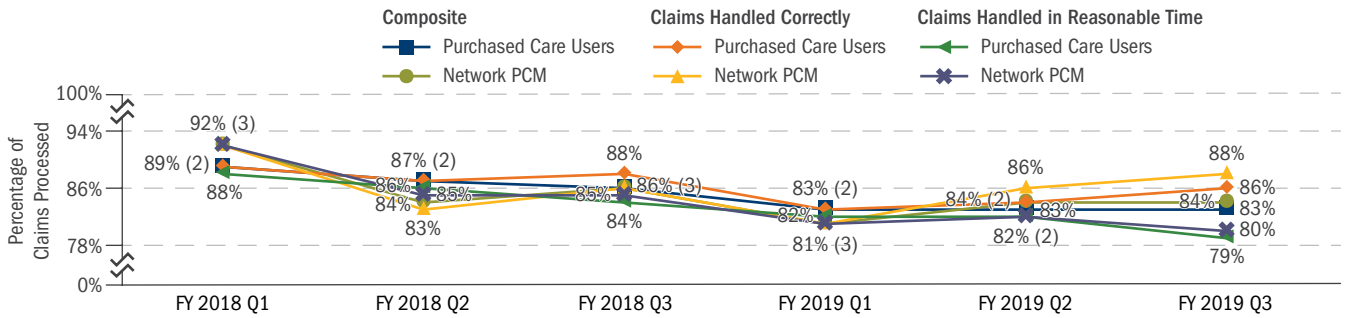
Note: HCSDB data were derived from the FYs 2017–2019 HCSDB, as of 11/1/2019, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the 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 2017 come from NCQA's 2015 data, while the benchmarks used in 2018 and 2019 come from NCQA's 2017 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 that 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 that 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.

TRENDS IN PURCHASED CARE/NETWORK PCM CLAIMS PROCESSING, FY 2018 Q1–FY 2019 Q3



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, MHS administrative data, 7/9/2019; HCSDB, current as of FY 2019 Q3
Notes:
– Purchased care users are beneficiaries who rely on civilian care financed by TRICARE through Prime or Select.
– For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

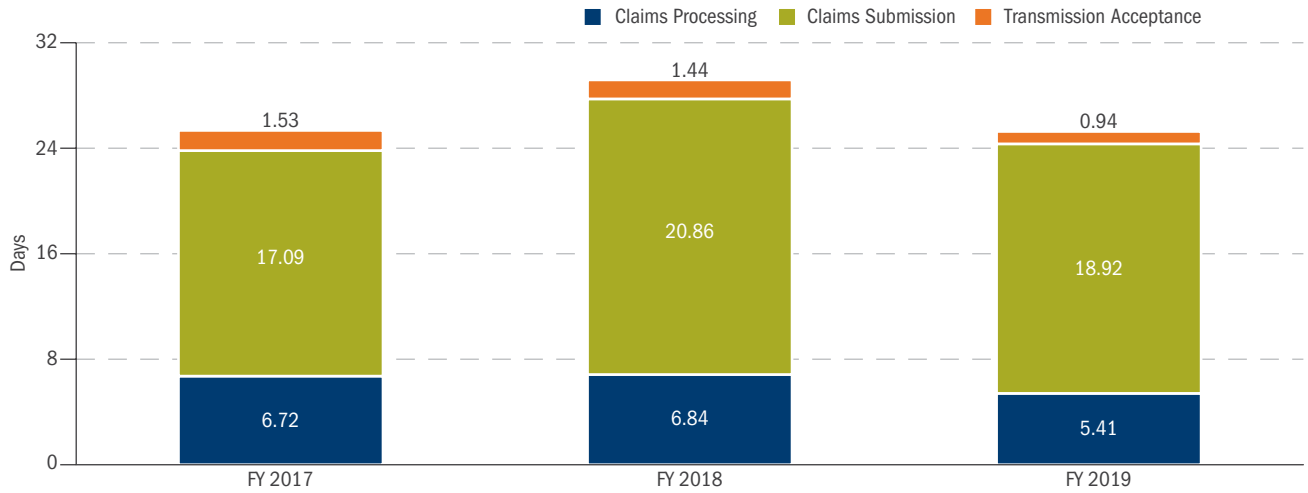
Customer Service, Claims Processing *(cont.)*

DHA pays MCSCs within seven days of the later of "Transmission Receive Date" or "Last Update Date," in compliance with contractual language. The chart below shows that TRICARE payments met time requirements, complying with managed care support contracts. It excludes paper claims and claims from OHI, pharmacy, TRICARE Dual Eligible Fiscal Intermediary Contract, and TRICARE Overseas Program contracts.

This fiscal year marked a return to a more standard level of processing times after the FY 2018 increases correlated with the contract changeover from T3 to T2017. The lengthiest portion of claims processing consistently is 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 shows results of analyses of claims counts of 39.7 million, 38.7 million, and 41.8 million for FY 2017, FY 2018, and FY 2019, respectively. The 3.1 million increase in claim counts from FY 2018 to FY 2019 is a return to a multiyear trend of year-to-year volume increases after the aberration of the FY 2018 decrease.

AVERAGE INTERVAL (DAYS) FOR CLAIMS PROCESSING, FYs 2017–2019



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, MHS administrative data, 12/5/2019

POPULATION HEALTH

The Military Health System (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.

HEALTH PROMOTION AND DISEASE PREVENTION EFFORTS

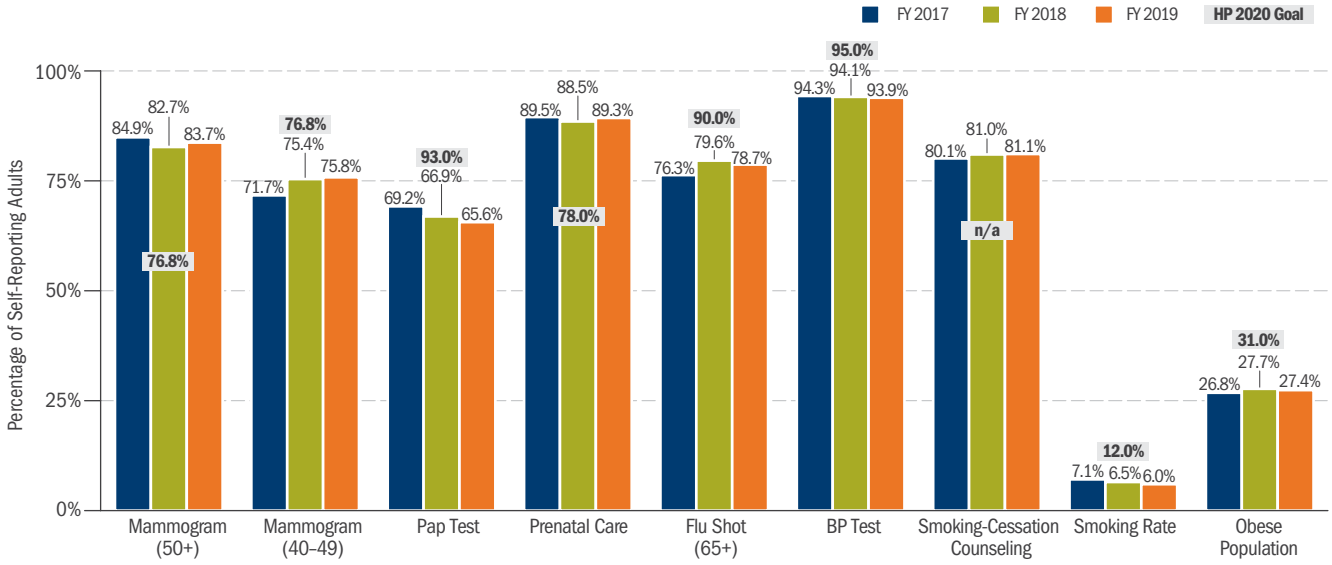
This section presents efforts toward meeting the MHS aim of "Better Health," part of the Quadruple Aim, to include preventive care, population health, tobacco cessation, and obesity and condition management. This section also provides selected measures benchmarked to the Healthy People 2020 (HP 2020) goals. The HP 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 over the age of 40 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 the next page).
- **Pap Test:** The percentage of MHS female beneficiaries receiving Pap tests declined from about 69 percent in fiscal year (FY) 2017 to about 66 percent in FY 2019. 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 6 percent in FY 2019, six percentage points below the HP 2020 goal of 12 percent for adults aged 18 years and over. Smoking-cessation counseling has held constant from just over 80 percent in FY 2017 to just over 81 percent in FY 2019.
- **Obesity:** The overall proportion of MHS beneficiaries identified as obese increased slightly from under 27 percent in FY 2017 to just over 27 percent in FY 2019. This is below the HP 2020 goal of 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 33.9 percent from 2005 to 2008 (Centers for Disease Control and Prevention [CDC] National Center for Health Statistics [NCHS], 2012; not shown). See additional charts on pages 169 and 170, which distinguish obesity rates by beneficiary category.

HEALTH PROMOTION AND DISEASE PREVENTION EFFORTS *(CONT.)*

TRENDS IN MEETING PREVENTIVE CARE STANDARDS, FYs 2017–2019



Sources: DHA/SP&FI (J-5)/Analytics and Evaluation Division, 2017–2019 HCSDB http://www.tricare.mil/survey/hcsdbsurvey/home/z_reports.cfm, results provided 1/10/2020, NHANES; CDC, 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

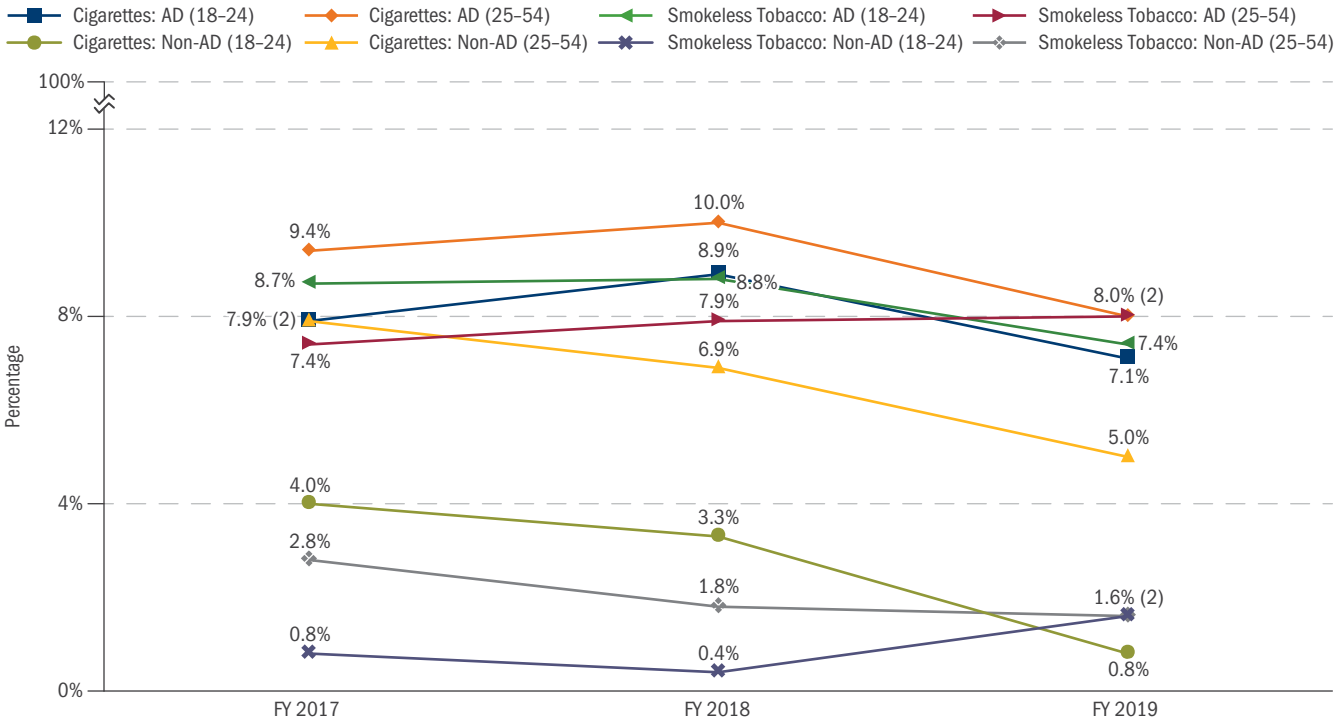
Mammogram: Women aged 50 or older who had a mammogram in the past year; women aged 40–49 who had a mammogram in the past two years. **Pap Test:** All women who had a Pap test in the last three years. **Prenatal Care:** Women pregnant in the last year who received care in the first trimester. **Flu Shot:** 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.

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 statistically declined over the past six years: from 16 percent in FY 2013, leveling to 8 percent in FY 2019 (not shown). This trend in lower Active Duty cigarette usage is most pronounced in the 18- to 24-year-old age range (7 percent in FY 2019, compared with 7.8 percent in the U.S. among the same age group). Use of smokeless tobacco products in the 25- to 54-year-old age range by Active Duty (8 percent) increased by one percentage point from FY 2017 to FY 2019, but decreased for non-Active Duty (2 percent) by one percentage point. Non-Active Duty appear to smoke cigarettes (5 percent in FY 2019) and use smokeless tobacco (1 percent) at lower rates than Active Duty (not shown). Active Duty and non-Active Duty rates are lower than the reported U.S. national average for smoking cigarettes (13.7 percent, reported in 2018), 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 NON-ACTIVE DUTY, FYs 2017–2019



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, 2017–2019 HCSDB https://tricare.mil/survey/hcsdbsurvey/home/z_reports.cfm, results provided 1/10/2020

Notes:

– 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 13.7 percent, 7.8 percent for adults aged 18–24 from https://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/, accessed 1/10/2020.

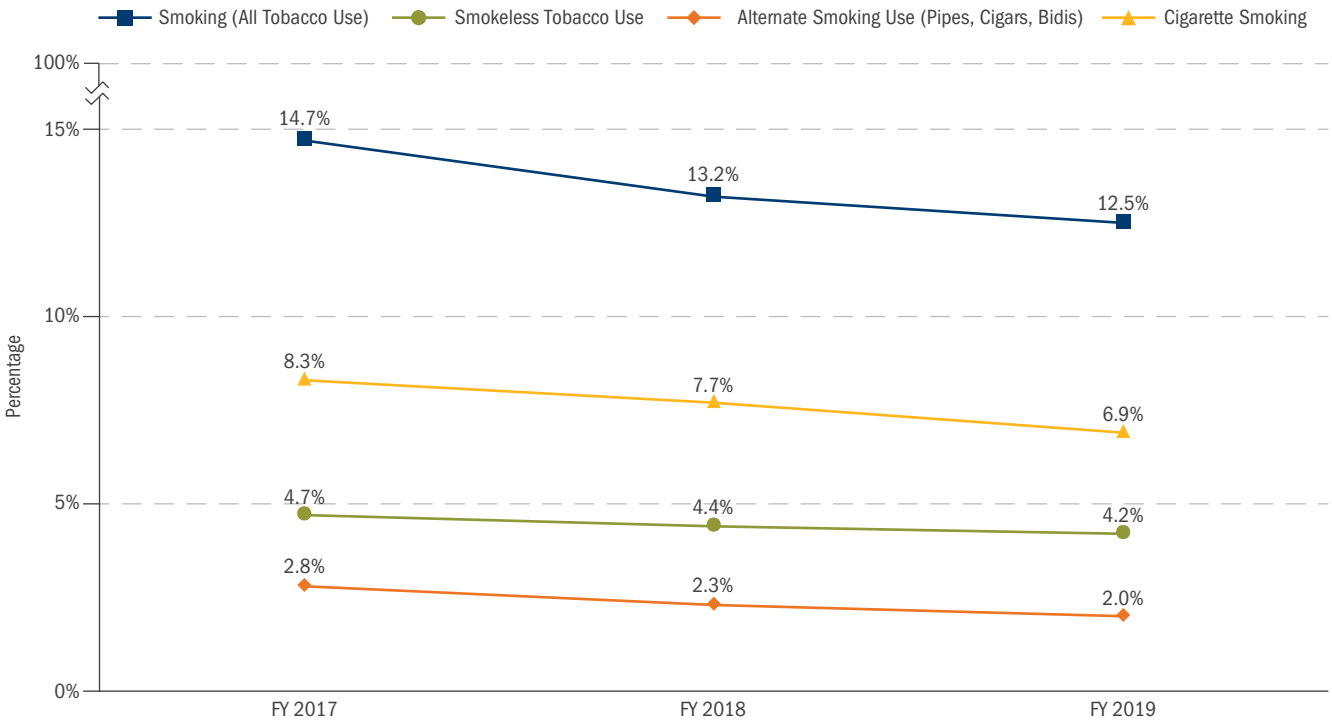
– U.S. adult smokeless tobacco rate of 3.4 percent in 2016 from http://www.cdc.gov/tobacco/data_statistics/fact_sheets/smokeless/use_us/index.htm, accessed 1/10/2020.

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

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 the 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 12 percent in FY 2019.
- Cigarette smoking, which is the most used form of tobacco among Prime enrollees, declined from 13 percent in FY 2013 to 7 percent in FY 2019 (but statistically has not changed over the past three years), while smokeless tobacco and alternate smoking use have remained nearly unchanged from FY 2017 to FY 2019 (at about 4–5 percent and 2–3 percent, respectively). 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 2017–2019



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, 2017–2019 HCSDB https://tricare.mil/survey/hcsdbsurvey/home/z_reports.cfm, results provided 1/10/2020

Notes:

– Smokeless tobacco may include dip, snuff, snus, 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.

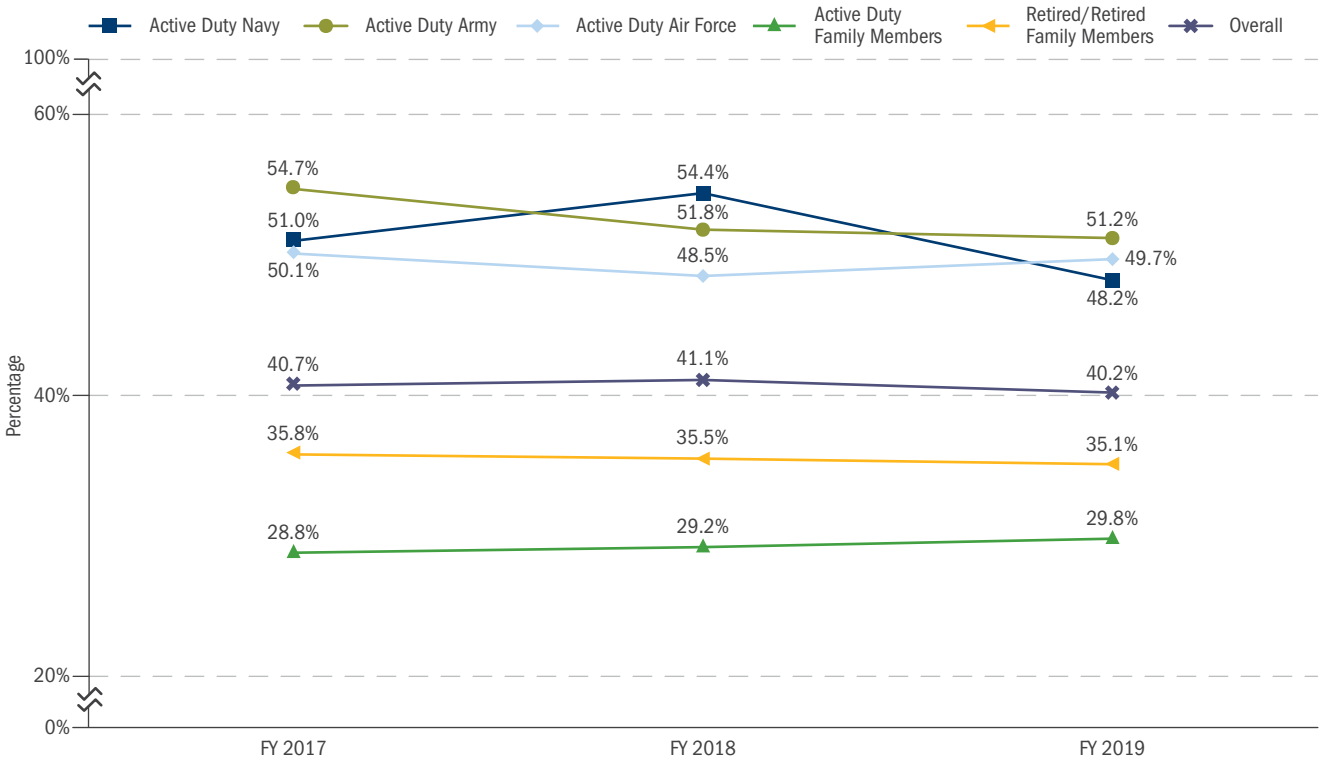
MHS ADULT OBESITY

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, 40.2 percent of all MHS beneficiaries were overweight in FY 2019. ADFMs, on average, have the lowest rate of being overweight (29.8 percent), followed by the retired and their family members at 35.1 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 but low obesity rates (13 to 16 percent), as shown in the second chart.

