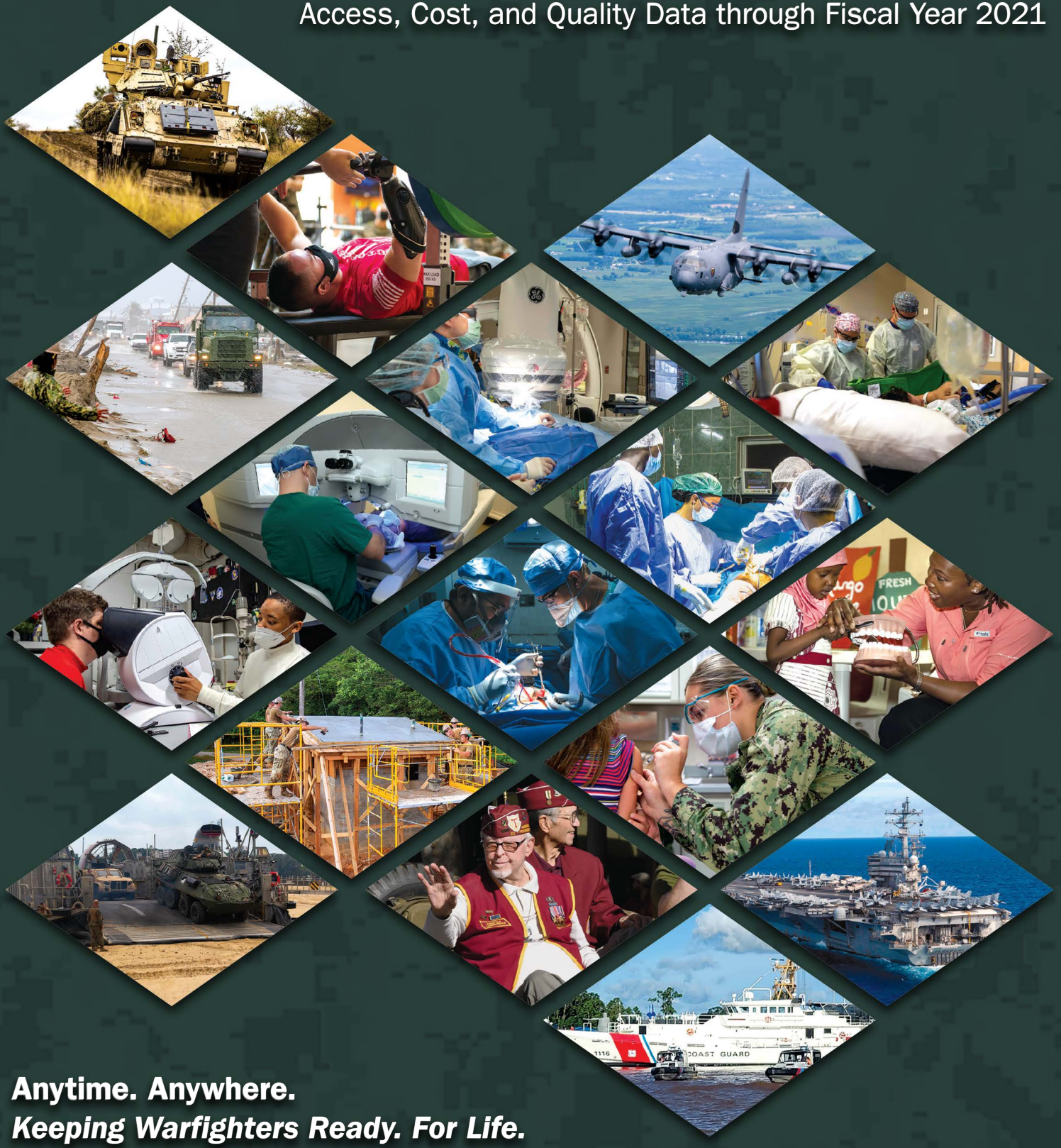
Evaluation of the TRICARE Program:

Fiscal Year 2022 Report to Congress

Access, Cost, and Quality Data through Fiscal Year 2021



Anytime. Anywhere.

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25th Annual

TRICARE Evaluation Report and Data

Evaluation of the TRICARE Program:

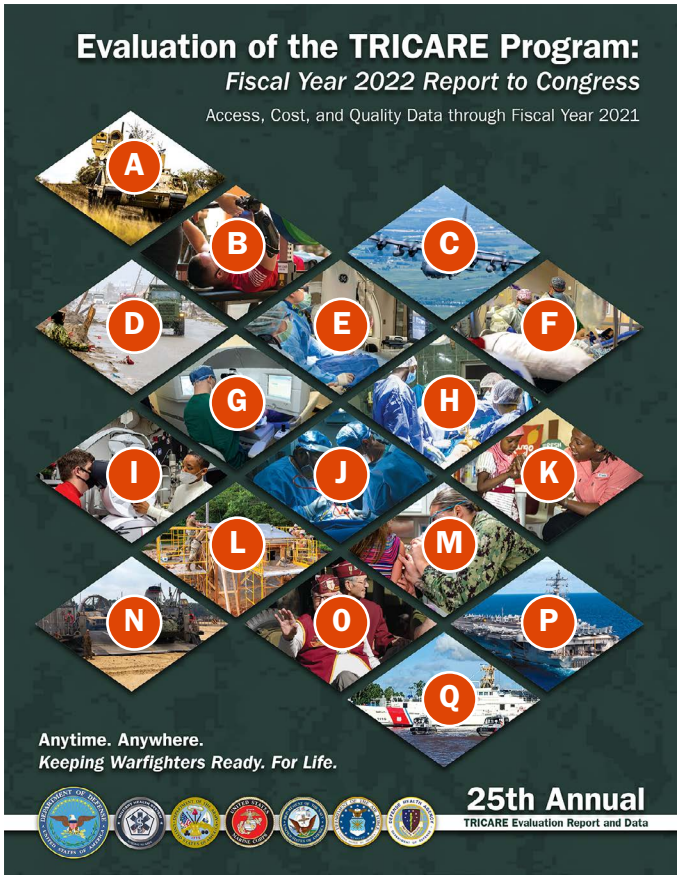
Fiscal Year 2022 Report to Congress

Access, Cost, and Quality Data through Fiscal Year 2021

FEBRUARY 28, 2022

The *Evaluation of the TRICARE Program: Fiscal Year 2022 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]). The intent of this report is an annual evaluation of the TRICARE Program only and is not intended to cover the costs of care delivered to dual eligible beneficiaries under the Veterans Administration. 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.

The estimated cost of this report for the Department of Defense is approximately $724,000.



Front cover photo descriptions:

A – U.S. Army soldiers move an Army M2 Bradley Fighting Vehicle toward an objective during a multinational situational training exercise in Cincu, Romania. (September 2021)

B – A Marine competes in the 2021 Military Adaptive Sports Virtual Challenge powerlifting event at Wounded Warrior Battalion East, Marine Corps Base Camp Lejeune, N.C. (September 2021)

C – An AC-130J Ghostrider assigned to the 4th Special Operations Squadron, Hurlburt Field, Fla., flies over Wisconsin during EAA AirVenture Oshkosh. (July 2021)

D – A naval equipment operator, assigned to Naval Mobile Construction Battalion (NMCB) 133, serves as a ground guide while assisting with road clearing operations during Hurricane Ida disaster relief efforts in Grand Isle, La. (September 2021)

E – A Navy cardiologist and medical resident with Naval Medical Center (NMC) San Diego conduct an electrophysiology study in the hospital's cardiac catheterization laboratory. (February 2021)

F – Army critical care nurses with the 627th Hospital Center prepare to move a COVID-19 positive patient during COVID-19 response operations at Kootenai Health regional medical center in Coeur d'Alene, Idaho. (October 2021)

G – A Navy surgeon performs Small Incision Lenticule Extraction (SMILE) [surgery] using the Zeiss VisuMax at NMC Camp Lejeune, N.C. (March 2021)

H – Orthopedic surgeons from the U.S. Army and Senagalese Army conduct partial hip replacement surgery at Ouakam Military Hospital in Dakar, Senegal. (July 2021)

I – A naval aviation ordnanceman receives an eye exam from a corpsman aboard the aircraft carrier USS Dwight D. Eisenhower (CVN 69) in the Red Sea. (April 2021)

J – U.S. Army medical personnel with the Medical Element, Joint Task Force-Bravo, Soto Cano Air Base, and Honduran hospital staff conduct a gallbladder removal during a Global Health Engagement in Puerto Cortés, Honduras. (September 2021)

K – A U.S. Army soldier teaches a young girl about oral hygiene during a partnership oral hygiene class in Djibouti. (August 2021)

L – Seabees assigned to NMCB 1 Detachment Guam smooth out the concrete roof on the bath house project onboard Naval Base Guam Ordnance Annex. (December 2021)

M – NMC Portsmouth is providing the COVID-19 pediatric vaccination to children between the ages of five and 11. (November 2021)

N – U.S. Marines with Battalion Landing Team 3/5, 31st Marine Expeditionary Unit, depart the beach in a light armored vehicle after a light armored reconnaissance raid rehearsal at Camp Schwab, Okinawa, Japan. (June 2021)

O – A World War II veteran and Korean War POW waves to parade onlookers during a Veterans Day Parade in Marysville, Calif. (November 2021)

P – The Navy's only forward-deployed aircraft carrier USS Ronald Reagan (CVN 76) transits the South China Sea. Reagan is part of Task Force 70/Carrier Strike Group 5, conducting underway operations in support of a free and open Indo-Pacific. (June 2021)

Q – The USCGC Winslow Griesser (WPC-1116) refuels as members from the U.S. Coast Guard and Guyana Defence Force Coast Guard practice small boat tactical training during Tradewinds 2021. (June 2021)

Photos used throughout this report are courtesy of www.army.mil, www.navy.mil, www.usmc.mil, www.af.mil, *and* www.dvidshub.net.

CONTENTS

BETTER CARE *(cont.)*

BETTER HEALTH

LOWER COST

APPENDIX

DHA VISION AND MISSION FOR FISCAL YEAR (FY) 2021

Vision: Unified and Ready…

Mission: We support the National Defense Strategy and service military departments by leading the MHS as an integrated, highly reliable system of readiness, medical training, and health.

The DHA exists to support leaders throughout the DoD—in the Combatant Commands, in the military departments, and in the Office of the Secretary of Defense. Our mission sets are vast and complex:

- Delivering health care to millions of our Service members, families, and retirees, with the principal purpose to keep our forces healthy and ready
- Managing the TRICARE program, which includes hundreds of thousands of civilian network providers' and integrating military and private sector care
- Leading a worldwide public health system that proactively prevents injuries and illnesses, and protects our communities from environmental threats
- Conducting and coordinating essential medical research to better prepare us for known and emerging threats, both natural and manmade
- Leading a military medical education and training system, providing superbly prepared staff for every medical mission

The DHA accomplishes these many missions through relentless focus on four priorities:

Great Outcomes. Ensuring a medically ready force is everyone's job—the Service members themselves, the units to which they belong, the military medical teams that deliver care, and our TRICARE network partners. We ensure that every Service member is medically ready through the delivery of safe, integrated, patient-centered care. To ensure quality and safety for our beneficiaries, we must move to a zero-harm environment and demonstrate our commitment to high-reliability practices.

Ready Medical Forces. Our entire health care team needs to be ready too. And they obtain and sustain their medical skills through daily practice—in clinical settings that build their skills in their specialty areas and prepare them to deliver that service anywhere in the world, under all possible conditions.

Satisfied Patients. Our patients have choices in where they receive their care. We strive to give our beneficiaries the confidence to make military clinics and hospitals their first choice.

Fulfilled Staff. Public service—in uniform or civilian clothes—is demanding. We ask a lot of our medical teams. In return, leaders have an obligation to provide a workplace that is fulfilling—professionally challenging, respectful, collaborative, and rewarding.

We aim to achieve ready, reliable care. This report shows how we are doing and what work remains ahead of us.

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

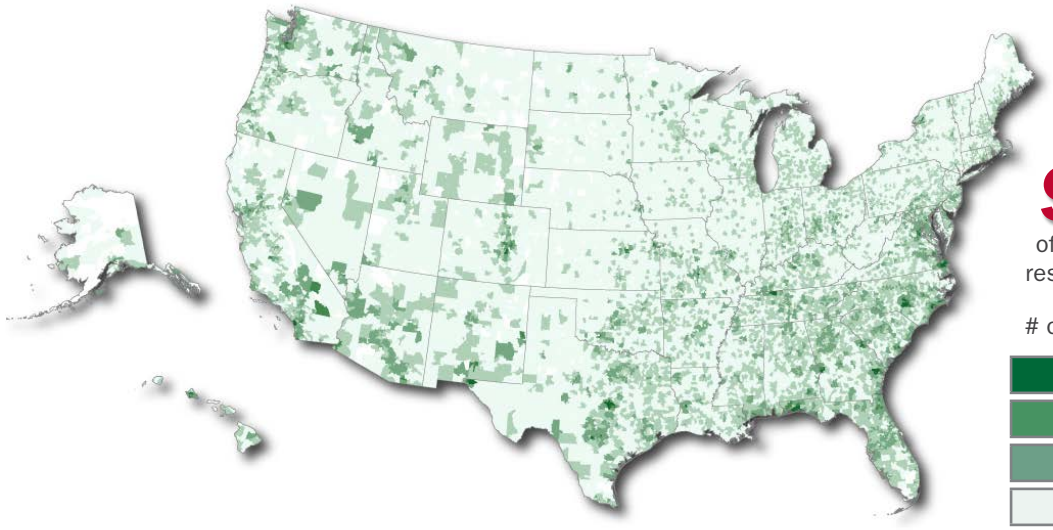
Evaluation of the TRICARE Program: Report to Congress
Executive Summary: Key Findings for FY 2021

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 38)



95% of beneficiaries reside in the U.S.

# of beneficiaries
- >10,000
- 5,001–10,000
- 501–5,000
- 100–500

Enrollment (page 34)

Prime Enrolled:
4.7 million beneficiaries

- ⬇ **3,336,000 Prime:** MTF PCM
- ⬇ **1,247,000 Prime:** Network PCM
- ⬆ **114,000 Prime:** USFHP
- ⬇ **6,000 Prime:** TYA Prime

Select Enrolled/Non-Enrolled:
2.4 million beneficiaries

- ⬆ **1,594,000** TRICARE Select
- ⬆ **393,000** TRS
- ⬆ **358,000** Direct Care Only
- ⬆ **33,000** TYA Select
- ⬇ **19,000** TRICARE Plus
- ⬆ **12,000** TRR

Medicare-Eligible:
2.5 million beneficiaries

- ⬆ **2,113,000** TFL
- **186,000** TRICARE Plus
- ⬆ **99,000** Direct Care Only
- ⬇ **40,000** USFHP
- ⬆ **33,000** Prime: Network PCM
- ⬇ **30,000** Prime: MTF PCM
- **3,000** Other

** Numbers rounded to the nearest thousand; ⬆ Increase from FY 2020; ⬇ Decrease from FY 2020*

Readiness (pages 59–60)

Active Duty	Reserve	Dental
Strategic Goal: 85%	Strategic Goal: 85%	Strategic Goal: 95%

COVID-19 (pages 14–25)

- Further developed and enhanced portfolio of COVID-19 tools, including COVID-19 Current Operations Dashboard
- Continued the COVID-19 Registry with more than 398,000 COVID-positive patients in the registry, and full manual data abstraction completed on 12,830 patients
- Total completed vaccination of 4,157,783

Pharmacy (page 187)

$957 million
pharmacy retail refunds

Hospital Ratings (page 155)

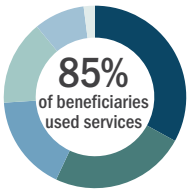
Patient overall rating of the hospital for inpatient encounters remains above the civilian benchmark for medical and surgical patients

EXECUTIVE SUMMARY: KEY FINDINGS FOR FISCAL YEAR 2021 *(CONT.)*

Budget (page 43)

FY 2021 Expenditures **$51.7 B** → FY 2022 Budget **$52.3 B**

Beneficiary Categories (pages 33, 41)



- 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 46–47, 51, 56)

DIRECT CARE		PRIVATE SECTOR CARE*
↓ 12% decrease	Inpatient Care	↓ 6% decrease
↓ 10% decrease	Outpatient Care	↑ 11% increase
↓ 16% decrease	Prescription Drugs	↑ 9% increase

Increase/decrease is from FY 2019 to FY 2021

* Excludes TRICARE for Life

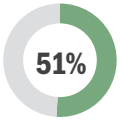
Total MHS Health Care Expenditures

Private sector care portion of total MHS health care expenditures increased from 56% in FY 2019 to 59% in FY 2021

Total Network Providers (pages 172–173)

25% ↑ increase in network **primary care providers** since FY 2017

18% ↑ increase in network **specialists** since FY 2017



of **behavioral health providers** accept new TRICARE patients (if they accept new patients at all)

FY 2021 MTF HEDIS Scores (page 127)

Low Back Pain Imaging	30-Day Mental Health Follow-Up	Well-Child Visits: 15 Months
78%	83%	77%
↓ 3%	↑ 8%	↓ 8%

According to the National Center for Quality Assurance, the trends in HEDIS measurements are consistent with industry as a result of the COVID-19 pandemic.

FY 2020 Perinatal Care Measures (pages 130–131)

	MTFs	National
Elective Delivery	0.5%	1.7%
Cesarean Section	21.5%	24.8%
Exclusive Breastfeeding	68.2%	51.1%

Direct Care Hospital Ratings (page 155)

Obstetric: 67% FY 2019 → 65% FY 2021

Surgical: 79% FY 2019 → 79% FY 2021

Medical: 76% FY 2019 → 76% FY 2021

Urgent Access (pages 74, 78–80)

In direct care, there was a **decrease** in the average number of days to third next available 24-hour (1.76 days) and future (5.51 days) appointments in FY 2021.

The rate of network urgent care visits by MTF enrollees has **continued to increase** in FY 2021. Emergency department utilization rate also slightly **increased** in FY 2021.

- **67% of beneficiaries enrolled in secure messaging** in FY 2021.
- **Over 80%** of patient messages were responded to within one business day.

Access Ratings (pages 83, 95)

Overall network leakage of MTF enrollees' primary care needs **increased** from 11.8% in FY 2020 to 12.6% in FY 2021.

In FY 2021, **78%** reported via JOES they can get care when needed (outpatient) in direct care, a **decrease** of 1 percentage point from the previous year.

EXECUTIVE SUMMARY: KEY FINDINGS FOR FY 2021 *(CONT.)*

Military Health System (MHS) Worldwide Summary

- The $52.3 billion Unified Medical Program (UMP) presented in the FY 2022 President's Budget, including estimated outlays from the Medicare-Eligible Retiree Health Care Fund (MERHCF), is 1.3 percent higher than the $51.7 billion in expenditures in FY 2021 and is 7 percent of total FY 2022 estimated Department of Defense (DoD) outlays (ref. pages 43–44).
- In FY 2021, 9.6 million beneficiaries were eligible for DoD medical care. Of those, about 4.7 million (49 percent) were enrolled in TRICARE Prime (including TRICARE Young Adult [TYA] Prime and Uniformed Services Family Health Plan [USFHP]) (ref. pages 33–34).
- TYA enrollment decreased to just over 39,500 beneficiaries in FY 2021, from about 40,000 in FY 2020, with most enrolled in TRICARE Select (ref. page 171).
- In FY 2021, there were 326,867 covered lives in the premium-based TRICARE Reserve Select (TRS), a significant decrease from the previous year (390,166 covered lives in FY 2020). Retired Reserve (TRR) had 11,519 covered lives in FY 2021, an increase from 10,861 in FY 2020 (ref. page 167).

MHS Workload and Cost Trends[1,2]

- The percentage of beneficiaries using Military Health System (MHS) services declined slightly from 86 percent in FY 2019 to 85 percent in FY 2021 (ref. page 41).
- Excluding TRICARE for Life (TFL), total MHS workload (direct and private sector care combined) fell from FY 2019 to FY 2021 for inpatient care (8 percent) and prescription drugs (8 percent). Outpatient care workload increased by 3 percent over the same time period (ref. pages 46–47, 51).
- From FY 2019 to FY 2021, direct care workload decreased for inpatient care (12 percent), outpatient care (10 percent), and prescription drugs (16 percent). Over the same period, total direct care costs fell by 19 percent (ref. pages 46–47, 51, 56).
- Excluding TFL, private sector care workload declined for inpatient care (6 percent) but increased for outpatient care (11 percent) and prescription drugs (9 percent). Overall, private sector care costs rose by 6 percent (ref. pages 46–47, 51, 56).
- The private sector care portion of total MHS health care expenditures rose from 56 percent in FY 2019 to 59 percent in FY 2021 (ref. page 56).
- In FY 2021, out-of-pocket costs for MHS beneficiary families under age 65 were between $6,800 and $7,400 lower than those for their civilian counterparts, while out-of-pocket costs for MHS senior families were $3,300 lower (ref. pages 205, 210).

Lower Cost

- MHS cost avoidance/recovery includes $987 million in retail pharmacy refunds in FY 2021 and $509 million in Program Integrity (PI) activities in calendar year (CY) 2020 (ref. page 187).

Improved Readiness

- **Force Health Protection:** At the end of FY 2021, the overall medical readiness of the Total Force was at 83 percent, with the Active Component and the Reserve Component both at 83 percent, not meeting the strategic goal of 85 percent. Dental readiness, at 93 percent, was below 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 59–63).

Better Care

- **Access to Care:** Patient-Centered Medical Home (PCMH) primary care administrative measures indicate that, in FY 2021, military medical treatment facility (MTF) enrollees saw their primary care provider 55 percent of the time. In FY 2021, there was an improvement in the average number of days to third next available 24-hour (1.76 days) and future (5.51 days) appointments. Network urgent care usage increased substantially from 18.4 visits per 100 enrollees in FY 2020 to 22.6 visits per 100 enrollees in FY 2021 due to COVID-19 screening and vaccination. MTF responsiveness to secure messaging was 81 percent. The Joint Outpatient Experience Survey (JOES) shows 70 to 80 percent of MTF users in FY 2021 reported they could get care when needed. Administrative data shows that 86 percent of non-Active Duty enrollees had at least one primary care visit in FY 2021 (ref. pages 73–74, 81, 89, 92).
- **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 129–133).
- **Outpatient Care:** In FY 2021, MTF Healthcare Effectiveness Data and Information Set (HEDIS®) rates exceed the national 90th percentile for mental health follow-up, surpass the national 75th percentile for colorectal cancer screening, and surpass the national 50th percentile for cervical cancer screening and lower back pain imaging (ref. pages 122–127).
- **Beneficiary Ratings of Inpatient Care—Overall Hospital Rating:** Direct care has shown improved patient hospital ratings from FY 2019 to FY 2021, meeting or exceeding the national Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) benchmark average in the medical and surgical product lines. Ratings in the obstetric product line remain stable and below the HCAHPS benchmark (ref. page 155).
- **Patient Safety:** The MHS direct care system has been focusing on reducing Wrong-Site Surgery (WSS) Reportable Event (RE) education and leadership engagement, with a goal of zero events. The MHS experienced a significant drop in WSS REs from 2019 to 2020 due to the pandemic and subsequently saw a return to 2019 levels as surgical volumes returned to pre-pandemic levels (ref. page 104).
- **MHS Provider Trends:** The number of TRICARE network providers increased by 22 percent from FY 2017 to FY 2021. The total number of participating primary care providers increased by 9 percent and by 8 percent for specialist since FY 2017 over the same time period (ref. page 172).
- **Access for TRICARE Select Users:** Results from the FY 2021 congressionally mandated four-year survey of civilian providers show 87 percent of physicians and 51 percent of behavioral health providers accept new TRICARE patients (ref. page 173).

[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] By the end of FY 2021, the DoD's new electronic health record, MHS GENESIS, had been deployed at 301 military hospitals and clinics worldwide. Because RVUs and cost data are currently unavailable for outpatient care at MHS GENESIS facilities, we included estimates of those quantities in our totals for the first time this year.

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," military medical treatment facilities [MTFs] and military dental treatment facilities [DTFs]) with network and non-network TRICARE-authorized civilian health care professionals, institutions, pharmacies, and suppliers (often referred to as "private sector care (PSC)") 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 Select** is an enrollment-based health plan comparable to preferred provider organization (PPO) plans that features access to both network and non-network TRICARE-authorized providers. Referrals are generally not required for coverage.
  - Beneficiaries other than Active Duty Service members (ADSMs) may qualify to enroll.
  - Retirees, their families, and certain survivors must pay enrollment fees to participate.
- **TRICARE Prime** is an enrollment-based health 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 drive time to reach provider, waiting times to get an appointment, and waiting times in provider offices.
  - TRICARE Prime's point-of-service (POS) feature offers enrollees freedom to obtain care from TRICARE-authorized providers other than their assigned PCM without a referral, but POS deductibles and cost shares are significantly higher than TRICARE Select.
  - **TRICARE Prime Remote (TPR)** enrollment is offered to certain Service members stationed remote from MTFs.
  - **TRICARE Prime Remote for Active Duty Family Members (TPRADFM)** enrollment is offered to qualified dependents of Service member sponsors, active and reserve, on Active Duty more than 30 days.
  - **Uniformed Services Family Health Plan (USFHP)** is a TRICARE Prime plan offered to non-Active Duty beneficiaries at statutorily specified locations in six areas: Washington, Texas, Maine, Maryland, Massachusetts, and New York/New Jersey. Enrollees receive all services, including pharmacy, exclusively from their particular enrolled USFHP plan; no MTF services.
- **TRICARE for Life (TFL)** is for TRICARE-eligible beneficiaries who have Medicare Parts A and B. TFL functions similar to Medigap policies; TFL pays secondary to Medicare for TRICARE-covered services. TFL celebrated 20 years in operation as of October 1, 2021.
- **Transitional Assistance Management Program (TAMP)** plan provides 180 days of premium-free coverage upon release of certain Service member sponsors, active or reserve, from Active Duty served more than 30 days.
- **Other plans and programs:** Some beneficiaries may qualify for the following depending on their location, Active/Reserve status, and/or other factors:
  - Premium-based health plans, including:
    - TRICARE Young Adult (TYA) is available for purchase by qualified former dependent children up to the age of 26. They may choose TRICARE Prime, where offered locally, or TRICARE Select coverage.
    - TRICARE Reserve Select (TRS) is available for purchase by qualified Selected Reserve members and qualified survivors. TRS delivers TRICARE Select coverage.
    - TRICARE Retired Reserve (TRR) is available for purchase by qualified Retired Reserve members.
    - TRICARE Dental Program (TDP) is available for purchase by Selected Reserve members and their family members, and family members of ADSMs.
    - Continued Health Care Benefit Program is comparable to Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage.
    - Federal Employees Dental and Vision Insurance Program (FEDVIP) offers dental plans for purchase by retirees, and offers vision plans for purchase by most non-Service member beneficiaries enrolled in a TRICARE health plan. FEDVIP is operated by the U.S. Office of Personnel Management, not DoD.
- **Other benefits and services, including:**
  - Dental benefits (DTFs and claims management for Active Duty using civilian dental services)
  - Pharmacy: MTFs, TRICARE retail network pharmacies, and TRICARE Pharmacy Home Delivery program
  - Overseas private sector care, customer service, and claims processing services
  - Women, Infants, and Children Overseas Program (www.tricare.mil/wic)
  - Extended Care Health Option (ECHO): non-medical benefits available to qualified Active Duty family members with special needs
  - Clinical and educational services demonstration programs (e.g., autism services and accountable care organization [ACO])

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 medical 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.

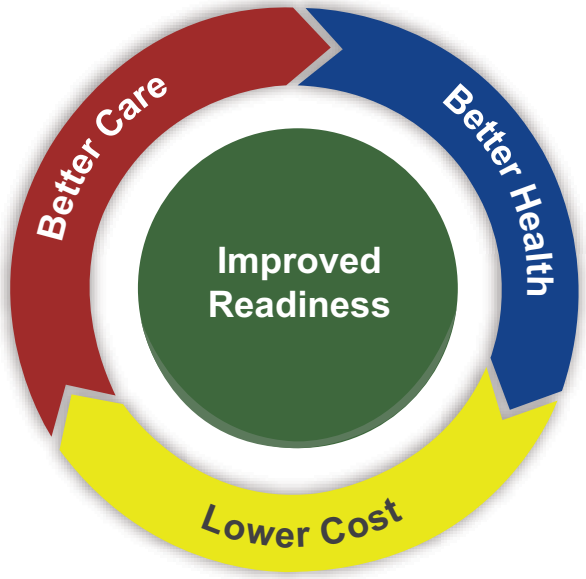
The MHS is one of the world's only global health systems capable of rapid deployment to austere environments. We realize that we must reform legacy processes and continue to integrate in order to meet the challenges of the ever-evolving nature of war while reducing costs to the American taxpayer.

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 2020–2021 *(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 top priorities of defending the nation, taking care of our people, and succeeding through teamwork. 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.

Office of the Assistant Secretary of Defense for Health Affairs Intent

The Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA]) provides policy, resources, and oversight necessary to achieve greater integration of readiness and health across the MHS. In doing so, the OASD(HA) oversees the transformation and modernization of the MHS, including the transition of authority, direction, and control of MTFs; implementation of a new electronic health record; and more integrated public health, research and development, and education and training. The OASD(HA) supports the DHA's Market-based approach to delivering health care to our Service members, their families or dependents, those retired from Service, and all others who entrust their health to the MHS.

DHA Director's Intent and the MHS Transformation

The DHA's priority effort was continued implementation of the provisions of National Defense Authorization Act (NDAA) FY 2017, section 702. In October 2019, the DHA undertook administration and management of all MTFs within the contiguous United States (CONUS). The DHA was establishing a Market-based structure to manage the hospitals and clinics within a region. The Deputy Secretary of Defense paused the MTF transition in early 2020 to allow the Military Medical Departments (MILDEPs) and the DHA to focus on the COVID-19 pandemic response efforts. In December 2020, the DHA resumed the transition.

The DHA health care Market structure includes 20 Direct Reporting Markets, where there are large concentrations of facilities and patients. Markets are centered on large medical centers, establishing centers of excellence for specialty care that meet the needs of beneficiaries across their Market regions. Nearly two-thirds of the current patient encounters happen in these 20 regions. Another 17 small Markets are centered on inpatient community hospitals, focused on providing ambulatory and some specialty and inpatient care across their regions. These small Markets, as well as many stand-alone hospitals and clinics located outside a Market region, report to the Small-Market and Stand-Alone Military Treatment Facility Organization (SSO) that provides administration and management support. When the DHA assumes responsibility for overseas hospitals and clinics, two regional offices called Defense Health Agency Regions will provide similar support, one for Europe and one for the Pacific.

Phased Implementation of NDAA FY 2017, Section 702

MHS Market Construct Overview

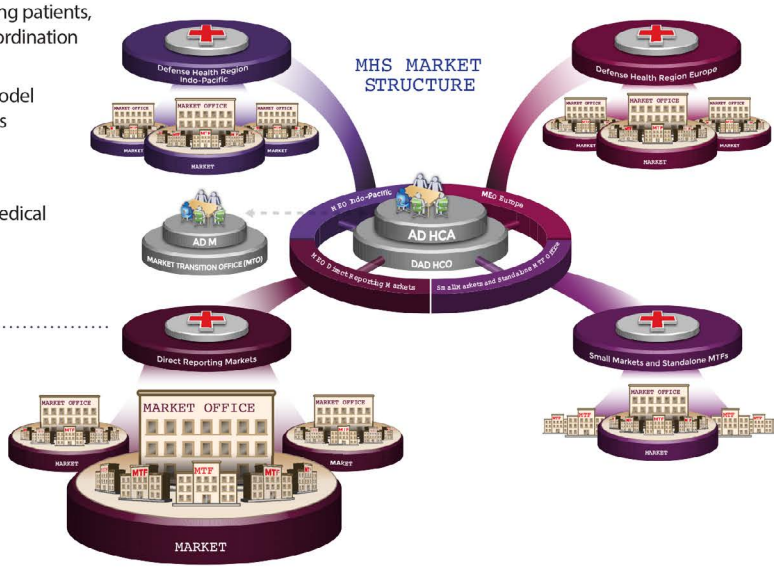
Designing an integrated health system that improves the delivery and coordination of health services, drives value for beneficiaries, and enhances medical readiness

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

Governance

Consistent with the "Department of Defense Memorandum on Military Health System Governance Reform," the Under Secretary of Defense for Personnel and Readiness (USD[P&R]) restructured oversight of the MHS for Fiscal Year (FY) 2021. The updated governance structure enables the Assistant Secretary of Defense for Health Affairs (ASD[HA]) to better inform policy and resourcing decisions in support of the MHS Quadruple Aim and National Defense Strategy. MHS Governance addresses strategic policy matters, directs enterprise-wide activities, and promotes high-reliability across the MHS.

MHS Governance is composed of three councils and one board. The Council of Colonels and Captains, chaired by the Director for MHS Governance, acts as an intake point for all governance topics. Once vetted by the Council, issues are presented to the Deputy Military Medical Action Council (DMMAC), chaired by the Principal Deputy Assistant Secretary of Defense for Health Affairs. Issues that cannot be resolved by the DMMAC are elevated to the Senior Military Medical Advisory Council (SMMAC), chaired by the ASD(HA). The SMMAC serves as an advisory council to the ASD(HA). When a decision cannot be made by the SMMAC, the ASD(HA) brings these concerns or issues to the MHS Executive Review Board at the Workforce Management Group, chaired by the USD(P&R).

Monitoring Strategic Performance

The ASD(HA) began building and testing a set of measures in FY 2021 to provide concise insight to senior DoD leadership and policymakers. The set of measures balances need for robust information with clarity. These measures align to the MHS Quadruple Aim to help target improvement across MTFs, the private sector care network, and military medical operations.

The DHA establishes system-wide standards for clinical and business operations to manage MTFs and the TRICARE health plan on a day-to-day basis. The DHA campaign plan derives from the MHS strategy and direction from the ASD(HA). In FY 2021, the DHA Campaign Plan established four lines of effort to support four strategic priorities: great outcomes, ready medical force, satisfied patients, and fulfilled staff.

The DHA evaluates the campaign plan and performance within health care Markets and associated MTFs using key performance indicators (KPIs) that roll up to ASD(HA)-level oversight. The figure below describes the relationship between tactical, operational, and strategic KPIs to MHS oversight.

Military Departments (MILDEPS) are the primary force providers for military combat operations, humanitarian missions, and support for civil authorities. The MILDEPS assess the readiness status of their forces with task lists for individuals, training and education, and clinical proficiency measures.

MHS PERFORMANCE MANAGEMENT *(CONT.)*

Monitoring Strategic Performance *(cont.)*

CASCADING PERFORMANCE MANAGEMENT

Tactical KPIs

Tactical KPIs are managed by the Market Directors and ADHCA. They are key drivers of operational KPIs within the Market's control.

Operational KPIs

Operational KPIs are managed by the Executive Steering Committee (Deputy Assistant Directors) and are selected to measure key drivers of strategic KPIs.

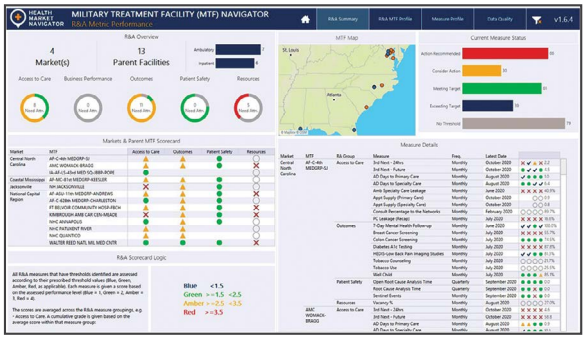
Strategic KPIs

Strategic KPIs are managed at the HQ-level by the Corporate Executive Board (Deputy Director and Assistant Directors) and are selected to measure critical outcomes of the four DHA priorities.

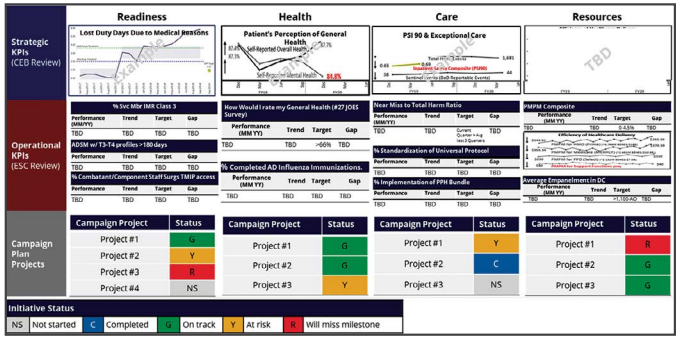
OSD Oversight

The ASD(HA) oversees system-wide performance and reports performance to the Senior Military Advisory Council and senior DoD leadership.

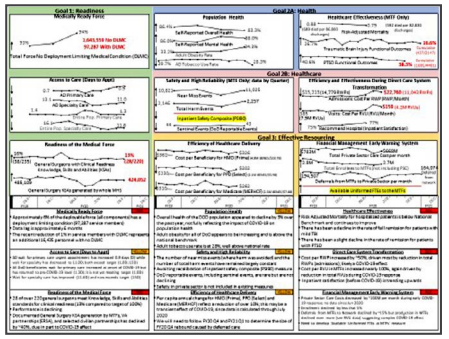
Market Dashboard



DHA Campaign Plan Dashboard (In Development)



ASD(HA) Dashboard



Market/MTF Annual Quadruple Aim Performance Plan (QPP) Initiatives

Market/MTF QPP initiatives should be designed to improve performance of tactical KPIs and operational KPIs below certain thresholds.

Campaign Plan Initiatives and Projects

Campaign plan initiatives and projects are designed to improve performance of our Strategic and Operational KPIs. Execution may lie within both the HQ and the Markets depending on the specific effort.

Oversight Measures

The ASD(HA) determines the measures that best describe the most salient outcomes and outputs of the Defense Health Program. DHA KPIs and initiatives align to these oversight measures

Management and Execution | **Oversight**

MHS PERFORMANCE MANAGEMENT *(CONT.)*

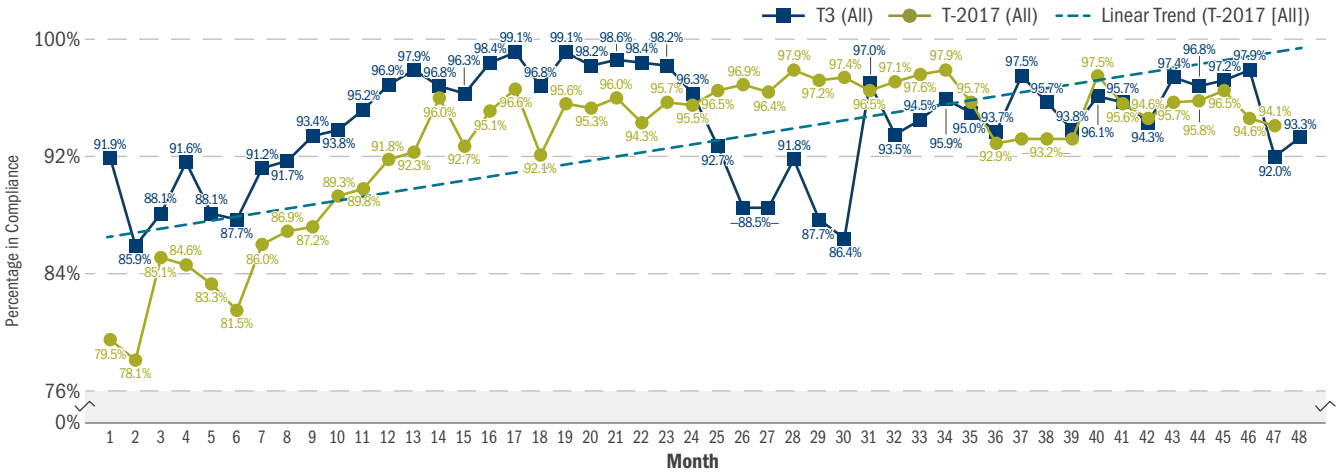
Private Sector Care Performance Management

To better synchronize clinical quality monitoring across the MHS, and compare data outcomes and promote system integration, the Private Sector Care (PSC) Dashboard is undergoing redesign and automation. Further benefits include the ability to populate the dashboard with timely data and offer easy user navigation. Recently developed direct/private sector care collaboration initiatives offer useful information and recommendations for updating dashboard data to reflect the most current and valuable clinical data measures for monitoring quality of care across the enterprise. Quarterly Clinical Quality and Safety Summit meetings encourage harmonizing direct and private sector care clinical quality data, programs and processes, and sharing of best medical practices. A newly created Clinical Measure Data Improvement Integrated Product Team aims to improve the accuracy and completeness of direct and private-sector Healthcare Effectiveness Data and Information Set (HEDIS) data. This work will lead to increased transparency and efficient and effective mechanisms to acquire, process, report, and store clinical data necessary for assessing and improving the quality of health care delivery to TRICARE beneficiaries.

The TRICARE (T2017) contractors started health care delivery on January 1, 2018. In comparing T2017 contract performance with the previous generation of TRICARE contract (T3) during the first 47 months of performance and after some initial challenges, T2017 compliance was similar to T3 across more than 20 contract requirements in seven critical areas. In FY 2020, T2017 compliance steadily improved and exceeded performance under T3 in months 24–35. In FY 2021, significant outages and challenges with the Defense Enrollment Eligibility Reporting System (DEERS) and DEERS Online Enrollment System impacted both contractors' performance related to customer service and call center requirements. Both received waivers from the contract standards for the affected performance periods.

In the fourth year of T2017 performance, the contractors' performance overall is stable. Both managed care support contractors (MCSCs) continue to experience a challenge meeting the standard for Provider Directory accuracy, although they have made significant progress in improving their Directories and both are maintaining an accuracy rate of 80 percent. In the East Region, Humana Military has made significant progress in improving claims systems and processing.

PERCENTAGE OF CONTRACTS IN COMPLIANCE, OPTION PERIODS 1 THROUGH 4



Source: Requirements from the Contract Quality Assurance Plan, 12/23/2021

In FY 2021, DHA continued numerous value-based demonstrations and pilots to meet the requirements of NDAA FY 2016, Section 726 and NDAA FY 2017, Sections 701(h), 704(a), 705(a), and 729 (a)(b) and (c). These projects included the Medication Adherence demonstration and the Performance-Based Maternity Payment (P-BMP) pilot. Additionally, a new pilot was started in FY 2020, an Accountable Care Organization (ACO) demonstration. This ACO demonstration was initiated in partnership with Kaiser Permanente in service of the Atlanta area. Further, DHA published the Home Health Value-Based Purchasing (HHVBP) demonstration and adopted Medicare's Hospital Value-Based Purchasing (HVBP) program in February 2021. Lastly, in FY 2020, DHA completed a value-based demonstration project launched in FY 2016 for Lower Extremity Joint Replacement/Reattachment (LEJR) in the Tampa Bay Market area. The LEJR demonstration was designed as an episode-based bundled payment program that established target episode prices for LEJR and all related services. Hospitals that demonstrated a cost savings and achieved or maintained a favorable quality rating received retrospective incentives. A final analysis of this demonstration was started.

Private Sector Care Performance Management *(cont.)*

The Medication Adherence demonstration, launched nationwide January 1, 2018, was designed to reduce or eliminate copayments for high-value drugs to encourage patient adherence to these medications. This program impacted approximately 136,000 users per quarter with a copayment savings for users of approximately $4.9 million per year. The P-BMP pilot began nationwide on April 1, 2018, and ended December 31, 2021. The program encouraged 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. In FY 2019, the first year of data for the P-BMP pilot revealed that approximately 12 percent of participating hospitals were eligible for an incentive payment. An analysis of this pilot is ongoing.

In FY 2020, DHA implemented an ACO demonstration in the Atlanta Market area in partnership with Humana Government Business (HGB) and Kaiser Permanente (KP). Enrollment in the HGB/KP demonstration was offered to TRICARE Prime and Select members in the Atlanta Prime Service Area during the 2019 Open Enrollment Season. Care delivery began January 1, 2020, and continues for three years. KP beneficiary enrollment for calendar year (CY) 2020 was 1,775, and increased to 2,674 KP enrolled beneficiaries for CY 2021. As of December 2021, KP Beneficiary enrollment for CY 2022 is 3,204. A unique feature of this demonstration is the beneficiary wellness incentive program, which encourages beneficiaries to participate in wellness activities in return for incentives.

The demonstration is in 10 demonstration states: Arizona, California, Colorado, Florida, Georgia, Kentucky, North Carolina, Ohio, Tennessee, and Virginia. The demonstration will test whether incentivizing participation in PT by waiving copayments will increase the use of PT services and reduce potentially unnecessary and harmful care to the beneficiary, such as unnecessary imaging, surgery, and opioids. Moreover, by incentivizing the use of PT, DHA may see a decrease in the overall cost of care for participating beneficiaries and a reduction in the number of beneficiaries who transition from acute to chronic LBP.

In September 2020, DHA published the HHVBP demonstration in the TRICARE manuals. The HHVBP demonstration was designed to improve the quality and delivery of home health services by rewarding providers who deliver higher quality and more efficient care with incentive payments. It was expected that TRICARE's adoption of HHVBP would strengthen the impact of the incentives included within the model by adding TRICARE's market share to Medicare's. Participation was mandatory for all TRICARE Home Health Agencies that were Medicare-certified and provided services in the following nine states: Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington. The HHVBP demonstration ended in December 2021.

DHA adopted Medicare's HVBP program in February 2021. The HVBP program provided incentives to hospitals that showed improvement in areas of health care delivery, process improvement, and increased patient satisfaction. The program offered incentive payments based on the hospital's Total Performance Score.

Adopting Medicare's HVBP program approach did not require any additional reporting from TRICARE hospitals, as they were already participating in the Medicare HVBP program. As with the HHVBP program, DHA hoped to boost the impact of theincentives included within the model by adding TRICARE's market share to Medicare's market share.

In FY 2021, DHA implemented the Buckley Prime Service Area (PSA) pilot in partnership with Health Net Federal Services (HNFS) under the T17 contract. The pilot began on January 1, 2021, and will continue through December 31, 2022. HNFS is capitated by age/sex for a population of approximately 14,000 beneficiaries who are Prime network enrolled and within the Buckley Space Force Base/460th Medical Group PSA. Beneficiaries are automatically enrolled in the pilot based on this criteria. HNFS is providing concierge services and outreach to beneficiaries for disease and case management as additional service. Data from the pilot will demonstrate the difference in outcomes of a capitated financial model as opposed to the traditional fee-for-service model, as well as allow the DHA to evaluate the processes needed for implementation of Alternative Payment Models within provider networks.

These projects will offer DHA the opportunity to test value-based payment models and methodologies to incorporate innovative ideas and solutions into current and future TRICARE managed care support contracts.

MHS RESPONSE TO COVID-19 PANDEMIC

COVID-19 Current Operation Dashboard

Overview of COVID-19 Current Operation Dashboard

As the COVID-19 pandemic continued to evolve, DHA J-5 further developed and enhanced a portfolio of COVID-19 tools, building upon existing efforts to streamline pandemic monitoring and response in support of operational decision making at the Market and MTF levels.

Collectively, these tools provided MHS leadership with intuitive and comprehensive views of pandemic pressures both locally and nationally:

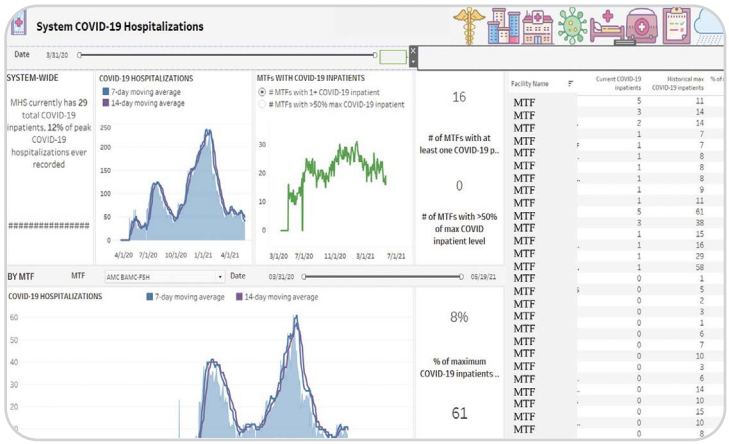
- Integrated MHS and U.S. population data, providing a picture of pandemic pressures both inside and outside the gate
- Aggregated authoritative data across MHS metrics into a single location (i.e., drawing on existing dashboards built by MHS subject-matter experts [SMEs], such as MEDLOG)
- Enabled prospective tracking of key metrics (bed capacity/case burden) over 30 and 60 days windows
- Provided a modular capability that was flexible enough to integrate new data as they became available
- Distilled multiple data into a single risk score for each MTF, based on a view of MTF capacity and pandemic burden in the surrounding Market

The tools were made available to all Markets and MTFs—across the DHA and the Services—and were intended to support planning across the MHS as well as potential system-wide collaboration with other agencies/organizations (e.g., U.S. Department of Veterans Affairs).

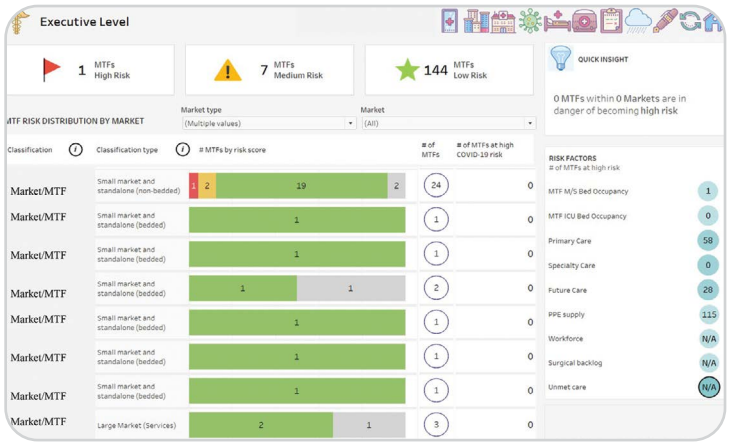
Description of Key COVID-19 Current Operation Dashboard Views

Various views were developed and refined based on feedback from MTF leadership, DHA, the Services, and the Deputy Secretary of Defense. In addition to the views referenced below, additional operational data and external risk factor information (e.g., weather events) were made available to all end users.

System Hospitalizations and Network View: Commercial hospital utilization and enterprise-wide COVID-19 hospitalizations to quickly identify MTFs requiring further review or attention based on depth and breadth of the pandemic across the system



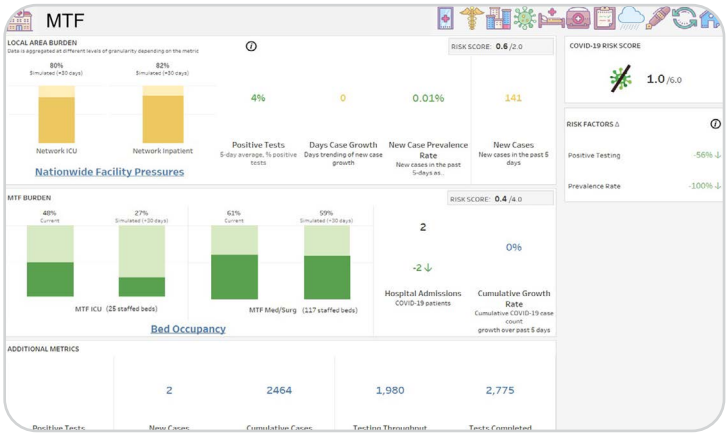
Executive-Level View/Market View: Review enterprise-wide capacity and quickly identify Markets requiring further review or attention based on availability of beds or personal protective equipment (PPE)



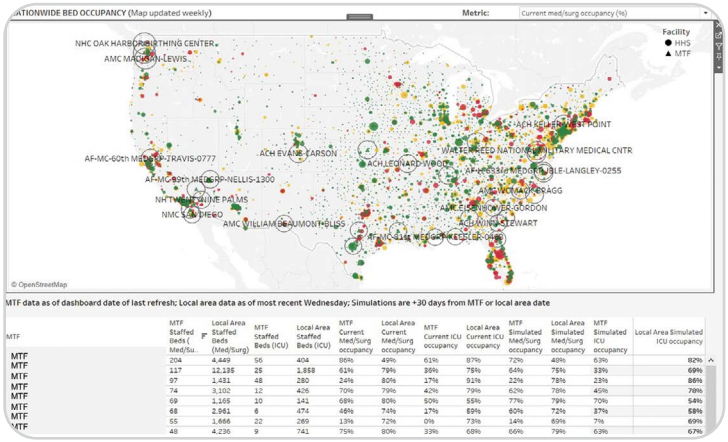
Source: DHA/Strategy, Plan, and Functional Integration (SP&FI) (J-5)/Analytics and Evaluation Division, 12/21/2021
Note: Screenshots of COVID-19 Current Operation Dashboard are illustrative only.

MHS RESPONSE TO COVID-19 PANDEMIC *(CONT.)*

COVID-19 Current Operation Dashboard *(cont.)*

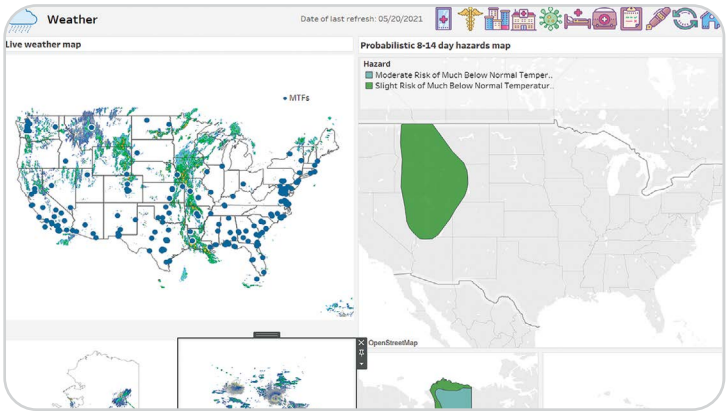


MTF-Level View: Assess MTF performance and identify operational areas requiring engagement based on MTF capacity



Nationwide Bed Occupancy: Bed occupancy pressures at MTFs and nationwide public acute hospitals

Source: HHS



Weather: Live weather updates and forecasted future hazards

Source: National Weather Service: https://www.cpc.ncep.noaa.gov/products/predictions/threats/threats.php

MHS RESPONSE TO COVID-19 PANDEMIC *(CONT.)*

COVID-19 Registry

The DHA established the COVID-19 Registry to provide a centralized DoD COVID-19 data collection platform to support clinical performance improvement. The purpose of the COVID-19 Registry is to (1) support clinical performance improvement for COVID-19 casualties, which requires detailed information verified and coded by registrars (for example, tracking the outcomes of patients who receive COVID Convalescent Plasma [CCP] compared to those who do not); and (2) track the epidemiology of disease, which requires large quantities of synchronized data, such as identifying vaccine breakthroughs and tracking the disease incidence and severity post-vaccine.

As of December 2, 2021, there were more than 398,000 COVID-positive patients in the registry, and full manual data abstraction had been completed on 12,830 patients, with data automation being applied to improve the ability to rapidly track trends for all patients. Registry records currently include patients treated in the direct care system only. The COVID-19 Registry does not include detailed records on all COVID cases in the DoD. Due to a large population needing abstraction into the Registry, the Joint Trauma System (JTS) developed a list of patient abstraction priorities.

Patients are abstracted into the COVID-19 Registry in the following order:

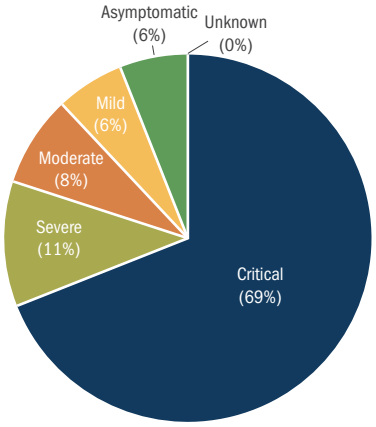
1. Inpatients (includes new treatment recipients [CCP, monoclonal antibody, etc.])
2. Vaccine breakthrough cases
3. Possible multisystem inflammatory syndrome in child cases
4. Persistent viremia/possible re-infection
5. Burn-pit exposure patients
6. Outpatients (if all other patients have been abstracted)

COVID-19 Registry Data Overview, February 2, 2020–December 2, 2021

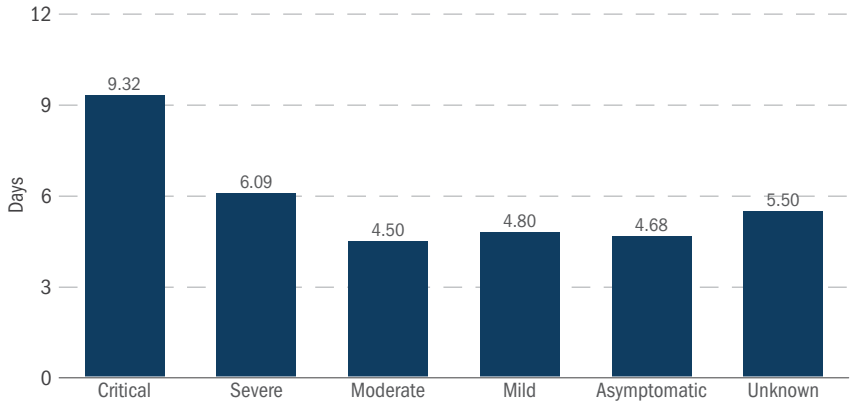
COVID-19 illness severity was difficult to track without the detailed information provided by the COVID registry.

COVID Disease Severity and Average Length of Hospital Stay

SEVERITY OF HOSPITALIZED PATIENTS, 2021



AVERAGE HOSPITALIZATION DAYS BY SEVERITY, 2021



Source: DHA Combat Support, JTS/COVID-19 Registry, 12/2/2021
Note: N=12,830 total patients in registrar-abstracted population with detailed chart review from February 2, 2020–December 2, 2021

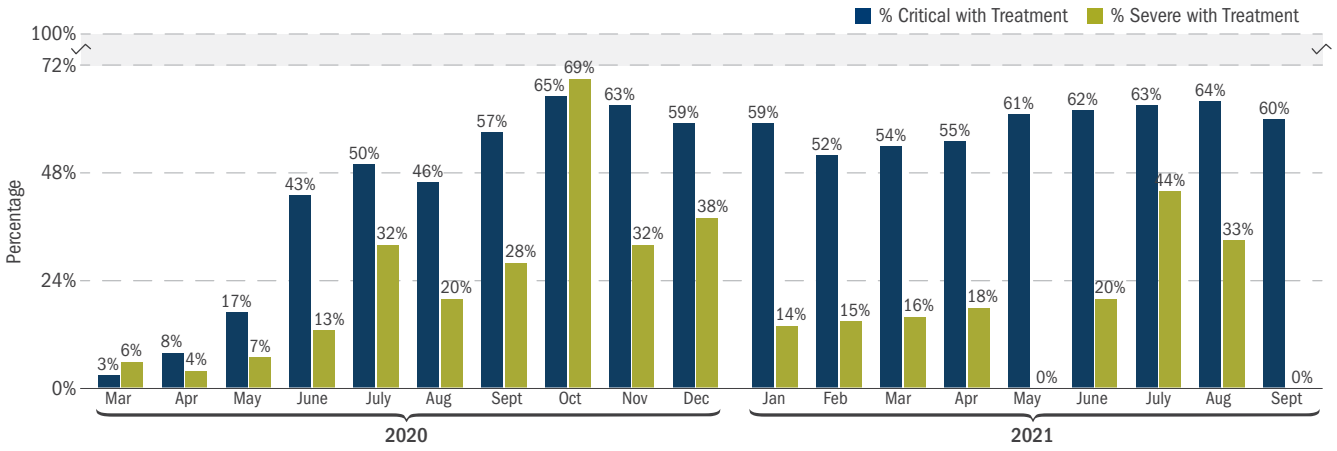
MHS RESPONSE TO COVID-19 PANDEMIC *(CONT.)*

COVID-19 Registry *(cont.)*

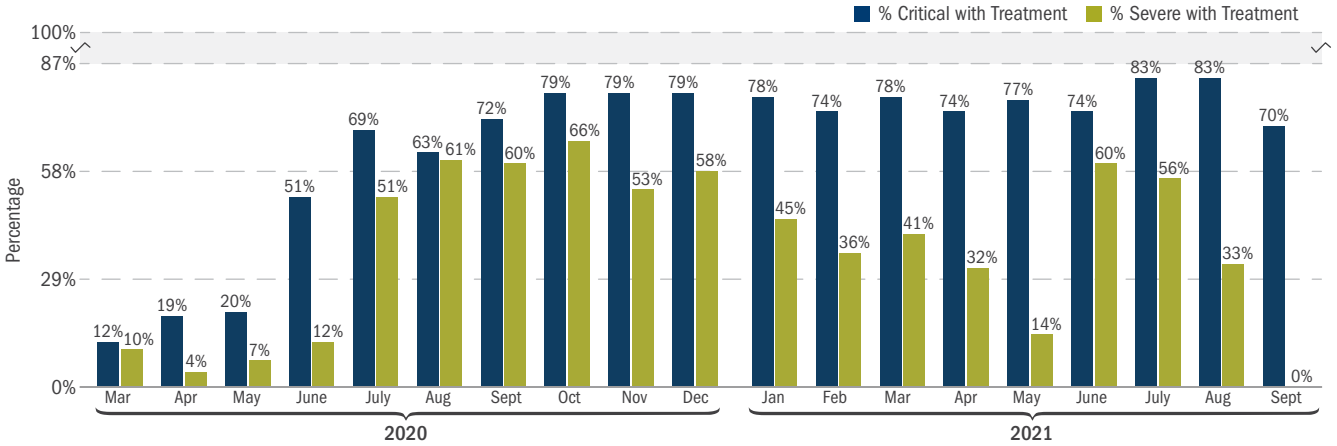
New therapies introduced for COVID-19 early in the pandemic included CCP, remdesivir, and glucocorticoids. The implementation of the new treatments was tracked in the registry. Use of remdesivir and glucocorticoids sharply increased throughout 2020 and have continued to be used to treat most critical and severe patients, while use of CCP decreased during 2021.

March through November Critical and Severe Patients Receiving Remdesivir and Glucocorticoids

PERCENTAGE OF CRITICAL AND SEVERE PATIENTS RECEIVING REMDESIVIR BY MONTH, 2020–2021



PERCENTAGE OF CRITICAL AND SEVERE PATIENTS RECEIVING GLUCOCORTICOIDS BY MONTH, 2020–2021



Source: DHA Combat Support, JTS/COVID-19 Registry, 12/2/2021

Note: N=12,830 total patients in registrar-abstracted population with detailed chart review from February 2, 2020–December 2, 2021

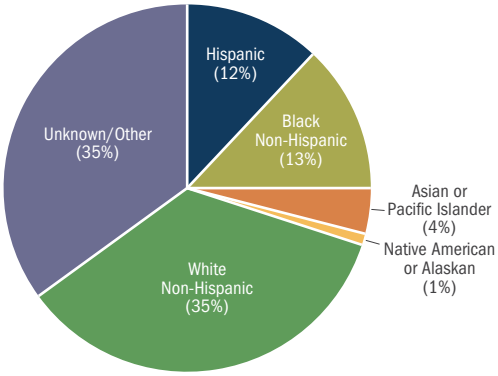
MHS RESPONSE TO COVID-19 PANDEMIC *(CONT.)*

COVID-19 Registry *(cont.)*

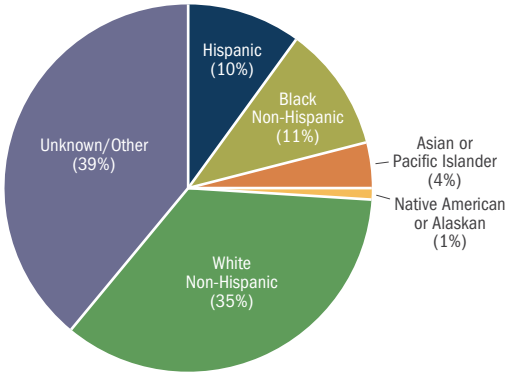
Overview of Race/Ethnicity of COVID Patients

There is a slightly higher incidence of Hispanics and Blacks who tested positive for COVID-19 compared with those who tested negative within the DoD population tested in the direct care system. The Unknown/Other percentage is per DEERS documentation. (See Race/Ethnicity of COVID- Positive/Negative Patients below.) Within the registrar-abstracted population, there was no difference detected for average age, average intensive care unit (ICU) days, and average days from positive COVID tests to hospitalization. All are similar among each race/ethnicity category when stratified by critical and severe disease severity.

RACE/ETHNICITY OF COVID-POSITIVE PATIENTS, 2021

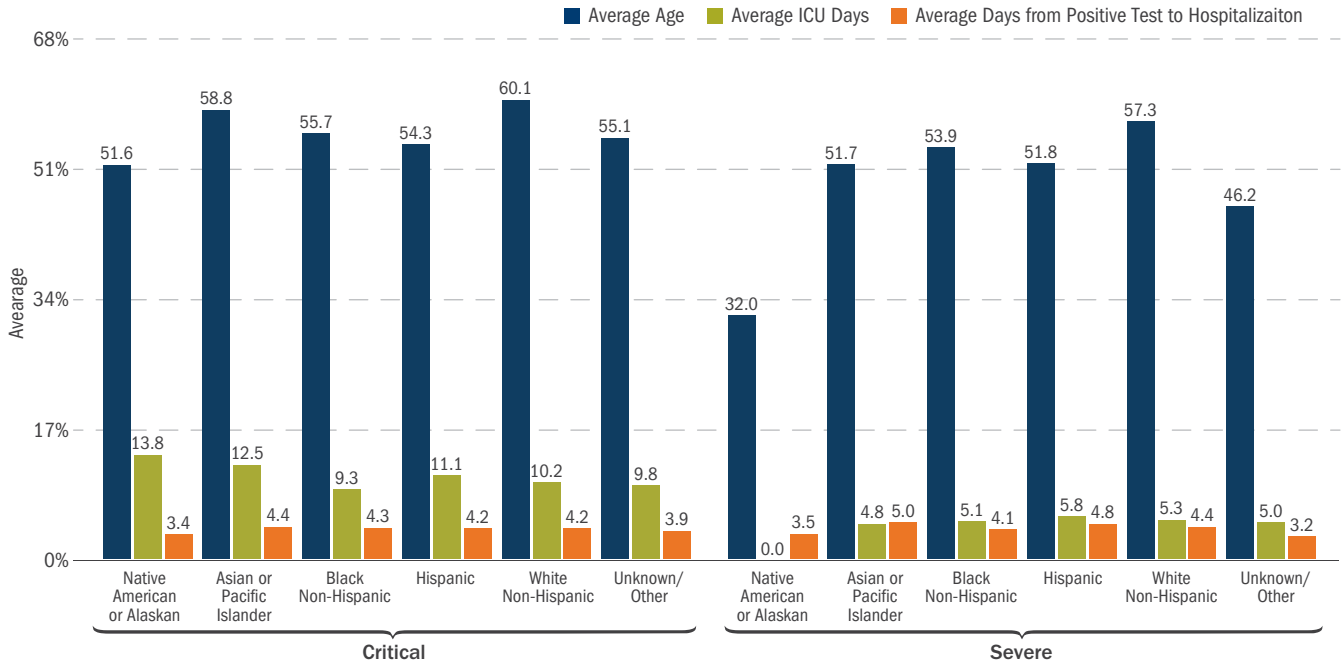


RACE/ETHNICITY OF COVID-NEGATIVE PATIENTS, 2021



Source: DHA Combat Support, JTS/COVID-19 Registry, 12/2/2021
Note: Patients treated in the direct care system February 2–December 2, 2021

AGE, SEVERITY, AND HOSPITALIZATION, BY RACE, 2021



Source: DHA Combat Support, JTS/COVID-19 Registry, 12/2/2021
Note: N=12,830 total patients in registrar-abstracted population with detailed chart review from February 2, 2020–December 2, 2021

MHS RESPONSE TO COVID-19 PANDEMIC *(CONT.)*

COVID-19 Registry *(cont.)*

Vaccination and Vaccine Breakthrough Cases, by Manufacturer

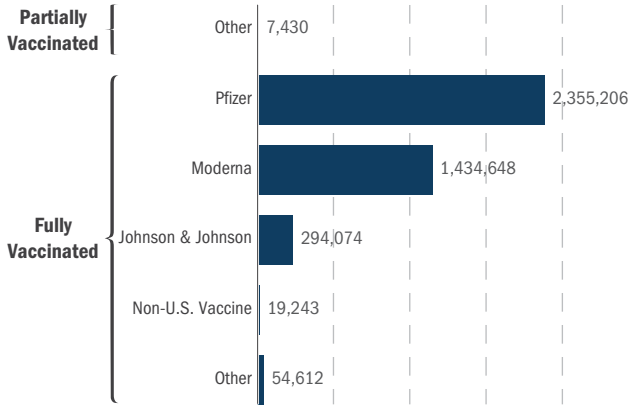
TOTAL COMPLETELY VACCINATED

4,157,783

VACCINE BREAKTHROUGH SUMMARY

	INPATIENT	GRAND TOTAL
Fully Vaccinated	163	31,137

VACCINES BY BRAND AND DOSE SEQUENCE



Source: DHA Combat Support, JTS/COVID-19 Registry, 12/2/2021

As part of the COVID-19 response, JTS has been tracking vaccination and vaccine breakthrough cases using DHA data. As of December 2, 2021, more than 4 million patients were fully vaccinated (fully vaccinated is defined as having both doses of the Pfizer or Moderna series, or single dose of the Johnson & Johnson vaccine, plus 14 days after the date of final vaccination). Over 2 million patients were vaccinated using the Pfizer series. The cumulative breakthrough rate for all fully vaccinated patients is 0.67 percent, with the highest breakthrough rate being 1.61 percent for Johnson & Johnson vaccinated individuals.

COVID-19 Registry Timeline

The COVID-19 Registry is temporarily housed in the DoD Trauma Registry platform because it was most readily available; however, this limits automation of data import from the electronic health record (EHR). The automation is being built within the Military Health Services (MHS) Information Portal (MIP) and will continue to increase with the complete Registry transition to MIP during CY 2022. The Registry dashboard prototype is established and capable of expanding to incorporate more demographics as well as performance improvement indicators and outcomes.

Milestones completed for March–October 2020

- **March 15:** Launched formal planning with JTS and Uniformed Services University
- **March 23:** Published DoD COVID-19 Practice Guideline and initiated Performance Improvement conferences
- **April 15:** Established initial Registry framework
- **April 20:** Developed data definitions
- **May 4:** Initiated training for trauma registrars on COVID-19
- **May 25:** Began piloting standardized COVID-19 notes in EHRs
- **June 1:** Initiated data abstraction of 195 data points per patient into Registry
- **July 13:** Health Affairs memo signed: Guidance for Reporting and Participating in DoD Pandemic/Epidemic Registry
- **July 14:** Received access to most inpatient records for data abstraction
- **July 17:** Delivered preliminary COVID-19 performance improvement report
- **September 1:** Established Registry dashboard prototype
- **September 15:** Developed detailed data analysis plan with stakeholders (Think Tank)
- **September 28:** Completed medical record abstraction for 714 inpatients
- **October 1:** Established automated medical record synchronization for outpatient
- **December 17:** Initiated NLT August 1: Expand COVID lab-testing survey to identify symptoms, asymptomatic disease, mitigation measures

  Registry dashboard to include abstracted records

Upcoming Milestones

- **NLT March 1:** Transition from temporary registry location to MIP
- **NLT March 1:** Establish sustainment plan

MHS RESPONSE TO COVID-19 PANDEMIC *(CONT.)*

COVID-19 Vaccine Administration

In December 2020, the DoD began administering the COVID-19 vaccine to ADSMs and DoD beneficiaries, Contractors and Civilians. Since the onset of vaccine administration, the DHA has tracked vaccinations across the enterprise, and continues to work towards vaccinating more than 9 million eligible beneficiaries. The J-5 DHA team has provided multiple daily and weekly reports to the White House, the Secretary of Defense, Joint Chiefs, LTG Place, and other senior leaders for the duration of COVID-19 vaccine administration efforts.

Throughout vaccine administration, the DHA has been able to rapidly get vaccines into arms with minimal waste. As vaccines are tracked, the DHA is able to closely monitor Breakthrough cases and Adverse Reactions, enabling leaders to have purview into vaccine safety and efficacy. The evolving climate of COVID-19 required an agile team to support daily ad hoc requests to design scalable, intuitive views with powerful data visualizations, statistical models, and machine learning algorithms. The J-5 DHA team was able to help agency leaders understand trends and make informed decisions backed by data. To date, the DoD has administered over 6 million doses of the COVID-19 vaccine, with 90.9 percent of the Active-Duty population vaccinated, compared to 72.1 percent of adults fully vaccinated across the U.S.

The DoD has remained vigilant in its response to the COVID-19 pandemic. In order to maintain timely insights into case and vaccination rates, the J-5 DHA team supported myriad hot taskers to get pertinent information into the hands of senior leaders. Some of these analyses include daily tracking of adolescent vaccinations, the effects of the Janssen vaccine pause from the Centers for Disease Control and Prevention (CDC), and tracking the vaccination and case rates among health care workers. During the summer of 2021, the MHS was faced with multiple high-priority missions that required analyses across the system. As the Delta variant was causing severe illness and rapid transmission of COVID-19, military medical teams were needed to deploy to at-risk areas to assist in patient care as ICUs were exceeding capacity. At the same time, refugees from Afghanistan were arriving in the U.S. and required immediate medical care. To maximize patient care and minimize risks to the system, the DHA J-5 team established a risk matrix framework and helped the MHS and the Services allocate resources without endangering the safety of patients or health care workers.

As the COVID-19 pandemic persists, the MHS response continues to be agile and focused, enabling leaders to make critical decisions while maintaining the health and safety of all DoD beneficiaries and the communities it serves.

MHS RESPONSE TO COVID-19 PANDEMIC *(CONT.)*

Overview of Private Sector Care during the COVID-19 Pandemic

In addition to the direct care response to the global pandemic, several changes occurred in private sector care to address ongoing beneficiary health care needs. The following private-sector changes were made in FY 2020 and 2021 in response to the pandemic.

- Implementation of the Families First Coronavirus Response Act and the Coronavirus Aid, Relief, and Economic Security (CARES) Act, including waiving copayments associated with testing
- Waiver of telehealth copayments during the national emergency
- Provider licensing flexibility during the national emergency
- Ensured that beneficiaries would have coverage under the medical program for investigational new drugs, like monoclonal antibodies and CCP
- Changes that ensured appropriate reimbursement of health care facilities during the national emergency and Department of Health and Human Services' Public Health Emergency
- Addition of COVID-19 clinical trials sponsored by the National Institute of Allergy and Infectious Diseases (NIAID) during the national emergency
- Waived certain acute care hospital requirements for temporary hospitals and freestanding ambulatory surgery centers that enroll with Medicare's Hospitals Without Walls initiatives to ensure patients had access to acute care facilities. In March 2020, the Centers for Medicare & Medicaid Services (CMS) announced the Hospitals Without Walls program, which provides broad regulatory flexibility to allow hospitals to provide services in locations beyond their existing facilities. According to CMS, "Under federal requirements, hospitals must provide services within their own buildings, raising concerns about capacity for treating COVID-19 patients, especially those requiring ventilator and intensive care. Under CMS's temporary new rules, hospitals will be able to transfer patients to outside facilities, such as ambulatory surgery centers, inpatient rehabilitation hospitals, hotels, and dormitories, while still receiving hospital payments under Medicare. For example, a health care system can use a hotel to take care of patients needing less intensive care while using its inpatient beds for COVID-19 patients." For additional information, see https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address- covid-19-patient.
- Expanded access for overseas telehealth
- Added coverage for telephonic office visits and implemented other telehealth flexibilities for the national emergency
- Added permanent coverage of remote physiologic monitoring services and supplies
- Waived the Skilled Nursing Facility three-day hospital stay prior to admission during the national emergency
- Clarified that TRICARE coverage of Food and Drug Administration (FDA) approved drugs includes drugs with an emergency use authorization
- Clarified coverage of behavioral telehealth, specifically intensive outpatient programs, medication assisted treatment, opioid treatment programs, and certain other behavioral health care that may be covered when rendered via telehealth
- Allowed for Applied Behavioral Analysis (ABA) services to be covered via telehealth for ABA parent or caregiver guidance services

Current information, such as COVID guidance, the DoD Coronavirus Symptom Checker, testing coverage, and DoD COVID-19 vaccine distribution, for TRICARE beneficiaries can be found through TRICARE online at https://tricare.mil/HealthWellness/HealthyLiving/Coronavirus as well as from regional contractor websites (www.tricare-west.com, www.tricare-east.com, www.tricare-overseas.com).

MHS RESPONSE TO COVID-19 PANDEMIC *(CONT.)*

Intentions to Vaccinate by Beneficiary Characteristics and Beliefs

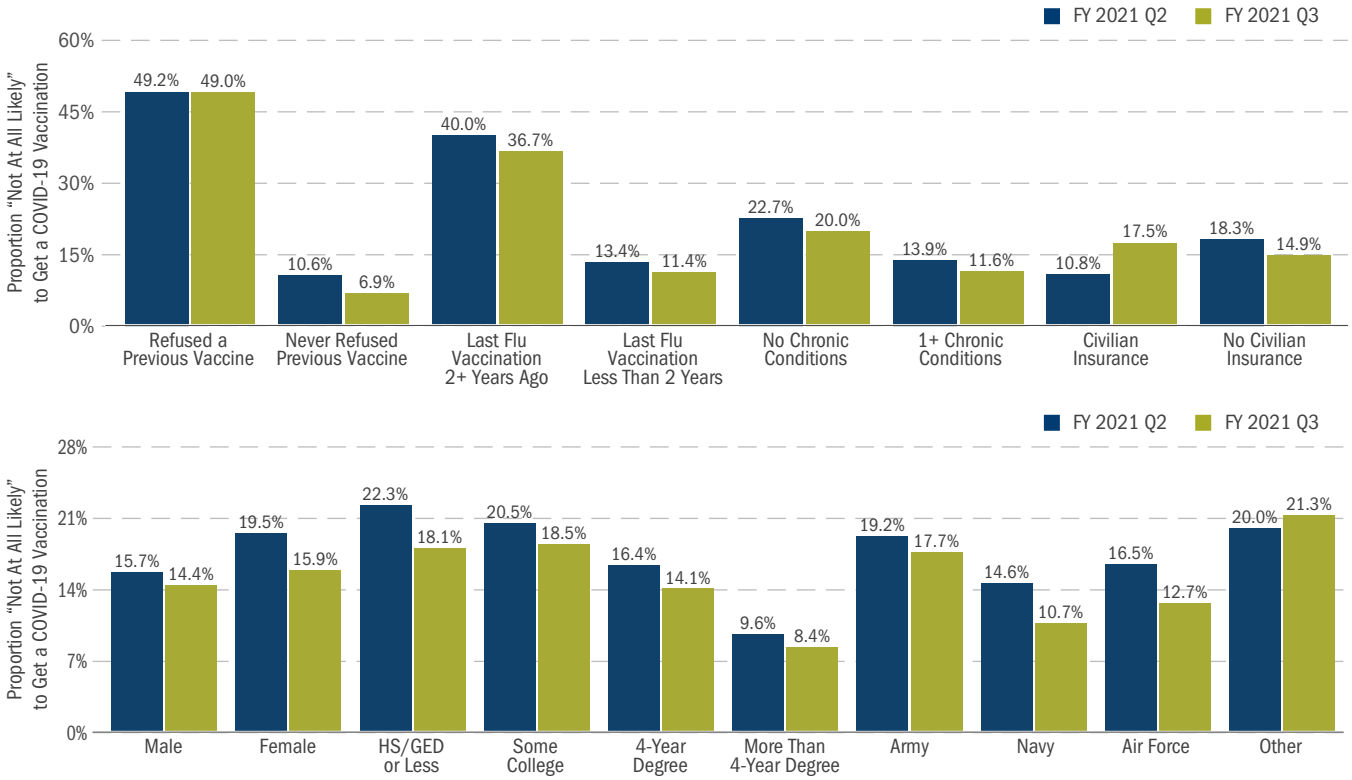
This analysis examines changes in intentions to vaccinate for COVID-19 over time and differences in vaccination beliefs among TRICARE beneficiaries from the FY 2021 Quarter 2 (Q2) and Quarter 3 (Q3) Health Care Survey of DoD Beneficiaries (HCSDB).

Vaccine intentions were measured with the question "When a vaccine for the coronavirus (COVID-19) becomes available, how likely are you to get vaccinated?" Response options of "very likely" and "somewhat likely" were counted as intending to vaccinate. A response of "not at all likely" was counted as not intending to vaccinate. Results are based on 8,853 completed FY 2021 Q2 surveys and 9,130 FY 2021 Q3 surveys, and are weighted to match the TRICARE beneficiary population characteristics. The Q2 survey was conducted between January and March 2021, and the Q3 survey was conducted between April and June 2021. These surveys were conducted before Secretary of Defense Lloyd J. Austin III issued a memo directing mandatory COVID-19 vaccinations for all uniformed Service members on August 24, 2021.

Overall, vaccine refusal intentions decreased from 18 percent in FY 2021 Q2 to 15 percent in FY 2021 Q3. Personal beliefs, such as trust in the health care system, were strongly associated with intentions to vaccinate.

Comparing changes from the FY 2021 Q2 to FY 2021 Q3 survey, results show respondents who have not previously refused a vaccine have become more open to a COVID-19 vaccine, dropping from 11 percent refusal in Q2 to 7 percent refusal in Q3. However, those who had previously refused a vaccine remained unchanged at 49 percent for both quarters. Beneficiaries who had refused a previous vaccine were 16 percent of the sample in Q2 and 18 percent in Q3. Active Duty respondents became less likely to refuse a vaccine, dropping from 28 percent refusal in Q2 to 23 percent refusal in Q3. Families of Active Duty/Reservists were also less likely to refuse a vaccine, dropping from 27 percent refusal in Q2 to 20 percent refusal in Q3. Retirees did not decrease significantly, with 12 percent refusal in Q2 and 11 percent refusal in Q3.

PROPORTION "NOT AT ALL LIKELY" TO GET VACCINATED FOR COVID-19 BY BENEFICIARY CHARACTERISTICS

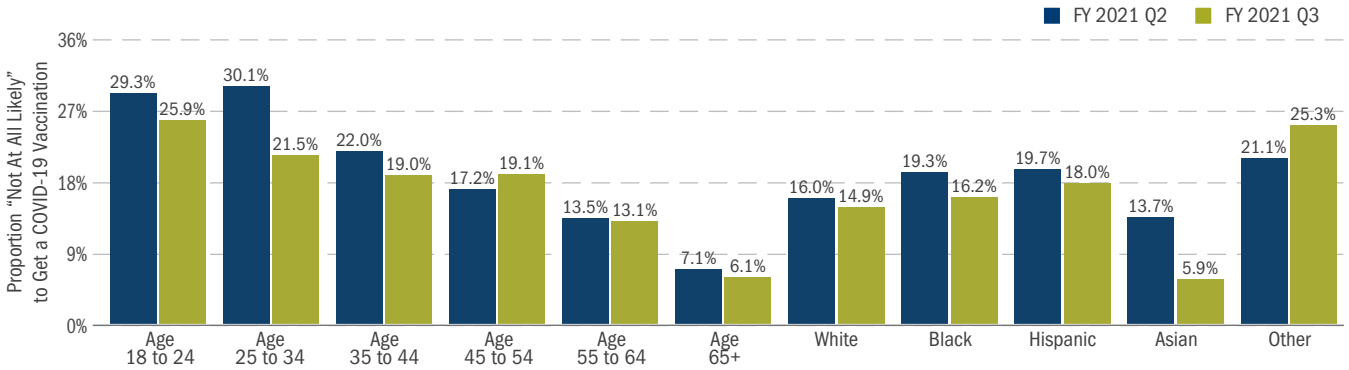


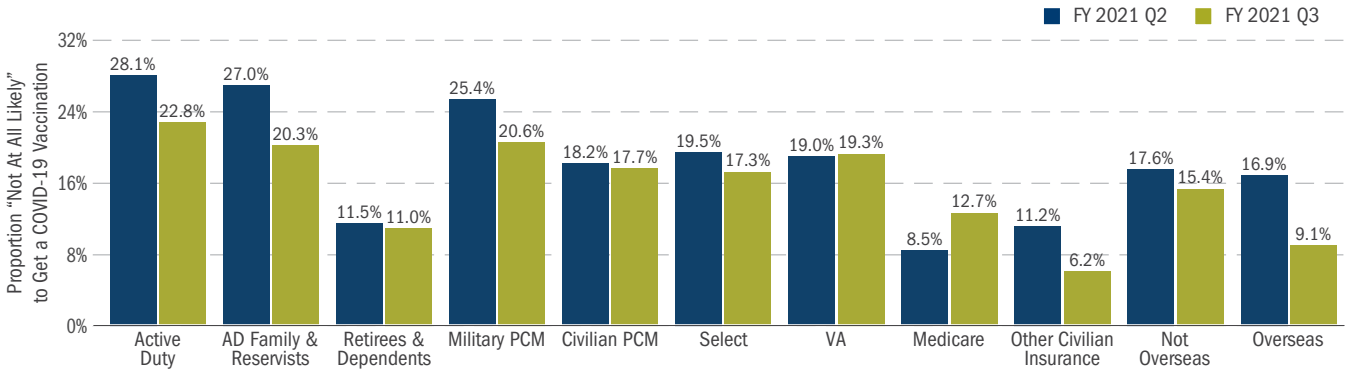
Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, 10/6/2021

Note: All tests compare the proportion "not at all likely" to get vaccinated for covid-19 vs. "somewhat/very likely" to get vaccinated or already vaccinated.

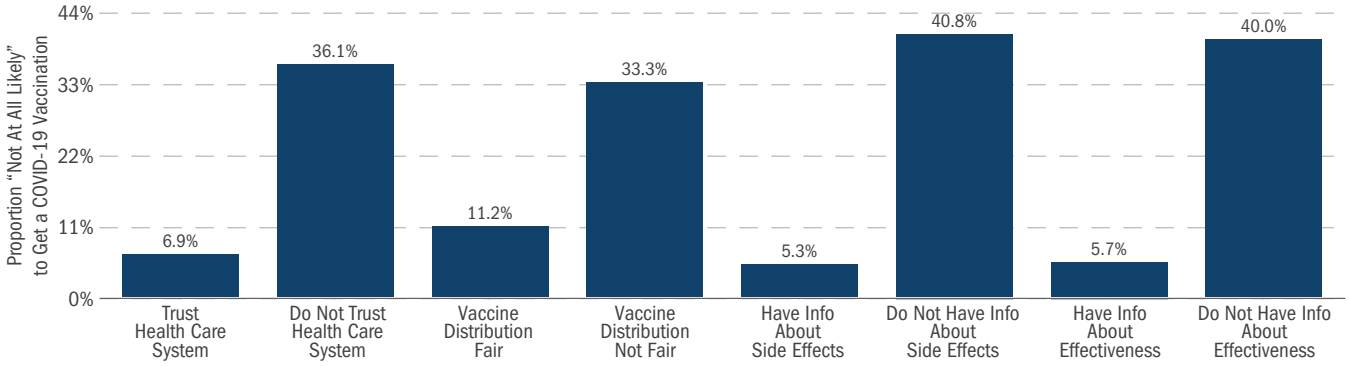
Intentions to Vaccinate by Beneficiary Characteristics and Beliefs *(cont.)*

PROPORTION "NOT AT ALL LIKELY" TO GET VACCINATED FOR COVID-19 BY BENEFICIARY CHARACTERISTICS





PROPORTION "NOT AT ALL LIKELY" TO GET VACCINATED FOR COVID-19 BY BENEFICIARY VACCINE BELIEFS, FY 2021 Q3



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, 10/6/2021

Note: All tests compare the proportion "not at all likely" to get vaccinated for COVID-19 vs. "somewhat/very likely" to get vaccinated or already vaccinated.

MHS RESPONSE TO COVID-19 PANDEMIC *(CONT.)*

Modeling COVID-19 Vaccination Intentions

To investigate how beneficiary beliefs and characteristics predicted COVID-19 vaccination intentions, a binary logistic regression was modeled using outcomes of already vaccinated, "very likely" or "somewhat likely" to vaccinate (modeled outcome) vs. "not at all likely." This analysis incorporates survey design characteristics and population weights to ensure the model resembles the TRICARE beneficiary population.

The binary logistic regression model used N = 6,949 completed surveys and 18 predictor variables. The overall model was a strong predictor of vaccination likelihood (Likelihood Ratio $\chi^2 = 76.12$, $p < 0.0001$; percent concordant 91.1 percent). Of the 18 predictors, 12 were statistically significant. The strongest predictor was refusing a previous vaccine, followed by several beliefs, such as trust in the health care system and concerns about vaccine side effects. Beliefs about fairness of vaccine distribution, prioritization, and effectiveness were also significant predictors. Other significant predictors include education level (those with at least a four-year degree were more likely to vaccinate than those with a high school education or less), age group (age 65+ were more likely to vaccinate than those age 18–24), and Service (Navy and Air Force were more likely to vaccinate than Army). These demographic groups have predictive power that is additive with vaccine beliefs and cannot solely be explained by differences in beliefs.

Key Regression Model Results:

Top predictors of vaccine intentions include refusing a previous vaccine, trusting the health care system, and concerns about side effects.

Other significant predictors of vaccine intentions include beliefs about fairness of vaccine distribution, prioritization, and effectiveness.

Vaccine beliefs may account for significant bivariate relationships that were not significant in the regression model, such as Active Duty status and having a chronic condition. This suggests differences in beliefs are driving the differences in vaccine intentions between these groups.

Some beneficiary characteristics were significantly in the bivariate comparisons but were not significant in the regression model. These include Active Duty status and having a chronic condition. This can occur because differences in vaccine intentions between those groups were correlated with differences in vaccine beliefs, and those beliefs were driving intentions. In other words, the differences in vaccine intentions between those groups may be explained through differences in their vaccine beliefs, but there was not an effect of those groups beyond their differences in vaccine beliefs. Full regression results are reported in the following tables.

EFFECTS AND SIGNIFICANCE FOR PREDICTORS OF VACCINATION STATUS

PREDICTOR	F	NUM DF	DEN DF	P
Refused a Previous Vaccine	133.60	1	6,948	<0.0001
Trust Health Care System	38.76	1	6,948	<0.0001
Info About Side Effects	22.18	1	6,948	<0.0001
Fair Distribution of Vaccines	21.89	1	6,948	<0.0001
Date of Last Flu Shot	17.44	1	6,948	<0.0001
Overseas	14.60	1	6,948	0.0001
Info about Prioritization	12.50	1	6,948	0.0004
Info about Effectiveness	12.39	1	6,948	0.0004
Race/Ethnicity	4.23	4	6,945	0.0020
Service	3.97	3	6,946	0.0078
Education Level	2.90	3	6,946	0.0338
Age Group	2.75	5	6,944	0.0173
Beneficiary Category	2.71	2	6,947	0.0668
Civilian Insurance	2.69	1	6,948	0.1008
Chronic Condition	2.32	1	6,948	0.1279
BMI Category	1.80	2	6,947	0.1654
Self-Reported Health	1.59	1	6,948	0.2081
Sex	0.02	1	6,948	0.9000

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, 10/6/2021

Note: Variables are listed in order of predictive strength as determined by their F-value. Variables above the red dashed line are statistically significant predictors of COVID-19 vaccination intentions. Predictors below the red dashed line are not statistically significant.

Modeling COVID-19 Vaccination Intentions *(cont.)*

ODDS RATIOS AND ESTIMATES FOR SIGNIFICANT PREDICTORS OF VACCINATION STATUS

PREDICTOR	COMPARISON	ODDS RATIO	ESTIMATE	STD ERROR	T	P
Refused a Previous Vaccine	No vs. Yes	5.951	1.7836	0.1543	11.56	<0.0001
Trust Health Care System	Almost All/Most of the Time vs. Some/Almost None of the Time	2.668	0.9812	0.1576	6.23	<0.0001
Info About Side Effects	No vs. Yes	3.425	1.2311	0.2614	4.71	<0.0001
Fair Distribution of Vaccines	Not Too/At All Confident vs. Very/Somewhat Confident	2.309	0.8363	0.1787	4.68	<0.0001
Date of Last Flu Shot	Less Than 2 Years Ago vs. More Recent	2.249	0.8103	0.1940	4.18	<0.0001
Race/Ethnicity	Asian vs. White	3.069	1.1214	0.2796	4.01	<0.0001
Overseas	Overseas vs. Not	2.417	0.8826	0.2310	3.82	0.0001
Info About Prioritization	No vs. Yes	2.002	0.6940	0.1963	3.54	0.0004
Info About Effectiveness	No vs. Yes	2.618	0.9621	0.2733	3.52	0.0004
Age Group	65+ vs. 18–24	3.098	1.1307	0.3786	2.99	0.0028
Service	Navy vs. Army	1.688	0.5235	0.1902	2.75	0.0059
Service	Air Force vs. Army	1.647	0.4987	0.1818	2.74	0.0061
Education Level	More Than 4-Year Degree vs. High School or Less	1.898	0.6410	0.2487	2.58	0.0100

Source: DHA/SP&FI(J-5)/Analytics and Evaluation Division, HCSDB data, 10/6/2021

Note: Variables are listed in order of predictive strength as determined by their t-value. Odds ratios (adjusted) and estimates are only shown for significant predictors.

Discussion

These results show TRICARE beneficiaries' intentions to vaccinate have increased over time, from 82 percent in FY 2021 Q2 to 85 percent in FY 2021 Q3, with significant increases for ADSMs and family members. However, these improvements occurred almost entirely among those who had not refused a previous vaccine. Among those who had refused a prior vaccine, there was no change in vaccine intentions between FY 2021 Q2 and FY 2021 Q3 surveys, with only 51 percent intending to vaccinate. Vaccine intentions also varied strongly by vaccine beliefs. Regression modeling shows:

- For beneficiaries who had refused a previous vaccine, the odds of refusing the COVID-19 vaccine were 6.0 times higher than others.
- For those who felt they did not have enough information about side effects, the odds of intending to refuse a COVID-19 vaccine were 3.4 times higher than others.
- For those who did not trust the health care system, the odds of intending to refuse a COVID-19 vaccine were 2.7 times higher than others.
- For those who had concerns about the effectiveness of vaccines, the odds of intending to refuse a COVID-19 vaccine were 2.6 times higher than others.
- For those who had concerns about the fairness of vaccine distribution, the odds of intending to refuse a COVID-19 vaccine were 2.3 times higher than others.
- For those who had concerns about the prioritization of vaccine distribution, the odds of intending to refuse a COVID-19 vaccine were 2.0 times higher than others.
- Age, education, and Service were also significant predictors, having an additive effect to the strong impact of vaccine beliefs.

These results show TRICARE beneficiaries have become more open to vaccination among those who have not refused a previous vaccine. Vaccine beliefs, especially related to trusting the health care system and concerns about side effects, are strong predictors of vaccine intentions. Age, education, and Service were additional predictors of vaccine intentions.

HOW TRICARE OPERATES

TRICARE consists of both care in the direct care system (military medical treatment facilities [MTFs]) and in the private sector (as administered by TRICARE contractors).

Effective October 25, 2019, the Defense Health Agency (DHA) became responsible for the administration, direction, and control (ADC) of MTFs and DTFs as required by section 1073c of title 10, United States Code (introduced by the National Defense Authorization Act [NDAA] for fiscal year 2017, section 702). This law endeavors to reduce process variance, eliminate redundant overhead, and support the MHS Quadruple Aim. DHA exercises ADC of the direct care system through enterprise-wide guidance, reporting relationships, and named direct-care Market offices worldwide. The DHA Health Care Operations (HCO) directorate supports the optimization of MTF/DTF and the Markets through its various divisions, including Healthcare Optimization, which focuses on direct care operations and optimization in primary care, specialty care, referral management, appointing, DoD and Veteran's Health Administration integration, patient experience, and virtual health execution. Other divisions include Compliance, Pharmacy, Laboratory, TRICARE Health Plan (THP), Patient Administration, and Market Integration.

Within HCO, the THP oversees performance of the other TRICARE contracts that administer coverage of private sector care. Humana Government Benefits (HGB) operates the TRICARE East Region contract in the United States, and Health Net Federal Services (HNFS) operates the TRICARE West Region contract. Wisconsin Physician Services operates the contract that administers TFL. Each of the six USFHP contracts is operated by a different contractor. The THP TRICARE Overseas Program (TOP) section oversees contract currently operated by International SOS. TOP supports the Combatant Commands in delivery of health care in remote locations and during natural disasters when military assets are not available. The Pharmacy Operations Division oversees the TRICARE pharmacy contract currently operated by Express Scripts, Inc.

