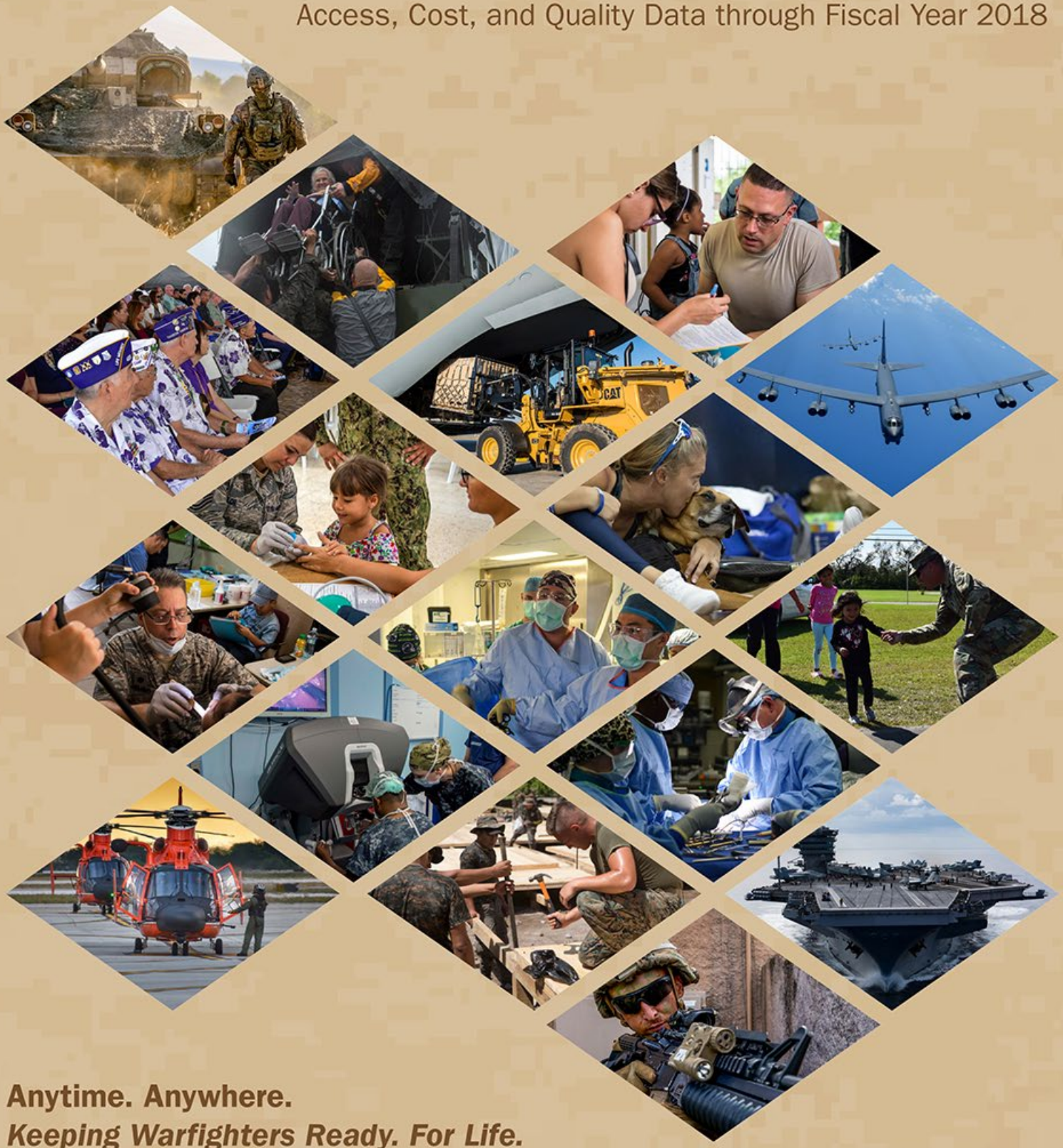
Evaluation of the TRICARE Program:

Fiscal Year 2019 Report to Congress

Access, Cost, and Quality Data through Fiscal Year 2018



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22nd Annual

TRICARE Evaluation Report and Data

Evaluation of the TRICARE Program:

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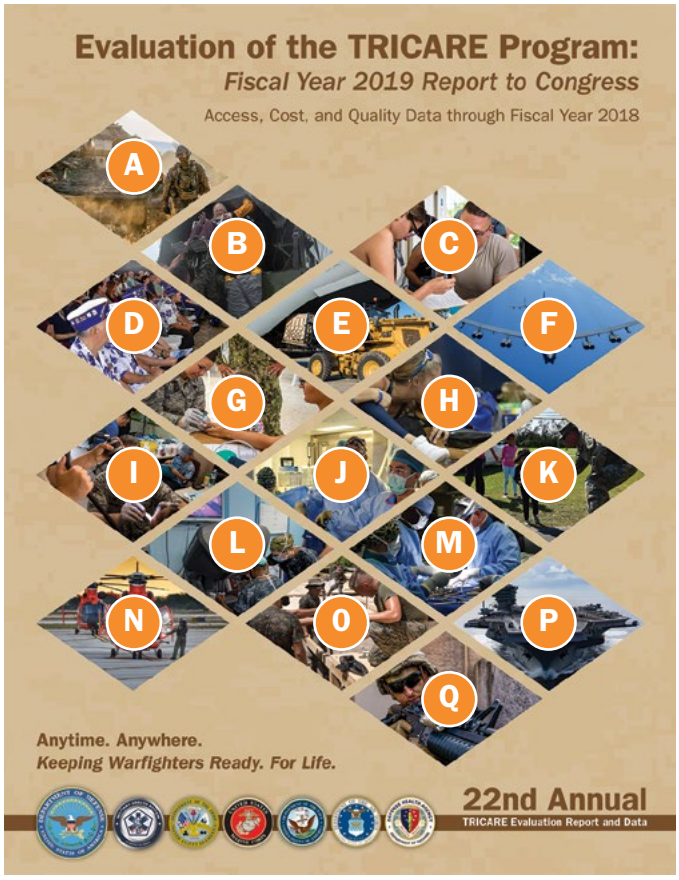
FEBRUARY 28, 2019

The *Evaluation of the TRICARE Program: Fiscal Year 2019 Report to Congress* is provided by the Defense Health Agency (DHA), Decision Support Division, in the Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]). Once the Report has been sent to Congress, an interactive digital version with enhanced functionality and searchability will be available at: http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program.



Front cover photo descriptions:

A – A Soldier assigned to the 1st Armored Brigade Combat Team, 1st Cavalry Division, ground guides a M2A3 Bradley Fighting Vehicle during a Table XII Live Fire Exercise at Novo Selo Training Area, Bulgaria. (August 2018)

B – U.S. Marines assigned to Combat Logistics Battalion 8 (CLB-8) and first responders of the Richlands Volunteer Fire Department 14 offload civilians affected by Hurricane Florence at a local shelter in Jacksonville, N.C. (September 2018)

C – A 174th Medical Group medical technician assists a mother with dental forms for herself and her children in Cataño, Puerto Rico, during Innovative Readiness Training Ola de Esperanza Sanadora. (September 2018)

D – U.S. military Service members, former prisoners of war, families, and Veterans gather during a ceremony for National POW/MIA Recognition Day at the National Memorial Cemetery of the Pacific, Honolulu, Hawaii. (September 2018)

E – Air transportation specialists offload cargo in support of relief efforts for Hurricane Michael at Tyndall Air Force Base, Fla. (October 2018)

F – Two B-52H Stratofortress bombers fly over the Pacific Ocean during a routine training mission in support of U.S. Indo-Pacific Command's Continuous Bomber Presence operations. (August 2018)

G – A 176th Medical Group medical technician performs a glucose check while a young girl consoles her mother during Innovative Readiness Training Ola de Esperanza Sanadora, Puerto Rico. (September 2018)

H – A retired Airman takes a break with her service dog after competing in sitting volleyball at the Department of Defense Warrior Games 2018, a Paralympic-style competition where wounded warriors compete in 11 different adaptive sporting events. (June 2018)

I – An officer from the 183rd Medical Group performs a dental checkup on a young patient receiving care during Innovative Readiness Training Ola de Esperanza Sanadora, Puerto Rico. (September 2018)

J – Naval officers perform an appendectomy in the medical ward during a regularly scheduled deployment of the Essex Amphibious Ready Group (ARG) and 13th Marine Expeditionary Unit (MEU). (August 2018)

K – The state command sergeant major and advisor for the Georgia Army National Guard shakes hands with young citizens of Donalsonville, Ga., while conducting relief missions following Hurricane Michael. (October 2018)

L – A surgeon assigned to Military Sealift Command hospital ship USNS Mercy (T-AH-19) for Pacific Partnership 2018 (PP18) and a Sri Lankan general surgeon from Base Hospital Mutur discuss robotic surgery techniques during the first robot-assisted surgery on a patient while aboard the Mercy using the Da Vinci XI Robot Surgical System. (May 2018)

M – A 99th Medical Group orthopedic spine surgeon performs a lumbar microdiscectomy surgery at Nellis Air Force Base, Nev. (August 2018)

N – A Coast Guard Air Station Miami aircrew prepares for an evening flight at Opa-locka Executive Airport in Opa-locka, Fla. (May 2018)

O – U.S. Marines work with members of the Guatemalan Army Corps of Engineers to nail prefabricated floor sections onto a frame at a construction site in Escuintla, Guatemala. (July 2018)

P – Nimitz-class aircraft carrier USS Carl Vinson (CVN-70) transits the Pacific. (October 2018)

Q – A U.S. Marine rifleman with India Company, 3rd Battalion, 3rd Marine Regiment, provides security during a village clearing drill, part of a company-level exercise at Marine Corps Training Area Bellows (MCTAB), Hawaii. (September 2018)

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

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BETTER CARE *(CONT.)*

BETTER HEALTH

LOWER COST

APPENDIX

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

I have been privileged to observe, learn from, and lead the Military Health System (MHS) up close since I joined the Department in August 2017. As such, I am honored to provide the Congress, for the second time in my tenure, with the Department of Defense (DoD) *Evaluation of the TRICARE Program* report. The enclosed report responds to the requirement in section 717 of the National Defense Authorization Act (NDAA) for FY 1996 (Public Law 104-106) and subsequent legislation guiding this report in FY 2013 and FY 2016.

This comprehensive report looks across the spectrum of health services we deliver, arrange, or pay for our 9.5 million beneficiaries, and provides an assessment of our performance. Our Department's $54 billion FY 2019 Unified Medical Program (UMP) represents about 8 percent of the total DoD budget for FY 2019. For the last several years, the DoD has successfully kept health care costs within projections.

I continue to be motivated in leading the MHS at a time of historical reform in how we manage and oversee military medicine. The NDAA FY 2017 and subsequent legislation established and reinforced a number of significant changes to both our benefit and our organizational structure, with the explicit goals of further improving readiness, access, and quality, and of wisely managing our costs.

We are guided in our efforts by the strategic direction delivered by the Secretary: RESTORE military readiness; STRENGTHEN alliances and attract new partners; and BRING business reforms to the DoD. The MHS has responsibilities within each of these lines of effort. Our key initiatives to support these goals include consolidation of the health care delivery system into the Defense Health Agency (DHA), optimizing medical support for military mission readiness, and implementing enterprise-wide reforms in key medical business areas.

The MHS is embarking on a new chapter, ushering in unprecedented reform for the military health enterprise. This transformation marks a new way of doing business for military health—from the way we organize and manage military treatment facilities, to the modernization of our electronic health record (EHR), to TRICARE benefit enhancements—we are working hard to provide medical readiness and health care delivery that is more integrated and effective than ever before.

Readiness remains the center focus across the Department, and the MHS is no exception. But we are not making these changes in isolation. MHS reform is aligned with the whole-department business reform effort; it is not just about cost savings, but is intended to create "a structure that drives improved outcomes."

October 1, 2018, was a landmark day for the DoD and military health care. Jump-starting one of the largest organizational changes in decades, the DHA began the process of assuming responsibility for the administration and management of military medical treatment facilities. Through a phased approach, the DHA will assume control of all MTFs across the MHS. On October 1, we began the first phase by welcoming into the DHA the hospitals and clinics at Fort Bragg, Pope Field, and Seymour Johnson Air Force Base, N.C.; Naval Air Station Jacksonville, Fla.; Keesler Air Force Base, Miss.; and Joint Base Charleston, S.C. Over the coming fiscal years, the DHA will be responsible for all MTFs with respect to all matters of operation, including budgetary matters, information technology, health care administration and management, administrative policy and procedure, and military medical construction.

Consistent with the Secretary's focus on strengthening partnerships, there is a large spectrum of partners with the MHS, including the federal interagency, private sector, international institutions, and partner nations. Some significant and successful MHS partnerships include our partnership with the Food and Drug Administration (FDA) to facilitate warfighter access to medical products, accelerate the DoD's development of safe and effective medical products, and strengthen DoD and FDA teamwork to advance medical product priorities. Our collaboration with the Department of Veterans Affairs (VA) is another important example—in May 2018, the VA signed a contract with Cerner, the same EHR DoD is implementing, and the two Department Secretaries recently signed a joint statement committing to implementing jointly so that we have one EHR across both Departments. This will enable us to provide a seamless transition for Service members as they move from entry into military service to separation from service to VA care, to identify opportunities to improve care, and for both Departments to realize increased efficiencies in our business operations.

We are deploying MHS GENESIS, the new EHR for the MHS, which will provide enhanced, secure technology to manage health—connecting medical and dental information for example across the continuum of care, from point of injury to the MTF. MHS GENESIS will replace our legacy systems, which lack the capability to support the delivery of modern, integrated health care. We will roll out the next wave of deployments in the fall of 2019, with the systemwide rollout targeted for completion by FY 2024.

Like the MHS's broader transformation plans, at the heart of these efforts is a concerted push toward standardization, integration, and readiness—and we are moving in the right direction.

As we look to the years ahead, the MHS is laser-focused on MHS Reform and NDAA implementation, deploying MHS GENESIS, and advancing Global Health Engagement. A successful future will reflect improved readiness for our troops, increased quality and value for our patients and system, and greater efficiency, without sacrificing effectiveness.

Our vision is to be recognized as an efficient, high-quality, safe, integrated health care system. We have come a long way, and much work remains.

Amid the sweeping changes underway, one thing remains a constant: our commitment to the women and men of our Uniformed Services. It is our highest priority to provide the best possible health care to the courageous women and men who defend our nation, as well as for their families, and we will deliver on this promise. At the same time, readiness is at the center of everything we do. We keep our Service members ready; we keep our medical forces ready. Throughout the MHS's transformation, our mission remains clear: support the warfighter, care for warfighter families, care for patients.

—Thomas McCaffery

EXECUTIVE SUMMARY: KEY FINDINGS FOR FY 2019

MHS Worldwide Summary

- The $53.7 billion Unified Medical Program (UMP) presented in the FY 2019 President's Budget, including estimated outlays from the Medicare-Eligible Retiree Health Care Fund (MERHCF), is 1 percent higher than the $53.1 billion in actual expenditures in FY 2018 and is almost 8 percent of total FY 2019 estimated Department of Defense (DoD) outlays (ref. pages 30–31).
- In 2018, 9.5 million beneficiaries were eligible for DoD medical care; almost 4.9 million (52 percent) enrolled in TRICARE Prime and most enrolled in military treatment facilities (MTFs; 70 percent) (ref. pages 21, 27).
- TRICARE Young Adult (TYA) enrollment decreased to almost 37,000 beneficiaries under age 26 in FY 2018, from almost 40,000 in FY 2017, with most enrolled in the new TRICARE Select benefit (63 percent) (ref. page 158).
- There were almost 384,000 enrollees in the premium-based TRICARE Reserve Select (TRS) in 143,000 plans, while retired Reservists and their families in TRICARE Retired Reserve (TRR) reached just under 3,200 plans and 9,000 covered lives (ref. pages 154–157).

MHS Workload and Cost Trends[1,2]

- The percentage of beneficiaries using Military Health System (MHS) services remained constant between FY 2016 and FY 2018, at 86 percent (ref. page 28).
- Excluding TRICARE for Life (TFL), total MHS workload (direct and purchased care combined) fell from FY 2016 to FY 2018 for inpatient care (–11 percent), outpatient care (–2 percent), and prescription drugs (–6 percent) (ref. pages 33, 34, 37).
- From FY 2016 to FY 2018, direct care workload decreased for inpatient care (–15 percent), outpatient care (–5 percent), and prescription drugs (–2 percent). Over the same period, total direct care costs fell by 5 percent (ref. pages 33, 34, 37, 43).
- Excluding TFL, purchased care workload fell for inpatient care (–8 percent), outpatient care (less than 1 percent), and prescription drugs (–13 percent). Overall, purchased care costs rose by 2 percent (ref. pages 33, 34, 37, 43).
- The purchased care portion of total MHS health care expenditures rose from 52 percent in FY 2016 to 54 percent in FY 2018 (ref. page 43).
- In FY 2018, out-of-pocket costs for MHS beneficiary families under age 65 were between $5,800 and $6,900 lower than those for their civilian counterparts, while out-of-pocket costs for MHS senior families were $3,100 lower (ref. pages 191, 193, 196).

Lower Cost

- MHS estimated savings include over $850 million in retail pharmacy refunds in FY 2018 and $89 million in Program Integrity (PI) activities in calendar year 2017 (ref. page 159).

Improved Readiness

- **Force Health Protection:** At the end of FY 2018, the overall medical readiness of the total force was at 86 percent, with the Active Component at 87 percent and the Reserve Component at 86 percent, all equaling or exceeding the strategic goal of 85 percent. Dental readiness, at 94 percent, was just under the MHS goal of 95 percent. The MHS surgical community is leading the way in identifying and enumerating critical clinical readiness skill sets (ref. pages 45–48).

Better Care

- **Access to Care:** Patient-Centered Medical Home (PCMH) primary care administrative measures indicate that, in FY 2018, MTF enrollees saw their primary care provider 57 percent of the time and a PCMH team member 92 percent of the time. Days to third next 24-hour or acute appointments met the goal of 1.0 day, and continued to be shorter than the minimum seven-day standard for future appointments. **Urgent care** usage increased by almost 60 percent over FY 2017, consistent with the enhanced benefit. Beneficiary enrollment in and MTF responsiveness to secure messaging increased slightly in FY 2018. The standardized JOES survey shows 82–84 percent of MTF users in FY 2018 reported they could get care when needed and that 89 percent of non-Active Duty enrollees had at least one primary care visit in the year; administrative data shows that 80 percent of those using purchased care had at least one visit during FY 2018 (ref. pages 59–62, 66, 86).
- **Hospital Quality of Care:** MTFs and MHS civilian network hospital performance perinatal quality measures are comparable to The Joint Commission 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 105–107).
- **Outpatient Care:** MTF HEDIS® rates exceed the national standards at the 90th percentile for colorectal cancer screening, 30-day mental health follow-up visits post hospitalization, and treatment of children with upper respiratory infection, and surpass the national 75th percentile for cervical cancer screenings, low back pain, well-child visits, and treating children for pharyngitis. Based on only claims data, purchased care is in the 50th percentile for colorectal cancer screening and well-child visits (ref. pages 110–112).
- **Surgical Services:** With 100 percent of MTFs participating in the American College of Surgeons National Surgical Quality Improvement Program, 26 MTFs met expected performance, eight were exemplary and six reflected "needs improvement" (ref. page 124).
- **Beneficiary Ratings of Inpatient Care—Overall Hospital Rating:** Direct care has shown improved patient hospital ratings from FY 2016 to FY 2018, exceeding the national Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) benchmark average in the medical and surgical product lines with four MTFs at the 90th percentile and seven MTFs at the 75th percentile. Although ratings continue to improve in the obstetric product line, they remain below the HCAHPS benchmark (ref. pages 141–142).
- **Patient Safety:** The MHS direct care system has been focusing on reducing Wrong-Site Surgery Sentinel Events (WSS SEs) education and leadership engagement, with a goal of zero events. Although there was a 32 percent reduction in WSS SEs between FY 2016 and FY 2017, there was an increase of 67 percent from FY 2017 to FY 2018 (with the largest increase in reporting of dental events) (ref. pages 95–103).
- **MHS Provider Trends:** The number of TRICARE network providers increased by 16 percent from FY 2014 to FY 2018. The total number of participating providers increased by 10 percent over the same time period (ref. page 159).
- **Access for TRICARE Select (Standard/Extra) Users:** Results from the second year of the congressionally mandated four-year survey (2017–2020) of civilian providers and MHS non-enrolled beneficiaries shows eight of 10 physicians accept new TRICARE Standard patients, a higher acceptance rate than reported for behavioral health providers. The remaining two years will address Select acceptance and access (ref. page 160).

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

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

MHS PURPOSE, MISSION, VISION, AND STRATEGY

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

The MHS maintains integrated medical teams that deliver health services to America's military, anytime and anywhere, all supported by a uniformed sustaining base, a robust health plan, medical evacuation capabilities, and military medical treatment facilities. 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.

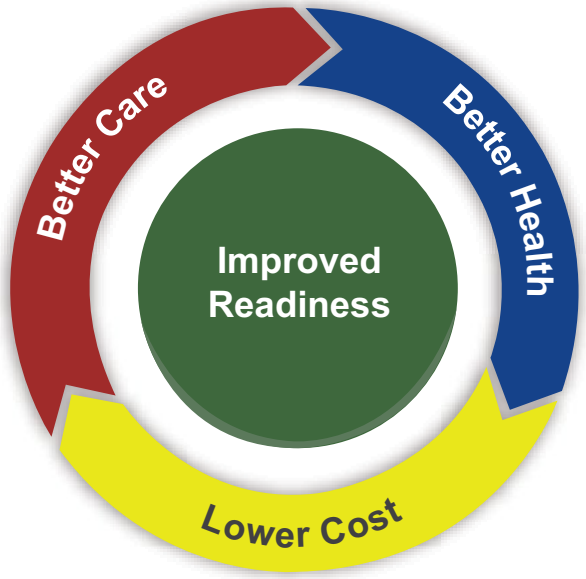
The MHS is one of the world's only global health systems, capable of rapid deployment to austere environments. We realize that we must reform legacy processes and continue to integrate in order to meet the challenges of the ever-evolving nature of war while reducing costs to the American taxpayer.

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 2018–2019

Vision: Unified and Ready…

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

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

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

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

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

DHA VISION AND MISSION FOR FYs 2018–2019 *(CONT.)*

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

In support of the Lines of Effort by the Secretary of Defense to increase lethality, readiness, good stewardship of resources, and affordability, the intent of the Office of the Under Secretary of Defense for Personnel and Readiness (OUSD[P&R]) is to maximize the medical readiness of operational and medical forces, while generating efficiencies in the delivery of high-quality health care to authorized beneficiaries. This undertaking will advance the initiative of the Department's Reform Management Group (RMG) to bring business reform to the DoD and will return human and fiscal resources to the MILDEPs.

Office of the Assistant Secretary of Defense for Health Affairs Intent

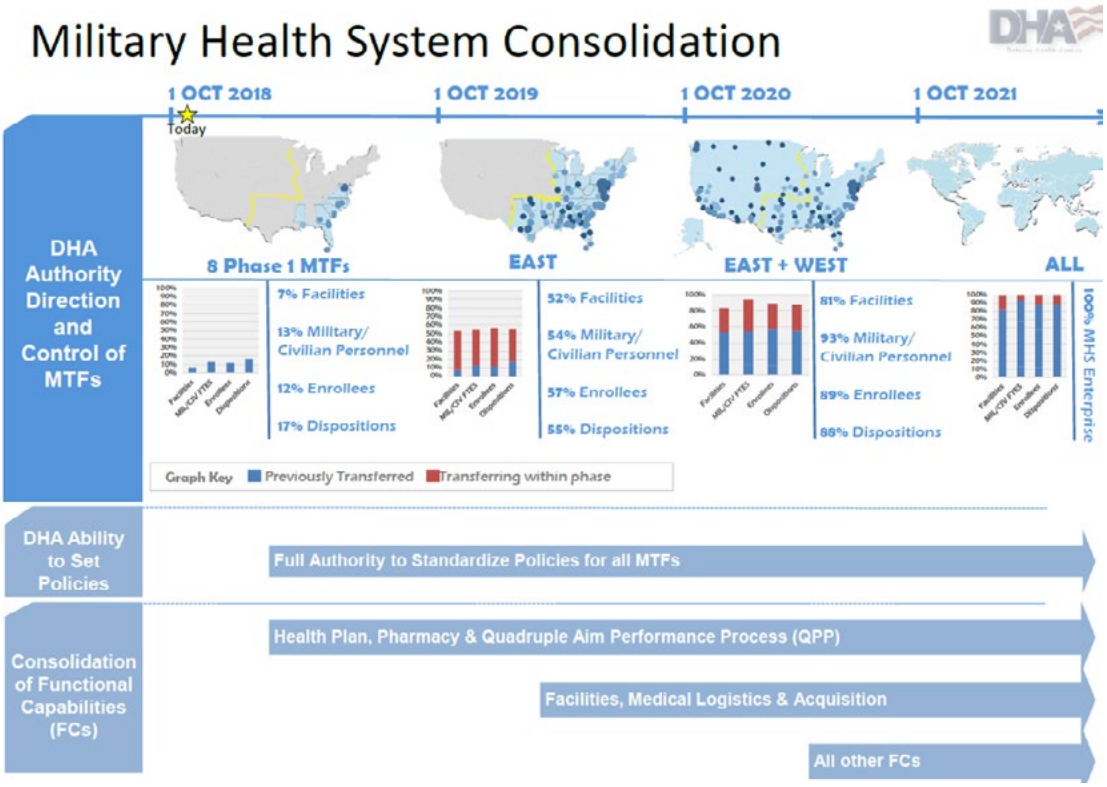
The intent of the Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA]) is to support an integrated system of readiness and health. The Department's phased deployment plan executes congressional guidance set forth in Title VII of the National Defense Authorization Act (NDAA) for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

DHA Director's Intent

The DHA's priority effort is continued implementation of the provisions of NDAA FY 2017, section 702, as modified by the NDAA FY 2019, from October 1, 2019, through September 30, 2022. This implementation plan encompasses Phases 2–4 of the Department's proposed multiyear implementation. In Phase 2, occurring in FY 2020, the DHA will assume management control of all MHS MTFs in the East Region of the continental United States and the complete transition of three functional capabilities: Acquisition, Facilities, and Medical Logistics. In Phase 3, occurring in FY 2021, the DHA will expand management control of MTFs in the West Region of the continental United States and complete the transition of all remaining functional capabilities. In Phase 4, occurring in FY 2022, the focus will be on the inclusion of overseas MTFs under the DHA. The four phases are shown below.

Success for Phases 2–4 is defined as DHA's full execution of authority, direction, and control (ADC) for all DoD MTFs within the contiguous United States (CONUS) and Outside of the contiguous United States (OCONUS), including enterprise execution of all functional capabilities.

Phased Implementation of NDAA FY 2017, Section 702



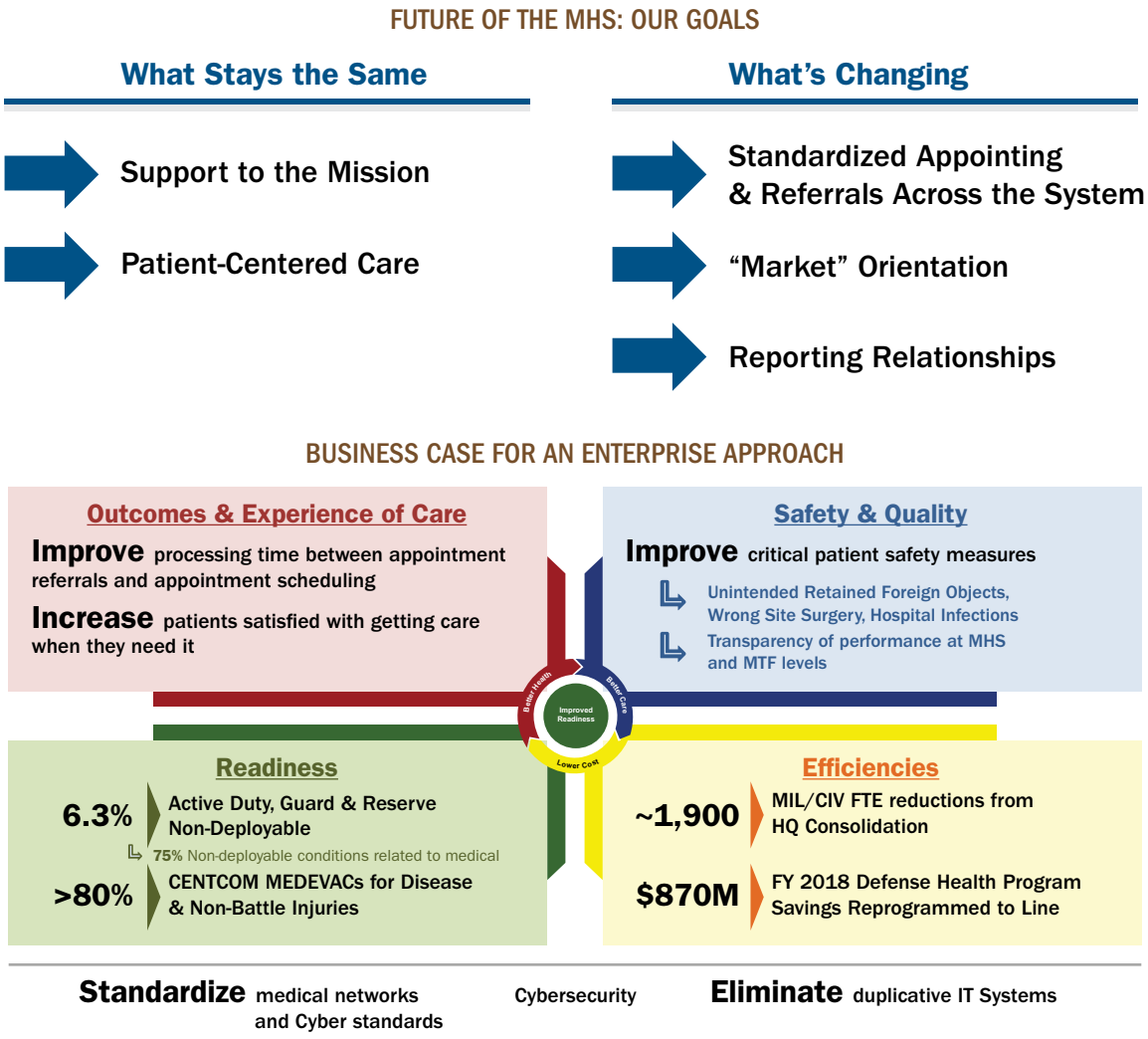
DHA VISION AND MISSION FOR FYs 2018–2019 *(CONT.)*

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

Guidance is under final review for aligning responsibilities for operational and installation-specific medical functions between the military departments and DHA in compliance with section 702 of the NDAA FY 2017, "Reform of Administration of the Defense Health Agency and Military Medical Treatment Facilities"; section 711 of the John S. McCain NDAA FY 2019, "Improvement of Administration of the Defense Health Agency and Military Medical Treatment Facilities"; and section 712 of NDAA FY 2019, "Organizational Framework of the Military Healthcare System to Support the Medical Requirements of the Combatant Commands."

Central precepts of this guidance are: that the military departments are responsible for determining the employability, deployability, and assignability of their personnel and for issuing policy and process guidance and laying out requirements, where appropriate, to assure proper evaluation of employability, deployability, and assignability; and that the DHA is responsible for clinical services supporting these readiness functions.

We need to be clear on what is changing, and what will not be changed, as shown below:



MHS MISSION

Performance Management System

MHS leaders have approved a core set of performance measures around the Quadruple Aim (Improved Readiness, Better Care, Better Health, and Lower Cost). Performance data for direct care are presented to and monitored quarterly by the Assistant Secretary of Defense for Health Affairs, the Service Surgeons General, and the Director of the Defense Health Agency (DHA). On a monthly basis, the Medical Deputies Action Group, comprising the Principal Deputy Assistant Secretary of Defense for Health Affairs, the Service Deputy Surgeons General, and the Deputy Director of the DHA, review detailed performance data related to three Process Improvement Priority areas: Achieve Zero Patient Harm, Improve Condition-Based Quality Care, and Improve Access. The SME workgroups, such as the Tri-Service Patient-Centered Medical Home (PCMH) Advisory Board, analyze the data monthly and identify performance outliers for Service action. The Tri-Service SME workgroups further explore reasons for challenges and opportunities for improvement and present plans to close performance gaps. The Services subsequently monitor performance of subordinate MTFs and identify reasons for and opportunities to resolve MTF variation in performance on the MHS core measures. The table below reflects both the core set of performance measures tracked in FY 2018, as well as the additional measures approved at the end of FY 2018 for monitoring in FY 2019.

MHS FY 2019 CORE MEASURES

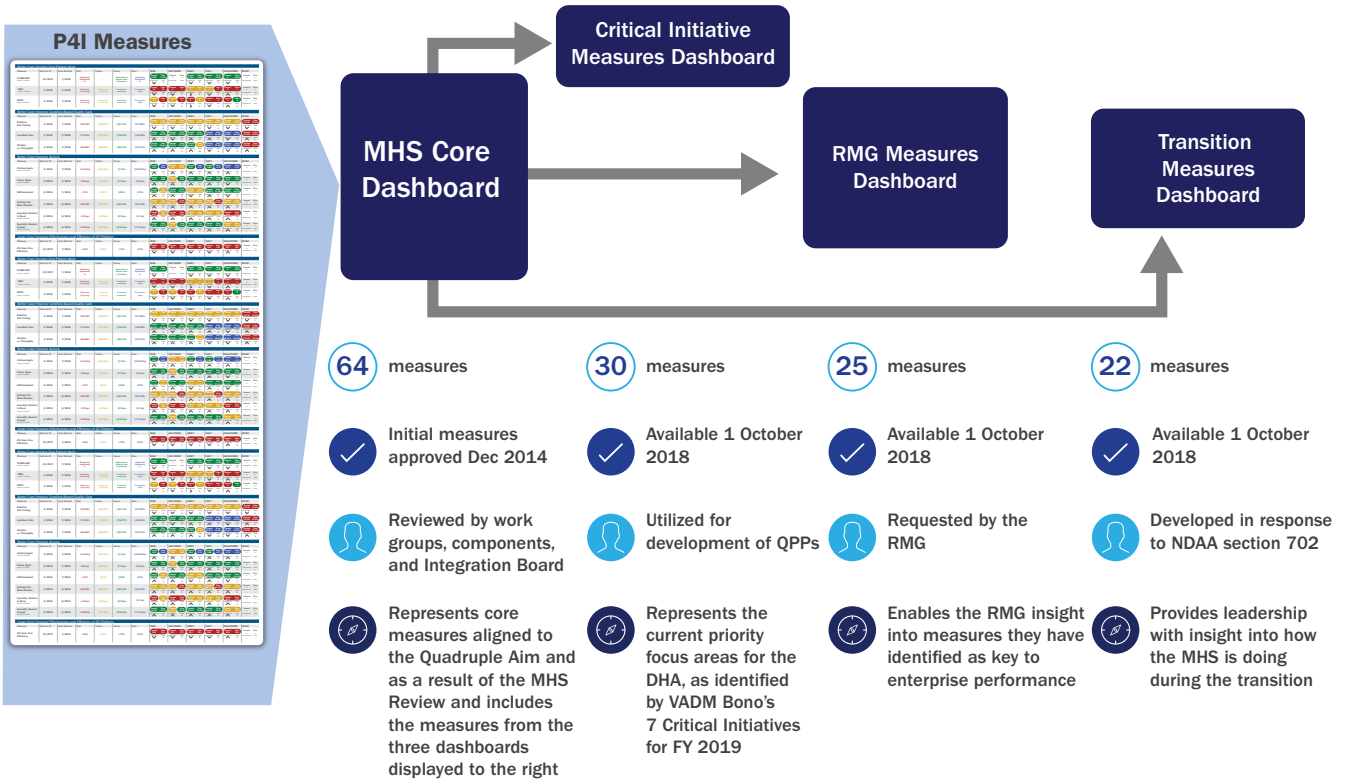
QUAD AIM	MEASURE NAME	STATUS	MHS FY 2019 CORE MEASURES	QPP CRITICAL INITIATIVES	RMG	NDAA TRANSITION
IMPROVED READINESS	Individual Medical Readiness (IMR)	Currently Used	●	●	●	●
	Percent of Providers Meeting KSAs for General Surgery	Prototype Approved	●	●	●	
	Percent of Providers Meeting KSAs for Orthopedic Surgery	Prototype Approved	●	●	●	
	Active Duty Non-Deployability	Prototype Approved	●	●	●	
	Capacity to Provide Health Services for Validated RFFs ISO Conventional Force Requirements	In Development	●	●	●	●
	Capacity to Provide Health Services for Validated RFFs ISO Non-Conventional Force Requirements	In Development	●	●	●	●
	Percent of Fill Against Authorized Billets	TBD	●	●	●	
	Defense Readiness Reporting System (DRRS) (Service)	In Development	●			●
BETTER HEALTH	Health Related Quality of Life (HRQOL)	Prototype Approved	●	●	●	
	Obesity Prevalence in Adults	Prototype Approved	●	●	●	
	Obesity Prevalence in Children	Prototype Approved	●	●	●	
	Overweight Prevalence in Adults	Prototype Approved	●	●	●	
	Overweight Prevalence in Children	Prototype Approved	●	●	●	
	Smoking Cessation	Prototype Approved	●	●		
	Tobacco Use Rate	Prototype Approved	●	●	●	
BETTER CARE	Risk Adjusted Mortality (Standardized Mortality Ratio)	Currently Used	●		●	
	NSQIP All Cases Morbidity	Currently Used	●			
	NSQIP All Cases Mortality	Currently Used	●			
	Inpatient: Recommend Hospital (Patient Satisfaction with Care)	Currently Used	●		●	●
	CAUTI-SIR	Currently Used	●			
	CLABSI-SIR	Currently Used	●	●	●	●
	Wrong Site Surgery	Currently Used	●	●		●
	URFO	Currently Used	●	●		●
	Diabetes A1c Testing	Currently Used	●	●		
	Low Back Pain	Currently Used	●	●		
	Children with Pharyngitis	Currently Used	●	●		
	Breast Cancer Screening	Currently Used	●			
	Cervical Cancer Screening	Currently Used	●			
	Colon Cancer Screening	Currently Used	●			
	7-Day Mental Health Follow-Up	Currently Used	●			
	All-Cause Readmissions	Currently Used	●			
	Primary Cesarean Section (AHRQ IQI 33)	Currently Used	●			
	Post-Partum Hemorrhage	Currently Used	●			
	Unexpected Newborn Complications	Currently Used	●			
	Well Child Visits	Currently Used	●			
	PCM Continuity	Currently Used	●			
	Potentially Recapturable Primary Care Leakage to the Network	Currently Used	●		●	●
	Ambulatory Specialty Care Leakage	Currently Used	●			
	Third Next Available Future Appointments	Currently Used	●	●		●
	Third Next Available 24-Hour Appointments	Currently Used	●	●	●	●
	Specialty Care: Average Days from Referral to Booking	Currently Used	●	●		
	Specialty Care: Average Days from Booking to Appointment	Currently Used	●	●		
	Secure Messaging Enrollment	Currently Used	●	●		
	Secure Messaging Response Within One Business Day	Currently Used	●			
	Outpatient Provider Communications Composite	Currently Used	●			
	Getting Care When Needed	Currently Used	●	●	●	●
	Active Duty Access for Primary Care	Prototype Approved	●	●	●	●
	Active Duty Access for Specialty Care	Prototype Approved	●	●	●	●
	Base/Operating Commander Assessment of Health Services Support	COA 1 Approved	●	●	●	
	Integrated Disability Evaluation System (Cycle Time)	Prototype Approved	●			●
	Residency Review Committee (ACGME) Pass Rate	Prototype Approved	●			●
	Joint Commission (Accreditation)	Prototype Approved	●			●
	College of American Pathologies (CAP)	Prototype Approved	●			●
LOWER COST	Per Member Per Month (PMPM)	Currently Used	●		●	●
	Total Purchased Care Cost	Currently Used	●			
	Private Sector Care Cost	Currently Used	●			●
	Total Empanelment	Currently Used	●			
	Pharmacy Percent Retail Spend	Currently Used	●			
	Active Duty: Specialty Care Provider Efficiency	Currently Used	●	●	●	
	Operating Room Utilization	Hold – Pending Brief to Mr. McCaffery	●			
	PCM Empanelment	In Development	●			
	Savings from Enterprise Shared Services and Reform Initiatives	Currently Used	●		●	
	Average Daily Patient Load	Prototype Approved	●			●
	Intensive Care Unit Bed Days	Prototype Approved	●			●

MHS MISSION *(CONT.)*

Performance Management System *(cont.)*

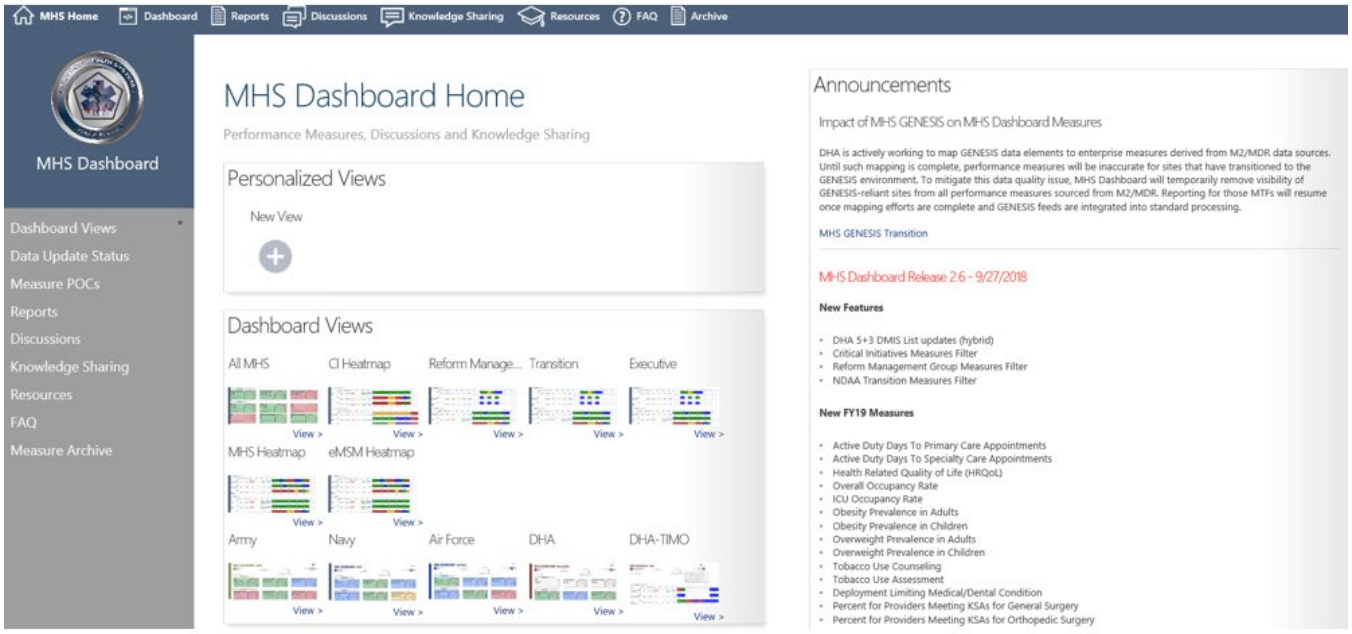
The MHS has different dashboards for different purposes and audiences, as shown below:

DIFFERENT DASHBOARDS FOR DIFFERENT PURPOSES (FY 2019 DASHBOARDS)



The MHS Performance Dashboard

The MHS Performance Dashboard is available to all Common Access Card holders on the DHA CarePoint Platform. Overall MHS data are presented for each measure compared to thresholds. Data can be further selected for each Service or purchased care (where applicable).



MHS MISSION *(CONT.)*

Performance Management System *(cont.)*

Process Improvement Priorities (PIP) Dashboard

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

Better Care/Achieve Zero Patient Harm

Measure	Data As Of	Next Refresh	Red	Yellow	Green	Blue	MHS	AIR FORCE	ARMY	NAVY	DHA-NCRMD	MCSC
CLABSI-SIR Lower is better	12/2017	7/2018	Statistically Significantly >1	—	Statistically no different than 1 (Predicted)	Statistically Significantly <1	Current 0.582 / Prior 1.156 Performance ↓ / Trend 1	Current — / Prior — Performance — / Trend —	Current 1.051 / Prior 1.521 Performance ↓ / Trend 1	Current 0 / Prior 1.285 Performance ↓ / Trend 2	Current 0 / Prior 0.523 Performance ↓ / Trend 2	Current — / Prior — Performance — / Trend —
WSS Lower is better	3/2018	7/2018	Current qtr ≥3 qtr avg	Current qtr <3 qtr avg	0 events in current qtr	0 events for 3 qtrs	Current 12 / Prior 13 Performance ↓ / Trend 1	Current 6 / Prior 7 Performance ↓ / Trend 1	Current 3 / Prior 3 Performance → / Trend 2	Current 1 / Prior 2 Performance ↓ / Trend 1	Current 2 / Prior 1 Performance ↑ / Trend 2	Current — / Prior — Performance — / Trend —
URFO Lower is better	3/2018	7/2018	Current qtr ≥3 qtr avg	Current qtr <3 qtr avg	0 events in current qtr	0 events for 3 qtrs	Current 5 / Prior 6 Performance ↓ / Trend 2	Current 1 / Prior 2 Performance ↓ / Trend 2	Current 2 / Prior 2 Performance → / Trend 3	Current 1 / Prior 2 Performance ↓ / Trend 1	Current 1 / Prior 0 Performance ↑ / Trend 1	Current — / Prior — Performance — / Trend —

Better Care/Improve Condition-Based Quality Care

Measure	Data As Of	Next Refresh	Red	Yellow	Green	Blue	MHS	AIR FORCE	ARMY	NAVY	DHA-NCRMD	MCSC
Diabetes A1c Testing	3/2018	7/2018	<90.54%	≥90.54%	≥93.37%	≥94.89%	Current 92.30% / Prior 92.48% Performance ↓ / Trend 3	Current 92.01% / Prior 92.29% Performance ↓ / Trend 3	Current 92.63% / Prior 92.72% Performance ↓ / Trend 3	Current 92.42% / Prior 92.51% Performance ↓ / Trend 3	Current 91.26% / Prior 91.96% Performance ↓ / Trend 2	Current 76.19% / Prior 76.42% Performance ↓ / Trend 1
Low Back Pain	3/2018	7/2018	<73.91%	≥73.91%	≥78.57%	≥82.98%	Current 82.53% / Prior 82.39% Performance ↑ / Trend 1	Current 82.00% / Prior 82.05% Performance ↓ / Trend 2	Current 81.68% / Prior 81.34% Performance ↑ / Trend 1	Current 84.13% / Prior 84.08% Performance ↑ / Trend 3	Current 85.82% / Prior 86.03% Performance ↓ / Trend 1	Current 70.25% / Prior 66.54% Performance ↑ / Trend 1
Children w/ Pharyngitis	3/2018	7/2018	<86.86%	≥86.86%	≥90.61%	≥94.12%	Current 92.41% / Prior 92.04% Performance ↑ / Trend 1	Current 91.43% / Prior 91.29% Performance ↑ / Trend 1	Current 91.18% / Prior 90.38% Performance ↑ / Trend 16	Current 94.87% / Prior 95.02% Performance ↓ / Trend 3	Current 95.46% / Prior 95.60% Performance ↓ / Trend 2	Current 72.22% / Prior 71.74% Performance ↑ / Trend 1

Better Care/Improve Access

Measure	Data As Of	Next Refresh	Red	Yellow	Green	Blue	MHS	AIR FORCE	ARMY	NAVY	DHA-NCRMD	MCSC
24-Hour Appts Lower is better	5/2018	7/2018	>1.5 Days	≤1.5 Days	≤1 Day	≤0.83 Days	Current 1.00 / Prior 0.82 Performance ↑ / Trend 1	Current 1.34 / Prior 1.05 Performance ↑ / Trend 2	Current 0.89 / Prior 0.76 Performance ↑ / Trend 1	Current 0.88 / Prior 0.72 Performance ↑ / Trend 1	Current 0.76 / Prior 0.73 Performance ↑ / Trend 1	Current — / Prior — Performance — / Trend —
Future Appts Lower is better	5/2018	7/2018	>8 Days	≤8 Days	≤7 Days	≤2 Days	Current 5.78 / Prior 4.96 Performance ↑ / Trend 1	Current 7.04 / Prior 5.93 Performance ↑ / Trend 1	Current 5.44 / Prior 4.70 Performance ↑ / Trend 1	Current 4.53 / Prior 3.80 Performance ↑ / Trend 1	Current 4.99 / Prior 5.09 Performance ↓ / Trend 1	Current — / Prior — Performance — / Trend —
SM Enrollment	5/2018	7/2018	<37%	≥37%	≥50%	≥75%	Current 50.00% / Prior 49.80% Performance ↑ / Trend 1	Current 51.09% / Prior 51.07% Performance ↑ / Trend 2	Current 42.59% / Prior 42.63% Performance ↓ / Trend 1	Current 58.24% / Prior 57.29% Performance ↑ / Trend 1	Current 59.62% / Prior 60.10% Performance ↓ / Trend 1	Current — / Prior — Performance — / Trend —
Getting Care When Needed	3/2018	8/2018	<81.20%	≥81.20%	≥84.40%	≥87.20%	Current 83.39% / Prior 81.59% Performance ↑ / Trend 1	Current 82.38% / Prior 79.67% Performance ↑ / Trend 1	Current 83.44% / Prior 82.81% Performance ↑ / Trend 1	Current 83.98% / Prior 80.43% Performance ↑ / Trend 1	Current 84.39% / Prior 83.31% Performance ↑ / Trend 2	Current — / Prior — Performance — / Trend —
Specialty: Referral to Book Lower is better	2/2018	6/2018	>4 Days	≤4 Days	≤3 Days	≤1 Day	Current 4.12 / Prior 3.88 Performance ↑ / Trend 1	Current 4.39 / Prior 4.21 Performance ↑ / Trend 1	Current 3.99 / Prior 3.75 Performance ↑ / Trend 1	Current 3.71 / Prior 3.36 Performance ↑ / Trend 1	Current 5.90 / Prior 5.74 Performance ↑ / Trend 1	Current — / Prior — Performance — / Trend —
Specialty: Booked tp Appt Lower is better	2/2018	6/2018	>24 Days	≤24 Days	≤15 Days	≤7.5 Days	Current 14.40 / Prior 13.73 Performance ↑ / Trend 1	Current 15.33 / Prior 14.56 Performance ↑ / Trend 1	Current 13.52 / Prior 12.88 Performance ↑ / Trend 1	Current 14.21 / Prior 13.41 Performance ↑ / Trend 1	Current 18.26 / Prior 18.02 Performance ↑ / Trend 1	Current — / Prior — Performance — / Trend —

Lower Cost/Increase Effectiveness and Efficiency of DC Platform

Measure	Data As Of	Next Refresh	Red	Yellow	Green	Blue	MHS	AIR FORCE	ARMY	NAVY	DHA-NCRMD	MCSC
AD: Spec Prov Efficiency	12/2017	7/2018	<61%	≥61%	<79%	≥79%	Current 28% / Prior 32% Performance ↓ / Trend 3	Current 22% / Prior 27% Performance ↓ / Trend 3	Current 31% / Prior 35% Performance ↓ / Trend 2	Current 28% / Prior 33% Performance ↓ / Trend 3	Current 32% / Prior 30% Performance ↑ / Trend 2	Current — / Prior — Performance — / Trend —

Purchased Care Performance Management

The Purchased Care Dashboard was developed by the TRICARE Health Plan (THP) Enterprise Support Activity Work Group to provide a method for determining the value of the services provided by THP to the Services and to our beneficiaries and other stakeholders. The goal was to identify and track important, actionable measures that directly impact each component of the Quadruple Aim. Thus there are measures that focus on quality, beneficiary experience, readiness, and cost of care/efficiency.

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

To the highest degree possible, measures were also selected to be benchmarked against civilian data, show performance in both adult and pediatric populations, and allow comparison with the direct care system. Several are also included on the Partnership for Improvement (P4I) Dashboard. In support of our efforts to better integrate purchased and direct care into one system of care, several additional quality measures have recently been added that can be measured in both direct and purchased care, and efforts are ongoing to identify additional measures that apply across the MHS. The total number of measures was based on ensuring a sufficiently broad approach to allow evaluation of all aspects of the Quadruple Aim while also limiting the number to that which could be reasonably managed. All of the measures were agreed upon by the Services and DHA.

MHS MISSION *(CONT.)*

Purchased Care Performance Management *(cont.)*

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

TRICARE HEALTH PLAN ENTERPRISE SUPPORT ACTIVITY—PURCHASED CARE DASHBOARD

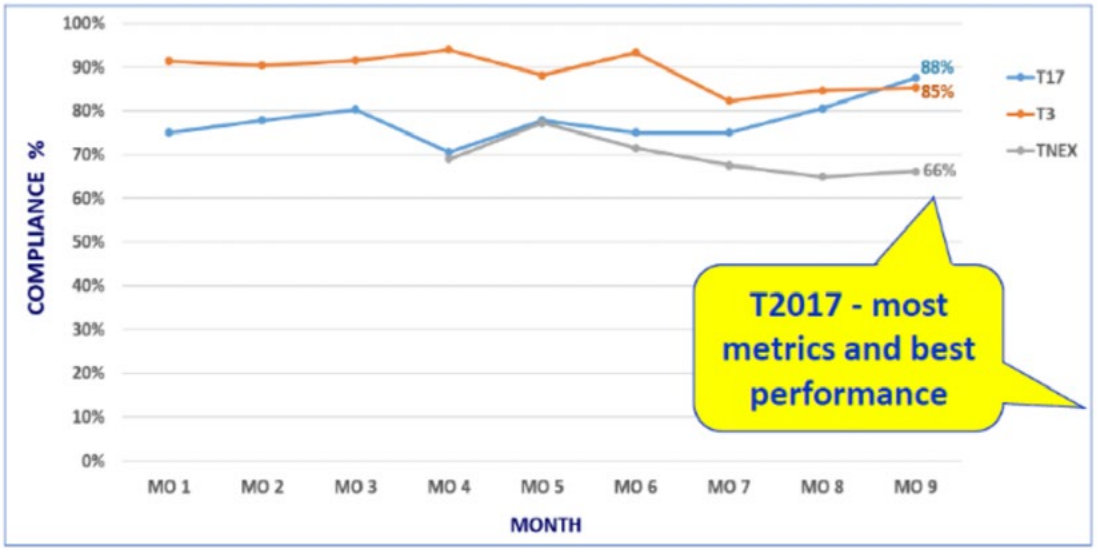
STRATEGIC ALIGNMENT	MEASURE	THRESHOLDS				CURRENT Managed Care Support Contract (MCSC) PERFORMANCE	PC COMPONENT PERFORMANCE			
							Managed Care Support Contract (MCSC)		TRICARE Overseas Prime (TOP)*	US Family Health Plans (6) Designated Providers (DP)
AIM	HEDIS Measures (QUALITY ONLY 2017)	RED <50th %ile	YELLOW ≥ 50th %ile	GREEN ≥75th %ile	BLUE >90th %ile		East	West	Overseas	DPs
Better Care and Better Health	Diabetes: Annual A1C Testing*	<90.78%	≥90.78%	>93.16%	>94.89%	76.37%				
	Imaging for Low Back Pain**	<75.95%	≥75.95%	>79.73%	>83.42%	71.01%				
	Children with Pharyngitis**	<85.54%	≥85.54%	>89.62%	>93.92%	71.25%				
	Children with URI**	<89.65%	≥88.65%	>92.87%	>96.26%	86.60%				
	Provider Communication	<85%	85-87.99%	88-90.99%	> 91%	86.6%	87.4%	85.7%		
	Care Coordination					71.1%	70.7%	69.7%		
	Beneficiary Satisfaction w/online enrollment svc									
	ATC Days to Specialty Care (Prime Enrolled)	<70%	70%	80%	90%	74%	79%	59%		
	AD Dental Care Access	<95%		95%	99%	99.7%				
	Referrals to Non-Network				<4%	2.8%	3.0%	2.1%		
	7-Day Mental Health Follow-up	<53%	≥53%	≥70%	≥90%	41%				
	Well Child Visits	<80.5%	≥80.5%	≥86.52%	≥89.52%	84.50%				
Increased Readiness	(M1) Medical capability reports provided to CCMDs upon request	<90%		≥90%	100%				95%	
	(M2) Are commands satisfied with the quality of the reports?	<90%		≥90%	100%				100%	
	(M1) Percentage of Patients moved from theater by TOP Contractor when deferred by TRANSCOM	<90%		≥90%	100%				100%	
	M2) Percentage of patient movement requests where a "go/no go" decision was provided to the unit within 90 minutes	<90%		≥90%	100%				100%	
Lower Costs		RED		GREEN	BLUE	MCSC	North	West	TOP	DPs
	PMPM	>3.2% yearly		>0 - 3.2% yearly	< 0% yearly growth	-3%				
	Private Sector Care Cost	>3.21%	≤3.21%	≤3.20%	≤0%	-3%				

MHS MISSION *(CONT.)*

Purchased Care Performance Management *(cont.)*

The new TRICARE (T2017) contracts successfully transitioned and went into effect on January 1, 2018. In comparing T2017 contract performance with the two previous generations of TRICARE contracts (T3 and TNEX) during the first nine months of performance, T2017 had the best compliance across more than 20 contract requirements in seven critical areas.

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



In FY 2018, DHA launched three new demonstrations/pilots to adhere to NDAA FY 2016, section 726 and NDAA FY 2017, sections 701(h), 704(a), and 705(a) requirements. These projects were Network Requirements and Standards for Urgent Care Centers, Medication Adherence, and Performance-Based Maternity Payment (P-BMP) program. Additionally, DHA maintained a demonstration project launched in FY 2016 for Lower Extremity Joint Replacement or Reattachment (LEJR) in the Tampa Bay market area. The Network Requirements and Standards for Urgent Care Centers pilot began in December 2017 and was implemented nationwide. The goal of this project was to improve access to and quality of care in urgent care center services in both MTFs and TRICARE preferred provider networks. It included removing referral requirements for network urgent care, extending hours at MTF urgent care, and requiring network urgent care facilities to comply with clinical practice guidelines. The Medication Adherence demonstration, launched in February 2018, was designed to reduce or eliminate copays for high-value drugs to encourage patient adherence to these medications. This program is expected to impact approximately 136,000 users per quarter with a copay savings for users of approximately $4.9 million per year. DHA is developing metrics related to desired clinical outcomes that are associated with these high-value drugs. Lastly, the P-BMP program began on April 1, 2018, redirecting maternity care to high-value, high-quality facilities, 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. Further, DHA is in the process of developing new value-based incentive programs for hospital value-based purchasing, home health value-based purchasing, modifications to reimbursement for physician-administered drugs, and episode-based bundled payment demonstrations. These projects will offer DHA the opportunity to test value-based payment models and incorporate innovative ideas and solutions into managed care support contracts under the TRICARE program.

WHAT IS TRICARE?

TRICARE is the worldwide Department of Defense (DoD) health care program serving 9.5 million Service members (Active and Guard/Reserve) on Active Duty (greater than 30 days) and their families; as well as retirees, their families, survivors, and certain former spouses (https://www.tricare.mil). As a major component of the Military Health System (MHS; www.health.mil), TRICARE brings together the military hospitals and clinics worldwide (often referred to as "direct care," usually in military treatment facilities, or MTFs) with network and non-network TRICARE-authorized civilian health care professionals, institutions, pharmacies, and suppliers (often referred to as "purchased care") to provide access to the full array of high-quality health care services while maintaining the capability to support military operations.

During FY 2018, in addition to providing care from MTFs where available, TRICARE offered beneficiaries a family of health plans, based on the following primary options:

- **TRICARE Prime** is comparable to health maintenance organization (HMO) benefits offered in many areas. Each enrollee chooses or is assigned a primary care manager (PCM), a health care professional who is responsible for helping the patient manage his or her care, promoting preventive health services (e.g., routine exams and immunizations), and arranging for specialty provider services as indicated. TRICARE Prime access standards apply to the travel time to reach a primary care or specialty care provider, waiting times to get an appointment, and waiting times in doctors' offices. TRICARE Prime's point-of-service (POS) option permits enrollees to obtain care from TRICARE-authorized providers other than the assigned PCM without a referral, but with deductibles and cost shares significantly higher than those under TRICARE Standard.
- **TRICARE Select** replaced TRICARE Standard and Extra on January 1, 2018. TRICARE Select is an enrollment-based, self-managed preferred provider network plan.
- **TRICARE for Life (TFL)** is Medicare wraparound coverage for TRICARE-eligible beneficiaries who have Medicare as their primary health care coverage. In most instances, Medicare pays first, then TRICARE pays second.
- **Other plans and programs:** Some beneficiaries may qualify for other benefit options depending on their location, Active/Reserve status, and/or other factors. Some examples are:
  - **Premium-based health plans**, including:
    - TRICARE Young Adult (TYA), available for purchase by qualified dependents up to the age of 26
    - TRICARE Reserve Select (TRS), available for purchase by qualified Selected Reserve members
    - TRICARE Retired Reserve (TRR), available for purchase by qualified Retired Reserve members
    - TRICARE Dental Program (TDP) and the TRICARE Retiree Dental Program (TRDP; terminated December 31, 2018)
    - Continued Health Care Benefit Program (CHCBP), which provides a Consolidated Omnibus Budget Reconciliation Act–like continuation benefit
  - **Other major benefits and plans**, including:
    - The Transitional Assistance Management Program (TAMP), which provides 180 days of premium-free continued access to the TRICARE benefit after release from Active Duty for certain Active Component members separating from Active Duty and Reserve Component members who have served more than 30 consecutive days in support of a Contingency Operation
    - Dental benefits (military dental treatment facilities and claims management for Active Duty using civilian dental services)
    - Pharmacy benefits in MTFs, via TRICARE retail network pharmacies, and through the TRICARE Pharmacy Home Delivery program (formerly called TRICARE Mail Order Pharmacy)
    - Overseas purchased care and claims processing services
  - **Supplemental programs**, including:
    - TRICARE Prime Remote (TPR) in the United States and overseas, DoD-Veterans Affairs (VA) sharing arrangements, and joint services
    - Uniformed Services Family Health Plan (USFHP), which provides the full TRICARE Prime benefit, including pharmacy (under capitated payment) to non-Active Duty MHS enrollees at six statutorily specified locations: Washington, Texas, Maine, Massachusetts, Maryland, and New York
    - Chiropractic care, limited to Service members (on Active Duty) at certain MTFs only (no purchased chiropractic care)
    - Clinical and educational services demonstration programs (e.g., chiropractic care, autism services, and the Acute Care Demonstration Pilot)

HOW TRICARE IS ADMINISTERED

TRICARE is administered on a regional basis, through two regions in the United States (East and West), and an overseas contractor aligned with counterpart TRICARE Regional Offices (TRO) responsible for managing purchased care operations and coordinating medical services available through civilian providers with the MTFs. TROs do the following:

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

NEW BENEFITS AND PROGRAMS IN FY 2018 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT

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

Contracts and Organizational Change

DHA Assumes Responsibility for the First Phase of MTFs

On October 1, 2018, the first phase of MTFs transitioned under DHA management as mandated by the 2017 National Defense Authorization Act (NDAA). The DHA will be responsible for budgetary matters, information technology, health care administration and management, administrative policy and procedure, and military medical infrastructure at all MTFs. The Services will retain responsibility for operational mission support, and recruiting, organizing, training, and equipping personnel. The first phase of transition includes hospitals and clinics at Fort Bragg, N.C.; Naval Air Station Jacksonville, Fla.; Joint Base Charleston, S.C.; Keesler Air Force Base, Miss.; and Seymour Johnson Air Force Base, N.C.; in addition to the Walter Reed National Military Medical Center and Fort Belvoir Community Hospital, both in the National Capital Region (NCR). The next phase of integration will comprised hospitals and clinics in the eastern United States and is scheduled to be complete by October 1, 2019.

New TRICARE Regions and Managed Care Support Contracts Operational January 1, 2018

As noted in last year's report, beginning January 1, 2018, the TRICARE North and South Regions combined to form TRICARE East, while TRICARE West remained largely unchanged. The new managed care support contracts ended their transition-in periods and became operational on January 1, 2018, consistent with the TRICARE Regions.

Value-Based Incentive Demonstration Programs

In FY 2018, DHA launched three new demonstrations/pilots to adhere to NDAA FY 2016, section 726 and NDAA FY 2017, sections 701(h), 704(a), and 705(a) requirements. These projects were Network Requirements and Standards for Urgent Care Centers, Medication Adherence, and Performance-Based Maternity Payment (P-BMP) program. Additionally, DHA maintained a demonstration project launched in FY 2016 for Lower Extremity Joint Replacement or Reattachment (LEJR) in the Tampa Bay market area. The Network Requirements and Standards for Urgent Care Centers pilot began in December 2017 and was implemented nationwide.

U.S. Secretaries of Veterans Affairs (VA) and Defense Pledge to Align Electronic Health Record (EHR) Systems

On September 26, 2018, Secretary of Defense James Mattis and Secretary of VA Robert Wilkie issued a joint statement reinforcing both departments' commitment to ensure the successful transition from legacy patient-data systems to streamlined and modern EHRs, which support Service members, Veterans, and their families. The DoD and the VA both selected Cerner to modernize EHR systems.

TRICARE Program Changes in 2018

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

Effective January 1, 2018:

- **TRICARE Select replaced TRICARE Standard and TRICARE Extra.** TRICARE Select features an enrollment requirement for purchased care with non-network and network care in a single plan that Congress named TRICARE Select.
- **All TRICARE beneficiaries in December 2017 were enrolled in their TRICARE plan effective January 1, 2018.** TRICARE Prime enrollees remained in TRICARE Prime, while TRICARE Standard and Extra beneficiaries were automatically enrolled into TRICARE Select.
- **No referral or authorization is needed for TRICARE Select enrollees** to obtain care from any TRICARE authorized provider.
- **Fixed fee copayments** apply for most network care in TRICARE Select after the annual deductible is met. Enrollees will welcome the simplicity and predictability of copayments, and providers will find it more attractive to participate in the TRICARE network.

NEW BENEFITS AND PROGRAMS IN FY 2018 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

- **TRICARE expanded coverage** of preventive care services, treatment of obesity, high-value care, and telehealth. There is no cost for preventive services from network providers.
- **Non-enrolled beneficiaries** may only receive care at a military clinic or hospital on a space available basis; non-enrollment means no coverage for civilian care. Beneficiaries need to be sure they are enrolled in TRICARE Prime or TRICARE Select if they want coverage for civilian care (see bullet below about grace period).
- **TRICARE expanded coverage of medically necessary foods and vitamins.** Medically necessary food, the medical equipment necessary to administer such food, and nutritional counseling may be covered effective January 1, 2018.

During Calendar Year 2018:

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

Legislative Changes to TRICARE Coverage for Guard and Reserve Members

In response to legislative changes in the NDAA FYs 2017 and 2018, TRICARE updated their operations and policy manuals in August 2018 to reflect these changes.

With regard to NDAA FY 2017, section 711 extended TRICARE coverage to National Guard members and their eligible family members who were on 502(f) orders under Title 32 and called to state disaster response duty. Section 748(b) eliminated the requirement of Reserve Component (RC) members activated for more than 30 days to be in support of a contingency operation for TRICARE to pay non-network, TRICARE-authorized providers up to 115 percent of the CHAMPUS Maximum Allowable Charge and waive the annual deductible for those family members using TRICARE Select.

Section 511 of NDAA FY 2018 extended pre-deployment/early TRICARE eligibility and transitional TRICARE coverage to those RC members and their eligible family members in receipt of 12304b orders under Title 10.

Federal Employees Dental and Vision Insurance Program (FEDVIP) Offered to Some TRICARE Beneficiaries

For the first time, FEDVIP benefits are available to some TRICARE beneficiaries. Those who previously qualified for the TRICARE Retiree Dental Program (TRDP, which ended in 2018—see page 15) are eligible to choose a dental plan from among the 10 participating dental carriers who participate in FEDVIP. Most beneficiaries in a TRICARE health plan may also enroll in a FEDVIP vision plan. This comprehensive vision coverage, including eyeglasses or contacts, is in addition to the routine eye examination benefit that many beneficiaries have under TRICARE Prime or TRICARE Select.

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

NEW BENEFITS AND PROGRAMS IN FY 2018 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

TRICARE Retiree Dental Program Ends

TRDP ended on December 31, 2018 in response to NDAA FY 2017. The program change affected 1.63 million beneficiaries. Those enrolled in TRDP were eligible to select a dental plan through FEDVIP during the 2018 Federal Benefits Open Season to maintain coverage. Enrollment was not automatic.

TRICARE Receives Highest Marks from Temkin Experience Ratings

TRICARE delivered the best customer experience among 14 health plans included in the 2018 Temkin Experience Ratings. The study is an annual customer experience benchmark of companies based on a survey of 10,000 U.S. consumers.

Quadruple Aim: Improved Readiness

DHA Highlights Provider Resilience App

The DHA highlighted its Provider Resilience App, which offers health care providers tools to guard against compassion fatigue and burnout. The app features a dashboard and resilience rating as well as self-assessments, words of encouragement, and videos from patients expressing their gratitude. The app has been downloaded more than 35,000 times and averages 924 new downloads per month.

Uniformed Services University Awarded the North Atlantic Treaty Organization (NATO) Highest Honor for Medical Support

NATO's highest honor for medical support was given to the Uniformed Services University of the Health Sciences (USUHS). The 2018 Dominique-Jean Larrey Award was presented to USUHS for consistent and extensive contributions to the enhancement of NATO multinationality and interoperability through support to the Chiefs of NATO Medical Services (COMEDS) working groups and the Science and Technology Organization (STO) Human Factors and Medicine Panel (HFM). USUHS was recognized for its contributions to improvements in health care for NATO forces through research, innovation, analysis, education and training, knowledge translation, and support to operations.

Disaster and Humanitarian Support

Health Care Support Following Hurricanes, Floods and Fires

Following the storms and wildfires in 2018, TRICARE put into place emergency procedures for impacted beneficiaries. Emergency prescription refill procedures or referral waivers were in effect for Alabama, Alaska, California, Florida, Georgia, Guam, Hawaii, Louisiana, Mariana Islands, Maryland, Mississippi, North Carolina, South Carolina, Virginia, Washington, D.C., and Wisconsin as follows:

- May 30–June 11, 2018: Maryland (emergency prescription refills)
- June 27–July 9, 2018: California (emergency prescription refills)
- August 10–20, 2018: California (emergency prescription refills)
- August 22–September 4, 2018: Hawaii (emergency prescription refills and referral waivers)
- August 30–September 10, 2018: Wisconsin (emergency prescription refills)
- September 3–13, 2018: Alabama, Louisiana, and Mississippi (emergency prescription refills)
- September 10–20, 2018: Guam and Mariana Islands (emergency prescription refills)
- September 19–30, 2018: Georgia, Maryland, North Carolina, South Carolina, Virginia, and Washington, D.C. (emergency prescription refills and referral waivers)
- November 1–30, 2018: Alabama, Georgia, Florida, North Carolina, South Carolina, and Virginia (emergency prescription refills and referral waivers)
- November 19–December 8, 2018: California (emergency prescription refills and referral waivers)
- November 30–December 10, 2018: Alaska (emergency prescription refills)

Hurricane Florence Response Efforts

Over 13,000 uniformed personnel provided support to areas impacted by Hurricane Florence. Along with personnel, the Army committed 90 helicopters and other aircraft for search and rescue efforts, along with about 30 watercraft and a few thousand high-water vehicles. 4,500 cots and 200 medical beds were made available to those who evacuated the storm.

First Robotic Surgery Performed on USNS Mercy

As part of Pacific Partnership 2018, a joint team of multinational surgeons successfully performed a cholecystectomy using a Da Vinci Xi Robotic Surgical System aboard the USNS Mercy. The Sri Lankan patient was transferred to the Mercy's post-anesthesia care unit and discharged from the ship in excellent condition for follow-up care with local physicians.

NEW BENEFITS AND PROGRAMS IN FY 2018 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

Quadruple Aim: Better Care

DoD and U.S. Food and Drug Administration (FDA) Work Together to Benefit Warfighters

On November 2, 2018, the FDA and DoD signed a Memorandum of Understanding (MOU) regarding medical product development and assessment. Under the terms of the MOU, the FDA and DoD will work closely to evaluate how to foster access to safe and effective medical products that serve the military's medical needs; give the highest level of attention to and expedite review of priority DoD medical products; provide ongoing technical advice to aid in the rapid development and manufacturing of medical products for use by the military; and examine products currently under development to determine opportunities to streamline review and expedite their availability.

MHS Nurse Advice Line Expands to South Korea and Japan

The MHS Nurse Advice Line is now available to Service members stationed in South Korea and Japan. The service allows beneficiaries to speak with a registered nurse at no cost and at any time. Nurses can help triage the appropriate level of care, help schedule appointments, and more. The service has been available to TRICARE beneficiaries in the U.S. and Europe since 2014.

Philippine Provider Network

The DHA established a preferred-provider network (PPN) in the Philippines to replace the Philippine Demonstration program, effective January 1, 2018. Any provider approved in the Philippine Demonstration program is still available as part of the new PPN. The program began as a way to offer high-quality health care for eligible TRICARE Overseas Program (TOP) Standard beneficiaries. Beginning January 1, 2018, copayments, cost-shares deductibles and catastrophic caps are the same as those in the TRICARE Select health plan.

Air Force Opens First Invisible Wounds Center (IWC)

On August 30, 2018, the 96th Medical Group opened the first IWC, modeled after the best practices of the Intrepid Spirit Centers. The IWC assembles 18 specialties under one roof to provide individual, holistic care using a combination of conventional and complementary therapies. The IWC will serve as a regional treatment center for post-traumatic stress, traumatic brain injury, associated pain conditions, and psychological injuries.

Naval Hospital Jacksonville Launches Navy Care App

The Navy Care app enables patients to have a live, virtual visit with a clinician, using a smartphone, tablet, or computer. Active Duty, retirees, and families can also use the virtual app for follow-up medical visits. The Navy Care app allows Sailors and Marines to complete their Period Health Assessment (PHA) from their unit or home, decreasing the amount of time away from their job. The patient and clinician see and talk to each other in real time, using Navy Care's secure app or website, from any video-enabled device (such as a smartphone, tablet, laptop, or desktop computer). The Navy Care app launched at Naval Hospital Jacksonville in February 2018.

Naval Health Clinic Oak Harbor First GENESIS Site to Complete Accreditation

On June 22, 2018, Naval Health Clinic Oak Harbor became the first clinic using the new electronic health records (EHR) to pass both The Joint Commission accreditation and Navy Medicine Medical Inspector General inspection. It was also the first MHS GENESIS facility to successfully complete a primary care medical home survey, passing with zero findings.

DHA Receives Five FedHealthIT Innovation Awards

The DHA announced it received five FedHealthIT Innovation awards for innovative federal health care programs. The award honorees were chosen by their peers for their willingness to take achievable risk and deliver real results. The awards this year went to:

- TRICARE Online Patient Portal, Solution Delivery Division
- Enterprise Intelligence and Data Solutions
- Pharmacy Analytic Support Services
- Enterprise Blood Management Systems: Transfusion and Donor
- Mitigation and Remediation Support Team

NEW BENEFITS AND PROGRAMS IN FY 2018 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

Quadruple Aim: Better Health

U.S. Navy Implements Long-Term Opioid Therapy Safety Program

The Navy has instituted new policies and developed training to ensure safe opioid use by patients who are seeking access to opioid medications for the long-term treatment of chronic pain. Patients with a projected course of therapy of 90 days or longer are now required to undergo a psychiatric and substance abuse history screening. Patients must also establish informed consents and an opioid care agreement with their clinician. Navy Medicine is also taking steps to limit opioid prescriptions by educating both patients and providers on alternative pain management methods.

Quadruple Aim: Lower Cost

TRICARE Annual Cost Increases

The DHA adjusted TRICARE costs on January 1, 2018. Some rates were set by the NDAA FY 2017. Others were based on factors such as the annual cost of living adjustment or average costs of covered services. To make costs more predictable for enrollees, the DHA introduced more copayments for in-network care under the new TRICARE Select program.

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

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

Increases to TRICARE Pharmacy Copayments

On February 1, 2018, copayments for prescription drugs at TRICARE Pharmacy Home Delivery and retail pharmacies increased. The changes were required by law and affected beneficiaries who were not on Active Duty. Using home delivery, copayments for a 90-day supply of generic formulary drugs increased from $0 to $7, while brand-name formulary drugs increased from $20 to $24. At retail pharmacies, 30-day supply copays increased from $10 to $11 for generic drugs and from $24 to $28 for brand-name pharmaceuticals. Prescriptions filled at military dispensaries continued to remain available at no cost.

BENEFICIARY TRENDS AND DEMOGRAPHICS

System Characteristics

TRICARE FACTS AND FIGURES—PROJECTED FOR FY 2019

	PROJECTED FOR FY 2019[a]	FY 2018 (AS PROJECTED LAST YEAR)
Total Beneficiaries	**9.5 million worldwide[b]**	9.4 million worldwide
MILITARY FACILITIES—DIRECT CARE SYSTEM[c]		
Inpatient Hospitals and Medical Centers	**51 (37 in U.S.)**	51 (38 in U.S.)
Ambulatory Care and Occupational Health Clinics	**424 (373 in U.S.)**	381 (329 in U.S.)
Dental Clinics	**248 (204 in U.S.)**	247 (200 in U.S.)
Veterinary Facilities	**251 (206 in U.S.)**	251 (206 in U.S.)
Military Health System (MHS) Defense Health Program–Funded Personnel	**144,217**	144,217
Military	**82,256**	82,562
	30,796 Officers	30,938 Officers
	51,460 Enlisted	51,624 Enlisted
Civilian (including Foreign National)	**61,639**	61,655
CIVILIAN RESOURCES—PURCHASED CARE SYSTEM[d]		
Network Primary Care, Behavioral Health, and Specialty Care Providers (i.e., individual, not institutional, providers)	**799,600**	604,279
Network Behavioral Health Providers (shown separately, but included in above)	**78,660**	84,029
TRICARE Network Acute Care Hospitals	**3,309**	3,664
Behavioral Health Facilities	**1,310**	833
Contracted (Network) Retail Pharmacies	**56,810**	58,427
Contracted Worldwide Pharmacy Home Delivery Vendor	**1**	1
TRICARE Dental Program (TDP) (for Active Duty families, Reservists and their families)	**Over 1.8 million covered lives in 767,000 contracts**	Over 1.8 million covered lives in 767,000 contracts
TDP Network Dentists	**Over 75,000 total dentists, including: 61,000 general dentists over 14,000 specialty dentists**	Over 76,000 total dentists including: almost 62,000 general dentists over 14,000 specialty dentists
TRICARE Retiree Dental Program (for retired Uniformed Services members and their families)	**Over 1.6 million covered lives in over 843,000 contracts[e]**	Over 1.6 million covered lives in over 721,000 contracts
Total Projected FY 2019 Unified Medical Program (UMP) (including Projected Trust Fund Receipts)	**$53.67 billion[f]**	**$53.64 billion**
Projected Receipts from MERHCF Trust Fund	**$10.65 billion**	**$10.38 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) 2019 is 9,506,000, rounded to 9.5 million, and is based on Director, Defense Health Agency (DHA) Memo dated December 6, 2018, "Estimate of Beneficiaries Eligible for Health Care in Fiscal Year 2019."

[c] Military treatment facility (MTF) clinic count includes occupational health, community-based, embedded behavioral health, Active Duty troop, centers of excellence, and joint DoD-VA clinics, and excludes leased/contracted facilities and Aid Stations; MTF counts are consistent with DHA/Resources & Management (J-1/J-8)/Budget and Execution and Programming Divisions. Source: DHA/Strategy, Plans, and Functional Integration (J-5)/Decision Support Division, 11/2/2018.

[d] As reported by TRICARE Regional Offices (TROs) for contracted network provider and hospital data (12/6/2018), and by TRICARE Dental Office, Health Plan Execution and Operations for dental provider data (11/27/2018).

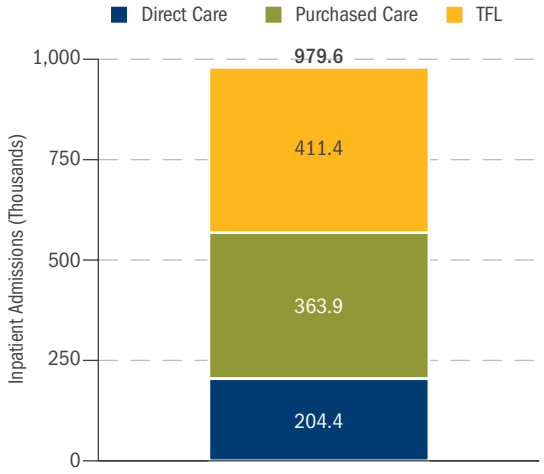
[e] TRICARE Retiree Program ended December 31, 2018.

[f] UMP presented here includes direct and private-sector care funding, military personnel, military construction, and the Medicare-Eligible Retiree Health Care Fund (MERHCF) ("Accrual Fund"). Change in reporting for FY 2017: presenting actual and projected MERHCF receipts from the Trust Fund instead of DoD Normal Cost Contribution. Budget and expense data from DHA/Resources & Management Directorate, 11/21/2018.

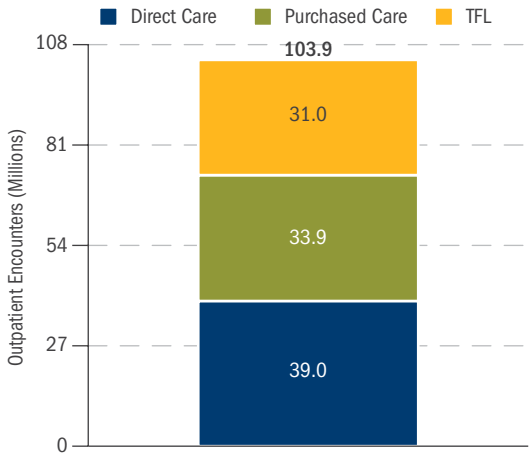
BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

FY 2018 TRICARE Workload and Population Summary

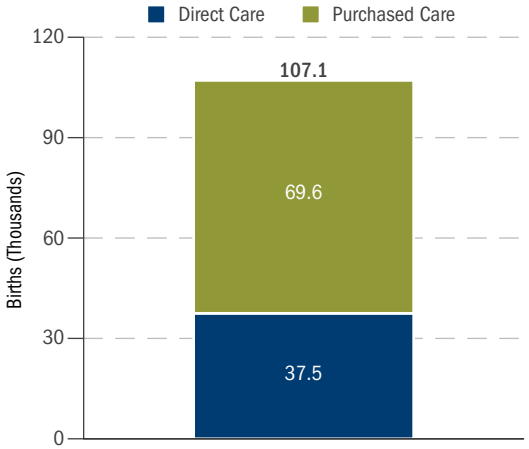
INPATIENT ADMISSIONS[a]



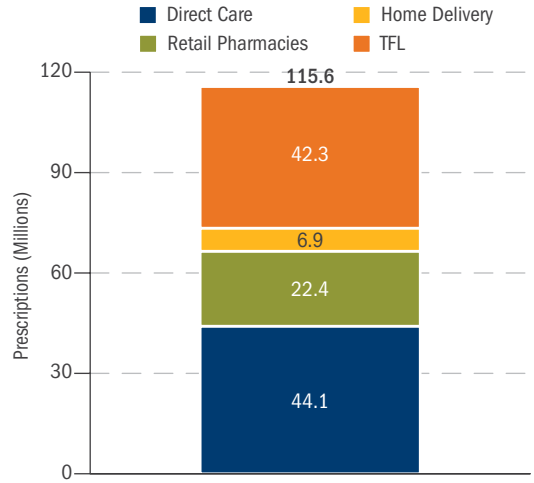
OUTPATIENT ENCOUNTERS[a]



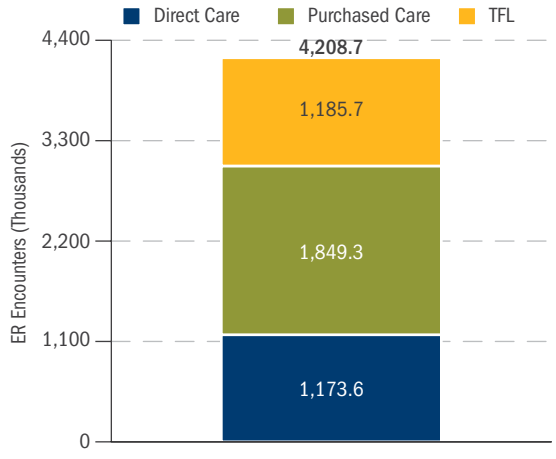
BIRTHS[a]



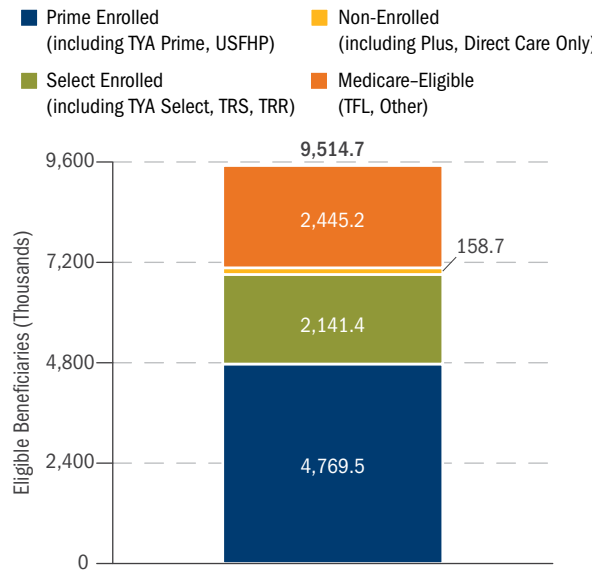
PRESCRIPTIONS[a]



ER ENCOUNTERS[a]



ELIGIBLE BENEFICIARIES



Source: MHS administrative data and Defense Enrollment Eligibility Reporting System (DEERS), 1/17/2019

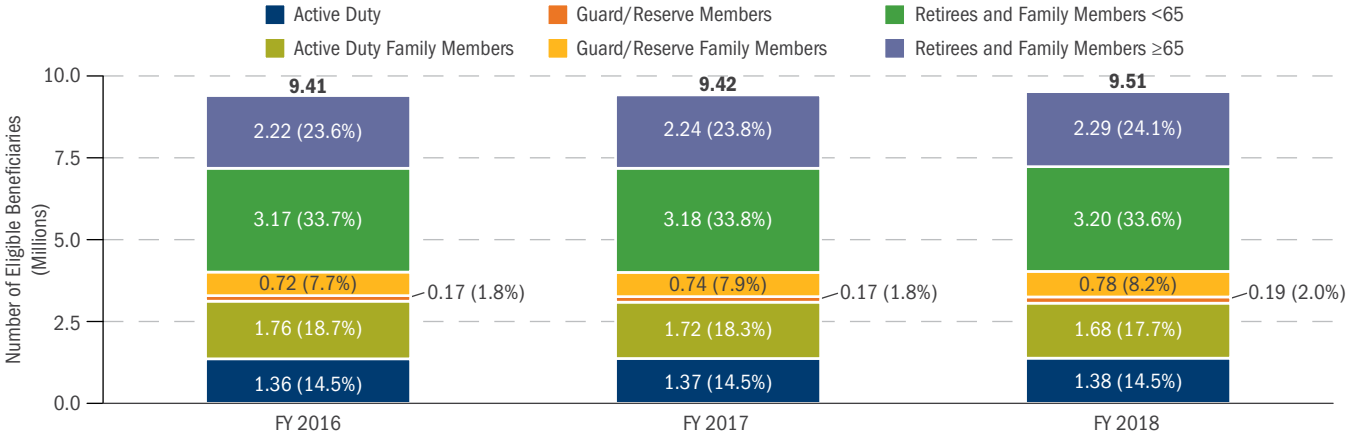
[a] Excludes USFHP because MHS administrative data used in this report have no USFHP utilization information

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Number of Eligible and Enrolled Beneficiaries Between FY 2016 and FY 2018

The number of beneficiaries eligible for DoD medical care (including TRICARE Reserve Select [TRS], TRICARE Young Adult [TYA], and TRICARE Retired Reserve [TRR]) increased from 9.4 million[1] in FY 2016 to 9.5 million in FY 2018. Although the number of Active Duty members increased slightly, the number of Active Duty family members (ADFMs) fell by 5 percent. The number of retirees and family members (RETFMs) under age 65 remained flat, but the number of RETFMs aged 65 and over increased by 3 percent.

TRENDS IN THE END-YEAR NUMBER OF ELIGIBLE BENEFICIARIES BY BENEFICIARY GROUP, FYs 2016–2018

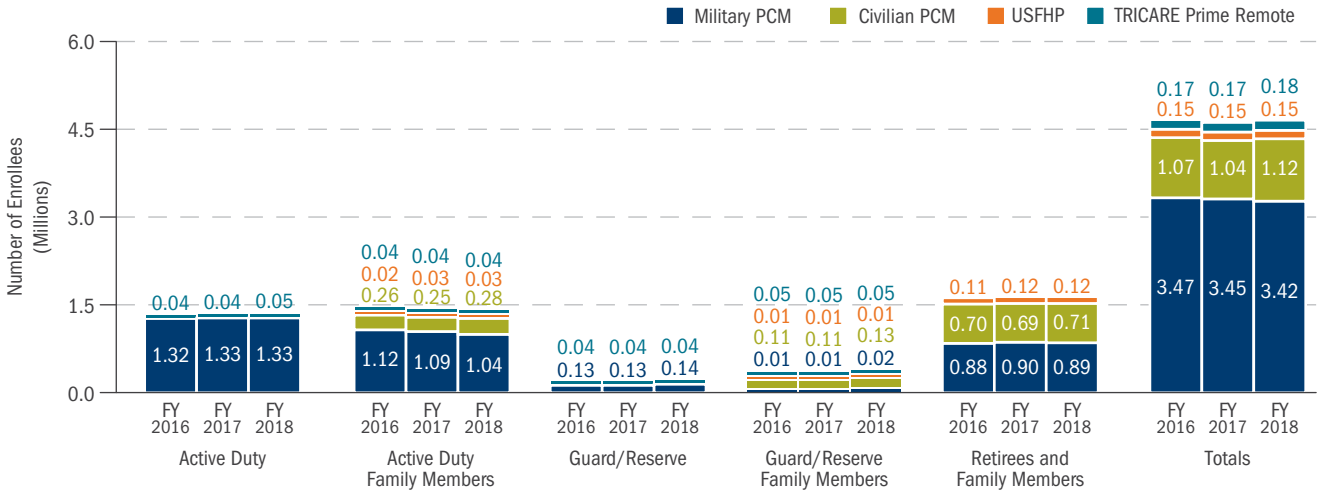


Source: DEERS, 1/17/2019

Note: The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere. Also, both inactive Guard/Reserve members and their families are included under Guard/Reserve Family Members because their benefits are similar to those of family members.

- ADFMs experienced a decline in Prime enrollment with both military and civilian primary care managers (PCMs). Prime enrollment by Guard/Reserve members and their families remained roughly the same.
- The trend in retiree and family member enrollments stabilized between FY 2016 and FY 2018, after shifting from civilian to military PCMs the past few years. About 56 percent of their enrollments are with military PCMs and 44 percent with civilian PCMs.
- TRICARE Prime Remote (TPR) and Uniformed Services Family Health Plan (USFHP) enrollment remained about the same from FY 2016 to FY 2018.

TRENDS IN THE END-YEAR NUMBER OF ENROLLED BENEFICIARIES BY BENEFICIARY GROUP, FYs 2016–2018



Source: DEERS, 1/17/2019

[1] This number should not be confused with the one displayed under TRICARE Facts and Figures on page 19. The population figure on page 19 is a projected FY 2019 total, whereas the population reported on this page is the actual for the end of FY 2018.

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 2018

PLAN TYPE	0–17	18–24	25–44	45–64	≥65	TOTAL[a]
Prime Enrolled	1,296,327	907,466	1,513,790	1,044,460	7,419	4,769,462
Prime	1,263,664	889,114	1,494,010	999,723	2,365	4,648,876
USFHP	32,663	7,775	16,684	44,737	5,054	106,913
TYA Prime	0	10,577	3,096	0	0	13,673
Select Enrolled	637,651	227,548	481,222	781,292	5,238	2,132,951
TRICARE Select	484,143	175,879	306,729	733,051	4,119	1,703,921
TRS	147,386	31,285	166,967	31,544	19	377,201
TRICARE Plus	6,047	1,537	3,300	16,299	1,100	28,283
TYA Select	0	18,737	4,218	0	0	22,955
TRR[b]	75	110	8	398	0	591
Non-Enrolled	30,431	29,477	40,412	38,549	19,865	158,734
Direct Care Only	30,431	29,477	40,412	38,549	19,865	158,734
Medicare-Eligible	24	984	35,752	151,195	2,257,208	2,445,163
TFL	5	547	17,681	82,749	1,954,863	2,055,845
TRICARE Plus[c]	0	5	152	743	187,160	188,060
Direct Care Only	1	39	4,355	15,807	73,984	94,186
Prime	13	303	12,283	49,077	26	61,702
USFHP	0	16	324	1,744	40,631	42,715
Other	5	74	957	1,075	544	2,655
Subtotal	**1,964,433**	**1,165,475**	**2,071,176**	**2,015,496**	**2,289,730**	**9,506,310**
TRR Enrollment Adjustment[b]						**8,428**
Total						**9,514,738**

Source: DEERS, 1/17/2019

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

[b] It is a known issue that TRR enrollment numbers are substantially understated in the MHS administrative data. From the Defense Manpower Data Center DEERS Medical Policy Report, the actual total number of TRR enrollments at the end of FY 2018 was 9,019 (see page 154). The incremental change in the total is reflected in the row labeled "TRR Enrollment Adjustment." DHA has found the cause of the error and is working to implement a fix but it was not yet ready at the time this report was written.

[c] Among Medicare eligibles, 185,057 with TRICARE Plus also have TFL. These numbers are not included in the TFL row.

- About one-third of USFHP enrollees are seniors (aged 65 and older), and one-fifth are children (aged 0–17).
- The vast majority of those aged 65 and above are enrolled in Medicare Part B and are covered by TRICARE for Life (TFL) as their supplemental plan. About 9 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 63 percent choose TFL and 37 percent choose Prime.
- Beneficiaries aged 45–64 had the lowest TRICARE Prime enrollment rate, at 52 percent. Enrollment rates for the other age groups were 66 percent for 0–17, 78 percent for 18–24, and 73 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 2018

PLAN TYPE	AD	ADFM	GR	GRFM	IGR	IGRFM	OTH	RET	RETFM	SRV	TOTAL[a]
Prime Enrolled	1,376,376	1,391,368	185,961	189,727	5,062	13,890	2,985	566,631	999,554	37,908	4,769,462
Prime	1,376,376	1,364,400	185,961	183,069	4,953	13,511	2,903	539,263	943,160	35,280	4,648,876
USFHP	0	25,761	0	6,464	109	375	79	27,368	44,445	2,312	106,913
TYA Prime	0	1,207	0	194	0	4	3	0	11,949	316	13,673
Select Enrolled	0	265,005	0	100,205	163,554	279,421	16,836	427,398	815,610	64,922	2,132,951
TRICARE Select	0	261,365	0	99,058	24,285	40,982	16,825	417,224	780,506	63,676	1,703,921
TRS	0	0	0	325	139,266	237,587	1	10	10	2	377,201
TRICARE Plus	0	2,025	0	152	1	4	2	9,952	15,571	576	28,283
TYA Select	0	1,615	0	670	0	843	6	0	19,159	662	22,955
TRR[b]	0	0	0	0	2	5	2	212	364	6	591
Non-Enrolled	0	18,872	0	4,380	19,321	2,870	18,832	28,902	59,204	6,353	158,734
Direct Care Only	0	18,872	0	4,380	19,321	2,870	18,832	28,902	59,204	6,353	158,734
Medicare-Eligible	0	2,615	0	788	152	943	2,269	1,183,667	758,514	496,215	2,445,163
TFL	0	0	0	0	0	0	1,663	979,550	640,693	433,939	2,055,845
TRICARE Plus[c]	0	426	0	49	0	0	29	95,762	60,547	31,247	188,060
Direct Care Only	0	1,644	0	299	1	28	499	50,729	21,509	19,477	94,186
Prime	0	0	0	0	0	0	27	36,433	21,703	3,539	61,702
USFHP	0	0	0	0	0	0	31	21,071	13,786	7,827	42,715
Other	0	545	0	440	151	915	20	122	276	186	2,655
Subtotal	**1,376,376**	**1,677,860**	**185,961**	**295,100**	**188,089**	**297,124**	**40,922**	**2,206,598**	**2,632,882**	**605,398**	**9,506,310**
TRR Enrollment Adjustment[b]											**8,428**
Total											**9,514,738**

Source: DEERS, 1/17/2019

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

[b] It is a known issue that TRR enrollment numbers are substantially understated in the MHS administrative data. From the Defense Manpower Data Center DEERS Medical Policy Report, the actual total number of TRR enrollments at the end of FY 2018 was 9,019 (see page 154). The incremental change in the total is reflected in the row labeled "TRR Enrollment Adjustment." DHA has found the cause of the error and is working to implement a fix but it was not yet ready at the time this report was written.

