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

PERSONNEL AND
READINESS

JUL 2 0 2021

The Honorable Jack Reed
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The Department's response to section 717 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 1996 (Public Law 104–106) is enclosed. Section 717 requires an annual evaluation of the effectiveness of the TRICARE program in meeting the goals of increasing the access of covered beneficiaries. This report also addresses section 714 of the NDAA for FY 2013, expanding the evaluation to all other beneficiary groups and chronic conditions; section 713 of the NDAA for FY 2016, requiring detailed reporting for measures of access to care, quality of care, and patient safety; and section 712 of the NDAA for FY 2016, providing public transparency of these data.

This comprehensive report looks across the spectrum of the health services we deliver, arrange, or pay for, and provides an assessment of our performance for 9.6M beneficiaries. The Department's $51B FY 2020 Unified Medical Program, including the accrual fund, represents approximately seven percent of the total Department of Defense budget for FY 2020. Recent legislation established significant changes to the Defense Health Agency. Amid the sweeping changes underway, one thing remains constant: our commitment to the men and women of our Uniformed Services.

Thank you for your continued strong support for the health and well-being of our Service members, veterans, and families. I am sending similar letters to the President of the Senate, the Speaker of the House, and the other congressional defense committees.

Sincerely,

Virginia S. Penrod

Virginia S. Penrod
Acting

Enclosure:
As stated

cc:
The Honorable James M. Inhofe
Ranking Member

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

PERSONNEL AND READINESS

JUL 2 0 2021

The Honorable Adam Smith
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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Virginia S. Penrod

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Acting

Enclosure:
As stated

cc:
The Honorable Mike D. Rogers
Ranking Member

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

PERSONNEL AND
READINESS

JUL 2 0 2021

The Honorable Patrick J. Leahy
Chairman
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

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Virginia S. Penrod

Virginia S. Penrod
Acting

Enclosure:
As stated

cc:
The Honorable Richard C. Shelby
Vice Chairman

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

PERSONNEL AND
READINESS

JUL 2 0 2021

The Honorable Rosa L. DeLauro
Chairwoman
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Madam Chairwoman:

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Sincerely,

Virginia S. Penrod

Virginia S. Penrod
Acting

Enclosure:
As stated

cc:
The Honorable Kay Granger
Ranking Member

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

PERSONNEL AND
READINESS

JUL 2 0 2021

The Honorable Kamala D. Harris
President of the Senate
United States Senate
Washington, DC 20510

Dear Madam President:

The Department's response to section 717 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 1996 (Public Law 104–106) is enclosed. Section 717 requires an annual evaluation of the effectiveness of the TRICARE program in meeting the goals of increasing the access of covered beneficiaries. This report also addresses section 714 of the NDAA for FY 2013, expanding the evaluation to all other beneficiary groups and chronic conditions; section 713 of the NDAA for FY 2016, requiring detailed reporting for measures of access to care, quality of care, and patient safety; and section 712 of the NDAA for FY 2016, providing public transparency of these data.

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Virginia S. Penrod
Acting

Enclosure:
As stated

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

PERSONNEL AND
READINESS

JUL 2 0 2021

The Honorable Nancy Pelosi
Speaker of the House
U.S. House of Representatives
H-209, The Capitol
Washington, DC 20515

Dear Madam Speaker:

The Department's response to section 717 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 1996 (Public Law 104–106) is enclosed. Section 717 requires an annual evaluation of the effectiveness of the TRICARE program in meeting the goals of increasing the access of covered beneficiaries. This report also addresses section 714 of the NDAA for FY 2013, expanding the evaluation to all other beneficiary groups and chronic conditions; section 713 of the NDAA for FY 2016, requiring detailed reporting for measures of access to care, quality of care, and patient safety; and section 712 of the NDAA for FY 2016, providing public transparency of these data.

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Virginia S. Penrod

Virginia S. Penrod
Acting

Enclosure:
As stated

Evaluation of the TRICARE Program:

Fiscal Year 2021 Report to Congress

Access, Cost, and Quality Data through Fiscal Year 2020

Anytime. Anywhere.

Keeping Warfighters Ready. For Life.

24th Annual

TRICARE Evaluation Report and Data

Evaluation of the TRICARE Program:

Fiscal Year 2021 Report to Congress

Access, Cost, and Quality Data through Fiscal Year 2020

FEBRUARY 26, 2021

The *Evaluation of the TRICARE Program: Fiscal Year 2021 Report to Congress* is provided by the Defense Health Agency (DHA), Analytics and Evaluation Division, in the Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA]). Once the Report has been sent to Congress, an interactive digital version with enhanced functionality and searchability will be available at: http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program.

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

Front cover photo descriptions:

A – A sailor signals an MH-60R helicopter from the Royal Australian Navy to land on the flight deck of the guided-missile destroyer USS John S. McCain during flight operations while conducting integrated maritime security operations. (October 2020)

B – The Military Sealift Command hospital ship USNS Mercy arrives in Los Angeles, Calif., as part of the nation's COVID-19 response efforts, to serve as a referral hospital for non-COVID-19 patients currently admitted to shore-based hospitals. (March 2020)

C – Marines prepare an F-35B Lightning II Joint Strike Fighter while conducting historic deployment training flights aboard the Royal Navy aircraft carrier HMS Queen Elizabeth on behalf of national and allied objectives. (September 2020)

D – A pediatric nurse practitioner at Naval Branch Health Clinic Mayport checks a patient's ears. (September 2020)

E – U.S. Army Service members from the 531st field hospital transport a patient to the intensive care unit at the Javits New York Medical Station in support of the Department of Defense COVID-19 response. (April 2020)

F – A Navy nurse performs a COVID-19 nasal swab screening. (March 2020)

G – A mammography technologist at Naval Hospital Jacksonville assists a patient during a mammogram. (September 2020)

H – An electrician lays out PVC conduit in a trench for electrical components for the construction of a concrete pavilion to support U.S. and partner nations to strengthen relationships, deter aggression, and enable expeditionary logistics and naval power projection. (October 2020)

I – A U.S. Army Veteran climbs up Hamburger Hill, where he fought more than 50 years earlier. (October 2020)

J – A member of the 106th Rescue Wing dons protective gear at the COVID-19 testing site at the Theodore Roosevelt Nature Center at Jones Beach, N.Y., to provide care and testing throughout the state as part of a coordinated response to the COVID-19 pandemic. (May 2020)

K – Naval urologists assigned to Naval Medical Center San Diego (NMCSD) prepare a robotic system for a surgical procedure. (August 2020)

L – A U.S. Army nurse assigned to the Javits New York Medical Station monitors a COVID-19 patient in the facility's intensive care unit. (March 2020)

M – A hospital corpsman prepares a syringe with the influenza vaccine before administering annual flu shots at Navy Medicine Readiness and Training Command Corpus Christi to reduce the overall impact of contagious respiratory illnesses on the population and decrease the burden on the health care system during the overlapping flu season and COVID-19 pandemic. (September 2020)

N – U.S. Air Force F-15C/D Eagles conduct a routine aerial mission during NATO Air Police operations at Keflavik Air Base, Iceland. (October 2020)

O – An airman uses a rowing machine during the Wounded Warrior Care Event on Joint Base Pearl Harbor-Hickam, Hawaii. (January 2020)

P – A Coast Guard cutter repairs buoys while servicing more than 240 aids to navigation in shipping channels along the west coast of Florida. (August 2020)

Q – U.S. Army soldiers communicate with one another during Lightning Forge 20. (July 2020)

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

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A MESSAGE FROM DR. TERRY ADIRIM, ACTING ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

I am pleased to provide Congress with the Department of Defense (DoD) Evaluation of the TRICARE Program report, as required per section 717 of the National Defense Authorization Act (NDAA) for fiscal year (FY) 1996 (Public Law 104–106). This report provides an assessment of the Military Health System (MHS) overall performance in providing full-spectrum health care services to our 9.6 million Service member, retiree, and family member beneficiaries—representing a $50.5 billion FY 2021 Unified Medical Program (UMP) critical for the warfighters and patients we serve.

This report comes at a time of unprecedented challenges as we tackle the COVID-19 pandemic, which continues to affect all of our lives. During the past year, COVID-19 has been our number one priority. Military medicine has been leading efforts to protect our workforce, maintain readiness, and support the national response. Whether it was standing up a COVID-19 Testing Task Force, collecting more than 10,000 units of COVID Convalescent Plasma, or distributing and administering the COVID vaccine worldwide, the MHS continues to lead the DoD in winning the war on COVID.

Before the pandemic, the MHS embarked on efforts for long-term strategic framework for coordination to ensure a ready medical force. Several reform efforts were paused during the pandemic. At the end of FY 2020, MHS leadership resumed these efforts, including lifting the pause on the MHS transformation set to be completed by September 30, 2021. The pandemic has shown the need for consolidated management of the MHS.

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

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

Our patients have already benefitted from recent TRICARE enhancements—including a successful rollout of two TRICARE Open Seasons; transition of more than 450 military hospitals and clinics to the TRICARE.mil website domain; and expansion of telehealth services specifically to meet patient needs during the pandemic. And in line with the National Defense Strategy, military medicine continues to engage with other federal agencies, the private sector, international institutions, and partner nations to better serve our providers and patients.

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

— Dr. Terry Adirim .

EXECUTIVE SUMMARY: KEY FINDINGS FOR FY 2021

Evaluation of the TRICARE Program: Report to Congress

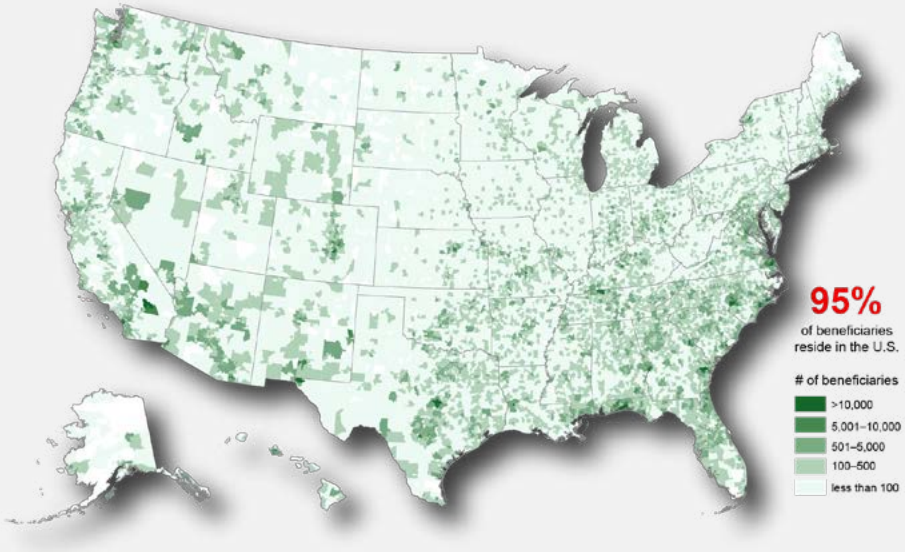
Executive Summary: Key Findings for FY 2021

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

The Quadruple Aim

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

Beneficiary Population (page 29)



Enrollment (page 36)

Prime Enrolled:
4.8 million beneficiaries

- ⬇ 3,405,000 Prime: MTF PCM
- ⬆ 1,248,000 Prime: Network PCM
- ⬆ 112,000 USFHP
- ⬇ 9,000 TYA Prime

Select Enrolled/Non-Enrolled:
2.3 million beneficiaries

- ⬆ 1,682,000 TRICARE Select
- ⬇ 376,000 TRS
- ⬆ 224,000 Direct Care Only
- ⬆ 31,000 TRICARE Plus
- ⬇ 24,000 TYA Select
- ⬆ 11,000 TRR

Medicare-Eligible:
2.5 million beneficiaries

- ⬆ 2,104,000 TFL
- 186,000 TRICARE Plus
- ⬆ 97,000 Direct Care Only
- ⬇ 41,000 USFHP
- ⬆ 33,000 Prime: MTF PCM
- ⬇ 30,000 Prime: Network PCM
- 3,000 Other

Numbers rounded to the nearest thousand; ⬆ Increase from FY 2019; ⬇ Decrease from FY 2019

Readiness (pages 59–60)

82% Active	82% Reserve	92% Dental
Strategic Goal: 85%	Strategic Goal: 85%	Strategic Goal: 95%

COVID-19 (pages 16–23)

- Developed and launched the COVID-19 Current Operation Dashboard
- Established the COVID-19 Registry with more than 128,000 COVID-positive patients in the registry and full manual abstraction completed on 3,604 patients since December 22, 2020
- Collected 13,651 COVID Convalescent Plasma (CCP) units and contacted 24,376 potential donors for donation as of December 11, 2020

Pharmacy (page 197)

$825 million
Retail Pharmacy Refunds

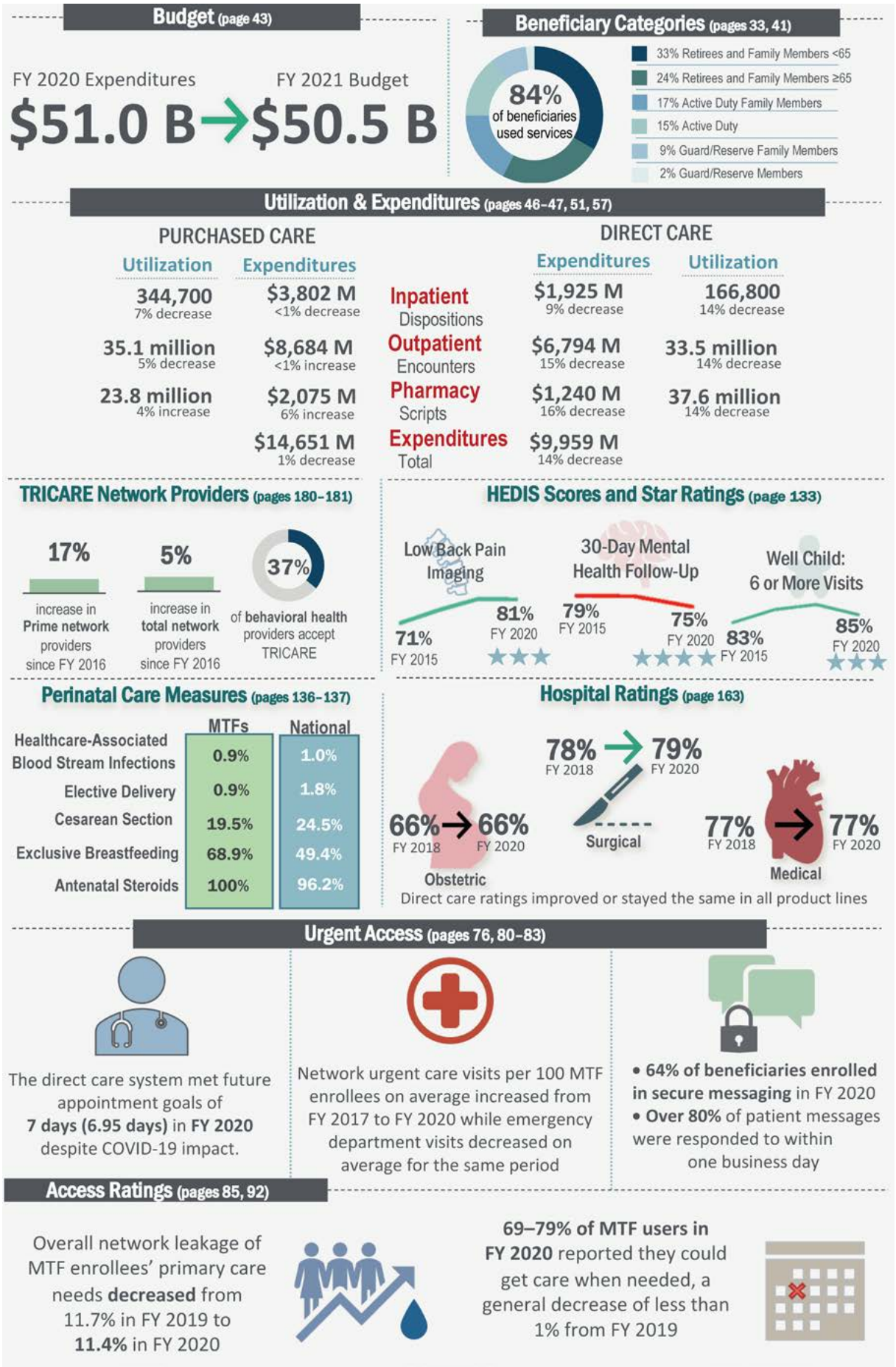
Surgical Safety (page 111)

22%
decrease in number of Wrong-Site Surgery Reportable Events

Hospital Ratings (page 167)

Patient opinions have continued to **increase** since FY 2017

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



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

MHS Worldwide Summary

- The $50.5 billion Unified Medical Program (UMP) presented in the FY 2021 President's Budget, including estimated outlays from the Medicare-Eligible Retiree Health Care Fund (MERHCF), is 1 percent lower than the $51.0 billion in estimated expenditures in FY 2020 and is 7 percent of total FY 2021 estimated Department of Defense (DoD) outlays (ref. pages 43–44).
- In FY 2020, 9.6 million beneficiaries were eligible for DoD medical care. Of those, almost 4.8 million (50 percent) were enrolled in TRICARE Prime (including TRICARE Young Adult [TYA] Prime and Uniformed Services Family Health Plan [USFHP]) (ref. pages 33–34).
- TYA enrollment increased to just over 40,000 beneficiaries under age 26 in FY 2020, from about 37,000 in FY 2019, with most enrolled in the TRICARE Select benefit (77 percent) (ref. page 179).
- There were almost 390,166 covered lives in the premium-based TRICARE Reserve Select (TRS) in 111,000 plans, while Retired Reserve members and their families in TRICARE Retired Reserve (TRR) reached just over 3,900 plans and almost 10,800 covered lives (ref. pages 175–176).

MHS Workload and Cost Trends[1,2]

- The percentage of beneficiaries using Military Health System (MHS) services declined slightly from 86 percent in FY 2018 to 85 percent in FY 2020 (ref. page 41).
- Excluding TRICARE for Life (TFL), total MHS workload (direct and purchased care combined) fell from FY 2018 to FY 2020 for inpatient care (13 percent), outpatient care (9 percent), and prescription drugs (6 percent) (ref. pages 46–47, 51).
- From FY 2018 to FY 2020, direct care workload decreased for inpatient care (17 percent), outpatient care (20 percent), and prescription drugs (8 percent). Over the same period, total direct care costs fell by 12 percent (ref. pages 46–47, 51, 56).
- Excluding TFL, purchased care workload declined for inpatient care (11 percent), outpatient care (2 percent), and prescription drugs (1 percent). Overall, purchased care costs rose by 4 percent (ref. pages 46–47, 51, 56).
- The purchased care portion of total MHS health care expenditures rose from 55 percent in FY 2018 to 59 percent in FY 2020 (ref. page 56).
- In FY 2020, out-of-pocket costs for MHS beneficiary families under age 65 were between $7,100 and $9,400 lower than those for their civilian counterparts, while out-of-pocket costs for MHS senior families were $3,500 lower (ref. pages 215, 217, 220).

Lower Cost

- MHS estimated savings include $825 million in retail pharmacy refunds in FY 2020 and $364 million in Program Integrity (PI) activities in calendar year (CY) 2019 (ref. page 197).

Improved Readiness

- **Force Health Protection:** At the end of FY 2020, the overall medical readiness of the Total Force was at 82 percent, with the Active Component and the Reserve Component both at 82 percent, not meeting the strategic goal of 85 percent. Dental readiness, at 92 percent, was below the MHS goal of 95 percent. The MHS surgical community is leading the way in identifying and enumerating critical clinical readiness skill sets (ref. pages 59–63).

Better Care

- **Access to Care:** Patient-Centered Medical Home (PCMH) primary care administrative measures indicate that, in FY 2020, military medical treatment facility (MTF) enrollees saw their primary care provider 56 percent of the time and a PCMH team member 91 percent of the time. In FY 2020, there was an increase in the average number of days to third next available 24-hour (2.0 days) and future (6.95 days) appointments, with greater variation in appointment availability due to COVID-19. Network urgent care usage slightly decreased from 19.86 visits per 100 enrollees in FY 2019 to 19.01 visits per 100 enrollees in FY 2020. Beneficiary enrollment in and MTF responsiveness to secure messaging increased in FY 2020 to 64.16 percent. The Joint Outpatient Experience Survey (JOES) shows 73 to 82 percent of MTF users in FY 2020 reported they could get care when needed. Administrative data shows that 85 percent of non-Active Duty enrollees had at least one primary care visit in FY 2020 (ref. pages 75–76, 81–82, 89, 96).
- **Hospital Quality of Care:** MTFs and MHS civilian network hospital performance perinatal quality measures are comparable to The Joint Commission® (TJC) hospital benchmarks. MHS civilian network hospitals and inpatient MTFs are required to maintain accreditation by a recognized external accreditation organization to demonstrate compliance with national standards of care (ref. pages 135–137).
- **Outpatient Care:** MTF Healthcare Effectiveness Data and Information Set (HEDIS®) rates exceed the national 75th percentile for appropriate treatment for children with upper respiratory infection and mental health follow-up, and surpass the national 50th percentile for colorectal cancer screening, lower back pain imaging, well-child visits (ref. pages 129–133).
- **Beneficiary Ratings of Inpatient Care—Overall Hospital Rating:** Direct care has shown improved patient hospital ratings from FY 2018 to FY 2020, meeting or exceeding the national Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) benchmark average in the medical and surgical product lines, with three MTFs at the 90th percentile and six MTFs at the 75th percentile. Ratings in the obstetric product line remain stable and below the HCAHPS benchmark (ref. pages 163–164).
- **Patient Safety:** The MHS direct care system has been focusing on reducing Wrong-Site Surgery Reportable Event (WSS RE) education and leadership engagement, with a goal of zero events. There was a reduction in REs from FY 2019 (27) to FY 2020 (21) (ref. page 111).
- **MHS Provider Trends:** The number of TRICARE network providers increased by 18 percent from FY 2016 to FY 2020. The total number of participating providers increased by 6 percent over the same time period (ref. page 180).
- **Access for TRICARE Select Users:** Results from the fourth year of the congressionally mandated four-year survey (2017–2020) of civilian providers and MHS non-enrolled beneficiaries shows eight of 10 physicians accept new TRICARE Select patients, a higher acceptance rate than reported for behavioral health providers (ref. page 181).

[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, at four additional sites in FY 2019, and at 10 more sites at the end of FY 2020. Any inpatient and outpatient workload performed at those facilities (and at clinics that report data to those facilities) from the deployment dates onward have not yet been fully captured in the MHS administrative data and will result in reported workload being lower than the actuals in FYs 2018-2020.

MHS PURPOSE, MISSION, VISION, AND STRATEGY

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

The MHS maintains integrated medical teams that deliver health services to America's military, anytime and anywhere, all supported by a uniformed sustaining base, a robust health plan, medical evacuation capabilities, and MTFs. We are ready to go into harm's way to meet our national security and military challenges at home or abroad, and remain committed to becoming a world leader in quality, safety, education, training, research, and technology.

Our capability to provide a continuum of health services across the full range of military operations is contingent on the ability to create and sustain a healthy, fit, and medically ready force. To do so, we partner with industry and academia as well as other federal agencies and allies to research, innovate, educate, and train. An agile, responsive capacity for research, innovation, and development is essential to achieve improvements on the battlefield.

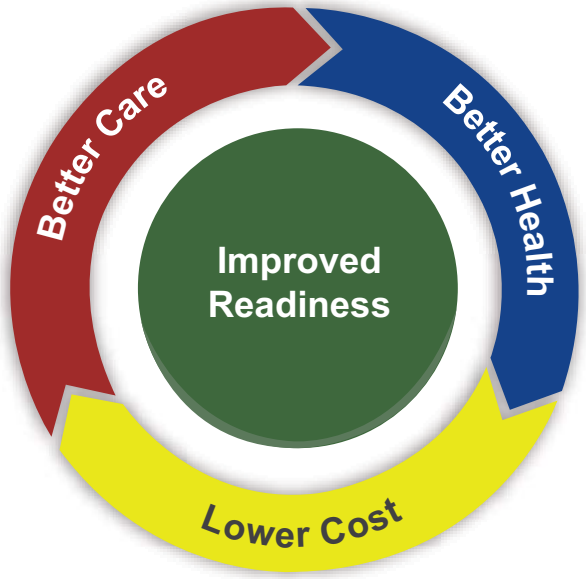
The MHS is one of the world's only global health systems, capable of rapid deployment to austere environments. We realize that we must reform legacy processes and continue to integrate in order to meet the challenges of the ever-evolving nature of war while reducing costs to the American taxpayer.

MHS QUADRUPLE AIM—STRATEGIC DIRECTION AND PRIORITIES

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

- **Improved Readiness:** Readiness means ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health services at a moment's notice in support of the full range of military operations, on the battlefield or during disaster response and humanitarian aid missions.
- **Better Care**: We are proud of our track record and recent improvements, but there is always more to accomplish. We continue to advance health care that is safe, timely, effective, efficient, equitable, and patient- and family-centered.
- **Better Health:** Our goal is to improve, maintain, and restore the health of the fighting force as well as all entrusted to our care. Doing so reduces the frequency of visits to our military hospitals and clinics by keeping the people we serve healthy. We are making the transformation from health care to health by encouraging healthy behaviors, increasing health resilience, and decreasing the likelihood of illness through focused prevention.
- **Lower Cost:** To lower costs, we increase value by focusing on quality, eliminating waste, and reducing unnecessary variation. As the industry moves toward value-based health care, we begin to consider the total cost of care over time, not just the cost of care at a single point in time. We are becoming more agile in our decision making and are implementing longer-term opportunities to improve the value of health services for all we serve.

MHS QUADRUPLE AIM



DHA VISION AND MISSION FOR FYs 2020–2021

Vision: Unified and Ready…

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

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

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

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

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

DHA VISION AND MISSION FOR FYs 2020–2021 *(CONT.)*

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

The Office of the Under Secretary of Defense for Personnel and Readiness (OUSD[P&R]) supports the Secretary of Defense (SECDEF) and the top priorities of defending the Nation, taking care of our people, and succeeding through teamwork. Committed to developing policies, plans, and programs to support the All-Volunteer Force, OUSD(P&R) oversees military health reform efforts and force health protection to take care of the Department's most valuable resource: our people.

Office of the Assistant Secretary of Defense for Health Affairs Intent

The Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA]) provides policy, resources, and oversight necessary to achieve integration of readiness and health across the MHS. The Department's phased plan implements congressional guidance for integration set forth in Title VII of the National Defense Authorization Act (NDAA) for fiscal year (FY) 2017, as supplemented by other statutes, and seeks to eliminate separate silos of military health and integrate management of military health care under the DHA. The OASD(HA) supports the DHA's implementation plan for transitioning authority, direction, and control (ADC) and management of MTFs from the military departments to DHA.

DHA Director's Intent and the MHS Transformation

The DHA's priority effort is continued implementation of the provisions of NDAA FY 2017, section 702. In October 2019, the DHA undertook administration and management of all MTFs within the contiguous United States (CONUS). The DHA is establishing a market-based structure to manage the hospitals and clinics. These market organizations will provide shared administrative services to the hospitals and clinics in their region. The markets will be responsible for generating medical readiness of Active Duty members and families in their regions, as well as ensuring the readiness of their medical personnel. This will be done by flexing resources throughout their market regions to ensure patient demand and the readiness needs of the medical troops are met, and by setting goals and monitoring progress through Quadruple Aim Performance Plans (QPP).

In 21 large markets where there are large concentrations of facilities and patients, markets will be centered on large medical centers, establishing centers of excellence for specialty care that meet the needs of beneficiaries across the market regions. Nearly two-thirds of the MHS current patient encounters occur in these 21 regions. Another 16 small markets will be centered on inpatient community hospitals, focused on providing ambulatory and some specialty and inpatient care across their regions. These small markets, as well as many stand-alone hospitals and clinics located outside a market region, will report to a Small-Market and Stand-Alone Organization (SSO) that will provide administrative support. When the DHA assumes responsibility for overseas hospitals and clinics, two regional offices will provide similar support, one for Europe and one for the Pacific.

The DHA established four military medical markets on January 30, 2020. The new markets include hospitals and clinics in the National Capital Region (Washington, D.C., southern Maryland, and northern Virginia); Jacksonville, Fla.; the Mississippi coast (Biloxi-Gulfport-Pascagoula); and Central North Carolina (Fayetteville).

The Deputy Secretary of Defense paused the MTF transition in early 2020 to allow the Military Medical Departments (MILDEPs) and the DHA to focus on the COVID-19 pandemic response efforts. During the pause, the DHA Transition Program Management Office (PMO) continued to prepare for the restart of transition. The MILDEPs also voiced concern to the SECDEF as to the best way forward for MHS transformation in a memorandum on August 3, 2020. The SECDEF listened to their concerns and later determined that the MHS could fully support the COVID-19 response and resume the agreed-to plan for MTF transition on November 9, 2020. The DHA resumed Wave 1 Market Office market establishment and certification activities by holding virtual market kickoff meetings at the end of November 2020 for Tidewater, San Antonio, Colorado, Puget Sound, and Hawaii markets. Further, the DHA plans to establish the remaining markets that began reporting directly to the DHA in March 2021.

Phased Implementation of NDAA FY 2017, Section 702

MHS Market Construct Overview

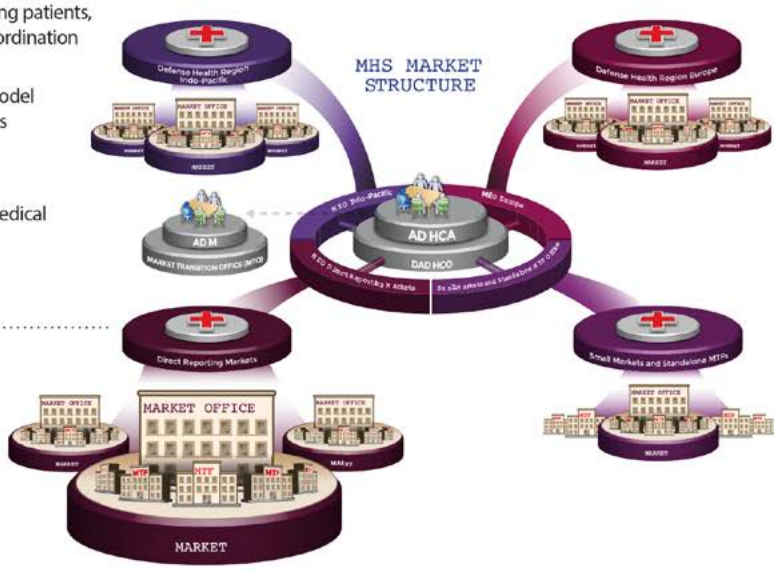
Designing an integrated health system that improves the delivery and coordination of health services, drives value for beneficiaries, and enhances medical readiness

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

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

A Market will:

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



Market Benefits

READINESS

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

PATIENT EXPERIENCE

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

STAFF EXPERIENCE

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

RESOURCES

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

RESOURCES

Market Information | Transition MilSuite Site | DHA Launchpad

Core Market Functions

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

CLINICAL

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

ADMINISTRATIVE

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

EXECUTIVE SUPPORT

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

ANALYTICS

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

Our Definition of Success

GREAT OUTCOMES

Our most important outcome is a medically ready force

READY MEDICAL FORCE

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

SATISFIED PATIENTS

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

FULFILLED STAFF

Our staff feel joy and purpose working in the MHS

MHS PERFORMANCE MANAGEMENT

Performance Management System

The MHS continued to oversee the system under the governance structure implemented by the Under Secretary of Defense for Personnel and Readiness (USD[P&R]) for FY 2019, coinciding with the beginning of the transition of MTF management from the Armed Services to the DHA. The four oversight councils covered specific policy domains—readiness, health, resource management, and health informatics. Each council is chaired by a Deputy Assistant Secretary of Defense, and co-chaired with the Joint Staff Surgeon for the readiness council. MHS governance does not require full consensus from MHS components at the oversight councils; the Assistant Secretary of Defense for Health Affairs (ASD[HA]) retains the authority to make decisions where disagreement between the DHA and Services exists.