NEW BENEFITS AND PROGRAMS IN FISCAL YEAR (FY) 2021 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 statutes governing the program and industry standard of care and best practices in order 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 Changes

Retired General Lloyd J. Austin III New Secretary of Defense
On January 22, 2021, retired General Lloyd J. Austin III was confirmed as the 28th Secretary of Defense.

Honorable Dr. Kathleen H. Hicks New Deputy Secretary of Defense
On February 9, 2021, the Honorable Dr. Kathleen H. Hicks was sworn in as the 35th Deputy Secretary of Defense.

TRICARE Program Changes in FY 2021

TRICARE Open Season

TRICARE Open Season occurred from November 9 through December 14, 2020.

NEW BENEFITS AND PROGRAMS IN FY 2021 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

Quadruple Aim: Improved Readiness

Uniformed Services University of the Health Sciences' (USUHS) Infectious Disease Clinical Research Program is Leading a Multi-Year Study to Identify Risk Factors for COVID-19 in the Military Population, Understand the Symptoms and Disease Course, and Investigate Clinical Outcomes

Epidemiology, Immunology, and Clinical Characteristics of Emerging Infectious Diseases with Pandemic Potential (EPICC) study hopes to inform the MHS on ways to improve the patient care and treatment, infection, and disease prevention of those with COVID-19. USUHS is working in partnership with a network of military commands, MTFs, and laboratories across the country for EPICC. Findings from the study will support further understanding of the impact of SARS-COV-2 infection on Active Duty readiness, acute and chronic clinical outcomes, the effectiveness of new treatments and vaccines, and address questions related to the emergence of new variants and their clinical impact.

Active Duty Service members (ADSMs) and MHS beneficiaries of any age with COVID-19-like illness who are admitted to the hospital or treated as outpatients at an EPICC site could join the study. Likewise, those 18 years or older who have been tested for COVID-19, whether they tested positive or negative, can participate in the online portion of the study, which includes self-collected blood specimens for selected participants. Data from inpatient, outpatient, and online participants, including their clinical characteristics, comorbidities, the clinical course of their illness, treatment, immunology, and outcomes, are being collected for the study.

Initiated in March 2020, EPICC is expected to continue enrolling participants at least through March 2022, or for as long as needed to fill in the knowledge gaps related to this disease.

EPICC is being conducted at ten MTFs:

- Brooke Army Medical Center (AMC) in Fort Sam Houston, Texas
- Carl R. Darnall Army Medical Center in Fort Hood, Texas
- Fort Belvoir Community Hospital in Fort Belvoir, Va.
- Joint Base Lewis-McChord, Wash.
- Naval Medical Center Portsmouth in Portsmouth, Va.
- Naval Medical Center San Diego in San Diego, Calif.
- Tripler Army Medical Center in Honolulu, Hawaii
- William Beaumont Army Medical Center in El Paso, Texas
- Womack Army Medical Center in Fort Bragg, N.C.
- Walter Reed National Military Medical Center in Bethesda, Md.

DHA Launched the Sexual Trauma Intensive Outpatient Program (IOP) Pilot

The Sexual Trauma IOP Pilot was provided to ADSMs who are experiencing posttraumatic stress disorder and other mental health conditions associated with sexual trauma. To be eligible, pilot participants must have been ADSMs stationed stateside who:

- Had a diagnosis from a TRICARE-authorized mental health provider, or military hospital or clinic mental health provider that is associated with a sexual trauma that they disclose
- Had both a pre-authorization and referral for their care
- Live within specialty care drive time (about 60 minutes) of a participating facility

The program was only available in certain areas—five TRICARE network locations and two military hospitals.

TRICARE Launched COVID-19 Video Series

The video series provides the latest information about the DoD's vaccine distribution, vaccine availability, and other COVID-19 information related to the TRICARE benefit. The short video updates are published three times a month and each video ends with an important but simple message: "Get the COVID-19 vaccine, and let's defeat this virus together."

The *Got Your 6* videos can be found here: https://newsroom.tricare.mil/videos.

COVID-19 Vaccinations Mandatory for Service Members

On August 24, 2021, Secretary of Defense Lloyd J. Austin III issued a memo directing mandatory COVID-19 vaccinations for all uniformed Service members.

NEW BENEFITS AND PROGRAMS IN FY 2021 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

Quadruple Aim: Better Care

MHS Deployed the MHS GENESIS Electronic Health Record to Four Additional Sites, Deployed the System on October 31, 2020

The latest deployment on major bases and medical facilities, Wave PENDLETON brings advanced quality health care and patient safety to:

- Marine Corps Base Camp Pendleton, Calif.
- Joint Base Elmendorf-Richardson, Alaska
- Fort Wainwright, Alaska
- Eielson Air Force Base, Alaska

The DHA works in close coordination with the Program Executive Office, Defense Healthcare Management Systems to deploy this new electronic health record (EHR) across the MHS. This was the third major deployment of MHS GENESIS, following the September 26 Wave NELLIS launch and Wave TRAVIS in September 2019. The initial operating capability (IOC) was launched at four sites in the Pacific Northwest in 2017. MHS GENESIS will deploy at military hospitals and clinics worldwide in planned waves through 2023.

TRICARE Formulary Search Tool Launched

Express Scripts, the pharmacy provider for the TRICARE pharmacy benefit, launched the TRICARE Formulary Search Tool, which offers beneficiaries information about their prescriptions. The search tool can help beneficiaries better understand the costs of prescriptions, know when the prescription will be ready for pickup and any copayments, provide coverage details and limitations, provide drug information, and provide other drug options if TRICARE does not cover a prescribed drug.

The tool is located: https://www.express-scripts.com/frontend/open-enrollment/tricare/fst/#/

HNFS Launched Buckley Prime Service Area (PSA) Pilot Program in Denver, Colorado, on January 1, 2021

The Buckley PSA Pilot shifted TRICARE's fee-for-service reimbursement model to value-based payment agreements. The pilot was designed to focus on value and data-driven patient care management that HNFS will demonstrate through improved health outcomes and increased beneficiary and provider satisfaction while maintaining budget certainty.

The beneficiaries participating in the pilot would receive at a minimum the following:

- Chronic care management, education, and support
- Provider locator and appointment assistance
- A personalized customer service experience
- Reminders of current and past-due preventive care

More information on the Buckley PSA Pilot can be found on page 13.

TRICARE Launched a New Text Messaging Service to Allow Beneficiaries to Activate and Manage a New Prescription Online When Using Military Pharmacy During Duty Hours

The Remote Pharmacy Check-In, which uses Q-Anywhere, will reduce the number of people waiting in line at the pharmacy or over the phone. Remote Pharmacy Check-In is not available for refilling prescriptions.

As part of a pilot program, Remote Pharmacy Check-In is available at limited pharmacies with the goal for it to be available at 150 locations before the end of the pilot. Some of the sites currently using Remote Pharmacy Check-In include:

- Fort Belvoir Community Hospital, Fort Belvoir, Va.
- 88th Medical Group, Wright-Patterson Air Force Base, Ohio
- 75th Medical Group, Hill Air Force Base, Utah
- 56th Medical Group, Luke Air Force Base, Ariz.
- Naval Hospital Bremerton, Bremerton, Wash.

NEW BENEFITS AND PROGRAMS IN FY 2021 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

Quadruple Aim: Better Care *(cont.)*

DHA Announced Online COVID-19 Vaccine Appointment Portal Available Worldwide to Military Service Members and Beneficiaries

The innovation originated at Madigan Army Medical Center, Joint Base Lewis-McChord in Washington State and has expanded across the globe. Each location has a unique landing page that details eligible patient groups and which vaccine is being used which vary and can change daily. The DHA Appointment Portal (DAP) is just one of the available paths to make a vaccine appointment.

More information about the DAP can be found at: https://health.mil/Military-Health-Topics/MHS-Toolkits/TRICARE-Communications-COVID-19-Vaccine-Toolkit/DHA-Appointing-Portal.

TRICARE Established Automated Pharmacy Kiosk and Locker Systems to Provide Safe, Secure, and Controlled Way for Beneficiaries to Pick Up Prescriptions

ScriptCenters are contactless automated locker or vending machine units at certain MTFs. Each kiosk or locker system can hold hundreds of prescriptions with the exception of refrigerated medications. They are mainly for prescription refill pickup. But some sites have adapted ScriptCenters for new prescriptions, same-day surgery, or staff-only prescription pickup, as well as any combination of these services. One benefit of ScriptCenters is that they allow pickup of prescriptions after pharmacy or clinics close, with some available 24/7. They can also be located away from the pharmacy.

DoD Initiated the In-Home Child Care Fee Assistance Pilot Program to Grant Fee Assistance to Military Families for Full-Time, In-Home Child Care Providers

The DoD provides support to families through a range of child care solutions, including on-installation care at child development centers, certified family child care homes, and before- and after-school care programs. Other options include fee assistance for community-based child care and free access to a subscription service that connects families with flexible hourly care.

The new pilot program will explore fee assistance for military families who have determined that full-time, in-home child care, such as nannies, is the best solution to fit their needs. It will be operated similarly to the child care fee assistance program currently in place for Service members using community-based care facilities.

In its first year, the pilot will be offered in the five regions with the highest demand and longest waitlists for DoD-facilitated child care for our military families. These locations are the National Capital Region; Hawaii; San Diego, Calif.; Norfolk, Va.; and San Antonio, Texas.

This pilot is in response to requirements of the National Defense Authorization Act for Fiscal Year 21, Section 589, Pilot Program to Provide Fee Assistance (In-Home Providers). Lessons learned from the initial year of the pilot will be used to explore options for future expansion.

Quadruple Aim: Better Health

DoD Announced TRICARE Will Cover Investigational Drugs Used to Treat COVID-19

Generally, TRICARE only covers Food and Drug Administration (FDA) approved drugs and therapies; however, for the duration of the President's national emergency in response to the COVID-19 outbreak, it will cover or cost-share, depending on the TRICARE plan, experimental therapies for the novel coronavirus that receive "expanded access" status by the FDA.

DHA Issued Waiver of the Referral Requirement for TRICARE Prime Enrollees to Allow COVID-19 Vaccines from Any TRICARE-Authorized Non-Network Provider without a Referral or Additional Costs

Normally, a beneficiary enrolled in TRICARE Prime is required to obtain a referral for care from their primary care manager prior to obtaining care under the TRICARE program; otherwise, point-of-service charges apply. The waiver is retroactive to December 13, 2020, and applies for the period of the COVID-19 national emergency.

NEW BENEFITS AND PROGRAMS IN FY 2021 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

Quadruple Aim: Better Health *(cont.)*

DoD Administered More Than One Million COVID-19 Vaccinations

The DoD continued to distribute and administer vaccines to MHS beneficiaries at more than 300 MTFs around the world, following a phased population schema as part of the federal government's COVID-19 response.

TRICARE Launched a New Podcast—Get to Know TRICARE

The podcast was designed to help beneficiaries learn the ins and outs of their TRICARE benefit. DHA experts at the offer insight into the TRICARE program, including details about health plans, dental care, pharmacy, and more. The first episode of the new podcast was Need a TRICARE Refresher? and featured an interview with Calvin Keller, who is a health systems analyst with the Benefit Education and Research Team at the DHA.

The podcast is available on Apple Podcasts, Spotify, and DVIDS.

Quadruple Aim: Lower Cost

Enrollment Fees for TRICARE Select Group A Retirees and Family Enrollment Fees Increased

Enrollment fees for TRICARE Select Group A retirees increased to $150 a year and family enrollment fees increased to $300 annually beginning on January 1, 2021.

Any beneficiary whose sponsor originally enlisted or commissioned before January 1, 2018, is in Select Group A, and Select Group B are those who enlisted or commissioned on or after January 1, 2018.

Premiums for TRICARE Young Adult (TYA) Coverage Increased

Beginning January 1, 2021, TYA Select increased by 12.7 percent and TYA Prime by 22 percent. These changes reflect the increase in TYA program costs for calendar year 2021. TYA is a premium-based plan available for purchase by qualified dependent children under the age of 26. Young adults who are 21 (or age 23 if a fulltime student) lose regular TRICARE coverage, but may be eligible to purchase TYA coverage. Specifically, TYA Select premiums increased from $228 to $257 per month and TYA Prime premiums increased from $376 to $459 per month.

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

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

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BENEFICIARY TRENDS AND DEMOGRAPHICS

System Characteristics

TRICARE FACTS AND FIGURES—PROJECTED FOR FISCAL YEAR (FY) 2022

	PROJECTED FOR FY 2022[a]	FY 2021 ACTUALS
Total Beneficiaries	**9.6 million worldwide[b]**	9.6 million worldwide[b]
MILITARY FACILITIES—DIRECT CARE SYSTEM[c]		
Inpatient Hospitals and Medical Centers	**45 (31 in U.S.)**	49 (35 in U.S.)
Ambulatory Care and Occupational Health Clinics[d]	**525 (458 in U.S.)**	465 (378 in U.S.)
Dental Clinics	**138 (115 in U.S.)**	192 (149 in U.S.)
Military Health System (MHS) Defense Health Program Personnel	**128,971**	127,214
Military	**71,865**	71,318
	27,372 Officers	26,404 Officers
	44,493 Enlisted	44,914 Enlisted
Civilian (including Foreign National)	**57,106**	55,896
CIVILIAN RESOURCES—PRIVATE SECTOR CARE SYSTEM[e]		
Network Primary Care, Behavioral Health, and Specialty Care Providers (i.e., individual, not institutional, providers)	**1,011,304**	1,000,428
Network Behavioral Health Providers (shown separately, but included in above)	**143,887**	142,975
TRICARE Network Acute Care Hospitals	**5,034**	5,037
Behavioral Health Facilities	**2,138**	2,127
Contracted (Network) Retail Pharmacies	**56,129**	56,924
Contracted Worldwide Pharmacy Home Delivery Vendor	**1**	1
TRICARE Dental Program (TDP) (for Active Duty families, Reserve members and their families)	**Over 1.80 million covered lives in 770,000 contracts**	Over 1.84 million covered lives in 767,000 contracts
TDP Network Dentists	**Over 73,200 total dentists, including: 57,600 general dentists over 16.500 specialty dentists**	Over 72,800 total dentists, including: 57,300 general dentists 15,500 specialty dentists
Total Requested FY 2022 Unified Medical Program (UMP) (including Projected Trust Fund Receipts)	**$52.32 billion[f]**	$51.67 billion[f]
Projected Receipts from Medicare-Eligible Retiree Health Care Fund (MERHCF) Trust Fund	**$9.34 billion**	$8.38 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) 2022 is 9,625,000, 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 End FY 2020 Defense Enrollment Eligibility Reporting System (DEERS) file.

[c] Military medical treatment facility (MTF) clinic count includes occupational health, community-based, embedded behavioral health, Active Duty troop, centers of excellence, and joint DoD-Department of Veterans Affairs (VA) clinics, and excludes leased/contracted facilities and Aid Stations. Military facility counts are that of the number of facilities (building information), not clinical functions Source: Defense Health Agency (DHA)/Resources & Management (J-1/J-8)/Budget and Execution and Programming Divisions, 1/26/2022.

[d] The projected increase in ambulatory clinics for FY 2022 is largely administrative in nature to ensure system alignment with MHS GENESIS Patient Care locations. The policy reinforcement has come from two different directions: 1) Defense Medical Information System Identifiers (DMIS IDs) table alignment with MHS GENESIS to resolve issues in clerk/patient appointing and 2) aligning overhead costs to a building or function to better reflect the cost of care (delineating buildings on the DMIS table that don't fall under a campus concept).

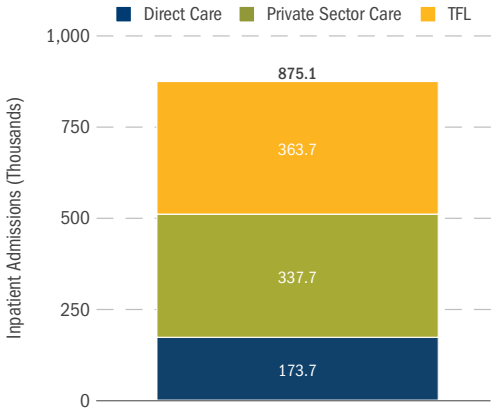
[e] As reported by the managed care support contractors (MCSCs) for contracted network provider and hospital data, 12/4/2020; and by TRICARE Dental Office, Health Plan Execution and Operations for dental provider data, 12/30/2019.

[f] UMP presented here includes direct and private sector care funding, military personnel, military construction, and the MERHCF ("Accrual Fund"). Budget and expense data from DHA/Resources & Management Directorate (J-8)/Budget & Execution Division, 11/30/2021.

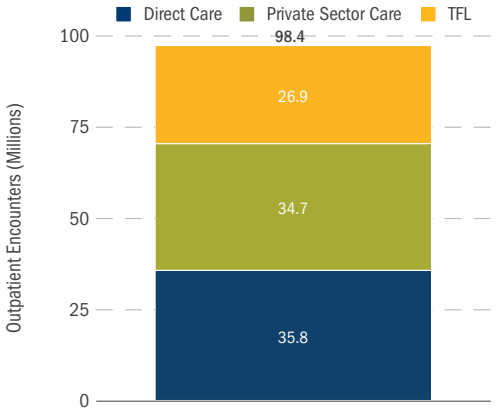
BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

FY 2021 TRICARE Workload and Population Summary

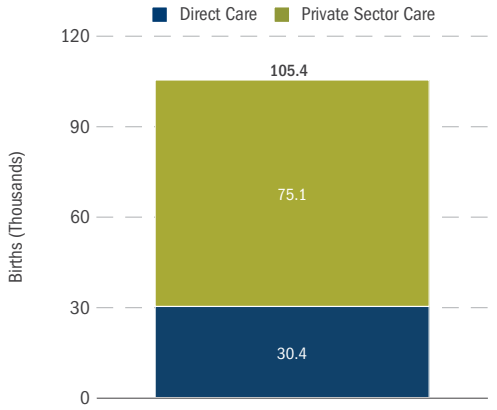
INPATIENT ADMISSIONS[a]



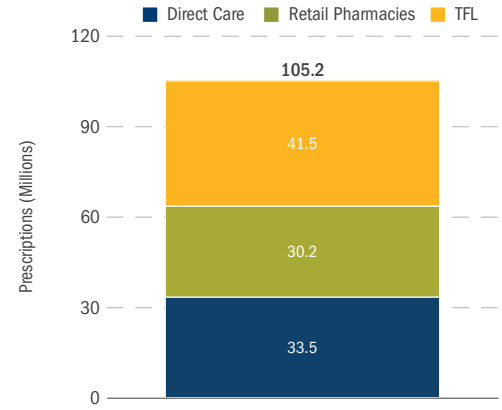
OUTPATIENT ENCOUNTERS[a]



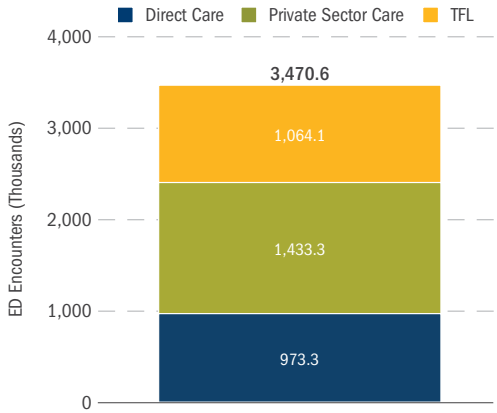
BIRTHS[a]



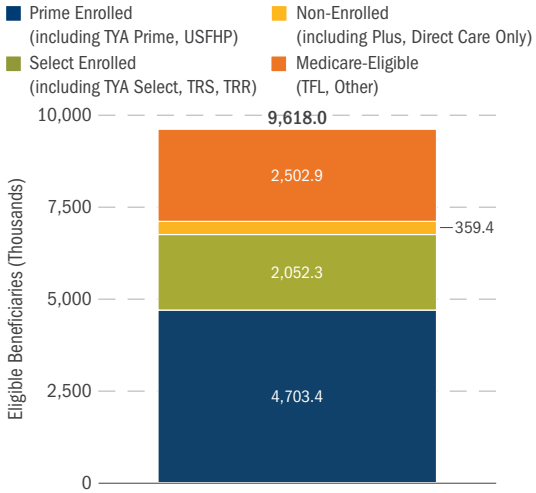
PRESCRIPTIONS[a]



EMERGENCY DEPARTMENT (ED) ENCOUNTERS[a]



ELIGIBLE BENEFICIARIES



Sources: MHS administrative data, 1/28/2022, and DEERS, 12/24/2021

[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.

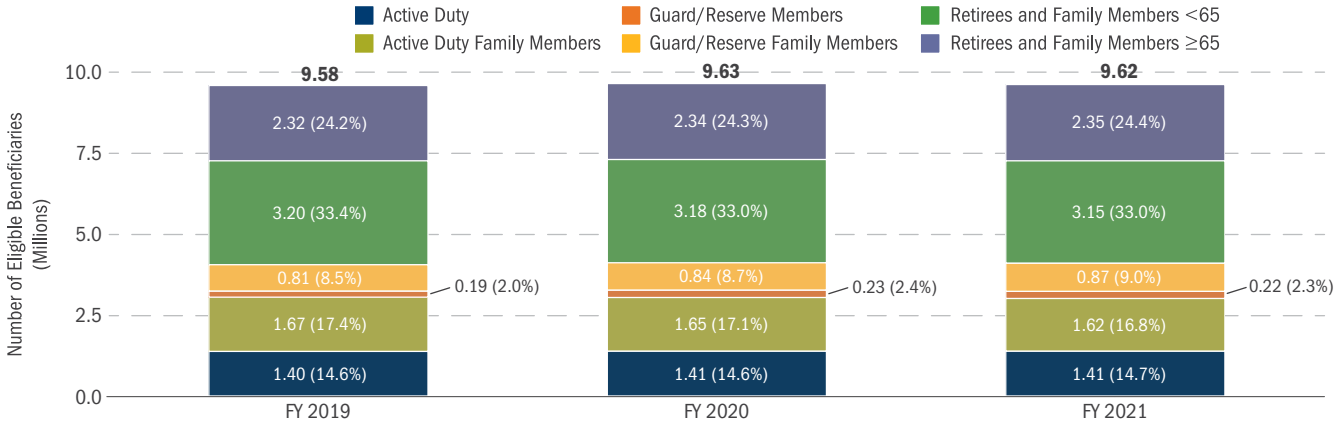
– Numbers may not sum to bar totals due to rounding.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Number of Eligible and Enrolled Beneficiaries Between FY 2019 and FY 2021

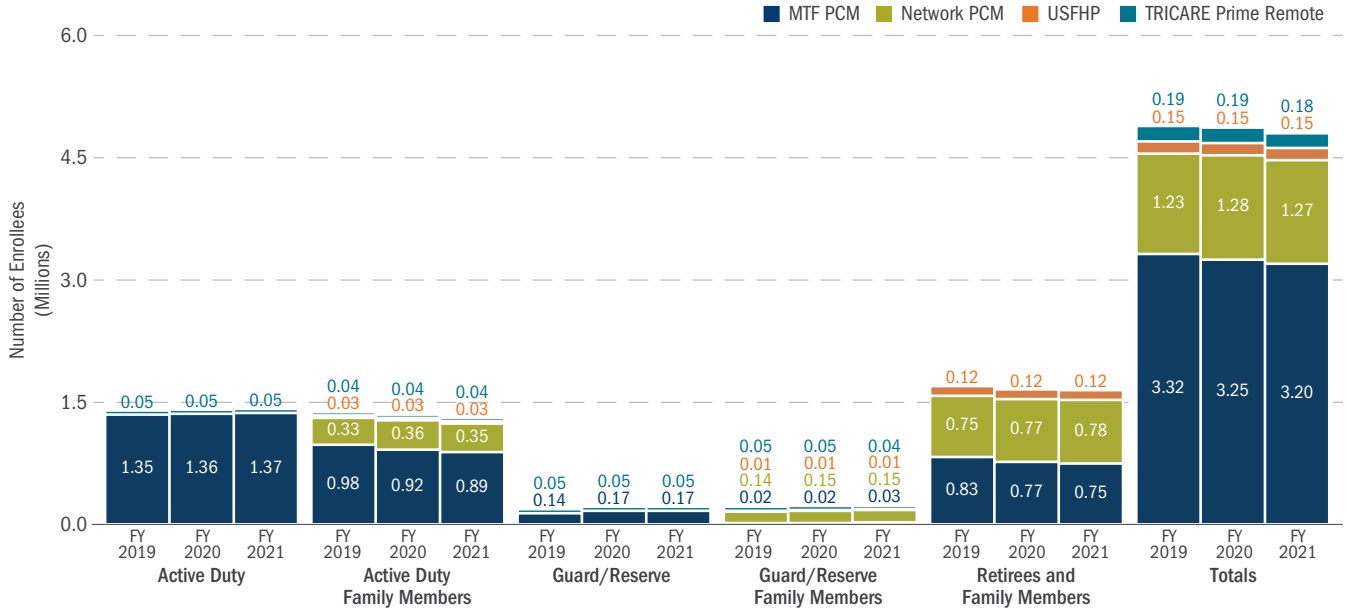
The number of beneficiaries eligible for DoD medical care (including TRR, TRS, and TYA) remained roughly constant at 9.6 million from FY 2019 to FY 2021.[1] Although the number of Active Duty Service members (ADSMs) increased slightly, the number of Active Duty family members (ADFMs) fell by 3 percent. The number of retirees and family members (RETFMs) under age 65 decreased by 1 percent, but the number of RETFMs aged 65 and over increased by 1 percent.

TRENDS IN THE END-YEAR NUMBER OF ELIGIBLE BENEFICIARIES BY BENEFICIARY GROUP, FYs 2019–2021



- 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 2021, for the first time, the number of RETFMs enrolled with a network PCM exceeded the number enrolled with an MTF PCM.
- TRICARE Prime Remote (TPR) and USFHP enrollment remained about the same from FY 2019 to FY 2021.

TRENDS IN THE END-YEAR NUMBER OF PRIME-ENROLLED BENEFICIARIES BY BENEFICIARY GROUP, FYs 2019–2021



Source: DEERS, 12/24/2021

[1] This number should not be confused with the one displayed under TRICARE Facts and Figures on page 31. The population figure on page 31 is a projected FY 2022 total, whereas the population reported on this page is the actual for the end of FY 2021.

Notes:

– 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.

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

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 2021

PLAN TYPE	0–17	18–24	25–44	45–64	≥65	TOTAL[a]
Prime Enrolled	1,242,225	896,757	1,552,818	1,004,255	7,314	4,703,369
Prime: MTF PCM	728,642	760,767	1,299,747	545,539	1,278	3,335,973
Prime: Network PCM	477,714	122,838	233,167	412,520	670	1,246,909
USFHP	35,869	8,451	18,435	46,196	5,366	114,317
TYA Prime	0	4,701	1,469	0	0	6,170
Select Enrolled	679,422	219,406	522,908	629,320	1,268	2,052,324
TRICARE Select	518,766	156,073	338,195	580,071	1,206	1,594,311
TRS	153,088	33,324	175,234	31,540	20	393,206
TYA Select	0	27,325	6,017	0	0	33,342
TRICARE Plus	4,331	1,225	2,291	11,407	42	19,296
TRR	3,237	1,459	1,171	6,302	0	12,169
Nonenrolled	53,925	48,068	66,813	164,551	26,083	359,440
Direct Care Only	53,912	48,065	66,798	163,824	25,262	357,861
TRICARE Plus	13	3	15	727	821	1,579
Medicare-Eligible	21	820	34,206	148,238	2,319,599	2,502,884
TFL	8	419	16,815	80,325	2,015,226	2,112,793
TRICARE Plus[b]	0	3	127	1,124	184,975	186,229
Direct Care Only	1	29	4,391	13,383	81,072	98,876
USFHP	0	17	324	1,714	37,773	39,828
Prime: Network PCM	3	132	6,362	26,518	8	33,023
Prime: MTF PCM	4	135	5,316	24,172	2	29,629
Other	5	85	871	1,002	543	2,506
Total	**1,975,593**	**1,165,051**	**2,176,745**	**1,946,364**	**2,354,264**	**9,618,017**

Source: DEERS, 12/24/2021

[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, 183,319 with TRICARE Plus also have TFL. These numbers are not included in the TFL row.

- About 28 percent of USFHP enrollees are seniors (aged 65 and older), and about 23 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 60 percent choose TFL and 40 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 63 percent for 0–17, 77 percent for 18–24, and 72 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 2021

PLAN TYPE	AD	ADFM	GR	GRFM	IGR	IGRFM	RET	RETFM	SRV	OTH	TOTAL[a]
Prime Enrolled	1,411,857	1,305,954	218,437	208,396	5,476	13,583	545,404	955,869	36,535	1,858	4,703,369
Prime: MTF PCM	1,411,857	924,058	218,437	63,361	2,599	4,310	268,367	426,921	15,025	1,038	3,335,973
Prime: Network PCM	0	354,159	0	137,060	2,563	8,623	248,335	476,431	18,995	743	1,246,909
USFHP	0	27,145	0	7,887	314	648	28,702	47,150	2,394	77	114,317
TYA Prime	0	592	0	88	0	2	0	5,367	121	0	6,170
Select Enrolled	0	291,834	0	107,733	193,047	306,289	365,526	729,213	44,945	13,737	2,052,324
TRICARE Select	0	288,912	0	106,466	44,978	60,601	353,827	682,414	43,698	13,415	1,594,311
TRS	0	1	0	136	148,069	244,584	21	45	38	312	393,206
TYA Select	0	2,490	0	1,042	0	1,104	0	27,806	892	8	33,342
TRICARE Plus	0	431	0	89	0	0	7,330	11,156	289	1	19,296
TRR	0	0	0	0	0	0	4,348	7,792	28	1	12,169
Non-Enrolled	0	22,354	0	4,361	22,483	2,709	99,146	167,145	24,512	16,730	359,440
Direct Care Only	0	21,482	0	4,325	22,483	2,709	99,033	166,646	24,453	16,730	357,861
TRICARE Plus	0	872	0	36	0	0	113	499	59	0	1,579
Medicare-Eligible	0	2,156	0	774	147	980	1,212,055	781,146	503,447	2,179	2,502,884
TFL	0	0	0	0	1	1	1,001,816	665,186	443,931	1,858	2,112,793
TRICARE Plus[b]	0	336	0	49	0	0	94,481	59,785	31,542	36	186,229
Direct Care Only	0	1,300	0	317	7	25	57,712	22,378	16,924	213	98,876
USFHP	0	0	0	0	0	0	19,312	12,872	7,619	25	39,828
Prime: Network PCM	0	0	0	0	0	0	20,464	10,882	1,651	26	33,023
Prime: MTF PCM	0	0	0	0	0	0	18,116	9,801	1,702	10	29,629
Other	0	520	0	408	139	954	154	242	78	11	2,506
Total	**1,411,857**	**1,622,298**	**218,437**	**321,264**	**221,153**	**323,561**	**2,222,131**	**2,633,373**	**609,439**	**34,504**	**9,618,017**

Source: DEERS, 12/24/2021

[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, 183,319 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 5 percent of non-Medicare-eligible beneficiaries were not enrolled in any TRICARE plan (i.e., they use space-available care or TRICARE Plus at MTFs or other health insurance [OHI]) in FY 2021. This is up from 3 percent in FY 2020.
- 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 16 percent in FY 2021.
- About 77 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 2019–2021

PLAN TYPE	FY 2019		FY 2020		FY 2021	
	POPULATION	% OF TOTAL	POPULATION	% OF TOTAL	POPULATION	% OF TOTAL
Prime Enrolled	4,778,158	49.9%	4,775,013	49.6%	4,703,369	48.9%
Prime: MTF PCM	3,459,264	36.1%	3,400,671	35.3%	3,335,973	34.7%
Prime: Network PCM	1,197,826	12.5%	1,252,733	13.0%	1,246,909	13.0%
USFHP	110,556	1.2%	112,300	1.2%	114,317	1.2%
TYA Prime	10,512	0.1%	9,309	0.1%	6,170	0.1%
Select Enrolled	2,135,418	22.3%	2,127,596	22.1%	2,052,324	21.3%
TRICARE Select	1,681,439	17.5%	1,684,706	17.5%	1,594,311	16.6%
TRS	391,954	4.1%	377,119	3.9%	393,206	4.1%
TRICARE Plus	26,695	0.3%	30,765	0.3%	33,342	0.3%
TYA Select	24,993	0.3%	23,572	0.2%	19,296	0.2%
TRR	10,337	0.1%	11,434	0.1%	12,169	0.1%
Nonenrolled	191,124	2.0%	233,146	2.4%	359,440	3.7%
Direct Care Only	189,351	2.0%	231,516	2.4%	357,861	3.7%
TRICARE Plus	1,773	0.0%	1,630	0.0%	1,579	0.0%
Medicare Eligible	2,478,785	25.9%	2,495,294	25.9%	2,502,884	26.0%
TFL	2,093,342	21.8%	2,104,327	21.8%	2,112,793	22.0%
TRICARE Plus	185,770	1.9%	185,897	1.9%	186,229	1.9%
Direct Care Only	92,160	1.0%	98,587	1.0%	98,876	1.0%
USFHP	41,926	0.4%	40,722	0.4%	39,828	0.4%
Prime: Network PCM	31,534	0.3%	32,541	0.3%	33,023	0.3%
Prime: MTF PCM	31,191	0.3%	30,434	0.3%	29,629	0.3%
Other/Unknown	2,862	0.0%	2,786	0.0%	2,506	0.0%
Total	**9,583,485**		**9,631,049**		**9,618,017**	

Source: DEERS, 12/24/2021

- After a year of grace in calendar year (CY) 2018, the open season model went into full effect for coverage beginning in CY 2019. Beneficiaries could no longer change their TRICARE coverage outside open season unless they had a TRICARE-recognized qualifying life event. As a result, plan enrollment has been relatively stable the past three years.
- As a percentage of the total eligible population, the number of Prime-enrolled beneficiaries declined slightly from FY 2019 to FY 2021. 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 Select plans declined slightly from FY 2019 to FY 2021. Over the same time period, the percentage of beneficiaries with direct-care-only coverage increased, with most of the increase occurring in FY 2021.

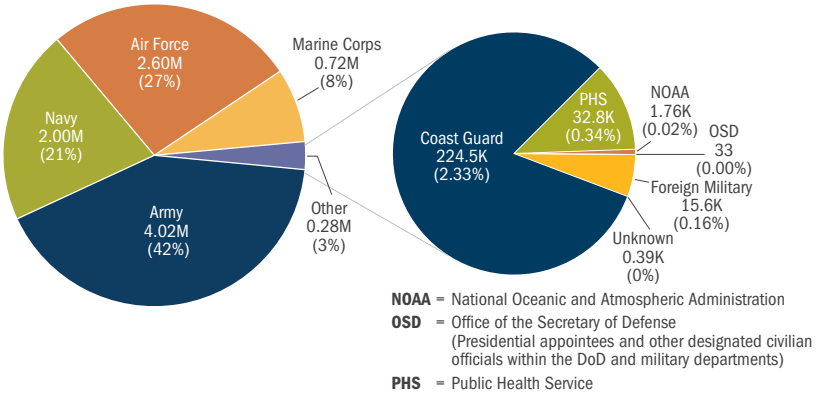
BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Eligible Beneficiaries in FY 2021

- There were a total of 9.62 million beneficiaries eligible for some form of DoD health care benefits at the end of FY 2021. 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 42, 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.

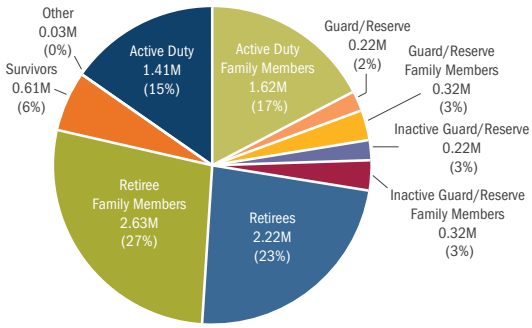
WORLDWIDE BENEFICIARIES ELIGIBLE FOR DoD HEALTH CARE BENEFITS, END OF FY 2021

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

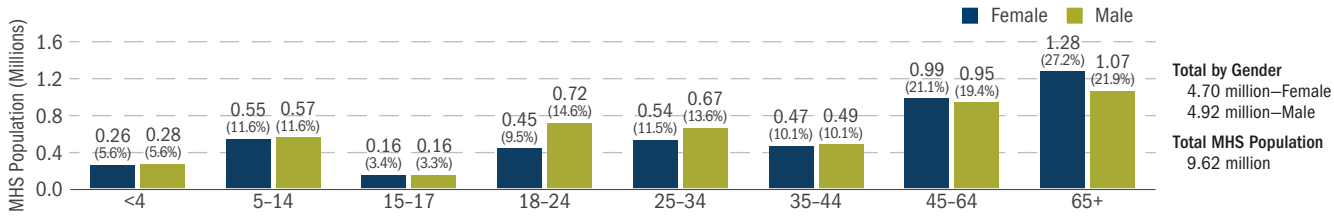
BY BENEFICIARY CATEGORY



TOTAL: 9.62 Million

Source: DEERS, 12/24/2021
Note: Percentages may not sum to 100 percent due to rounding.

MHS POPULATION BY AGE GROUP AND GENDER, END OF FY 2021



Source: FY 2021 actuals from DEERS as of 12/24/2021

PROJECTED END-YEAR MHS POPULATIONS (MILLIONS) BY BENEFICIARY CATEGORY, FYs 2022–2032

BENEFICIARY CATEGORY	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027	FY 2028	FY 2029	FY 2030	FY 2031	FY 2032
Active Duty	1.41	1.39	1.38	1.38	1.37	1.36	1.36	1.36	1.37	1.37	1.37
Active Duty Family Members	1.62	1.60	1.59	1.59	1.58	1.57	1.57	1.57	1.57	1.57	1.57
Guard/Reserve	0.22	0.22	0.22	0.22	0.22	0.22	0.22	0.22	0.22	0.22	0.22
Guard/Reserve Family Members	0.33	0.33	0.33	0.33	0.32	0.32	0.32	0.32	0.32	0.32	0.32
Inactive Guard/Reserve	0.22	0.22	0.22	0.22	0.22	0.22	0.22	0.22	0.22	0.22	0.22
Inactive Guard/Reserve Family Members	0.32	0.32	0.32	0.32	0.32	0.32	0.32	0.32	0.32	0.32	0.32
Retirees	2.23	2.24	2.25	2.26	2.26	2.26	2.26	2.25	2.25	2.24	2.23
Retiree Family Members	2.64	2.65	2.65	2.65	2.65	2.65	2.65	2.64	2.64	2.63	2.62
Survivors	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60
Other	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03	0.03
Total	**9.63**	**9.60**	**9.60**	**9.60**	**9.59**	**9.57**	**9.57**	**9.56**	**9.55**	**9.54**	**9.52**

Source: Projection of Eligible Population as of 1/27/2022

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Locations of MTFs (Hospitals and Ambulatory Care Clinics) at the End of FY 2021

The map on the following page shows the geographic dispersion of the 9.1 million beneficiaries eligible for the TRICARE benefit residing within the United States (95 percent of the 9.6 million eligible beneficiaries). 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. The map also shows the recently established 20 direct reporting DHA Markets.

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.

MHS ELIGIBLE BENEFICIARY PROXIMITY TO MTFs, END OF FY 2021[a]

BENEFICIARY GROUP[b]	POPULATION TOTAL	POPULATION IN PSAs	% IN PSAs	POPULATION IN MTF SERVICE AREA	% IN MTF SERVICE AREAS
Active Duty and Their Families	2,752,113	2,628,828	96%	2,565,988	93%
Inactive Guard/Reserve and Their Families[c]	541,883	359,086	66%	286,530	53%
Retirees, Their Families, Survivors, and Other Eligibles	5,853,479	4,362,063	75%	3,692,346	63%
Total MHS Eligibles, U.S.	9,147,475	7,349,977	80%	6,544,864	72%
MHS Eligible, Overseas and Unknown	454,204				
Total MHS Eligibles, Worldwide	9,601,679				

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, population as of 1/25/2022

Notes:

[a] Eligible MHS beneficiary data from the MHS Data Repository (MDR) DEERS, as of 1/25/2022. Residential ZIP code was used as the location for all beneficiaries.

[b] Location information determined by DHA Catchment Area Directory database, September 2021.

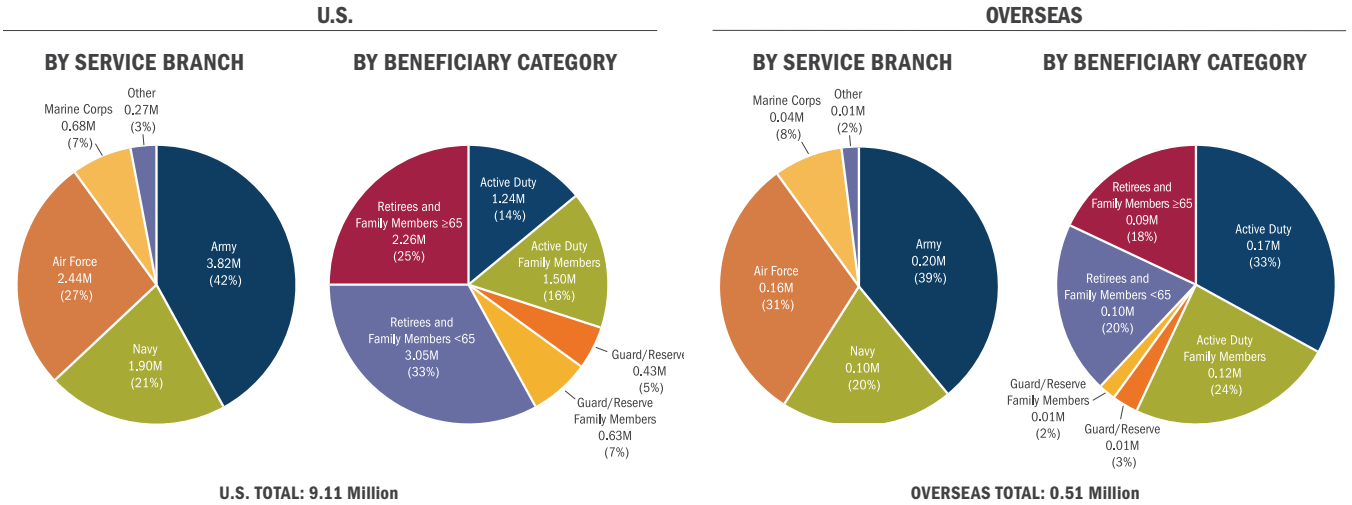
[c] TRICARE medically eligible Guard/Reserve beneficiaries, including those who have enrolled in TRS, TRR, or TYA (does not include all Select Reserve).

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.

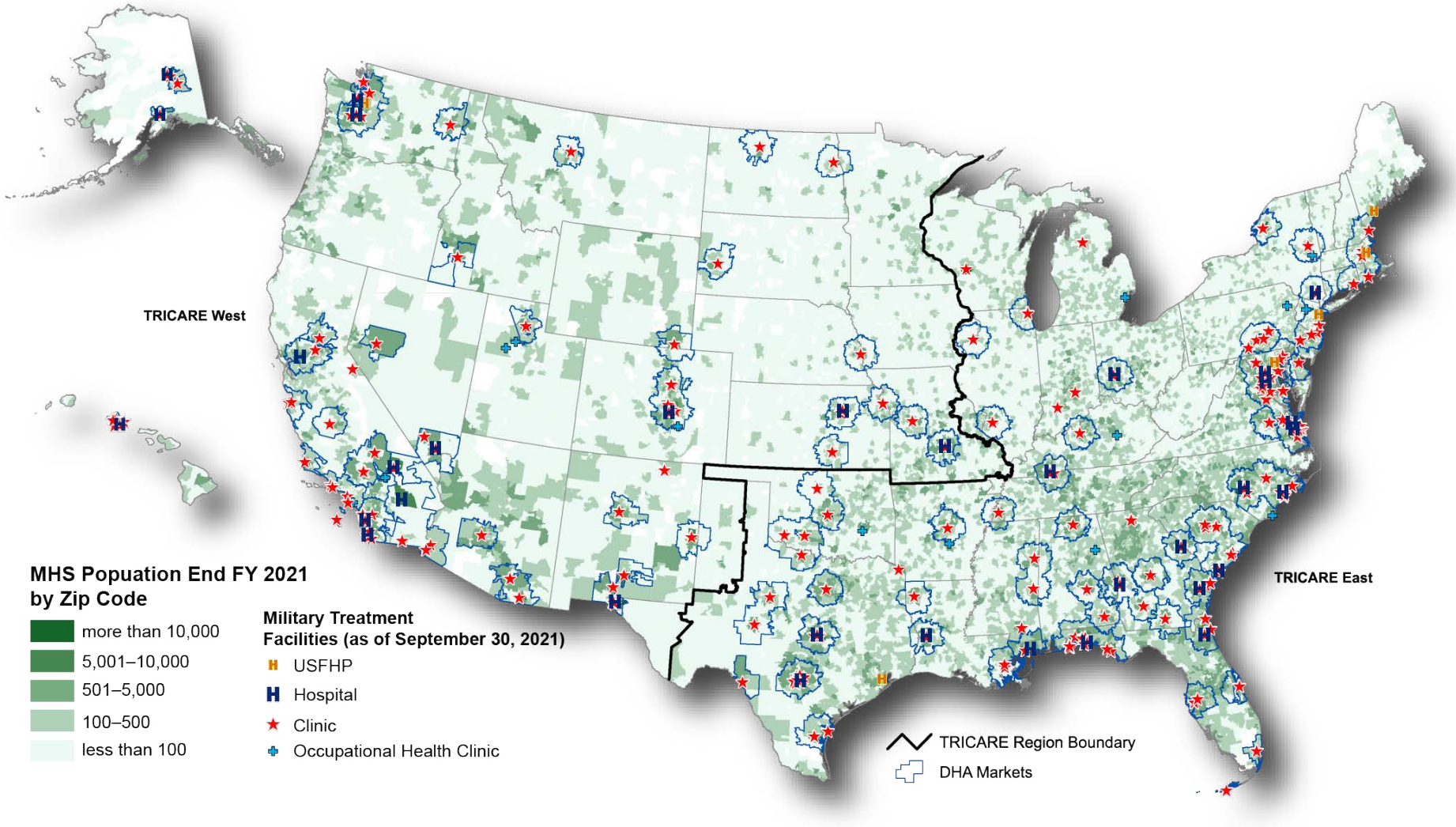
BENEFICIARIES ELIGIBLE FOR DoD HEALTH CARE BENEFITS, END OF FY 2021



Source: DEERS, 12/24/2021

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

MHS POPULATION DISTRIBUTION IN THE U.S. RELATIVE TO MTFs, END OF FY 2021



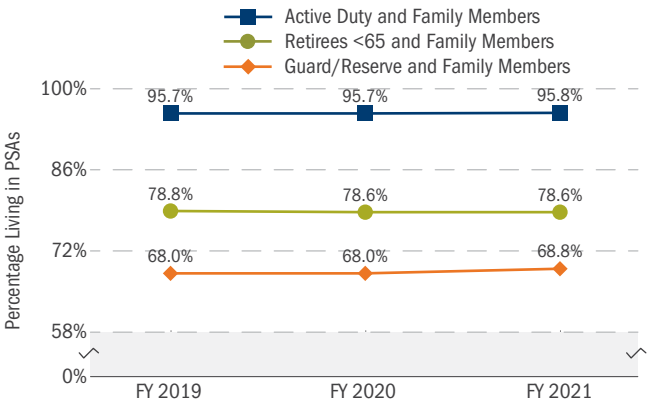
Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, population as of 9/30/2021
Note: For in-depth market area maps, visit https://info.health.mil/staff/analytics/decsupmp/gismaps (a DoD-issued Common Access Card [CAC] is required for access).

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Beneficiary Access to Prime

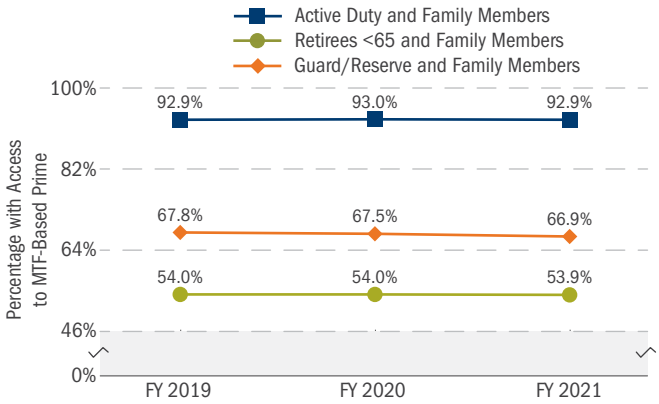
The left chart below shows the percentage of beneficiaries living in PSAs (defined only in the U.S.). The right chart below shows the percentage of the eligible population in the U.S. with access to MTF-based Prime. The latter is defined as the percentage living in both a PSA and an MTF Service Area (see the last remark below the table on page 38 for the definition of an MTF Service Area).

TREND IN ELIGIBLE POPULATION LIVING IN PSAs, FYs 2019–2021



- Between FY 2019 and FY 2021, the percentage of each beneficiary group above living in PSAs remained about the same.
- As determined by residence in an MTF PSA, access to MTF-based Prime for each beneficiary group above remained about the same from FY 2019 to FY 2021.

TREND IN ELIGIBLE POPULATION WITH ACCESS TO MTF-BASED PRIME, FYs 2019–2021



- 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.

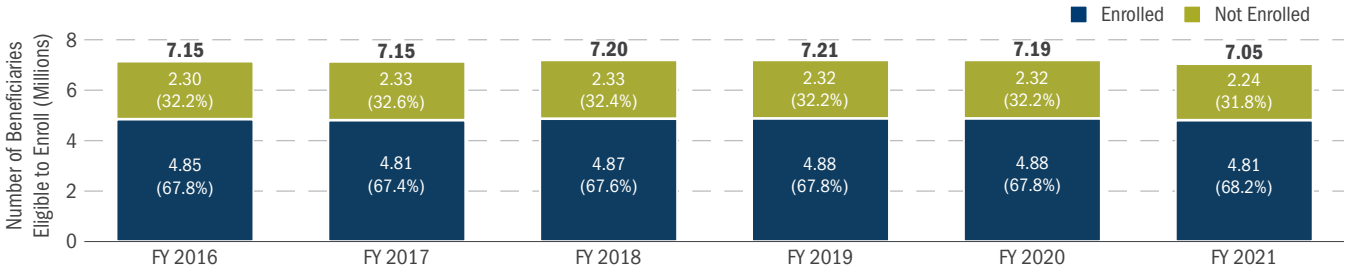
Eligibility and Enrollment in TRICARE Prime

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 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 was roughly flat between FY 2016 and FY 2020 but dropped in FY 2021. However, as a percentage of the beneficiary population, TRICARE Prime enrollment was roughly flat between FY 2016 and FY 2020, but increased slightly in FY 2021.
- By the end of FY 2021, about 68 percent of all eligible beneficiaries were enrolled (4.81 million enrolled of the 7.05 million eligible).

HISTORICAL END-YEAR PRIME ENROLLMENT NUMBERS, FYs 2016–2021



Source: DEERS, 12/24/2021

Note: Numbers may not sum to bar totals due to rounding. Detailed MHS enrollment data by state can be found on page 42.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

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

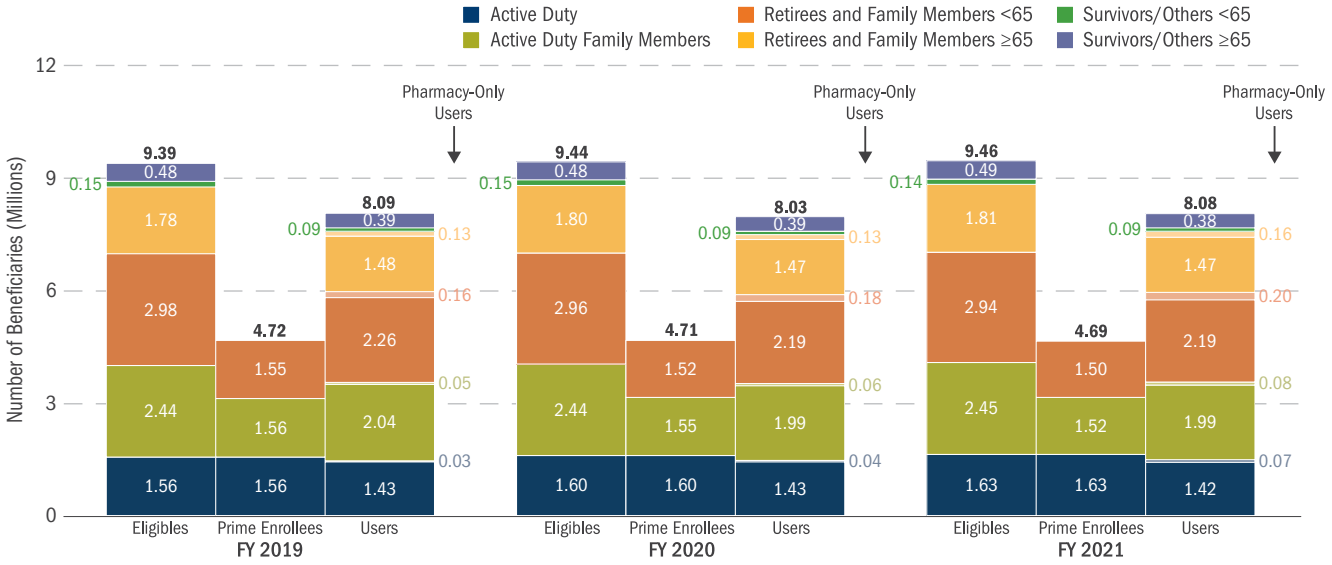
This section compares the number of users of MHS services with the numbers of eligibles and Prime enrollees. Because beneficiaries eligible for any part of the year can be users, average (rather than end-year) beneficiary counts were used for all calculations.

The average numbers of eligibles and TRICARE Prime enrollees by beneficiary category[1] from FY 2019 to FY 2021 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 Select enrollees (including TRS, TYA Select, TRR, and TRICARE Plus) 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 private sector 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 2 percent between FY 2019 and FY 2021. The number of RETFMs under age 65 declined by 1 percent, while the number of RETFMs age 65 and older increased by 2 percent. The number of survivors and others (SRV/OTHs) declined by 6 percent for those under age 65 and rose by 1 percent for those age 65 and older.[2]
- The percentage of ADFMs enrolled in TRICARE Prime declined from 64 percent in FY 2019 to 62 percent in FY 2021. The percentage of RETFMs under age 65 enrolled in Prime declined slightly from 52 percent to 51 percent and the percentage of SRV/OTHs under age 65 enrolled in Prime remained constant at 27 percent.
- The overall user rate declined slightly from 86 percent in FY 2019 to 85 percent in FY 2021. The user rate declined for each beneficiary group except RETFMs under age 65 (almost unchanged), ranging from 1 percentage point for RETFMs aged 65 and older to 2 percentage points for Active Duty members.
- 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 2019–2021



Sources: DEERS and MHS administrative data, 1/28/2022

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

[2] The percent changes are based on unrounded numbers.

Note: The bar totals reflect the average number of eligibles and Prime 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	81,752	1,371	23,147	23,734	4,642	8,175	59,698
AL	212,706	9,528	14,443	23,512	18,065	31,443	87,463
AR	85,016	5,218	6,674	8,523	4,860	8,424	28,481
AZ	213,426	9,392	24,480	28,397	16,463	28,797	98,137
CA	769,362	23,002	178,017	147,103	39,172	74,710	439,002
CO	253,214	10,481	45,520	46,598	17,940	32,934	142,992
CT	50,228	2,353	9,892	7,671	2,095	3,529	23,187
DC	22,868	652	12,554	2,981	758	840	17,133
DE	34,769	1,686	4,954	5,109	2,662	4,003	16,728
FL	744,336	25,083	79,784	89,956	62,226	103,331	335,297
GA	444,814	16,192	77,780	74,172	37,333	65,066	254,351
HI	149,673	2,006	45,849	45,186	5,206	8,841	105,082
IA	49,622	4,771	3,149	3,726	762	1,585	9,222
ID	57,672	4,314	4,997	6,055	3,092	5,789	19,933
IL	154,160	9,243	29,408	18,432	8,590	14,863	71,293
IN	97,420	9,529	5,627	8,403	4,317	8,419	26,766
KS	120,503	5,670	25,341	25,673	6,303	12,168	69,485
KY	149,150	6,329	39,747	22,097	7,586	13,484	82,914
LA	125,184	6,037	22,882	20,722	6,662	12,017	62,283
MA	70,115	5,991	7,047	7,779	6,038	9,146	30,010
MD	244,805	8,262	40,206	47,202	27,802	41,125	156,335
ME	39,894	2,051	2,095	3,640	7,266	10,382	23,383
MI	103,635	6,507	5,728	7,599	3,637	6,284	23,248
MN	72,931	9,643	5,756	4,410	118	275	10,559
MO	159,835	11,503	20,983	19,795	8,367	15,633	64,778
MS	112,307	6,255	15,369	13,186	6,117	10,235	44,907
MT	38,291	2,316	4,476	4,393	928	1,753	11,550
NC	511,075	15,043	106,642	100,422	28,135	49,502	284,701
ND	34,031	2,001	9,045	7,585	1,164	1,981	19,775
NE	61,703	4,348	7,882	8,631	3,635	6,699	26,847
NH	32,435	1,673	2,845	2,596	4,689	6,868	16,998
NJ	85,698	5,594	12,886	14,732	5,154	8,984	41,756
NM	82,203	2,041	14,391	13,984	5,531	9,160	43,066
NV	110,011	3,945	14,517	14,936	8,320	13,666	51,439
NY	177,589	7,405	31,898	30,320	9,625	16,614	88,457
OH	174,598	13,556	13,096	15,470	7,261	13,015	48,842
OK	156,167	6,749	26,397	24,240	10,616	19,232	80,485
OR	69,213	3,314	5,592	4,357	757	1,355	12,061
PA	165,967	10,586	9,219	12,265	7,733	13,357	42,574
RI	25,161	1,193	4,844	3,788	1,503	2,411	12,546
SC	252,943	10,647	43,648	32,220	16,596	28,402	120,866
SD	36,384	4,184	4,492	4,761	1,418	2,479	13,150
TN	205,506	11,819	8,019	25,911	11,346	20,361	65,637
TX	926,849	36,838	135,007	143,019	80,510	149,080	507,616
UT	80,390	9,824	7,954	11,384	4,653	9,415	33,406
VA	740,701	15,400	137,854	139,380	54,069	86,843	418,146
VT	14,738	811	2,021	1,679	1,351	2,003	7,054
WA	348,694	8,150	69,250	66,884	26,470	45,006	207,610
WI	77,716	8,097	4,499	5,271	1,079	1,974	12,823
WV	37,409	2,513	2,830	2,263	1,065	1,665	7,823
WY	24,341	1,775	4,027	4,100	1,243	2,026	11,396
Subtotal	**9,089,210**	**392,891**	**1,434,760**	**1,406,252**	**602,930**	**1,045,349**	**4,489,291**
Overseas	**528,807**	**2,818**	**195,534**	**108,098**	**366**	**12,560**	**316,558**
Total	**9,618,017**	**395,709**	**1,630,294**	**1,514,350**	**603,296**	**1,057,909**	**4,805,849**

Source: MHS administrative data systems, as of 12/24/2021 for end of FY 2021

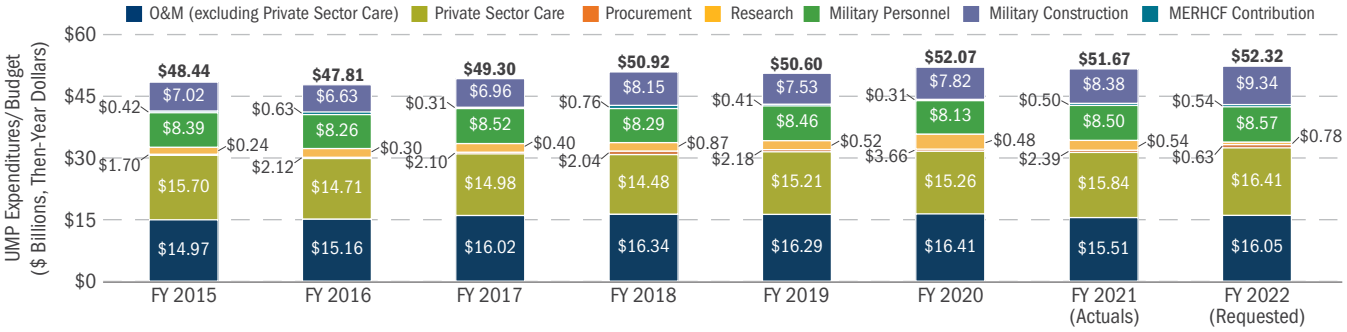
Note: Prime Enrolled includes Prime (MTF and network PCMs), TRICARE Prime Remote (and Overseas equivalent), TYA Prime, and USFHP; and excludes members in TRICARE Select, TYA Select, TRS, TRR, TRICARE Plus, and TFL.

UNIFIED MEDICAL PROGRAM FUNDING

The Defense Department's FY 2022 budget request for health care services was $52.3 billion. In nominal terms, this is about 1.3 percent higher than the estimated $51.7 billion FY 2021 expenditures.

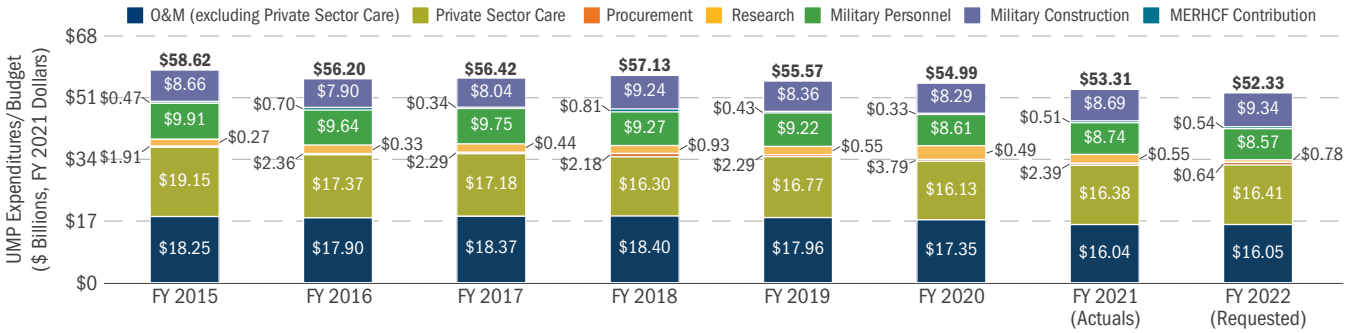
The FY 2022 budget request has three components. First, it is the direct appropriation to the Defense Health Program (DHP), which includes operations and maintenance (O&M); procurement; and research, development, test, and evaluation (RDT&E) funding, totaling $35.6 billion. The second is comprised of transfers from DoD, including military personnel and military construction, totaling $9.1 billion. 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 private sector 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 fund out of DoD personnel accounts. The FY 2022 contribution has been set at $9.3 billion.

UMP FUNDING AND TRUST FUND CONTRIBUTIONS ($ BILLIONS) IN CURRENT (THEN-YEAR) DOLLARS, FYs 2015–2022



Using constant dollars, the FY 2022 request is about $6.3 billion (11 percent) less than real FY 2015 expenditures.

UMP FUNDING AND TRUST FUND CONTRIBUTIONS ($ BILLIONS) IN CONSTANT 2021 DOLLARS, FYs 2015–2022



Source: UMP cost and budget estimates, DHA/Resources Management Directorate (J-8)/Budget & Execution Division, 11/30/2021

Notes:

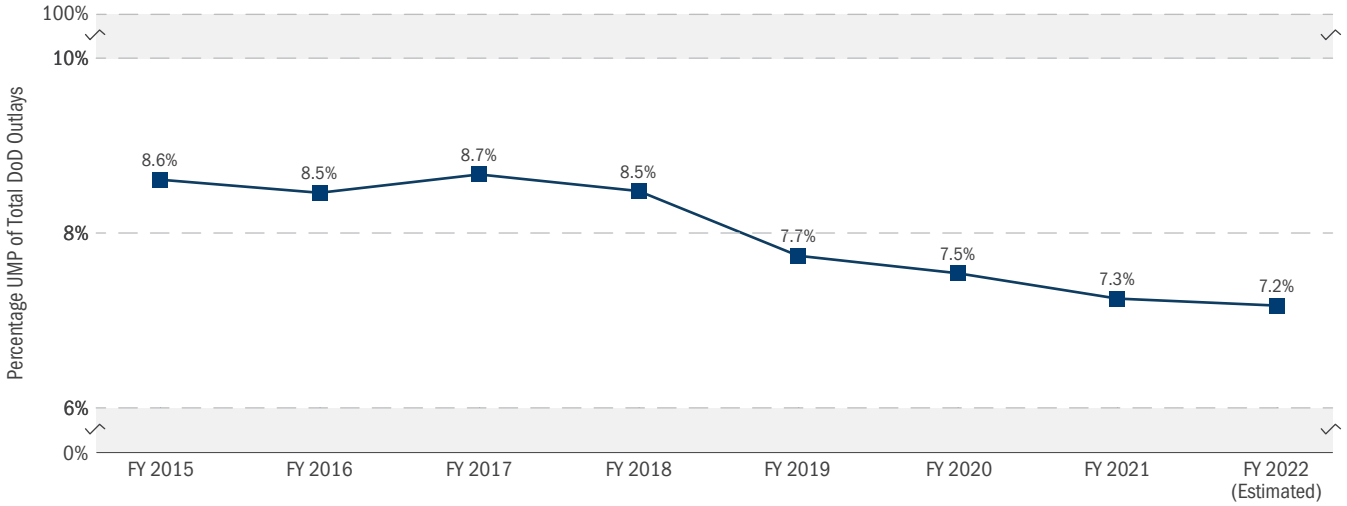
- FYs 2015–2021 reflect Comptroller Information System actual execution.
- FY 2022 reflects the DHP President's Budget Request.
- Source of data for deflators (MILPER, DHP, Procurement, RDT&E, and MILCON) is Table 5-5, Department of Defense Deflators—TOA by Category–TOA, National Defense Budget Estimates for FY 2022 (Green Book).
- Medicare Eligible Retiree Healthcare Fund Deflator computed using a combination of MILPER (5 percent) and DHP factors (95 percent).
- FY 2015 actuals include $344.645M for Overseas Contingency Operations (OCO).
- FY 2016 actuals include $285.032M for OCO.
- FY 2017 actuals include $332.603M for OCO.
- FY 2018 actuals include $405.856M for OCO.
- FY 2019 actuals include $349.422M for OCO.
- FY 2020 includes $2.503B CARES Act Supplemental and $347.746M OCO supplemental funding enacted for O&M.
- FY 2021 actuals includes $354.322M OCO supplemental funding execution. It also includes $663M reprogrammed into O&M.
- FY 2022 estimate includes $251.851M for Direct War costs and $429.415M for enduring COVID-19 requirements.

UNIFIED MEDICAL PROGRAM FUNDING *(CONT.)*

UMP Share of Defense Budget

The UMP funding share of total DoD expenditures has declined for four consecutive years and is below FY 2015 levels.

UMP EXPENDITURES AS A PERCENTAGE OF TOTAL DoD OUTLAYS, FYs 2015–2022 (EST.)

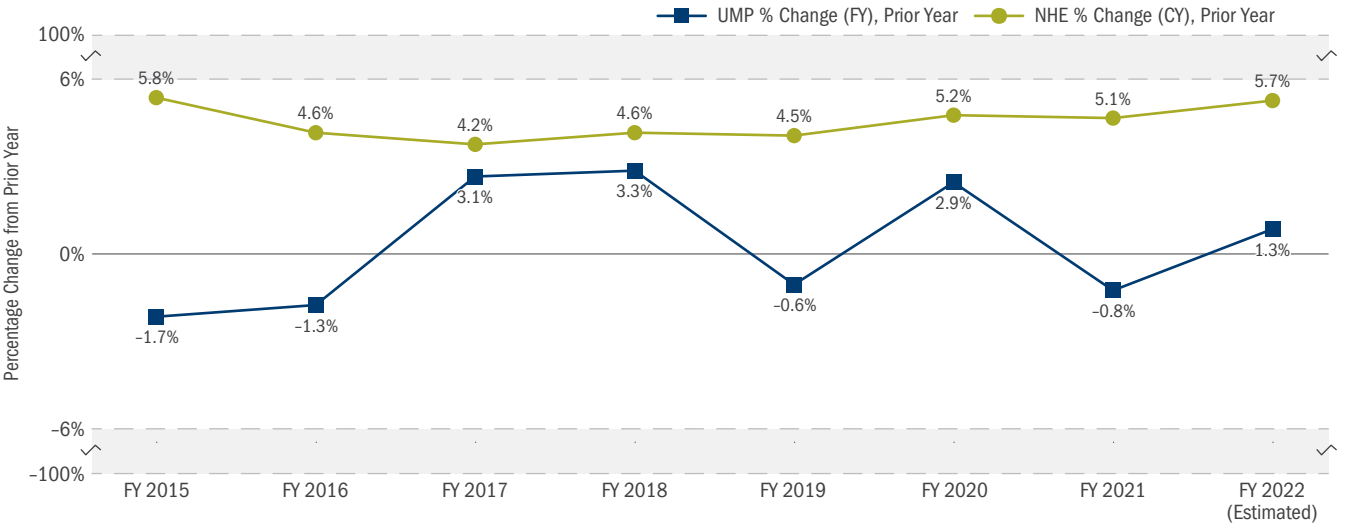


Source: UMP cost and budget estimates, DHA/Resources and Management Directorate (J-8)/Budget and Execution Division, 11/30/2021
Note: Percentages are estimates of total DoD outlays reflected in the FY 2021 President's Budget.

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 1.3 percent projected in FY 2022. By comparison, the NHE series compiled by the Centers for Medicare & Medicaid Services (CMS) has been growing at about 5.0 percent year-over-year for the same period.

COMPARISON OF CHANGE IN ANNUAL UMP (INCLUDING TRUST FUND OUTLAYS) AND NHE ESTIMATED EXPENDITURES OVER TIME (UNADJUSTED, THEN-YEAR DOLLARS): 2015–2022 (EST.)



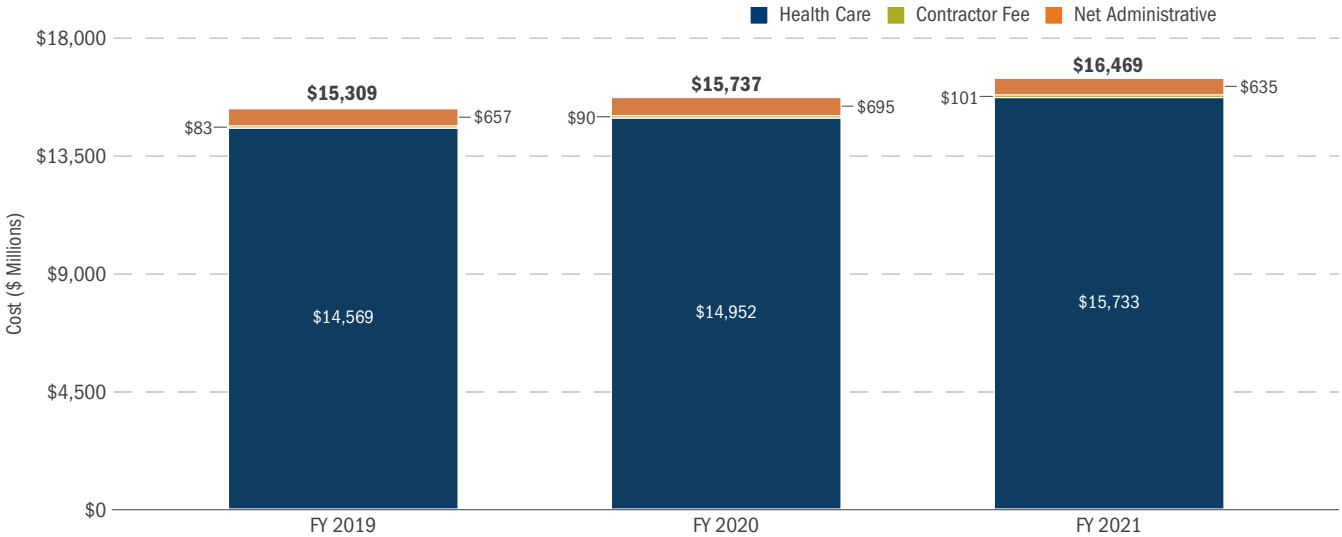
Source: UMP cost and budget estimates, DHA/Resources and Management Directorate (J-8)/Budget and Execution Division, 11/30/2021, using NHE data from CMS, Office of the Actuary, NHE Projections 2019–2028, Tables Table 02, National Health Expenditure Amounts and Annual Percent Change by Type of Expenditure: Calendar Years 2012–2028; https://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 increased from $15,309 million in FY 2019 to $16,469 million (8 percent) in FY 2021. Costs increased by 3 percent in FY 2020 and by another 5 percent in FY 2021.
- On January 1, 2018, DHA began collecting Prime enrollment fees that were previously held by the contractors to offset their administrative costs. DHA collected $307 million in Prime enrollment fees in FY 2019, and $293 million in FY 2020.
- On January 1, 2021, DHA began collecting Select enrollment fees as well for Group A retirees (those whose initial enlistment or appointment or that of the uniformed services sponsor began before January 1, 2018). As a result, DHA saw a $70 million increase in its enrollment fee collections to $363 million in FY 2021. Net of Prime/Select enrollment fees, PSC administrative costs increased by 6 percent in FY 2020 but decreased by 9 percent in FY 2021.
- Excluding contractor fees, net administrative expenses decreased from 4.3 percent of total PSC costs in FY 2019 ($657 million of $15,226 million) to 3.9 percent in FY 2021 ($635 million of $16,368 million). Including contractor fees (in both administrative and total costs), net administrative expenses decreased from 4.8 percent of total PSC costs in FY 2019 ($740 million of $15,309 million) to 4.5 percent in FY 2021 ($736 million of $16,469 million).
- Contractor fees increased by 22 percent between FY 2019 and FY 2021, although they remain less than 1 percent of total PSC costs.

TRENDS IN PRIVATE SECTOR CARE COSTS, FYs 2019–2021



Source: DHA/Resources & Management (J-1/J-8)/CRM (Administrative Costs), 1/5/2022

[1] DHA has congressional authority to carry over 1 percent of its O&M funding into the following year. The amount carried forward from the prior-year appropriation was $315 million in FY 2019, nothing in FY 2020, and $313 million in FY 2021.

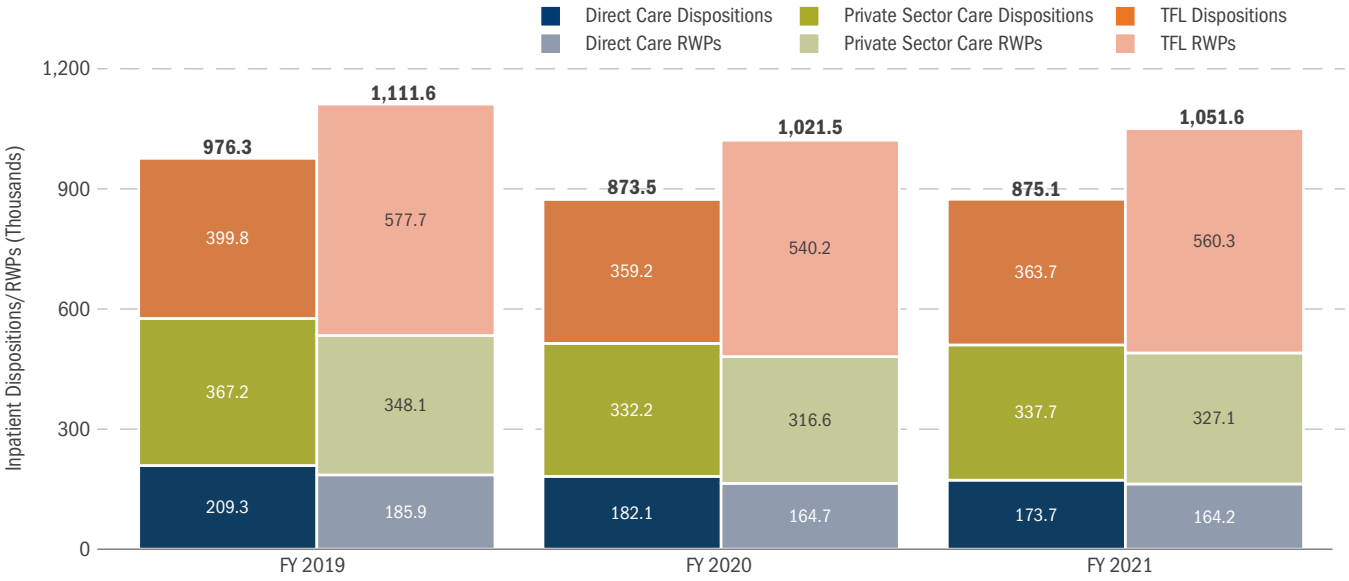
MHS WORKLOAD TRENDS (DIRECT AND PRIVATE SECTOR CARE)

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 private sector care combined) declined by 11 percent and RWPs by 8 percent between FY 2019 and FY 2021, excluding the effect of TFL. Possible reasons for the large drop in total dispositions are the downsizing of four MHS hospitals to clinics and the impact of the COVID-19 pandemic.[1]
- Direct care inpatient dispositions decreased by 17 percent and RWPs by 12 percent over the past three years. Possible reasons for the large drop in direct care dispositions is the downsizing of four MHS hospitals to clinics and the impact of the COVID-19 pandemic.
- Excluding TFL workload,[2] private sector care inpatient dispositions decreased by 8 percent, while RWPs decreased by 6 percent between FY 2019 and FY 2021.
- Including TFL workload, private sector care dispositions decreased by 9 percent, while RWPs decreased by 4 percent between FY 2019 and FY 2021.
- Although not shown, about 10 percent of direct care inpatient workload (dispositions) was performed abroad in FY 2021. Private sector care and TFL inpatient workload performed abroad accounted for about 2 percent of the worldwide total.

TRENDS IN MHS INPATIENT WORKLOAD, FYs 2019–2021



Source: MHS administrative data, 1/24/2022

[1] John D. Birkmeyer, Amber Barnato, Nancy Birkmeyer, Robert Bessler, and Jonathan Skinner, "The Impact of the COVID-19 Pandemic on Hospital Admissions in the United States," Health Affairs 2020 39:11, https://doi.org/10.1377/hlthaff.2020.00980.

[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.

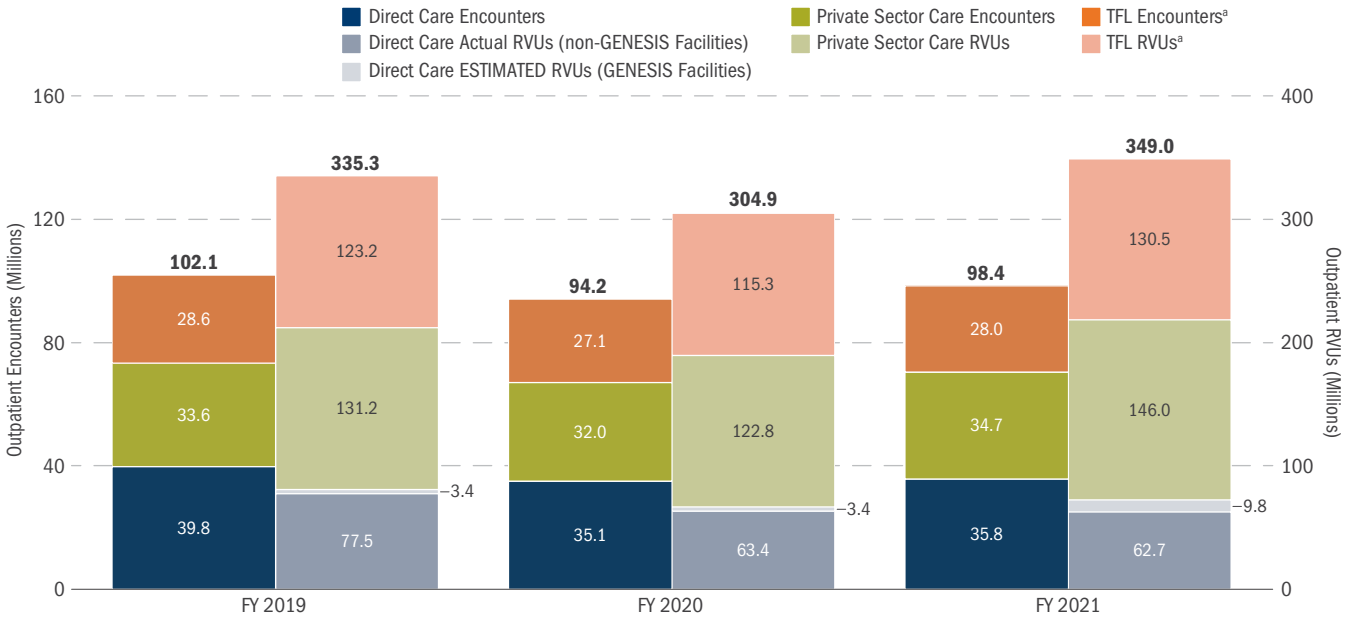
MHS WORKLOAD TRENDS (DIRECT AND PRIVATE SECTOR CARE) *(CONT.)*

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 private sector 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.) Note that direct care RVUs at non-GENESIS facilities are actuals, whereas RVUs at GENESIS facilities are estimates.

- Total outpatient encounters (direct and private sector care combined) decreased by 4 percent, while RVUs increased by 3 percent between FY 2019 and FY 2021, excluding the effect of TFL. One possible reason for the large drop in total encounters is the impact of the COVID-19 pandemic.[1]
- Direct care outpatient encounters and RVUs each decreased by 10 percent[1] over the past three years. The large drop is partially due to the impact of COVID-19.
- Excluding TFL workload, private sector care outpatient encounters increased by 3 percent and RVUs by 11 percent. Including TFL workload, private sector care outpatient encounters increased by 1 percent and RVUs by 9 percent.[2]
- Although not shown, about 9 percent of direct care outpatient workload (encounters) was performed abroad. Private sector care and TFL outpatient workload performed abroad accounted for less than 1 percent of the worldwide total.

TRENDS IN MHS OUTPATIENT WORKLOAD, FYs 2019–2021



Source: MHS administrative data, 1/28/2022

[a] Private sector care only

[1] COVID-19 Shocks the U.S. Health Sector: A Review of Early Economic Impacts, Health Affairs Blog, December 16, 2020. https://www.healthaffairs.org/do/10.1377/hblog20201214.543463/full/.

[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.

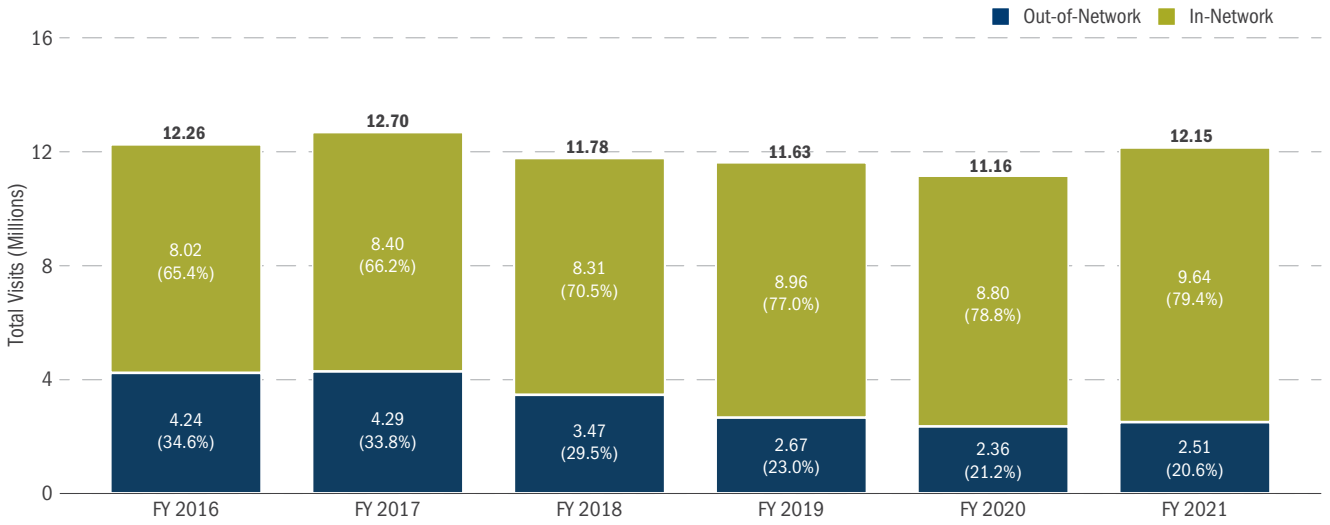
Note: Numbers may not sum to bar totals due to rounding.

MHS WORKLOAD TRENDS (DIRECT AND PRIVATE SECTOR CARE) *(CONT.)*

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 steadily increased. 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 2021, 79 percent of all non-Prime visits were to in-network providers. One likely reason for the increasing use of in-network providers is the expansion of the TRICARE provider network (see page 172).

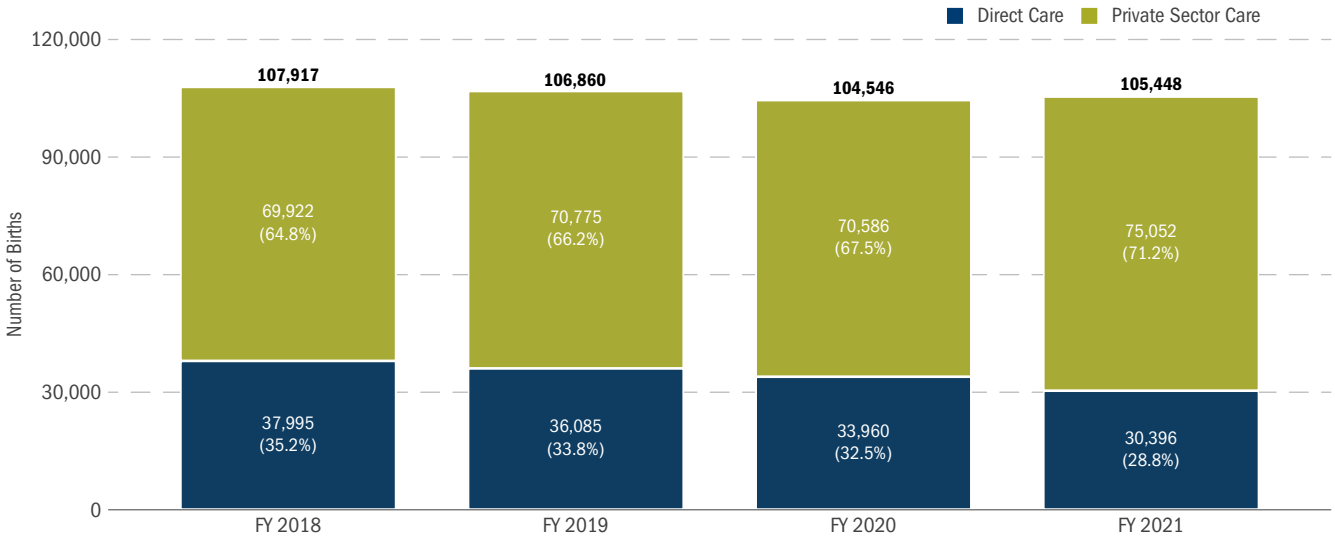
TRENDS IN OUT-OF-NETWORK VS. IN-NETWORK VISITS, FYs 2016–2021



MTF Market Share for Childbirths

Overall MTF obstetric market share decreased from 35 percent to 29 percent between FY 2018 and FY 2021. 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 36) and the downsizing of four MTF hospitals to clinics during that time period. In FY 2021, individual MTF shares in the U.S. ranged from 15 percent to 97 percent.

TRENDS IN MTF MARKET SHARE FOR CHILDBIRTHS, FYs 2018–2021



Source: MHS administrative data, 1/24/2022

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

MHS WORKLOAD TRENDS (DIRECT AND PRIVATE SECTOR CARE) *(CONT.)*

Urgent Care (UC) Utilization

The National Defense Authorization Act (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 115 percent from FY 2018 to FY 2021, while RVUs increased by 160 percent (FY 2018 not shown).
- The government share of the cost for UC increased by $132 million (200 percent) from FY 2018 to FY 2021 (FY 2018 not shown).
- UC utilization and costs increased steadily from FY 2017 to FY 2019 but leveled off in FY 2020. However, they rose again in FY 2021 (21 percent for encounters, 43 percent for RVUs, and 59 percent for government costs).
- ADFMs with an MTF PCM constitute by far the largest share of total UC utilization and government cost.

TRENDS IN UC UTILIZATION, FYs 2019–2021

BENEFICIARY CATEGORY	ENROLLMENT STATUS	FY	ENCOUNTERS	RVUs	GOVERNMENT COST
Active Duty	All	2019	115,280	314,234	$13,616,781
		2020	127,636	334,007	$14,710,122
		2021	228,221	698,691	$31,482,061
Active Duty Family Members	MTF PCM	2019	367,152	940,620	$39,082,203
		2020	314,311	811,328	$33,961,318
		2021	303,236	920,813	$39,248,154
	Network PCM	2019	134,914	343,261	$14,704,654
		2020	143,098	369,099	$15,980,795
		2021	166,025	506,553	$22,304,127
	Non-Enrolled	2019	239,553	608,382	$17,122,609
		2020	238,258	609,572	$18,351,689
		2021	289,127	871,810	$31,702,576
Retirees and Family Members <65	MTF PCM	2019	162,781	426,106	$12,836,445
		2020	157,741	402,640	$12,575,541
		2021	190,584	568,565	$20,740,381
	Network PCM	2019	155,720	407,238	$12,697,654
		2020	174,314	449,582	$14,810,077
		2021	225,953	687,481	$25,971,330
	Non-Enrolled	2019	218,565	553,686	$12,539,020
		2020	219,365	556,037	$13,657,789
		2021	263,522	784,810	$25,874,101
Retirees and Family Members ≥65	All	2019	299	660	$133,229
		2020	262	572	$234,920
		2021	412	1,033	$198,670
Total	**All**	**2019**	**1,394,264**	**3,594,186**	**$122,732,595**
		2020	**1,374,985**	**3,532,836**	**$124,282,251**
		2021	**1,667,080**	**5,039,757**	**$197,521,400**

Source: MHS administrative data, 1/24/2022

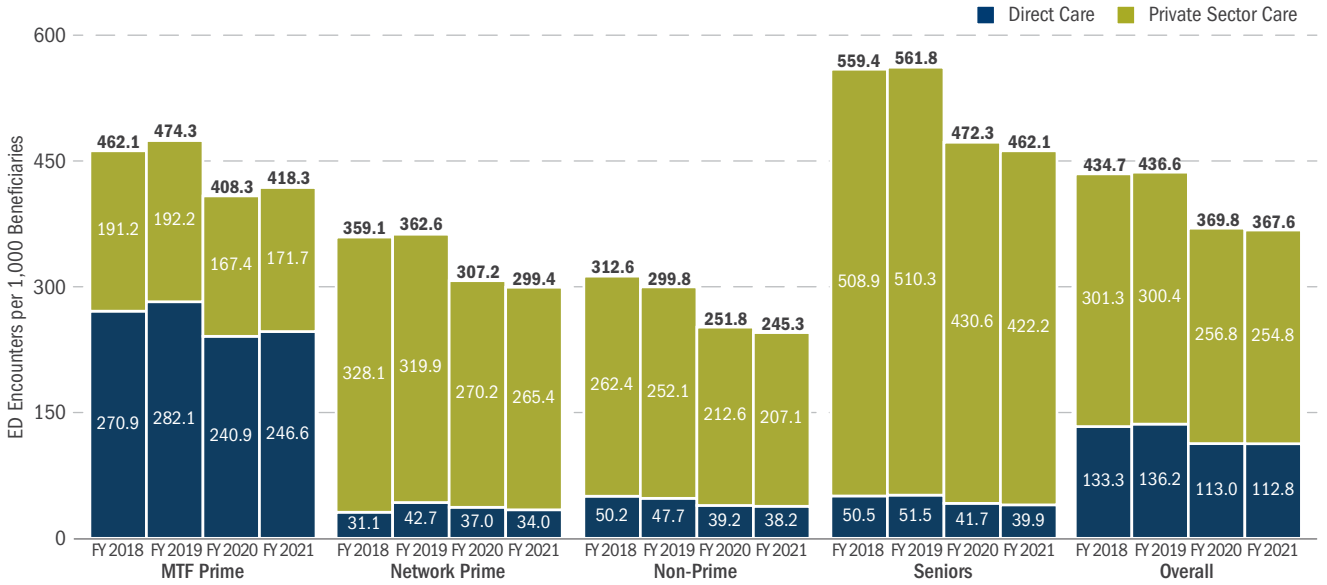
MHS WORKLOAD TRENDS (DIRECT AND PRIVATE SECTOR CARE) *(CONT.)*

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 excessively use EDs as a source of care if they cannot get timely access to their PCMs under the normal appointment process. To provide a preliminary evaluation of this issue, direct and private sector 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. Seniors (age ≥65) are broken out separately for completeness, but they are not compared with the three enrollment groups.

- ED utilization per capita declined for Prime enrollees from FY 2018 to FY 2021 (9 percent for MTF enrollees and 17 percent for network enrollees). The rate for non-Prime enrollees declined by 22 percent over the same time period. One possible reason for the decline is increased access to urgent care by TRICARE beneficiaries (see page 49).
- In FY 2021, MTF Prime enrollees had an ED utilization rate 40 percent higher than that of network Prime enrollees and 71 percent higher than that of non-enrollees. Network Prime enrollees had an ED utilization rate 22 percent higher than that of non-enrollees.
- For MTF Prime enrollees, 41 percent of ED encounters were in private sector care facilities (not necessarily in-network) in FY 2021.
- Children under five years old had the highest ED utilization rate for all enrollment groups (not shown).
- The FY 2021 MHS rate of 368 encounters per 1,000 beneficiaries is 10 percent lower than the civilian rate of 409 per 1,000 reported in CY 2018, the most recent year for which data are available.[2] One likely reason for the sudden drop in MHS ED encounters in FYs 2020 and 2021 is the impact of the COVID-19 pandemic.[3,4] The civilian rate is considerably higher than the MHS rate at least partly because the former was calculated prior to the pandemic.

ED UTILIZATION BY ENROLLMENT STATUS AND SOURCE OF CARE (ENCOUNTERS PER 1,000 BENEFICIARIES), FYs 2018–2021



Source: MHS administrative data, 1/24/2022

[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: 2018 Emergency Department Summary Tables," Table 2, https://www.cdc.gov/nchs/data/nhamcs/web_tables/2018-ed-web-tables-508.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.

[3] CDC, "Impact of the COVID-19 Pandemic on Emergency Department Visits — United States, January 1, 2019–May 30, 2020." MMWR Morb Mortal Wkly Rep 2020; 69:699–704.

[4] CDC, "Update: COVID-19 Pandemic–Associated Changes in Emergency Department Visits — United States, December 2020–January 2021." MMWR Morb Mortal Wkly Rep 2021; 70:552–556.

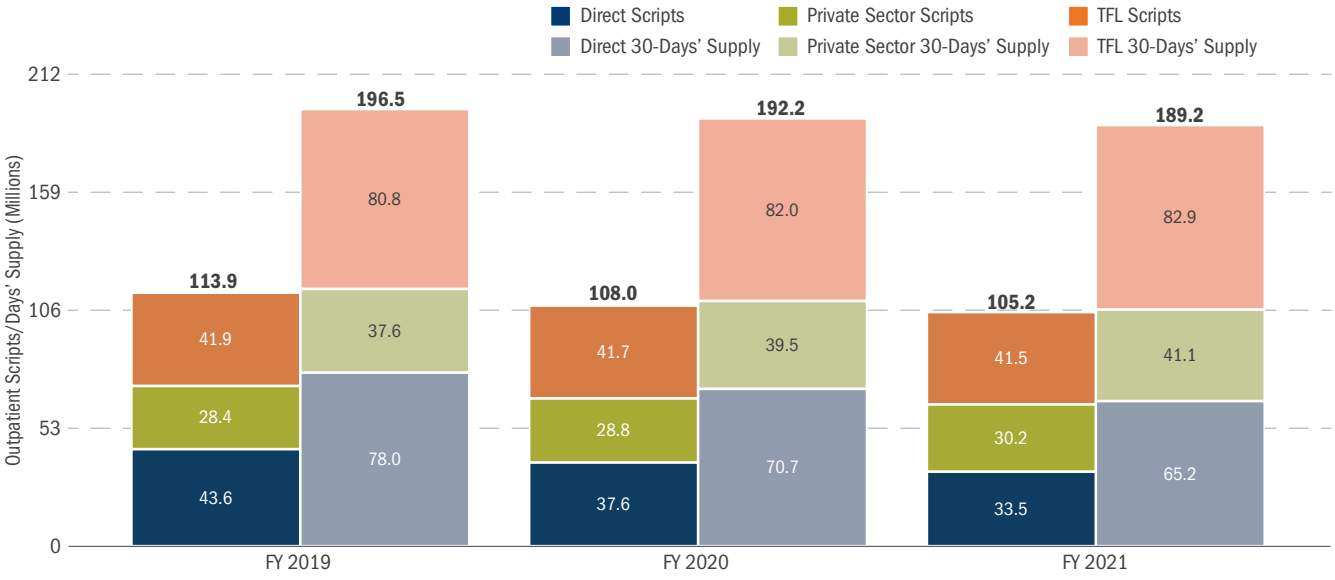
Note: Numbers may not sum to bar totals due to rounding.