[c] Among Medicare eligibles, 185,057 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

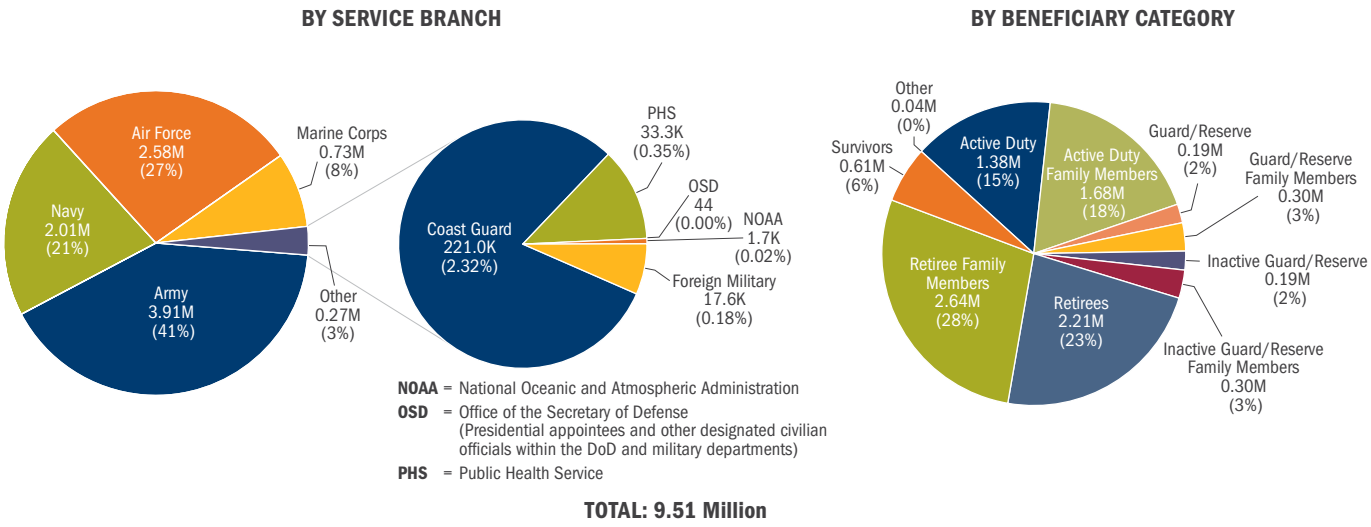
- Only 2 percent of non-Medicare-eligible beneficiaries are not enrolled in any TRICARE plan (i.e., they use space-available care at MTFs or other health insurance (OHI).
- Almost 80 percent of inactive Guard/Reserve and family members who are eligible for TRICARE benefits are enrolled in TRS.
- The large majority of beneficiaries enrolled in TYA are children of retirees under the age of 65 (most Active Duty members are not old enough to have children in the requisite age group). TYA Prime enrollment has declined from 58 percent of total TYA enrollment in FY 2015 to 37 percent in FY 2018.
- Almost 80 percent of beneficiaries enrolled in the USFHP are retirees and family members (including survivors), most of whom are under age 65. The USFHP is available at only six sites nationwide, so enrollment is low relative to Prime.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Eligible Beneficiaries in FY 2018

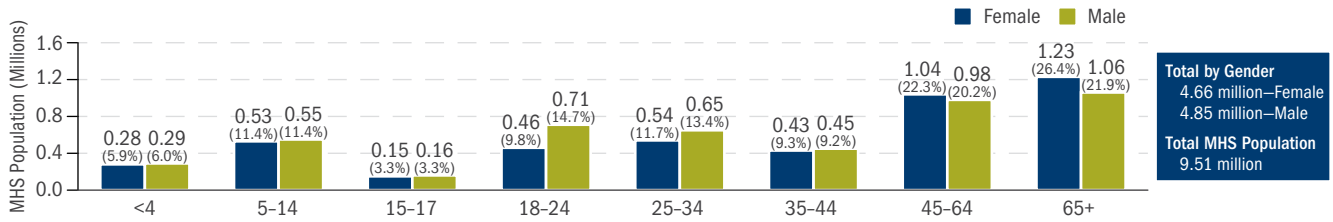
- There were a total of 9.51 million beneficiaries eligible for some form of DoD health care benefits at the end of FY 2018. The Army has the most beneficiaries eligible for Uniformed Services health care benefits, followed (in order) by the Air Force, Navy, Marine Corps, and other Uniformed Services (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 29, 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 2018



Source: DEERS, 1/17/2019
Note: Percentages may not sum to 100 percent due to rounding.

MHS POPULATION BY AGE GROUP AND GENDER, END OF FY 2018



Source: FY 2018 actuals from DEERS as of 1/17/2019

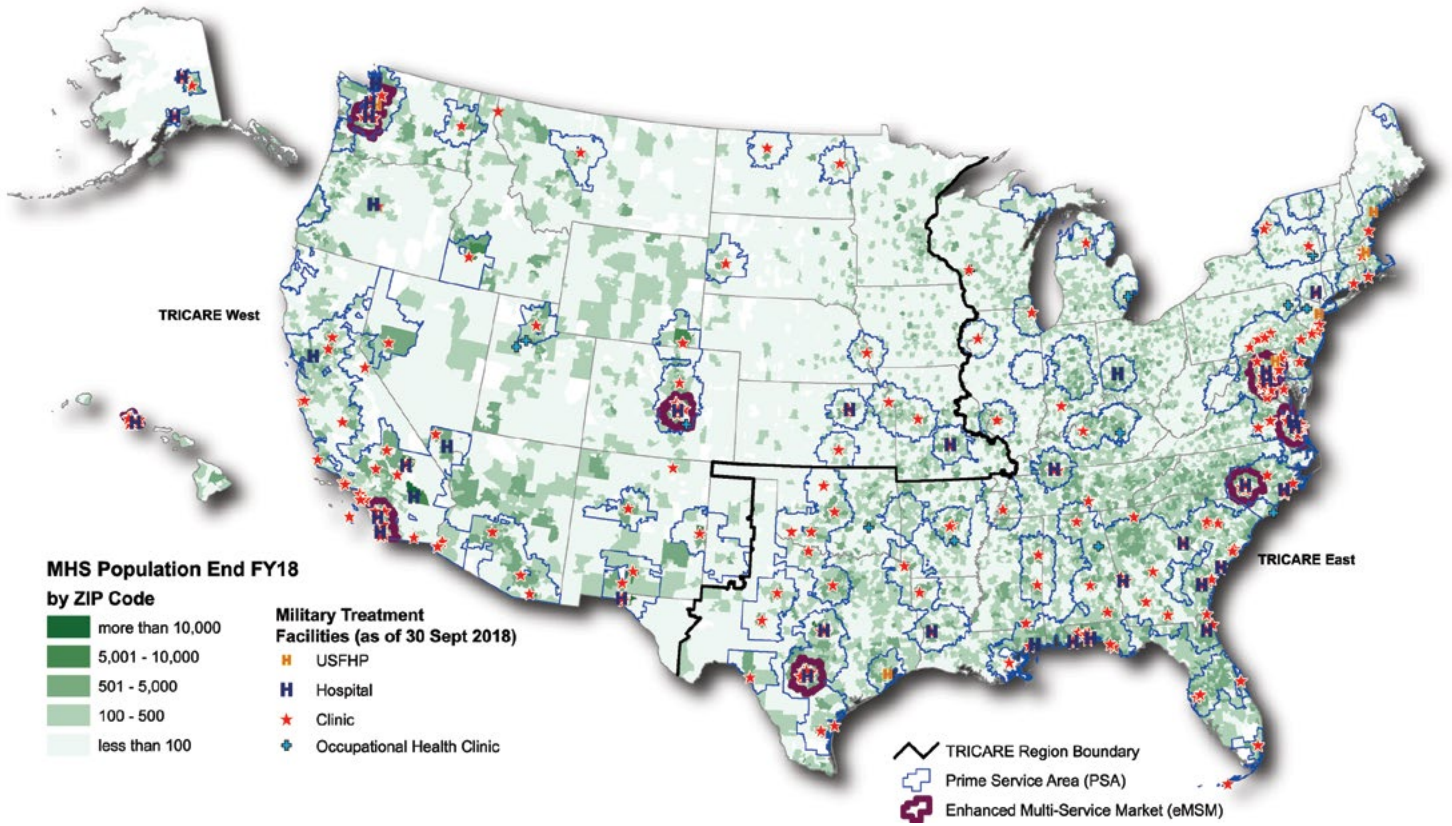
PROJECTED END-YEAR MHS POPULATIONS (MILLIONS) BY BENEFICIARY CATEGORY, FYs 2019–2026

BENEFICIARY CATEGORY	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026
Active Duty	1.39	1.40	1.41	1.41	1.42	1.43	1.43	1.43
Active Duty Family Members	1.69	1.70	1.71	1.72	1.73	1.74	1.74	1.74
Guard/Reserve	0.19	0.19	0.20	0.20	0.20	0.20	0.20	0.20
Guard/Reserve Family Members	0.30	0.31	0.31	0.31	0.31	0.31	0.31	0.31
Inactive Guard/Reserve	0.19	0.19	0.19	0.19	0.19	0.19	0.19	0.19
Inactive Guard/Reserve Family Members	0.30	0.30	0.30	0.30	0.30	0.30	0.30	0.30
Retirees	2.21	2.22	2.22	2.23	2.24	2.24	2.24	2.24
Retiree Family Members	2.63	2.64	2.64	2.64	2.64	2.64	2.64	2.64
Survivors	0.61	0.61	0.61	0.61	0.61	0.61	0.61	0.62
Other	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04
Total	**9.55**	**9.59**	**9.62**	**9.65**	**9.67**	**9.69**	**9.69**	**9.69**

Source: FYs 2019–2026 estimates from DHA Projections of Eligible Population (PEP) model as of 1/2/2019

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

MHS POPULATION DISTRIBUTION IN THE U.S. RELATIVE TO MTFs, END OF FY 2018



MHS ELIGIBLE BENEFICIARY PROXIMITY TO MILITARY TREATMENT FACILITIES, END OF FY 2018[a]

BENEFICIARY GROUP[b]	POPULATION TOTAL (FY 2018)	POPULATION IN PSAs	% IN PSAs	% IN CATCHMENTS	% IN PRISMs	% IN MTF SERVICE AREAS	% IN eMSMs
Active Duty and Their Families	2,757,211	2,639,927	95.7%	66.9%	88.9%	93.0%	38.0%
Guard/Reserves and Their Families[c]	944,757	645,154	68.3%	22.1%	39.5%	54.4%	12.6%
Retirees, Their Families, Survivors, and Other Eligibles	5,300,859	4,029,635	76.0%	33.9%	50.2%	64.1%	19.2%
Total MHS Eligibles, U.S.	9,002,827	7,314,716	81.2%	42.8%	60.9%	72.0%	24.3%
MHS Eligibles, Overseas	497,307						
Total MHS Eligibles, Worldwide	9,500,134						
VETERANS HEALTH ADMINISTRATION PRIORITY BENEFICIARIES	**POPULATION TOTAL (FY 2015)**	**POPULATION IN PSAs**	**% IN PSAs**	**% IN CATCHMENTS**	**% IN PRISMs**	**% IN MTF SERVICE AREAS**	**% IN eMSMs**
Eligible Veterans without TRICARE Eligibility	7,320,486	4,305,970	58.8%	15.0%	24.2%	42.7%	6.6%
Dual TRICARE-Eligible and VHA-Eligible, Veterans	1,441,912	1,070,891	74.3%	31.8%	48.7%	62.1%	17.2%
Total VHA Priority Veterans, U.S.	8,762,398	5,376,861	61.4%	17.8%	28.2%	45.9%	8.3%
VHA Veterans, Overseas	203,524						
Total VHA Veterans, Worldwide	8,965,922						

Sources: DHA/SP&FI (J-5)/ Decision Support, population as of 9/30/2018, pulled 12/11/2018; and Veterans Health Administration (VHA) population as of 9/30/2015, provided 11/18/2015

Notes:

[a] Eligible MHS beneficiary data from the MHS Data Repository (MDR) DEERS, effective 9/30/2018. Residential ZIP code was used as the location for all beneficiaries.

[b] Location information determined by DHA Catchment Area Directory database, September 2018.

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

Definitions:

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

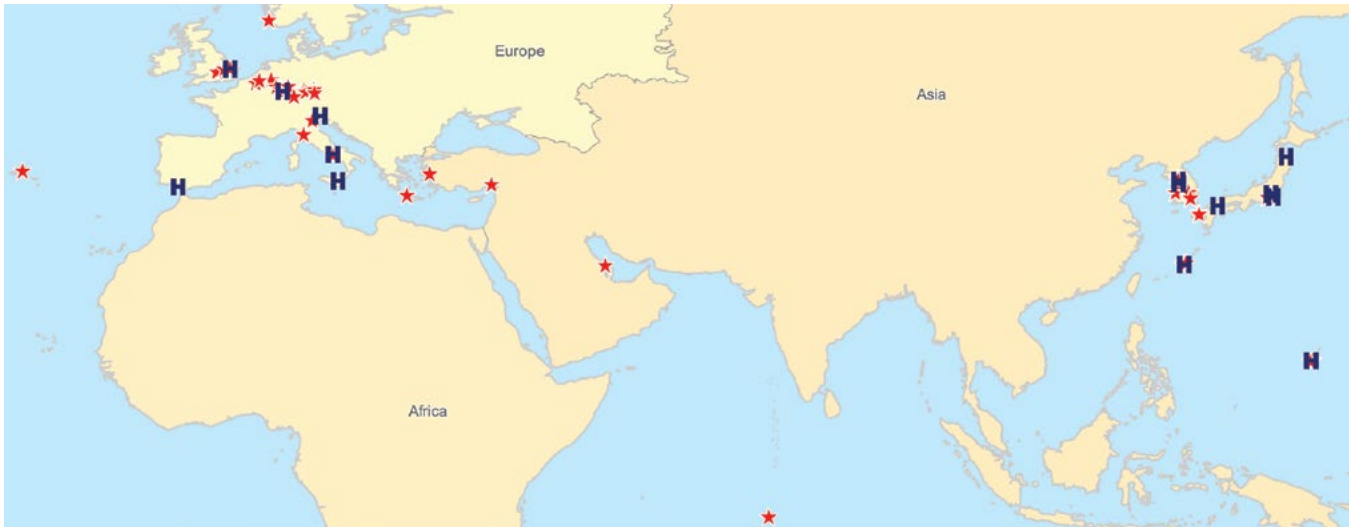
– Provider Requirement Integrated Specialty Model (PRISM) Area: Includes ZIP codes in the 20-mile circle around an active MTF (inpatient or outpatient), subject to overlap rules, barriers, and other policy overrides.

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

– Prime Service Areas (PSAs) are those in effect in 2018, defined as the 40-mile area around existing MTFs, as well as previously closed MTFs (Base Realignment and Closure [BRAC] sites).

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

MTFs OUTSIDE THE U.S., FY 2018



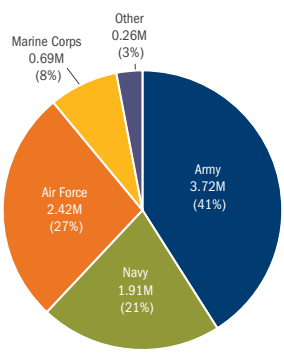
Locations of MTFs (Hospitals and Ambulatory Care Clinics) at the End of FY 2018

The map on the previous page shows the geographic dispersion of the 9 million beneficiaries eligible for the TRICARE benefit residing within the United States (95 percent of the 9.5 million eligible beneficiaries described on the previous pages). An overlay of the major DoD MTFs (medical centers and community hospitals, as well as medical clinics) reflects the extent to which the MHS population has access to TRICARE Prime. A beneficiary is considered to have access to Prime if he or she resides within a PSA. PSAs are geographic areas in which the TRICARE managed care support contractors (MCSCs) offer the TRICARE Prime benefit through established networks of providers. TRICARE Prime is available at MTFs, in areas around most MTFs ("MTF PSAs"), in areas where an MTF was eliminated in the BRAC process ("BRAC PSAs"), and by designated providers through the USFHP as of October 1, 2013. The overlay of MTF and BRAC PSAs on the map on the previous page shows the eligible beneficiary population.

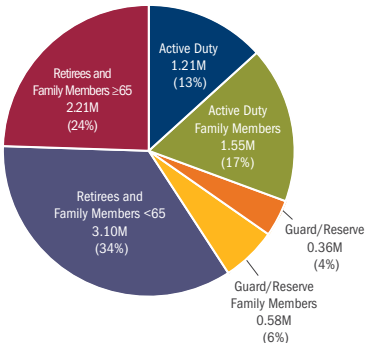
BENEFICIARIES ELIGIBLE FOR DoD HEALTH CARE BENEFITS, END OF FY 2018

U.S.

BY SERVICE BRANCH



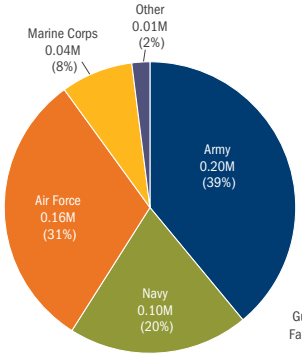
BY BENEFICIARY CATEGORY



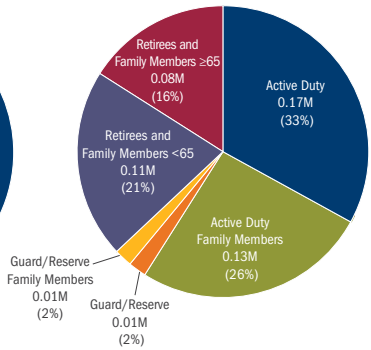
U.S. TOTAL: 9.01 Million

OVERSEAS

BY SERVICE BRANCH



BY BENEFICIARY CATEGORY



OVERSEAS TOTAL: 0.51 Million

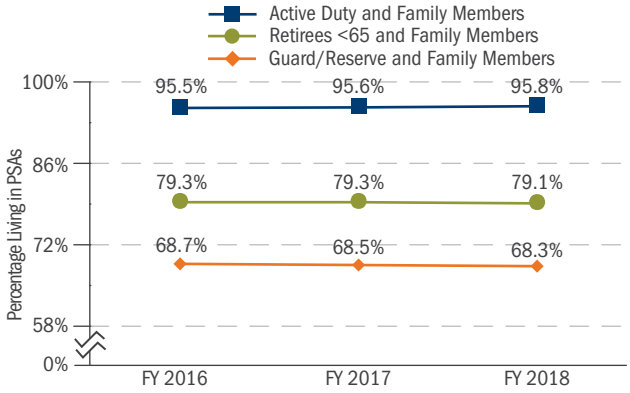
Source: DEERS, 1/17/2019
Note: Percentages may not sum to 100 percent due to rounding.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

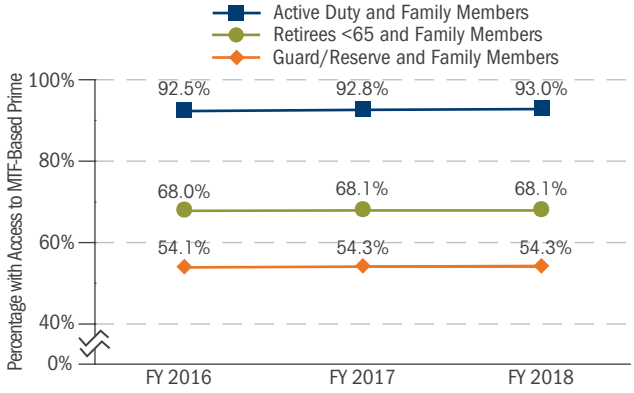
Beneficiary Access to Prime

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 notes to the right of the map on the previous page for the definition of an MTF Service Area).

TREND IN ELIGIBLE POPULATION LIVING IN PSAs, FYs 2016–2018



TREND IN ELIGIBLE POPULATION WITH ACCESS TO MTF-BASED PRIME, FYs 2016–2018



Source: DEERS, 1/17/2019

- Between FY 2016 and FY 2018, the percentage of Active Duty and family members living in PSAs increased slightly. The percentage of the other beneficiary groups living in PSAs decreased slightly.
- As determined by residence in an MTF PSA, access to MTF-based Prime increased slightly from FY 2016 to FY 2018 for all beneficiary groups.
- As expected, Active Duty and their families have the highest level of access to MTF-based Prime, whereas Guard/Reserve members and their families have the lowest. Retirees, some of whom move to locations near an MTF to gain access to care in military facilities, fall in between.

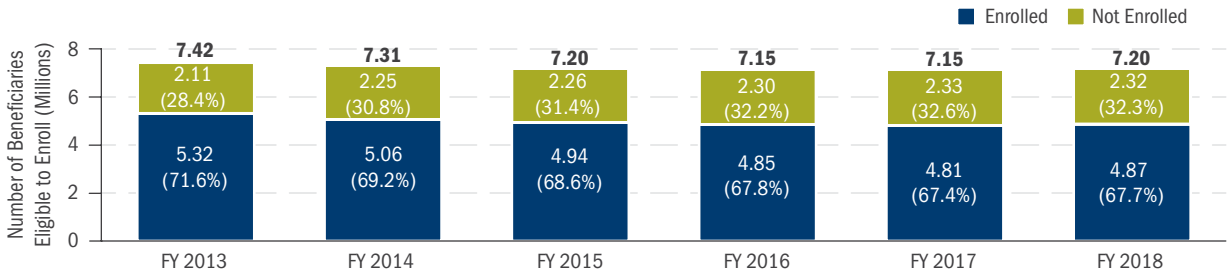
Eligibility and Enrollment in TRICARE Prime

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

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

- The number of beneficiaries enrolled in TRICARE Prime had been continuously dropping from FY 2013 to FY 2017 but rebounded slightly in FY 2018. As a percentage of the beneficiary population, TRICARE Prime enrollment dropped significantly in FY 2014, due to a drop in Active Duty end-strength and a reduction in the number of locations designated as PSAs. The percentage continued to drop (albeit at a slower rate) until FY 2017 but increased slightly in FY 2018.
- By the end of FY 2018, about 68 percent of all eligible beneficiaries were enrolled (4.87 million enrolled of the 7.20 million eligible to enroll).

HISTORICAL END-YEAR PRIME ENROLLMENT NUMBERS, FYs 2013–2018



Source: DEERS, 1/17/2019
Note: Numbers may not sum to bar totals due to rounding. Detailed MHS enrollment data by state can be found on page 29.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

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

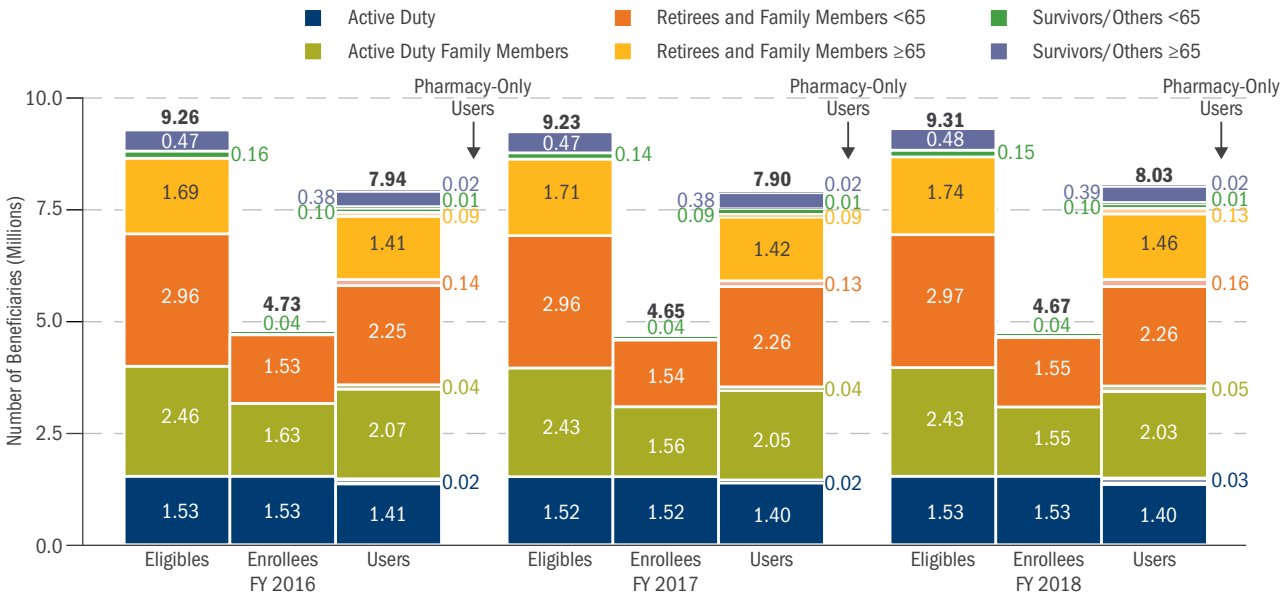
This section compares the number of users of MHS services with the numbers of eligibles and enrollees. Because beneficiaries eligible for any part of the year can be users, average (rather than end-year) beneficiary counts were used for all calculations.

The average numbers of eligibles and TRICARE Prime enrollees by beneficiary category[1] from FY 2016 to FY 2018 were determined from DEERS data. The eligible counts include all beneficiaries eligible for some form of the military health care benefit and, therefore, include those who may not be eligible to enroll in Prime. TRICARE Plus and Reserve Select enrollees are not included in the enrollment counts. USFHP enrollees are excluded from both the eligible and enrollment counts because information about users of that plan was not available.

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

- The number of Active Duty and eligible family members declined by 1 percent between FY 2016 and FY 2018. The number of RETFMs under age 65 remained about the same, while the number of RETFMs aged 65 and older increased by 3 percent. The number of survivors and others (SRV/OTHs), both under and over age 65, remained about the same.
- The percentage of ADFMs enrolled in TRICARE Prime declined from 66 percent in FY 2016 to 64 percent in FY 2018. The percentage of RETFMs under age 65 enrolled in Prime remained constant at 52 percent and the percentage of SRV/OTHs under age 65 enrolled in Prime remained constant at 27 percent.
- The overall user rate remained about the same between FY 2016 and FY 2018 at about 86 percent. The user rate for RETFMs aged 65 and older increased by two percentage points from 89 percent to 91 percent, whereas the user rates for the other beneficiary groups varied by less than one percentage point.
- RETFMs under age 65 constituted the greatest number of MHS users but had the second lowest user rate. Their MHS user rate was lower than all but SRV/OTHs (a much smaller beneficiary group) because some RETFMs had OHI.

AVERAGE NUMBERS OF ELIGIBLES, ENROLLEES, AND USERS BY BENEFICIARY CATEGORY, FYs 2016–2018



Sources: DEERS and MHS administrative data, 1/17/2019

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

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

MHS POPULATION: ENROLLEES AND TOTAL POPULATION BY STATE

STATE	TOTAL POPULATION	TRS ENROLLED	PRIME ENROLLED				
			ACTIVE DUTY AND GUARD/RESERVE ON ACTIVE DUTY	DEPENDENTS OF ACTIVE DUTY AND GUARD/RESERVE ON ACTIVE DUTY	RETIRED	RETIRED FAMILY MEMBERS/ OTHERS	TOTAL
AK	81,790	1,353	22,001	25,377	4,994	9,001	61,373
AL	210,146	8,702	13,228	23,653	18,194	32,437	87,512
AR	85,241	5,130	5,932	8,571	5,124	9,352	28,979
AZ	209,652	7,905	23,446	29,207	16,992	29,702	99,347
CA	793,318	22,010	171,549	153,936	43,893	83,733	453,111
CO	247,347	9,636	42,809	47,016	19,441	36,113	145,379
CT	48,471	2,363	8,992	7,671	2,038	3,401	22,102
DC	22,228	627	11,772	3,080	809	851	16,512
DE	34,037	1,570	4,620	5,031	2,712	4,158	16,521
FL	715,921	25,108	73,478	91,632	62,576	103,808	331,494
GA	436,810	14,326	72,324	76,373	38,539	68,802	256,038
HI	154,602	1,858	46,746	50,312	5,560	9,761	112,379
IA	46,775	4,614	2,848	4,122	799	1,477	9,246
ID	53,867	4,113	4,802	6,529	3,047	5,447	19,825
IL	150,046	8,891	26,639	18,818	9,011	16,074	70,542
IN	93,838	9,155	4,937	8,044	4,149	8,181	25,311
KS	123,208	5,058	25,292	27,537	6,508	12,697	72,034
KY	145,652	6,221	36,925	22,226	8,014	14,315	81,480
LA	125,671	7,275	20,581	22,040	7,076	13,068	62,765
MA	70,716	5,518	6,908	7,781	6,334	9,528	30,551
MD	246,278	7,320	40,472	48,629	28,807	42,939	160,847
ME	39,390	2,272	1,716	3,607	7,499	10,529	23,351
MI	100,361	6,875	4,826	7,927	3,569	6,326	22,648
MN	69,701	10,124	4,119	4,684	146	554	9,503
MO	157,384	10,974	20,783	20,115	8,526	15,862	65,286
MS	115,826	5,490	18,429	14,987	6,397	11,111	50,924
MT	35,832	2,420	4,265	4,850	963	1,752	11,830
NC	509,354	13,707	107,332	107,032	27,974	49,939	292,277
ND	32,947	2,381	8,504	7,678	1,286	2,207	19,675
NE	61,700	4,645	7,641	9,357	4,070	7,348	28,416
NH	30,504	1,943	1,896	2,464	4,769	6,739	15,868
NJ	85,952	4,856	12,070	14,295	5,126	9,302	40,793
NM	83,713	2,002	13,942	15,073	6,116	10,251	45,382
NV	105,911	3,741	12,711	15,526	8,744	14,324	51,305
NY	177,877	7,069	31,938	30,942	9,638	16,699	89,217
OH	169,505	12,286	12,438	16,373	7,381	13,714	49,906
OK	156,251	6,528	25,838	23,421	11,120	20,672	81,051
OR	67,589	3,746	3,557	4,916	891	1,569	10,933
PA	162,715	10,076	8,200	12,276	7,643	13,083	41,202
RI	24,068	1,122	4,356	3,835	1,543	2,388	12,122
SC	249,312	10,455	44,179	33,193	17,140	29,703	124,215
SD	35,465	4,591	4,637	5,199	1,461	2,652	13,949
TN	199,669	11,144	7,175	28,117	11,587	21,036	67,915
TX	904,664	33,906	132,793	148,213	79,649	150,280	510,935
UT	78,354	8,567	7,928	12,302	4,571	9,549	34,350
VA	744,417	14,874	133,328	145,951	57,858	93,976	431,113
VT	13,166	1,141	957	1,306	1,346	1,924	5,533
WA	348,509	8,866	64,473	69,733	28,638	48,985	211,829
WI	74,250	7,305	4,439	5,477	1,109	2,008	13,033
WV	36,656	2,517	2,350	2,162	987	1,624	7,123
WY	23,822	1,546	3,894	4,356	1,287	2,267	11,804
U.S.	**8,990,478**	**375,922**	**1,377,015**	**1,462,952**	**623,651**	**1,093,218**	**4,556,836**
Overseas	**515,832**	**2,832**	**185,322**	**118,143**	**484**	**13,094**	**317,043**
Subtotal	**9,506,310**	**378,754**	**1,562,337**	**1,581,095**	**624,135**	**1,106,312**	**4,873,879**
TRR Enrollment Adjustment[a]	**8,428**						
Total	**9,514,738**						

Source: MHS administrative data systems, as of 1/17/2019 for end of FY 2018

Note: "Prime Enrolled" includes Prime (military and civilian 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.

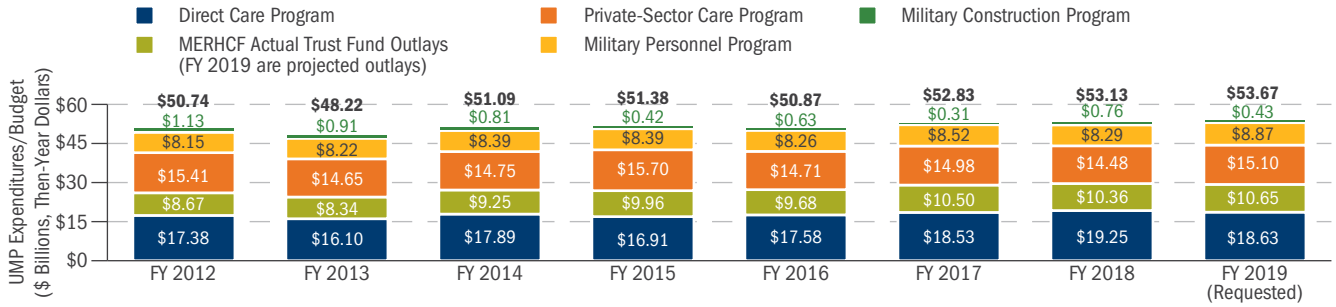
[a] It is a known issue that TRR enrollment numbers are substantially understated in the MHS administrative data. From the Defense Manpower Data Center DEERS Medical Policy Report, the actual total number of TRR enrollments at the end of FY 2018 was 9,019 (see page 154). The incremental change in the total is reflected in the row labeled "TRR Enrollment Adjustment." DHA has found the cause of the error and is working to implement a fix but it was not yet ready at the time this report was written.

UMP FUNDING

The UMP, requested at $53.67 billion for FY 2019 in the FY 2019 President's Budget, is about 1 percent higher than the FY 2018 $53.13 billion in actual expenditures (unadjusted, then-year dollars). The UMP displayed here includes the actual Trust Fund outlays from the MERHCF, or the "Accrual Fund." This fund (effective October 1, 2002) pays the cost of DoD health care programs (both direct and purchased care) for Medicare-eligible retirees, retiree family members, and survivors. The majority of Accrual Fund payments for health care provided to Medicare-eligible beneficiaries are for purchased care, pharmacy, and outpatient care.

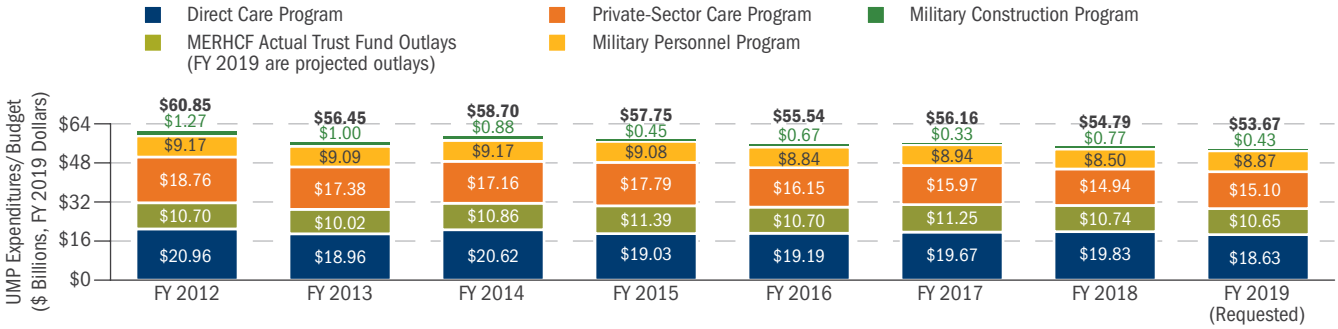
At $18.63 billion estimated for FY 2019, direct care expenditures represent the largest sector of the UMP (35 percent), followed by the private sector program ($15.10 billion, 28 percent). Outlays from the Trust Fund have increased from $8.67 billion in FY 2012 to $10.65 billion requested for FY 2019.

UMP FUNDING AND TRUST FUND OUTLAYS ($ BILLIONS) IN UNADJUSTED, THEN-YEAR DOLLARS, FYs 2012–2019 (REQUESTED)



As shown in the chart below, in constant FY 2019 dollar funding, when actual expenditures or projected funding are adjusted for inflation as estimated by the Department, the FY 2019 $53.67 billion estimated budget in purchasing value is currently programmed to be 2 percent less than the $54.79 billion adjusted FY 2018 actual expenditures and about $7.2 billion (almost 12 percent) less than the peak in FY 2012 of $60.85 billion in purchasing value (in FY 2019 dollars).

UMP FUNDING AND TRUST FUND OUTLAYS ($ BILLIONS) IN CONSTANT FY 2019 DOLLARS, FYs 2012–2019 (REQUESTED)



Source: Cost and budget estimates, DHA/Resources and Management Directorate (J-8)/DHP Programming, 11/21/2018

Notes:

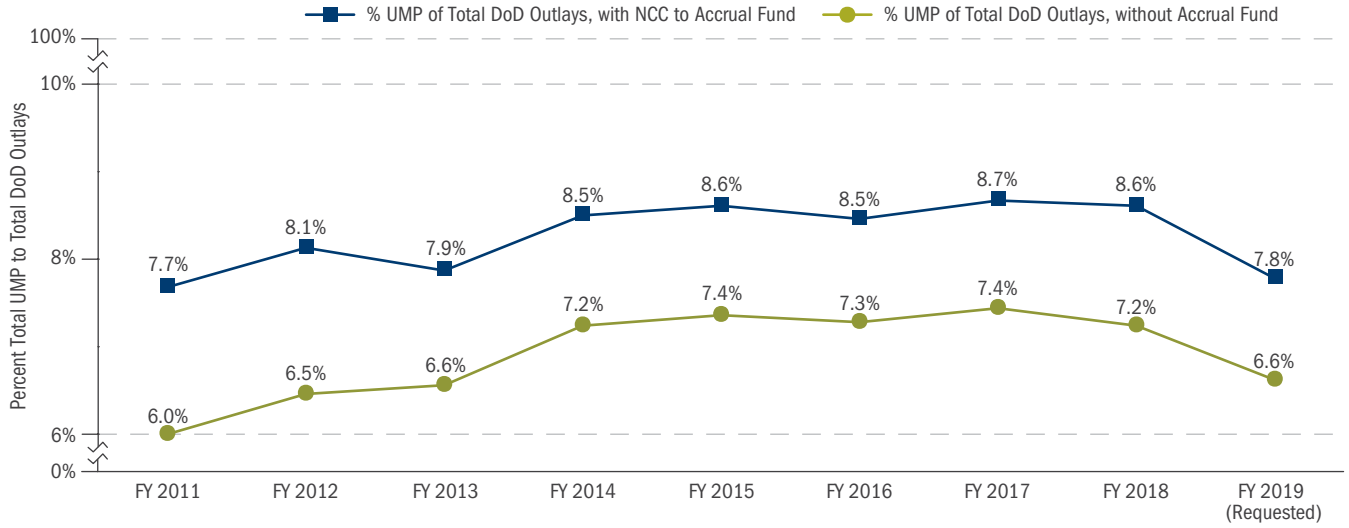
– FYs 2012–2016 reflect Comptroller Information System actual execution.
– Source of data for deflators (MILPERS; DHP; Procurement; Research, Development, Test, and Evaluation [RDT&E]; and MILCON) is Table 5-5, Department of Defense Deflators—TOA, National Defense Budget Estimates for FY 2019 (Green Book). Medicare Eligible Retiree Health Care Fund Deflator computed using a combination of MILPER (5 percent) and DHP factors (95 percent).
– FY 2012 includes $1.2 billion OCO supplemental funding for Operations and Maintenance (O&M) and reductions for Department of Defense efficiency initiatives. FY 2012 OCO includes $452 million in private sector, $765 million in direct care.
– FY 2013 includes $966.022 million in OCO supplemental funding for O&M; reflects reductions for sequestration, NDAA sections 3001, 3004, and 8123.
– FY 2014 includes $715.484 million in OCO supplemental funding for O&M, as well as congressional additions and statutory reductions as reflected in Public Law 113-76.
– FY 2015 includes $300.531 million in OCO supplemental funding for O&M, as well as congressional additions and statutory reductions as reflected in Public Law 113-64.
– FY 2016 includes $272.704 million in OCO supplemental funding for O&M, as well as congressional additions and statutory reductions as reflected in Public Law 114-113.
– FY 2017 reflects the amended request of $331.764 million in OCO funding after amended request was not considered.
– FY 2018 request for O&M OCO is $395.805 million.
– FY 2019 request for O&M OCO is $352.068 million.

UMP FUNDING *(CONT.)*

UMP Share of Defense Budget

UMP expenditures as a percentage of total DoD expenditures (outlays, which include DoD normal cost contributions to the MERHCF in both the UMP and DoD expenditures) has returned to the percentage of FY 2011: from 7.7 percent in FY 2011 to 7.8 percent estimated for FY 2019 (with Accrual Fund), or from 6 percent to 6.6 percent (without Accrual Fund).

UMP EXPENDITURES AS A PERCENTAGE OF TOTAL DOD OUTLAYS, FYs 2011–2019 (REQUESTED)

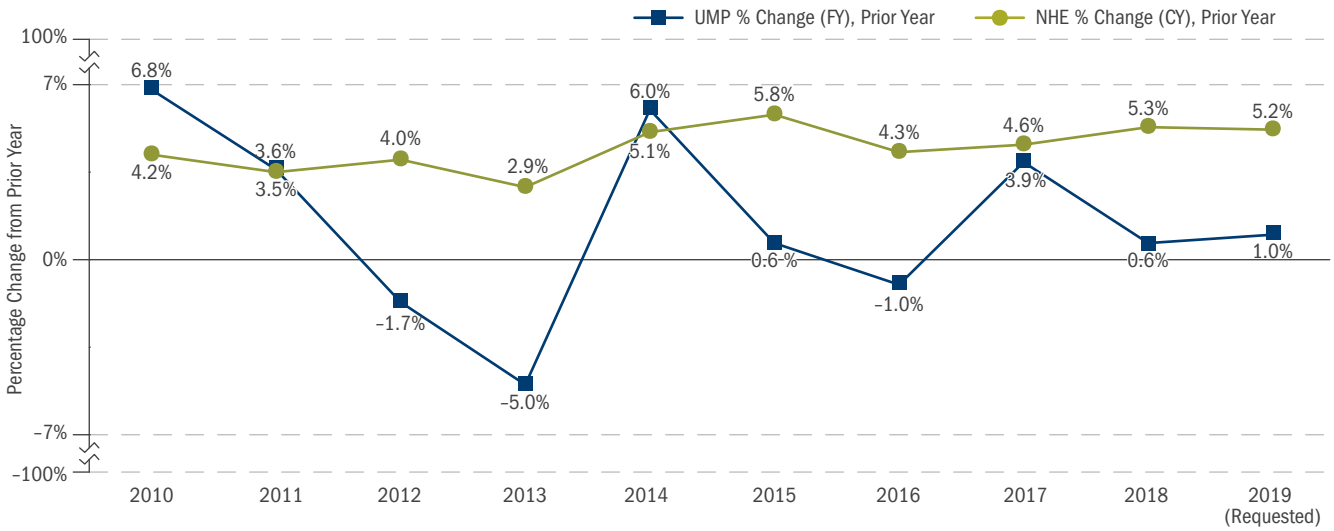


Source: UMP cost and budget estimates, DHA/Resources and Management Directorate (J-8)/DHP Programming, 11/21/2018
Note: Percentages are estimates of total DoD outlays reflected in the FY 2019 President's Budget.

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

As shown in the chart below, the annual rate of growth in the UMP (in then-year dollars—including Trust Fund Outlays) has fluctuated from a high of 6.8 percent in FY 2010, to a low of –5 percent in FY 2013, and was below the change in NHE for the past five years. In comparison, the Centers for Medicare & Medicaid Services (CMS) estimates that annual percentage changes in NHE have fluctuated by between 3 and 6 percent since calendar year (CY) 2008 (not shown), with expenditures projected to reach nearly an estimated $3.9 trillion in CY 2019 (ref. source notes below).

COMPARISON OF CHANGE IN ANNUAL UMP (FY) AND NHE (CY) ESTIMATED EXPENDITURES OVER TIME, 2010–2019 (REQUESTED)



Sources: UMP cost and budget estimates, DHA/Resources and Management Directorate (J-1/J-8)/DHP Programming, 11/21/2018; DHA (J-5)/Decision Support using NHE expenditure data from: Centers for Medicare & Medicaid Services, Office of the Actuary, Table 2, National Health Expenditure Amounts and Annual Percent Change by Type of Expenditure: Calendar Years 2010–2026. NHE Projections 2016–2026 table modified 8/1/2018, accessed 11/21/2018. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html

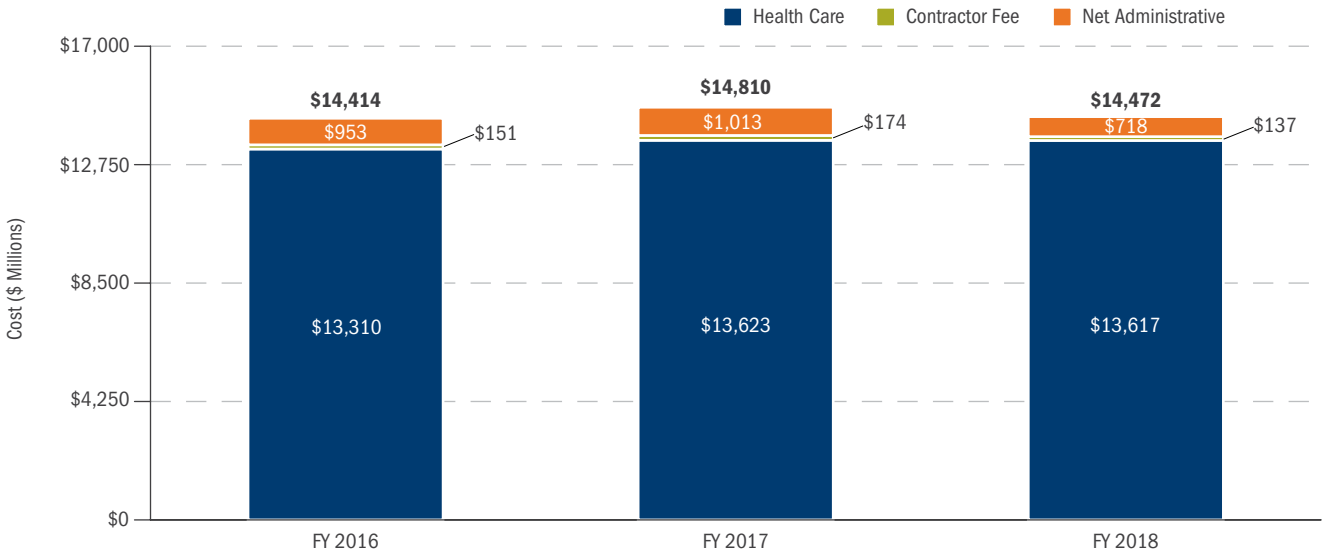
Note: CMS data are in calendar years, and DoD's UMP data are in fiscal years.

PRIVATE-SECTOR CARE ADMINISTRATIVE COSTS

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

- Total private-sector care costs increased from $14,414 million in FY 2016 to $14,810 million (3 percent) in FY 2017, but then returned to approximately their FY 2016 level in FY 2018.
- After rising by 6 percent from FY 2016 to FY 2017, PSC administrative costs decreased to their FY 2016 level in FY 2018. However, DHA began collecting Prime enrollment fees on January 1, 2018. Those fees were previously held by the contractors to offset their administrative costs. Offsetting administrative costs in FY 2018 by Prime enrollment fees resulted in net administrative fees dropping by $234 million in the nine months that the new T2017 contract was in effect.
- Excluding contractor fees, net administrative expenses decreased from 7 percent of total private-sector care costs in FY 2016 ($953 million of $14,263 million) to 5 percent in FY 2018 ($718 million of $14,335 million). Including contractor fees (in both administrative and total costs), net administrative expenses decreased from 8 percent of total private-sector care costs in FY 2016 ($1,104 million of $14,414 million) to 6 percent in FY 2018 ($855 million of $14,472 million).
- Contractor fees declined by 9 percent between FY 2016 and FY 2018, due in part to lower incentive payments earned for obtaining discounts from hospitals and provider groups.

TRENDS IN PRIVATE-SECTOR CARE COSTS, FYs 2016–2018



Source: DHA/R&M (J-1/J-8)/CRM (Administrative Costs), 10/25/2018

[1] DHA has congressional authority to carry over 1 percent of its O&M funding into the following year. There was no funding carried over in FYs 2016 and 2017. The amount carried forward from the prior-year appropriation was $200 million in FY 2018.

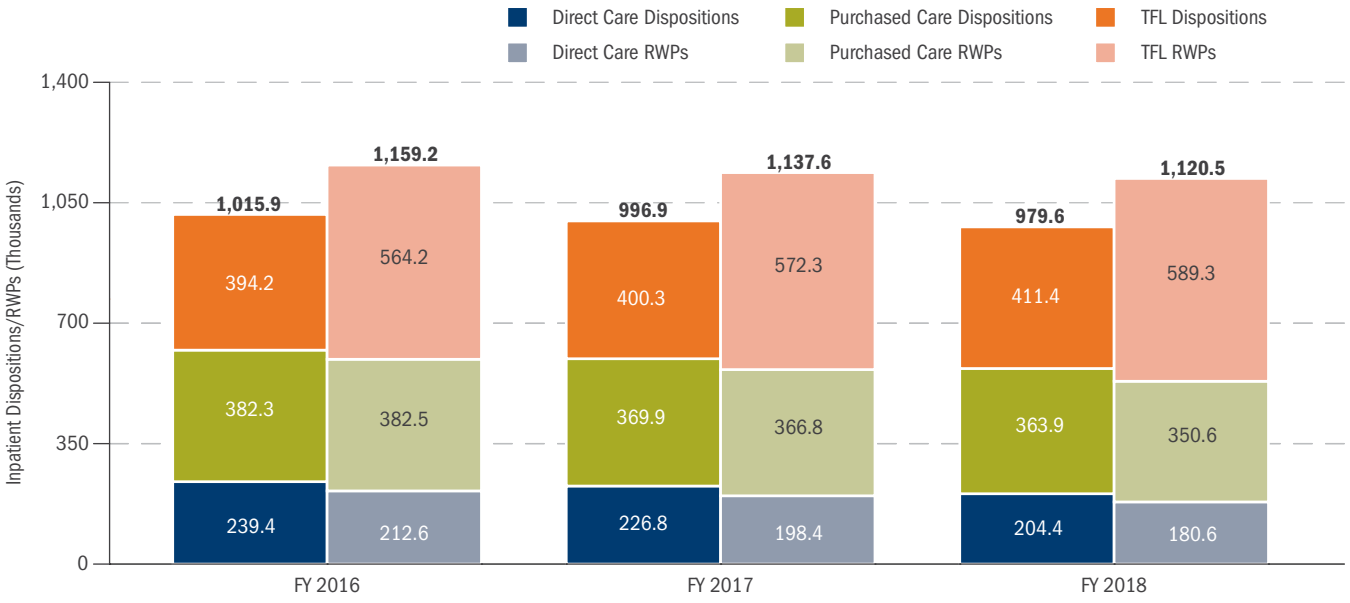
MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE)

MHS Inpatient Workload

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

- Total inpatient dispositions (direct and purchased care combined) declined by 9 percent and total RWPs declined by 11 percent between FY 2016 and FY 2018, excluding the effect of TFL.
- Direct care inpatient dispositions and RWPs each decreased by 15 percent over the past three years.[1]
- Excluding TFL workload, purchased care inpatient dispositions decreased by 5 percent, while RWPs decreased by 8 percent between FY 2016 and FY 2018.
- Including TFL workload,[2] purchased care dispositions and RWPs each decreased by less than 1 percent between FY 2016 and FY 2018.
- Although not shown, about 7 percent of direct care inpatient workload (dispositions) was performed abroad in FY 2018. Purchased care and TFL inpatient workload performed abroad accounted for about 2 percent of the worldwide total.

TRENDS IN MHS INPATIENT WORKLOAD, FYs 2016–2018



Source: MHS administrative data, 1/17/2019

[1] The DoD's new electronic health record, MHS GENESIS, was deployed at four initial fielding sites in 2017: 92nd Medical Group, Fairchild Air Force Base, in February; Naval Hospital (NH) Oak Harbor in July; NH Bremerton in September; and Madigan Army Medical Center (AMC) in October (FY 2018). Of those four sites, only the latter three offer inpatient care. Any inpatient workload performed at those facilities from the deployment dates onward has not yet been fully captured in the MHS administrative data. Considering all direct care facilities except the MHS GENESIS sites, total inpatient workload decreased by 5 percent in FY 2017 and by another 3 percent in FY 2018, for a cumulative decrease of 8 percent from FY 2016 to FY 2018 (about 1 percent of the cumulative decrease was due to the downsizing of three small military hospitals to clinics in FYs 2017–2018). The three MHS GENESIS hospitals contributed an additional 7 percent to the decrease in total direct care inpatient workload, resulting in the 15 percent decrease across the three years reported above.

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

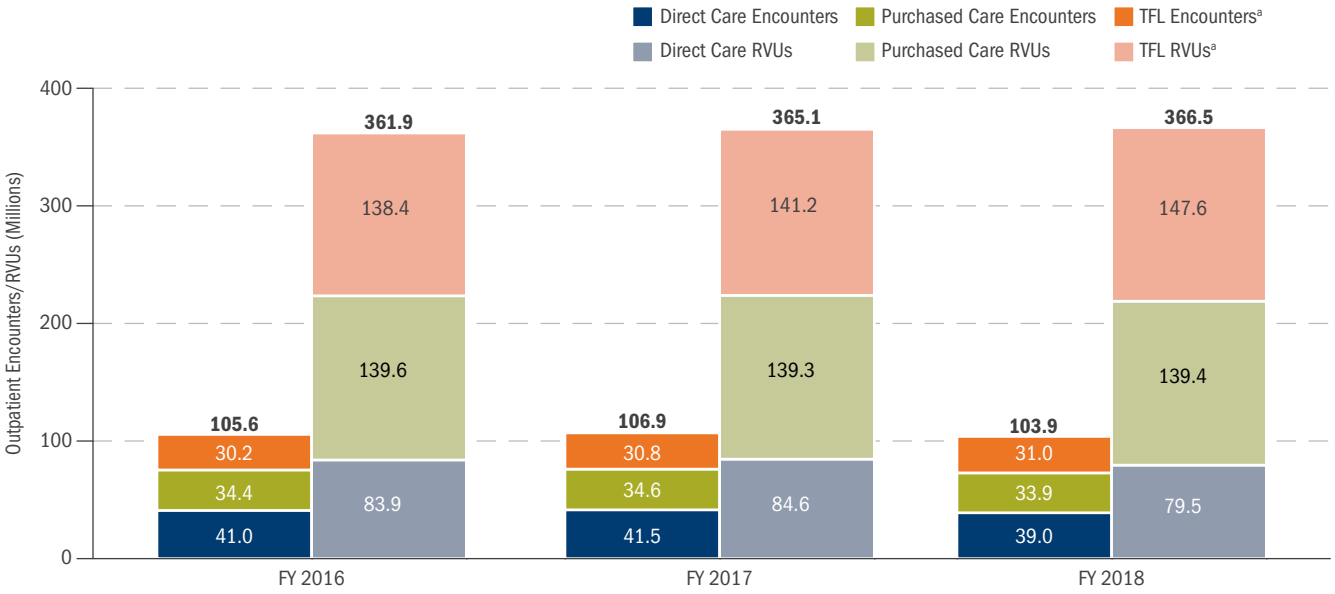
MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE) *(CONT.)*

MHS Outpatient Workload

Total MHS outpatient workload is measured two ways: as the number of encounters (outpatient visits and ambulatory procedures) and as the number of relative value units (RVUs). Because encounters do not appear on purchased care claims, they are calculated using a DHA-developed algorithm.[1] RVUs reflect the relative resources consumed by a single encounter compared with the average of those consumed by all encounters. See the appendix for a more detailed description of the RVU measure.

- Total outpatient encounters (direct and purchased care combined) decreased by 3 percent, while RVUs decreased by 2 percent between FY 2016 and FY 2018,[2] excluding the effect of TFL.
- Direct care outpatient encounters and RVUs each decreased by 5 percent over the past three years.
- Excluding TFL workload, purchased care outpatient encounters decreased by 1 percent while RVUs remained about the same. Including TFL workload, encounters decreased by less than 1 percent and RVUs increased by 3 percent.
- Although not shown, about 8 percent of direct care outpatient workload (encounters) was performed abroad. Purchased care and TFL outpatient workload performed abroad accounted for less than 1 percent of the worldwide total.

TRENDS IN MHS OUTPATIENT WORKLOAD, FYs 2016–2018



Source: MHS administrative data, 1/17/2019

[a] Purchased care only

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

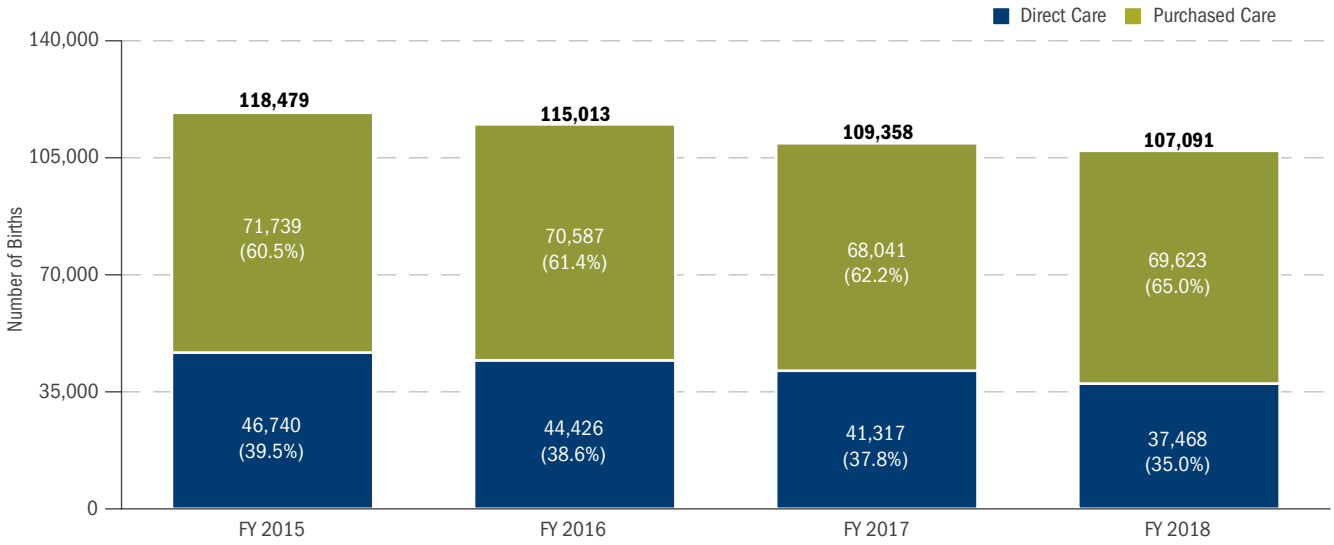
[2] The DoD's new electronic health record, MHS GENESIS, was deployed at four initial fielding sites in 2017: 92nd Medical Group, Fairchild Air Force Base, in February; NH Oak Harbor in July; NH Bremerton in September; and Madigan AMC in October (FY 2018). Any outpatient workload performed at those facilities (and at clinics that report data to those facilities) from the deployment dates onward has not yet been fully captured in the MHS administrative data. Considering all direct care facilities except the MHS GENESIS sites, total outpatient workload increased by 1 percent in FY 2017 and decreased by 2 percent in FY 2018, for a cumulative decrease of 1 percent from FY 2016 to FY 2018. The four MHS GENESIS facilities contributed an additional 4 percent to the decrease in total direct care outpatient workload, resulting in the 5 percent decrease across the three years reported above.

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

MTF Market Share for Childbirths

Overall MTF obstetric (OB) market share decreased from 40 percent to 35 percent between FY 2015 and FY 2018, but that is likely due to the reduction in the number of ADFMs (most of whom use direct care) during that time period. In FY 2018, individual MTF shares in the U.S. ranged from 17 percent to 98 percent.

TRENDS IN MTF MARKET SHARE FOR CHILDBIRTHS, FYs 2015–2018



Source: MHS administrative data, 1/17/2019

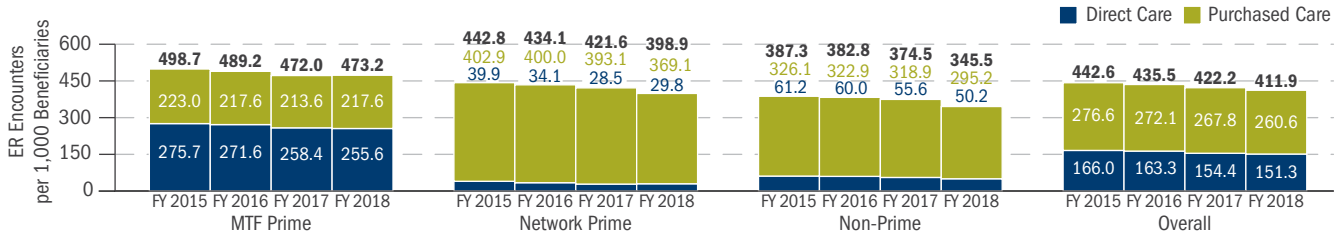
MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE) *(CONT.)*

Emergency Room Utilization

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

- ER utilization per capita declined for Prime enrollees from FY 2015 to FY 2018 (5 percent for MTF enrollees and 10 percent for network enrollees). The rate for non-Prime enrollees declined by 11 percent over the same time period.
- In FY 2018, MTF Prime enrollees had an ER utilization rate 19 percent higher than that of network Prime enrollees and 37 percent higher than that of non-enrollees. Network Prime enrollees had an ER utilization rate 15 percent higher than that of non-enrollees.
- For MTF Prime enrollees, 46 percent of ER encounters were in purchased care facilities (not necessarily in-network).
- Children under five years old had the highest ER utilization rate for all enrollment groups (not shown).
- The FY 2018 rate of 412 encounters per 1,000 beneficiaries is 3 percent lower than the civilian rate of 426 per 1,000 reported in CY 2015, the most recent year for which data are available.[3]

ER UTILIZATION BY ENROLLMENT STATUS AND SOURCE OF CARE (ENCOUNTERS PER 1,000 BENEFICIARIES), FYs 2015–2018

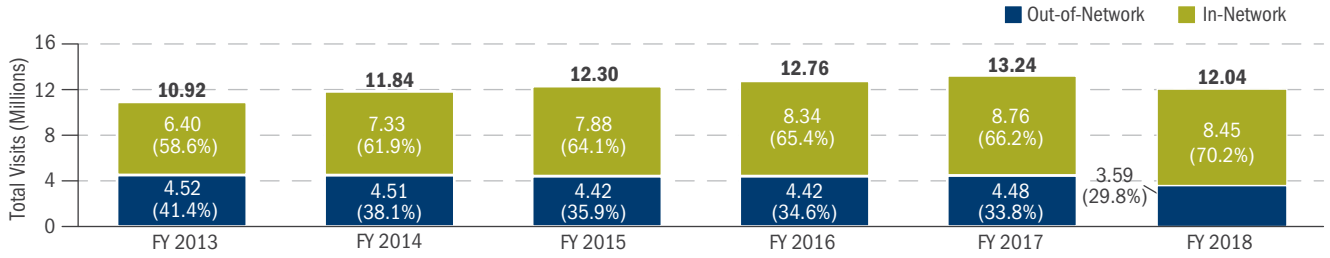


Source: MHS administrative data, 1/17/2019

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

For beneficiaries not enrolled in Prime, the ratio of in-network to out-of-network visits has been steadily increasing. In FY 2008, in-network visits accounted for only 46 percent of all non-Prime visits. By FY 2009, the number of in-network visits exceeded the number of out-of-network visits for the first time (51 percent). In FY 2018, 70 percent of all non-Prime visits were to in-network providers. One reason for the increasing use of in-network providers is the expansion of the TRICARE provider network (see page 159).

TRENDS IN IN-NETWORK VS. OUT-OF-NETWORK VISITS, FYs 2013–2018



Source: MHS administrative data, 1/17/2019

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

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

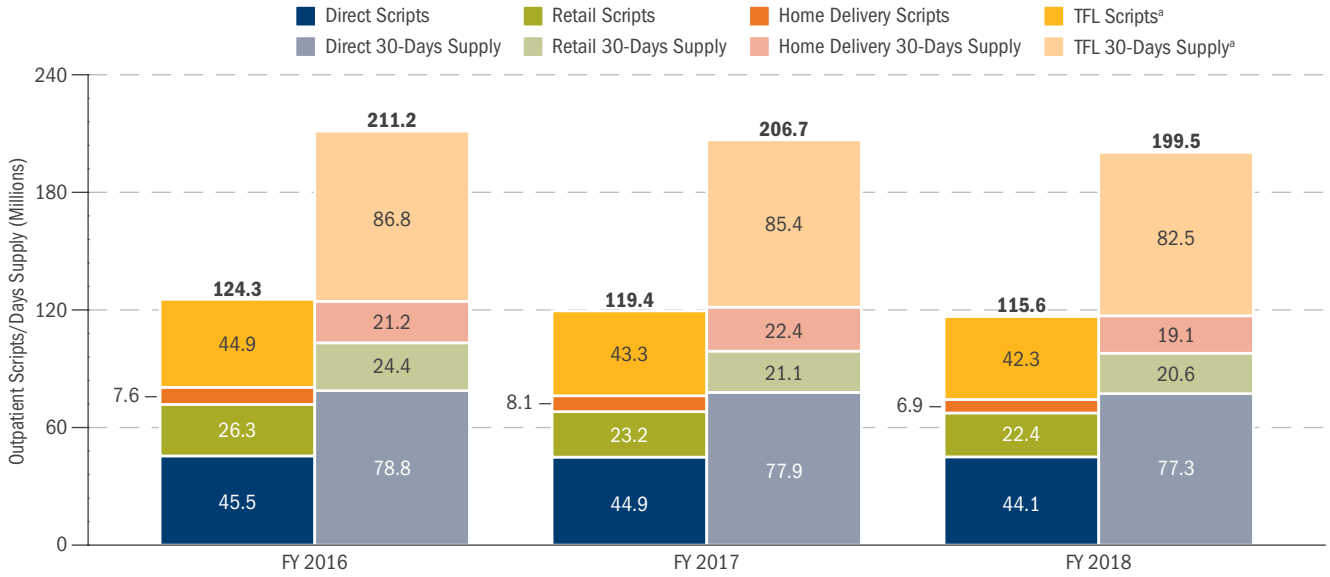
[3] Centers for Disease Control and Prevention (CDC), "National Hospital Ambulatory Medical Care Survey: 2015 Emergency Department Summary Tables," Table 1, https://www.cdc.gov/nchs/data/nhamcs/web_tables/2015_ed_web_tables.pdf. The civilian ER rate reported on this page is somewhat lower than the rate reported by the CDC because we adjust the rate for the age/sex distribution of the military population.

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

MHS Prescription Drug Workload

TRICARE beneficiaries can fill prescription medications at MTF pharmacies through home delivery (mail order), at TRICARE retail network pharmacies, and at non-network pharmacies. Total outpatient prescription workload is measured two ways: as the number of prescriptions and as the number of days supply (in 30-day increments). Total prescription drug workload (all sources combined) decreased between FY 2016 and FY 2018 (prescriptions by 8 percent and days supply by 6 percent), excluding the effect of TFL purchased care pharmacy usage.

TRENDS IN MHS PRESCRIPTION WORKLOAD, FYs 2016–2018



Source: MHS administrative data, 1/17/2019

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

- Direct care prescriptions decreased by 3 percent and days supply by 2 percent between FY 2016 and FY 2018.
- Purchased care prescriptions (retail and home delivery combined) decreased by 14 percent and days supply by 13 percent from FY 2016 to FY 2018, excluding TFL utilization. Including TFL utilization, purchased care prescriptions decreased by 9 percent and days supply decreased by 8 percent.
- Although not shown, about 6 percent of direct care prescriptions were issued abroad. Purchased care prescriptions issued abroad accounted for 3 percent of the worldwide total.

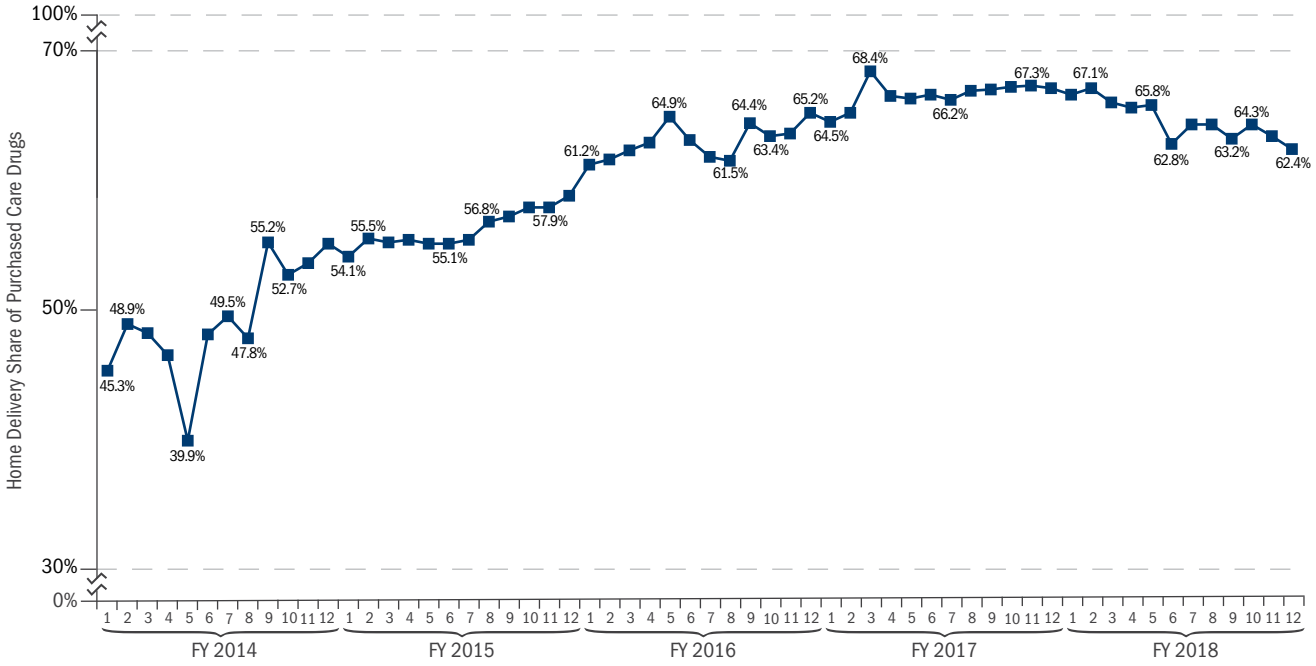
MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE) *(CONT.)*

MHS Prescription Drug Workload *(cont.)*

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

The home delivery share of total purchased care utilization had been on the rise since the DoD changed the copayment structure for retail/home delivery drugs at the beginning of FY 2012. From FY 2014 to FY 2017, the home delivery share of purchased care pharmacy utilization (as measured by days supply) increased from 55 percent to 67 percent. However, in FY 2018, the home delivery copayment for a 90-day supply of generic formulary drugs rose from $0 to $7, whereas the retail network pharmacy copayment for a 30-day supply of generic formulary drugs rose by only $1 (from $10 to $11). This likely contributed to the drop in the home delivery share of total purchased care utilization to 62 percent in FY 2018.

TREND IN HOME DELIVERY UTILIZATION (DAYS SUPPLY) AS A SHARE OF TOTAL PURCHASED CARE UTILIZATION, FYs 2014–2018[a]



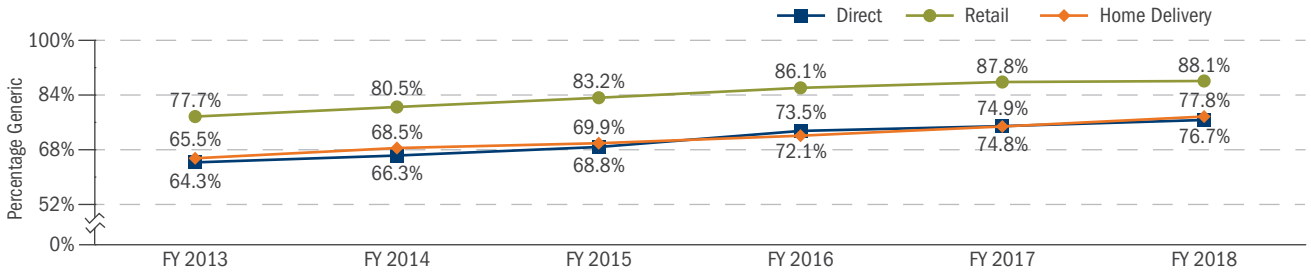
Source: MHS administrative data, 1/17/2019

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

COST SAVINGS EFFORTS IN DRUG DISPENSING

- The rate of generic drug dispensing has been increasing for all sources: direct, retail, and home delivery. Home delivery pharmacies have seen the greatest increase, from 66 percent in FY 2013 to 78 percent in FY 2018. However, retail pharmacies dispensed the highest percentage of generic drugs in FY 2018 (88 percent).
- The retail generic drug dispensing rate in FY 2018 was about the same as that of the private sector (90 percent).[1] However, the direct care rate (77 percent) was well below that of the private sector.[2]
- The average cost to the DoD for a 30-day supply of a brand versus generic drug in FY 2018 was $70 versus $15 for direct care, $339 (net of manufacturer refunds) versus $14 for retail pharmacies, and $126 versus $26 for home delivery (costs are not adjusted for differences in drug types between brand and generic). Therefore, all other factors being equal, the trend toward greater generic drug dispensing is likely to lower DoD costs for prescription drugs.

TRENDS IN GENERIC DRUG DISPENSING, FYs 2013–2018

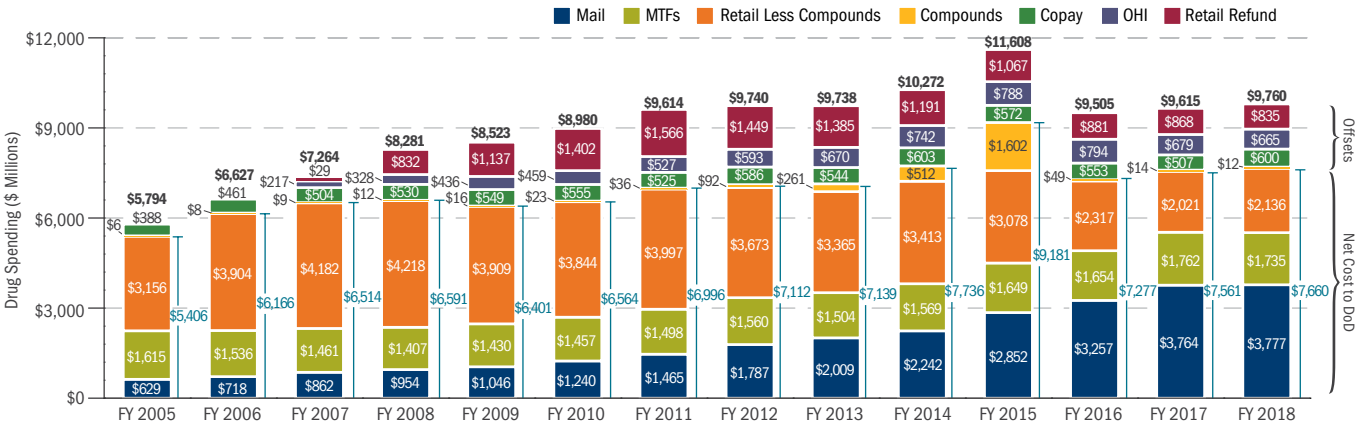


Source: MHS administrative data, 1/17/2019

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 2018, the refunds are estimated to have saved the DoD $835 million. After rising an average of only 2.7 percent per year from FY 2008 to FY 2014, net DoD costs rose by 19 percent in FY 2015 alone, driven largely by a threefold increase in expenditures for compound drugs. Once the DoD got compound drug prices under control, net DoD costs fell by 21 percent in FY 2016 and then rose by 4 percent in FY 2017 and by another 1 percent in FY 2018, but to a level still 1 percent below that of FY 2014.

MHS OUTPATIENT DRUG SPENDING, FYs 2006–2018



Sources: Pharmacy Data Transaction Service (PDTS) Data Warehouse; DHA Pharmacy Operations Division (refunds) as of 12/17/2018

Notes: Net cost to the DoD represents total prescription expenditures minus copays, coverage by OHI, and retail refunds invoiced. It does not include an MHS-derived dispensing fee as in the charts on pages 43–44. Mail order dispensing fees are included; however, other retail/mail contract costs and MTF cost of dispensing are not included. Retail refunds are reported on an accrual rather than a cash basis, corresponding to the original prescription claim data and updated refund adjustments. Retail compound spending, broken out separately, is not adjusted for any recoveries or settlements with compound pharmacies outside of claims reversals.

[1] Association for Accessible Medicines, "Generic Drug Access and Savings in the U.S.," 2018, https://accessiblemeds.org/sites/default/files/2018_aam_generic_drug_access_and_savings_report.pdf.

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

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

DoD/VA Pharmacy Contracting Initiatives

The Departments continued to maximize efficiencies through joint efforts when possible. National contracts are at an all-time high with 187 existing contracts, of which 47 were new in FY 2018. There are currently 15 joint contracts pending at the National Acquisition Center and 35 pending at the Defense Logistics Agency. The DoD/VA pharmacy team identified 28 commonly used pharmaceutical products and manufacturers for potential joint contracting action and continue to seek new joint contracting opportunities where practicable. In FY 2018, the VA spent $494 million on joint national contracts, and the DoD spent $231 million. Over the same time period, VA joint national contract prime vendor (PV) purchases represented 8 percent of total PV purchases, whereas DoD purchases represented 4.65 percent.

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 the DoD.

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

TOP 20 SPECIALTY CLASSES ($ MILLIONS), AS DEFINED BY P&T COMMITTEE, FYs 2016–2018

FY 2018 RANK	SPECIALTY CLASS	FY 2016	FY 2017	FY 2018	FYs 2017–2018 % CHANGE[a]
1	ONCOLOGICAL	$536	$631	$758	20%
2	TARGETED IMMUNOMOD BIOLOGICS	$308	$349	$418	20%
3	MULTIPLE SCLEROSIS	$193	$197	$195	–1%
4	ANTIRETROVIRALS	$102	$113	$127	12%
5	PULMONARY ARTERIAL HYPERTENSION	$76	$86	$97	14%
6	ANTIHEMOPHILIC FACTORS	$69	$76	$74	–3%
7	CORTICOSTEROID-IMMUNE MODULATORS	$50	$48	$65	35%
8	PULMONARY-1 (e.g., nintedanib, pirfenidone)	$48	$65	$58	–10%
9	ENDOCRINE MISC (e.g., cinacalcet, deferasirox)	$38	$44	$47	6%
10	CYSTIC FIBROSIS	$26	$29	$42	42%
11	HEMATOLOGICAL	$36	$36	$39	9%
12	OSTEOPOROSIS	$27	$35	$38	9%
13	ANTILIPIDEMICS-1 (evolocumab, alirocumab)	$12	$24	$29	19%
14	ADHD—WAKEFULNESS (sodium oxybate)	$24	$25	$27	8%
15	GROWTH STIMULATING	$26	$25	$26	5%
16	ANTISERA (immune globulins)	$17	$19	$25	31%
17	NEUROLOGICAL MISC (e.g., botulinum toxin, deutetrabenazine)	$43	$58	$25	–58%
18	METABOLIC MISC (e.g., asfotase alfa, sapropterin)	$13	$16	$23	47%
19	OPHTHALMIC MISC (e.g., aflibercept, ranibizumab)	$24	$25	$22	–13%
20	HEPATITIS C	$86	$44	$21	–52%

Source: Pharmacy Data Transaction Service (PDTS) Data Warehouse, 10/31/2018

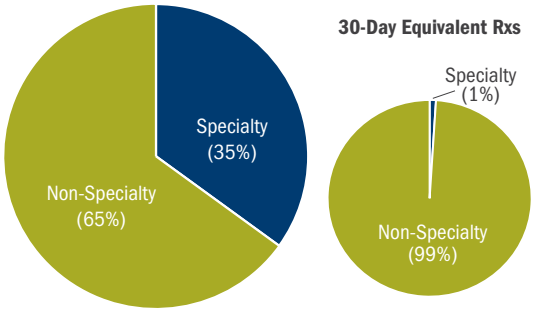
[a] The percentage changes are based on the original unrounded numbers.

Note: FY 2018 Q4 Specialty Agent Reporting List applied to all data; total costs adjusted for retail refunds (FY 2018 Q3 refund per unit applied to FY 2018 Q4 data), MTF PV cost per unit, home delivery PV cost per unit.

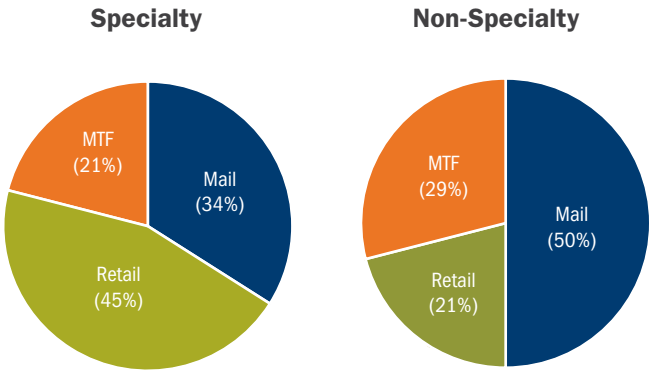
SPECIALTY DRUG COST TRENDS *(CONT.)*

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

FY 2018 TOTAL SPENDING



FY 2018 TOTAL SPENDING BY POINT OF SERVICE



Source: Pharmacy Data Transaction Service (PDTS) Data Warehouse, 10/31/2018

TOTAL ESTIMATED SPENDING ($ MILLIONS) BY QUARTER, FYs 2015–2018

	FY 2015				FY 2016				FY 2017				FY 2018			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Non-Specialty	$1,368	$1,430	$1,355	$1,350	$1,262	$1,319	$1,110	$1,156	$1,152	$1,245	$1,237	$1,149	$1,084	$1,090	$1,087	$1,061
Specialty	$465	$488	$482	$491	$470	$494	$484	$490	$488	$545	$551	$550	$551	$592	$596	$621
Percentage Specialty[a]	25.4%	25.4%	26.2%	26.7%	27.1%	27.2%	30.4%	29.8%	29.8%	30.4%	30.8%	32.4%	33.7%	35.2%	35.4%	36.9%

Source: As of 10/31/2018; based on Specialty Agent Reporting List for applicable quarters; totals adjusted for retail refunds (FY 2018 Q3 refund per unit applied to FY 2018 Q4 data), copays, and against PV cost per unit for MTF and home delivery drugs.

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

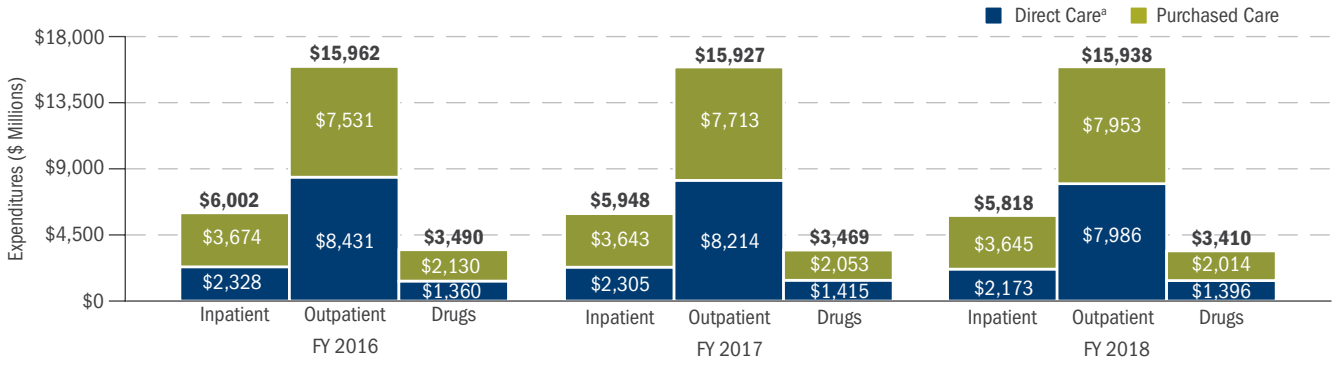
- In FY 2018, specialty drugs accounted for less than 1 percent of total MHS prescription drug utilization (30-day equivalents), but for 35 percent of total spending.
- As a percentage of total drug costs, specialty drug costs continued to increase from FY 2013 to FY 2018. A large proportion of specialty spending comes from retail prescriptions, reflecting the limited distribution mechanisms in place for many of these agents. This limits availability through mail order and MTFs, which are generally lower cost points of service.
- The highest spending specialty class—oncological agents—accounted for about $758 million in drug spending in FY 2018. The DoD P&T Committee has made progress defining and evaluating subclasses of oncological agents; however, many oncological agents treat rare diseases and are difficult to categorize into competitive classes. The top five oncological subclasses (by total FY 2018 spending) were multiple myeloma ($207 million), prostate-2 ($90 million), breast cancer ($73 million), renal cell carcinoma ($61 million), and chronic myelogenous leukemia ($59 million). Other subclasses and unclassified oncological agents accounted for another $268 million.
- After peaking in FY 2015 in fourth place, hepatitis C agents have now fallen to twentieth on the list of specialty drug classes based on total cost, reflecting both normalization of demand and reductions in unit price following DoD P&T Committee evaluations.
- 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 FDA approval, including all new specialty agents.

MHS COST TRENDS

Net of MERHCF costs, total DoD expenditures for health care decreased by 1 percent between FY 2016 and FY 2018. Inpatient expenses decreased by 3 percent, outpatient expenses remained about the same, and prescription drug expenses decreased by 2 percent.

- The share of DoD expenditures for outpatient care relative to total expenditures for inpatient and outpatient care remained steady at 73 percent from FY 2016 to FY 2018. For example, in FY 2018, DoD expenses for inpatient and outpatient care totaled $21,756 million, of which $15,938 million were for outpatient care, for a ratio of $15,938/$21,756 = 73 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. Purchased care drug costs shown below have been reduced by manufacturer refunds for retail name brand drugs accrued to the years in which the drugs were dispensed.
- In FY 2018, the DoD spent $2.74 on outpatient care for every $1 spent on inpatient care.

TRENDS IN DoD EXPENDITURES FOR HEALTH CARE (EXCLUDING MERHCF), FYs 2016–2018



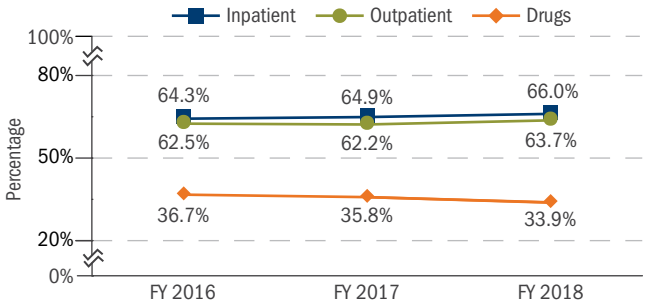
Source: MHS administrative data, 1/17/2019

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

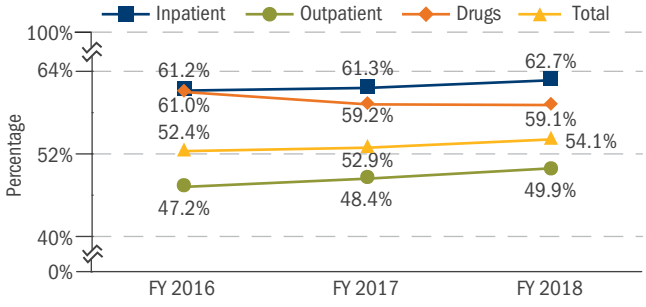
Note: Numbers may not sum to bar totals due to rounding.

- The purchased care share of total inpatient and outpatient utilization each increased from FY 2016 to FY 2018 while the purchased care share of total prescription drug utilization dropped over the same time period.
- The purchased care share of total MHS costs increased by almost two percentage points between FY 2016 and FY 2018. The purchased care share of total drug costs dropped by two percentage points, the purchased care share of total inpatient costs increased by one percentage point, and the share of total outpatient costs increased by almost three percentage points.

TRENDS IN PURCHASED CARE UTILIZATION[a] AS PERCENTAGE OF MHS TOTAL BY TYPE OF SERVICE, FYs 2016–2018



TRENDS IN PURCHASED CARE COST AS PERCENTAGE OF MHS TOTAL BY TYPE OF SERVICE, FYs 2016–2018



Source: MHS administrative data, 1/17/2019

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

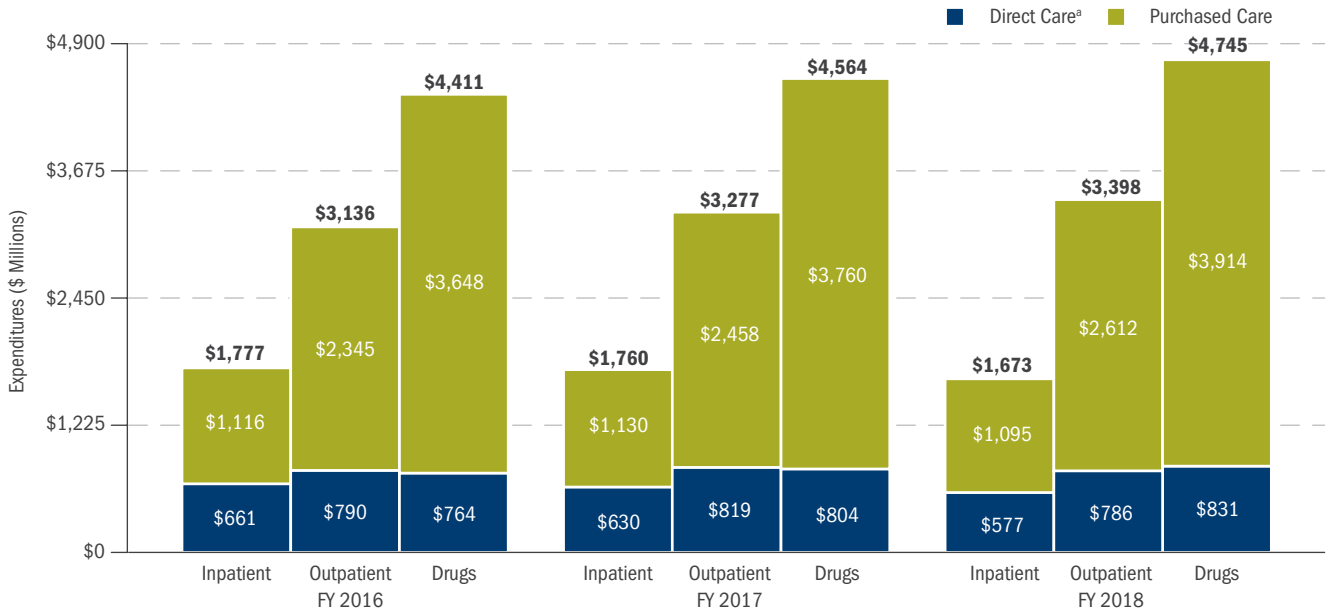
MHS COST TRENDS *(CONT.)*

MERHCF Expenditures for Medicare-Eligible Beneficiaries

The MERHCF covers Medicare-eligible retirees, retiree family members, and survivors only, regardless of age or Part B enrollment status. The MERHCF is not identical to TFL, which covers Medicare-eligible non-Active Duty beneficiaries enrolled in Part B. For example, the MERHCF covers MTF care and USFHP costs, whereas TFL does not. Total MERHCF expenditures increased from $9,324 million in FY 2016 to $9,816 million in FY 2018 (5 percent), including manufacturer refunds on retail prescription drugs. The percentage of TFL-eligible beneficiaries who filed at least one claim remained at about 83 percent.

- Total DoD direct care expenses for MERHCF-eligible beneficiaries decreased by 1 percent from FY 2016 to FY 2018. Inpatient costs fell by 13 percent and outpatient costs fell by 1 percent, but prescription drug costs increased by 9 percent.
- From FY 2016 to FY 2018, TRICARE Plus enrollees accounted for 73 percent of DoD direct care inpatient and outpatient expenditures on behalf of MERHCF-eligible beneficiaries.
- Including prescription drugs, TRICARE Plus enrollees accounted for 59 percent of total DoD direct care expenditures on behalf of MERHCF-eligible beneficiaries from FY 2016 to FY 2018.
- Total purchased care MERHCF expenditures increased by 7 percent from FY 2016 to FY 2018. Inpatient expenditures declined by 2 percent, outpatient expenditures increased by 11 percent, and prescription drug expenditures increased by 7 percent.

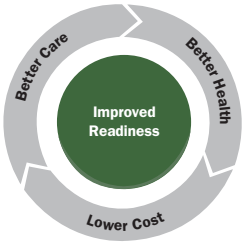
MERHCF EXPENDITURES BY TYPE OF SERVICE, FYs 2016–2018



Source: MHS administrative data, 1/17/2019

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

MEDICAL READINESS OF THE FORCE



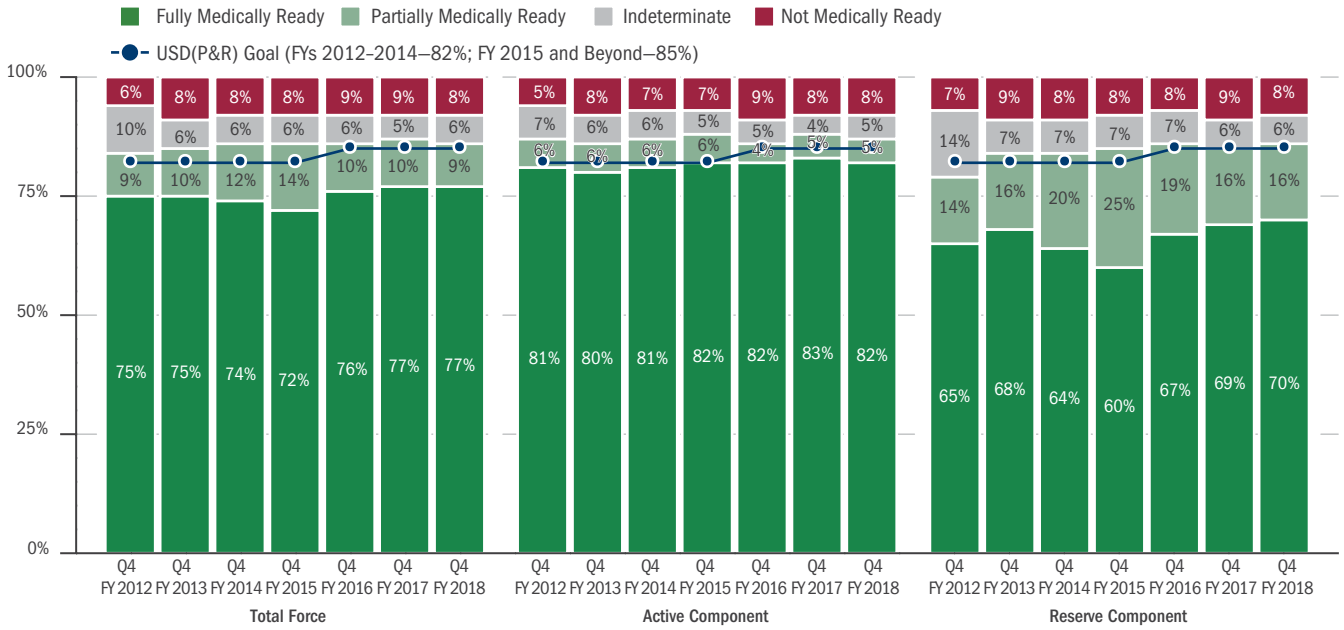
The Department of Defense (DoD) Individual Medical Readiness (IMR) program assesses the medical readiness of an individual Service member or larger cohort (e.g., unit or Service component) against established readiness requirements and metrics of key elements to determine medical deployability in support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

The IMR chart below shows that by the end of fiscal year (FY) 2018, the Total Force medical readiness, at 86 percent, surpassed the Office of the Under Secretary of Defense for Personnel and Readiness (USD[P&R]) goal of 85 percent, with the AC at 87 percent, and the RC at 86 percent (these percentages are shown as the sum of the percentages in the dark and light green sections). The overall medical readiness of the Total Force since FY 2011 has increased by eight percentage points (from 78 percent in FY 2011 to 86 percent in FY 2018), and, separately, the AC has increased by three percentage points (from 84 percent to 87 percent), and the RC by 18 percentage points (from 68 percent to 86 percent).

As Total Force medical readiness has improved, the USD(P&R) medical readiness goal has increased, from 80 percent in FY 2011, to 82 percent from FY 2012 to FY 2014, to 85 percent in FY 2015 to present. The Total Force and, separately, the AC and RC have met the higher USD(P&R) goal since it was last increased in FY 2015. Increasing the medical readiness goal above 85 percent to 90 percent is currently being pursued by the USD(P&R).

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

OVERALL INDIVIDUAL MEDICAL READINESS STATUS (ALL COMPONENTS NOT DEPLOYED), FY 2012 Q4 TO FY 2018 Q4



Source: Defense Health Agency (DHA), Healthcare Operations Directorate, Public Health Division, 10/31/2018
Note: Percentages may not sum to 100 percent due to rounding.