To accommodate joint oversight for large-scale disruptions and changes to the MHS, like the COVID-19 pandemic and issues arising from the transition of authorities to the DHA, the ASD(HA) instituted a Joint Medical Oversight Council as a bridge to further streamline governance planned for FY 2021. Given the breadth of issues covered by governance, the councils were supported by an action team responsible for strategic performance measures and a liaison group to facilitate communication and coordination. Above the level of the oversight councils, the Senior Military Medical Advisory Committee and MHS Executive Review continue to adjudicate issues that require a department-wide response or decisions from Under Secretaries and higher.

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

The MHS core measures for FY 2020 largely carry over from FYs 2018 and 2019 to provide constancy of purpose on the MHS Quadruple Aim of Improved Readiness, Better Care, Better Health, and Lower Cost. Each measure was assigned to the most relevant Oversight Council to track progress. These measures are used to reduce the uncertainty of policy-related decision making drive improvement at all levels, including markets and facilities. Metrics selected from the coreset continue underpinning MHS guidance at multiple levels of the organization by measuring performance improvement at the MTFs and markets through the QPP; tracking progress made by the Reform Management Group (RMG) led by the DoD Chief Management Officer; and monitoring system risk during the transition of ADC of MTFs to the DHA.

MHS FY 2020 CORE MEASURES

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

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

MHS PERFORMANCE MANAGEMENT *(CONT.)*

Performance Management System *(cont.)*

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

DIFFERENT DASHBOARDS FOR DIFFERENT PURPOSES (FY 2020 DASHBOARDS)

MHS Core Dashboard

Critical Initiative Measures Dashboard

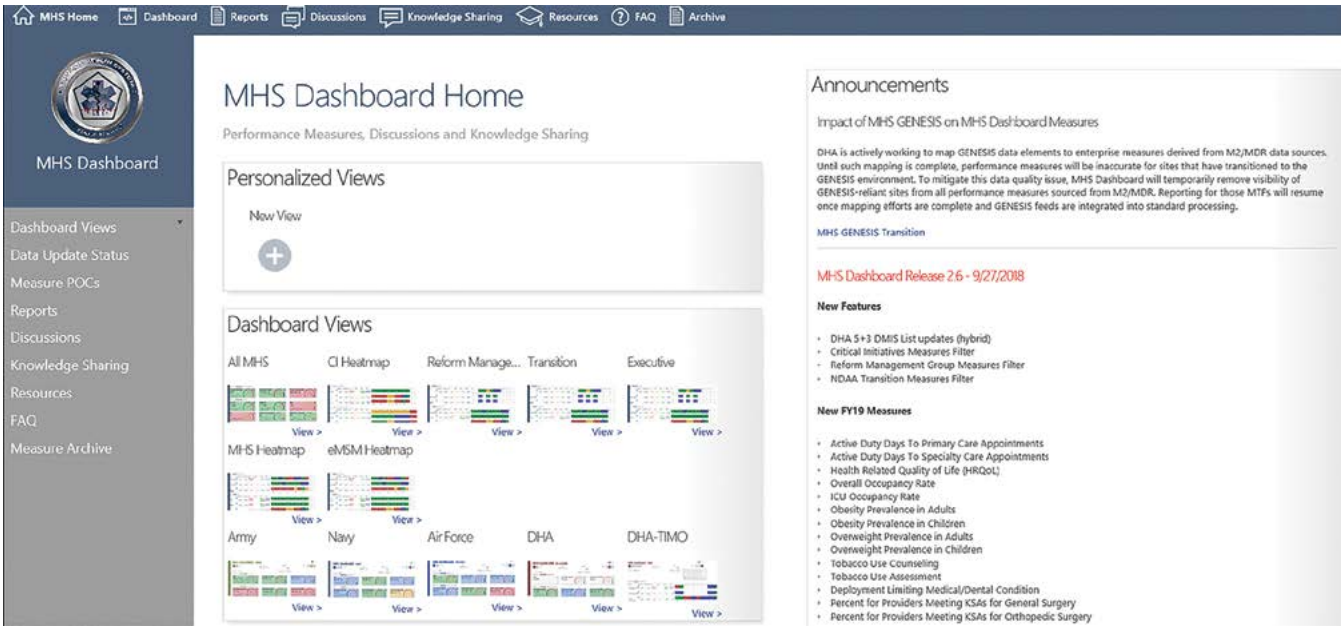
RMG Measures Dashboard

Transition Measures Dashboard

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

The MHS Performance Dashboard

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



MHS PERFORMANCE MANAGEMENT *(CONT.)*

Performance Management System *(cont.)*

QPP Critical Initiatives Dashboard

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

Readiness/Medically Ready Force

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

Better Health/Improve Well-Being

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

Better Care/Improve Safety

Measure	Data As Of	Next Refresh	Red	Yellow	Green	Blue	MHS	AIR FORCE	ARMY	NAVY	DHA	MCSC
CLABSI – SIR Lower is better	6/2019	1/2020	Statistically Significantly >1	—	Statistically no different than 1 (Predicted)	Statistically Significantly <1	Current 1.004 Prior 0.825	Current 0 Prior —	Current 1.222 Prior 1.109	Current 0.749 Prior 0.678	Current 0.797 Prior 0	Current — Prior —
WSS Lower is better	9/2019	1/2020	Current qtr ≥3 qtr avg	Current qtr <3 qtr avg	0 events in current qtr	0 events for 3 qtrs	Current 9 Prior 3	Current 2 Prior 0	Current 3 Prior 2	Current 2 Prior 1	Current 2 Prior 0	Current — Prior —
URFO Lower is better	9/2019	1/2020	Current qtr ≥3 qtr avg	Current qtr <3 qtr avg	0 events in current qtr	0 events for 3 qtrs	Current 5 Prior 5	Current 3 Prior 3	Current 1 Prior 1	Current 0 Prior 0	Current 1 Prior 0	Current — Prior —

Better Care/Improve Condition-Based Quality Care

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

Better Care/Improve Comprehensive Primary Care

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

Better Care/Optimize & Standardize Access

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

Lower Cost/Improve Stewardship

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

Note: MCSC=Managed Care Support Contractor

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

MHS MISSION

MHS PERFORMANCE MANAGEMENT *(CONT.)*

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.

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 direct and purchased 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 that could be reasonably managed. All of the measures were agreed upon by the Services and DHA.

MHS PERFORMANCE MANAGEMENT *(CONT.)*

Purchased Care Performance Management *(cont.)*

The Purchased Care Dashboard is used by the work group to monitor the performance of the THP with the goal of continuous improvement. The work group reviews the entire dashboard on a regular basis and recommends actions for improvement as needed. Data are updated constantly and can also be discussed as they are received. The dashboard is shared internally within THP and DHA to guide improvement efforts and improve transparency. In addition, the dashboard is a "living" tool. As noted previously, 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

Threshold Key

RED: <50th %ile | YELLOW: >50th %ile | GREEN: >75th %ile | BLUE: >90th %ile

Strategic Alignment	Measure	Thresholds				Direct Care	As of	Current Managed Care Support Contractor (MCSC) Performance	PURCHASED CARE COMPONENT PERFORMANCE					As of	Uniformed Services Family Health Plans Designated Providers (DP)							
									Managed Care Support Contractor (MCSC)		TRICARE Overseas Program (TOP)											
Quad Aim									East	West	Overseas	TOP 13 (Eurasia Africa)	TOP 14 (Pacific)	TOP 15 (TLAC)								As of
Better Health	Breast Cancer Screening					70.59	8/2020	65.23	65.98	63.13		49.06	44.44	59.18	5/2020	81.70	66.37	73.86	77.90	70.78	60.01	74.43	5/2020
	Colorectal Cancer Screening					74.94	8/2020	66.63	67.62	63.75		62.44	61.05	51.59	5/2020	73.46	67.18	73.92	72.59	69.72	57.27	71.24	5/2020
	Cervical Cancer Screening					79.91	8/2020	65.84	66.32	64.67		87.19	84.29	83.55	5/2020	74.96	59.39	75.32	67.70	50.12	64.13	68.64	5/2020
	Well-Child Visits in the First 15 Months					81.67	8/2020	84.11	84.76	82.92		32.61	26.47	36.23	5/2020	84.62	50.00	70.65	72.78	51.71	77.31	69.34	5/2020
Better Care	Diabetes: Annual A1c Testing					86.66	8/2020	74.97	75.30	73.87		38.46	45.45	50.00	5/2020	85.01	79.11	82.09	87.34	29.48	70.01	77.67	5/2020
	Imaging for Low Back Pain					81.46	8/2020	70.21				69.53			11/2019	85.33	66.67	79.29	73.84	76.23	75.86	77.26	11/2019
	Pharyngitis Screening of Children					94.36	11/2019	80.00				72.00			11/2019	97.42	77.78	95.05	91.18	84.62	84.21	92.68	11/2019
	Inpatient: Recommend Hospital	<65.00	≥65.00	≥73.00	≥78.00	75.70	6/2020	72.60	71.30	75.30					6/2020								
	Satisfaction: Getting Care When Needed	<81.20	≥81.20	≤84.40	≥87.20	79.70	9/2020																
	Provider Communication	<85.00	≥85.00	≥88.00	≥91.00	82.70	6/2020	88.20	88.60	87.20					6/2020								
	Care Coordination					62.70	6/2020	71.90	72.40	70.50					6/2020								
	ATC Days to Specialty Care (Prime Enrolled)	>24 days	≤24 days	≤15 days	≤7.5 days	12.73	12/2020	77.30	80.20	73.40					Apr–Jun 2020								
	Active Duty Dental Care Access	<95.00		95.00	99.00			99.80							Aug–Oct 2020								
	Referrals to Non-Network				<4.00			2.00	2.40	0.20					Jul–Sep 2020								
	CLABSI ICU and Wards SIR (O/E Ratio) ∨	Statistically significantly >1		Statistically no different than 1 (predicted)	Statistically significantly <1	1.67	9/2020																
	CAUTI ICU and Wards SIR (O/E Ratio) ∨	Statistically significantly >1		Statistically no different than 1 (predicted)	Statistically significantly <1	0.68	9/2020																
	7-Day Mental Health Follow-Up							41.19							8/2020								
Improved Readiness	(M1) Medical Capability Reports Provided to CCMDs upon Request	<90.00		≥90.00	100						100				11/2020								
	(M2) Are Commands Satisfied with the Quality of the Reports?	<90.00		≥90.00	100						100				11/2020								
	(M1) Percentage of Patients Moved from Theater by TOP Contractor When Deferred by TRANSCOM	<90.00		≥90.00	100						87.00				11/2020								
	(M2) Percentage of Patient Movement Requests Where a "Go/No Go" Decision Was Provided to the Unit within 90 Minutes	<90.00		≥90.00	100						100				11/2020								
Lower Cost						MHS		MCSC															
	Per Member Per Month	>3.20 Yearly Growth		>0-3.20 Yearly Growth	<0 Yearly Growth	13.63	10/2020	8.20							10/2020								
	Private-Sector Care Cost	>3.21	≤3.21	≤3.20	≤0.00	8.48	10/2020	8.40							10/2020								

Source: DHA/TRICARE Health Plan Division, CarePoint MHS Dashboard, 2/2/2021

Notes:

– TLAC=TRICARE Latin America & Canada; ATC=Access to Care; O/E Ratio=Observed to Expected Mortality.
– Gray cells represent unavailable data.
– NCQA HEDIS benchmarks are proprietary information and cannot be displayed.

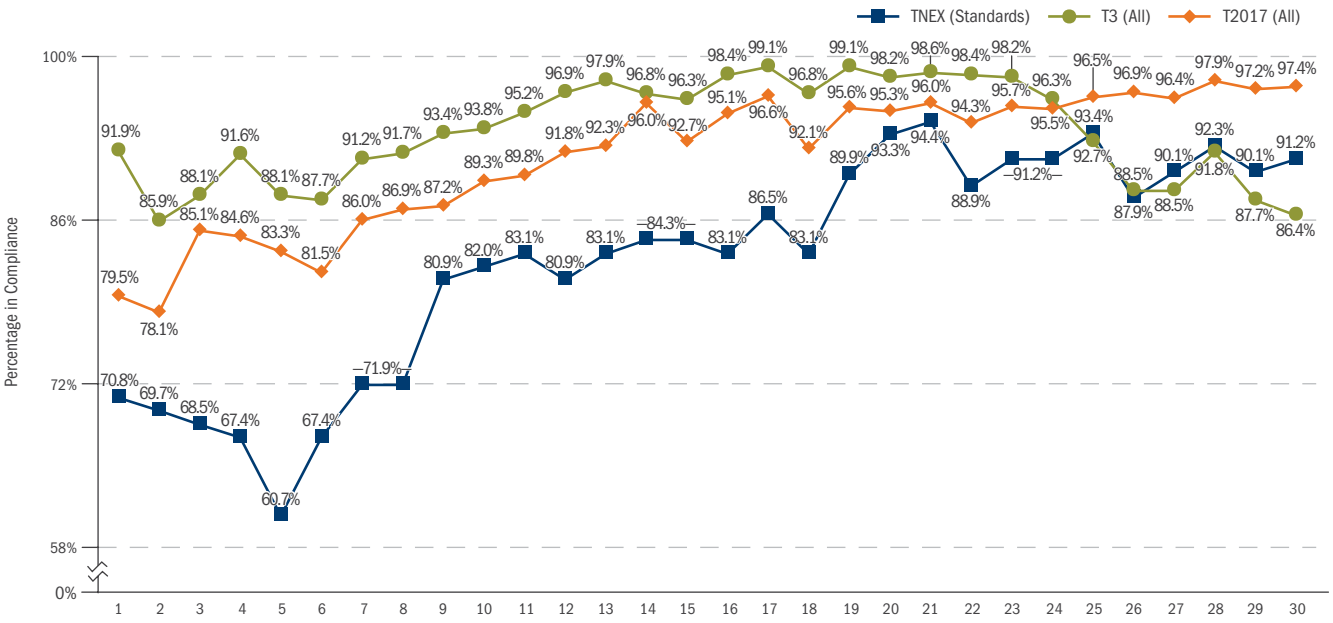
MHS PERFORMANCE MANAGEMENT *(CONT.)*

Purchased Care Performance Management *(cont.)*

The TRICARE (T2017) contractors started health care delivery on January 1, 2018. In comparing T2017 contract performance with the two previous generations of TRICARE contracts (T3 and TNEX) during the first nine months of performance and after some initial challenges, T2017 compliance was similar to T3 across more than 20 contract requirements in seven critical areas. In FY 2020, T2017 compliance steadily improved and exceeded performance under T3 in months 24–30.

In the first year of T2017 performance, the MCSC for the West Region, HealthNet Federal Services, faced a shortage of primary care providers and specialists across some regional areas, and their provider directory had a significant rate of inaccuracy. In the East Region, Humana Military faced difficulties processing timely and accurate claims, and also had a high rate of provider directory inaccuracy. Both contractors have improved their directories and are maintaining an accuracy rate of 77 percent. Humana Military continues to make progress in improving claims systems and processing.

PERCENTAGE OF CONTRACTS IN COMPLIANCE, OPTION PERIODS 1 AND 2



Source: Requirements from the Contract Quality Assurance Plan

In FY 2020, DHA continued numerous value-based demonstrations and pilots to meet the requirements of NDAA FY 2016, Section 726 and NDAA FY 2017, Sections 701(h), 704(a), 705(a), and 729 (a)(b) and (c). These projects included: the Network Requirements and Standards for Urgent Care Centers, a Medication Adherence Demonstration, and the Performance-Based Maternity Payment (P-BMP) pilot. Additionally, a new pilot was started in FY 2020, an Accountable Care Organization (ACO) demonstration. This ACO demonstration is in partnership with Kaiser Permanente and services the Atlanta area. Further, DHA published the Home Health Value-Based Purchasing (HHVBP) demonstration and will adopt Medicare's Hospital Value-Based Purchasing (HVBP) program beginning in early 2021. Additionally, DHA is planning to implement a Physical Therapy for Low Back Pain Demonstration (expected to launch in January 2021) and is in the process of modifying reimbursement for physician-administered drugs. Lastly in FY 2020, DHA completed a value-based demonstration project launched in FY 2016 for Lower Extremity Joint Replacement/ Reattachment (LEJR) in the Tampa Bay market area. The LEJR demonstration was designed as an episode-based bundled payment program that established target episode prices for LEJR and all related services. Hospitals that demonstrated a cost savings and achieved or maintained a favorable quality rating received retrospective incentives. A final analysis of this demonstration is underway.

MHS PERFORMANCE MANAGEMENT *(CONT.)*

Purchased Care Performance Management *(cont.)*

The Network Requirements and Standards for Urgent Care Centers Program 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 in TRICARE preferred provider networks. This program removed referral requirements for network urgent care, extended hours at MTFs for urgent care, and required network urgent care facilities to comply with clinical practice guidelines. The Medication Adherence demonstration, launched nationwide in February 2018, was designed to reduce or eliminate copayments for high- value drugs in order to encourage patient adherence to these medications. This program is expected to impact approximately 136,000 users per quarter with a copayment savings for users of approximately $4.9 million per year. The P-BMP pilot began nationwide on April 1, 2018, and will run through December 30, 2021. The program encourages beneficiaries to utilize high-value, high-quality facilities for maternity care, inline with Leapfrog Group quality metrics. In October 2018, this program was expanded to incorporate quality incentive payments to providers that exceed national benchmarks for maternity care quality. In FY 2019, the first year of data for the P-BMP pilot revealed that approximately 12 percent of participating hospitals were eligible for an incentive payment. An analysis of this pilot is ongoing.

In FY 2020, DHA implemented an ACO demonstration in the Atlanta market area in partnership with Humana Government Business (HGB) and Kaiser Permanente (KP). Enrollment in the HGB/KP demonstration was offered to TRICARE Prime and Select members in the Atlanta Prime Service Area during the 2019 Open Enrollment Season. Care delivery began January 1, 2020, and continues for three years. As of October 2020, KP beneficiary enrollment is 1,775. A unique feature of this demonstration is the beneficiary wellness incentive program, provided at no cost to the government, which encourages beneficiaries to participate in wellness activities in return for incentives.

As noted above, in January 2021, DHA is planning the implementation of a three-year Physical Therapy for Low Back Pain demonstration to evaluate the impact of waiving cost shares and copayments for the initial three visits for physical therapy (PT) for beneficiaries with low back pain (LBP). The demonstration will occur in 10 demonstration states: Arizona, California, Colorado, Florida, Georgia, Kentucky, North Carolina, Ohio, Tennessee, and Virginia. The demonstration will test whether incentivizing participation in PT by waiving copayments will increase the use of PT services and reduce potentially unnecessary and harmful care to the beneficiary, such as unnecessary imaging, surgery, and opioids. Moreover, by incentivizing the use of PT, DHA may see a decrease in the overall cost of care for participating beneficiaries and a reduction in the number of beneficiaries who transition from acute to chronic LBP.

In September 2020, DHA published the HHVBP demonstration in the TRICARE manuals. The demonstration is scheduled to run through December 31, 2022, and adopts Medicare's HHVBP reimbursement model for the TRICARE program. The HHVBP demonstration is designed to improve the quality and delivery of home health services by rewarding providers with incentive payments who deliver higher quality and more efficient care. It is expected that TRICARE's adoption of HHVBP will strengthen the impact of the incentives included within the model by adding TRICARE's market share to Medicare's. Participation is mandatory for all TRICARE Home Health Agencies that are Medicare-certified and provide services in the following nine states: Arizona, Florida, Iowa, Maryland, Massachusetts, Nebraska, North Carolina, Tennessee, and Washington.

DHA will adopt Medicare's HVBP program beginning in early 2021. The HVBP program provides incentives to hospitals that show improvement in areas of health care delivery, process improvement, and increased patient satisfaction. The program offers incentive payments based on the hospital's Total Performance Score. Adopting Medicare's HVBP program approach does not require any additional reporting from TRICARE hospitals, as they are currently participating in the Medicare HVBP program. As with the HHVBP program, DHA hopes to boost the impact of the incentives included within the model by adding TRICARE's market share to Medicare's.

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

MHS RESPONSE TO COVID-19 PANDEMIC

COVID-19 Current Operation Dashboard

Overview of COVID-19 Current Operation Dashboard

In response to the emergence of the COVID-19 pandemic, DHA J-5 developed and launched the COVID-19 Current Operation Dashboard (CUOP). The COVID-19 CUOP builds upon existing efforts to streamline pandemic monitoring and response, and enable operational decision making at the market and MTF levels.

Specifically, this dashboard provides leaders at the MHS leadership level as well as the markets and MTFs with an intuitive and comprehensive view of pandemic pressures:

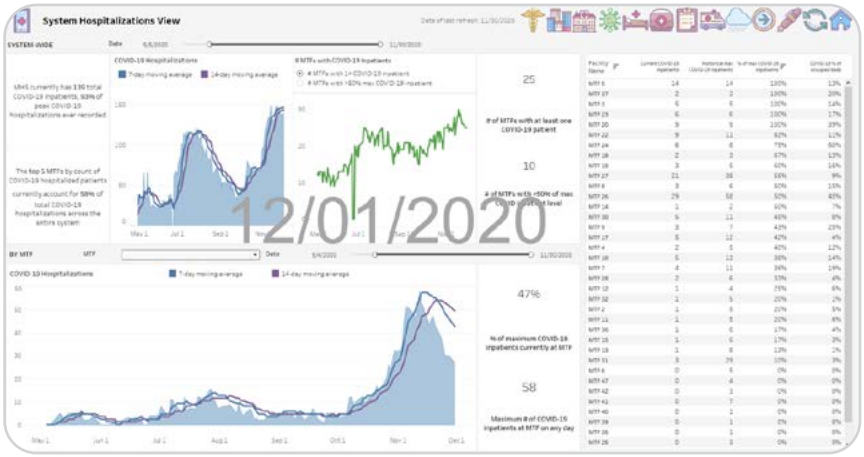
- Integrates MHS and U.S. population data, providing a picture of pandemic pressures both inside and outside the gate
- Aggregates authoritative data across MHS metrics into a single location (i.e., drawing on existing dashboards built by MHS subject matter experts [SMEs], such as MEDLOG)
- Enables prospective tracking of key metrics, showing bed capacity and case burden in 30 and 60 days
- Provides a modular capability and is flexible enough to integrate more data as they become available
- Distills multiple data into a single risk score for each MTF, based on a view of MTF capacity and pandemic burden in the surrounding market

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

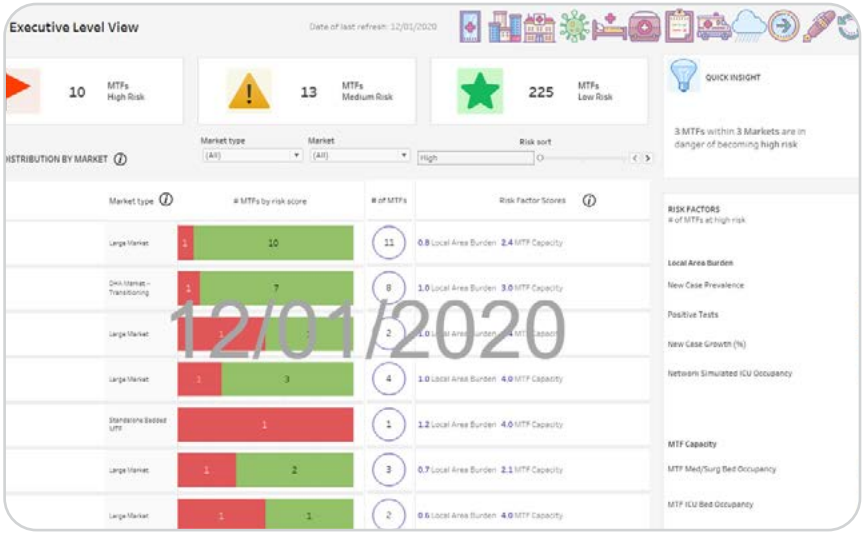
Description of Key COVID-19 Current Operation Dashboard Views

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

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



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

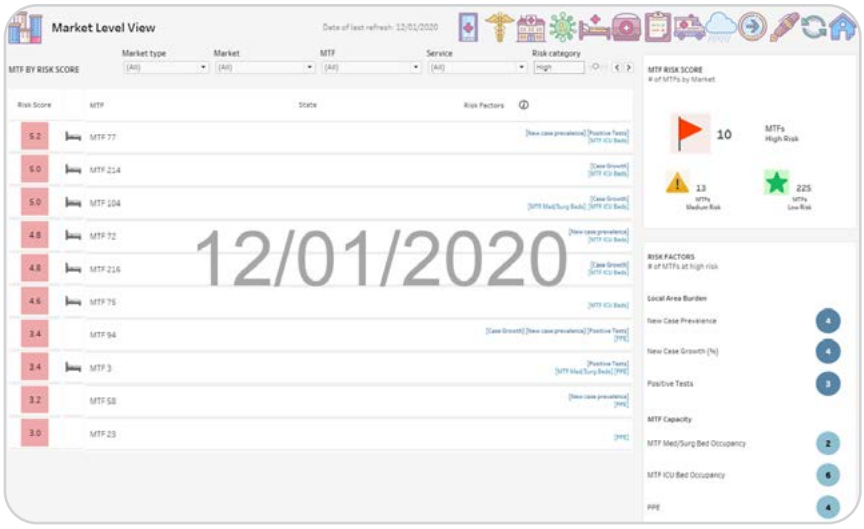


Source: DHA/Strategy, Plan, and Functional Integration (SP&FI) (J-5)/Analytics and Evaluation Division, 12/1/2020
Note: Screenshots of COVID-19 Current Operation Dashboard are illustrative only. The full dashboard is live and available on CarePoint.

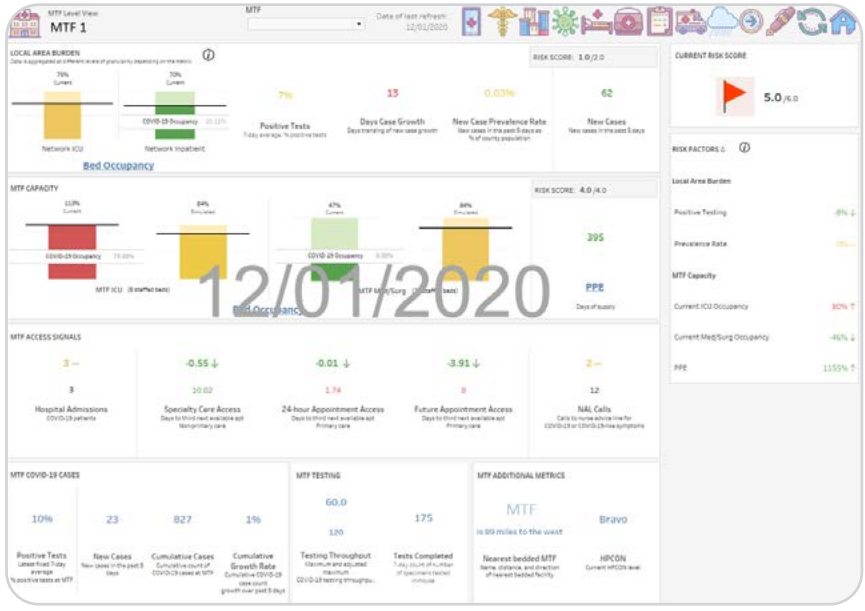
MHS RESPONSE TO COVID-19 PANDEMIC *(CONT.)*

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

Market-Level View: Review market-specific capacity to understand level of pandemic burden for each MTF within that market



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



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, 12/1/2020
Note: Screenshots of COVID-19 Current Operation Dashboard are illustrative only. The full dashboard is live and available on CarePoint.

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

COVID-19 Registry

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

As of December 22, 2020, there were more than 128,000 COVID-positive patients in the registry, and full manual data abstraction had been completed on 3,604 patients, with data automation being applied to improve the ability to rapidly track trends for all patients. Registry records currently include patients treated in the direct care system only. The COVID-19 Registry does not include detailed records on all COVID cases in the DoD. Due to a large population needing abstraction into the Registry, the Joint Trauma System (JTS) developed a list of patient abstraction priorities.

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

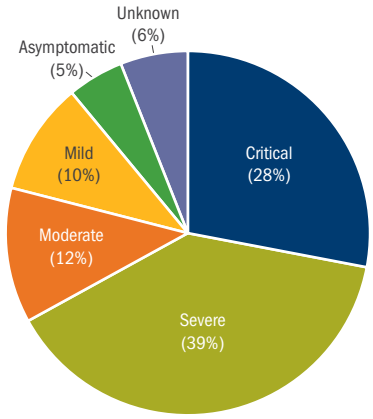
1. New treatment recipients (CCP, monoclonal antibody, etc.)
2. Burn Pit exposure patients with COVID-19
3. Inpatients and mortalities
4. Outpatients (if none of the above patients are currently pending)

COVID-19 Registry Data Overview, February 2–December 22, 2020

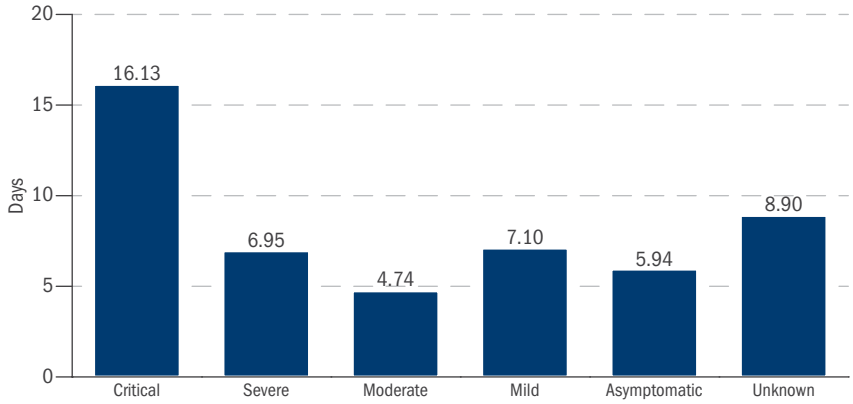
COVID-19 illness severity was difficult to track without the detailed information provided by the COVID registry.