MHS OVERWEIGHT RATE (BMI 25–29.9), FYs 2017–2019



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, 2017–2019 HCSDB https://tricare.mil/survey/hcsdbsurvey/home/z_reports.cfm, results provided 2/4/2020

Notes:

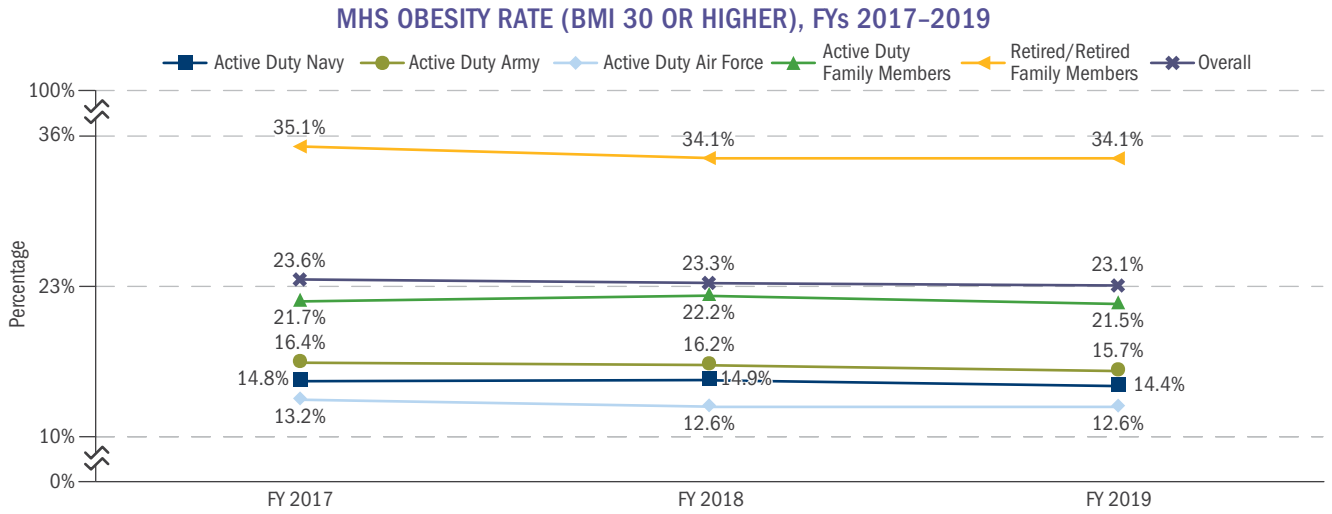
– BMI is defined as the individual's body weight divided by the square of his or her height. The formula universally used in medicine produces a unit of measure of kg/m^2. Because the HCSDB collects height and weight in inches and pounds, BMI is calculated as lb/in^2 x 703. A BMI of 18.5 to 25 may indicate 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 (39.8 percent) and combined overweight plus obesity (71.6 percent) rates for U.S. adults aged 20 and over: http://www.cdc.gov/nchs/fastats/obesity-overweight.htm, accessed 11/19/2018.

- 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 approximately 13 and 16 percent) in FY 2019. The overall MHS obesity rate has been unchanged from FY 2017 to FY 2019 (between 23 and almost 24 percent), as well as obesity rates for Active Duty family members (22 percent) and the retired and their family members (34 to 35 percent). All groups are lower than the U.S. average rate for adults aged 20 and over (almost 40 percent from 2015 to 2016). Overweight and obesity rates for Active Duty and their family members or retired and their family members did not statistically change from FY 2017 to FY 2019 (i.e., there was no statistically significant difference, although numerically the numbers appear different).

MHS ADULT OBESITY *(CONT.)*



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, 2017–2019 HCSDB https://tricare.mil/survey/hcsdbsurvey/home/z_reports.cfm, results provided 2/4/2020

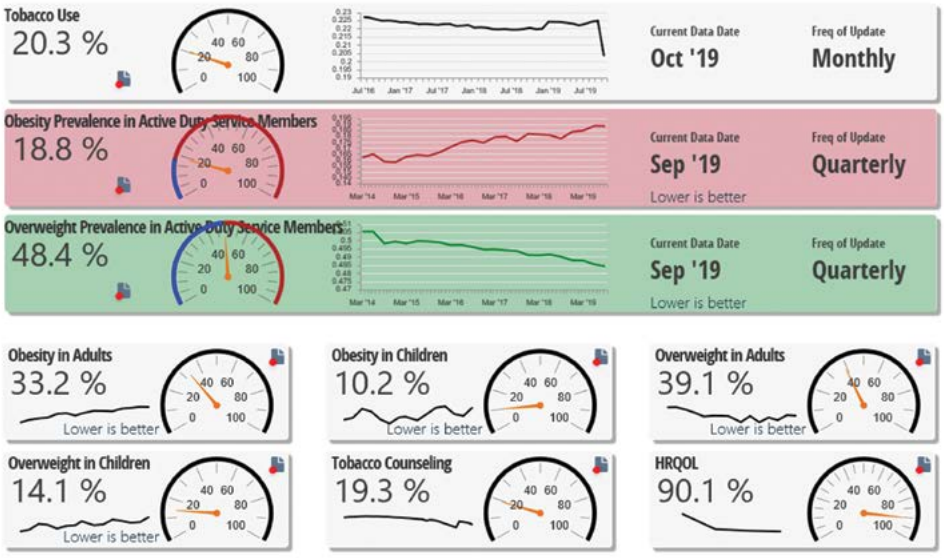
Notes:

– 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 11/19/2018.

The MHS Dashboard measures for tobacco, obesity, and overweight have undergone enhancements. These measures use clinical data, measuring performance among the care-seeking direct care population (see the MHS Dashboard display below). The MHS retired the Tobacco Use Assessment measure, replacing it with Tobacco Use and establishing a performance target of 18.2 percent by January 1, 2021. As of October 2019, 20.3 percent of direct care beneficiaries screened for tobacco use were current users. The MHS established two additional dashboard measures for ADSMs: one for obesity and one for overweight. These measures mirror the general population obesity and overweight measures as population prevalence measures ascertained by BMI. As of September 2019, Active Duty obesity and overweight prevalence were 18.8 percent and 48.4 percent, respectively. For calendar year (CY) 2019, the MHS has established obesity and overweight performance targets of 17.9 percent and 48.6 percent, respectively. Differences between MHS Dashboard measures and the survey-based measures can be explained by differences in the population assessed (MTF users vs. a sample of the entire MHS-eligible population).



Source: CarePoint (available only on the MHS intranet), MHS Dashboard, data accessed 1/16/2020

Notes:

– The October tobacco use rate statistic is preliminary and under review because of platform and processing changes applied during that measure month.

– The obesity and overweight dashboard measure data are presumed objective clinical measurements. The survey-derived obesity statistics, described earlier, are self-reported data, which 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).

HEALTH-RELATED QUALITY OF LIFE

Using CDC's Health-Related Quality of Life Questions as a Proxy Measure of "Better Health"

During FY 2018, senior DHA and Service medical leadership directed adding an overall measure of our MHS population health. Ultimately, it was proposed to assess and trend the overall health of the MHS population using the same Health-Related Quality of Life (HRQOL) measurement as the Centers for Disease Control and Prevention's (CDC) State-based Behavioral Risk Factor Surveillance System (BRFSS). Self-perceived health status is considered a valid proxy measure for the state of U.S. national health; research has shown that people's perception of their health is highly correlated with their actual health, and can be used at the population level.

HRQOL refers to the perceived physical and mental health of an individual or group over a period of time. The standard four-item set of Healthy Days core questions (CDC HRQOL–4) has been in the State-based BRFSS since 1993 (see the BRFSS website at https://www.cdc.gov/brfss).

- From 2000 to 2012, the CDC HRQOL–4 has been in the National Health and Nutrition Examination Survey (NHANES) for persons aged 12 and older.
- Since 2003, the CDC HRQOL–4 has been in the Medicare Health Outcomes Survey (HOS)—a measure in the Healthcare Effectiveness Data and Information Set (HEDIS) of the National Committee for Quality Assurance (NCQA) (https://www.cdc.gov/HRQOL/HRQOL14_measure.htm).

The HRQOL–4 questions are:

1. **Self-rated health:** In general, how would you rate your overall health? (Respondents have five choices: poor, fair, good, very good, or excellent. "Good health" is coded as the proportion of those rating their overall health as good, very good, or excellent.)
2. **Number of recent days physical health not good:** Thinking about your physical health, including physical illness and injury, how many days during the past 30 days was your physical health not good? (Referred to as "poor physical health.")
3. **Number of recent days mental health not good:** Thinking about your mental health—including stress, depression, and problems with emotions—how many days during the past 30 days was your mental health not good? (Referred to as "poor mental health.")
4. **Number of recent days limited due to poor physical/mental health:** During the past 30 days, how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? (Referred to as "limited by poor health.")

Although the CDC currently reports BRFSS data from 2010 on its website, and these results are used to inform the HP 2020 Goals, HCSDB HRQOL results are compared to norms calculated from 2017 BRFSS micro data, which are not currently reported in summary like 2010, but rather containing responses from approximately 440,000 respondents in 53 states/territories, and reweighted to match our MHS population. Mode differences between the BRFSS and HCSDB may result in mode effects and make comparison more difficult.

Because the MHS population differs from the U.S. population in age, gender, and ethnic composition, BRFSS rates were reweighted to match MHS users' characteristics in those areas. However, the populations may differ in other ways that complicate the comparisons between estimates from the BRFSS and HCSDB—for example, employment, education, and access to health care.

As shown in the figure to follow, the overall MHS population in general—and the Active Duty military component within the MHS population—rate their health status higher than the general U.S. population did in 2015, and both are higher than the HP 2020 goal of 79.8 percent.

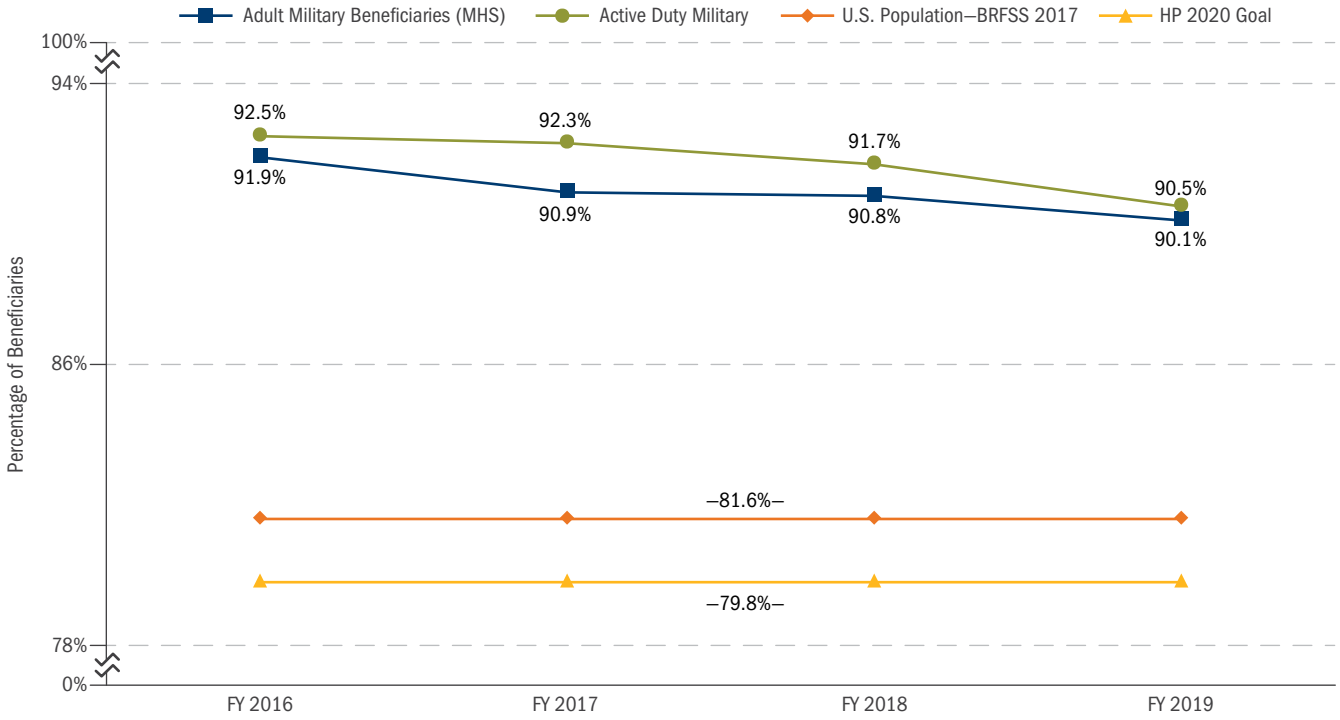
- The overall MHS population rating of good or better health appears to have declined slightly between FY 2016 and FY 2019 by about two percentage points, and the Active Duty military rating (included in the overall MHS population) has also declined by about two percentage points.
- Not shown: Similar to BRFSS 2015 results, smokers report statistically significantly more limited days than nonsmokers, as do those measured as obese compared to normal weight, and those with hypertension compared to those without.

After examining both the HP and BRFSS benchmarks, the MHS established a performance target of 90.5 percent (the highest current beneficiary category score of Active Duty for FY 2019) by January 1, 2021.

HEALTH-RELATED QUALITY OF LIFE *(CONT.)*

Using CDC's Health-Related Quality of Life Questions as a Proxy Measure of "Better Health" *(cont.)*

PERCENTAGE OF MILITARY BENEFICIARIES SELF-RATING HEALTH STATUS AS GOOD OR BETTER, BASED ON BRFSS, FYs 2016–2019



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, 2/4/2020

Notes:

– BRFSS results are from the 2017 survey conducted by CDC, reweighted to match the 2017 MHS population; DHA results for FYs 2016–2019 are recalculated to accommodate the tIMO as of October 1, 2018.

– FY 2016 (Q2 and Q3), FY 2017 (Q3), FY 2018 (Q3), and FY 2019 (Q3) HRQOL questions tested using population-based HCSDB.

Survey fielding:

– Random sample of U.S. MHS-eligible adult population under age 65. Invitation letter and reminder letter mailed to all sampled beneficiaries with known name and address.

– E-mail and follow-ups to Active Duty members.

– Response by Internet for all, and paper questionnaire mailed to a sample of all nonresponding Active Duty family members, retirees, and their family members living in the United States.

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.

There are two main drivers for the decline in rebates on retail drugs: (1) the implementation of the maintenance drugs benefit program influenced 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 2015–2019

	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Total Receivables	$1,068.04	$929.44	$850.71	$841.78	$836.01
Total Collections	$1,117.14	$982.73	$847.40	$853.44	$860.82

Source: DHA Business Support Directorate, Contract Resource Management, 9/30/2019

Note: Refund amounts are netted out of pharmacy costs provided within this report. The refunds in the table above are categorized in the fiscal year (FY) they were validated and billed to the manufacturers.

Program Integrity Activities

The Defense Health Agency (DHA) Office of Program Integrity (PI) is responsible for health care anti-fraud to safeguard beneficiaries and protect benefit dollars. DHA PI develops and executes anti-fraud and abuse policies and procedures, provides oversight of contractor program integrity activities, and coordinates investigative activities. PI also develops cases for criminal prosecutions, civil litigations, and initiates administrative measures. Through a Memorandum of Understanding (MOU), 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 2016–2018

	CY 2016	CY 2017	CY 2018
Total Recoveries	$104.9	$88.8	$149.4
Court-Ordered Fraud Judgments/Settlements	$92.7	$66.3	$125.9
PI Contractor Administrative Recoupment/Offsets (Received)	$12.2	$22.5	$23.5
Total PI Contractors Cost Avoidance	$33.0	$55.0	$48.9
Contractor Prepayment Reviews	$31.9	$53.6	$48.5
Excluded Providers	$1.1	$1.4	$0.4

Sources: TRICARE Program Integrity Operational Reports and Quarterly Fraud and Abuse Reports, CY 2016–CY 2018; CY 2018 data are the latest reported as of 11/26/2019

SAVINGS AND RECOVERIES *(CONT.)*

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 2017–2019

RECOVERIES	FY 2017	FY 2018	FY 2019
Post-Payment Duplicate Claim Recoveries	$7.1	$4.5	$6.1

Recovery B—Improper Payment Recoveries: The DHA is vigilant in ensuring the accuracy of health care claim payments 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 OUTSIDE OF PAYMENT RECAPTURE AUDITS ($ MILLIONS), FY 2018

ACTUAL OVERPAYMENT DOLLARS IDENTIFIED VIA RANDOM SAMPLES[a]	AMOUNT RECAPTURED (ACTUAL REFUNDS)
$8.95	$827.47

Sources: DHA/R&M (J-1/J-8)/Trust Fund and Revenue Cycle Management Improper Payment Evaluation Branch, 12/19/2019; Operational Reports and Quarterly Fraud and Abuse Reports

[a] "Actual overpayment dollars identified via random samples" in FY 2018 represents the total overpayment dollars from sampled claims.

Notes:

– These numbers include recoupments for overpayments identified in audits as well as refunds occurring in the course of routine claim adjustments (for claims initially paid in FY 2018 and other fiscal years). DHA has no way to distinguish overpayment recoupments from routine claim adjustments.

– The Active Duty Dental Program (ADDP) refunds were calculated differently. The amount recovered in FY 2018 figure for ADDP represents refunds shown on contractor invoices to DHA. ADDP data is not included in the TED system, thus contractor invoices were used because TED transactions are not available.

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 2018 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)

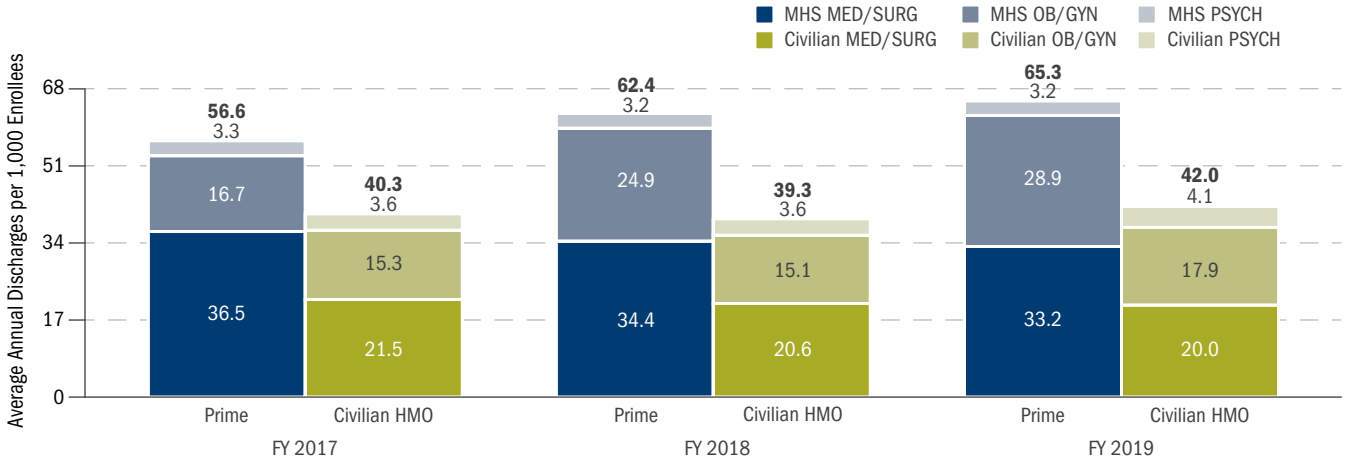
TRICARE Prime Enrollees

This section compares the inpatient utilization of TRICARE Prime enrollees (including TYA Prime) 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 aged 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.

- The TRICARE Prime inpatient utilization rate increased by 15 percent between FY 2017 and FY 2019, while the civilian HMO rate increased by 4 percent. The increase in the Prime inpatient utilization rate was driven largely by a 73 percent increase in OB/GYN utilization. In FY 2019, the TRICARE Prime inpatient utilization rate (direct and purchased care combined) was 55 percent higher than the civilian HMO utilization rate (65.3 discharges per 1,000 Prime enrollees compared with 42.0 per 1,000 civilian HMO enrollees).
- In FY 2019, the TRICARE Prime inpatient utilization rate was 66 percent higher than the civilian HMO rate for MED/SURG procedures, 61 percent higher for OB/GYN procedures, and 23 percent lower for PSYCH procedures.
- The average length of stay (LOS) for MHS Prime enrollees (direct and purchased care combined) increased slightly from 3.3 days in FY 2017 to 3.4 days in FY 2019, whereas the average LOS for civilian HMO enrollees remained constant at 3.6 days. In FY 2019, the average LOS for MHS Prime enrollees was 7 percent lower than that of civilian HMO enrollees (not shown).

INPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK, FYs 2017–2019



Sources: MHS administrative data, 1/13/2020, and IBM Watson Health, MarketScan® Commercial Claims and Encounters (CCAE) database, 2/5/2020

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2019 civilian benchmarks 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.)*

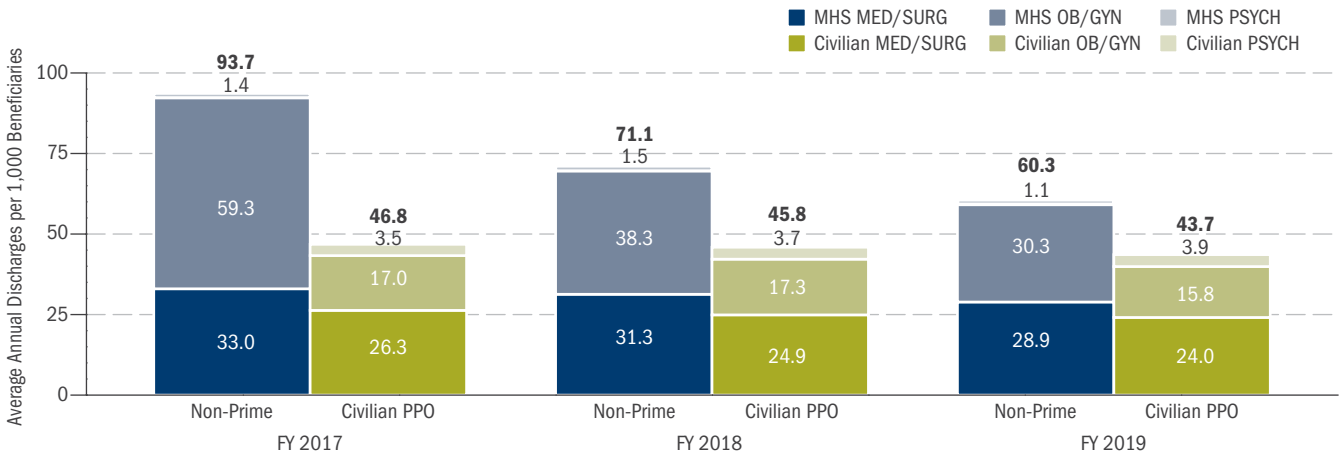
Non-Prime-Enrolled Beneficiaries

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 aged 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-Prime-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 18 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 2017 and FY 2019, the TRICARE non-Prime utilization rate decreased by 36 percent, whereas the civilian PPO inpatient utilization rate decreased by 7 percent. Despite the sharp overall decline, the TRICARE rate remains well above the civilian benchmark. In FY 2019, the inpatient utilization rate (direct and purchased care combined) for non-Prime-enrolled beneficiaries was 38 percent higher than 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 2017 to FY 2019, the MHS OB/GYN disposition rate decreased by 49 percent, whereas it decreased by 7 percent in the civilian sector. Despite the precipitous drop in the MHS non-Prime OB/GYN disposition rate, it was still almost double that of the corresponding civilian PPO rate in FY 2019.
- 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-Prime-enrolled beneficiaries (direct and purchased care combined) remained at about 3.6 days between FY 2017 and FY 2019, 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 3 percent higher than that of civilian PPO participants in FY 2019 (not shown).

INPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK, FYs 2017–2019



Sources: MHS administrative data, 1/13/2020, and IBM Watson Health, MarketScan® CCAE database, 2/5/2020

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2019 civilian benchmarks are based on two quarters of data, which were seasonally adjusted and annualized.

– Numbers may not sum to bar totals due to rounding.

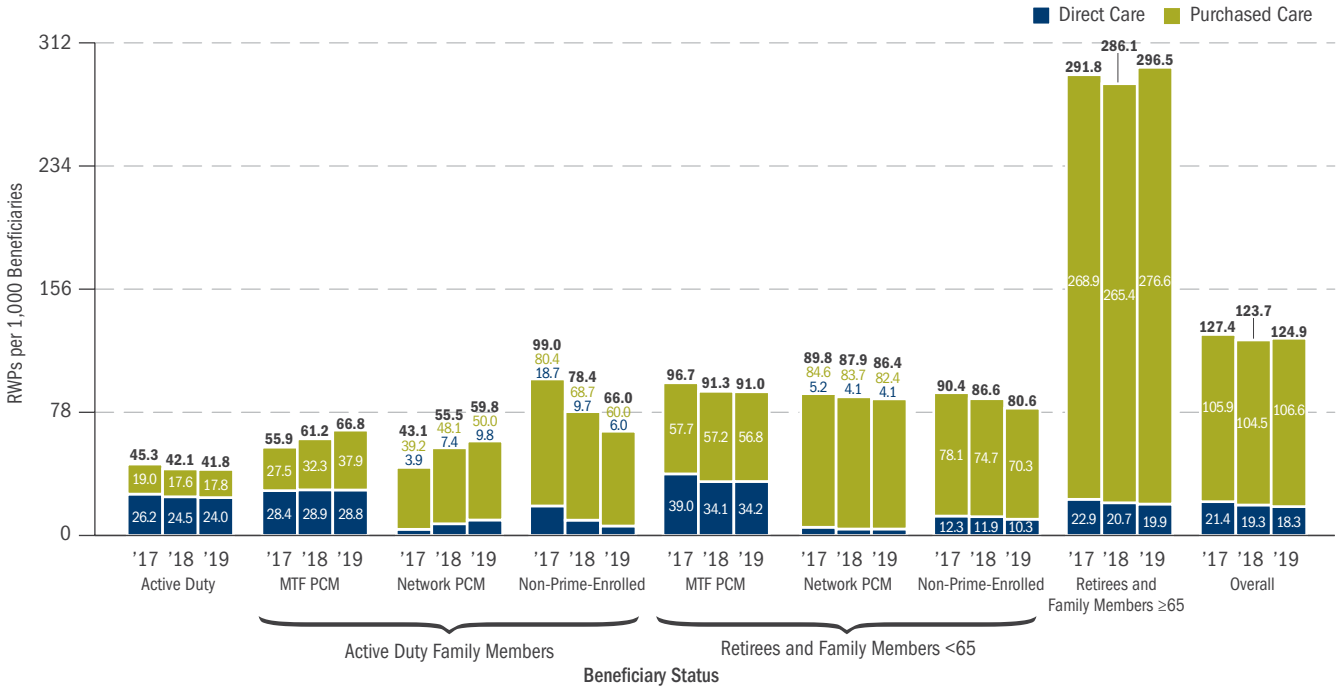
INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

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) decreased by 2 percent from FY 2017 to FY 2019.
- Between FY 2017 and FY 2019, the direct care inpatient utilization rate decreased by 15 percent overall, due in part to the downsizing of four military hospitals to clinics over that time period and in part because of the lack of visibility of MHS GENESIS data for some facilities. Non-Prime-enrolled Active Duty family members (ADFMs) experienced the largest decline (68 percent). Retirees under age 65 with a network primary care manager (PCM) also experienced a large decline (22 percent) but direct care utilization by that group is relatively small. The only group with a sizable increase in utilization was ADFMs with a network PCM (154 percent) but, again, that is based on a low utilization level.
- The overall purchased acute care inpatient utilization rate increased by less than 1 percent between FY 2017 and FY 2019 but there was a great deal of variation across beneficiary groups. Enrolled ADFMs experienced large increases (38 percent for those with a military treatment facility [MTF] PCM and 27 percent for those with a network PCM). However, non-Prime-enrolled ADFMs experienced a large decline in utilization (25 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 increased from 72 percent in FY 2017 to 74 percent in FY 2019 (the MHS GENESIS issue likely played a role in this result).
- From FY 2017 to FY 2019, the percentage of per capita inpatient workload referred to the network on behalf of beneficiaries enrolled with an MTF PCM (including Active Duty personnel) rose from 53 percent to 56 percent (again, the MHS GENESIS issue likely had an effect).

AVERAGE ANNUAL INPATIENT RWPs PER 1,000 BENEFICIARIES, FYs 2017–2019



Source: MHS administrative data, 1/13/2020

Notes:

– The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere.

– Numbers may not sum to bar totals due to rounding.

LOWER COST

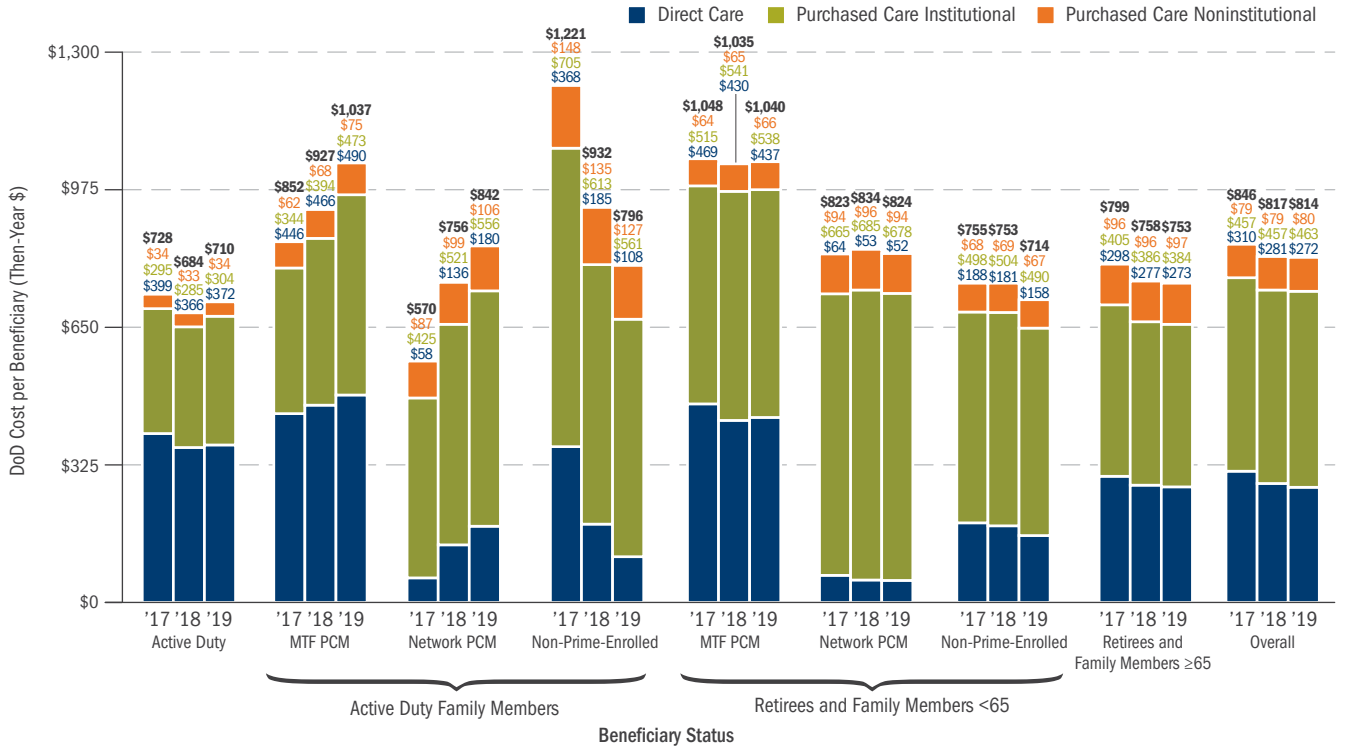
INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

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), decreased by 4 percent between FY 2017 and FY 2019.

- All beneficiary groups except enrolled ADFMs experienced either no change (RETFMs under age 65 with a network PCM) or declines (ranging from 1 percent for RETFMs under age 65 with an MTF PCM to 35 percent for non-Prime-enrolled ADFMs) in total (direct plus purchased care) per capita inpatient costs. ADFMs with an MTF PCM experienced a 22 percent increase, while ADFMs with a network PCM experienced a 48 percent increase.
- Direct care inpatient costs per capita decreased by 12 percent between FY 2017 and FY 2019. Purchased care inpatient costs (institutional plus noninstitutional) per capita increased by 1 percent over the same time period.
- The direct care cost per RWP increased from $14,474 in FY 2017 to $14,881 in FY 2019 (3 percent).
- Exclusive of TFL, DoD purchased care cost (institutional plus noninstitutional) per RWP in acute care facilities increased from $7,519 in FY 2017 to $8,079 in FY 2019 (7 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 $8,975 in FY 2017 to $9,522 (6 percent) in FY 2019, exclusive of TFL.

AVERAGE ANNUAL DoD INPATIENT COSTS PER BENEFICIARY, FYs 2017–2019



Source: MHS administrative data, 1/13/2020

Notes:

– 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 costs, and overhead expenses.

– The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere.

– Numbers may not sum to bar totals due to rounding.

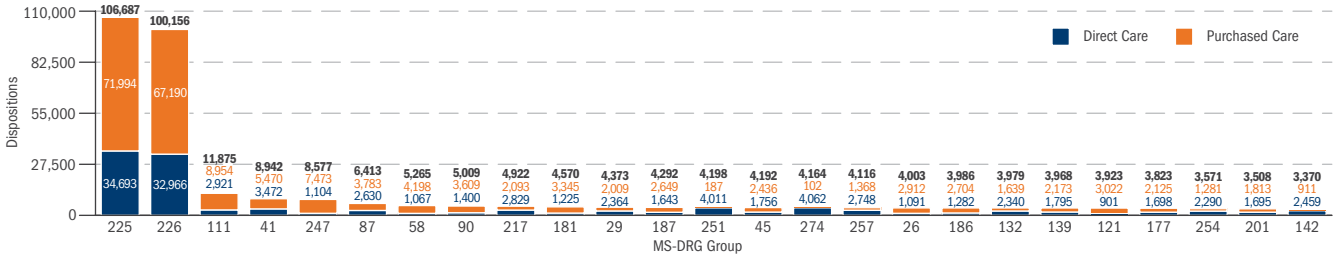
INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Leading Inpatient Diagnosis Groups (U.S. Only)

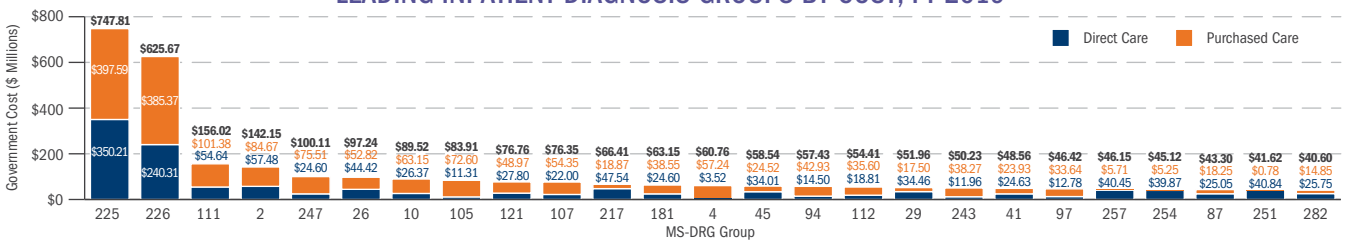
The MHS uses the MS-DRG system to classify acute care hospital inpatient cases into clinically related categories having similar treatment costs. For the purpose of this section, MS-DRGs exhibiting variations in complications and comorbidities were grouped into like categories[1] and numbered sequentially. 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 2019 accounted for 67 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 2019 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 2019 accounted for 57 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 2019



LEADING INPATIENT DIAGNOSIS GROUPS BY COST, FY 2019



Source: MHS administrative data, 1/13/2020

MS-DRG Groups

2 ECMO 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
105 Combined Anterior/Posterior Spinal Fusion
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 Operating Room Procedures for Obesity
186 Diabetes
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 Condition Originating in Perinatal Period
243 Infectious and Parasitic Diseases with Operating Room Procedure
247 Septicemia or Severe Sepsis
251 Neuroses Except Depressive
254 Psychoses
257 Alcohol/Drug Abuse or Dependence
274 Other Factors Influencing Health Status
282 Extensive Operating Room Procedure Unrelated to Principle Diagnosis

- The top two procedures by volume are related to childbirth, accounting for 43 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 64 percent of the total volume of the top 25 MS-DRG groups and 58 percent of the total cost.
- Admissions in direct care facilities exceed those in purchased care facilities for only eight of the top 25 MS-DRG groups, whereas expenditures in direct care facilities exceed those in purchased care facilities for nine of the top 25 MS-DRG groups (not all the DRG groups based on cost are the same as those for admissions).
- Surgical procedures for obesity rank 10th in volume and 12th in cost among the top 25 MS-DRG groups. Thus, the obesity epidemic in the civilian sector (as per the CDC) 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)

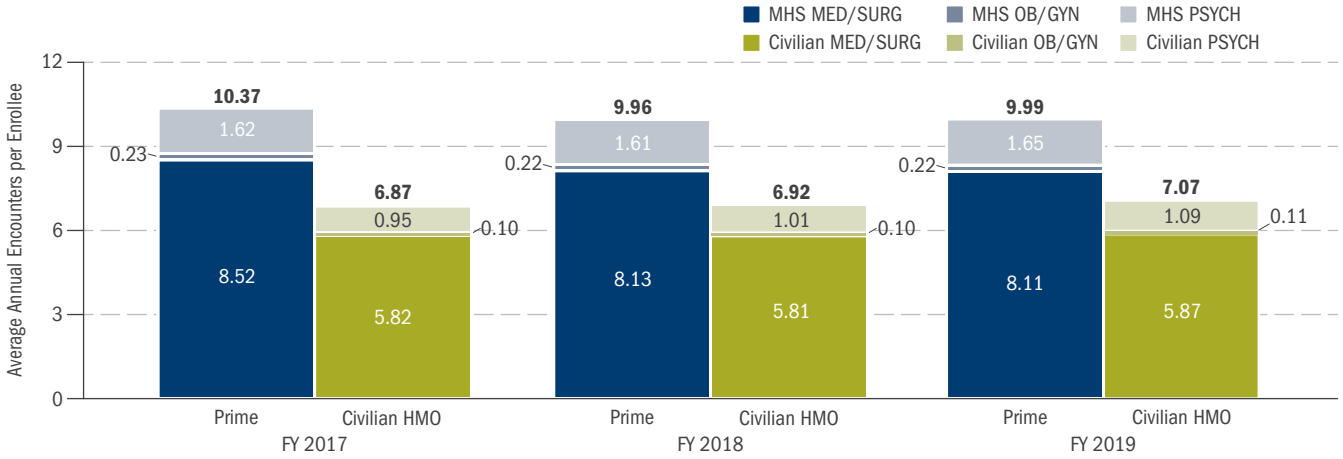
TRICARE Prime Enrollees

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 4 percent between FY 2017 and FY 2019. The civilian HMO outpatient utilization rate increased by 3 percent over the same period.
- In FY 2019, the overall Prime outpatient utilization rate was 41 percent higher than the civilian HMO rate.
- In FY 2019, the Prime outpatient utilization rate for MED/SURG procedures was 38 percent higher than the civilian HMO rate.
- The Prime outpatient utilization rate for OB/GYN procedures fell by 6 percent between FY 2017 and FY 2019 (albeit from a low base rate) but still remained about double that for civilian HMOs in FY 2019. However, the disparity is due in part to how the direct care system records global procedures.[1]
- The Prime outpatient utilization rate for PSYCH procedures was 52 percent higher than the corresponding rate for civilian HMOs in FY 2019. This disparity, though based on relatively low MHS and civilian mental health utilization rates, may reflect the more stressful environment that many ADSMs and their families endure.

OUTPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK, FYs 2017–2019



Sources: MHS administrative data, 1/13/2020, and IBM Watson Health, MarketScan® CCAE database, 2/5/2020

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2019 civilian benchmarks are based on two quarters of data, which were seasonally adjusted and annualized.

– Numbers may not sum to bar totals due to rounding.