HEALTHY, FIT, AND PROTECTED FORCE

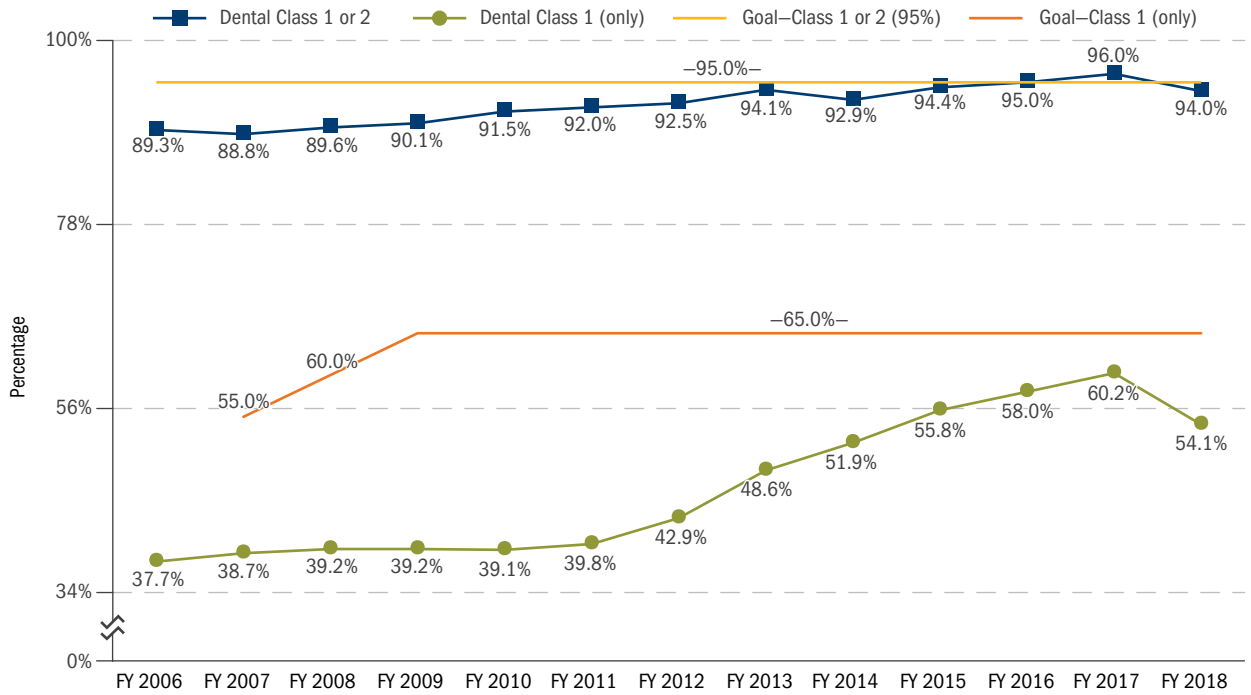
Key among the measures of performance related to providing an efficient and effective deployable medical capability and offering force medical readiness are those related to how well we (1) maintain the worldwide deployment capability of our Service members, as in dental readiness and immunization rates 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 note below chart). This goal also provides a measure of Active Duty access to necessary dental services.

- Overall MHS dental readiness in the combined Classes 1 and 2 remains high. Following a generally steady annual increase since FY 2007, the combined Classes 1 and 2 percentage fell in FY 2018 to just under 94 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 percent in FY 2017 to 54 percent in FY 2018—or nine percentage points short of the MHS goal of 65 percent. The MHS goal of 65 percent was increased in FY 2009 from the 55 percent goal established in FY 2007.

ACTIVE DUTY DENTAL READINESS: PERCENT CLASS 1 OR 2, FYs 2006–2018



Source: The Services' Dental Corps–DoD Dental Readiness Classifications, 11/27/2018

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

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

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

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

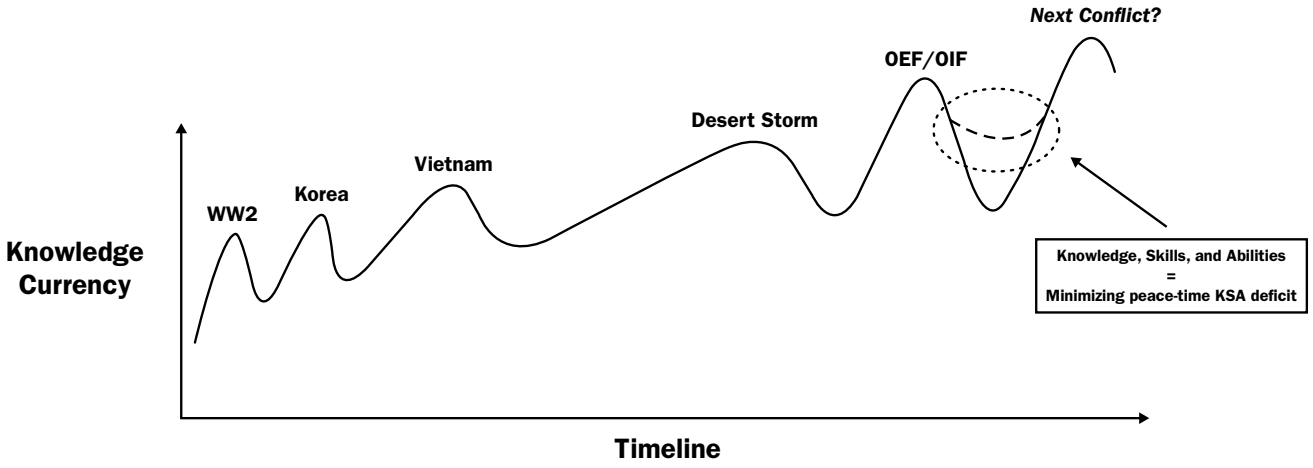
This approach has been piloted at six facilities from each Service and is in the process of being implemented across the MHS. In addition, a program management office has been established to expand the process to an additional 29 specialty areas in the next year. A knowledge assessment with an associated online curriculum will be operational for general surgery in the first quarter of CY 2019 with skills assessments and other specialties for the CCC team to follow. Finally, with the integration of the Joint Trauma System into the DHA, the MHS has the infrastructure in place to sustain the CCC team readiness metrics.

Sources:

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

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

EVOLUTION OF KNOWLEDGE SKILL CURRENCY ACROSS CONFLICTS



SHORTFALLS IN CURRENT KNOWLEDGE AND SKILLS MAINTENANCE

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

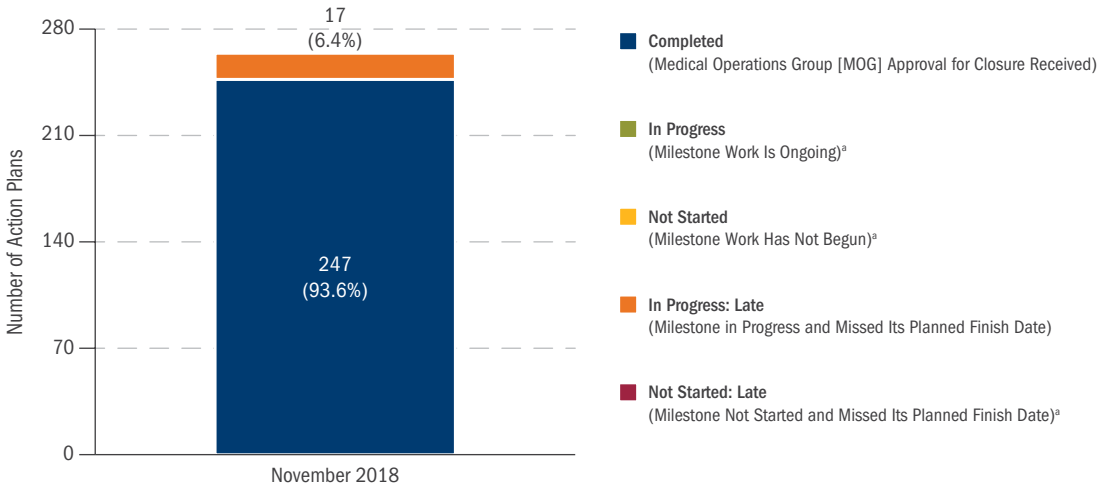
Source: HA/SP&FI (J-5)/Decision Support, Change Management detailee supporting NDAA 2017 section 703, 1/28/2018

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

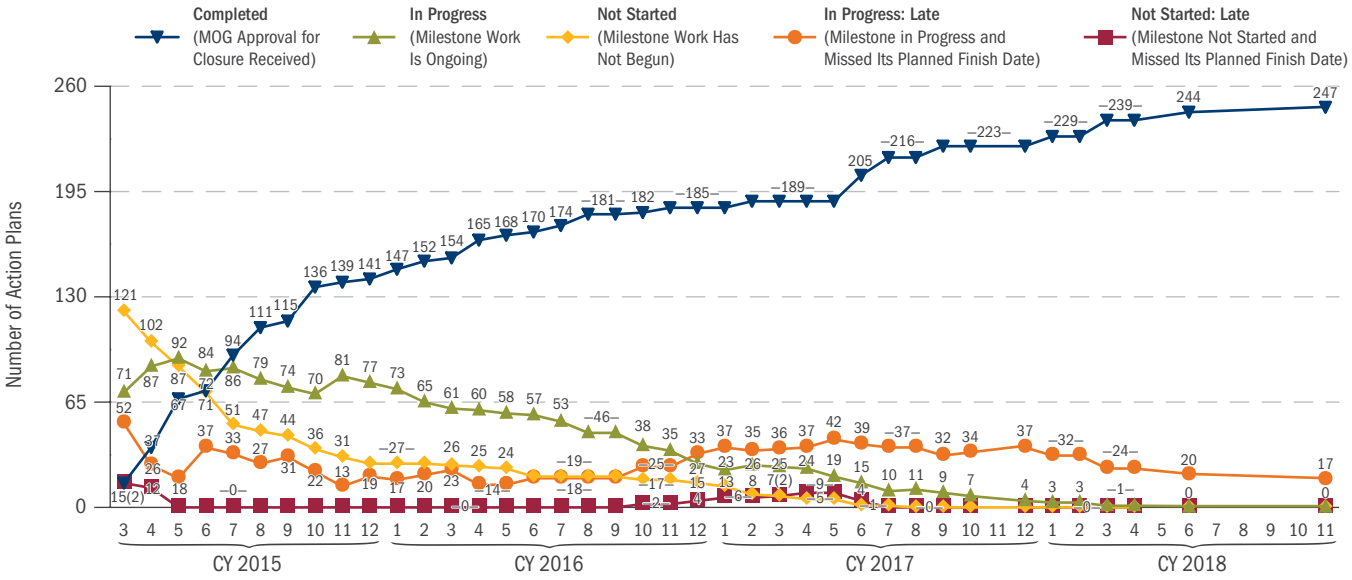
MHS Review—Status Update

The Secretary of Defense (SECDEF) directed a complete review of the Military Health System (MHS) in 2014. To fully address all the recommendations from the MHS review, 41 action plans were developed for a comprehensive approach. To date, 37 of these 41 action plans have been closed, with the remaining near closure. While short-term milestones may have been completed warranting action plan closure, the intent of most of the MHS review recommendations is to drive long-term project or program management for delivering high quality, safety, and access into the future. Therefore, capstone summaries are being developed for each closed action plan to ensure that the original intent of these recommendations is met and handoff to the appropriate entities to continue this work is documented. To date, three of the completed capstone summaries have been approved by MHS leadership. The remaining capstone summaries are in various stages of development and approval.

CURRENT MILESTONE STATUSES, OCTOBER 2018



MILESTONE STATUS TREND, CYs 2015–2018



[a] Zero action plans

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

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

High Reliability Organization Journey

As a result of the MHS review and subsequent findings, the SECDEF directed the MHS to adopt the practices and principles of high reliability organizations (HROs) as the framework to improve the quality of health care provided. To meet the charge, the MHS developed the HRO Operating Model (HROM), a visual representation of organizational relationships within the MHS that supports the Quadruple Aim of Improved Readiness, Better Care, Better Health, and Lower Cost.

MHS INTEGRATED HEALTH CARE DELIVERY SYSTEM HRO OPERATING MODEL

High Reliability Organization Journey *(cont.)*

The MHS HROM is a vehicle for clinical quality improvement in the MHS that marks a cultural change for an Integrated System of Readiness and Health. The model enables frontline staff to drive MHS-wide performance improvements in readiness and health, empowers MHS Clinical Communities to create conditions for high reliability at points of care, and holds the MHS accountable for standards and clinical outcomes.

Key to enhancing quality, safety, and patient experience is the Clinical Community construct at the core of the HROM. MHS Clinical Communities are networks of MHS clinicians who collaborate on clinical process improvement and standardization to improve patient outcomes. They enable the MTF-level identification of clinical performance improvement initiatives and leading MHS practices, then support MTFs in the dissemination of those initiatives and practices through the MHS HROM. The MHS Clinical Communities drive improvement from the bottom up, drawing on the leadership of actively practicing senior clinicians. The entire construct is designed to deliver faster and more streamlined decision making by MHS governance bodies, standardize care delivery where appropriate, and provide highly reliable, high-quality, safe care to patients.

As shown in the figure on the previous page, the MHS HROM creates a system of continuous feedback and communication across all levels of the MHS, supporting both a culture of safety and the MHS as a learning organization.

- **Completing the MHS Clinical Community proof of concept:** In FY 2018, the MHS took a significant next step by completing a proof of concept with four MHS Clinical Communities: Behavioral Health, Primary Care, Neuromusculoskeletal, and Women and Infant. Proof-of-concept communities were selected based on an overarching Key Process Analysis (KPA) that identified these areas as offering the highest potential for improvement based on volume and range of variability in care.

  During the proof of concept, the MHS looked into key elements of the model to enable continued progress on the MHS's HRO journey:

- Exploration of the resource needs of the MHS Clinical Communities.
- Identification of early projects of significance to demonstrate supporting relationships in the HROM.
- Investigation of how to track and evaluate success of projects.
- **Resource considerations:** During the proof of concept, the DHA focused on relationships and interactions for select Enabling Expertise and Clinical Support Services (see the figure on the next page) to understand how to resource the MHS Clinical Communities with supporting capabilities, skills, and staff. The proof of concept included testing functionality, determining financial and personnel resources required, identifying analytic and process improvement requirements, and establishing structural relationships to inform the way ahead for the stand-up of all MHS Clinical Communities. Due to the proven success of the proof-of-concept phase, on June 19, 2018, the Medical Deputies Action Group (MDAG) unanimously voted to support the further development of the four initial MHS Clinical Communities, along with the stand-up of the Dental Clinical Community. MHS senior leaders now view MHS Clinical Communities as the mechanism to drive clinical process improvement across the system.
- **Early identification of projects:** Each of the four MHS Clinical Communities identified initiatives to test concepts of the HROM during the proof of concept. More information about the individual Clinical Communities' activities is provided later in this report.

  As an example, the Neuromusculoskeletal and Women and Infant Clinical Communities adopted previously launched pilot projects to develop care pathways for Low Back Pain Care and Perinatal Care respectively. The care pathways pilots consist of interdisciplinary provider teams that designed, developed, and implemented the activities required to provide standardized, measurable, and patient-centric care. The process of developing and implementing the care pathway pilots has highlighted lessons, training, and infrastructure requirements that will inform the development and scale of future pathways for additional MHS Clinical Communities.
- **Tracking success:** Finally, during the proof of concept, the MHS worked to enhance its performance management system to accommodate both strategic performance management and the work of the MHS Clinical Communities to support and inform strategic performance guidance.

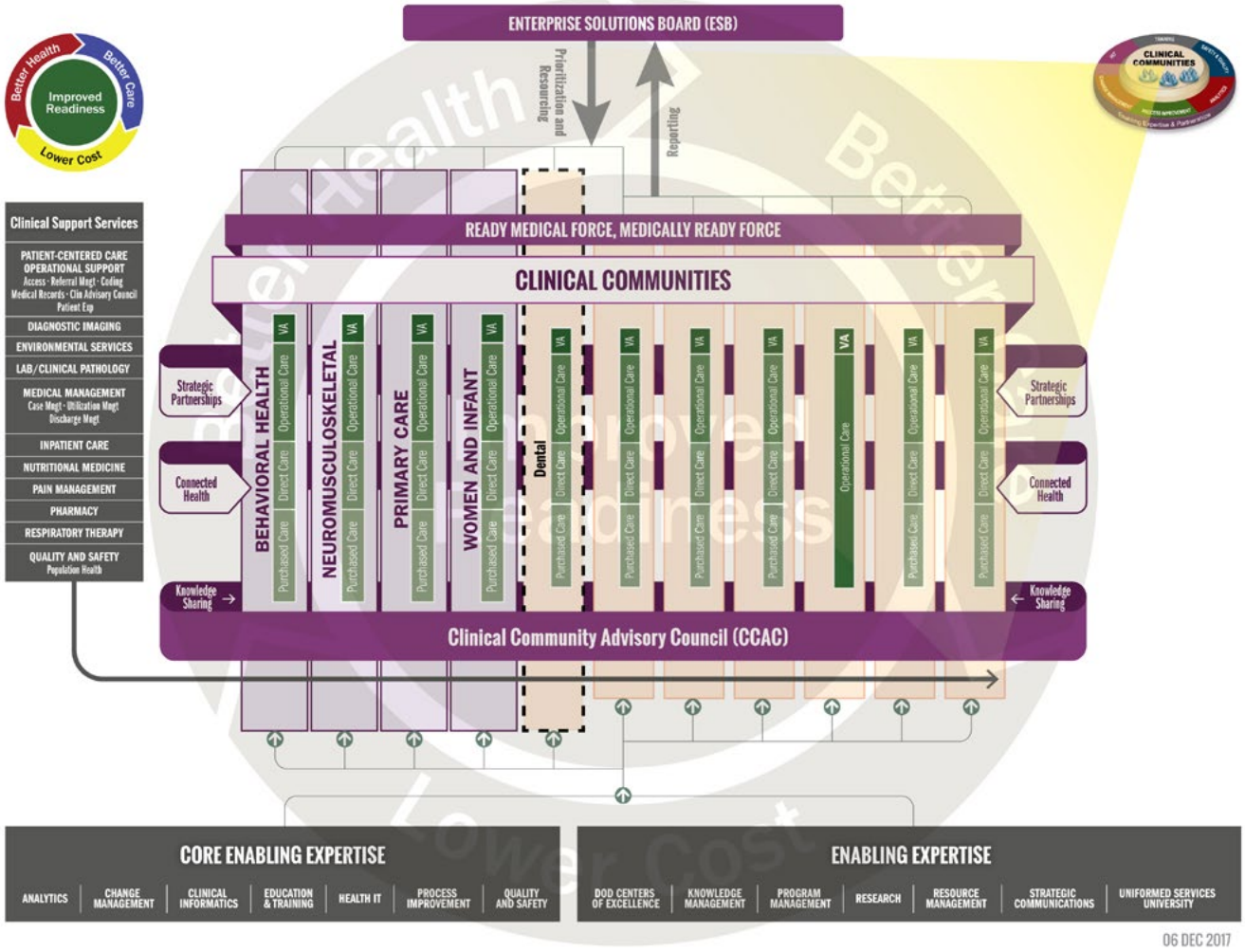
BETTER CARE: ACCESS, QUALITY, SAFETY, AND PATIENT ENGAGEMENT *(CONT.)*

High Reliability Organization Journey *(cont.)*

Although the MHS must wait for more longevity of Clinical Community initiatives to evaluate all relevant outcomes, the MHS is striving to disseminate best practices and facilitate the organizational shift to HRO through:

- Hosting an MHS Clinical Community Onboarding Session for the 16 Service/DHA-appointed leaders of the four proof-of-concept Clinical Communities to establish a continuous clinical quality improvement culture and capability.
- Developing customer service and access to care computer-based trainings to facilitate consistency in MTF staff performance regarding patient-facing communications and adherence to best-practice appointing procedures. The mandatory trainings serve as the initial step in improving and standardizing MTF staff roles, responsibilities, and competency expectations across the Services regarding customer service and access to care.

MHS CLINICAL COMMUNITIES



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

MHS Data Transparency

This report and MHS transparency efforts continue to evolve in response to both: (a) the 2014 SECDEF–directed MHS review and subsequent October 1, 2014, Secretary's Action Plan with corrective strategies, and (b) the NDAA FY 2016 legislation requirements to report specific clinical quality data down to the MTF level. This section provides a review of the continuing efforts to fulfill the intent of NDAA FY 2106, MHS reporting on Hospital Compare (the effort to participate in registries that can publicly report care in MHS direct care facilities alongside civilian facilities), and a framework for evolving MHS transparency,

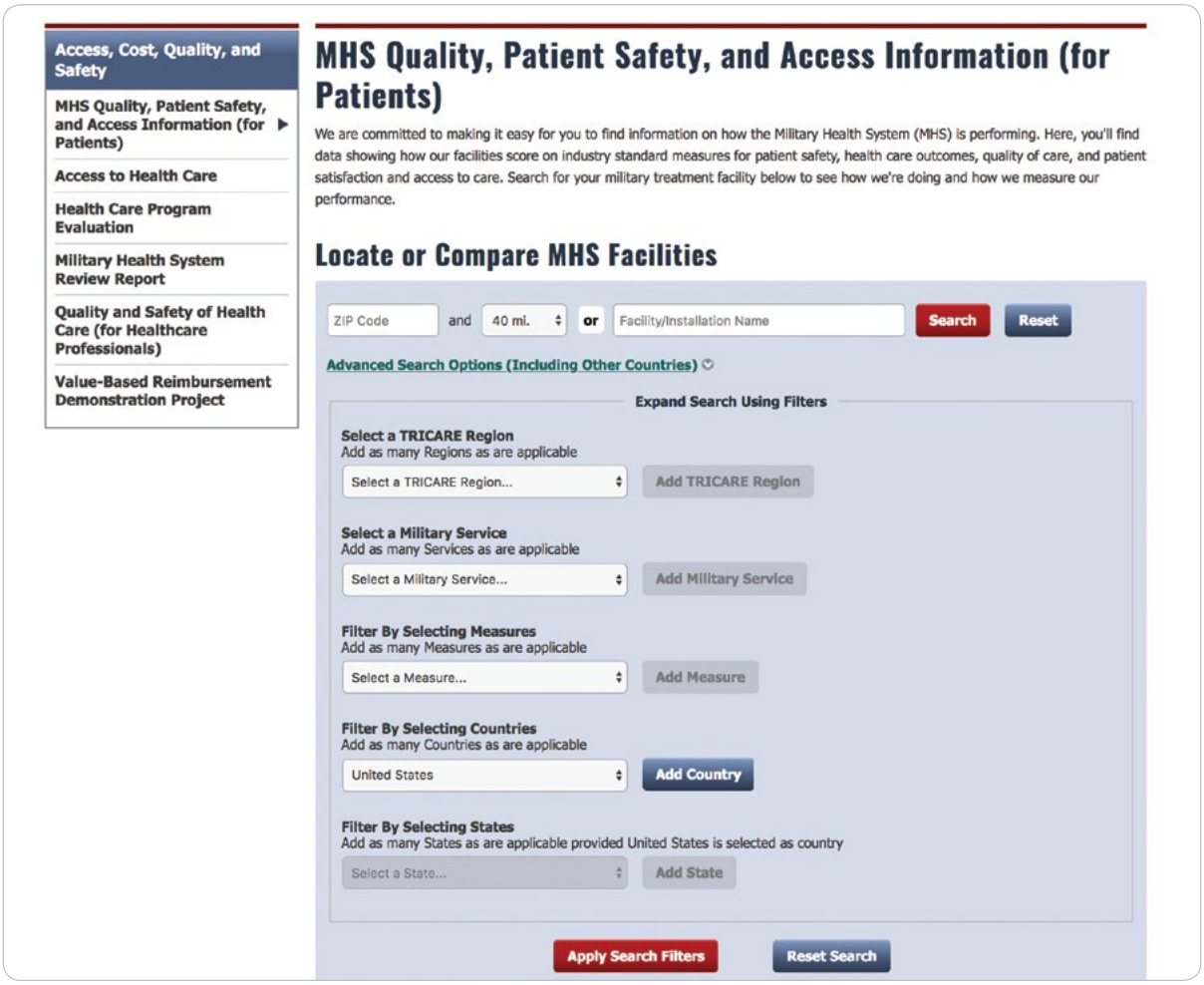
Summary of Key Data Responding to NDAA FY 2016

In response to section 712 of NDAA FY 2016:

1. Publication of data on patient safety, quality of care, satisfaction, and health outcome measures. The Defense Health Agency (DHA) met the requirement by the suspense requested for DoD data on all measures to assess patient safety, quality of care, patient satisfaction, and health outcomes for health care the SECDEF considered appropriate. These measures can be found on www.health.mil/transparency. The Tri-Service Transparency Initiative Working Group maintains responsibility for public reporting efforts of these measures, and as such continues to review and iterate on the approach and display of publicly reported information. During FY 2018, the following improvements were made to the public site (figure below):

- Enhanced search functionality, helping users narrow down their search by location, TRICARE region, Military Service, and specific measures.
- Improved accreditation reporting, through which users can now see accreditation status for each individual facility, not just parent facilities.
- Expanded metrics reporting in accordance with the NDAA FY 2017, section 728 requirements surrounding metrics reporting.
- Continued development of and improvements to plain-language measure descriptions to improve the user's ability to interpret the data.

VISIT HEALTH.MIL/TRANSPARENCY



MHS Data Transparency *(cont.)*

In response to section 713 of NDAA 2016:

1. Reporting to the National Practitioner Data Bank (NPDB). This is reported in the Health Care Risk Management section under Clinical Quality Management of this report (ref. page 104).

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

- **The current accreditation status, including recommendations for corrective action.** Accredited organizations, including DoD inpatient and freestanding ambulatory clinic MTFs, can be found on TJC's website at: http://www.qualitycheck.org/consumer/searchQCR.aspx. All other clinics are subordinate to one of these MTFs and are included in the respective facility TJC accreditation. MTF-specific hospital and clinic accreditation status, accreditation organization, survey dates, and requirements for improvement to meet full accreditation are displayed on www.health.mil/AccreditationandPolicy (ref. pages 105–107).
- **Any policies or procedures implemented during the year by the Secretary of the military department concerned, designed to improve patient safety, quality of care, and access to care.** A consolidated summary of relevant Health Affairs and Service policies is provided at www.health.mil/AccreditationandPolicy. DHA is currently in the process of developing and publishing critical, urgent and routine publications to supersede both DoD and Service level policies (where appropriate) in order to manage and administer 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 59, 72, 93, and 107).
- **Data on surgical and maternity care outcomes during the year.** MHS-level data are presented in this report (ref. pages 115–117 and 123–127). 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 58–62), 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.

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

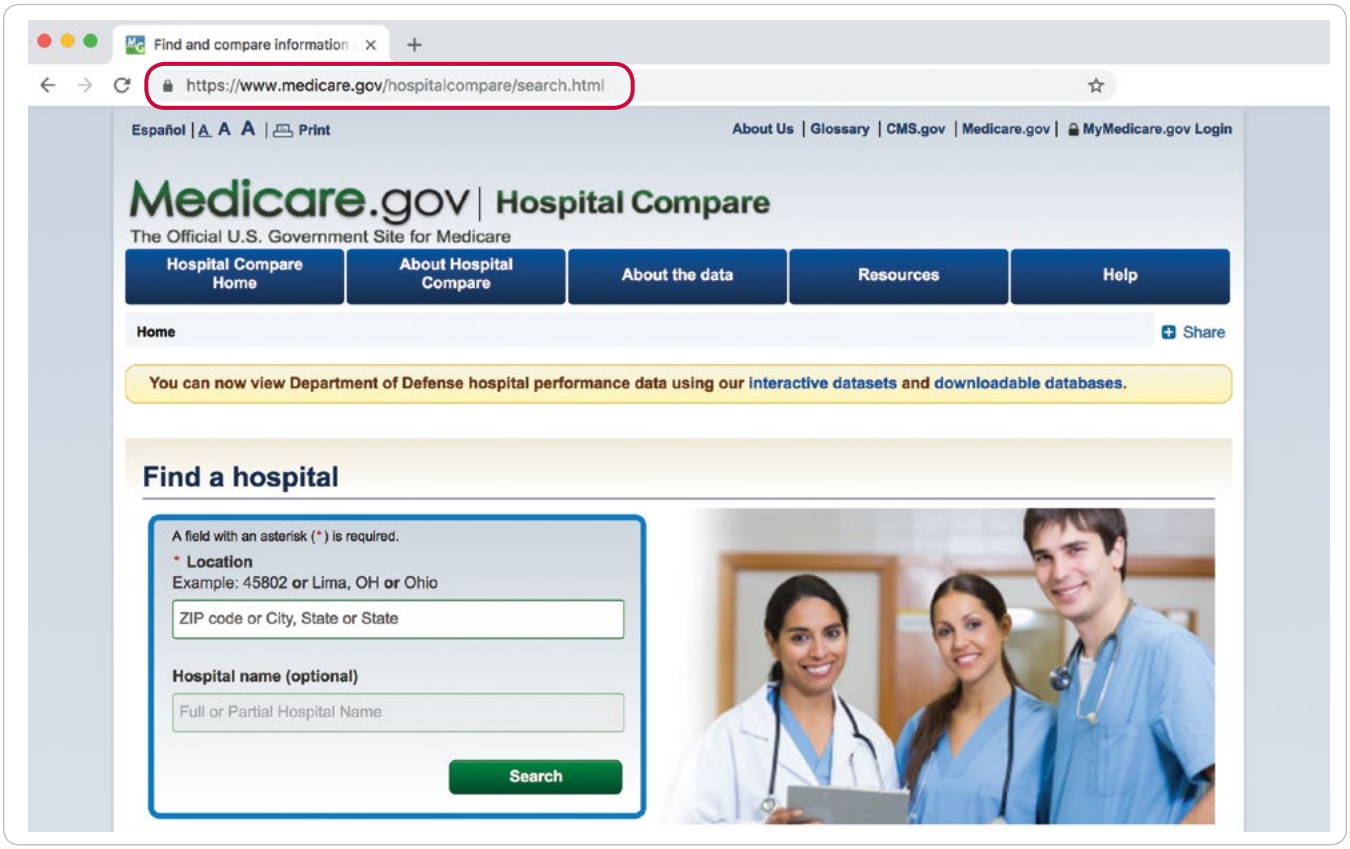
MHS Data Transparency *(cont.)*

MHS Transparency on Hospital Compare

The MHS has signed an agreement with CMS to participate in Hospital Compare. Hospital Compare is a consumer-oriented website providing information on how well hospitals perform on quality measures, with more than 4,000 U.S. hospitals participating. The information on Hospital Compare helps patients make decisions about where to get health care and encourages hospitals to improve the quality of care they provide. The TRICARE Inpatient Satisfaction Survey (TRISS) and Timely and Effective Care results are now publicly posted on Hospital Compare for all military hospitals in the United States. TRISS is administered randomly throughout the year and assesses the patient's perceptions of staff communication/responsiveness, cleanliness, quietness, 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 preventive services. An example of these measures would include average time for an EKG in the emergency room and patient experience with staff responsiveness.

New this year, CMS began making available to the public a downloadable embedded CSV file of DoD MTF performance data (see figures below and on the next page).

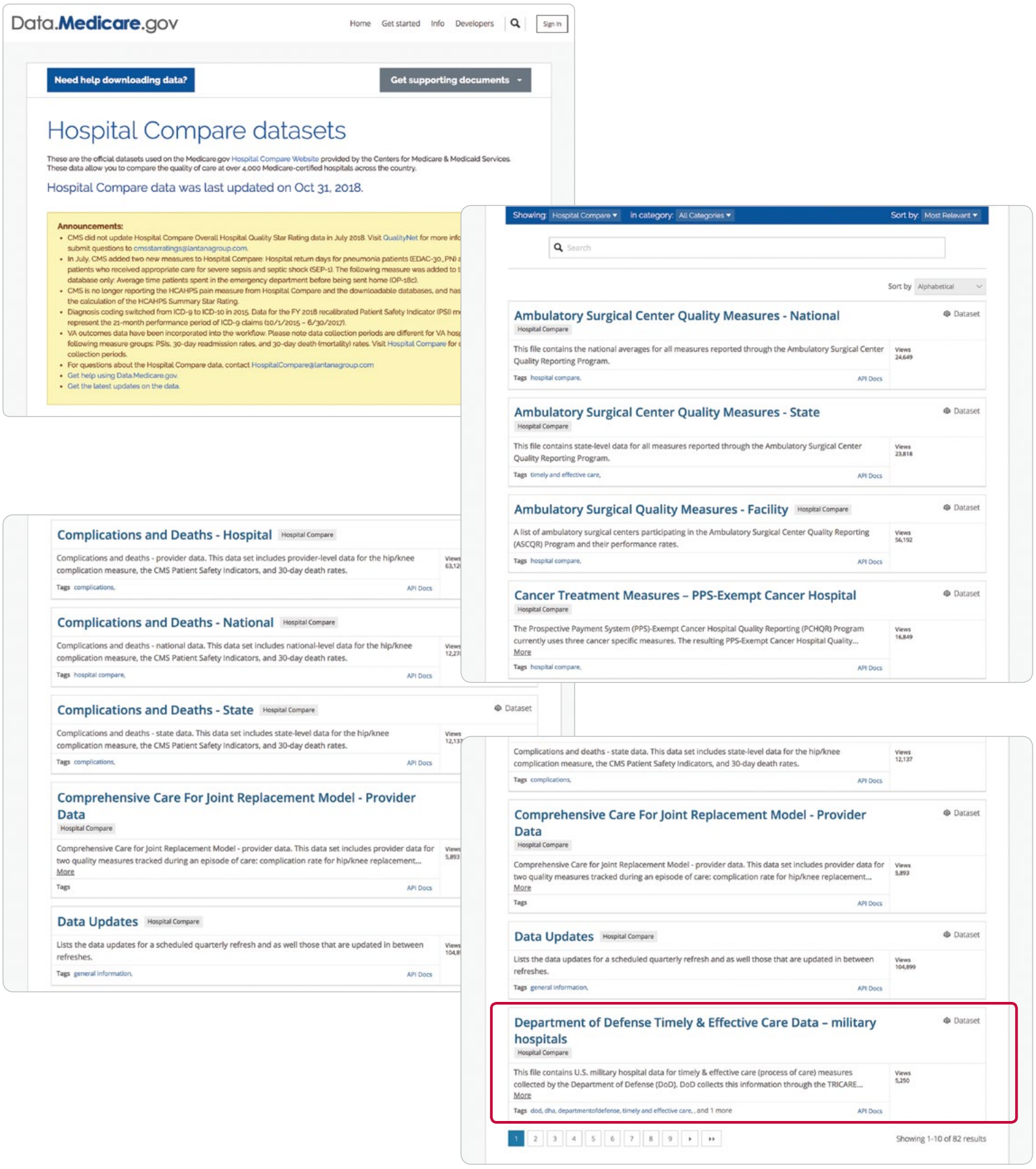
THE MHS IS COLLABORATING WITH CMS TO POST MTF HOSPITAL RESULTS ON THE HOSPITAL COMPARE WEBSITE



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

MHS Data Transparency *(cont.)*

THIS YEAR, CMS ADDED COMPLETE DoD DATA TO ITS DOWNLOADABLE DATA SETS OFFERING (CSV FORMAT)



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

The MHS Transparency Framework

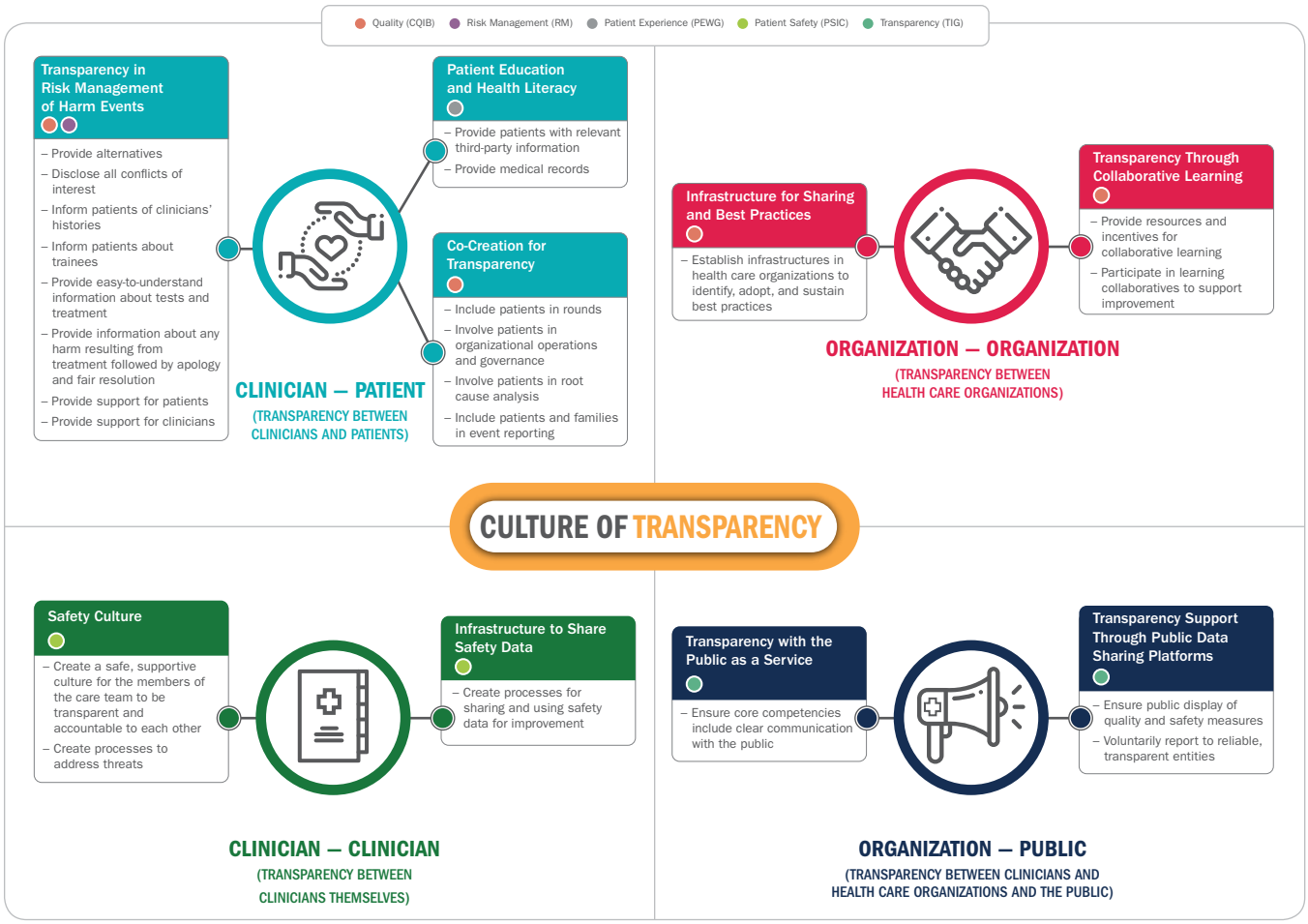
Although the MHS has been meeting its public reporting mandates through quarterly postings on www.health.mil/Transparency, this year the MHS tackled for the first time a system-level transparency framework necessary to foster a culture of safety and accountability. While developing this framework, the MHS continued its efforts to publicly share MTF performance data in ways most valuable to patients and the public.

The MHS Transparency Initiative Group (TIG) developed an MHS Transparency Framework structured on the four domains of transparency identified by the National Patient Safety Foundation:

- Transparency Between Clinicians and Patients
- Transparency Between Clinicians Themselves
- Transparency Between Healthcare Organizations
- Transparency Between Clinicians and Healthcare Organizations and the Public

In developing this framework, the TIG matched responsibilities identified in each working group's charter to the components of each domain and assigned responsibility (see figure below). This framework provides general guidance, though key working groups in the MHS have already begun work on initiatives related to the key tenets within these domains.

MHS TRANSPARENCY FRAMEWORK



ACCESS TO MHS CARE

Access to Outpatient Care in the MHS

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

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

In FY 2018, the direct care system continued optimization efforts to enhance patient experience and eliminate unwarranted variance among MTFs. The direct care system improved access, particularly in primary care, by implementing standard appointing and capacity processes codified in DHA policy to meet requirements in the NDAA for 2017. The NDAA FY 2017 section 704 directed MTFs to improve access to urgent care by expanding operating hours in MTF PCMHs, implementing additional MTF urgent care clinics at locations where sufficient patient demand existed to justify operating costs, and integrating the nurse advice line (NAL) urgent care 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 in the Tri-Service Workflow (TSWF) templates in the MHS electronic health record; (4) implementation of enhanced access initiatives, including team-based care, integrated specialists, and nurse-run walk-in clinics for common acute conditions; (5) standard First Call Resolution processes in both primary and specialty care to ensure beneficiaries' needs are met the first time they call for an appointment; and (6) use of DHA-developed centralized data and standard tools to better match appointment supply to patient demand by day of week and hour of day. The MHS also established productivity standards on the expected number of encounters per provider to meet the congressional intent of the NDAA FY 2017 section 709. Finally, the MHS has established standard primary care empanelment goals per provider and MTF to optimize direct care system capacity and provide a basis for primary care staff resource allocation across the direct care system based on patient demand.

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

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

ACCESS TO MHS CARE *(CONT.)*

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

The following summarizes key DHA and Tri-Service initiatives accomplished by the direct care system in FY 2018 and underway for FY 2019.

TRI-SERVICE INITIATIVES, FYs 2018–2019

FY 2018	FY 2019
Implement DHA-IPM 18-001 on Standardized Appointing and Referrals	Implement DHA-PI 6025.11 on Empanelment and Capacity Standards
Implement DHA-PI 6025.03 on Expanded Hours and Urgent Care	Implement Centralized Template Optimization and Demand Tool
Implement Patient and Family Partnership Councils (PFPCs) at MTFs	Implement Centralized Urgent Care Build or Buy Tool
Optimize Centralized Direct Access Reporting Tool	Implement DHA-PI 6025.xx on PFPCs
Deploy Nurse Advice Line Globally	Centralize Specialty Care Referral Review and Appointing
Begin MHS GENESIS Implementation	Continue MHS GENESIS Implementation

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

Patient-Centered Medical Home (PCMH) Primary Care

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

ACCESS TO MHS CARE *(CONT.)*

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

PCM and PCMH Team Continuity

The PCM-patient relationship remains the driving force to improve access, quality and better health outcomes for MTF-enrolled beneficiaries because it leads to more integrated/coordinated care, a more proactive, preventive focus on health, lower unnecessary healthcare utilization, higher satisfaction and reduced healthcare costs. In the direct care system, data demonstrate 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 appointment. 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.

- As shown in the tables below, in FY 2018, enrollees saw their own PCMs during primary care visits 57 percent of the time, and 92 percent of the time were seen by their own PCM or a fellow PCMH team provider. Median PCM Continuity was 58 percent. The Interquartile Range (IQR) or variance among MTFs increased slightly to 12 percent. PCM Continuity is expected to improve in FY 2019 through a renewed emphasis on PCMH principles and the implementation of the DHA policy on standardized appointing processes, which requires each PCM to schedule the required number of appointments per DHA policy and encourages PCMs' use of virtual telephone appointments when clinically appropriate and if accepted by the patient.

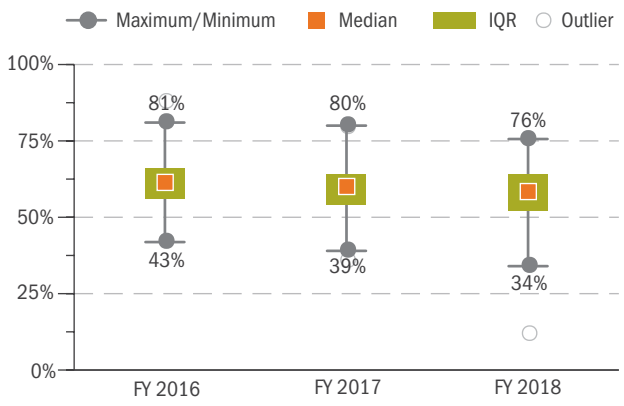
PCM AND PCMH TEAM CONTINUITY, FYs 2012–2018

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

PCM CONTINUITY, FYs 2016–2018

	FY 2016	FY 2017	FY 2018
Median	61%	60%	58%
75th Percentile (Q3)	66%	64%	64%
25th Percentile (Q1)	56%	54%	52%
IQR	10%	10%	12%
Positive Outlier (>)	81%	80%	82%
Negative Outlier (<)	41%	39%	34%
Maximum	88%	80%	76%
Minimum	43%	38%	15%

PCM CONTINUITY, FYs 2016–2018



Source: MHS Administrative Data (M2); DHA/Ops (J-3)/Clinical Business Operations, 11/18/2018

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

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

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

In FY 2018, the direct care system overall met the third next 24-hour appointment goal of 1.0 days or fewer with mean and median performance of 1.00 and 0.98 days, respectively. The direct care system also met the future appointment goal of 7.0 days or fewer, achieving an annual average of 5.90 days and median performance of 5.75 days. The 24-hour IQR improved by 19 percent from FY 2017, reflecting the efforts by all MTFs to provide more appointments within 24 hours for when patients need or want to be seen on the same or next day.

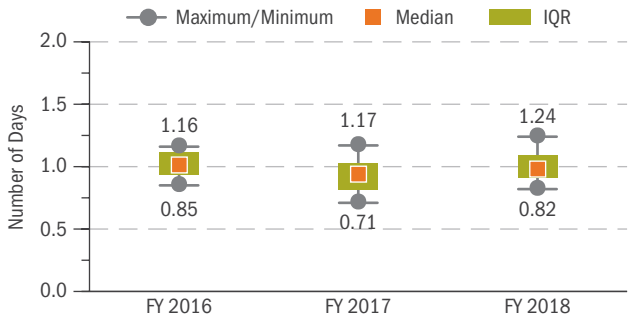
AVERAGE NUMBER OF DAYS TO 24-HOUR AND FUTURE APPOINTMENTS IN PRIMARY CARE, FYs 2016–2018

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

DAYS TO THIRD NEXT AVAILABLE 24-HOUR APPOINTMENT, FYs 2016–2018

	FY 2016	FY 2017	FY 2018
Median	1.00	0.91	0.98
75th Percentile (Q3)	1.12	1.03	1.09
25th Percentile (Q1)	0.94	0.82	0.91
IQR	0.18	0.21	0.17
Positive Outlier (>)	1.39	1.34	1.35
Negative Outlier (<)	0.67	0.51	0.65
Maximum	1.16	1.17	1.24
Minimum	0.85	0.71	0.82

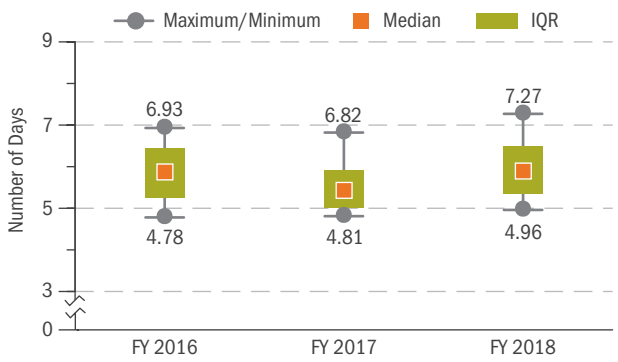
DAYS TO THIRD NEXT AVAILABLE 24-HOUR APPOINTMENT, FYs 2016–2018



DAYS TO THIRD NEXT AVAILABLE FUTURE APPOINTMENT, FYs 2016–2018

	FY 2016	FY 2017	FY 2018
Median	5.82	5.34	5.75
75th Percentile (Q3)	6.44	5.93	6.50
25th Percentile (Q1)	5.25	5.02	5.36
IQR	1.19	0.91	1.14
Positive Outlier (>)	8.21	7.29	8.21
Negative Outlier (<)	3.47	3.66	3.66
Maximum	6.93	6.82	7.27
Minimum	4.78	4.81	4.96

DAYS TO THIRD NEXT AVAILABLE FUTURE APPOINTMENT, FYs 2016–2018



Source: MHS Administrative Data (M2); DHA/Ops (J-3)/Clinical Business Operations, 11/18/2018

ACCESS TO MHS CARE *(CONT.)*

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

Sources of Primary Care Appointing

The direct care system offers multiple options for scheduling primary care appointments in MTFs. In September 2018, approximately 91 percent of primary care appointments were scheduled by the MTF through appointment centers or directly by PCMHs. Although the percentage of appointments scheduled by the MTF and market appointment centers or by the clinics decreased, the proportion of primary care appointments scheduled through other enhanced means increased in FY 2018. The percentage of appointments scheduled by patients using the TOL Patient Portal increased from almost 4 percent in September 2016 to over 6 percent in September 2018. The direct care system is expanding efforts to publicize appointing capabilities in the TOL Patient Portal and deployed a mobile TOL application in FY 2017. Slightly less than 2 percent of appointments are arranged via a secure message between patients and health care teams, and approximately 0.3 percent of appointments are scheduled by the centralized NAL for patients needing an MTF PCMH appointment within 24 hours or less. In FY 2019, the MHS will implement standard processes to increase the ability for the NAL–to schedule appointments for beneficiaries empaneled to MTFs who NAL–registered nurse triage indicate need to be seen within 24 hours.

PRIMARY CARE APPOINTMENT BOOKING SOURCES, SEPTEMBER 2016, 2017, AND 2018

	SEPT. 2016 PERCENT BOOKED	SEPT. 2017 PERCENT BOOKED	SEPT. 2018 PERCENT BOOKED
Appointment Center or Clinic Booked	94.3%	93.0%	91.4%
TRICARE Online Patient Portal	3.9%	5.2%	6.4%
Arranged on Secure Messaging	1.7%	1.7%	1.9%
NAL Booked	0.2%	0.2%	0.3%
Total Booked	100.0%	100.0%	100.0%

Source: MHS Administrative Data (M2); DHA/Ops (J-3)/Clinical Business Operations, 11/18/2018

TOL Patient Portal Automatic Appointment Reminders

The TOL Patient Portal added the capability allowing beneficiaries to select the option of receiving reminders of upcoming MTF primary or specialty appointments by text and/or e-mail. Once the beneficiary provides a preferred telephone number and/or e-mail address, the beneficiary receives several reminders of each upcoming appointment, regardless of whether the appointment was scheduled on TOL, by calling an appointment center, or in person. The appointment reminders are sent at least one week in advance, three days in advance, one day in advance, and then several hours in advance, depending how far in advance the appointment was scheduled. Each reminder notifies the beneficiary of the appointment date, time, provider, clinic, and MTF; the reminders also provide information on how to cancel the appointment, if necessary. In FY 2018, the MHS continued educating beneficiaries about the capability to set text and e-mail reminders in the TOL Patient Portal. During the fourth quarter of FY 2018, TOL sent an average of 221,282 e-mail and 153,628 text appointment reminders per week.

Access to Integrated Specialists in the PCMH

The most common conditions in the direct care enrollee population, excluding pregnancy, are behavioral health-related, musculoskeletal issues, and miscellaneous conditions such as hypertension, hyperlipidemia, obesity, and diabetes. To improve access and outcomes for the beneficiaries affected by these conditions, the direct care system continues optimizing the use and integration of specialists in PCMHs to provide more continuous, comprehensive care in the primary care setting and to facilitate coordinated care. Currently, over 80 percent of PCMHs serving adult enrollees have integrated behavioral health specialists who provide treatment for mental health and behavioral health issues. Directly integrating behavioral health providers ensures that the integrated specialists are able to work closely in partnership with the patient, PCM, and PCMH team; moreover, because the specialties are colocated, 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 purchased care costs. In FY 2019, the MHS will implement standard processes to enhance access to integrated specialists in PCMHs by allowing direct booking without first requiring a PCM appointment, when clinically appropriate.

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

Dispositions and Bed-Days per 1,000 MTF Enrollees

By focusing on prevention, proactive care coordination and improving outcomes for common conditions, MTF PCMHs focus on reducing the incidence of dispositions (admissions) and bed-days per 1,000 MTF enrollees. PCMH teams continue efforts to reduce the number of times MTF enrollees are admitted to hospitals and medical centers in both the direct and purchased care sectors, and the length of time they spend as inpatients if they are admitted, which is measured by bed-days (number of dispositions multiplied by the length of stay). The average monthly disposition count per 1,000 MTF enrollees was 5.25 in FY 2018, an undesired increase of 1 percent from FY 2017. While inpatient dispositions have been declining since FY 2012, the slight increase in inpatient dispositions in FY 2018 appears to be associated with increased network emergency room (ER) utilization by MTF enrollees. The IQR or variance among MTFs in both dispositions and average monthly bed-days per 1,000 MTF enrollees increased. Also, in FY 2015, 41 percent of dispositions and 48 percent of bed-days occurred in the TRICARE network; in FY 2018, the network share of MTF enrollee dispositions and bed-days increased to 45 percent and 52 percent, respectively (not shown). The top five reasons for admissions remain: childbirth, musculoskeletal, circulatory, digestive, and respiratory conditions. In FY 2018, the DHA implemented a centralized dashboard for MTFs on the CarePoint Information Portal, which provides data and trend analysis of dispositions by beneficiary category and age of patient, zip code where dispositions occurred and diagnoses categories to facilitate MTFs in capturing a greater share of enrollee dispositions, where feasible.

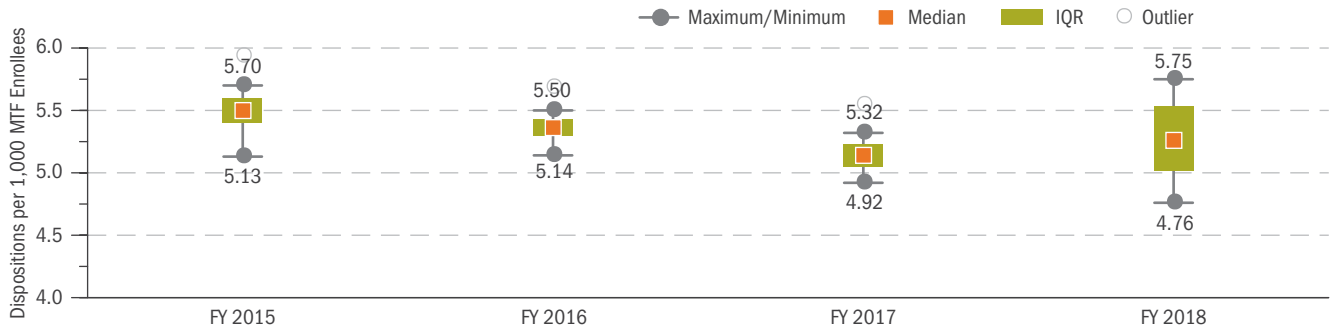
AVERAGE MONTHLY DISPOSITIONS AND BED-DAYS PER 1,000 MTF ENROLLEES, FYs 2012–2018

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Average Monthly Dispositions per 1,000 MTF Enrollees	6.87	6.26	5.74	5.51	5.37	5.18	5.25
Average Monthly Bed-Days per 1,000 MTF Enrollees	21.46	19.57	17.82	16.86	16.87	16.20	16.46

AVERAGE MONTHLY DISPOSITIONS PER 1,000 MTF ENROLLEES, FYs 2015–2018

	FY 2015	FY 2016	FY 2017	FY 2018
Median	5.54	5.37	5.15	5.24
75th Percentile (Q3)	5.60	5.43	5.23	5.54
25th Percentile (Q1)	5.40	5.30	5.05	5.02
IQR	0.20	0.13	0.18	0.52
Positive Outlier (>)	5.70	5.50	5.32	5.80
Negative Outlier (<)	5.10	5.10	4.78	4.25
Maximum	5.93	5.68	5.54	5.75
Minimum	5.13	5.14	4.92	4.76

AVERAGE MONTHLY DISPOSITIONS PER 1,000 MTF ENROLLEES, FYs 2015–2018



Source: MHS Administrative Data (M2); DHA/Ops (J-3)/Clinical Business Operations, 11/18/2018

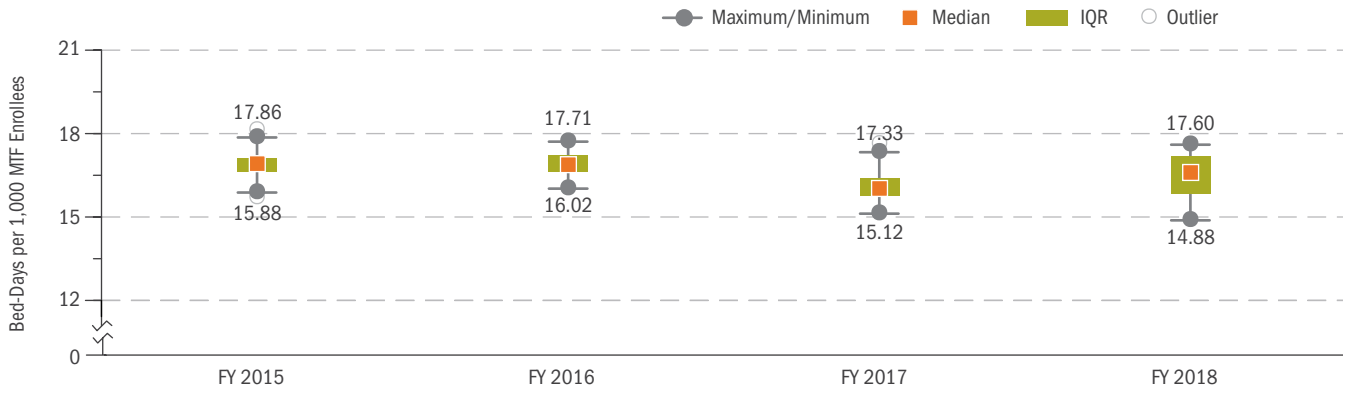
ACCESS TO MHS CARE *(CONT.)*

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

AVERAGE MONTHLY BED-DAYS PER 1,000 MTF ENROLLEES, FYs 2015–2018

	FY 2015	FY 2016	FY 2017	FY 2018
Median	16.88	16.78	16.07	16.90
75th Percentile (Q3)	17.11	17.22	16.40	17.18
25th Percentile (Q1)	16.62	16.64	15.78	15.83
IQR	0.50	0.58	0.62	1.35
Positive Outlier (>)	17.86	18.08	17.33	19.21
Negative Outlier (<)	15.88	15.78	14.85	13.80
Maximum	18.10	17.71	17.60	17.60
Minimum	15.67	16.02	15.12	14.88

AVERAGE MONTHLY BED-DAYS PER 1,000 MTF ENROLLEES, FYs 2015–2018



Source: MHS Administrative Data (M2); DHA/Ops (J-3)/Clinical Business Operations, 11/18/2018

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

Recapturable ER Visits in the Private Sector per 100 MTF Enrollees

Network ER visits for primary care reasons increased in FY 2018 compared to FY 2017, reversing a five-year trend of decreased network ER utilization. A month-by-month analysis from FY 2016 to FY 2018 appear to demonstrate increased network ER and network UC visits began with the approval of unlimited self-referred network UC visits. Qualitative data demonstrate beneficiaries do not always differentiate between ERs and UCs as delivery venues when they seek urgent care. ER visits for primary care reasons are a small percentage of all ER visits and are defined by the Tri-Service Emergency Medicine consultants and industry as Evaluation and Management Codes 99281 and 99282. MTF efforts to reduce ER visits include better access to 24-hour care in PCMH, walk-in clinics for common acute conditions, the PCMH team-based care to meet patients' needs and the use of the NAL and Secure Messaging.

- As shown in the table below, the average number of primary care network ER visits per 100 MTF enrollees for primary care reasons increased 23.4 percent compared to FY 2017. Overall, network ER visits for all reasons also increased approximately 4 percent when comparing the same periods.

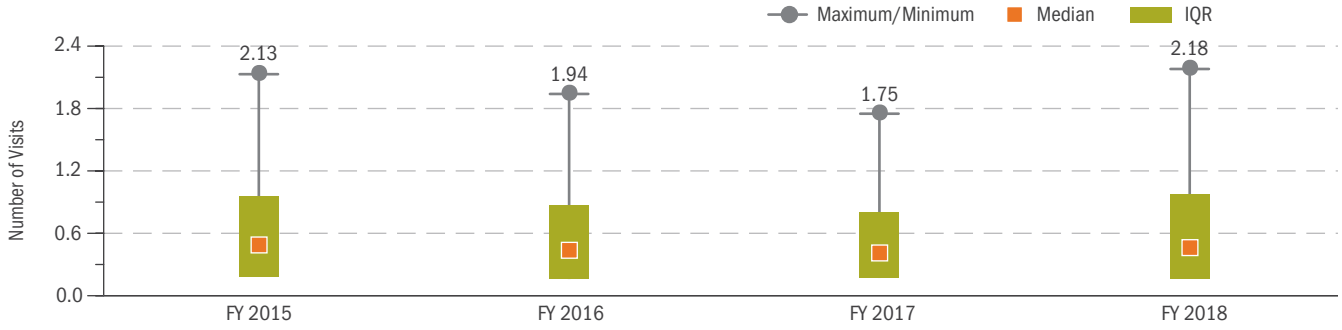
AVERAGE NETWORK ER VISITS PER 100 MTF ENROLLEES, FYs 2012–2018

	AVERAGE NETWORK ER VISITS PER 100 MTF ENROLLEES (INCLUDING TRUE EMERGENCIES)	AVERAGE NETWORK ER VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS
FY 2012	20.51	1.03
FY 2013	20.26	0.89
FY 2014	20.44	0.79
FY 2015	20.74	0.78
FY 2016	20.16	0.73
FY 2017	19.58	0.69
FY 2018	20.31	0.85
One-Year Change (FY 2017 to FY 2018)	**3.7%**	**23.4%**

NETWORK ER VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS, FYs 2015–2018

	FY 2015	FY 2016	FY 2017	FY 2018
Median	0.54	0.47	0.42	0.51
75th Percentile (Q3)	0.96	0.87	0.80	0.98
25th Percentile (Q1)	0.19	0.16	0.17	0.17
IQR	0.78	0.71	0.63	0.80
Positive Outlier (>)	2.13	1.94	1.75	2.18
Negative Outlier (<)	–	–	–	–
Maximum	8.39	14.08	19.63	18.51
Minimum	–	–	–	–

NETWORK ER VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS, FYs 2015–2018



Source: MHS Administrative Data (M2); DHA/Ops (J-3)/Clinical Business Operations, 11/18/2018
Note: Tri-Service ER Consultants' guidance and the National Patient Centered Primary Care/AHRQ (how they count primary care sensitive ER visits).

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

Network Urgent Care (UC) Visits per 100 Enrollees

As shown in the below table, network UC visits by MTF enrollees increased almost 58 percent in FY 2018 compared to FY 2017, after a five-year period of relatively stable utilization. While network UC visits did not increase dramatically during the short UC pilot monitored through FY 2017 discussed on page 82, visits have nearly doubled with the change in the benefit in FY 2018 allowing unlimited self-referred network UC visits. Since the change to allow unlimited network UC visits, recapturable network ER visits also increased with most visits, resulting in a net cost increase to the MHS. The majority of network UC and recapturable ER visits were for upper respiratory illness. During this same period, MTF access in PCMHs improved and utilization of MTF PCMH appointments was relatively stable, although there was variance among the Uniformed Services. That most network UC visits are for upper respiratory illnesses or colds is consistent with industry results that unlimited self-referred UC visits increase demand for care for self-limiting or low-acuity issues, beyond that which occurred in a given population previously. Due to the large increase in network UC utilization, additional analysis on median performance and variance will be provided in next year's report. The DHA developed a UC demand dashboard on the CarePoint Information Portal that provides data by patient age, beneficiary category, zip code, and diagnosis reason, and recommends either MTF expanded hours or implementation of an MTF or market-based UC clinic to meet demand, if sufficient demand exists to justify the expense. In FY 2019, the MHS will evaluate this data and recommend additional expanded hours or direct care UCs to increase convenience for enrolled beneficiaries and optimize direct care resources.

AVERAGE NETWORK UC VISITS PER 100 MTF ENROLLEES, FYs 2012–2018

	AVERAGE NETWORK UC VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS
FY 2012	7.62
FY 2013	7.58
FY 2014	6.72
FY 2015	7.88
FY 2016	7.88
FY 2017	8.95
FY 2018	14.11
One-Year Change (FY 2017 to FY 2018): 57.7%	

Source: MHS Administrative Data (M2); DHA/Ops (J-3)/Clinical Business Operations, 11/18/2018

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

Secure Messaging

Percentage of Enrollees Registered to Use Secure Messaging: The direct care system offers enhanced access to care through the use of a commercially available secure messaging system. In FY 2018, the direct care system continued efforts to deploy secure messaging in specialty care. Secure messaging allows MTF enrollees to communicate directly with their PCMs and care teams to ask questions about their health or medical tests and to arrange referrals or appointments. As of the end of FY 2018, over 1.8 million MTF enrollees (MTF Prime and TRICARE Plus seniors) were registered in secure messaging, or 50.3 percent of all enrollees, exceeding the goal of 50 percent or more. The MHS prioritized enrollment in secure messaging starting in FY 2017; this unified effort to implement standard secure messaging processes in PCMHs resulted in a reduction in the interquartile range or variance among MTFs of almost 100 percent in FY 2018 compared to FY 2017. Analysis of the primary reasons that patients initiate messages include: asking a medical question (55 percent), arranging appointments (15 percent), or renewing medications (14 percent).

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

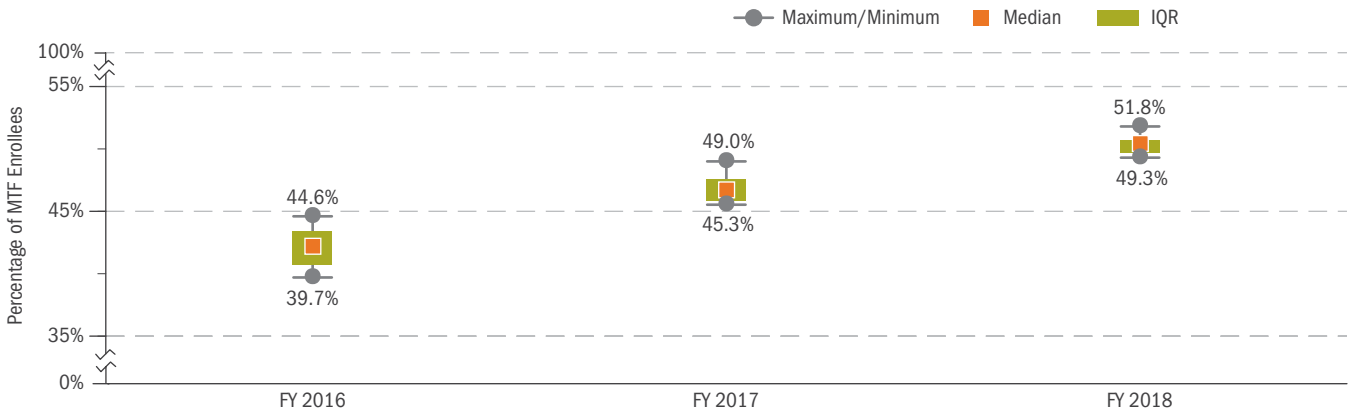
ACCESS TO MHS CARE *(CONT.)*

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

PERCENTAGE OF MTF ENROLLEES REGISTERED IN SECURE MESSAGING, FYs 2016–2018

	FY 2016	FY 2017	FY 2018
Average	44.0%	49.0%	50.3%
Median	42.0%	46.6%	49.9%
75th Percentile (Q3)	43.4%	47.6%	50.7%
25th Percentile (Q1)	40.7%	45.9%	49.7%
IQR	2.6%	1.7%	1.0%
Positive Outlier (>)	47.3%	50.1%	52.2%
Negative Outlier (<)	36.8%	43.4%	48.2%
Maximum	44.6%	49.0%	51.8%
Minimum	39.7%	45.3%	49.3%

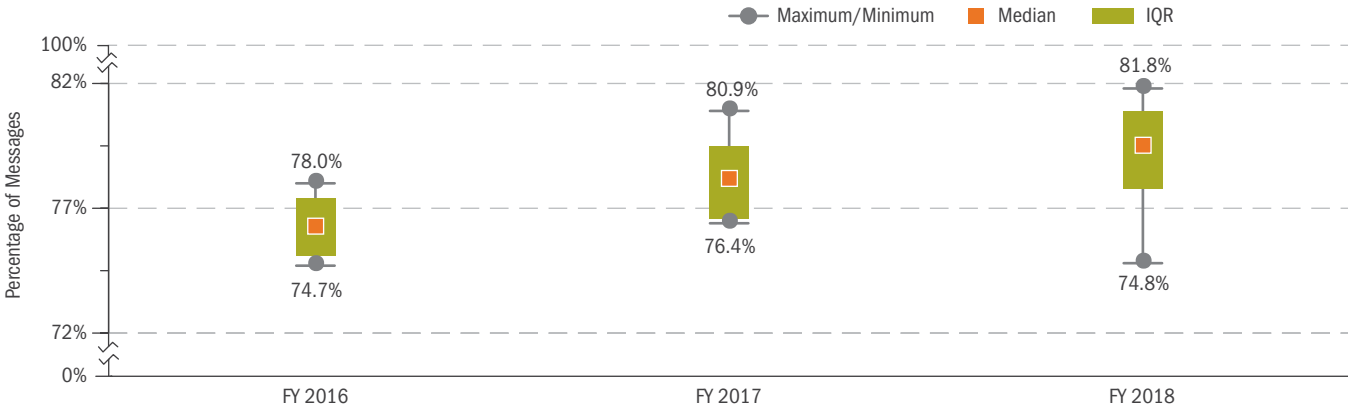
PERCENTAGE OF MTF ENROLLEES REGISTERED IN SECURE MESSAGING, FYs 2016–2018



PERCENTAGE OF SECURE MESSAGES RESPONDED TO WITHIN ONE BUSINESS DAY, FYs 2016–2018

	FY 2016	FY 2017	FY 2018
Average	76.2%	78.2%	79.3%
Median	76.0%	78.1%	79.9%
75th Percentile (Q3)	77.4%	79.5%	80.9%
25th Percentile (Q1)	75.1%	76.6%	77.8%
IQR	2.3%	2.9%	3.1%
Positive Outlier (>)	80.8%	83.9%	85.6%
Negative Outlier (<)	71.7%	72.3%	73.1%
Maximum	78.0%	80.9%	81.8%
Minimum	74.7%	76.4%	74.8%

PERCENTAGE OF SECURE MESSAGES RESPONDED TO WITHIN ONE BUSINESS DAY, FYs 2016–2018



Source: Secure Messaging Program: DHA/Solutions Delivery and DHA/Ops (J-3)/Clinical Business Operations 11/18/2018

Nurse Advice Line (NAL)

The MHS NAL continues to provide valuable, quality, and convenient nurse triage and care coordination services to our MHS beneficiaries 24 hours a day, seven days a week, directing over half a million callers per year to the most clinically appropriate level of care. Since implementation in late FY 2014, the NAL has provided access to registered nurses (RNs) who address health concerns, offer self-care advice, and answer general health questions. The NAL receives approximately 1,600 to 2,200 calls per day and potentially saves 12 lives per day by recommending or activating emergency procedures and assisting callers in crisis.

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

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

The MHS analyzes NAL performance by comparing the beneficiary's pre-intent—what the caller states he/she would have done if they did not call the NAL—to the NAL RN's advice for care. The NAL provides this data to a third-party vendor, who pulls the purchased care claims and MTF encounter data from the MHS Mart (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.

Results from the previous (U.S.-Based) NAL are compared to results from the Global NAL. The percentage of Global NAL callers seeking care in MTFs is lower; however, the percentage of callers who did not seek follow-on care and who used RN self-care advice is 44 percent, compared to the previous 30 percent. Patient satisfaction with the NAL remains over 92 percent, based on responses from a sample of beneficiaries who are surveyed by DHA following the call.

U.S.-BASED NAL CALLER INFORMATION FOR MTF ENROLLEES, FYs 2015–2017 (THROUGH JUNE 2017)

NAL DISPOSITION	CALLER'S PRE-INTENT	NURSE ADVICE	CALLER'S ACTION WITHIN 24 HOURS
Network ER	36%	11%	13%
Network UC	26%	25%	20%
MTF Care	20%	24%	37%
Self-Care	7%	31%	30%
General Health and Other Miscellaneous Questions	11%	9%	0%
Total	100%	100%	100%

GLOBAL NAL CALLER INFORMATION FOR MTF ENROLLEES, FY 2018 (THROUGH JUNE 2018)

NAL DISPOSITION	CALLER'S PRE-INTENT	NURSE ADVICE	CALLER'S ACTION WITHIN 24 HOURS
Network ER	25%	16%	16%
Network UC	19%	15%	16%
MTF Care	19%	26%	24%
Self-Care	13%	27%	44%
General Health and Other Miscellaneous Questions	24%	16%	0%
Total	100%	100%	100%

Source: NAL Program and MHS Administrative Data (M2/MDR); DHA/Ops (J-3)/Clinical Business Operations, 11/18/2018

ACCESS TO MHS CARE *(CONT.)*

Primary Care Utilization, PCMH Market Share, and Network Leakage

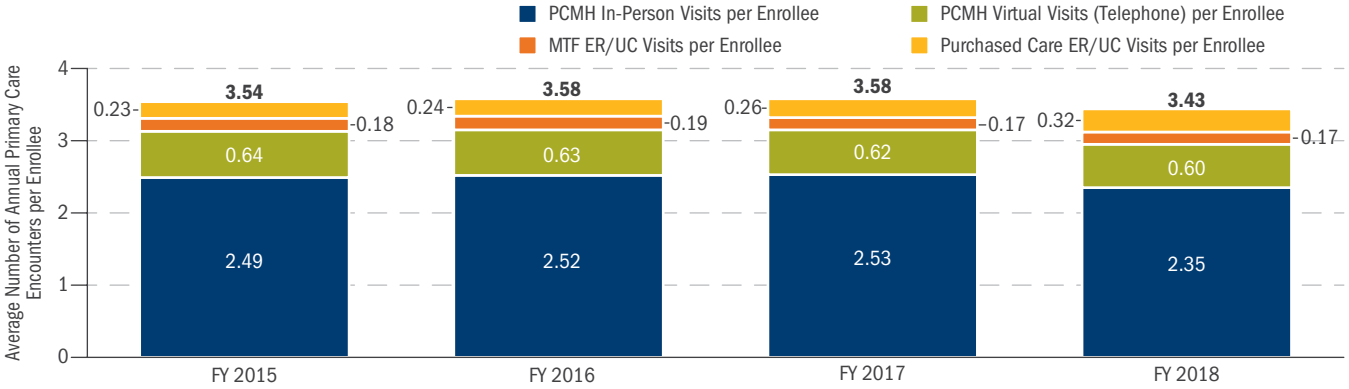
The average annual number of direct care system enrollees' primary care visits decreased slightly from 3.58 in FY 2017 to 3.43 in FY 2018. The MTF PCMH market share of empaneled beneficiaries' primary care needs decreased from 88 percent in FY 2017 to 86 percent in FY 2018. During this same period, the number of MTF enrollees' in-person and virtual PCMH visits decreased 7 percent, MTF ER/UC visits decreased 4 percent, and the number of network ER and UC visits increased 26 percent due to the benefit change allowing unlimited self-referred network UC visits for non-Active Duty enrollees. As a result, overall network leakage of MTF enrollees' primary care needs increased from 7.2 percent in FY 2017 to 9.4 percent in FY 2018. Results vary by Uniformed Service.

A major goal of the MHS's PCMH program is to reduce unnecessary health care utilization by maximizing the primary care managers' (PCM) abilities 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. In FY 2018, mean MTF enrollee primary care utilization decreased 4 percent, median utilization decreased 6 percent, and the IQR or variance among MTFs decreased 17 percent. In FY 2019, 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 2012–2018

FISCAL YEAR	PCMH IN-PERSON VISITS PER ENROLLEE	PCMH VIRTUAL VISITS (TELEPHONE) PER ENROLLEE	MTF ER/UC VISITS PER ENROLLEE	NETWORK ER/UC VISITS PER ENROLLEE	TOTAL ANNUAL PRIMARY CARE VISITS PER ENROLLEE	PERCENT PCMH MARKET SHARE	PERCENT NETWORK PRIMARY CARE LEAKAGE
FY 2012	2.54	0.49	0.18	0.23	3.44	88.2%	6.67%
FY 2013	2.55	0.54	0.17	0.23	3.49	88.7%	6.59%
FY 2014	2.52	0.57	0.16	0.22	3.47	89.1%	6.38%
FY 2015	2.49	0.64	0.18	0.23	3.54	88.3%	6.58%
FY 2016	2.52	0.63	0.19	0.24	3.58	88.1%	6.67%
FY 2017	2.53	0.62	0.17	0.26	3.58	88.0%	7.16%
FY 2018	2.35	0.60	0.17	0.32	3.43	85.7%	9.44%

AVERAGE NUMBER OF ANNUAL PRIMARY CARE ENCOUNTERS PER ENROLLEE, FYs 2015–2018



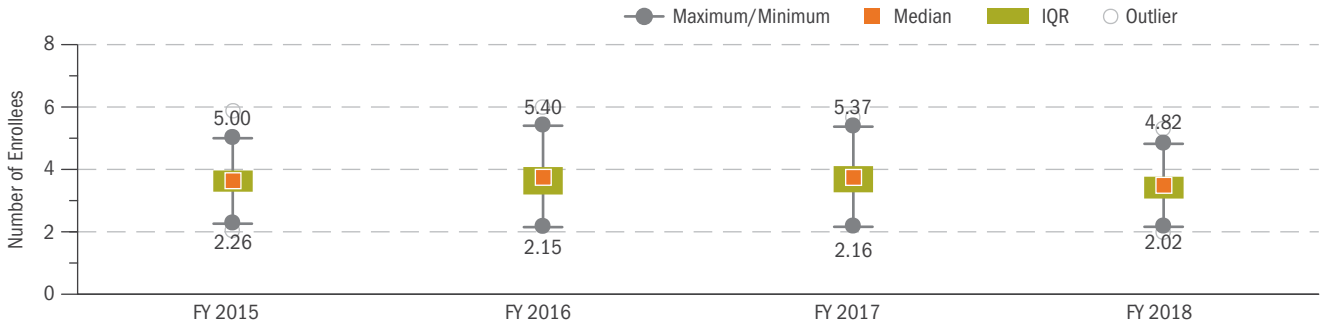
Source: MHS Administrative Data (M2); DHA/Ops (J-3)/Clinical Business Operations, 11/18/2018

Primary Care Utilization, PCMH Market Share, and Network Leakage *(cont.)*

AVERAGE NUMBER OF ANNUAL MTF ENROLLEE VISITS FOR PRIMARY CARE OVERALL, FYs 2015–2018

	FY 2015	FY 2016	FY 2017	FY 2018
Median	3.53	3.57	3.58	3.37
75th Percentile (Q3)	3.97	4.08	4.11	3.77
25th Percentile (Q1)	3.29	3.20	3.27	3.07
IQR	0.69	0.88	0.84	0.70
Positive Outlier (>)	5.00	5.40	5.37	4.82
Negative Outlier (<)	2.26	1.88	2.01	2.02
Maximum	5.82	5.94	5.61	5.25
Minimum	2.05	2.15	2.16	1.93

AVERAGE NUMBER OF ANNUAL MTF ENROLLEE VISITS FOR PRIMARY CARE OVERALL, FYs 2015–2018



Source: MHS Administrative Data (M2); DHA/Ops (J-3)/Clinical Business Operations, 11/18/2018

ACCESS TO MHS CARE *(CONT.)*

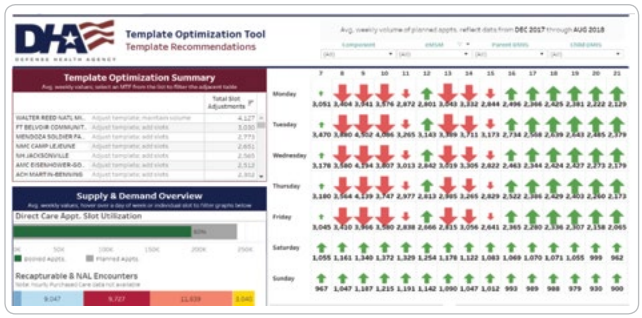
Improvement Tools

In FY 2018, 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 2019, the DART will also include new reports to measure MTF compliance with DHA policies on expanded hours and standardized appointing. Additional dashboards are available on the CarePoint Information Portal. In FY 2019, the tools below will be expanded to report and predict unexpected events, including missed appointments and cancellations by beneficiary age and category and by type of care. Finally, all tools will be expanded to show specialty care and inpatient data to support market optimization efforts.

Template Optimization Tool

The Template Optimization Tool provides information on scheduled appointments and appointment utilization by day of week and hour of day, compares scheduled appointments to beneficiary demand signals, and finally, recommends template changes to better meet patient demand. The image at right depicts a sample result demonstrating that fewer appointments are needed during midmorning while more are needed at noon, in the afternoon, and on weekends.

TEMPLATE OPTIMIZATION TOOL ON CAREPOINT

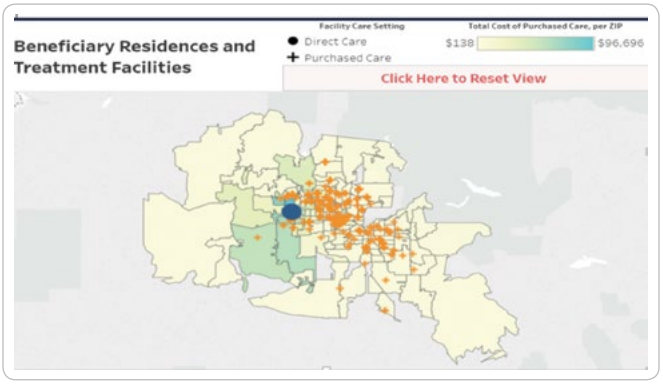


Source: MHS CarePoint Information Portal; DHA/Ops (J-3)/Clinical Business Operations, 11/18/2018

Build or Buy Tool on CarePoint

In FY 2018, MTFs expanded PCMH operating hours based on standard criteria including patient demand and readiness needs, as required by DHA policy. By September 2018, 45 percent of MTFs offered appointments at 5 PM or later. In FY 2019, 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 ER 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. The image at right represents a sample market. In this example, beneficiaries reside near the MTF, as depicted by the blue and green shaded areas; however, because the MTF's PCMH hours are not optimally available to meet patient demand based on the Template Optimization Tool, MTF enrollees are seeking network UC at locations farther away from the MTF and their homes. The conclusion from this example is that the MTF should reevaluate its operating hours to better meet beneficiary demand for care.

BeNEFICIARY RESIDENCES AND TREATMENT FACILITIES



Source: MHS CarePoint Information Portal; DHA/Ops (J-3)/Clinical Business Operations, 11/18/2018

Specialty Care Access

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

Average Number of Days from Consult to Booking

The average number of days from consult to booking measures how long it takes for the patient to obtain a scheduled appointment date and time after receiving a referral from a primary care or other provider. Survey and qualitative data demonstrate a longer wait to obtain a scheduled appointment is a source of patient dissatisfaction and also delays needed care. DHA-IPM 18-001 identified standard processes to centralize referral review and appointing at the MTF or market level compared to existing decentralized and time-consuming processes in which each specialty clinic reviewed referrals and scheduled appointments. As stated in DHA-IPM 18-001, MTFs are required to implement processes to ensure that the MTF decides to accept or defer the referral to the network within 24 hours and subsequently to schedule the beneficiary's appointment within two business days; the MHS goal is for the entire process to be accomplished in three business days or fewer. Currently, the MHS is not meeting the goal and not all MTFs are in compliance with DHA-IPM 18-001. In FY 2019, the MHS will emphasize implementation of centralized specialty care referral review and appointing, and further streamline the specialty referral process to eliminate unnecessary administrative burden or delays from the patient perspective.

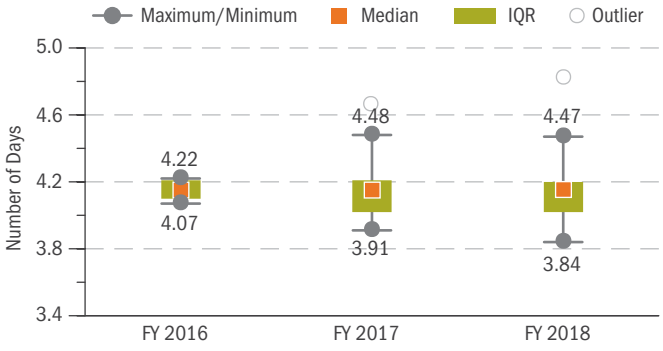
AVERAGE NUMBER OF DAYS FROM ORDERED TO MTF BOOKED, FYs 2016–2018

	FY 2016	FY 2017	FY 2018
Days from Ordered to MTF Booked	4.15	4.16	4.16

AVERAGE NUMBER OF DAYS FROM ORDERED TO MTF BOOKED, FYs 2016–2018

	FY 2016	FY 2017	FY 2018
Median	4.14	4.14	4.13
75th Percentile (Q3)	4.10	4.02	4.02
25th Percentile (Q1)	4.21	4.21	4.20
IQR	0.11	0.19	0.18
Positive Outlier (>)	4.38	4.48	4.47
Negative Outlier (<)	3.94	3.74	3.75
Maximum	4.22	4.64	4.80
Minimum	4.07	3.91	3.84

AVERAGE NUMBER OF DAYS FROM ORDERED TO MTF BOOKED, FYs 2016–2018



Source: MHS Administrative Data (M2); DHA/Ops (J-3)/Clinical Business Operations, 11/18/2018

ACCESS TO MHS CARE *(CONT.)*

Specialty Care Access *(cont.)*

Average Number of Days from Booking to Appointment

The average number of days from booking to appointment measures how long the patient waits for a scheduled appointment from the time the appointment was scheduled. DHA-IPM 18-001 identifies standard processes and specialty provider productivity requirements in order to increase the number of available specialty care appointments, standardize appointment templates, and optimize direct care system specialty care capacity. The goal is for beneficiaries to have a specialty care appointment within 15 days of being scheduled for the appointment. Currently, the direct care system is not meeting the goal; the IQR or variance among MTFs increased almost 70 percent from FY 2017 to FY 2018. In FY 2019, the MHS will emphasize implementation of standard processes in specialty care to enhance patient experience, eliminate unwarranted variance, and expand MTF specialty care capacity to optimize direct care system resources and support specialty providers' clinical currency needs.

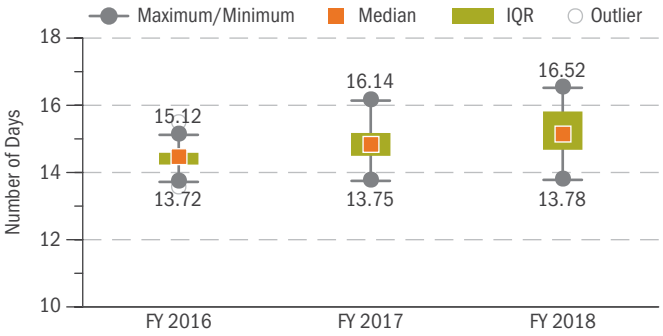
AVERAGE NUMBER OF DAYS FROM MTF BOOKED TO MTF APPOINTMENT, FYs 2016–2018

	FY 2016	FY 2017	FY 2018
Days from MTF Booked to MTF Appt.	14.51	14.91	15.17

AVERAGE NUMBER OF DAYS FROM MTF BOOKED TO MTF APPOINTMENT, FYs 2016–2018

	FY 2016	FY 2017	FY 2018
Median	14.46	14.84	15.02
75th Percentile (Q3)	14.24	14.50	14.68
25th Percentile (Q1)	14.59	15.18	15.82
IQR	0.35	0.67	1.14
Positive Outlier (>)	15.12	16.18	17.53
Negative Outlier (<)	13.72	13.49	12.97
Maximum	15.45	16.14	16.52
Minimum	13.52	13.75	13.78

AVERAGE NUMBER OF DAYS FROM MTF BOOKED TO MTF APPOINTMENT, FYs 2016–2018



Source: MHS Administrative Data (M2); DHA/Ops (J-3)/Clinical Business Operations, 11/18/2018

Specialty Care Ambulatory Leakage

In FY 2018, the MHS established a specialty care ambulatory leakage measure to assess performance in capturing specialty care to MTFs or markets with the capability to deliver that care. The MHS goal is to reduce network specialty care leakage to 10.7 percent or less. The MHS is not meeting the goal. In FY 2019, the MHS will further analyze performance and variance at each MTF and by product lines to identify reasons for and solutions to improve direct care system capacity.

AVERAGE AMBULATORY SPECIALTY CARE LEAKAGE, FYs 2014–2018 (THROUGH AUGUST 2018)

	ANNUAL AVERAGE
FY 2014	13.5%
FY 2015	13.2%
FY 2016	13.1%
FY 2017	13.5%
FY 2018	13.3%

Source: MHS Administrative Data (M2); DHA/Ops (J-3)/Clinical Business Operations, 11/18/2018

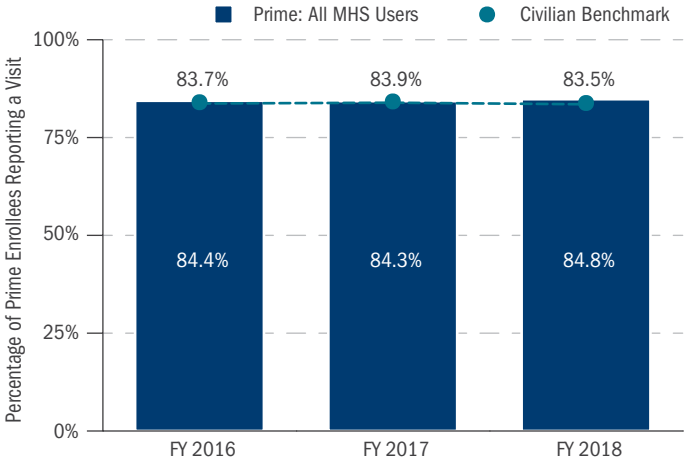
ACCESS TO MHS CARE *(CONT.)*

Measures of Availability and Ease of Access

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

- **Self-Reported Access:** The ability to see a doctor reflects one measure of successful access to the health care system. Prime enrollees were asked whether they had at least one outpatient visit during the past year. As shown in the chart (at right), access to and use of outpatient services remain high among Prime enrollees (with either a military or civilian PCM), with almost 85 percent reporting at least one visit in FY 2018. This rate has been statistically stable since FY 2015, following a marked decrease from almost 88 percent in FY 2014 (shown in the FY 2017 report). MHS results remain statistically comparable to the civilian benchmark of almost 84 percent. Actual administrative data demonstrate 89 percent of direct care system enrollees had at least one primary care encounter in FY 2018.

TRENDS IN PRIME ENROLLEES HAVING AT LEAST ONE OUTPATIENT VISIT DURING THE YEAR, FYs 2016–2018



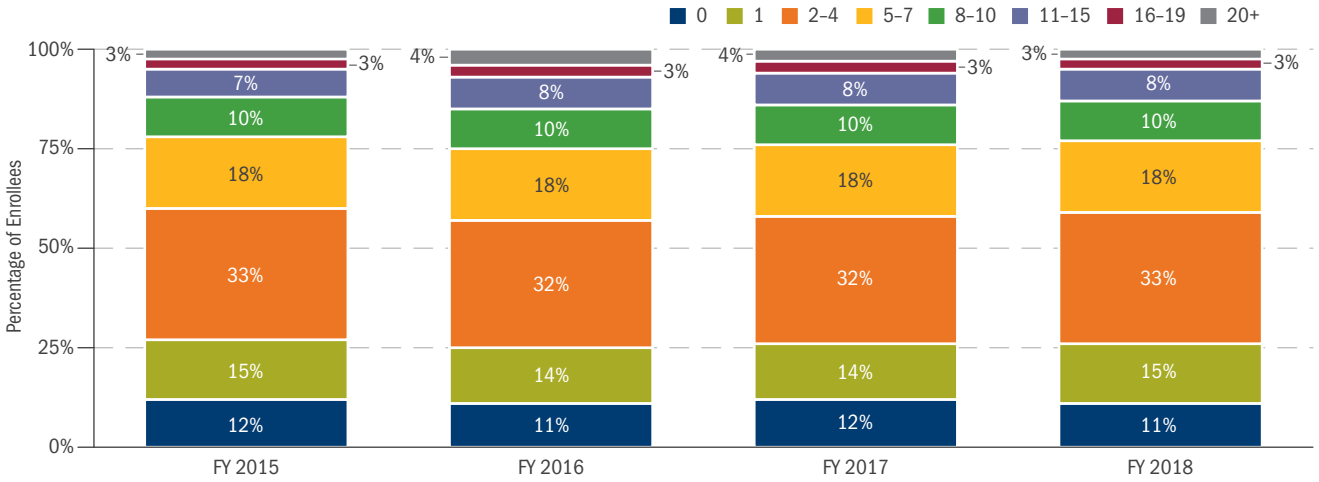
Note: DoD data were derived from the FYs 2016–2018 Health Care Survey of DoD Beneficiaries (HCSDB), as of 11/15/2018, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the National Committee for Quality Assurance (NCQA) by commercial plans. Benchmarks used in 2016 and 2017 come from NCQA's 2015 data, while the benchmarks used in 2018 come from NCQA's 2017 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

ACCESS TO MHS CARE *(CONT.)*

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

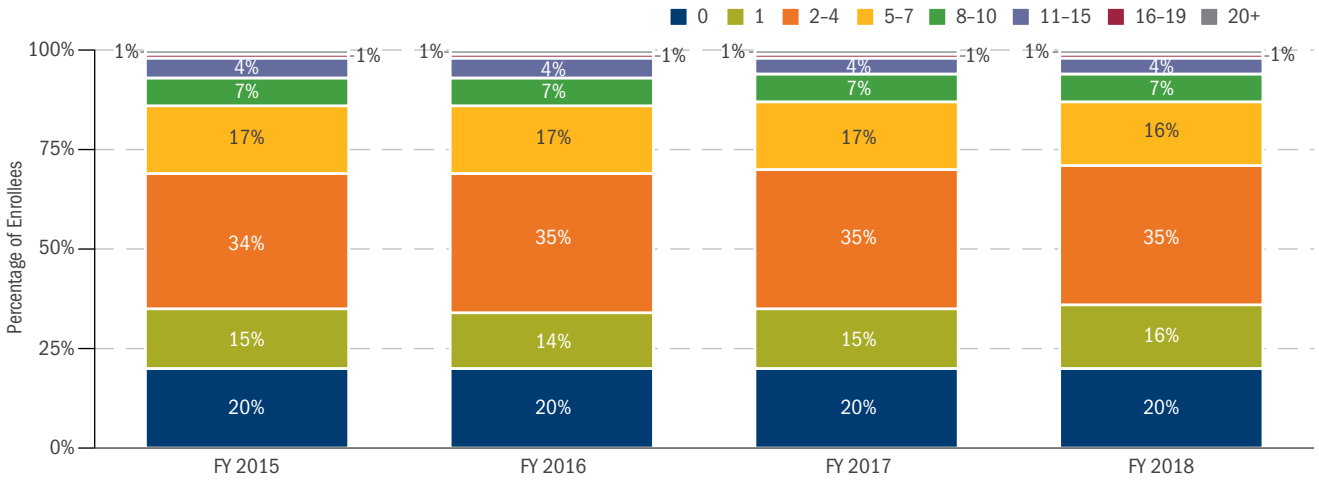
- **Direct Care Enrollee Access:** Based on administrative utilization data shown in the chart below, 89 percent of all non-Active Duty MTF enrollees under age 65 had at least one recorded outpatient visit for primary care reasons in FY 2018 (i.e., 11 percent did not have at least one visit). This access has been relatively stable since 2014. In FY 2018, 48 percent had between one and four visits, and 42 percent had five or more visits.

PERCENTAGE OF MTF NON-ACTIVE DUTY ENROLLEES <65
BY NUMBER OF ANNUAL VISITS FOR PRIMARY CARE (ANY VENUE), FYs 2015–2018



- **Purchased Care Enrollee Access:** Based on administrative claims utilization data, the chart below shows that 80 percent of all non-Active Duty MCSC Network Prime enrollees under age 65 had at least one recorded outpatient visit for primary care reasons in FY 2018 (i.e., 20 percent had no visits). Also in FY 2018, 51 percent had between one and four visits, and 29 percent had five or more visits.

PERCENTAGE OF MCSC/NETWORK NON-ACTIVE DUTY ENROLLEES <65
BY NUMBER OF ANNUAL VISITS FOR PRIMARY CARE (ANY VENUE), FYs 2015–2018



Source: MHS Administrative Data Systems (M2), DHA/(J-5)/Decision Support Division, 12/28/2018

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

Missed Medical Appointments

This study, completed in 2018, describes changes in the beneficiary-reported prevalence of and reasons for missed, canceled, and rescheduled appointments with military or civilian providers between 2013 and 2018. In 2015, TRICARE introduced an online feature that enables beneficiaries to set reminders via an automated telephone message, text message, and/or e-mail for their appointments at military facilities.[1] Differences over time in the prevalence of and reasons for missed, canceled, and rescheduled appointments might mean that the reminder system is helping beneficiaries keep their appointments.

According to an analysis of the 2013 Health Care Survey of Department of Defense Beneficiaries (HCSDB), nearly one in ten beneficiaries missed a scheduled appointment during the year before the survey. Around one-third canceled or rescheduled an appointment during that same period (FY 2013 Q2 HCSDB). Missed appointments and last-minute cancellations disrupt physicians' schedules and occupy appointment slots that other patients could have used.[2] Research shows that appointment reminder systems can reduce the number of missed appointments.[3] Our current analyses are based on responses from the first quarter of the 2018 HCSDB (FY 2018 Q1 HCSDB) and compares the results to those found in the second quarter of the 2013 HCSDB (FY 2013 Q2 HCSDB). We examined differences over time, as well as differences between MHS beneficiaries who made appointments in MTFs and those who made appointments in civilian provider offices. This study also examined whether there are differences in rates of missed appointments for beneficiaries who have to call multiple times to make an appointment.

Prevalence of Missed Appointments

The HCSDB asked beneficiaries to report if they had missed, canceled, or rescheduled any appointments with a provider at the facility where they went for health care most often in the past 12 months. In the 2018 survey, 7 percent of beneficiaries reported missing an appointment in the last 12 months (survey question 1, see notes for top figure on next page). This is consistent with the MHS's annual report of missed appointments, which says that 6.7 percent of appointments made at MTFs in FY 2017 were missed.[4]

Canceling or rescheduling appointments was more common than missing appointments, with 37 percent of beneficiaries reporting canceling or rescheduling in the last year. These rates were similar to the rates from 2013, when 8 percent of beneficiaries missed an appointment and 36 percent canceled or rescheduled (not shown).