MHS WORKLOAD TRENDS (DIRECT AND PRIVATE SECTOR CARE) *(CONT.)*

MHS Prescription Drug Workload

TRICARE beneficiaries can fill prescription medications at MTF and private sector care pharmacies (including retail network and non-network pharmacies and through home delivery). 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 2019 and FY 2021 (prescriptions fell by 11 percent and days' supply by 8 percent), excluding the effect of TFL private sector care pharmacy usage.

TRENDS IN MHS PRESCRIPTION WORKLOAD, FYs 2019–2021



Source: MHS administrative data, 1/24/2022
Note: Numbers may not sum to bar totals due to rounding.

- Direct care prescriptions decreased by 23 percent, while days' supply declined by 16 percent between FY 2019 and FY 2021.
- Private sector care prescriptions (retail and home delivery combined) increased by 6 percent and days' supply by 9 percent from FY 2019 to FY 2021, excluding TFL utilization. Including TFL utilization, private sector care prescriptions increased by 2 percent and days' supply by 5 percent.
- Although not shown, about 7 percent of direct care prescriptions were issued abroad in FY 2021. Private sector care prescriptions issued abroad accounted for 2 percent of the worldwide total.

MHS WORKLOAD TRENDS (DIRECT AND PRIVATE SECTOR CARE) *(CONT.)*

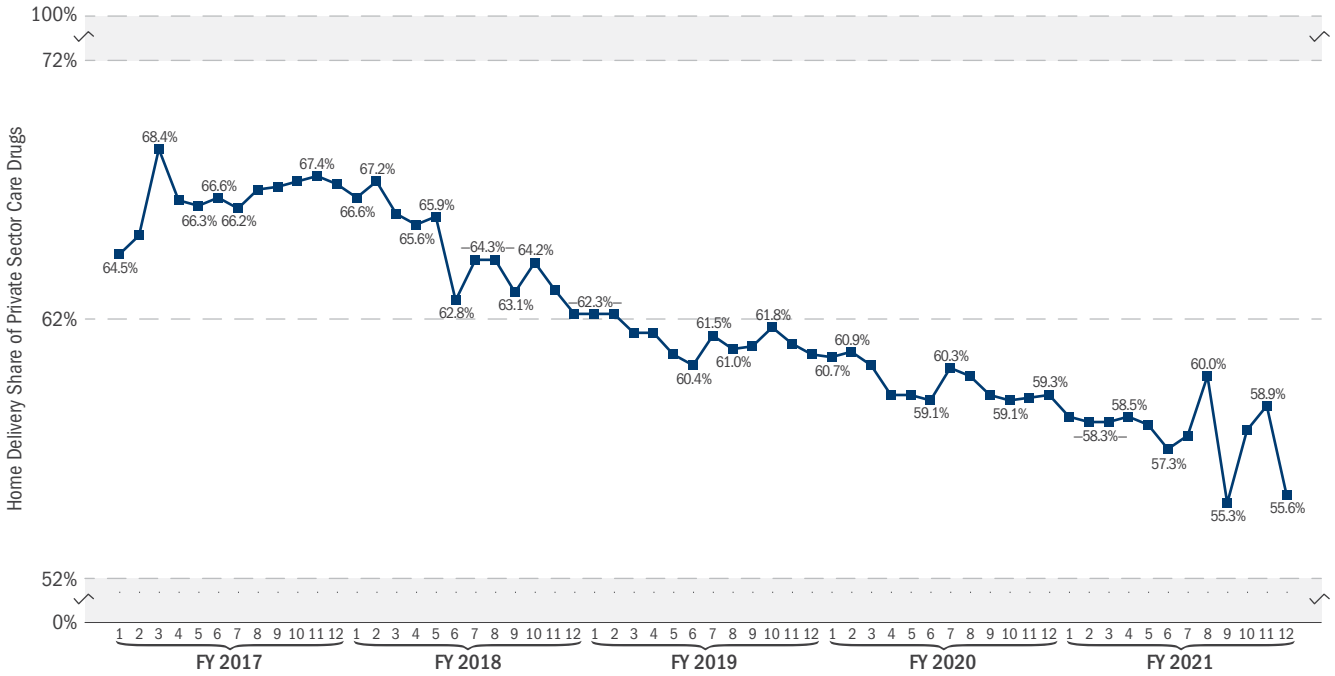
MHS Prescription Drug Workload *(cont.)*

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.

The NDAA for FY 2015 mandated that beneficiaries obtain refills for select non-generic maintenance medications from the TRICARE home delivery program or MTF pharmacies.

The home delivery share of total private sector 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 2016 to FY 2017, the home delivery share of private sector care pharmacy utilization (as measured by days' supply) increased from 63 percent to 67 percent (not shown).[1] However, in FY 2018, the home delivery copayment for a 90-day supply of generic formulary drugs rose from $0 to $7 and then to $10 in FY 2020 (it remained the same in FY 2021), which reduced the disparity in copayments between home delivery and retail drugs. This likely contributed to the decrease in the home delivery share of total private sector care utilization in FY 2018 (65 percent), FY 2019 (61 percent), FY 2020 (60 percent), and FY 2021 (58 percent). Another possible explanation for the decline in the home delivery share is that because the copayment for retail generic drugs is the lower of the statute copayment and the actual government cost (after rebates), the average retail generic drug copayment is less than that for home delivery drugs (albeit for a lower average days' supply).

TREND IN HOME DELIVERY UTILIZATION (DAYS' SUPPLY) AS A SHARE OF TOTAL PRIVATE SECTOR CARE UTILIZATION, FYs 2017–2021



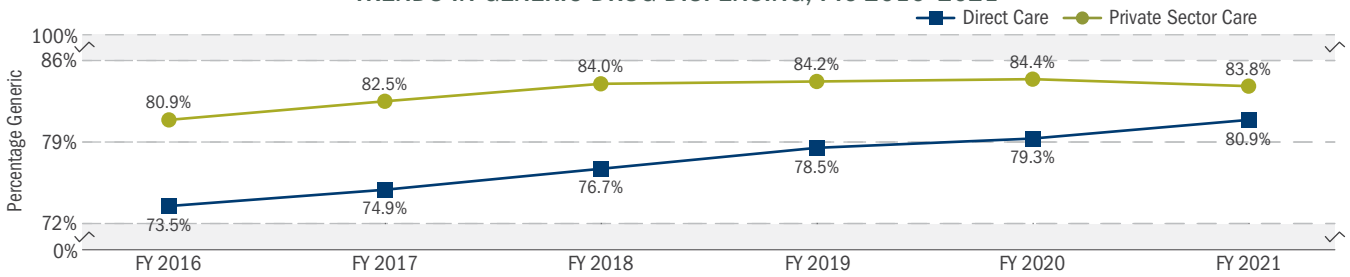
Source: MHS administrative data, 1/24/2022

[1] All the percentages reported in this paragraph are based on annual averages, not end-year numbers.

COST SAVINGS EFFORTS IN DRUG DISPENSING

- The rate of generic drug dispensing has been increasing for both direct and private sector care pharmacies. Direct care pharmacies have seen the larger increase, from 73 percent in FY 2016 to 81 percent in FY 2021. The PSC generic dispensing rate has been trending upward as well (from 81 percent to 84 percent) but at a slower rate and even dipped slightly in FY 2021. By FY 2021, the gap in the generic dispensing rate between direct and PSC pharmacies had narrowed to only 3 percentage points.
- The direct and PSC generic drug dispensing rates in FY 2021 were both lower than that of the civilian sector (90 percent).[1,2]
- The average cost to the DoD for a 30-day supply of a brand versus generic drug in FY 2021 was $89 versus $15 for direct care and $258 (net of manufacturer refunds) versus $7 for private sector care (costs are not adjusted for differences in drug types between brand and generic or pharmacy source system). 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 2016–2021

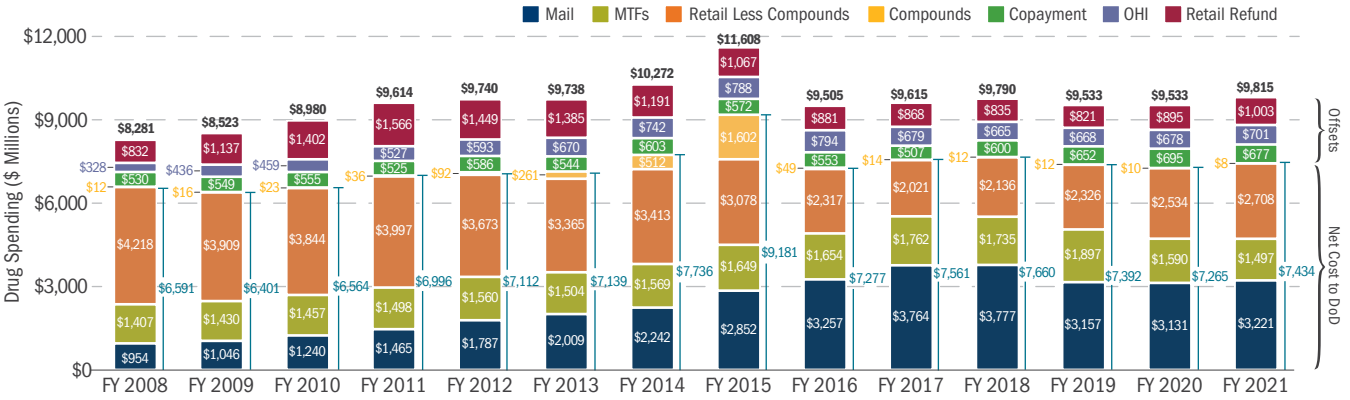


Source: MHS administrative data, 1/24/2022

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 2021, the refunds are estimated to have saved the DoD $1 billion. 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. After the DoD was able to control compound drug prices, net DoD costs fell by 21 percent in FY 2016 and have increased only slightly since then.

MHS OUTPATIENT DRUG SPENDING, FYs 2008–2021



Source: Pharmacy Data Transaction Service (PDTS) Data Warehouse, 2/17/2022; DHA Pharmacy Operations Division (refunds), 2/14/2022

[1] Association for Accessible Medicines, "The U.S. Generic & Biosimilar Medicines Savings Report," October 2021, https://accessiblemeds.org/sites/default/files/2021-10/AAM-2021-US-Generic-Biosimilar-Medicines-Savings-Report-web.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.

Notes:

– Net cost to DoD represents total prescription expenditures minus copayments, OHI, and retail refunds invoiced.
– Mail Order dispensing fees are included; however, other retail/mail contract costs and MTF cost of dispensing are not included.
– Retail refunds reported on an accrual rather than a cash basis, based on original prescription claim data and updated refund adjustments.
– Retail compound spending is not adjusted for any recoveries or settlements with compound pharmacies outside of claims reversals.
– Numbers may not sum to bar totals due to rounding.

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 were at a high with 213 existing contracts, of which 58 became effective in FY 2021. There are currently 13 joint contracts pending at the National Acquisition Center and 16 pending at the Defense Logistics Agency. The DoD/VA pharmacy team identified 38 commonly used pharmaceutical products and manufacturers for potential joint contracting action and continues to seek new joint contracting opportunities where possible. In FY 2021, the VA spent $490 million on joint national contracts, and the DoD spent $169 million over the same period.

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 DoD Pharmacy & Therapeutics (P&T) committee are oncological agents, targeted immunological biologics, multiple sclerosis agents, antiretroviral agents, and pulmonary arterial hypertension agents. The DoD P&T committee continually reviews new specialty medications as part of its new drug review process, with a particular focus on the large number of new oncological agents being introduced to the market.

TOP 20 SPECIALTY CLASSES ($ MILLIONS), AS DEFINED BY P&T COMMITTEE, FYs 2019–2021

FY 2020 RANK	SPECIALTY CLASS	FY 2019	FY 2020	FY 2021	FYs 2020–2021 % CHANGE[a]
1	Oncological	$705	$835	$919	10%
2	Targeted Immunomod Biologics	$529	$619	$676	9%
3	Multiple Sclerosis	$183	$178	$152	–15%
4	Leukemia and Lymphoma	$101	$126	$144	14%
5	Antiretrovirals	$137	$143	$139	–3%
6	Pulmonary Arterial Hypertension	$119	$130	$134	3%
7	Respiratory Interleukins	$58	$94	$134	42%
8	Breast Caner Agents	$88	$102	$116	14%
9	Immunological Misc	$68	$93	$108	16%
10	Cystic Fibrosis	$54	$99	$100	1%
11	Neurological Misc (e.g., botulinum toxin, VMAT2s)	$24	$51	$74	46%
12	Pulmonary-1 (e.g., nintedanib, pirfenidone)	$55	$60	$69	15%
13	Antihemophilic Factors	$68	$66	$60	–8%
14	Sleep Disorders	$50	$63	$55	–12%
15	Metabolic Misc (e.g., asfotase alfa, sapropterin)	$36	$46	$50	8%
16	Corticosteroid-Immune Modulators	$43	$43	$44	3%
17	Hematological	$27	$34	$40	17%
18	Endocrine Misc (e.g., cinacalcet, deferasirox)	$38	$34	$33	–4%
19	Gastrointestinal-2	$22	$30	$33	12%
20	Osteoporosis	$36	$30	$26	–12%

Source: PDTS Data Warehouse, 2/16/2022

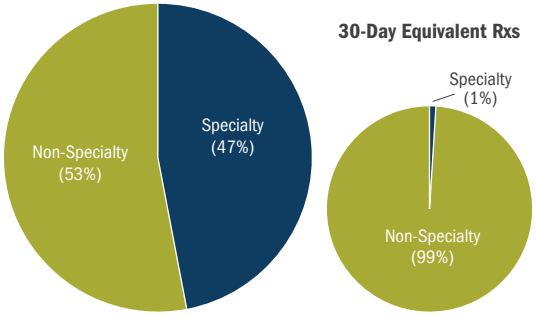
[a] The percentage changes are based on the original unrounded numbers.

Note: FY 2021 Q4 Specialty Agent Reporting List applied to all data; total costs adjusted for retail refunds, MTF prime vendor (PV) cost per unit, and home delivery PV cost per unit.

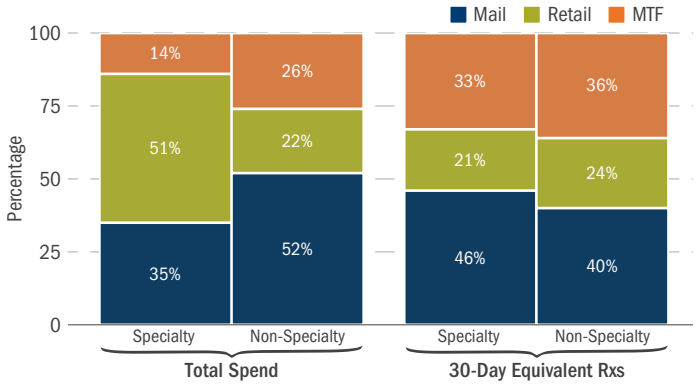
SPECIALTY DRUG COST TRENDS *(CONT.)*

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

FY 2021 TOTAL SPENDING



FY 2021 TOTAL SPENDING BY POINT OF SERVICE



Source: PDTS Data Warehouse, 2/16/2022

TOTAL ESTIMATED SPENDING ($ MILLIONS) BY QUARTER, FYs 2018–2021

	FY 2018				FY 2019				FY 2020				FY 2021			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Non-Specialty	$1,084	$1,090	$1,087	$1,061	$1,058	$1,126	$1,130	$1,128	$1,050	$980	$899	$982	$1,008	$949	$954	$948
Specialty	$551	$592	$596	$621	$612	$665	$685	$729	$739	$794	$788	$828	$819	$825	$853	$872
Percentage Specialty[a]	33.7%	35.2%	35.4%	36.9%	36.7%	37.1%	37.7%	39.3%	41.3%	44.8%	46.7%	45.7%	44.8%	46.5%	47.2%	47.9%

Source: As of 2/16/2022; based on Specialty Agent Reporting List for applicable quarters; totals adjusted for retail refunds, copayments, and against PV cost per unit for MTF and home delivery drugs.

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

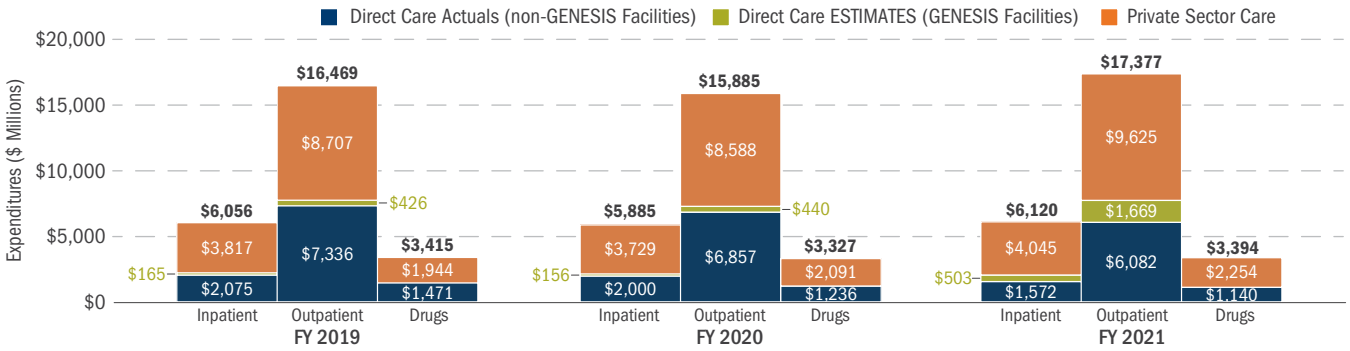
- In FY 2021, specialty drugs accounted for less than 1 percent of total MHS prescription drug utilization (30-day equivalents), but for 47 percent of total spending.
- As a percentage of total drug costs, specialty drug costs continued to increase from FY 2013 to FY 2021. A large proportion of specialty 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 drugs were the oncological agents. Overall, oncological agents accounted for about $1,189 in drug spend in FY 2021, up from $1,075 million in FY 2020 and $909 million in FY 2019. The top five oncological subclasses (by total FY 2021 spend) were multiple myeloma ($291 million), leukemia/lymphoma ($144 million), breast cancer ($116 million), renal cell carcinoma ($103 million), and second generation antiandrogens ($93 million). Other oncological agents accounted for another $342 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 Food and Drug Administration (FDA) approval, including all new specialty agents, in order to promote appropriate use through formulary management tools such as prior authorization and to evaluate ongoing strategies for drug class evaluations in classes where two or more agents compete for the same clinical niche.

MHS COST TRENDS

Total DoD expenditures include actual direct care expenditures at non-GENESIS facilities, estimated expenditures at GENESIS facilities, and private sector care costs. Net of MERHCF costs, total DoD expenditures for health care increased by 4 percent between FY 2019 and FY 2021. Inpatient expenses increased by 1 percent, outpatient expenses increased by 6 percent, and prescription drug expenses decreased by 1 percent.

- The share of DoD expenditures for outpatient care relative to total expenditures for inpatient and outpatient care increased slightly from 73 percent in FY 2019 to 74 percent in FY 2021. For example, in FY 2021, DoD expenses for inpatient and outpatient care totaled $23,497 million, of which $17,377 million were for outpatient care, for a ratio of $17,377/$23,497 = 74 percent.
- The FY 2015 NDAA 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. Private sector 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 2021, the DoD spent $2.84 on outpatient care for every $1 spent on inpatient care.

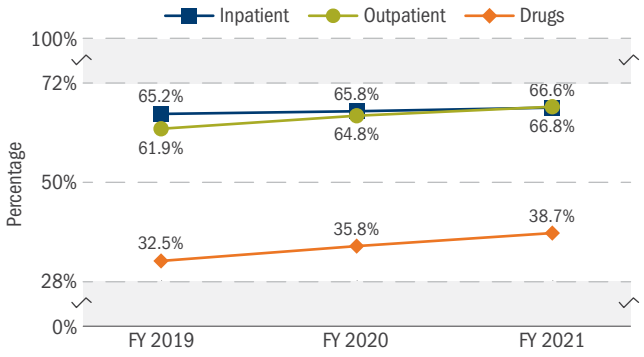
TRENDS IN DoD EXPENDITURES FOR HEALTH CARE (EXCLUDING MERHCF), FYs 2019–2021



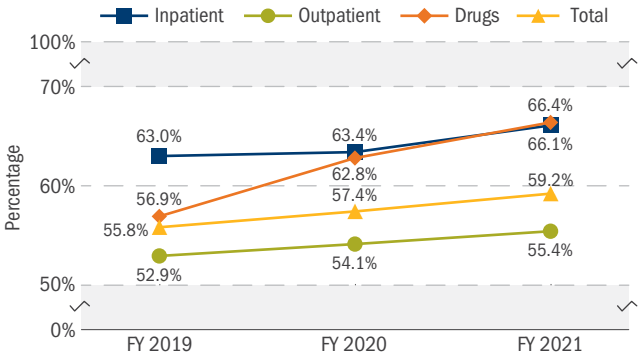
Note: Numbers may not sum to bar totals due to rounding.

- The private sector care shares of total inpatient, outpatient, and prescription drug utilization each increased from FY 2019 to FY 2021. The increases were 1 percentage point for inpatient, 5 percentage points for outpatient, and 6 percentage points for prescription drugs.
- The private sector care share of total MHS costs increased by 4 percentage points between FY 2019 and FY 2021. The private sector care share of total inpatient and outpatient costs both increased by 3 percentage points, and the share of total prescription drug costs increased by 10 percentage points.

TRENDS IN PRIVATE SECTOR CARE UTILIZATION[a] AS PERCENTAGE OF MHS TOTAL BY TYPE OF SERVICE, FYs 2019–2021



TRENDS IN PRIVATE SECTOR CARE COST AS PERCENTAGE OF MHS TOTAL BY TYPE OF SERVICE, FYs 2019–2021



Source: MHS administrative data, 1/24/2022

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

MHS COST TRENDS *(CONT.)*

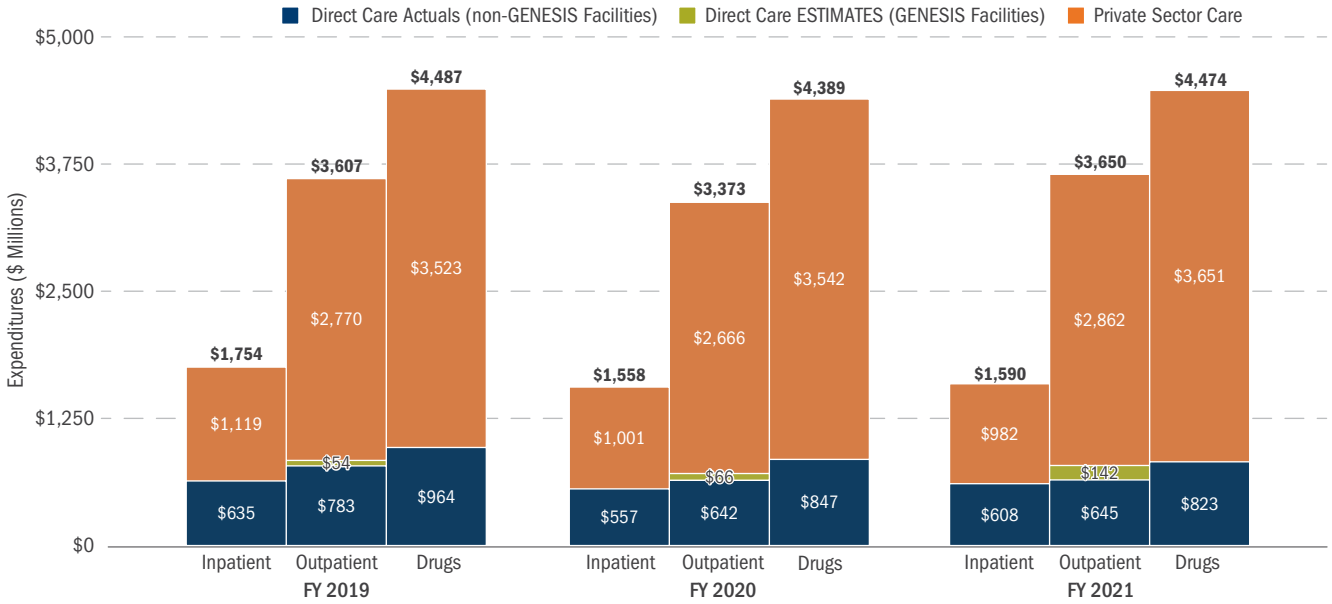
MERHCF Expenditures for Medicare-Eligible Beneficiaries

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 who have Medicare Parts A and B. For example, the MERHCF covers MTF care and USFHP costs, whereas TFL does not.

Total MERHCF expenditures include actual direct care expenditures at non-GENESIS facilities, estimated expenditures at GENESIS facilities, and private sector care costs. Total MERHCF expenditures decreased from $9,848 million in FY 2019 to $9,714 million in FY 2021 (1 percent), net of manufacturer refunds on retail prescription drugs.

- Total DoD direct care expenses for MERHCF-eligible beneficiaries decreased by 9 percent from FY 2019 to FY 2021. Inpatient costs fell by 4 percent, outpatient costs by 6 percent, and prescription drug costs by 15 percent.
- In FY 2018, TRICARE Plus enrollees accounted for 73 percent of DoD direct care inpatient and outpatient expenditures on behalf of MERHCF-eligible beneficiaries (not shown). That percentage dropped to 71 percent by FY 2021.
- Including prescription drugs, TRICARE Plus enrollees accounted for 59 percent of total DoD direct care expenditures on behalf of MERHCF-eligible beneficiaries in FY 2018 (not shown). That percentage dropped slightly to 58 percent by FY 2021.
- Total private sector care MERHCF expenditures increased by 1 percent from FY 2019 to FY 2021. Inpatient expenditures declined by 12 percent, outpatient expenditures increased by 3 percent, and prescription drug expenditures increased by 4 percent.

MERHCF EXPENDITURES BY TYPE OF SERVICE, FYs 2019–2021



Source: MHS administrative data, 1/24/2022
Note: Numbers may not sum to bar totals due to rounding.

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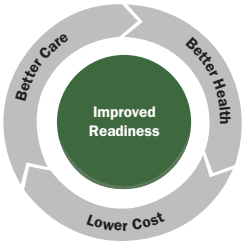
MEDICAL READINESS OF THE FORCE



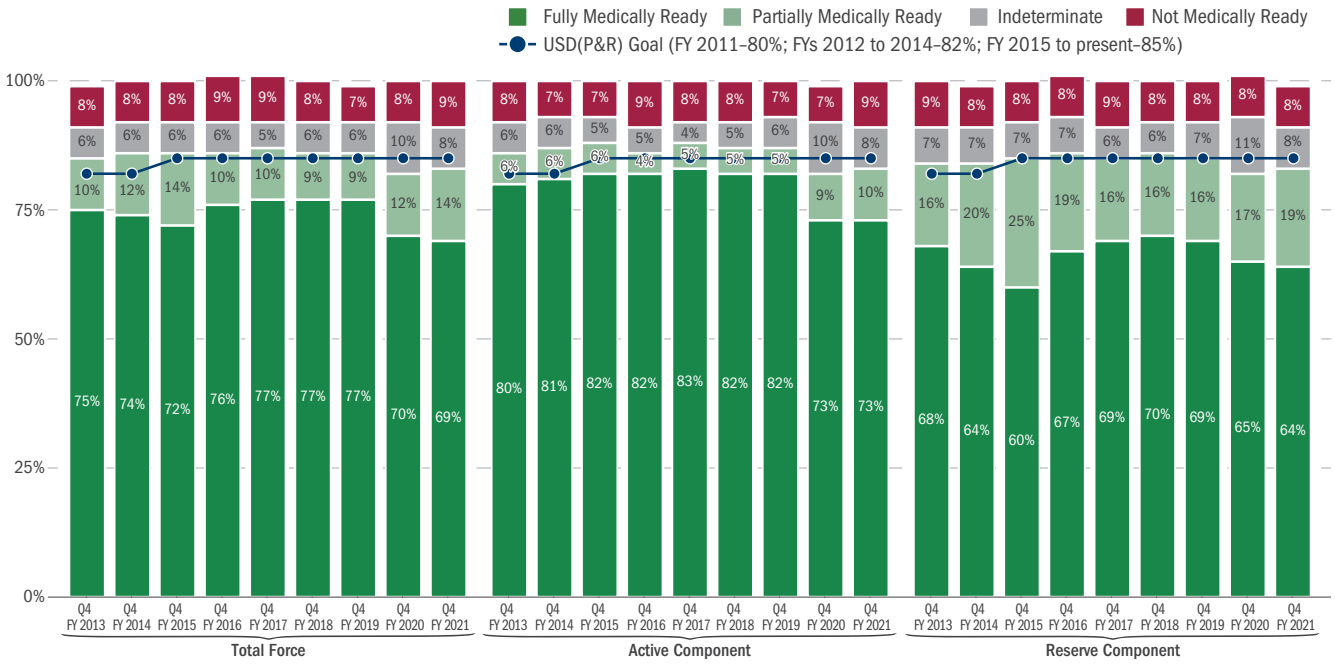
The Department of Defense (DoD) Individual Medical Readiness (IMR) program assesses individual Service members' compliance with established medical readiness elements and determines medical deployability in support of military operations. The IMR metric enables commanders to monitor and sustain Service members' and units' medical, dental, and behavioral health requirements necessary to perform their assigned missions. 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" include: Completion of Dental Readiness Assessments with Satisfactory Dental Health, Completion of Periodic Health Assessments, Deployment-Limiting Medical Conditions Status, 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) 2021, the Total Force Medical Readiness (TFMR), at 83 percent, did not meet the Office of the Under Secretary of Defense for Personnel and Readiness (OUSD[P&R]) goal of 85 percent, with the AC and RC both at 83 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 2013 has decreased by 2 percentage points (from 85 percent in FY 2013 to 83 percent in FY 2021). The AC medical readiness remained steady from FY 2013 to FY 2019 (between 86 and 88 percent), but then decreased 4 percentage points in FY 2020 (from 87 percent to 83 percent), and the RC also decreased from 86 percent in FY 2019 to 81 percent in FY 2020.

As TFMR has improved, the OUSD(P&R) medical readiness goal has increased, from 82 percent from FY 2013 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 until FY 2020. The TFMR rate decreased from FY 2020 Q2 to FY 2021 Q4 due to the global Coronavirus Disease 2019 pandemic's effect on military medical capabilities and access to care, which resulted in all three groups falling short of the goal. 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 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 2013 Q4 TO FY 2021 Q4



Source: Defense Health Agency (DHA), Public Health Directorate, 10/21/2021
Note: Percentages may not sum to 100 percent due to rounding.

HEALTHY, FIT, AND PROTECTED FORCE

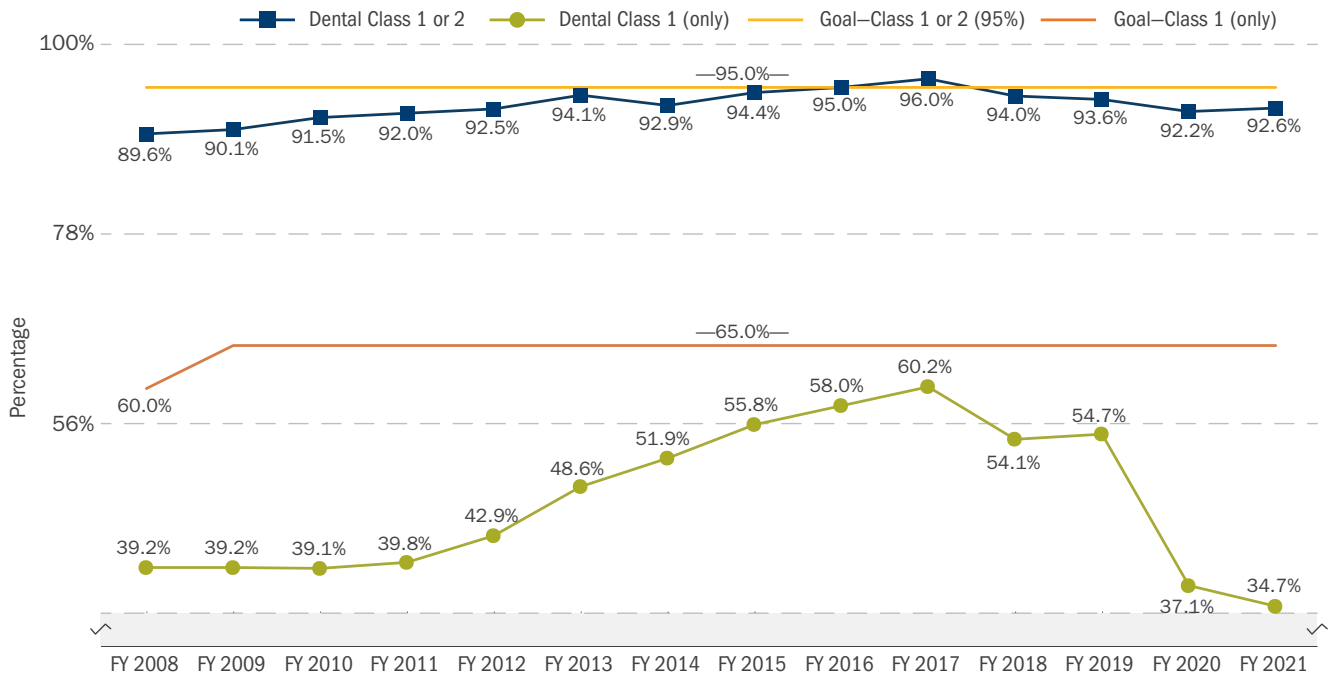
Key among the measures of performance related to providing an efficient and effective deployable medical capability and offering force medical readiness are those related to how well we (1) maintain the worldwide deployment capability of our Service members, as in dental readiness and immunization rates 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 just under 94 percent and in FY 2020 fell to 92.2 percent, 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 34.7 percent in FY 2021—30 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 2008–2021



Source: The Services' Dental Corps–DoD Dental Readiness Classifications, 11/17/21

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 medical treatment facilities (MTFs). The key to the military mission is identifying which aspects of care are relevant to clinical "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 DHA campaign plan refers to the Clinical Readiness Project in its strategic objectives for the Sustainment of Expeditionary Medical Skills as it supports the DoD requirement to optimize trauma care delivery and sustain a ready medical force. The DHA campaign plan establishes KPIs to confirm progress, one of which is the percentage of DHA facilities postured to support the Combatant Commands. 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 CCCT+ Specialties below, although the process can be applied generally. The metrics are used to assess the ability of an MTF or a military-civilian partnership (MCP) to support clinical readiness.

CCCT+ SPECIALTIES			
1	General Surgery (and Colorectal Surgery)	9	Ophthalmology
2	Orthopedic Surgery	10	Cardiothoracic 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 Surgery
7	Critical Care Nursing	15	Otorhinolaryngology
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 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, inclusive of periodic knowledge assessment, clinical currency, skills assessment, and train/retrain in support of deployment readiness.

Clinical Currency Metric

To date, clinical readiness KSAs have been developed for 16 CCCT specialties. The clinical currency measure and threshold were developed for seven of the CCCT specialties, with the remaining specialties in late-stage development. Dashboards for five of the specialties are available on common access card (CAC)-enabled CarePoint for use in Service, Market, and facility decision making. Additionally, there are plans for development of metrics and assessments for the Operational Medical Officer as well as operating room nurses and technicians. The KSA Program will collaborate with assessment for Role 1 enlisted medical personnel currently in development by the JTS Committee on Tactical Combat Casualty Care. The Joint Knowledge, Skills, and Abilities Program Management Office (PMO) team completed 47 non-specialty Expeditionary Scopes of Practice (ESPs), delineating shared specialty requirements, related to both occupational currency and training completions. The department has implemented a PMO to be hosted by the DHA that will manage the sustainment and development of clinical readiness metrics for additional specialties. In the next year, the department will begin expansion of readiness metrics into nursing and enlisted medical specialty areas.

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

Knowledge Assessment

Periodic knowledge assessment ensures the sustainment of clinical proficiencies by identifying knowledge gap areas that may challenge expeditionary military surgeons and informs the requirements for focused training resources to assure ongoing readiness. Knowledge assessments are specialty specific and supported through Tri-Service development and implementation in partnership with the specialty's professional organization, such as the American College of Surgeons (ACS), American Society of Anesthesiologists, and Society for Critical Care Medicine. Implementation outcomes for General Surgery and Orthopedic Surgery yielded rigorous, high-reliability exams with strong psychometric integrity covering the expeditionary surgical domains for each specialty. Test outcomes documented performance gaps in multiple domains, as well as differentiated between subspecialty training and deployment experience. Test forms of 200 items each were completed by 238 general surgeons and 104 orthopedic surgeons of varying experience levels. The consensus derived benchmark score for both exams is 70 percent. The baseline mean scores for general surgeons and orthopedic surgeons were 73 percent and 68 percent, respectively. Test outcomes documented performance gaps in multiple domains, as well as differentiated between subspecialty training and deployment experience.

Test development and implementation for the remaining specialties is in process, with ongoing Tri-Service engagement. Knowledge tests are fully developed for Critical Care and Trauma Surgery and will be released in 2022. Knowledge tests for Anesthesiology and Emergency Medicine will be completed in 2022 and released in 2023. Knowledge tests for the Plastic Surgery, Oral-Maxillofacial Surgery, Otorhinolaryngology, Urology, and Ophthalmology will begin development in 2022. The development of knowledge tests for both Critical Care and Emergency Nursing are also underway in conjunction with ongoing TIP-TOP Project at the JTS.

Completion of knowledge tests provides the clinical readiness program with critical information about capability gaps and facilitates development of focused resources designed to close those gaps through easily accessible training mechanisms. These training resources are available through the JTS Deployed Medicine portal, as well as on-demand, multimedia-supported training resources developed in partnership with the ACS, which are scheduled to be available in 2022. Test takers earn 60 continuing medical education through DHA J9 for completing the knowledge tests and associated training content for identified gap areas. Knowledge tests will be implemented every three years to identify areas of knowledge decay and inform ongoing training refreshment intervals, but may be completed as often as desired at any time to support pre-deployment preparations.

Skills Assessment

Current training and practice do not fully prepare expeditionary surgeons and their teams to perform vital life-, limb, and eyesight-saving procedures. The existing Emergency War Surgery Course (EWSC) is an inconsistently funded and nominally enforced "mandate" that suffers from lack of standardization, low faculty-to-student ratios, dependence on live tissue, and does not provide meaningful assessment of participant's ability to competently perform the skills required. We have developed and validated a standardized skills course (ASSET+) that utilizes best-in-class educational principles to teach and robustly assess over 25 life-, limb-, and eyesight-saving procedures using a partially perfused fresh cadaver model and procedure-specific simulators, in a time-pressured fashion. During the two-day course, participants receive one-on-one hands-on training with four experienced trauma surgeons and selected subspecialists who provide real-time assessment and individualized feedback. Initial experience with this course over the last year has demonstrated significant improvements in participant's integration of knowledge, skills, decision making, and confidence to handle injuries likely to be seen in the expeditionary environment, using rigorous assessment measures. Instructors and Surgical Technician team members have also found the course to be extremely valuable as preparation for expeditionary care and civilian trauma care. This novel and efficient assessment-driven training paradigm is applicable to all medical outcomes and underscores the critical need to identify and address readiness capability gaps prior to deployment through focused performance assessment and essential retraining to ensure clinical competency and currency. In addition, the Combat Orthopedic Trauma Skills (COTS+) course is similar to ASSET+ with the focus on orthopedic surgeons and orthopedic trauma. Orthopedic trauma remains a primary injury pattern for both combat and civilian occurrences of terrorism and other mass casualty events.

ASSET+ and COTS+ outcomes from 2020–2021 confirmed that at baseline, less than 3 percent of surgeons were able to meet the established benchmark

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

performance score of 90/100 for the identified surgical procedures. After focused training, 99 percent of surgeons met or exceeded the performance benchmarks and 85 percent were able to do so independently. This underscores the need for these programs to ensure clinical competency and currency ahead of deployment and on an ongoing basis to manage casualties resulting from terrorism and natural disasters. Importantly, outcomes from the first year of skills assessment implementation demonstrate significant correlation between individual KSA metric values and performance of critical trauma surgical procedures, such as control of bleeding from major blood vessels. This underscores the link between ongoing complex elective and emergency surgical care and the key skills needed during deployment.

The ASSET+ and COTS+ courses are designed to fully replace the existing EWSC as a doctrinally mandated and centrally funded effort intended to be delivered to all military surgeons either every two years or in a pre-deployment window. This approach is scalable, cost effective, and with future expansion, will enable predictable performance capabilities for surgeons and expeditionary team members as a component of the Clinical Readiness Lifecycle. The Critical Skills for Expeditionary Medicine is a similar skills assessment course that fully developed and will be released in 2022 for any physician who would provide critical care in a deployed setting. Other skills assessment courses that are in development and will be released in 2022 include the Ocular Trauma Surgery Lab and the Combat Craniomaxillofacial Trauma Surgery Course. Development for skills assessment courses is planned to begin in 2022 for anesthesiology, emergency medicine, and nursing (critical care and emergency medicine).

KSA Integration with Enterprise Planning

Throughout the implementation process for the Clinical Readiness Program, Service support and collaboration has been a critical aspect of development and improvement of the assessments and clinical currency metrics. These assessments and metrics are currently being incorporated into relevant Service readiness systems (Army Individual Critical Task Lists, Naval Readiness Criteria, and Air Force Comprehensive Medical Readiness Program). Services are utilizing KSA metrics in their Readiness Demand Signal determinations, informing their Readiness Performance Plans and submissions for the Quadruple Aim Performance Plan (QPP). To successfully transition the MHS from solely an economically based model focused on productivity to a readiness-based model focused on meeting operational requirements with significant economic benefits, there is a three-pronged strategy to improve clinical currency scores, outlined as follows:

Recapture: By aligning the beneficiary care mission to support the ready medical force mission, MTFs can focus efforts on beneficiaries with the right mix of diversity and acuity to increase generation of readiness value across the enterprise. This can involve efforts to recapture high-readiness-value cases through shaping referral management, strategic communications with specific patient populations, and a focus on policies that support bringing high-readiness-value cases back into the MTFs. KSA methodologies are already in use in several Markets to support recapture, and the KSA scores for specific procedure groups are being included in the development of the new TRICARE contract (T5).

Expand: MTFs can expand services to other than DoD beneficiaries to increase KSA readiness generation. Partnerships with the VA, building Centers of Excellence for subspecialty care, and caring for local civilian trauma patients can all expand volume, acuity, and complexity of cases performed within the MTF. KSAs are being utilized to guide efforts to determine the potential for expanding trauma capabilities at several MTFs, using a cost-benefit analysis to assess potential readiness generation from trauma cases.

Partner: MCPs create opportunities for individuals or teams to embed part- time or full-time in civilian trauma centers. The Joint Trauma Education and Training Branch, guided by National Defense Authorization Act (NDAA) FY 2017, Section 717, has established a working group composed of representatives from the Services to facilitate and coordinate these efforts. This working group, having supported development of the ACS "Blue Book: Military-Civilian Partnerships for Trauma Training, Sustainment, and Readiness," has continued to review current MCP efforts and determine ways to support Service usage of partnerships for readiness attainment and sustainment. KSA metrics will be leveraged to assess the effectiveness of these partnerships over time.

Using this three-pronged approach, as well as leveraging the Readiness functional review within the QPP to aid leadership's prioritization of proposed initiatives and/or acceptance of reclamas based on the anticipated readiness impacts, we can facilitate the shift in focus to meeting the operational requirements of the Services and Combatant Commands.

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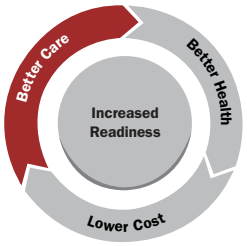
ACCESS, QUALITY, SAFETY, AND PATIENT ENGAGEMENT

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 approved by MHS Governance and completed. While the milestones fulfilled the intent of the MHS review and warranted action plan closure, the enduring work of these improvement initiatives continues, captured as standard work throughout the MHS. In addition, the MHS continues to pursue its organizational goal of becoming a high reliability organization.

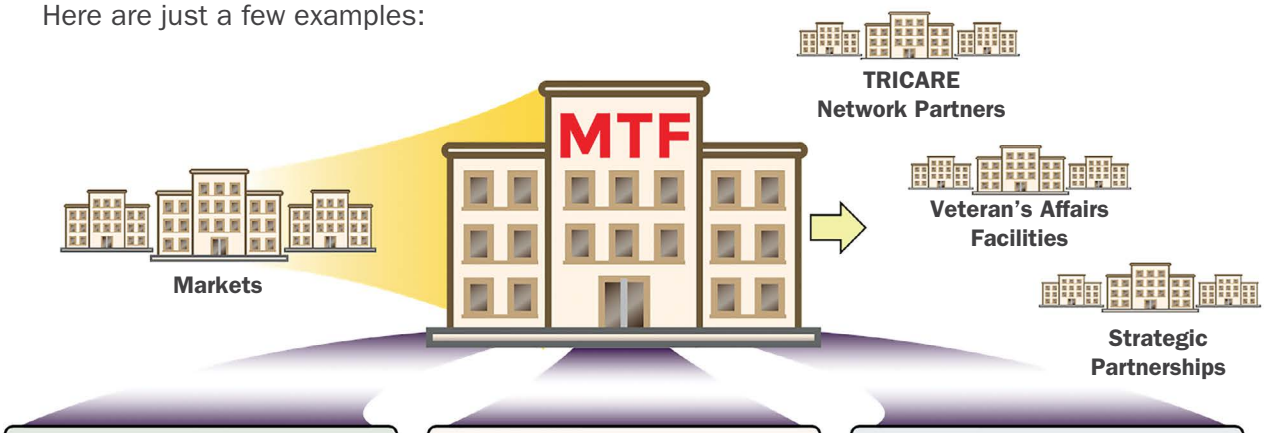
High Reliability Organization Journey

The MHS is incorporating the principles of high reliability at the same time it is undergoing the current transition of operational control of the military treatment facilities (MTFs) from the military Services to the Defense Health Agency (DHA). A high reliability organization (HRO) achieves top outcomes despite operating in complex or high-risk environments. HROs, commonly seen in aviation and nuclear industries, achieve top outcomes by: improving standardization and reducing variability; mitigating errors to achieve zero harm; celebrating transparency and accountability; and valuing the contributions of all individuals, regardless of rank. The graphic below illustrates how HRO represents an organizational cultural change throughout the entire MHS.

DRIVING HIGH RELIABILITY AT MTFs AND WITH OUR PARTNERS

Every day, in every position, MHS staff can advance the goal of high reliability.

Here are just a few examples:



PROVIDERS

The nurses notice increased infection among patients and identify poor hand hygiene as a significant cause. In response, the hospital director demonstrates commitment to resilience by launching a hand-washing campaign.

PATIENTS

A patient visiting for a routine procedure contributes to a culture of safety by asking questions to inform care decisions and helps create an environment of transparency and accountability.

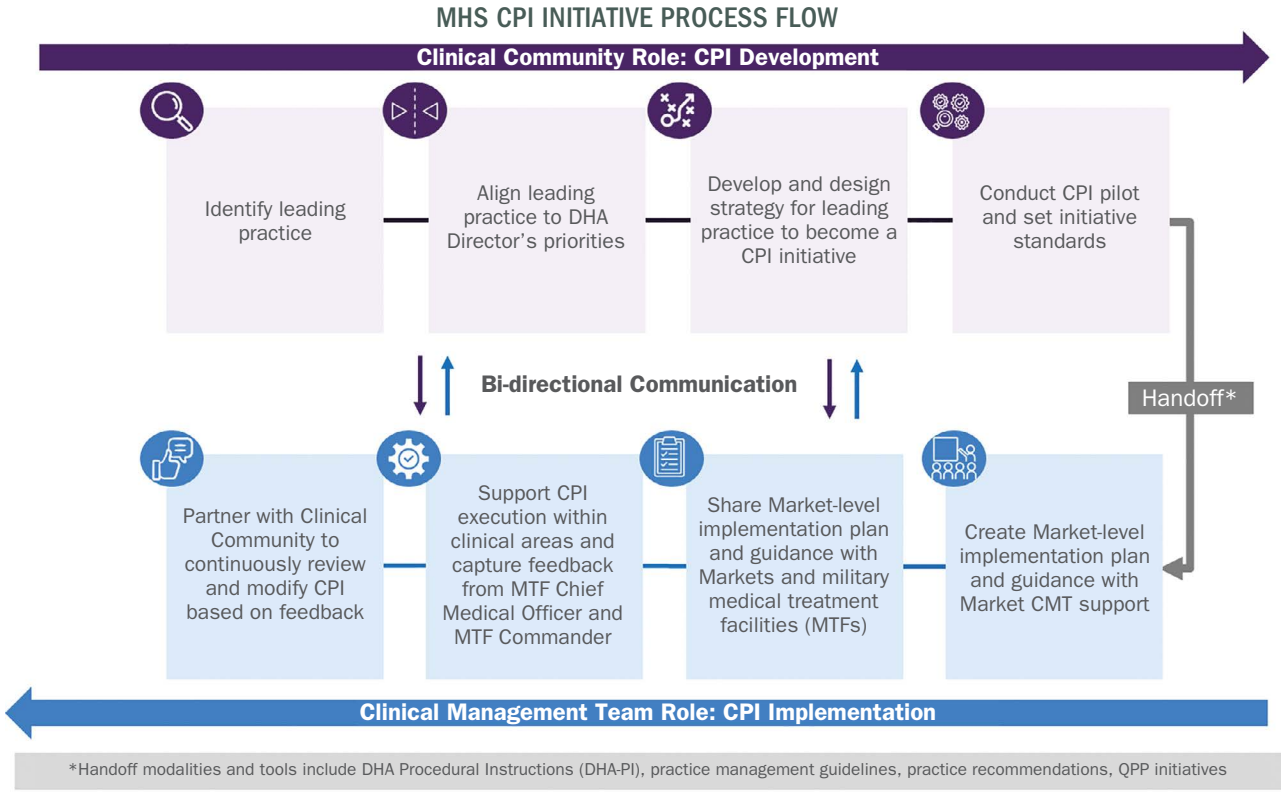
SUPPORT STAFF

Housekeeping notices a torn privacy screen and informs facilities so it is promptly replaced, demonstrating a commitment to process improvement and a constancy of purpose to ensure a carefully managed patient experience.

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 interdisciplinary networks of MHS providers who advise the DHA on how to optimize health care delivery for every patient across 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 fiscal year (FY) 2021, these communities were actively supported by Clinical Support Services and Enabling Expertise to drive enterprise-wide clinical quality improvement (CQI). Additionally, the DHA established Clinical Management Teams at the Headquarters and Market levels to implement CPI initiatives developed and promoted by the Clinical Communities. The graphic below depicts the CPI development and implementation process.



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

High Reliability Organization Journey *(cont.)*

The DHA FY 2022–2026 Campaign Plan's strategic initiative to "Improve Patient Outcomes" leverages the collective expertise of Clinical Communities, Clinical Quality Management (CQM), and Clinical Support Services efforts to accelerate High Reliability across the MHS to deliver continuous process improvement in clinical practice. This initiative will spread leading clinical process improvements across the MHS for appropriate standardization to minimize or avoid system failures, prevent harm, reduce unwarranted variation, and eliminate waste. It aims to establish and monitor metrics that measure adoption, effectiveness, and performance outcomes of leading practices and process improvements across the MHS while maximizing value by embedding exemplary standards of care as well as effective and efficient patient-centered solutions. Specific projects under the Improve Patient Outcomes strategic initiative include the following:

- Low Back Pain Clinical Care Pathway
- Musculoskeletal Triage Decision Support Tool
- Direct Physical Therapy Referral
- Cancer Screening for Active Duty Service Members (Testicular, Melanoma, or Breast Cancer)
- Lung Cancer Screening (GENESIS Work Flow Collaboration with the VA)
- Screening for Colorectal Cancer with Fecal Immunochemical Test
- Measurement of Patient Reported Outcomes
- Bedside Sepsis Detection and Prevention
- Standardization of Depression and Suicide Risk Screening in Primary Care
- Opioid Overdose Education and Naloxone Distribution
- Pain Assessment Screening Tool and Outcomes Registry (PASTOR) Adoption
- Reduce DHA Pressure Injury Rate
- Acute Concussion Care Pathway
- Behavioral Health Treatment and Outcomes Monitoring
- Implement Dental Universal Protocol to Reduce Wrong-Site Procedures
- Severe Maternal Morbidity Project Placeholder
- Stepped Care Model for Pain
- Musculoskeletal Treatment and Outcomes Monitoring Adoption
- Bar Code Medication Administration Compliance Project

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.

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

High Reliability Organization Journey *(cont.)*

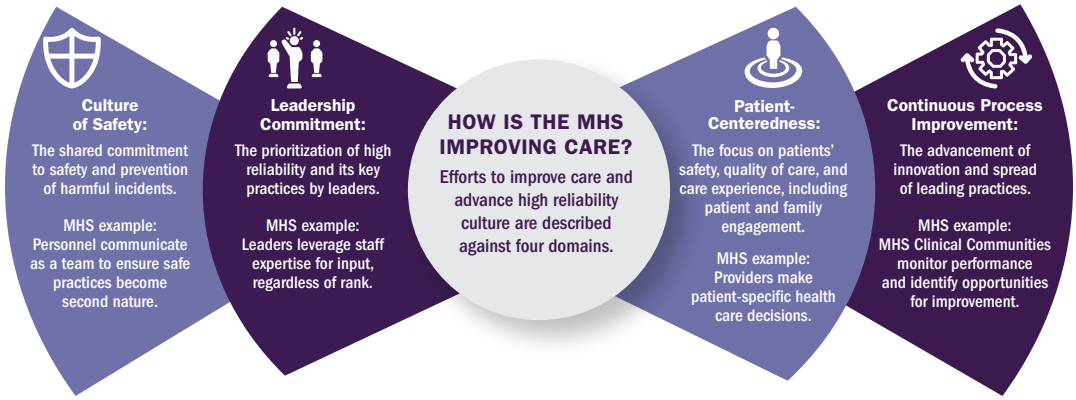
Ready Reliable Care (RRC)

Following a review of MTF performance in 2014, each Service took specific action to improve health care access, quality, safety, transparency, and patient engagement. Now the DHA is working to standardize and expand these efforts in a coordinated approach to HRO for the entire MHS: Ready Reliable Care. RRC supports the MHS Quadruple Aim of better health, better care, lower costs, and improved readiness. It will enable the MHS to manage system-wide processes to root out potential for error and sources of waste and identify tools to deliver better care. Increasing standardization will deliver consistent high-quality care from one facility to the next, one patient to the next. RRC supports the DHA in achieving great outcomes, a ready medical force, satisfied beneficiaries, and a fulfilled staff.

RRC Next Steps:

- Launch MHS Ready Reliable Care campaign
- Develop MHS HRO education and training program, assessment strategy, and tools
- Advance and leverage partnerships that support the domains of change
- Implement leader engagement strategies and an organizational structure that aligns HRO functions at every level
- Incentivize a just culture which supports continuous learning and transparency
- Establish an HRO recognition program at every level
- Standardize Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) across the MHS
- Implement enterprise-wide RRC Safety Communication Bundle
- Develop, standardize, integrate, and mature continuous process improvement and change management across the MHS
- Implement and improve standard evidence-based practices to reduce variability
- Prioritize the patient and family experience of care
- Conduct a comprehensive environmental scan to identify best patient experience practices

MHS READY RELIABLE CARE DOMAINS OF CHANGE



HRO PRINCIPLES

MHS Data Transparency

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, health care organizations, and the public) and integrates the domains in work groups, programs, and activities across the organization. The National Patient Safety Foundation is currently incorporated into the Institute for Healthcare Improvement.

The National Defense Authorization Act (NDAA) FY 1996, Section 728 required incorporation and public reporting of Core Quality Measures Collaborative (CQMC) core measures, MHS reporting on the Centers for Medicare & Medicaid Services (CMS) Care Compare website, and development of 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 data for 13 measures relating to accountable care organizations (ACOs), patient-centered medical homes (PCMHs), primary care, obstetrics and gynecology, and pediatrics, available on the MHS Transparency site for public access.
  - Phase 2 measure for cardiovascular and HIV/hepatitis C have completed development and are pending production and public display.
  - Phase 3 measures for gastroenterology and oncology are undergoing feasibility analysis and technical development. The development of the orthopedics measure has been completed with production and public display pending.
  - CQMC has subsequently released a new Neurology Core Measure Set. MHS clinical teams are currently reviewing the associated available measures to determine which would best represent the MHS.

Additionally, the MHS is furthering its data transparency efforts in alignment with section 717 of NDAA FY 2017, as amended by section 713 of NDAA FY 2016, which requires:

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 112).

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 112–116).
- **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 65, 101).
- **Data on surgical and maternity care outcomes during the year.** MHS-level data are presented in this report (ref. pages 129–133, 140–141). 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 74–75), 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 Care 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.

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

MHS Data Transparency *(cont.)*

Responsibility for public reporting efforts of MHS measures on the www.health.mil/transparency website transitioned to the CQM Clinical Measurement (CM) Program, in collaboration with the Services, in 2021. Through collaboration, the CM Program continues to review and iterate on the approach and display of publicly reported information, to include enhancements in search functionality, improved measure visualization, and development of plain language measure descriptions to facilitate end-user value. In 2021, information was added to the reporting website to clarify terminology, reporting intervals, and measure highlights such as a label for the CQMC measures to enhance the availability and usability of data for beneficiaries. Data for each MTF can be accessed by the beneficiary from the MTF main webpage under "Quality and Safety" reports. The MHS publication of data and information on patient safety, quality of care, patient experience and satisfaction, and health outcomes is available on www.health.mil/transparency. Webpage example is shown below.

VISIT HEALTH.MIL/TRANSPARENCY

MHS clinical measurement results data are found on the following public-facing websites: Leapfrog (https://www.leapfroggroup.org); Care Compare (https://www.medicare.gov/care-compare); 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).

ACCESS TO MHS CARE

Access to Outpatient Care in the MHS

Access to the direct care component 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 virtual care means, including video and telephone visits 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 private sector 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. This is especially noteworthy given the direct care systems' continued response to the COVID-19 pandemic by leveraging existing standard processes in DHA guidance. DHA issued extensive and responsive guidance to MTFs and Markets on access to care, supporting health care operations activities and the use of health (VH), which enabled the direct care system to provide medically necessary care throughout the pandemic. As the MTFs began resuming full operations while continuing to minimize risk of infection for patients and staff, the direct care system implemented processes to catch up on delayed chronic and preventive care, with strong emphasis on cancer screening. Direct care system access to care efforts gained momentum after the SECDEF directed the 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 2021, the direct care system continued optimization efforts to enhance access, improve 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 Patient-Centered Medical Homes (PCMH), 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 electronic health record (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
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. Efforts have also begun on optimizing operating rooms in order to recapture care and increase provider and staff medical readiness and clinical currency.

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 in the Senior Military Medical Advisory Council. Subject-matter experts 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 Assistant Director, Healthcare Administration for DHA.

ACCESS TO MHS CARE *(CONT.)*

Patient-Centered Medical Home Primary Care

The direct care system has implemented the PCMH model of value-based primary care at all MTFs. The direct care system's long-standing PCMH strategies remain: (1) optimizing processes to support primary care manager (PCM) continuity; (2) proactively addressing current and future health care needs and focusing on prevention; (3) using 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) using 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.

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 parent facility scores over time. Results represent the composition of the MHS population using care. The mean is shown between the whiskers and represents how the MHS is performing on average. The whiskers extend to the lower and upper bound of the standard deviation, which represents the variation of parent facility scores. The highest and lowest points are the maximum and minimum scores, respectively.

- As shown in the tables, in FY 2021, enrollees saw their own PCM during primary care visits 55 percent of the time. 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).

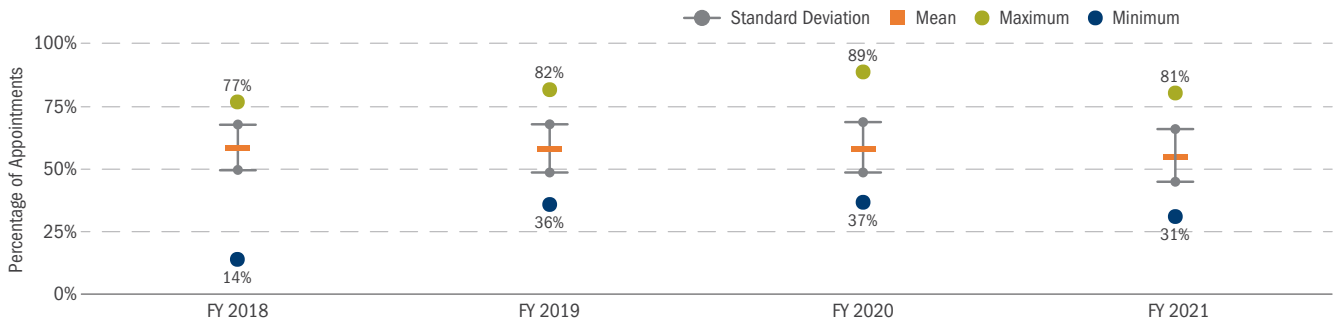
PCM CONTINUITY, FYs 2014–2021

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
PCM Continuity	60%	60%	60%	59%	57%	57%	56%	55%

PCM CONTINUITY, FYs 2018–2021

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2018–FY 2021 % POINT CHANGE
Mean	58%	58%	58%	55%	–3
Standard Deviation	9.4%	9.6%	10.1%	10.2%	1
Median	58%	58%	58%	55%	–3
75th Percentile	64%	65%	65%	62%	–3
25th Percentile	53%	52%	51%	49%	–4
Maximum	77%	82%	89%	81%	4
Minimum	14%	36%	37%	31%	17
Range	63%	46%	52%	49%	–14

PCM CONTINUITY, FYs 2018–2021



Source: MHS administrative data (MHS Data Repository [MDR]); DHA/HCO/Healthcare Optimization Division, 11/3/2021

Notes:

– Parent facility scores were used to describe variability in the results above.
– Data include MHS GENESIS sites beginning August 2019.
– Numbers may not sum due to rounding.

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

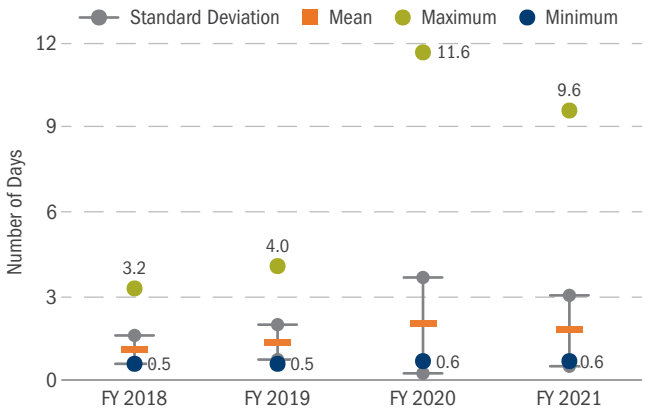
The direct care system prospectively measures access to primary care by evaluating the average number of days to the third next available 24-hour or acute appointment and third next available future appointment against the MHS goals of 1.0 and 7.0 days, respectively. Measuring third next for a prospective 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 2021, there was a decrease in the average number of days to third next available 24-hour (1.76 days) and future (5.51 days) appointments, which is partially due to clinics' increased adoption of virtual health (VH) services and improved access to in-person appointments since the height of the pandemic. Future appointments remain within the seven-day standard in FY 2021; the MHS aims to meet the 24-hour target of 1.0 day as we continue to adapt to pandemic and post-pandemic conditions.

DAYS TO THIRD NEXT AVAILABLE 24-HOUR APPOINTMENT, FYs 2018–2021

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2018–FY 2021 CHANGE
Mean	1.1	1.3	2.0	1.8	0.6
Standard Deviation	0.5	0.6	1.7	1.2	0.8
Median	1.0	1.2	1.5	1.4	0.4
75th Percentile	1.2	1.6	2.1	2.1	0.8
25th Percentile	0.8	0.9	1.0	1.0	0.2
Maximum	3.2	4.0	11.6	9.6	6.4
Minimum	0.5	0.5	0.6	0.6	0.1
Range	2.7	3.5	11.0	8.9	6.3

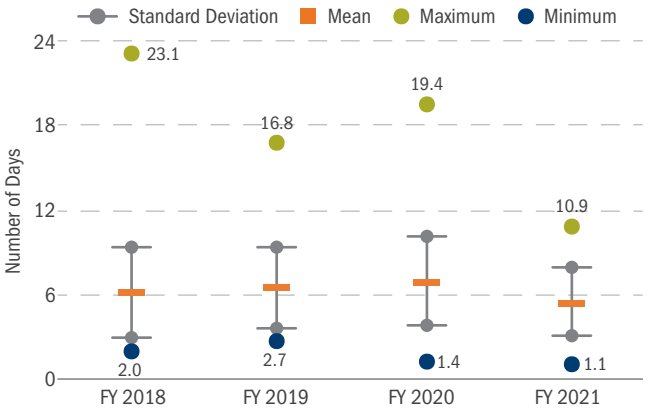
DAYS TO THIRD NEXT AVAILABLE 24-HOUR APPOINTMENT, FYs 2018–2021



DAYS TO THIRD NEXT AVAILABLE FUTURE APPOINTMENT, FYs 2018–2021

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2018–FY 2021 CHANGE
Mean	6.2	6.6	7.0	5.5	-0.6
Standard Deviation	3.2	2.9	3.2	2.4	-0.8
Median	5.2	6.2	6.2	4.8	-0.4
75th Percentile	7.6	7.7	8.4	7.2	-0.3
25th Percentile	4.1	4.5	4.7	3.7	-0.4
Maximum	23.1	16.8	19.4	10.9	-12.2
Minimum	2.0	2.7	1.4	1.1	-0.9
Range	21.1	14.0	18.0	9.8	-11.3

DAYS TO THIRD NEXT AVAILABLE FUTURE APPOINTMENT, FYs 2018–2021



Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 11/5/2021

Notes:

– Parent facility scores were used to describe variability in the results above.
– Data excludes MHS GENESIS results.
– Numbers may not sum due to rounding.

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 on 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 2021, the MHS continued educating beneficiaries about the capability to set text and e-mail reminders in the TOL Patient Portal. During Q4 of FY 2021, TOL sent an average of 359,350 e-mail and 253,190 text appointment reminders per week.

Access to Integrated Specialists in the PCMH

The most common reason why enrollees sought direct care in FY 2021 was for infectious disease screening and immunizations. Otherwise, the most common conditions, excluding pregnancy, are behavioral health–related, musculoskeletal issues, and miscellaneous conditions such as skin disorders, 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 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. An 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 private sector care costs.

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 private sector care sectors, and the length of time as inpatients if 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 4.0 in FY 2021; the average number of monthly bed-days was 13.8 per 1,000 enrollees. The top five reasons for admissions remain childbirth, musculoskeletal, circulatory, digestive, and respiratory conditions.

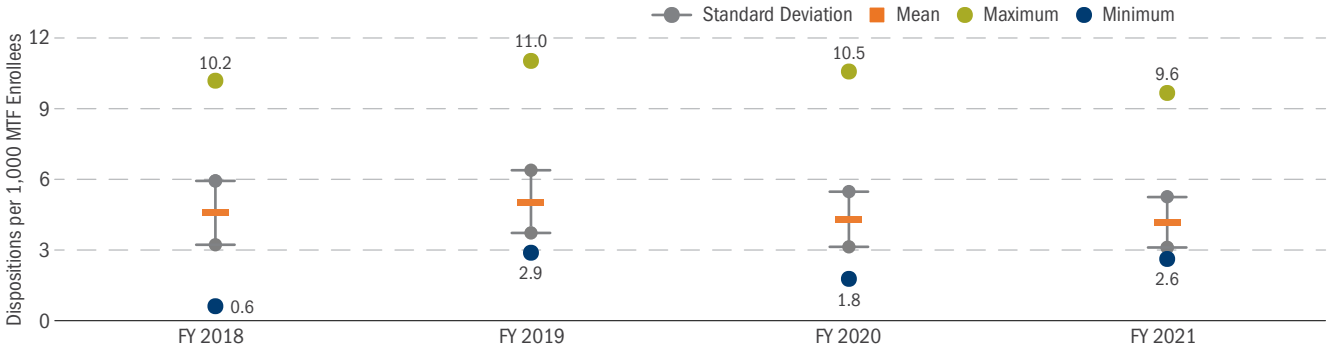
AVERAGE MONTHLY DISPOSITIONS AND BED-DAYS PER 1,000 MTF ENROLLEES, FYs 2018–2021

	FY 2018	FY 2019	FY 2020	FY 2021
Average Monthly Dispositions per 1,000 MTF Enrollees	4.9	5.2	4.5	4.0
Average Monthly Bed-Days per 1,000 MTF Enrollees	15.6	16.7	14.8	13.8

AVERAGE MONTHLY DISPOSITIONS PER 1,000 MTF ENROLLEES, FYs 2018–2021

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2018–FY 2021 CHANGE
Mean	4.6	5.0	4.3	4.2	-0.5
Standard Deviation	1.3	1.3	1.2	1.1	-0.3
Median	4.5	4.8	4.1	3.9	-0.6
75th Percentile	5.2	5.6	4.8	4.6	-0.6
25th Percentile	4.0	4.2	3.6	3.5	-0.5
Maximum	10.2	11.0	10.5	9.6	-0.6
Minimum	0.6	2.9	1.8	2.6	2.0
Range	9.6	8.1	8.8	7.0	-2.6

AVERAGE MONTHLY DISPOSITIONS PER 1,000 MTF ENROLLEES, FYs 2018–2021



Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 12/1/2021

Notes:

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

– Private sector care claims may take up to a year to be finalized and are not complete for FY 2021.

– Numbers may not sum due to rounding.

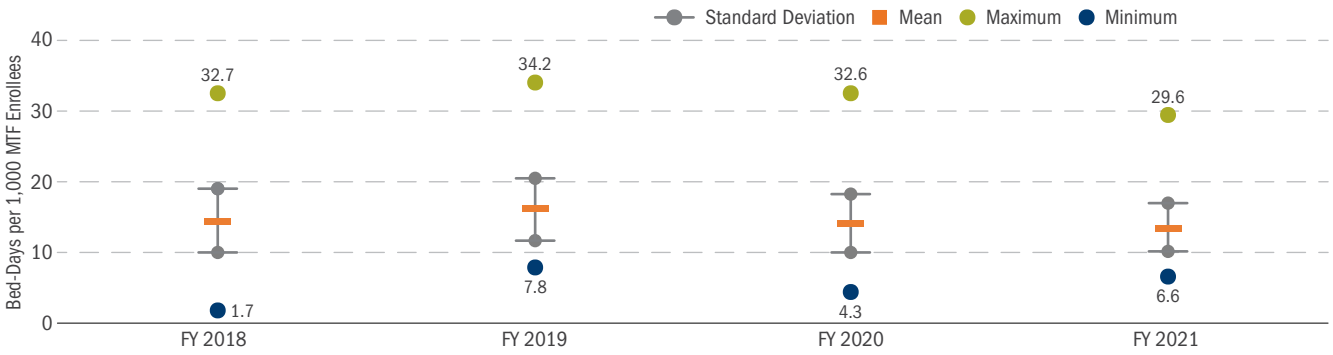
ACCESS TO MHS CARE *(CONT.)*

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

AVERAGE MONTHLY BED-DAYS PER 1,000 MTF ENROLLEES, FYs 2018–2021

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2018–FY 2021 CHANGE
Mean	14.5	16.2	14.2	13.5	-1.1
Standard Deviation	4.4	4.2	4.0	3.4	-1.0
Median	14.3	15.8	13.5	13.0	-1.3
75th Percentile	16.5	18.5	15.7	15.3	-1.2
25th Percentile	12.2	13.6	12.1	11.2	-1.0
Maximum	32.7	34.2	32.6	29.6	-3.1
Minimum	1.7	7.8	4.3	6.6	4.8
Range	31.0	26.3	28.3	23.0	-8.0

AVERAGE MONTHLY BED-DAYS PER 1,000 MTF ENROLLEES, FYs 2018–2021



Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 12/1/2021

Notes:

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

– Private sector care claims may take up to a year to be finalized and are not complete for FY 2021.

– Numbers may not sum due to rounding.

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

Recapturable Emergency Department (ED) Visits in the Private Sector per 100 MTF Enrollees

The ED utilization rate is projected to increase from 16.5 visits per 100 enrollees in FY 2020 to 17.4 visits per 100 enrollees in FY 2021. 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 is projected to increase 37 percent from FY 2020 to FY 2021. 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, the Nurse Advice Line, and secure messaging.

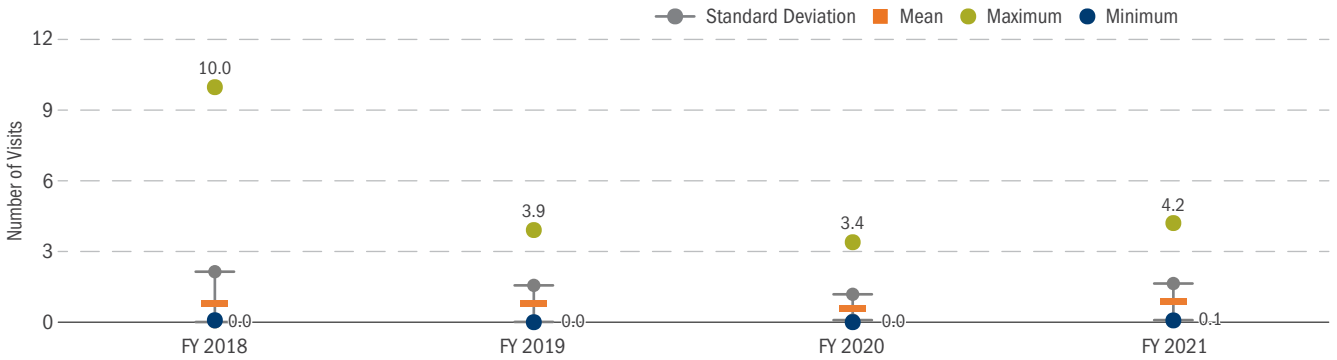
AVERAGE NETWORK ED VISITS PER 100 MTF ENROLLEES, FYs 2018–2021

	AVERAGE NETWORK ED VISITS PER 100 MTF ENROLLEES (INCLUDING TRUE EMERGENCIES)	AVERAGE NETWORK ED VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS
FY 2018	18.1	0.6
FY 2019	18.2	0.6
FY 2020	16.5	0.5
FY 2021	17.4	0.7

NETWORK ED VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS, FYs 2018–2021

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2018–FY 2021 CHANGE
Mean	0.8	0.8	0.6	0.8	0.0
Standard Deviation	1.1	0.8	0.6	0.8	–0.3
Median	0.5	0.6	0.5	0.6	0.0
75th Percentile	1.0	0.9	0.8	1.0	–0.0
25th Percentile	0.3	0.3	0.3	0.4	0.1
Maximum	10.0	3.9	3.4	4.2	–5.8
Minimum	0.0	0.0	0.0	0.1	0.0
Range	10.0	3.9	3.4	4.2	–5.8

NETWORK ED VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS, FYs 2018–2021



Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 11/22/2021

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.
– Numbers may not sum due to rounding.
– ED values are projections due to maturing private sector care claims.

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

Network 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 2021 compared to previous years, timed with the change to allow unlimited network UC visits. The most common reason why beneficiaries went to network UCs in FY 2021 was for immunizations or screening for infectious disease. Although this contributed to high vaccination rates among beneficiaries, the preferable option is for this care to be administered by MTF staff. In FY 2022, the DHA will continue to promote MTF services and encourage MTFs to be conducive to patient schedules.

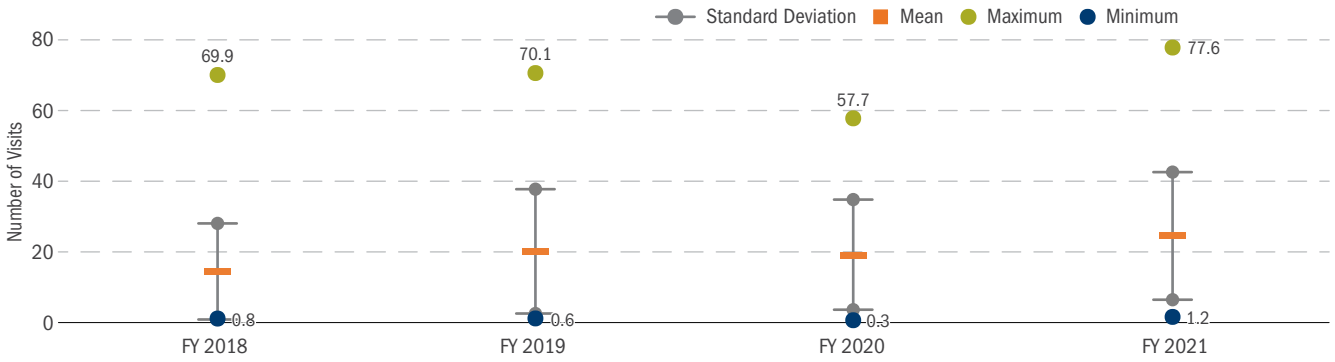
AVERAGE NETWORK UC VISITS PER 100 MTF ENROLLEES, FYs 2018–2021

	AVERAGE NETWORK UC VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS
FY 2018	13.0
FY 2019	18.3
FY 2020	18.4
FY 2021	22.6

NETWORK UC VISITS PER 100 MTF ENROLLEES, FYs 2018–2021

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2018–FY 2021 % CHANGE
Mean	13.9	19.9	19.0	24.2	74.1%
Standard Deviation	13.7	17.7	15.6	17.9	30.7%
Median	9.3	15.7	17.0	22.8	145.2%
75th Percentile	21.7	32.2	30.1	36.4	67.7%
25th Percentile	2.8	3.0	3.4	7.9	182.1%
Maximum	69.9	70.1	57.7	77.6	11.0%
Minimum	0.8	0.6	0.3	1.2	50.0%
Range	69.1	69.5	57.4	76.4	10.6%

NETWORK UC VISITS PER 100 MTF ENROLLEES, FYs 2018–2021



Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 11/24/2021

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.

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

Secure Messaging

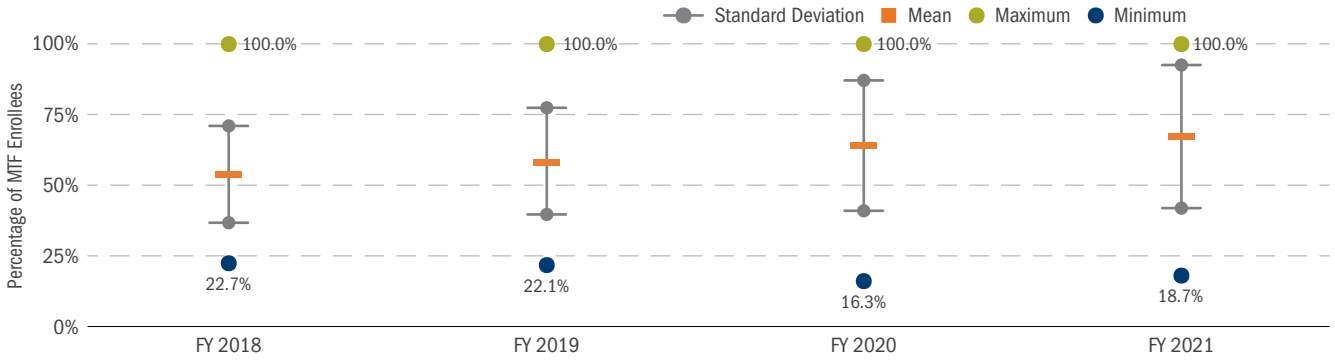
Percentage of Enrollees Registered to Use Secure Messaging: The direct care system offers enhanced access to care through the use of a commercially available secure messaging system. Secure messaging allows MTF enrollees to communicate directly with their PCMs and care teams to ask questions about their health or medical tests and to arrange referrals or appointments. The MHS prioritized enrollment in secure messaging starting in FY 2017. In FY 2020 and FY 2021, secure messaging was particularly important to maintain communication between the provider and patient while preventing the spread of COVID-19. The proportion of beneficiaries registered to use secure messaging at parent facilities has increased with each fiscal year, with an average of 67 percent of beneficiaries registered to use secure messaging for FY 2021. Analysis of the primary reasons that patients initiate messages include: asking a medical question (66 percent), arranging appointments/referrals (16 percent), and renewing medications (10 percent). Use of broadcast messaging as a way to keep beneficiaries informed increased from 8.15 million broadcast/blast messages sent in FY 2020 (including a monthly high of 2.6 million in March 2020 during the start of the pandemic) to 9.95 million for FY 2021, an increase of 1.8 million broadcast messages. Broadcast messaging allows clinic administrators the ability to send a mass message to all online secure messaging patients or to a select group based on clinic population. Broadcast messaging is also used to inform patient population on COVID booster/flu vaccination information as well as provide information for upcoming MHS GENESIS deployments.

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. For FY 2021, the number of patient-initiated messages responded to within one business day remained around historic performance at 81 percent.

PERCENTAGE OF MTF ENROLLEES REGISTERED TO USE SECURE MESSAGING, FYs 2018–2021

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2018–FY 2021 % POINT CHANGE
Mean	54.3%	58.9%	64.2%	67.2%	12.9
Standard Deviation	16.9%	18.8%	23.7%	25.1%	8.2
Median	53.6%	56.6%	62.4%	64.3%	10.7
75th Percentile	65.6%	70.4%	76.2%	80.3%	14.7
25th Percentile	43.4%	46.4%	49.0%	51.2%	7.8
Maximum	100.0%	100.0%	100.0%	100.0%	0.0
Minimum	22.7%	22.1%	16.3%	18.7%	-4.1
Range	77.3%	77.9%	83.7%	81.3%	4.1

PERCENTAGE OF MTF ENROLLEES REGISTERED TO USE SECURE MESSAGING, FYs 2018–2021



Source: MHS administrative data; DHA/HCO/Healthcare Optimization Division, 11/5/2021

Notes:

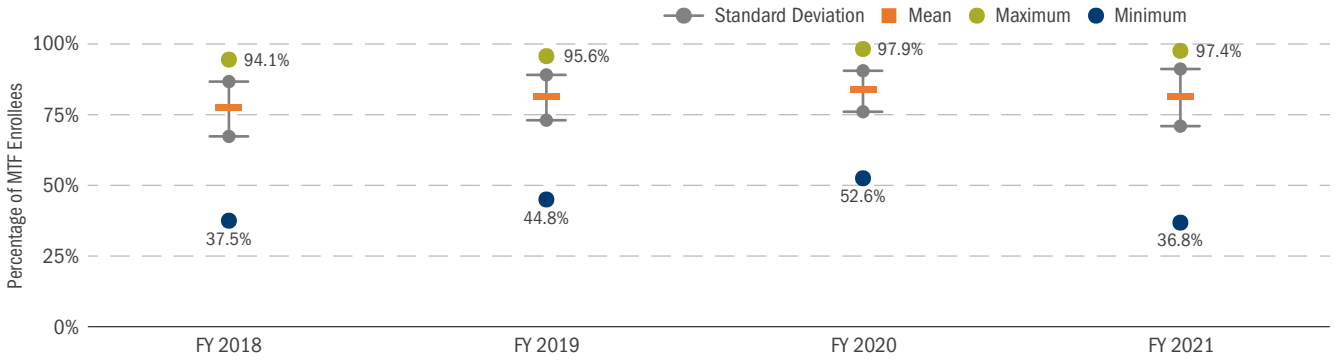
– Parent facility scores were used to describe variability in the results above.
– Data exclude MHS GENESIS sites.
– Numbers may not sum due to rounding.

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

PERCENTAGE OF SECURE MESSAGES RESPONDED TO WITHIN ONE BUSINESS DAY, FYs 2018–2021

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2018–FY 2021 % POINT CHANGE
Mean	77.1%	81.3%	83.3%	81.0%	3.9
Standard Deviation	9.4%	8.1%	7.4%	9.9%	0.5
Median	79.1%	82.2%	84.2%	83.0%	4.0
75th Percentile	84.4%	86.8%	87.5%	87.7%	3.3
25th Percentile	72.4%	77.7%	79.9%	77.2%	4.8
Maximum	94.1%	95.6%	97.9%	97.4%	3.3
Minimum	37.5%	44.8%	52.6%	36.8%	-0.7
Range	56.6%	50.7%	45.3%	60.6%	4.0

PERCENTAGE OF SECURE MESSAGES RESPONDED TO WITHIN ONE BUSINESS DAY, FYs 2018–2021



Source: MHS administrative data; DHA/HCO/Healthcare Optimization Division, 11/5/2021

Notes:

– Parent facility scores were used to describe variability in the results above.
– Data exclude MHS GENESIS sites.
– Numbers may not sum due to rounding.

Nurse Advice Line

The MHS NAL continues to provide valuable, quality, and convenient nurse triage and care coordination services to our MHS beneficiaries 24 hours a day, seven days a week, directing over half a million callers per year to the most clinically appropriate level of care. Since implementation in late FY 2014, the NAL has provided access to registered nurses (RNs) who address health concerns, offer self-care advice, and answer general health questions. The NAL received approximately 2,200 calls per day with the overall call volume decreasing by 7 percent from FY 2020. Total call volume still remains 16 percent higher than pre-COVID-19 levels.

The NAL falls under the DHA Healthcare Optimization program organizationally and is fully integrated with the MTF PCMH primary care clinics to support enhanced access strategies. MTF enrollees make up 83 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.

The MHS analyzes NAL performance by comparing the beneficiary's pre-intent—what the caller states they 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 private sector care claims and MTF encounter data from the MHS Management Analysis and Reporting Tool (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 significantly reduced, by 64 percent. Over half of the 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 were surveyed by the DHA following the call.

NAL CALLER INFORMATION FOR MTF ENROLLEES, FY 2021

NAL DISPOSITION	CALLER'S PRE-INTENT	NURSE ADVICE	CALLER'S ACTION WITHIN 24 HOURS
Network ED	23%	8%	4%
Network UC	13%	17%	21%
MTF Care	25%	34%	22%
Self-Care	18%	27%	54%
General Health and Other Miscellaneous Questions	21%	12%	0%
Total	100%	100%	100%

Source: NAL Program and administrative data (M2/MDR): DHA/HCO/Healthcare Optimization Division, 11/30/2021

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

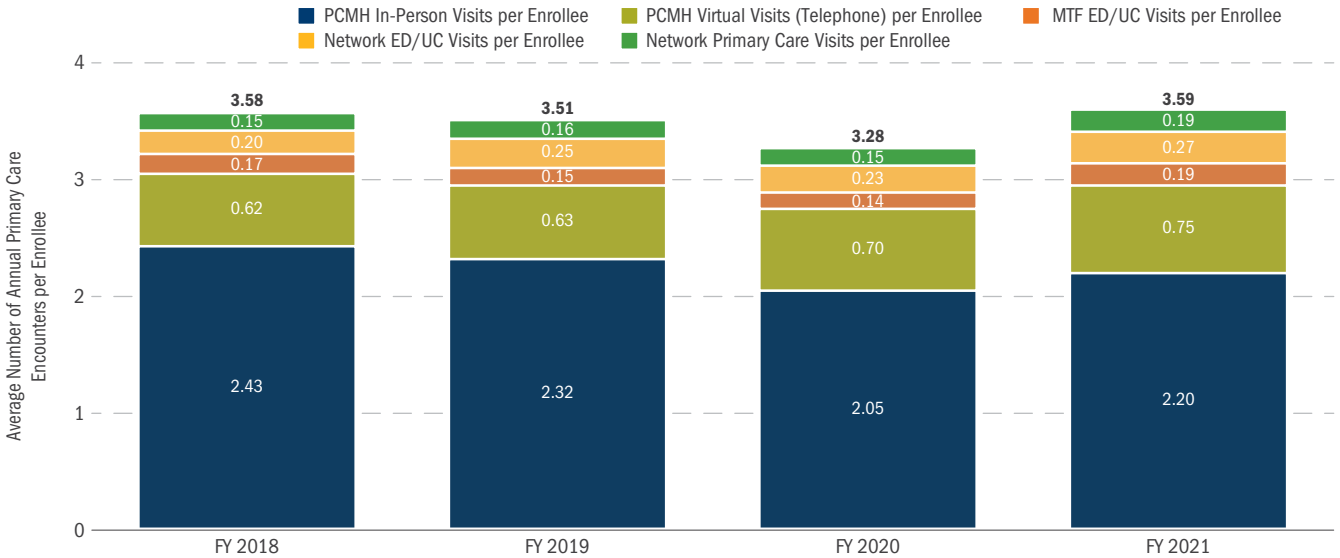
In FY 2021, primary care utilization returned to rates similar to FY 2018 and FY 2019 at 3.6 visits per enrollee. Also in FY 2021, network ED and urgent care rates increased disproportionately to care provided by the MTF, resulting in the lowest direct care market share since the primary care leakage to the network metric began. Primary care leakage to the network is 12.6 percent for FY 2021, with additional private sector care claims expected to be processed for FY 2021.

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 2022, 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 2018–2021

	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 2018	2.43	0.62	0.17	0.20	0.15	3.58	85.3%	10.0%
FY 2019	2.32	0.63	0.15	0.25	0.16	3.51	84.0%	11.7%
FY 2020	2.05	0.70	0.14	0.23	0.15	3.28	84.0%	11.8%
FY 2021	2.20	0.75	0.19	0.27	0.19	3.59	82.0%	12.6%

AVERAGE NUMBER OF ANNUAL PRIMARY CARE ENCOUNTERS PER ENROLLEE, FYs 2018–2021



Source: MHS administrative data; DHA/HCO/Healthcare Optimization Division, 11/15/2021

Notes:

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

– Private sector care data may not be complete for up to one year due to claims processing.

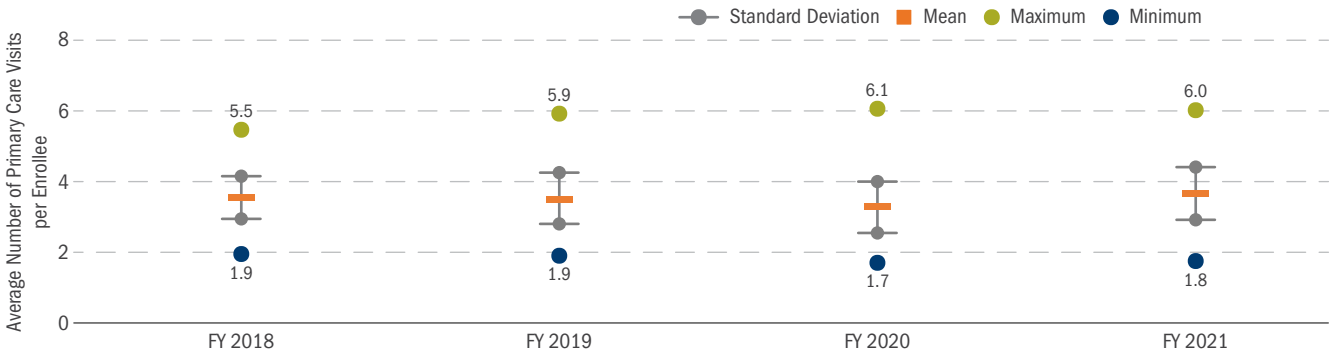
– Numbers may not sum to bar totals due to rounding.

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 2018–2021

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2018–FY 2021 CHANGE
Mean	3.6	3.5	3.3	3.7	0.1
Standard Deviation	0.6	0.7	0.7	0.8	0.2
Median	3.5	3.4	3.1	3.5	0.1
75th Percentile	3.9	4.0	3.8	4.3	0.4
25th Percentile	3.2	3.1	2.8	3.2	0.0
Maximum	5.5	5.9	6.1	6.0	0.6
Minimum	1.9	1.9	1.7	1.8	–0.2
Range	3.5	4.0	4.4	4.3	0.7

AVERAGE NUMBER OF ANNUAL MTF ENROLLEE VISITS FOR PRIMARY CARE OVERALL, FYs 2018–2021



Source: MHS administrative data; DHA/HCO/Healthcare Optimization Division, 11/18/2021
Notes:
– Parent facility scores were used to describe variability in the results above.
– Results exclude MHS GENESIS sites, and only include Prime, Plus, and Reliant enrollments.
– Private sector care data may not be complete for up to one year due to claims processing.
– Numbers may not sum due to rounding.

Improvement Tools

In FY 2020, the MHS continued expanding the centralized performance report capabilities in the Direct Access Reporting Tool (DART) on the CarePoint Information Portal to provide additional tools for MTFs to adjust supply to meet beneficiary demand. In FY 2020, the DART also released new reports to measure MTF compliance with DHA policies on expanded hours and standardized appointing. Additional dashboards are available on the CarePoint Information Portal. 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.

Specialty Care Access

In FY 2021, the MHS continued monitoring specialty care performance for several reasons: most private sector care costs for MTF enrollees are due to specialty deferrals to private sector 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, a new measure was implemented—the percentage of referrals dispositioned within one business day—to complement the existing measure on the number of days between the appointment creation date and the appointment date. DHA-IPM 18-001 identifies standard MTF and Market processes to improve both measures.

Percentage of Referrals Dispositioned within One Business Day

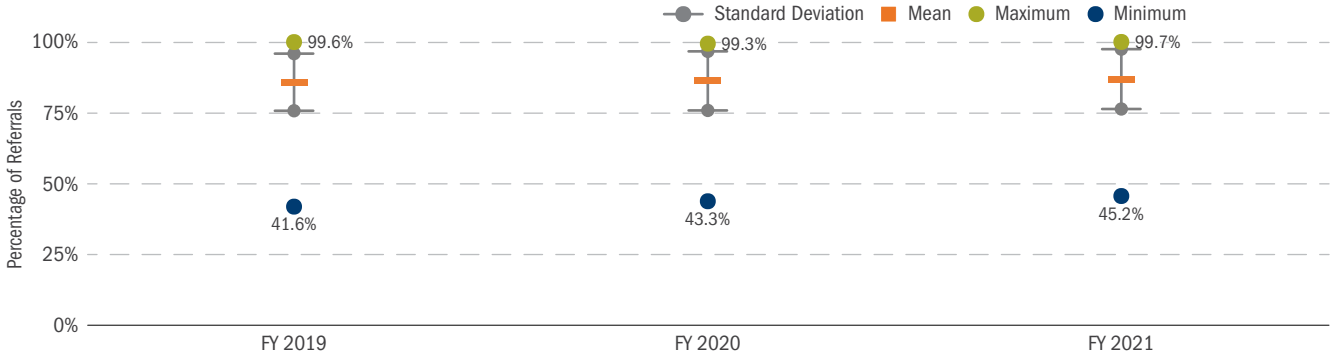
To "disposition" a referral is to determine whether the patient will be seen at the MTF, in the network, or if no appointment is required. Survey and qualitative data demonstrate a longer wait to obtain a scheduled appointment is a source of patient dissatisfaction and also delays needed care. DHA-IPM 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.

In FY 2021, an average of 86.6 percent of referrals were dispositioned within one business day, which is consistent with FY 2020 rates. The MHS has a standard of 90 percent of referrals being dispositioned within one business day. As the MHS is now monitoring this metric, we expect performance to improve to meet the standard in FY 2022.

PERCENTAGE OF REFERRALS DISPOSITIONED WITHIN ONE BUSINESS DAY FYs 2019–2021

	FY 2019	FY 2020	FY 2021	FY 2019–FY 2021 % POINT CHANGE
Mean	85.7%	86.1%	86.6%	0.9
Standard Deviation	10.1%	10.8%	10.6%	0.4
Median	87.7%	88.7%	88.2%	0.5
75th Percentile	93.2%	94.2%	94.8%	1.6
25th Percentile	80.8%	81.1%	81.9%	1.2
Maximum	99.6%	99.3%	99.7%	0.1
Minimum	41.6%	43.3%	45.2%	3.6
Range	58.0%	56.0%	54.5%	-3.5

PERCENTAGE OF REFERRALS DISPOSITIONED WITHIN ONE BUSINESS DAY FYs 2019–2021



Source: MHS Administrative Data; DHA/HCO/Healthcare Optimization Division, 11/18/2021

Notes:

– Parent facility scores were used to describe variability in the results above.
– Parent facilities with fewer than 100 referrals issued were not included in the results.
– Results continue to be revised for four months after referral issuance.
– Data exclude MHS GENESIS results.
– Numbers may not sum due to rounding.