COVID Disease Severity and Average Length of Hospital Stay

SEVERITY OF HOSPITALIZED PATIENTS, 2020



AVERAGE HOSPITALIZATION DAYS BY SEVERITY, 2020



Source: DHA Combat Support, JTS/COVID-19 Registry, 12/22/2020
Note: N=3,604 total patients in registrar-abstracted population with detailed chart review from February 2–December 22, 2020

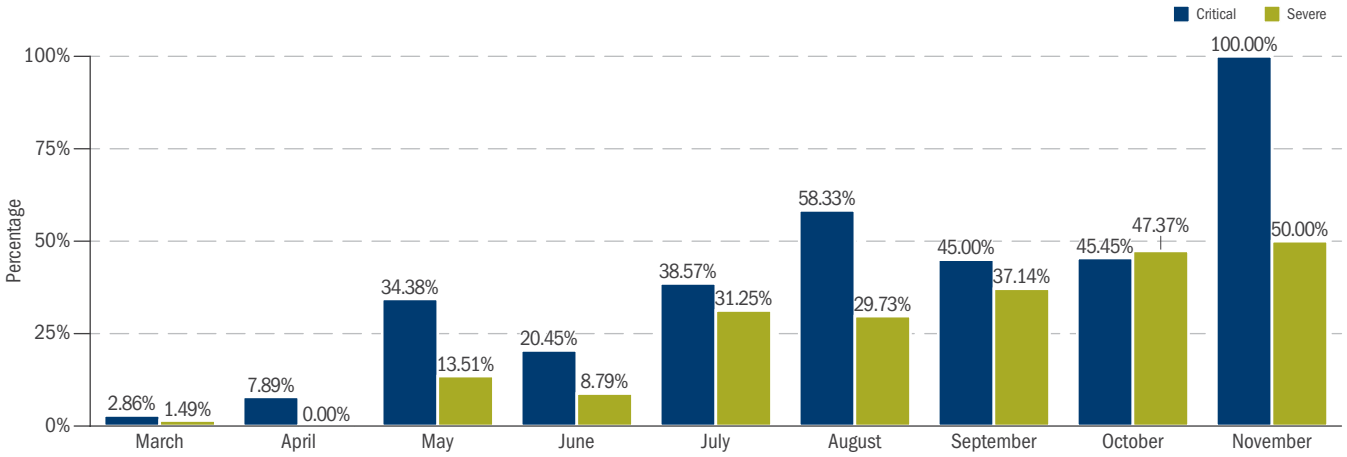
MHS RESPONSE TO COVID-19 PANDEMIC *(CONT.)*

COVID-19 Registry *(cont.)*

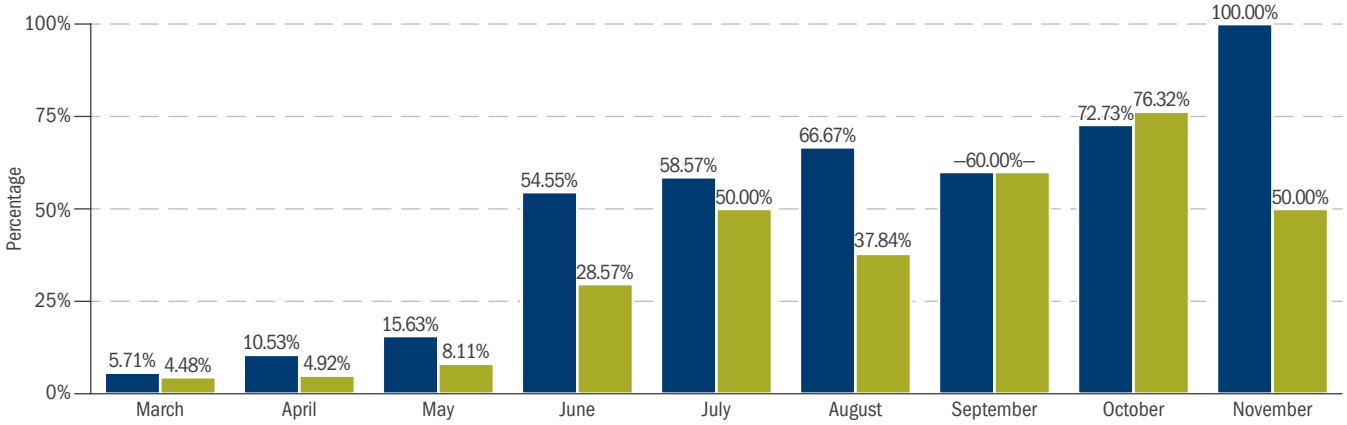
New therapies introduced for COVID-19 early in the pandemic included CCP, Remdesivir, and glucocorticoids. The implementation of new treatments was tracked in the registry. Use of these three treatments for critical and severely ill patients increased every month, reaching 100 percent of critical patients receiving all three treatments by November 2020.

March through November Critical and Severe Patients Receiving CCP, Remdesivir, Glucocorticoids

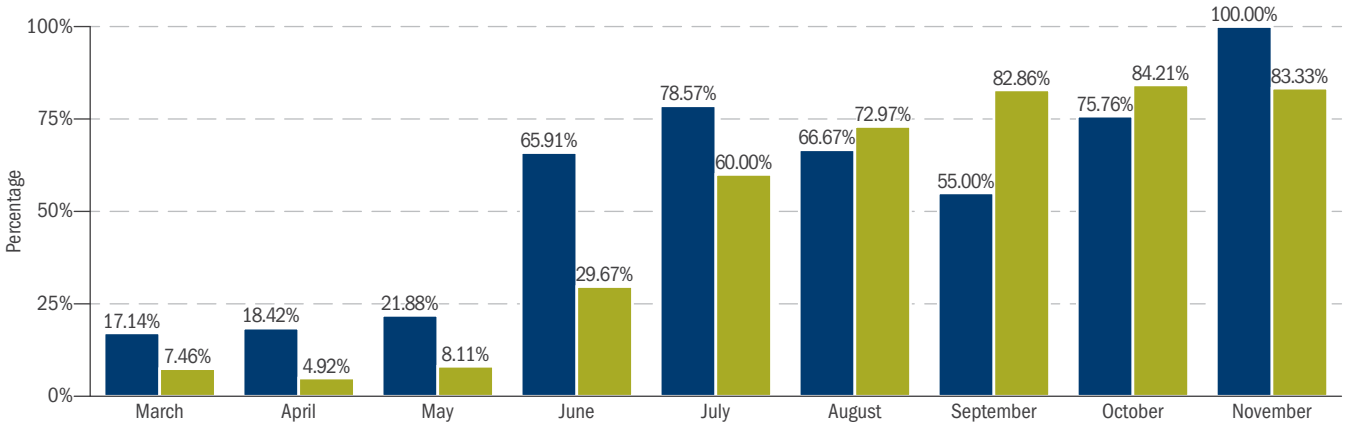
PERCENTAGE OF CRITICAL AND SEVERE PATIENTS RECEIVING CCP BY MONTH, 2020



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



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



Source: DHA Combat Support, JTS/COVID-19 Registry, 12/16/2020

Note: N=3,604 total patients in registrar-abstracted population with detailed chart review from February 2–December 22, 2020

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

COVID-19 Registry *(cont.)*

Post-COVID Specific Diagnosis

DHA analysts continuously examine specific diagnostic characteristics of COVID patients. A recent study included 21,382 Active Duty beneficiaries for the COVID group and approximately 358,468 Active Duty beneficiaries for the control group (matched to the COVID group in terms of age and gender) with COVID diagnosis (index date) between December 2, 2019, and September 21, 2020. Results showed that Active Duty COVID-positive patients had the strongest increased odds of taste loss, shortness of breath, pulmonary embolism, asthma, and chest pain post-COVID compared with the control group.

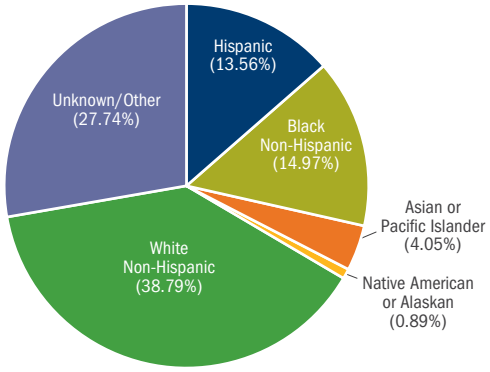
Using the same methodology for all beneficiaries, the analysis found similar results but with stronger increased odds for cardiac diagnoses post-COVID. The analysis included 55,201 beneficiaries for the COVID group and 4,753,500 beneficiaries for the control group (matched to the COVID group in terms of age and gender) with COVID diagnosis (index date) between December 2, 2019, and September 21, 2020. Results found that COVID patients had the strongest increased odds for taste loss, shortness of breath, pulmonary embolism, chest pain, atrial fibrillation, tachycardia, heart failure, and bradycardia post-COVID for COVID-positive patients compared to the control group.

It should be noted that the COVID-positive groups' diagnosis rates may be artificially elevated due to a more aggressive follow-up on these patients. The long-term effects are not yet evaluated by this analysis, but they will continue to be tracked. Also, the control groups may be skewed and potentially not reflective of the baseline, due to current COVID-related incomplete medical care. However, these control group patients were selected to capture effects of the pandemic on their mental health.

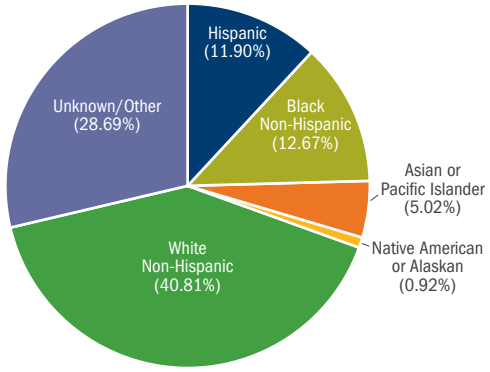
Overview of Race/Ethnicity of COVID Patients

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

RACE/ETHNICITY OF COVID-POSITIVE PATIENTS, 2020



RACE/ETHNICITY OF COVID-NEGATIVE PATIENTS, 2020

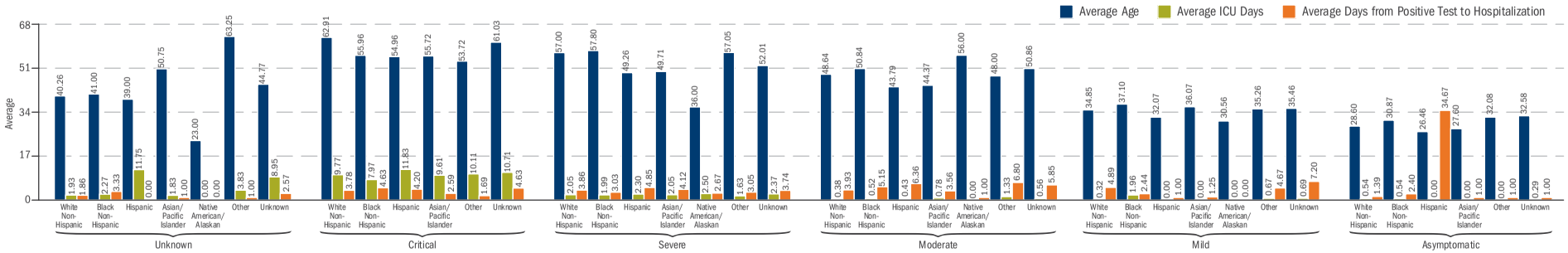


Source: DHA Combat Support, JTS/COVID-19 Registry, 12/22/2020
Note: Patients treated in the direct care system February 2–December 22, 2020

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

COVID-19 Registry *(cont.)*

AGE, SEVERITY, AND HOSPITALIZATION, BY RACE, 2020



Source: DHA Combat Support, JTS/COVID-19 Registry, 12/22/2020

Note: N=3,604 total patients in registrar-abstracted population with detailed chart review from February 2–December 22, 2020

COVID-19 Registry Timeline

The COVID-19 Registry is temporarily housed in the DoD Trauma Registry platform because it was most readily available; however, this limits automation of data import from the EHR. The automation is being built within the Military Health Services (MHS) Information Portal (MIP) and will continue to increase with the complete Registry transition to MIP during CY 2021. The Registry dashboard prototype is established and capable of expanding to incorporate more demographics as well as performance improvement indicators and outcomes.

Milestones completed for March–October 2020

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

Upcoming Milestones

- **NLT February 1:** Expand registry dashboard to include abstracted records
- **NLT March 1:** Transition from temporary registry location (DoDTR) to MIP
- **NLT March 1:** Establish sustainment plan

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

COVID Convalescent Plasma (CCP)

In June 2020, the DoD began an effort to collect donated units of plasma from patients who had fully recovered from COVID-19 to support the development of an effective treatment against the disease. The DoD's goal was to obtain 10,000 units by September 30, 2020. Donations are accepted at Armed Services Blood Program (ASBP) donation centers across the continental United States and in Hawaii, Guam, and Germany, or through scheduled mobile collection drives. Collected CCP will be made available for investigational treatment of COVID-positive patients in DoD treatment facilities who meet established criteria and in accordance with approved protocols. Since March 2020, more than 16.6 million Americans have tested positive for COVID-19. As of December 15, 2020, there were 94,644 military cases reported.

CCP is the liquid part of blood collected from patients who have recovered from a COVID-19 infection. The Food and Drug Administration (FDA) recently issued Emergency Use Authorization for CCP, authorizing its administration by health care providers, as appropriate, to treat suspected or laboratory-confirmed COVID-19 hospitalized patients. In order to sustain the readiness of the Force, the DoD established a goal to collect 10,000 CCP units by September 30, 2020. A secondary goal was to facilitate and achieve 100 percent contact with patients who are eligible to contribute to the CCP program and recruit consenting patients for donations. The DoD exceeded the Secretary's goal of 10,000 units by September 30, 2020, with a total of 10,745 units of CCP.

To achieve this goal, DHA's J-5 integrated data and teams to determine how and where to mobilize the campaign. J-5 analyzed "hot spots" to inform blood donor mobile drive planning, implementation, and execution. Utilizing these insights, ASBP planned and successfully executed 15 mobile drives, collecting over 790 additional units. J-5 specifically targeted drives based on the availability of eligible donors by employing the knowledge and insights gained from data driven dashboards. As of December 11, 2020, DoD collected 13,651 CCP units and has contacted 24,376 potential donors for donation. J-5 initiated the reporting contacts in addition to identifying populations to contact. Once bottlenecks in processing time were identified, two-thirds of Blood Donor Centers reduced their lab processing time for pending units. Supplementing the data, J-5 helped distribute a framework to determine the number of full-time employees to supplement donor contact recruitment efforts. If not for the reporting capabilities created by J-5, the initial gaps to meet the target would not have been identified and mitigated.

After successfully achieving the goal of 10,000 units of CCP ahead of schedule, the J-5 team recommended sustainment inventory levels to accommodate for upcoming fluctuations. They continue to monitor and track the CCP collection, inventory, and usage across the MHS. The team currently highlights future declines in inventory due to demand or upcoming expiration of units and advises ASBP on collection goals to mitigate risks of inventory decline. Now the sustainment plan monitors six months ahead to anticipate CCP collection needs.

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

Overview of Private-Sector Care during the COVID-19 Pandemic

In addition to the direct care response to the global pandemic, several changes occurred in private-sector care to address ongoing beneficiary health care needs. The following purchased-care sector changes were made in FY 2020 in response to the pandemic. (Additional efforts and changes are discussed on pages 25–29.)

- Implementation of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, including waiving copayments associated with testing
- Waiver of telehealth copayments during the national emergency
- Provider flexibility during the national emergency
- Ensuring that beneficiaries would have coverage for investigational new drugs, like monoclonal antibodies and CCP
- Reimbursement changes that ensure access to care during the national emergency
- Addition of COVID-19 clinical trials sponsored by the National Institute of Allergy and Infectious Diseases (NIAID) during the national emergency
- Adopting Medicare's Hospitals Without Walls initiatives to ensure patients can access care for COVID-19. In March 2020, the Centers for Medicare & Medicaid Services (CMS) announced the Hospitals Without Walls program, which provides broad regulatory flexibility to allow hospitals to provide services in locations beyond their existing facilities. According to CMS, "Under federal requirements, hospitals must provide services within their own buildings, raising concerns about capacity for treating COVID-19 patients, especially those requiring ventilator and intensive care. Under CMS's temporary new rules, hospitals will be able to transfer patients to outside facilities, such as ambulatory surgery centers, inpatient rehabilitation hospitals, hotels, and dormitories, while still receiving hospital payments under Medicare. For example, a health care system can use a hotel to take care of patients needing less intensive care while using its inpatient beds for COVID-19 patients." For additional information, see https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient.
- Expanding access for overseas telehealth
- Adding coverage for audio-only telehealth and implementing other telehealth flexibilities for the national emergency
- Waiving the Skilled Nursing Facility (SNF) three-day hospital stay prior to admission during the public health emergency
- Clarifying that TRICARE coverage of FDA-approved drugs includes drugs with an emergency use authorization

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

WHAT IS TRICARE?

TRICARE is the worldwide Department of Defense (DoD) health care program serving 9.6 million Service members (Active and Guard/Reserve) on Active Duty (greater than 30 days) and their families; as well as retirees, their families, survivors, and certain former spouses (tricare.mil). As a major component of the Military Health System (MHS; health.mil), TRICARE brings together the military hospitals and clinics worldwide (often referred to as "direct care," military medical treatment facilities [MTFs] and military dental treatment facilities [DTFs]) with network and non-network TRICARE-authorized civilian health care professionals, institutions, pharmacies, and suppliers (often referred to as "private-sector care (PSC)") to provide access to the full array of high-quality health care services while maintaining the capability to support military operations.

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

- **TRICARE Prime** is an enrollment-based health plan comparable to health maintenance organization (HMO) plans. Each enrollee is assigned a primary care manager (PCM), a health care provider who is responsible for helping the patient manage his or her care, promoting preventive health services (e.g., routine exams and immunizations) and arranging for specialty provider services as indicated.
  - TRICARE Prime access standards apply to the drive time to reach provider, waiting times to get an appointment, and waiting times in provider offices.
  - TRICARE Prime's point-of-service (POS) feature offers enrollees freedom to obtain care from TRICARE-authorized providers other than their assigned PCM without a referral, but POS deductibles and cost shares are significantly higher than TRICARE Select.
  - **TRICARE Prime Remote (TPR)** enrollment is offered to certain Service members remote from MTFs.
  - **TRICARE Prime Remote for Active Duty Family Members (TPRADFM)** enrollment is offered to qualified dependents of Service member sponsors, active and reserve, on active duty more than 30 days.
  - **Uniformed Services Family Health Plan (USFHP)** is a TRICARE Prime plan offered to non-Active Duty beneficiaries at statutorily specified locations in six areas: Washington, Texas, Maine, Maryland, Massachusetts, and New York/New Jersey. Enrollees receive all services, including pharmacy, exclusively from their particular enrolled USFHP plan; no MTF services.
- **TRICARE Select** is an enrollment-based health plan comparable to preferred provider organization (PPO) plans that features access to both network and non-network TRICARE-authorized providers. Referrals are generally not required for coverage.
- **TRICARE for Life (TFL)** is for TRICARE-eligible beneficiaries who have Medicare Parts A and B. TFL functions similar to Medigap policies; TFL pays secondary to Medicare for TRICARE-covered services.
- **Transitional Assistance Management Program (TAMP)** plan provides 180 days of premium-free coverage upon release of certain Service member sponsors, active or reserve, from Active Duty served more than 30 days.
- **Other plans and programs:** Some beneficiaries may qualify for the following depending on their location, Active/Reserve status, and/or other factors:
  - Premium-based health plans, including:
    - TRICARE Young Adult (TYA) is available for purchase by qualified former dependent children up to the age of 26.
    - TRICARE Reserve Select (TRS) is available for purchase by qualified Selected Reserve members.
    - TRICARE Retired Reserve (TRR) is available for purchase by qualified Retired Reserve members.
    - TRICARE Dental Program (TDP) is available for purchase by Selected Reserve members and their family members, and family members of Active Duty members.
    - Continued Health Care Benefit Program (CHCBP) is comparable to Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage.
    - Federal Employees Dental and Vision Insurance Program (FEDVIP) offers dental plans for purchase by retirees and vision plans for purchase by most non-Service member beneficiaries enrolled in a TRICARE health plan. FEDVIP is operated by the U.S. Office of Personnel Management, not DoD.
- **Other benefits and services, including:**
  - Dental benefits (DTFs and claims management for Active Duty using civilian dental services)
  - Pharmacy: MTFs, TRICARE retail network pharmacies, and TRICARE Pharmacy Home Delivery program
  - Overseas private-sector care and claims processing services
  - Women, Infants, and Children Overseas Program (www.tricare.mil/wic)
  - Chiropractic care, limited to Service members (on Active Duty) at certain MTFs only (no private-sector chiropractic care is authorized)
  - Extended Care Health Option (ECHO): financial assistance to qualified Active Duty family members with special needs
  - Clinical and educational services demonstration programs (e.g., chiropractic care, autism services, and the accountable care organization [ACO])

HOW TRICARE OPERATES

TRICARE consists of both care in the direct care system and in the private sector through TRICARE contracts that administer delivery of the TRICARE health care benefit.

Effective October 25, 2019, the Defense Health Agency (DHA) became responsible for the administration, direction, and control (ADC) of MTFs and DTFs as required by section 1073c of title 10, United States Code (introduced by the National Defense Authorization Act [NDAA] for fiscal year 2017, section 702). This law endeavors to reduce process variance, eliminate redundant overhead, and support the MHS Quadruple Aim. DHA exercises ADC of the direct care system through enterprise-wide guidance, reporting relationships, and named direct-care market offices worldwide. The DHA Health Care Operations (HCO) directorate supports the optimization of MTF/DTF markets: small, large, and stand-alone.

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

NEW BENEFITS AND PROGRAMS IN FY 2020 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT

The MHS continues to meet the challenge of providing the world's finest combat medicine and aeromedical evacuation, while supporting the TRICARE benefit to DoD beneficiaries at home and abroad. Since its inception in 1995, TRICARE continues to offer an increasingly comprehensive health care plan to Uniformed Services members, retirees, and their families. Even as the MHS aggressively works to sustain the TRICARE program through good fiscal stewardship, it also refines and enhances the benefits and programs in a manner consistent with the industry standard of care, best practices, and statutes to meet the changing health care needs of its beneficiaries (see TRICARE Program and Benefits Evolution over the Years in the Appendix. This section also highlights TRICARE and DoD COVID-19-related efforts and changes that took place during FY 2020).

Contracts and Organizational Changes

DHA Established Four Military Medical Markets on January 30, 2020

The new markets include hospitals and clinics in the National Capital Region (Washington, D.C., southern Maryland, and northern Virginia); Jacksonville, Florida; the Mississippi coast (Biloxi-Gulfport-Pascagoula); and Central North Carolina (Fayetteville). Each market will share patients, staff, budgets, and many other functions across facilities to optimize readiness and the delivery and coordination of health services. This effort is driven by Section 702 of FY 2017 NDAA and succeeding guidance provided by Congress in 2018, 2019, and 2020 that directed the MHS to reorganize, redefining the roles of the military departments and DHA in the administration and management of hospitals and clinics. See pages 7–8 for more information on the MHS Transformation.

DoD Announced Restructuring and Realigning of 50 Military Medical Treatment Facilities

These plans were explained in a February 19, 2020, report sent to Congress titled "Restructuring and Realignment of Military Medical Treatment Facilities." The report summarizes the decisions to align MTFs to increase the readiness of operational and medical forces.

Of the 343 facilities in the U.S. initially screened for this report, 77 were selected for additional assessment, with 21 identified for no changes. Of the 50 facilities designated for restructuring, 37 outpatient clinics now open to all beneficiaries will eventually see primarily only Active Duty personnel. Active Duty family members, retirees, and their families who currently receive care at those facilities will transition over time to TRICARE's civilian provider network. The report states that seven of these clinics may continue to enroll Active Duty family members on a space-available basis.

In addition, many Active Duty–only clinics will continue to provide occupational health services to installation civilian employees related to their employment.

For a complete list of military hospital and clinic changes in the report, go to http://www.health.mil/MTFrestructuring.

On September 1, 2020, DHA Launched 74 New Military Hospital and Clinic Air Force Websites

This is an important milestone in the effort to modernize the web presence of all MTFs. Each website transitioned to the TRICARE domain to provide a standardized patient experience across the MHS. The transition to the TRICARE.mil domain incorporates new layouts and adds features to enhance the user experience and provide easier access to information about the local military hospital or clinic and the TRICARE benefit.

NEW BENEFITS AND PROGRAMS IN FY 2020 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

TRICARE Program Changes in FY 2020

TRICARE Open Season

TRICARE Open Season occurred from November 11 through December 9, 2019.

TRICARE Website Added Information about Several Military Hospitals and Clinics

Beginning October 1, 2019, four military hospitals and clinics (Fort Belvoir Community Hospital [FBCH], Naval Hospital Jacksonville, Walter Reed National Military Medical Center [WRNMMC], and Womack Army Medical Center) now have microsites under TRICARE.mil. This is part of the larger MHS transformation. By 2021, over 350 individual military hospital and clinic websites will move to TRICARE.mil.

Humana Military Partnership with Kaiser Permanente Supports Value-Based TRICARE Prime Option

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

TRICARE Now Covers Portable Continuous Positive Airway Pressure (CPAP) Machines for Service Members Diagnosed with Obstructive Sleep Apnea (OSA), Retroactively to January 24, 2019

To be eligible, the Service member must be deployed or travel on official business at least three days a month. The Service member cannot be retiring or separating from the military within the year and the portable device must have humidification and battery capability. The policy change will not apply to Variable Positive Airway Pressure (VPAP) or Adaptive Servo-Ventilation (ASV) machines.

In March 2020, TRICARE Released Guidance on Steps Beneficiaries Should Take to Avoid Getting COVID-19 and What to Do If They Suspect They Have Contracted It

Guidance explained that for beneficiaries who begin to experience symptoms of new COVID-19 and have been in close contact with a person sick with COVID-19 or traveled to areas where infection is ongoing, do not make an appointment or walk into their local military hospital or clinic. Instead, stay at home and speak with an MHS registered nurse, who will assess symptoms, by contacting the nurse advice line (NAL); calling their military hospital, clinic primary care team, civilian provider, or appointment line; or sending a secure message through TRICARE Online.

All MTFs and DTFs Postpone Elective Surgeries and Procedures for 60 Days, Effective March 31, 2020

The policy applies to all beneficiaries: Active Duty Service members and their families, retirees, and Reserve and National Guard Service members on active duty or a delayed effective date Active Duty order.

The policy is designed to meet three main objectives during the COVID-19 pandemic: (1) to enhance the safety of military medical staff; (2) to prolong supplies of personal protective equipment (PPE) and ensure the availability for emergency use; and (3) to ensure military medical staff is available to provide care related to the pandemic.

Exceptions to the policy include procedures a Service member needs in order to be ready to deploy, as well as procedures a provider has determined cannot be delayed without causing harm. For these cases, the hospital or dental facility commander will determine whether there is adequate capacity to safely authorize the procedure.

On May 21, 2020, the DoD Announced Updates to the Policy on Elective Surgeries and Procedures

This policy aligns the resumption of elective procedures with the department's Health Protection Condition (HPCON) framework and the administration's Opening Up America Again plan. The policy instructs MTF and DTF directors and commanders to consider a number of factors before resuming elective procedures, including:

- Installation HPCON
- Healthcare capacity, including TRICARE network capacity
- MTF and DTF staffing
- Individual personal protective equipment availability
- COVID-19 testing availability for DoD patients and staff

TRICARE Covers Telehealth Services to Include Otherwise-Covered Mental Health Services

Telehealth options include:

- Telemental health services, including individual psychotherapy, crisis management, family therapy, or group therapy (expected to continue after the coronavirus pandemic)
- Medication-assisted treatment (only available during the pandemic)
- Opioid treatment programs (only available during the pandemic)

NEW BENEFITS AND PROGRAMS IN FY 2020 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

- Intensive outpatient programs (only available during the pandemic), which include medication management, case management, recreational therapy, occupational therapy, and discharge planning

More information on covered services can be found here: https://www.tricare.mil/CoveredServices/IsItCovered/Telemedicine.

TRICARE Temporarily Covers Telehealth Support for Applied Behavior Analysis (ABA) Parent or Caregiver Guidance Services March 31–May 31, 2020

This is to help support Autism Care Demonstration (ACD) beneficiaries during social distancing and the COVID-19 response. If a child is enrolled in the ACD, then they can get remote, unlimited ABA parent or caregiver support guidance services at home. The child does not need to be present. A TRICARE-authorized, board-certified behavior analyst or assistant behavior analyst must provide the services.

TRICARE Covers the Cost of Digital Breast Tomosynthesis, Known as 3D Mammography or DBT, under Provisional Coverage Program, Effective May 29, 2020

All women over the age of 40 are eligible for coverage. Annual coverage will be available to women 30 and older who are deemed at high risk for developing breast cancer.

TRICARE No Longer Covers Vitamin D Screenings for Patients Who Have No Signs of a Deficiency

This decision aligns with some medical associations and the U.S. Preventive Services Task Force, which has questioned the accuracy of vitamin D screenings and noted a lack of a consensus in the medical community on what lab results constitute a deficiency.

Quadruple Aim: Improved Readiness

DHA Implemented Emergency Procedures Due to California Wildfires

Beginning October 28, 2019, TRICARE beneficiaries could fill their prescriptions with any TRICARE retail network pharmacy or another store in the retail chain if the beneficiary uses a retail chain.

USNS Comfort and USNS Mercy Provided Medical Care to Regions Significantly Affected by COVID-19

The Comfort, previously in Norfolk, Va., went to New York, and the Mercy provided care on the West Coast to communities with the greatest need. The Comfort provided care to critical and non-critical patients regardless of their COVID-19 status in New York City in March 2020. The Mercy arrived in Los Angeles in March 2020 and in San Diego in May 2020 to provide care.

Army Assembled 250-Bed Field Hospital at CenturyLink Event Center Seattle to Treat Non-COVID-19 Patients

The field hospital will relieve some of the burden on local hospitals, allowing them to better care for patients who have contracted the coronavirus disease. The field hospital involves approximately 500 military medical personnel from multiple units.

Naval Medical Center Portsmouth Conducted "Car Triage" Screening Process to Triage, Test, and Treat Low-Acuity Patients Suspected of Having COVID-19

Vehicles that pull up to the main gate are directed to the right lane if they intend to go to the emergency department (ED) or if they have potential COVID-19 concerns. The vehicles then head to a parking lot where tents are set up and an initial screener asks a few questions while the patients remain in their vehicles. Patients are directed either to the ED or to the car triage station, as appropriate. This process also protects medical staff by being in an open-air environment. A portable X-ray capability is available. After the evaluation, the provider may prescribe medicines that are all on hand, eliminating the need for patients to wait in the pharmacy.

On March 11, 2020, WRNMMC Allergy and Immunology Service Began the Drive-Up Immunization Clinic

The clinic is set up outside of the main hospital building to prevent the possible spread of the coronavirus within the hospital. All screening and waiting are done in the beneficiary's car. For some adults, the clinic can deliver the vaccines in the car so the patient does not have to exit.

Quadruple Aim: Better Care

Madigan Army Medical Center One of the First MTFs to Use Clairvia, a Workload Management Tool in the Electronic Health Record (EHR) MHS GENESIS

Madigan's Inpatient Services can now track how individual patients' health statuses are trending to see if they should receive additional interventions or be rounded on more often. It also allows for nursing assignments to be refined to both ensure each nurse has the appropriate workload and continues to safely build their skills. Clairvia automatically calculates in real time the actual amount of work and nursing hours per individual patients based on their interventions and outcomes as shown in MHS GENESIS.

NEW BENEFITS AND PROGRAMS IN FY 2020 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

Keesler Cardiology Pulmonary Clinic's Cardiac Catheterization Laboratory Renovated

In an approximately 10-month process, the lab was upgraded with an entire suite of technology to provide better and safer care for patients as well as the surgical team. During operations, catheterization lab workers had to be monitored for radiation exposures due to the high volume of procedures they perform. The radiation levels were found to be high.

Historically, the Keesler Medical Center catheterization lab has been leading the way in cardiovascular care, not only in the Air Force and the DoD, but locally as well. This leadership was demonstrated when Keesler Medical Center implanted one of the first Micra Pacemakers in Mississippi. These advancements also further the readiness of the medical and surgical specialties by enhancing the number and acuity of patients seen in the facility.