[1] 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-Prime-Enrolled Beneficiaries

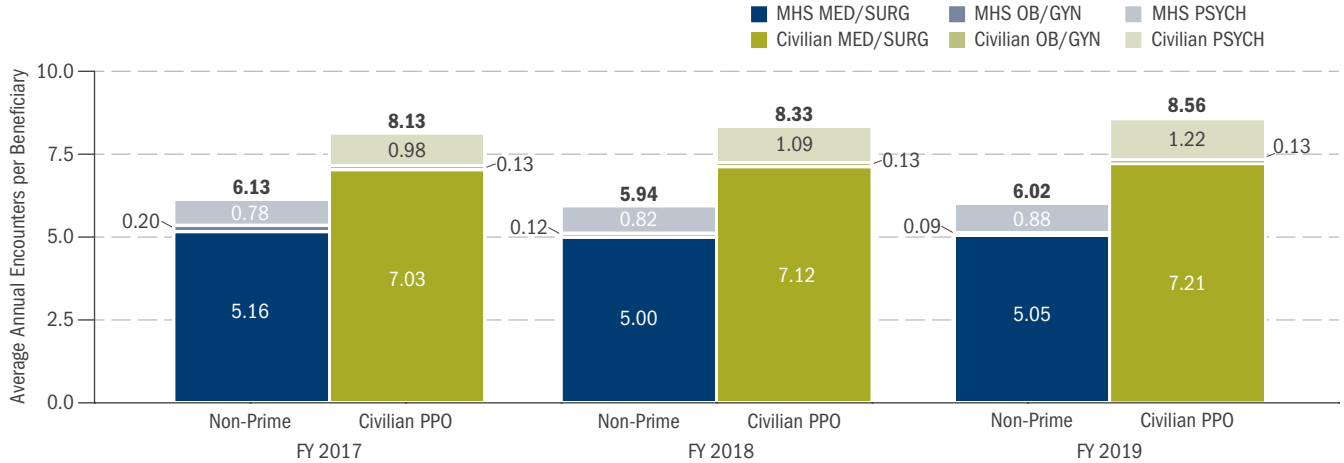
This section compares the outpatient utilization of beneficiaries not enrolled in TRICARE Prime (including TRICARE Select in FYs 2018–2019, TRICARE Standard/Extra in FY 2017, and space-available MTF care) with that of participants in civilian employer-sponsored PPO plans. The comparisons are limited 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-Prime-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 18 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 outpatient utilization rate (direct and purchased care combined) for non-Prime-enrolled beneficiaries decreased by 2 percent between FY 2017 and FY 2019. The civilian PPO outpatient utilization rate increased by 5 percent over the same period.
- The overall TRICARE non-Prime outpatient utilization rate remained well below the level observed for civilian PPOs. In FY 2019, TRICARE non-Prime outpatient utilization was 30 percent lower than in civilian PPOs.
- In FY 2019, the non-Prime outpatient utilization rate for MED/SURG procedures was 30 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 decreased by 52 percent between FY 2017 and FY 2019 and was 28 percent below the rate for civilian PPO participants in FY 2019.
- The PSYCH outpatient utilization rate for non-Prime-enrolled MHS beneficiaries increased by 13 percent from FY 2017 to FY 2019; the rate increased by 25 percent for civilian PPO participants. In FY 2019, the PSYCH outpatient utilization rate for non-Prime-enrolled beneficiaries was 28 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 2017–2019



Sources: MHS administrative data, 1/13/2020, and IBM Watson Health, MarketScan® CCAE database, 2/5/2020

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2019 civilian benchmarks are based on two quarters of data, which were seasonally adjusted and annualized.

– Numbers may not sum to bar totals due to rounding.

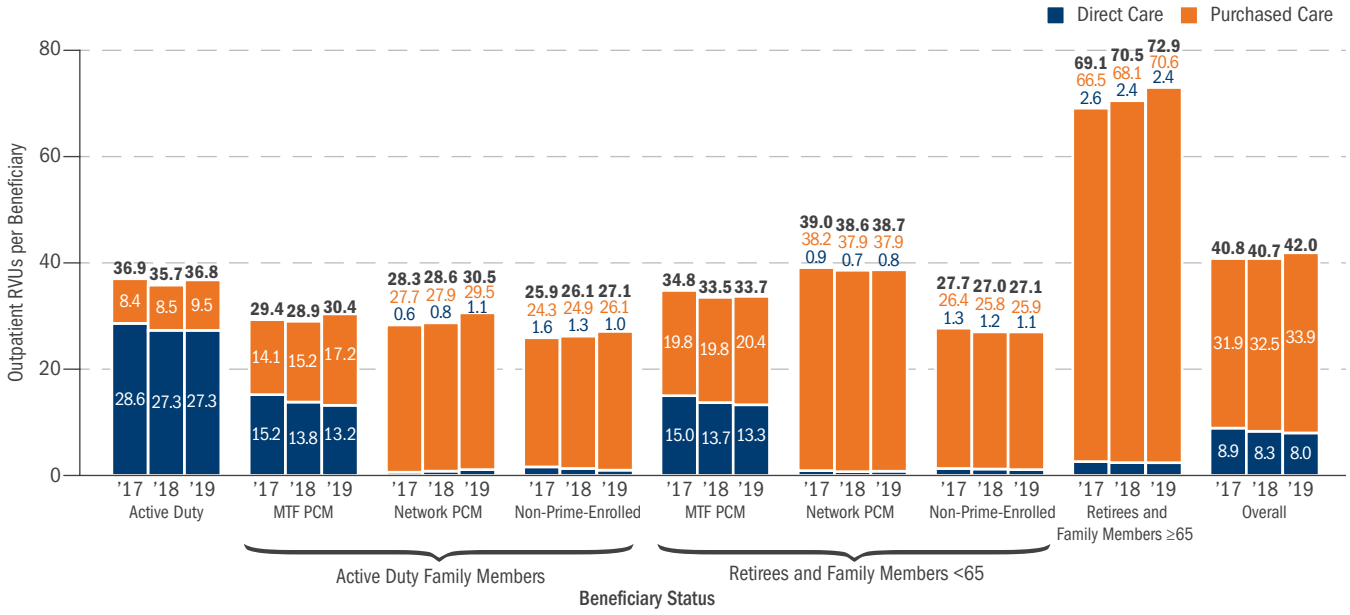
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

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).

- Total per capita MHS utilization (direct plus purchased care) increased by 3 percent from FY 2017 to FY 2019.
- Overall direct care outpatient utilization decreased by 10 percent from FY 2017 to FY 2019. Declines were experienced by every beneficiary group except ADFMs with a network PCM (70 percent increase). The declines ranged from 4 percent for Active Duty to 38 percent for non-Prime-enrolled ADFMs.
- From FY 2017 to FY 2019, purchased care outpatient utilization increased by 6 percent overall. ADFMs with an MTF PCM experienced a 22 percent increase, while Active Duty members experienced a 13 percent increase. Except for RETFMs under age 65 with a network PCM (1 percent decline) and non-Prime-enrolled RETFMs under age 65 (2 percent decline), the remaining beneficiary groups experienced small to moderate increases in purchased care outpatient utilization.
- The TFL (purchased care) outpatient utilization rate increased by 6 percent from FY 2017 to FY 2019.[1]

AVERAGE ANNUAL OUTPATIENT RVUs PER BENEFICIARY, FYs 2017–2019



Source: MHS administrative data, 1/13/2020

Notes:

– The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere.

– Numbers may not sum to bar totals due to rounding.

[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.

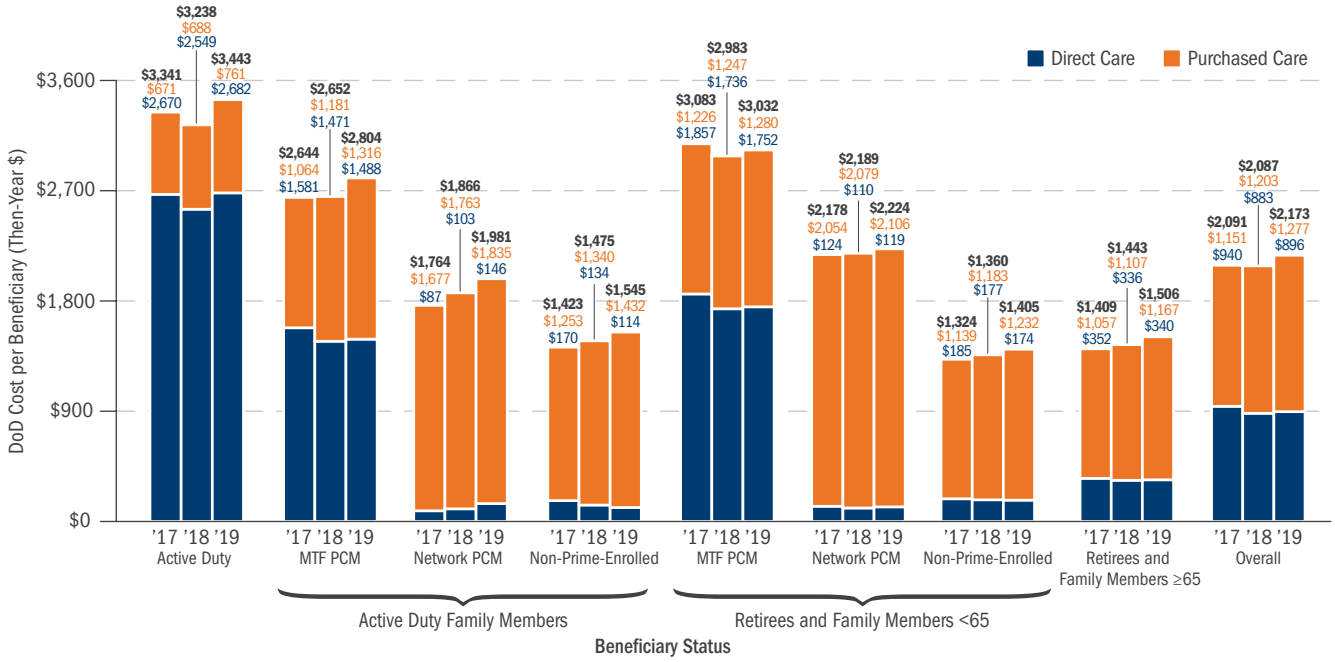
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

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 4 percent from FY 2017 to FY 2019. This was only slightly more than the increase in overall outpatient utilization.

- The direct care cost per beneficiary decreased by 5 percent overall from FY 2017 to FY 2019. All beneficiary groups except ADFMs with a network PCM (67 percent increase) and Active Duty members (no change) experienced a decline. Non-Prime-enrolled ADFMs experienced the largest decline (33 percent). Government expenditures on those beneficiary groups, however, were relatively small compared to beneficiaries enrolled with an MTF PCM.
- Excluding TFL, the per capita DoD purchased care outpatient cost increased by 11 percent overall. Every beneficiary group experienced an increase. Increases ranged from 3 percent for RETFMs under age 65 with a network PCM to 24 percent for ADFMs with an MTF PCM.
- The TFL (purchased care) outpatient cost per beneficiary increased by 10 percent between FY 2017 and FY 2019.[1]

AVERAGE ANNUAL DoD OUTPATIENT COSTS PER BENEFICIARY, FYs 2017–2019



Source: MHS administrative data, 1/13/2020

Notes:

– The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere.

– Numbers may not sum to bar totals due to rounding.

[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.

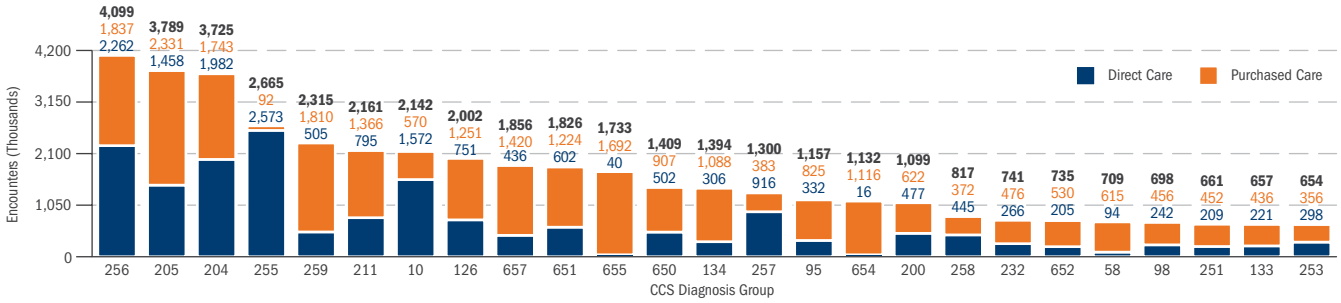
LOWER COST

OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

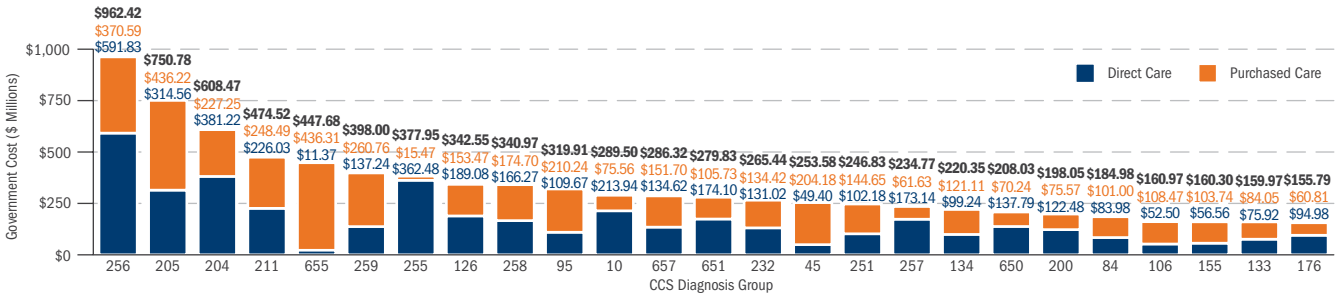
Leading Outpatient Diagnosis Groups (U.S. Only)

Leading outpatient diagnoses were determined by grouping ICD-10-CM primary diagnosis codes into like categories using the Clinical Classifications Software (CCS) tool developed through a federal-state-industry partnership and sponsored by the Agency for Healthcare Research and Quality (AHRQ). The top 25 outpatient diagnosis groups in FY 2019 accounted for 65 percent of all outpatient encounters (direct care and purchased care combined) and 53 percent of total outpatient costs.[1] 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 2019



LEADING OUTPATIENT DIAGNOSIS GROUPS BY COST, FY 2019



Source: MHS administrative data, 1/13//2020

CCS Diagnosis Groups

10 Immunizations and Screening for Infectious Disease
45 Maintenance Chemotherapy; Radiotherapy
58 Other Nutritional, Endocrine, and Metabolic Disorders
84 Headache, Including Migraine
95 Other Nervous System Disorders
98 Essential Hypertension
106 Cardiac Dysrhythmias
126 Other Upper Respiratory Infections
133 Other Lower Respiratory Disease
134 Other Upper Respiratory Disease
155 Other Gastrointestinal Disorders
176 Contraceptive and Procreative Management
200 Other Skin Disorders
204 Other Nontraumatic Joint Disorders
205 Spondylosis; Intervertebral Disc Disorders; Other Back Problems
211 Other Connective Tissue Disease
232 Sprains and Strains
251 Abdominal Pain
253 Allergic Reactions
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 three diagnosis groups in terms of volume are the same, in order, as those in terms of cost. Those diagnosis groups are general health examinations (adults and children), intervertebral disc disorders, and other nontraumatic joint disorders.
- Diagnoses treated in purchased care facilities account for 58 percent of the total volume of the top 25 diagnosis groups and 50 percent of the total cost.
- Encounters in direct care facilities exceed those in purchased care facilities for only six of the 25 top diagnosis groups. However, expenditures in direct care facilities exceed those in purchased care facilities for 10 of the top 25 diagnosis groups.

[1] 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 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.

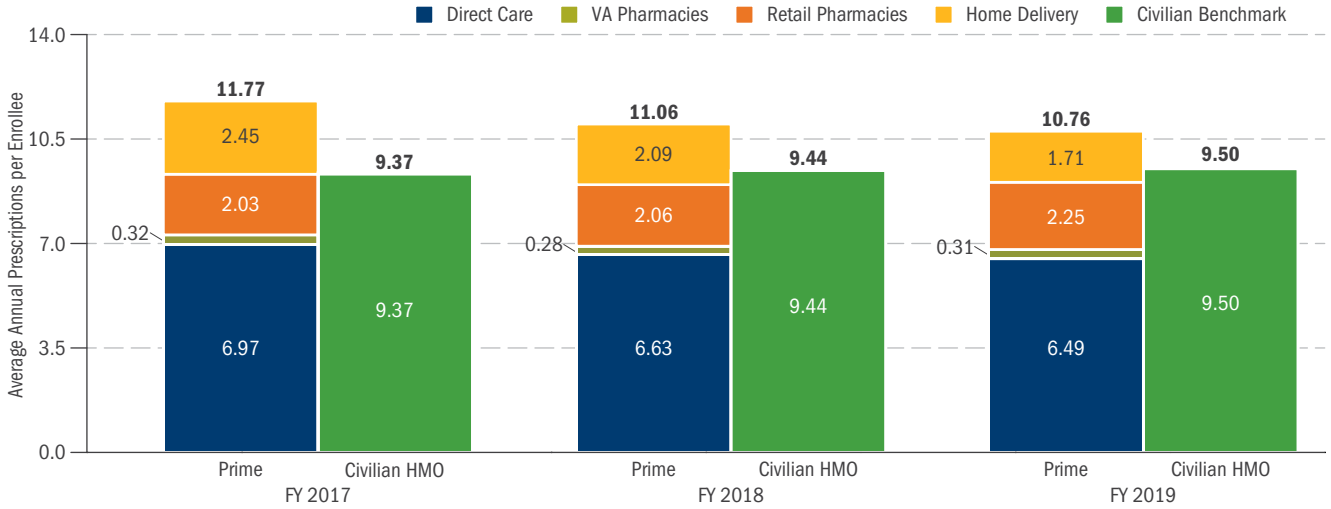
TRICARE Prime Enrollees

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 Department of Veterans Affairs (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 9 percent between FY 2017 and FY 2019, while the civilian HMO benchmark rate increased by 1 percent. In FY 2019, the TRICARE Prime prescription utilization rate was 13 percent higher than the civilian HMO rate.
- Prescription utilization rates for Prime enrollees at DoD pharmacies decreased by 7 percent between FY 2017 and FY 2019, whereas the utilization rate at retail pharmacies increased by 11 percent.
- Although the number of prescriptions is small, prescription utilization rates for Prime enrollees at VA pharmacies declined by 4 percent between FY 2017 and FY 2019.
- Home delivery prescription utilization had been on the upswing since the DoD began increasing the disparity in copayments between retail and home delivery drugs in FY 2012. However, between FY 2017 and FY 2019, enrollee home delivery prescription utilization decreased by 30 percent, likely due, at least in part, to a sharp increase in copayments for home delivery drugs. In FY 2019, home delivery accounted for 43 percent of per capita purchased care prescription utilization by Prime enrollees (as measured by 30-day supply), which is down from 55 percent in FY 2017. The overall purchased care share of prescription utilization for Prime enrollees decreased from 38 percent in FY 2017 to 37 percent in FY 2019.

LOWER COST

PRESCRIPTION UTILIZATION RATES BY SOURCE OF CARE[a]:
TRICARE PRIME VS. CIVILIAN HMO BENCHMARK, FYs 2017–2019



Sources: MHS administrative data, 1/13/2020, and IBM Watson Health, MarketScan® CCAE database, 2/5/2020

[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.

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2019 civilian benchmarks are based on two quarters of data, which were seasonally adjusted and annualized.

PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT.)*

TRICARE Prescription Drug Utilization Rates Compared with Civilian Benchmarks (U.S. Only) *(cont.)*

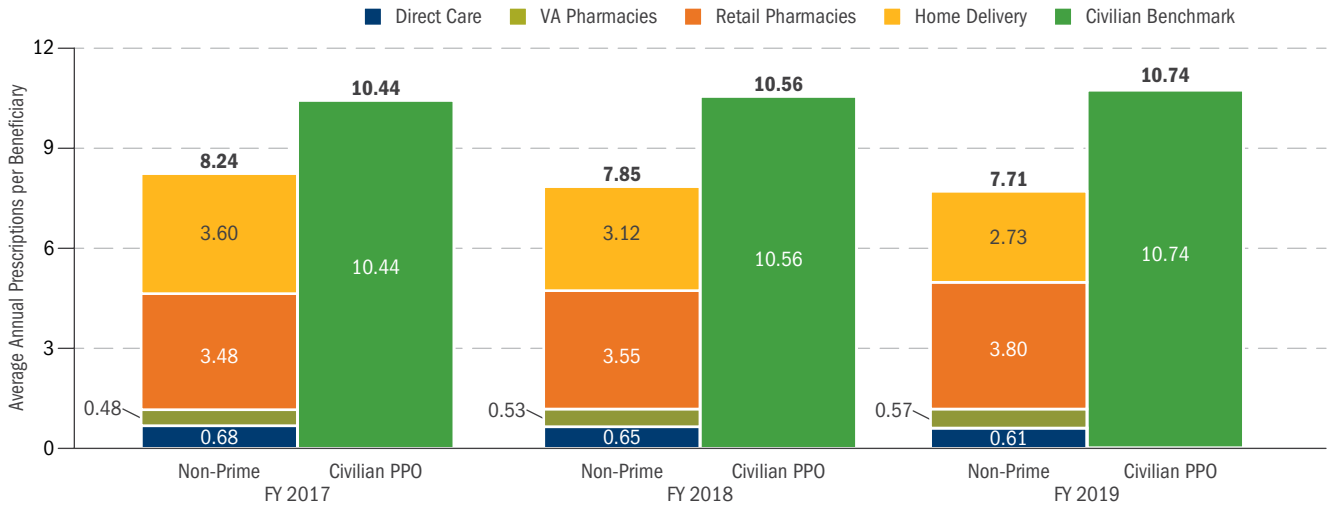
Non-Prime-Enrolled Beneficiaries

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-Prime-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 18 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-Prime-enrolled beneficiaries fell by 6 percent between FY 2017 and FY 2019. During the same period, the civilian PPO benchmark rate increased by 3 percent. In FY 2019, the TRICARE prescription utilization rate for non-Prime enrollees was 28 percent lower than the civilian PPO rate.
- The direct care prescription utilization rate for non-Prime-enrolled beneficiaries decreased by 10 percent from FY 2017 to FY 2019, whereas the utilization rate at retail pharmacies increased by 9 percent.
- Prescription utilization rates for non-Prime enrollees at VA pharmacies increased by 19 percent between FY 2017 and FY 2019.
- Home delivery prescription utilization had been on the upswing since the DoD began increasing the disparity in copayments between retail and home delivery drugs in FY 2012. However, between FY 2017 and FY 2019, non-Prime-enrollee home delivery prescription utilization decreased by 24 percent, likely due, at least in part, to a sharp increase in copayments for home delivery drugs. In FY 2019, home delivery accounted for 42 percent of per capita purchased care prescription utilization by non-Prime enrollees (as measured by 30-day supply), which is down from 51 percent in FY 2017. The overall purchased care share of prescription utilization for non-Prime enrollees decreased from 86 percent in FY 2017 to 85 percent in FY 2019.

PRESCRIPTION UTILIZATION RATES BY SOURCE OF CARE[a]: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK, FYs 2017–2019



Sources: MHS administrative data, 1/13/2020, and IBM Watson Health, MarketScan® CCAE database, 2/5/2020

[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.

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2019 civilian benchmarks are based on two quarters of data, which were seasonally adjusted and annualized.

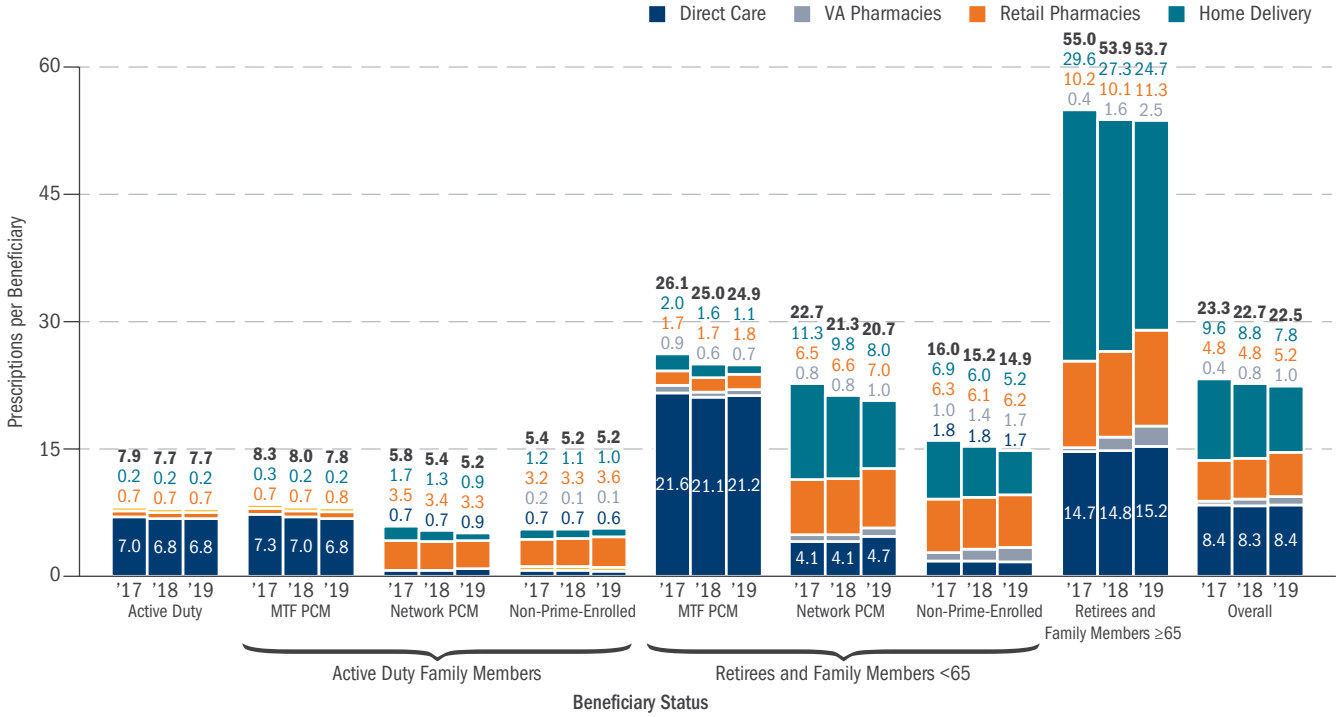
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT.)*

TRICARE Prescription Drug Utilization Rates by Beneficiary Status (U.S. Only)

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 2017 to FY 2019, exclusive of the TFL benefit. Including TFL, the total number of prescriptions decreased by 4 percent.
- The overall direct care prescription utilization rate declined by 1 percent between FY 2017 and FY 2019. Declines were experienced by non-Prime-enrolled ADFMs (18 percent), non-Prime-enrolled RETFMs under age 65 (8 percent), ADFMs with an MTF PCM (7 percent), and Active Duty members (3 percent). Increases were experienced by ADFMs with a network PCM (45 percent), RETFMs under age 65 with a network PCM (14 percent), and seniors (3 percent).
- Average per capita VA pharmacy prescription utilization increased by 138 percent from FY 2017 to FY 2019.
- Average per capita prescription utilization through retail pharmacies increased by 9 percent overall, despite the congressionally mandated requirement for non-Active Duty beneficiaries to refill prescriptions for select nongeneric maintenance medications at TRICARE home delivery or MTF pharmacies and an increase in copayments for retail drugs. Increases of between 8 percent (Active Duty members) and 18 percent (ADFMs with an MTF PCM) occurred for every beneficiary group except ADFMs with a network PCM (5 percent decline) and non-Prime-enrolled RETFMs under age 65 (no change).
- Home delivery utilization, which had been on the rise the past several years, reversed course in FY 2018 and continued to drop in FY 2019 (18 percent below its FY 2017 level). The drop is likely due to a large increase in copays for home delivery drugs mandated by the National Defense Authorization Act (NDAA) for FY 2018. In FY 2019, home delivery drugs accounted for 60 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 42 percent of total purchased care prescription drug utilization, whereas for seniors it accounts for 69 percent.

AVERAGE ANNUAL PRESCRIPTION UTILIZATION PER BENEFICIARY, FYs 2017–2019



Source: MHS administrative data, 1/13/2020

Notes:

– The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere.

– Numbers may not sum to bar totals due to rounding.

LOWER COST

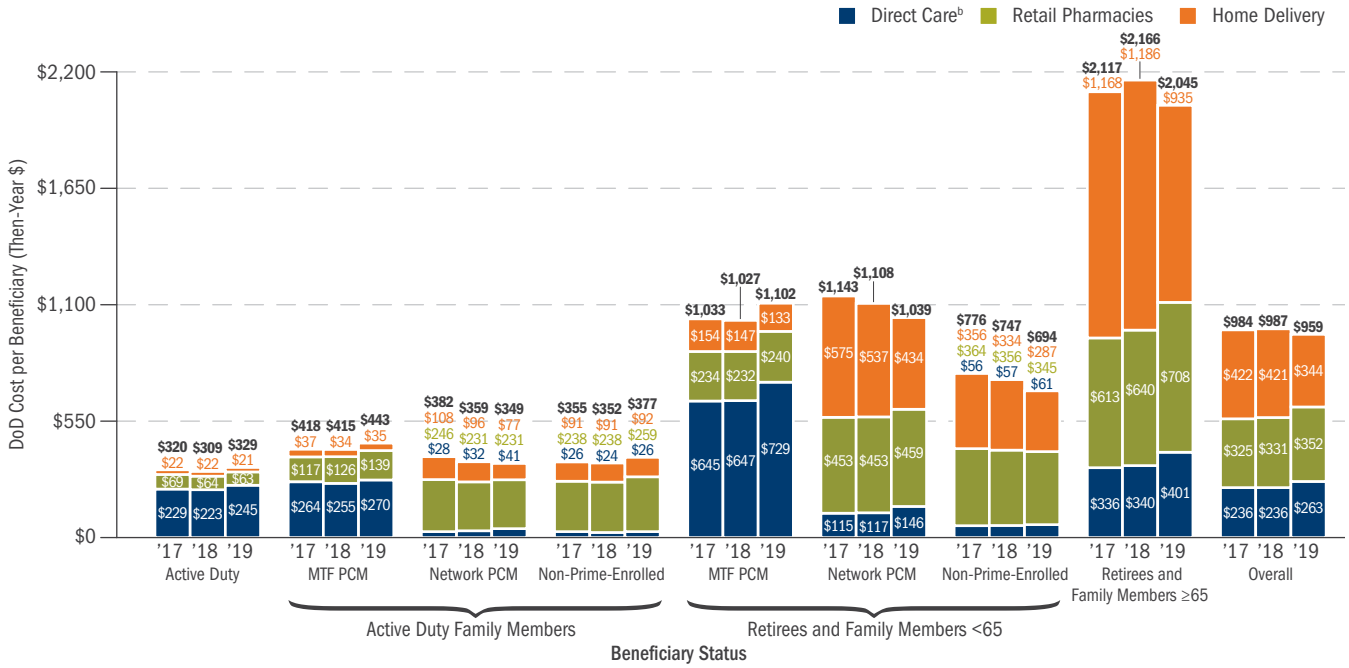
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT.)*

Prescription Drug Cost by Beneficiary Status

Although the drug refunds referenced on page 43 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 2 percent from FY 2017 to FY 2019. The annual pharmacy cost for non-Prime-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 2 percent between FY 2017 and FY 2019. Declines ranged from 9 percent for ADFMs with a network PCM to 11 percent for non-Prime-enrolled RETFMs.
- Direct care costs per beneficiary increased by 12 percent, while retail pharmacy costs increased by 1 percent excluding TFL and by 8 percent including TFL.
- Home delivery costs per beneficiary decreased by 18 percent excluding TFL and by 19 percent including TFL. All beneficiary groups except non-Prime-enrolled ADFMs (1 percent increase) experienced declines ranging from 5 percent for ADFMs with an MTF PCM to 28 percent for ADFMs with a network PCM.

AVERAGE ANNUAL DoD PRESCRIPTION COSTS PER BENEFICIARY, FYs 2017–2019[a]



Source: MHS administrative data, 1/13/2020

[a] Excludes retail drug refunds.

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

Notes:

– The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere.

– Numbers may not sum to bar totals due to rounding.

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 employer-sponsored OHI.

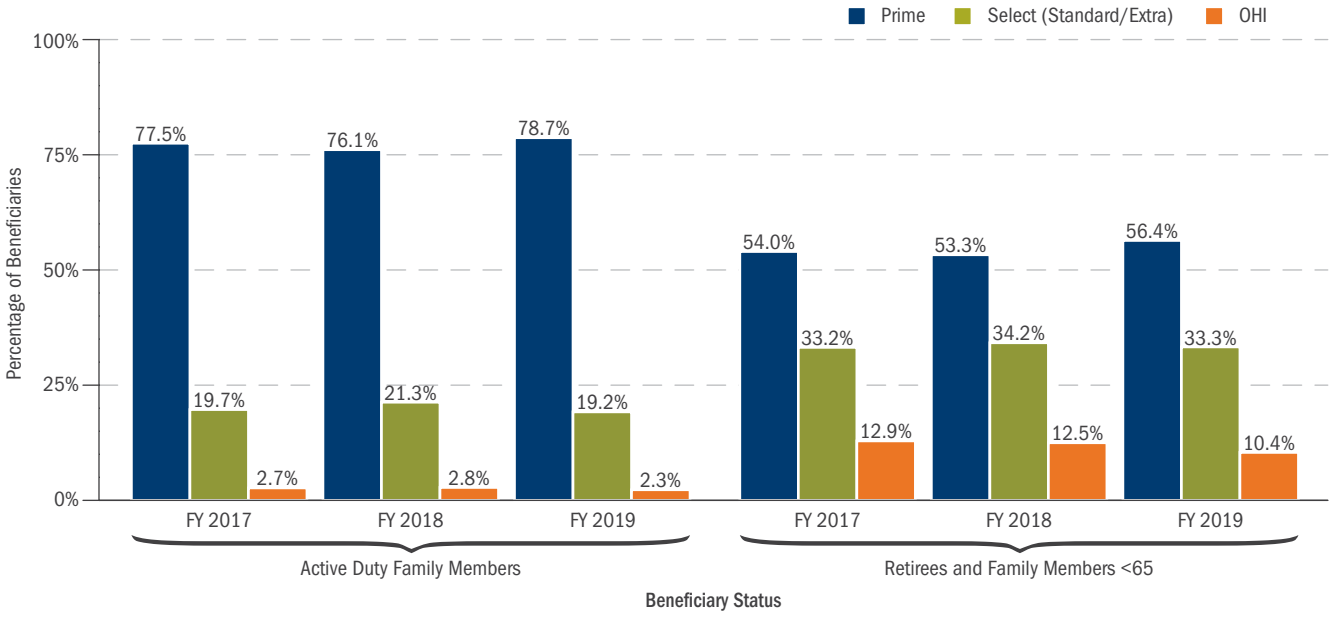
Health Insurance Coverage of MHS Beneficiaries Under Age 65

MHS beneficiaries have a choice of (1) TRICARE Prime, including TYA Prime and USFHP; (2) TRICARE Select (Standard/Extra in FY 2017), including TYA Select, TRS, and TRR; (3) direct care only (space-available care); and (4) 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 2019, 78.7 percent of Active Duty families and 56.4 percent of retiree families were in this group.
- **TRICARE Select (Standard/Extra):** Family enrolled in TRICARE Select or relying on space-available MTF care in FYs 2018–2019 (or using Standard/Extra in FY 2017) and who do not have OHI coverage. In FY 2019, 19.2 percent of Active Duty families and 33.3 percent of retiree families were in this group.
- **OHI:** Family covered by OHI. In FY 2019, 2.3 percent of Active Duty families and 10.4 percent of retiree families were in this group.

HEALTH INSURANCE COVERAGE OF BENEFICIARIES UNDER AGE 65, FYs 2017–2019



Source: Insurance coverage in FYs 2017–2019 based on Defense Enrollment Eligibility Reporting System (DEERS) and Health Care Survey of DoD Beneficiaries (HCSDB) responses; as of 12/31/2019

Notes:

– The Prime group includes HCSDB respondents enrolled in Prime based on DEERS plus enrollees in the USFHP. The Select (Standard/Extra) group includes HCSDB respondents without OHI who are not enrolled in Prime 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 percent due to rounding.

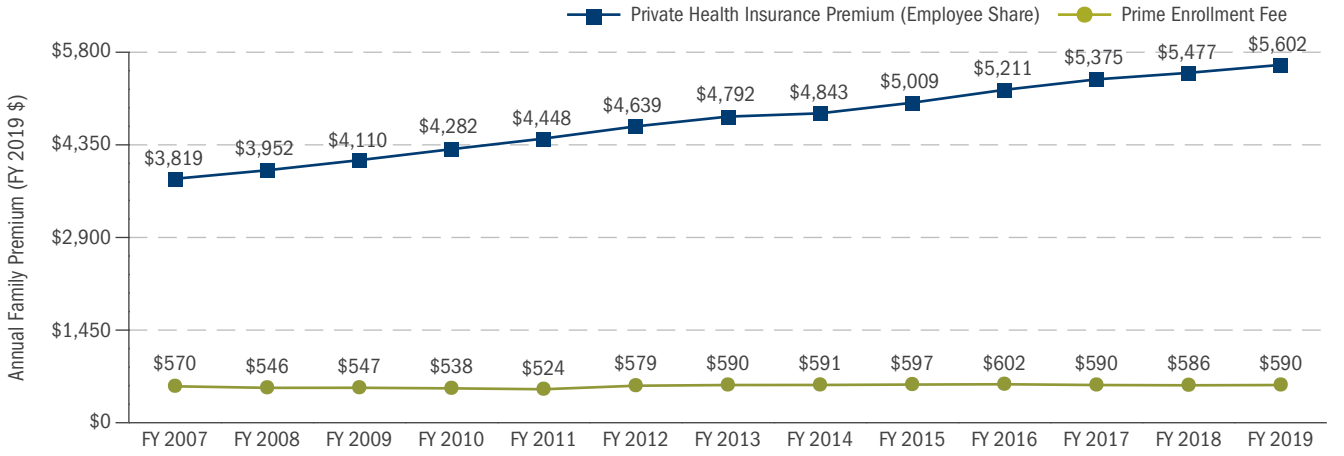
LOWER COST

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 2007 to FY 2019, the average private health insurance family premium increased substantially, whereas the TRICARE Prime enrollment fee remained essentially flat. In FY 2019 dollars, private health insurance premiums increased by $1,783 (47 percent) over this time period; the TRICARE Prime enrollment fee increased by $20 (4 percent).

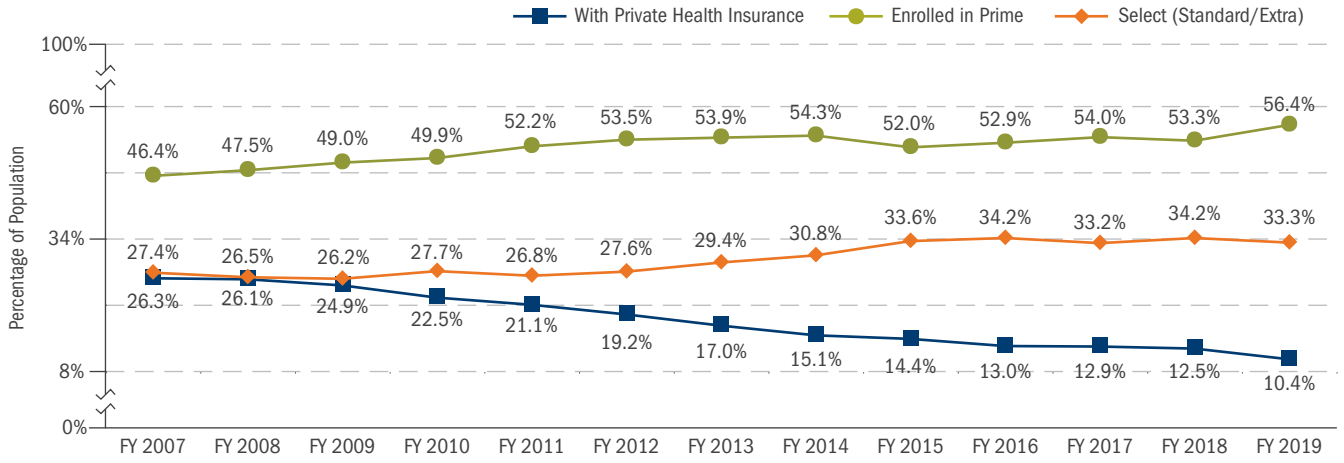
TRENDS IN PRIVATE INSURANCE PREMIUMS VS. TRICARE PRIME ENROLLMENT FEE, FYs 2007–2019



Sources: The employee share of insurance premium for a typical employer-sponsored family health plan in FYs 2007–2019 from the Insurance Component of the Medical Expenditure Panel Survey (MEPS) 2006–2018; OHI premiums in FY 2019 projected by the Institute for Defense Analyses (IDA) based on the average growth rate of premiums in FYs 2014–2018; as of 12/31/2019

Between FY 2007 and FY 2019, 15.9 percent of retirees switched from private health insurance to TRICARE. Most switched because of an increasing disparity in premiums and out-of-pocket expenses; some lost coverage due to above-average unemployment in FYs 2009–2014.[1] As a result of declines in private insurance coverage, about 500,000 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 2007–2019



Sources: Insurance coverage in FYs 2007–2019 based on DEERS and HCSDB responses in FYs 2007–2019; as of 12/31/2019

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," IDA Document D-5098, May 2015, Alexandria, VA: IDA.