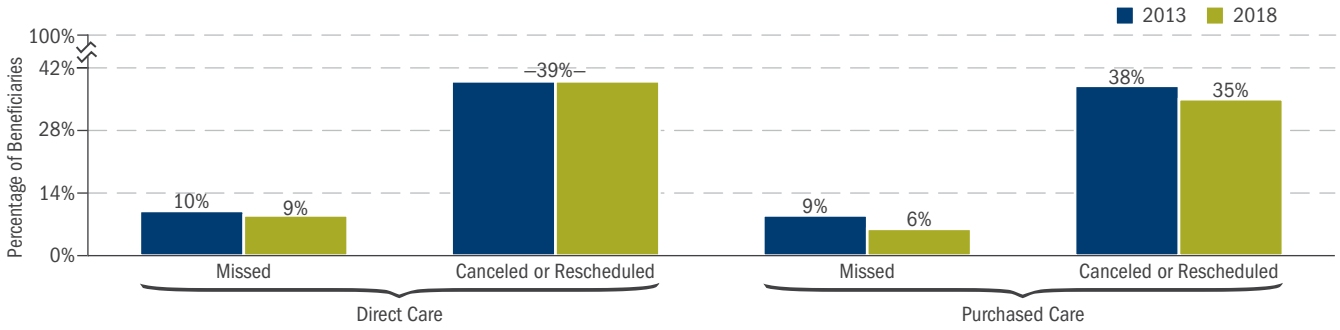
The type of care (direct or purchased) was not a major driver of whether a beneficiary missed an appointment (survey question 2, see notes for top figure on next page). In 2018, among beneficiaries with purchased care, 6 percent missed an appointment and 35 percent canceled or rescheduled, compared with 9 percent of direct care users who missed an appointment and 39 percent who canceled or rescheduled. These differences were not statistically significant. The rates were also similar to the 2013 rates; although the rates of missed and canceled or rescheduled appointments for purchased care beneficiaries fell from 2013 to 2018, the differences were not statistically significant (see top figure on next page).

[1] Military.com. "TRICARE Appointment Text Reminders." 2015. Available at https://www.military.com/military-report/tricare-appointment-text-reminders.html. Accessed April 17, 2018.
[2] White, David M. "'No-Show' Appointments Cost EAMC $3M Last Year." 2017. Available at https://www.army.mil/article/183361/no_show_ appointments_cost_eamc_3m_last_year. Accessed April 17, 2018.
[3] McLean, S.M., A. Booth, M. Gee, S. Salway, M. Cobb, S. Bhanbhro, and S.A. Nancarrow. "Appointment Reminder Systems Are Effective but Not Optimal: Results of a Systematic Review and Evidence Synthesis Employing Realist Principles." Patient Preference and Adherence, vol. 10, 2016, pp. 479–499. doi: 10.2147/PPA.S93046.
[4] Under Secretary of Defense. "Annual Report on Missed Appointments in Military Treatment Facilities." March 2018. Available at https://health.mil/Reference-Center/Reports/2018/03/27/Standardized-System-for-Scheduling-Medical-Appointments-at-MTFs. Accessed April 16, 2018.

ACCESS TO MHS CARE *(CONT.)*

Missed Medical Appointments *(cont.)*

BENEFICIARIES REPORTING MISSED, CANCELED, AND RESCHEDULED APPOINTMENTS, DIRECT CARE VS. PURCHASED CARE, BY YEAR



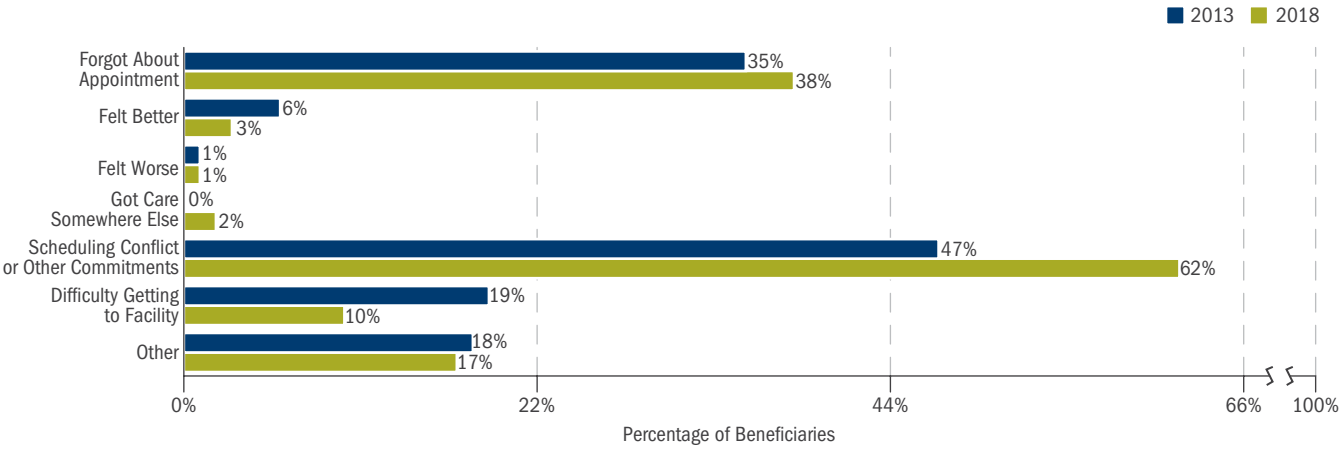
Note: DoD data were derived from the Health Care Survey of DoD Beneficiaries (HCSDB), and adjusted for age and health status.
FY 2018 Q2 HCSDB. N = 10,813. The response rate was 10.8 percent. The survey was fielded from October 18, 2017, to January 31, 2018.
FY 2013 Q2 HCSDB. N = 8,066. The response rate was 16.0 percent. The survey was fielded from December 12, 2012, to March 8, 2013.

- The survey asked two questions about the facility where beneficiaries went most often for health care: (1) In the last 12 months, have you missed any scheduled appointments with a provider at this facility? (2) In the last 12 months, did you cancel or reschedule an appointment with a provider at this facility?
- Beneficiaries were defined as having purchased care if they were under age 65 and had either a civilian primary care manager or one of the following types of insurance coverage: TRICARE Select (Standard/Extra), TRICARE Plus, TRICARE Retired Reserve, or TRICARE Young Adult Select (Standard).

The most common reason given by beneficiaries with direct care for missing appointments was a scheduling conflict (62 percent of direct care users who missed an appointment cited this as one of their reasons in 2018). Scheduling conflicts were slightly less common in 2013—when 47 percent of direct care users cited this reason—but this difference between years was not significant.

Forgetting about the appointment was also a common reason: 38 percent of direct care users who missed an appointment cited this as a reason in 2018, compared with 35 percent in 2013. However, this difference was not statistically significant, either (see figure below).

REASONS FOR MISSED APPOINTMENTS AMONG BENEFICIARIES WITH DIRECT CARE, BY YEAR



Source: DHA/SP&FI (J-5)/Decision Support, 1/28/2018

Purchased care users had similar reasons for missing an appointment, with scheduling conflicts and forgetting about the appointment as the two most commonly cited reasons in both 2013 and 2018. Although forgetting about an appointment slightly increased and scheduling conflicts slightly decreased since 2013, neither of these differences were statistically significant (see top figure on next page). Beneficiaries with direct care reported slightly different reasons for canceling or rescheduling an appointment than for missing it. In 2018, 83 percent of direct care users reported that they canceled or rescheduled because of a scheduling conflict or other commitment. This was slightly higher than the 81 percent of direct care users who reported this in 2013, although the difference was not significant.

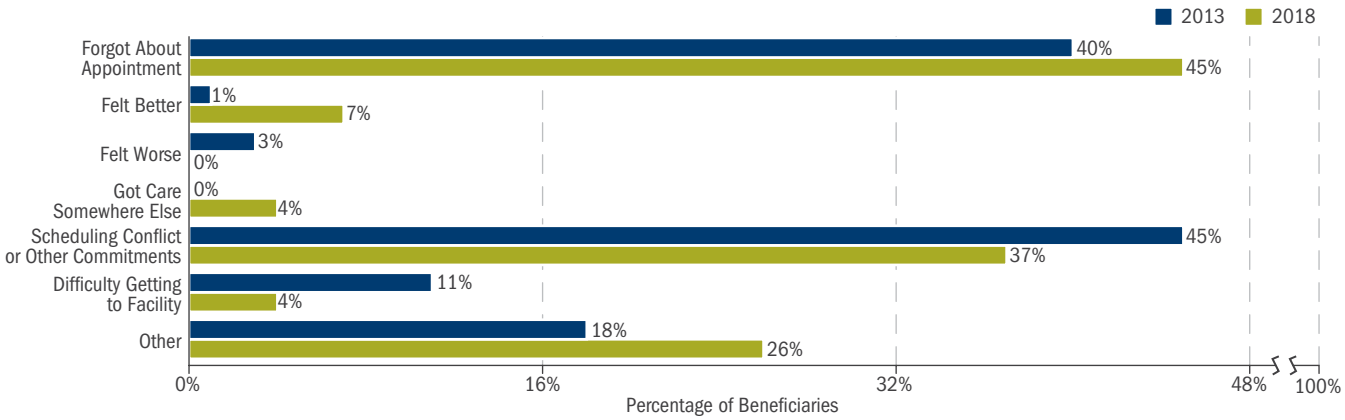
ACCESS TO MHS CARE *(CONT.)*

Missed Medical Appointments *(cont.)*

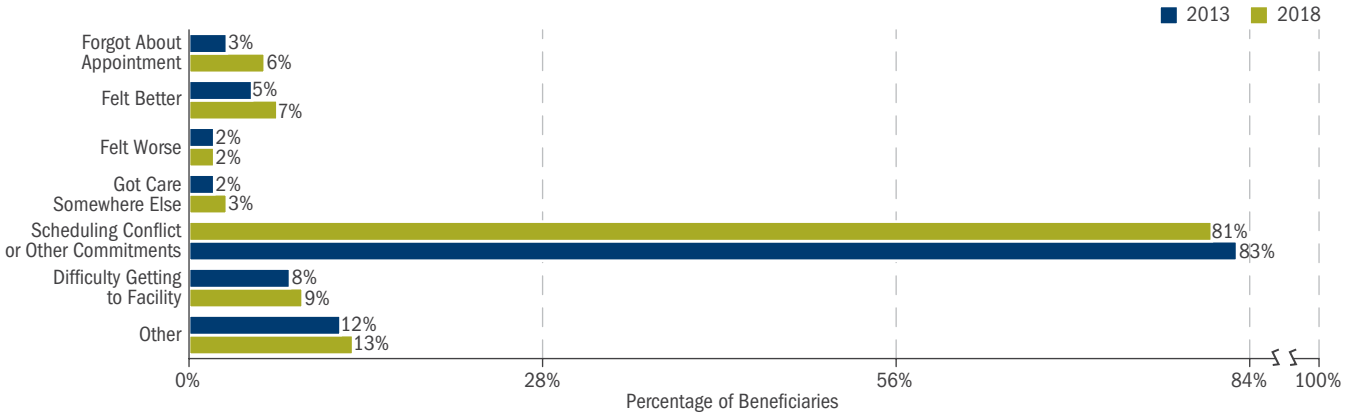
Forgetting an appointment was less commonly given as a reason for canceling or rescheduling an appointment than for missing it, with 6 percent of direct care users giving this reason in 2018 (see middle figure).

Purchased care users were most likely to cancel or reschedule an appointment because of a scheduling conflict, similar to direct care users (see figure furthest below).

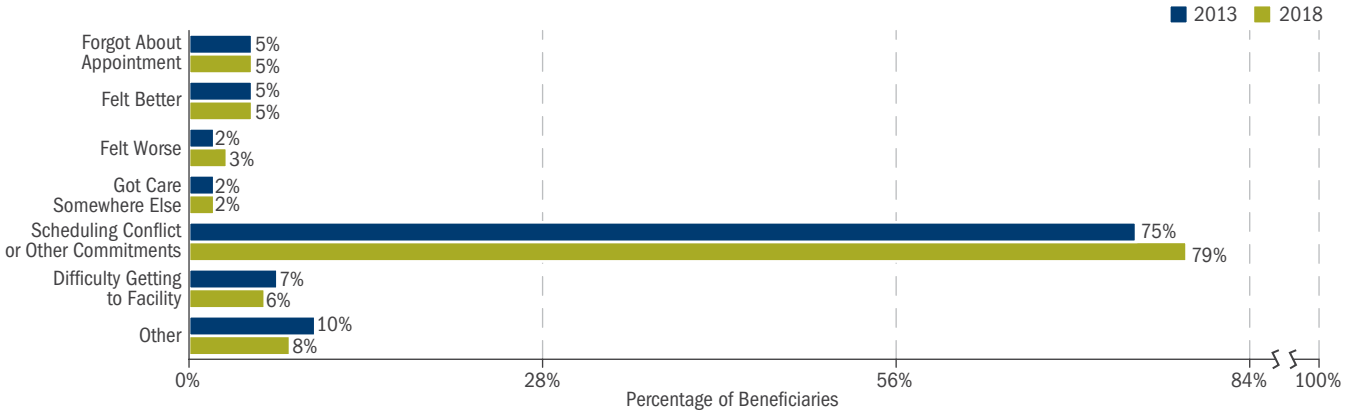
REASONS FOR MISSED APPOINTMENTS AMONG BENEFICIARIES WITH PURCHASED CARE, BY YEAR



REASONS FOR CANCELED OR RESCHEDULED APPOINTMENTS AMONG BENEFICIARIES WITH DIRECT CARE, BY YEAR



REASONS FOR CANCELED OR RESCHEDULED APPOINTMENTS AMONG BENEFICIARIES WITH PURCHASED CARE, BY YEAR



Source: DHA/SP&FI (J-5)/Decision Support, 1/28/2018

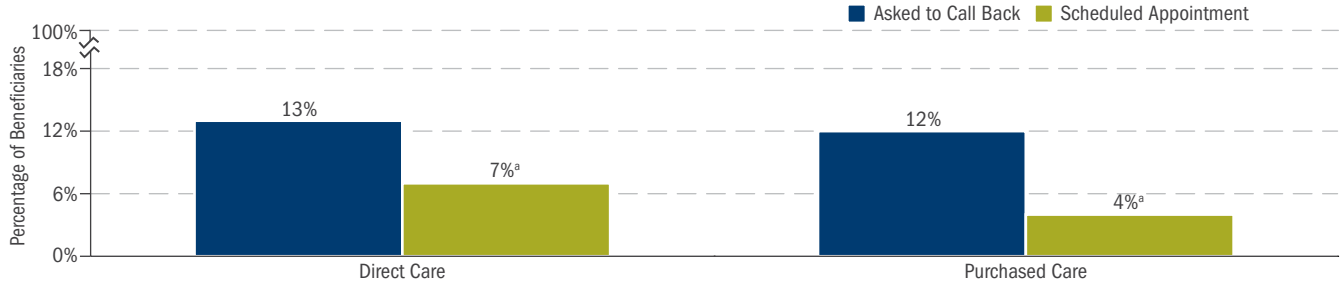
ACCESS TO MHS CARE *(CONT.)*

Missed Medical Appointments *(cont.)*

Barriers to Scheduling Appointments

In 2018, beneficiaries were asked whether, when trying to make an appointment in the last 12 months, they were told that no appointments were available but to call back later. Being asked to call back was more common at military facilities than at civilian facilities. Sixteen percent of beneficiaries said they were asked to call back at military facilities, compared with only 7 percent at civilian facilities (not shown). Being asked to call back was a significant factor for beneficiaries who missed at least one appointment in the past 12 months. Beneficiaries who were asked to call back (regardless of the facility type) were more likely to miss an appointment than beneficiaries who were able to schedule an appointment in one phone call. Thirteen percent of direct care users who were asked to call back missed an appointment, compared with only 7 percent who did not need to call back. These rates were similar for purchased care users: 12 percent who were asked to call back missed an appointment, compared with 4 percent who did not need to call back (see first figure below). Note that we were unable to determine whether the appointment that was scheduled through the follow-up phone call was the one that was missed.

PERCENTAGE OF BENEFICIARIES WHO MISSED APPOINTMENTS, BY SCHEDULING SUCCESS AFTER ONE PHONE CALL, DIRECT CARE VS. PURCHASED CARE, 2018

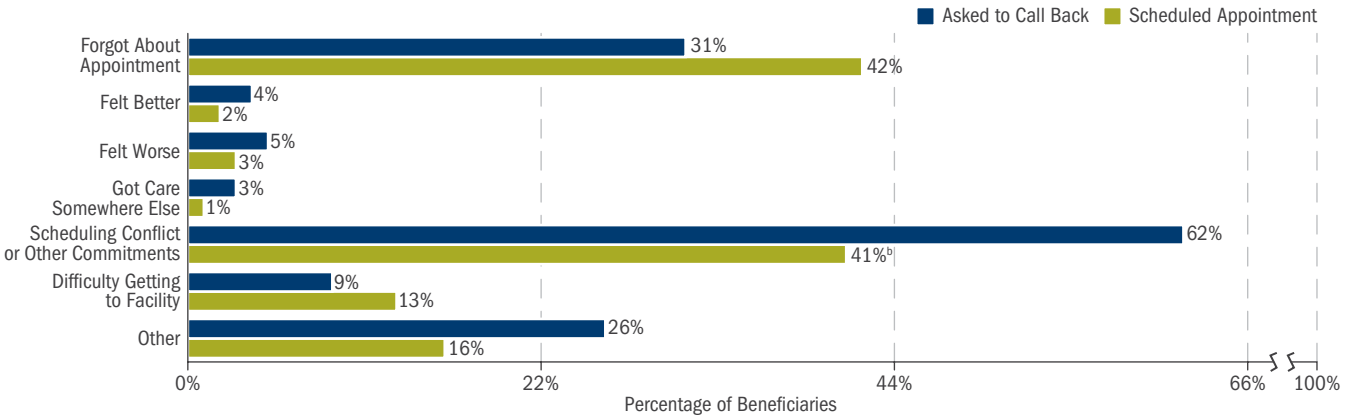


Source: DHA/SP&FI (J-5)/Decision Support, 1/28/2018

[a] Significantly different from the percentage of beneficiaries who missed appointments after being asked to call back to schedule ($p < 0.05$).

The figure below shows the reasons that beneficiaries gave for missing appointments, by whether they were able to schedule an appointment in one phone call or asked to call back. The only significant difference between beneficiaries who scheduled an appointment or were asked to call back was how often they reported missing appointments because of a scheduling conflict or other commitments. Among those asked to call back, 62 percent missed an appointment because of a scheduling conflict, compared with only 41 percent of those who did not need to call back.

REASONS FOR A MISSED APPOINTMENT, BY SCHEDULING SUCCESS AFTER ONE PHONE CALL, 2018



Source: DHA/SP&FI (J-5)/Decision Support, 1/28/2018

[b] Significantly different from the percentage of beneficiaries who missed appointments because of scheduling conflicts after being asked to call back to schedule ($p < 0.05$).

Missed Medical Appointments *(cont.)*

Conclusion

Although missed appointments are not all that common, they are costly. This section discussed several aspects of this problem, including changes in the number of missed appointments over time, beneficiaries' reasons for missing an appointment, the characteristics of the beneficiaries who often miss appointments, and the link between missing an appointment and inconvenient mechanisms for scheduling appointments.

We found that rates of missed appointments and the reasons beneficiaries give for missing appointments were generally similar in 2013 and 2018. The rates of missed, canceled, or rescheduled appointments were also similar for beneficiaries with direct and purchased care. Taken together, this may indicate that the reminder function in TRICARE's online appointment system is not helping users keep their appointments, possibly because they are not using this feature.

There is also evidence that an appointment system that requires beneficiaries to call multiple times is linked to more missed appointments, in part because of scheduling conflicts. That is, beneficiaries who need to call several times to make an appointment may have trouble getting an appointment that fits their schedules. Changing such systems so beneficiaries can make an appointment in one call may reduce the number of missed appointments.

Additional References:

– Nguyen, D.L., R.S. DeJesus, and M.L. Wieland. "Missed Appointments in Resident Continuity Clinic: Patient Characteristics and Health Care Outcomes." *Journal of Graduate Medical Education*, vol. 3, no. 3, 2011, pp. 350–355. doi: 10.4300/JGME-D-10-00199.1.

– Williamson, A.E., D.A. Ellis, P. Wilson, R. McQueenie, and A. McConnachie. "Understanding Repeated Non-Attendance in Health Services: A Pilot Analysis of Administrative Data and Full Study Protocol for a National Retrospective Cohort." BMJ Open, vol. 7, 2017, p. e014120. doi: 10.1136/bmjopen-2016-014120.

Urgent Care Pilot and TRICARE Benefit

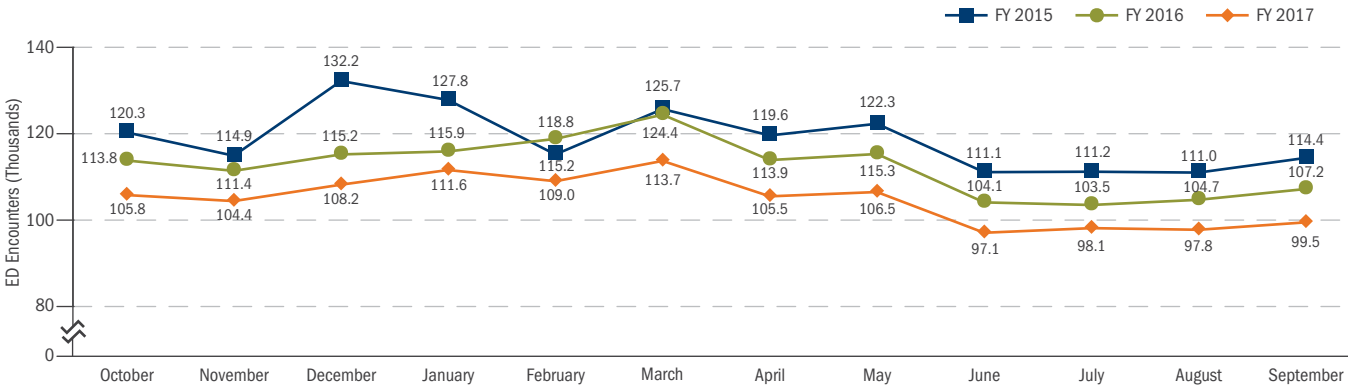
Section 725(c)(1) of the National Defense Authorization Act (NDAA) for FY 2016 (Public Law 114-92) required the implementation of a pilot program, beginning May 23, 2016, to allow TRICARE Prime beneficiaries to visit network urgent care clinics (UCCs) without preauthorization. Previously, a TRICARE Prime beneficiary had to obtain a referral from their primary care manager to visit a network UCC, but a referral was not required for a visit to an emergency department (ED). Because of this policy, many beneficiaries visited the more costly ED in lieu of a UCC, despite exhibiting symptoms that could be appropriately addressed at a UCC. The pilot was structured to encourage beneficiaries to obtain care in the setting most appropriate to their condition, while easing the administrative burden of the preauthorization requirement from a primary care manager. As part of the pilot program, utilization patterns, cost of care, and beneficiary satisfaction were monitored to ensure a comprehensive understanding of its impacts. Section 704 of the NDAA for FY 2017 (Public Law 114-328), implemented by the Interim Final Rule (199.17(n)(2)(iii)(B)), authorized covered beneficiaries to access urgent care (UC) facilities without the need for preauthorization. As of January 1, 2018, the UC benefit has been expanded to allow unlimited self-referred private-sector care (PSC) UC visits for the covered beneficiary population. Because of this expansion, the pilot program has been terminated.

Network UC and ED statistics were monitored for TRICARE Prime beneficiaries across FY 2015, FY 2016, and FY 2017 related to the pilot program. As shown in the table below, the initial analysis identified preliminary changes in UC and ED use by covered beneficiaries. Within PSC statistics, UC encounter volume rose by 13 percent from FY 2016 to FY 2017, and ED encounter volume fell by 6 percent during the same time period (see chart). Total PSC UC nonpharmaceutical costs rose 33 percent from FY 2016 to FY 2017, although PSC UC costs per visit remained significantly lower than PSC ED costs per visit; however, these changes could not be attributed solely to the pilot and its associated limited benefit, and, in fact, as noted on page 66, network UC visits nearly doubled in FY 2018.

FYs 2015–2017 UC VS. ED COST ANALYSIS FOR COVERED BENEFICIARIES

	FY 2015	FY 2016	FY 2017	CHANGE FYs 2015–2016	CHANGE FYs 2016–2017	CHANGE FYs 2015–2017
VOLUME						
UC	441,385	424,684	478,000	-16,701	53,316	36,615
ED	838,600	798,969	754,880	-39,631	-44,089	-83,720
VISIT COST						
UC	$35,253,021	$33,587,248	$44,808,161	($1,665,773)	$11,220,913	$9,555,141
ED	$337,421,816	$349,841,999	$344,607,475	$12,420,183	($5,234,525)	$7,185,658
VISIT UNIT COST						
UC	$79.87	$79.09	$93.74	($0.78)	$14.65	$13.87
ED	$402.36	$437.87	$456.51	$35.50	$18.64	$54.14
PHARMACY UNIT COST						
UC	$22.28	$14.25	$12.72	($8.03)	($1.53)	($9.56)
ED	$18.30	$14.44	$14.59	($3.86)	$0.15	($3.71)

EMERGENCY DEPARTMENT (ED) PURCHASED CARE AND DIRECT CARE ENCOUNTER VOLUME FOR COVERED BENEFICIARIES, FYs 2015–2017



Source: DHA/J-5 Decision Support Division, 9/14/2018

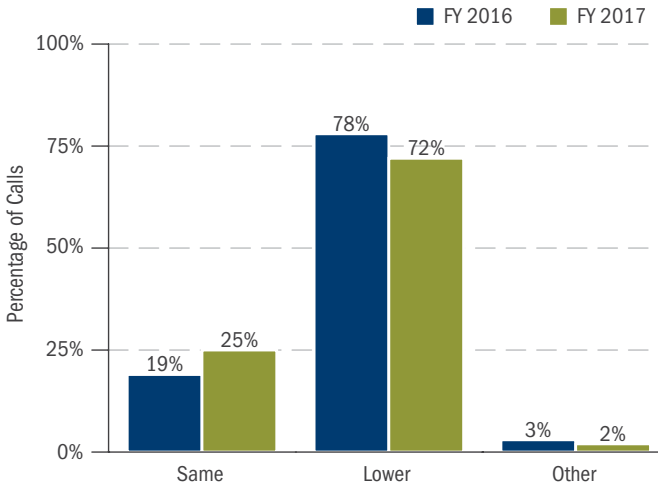
Note: In the context of the UC pilot and the associated report to Congress, "Covered Beneficiaries" refers to beneficiaries covered by the UC benefit in the United States; this includes all MTF and MCSC Prime enrollees, excluding Active Duty and Guard/Reserve on Active Duty.

ACCESS TO MHS CARE *(CONT.)*

Urgent Care Pilot and Nurse Advice Line Support

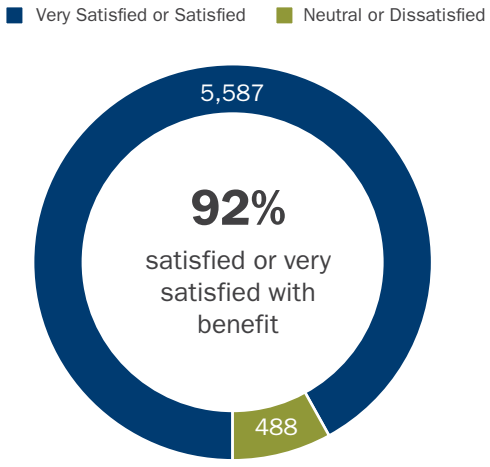
The data also demonstrate the positive impact of the Nurse Advice Line (NAL) in directing covered beneficiaries to the appropriate care setting. For example, of the callers who intended to visit an ED facility, 72 percent were directed to less resource-intensive care centers. Additionally, data analysis shows that more than 98 percent of covered beneficiaries visited two or fewer UCCs during the first 16 months of the pilot. Beneficiary surveys reveal that 92 percent of beneficiaries who participated in the pilot were satisfied with the increased access to care under the pilot.

FYs 2016–2017 ED PRE-INTENT RESULTING DISPOSITIONS



Source: DHA/J-5 Decision Support Division, 9/14/2018

BENEFICIARY SURVEY RESULTS, FY 2017

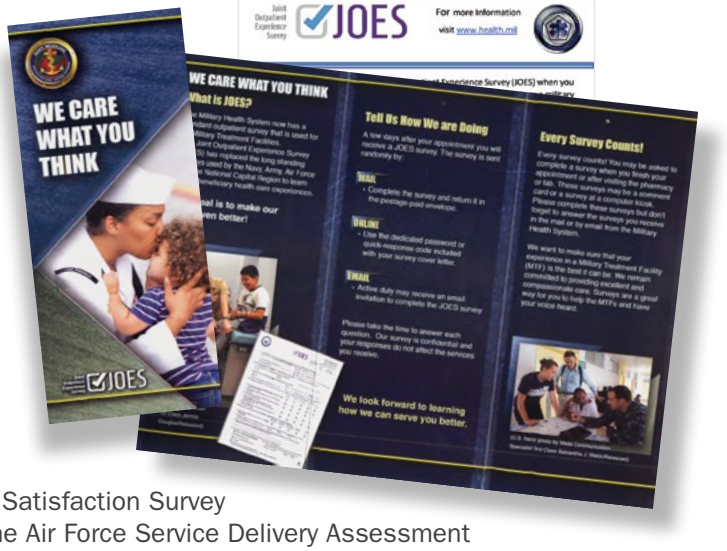


ACCESS TO MHS CARE *(CONT.)*

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 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 2018 marks the second 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). More than 400,000 JOES surveys were returned during FY 2018, providing targeted areas for improvement in outpatient care at military facilities. As shown below, JOES results are comparable between each Service and have varied only minimally over the time studied.

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 and Group Survey (CAHPS® C&G), as was the predecessor to the JOES-C: the TRICARE Outpatient Satisfaction Survey (TROSS). This allows MHS comparison to civilian benchmarks, as well as MHS beneficiary ratings across direct and purchased care venues.

The JOES and JOES-C have improved in efficiency and representation, demonstrated through the collection of web-based surveys by Active Duty Service members in FY 2018 in response to e-mailed invitations. More surveys are now being completed by Service members stationed overseas, providing invaluable feedback on their care. The results of several JOES and JOES-C measures are published in order to examine the quality of care across the MHS. Additionally, some of these measures are routinely reported to senior MHS leadership as core measures on the MHS Dashboard, and are also reported publicly on the transparency website of health.mil. In this report, the JOES and JOES-C measures reported include Getting Care When Needed, Satisfaction with Care, Rating of Provider, Provider Communication composite, and Access to Care composite.

Results from the MHS population survey, the Health Care Survey of DoD Beneficiaries (HCSDB), are also included in the results that follow, where appropriate, as a comparison against outpatient surveys that are administered following care. The HCSDB, based on the CAHPS Health Plan survey, is administered quarterly to a sample of the approximately 9.4 million members of the eligible MHS population, irrespective of where they might have received care, and uses a 12-month recall period for most questions (i.e., "In the last 12 months..."). As such, the focus of the HCSDB and CAHPS Health Plan survey is the performance of the health plan over time from the beneficiary's perspective, while the focus of the JOES-C/TROSS CAHPS® C&G–based survey is about health care received over the six months following a specific outpatient visit, and the focus of the JOES is solely about a specifically referenced visit. The comparison of these surveys provides a more comprehensive understanding of the experiences of beneficiaries, regardless of the survey that they are completing or the care that they may or may not have received. Additional results on the HCSDB can be found on page 92.

ACCESS TO MHS CARE *(CONT.)*

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

Privacy of Adolescents

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

The HIPAA Privacy Rule and Adolescents[1]

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

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

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

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

ACCESS TO MHS CARE *(CONT.)*

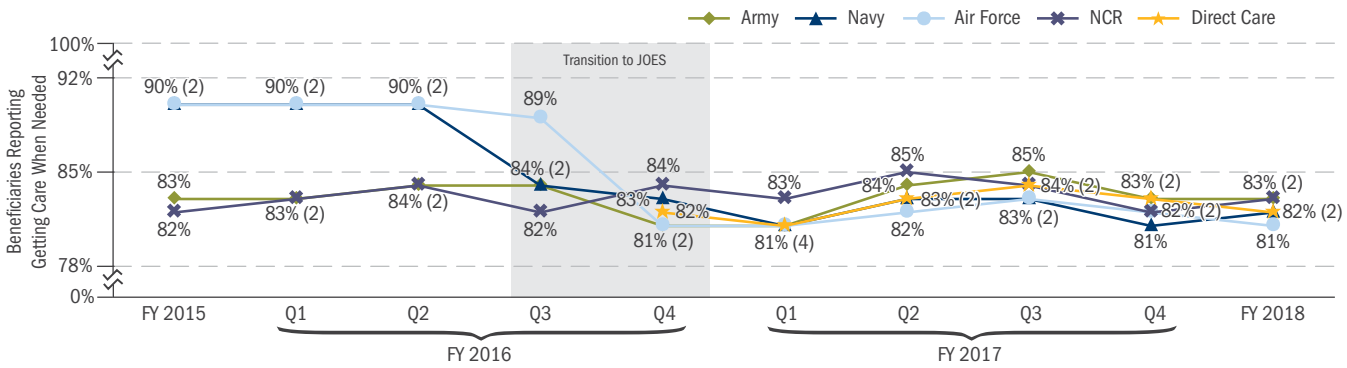
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care

Ratings of Getting Care When Needed

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

- Prior to FY 2017, a comparison of Getting Care When Needed results was not appropriate between the Services using Service-specific surveys. With the introduction of JOES in the second half of FY 2016, Service results are now comparable and have clearly converged.
- Scores for each Service have been largely consistent from FY 2017 to FY 2018; Air Force scores have ranged from 81 percent to 83 percent, Army scores from 81 percent to 85 percent, Navy scores from 81 percent to 83 percent, and NCR scores from 82 percent to 85 percent.

SERVICE SURVEYS/JOES GETTING CARE WHEN NEEDED, FYs 2015–2018



Source: DHA/SP&FI (J-5)/Decision Support, analyzing APLSS, PSS, SDA, and JOES, compiled 11/25/2018
Notes:
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration.
– JOES results displayed above begin in FY 2016 Q3 for Navy and NCR; JOES results for Air Force, Army, and Direct Care begin in FY 2016 Q4. The following time periods are the first available month of data for each of the Services: Navy—May 2016, NCR—June 2016, Army—July 2016, Air Force—September 2016.
– Prior to JOES, the Service-specific survey results above were not reported as weighted. JOES results displayed above are weighted to represent the composition of the MHS population receiving care.
– "Getting Care When Needed" is posed in each survey as an agreement to the following statement: "In general, I am able to see my provider when needed." The five-point scale for this question ranges from "Strongly Disagree" to "Strongly Agree." The results provided above are for those beneficiaries who reported either "Somewhat Agree" or "Strongly Agree."
– For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

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

Extent of Change in Variability in Patient Ratings Over Time

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

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

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

JOES Getting Care When Needed—Variability Over Time

The table on the following page displays the extent to which the measure of Getting Care When Needed changed over time in terms of improvement (increasing mean or median), or decreased dispersion (reduced range or IQR).

- From FY 2017 Q1 & Q2 to FY 2018 Q3 & Q4, the mean and median scores decreased for each Service. Referring to the exhibit on page 89, FY 2018 scores are similar, as a group, to FY 2017 Q4 scores.
- Dispersion, in terms of the IQR, increased for Army between FY 2017 Q3 & Q4 and FY 2018 Q3 & Q4; the 75th percentile improved (86.0 percent to 86.3 percent) while the 25th percentile worsened (81.0 percent to 79.6 percent). The IQR decreased for Air Force, but this resulted from a reduction in the 75th percentile. The IQR did not change for Navy, and could not be assessed for NCR (as there were only two parent facilities in the NCR Service).
- From the beginning of JOES, the IQR (the difference between the 75th and 25th percentiles) has remained below 10 percent for all the Services.
- Dispersion, in terms of the range between the highest and lowest scoring parent facility, decreased for Army and Navy, and increased for Air Force.

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

VARIABILITY IN JOES GETTING CARE WHEN NEEDED, FYs 2017–2018

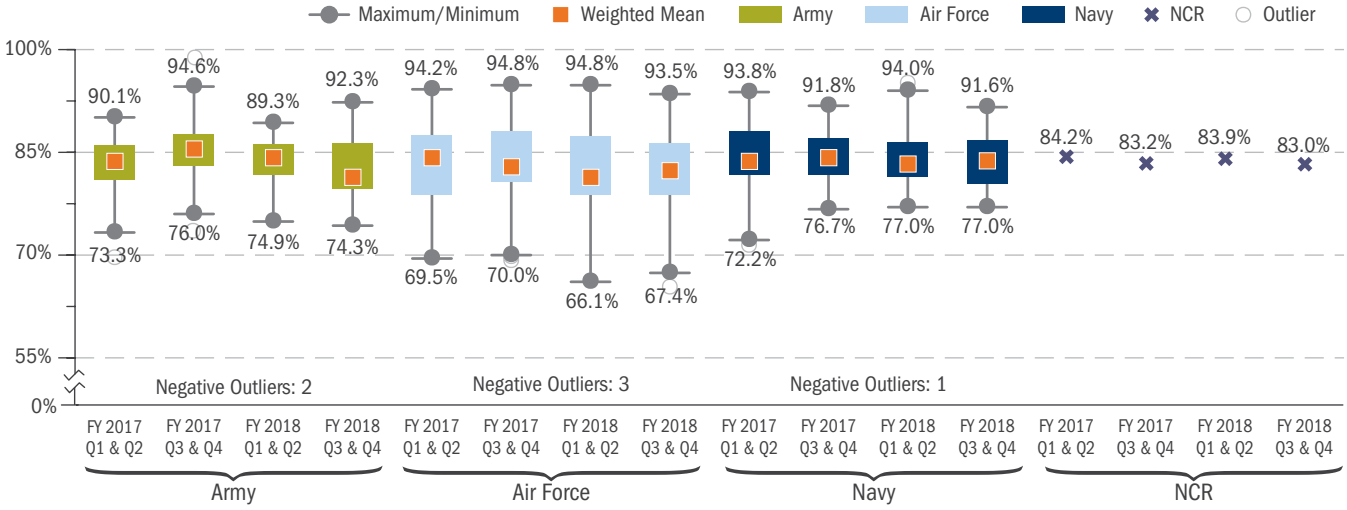
	FY 2017 Q1 & Q2	FY 2017 Q3 & Q4	FY 2018 Q1 & Q2	FY 2018 Q3 & Q4	% POINT CHANGE (FY 2017 Q1 & Q2 TO FY 2018 Q3 & Q4)
ARMY					
Service Score (Mean)	82.4%	83.8%	83.1%	82.3%	–0.1
Median	83.5%	85.3%	84.3%	82.5%	–1.0
75th Percentile	86.0%	87.6%	86.1%	86.3%	0.3
25th Percentile	81.0%	83.0%	81.6%	79.6%	–1.4
IQR	5.1%	4.6%	4.5%	6.7%	1.6
Positive Outlier (>)	93.7%	94.5%	92.9%	96.4%	2.7
Negative Outlier (<)	73.4%	76.1%	74.9%	69.6%	–3.8
Maximum	90.1%	98.6%	89.3%	92.3%	2.2
Minimum	69.4%	73.3%	74.9%	74.3%	4.9
Range	20.7%	25.3%	14.3%	18.0%	–2.7
AIR FORCE					
Service Score (Mean)	81.8%	82.7%	81.1%	81.1%	–0.7
Median	84.3%	83.3%	82.6%	83.1%	–1.2
75th Percentile	87.4%	87.9%	87.3%	86.3%	–1.1
25th Percentile	78.7%	80.7%	78.7%	78.8%	0.1
IQR	8.7%	7.2%	8.6%	7.6%	–1.1
Positive Outlier (>)	100.0%	98.7%	100.0%	97.7%	–2.3
Negative Outlier (<)	65.7%	69.9%	65.8%	67.4%	1.7
Maximum	94.2%	94.8%	94.8%	93.5%	–0.7
Minimum	69.5%	69.0%	66.1%	65.1%	–4.4
Range	24.7%	25.8%	28.7%	28.4%	3.7
NAVY					
Service Score (Mean)	82.1%	82.4%	82.2%	81.9%	–0.2
Median	83.5%	83.6%	83.1%	83.3%	–0.2
75th Percentile	88.0%	87.0%	86.4%	86.7%	–1.3
25th Percentile	81.7%	81.6%	81.3%	80.4%	–1.3
IQR	6.3%	5.4%	5.1%	6.3%	0.0
Positive Outlier (>)	97.5%	95.1%	94.1%	96.2%	–1.3
Negative Outlier (<)	72.3%	73.5%	73.7%	71.0%	–1.3
Maximum	93.8%	91.8%	94.9%	91.6%	–2.2
Minimum	71.2%	76.7%	77.0%	77.0%	5.8
Range	22.6%	15.0%	18.0%	14.6%	–8.0
NCR					
Service Score (Mean)	84.2%	83.2%	83.9%	83.0%	1.2

Source: DHA/SP&FI (J-5)/Decision Support, JOES, weighted data, compiled 11/24/2018
– Parent facility scores were used in the table above and those reporting fewer than 25 responses in the time period were excluded from analyses.
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration.

ACCESS TO MHS CARE *(CONT.)*

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

VARIABILITY IN BENEFICIARY RATINGS: GETTING CARE WHEN NEEDED, FYs 2017–2018



Source: DHA/SP&FI (J-5)/Decision Support, JOES, weighted data, compiled 12/3/2018

Notes:

– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration.
– The box shows the IQR (25th to 75th percentiles) with the Service score (weighted mean) highlighted.
– Length of the whiskers are at 1.5 times the IQR or the maximum/minimum value.
– Parent facility scores were used in the box and whisker plot above, and those reporting fewer than 25 responses within the time period were excluded from analyses.
– Parent facilities Fort Belvoir and Walter Reed compose the NCR category, which is represented by the weighted average.

ACCESS TO MHS CARE *(CONT.)*

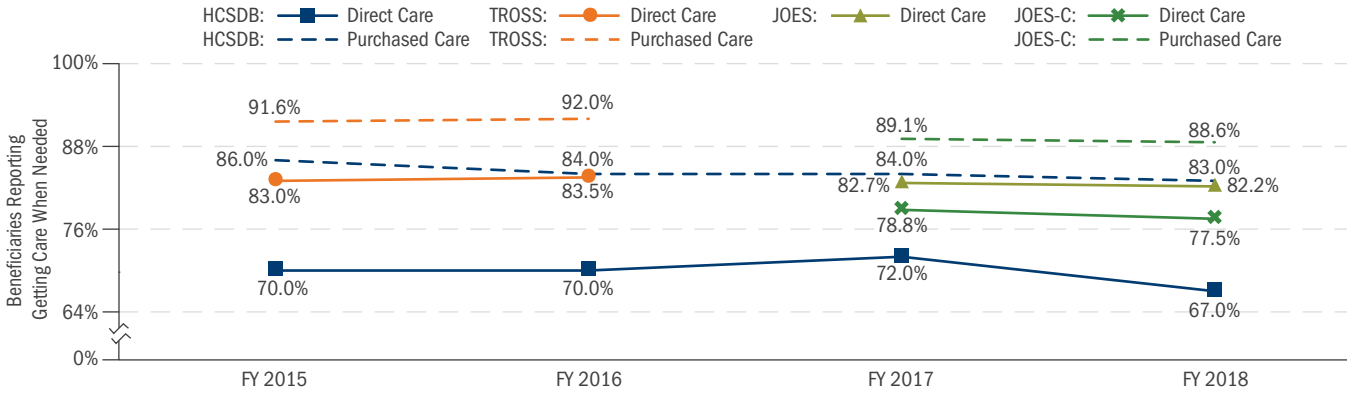
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care *(cont.)*

Comparison of Multiple Surveys—Getting Care When Needed

In addition to each of the Service surveys and JOES, JOES-C (and its predecessor, the TROSS), as well as the population-based HCSDB, also report results for the measure of Getting Care When Needed. Having this measure in each of the survey instruments provides important information about the differences between surveys and the beneficiaries who respond to them. A description of the differences between each of the surveys can be found on page 84.

- Beneficiaries who use or are assigned to purchased care report greater access to their provider than those who use or are assigned to direct care, regardless of time period. For JOES-C, scores for purchased care are about 10 percentage points higher than those for direct care from FY 2017 to FY 2018.
- Beneficiaries who completed JOES-C reported greater access than beneficiaries who completed HCSDB, over time, for direct care and purchased care. This may be because beneficiaries who complete JOES-C are beneficiaries who responded to a survey after having received care, whereas those who complete the HCSDB may not have received care or may not have received care as needed over the previous 12 months.
- Ratings of Getting Care When Needed have declined over time for respondents to the HCSDB and JOES-C for both direct and purchased care surveys. Ratings from beneficiaries completing the JOES survey have declined as well but only slightly, by less than one percentage point.

HCSDB, TROSS, JOES, AND JOES-C RATINGS OF GETTING CARE WHEN NEEDED, FYs 2015–2018



Source: DHA/SP&FI (J-5)/Decision Support, JOES, weighted data, compiled 12/5/2018

Notes:

– Health Care Survey of DoD Beneficiaries, TRICARE Outpatient Satisfaction Survey (TROSS), Joint Outpatient Experience Survey (JOES), and Joint Outpatient Experience Survey-CAHPS (JOES-C) results provided above.

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

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

– Results for JOES-C FY 2018 direct care and purchased care include data from September 2017 to August 2018.

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

– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration, respective to the JOES and JOES-C surveys.

– DoD data were derived from the FYs 2016–2018 Health Care Survey of DoD Beneficiaries (HCSDB), as of 12/5/2018, and adjusted for age and health status. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology.

ACCESS TO MHS CARE *(CONT.)*

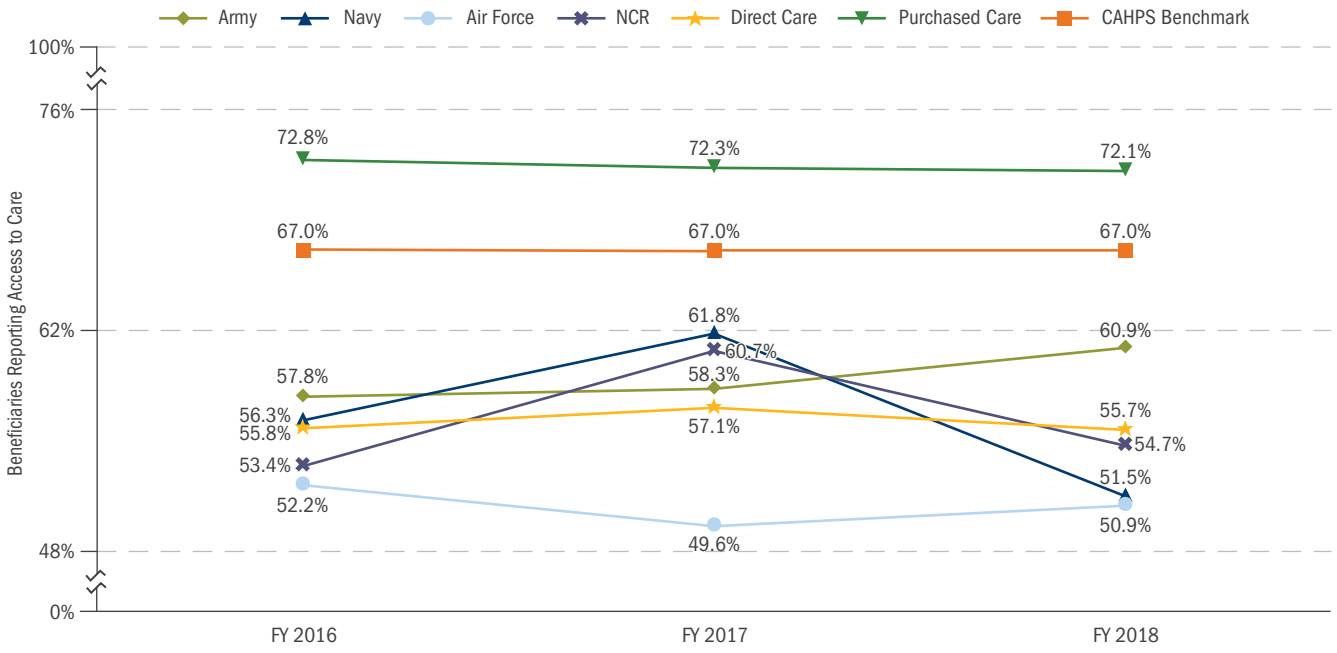
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care *(cont.)*

JOES-C Access to Care Composite

The Access to Care composite differs from the Getting Care When Needed measure, because it is based on guidelines from AHRQ's Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey (CAHPS C&G). 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 with 24–48 hours for JOES. Component questions that are part of the Access to Care composite include whether the patient was able to be seen for routine and urgent appointments and if the patient received an answer to a question within an appropriate time.

- The Access to Care composite ratings for beneficiaries receiving outpatient care at civilian facilities (purchased care) are higher than for those receiving care from MTFs (direct care).
- With the introduction of JOES-C in FY 2016, overall scores for purchased care have decreased, yet they have remained above the CAHPS benchmark. Scores for all of the Services and direct care overall remain below the benchmark. From FY 2016 to FY 2018, scores for Army and NCR increased, while scores for Navy and Air Force decreased overall.

JOES-C ACCESS TO CARE COMPOSITE, FYs 2016–2018



Source: DHA/SP&FI (J-5)/Decision Support, compiled 12/5/2018

Notes:

– Joint Outpatient Experience Survey-CAHPS (JOES-C) began fielding for encounters occurring in the following months: direct care June 2016; purchased care May 2016.

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

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

– Benchmarks are the 50th percentiles from the 2015 Adult Survey 3.0, the 2016 Adult 6-Month Survey 3.0 with/without PCMH items, and the 2017 Adult 6-Month Survey 3.0 with/without PCMH items.

ACCESS TO MHS CARE *(CONT.)*

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

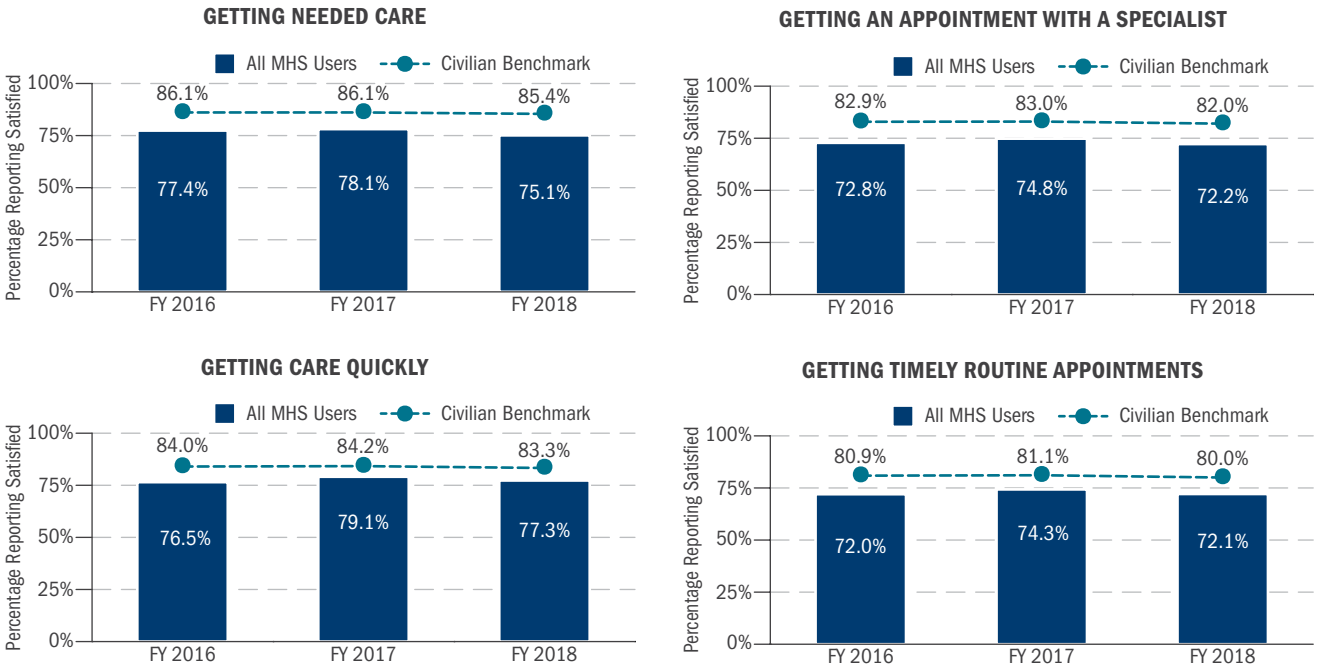
Instead of focusing on a specific health care event to assess patient experience with care, population surveys are designed to sample populations based on the demographics being considered (e.g., a survey of all ADSMs about their health behaviors, or a survey of all MHS beneficiaries to assess their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

Availability and Ease of Obtaining Care

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

- Overall MHS beneficiary ratings for Getting Needed Care declined from FY 2016 to FY 2018. After showing slight improvements in FY 2017, ratings for the other three access measures (Getting an Appointment with a Specialist, Getting Timely Routine Appointments, and Getting Care Quickly) dropped in FY 2018 to roughly their FY 2016 levels. Civilian benchmarks for all four access measures fell slightly over the same time period.
- MHS beneficiary satisfaction with all four access measures was lower than the comparable civilian benchmarks in each year between FY 2016 and FY 2018.

TRENDS IN MEASURES OF ACCESS FOR ALL MHS BENEFICIARIES (ALL SOURCES OF CARE), FYs 2016–2018



Note: DoD data were derived from the FYs 2016–2018 Health Care Survey of DoD Beneficiaries (HCSDB), as of 11/15/2018, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the National Committee for Quality Assurance (NCQA) by commercial plans. Benchmarks used in 2016 and 2017 come from NCQA's 2015 data, while the benchmarks used in 2018 come from NCQA's 2017 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

CLINICAL QUALITY MANAGEMENT IN THE MHS

Clinical Quality Management Oversight

Through Clinical Quality Management (CQM) functional capability, the MHS affirms its unwavering commitment to quality of health care for beneficiaries, joint health care teams, and Combatant Commands around the globe. CQM provides an organized structure for an integrated framework of programs to objectively define, measure, assure, and improve the quality of care at MHS.

In FY 2018, the MHS focused on three overall efforts as pertaining to CQM:

- Identification and organization of key areas of CQM.
- Development of policy manual volumes for each of the key areas.
- Development of transitional policy guidance on CQM activities within MHS's transitioning organizational structure.

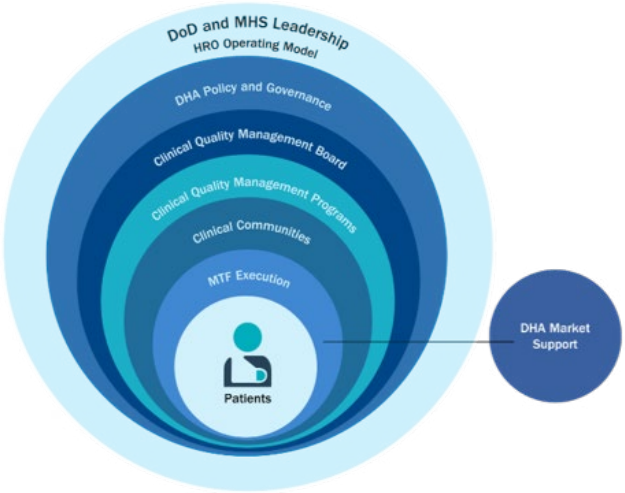
Developing Clinical Quality Management Policy

In FY 2018, the DHA began development of the DHA-Procedures Manual (DHA-PM) for CQM that will supersede the current DoD Manual. The DHA-PM aligns to the mandate established in the NDAA for FY 2017, which assigns the DHA with the responsibility for developing the policies and procedures for all functions (including CQM) and for the administration and management of MHS MTFs.

The CQM DHA-PM comprises seven volumes, the first volume addressing general oversight of the CQM functional capability. The remaining volumes align to the six CQM programs: Patient Safety, Health Care Risk Management, Credentialing and Privileging, Accreditation and Compliance, Clinical Measurement, and Clinical Quality Improvement. The CQM DHA-PM updates and expands on the published DoD Manual 6025.13. It provides a means for the MHS to operate a fully integrated CQM functional capability; supports the need to streamline CQM programs, processes, and procedures; and ensures standardization of leading practices across the MHS. It outlines the CQM structure and framework, through which the MHS defines, measures, assures, and improves the quality of care received by beneficiaries, and it defines foundational aims and principles that guide CQM in the MHS. It also describes evidence-based behaviors that build a culture of safety aligned to the principles of high reliability.

The DHA-PM is directly overseen by a collaborative board of subject matter experts with systemwide representation and works in alignment and coordination with associated DHA integration committees and working groups. The figure to the left provides a high-level conceptual framework for how the MHS might govern CQM from senior MHS leadership to the MTF and its patients.

MHS GOVERNANCE OF CLINICAL QUALITY MANAGEMENT



CQM Transition Plan

The DHA also continues to refine its CQM Transition Plan in accordance with NDAA FY 2017, section 702. The efforts outlined in this plan will directly influence the development and alignment of the organizational structure, resources, and functions of CQM starting in FY 2019. The plan includes a transition schedule detailing the DHA plan to execute the management and administration of the CQM programs at the DHA, transitional Intermediate Management Organization (tIMO), and MTF levels through a functional model approach, and demonstrates how a top-performing integrated system of readiness and health can be achieved.

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

CLINICAL QUALITY MANAGEMENT IN THE MHS

Healthcare Resolutions Program

There are three primary components to the Healthcare Resolutions Program situated in large MTFs, with each assigned Healthcare Resolutions specialist having regional responsibilities. The Healthcare Resolutions Program incorporates the five core principles of HROs (preoccupation with failure, reluctance to simplify, sensitivity to operations, commitment to resilience, and deference to expertise) 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 is being 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 without interference from legal or regulatory Quality Assurance processes. Representatives from Quality Assurance may be included in sessions when patients or families request such an opportunity, which then becomes a separate discussion. In preparation for these occurrences, Healthcare Resolutions specialists advise patients/families in advance that results of Quality Assurance reviews may not be released per federal regulations; however, that does not preclude their ability to provide their perspective. These 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.

Disclosure Training

Healthcare Resolutions specialists 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 The Joint Commission (TJC) disclosure standard, TJC patient-centered communication standard, American Medical Association Code of Ethics, DoD policy, and state apology laws, while respecting the boundaries of federal regulation (i.e., 10 U.S.C. §1102). The program is also responsible for drafting disclosure letters to notify a broad base of patients who may have been potentially harmed by noted discrepancies in care delivery, products that have been recalled, unsafe care-related practices such as instrument sterilization, or other issues of similar magnitude. Disclosure is promoted as a clinical dialogue.

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 adverse event during their careers. Rates of provider suicide and provider attrition continue to escalate. Peer Support Programs are being developed by Healthcare Resolutions to establish early involvement with providers following adverse events. In cooperative partnerships with other organizational entities, these programs are intended to promote provider-to-provider engagement following adverse events, with an emphasis upon emotional recovery and psychosocial support in a blame-free discussion. 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 Behavioral Health referrals should be sought. This initiative supports providers, 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.

CLINICAL QUALITY MANAGEMENT IN THE MHS

Patient Safety: Program to Prevent Harm

The mission of the DoD Patient Safety Program (PSP) is to promote a culture of safe, high-quality patient care to end preventable patient harm. The DoD PSP strives to achieve this by establishing data-driven, standardized processes through 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. As the MHS system continues its HRO journey, the PSP aims to present an integrated picture of safety, using available information from the entire organization. To accomplish this, the DoD PSP regularly monitors, measures, and identifies trends in patient safety data to prioritize areas of focus for improvement.

In collaboration with the Services and the DHA tIMO, the PSP used a data-driven approach to recognize patient safety needs, and then with the Clinical Communities developed targeted solutions to these needs. These efforts were key in continuously working to maintain and improve the culture of safety and high-quality patient care across MHS. To reward and highlight successful initiatives across the MHS, the PSP administers an awards program that incorporates safety, quality, access, and patient engagement.

Assessing Data to Identify Patient Safety Needs

Reporting patient safety events is a component of the MHS's effort to achieve high reliability, continuously improve, and provide the safest patient care possible. The reporting of patient safety events, including those that did not reach the patient (i.e., near-miss events), allows the DoD PSP to analyze the sequence of events that potentially lead to an error, identify trends in patient harm across the MHS, and share lessons learned to prevent future harm events from reaching the patient. The MHS tracks safety data through several mechanisms and systems, including:

1. Joint Patient Safety Reporting (JPSR), a self-reporting system that allows individuals to anonymously report all patient safety events;
2. Department of Defense Reportable Events (DoD REs), the most severe events from across the organization;
3. Health care-associated infections (HAI), which are tracked through the Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN); and
4. Global Trigger Tool (GTT) adverse events, which are collected through a sampling methodology from patient charts.

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

1. Joint Patient Safety Reporting

MHS leadership has directed MTF commanders and staff to report all patient safety events reaching the patient and encourage the reporting of near misses to the greatest extent possible through JPSR. Introduced in 2011, JPSR is a standardized, anonymous, and voluntary web-based reporting system that was implemented across the MHS system to capture patient safety events. The table below compares FYs 2015–2018 patient safety reporting, stratified by harm classification. In FY 2018, a total of 102,112 patient safety reports were submitted from the direct care system, which included 55 hospitals, 373 ambulatory clinics, and 251 dental clinics. Near-miss JPSR events accounted for 54 percent of all JPSR events reported in FY 2018. Although the number of harm and no-harm events decreased by 14 percent and 7 percent, respectively, the number of near-miss JPSR events remained flat from the previous year. Where feasible, the operational environment also reports patient safety events using the JPSR system.

During FY 2018, the initial phases of rolling out JPSR to the Navy Fleet were completed, as were USTRANSCOM initial draft requirements and configurations. Implementation in USTRANSCOM is scheduled for the first quarter of CY 2019. These implementations will enable an integrated view of patient safety in the operational and the MTF environment. In addition, JPSR was fully adopted by Veterans Affairs (VA) in FY 2018. Currently, JPSR has been implemented at more than 1,200 VA health care facilities across the country. This effort represents the first time that both MHS and VA have used the same reporting system, and will greatly enable the two organizations to collaborate on improvement efforts, learn from each other, and implement solutions that will address needs across both systems.

JOINT PATIENT SAFETY EVENTS REPORTED, FYs 2015–2018

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

Source: DHA/Medical Affairs/CSD, 10/19/2018

2. DoD Reportable Events

The DoD also looks at safety through the reporting of DoD REs, previously referred to as Sentinel Events (SEs). The DoD has mandated the reporting of all DoD REs, which are defined as any patient safety events resulting in death, permanent harm, severe temporary harm, or risk thereof, and includes The Joint Commission Sentinel Event (TJC SE) and the National Quality Forum's (NQF) serious reportable events (SRE). The most commonly reported medical and dental DoD REs reported to TJC are shown in the table below.

DOD REs REPORTED, FYs 2015–2018

EVENT TYPE	FY 2015	FY 2016	FY 2017	FY 2018	TOTAL
	#	#	#	#	#
Wrong-Site Surgery: Wrong Patient, Wrong Site, Wrong Procedure	33	38	27	45	**143**
Unintended Retained Foreign Object	24	18	25	27	**94**
Delay in Treatment: Lab, Path, Radiology, Referral, Treatment Order	19	25	19	27	**90**
Maternal (≥20 Week Gestational Age–42 Days Postpartum): Hemorrhage, Hysterectomy	21	28	9	12	**70**
Intraoperative or Immediate Post-Op/Post-Procedure or Surgery	16	25	13	11	**65**

Source: DHA/Medical Affairs/CSD, 10/18/2018

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

- **Wrong-Site Surgery (WSS):** WSS is a preventable DoD RE involving surgeries on the wrong site, wrong side, wrong person, or wrong procedure in the system. The MHS goal for WSS is zero events. In FY 2018, the MHS saw a 67 percent increase from FY 2017 in the number of reported WSS DoD REs (from 27 to 45). The increase in FY 2018 is primarily due to reporting of surgeries performed on the wrong site, from 10 in FY 2017 to 20 in FY 2018, with the largest increase in reporting of dental events. Efforts to prevent WSS include developing and disseminating prevention tool kits, continuous and focused communication to leadership, direct MTF coaching to implement stronger corrective actions after an event, sustained deployment of Universal Protocol, development of a Dental Reporting Guidebook, and webinar with detailed information and innovative Service-level mitigation strategies for dental WSS. The MHS goes above and beyond the civilian sector in reporting WSS as a DoD RE.
- **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 2018, the number of reported URFO DoD REs increased 8 percent over FY 2017 (from 25 to 27). The MHS goal for URFOs is zero events. To combat the occurrence of these events, the Services/DHA tIMO continue to monitor the use of time-outs in a standardized manner, participate in the Institute for Healthcare Improvement (IHI) surgical collaborative, and have disseminated an URFO Prevention Guidebook.
- **Delay in Treatment:** Delay in treatment events can be the result of a misdiagnosis, delay in diagnosis, or failure to follow up or communicate test results. These events can be serious DoD REs that ultimately result in serious harm or patient death. In FY 2018, there was a 42 percent increase in the number of reported delay in treatment events (from 19 to 27). To prevent these events, the Services/DHA tIMO are conducting a proactive risk assessment on what errors cause delay in treatment events. In addition, the DoD will collaborate with the VA National Patient Safety Center (NCPS) in FY 2018 and FY 2019 and do a deep-dive analysis on these events.
- **Maternal:** Maternal DoD REs include events in which the mother receives more than four units of blood, is transferred to a higher level of care, or receives a hysterectomy due to hemorrhage. From FY 2015 to FY 2018, there was a 43 percent decrease in the number of maternal DoD REs reported (from 21 to 12). To address maternal events, the Women and Infant Clinical Community is expanding a postpartum hemorrhage bundle that has shown success in several pilot hospitals.
- **Intraoperative:** Intraoperative events include serious events that occur during a surgery or procedure, or immediately post-operative or post-procedure. There was a 15 percent decrease in reported intraoperative events from FY 2017 to FY 2018 (from 13 to 11). The MHS measures events not primarily related to the patient's underlying medical condition and for ASA 1 (American Society of Anesthesiologists) patients. To further prevent these events, the Services/DHA tIMO have implemented dedicated surgical perioperative safety subgroups for all intraoperative events and enforced a 60-second pause before all surgeries.

In addition to capturing patient safety events through DoD REs, the DoD PSP receives root cause analyses (RCAs), which are required from MTFs for every DoD RE that occurs within a facility. For performance improvement, the Services/DHA tIMO may also voluntarily elect to complete an RCA for events that do not meet the threshold of a DoD RE, representing an opportunity for learning and improvement. In total, 195 RCAs were received in FY 2018, representing a 42 percent increase over FY 2017. An additional 27 performance improvement RCAs, previously known as internal RCAs, were received in FY 2018, representing a 45 percent decrease from FY 2017. For each RCA received, the DoD PSP reviews the strength of corrective actions (CAs) and submits a review back to the Service/DHA tIMO. The DoD PSP's corrective rating system is based on the VA Action Hierarchy, which breaks down actions by strength based on likelihood of preventing the event from happening again. The actions can be strong, intermediate, or weak. Stronger actions focus on system change and are not reliant on individual memory or vigilance. Through this process, the DoD PSP guides MTFs to implement strong CAs that are more likely to prevent a similar event from happening again. In FY 2018, the percentage of RCAs that included at least one strong or intermediate CA increased by 26 percent over FY 2017.

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

3. Centers for Disease Control and Prevention National Healthcare Safety Network

The DoD focuses on HAI. Central line-associated blood stream infections (CLABSIs) and catheter-associated urinary tract infections (CAUTIs) are HAIs that occur after placement of a central line or catheter, respectively. These infections are associated with increased morbidity, mortality, excessive health care costs, and increased length of stay per the CDC; however, they can be prevented when recommended infection control measures are followed. To combat and track these infections, MHS participates in CDC's NHSN, which allows the DoD to track performance on infections compared to a national benchmark and use the CDC's risk-adjusted model. There are five specific ICU types and four specific ward types within the MHS that are reported to the CDC's NHSN: medical, pediatric medical/surgical, medical/surgical, surgical, and trauma ICUs; labor and delivery, medical, medical/surgical, and surgical wards. These types were agreed on by the Infection Prevention and Control Working Group and are the most important for infection control within the MHS.

- The CDC recommends that the most reliable way to track CLABSIs and CAUTIs is by using the standardized infection ratio (SIR). This measure compares the number of infections (CLABSI and CAUTI) that occurred in MHS with the number of infections that were predicted in these settings by a statistical model that adjusts for patient characteristics that may increase the risk of infection. These methods were developed by the CDC and are the current benchmarks used for performance comparisons by Medicare.
- As shown in the table below (where lower than one is better than the national benchmark), the MHS performed either better than or the same as the national benchmark performance for both CLABSIs and CAUTIs in the first three quarters of FY 2018. To combat the occurrence of both of these infections, MHS facilities are focusing on monitoring best practice techniques such as practicing hand hygiene and standard precautions, focusing on catheter insertion only for appropriate indications, using aseptic technique and sterile equipment, disseminating focused reviews on HAIs, employing CLABSI and CAUTI bundles, and spreading best practices by using kits and guidebooks.

HEALTH CARE–ASSOCIATED INFECTIONS, FY 2015 Q2–FY 2018 Q3, STANDARDIZED INFECTION RATIO

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

Source: DHA/Medical Affairs/CSD, 10/9/2018
Note: FY 2018 Q4 data is unavailable due to a three-month lag in data maturity.

4. Global Trigger Tool Data

In FY 2018, MHS completed the implementation of the GTT, which is based on IHI methodology. Voluntary reporting methods detect only a fraction of harms; GTT uses a standardized process shown to detect adverse events (AEs) not otherwise reported. It is a validated, objective, and consistent retrospective method for medical record review. The tool is used to determine and monitor rates of patient harm over time and supplements other reporting systems to help direct resources and monitor impact. The IHI methodology recommends a minimum of 12 months of data collection to determine a baseline. Therefore, GTT data will be available for this report beginning in FY 2019.

In an effort to share lessons learned and data from these four sources (JPSR, DoD REs, NHSN, GTT) between Services/DHA tIMO and MTFs, the DoD implemented and expanded several initiatives in FY 2018. One such effort is the DHA SERCA (Safety Event and Root Cause Analysis) Tool. This tool allows designated users to view DoD REs, RCA, JPSR, NHSN, and GTT data for their own facilities and others across the MHS, and access all CAs implemented for safety events across the DoD. With enhanced transparency, MTFs now have real-time visibility into what other facilities in the DoD are doing to prevent events and improve safety.

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

Targeted Solutions to Meet Patient Safety Needs

The DoD PSP continued its work in 2018 to identify and refine competencies related to patient safety, quality, and process improvement (PS/Q/PI) to support the MHS in its transformation to a high reliability organization (HRO). The DoD PSP is working with clinical quality management subject matter experts to identify competencies related to patient safety, health care risk management, credentialing and privileging, accreditation and compliance, clinical measurement and analytics, clinical quality improvement, and identifying how learning resources used by the Services/DHA tIMO support these as well as the original PS/Q/PI competencies.

In addition to defining competencies, the DoD PSP offers an array of resources and solutions to target causal and contributing factors to patient safety events in the MHS, such as breakdowns in staff-to-staff communication. Included in these resources is Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS®), an evidence-based teamwork development system designed to improve health care team communication techniques and produce teams that optimize the use of information, people, and resources to achieve the best clinical outcomes. The DoD PSP supports the Services/DHA tIMO and MTF teams by providing infrastructure to obtain continuing education for multiple training courses, offering one-on-one team coaching, and evaluating the system's effectiveness. Throughout the MHS system, more than 70,000 MHS staff (CY 2010 to CY 2018) have completed training as reported through the Online Registration Center. The DoD PSP also sponsors selected Active Duty and civilian government employees to participate in the annual TeamSTEPPS conference, which includes a DoD breakout session. The goal of the annual conference and the DoD session is to provide opportunities for attendees to participate in educational offerings, share lessons learned, and build community.

Further training is offered for Patient Safety Managers (PSMs) through the Patient Safety Professional Course (PSPC)—a week-long course hosted four times a year to provide new PSMs and interested parties with standardized knowledge, skills, and tools to implement patient safety initiatives at their facility. The PSPC offers an award-winning, state-of-the-art learning system with a pre-work module, five days of face-to-face training, post-training virtual coaching, and opportunities for continued development through a PSM Ongoing Learning Certificate. The PSPC curriculum is regularly updated to integrate HRO principles and foundational knowledge within the course content, to reflect the MHS transition and policy changes, and to keep attendees trained on the latest innovative health care information and resources. The PSPC has had proven success in training Patient Safety Professionals (PSPs). For example, before the October 2018 PSPC, 40 percent of the participating PSPs highly or very highly believed they could apply MHS HRO guiding principles at their facility. After the course, that percentage increased to 87 percent.

The DoD PSP also sponsors learning events and resources to engage leadership, physicians, and patient safety champions in advancing quality and patient safety. In addition to training more than 70,000 MHS staff through the Online Registration Center (ORC), these resources equip MTF staff with information on leading practices and resources to facilitate large-scale change. The DoD PSP used more than 150,000 pieces of educational materials, including badge cards, brochures, posters, pocket guides, training DVDs, etc., designed to help advance their improvement initiatives for FY 2018.

Education and shared knowledge is further promoted through the development and release of key resources that are developed based on identified gaps or needs. For example, in FY 2018, the PSP sponsored *Dental Guidebook: Preventing Dental Patient Safety Errors through Improved Identification and Reporting of Events,* with a supporting webinar attended by over 1,500 dentists, dental technicians, and other allied health professionals. This guidebook was developed because the Services/DHA tIMO noticed variations in reporting of dental events and recognized an opportunity for collaboration. Additional resources include *Eliminating WSS and Procedure Events: A Guidebook for Inpatient and Ambulatory Facilities,* designed to provide the Services/DHA tIMO and MTF leaders and staff with a resource for identifying, understanding, and implementing nationally and internally recognized leading practices to help eliminate WSS, which is consistently a top DoD RE. In 2018, the PSP published three focused review publications on the topics of medication safety, falls, and pressure ulcers, which are three of the top ten most common DoD REs, as well as the CY 2017 Patient Safety Annual Summary, which is a retrospective annual review of MHS patient safety trends for CY 2017 compared with previous years. These publications act as a catalyst for transparency, sharing success stories and areas of improvement to focus on. They also aid in understanding the complex care network that contributes to quality and safety in the MHS. Key findings and other evidence-based practices have been incorporated into the DHA-PM for Clinical Quality Management (6025.13; anticipated early release in 2019) and additional guidance is in development.

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

MHS Patient Safety Culture

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

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

MHS Advancement toward High Reliability in Healthcare Awards

The DoD has been on a journey to transform the MHS to an HRO, which shares a single-minded focus on identifying potential problems and high-risk situations before they lead to an adverse event. The principles for becoming an HRO are necessary for the MHS to achieve strategic goals and support the ultimate goal for the MHS, the MHS Quadruple Aim: Improved Readiness, Better Care, Better Health, and Lower Cost. The DoD PSP assists the Services/DHA tIMO in their HRO efforts by facilitating collaboration and sharing leading practices. Currently, the PSP provides products, resources, and services that complement the Services/DHA tIMO in their patient safety HRO and improvement efforts.

The DoD PSP also encourages and engages field members through its facilitation of the 2018 Advancement toward High Reliability in Healthcare Awards, which were conceived to raise awareness, reward successful efforts, inspire organizations, and communicate success throughout the MHS. The awards identify those who have shown innovation and commitment to the development of systems and processes focused on the needs of the patient, eliminating preventable harm, and enhancing the integration of nationally recognized standards of care. There were a total of 68 submissions received for the 2018 awards program: 40 for Healthcare Quality and Patient Safety, and 28 for Improved Access and Patient Engagement. The Healthcare Quality and Patient Safety Award had 14 winners, and the Improved Access and Patient Engagement Award had seven winners across seven categories.

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

- **Brooke Army Medical Center, Decreased Unnecessary Antibiotic Usage in Uncomplicated Cystitis through Modification of Default Prescribing Directions:** The objective of this project was to reduce antibiotic days of therapy (DOT) prescribed for uncomplicated cystitis by 15 percent at patient-centered medical homes (PCMHs), and to increase adherence with the correct DOT to greater than 70 percent. After the project, the prescribing compliance with the recommended DOT improved from 29 percent to 77 percent in the PCMHs. The total DOT decreased by 22.5 percent, from 665 days per 100 cases to 515 days per 100 cases. Similar improvements were seen in cases treated in the emergency department with an increase in compliance from 38 percent to 72 percent. No increase in 30-, 45-, or 60-day relapse rates was noted.
- **MEDDAC Bavaria, Improving Opioids Safety:** The main objective of the project was to actively look for ways to improve opioid safety. The goals were to internalize the risk screening step into the pharmacy workflow for all patients receiving opioids as well as document the Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression (RIOSORD) score in the prescription record and offer naloxone to all high-risk patients. To have an efficient process for capturing 15 different risk factors for the assessment, the MTF realized the

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

- need for a web-based RIOSORD calculator linked with the electronic health record database. It submitted the idea to the Enterprise Intelligence and Data Solutions (EIDS). This suggestion led to the introduction of the CarePoint MHSPHP's Patient Lookup tool in April 2017.
- **Naval Hospital Camp Pendleton, Used Surgical Instrument Cleaning Error Reduction:** The objectives of this Lean Six Sigma project were to determine root causes for all three process failures, ensure the implementation of correct solutions and replicate within the 12 applicable clinics, and ensure process performance is sustained through monthly tracking and intrusive Lean Champion and Process Owner engagement. As a result, the facility witnessed sterilization and safety protocol process improvements not only in the original targeted oral and maxillofacial surgery (OMFS) clinic but in the additional 12 applicable clinics, facilitating meeting and exceeding The Joint Commission, Navy Medicine, and HRO standards.
- **Naval Medical Center Portsmouth, Long-Term Opioid Therapy Safety (LOTS) Program:** The objectives for this project were to decrease the number of patients on long-term opioids, to stop unsafe prescribing practices, to create a cultural change where opioids are not the first-line therapy for patients with chronic pain, and to afford the tools needed by providers to accomplish these goals. Within one fiscal year of program initiation, a culture of safer opioid prescribing was evident. Provider understanding and commitment to change was noted with a 30 percent decrease in the number of patients on long-term opioids, a 45 percent decrease in the number of patients on long-term opioids and concurrent long-term benzodiazepines, and a 41 percent decrease in patients using high-risk long-term opioids, defined as 90 morphine equivalent dose. Additionally, the percentage of charts with appropriate safe opioid prescribing practices in place improved by 15 percent.
- **Irwin Army Community Hospital, Adopting a Tiered Huddle System to Empower Broad-Based Action:** The objective of the project was to create a tiered huddle system using the TeamSTEPPS concepts to facilitate intraorganizational communication and collaboration. The tiered huddle system resulted in increased staff engagement and ownership in front-line problem solving. The system also significantly improved the overall reporting of Joint Patient Safety Events as well as improved the closure of patient engagement and concerns comments. This resulted in a removal of briefing events outside of the daily operational focus; further, staff engagement with satisfaction issues battle drill has improved.
- **Naval Hospital Camp Pendleton, Neonatal Hearing Exam Optimization:** This process improvement project involved all newborn infants born and discharged from the hospital with the objective of decreasing hearing screen failure rates to 10 percent and missed hearing screens to five per month by November 2017. The resulting new process decreased parental stress, reduced the number of audiology walk-in appointments for rescreening, and led to earlier detection of true hearing loss.
- **Fort Belvoir Community Hospital, Streamlining the Discharge Medication Reconciliation:** The objective of this project was to improve the average discharge prescription filling time from an average of 2.3 hours to 1.5 hours by April 30, 2018. Post implementation of a dedicated pharmacy technician led to a significant reduction in wait time, to less than 1.5 hours per patient, regardless of the number of prescriptions per patient. Furthermore, the accuracy of the provider order entries improved by more than 50 percent due to medication reconciliation efforts. The process improvement project resulted in a dramatic reduction in discharge medication processing time.
- **Brooke Army Medical Center, Implementation of a Pharmacy-Driven Intravenous to Oral Substitution Protocol for Antimicrobials:** The objective was to successfully implement a policy and procedure by which an inpatient pharmacist may change the route of a medication from intravenous to oral or per tube. The primary goal of this initiative was to significantly decrease intravenous DOT of targeted antibiotics by switching to oral formulations when appropriate, thereby increasing the percentage of oral DOT.
- **MEDDAC Bavaria, Enhancing Antibiotic Stewardship among Pediatric Patients:** The objective of the project was for the MTF to begin its antibiotic stewardship journey after the publication of the Director of Health Services Assessment Measures in January 2017 and, shortly thereafter, the publication of MEDDAC Bavaria's Regional Health Command's Campaign Plan. The MTF's NCQA Healthcare Effectiveness Data and Information Set (HEDIS) performance for Appropriate Testing for Children with Pharyngitis (CWP) climbed from the 10th percentile to the 90th percentile between January 2017 and April 2018—setting the MTF on a trajectory of excellent antibiotic stewardship practices.
- **U.S. Naval Hospital Yokosuka, Evidence-Based Healthcare Committee Diabetes Management Initiative:** The objective was to increase the overall HEDIS metric for Chronic Condition Management Measures of Diabetes Management. The results and effectiveness of the initiative were measured

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

- by HEDIS metrics standardized at the DHA level. The percentage of IV DOT decreased from about 85 percent in the pre-intervention period to about 70 percent in the pilot and post-intervention periods without an increase in in-hospital mortality or 30-day readmission for infection. The implementation of the protocol also resulted in an estimated cost savings of approximately $721.93 over the six weeks assessed, with projected savings of $6,256 per year.
- **U.S. Naval Hospital Yokosuka, Human Papilloma Virus (HPV) Vaccination Process Improvement Project:** The objective was to improve the HPV vaccination rate among Active Duty men and women aged 17–26 enrolled at the hospital, from 6.34 percent in April 2018 to 15 percent in April 2019. As its secondary set of objectives, the project sought to improve HPV vaccination rates among Active Duty Operational Forces and adolescent males and females aged 9–14 posted to this overseas installation. From April 2018 to July 2018, the percentage of vaccinated patients enrolled at the hospital increased from 6.4 percent to 10.2 percent. A total of 265 vaccinations were given to 141 Active Duty personnel, representing a 120 percent increase in the number of vaccinations administered from a baseline rate of 30 per month.
- **U.S. Naval Hospital Yokosuka, Hospital Corpsmen Drive Process and Performance Improvement in Dental Watch-Standing:** The objective of this Lean Six Sigma project was to improve the efficiency and effectiveness of watch-standing corpsmen. Standardization of procedures, dental carts, and training resulted in a positive impact on the corpsmen's clinical performance. Empowering corpsmen by having them drive this process improvement initiative has also led to successful outcomes and change management.
- **Naval Medical Center Portsmouth, Accreditation of the Chest Pain Center:** The objective of this project was for the MTF to become an Accredited Chest Pain Center to reduce mortality and morbidity in patients who experience acute coronary syndromes (ACS) and ST-segment myocardial infarctions (STEMI). Six subcommittees were formed that fulfilled more than 300 essential component requirements, resulting in accreditation. The accreditation process and implementation of evidence-based policies and initiatives positively impacted care for ACS and eight STEMI patients. The 2018 median door-to-reperfusion time as of July 2018 was 33 minutes, far below the national benchmark of 90 minutes.
- **Naval Hospital Camp Annapolis, Improvements in Central Sterilization Room Processes:** The objective of the project was to improve central sterilization room (CSR) processes to mitigate the risk of unsterilized instruments being distributed into clinical spaces. Validation strategy by weekly tracers of load reports indicated a 60 percent average reduction in the number of discrepancies over the reporting period.

2018 HEALTHCARE QUALITY AND PATIENT SAFETY AWARD WINNERS

MILITARY TREATMENT FACILITY/TRICARE REGIONAL OFFICE	AWARD-WINNING INITIATIVE
Brooke Army Medical Center	Decreased Unnecessary Antibiotic Usage in Uncomplicated Cystitis through Modification of Default Prescribing Directions
MEDDAC Bavaria	Improving Opioids Safety
Naval Hospital Camp Pendleton	Used Surgical Instrument Cleaning Error Reduction
Naval Medical Center Portsmouth	Long-Term Opioid Therapy Safety (LOTS) Program
Irwin Army Community Hospital	Adopting a Tiered Huddle System to Empower Broad-Based Action
Naval Hospital Camp Pendleton	Neonatal Hearing Exam Optimization
Fort Belvoir Community Hospital	Streamlining the Discharge Medication Reconciliation
Brooke Army Medical Center	Implementation of a Pharmacy-Driven intravenous to Oral Substitution Protocol for Antimicrobials
MEDDAC Bavaria	Enhancing Antibiotic Stewardship among Pediatric Patients
U.S. Naval Hospital Yokosuka	Evidence-Based Healthcare Committee Diabetes Management Initiative
U.S. Naval Hospital Yokosuka	Human Papilloma Virus (HPV) Vaccination Process Improvement Project
U.S. Naval Hospital Yokosuka	Hospital Corpsmen Drive Process and Performance Improvement in Dental Watch-Standing
Navy Medical Center Portsmouth	Accreditation of the Chest Pain Center
Naval Health Clinic Annapolis	Improvements in Central Sterilization Room Processes

Source: DHA/Medical Affairs/CSD, 10/9/2018

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

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

In addition to the specific efforts discussed at the DHA level, each Service conducts its own initiatives and improvement efforts regarding patient safety. Some of these efforts are highlighted below.

Navy Example: Between MHS surveys, Navy Medicine meets the challenge of the journey toward a strong culture of safety through TeamSTEPPS tools and periodic assessments of its culture. During Phase I of the TeamSTEPPS implementation, leaders and staff members reviewed safety culture survey data to identify opportunities for process improvement. TeamSTEPPS training principles and tools were implemented into command orientation programs and on-the-job training for designated high-risk areas, including operating rooms, intensive care units, and emergency rooms. The staff used key TeamSTEPPS tools including huddles, briefings, debriefs, and the two-challenge rule.

In addition, periodic assessments of culture occur through Comprehensive Unit-Based Safety Program (CUSP) unit level cultural assessments and Oro™ 2.0 HRO maturity assessments. CUSP unit level cultural assessments are the first task in the pre-CUSP phase. They are used to target a result for improvement shortly after the culture assessment, every 36 months or as needed to promote conversations on culture, evaluate cultural issues, and monitor the progress of cultural change. Among the 14 different areas included in the Oro™ 2.0 assessment, with deep dives into an organizations levels of trust, accountability, identifying unsafe conditions, strengthening systems, and assessment, safety culture features prominently. In addition, Navy Medicine's Patient Safety change plan deliverables include Clinical Surveillance System (CSS), Harm Evaluation and Risk Assessment Tool (HERA), and SQUAD.

Army Example: Over the past several years, elements within Army Medicine have piloted and implemented initiatives aimed at reducing preventable harm through the development of high-performing teams and the use of communication practices known to support safe patient care. In August 2018, six leading practices, collectively referred to as the "Top 6," were identified for reemphasis and mandatory adherence to standards. In order to reduce variability and improve safety within MTFs and DTFs, Army Medicine established mandatory adherence to standards for leader daily safety briefs, safety leadership rounds, unit-based huddles, Situation-Background-Assessment-Recommendation (SBAR) communication tool, TeamSTEPPS brief and debrief checklists, and universal protocol procedure verification. Facilities are to routinize the conduct of the "Top 6" and continuously assess compliance. The end state is defined as enterprise-wide adoption of the "Top 6" leading practices so that leaders rotating through MTFs and DTFs readily recognize the purpose, structure, and flow of the six practices, no matter the location.

Air Force Example: The Air Force Medical Service (AFMS) invested persistent systematic efforts with a standardized tool kit and key MTF site visits to drive CLABSI to zero harm with a clear payoff to the AFMS inpatient population. There were 750+ zero harm days as of November 8, 2018. The new Air Force Safety Center (AFSEC) MED Survey now gives frontline unit commanders a validated tool that supplies real-time data on their unique safety culture and practical HRO dimension applications, and individualized mentoring by AFSEC experts to improve performance. In addition, the data is rapidly available but with a 12-month lag, response rates are phenomenal at 90%+ return, and questions can be tailored to meet local mission parameters. This Air Force approach, which is replicable across the Services, represents a fresh, innovative departure from the antiquated AHRQ-based three-year interval survey which has proven ineffective in moving the needle on safety culture based on 12 mean opinion score (MOS) metrics.

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

Health Care Risk Management: Programs to Address Risk

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

The MHS risk management program supports the MHS strategy for managing systemic risks. Oversight of the risk management process in the MHS is the responsibility of the Risk Management Work Group (RMWG). This governance body is directed by the Department of Defense Instruction (DoDI) 6025.13 and the Department of Defense Manual (DoDM) 6025.13, and is the primary body for oversight of risk management processes and reporting of malpractice and adverse privileging actions to the NPDB. The RMWG provides a forum to discuss relevant risk management topics, share clinical lessons learned from risk management events within the MHS, identify variance in health care delivery, and promote uniform Tri-Service implementation of health care risk management processes.

Reporting to the NPDB. In FY 2018, 113 practitioners providing health care in MTFs worldwide were reported to the NPDB (reported by the Services to the MHS RMWG). The activities that gave rise to the reports include the following: paid tort claims (malpractice claims), adverse privilege actions, government administrative actions, Active Duty death cases, adverse practice actions, judgments or convictions, and Active Duty disability cases. As noted in last year's report (page 50), 103 practitioners were reported in FY 2017.

Credentialing and Privileging: Program to Assure Appropriate Credentials and Privileges

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

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

FY 2018 JCCQAS Accomplishments

- Two DoD User Training sessions for over 300 DoD credentialing staff individuals in the second quarter of FY 2018.
- Summary of the Health Executive Committee (HEC) decisions:
  - Approved delay of DoD implementation to April 2018 and VHA implementation to September 2018.
  - Approved request for $1.75 million set aside to resume VHA required tasks/deliverables for testing, training, and implementation.
  - Approved pursuit of funding sources for potential VHA/DoD joint privileging initiative.
- The HEC also requested an update of the JCCQAS timeline, milestones, and budget as well as a timeline to pursue a VHA/DoD joint privileging business process.

Once implemented, JCCQAS will merge over 13 million documents and 1 million credentialing records into a single, secure database.

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

Accreditation and Compliance: Program to Address Compliance with Standards

MTF/TJC Accreditation, Top Five JC Standards

The MHS aligns with industry practices for the assessment of care provided to beneficiaries. Nationally recognized standards for health care organizations are utilized for the development of policies and practices at MTFs. Civilian network health care facilities are contractually required to maintain accreditation with an approved accrediting organization. Accreditation and certification by external organizations provide the MHS with valuable information to validate compliance with standards and to identify opportunities for improvement.

MTF-specific hospital and clinic accreditation status is available publicly on the accreditation organization site, The Joint Commission (TJC) Quality Check (https://www.qualitycheck.org). MTF survey dates and requirements for improvement to meet full accreditation are displayed at the OASD(HA) public-facing web portal www.health.mil/AccreditationandPolicy.

This transparency is consistent with standardized management across an enterprise journeying toward an HRO, and supports the section 713 requirements.

MTF Accreditation

All fixed MTFs maintain accreditation by TJC and use the standards relevant to the care provided at the facility. TJC survey teams consist of clinical and facility surveyors with expertise in the standards applicable to the facility. The standards most commonly utilized for MTF surveys are in the Comprehensive Accreditation Manuals for Hospitals, Ambulatory Care, Behavioral Health Care, and Home Care. The chapters in TJC accreditation manuals contain standards for patient-focused functions and organization functions.

CHAPTERS IN TJC ACCREDITATION

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

The largest number of surveys are focused on ambulatory care, followed by hospital and then behavioral health care. Only one MTF participates in home care accreditation due to geographical location. As shown in the table below, 12 inpatient MTFs, 24 ambulatory care MTFs, and four behavioral health units were surveyed in CY 2017 and successfully received full accreditation.

MTF HEALTH CARE ORGANIZATION 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

Source: DHA/Medical Affairs/Clinical Support Division, 1/2/2019

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

TOP 5 JOINT COMMISSION AMBULATORY STANDARDS CITED IN MTF SURVEYS, CYs 2014–2017

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

TOP 5 JOINT COMMISSION HOSPITAL STANDARDS CITED IN MTF SURVEYS, CYs 2014–2017

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

Source: DHA/Medical Affairs/Clinical Support Division, 1/2/2019

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

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

DHA, in collaboration with the Services, recently completed the establishment of a data repository with all TJC accreditation findings for MTFs over the past four years. The repository serves as a tool to share information between facilities, monitor for patterns or trends, and identify systemwide improvement opportunities. As shown in the tables on this page, the top five hospital and ambulatory findings provide areas for a focused review to identify common themes for improvement activities as well as continuous compliance monitoring.

TJC accreditation process requires the completion of an annual self-assessment as a means to continually evaluate compliance with standards between surveys. MTF staff initiate performance improvement activities to address any areas of noncompliance. Continuous compliance with TJC standards contributes to the maintenance of safe, quality patient care, and improved performance.

In addition to the survey process for accreditation, TJC requires hospitals to submit national clinical quality measures data on a quarterly basis. Each MTF selected the measures for data submission. Data was collected centrally by trained abstractors and reported to the MTFs for analysis and improvement as indicated. The perinatal care (PC) measures are included in the women and infant quality measures section of this report (see page 115–117).

Looking to the future and maximizing electronic health record (EHR) capabilities, the health care industry has developed electronic clinical quality measures (eCQMs). These measures do not require chart abstraction and are intended to decrease the burden of data collection. DHA is in the process of developing eCQM data collection capabilities for MTFs with ESSENTRIS as EHR.

Clinical Laboratory Services Accreditation

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

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

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

through inspections conducted by an accreditation organization that has been granted deeming authority by the Centers for Medicare & Medicaid Services's Division of Clinical Laboratory Improvement and Quality, such as the College of American Pathologists (CAP), Commission on Laboratory Accreditation (COLA), The Joint Commission, 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, Defense Health Agency, and the Service's Surgeons General, on a periodic basis and when requested. The office also manages a DoD contract with the Clinical and Laboratory Standards Institute, providing access to consensus-based standards regarding the management and operation of clinical laboratories.

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

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

In FY 2018, CLMS began the process of reviewing the DoDI and DoDM to assure the DoD's policies, conditions, and standards regarding clinical laboratory regulatory compliance were current and updated as compared to CLIA, as implemented by Title 42, Code of Federal Regulations, Part 493. Last, in FY 2018, 100 percent of all MHS clinical laboratories on the cycle for inspection were reaccredited. One hundred and seven Army laboratories were inspected and attained an average accreditation score of 99.42 percent and a proficiency testing score of 98.6 percent; 93 Air Force laboratories achieved an average accreditation score of 99.38 percent and a proficiency testing score of 98.85 percent; and 103 Navy laboratories were inspected with an average accreditation score of 99.40 percent and a proficiency testing score of 99.2 percent. Overall, the MHS's clinical laboratories outperformed the CAP average for three years in a row as it pertains to these top two regulatory metrics, proficiency testing scores and percent deficiencies during inspections. As in FY 2017, the top area identified for improvement during inspections was the documentation of staff's competency assessment. Although the DoD deficiency rate for this requirement is lower than the average for all laboratories inspected by the CAP, CLMS will communicate strategies for success to further mitigate and lower the rate of occurrence for this finding.

Blood Bank Services Accreditation

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

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

In FY 2018, 100 percent of the Armed Services Blood Program (ASBP) centers maintained FDA licensure and registrations, as well as AABB and CAP accreditations.

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

Clinical Measurement and Clinical Quality Improvement

The DHA supports the MHS with a program for comprehensive oversight and accountability of clinical quality improvement (CQI) initiatives. The overarching goal of this program is to ensure that quality is integrated into the health care system to improve patient outcomes. The MHS defines quality in health care as "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[1] CQI is facilitated by the MHS process improvement infrastructure to promote data-driven improvement initiatives and implement evidence-based and leading-practice guidelines into clinical practice.

The MHS established Clinical Communities to empower frontline clinicians for identification of clinical processes and patient-centered outcomes that should be prioritized for improvement efforts. The MHS is currently developing analytics and infrastructure supported by improvement science to identify clinical processes with the highest variation and frequency to target potential intervention, and to assist with planning and reporting improvement initiatives.

The Quadruple Aim Performance Process (QPP) is the strategic planning and execution process by which MTFs and markets translate strategic guidance to action by resourcing improvement projects that align to the Quadruple Aim—Improved Readiness, Better Care, Better Health, and Lower Cost. Improvement initiatives prior to QPP used Service-specific guidance, which resulted in variance in performance and limited learning across the MHS. This new QPP process will achieve efficiencies by using DHA strategic priorities to determine resource decisions. To further promote a learning environment, performance gaps identified in one year will be incorporated into strategic guidance and QPP critical initiatives for the subsequent year.

The success of our journey to establish an HRO requires a workforce equipped with core competencies in quality improvement and patient safety. Empowering individuals to use evidence-based tools and the techniques of improvement science to help identify improvement opportunities and promote data-driven improvement behaviors throughout the system is the foundation of continuous learning. Education will be customized to different audiences, including the general workforce, quality professionals, and senior leadership. Currently, Services have robust performance improvement education and training programs that will be leveraged by DHA leadership to develop a single, comprehensive education and training platform.

The MHS is also involved in conducting clinical quality improvement studies designed to analyze and compare the performance of MHS direct care and purchased care with civilian national benchmarks, whenever available, to identify opportunities for improvement. The goal is to conduct two studies per fiscal year with proposed topics originating from data analysis, evolving evidence-based practice, and Clinical Communities. Two current studies for FY 2018 are as follows:

1. **Opioid Overdose:** The purpose is to assess the patterns of risk-reduction activities implemented by direct and purchased care clinicians for MHS patients who experienced an opioid overdose. This project was proposed by the Pharmacy Division, and is supported by an advisory subcommittee of DoD experts in pain management and pharmacy.
2. **Maternal Depression:** The purpose is to examine the prevalence of postpartum depression screening practices in the prenatal and postnatal periods for MHS direct care beneficiaries to determine if standard screening practices are associated with best practices and clinical practice guidelines, and to examine the timeliness of follow-up care for mother and newborn. This project was proposed by the Women and Infant Clinical Community, and is supported by an advisory subcommittee of DoD experts in maternal care.