DoD and Department of Veterans Affairs (VA) Launched Joint Health Information Exchange (HIE)

With the joint HIE, MHS providers gain access to VA's community health care partners' records, and VA providers gain access to MHS community health care partners' records. Providers can go here to safely and securely access and share their patients' health information and medical records electronically. This integration leads to efficiencies and supports more informed decision making for the health care of service members, veterans, and family members, regardless of where they access this care. The joint HIE capability honors patient consent; the departments will not exchange health records of beneficiaries who opt out of sharing.

MHS has operated its own HIEs for decades, sharing health information electronically between providers at MTFs and VA facilities as well as between MTF providers and community health care partners. But MHS providers could access only MHS community health care partners' data. In turn, VA providers could access only VA community health care partners' data. Now, data from all community partners will be accessible to all providers.

DHA Published a Memorandum Standardizing Reporting and Tracking of Diseases and Other Conditions of Public Health and Military Importance

The memorandum was published on December 11, 2019. Although the Services may choose to track additional conditions, additions and deletions to the Reportable Medical Event (RME) Guidelines should be reported through the Public Health Collaboration and Coordination Working Group. The updated guidelines can be found at: https://health.mil/Military-Health-Topics/Combat-Support/Armed-Forces-Health-Surveillance-Branch.

Quadruple Aim: Better Health

MHS and Army's Telemedicine and Advanced Technology Research Center (TATRC) Developed COVID-19 Airway Management Isolation Chamber (CAMIC) to Better Protect Health Care Workers from COVID-19 and Other Viruses

CAMIC, which recently received approval from the Food and Drug Administration (FDA) for emergency use, was the first FDA-approved adjunct personal protective equipment (PPE) of its kind with a negative pressure vacuum validated to be effective in containing and reducing aerosols and airborne particles.

On July 28, 2020, TRICARE Provided Guidance about the Types of COVID-19 Tests Available and Covered by TRICARE

Two kinds of tests are used to determine SARS-CoV-2 (the virus that causes COVID-19) infection: diagnostic (viral) and antibody testing. TRICARE covers diagnostic and/or antibody testing that is medically necessary.

DoD Identified Five Locations to Participate in the Phase III Trial Evaluating the Vaccine Candidate AZD1222 Under Development by AstraZeneca

The DoD sites selected were:

- Naval Medical Center San Diego (Site Code: NMSD)
- Joint Base San Antonio Brooke Army Medical Center (Site Code: BAMC)
- Wilford Hall Ambulatory Surgical Center (San Antonio) (Site Code: WHASC)
- Walter Reed National Military Medical Center (Bethesda, Md.) (Site Code: WRMC)
- Fort Belvoir Community Hospital (Fort Belvoir, Va.) (Site Code FBCH)

Quadruple Aim: Lower Cost

Increases to TRICARE Pharmacy Copayments

Effective January 1, 2020, a 90-day supply of generic drugs received through the program's Express Scripts mail-order pharmacy increased from $7 to $10. Copayments on brand-name drugs received through the mail went from $24 to $29; the price increased from $53 to $60 for non-formulary drugs.

Generic drug prescriptions filled at retail pharmacies saw the cost rise from $11 to $13 for a 30-day supply, while the same supply of brand-name medications increased from $28 to $33. Non-formulary drugs—those not on Tricare's list of fully covered medications—went from $53 to $60.

Prescriptions filled on base will continue to be free.

NEW BENEFITS AND PROGRAMS IN FY 2020 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

DoD Provided Guidelines for TRS Beneficiaries on April 23, 2020

While TRS premiums cannot be waived, DoD announced that during the COVID-19 emergency, TRS health coverage will continue whether or not the premium is paid. If families are unable to pay TRS premiums during the COVID-19 emergency, coverage will continue, up to 90 days after the emergency has ended. The missed payments will need to be paid within 90 days of the designated end date or coverage will be terminated. If any TRICARE payments were made for uncovered dates of service, TRICARE is required to recoup the payments.

TRICARE Covers Telehealth Appointments and Eliminates Copayments for Telehealth Services during COVID-19 Pandemic, Effective May 12, 2020

The Assistant Secretary of Defense for Health Affairs [ASD(HA)] issues this interim final rule with comment to: provide an exception to the prohibition on telephone, audio-only telehealth services; to authorize reimbursement for interstate or international practice by TRICARE-authorized providers when such authority is consistent with governing state, federal, or host nation licensing requirements; and to eliminate copayments and cost-shares for telehealth services.

TRICARE Select Group A Retired Beneficiaries Must Pay Monthly Enrollment Fees to Maintain TRICARE Health Coverage, Effective January 1, 2021

This is the first time this beneficiary group will pay enrollment fees. This change was mandated in the NDAA FY 2017, but Congress granted a delay in implementation to calendar year 2021.

The enrollment fees will be collected via monthly installments from the sponsor's military pay system where retired pay is disbursed as follows:

- Individual plan: $12.50 per month
- Family plan: $25 per month

TDP Contractor Expanded Annual Maximum Benefit

United Concordia, contractor for TDP, expanded the annual maximum benefit $300 to $1,800 effective May 1, 2020–April 30, 2021.

TDP Enrollees Receive an Additional $300 in Coverage This Contract Year (May 1, 2020–April 30, 2021)

This is to to help improve access that may be hindered due to the COVID-19 pandemic. The change applies to enrollees based both in the U.S. and overseas, and takes effect automatically. The $300 does not cover all services, such as orthodontics, which are subject to a separate lifetime maximum.

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

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

BENEFICIARY TRENDS AND DEMOGRAPHICS

System Characteristics

TRICARE FACTS AND FIGURES—PROJECTED FOR FY 2021

	PROJECTED FOR FY 2021[a]	FY 2020 (AS PROJECTED LAST YEAR)
Total Beneficiaries	**9.6 million worldwide[b]**	9.6 million worldwide[b]
MILITARY FACILITIES—DIRECT CARE SYSTEM[c]		
Inpatient Hospitals and Medical Centers[d]	**49 (32 in U.S.)**	50 (37 in U.S.)
Ambulatory Care and Occupational Health Clinics	**465 (373 in U.S.)**	425 (372 in U.S.)
Dental Clinics	**192 (149 in U.S.)**	246 (203 in U.S.)
Veterinary Facilities[e]	**250 (185 in U.S.)**	251 (206 in U.S.)
Military Health System (MHS) Defense Health Program–Funded Personnel	**134,237**	138,283
Military	**77,317**	77,739
	27,495 Officers	28,824 Officers
	42,822 Enlisted	48,915 Enlisted
Civilian (including Foreign National)	**56,920**	60,544
CIVILIAN RESOURCES—PURCHASED CARE SYSTEM[f]		
Network Primary Care, Behavioral Health, and Specialty Care Providers (i.e., individual, not institutional, providers)[g]	**713,395**	548,297
Network Behavioral Health Providers (shown separately, but included in above)	**127,486**	97,727
TRICARE Network Acute Care Hospitals	**4,953**	4,372
Behavioral Health Facilities	**1,902**	1,612
Contracted (Network) Retail Pharmacies	**56,924**	56,696
Contracted Worldwide Pharmacy Home Delivery Vendor	**1**	1
TRICARE Dental Program (TDP) (for Active Duty families, Reserve members and their families)	**Over 1.84 million covered lives in 761,000 contracts**	Over 1.8 million covered lives in 769,000 contracts
TDP Network Dentists	**Over 72,000 total dentists, including: 57.5K general dentists over 14.5K specialty dentists**	Over 73,000 total dentists, including: 60,000 general dentists over 14,000 specialty dentists
Total Projected FY 2021 Unified Medical Program (UMP) (including Projected Trust Fund Receipts)	**$50.53 billion[h]**	$49.20 billion[h]
Projected Receipts from Medicare-Eligible Retiree Health Care Fund (MERHCF) Trust Fund	**$8.37 billion**	$7.53 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) 2021 is 9,648,000, rounded to 9.6 million, and is based on the DoD Comptroller's Budget End Strength, the DoD Actuary's forecast of retiree populations and the historical counts of family members per sponsor from the Defense Manpower Data Center (DMDC) End FY 2020 Defense Enrollment Eligibility Reporting System (DEERS) file.

[c] Military medical treatment facility (MTF) clinic count includes occupational health, community-based, embedded behavioral health, Active Duty troop, centers of excellence, and joint DoD-Department of Veterans Affairs (VA) clinics, and excludes leased/contracted facilities and Aid Stations; MTF counts are consistent with Defense Health Agency (DHA)/Resources & Management (J-1/J-8)/Budget and Execution and Programming Divisions. Source: DHA/Strategy, Plans, and Functional Integration (SP&FI) (J-5)/Analytics and Evaluation Division, 11/23/2020.

[d] AHC-Vicenza, AF-C-366th MED SQ–Mountain Home, AF-ASU-31st MEDGRP-AVIANO, and Kimbrough Ambulatory Care Center–Meade originated as medical clinics. Due to COVID-19 initiatives, their status was expanded to inpatient facilites. They will return to medical clinics in FY 2021.

[e] All 250 Veterinary Facilities moved to Army Line as the DoD Executive Agent for Veterinary Services.

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

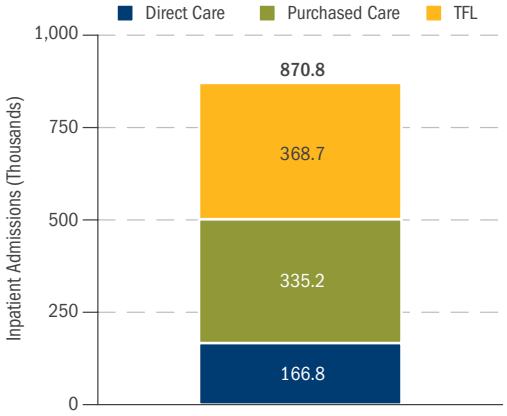
[g] This does not include 309,189 ancillary provider count.

[h] UMP presented here includes direct and private-sector care funding, military personnel, military construction, and the MERHCF ("Accrual Fund"). Budget and expense data from DHA/Resources & Management Directorate (J-8)/Budget & Execution Division, 9/30/2020.

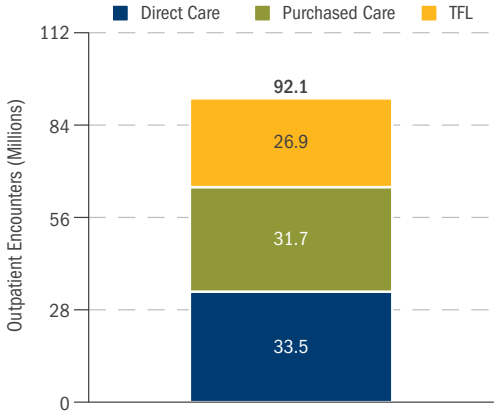
BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

FY 2020 TRICARE Workload and Population Summary

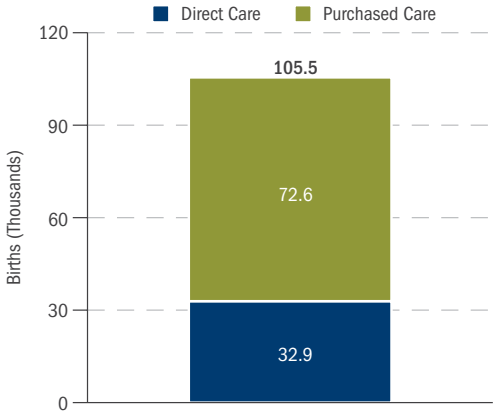
INPATIENT ADMISSIONS[a]



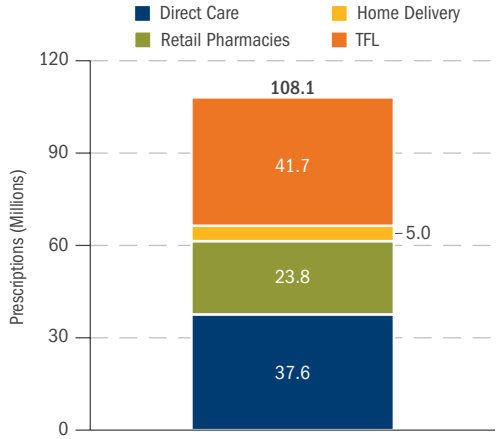
OUTPATIENT ENCOUNTERS[a]



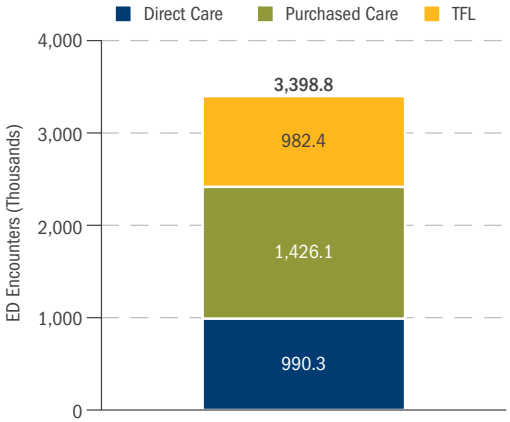
BIRTHS[a]



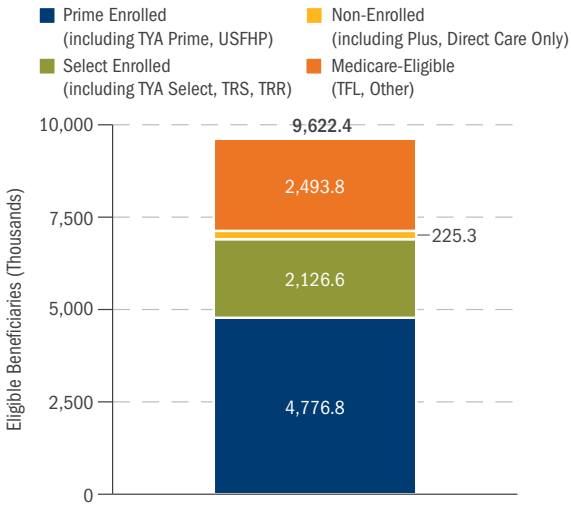
PRESCRIPTIONS[a]



EMERGENCY DEPARTMENT (ED) ENCOUNTERS[a]



ELIGIBLE BENEFICIARIES



Sources: MHS administrative data, 2/5/2021, and DEERS, 1/12/2021

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

Notes:

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

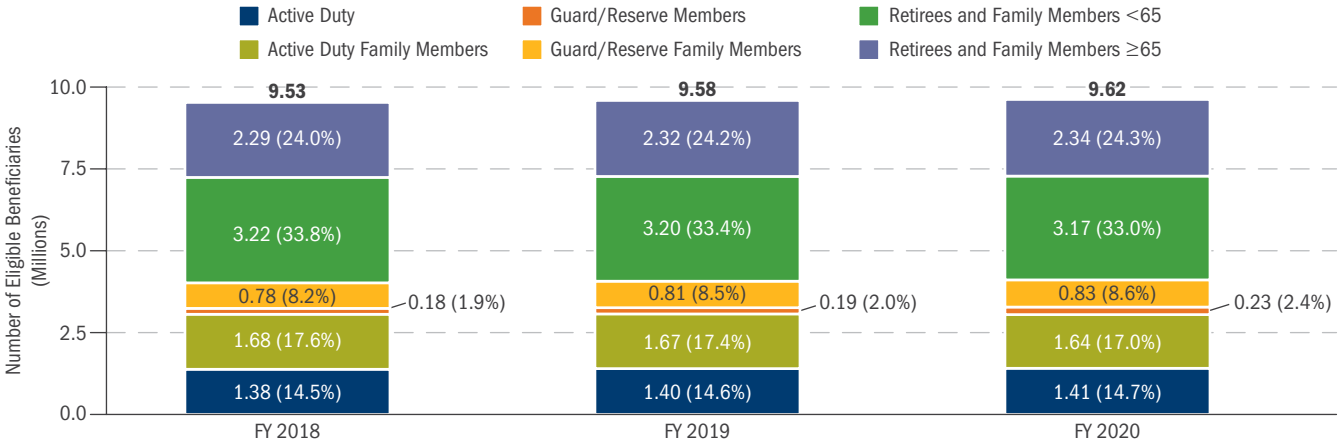
– Numbers may not sum to bar totals due to rounding.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Number of Eligible and Enrolled Beneficiaries Between FY 2018 and FY 2020

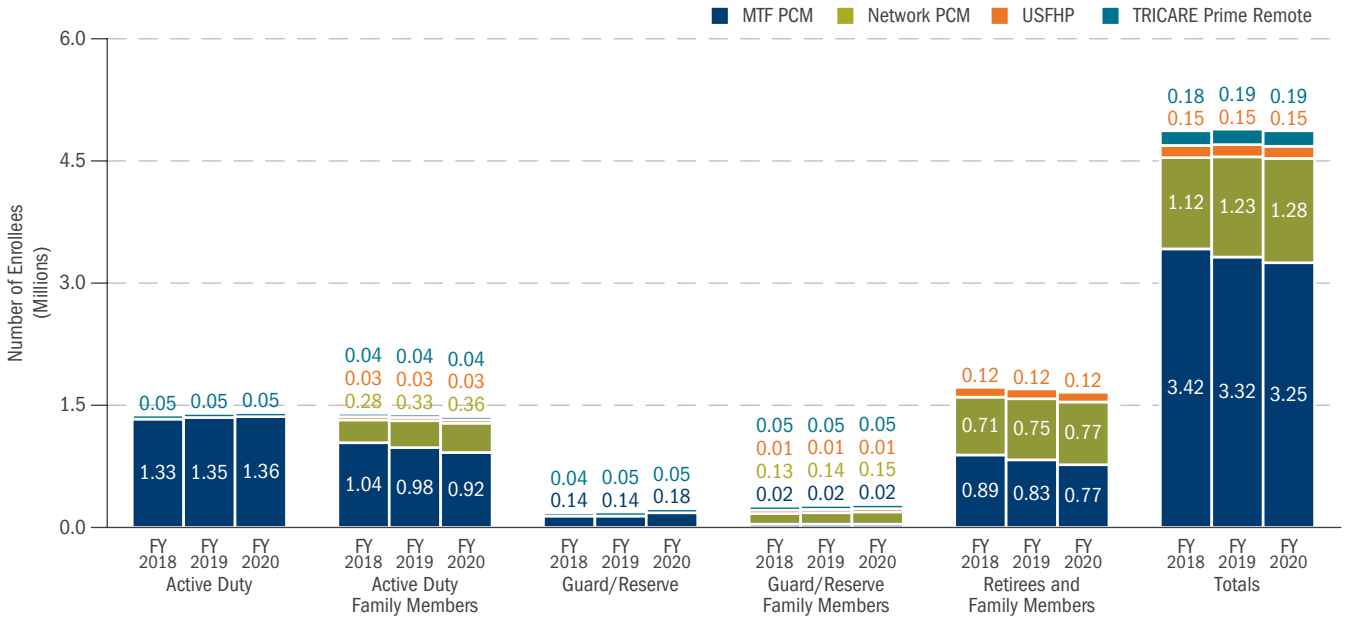
The number of beneficiaries eligible for DoD medical care (including TRR, TRS, and TYA) increased from 9.5 million in FY 2018 to 9.6 million in FY 2020.[1] Although the number of Active Duty members increased slightly, the number of Active Duty family members (ADFMs) fell by 2 percent. The number of retirees and family members (RETFMs) under age 65 decreased by 1 percent, but the number of RETFMs aged 65 and over increased by 2 percent.

TRENDS IN THE END-YEAR NUMBER OF ELIGIBLE BENEFICIARIES BY BENEFICIARY GROUP, FYs 2018–2020



- ADFMs experienced a decline in Prime enrollment with an MTF primary care manager (PCM) but an increase in Prime enrollment with a network PCM. Prime enrollment by Guard/Reserve members and their families increased slightly.
- The trend in RETFM Prime enrollments was similar to that of ADFMs, with the number of beneficiaries with an MTF PCM decreasing and the number with a network PCM increasing. In FY 2020, for the first time, an equal number of RETFMs were enrolled with MTF and network PCMs.
- TRICARE Prime Remote (TPR) and USFHP enrollment remained about the same from FY 2018 to FY 2020.

TRENDS IN THE END-YEAR NUMBER OF ENROLLED BENEFICIARIES BY BENEFICIARY GROUP, FYs 2018–2020



Source: DEERS, 1/12/2021

[1] This number should not be confused with the one displayed under TRICARE Facts and Figures on page 31. The population figure on page 31 is a projected FY 2021 total, whereas the population reported on this page is the actual for the end of FY 2020.

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

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Beneficiary Plan Choice by Age Group and Beneficiary Category

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

PLAN CHOICE BY AGE GROUP, END OF FY 2020

PLAN TYPE	0–17	18–24	25–44	45–64	≥65	TOTAL[a]
Prime Enrolled	1,275,076	913,724	1,558,728	1,021,203	8,025	4,776,756
Prime: MTF PCM	757,408	773,150	1,307,854	564,672	1,626	3,404,710
Prime: Network PCM	482,439	125,203	231,025	410,675	996	1,250,338
USFHP	35,229	8,185	17,707	45,856	5,403	112,380
TYA Prime	0	7,186	2,142	0	0	9,328
Select Enrolled	666,602	220,543	497,479	738,079	3,940	2,126,643
TRICARE Select	511,502	159,897	320,489	688,068	3,769	1,683,725
TRS	146,948	32,255	168,044	29,825	16	377,088
TYA Select	0	25,490	5,297	0	0	30,787
TRICARE Plus	5,183	1,516	2,721	14,040	155	23,615
TRR	2,969	1,385	928	6,146	0	11,428
Nonenrolled	40,699	40,102	55,579	65,671	23,217	225,268
Direct Care Only	40,698	40,098	55,571	64,880	22,371	223,618
Plus	1	4	8	791	846	1,650
Medicare-Eligible	20	897	35,309	150,103	2,307,434	2,493,763
TFL	7	458	17,376	82,659	2,003,305	2,103,805
TRICARE Plus[b]	0	2	132	1,053	184,725	185,912
Direct Care Only	1	31	4,450	13,156	80,042	97,680
USFHP	0	18	333	1,681	38,696	40,728
Prime: Network PCM	3	156	6,404	25,943	11	32,517
Prime: MTF PCM	4	151	5,704	24,539	8	30,406
Other	5	81	910	1,072	647	2,715
Total	**1,982,397**	**1,175,266**	**2,147,095**	**1,975,056**	**2,342,616**	**9,622,430**

Source: DEERS, 1/12/2021

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

[b] Among Medicare eligibles, 183,031 with TRICARE Plus also have TFL. These numbers are not included in the TFL row.

- About 30 percent of USFHP enrollees are seniors (aged 65 and older), and about 23 percent are children (aged 0–17).
- The vast majority of those aged 65 and above are enrolled in Medicare Part B and are covered by TFL as their supplemental plan. About 8 percent of seniors covered by TFL are also enrolled in TRICARE Plus, the primary care–only plan available at selected MTFs.
- Medicare-eligible beneficiaries under age 65 have a choice between TRICARE Prime (including the USFHP) and TFL. About 61 percent choose TFL and 39 percent choose Prime.
- Beneficiaries aged 45–64 had the lowest TRICARE Prime enrollment rate, at 56 percent. Enrollment rates for the other age groups were 64 percent for 0–17, 78 percent for 18–24, and 74 percent for 25–44. Beneficiaries aged 65 and older predominantly use TFL.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

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

PLAN CHOICE BY BENEFICIARY CATEGORY, END OF FY 2020

PLAN TYPE	AD	ADFM	GR	GRFM	IGR	IGRFM	RET	RETFM	SRV	OTH	TOTAL[a]
Prime Enrolled	1,407,462	1,343,509	229,732	215,366	4,783	13,841	551,918	971,365	36,652	2,128	4,776,756
Prime: MTF PCM	1,407,462	958,782	229,732	64,345	2,307	3,839	277,641	444,195	15,330	1,077	3,404,710
Prime: Network PCM	0	356,663	0	143,580	2,323	9,574	245,894	472,582	18,772	950	1,250,338
USFHP	0	27,094	0	7,290	153	424	28,383	46,565	2,370	101	112,380
TYA Prime	0	970	0	151	0	4	0	8,023	180	0	9,328
Select Enrolled	0	271,124	0	118,278	166,515	280,141	412,028	801,273	60,168	17,116	2,126,643
TRICARE Select	0	268,329	0	116,923	25,274	44,016	398,972	754,692	58,845	16,674	1,683,725
TRS	0	2	0	266	141,240	235,123	18	40	0	399	377,088
TYA Select	0	2,260	0	1,014	0	1,001	0	25,685	817	10	30,787
TRICARE Plus	0	533	0	75	1	1	8,921	13,576	505	3	23,615
TRR	0	0	0	0	0	0	4,117	7,280	1	30	11,428
Non-Enrolled	0	24,818	0	5,588	25,069	3,101	51,417	91,809	9,247	14,219	225,268
Direct Care Only	0	23,827	0	5,538	25,069	3,101	51,362	91,312	9,191	14,218	223,618
TRICARE Plus	0	991	0	50	0	0	55	497	56	1	1,650
Medicare-Eligible	0	2,273	0	821	163	962	1,206,467	780,791	500,137	2,149	2,493,763
TFL	0	0	0	0	0	1	996,923	664,084	440,985	1,812	2,103,805
TRICARE Plus[b]	0	352	0	50	0	1	94,442	59,717	31,301	49	185,912
Direct Care Only	0	1,384	0	304	9	35	56,925	22,248	16,578	197	97,680
USFHP	0	0	0	0	0	0	19,817	13,128	7,756	27	40,728
Prime: Network PCM	0	0	0	0	0	0	19,822	11,019	1,650	26	32,517
Prime: MTF PCM	0	0	0	0	0	0	18,376	10,264	1,752	14	30,406
Other	0	537	0	467	154	925	162	331	115	24	2,715
Total	**1,407,462**	**1,641,724**	**229,732**	**340,053**	**196,530**	**298,045**	**2,221,830**	**2,645,238**	**606,204**	**35,612**	**9,622,430**

Source: DEERS, 1/12/2021

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

[b] Among Medicare eligibles, 183,031 with TRICARE Plus also have TFL. These numbers are not included in the TFL row.

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

- Only 3 percent of non-Medicare-eligible beneficiaries are not enrolled in any TRICARE plan (i.e., they use space-available care or Plus at MTFs or other health insurance (OHI).
- The large majority of beneficiaries enrolled in TYA are children of retirees under the age of 65 (most Active Duty members are not old enough to have children in the requisite age group). TYA Prime enrollment has declined from 58 percent of total TYA enrollment in FY 2015 to 23 percent in FY 2020.
- Almost 80 percent of beneficiaries enrolled in the USFHP are retirees and family members (including survivors), most of whom are under age 65. The USFHP is available at only six sites nationwide, so enrollment is low relative to Prime.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Trends in Plan Choice

PLAN CHOICE AND PERCENTAGE OF TOTAL ENROLLMENT, END OF FYs 2018–2020

PLAN TYPE	FY 2018		FY 2019		FY 2020	
	POPULATION	% OF TOTAL	POPULATION	% OF TOTAL	POPULATION	% OF TOTAL
Prime Enrolled	4,768,800	50.0%	4,778,158	49.9%	4,776,756	49.6%
Prime: MTF PCM	3,560,392	37.4%	3,459,264	36.1%	3,404,710	35.4%
Prime: Network PCM	1,087,891	11.4%	1,197,826	12.5%	1,250,338	13.0%
USFHP	106,865	1.1%	110,556	1.2%	112,380	1.2%
TYA Prime	13,652	0.1%	10,512	0.1%	9,328	0.1%
Select Enrolled	2,142,747	22.5%	2,135,418	22.3%	2,126,643	22.1%
TRICARE Select	1,705,083	17.9%	1,681,439	17.5%	1,683,725	17.5%
TRS	377,146	4.0%	391,954	4.1%	377,088	3.9%
Plus	28,244	0.3%	26,695	0.3%	30,787	0.3%
TYA Select	22,882	0.2%	24,993	0.3%	23,615	0.2%
TRR	9,392	0.1%	10,337	0.1%	11,428	0.1%
Direct Care Only	165,298	1.7%	191,124	2.0%	225,268	2.3%
Medicare Eligible	2,454,987	25.8%	2,478,785	25.9%	2,493,763	25.9%
TFL	2,068,919	21.7%	2,093,342	21.8%	2,103,805	21.9%
Plus	188,077	2.0%	185,770	1.9%	185,912	1.9%
Direct Care Only	90,595	1.0%	92,160	1.0%	97,680	1.0%
USFHP	42,708	0.4%	41,926	0.4%	40,728	0.4%
Prime: Network PCM	32,148	0.3%	31,534	0.3%	32,517	0.3%
Prime: MTF PCM	29,609	0.3%	31,191	0.3%	30,406	0.3%
Other/Unknown	2,931	0.0%	2,862	0.0%	2,715	0.0%
Total	**9,531,832**		**9,583,485**		**9,622,430**	

Source: DEERS, 1/12/2021

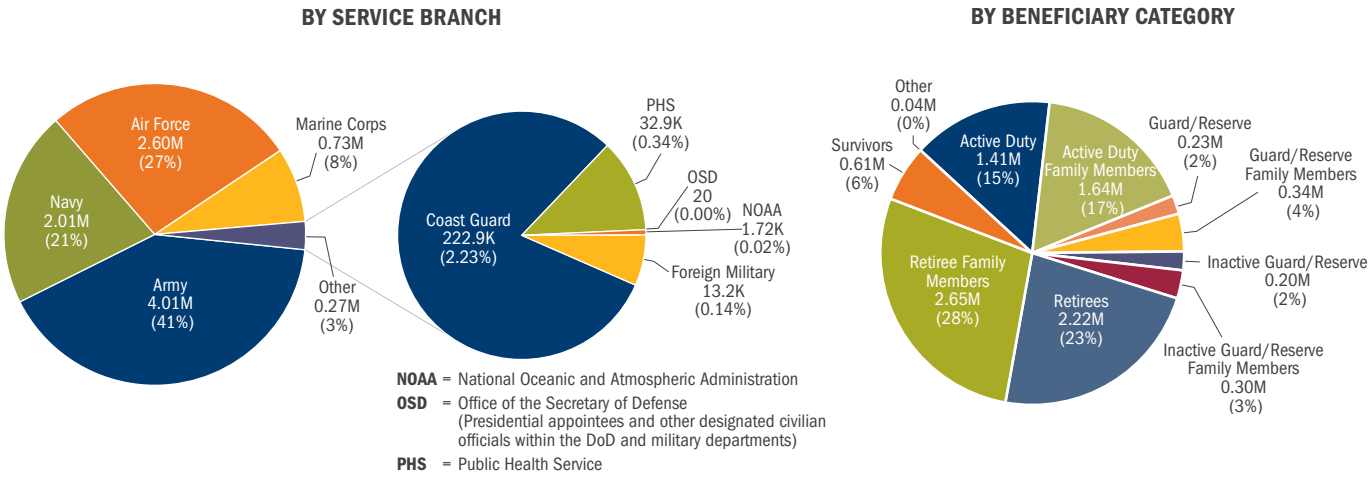
- After a year of grace in CY 2018, the open season model went into full effect for coverage beginning in CY 2019. Beneficiaries could no longer change their TRICARE coverage outside open season unless they had a TRICARE-recognized qualifying life event (QLE). As a result, plan enrollment has been relatively stable the past three years.
- As a percentage of the total eligible population, the number of Prime-enrolled beneficiaries remained about the same from FY 2018 to FY 2020. However, the number with an MTF PCM decreased, whereas the number with a network PCM increased.
- As a percentage of the total eligible population, the number of beneficiaries with TRICARE Select plans remained about the same from FY 2018 to FY 2020. Over the same time period, the percentage of beneficiaries with direct-care-only coverage increased, but the number of beneficiaries in that group is very small.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Eligible Beneficiaries in FY 2020

- There were a total of 9.62 million beneficiaries eligible for some form of DoD health care benefits at the end of FY 2020. The Army has the most beneficiaries eligible for Uniformed Services health care benefits, followed (in order) by the Air Force, Navy, Marine Corps, and other Uniformed Services (Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration). Although the proportions are different, the Service rankings (in terms of eligible beneficiaries) are the same abroad as they are in the U.S.
- Retirees and their family members (including survivors) constitute the largest percentage of the eligible beneficiary population (57 percent). The U.S. MHS population is presented at the state level on page 42, reflecting those enrolled in the Prime benefit and the total population, enrolled and non-enrolled.
- Mirroring trends in the civilian population, the MHS is confronted with an aging beneficiary population.