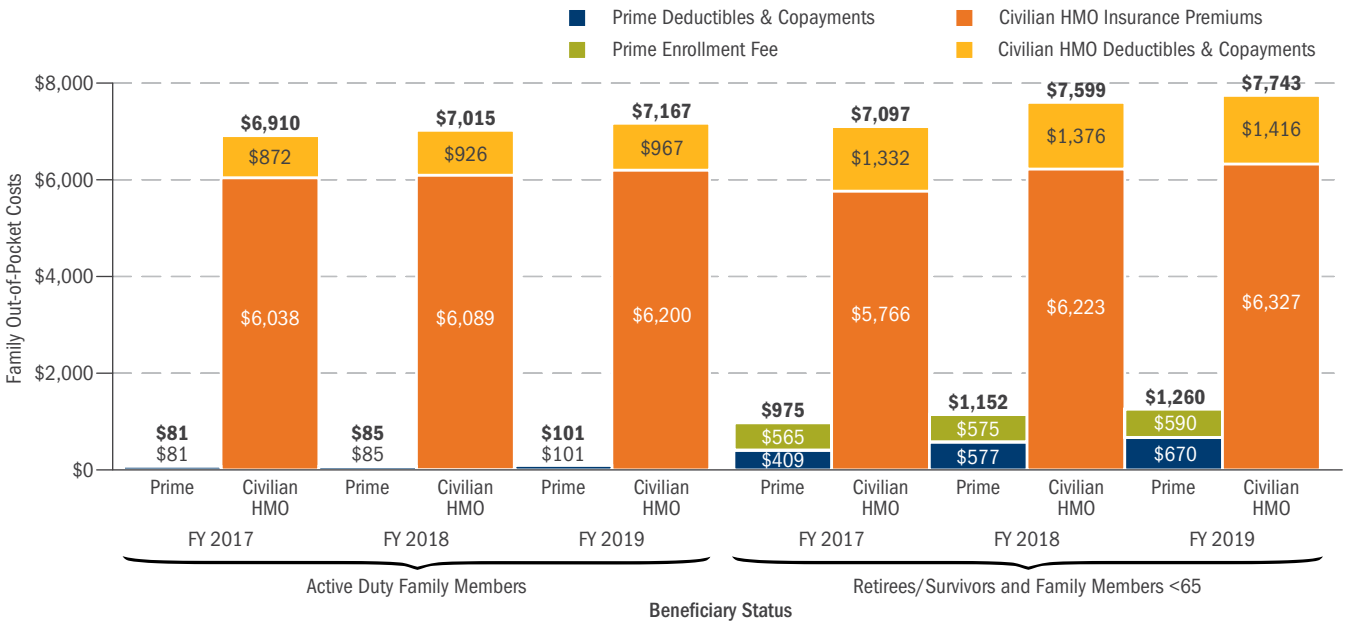
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Out-of-Pocket Costs for Families Enrolled in TRICARE Prime vs. Civilian HMO Counterparts

In FYs 2017–2019, civilian counterpart families enrolled in HMO plans had substantially higher out-of-pocket costs than did TRICARE Prime enrollees.

- Civilian HMO counterparts paid more for insurance premiums, deductibles, and copayments.
- In FY 2019, costs for civilian HMO counterparts were:
  - $7,100 more than those incurred by Active Duty families enrolled in Prime.
  - $6,500 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 2017–2019



Sources: TRICARE beneficiary expenditures for deductibles and copayments in FYs 2017–2019 from MHS administrative data for all families enrolled in Prime without OHI payments, 12/31/2019; civilian benchmark expenditures for deductibles and copayments from IBM Watson Health, MarketScan® CCAE database, 2/5/2020; civilian benchmark insurance premiums from the Insurance Component of the MEPS (actuals in FYs 2017–2018, projected in FY 2019), 12/31/2019

Notes:

– Estimates are for a demographically typical family. For Active Duty dependents, a family includes a spouse and 1.54 children, on average. For retirees, a family includes a sponsor, spouse, and 0.65 children.

– MarketScan data cover a full four quarters in FYs 2017 and 2018. Only two quarters of data were available for FY 2019, which were seasonally adjusted and annualized.

– Some dual-eligible retirees receive care from the VA, which is not included in MHS administrative data. Using regression analyses, we estimated utilization at VA facilities in FYs 2017–2019 for retirees enrolled in Prime and included those estimates in total utilization (e.g., $461 per retiree family in FY 2019).

– Civilian expenditures for deductibles and copayments are somewhat higher than in previous reports. Our previous source was the MEPS, which marginally understates those expenditures relative to MarketScan (see Zuvekas, S. "Comparing MEPS Use and Expenditure Estimates for the Privately Insured to Truven MarketScan® and OptumLabs™ Claims Data, 2008–2013." Center for Financing, Access and Cost Trends, AHRQ. October 2017).

LOWER COST

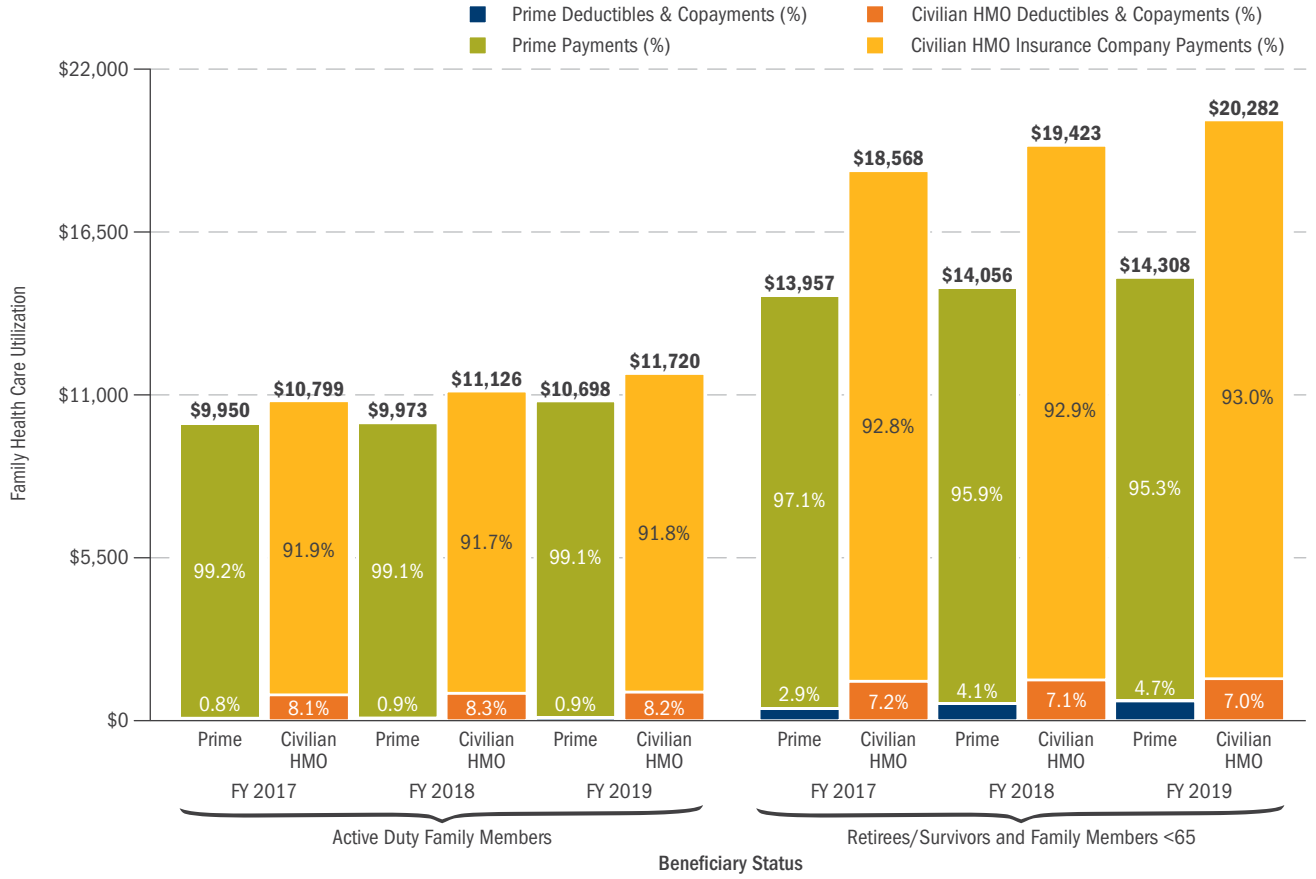
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Coinsurance and Health Care Utilization for Families Enrolled in TRICARE Prime vs. Civilian HMO Counterparts

In FYs 2017–2019, TRICARE Prime enrollees had lower coinsurance rates (deductibles and copayments per dollar of utilization) and less utilization than their civilian HMO counterparts.

- In FYs 2017–2019, TRICARE Prime enrollees had coinsurance rates that were two to eight percentage points below those of their civilian HMO counterparts.
  - In FY 2019, the coinsurance rate for Active Duty families was 0.9 percent—7.3 percentage points lower than civilian HMO counterparts (8.2 percent).
  - In FY 2019, the coinsurance rate for retiree families was 4.7 percent—2.3 percentage points lower than civilian HMO counterparts (7.0 percent).
- In FYs 2017–2019, TRICARE Prime enrollees had lower health care utilization than their civilian HMO counterparts.
  - In FY 2019, Active Duty families consumed $10,700 of medical services—$1,000 less than civilian HMO counterparts ($11,700).
  - In FY 2019, retiree families consumed $14,300 in medical services—$6,000 less than civilian HMO counterparts ($20,300).

COINSURANCE AND HEALTH CARE UTILIZATION FOR FAMILIES ENROLLED IN TRICARE PRIME VS. CIVILIAN HMO COUNTERPARTS, FYs 2017–2019



Sources: TRICARE health care utilization expenditures by both the government and beneficiaries in FYs 2017–2019 from MHS administrative data for all families enrolled in Prime without OHI payments for TRICARE utilization, 12/31/2019; civilian insurance company and beneficiary benchmark expenditures from IBM Watson Health, MarketScan® CCAE database, 2/5/2020

Notes:

– MarketScan data cover a full four quarters in FYs 2017 and 2018. Only two quarters of data were available for FY 2019, which were seasonally adjusted and annualized.

– Some dual-eligible retirees receive care from the VA, which is not included in MHS administrative data. Using regression analyses, we estimated utilization at VA facilities in FYs 2017–2019 for retirees enrolled in Prime and included those estimates in total utilization (e.g., $461 per retiree family in FY 2019).

– Civilian benchmark total utilization expenditures (i.e., beneficiary plus insurance company payments) are notably higher than those in previous reports. Our previous source for civilian benchmark expenditures was the MEPS, which has been found to significantly understate actual expenditures relative to MarketScan (see Zuvekas, S. "Comparing MEPS Use and Expenditure Estimates for the Privately Insured to Truven MarketScan® and OptumLabs™ Claims Data, 2008–2013." Center for Financing, Access and Cost Trends, AHRQ. October 2017).

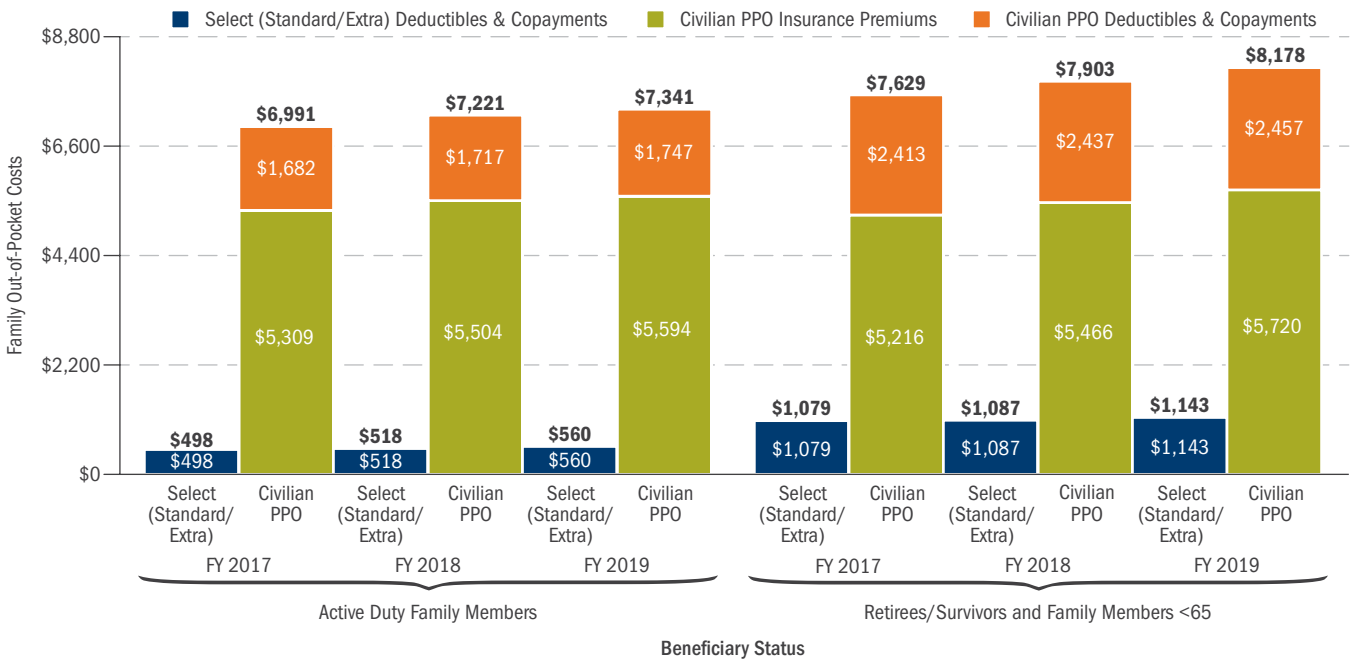
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Out-of-Pocket Costs for Families Who Rely on TRICARE Select (Standard/Extra) or Direct Care vs. Civilian PPO Counterparts

In FYs 2017–2019, civilian counterpart families enrolled in PPO plans had much higher out-of-pocket costs than did TRICARE Select (Standard/Extra) users.

- In FYs 2017–2019, civilian PPO counterparts paid $6,500 to $7,000 more for insurance premiums, deductibles, and copayments.
- In FY 2019, costs for civilian PPO counterparts were:
  - $6,800 more than those incurred by Active Duty families who relied on TRICARE Select.
  - $7,000 more than those incurred by retiree families who relied on TRICARE Select.

OUT-OF-POCKET COSTS FOR FAMILIES WHO RELY ON TRICARE SELECT (STANDARD/EXTRA) OR DIRECT CARE VS. CIVILIAN PPO COUNTERPARTS, FYs 2017–2019



Sources: TRICARE beneficiary expenditures for deductibles and copayments in FYs 2017–2019 from MHS administrative data for all TRICARE Select (Standard/Extra)–reliant families without OHI payments for TRICARE utilization, 12/31/2019; civilian benchmark expenditures for deductibles and copayments from IBM Watson Health, MarketScan® CCAE database, 2/5/2020; civilian benchmark insurance premiums from the Insurance Component of the MEPS (actuals in FYs 2017–2018, projected in FY 2019), 12/31/2019

Notes:

– Estimates are for a demographically typical family. For Active Duty dependents, a family includes a spouse and 1.54 children, on average. For retirees, a family includes a sponsor, spouse, and 0.65 children.

– MarketScan data cover a full four quarters in FYs 2017 and 2018. Only two quarters of data were available for FY 2019, which were seasonally adjusted and annualized.

– Some dual-eligible retirees receive care from the VA, which is not included in MHS administrative data. Using regression analyses, we estimated utilization at VA facilities in FYs 2017–2019 for retirees enrolled in Prime and included those estimates in total utilization (e.g., $383 per retiree family in FY 2019).

– Civilian expenditures for deductibles and copayments are somewhat higher than in previous reports. Our previous source was the MEPS, which marginally understates those expenditures relative to MarketScan (see Zuvekas, S. "Comparing MEPS Use and Expenditure Estimates for the Privately Insured to Truven MarketScan® and OptumLabs™ Claims Data, 2008–2013." Center for Financing, Access and Cost Trends, AHRQ. October 2017).

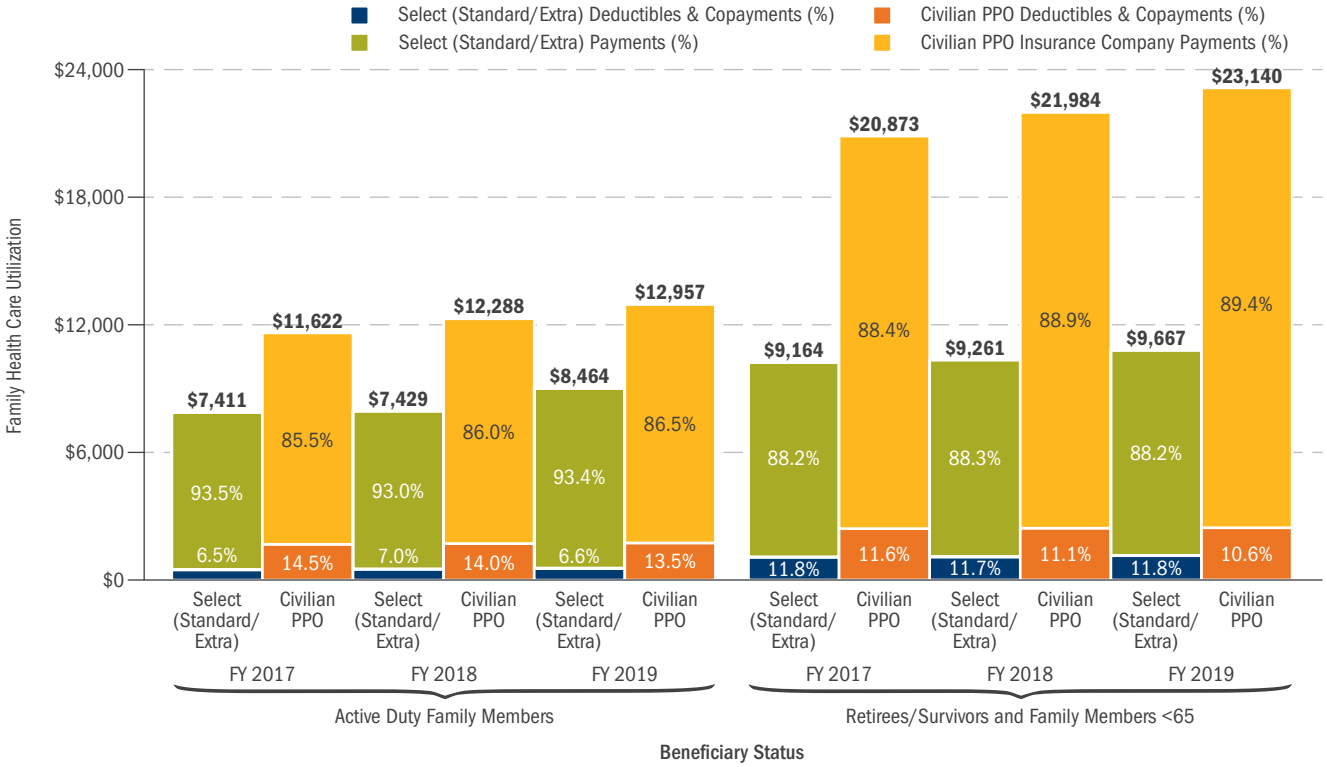
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Coinsurance and Health Care Utilization for Families Who Rely on TRICARE Select (Standard/Extra) or Direct Care vs. Civilian PPO Counterparts

Active Duty families who relied on TRICARE Select (Standard/Extra) had lower coinsurance rates (deductibles and copayments per dollar of utilization) and lower health care utilization (dollar value of health care services consumed) than their civilian counterparts enrolled in PPO plans. Retiree families and their civilian counterparts had similar coinsurance rates, but retiree families had substantially lower utilization.

- In FY 2019 for Active Duty families:
  - Coinsurance rates were 6.6 versus 13.5 percent for civilian PPO counterparts (6.9 percentage points lower).
  - Health care utilization was $8,500 versus $13,000 for civilian PPO counterparts ($4,500 less).
- In FY 2019 for retiree families:
  - Coinsurance rates were 11.8 versus 10.6 percent for civilian PPO counterparts (1.2 percentage points higher).
  - Health care utilization was $9,700 versus $23,000 for civilian PPO counterparts ($13,500 less).

COINSURANCE AND HEALTH CARE UTILIZATION FOR FAMILIES WHO RELY ON TRICARE SELECT (STANDARD/EXTRA) OR DIRECT CARE VS. CIVILIAN PPO COUNTERPARTS, FYs 2017–2019



Sources: TRICARE health care utilization expenditures by both the government and beneficiaries in FYs 2017–2019 from MHS administrative data for all TRICARE Select (Standard/Extra)–reliant families without OHI payments for TRICARE utilization, 12/31/2019; civilian insurance company and beneficiary benchmark expenditures from IBM Watson Health, MarketScan® CCAE database, 2/5/2020

Notes:

– MarketScan data cover a full four quarters in FYs 2017 and 2018. Only two quarters of data were available for FY 2019, which were seasonally adjusted and annualized.