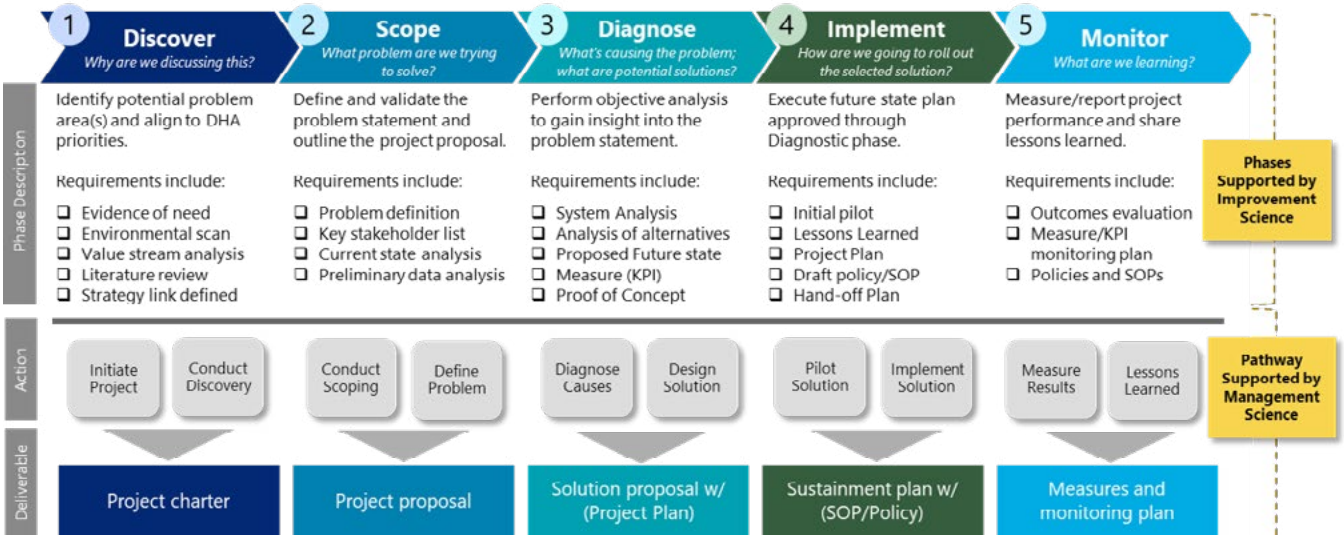
Improvement Science

The overall MHS leadership approach for promoting improvement, and the necessary supporting tools and systems, is built on common science-of-improvement principles. Derived from the science of improvement is the System of Profound Knowledge, which requires focus on four primary aspects of a system before implementing any change. The first is appreciation of a system as a network of interdependent components and/or processes to accomplish an aim. The second is understanding the differences between controlled, random, and common cause variation. The third is acknowledging that theories must be developed, applied, and tested to advance knowledge in a systemic way. Finally, the fourth is recognizing that the varied strengths, beliefs, and motivations of individuals within the organization will impact change and outcomes. The execution framework the MHS has adopted to apply

[1] Health.mil. "Clinical Quality Management." Available at https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Clinical-Quality-Management. Accessed December 5, 2018.

Improvement Science *(cont.)*

these four aspects is known as the Health Systems Optimization (HSO) model. The HSO model ensures leaders and stakeholders follow a scientific improvement methodology when applying improvements to complex systems and processes. This is executed through a multiphased approach organized in five stages: Discover, Scope, Diagnose, Implement, and Monitor. Each of the stages are separate and distinct from the others to ensure the organization not only understands the symptoms of the problem, but has an understanding of its root causes before implementing solutions. The HSO model is illustrated below.



THE HEALTH SYSTEMS OPTIMIZATION MODEL

Knowledge management is key in operationalizing a performance improvement system. A robust knowledge management system (KMS) will enable enterprise transparency and accountability through a unified, systemwide portfolio of all quality improvement efforts. A mature KMS will ultimately serve as a central repository for performance improvement project information, tools, templates, and best practices. This will include a standardized feedback process designed to continuously improve capabilities to meet the needs of clinical/administrative leads. In 2018, the MHS Performance Improvement Community of Practice performed a 2018 environmental scan of KMS options, and identified the U.S. Army Medical Command's Continuous Process Improvement Management System (CPIMS), the Air Force Medical Operations Agency's Leading Practice Management System, and the Bureau of Medicine and Surgery's Strategic Performance Improvement Data Repository (SPIDR). The DHA will leverage best practices of all Services and use a KMS that is both relevant and suitable for the DHA's requirements. Current work is underway to adopt SPIDR and the Leading Practice Management System, with a goal of enabling performance improvement professionals across the enterprise to not only engage with one another and share results, but also access and share Service performance improvement best practices.

Additional References:
– "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," *Department of Defense Manual*, no. 6025.13, 2013, http://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodm/602513m.pdf.
– "Enterprise Performance Life Cycle (EPLC)," National Institutes of Health, Department of Clinical Research Informatics, https://clinicalcenter.nih.gov/dcri/epcl.html.
– DHA, *Evaluation of the TRICARE Program Fiscal Year 2018 Report to Congress*, Washington, D.C.: U.S. Dept of Defense, 2018. https://www.health.mil/Reference-Center/Reports/2018/05/09/Evaluation-of-the-TRICARE-Program-Fiscal-Year-2018-Report-to-Congress.
– Koenig, M.E.D., "What is KM? Knowledge Management Explained," *KMWorld*, January 15, 2018, http://www.kmworld.com/Articles/Editorial/What-Is/What-is-KM-Knowledge-Management-Explained-122649.aspx.

HIGH-RELIABILITY OPERATING MODEL/CLINICAL COMMUNITIES

Primary Care Clinical Community (PCCC)

Primary Care Services

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

The VA and DoD clinical practice guideline (CPG) collaboration has established a rigorous systematic review of medical evidence to help primary care providers and health care teams deliver consistent high-quality health care to beneficiaries. CPGs are developed by multidisciplinary clinical experts and are based on unbiased clinical research studies and literature reviews. Twenty-two CPGs have been developed and updated to provide practitioners with information and tool kits to support evidence-based practice. The VA/DoD CPGs are available at https://www.healthquality.va.gov/. To enhance the availability and use of information in the CPGs, the TSWF team embedded CPG information into the electronic health record 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.

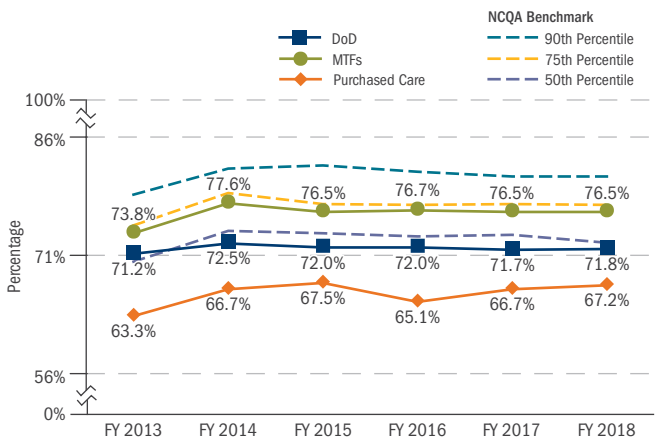
Additionally, the MHS monitors the performance of primary care services with a variety of nationally recognized quality measures. The NCQA HEDIS includes primary care–focused health plan measures with methodologies. HEDIS is a tool used by more than 90 percent of America's health plans to measure performance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

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

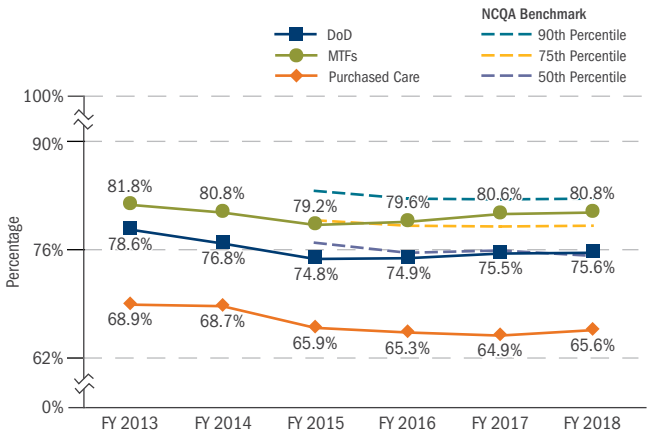
Adult HEDIS Measures

- **Breast and Cervical Cancer Screening:** HEDIS measure focused on cancer screening for early detection and treatment to maximize the potential for a cure. Breast cancer screening is at the NCQA 50th percentile and is within one percentage point of reaching the 75th percentile in direct care. Cervical cancer screening is at the 50th percentile and at the 75th percentile for direct care. Purchased care improved performance on breast cancer and cervical cancer screening in FY 2018. Initiatives to streamline appointments, engage patients, and optimize technology are underway to continue to improve compliance with these important clinical service screenings.

BREAST CANCER SCREENING, FYs 2013–2018



CERVICAL CANCER SCREENING, FYs 2013–2018

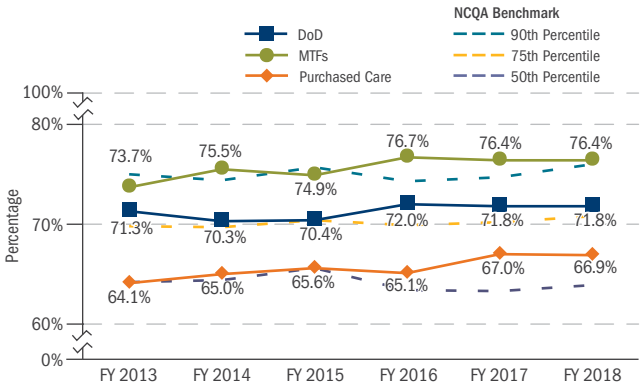


Source: DHA/Medical Affairs/Clinical Support Division, 1/2/2019

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

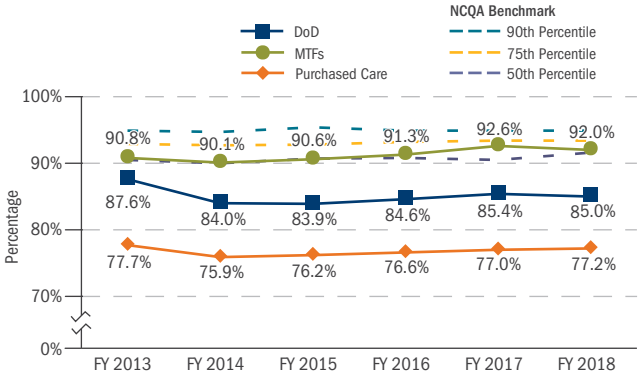
Primary Care Clinical Community (PCCC) *(cont.)*

COLORECTAL CANCER SCREENING, FYs 2013–2018



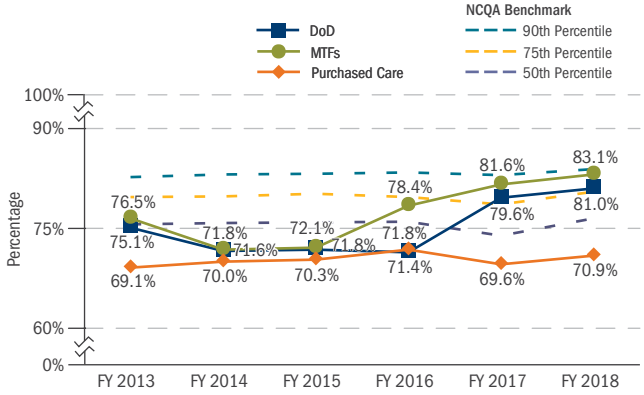
- **Colorectal Cancer Screening:** HEDIS measure focused on detecting colorectal cancer as well as screening for premalignant polyps to prevent cancer. MHS direct and purchased care rates have improved in colorectal cancer screening over time. MHS direct care MTF rates are consistent with the NCQA 90th percentile in FY 2018; purchased care rates are consistent with the NCQA 50th percentile.

DIABETES HbA1c SCREENING, FYs 2013–2018



- **Diabetes HbA1c Screening:** HEDIS measure focused on annual testing to help health care providers with care for the common and serious chronic disease of diabetes. The MHS continues to work to improve the management of diabetic patients. The FY 2018 rate of performance for direct care facilities is consistent with the NCQA 50th percentile and is 1.5 percentage points from the 75th percentile.

LOW BACK PAIN IMAGING, FYs 2013–2018

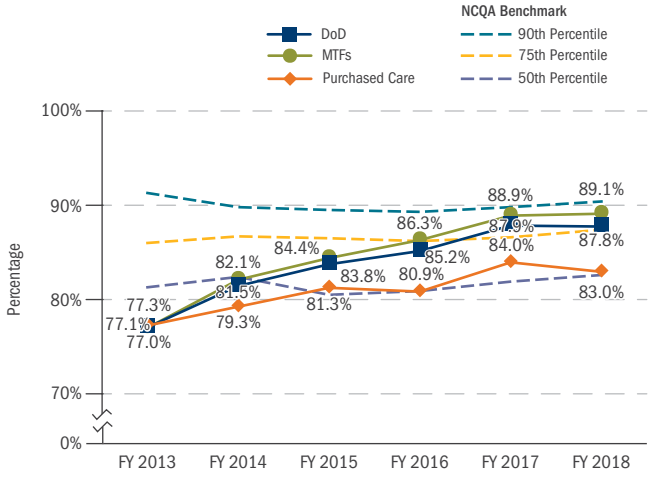


- **Low Back Pain (LBP) Imaging:** HEDIS measure focused on overuse of imaging for acute LBP. MHS has integrated the VA/DoD LBP CPG into the electronic medical record to support providers with improvement initiatives. Performance reporting capabilities were developed for each level of care, MTF, Provider Team, and Individual Provider to support feedback. The FY 2018 rate of performance for direct care facilities is consistent with the NCQA 75th percentile and is near the 90th percentile, while the purchased care provider performance increased from the previous year.

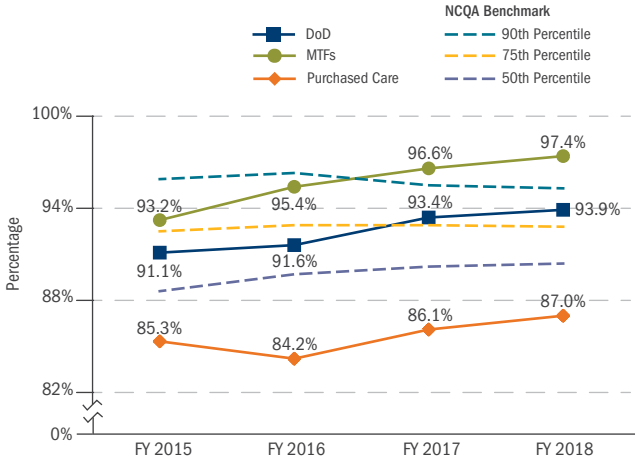
Source: DHA/Medical Affairs/Clinical Support Division, 1/2/2019

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

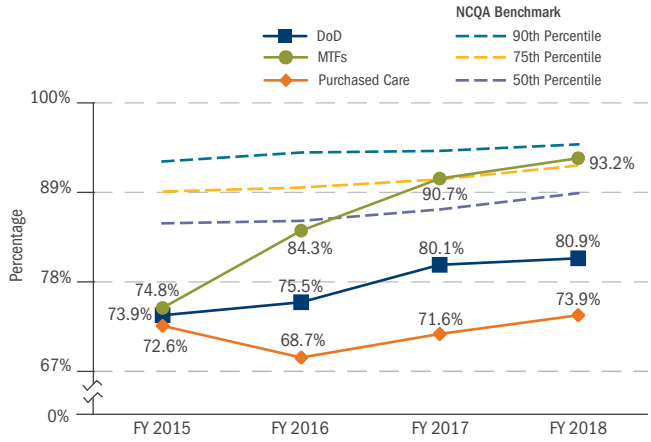
WELL-CHILD VISITS, FYs 2013–2018



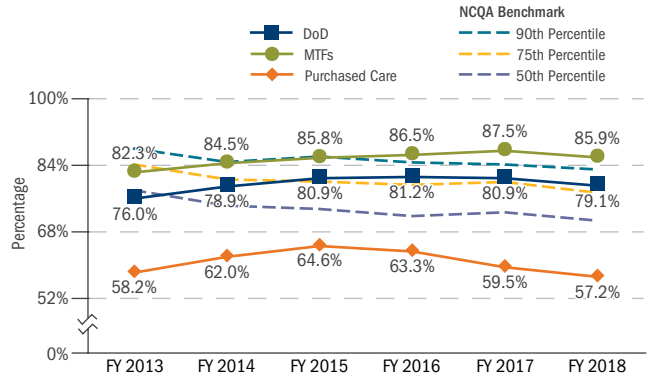
CHILDREN WITH UPPER RESPIRATORY INFECTION, FYs 2015–2018



CHILDREN WITH PHARYNGITIS, FYs 2015–2018



MENTAL HEALTH FOLLOW-UP, FYs 2013–2018



Source: DHA/Medical Affairs/Clinical Support Division, 1/2/2019

- **Well-Child Visits:** HEDIS measures focused on the adequacy of well-child care for infants. The MHS continues to demonstrate improvement in this measure, which focuses on children having six visits within the first 15 months of life. Direct care facilities are in the NCQA 75th percentile in FY 2018 and are near the 90th percentile. The purchased care providers are in the 50th percentile.
- **Children With Pharyngitis:** HEDIS measure focused on appropriate use of antibiotics based on laboratory data. Pharyngitis diagnosis can be easily and objectively validated through administration of a group A strep test at the point of care. Validation of the diagnosis prevents unnecessary use of antibiotics. The FY 2018 rate of performance for direct care facilities is consistent with the NCQA 75th percentile, while the purchased care provider performance increased from the previous year.
- **Children With Upper Respiratory Infection:** HEDIS measure focused on the prevalence of inappropriate antibiotic prescribing and on increasing awareness of the importance of antibiotic stewardship to prevent antibiotic resistance. The rate of performance for direct care facilities in FY 2018 reached the NCQA 90th percentile. The purchased care provider performance improved from the previous year.
- **Mental Health Follow-Up:** This HEDIS measure examines 30-day mental health (MH) follow-up care in the MHS MTF and purchased care venues. MTF results include all participating MTFs as a group. Purchased care includes the regional MCSC networks, the Designated Provider/USFHPs, and overseas participating networks. The MHS continues to focus its efforts on seamless transitions of MH care in both MTF and purchased care venues.

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

Primary Care Clinical Community (PCCC) *(cont.)*

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

MHS performed well compared with national HEDIS benchmarks, obtaining the national 90th percentile benchmarks for Diabetes A1c Level <7%, and the 75th percentile for Mental Health Follow-Up: 7 and 30 days; Well Child Visits; Treatment of Children with Upper Respiratory Infection; Colorectal Cancer Screening; Chlamydia Screening; Low Back Pain Imaging; and Diabetes A1c Level <8% and ≤9%. The decrease in the rate of performance for Mental Health Follow-Up: 7 and 30 days is related to a change in the methodology that excludes outpatient visits the day of discharge from the hospital.

MHS HEDIS BENCHMARK PERFORMANCE, JUNE 2014–JUNE 2018

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

Source: MHS Population Health Portal, June 2018

Notes:

– 2014: Rates for June 2014; 2015: Rates for June 2015; 2016: Rates for June 2016; 2017: Rates for June 2017; 2018: Rates for June 2018

– Statistical Testing: Two-sample Z test; Green or Red: statistically significant at p=0.05 level

– 2017 and 2018 data excludes the MHS GENESIS initial operating capability (IOC) sites

– HEDIS Benchmark Status

- 1 star: Below 25th percentile
- 2 stars: Between 25th and 49th percentile
- 3 stars: Between 50th and 74th percentile
- 4 stars: Between 75th and 89th percentile
- 5 stars: At or above 90th percentile

Neuromusculoskeletal Clinical Community

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

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

The NMSKCC is implementing the LBP Care Pathway at Walter Reed National Military Medical Center (WRNMMC) to promote a standardized and measurable approach to LBP care delivery. The pathway focuses on patient outcomes, in line with high-reliability principles. The pathway seeks to return patients to military readiness earlier and to facilitate early access to physical therapy (PT), which has been shown to improve patient outcomes and reduce cost and additional utilization of health care resources. The pathway aims to improve pain management and the patient experience through the reduction of unnecessary imaging, opioid prescriptions, and pain-related disability. The pathway is currently in the pilot phase of implementation at WRNMMC and will use the MDP to collect outcome data.

The NMSKCC, via the TBI Advisory Committee, developed the Acute Concussion Care Pathway that rolled out 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) gradual return to activity. Referral to a National Intrepid Center of Excellence is also an option if further intervention is required. Early identification and treatment of concussions can prevent long-term negative consequences to cognitive, psychological, and physical functions. The Service TBI leads and the Defense and Veterans Brain Injury Center worked to modernize an acute concussion screening tool (Military Acute Concussion Evaluation 2 [MACE2]) and updated the Concussion Management Tool (CMT). The MACE2 incorporates state-of-the-science advances in concussion evaluation, with particular focus on vestibular and oculomotor areas. The CMT is a draft revision of the previous concussion management algorithm to further drive modernized concussion management.

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

Women and Infant Clinical Community

Women, Newborn, and Infant Initiatives

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

Perinatal Care Measures

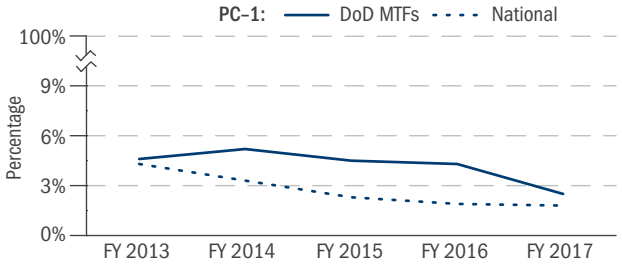
Perinatal care is a high-volume specialty in the MHS. Nationally recognized measures are continually monitored to assess the quality and safety of perinatal care provided across the system. The perinatal care measures used are endorsed by the National Quality Forum. The collection and submission of perinatal quality measures data to TJC are required to meet accreditation requirements.

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

PC–1 ELECTIVE DELIVERY[a]

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
DoD MTFs	4.6%	5.2%	4.5%	4.3%	2.5%
National[b]	4.3%	3.3%	2.3%	1.9%	1.8%

DoD HOSPITAL QUALITY MEASURE: ELECTIVE DELIVERY PC–1, FYs 2013–2017[a]

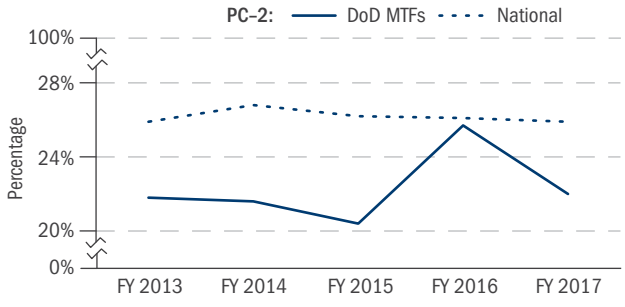


- **Cesarean Rates:** This measure (PC–02) focuses on safe and appropriate use of cesarean delivery for women who have not previously given birth and have a single, term fetus. The goal of the measure is to reduce risk and increase safety for mothers and infants. DoD MTF rates continue to be below the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

PC–2 CESAREAN SECTION[a]

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
DoD MTFs	21.8%	21.6%	20.4%	25.7%	22.0%
National[b]	25.9%	26.8%	26.2%	26.1%	25.9%

DoD HOSPITAL QUALITY MEASURE: CESAREAN SECTION PC–2, FYs 2013–2017[a]



[a] Lower rates are better.

[b] The national rate is the FY fourth quarter rate rather than an annual rate. Please see link for TJC Annual Report, http://www.new-media-release.com/jointcommission/2017_annual_report/2017-annual-report.pdf.

Source: DHA/Medical Affairs/Clinical Support Division, 1/3/2019

BETTER CARE

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

Women and Infant Clinical Community *(cont.)*

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

PC–3 ANTENATAL STEROIDS

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
DoD MTFs	79.0%	83.3%	99.0%	98.4%	96.7%
National[a]	89.7%	91.8%	97.2%	97.8%	95.5%

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

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

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
DoD MTFs	4.1%	0.9%	1.7%	1.2%	0.2%
National[a]	2.5%	3.2%	2.4%	1.1%	0.7%

- **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).

PC–5 EXCLUSIVE BREASTFEEDING

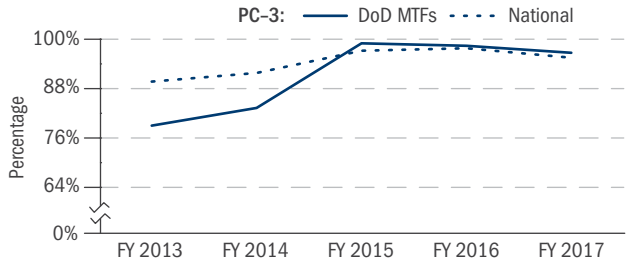
	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
DoD MTFs	68.8%	70.5%	70.9%	74.8%	71.1%
National[a]	53.6%	49.4%	51.8%	52.9%	49.9%

[a] The national rate is the FY fourth quarter rate rather than an annual rate. Please see link for TJC Annual Report, http://www.new-media-release.com/jointcommission/2017_annual_report/2017-annual-report.pdf.

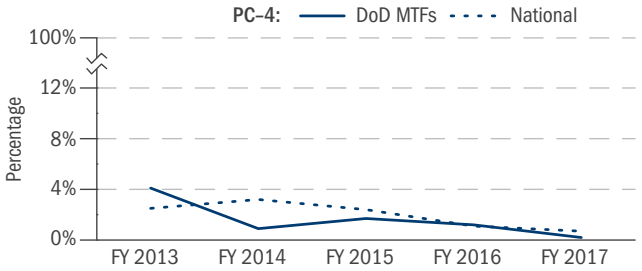
[b] Lower rates are better.

Source: DHA/Medical Affairs/Clinical Support Division, 1/3/2019

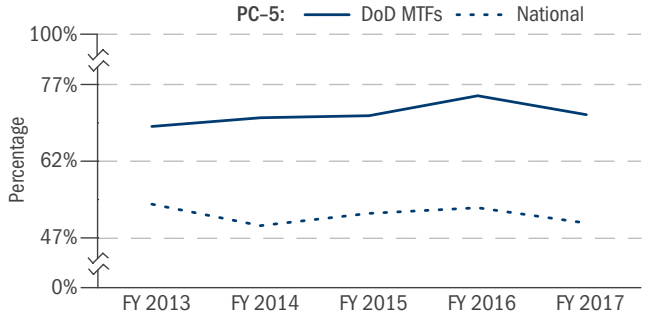
DoD HOSPITAL QUALITY MEASURE: PERINATAL CARE, ANTENATAL STEROIDS PC–3, FYs 2013–2017



DoD HOSPITAL QUALITY MEASURE: HEALTH CARE–ASSOCIATED BLOODSTREAM INFECTIONS IN NEWBORNS PC–4, FYs 2013–2017[b]



DoD HOSPITAL QUALITY MEASURE: EXCLUSIVE BREASTFEEDING PC–5, FYs 2013–2017



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

Women and Infant Clinical Community *(cont.)*

Perinatal metrics are provided through a contract with National Perinatal Information Center (NPIC), the vendor which serves as an analytic service to provide MTF, Service, and MHS-level data on over 100 metrics for the direct care component. Purchased care component data became available in late CY 2018 for facilities that deliver care for 150 or more TRICARE beneficiaries. NPIC data is used as a civilian benchmark for outcomes and metrics that have no national benchmark.

NATIONAL PERINATAL INFORMATION CENTER COMPARATIVE DATA ALL SERVICES COMBINED, CY 2017 Q1–CY 2018 Q1

	CY 2017 Q1			CY 2017 Q2			CY 2017 Q3			CY 2017 Q4			CY 2018 Q1		
Total Deliveries	9,840			9,595			10,782			9,196			8,882		
Maternal Outcome Measures	**MHS Avg**	**NPIC Avg**		**MHS Avg**	**NPIC Avg**		**MHS Avg**	**NPIC Avg**		**MHS Avg**	**NPIC Avg**		**MHS Avg**	**NPIC Avg**	
Inpatient Quality Indicator (IQI) 33 Low-Risk Cesarean Birth Rate	14.6%	18.4%	●	14.8%	18.4%	●	13.6%	17.9%	●	13.8%	18.2%	●	14.4%	18.7%	●
Postpartum Hemorrhage Rate	3.1%	3.5%	●	3.6%	3.7%	●	2.9%	3.9%	●	3.6%	4.0%	●	3.6%	4.2%	●
Severe Maternal Morbidity Overall Rate	1.9%	UNK	●	1.9%	2.2%	●	2.0%	2.2%	●	1.7%	2.2%	●	2.5%	2.3%	●
Maternal Readmit Rate to Delivery Hospital	1.3%	0.8%	●	1.7%	0.9%	●	1.6%	1.2%	●	2.0%	1.0%	●	1.5%	1.1%	●
Total Neonates	10,432			10,123			11,306			9,742			9,945		
Neonatal Outcome Measures	**MHS Avg**	**NPIC Avg**		**MHS Avg**	**NPIC Avg**		**MHS Avg**	**NPIC Avg**		**MHS Avg**	**NPIC Avg**		**MHS Avg**	**NPIC Avg**	
Total Unexpected Newborn Complications (UNC) Rate	No data available[a]						4.2%	3.0%	●	5.1%	3.3%	●	4.8%	3.1%	●
Inborn Readmit Rate to Delivery Hospital	4.3%	1.3%	●	3.1%	1.1%	●	3.6%	1.1%	●	4.3%	1.1%	●	4.4%	1.1%	●
Inborn Mortality ≥2,000 Grams (Per 1,000 births)	0.77	0.66	●	0.26	0.47	●	0.56	0.57	●	0.32	0.55	●	0.22	0.54	●

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

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

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

NUMBER OF MTF NPIC MEASURE OUTLIERS, CY 2017 Q4 & CY 2018 Q1

NPIC MEASURE OUTLIER	ARMY	NAVY	AIR FORCE	NCR
Severe Maternal Morbidity Overall Rate	0	0	0	0
Total UNC Rate	2	2	0	0
Maternal Readmit Rate to Delivery Hospital	2	1	0	0
Inborn Readmit Rate to Delivery Hospital	7	5	4	2

Source: DHA/Medical Affairs/Clinical Support Division, 1/18/2019

[a] As of CY 2017 Q3, UNC rates are calculated using updated specifications (version 2.4, 2018-03-28). As a result, previous quarters are no longer displayed.

RED indicates the number of Service-aligned MTFs that performed worse (higher) than the NPIC/QAS rate for the two consecutive quarters shown (CY 2017 Q4 and CY 2018 Q1).

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

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

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

Postpartum Hemorrhage (based on American College of Obstetricians and Gynecologists and the members of the Women's Health Registry Alliance standardized definition). The MHS average continues to be lower than the NPIC benchmark. The MHS continues to focus its attention on postpartum hemorrhage 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 (SMM) to align with national concerns in the multiple conditions that can impact a mother's health during pregnancy and delivery. The MHS average is below the SMM overall rate.

Maternal and Infant Readmission to Delivery Hospital: Occurs within 30–42 days of delivery; related to delivery process. Metrics continue to exceed NPIC benchmarks. The most prominent readmission diagnosis is hypertension (40 percent) for mother and jaundice (43 percent) for newborn. The primary readmission diagnosis is consistent with NPIC, but the volume is higher in the MHS; likely related to readmissions to help families without local support or with a deployed spouse.

UNC includes and represents a more comprehensive rate of newborn complications, while including the measures of birth injury/trauma. The MHS rate of total birth trauma is within the NPIC benchmark for the last three quarters. Continued work is being done to decrease the rate of UNC for the categories of respiratory distress followed by infection, transfer to another hospital, neurologic/birth injury, shock/resuscitation, and lastly, by longer length of stay.

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

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

Behavioral Health Clinical Community

Developing the Behavioral Health High-Reliability Operating Model

The Behavioral Health Clinical Community (BHCC) was chartered under DHA Healthcare Operations on November 8, 2017 and meets weekly. The BHCC Chair and other voting members are Directors of Psychological Health from Army, Air Force, Navy, and the National Capital Region (NCR); 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.

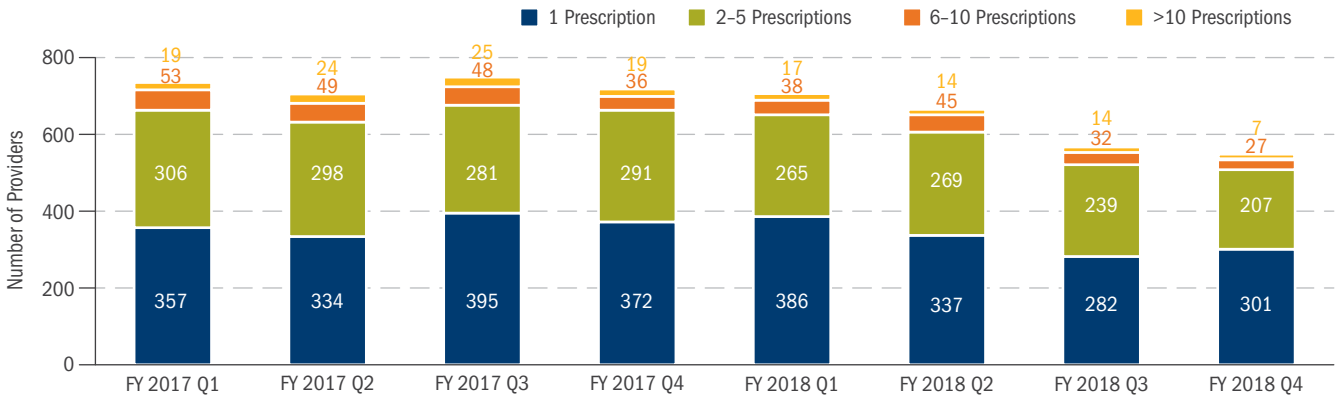
To attain its objectives, BHCC established working relationships with persons and entities with the following types of enabling expertise: analytics, change management, clinical informatics, education and training, health information technology, process improvement, quality, and patient safety. Strategic 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 three priorities and has made the following progress:

1. **Behavioral Health Treatment and Outcomes Monitoring:** The NDAA FY 2016 section 729 and the 2013 Assistant Secretary of Defense Memo (Military Treatment Facility Mental Health Clinical Outcomes Guidance) required DoD to collect behavioral health treatment specific outcome measurements, and assess behavioral health outcomes, variations, and barriers to VA/DoD Clinical Practice Guidelines. DHA published Defense Health Agency Procedural Instruction (DHA-PI 6490.01), "Behavioral Health Treatment and Outcomes Monitoring." DHA-PI 6490.01 sets outcomes monitoring requirements in specialty care behavioral health, substance use disorder, and primary care clinics at military medical treatment facilities.

   DHA-PI 6490.15 includes three types of metrics that are required for collection, reporting, and analyzing: structure (i.e., equipment and training compliance), process (i.e., treatment dosage rate, evidence-based treatment rates), and clinical outcome metrics (i.e., improvement and/or remission in Major Depressive Disorder and Posttraumatic Stress Disorder [PTSD]). The main tool for collecting and reporting these data is the Behavioral Health Data Portal (BHDP), which is described below. These metrics are currently under BHCC review with an anticipated publication of data in spring 2019. Next year's report will include these outcome metrics.
2. **BHDP Implementation:** An enterprise-wide web application that enables standardized behavioral health assessments and outcome tracking in behavioral health clinics. Use of BHDP allows for real-time graphing of outcomes measures for clinical care, consolidation of data from multiple sources into one clinician dashboard, and aggregation of data for meaningful program evaluation.
3. **PTSD Prescriber Tool:** NDAA FY 2017, section 745 required DoD to implement a process to monitor MTF prescribing practices of pharmaceutical agents that are discouraged from use under the VA/DoD Clinical Practice Guideline for the Management of PTSD and Acute Stress Disorder (e.g., benzodiazepines). BHCC developed a PTSD Prescriber Profile that identifies, on a quarterly basis, individual providers who write a high number of benzodiazepine prescriptions to patients with PTSD. The number of providers prescribing benzodiazepines and the overall number of benzodiazepine prescriptions to patients with PTSD declined every quarter in FY 2018 (see charts below).

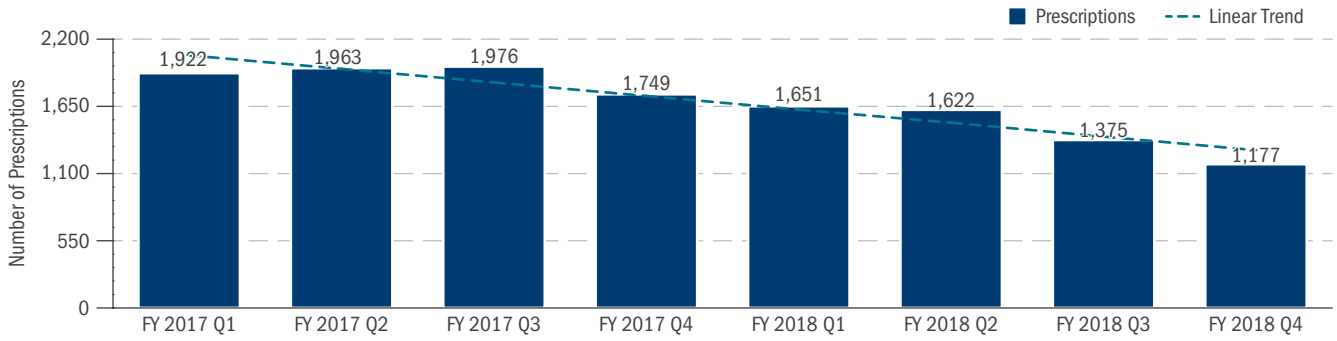
NUMBER OF PROVIDERS PRESCRIBING BENZODIAZEPINES TO BENEFICIARIES DIAGNOSED WITH PTSD, FYs 2017–2018



Source: DHA/Medical Affairs/Clinical Support Division, 1/14/2019

Behavioral Health Clinical Community *(cont.)*

NUMBER OF PRESCRIPTIONS FOR BENZODIAZEPINES TO BENEFICIARIES DIAGNOSED WITH PTSD, FYs 2017–2018



Source: DHA/Medical Affairs/Clinical Support Division, 1/14/2019

Behavioral Health Update: Availability of Mental Health and Substance Use Disorder Services for Eligible TRICARE Beneficiaries

Given the tremendous growth in DoD mental health (MH) staffing since early FY 2002, the current level of MH resourcing continues to be adequate to serve all Active Duty and eligible Reserve Component (RC) members and their families, as well as retirees and their dependents. This care is typically available through MTFs and clinics (direct care), and is supplemented by care provided through networks of civilian providers (purchased care).

On September 2, 2016, the DoD published the *Final Rule: TRICARE; Mental Health and Substance Use Disorder Treatment*, which contained comprehensive revisions to the TRICARE regulation to reduce administrative barriers to accessing MH benefit coverage and to improve access to substance use disorder (SUD) treatment for all TRICARE beneficiaries. The expanded benefit is relatively new and is currently maturing in network development and beneficiary usage. Mental health and SUD intensive outpatient program (IOP) visits quadrupled from FY 2016 to FY 2017. This reflects the implementation of the new IOP benefit and the creation and expansion of the IOP network. SUD Partial Hospitalization Program (PHP) visits increased by 17 percent in FY 2017 and MH PHP visits increased by 5 percent. Also noteworthy is the 66-percent expansion of the child and adolescent Residential Treatment Center (RTC) network.

The overall MH and SUD cost expenditure, including pharmacy, increased by 8 percent for FY 2017. The largest increases were for outpatient care (12 percent) and other levels of care (21 percent), especially psychiatric RTCs for children and adolescents and IOPs. SUD treatment only made up 13 percent of the nonpharmacy cost for MH services, but it is growing at a faster pace than MH care.

For FY 2017, 70 percent of the more than 8 million outpatient mental health visits occurred in purchased care and 30 percent occurred in the direct care system. For inpatient MH services, approximately 77 percent of inpatient stays occurred in purchased care and 23 percent in direct care. To deliver MH care, the military Services use a range of strategies, including telehealth, embedding MH providers within units, and integrating MH providers in primary care.

In direct care, MH stays increased from FY 2016 to FY 2017 by 6 percent, while purchased care inpatient utilization remained almost constant. Similarly, inpatient direct care SUD stays increased by 8 percent from FY 2016 to FY 2017, while inpatient purchased care stays remained almost constant. In comparison, there was an increase in outpatient mental health (excluding applied behavior analysis [ABA] services) and SUD encounters in purchased care from FY 2016 to FY 2017 (4 percent for mental health, 8 percent for SUD). The increase in purchased care was mostly due to non-Active Duty dependents (NADDs) (7 percent increase in mental health, 11 percent increase in SUD). ADSM outpatient encounters for SUD increased 54 percent from FY 2016 to FY 2017, from about 341,000 visits to 524,000 visits. Most of this increase (85 percent) is due to increased treatment for alcohol-related disorders. This increase is almost entirely attributed to a 60-percent increase in the number of ADSMs who received outpatient alcohol-related disorder care in the MTF (from 16,479 users to 26,349). This increase in utilization of outpatient treatment for alcohol-use disorder by ADSMs may signal a reduction in stigma for seeking treatment.

Encounters and costs for the treatment of opioid use disorder have increased since FY 2016 for nearly all types of therapy besides inpatient. Encounters for psychotherapy and opioid treatment programs in purchased care increased by 50 percent from FY 2016 to FY 2017, while PHP and medication-assisted treatment (MAT) increased at slower rates of 11 percent and 3 percent, respectively. IOPs have increased from an extremely low level in FY 2016 to over 900 visits so far in FY 2018. In FY 2018 to date (through the first three quarters), all of these measures besides PHP are on pace to increase from their volumes in FY 2017. In direct care, encounters for psychotherapy increased by 44 percent from FY 2016 to FY 2017 but appear to be decreasing so far in FY 2018.

Behavioral Health Clinical Community *(cont.)*

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

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

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

In June 2014, TRICARE published the Comprehensive Autism Care Demonstration (ACD) Notice in the *Federal Register* on the approval of the Office of Management and Budget, and in compliance with the regulations that govern TRICARE demonstrations. Based on limited demonstration authority, in July 2014, the ACD consolidated the three previous programs into a single program for eligible TRICARE beneficiaries. This consolidated demonstration will ensure consistent ABA coverage for all TRICARE beneficiaries—including Active Duty family members (ADFMs) and non-ADFMs diagnosed with ASD. ABA services are not limited by the beneficiary's age, the dollar amount spent, or the number of services provided, and there are no annual caps of government cost shares. These changes attempt to strike a balance that maximizes access while ensuring the highest level of quality care for our beneficiaries. The most recent full-year fiscal data available, FY 2017, show that the total ABA services program expenditures were $268 million. ABA services are not provided at MTFs, but rather through the ACD in the purchased care system. However, two installations, Fort Belvoir and Joint Base Lewis–McChord, have developed two distinct programs that function as a resource to those beneficiaries diagnosed with ASD, and their families, who are enrolled at the MTF. At Fort Belvoir Community Hospital, the Autism Resource Center provides a resource in which parents and caregivers can participate in a monthly meeting where the family can obtain information from other clinics, TRICARE, public schools, local support resources, and other nonmedical services. At Madigan Army Medical Center, the Center for Autism Resources, Education, and Services (C.A.R.E.S.) program offers a multidisciplinary clinic as a resource of services for beneficiaries newly diagnosed with ASD and their families until services through the purchased care system become available. The ACD, which began on July 25, 2014, has been extended and will run through December 31, 2023.

As evidenced in our previous reports, participation in the ACD by beneficiaries and ABA providers is growing. By the end of FY 2017, 14,015 beneficiaries participating in the ACD had filed claims.

In summation, the DoD has implemented a robust benefit that serves all eligible TRICARE beneficiaries diagnosed with ASD and their families. Unlike many civilian insurance plans, the TRICARE benefit has no limits on medically necessary hours of ABA services or cost per beneficiary. In addition, other services such as occupational therapy and speech and language therapy are available to beneficiaries with ASD. Our managed care support contractors continue to recruit new providers to expand the network. The TRICARE benefit is one of the best in the nation and that is especially true since ABA providers never have to collect a copayment, deductible, or any other payment from Active Duty families, who have 100 percent coverage. Retirees have nominal out-of-pocket costs and are protected by the catastrophic cap.

Child and Adolescent Mental Health and Substance Use Disorder Treatment

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

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

TRICARE has a robust MH/SUD provider network across the continuum of MH/SUD care to meet the needs of the approximately 2.25 million pediatric beneficiaries. In FY 2016, 10,798 pediatric beneficiaries received inpatient MH/SUD treatment, 1,706 received psychiatric residential treatment center care, and 59 received SUD rehabilitation facility care. Over 30,000 providers delivered MH and SUD outpatient treatment to over 40,000 pediatric beneficiaries in DC and PC. Further, 68,994 pediatric beneficiaries received 578,005 psychotropic medication prescriptions under the pharmacy benefit. This does not include pediatric beneficiaries who received care from developmental pediatricians or neurologists for the diagnosis and treatment of a developmental disorder or those diagnosed with ASD who received ABA under the ACD, which is discussed separately.

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

Dental Clinical Community (DCC)

The MHS-level Dental Clinical Community (DCC) was newly established in October 2018 and enables frontline clinicians to drive MHS-wide performance improvements in readiness and health, empowers the DCC to create conditions for high reliability at the point of care (processes, standards, metrics), and holds the DCC accountable to MHS standards and clinical outcomes. This Clinical Community provides leadership to the patient-centered, clinician-led dental networks that span all Service components, environments, and care impacting areas from the headquarters through MTFs. It is guided by the Quadruple Aim, HRO Domains of Change, and HRO Principles, and is the primary mechanism for improving patient outcomes and embedding learning and safety culture about dental-related clinical practices across the MHS global integrated delivery system. The DCC will pay particular attention to the patient's experience in navigating care throughout the spectrum of austere military operations, direct care, and purchased care.

The DCC milestones for FYs 2018 and 2019 include the following actions:

- The dental subject matter experts (SMEs) began teamwork relationships and have received monthly training in HRO models, key process analysis, and the MHS requirements submission portal.
- August: Clinical SME nominations by the military Services, NCR, and DHA were presented to the MHS Enterprise Solutions Board (ESB), and gained endorsement as voting and nonvoting members.
- November: A DCC governance charter, accepted by the Clinical Community Advisory Council (CCAC), moves to the Deputy ESB (DESB) in December, then to the ESB in January 2019. A DHA mentor was nominated for appointment and endorsement by the governance structure.
- Future: A DCC operations plan, dental priorities, and dental process improvement plan are ongoing milestones in development for endorsement by MHS governance.

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

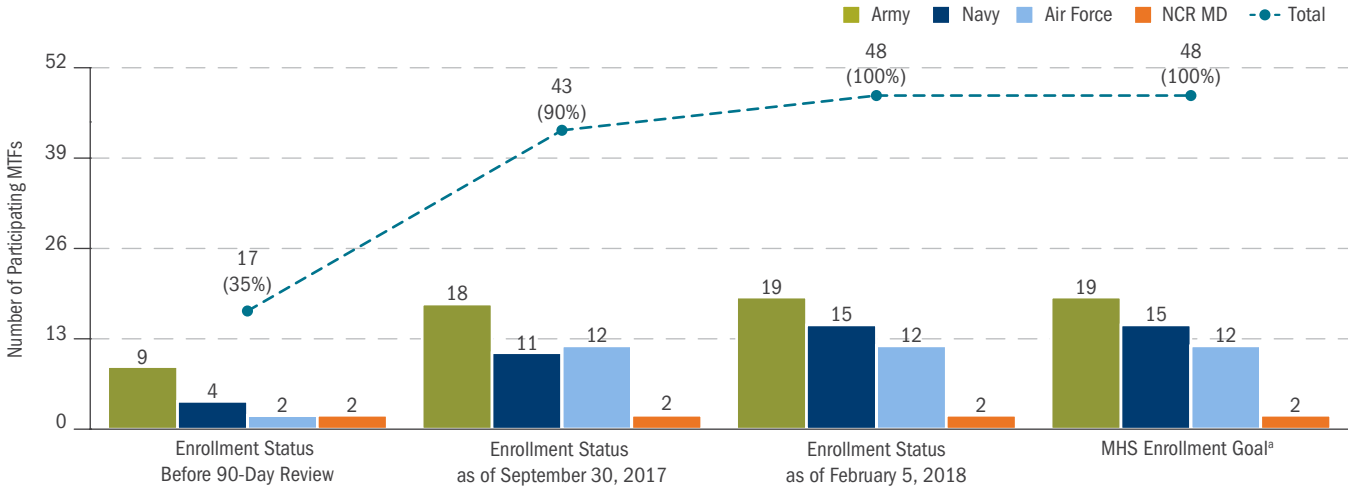
Ongoing Quality Initiatives (Potential Clinical Community): Surgical Services

Surgical Services across the system focus on providing quality surgical care to our beneficiaries. The MHS monitors the quality of surgical care through the ongoing assessment of process, outcome, and experience of care data. This data is used to focus improvement initiatives and drive desired outcomes.

NSQIP Quality Outcomes

The MHS continuously monitors surgical outcomes through morbidity and mortality data from the American College of Surgeons (ACS) NSQIP. In February 2018, the MHS completed its NSQIP expansion goal of 100 percent participation from all MTFs providing inpatient surgery across the enterprise. The number of MTFs participating in the program has increased almost threefold from an enrollment of 17 MTFs before the 90-day review to 48 MTFs as of February 5, 2018 (shown on graph below). The total number of inpatient MTFs participating in NSQIP will decrease to 46 by the end of FY 2018 with the transition of two hospitals to ambulatory care sites.

MTF NSQIP ENROLLMENT STATUS (UPDATED FEBRUARY 5, 2018)



Source: DHA/Medical Affairs/Clinical Support Division, 11/28/2018

[a] MHS Enrollment Status: 100 percent of MTFs are now enrolled in NSQIP.

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

Focused Quality Initiatives

The 2017 mortality data indicated that all MTFs reporting data met the expected performance level, including one facility that exceeded the expected performance. The morbidity data indicated that of the 40 sites reporting data for CY 2017, 26 MTFs met expected performance levels while eight were exemplary. Six MTFs were in the "needs improvement" category, which enables the hospitals to recognize, identify, and dive deeper to improve the quality of their surgical care (see below table).

MTF MORTALITY AND MORBIDITY PERFORMANCE, CYs 2014-2017

			CY 2014		CY 2015		CY 2016		CY 2017	
			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/Clinical Support Division, 11/28/2018
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.)*

Overall, the most recent DoD collaborative report summary indicates that the MHS surgical performance meets or exceeds performance standards relative to the NSQIP population reference rate (708 hospitals participate in the ACS NSQIP adult program). One area of "needs improvement" noted in the DoD collaborative report is All Cases Return to Operating Room (ROR). The NSQIP Steering Panel is currently addressing this issue and developing strategies to improve performance.

DOD COLLABORATIVE JULY 2018 SUMMARY (SURGERY DATES JANUARY 1, 2017, TO DECEMBER 31, 2017)

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	40,370	57	0.14%	0.64%	0.47%	0.83%	Low	0.64	0.99%
All Cases Morbidity	40,370	947	2.35%	5.59%	5.24%	5.95%	Low	0.91	6.12%
All Cases Cardiac	40,370	48	0.12%	0.44%	0.31%	0.59%	Low	0.70	0.63%
All Cases Pneumonia	40,362	78	0.19%	0.65%	0.49%	0.82%	Low	0.66	0.97%
All Cases Unplanned Intubation	40,367	46	0.11%	0.46%	0.32%	0.62%	Low	0.64	0.72%
All Cases Ventilator >48 Hours	40,361	49	0.12%	0.56%	0.41%	0.73%	Low	0.74	0.76%
All Cases VTE	40,370	146	0.36%	0.77%	0.65%	0.90%		0.94	0.82%
All Cases Renal Failure	40,363	38	0.09%	0.34%	0.24%	0.47%		0.73	0.47%
All Cases UTI	40,308	249	0.62%	1.12%	0.99%	1.26%		1.05	1.06%
All Cases SSI	40,227	431	1.07%	2.23%	2.01%	2.45%	Low	0.87	2.55%
All Cases Sepsis	40,307	100	0.25%	0.76%	0.61%	0.93%	Low	0.78	0.97%
All Cases C. Diff Colitis	40,370	36	0.09%	0.27%	0.18%	0.38%		0.72	0.38%
All Cases ROR	40,370	608	1.51%	2.80%	2.61%	3.00%	High	1.19	2.36%
All Cases Readmission	40,370	1,020	2.53%	5.22%	4.92%	5.52%		1.04	5.03%

EXEMPLARY AS EXPECTED NEEDS IMPROVEMENT

Source: American College of Surgeons National Surgical Quality Improvement Program DoD Collaborative Report, released July 2018

[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.

Focused Quality Initiatives *(cont.)*

Surgical Quality Program Expansion

The MHS expanded its surgical quality improvement programs in 2018 to include the ACS NSQIP pediatric program, the ACS Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP), the ACS Trauma Verification, Review, and Consultation (VRC) Program, and the ACS Trauma Quality Improvement Program (TQIP).

The ACS NSQIP pediatric program is the first multispecialty national database to measure pediatric surgical outcomes. Similar to the ACS NSQIP adult program, NSQIP pediatric outcome data are risk-adjusted and case-mix adjusted. The program currently has more than 121 hospitals participating nationwide and gathers more than 100 clinical variables providing invaluable data to identify opportunities for quality improvement. Initial participation in the ACS NSQIP pediatric program focused on three MTFs with the largest pediatric surgical populations. These facilities include San Antonio Military Medical Center, Naval Medical Center Portsmouth, and Naval Medical Center San Diego. Data collection is expected to begin in early 2019.

The ACS MBSAQIP provides a quality improvement and patient safety initiative for patients suffering from severe obesity. Bariatric procedures are considered low-volume, high-risk surgeries. There are 11 MTFs performing bariatric procedures on a regular basis. These surgeries are among the few foregut surgical procedures currently available to surgeons that offer wartime surgical skill experience. Currently, there are two MTFs (William Beaumont Army Medical Center and Madigan Army Medical Center) participating in the program with nine other sites interested in MBSAQIP membership. Data collection started in 2018.

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 (COT) mandated that all trauma centers use a quality improvement program. One membership benefit of TQIP is access to the National Trauma Data Bank (NTDB), a large aggregation of U.S. trauma registry data and a key performance tool of trauma care. In addition, outcome data gathered from participation in TQIP will assist the Joint Trauma System (JTS) Director with the directive to "develop evidence-based best-practice trauma care guidelines for clinical practice and program improvement processes" as directed by the Department of Defense Instructions (DoDI) 6040.47 Joint Trauma System. The ACS currently has more than 450 hospitals participating in their trauma programs.

ACS NSQIP CY 2017 Meritorious Award

The annual ACS Meritorious Award is presented to recognize top-performing hospitals for the quality of surgical care provided to their beneficiaries. This year for the first time there are two lists of meritorious hospitals: the All Cases Meritorious List and the High Risk Meritorious List. Selection is based upon composite quality scores for surgical care provided in CY 2017 in eight All Cases outcome areas: mortality, cardiac (cardiac arrest and myocardial infarction), pneumonia, unplanned intubation, ventilator >48 hours, renal failure, urinary tract infection, and surgical site infections. The MTFs below were recognized by the ACS NSQIP as meritorious hospitals for CY 2017:

All Cases Meritorious List:

- David Grant Medical Center (third year in a row)
- Naval Medical Center Portsmouth
- Naval Hospital Jacksonville
- Carl R. Darnall Army Medical Center

High Risk Meritorious List:

- David Grant Medical Center
- Naval Medical Center Portsmouth

These sites are among the 83 facilities representing the top 10 percent of all NSQIP-participating hospitals worldwide in 2017.

Focused Quality Initiatives *(cont.)*

Surgical Care Performance

The ACS NSQIP continues to be the cornerstone for surgical quality improvement in the MHS. It sets the standard for identifying, evaluating, and improving surgical outcomes. The DoD collaborative unites surgical subject matter experts 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.

The National Clinical Quality Database

In the MHS action plan for Access, Quality of Care, and Patent Safety Memorandum dated October 1, 2014, and signed by the Secretary of Defense, the DHA was directed to establish an MHS performance management system. The goal is to drive systemwide improvement 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 seven clinical quality databases:

- National Surgical Quality Improvement Program (adult)
- National Perinatal Information Center Data Base
- National Healthcare Safety Network
- Hospital Compare
- Ambulatory Surgical Center Quality Reporting Program
- Targeted Solutions Tool
- Joint Commission National Hospital Measure

The 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

Medical Management

The DHA is dedicated to improving the health of all MHS beneficiaries. In support of this mission, ongoing efforts to promote an integrated and evidence-based approach to improve care are underway, aiming to optimize and encourage proactive patient engagement. These initiatives include improved collaboration and documentation with patient-centered medical home teams. Combined, these efforts support improved care team communication and the comprehensive coordination necessary to support beneficiary care requirements.

MHS Medical Management (MM) programs continue to integrate the use of enhanced predictive analytics. Specifically, dedicated patient registries created using direct care and purchased care resource utilization are analyzed against the Johns Hopkins Adjusted Clinical Groups® (ACG®) System. Information is then readily available to MM teams on the MHS CarePoint site by select conditions. Further, this evidence-based system is able to identify morbidity patterns, which can be leveraged by MTF MM representatives to target specific high-risk populations and dedicated engagement.

Traditionally, MM program requirements have been developed and executed through Service-specific policy. To reduce redundancy, varied program approaches, and fragmentation, efforts are underway to centralize and standardize program policy guidance. Standardized program and dedicated policy guidance for MTFs within the direct care system will serve to promote positive patient engagement, improved care management, continuity of care, and enhanced care team collaboration.

HIGH-RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Pain Management

During FY 2018, MHS continued to mature the pain management capabilities and resources for our beneficiaries and health care workforce. Improved coordination and collaboration across the Services, DHA, and Uniformed Services University of the Health Sciences (USUHS) has resulted in several advances in pain management policy, clinical care, and fielding of innovative education, training products, and clinical tools, including:

- Continued MHS implementation of the Stepped Care Model of Pain Management to ensure the appropriate level of pain care is available and delivered to patients throughout the continuum of acute and chronic pain.
- Continued implementation of pain-related CPGs, as well as continued identification of requirements for updated CPGs by using resources available through the Pain Management Clinical Support Service, Clinical Communities, and VA/DoD HEC Work Groups.
- Increasing pain telehealth integration in NCR primary care by both direct care visits and provider webinar case-based education.
- Continued primary care pain skills training offered annually by the NCR Pain Care Initiative.
- Continued integration of specialty pain care services in primary care and increasing access to specialized pain care in the NCR and the Services.
- Expansion of pilot in-home telehealth visits to transitioning and rural service members and beneficiaries.
- Continued development and deployment of the Pain Assessment Screening Tool and Outcome Registry (PASTOR) to integrate the National Institutes of Health (NIH) Patient Reported Outcomes Measurement Information System (PROMIS) into a pain registry and clinical decision-making tool for providers.
- Continued execution of the Joint Pain Education Project in disseminating a standardized VA/DoD pain management curriculum and supplemental pain videos for widespread use in education and training programs.
- Participation in research efforts offered by DoD, VA, and NIH to examine non-pharmacological treatments to complex pain syndromes experienced by military populations.
- Conducting a pilot study in response to section 746 of the NDAA for FY 2017 to evaluate the feasibility and effectiveness of preventing diversion of opioid medications by dispensing opioids in locking cap vials, and providing education to patients and their family members, with particular consideration for adolescents.
- Conducted a study in response to section 735 of the NDAA for FY 2018 to evaluate the effectiveness of opioid prescriber safety training and assess the necessity for strengthened opioid prescribing initiatives in the MHS.
- Participation in the DHHS Pain Management Best Practices Inter-Agency Task Force.
- Drafting DHA Procedural Instruction (DHA-PI), "Acupuncture Practice in Medical Treatment Facilities," to establish DHA's guidance for implementing tiered acupuncture training, privileging providers in acupuncture, and supporting the clinical practice of acupuncture by designated clinical staff through the DoD Medicine Enterprise.

Pain Management *(cont.)*

DoD continues to track patient satisfaction utilizing the Joint Outpatient Experience Survey (JOES) program. JOES is a single survey for all MTFs across all Services that combines and standardizes long-standing methods used by Army, Navy, Air Force, and NCR to learn about beneficiary health care. As of December 2018, results include:

- **Access to Pain Care:**
  - 98.1 percent out of 455,053 respondents stated that their care was received in person.
  - 95.3 percent out of 410,665 respondents stated that their needs were addressed within 30 minutes of their appointment.
- **Facility:**
  - 92.4 percent out of 457,839 respondents stated they were satisfied with their health care facility.
  - 88.7 percent out of 456,689 respondents stated they were likely to recommend the facility.
- **Patient:**
  - 89.0 percent out of 452,691 respondents felt that they make healthy choices.
  - 89.1 percent out of 452,076 respondents stated that they feel they have influence over their own health.
- **Provider:**
  - 92.2 percent out of 451,507 respondents stated they were satisfied with their provider.
  - 94.7 percent out of 453,237 respondents stated their provider was courteous and respectful.

Beginning in January 2018, two new pain management satisfaction questions were added to the annual Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, which assesses patient satisfaction with inpatient pain management.

- "During this hospital stay, how often did hospital staff talk with you about how much pain you had?"
- "During this hospital stay, how often did hospital staff talk with you about how to treat your pain?"

PATIENT SATISFACTION WITH INPATIENT PAIN MANAGEMENT, JANUARY 2018–SEPTEMBER 2018

MEASURE	SCORE[a]	NUMBER OF RESPONDENTS
Communication About Pain Composite	77.7%	5,643
Discussed Amount of Pain	78.4%	5,648
Talked About Pain Treatment	77.1%	5,637

[a] Score based on number of respondents who responded to the question with an answer of "always."

Preventing Opioid Misuse by Military Service Members

DHA-PI "Pain Management and Opioid Safety in the MHS," published June 8, 2018, establishes DHA's procedures to:

- Establish the MHS Stepped Care Model as the comprehensive standardized pain management model for MHS to provide consistent, quality, and safe care for patients experiencing pain, with an emphasis on non-pharmacological treatments;
- Educate patients in effective self-management of pain and injury rehabilitation;
- Educate clinicians regarding effective pain management and optimal opioid safety consistent with VA/DoD and CDC CPGs;
- Provide tools, including those through MHS GENESIS and legacy electronic health records, to assist clinicians in evidence-based and patient-centered pain management; and,
- Conduct pain research to continuously improve the MHS approach to pain management.

The DHA-PI provides specific guidelines on opioid prescribing for MTF providers, consistent with VA/DoD CPGs, including: acquiring informed consent for patients who require opioids; prescribing less than a five-day supply of short-acting opioids for acute pain episodes and minor procedures in opioid-naïve patients; prescribing less than a 10-day supply of short-acting opioids for major procedures in opioid-naïve patients; providing medication assisted therapy for those with opioid use disorders; and providing naloxone (opioid reversal) for those at higher risk for overdose. It also provides guidance for the TRICARE health plan to partner with managed care support contractors to minimize inappropriate opioid prescribing and conduct value-based pilots of non-pharmacologic pain treatments.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient Centered Care/Experience

Satisfaction with Provider

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

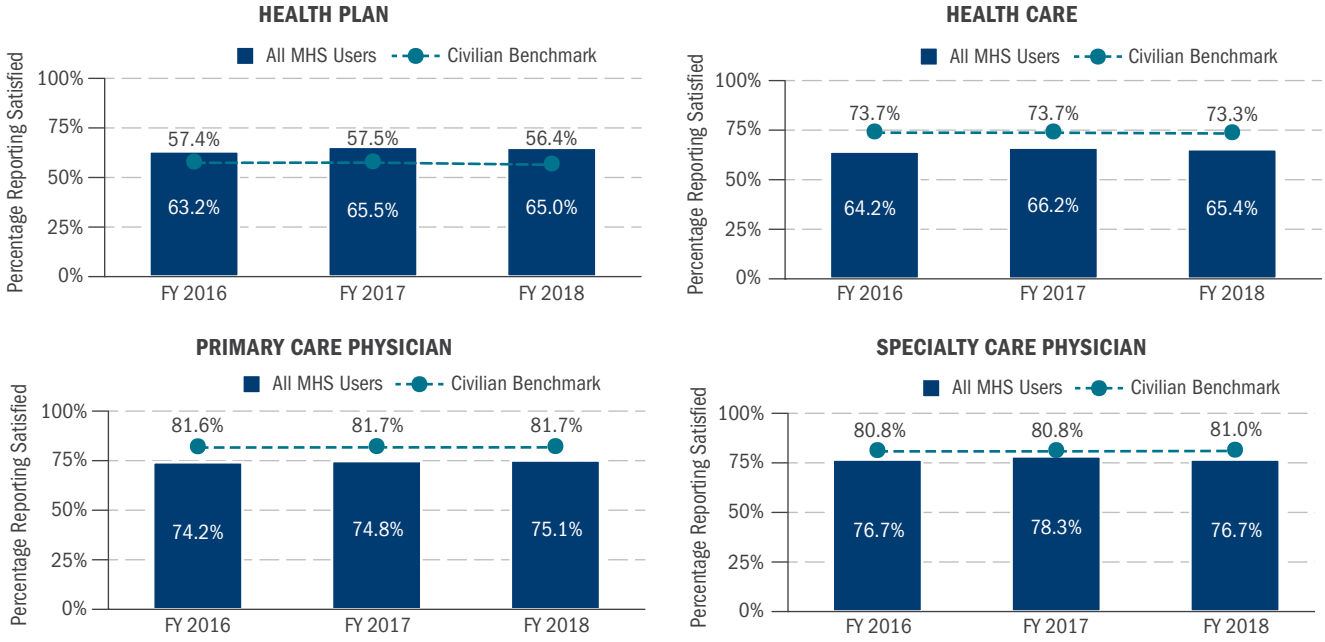
In this section, MHS beneficiaries in the U.S. who have used TRICARE are compared with the civilian benchmark with respect to ratings of (1) the health plan in general; (2) health care; (3) their personal physician; and (4) specialty care. Health plan ratings depend on access to care and how the plan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

Beneficiary Ratings of Their Health Plan through Population-Based Surveys

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

- MHS beneficiary satisfaction with their health plan increased from FY 2016 to FY 2018, whereas the civilian benchmark for that aspect of care declined slightly. There were no significant trends for the remaining aspects of care.
- MHS beneficiary satisfaction with their health plan exceeded that of the civilian benchmark in each year between FY 2016 and FY 2018. However, MHS beneficiary satisfaction with health care quality and with primary and specialty care physicians was lower than the comparable civilian benchmarks.

TRENDS IN SATISFACTION RATINGS OF KEY HEALTH PLAN ASPECTS, FYs 2016–2018



Note: DoD data were derived from the FYs 2016–2018 Health Care Survey of DoD Beneficiaries (HCSDB), as of 11/15/2018, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the National Committee for Quality Assurance (NCQA) by commercial plans. Benchmarks used in 2016 and 2017 come from NCQA's 2015 data, while the benchmarks used in 2018 come from NCQA's 2017 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

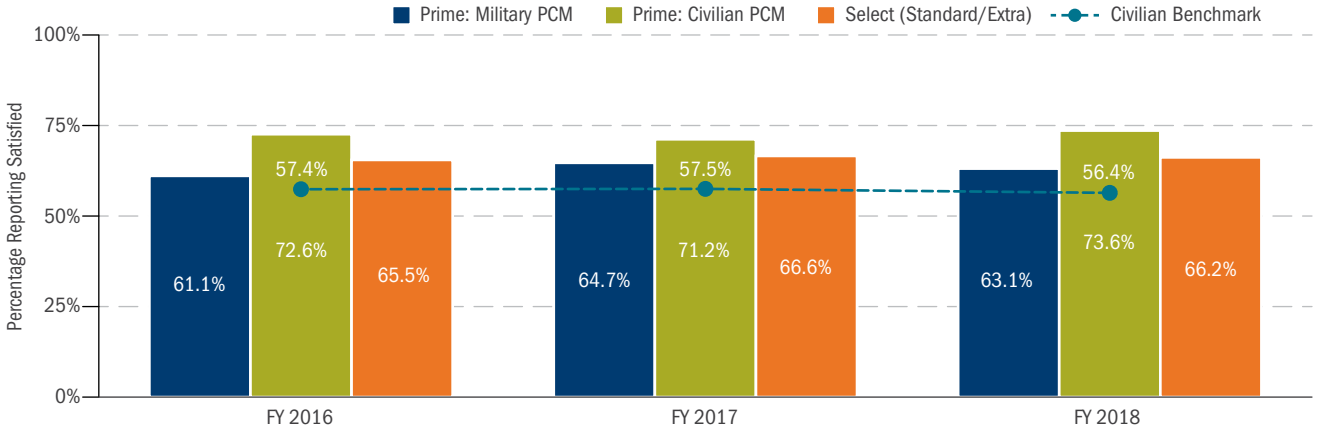
Patient Centered Care/Experience *(cont.)*

Beneficiary Ratings of Their Health Plan Based on Enrollment Status

Most DoD health care beneficiaries participate in TRICARE in one of two ways: by enrolling in the Prime option or by using the traditional indemnity option for seeing participating or network providers (TRICARE Standard/Extra in FYs 2016–2017 or TRICARE Select in FY 2018). Satisfaction levels with one's health plan across the TRICARE options are compared with commercial plan counterparts.

- Satisfaction with the TRICARE health plan increased from FY 2016 to FY 2018 for Prime enrollees with a military PCM and remained stable for those with a civilian PCM and for non-enrollees.
- For each year between FY 2016 and FY 2018, all MHS enrollment groups reported higher levels of satisfaction with their health plan than did their civilian counterparts.

TRENDS IN SATISFACTION WITH THE HEALTH PLAN BY ENROLLMENT STATUS, FYs 2016–2018

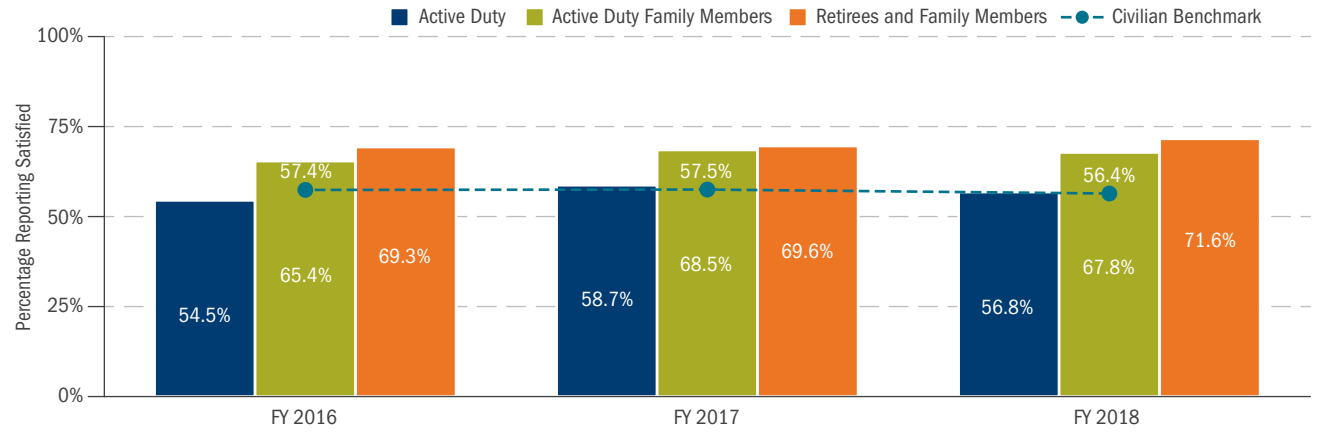


Beneficiary Ratings of Their Health Plan Based on Beneficiary Category

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

- Satisfaction with the TRICARE health plan remained stable from FY 2016 to FY 2018 for all beneficiary groups. The corresponding civilian benchmark declined slightly over the same time period.
- Active Duty satisfaction was lower than the civilian benchmark in FY 2016 but caught up to the benchmark in FYs 2017 and 2018. However, satisfaction levels for ADFMs and RETFMs were higher than the civilian benchmark in each year from FY 2016 to FY 2018.

TRENDS IN SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY, FYs 2016–2018



Note: DoD data were derived from the FYs 2016–2018 Health Care Survey of DoD Beneficiaries (HCSDB), as of 11/15/2018, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the National Committee for Quality Assurance (NCQA) by commercial plans. Benchmarks used in 2016 and 2017 come from NCQA's 2015 data, while the benchmarks used in 2018 come from NCQA's 2017 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

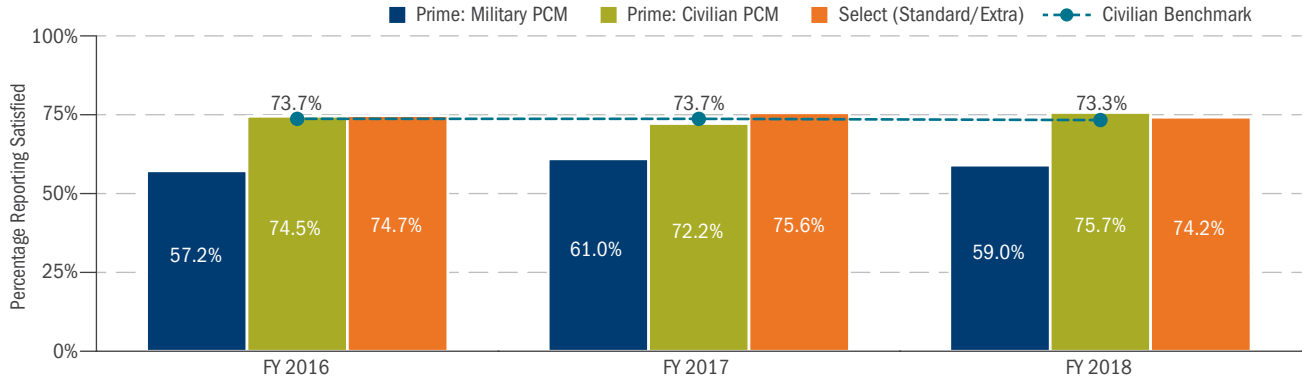
Patient Centered Care/Experience *(cont.)*

Beneficiary Ratings of Satisfaction with Health Care by Enrollment Status and Beneficiary Category

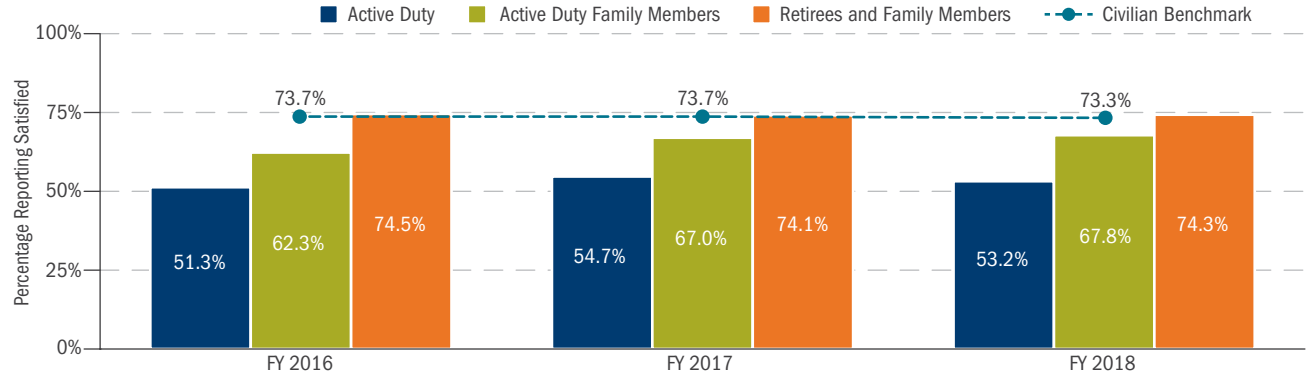
Similar to satisfaction with the TRICARE health plan, satisfaction levels with the health care received differ by beneficiary category and enrollment status.

- Beneficiary satisfaction with their health care remained stable between FY 2016 and FY 2018 for all enrollment groups. The civilian benchmark was also stable over the same time period.
- Satisfaction with health care for beneficiaries with a military PCM was significantly lower than the civilian benchmark in each year between FY 2016 and FY 2018. Satisfaction levels for the other enrollment groups were about the same as the civilian benchmark.
- Beneficiary satisfaction with their health care increased substantially for ADFMs between FY 2016 and FY 2018 but remained about the same for the other beneficiary groups. The civilian benchmark was also stable over the same time period.
- Satisfaction with health care for Active Duty and ADFMs was well below the civilian benchmarks for each year between FY 2016 and FY 2018. Satisfaction for RETFMs was about the same as the civilian benchmark.

TRENDS IN SATISFACTION WITH TRICARE HEALTH CARE BY ENROLLMENT STATUS, FYs 2016–2018



TRENDS IN SATISFACTION WITH TRICARE HEALTH CARE BY BENEFICIARY CATEGORY, FYs 2016–2018



Note: DoD data were derived from the FYs 2016–2018 Health Care Survey of DoD Beneficiaries (HCSDB), as of 11/15/2018, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the National Committee for Quality Assurance (NCQA) by commercial plans. Benchmarks used in 2016 and 2017 come from NCQA's 2015 data, while the benchmarks used in 2018 come from NCQA's 2017 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient Centered Care/Experience *(cont.)*

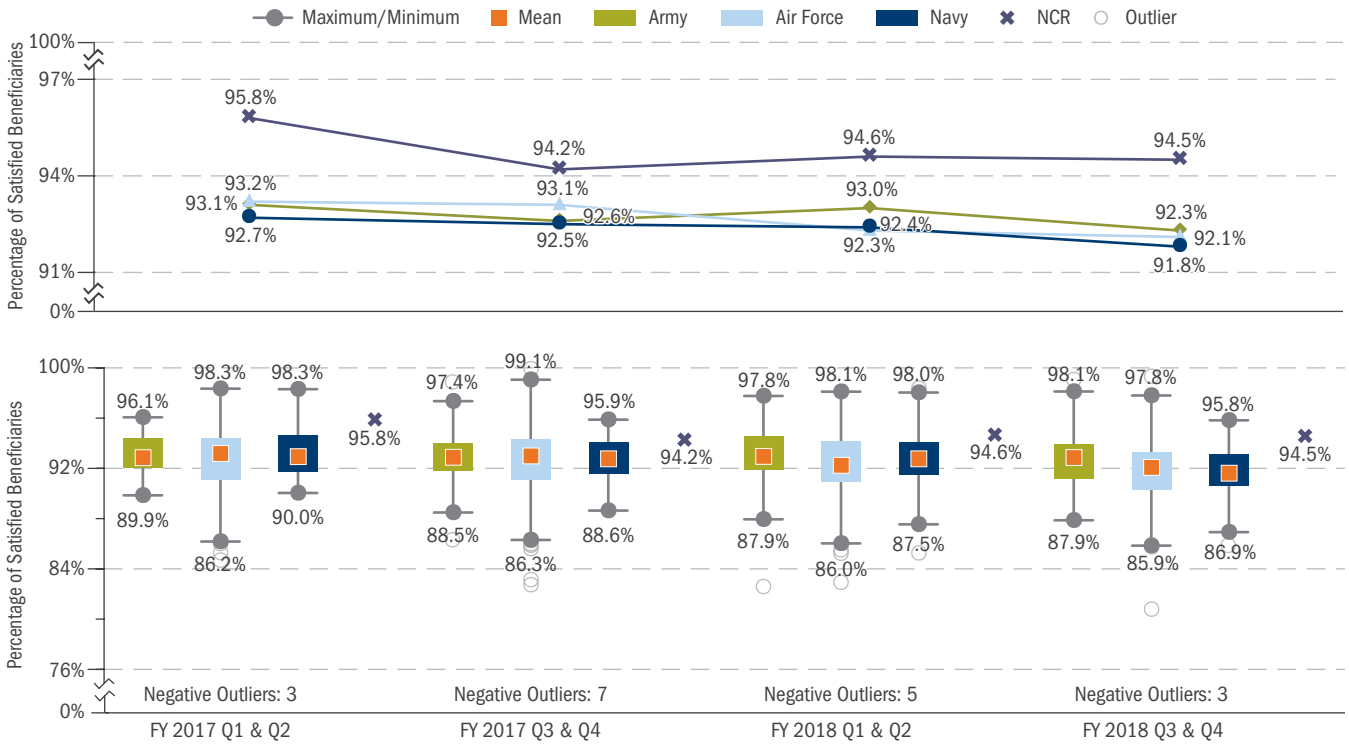
Beneficiary Ratings of Satisfaction with Care Following Outpatient Treatment

As of FY 2017, the JOES and the JOES-C measure various aspects of the patient experience with MHS care. Some aspects that the beneficiary reports on include: his/her experience with the pharmacy, laboratory, or radiology department (JOES); the communication of the receptionists and providers (JOES, JOES-C); how care was received (JOES); and if the provider knew and communicated information about the beneficiary's medical history and prescription medicines (JOES, JOES-C). During and prior to FY 2016, similar aspects were captured in Service-specific surveys and in TROSS. Additional description on the transition from the Service-specific surveys to JOES, and an example of the convergence of the results, can be found under "Patient-Centered, Self-Reported Measures" on page 84.

An important item in each of these surveys addresses how the beneficiary feels about his/her episode of care in general. The item asks for the beneficiary's agreement with the following statement: "Overall, I am satisfied with the health care I received on this visit." Drivers of satisfaction with care, or what may lead a beneficiary to respond favorably or negatively to this question, are shown starting on page 151.

Rating of Satisfaction with Care: The scores for each Service are tightly grouped together and above 90 percent—indicating that a large proportion of individuals are "Somewhat Satisfied" or "Very Satisfied" with the care that they received. There has been little change in these scores over time. The dispersion of the scores, as displayed with the box and whisker plot, also shows limited dispersion of the parent facility scores—scores generally range between 85 percent to 100 percent, regardless of the time period or Service. There are three to seven negative outliers, illustrated as hollow circles, indicating that respondents scored these facilities lower than what would be expected in the MHS. Additional description of the box and whisker plot creation can be found under "Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care" on page 86. JOES is not fielded to beneficiaries using purchased care, so purchased care results are not available for display below.

JOES SATISFACTION WITH CARE, FYs 2017–2018



Source: DHA/SP&FI (J-5)/Decision Support, JOES, weighted data, compiled 12/3/2018

Notes:

– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration.
– The box shows the IQR (25th to 75th percentiles) with the Service score (weighted mean) highlighted.
– Length of the whiskers are at 1.5 times the IQR or the maximum/minimum value.
– Parent facility scores were used above, and those reporting fewer than 25 responses within the time period were excluded from analyses.
– Parent facilities Fort Belvoir and Walter Reed compose the NCR category, which is represented by the weighted average.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient Centered Care/Experience *(cont.)*

JOES Satisfaction with Care—Variability Over Time

The table below displays the extent to which the ratings of satisfaction with care changed over time in terms of improvement (increasing mean or median) or decreased dispersion (reduced range or IQR).

- From FY 2017 Q1 & Q2 to FY 2018 Q3 & Q4, Army, Air Force, and Navy worsened in terms of the mean and median ratings by approximately one percentage point, meaning that satisfaction slightly decreased.
- Dispersion, meaning variability of scores using the IQR, increased for Army and decreased for Air Force and Navy. All changes were less than one percentage point.
- Dispersion, in terms of the range between the lowest- and highest-performing parent facilities, increased overall from FY 2017 Q1 & Q2 to FY 2018 Q3 & Q4 for Army, Air Force, and Navy, meaning that variation in satisfaction scores increased.

VARIABILITY IN JOES RATINGS: SATISFACTION WITH CARE, FYs 2017–2018

	FY 2017 Q1 & Q2	FY 2017 Q3 & Q4	FY 2018 Q1 & Q2	FY 2018 Q3 & Q4	% POINT CHANGE (FY 2017 Q1 & Q2 TO FY 2018 Q3 & Q4)
ARMY					
Service Score (Mean)	93.1%	92.6%	93.0%	92.3%	-0.8
Median	93.5%	92.8%	93.3%	92.3%	-1.2
75th Percentile (Q3)	94.4%	94.0%	94.6%	94.0%	-0.4
25th Percentile (Q1)	92.1%	91.8%	91.9%	91.2%	-0.9
IQR	2.3%	2.2%	2.7%	2.8%	0.5
Positive Outlier (>)	97.9%	97.3%	98.7%	98.2%	0.3
Negative Outlier (<)	88.7%	88.5%	87.9%	87.0%	-1.7
Maximum	96.1%	98.3%	97.8%	98.9%	2.8
Minimum	89.9%	86.3%	82.5%	87.9%	-2.0
Range	6.2%	12.0%	15.3%	11.1%	4.9
AIR FORCE					
Service Score (Mean)	93.2%	93.1%	92.3%	92.1%	-1.1
Median	92.7%	92.9%	92.4%	91.7%	-1.0
75th Percentile (Q3)	94.4%	94.3%	94.1%	93.3%	-1.1
25th Percentile (Q1)	91.1%	91.1%	90.9%	90.3%	-0.8
IQR	3.3%	3.2%	3.2%	3.0%	-0.3
Positive Outlier (>)	99.4%	99.1%	98.9%	97.8%	-1.6
Negative Outlier (<)	86.2%	86.3%	86.1%	85.8%	-0.4
Maximum	98.3%	100.0%	98.1%	99.0%	0.7
Minimum	84.5%	82.2%	82.8%	80.6%	-3.9
Range	13.8%	17.8%	15.3%	18.3%	4.5
NAVY					
Service Score (Mean)	92.7%	92.5%	92.4%	91.8%	-0.9
Median	93.0%	92.8%	92.7%	92.1%	-0.9
75th Percentile (Q3)	94.7%	94.1%	94.1%	93.1%	-1.6
25th Percentile (Q1)	91.7%	91.5%	91.5%	90.7%	-1.0
IQR	2.9%	2.5%	2.6%	2.5%	-0.4
Positive Outlier (>)	99.1%	97.9%	98.0%	96.9%	-2.2
Negative Outlier (<)	87.4%	87.8%	87.6%	87.0%	-0.4
Maximum	98.3%	95.9%	98.2%	95.8%	-2.5
Minimum	90.0%	88.6%	85.1%	85.7%	-4.3
Range	8.3%	7.2%	13.1%	10.1%	1.8
NCR					
Service Score (Mean)	95.8%	94.2%	94.6%	94.5%	-1.3

Source: DHA/SP&FI (J-5)/Decision Support, JOES, weighted data, compiled 12/3/2018

Notes:

– Parent facility scores were used in the above table and those reporting fewer than 25 responses within the time period were excluded from analyses.

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

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

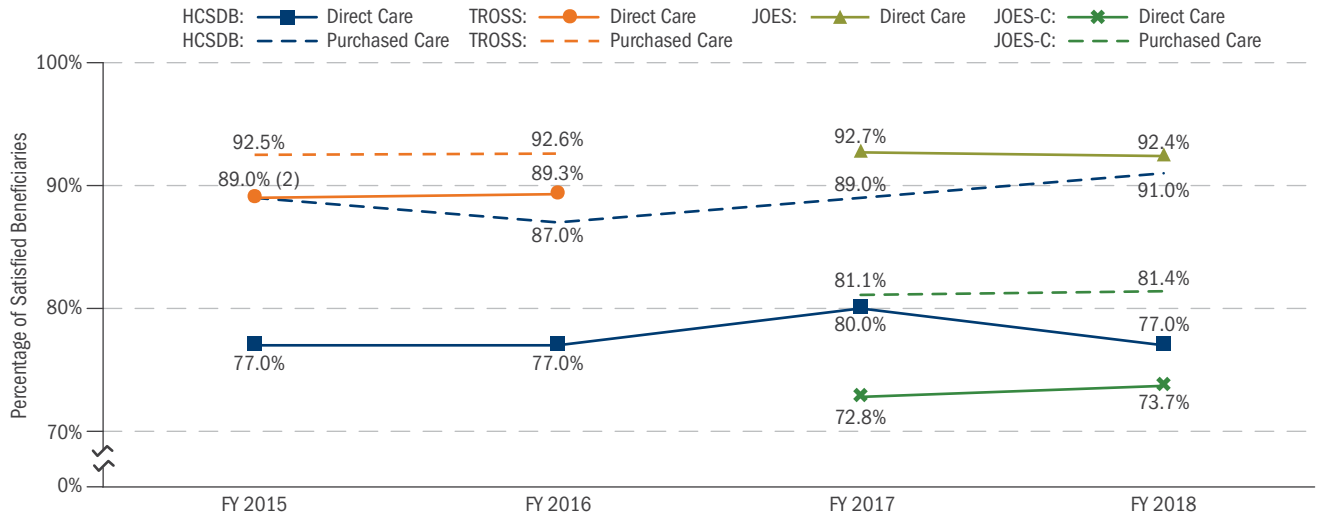
Patient Centered Care/Experience *(cont.)*

DHA Surveys—Satisfaction with Care

In addition to each of the Service surveys and JOES, the population-based HCSDB and JOES-C surveys also report results for the Satisfaction with Care measure. Including this same item in each survey provides important information about the differences between surveys and the beneficiaries who respond to them. A description of the differences between each of the surveys can be found on page 84.

- From FY 2015 to FY 2018, beneficiaries using purchased care reported greater satisfaction with care than those using direct care, regardless of time period. The differences between purchased care and direct care results range from approximately 5 to 15 percent.
- Beneficiaries completing the HCSDB reported greater satisfaction than beneficiaries completing the JOES-C, over time, for direct care and purchased care.
- Trends for Satisfaction with Care are mixed by survey. HCSDB purchased care ratings improved through FY 2018, while direct care ratings varied but ended the same in FY 2018 as began in FY 2015. From FY 2017 to FY 2018, JOES-C direct care ratings improved slightly, while purchased care ratings appear stable.

HCSDB, TROSS, JOES, AND JOES-C RATINGS OF SATISFACTION WITH CARE, FYs 2015–2018



Source: DHA/SP&FI (J-5)/Decision Support, HCSDB, TROSS, and JOES, compiled 12/5/2018

Notes:

– Results for each survey above are weighted to appropriately represent the composition of the MHS population.
– TROSS results for FY 2016 continue from October 2015 to May 2016 for direct care, and from October 2015 to April 2016 for purchased care.
– Results for HCSDB are for Prime enrollees only. "HCSDB Purchased Care" is defined as those who are assigned to an MCSC. "Satisfaction With Care" is worded very similarly in each survey as the following statement: "Overall, I am satisfied with the health care I received on this visit." The five-point scale for this question ranges from "Strongly Disagree" to "Strongly Agree." The results provided above are for those beneficiaries who reported either "Somewhat Agree" or "Strongly Agree."
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration, respective to the JOES and JOES-C surveys.
– For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

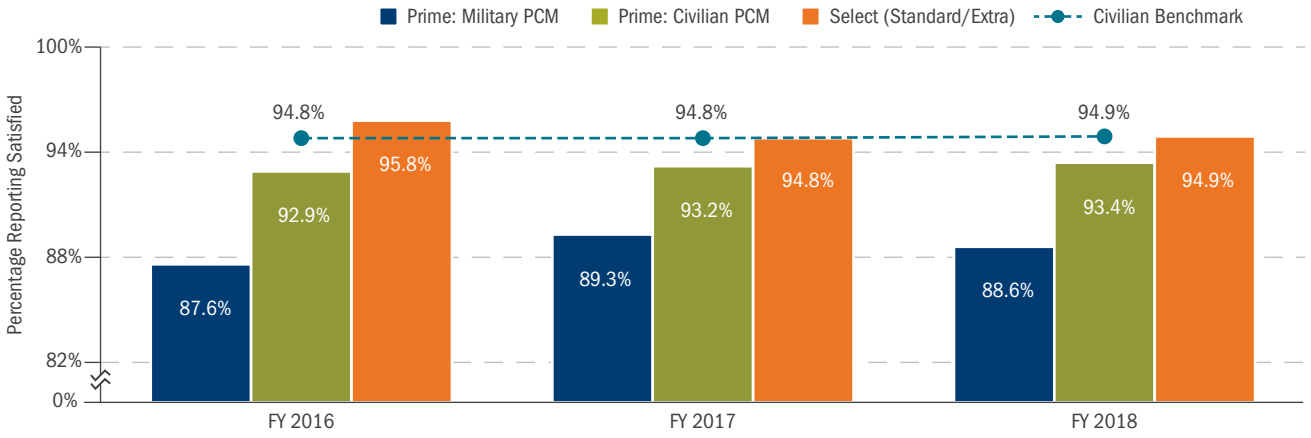
Patient Centered Care/Experience *(cont.)*

Satisfaction with Doctors' Communication

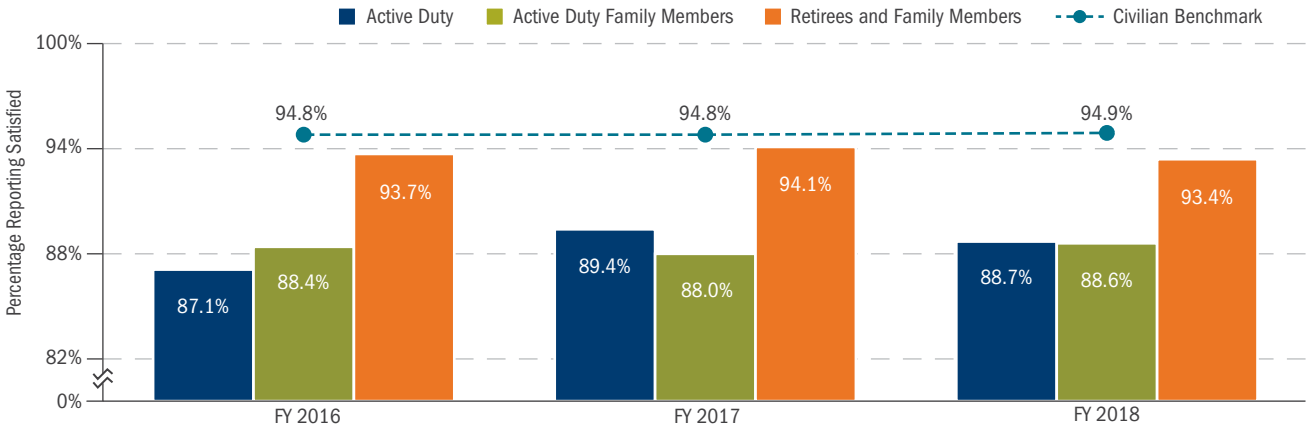
Communication between doctors and patients is an important factor in beneficiaries' satisfaction and their ability to obtain appropriate care. The following charts present beneficiary-reported perceptions of how well their doctor communicates with them.

- Beneficiary satisfaction with their doctors' communication remained stable between FY 2016 and FY 2018, regardless of their enrollment status. The civilian benchmark also remained stable over the same time period.
- For Prime enrollees with a military PCM, satisfaction with their doctors' communication remained below the civilian benchmark for each year between FY 2016 and FY 2018. For the other enrollment groups, satisfaction reached parity with the civilian benchmark by FY 2018.
- Satisfaction with doctors' communication remained stable between FY 2016 and FY 2018 for all beneficiary groups. The civilian benchmark also remained stable over the same time period.
- Satisfaction with doctors' communication was lower than the civilian benchmark for all beneficiary groups, but was closest to the benchmark for retirees and family members (RETFMs).