WORLDWIDE BENEFICIARIES ELIGIBLE FOR DoD HEALTH CARE BENEFITS, END OF FY 2020

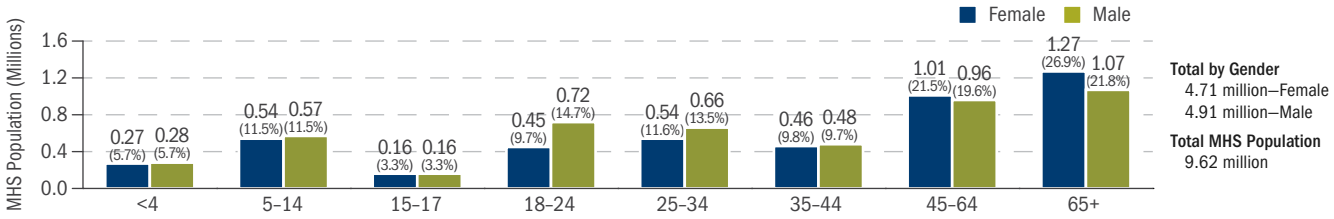


TOTAL: 9.62 Million

Source: DEERS, 1/12/2021

Note: Percentages may not sum to 100 percent due to rounding.

MHS POPULATION BY AGE GROUP AND GENDER, END OF FY 2020



Source: FY 2020 actuals from DEERS as of 1/12/2021

PROJECTED END-YEAR MHS POPULATIONS (MILLIONS) BY BENEFICIARY CATEGORY, FYs 2021–2031

BENEFICIARY CATEGORY	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027	FY 2028	FY 2029	FY 2030	FY 2031
Active Duty	1.41	1.41	1.41	1.41	1.42	1.42	1.42	1.42	1.42	1.42	1.42
Active Duty Family Members	1.64	1.64	1.64	1.65	1.65	1.65	1.65	1.66	1.66	1.66	1.66
Guard/Reserve	0.23	0.24	0.24	0.24	0.24	0.24	0.24	0.24	0.24	0.24	0.24
Guard/Reserve Family Members	0.35	0.35	0.35	0.35	0.35	0.35	0.35	0.35	0.35	0.35	0.35
Inactive Guard/Reserve	0.19	0.19	0.19	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	0.30	0.30	0.30
Retirees	2.23	2.24	2.25	2.26	2.27	2.27	2.27	2.27	2.27	2.27	2.26
Retiree Family Members	2.65	2.66	2.66	2.67	2.67	2.67	2.67	2.67	2.66	2.66	2.66
Survivors	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.60	0.61
Other	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04	0.04
Total	**9.65**	**9.67**	**9.69**	**9.70**	**9.72**	**9.73**	**9.73**	**9.73**	**9.73**	**9.72**	**9.72**

Source: Projection of Eligible Population (PEP) as of 12/17/2020

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Locations of MTFs (Hospitals and Ambulatory Care Clinics) at the End of FY 2020

The map on the following page shows the geographic dispersion of the 9.1 million beneficiaries eligible for the TRICARE benefit residing within the United States (95 percent of the 9.6 million eligible beneficiaries). An overlay of the major DoD MTFs (medical centers and community hospitals, as well as medical clinics) reflects the extent to which the MHS population has access to TRICARE Prime. A beneficiary is considered to have access to Prime if he or she resides within a Prime Service Area (PSA). PSAs are geographic areas in which the TRICARE MCSCs offer the TRICARE Prime benefit through established networks of providers. TRICARE Prime is available at MTFs, in areas around most MTFs (MTF PSAs), in areas where an MTF was eliminated in the Base Realignment and Closure (BRAC) process (BRAC PSAs), and by designated providers through the USFHP as of October 1, 2013. The overlay of MTF PSAs and BRAC PSAs on the map shows the eligible beneficiary population.

MHS ELIGIBLE BENEFICIARY PROXIMITY TO MTFs, END OF FY 2020[a]

BENEFICIARY GROUP[b]	POPULATION TOTAL	POPULATION IN PSAs	% IN PSAs	% IN MTF SERVICE AREAS
Active Duty and Their Families	3,310,902	3,021,955	91%	
Guard/Reserve and Their Families[c]	485,978	324,435	67%	52%
Retirees, Their Families, Survivors, and Other Eligibles	5,310,246	4,023,053	76%	64%
Total MHS Eligibles, U.S.	9,107,126	7,369,443	81%	72%
MHS Eligible, Overseas and Unknown	507,635			
Total MHS Eligibles, Worldwide	9,614,761			

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, population as of 9/30/2020

Notes:

[a] Eligible MHS beneficiary data from the MHS Data Repository (MDR) DEERS, as of 9/30/2020. Residential ZIP code was used as the location for all beneficiaries.

[b] Location information determined by DHA Catchment Area Directory database, September 2020.

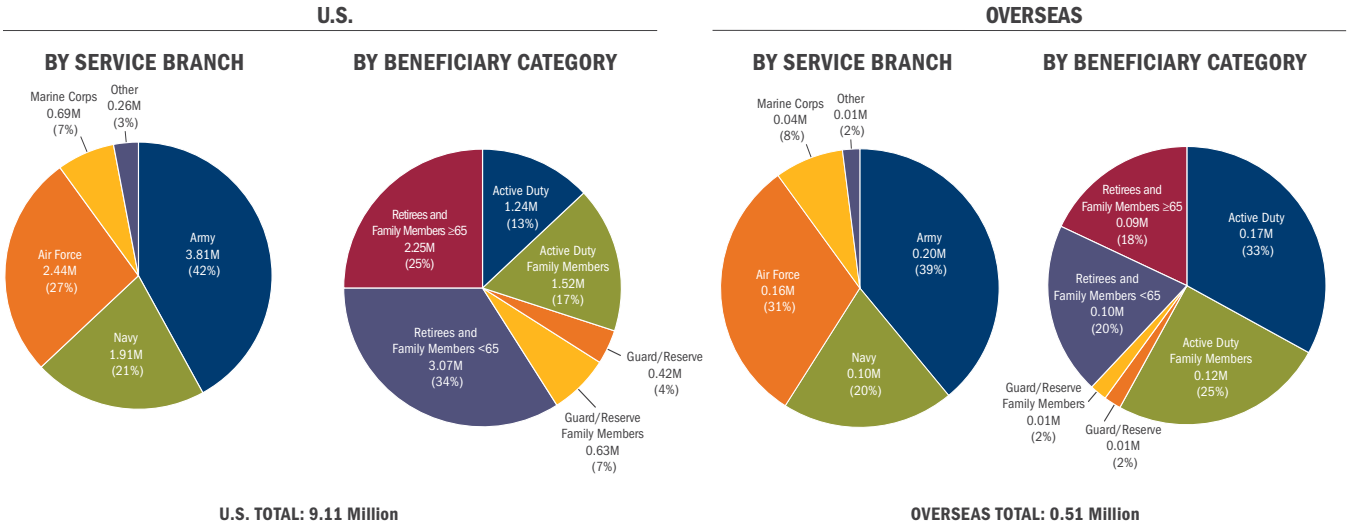
[c] TRICARE medically eligible Guard/Reserve beneficiaries, including those who have enrolled in TRS, TRR, or TYA (does not include all Select Reserve).

Definitions:

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

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

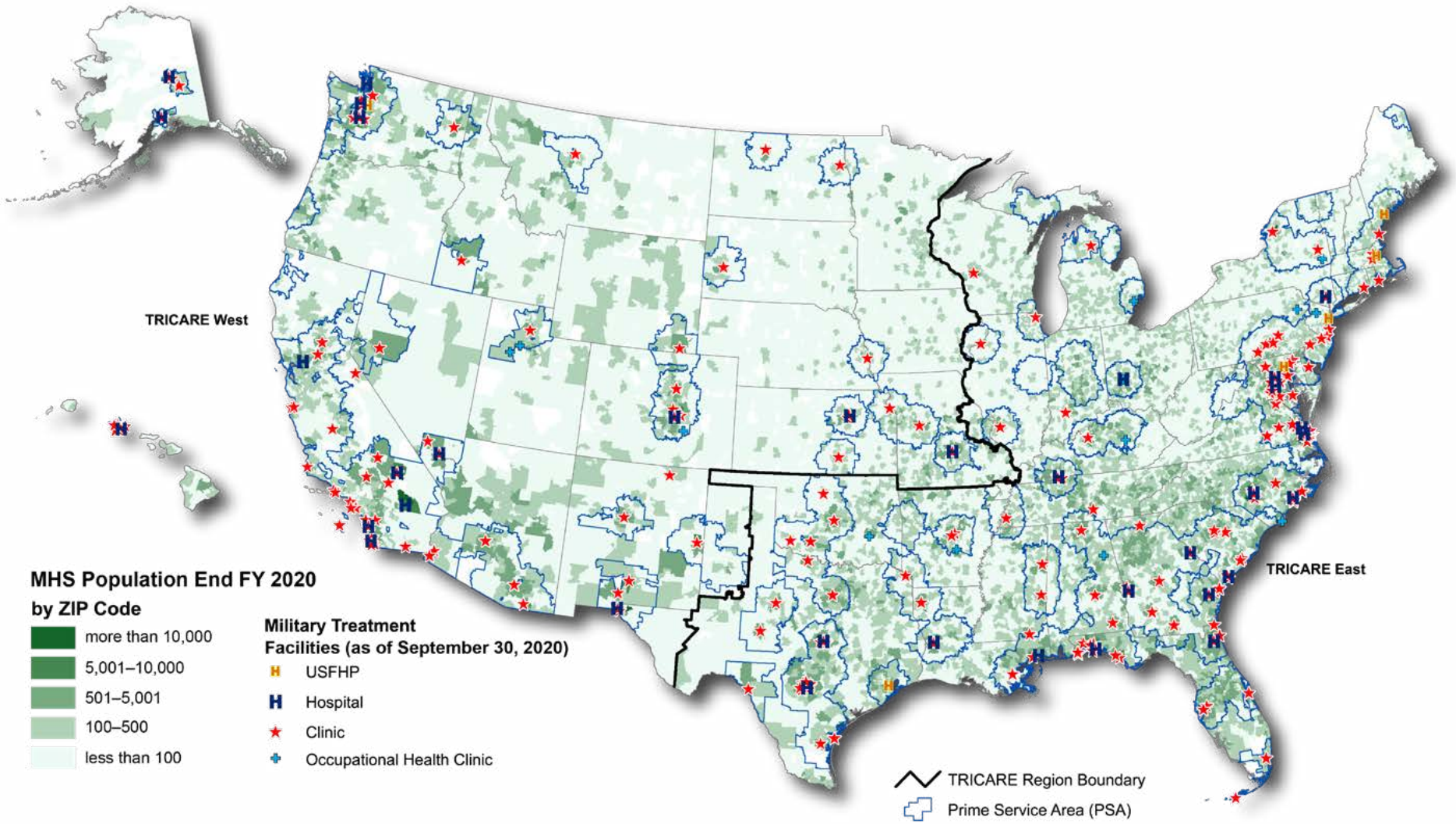
BENEFICIARIES ELIGIBLE FOR DoD HEALTH CARE BENEFITS, END OF FY 2020



Source: DEERS, 1/12/2021

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

MHS POPULATION DISTRIBUTION IN THE U.S. RELATIVE TO MTFs, END OF FY 2020



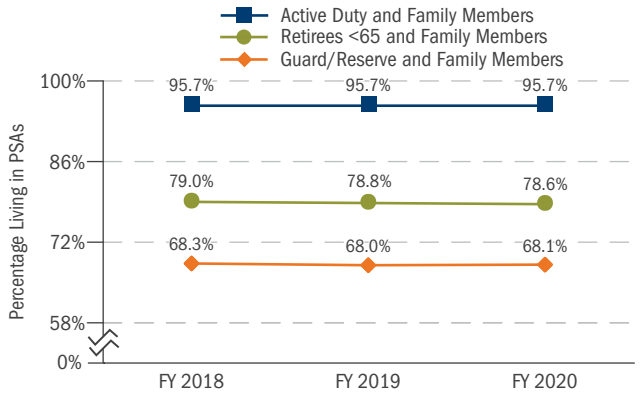
Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, population as of 1/19/2021
Note: For in-depth market area maps, visit https://info.health.mil/staff/analytics/decsupmp/gismaps (a DoD-issued Common Access Card [CAC] is required for access).

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Beneficiary Access to Prime

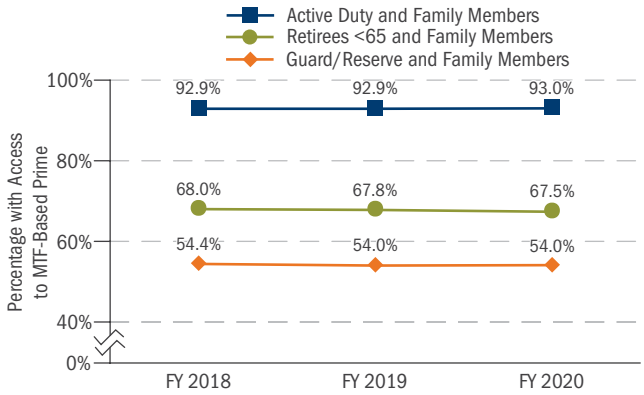
The left chart below shows the percentage of beneficiaries living in PSAs (defined only in the U.S.). The right chart below shows the percentage of the eligible population in the U.S. with access to MTF-based Prime. The latter is defined as the percentage living in both a PSA and an MTF Service Area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

TREND IN ELIGIBLE POPULATION LIVING IN PSAs, FYs 2018–2020



- Between FY 2018 and FY 2020, the percentage of each beneficiary group above living in PSAs remained about the same.
- As determined by residence in an MTF PSA, access to MTF-based Prime for each beneficiary group above remained about the same from FY 2018 to FY 2020.

TREND IN ELIGIBLE POPULATION WITH ACCESS TO MTF-BASED PRIME, FYs 2018–2020



- As expected, Active Duty and their families have the highest level of access to MTF-based Prime, whereas Guard/Reserve members and their families have the lowest. Retirees, some of whom move to locations near an MTF to gain access to care in military facilities, fall in between.

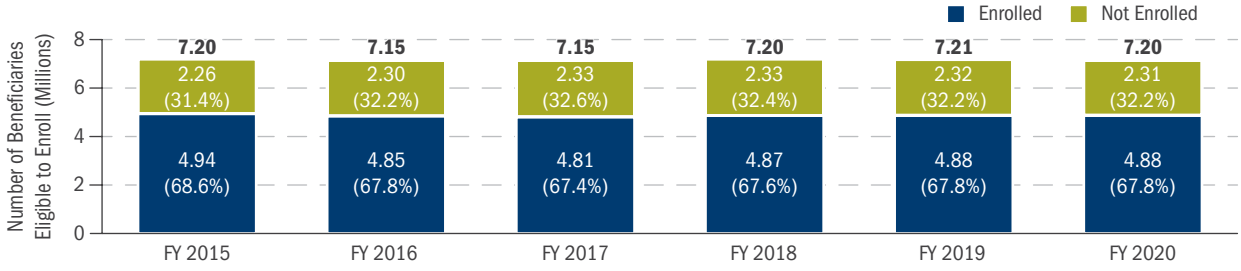
Eligibility and Enrollment in TRICARE Prime

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

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

- The number of beneficiaries enrolled in TRICARE Prime had been dropping from FY 2015 to FY 2017, but rebounded slightly in FY 2018 and remained roughly flat after that. As a percentage of the beneficiary population, TRICARE Prime enrollment had been dropping from FY 2015 to FY 2017, due to a drop in Active Duty end-strength and a reduction in the number of locations designated as PSAs. The percentage started to climb slightly in FY 2018 and again in FYs 2019 and 2020.
- By the end of FY 2020, about 68 percent of all eligible beneficiaries were enrolled (4.88 million enrolled of the 7.19 million eligible to enroll).

HISTORICAL END-YEAR PRIME ENROLLMENT NUMBERS, FYs 2015–2020



Source: DEERS, 1/12/2021
Note: Numbers may not sum to bar totals due to rounding. Detailed MHS enrollment data by state can be found on page 42.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

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

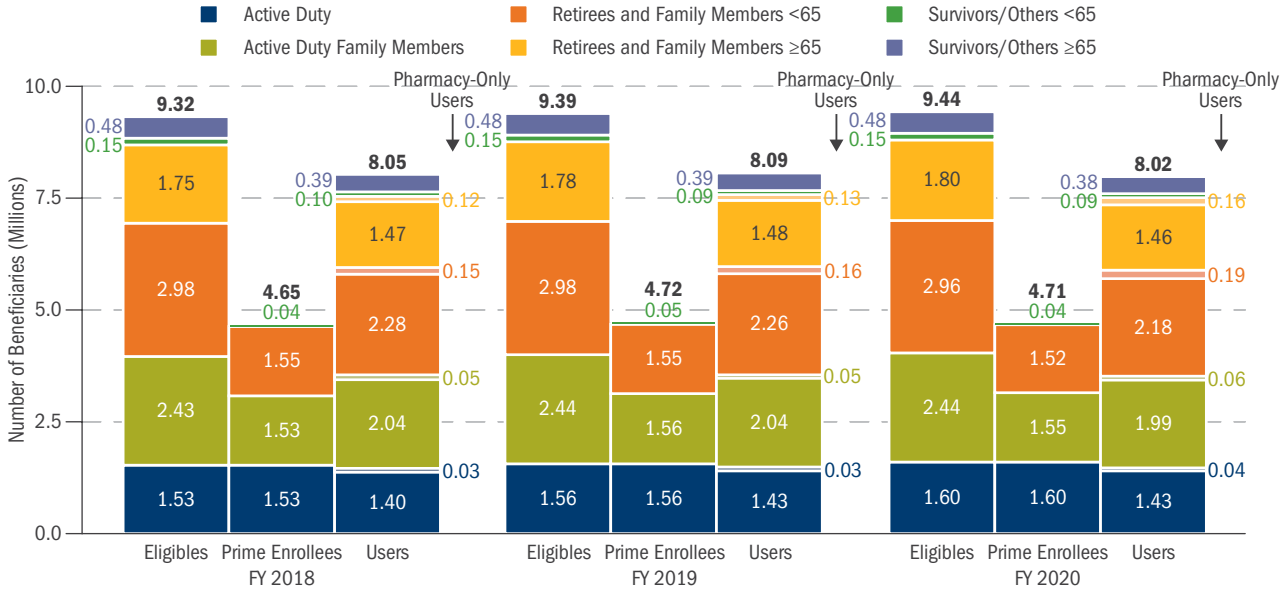
This section compares the number of users of MHS services with the numbers of eligibles and Prime enrollees. Because beneficiaries eligible for any part of the year can be users, average (rather than end-year) beneficiary counts were used for all calculations.

The average numbers of eligibles and TRICARE Prime enrollees by beneficiary category[1] from FY 2018 to FY 2020 were determined from DEERS data. The eligible counts include all beneficiaries eligible for some form of the military health care benefit and, therefore, include those who may not be eligible to enroll in Prime. TRICARE Select enrollees (including TRS, TYA Select, TRR, and TRICARE Plus) are not included in the enrollment counts. USFHP enrollees are excluded from both the eligible and enrollment counts because information about users of that plan was not available.

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

- The number of Active Duty (including Guard/Reserve) and eligible family members increased by 2 percent between FY 2018 and FY 2020. The number of RETFMs under age 65 declined by less than 1 percent, while the number of RETFMs age 65 and older increased by 3 percent. The number of survivors and others (SRV/OTHs) declined by 4 percent for those under age 65 and rose by 1 percent for those age 65 and older.[2]
- The percentage of ADFMs enrolled in TRICARE Prime remained constant at 63 percent from FY 2018 to FY 2020. 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 declined slightly from 86 percent in FY 2018 to 85 percent in FY 2020. The user rate declined for each beneficiary group, ranging from one percentage point for RETFMs aged 65 and older to three percentage points for SRV/OTHs under age 65.
- RETFMs under age 65 constituted the greatest number of MHS users but had the second lowest user rate. Their MHS user rate was lower than all but SRV/OTHs under age 65 (a much smaller beneficiary group) because some RETFMs had OHI.

AVERAGE NUMBERS OF ELIGIBLES, ENROLLEES, AND USERS BY BENEFICIARY CATEGORY, FYs 2018–2020



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

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

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

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

MHS POPULATION: ENROLLEES AND TOTAL POPULATION BY STATE

STATE	TOTAL POPULATION	TRS ENROLLED	PRIME ENROLLED				
			ACTIVE DUTY AND GUARD/RESERVE ON ACTIVE DUTY	DEPENDENTS OF ACTIVE DUTY AND GUARD/RESERVE ON ACTIVE DUTY	RETIRED	RETIRED FAMILY MEMBERS/ OTHERS	TOTAL
AK	82,055	1,221	22,842	24,460	4,767	8,417	60,486
AL	211,844	9,068	13,442	23,588	18,093	32,580	87,703
AR	85,400	5,035	6,813	8,520	4,924	8,775	29,032
AZ	214,810	8,794	25,189	29,421	16,680	29,112	100,402
CA	784,837	23,633	179,845	152,241	40,835	77,317	450,238
CO	250,606	10,596	44,585	47,084	18,467	33,663	143,799
CT	48,648	2,455	9,031	7,573	2,089	3,506	22,199
DC	22,760	700	12,361	3,056	778	837	17,032
DE	35,072	1,608	5,047	5,255	2,698	4,049	17,049
FL	733,866	24,395	79,286	91,689	61,866	102,724	335,565
GA	444,265	14,785	78,365	76,217	37,744	66,334	258,660
HI	151,116	1,865	46,244	47,086	5,310	8,972	107,612
IA	49,762	4,360	3,868	4,057	746	1,535	10,206
ID	56,633	4,077	5,575	6,612	3,060	5,558	20,805
IL	156,112	8,575	31,724	18,893	8,665	15,195	74,477
IN	97,473	8,982	6,034	8,644	4,256	8,171	27,105
KS	121,214	5,625	25,281	26,320	6,391	12,489	70,481
KY	148,473	5,907	38,920	22,780	7,723	13,773	83,196
LA	125,993	5,870	21,375	21,082	6,776	12,905	62,138
MA	71,249	5,599	7,790	8,075	6,129	9,411	31,405
MD	245,116	8,107	40,099	47,553	28,257	42,044	157,953
ME	39,620	2,278	1,731	3,405	7,392	10,609	23,137
MI	103,208	6,516	6,139	7,937	3,620	6,248	23,944
MN	74,327	8,722	5,903	4,850	98	309	11,160
MO	161,916	11,513	23,402	20,410	8,367	15,735	67,914
MS	113,096	6,299	17,610	14,017	6,188	10,603	48,418
MT	37,683	2,316	4,864	4,660	935	1,581	12,040
NC	511,630	13,072	108,582	103,546	28,155	49,805	290,088
ND	33,827	2,292	9,009	7,683	1,185	1,989	19,866
NE	61,812	4,729	8,032	8,981	3,784	6,872	27,669
NH	31,270	1,820	2,163	2,590	4,732	6,814	16,299
NJ	85,302	5,622	12,595	14,668	5,137	8,852	41,252
NM	83,501	2,012	14,650	14,441	5,760	9,637	44,488
NV	109,029	3,613	14,331	15,252	8,429	13,898	51,910
NY	177,204	7,050	32,228	30,627	9,725	16,784	89,364
OH	175,089	13,038	14,605	16,177	7,353	13,373	51,508
OK	156,697	6,517	27,153	23,931	10,737	19,772	81,593
OR	70,383	3,146	5,514	4,980	729	1,370	12,593
PA	165,088	10,128	9,632	13,043	7,684	13,066	43,425
RI	24,988	1,147	5,204	3,958	1,521	2,377	13,060
SC	256,152	10,113	47,915	33,359	16,693	28,627	126,594
SD	36,081	4,211	4,704	5,055	1,393	2,501	13,653
TN	202,085	11,901	7,308	26,811	11,416	20,674	66,209
TX	920,907	33,636	134,686	147,712	79,942	149,300	511,640
UT	80,575	8,721	8,422	12,201	4,605	9,272	34,500
VA	744,789	15,561	137,915	143,306	55,861	90,053	427,135
VT	13,891	1,022	1,110	1,366	1,368	2,119	5,963
WA	350,384	8,004	67,784	68,183	27,282	46,799	210,048
WI	77,737	7,258	5,442	5,581	1,093	1,956	14,072
WV	37,674	2,328	3,027	2,228	1,013	1,617	7,885
WY	24,852	1,337	4,205	4,423	1,220	2,106	11,954
Subtotal	**9,098,101**	**377,179**	**1,449,581**	**1,445,587**	**609,671**	**1,062,085**	**4,566,924**
Overseas	**524,329**	**2,714**	**187,613**	**113,288**	**262**	**12,320**	**313,483**
Total	**9,622,430**	**379,893**	**1,637,194**	**1,558,875**	**609,933**	**1,074,405**	**4,880,407**

Source: MHS administrative data systems, as of 1/12/2021 for end of FY 2020

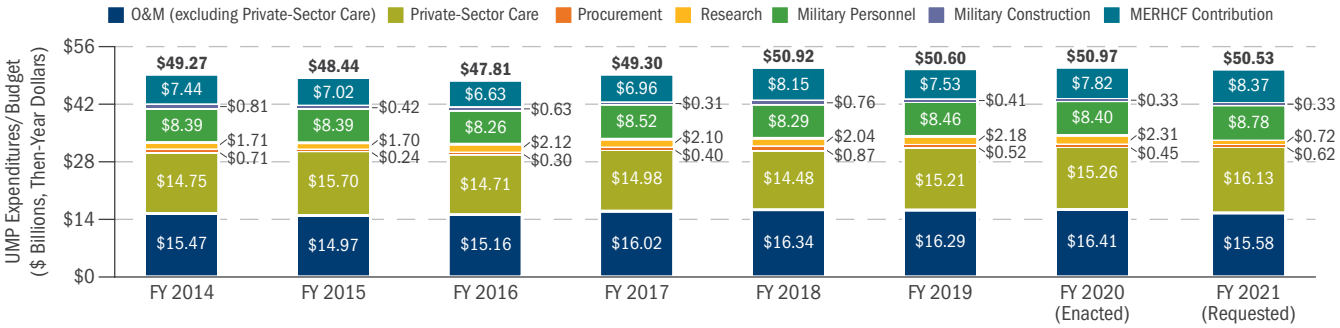
Note: "Prime Enrolled" includes Prime (MTF and network PCMs), TRICARE Prime Remote (and Overseas equivalent), TYA Prime, and USFHP; and excludes members in TRICARE Select, TYA Select, TRS, TRR, TRICARE Plus, and TFL.

UNIFIED MEDICAL PROGRAM FUNDING

The DoD's FY 2021 budget request for current and future healthcare services was $50.5 billion. In nominal terms, this is about 1 percent lower than the estimated $51.0 billion FY 2020 estimated expenditures.

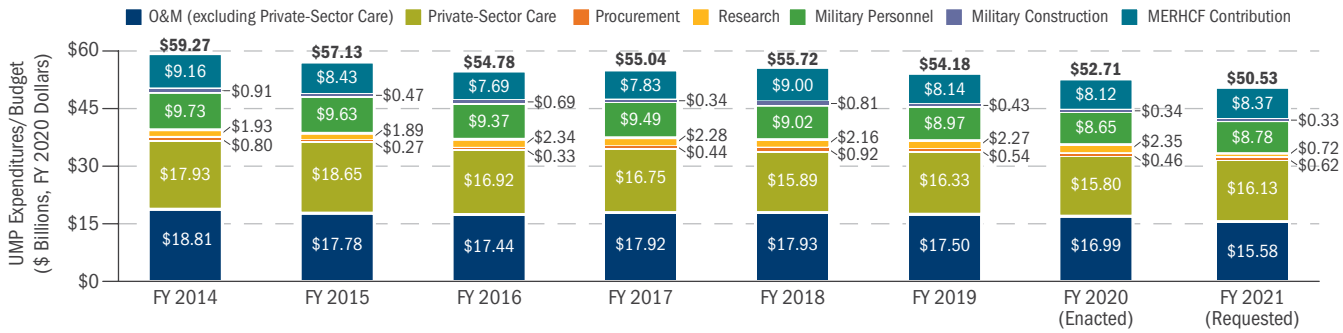
The budget request has three components. First is the direct appropriation to the DHP, which includes operations and maintenance (O&M), procurement, and research, development, test and evaluation (RDT&E) funding totaling $33.2 billion. The second is composed of transfers from DoD including military personnel and military construction, totaling $9.1 billion. The third component is the DoD contribution to 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 DoD office of the Actuary determines how much funding should be set aside to pay the package of future benefits promised to those currently on Active Duty. These funds are paid into the MERHCF out of DoD personnel accounts. The FY 2021 contribution has been set at $8.4 billion.

UMP FUNDING AND TRUST FUND CONTRIBUTIONS ($ BILLIONS) IN THEN-YEAR DOLLARS, FYs 2014–2021



Using constant dollars, the FY 2021 request is about $8.7 billion (15 percent) less than real FY 2014 expenditures.

UMP FUNDING AND TRUST FUND CONTRIBUTIONS ($ BILLIONS) IN CONSTANT 2021 DOLLARS, FYS 2014–2021



Source: UMP cost and budget estimates, DHA/Resources Management Directorate (J-8)/Budget & Execution Division, 9/30/2020

Notes:

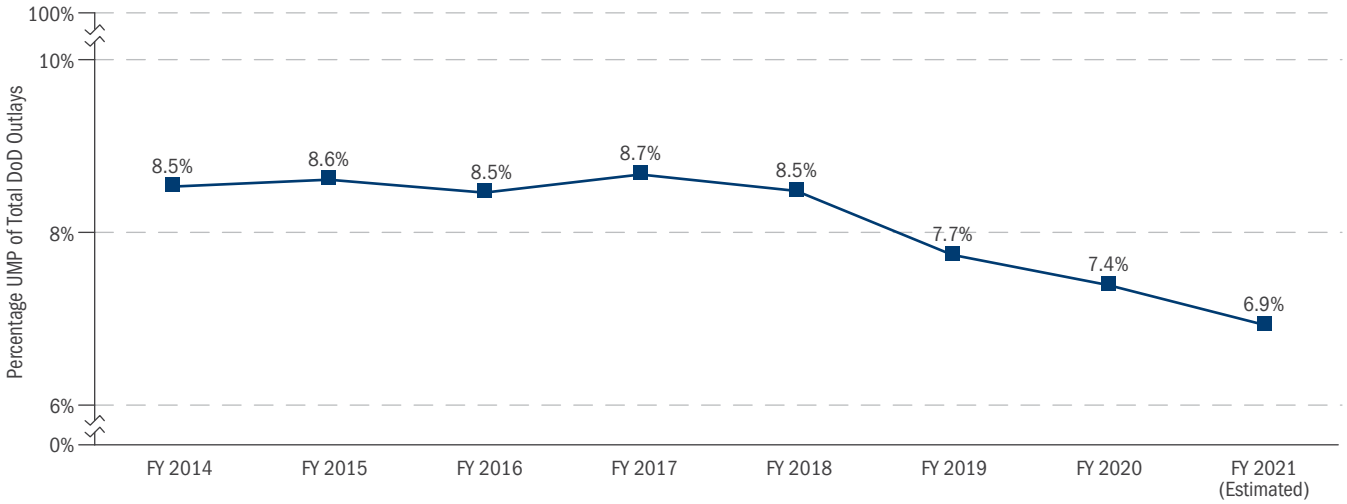
- FYs 2014–2019 reflect Comptroller Information System actual execution; FY 2020 reflects the enacted budget.
- Source of data for deflators (Milpers, DHP, Procurement, RDT&E, and military construction) is Table 5-9, DoD Deflators—TOA, National Defense Budget Estimates for FY 2021 (Green Book).
- Medicare Eligible Retiree Healthcare Fund Deflator computed using a combination of MILPER (5 percent) and DHP factors (95 percent).
- FY 2014 actuals include $715.484M for Overseas Contingency Operations (OCO).
- FY 2015 actuals include $344.645M for OCO.
- FY 2016 actuals include $285.032M for OCO.
- FY 2017 actuals include $332.603M for OCO.
- FY 2018 actuals include $405.856M for OCO.
- FY 2019 actuals include $349.422M for OCO.
- FY 2020 enacted includes $347.746M for OCO.
- FY 2021 estimate includes $365.098M for OCO.