– Some dual-eligible retirees receive care from the VA, which is not included in MHS administrative data. Using regression analyses, we estimated utilization at VA facilities in FYs 2017–2019 for retirees enrolled in Prime and included those estimates in total utilization (e.g., $383 per retiree family in FY 2019).

– Civilian benchmark total utilization expenditures (i.e., beneficiary plus insurance company payments) are notably higher than those in previous reports. Our previous source for civilian benchmark expenditures was the MEPS, which has been found to significantly understate actual expenditures relative to MarketScan (see Zuvekas, S. "Comparing MEPS Use and Expenditure Estimates for the Privately Insured to Truven MarketScan® and OptumLabs™ Claims Data, 2008–2013." Center for Financing, Access and Cost Trends, AHRQ. October 2017).

BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES)

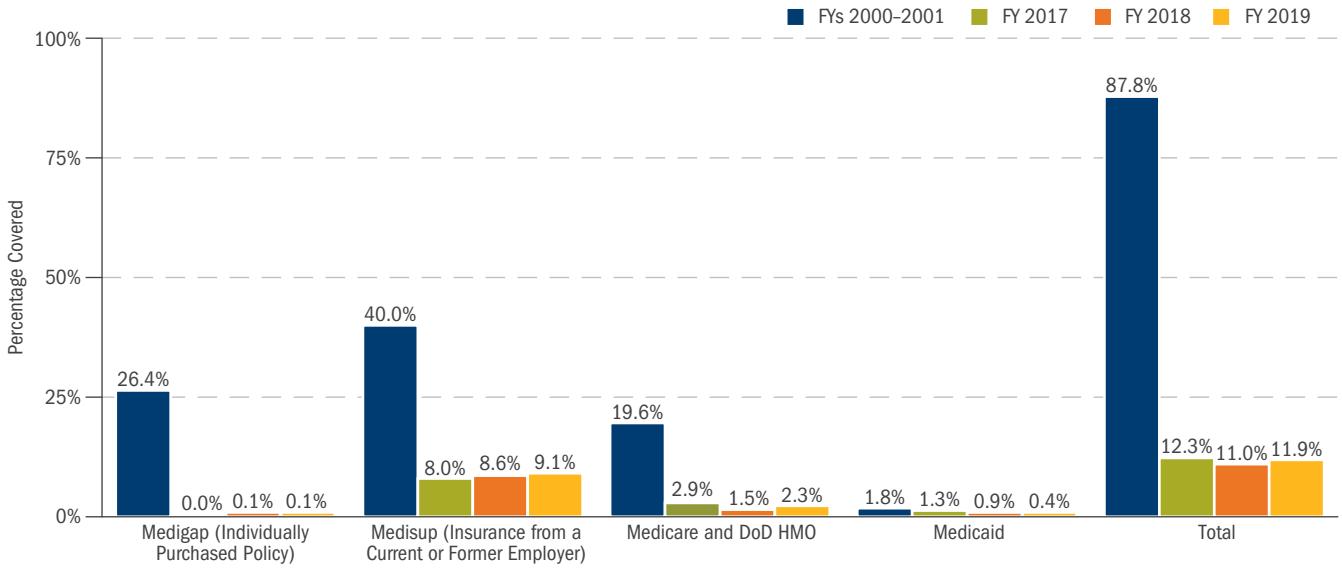
Out-of-pocket costs for retirees aged 65 and older (seniors) and their families include deductibles and copayments for medical care and drugs, TRICARE enrollment fees, and insurance premiums. In April 2001, the DoD expanded drug benefits for seniors; on October 1, 2001, the DoD implemented the TFL program, 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 about 11.7 percent in FYs 2017–2019.
- Why do some seniors 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 VS. FYs 2017–2019



Source: FYs 2000–2001 and FYs 2017–2019 HCSDB, as of 12/31/2019

[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 1 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 12/31/2019.

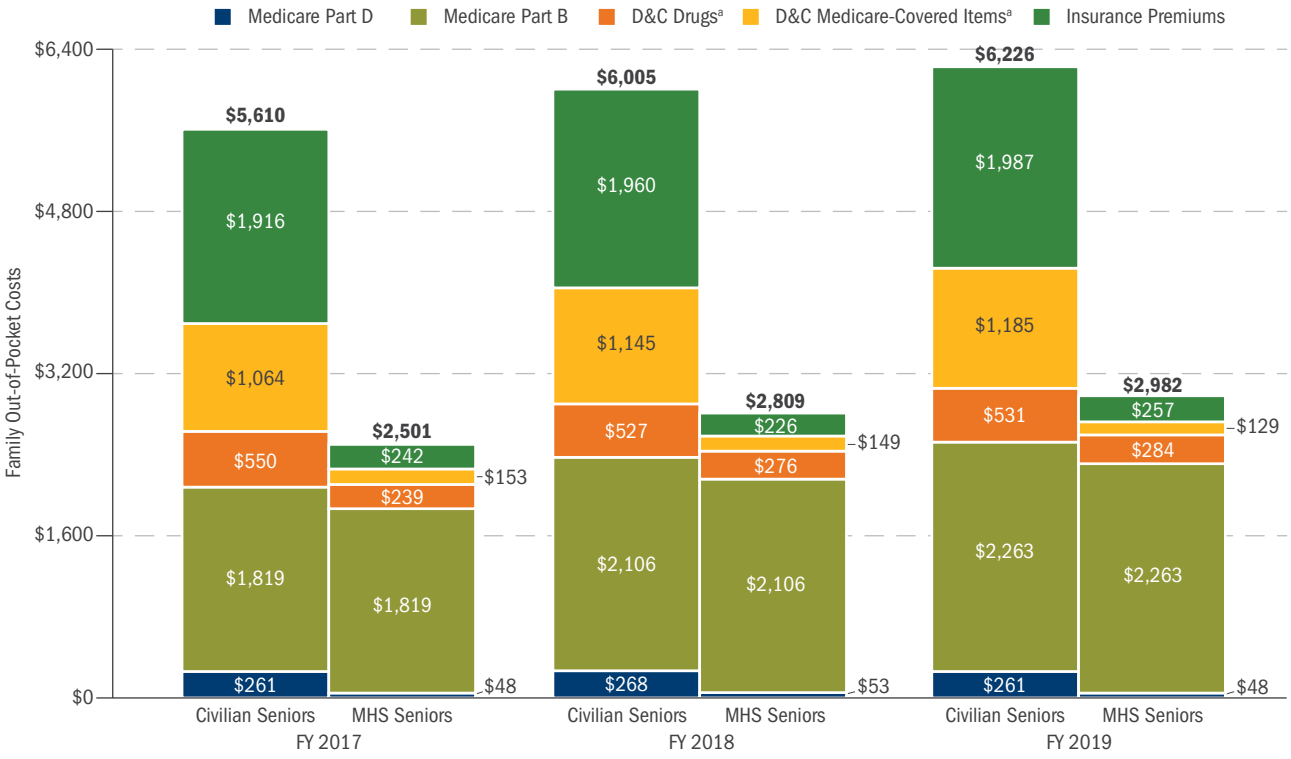
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT.)*

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 their civilian counterparts having supplemental insurance coverage similar to TRICARE senior families in FYs 2000–2001 (before TFL).

- In FY 2019, out-of-pocket costs for MHS senior families were 52 percent less than those of their "before TFL" civilian counterparts.
- In FY 2019, MHS senior families saved about $3,200 as a result of TFL and added drug benefits.

OUT-OF-POCKET COSTS OF MHS SENIOR FAMILIES AFTER TFL VS. CIVILIAN COUNTERPARTS, FYs 2017–2019



Sources: TRICARE senior family deductibles and copayments for MHS users in FYs 2017–2019 from MHS administrative data, 12/31/2019; for MHS non-users and civilian benchmark senior families, deductibles and copayments by type of Medicare supplemental coverage in FYs 2017–2019 projected from the Household Component of the MEPS; Medicare Part B and Medicare HMO premiums in FYs 2017–2019 from the Centers for Medicare & Medicaid Services (CMS); Medigap premiums in FYs 2017–2019 from Weiss Research, Inc.; Medisup premiums from Towers Watson Health Care Cost Surveys in 2013–2014 projected to FYs 2017–2019 based on their long-run growth rates; Medicare Part D premiums in FYs 2017–2019 from Kaiser Family Foundation Surveys; Medicare supplemental insurance coverage, before and after TFL, from HCSDB, FYs 2000–2001, 2017–2019, as of 12/31/2019

[a] "D&C" is deductibles and copayments.

Notes:

– 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.

– There are three limitations of the MEPS utilization expenditures data for seniors. First, they are known to understate expenditures for inpatient and outpatient services by about 19 percent (see Zuvekas and Olin. Accuracy of Medicare Expenditures in the Medical Expenditure Panel Survey. *Inquiry* 46: 92–108 [Spring 2009]). Expenditures for inpatient and outpatient services were adjusted upward to account for the bias. Second, the data are volatile due to small samples; the data were smoothed to mitigate the effects of volatility. Third, the sample is not up to date; the last observation period is CY 2017. The long-run growth rate between FY 2007 and FY 2017 was used to project utilization expenditures in FYs 2017–2019.

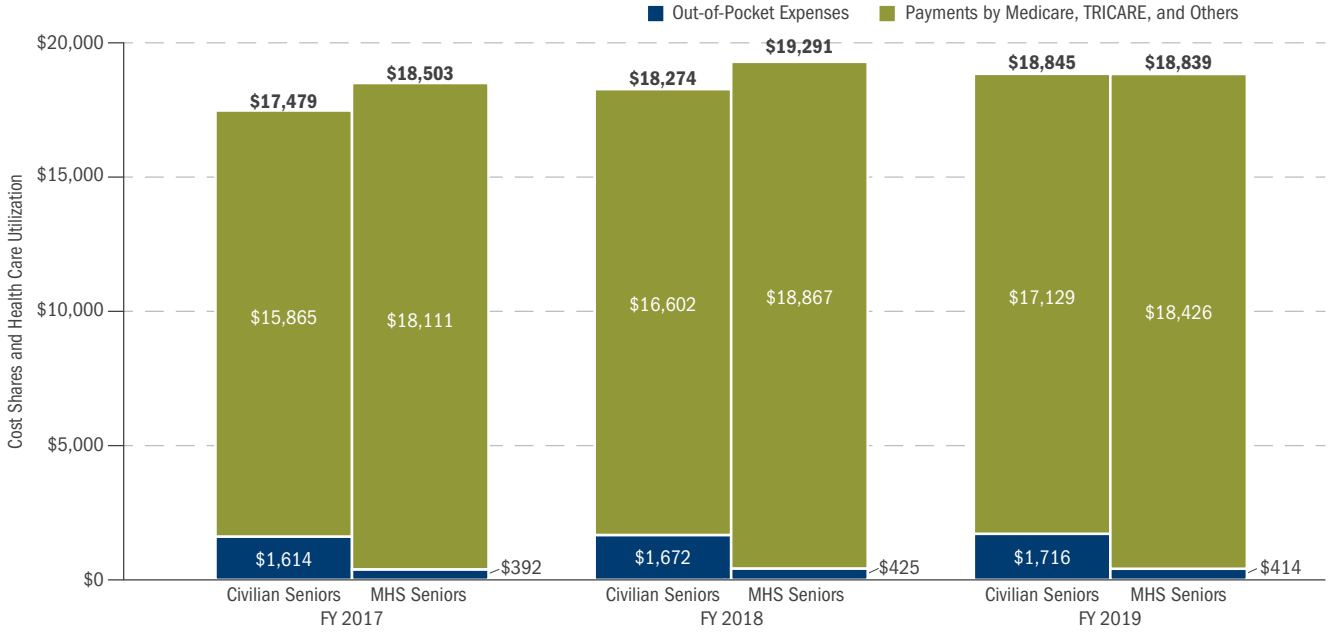
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT.)*

Coinsurance and Health Care Utilization for MHS vs. Civilian Senior Families

TRICARE senior families have lower coinsurance rates (deductibles and copayments per dollar of utilization) than their "before TFL" civilian counterparts. Utilization is similar for both groups.

- MHS senior families have relatively low coinsurance rates.
  - In FY 2019, the coinsurance rate for civilian senior counterparts was 9.1 percent; it was 2.2 percent for MHS seniors (6.9 percentage points lower).
- MHS senior families and civilian senior families have similar health care utilization.
  - In FY 2019, civilian senior counterparts consumed $18,845 in medical services; MHS senior families consumed $18,839 (virtually the same).

COINSURANCE AND HEALTH CARE UTILIZATION FOR SENIOR FAMILIES VS. CIVILIAN COUNTERPARTS, FYs 2017–2019



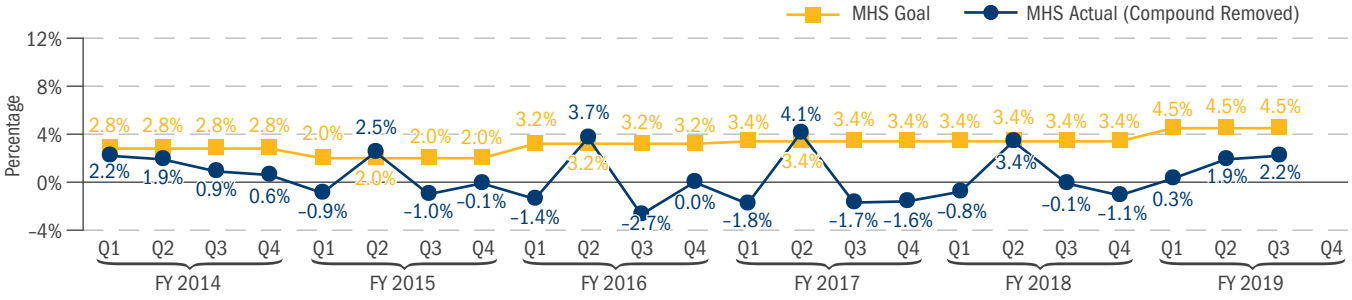
Sources: TRICARE senior family utilization, deductibles, and copayments for MHS users in FYs 2017–2019 from MHS administrative data, 12/31/2019; for MHS non-users and civilian benchmark senior families, utilization, deductibles, and copayments by type of Medicare supplemental coverage in FYs 2017–2019 projected from the Household Component of the MEPS in FYs 2007–2017; Medicare supplemental insurance coverage, before and after TFL, from HCSDB, FYs 2000–2001 and 2017–2019, as of 12/31/2019

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 measure focuses on the annual overall cost growth for TRICARE Prime enrollees and includes all costs related to health care delivered to enrollees. The objective is to keep the rate of cost growth for Prime enrollees to a level at or below the increases for the civilian health care plans at the national level. Currently, the measure provides insight to issues regarding unit cost, utilization management, and purchased care management. The metric has been enhanced to properly account for differences in population demographics and health care requirements of the enrolled population. During FY 2017 and FY 2018, 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. In FY 2018, the MHS sustained growth in provider productivity, demonstrating that improvement processes continue to work. With productivity improvements, the MHS will need to ensure that ambulatory care utilization remains under control.

- 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 for FY 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 nonmaintenance medication. The impact of these actions resulted in achievement of the goal through FY 2016.
- 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, work 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 time period from FY 2014 to FY 2016, the MHS goal was set at one percentage point below the survey. Starting in FY 2017, the goal reverted back to the actual survey result.

PERCENTAGE CHANGE IN MEDICAL COST PER PRIME EQUIVALENT LIFE (FROM PRIOR YEAR), FYs 2014–2019



Sources: DHA, Analytics and Evaluation Division, 12/6/2019. Data are as of November 2019, and MHS administrative data (M2); Standard Inpatient Data Record/ Standard Ambulatory Data Record/Comprehensive Ambulatory/Professional Encounter Record/TED Institutional/TED Noninstitutional; Pharmacy Data Transaction Service; Expense Assignment System IV.

Notes:

– Enrollees are adjusted for health risk status.

– FY 2019 data are reported through FY 2019 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 Improved Readiness, Better Care, Better Health, and Lower Cost. The 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 IBM Watson Health, 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 Healthcare Providers and Systems (CAHPS®), to include CAHPS Health Plan Survey, Hospital CAHPS (HCAHPS), and CAHPS Clinician & Group Survey (CG-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—Health Care Survey of DoD Beneficiaries (HCSDB) (11/1/2019); Joint Outpatient Experience Survey (JOES)/Joint Outpatient Experience-CAHPS (JOES-C) (10/14/2019); TRICARE Inpatient Satisfaction Survey (TRISS) (10/18/2019). JOES combines and standardizes the long-standing Services outpatient surveys: Army Provider Level Satisfaction Survey (APLSS), Navy Patient Satisfaction Survey (PSS), Air Force Service Delivery Assessment (SDA), and TRICARE Outpatient Satisfaction Survey (TROSS).
  - Eligibility/enrollment data—12/18/2019
  - MHS workload/costs—1/13/2020
- 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

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 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., the Centers for Disease Control and Prevention [CDC] Behavioral Risk Factor Surveillance System [BRFSS], 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; use of urgent care centers; and measures of Health-Related Quality of Life (HRQOL).

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 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 nonrespondents, 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 27,000 respondents from about 303,500 beneficiaries sampled in FY 2019 (about a 12.7 percent raw response and a 10.9 percent weighted response rate, compared to a 12.5 percent raw response rate in FY 2018). 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 2017–2019 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).

NCQA collects responses to the survey from a national sample of health plans that serve the civilian population. Results from each plan for beneficiaries who responded by mail or Internet are averaged together, weighted equally. The benchmarks are adjusted to correspond to the age and health status of TRICARE users.

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.

TRISS

The purpose of the Office of the Assistant Secretary of Defense for 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 AHRQ and the Centers for Medicare & Medicaid Services (CMS) for the 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 44-item survey instrument. The survey includes HCAHPS questions asking how often or whether patients experienced a critical aspect of hospital care, rather than whether they were "satisfied" with their care, and 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 CMS. 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 overall FY 2019 Q1–Q3 response rate for direct care was 33 percent, and for purchased care almost 36 percent.

JOES/JOES-C

The 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. The JOES-C is a companion survey to the JOES, measuring outpatient care at military and civilian facilities. The JOES-C is based on the CG-CAHPS, as was the predecessor to the JOES-C: the TROSS. JOES-C allows the 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® (TJC) for national benchmarking. The data for direct care hospitals participating in the National Surgical Quality Improvement Program (NSQIP) are abstracted by trained surgical case reviewers and submitted to the American College of Surgeons (ACS). The perinatal data are obtained from the electronic data system through an administrative data pull and are submitted to the National Perinatal Information Center (NPIC) to support comparison with other participating organizations 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 in CarePoint provides views for all measures as well as executive and improvement priorities. The CarePoint portal includes a discharge tool to ensure that 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 (a milSuite account and DoD-issued Common Access Card [CAC] are required to access this site).

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 2020, 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 preferred provider organization (PPO) plans, point-of-service (POS) plans, health maintenance organization (HMO) plans, 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.