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 for appointments requiring referrals. 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. Many MTFs met this goal in FY 2021, but as an enterprise, beneficiaries waited 15.8 days on average for a specialty care appointment requiring a referral. With improved referral processes and appointing expected with the new MHS GENESIS rollout and enforced DHA policy, performance is expected to improve in FY 2022.

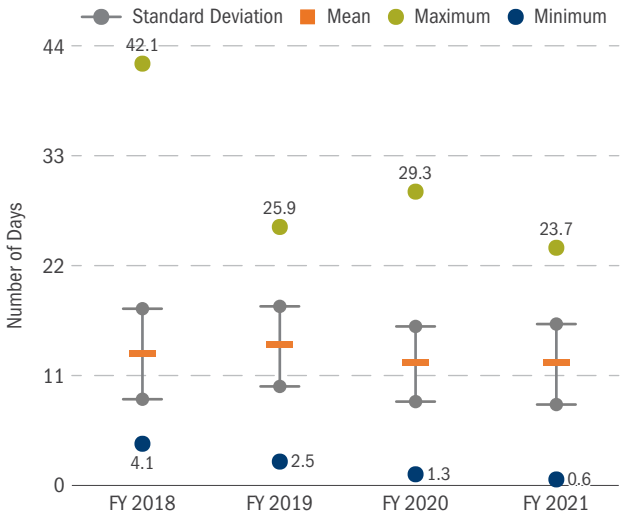
AVERAGE NUMBER OF DAYS FROM MTF BOOKED TO MTF APPOINTMENT, FYs 2018–2021

	FY 2018	FY 2019	FY 2020	FY 2021
Days from MTF Booked to MTF Appt.	15.3	16.4	14.2	15.8

AVERAGE NUMBER OF DAYS FROM MTF BOOKED TO MTF APPOINTMENT, FYs 2018–2021

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2018–FY 2021 CHANGE
Mean	13.2	13.9	12.1	12.2	–1.0
Standard Deviation	4.6	4.0	3.7	4.0	–0.5
Median	12.8	14.0	12.0	12.1	–0.7
75th Percentile	14.8	16.6	14.1	14.4	–0.3
25th Percentile	10.9	11.6	10.1	9.4	–1.5
Maximum	42.1	25.9	29.3	23.7	–18.3
Minimum	4.1	2.5	1.3	0.6	–3.4
Range	38.0	23.3	28.0	23.1	14.9

AVERAGE NUMBER OF DAYS FROM MTF BOOKED TO MTF APPOINTMENT, FYs 2018–2021



Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 11/18/2021
Notes:
– Parent facility scores were used to describe variability in the results above.
– Data exclude MHS GENESIS sites.
– FY 2021 results exclude September 2021.
– Results include referrals filled up to seven months after referral issuance.

Specialty Care Ambulatory Leakage

In FY 2021 (September 2020–June 2021), the MHS had elevated specialty care leakage above previous years at 15.1 percent. The MHS goal is to reduce this leakage to 10.7 percent. In FY 2022, 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 2015–2021

	ANNUAL AVERAGE
FY 2015	13.2%
FY 2016	13.1%
FY 2017	13.5%
FY 2018	13.4%
FY 2019	13.7%
FY 2020	14.7%
FY 2021	15.1%

Source: MHS administrative data; DHA/HCO/Healthcare Optimization Division, 11/30/2021
Note: FY 2021 excludes September 2021 records.

ACCESS TO MHS CARE *(CONT.)*

Virtual Health

Since 2017, the MHS has been working to implement Congress's FY 2017 NDAA Section 718 requirement for comprehensive expansion of DoD VH services, to occur within the context of a restructured MHS. Presently, the MHS leverages VH locally, regionally, and globally with a robust portfolio of capabilities to serve beneficiaries both in garrison and operational settings. The MHS organizes capabilities into three types from least to most complex: patient-to-provider, provider-to-provider, and complex real-time monitoring technologies. In FY 2021, the DHA conducted an evaluation of all VH capabilities to meet NDAA FY 2021 Section 756 requirements. Based on the results, the DHA began integrating VH capabilities into the overall health care delivery model to better leverage the benefits provided by technology. To develop plans for rightsizing and possible expansion, the DHA continues to evaluate each technology and the current and potential future- use cases to meet demand for care. DHA uses the following criteria to identify and prioritize VH technology: operational need; support of high-volume, high-risk, or high-cost care; reduction in private sector care costs; and reduction in unnecessary health care utilization.

The 2018 MHS VH strategic plan was the initial effort to combine MILDEP and DHA VH efforts into a coordinated global MHS VH strategy. With transition of all military MTFs and Markets in the 50 United States now to DHA's authority, DHA's oversight of and responsibility for all VH capabilities and the Virtual Medical Center (VMC) construct is accelerating planning and progress to extend technologies to all MILDEPs. To support integration of VH capabilities into the health care delivery model, DHA is developing guidance and standardized workflows, training, and procedural manuals for critical platforms, including Tele-Critical Care (TCC). In support of MHS strategy, the DHA is focusing on standardized integration and use of all VH capabilities and is prioritizing implementation of MHS Video Connect, TCC, tele-radiology, and tele-behavioral health. Finally, the DHA developed a technology maturation roadmap and funding strategy to support technology acquisition and implementation.

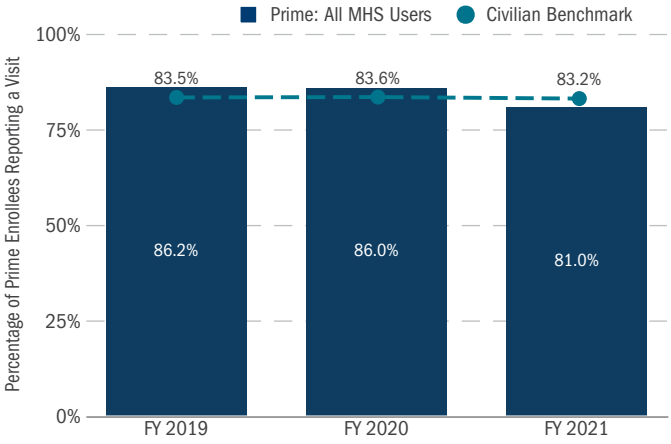
ACCESS TO MHS CARE *(CONT.)*

Measures of Availability and Ease of Access

Access to MHS care is measured in multiple ways: by survey, asking beneficiaries about their experiences 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, access to and use of outpatient services declined among Prime enrollees (with either a military or civilian PCM), with 81 percent reporting at least one visit in FY 2021, compared with 86 percent in FY 2020. MHS results remain statistically comparable to the civilian benchmark of just over 83 percent. Actual administrative data demonstrate 86 percent of direct care system (non-Active Duty) enrollees under age 65 had at least one primary care encounter in FY 2021.

TRENDS IN PRIME ENROLLEES HAVING AT LEAST ONE OUTPATIENT VISIT DURING THE YEAR, FYs 2019–2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, Health Care Survey of DoD Beneficiaries (HCSDB) data, adjusted for age and health status, as of 1/21/2022

Notes:

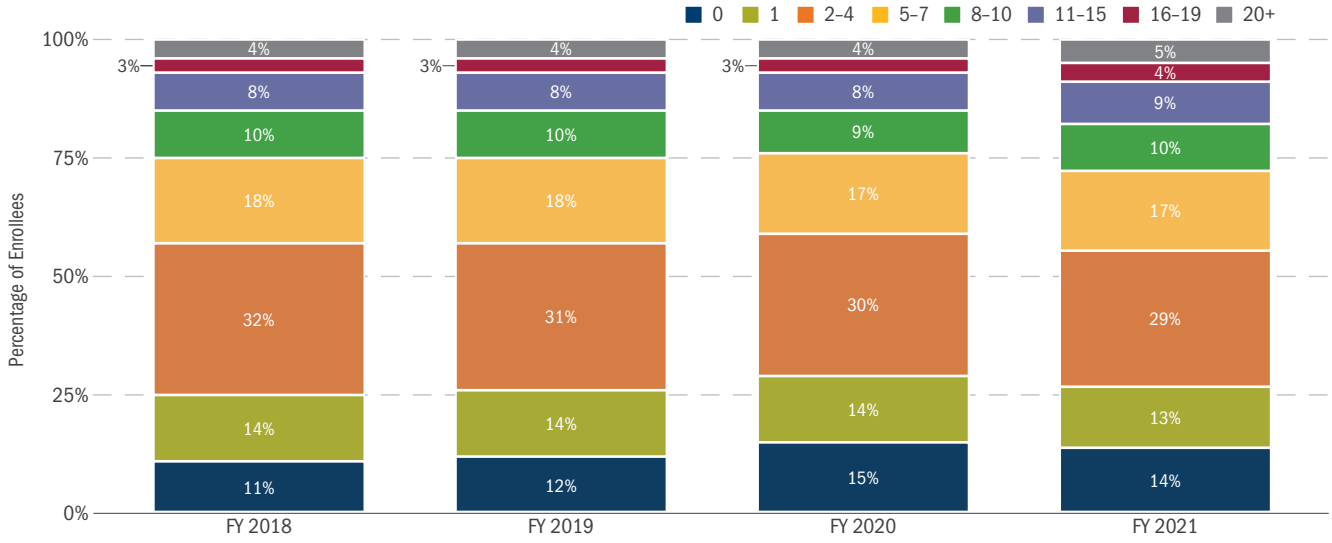
– All MHS Users applies to survey respondents in the 50 United States and the District of Columbia. Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric 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 2019 and 2020 come from NCQA's 2017 data and in 2021 from NCQA's 2019 data.

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

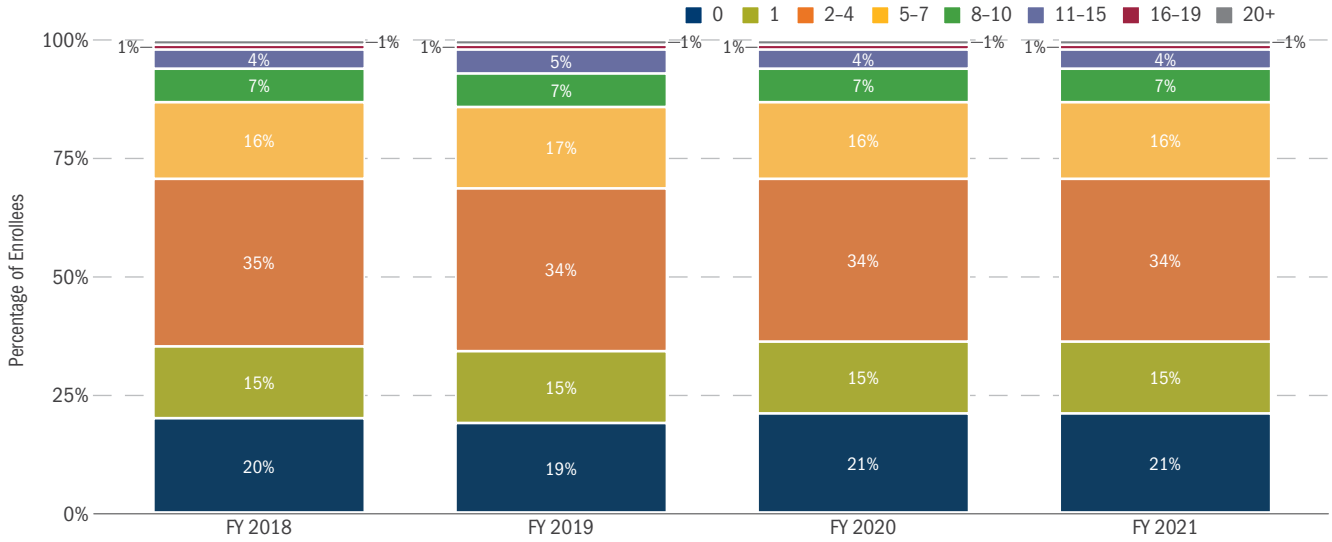
- **Direct Care Enrollee Access:** Based on administrative utilization data shown in the chart below, 86 percent of all non-Active Duty MTF enrollees under age 65 had at least one recorded outpatient visit for primary care reasons in FY 2021 (i.e., 14 percent did not have at least one visit). This access has been relatively stable since 2014. In FY 2021, 42 percent had between one and four visits, and 44 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 2018–2021



- **Private Sector Care Enrollee Access:** Based on administrative claims utilization data, the chart below shows that 79 percent of all non-Active Duty managed care support contractor (MCSC) Network Prime enrollees under age 65 had at least one recorded outpatient visit for primary care reasons in FY 2021 (i.e., 21 percent had no visits). Forty-nine percent of non-Active Duty MCSC Network Prime enrollees had between one and four visits, and 30 percent had five or more visits in FY 2021.

PERCENTAGE OF NON-ACTIVE DUTY ENROLLEES <65, BY NUMBER OF ANNUAL VISITS FOR MCSC/NETWORK PRIMARY CARE (ANY VENUE), FYs 2018–2021



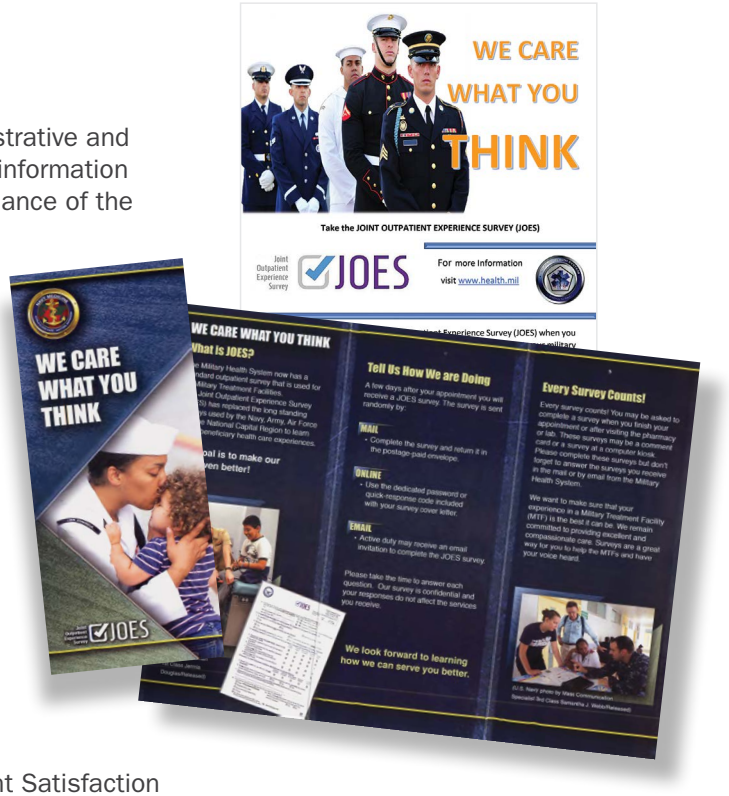
Source: MDR, DHA/SP&FI (J-5)/Analytics and Evaluation Division, 12/13/2021

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.)*



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 2021 marks the fifth 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).

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 (CAHPS-CG), as was the predecessor to the JOES-C: the TRICARE Outpatient Satisfaction Survey. This allows MHS comparison to civilian benchmarks, as well as MHS beneficiary ratings across direct and private sector care facilities.

Approximately 484,000 JOES/JOES-C were returned during FY 2021, including 398,000 JOES and 86,000 JOES-C, providing targeted areas for improvement in outpatient care for MHS beneficiaries.

The JOES and JOES-C have improved in efficiency and representation, demonstrated through the collection of web-based surveys by Active Duty Service members (ADSMs) in FY 2019 in response to e-mailed invitations. In FY 2020, a pilot program began to send the JOES via text message to beneficiaries at select MTFs and continued to expand to additional MTFs in 2021. A text was sent to consenting beneficiaries with a link to complete the JOES online. Early analyses found response rates were higher for text message recipients and the data was comparable to mail and e-mail survey responses.

Additionally, 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. Some of these measures are routinely reported to senior MHS leadership as core measures on various dashboards and are reported publicly on the transparency website of www.health.mil.

Results from the MHS population survey, the 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 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..."). Both the HCSDB and CAHPS Health Plan Surveys focus on the performance of the health plan over time from the beneficiary's perspective. The JOES-C 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.

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

Privacy of Adolescents

In support of state and federal statutes, the MHS respects and upholds the privacy rights of adolescents to protect teen confidentiality for specific services—particularly with respect to 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 TRICARE Inpatient Satisfaction Survey (TRISS), JOES-C, or HCSDB. The MHS protected the privacy rights of adolescents when administering the JOES 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 sexually transmitted diseases, 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.
Note: By law, DoD does not provide or pay for abortions except in very rare cases where the life of the mother would be endangered if the fetus were carried to term or in cases where the pregnancy is the result of an act of rape or incest.

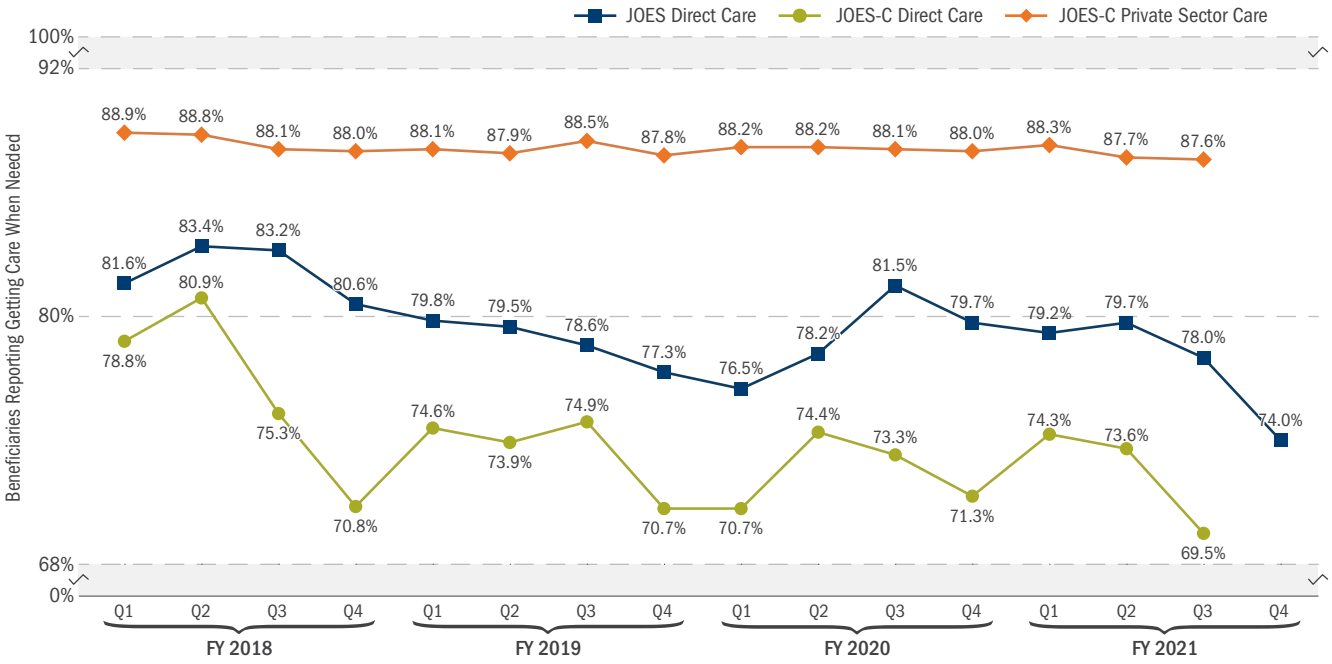
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care

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 (TRISS, 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.

- JOES-C private sector care scores for Getting Care When Needed have been above JOES-C direct care and JOES direct care for the last four years.
- JOES-C private sector care Getting Care When Needed scores have remained relatively stable from the beginning of FY 2018 through FY 2021.
- JOES direct care scores for satisfaction with Getting Care When Needed have continued to decline throughout FY 2021, from 79.2 percent in Q1 to 74 percent in Q4. Similar trends are shown for JOES-C direct care scores in FY 2021.

JOES AND JOES-C GETTING CARE WHEN NEEDED, FYs 2018–2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES, weighted data, compiled 12/2/2021

Notes:

– 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."

– FY 2021 is from October 2020 to July 2021 for JOES-C direct care and from October 2020 to June 2021 for JOES-C private sector care.

ACCESS TO MHS CARE *(CONT.)*

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 disparities in care and patient management processes.

JOES and JOES-C Getting Care When Needed—Variability over Time

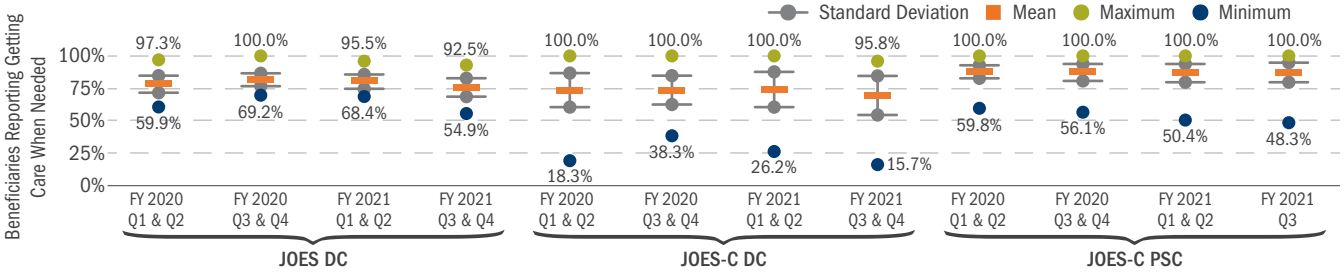
The table below displays the extent to which the measure of Getting Care When Needed changed over time in terms of improvement (increasing mean or median) or decreased dispersion (reduced range or standard deviation).

- From FY 2020 to FY 2021, the mean scores decreased by 5 percentage points for JOES-C direct care and 2.5 percentage points for JOES direct care.
- JOES-C private sector care had a less than 1 percentage point decrease over the same time period.

VARIABILITY IN JOES GETTING CARE WHEN NEEDED, FYs 2020–2021

	FY 2020 Q1 & Q2	FY 2020 Q3 & Q4	FY 2021 Q1 & Q2	FY 2021 Q3 & Q4	% POINT CHANGE (FY 2020 Q1 & Q2 TO FY 2021 Q3 & Q4)
JOES DIRECT CARE					
Number of Respondents	222,540	204,686	188,985	156,185	
Service Score (Mean)	78.4%	81.6%	80.4%	75.9%	-2.5
Standard Deviation	0.067	0.054	0.054	0.070	0.003
Median	78.4%	81.3%	80.3%	75.7%	-2.7
75th Percentile	82.2%	85.0%	83.5%	80.8%	-1.4
25th Percentile	74.5%	78.2%	77.2%	72.1%	-2.4
Maximum	97.3%	100.0%	95.5%	92.5%	-4.8
Minimum	59.9%	69.2%	68.4%	54.9%	-5.0
Range	37.4%	30.8%	27.4%	37.6%	0.2
JOES-C DIRECT CARE					
Number of Respondents	11,408	8,566	7,416	4,685	
Service Score (Mean)	73.8%	73.7%	73.9%	69.2%	-5.0
Standard Deviation	0.132	0.114	0.139	0.150	0.018
Median	74.7%	73.3%	74.4%	71.1%	-3.6
75th Percentile	82.3%	80.6%	83.0%	77.6%	-4.7
25th Percentile	67.0%	66.7%	64.1%	61.2%	-5.8
Maximum	100.0%	100.0%	100.0%	95.8%	-4.2
Minimum	18.3%	38.3%	26.2%	15.7%	-2.6
Range	81.7%	61.7%	73.8%	80.1%	-1.6
JOES-C PRIVATE SECTOR CARE					
Number of Respondents	43,347	30,290	30,794	14,767	
Service Score (Mean)	87.8%	87.5%	87.1%	87.4%	-0.4
Standard Deviation	0.054	0.065	0.070	0.077	0.023
Median	88.2%	88.3%	88.1%	88.6%	0.4
75th Percentile	91.1%	91.2%	91.0%	92.0%	0.9
25th Percentile	85.1%	84.7%	84.5%	84.0%	-1.1
Maximum	100.0%	100.0%	100.0%	100.0%	0.0
Minimum	59.8%	56.1%	50.4%	48.3%	-11.5
Range	40.2%	43.9%	49.6%	51.7%	11.5

VARIABILITY IN BENEFICIARY RATINGS: GETTING CARE WHEN NEEDED, FY 2020-2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES, weighted data, compiled 12/2021

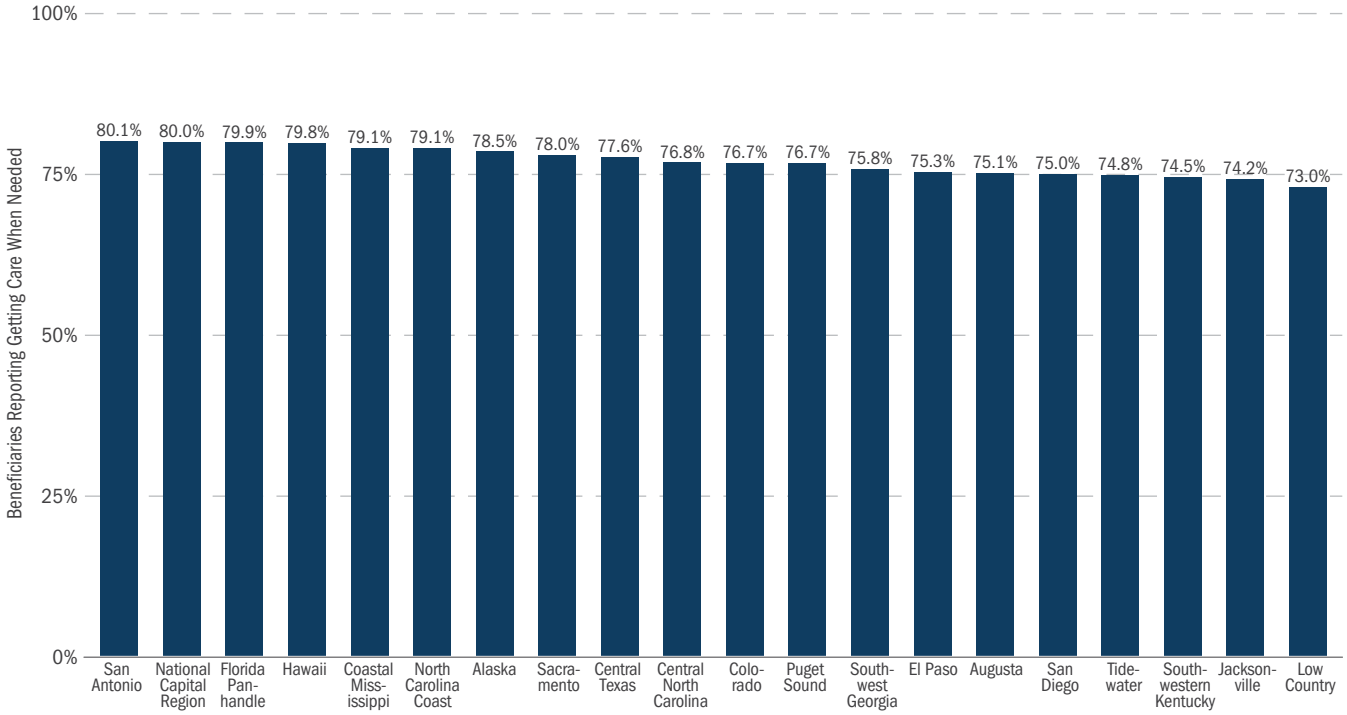
Note: FY 2021 is from October 2020 to July 2021 for JOES-C direct care and from October 2020 to June 2021 for JOES-C private sector care.

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

JOES Getting Care When Needed—By Markets

The chart below shows JOES scores for Getting Care When Needed for FY 2021 for the recently established DHA Markets. San Antonio was the highest scoring Market, with 80.1 percent of respondents indicating satisfaction with Getting Care When Needed. The lowest scoring Market for Getting Care When Needed in FY 2021 was Low Country at 73 percent satisfaction.

JOES GETTING CARE WHEN NEEDED BY MARKET, FY 2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES, weighted data, compiled 12/2/2021

Notes:

– 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."

– This analysis only includes the large DHA Markets.

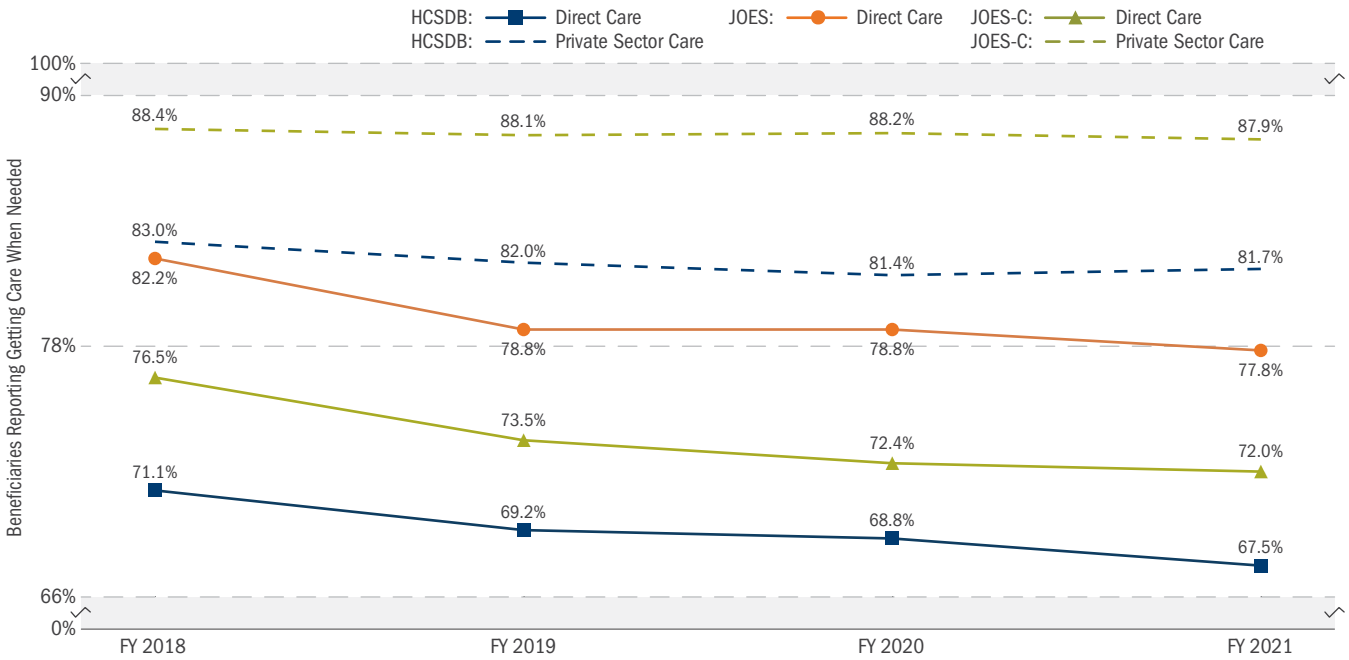
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care *(cont.)*

Comparison of Multiple Surveys—Getting Care When Needed

The results for the measure Getting Care When Needed is reported in JOES and JOES-C as well as the population-based HCSDB. Having this measure in each of the survey instruments makes the measure comparable across surveys and provides information about the beneficiaries who respond to them.

- Beneficiaries who utilize or are assigned to private sector care report greater access to their provider than those who utilize or are assigned to direct care, regardless of the time period or the survey. For JOES-C, scores for private sector care are almost 16 percentage points higher than those for direct care in FY 2021. Private sector care scores for HCSDB are 14 percentage points higher than their direct care counterpart scores in FY 2021.
- Ratings of Getting Care When Needed have declined over time for all surveys from FY 2018 to FY 2021.
- Beneficiaries who completed JOES-C reported greater access to care than beneficiaries who completed HCSDB, over time, for direct care and private sector care, respectively. 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.

HCSDB, JOES, AND JOES-C RATINGS OF GETTING CARE WHEN NEEDED, FYs 2018–2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB, JOES, and JOES-C, weighted data, compiled 12/2/2021

Notes:

– FY 2021 is from October 2020 to July 2021 for JOES-C direct care and from October 2020 to June 2021 for JOES-C private sector care.

– Results for HCSDB are for Prime enrollees only. "HCSDB Direct Care" represents care received as Active Duty or through a military PCM for individuals under 65 and who have been enrolled for at least six months. "HCSDB Private sector care" is defined as care received from civilian PCM for individuals under 65 who were enrolled in the following healthcare plans for at least six months: TRICARE Select, TRICARE Reserve Select, TRICARE Retired Reserve, or TRICARE Young Adult Select.

– 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."

ACCESS TO MHS CARE *(CONT.)*

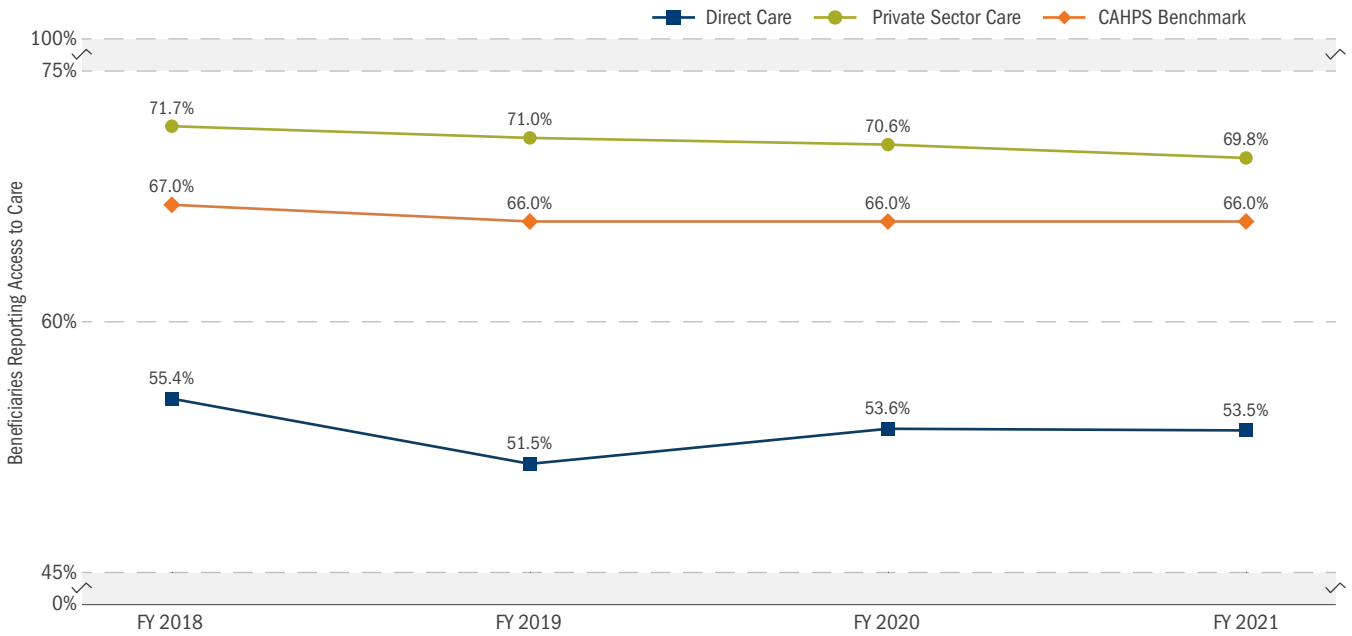
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care *(cont.)*

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 CAHPS-CG. 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 (private sector care) are higher than for those receiving care from MTFs (direct care).
- From FY 2018 through FY 2021, JOES-C Access to Care scores for private sector care have remained above the CAHPS benchmark by 4 to 5 percentage points. During the same time period, JOES-C direct care scores have remained 12 to 14 percentage points below the CAHPS benchmark.

JOES-C ACCESS TO CARE COMPOSITE, FYs 2018–2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES-C, weighted data, compiled 12/2/2021

Notes:

– FY 2021 is from October 2020 to July 2021 for JOES-C direct care and from October 2020 to June 2021 for JOES-C private sector care.

– CAHPS benchmarks are the 50th percentiles from the respective 2017 and 2018 CAHPS-CG national civilian scores.

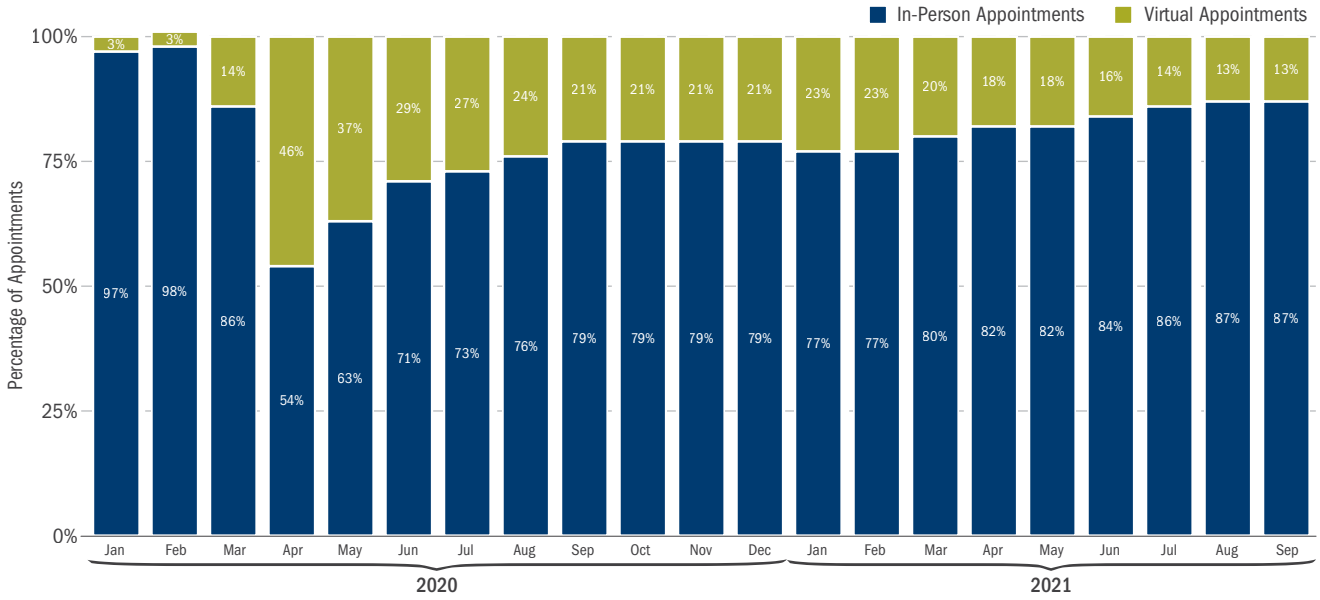
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care *(cont.)*

Impact of COVID-19 on Patient Experience

COVID-19 has affected nearly all areas of health care across the MHS. During the coronavirus pandemic, the MHS has experienced an unprecedented increase in the use of VH, specifically for outpatient care. VH for purposes of this analysis includes appointment types that are not in person (i.e., appointments occurring via phone, video, and e-mail/secure messaging).

- Based on self-reported survey data from the JOES, the vast majority (approximately 98 percent) of outpatient appointments were in person prior to the pandemic (until March 2020) with the combined virtual appointments accounting for approximately 2 percent of appointment types during this time.
- April 2020 had the largest percentage of virtual outpatient appointments for the past two years at 46 percent.
- The majority of virtual appointments are phone appointments during both calendar years (CYs) 2020 and 2021.
- Virtual care has steadily decreased from each month from the beginning of the pandemic in March 2020 through September 2021 but still remains at 13 percent, which is much higher than before the pandemic.

SELF-REPORTED PROPORTION OF OUTPATIENT VISITS BY APPOINTMENT TYPE, CYs 2020–2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, compiled 12/2/2021

Notes:

– Appointment type is from beneficiary response to the survey question: How did you receive care during this visit? with response options of in person, via video visit, via telephone (audio only), and via e-mail/secure messaging. These numbers may differ from administrative data of appointment type.

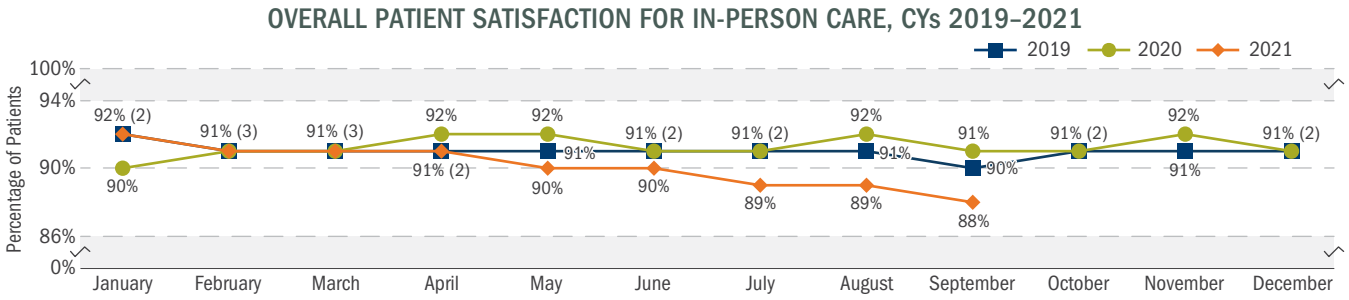
– Percentages may not sum to 100 percent due to rounding.

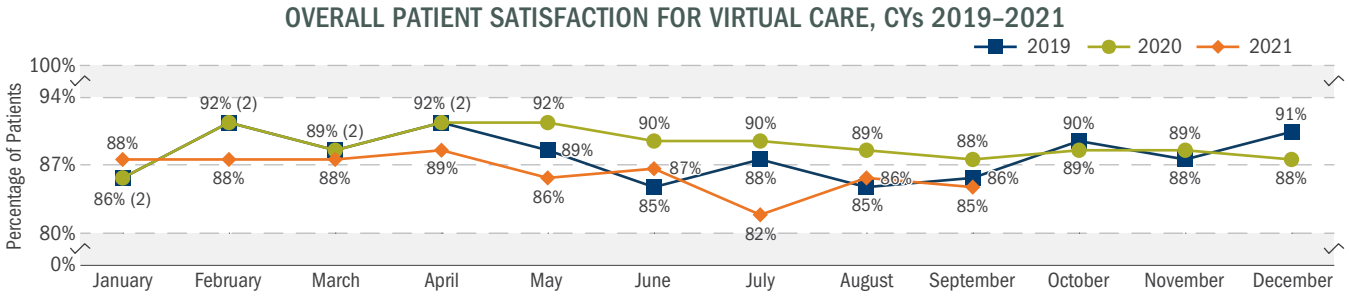
ACCESS TO MHS CARE *(CONT.)*

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

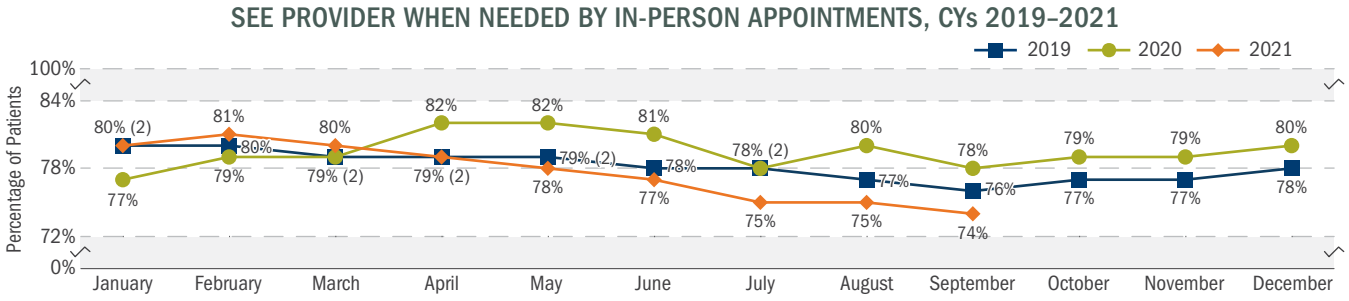
Impact of COVID-19 on Patient Experience *(cont.)*

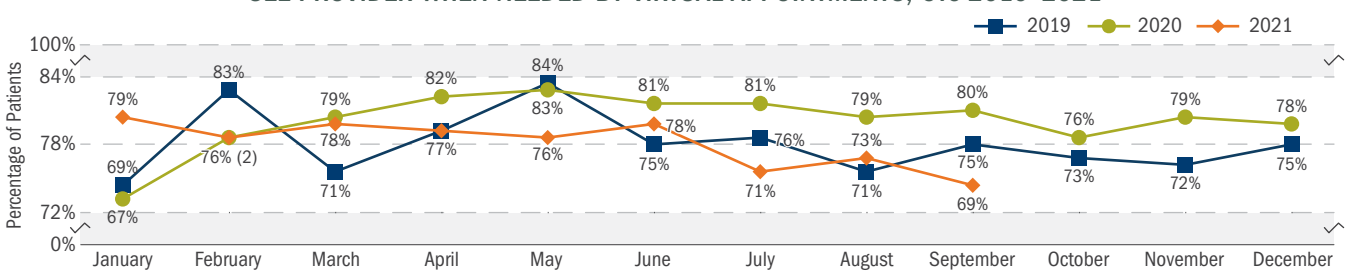
The graphs below display Access to Care (See Provider When Needed) scores (in-person or virtual) for CYs 2019, 2020, and 2021 to compare if satisfaction scores have changed during the COVID-19 pandemic. Patient satisfaction for in-person appointments remained relatively stable from 2019 through 2021. Virtual appointments over the past three years had more fluctuation in scores. In general, comparing by month, 2021 scores were lower than 2019 and 2020 for the respective month, ranging from 88 percent to 92 percent.





The graphs below display Access to Care (See Provider When Needed) scores for in-person and virtual appointments that follow similar trends as overall patient satisfaction. In CYs 2019 and 2020, scores remained stable for Able to See Provider When Needed for in-person appointments, but started to decrease in July 2021. Moreover, from January 2019 to September 2021, Access to Care for in-person appointments decreased by 6 percentage points. For virtual appointments, CY 2021 scores are generally lower than CY 2020 when comparing by month.





Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, compiled 12/2/2021

Note: Appointment type is from beneficiary response to the survey question: How did you receive care during this visit? with response options in person, via video visit, via telephone (audio only), and via e-mail/secure messaging. These numbers may differ from administrative data of appointment type.

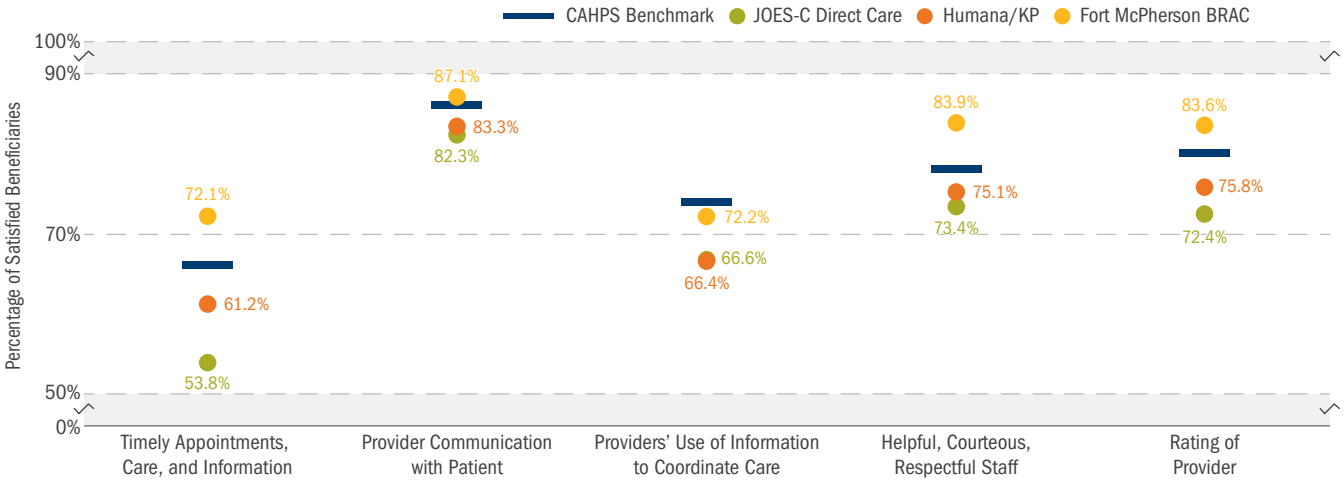
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care *(cont.)*

Patient Experience of Care: Comparing Humana/Kaiser Permanente Pilot Participants and Fort McPherson Base Realignment and Closure (BRAC)/Atlanta Area TRICARE Beneficiaries

In FY 2020, DHA implemented an ACO demonstration in the Atlanta Market area in partnership with Humana and Kaiser Permanente (KP). Enrollment in the Humana/KP demonstration was offered to TRICARE Prime and Select members in the Atlanta Prime Service Area during the 2019 Open Enrollment Season (January 1, 2020, start). Care delivery began January 1, 2020, and will continue for three years. From October 2020 to June 2021, KP beneficiary enrollment was 247. This section compares patient experience scores of participants in the Humana/KP pilot and TRICARE beneficiaries in the Atlanta area (Fort McPherson BRAC) from JOES-C direct care and private sector care during October 2020 to June 2021.

- Humana/KP pilot participant ratings were above direct care ratings for all measures from October 2020 to June 2021. Humana/KP ratings were generally below those in the Atlanta area (Fort McPherson BRAC) and below the civilian CAHPS benchmark for all measures during the same period.

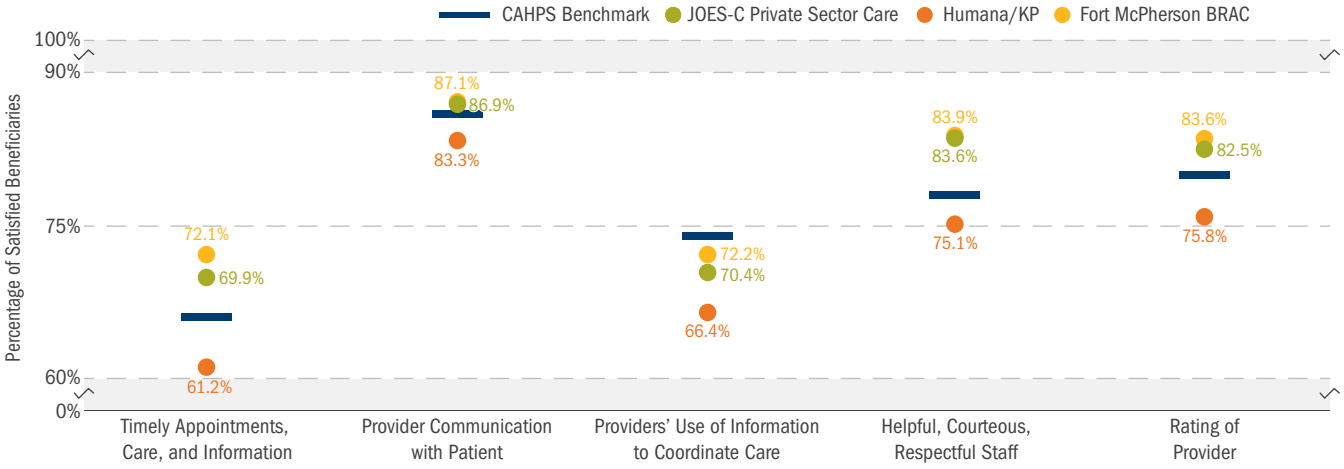
CAHPS COMPOSITE SCORES COMPARED WITH DIRECT CARE, OCTOBER 2020–JUNE 2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES-C, weighted data, compiled 12/6/2021
Note: Humana/KP N=247

- Humana/KP pilot participant ratings were also below the private sector care scores during the period of October 2020 through June 2021.
- Results should be interpreted with caution due to the small sample size for the Human/KP pilot survey respondents.

CAHPS COMPOSITE SCORES COMPARED WITH PRIVATE SECTOR CARE, OCTOBER 2020–JUNE 2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES-C, weighted data, compiled 12/6/2021
Note: Humana/KP N=247

ACCESS TO MHS CARE *(CONT.)*

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

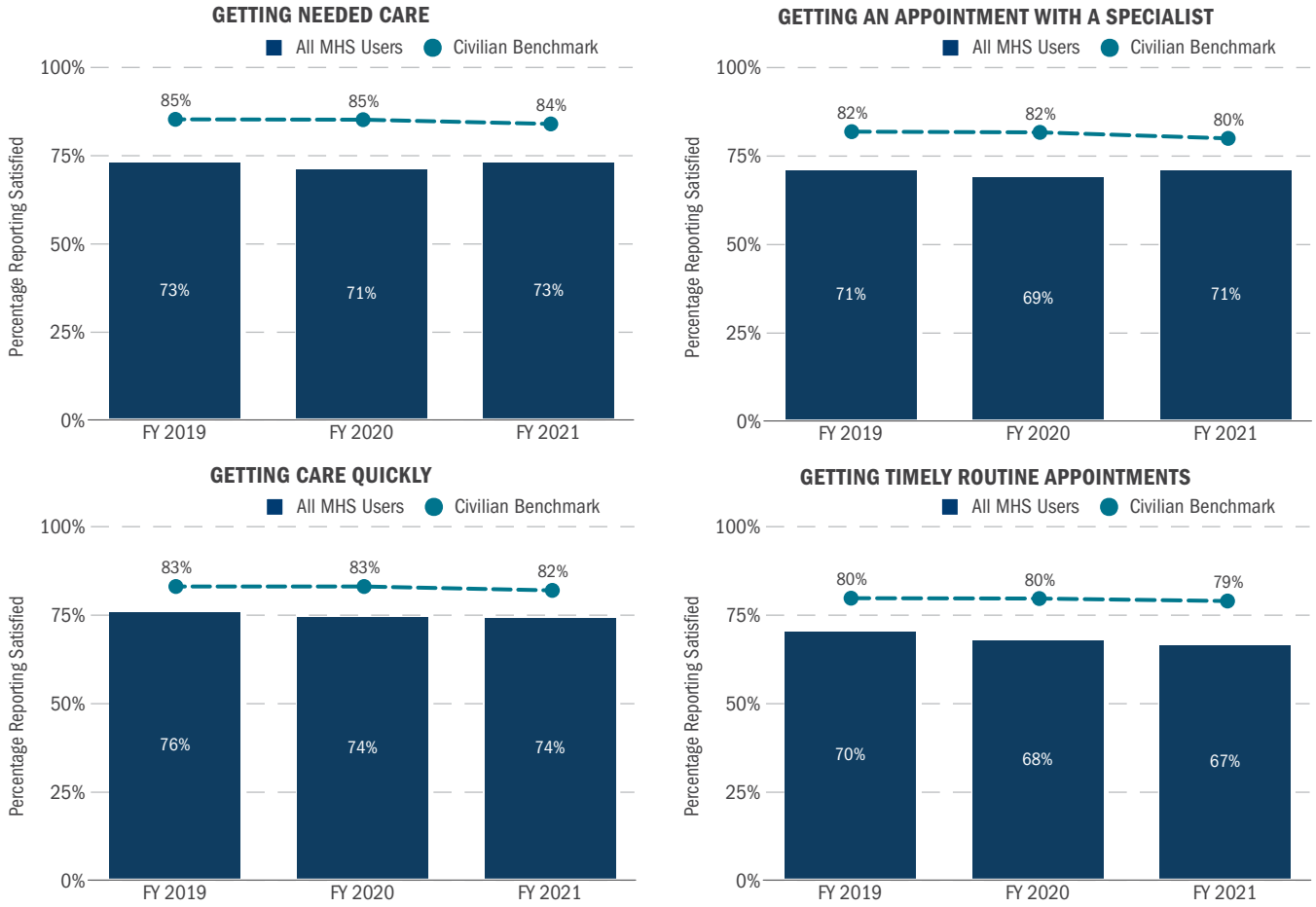
Instead of focusing on a specific health care event to assess patient experience with care, population surveys are designed to sample populations based on the demographics being considered (e.g., a survey of all ADSMs about their health behaviors, or a survey of all MHS beneficiaries to assess their 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, not 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.

- MHS beneficiary ratings for Getting Care Quickly and Getting Timely Routine Appointments declined slightly from FY 2019 to FY 2021. MHS beneficiary satisfaction with Getting Needed Care and Getting an Appointment with a Specialist remained about the same from FY 2019 to FY 2021.
- MHS beneficiary satisfaction with all four access measures was lower than the comparable civilian benchmarks in each year between FY 2019 and FY 2021.

TRENDS IN MEASURES OF ACCESS FOR ALL MHS BENEFICIARIES (ALL SOURCES OF CARE), FYs 2019–2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 1/21/2022

Notes:

– All MHS Users applies to survey respondents in the 50 United States and the District of Columbia.

– 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 2019 and 2020 come from NCQA's 2017 data and in 2021 from NCQA's 2019 data.

CLINICAL QUALITY MANAGEMENT IN THE MHS

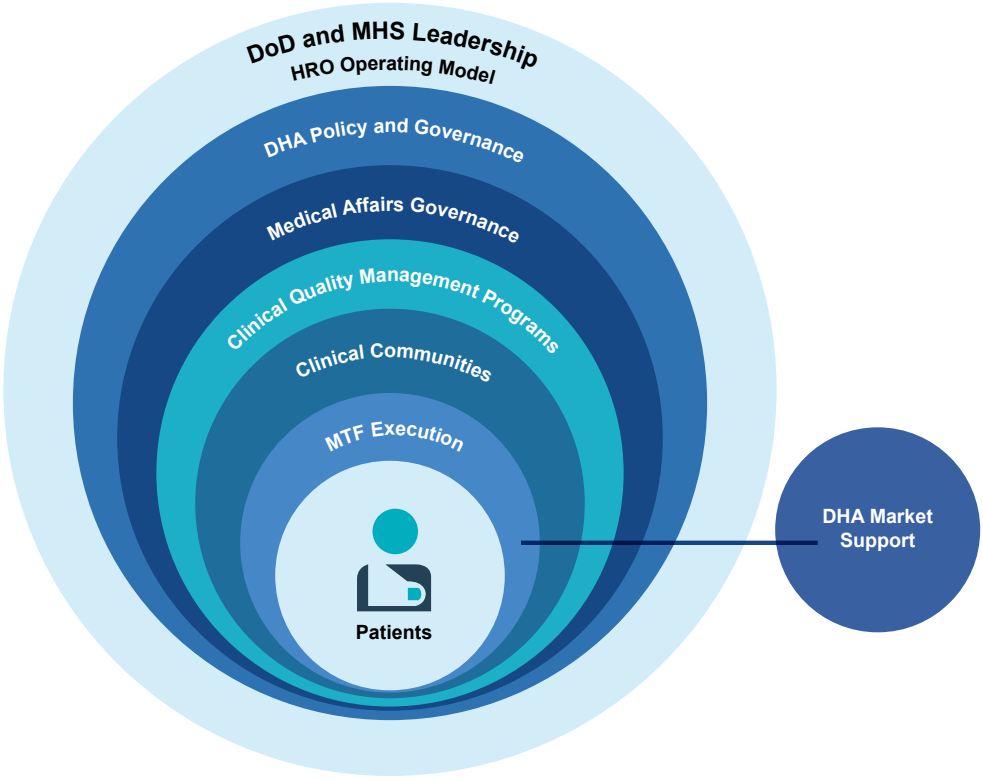
Clinical Quality Management Oversight

Through the MHS Quadruple Aim, the CQM functional capability affirms its unwavering commitment to provide health care of the highest quality and value to all of our beneficiaries. Recent NDAAs have enacted significant TRICARE and MHS reforms, including changes to the administration and management structure, and specific requirements for CQM in both direct and private sector care systems. Together, these reforms are 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 in 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 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 private-sector care network to further drive transparency, accountability, standardization, prevention, and improvement across all care continuum environments.

The sections that follow provide additional details 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 Assistant 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 law (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 interests 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 DHA Patient Safety Program (PSP) is to promote a culture of safe, high quality patient care to end preventable patient harm throughout the MHS. The 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 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 PSP aims to present an integrated picture of safety, utilizing available information from the entire organization. To accomplish this, the 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 DHA Markets, the Small Market and Stand-Alone MTF Office (SSO), Defense Health Agency Regions (DHARs), MTFs, and the Services, the PSP focuses on four 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
3. Fostering a culture of safety
4. Infection prevention and control

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

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

Reporting patient safety events is a component of the MHS 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 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 (REs), the most severe events from across the organization
3. Healthcare-associated infections (HAIs), which are tracked through the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN)
4. Global Trigger Tool (GTT), 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 requires MTF Directors 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, the PSP has seen increased collaboration on improvement efforts, knowledge exchange, and the development of enterprise solutions. In FY 2021, a total of 84,897 patient safety reports were submitted from the direct-care system. Near-miss events, which did not reach a patient, accounted for 51 percent of all JPSR events reported in FY 2021. Across the deployed environment, JPSR has become an important tool in delivering safer care in austere environments where we take extraordinary care to stabilize and safely transport our wounded warriors back to contiguous United States (CONUS) in our global Aeromedical Evacuation system.

The table below compares FY 2017 to FY 2021 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 2017–2021

HARM GROUP	FY 2017		FY 2018		FY 2019		FY 2020		FY 2021	
	#	%	#	%	#	%	#	%	#	%
Harm	10,457	11%	9,987	10%	10,274	10%	9,467	11%	8,906	10%
No Harm	39,103	39%	40,630	39%	40,639	38%	34,411	39%	32,807	39%
Near Miss	49,475	50%	54,212	52%	55,110	52%	44,380	50%	43,184	51%
Total	**99,035**	**100%**	**104,829**	**100%**	**106,023**	**100%**	**88,258**	**100%**	**84,897**	**100%**

Source: DHA/Medical Affairs/Clinical Support Division (CSD), 12/1/2021. Data reported as of 11/27/2021

Notes:

– Due to the process of event investigation and resolution, data may shift slightly from year to year as the JPSR system closes out the event.

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

2. DoD Reportable Events

DoD Reportable Events (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 encompass situations as included in The Joint Commission (TJC) Sentinel Events and National Quality Forum (NQF) serious reportable events. The table below provides the most common medical and dental DoD REs that the MHS reported to TJC between FYs 2017–2021.

DoD RES REPORTED, FYs 2017–2021

EVENT TYPE	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
	#	#	#	#	#
Wrong-Site Surgery: Wrong Patient, Wrong Site, Wrong Procedure	27	46	27	21	27
Fall	7	8	6	12	19
Delay in Treatment: Lab, Path, Radiology, Referral, Treatment Order	20	25	15	15	18
Unintended Retained Foreign Object	25	27	20	18	15
Maternal (≥20 Week Gestational Age–42 Days Postpartum): Hemorrhage, Hysterectomy	9	11	<4[a]	10	9

Source: DHA/Medical Affairs/CSD, 12/1/2021. Data reported as of 11/30/2021

[a] Contents confidential and privileged in accordance with 10 U.S.C. §1102. Data include only TJC reportable events.

- **Wrong-Site Surgery (WSS):** WSS is a preventable DoD RE involving surgeries on the wrong site, wrong side, wrong person, or performance of the wrong procedure. The MHS goal for WSS is zero events. In FY 2021, the MHS saw a 29 percent increase from FY 2020 in the number of reported WSS DoD REs (from 21 to 27). Efforts to prevent WSS include the development of concise incident analysis (CIA). Initially intended for dental WSS events, the PSP has developed a CIA methodology which was piloted successfully over the last year. Currently, the PSP is working to adapt the program more broadly to facilitate learning across the MHS and increase efficiency in mild- or no-harm safety investigations.
- **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 2021, the number of reported URFO DoD REs decreased 17 percent from FY 2020 (from 18 to 15).

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. To bring greater awareness to leading practices for prevention in FY 2019, DHA published a focused review on delay in treatment. However, there was an increase in the number of delay in treatment events reported in FY2021, most likely explained by disruptions in medical care since March 2020 due to the COVID-19 pandemic.
- **Fall:** A fall is considered a DoD RE when the fall occurs while the patient is being cared for in a healthcare setting and causes death or serious injury. In FY 2021, the MHS saw a 58 percent increase in the number of reported fall DoD REs (from 12 to 19). To bring greater awareness to practices for prevention, DHA published a tool kit that offers guidance on education, assessment, reassessment, intervention, and continuous improvement.
- **Maternal:** Maternal DoD REs include events during which the mother receives more than four units of blood, is transferred to a higher level of care, or undergoes a hysterectomy due to hemorrhage. To address maternal events, the PSP partners with the Women and Infant Clinical Community (WICC) to improve the safety of women and infants.

Policy mandates that MTFs must submit a comprehensive systematic analysis (CSA) for each DoD RE that occurs in the facility. In addition to mandatory completion, the Services/Markets may also voluntarily elect to complete a CSA for events that do not meet the threshold of a DoD RE, which provides an opportunity for learning and improvement for the MTF. In total, the DHA submitted 121 CSAs for DoD REs to TJC in FY 2021, representing a 12 percent increase from FY 2020 (not shown). For each CSA received, the PSP reviews the strength of corrective actions (CAs) and submits a review back to the Service/Market. The PSP's corrective rating system is based on the Department of Veterans Affairs (VA) Action Hierarchy of Corrective Actions, which breaks down actions by strength based on likelihood of preventing the event from happening again. The actions can be strong, intermediate, or weak. Strong actions focus on a system change and are not reliant on individual memory or vigilance. Through this process, the PSP guides MTFs in implementing strong CAs that are more likely to prevent a similar event from happening again. In FY 2021, the percentage of CSAs received for TJC DoD REs that included at least one strong or intermediate CA decreased by 19 percent over FY 2020 (not shown).

Success Story: Dental Instrument Sterilization Project at 423rd MDG

With a strong culture of safety employing trend analysis and engaged feedback loops, the Dental Team revamped the sterilization process in the instrument processing center. Through detailed root cause analysis, the team uncovered underlying risk factors related to water quality, which compromised the sterility of instruments and potentially placed patients at risk. After a water distilling unit was installed, the peel pack staining rate dropped, which decreased the need to reprocess instruments. Facility changes, process improvement, and continuous auditing of progress within the unit have increased efficiency and reduced potential for infection.

3. CDC National Healthcare Safety Network (NHSN)

The reduction and prevention of HAIs, improved antibiotic stewardship, and reduction of multidrug-resistant organisms remain top priorities for the PSP. To ensure standardization of reporting practices across the health care system, the MHS participates in the CDC's NHSN, the nation's most widely used HAI tracking system. NHSN participation directly aligns with the MHS goal of achieving zero harm by allowing the tracking of data needed to identify problem areas, measuring progress, and ultimately eliminating HAIs through implementation of targeted process improvement initiatives based on standardized measures and benchmarks. The MHS participates in the NHSN device-associated module and the antimicrobial use and resistance (AUR) module. The device-associated module includes submission of central line–associated blood stream infection (CLABSI) and catheter-associated urinary tract infection (CAUTI) data for all ICUs and wards while the AUR modules include submission of antimicrobial administration and resistance data for all inpatient military treatment facilities.

The PSP analyzes MHS data and conforms to national standards. The standardized infection ratio (SIR) and the standardized antibiotic administration ratio (SAAR) are the two primary measures the PSP uses to benchmark and compare internal MHS data to national benchmarks. For both measures, a value of 1.0 or less indicates that the MHS performs the same or better than the national benchmark.

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

To facilitate integration of leading practices, the DHA developed and distributed a comprehensive CLABSI Toolkit and a CAUTI Implementation Guide for HAI Prevention. These two critical documents provide frontline staff with evidence-based resources and serve to advance DHA's role in supporting standardization across the health care system. The table below demonstrates how the MHS performed in comparison with the national benchmark for both CAUTIs and CLABSIs. The MHS faced challenges in meeting the 2020 national benchmarks as a result of the COVID-19 pandemic (SIR >1.0).

HAIs, FY 2018 Q1–FY 2021 Q3, STANDARDIZED INFECTION RATIO

	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4
CLABSIs	0.6	0.5	0.8	0.7	1.4	0.8	1.0	0.5	0.6	0.3	0.9	1.5	1.3	1.4	0.5	1.4
CAUTIs	0.8	0.8	0.5	0.8	0.4	0.5	0.5	0.6	0.3	0.1	0.6	0.6	0.8	0.5	0.6	1.3

Source: DHA/Medical Affairs/CSD, 1/19/2022

Note: These data are inclusive of 12 locations: six ICUs and six wards. ICUs: Burn; Medical/Surgical; Medical; Trauma; Pediatrics; Surgical; Wards: Burn, Medical/Surgical; Medical; Surgical; Labor, Delivery, Recovery, and Postpartum Suite; Oncology; and Hematology.

To facilitate dissemination and access to antimicrobial use data to all inpatient MTFs, the Patient Safety Pharmacovigilance Center publishes quarterly reports and dashboard metrics that enable each facility to monitor its data. Additional SAAR statistics for 22 antimicrobial types and 17 inpatient ward categories are also available for review. The table below displays the two primary SAARs for adults and pediatrics. For FY 2018 Q2 to FY 2021 Q3, the MHS performed better or the same as the national benchmark if the value shown is 1.0 or less.

ANTIMICROBIAL USE, FY 2018 Q2–FY 2021 Q3, STANDARDIZED ANTIMICROBIAL ADMINISTRATION RATIO

	2018 Q2	2018 Q3	2018 Q4	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3
All Antibiotics – All Adult Wards	0.9	0.9	0.9	0.9	1.0	0.9	0.9	0.9	1.0	1.0	1.0	1.0	0.9	0.9
All Antibiotics – All Pediatric Wards	0.9	1.0	1.1	1.0	0.9	0.7	0.9	0.8	0.9	1.1	0.8	0.8	0.6	0.9

Source: DHA/Medical Affairs/CSD, 9/23/2021

Note: These data are inclusive of 12 locations: six ICUs and six wards. ICUs: Burn, Medical/Surgical, Medical, Trauma, Pediatrics Medical/Surgical, and Surgical. Wards: Burn; Medical/Surgical; Medical; Surgical; Labor, Delivery, Recovery and Postpartum Suite; and Oncology and Hematology.

Infection Prevention and Control (IPC) COVID-19 Response

In response to the COVID-19 pandemic, the DHA established an IPC Tiger Team that consisted of multidisciplinary Tri-Service experts. The team has now transitioned into the DHA IPC Standardization Group and continues to provide agile response to IPC-related inquiries received from the field. The team also supports the field by providing current information regarding resumption of services and reopening of clinics to ensure continuity of safe patient care.

4. Global Trigger Tool (GTT)

In FY 2018, the MHS implemented the GTT, leveraging methodology gleaned from the Institute for Healthcare Improvement (IHI). Voluntary reporting methods detect only a fraction of AEs that cause patient harm. However, GTT uses a standardized process to detect AEs not otherwise reported. It is a validated, objective, and consistent retrospective method for medical record review. The DHA uses the GTT to determine and monitor rates of patient harm over time and supplements other reporting systems to help direct resources and monitor impact. The IHI methodology recommends a minimum of 12 months of data collection to determine a baseline; therefore, FY 2019 was the first year when GTT data were reportable. The table below shows GTT statistics from FY 2019 to FY 2021 Q3.

GLOBAL TRIGGER TOOL ADVERSE EVENTS, FY 2019 Q1–FY 2021 Q4

	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3
AEs per 100 Admissions	7.1	8.2	6.9	7.9	6.0	6.4	6.6	7.1	6.5	6.7	5.5

Source: DHA/Medical Affairs/CSD, 11/12/2021

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

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

Throughout the MHS transformation, the PSP continued to work toward improved patient safety, quality, and process improvement. Over the course of the past year, the PSP has focused on engaging, educating, and equipping our MTFs and their leadership teams to increase patient safety. This focus includes collaboration with the Services and Clinical Communities to provide improved patient safety. The sections below describe examples of patient safety solutions that engage, educate, and equip.

Engage

The PSP supports several efforts throughout the year to engage the enterprise in patient safety education, recognition, and standardization. Examples include:

Patient Safety Awareness Week (PSAW): This week is a multiorganizational effort that serves as a national education campaign for promoting patient safety practices. The PSP collaborates with external organizations, including AHRQ and IHI, on this awareness initiative. In FY 2021, PSAW included 20 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 the PSP reaches into all areas of the organization to promote and encourage the adoption of leading safety practices.

COVID-19 Response – Ready and Resilient Award Program: The PSP created the Ready and Resilient Award program to encourage peer-to-peer recognition of patient safety during the onset of the COVID-19 pandemic. During this time-limited program, MTF staff nominated more than 500 team members. The Ready and Resilient Award program demonstrated how MHS professionals are going above and beyond to improve patient and staff safety.

Clinical Communities: Clinical Communities improve patient safety and quality of care by engaging appropriate clinical experts to guide process improvement and professional collaboration within specialties. These dedicated clinicians share knowledge, define practice guidelines, and establish the standard of care for each discipline to bolster force readiness and support our clinicians and staff in delivering the best health outcomes for all our recipients of care. Since the establishment of the DHA Clinical Communities in 2019, the PSP has engaged with these groups and has provided enabling expertise to the communities. For example, this year, the PSP partnered with Clinical Communities for an initiative to further target zero harm by eliminating wrong-site, wrong-person, and wrong-side surgeries. Together, PSP and the Clinical Communities have developed the Ready Reliable Care (RRC) Safety Communication Bundle to standardize six patient safety practices, including Universal Protocol for surgical procedures. The Safety Communications Bundle launches in FY 2022 across all MTFs to standardize the processes that allow the MTS to deliver high-quality care, prevent harm to patients, and reduce workplace stressors related to staff burnout.

Success Story: Medication Error Reduction in Outpatient Pharmacy at Walter Reed National Military Medical Center

Medication errors undermine the MTF's mission to provide safe quality care while maintaining zero harm to patients. To reduce prescription errors, Walter Reed National Military Medical Center initiated a project with the objective of achieving a 30 percent or greater reduction in medication errors that reached patients per 100,000 prescriptions in the Main Pharmacy. Aligning to the six RRC/HRO principles and following the eight-step Practical Problem Solving Methodology, the team compared three performance measures before and after implementation of countermeasures. The objective was achieved, and the results demonstrated that the five countermeasures were effective for reducing medication errors that reached patients in our pursuit of becoming a high reliability organization.

Healthcare Event Analysis Response Team (HEART): Historically, each Service developed the capability to send external investigation experts to review quality of care concerns and patient safety events warranting their most robust response. With the transition to the DHA, these diverse capabilities were standardized and consolidated into a standing team available to promote standardization, improvement, and drive systematic changes from lessons learned across the enterprise. The HEART consists of a team of experts with specialized training in investigation and support of patient safety investigations. The team includes physicians, nurses, Human Factors subject-matter experts (SME), and other patient safety experts. The PSP launches a HEART mission to complete a full investigative analysis, which identifies clinical process failures and latent vulnerabilities, recognizes human factor contributions, and determines corrective actions to mitigate future risk. HEART leverages SME input and coordinates with the appropriate Clinical Communities to assess enterprise-level challenges to find effective system-level solutions. HEART engages Markets and MTFs via direct investigation activity as well as coaching support to MTFs who are completing independent comprehensive systematic analyses internally.

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

Educate

An HRO strives for zero preventable harm and remains committed to continuous learning and improvement despite operating in complex or high-risk environments. RRC is the DHA approach to increasing high reliability across the MHS. It builds on the existing work and best practices of the Service medical departments and the DHA. RRC works across clinical and non-clinical settings to drive better outcomes for patients, staff, and the enterprise. To that end, the PSP has developed and implemented multiple evidence-based learning resources to eliminate preventable patient harm. These include learning systems designed to establish a common knowledge base for entry level patient safety professionals and identify opportunities to assist these professionals in advancing to intermediate and advanced levels. In addition, the PSP has designed and sustained curricula and materials that enhance communication and teamwork, address any new regulations and protocols, and identify learning needs or educational gaps based on patient safety data and changes in the environment.

The PSP uses a competency-based model to identify gaps in learning and develops an education and training strategy plan to address those gaps. The PSP uses a blended learning approach for successful implementation and long-term sustainment of learning. This includes structured training, social interaction, and experiential learning. The PSP has developed and sustained resources in all three categories to include live webinars, on-demand videos, coaching, office hours, apps, simulation, tool kits and guidebooks, networking opportunities, access to real-time data, SharePoint sites, and Communities of Practice. The PSP has multiple tools and materials to supplement learning. Between January and September 2021, the PSP disseminated over 4,600 materials to the MTFs.

The PSP supports the Services/Markets and MTF teams by providing the infrastructure to obtain continuing education (CE) for multiple training courses, offering one-on-one team coaching and evaluating the system's effectiveness. From January through November 2021, the PSP held 781 courses; trained 11,085 leaders, providers, and staff; and provided 15,322 CE credits. 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® Train the Staff Simulation Based 2.0
- Root Cause Analysis

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. Four times a year, this week-long course provides them with evidence-based knowledge, skills, and tools to implement patient safety initiatives at their facilities. The PSPC offers an award-winning, state-of-the-art learning system with a pre-work module, five days of face-to-face training, including two days of TapRooT® training, post-training virtual coaching, and opportunities for continued development through a patient safety Manager Ongoing Learning Certificate. The PSP regularly updates the PSPC curriculum 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. In FY 2020 and 2021, the PSP conducted the PSP virtually for participants across the globe as the initial and ongoing response to the constraints and complexities of COVID-19. The PSPC determines success in educating patient safety professionals to the knowledge, skill, insight, and confidence essential to perform by the triangulation of select data. Data are derived from (1) self-evaluation of pre-post Course knowledge and confidence in ability to perform; (2) Interview data gathered during 3, 6 and 12-month post-Course Coaching Sessions; and (3) anecdotal self-reports regarding the impact of the Course and Coaching on the success of individual practices.

Course to Course, faculty review all evaluation data to assess for actionable variables that impact participants during or after each Course to determine whether data are exceptional to one particular training or represent a trend. As an example, a key pre-post Course actionable question tracked through the Patient Safety Core Content evaluation is: "Know my patient safety roles and responsibilities and the expected impact of my activities on patient safety at my organization…"

Of the 115 respondents in 2021, 20 self-rated as high or very high before training with an increase to 75 of the 115 self-rating as high or very high after the training.

PSPC faculty review and analyze all data for the opportunity to innovate and improve upon both the experience and the transfer of knowledge into performance excellence for the Patient Safety Professional.

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

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 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. The MHS has adopted TeamSTEPPS worldwide and provides leadership engagement, training, implementation, and sustainment on the local level at each MTF. Though structured training has its place, the focus is turning more toward implementation and sustainment of the concepts and tools. In CY 2021, through November 2021, the MHS held 777 TeamSTEPPS classes with 10,966 participants and awarded 10,746 continuing education credits. In CY 2021, the PSP completed the development of a mobile and web-based TeamSTEPPS application, available on all platforms at https://mobile.health.mil/teamstepps/.

DHA-PM 6025.13 Volume 2 identifies TeamSTEPPS as foundational to patient safety and the MHS standard for maximally integrating teamwork principles into practice. For a blended learning approach, the PSP supports the MTFs with several adjuncts to learning, to include coaching, questionnaires, badge cards, posters, pocket guides, and tips and scenarios. Since 2009, the PSP has sponsored Active Duty and DoD civilian government employees to participate in the National TeamSTEPPS conference, sponsored by the American Hospital Association (AHA), which includes a DoD breakout session. The conference was canceled in FY 2020 and in October 2021 due to the COVID-19 pandemic. AHA is planning an in-person conference for spring 2022.

Equip

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

The DHA has made great strides in developing a formal IPC structure, and efforts continue to be leveraged to drive progress through the DHA IPC Standardization Group. Key deliverables and initiatives have focused on the development and MHS-wide implementation of evidence-based guidance for critical IPC processes. This included the completion of the High Level Disinfection Guide leveraging standardized tracers, as well as the tri-service CLABSI tool kit that was developed prior to the COVID-19 outbreak.

Success Story: Program Changes to Resident Call: A Transition from 24-Hour Call Shifts to a Night Float System at Naval Medical Center Portsmouth

Resident feedback and a facility Culture of Safety Project identified the resident call system as a significant source of staff burnout. Peer-reviewed literature demonstrate that frequent call shifts, long work hours, and sleep deprivation all lead to burnout and adversely impact provider health, performance, and quality of life. The goal of this project was to reduce resident total call hours by 20 percent, reduce total call shifts, and increase training time in program without increased risk of adverse patient outcomes. To achieve this goal, a new standardized process was implemented, which resulted in a 58 percent overall reduction of total call hours, reduction in days away from training, improved resident call satisfaction, and improved continuity of care without adverse clinical outcomes. This project exceeded all goals without requiring additional resources and improved communication and patient safety.

Additionally, the PSP established a standardized IPC competency model and continues to make progress in the standardization of formal training and mentorship program for infection preventionists. Lastly, the IPC Program has initiated routine Market Brief Sessions to facilitate enhanced communication of essential headquarters-level information with transitioning Markets and their subordinate units.

MHS GENESIS and Patient Safety: The MHS is in the process of deploying the new EHR, MHS GENESIS, across 450 MTFs globally. The PSP has employed a strong clinical review process in concert with a robust incident response and change request system to ensure the safest rollout possible. The PSP is sharing lessons learned with VA partners that are just beginning their journey with the same EHR vendor to leverage opportunities for improved safety with this major change. The 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. A sustainment training supplement with DoD Healthcare Management System Modernization Operations and Support webinars prior to each go-live site, practice exercises, and communication materials that target patient safety professionals transitioning to the new system. In FY 2020, the PSP participated in deployment training with 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.

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

Transparency

Transparency is key to patient safety improvement. The PSP is making strides in increasing and improving the transparency of patient safety care and data for Service members and their families. The DHA has focused on data transparency while standing up the Markets and centralizing the MTFs under a unified structure. Data transparency promises open communication among the organization, its employees, and its customers on common quality metrics that affect patient outcomes. Pages 70 and 119 further describe the MHS transparency efforts.

Safety Event and Root Cause Analysis (SERCA): The MHS has implemented the DHA SERCA tool to share lessons learned and data from four data sources (JPSR, DoD REs, CDC NHSN, and GTT), between Services/Markets, SSO, DHARs, and MTFs. 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. Enhanced transparency affords MTFs real-time visibility into what other facilities in the DoD are doing to prevent events and improve safety. The SERCA tool has over 400 active users and over 18,000 views since initial deployment in FY 2017.

MHS Patient Safety Culture Survey

Since 2005, the 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 evaluates culture across several key dimensions, including leadership support, teamwork, staff empowerment, trust, and reporting and learning from errors. The 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 PSP uses the data to define the current state of safety culture across the MHS, track trends and advancements over time, and identify opportunities for improvement.

The PSP most recently administered the MHS Patient Safety Culture Survey from April 2019 to June 2019. For the 2019 survey, the PSP added questions to assess associations of staff burnout and resilience with safety culture and to further inform improvement strategies. As with previous culture surveys, the PSP provided MTFs with multiple resources, including a guidebook, 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.

Respondents to the 2019 MHS Patient Safety Culture Survey identified opportunities for improvement in our culture, including high rates of perceived burnout across the MHS workforce, ranging from 33 percent to 48 percent reported overall. Survey analyses additionally revealed that higher burnout rates and higher reported workplace chaos were associated with lower teamwork within and across units. To address burnout, the PSP is developing an HRO Ready Reliable Care Safety Communication Bundle, consisting of six practices that address leadership engagement, teamwork, and the Universal Protocol. Concurrently, MHS experts are developing an online OR debriefing tool based on a program validated by Army MTFs. This innovative process captures and shares lessons learned by OR personnel across the DoD. In addition to policy and guidance, the PSP will develop and execute blended strategies to support the implementation, including webinars, micro-learning, coaching, office hours, safety forums, and a mobile application to augment patient safety practices. In 2021, the Patient Safety Program started planning for the release of the next Patient Safety Culture Survey to be launched in January 2022.

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 patient needs, eliminating preventable harm, and enhancing the integration of nationally recognized standards of care. In 2021, the PSP organized the award disciplines to align with the HRO principles and received 84 highly competitive submissions for consideration. By award discipline, these included 17 for Leadership Commitment, 15 for Culture of Safety, 34 for Continuous Process Improvement, and 18 for Patient Centeredness. See below for the full breakdown of submissions across Army, Navy, Air Force, and the Markets.

The DHA selected this year's winners from various MTFs across the country. There were three winners selected for the Leadership Commitment Award and six winners selected for the Culture of Safety Award. In addition, several of the winning submissions aligned with the Clinical Communities. Below is a short summary of the winning Leadership Commitment and Culture of Safety Award submissions.

2021 LEADERSHIP COMMITMENT AND CULTURE OF SAFETY AWARD WINNERS

MILITARY MEDICAL TREATMENT FACILITY/ TRICARE REGIONAL OFFICE	AWARD-WINNING INITIATIVE
Leadership Commitment	
U.S. Naval Hospital Okinawa	An Alternative Vaccination Model for COVID-19 #vaxoki
U.S. Naval Hospital Rota	An Overseas COVID-19 Vaccination HRO Execution
Walter Reed National Military Medical Center	Implementation of Standardized Patient Care Handoff Communication at a Military Organization
Culture of Safety	
Navy Medical Readiness & Training Command Okinawa	Bringing Opiates Off the Streets & Undertaking Excess Scripts (BOOTS & UTES)
423rd Medical Group	Dental Instrument Sterilization Project
Navy Medical Readiness & Training Command Beaufort	Instrument Sterilization Process
Walter Reed National Military Medical Center	Medication Error Reduction in Outpatient Pharmacy
Navy Medical Readiness & Training Command Beaufort	Storage and Surveillance of Reusable Medical Equipment
Naval Medical Center Portsmouth	Program Changes to Resident Call: A Transition from 24-Hour Call Shifts to a Night Float System

Total submissions received: 84

- **Leadership Commitment: 17**
  - Army: 1
  - Navy: 10
  - Air Force: 5
  - National Capital Region (NCR): 1
- **Continuous Process Improvement: 34**
  - Army: 7
  - Navy: 19
  - Air Force: 8
  - NCR: 0
- **Culture of Safety: 15**
  - Army: 1
  - Navy: 9
  - Air Force: 4
  - NCR: 1
- **Patient Centeredness: 18**
  - Army: 2
  - Navy: 11
  - Air Force: 4
  - NCR: 1

Health Care Risk Management: Addressing Enterprise Risk

The focus of health care risk management (HRM) 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 DHA HRM Program promotes accountability, transparency, and standardization through support of the MHS strategy for managing clinical, operational, human capital, technical, and corporate compliance risks. To execute this mission, the HRM Program works in close collaboration with other CQM Programs, Markets, the SSO, DHARs, the Services and Health Affairs to ensure a robust capability that drives accountability, transparency, standardization, and improvement. Oversight of HRM processes in the MHS is the responsibility of the DoD Risk Management Working Group (RMWG), led by the Office of the Assistant Secretary of Defense for Health Affairs.

HRM is directed by the Department of Defense Instruction (DoDI) 6025.13 and executes through the DHA-PM 6025.13 for HRM processes and reporting to the National Practitioner Data Bank (NPDB), states of licensure, and other regulatory/certifying bodies. Reporting to NPDB occurs for paid malpractice tort cases, Active Duty death and disabilities cases associated with health care when the standard of care is breached. Reporting also occurs to NPDB and/or regulatory agencies for adverse privileging/practice actions, and administrative/criminal actions with nexus to healthcare delivery, following required due process procedures. The HRM Program provides a forum to discuss relevant risk management topics, share clinical lessons learned from reported adverse events within the MHS, identify variance in health care delivery, apply effective risk-reduction strategies, and promote uniform implementation of HRM processes across the MHS.

Reporting to the NPDB and Regulatory Agencies. Healthcare Risk Management confirmed that for FY 2021, 134 practitioners were reported to the NPDB and regulatory agencies for risk management–related events/actions occurring within the MHS (source: Services' quarterly report to DoD RMWG). In FY 2020, 116 reports were made, and 115 practitioners were reported in FY 2019.

Credentialing and Privileging: Program to Ensure Appropriate Credentials and Privileges

The Credentialing and Privileging (CP) Program serves as the foundation for high-quality and safe care by ensuring qualified and competent staff deliver care in a manner that is consistent with their education and training, demonstrate current competency, approved scope of services, and is compliant with accreditation standards and applicable state and federal laws. This foundational and robust validation process within the MHS mitigates the exposure of risk and harm for MHS patients by ensuring providers are eligible, qualified, and competent.

The primary tool for CP Program mission execution is the DoD's Centralized Credentialing and Quality Assurance System (CCQAS), which is a web-based application that serves as the DoD global application for credentialing and privileging of MHS providers. Under the leadership of the CP Program managers and in collaboration with key stakeholders, required CCQAS system updates to support the MHS transition have been enabled and continue to promote increased transparency, accountability, and standardization. The CP Program endeavors to standardize and streamline credentialing and privileging processes throughout the DoD to gain efficiencies in provider sharing and cross-leveling.

For example, the CP Program managers developed a privileging process for the Virtual Medical Center (VMC) that facilitates VH services capabilities MHS-wide. To promote the VMC's mission with an effective and efficient privileging method, the CP Program has enabled a specific process where, once privileged through this platform, a provider is authorized to provide VH services throughout the entire enterprise per the defined scope of privileges granted. Another expample, the expedited privileging process, has been instrumental in rapidly moving providers in response to COVID-19 pandemic missions, both within the MHS as well as supporting civilian and humanitarian missions. This highlights how the CP Program is organized to quickly and efficiently respond to changing conditions and emergent requirements that necessitate provider movement to meet the needs of the MHS and the nation.

Additionally, as part of its broader efforts, the CP Program collaborates closely with the Department of Veterans Affairs (VA) to promote increased, standardized, and agile movement of providers between VA and DoD treatment facilities in the better service of both our shared and individual missions.

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

Accreditation and Compliance Program: Ensuring Industry Standards for Quality and Safety across the MHS

MTF Accreditation

The MHS is committed to providing 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 DHA Accreditation and Compliance (AC) Program enables the application of nationally recognized accreditation standards for health care organizations to provide guidance for the development of policies and practices that ensure quality and safe care delivery in the MHS direct care system. Further, 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 national quality and safety standards and to identify opportunities for improvement and to further affirm the MHS commitment to high reliability and providing the best care to all our beneficiaries.

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. Maintaining national healthcare quality and safety standards through a rigorous self- and external assessment program with benchmarking and public reporting is foundational to high reliability in healthcare. The AC Program enables this through support for the requirements in NDAAs 2016 through 2021.

Establishment of the DHA AC Program to manage and administer accreditation and compliance activities in DHA Markets, the SSO, DHARs, and MTFs has been completed in close collaboration with the Services, building off the success of their former accreditation programs while standardizing and gaining efficiencies through an enterprise approach aligned to the requirements set forth in the DHA-PM 6025.13 and the DoDI 6025.13.

The AC Program is focusing its efforts on the establishment of a comprehensive, systematic process of review across the MHS, which allows MTFs to demonstrate their ability to meet DoD policy mandates, regulatory requirements, and health care standards. Achieving and maintaining accreditation by a recognized external accrediting organization (AO) provides benchmarks for measuring standards compliance and builds stakeholder confidence in the quality of health care delivered. The mandate to accredit MTFs by an external AO demonstrates DoD's commitment to the provision of safe, quality care to all beneficiaries and supports the DHA HRO journey. Private sector TRICARE network health care facilities are mandated to meet contractual requirements for accreditation by an approved AO. Accreditation by external organizations provides the MHS with valuable information to validate compliance with standards and to identify opportunities for improvement.

The DHA Procedural Manual 6025.13 Clinical Quality Management in the Military Health System Volume 5: Accreditation and Compliance provides direction and guidance for the development of a unified, robust accreditation program. DHA continues to work closely with the Services during this time of transition with a goal of leveraging lessons learned to build better.

Program to Monitor and Support MTF Accreditation

MTFs are required to maintain facility accreditation by an external nationally recognized AO based on the health care services provided at the facility. The accreditation programs required by the MTFs include hospital, ambulatory, behavioral health, and home health. Currently, the same AO, The Joint Commission (TJC), is utilized across the direct-care system to reduce variation in the accreditation standards and survey process. This uniformity of effort is critical for supporting the MHS's high reliability journey.

TJC accreditation survey teams consist of surveyors with expertise in clinical, administrative, and facility specialties for the assessment of standards compliance through the survey process. TJC standards assess both patient-focused and organizational functions during the triennial on-site survey as indicated by the accreditation standard manuals chapter titles.

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

Accreditation and Compliance Program: Ensuring Industry Standards for Quality and Safety across the MHS *(cont.)*

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			

TJC's accreditation process includes a triennial on-site survey. During the survey process, compliance with the applicable accreditation program standards based on the services provided at the facility is assessed. A total of 131 MTFs are accredited by TJC. Eighty-three of the MTFs require accreditation under the ambulatory program. Forty-eight MTFs are accredited through the hospital program. Forty-five of the ambulatory or hospital surveys include behavioral health units that require accreditation utilizing additional behavioral health program standards. Only one inpatient MTF requires home care accreditation due to the geographical location. As shown in the following table, 15 inpatient MTFs, 27 ambulatory care MTFs, and 15 behavioral health units underwent health care accreditation surveys in CY 2021. All the facilities 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
2019	19	35	22	0
2020	1	9	0	0
2021	15	27	15	0

Source: DHA/Medical Affairs/CSD, 1/20/2022

The triennial accreditation surveys provide MTFs, Markets, Services, and DHA with valuable feedback on the observed level of compliance with applicable accreditation standards, national patient safety goals, and participation requirements. Reports generated from on-site accreditation survey activities include the findings of noncompliance and the requirements for improvement displayed in a matrix according to likelihood of the finding causing harm to patients, staff, or visitors in addition to how widespread the finding was, based on the surveyor observations. The submission of corrective actions as Evidence of Standards Compliance within prescribed time frames are required for noncompliant standards identified as Requirements for Improvement (RFIs) in the final survey report. Once this process is successfully completed, the MTF is provided with their effective date for accreditation.

The top five accreditation standards chapters most frequently cited for RFIs at ambulatory MTF surveys remained fairly consistent over the past six years. Leadership was not in the top five for CYs 2016 and 2017 but has been included for CYs 2018 and 2019 data. The sequence varies, but the same chapters are generally included each year. The top five accreditation standards chapters most frequently cited for RFIs at inpatient MTF surveys remained consistent over the past seven years and only change in sequence. The chapters cited most frequently in the MTFs are consistent with the standards chapters identified by TJC as most challenging during the annual review of previous year findings.

Accreditation and Compliance Program: Ensuring Industry Standards for Quality and Safety across the MHS *(cont.)*

TOP 5 TJC AMBULATORY STANDARDS CITED BY CHAPTER IN MTF SURVEYS, CYs 2014–2021

CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
Medication Management	Environment of Care	Environment of Care	Environment of Care	Provision of Care, Treatment, and Services	Environment of Care	Infection Prevention and Control	Infection Prevention and Control
Environment of Care	Medication Management	Medication Management	Medication Management	Infection Prevention and Control	Medication Management	Environment of Care	Environment of Care
Leadership	Leadership	Infection Prevention and Control	Infection Prevention and Control	Medication Management	Infection Prevention and Control	Medication Management	National Patient Safety Goals
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	Medication Management	Provision of Care, Treatment, and Services	Medication Management
Human Resources	National Patient Safety Goals	National Patient Safety Goals	Record of Care, Treatment, and Services	Leadership	Leadership	Record of Care, Treatment, and Services	Provision of Care, Treatment, and Services

TOP 5 TJC HOSPITAL STANDARDS CITED BY CHAPTER IN MTF SURVEYS, CYs 2014–2021

CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
Environment of Care	Environment of Care	Life Safety	Environment of Care	Environment of Care	Environment of Care	Environment of Care	National Patient Safety Goals
Infection Prevention and Control	Life Safety	Environment of Care	Life Safety	Life Safety	Life Safety	Infection Prevention and Control	Infection Prevention and Control
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	Medication Management	Environment of Care
Provision of Care, Treatment, and Services	Provision of Care, Treatment, and Services	Infection Prevention and Control	Infection Prevention and Control	Infection Prevention and Control	Infection Prevention and Control	National Patient Safety Goals	Life Safety
Medication Management	Medication Management	Medication Management	Medication Management	Medication Management	Medication Management	Provision of Care, Treatment, and Services	Medication Management

Source: DHA/Medical Affairs/CSD, 9/30/2021

The status of MTF-specific hospital and clinic accreditation is available publicly on the TJC Quality Check website (www.qualitycheck.org). The website includes facility-specific information such as the sites of care included in the MTF accreditation, the services provided at the MTF, the accreditation programs, and effective date of the accreditation. Additionally, the MTF survey completion dates and requirements for improvement to meet full accreditation are displayed at the OASD (HA) public-facing web portal, https://health.mil/AccreditationStatus. The public display of accreditation information aligns with the MHS initiative to enhance transparency and supports compliance with NDAA FY 2016, section 713 requirements.

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 129–133).