TRENDS IN SATISFACTION WITH DOCTORS' COMMUNICATION BY ENROLLMENT STATUS, FYs 2016–2018



TRENDS IN SATISFACTION WITH DOCTORS' COMMUNICATION BY BENEFICIARY CATEGORY, FYs 2016–2018



Note: DoD data were derived from the FYs 2016–2018 Health Care Survey of DoD Beneficiaries (HCSDB), as of 11/15/2018, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the National Committee for Quality Assurance (NCQA) by commercial plans. Benchmarks used in 2016 and 2017 come from NCQA's 2015 data, while the benchmarks used in 2018 come from NCQA's 2017 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

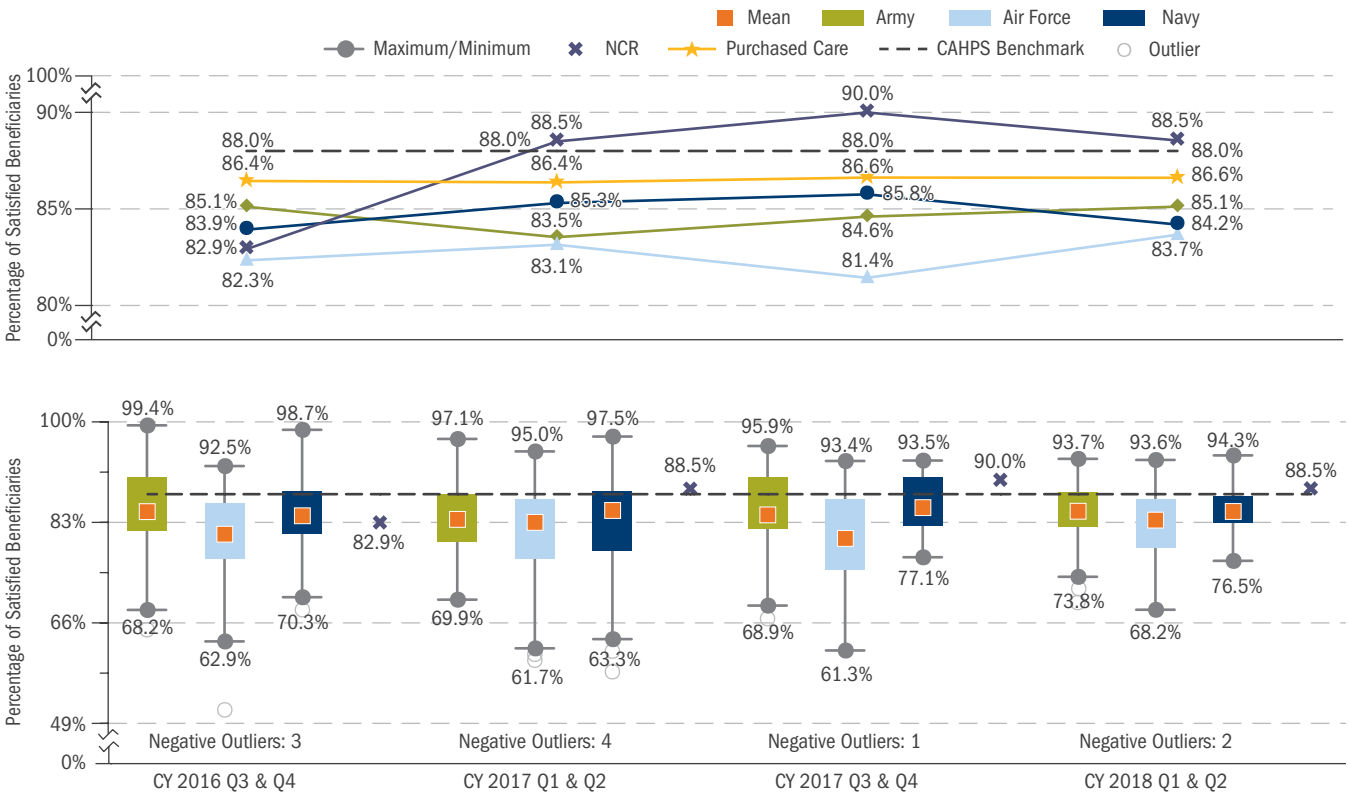
HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient Centered Care/Experience *(cont.)*

As detailed in "Drivers of Patient Experience Ratings" on pages 151–152, communication between the beneficiary and the provider is one of the leading drivers of overall patient satisfaction across care settings, in both outpatient and inpatient care, and is cross-validated by the three core surveys (JOES, JOES-C, and HCSDB). The TRISS, JOES-C, and HCSDB surveys measure provider communication (or doctor and nurse communication) from the beneficiary's perspective, which remains vitally important to quality of care ratings. Some of the questions in these surveys ask: if the provider was understandable, if the provider listened, if the provider was respectful, and if the provider spent enough time with the patient. The results of these questions make up the score for the composite measure Provider Communication. These results can be compared with nationally representative civilian and military benchmarks, and across all levels of the MHS.

- JOES-C was introduced in June 2016 for direct care and May 2017 for purchased care. Results for NCR rose from 2016 to exceed the civilian CAHPS C&G benchmark and MHS target for the past six quarters, while results for Army and Navy varied across time but ended CY 2018 Q1 & Q2 about the same as CY 2016 Q3 & Q4, and Air Force increased by one percentage point over the same period.
- There is a wide variation in the direct care scores, as shown by the box and whisker plot below. Parent facility scores have generally ranged from 60 to 100 percent, with an improvement (reduction) in the dispersion of the scores in CY 2018 Q1 & Q2.

JOES-C PROVIDER COMMUNICATION, CY 2016 Q3 & Q4 TO CY 2018 Q1 & Q2



Source: DHA/SP&FI (J-5)/Decision Support, JOES, weighted data, compiled 11/24/2018

Notes:

– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration.
– The box shows the IQR (25th to 75th percentiles) with the Service score (weighted mean) highlighted.
– Length of the whiskers are at 1.5 times the IQR or the maximum/minimum value.
– Parent facility scores were used above, and those reporting fewer than 25 responses within the time period were excluded from analyses.
– Parent facilities Fort Belvoir and Walter Reed compose the NCR category, which is represented by the weighted average.
– CAHPS benchmarks are the 50th percentiles from the 2015 Adult Survey 3.0, the 2016 Adult 6-Month Survey 3.0 with/without PCMH items, and the 2017 Adult 6-Month Survey 3.0 with/without PCMH items.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient Centered Care/Experience *(cont.)*

The table below displays the extent to which the ratings of the provider communication composite changed over time in terms of improvement (increasing mean or median) or decreased dispersion (reduced range or IQR).

- From CY 2016 Q3 & Q4 to CY 2018 Q1 & Q2, the median score for all Services increased. The Service score, or weighted mean, increased for Air Force and decreased slightly for Navy during the same time period.
- Dispersion, in terms of the IQR, decreased for Army, Air Force, and Navy. This resulted, at least in part, from an improvement in scores in the 25th percentile for each Service.
- Dispersion, in terms of the range between the lowest- and highest-performing parent facilities, decreased significantly from CY 2016 Q3 & Q4 to CY 2018 Q1 & Q2 for Army, Air Force, and Navy. This was largely driven by dramatic improvements in the lowest-performing facilities in each Service.

JOES-C: PROVIDER COMMUNICATION COMPOSITE, CY 2016 Q3 & Q4 TO CY 2018 Q1 & Q2

	CY 2016 Q3 & Q4	CY 2017 Q1 & Q2	CY 2017 Q3 & Q4	CY 2018 Q1 & Q2	% POINT CHANGE (CY 2016 Q3 & Q4 TO CY 2018 Q1 & Q2)
ARMY					
Service Score (Mean)	85.1%	83.5%	84.6%	85.1%	0.0
Median	84.4%	84.6%	87.6%	86.2%	1.8
75th Percentile	90.8%	88.0%	90.8%	88.2%	-2.6
25th Percentile	81.8%	79.9%	82.1%	82.4%	0.6
IQR	9.1%	8.1%	8.8%	5.8%	-3.3
Positive Outlier (>)	100.0%	100.0%	100.0%	96.8%	-3.2
Negative Outlier (<)	68.2%	67.7%	68.9%	73.8%	5.6
Maximum	99.4%	97.1%	95.9%	93.7%	-5.7
Minimum	64.4%	69.9%	66.3%	69.0%	4.6
Range	35.0%	27.2%	29.6%	24.8%	-10.2
AIR FORCE					
Service Score (Mean)	82.3%	83.1%	81.4%	83.7%	1.4
Median	82.1%	84.3%	81.4%	84.0%	1.9
75th Percentile	86.3%	87.0%	87.0%	87.1%	0.8
25th Percentile	76.9%	76.9%	75.1%	78.9%	2.0
IQR	9.4%	10.1%	11.9%	8.2%	-1.2
Positive Outlier (>)	100.0%	100.0%	100.0%	99.4%	-0.6
Negative Outlier (<)	62.9%	61.7%	57.3%	66.6%	3.7
Maximum	92.5%	95.0%	93.4%	93.6%	1.1
Minimum	50.8%	59.2%	61.3%	68.2%	17.4
Range	41.7%	35.8%	32.1%	25.3%	-16.4
NAVY					
Service Score (Mean)	83.9%	85.3%	85.8%	84.2%	-0.3
Median	84.4%	85.7%	86.0%	85.3%	0.9
75th Percentile	88.4%	88.5%	90.8%	87.6%	-0.8
25th Percentile	81.2%	78.4%	82.5%	83.1%	1.9
IQR	7.2%	10.1%	8.3%	4.5%	-2.7
Positive Outlier (>)	99.2%	100.0%	100.0%	94.4%	-4.8
Negative Outlier (<)	70.3%	63.3%	70.1%	76.3%	6.0
Maximum	98.7%	97.5%	93.5%	94.3%	-4.4
Minimum	67.8%	57.3%	77.1%	76.5%	8.7
Range	30.9%	40.2%	16.4%	17.8%	-13.1
NCR					
Service Score (Mean)	82.9%	88.5%	90.0%	88.5%	5.6

Source: DHA/SP&FI (J-5)/Decision Support, JOES, weighted data, compiled 11/24/2018

Notes:

– Parent facility scores were used in the above table and those reporting fewer than 25 responses within the time period were excluded from analyses.

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

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

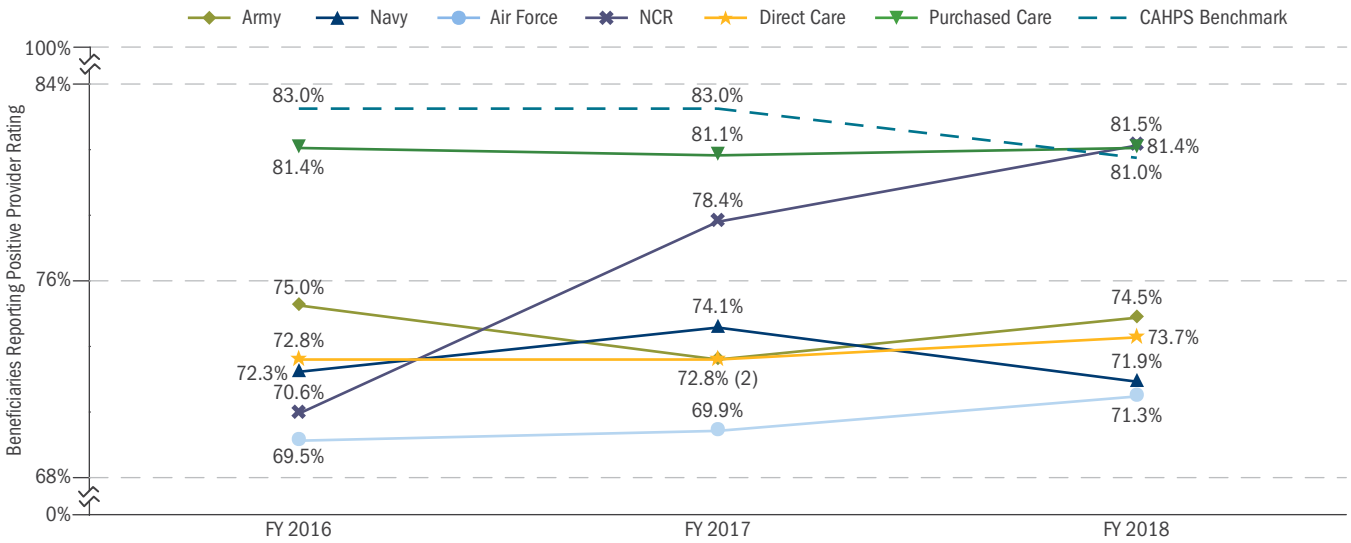
Patient Centered Care/Experience*(cont.)*

Beneficiary Ratings of Provider Following Outpatient Treatment

In the JOES-C, beneficiaries are also asked to provide an overall rating for their provider, based on a scale from zero (worst provider possible) to 10 (best provider possible). The percentages of beneficiaries rating their provider a nine or 10 are provided in the following graph. The results to this question are comparable to civilian results, and the civilian 50th percentile score is used as the CAHPS benchmark in the figure provided below.

- Provider ratings were captured by JOES-C from FY 2016 to FY 2018. The annual aggregated rating from FY 2016 to FY 2018 was fairly stable for the Air Force, Army, and Navy, which saw a change of less than one percentage point. However, provider ratings for NCR increased by over 10 percentage points over this same period.
- Direct and purchased care scores remained relatively steady between FY 2016 and FY 2018.
- The chart below shows that most of the Services are still below the national CAHPS 50th percentile as of FY 2018, with the exception of the purchased care and NCR scores, which are similar to or slightly higher than the benchmark, respectively.

JOES-C RATING OF PROVIDER, FYs 2016–2018



Source: DHA/SP&FI (J-5)/Decision Support, 12/5/2018, TROSS (October 2015–March 2016) and JOES-C (direct care June 2016–June 2018; purchased care May 2016–June 2018), compiled 12/4/2018

Notes:

– The transition from TROSS to JOES-C occurred in FY 2016 Q3.
– Results displayed above were weighted to represent the composition of the MHS population.
– Benchmarks are the 50th percentiles from the 2015 Adult Survey 3.0, the 2016 Adult 6-Month Survey 3.0 with/without PCMH items, and the 2017 Adult 6-Month Survey 3.0 with/without PCMH items.
– FY 2016 JOES-C data include June 2016–September 2016 ratings and FY 2018 data include September 2017–August 2018 ratings.
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration.

Patient Centered Care/Experience *(cont.)*

Beneficiary Ratings of Care Following Inpatient Treatment

TRICARE Inpatient Satisfaction Survey (TRISS). The purpose of the TRISS survey is to monitor and report on the perceptions and experiences of MHS beneficiaries who have been admitted to MTF and civilian hospitals. The survey instrument incorporates the questions developed by the 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, 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 National Quality Forum.

The goal of the HCAHPS initiative is to measure uniformly and report publicly on inpatient care experiences through the use of a standardized survey instrument and data collection methodology. The information derived from the survey can provide feedback to providers and patients, valuable insight for internal quality improvement initiatives, and an assessment of the impact of changes in operating procedures.

Comparison of these data with the results from previous surveys, as well as comparisons to civilian benchmark data, enable the DoD to measure progress in meeting its goals and objectives of high-quality health care. The TRISS compares care across all Services and across venues (i.e., direct MTF-based care and private-sector/purchased care) including inpatient surgical, medical, and obstetric care. The TRISS continues to update and change as new HCAHPS requirements are tested and implemented, and these changes over time have resulted in more reliable measures and higher response rates. Data collected by the TRISS includes but is not limited to:

- Overall rating of hospital and recommendation of hospital to others;
- Nursing care (care, respect, listening, and explanations);
- Physician care (care, respect, listening, and explanations);
- Communication (with nurses and doctors, and regarding medications);
- Responsiveness of staff;
- Communication about pain (recently updated);
- Hospital environment (cleanliness and quietness); and
- Post-discharge (such as written directions for post-discharge care).

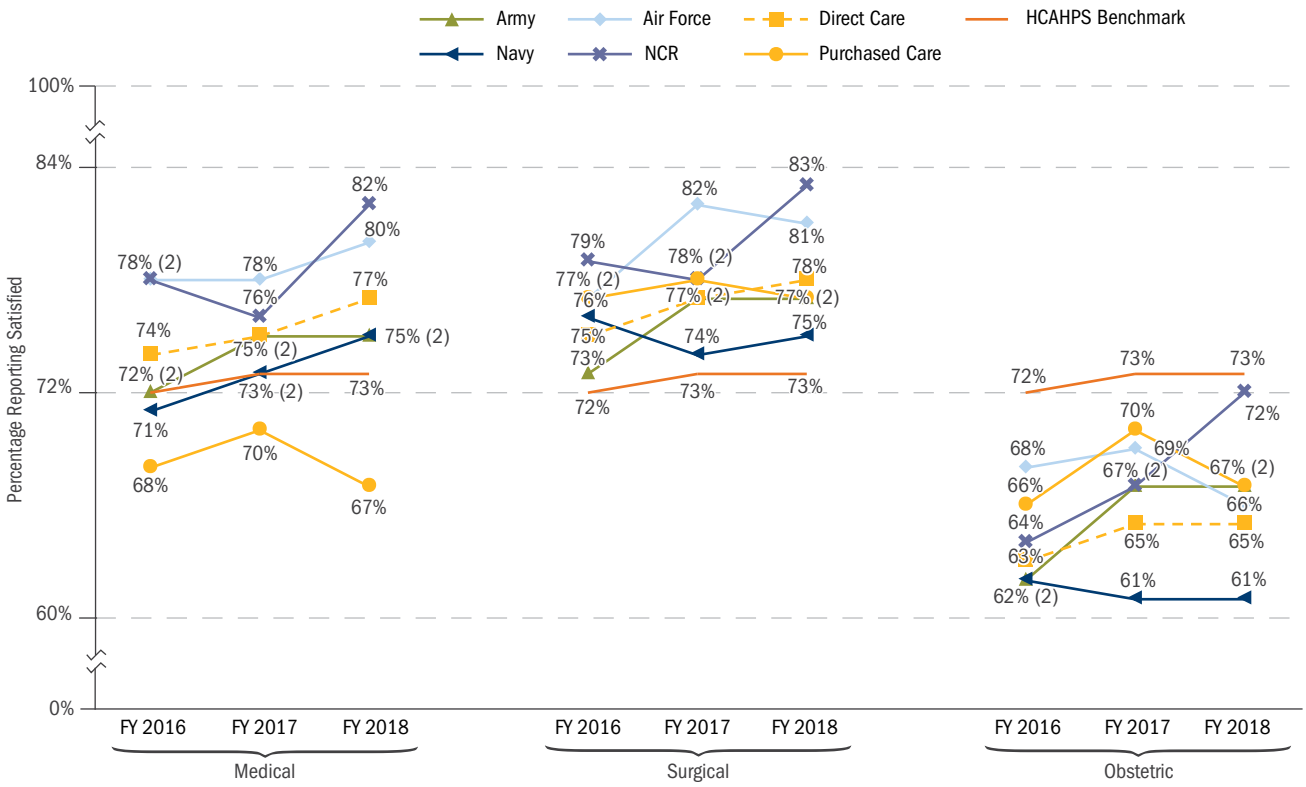
In the following sections, we detail specific findings focused primarily on two measures of patient experience: overall rating of the hospital and willingness to recommend the hospital to others. These results are produced by the DHA J-5 Decision Support Division and do not represent official HCAHPS results. Official HCAHPS results are published on the Hospital Compare website (https://www.medicare.gov/hospitalcompare/).

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient Centered Care/Experience *(cont.)*

Overall Hospital Rating. Overall, direct care has improved patient satisfaction over time in each inpatient product line from FY 2016 to FY 2018. Each of the Services met or exceeded the national HCAHPS benchmark in FY 2018 in the medical and surgical product lines, which continue to see improvement overall. Although the obstetric product line results for all Services and purchased care are below the HCAHPS benchmark, scores have trended upward for NCR significantly, and for Army in FYs 2016–2017, somewhat slowing in FYs 2017–2018.

TRISS OVERALL HOSPITAL RATING TRENDS, FYs 2016–2018



Source: DHA/SP&FI (J-5)/Decision Support, 12/5/2018, TRISS, weighted data

Notes:

– FY 2018 includes results from FY 2018 Q1–Q3 for direct care and the Services.

– HCAHPS benchmarks are the U.S. scores from the October 2015, October 2016, and July 2018 HCAHPS Public Reports. More information about these scores can be found at: http://hcahpsonline.org/en/summary-analyses/.

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

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

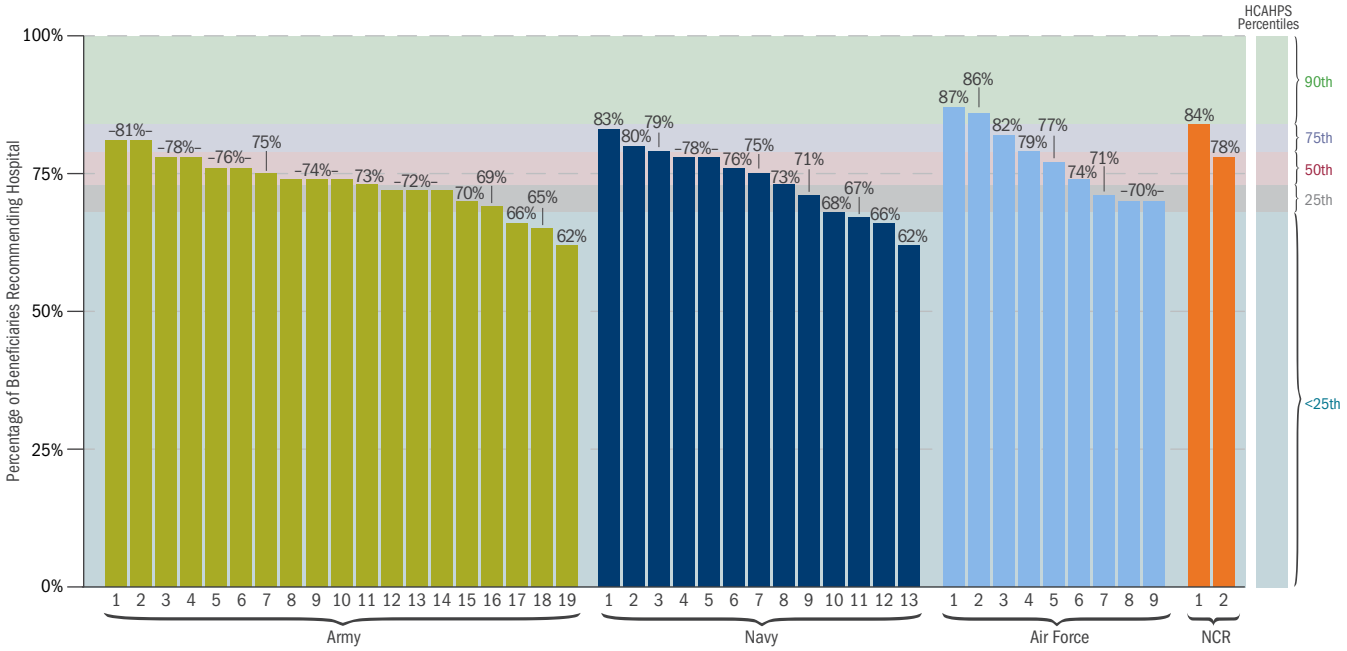
HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient Centered Care/Experience *(cont.)*

The facilities in both TRISS histogram charts have been de-identified within their respective Service. The de-identified labels (e.g., Army 1, Army 2, etc.) in Overall Hospital Ratings correspond with the same facilities in the Recommend Hospital histogram chart on page 147.

The chart below shows the distribution for Overall Hospital Ratings of direct care inpatient facilities, and how they compared with the national HCAHPS percentiles. The facilities with ratings in the HCAHPS 90th percentile were AF-H-31st MEDGRP-Aviano, AF-MC-81st MEDGRP-Keesler, and Ft. Belvoir Community Hospital-FBCH. Seven facilities had ratings in the HCAHPS 75th percentile; 12 facilities had ratings in the HCAHPS 50th percentile. The remaining facilities were below the HCAHPS 50th percentile.

TRISS OVERALL HOSPITAL RATING: DIRECT CARE, FY 2018



Source: DHA/SP&FI (J-5)/Decision Support, 12/5/2017, TRISS, weighted data, compiled 11/16/2018

Notes:

– Facilities that have fewer than 25 responses do not have a score displayed above.

– The increments of the above percentiles were set at <25th, 25th, 50th, 75th, and 90th. Percentiles are based on nationally representative civilian and military facility scores (October 2018 Public Report: January 2017–December 2017 discharges). More information about these percentiles can be found at: http://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 measure of Overall Hospital Rating changed over time in terms of improvement (increasing mean or median) or decreased dispersion (reduced range or IQR).

- From FY 2015 to FY 2018, direct care improved by more than five percentage points in terms of the median and mean ratings—a substantial change over time for an HCAHPS-based survey.
- Dispersion also decreased in terms of the range and IQR from FY 2015 to FY 2018; the range between the lowest- and highest-performing MTFs decreased by eight percentage points from FY 2015 to FY 2018 for direct care.
- Dispersion of purchased care scores has changed minimally from FY 2015 to FY 2018—all changes were less than one percentage point over time. The IQR was lower for direct care than for purchased care in FY 2018, indicating less dispersion of direct care scores than purchased care scores during the time period.

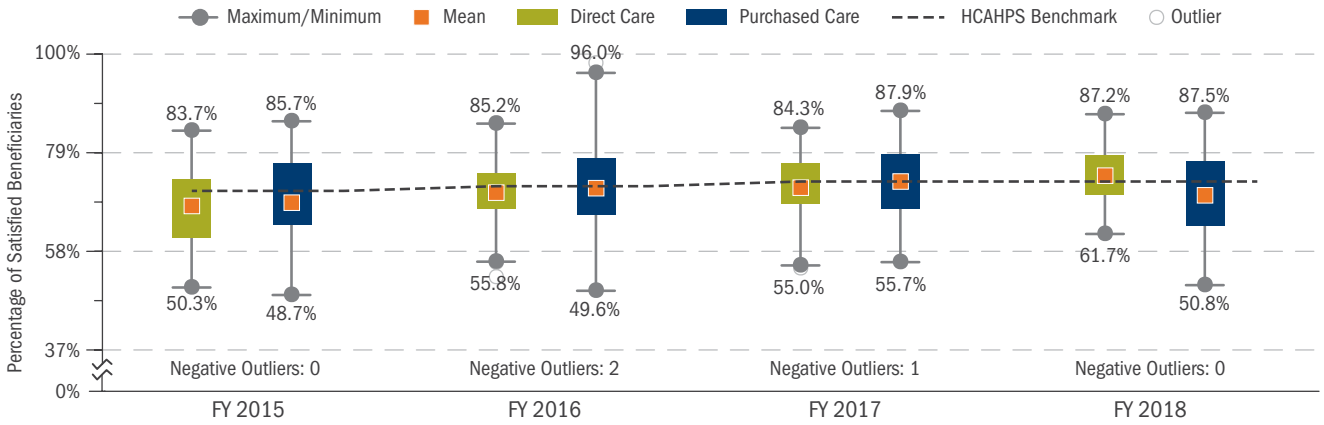
TRISS OVERALL HOSPITAL RATING: FYs 2015–2018

	FY 2015	FY 2016	FY 2017	FY 2018	% POINT CHANGE (FY 2015–FY 2018)
DIRECT CARE					
Weighted Mean	68.2%	70.5%	72.5%	73.6%	5.4
Median	67.8%	71.6%	73.5%	74.1%	6.3
75th Percentile (Q3)	73.4%	74.5%	76.8%	78.5%	5.1
25th Percentile (Q1)	60.9%	67.0%	68.1%	70.0%	9.1
IQR	12.5%	7.5%	8.7%	8.5%	–4.0
Positive Outlier (>)	92.2%	85.8%	89.9%	91.3%	–0.9
Negative Outlier (<)	42.2%	55.8%	55.1%	57.3%	15.1
Maximum	83.7%	85.2%	84.3%	87.2%	3.5
Minimum	50.3%	52.8%	54.6%	61.7%	11.4
Range	33.4%	32.4%	29.7%	25.4%	–8.0
PURCHASED CARE					
Weighted Mean	69.9%	71.4%	73.0%	70.7%	0.8
Median	71.7%	72.6%	72.3%	73.8%	2.1
75th Percentile (Q3)	76.7%	77.8%	78.7%	77.0%	0.2
25th Percentile (Q1)	63.7%	65.7%	67.0%	63.3%	–0.5
IQR	13.0%	12.1%	11.7%	13.7%	0.7
Positive Outlier (>)	96.2%	96.0%	96.2%	97.5%	1.3
Negative Outlier (<)	44.3%	47.5%	49.6%	42.7%	–1.5
Maximum	85.7%	97.7%	87.9%	87.5%	1.8
Minimum	48.7%	49.6%	55.7%	50.8%	2.1
Range	37.0%	48.1%	32.3%	36.7%	–0.3

Source: DHA/SP&FI (J-5)/Decision Support, TRISS, weighted data, compiled 12/3/2018
Notes:
– Inpatient facility scores were used in the table above and those reporting fewer than 25 responses in the time period were excluded from analyses.
– FY 2018 includes results from FY 2018 Q1–Q3 for direct care and FY 2018 Q1–Q2 for purchased care.
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration.

Patient Centered Care/Experience *(cont.)*

VARIABILITY IN TRISS OVERALL HOSPITAL RATINGS, FYs 2015–2018



Source: DHA/SP&FI (J-5)/Decision Support, TRISS, weighted data, compiled 12/3/2018

Notes:

- FY 2018 includes results from FY 2018 Q1–Q3 for direct care and FY 2018 Q1–Q2 for purchased care.
- Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration.
- The box shows the IQR (25th to 75th percentiles) with the direct care or purchased care score highlighted.
- Length of the whiskers are at 1.5 times the IQR or the maximum/minimum value.
- Inpatient facility scores were used in the box and whisker plot above and those reporting fewer than 25 responses within the time period were excluded from analyses.
- HCAHPS benchmarks are U.S. scores from the October 2015, October 2016, October 2017, and July 2018 HCAHPS Public Reports.
- More information about these benchmarks can be found at: http://hcahpsonline.org/en/summary-analyses/.

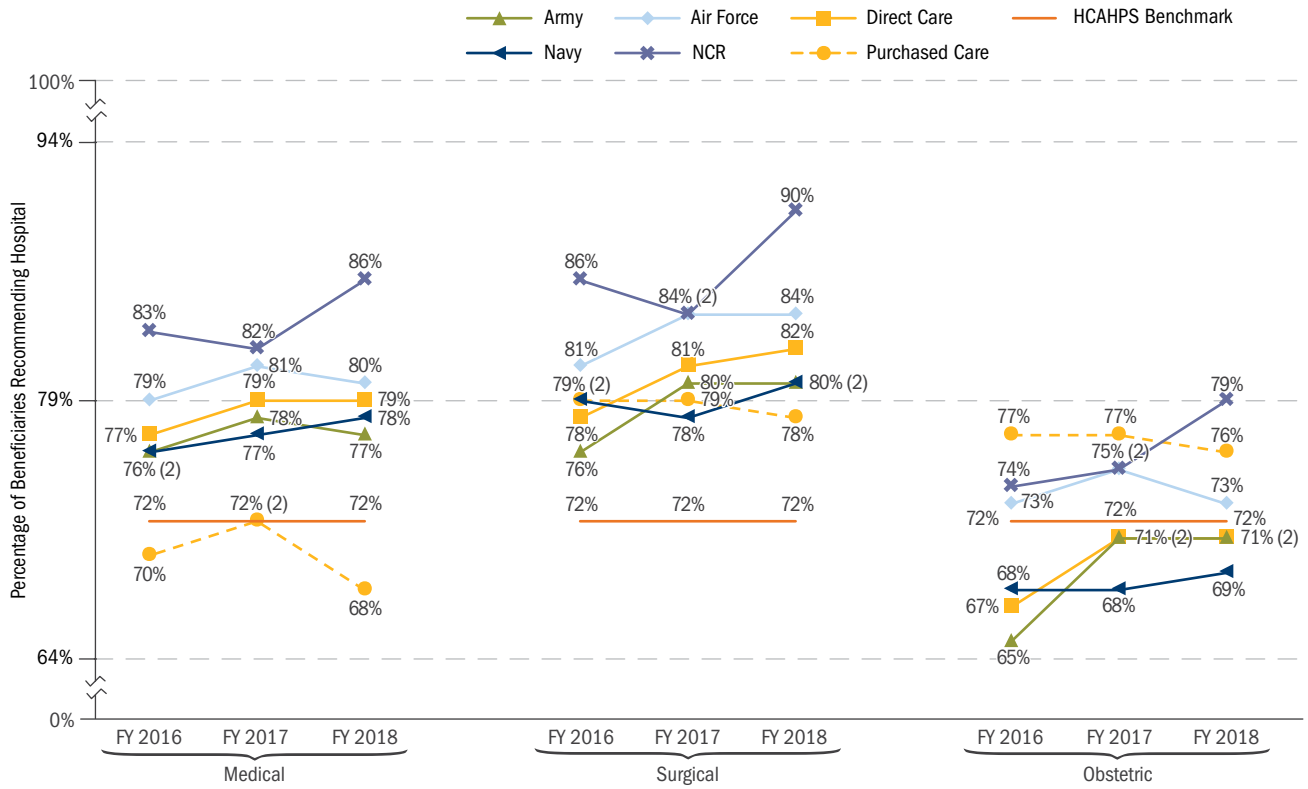
HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient Centered Care/Experience *(cont.)*

Beneficiary Recommendation of Hospital Following Inpatient Treatment

Results for Recommend Hospital follow trends similar to those for Overall Hospital Rating, with overall improvement from FY 2016 to FY 2018. Both the medical and surgical product lines remain above the HCAHPS benchmarks with the exception of purchased care scores for the medical product line, which saw a decrease from FY 2016 to FY 2018. For the obstetric product line, purchased care, Air Force, and NCR scores remain steadily above the benchmark. NCR again demonstrates leadership in patient care ratings, with significant increases through FY 2018. Although obstetric ratings also increased over time for Army and Navy, they remain at or below the benchmark as of FY 2018.

TRISS RECOMMEND HOSPITAL TRENDS, FYs 2016–2018



Source: DHA/SP&FI (J-5)/Decision Support, 12/5/2018, TRISS, weighted data

Notes:

– FY 2018 includes results from FY 2018 Q1–Q3 for direct care and the Services.

– HCAHPS benchmarks are the U.S. scores from the October 2015, October 2016, and July 2018 HCAHPS Public Reports. More information about these scores can be found at: http://hcahpsonline.org/en/summary-analyses/.

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

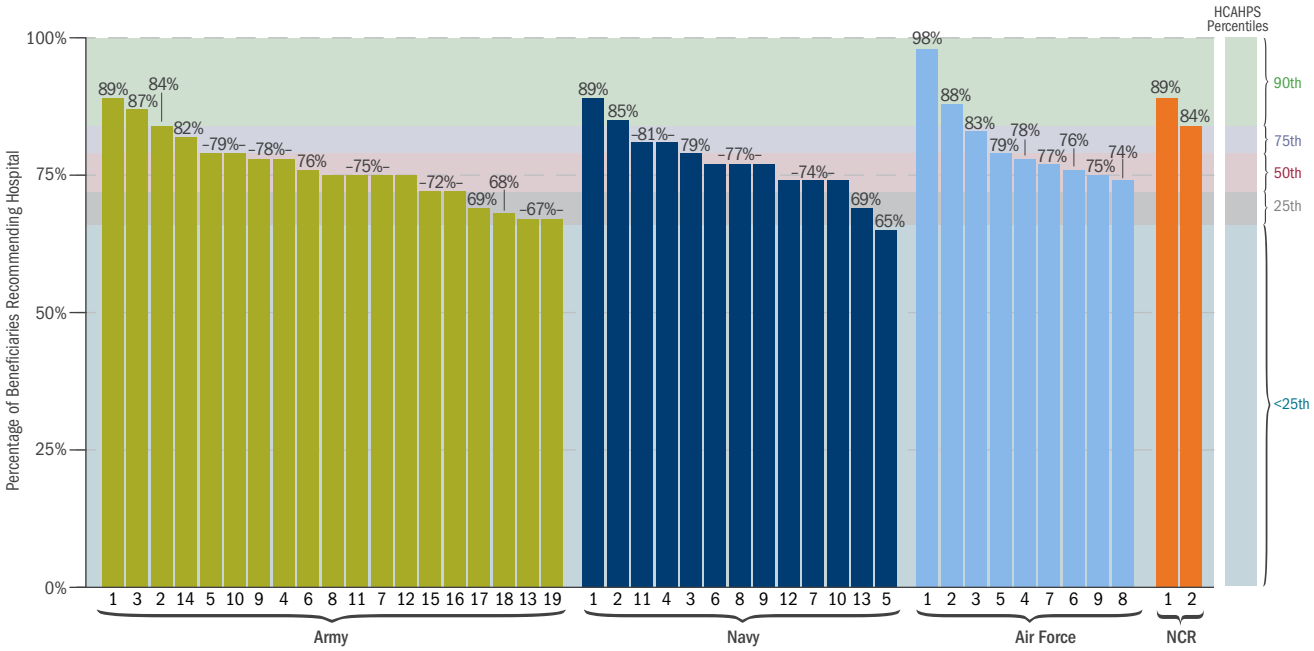
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient Centered Care/Experience *(cont.)*

The chart below shows the distribution for Recommend Hospital of direct care inpatient facilities, and how these ratings compared with the national HCAHPS percentiles. Nine facilities had ratings that reached the HCAHPS 90th percentile: three Army, two Navy, two Air Force, and two NCR. Eight facilities had ratings in the HCAHPS 75th percentile; 18 facilities had ratings in the HCAHPS 50th percentile. The remaining facilities were below the HCAHPS 50th percentile.

TRISS RECOMMEND HOSPITAL: DIRECT CARE, FY 2018



Source: DHA/SP&FI (J-5)/Decision Support, TRISS, weighted data, compiled 11/26/2018

Note:

– FY 2018 includes results from FY 2018 Q1–Q3 for direct care and the Services.
– Facilities that have fewer than 25 responses do not have a score displayed above.
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration.
– The increment of the above percentiles was set at <25th, 25th, 50th, 75th, and 90th. Percentiles are based on nationally representative civilian and military facility scores (October 2018 Public Report: January 2017–December 2017 discharges). More information about these percentiles can be found at: http://hcahpsonline.org/en/summary-analyses/.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient Centered Care/Experience *(cont.)*

The table below displays the extent to which the ratings of Recommend Hospital changed over time in terms of improvement (increasing mean or median) or decreased dispersion (reduced range or IQR).

- From FY 2015 to FY 2018, direct care improved by approximately five percentage points in terms of the median and mean ratings—a substantial change over time for an HCAHPS-based survey.
- The change in the IQR for direct care was as dramatic as the change in the median and mean—there was a five-percentage-point improvement in the 75th percentile and a 10-percentage-point improvement in the 25th percentile.
- There was a slight decrease in the range between the lowest- and highest-performing inpatient facilities for direct care and purchased care.

TRISS RECOMMEND HOSPITAL RATING: FYs 2015–2018

	FY 2015	FY 2016	FY 2017	FY 2018	% POINT CHANGE (FY 2015–FY 2018)
DIRECT CARE					
Weighted Mean	71.9%	74.3%	76.6%	77.5%	5.6
Median	71.8%	75.3%	77.7%	76.8%	5.0
75th Percentile (Q3)	77.5%	81.8%	81.8%	82.5%	5.0
25th Percentile (Q1)	64.0%	68.8%	73.2%	74.1%	10.1
IQR	13.4%	13.0%	8.7%	8.4%	–5.0
Positive Outlier (>)	97.6%	100.0%	94.9%	95.1%	–2.5
Negative Outlier (<)	43.9%	49.3%	60.2%	61.5%	17.6
Maximum	89.8%	89.7%	90.4%	98.0%	8.2
Minimum	55.2%	56.8%	64.4%	65.2%	10.0
Range	34.6%	32.9%	26.0%	32.7%	–1.9
PURCHASED CARE					
Weighted Mean	72.9%	74.6%	75.3%	72.9%	0.0
Median	75.0%	75.8%	76.0%	74.9%	–0.1
75th Percentile (Q3)	80.9%	82.3%	81.6%	80.1%	–0.8
25th Percentile (Q1)	65.9%	68.0%	68.9%	65.2%	–0.7
IQR	15.0%	14.3%	12.7%	14.9%	–0.1
Positive Outlier (>)	100.0%	100.0%	100.0%	100.0%	0.0
Negative Outlier (<)	43.4%	46.6%	49.9%	42.9%	–0.5
Maximum	89.0%	97.2%	88.5%	91.9%	2.9
Minimum	46.2%	48.2%	52.4%	50.5%	4.3
Range	42.8%	49.0%	36.1%	41.4%	–1.4

Source: DHA/SP&FI (J-5)/Decision Support, TRISS, weighted data, compiled 12/3/2018

Notes:

– Inpatient facility scores were used in the table above and those reporting fewer than 25 responses in the time period were excluded from analyses.

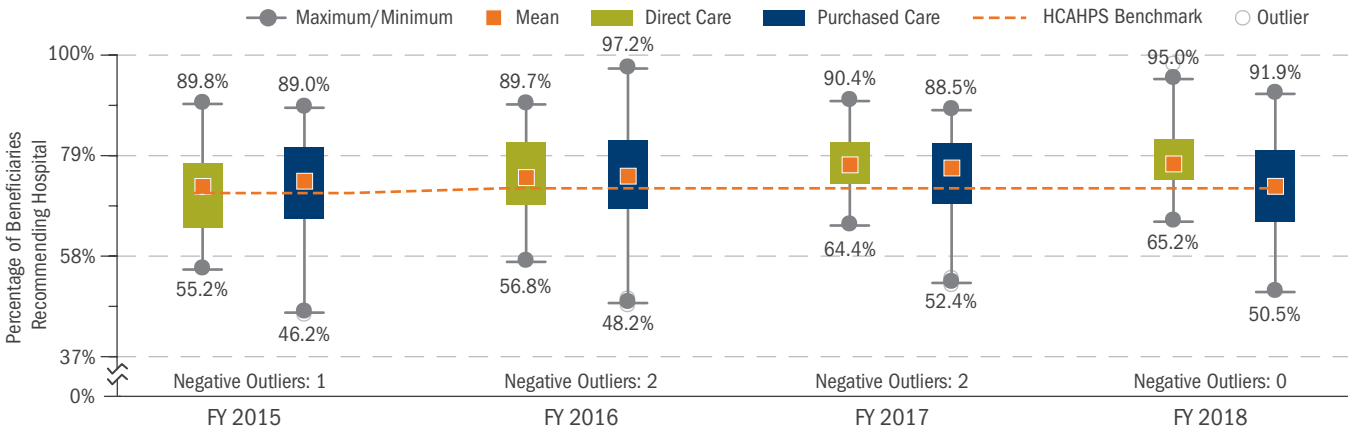
– FY 2018 includes results from FY 2018 Q1–Q3 for direct care and FY 2018 Q1–Q2 for purchased care.

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

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient Centered Care/Experience *(cont.)*

VARIABILITY IN TRISS RECOMMEND HOSPITAL RATINGS, FYs 2015–2018



Source: DHA/SP&FI (J-5)/Decision Support, TRISS, weighted data, compiled 12/3/2018

Notes:

– FY 2018 includes results from FY 2018 Q1–Q3 for direct care and FY 2018 Q1–Q2 for purchased care.
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration.
– The box shows the IQR (25th to 75th percentiles) with the direct care or purchased care score highlighted.
– Length of the whiskers are at 1.5 times the IQR or the maximum/minimum value.
– Inpatient facility scores were used in the box and whisker plot above and those reporting fewer than 25 responses within the time period were excluded from analyses.
– HCAHPS benchmarks are U.S. scores from the October 2015, October 2016, October 2017, and July 2018 HCAHPS Public Reports.
– More information about these benchmarks can be found at: http://hcahpsonline.org/en/summary-analyses/.

Patient Centered Care/Experience *(cont.)*

Patient Experience Star Ratings—Inpatient Facilities

Star ratings are used by CMS to enable consumers to assess patients' experience of care across health care facilities. The summary star rating for patient experience takes into account all 10 publicly reported HCAHPS measures, referenced on page 141, including Overall Hospital Rating and Recommend Hospital as components. Official star ratings for CY 2017, including for military hospitals in the United States, are posted publicly on the CMS Hospital Compare website. The MHS calculates star ratings similarly to the method employed by CMS using the most recently available civilian benchmarks, and these results are published on the TRISS reporting website.

The MHS performed very well as measured by star ratings from FY 2017 Q4 to FY 2018 Q3. Three stars can be considered an "average" patient experience, so most of the MHS facilities are performing above average in terms of patient care, with 30 four-star-rated facilities and one facility rated as five-star.

PATIENT EXPERIENCE STAR RATINGS, FY 2017 Q4–FY 2018 Q3

★★★★★	★★★★	★★★
1 FACILITY	30 FACILITIES	7 FACILITIES

Source: DHA/SP&FI (J-5)/Decision Support, TRISS, weighted data, compiled 11/24/2018
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 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 the care received in determining their overall experience, satisfaction, and ratings of hospital facilities.

As stated previously, three key beneficiary surveys measure self-reported access to and satisfaction with MHS direct and purchased care experiences:

- TRISS—event-based after a discharge from a hospital (based on HCAHPS);
- JOES-C—event-based following an outpatient visit, asking about health care plan rating (based on CAHPS C&G); and
- HCSDB—population-based quarterly survey sampling MHS-eligible beneficiaries who may use the MHS or their own health insurance, asking about care received in the preceding 12 months (based on CAHPS Plan).

Results from these surveys for FYs 2017 and 2018 (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, getting care when needed, and getting care quickly. In addition to the above, use of information to coordinate care and cleanliness of the hospital 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 2017–2018

FISCAL YEAR	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 2017	#1	Communication with Nurses	How Well Providers Communicate with Patients	Provider Communication
	#2	Communication with Doctors	Providers' Use of Information to Coordinate Care	Getting Needed Care
	#3	Cleanliness and Quietness of Hospital Environment	Getting Timely Appointments, Care, and Information	Getting Care Quickly
FY 2018	#1	Communication with Nurses	How Well Providers Communicate with Patients	Provider Communication
	#2	Communication with Doctors	Providers' Use of Information to Coordinate Care	Getting Needed Care
	#3	Cleanliness and Quietness of Hospital Environment	Getting Timely Appointments, Care, and Information	Treatment by Office Staff

Source: DHA/SP&FI (J-5)/Decision Support, TRISS results, compiled 11/22/2018, JOES-C results, compiled 11/9/2018, and HCSDB, FYs 2017–2018 (Q1–Q3 only for TRISS and JOES-C)

Notes:

– Composite measure generation followed guidelines established by the AHRQ.

– TRISS followed HCAHPS composite construction found at: http://www.hcahpsonline.org/

– JOES-C followed CG-CAHPS version 3.0 guidelines detailed at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/cg/about/cg_3-0_overview.pdf

– HCSDB followed CAHPS guidelines provided at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/hp/about/measures_hp50_2109.pdf

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(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 DHA/NCR to learn about beneficiary health care experiences. The JOES aims to more efficiently gather beneficiary health care experiences so that the information obtained can be better used to improve care within and across the Services.

Respondent data from the JOES for FYs 2017 and 2018 (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 2017–2018

FISCAL YEAR	RANKING	SATISFACTION WITH HEALTH CARE	SATISFACTION WITH PROVIDER
FY 2017	#1	Provider Explained Things in a Way That Was Easy to Understand	Provider Knew Important Medical History
	#2	Provider Knew Important Medical History	Provider Explained Things in a Way That Was Easy to Understand
	#3	Ease of Making the Appointment	Provider Treated Patient with Courtesy and Respect
FY 2018	#1	Provider Explained Things in a Way That Was Easy to Understand	Provider Explained Things in a Way That Was Easy to Understand
	#2	Provider Knew Important Medical History	Provider Knew Important Medical History
	#3	Ease of Making the Appointment	Provider Treated Patient with Courtesy and Respect

Source: DHA/SP&FI (J-5)/Decision Support, JOES results, FYs 2017–2018, compiled 10/9/2018
Note: JOES questions continue to be updated over time; drivers analysis was based on the most recent survey questions.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

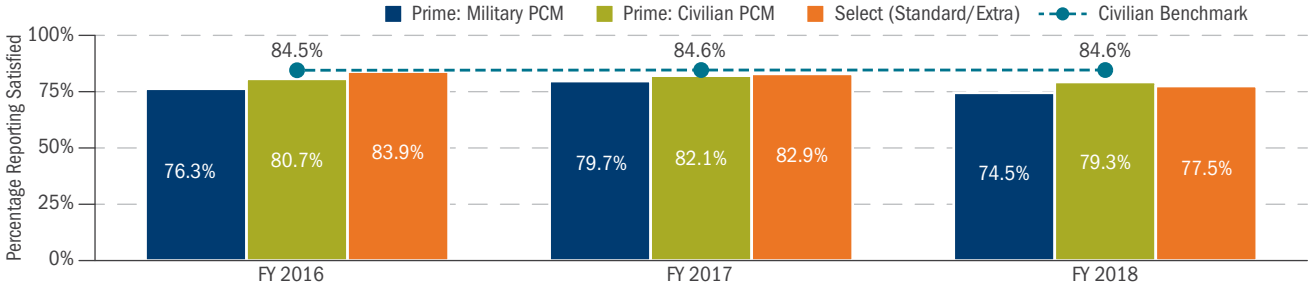
Drivers of Patient Experience Ratings *(cont.)*

Satisfaction with Customer Service

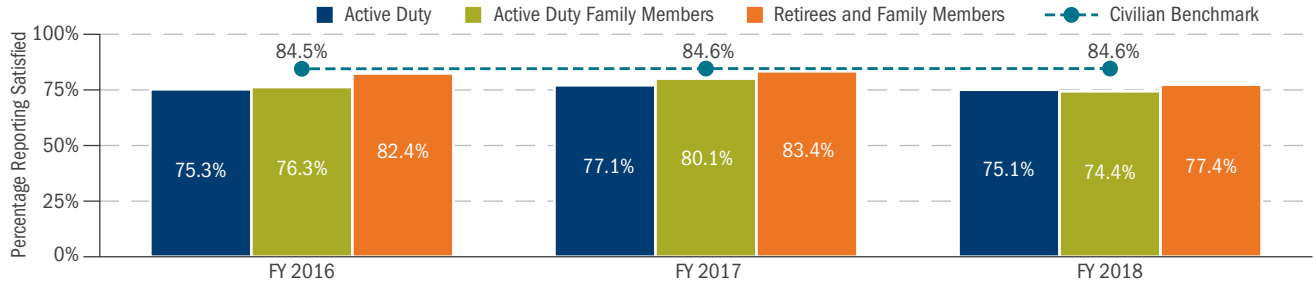
Most DoD health care beneficiaries participate in TRICARE in one of two ways: by enrolling in the Prime option or by using the traditional indemnity option for seeing participating or network providers (TRICARE Standard/Extra in FYs 2016–2017 or TRICARE Select in FY 2018) Access to and understanding 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 remained stable for Prime enrollees with both a military and civilian PCM, but declined for non-enrolled beneficiaries from FY 2016 to FY 2018. The civilian benchmark remained steady over the same time period.
- Satisfaction with customer service for all enrollment groups was significantly lower than the civilian benchmark in FY 2018.
- MHS beneficiary satisfaction with customer service remained stable for Active Duty and ADFMs, but declined significantly for RETFMs between FY 2016 and FY 2018. The civilian benchmark held steady over the same period.
- Satisfaction with customer service for all beneficiary groups was significantly lower than the civilian benchmark in FY 2018.

TRENDS IN RESPONSIVE CUSTOMER SERVICE: COMPOSITE MEASURE OF FINDINGS (UNDERSTANDING WRITTEN MATERIAL, GETTING CUSTOMER ASSISTANCE, AND DEALING WITH PAPERWORK) BY ENROLLMENT STATUS, FYs 2016–2018



TRENDS IN RESPONSIVE CUSTOMER SERVICE: COMPOSITE MEASURE OF FINDINGS (UNDERSTANDING WRITTEN MATERIAL, GETTING CUSTOMER ASSISTANCE, AND DEALING WITH PAPERWORK) BY BENEFICIARY CATEGORY, FYs 2016–2018



Note: DoD data were derived from the FYs 2016–2018 Health Care Survey of DoD Beneficiaries (HCSDB), as of 11/15/2018, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the National Committee for Quality Assurance (NCQA) by commercial plans. Benchmarks used in 2016 and 2017 come from NCQA's 2015 data, while the benchmarks used in 2018 come from NCQA's 2017 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

OTHER PLANS AND PROGRAMS

Additional benefit options may be available to beneficiaries depending on location, Active/Reserve status, and/or other factors. These supplemental plans and programs can enhance existing benefits or are a blend of the Prime and Select options with some limitations.

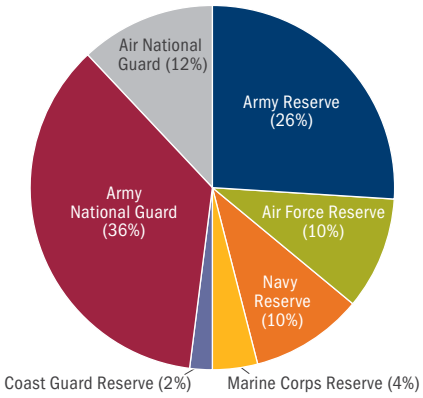
TRICARE Benefits for the Reserve Component

TRICARE offers a broad array of benefits coverage for RC members who qualify and their eligible family members pre-deployment, during deployment, post-deployment, and into retirement.

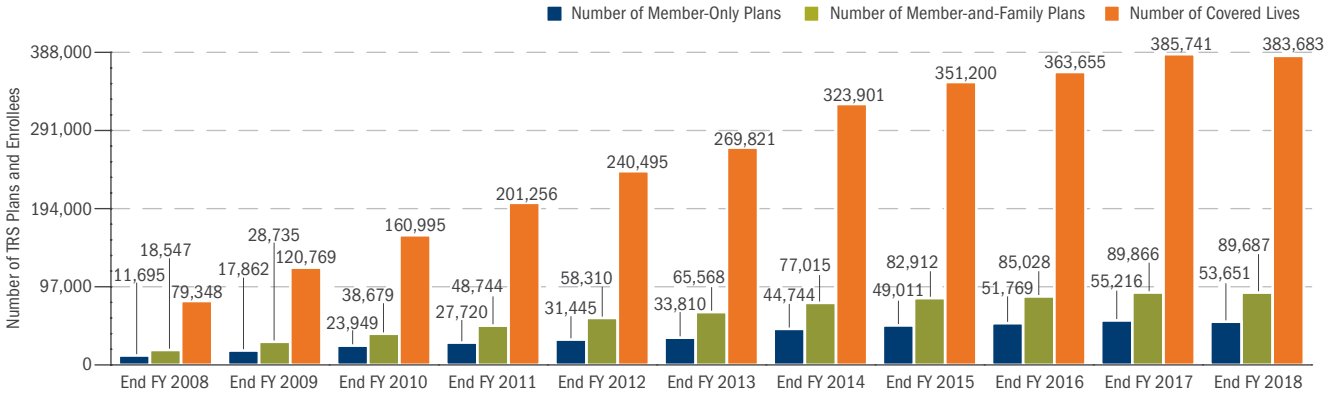
TRICARE Reserve Select (TRS). The premium-based TRS health plan offers comprehensive TRICARE Standard and Extra coverage for purchase by qualified members of the Selected Reserve. TRS fell to just over 143,000 plans with nearly 384,000 covered lives by the end of FY 2018. The chart below shows TRS enrollment growth since the NDAA FY 2007 enacted current member qualifications, effective October 1, 2007.

- As shown in the pie chart at right, Army National Guard and Army Reserve combined constitute 61 percent of the 383,683 TRS covered lives.
- NDAA FY 2018, section 511, expanded early eligibility TRICARE (before activation) and Transitional Assistance Management Program (TAMP) coverage (upon deactivation) to include RC members activated for a preplanned mission (under authority of 10 U.S.C. §12304b).

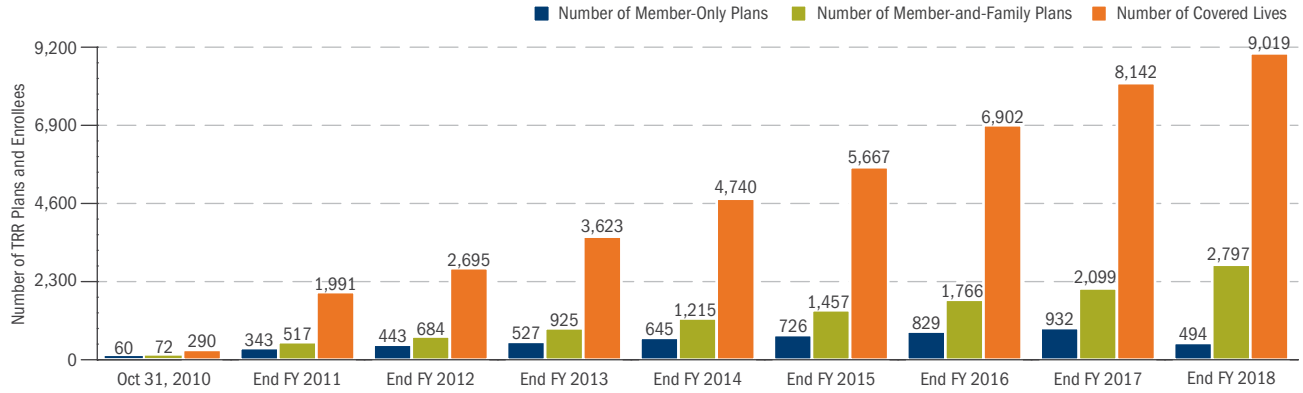
TRICARE RESERVE SELECT: POPULATION BY COMPONENT (383,683 SPONSORS AND FAMILY MEMBERS AS OF SEPTEMBER 2018)



TRENDS IN RESERVE COMPONENT ENROLLMENT IN TRS, SEPTEMBER 2008–SEPTEMBER 2018



TRENDS IN ENROLLMENT IN TRR, OCTOBER 2010–SEPTEMBER 2018



Source: Defense Manpower Data Center (DMDC)/Defense Enrollment Eligibility Reporting System (DEERS) Medical Policy Report, TRS, 12/14/2018

OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Benefits for the Reserve Component *(cont.)*

TRICARE Retired Reserve (TRR). Coverage under the TRR premium-based health plan began on October 1, 2010 (NDAA for FY 2010, section 705 and encoded at 10 U.S.C. §1076e). The law allows qualified members of the Retired Reserve to purchase full-cost, premium-based coverage under TRR until they reach age 60, when they receive premium-free TRICARE coverage for themselves as retirees and their eligible family members.

Although coverage under TRR is similar to TRS, it differs in the cost contribution. Unlike TRS, where the Department and member share in the cost of the premium, TRR members pay the full cost of the premium. Premiums are calculated annually for both.

Linear enrollment growth continues and by the end of FY 2018, over 9,000 retired Reservists and their families were covered by TRR in 3,291 member-only and member-and-family plans.

TRS and TRR Premiums. As of December 1, 2017, purchasing coverage is done through mainstream Beneficiary Web Enrollment (BWE), and the previous Reserve Component Purchase TRICARE Application was retired.

On January 1, 2018, a new TRICARE Select cost-sharing structure began for TRS and TRR. Premiums are derived from actual prior year costs, and will change for CY 2019 as follows:

MONTHLY PREMIUMS FOR TRS AND TRR, CYs 2018–2019

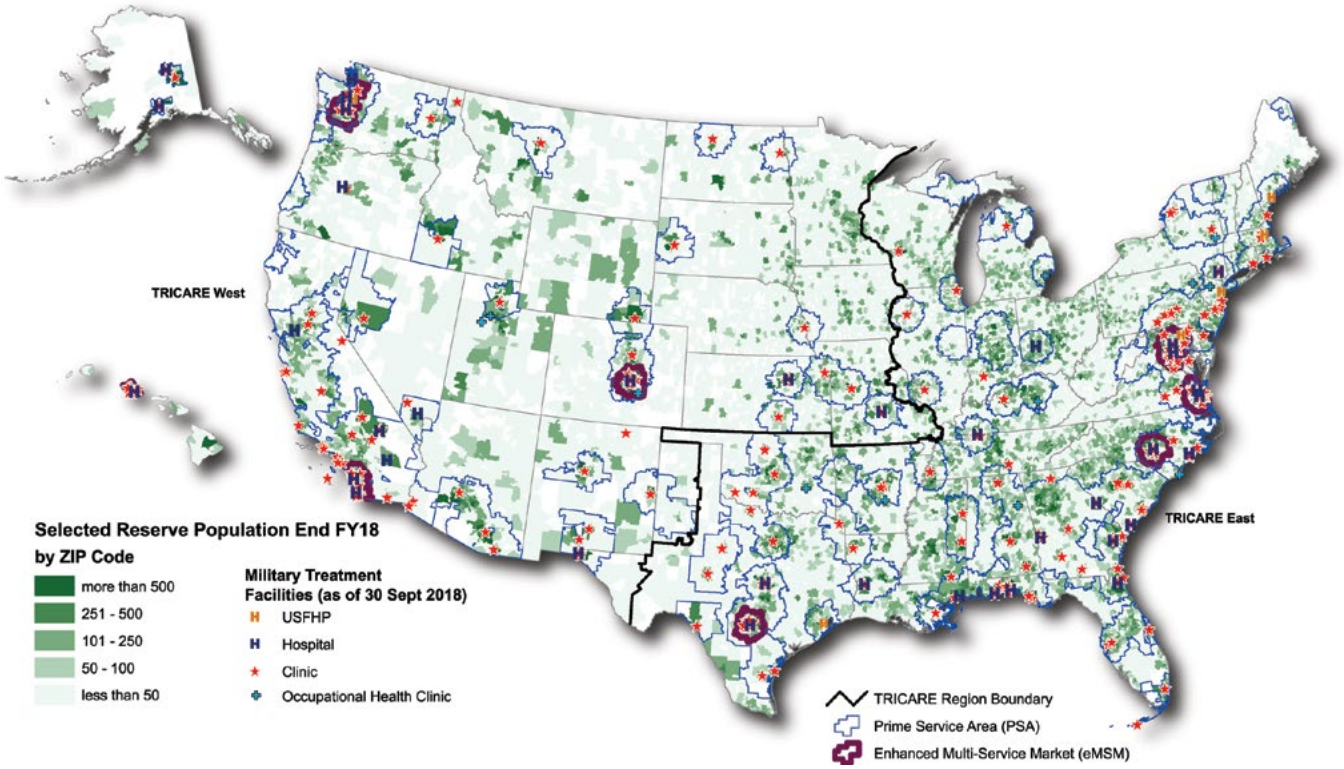
TYPE OF COVERAGE	CY 2018 MONTHLY	CY 2019 MONTHLY	% CHANGE
TRS Member Only	$46.09	$42.83	–7.6%
TRS Member and Family	$221.38	$218.01	–1.5%
TRR Member Only	$431.35	$451.51	4.7%
TRR Member and Family	$1,038.31	$1,083.40	4.3%

Source: TRS and TRR data from http://tricare.mil/Costs/Compare, accessed 12/14/2018

OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Benefits for the Reserve Component *(cont.)*

SELECTED RESERVE POPULATION IN THE U.S. RELATIVE TO MTF, PRIME, AND NON-PRIME SERVICE AREAS, END OF FY 2018



COMPARISON OF SELECTED RESERVE AND ACTIVE DUTY SPONSORS AND FAMILY MEMBER PROXIMITY TO MTFs AND NETWORK PROVIDERS IN THE U.S. (END OF FY 2018)

BENEFICIARY GROUP	POPULATION TOTAL (FY 2018)	POPULATION IN PSAs	% IN PSAs	POPULATION IN CATCHMENTS	% IN CATCHMENTS	POPULATION IN PRISMs	% IN PRISMs	POPULATION IN MTF SERVICE AREAS	% IN MTF SERVICE AREAS	POPULATION IN MULTI-SERVICE MARKET AREAS	% IN MULTI-SERVICE MARKET AREAS
Active Duty and Their Families	2,757,211	2,639,927	95.7%	1,845,769	66.9%	2,451,930	88.9%	2,565,361	93.0%	1,046,836	38.0%
Selected Reservists and Their Families	1,929,687	1,317,367	68.3%	443,702	23.0%	731,873	37.9%	1,053,338	54.6%	236,707	12.3%

Sources: DHA/SP&FI (J-5)/Decision Support for population and geospatial representation, 12/12/2018, and DHA/R&M (J-1/J-8) Facilities for MTF designations Population Data: Selected Reserve and family member data provided by Office of the Deputy Assistant Secretary of Defense (ODASD)/Military Personnel Policy (MPP) RCCPDS and DEERS database extract as of 9/30/2018, provided 12/5/2018; Active Duty and their families from MHS Data Repository (MDR) DEERS extract as of 9/30/2018, provided 12/11/2018.

Notes:

– MTF Service Areas are 40-mile circles around inpatient and outpatient MTFs, rounded to include all complete and partial ZIP codes, subject to overlap rules, barriers, and other policy overrides.

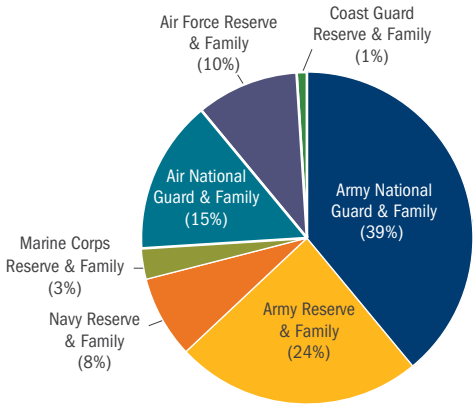
– Prime Service Areas are MTF Service Areas and similar geographies around closed MTFs (Base Realignment and Closure [BRAC] Prime Service Areas), effective 9/30/2018.

– Multi-Service market areas are the six enhanced multi-Service market (eMSM) areas used in the MHS strategy and metrics calculations (i.e., National Capital Region, Puget Sound, Colorado Springs, San Antonio, Tidewater, and Hawaii areas) and two densely populated multiple-market areas in San Diego and Fort Bragg.

TRICARE Benefits for the Reserve Component *(cont.)*

- As of September 30, 2018, there were more than 2 million Selected Reserve Service members and their families (2,049,835), of which 802,714 were sponsors and 1,247,121 were family members.
- The map on page 156 depicts where Selected Reservists and their family members reside in the U.S. relative to the direct care MTFs, and also to all areas where TRICARE Prime networks are available. As shown in the accompanying table, by September 30, 2018, over 68 percent of Selected Reservists and their family members (almost 96 percent for Active Duty and their family members) in the U.S. live within the area covered by the TRICARE network (PSAs). Slightly more than half (almost 55 percent) of this population resides near a clinic or inpatient MTF, compared with 93 percent of Active Duty and their family members.
- As shown below, almost two-thirds (63 percent) of the worldwide Selected Reserve population of 2 million sponsors and their family members are Army National Guard (39 percent) and Army Reserve (24 percent), similar to the 62 percent enrolled in TRICARE Reserve Select.

SELECTED RESERVE POPULATION (2,049,835): SPONSORS AND FAMILY MEMBERS BY SERVICE (SEPTEMBER 2018)



Source: RCCPDS and DEERS Database Extract as of 12/4/2018

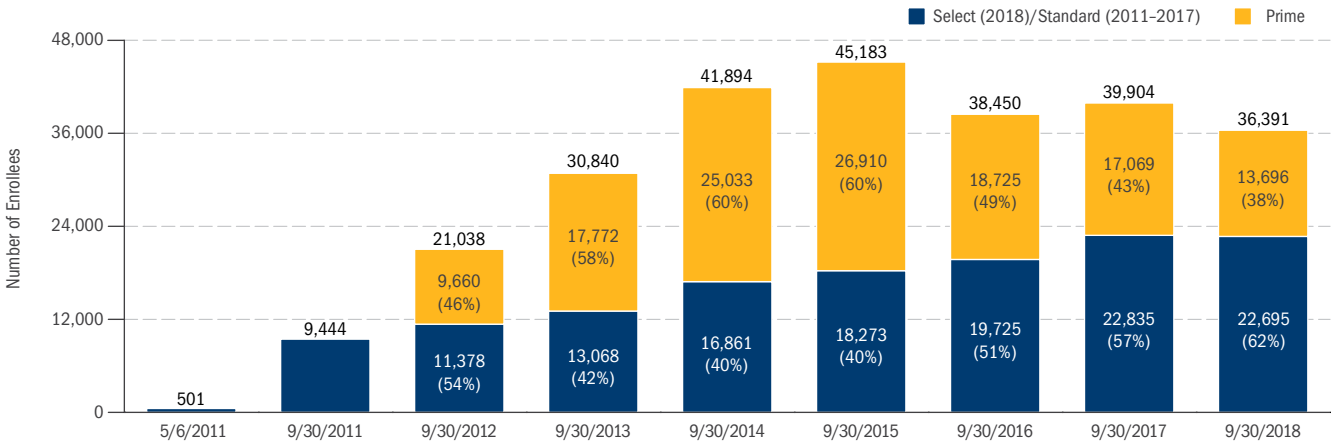
OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Young Adult

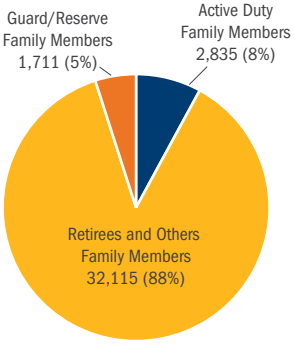
The TRICARE Young Adult (TYA) program is a premium-based TRICARE plan coverage available for purchase by qualified adult-age dependents who lose eligibility for TRICARE due to age. TYA extends specific TRICARE health care coverage options based on where the adult-age dependent lives and the sponsor's status, and can provide coverage up to the age of 26 if not otherwise qualified. TYA is an umbrella plan that offers Prime and Select (previously Standard) coverage across all TRICARE plans (Prime, TRICARE Prime Remote [TPR] ADFM, Prime Overseas, Prime Overseas Remote, Select [Standard], Standard Overseas, TRR, TRS, and USFHP). TYA Standard plans began in May 2011 and expanded to TYA Prime plans in January 2012. Monthly premiums are established to actuarially cover the full cost of the coverage. When purchased, TYA meets the minimum essential coverage requirements of the Patient Protection and Affordable Care Act.

- As shown in the chart below, enrollment decreased from just under 40,000 in FY 2017 to almost 37,000 in FY 2018. Enrollment in the new TRICARE Select option accounted for 62 percent of total TYA enrollment.
- As shown in the accompanying pie chart, most TYA enrolled (88 percent) are family members of those who are not Active Duty (e.g., dependents of retirees and others).
- Based on actual prior year costs, TYA monthly premiums will increase from $324 to $358 per month for Prime and will decrease from $225 to $214 per month for Select in CY 2019 (table below; see http://tricare.mil/Costs/HealthPlanCosts/TYA.aspx).

TRENDS IN TYA ENROLLMENT SINCE INCEPTION (MAY 2011–SEPTEMBER 2018)



TYA ENROLLMENT BY SPONSOR CAREER STATUS, AS OF SEPTEMBER 30, 2018



MONTHLY TYA PREMIUMS, CYs 2016–2019

	CY 2016	CY 2017	CY 2018	CY 2019
Prime	$306	$319	$324	$358
Select (Standard)	$228	$216	$225	$214

Source: DHA/SP&FI (J-5)/Decision Support Division, 1/2/2019

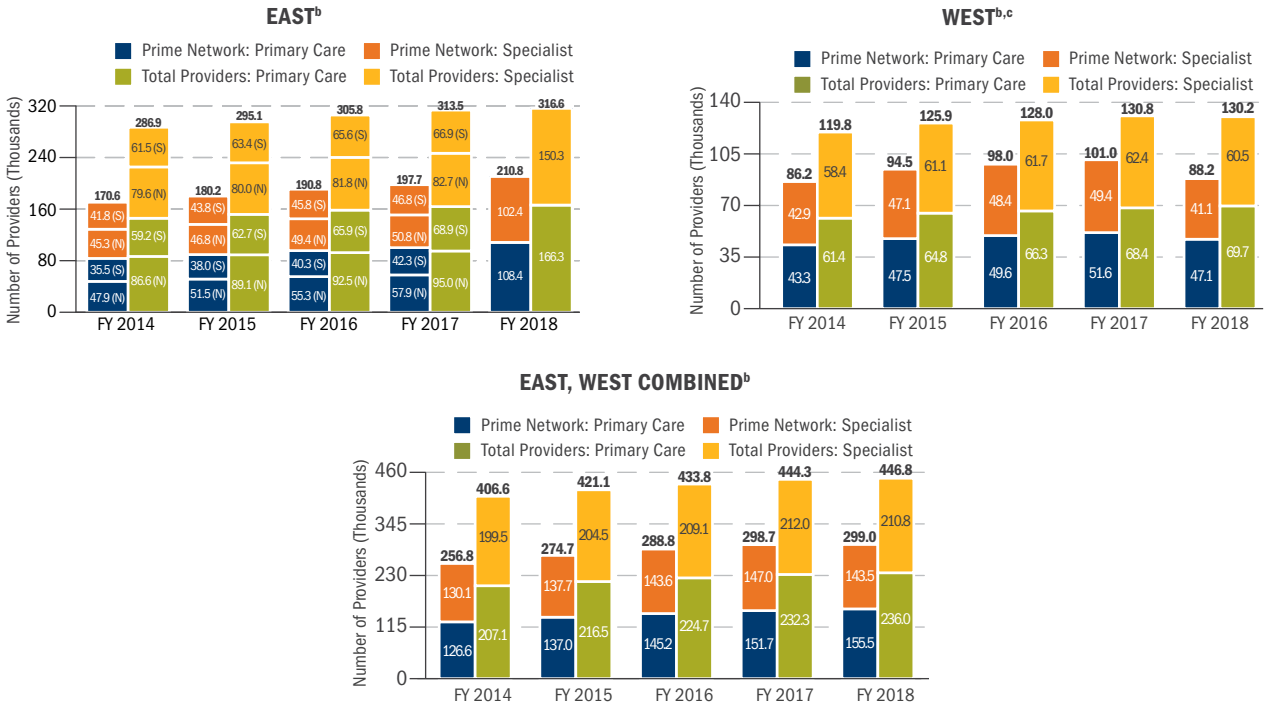
OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Provider Participation

The National Provider Identifier (NPI) is a unique identification number issued to health care providers in the U.S. by CMS. All HIPAA-covered individual health care providers and organizations must obtain an NPI for use in all HIPAA standard transactions. In this report, providers are counted using the NPI. The number of TRICARE-participating providers was determined by the number of unique providers filing TRICARE (excluding TFL) claims.[1] Providers were counted in terms of full-time equivalent (FTE) units (1/12 of a provider for each month the provider saw at least one MHS beneficiary). The total number of participating providers has been rising steadily for more than a decade. The trend is due exclusively to an increase in the number of network providers; the number of non-network providers has actually slightly declined. Since FY 2014, the number of network primary care providers has increased at a higher rate (23 percent) than that of specialists (10 percent), and the total number of participating primary care providers has increased at a higher rate (14 percent) than that of total participating specialists (6 percent).[2]

- Between FY 2014 and FY 2018, the East Region saw an increase of 10 percent in the total number of TRICARE providers (8 percent in the former North Region and 14 percent in the former South Region), while the West Region saw an increase of 9 percent.
- The East Region saw an increase of 24 percent in the total number of network providers (27 percent in the former North Region and 20 percent in the former South Region), while the West Region saw an increase of only 2 percent.
- The total number of TRICARE providers decreased by 12 percent in PSAs and increased by 106 percent in non-PSAs (not shown). This pattern is not due to any fundamental shift in where providers practice, but rather to the reduction in the number of PSAs in FY 2014.
- The number of network providers decreased by 8 percent in PSAs and increased by 155 percent in non-PSAs, also due to the reduction in the number of PSAs in FY 2014.
- In FY 2018, 67 percent of all network providers and 65 percent of all participating providers were in PSAs.

TRENDS IN NETWORK AND TOTAL PARTICIPATING PROVIDER FTEs, FYs 2014–2018[a]



Source: MHS administrative data, 12/26/2018

Notes: The source for the provider counts shown above was the TRICARE purchased care claims data for each of the years shown, in which a provider was counted if he or she was listed as a TRICARE-participating provider. The claims also explicitly identify network providers. Numbers may not sum to bar totals due to rounding.

[a] Network providers are TRICARE-authorized providers who have a signed agreement with the regional contractors to provide care at a negotiated rate. Participating providers include network providers and those non-network providers who have agreed to file claims for beneficiaries, to accept payment directly from TRICARE, and to accept the TRICARE allowable charge, less any applicable cost shares paid by beneficiaries, as payment in full for their services.

[b] Numbers may not sum to regional totals due to rounding.

[c] The West Region includes Alaska.

[1] Providers include physicians, physician assistants, nurse practitioners, and select other health professionals. Providers of support services (e.g., nurses, laboratory technicians) were not counted.

[2] Primary care providers were defined as general practice, family practice, internal medicine, obstetrics/gynecology, pediatrics, physician assistant, nurse practitioner, and clinic or other group practice.

OTHER PLANS AND PROGRAMS *(CONT.)*

Civilian Provider Acceptance of, and Beneficiary Access to, TRICARE Standard and Extra

The DoD has completed the first two years (2017–2018) of a congressionally mandated four-year survey (2017–2020) of civilian providers and MHS non-enrolled beneficiaries, designed to determine civilian provider acceptance of, and beneficiary access to, the TRICARE Standard benefit option. This survey complies with the requirements of NDAA FY 2015, section 712 (Public Law 113-291). This four-year survey is required as a follow-on to two previous four-year surveys completed from 2008 to 2011 (section 711, NDAA FY 2008 Public Law 110-181) and 2012 to 2015 (section 721, NDAA FY 2012, Public Law 112). The survey is licensed by the Office of Management and Budget (provider survey) and Washington Headquarters Service (beneficiary survey), and has been reviewed by the GAO as required by the guiding legislation.

- **Provider survey results and key points after the first year:**
  - About six of 10 providers overall (56 percent of physicians and nonphysician behavioral health providers) and eight of 10 physicians (77 percent) accept new TRICARE Standard patients if they accept new patients of any insurance. These acceptance rates are statistically similar to the 2012–2015 benchmark survey for physicians (76 percent), and lower for all providers (59 percent). However, results are likely to change, up or down, as the survey progresses through the remaining two years and results accumulate as more locations and providers are surveyed.
  - Almost nine of 10 providers (85 percent) and over nine of 10 physicians (94 percent) are aware of the TRICARE program in general (greater than the 2012–2015 and 2008–2011 benchmarks, respectively, 84 and 82 percent for all providers and 93 and 91 percent for physicians).
  - Similar to the 2012–2015 and 2008–2011 benchmark surveys, behavioral health providers (including psychiatrists, psychologists, and nonphysician providers) report lower rates than physicians for awareness (77 percent) and acceptance (36 percent), pulling down the all-provider acceptance rates.
  - Primary care and specialist physicians report similar rates of awareness, while specialists report higher rates of acceptance. Both meet or exceed the 2012–2015 benchmark.
  - Providers in non-PSAs report greater awareness and acceptance of new TRICARE Standard and Medicare patients than do PSA providers.
- **Beneficiary survey results and key points after the first year:**
  - Compared with the civilian benchmark, MHS non-enrolled beneficiaries eligible for Select (Standard/Extra) rate their care experience and access to care higher than or comparable to the civilian benchmarks (higher for three of four global measures; higher for one of five access measures; equal for the remaining). This is the same regardless of whether we separate beneficiaries by PSA/non-PSA or analyze all beneficiaries together.
  - Comparing PSAs to non-PSAs, there are no significant differences between beneficiaries residing in PSAs and non-PSAs with regard to global or access measures, except beneficiaries in non-PSAs reported higher rates of getting care quickly than those in PSAs.
- Provider and beneficiary results vary among PSAs, non-PSAs, and Health Service Areas, offering opportunities for improvement in some local areas, for certain provider types (e.g., primary care in Portland/Eugene, Oregon, or mental health care in Colorado Springs/Denver, Colorado).

Even as the DHA reports the 2017–2018 results of this study, section 701 of NDAA FY 2017 established the new enrollment-based TRICARE Select benefits program, and terminated the non-enrolled Standard program effective January 1, 2018. This survey will be useful in supporting evaluation of the effectiveness of TRICARE Select as it matures in 2018 and beyond.

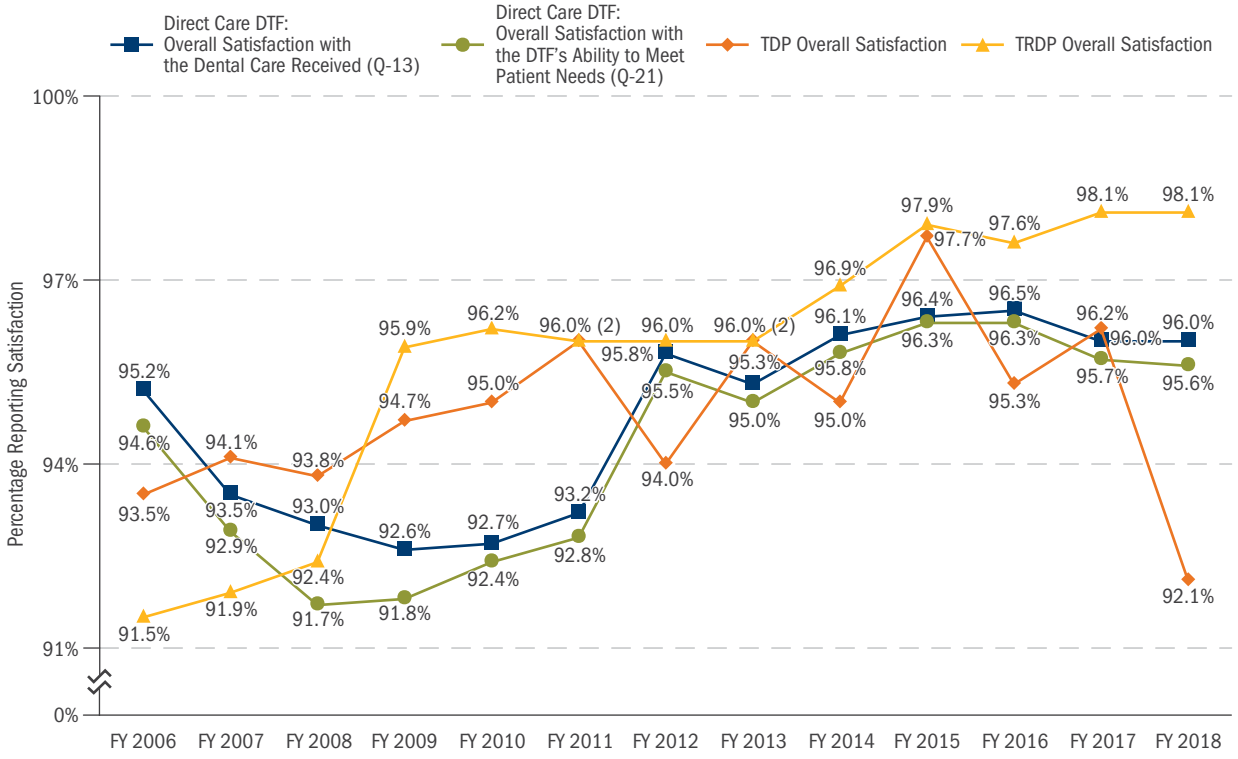
OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Dental Programs Customer Satisfaction

The overall TRICARE dental benefit is composed of several delivery programs serving the MHS beneficiary population. Consistent with other benefit programs, beneficiary satisfaction is routinely measured for each of these important dental programs.

- **Military Dental Treatment Facilities (DTFs)** are responsible for the dental care of about 1.54 million ADSMs worldwide and eligible family members residing outside the continental U.S. (OCONUS). The Tri-Service Center for Oral Health Studies completed 146,465 surveys in FY 2018. Reports of overall satisfaction have remained at or just over 96 percent since FY 2014.
- The **TRICARE Dental Program (TDP)** composite overall average enrollee satisfaction declined from FY 2017 (96.2 percent) to FY 2018 (92.1 percent). The TDP is a voluntary, premium-sharing dental insurance program available to eligible ADFMs, Selected Reserve and Individual Ready Reserve members, and their families. As of September 30, 2018, the TDP enrollment totaled 767,113 contracts, covering almost 2 million lives (1,822,645), 94 percent of which were in the U.S. The TDP network has 75,362 total dentists, a slight decline from the 76,010 in FY 2017—of which 61,011 are general dentists and 14,351 are specialists.
- The **TRICARE Retiree Dental Program (TRDP)** overall retired enrollee satisfaction rate remained at just over 98 percent in FY 2018, after steadily climbing up over the past four years from 96 percent in FY 2013. The TRDP is a full premium insurance program open to retired Uniformed Services members and their families. TRDP enrollment at the end of FY 2018 was higher by 11 percent than in FY 2015, with over 1.6 million total covered lives in over 843,000 contracts in FY 2018, compared with just under 1.5 million lives in nearly 758,800 contracts in FY 2015.

SATISFACTION WITH TRICARE DENTAL CARE: MILITARY AND CONTRACT SOURCES, FYs 2006–2018



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), 11/27/2018.

Note: The three dental satisfaction surveys (direct care, TDP, and TRDP) are displayed above for ease of reference, but are not directly comparable because they are based on different survey instruments and methodologies. For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

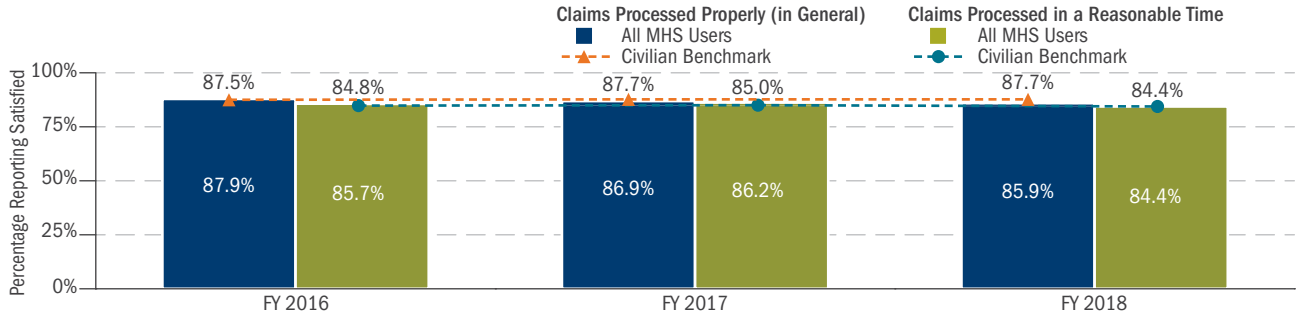
Customer Service, Claims Processing

Beneficiaries and their providers alike have an interest in the promptness and accuracy of claims processing and payment. The MHS monitors the performance of TRICARE claims processing through surveys of beneficiary perceptions and administrative tracking.

Beneficiary Perceptions of Claims Filing Process

- Satisfaction both with claims being processed properly and with processing speed remained stable from FY 2016 to FY 2018. The civilian benchmarks also remained stable over the same time period.
- MHS satisfaction levels with both the accuracy and the speed of claims processing were not significantly different from the civilian benchmarks from FY 2016 to FY 2018.

TRENDS IN SELF-REPORTED ASPECTS OF CLAIMS PROCESSING (ALL SOURCES OF CARE), FYs 2016–2018



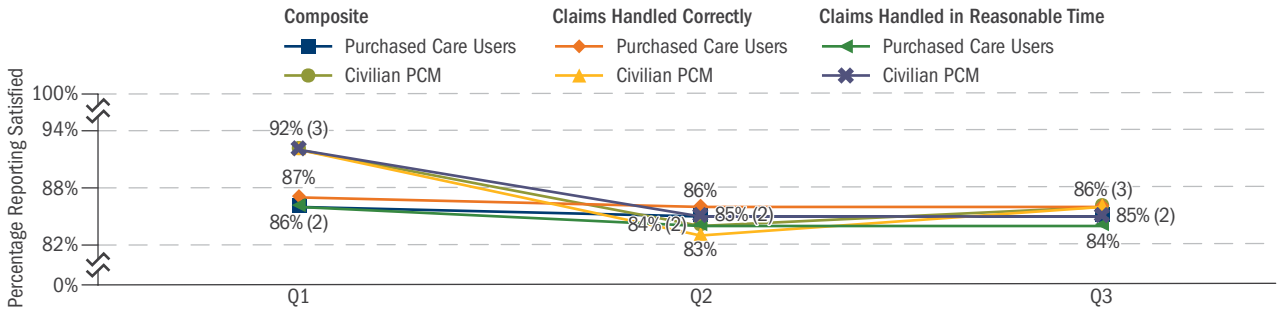
Note: DoD data were derived from the FYs 2016–2018 Health Care Survey of DoD Beneficiaries (HCSDB), as of 11/15/2018, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the National Committee for Quality Assurance (NCQA) by commercial plans. Benchmarks used in 2016 and 2017 come from NCQA's 2015 data, while the benchmarks used in 2018 come from NCQA's 2017 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

Trends in Claims Filing Process

TRICARE monitors claims processing to ensure compliance with contractual requirements and to ensure that our participating providers are paid on a timely basis. Claims processing for purchased care comprises three intervals: claims submission, claims processing, and transmission acceptance.

- **Claims Submission:** The claims submission interval is the time from the patient's last date of care to the date that the treating provider files a claim for payment with the Purchased Care Processing Contractor.
- **Claims Processing:** The Purchased Care Processing Contractor adjudicates the claim and sends a TRICARE Encounter Data (TED) record to DHA requesting payment. Claims processing includes the time needed for the Purchased Care Processing Contractor to ensure that the TED records pass all TRICARE validation edits (services are "Accepted").
- **Transmission Acceptance:** The transmission acceptance interval is the time between when DHA takes an "Accepted" TED record and when it identifies the appropriate program cost fund for payment. The accept date is defined as the "Last Update Date" in the TED record by current contracts. Contracts between DHA and MCSCs require that TED records be received by 10 AM Eastern time for DHA to accept the same day; otherwise, the cutoff moves the TED "Accepted" record to the next day.

TRENDS IN PURCHASED CARE/CIVILIAN PCM CLAIMS PROCESSING, FY 2018 Q1–Q3



Source: DHA/SP&FI (J-5)/Decision Support, MHS administrative data, 7/9/2018; Health Care Survey of DoD Beneficiaries, current as of FY 2018 Q3
Note: Purchased care users are beneficiaries who rely on civilian care financed by TRICARE through Prime or Select (Standard/Extra).

Customer Service, Claims Processing *(cont.)*

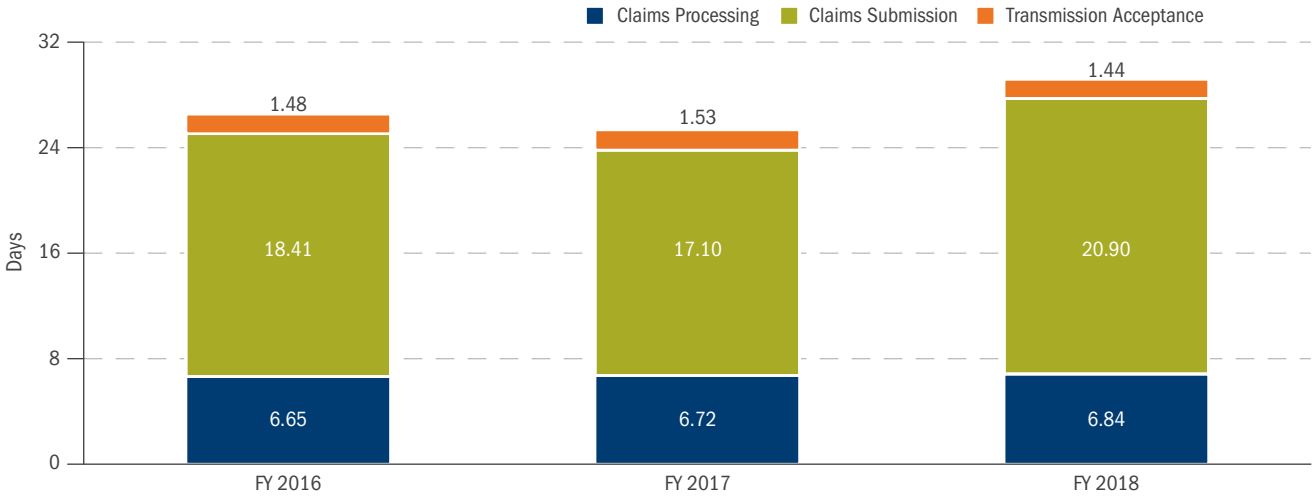
DHA pays MCSCs within seven days of the later of "Transmission Receive Date" or "Last Update Date," in compliance with contractual language. The graph below shows that TRICARE payments met time requirements, complying with managed care support contracts.

It excludes paper claims and claims from OHI, pharmacy, TRICARE Dual Eligible Fiscal Intermediary Contract, and TRICARE Overseas Program contracts.

This fiscal year reversed the previous trend of decreases in overall processing times, with a slight increase in claims processing time and a larger increase in claims submission time, potentially due to the contractual migration from T3 to T2017 beginning in January 2018. The lengthiest portion of claims processing is consistently claims submission—the time it takes for the treating provider to submit claims. Since institutional claims represent less than 5 percent of the total claims, the claims submission time is not affected by institutional claims.

The graph shows results of analysis of claims counts of 38.8 million, 39.7 million, and 38.9 million for FY 2016, FY 2017, and FY 2018, respectively. The most recent fiscal year is a 0.8 million claim decrease from the previous fiscal year, partly due to canceled claims and an ongoing OHI discovery process.

AVERAGE INTERVAL (DAYS) FOR CLAIMS PROCESSING, FYs 2016–2018



Source: DHA/SP&FI (J-5)/Decision Support, MHS Administrative data, 12/19/2018

POPULATION HEALTH

The MHS is dedicated to Population Health management and engagement. Although this concept is generally associated with managing the clinical risks associated with patients, the MHS has extended this concept to include helping the population manage their own health and creating an environment where the healthy choice is the easy choice. The MHS model continues to evolve to include strategies such as strengthening the connections between our military treatment facilities (MTFs) and Regional managed care support contractor (MCSC) engagement.

HEALTH PROMOTION AND DISEASE PREVENTION EFFORTS

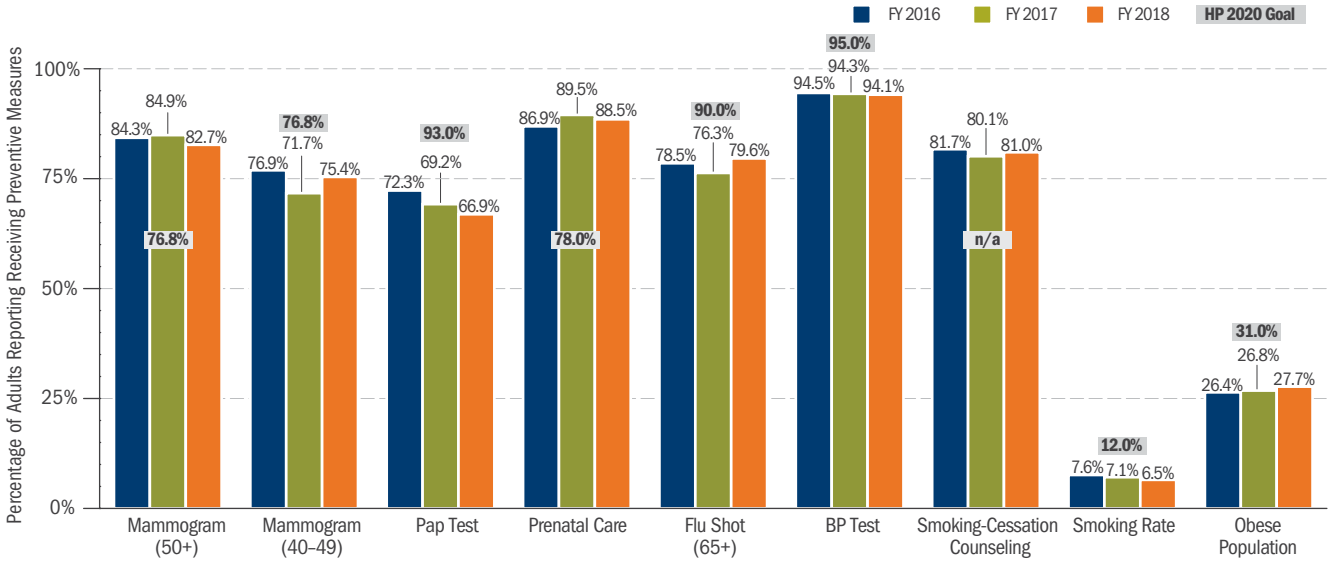
This section presents efforts toward meeting the Military Health System (MHS) aim of "Better Health," part of the Quadruple Aim, to include preventive care, population health, tobacco cessation, obesity, and condition management. This section also provides selected measures benchmarked to the Healthy People (HP) 2020 goals. The Healthy People 2020 goals are national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce those threats; these goals have been embraced by the Department of Defense (DoD).

The MHS strategic goals go beyond those for primary health and wellness. The graph on the following page reflects secondary prevention efforts via self-reported responses from all eligible MHS beneficiaries within the categories shown (e.g., all adult women for mammography, all adult pregnant women for prenatal care, etc.).

- The MHS has set as goals a subset of the health promotion and disease prevention objectives specified by the Department of Health and Human Services (DHHS) in HP 2020. Over the past three years, the MHS has exceeded targeted HP 2020 goals for providing mammograms (ages 50 and over) and prenatal care for women, as well as for rates of smoking and obesity (see notes on the next page).
- **Pap Test:** Although exceeding the HP 2020 targets, the percentage of MHS female beneficiaries receiving Pap tests declined from about 72 percent in fiscal year (FY) 2016 to just under 67 percent in FY 2018. In March 2012, the U.S. Preventive Services Task Force offered an updated "Final Recommendation Statement: Cervical Cancer Screening" (https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/cervical-cancer-screening), which may have contributed to the decline in Pap tests.
- **Tobacco Use:** The overall self-reported smoking rate among all MHS beneficiaries has declined for the past five years, decreasing from almost 15 percent in 2010 (not shown) to under 7 percent in FY 2018, five percentage points below the HP 2020 goal of 12 percent and the national cigarette smoking rate of 20.6 percent for adults aged 18 years and over. Smoking-cessation counseling has decreased slightly from almost 82 percent in FY 2016 to 81 percent in FY 2018.
- **Obesity:** The overall proportion of MHS beneficiaries identified as obese increased slightly from under 26 percent in FY 2015 to over 28 percent in FY 2018. This is below the HP 2020 goal of almost 31 percent (revised from 34 percent in 2012, consistent with reporting from the National Health and Nutrition Examination Survey [NHANES]) and below the most recently identified U.S. population average of 33.9 percent from 2005 to 2008 (Centers for Disease Control and Prevention [CDC] National Center for Health Statistics, 2012; not shown). See additional charts on the following pages, which distinguish obesity rates by beneficiary category.

HEALTH PROMOTION AND DISEASE PREVENTION EFFORTS *(CONT.)*

TRENDS IN MEETING PREVENTIVE CARE STANDARDS, FYs 2016–2018



Source: DHA/SP&FI (J-5)/Decision Support Division, 2016–2018 Health Care Surveys of DoD Beneficiaries (HCSDB) http://www.tricare.mil/survey/hcsdbsurvey/home/z_reports.cfm, results provided 11/19/2018, the National Health and Nutrition Examination Survey (NHANES); CDC, National Center for Health Statistics (NCHS) http://www.healthypeople.gov/2020/Data/SearchResult.aspx?ztopicid=29&topic=Nutrition+and+Weight+Status&objective=NWS-9&anchor=141

Notes:

– Unlike the objective for all other categories, the objective for Smoking Rate and Obese Population is for actual rates to be below the HP 2020 goals.
– The goal for Prenatal Care was revised down from 90 percent in the HP 2010 goals to 77.6 percent in the HP 2020 goals.
– The goal for Obese Population was revised up from 15 percent in the HP 2010 goals to 30.5 percent in the HP 2020 goals (see http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx for more information).