UNIFIED MEDICAL PROGRAM FUNDING *(CONT.)*

UMP Share of Defense Budget

The UMP funding share of total DoD expenditures has declined for four consecutive years and is below FY 2014 levels.

UMP EXPENDITURES AS A PERCENTAGE OF TOTAL DoD OUTLAYS, FYs 2014–2021

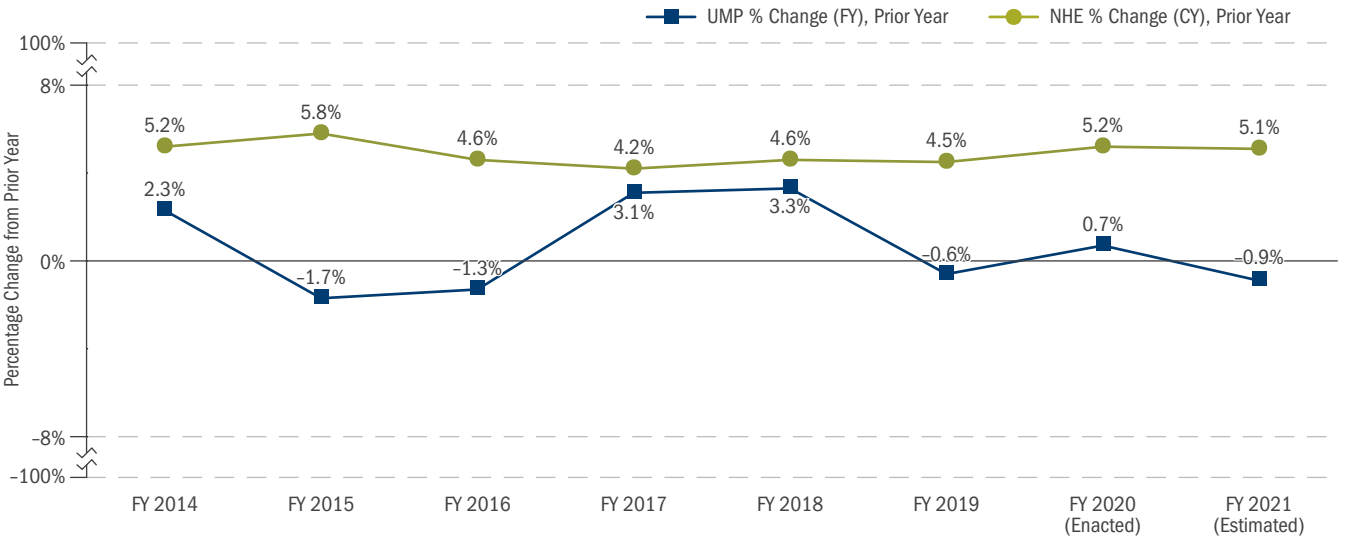


Source: UMP cost and budget estimates, DHA/Resources and Management Directorate (J-8)/Budget and Execution Division, 9/30/2020
Note: Percentages are estimates of total DoD outlays reflected in the FY 2020 President's Budget.

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

As shown in the chart below, the annual rate of growth in the UMP (in then-year dollars, including Trust Fund contributions) has fluctuated from a high of 3.3 percent in FY 2018 to negative 0.9 percent projected in FY 2021. By comparison, the NHE series compiled by the Centers for Medicare & Medicaid Services (CMS) has been growing at about 4.9 percent year-over-year for the same period.

COMPARISON OF CHANGE IN ANNUAL UMP FY AND NHE (CY) ESTIMATED EXPENDITURES OVER TIME, 2014–2021



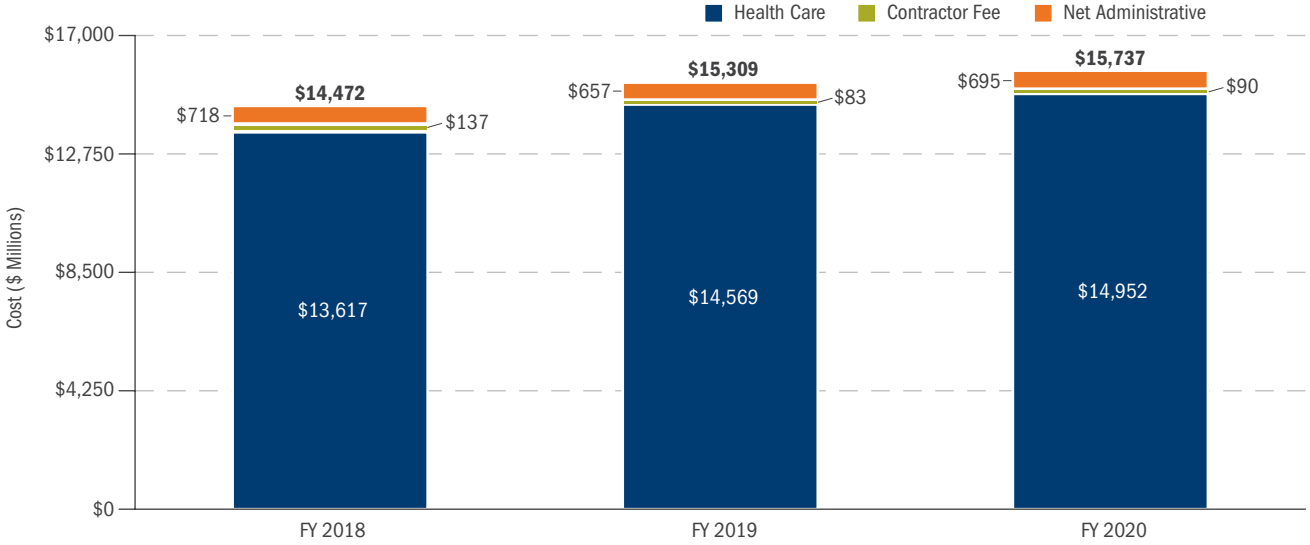
Sources: UMP cost and budget estimates, DHA/Resources and Management Directorate (J-8)/Budget and Execution Division, 9/30/2020, using NHE data from CMS, Office of the Actuary, NHE Projections 2019–2028, Tables Table 02, National Health Expenditure Amounts and Annual Percent Change by Type of Expenditure: Calendar Years 2012–2028; https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html
Note: DoD UMP data are in fiscal years; CMS NHE data are in calendar years.

PRIVATE-SECTOR CARE ADMINISTRATIVE COSTS

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

- Private-sector care (PSC) costs increased from $14,472 million in FY 2018 to $15,737 million (9 percent) in FY 2020. Costs increased by 6 percent in FY 2019 and by another 3 percent in FY 2020.
- On January 1, 2018, DHA began collecting Prime enrollment fees that were previously held by the contractors to offset their administrative costs. DHA collected $234 million in Prime enrollment fees during the nine months of FY 2018 that the new T2017 contract was in effect, $307 million in FY 2019, and $293 million in FY 2020. Net of Prime enrollment fees, PSC administrative costs decreased by 8 percent in FY 2019 but increased by 6 percent in FY 2020.
- Excluding contractor fees, net administrative expenses decreased from 5 percent of total PSC costs in FY 2018 ($718 million of $14,335 million) to 4 percent in FY 2020 ($695 million of $15,647 million). Including contractor fees (in both administrative and total costs), net administrative expenses decreased from 6 percent of total PSC costs in FY 2018 ($855 million of $14,472 million) to 5 percent in FY 2020 ($785 million of $15,737 million).
- Contractor fees declined by 34 percent between FY 2018 and FY 2020, due in part to lower incentive payments earned for obtaining discounts from hospitals and provider groups.

TRENDS IN PRIVATE-SECTOR CARE COSTS, FYs 2018–2020



Source: DHA/R&M (J-1/J-8)/CRM (Administrative Costs), 11/9/2020

[1] DHA has congressional authority to carry over 1 percent of its O&M funding into the following year. The amount carried forward from the prior-year appropriation was $200 million in FY 2018 and $315 million in FY 2019. No funding was carried over in FY 2020.

MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE)

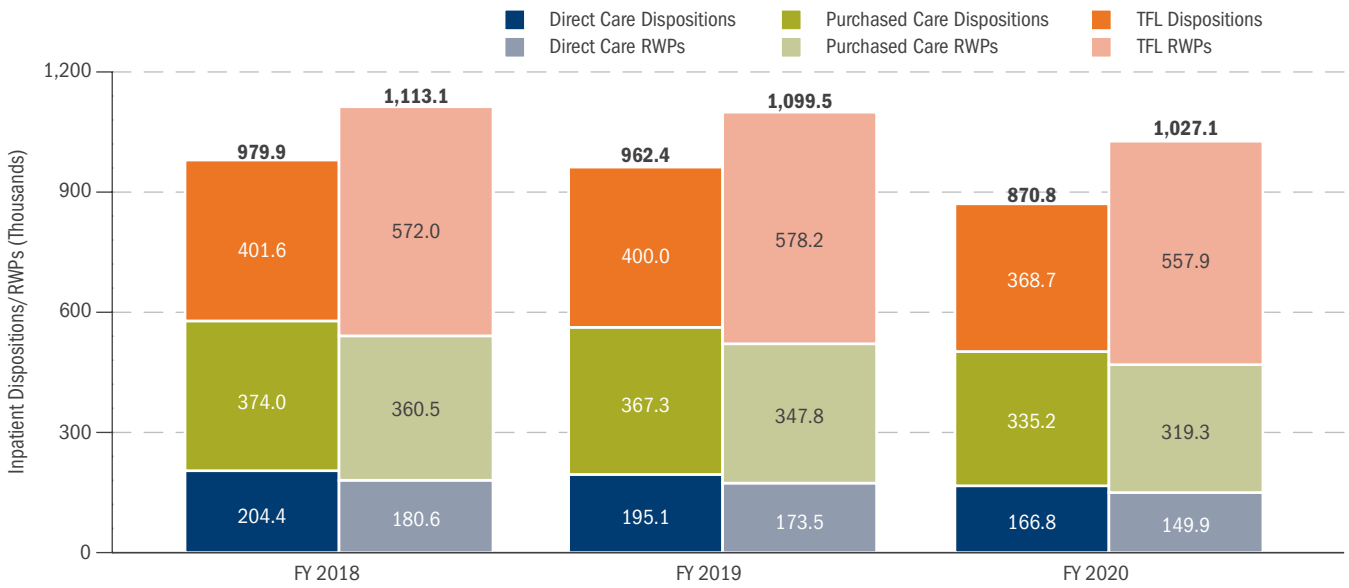
MHS Inpatient Workload

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.

Direct care utilization data from MHS GENESIS sites are excluded from the analyses because the MHS does not consider them to be reliable at this time.

- Both total inpatient dispositions (direct and purchased care combined) and RWPs declined by 13 percent between FY 2018 and FY 2020, excluding the effect of TFL. One likely reason for the large drop in total dispositions is the impact of the COVID-19 pandemic.[1]
- Direct care inpatient dispositions decreased by 18 percent and RWPs by 17 percent over the past three years. The large drop is partially due to the exclusion of MHS GENESIS data[2] and to the effects of COVID-19.
- Excluding TFL workload,[3] purchased care inpatient dispositions decreased by 10 percent while RWPs decreased by 11 percent between FY 2018 and FY 2020.
- Including TFL workload,[2] purchased care dispositions decreased by 9 percent while RWPs decreased by 6 percent between FY 2018 and FY 2020.
- Although not shown, about 9 percent of direct care inpatient workload (dispositions) was performed abroad in FY 2020. Purchased care and TFL inpatient workload performed abroad accounted for about 2 percent of the worldwide total.

TRENDS IN MHS INPATIENT WORKLOAD, FYs 2018–2020



Source: MHS administrative data, 2/5/2021

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

[2] The DoD's new electronic health record (EHR), MHS GENESIS, was deployed at four initial fielding sites in 2017: 92nd Medical Group, Fairchild Air Force Base, in February; Naval Hospital (NH) Oak Harbor in July; NH Bremerton in September; and Madigan Army Medical Center (AMC) in October (FY 2018). In September 2019, the DoD deployed MHS GENESIS to four additional locations: 60th Medical Group, Travis Air Force Base; Army Dental Clinic Presidio of Monterey; Naval Air Station Lemoore; and 366th Medical Group, Mountain Home Air Force Base. Of those eight sites, only four offer inpatient care. Any inpatient workload performed at those facilities from the deployment dates onward has not yet been fully captured in the MHS administrative data. MHS GENESIS went live at 10 other facilities on September 26, 2020, but that was too late in the fiscal year to have any appreciable effect on total inpatient utilization. Considering all direct care facilities except the MHS GENESIS sites, total inpatient workload decreased by 15 percent between FY 2018 and FY 2020. The MHS GENESIS hospitals contributed an additional 3 percent to the decrease in total direct care inpatient workload, resulting in the 18 percent decrease across the three years reported above.

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

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

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

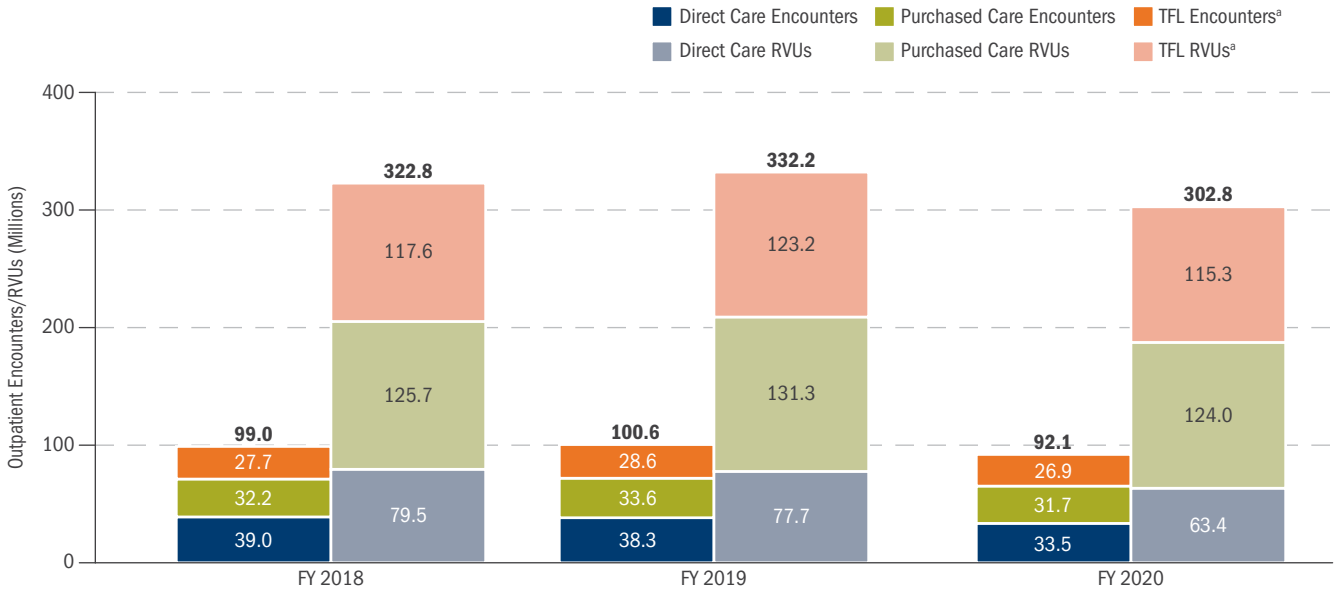
MHS Outpatient Workload

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

Direct care utilization data from MHS GENESIS sites are excluded from the analyses because the MHS does not consider them to be reliable at this time.

- Total outpatient encounters (direct and purchased care combined) decreased by 8 percent, while RVUs decreased by 9 percent between FY 2018 and FY 2020, excluding the effect of TFL. One likely reason for the large drop in total encounters is the impact of the COVID-19 pandemic.[1]
- Direct care outpatient encounters decreased by 14 percent[1] and RVUs by 20 percent over the past three years. The large drop is partially due to the exclusion of MHS GENESIS data[2] and to the impact of COVID-19.
- Excluding TFL workload, purchased care outpatient encounters decreased by 2 percent and RVUs by 1 percent. Including TFL workload, purchased care outpatient encounters and RVUs each decreased by 2 percent.[3]
- Although not shown, about 9 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 2018–2020



Source: MHS administrative data, 2/5/2021

[a] Purchased care only

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

[2] The DoD's new EHR, MHS GENESIS, was deployed at four initial fielding sites in 2017: 92nd Medical Group, Fairchild Air Force Base, in February; NH Oak Harbor in July; NH Bremerton in September; and Madigan AMC in October (FY 2018). In September 2019, the DoD deployed MHS GENESIS to four additional locations: 60th Medical Group, Travis Air Force Base; Army Dental Clinic Presidio of Monterey; Naval Air Station Lemoore; and 366th Medical Group, Mountain Home Air Force Base. Any outpatient workload performed at those facilities (and at clinics that report data to those facilities) from the deployment dates onward has not yet been fully captured in the MHS administrative data. MHS GENESIS went live at 10 other facilities on September 26, 2020, but that was too late in the fiscal year to have any appreciable effect on total outpatient utilization. Considering all direct care facilities except the MHS GENESIS sites, total outpatient workload decreased by 11 percent between FY 2018 and FY 2020. The MHS GENESIS facilities contributed an additional 3 percent to the decrease in total direct care outpatient workload, resulting in the 14 percent decrease across the three years reported above.

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

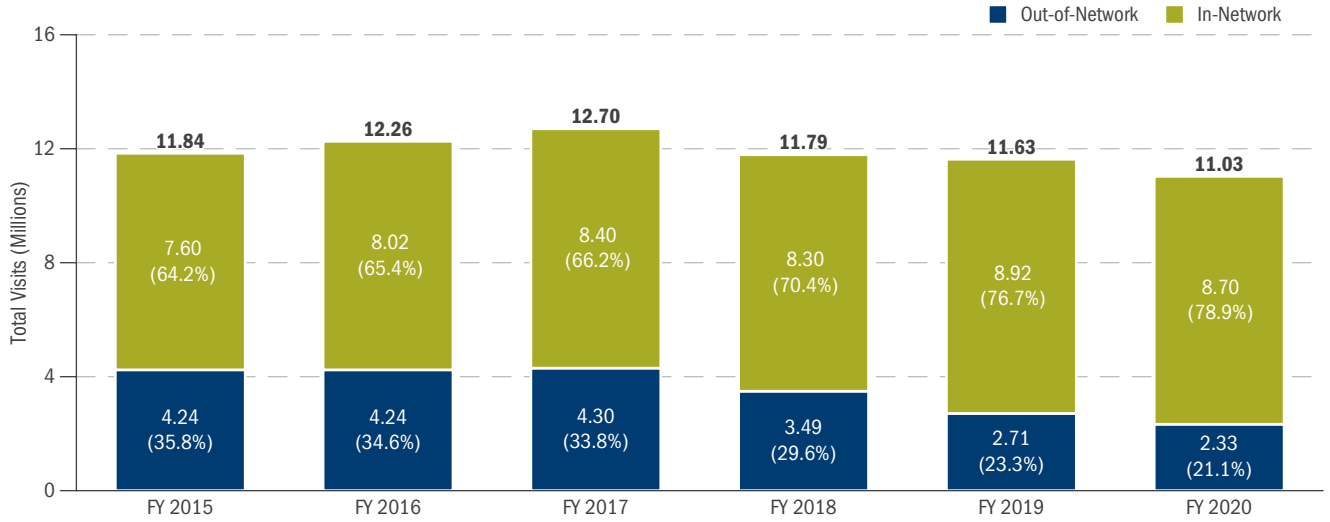
Note: Numbers may not sum to bar totals due to rounding.

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

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

For beneficiaries not enrolled in Prime, the ratio of in-network to out-of-network visits has steadily increased. In FY 2008, in-network visits accounted for only 46 percent of all non-Prime visits. By FY 2009, the number of in-network visits exceeded the number of out-of-network visits for the first time (51 percent). In FY 2020, 79 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 180).

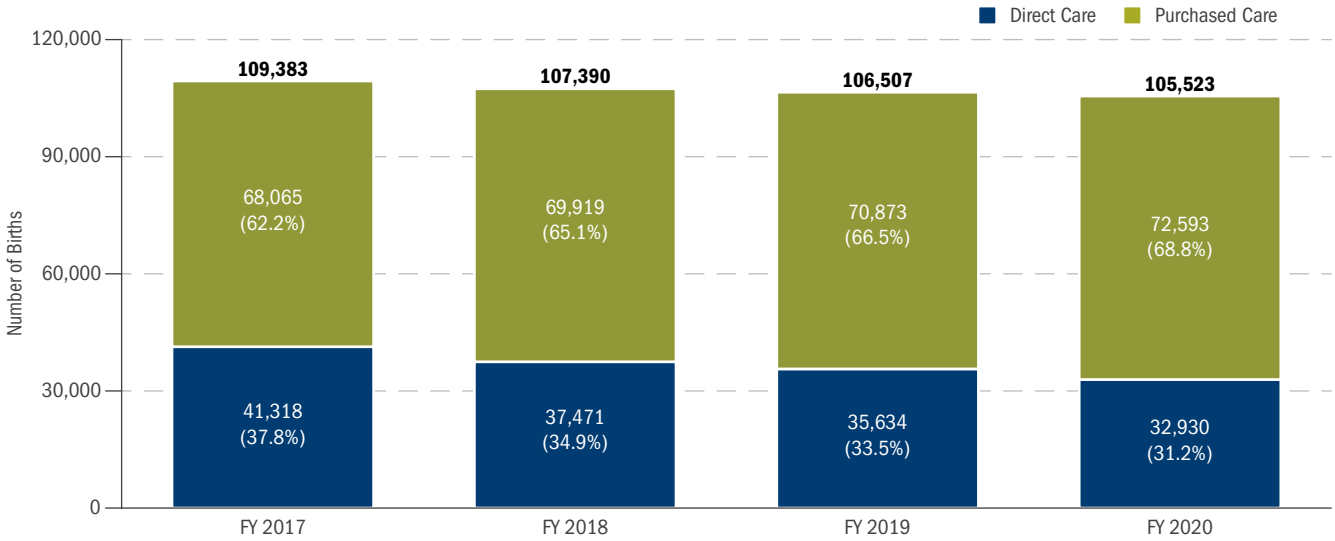
TRENDS IN OUT-OF-NETWORK VS. IN-NETWORK VISITS, FYs 2015–2020



MTF Market Share for Childbirths

Overall MTF obstetric (OB) market share decreased from 38 percent to 31 percent between FY 2017 and FY 2020. This trend is likely due, at least in part, to the migration of Prime enrollees from an MTF to a network PCM (see the table on page 36) and the downsizing of five MTF hospitals to clinics during that time period. In FY 2020, individual MTF shares in the U.S. ranged from 14 percent to 96 percent.

TRENDS IN MTF MARKET SHARE FOR CHILDBIRTHS, FYs 2017–2020



Source: MHS administrative data, 2/5/2021
Note: Numbers may not sum to bar totals due to rounding.

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

Urgent Care (UC) Utilization

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

- UC encounters increased by 76 percent from FY 2017 to FY 2020, while RVUs increased by 84 percent (FY 2017 not shown).
- The government share of the cost for UC increased by $59 million (89 percent) from FY 2017 to FY 2020 (FY 2017 not shown).
- UC utilization and costs increased steadily from FY 2017 to FY 2019 but leveled off in FY 2020.
- ADFMs with a military PCM constitute by far the largest share of total UC utilization and government cost.

TRENDS IN UC UTILIZATION, FYs 2018–2020

BENEFICIARY CATEGORY	ENROLLMENT STATUS	FY	ENCOUNTERS	RVUs	GOVERNMENT COST
Active Duty	All	2018	83,594	229,573	$10,070,733
		2019	115,221	314,274	$13,629,820
		2020	125,260	334,858	$14,726,220
Active Duty Family Members	Mil PCM	2018	245,989	632,647	$26,600,111
		2019	367,714	942,692	$39,176,902
		2020	313,627	822,602	$34,423,506
	Civ PCM	2018	78,546	198,143	$8,587,540
		2019	135,050	343,822	$14,727,620
		2020	142,548	374,193	$16,206,770
	Non-Enrolled	2018	202,919	512,182	$15,007,579
		2019	239,048	607,504	$17,064,135
		2020	235,639	614,053	$18,214,651
Retirees and Family Members <65	Mil PCM	2018	133,739	349,945	$11,535,865
		2019	162,808	426,473	$12,846,927
		2020	156,770	408,022	$12,554,847
	Civ PCM	2018	114,412	297,764	$10,103,647
		2019	155,746	407,626	$12,714,024
		2020	172,720	454,617	$14,750,973
	Non-Enrolled	2018	191,226	481,052	$11,206,326
		2019	218,566	554,025	$12,531,249
		2020	216,989	560,491	$13,425,110
Retirees and Family Members ≥65	All	2018	341	799	$18,521
		2019	297	655	$133,103
		2020	257	573	$235,351
Total	**All**	**2018**	**1,050,766**	**2,702,105**	**$93,130,320**
		2019	**1,394,450**	**3,597,071**	**$122,823,779**
		2020	**1,363,810**	**3,569,410**	**$124,537,429**

Source: MHS administrative data, 2/5/2021

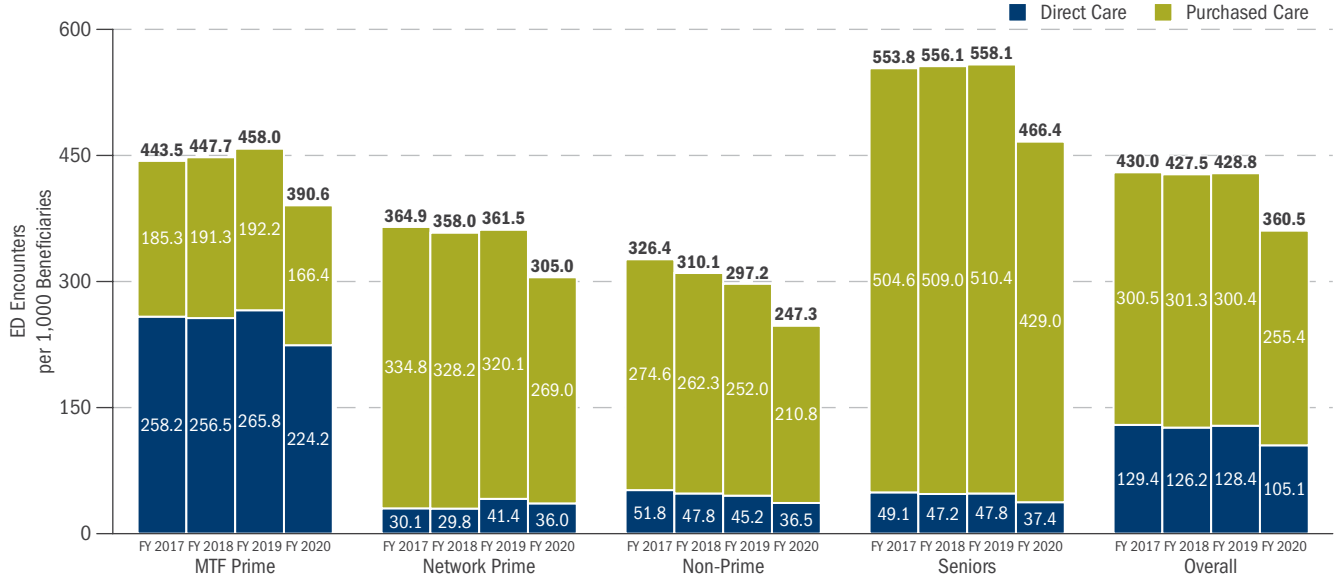
MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE) *(CONT.)*

ED Utilization

ED utilization is sometimes used as an indirect measure of access to care, particularly for Prime enrollees. Using data from the National Health Interview Survey, the National Center for Health Statistics (NCHS) reports that almost 80 percent of civilians who use the ED do so because of lack of access to other providers.[1] Although not equivalent, it is reasonable to ask whether a similar situation occurs in the MHS, in particular whether Prime enrollees excessively use EDs as a source of care if they cannot get timely access to their PCMs under the normal appointment process. To provide a preliminary evaluation of this issue, direct and purchased care ED utilization rates were compared across three enrollment groups: MTF enrollees, network enrollees, and non-enrollees. The rate for each enrollment group was calculated by dividing ED encounters by the average population in that group. The rates were then adjusted to reflect the age/sex distribution of the overall MHS population. Seniors (age ≥65) are broken out separately for completeness, but they are not compared with the three enrollment groups.

- ED utilization per capita declined for Prime enrollees from FY 2017 to FY 2020 (12 percent for MTF enrollees and 16 percent for network enrollees). The rate for non-Prime enrollees declined by 24 percent over the same time period. One possible reason for the decline is increased access to urgent care by TRICARE beneficiaries (see page 49).
- In FY 2020, MTF Prime enrollees had an ED utilization rate 28 percent higher than that of network Prime enrollees and 58 percent higher than that of non-enrollees. Network Prime enrollees had an ED utilization rate 23 percent higher than that of non-enrollees.
- For MTF Prime enrollees, 43 percent of ED encounters were in purchased care facilities (not necessarily in-network) in FY 2020.
- Children under five years old had the highest ED utilization rate for all enrollment groups (not shown).
- The FY 2020 rate of 361 encounters per 1,000 beneficiaries is 17 percent lower than the civilian rate of 433 per 1,000 reported in CY 2017, the most recent year for which data are available. One likely reason for the sudden drop in MHS ED encounters in FY 2020 is the impact of the COVID-19 pandemic.[2] The civilian rate is considerably higher than the MHS rate because the former was calculated prior to the pandemic.

ED UTILIZATION BY ENROLLMENT STATUS AND SOURCE OF CARE (ENCOUNTERS PER 1,000 BENEFICIARIES), FYs 2017–2020



Source: MHS administrative data, 2/5/2021

[1] Gindi, R. M., et al., "Emergency Room Use Among Adults Aged 18–64: Early Release of Estimates from the National Health Interview Survey, January–June 2011," NCHS, May 2012, https://www.cdc.gov/nchs/data/nhis/earlyrelease/emergency_room_use_january-june_2011.pdf.

[2] Centers for Disease Control and Prevention (CDC), "Impact of the COVID-19 Pandemic on Emergency Department Visits — United States, January 1, 2019–May 30, 2020." MMWR Morb Mortal Wkly Rep 2020; 69:699–704.