Continuous compliance with health care accreditation standards contributes to the maintenance of safe, quality patient care, improved performance and consistent survey readiness. The recently published DHA Procedural Manual 6025.13 Clinical Quality Management in the Military Health System Volume 5: Accreditation and Compliance requires all MTFs to continuously assess and maintain compliance with accreditation standards, policy mandates, and regulatory requirements. A self-assessment of the accreditation standards is conducted, documented, and assessed annually to confirm compliance and identify opportunities for improvement. More frequently, MTFs conduct tracer activities to step through the processes a patient would use to obtain various aspects of care or MTF staff would complete to meet established policies. Tracer activities assist MTF staff with continually monitoring compliance and providing safe, quality health care based on national standards.

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 Clinical Laboratory Improvement Program (CLIP) and 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) 21–48, between the DoD and the Department of Health and Human Services, 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. The regulatory compliance of clinical laboratories in the MHS is, in part, evaluated through inspections conducted by an AO that has been granted deeming authority by CMS's

Accreditation and Compliance Program: Ensuring Industry Standards for Quality and Safety across the MHS *(cont.)*

Division of Clinical Laboratory Improvement and Quality, such as the College of American Pathologists (CAP), Commission on Laboratory Accreditation, 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.

Accreditation Performance

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.

COVID-19 and Accreditation Inspections

Many accreditation inspections were delayed due to COVID travel restrictions. As a result, CAP chose to conduct hybrid inspections, which are a combination of in-person and virtual inspections. The CLMS and CAP are working together to resolve the backlog of inspections.

COVID-19 and Future State

CLMS continues to uphold the highest standards of laboratory quality, which is clearly demonstrated by the combined inspection compliance rating of 99 percent and the reaccreditation of 68 MTFs in 2021 by the College of American Pathologists. Supporting the medical readiness of our force, as well as the care of other beneficiaries, CLMS leveraged the expertise of the three Clinical Laboratory Service Consultants to enhance and optimize the usage of COVID-19 testing platforms and strategies to perform both diagnostic and public health surveillance testing. Since the beginning of 2021, the DoD has performed a total of 3.4 million diagnostic COVID-19 polymerase chain reaction tests. In an effort to improve overall patient satisfaction throughout the enterprise, CLMS has leveraged eight lines of effort to standardize patient flow, lab order management, and patient education. These lines of effort will be further improved upon based on critical feedback from both patients and providers. In addition, CLMS is working to better optimize its monetary resources by developing comprehensive business case analyses to determine which laboratory tests perform better within its laboratories versus those sent to commercial reference laboratories. Utilization and implementation of these initiatives will improve the overall performance of DoD laboratories throughout the MHS.

MHS CLINICAL LABORATORY ACCREDITATION SCORES, BY SERVICE, CY 2021

SERVICE	COMPLETED CAP INSPECTIONS IN 2021	COMPLETED SITE SELF-INSPECTIONS IN 2021 (CAP INSPECTION SCHEDULED 2022)[a]	UPCOMING CAP INSPECTIONS IN 2021	UPCOMING SELF-INSPECTIONS IN 2021 (CAP INSPECTION SCHEDULED FOR 2022)	TOTAL
Army	29	34	16	45	124
Air Force	15	82	39	0	136
Navy	24	59	49	27	159
Total	68	175	104	72	419

Source: CAP, 9/24/2021

[a] CAP inspections occur every two years. On the year that a site is not inspected by CAP, the site will undergo a self-inspection where they verify their practices against the CAP checklists.

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 the CMS Division of Clinical Laboratory Improvement and Quality. Blood Bank Services in MTFs are surveyed by external organizations based on the services provided. For MTFs with blood collection and blood product manufacturing operations, registration and regulatory compliance is demonstrated through an inspection process required by the U.S. Food and Drug Administration (FDA) as well as inspection by the AABB (formerly known as the American Association of Blood Banks) and the 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. AABB, CAP, and the FDA inspect and assess the Armed Services Blood Program (ASBP) Blood Donor Centers (BDCs) and Transfusion Service Activities biennially.

Stringent quality oversight is conducted by the Service Blood Program Offices. MTF quality assurance (QA) personnel also conduct internal audits to track performance on an ongoing basis and conduct annual training on Current Good Manufacturing Practices 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 QA in Blood Bank Services.

There are approximately 72 Blood Donor Center and Transfusion Service Activities. As in FY 2019, 100 percent of the ASBP centers maintained FDA licensure and registration, as well as AABB and CAP accreditation. There was a decrease in inspections in 2020 as a result of the COVID-19 pandemic.

Inspections and assessment in 2021 increased as COVID restrictions were reduced. The Service Blood Program QAs also performed inspections during 2021.

INSPECTION	2019 INSPECTIONS	2020 INSPECTIONS	2021 INSPECTIONS
FDA	31	1	1
AABB/CAP	31	16	55
Blood Programs	n/a	n/a	10

In May 2020, the ASBP BDCs were tasked to obtain 10,000 units of COVID Convalescent Plasma (CCP) as a therapeutic treatment for COVID-19 disease by September 30, 2020. The CCP Campaign kicked off in June 2020 and the ASBP BDCs were successful in obtaining the 10,000 CCP units. Although vaccines have been developed, COVID-19 is still considered a pandemic disease. In 2021, the ASBP BDCs were ordered to maintain a sustainment level of 1,000 units of CCP as a therapeutic treatment for COVID-19 disease. The ASBP BDCs were successful in maintaining at least 1,800 units of CCP and supported our civilian partners with CCP when requests were received.

The ASBP Quality Plan has been drafted and is going through Service Blood Program Review. The ASBP QA and Regulatory Branch Chief will establish metrics to monitor overall QA in the Blood Donor Centers and Transfusion Services Activities.

The ASBP QA Manager is actively supporting the MHS transition to the electronic system of record for patient healthcare. Sixteen ASBP Transfusion Service Activities have transitioned from the ASBP Enterprise Blood Management System of record to the MHS Genesis PathNet, Blood Bank Transfusion system of record for patient transfusion testing and transfusion history. The ASBP provides technical bulletin updates to all MHS GENESIS Transfusion Services to ensure all sites are notified of any configuration changes to ensure testing and products provided meet the desired outcome.

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

Clinical Measurement Program: A Program to Define and Measure the Quality Care Provided in the MHS

The goal of the CM Program is to objectively define and measure the quality of care provided in the MHS. CM is an integral and integrating part of MHS clinical performance review and analysis. The CM Program is composed of three distinct functional areas: internal assessment of the quality of health care delivered in the MHS; participation in external quality programs and partnerships, including other federal partners; and facilitation of MHS transparency efforts, including Health.mil, CMS Care Compare, and Leapfrog participation.

CM Program activities include the internal assessment of quality of care delivered, identification of actionable information for improvement, performance monitoring, and providing clinical measurement support and education to Markets, the SSO, DHARs and MTFs.

To fulfill its mission, the CM Program utilizes a variety of external and internal clinical healthcare measure sets. The use of nationally recognized, endorsed measures provides a consistent methodology and enables risk-adjusted results and comparison with established benchmarks. Where no nationally recognized consensus measures exist, the MHS develops measures to support strategic priorities, including the MHS Quadruple Aim, and to provide insight into a variety of care functions and settings. 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 analyze 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 national comparison, greater performance improvement analysis, and tailored quality/safety measurements.

The DoD currently participates in 11 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)
- American Society of Clinical Oncology (ASCO) Quality Oncology Practice Initiative
- National Perinatal Information Center (NPIC) Database
- National Healthcare Safety Network (NHSN)
- CMS Care Compare (formerly Hospital Compare)
- The Joint Commission (TJC) National Hospital Measure
- Leapfrog Hospital Survey
- Leapfrog Ambulatory Surgery Center Survey

This list is evolving and expanding as programs are selected based on their contributions toward generating value through investment return by improving care outomes for MHS beneficiaries.

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 CQMC Core Measure sets, MHS transparency efforts have continued to evolve.

Leapfrog: The MHS continues to focus on the needs of our stakeholders by modernizing and standardizing transparency efforts. In order to place meaningful, user-friendly, and actionable clinical quality and safety information in the hands of patients and decision makers, the MHS began the first federal multifacility participation in the Leapfrog Group's Hospital Survey with the submission of survey data from five pilot inpatient MTFs in November 2019.

These facilities' data are now publicly reported on the Leapfrog website (www.leapfroggroup.org), allowing comparison of industry standard clinical quality and patient safety measures across both direct and private sector care. This new partnership will provide visibility to empower our Service members and their families to make the best decisions for their health care. Thirty-four inpatient facilities and six ambulatory surgery centers (ASCs) submitted surveys in 2021. It is anticipated that all CONUS MTFs with inpatient capability and all CONUS ASCs will submit responses to the Leapfrog Hospital Survey in June 2022.

Clinical Measurement Program: A Program to Define and Measure the Quality Care Provided in the MHS *(cont.)*

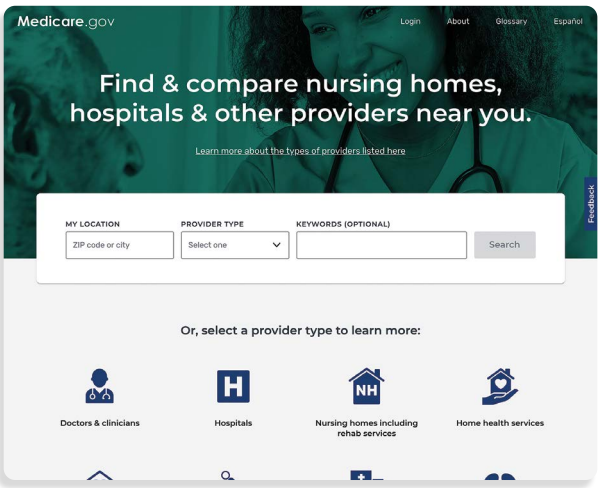
Health.mil: In response to the 2014 MHS Review, the health.mil website was designed as the first step for the MHS in providing data topatients to assess how the facilities at which they receive care are performing in terms of quality, safety, and access. There are more than 60 metrics reported on health.mil.

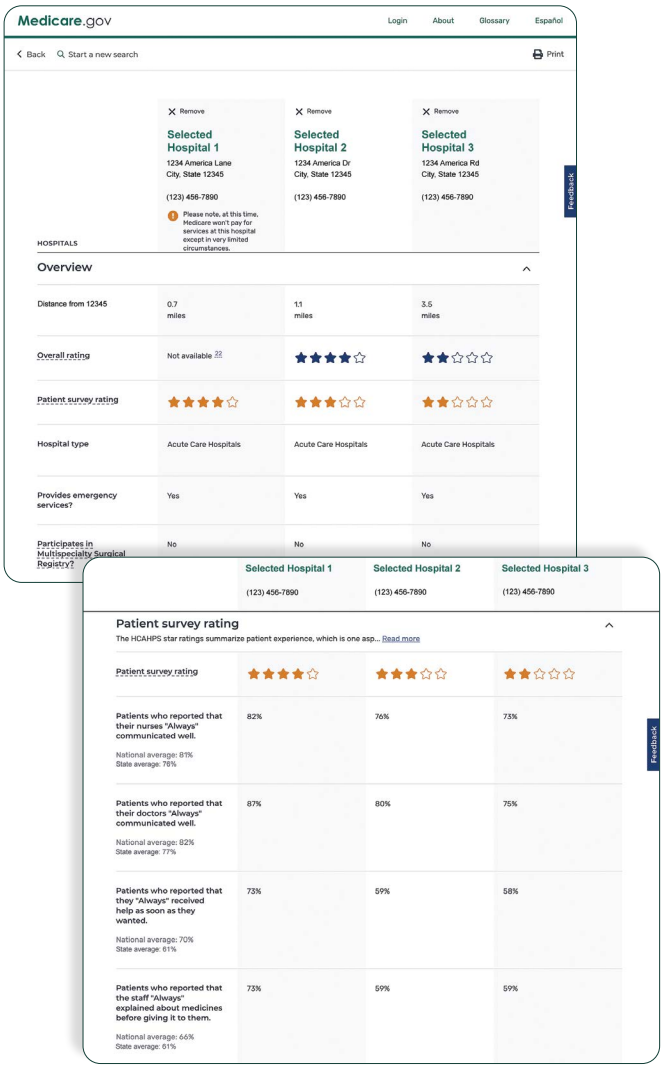
MHS Transparency on CMS Care Compare (formerly Hospital Compare)

The MHS provides patient experience and timely and effective care measurement data to CMS for public reporting on Care Compare, formerly Hospital Compare. In late 2020, CMS launched Care Compare, a streamlined redesign of eight existing CMS health care comparison tools, now in a single user-friendly interface. Further, Care Compare is a consumer-oriented website providing information on how hospitals perform on quality measures, with more than 4,000 U.S. hospitals participating. The information on Care Compare helps patients make decisions about where to get health care and encourages hospitals to improve the quality of care they provide.

The TRISS and Timely and Effective Care results are publicly posted on Care 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. The CM Program facilitated the addition of a Sepsis measure and an additional emergency department (ED) measure to its public reporting on Care Compare in January 2021. The Sepsis measure assesses facilities' appropriate early management of severe sepsis and septic shock and the additional ED measure reports facilities' percentage of patients who left the ED without being seen. As part of the evolution of MHS transparency efforts, the CM Program continues to develop plans to expand reporting of measures on Care Compare. MTFs can be searched by ZIP code or hospital name and compared with civilian facilities in the same location. Visit https://www.medicare.gov/care-compare/ for more information.

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





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

Clinical Quality Improvement (CQI) Program: A Program to Identify, Implement, and Sustain Clinical Quality Improvement

The DHA supports the MHS with a CQI program responsible for establishing an infrastructure enabling 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 clinical quality improvement activities are strategically aligned to support the goals of CQM and fulfill the promise of an integrated system of readiness and health with optimized patient outcomes. The CQI program is integrated within the CQM functional capability and supported by each of the CQM Programs and the DHA performance management system to ensure that improvement opportunities are identified, capitalized upon, and sustained through planning, education guideline development, and knowledge management.

CQI activities include improvement initiative planning, implementation and sustainment, education and training activities for all of CQM, evidence-based practice and quality improvement studies, and knowledge management activities across CQM.

Improvement Initiative Planning

The CQI program works closely with the Clinical Communities to identify, plan, implement, measure, and sustain improvement initiatives. This includes collaboration with the DHA Quadruple Aim Performance Plan (QPP) efforts. Briefly, the QPP is the enterprise-wide planning process that integrates capabilities in strategic planning, performance planning, financial operations, performance improvement, and decision making. CQI ensures that CQM and all of its capabilities are represented and have a voice in this process, aligning Market, SSO, DHAR, and MTF activities to the Quadruple Aim of Improved Readiness, Better Care, Better Health, and Lower Cost.

The CQI program participates in the development of QPP supplemental guidance that will further align clinical quality improvement efforts from the headquarters down to the MTFs and ensure that frontline efforts are in sync with system opportunities identified in the various CQM Program work streams, providing a critical link between quality monitoring and execution.

CQM Education & Training (E&T)

The CQM E&T assists the CQM Programs in developing a workforce equipped with core competencies in health care quality, patient safety, and quality improvement. As a critical foundational element, CQI supports value generation from quality improvement efforts through the development of a competent and educated CQM staff MHS-wide. In this role, CQI sets the conditions for successful improvement work and sustainment by ensuring MHS CQM staff have access to training and education that leads to competence in their organizational roles. CQM E&T and CQM Programs empower individuals to use evidence-based tools and improvement science to help identify improvement opportunities and promote data-driven improvement behaviors throughout the system in alignment with the MHS HRO journey. In collaboration with the Services, CQM E&T developed applicable MHS CQM competencies and is piloting new DHA learning resources for the general workforce and CQM professionals. CQM E&T continues to advocate for this critical infrastructure capability for MHS clinical quality improvement and high reliability.

Evidence-Based Practice

The CQI program assumed the DoD program management of the joint VA/DoD Evidence-Based Practice Work Group (EBPWG), which is chartered through the Health Executive Committee (HEC) Clinical Care 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. The VA and DoD collaborate to update and develop new CPGs that are nationally and internationally recognized and meet the needs of the military and veterans' health care systems. VA/DoD CPGs consistently receive national recognition, including the ECRIs Guidelines Trust approval. The VA/DoD partnership facilitates the development of both CPGs and clinical support tool kits for clinicians and patients to promote continuous learning. The choice of guidelines is established by the VA/DoD EBPWG and is based on careful consideration of the readiness need of the military and the continued care of the veteran population as well as high-volume and high-cost health conditions treated within the VHA and MHS.

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

Evidence-Based Practice *(cont.)*

As of September 2021, there are 24 VA/DoD CPGs completed or in the update/development process. The four FY 2020–FY 2021 CPGs being updated are: Diagnosis and Treatment of Low Back Pain, Management of Major Depressive Disorder, Management of Opioid Therapy for Chronic Pain, and Management of Upper Extremity Amputation Rehabilitation. There are also two mental health CPGs under development in FY 2021–FY 2022: Schizophrenia and Bipolar Disorder. Projected CPG updates for FY 2022 include: Management of Diabetes Mellitus in Primary Care, Management of Post-Traumatic Stress Disorder (PTSD), Management of Pregnancy, and the Primary Care Management of Headache.

Clinical Quality Improvement Studies

The CQI program conducts clinical quality improvement studies designed to validate and improve both processes and outcomes of the health care delivered to MHS beneficiaries. These studies utilize clinical and administrative MHS data, comparing the performance of MHS direct care and private sector care with civilian national benchmarks. To direct these investigations, the CQI program has established a Clinical Quality Improvement Studies Working Group, which serves as the DHA lead for such improvement and safety studies. This working group comprises multiple stakeholders across CQM and medical affairs, including representatives from the MHS Clinical Communities, DHA Markets, and senior medical advisors.

In FY 2021, three clinical quality improvement studies were completed by this group: Opioid Prescribing to Cancer Patients; Diagnosis and Management of Primary Hypertension among Active Duty Military Personnel; and the Use of the AHRQ's Quality and Safety Review System to Detect Adverse Events and Assessment of the Readability of Contracted Purchased Care Inpatient Medical Records in the Military Health System.

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.

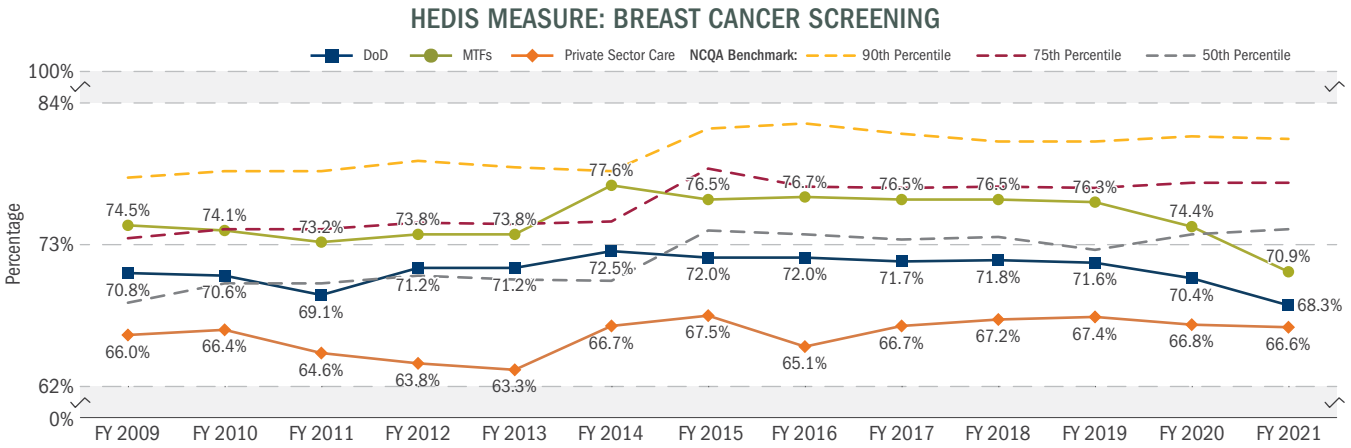
VA and DoD CPG collaboration has established a rigorous systematic review of medical evidence to help primary care providers and health care teams deliver consistent high-quality health care to beneficiaries. CPGs are developed by multidisciplinary clinical experts and are based on unbiased clinical 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

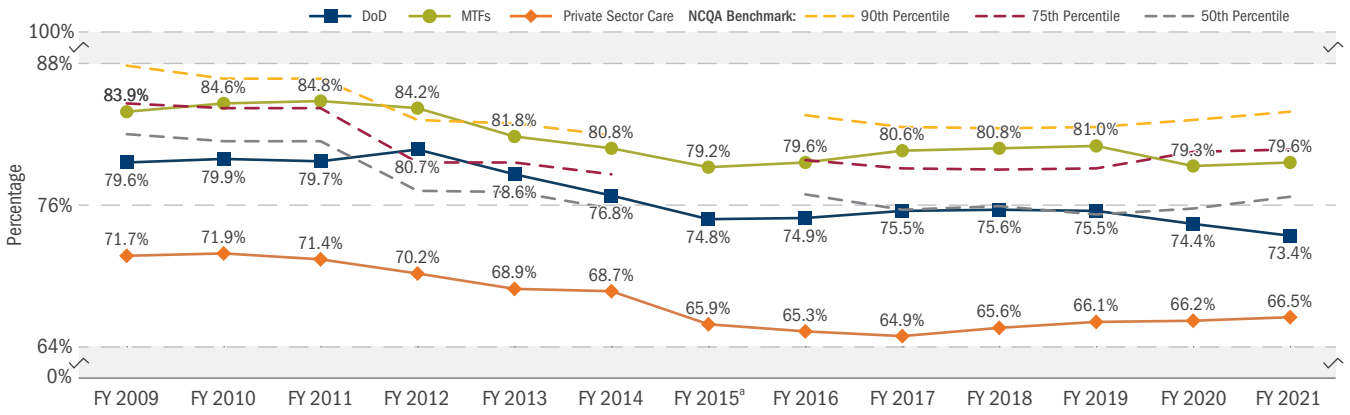
- **Breast and Cervical Cancer Screening:** HEDIS measures focused on cancer screening for early detection and treatment to maximize the potential for a cure. Likely due to COVID-19 impacts, the DoD Breast Cancer Screening rate is below the 50th percentile. The smallest losses were noted in private sector care with only a 0.2 percentage point change in rate. The MTF Cervical Cancer Screening rate is slightly below the 75th percentile, only 0.3 percentage point change from FY 2020 to FY 2021. The DoD rate remains below the 50th percentile with the Private Sector Care rate increasing slightly from 66.2 percent to 66.5 percent. For cervical cancer screening, major measure specification changes in FY 2014 resulted in a break in benchmark applicability, which led to the absence of a benchmark for FY 2015, as reflected in the graph.



Source: DHA/Medical Affairs/CSD, 12/7/2021
Note: Data for FY 2020 are through May 2020.

Primary Care Clinical Community *(cont.)*

HEDIS MEASURE: CERVICAL CANCER SCREENING



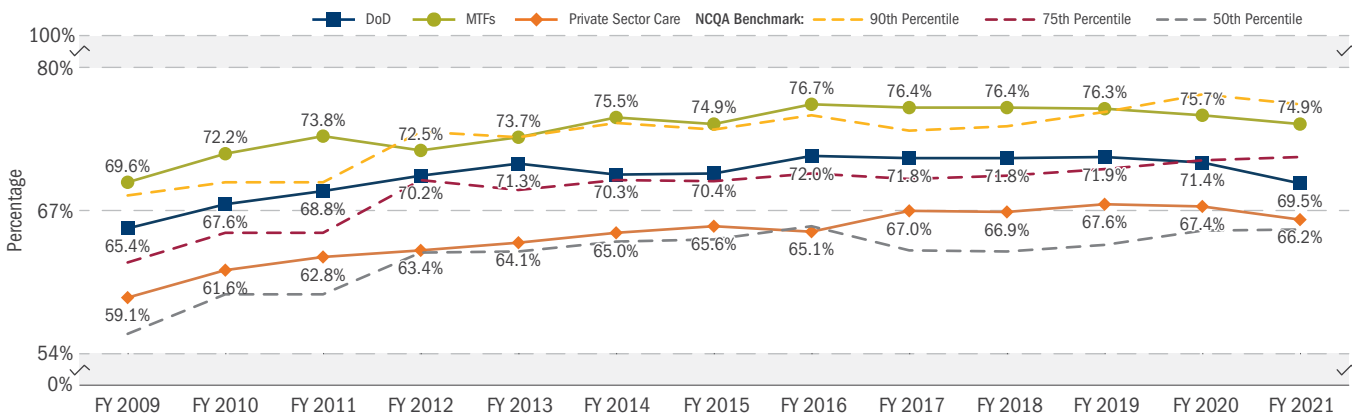
Source: DHA/Medical Affairs/CSD, 12/7/2021

[a] No benchmark for 2015 due to methodology change.

Note: Data for FY 2020 are through May 2020.

- **Colorectal Cancer Screening:** HEDIS measure focused on detecting colorectal cancer as well as screening for premalignant polyps to prevent cancer. The MTF rate remains above the 75th percentile, while the DoD and private sector care rates remain above the 50th percentile. The rates in both private-sector and direct care have continued to decrease slightly since FY 2019, likely due to impacts from COVID-19.

HEDIS MEASURE: COLORECTAL CANCER SCREENING

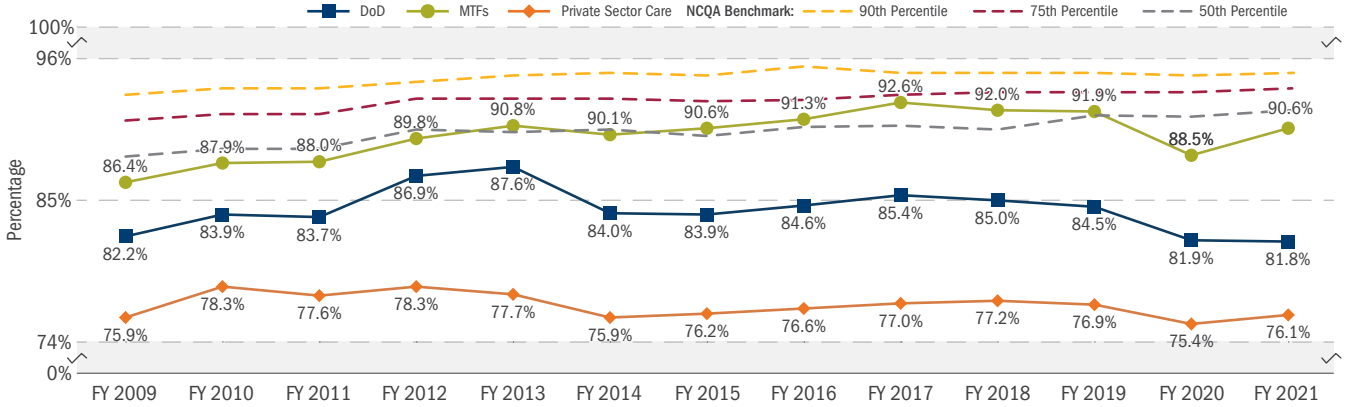


Source: DHA/Medical Affairs/CSD, 12/7/2021

Note: Data for FY 2020 are through May 2020.

- **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. Although private-sector and direct care rates remained below the 50th percentile, the MTF rate increased by 2.1 percent in FY 2021 and the private sector care showed improvement as well. The 2020 and 2021 rates were likely negatively impacted by COVID-19 for this screening measure.

HEDIS MEASURE: DIABETES HbA1c SCREENING



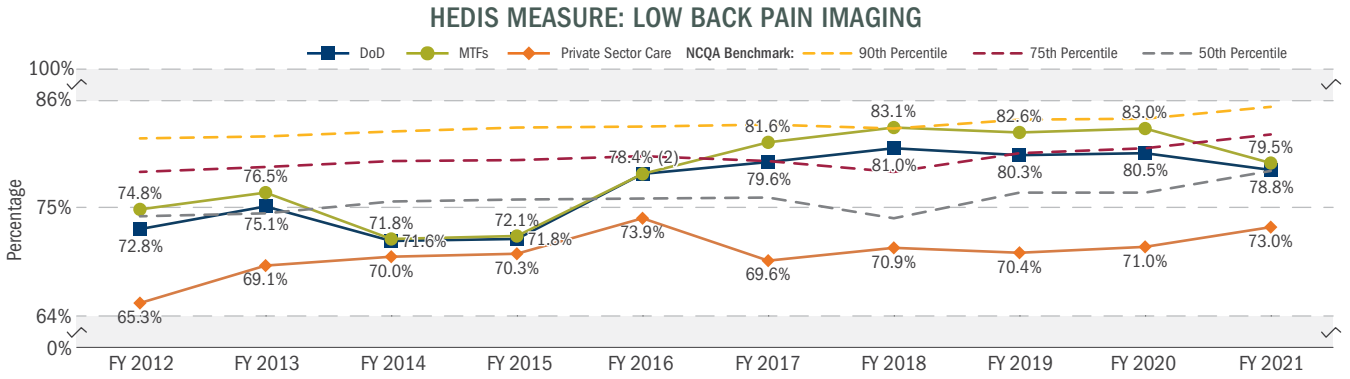
Source: DHA/Medical Affairs/CSD, 12/7/2021

Note: Data for FY 2020 are through May 2020.

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

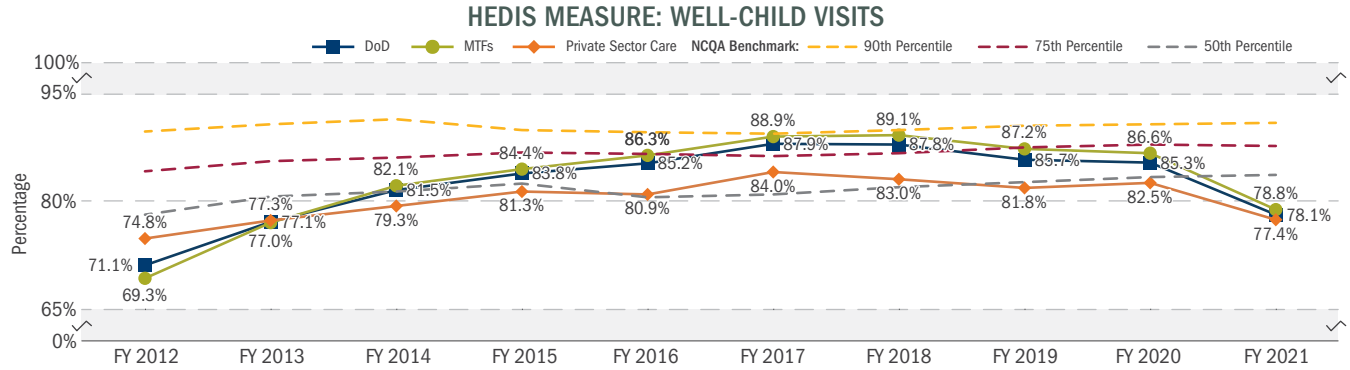
Primary Care Clinical Community *(cont.)*

- **Low Back Pain (LBP) Imaging:** HEDIS measure focused on overuse of imaging for acute LBP. MHS has integrated the VA/DoD LBP 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 DoD overall and MTF rates are at or slightly above the 50th percentile. Private sector care remains below the 50th percentile but gained 2 percentage points from FY 2020 to FY 2021.



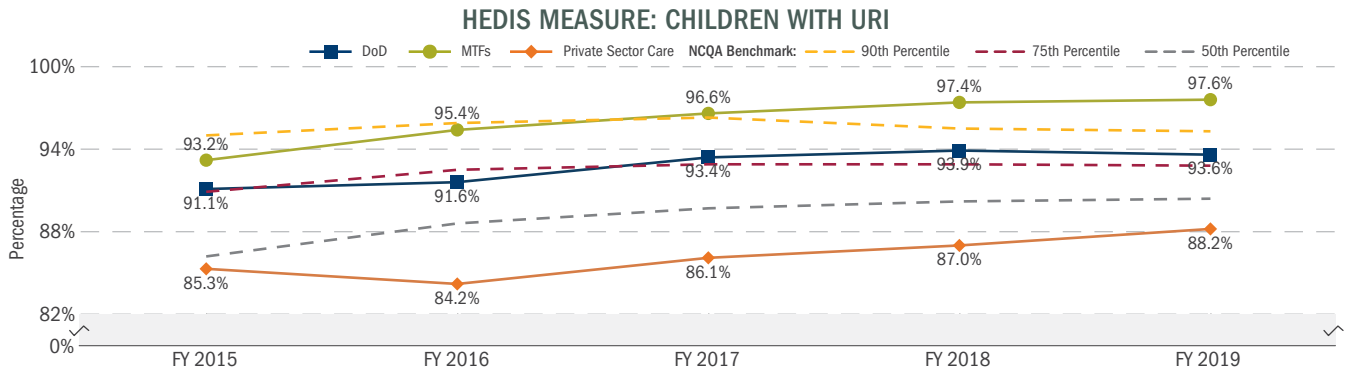
Source: DHA/Medical Affairs/CSD, 12/7/2021
Note: Data for FY 2020 are through May 2020.

- **Well-Child Visits:** HEDIS measure focused on the adequacy of well-child care for infants, as demonstrated by children having six visits within the first 15 months of life. Well-child visits remain below the 50th percentile for private-sector and direct care. Rate decreases from FY 2020 to FY 2021 are likely a reflection of continued COVID-19 impacts to in-person visit availability.



Source: DHA/Medical Affairs/CSD, 12/7/2021
Note: Data for FY 2020 are through May 2020.

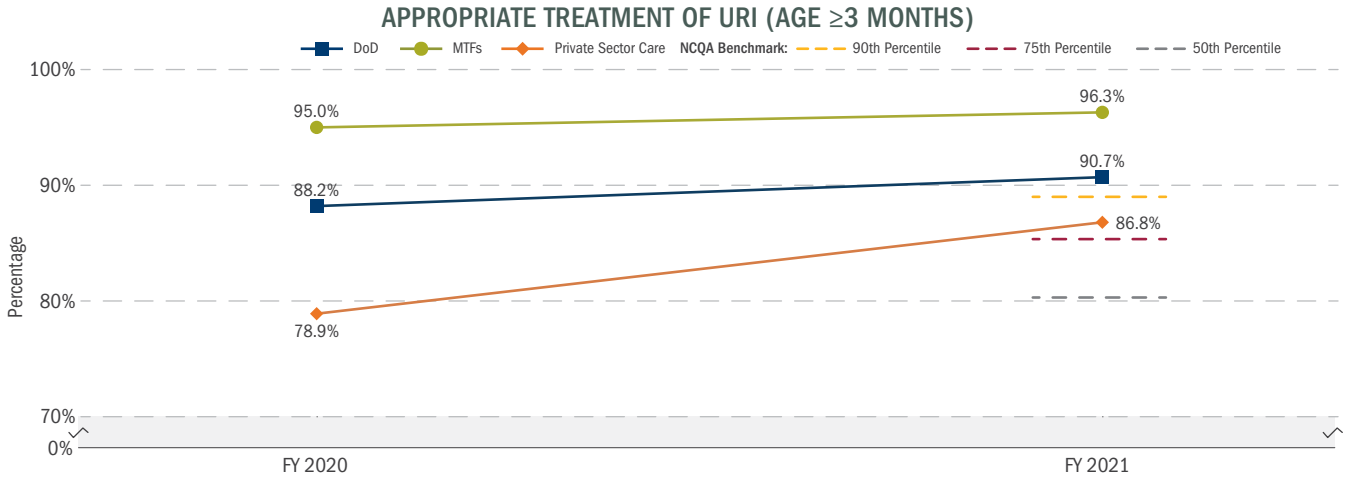
- **Children with Upper Respiratory Infection (URI):** HEDIS measure focused on the avoidance of antibiotic prescribing for children diagnosed with a URI, thereby increasing awareness of the importance of antibiotic stewardship to prevent antibiotic resistance. A higher rate indicates appropriate treatment for URI. Due to significant changes, measure specifications are not comparable to prior years starting in 2020. Data through FY 2019 are provided in the graph below for historical purposes. Please refer to the new measure Appropriate Treatment of URI on the following page for data starting in FY 2020.



Source: DHA/Medical Affairs/CSD, 12/7/2021

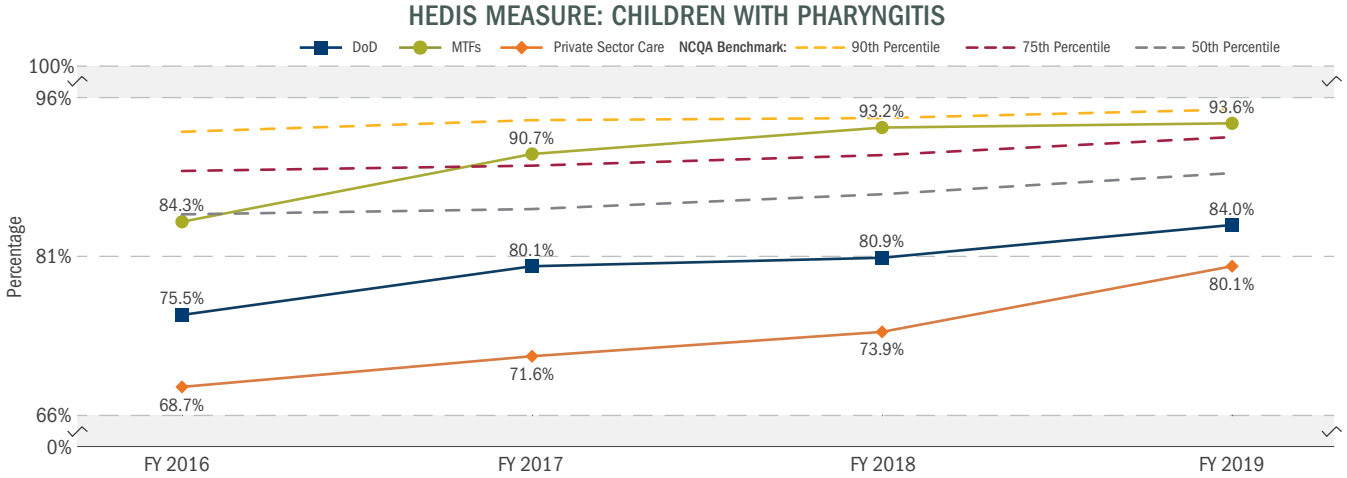
Primary Care Clinical Community *(cont.)*

- **Appropriate Treatment of URI:** HEDIS measure focused on the avoidance of antibiotic prescribing for anyone three months of age or older diagnosed with a URI. This measure increases awareness of the importance of antibiotic stewardship among children and adults to prevent antibiotic resistance. This is a new measure as of 2020. New measure benchmarks became available in 2021. The DoD and MTF scores in FY 2021 are above the 90th percentile with the MTFs exceeding this benchmark by 7.3 percentage points. The private sector care rate is above the 75th percentile. This new measure is not comparable to the NCQA Appropriate Treatment of Children with URI measure from previous years due to significant measure specification changes.



Source: DHA/Medical Affairs/CSD, 12/7/2021
Note: Data for FY 2020 are through May 2020.

- **Children with Pharyngitis:** HEDIS measure focused on appropriate use of antibiotics for children diagnosed with pharyngitis 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. A higher rate indicates appropriate laboratory testing confirmation prior to prescribing antibiotics for pharyngitis. Due to significant changes, measure specifications are not comparable to prior years starting in 2020. Data through FY 2019 are provided in the graph below for historical purposes. Please refer to the new measure Appropriate Treatment for Pharyngitis on the following page for data starting in 2020. In the graph below, 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 graph below reflects the transition to place of care attribution for data reporting in FY 2016 and in subsequent years following the attribution change.

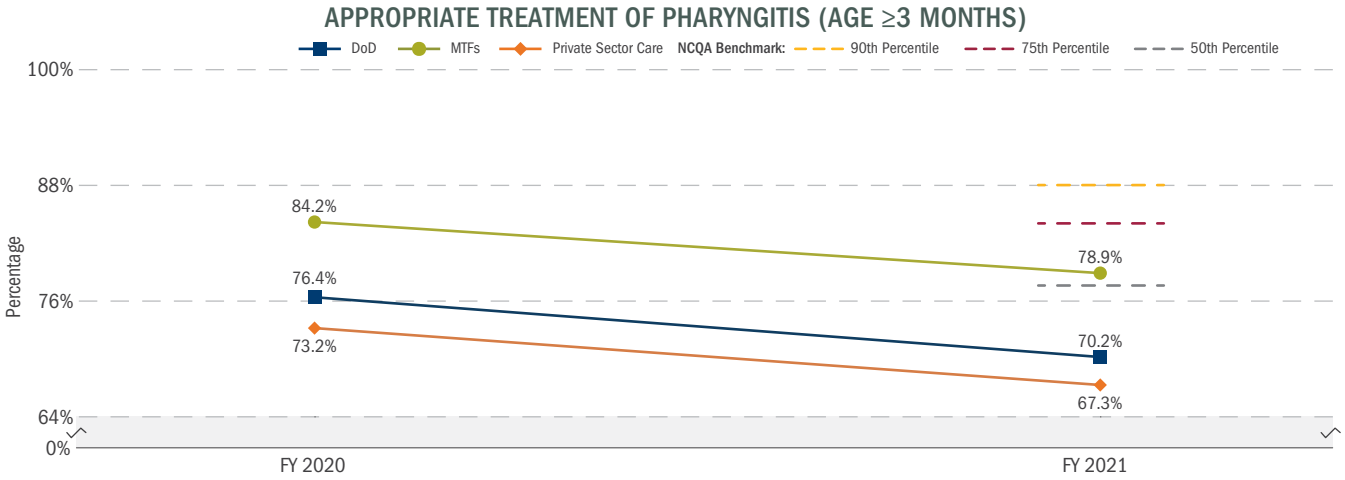


Source: DHA/Medical Affairs/CSD, 12/7/2021

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

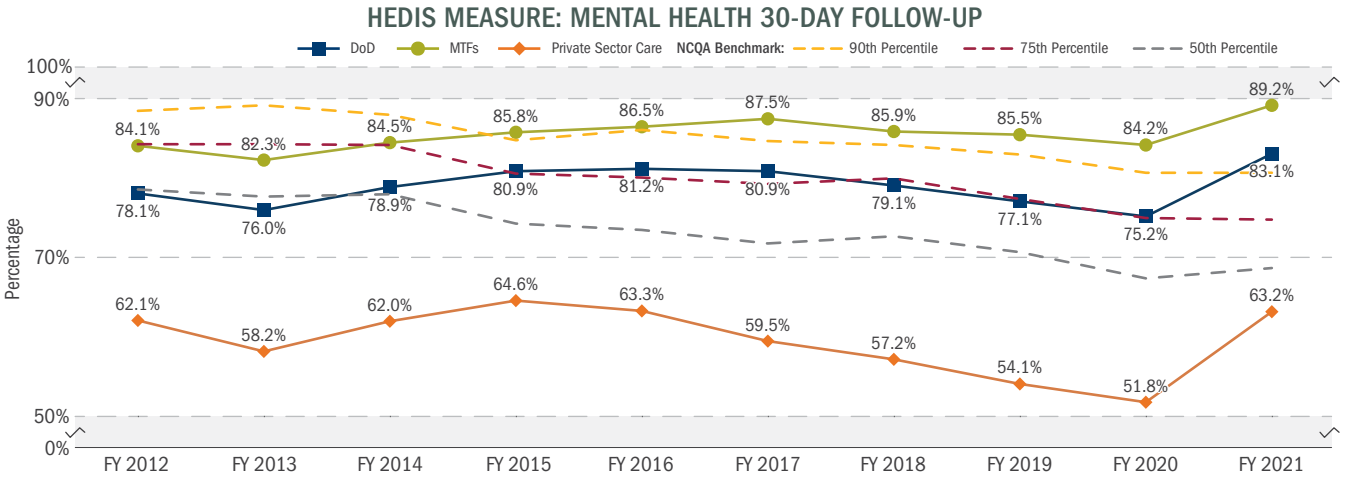
Primary Care Clinical Community *(cont.)*

- **Appropriate Treatment of Pharyngitis:** HEDIS measure focused on appropriate use of antibiotics for anyone three months of age or older diagnosed with pharyngitis, based on laboratory data. This measure increases awareness of the importance of laboratory testing and confirmation prior to prescribing antibiotics for pharyngitis. This is a new measure as of 2020. New measure benchmarks became available in 2021. The MTF rate is above the 50th percentile, while the DoD and private sector care rates are below this same benchmark. This new measure is not comparable to the NCQA Appropriate Testing for Children with Pharyngitis measure from previous years due to significant measure specification changes.



Source: DHA/Medical Affairs/CSD, 12/7/2021
Note: Data for FY 2020 are through May 2020.

- **Mental Health (MH) Follow-Up:** This HEDIS measure examines 30-day MH follow-up care in the MHS MTF and private sector care venues. The DoD and MTF rates are above the 90th percentile. The DoD rate increased 7.9 percentage points from FY 2020 to FY 2021, moving from the 75th percentile to now exceeding the 90th percentile. The largest increase in MH follow-up rates is seen in private sector care, with a rate increase of 11.4 percentage points from FY 2020 to FY 2021.



Source: DHA/Medical Affairs/CSD, 12/7/2021
Note: Data for FY 2020 are through May 2020.

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

Primary Care Clinical Community *(cont.)*

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

MHS performed extremely well compared with national HEDIS benchmarks, exceeding the 90th percentile for MH Follow-Up (7 and 30 day) and Treatment for URI (age ≥3 months). COVID-19 negatively impacted the availability of onsite clinical services and caused a positive shift in the use of VH across the MHS. These impacts are suspected to have played a role in the rate decreases seen across the MHS for most of the HEDIS measures in 2020 and continuing into 2021, especially for acute care and screening measures dependent on in-person tests and evaluations. Measures with longer look-back periods (e.g., Colorectal Cancer Screening) tend to be less acutely impacted by COVID-19. Measure results for 2020 may have been impacted by a necessary data platform change and system security update midway through the year. Overall MHS performance, shown below, includes TRICARE Prime enrollees to facilities containing 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, Uniformed Services Family Health Plan (USFHP), or Coast Guard facility service code. Direct care, private sector care, and DoD performance calculations (pages 147–150) only include TRICARE Prime beneficiaries and do not include Coast Guard facilities.

MHS HEDIS BENCHMARK PERFORMANCE, JUNE 2015–MAY 2021

HEDIS MEASURE	2015	2016	2017	2018	2019	2020	2021	2015 TO 2016 CHANGE	2016 TO 2017 CHANGE	2017 TO 2018 CHANGE	2018 TO 2019 CHANGE	2019 TO 2020 CHANGE	2020 TO 2021 CHANGE	HEDIS BENCHMARK STATUS 2021
Mental Health														
Mental Health Follow-Up: 30 Days	78.86	81.08	80.90	77.68	77.05	75.20	83.46	2.22	–0.18	–3.23	–0.63	–1.85	8.26	★★★★★
Mental Health Follow-Up: 7 Days	64.01	68.03	69.03	61.31	59.34	58.04	69.36	4.01	1.01	–7.73	–1.97	–1.29	11.32	★★★★★
Pediatric														
Well-Child: 15 Months	83.09	84.09	87.09	88.25	85.95	85.28	77.01	1.01	2.99	1.16	–2.30	–0.67	–8.28	★
Well-Child: 30 Months							74.63							–
Children with Pharyngitis[a]	73.04	74.91	79.31	80.89	83.76			1.87	4.41	1.57	2.87			
Children with Upper Respiratory Infection[a]	90.48	91.32	93.32	93.79	93.64			0.84	2.00	0.47	–0.15			–
PCMH														
Treatment for Pharyngitis[b]						76.38	70.07						–6.30	★
Treatment for Upper Respiratory Infection[b]						88.17	91.38						3.21	★★★★★
Breast Cancer Screening	72.27	72.08	71.59	71.84	71.70	70.37	67.99	–0.19	–0.49	0.24	–0.14	–1.33	–2.37	★
Cervical Cancer Screening	74.38	74.73	75.24	75.32	75.38	74.39	74.06	0.35	0.51	0.08	0.06	–0.98	–0.33	★★
Colorectal Cancer Screening	70.91	71.81	73.27	72.18	72.36	71.37	69.79	0.91	1.46	–1.09	0.18	–1.00	–1.58	★★★
Chlamydia Screening in Women	62.36	64.43	65.41	65.68	66.50	64.13	52.29	2.07	0.97	0.27	0.82	–2.37	–11.85	★★★
Low Back Pain Imaging	71.38	76.36	78.70	80.56	80.48	80.54	77.92	4.98	2.34	1.86	–0.07	0.05	–2.62	★★
Diabetes Screening	83.68	84.30	84.94	85.31	84.60	81.86	81.77	0.62	0.65	0.37	–0.71	–2.74	–0.08	★
Diabetes A1c Level <7%	48.52	48.33	46.82	47.29	46.80	42.71		–0.18	–1.51	0.47	–0.49	–4.09		–
Diabetes A1c Level <8%	67.69	67.87	66.90	67.75	67.62	63.19	54.91	0.17	–0.96	0.84	–0.13	–4.43	–8.28	★
Diabetes A1c Level ≤9%	76.77	77.31	76.70	77.93	77.21	73.52	64.06	0.54	–0.61	1.22	–0.71	–3.69	–9.46	–

Source: MHS Population Health Portal, May 2021

[a] Significant methodology change, break in trending in 2020

[b] New measure in 2020

Notes:

– The data are June–May look-backs for the given year.
– Rates include TRICARE Prime enrollees to Army, Air Force, Navy, DHA, MCSCs, Coast Guard, and associated USFHP DMIS IDs.
– 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 from 2017–2021.
– 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
– Private sector care measure results are derived from TRICARE encounter data and other administrative data.

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

Neuromusculoskeletal Clinical Community (NMSKCC)

The mission of the 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, improving outcomes, and ensuring 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, traumatic brain injury (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, 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. Early identification and treatment of concussions can prevent long-term negative consequences to cognitive, psychological, and physical functions. Referral to a concussion clinic, such as the National Intrepid Center of Excellence, is also an option for Service members with delayed recovery. 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 Progressive Return to Activity (PRA) Clinical Recommendation. The MACE2 incorporates state-of-the- science advances in concussion evaluation, with particular focus on vestibular and oculomotor areas. The PRA has been revised and integrates the previous concussion management tool to simplify care and further drive modernized concussion management. In early 2021, the PRA was implemented at four Market sites. Data collection shows an incremental increase in Markets meeting the goal of early identification, assessment, and management of acute concussion.

The NMSKCC is fielding the Patient Reported Outcomes Clinical Record (PROCR)/Military Orthopaedics Tracking Injuries and Outcomes Network (MOTION) program on the Clinical Assessment Management Portal (CAMP), an application on CarePoint. NMSK adoption of MOTION on the CAMP is a DHA enterprise FY 2022 supplemental Quadruple Aim Performance Process (QPP) metric that will be assessed quarterly with the DHA Regional Directors. Enterprise MOTION use in the NMSK community will provide unprecedented clinical insight, accelerate continuous process improvement, and has the potential to establish the Military Health System as the world leader in NMSK care. Merging patient reported outcomes with all available clinical data will enable increasingly sophisticated predicted and prescriptive analyses that will drive adherence to clinically based guidelines and leading processes. The end state will support both improved military medical readiness and value-based care, improve musculoskeletal injury prevention, establish and incorporate best practices for the delivery of health care services, and eliminate variability in health outcomes in MTFs. The NMSKCC clinicians have started to leverage actionable clinician-level outcome reports and musculoskeletal triage clinical practice guidelines with mentorship in a process modeled after industry-leading practices.

The NMSKCC is also working to implement a Direct Access to Physical Therapy initiative. The initiative 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 work group is currently finalizing plans for phased implementation, sustainment, and monitoring. Pilot sites are currently being determined, with anticipated initial data collection in the second quarter of 2022.

With the onset of the COVID-19 pandemic, emphasis was placed on increased readiness training, focusing on rehabilitation foundation skills for the acute hospital setting. The Acute and Critical Care Rehabilitation Working Group (ACCRWG) established the DHA Rehabilitation clinical practice guidelines for the acute care setting for use throughout the enterprise. Within the first month of known cases, Acute Inpatient Rehabilitation personnel, consisting of physical and occupational therapists, physical medicine and rehabilitation physiatrists, and speech-language pathologists from across the enterprise, trained more than 280 rehabilitation staff in basic skills for providing care within the acute and critical care setting for both the traditional MTF and forward deployed in support of nontraditional settings such as the USS Mercy and the Javits Center. These personnel also trained almost 500 nursing staff in early mobility, transfers, basic exercises using handouts, gait training, fall prevention, and use of lift systems and additional equipment commonly used for safe patient handling to help minimize the use of critical PPE at a time of known shortages. With a renewed awareness for the need of acute rehabilitation skills, the ACCRWG has set priorities to be the key driver in moving enterprise health care delivery to a value-based system, decrease risk of harm to hospitalized patients, and support the DoD's readiness mission by providing critical war time and pandemic skills training and sustainment for our deployable medical force.

Three focused areas are: (1) staffing aligned with the American College of Surgeons Trauma Center Verification Rehabilitation Requirements as established in the ACS's Orange book, chapter 12; (2) establish access to data from validated outcome measures, decision support tools, and programs, such as the Activity and Mobility Promotions initiative with Johns Hopkins Hospital, to drive clinical decision making, streamline practices, and promote wise use of resources; and (3) develop the Acute and Critical Care Foundations Course to ensure the safe provision of acute and critical care at a moment's notice anywhere we are called to go, including our home facilities as casualty receiving centers.

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

Women and Infant Clinical Community and Women's Health Clinical Management Team (WHCMT)

Women and Infant Initiatives

The WICC promotes readiness, process improvement, maximum value, and desired patient outcomes, while catalyzing innovation and eliminating preventable harm and waste. The WICC utilizes available evidence and community practices to support standardization to avoid unwarranted variation in clinical processes that impact women's health, perinatal (maternity), and infant (birth to one year of age) care.

The WHCMT is the execution arm of clinical care delivery, designed to standardize clinical process improvement (CPI) approaches developed by the WICC to implement and monitor adoption. Bidirectional communication from the WHCMT to the DHA Market WHCMTs ensures widest dissemination of CPI approaches developed by the WICC. The WHCMT is also responsible for monitoring implementation progress, Market data, and clinical outcomes.

WICC and WHCMT collaborate both internally within MHS as well as externally with the Veterans Administration and other national organizations, including the CDC; the American College of Obstetricians and Gynecologists (ACOG); the Association of Women's Health, Obstetric and Neonatal Nurses; and the Alliance for Innovation on Maternal Health (AIM).

The WICC and WHCMT also utilize national collaboratives and existing processes to expand quality of care transparency and transform leading practices. The focus for FY 2022 will be the establishment of a framework for severe maternal morbidity and mortality reviews across the MHS, using structures developed by the CDC and ACOG. Efforts are ongoing to expand capacity for same-day or walk-in contraception appointments, to standardize MHS-wide documentation in both legacy (Essentris) and MHS GENESIS electronic health systems, and to align practice with AIM bundles to decrease adverse events for families.

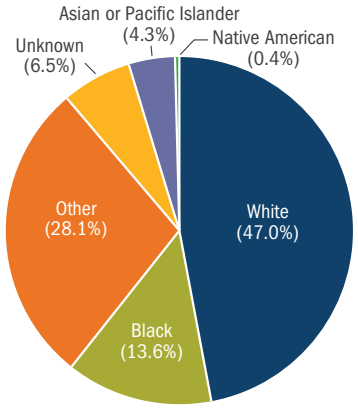
Perinatal Care Measures

Perinatal care is an MHS high-volume specialty. Nationally recognized measures are continually monitored at the enterprise, community, Market, and MTF levels to assess the quality and safety of perinatal care provided across the system for both community based and MTF-based care. Data available through the National Perinatal Information Center (NPIC) and The Joint Commission (TJC) provide quality data and benchmarks for perinatal care in both community-based and MTF-based care.

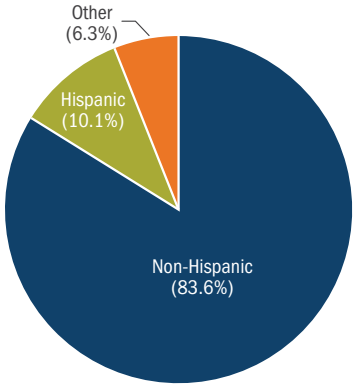
MHS reports multiple perinatal metrics externally to beneficiaries and interested parties to demonstrate quality of care. Increasing transparency to MHS beneficiaries and the public at large continues to expand with the 2021 addition of five Leapfrog maternity care measures to the previously existing measures from the NQF, TJC, and the AHRQ. These measures provide a basis for comparison of MHS performance to national measures of quality care.

Each year across the MHS, more than 100,000 babies are born, with 30,000 babies born in MTFs, representing a wide variety of races and ethnicities, as shown below. Tracking maternal and neonatal outcome measures by race and ethnicity began in 2021 and will continue to be a focus for the WICC in 2022 in order to understand changes in care delivery needed to decrease disparities.

DELIVERIES IN DIRECT CARE, BY RACE, APRIL 2020–MARCH 2021



DELIVERIES IN DIRECT CARE, BY ETHNICITY, APRIL 2020–MARCH 2021



Source: NPIC, 9/30/2021

Notes:

– Data provided above include both Essentris and MHS GENESIS facilities.

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

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

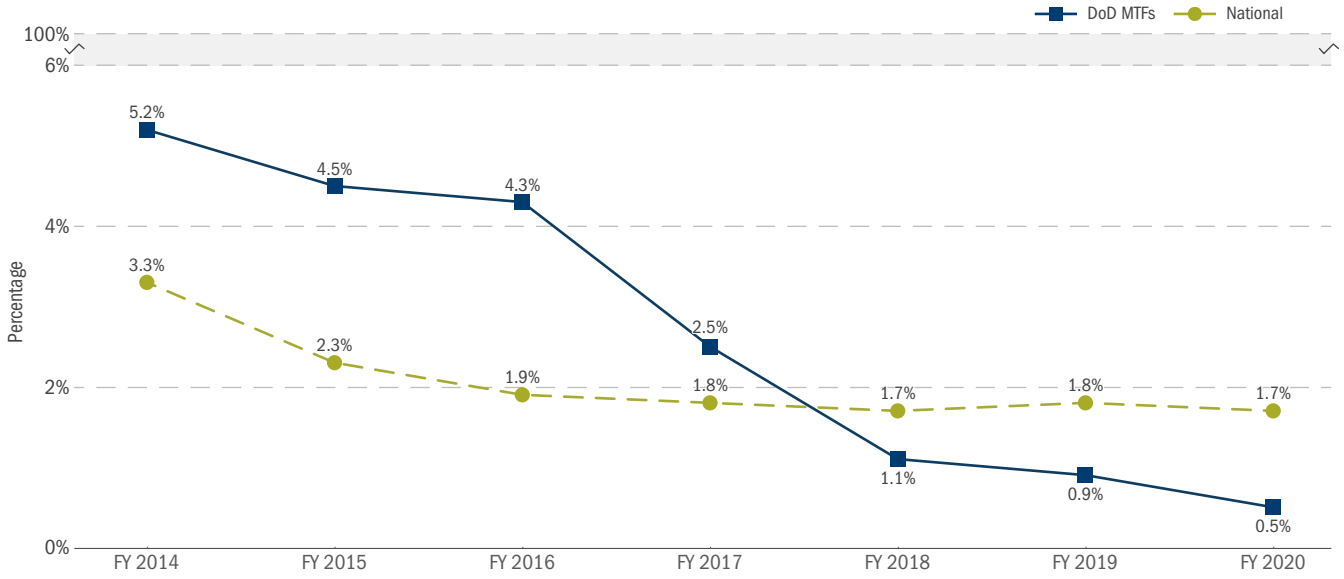
Women and Infant Clinical Community and Women's Health Clinical Management Team (WHCMT) *(cont.)*

TJC

Currently has four perinatal core (PC) measures the MHS tracks at the MTF and MHS level. Previously reported measures that were retired in 2021 are Antenatal Steroids (PC-03) and Newborn Bloodstream Infections (PC-04).

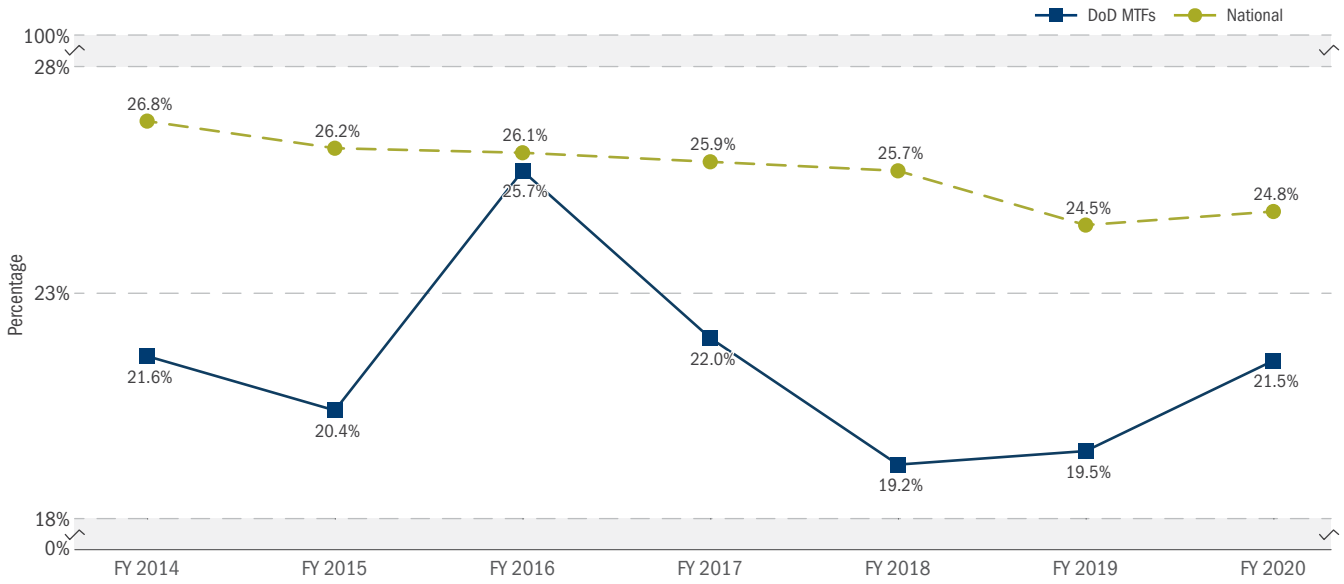
- **Elective Delivery:** This measure (PC-01) focuses on improving the health and outcomes of infants and mothers by avoiding non-medically indicated early elective births (before 39 weeks gestation). Elective inductions result in more cesarean births, longer maternal length of stay, and increased short-term 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 2014–2020



- **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 are below the national rates (lower is better).

DOD HOSPITAL QUALITY MEASURE: CESAREAN SECTION PC-02, FYs 2014–2020



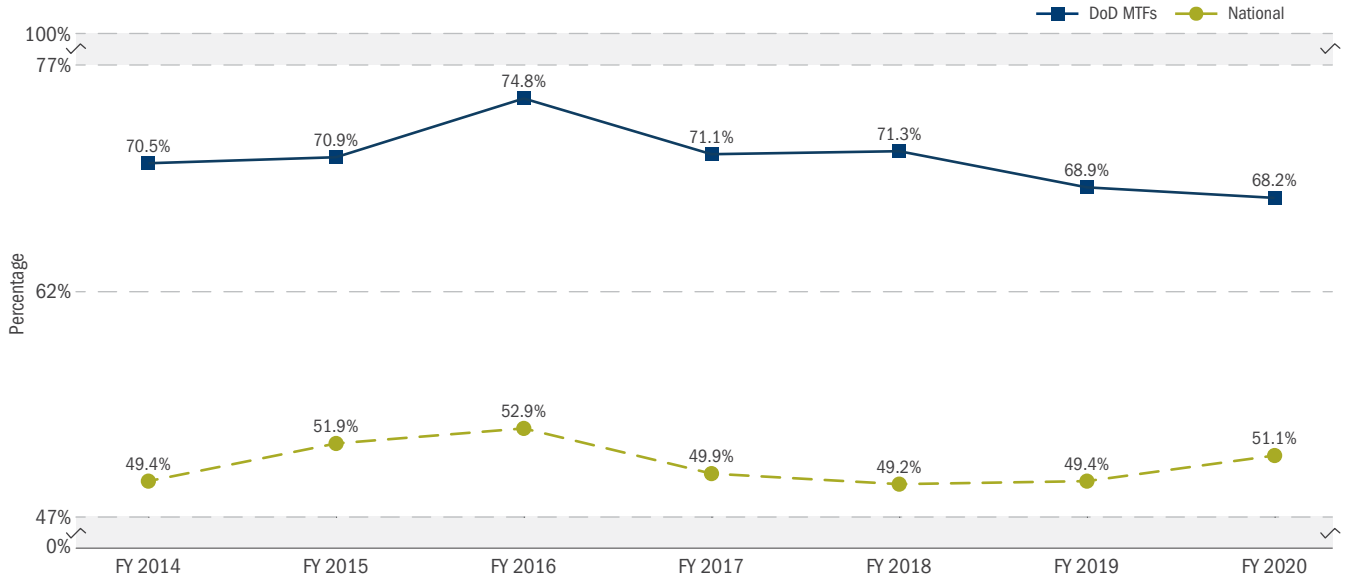
Sources: for DoD MTFs, DHA/Medical Affairs/CSD, 12/10/2020; for National, TJC/TJC Connect/Performance Measurement System Extranet Track (PET), 12/20/2021

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

Women and Infant Clinical Community and Women's Health Clinical Management Team (WHCMT) *(cont.)*

- **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 2014–2020



- **Unexpected Complications in Term Newborns:** This measure (PC-06), which began 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, FYs 2019–2021

	FY 2019[a]	FY 2020	FY 2021
DoD	43.9 per 1,000	39.0 per 1,000	42.6 per 1,000
National	34.4 per 1,000	31.6 per 1,000	30.8 per 1,000

Sources: for DoD MTFs, DHA/Medical Affairs/CSD, 2/18/2022; for National, TJC/TJC Connect/PET, 2/18/2022

[a] FY 2019 includes three quarters of data; new measure as of 1/1/2019.

Note: Rates are calculated using TJC Specifications Manual v2018B1, www.jointcommission.org.

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

Women and Infant Clinical Community and Women's Health Clinical Management Team (WHCMT) *(cont.)*

In addition to nationally reported measures, the MHS has maintained a rigorous internal review process through a partnership with NPIC. NPIC provides analytics, benchmarking, and aggregation of MTF data quarterly. Community-based care data are tracked by NPIC semiannually for facilities that deliver 150 babies or more annually among TRICARE beneficiaries. Community-based care data elements allow comparison of care quality and outcomes between MTF and community-based care in regions and Markets.

NATIONAL PERINATAL INFORMATION CENTER COMPARATIVE DATA ALL SERVICES COMBINED, CY 2020 Q2–CY 2021 Q1

	CY 2020 Q2			CY 2020 Q3			CY 2020 Q4			CY 2021 Q1		
Total Deliveries	7,612			8,276			6,783			6,126		
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	15.8%	18.5%	●	14.7%	18.4%	●	16.9%	18.9%	●	14.0%	17.8%	●
Postpartum Hemorrhage (PPH) Rate	5.1%	5.0%	●	5.2%	5.3%	●	5.8%	5.3%	●	5.6%	5.3%	●
Severe Maternal Morbidity Overall Rate	2.4%	2.4%	●	2.6%	2.5%	●	2.9%	2.7%	●	2.5%	2.8%	●
Maternal Readmit Rate to Delivery Hospital	1.9%	1.2%	●	2.3%	1.6%	●	2.1%	1.6%	●	2.0%	1.6%	●
Total Neonates	8,032			8,714			7,226			6,515		
Neonatal Outcome Measures	**MHS Avg**	**NPIC Avg**		**MHS Avg**	**NPIC Avg**		**MHS Avg**	**NPIC Avg**		**MHS Avg**	**NPIC Avg**	
Inborn Readmit Rate to Delivery Hospital	3.2%	0.7%	●	2.9%	0.7%	●	4.0%	0.8%	●	3.6%	0.9%	●
Inborn Mortality ≥2,000 Grams (Per 1,000 births)	0.519	0.597	●	0.716	0.554	●	0.581	0.701	●	0.486	0.597	●

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

RED indicates the MHS average rate is significantly ABOVE the NPIC database rate.

GREEN indicates the MHS average rate is either significantly BELOW or not significantly different from the NPIC database average rate.

MHS Average and NPIC Database Average Rates are the sum of all numerators/sum of all denominators (case level rates).

NPIC Average is a weighted average from all NPIC/Quality Analytic Service civilian hospitals in the database.

IQI 33 Primary Cesarean Delivery Rate: 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 Rate: (based on ACOG 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.

Readmissions may be aligned with MHS role to support families who don't have local support or whose spouse is deployed.

Readmission work continues to be reviewed in collaboration with MHS's overall readmission project.

- **Maternal Readmit Rate to Delivery Hospital:** Based on the NPIC benchmark, the National and MHS most common reason for readmission (within 30–42 days of delivery) is hypertension. This accounts for 40 percent of MHS readmissions.
- **Inborn Readmit Rate to Delivery Hospital:** Based on the NPIC benchmark, the National and MHS most common reason for newborn readmission to delivery hospital is jaundice. This accounts for 43 percent of MHS readmissions.

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

NUMBER OF MTF NPIC MEASURE OUTLIERS, CY 2020 Q4 & CY 2021 Q1

NPIC MEASURE OUTLIER	ARMY	NAVY	AIR FORCE	NCR
Severe Maternal Morbidity Overall Rate	0	1	0	0
Maternal Readmit Rate to Delivery Hospital	0	1	0	0
Inborn Readmit Rate to Delivery Hospital	3	5	4	2

Source: DHA/Medical Affairs/CSD, 9/29/2021

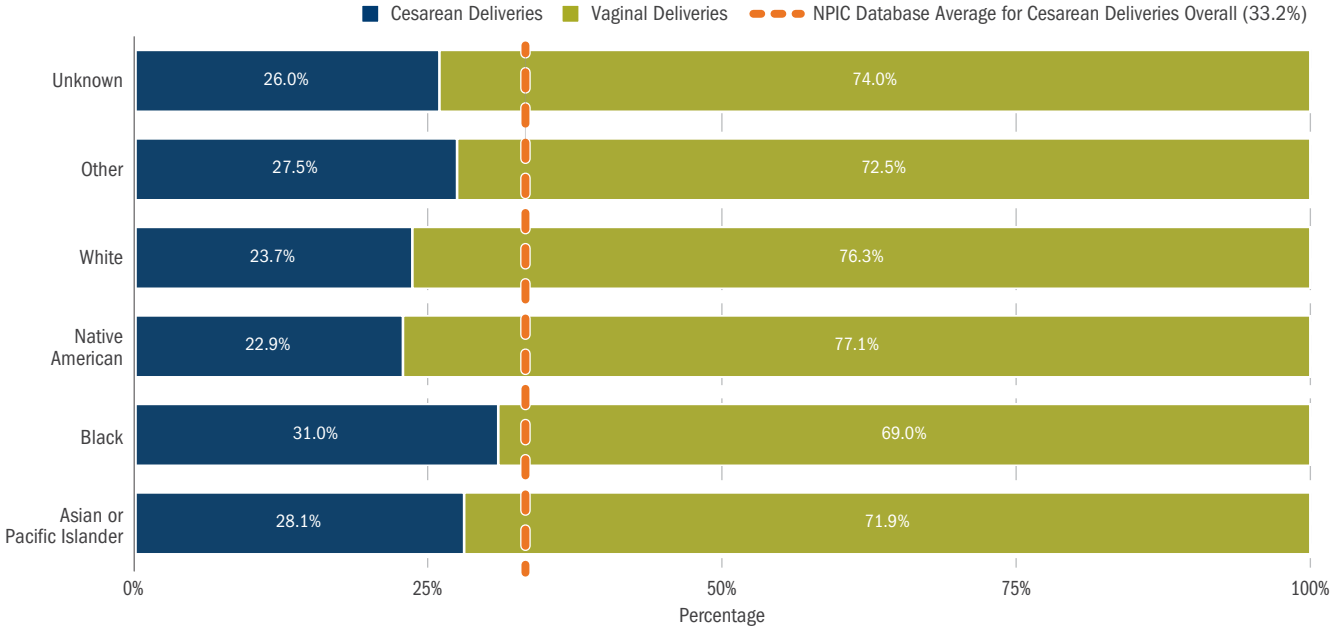
RED indicates the number of Service-aligned MTFs that performed worse (higher) than the NPIC database average for the two consecutive quarters shown (CY 2020 Q4 and CY 2021 Q1).

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

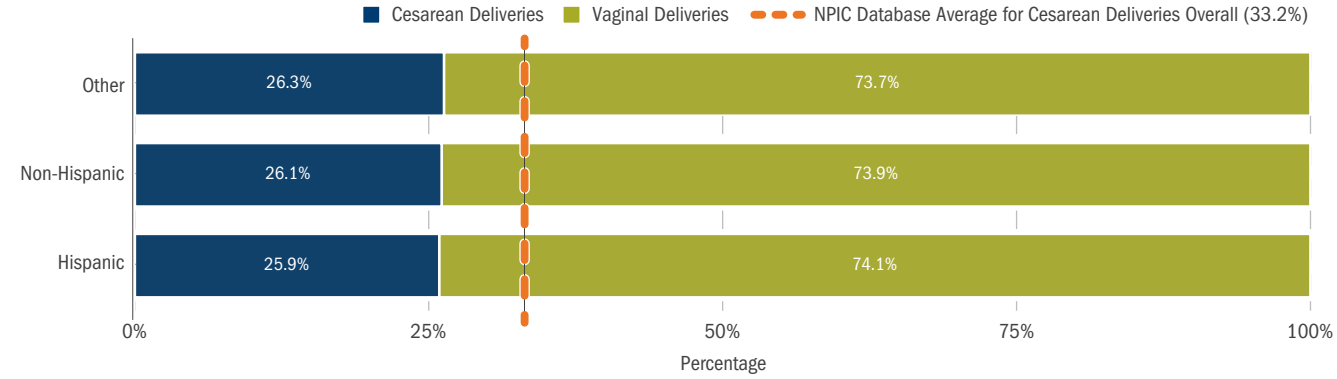
Women and Infant Clinical Community and Women's Health Clinical Management Team (WHCMT) *(cont.)*

Additionally, NPIC has been responsive to congressional reports and requests for information related to perinatal outcomes, with data on racial and ethnic subgroups. WICC began adding racial and ethnic subgroups to identify disparities among the populations. Future reports will include additional findings related to race and ethnicity in the perinatal population (lower is better).

DELIVERIES IN DIRECT CARE, BY RACE, APRIL 2020–MARCH 2021



DELIVERIES IN DIRECT CARE, BY ETHNICITY, APRIL 2020–MARCH 2021



Source: Standard Inpatient Data Record (SIDR), NPIC

Behavioral Health Clinical Community (BHCC)

Developing the Behavioral Health High Reliability Operating Model

The BHCC was chartered under DHA Healthcare Operations on November 8, 2017, and meets biweekly, with executive sessions including only core members immediately following. Back-briefs are provided 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.

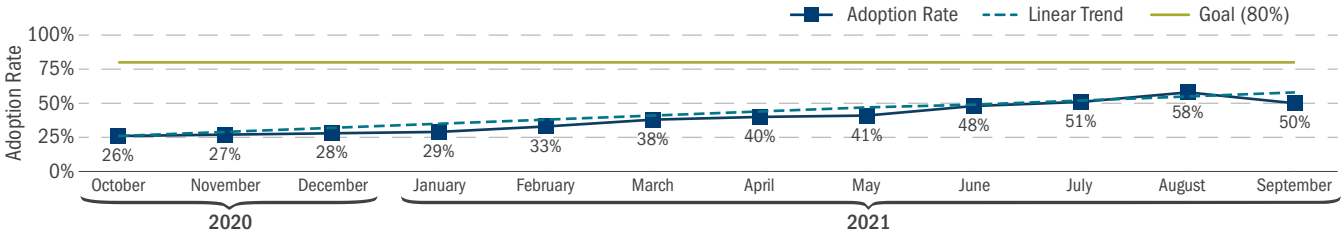
Since its inception, BHCC has focused on standardizing MHS behavioral health policy and implementing programs to advance improved outcomes and safe, quality behavioral health care. Specifically, the following progress has been made:

1. **Behavioral Health Treatment and Outcomes Monitoring:** 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 (BH) 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" on July 12, 2018. DHA-PI 6490.02 sets outcome monitoring requirements in specialty care behavioral health, substance use disorder, and primary care clinics at MTFs. The types of metrics required by DHA-PI 6490.02 for collection, reporting, and analysis include: structure (equipment and training compliance); process (treatment dosage rate, evidence-based treatment rates); and clinical outcome metrics (improvement and/or remission in major depressive disorder [MDD] and PTSD). Currently, the BHCC is revising DHA-PI 6490.02 to set revised expectations and establish standardized responsibilities and procedures, as MTFs move under DHA authority, direction, and control; publication is expected by end of FY 2022.
2. **Behavior Health Data Portal (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 outcome 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 2022 QPP initiatives. Enterprise-wide, the BHDP Adoption Rate has improved since BHDP inception until the COVID-19 pandemic significantly affected MTF performance on this metric. While MTFs were quickly able to adapt to virtual BH visits, the MHS did not have a mechanism in place that allowed patients to enter BHDP data from home that would be counted as a completed survey. Since March 2020, BHDP Adoption Rate has been higher for in-person visits compared to virtual visits, but many clinics are still well below previous levels, due to continued safety precautions in clinics around sharing equipment and maintaining social distancing. BHCC efforts are underway to continue improving performance on this metric through continued staff training and the development of a remote-access BHDP tool, which is expected to be released in Q1 FY 2022.

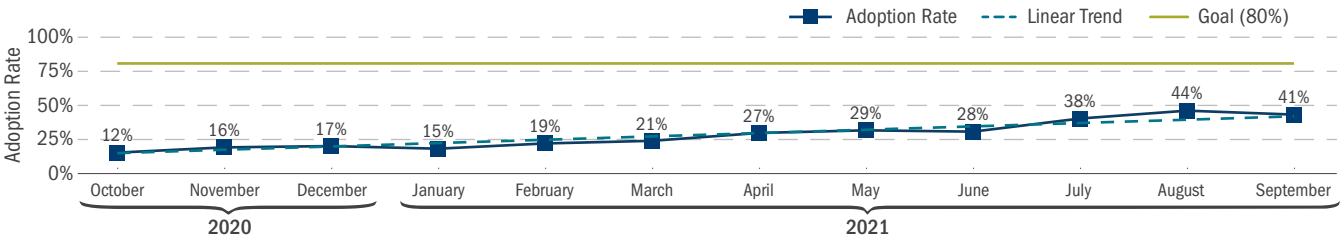
HIGH RELIABILITY OPERATING MODEL/CLINICAL COMMUNITIES *(CONT.)*

Behavioral Health Clinical Community *(cont.)*

DoD BHDP ADOPTION RATE, AHLTA SITES, OCTOBER 2020–SEPTEMBER 2021

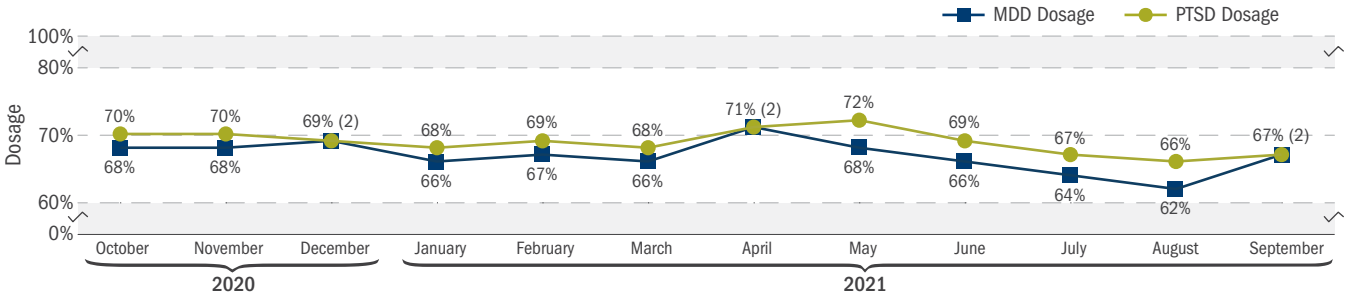


DoD BHDP ADOPTION RATE, MHS GENESIS SITES, OCTOBER 2020–SEPTEMBER 2021

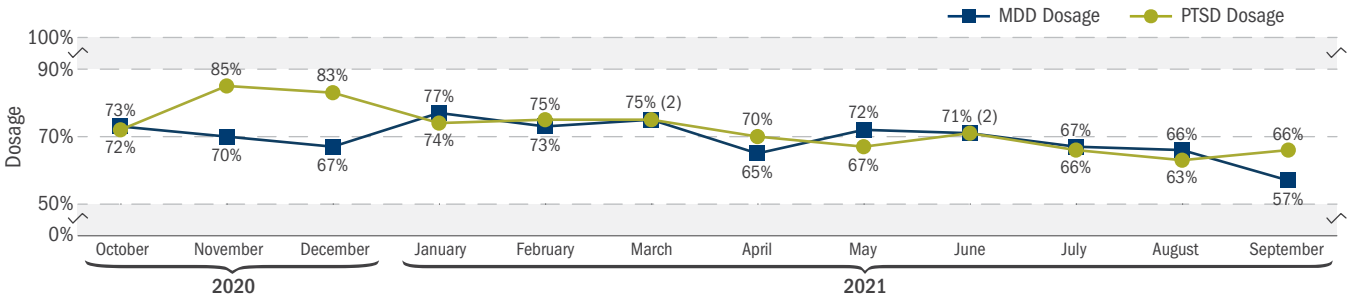


3. **Treatment Dosage for MDD and PTSD:** As described in DHA-PI 6490.02, Treatment Dosage Rate is the percentage of patients with a new diagnosis of PTSD or MDD who receive at least three follow-up appointments within 90 days of diagnosis. While three visits within 90 days is not optimal care, according to VA/DoD clinical practice guidelines, Army studies showed this dosage was associated with better outcomes, compared with fewer than three follow-up visits. Receiving adequate frequency of care improves outcomes over a shorter period of time, returning the patient to well-being and higher functioning more quickly. Despite challenges to usual clinic workflows due to COVID-19, the MHS was able to maintain good performance on this metric (see graph below).

TREATMENT DOSAGE FOR MDD AND PTSD, AHLTA SITES, OCTOBER 2020–SEPTEMBER 2021



TREATMENT DOSAGE FOR MDD AND PTSD, MHS GENESIS SITES, OCTOBER 2020–SEPTEMBER 2021

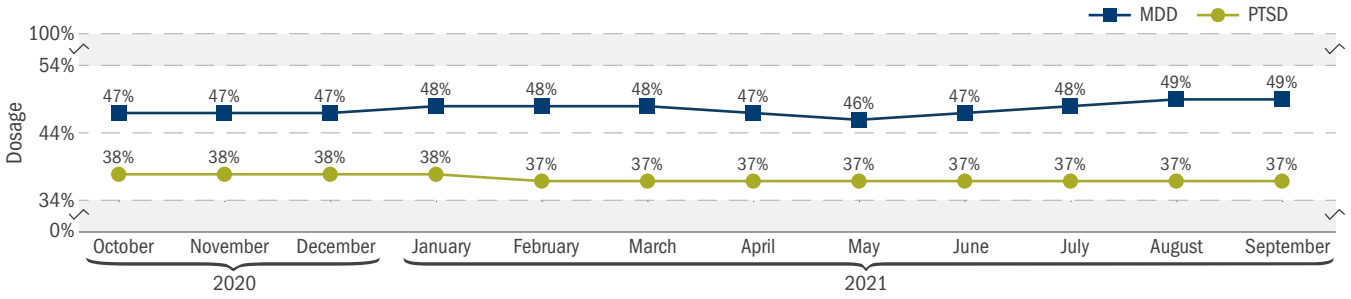


Source: DHA/Medical Affairs/CSD, 9/30/2021

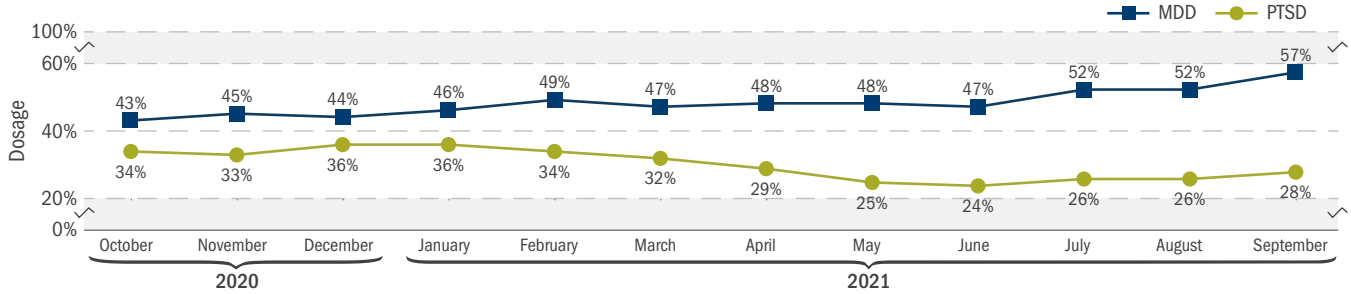
Behavioral Health Clinical Community *(cont.)*

4. **MDD and PTSD Positive Outcomes:** DHA-PI 6490.02 requires MTFs to monitor patient-reported outcomes for PTSD and MDD using standardized assessments mandated by Assistant Secretary of Defense for Health Affairs (ASD[HA]) memorandum. The BHCC set current targets for patient improvement or remission at 47 percent for MDD and 36 percent for PTSD. The graph below shows outcomes for both disorders. As Treatment Dosage Rate and Evidence-Based Treatment Utilization Rate improve, positive outcome rates will also improve.

MDD AND PTSD POSITIVE OUTCOMES, AHLTA SITES, OCTOBER 2020–SEPTEMBER 2021

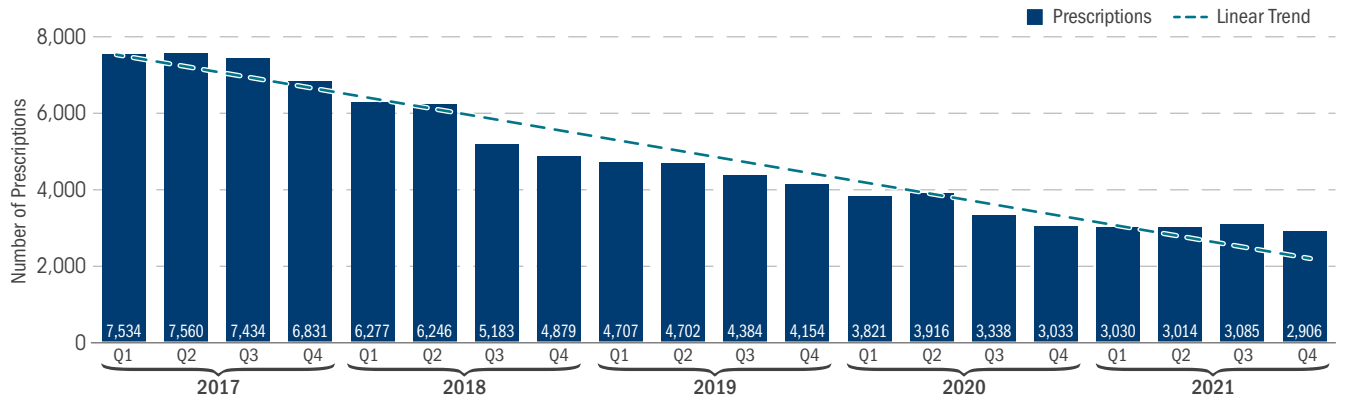


MDD AND PTSD POSITIVE OUTCOMES, MHS GENESIS SITES, OCTOBER 2020–SEPTEMBER 2021



5. **PTSD Prescriber Tool:** NDAA FY 2017, section 745, required DoD to implement a process to monitor MTF prescribing practices of pharmaceutical agents that are not recommended under the VA/DoD CPG for the Management of PTSD and Acute Stress Disorder, such as benzodiazepines (BZDs). 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 2017 to FY 2021, resulting in a 61 percent reduction in BZD prescriptions over this time period (see chart below).

NUMBER OF PRESCRIPTIONS FOR BZD TO BENEFICIARIES DIAGNOSED WITH PTSD, FY 2017 Q1–FY 2021 Q4



Source: DHA/Medical Affairs/CSD, 9/30/2021

Behavioral Health Clinical Community *(cont.)*

Access to MHS Care and Services for Family Members of Active Duty and Non-Active Duty Service 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 and non-Active Duty with severe disabilities and chronic health care needs.

Applied behavior analysis (ABA) services are covered by TRICARE as part of a demonstration project for beneficiaries diagnosed with ASD. All ABA services are provided through the private sector care network. Other services covered for beneficiaries diagnosed with ASD 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 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 Active Duty family members (ADFMs) and non-ADFMs diagnosed with ASD. ABA services are not limited by the beneficiary's age, the dollar amount spent, or the number of services provided, and there are no annual caps on government cost shares. ABA services are authorized based on the clinical necessity and appropriateness of the individual beneficiary's needs. The program provisions attempt to strike a balance that maximizes access while ensuring care at the highest level of quality for our beneficiaries. An extension for the demonstration through December 31, 2023, 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 outcome 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 2020, show that ABA services had a total program expenditure of $397.7 million. The total number of ADFMs participating in the ACD did not increase FY 2019 to FY 2020, and the total number of non-AD dependents participating in the ACD increased by only 2 percent from FY 2019 to FY 2020. By the end of FY 2020, the number of beneficiaries participating in the ACD who had filed claims for ABA services was 16,160.

In March 2021, the DHA published policy revisions to the ACD. With this policy update, the ACD will focus on providing enhanced beneficiary and family support, improving outcomes, encouraging parental involvement, and improving utilization management controls. These notable revisions include: implementation of a specialized care manager (known as an Autism Services Navigator), revisions to the outcome measures, expanding coverage of certain Adaptive Behavior Services for the delivery of ABA services to TRICARE eligible beneficiaries diagnosed with ASD, and streamlining ABA provider requirements. These comprehensive updates move the program to a more beneficiary-centric model. These updates will improve the quality of, and access to, care and services and will also improve management and accountability of both the MCSCs and the ABA providers.

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 and dental treatment facilities (DTFs). 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 private sector care.

The DCC milestones for FY 2021 include the following actions:

- DCC members and dental SMEs continue using teamwork, HRO models, key process analysis, and the DHA submission portal; additional nonvoting members are included in the DCC to support numerous strategic dental health initiatives.
- A new DCC DHA member was selected by the DCC Core Members in January 2021, as per the guidance set forth by the DCC charter.
- Biweekly core member meetings and quarterly enterprise-wide dental SME and Service representative meetings are held.
- A working group continued to develop standardized dental performance and outcome metrics that support the Quadruple Aim.
- SMEs have been established to develop standardized enterprise-wide Dental Infection Control guidance.
- Working groups developed enterprise-wide guidance and updates to the military dental enterprise to ensure safe and effective care during the COVID-19 pandemic in line with CDC, OSH, American Dental Association, and other applicable local, state and federal guidance.
- Working groups developed, drafted, coordinated, and aided the publishing of the following DHA procedural instructions: (1) DHA-PI 6410.01 Dental Sedation Medical Management, published May 4, 2021; (2) DHA-PI 6410.02 Dental Universal Protocol, published May 21, 2021, and (3) DHA-PI 6410.03 Processes and Procedures for Implementation of Standardized Dental Cone Beam Computed Tomography Operations and Training, published August 23, 2021.

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. These data are 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). Currently, at the end of FY 2021, the total number of participating MTFs has decreased to 45 with the transition of several hospitals to stand-alone ambulatory surgical centers. DoD NSQIP collaborates closely with the new DHA Surgical Services Clinical Community 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 2020 mortality data indicated that all MTFs reporting data met the expected performance level, including one facility that was "exemplary" (results in the top quartile of hospitals). No facilities were in the "needs improvement" category (results in the bottom quartile of hospitals) for mortality. The morbidity data indicated that of the 44 sites reporting data for CY 2020, 33 MTFs met expected performance levels, while seven were "exemplary." Four 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 2015–2020

			CY 2015		CY 2016		CY 2017		CY 2018		CY 2019		CY 2020	
			MORTALITY	MORBIDITY	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, 12/3/2021

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 (706 hospitals across the United States currently participate in the ACS NSQIP Adult Program). The DoD Collaborative performed "exemplary" in six of 14 statistical models, exceeding expected performance even after adjustments for patient risk profiles. One area that needs improvement, as noted in the DoD collaborative report, was All Cases Return to Operating Room (ROR). The NSQIP Steering Panel is currently collaborating with the Surgical Services Clinical Community to understand these issues and develop strategies to improve performance. Improvements are often highly influenced by drivers specific to each MTF. While there is rarely a one-size-fits-all solution, interfacility collaboration drives the sharing of problem-solving strategies.

DoD COLLABORATIVE JULY 2021 SUMMARY (SURGERY DATES JANUARY 1 TO DECEMBER 31, 2020)

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	37,898	71	0.19%	0.73%	0.57%	0.90%	Low	0.75	0.97%
All Cases Morbidity	37,898	1,137	3.00%	5.99%	5.66%	6.32%		0.99	6.03%
All Cases Cardiac	37,898	48	0.13%	0.40%	0.28%	0.55%	Low	0.63	0.63%
All Cases Pneumonia	37,889	67	0.18%	0.55%	0.40%	0.72%	Low	0.61	0.90%
All Cases Unplanned Intubation	37,894	58	0.15%	0.51%	0.39%	0.65%		0.83	0.61%
All Cases Ventilator >48 Hours	37,888	41	0.11%	0.43%	0.30%	0.59%	Low	0.68	0.64%
All Cases VTE	37,898	143	0.38%	0.76%	0.65%	0.89%		0.97	0.79%
All Cases Renal Failure	37,894	32	0.08%	0.30%	0.20%	0.42%	Low	0.68	0.44%
All Cases Urinary Tract Infection (UTI)	37,840	266	0.70%	1.19%	1.06%	1.33%		1.12	1.07%
All Cases Surgical Site Infection	37,736	636	1.69%	2.76%	2.56%	2.97%		1.05	2.63%
All Cases Sepsis	37,835	79	0.21%	0.59%	0.44%	0.75%	Low	0.65	0.90%
All Cases C. Diff Colitis	37,898	40	0.11%	0.29%	0.20%	0.38%		0.88	0.33%
All Cases ROR	37,898	590	1.56%	2.86%	2.66%	3.06%	High	1.22	2.35%
All Cases Readmission	37,898	927	2.45%	4.79%	4.50%	5.09%		0.99	4.83%

EXEMPLARY AS EXPECTED NEEDS IMPROVEMENT

Source: American College of Surgeons National Surgical Quality Improvement Program DoD Collaborative Report, released July 2021

[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 2019 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 148 hospitals participating across the nation. Naval Medical Center (NMC) Portsmouth has been participating in the program since May 2019. In June 2020, NMC San Diego and Tripler Army Medical Center (AMC) also began participating in the program. Plans are in development to expand the program to other sites in 2022.

The ACS MBSAQIP provides a quality improvement program for patients suffering from severe obesity. Bariatric surgery is a procedure group with studied relationships between procedural volume and surgical outcomes and features frequently in discussions of high-risk procedures performed at low-volume facilities. These are also one of the few foregut procedures currently available to a broad range of surgeons that can offer surgical skill experience referable to deployment-relevant knowledge, skills, and abilities (KSAs). There are 21 MTFs performing bariatric procedures on a regular basis. Six MTFs are currently participating in MBSAQIP, with 15 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 12 MTFs working on or designated trauma centers.

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 2020 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 CY 2020 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 CY 2020:

All Cases Meritorious List:

- Carl R. Darnall Army Medical Center
- Evans Army Community Hospital
- Portsmouth Naval Medical Center
- San Diego Naval Medical Center

High-Risk Meritorious List:

- Brooke Army Medical Center
- 60th Med Group (David Grant, Travis)

These sites are among the 90 facilities representing the top 10 percent of all NSQIP participating hospitals worldwide in 2020.

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. Prior to the COVID-19 pandemic, this collaborative met in person twice a year for professional development and cross-pollination of ideas. These face-to-face opportunities are critical to the rapid on-boarding of personnel new to NSQIP and help ensure sustained return on investment by mitigating impacts of turnover inherent to military practice.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES

The National Clinical Quality Database

On October 1, 2014, the MHS action plan for Access, Quality of Care, and Patient Safety Memorandum was signed by the Secretary of Defense. This memorandum directed the DHA to establish a 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 additional strategically selected national databases, such as NSQIP, was identified as a means to significantly contribute to meeting this requirement.