MHS-TARGETED PREVENTIVE CARE MEASURES

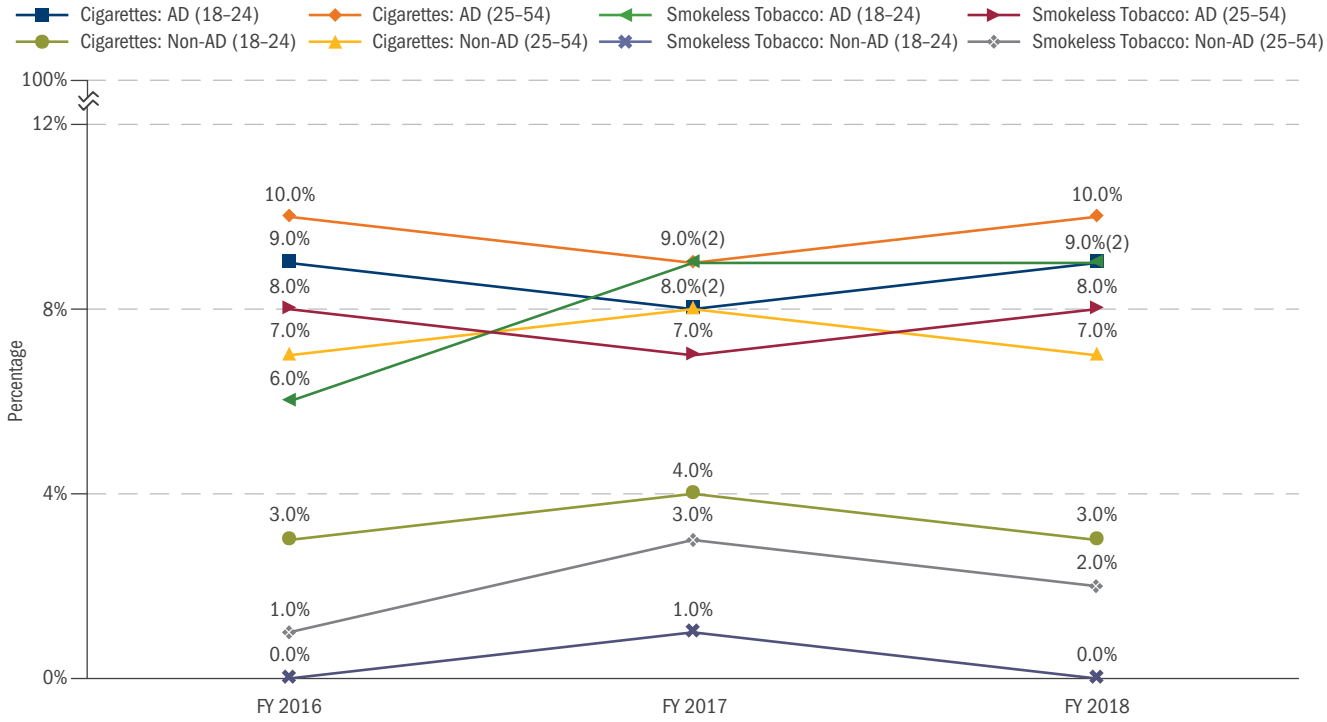
Mammogram: Women aged 50 or older who had a mammogram in the past year; women aged 40–49 who had a mammogram in the past two years. **Pap Test:** All women who had a Pap test in the last three years. **Prenatal Care:** Women pregnant in the last year who received care in the first trimester. **Flu Shot:** People aged 65 and older who had a flu shot in the last 12 months. **Blood Pressure (BP) Test:** People who had a blood pressure check in the last two years and know the results. **Obese:** Obesity is defined as a body mass index (BMI) of 30 or above, which is calculated from self-reported data from the HCSDB. An individual's BMI is calculated using height and weight (BMI = 703 times weight in pounds, divided by height in inches squared). Although BMI is a risk measure, it does not measure actual body fat; as such, it provides a preliminary indicator of possible excess weight, which in turn provides a preliminary indicator of risk associated with excess weight. It should therefore be used in conjunction with other assessments of overall health and body fat. **Smoking-Cessation Counseling:** People advised to quit smoking in the last 12 months.

TOBACCO CESSATION

Tobacco continues to be the leading cause of preventable death, according to the CDC, and smoking rates in the military remain higher than desired. Military personnel who smoke experience reduced physical performance capability, impaired night vision, increased risk of respiratory illnesses and surgical complications, delayed wound healing, and accelerated age-related hearing loss. Furthermore, there are negative impacts on dental readiness, and long-term effects of tobacco use often include cancer, stroke, emphysema, and heart disease.

- Based on self-reported usage, cigarette smoking for Active Duty Service members (ADSMs) of all ages statistically declined over the past six years: from 16 percent in FY 2013, leveling to 9 percent in FYs 2017 and 2018 (not shown). This trend in lower Active Duty cigarette usage is most pronounced in the 18- to 24-year-old age range (9 percent in FY 2018, compared with 13.1 percent in the U.S. among the same age group). Use of smokeless tobacco products in the 25- to 54-year-old age range by Active Duty (8 percent) and non-Active Duty (1–2 percent) remains lower, and has not changed from FY 2016 to FY 2018. Non-Active Duty appear to smoke cigarettes (6 percent in FY 2018) and use smokeless tobacco (1 percent) at lower rates than Active Duty. Active Duty and non-Active Duty rates are lower than the reported U.S. national average for smoking cigarettes (15.5 percent, reported in 2016), while the non-Active Duty smokeless tobacco rate is comparable to, or lower than, the national average (3.4 percent).

MHS CIGARETTE AND SMOKELESS TOBACCO USE RATES AMONG ACTIVE DUTY AND FAMILY MEMBERS, FYs 2016–2018



Source: DHA/SP&FI (J-5)/Decision Support Division, 2016–2018 HCSDB https://tricare.mil/survey/hcsdbsurvey/home/z_reports.cfm, results provided 11/19/2018

Notes:

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

– Percentages are weighted for the probability of selection and nonresponse; variation in quarterly estimates may not be significant and should not be assumed as such without appropriate tests of significance.

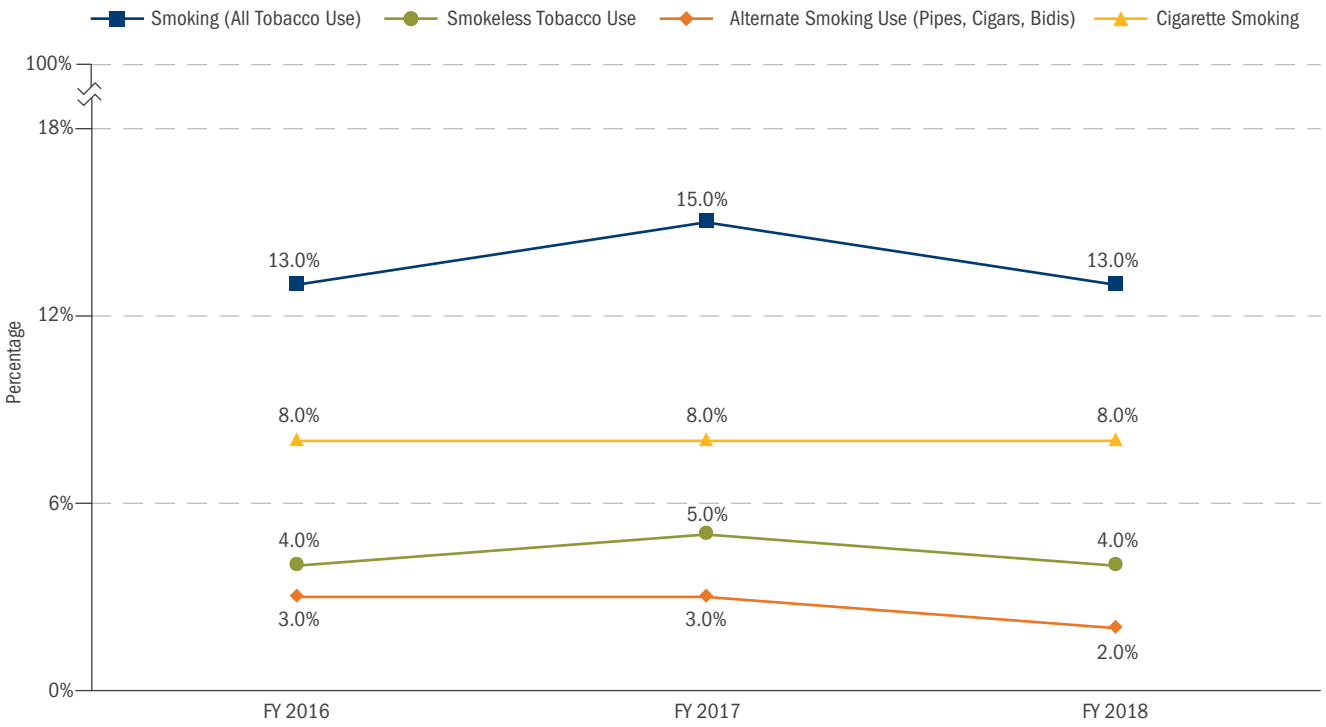
– U.S. adult cigarette smoking rate of 15.5 percent, 13.1 percent for adults aged 18–24 from http://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/, accessed 11/19/2018

– U.S. adult smokeless tobacco rate of 3.4 percent in 2016 from http://www.cdc.gov/tobacco/data_statistics/fact_sheets/smokeless/use_us/index.htm, accessed 11/19/2018

TOBACCO CESSATION *(CONT.)*

- **MHS Prime Enrollee Use of Any Tobacco Products:** Although attention has historically been focused on cigarette smoking, the HCSDB has also been directed to assess the use of various tobacco products across MHS. The chart below presents the self-reported estimates of the prevalence of MHS Prime enrollees using different tobacco products (cigars, pipes, bidis, or kreteks). Prime enrollee use of tobacco in one form or another declined from 19 percent in FY 2013 to 13 percent in FY 2016 and FY 2018.
- Cigarette smoking, which is the most used form of tobacco among Prime enrollees, declined from 13 percent to 8 percent from FY 2013 to FY 2018 (but statistically has not changed over the past three years), while smokeless tobacco and alternate smoking use have remained unchanged from FY 2016 to FY 2018 (at 4 percent and about 2–3 percent, respectively). Usage of various tobacco products shown in the chart is not mutually exclusive (e.g., a cigarette smoker may also report being a snuff user [smokeless tobacco] or a pipe smoker [alternate smoking tobacco]), and thus is not additive.

MHS PRIME ENROLLEE USE OF TOBACCO PRODUCTS, BY TYPE OF TOBACCO USE: CIGARETTES, ALTERNATE SMOKING TOBACCO, AND SMOKELESS TOBACCO, FYs 2016–2018



Source: DHA/SP&FI (J-5)/Decision Support Division, 2016–2018 HCSDB https://tricare.mil/survey/hcsdbsurvey/home/z_reports.cfm, results provided 11/19/2018

Notes:

– Smokeless tobacco may include dip, snuff, snus, chew, etc., while alternate smoking tobacco may include cigars, pipes, hookahs, bidis, or kreteks.

– Percentages are weighted for the probability of selection and nonresponse; variation in quarterly estimates may not be significant and should not be assumed as such without appropriate tests of significance.

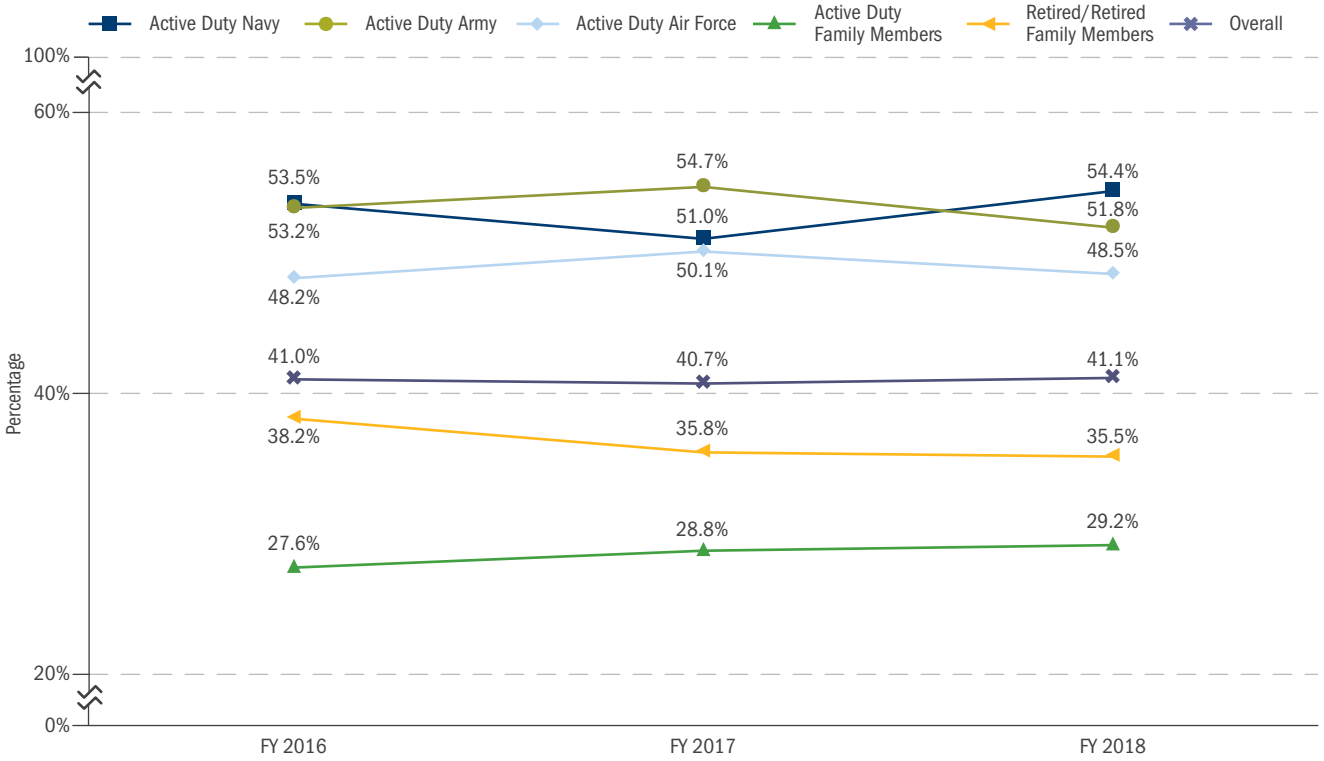
MHS ADULT OBESITY

This measure provides important information about the overall health of DoD beneficiaries for use by MHS leadership to help promote military initiatives that encourage exercise and healthy nutritional habits. These data can also shape the need for, and development of, medical interventions or modalities that are effective in maintaining healthy weights for all age groups.

The chart below displays the percentage of the population reporting in the HCSDB a height and weight that, when used in calculating BMI, result in a measurement of 30 or higher (30 is the threshold for obesity).

- As shown in the first chart below, 41.1 percent of all MHS beneficiaries were overweight in FY 2018, lower than the overall U.S. rate of 70.6 percent (CDC's NCHS 2015–2016). Active Duty family members (ADFMs), on average, have the lowest rate of being overweight (29.2 percent), followed by the retired and their family members at 35.5 percent. Calculated BMI rates reflecting overweightness may not be reflective of Active Duty fitness without consideration of muscle mass, and may explain why Active Duty appear to have high prevalence rates of being overweight but low obesity rates (13 to 16 percent), as shown in the second chart.

MHS OVERWEIGHT RATE (BMI 25–29.9), FYs 2016–2018



Source: DHA/SP&FI (J-5)/Decision Support Division, 2016–2018 HCSDB https://tricare.mil/survey/hcsdbsurvey/home/z_reports.cfm, results provided 11/19/2018

Notes:

– BMI is defined as the individual's body weight divided by the square of his or her height. The formula universally used in medicine produces a unit of measure of kg/m^2. Because the HCSDB collects height and weight in inches and pounds, BMI is calculated as lb/in^2 x 703. A BMI of 18.5 to 25 may indicate optimal weight; a BMI lower than 18.5 suggests the person is underweight, while a number above 25 may indicate the person is overweight; a number of 30 or above suggests the person is obese (Division of Nutrition, Physical Activity and Obesity, National Center for Chronic Disease Prevention and Health Promotion, CDC).

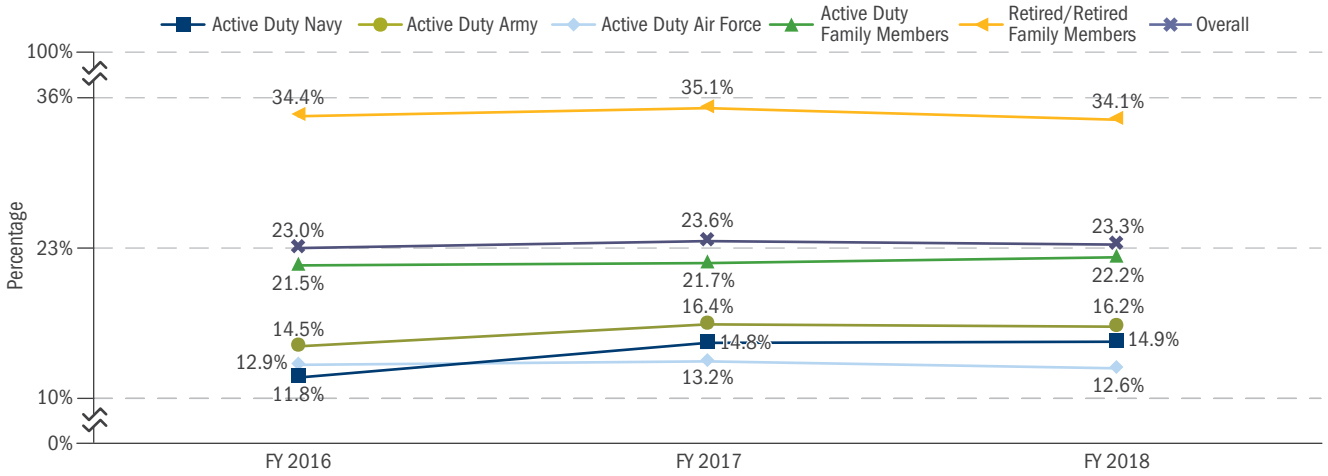
– Since the data are self-reported, they are subject to recall bias, while provider measurements are subject to instrument error (e.g., lack of calibration of weight scales) and inconsistency in recording (e.g., asking patient's height or weight versus measuring). Self-reported scores are adjusted for user characteristics that allow comparison with civilian benchmarks. No objective validation tool is used to verify accuracy of BMI results.

– CDC-reported obesity (39.8 percent) and overweight (70.6 percent) rates for U.S. adults aged 20 and over: http://www.cdc.gov/nchs/fastats/obesity-overweight.htm, accessed 11/19/2018.

- The second chart displays the prevalence of obesity in the MHS population (i.e., a calculated BMI of 30 or higher based on self-reported height and weight). Active Duty present the lowest rates (between approximately 13 and 16 percent) in FY 2018. The overall MHS obesity rate has been unchanged from FY 2016 to FY 2018 (between 23 and almost 24 percent), as well as obesity rates for active duty family members (22 percent) and the retired and their family members (34–35 percent). All groups are lower than the U.S. average rate for adults aged 20 and over (almost 40 percent from 2015 to 2016). Overweight and obesity rates for active duty and their family members or retired and their family members did not statistically change from FY 2016 to FY 2018 (i.e., there was no statistically significant difference, although numerically the numbers appear different).

MHS ADULT OBESITY *(CONT.)*

MHS OBESITY RATE (BMI 30 OR HIGHER), FYs 2016–2018



Source: DHA/SP&FI (J-5)/Decision Support Division, 2016–2018 HCSDB https://tricare.mil/survey/hcsdbsurvey/home/z_reports.cfm, results provided 11/19/2018

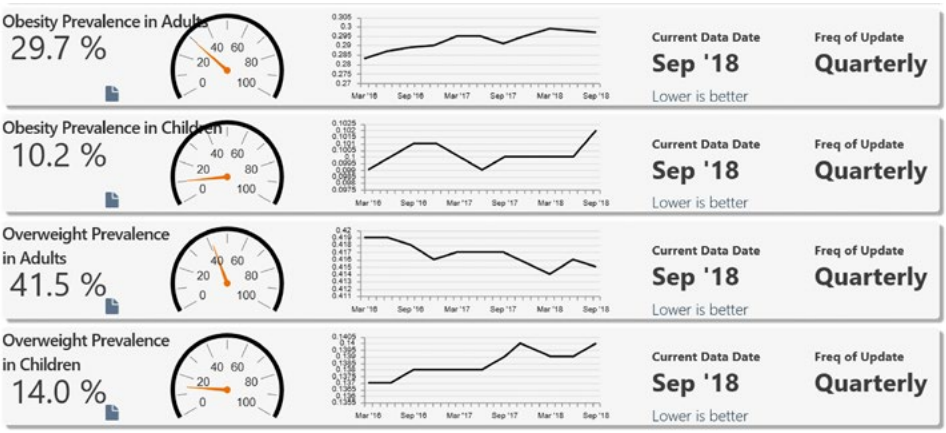
Notes:

– BMI is defined as the individual's body weight divided by the square of his or her height. The formula universally used in medicine produces a unit of measure of kg/m^2. Because the HCSDB collects height and weight in inches and pounds, BMI is calculated as lb/in^2 x 703. A BMI of 18.5 to 25 may indicate optimal weight; a BMI lower than 18.5 suggests the person is underweight, while a number above 25 may indicate the person is overweight; a number of 30 or above suggests the person is obese (Division of Nutrition, Physical Activity and Obesity, National Center for Chronic Disease Prevention and Health Promotion, CDC).

– Since the data are self-reported, they are subject to recall bias, while provider measurements are subject to instrument error (e.g., lack of calibration of weight scales) and inconsistency in recording (e.g., asking patient's height or weight versus measuring). Self-reported scores are adjusted for user characteristics that allow comparison with civilian benchmarks. No objective validation tool is used to verify accuracy of BMI results.

– CDC-reported obesity and overweight rates in U.S. adults: http://www.cdc.gov/nchs/fastats/obesity-overweight.htm, accessed 11/19/2018.

In an effort to capture administration data on the prevalence of overweightness and obesity among the MHS population to compare against the survey-based prevalence measures discussed above, an MHS guideline is under development to support the documentation of BMI with all direct care patient encounters. Preliminary results developed as a baseline leading into the FY 2019 MHS Dashboard review are presented here. Preliminary administrative results corroborate the survey results for overweightness (about 41 percent) and less so for obesity (30 percent below, compared to 23 percent from the survey). Differences in either measure may be explained by differences in the population assessed (MTF users vs. a sample of the entire MHS-eligible population).



HEALTH-RELATED QUALITY OF LIFE

Using CDC's Health-Related Quality of Life (HRQOL) 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 HRQOL measurement as the Centers for Disease Control's (CDC) State-based Behavioral Risk Factor Surveillance System (BRFSS). Self-perceived health status is considered a valid proxy measure for the state of U.S. national health; research has shown that people's perception of their health is highly correlated with their actual health, and can be used at the population level.

HRQOL refers to the perceived physical and mental health of an individual or group over a period of time. The standard four-item set of Healthy Days core questions (CDC HRQOL–4) has been in the State-based BRFSS since 1993 (see the BRFSS website at https://www.cdc.gov/brfss).

- From 2000 to 2012, the CDC HRQOL–4 has been in the National Health and Nutrition Examination Survey (NHANES) for persons aged 12 and older.
- Since 2003, the CDC HRQOL–4 has been in the Medicare Health Outcomes Survey (HOS)—a measure in the Healthcare Effectiveness Data and Information Set (HEDIS) of the National Committee for Quality Assurance (NCQA) (https://www.cdc.gov/HRQOL/HRQOL14_measure.htm).

The HRQOL–4 questions are:

1. **Self-rated health:** In general, how would you rate your overall health? (Respondents have five choices: poor, fair, good, very good, or excellent. "Good health" is coded as the proportion of those rating their overall health as good, very good, or excellent.)
2. **Number of recent days physical health not good:** Thinking about your physical health, including physical illness and injury, how many days during the past 30 days was your physical health not good? (Referred to as "poor physical health.")
3. **Number of recent days mental health not good:** Thinking about your mental health—including stress, depression, and problems with emotions—how many days during the past 30 days was your mental health not good? (Referred to as "poor mental health.")
4. **Number of recent days limited due to poor physical/mental health:** During the past 30 days, how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? (Referred to as "limited by poor health.")

Although the CDC currently reports BRFSS data from 2010 on its website, and these results are used to inform the HP 2020 Goals, HCSDB HRQOL results are compared to norms calculated from 2015 BRFSS micro data, which are not currently reported in summary like 2010, but rather containing responses from approximately 440,000 respondents in 53 states/territories, and reweighted to match our MHS population. Mode differences between the BRFSS and HCSDB may result in mode effects and make comparison more difficult.

Because the MHS population differs from the U.S. population in age, gender, and ethnic composition, BRFSS rates were reweighted to match MHS users' characteristics in those areas. However, the populations may differ in other ways that complicate the comparisons between estimates from the BRFSS and HCSDB—for example, employment, education, and access to health care.

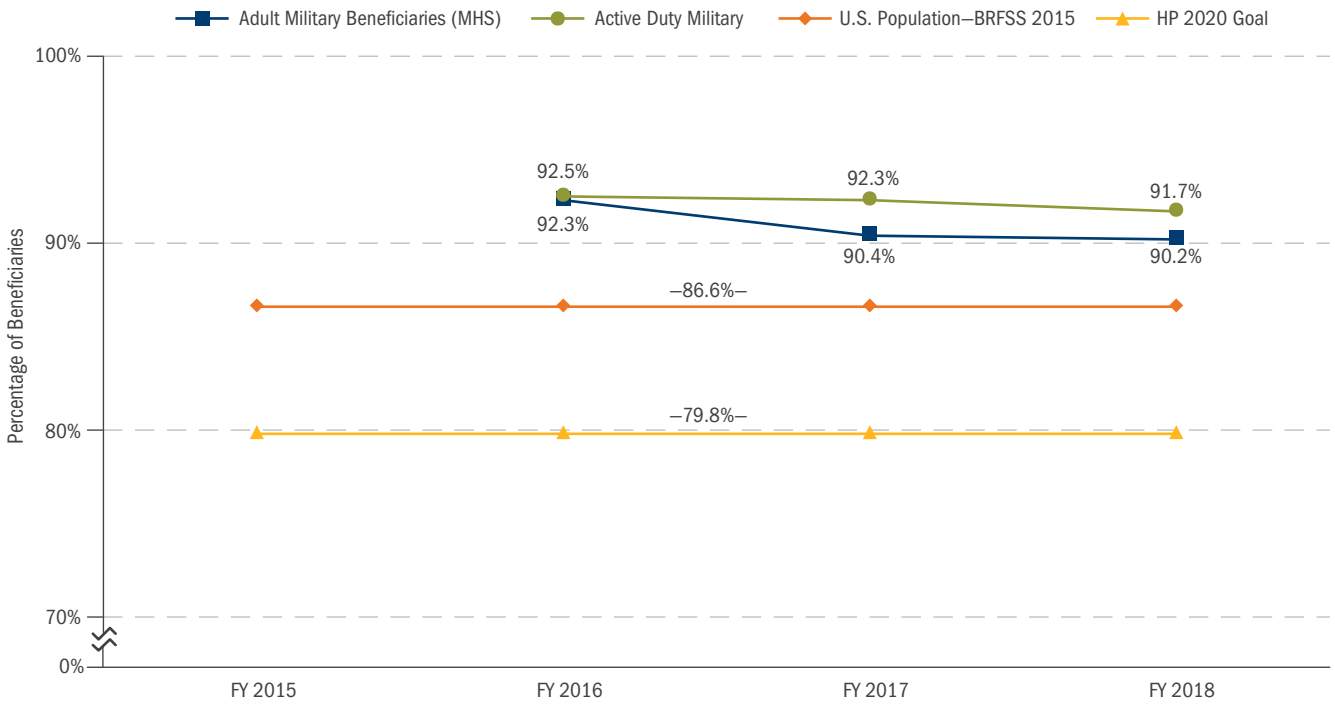
As shown in the figure to follow, the overall MHS population in general—and the Active Duty military component within the MHS population—rate their health status higher than the general U.S. population did in 2015, and both are higher than the HP 2020 goal of 79.8 percent.

- The overall MHS population rating of good or better health appears to have declined slightly between FY 2016 and FY 2018 by about two percentage points, while the Active Duty military (included in the overall MHS population) has declined less than a percentage point.
- Not shown: Similar to BRFSS 2015 results, smokers report statistically significantly more limited days than nonsmokers, as do those measured as obese compared to normal weight, and those with hypertension compared to those without.

HEALTH-RELATED QUALITY OF LIFE *(CONT.)*

Using CDC's Health-Related Quality of Life (HRQOL) Questions as a Proxy Measure of "Better Health" *(cont.)*

PERCENTAGE OF MILITARY BENEFICIARIES SELF-RATING HEALTH STATUS AS GOOD OR BETTER, BASED ON BRFSS



Source: DHA/SP&FI (J-5)/Decision Support, 1/28/2018

Notes:

– BRFSS results are from the 2015 survey administered by CDC, reweighted to match 2016 MHS population.
– FY 2016 (Q2 and Q3) and FY 2017 (Q3) HRQOL questions tested using population-based HCSDB.

Survey fielding:

– Random sample of U.S. MHS-eligible adult population under age 65. Invitation letter and reminder letter mailed to all sampled beneficiaries with known name and address.
– E-mail and follow-ups to Active Duty members.
– Response by Internet for all, and paper questionnaire mailed to a sample of all nonresponding Active Duty family members, retirees, and their family members living in the United States.

SAVINGS AND RECOVERIES

Pharmacy Retail Refunds

The District Court's 2008 decision granted the Department of Defense (DoD) the authority to require refunds from drug manufacturers, a decision upheld by the U.S. Court of Appeals in 2013. Due to enhancements in the Retail Refund Calculation process and improvements in communication of eligible products among drug manufacturers, the Department of Veterans Affairs (VA), and the DoD, utilization data/refund recalculations were performed to ensure the accuracy of the data reported to drug manufacturers, as well as refunds due to the DoD, since the inception of the Final Rule from the U.S. Court of Appeals. Recalculations were conducted for CY 2009 Q3 through CY 2011 Q4 bill quarters during FY 2013 and FY 2014.

There are two main drivers for the decline in rebates on retail drugs: (1) the implementation of the maintenance drugs benefit program influenced beneficiaries to purchase maintenance drugs through mail order rather than retail pharmacies, and (2) many drugs included under the TRICARE Retail Refund Program have patents expiring and therefore are no longer included in the program.

PHARMACY RETAIL REFUNDS ($ MILLIONS), FYs 2014–2018

	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018
Total Receivables	$1,319.28	$1,068.04	$929.44	$850.71	$841.78
Routine	$1,280.96	$1,068.04	$929.44	$850.71	$841.78
Additional From Recalculations (CY 2009 Q3–CY 2011 Q4)	$38.32	–	–	–	–
Total Collections	$1,496.25	$1,117.14	$982.73	$847.40	$853.44

Source: DHA Business Support Directorate, Contract Resource Management, 12/20/2018

Notes: Refund amounts are netted out of pharmacy costs provided within this report. The refunds in the chart above are categorized in the fiscal year (FY) they were validated and billed to the manufacturers.

Program Integrity Activities

The Defense Health Agency (DHA) Office of Program Integrity (PI) is responsible for health care anti-fraud to safeguard beneficiaries and protect benefit dollars. DHA PI develops and executes anti-fraud and abuse policies and procedures, provides oversight of contractor program integrity activities, coordinates investigative activities, develops cases for criminal prosecutions and civil litigations, and initiates administrative measures. Through a Memorandum of Understanding, DHA PI refers its fraud cases to the Defense Criminal Investigative Services. DHA PI also coordinates investigative activities with Military Criminal Investigative Offices, as well as other federal, state, and local agencies.

PROGRAM INTEGRITY RECOVERIES/COST AVOIDANCE ($ MILLIONS), CYs 2015–2017

	CY 2015	CY 2016	CY 2017
Total Recoveries	$70.0	$104.9	$88.8
Court-Ordered Fraud Judgments/ Settlements	$61.2	$92.7	$66.3
PI Contractor Administrative Recoupment/Offsets (Received)	$8.8	$12.2	$22.5
Total PI Contractors Cost Avoidance	$34.2	$33.0	$55.0
Contractor Prepayment Reviews	$33.5	$31.9	$53.6
Excluded Providers	$0.7	$1.1	$1.4

Sources: TRICARE Program Integrity Operational Reports and Quarterly Fraud and Abuse Reports, CY 2014–CY 2017. CY 2017 data are the latest reported as of 10/22/2018.

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 claim system was developed by the DHA Healthcare Operations Directorate/TRICARE Health Plan Division for use by TRICARE purchased care contractors. The system was designed as a retrospective auditing tool and facilitates the identification of actual duplicate claim payments and the initiation and tracking of recoupments. The table below provides the historical recovery of duplicate claim payments. Duplicate claim recoveries are consistent with previous years.

RECOVERIES ($ MILLIONS), FYs 2016–2018

	FY 2016	FY 2017	FY 2018
Recovery A—Post-Payment Duplicate Claim Recoveries	$6.8	$7.1	$4.5

SAVINGS AND RECOVERIES *(CONT.)*

Program Savings and Claim Recoveries

Recovery B—Improper Payment Recoveries: The DHA is vigilant in ensuring the accuracy of health care claim payment within the military health benefits program. The DHA has contracted with an external independent contractor (EIC) who is responsible for conducting post-payment accuracy reviews of TRICARE health benefit claims. The EIC is responsible for identifying improper payment made by TRICARE purchased care contractors as a result of contractor noncompliance with TRICARE policy, benefit, and/or reimbursement requirements.

OVERPAYMENTS RECAPTURED OUTSIDE OF PAYMENT RECAPTURE AUDITS ($ MILLIONS), FY 2017

PROGRAM OR ACTIVITY	ACTUAL OVERPAYMENT DOLLARS IDENTIFIED VIA RANDOM SAMPLES	TOTAL AMOUNT EXTRAPOLATED (ESTIMATED THROUGHOUT TOTAL OUTLAYS)	AMOUNT RECAPTURED[a] (REFUNDS)
Total	$4.14	$72.38	$22.48

Sources: DHA/R&M (J-1/J-8)/Trust Fund and Revenue Cycle Management Improper Payment Evaluation Branch, 12/19/2018; Operational Reports and Quarterly Fraud and Abuse Reports

[a] "Amount Recaptured" in FY 2017 represents the total overpayment dollars from sampled claims.

Notes:

– These numbers include recoupments for overpayments identified in audits as well as refunds occurring in the course of routine claim adjustments (for claims initially paid in FY 2017 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 2017 figure for ADDP represents refunds shown on contractor invoices to DHA. ADDP data is not included in the TED system, thus contractor invoices were used because TED transactions are not available.

In addition to the EIC post-payment reviews, DHA requires TRICARE purchased care contractors to use industry best business practice when processing TRICARE claims. Contractors are required to use claim auditing software and develop prepayment initiatives that are manual and/or automated to avoid or prevent improper payments. The above table provides FY 2017 improper payment recoveries of health care as a result of the EIC compliance reviews and ongoing purchased care contractor efforts to identify and recover improper payments.

INPATIENT UTILIZATION RATES AND COSTS

TRICARE Inpatient Utilization Rates Compared with Civilian Benchmarks (U.S. Only)

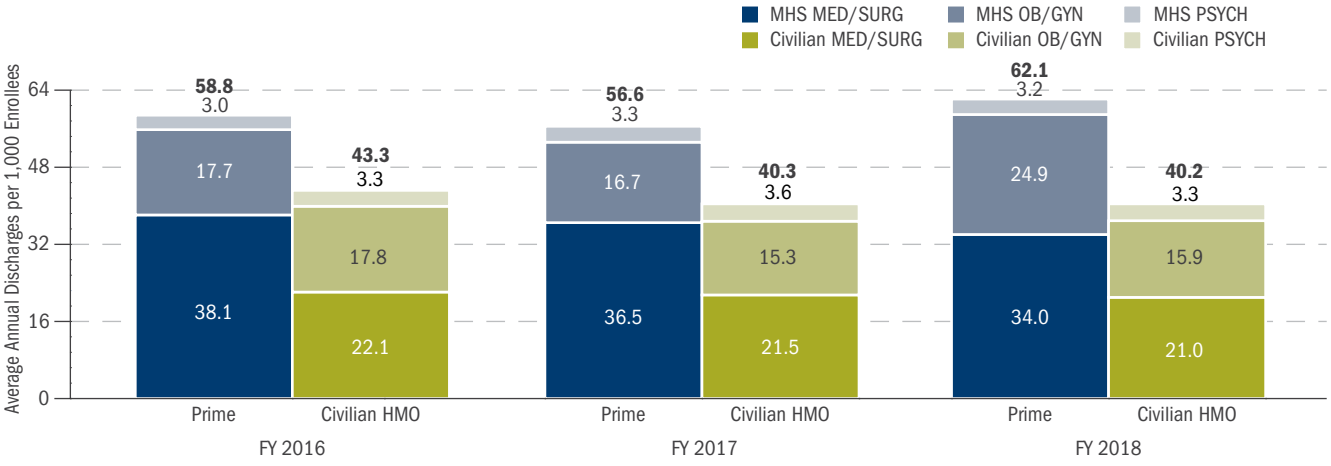
TRICARE Prime Enrollees

This section compares the inpatient utilization of TRICARE Prime enrollees (including TYA Prime) with that of enrollees in civilian employer-sponsored health maintenance organization (HMO) plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. Inpatient utilization is measured as the total number of dispositions (i.e., the sum of direct and purchased care dispositions) because relative weighted products (RWPs) are not available in the civilian-sector data.

Dispositions are computed for three broad product lines—obstetrics/gynecology (OB/GYN), mental health (PSYCH), and other medical/surgical (MED/SURG)—and compared for acute care facilities only. The comparisons exclude beneficiaries aged 65 and older because very few are covered by employer-sponsored plans. The Military Health System (MHS) data further exclude beneficiaries enrolled in the Uniformed Services Family Health Plan (USFHP) and TRICARE Plus.

- TRICARE Prime inpatient utilization rates increased by 6 percent between FY 2016 and FY 2018, while the civilian HMO rates decreased by 7 percent. The increase in Prime inpatient utilization rates was driven largely by a 41 percent increase in OB utilization. In FY 2018, the TRICARE Prime inpatient utilization rate (direct and purchased care combined) was 54 percent higher than the civilian HMO utilization rate (62.1 discharges per 1,000 Prime enrollees compared with 40.2 per 1,000 civilian HMO enrollees).
- In FY 2018, the TRICARE Prime inpatient utilization rate was 62 percent higher than the civilian HMO rate for MED/SURG procedures, 56 percent higher for OB/GYN procedures, and 3 percent lower for PSYCH procedures.
- The average length of stay (LOS) for MHS Prime enrollees (direct and purchased care combined) remained constant at 3.3 days from FY 2016 to FY 2018, whereas the average LOS for civilian HMO enrollees remained constant at 3.6 days. In FY 2018, the average LOS for MHS Prime enrollees was 8 percent lower than that of civilian HMO enrollees (not shown).

INPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK, FYs 2016–2018



Sources: MHS administrative data, 1/17/2019, and IBM Watson Health, MarketScan® Commercial Claims and Encounters (CCAE) database, 12/26/2018

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2018 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

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

LOWER COST

INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

TRICARE Inpatient Utilization Rates Compared with Civilian Benchmarks (U.S. Only) *(cont.)*

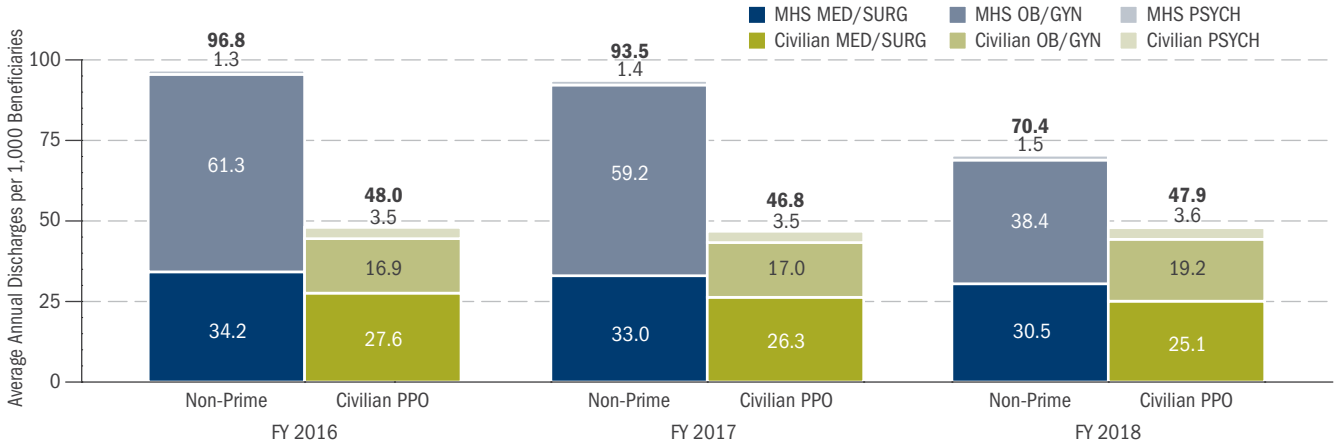
Non-Prime-Enrolled Beneficiaries

This section compares the inpatient utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored preferred provider organization (PPO) plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. Inpatient utilization is measured as the total number of dispositions (i.e., the sum of direct and purchased care dispositions) because RWPs are not available in the civilian-sector data.

Dispositions are computed for three broad product lines—OB/GYN, PSYCH, and other MED/SURG procedures—and compared for acute care facilities only. The comparisons exclude beneficiaries aged 65 and older because very few are covered by employer-sponsored plans. To make the utilization rates of MHS and civilian beneficiaries more comparable, non-Prime-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Although most beneficiaries who fail to file a TRICARE claim have private health insurance, we estimate that about 16 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 2016 and FY 2018, the TRICARE non-Prime utilization rate decreased by 27 percent, whereas the civilian PPO inpatient utilization rate remained unchanged. Despite the sharp overall decline, the TRICARE rate remains well above the civilian benchmark. In FY 2018, the inpatient utilization rate (direct and purchased care combined) for non-Prime-enrolled beneficiaries was almost 47 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 2016 to FY 2018, the MHS OB/GYN disposition rate decreased by 37 percent, whereas it increased by 13 percent in the civilian sector. Despite the precipitous drop in the MHS non-Prime OB/GYN disposition rate, it was still double that of the corresponding civilian PPO rate in FY 2018.
- Of the three product lines considered in this report, only PSYCH procedures had lower utilization in the MHS than in the civilian sector.
- The average LOS for MHS non-Prime-enrolled beneficiaries (direct and purchased care combined) remained at about 3.6 days between FY 2016 and FY 2018, whereas the average LOS for civilian PPO participants declined slightly from 3.6 to 3.5 days. As a result, the average LOS for MHS non-Prime beneficiaries was 3 percent higher than that of civilian PPO participants in FY 2018 (not shown).

INPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK, FYs 2016–2018



Sources: MHS administrative data, 1/17/2019, and IBM Watson Health, MarketScan® CCAE database, 12/26/2018

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2018 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

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

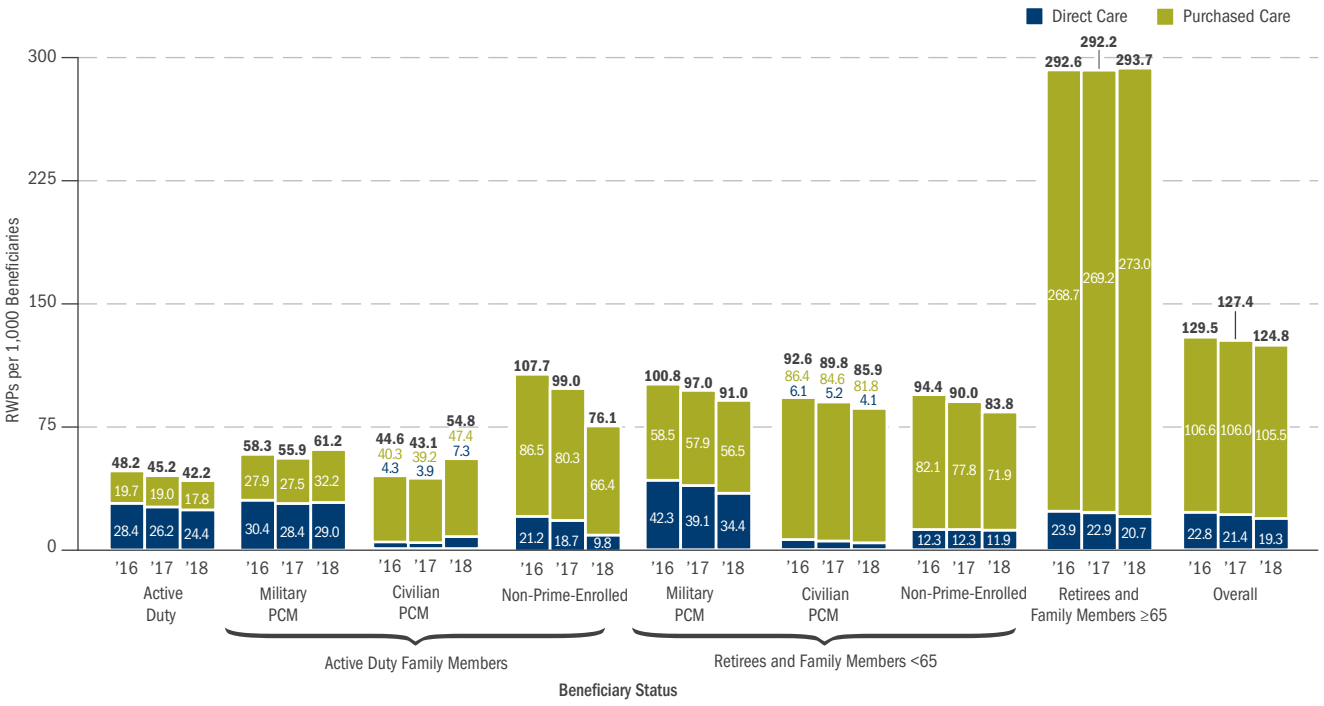
INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Inpatient Utilization Rates by Beneficiary Status (U.S. Only)

When breaking out inpatient utilization by beneficiary group, RWPs per capita more accurately reflect differences across beneficiary groups than do discharges per capita. MHS RWPs are based on the Medicare Severity Diagnosis Related Group (MS-DRG) system of classifying inpatient hospital cases under the Medicare Prospective Payment System and are relevant only for acute care hospitals.

- The overall (direct and purchased care combined) inpatient utilization rate (RWPs per 1,000 beneficiaries) decreased by 4 percent from FY 2016 to FY 2018.
- Between FY 2016 and FY 2018, the direct care inpatient utilization rate decreased by 15 percent overall, due in part to the downsizing of four military hospitals to clinics over that time period and in part because of the lack of visibility of MHS GENESIS data for some facilities in FY 2017 and FY 2018. Non-Prime-enrolled ADFMs experienced the largest decline (54 percent). Retirees under 65 with a civilian PCM also experienced a large decline (33 percent) but direct care utilization by that group is relatively small. The only group with an increase in utilization was ADFMs with a civilian PCM (73 percent) but, again, that is based on a low utilization level.
- The overall purchased acute care inpatient utilization rate declined by 1 percent between FY 2016 and FY 2018 but there was a great deal of variation across beneficiary groups. Enrolled ADFMs experienced large increases (15 percent for those with a military PCM and 18 percent for those with a civilian PCM). However, non-Prime-enrolled ADFMs experienced a large decline in utilization (23 percent).
- Excluding Medicare-eligible beneficiaries (for whom Medicare is likely their primary source of care and TRICARE is second payer), the percentage of per capita inpatient workload performed in purchased care facilities increased from 71 percent in FY 2016 to 73 percent in FY 2018 (the MHS GENESIS issue likely played a role in this result).
- From FY 2016 to FY 2018, the percentage of per capita inpatient workload referred to the network on behalf of beneficiaries enrolled with a military PCM (including Active Duty personnel) rose from 50 percent to 53 percent (again, the MHS GENESIS issue likely had an effect).

AVERAGE ANNUAL INPATIENT RWPs PER 1,000 BENEFICIARIES, FYs 2016–2018



Source: MHS administrative data, 1/17/2019

Notes:

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

– The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere.

LOWER COST

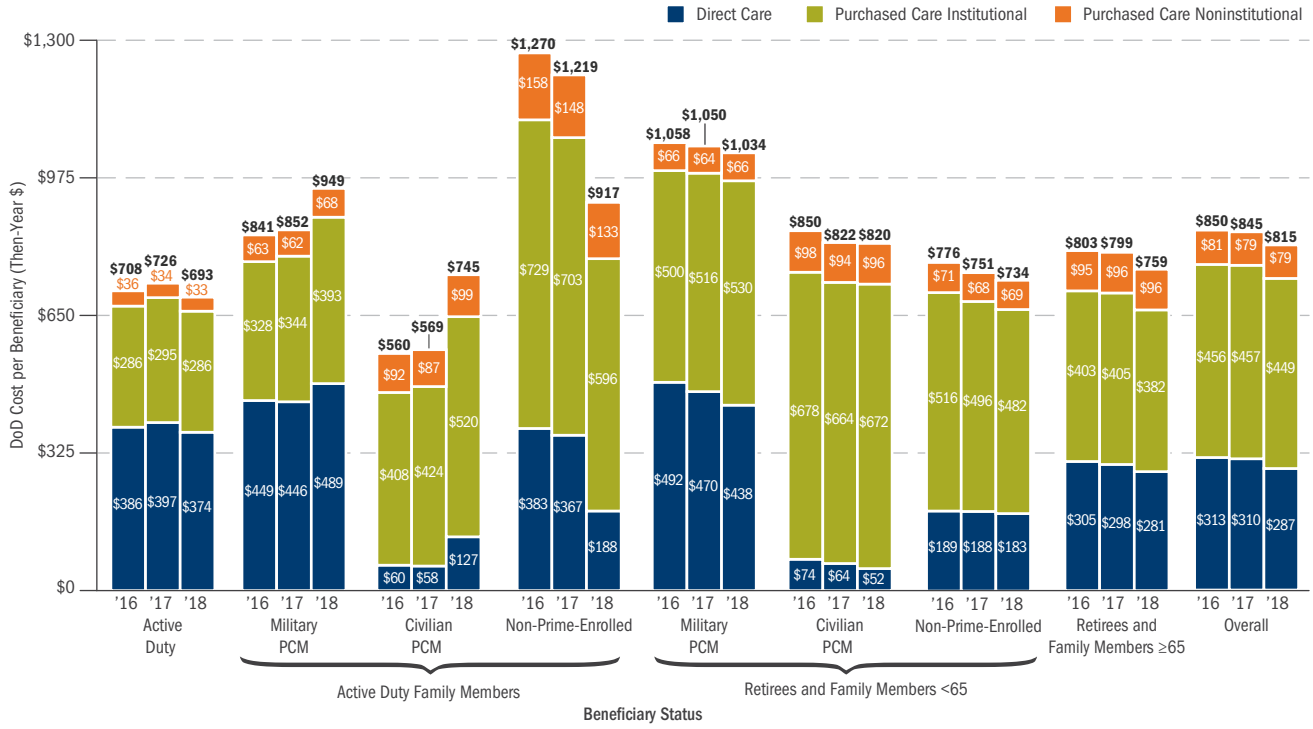
INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Inpatient Cost by Beneficiary Status (U.S. Only)

MHS costs for inpatient care include costs incurred in both acute and non-acute care facilities. They also include the cost of inpatient professional services (i.e., noninstitutional charges [e.g., physician, lab, anesthesia]) associated with a hospital stay. The overall MHS inpatient cost (in then-year dollars) per beneficiary (far-right columns below), including TFL, decreased by 4 percent between FY 2016 and FY 2018.

- All beneficiary groups except enrolled ADFMs experienced declines (ranging from –2 percent for RETFMs under 65 with a military PCM to –28 percent for non-Prime-enrolled ADFMs) in total (direct plus purchased care) per capita inpatient costs. ADFMs with a military PCM experienced a 13 percent increase, while ADFMs with a civilian PCM experienced a 33 percent increase.
- Direct care inpatient costs per capita decreased by 8 percent between FY 2016 and FY 2018. Purchased care inpatient costs (institutional plus noninstitutional) per capita decreased by 2 percent over the same period.
- The direct care cost per RWP increased from $13,738 in FY 2016 to $14,869 in FY 2018 (8 percent).
- Exclusive of TFL, DoD purchased care cost (institutional plus noninstitutional) per RWP in acute care facilities increased from $7,416 in FY 2016 to $7,722 in FY 2018 (4 percent).
- The DoD purchased care cost per RWP is much lower than that for direct care partly because some beneficiaries (e.g., retirees) have substantial cost shares and may also have other health insurance (OHI). When beneficiaries have OHI, TRICARE becomes second payer, and the government pays a smaller share of the cost. If OHI claims are excluded, the DoD cost per RWP in acute care facilities increased slightly from $8,883 in FY 2016 to $9,178 (3 percent) in FY 2018, exclusive of TFL.
- Note: The reader should exercise caution when comparing the direct versus purchased care costs per RWP. The data on this page are unadjusted for differences in beneficiary mix, enrollment status, geographical location of care, etc. They represent DoD health care costs only, and specifically exclude beneficiary cost shares, administrative costs, and overhead expenses.

AVERAGE ANNUAL DoD INPATIENT COSTS PER BENEFICIARY, FYs 2016–2018



Source: MHS administrative data, 1/17/2019

Notes:

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

– The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere.

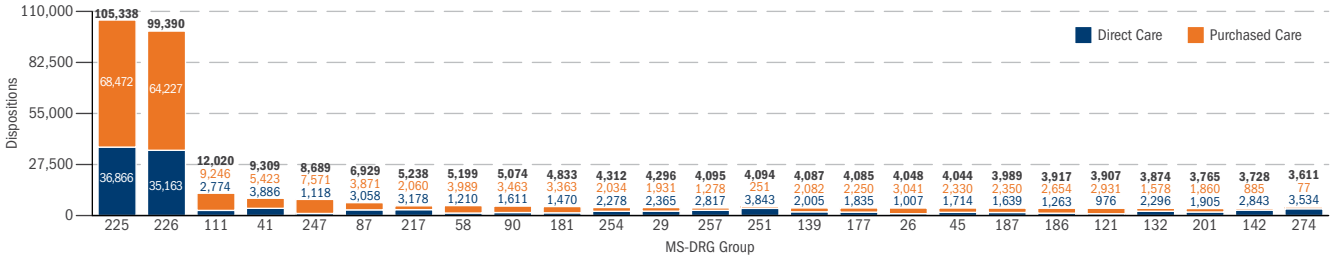
INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Leading Inpatient Diagnosis Groups (U.S. Only)

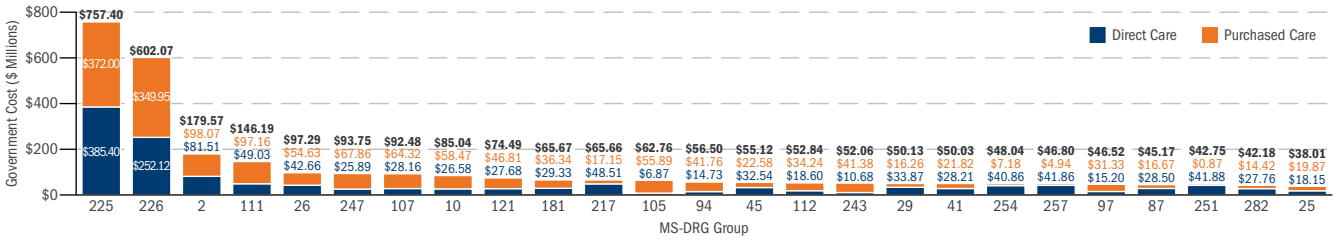
The MHS uses the MS-DRG system to classify acute care hospital inpatient cases into clinically related categories having similar treatment costs. For the purpose of this section, MS-DRGs exhibiting variations in complications and comorbidities were grouped into like categories[1] and numbered sequentially. The category numbers have no significance other than to identify the DRG groups on the horizontal axes in the charts below. See the Appendix for additional detail on the DRG grouping methodology.

The top 25 MS-DRG groups in terms of volume in FY 2018 accounted for 66 percent of all inpatient admissions (direct care and purchased care combined) in acute care hospitals. The leading MS-DRG groups in terms of cost in FY 2018 include both institutional and noninstitutional claims (i.e., they include hospital, attendant physician, drug, and ancillary service charges). The top 25 MS-DRG groups in terms of cost in FY 2018 accounted for 57 percent of total inpatient costs (direct and purchased care combined) in acute care hospitals. TFL admissions and observation stays are excluded from the calculations for both volume and cost.

LEADING INPATIENT DIAGNOSIS GROUPS BY VOLUME, FY 2018



LEADING INPATIENT DIAGNOSIS GROUPS BY COST, FY 2018



Source: MHS administrative data, 1/17/2019

MS-DRG Groups

002 Ecmo or Tracheostomy
010 Craniotomy
025 Stomach, Esophageal, and Duodenal Procedures
026 Major Small and Large Bowel Procedures
029 Appendectomy
041 Esophagitis, Gastroenteritis, and Miscellaneous Digestive Disorders
045 Cholecystectomy
058 Seizures and Headaches
087 Simple Pneumonia and Pleurisy
090 Bronchitis and Asthma
094 Cardiac Valve and Other Major Cardiothoracic Procedures
097 Coronary Bypass
105 Combined Anterior/Posterior Spinal Fusion
107 Spinal Fusion Except Cervical
111 Major Joint Replacement or Reattachment of Lower Extremity
112 Cervical Spinal Fusion
121 Percutaneous Cardiovascular Procedures with Coronary Artery Stent
132 Heart Failure and Shock
139 Cardiac Arrhythmia and Conduction Disorders
142 Chest Pain
177 Cellulitis
181 O.R. Procedures for Obesity
186 Diabetes
187 Nutritional and Miscellaneous Metabolic Disorders
201 Kidney and Urinary Tract Infections
217 Uterine and Adnexal Procedures for Nonmalignancy
225 Pregnancy, Childbirth, and the Puerperium
226 Newborns and Other Neonates with Condition Originating in Perinatal Period
243 Infectious and Parasitic Diseases with O.R. Procedure
247 Septicemia or Severe Sepsis
251 Neuroses Except Depressive
254 Psychoses
257 Alcohol/Drug Abuse or Dependence
274 Other Factors Influencing Health Status
282 Extensive O.R. Procedure Unrelated to Principle Diagnosis

- The top two procedures by volume are related to childbirth, accounting for 42 percent of all hospital admissions and 26 percent of total hospital costs (not just among the top 25).
- Procedures performed in private-sector acute care hospitals account for 62 percent of the total volume of the top 25 MS-DRG groups and 54 percent of the total cost.
- Admissions in direct care facilities exceed those in purchased care facilities for only nine of the top 25 MS-DRG groups. However, expenditures in direct care facilities exceed those in purchased care facilities for 10 of the top 25 MS-DRG groups.
- Surgical procedures for obesity rank 10th in both volume and cost among the top 25 MS-DRG groups. Thus, the obesity epidemic in the civilian sector appears to be mirrored to an extent in the DoD population as well.

[1] DRGs were grouped into like categories using a code set available on www.findacode.com/code-set.php?set=DRG, an online database of medical billing codes and information. The site lists surgical and medical DRGs within each Major Diagnostic Category (MDC) with headings above diagnostically related DRGs. In some cases (e.g., DRGs related to pregnancy and childbirth), the headings were further grouped into larger, descriptively similar categories. The headings were then sequentially numbered, providing the basis for the DRG grouping methodology.

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

OUTPATIENT UTILIZATION RATES AND COSTS

TRICARE Outpatient Utilization Rates Compared with Civilian Benchmarks (U.S. Only)

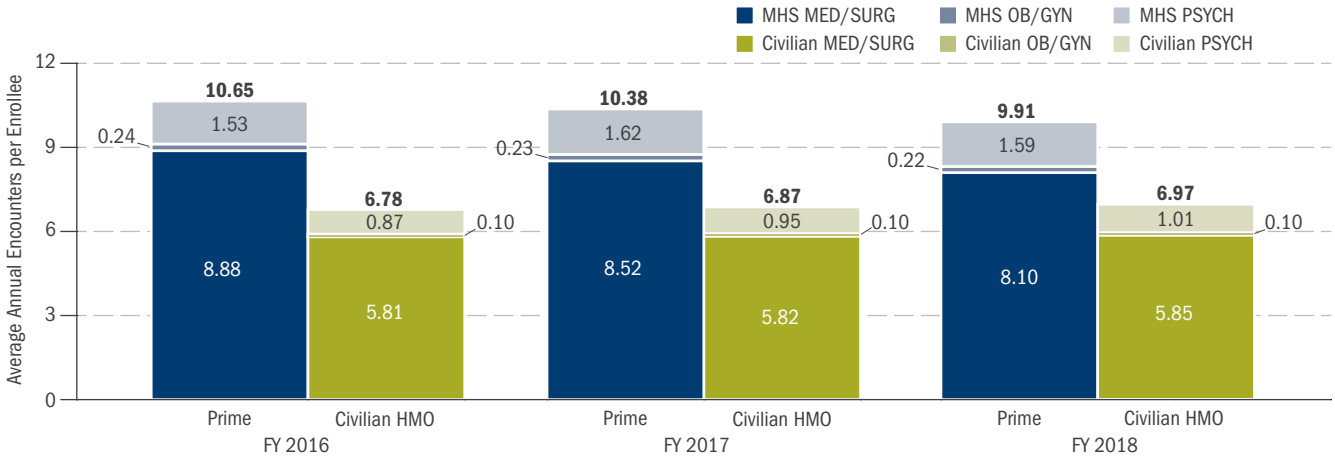
TRICARE Prime Enrollees

This section compares the outpatient utilization of TRICARE Prime enrollees with that of enrollees in civilian employer-sponsored HMO plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. Outpatient utilization is measured in terms of encounters because the civilian-sector data used in the comparisons do not contain a measure of relative value units (RVUs). However, there is no fixed definition for what constitutes a "face-to-face" encounter with a physician. TRICARE and the private sector may therefore use varying methodologies to calculate the number of encounters.

Encounters are computed for three broad product lines: OB/GYN, PSYCH, and other MED/SURG procedures. The comparisons are made for beneficiaries under age 65 only. The MHS data exclude beneficiaries enrolled in the USFHP and TRICARE Plus. Because telephone consults are routinely recorded in direct care data, but appear very infrequently in private-sector claims, they are also excluded from the direct care utilization computations.

- The overall TRICARE Prime outpatient utilization rate (direct and purchased care combined) decreased by 7 percent between FY 2016 and FY 2018. The civilian HMO outpatient utilization rate increased by 3 percent over the same period.
- In FY 2018, the overall Prime outpatient utilization rate was 42 percent higher than the civilian HMO rate.
- In FY 2018, the Prime outpatient utilization rate for MED/SURG procedures was 38 percent higher than the civilian HMO rate.
- The Prime outpatient utilization rate for OB/GYN procedures fell by 8 percent between FY 2016 and FY 2018 (albeit from a low base rate) but still remained more than double that for civilian HMOs in FY 2018. 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 57 percent higher than the corresponding rate for civilian HMOs in FY 2018. 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 2016–2018



Sources: MHS administrative data, 1/17/2019, and IBM Watson Health, MarketScan® CCAE database, 12/26/2018

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2018 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

[1] Outpatient encounters are not precisely comparable between the direct and private care sectors (including purchased care). In particular, services that are bundled in the private sector (such as newborn delivery, including prenatal and postnatal care) will not generate any outpatient encounters but will generate a record for each encounter in the direct care system. Because maternity care is a high-volume procedure, the disparity in utilization rates between the direct care and civilian systems will be exaggerated.

OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

TRICARE Outpatient Utilization Rates Compared with Civilian Benchmarks (U.S. Only) *(cont.)*

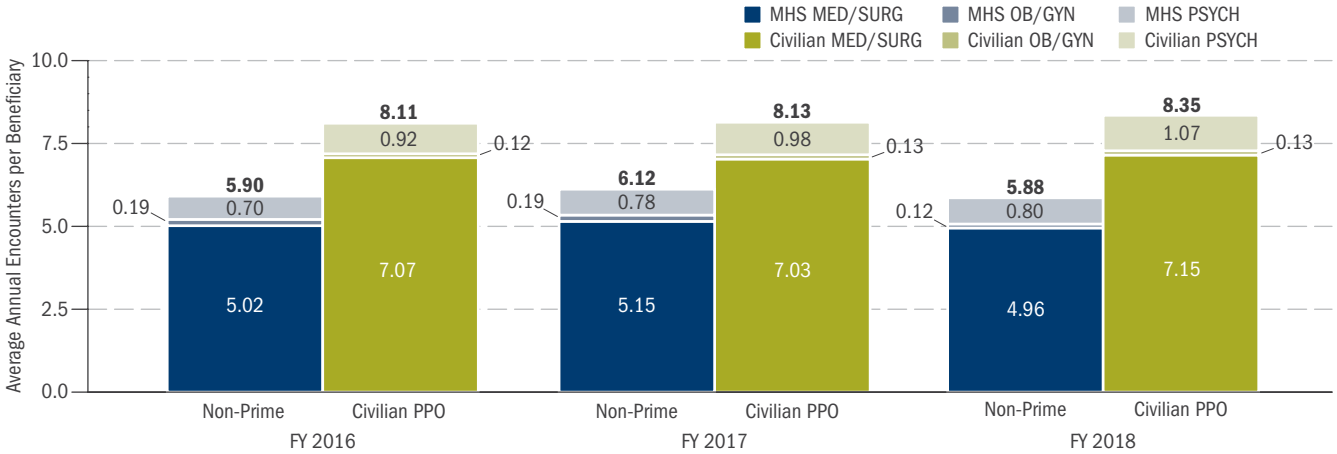
Non-Prime-Enrolled Beneficiaries

This section compares the outpatient utilization of beneficiaries not enrolled in TRICARE Prime (including TRICARE Select in FY 2018, TRICARE Standard/Extra in FYs 2016–2017, and space-available MTF care) with that of participants in civilian employer-sponsored PPO plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. Outpatient utilization is measured in terms of encounters because the civilian-sector data used in the comparisons do not contain a measure of RVUs. However, there is no fixed definition for what constitutes a "face-to-face" encounter with a physician. TRICARE and the private sector may therefore use varying methodologies to calculate the number of encounters.

Encounters are computed for three broad product lines: OB/GYN, PSYCH, and other MED/SURG. The comparisons are made for beneficiaries under age 65 only. To make the utilization rates of MHS and civilian beneficiaries more comparable, non-Prime-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Because telephone consults are routinely recorded in direct care data, but appear very infrequently in private-sector claims, they are also excluded from the direct care utilization computations. Although most beneficiaries who fail to file a TRICARE claim have private health insurance, we estimate that about 16 percent do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable to the civilian rates, which also include non-users.

- The overall TRICARE outpatient utilization rate (direct and purchased care combined) for non-Prime-enrolled beneficiaries remained unchanged between FY 2016 and FY 2018. The civilian PPO outpatient utilization rate increased by 3 percent over the same period.
- The overall TRICARE non-Prime outpatient utilization rate remained well below the level observed for civilian PPOs. In FY 2018, TRICARE non-Prime outpatient utilization was 30 percent lower than in civilian PPOs.
- In FY 2018, the non-Prime outpatient utilization rate for MED/SURG procedures was 31 percent lower than the civilian PPO rate. MED/SURG procedures account for almost 90 percent of total outpatient utilization in both the military and private sectors.
- The non-Prime outpatient utilization rate for OB/GYN procedures decreased by 37 percent between FY 2016 and FY 2018 but still remained 10 percent below the rate for civilian PPO participants in FY 2018.[1]
- The PSYCH outpatient utilization rate for non-Prime-enrolled MHS beneficiaries increased by 15 percent from FY 2016 to FY 2018; the rate increased by 17 percent for civilian PPO participants. In FY 2018, the PSYCH outpatient utilization rate for non-Prime-enrolled beneficiaries was 25 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.

OUTPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK, FYs 2016–2018



Sources: MHS administrative data, 1/17/2019, and IBM Watson Health, MarketScan® CCAE database, 12/26/2018

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2018 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

[1] The numbers on the chart are the same when rounded to two digits but are slightly different when not rounded.

LOWER COST

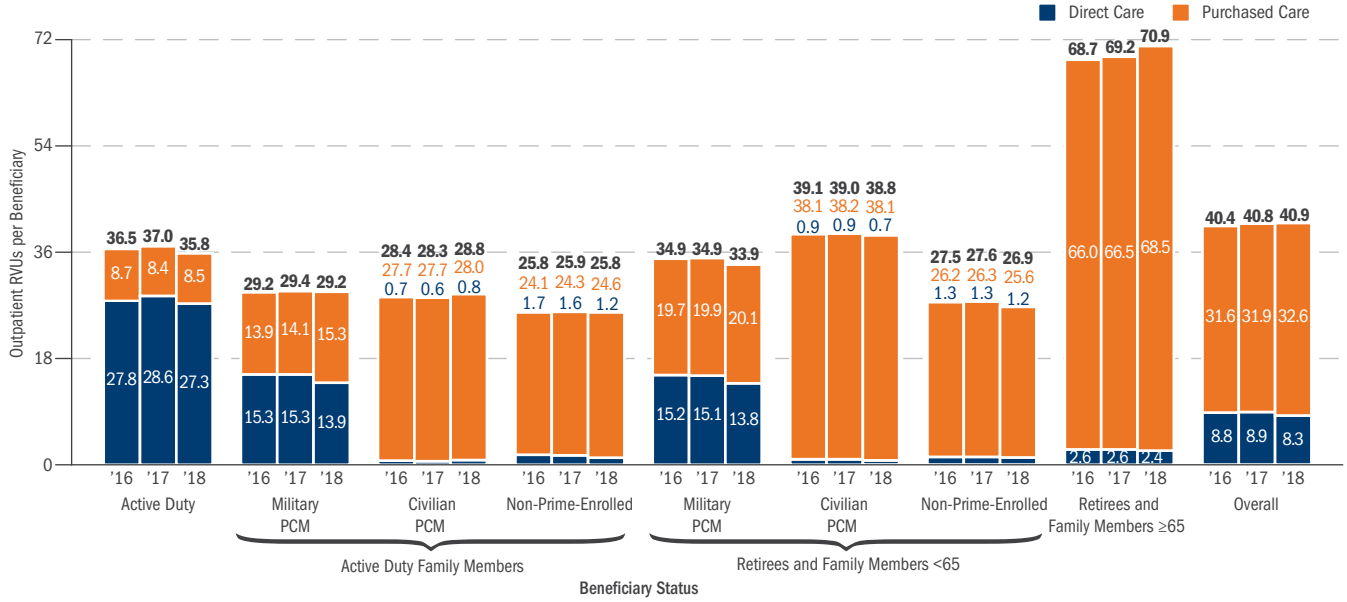
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Outpatient Utilization Rates by Beneficiary Status (U.S. Only)

When breaking out outpatient utilization by beneficiary group, RVUs per capita more accurately reflect differences across beneficiary groups than encounters per capita. The RVU measure used in this report is the sum of the Physician Work and Practice Expense RVUs (see the Appendix for a detailed description of the Physician Work and Practice Expense RVU measures).

- Total per capita MHS utilization (direct plus purchased care) increased by 1 percent from FY 2016 to FY 2018.
- Overall direct care outpatient utilization decreased by 6 percent from FY 2016 to FY 2018. Declines were experienced by every beneficiary group except ADFMs with a civilian PCM (15 percent increase). The declines ranged from –2 percent for Active Duty to –27 percent for non-Prime-enrolled ADFMs.
- From FY 2016 to FY 2018, purchased care outpatient utilization increased by 3 percent overall. ADFMs with a military PCM experienced a 10 percent increase. The remaining beneficiary groups experienced small increases or decreases in purchased care outpatient utilization.
- The TFL purchased care outpatient utilization rate increased by 4 percent from FY 2016 to FY 2018.

AVERAGE ANNUAL OUTPATIENT RVUs PER BENEFICIARY, FYs 2016–2018



Source: MHS administrative data, 1/17/2019

Notes:

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

– The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere.

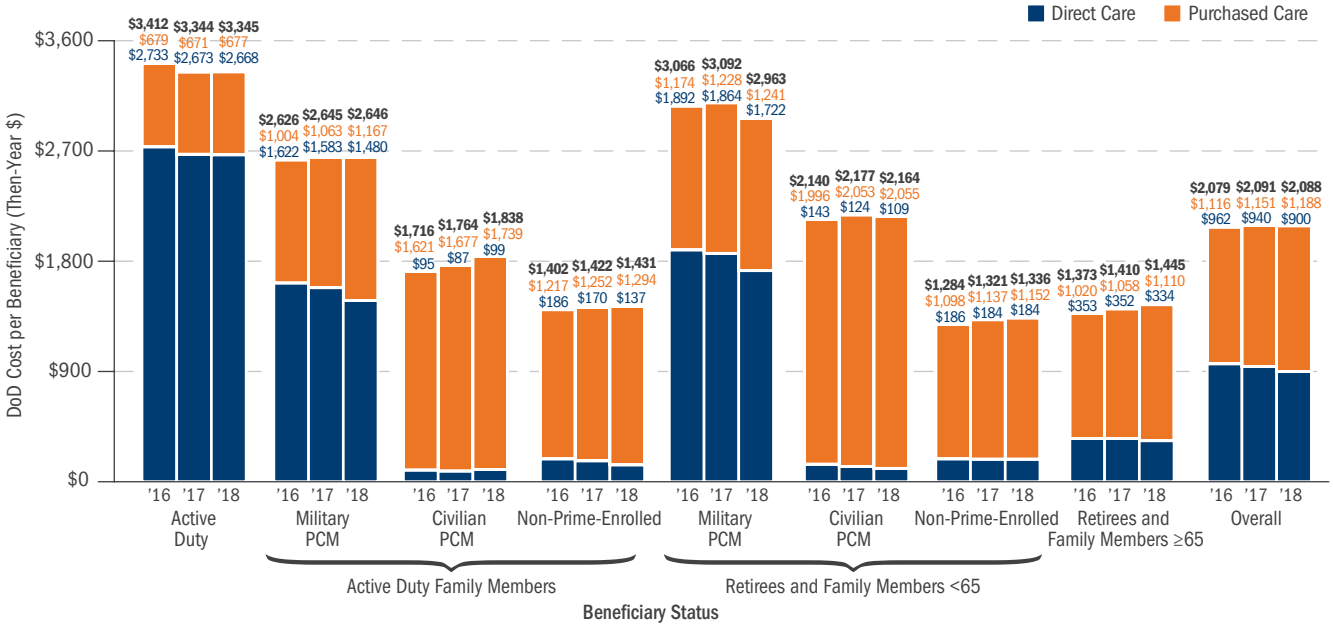
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Outpatient Costs by Beneficiary Status (U.S. Only)

Overall MHS outpatient costs (in then-year dollars) per beneficiary (far-right columns below), including TFL, increased by by less than 1 percent from FY 2016 to FY 2018. This was slightly below the rise in overall outpatient utilization (1 percent).

- The direct care cost per beneficiary decreased by 6 percent overall from FY 2016 to FY 2018. All beneficiary groups except ADFMs with a civilian PCM (4 percent increase) experienced a decline. Non-Prime-enrolled ADFMs experienced the largest decline (–26 percent). Government expenditures on those beneficiary groups, however, were relatively small compared to beneficiaries enrolled with a military PCM.
- Excluding TFL, the per capita DoD purchased care outpatient cost increased by 6 percent overall. Every beneficiary group except Active Duty (no change) experienced an increase. Increases ranged from 3 percent for RETFMs under 65 with a civilian PCM to 16 percent for ADFMs with a military PCM.
- The TFL purchased care outpatient cost per beneficiary increased by 9 percent between FY 2016 and FY 2018.[1]

AVERAGE ANNUAL DoD OUTPATIENT COSTS PER BENEFICIARY, FYs 2016–2018



Source: MHS administrative data, 1/17/2019

Notes:

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

– The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere.

[1] The basis for this statement is the collection of stacked bars labeled "Retirees and Family Members ≥65." Although the vast majority of TFL-eligible beneficiaries are retirees and family members ≥65, there is a small number who are not.

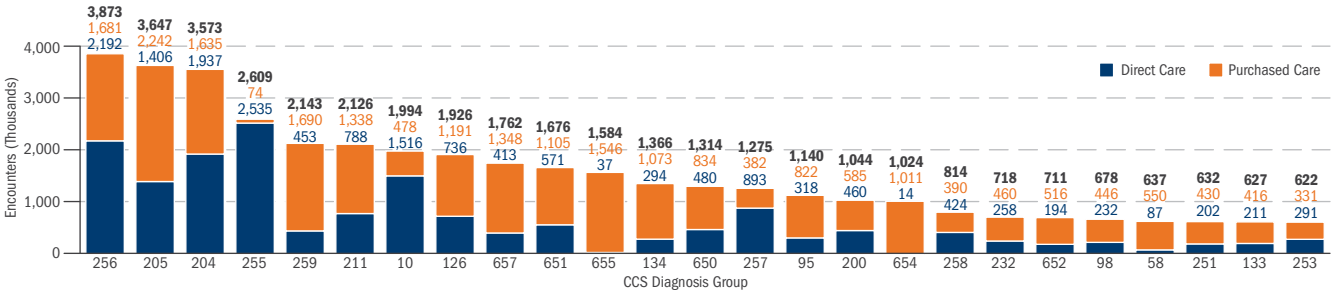
LOWER COST

OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

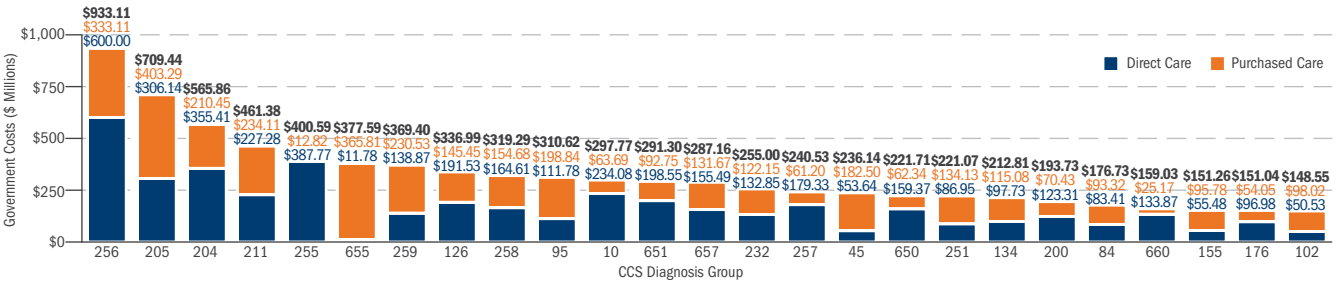
Leading Outpatient Diagnosis Groups (U.S. Only)

Leading outpatient diagnoses were determined by grouping ICD-10-CM primary diagnosis codes into like categories using the Clinical Classifications Software (CCS) tool developed through a federal-state-industry partnership and sponsored by the Agency for Healthcare Research and Quality.[1] The top 25 outpatient diagnosis groups in FY 2018 accounted for 65 percent of all outpatient encounters (direct care and purchased care combined) and 53 percent of total outpatient costs.[2] Direct care drug expenses, which are included in outpatient costs in the direct care administrative data, are excluded from the cost totals in this section. TFL encounters and telephone consults are excluded from the calculations for both volume and cost.

LEADING OUTPATIENT DIAGNOSIS GROUPS BY VOLUME, FY 2018



LEADING OUTPATIENT DIAGNOSIS GROUPS BY COST, FY 2018



Source: MHS administrative data, 1/17/2019

CCS Diagnosis Groups

10 Immunizations and screening for infectious disease
45 Maintenance chemotherapy; radiotherapy
58 Other nutritional; endocrine; and metabolic disorders
84 Headache; including migraine
95 Other nervous system disorders
98 Essential hypertension
102 Nonspecific chest pain
126 Other upper respiratory infections
133 Other lower respiratory disease
134 Other upper respiratory disease
155 Other gastrointestinal disorders
176 Contraceptive and procreative management
200 Other skin disorders
204 Other non-traumatic joint disorders
205 Spondylosis; intervertebral disc disorders; other back problems
211 Other connective tissue disease
232 Sprains and strains
251 Abdominal pain
253 Allergic reactions
255 Administrative/social admission
256 Medical examination/evaluation
257 Other aftercare
258 Other screening for suspected conditions (not mental disorders or infectious disease)
259 Residual codes; unclassified
650 Adjustment disorders
651 Anxiety disorders
652 Attention-deficit, conduct, and disruptive behavior disorders
654 Developmental disorders
655 Disorders usually diagnosed in infancy, childhood, or adolescence
657 Mood disorders
660 Alcohol-related disorders

- Five of the top six diagnosis groups in terms of volume are the same as those in terms of cost, albeit in different orders. The top three diagnosis groups by both volume and cost are general health examinations (adults and children), intervertebral disc disorders, and other nontraumatic joint disorders.
- Diagnoses treated in purchased care facilities account for 57 percent of the total volume of the top 25 diagnosis groups and 46 percent of the total cost.
- Encounters in direct care facilities exceed those in purchased care facilities for only six of the 25 top diagnosis groups. However, expenditures in direct care facilities exceed those in purchased care facilities for 14 of the top 25 diagnosis groups.

[1] The MHS began using the ICD-10-CM coding system for the first time in FY 2016. The analogous charts in reports prior to FY 2016 were based on the ICD-9-CM coding system.

[2] All costs were aggregated based on the primary diagnosis. Although some costs may be attributable to additional diagnoses on the record, there is no easy way to allocate the total cost to multiple diagnoses on the same record.

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

PRESCRIPTION DRUG UTILIZATION RATES AND COSTS

TRICARE Prescription Drug Utilization Rates Compared with Civilian Benchmarks (U.S. Only)

Prescription utilization is difficult to quantify since prescriptions come in different forms (e.g., liquid or pills), quantities, and dosages. Moreover, home delivery and military treatment facility (MTF) prescriptions can be filled for up to a 90-day supply, whereas retail prescriptions are usually based on 30-day increments for copay purposes. Prescription counts from all sources (including civilian) were normalized by dividing the total days supply for each by 30 days.

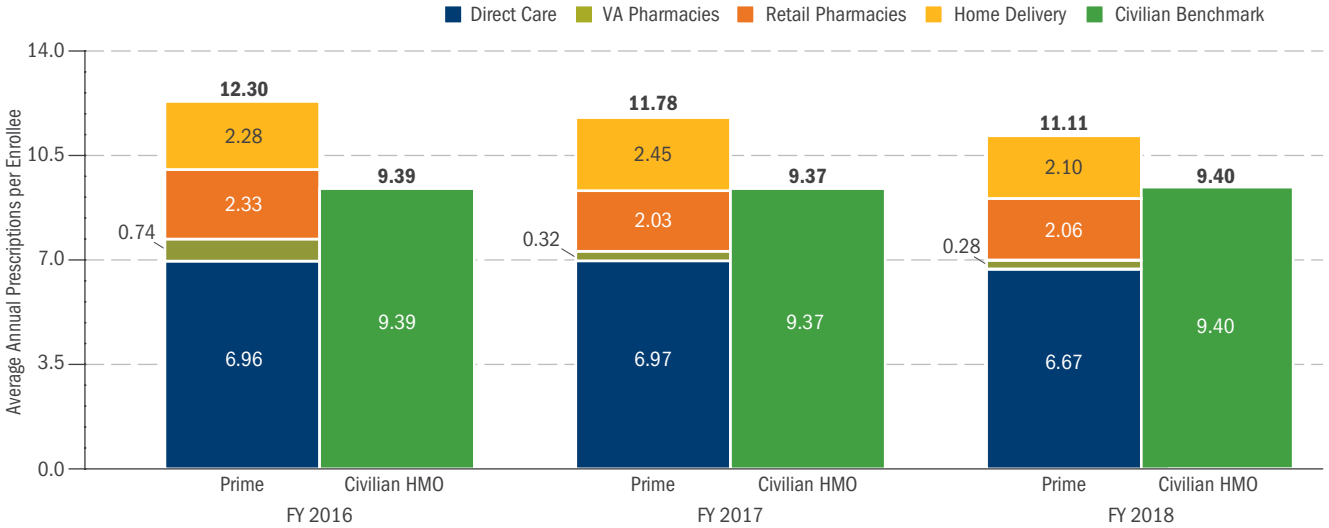
Direct care pharmacy data differ from private-sector claims in that they include over-the-counter medications. To make the utilization rates of MHS and civilian beneficiaries more comparable, over-the-counter medications were backed out of the direct care data using factors provided by the DHA Pharmacy Operations Division.

TRICARE Prime Enrollees

This section compares the outpatient prescription drug utilization of TRICARE Prime enrollees with that of enrollees in civilian employer-sponsored HMO plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. To give a more complete picture of total prescription drug utilization by TRICARE beneficiaries, prescriptions filled at VA pharmacies as part of a beneficiary's VA benefit (and paid for by VA) are included. Prescriptions filled at VA pharmacies under the TRICARE benefit have always been included with retail pharmacy prescriptions. Comparisons are made for beneficiaries under age 65 only. The MHS data exclude beneficiaries enrolled in the USFHP and TRICARE Plus.

- The overall prescription utilization rate (direct care, VA, and purchased care combined) for TRICARE Prime enrollees decreased by 10 percent between FY 2016 and FY 2018, while the civilian HMO benchmark rate remained unchanged. In FY 2018, the TRICARE Prime prescription utilization rate was 18 percent higher than the civilian HMO rate.
- Prescription utilization rates for Prime enrollees at DoD pharmacies decreased by 4 percent between FY 2016 and FY 2018, whereas the utilization rate at retail pharmacies decreased by 11 percent.
- Although the number of prescriptions is small, prescription utilization rates for Prime enrollees at VA pharmacies declined by 62 percent between FY 2016 and FY 2018.[1]
- Home delivery prescription utilization had been on the upswing since the DoD began increasing the disparity in copayments between retail and home delivery drugs in FY 2012. However, between FY 2016 and FY 2018, enrollee home delivery prescription utilization decreased by 8 percent, likely due, at least in part, to a sharp increase in copayments for home delivery drugs. In FY 2018, home delivery accounted for 50 percent of per capita purchased care prescription utilization by Prime enrollees (as measured by 30-day supply), down from 55 percent in FY 2017.

PRESCRIPTION UTILIZATION RATES BY SOURCE OF CARE[a]: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK, FYs 2016–2018



Sources: MHS administrative data, 1/17/2019, and IBM Watson Health, MarketScan® CCAE database, 12/26/2018

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2018 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

[a] Source of care (direct, VA, retail, or home delivery) is based solely on where the prescriptions were filled, not on where the prescribing services were provided.

[1] The DHA Pharmacy Operations Division suspects the drop was due to issues with the VA computer system that reports the use of VA pharmacies by DoD beneficiaries but there is no direct evidence to corroborate this.

LOWER COST

PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT.)*

TRICARE Prescription Drug Utilization Rates Compared with Civilian Benchmarks (U.S. Only) *(cont.)*

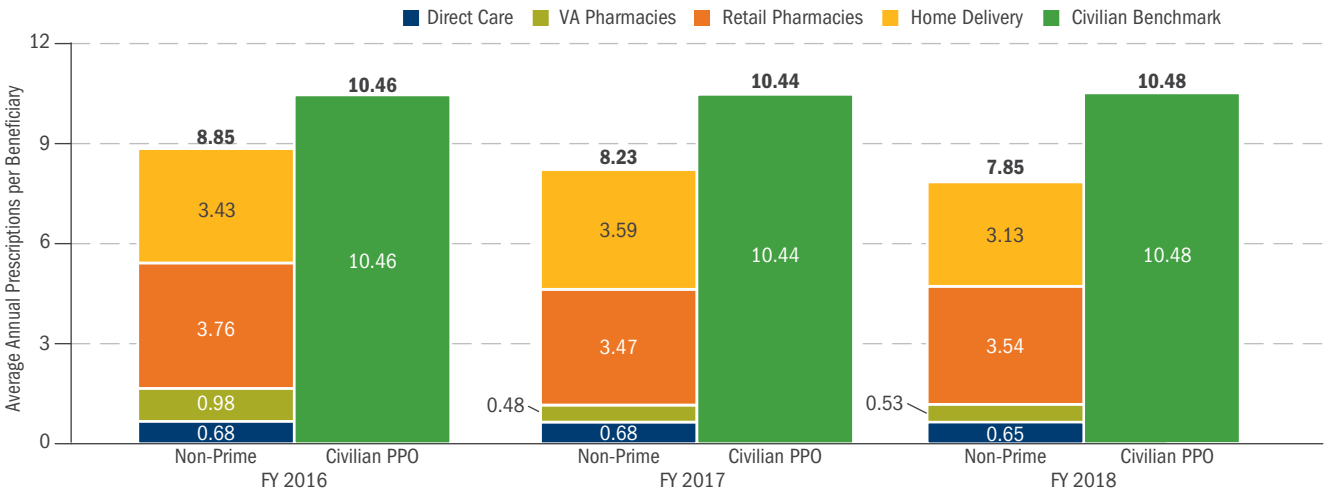
Non-Prime-Enrolled Beneficiaries

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 16 percent do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable to the civilian rates, which also include non-users.

- The overall prescription utilization rate (direct care, VA, and purchased care combined) for non-Prime-enrolled beneficiaries fell by 11 percent between FY 2016 and FY 2018. During the same period, the civilian PPO benchmark rate remained unchanged. In FY 2018, the TRICARE prescription utilization rate for non-Prime enrollees was 25 percent lower than the civilian PPO rate.
- The direct care prescription utilization rate for non-Prime-enrolled beneficiaries decreased by 4 percent from FY 2016 to FY 2018, whereas the utilization rate at retail pharmacies decreased by 6 percent.
- Prescription utilization rates for non-Prime enrollees at VA pharmacies decreased by 46 percent between FY 2016 and FY 2018.[1]
- Home delivery prescription utilization had been on the upswing since the DoD began increasing the disparity in copayments between retail and home delivery drugs in FY 2012. However, between FY 2016 and FY 2018, non-Prime-enrollee home delivery prescription utilization decreased by 9 percent, likely due, at least in part, to a sharp increase in copayments for home delivery drugs. In FY 2018, home delivery accounted for 47 percent of per capita purchased care prescription utilization by non-Prime enrollees (as measured by 30-day supply), down from 51 percent in FY 2017.

PRESCRIPTION UTILIZATION RATES BY SOURCE OF CARE[a]: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK, FYs 2016–2018



Sources: MHS administrative data, 1/17/2019, and IBM Watson Health, MarketScan® CCAE database, 12/26/2018

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2018 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

[a] Source of care (direct, VA, retail, or home delivery) is based solely on where the prescriptions were filled, not on where the prescribing services were provided.

[1] The DHA Pharmacy Operations Division suspects the drop was due to issues with the VA computer system that reports the use of VA pharmacies by DoD beneficiaries but there is no direct evidence to corroborate this.

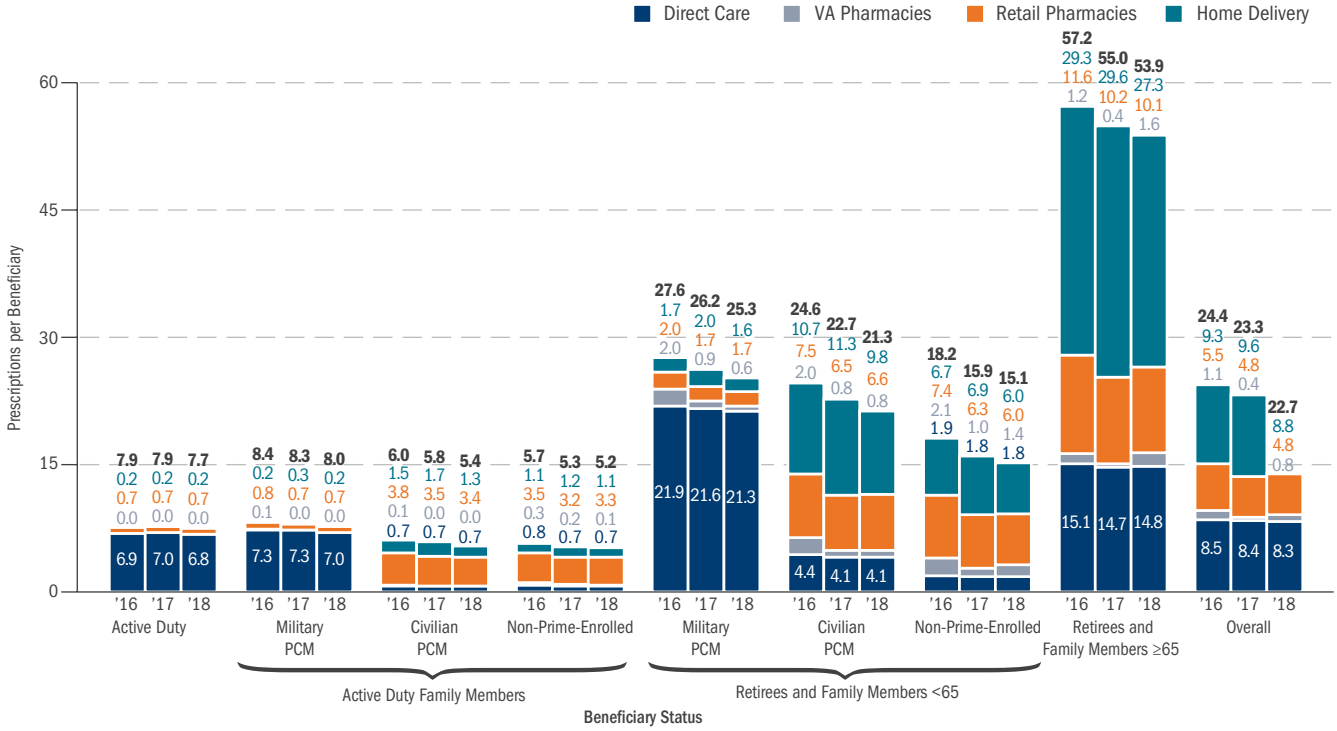
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT.)*

TRICARE Prescription Drug Utilization Rates by Beneficiary Status

Prescriptions include all initial and refill prescriptions filled at military pharmacies, VA pharmacies (for DoD/VA dual-eligible beneficiaries), retail pharmacies, and home delivery. VA prescriptions include those filled as part of a beneficiary's VA benefit and paid for by VA. Prescriptions filled at a VA pharmacy under the TRICARE benefit are included with retail pharmacy prescriptions. Prescription counts from all sources were normalized by dividing the total days supply for each by 30 days.

- The total (direct, VA, retail, and home delivery) number of prescriptions per beneficiary decreased by 11 percent from FY 2016 to FY 2018, exclusive of the TFL benefit. Including TFL, the total number of prescriptions decreased by 7 percent.
- The overall direct care prescription utilization rate declined by 2 percent between FY 2016 and FY 2018. Declines were experienced by all beneficiary groups except ADFMs with a civilian PCM (6 percent increase). The largest decline was experienced by non-Prime-enrolled ADFMs (–15 percent).
- After a dramatic drop of 56 percent in average per capita VA pharmacy prescription utilization from FY 2015 to FY 2017, utilization rebounded by 75 percent in FY 2018.[1]
- Average per capita prescription utilization through retail pharmacies decreased by 13 percent overall, partially because of the congressionally mandated requirement for non-Active Duty beneficiaries to refill prescriptions for select nongeneric maintenance medications at TRICARE home delivery or MTF pharmacies, effective October 1, 2015. Another contributor to the decline was the increase in copayments for retail drugs. Declines of between 6 percent (non-Prime-enrolled ADFMs) and 19 percent (non-Prime-enrolled RETFMs under 65) occurred for every beneficiary group.
- Home delivery utilization, which had been on the rise the past several years, reversed course in FY 2018 and dropped by 6 percent from its FY 2017 level. The drop was likely due to the large increase in copays for home delivery drugs mandated by the FY 2018 National Defense Authorization Act. In FY 2018, home delivery drugs accounted for 65 percent of total purchased care prescription drug utilization (as measured by 30-day supply) per capita. For beneficiaries under age 65, home delivery accounts for 48 percent of total purchased care prescription drug utilization, whereas for seniors it accounts for 73 percent.

AVERAGE ANNUAL PRESCRIPTION UTILIZATION PER BENEFICIARY, FYs 2016–2018



Source: MHS administrative data, 1/17/2019

Notes:

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

– The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere.

[1] The DHA Pharmacy Operations Division suspects the drop was due to issues with the VA computer system that reports the use of VA pharmacies by DoD beneficiaries but there is no direct evidence to corroborate this.