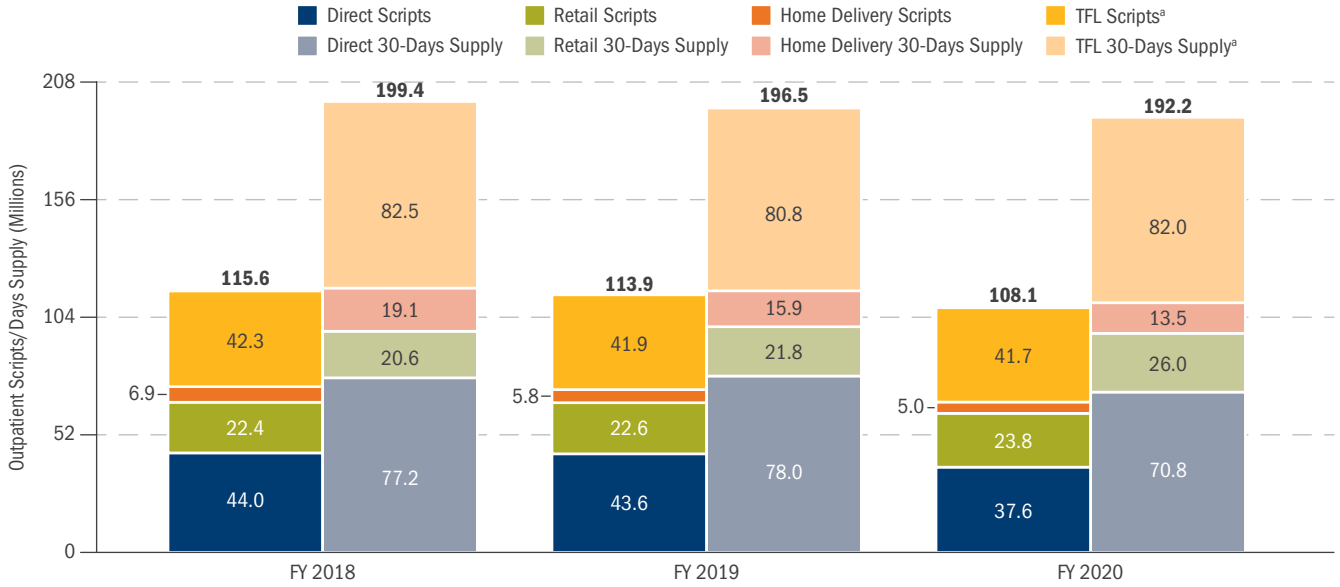
Note: Numbers may not sum to bar totals due to rounding.

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

MHS Prescription Drug Workload

TRICARE beneficiaries can fill prescription medications at MTF pharmacies through home delivery (mail order), at TRICARE retail network pharmacies, and at non-network pharmacies. Total outpatient prescription workload is measured two ways: as the number of prescriptions and as the number of days supply (in 30-day increments). Total prescription drug workload (all sources combined) decreased between FY 2018 and FY 2020 (prescriptions fell by 9 percent and days supply by 6 percent), excluding the effect of TFL purchased care pharmacy usage.

TRENDS IN MHS PRESCRIPTION WORKLOAD, FYs 2018–2020



Source: MHS administrative data, 2/5/2021

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

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

- Direct care prescriptions decreased by 14 percent, while days supply declined by 8 percent between FY 2018 and FY 2020.
- Purchased care prescriptions (retail and home delivery combined) decreased by 2 percent and days supply by less than 1 percent from FY 2018 to FY 2020, excluding TFL utilization. Including TFL utilization, purchased care prescriptions decreased by 2 percent and days supply by 1 percent.
- Although not shown, about 6 percent of direct care prescriptions were issued abroad in FY 2020. Purchased care prescriptions issued abroad accounted for 2 percent of the worldwide total.

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

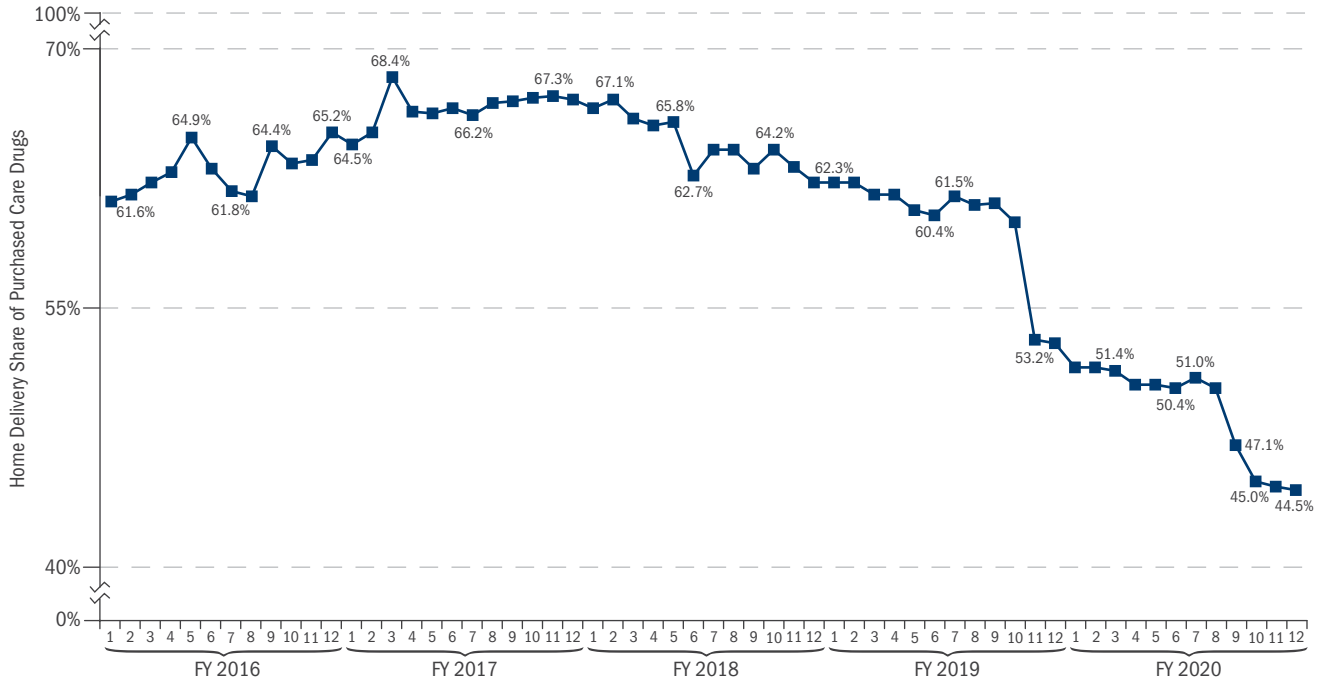
MHS Prescription Drug Workload *(cont.)*

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.

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

The home delivery share of total 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 2016 to FY 2017, the home delivery share of purchased care pharmacy utilization (as measured by days supply) increased from 63 percent to 67 percent.[1] However, in FY 2018, the home delivery copayment for a 90-day supply of generic formulary drugs rose from $0 to $7 and then to $10 in FY 2020, which reduced the disparity in copayments between home delivery and retail drugs. This likely contributed to the decrease in the home delivery share of total purchased care utilization in FY 2018 (65 percent), FY 2019 (60 percent), and FY 2020 (49 percent).

TREND IN HOME DELIVERY UTILIZATION (DAYS SUPPLY) AS A SHARE OF TOTAL PURCHASED CARE UTILIZATION, FYs 2016–2020



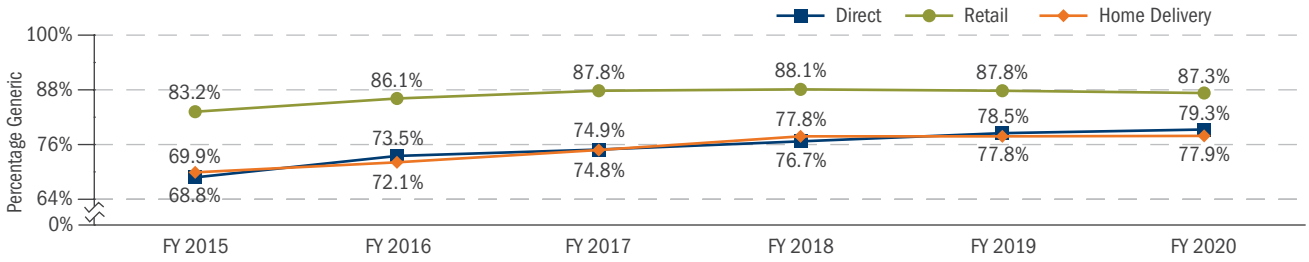
Source: MHS administrative data, 2/5/2021

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

COST SAVINGS EFFORTS IN DRUG DISPENSING

- The rate of generic drug dispensing has been increasing for all sources: direct, retail, and home delivery. Direct care pharmacies have seen the greatest increase, from 70 percent in FY 2015 to 79 percent in FY 2020. However, retail pharmacies dispensed the highest percentage of generic drugs in FY 2020 (87 percent).
- The retail generic drug dispensing rate in FY 2020 was only slightly lower than that of the private sector (90 percent).[1] However, the direct care and home delivery rates were 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 2020 was $83 versus $15 for direct care, $336 (net of manufacturer refunds) versus $9 for retail pharmacies, and $175 versus $12 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 2015–2020

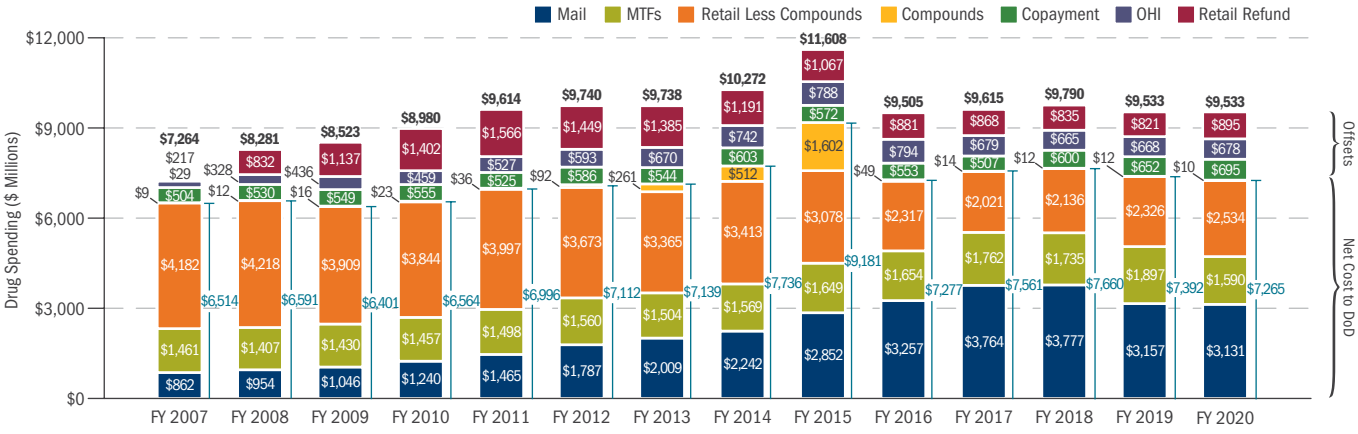


Source: MHS administrative data, 2/5/2021

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 2020, the refunds are estimated to have saved the DoD $895 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. After the DoD was able to control compound drug prices, net DoD costs fell by 21 percent in FY 2016 and have remained relatively constant since then.

MHS OUTPATIENT DRUG SPENDING, FYs 2007–2020



Source: Pharmacy Data Transaction Service (PDTS) Data Warehouse, 12/16/2020; DHA (Defense Health Agency) Pharmacy Operations Division (POD) (refunds), 12/9/2020

[1] Association for Accessible Medicines, "2020 Generic Drug & Biosimilars Access & Savings in the U.S. Report," 2020, https://accessiblemeds.org/sites/default/files/2020-09/AAM-2020-Generics-Biosimilars-Access-Savings-Report-US-Web.pdf.

[2] The direct care generic dispensing rate may be lower than in the private sector because the MHS can frequently buy a branded drug at a lower cost, either under contract or at federal pricing, than the generic drug (this occurs during the 180-day exclusivity period when there is only one generic drug competing against the branded drug). This is not the case for most commercial plans. The MHS is also forbidden by law to purchase generic drugs from countries that do not comply with the requirements established by the Trade Agreements Act. In addition, the MHS has a higher fraction of brand-name maintenance drugs. As per NDAA FY 2016, these drugs must be dispensed at the MTF or home delivery point of service.

Notes:

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

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

DoD/VA Pharmacy Contracting Initiatives

The Departments continued to maximize efficiencies through joint efforts when possible. National contracts were at an all-time high with 222 existing contracts, of which 60 became effective in FY 2020. There are currently 21 joint contracts pending at the National Acquisition Center and 18 pending at the Defense Logistics Agency. The DoD/VA pharmacy team identified 60 commonly used pharmaceutical products and manufacturers for potential joint contracting action and continue to seek new joint contracting opportunities where practicable. In FY 2020, the VA spent $479 million on joint national contracts, and the DoD spent $206 million over the same time period.

SPECIALTY DRUG COST TRENDS

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

Although the definition of a specialty drug varies across insurers, the DoD has adopted the following guidelines in order to designate a medication as a specialty drug: (1) cost is greater than or equal to $500 per dose or greater than or equal to $6,000 per year; (2) has difficult or unusual process of delivery; (3) requires patient management beyond traditional dispensing practices; or (4) as defined by 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 reviews new specialty medications as part of its new drug review process, with a particular focus on the large number of new oncological agents being introduced to the market.

TOP 20 SPECIALTY CLASSES ($ MILLIONS), AS DEFINED BY P&T COMMITTEE, FYs 2018–2020

FY 2020 RANK	SPECIALTY CLASS	FY 2018	FY 2019	FY 2020	FYs 2019–2020 % CHANGE[a]
1	Oncological	$758	$894	$1,062	19%
2	Targeted Immunomod Biologics	$418	$529	$619	17%
3	Multiple Sclerosis	$195	$183	$178	–2%
4	Antiretrovirals	$127	$137	$143	5%
5	Pulmonary Arterial Hypertension	$97	$119	$130	9%
6	Cystic Fibrosis	$42	$54	$99	83%
7	Immunological Misc	$41	$68	$93	37%
8	Antihemophilic Factors	$73	$68	$66	–3%
9	Sleep Disorders	$28	$50	$63	26%
10	Pulmonary-1 (e.g., nintedanib, pirfenidone)	$56	$55	$60	9%
11	Neurological Misc (e.g., botulinum toxin, VMAT2s)	$25	$35	$60	73%
12	Metabolic Misc (e.g., asfotase alfa, sapropterin)	$27	$36	$46	28%
13	Endocrine Misc (e.g., cinacalcet, deferasirox)	$47	$51	$46	–9%
14	Corticosteroid-Immune Modulators	$50	$43	$43	–1%
15	Hematological	$22	$27	$34	27%
16	Osteoporosis	$38	$36	$30	-17%
17	Gastrointestinal-2	$16	$22	$30	33%
18	Respiratory Misc	$21	$21	$22	8%
19	Cardiovascular Misc	$16	$21	$22	4%
20	Antibiotics	$14	$18	$20	9%

Source: PDTS Data Warehouse, 12/16/2020

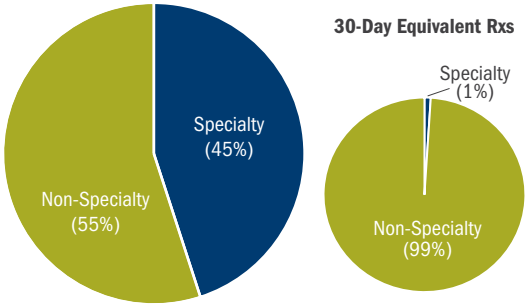
[a] The percentage changes are based on the original unrounded numbers.

Note: FY 2020 Q4 Specialty Agent Reporting List applied to all data; total costs adjusted for retail refunds, MTF prime vendor (PV) cost per unit, and home delivery PV cost per unit.

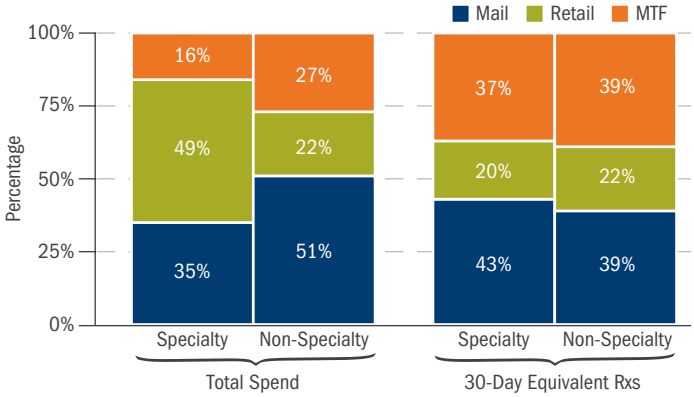
SPECIALTY DRUG COST TRENDS *(CONT.)*

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

FY 2020 TOTAL SPENDING



FY 2020 TOTAL SPENDING BY POINT OF SERVICE



Source: PDTS Data Warehouse, 12/16/2020

TOTAL ESTIMATED SPENDING ($ MILLIONS) BY QUARTER, FYs 2017–2020

	FY 2017				FY 2018				FY 2019				FY 2020			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Non-Specialty	$1,152	$1,245	$1,237	$1,149	$1,084	$1,090	$1,087	$1,061	$1,058	$1,126	$1,130	$1,128	$1,050	$980	$899	$982
Specialty	$488	$545	$551	$550	$551	$592	$596	$621	$612	$665	$685	$729	$739	$794	$788	$828
Percentage Specialty[a]	29.8%	30.4%	30.8%	32.4%	33.7%	35.2%	35.4%	36.9%	36.7%	37.1%	37.7%	39.3%	41.3%	44.8%	46.7%	45.7%

Source: As of 12/16/2020; based on Specialty Agent Reporting List for applicable quarters; totals adjusted for retail refunds (FY 2020 Q3 refund per unit applied to FY 2020 Q4 data), copayments, and against PV cost per unit for MTF and home delivery drugs.

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

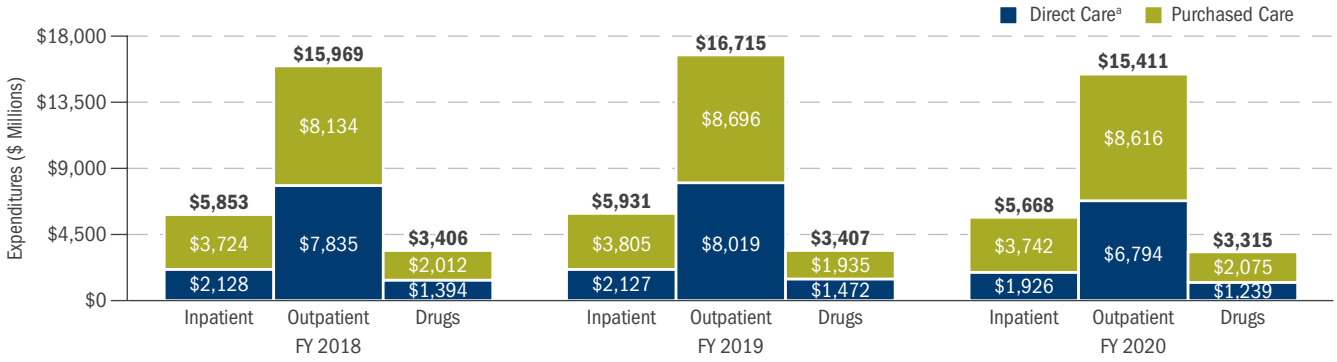
- In FY 2020, specialty drugs accounted for less than 1 percent of total MHS prescription drug utilization (30-day equivalents), but for 45 percent of total spending.
- As a percentage of total drug costs, specialty drug costs continued to increase from FY 2013 to FY 2020. A large proportion of specialty spend comes from retail prescriptions, reflecting the limited distribution mechanisms in place for many of these agents. This limits availability at mail order and MTFs, which are generally lower cost points of service.
- The highest spend specialty class, oncological agents, accounted for about $1,062 million in drug spend in FY 2020, up from $891 million in FY 2018. The top five oncological subclasses (by total FY 2020 spend) were multiple myeloma ($286 million), breast cancer ($117 million), renal cell carcinoma ($89 million), second generation antiandrogens ($74 million), and lung cancer ($66 million). Other subclasses accounted for another $430 million.
- The DoD P&T Committee considers the clinical and cost effectiveness of reviewed specialty agents with the end goal of selecting safe, efficacious, and cost-effective treatments for beneficiaries. The Committee reviews new drugs shortly after Food and Drug Administration (FDA) approval, including all new specialty agents, in order to promote appropriate use through formulary management tools such as prior authorization and to evaluate ongoing strategies for drug class evaluations in classes where two or more agents compete for the same clinical niche.

MHS COST TRENDS

Net of MERHCF costs, total DoD expenditures for health care decreased by 3 percent between FY 2018 and FY 2020. Inpatient, outpatient, and prescription drug expenses each decreased by 3 percent.

- The share of DoD expenditures for outpatient care relative to total expenditures for inpatient and outpatient care remained at 73 percent from FY 2018 to FY 2020. For example, in FY 2020, DoD expenses for inpatient and outpatient care totaled $21,079 million, of which $15,411 million were for outpatient care, for a ratio of $15,411/$21,079 = 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 brand-name drugs accrued to the years in which the drugs were dispensed.
- In FY 2020, the DoD spent $2.72 on outpatient care for every $1 spent on inpatient care.

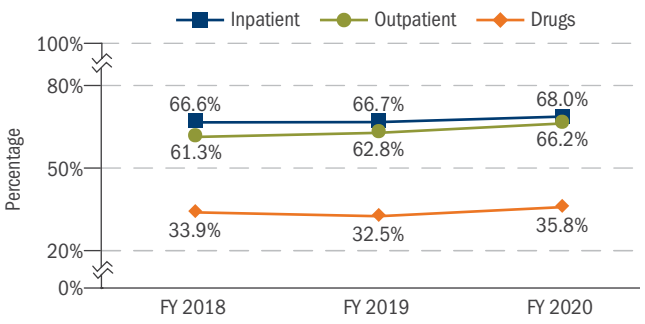
TRENDS IN DoD EXPENDITURES FOR HEALTH CARE (EXCLUDING MERHCF), FYs 2018–2020



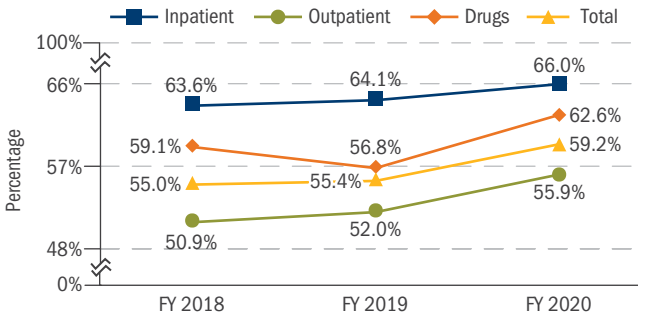
[a] Direct care prescription costs include an MHS-derived dispensing fee.
Note: Numbers may not sum to bar totals due to rounding.

- The purchased care shares of total inpatient, outpatient, and prescription drug utilization each increased from FY 2018 to FY 2020. The increases were one percentage point for inpatient, five percentage points for outpatient, and two percentage points for prescription drugs.
- The purchased care share of total MHS costs increased by four percentage points between FY 2018 and FY 2020. The purchased care share of total inpatient costs increased by two percentage points, the purchased care share of total outpatient costs increased by five percentage points, and the share of total prescription drug costs increased by four percentage points.

TRENDS IN PURCHASED CARE UTILIZATION[a] AS PERCENTAGE OF MHS TOTAL BY TYPE OF SERVICE, FYs 2018–2020



TRENDS IN PURCHASED CARE COST AS PERCENTAGE OF MHS TOTAL BY TYPE OF SERVICE, FYs 2018–2020



Source: MHS administrative data, 2/5/2021

[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.

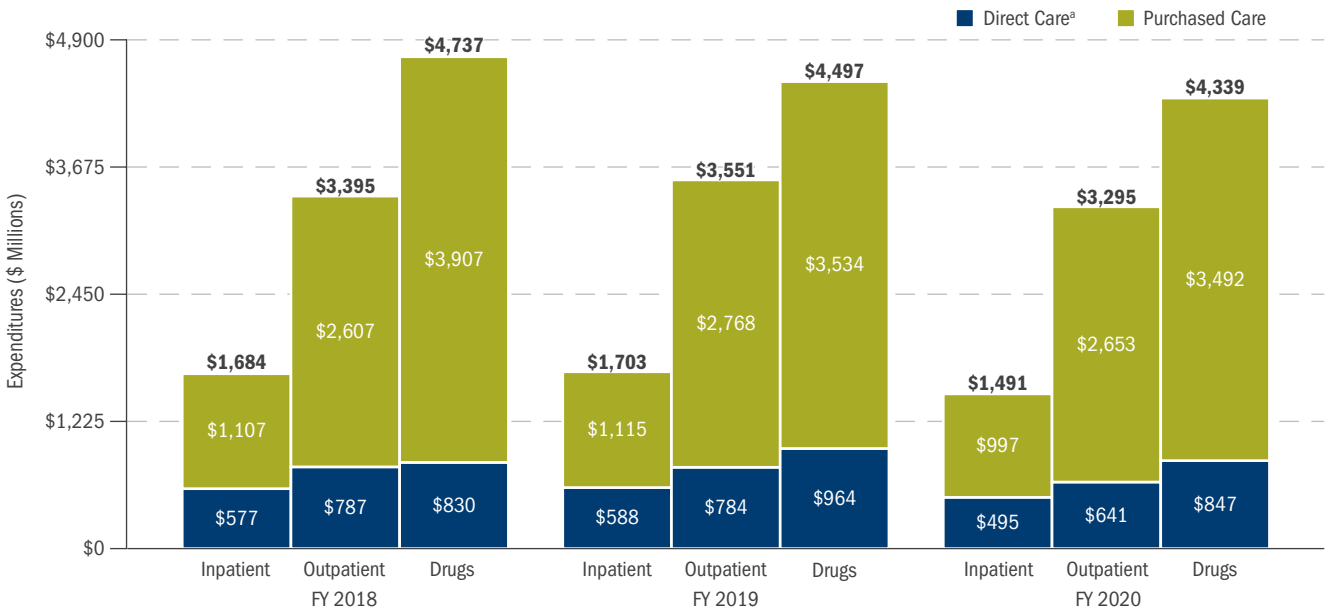
MHS COST TRENDS *(CONT.)*

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 decreased from $9,816 million in FY 2018 to $9,125 million in FY 2020 (7 percent), including manufacturer refunds on retail prescription drugs. The percentage of TFL-eligible beneficiaries who filed at least one claim dropped from 84 percent in FY 2018 to 81 percent in FY 2020.

- Total DoD direct care expenses for MERHCF-eligible beneficiaries decreased by 10 percent from FY 2018 to FY 2020. Inpatient costs fell by 14 percent and outpatient costs fell by 19 percent, but prescription drug costs increased by 2 percent.
- In FY 2018, TRICARE Plus enrollees accounted for 73 percent of DoD direct care inpatient and outpatient expenditures on behalf of MERHCF-eligible beneficiaries. That percentage dropped to 71 percent by FY 2020 (not shown).
- Including prescription drugs, TRICARE Plus enrollees accounted for 59 percent of total DoD direct care expenditures on behalf of MERHCF-eligible beneficiaries in FY 2018. That percentage dropped to 55 percent by FY 2020 (not shown).
- Total purchased care MERHCF expenditures decreased by 6 percent from FY 2018 to FY 2020. Inpatient expenditures declined by 10 percent, outpatient expenditures increased by 2 percent, and prescription drug expenditures decreased by 11 percent.

MERHCF EXPENDITURES BY TYPE OF SERVICE, FYs 2018–2020

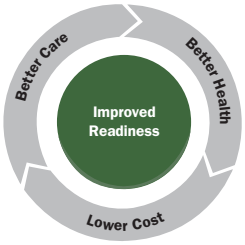


Source: MHS administrative data, 2/5/2021

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

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

MEDICAL READINESS OF THE FORCE



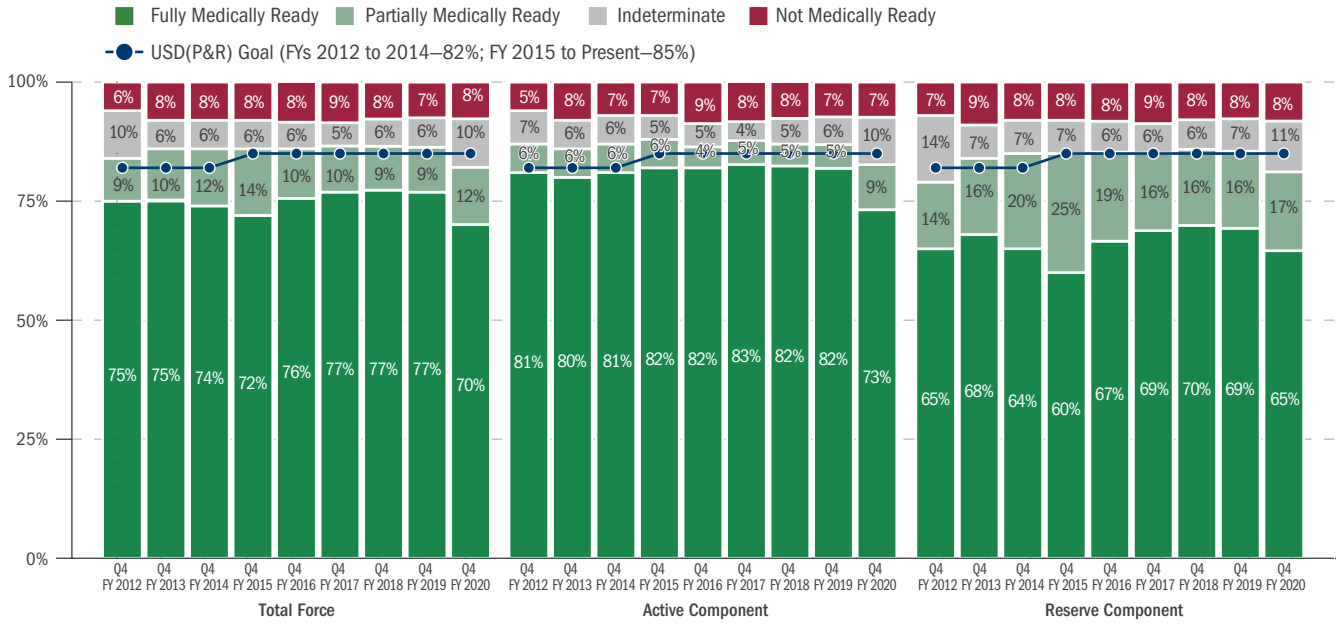
The Department of Defense (DoD) Individual Medical Readiness (IMR) program assesses individual Service members' compliance with established medical readiness elements and determines medical deployability in support of military operations. The IMR metric enables commanders to monitor and sustain Service members' and units' medical, dental, and behavioral health requirements necessary to perform their assigned missions. The DoD began tracking IMR status in 2003 to help ensure that Service members, both Active Component (AC) and Reserve Component (RC), were medically ready to deploy when required. The six requirements tracked per DoD Instruction 6025.19 "Individual Medical Readiness" include: Completion of Dental Readiness Assessments with Satisfactory Dental Health, Completion of Periodic Health Assessments, Deployment-Limiting Medical Conditions Status, Current Immunization Status, Completion of Required Medical Readiness Laboratory Tests, and Possession of Required Individual Medical Equipment.