The DoD's participation in national clinical quality databases 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 11 clinical quality databases:

- ACS National Surgical Quality Improvement Program Adult Program
- ACS National Surgical Quality Improvement Program Pediatric Program
- ACS Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program
- ACS Trauma Verification, Review, and Consultation and Trauma Quality Improvement Programs
- ASCO Quality Oncology Practice Initiative
- National Perinatal Information Center Database
- National Healthcare Safety Network
- CMS Care Compare
- The Joint Commission National Hospital Measure
- Leapfrog Hospital Survey
- Leapfrog Ambulatory Surgery Center Survey

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.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Medical Management

The MHS is engaging in an organizational health care transformation across the MHS, including the delivery of Medical Management (MM) services to members of the Armed Forces and other covered beneficiaries. In direct support of this mission, the DHA MM program is focused on the development and integration of standardized clinical and business process workflows to support improved patient outcomes. To achieve this, the MHS MM program has integrated use of technology, tools, and industry evidence-based best practices to support higher reliability in health care delivery and uniformity of MM clinical processes within MTFs. Additionally, the DHA MM program has expanded engagement and collaboration between DHA and the MILDEPs, as a result of the required transition of MTF administration, direction, and control (ADC) to DHA, to ensure improved standardization of clinical practice efforts. Through these ongoing transition efforts, the DHA will continue to reduce practice variation, decrease fragmentation in care processes, and enhance MM delivery of services through an integrated and enterprise-wide approach.

An example of MM improvements includes efforts taken and now in place to support improved Case Management (CM) services. Enhanced enterprise-wide programmatic improvements have reinforced the need for CM integration and services across various MHS care platforms. Case managers support the identification of individuals with chronic, complex, high-risk, and/or high-cost conditions that would benefit from engagement and coordination with dedicated health care teams to reduce fragmentation across the MHS. This transformation supports the MHS Quadruple Aim to optimize health system performance. As part of the transition, and in coordination with the MILDEPs, DHA participated in strategic policy development and collaboration to initiate policy directives in support of the MHS transformation. A dedicated DHA Procedural Instruction (PI), 6025.20 "MM Program within the MHS" (August 27, 2019), was developed and is now being executed for CM services throughout DHA.

Historically, CM targeted complex high-risk patients and beneficiary populations with high resource utilization. Today, the MHS has improved capabilities in utilization of evidence-based tools with proactive identification management of those beneficiaries that may benefit from CM services using predictive analytics. Specifically, the MHS leverages the evidence-based Johns Hopkins Adjusted Clinical Groupings (ACG) to identify patients through a population-based approach, rather than a single diagnosis. Patients identified as high risk are listed on the web based MHS Population Health Portal (MHSPHP) utilized by CM personnel at the point of care. Utilization of the MHSPHP tool provides CM personnel the capability to identify and intervene for at-risk populations proactively, as opposed to retroactively. Unlike many traditional methods for case identification (such as hospital concurrent review and ED utilization reports), the ACG Predictive Model identifies those in need of care management intervention before they become high utilizers (Johns Hopkins, 2015). Standardizing CM processes benefits military health care beneficiaries and closes the gap on operational variance.

The strategy for the MHS MM practice is built around core concepts that include a shared vision of patient-centric care and an enterprise-wide commitment to quality, evidence-base approaches in alignment with executive leadership support of a MM program across the continuum as it parallels the organization's preparations for a value based environment, and alignment around shared values and a shared spirit of cooperation, teamwork and respect. DHA MM program remains committed to these principles and harmonizing MHS MM policies and procedures.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Pain Management

During FYs 2020 and 2021, the MHS continued to mature 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) 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 review and 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 Health Executive Committee (HEC) Work Groups.
- Increasing pain VH integration in NCR primary care by both direct care visits and provider webinar case-based education. This was greatly enhanced with the 2020 public health crisis (COVID-19). Over 200 people attended the Substance Use Disorder Symposium for 2021.
- Continued primary care pain skills training offered annually by the NCR Pain Care Initiative. Since 2020, Pain Skills moved to a virtual online forum. There were 324 participants for the training in 2021.
- Expansion of pilot in-home VH visits to transitioning and rural Service members and beneficiaries. Enhanced by DHA Connected Health and HEC Pain Management Work Group regarding COVID-related VH support for pain management and opioid safety. Examples include integration of virtual pain assessment utilization of the DVPRS and establishing DoD access to VA virtual functional restoration programs for chronic pain conditions.
- Continued development and deployment of the Pain Assessment Screening Tool and Outcome Registry (PASTOR), the MHS pain outcome registry and clinical decision-making tool. PASTOR is one of a growing number of use cases within the MHS PROCR that leverage the National Institutes of Health (NIH) Patient Reported Outcomes Measurement Information System.
- Established Opioid Prescribers Trend Report, which provides providers and pain leaders insights about opioid prescribing trends at the Market, MTF, clinic, and provider levels. This tool is used to support Stepped Care Model Implementation, CPG adherence, and local QI efforts and provider peer review.
- Continued dissemination of the Joint Pain Education Project, which created a standardized VA/DoD pain management curriculum and supplemental pain videos for widespread use in education and training programs.
- Participation in research efforts under the NIH/DoD/VA Pain Management Collaboratory to examine the effectiveness of nonpharmacological treatments for acute and chronic pain and complex pain syndromes experienced by military and Veteran populations.
- Continued standardization of acupuncture practice in the MHS following the 2020 Publication of DHA-Procedural Instruction (DHA- PI) 6025.33 Acupuncture Practice in Medical Treatment Facilities.
- Opioid Education and Naloxone Distribution program being implemented throughout the MHS. Educating patients and families on opioid risks and dispensing the overdose antidote naloxone.
- Naloxone metric established as QPP metric for FY 2021 will be percentage of at-risk population receiving naloxone prescription in past year.
- Reductions in number of opioid prescriptions, number on long-term opioid therapy, those prescribed high doses Morphine Equivalent Daily Dose (MEDD>50), and those co-prescribed benzodiazepines continues.
- Conducted full review and update of content for the DoD Opioid Prescriber Safety Training, a requirement for all MHS prescribers.
- Pain Management Clinical Support Service is developing recommendations for opioid prescribing safety alerts to be integrated into the new electronic health record, MHS GENESIS.

Preventing Opioid Misuse by Military Service Members

DHA-PI 6025.04 Pain Management and Opioid Safety in the MHS, originally published June 8, 2018, and revised in 2021 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.
- Provide MHS providers with clear guidance regarding standards, processes, and decision support tools for safe and effective opioid prescribing.
- 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.
- 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: documentation of informed consent for patients who require long-term opioid therapy; guidance on the recommended days supply, dosage, and refill procedures for opioid prescribing; provision of Medication for Opioid Use Disorder; and provision of naloxone (opioid reversal medication) 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.

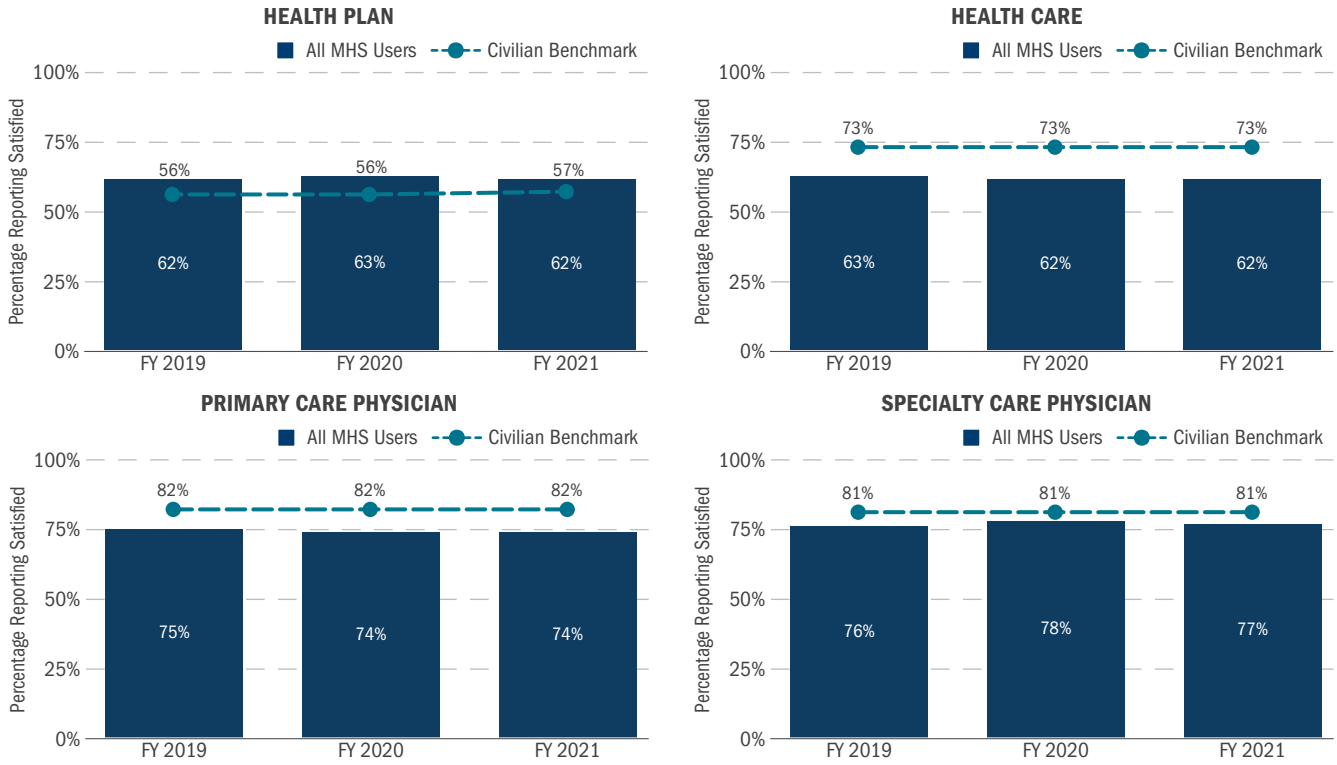
In this section, MHS beneficiaries in the U.S. who have used TRICARE are compared with the civilian benchmark with respect to ratings of (1) the health plan in general; (2) health care; (3) their personal physician; and (4) specialty care. Health plan ratings depend on access to care and how the plan 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 Health Plan survey, and is used to routinely assess MHS beneficiary experience with health care, whether in the direct or private sector 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 who may or may not have had an outpatient or inpatient encounter in the previous year. 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, primary care physician (i.e., personal doctor), and specialty care physician remained relatively the same for the past three years.
- MHS beneficiary satisfaction with their health plan exceeded that of the civilian benchmark in each year between FY 2019 and FY 2021. However, MHS beneficiary satisfaction with health care quality and with personal doctor and specialty care physicians were lower than the comparable civilian benchmarks.

TRENDS IN SATISFACTION RATINGS OF KEY HEALTH PLAN ASPECTS, FYs 2019–2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 12/16/2021

Notes:

– All MHS Users applies to survey respondents in the 50 United States and the District of Columbia.

– 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 2019 and 2020 come from NCQA's 2017 data and in 2021 from NCQA's 2019 data.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

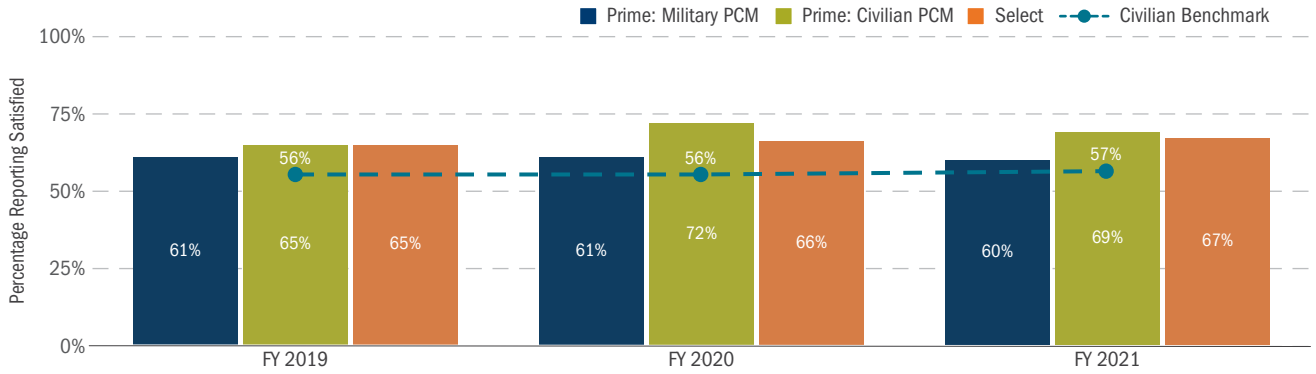
Patient-Centered Care/Experience *(cont.)*

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 enrolling in the Select option. Satisfaction levels with one's health plan across the TRICARE options are compared with commercial plan counterparts.

- Satisfaction with the TRICARE health plan decreased by 3 percentage points from FY 2020 to FY 2021 for Prime enrollees with a civilian PCM and 1 percentage point for Prime enrollees with a military PCM.
- For each year between FY 2019 and FY 2021, all MHS enrollment groups reported higher levels of satisfaction with their health plan than the civilian benchmark.

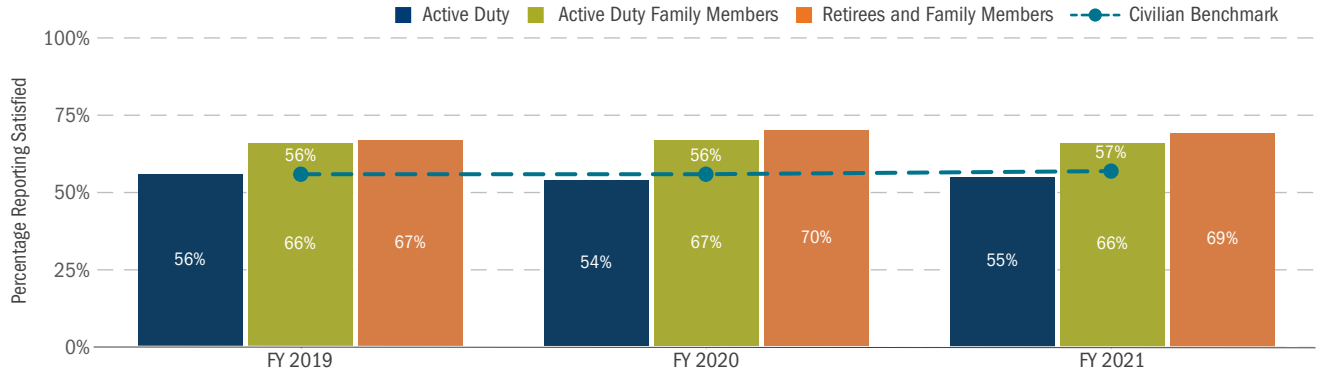
TRENDS IN SATISFACTION WITH THE HEALTH PLAN BY ENROLLMENT STATUS, FYs 2019–2021



Beneficiary Ratings of Their Health Plan Based on Beneficiary Category

- Satisfaction with the TRICARE health plan declined by 1 percentage point from FY 2019 to FY 2021 for Active Duty, while increasing by 2 percentage points for retirees and family members over the same time period.
- Satisfaction with health plan scores for Active Duty was below the benchmark in FY 2021.

TRENDS IN SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY, FYs 2019–2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 12/16/2021

Note: 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 2019 and 2020 come from NCQA's 2017 data and in 2021 from NCQA's 2019 data.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

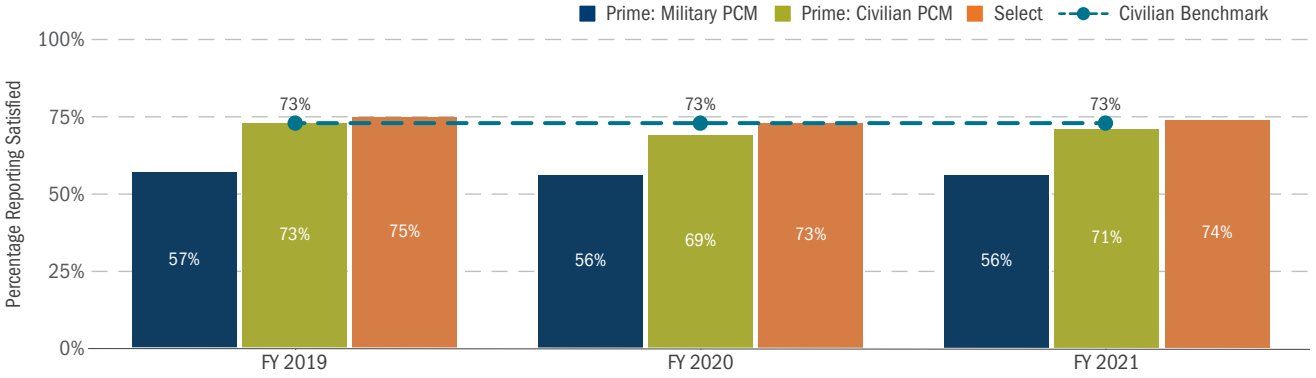
Patient-Centered Care/Experience *(cont.)*

Beneficiary Ratings of Satisfaction with Health Care by Enrollment Status and Beneficiary Category

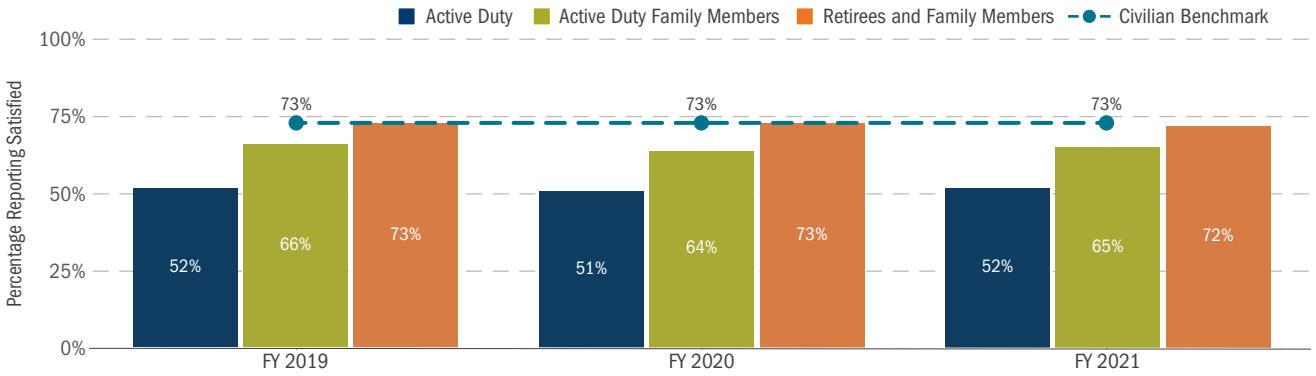
Similar to satisfaction with the TRICARE health plan, satisfaction levels with the health care received differ by beneficiary category and enrollment status.

- Beneficiary satisfaction with their health care declined slightly between FY 2019 and FY 2021 by enrollment status.
- In FY 2021, satisfaction with health care for beneficiaries with military and civilian PCMs were lower than the civilian benchmark.
- Satisfaction with health care for Active Duty and ADFMs were below the civilian benchmark for each year between FY 2019 and FY 2021 and remained relatively stable across the last three years.

TRENDS IN SATISFACTION WITH TRICARE HEALTH CARE BY ENROLLMENT STATUS, FYs 2019–2021



TRENDS IN SATISFACTION WITH TRICARE HEALTH CARE BY BENEFICIARY CATEGORY, FYs 2019–2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 12/16/2021

Note: 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 2019 and 2020 come from NCQA's 2017 data and in 2021 from NCQA's 2019 data.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

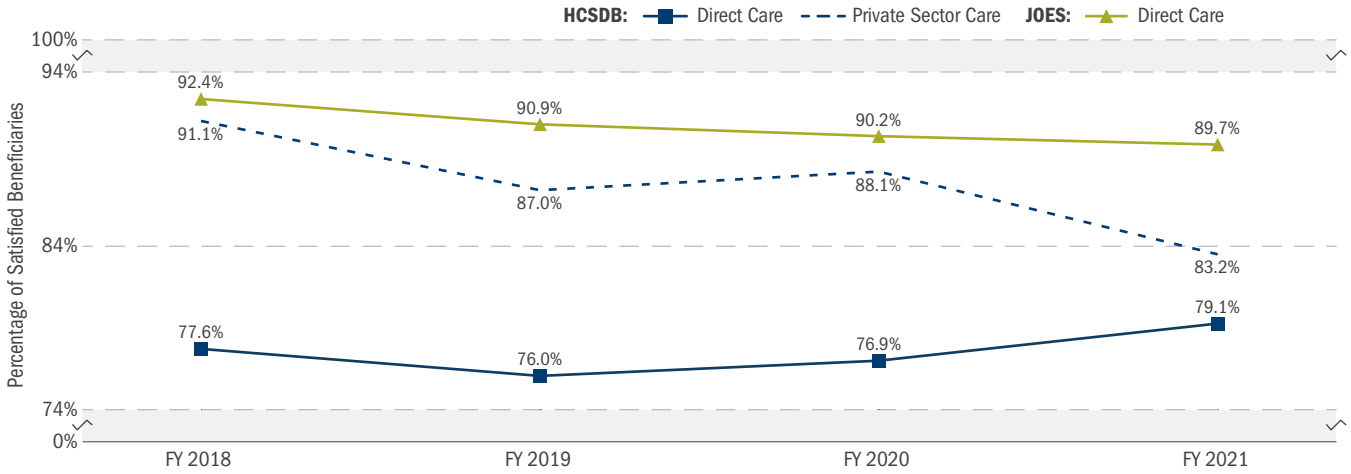
Patient-Centered Care/Experience *(cont.)*

DHA Surveys—Satisfaction with Care and Health Care Rating

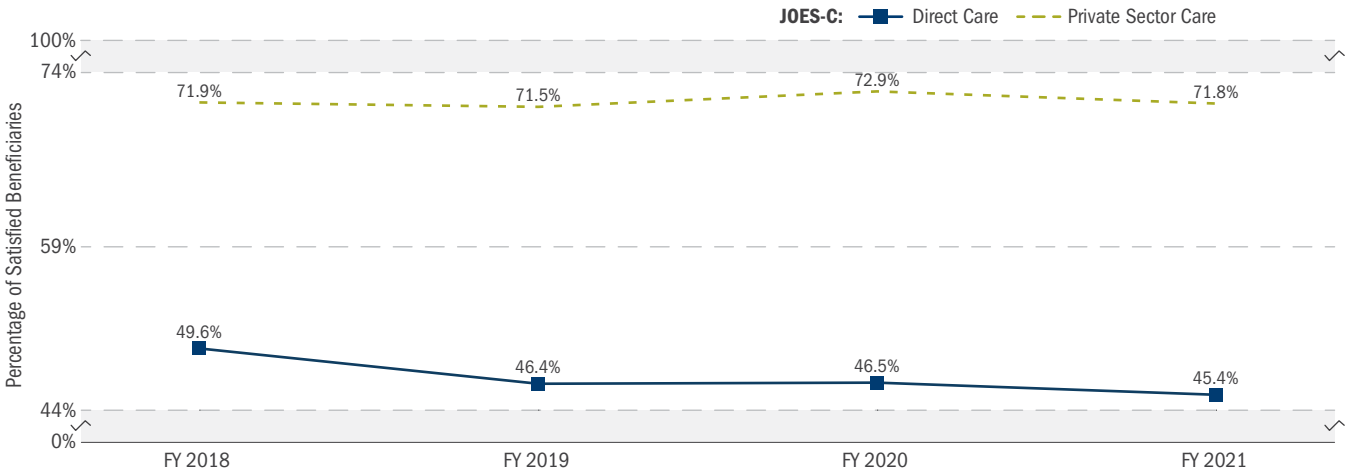
In addition to JOES and JOES-C, the population-based HCSDB survey also reports results for the Satisfaction with Care measure. Including this same item in each survey provides important information about the differences between surveys and the beneficiaries who answer them.

- From FY 2018 to FY 2021, JOES direct care beneficiaries reported the greatest satisfaction with care when compared with beneficiaries responding to HCSDB direct care or private sector care. HCSDB private sector care users reported greater satisfaction with care than those using direct care from FY 2018 through FY 2021.
- HCSDB private sector care scores for satisfaction with care decreased by eight percentage points from 2018 to 2021, while HCSDB direct care increased by one percentage point.
- JOES-C health care rating scores for private sector care remained relatively unchanged from FY 2018 to FY 2021 and well above those for JOES-C direct care.

HCSDB AND JOES RATINGS OF SATISFACTION WITH CARE, FYs 2018–2021



JOES-C HEALTH CARE RATING, FYs 2018–2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB, JOES, and JOES-C, compiled 12/2/2021

Notes:

– Results for HCSDB are for Prime enrollees only. "HCSDB Direct Care" represents care received as Active Duty or through a military PCM for individuals under 65 and who have been enrolled for at least six months. "HCSDB Private Sector Care" is defined as care received from civilian PCM for individuals under 65 who were enrolled in the following healthcare plans for at least six months: TRICARE Select, TRICARE Reserve Select, TRICARE Retired Reserve, or TRICARE Young Adult Select.

– Results for JOES-C FY 2021 is from October 2020 to July 2021 for direct care and from October 2020 to June 2021 for private sector care. Satisfaction with Care is worded very similarly in JOES and HCSDB surveys 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."

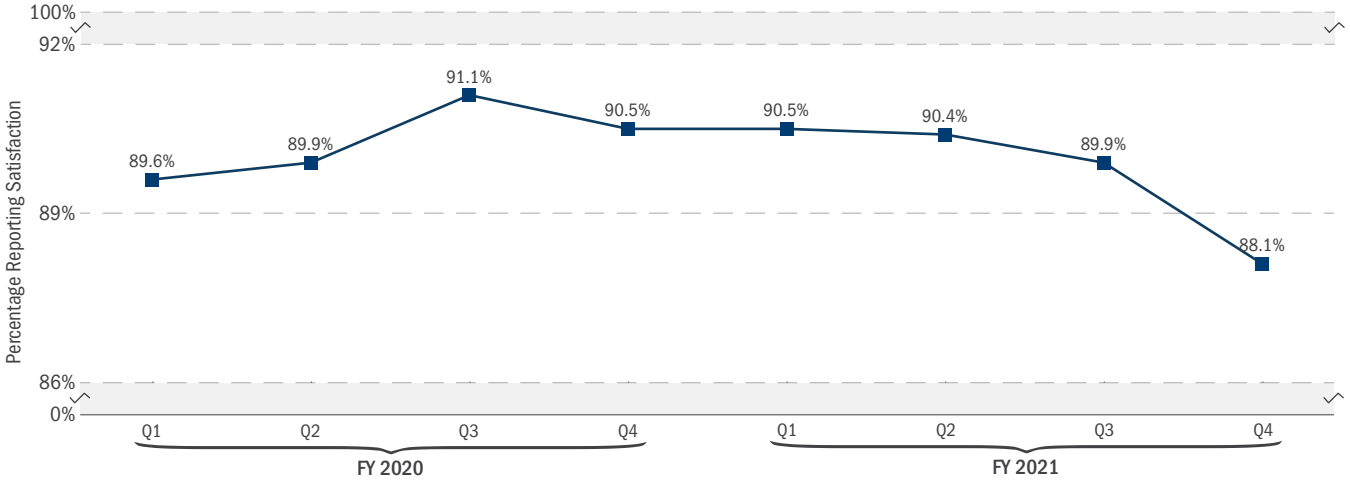
– Health Care Rating in JOES-C is worded as the following statement: "Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate your health care?" The results reported above are for those beneficiaries who provided a rating of 9 or 10.

Patient-Centered Care/Experience *(cont.)*

JOES Satisfaction with Care

From FY 2020 Q1 through FY 2021 Q4, there was little change in Satisfaction with Care scores from JOES.

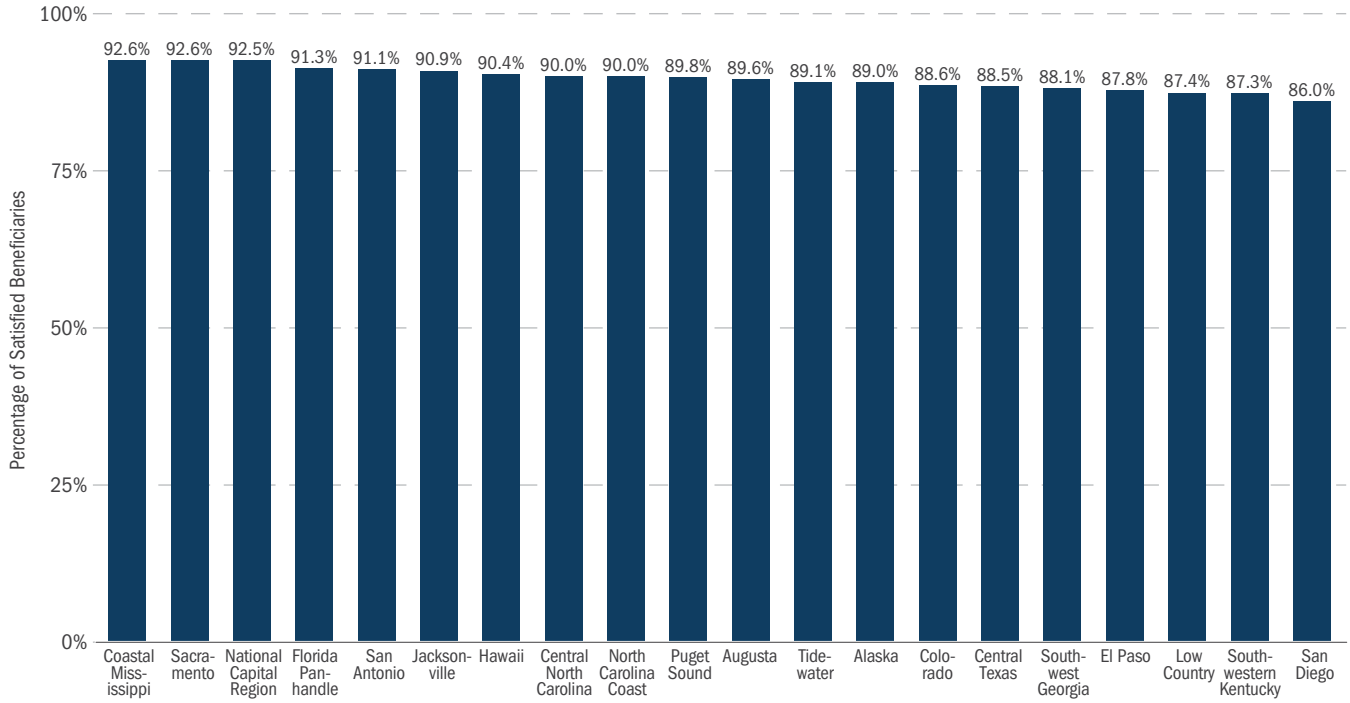
JOES SATISFACTION WITH CARE, FYs 2020–2021



The chart below shows JOES Satisfaction with Care by DHA Markets in FY 2021.

- At the end of FY 2021, Coastal Mississippi and Sacramento tied for the highest scoring Market for Satisfaction with Care at 92.6 percent, while San Diego was the lowest at 86 percent satisfaction.

JOES SATISFACTION WITH CARE BY MARKET, FY 2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES, weighted data compiled 12/2/2021

Note: Satisfaction with Care is assessed in each survey as an agreement to 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."

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

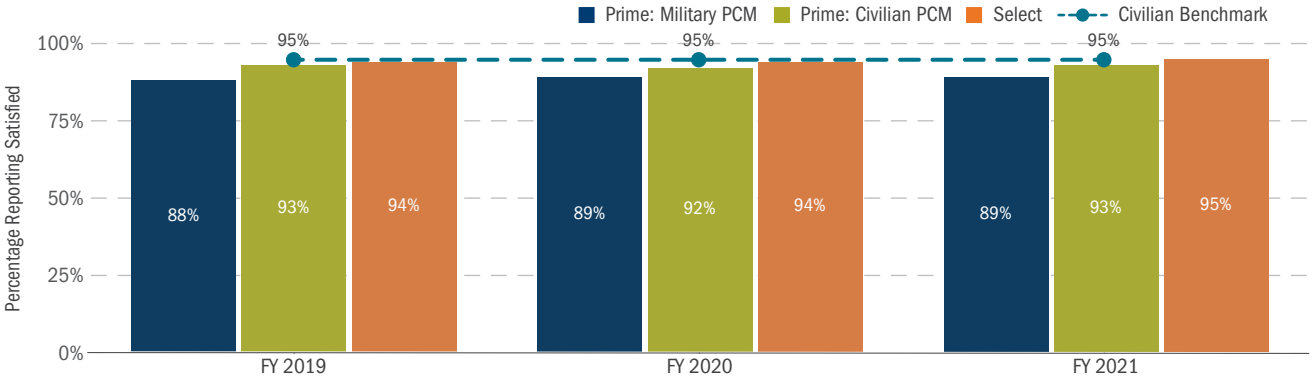
Patient-Centered Care/Experience *(cont.)*

Satisfaction with Doctors' Communication

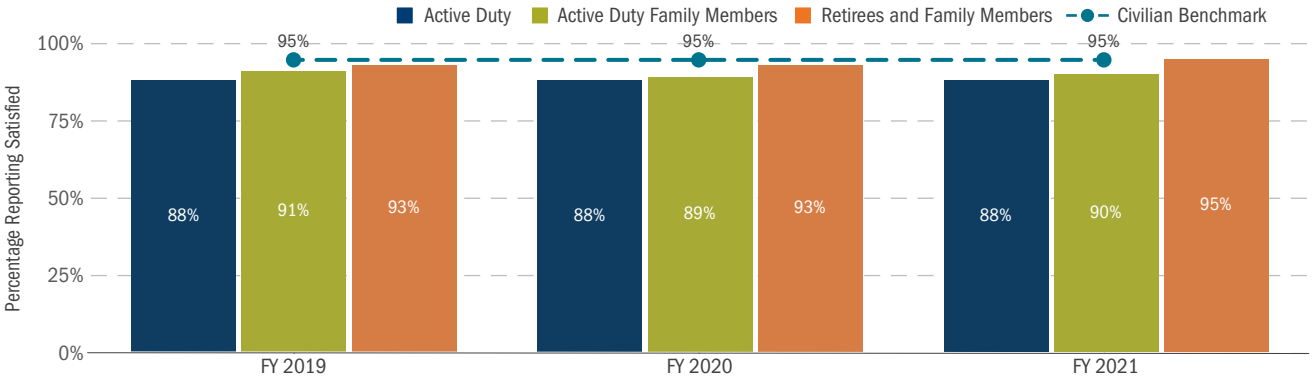
Communication between doctors and patients is an important factor in beneficiaries' satisfaction and their ability to obtain appropriate care. The following charts present beneficiary-reported perceptions of how well their doctor communicates with them.

- Beneficiary satisfaction with their doctors' communication remained relatively stable between FY 2019 and FY 2021, regardless of their enrollment status.
- Satisfaction with doctors' communication was below the benchmark for Prime enrollees with a military or civilian PCM for all three years.
- Satisfaction with doctors' communication remained relatively stable between FY 2019 and FY 2021 for Active Duty and ADFMs, while slightly increasing for retirees and family members
- Satisfaction with doctors' communication was lower than the civilian benchmark for Active Duty and ADFMs in FY 2021.

TRENDS IN SATISFACTION WITH DOCTORS' COMMUNICATION BY ENROLLMENT STATUS, FYs 2019–2021



TRENDS IN SATISFACTION WITH DOCTORS' COMMUNICATION BY BENEFICIARY CATEGORY, FYs 2019–2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 12/16/2021

Note: 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 2019 and 2020 come from NCQA's 2017 data and in 2021 from NCQA's 2019 data.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

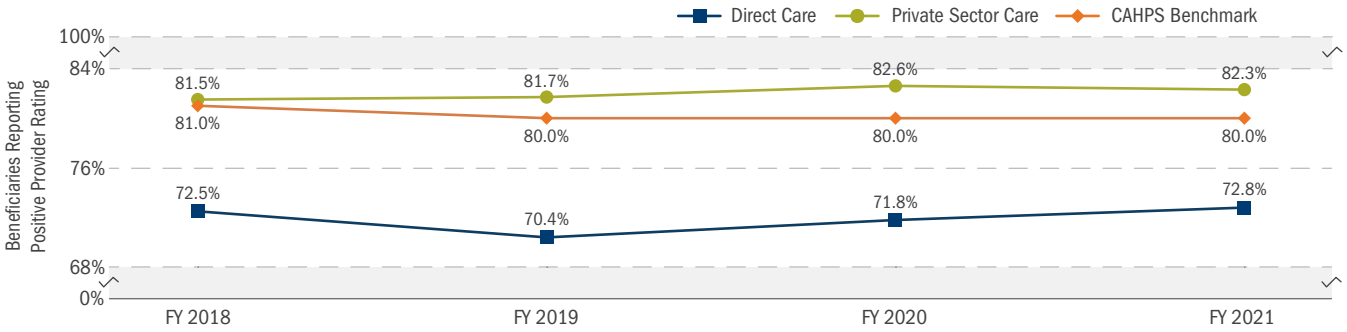
Patient-Centered Care/Experience *(cont.)*

Beneficiary Ratings of Provider Following Outpatient Treatment

In the JOES-C, beneficiaries are 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.

- The rating of provider from FY 2018 to FY 2021 remained relatively constant for JOES-C direct care despite a decrease in FY 2019. From FY 2018 to FY 2021, scores remained below the civilian CAHPS benchmark for direct care.
- Rating of provider scores for JOES-C private sector care have remained about the same from FY 2018 to FY 2021 at 82 percent. This is above the civilian CAHPS benchmark.

JOES-C RATING OF PROVIDER, FYs 2018–2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES-C weighted data, compiled 12/2/2021

Notes:

– CAHPS benchmarks are the 50th percentiles from the 2018 CAHPS-CG national civilian scores.

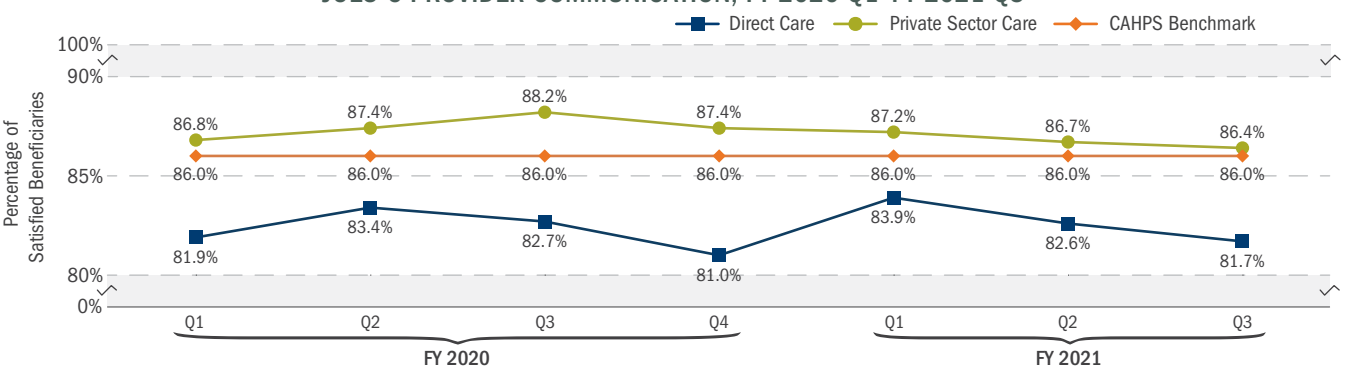
– Results for JOES-C FY 2021 is from October 2020 to July 2021 for direct care and from October 2020 to June 2021 for private sector care.

Provider Communication

As detailed in Drivers of Patient Experience Ratings on pages 162–163, 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 core surveys (JOES, JOES-C, TRISS, and HCSDB). The patient experience 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: was the provider understandable, did the provider listen, was the provider respectful, and did the provider spend 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.

- For FY 2020 and FY 2021, private sector care scores for provider communication have exceeded the benchmark, while direct care scores have fallen below.
- Provider communication scores for direct care range from 81 to 84 percent satisfaction in FY 2020 and FY 2021. Private sector care scores range from 86 to 88 percent for the same period.

JOES-C PROVIDER COMMUNICATION, FY 2020 Q1–FY 2021 Q3



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES-C, weighted data, compiled 12/2/2021

Note: CAHPS benchmarks are the 50th percentiles from the 2018 CAHPS-CG national civilian scores.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient-Centered Care/Experience *(cont.)*

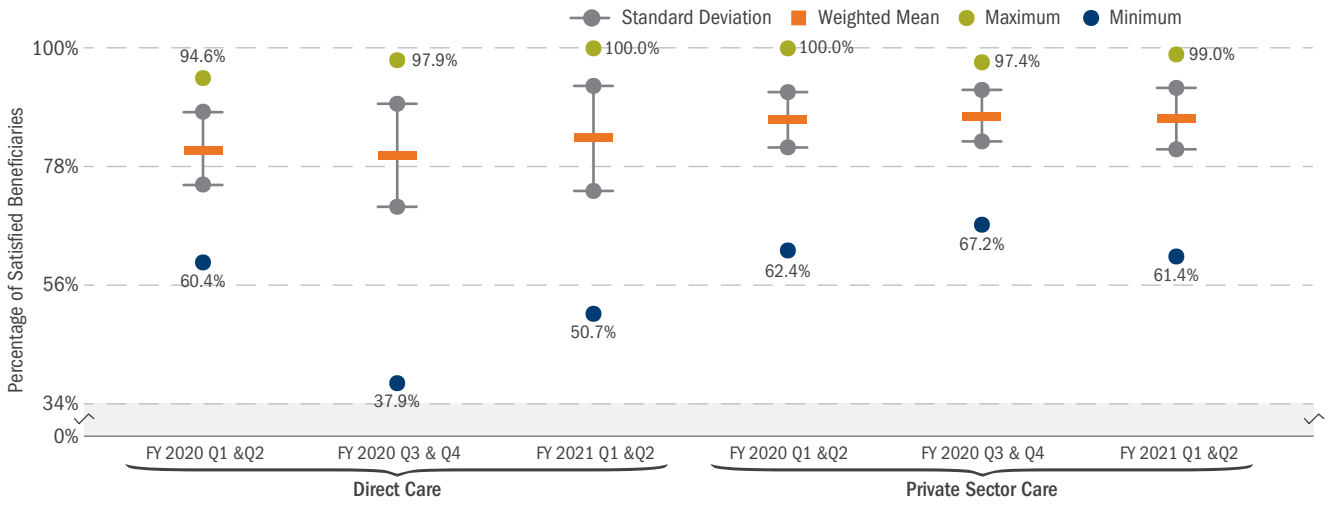
Provider Communication

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 standard deviation).

- From FY 2020 Q1 & Q2 to FY 2021 Q1 & Q2, the median score and weighted mean for the provider communication composite direct care increased by 4 percentage points and 2 percentage points, respectively.
- For private sector care from FY 2021 Q1 & Q2 to FY 2021 Q1 & Q2, the median score and weighted mean for the provider communication composite increased slightly at less than 1 percentage point each.

JOES-C: PROVIDER COMMUNICATION COMPOSITE, FY 2020 Q1 & Q2 TO FY 2021 Q1 & Q2

	FY 2020 Q1 & Q2	FY 2020 Q3 & Q4	FY 2021 Q1 & Q2	% POINT CHANGE FY 2020 Q1 & Q2 TO FY 2021 Q1 & Q2
JOES-C DIRECT CARE				
Number of Respondents	9,617	6,773	5,923	
Service Score (Mean)	81.3%	80.1%	83.4%	2.1
Standard Deviation	6.8%	9.7%	9.7%	0.029
Median	81.8%	81.8%	85.8%	4.0
75th Percentile	85.7%	86.4%	89.4%	3.7
25th Percentile	76.5%	75.7%	78.3%	1.8
Maximum	94.6%	97.9%	100.0%	5.4
Minimum	60.4%	37.9%	50.7%	-9.7
Range	34.2%	60.0%	49.3%	15.1
JOES-C PRIVATE SECTOR CARE				
Number of Respondents	38,347	26,708	27,208	
Service Score (Mean)	86.8%	87.4%	87.0%	0.2
Standard Deviation	5.2%	4.8%	5.6%	0.004
Median	87.2%	88.1%	87.4%	0.2
75th Percentile	89.8%	90.4%	90.0%	0.2
25th Percentile	84.9%	85.1%	84.8%	-0.1
Maximum	100.0%	97.4%	99.0%	-1.0
Minimum	62.4%	67.2%	61.4%	-1.0
Range	37.6%	30.2%	37.6%	0.016



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES-C, weighted data, compiled 12/2/21

Patient-Centered Care/Experience *(cont.)*

Beneficiary Ratings of Care Following Inpatient Treatment

TRISS: The purpose of the TRISS is to monitor and report on the perceptions and experiences of MHS beneficiaries who have been admitted to military 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/ private sector 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
- Hospital environment (cleanliness and quietness)
- Post-discharge (such as written directions for post-discharge care)

In addition to the above TRISS measures from the HCAHPS survey instrument, TRISS also includes DoD supplemental measures such as education on breastfeeding and repeat obstetrics care, nurse hourly rounding, and nurse leader visit.

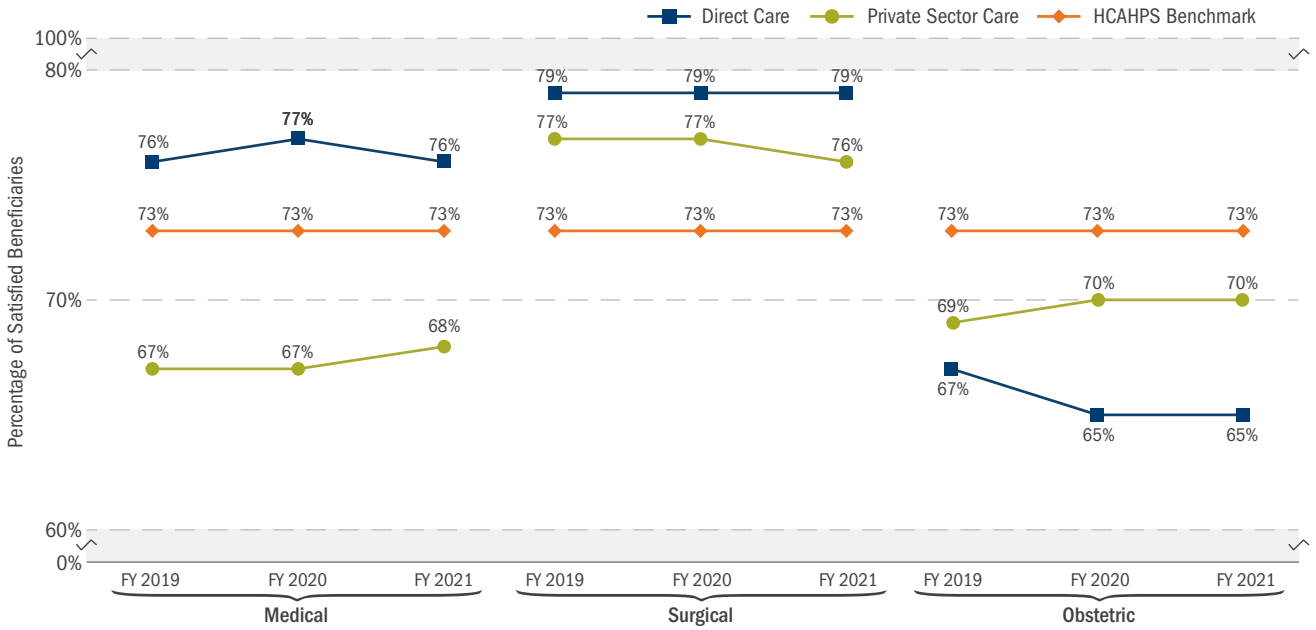
In the following sections, we detail specific findings focused primarily on two measures of patient experience: overall rating of the hospital and willingness to recommend the hospital to others. Inpatient facilities with fewer than 25 responses are not included in the analyses. These results are produced by the DHA J-5 Analytics and Evaluation Division and do not represent official HCAHPS results. Official HCAHPS results are published on the CMS Care Compare website (https://www.medicare.gov/care-compare).

Patient-Centered Care/Experience *(cont.)*

Overall Hospital Rating

Overall hospital rating is measured by the TRISS question "Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?" Scores are shown for those who indicated 9 or 10. Overall, the medical and surgical product lines of direct care have exceeded the national HCAHPS benchmark in overall hospital rating from FY 2019 to FY 2021, while the obstetric product line of direct care is below the national HCAHPS benchmark during the same time period. The surgical product lines of private sector care has exceeded the national HCAHPS benchmark in overall hospital rating from FY 2019 to FY 2021. However, the medical and obstetric product lines of private sector care are below the national HCAHPS benchmark in overall hospital rating from FY 2019 to FY 2021.

TRISS OVERALL HOSPITAL RATING BY PRODUCT LINE, FYs 2019–2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/1/2021

Notes:

– FY 2021 includes results from FY 2021 Q1–Q3 for direct care and FY 2021 Q1–Q2 for private sector care.

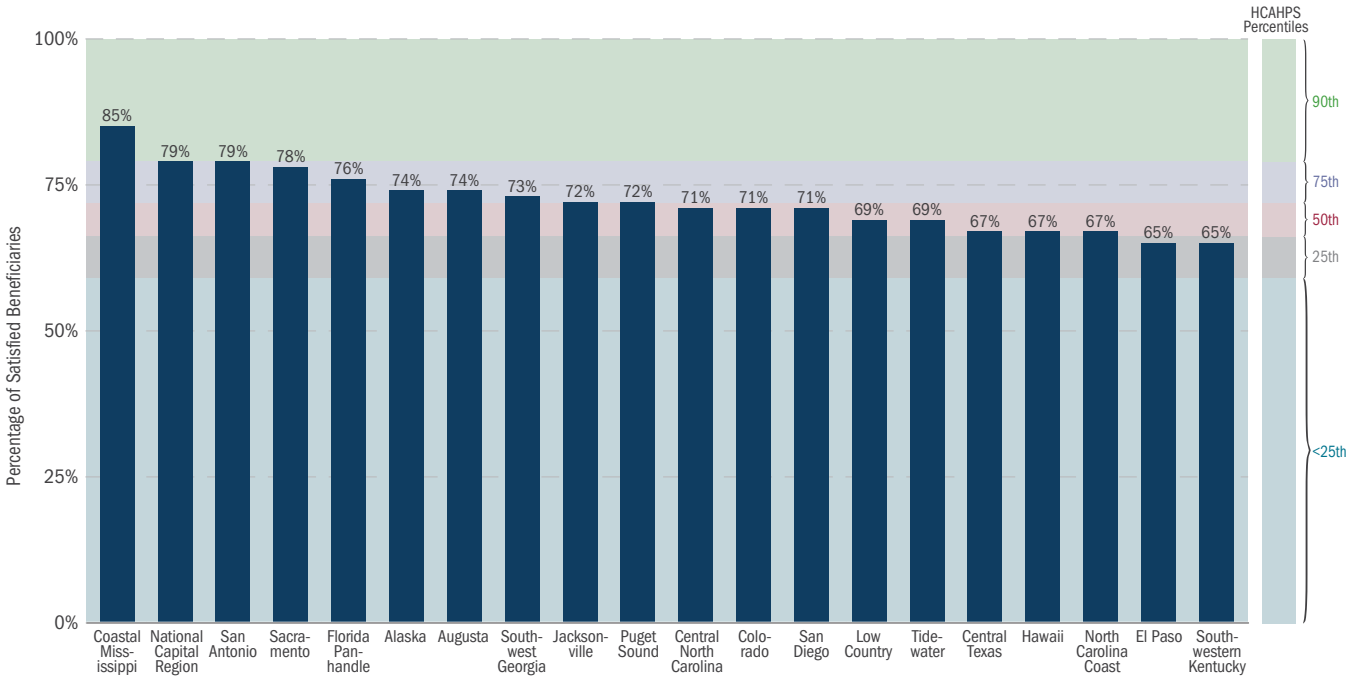
– HCAHPS benchmarks are the U.S. scores from the July 2020, October 2020, and October 2021 HCAHPS Public Reports.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient-Centered Care/Experience *(cont.)*

The chart below shows the distribution for overall hospital ratings by Market for FY 2021. The Coastal Mississippi Market has the highest overall rating of the hospital at 85 percent satisfaction, while the Southwestern Kentucky Market is lowest at 65 percent overall hospital rating.

TRISS OVERALL HOSPITAL RATING BY MARKET: DIRECT CARE, FY 2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/1/2021

Notes:

– FY 2021 includes results from FY 2021 Q1–Q3.

– The increment of the above percentiles was set at <25th, 25th, 50th, 75th, and 90th. HCAHPS percentiles are based on the October 2021 Public Report. 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).

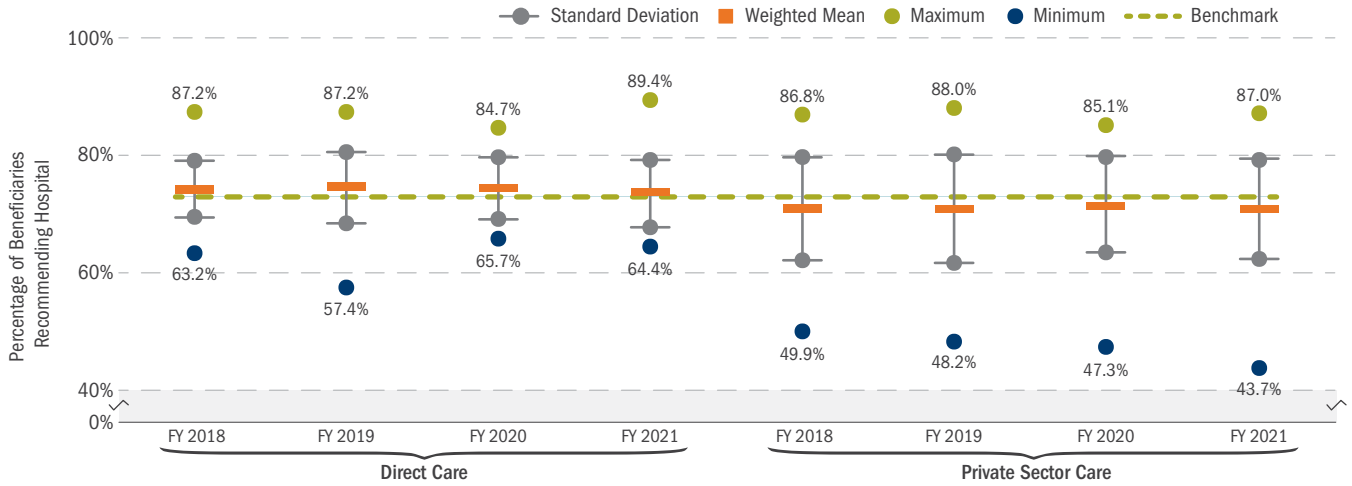
- From FY 2018 to FY 2021, direct care decreased by 0.9 percentage point with regard to the mean; median ratings decreased by 2.1 percentage points between FY 2018 and FY 2021.
- From FY 2018 to FY 2021, private sector care scores have improved in terms of the mean (0.1 percentage point increase) and median (1.0 percentage point increase) ratings.

TRISS OVERALL HOSPITAL RATING: FYs 2018–2021

	FY 2018	FY 2019	FY 2020	FY 2021	% POINT CHANGE (FY 2018–FY 2021)
DIRECT CARE					
Number of Respondents	39,209	36,860	32,309	33,184	
Weighted Mean	74.4%	74.4%	74.3%	73.5%	-0.9
Standard Deviation	4.9%	6.0%	5.3%	5.8%	
Median	74.3%	73.9%	74.9%	72.2%	-2.1
75th Percentile (Q3)	76.9%	77.3%	77.8%	76.0%	-0.9
25th Percentile (Q1)	70.0%	72.4%	70.5%	69.7%	-0.3
Maximum	87.2%	87.2%	84.7%	89.4%	2.2
Minimum	63.2%	57.4%	65.7%	64.4%	1.2
Range	24.0%	29.8%	19.1%	25.0%	1.0
PRIVATE SECTOR CARE					
Number of Respondents	20,966	20,644	21,003	22,619	
Weighted Mean	70.8%	70.9%	71.6%	70.9%	0.1
Standard Deviation	8.7%	9.2%	8.2%	8.5%	
Median	71.7%	71.5%	72.9%	72.7%	1.0
75th Percentile (Q3)	76.8%	77.5%	77.7%	77.1%	0.3
25th Percentile (Q1)	65.2%	65.2%	66.6%	65.5%	0.3
Maximum	86.8%	88.0%	85.1%	87.0%	0.2
Minimum	49.9%	48.2%	47.3%	43.7%	-6.2
Range	36.9%	39.8%	37.8%	43.3%	6.4

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/1/2021
Note: FY 2021 includes results from FY 2020 Q1–Q3 for direct care and FY 2021 Q1–Q2 for private sector care.

VARIABILITY IN TRISS OVERALL HOSPITAL RATINGS, FYs 2018–2021

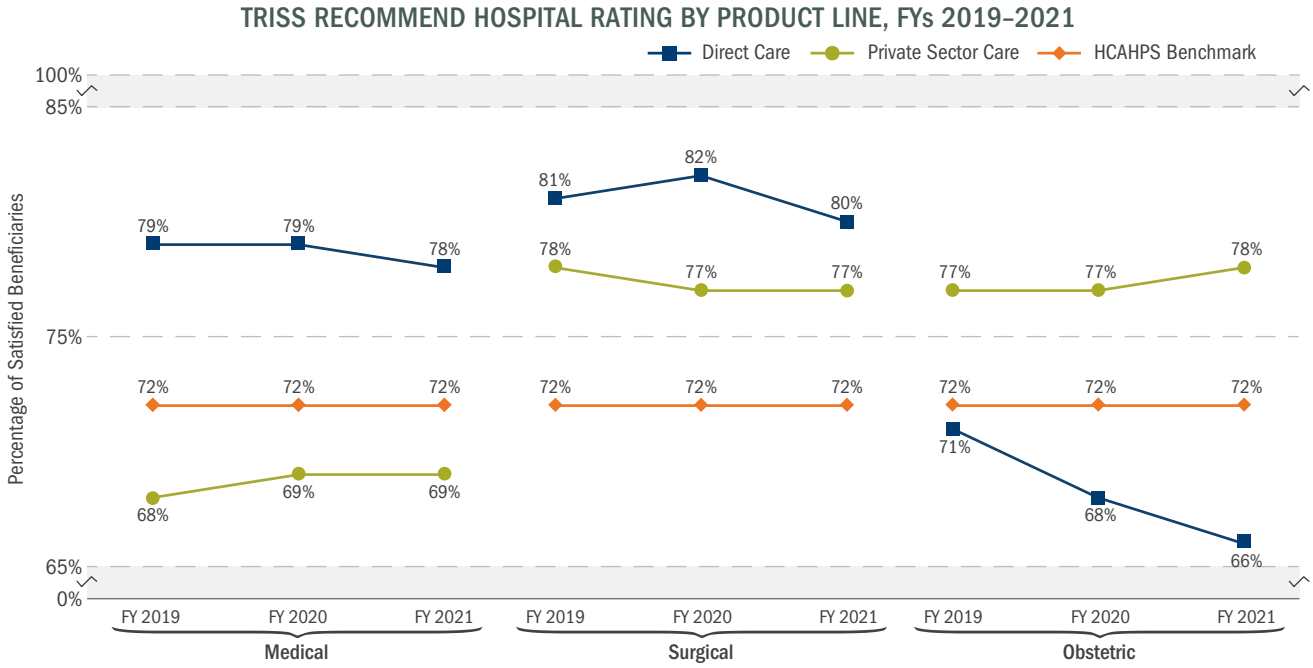


Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/1/2021
Notes:
– FY 2021 includes Q1–Q3 for direct care and Q1–Q2 for private sector care results.
– HCAHPS benchmarks are U.S. scores from the October 2018, October 2019, October 2020, and October 2021 HCAHPS Public Reports, respectively.

Patient-Centered Care/Experience *(cont.)*

Beneficiary Recommendation of Hospital Following Inpatient Treatment

Hospital recommendation is measured by the TRISS question "Would you recommend this hospital to your friends and family?" with response options of definitely no, probably no, probably yes, definitely yes. Scores are shown for those who indicated definitely yes. The medical and surgical product lines of direct care have exceeded the national HCAHPS benchmark in recommending the hospital from FY 2019 to FY 2021. The obstetric product line of direct care is below the national HCAHPS benchmark during this time period and has fallen from 71 percent in FY 2019 to 66 percent in FY 2021. The surgical and obstetric product lines of private sector care have exceeded the national HCAHPS benchmark in recommending the hospital from FY 2019 to FY 2021; however, the medical product line of private sector care is below the national HCAHPS benchmark.



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/1/2021

Notes:

– FY 2021 includes results from FY 2021 Q1–Q3 for direct care and Q1–Q2 for private sector care.

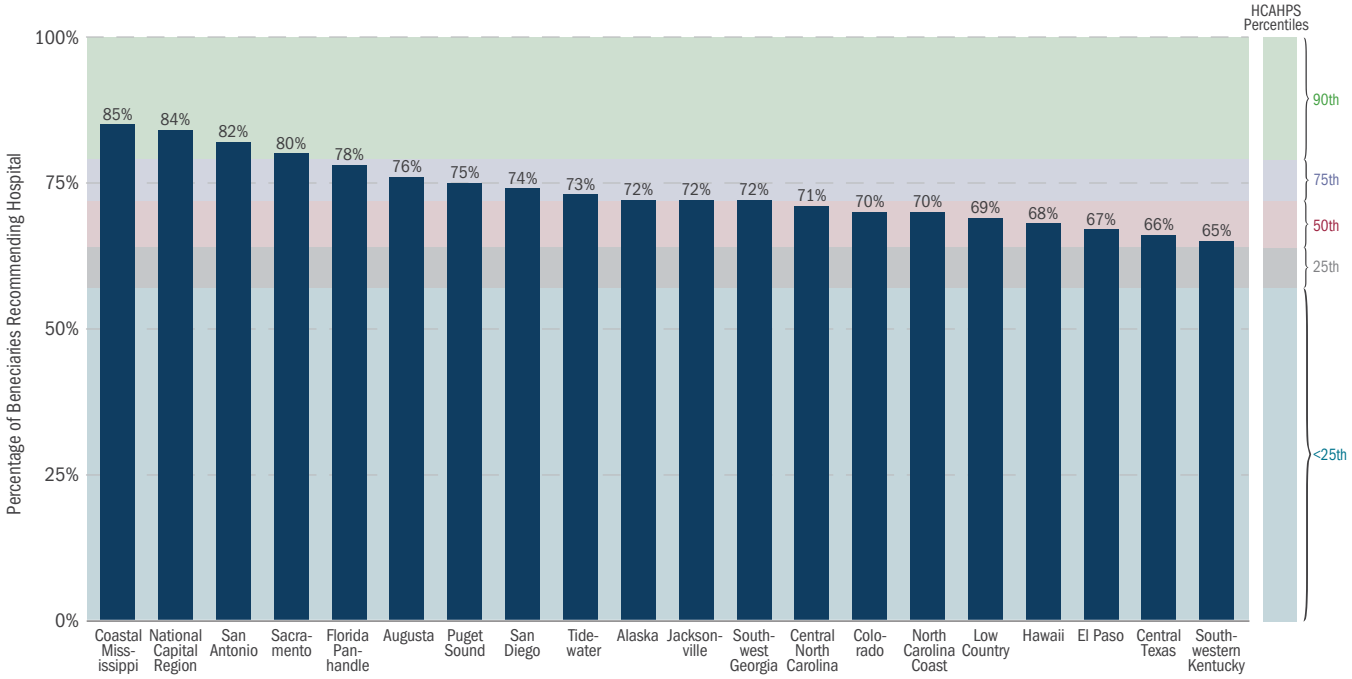
– HCAHPS benchmarks are the U.S. scores from the July 2019, July 2020, and October 2021 HCAHPS Public Reports.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient-Centered Care/Experience *(cont.)*

The chart below shows the distribution for recommend hospital scores of the DHA Markets for FY 2021. The Coastal Mississippi Market has the highest rating at 85 percent satisfaction, followed by the NCR Market at 84 percent. The Southwestern Kentucky Market is the lowest scoring Market for recommend the hospital at 65 percent.

TRISS RECOMMEND HOSPITAL BY MARKET, FY 2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/1/2021

Notes:

– FY 2021 includes results from FY 2021 Q1–Q3.

– The increment of the above percentiles was set at <25th, 25th, 50th, 75th, and 90th. HCHAPS percentiles are based on the October 2021 Public Report. 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).

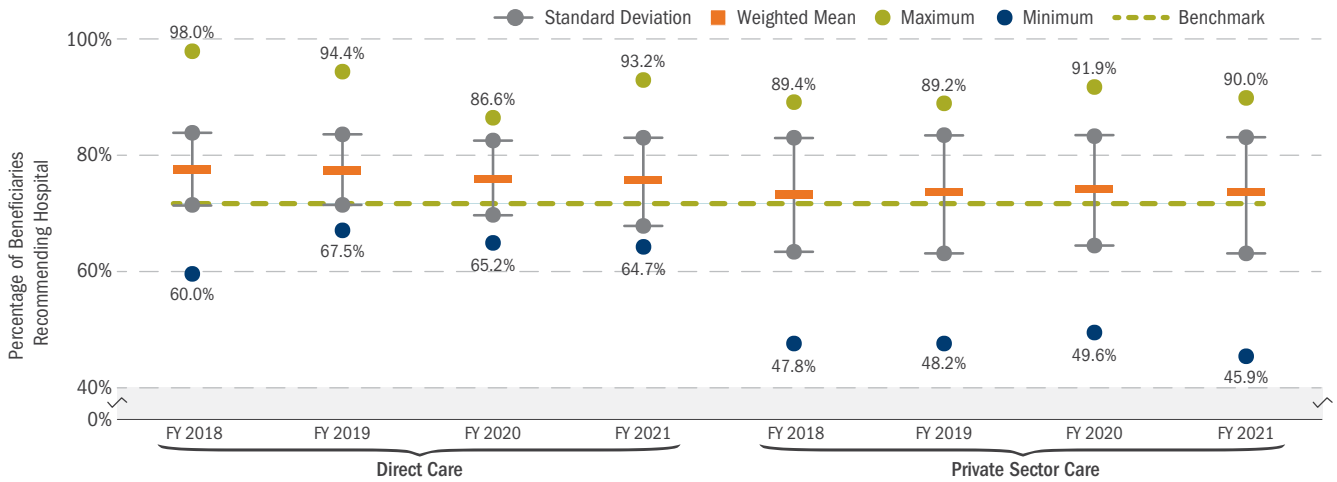
- From FY 2018 to FY 2021, direct care decreased by 2.1 percentage points with regard to the mean; median ratings decreased by 2.2 percentage point between FY 2018 and FY 2021.
- From FY 2018 to FY 2021, private sector care scores have improved in terms of the mean (0.1 percentage point increase) and median (1.0 percentage point increase) ratings.

TRISS RECOMMEND HOSPITAL RATING: FYs 2018–2021

	FY 2018	FY 2019	FY 2020	FY 2021	% POINT CHANGE (FY 2018–FY 2021)
DIRECT CARE					
Number of Respondents	39,209	36,860	32,192	33,063	
Weighted Mean	77.8%	77.5%	76.3%	75.7%	-2.1
Standard Deviation	6.3%	6.0%	6.3%	7.5%	
Median	76.2%	76.2%	76.3%	74.0%	-2.2
75th Percentile	81.3%	80.6%	79.1%	80.3%	-1.0
25th Percentile	73.0%	73.4%	71.2%	70.4%	-2.6
Maximum	98.0%	94.4%	86.6%	93.2%	-4.8
Minimum	60.0%	67.5%	65.2%	64.7%	4.7
Range	37.9%	26.8%	21.4%	28.5%	-9.4
PRIVATE SECTOR CARE					
Number of Respondents	20,966	20,644	20,939	22,582	
Weighted Mean	73.4%	73.5%	74.2%	73.5%	0.1
Standard Deviation	9.6%	10.0%	9.4%	9.9%	
Median	73.9%	73.7%	74.8%	74.9%	1.0
75th Percentile (Q3)	79.8%	81.2%	82.2%	81.4%	1.6
25th Percentile (Q1)	67.9%	68.3%	68.6%	68.0%	0.1
Maximum	89.4%	89.2%	91.9%	90.0%	0.6
Minimum	47.8%	48.2%	49.6%	45.9%	-1.9
Range	41.6%	41.1%	42.4%	44.1%	2.5

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/1/2021.
Note: FY 2021 includes results from FY 2021 Q1–Q3 for direct care and Q1–Q2 for private sector care.

VARIABILITY IN TRISS RECOMMEND HOSPITAL RATINGS, FYs 2018–2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/1/2021
Notes:
– FY 2021 includes results from FY 2021 Q1–Q3 for direct care and Q1–Q2 for private sector care.
– HCAHPS benchmarks are U.S. scores from the October 2018, October 2019, July 2020, and October 2021 HCAHPS Public Reports, respectively.

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 162, including Overall Hospital Rating and Recommend Hospital as components. Official star ratings including for military hospitals in the United States, are posted publicly on the CMS Care Compare website. The MHS calculates star ratings similar 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 2020 Q4 to FY 2021 Q3. Three stars can be considered an "average" patient experience; therefore, most of the MHS facilities are performing above average in terms of patient care, with 25 four-star-rated facilities and two facilities rated as five-star.

PATIENT EXPERIENCE STAR RATINGS, FY 2020 Q4–FY 2021 Q3

★★★★★	★★★★	★★★
2 FACILITIES	25 FACILITIES	8 FACILITIES

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 2/9/2022
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 private sector 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 CAHPS-CG)
- 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 FYs 2020 and 2021 (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 2020–2021

	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 2020	#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
FY 2021	#1	Care Transition	How Well Providers Communicate with Patients	Provider Communication
	#2	Communication with Nurses	Helpful, Courteous, and Respectful Office Staff	Getting Needed Care
	#3	Communication with Doctors	Providers' Use of Information to Coordinate Care	Claim Handling

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS results, JOES-C results, and HCSDB, FYs 2020–2021 (Q1–Q3 only for TRISS and JOES-C), compiled 12/1/2021

Notes:

– Composite measure generation followed guidelines established by AHRQ.
– TRISS followed HCAHPS composite construction found at: https://www.hcahpsonline.org/
– JOES-C followed CAHPS-CG version 3.0 guidelines detailed at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/cg/about/cg_3-0_overview.pdf
– HCSDB followed CAHPS guidelines provided at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/hp/about/measures_hp50_2109.pdf

Patient-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 FYs 2020 and 2021 (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 2020–2021

	RANKING	SATISFACTION WITH HEALTH CARE	SATISFACTION WITH PROVIDER
FY 2020	#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 an Appointment	Provider Treated Patient with Courtesy and Respect
FY 2021	#1	Provider Knew Important Medical History	Provider Knew Important Medical History
	#2	Provider Explained Things in a Way That Was Easy to Understand	Provider Explained Things in a Way That Was Easy to Understand
	#3	Ease of Making an Appointment	Provider Treated Patient with Courtesy and Respect

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES results, FYs 2020–2021, compiled 12/1/2021
Note: JOES questions continue to be updated over time; drivers analysis was based on the most recent survey questions.

Patient-Centered Care/Experience *(cont.)*

Best Practices to Foster Positive Patient Experience

In addition to the patient experience quantitative survey analyses in the preceding pages (pages 92–100; 146–153), the DHA also frequently conducts special qualitative analyses and interviews with MTF staff and leadership to identify potential leading practices that foster positive patient experience across the MHS. The following section highlights findings of best practices from interviews with various MTFs/clinics that scored high on patient experience measures from the JOES "Best of the Best" quarterly reports.

- In FY 2021 Q1, one of the highest scoring outpatient clinics in the MHS was Naval Health Clinic Annapolis – Branch Health Clinic (BHC) Earle Primary Care Clinic. Best practices from BHC Earle for overall patient satisfaction include:
  - Following the Patient-Centered Medical Home (PCMH) model developed by the AHRQ, which focuses on comprehensive patient-centered and coordinated care, as well as accessibility, quality, and safety; specifically at BHC Earle, this includes eliminating the "one issue, one visit" practice
  - Practicing positive patient engagement and all staff being responsible for promoting a positive experience for the patient
- In FY 2021 Q1, Walter Reed National Military Medical Center Family Medicine Clinic at the USUHS was also one of the highest scoring outpatient clinics in the MHS. Best practices from the Family Medicine Clinic at USUHS for overall patient satisfaction include:
  - Providing patient-centered care by providing a spectrum of high-quality services and ensuring flexibility to the students of USUHS on campus
  - Empowering all clinic staff to intervene and assist patients whenever possible, including ensuring follow-up calls occur; all staff act as patient advocates/representatives
- In FY 2021 Q2, one of the highest scoring outpatient clinics in the MHS was AF-C-49th Medical Group Holloman Internal Medicine Clinic. Best practices from the 49th Medical Group Internal Medicine Clinic for overall patient satisfaction include:
  - Creating a positive culture within the clinic by setting the tone as soon as the patient arrives (being ready for the patient at check-in and respecting patients' time) and staff and patients having a personal relationship
  - Being accessible to patients, including virtual appointment options and longer appointment lengths
- In FY 2021 Q2, Fort Belvoir Community Hospital was one of the highest scoring MTFs for outpatient care in the MHS. Best practices from Fort Belvoir Community Hospital for overall patient satisfaction include:
  - Dedicated providers who go above and beyond for patients, including those in the Oncology Clinic who provide tutorials on using the patient portal and being accessible to patients through many channels
  - Utilizing VH to provide continuity of care, especially in the Endocrinology Clinic, which is also working on expanding its VH options to provide specialized care for MHS beneficiaries who do not have endocrinology services in their area

Patient-Centered Care/Experience *(cont.)*

- In FY 2021 Q3, one of the highest scoring outpatient specialty care clinics in the MHS was Naval Hospital (NH) Camp Pendleton Internal Medicine Clinic. Best practices from NH Camp Pendleton Internal Medicine Clinic for overall patient satisfaction include:
  - Understanding and being aware of the patient's perspective by putting the patient first, respecting the patient's time, and being mindful of the patient's needs
  - Adopting new practices during the pandemic, including expansion of VH services and creating an outdoor COVID-19 screening tent; Internal Medicine Clinic also closely tracked patient access to routine care during the pandemic and currently does not have a backlog
- In FY 2021, Q3 AF-C-6th Medical Group MacDill, Sabal Park Pediatric Clinic was one of the highest scoring outpatient clinics in the MHS. Best practices from Sabal Park Pediatric Clinic for overall patient satisfaction include:
  - Modifying practices to ensure the patient is put first, especially during the pandemic, by offering COVID testing to anyone at any time, limiting personnel in the clinic to reduce exposure, and utilizing VH appointments as much as possible
  - Setting the standard for patients by "doing the right thing" and ensuring every clinic across the MTF provides the same quality of care, as well as having a passionate team working together toward the same goals and expectations
- In FY 2021 Q4, one of the highest scoring outpatient clinics in the MHS was AF-C-436th Medical Group Dover Pediatric Clinic. Best practices from Dover Pediatric Clinic for overall patient satisfaction include:
  - Adopting new care practices during the pandemic to retain patients, including "curbside medicine," where providers and nurses provide medical services to pediatric patients in the car to minimize exposure to COVID, allowing patients to be seen who may have tested positive to reduce number of patients seeking care within the network
  - Providing a standardized patient checkout process by using the Checkout Guide, which is used across the MTF and includes information on follow-up care and resources; the Pediatric Clinic also ensures future well-child appointments are scheduled before patients leave the clinic

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

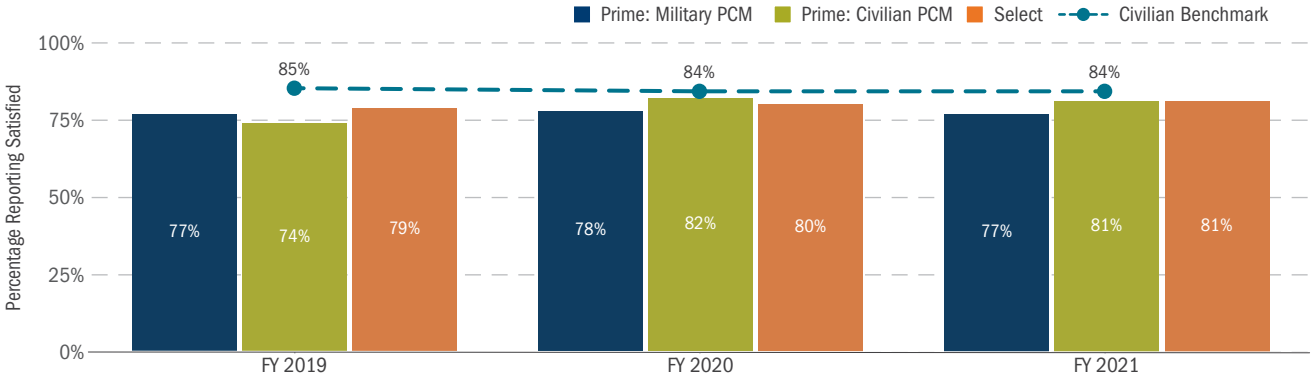
Patient-Centered Care/Experience *(cont.)*

Satisfaction with Customer Service

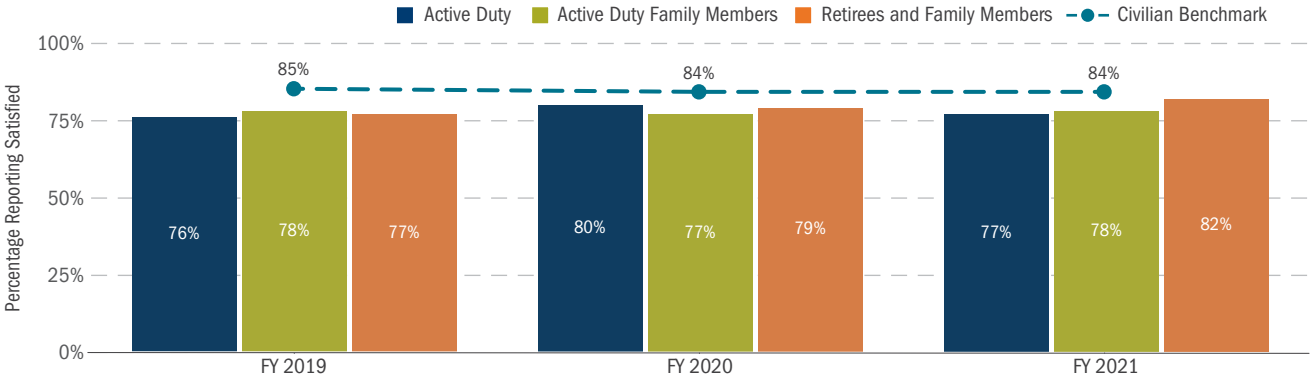
Most DoD health care beneficiaries participate in TRICARE in one of two ways: by enrolling in the Prime option or enrolling in the Select option. Access to and understanding written materials about one's health plan are important determinants of overall satisfaction with the plan.

- MHS beneficiary satisfaction with customer service in terms of understanding written material, getting customer assistance, and dealing with paperwork improved for Prime enrollees with a civilian PCM by 7 percentage points from FY 2019 to FY 2021 and remained about the same for Prime enrollees with a military PCM.
- Satisfaction with customer service for all enrollment groups was lower than the civilian benchmark in FY 2021.
- MHS beneficiary satisfaction with customer service increased by 5 percentage points for retirees and their family members from FY 2019 to FY 2021, and remained relatively stable for Active Duty (AD) and ADFMs over the same time period.

TRENDS IN RESPONSIVE CUSTOMER SERVICE: COMPOSITE MEASURE (UNDERSTANDING WRITTEN MATERIAL, GETTING CUSTOMER ASSISTANCE, AND DEALING WITH PAPERWORK) BY ENROLLMENT STATUS, FYs 2019–2021



TRENDS IN RESPONSIVE CUSTOMER SERVICE: COMPOSITE MEASURE (UNDERSTANDING WRITTEN MATERIAL, GETTING CUSTOMER ASSISTANCE, AND DEALING WITH PAPERWORK) BY BENEFICIARY CATEGORY, FYs 2019–2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 12/16/2021

Note: 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 2019 and 2020 come from NCQA's 2017 data and in 2021 from NCQA's 2019 data.

OTHER PLANS AND PROGRAMS

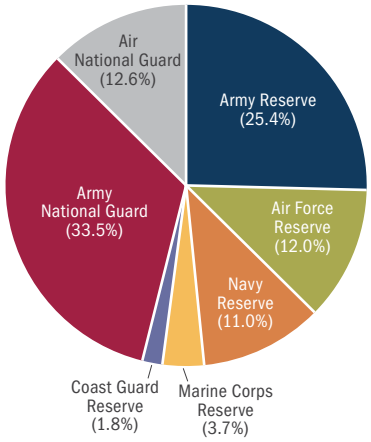
TRICARE Benefits for the Reserve Component

TRICARE offers a broad array of health care coverage and benefits for Reserve Component (RC) members who qualify, and their eligible family members, during active Guard or Reserve status, pre-deployment, deployment, post-deployment, and into retirement.

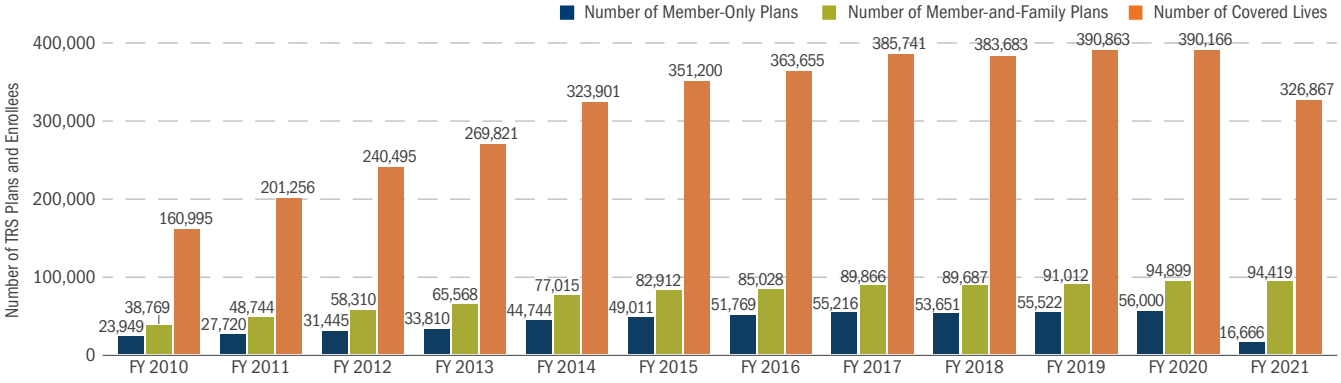
TRICARE Reserve Select (TRS). The subsidized premium-based TRS health plan provides TRICARE Select coverage for purchase by qualified members of the Selected Reserve (SelRes). While TRS enrollment has marginally increased over the past few years, individual plans and covered lives saw a significant decrease in the past year. The chart below shows TRS enrollment since October 1, 2010.

- As shown in the pie chart at right, Army Reserve and Army National Guard combined constitute nearly 60 percent of the 335,241 TRS members.
- The NDAA FY 2020, Section 701, removed the exclusion to those SelRes members eligible for, or enrolled in Federal Employees Health Benefits Program (FEHB), from purchasing TRS coverage, to be effective January 1, 2030.

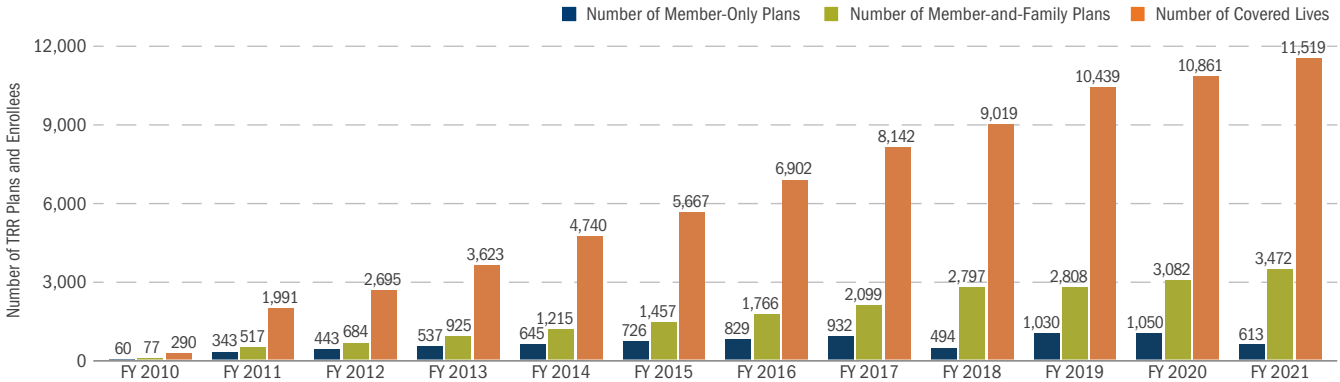
TRS: POPULATION BY COMPONENT (335,241 SPONSORS AND FAMILY MEMBERS AS OF AUGUST 2021)



TRENDS IN RC ENROLLMENT IN TRS, SEPTEMBER 2010–SEPTEMBER 2021



TRENDS IN ENROLLMENT IN TRICARE RETIRED RESERVE (TRR), OCTOBER 2010–SEPTEMBER 2021



Source: Defense Manpower Data Center/Defense Enrollment Eligibility Reporting System (DEERS) Medical Policy Report, September 2021
Note: For FY 2021, individual plans are an estimate based on prior year, due to changes in how the data are recorded in the M2 database.

TRICARE Benefits for the Reserve Component *(cont.)*

TRICARE Retired Reserve (TRR). Qualified members of the Retired Reserve may purchase full-cost premium-based healthcare 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 premium-free TRICARE health plan options available for retirees.

TRR enrollment continued to grow in a linear fashion, increased by family plans and covered lives, but with a significant reduction in individual plans.

TRS and TRR Costs. Both TRS and TRR adopted the new TRICARE Select cost-sharing structure (Group B) on January 1, 2018.

TRR enrollees pay the full cost of the premium, unlike TRS, where the enrolled's share of the premium is 28 percent, with the Department subsidizing the rest. Premiums are calculated annually for both TRS and TRR and are derived from actual prior year costs. Premium rates for CYs 2021–2022 are as follows:

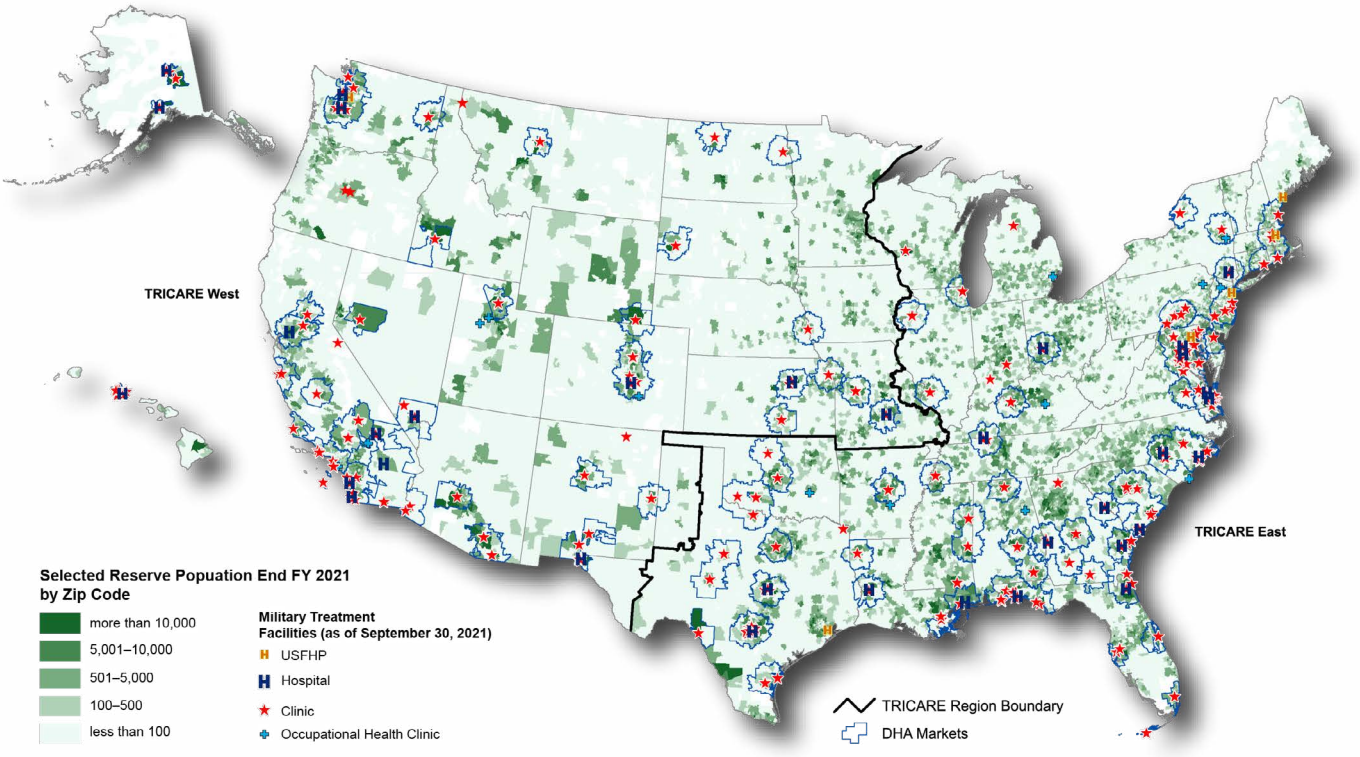
MONTHLY PREMIUMS FOR TRS AND TRR, CYs 2021–2022

TYPE OF COVERAGE	CY 2021 MONTHLY	CY 2022 MONTHLY	% CHANGE
TRS Member Only	$47.20	$46.70	–1.0%
TRS Member and Family	$238.99	$229.99	–3.7%
TRR Member Only	$484.83	$502.32	+3.6%
TRR Member and Family	$1,165.01	$1,206.59	+3.6%

Source: TRS and TRR data from https://tricare.mil/Costs/Compare, accessed 10/14/2021

TRICARE Benefits for the Reserve Component *(cont.)*

SELECTED RESERVE POPULATION IN THE U.S. RELATIVE TO MTF, PRIME, AND NON-PRIME SERVICE AREAS (PSAs), END OF FY 2021



COMPARISON OF SELECTED RESERVE AND ACTIVE DUTY SPONSORS AND FAMILY MEMBER PROXIMITY TO MTFs, END OF FY 2021[a]

BENEFICIARY GROUP[b]	POPULATION TOTAL	POPULATION IN PSAs	% IN PSAs	POPULATION IN MTF SERVICE AREAS	% IN MTF SERVICE AREAS
Active Duty and Their Families	2,752,113	2,628,828	96%	2,565,988	93%
Selected Reserve and Their Families	1,919,028	1,293,530	67%	1,058,583	55%
Select Reserve and Their Families, Overseas or Unknown	88,944				
Total Select Reserve and Their Families, Worldwide	2,007,972				

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, population as of 1/25/2022

Notes:

[a] Eligible MHS beneficiary data from the MDR DEERS, as of 1/25/2022. Residential ZIP code was used as the location for all beneficiaries.

[b] Location information determined by DHA Catchment Area Directory database, September 2021.

Definitions:

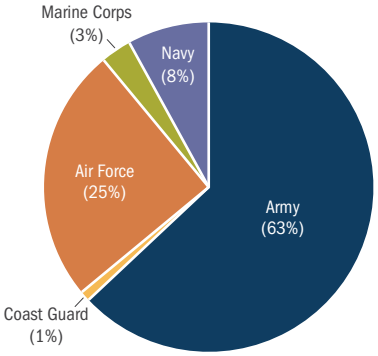
– PSAs are based on ZIP codes in which MCSCs must offer the TRICARE Prime benefit.

– 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.

TRICARE Benefits for the Reserve Component *(cont.)*

- As of September 2021, there were more than 2 million Selected Reserve and their family members (2,007,972).
- Approximately 67 percent of Selected Reserve and their family members (about 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 169). Slightly more than half (approximately 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 (23 percent).

SELECTED RESERVE POPULATION (2,007,972): SPONSORS AND FAMILY MEMBERS BY SERVICE (SEPTEMBER 2021)



Source: DEERS Database Extract

OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Young Adult

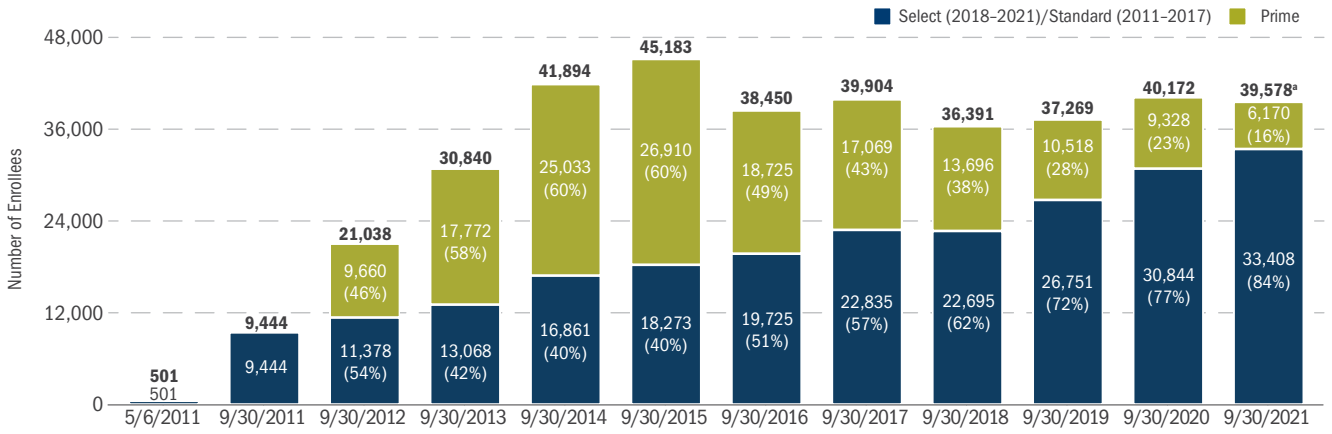
The TRICARE Young Adult (TYA) program is a premium-based TRICARE plan available for purchase by qualified adult-age children who lose eligibility for TRICARE due to age. TYA offers Prime and/or Select coverage based on sponsor status and beneficiary location. Monthly premiums cover the full cost of the 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 fell from over 40,000 in FY 2020 to over 39,500 in FY 2021. Enrollment in the TRICARE Select option accounted for 84 percent of total TYA enrollment, an increase from 77 percent in the previous year.
- TYA Prime premiums increased by 50 percent from $306 in CY 2016 to $459 in CY 2021, whereas TYA Select premiums increased by only 13 percent (from $228 to $257) over the same period (see table below). The increasing disparity in premiums between TYA Prime and Select likely explains the shift in enrollment from the former plan to the latter.
- TYA monthly premiums increased for CY 2022 from $459 to $512 per month for Prime and from $257 to $265 per month for Select (table below; tricare.mil/Costs/HealthPlanCosts/TYA). The continuing increase in premiums suggests that the shift in enrollment is likely to continue.
- Most TYA enrolled are family members of those who are not Active Duty (90 percent for TYA Prime and 91 percent for TYA Select). A detailed tabulation of enrollment by plan and beneficiary category is on page 35.

MONTHLY TYA PREMIUMS, CYs 2016–2022

	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
Prime	$306	$319	$324	$358	$376	$459	$512
Select (Standard)	$228	$216	$225	$214	$228	$257	$265

TRENDS IN TYA ENROLLMENT SINCE INCEPTION (MAY 2011–SEPTEMBER 2021)



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, 10/14/2021

[a] The number of FY 2021 TYA Select enrollees on this chart is slightly larger than the one shown on pages 34 and 35. There are 66 Medicare-eligible TYA Select enrollees that are included in the "Other" group on those pages because their number is too small to justify breaking them out separately.