We tasked IBM Watson Health to compute quarterly benchmarks for HMOs and PPOs, broken out by product line (i.e., MED/SURG, OB/GYN, PSYCH) and several sex/age group combinations. The quarterly breakout, available through the second quarter of FY 2019, allowed us to derive annual benchmarks by fiscal year and to estimate FY 2019 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 aged 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 | 18
AC	Active Component | 49
ACD	Autism Care Demonstration | 18
ACS	American College of Surgeons | 51
ADC	authority, direction, and control | 7
ADFM	Active Duty family member | 17
ADSM	Active Duty Service member | 56
AE	adverse event | 96
AHRQ	Agency for Healthcare Research and Quality | 9
AMC	Army Medical Center | 36
APLSS	Army Provider Level Satisfaction Survey | 86
ASD	autism spectrum disorder | 124
ASD(HA)	Assistant Secretary of Defense for Health Affairs | 9
BHCC	Behavioral Health Clinical Community | 56
BHDP	Behavioral Health Data Portal | 56
BMI	body mass index | 166
BRAC	Base Realignment and Closure | 28
BRFSS	Behavioral Risk Factor Surveillance System | 171
CA	corrective action | 99
CAHPS	Consumer Assessment of Healthcare Providers and Systems | 63
CAP	College of American Pathologists | 9
CAPER	Comprehensive Ambulatory/Professional Encounter Record | 201
CAUTI	catheter-associated UTI | 9
CCAC	Clinical Communities Advisory Council | 111
CCAE	Commercial Claims and Encounters | 175
CCCT	Combat Casualty Care Team | 51
CCS	Clinical Classifications Software | 184
CDC	Centers for Disease Control and Prevention | 40
CE	continuing education | 102
CG-CAHPS	CAHPS Clinician & Group Survey | 86
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services | 205
CHCBP	Continued Health Care Benefit Program | 15
CLABSI	central line–associated bloodstream infection | 9
CLIA	Clinical Laboratory Improvement Amendment | 107
CLIP	Clinical Laboratory Improvement Program | 107
CMS	Centers for Medicare & Medicaid Services | 34
CONUS	within the contiguous United States | 7
CPG	clinical practice guideline | 14
CPI	Continuous Process Improvement | 55
CQI	clinical quality improvement | 55
CQIS	CQI studies | 111
CQM	Clinical Quality Management | 95
CQMC	Core Quality Measures Collaborative | 58
CSA	comprehensive systematic analysis | 98
CSD	Clinical Support Division | 98
CY	calendar year | 4
DEERS	Defense Enrollment Eligibility Reporting System | 22
DHA	Defense Health Agency | 5
DHA-IPM	DHA Interim Procedures Memorandum | 65
DHA-PM	DHA Procedures Manual | 59
DHHS	Department of Health and Human Services | 18
DHP	Defense Health Program | 16
DoD	Department of Defense | 1
DoDI	DoD Instruction | 105
DoDM	DoD Manual | 107
EBPWG	Evidence-Based Practice Work Group | 111
ED	emergency department | 22
EHR	electronic health record | 4
eMSM	enhanced multi-Service market | 74
ESB	Enterprise Solutions Board | 63
FDA	Food and Drug Administration | 46
FEDVIP	Federal Employees Dental and Vision Insurance Program | 1
FY	fiscal year | 1
GTT	Global Trigger Tool | 100
HAI	health care–associated infection | 97
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems | 4
HCSDB	Health Care Survey of DoD Beneficiaries | 80
HEDIS	Healthcare Effectiveness Data and Information Set | 4
HIPAA	Health Insurance Portability and Accountability Act | 87
HMO	health maintenance organization | 15
HP	Healthy People | 165
HRO	high reliability organization | 54
HROM	high reliability operating model | 54
HRQOL	Health-Related Quality of Life | 9
ICU	intensive care unit | 9
IDA	Institute for Defense Analyses | 190
IHI	Institute for Healthcare Improvement | 100
IMR	Individual Medical Readiness | 9
IOP	intensive outpatient program | 123
IQR	interquartile range | 65
JOES	Joint Outpatient Experience Survey | 4
JOES-C	Joint Outpatient Experience Survey-CAHPS | 86
JPSR	Joint Patient Safety Reporting | 98
KM	knowledge management | 111
KSAs	knowledge, skills, and abilities | 9
LOS	length of stay | 68
M2	MHS Management Analysis and Reporting Tool | 74
MBSAQIP	Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program | 110
MCSC	managed care support contractor | 14
MDR	MHS Data Repository | 28
MED/SURG	medical/surgical product line | 175
MEPS	Medical Expenditure Panel Survey | 190
MERHCF	Medicare-Eligible Retiree Health Care Fund | 4
MH	mental health | 112

ABBREVIATIONS *(CONT.)*

MHS	Military Health System | 1
MS-DRG	Medicare Severity Diagnosis Related Group | 177
MTF	military treatment facility | 4
NADD	non-Active Duty dependent | 123
NAL	nurse advice line | 39
NCHS	National Center for Health Statistics | 40
NCQA	National Committee for Quality Assurance | 80
NCR	National Capital Region | 74
NDAA	National Defense Authorization Act | 1
NH	Naval Hospital | 36
NHANES	National Health and Nutrition Examination Survey | 165
NHSN	National Healthcare Safety Network | 100
NPDB	National Practitioner Data Bank | 59
NPIC	National Perinatal Information Center | 110
NQF	National Quality Forum | 98
NSQIP	National Surgical Quality Improvement Program | 9
OB/GYN	obstetrics/gynecology product line | 175
OCONUS	outside the contiguous United States | 7
OHI	other health insurance | 25
O&M	operations and maintenance | 33
OPM	Office of Personnel Management | 17
P4I	Partnership for Improvement | 12
PCM	primary care manager | 9
PCMH	Patient-Centered Medical Home | 4
PDTS	Pharmacy Data Transaction Service | 43
PHP	partial hospitalization program | 123
PI	Program Integrity | 4
PPH	postpartum hemorrhage | 56
PPO	preferred provider organization | 15
PSA	Prime Service Area | 28
PSP	Patient Safety Program | 97
PSS	Navy Patient Satisfaction Survey | 86
PSYCH	mental health product line | 175
P&T	Pharmacy & Therapeutics | 45
PTSD	posttraumatic stress disorder | 56
PV	prime vendor | 44
QLE	qualifying life event | 17
QPP	Quadruple Aim Performance Plan | 9
RC	Reserve Component | 49
RE	Reportable Event | 4
RETFM	retirees and family member | 23
RMG	Reform Management Group | 7
RN	registered nurse | 74
RTC	residential treatment center | 123
RVU	relative value unit | 4
RWP	relative weighted product | 4
S2C2	Surgical Services Clinical Community | 127
SDA	Air Force Service Delivery Assessment | 86
SE	Sentinel Event | 56
SECDEF	Secretary of Defense | 7
SIDR	Standard Inpatient Data Record | 201
SIR	standardized infection ratio | 9
SME	subject matter expert | 19
SRV/OTHs	survivors and others | 31
SSO	Small-Market and Stand-Alone Organization | 7
SUD	substance use disorder | 122
SUDRF	SUD rehabilitation facility | 123
TAMP	Transitional Assistance Management Program | 15
TBI	traumatic brain injury | 19
TDP	TRICARE Dental Program | 15
TeamSTEPPS	Team Strategies and Tools to Enhance Performance and Patient Safety | 57
TED	TRICARE Encounter Data | 163
TFL	TRICARE for Life | 4
THP	TRICARE Health Plan | 12
tIMO	transitional Intermediate Management Organization | 16
TJC	The Joint Commission | 4
TOL	TRICARE Online | 64
TPR	TRICARE Prime Remote | 15
TQIP	Trauma Quality Improvement Program | 110
TRDP	TRICARE Retiree Dental Program | 17
TRISS	TRICARE Inpatient Satisfaction Survey | 60
TROSS	TRICARE Outpatient Satisfaction Survey | 86
TRR	TRICARE Retired Reserve | 4
TRS	TRICARE Reserve Select | 4
TYA	TRICARE Young Adult | 4
UC	urgent care | 14
UMP	Unified Medical Program | 1
URFO	unintended retained foreign object | 9
USD(P&R)	Under Secretary of Defense for Personnel and Readiness | 9
USFHP	Uniformed Services Family Health Plan | 4
UTI	urinary tract infection | 129
VA	Department of Veterans Affairs | 15
VHA	Veterans Health Administration | 19
VRC	Verification, Review, and Consultation | 110
WICC	Women and Infant Clinical Community | 56
WSS	Wrong-Site Surgery | 4

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)

TRICARE

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, Colo.
- Non-availability statements for civilian inpatient care in MTF catchment areas
- Program for Persons with Handicaps supplements basic program with nonmedical benefits for Active Duty family members (ADFMs) 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 rollout 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

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS *(CONT.)*

- Expanded beneficiary access to additional options for cancer treatment with a demonstration
  - 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

- Dropped requirement for outpatient Non-Availability Statement (NAS)
- Increased beneficiary access to preventive services by expanding access in TRICARE Standard/Extra (expanded further in 1997 to be very similar to TRICARE Prime)
- Launched TRICARE website

1997

- Began National Mail Order Pharmacy program
- 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
- Expanded comprehensive preventive benefits to TRICARE Standard/Extra
- Began TRICARE Retiree Dental Program—full-cost premiums with no DoD subsidy

- Completed TRICARE rollout with 11 regions operational (regions 7 and 8 consolidated)
- Removed TRICARE Prime copayments for ancillary services (radiology, laboratory, and diagnostic testing) conducted as a result of an outpatient visit

1998

- Began TRICARE Senior Prime demonstration

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
- Began TRICARE Prime Remote benefit
- NAS are required for maternity care

2000

- 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
- The DoD waives charges for Active Duty Prime Remote family members through August 31, 2000
- Expanded TRICARE benefits to cover school physicals

2001

- Eliminated TRICARE Prime copays for ADFMs
- Began TRICARE for Life (TFL) benefit, 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
- Began TRICARE Senior Pharmacy (TSRx) benefit, adding pharmacy benefits for retirees over 65 years of age who formerly lost all TRICARE benefits upon becoming eligible for Medicare at age 65
- Reduced and simplified TRICARE copay structure for prescription drugs
- Began permanent chiropractic care benefit in MTFs for Active Duty Service members (ADSMs)
- Began 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

- Began TRICARE Prime Remote for Active Duty Family Members (TPRADFM) benefit
- Awarded TRICARE Mail Order Pharmacy (TMOP) contract (formerly managed by Defense Logistics Agency [DLA] as the National Mail Order Program)
- Began TRICARE Global Remote Overseas (TGRO) contract, 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

- Modified TPRADFM to allow family members residing in Prime Remote locations to remain enrolled when sponsors undergo Permanent Change of Station on unaccompanied tour
- Began requirement for RC sponsor's activation orders for TRICARE Global Remote Overseas benefit
- Eliminated NAS requirement for TRICARE Standard, except for mental health
- Awarded TRICARE Retail Pharmacy contract (TRRx), carving the benefit out of the managed care support contracts into a single program

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS *(CONT.)*

- Expanded Transitional Assistance Management Program (TAMP) coverage temporarily to 180 days for all participants (made permanent in 2005)
- Began early eligibility for RC members activated for more than 30 days in support of a contingency operation (made permanent in 2005)

2004

- Consolidated managed care support contracts and 11 TRICARE Regions to three (North, South, and West)

2005

- Began premium-based TRICARE Reserve Select (TRS) benefit 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

2006

- Expanded TRS to all members of the Selected Reserve by adding two premium tiers
- Expanded TRICARE coverage to gastric bypass, gastric stapling, or gastroplasty
- Gave family members a 30-day period to submit a TRICARE Prime enrollment form
- Added 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

- Expanded TRICARE coverage to anesthesia and other costs for dental care for certain children and other beneficiaries
- Standardized claims processing under TRICARE program and Medicare program
- Enhanced mental health screening and services for members of the Armed Forces
- Simplified TRS—superseded three-tier TRS with a single 28 percent premium tier; opened to all Selected Reserve members other than those eligible for, or enrolled in, Federal Employees Health Benefits (FEHB) program

- Included mental health care program in definition of health care
- Implemented the Enhanced Access to Autism Care Demonstration (ACD) 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

- Began 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
- Established TRICARE Pharmacy manufacturer refunds (retroactive to January 2008)
- Implemented Outpatient Prospective Payment System (OPPS)
- Improved beneficiary access to vaccines by expanding coverage under pharmacy benefit for H1N1 at retail pharmacies at zero copay

2010

- Began TRICARE Overseas Program 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 Reserve members 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 ACD
- Increased access to needed treatment by expanding coverage of the available surgical options for morbid obesity
- Decreased copay for TRICARE Pharmacy Home Delivery, coinciding with increases to copays for retail pharmacy purchases
- Adjusted TRICARE Prime enrollment fee and began option for annual collection (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

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS *(CONT.)*

- Eliminated TRICARE Standard/Extra cost shares for authorized preventive services (always free of cost-sharing in TRICARE Prime)
- Expanded TYA to offer TRICARE Prime coverage
- Revised TRICARE 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

2012

deceased sponsors and medically retired members and dependents

- 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

2013

- 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 (expired in 2018 by law)
- 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

- 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)
- Defense Health Agency (DHA) became initially operational (October 1, 2013) under authority of the ASD(HA) and designated as a Combat Support Agency with oversight from the Chairman of the Joint Chiefs

- Reinstated Prime eligibility 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
- Expanded TRICARE coverage to single-level cervical total disc replacement
- Increased access to TRICARE mental health counselors
- Expanded available treatments for substance abuse
- Began TFL Pharmacy Pilot, requiring TFL beneficiaries living in the U.S. and the U.S. territories to fill select maintenance medications through TRICARE Pharmacy Home Delivery or at a military pharmacy

2014

- Extended the TRICARE Over-the-Counter demonstration, which permits beneficiaries to fill prescriptions for certain OTC drugs, from network pharmacies and through home delivery for free
- Added Certified Mental Health Counselors as authorized TRICARE providers
- Eliminated day limits for inpatient mental health stays
- Closed U.S.-based TRICARE Service Centers
- Expanded breast pump (and supplies) coverage to all TRICARE beneficiaries
- Expanded TRICARE 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

- Changed TRICARE Prime access to allow beneficiaries to enroll in a region where their desired primary care 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)

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
- Created DoD/VA Continuity of Care Drug List 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 enrollees within the contiguous United States (CONUS) up to four network visits per year without referral or prior authorizations
- Expanded inpatient mental health hospital services coverage
- Expanded TRICARE pharmacy benefit permanently for over-the-counter drug coverage
- Increased copays slightly for prescription drugs at Home Delivery and retail network pharmacies
- Introduced provisional coverage program to provide coverage for emerging treatments and technologies
- Expanded TRICARE Basic Program to cover:
  - 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 ADSMs
- Began 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
- Revised substance use disorder (SUD) treatment benefit to allow office-based opioid treatment by individual TRICARE-authorized physicians and added coverage of qualified opioid treatment programs as TRICARE authorized providers of SUD treatment for opioid use disorder
- Began health care delivery under second-generation TRICARE Overseas Program contract September 1, 2016 (included 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
- Changed PSA definition 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

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS *(CONT.)*

- Replaced TRICARE Standard/Extra with TRICARE Select, with grace transition period in 2018
- Extended Autism Care Demonstration for five years, through 2023, providing Applied Behavior Analysis coverage
- First annual TRICARE Open Season; coincided with the annual open season by U.S. Office of Personnel Management (OPM)

2018

- Enhanced TRICARE Coverage for Guard and Reserve members:
  - Extended TRICARE coverage to National Guard members and their eligible family members on 502(f) orders under Title 32 and called to state disaster response duty
  - Extended pre-deployment/early TRICARE eligibility and transitional coverage to Reserve Component members and eligible family members in receipt of 12304b orders for pre-planned missions under Title 10

2019

- Ended TRICARE Retiree Dental Program (TRDP)
- OPM welcomed beneficiaries previously eligible for TRDP to enroll in a dental plan under their Federal Employees Dental and Vision Insurance Program (FEDVIP)
- Opened FEDVIP vision enrollment to ADFMs, retirees and their families, as well as TRS and TRR members
- Assigned administration, direction, and control (ADC) of MTFs in U.S. to DHA (Deputy Secretary of Defense memo October 25, 2019)
- Offered TRICARE Prime enrollment in a Kaiser Permanente demonstration to beneficiaries in the Atlanta region
- Updated coverage of breastfeeding supplies and equipment
- Continued rollout of MHS GENESIS, the electronic health record (EHR) to MTFs

The **Evaluation of the TRICARE Program: Fiscal Year 2020 Report to Congress** is provided by the Defense Health Agency, Analytics and Evaluation 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.

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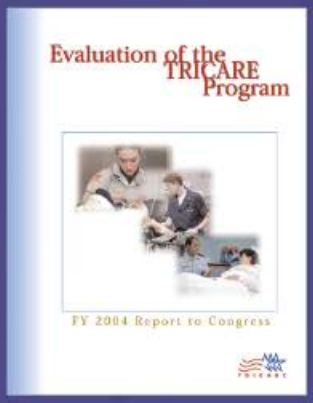
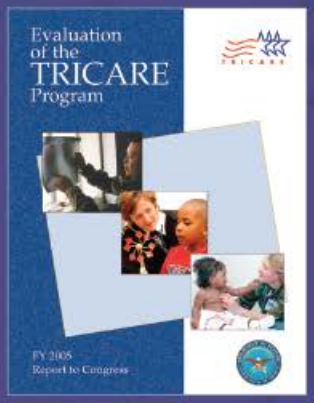
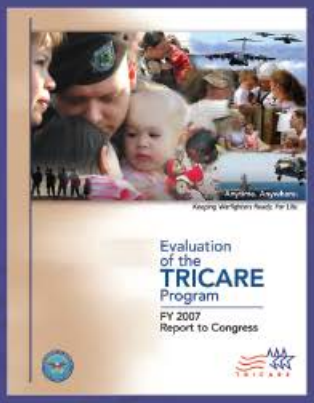
CRM = Contract Resource Management
CSD = Clinical Support Division
HRM&P = Health Resources Management & Policy
OPS = Operations
PCMH = Patient-Centered Medical Home
PHD = Public Health Division
R&M = Resources & Management
SP&FI = Strategy, Plans, and Functional Integration
THP = TRICARE Health Plan

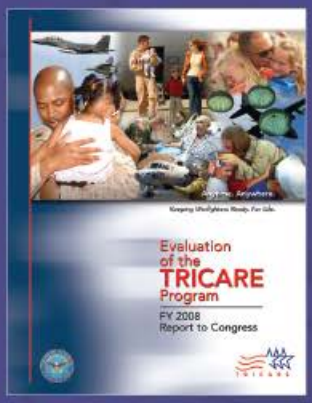
v10b

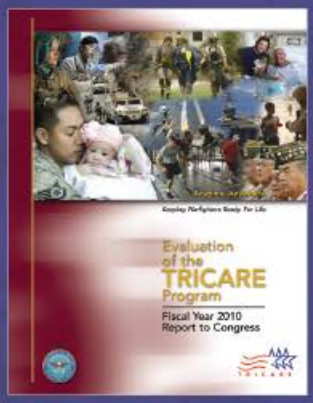
DHA
Defense Health Agency

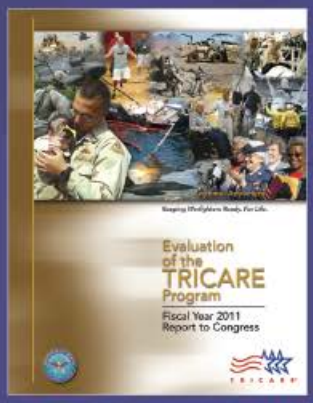


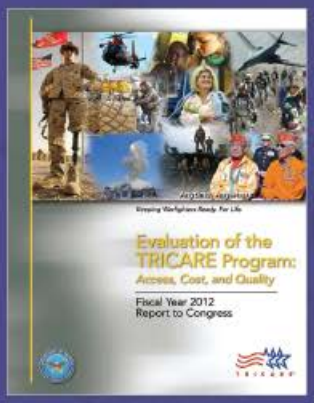


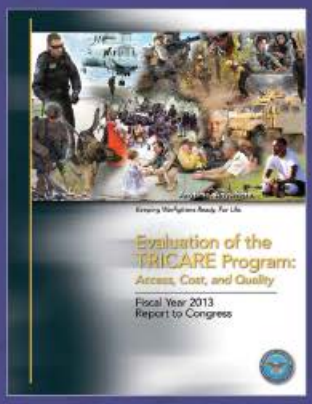


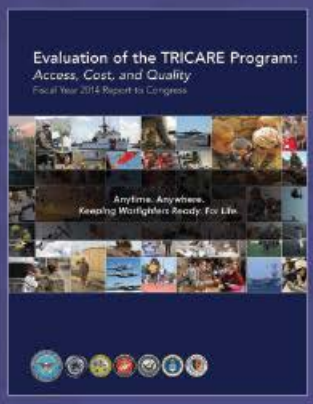


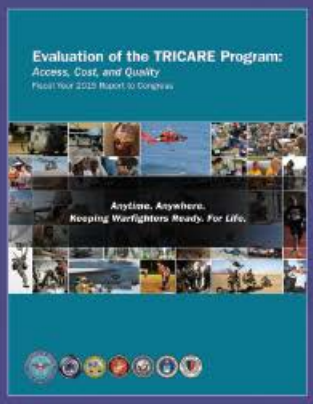


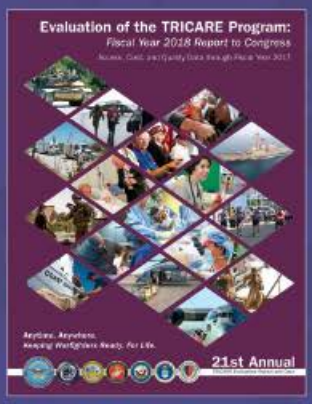


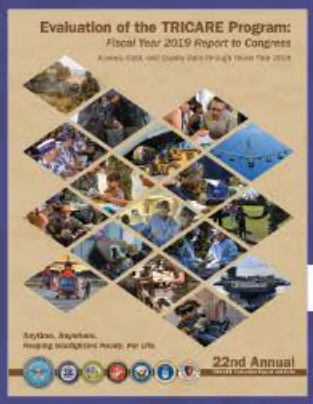












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