LOWER COST

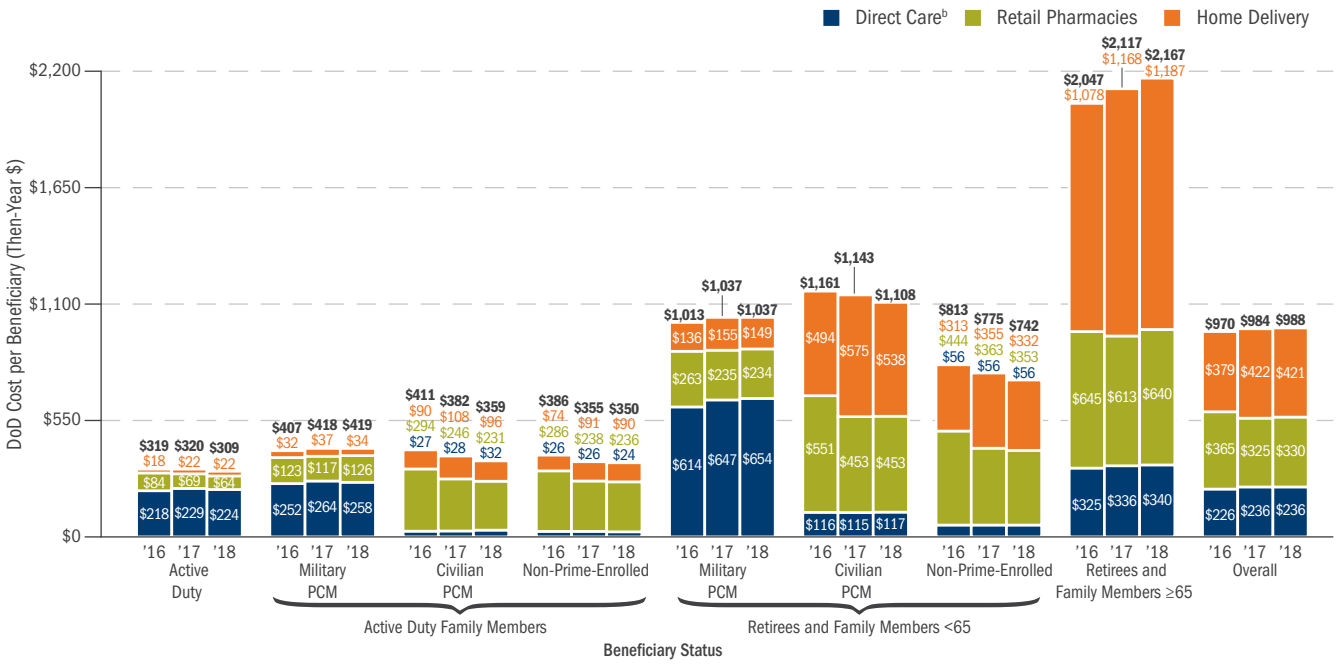
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT.)*

Prescription Drug Cost by Beneficiary Status

Although the drug refunds referenced on page 39 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, increased by 2 percent from FY 2016 to FY 2018. The annual pharmacy cost for non-Prime-enrollees is diluted by the larger number of beneficiaries with OHI coverage where the DoD pays approximately 30 percent of their prescription coverage cost.

- Exclusive of TFL, per capita prescription drug costs fell by 4 percent between FY 2016 and FY 2018. Declines occurred for all beneficiary groups except those with a military PCM and ranged from 3 percent for Active Duty to 13 percent for ADFMs with a civilian PCM.
- Direct care costs per beneficiary increased by 5 percent, while retail pharmacy costs decreased by 17 percent excluding TFL and by 9 percent including TFL.
- Home delivery costs per beneficiary increased by 8 percent excluding TFL and by 11 percent including TFL. All enrollment groups experienced increases ranging from 6 percent for non-Prime-enrolled RETFMs under 65 to 21 percent for non-Prime-enrolled ADFMs.

AVERAGE ANNUAL DoD PRESCRIPTION COSTS PER BENEFICIARY, FYs 2016–2018[a]



Source: MHS administrative data, 1/17/2019

Notes:

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

– The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere.

[a] Excludes retail drug refunds.

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

BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65)

Out-of-pocket costs are computed for Active Duty and retiree families in the U.S. grouped by sponsor age: (1) under 65; and (2) 65 and older (seniors). Costs include deductibles and copayments for medical care and drugs, TRICARE enrollment fees, and insurance premiums. Costs are compared with those of civilian counterparts (i.e., civilian families with the same demographics as the typical MHS family). For beneficiaries under age 65, civilian counterparts are assumed to be covered by other employer-sponsored group health insurance (OHI).

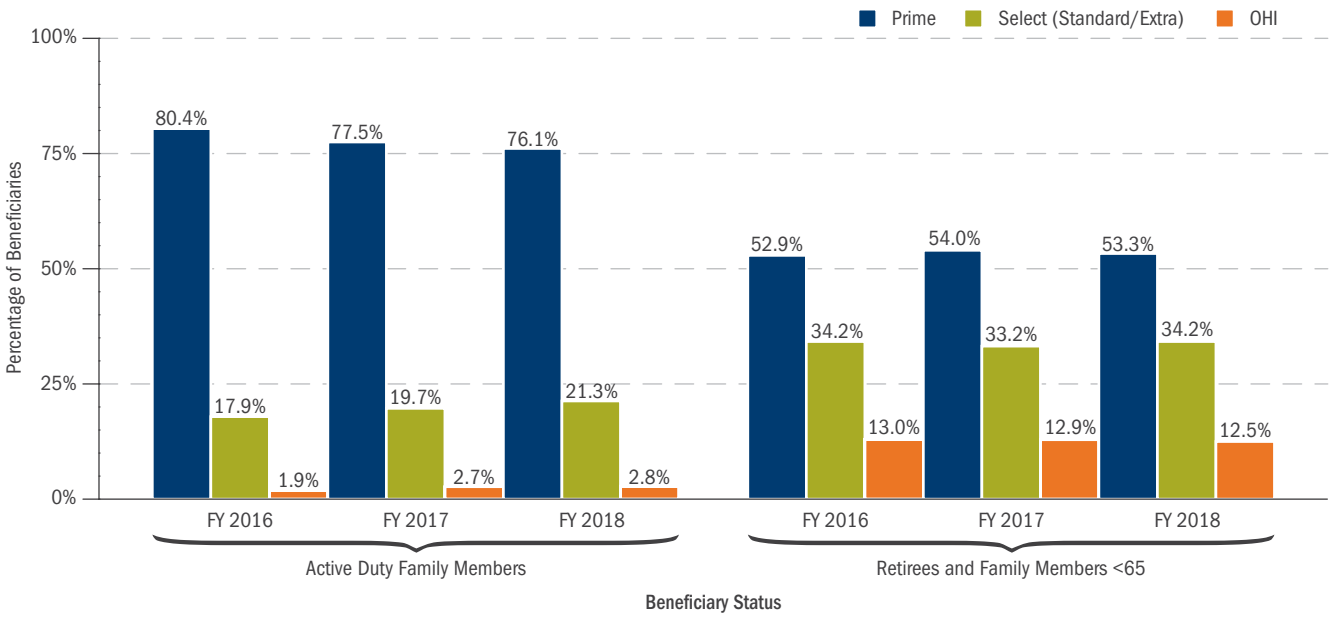
Health Insurance Coverage of MHS Beneficiaries Under Age 65

MHS beneficiaries have a choice of (1) TRICARE Prime, including TYA Prime and USFHP; (2) TRICARE Select (Standard/Extra in FYs 2016–2017), including TYA Select, TRS, and TRR; (3) direct care only (space-available care); and (4) OHI. Many beneficiaries with OHI have no TRICARE utilization; however, some use TRICARE as a second payer.

Beneficiaries are grouped by their primary health plan:

- **TRICARE Prime:** Family enrolled in TRICARE Prime (including a small percentage who also have OHI coverage). In FY 2018, 76.1 percent of Active Duty families and 53.3 percent of retiree families were in this group.
- **TRICARE Select (Standard/Extra):** Family enrolled in TRICARE Select or relying on space-available MTF care in FY 2018 (or using Standard/Extra in FYs 2016–2017) and who do not have OHI coverage. In FY 2018, 21.3 percent of Active Duty families and 34.2 percent of retiree families were in this group.
- **OHI:** Family covered by OHI. In FY 2018, 2.8 percent of Active Duty families and 12.5 percent of retiree families were in this group.

HEALTH INSURANCE COVERAGE OF BENEFICIARIES UNDER AGE 65, FYs 2016–2018



Source: Insurance coverage in FYs 2016–2018 based on Defense Enrollment Eligibility Reporting System (DEERS) and Health Care Survey of DoD Beneficiaries (HCSDB) responses; as of 12/31/2018

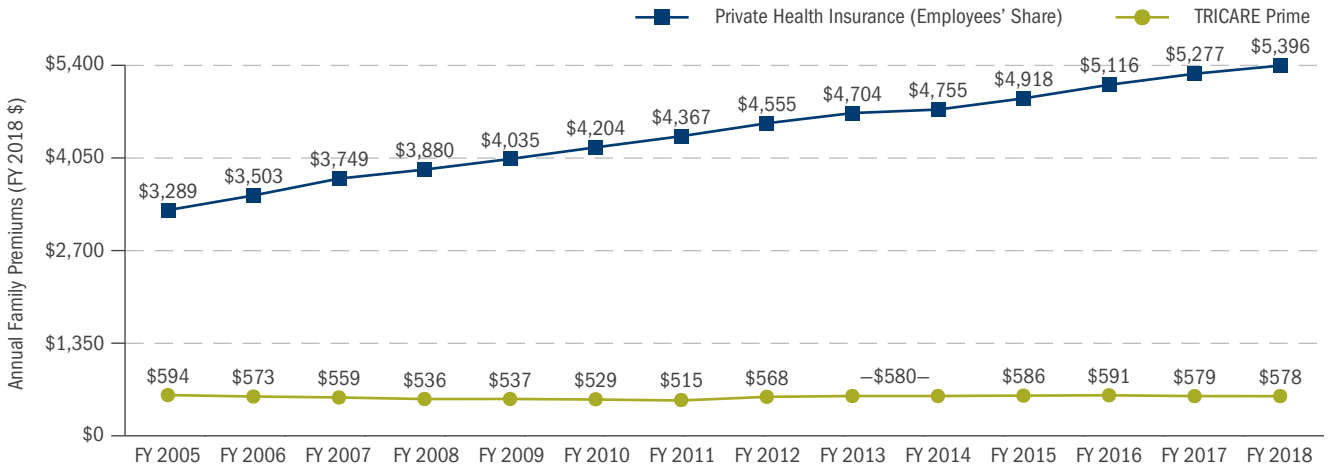
Note: The Prime group includes HCSDB respondents enrolled in Prime based on DEERS plus enrollees in the USFHP. The Select (Standard/Extra) group includes HCSDB respondents without OHI who are not enrolled in Prime based on DEERS. The OHI group includes HCSDB respondents with private health insurance (i.e., Federal Employees Health Benefits Plan [FEHBP]), a civilian HMO such as Kaiser, or other civilian insurance such as Blue Cross. A small percentage of Prime enrollees are also covered by OHI; these beneficiaries are included in the Prime group. Percentages may not sum to 100 due to rounding.

BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Retirees and Family Members Under Age 65 Returning to the MHS

From FY 2005 to FY 2018, the average private health insurance family premium increased substantially, whereas the TRICARE Prime enrollment fee declined slightly. In FY 2018 dollars, private health insurance premiums increased by $2,107 (64 percent); the TRICARE Prime enrollment fee declined by $16 (3 percent).

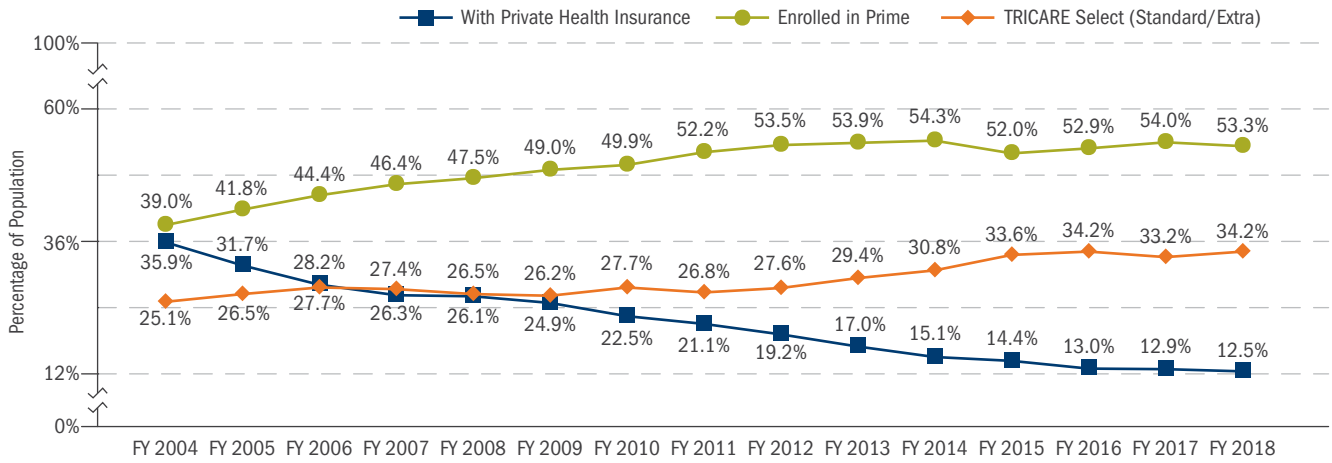
TRENDS IN PRIVATE INSURANCE PREMIUMS VS. TRICARE ENROLLMENT FEE, FYs 2005–2018



Sources: Employees' share of insurance premium for typical employer-sponsored family health plan in FYs 2005–2017 from the Insurance Component of the Medical Expenditure Panel Surveys (MEPS) 2004–2017; OHI premiums in FY 2018 forecasted by the Institute for Defense Analyses based on trends in total premiums from Kaiser Family Foundation surveys; as of 12/31/2018

Between FY 2004 and FY 2018, 23.4 percent of retirees switched from private health insurance to TRICARE. Most switched because of an increasing disparity in premiums and out-of-pocket expenses; in recent years, some lost coverage due to a recession.[1] As a result of declines in private insurance coverage, about 900,000 more retirees and family members under age 65 in the U.S. are now relying primarily on TRICARE instead of on private health insurance.

TRENDS IN RETIREE (<65) HEALTH INSURANCE COVERAGE, FYs 2004–2018



Sources: Insurance coverage in FYs 2004–2018 based on DEERS and HCSDB responses, as of 12/31/2018

Note: The Prime enrollment rates above include about 4 percent of retirees who also have private health insurance.

[1] For an analysis of retirees' switching from OHI to TRICARE, see Goldberg et al., "Demand for Health Insurance by Military Retirees," Institute for Defense Analyses (IDA) Document D-5098, May 2015, Alexandria, VA: IDA.

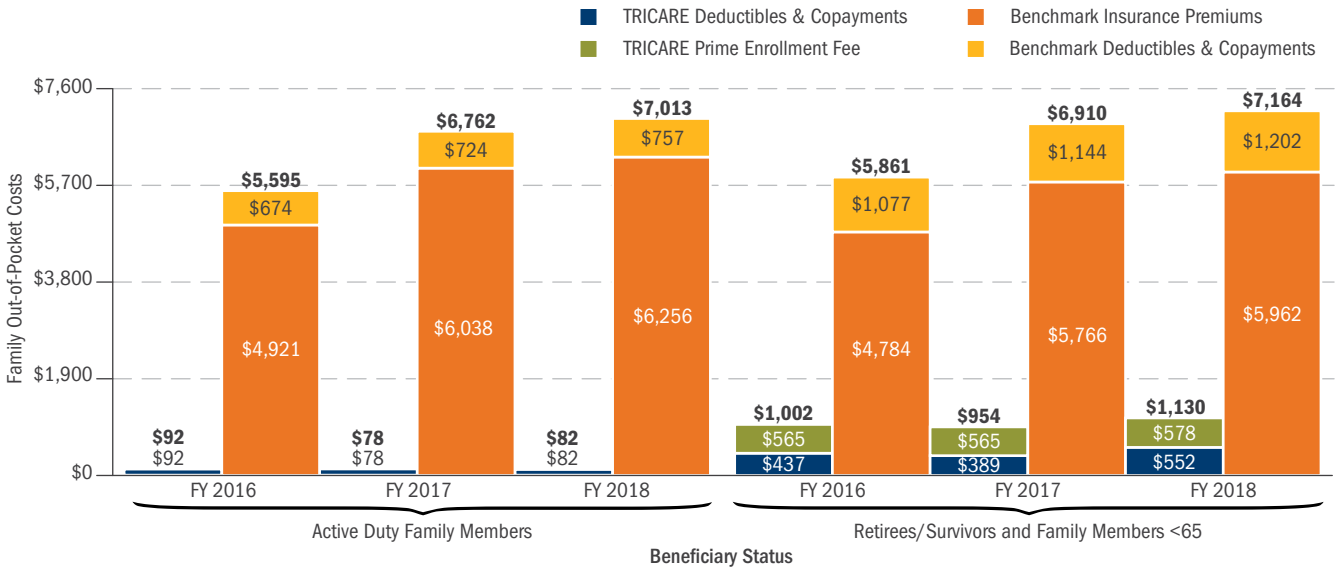
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Out-of-Pocket Costs for Families Enrolled in TRICARE Prime vs. Civilian HMO Counterparts

In FYs 2016–2018, civilian counterpart families had substantially higher out-of-pocket costs than did TRICARE Prime enrollees.

- Civilian HMO counterparts paid more for insurance premiums, deductibles, and copayments.
- In FY 2018, costs for civilian counterparts were:
  - $6,900 more than those incurred by Active Duty families enrolled in Prime.
  - $6,000 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 2016–2018



Sources: TRICARE beneficiary expenditures for deductibles and copayments in FYs 2016–2018 from MHS administrative data for all families enrolled in Prime without OHI payments; civilian benchmark expenditures for deductibles and copayments from the Household Component of the MEPS, actual MEPS in FY 2016, and projected MEPS in FYs 2017–2018; civilian benchmark insurance premiums in FYs 2016–2017 from the 2015–2017 Insurance Component of the MEPS; OHI premiums in FY 2018 forecasted by IDA based on trends in total premiums from Kaiser Family Foundation surveys; as of 12/31/2018

Note: Estimates are for a demographically typical family. For Active Duty dependents, the family includes a spouse and 1.54 children, on average. For retirees, a family includes a sponsor, spouse, and 0.65 children.

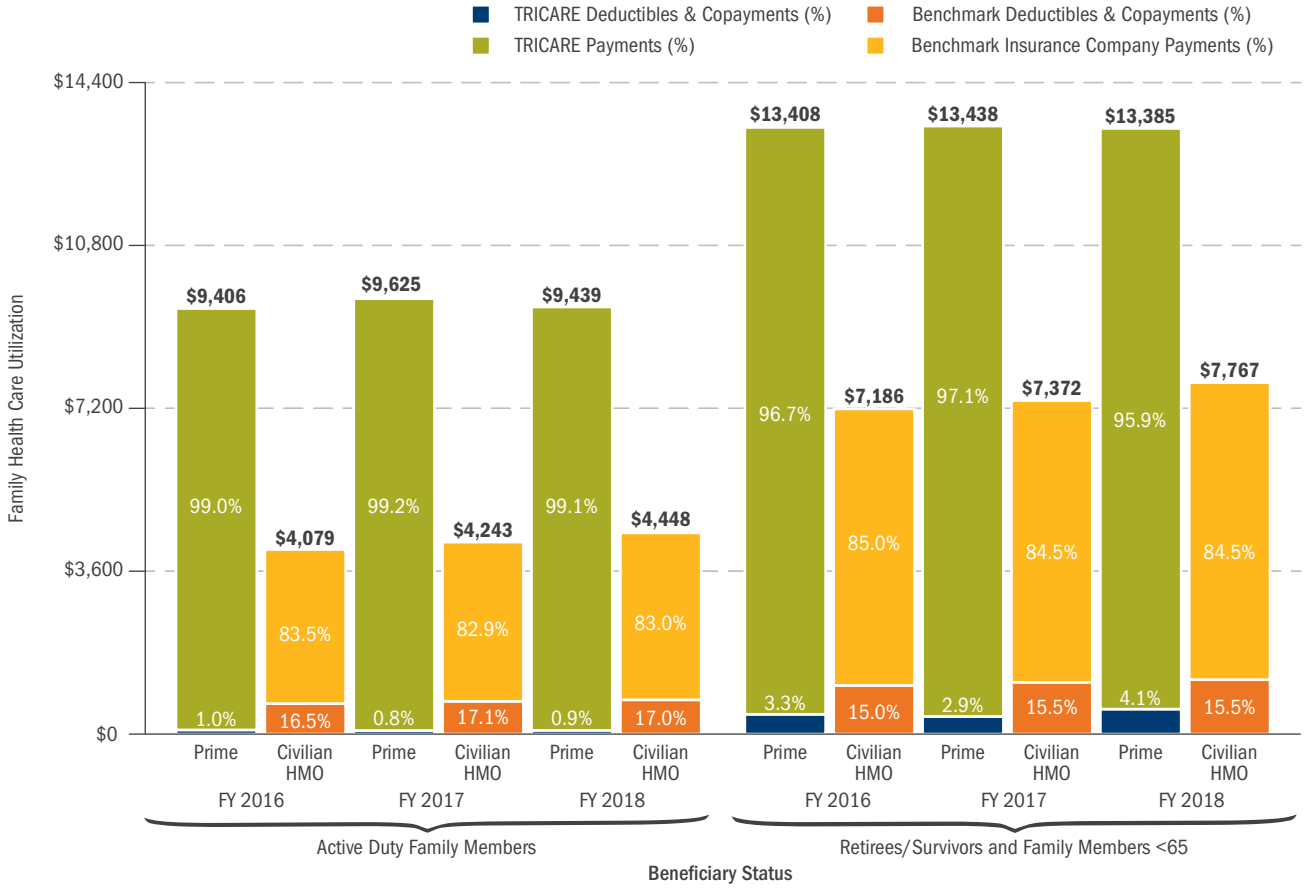
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Coinsurance and Health Care Utilization for Families Enrolled in TRICARE Prime vs. Civilian HMO Counterparts

Previous private-sector studies found that very low coinsurance rates increase health care utilization (dollar value of health care services).[1] In FYs 2016–2018, TRICARE Prime enrollees had negligible coinsurance rates (deductibles and copayments per dollar of utilization) and, not surprisingly, much higher utilization than civilian HMO counterpart families. Differences in coinsurance rates are a major reason for the higher utilization of health care services by Prime enrollees.

- In FYs 2016–2018, TRICARE Prime enrollees had coinsurance rates that were 11.4 to 16.3 percentage points below those of civilian HMO counterparts.
  - In FY 2018, the coinsurance rate for Active Duty families was 0.9 percent versus 17.0 percent for civilian counterparts (16.1 points lower).
  - In FY 2018, the coinsurance rate for retiree families was 4.1 percent versus 15.5 percent for civilian counterparts (11.4 points lower).
- In FYs 2016–2018, TRICARE Prime enrollees had substantially higher health care utilization than civilian HMO counterparts.
  - In FY 2018, Active Duty families consumed $9,400 of medical services versus $4,400 by civilian counterparts ($5,000 more).
  - In FY 2018, retiree families consumed $13,400 in medical services versus $7,800 by civilian counterparts ($5,600 more).

COINSURANCE AND HEALTH CARE UTILIZATION FOR FAMILIES ENROLLED IN TRICARE PRIME VS. CIVILIAN HMO COUNTERPARTS, FYs 2016–2018



Sources: TRICARE utilization expenditures by the MHS and beneficiaries in FYs 2016–2018 from MHS administrative data for all families enrolled in Prime without OHI payments for TRICARE utilization; civilian benchmark utilization payments by insurance companies and families from the Household Component of the MEPS, actual MEPS in FY 2016, and projected MEPS in FYs 2017–2018; as of 12/31/2018. Dual-eligible retirees obtain some care at Department of Veterans Affairs (VA), which is not included in MHS administrative data. Using regression analyses, IDA estimated utilization at VA in FYs 2016–2018 for retirees enrolled in Prime and included these estimates in total utilization (e.g., $620 per retiree family in FY 2018).

[1] Newhouse, Joseph P., and Insurance Experiment Group. *Free for All? Lessons from the RAND Health Insurance Experiment. A RAND Study.* Cambridge, MA: Harvard University Press, 1993.

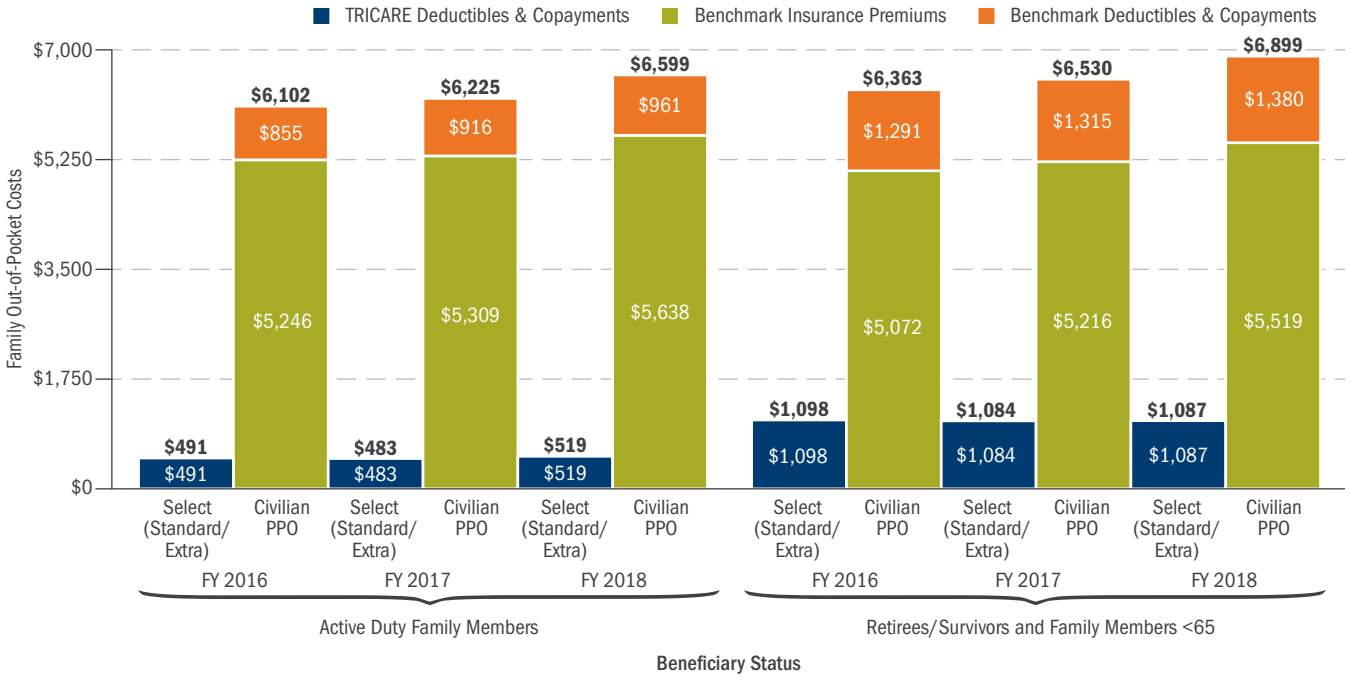
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Out-of-Pocket Costs for Families Who Rely on TRICARE Select (Standard/Extra) or Direct Care vs. Civilian PPO Counterparts

In FYs 2016–2018, civilian counterparts had much higher out-of-pocket costs than did TRICARE Select (Standard/Extra) users.

- In FYs 2016–2018, civilian PPO counterparts paid $5,300 to $6,100 more for insurance premiums, deductibles, and copayments.
- In FY 2018, costs for civilian counterparts were:
  - $6,100 more than those incurred by Active Duty families who relied on TRICARE Select.
  - $5,800 more than those incurred by retiree families who relied on TRICARE Select.

OUT-OF-POCKET COSTS FOR FAMILIES WHO RELY ON TRICARE SELECT (STANDARD/EXTRA) OR DIRECT CARE VS. CIVILIAN PPO COUNTERPARTS, FYs 2016–2018



Sources: TRICARE beneficiary expenditures for deductibles and copayments in FYs 2016–2018 from MHS administrative data for all TRICARE Select (Standard/Extra)–reliant families without OHI payments for TRICARE utilization; civilian benchmark expenditures for deductibles and copayments from the Household Component of the MEPS, actual MEPS in FY 2016, and projected MEPS in FYs 2017–2018; civilian benchmark insurance premiums in FYs 2016–2017 from the 2015–2017 Insurance Component of the MEPS; OHI premiums in FY 2018 forecasted by IDA based on trends in total premiums from Kaiser Family Foundation surveys; insurance coverage from HCSDB, FYs 2016–2018; as of 12/31/2018

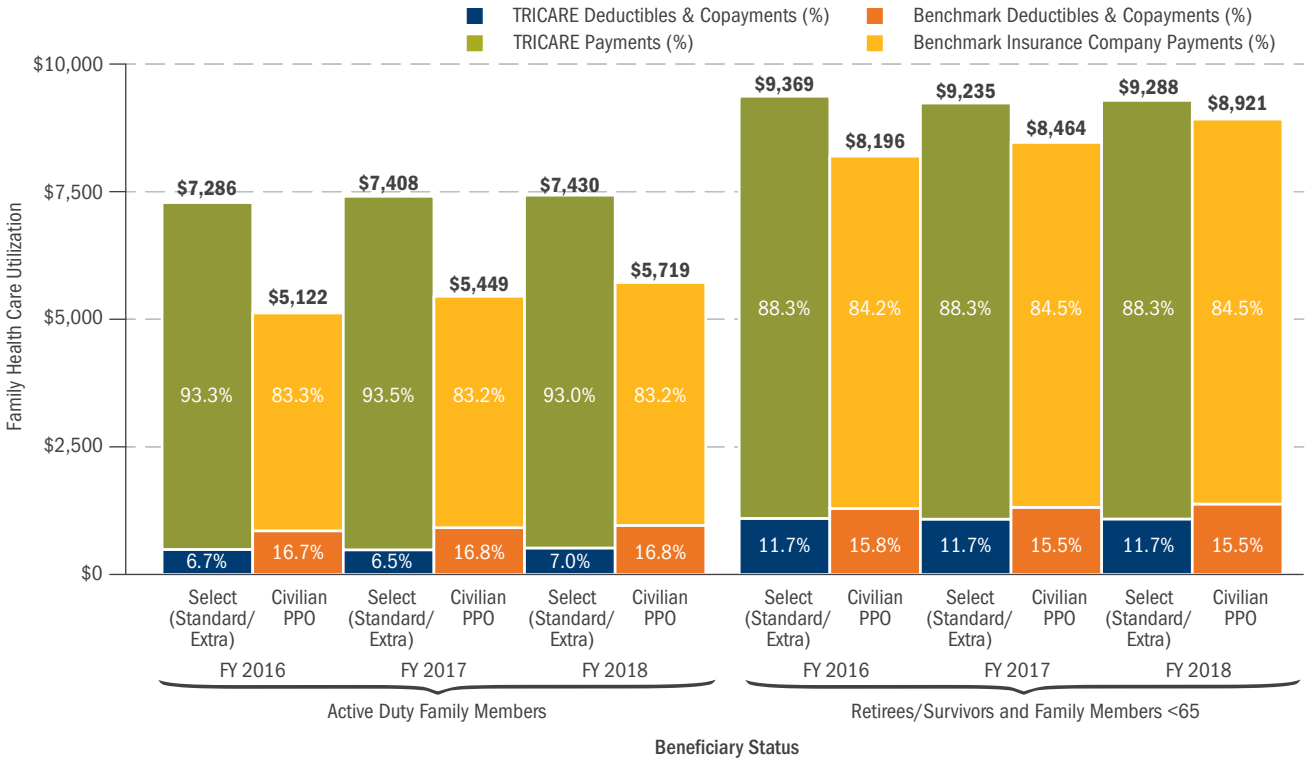
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Coinsurance and Health Care Utilization for Families Who Rely on TRICARE Select (Standard/Extra) or Direct Care vs. Civilian PPO Counterparts

Active Duty families who relied on TRICARE Select (Standard/Extra) had lower coinsurance rates (deductibles and copayments per dollar of utilization) and consequently higher health care utilization (dollar value of health care services consumed) than civilian counterparts. For retiree families, both coinsurance rates and utilization were similar.

- In FY 2018 for Active Duty families:
  - Coinsurance rates were 7.0 versus 16.8 percent for civilian counterparts (9.8 percentage points lower).
  - Health care utilization was $7,400 versus $5,700 for civilian counterparts ($1,700 more).
- In FY 2018 for retiree families:
  - Coinsurance rates were 11.7 versus 15.5 percent for civilian counterparts (just 3.8 points lower).
  - Health care utilization was $9,300 versus $8,900 for civilian counterparts (just $400 more).

COINSURANCE AND HEALTH CARE UTILIZATION FOR FAMILIES WHO RELY ON TRICARE SELECT (STANDARD/EXTRA) OR DIRECT CARE VS. CIVILIAN PPO COUNTERPARTS, FYs 2016–2018



Sources: TRICARE utilization payments by the MHS and beneficiaries in FYs 2016–2018 from MHS administrative data for all TRICARE Select (Standard/Extra)–reliant families without OHI payments; civilian benchmark utilization payments by insurance companies and families from the Household Component of the MEPS, actual MEPS in FY 2016, and projected MEPS in FYs 2017–2018; as of 12/31/2018. Dual-eligible retirees obtain some care at VA, which is not included in MHS administrative data. Using regression analyses, IDA estimated utilization at VA in FYs 2016–2018 for retirees who relied on TRICARE Select (Standard/Extra) and included these estimates in total utilization (e.g., $375 per retiree family in FY 2018).

BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES)

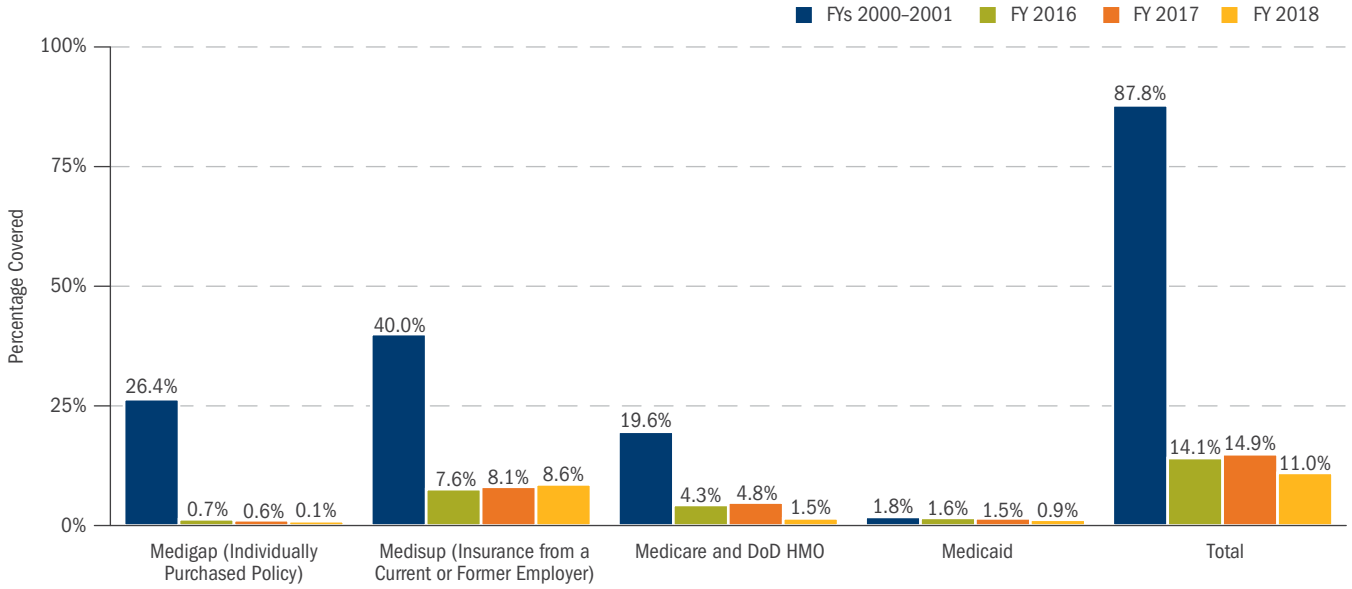
Out-of-pocket costs for retirees aged 65 and older (seniors) and their families include deductibles and copayments for medical care and drugs, TRICARE enrollment fees, and insurance premiums. In April 2001, the DoD expanded drug benefits for seniors; on October 1, 2001, the DoD implemented the TFL program, which provides Medicare wraparound coverage (i.e., TRICARE acts as second payer to Medicare, minimizing beneficiary out-of-pocket expenses). For seniors, costs are compared with civilian counterparts enrolled in Medicare having pre-TFL supplemental insurance coverage.

Health Insurance Coverage of MHS Senior Beneficiaries Before and After TFL

Although Medicare provides coverage for medical services, there are substantial deductibles and copayments. Until FY 2001, most MHS seniors purchased some type of Medicare supplemental insurance (e.g., Medigap, Medisup).[1] A small number were active employees with employer-sponsored insurance or were covered by Medicaid. Because of the improved drug and TFL benefits, most MHS seniors dropped their supplemental insurance.

- Before TFL (FYs 2000–2001), 87.8 percent of MHS seniors had Medicare supplemental insurance or were covered by Medicaid. After TFL, the percentage of MHS seniors with supplemental insurance or Medicaid fell sharply. It was about 14.5 percent in FYs 2016–2017.[2]
- Why do some seniors retain supplemental insurance, especially a Medisup policy, when they can use TFL for free? Some possible reasons are:
  - A lack of awareness of the TFL benefit.
  - A desire for dual coverage.
  - Higher family insurance costs if a spouse is not yet Medicare-eligible. Dropping a non-Medicare-eligible spouse from an employer-sponsored plan can result in higher family costs if the spouse must purchase a nonsubsidized individual policy.

MEDICARE SUPPLEMENTAL INSURANCE COVERAGE OF MHS SENIORS, FYs 2000–2001 TO FY 2018



Source: FYs 2000–2001 and FYs 2016–2018 HCSDB, as of 12/31/2018

[1] Medigap is an individually purchased policy that covers Medicare deductibles and copays. Medisup is group insurance from a current or former employer (or a union). It includes those with Medicare who are covered either by FEHBP, a civilian HMO such as Kaiser, or other civilian health insurance such as Blue Cross. Individually obtained HMO policies include Medicare Advantage, USFHP, and TRICARE Senior Prime (until December 2001). Almost all TRICARE seniors are covered by Medicare and are enrolled in Parts A and B; only 1.3 percent have just Part A. About 2 percent of TRICARE seniors are covered by government-sponsored Medicaid. About 1 percent of TRICARE seniors have OHI and are not covered by Medicare; these are excluded from the above figure; as of 12/31/2018.

[2] Due to changes in the HCSDB, estimates of the total and mix of supplemental insurance in FY 2018 are less accurate than those in FYs 2016–2017.

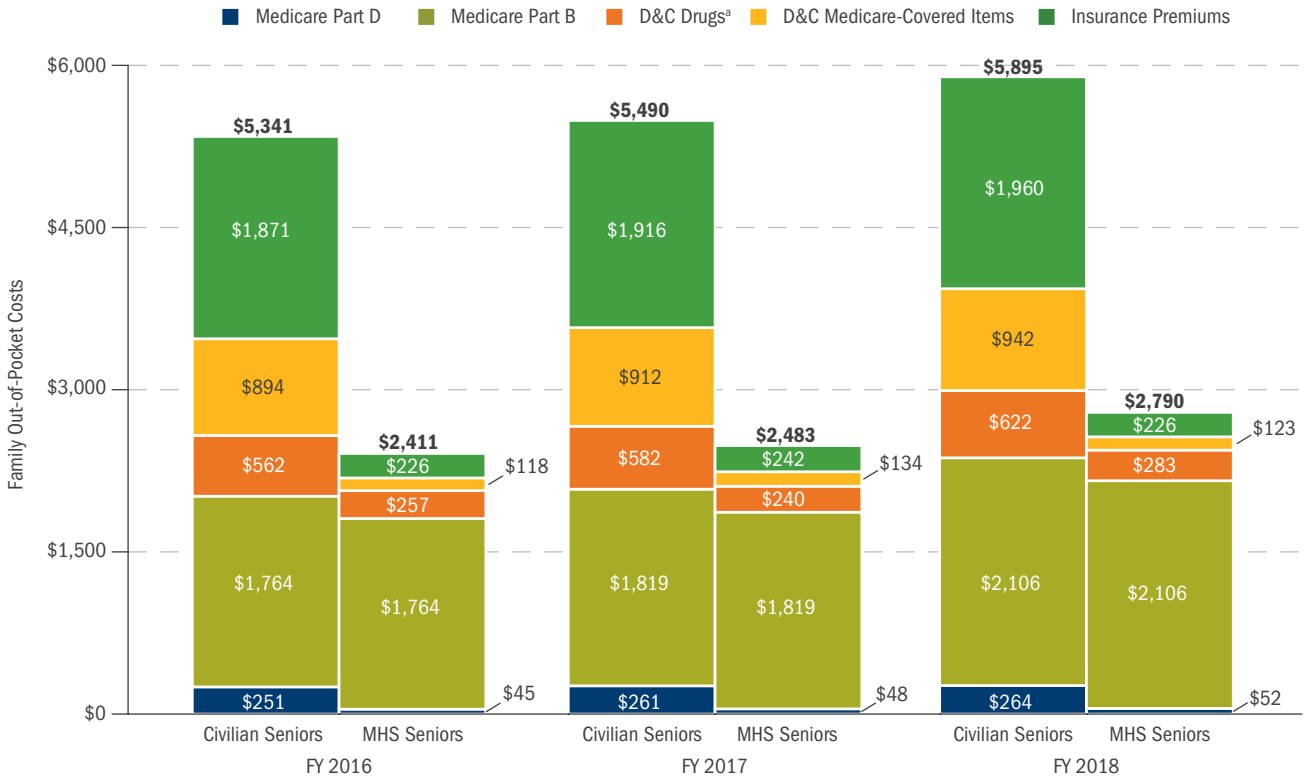
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT.)*

Out-of-Pocket Costs for MHS Senior Families Before and After TFL

About 87 percent of TRICARE senior families use MHS health care. TFL and added drug benefits have enabled MHS seniors to reduce their out-of-pocket costs for deductibles/copayments and supplemental insurance. The costs for a typical TRICARE senior family after TFL, including MHS users and non-users, are compared with those of civilian counterparts having the supplemental insurance coverage of TRICARE senior families before TFL in FYs 2000–2001.

- In FY 2018, out-of-pocket costs for MHS senior families were 53 percent less than those of their "before TFL" civilian counterparts.
- In FY 2018, MHS senior families saved about $3,100 as a result of TFL and added drug benefits.

OUT-OF-POCKET COSTS OF MHS SENIOR FAMILIES AFTER TFL VS. CIVILIAN COUNTERPARTS, FYs 2016–2018



Sources: TRICARE senior family deductibles and copayments for MHS users in FYs 2016–2018 from MHS administrative data on all TRICARE senior families. For MHS non-users and civilian benchmark senior families, deductibles and copayments by type of Medicare supplemental coverage from the Household Component of the MEPS, actual MEPS in FY 2016, and projected MEPS in FYs 2017–2018; Medicare Part B and Medicare HMO premiums in FYs 2016–2018 from the Centers for Medicare & Medicaid Services; Medigap premiums in FYs 2016–2018 from Weiss Research, Inc.; Medisup premiums from Towers Watson Health Care Cost Surveys in 2013–2014 (FY 2014) projected to FYs 2016–2018 based on the premium growth rate of single OHI policies; Medicare Part D premiums in FYs 2016–2018 from Kaiser Family Foundation Surveys; Medicare supplemental insurance coverage, before and after TFL, from HCSDB, FYs 2000–2001, 2016–2018; as of 12/31/2018.

Note: Estimates are for a demographically typical senior family. On average, this consists of 0.7 men and 0.7 women over the age of 65.

[a] "D&C" is deductibles and copayments.

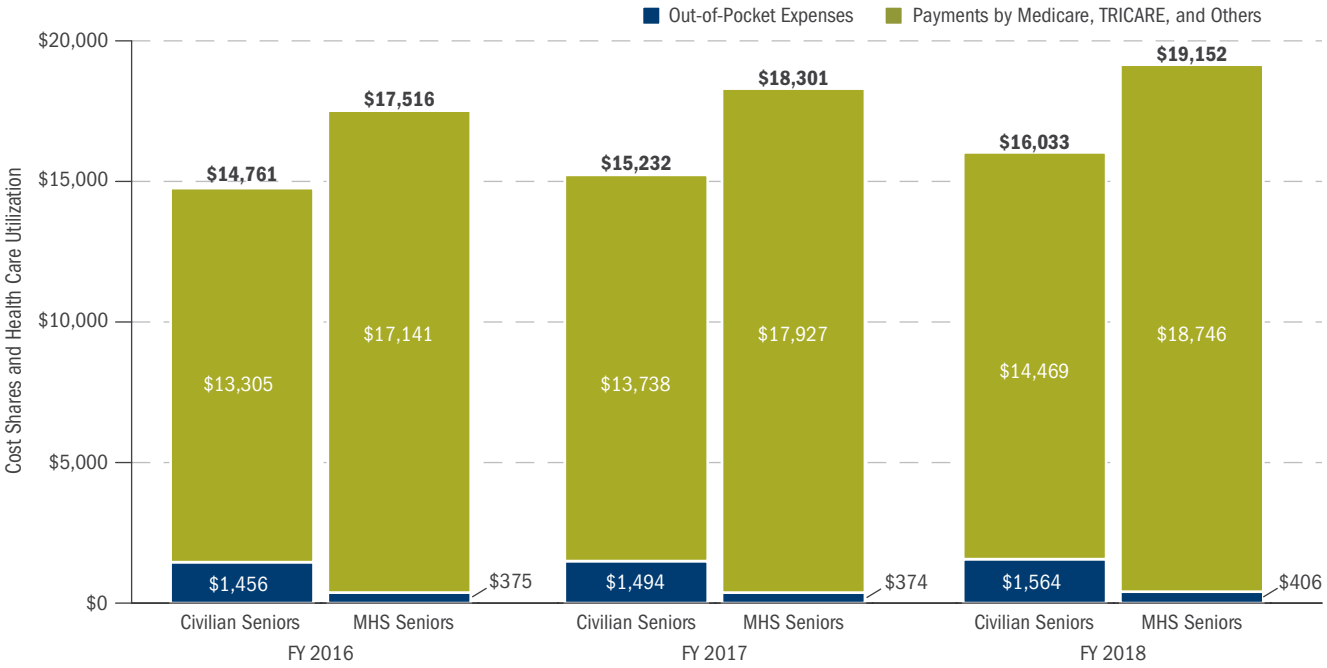
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT.)*

Coinsurance and Health Care Utilization for MHS vs. Civilian Senior Families

Medicare supplemental insurance lowers the coinsurance rate (deductibles and copayments per dollar of utilization), and previous studies have found that this leads to more health care services consumed by seniors.[1] TFL and added drug benefits substantially lowered coinsurance rates; not surprisingly, utilization is moderately higher for MHS seniors compared with "before TFL" civilian counterparts.

- TRICARE senior families have coinsurance rates below those of civilian counterparts.
  - In FY 2018, the coinsurance rate for civilian counterparts was 9.8 percent; for MHS seniors, 2.1 percent (7.7 percentage points lower).
- TRICARE senior families have relatively high health care utilization.
  - In FY 2018, MHS senior families consumed $3,100 more in medical services than their civilian counterparts (19.5 percent greater).

COINSURANCE AND HEALTH CARE UTILIZATION FOR SENIOR FAMILIES VS. CIVILIAN COUNTERPARTS, FYs 2016–2018



Sources: TRICARE senior family utilization, deductibles, and copayments for MHS users in FYs 2016–2018 from MHS administrative data. For MHS non-users and civilian benchmark senior families, utilization, deductibles, and copayments by type of Medicare supplemental coverage from the Household Component of the MEPS, actual MEPS in FY 2016, and projected MEPS in FYs 2017–2018; Medicare supplemental insurance coverage, before and after TFL, from HCSDB, FYs 2000–2001 and 2016–2018; as of 12/31/2018.

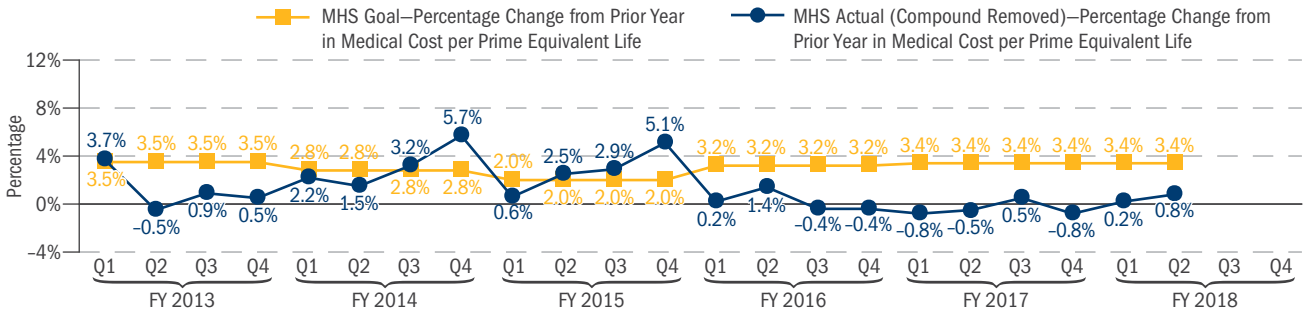
[1] Physician Payment Review Commission, "Private Secondary Insurance for Medicare Beneficiaries," in *Annual Report to Congress: Fiscal Year 1997* (Washington, D.C.: U.S. Government Printing Office, 1997), 27–28.

SYSTEM PRODUCTIVITY: MHS MEDICAL COST PER PRIME ENROLLEE

The goal in using this financial and productivity metric is to support the Quadruple Aim of managing lowering costs. This metric focuses on per capita costs to examine the extent to which the MHS stays below a targeted annual rate of increase based on industry practice, including how well MHS manages the care for those individuals who have chosen to enroll in an HMO-type benefit provided by MTFs. Designed to capture aspects of three major management issues, this metric measures (1) how efficiently MTFs provide care, (2) how efficiently MTFs manage the demand of their enrollees, and (3) how well MTFs determine which care should occur internally versus which should be purchased externally from a managed care support contractor.

- During FY 2017 and FY 2018, the DoD Components focused on improvements in provider productivity through improved access standards, MTF site visits, effective use of resources, capturing of inpatient RVUs, and optimization of referral management. In FY 2017, provider productivity performance levels were the highest achieved, demonstrating that improvement processes are starting to work. With productivity improvements, the MHS will need to ensure that ambulatory care utilization remains under control.
- Pharmacy compounded products were removed from all years, because the vast majority of compounded products in FY 2014 and FY 2015 were found to be fraudulent, and, if included, would unrealistically demonstrate dramatic decreases in growth rates for FY 2016. During FY 2016, pharmacy showed dramatic improvement due to the National Defense Authorization Act (NDAA) 2015 maintenance medication and operational changes. Under the NDAA for FY 2015, maintenance medications were redirected from the retail pharmacy to either TRICARE Home Delivery or MTFs, which resulted in significant reduction in pharmacy costs to the government. Additionally, further reductions in overall pharmacy costs were achieved through the Pharmacy & Therapeutics Committee explicit formulary management and actionable Prime enrollee leakage reports for nonmaintenance medication. The impact of these actions resulted in achievement of the goal through FY 2016.
- Through FY 2014, increases in purchased care outpatient costs were eased by DHA's implementation of the Outpatient Prospective Payment System (OPPS), beginning in May 2009 and completely phased in by May 2013, aligning TRICARE reimbursement with Medicare rates for hospital outpatient services. Pharmacy refunds continue to partially mitigate retail pharmacy costs—the highest-cost pharmacy venue. OPPS and refunds have provided short-term pricing decreases; however, as they have been phased in fully, pricing has stabilized and utilization has again become a cost driver, as reflected in increases beginning in FY 2014.
- The MHS continues to expand the Patient-Centered Medical Home (PCMH) strategy, a practice model in which a team of health care professionals, coordinated by a personal physician, works collaboratively to provide high levels of care, access, and communication; care coordination and integration; and care quality and safety. Care delivered in a PCMH is meant to produce better outcomes; reduce mortality, unnecessary emergency department visits, and preventable hospital admissions for patients with chronic diseases; lower overall utilization; and improve patient compliance with recommended care, resulting in lower spending for the same population.
- The MHS goal in percentage change in medical costs from the prior year is based on the annual national survey of nonfederal private and public employers with three or more workers, conducted by the Kaiser Family Foundation and the Health Research and Educational Trust. From this survey, the MHS rate is set, based on the average annual premiums for employer-sponsored health insurance for family coverage. For the FY 2013 to FY 2016 time period, the MHS goal was set at one percentage point below the survey. Starting in FY 2017, the goal reverted back to the actual survey result.

PERCENTAGE CHANGE IN MEDICAL COST PER PRIME EQUIVALENT LIFE (FROM PRIOR YEAR), FYs 2013–2018



Source: Office of the Assistant Secretary of Defense for Health Affairs, Health Resources Management and Policy, provided 11/20/2018. Data as of August 2018, and MHS administrative data (M2: Standard Inpatient Data Record/Standard Ambulatory Data Record/Comprehensive Ambulatory/Professional Encounter Record/TRICARE Encounter data-institutional/TED-Noninstitutional, Pharmacy Data Transaction Service; Expense Assignment System IV. Enrollees are adjusted for health risk status. FY 2018 data are reported through FY 2018 Q2, and data from this quarter should be considered preliminary.

GENERAL METHOD

This report presents the overall performance of the TRICARE program with respect to the Military Health System (MHS) Quadruple Aim of Improved Readiness, Better Care, Better Health, and Lower Cost. MHS monitors various metrics to assess performance and, where possible, tries to compare MHS performance with relevant civilian health care performance. This report examines the effects of TRICARE on beneficiary utilization of inpatient, outpatient, and prescription services, as well as on MHS and beneficiary costs. Wherever feasible, the report contrasts various aspects of TRICARE and national health care trends. These include comparison of TRICARE utilization and cost measures with comparable civilian sector benchmarks derived from the MarketScan® Commercial Claims and Encounters (CCAE) database provided by IBM Watson Health, trended changes in medical costs based on the national survey of nonfederal health plans and public employers conducted by the Kaiser Family Foundation and the Health Research and Education Trust (HRET), and national patient survey results from the consortium of the Agency for Healthcare Research and Quality (AHRQ) and the Consumer Assessment of Health Providers and Systems (CAHPS), to include CAHPS-Plan, Hospital CAHPS (HCAHPS), and Clinician and Group CAHPS (C&G CAHPS).

Notes on Methodology

- Numbers in charts or text may not sum to the expressed totals due to rounding.
- Unless otherwise indicated, all years referenced are federal fiscal years (FYs; October 1–September 30).
- Unless otherwise indicated, all dollar amounts are expressed in then-year dollars for the fiscal year represented.
- All photographs in this document were obtained from websites accessible by the public. These photos have not been tampered with other than to mask an individual's name.
- Differences between MHS survey-based data and the civilian benchmark, or the MHS over time, were considered statistically significant if the significance level was less than or equal to 0.05.
- All workload and costs are estimated to completion based on separate factors derived from MHS administrative data for direct care and recent claims experience for purchased care.
- Data were current as of:
  - Surveys—Health Care Survey of DoD Beneficiaries (HCSDB) (11/15/2018); Joint Outpatient Experience Survey/Joint Outpatient Experience-CAHPS (JOES)/JOES-C (11/25/2018); TRICARE Inpatient Satisfaction Survey (TRISS) (11/25/2018). JOES combines and standardizes the long-standing Services outpatient surveys: Army Provider Level Satisfaction Survey (APLSS), Navy Patient Satisfaction Survey (PSS), Air Force Service Delivery Assessment (SDA), and TRICARE Outpatient Satisfaction Survey (TROSS).
  - Eligibility/enrollment data—1/17/2019
  - MHS workload/costs—1/17/2019
  - Website uniform resource locators—1/26/2018
- The Defense Health Agency (DHA) regularly updates its encounters and claims databases as more current data become available. It also periodically "retrofits" its databases as errors are discovered. The updates and retrofits can sometimes have significant impacts on the results reported in this and previous documents if they occur after the data collection cutoff date. The reader should keep this in mind when comparing this year's results with those from previous reports.

DATA SOURCES

Health Care Survey of DoD Beneficiaries (HCSDB)

The Health Care Survey of DoD Beneficiaries (HCSDB) was developed by the DHA and its predecessor, the TRICARE Management Activity, to fulfill the 1993 National Defense Authorization Act (NDAA) requirements and to provide a routine mechanism to assess TRICARE-eligible beneficiary access to and experience with the MHS or with alternate health plans. Conducted continuously since 1995, the HCSDB was designed to provide a comprehensive look at beneficiary opinions about their Department of Defense (DoD) health care benefits. The HCSDB provides information on a wide range of health care issues, such as beneficiaries' ease of access to health care, preventive care services, and healthy behaviors.

The worldwide, multiple-mode Adult HCSDB has been conducted on a quarterly basis (three fiscal year quarters: October, January, and April) since FY 2013, and reported quarterly on a publicly accessible website (https://TRICARE.mil/survey/hcsdbsurvey/home/z_ reports.cfm). Mathematica Policy Research, Inc. has been the lead contractor providing independent analysis and assessment of the HCSDB and TRICARE Standard Survey results presented in this report.

The CAHPS is a nationally recognized set of standardized questions and reporting formats that has been used to collect and report meaningful and reliable information about the health care experiences of consumers. It was developed by a consortium of research institutions and sponsored by the AHRQ. It has been tested in the field and evaluated for validity and reliability. The questions and reporting formats have been tested to ensure that the answers can be compared across plans and demographic groups.

About three-fourths of HCSDB questions are closely modeled on the CAHPS Health Plan survey in wording, response choices, and sequencing. The other one-fourth of HCSDB questions are designed to obtain information unique to TRICARE benefits or operations, and to solicit information about healthy lifestyles or health promotion, often based on other nationally recognized health care survey questions (e.g., Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System, National Health Interview Survey, or the National Health and Nutrition Examination Survey). Supplemental questions are added on a quarterly basis to explore specific topics of interest, such as the acceptance and prevalence of preventive services, including colorectal cancer screening and annual influenza immunizations; availability of other non-DoD health insurance; use of urgent care centers; and measures of health related quality of life (HRQOL).

Because the HCSDB uses CAHPS questions, TRICARE can be benchmarked to civilian managed care health plans reporting CAHPS Health Plan results. More information on CAHPS can be obtained at https://www.cahps.ahrq.gov.

The survey request is sent by postal mail to all beneficiaries and also by e-mail to Active Duty members, with responses accepted via web and, for a random sample of initial nonrespondents, by postal mail. The HCSDB is fielded to a stratified random sample of beneficiaries. In order to calculate representative rates and means from their responses, sampling weights are used to account for different sampling rates and different response rates in different sample strata. Beginning with the FY 2006 report, weights were adjusted for factors such as age, sex, and rank that do not define strata, but make some beneficiaries more likely to respond than others. Because of the adjustment, rates calculated from the same data differ from past evaluation reports and are more representative of the population of TRICARE users.

The DHA HCSDB is sent to a random sample of all MHS-eligible users and non-users. Survey results are reported quarterly, with almost 35,500 respondents from about 302,000 beneficiaries sampled in FY 2018 (about a 12.5 percent raw response and over a 17.5 percent weighted response rate, compared to a 12 percent raw response rate in FY 2017). Results can be estimated from the HCSDB for all beneficiary groups eligible for MHS benefits, whether they use direct care, purchased care, or other health insurance available to them, and are compared with benchmark results from a national sample of commercial civilian health plans administering the CAHPS Health Plan survey.

Results provided from HCSDB in FYs 2015–2018 were based on questions taken from the CAHPS Version 5.0. As CAHPS versions change, the HCSDB results will be compared to the like-CAHPS version results each year because changes in the questionnaires and changes in rates are only meaningful when compared with changes in the relevant benchmark. CAHPS Version 5.0 benchmark microdata were obtained from the National Committee for Quality Assurance (NCQA).

The National CAHPS Benchmarking Database collects CAHPS results voluntarily submitted by participating health plans and is funded by the AHRQ and administered by a contractor. The NCQA's file also contains voluntarily submitted health plan survey results. Only health maintenance organization (HMO), preferred provider organization (PPO), and HMO/point-of-service (POS) plans from either source are used in the calculation of the benchmark scores. Both benchmarks and TRICARE results are adjusted for age and health status.

Differences between the MHS and civilian benchmark were considered significant at less than or equal to 0.05, using the normal approximation. The significance test for a change between years is based on the

change in the MHS estimate minus the change in the benchmark, which is adjusted for age and health status to match the MHS. T-tests measure the probability that the difference between the change in the MHS estimate and the change in the benchmark occurred by chance. Tests are performed using a Z-test, and standard errors are calculated using SUDAAN to account for the complex stratified sample and unequal weights. If *p* is less than 0.05, the difference is significant.

Within the context of the HCSDB, Prime enrollees are defined as those enrolled at least six months.

TRICARE Inpatient Satisfaction Survey (TRISS)

The purpose of the Office of the Assistant Secretary of Defense (Health Affairs) TRISS is to monitor and report on the experience and satisfaction of MHS beneficiaries who have been admitted to military treatment facilities (MTFs) and civilian hospitals. The survey instrument incorporates the questions developed by the AHRQ and Centers for Medicare & Medicaid Services (CMS) for the Hospital CAHPS (HCAHPS®) initiative. The goal of the HCAHPS initiative is to measure uniformly and report publicly patient experiences with inpatient care through the use of a standardized survey instrument and data collection methodology. The information derived from the survey can be useful for internal quality improvement initiatives, to assess the impact of changes in policy, and to provide feedback to providers and patients.

The TRISS is a 43-item survey instrument with 21 questions asking how often or whether patients experienced a critical aspect of hospital care, rather than whether they were "satisfied" with their care, and 22 DoD-specific questions, including an open-ended question to solicit location-specific comments from our beneficiaries.

The TRISS questionnaire is sent to all (census) adult MTF inpatients worldwide between 48 hours and six weeks after discharge. The TRISS survey is also administered to a random sample of adult MHS inpatients discharged from civilian network/purchased care hospitals. The TRISS follows the HCAHPS protocols developed by the CMS. HCAHPS protocols for sampling, data collection, and coding can be found in the HCAHPS Quality Assurance Guidelines manual on the official HCAHPS website, http://www.hcahpsonline.org. The overall FY 2018 Q1–Q3 response rate for direct care was almost 35 percent, and for purchased care almost 39 percent.

TRICARE Outpatient Satisfaction Survey (TROSS) and Service Outpatient Surveys

JOES continues to focus on the beneficiary experience with care received in MTFs, and is centrally managed under the direction of Service and DHA survey leads. JOES results are reported centrally, and reported for each Service, multi-Service market area, and down to each MTF and provider. JOES also includes a separate monthly survey based on the DHA TROSS, called JOES-C (where "C" stands for CAHPS Clinician and Group Survey). JOES-C continues to focus on beneficiary experience in both direct and purchased care provider offices, allowing MHS to compare beneficiary results to the civilian benchmark results.

Quality

Military hospital inpatient quality measures were abstracted from clinical records by trained specialists and reported to The Joint Commission for national benchmarking. The data for direct care hospitals participating in the National Surgical Quality Improvement Program are abstracted by trained surgical case reviewers and submitted to the American College of Surgeons. The perinatal data are obtained from the electronic data system through an administrative data pull and are submitted to the National Perinatal Information Center to support comparison with other participating organizations across the nation. The availability of data for MHS providers continues to increase through the MHS Population Health Portal in CarePoint, via a streamlined access process, registry development for population management, and improved data displays. The MHS Dashboard in CarePoint provides views for all measures as well as executive and improvement priorities. The CarePoint portal includes a discharge tool to ensure that patients at high risk for readmission are identified during hospitalization. This facilitates continuity of care and provides caregivers with time for patient education and follow-up appointment scheduling to reduce the risk of readmissions.

Utilization and Costs

Data on MHS and beneficiary utilization and costs came from several sources. We obtained the health care experience of eligible beneficiaries by aggregating Standard Inpatient Data Records (SIDRs—MTF hospitalization records), Comprehensive Ambulatory/ Professional Encounter Records (CAPERs—MTF outpatient records), TRICARE Encounter Data (TED—purchased care claims information) for institutional and noninstitutional services, and Pharmacy Data Transaction Service (PDTS) claims within each beneficiary category.

Inpatient utilization was measured using dispositions (direct care)/admissions (purchased care) and Medical Severity Diagnosis Related Group (MS-DRG) relative weighted products (RWPs), the latter being a measure of the intensity of hospital services provided. Outpatient utilization for both direct and purchased care was measured using encounters and an MHS-derived measure of intensity called Enhanced Total Relative Value Units (RVUs). MHS uses several different RVU

measures to reflect the relative costliness of the provider effort for a particular procedure or service. Enhanced Total RVUs were introduced by MHS in FY 2010 and subsequently revised in FY 2016 (in both cases, they were retroactively applied to earlier years) to account for units of service (e.g., 15-minute intervals of physical therapy) and better reflect the resources expended to produce an encounter. The word "Total" in the name reflects that it is the sum of Work RVUs and Practice Expense RVUs. Work RVUs measure the relative level of resources, skill, training, and intensity of services provided by a physician. Practice Expense RVUs account for nonphysician clinical labor (e.g., a nurse), medical supplies and equipment, administrative labor, and office overhead expenses. In the private sector, Malpractice RVUs are also part of the formula used to determine physician reimbursement rates, but since military physicians are not subject to malpractice claims, they are excluded from Total RVUs to make the direct and purchased care workload measures more comparable. For a more complete description of enhanced as well as other RVU measures, see https://www.milsuite.mil/video/watch/video/9653.

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 2018, as referenced above.

The CCAE database contains the health care experience of several million individuals (annually) covered under a variety of health plans offered by large employers, including PPOs, POS plans, HMOs, and indemnity plans. The database links inpatient services and admissions, outpatient claims and encounters, and, for most covered lives, outpatient pharmaceutical drug data and individual-level enrollment information.

We tasked IBM Watson Health to compute quarterly benchmarks for HMOs and PPOs, broken out by product line (MED/SURG, OB, PSYCH) and several sex/age group combinations. The quarterly breakout, available through the second quarter of FY 2018, allowed us to derive annual benchmarks by fiscal year and to estimate FY 2018 data to completion. Product lines were determined by aggregating Major Diagnostic Categories (MDCs) as follows: OB = MDC 14 (Pregnancy, Childbirth, and Puerperium) and MDC 15 (Newborns and Other Neonates with Conditions Originating in Perinatal Period), PSYCH = MDC 19 (Mental Diseases and Disorders) and MDC 20 (Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders), and MED/SURG = all other MDCs. The breakouts by gender and age group allowed us to apply DoD-specific population weights to the benchmarks and aggregate them to adjust for differences in DoD and civilian beneficiary populations. We excluded individuals aged 65 and older from the calculations because most of them are covered by Medicare and Medigap policies rather than by a present or former employer's insurance plan.

DRG Grouping Methodology

In the section that displays the "Top 25" inpatient diagnosis groups, Diagnosis Related Groups (DRGs) are grouped into descriptively (but not necessarily clinically) similar categories using a code set available on http://www.findacode.com/code-set.php?set=DRG, an online database of medical billing codes and information. The site lists DRGs within each MDC, with headings above diagnostically related DRGs. These headings provide a broad description of the DRGs underneath and distinguish between medical and surgical DRGs, but do not distinguish among DRGs with different (or any) levels of complications and comorbidities. For the purposes of this report, the DRGs were too detailed and the MDCs too broad to provide the reader with a general sense of the most common inpatient diagnoses the MHS confronts; therefore, the headings were used as the basis for broadening the groupings in this report into descriptively related categories, without regard for whether they are medical or surgical, whether there are complications, or which parts of the body are affected. For example, the "ECMO or Tracheostomy" group includes DRGs 003, 004, 011, 012, and 013. The description for each of those DRGs includes the words "ECMO" or "Tracheostomy"—some with complications, some without; some for face, mouth, and neck; and some for other parts of the body. Once all the groups were formed, they were numbered sequentially following the order in which they were presented on the website. This resulted in a reduction from 818 DRGs to 284 DRG groups.

ABBREVIATIONS

ABA	applied behavior analysis | 119
AC	Active Component | 2
ACD	Autism Care Demonstration | 120
ADFM	Active Duty family member | 21
ADSM	Active Duty Service member | 84
AHRQ	Agency for Healthcare Research and Quality | 84
APLSS	Army Provider Level Satisfaction Survey | 84
ASD	autism spectrum disorder | 120
BMI	body mass index | 166
BRAC	Base Realignment and Closure | 25
BUMED	Bureau of Medicine and Surgery | 48
CAHPS	Consumer Assessment of Healthcare Providers and Systems | 75
CAUTI	catheter-associated urinary tract infection | 98
CCC	combat casualty care | 47
CCS	Clinical Classifications Software | 184
CDC	Centers for Disease Control and Prevention | 36
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services | 14
CLABSI	central line-associated bloodstream infection | 98
CMS	Centers for Medicare & Medicaid Services | 31
CONUS	within the contiguous United States | 5
CY	calendar year | 2
DEERS	Defense Enrollment Eligibility Reporting System | 20
DHA	Defense Health Agency | 1
DHHS	Department of Health and Human Services | 106
DHP	Defense Health Program | 6
DMDC	Defense Manpower Data Center | 22
DoD	Department of Defense | 1
ECHO	Extended Care Health Option | 209
ED	emergency department | 82
eMSM	enhanced multi-Service market | 25
ER	emergency room | 36
FDA	Food and Drug Administration | 1
FEDVIP	Federal Employees Dental and Vision Insurance Program | 14
FTE	full-time equivalent | 159
FY	fiscal year | 5
GAO	Government Accountability Office | 48
GRDFM	Guard/Reserve Family Members | 21
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems | 2
HCSDB	Health Care Survey of DoD Beneficiaries | 75
HEDIS	Healthcare Effectiveness Data and Information Set | 2
HIPAA	Health Insurance Portability and Accountability Act | 85
HMO	Health Maintenance Organization | 12
HP	Healthy People | 165
HRO	High Reliability Organization | 50
IMR	Individual Medical Readiness | 7
IOC	initial operating capability | 113
IQR	interquartile range | 60
JOES	Joint Outpatient Experience Survey | 84
JOES-C	Joint Outpatient Experience Survey-CAHPS | 84
JPSR	Joint Patient Safety Reporting | 95
KSAs	knowledge, skills, and abilities | 47
LBP	low back pain | 111
MCSC	managed care support contractor | 14
MDR	MHS Data Repository | 25
MERHCF	Medicare-Eligible Retiree Health Care Fund | 2
MH	mental health | 112
MHS	Military Health System | 1
MHSPHP	MHS Population Health Portal | 110
MS-DRG	Medicare Severity Diagnosis Related Group | 177
MTF	military treatment facility | 1
NAL	nurse advice line | 16
NCHS	National Center for Health Statistics | 36
NCQA	National Committee for Quality Assurance | 75
NCR	National Capital Region | 13
NCRMD	National Capital Region Medical Directorate | 9
NDAA	National Defense Authorization Act | 1
NHANES	National Health and Nutrition Examination Survey | 165
NHE	National Health Expenditures | 31
NHSN	National Healthcare Safety Network | 95
NPDB	National Practitioner Data Bank | 54
NPI	National Provider Identifier | 159
NPIC	National Perinatal Information Center | 117
NSQIP	National Surgical Quality Improvement Program | 2
OCONUS	outside the contiguous United States | 5
OHI	other health insurance | 23
O&M	Operations and Maintenance | 30
P4I	Partnership for Improvement | 9
P&T	Pharmacy & Therapeutics | 41
PC	perinatal care | 106
PCM	primary care manager | 12
PCMH	Patient-Centered Medical Home | 2
PDTS	Pharmacy Data Transaction Service | 39
PI	Program Integrity | 2
POS	point-of-service | 12
PPO	preferred provider organization | 176
PRISM	Provider Requirement Integrated Specialty Model | 25

ABBREVIATIONS *(CONT.)*

PSA	Prime Service Area | 25
PSM	Patient Safety Manager | 99
PSP	Patient Safety Program | 95
PSPC	Patient Safety Professional Course | 99
PSS	Navy Patient Satisfaction Survey | 84
RC	Reserve Component | 2
RCA	root cause analysis | 57
RE	Reportable Event | 95
RETFMs	Retirees and Family Members | 21
RVUs	relative value units | 2
RWPs	relative weighted products | 2
SDA	Air Force Service Delivery Assessment | 84
SE	Sentinel Event | 2
SECDEF	Secretary of Defense | 5
SME	subject matter expert | 93
SUD	Substance Use Disorder | 119
TAMP	Transitional Assistance Management Program | 12
TBI	traumatic brain injury | 114
TDP	TRICARE Dental Program | 12
TeamSTEPPS	Team Strategies and Tools to Enhance Performance and Patient Safety | 99
TED	TRICARE Encounter Data | 162
TFL	TRICARE for Life | 2
TJC	The Joint Commission | 2
TOL	TRICARE Online | 16
TPR	TRICARE Prime Remote | 12
TRDP	TRICARE Retiree Dental Program | 12
TRISS	TRICARE Inpatient Satisfaction Survey | 55
TRO	TRICARE Regional Office | 12
TROSS	TRICARE Outpatient Satisfaction Survey | 84
TRR	TRICARE Retired Reserve | 2
TRS	TRICARE Reserve Select | 2
TYA	TRICARE Young Adult | 2
UMP	Unified Medical Program | 1
URFO	unintended retained foreign object | 97
USD(P&R)	Under Secretary of Defense for Personnel and Readiness | 5
USFHP	Uniformed Services Family Health Plan | 12
VHA	Veterans Affairs Health Administration | 25
WRNMMC	Walter Reed National Military Medical Center | 10
WSS	Wrong-Site Surgery | 97

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS

1988-1995

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Era Leading to TRICARE

- Managed care demonstrations—mental health review, contracted provider arrangement for mental health, home health care/case management, catchment area management projects including the Tri-Service TRICARE Tidewater demonstration, the inaugural use of TRICARE branding
- CHAMPUS Reform Initiative demonstration contract for California and Hawaii offered CHAMPUS Prime, CHAMPUS Extra, and standard CHAMPUS (basis of later TRICARE triple option)

1993–1994

TRICARE Managed Care Legislation

- Administered under CHAMPUS fiscal intermediary contracts with oversight by the Office of CHAMPUS at Fitzsimmons Army Hospital installation in Aurora, CO
- Non-availability statements for civilian inpatient care in MTF catchment areas
- Program for Persons with Handicaps supplements basic program with non-medical benefits for Active Duty family members with serious disabilities
- Demonstration program to cover CHAMPUS Breast Cancer Treatment Clinical Trial; access to high-dose chemotherapy with stem-cell rescue; beginning of a partnership between CHAMPUS and the National Cancer Institute
- Added coverage of screening mammography and Papanicolaou (Pap) tests, added Certified Marriage and Family Therapists as TRICARE-authorized providers
- Added Continued Health Care Benefits Program for certain former DoD beneficiaries at full-cost premiums, providing beneficiaries with an option comparable to "COBRA" coverage to continue health care coverage for a limited period after leaving military service
- Reduced the catastrophic cap from $10,000 to $7,500 per year for retirees and their family members, capping their out-of-pocket expenses for any given fiscal year

1995

- Provided beneficiaries with greater choice, access to care, and coverage of preventive services through restructuring the MHS with publication of the TRICARE Final Rule (October 5, 1995; 60 FR 52078-52103) to implement managed care legislation of 1993
- TRICARE overlaid the CHAMPUS program established in 1966
- Established cost-neutral TRICARE triple option (TRICARE Prime, Extra and Standard)
- Started nationwide roll-out of managed care support contracts (seven contracts) across 12 regions, each headed by a lead agent (five Army, two Navy, four Air Force, one rotating)
- Built a TRICARE provider network to wrap around the MTFs
- Increased beneficiary access to pharmacy options by adding home delivery and retail pharmacy points of service as a result of Base Realignment and Consolidation (BRAC) commission
- Preventive services first offered exclusively under TRICARE Prime
- Reduced catastrophic cap for non-Active Duty enrollees from $7,500 to $3,000
- Expanded Active Duty Dental Benefit Plan begins

- Cancer Treatment Clinical Trial demonstration begins. Expanded beneficiary access to additional options for cancer treatment and through implementing a demonstration project Phase II and III Cancer Treatment Clinical Trials
  - Expanded coverage to all Phase II and III cancer clinical trials sponsored by the National Cancer Institute (NCI)
  - Widened access to promising cancer therapies, and contributed to the NCI's efforts to further the science of cancer treatment
  - Eventually became a permanent TRICARE Basic benefit available to all beneficiaries

1996

- Requirement for outpatient Non-Availability Statement (NAS) dropped
- Increased beneficiary access to preventive services by expanding access in TRICARE Standard/Extra (expanded further in 1997 to be very similar to TRICARE Prime)
- TRICARE website is launched

1997

- National Mail Order Pharmacy program begins
- Improved access to services for families with a disabled family member through the implementation of the Program for Persons with Disabilities (PFPWD), simplifying the process and making access easier for families
- TRICARE Standard/Extra get comprehensive preventive benefits
- TRICARE Retiree Dental Program begins—full-cost premiums with no DoD subsidy

- TRICARE roll-out is complete with 11 regions operational (regions 7 and 8 consolidated)
- Increased beneficiary access to ancillary care, making it easier and cheaper by removing TRICARE Prime copayments for ancillary services (radiology, laboratory, and diagnostic testing) conducted as a result of an outpatient visit

1998

- TRICARE Senior Prime demonstration begins

1999

- Increased beneficiary access to more providers by adding Corporate Services Provider Class
  - Allowed provider groups and foundations to become TRICARE-authorized providers; the care rendered by these providers was previously not cost-shared
  - Included freestanding corporations or foundations that rendered professional ambulatory care (e.g., physical therapy), in-home care, or technical diagnostic procedures
- TRICARE Prime Remote benefit begins
- NAS are required for maternity care

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS *(CONT.)*

2000

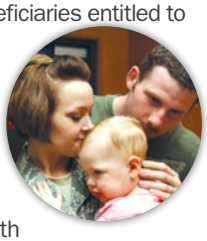
- Expansion of TRICARE Retiree Dental Program to dependents begins
- Reduced catastrophic cap for retirees, their family members, and survivors under TRICARE Standard/Extra from $7,500 to $3,000
- The DoD waives charges for Active Duty Prime Remote family members through August 31, 2000
- Expanded TRICARE benefits to cover school physicals

2001

- TRICARE eliminates Prime copays for Active Duty family members
- TRICARE for Life (TFL) benefit begins, superseding TRICARE Senior Prime Demonstration. TFL is Medicare wraparound coverage for TRICARE beneficiaries who have Medicare Part A and Medicare Part B; TRICARE pays after Medicare and other health insurance for TRICARE-covered health care services.
- TRICARE Senior Pharmacy (TSRx) benefit begins, adding pharmacy benefits for retirees over 65 years of age who formerly lost all TRICARE benefits upon becoming eligible for Medicare at age 65
- TRICARE simplifies and reduces copay structure for prescription drugs
- Active Duty Service members get permanent chiropractic care benefit in MTFs
- TRICARE Prime travel benefit to reimburse travel expenses when a TRICARE Prime enrollee has to travel more than 100 miles for referred specialty care

2002

- TRICARE Prime Remote for Active Duty Family Members (TPRADFM) benefit begins
- TRICARE Mail Order Pharmacy (TMOP) contract awarded (formerly managed by Defense Logistics Agency [DLA] as the National Mail Order Program)
- TRICARE Global Remote Overseas (TGRO) contract begins, providing cashless/claimless health care to overseas ADSMs/ADFMs assigned to Prime Remote locations
- Improved beneficiary access to needed care by revising the Coverage Criteria for Transplants and Cardiac and Pulmonary Rehabilitation
  - Added coverage of heart-lung, single or double lung, and combined liver-kidney transplants
  - Added coverage of pulmonary rehabilitation
  - Enhanced access to life-saving treatments for seriously ill TRICARE beneficiaries
  - Expanded coverage for pulmonary rehabilitation services to additional diagnoses as determined by the Director or designee
- Demonstration that waived (a) NASs and (b) annual TRICARE Standard/Extra deductible for family of mobilized Reserve Component (RC) sponsor (extended five times until made permanent in 2008)
- Deployed PDTS—improving patient safety—an online, real-time worldwide prospective drug utilization review (clinical screening) against a patient's complete medication history for each new or refilled prescription; these clinical screenings identify potential medication issues, which are immediately resolved to ensure the patient receives safe and quality care
- Created Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC)—a discretionary program for beneficiaries with extraordinary medical or psychological conditions, providing coverage of care normally excluded by law or regulation, as long as the benefit was cost effective
- Created Custodial Care Transition Policy (CCTP) developed to cover new cases of custodial care for beneficiaries entitled to expanded benefits



2003

- TPRADFM is modified to allow family members residing in Prime Remote locations to remain enrolled when sponsors undergo Permanent Change of Station on unaccompanied tour
- Requirement for RC sponsor's activation orders for TRICARE Global Remote Overseas benefit begins
- Eliminated NAS requirement for TRICARE Standard, except for mental health
- TRICARE Retail Pharmacy contract (TRRx) awarded, carving the benefit out of the managed care support contracts into a single program

2004

- Transitional Assistance Management Program (TAMP) coverage is temporarily extended to 180 days for all participants (made permanent in 2005)
- Early eligibility begins for RC members activated for more than 30 days in support of a contingency operation (made permanent in 2005)
- TRICARE Regions and managed care support contracts consolidated to three (North, South, and West) from 11

2005

- Premium-based TRICARE Reserve Select (TRS) benefit begins for certain Reserve Component members
- Superseded the PFPWD with Extended Health Care Option/Home Health Care (ECHO/EHHC) program, including 16 hours of respite care per month
- Improved beneficiary access to needed medications and, in many cases, decreased beneficiary cost share, by implementing the DoD Pharmacy Uniform Formulary/three-tier cost-share system
- Implemented the Uniform Formulary three-tier copay, administered by the DoD Pharmacy & Therapeutics (P&T) committee under the Pharmacy Program

2006

- Two premium tiers added to TRS so all members of the Selected Reserve can purchase coverage
- Gastric bypass, gastric stapling, or gastroplasty become covered benefits under TRICARE
- Family members are given a 30-day period to submit a TRICARE Prime enrollment form
- Improved access to care for beneficiaries by adding transitional TRICARE survivor coverage for dependents whose sponsor dies on Active Duty (greater than 30 days)
- Expanded coverage to certain direct commission reserve officers awaiting Active Duty

2007

- Anesthesia and other costs for dental care for certain children and other beneficiaries are authorized
- Claims processing under TRICARE program and Medicare program is standardized
- Mental health screening and services for members of the Armed Forces are enhanced
- TRS is simplified—superseded three-tier TRS with a single 28 percent premium tier; opened to all Selected Reservists other than those eligible for, or enrolled in, Federal Employees Health Benefits (FEHB) program.

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS *(CONT.)*

- Mental health care program is included in definition of health care
- Implemented the Enhanced Access to Autism Care Demonstration through the ECHO for ADFMs
- Improved the care provided to Wounded Warriors by adding numerous benefits, including:
  - Expanded ECHO services to Service members with respite care added
  - Added retiree combat-related disability travel
  - Added transitional care for service-related conditions first identified during TAMP for RC members

2008

- Integrated disability evaluation system—ensured DoD disability ratings and VA disability ratings were established prior to medical retirement from Active Duty

2009

- Started Active Duty Dental Program (ADDP)
- Eased the potential burden on families with special needs by increasing the ECHO cap to $36,000 per year for certain services
- Increased access to care by expanding the TAMP program:
  - Separated Active Duty members who affiliate with the Selected Reserve
  - Members in receipt of a sole survivorship discharge
- Improved beneficiary access to behavioral health care by allowing a streamlined certification for Hospital-Based Psychiatric Partial Hospitalization Programs
- TRICARE Pharmacy manufacturer refunds are established (retroactive to January 2008)
- Outpatient Prospective Payment System (OPPS) is implemented
- Improved beneficiary access to vaccines by expanding coverage under pharmacy benefit for H1N1 at retail pharmacies at zero copay

2010

- Expanded ADDP to Reservists during TAMP
- TRICARE Overseas Program begins health care delivery
- Launched premium-based TRICARE Retired Reserve (TRR) program—TRICARE Standard/Extra coverage offered for purchase by Retired Reserve members (gray-area) for themselves and eligible family members

2011

- Launched premium-based TRICARE Young Adult (TYA)—TRICARE Standard/Extra coverage offered for purchase for certain beneficiaries up to age 26
- Increased access to support services by expanding the Autism Care Demonstration
- Increased access to needed treatment by expanding coverage of the available surgical options for morbid obesity
- TRICARE Pharmacy announces copay decreases for the home delivery option, coinciding with increases to copays for retail pharmacy purchases
- TRICARE Prime enrollment fee is adjusted and can now be collected annually (frozen for survivors and certain significantly injured or ill retirees)
- Increased beneficiary access to behavioral health services by adding Certified Mental Health Counselors as independent practitioners

2012

- Eliminated TRICARE Standard/Extra cost shares for authorized preventive services (always free of cost-sharing in TRICARE Prime)
- TYA expanded to offer TRICARE Prime coverage
- TRICARE revises compound drug coverage by adopting a more rigorous screening process to ensure they are safe and effective, and covered by TRICARE
- Decreased beneficiary cost by freezing TRICARE Prime enrollment fees at rate effective when first enrolled for Survivors of Active Duty deceased sponsors and medically retired members and dependents
- Added coverage for off-label uses of devices if reliable evidence indicates it is safe, effective, and in accordance with nationally accepted standards of practice in the medical community
- Added assisted reproductive services for seriously or severely ill or injured service members

2013

- Reduction in Prime Services Areas (closed all PSAs not built around an MTF or BRAC site)
- TRS termination date delayed 180 days for Selected Reserve members involuntarily separated under honorable conditions
- Expanded Autism Care Demonstration to include retiree family members
- Restricted US Family Health Plan enrollment to beneficiaries (65 years and younger)
- Permanent authority to include certain OTC drugs under Uniform Formulary based on P&T recommendation
- Modified Over-the-Counter Demonstration Project to include Plan B One-Step (levonorgestrel) without prescription requirement
- Added coverage for abortions for rape or incest and brought coverage into conformance with existing federal statutory laws, including the Hyde Amendment, the Affordable Care Act, and President's Executive Order #13535 (March 24, 2010)
- Added coverage of hippotherapy under ECHO (horseback riding as a therapeutic or rehabilitative treatment)
- Defense Health Agency (DHA) became initially operational (October 1, 2013) under authority of the ASD(Health Affairs) and designated as a Combat Support Agency with oversight from the Chairman of the Joint Chiefs

2014

- Prime eligibility reinstated for some beneficiaries
- Launched Laboratory-Developed Test demonstration—authority to determine whether tests not yet approved by the FDA are safe and effective for use and thus eligible for TRICARE coverage
- TRICARE adds single-level cervical total disc replacement to list of covered procedures
- TRICARE increases access to mental health counselors
- The DoD expands available treatments for substance abuse
- TRICARE for Life (TFL) Pharmacy Pilot begins, requiring TFL beneficiaries living in the U.S. and the U.S. territories who use select maintenance medications to fill those prescriptions using TRICARE Pharmacy Home Delivery or a military pharmacy
- TRICARE extends the Over-the-Counter demonstration, which permits beneficiaries to fill prescriptions for certain OTC drugs, from network pharmacies and through home delivery for free
- Certified Mental Health Counselors added as authorized TRICARE providers
- Day limits for inpatient mental health stays eliminated
- U.S.-based TRICARE Service Centers closed
- Expanded breast pump (and supplies) coverage to all TRICARE beneficiaries
- TRICARE extended coverage to same-sex spouses and their family members
- Clarified the Unfortunate Sequelae policy, ensuring that treatment of complications or medically necessary follow-on care that occurs subsequent to noncovered initial surgery/treatment at an MTF is covered

2015

- TRICARE Prime access changed to allow beneficiaries to enroll in a region where their desired primary 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)

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS *(CONT.)*

2016

- Implemented first Value-Based Demonstration
  - The lower extremity joint replacement (LEJR) demonstration in the Tampa-St. Petersburg market has a direct linkage between quality and reimbursement
  - Better care coordination between the hospital and post-op care providers
- Comprehensive mental health parity—improved access at lower out-of-pocket expense
- Centralized approach for the MHS to support safe disposal of unwanted medications from patients
- Developed Medication Therapy Management Pilot
- DoD/VA Continuity of Care Drug List created for the purpose of including pharmaceutical agents critical for the treatment transition of Service members from the DoD to VA
- Added Advance Care Planning Services policy—provider reimbursement for end-of-life care beneficiary planning consultations, including the completion of Advance Directive documents
- Provided enhancements to preventive services and eliminated cost share/copays for some preventive services
- Comprehensive Autism Care Demonstration cost shares reduced for all applied behavior analysis services provided by authorized providers
- Added requirement for all beneficiaries (other than Service members) to get select brand name maintenance drugs through either TRICARE Pharmacy Home Delivery or from a military pharmacy
- Awarded TRICARE regional contracts, consolidating regions from three (North, South, and West) to two (East and West)
- Launched Urgent Care Pilot Program allowing non-ADSM Prime CONUS enrollees up to four network visits per year without referral or prior authorizations
- Expanded inpatient mental health hospital services coverage
- Over-the-counter drug coverage made permanent part of the TRICARE pharmacy benefit
- Slightly increased copays for prescription drugs at Home Delivery and retail network pharmacies
- Provisional coverage program introduced to provide coverage for emerging treatments and technologies
- Coverage additions under the TRICARE Basic Program
  - Surgery for femoroacetabular impingement (FAI)
  - Transcranial magnetic stimulation (TMS) for treatment of major depressive order and two-level cervical disc replacement
  - Nonsurgical treatment of gender dysphoria for all MHS beneficiaries; gender reassignment surgery only for Active Duty Service members
- U.S.-based pilot to encourage MHS beneficiaries seen in civilian emergency rooms (in designated markets) to voluntarily transfer to a participating MTF if an inpatient admission is needed and if determined safe for transfer
- Substance use disorder (SUD) Treatment Benefit revised to allow office-based opioid treatment by individual TRICARE-authorized physicians and add coverage of qualified opioid treatment programs as TRICARE authorized providers of SUD treatment for opioid use disorder.
- Health care delivery under second-generation TRICARE Overseas Program contract began September 1, 2016 (includes inpatient medical management of TOP Prime enrollees in civilian facilities and translation of medical documentation for all TOP Prime and Prime Remote beneficiaries)
- Implemented CHAMPUS Maximum Allowable Charges (CMAC) rates for professional services in all U.S. territories
- PSA definition changed to include newly created ZIP codes enclosed entirely within the existing PSA boundary

2017

- Initial deployment of MHS GENESIS to four MTFs and their child sites

2018

- TRICARE Select replaces TRICARE Standard/Extra per the National Defense Authorization Act (NDAA) for FY 2017; Standard beneficiaries are automatically enrolled effective January 1; 2018 considered a transition period with Select enrollment fee waived and beneficiaries allowed to change plans anytime up to and through first annual enrollment period
- Autism Care Demonstration extended for five years, through 2023, providing Applied Behavior Analysis coverage
- October 1 begins the multiyear transition of administration and management of MTFs from the military departments to the DHA, responding to provisions of NDAA 2017
- Federal Employees Dental and Vision Insurance Program (FEDVIP) authorized for military retirees and their family members, expanding benefits options and carriers for beneficiaries previously eligible for Tricare Retiree Dental Program (TRDP) coverage. Most Active Duty family members, retirees and reservists and their family members are now eligible for a new vision benefit that provides extra coverage beyond that of TRICARE plans
- First TRICARE open enrollment season for military family members, and retirees and their families; adding TRICARE Select with enrollment fees, and Office of Personnel Management's FEDVIP to replace the dental and optometry benefits that terminated at the end of CY 2018
- Enhancements to 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

The **Evaluation of the TRICARE Program: Fiscal Year 2019 Report to Congress** is provided by the Defense Health Agency, Decision Support Division, in the Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]). Once the Report has been sent to Congress, an interactive digital version with enhanced functionality and searchability will be available at: http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program.

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CRM = Contract Resource Management
CSD = Clinical Support Division
HRM&P = Health Resources Management & Policy
M&RA = Manpower & Reserve Affairs
OPS = Operations
PCMH = Patient-Centered Medical Home
PHD = Public Health Division
R&M = Resources & Management
SP&FI = Strategy, Plans, and Functional Integration
THP = TRICARE Health Plan

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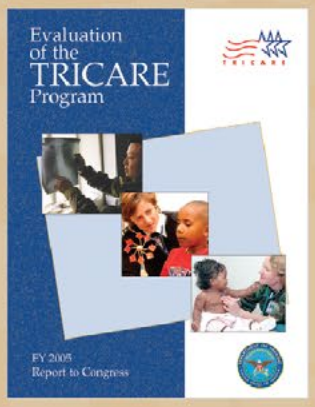

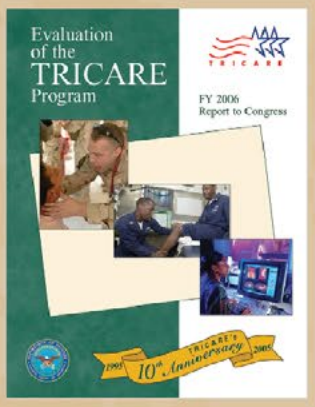

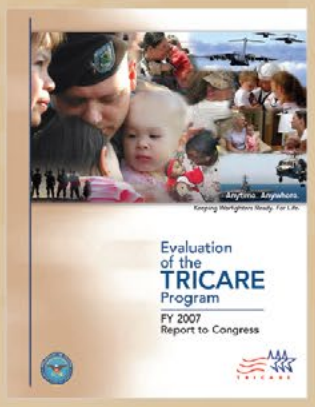

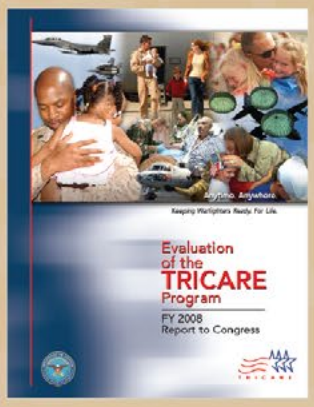

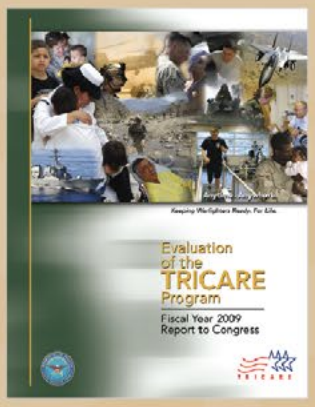

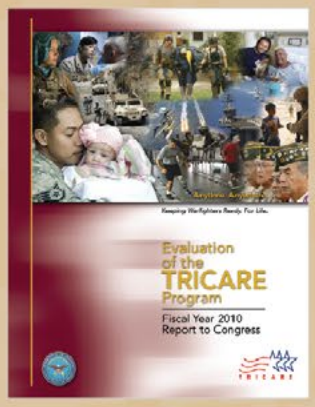

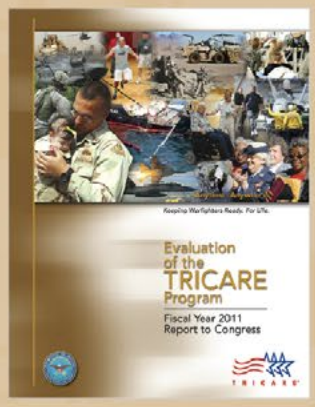

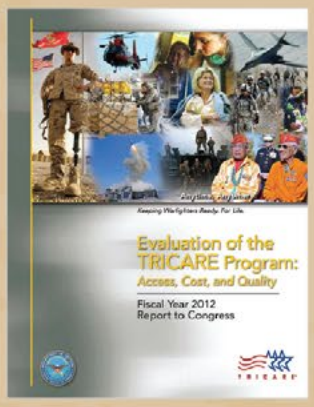

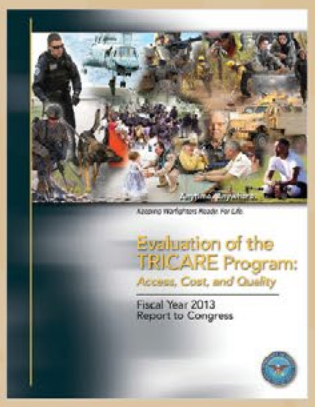

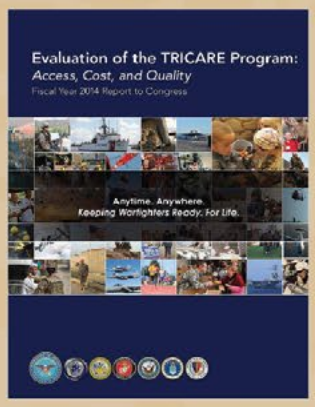

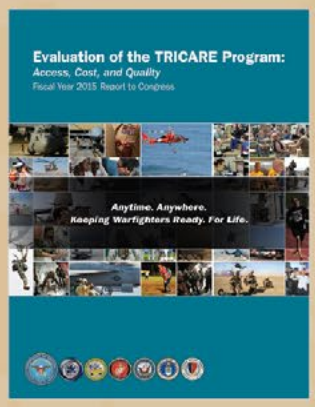

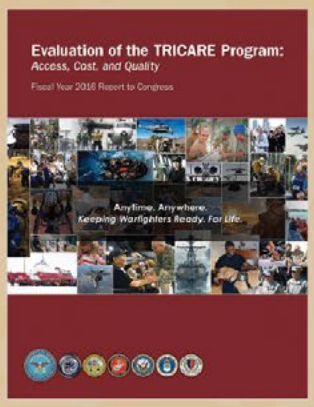

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