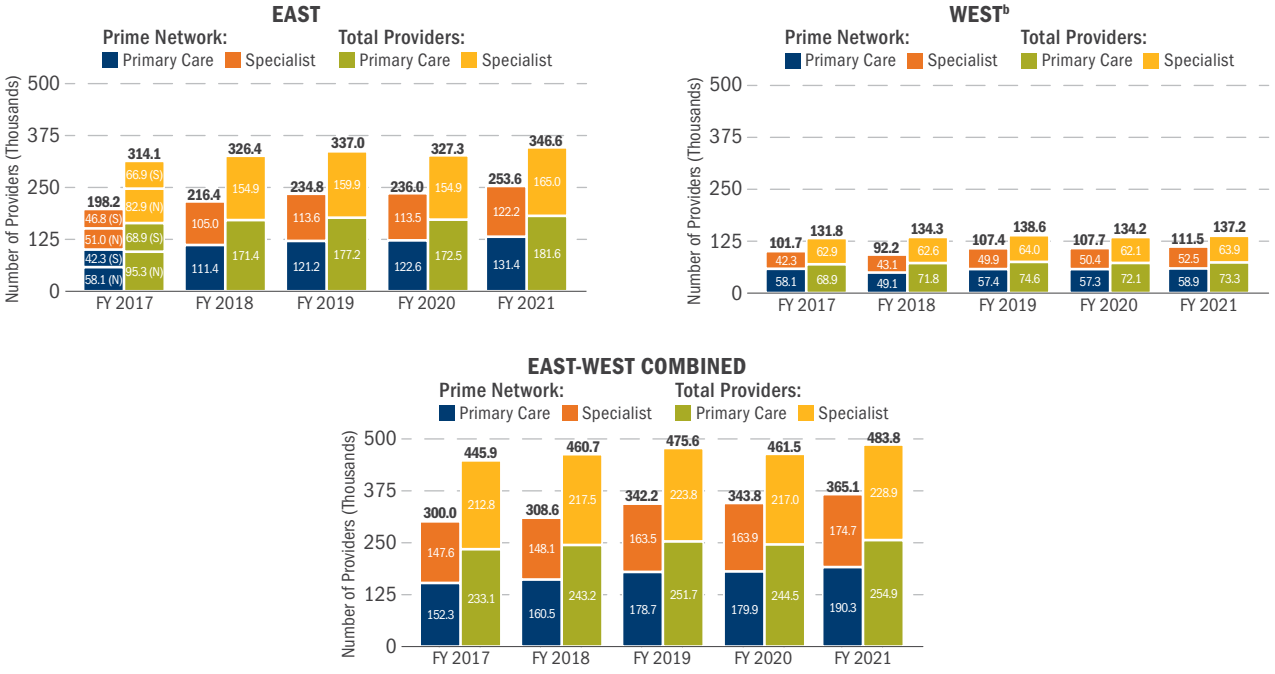
OTHER PLANS AND PROGRAMS *(CONT.)*

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 TRICARE for Life [TFL]) claims.[1] Providers were counted in terms of full-time equivalent 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 2017, the number of network primary care providers has increased at a higher rate (25 percent) than that of specialists (18 percent), and the total number of participating primary care providers has increased at a slightly higher rate (9 percent) than that of total participating specialists (8 percent).[2]

- Between FY 2017 and FY 2021, the East Region saw an increase of 10 percent in the total number of TRICARE providers (8 percent in the former North Region and 13 percent in the former South Region), while the West Region saw an increase of 4 percent.
- The East Region saw an increase of 28 percent in the total number of network providers (30 percent in the former North Region and 26 percent in the former South Region), while the West Region saw an increase of 10 percent.
- The total number of TRICARE providers increased by 11 percent in Prime Service Areas (PSAs) and by 5 percent in non-PSAs (not shown).
- The number of network providers increased by 21 percent in PSAs and by 22 percent in non-PSAs (not shown).
- In FY 2021, 68 percent of all network providers and 66 percent of all participating providers were in PSAs (not shown).

TRENDS IN NETWORK AND TOTAL PARTICIPATING PROVIDER FTEs, FYs 2017–2021[a]



Source: MHS administrative data, 1/28/2022

[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.

[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.

Notes:

– The source for the provider counts shown above was the TRICARE private sector 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.

OTHER PLANS AND PROGRAMS *(CONT.)*

Civilian Provider Acceptance of, and Beneficiary Access to, TRICARE Select

The TRICARE Select Survey (TSS) evaluates access to care and patient experience for TRICARE Select beneficiaries and awareness and acceptance of TRICARE Select among providers nationwide. It does this through two surveys: a beneficiary survey (TSS-B) and a provider survey (TSS-P).

- **Results from the FY 2021 Beneficiary Survey (TSS-B):**
  - **Reasons for Not Using TRICARE.** Fourteen percent of TSS beneficiaries reported not using TRICARE in the last 12 months and were asked why. The top reasons for not using TRICARE are "another reason" (37 percent) and "I have not needed health care" (36 percent). Beneficiaries in a PSA are more likely to say they get a greater choice of providers with a civilian plan (16 percent versus 9 percent not in a PSA), and they did not want to pay the TRICARE premium (11 percent versus 4 percent not in a PSA). Beneficiaries in a non-PSA were much more likely to say there was no military facility nearby compared with those in a PSA (24 percent versus 9 percent).
  - **Access to Care.** In FY 2021, 84 percent of TSS beneficiaries indicated satisfaction with Getting Needed Care CAHPS composite (slightly below the 87 percent benchmark). However, 88 percent of beneficiaries indicated satisfaction with Getting Care Quickly CAHPS composite, two percentage points above the benchmark. Access to personal doctor or behavioral health were statistically the same as FY 2020. There were few differences between PSA and non-PSA in access to care except for travel time, where 89 percent of beneficiaries within a PSA reported a travel time of 30 minutes or less to a personal doctor, compared with 85 percent in a non-PSA. Similarly, 93 percent of those within a PSA reported a travel time of 60 minutes or less to a specialist, compared with 85 percent of those in a non-PSA.
  - **Global Patient Experience Ratings.** Global ratings for Health Care (78 percent) and Health Plan (68 percent) were both above CAHPS benchmarks. Global ratings for Personal Doctor (82 percent) and Specialist (82 percent) were both at CAHPS benchmarks. There were few differences between beneficiaries in PSAs and those not in PSAs.
  - **Problems Finding a Personal Doctor.** Twenty-two percent of TSS beneficiaries reported a problem finding a personal doctor. The top reasons were "doctors not accepting TRICARE" (53 percent) and "doctors not accepting new TRICARE patients" (40 percent). Beneficiaries within a PSA were more likely to say the wait for an appointment was too long (29 percent versus 14 percent). Beneficiaries outside of PSAs were more likely to say personal doctors did not accept TRICARE (57 percent versus 51 percent) and the travel distance was too long (39 percent versus 26 percent).
  - **Problems Finding a Specialist.** Twenty-three percent of TSS beneficiaries reported a problem finding a specialist. The top reasons were "specialists not accepting TRICARE" (51 percent) and "specialists not accepting new TRICARE patients" (37 percent). Beneficiaries outside of PSAs were more likely to say the travel distance was too long (37 percent versus 26 percent).
  - **Problems Finding Mental Health Care.** Forty percent of TSS beneficiaries reported a problem finding mental health care. The top reasons were "mental health providers not accepting TRICARE" (44 percent) and the wait for an appointment was too long (34 percent). Beneficiaries outside of PSAs were more likely to say mental health providers did not accept TRICARE (47 percent versus 42 percent). Beneficiaries within PSAs were more likely to say the wait was too long (42 percent versus 22 percent).
- **Results from the FY 2021 Provider Survey (TSS-P):**
  - **TRICARE Acceptance.** Eighty-two percent of physicians and 60 percent of behavioral health providers were aware of TRICARE Select. Eighty-seven percent of physicians and 51 percent of behavioral health providers accept new TRICARE patients if they were accepting new patients at all.
  - **Reasons for Not Accepting TRICARE.** Of the 41 percent of providers who do not accept TRICARE Select, the top reasons were "other" (36 percent), "not aware of TRICARE Select" (17 percent), and "not accepting new patients" (16 percent). Physicians were more likely to not accept TRICARE Select because they were not accepting new patients. Behavioral health providers were more likely to not accept TRICARE Select because of "other"—they were not aware of it, they had problems being accepted, or they only took private insurance. Open text analysis revealed many behavioral health providers were not eligible to be credentialed or worked in facilities or positions that did not accept insurance, such as in schools, prisons, or as social workers. Some providers stopped accepting TRICARE Select because of non-payment of claims.

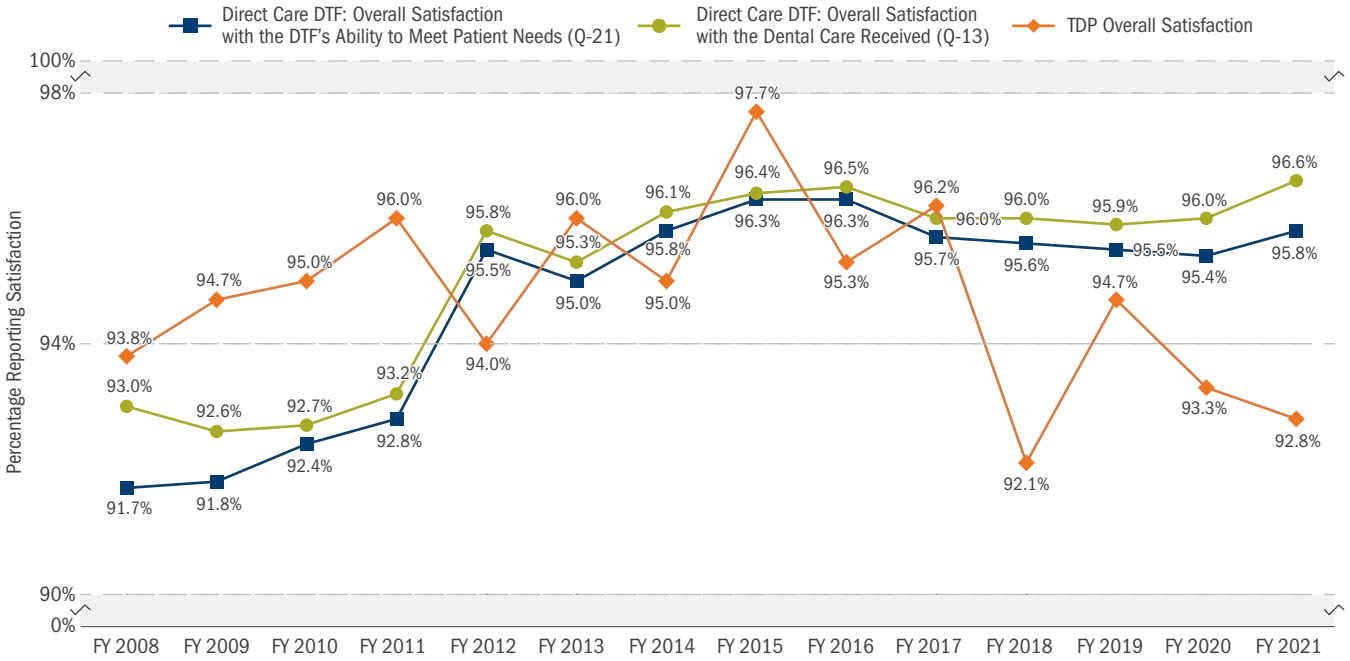
OTHER PLANS AND PROGRAMS *(CONT.)*

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 DTFs** are responsible for the dental care of about 1.64 million ADSMs worldwide and eligible family members residing outside the contiguous United States. The Tri-Service Center for Oral Health Studies completed 80,746 surveys in FY 2021. This is a substantial decrease from 131,059 completed surveys in FY 2019, potentially due to the COVID-19 pandemic. Reports of overall satisfaction have remained at around 96 percent since FY 2014.
- The **TRICARE Dental Program (TDP)** is a voluntary, premium-sharing dental insurance program available to eligible ADFMs, Selected Reserve and Individual Ready Reserve members, and their families. The TDP composite overall average enrollee satisfaction for FY 2021 is 92.8 percent. This is a decrease from the previous year of 93.3 percent. It should be noted that the survey does not allow for questions to improve quality. As of November 1, 2021, TDP enrollment totaled 1,843,408 contracts, covering almost 2 million lives, 98 percent of which were in the U.S. The TDP network has 71,142 total dentists in FY 2021—56,404 are general dentists and 14,738 are specialists.

SATISFACTION WITH TRICARE DENTAL CARE: MILITARY AND CONTRACT SOURCES, FYs 2008–2021



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), 11/16/2021

Note: The dental satisfaction surveys are displayed above for ease of reference, but are not directly comparable because they are based on different survey instruments and methodologies.

OTHER PLANS AND PROGRAMS *(CONT.)*

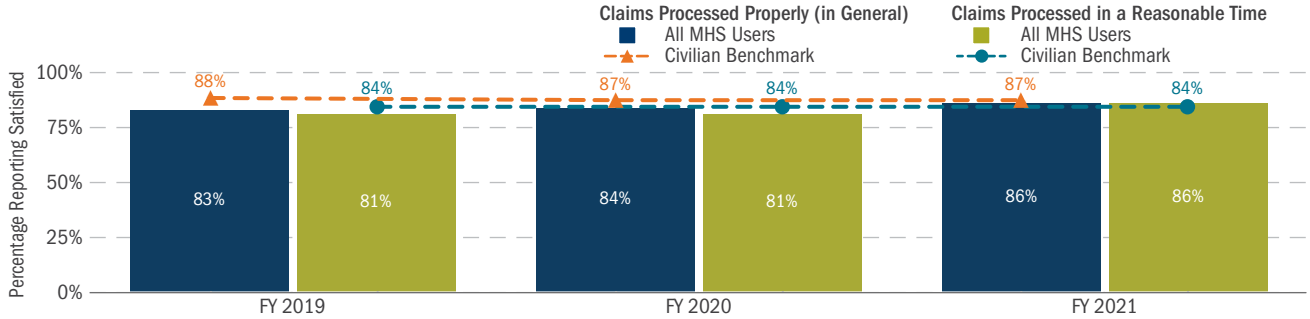
Customer Service, Claims Processing

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 with claims being processed properly and with processing speed both increased from FY 2019 to FY 2021.
- MHS satisfaction levels with the accuracy of claims processing were lower than the civilian benchmarks for FY 2021, but were higher than the benchmark for processing claims in a reasonable time.

TRENDS IN SELF-REPORTED ASPECTS OF CLAIMS PROCESSING (ALL SOURCES OF CARE), FYs 2019–2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 1/21/2022

Notes:

– All MHS Users applies to survey respondents in the 50 United States and the District of Columbia.

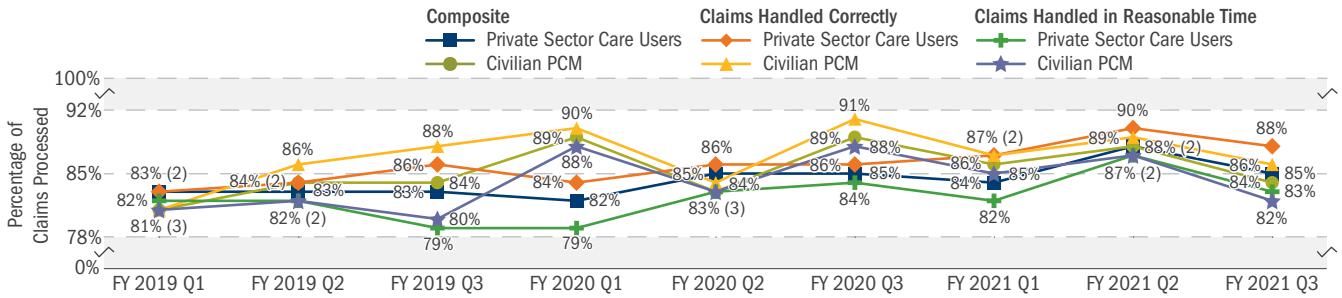
– Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used in 2019 and 2020 come from NCQA's 2017 data and in 2021 from NCQA's 2019 data.

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 private sector 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 Private Sector Care Processing Contractor.
- **Claims Processing:** The Private Sector 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 Private-Sector 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 PRIVATE SECTOR CARE/CIVILIAN PCM CLAIMS PROCESSING, FY 2019 Q1–FY 2021 Q3



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division; HCSDB, current as of FY 2021 Q3

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

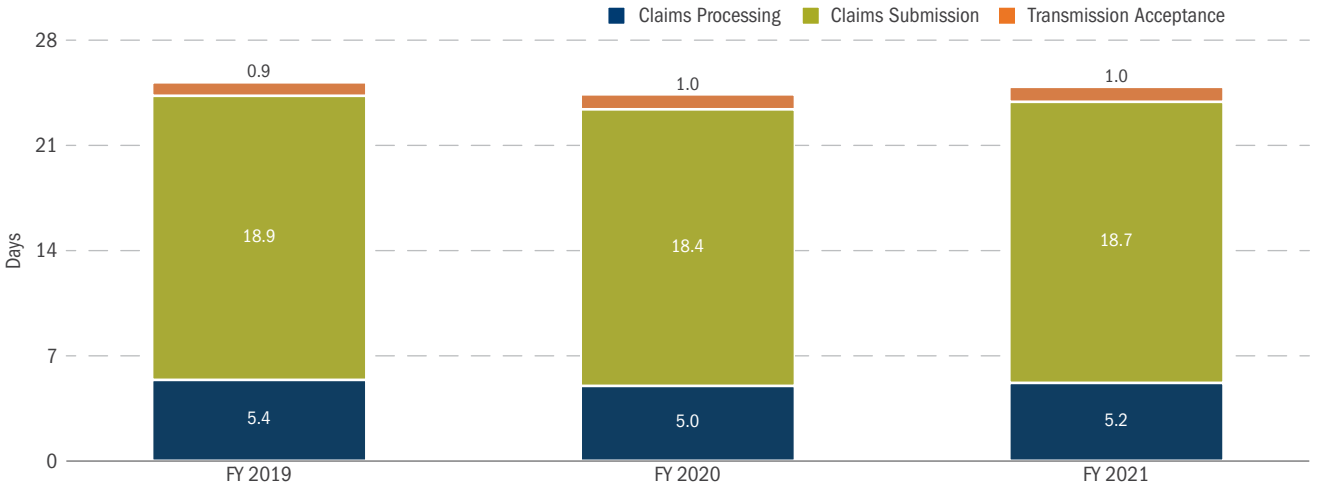
Customer Service, Claims Processing *(cont.)*

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.

FY 2021 showed a statistically insignificant increase in overall processing times, driven by miniscule increases in average claim processing and claim submission times from FY 2020. The lengthiest portion of claims processing consistently is claims submission—the time it takes for the treating provider to submit claims.

The chart shows results of analyses of claims counts of 41.7 million, 41.7 million, and 46.3 million for FY 2019, FY 2020, and FY 2021, respectively.

AVERAGE INTERVAL (DAYS) FOR CLAIMS PROCESSING, FYs 2019–2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, MHS administrative data, 12/15/2021

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 medical treatment facilities (MTFs) and regional managed care support contractor (MCSC) engagement.

HEALTH PROMOTION AND DISEASE PREVENTION EFFORTS

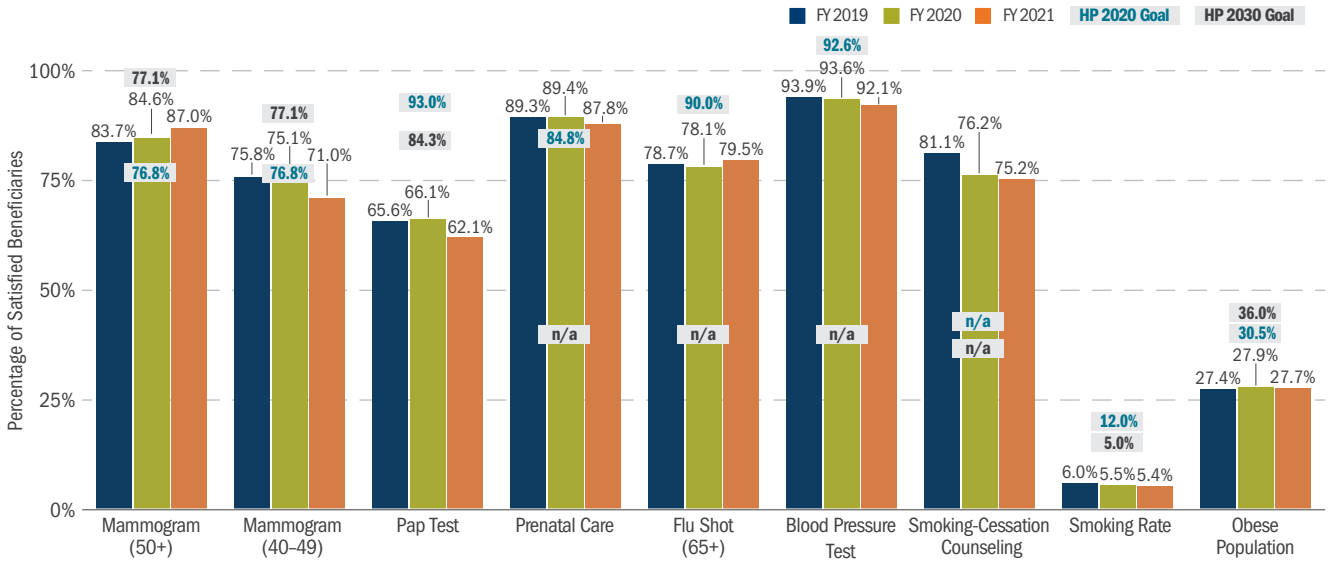
This section presents efforts toward meeting the MHS aim of "Better Health," part of the Quadruple Aim, to include preventive care, population health, tobacco cessation, and obesity and condition management. This section also provides selected measures benchmarked to the Healthy People 2020 (HP 2020) and Healthy People 2030 (HP 2030) goals. The HP 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 graphs on pages 122–126 reflect 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 graphs on pages 181–184 show Better Health Measures that are housed on the MHS Dashboard and use clinical records to track and assess enterprise performance on obesity/overweight prevalence and tobacco use/cessation counseling.

- 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 (through 2020) and HP 2030 (beginning in 2021). Over the past three years, the MHS has exceeded targeted HP goals for providing mammograms (ages 50 and over) and prenatal care for women, as well as for rates of smoking and obesity.
- Pap Test: According to self-reported Health Care Survey of DoD Beneficiaries (HCSDB) data, the percentage of MHS female beneficiaries receiving Pap tests decreased in FY 2021 to 62 percent (from about 66 percent the previous two years). 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 slightly over the past three years. Smoking-cessation counseling has decreased from 81 percent in FY 2019 to 75 percent in FY 2021 (pages 179–182). MHS Dashboard measure data for tobacco use and counseling are available on page 182. These measures apply to the direct care population only and use different sources and methods. Therefore, the results differ from the survey-based measures. As of FY 2021 Q4, 22.1 percent of direct care beneficiaries screened for tobacco use were current users based on data from the MHS Dashboard.
- Obesity: Based on self-reported survey data, the overall proportion of MHS beneficiaries identified as obese remained about the same for the past three years at 23 to 24 percent. This is below the HP 2020 goal of 30.5 percent and the HP 2030 goal of 36 percent. MHS Dashboard measure data for overweight and obesity are available on pages 183–184. These measures apply to the direct care population only and use different sources and methods. Therefore, the results differ from the survey-based measures. In FY 2021 Q4, the MHS adult obesity rate per the MHS Dashboard was 30.5 percent.

HEALTH PROMOTION AND DISEASE PREVENTION EFFORTS *(CONT.)*

TRENDS IN MEETING PREVENTIVE CARE STANDARDS, FYs 2019–2021



Sources: Defense Health Agency (DHA)/Strategy, Plans, and Functional Integration (SP&FI) (J-5)/Analytics and Evaluation Division, results provided 12/28/2021

Notes:

– The Trends in Meeting Preventative Care Standards estimates are for TRICARE users (i.e., enrollees of Prime, Select, or Retired Reserve) who are younger than 65.

– 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 Healthy People 2020 goals are for data through 2020. Healthy People 2030 goals were released in late 2021 and should be used for 2021 data.

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 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.

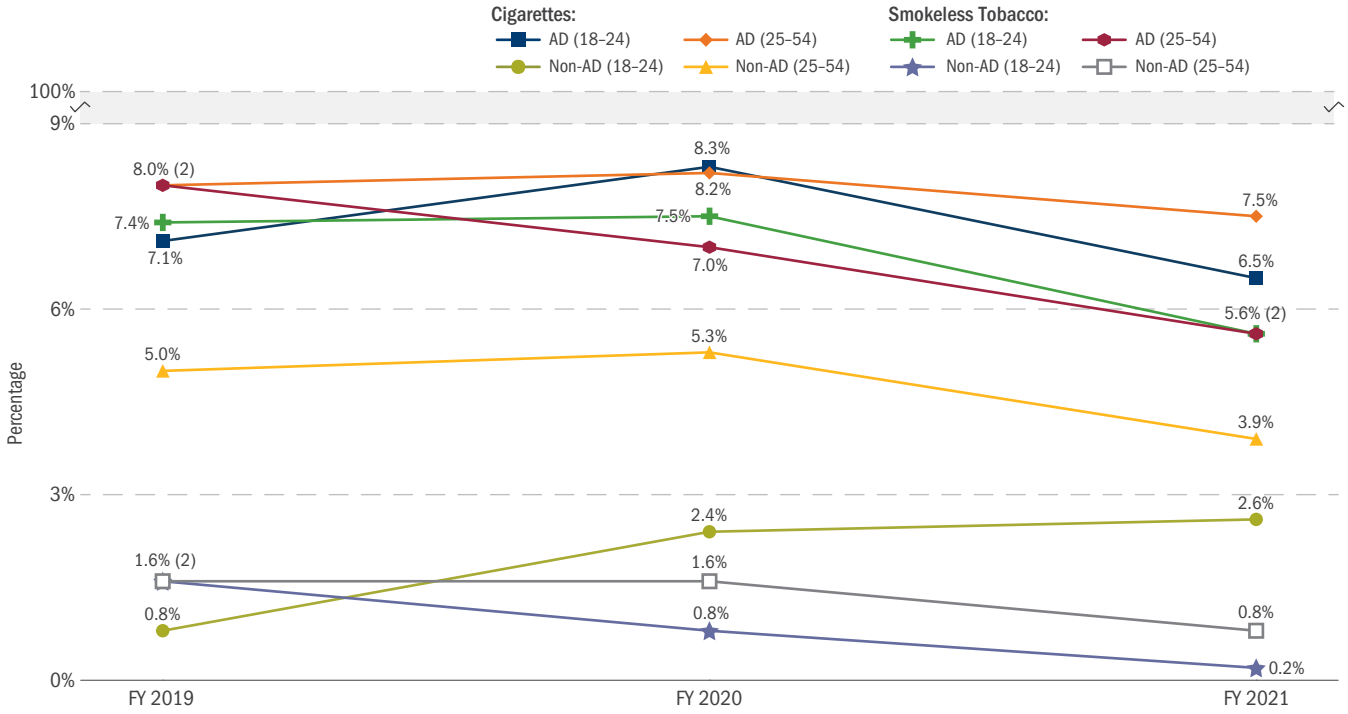
SELF-REPORTED PREVENTATIVE HEALTH MEASURE

Tobacco Cessation

Tobacco continues to be the leading cause of preventable death, according to the Centers for Disease Control and Prevention (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 and smokeless tobacco use for Active Duty Service members (ADSMs) of all ages declined from FY 2019 to FY 2021.
- Cigarette smoking for non-Active Duty beneficiaries aged 18–24 increased by approximately two percentage points from FY 2019 to FY 2021, while smokeless tobacco for non-Active Duty of all ages decreased over the same time period.
- Cigarette smoking for MHS beneficiaries is well below the U.S. average of 14 percent (reported in 2019 from the CDC).

SELF-REPORTED CIGARETTE AND SMOKELESS TOBACCO USE RATES AMONG ACTIVE DUTY (AD) AND NON-ACTIVE DUTY, FYs 2019–2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, 2/10/2022

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.

– The U.S. adult cigarette smoking rate in 2019 was 14% for all ages, https://www.cdc.gov/tobacco/data_statistics/fact_sheets/index.htm?s_cid=osh-stu-home-spotlight-001, accessed 2/11/2022.

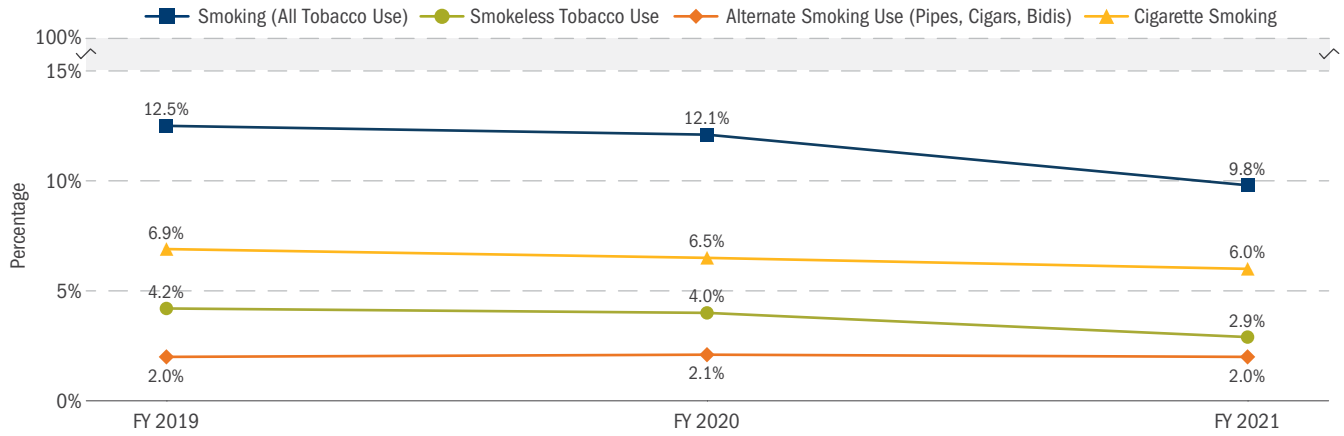
– For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

SELF-REPORTED PREVENTATIVE HEALTH MEASURE *(CONT.)*

Tobacco Cessation *(cont.)*

- **MHS Prime Enrollee Use of Any Tobacco Products:** In addition to cigarette smoking, the HCSDB assesses 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 12.5 percent in FY 2019 to 9.8 percent in FY 2021.
- Cigarette smoking, which is the most used form of tobacco among Prime enrollees, remained about the same for the past three years, while smokeless tobacco use decreased from 4.2 percent in FY 2019 to 2.9% in FY 2021.

SELF-REPORTED MHS PRIME ENROLLEE USE OF TOBACCO PRODUCTS, BY TYPE OF TOBACCO USE: CIGARETTES, ALTERNATE SMOKING TOBACCO, AND SMOKELESS TOBACCO, FYs 2019–2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, 2/11/2022

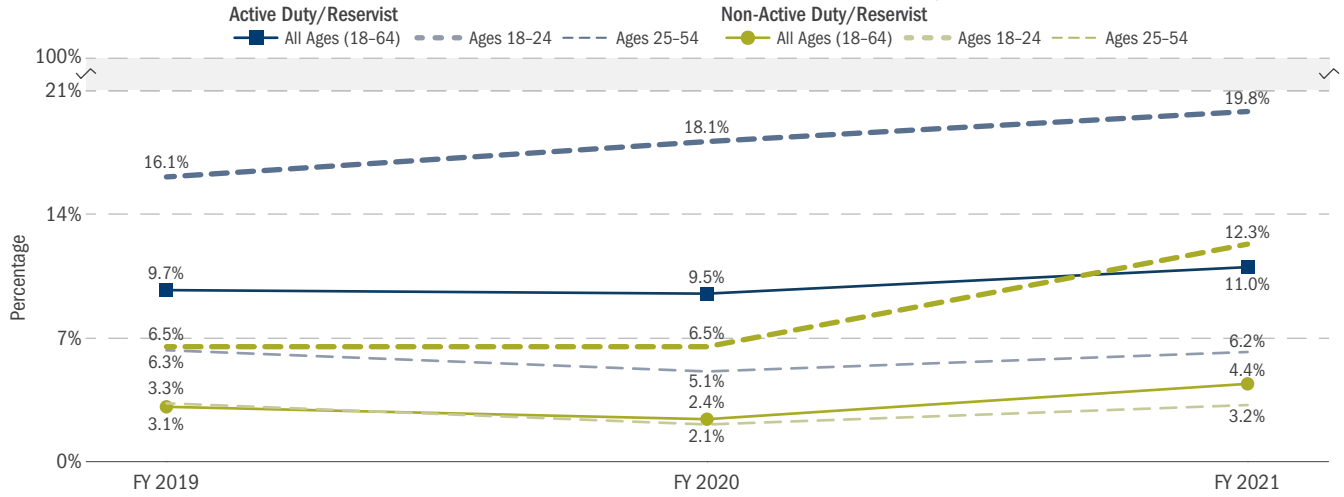
Notes:

– 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.

- Self-reported use of e-cigarette or vaping products in the 18 to 64 age range by AD/Reservists increased by 1.3 percentage points from FY 2019 to FY 2021, where it remained relatively the same for AD/Reservists 25–54 years old but increased by 3.7 percentage points for the younger AD/Reservists (ages 18–24). AD reported higher use than non-AD for each age group.
- Non-AD/Reservists e-cigarette use among those 18–24 years old nearly doubled during the past two years, increasing from 6.5 percent in FY 2020 to 12.3 percent in FY 2021.

SELF-REPORTED E-CIGARETTE USAGE AMONG SELECT COHORTS, FYs 2019–2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, 2/11/2022

Note: Data are derived from the HCSDB question "Do you now vape or use e-cigarettes every day, some days, or not at all?" with scores shown for those indicated "every day."

SELF-REPORTED PREVENTATIVE HEALTH MEASURE *(CONT.)*

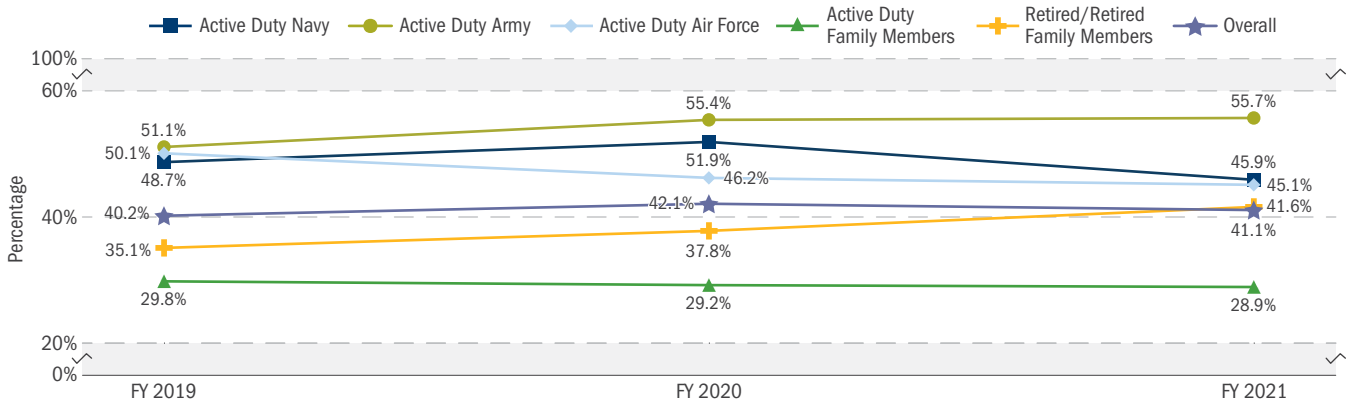
MHS Adult Obesity

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 charts below display the percentage of the population reporting in the HCSDB a height and weight that, when used in calculating BMI, result in a measurement of 25 or higher (30 is the threshold for obesity).

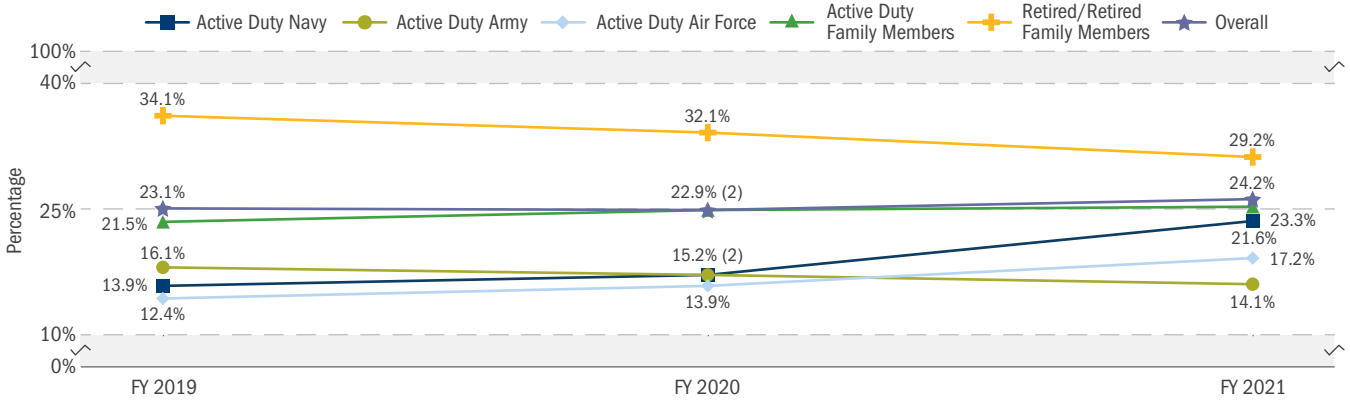
- As shown in the chart below, 41.1 percent of all MHS beneficiaries were overweight in FY 2021. Active Duty family members (ADFMs), on average, have the lowest rate of being overweight (28.9 percent). Calculated BMI rates reflecting overweightness may not be reflective of AD fitness without consideration of muscle mass, and may explain why AD appear to have high prevalence rates of being overweight but low obesity rates, as shown in the second chart.

SELF-REPORTED MHS OVERWEIGHT RATE (BMI 25–29.9), FYs 2019–2021



- The chart below 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 survey data from the HCSDB. The overall MHS obesity rate has been relatively unchanged from FY 2019 to FY 2021.
- In FY 2021, AD Army had the lowest obesity rates, compared with AD Navy and Air Force.
- AD Navy obesity rates for FY 2021 increased by 6.4 percentage points, while overweight rates decreased by 6 percentage points.

SELF-REPORTED MHS OBESITY RATE (BMI 30 OR HIGHER), FYs 2019–2021



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data 2/23/2022

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). No objective validation tool is used to verify accuracy of BMI results.

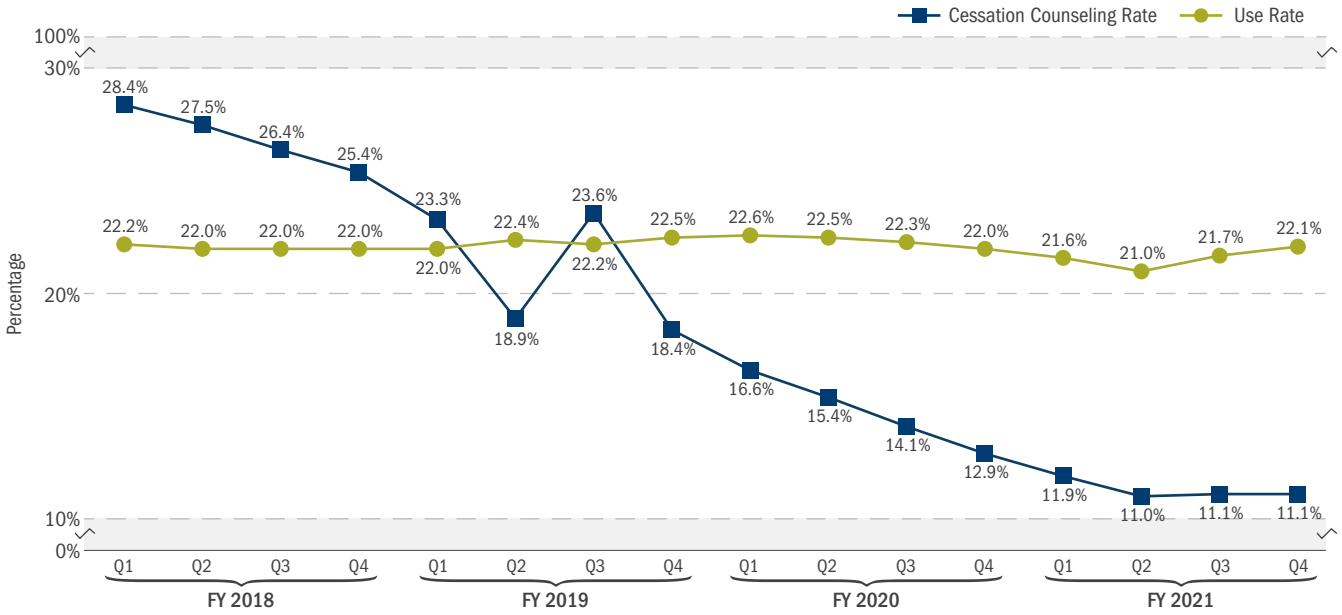
MHS DASHBOARD BETTER HEALTH MEASURES

Better Health Measures housed on the MHS Dashboard use clinical records to track and assess enterprise performance on obesity/overweight prevalence and tobacco use/cessation counseling. These measures are enrollment-based indicators of performance among the direct care population with health care encounters in MHS facilities.

Tobacco Use and Cessation Counseling

The use rate has remained largely unchanged from Q1 FY 2018 to Q4 FY 2021. The cessation counseling rate decreased during this time; however, the reason for the decreased counseling rate and its relationship to the measured use rate is unclear and remains to be evaluated for the MHS.

MHS DASHBOARD TOBACCO MEASURES, FYs 2018–2021



Source: CarePoint (available only on the MHS intranet), MHS Dashboard, data accessed 12/7/2021

Notes:

– Reflects rate during last month of each quarter.

– Tobacco dashboard measure includes beneficiaries 18 years of age and up, or pregnant at any age, continuously enrolled (11 months) to TRICARE Prime or Plus, with a primary care MTF encounter in the last 12 months.

– The tobacco use rate measure does not distinguish among use modalities and is presumed to include traditional tobacco products as well as newer products such as e-cigarettes.

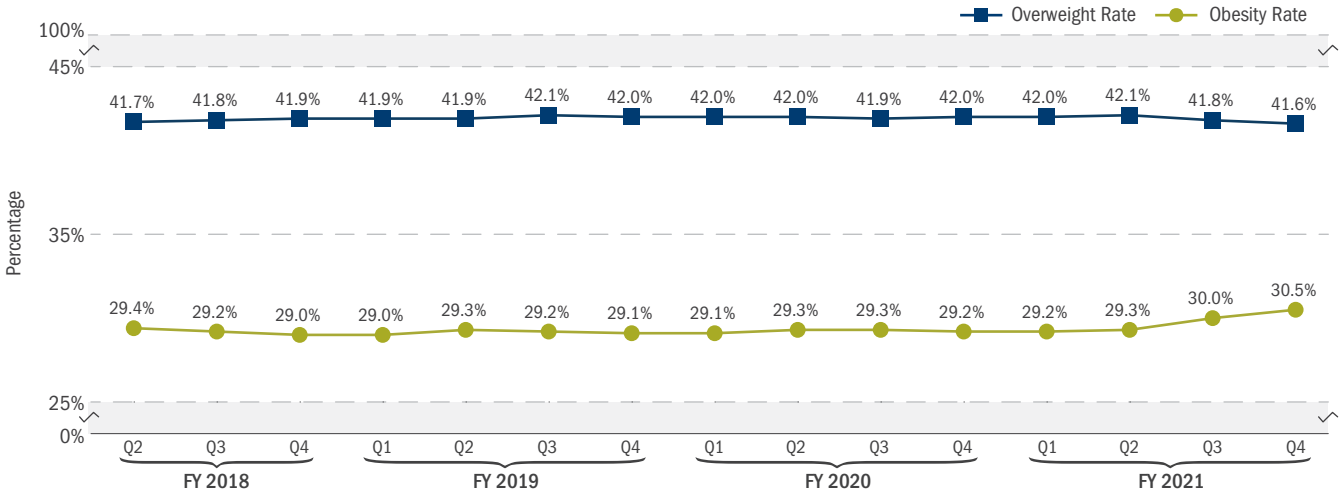
– The tobacco counseling dashboard measure data are presumed objective clinical observations. The survey-derived use and cessation statistics, described earlier, are self-reported data, which are subject to recall bias, while clinical records based data are subject to variances in clinical coding habits, policies, and practice patterns across the enterprise.

MHS DASHBOARD BETTER HEALTH MEASURES *(CONT.)*

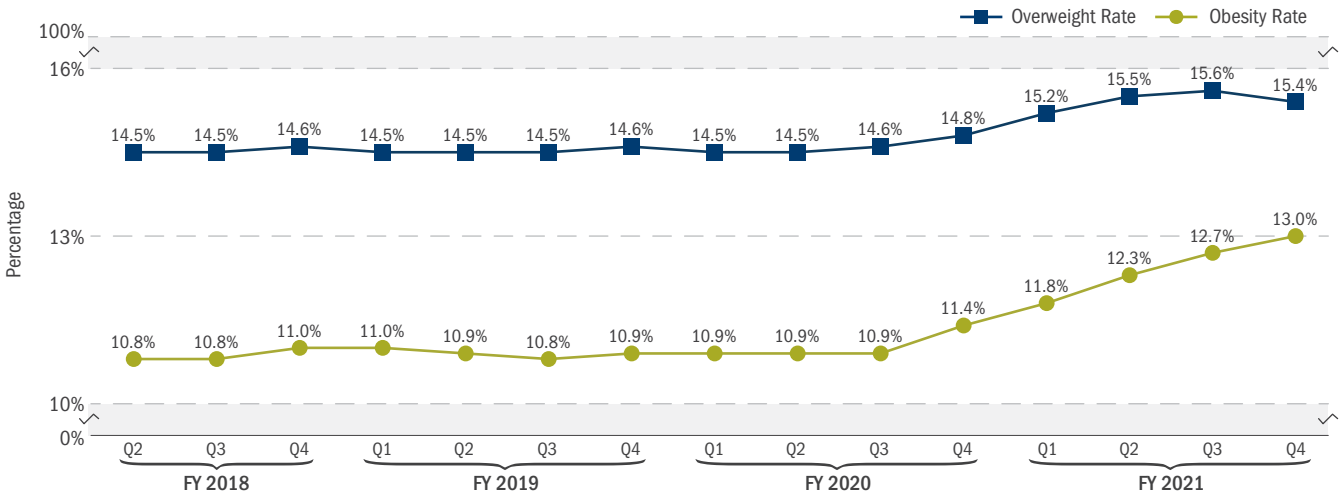
Obesity and Overweight Prevalence

Trends in obesity and overweight prevalence among youth and adult direct-care beneficiaries in the MHS are consistent with those in the general population in National Health and Nutrition Examination Survey (NHANES). Overall, as of Q4 FY 2021, the MHS adult population obesity prevalence rate (30.5 percent, adjusted for age and sex) is less than that of the general U.S. population, as estimated by the 2017–2018 NHANES measurement cycle (42.4 percent, adjusted for age and sex). Using the same comparator data source for overweight burden, adjusted prevalence among MHS beneficiary adults (41.6 percent, adjusted for age and sex) is higher than the national average (31.1 percent, adjusted). Estimates of obesity and overweight prevalence in Q4 FY 2021 for MHS beneficiary youth (13.0 percent and 15.4 percent respectively, both adjusted for age and sex) remain below the national average (19.3 percent and 16.1 percent respectively, both adjusted).

MHS DASHBOARD ADULT OBESITY AND OVERWEIGHT RATE, FYs 2018–2021



MHS DASHBOARD YOUTH OBESITY AND OVERWEIGHT RATE, FYs 2018–2021



Source: CarePoint (available only on the MHS intranet), MHS Dashboard, data accessed 12/3/2021

Notes:

– Reflects rate during last month of each quarter.

– Adult dashboard measure includes beneficiaries 20 years of age and up, continuously enrolled (three months) in TRICARE Prime or Plus, with an MTF encounter in the last 12 months. Rates shown are age and sex adjusted (to the 2000 U.S. Census population). Crude obesity and overweight prevalence for FY 2021 Q4 are 31.5 percent and 41.2 percent, respectively. Obesity and overweight in adults are defined as having a BMI ≥30.0 kg/m^2 and at least 25.0 kg/m^2 but less than 30.0 kg/m^2, respectively.

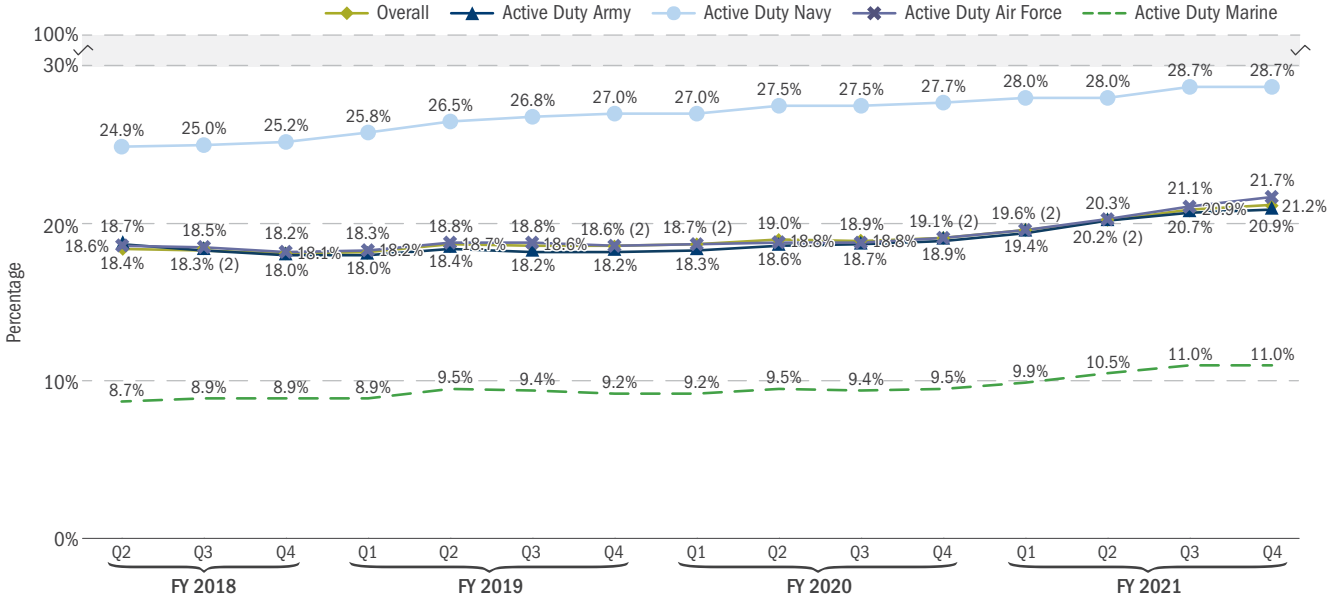
– Youth dashboard measure includes beneficiaries aged 3 years to 19 years, continuously enrolled (3 months) in TRICARE Prime or Plus, with an MTF encounter in the last 12 months. Rates shown are age adjusted (to the 2000 U.S. Census Population). Crude obesity and overweight prevalence for FY 2021 Q4 are 12.5 percent and 15.0 percent, respectively. Obesity and overweight among youth is defined as having a BMI ≥95th or ≥85th and <95th percentile of the CDC's sex-specific BMI for age growth chart, respectively.

– 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).

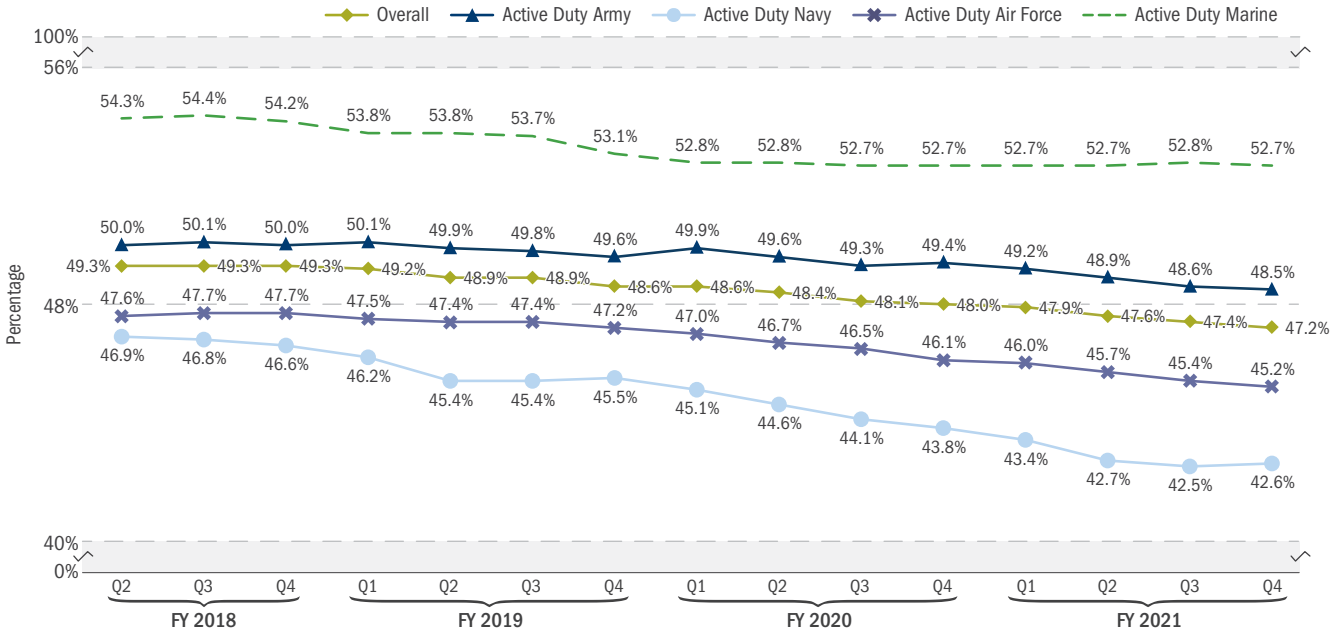
MHS DASHBOARD BETTER HEALTH MEASURES *(CONT.)*

Obesity and overweight rates among ADSMs have continued along similar trends as the general population. While obesity remains relatively low in comparison with other MHS beneficiaries, it continues to increase as the rate of overweight ADSMs declines. When stratified by Service Branch, obesity is highest among Navy ADSMs (28.7 percent) and lowest among Marines (11.0 percent). The opposite is true for overweight rates (Marines – 52.7 percent, Army – 48.5 percent, Air Force – 45.2 percent, Navy – 42.6 percent). BMI may not be an accurate indicator of adiposity, and higher rates of overweight among ADSMs may be partially biased by muscularity and hyper fitness.

MHS DASHBOARD ACTIVE DUTY SERVICE MEMBER OBESITY RATE, FYs 2018–2021



MHS DASHBOARD ACTIVE DUTY SERVICE MEMBER OVERWEIGHT RATE, FYs 2018–2021



Source: CarePoint (available only on the MHS intranet), MHS Dashboard, data accessed 12/3/2021

Notes:

– Reflects rate during last month of each quarter.

– ADSM Dashboard measure includes Active Duty beneficiaries 17 years of age and up, continuously enrolled (three months) in TRICARE Prime or Plus, with an MTF encounter in the last 12 months.

– Obesity and overweight are defined as described for youth and adults, depending on the age of the ADSM.

– 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 CDC's 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 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. Healthy People 2030 does not include HRQOL goals.

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.

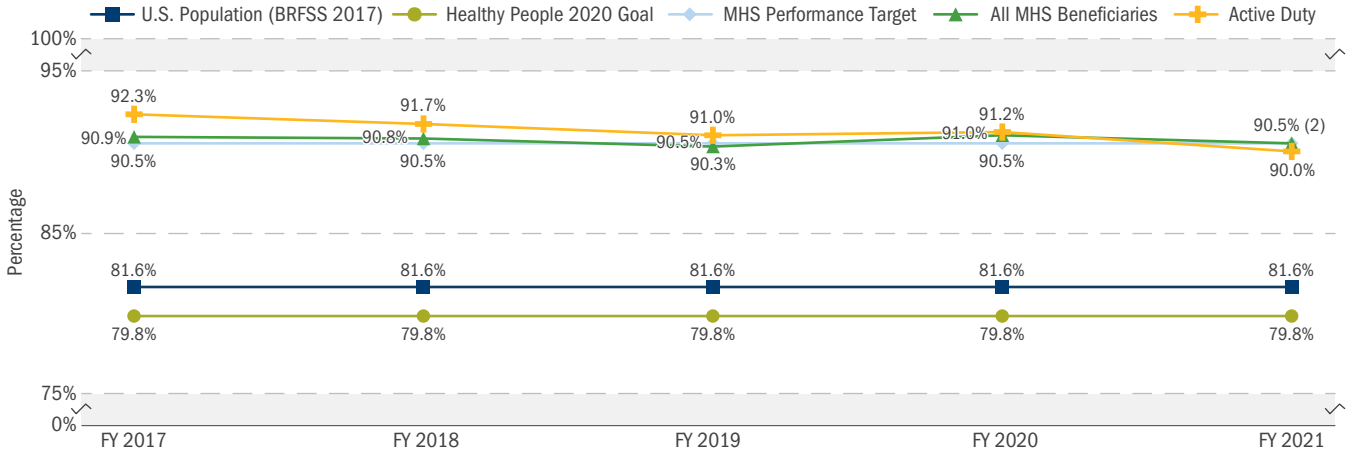
After examining both the HP and BRFSS benchmarks, the MHS established a performance target of 90.5 percent by January 1, 2021. As shown in the following graphs, the overall MHS population in general, including ADSM, rate their health status higher than the general U.S. population did in 2017, and both are higher than the HP 2020 goal of 79.8 percent.

- The overall MHS population rating of good or better health appears to have remained about the same from FY 2017 through FY 2021, ranging from 90 percent to 92 percent. ADSM rating their health as good or better declined slightly between FY 2016 and FY 2021, by about 3 percentage points.
- In 2021, the number of physically unhealthy days for ADSM/Reservists was 3.7 (out of 30 days), a slight decrease from 4.6 days in 2020. While self-reported physically unhealthy days decreased during the last two years for ADSM/Reservists, mentally unhealthy days increased from 4.1 in 2020 to 4.5 in 2021.

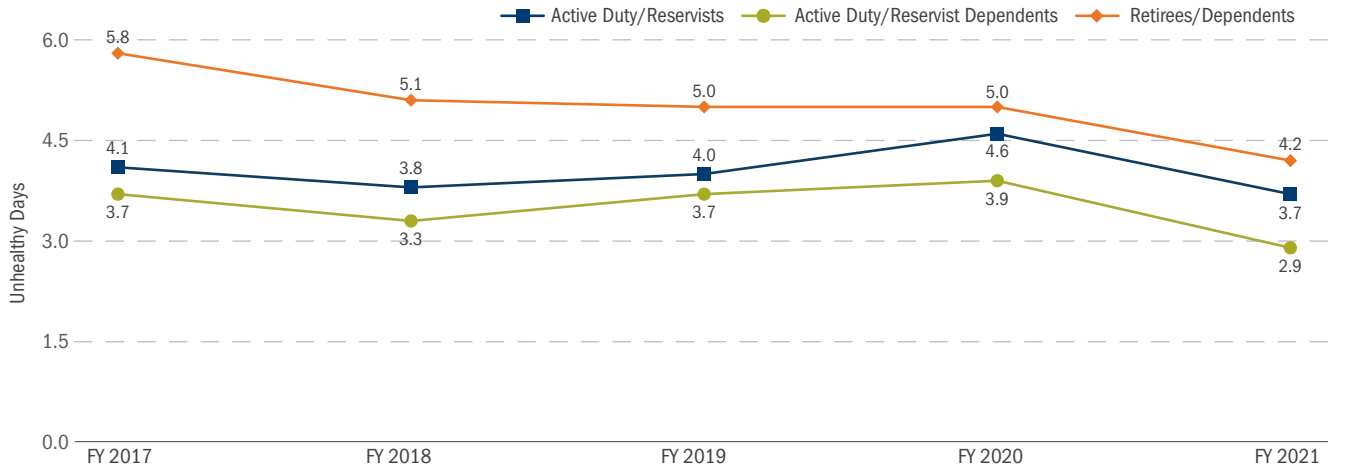
HEALTH-RELATED QUALITY OF LIFE *(CONT.)*

Using CDC's Health-Related Quality of Life Questions as a Proxy Measure of "Better Health" *(cont.)*

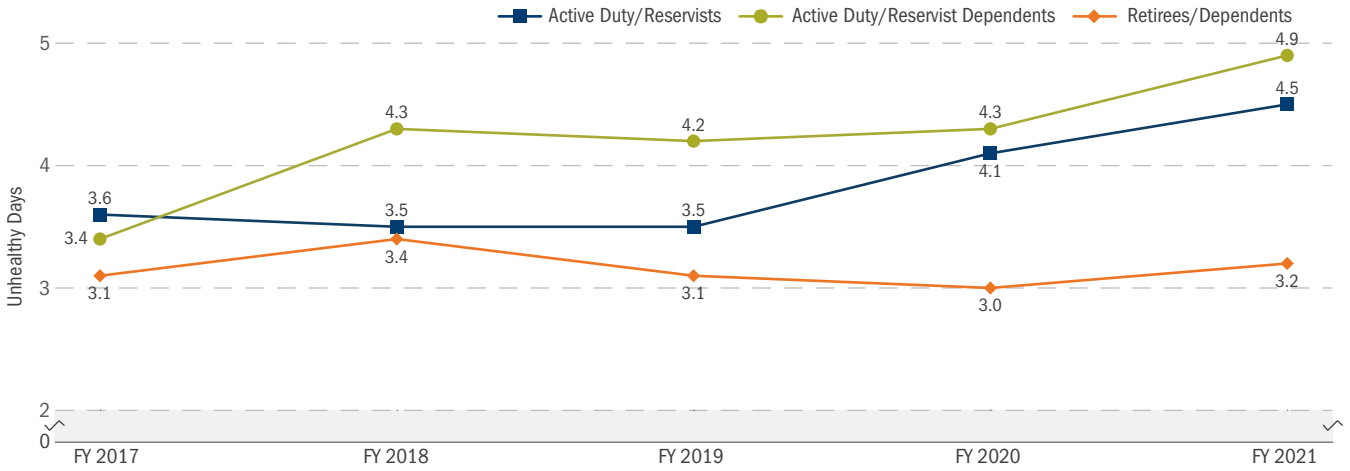
PERCENTAGE OF MILITARY BENEFICIARIES SELF-RATING HEALTH STATUS AS GOOD OR BETTER, FYs 2017–2021



PHYSICALLY UNHEALTHY DAYS FOR TRICARE BENEFICIARIES, FYs 2017–2021



EMOTIONALLY UNHEALTHY DAYS FOR TRICARE BENEFICIARIES, FYs 2017–2021



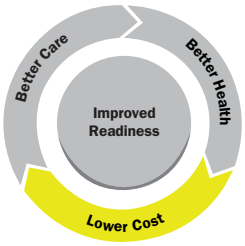
Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, 1/3/2022

Notes:

– BRFSS results are from the 2017 survey conducted by CDC, reweighted to match the 2017 MHS population.

– Unhealthy days are measured from 0 to 30 out of the last 30 days, as indicated in HRQOL questions 3 and 4 on the previous page.

SAVINGS AND RECOVERIES



Pharmacy Retail Refunds

The authority at 38 USC 8126 directly authorizes refunds when direct purchases of pharmaceuticals are made by the government (i.e., MTFs, TRICARE mail order pharmacy, etc.) and is made applicable to the TRICARE retail pharmacy program by the TRICARE Pharmacy Benefits Program statute at 10 U.S.C. 1074g(f) and the implementing TRICARE regulation.

The increase in refunds on drugs dispensed in retail is likely caused by several factors. Potential drivers include a shift of prescription volume from the military medical treatment facility (MTF) point of service to the retail point of service starting in early 2020 driven by the COVID-19 pandemic, cost increases for branded medications, increasing availability and use of costly specialty medications, and additional discounts offered by manufacturers through the DoD Pharmacy & Therapeutics (P&T) process.

PHARMACY RETAIL REFUNDS ($ MILLIONS), FYs 2017–2021

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
Total Receivables	$850.71	$841.78	$836.01	$859.28	$986.97
Total Collections	$847.40	$853.44	$860.82	$824.89	$957.52

Source: Defense Health Agency (DHA) Business Support Directorate, Contract Resource Management, 9/30/2021

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 DHA Office of Program Integrity (DHA 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. DHA 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), CALENDAR YEARS (CYs) 2018–2020

	CY 2018	CY 2019	CY 2020
Total Recoveries	$149.4	$363.6	$509.2
Court-Ordered Fraud Judgments/Settlements	$125.9	$328.2	$493.1
PI Contractor Administrative Recoupment/Offsets (Received)	$23.5	$34.4	$16.1
Total PI Contractors Cost Avoidance	$48.9	$67.5	$41.2
Contractor Prepayment Reviews	$48.5	$67.5	$40.3
Excluded Providers	$0.4	$0.1	$0.9

Source: 2020 Annual Program Integrity Operational Report/Contractor Submitted Fraud and Abuse Reports, CY 2018–CY 2020; CY 2020 data are the latest reported as of 11/19/2021.

Note: Annual Reports are located here: https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Program-Integrity.

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 private sector 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 show a decrease due to a regional contractor correcting claims processing issues.

RECOVERIES ($ MILLIONS), FYs 2019–2021

RECOVERIES	FY 2019	FY 2020	FY 2021
Post-Payment Duplicate Claim Recoveries	$20.2	$21.1	$10.8

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 private sector 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 2020

ACTUAL OVERPAYMENT DOLLARS IDENTIFIED VIA RANDOM SAMPLES[a]	AMOUNT RECAPTURED (REFUNDS THROUGH FY 2020)
$7.49	$246.32

Sources: DHA/R&M (J-1/J-8)/Trust Fund and Revenue Cycle Management Improper Payment Evaluation Branch, 10/23/2020; Operational Reports and Quarterly Fraud and Abuse Reports

[a] "Actual overpayment dollars identified via random samples" in FY 2020 represents the total overpayment dollars from sampled claims.

Notes:

– DHA's methodology to calculate recoveries takes into consideration subsequent repayments and nets them against refunds.

– 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 2020 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 2020 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 private sector 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 2020 improper payment recoveries of health care as a result of the EIC compliance reviews and ongoing private sector 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)

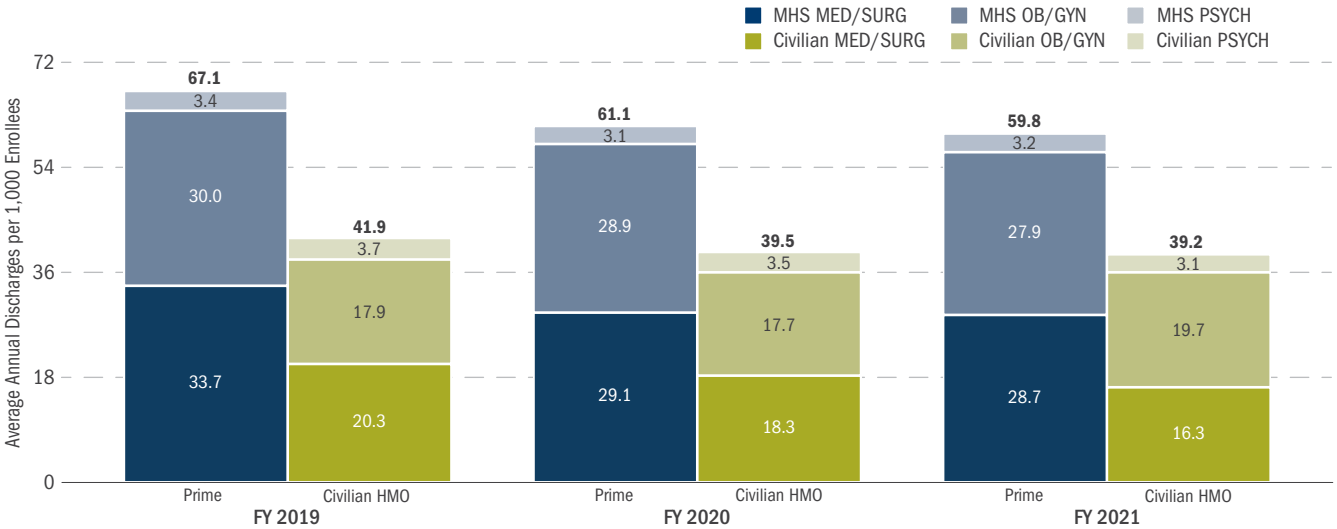
TRICARE Prime Enrollees

This section compares the inpatient utilization of TRICARE Prime enrollees (including TRICARE Young Adult [TYA] Prime but excluding the Uniformed Services Family Health Plan [USFHP]) 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 private sector 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 overall TRICARE Prime inpatient utilization rate decreased by 11 percent between FY 2019 and FY 2021, while the civilian HMO rate decreased by 7 percent. The overall TRICARE Prime decrease was driven by a 15 percent decline in MED/SURG utilization and 7 percent declines in both OB/GYN and PSYCH utilization.
- In FY 2021, the TRICARE Prime inpatient utilization rate (direct and private sector care combined) was 53 percent higher than the civilian HMO utilization rate (59.8 discharges per 1,000 Prime enrollees compared with 39.2 per 1,000 civilian HMO enrollees).
- In FY 2021, the TRICARE Prime inpatient utilization rate was 76 percent higher than the civilian HMO rate for MED/SURG procedures, 42 percent higher for OB/GYN procedures, and 2 percent higher for PSYCH procedures.
- The average length of stay (LOS) for MHS Prime enrollees (direct and private sector care combined) increased slightly from 3.4 days in FY 2019 to 3.5 days in FY 2021, whereas the average LOS for civilian HMOs remained steady at 3.8 days. In FY 2021, 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 2019–2021



Sources: MHS administrative data, 1/24/2022, and IBM Watson Health, MarketScan® Commercial Claims and Encounters (CCAE) database, 2/8/2022

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2021 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.)*

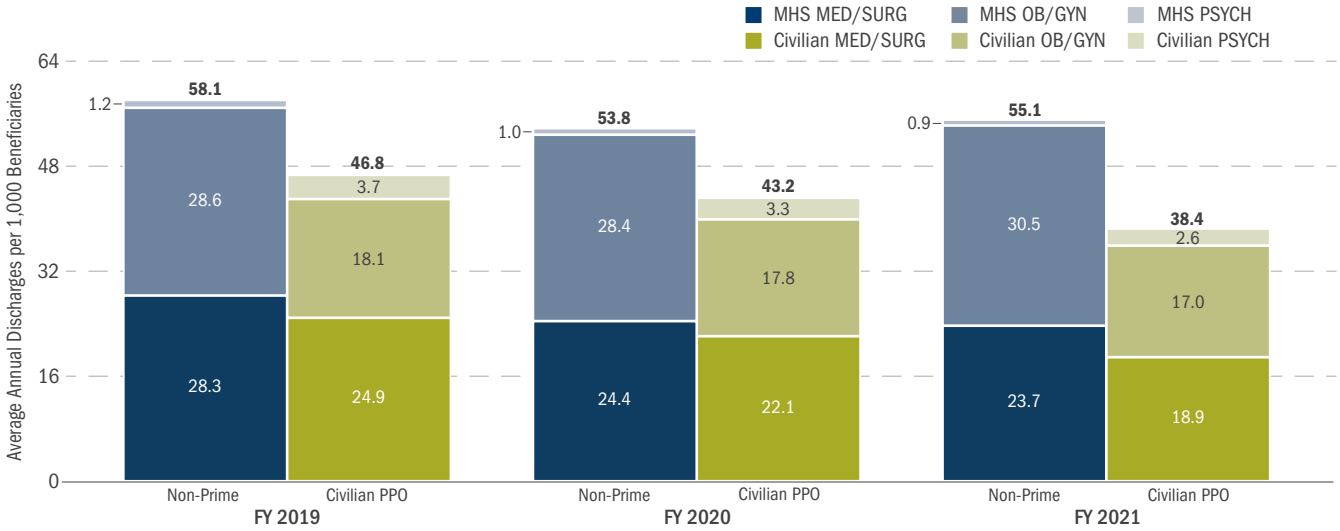
Non-Prime-Enrolled Beneficiaries

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 private sector 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 2019 and FY 2021, the overall TRICARE non-Prime utilization rate decreased by 5 percent, whereas the civilian PPO inpatient utilization rate declined by 18 percent. Despite the sharp overall decline, the TRICARE rate remains well above the civilian benchmark. In FY 2021, the inpatient utilization rate (direct and private sector care combined) for non-Prime-enrolled beneficiaries was 43 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 2019 to FY 2021, the MHS OB/GYN disposition rate increased by 6 percent, whereas it decreased by 6 percent in the civilian sector. In FY 2021, the MHS OB/GYN disposition rate was 80 percent higher than the corresponding civilian PPO rate.
- Of the three product lines considered in this report, only PSYCH procedures had lower utilization in the MHS than in the civilian sector.
- The average LOS for MHS non-Prime-enrolled beneficiaries (direct and private sector care combined) remained unchanged at 3.6 days from FY 2019 to FY 2021, whereas the average LOS for civilian PPO participants remained unchanged at 3.8 days. As a result, the average LOS for MHS non-Prime beneficiaries was 5 percent lower than that of civilian PPO participants in FYs 2019–2021 (not shown).

INPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK, FYs 2019–2021



Sources: MHS administrative data, 1/24/2022, and IBM Watson Health, MarketScan® CCAE database, 2/8/2022

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2021 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.

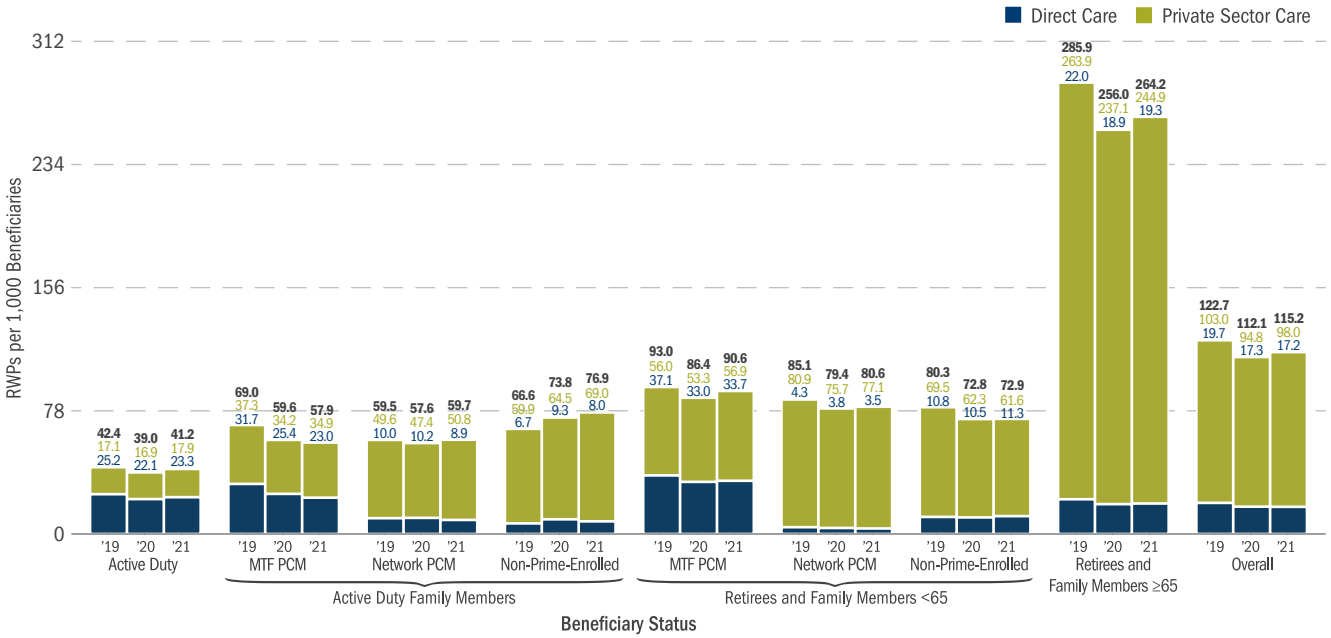
INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

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 private sector care combined) inpatient utilization rate (RWPs per 1,000 beneficiaries) decreased by 6 percent from FY 2019 to FY 2021.
- Between FY 2019 and FY 2021, the direct care inpatient utilization rate decreased by 13 percent overall, due in part to the downsizing of three military hospitals to clinics over that time period and in part because of the adverse impact of the COVID-19 pandemic. Active Duty family members (ADFMs) with an MTF primary care manager (PCM) experienced the largest decline (28 percent). Retirees and family members (RETFMs) with a network PCM also experienced a large decline (18 percent). The only groups with an increase in utilization were non-Prime-enrolled ADFMs and RETFMs under age 65 (19 percent and 5 percent, respectively), but direct care utilization by those beneficiary groups is still relatively low.
- The overall private-sector acute care inpatient utilization rate decreased by 5 percent between FY 2019 and FY 2021, but there was a great deal of variation across beneficiary groups. Non-Prime-enrolled ADFMs experienced a 15 percent increase, while smaller increases, ranging from 2 to 4 percent, were experienced by Active Duty members, ADFMs with a network PCM, and RETFMs under age 65 with an MTF PCM. The remaining beneficiary groups experienced declines, with the largest experienced by non-Prime-enrolled RETFMs under age 65 (11 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 private sector care facilities increased from 73 percent in FY 2019 to 75 percent in FY 2021.
- From FY 2019 to FY 2021, 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.

AVERAGE ANNUAL INPATIENT RWPs PER 1,000 BENEFICIARIES, FYs 2019–2021



Source: MHS administrative data, 1/24/2022

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

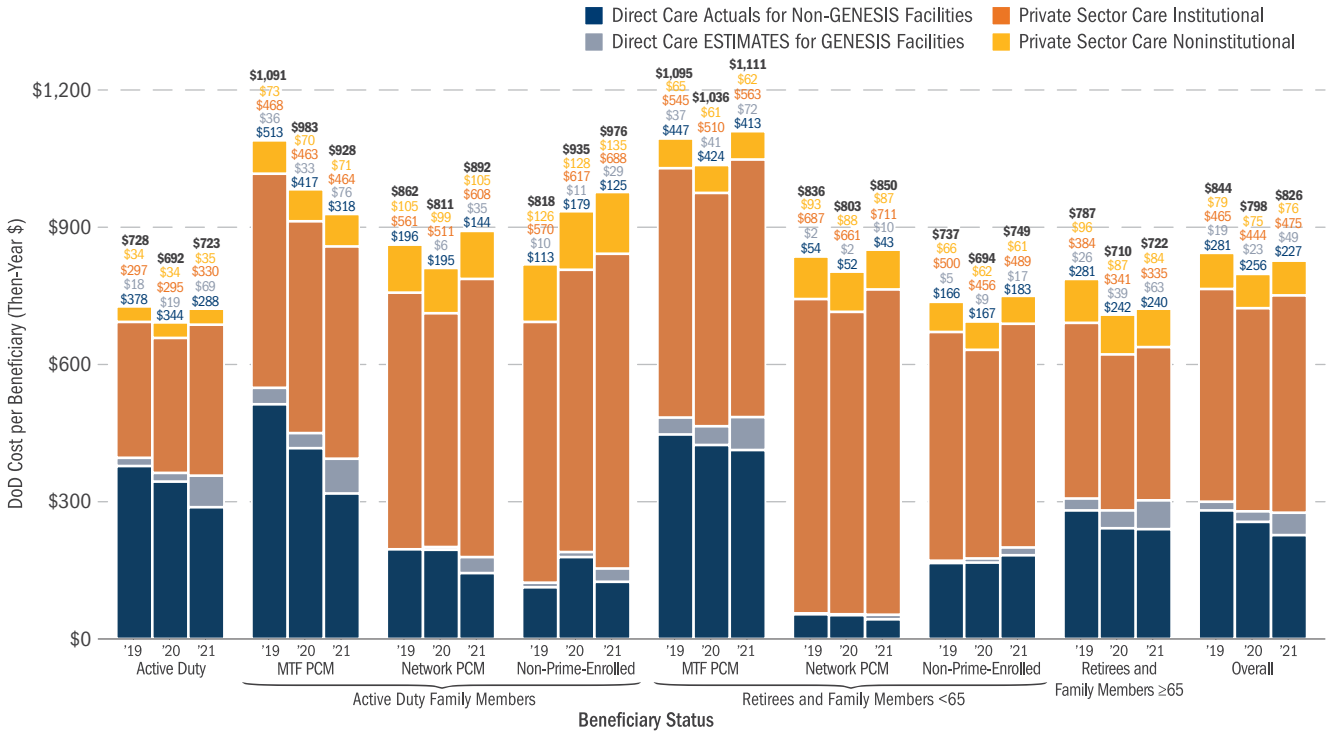
INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Inpatient Cost by Beneficiary Status (U.S. Only)

Total DoD expenditures include actual direct care expenditures at non-GENESIS facilities, estimated expenditures at GENESIS facilities, and private sector care costs. 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 2 percent between FY 2019 and FY 2021.

- Most beneficiary groups experienced increases in total (direct plus private sector care) per capita inpatient costs, with the largest being for non-Prime-enrolled ADFMs (19 percent). ADFMs with a network PCM and RETFMs under age 65 (regardless of enrollment status) experienced only modest increases, ranging from 1 to 4 percent. Two beneficiary groups experienced large declines—ADFMs with an MTF PCM (15 percent) and RETFMs age 65 and older (8 percent)—while Active Duty members experienced a small decline of 1 percent.
- Direct care inpatient costs per capita decreased by 8 percent between FY 2019 and FY 2021. Private sector 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 $15,205 in FY 2019 to $16,092 in FY 2021 (6 percent).
- Exclusive of TFL, DoD private sector care cost (institutional plus noninstitutional) per RWP in acute care facilities increased from $8,329 in FY 2019 to $9,547 in FY 2021 (15 percent).
- The DoD private sector 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 from $9,838 in FY 2019 to $10,400 (6 percent) in FY 2021, exclusive of TFL.

AVERAGE ANNUAL DoD INPATIENT COSTS PER BENEFICIARY, FYs 2019–2021



Source: MHS administrative data, 1/24/2022

Notes:

– The reader should exercise caution when comparing the direct versus private sector 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.

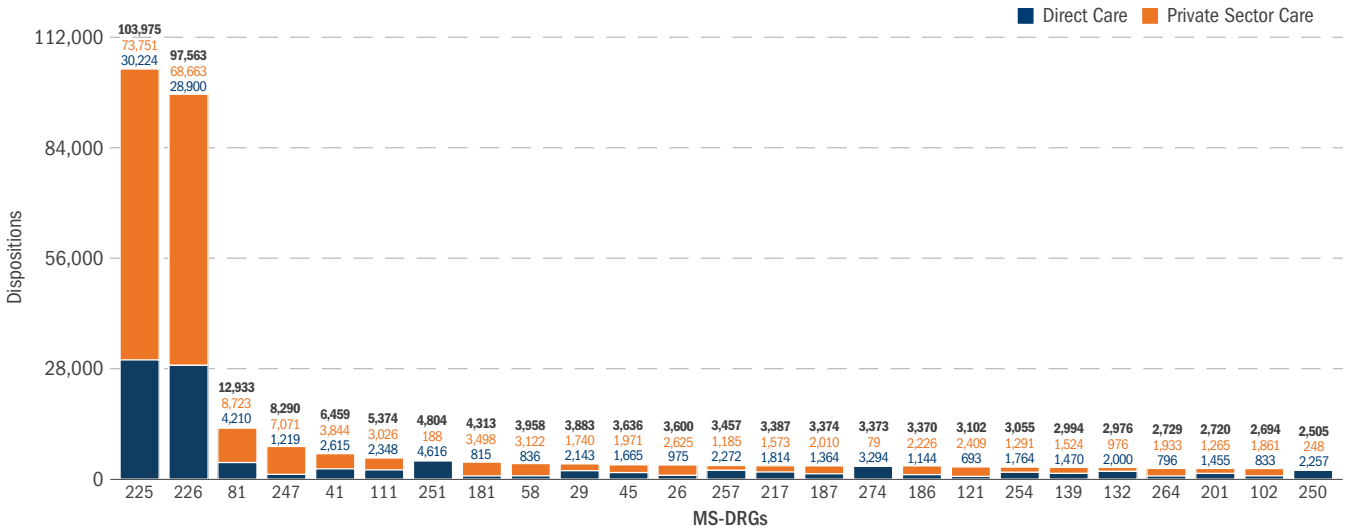
INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

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 DRGs on the horizontal axes in the charts below. See the Appendix for additional detail on the DRG grouping methodology.

The top 25 MS-DRGs in terms of volume in FY 2021 accounted for 70 percent of all inpatient admissions (direct care and private sector care combined) in acute care hospitals. TFL admissions and observation stays are excluded from the calculations.

LEADING INPATIENT DIAGNOSIS GROUPS BY VOLUME, FY 2021



MS-DRGs

- 26 Major Small and Large Bowel Procedures
- 29 Appendectomy
- 41 Esophagitis, Gastroenteritis, and Miscellaneous Digestive Disorders
- 45 Cholecystectomy
- 58 Seizures and Headaches
- 81 Respiratory Infections and Inflammations
- 102 Disorders of Pancreas Except Malignancy
- 111 Major Joint Replacement or Reattachment of Lower Extremity
- 121 Percutaneous Cardiovascular Procedures with Coronary Artery Stent
- 132 Heart Failure and Shock
- 139 Cardiac Arrhythmia and Conduction Disorders
- 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
- 247 Septicemia or Severe Sepsis
- 250 Depressive Neuroses
- 251 Neuroses Except Depressive
- 254 Psychoses
- 257 Alcohol/Drug Abuse or Dependence
- 264 Poisoning and Toxic Effects of Drugs
- 274 Other Factors Influencing Health Status

- The top two procedures by volume are related to childbirth, accounting for 47 percent of all hospital admissions (not just among the top 25).
- Procedures performed in private-sector acute care hospitals account for 66 percent of the total volume of the top 25 MS-DRGs.
- Admissions in direct care facilities exceed those in private sector care facilities for only nine of the top 25 MS-DRGs.
- Surgical procedures for obesity ranks 8th in volume among the top 25 MS-DRGs. Thus, the obesity epidemic in the civilian sector (as per the Centers for Disease Control and Prevention [CDC]) appears to be mirrored to an extent in the DoD population as well.

Source: MHS administrative data, 1/24/2022

[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 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)

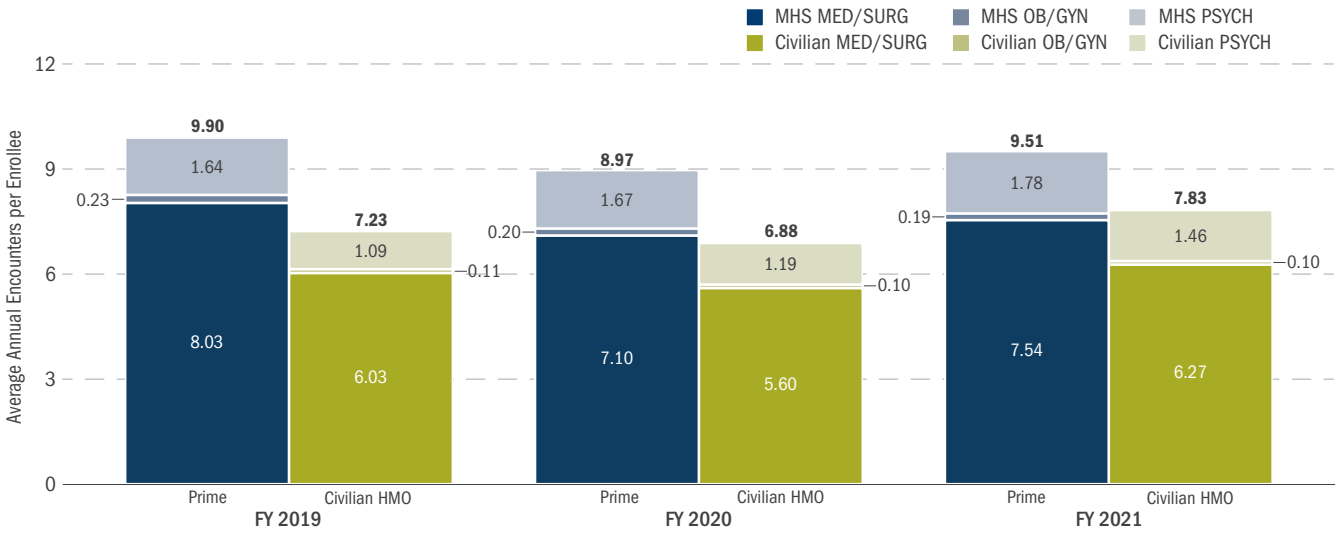
TRICARE Prime Enrollees

This section compares the outpatient utilization of TRICARE Prime enrollees (including TYA Prime but excluding the USFHP) 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 differing 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. 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 private sector care combined) decreased by 4 percent between FY 2019 and FY 2021. The civilian HMO outpatient utilization rate increased by 8 percent over the same period.
- In FY 2021, the overall Prime outpatient utilization rate was 21 percent higher than the civilian HMO rate.
- In FY 2021, the Prime outpatient utilization rate for MED/SURG procedures was 20 percent higher than the civilian HMO rate.
- The Prime outpatient utilization rate for OB/GYN procedures fell by 17 percent between FY 2019 and FY 2021 (albeit from a low base rate) but still remained 90 percent higher than for civilian HMOs in FY 2021. 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 22 percent higher than the corresponding rate for civilian HMOs in FY 2021. This disparity, though based on relatively low MHS and civilian mental health utilization rates, may reflect the more stressful environment that many Active Duty Service members (ADSMs) and their families endure.

OUTPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK, FYs 2019–2021



Sources: MHS administrative data, 1/28/2022, and IBM Watson Health, MarketScan® CCAE database, 2/8/2022

[1] Outpatient encounters are not precisely comparable between the direct and private care sectors (including private sector 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.

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2021 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.)*

TRICARE Outpatient Utilization Rates Compared with Civilian Benchmarks (U.S. Only) *(cont.)*

Non-Prime-Enrolled Beneficiaries

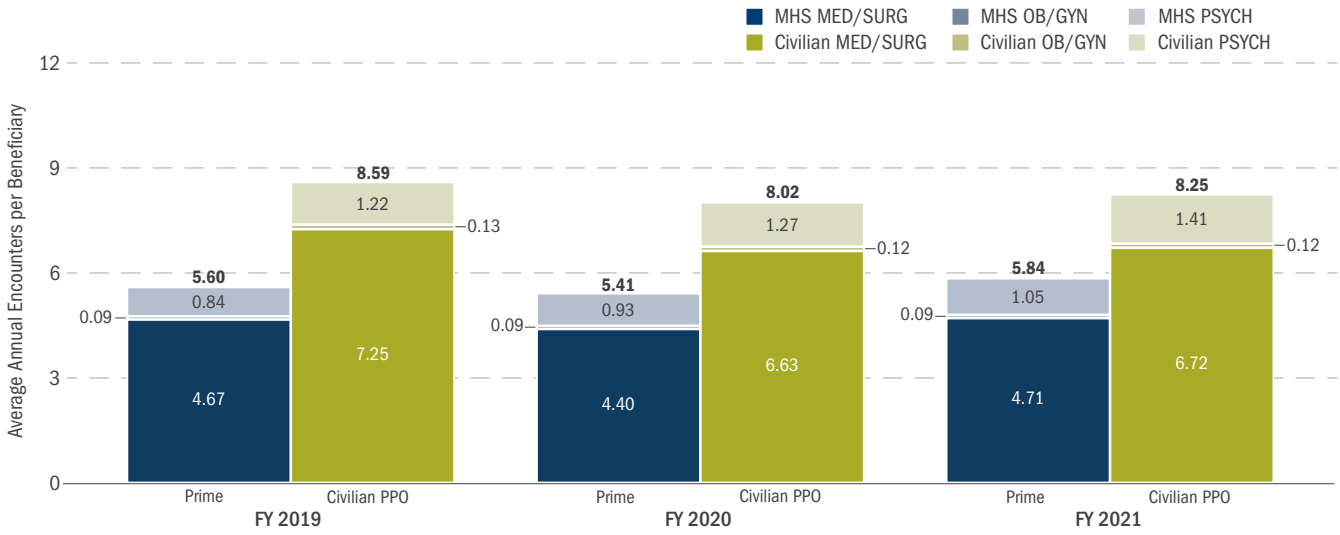
This section compares the outpatient utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored PPO plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. Outpatient utilization is measured 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 differing 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 private sector care combined) for non-Prime-enrolled beneficiaries increased by 4 percent between FY 2019 and FY 2021. The civilian PPO outpatient utilization rate decreased by 4 percent over the same period.
- The overall TRICARE non-Prime outpatient utilization rate remained well below the level observed for civilian PPOs. In FY 2021, TRICARE non-Prime outpatient utilization was 29 percent lower than in civilian PPOs.
- In FY 2021, the non-Prime outpatient utilization rate for MED/SURG procedures was 30 percent lower than the civilian PPO rate. MED/SURG procedures account for roughly 80 percent of total outpatient utilization in both the military and civilian sectors.
- The non-Prime outpatient utilization rate for OB/GYN procedures remained the same between FY 2019 and FY 2021 and was 24 percent below the rate for civilian PPO participants in FY 2021.
- The PSYCH outpatient utilization rate for non-Prime-enrolled MHS beneficiaries increased by 24 percent from FY 2019 to FY 2021; the rate increased by 16 percent for civilian PPO participants. In FY 2021, the PSYCH outpatient utilization rate for non-Prime-enrolled beneficiaries was 26 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 2019–2021



Sources: MHS administrative data, 1/28/2022, and IBM Watson Health, MarketScan® CCAE database, 2/8/2022

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2021 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.

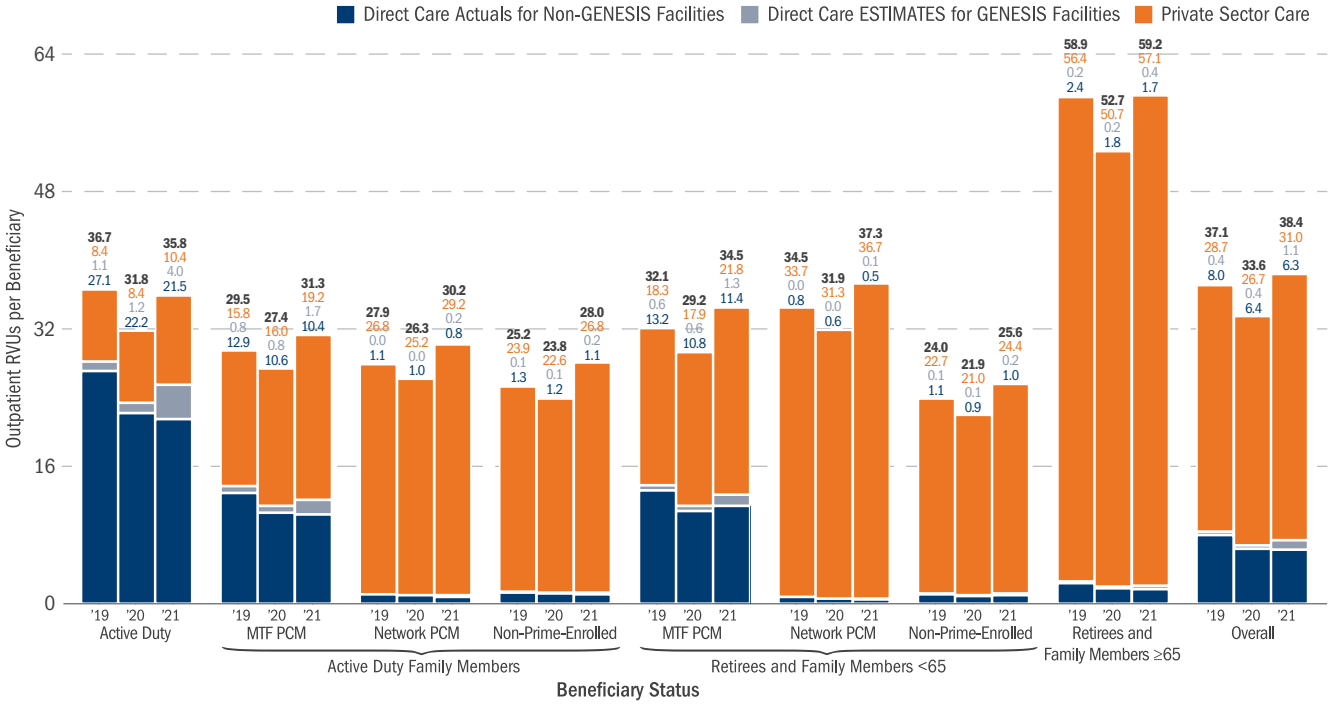
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

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). Note that direct care RVUs at non-GENESIS facilities are actuals, whereas RVUs at GENESIS facilities are estimates.

- Total per capita MHS utilization (direct plus private sector care) increased by 3 percent from FY 2019 to FY 2021.
- Overall direct care outpatient utilization decreased by 12 percent from FY 2019 to FY 2021. Declines were experienced by every beneficiary group, ranging from 2 percent for non-Prime-enrolled RETFMs under age 65 to 24 percent for RETFMs under age 65 with a network PCM.
- From FY 2019 to FY 2021, private sector care outpatient utilization increased by 8 percent overall. Increases were experienced by every beneficiary group, ranging from 1 percent for RETFMs age 65 and older to 23 percent for Active Duty members.

AVERAGE ANNUAL OUTPATIENT RVUs PER BENEFICIARY, FYs 2019–2021



Source: MHS administrative data, 1/28/2022

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.

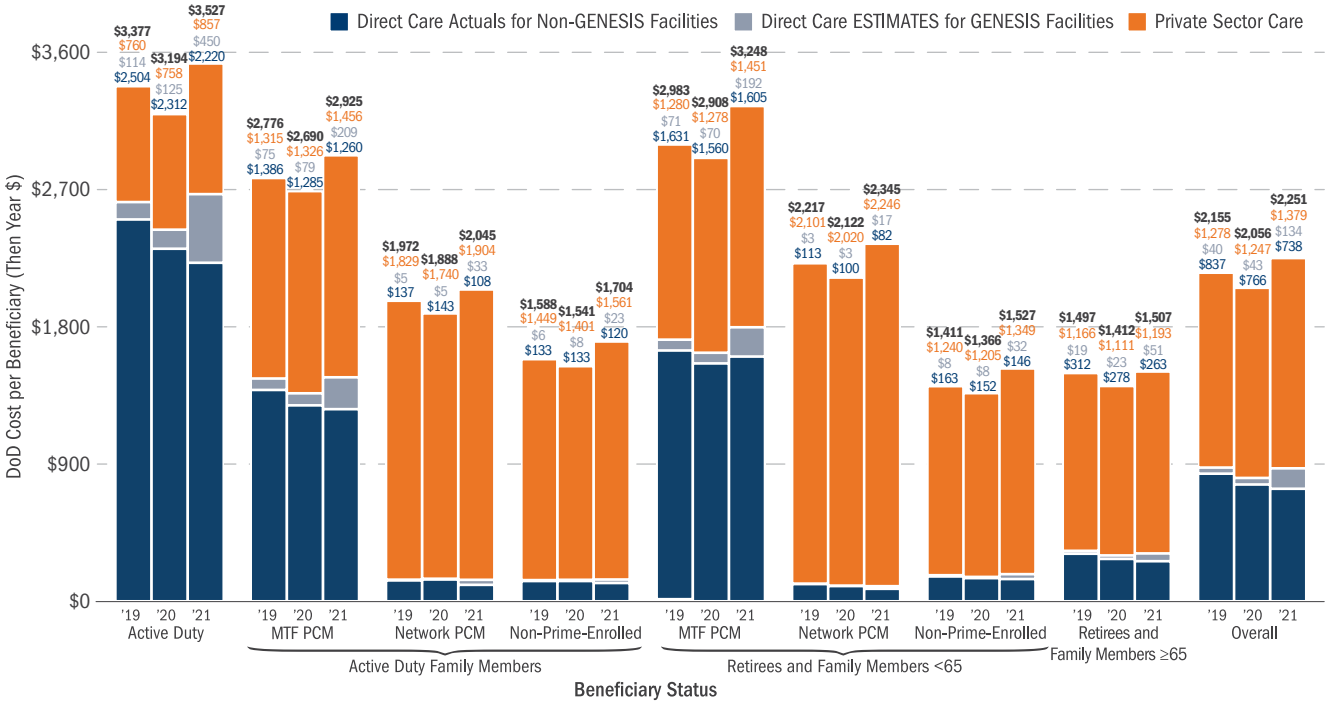
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Outpatient Costs by Beneficiary Status (U.S. Only)

Total DoD expenditures include actual direct care expenditures at non-GENESIS facilities, estimated expenditures at GENESIS facilities, and private sector care costs. Overall MHS outpatient costs (in then-year dollars) per beneficiary (far-right columns below), including TFL, increased by 4 percent from FY 2019 to FY 2021. This was only slightly more than the corresponding increase in overall outpatient utilization (3 percent).

- The direct care cost per beneficiary decreased by 1 percent overall from FY 2019 to FY 2021. Most beneficiary groups experienced increases in cost ranging from 1 percent for ADFMs with an MTF PCM to 6 percent for RETFMs under age 65 with an MTF PCM. However, a large decrease (14 percent) for RETFMs under age 65 with a network PCM drove the overall rate down.
- Excluding TFL, the per capita DoD private sector care outpatient cost increased by 10 percent overall. Every beneficiary group except those with a network PCM (decreases of 1 percent for ADFMs and 2 percent for RETFMs under age 65) experienced an increase. Increases ranged from 1 percent for non-Prime-enrolled RETFMs under age 65 to 13 percent for ADFMs with an MTF PCM.
- The TFL (private sector care) outpatient cost per beneficiary increased by 2 percent between FY 2019 and FY 2021.[1]

AVERAGE ANNUAL DoD OUTPATIENT COSTS PER BENEFICIARY, FYs 2019–2021



Source: MHS administrative data, 1/28/2022

[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.

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.

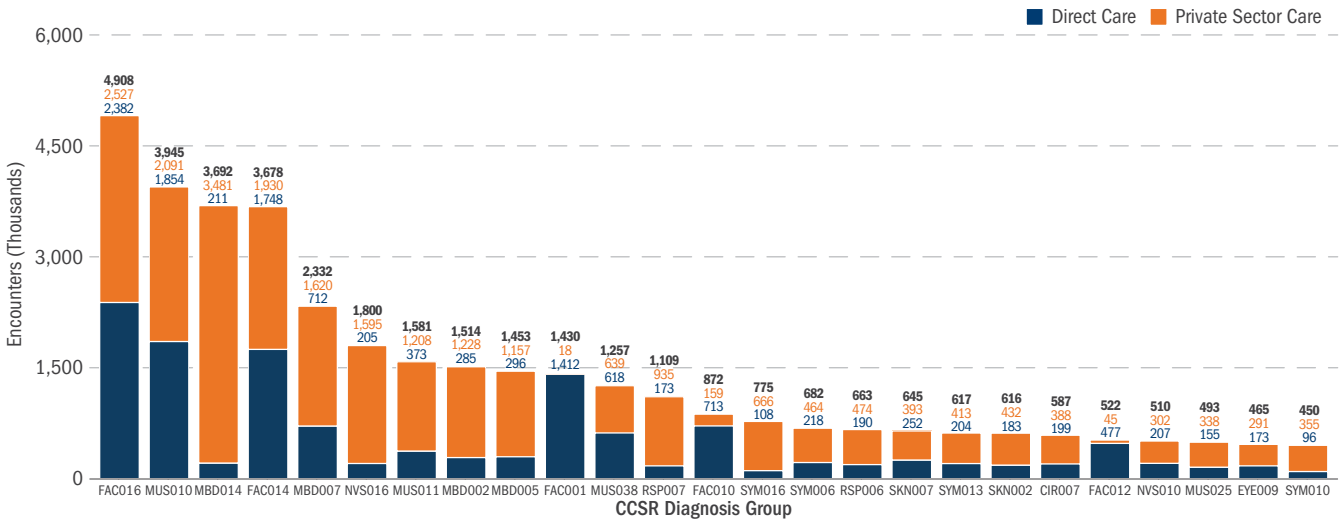
LOWER COST

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 Refined (CCSR) tool developed through a federal-state-industry partnership sponsored by the Agency for Healthcare Research and Quality (AHRQ). The CCSR replaces the Clinical Classifications Software tool and takes advantage of the specificity of ICD-10-CM diagnoses to create new clinical categories. The top 25 outpatient diagnosis groups in FY 2021 accounted for 64 percent of all outpatient encounters (direct care and private sector care combined). TFL encounters and telephone consults are excluded from the calculations.

LEADING OUTPATIENT DIAGNOSIS GROUPS BY VOLUME, FY 2021



CCSR Diagnosis Groups

CIR007	Essential Hypertension
EYE009	Refractive Error
FAC001	Encounter for Administrative Purposes
FAC010	Other Aftercare Encounter
FAC012	Other Specified Encounters and Counseling
FAC014	Medical Examination/Evaluation
FAC016	Exposure, Encounters, Screening or Contact with Infectious Disease
MBD002	Depressive Disorders
MBD005	Anxiety and Fear-Related Disorders
MBD007	Trauma- and Stressor-Related Disorders
MBD014	Neurodevelopmental Disorders
MUS010	Musculoskeletal Pain, Not Low Back Pain
MUS011	Spondylopathies/Spondyloarthropathy (Including Infective)
MUS025	Other Specified Connective Tissue Disease
MUS038	Low Back Pain
NVS010	Headache; Including Migraine
NVS016	Sleep Wake Disorders
RSP006	Other Specified Upper Respiratory Infections
RSP007	Other Specified and Unspecified Upper Respiratory Disease
SKN002	Other Specified Inflammatory Condition of Skin
SKN007	Other Specified and Unspecified Skin Disorders
SYM006	Abdominal Pain and Other Digestive/Abdomen Signs and Symptoms
SYM010	Nervous System Signs and Symptoms
SYM013	Respiratory Signs and Symptoms
SYM016	Other General Signs and Symptoms

- The top diagnosis group in terms of volume is FAC016: exposure, encounters, screening, or contact with infectious disease. Contact with or exposure to COVID-19 accounts for a quarter of diagnoses in this category. Negative or unknown test results for COVID-19 are included in CCSR category FAC016 but cannot be separately identified.
- Positive test results are included in a CCSR category of its own (INF012), but it is not one of the top 25 in terms of volume.
- Diagnoses treated in private sector care facilities account for 63 percent of the total volume of the top 25 diagnosis groups.
- Encounters in direct care facilities exceed those in private sector care facilities for only three of the 25 top diagnosis groups.

Source: MHS administrative data, 1/24/2022
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 copayment purposes. Prescription counts from all sources (including civilian) were normalized by dividing the total days' supply for each by 30 days.

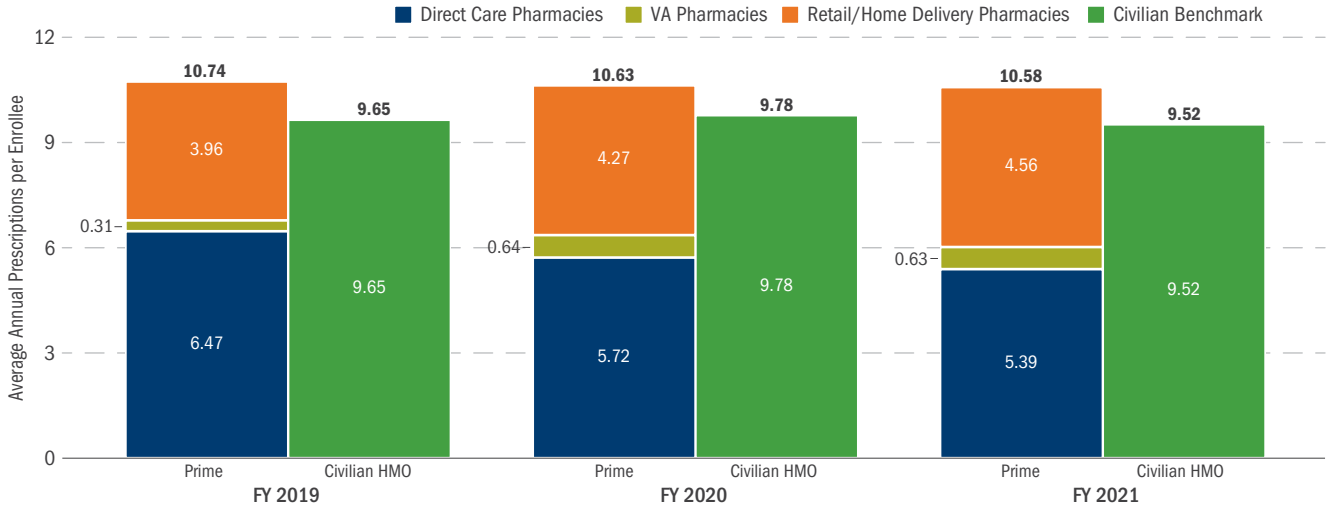
Direct care pharmacy data differ from private-sector claims in that they include over-the-counter medications. To make the utilization rates of MHS and civilian beneficiaries more comparable, over-the-counter medications were backed out of the direct care data using factors provided by the DHA Pharmacy Operations Division.

TRICARE Prime Enrollees

This section compares the outpatient prescription drug utilization of TRICARE Prime enrollees (including TYA Prime but excluding the USFHP) 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.

- The overall prescription utilization rate (direct care, VA, and private sector care combined) for TRICARE Prime enrollees decreased by 2 percent between FY 2019 and FY 2021, while the civilian HMO benchmark rate decreased by 1 percent. In FY 2021, the TRICARE Prime prescription utilization rate was 11 percent higher than the civilian HMO rate.
- Prescription utilization rates for Prime enrollees at DoD pharmacies decreased by 17 percent between FY 2019 and FY 2021, whereas the utilization rate at private sector care pharmacies increased by 15 percent.
- Although the number of prescriptions is small, prescription utilization rates for Prime enrollees at VA pharmacies doubled between FY 2019 and FY 2021.
- The overall private sector care share of prescription utilization for Prime enrollees increased from 40 percent in FY 2019 to 49 percent in FY 2021.

PRESCRIPTION UTILIZATION RATES BY SOURCE OF CARE[a]:
TRICARE PRIME VS. CIVILIAN HMO BENCHMARK, FYs 2019–2021



Sources: MHS administrative data, 1/28/2022, and IBM Watson Health, MarketScan® CCAE database, 2/8/2022

[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 2021 civilian benchmarks are based on two quarters of data, which were seasonally adjusted and annualized.

LOWER COST

PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT.)*

TRICARE Prescription Drug Utilization Rates Compared with Civilian Benchmarks (U.S. Only) *(cont.)*

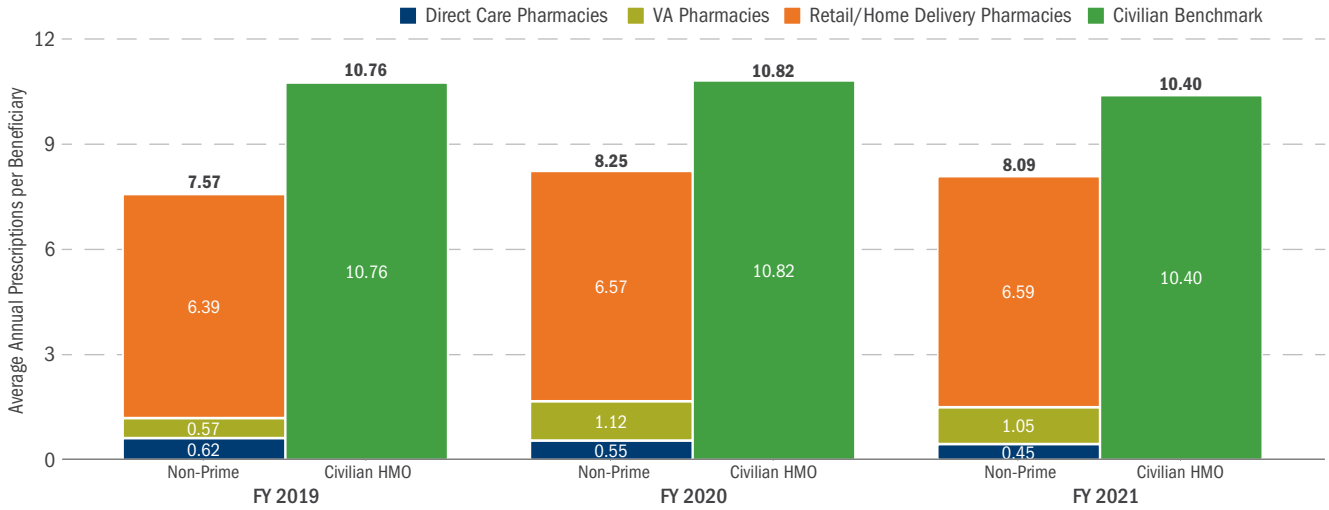
Non-Prime-Enrolled Beneficiaries

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 private sector care combined) for non-Prime-enrolled beneficiaries increased by 7 percent between FY 2019 and FY 2021. During the same period, the civilian PPO benchmark rate decreased by 3 percent. In FY 2021, the TRICARE prescription utilization rate for non-Prime enrollees was 22 percent lower than the civilian PPO rate.
- The direct care prescription utilization rate for non-Prime-enrolled beneficiaries decreased by 28 percent from FY 2019 to FY 2021, whereas the utilization rate at private sector care pharmacies increased by 3 percent.
- Prescription utilization rates for non-Prime enrollees at VA pharmacies increased by 84 percent between FY 2019 and FY 2021.
- The overall private sector care share of prescription utilization for non-Prime enrollees increased from 92 percent in FY 2019 to 94 percent in FY 2021.

PRESCRIPTION UTILIZATION RATES BY SOURCE OF CARE[a]: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK, FYs 2019–2021



Sources: MHS administrative data, 1/28/2022, and IBM Watson Health, MarketScan® CCAE database, 2/8/2022

[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 2021 civilian benchmarks are based on two quarters of data, which were seasonally adjusted and annualized.

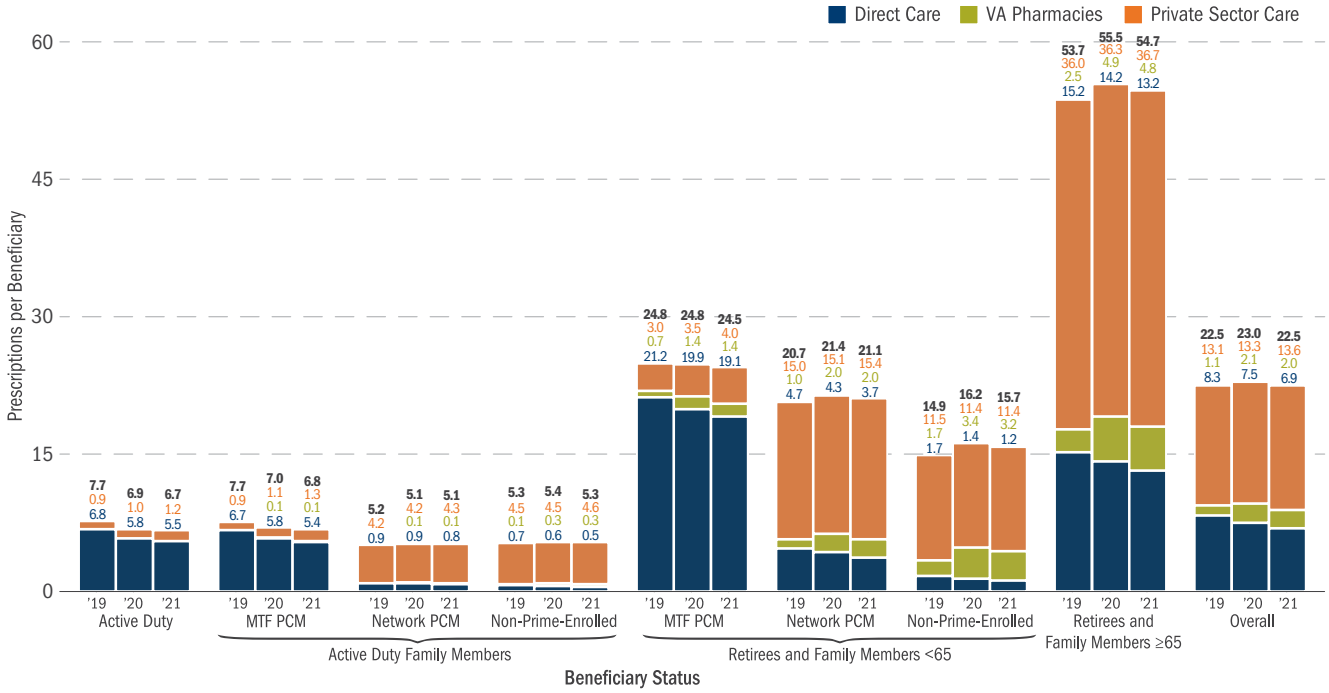
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT.)*

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 3 percent from FY 2019 to FY 2021, exclusive of the TFL benefit. Including TFL, the total number of prescriptions remained about the same.
- The overall direct care prescription utilization rate declined by 17 percent between FY 2019 and FY 2021. Declines were experienced by all beneficiary groups, ranging from 10 percent for RETFMs under age 65 with an MTF PCM to 31 percent for non-Prime-enrolled ADFMs.
- Average per capita VA pharmacy prescription utilization increased by 93 percent from FY 2019 to FY 2021.
- Overall per capita prescription utilization through private sector care pharmacies increased by 4 percent between FY 2019 and FY 2021.
- Increases occurred for every beneficiary group except non-Prime-enrolled RETFMs under age 65 (1 percent decline), ranging from 1 percent for non-Prime-enrolled ADFMs to 40 percent for ADFMs with an MTF PCM (albeit from a low base rate).

AVERAGE ANNUAL PRESCRIPTION UTILIZATION PER BENEFICIARY, FYs 2019–2021



Source: MHS administrative data, 1/28/2022

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

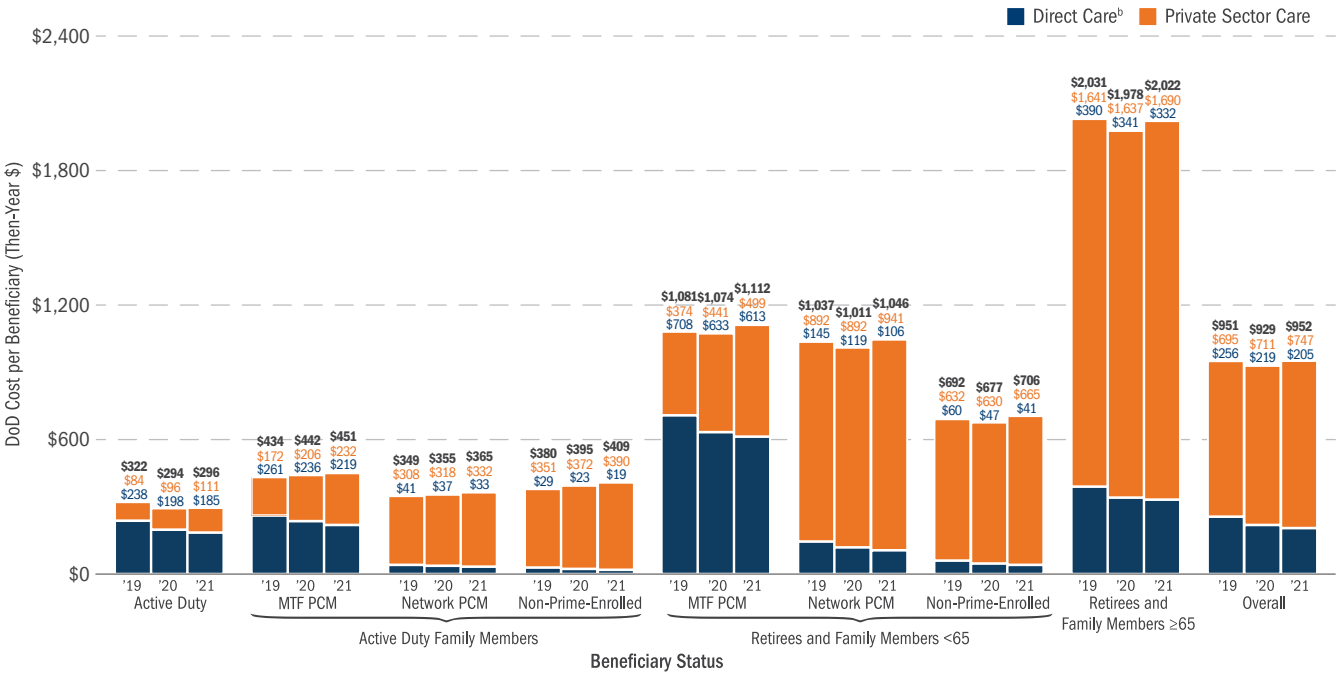
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT.)*

Prescription Drug Cost by Beneficiary Status

Although the drug refunds referenced on page 53 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, remained about the same between FY 2019 and FY 2021. 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, overall per capita prescription drug costs remained about the same between FY 2019 and FY 2021.
- Only Active Duty members and RETFMs 65 and older experienced declines in overall per capita prescription drug costs (8 percent and less than 1 percent, respectively). The remaining beneficiary groups experienced modest increases in overall per capita prescription drug costs, ranging from 1 percent for RETFMs under age 65 with a network PCM to 8 percent for non-Prime-enrolled ADFMs.
- Overall direct care costs per beneficiary decreased by 20 percent, while private sector care pharmacy costs increased by 13 percent excluding TFL and by 8 percent including TFL.

AVERAGE ANNUAL DoD PRESCRIPTION COSTS PER BENEFICIARY, FYs 2019–2021[a]



Source: MHS administrative data, 1/28/2022

[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 PLAN 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 private 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.

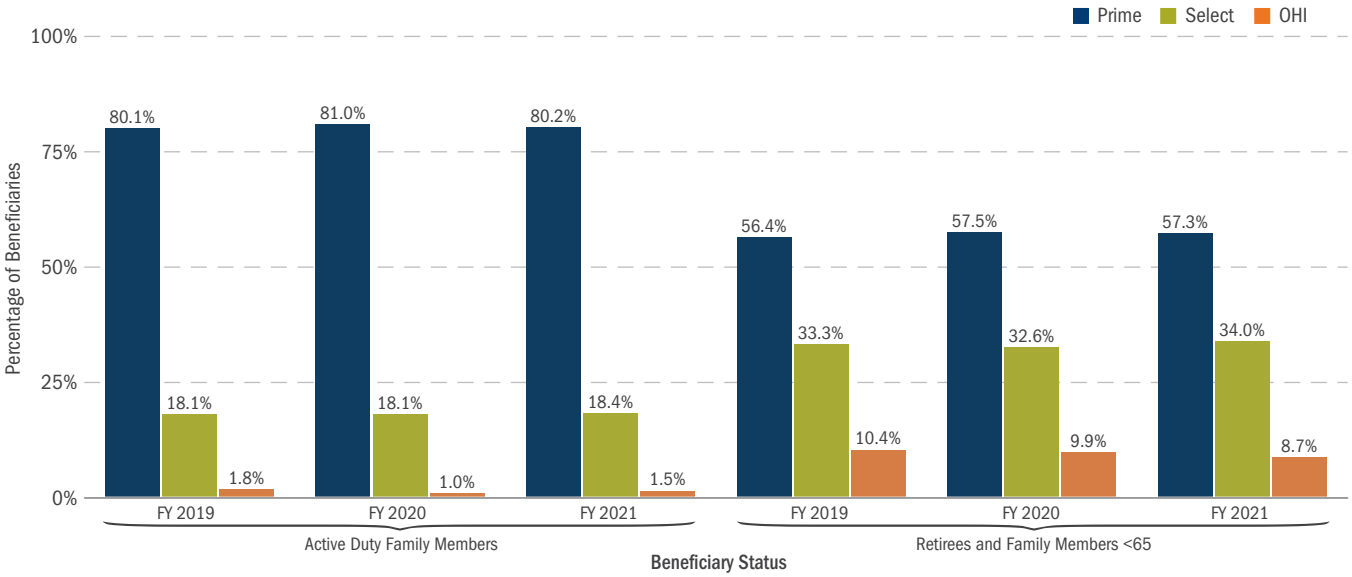
Health Plan Coverage of MHS Beneficiaries Under Age 65

MHS beneficiaries have a choice of (1) TRICARE Prime, including TYA Prime and USFHP; (2) TRICARE Select, including TYA Select, TRICARE Reserve Select (TRS), and TRICARE Retired Reserve (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 2021, 80 percent of Active Duty families and 57 percent of retiree families were in this group.
- **TRICARE Select:** Family enrolled in TRICARE Select or relying on space-available MTF care in FYs 2019–2021 and who do not have OHI coverage. In FY 2021, 18 percent of Active Duty families and 34 percent of retiree families were in this group.
- **OHI:** Family covered by OHI. In FY 2021, 2 percent of Active Duty families and 9 percent of retiree families were in this group.

HEALTH PLAN COVERAGE OF BENEFICIARIES UNDER AGE 65, FYs 2019–2021



Source: TRICARE and OHI coverage in FYs 2019–2021 based on Defense Enrollment Eligibility Reporting System (DEERS) and Health Care Survey of DoD Beneficiaries (HCSDB) responses; as of 12/31/2021

Notes:

– The Prime group includes HCSDB respondents enrolled in Prime based on DEERS plus enrollees in the USFHP. The Select group includes HCSDB respondents without OHI who are enrolled in a Select plan based on DEERS. The OHI group includes HCSDB respondents with private health insurance (e.g., the Federal Employees Health Benefits [FEHB] Program, 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.

– Numbers for FYs 2019 and 2020 may differ slightly from prior reports. FYs 2020 and 2021 HCSDB data showed a higher sampling of Inactive Guard/Reserve family members by nearly a factor of 10 compared with previous years. To account for this discrepancy, we excluded Inactive Guard/Reserve family members for all years to avoid biasing the calculations.

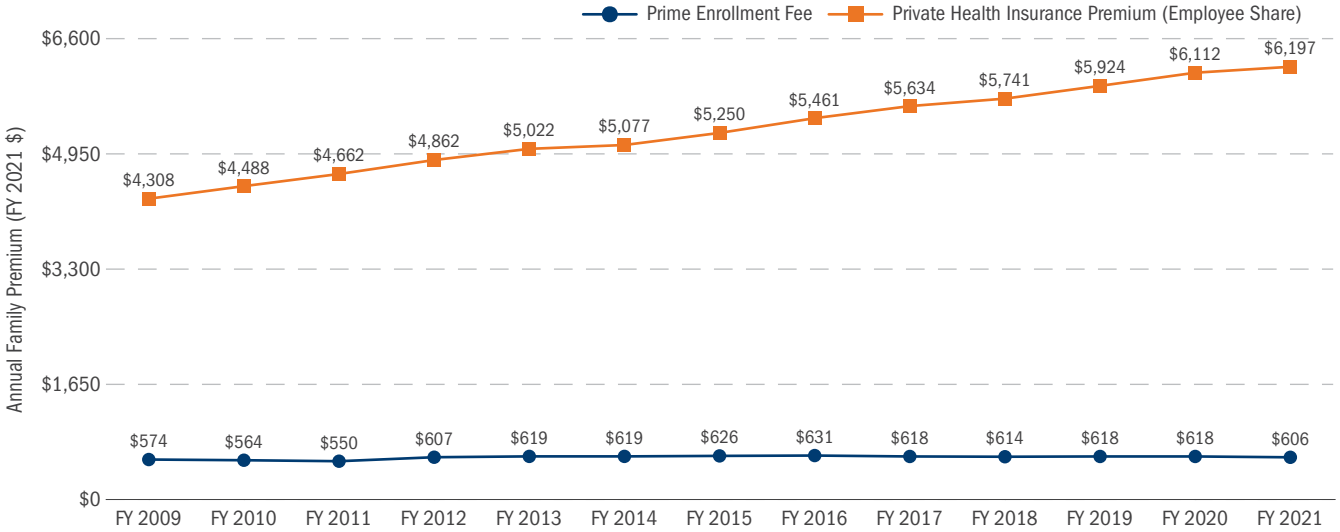
– Percentages may not sum to 100 percent due to rounding.

BENEFICIARY FAMILY HEALTH PLAN COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Retirees and Family Members Under Age 65 Returning to the MHS

From FY 2009 to FY 2021, the average private health insurance family premium increased, whereas the TRICARE Prime enrollment fee remained essentially flat. In FY 2021 dollars, private health insurance premiums increased by $1,889 (44 percent) over this period, whereas the TRICARE Prime enrollment fee increased by only $32 (6 percent).

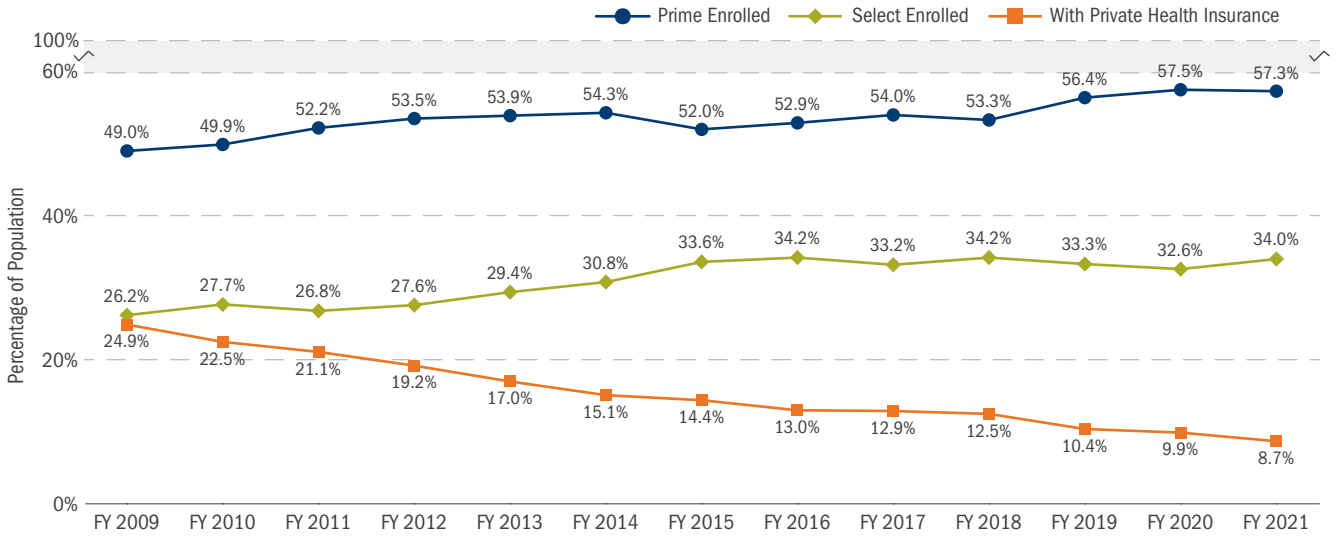
TRENDS IN PRIVATE INSURANCE PREMIUMS VS. TRICARE PRIME ENROLLMENT FEE, FYs 2009–2021



Sources: The employee share of insurance premiums for a typical employer-sponsored family health plan in FYs 2009–2021 from the Insurance Component of the Medical Expenditure Panel Survey (MEPS) 2006–2020; OHI premiums in FY 2021 projected by the Institute for Defense Analyses (IDA) based on the average growth rate of premiums in FYs 2015–2020. Data from the Kaiser Family Foundation (KFF) is used to account for pandemic-related changes to health care spending. KFF found that on average, spending remains 7.1 percent below the pre-pandemic trend. IDA used KFF's data to construct monthly growth rates to adjust spending. https://www.healthsystemtracker.org/brief/early-2021-data-show-no-rebound-in-health-care-utilization/ as of 1/31/2022.

Between FY 2011 and FY 2021, 12 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 PLAN COVERAGE, FYs 2009–2021



Source: TRICARE and private health insurance coverage in FYs 2009–2021 based on DEERS and HCSDB responses in FYs 2009–2021; as of 12/31/2021

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.

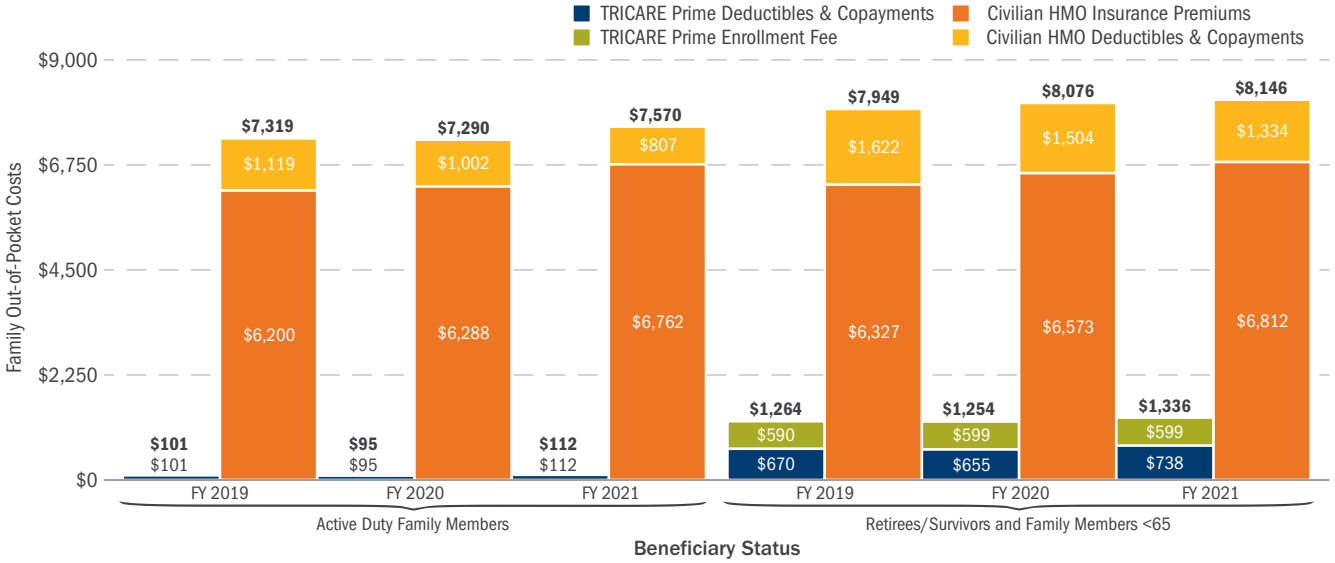
BENEFICIARY FAMILY HEALTH PLAN COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Out-of-Pocket Costs for Families Enrolled in TRICARE Prime vs. Civilian HMO Counterparts

In FYs 2019–2021, civilian counterpart families enrolled in HMO plans had substantially higher out-of-pocket costs than TRICARE Prime enrollees.

- Civilian HMO counterparts paid more for insurance premiums, deductibles, and copayments.
- In FY 2021, costs for civilian HMO counterparts were:
  - $7,400 more than those incurred by Active Duty families enrolled in Prime
  - $6,800 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 2019–2021



Sources: TRICARE beneficiary expenditures for deductibles and copayments in FYs 2019–2021 from MHS administrative data for all families enrolled in Prime without OHI payments, 12/31/2021; civilian benchmark expenditures for deductibles and copayments from IBM Watson Health, MarketScan® CCAE database, 1/31/2022; civilian benchmark insurance premiums from the Insurance Component of the MEPS (projected from FY 2018 data), 12/31/2021

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.

– The Peterson Center on Healthcare and Kaiser Family Foundation's Health System Tracker has published estimates of the impacts to spending and utilization during the COVID-19 pandemic. They estimate that health services spending since the pandemic has remained 7.1 percent below the pre-pandemic trend. As the data used to calculate civilian comparisons has a lag time to publication, IDA uses the Peterson/Kaiser Family Foundation report to adjust civilian estimates of spending and utilization to account for the impacts of the COVID pandemic. https://www.healthsystemtracker.org/brief/early-2021-data-show-no-rebound-in-health-care-utilization/

– MarketScan data cover a full four quarters in FYs 2019 and 2020. Only two quarters of data were available for FY 2021. The remaining quarters were projected with year-on-year quarterly estimates from the Peterson/Kaiser Family Foundation report.

– 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).

– Currently, there is no cost information for MHS GENESIS records. While direct care cost shares are relatively uncommon, this will slightly underestimate out-of-pocket costs particularly as more sites deploy the new EHR.

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

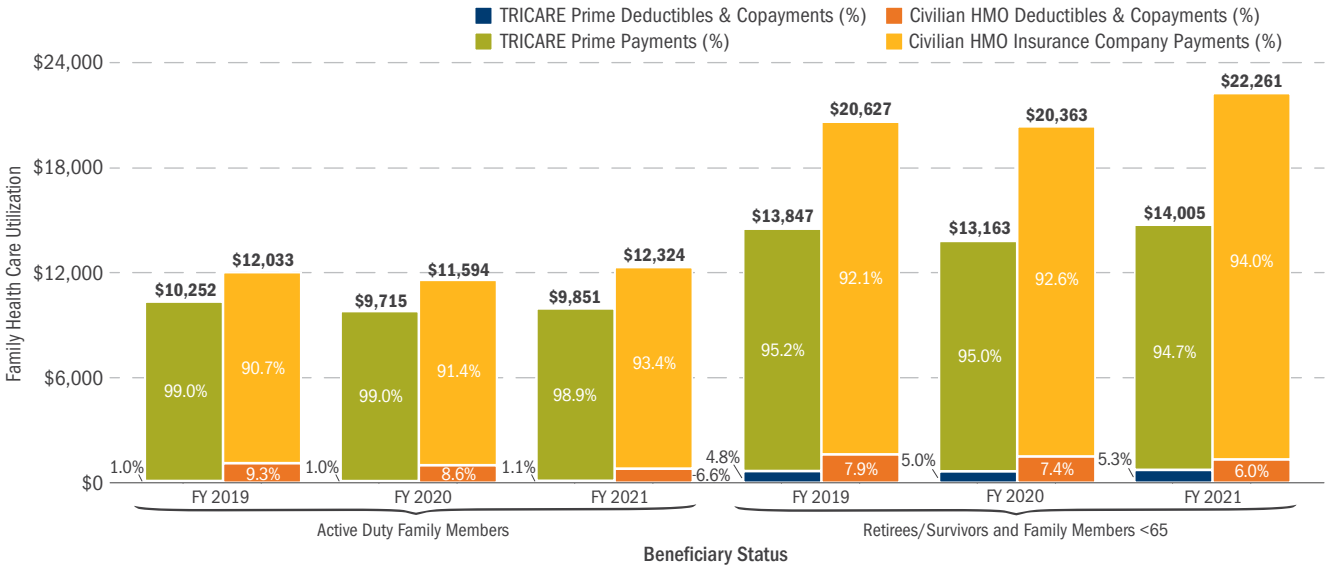
BENEFICIARY FAMILY HEALTH PLAN COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Coinsurance and Health Care Utilization for Families Enrolled in TRICARE Prime vs. Civilian HMO Counterparts

In FYs 2019–2021, TRICARE Prime enrollees had lower coinsurance rates (deductibles and copayments per dollar of utilization) and less utilization than their civilian HMO counterparts.

- In FYs 2019–2021, TRICARE Prime enrollees had coinsurance rates that were 1 to 5 percentage points below those of their civilian HMO counterparts.
  - In FY 2021, the coinsurance rate for Active Duty families was 1 percent—6 percentage points lower than civilian HMO counterparts (7 percent).
  - In FY 2021, the coinsurance rate for retiree families was 5 percent—1 percentage point lower than civilian HMO counterparts (6 percent).
- In FYs 2019–2021, TRICARE Prime enrollees had lower health care utilization than their civilian HMO counterparts.
  - In FY 2021, Active Duty families consumed $9,900 of medical services—$2,400 less than civilian HMO counterparts ($12,300).
  - In FY 2021, retiree families consumed $14,000 in medical services—$8,300 less than civilian HMO counterparts ($22,300).

COINSURANCE AND HEALTH CARE UTILIZATION FOR FAMILIES ENROLLED IN TRICARE PRIME VS. CIVILIAN HMO COUNTERPARTS, FYs 2019–2021



Sources: TRICARE health care utilization expenditures by both the government and beneficiaries in FYs 2019–2021 from MHS administrative data for all families enrolled in Prime without OHI payments for TRICARE utilization, 12/31/2021; civilian insurance company and beneficiary benchmark expenditures from IBM Watson Health, MarketScan® CCAE database, 1/31/2022

Notes:

– The Peterson Center on Healthcare and Kaiser Family Foundation's Health System Tracker has published estimates of the impacts to spending and utilization during the COVID-19 pandemic. They estimate that health services spending since the pandemic has remained 7.1 percent below the pre-pandemic trend. As the data used to calculate civilian comparisons has a lag time to publication, IDA uses the Peterson/Kaiser Family Foundation report to adjust civilian estimates of spending and utilization to account for the impacts of the COVID pandemic. https://www.healthsystemtracker.org/brief/early-2021-data-show-no-rebound-in-health-care-utilization/

– MarketScan data cover a full four quarters in FYs 2019 and 2020. Only two quarters of data were available for FY 2021. The remaining quarters were projected with year-on-year quarterly estimates from the Peterson/Kaiser Family Foundation report.

– 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).

– Currently, there is no cost information for MHS GENESIS records. This will impact both out-of-pocket costs paid by beneficiaries and utilization costs paid by TRICARE.

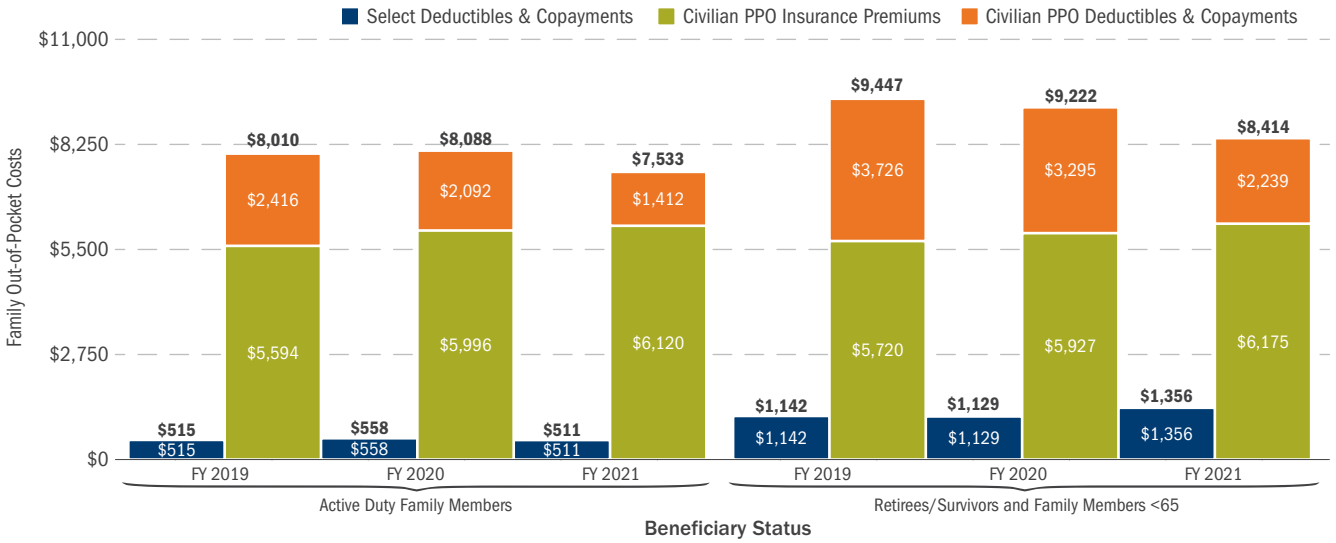
BENEFICIARY FAMILY HEALTH PLAN COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Out-of-Pocket Costs for Families Who Rely on TRICARE Select or Direct Care vs. Civilian PPO Counterparts

In FYs 2019–2021, civilian counterpart families enrolled in PPO plans had much higher out-of-pocket costs than TRICARE Select users.

- In FYs 2019–2021, civilian PPO counterparts paid $7,000 to $8,000 more for insurance premiums, deductibles, and copayments.
- In FY 2021, costs for civilian PPO counterparts were:
  - $7,000 more than those incurred by Active Duty families who relied on TRICARE Select
  - $7,100 more than those incurred by retiree families who relied on TRICARE Select

OUT-OF-POCKET COSTS FOR FAMILIES WHO RELY ON TRICARE SELECT OR DIRECT CARE VS. CIVILIAN PPO COUNTERPARTS, FYs 2019–2021



Sources: TRICARE health care utilization expenditures by both the government and beneficiaries in FYs 2019–2021 from MHS administrative data for all families enrolled in Select without OHI payments for TRICARE utilization, 12/31/2021; civilian insurance company and beneficiary benchmark expenditures from IBM Watson Health, MarketScan® CCAE database, 1/31/2022

Notes:

– The Peterson Center on Healthcare and Kaiser Family Foundation's Health System Tracker has published estimates of the impacts to spending and utilization during the COVID-19 pandemic. They estimate that health services spending since the pandemic has remained 7.1 percent below the pre-pandemic trend. As the data used to calculate civilian comparisons has a lag time to publication, IDA uses the Peterson/Kaiser Family Foundation report to adjust civilian estimates of spending and utilization to account for the impacts of the COVID pandemic. https://www.healthsystemtracker.org/brief/early-2021-data-show-no-rebound-in-health-care-utilization/

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LOWER COST

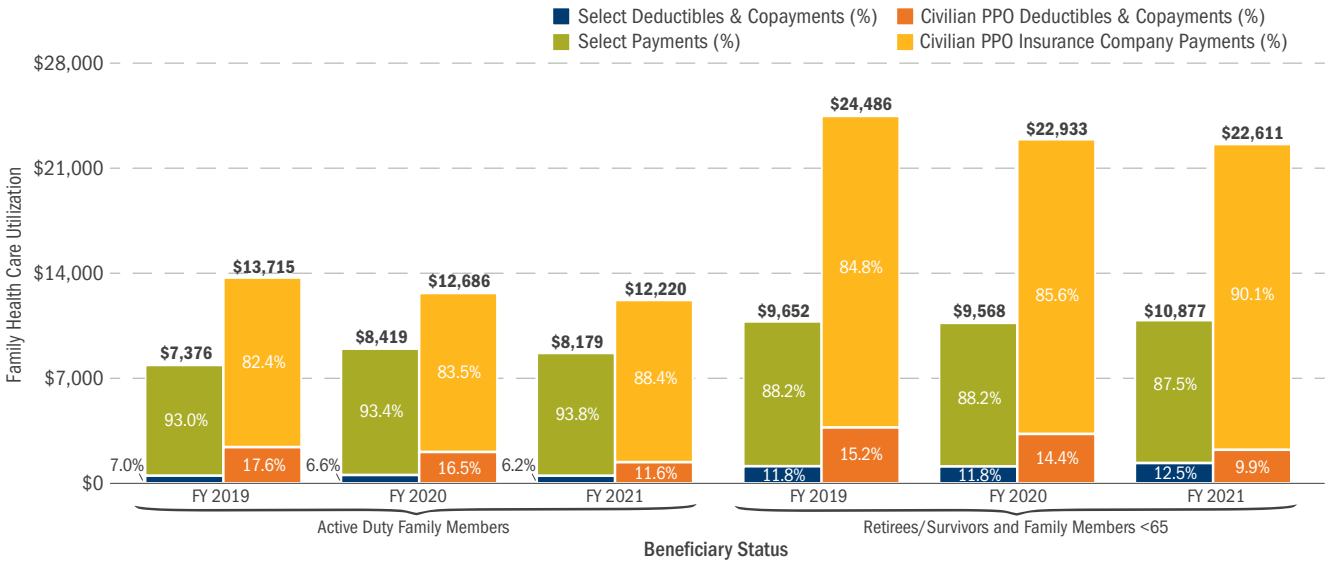
BENEFICIARY FAMILY HEALTH PLAN COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Coinsurance and Health Care Utilization for Families Who Rely on TRICARE Select or Direct Care vs. Civilian PPO Counterparts

Active Duty families who relied on TRICARE Select 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 have seen their coinsurance rates remain relatively stable, while their civilian counterparts have faced rising rates. Retiree families exhibited substantially lower utilization.

- In FY 2021, for Active Duty families:
  - Coinsurance rates were 6 percent versus 12 percent for civilian PPO counterparts (6 percentage points lower).
  - Health care utilization was $8,200 versus $12,200 for civilian PPO counterparts ($4,000 less).
- In FY 2021, for retiree families:
  - Coinsurance rates were 13 percent versus 10 percent for civilian PPO counterparts (3 percentage points higher). This reversal in prior year trends is due to the decline in civilian utilization attributable to the pandemic.
  - Health care utilization was $10,900 versus $22,600 for civilian PPO counterparts ($11,700 less).

COINSURANCE AND HEALTH CARE UTILIZATION FOR FAMILIES WHO RELY ON TRICARE SELECT OR DIRECT CARE VS. CIVILIAN PPO COUNTERPARTS, FYs 2019–2021



Sources: TRICARE health care utilization expenditures by both the government and beneficiaries in FYs 2019–2021 from MHS administrative data for all families enrolled in Select without OHI payments for TRICARE utilization, 12/31/2021; civilian insurance company and beneficiary benchmark expenditures from IBM Watson Health, MarketScan® CCAE database, 1/31/2022

Notes:

– The Peterson Center on Healthcare and Kaiser Family Foundation's Health System Tracker has published estimates of the impacts to spending and utilization during the COVID-19 pandemic. They estimate that health services spending since the pandemic has remained 7.1 percent below the pre-pandemic trend. As the data used to calculate civilian comparisons has a lag time to publication, IDA uses the Peterson/Kaiser Family Foundation report to adjust civilian estimates of spending and utilization to account for the impacts of the COVID pandemic. https://www.healthsystemtracker.org/brief/early-2021-data-show-no-rebound-in-health-care-utilization/

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– 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).

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BENEFICIARY FAMILY HEALTH PLAN COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES)

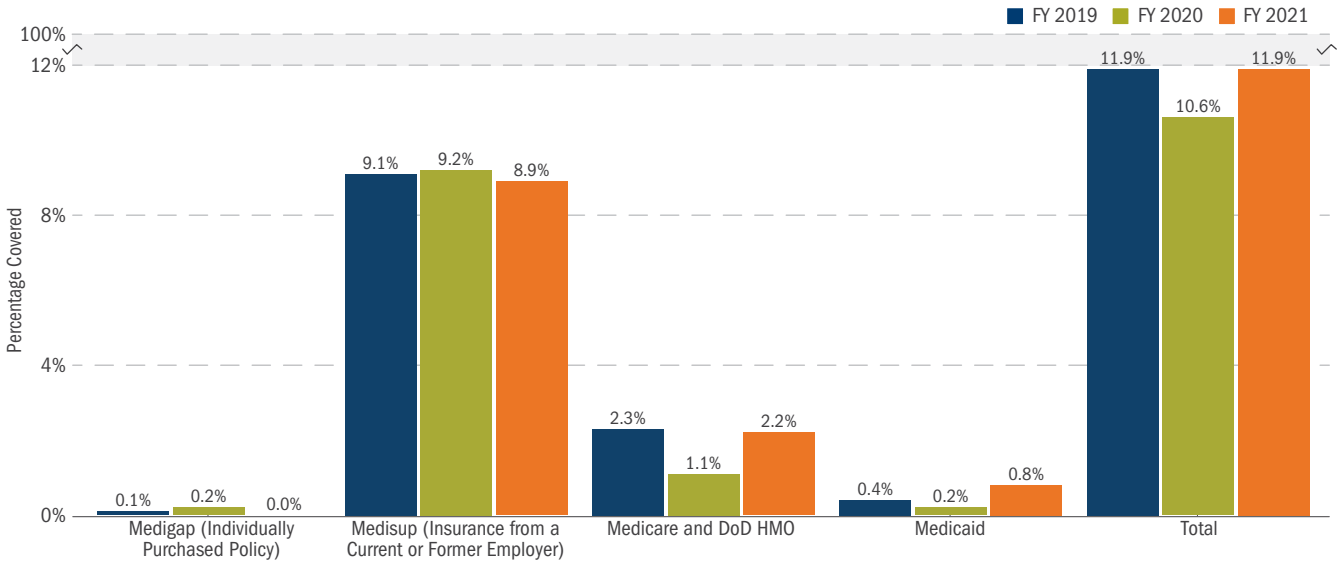
Out-of-pocket costs for retirees aged 65 and older (seniors) and their families include deductibles and copayments for medical care and drugs, TRICARE enrollment fees, and private insurance premiums. In April 2001, the DoD expanded drug benefits for seniors; on October 1, 2001, the DoD implemented the 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 with supplemental insurance coverage.

Supplemental Health Insurance Coverage of MHS Senior Beneficiaries

Although Medicare provides coverage for medical services, there are substantial deductibles and copayments. Until FY 2001, 88 percent of 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.

- In FY 2021, nearly 12 percent of MHS seniors retained some form of supplemental insurance. While still a small percentage overall, the number of MHS seniors with Medicaid coverage doubled relative to pre-pandemic levels (0.4 percent in FY 2019 vs. 0.8 percent in FY 2021).
- 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 2019–2021



Source: FYs 2019–2021 HCSDB, as of 12/31/2021

[1] Medigap is an individually purchased policy that covers Medicare deductibles and copayments. 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 and USFHP. 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; as of 12/31/2021.

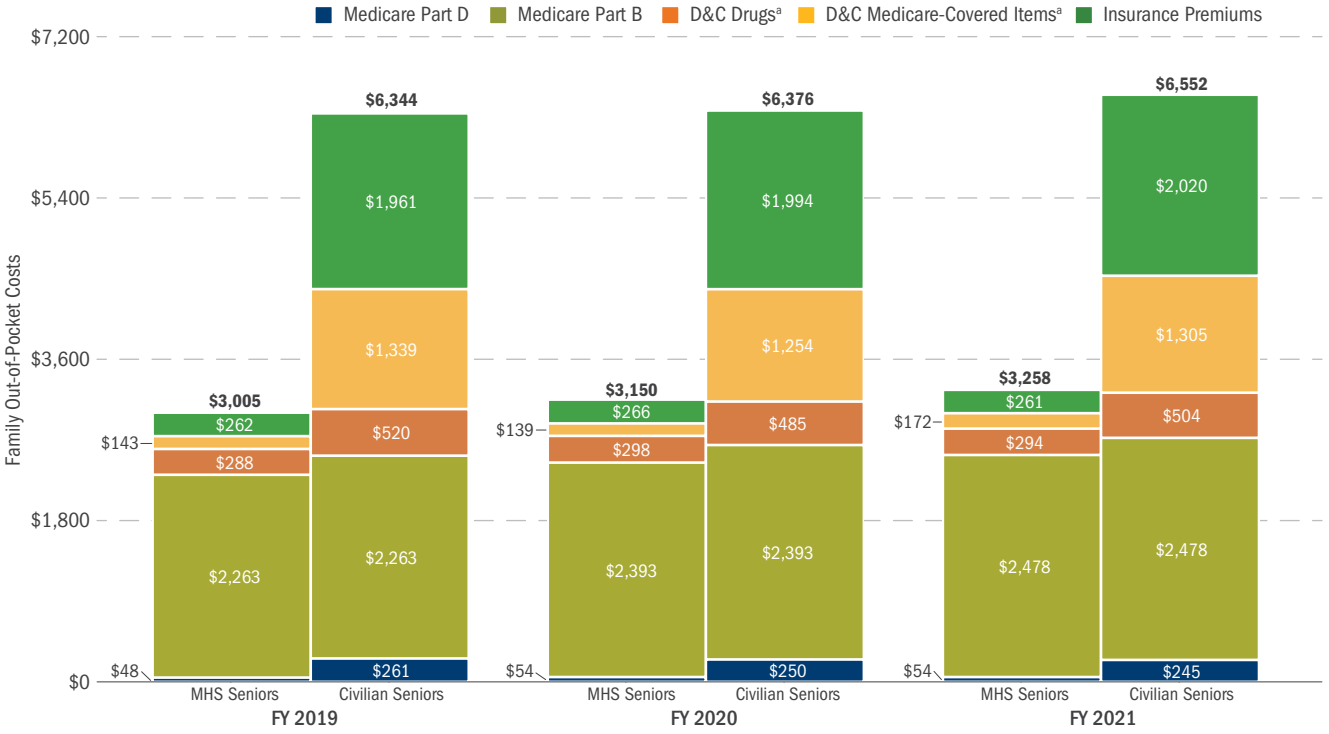
BENEFICIARY FAMILY HEALTH PLAN COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT.)*

Out-of-Pocket Costs for MHS Senior Families

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 their civilian counterparts.

- In FY 2021, out-of-pocket costs for MHS senior families were 50 percent less than those of their civilian counterparts.
- In FY 2021, MHS senior families saved about $3,300 as a result of TFL and added drug benefits.

OUT-OF-POCKET COSTS OF MHS SENIOR FAMILIES AFTER TFL VS. CIVILIAN COUNTERPARTS, FYs 2019–2021



Sources: TRICARE senior family deductibles and copayments for MHS users in FYs 2019–2021 from MHS administrative data, 12/31/2021; for MHS non-users and civilian benchmark senior families, deductibles and copayments by type of Medicare supplemental coverage in FYs 2019–2021 projected from the Household Component of the MEPS; Medicare Part B and Medicare HMO premiums in FYs 2019–2021 from the Centers for Medicare & Medicaid Services (CMS); Medigap premiums in FYs 2019–2021 from Weiss Research, Inc.; Medigap enrollment distribution is taken from America's Health Insurance Plans report entitled "The State of Medigap 2019"; Medisup premiums from Towers Watson Health Care Cost Surveys in 2013–2014 projected to FYs 2019–2021 based on their long-run growth rates; Medicare Part D premiums in FYs 2019–2021 from Kaiser Family Foundation Surveys; Medicare supplemental insurance coverage is from HCSDB, FYs 2019–2021, as of 1/31/2022

[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 2019–2021.

– The Peterson Center on Healthcare and Kaiser Family Foundation's Health System Tracker has published estimates of the impacts to spending and utilization during the COVID-19 pandemic. They estimate that health services spending since the pandemic has remained 7.1 percent below the pre-pandemic trend. As the data used to calculate civilian comparisons has a lag time to publication, IDA uses the Peterson/Kaiser Family Foundation report to adjust civilian estimates of spending and utilization to account for the impacts of the COVID pandemic. Source: https://www.healthsystemtracker.org/brief/early-2021-data-show-no-rebound-in-health-care-utilization/

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

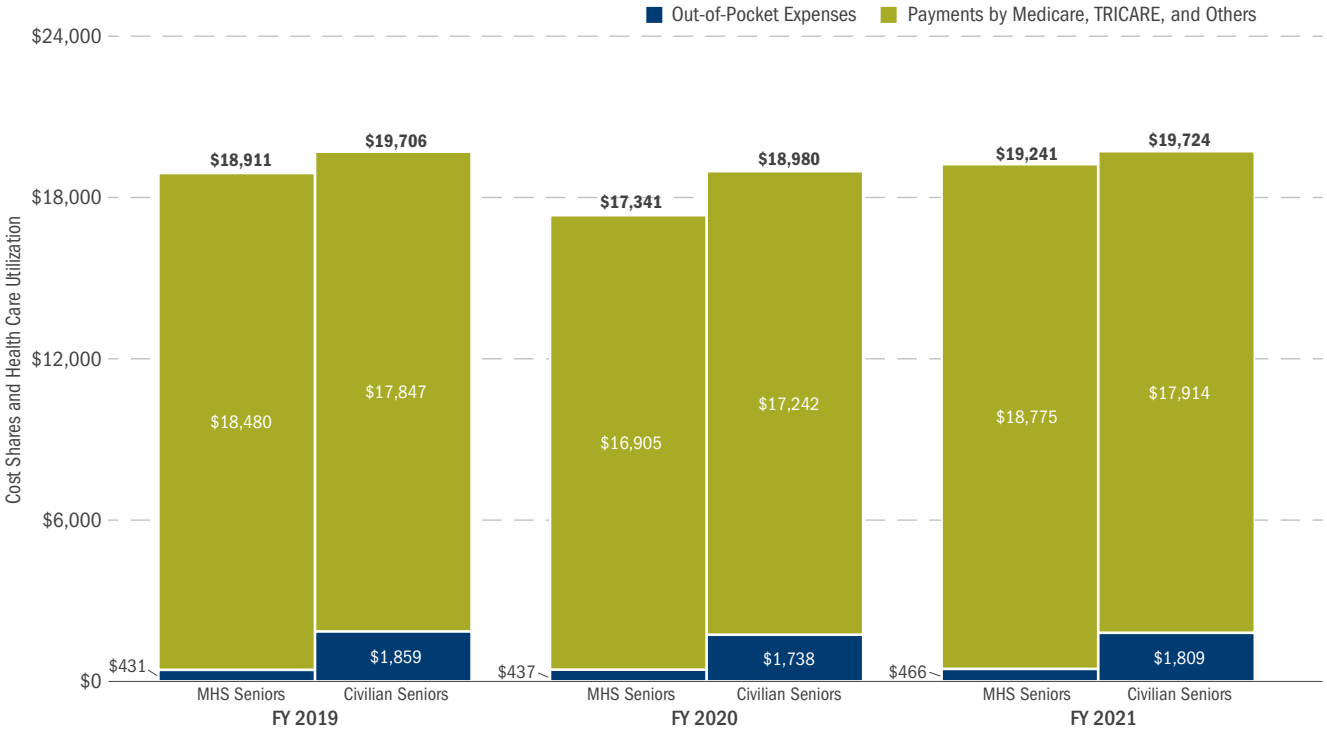
BENEFICIARY FAMILY HEALTH PLAN COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT.)*

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 civilian counterparts. Utilization is similar for both groups.

- MHS senior families have relatively low coinsurance rates.
  - In FY 2021, the coinsurance rate for civilian senior counterparts was 9 percent; it was 2 percent for MHS seniors (7 percentage points lower).
- MHS senior families have very similar utilization than civilian senior families.
  - In FY 2021, civilian senior counterparts consumed $19,700 in medical services; MHS senior families consumed $19,200 ($500 less).

COINSURANCE AND HEALTH CARE UTILIZATION FOR SENIOR FAMILIES VS. CIVILIAN COUNTERPARTS, FYs 2019–2021



Sources: TRICARE senior family utilization, deductibles, and copayments for MHS users in FYs 2019–2021 from MHS administrative data, 12/31/2021; for MHS non-users and civilian benchmark senior families, utilization, deductibles, and copayments by type of Medicare supplemental coverage in FYs 2019–2021 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 2019–2021, as of 12/31/2021

Notes:

– The Peterson Center on Healthcare and Kaiser Family Foundation's Health System Tracker has published estimates of the impacts to spending and utilization during the COVID-19 pandemic. They estimate that health services spending since the pandemic has remained 7.1 percent below the pre-pandemic trend. As the data used to calculate civilian comparisons has a lag time to publication, IDA uses the Peterson/Kaiser Family Foundation report to adjust civilian estimates of spending and utilization to account for the impacts of the COVID pandemic. https://www.healthsystemtracker.org/brief/early-2021-data-show-no-rebound-in-health-care-utilization/

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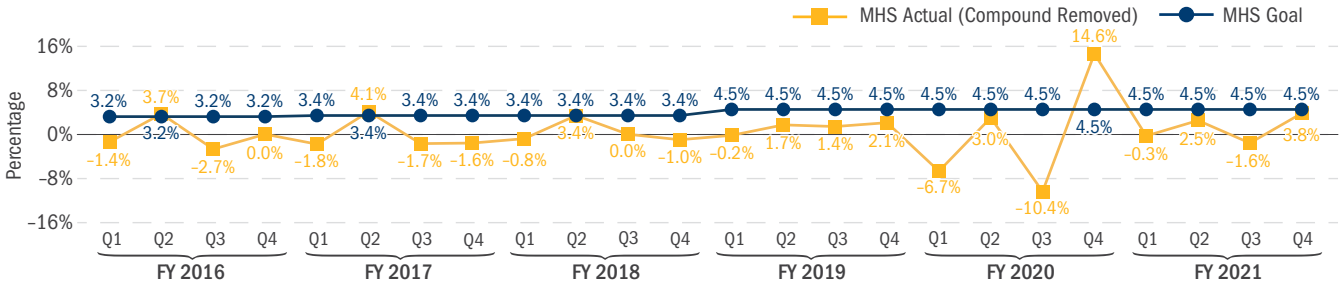
– Numbers may not sum to bar totals due to rounding

SYSTEM PRODUCTIVITY: MHS MEDICAL COST PER PRIME ENROLLEE

The goal in using this financial and productivity metric is to support the Quadruple Aim of lower 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 on issues regarding unit cost, utilization management, and private sector 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 2019 and FY 2020, 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 2020, provider efficiency declined due to the COVID-19 pandemic, resulting in a decrease in utilization without a corresponding decrease in expenses. In FY 2021, the MHS re-established growth in provider efficiency after COVID-19 protocols allowed for health care encounters to return to some level of normalcy, 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 non-maintenance 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.
- Due to the COVID-19 pandemic, in FY 2020, MTFs experienced significant decreases in workload while their expenses did not. This caused significant fluctuations in percentage change. FY 2021 Medical Expense and Performance Reporting System (MEPRS) expenses are not complete as of the time of this report and a rolling algorithm is used to populate the missing expenses for those months.

PERCENTAGE CHANGE IN MEDICAL COST PER PRIME EQUIVALENT LIFE (FROM PRIOR YEAR), FYs 2016–2021



Sources: DHA, Analytics and Evaluation Division, 11/18/2021. Data are as of November 2021, MHS Management Analysis and Reporting Tool (M2); Standard Inpatient Data Record/Standard Ambulatory Data Record/Comprehensive Ambulatory/Professional Encounter Record/TED Institutional/TED Non-institutional; Pharmacy Data Transaction Service; and Expense Assignment System IV

Notes:

– Enrollees are adjusted for health risk status.

– FY 2021 data are reported through FY 2021 Q4 but only FMs 10–11, and data from this time period should be considered preliminary.

– For sites that have implemented MHS GENESIS, their encounter data do not currently have the requisite information needed to compute the cost per Prime enrollee. Those sites are therefore excluded from the calculations.

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, 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 (CAHPS-CG).

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. The 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 private sector care.
- Data were current as of:
  - Surveys—Health Care Survey of DoD Beneficiaries (HCSDB) (12/28/2021); Joint Outpatient Experience Survey (JOES)/Joint Outpatient Experience-CAHPS (JOES-C) (12/2/2021); TRICARE Inpatient Satisfaction Survey (TRISS) (12/1/2021)
  - Eligibility/enrollment data—12/24/2021
  - MHS workload/costs—1/28/2022
- 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 times a fiscal year, since FY 2013, and reported on a publicly accessible website (https://health.mil/hcsdb).

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); and special timely topics such as COVID-19 vaccination opinions.

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 HCSDB 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. In FY 2021, there were approximately 26,000 annual responses from the sample of 301,500, resulting in a raw response rate of 8.6 percent. This is a slight decline from 9.2 percent raw response rate the previous year. Results can be estimated from the HCSDB for all beneficiary groups eligible for MHS benefits, whether they use direct care, private sector 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 2019–2021 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 TRISS is to monitor and report on the experience and satisfaction of MHS beneficiaries who have been admitted to military medical 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 41-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/private sector 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 2021 Q1–Q3 response rate for direct care was 34 percent and 34 percent for private sector care.

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 TRICARE Outpatient Satisfaction Survey (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— private sector 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 (private sector 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 private sector 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 private sector 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).

By the end of FY 2021, the DoD's new electronic health record, MHS GENESIS, had been deployed at 301 military hospitals and clinics worldwide. The data feed from MHS GENESIS does not currently include the information needed (which provider worked on which procedure) to compute RVUs. Additionally, the algorithms and data needed by the MEPRS Program Office to allocate costs within its data capture system are not built into MHS GENESIS, which is based on a commercial off-the-shelf product. Consequently, costs are also currently unavailable for GENESIS facilities.

In the past, we simply excluded MHS GENESIS facilities from most of our direct care utilization and cost analyses because their impact was only modest. However, because more and larger facilities are transitioning to GENESIS each year, excluding those facilities is no longer tenable. Consequently, we developed algorithms to estimate outpatient RVUs and both inpatient and outpatient costs for the period of time each facility was under the GENESIS regime. Prior to transitioning to MHS GENESIS, actual RVUs and costs were available and reported for each facility under the legacy system (the Composite Health Care System).

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 2021, 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., medical/surgical [MED/SURG], obstetrics/gynecology [OB/GYN], mental health [PSYCH]), and several sex/age group combinations. The quarterly breakout, available through the second quarter of FY 2020, allowed us to derive annual benchmarks by fiscal year and to estimate FY 2020 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 DRGs.

ABBREVIATIONS

AABB	American Association of Blood Banks | 117
ABA	applied behavior analysis | 21
AC	Active Component | 59
AC	Accreditation and Compliance | 113
ACCRWG	Acute and Critical Care Rehabilitation Working Group | 128
ACD	Autism Care Demonstration | 137
ACG	Adjusted Clinical Groupings | 143
ACH	Army Community Hospital | 139
ACO	Accountable Care Organization | 5
ACOG	American College of Obstetricians and Gynecologists | 129
ACS	American College of Surgeons | 62
AD	Active Duty | 35
ADC	administration, direction, and control | 26
ADDP	Active Duty Dental Program | 188
ADFM	Active Duty family member | 33
ADSM	Active Duty Service member | 27
AE	adverse event | 102
AHA	American Hospital Association | 109
AHRQ	Agency for Healthcare Research and Quality | 90
AIM	Alliance for Innovation on Maternal Health | 129
AMC	Army Medical Center | 27
AO	accrediting organization | 113
APLSS	Army Provider Level Satisfaction Survey | 90
ASBP	Armed Services Blood Program | 117
ASC	ambulatory surgery center | 118
ASCO	American Society of Clinical Oncology | 118
ASD	autism spectrum disorder | 137
ASD(HA)	Assistant Secretary of Defense for Health Affairs | 10
ASSET+	standardized skills course | 62
AUR	antimicrobial use and resistance | 105
BDC	blood donor centers | 117
BH	behavioral health | 134
BHC	Branch Health Clinic | 164
BHCC	Behavioral Health Clinical Community | 134
BHDP	Behavioral Health Data Portal | 134
BMI	body mass index | 178
BRAC	Base Realignment and Closure | 99
BRFSS	Behavioral Risk Factor Surveillance System | 185
BZD	benzodiazepine | 136
CA	corrective action | 105
CAC	Common Access Card | 61
CAHPS	Consumer Assessment of Healthcare Providers and Systems | 71
CAHPS-CG	CAHPS Clinician & Group Survey | 90
CAMP	Clinical Assessment Management Portal | 128
CAP	College of American Pathologists | 116
CARES Act	Coronavirus Aid, Relief, and Economic Security Act | 21
CAUTI	catheter-associated UTI | 105
CCAE	Commercial Claims and Encounters | 189
CCCT	Combat Casualty Care Team | 61
CCP	COVID Convalescent Plasma | 16
CCQAS	Centralized Credentialing and Quality Assurance System | 112
CCSR	Clinical Classifications Software Refined | 198
CDC	Centers for Disease Control and Prevention | 20
CE	continuing education | 108
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services | 219
CIA	concise incident analysis | 104
CLABSI	central line–associated bloodstream infection | 105
CLIA	Clinical Laboratory Improvement Amendment | 115
CLIP	Clinical Laboratory Improvement Program | 115
CLMS	Joint-Service Center for Laboratory Medicine Services | 116
CM	clinical measurement | 70
CM	case management | 149
CMS	Centers for Medicare & Medicaid Services | 21
COBRA	Consolidated Omnibus Budget Reconciliation Act | 5
CONUS	contiguous United States | 8
COTS+	Combat Orthopedic Trauma Skills | 62
CP	Credentialing and Privileging | 112
CPG	clinical practice guideline | 71
CPI	continuous process improvement | 66
CQI	clinical quality improvement | 66
CQM	clinical quality management | 107
CQMC	Core Quality Measures Collaborative | 69
CSA	comprehensive systematic analysis | 105
CSD	Clinical Support Division | 104
CY	calendar year | 4
DAP	DHA Appointment Portal | 29
DART	Direct Access Reporting Tool | 84
DCC	Dental Clinical Community | 138
DEERS	Defense Enrollment Eligibility Reporting System | 12
DHA	Defense Health Agency | b
DHA PI	DHA Office of Program Integrity | 187
DHA-IPM	DHA Interim Procedures Memorandum | 73
DHA-PI	DHA Procedural Instructions | 66
DHA-PM	DHA Procedures Manual | 69
DHARs	Defense Health Agency Regions | 103
DHHS	Department of Health and Human Services | 177
DHP	Defense Health Program | 1
DMIS IDs	Defense Medical Information System Identifiers | 31
DMMAC	Deputy Military Medical Action Council | 10
DoD	Department of Defense | b
DoDI	DoD Instruction | 112
DoDM	DoD Manual | 115
DTF	dental treatment facility | 5
DVPRS	Defense and Veterans Pain Rating Scale | 144
E&T	Education and Training | 120
EBPWG	Evidence-Based Practice Work Group | 120
ECHO	Extended Care Health Option | 5
ED	emergency department | 49
EHR	electronic health record | 19
EIC	external independent contractor | 188
EPICC	Epidemiology, Immunology, and Clinical Characteristics of Emerging Infectious Diseases with Pandemic Potential | 27
ESB	Enterprise Solutions Board | 71
EWSC	Emergency War Surgery Course | 62
FDA	Food and Drug Administration | 21
FEDVIP	Federal Employees Dental and Vision Insurance Program | 5
FEHB	Federal Employees Health Benefits Program | 167
FY	fiscal year | 1
GTT	Global Trigger Tool | 103
HAI	healthcare-associated infection | 103
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems | 4
HCO	Health Care Operations | 26
HCSDB	Health Care Survey of DoD Beneficiaries | 22
HEART	Healthcare Event Analysis Response Team | 107
HEC	Health Executive Committee | 120
HEDIS	Healthcare Effectiveness Data and Information Set | 4
HGB	Humana Government Business | 13
HHVBP	Home Health Value-Based Purchasing | 12
HIPAA	Health Insurance Portability and Accountability Act | 91
HMO	health maintenance organization | 5
HNFS	Health Net Federal Services | 13
HRM	healthcare risk management | 112
HRO	high reliability organization | 65
HRQOL	Health-Related Quality of Life | 185
HVBP	Hospital Value-Based Purchasing | 12
ICU	intensive care unit | 18
IDA	Institute for Defense Analysis | 204
IHI	Institute for Healthcare Improvement | 106
IMR	Individual Medical Readiness | 59
IOP	intensive outpatient program | 27
IPC	Infection Prevention and Control | 106
IQI	inpatient quality indicator | 132
JOES	Joint Outpatient Experience Survey | 4
JOES-C	Joint Outpatient Experience Survey-CAHPS | 90
JPSR	Joint Patient Safety Reporting | 104
JTS	Joint Trauma System | 16
KFF	Kaiser Family Foundation | 204
KP	Kaiser Permanente | 13
KPIs	key performance indicators | 10
KSAs	knowledge, skills, and abilities | 61
LBP	low back pain | 13
LEJR	Lower Extremity Joint Replacement/Reattachment | 12
LOS	length of stay | 78
M2	MHS Management Analysis and Reporting Tool | 82
MACE2	Military Acute Concussion Evaluation 2 | 128
MBSAQIP	Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program | 118

ABBREVIATIONS *(CONT.)*

MCP	military-civilian partnership | 61
MCSC	managed care support contractor | 12
MDD	major depressive disorder | 134
MDG	Medical Group | 172
MED/SURG	medical/surgical | 189
MEPRS	Medical Expense and Performance Reporting System | 112
MEPS	Medical Expenditure Panel Survey | 204
MERHCF	Medicare-Eligible Retiree Health Care Fund | 4
MH	mental health | 126
MHS	Military Health System | 1
MILDEP	military department | 8
MIP	MHS Information Portal | 19
MM	Medical Management | 143
MOTION	Military Orthopedics Tracking Injuries and Outcomes Network | 128
MOU	Memorandum of Understanding | 115
MS-DRG	Medicare Severity Diagnosis Related Group | 191
MHSPHP	MHS Population Health Portal | 143
MTF	military medical treatment facility | 4
NAL	nurse advice line | 49
NAS	Non-Availability Statement | 219
NCHS	National Center for Health Statistics | 50
NCI	National Cancer Institute | 220
NCQA	National Committee for Quality Assurance | 88
NCR	National Capital Region | 111
NDAA	National Defense Authorization Act | 1
NH	Naval Hospital | 165
NHANES	National Health and Nutrition Examination Survey | 183
NHE	National Health Expenditures | 44
NHSN	National Healthcare Safety Network | 103
NIAID	National Institute of Allergy and Infectious Diseases | 21
NIH	National Institutes of Health | 144
NMC	Naval Medical Center | b
NMCB	Naval Mobile Construction Battalion | b
NMSKCC	Neuromusculoskeletal Clinical Community | 128
NPDB	National Practitioner Data Bank | 69
NPI	National Provider Identifier | 172
NPIC	National Perinatal Information Center | 118
NQF	National Quality Forum | 104
NSQIP	National Surgical Quality Improvement Program | 118
OASD(HA)	Office of the Assistant Secretary of Defense for Health Affairs | b
OB/GYN	obstetrics/gynecology | 189
OCO	overseas contingency operations | 43
OHI	other health insurance | 35
O&M	operations and maintenance | 43
OPM	Office of Personnel Management | 225
OTH	others | 35
OUSD(P&R)	Office of the Under Secretary of Defense for Personnel and Readiness | 8
P-BMP	Performance-Based Maternity Payment | 12
P&T	Pharmacy & Therapuetics | 54
PASTOR	Pain Assessment Screening Tool and Outcome Registry | 67
PC	perinatal core | 130
PCCOB	Patient-Centered Care Operations Board | 71
PCM	primary care manager | 5
PCMH	Patient-Centered Medical Home | 4
PDTS	Pharmacy Data Transaction Service | 53
PFPWD	Program for Persons with Disabilities | 220
PMCSS	Pain Management Clinical Support Service | 150
PMO	Program Management Office | 61
POS	point of service | 5
PPE	personal protective equipment | 14
PPH	postpartum hemorrhage | 132
PPM	provider-performed microscopy | 116
PPO	preferred provider organization | 5
PRA	Progressive Return to Activity | 128
PROCR	Patient-Reported Outcomes Clinical Record | 134
PSA	Prime Service Area | 13
PSAW	Patient Safety Awareness Week | 107
PSC	private sector care | 5
PSC BAG	Private Sector Care Budget Activity Group | 45
PSP	Patient Safety Program | 103
PSPC	Patient Safety Professional Course | 108
PSS	Navy Patient Satisfaction Survey | 90
PSYCH	mental health | 189
P&T	Pharmacy & Therapeutics | 54
PT	physical therapy | 13
PTSD	posttraumatic stress disorder | 121
PV	prime vendor | 54
QA	quality assurance | 117
QPP	Quadruple Aim Performance Plan | 11
RC	Reserve Component | 59
RDT&E	research, development, test, and evaluation | 43
RE	reportable event | 4
RETFM	retiree and family member | 33
RFI	Requirements for Improvement | 114
RMWG	Risk Management Work Group | 112
RN	registered nurse | 82
ROR	Return to Operating Room | 140
RRC	Ready Reliable Care | 68
RVU	relative value unit | 47
RWP	relative weighted product | 46
SAAR	standardized antibiotic administration ratio | 105
SDA	Air Force Service Delivery Assessment | 90
SECDEF	Secretary of Defense | 8
SelRes	Selected Reserve | 167
SERCA	Safety Event and Root Cause Analysis | 110
SIDR	Standard Inpatient Data Record | 133
SIR	standardized infection ratio | 105
SMMAC	Senior Military Advisory Council | 10
SME	subject-matter expert | 14
SP&FI	Strategy, Plans, and Functional Integration | 14
SRV	survivors | 35
SSO	Small-Market and Stand-Alone Organization | 8
TAMP	Transitional Assistance Management Program | 5
TBI	traumatic brain injury | 128
TCC	Tele-Critical Care | 87
TDP	TRICARE Dental Program | 5
TeamSTEPPS	Team Strategies and Tools to Enhance Performance and Patient Safety | 68
TED	TRICARE Encounter Data | 175
TFL	TRICARE for Life | 5
TFMR	Total Force Medical Readiness | 59
THP	TRICARE Health Plan | 26
TJC	The Joint Commission | 4
TOL	TRICARE Online | 72
TPR	TRICARE Prime Remote | 5
TPRADFM	TRICARE Prime Remote for Active Duty Family Members | 5
TQIP	Trauma Quality Improvement Program | 118
TRDP	TRICARE Retiree Dental Program | 226
TRISS	TRICARE Inpatient Satisfaction Survey | 91
TRR	TRICARE Retired Reserve | 5
TRS	TRICARE Reserve Select | 5
TSS	TRICARE Select Survey | 173
TYA	TRICARE Young Adult | 5
UC	urgent care | 49
UMP	Unified Medical Program | 4
URFO	unintended retained foreign object | 104
URI	upper respiratory infection | 124
USD(P&R)	Under Secretary of Defense for Personnel and Readiness | 10
USFHP	Uniformed Services Family Health Plan | 5
USUHS	Uniformed Services University of the Health Sciences | 27
UTI	urinary tract infection | 140
VA	Department of Veterans Affairs | 31
VH	Virtual Health | 87
VHA	Veterans Health Administration | 120
VMC	Virtual Medical Center | 87
VRC	Verification, Review, and Consultation | 118
WHCMT	Women's Health Clinical Management Team | 129
WICC	Women and Infant Clinical Community | 105
WSS	wrong-site surgery | 2

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 (NASs) 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 Benefit Program for certain former Department of Defense (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 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
- NASs 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 copayments 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 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 copayment 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 an 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 NASs and annual TRICARE Standard/Extra deductible for family of mobilized Reserve Component (RC) sponsor (extended five times until made permanent in 2008)
- Deployed Pharmacy Data Transaction Service (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 contract (formerly managed by Defense Logistics Agency as the National Mail Order Program)
- Began TRICARE Global Remote Overseas 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—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 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, carving the benefit out of the managed care support contracts into a single program

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS *(CONT.)*

2004

- 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)
- 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 copayment, 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 Department of Veterans Affairs (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
- Improved beneficiary access to vaccines by expanding coverage under pharmacy benefit for H1N1 at retail pharmacies at zero copayment

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 adult children 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 copayment for TRICARE Pharmacy Home Delivery, coinciding with increases to copayments 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.)*

2012

- 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 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 service areas (PSAs; closed all those 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 U.S. 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
- Added coverage of hippotherapy under ECHO (horseback riding as a therapeutic or rehabilitative treatment)
- Defense Health Agency (DHA) became initially operational under authority of the Assistant Secretary of Defense for Health Affairs (ASD[HA]) and designated as a Combat Support Agency with oversight from the Chairman of the Joint Chiefs

2014

- 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
- 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—lower extremity joint replacement
- Launched network Urgent Care Pilot Program—up to four visits per year without referral or prior authorizations for non-ADSM Prime enrollees in contiguous United States
- Improved mental health access and parity with lower out-of-pocket expense
  - Expanded inpatient mental health hospital services coverage
  - Reduced cost shares for all applied behavior analysis services under Comprehensive Autism Care Demonstration
  - Expanded opioid treatment
- Improved TRICARE pharmacy benefit
  - Safe disposal of unwanted medications
  - Medication Therapy Management Pilot
  - DoD/VA Continuity of Care Drug List
  - Required brand name maintenance drug fills through either TRICARE Pharmacy Home Delivery or from a military pharmacy
  - Increased copayments slightly for Home Delivery and retail network pharmacies
  - Expanded over-the-counter drug coverage permanently
- Added reimbursement for end-of-life care beneficiary planning consultations
- Enhanced preventive services and eliminated some cost share/copayments
- Introduced provisional coverage for emerging treatments and technologies
- Expanded TRICARE Basic Program to cover:
  - Surgery for femoroacetabular impingement
  - Transcranial magnetic stimulation 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
- Started second-generation TRICARE Overseas Program contract
  - Translation of medical documentation for all TOP Prime and Prime Remote beneficiaries
  - Implemented CHAMPUS Maximum Allowable Charges rates for professional services in all U.S. territories

2017

- Initial deployment of MHS GENESIS to four MTFs and their child sites

2018

- 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)
- 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

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS *(CONT.)*

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

2020

- Operation Warp Speed for COVID-19 vaccine development—massive HHS/DoD joint project; DoD phased vaccine administration began December 2020
- MTF COVID-19 adaptations included telemedicine
- Temporary TRICARE adaptations for COVID-19
  - Asymptomatic testing for Service members
  - Expanded telemedicine to audio only, eliminated Prime/Select cost shares, and authorized interstate or international practice
  - Expanded coverage to investigational drugs and emerging treatments, including vaccines and NIAID-sponsored clinical trials
  - Increased certain hospital payments by 20 percent
  - Relaxed criteria for skilled nursing facility care
  - Relaxed certification of temporary hospital facilities and free-standing surgical centers
- MHS transformation—MTF transition to DHA
  - Resumed after a pause for COVID-19 response
  - A number of Service medical department staff transferred to DHA
  - MHS GENESIS rollout to MTFs continued
- Added occupational therapy assistants and physical therapist assistants as TRICARE-authorized providers; podiatrists can refer to PT and OT
- Enhanced TRICARE Pharmacy Benefits Program; encouraged use of high-value products
- Extended TRICARE demonstration project for Laboratory Developed Tests by three years
- Adopted Medicare's authority for Hospital Value-Based Purchasing (HVBP) program
- Fourth Annual Open Season—new for 2021, TRICARE Select enrollment fees. About 900,000 grandfathered retirees, their families, and survivors completed arrangements for fee collection with contractors

2021

- Completed transfer of stateside MTFs to DHA
- Started TRICARE Overseas Program follow-on contract. Enhancements included:
  - Started Near Patient Program
  - Improved Clinical Quality Program
  - Facilitated medical document collection
- Clarified COVID-19–related TRICARE coverage
  - Covered testing with provider's order, including in-home test kits
  - Covered vaccine with zero cost share
  - Covered vaccine from retail pharmacies
- Adjusted TRICARE policies temporarily for COVID-19 patients during declared public health emergency
  - Increased inpatient payment by 20 percent
  - Relaxed long-term care hospital admission requirements
  - Covered skilled nursing facility services for COVID-19 transfer patients without the usual prior three-day qualifying hospital stay
- Started TRICARE pilot programs to test innovations
  - Ten states – waive cost shares on up to three physical therapy visits for low back pain through December 31, 2023
  - Metro Denver – test value-based care through December 31, 2022
- Added remote physiologic monitoring coverage for acute and chronic conditions
- Added laser treatment provisional coverage for symptomatic scars from burns and other trauma
- Eliminated concurrent ECHO benefits as a qualification to receive respite care
- Started allowing Active Duty members to file medical malpractice claims as the patient against military MTFs
- Reduced reimbursable costs for certain durable medical equipment, prosthetics/orthotics, and supplies
- Adopted Medicare's HVBP for the TRICARE program
  - Incentivizes health care providers to improve service delivery and quality
- Adopted Medicare's special "New Technology Add-On Payments"
  - Increases payments for new medical services/technologies until standardized rates can be adjusted accordingly
  - Promises to improve clinical outcomes while modernizing the TRICARE benefit
- Amended federal regulation to repeal Federal Employees Health Benefits eligibility as a disqualification for TRICARE Reserve Select effective January 1, 2030

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The **Evaluation of the TRICARE Program: Fiscal Year 2022 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: https://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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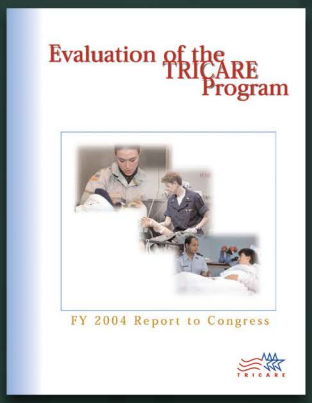
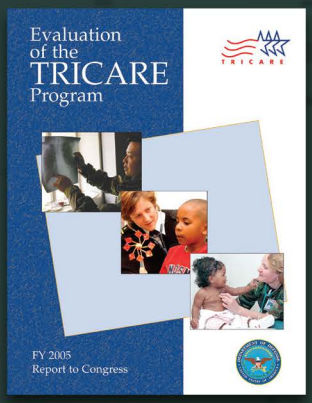
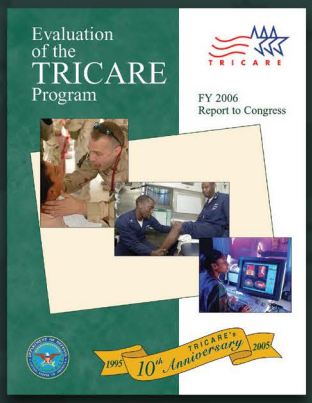
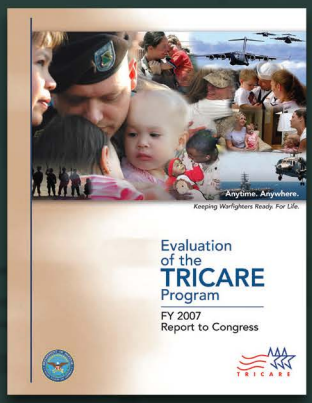
CSD = Clinical Support Division
HA = Health Affairs
HRO = High Reliability Organization
KSA = Knowledge, Skills, and Abilities
NMSK = Neuromusculoskeletal
OPS = Operations
OSD = Office of the Secretary of Defense
PCMH = Patient-Centered Medical Home
PHD = Public Health Division
P&R = Personnel & Readiness
R&M = Resources & Management
SP&FI = Strategy, Plans, & Functional Integration
THP = TRICARE Health Plan
USUHS = Uniformed Services University of the Health Sciences

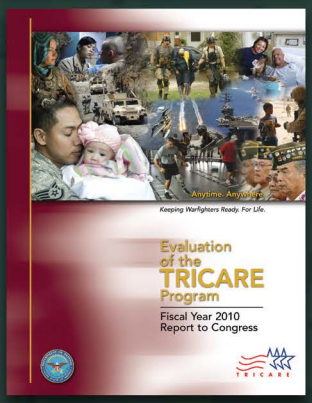
DHA
Defense Health Agency

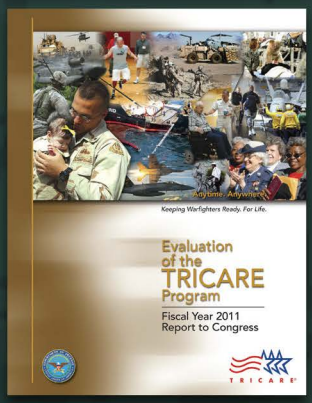


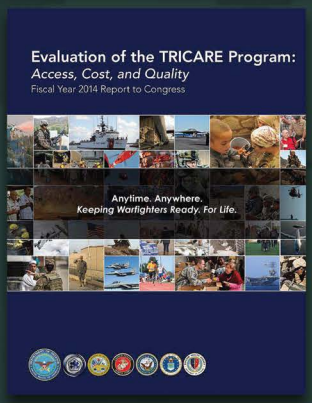


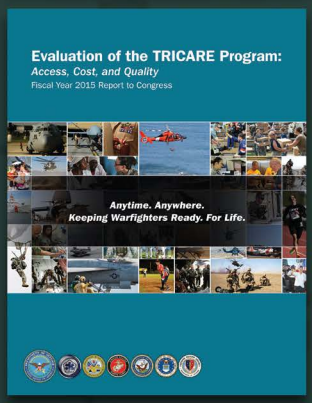


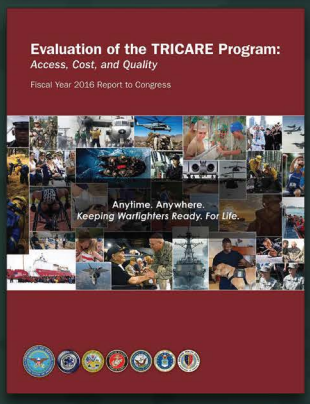


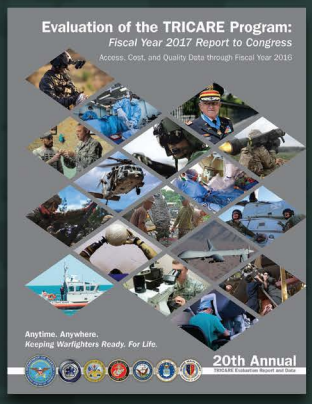


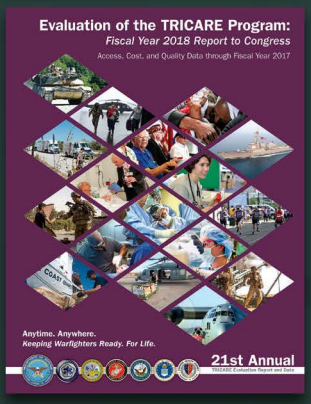


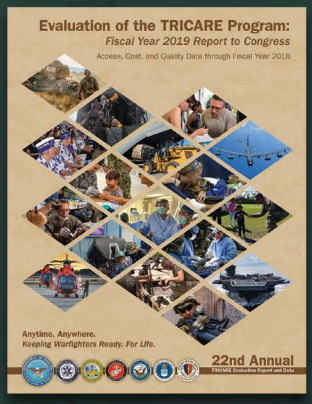


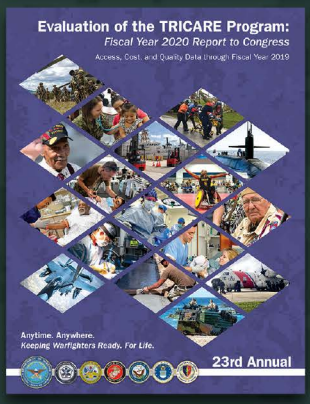


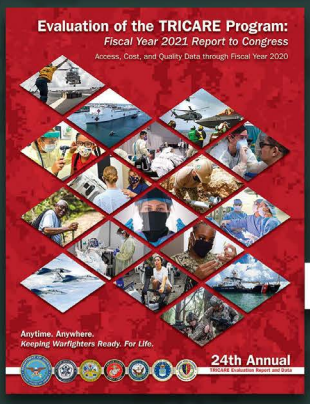












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