The IMR chart below shows that by the end of fiscal year (FY) 2020, the Total Force Medical Readiness (TFMR), at 82 percent, did not meet the Office of the Under Secretary of Defense for Personnel and Readiness (OUSD[P&R]) goal of 85 percent, with the AC and RC both at 82 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 2012 has decreased by two percentage points (from 84 percent in FY 2012 to 82 percent in FY 2020). The AC medical readiness remained steady from FY 2012 to FY 2019 (at 87 percent), but then decreased five percentage points in FY 2020 (from 87 percent to 82 percent), and the RC increased by three percentage points (from 79 percent in FY 2012 to 82 percent in FY 2020).

As TFMR has improved, the USD(P&R) medical readiness goal has increased, from 82 percent from FY 2012 to FY 2014, to 85 percent in FY 2015 to present. The Total Force and, separately, the AC and RC have met the higher OUSD(P&R) goal since it was last increased in FY 2015 until FY 2020. The TFMR rate decreased from FY 2020 Q2 to FY 2020 Q4 due to the global coronavirus disease 2019 pandemic's effect on military medical capabilities and access to care, which resulted in all three groups falling short of the goal. Increasing the medical readiness goal above 85 percent to 90 percent is currently being pursued by the OUSD(P&R).

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

OVERALL INDIVIDUAL MEDICAL READINESS STATUS (ALL COMPONENTS NOT DEPLOYED), FY 2012 Q4 TO FY 2020 Q4



Source: Defense Health Agency (DHA), Public Health Directorate, 10/5/2020
Note: Percentages may not sum to 100 percent due to rounding.

HEALTHY, FIT, AND PROTECTED FORCE

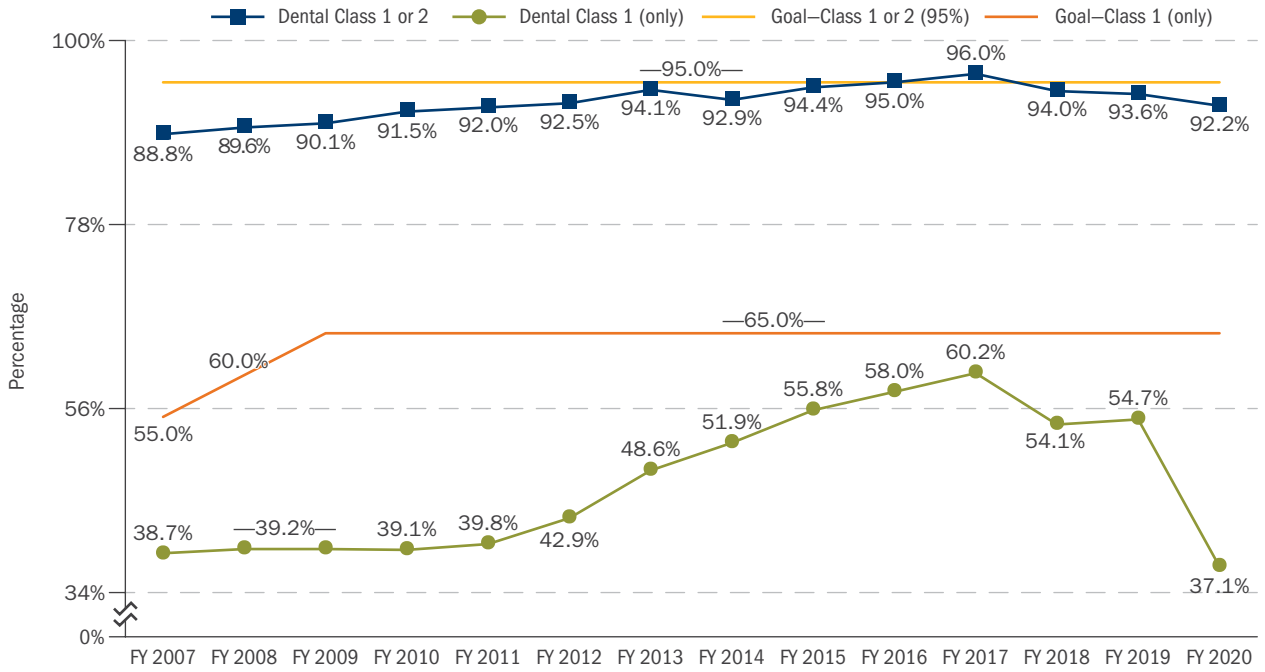
Key among the measures of performance related to providing an efficient and effective deployable medical capability and offering force medical readiness are those related to how well we (1) maintain the worldwide deployment capability of our Service members, as in dental readiness and immunization rates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

DENTAL READINESS

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

- Overall MHS dental readiness in the combined Classes 1 and 2 remains high. Following a generally steady annual increase since FY 2007, the combined Classes 1 and 2 percentage fell in FY 2018 just under 94 percent and in FY 2020 fell to 92.2 percent, down from 96 percent in FY 2017, falling short of the long-standing MHS goal of 95 percent.
- The rate for Active Duty personnel in Dental Class 1 had risen steadily since FY 2010 (39.1 percent), but fell from 60.2 percent in FY 2017 to 37.1 percent in FY 2020—28 percentage points short of the MHS goal. The MHS goal of 65 percent was increased in FY 2009 from the 55 percent goal established in FY 2007.

ACTIVE DUTY DENTAL READINESS: PERCENT CLASS 1 OR 2, FYs 2007–2020



Source: The Services' Dental Corps–DoD Dental Readiness Classifications, 9/30/20

Definitions:

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

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

MAINTENANCE OF EXPEDITIONARY CURRENCY AND COMPETENCY: THE CLINICAL READINESS PROJECT

The MHS is unique in that it must provide expertise in stateside hospitals as well as across the globe in support of military operations. The MHS sustains the clinical readiness of its providers through routine medical practice, particularly in military medical treatment facilities (MTFs). The key to the military mission is identifying which aspects of care are relevant to clinical "readiness" and ensuring that military providers are proficient in those areas. While there are many components that comprise readiness, the basis of the DoD's expeditionary medical systems rests on individual clinical proficiency. The Clinical Readiness Project provides an innovative approach to measuring, evaluating, and sustaining individual clinical proficiency, with a focus on the Combat Casualty Care Team (CCCT), shown in CCCT+ Specialties below, although the process can be applied generally. The metrics are used to assess the ability of an MTF or a civilian/military partnership to support clinical readiness.

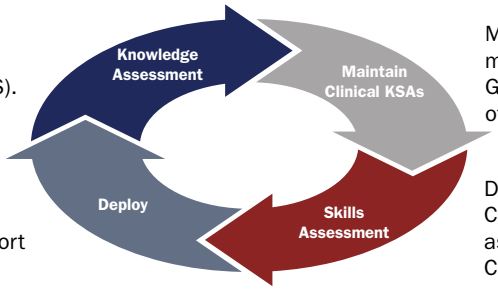
CCCT+ SPECIALTIES			
1	General Surgery (and Colorectal)	9	Ophthalmology
2	Orthopedic Surgery	10	Cardiothoracic (CT) Surgery
3	Critical Care	11	Vascular Surgery
4	Emergency Medicine	12	Plastic Surgery
5	Anesthesiology (and Certified Registered Nurse Anesthetists)	13	Urology
6	Emergency Department (ED)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

Clinical Currency

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

KSA DEVELOPMENT PROCESS

Individual assessment of expeditionary clinical knowledge. KSA lists periodically updated via the Joint Trauma System (JTS).



MTF practice aligned with KSAs to maintain readiness-related clinical skills. Gaps addressed through the Department of Veterans Affairs (VA) and partnerships.

Knowledge assessment and skills training information provided to Services to determine "deployment ready" in support of Commander's assessment.

Deliver in pre-deployment "window." Complete expeditionary clinical skills assessment, train/maintain as needed. Conduct team training as necessary.

Clinical Currency Metric

To date, clinical readiness KSAs have been developed for 16 CCCT specialties. The clinical currency measure and threshold were developed for seven of the CCCT specialties, with the remaining specialties in late stage development. Dashboards for six of the specialties are available on CAC-enabled CarePoint for use in Service, market, and facility decision making. Additionally, there are plans for development of metrics and assessments for operating room nurses and technicians. The KSA Program will collaborate with assessment for Role 1 enlisted medical personnel currently in development by the JTS Committee on Tactical Combat Casualty Care.

The Joint Knowledge, Skills, and Abilities Program Management Office (JKSA PMO) team completed 47 non-CCCT specialty Expeditionary Scopes of Practice (ESPs), and coordinated the first package of 29 with the Service Manpower and Reserve Affairs (M&RAs). An additional 18 non-CCCT specialties are complete and are in the coordination process within the Bureau of Medicine and Surgery initiated in February 2020. Six additional non-CCCT specialties are currently in development.

The Department has implemented a PMO to be hosted by the DHA that will manage the sustainment and development of clinical readiness metrics for additional specialties. In the next year, the Department will begin expansion of readiness metrics into nursing and enlisted medical specialty areas.

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

Knowledge Assessment

Periodic knowledge assessment assures the sustainment of clinical proficiencies by identifying gap areas that may challenge expeditionary military surgeons, and informing the requirements for targeted training resources to assure ongoing readiness. Knowledge assessments are specialty specific and supported through Tri-Service development and implementation in partnership with the American College of Surgeons. Implementation outcomes for General Surgery yielded a rigorous, high-reliability exam with strong psychometric integrity covering eight expeditionary surgical domains. Test outcomes documented performance gaps in multiple domains, as well as differentiated between subspecialty training and deployment experience. Test forms of 200 items each were completed by 238 surgeons of varying experience levels, with a mean score of 73 percent. Test outcomes documented performance gaps in multiple domains, as well as differentiated between subspecialty training and deployment experience. The outcomes underscore the critical need to identify and address readiness knowledge gaps prior to deployment through focused training resources designed to assure clinical competency and currency. To reduce identified knowledge gaps, on-demand, multimedia-supported training resources developed in partnership with the American College of Surgeons (ACS) will be available on the ACS website in September 2020. Knowledge assessments will be implemented every three years to identify areas of knowledge decay and inform ongoing training refreshment intervals. This process has been replicated for orthopedics, critical care and trauma surgery with the remainder of surgical specialties and emergency medicine currently in development. The orthopedic surgery and trauma surgery exams were opened to test-takers this Fall with results pending. The development of an assessment for both critical care and emergency nursing are also currently underway in conjunction with ongoing TIP-TOP Project at the JTS.

Skills Assessment

Current training and practice do not fully prepare expeditionary surgeons and their teams to perform vital life, limb, and eyesight saving procedures. The existing Emergency War Surgery Course (EWSC) is an inconsistently funded and nominally enforced "mandate" that suffers from lack of standardization, low faculty to student ratios, dependence on live tissue, and does not provide meaningful assessment of participant's ability to competently perform the skills. We have developed and validated a standardized skills course (ASSET+) that utilizes best-in-class educational principles to teach and robustly assess over 25 life-, limb-, and eyesight-saving procedures using a partially perfused fresh cadaver model and procedure-specific simulators, in a time-pressured fashion. During the two-day course, participants receive one-on-one hands-on training with four experienced trauma surgeons and selected subspecialists who provide real-time assessment and individualized feedback.

Initial experience with this course over the last year has demonstrated significant improvements in participant's integration of knowledge, skills, decision making, and confidence to handle injuries likely to be seen in the expeditionary environment, using a summative assessment metric. Instructors and Surgical Technician team members have also found the course to be extremely valuable as preparation for expeditionary care. This novel educational and assessment paradigm is applicable to all medical specialties, and the ongoing lessons learned will be integrated into procedural training for all expeditionary team members. Importantly, outcomes from the first year of skills assessment implementation demonstrate significant correlation between individual KSA metric values and performance of critical trauma surgical procedures such as control of bleeding from major blood vessels. This underscores the link between ongoing complex elective and emergency surgical care and the key skills needed during deployment.

In addition, the Combat Orthopedic Trauma Skills (COTS+) course has been developed and initial course conducted in September 2020. This course is similar to ASSET+ with the focus on orthopedic surgeons. The COTS+ has been implementated as the pre-deployment war surgery course for orthopedic surgeons.

The ASSET+ and COTS+ courses are designed to fully replace the existing EWSC as a doctrinally mandated and centrally funded effort intended to be delivered to all military surgeons either every two years or in a pre-deployment window. This approach is scalable, cost effective, and with future expansion, will allow the ability to predict performance capabilities for surgeons and expeditionary team members as a component of the Clinical Readiness Lifecycle.

Skills assessment courses for critical care and emergency medicine physicians and nurses are currently under development and are expected in mid-2021.

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

KSA Integration with Enterprise Planning

Throughout the implementation process for the Clinical Readiness Program, Service support and collaboration has been a critical aspect of development and improvement of the assessments and clinical currency metrics. These assessments and metrics are currently being incorporated into relevant Service readiness systems (Army Individual Critical Task Lists [ICTLs], Naval Readiness Criteria, and Air Force CMRP). Services are utilizing KSA metrics in their Readiness Demand Signal determinations, informing their Readiness Performance Plans and submissions for the Quadruple Aim Performance Plan (QPP).

To successfully transition the MHS from solely an economically based model focused on productivity to a readiness-based model focused on meeting operational requirements with significant economic benefits, there is a three-pronged strategy to improve clinical currency scores, outlined as follows:

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

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

Partner: Military-civilian partnerships (MCPs) create opportunities for individuals or teams to embed part-time or full-time in civilian trauma centers. The Joint Trauma Education and Training (JTET), guided by National Defense Authorization Act (NDAA) FY 2017, Section 717, has established a work group composed of representatives from the Services to facilitate and coordinate these efforts. A blueprint for these MCPs has already been completed (ACS "Blue Book"). KSA metrics will be leveraged to assess the effectiveness of these partnerships over time.

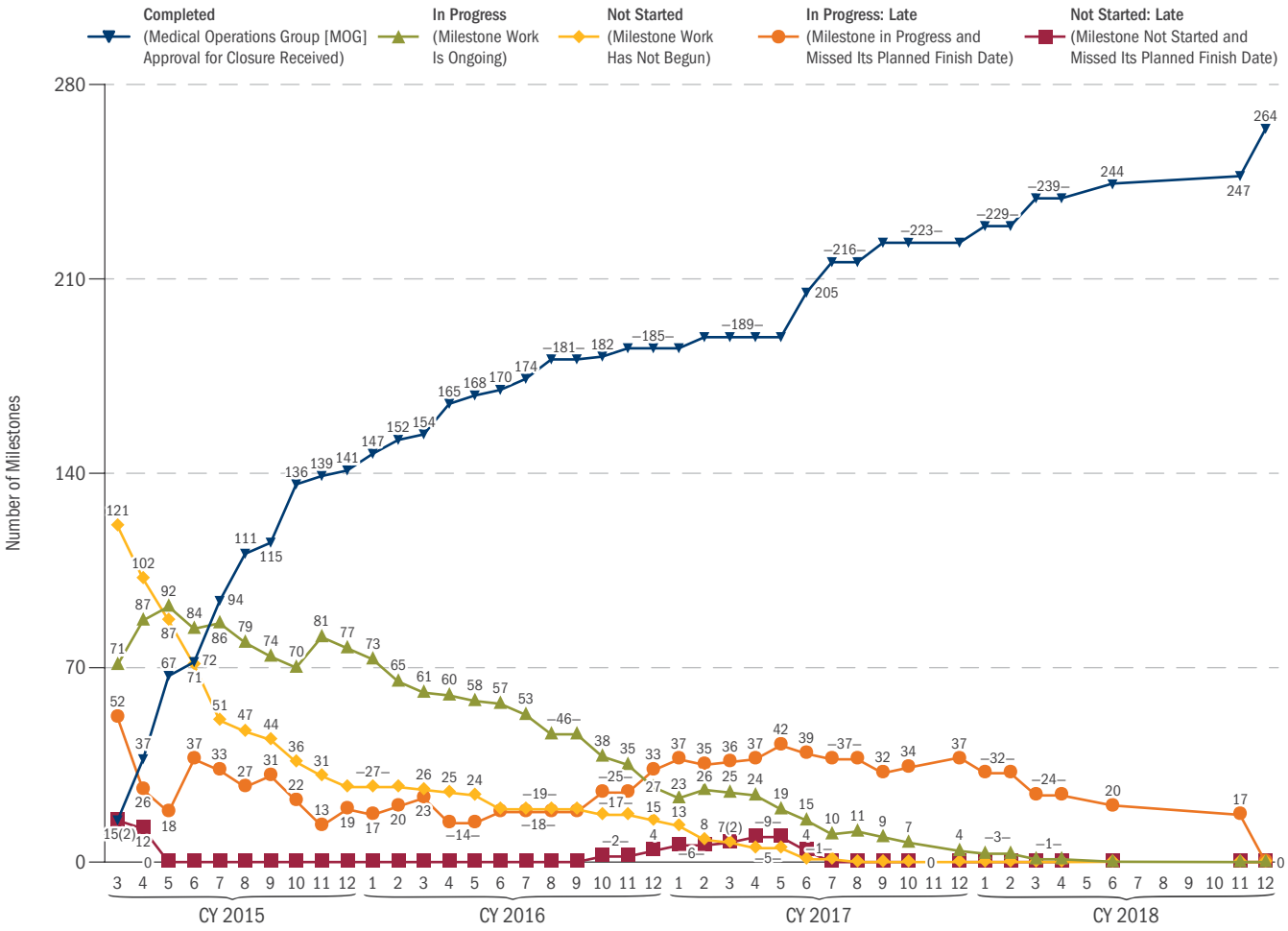
Using this three-pronged approach, as well as leveraging the Readiness functional review within the QPP to aid leadership's prioritization of proposed initiatives and/or acceptance of reclamas based on the anticipated readiness impacts, we can facilitate the shift in focus to meeting the operational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

ACCESS, QUALITY, SAFETY, AND PATIENT ENGAGEMENT

MHS Review—Status Update

The Secretary of Defense (SECDEF) directed a review of the Military Health System (MHS) in 2014, focused on safety, quality of care, and access to care. To fully address all the recommendations from the MHS review, 41 action plans were developed. As of November 18, 2019, all 41 action plans, comprised 264 milestones, have been approved by MHS Governance and completed. While the milestones fulfilled the intent of the MHS review and warranted action plan closure, the enduring work of these improvement initiatives continues throughout the MHS. In addition, the MHS is continuing to pursue transformation into a high reliability organization. While the COVID-19 pandemic delayed the final report to the Deputy Secretary of Defense, it will be finalized for approval by the second quarter of 2021.

MILESTONE STATUS TREND, CYs 2015–2018



Source: Defense Health Agency (DHA)/Medical Affairs/Clinical Support Division (CSD), 10/26/2020

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

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

High Reliability Organization Journey

As a result of the MHS review and subsequent findings, the SECDEF directed the MHS to adopt the practices and principles of high reliability organizations (HROs) as the framework to improve the quality of health care delivered. To meet the charge, the MHS developed the high reliability operating model (HROM), a visual representation of organizational relationships within the MHS that supports the Quadruple Aim of Improved Readiness, Better Care, Better Health, and Lower Cost is depicted below. Throughout FY 2020, the DHA and Services advanced and supported the HROM through the MHS Clinical Communities, strategically aligning quality improvement initiatives with the Quadruple Aim Performance Plan (QPP) process. DHA and the Services will continue to sustain and further these advances in FY 2021.

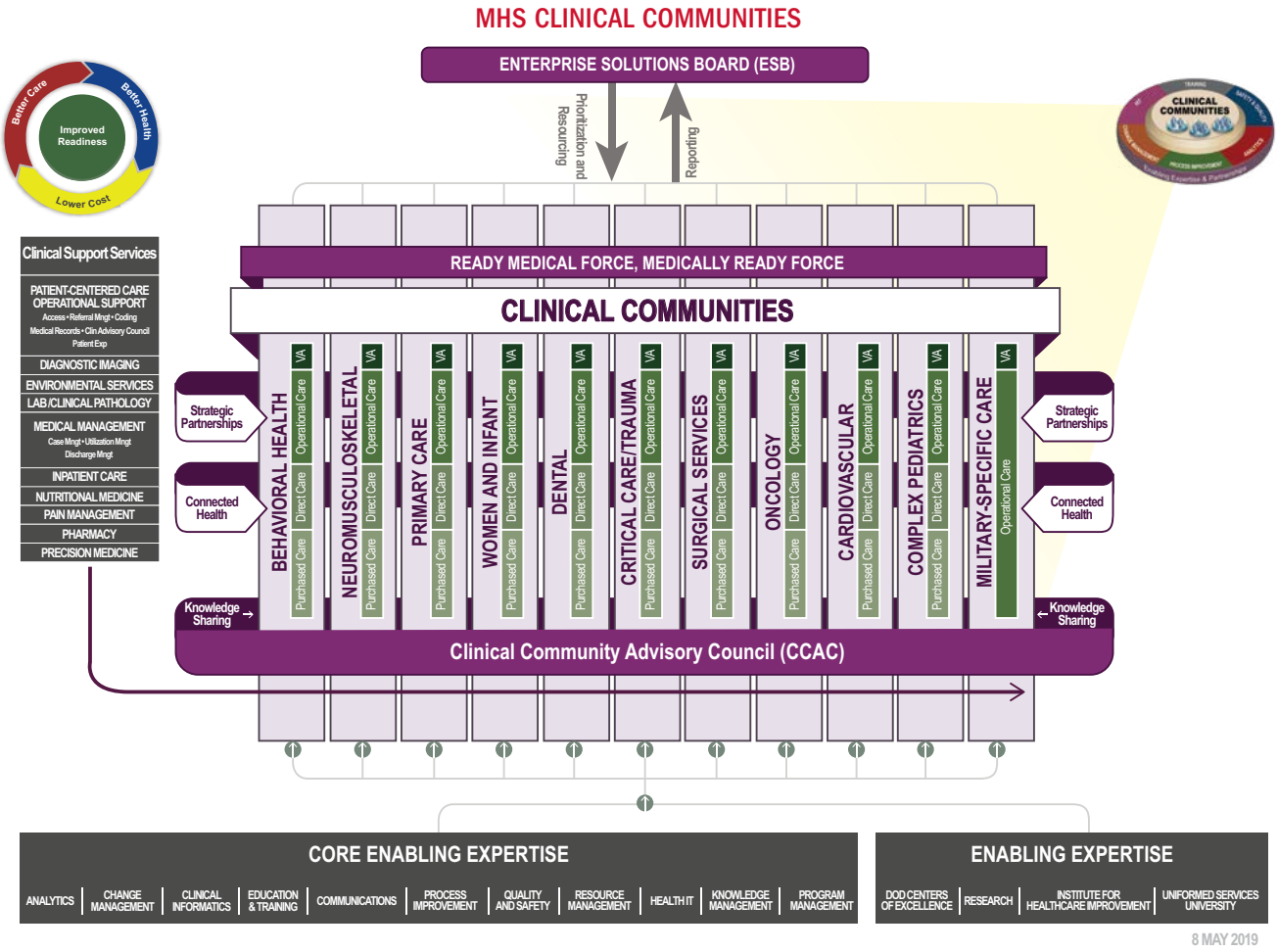
MHS INTEGRATED HEALTH CARE DELIVERY SYSTEM HROM

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

High Reliability Organization Journey *(cont.)*

MHS Clinical Communities

The MHS Clinical Communities are a key driver promoting HRO and continuous process improvement (CPI) in health care delivery across the MHS. Clinical Communities are interdisciplinary networks of MHS providers who work to optimize health care delivery for every patient across the MHS. In May 2019, the MHS stood up its remaining six Clinical Communities, following the initial proof of concept period for the first five communities. As seen in the visual representation below, the MHS Clinical Communities now include: Behavioral Health, Neuromusculoskeletal, Primary Care, Women and Infant, Dental, Critical Care/Trauma, Surgical Services, Oncology, Cardiovascular, Complex Pediatrics, and Military-Specific Care. In FY 2020, these communities were actively supported by Clinical Support Services and Enabling Expertise to drive enterprise-wide clinical quality improvement (CQI).



High Reliability Organization Journey *(cont.)*

Also in FY 2020, the Clinical Communities expanded several clinical care pathways at all military medical treatment facilities (MTFs) within the contiguous United States (CONUS). Care pathways approach care from the patient's perspective and guide a patient with a specific condition through each step of the care experience. Providers use the pathway to ensure that all patients receive consistent, high-quality care aligned to best practices. The following are just a few initiatives underway (additional Clinical Community accomplishments and associated measurements can be found on pages 129–145).

- **Behavioral Health:** The MHS Behavioral Health Clinical Community (BHCC) implemented an enterprise-wide means to assess posttraumatic stress disorder (PTSD) and major depressive disorder (MDD) outcomes using the Behavioral Health Data Portal (BHDP). The BHDP enables collection and analysis of self-reported patient data that inform MHS behavioral health care improvements. With consistent and comprehensive use of BHDP, the MHS can reliably monitor patient self-reported behavioral health outcomes. The BHCC is piloting use of the BHDP with transitioned DHA MTFs with a goal to increase BHDP adoption and use, and to ultimately improve analysis of behavioral health outcomes.
- **Neuromusculoskeletal:** The MHS Neuromusculoskeletal Clinical Community (NMSKCC) partnered with the Traumatic Brain Injury Advisory Committee (TAC) to pilot the clinical pathway to improve treatment outcomes for patients with acute concussion. This care pathway pilot will enable modernization of the standard assessment protocol for patients who sustain concussion or mild traumatic brain injuries (TBIs) and ultimately to reduce chronic concussion-related symptoms that may be avoidable if they are appropriately identified earlier in the clinical course. Timely follow-up and access to care are among the focused improvement targets to improve outcomes and progressive return to activity for our Active Duty Service members (ADSMs).
- **Primary Care:** The MHS Primary Care Clinical Community (PCCC) developed and launched the Stepped Care Model for Pain, an evidence-based process for improving assessment and treatment of acute and chronic pain in primary care. The goal of this pathway is to achieve enhanced delivery of nonpharmacological pain treatment and improve opioid prescribing practices. To ensure successful rollout of the pathway, the PCCC implementation team is providing training, data feedback, and ongoing support to all MHS primary care clinics and pain champions.
- **Women and Infant:** The MHS Women and Infant Clinical Community (WICC) continues work to improve outcomes related to postpartum hemorrhage (PPH) through DHA policy publication and is developing an implementation plan for the Alliance for Innovation on Maternal Health (AIM) PPH Bundle. The goal of the bundle is to decrease morbidity associated with hemorrhage by standardizing obstetric hemorrhage supplies, equipment, and protocols. This bundle is an expansion of the Navy Medicine Obstetric Hemorrhage Bundle, which decreased peripartum hysterectomies, intensive care unit (ICU) admissions, blood product transfusions, and maternal sentinel events (SEs).

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

To evaluate MTF performance in key clinical areas, the DHA reinserted Clinical Community metrics into the requirements of the FY 2022 cycle of the QPP. Four Clinical Communities (Behavioral Health, Neuromusculoskeletal, Primary Care, and Women and Infant) identified top CQI requirements in the planning of FY 2022 QPP supplemental guidance. The QPP is the process by which the DHA identifies and resources improvement priorities across the system. The QPP also serves as a guide for evaluating provider performance and enhancing accountability. MHS Clinical Communities inform DHA resourcing decisions by analyzing current gaps in care delivery and targeting high-impact and high-risk areas for improvement. Their insights inform the DHA's annual strategy development that aligns resources to DHA leaders' top objectives. Clinical Communities are supported in the review of FY 2021 QPP plans and continue to evaluate a subset of the QPP plans to learn what improvements at the MTF level should be incorporated into the next fiscal year's enterprise-wide strategy, resourcing, and performance assessments. To further promote a learning environment, performance gaps identified in one year are considered for incorporation into the strategic guidance and QPP critical initiatives for the subsequent year.

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

High Reliability Organization Journey *(cont.)*

HRO Integrated Product Team

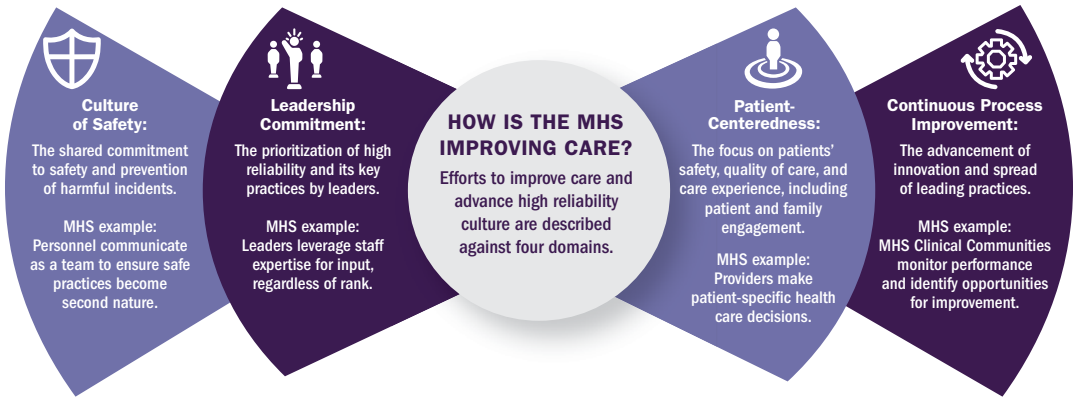
As the Services and DHA continue to work together to drive process improvement through the work of the Clinical Communities, they also collaborate to develop an enterprise-wide change plan for the advancement of HRO across the other domains of change: Culture of Safety, Leadership Commitment, and Patient-Centeredness. During FY 2020, the HRO Integrated Product Team (IPT), a group of safety, quality, and improvement representatives from across the DHA and the Services, led the prioritization and alignment of HRO across the MHS. In follow-up to Action Plan (AP) 1 of the 2014 MHS review, the HRO IPT implemented the AP 1 Narrative Summary to continue the enduring work that is required to unify Service-specific improvements, spread the adoption of HRO culture and practices across the MHS, and promote MHS HRO transformation.

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

MHS HRO Priorities:

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

REVISED MHS HRO DOMAINS OF CHANGE



HRO PRINCIPLES

MHS Data Transparency

Summary of Key Data Responding to National Defense Authorization Act (NDAA) FY 2017, Section 728 for incorporating Core Quality Measures Collaborative (CQMC) core measures, MHS reporting on the Centers for Medicare & Medicaid Services (CMS) Hospital/Care Compare website, and a framework for evolving MHS transparency:

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

In response to section 713 of NDAA 2016:

1. Reporting to the National Practitioner Data Bank (NPDB). This is reported in the Healthcare Risk Management section under Clinical Quality Management of this report (ref. page 119).

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

- **The current accreditation status, including recommendations for corrective action.** Accredited organizations, including Department of Defense (DoD) inpatient and freestanding ambulatory clinic MTFs, can be found on The Joint Commission (TJC) website at www.qualitycheck.org. Other associated clinics subordinate to one of these MTFs are included in the respective facility TJC accreditation. Additionally, MTF-specific hospital and clinic accreditation status, accreditation organization, completed survey dates, and requirements for improvement to meet full accreditation are found in the downloadable report at www.health.mil/AccreditationStatus (ref. pages 119–123).
- **Policies or procedures concerned with or designed to improve patient safety, quality of care, and access to care that were implemented during the year by the SECDEF include:** A consolidated summary of relevant Health Affairs and Service policies is provided at www.health.mil/AccreditationStatus. The DHA is currently in the process of developing and publishing publications to supersede both DoD and Service level policies (where appropriate) in support of management and administration of MTFs in accordance with NDAA FY 2017, section 702. Relevant Health Affairs, DHA, and Service policies can be found in their associated subject areas related to access, patient safety, and quality of care at www.health.mil (ref. pages 86–87, 110).
- **Data on surgical and maternity care outcomes during the year.** MHS-level data are presented in this report (ref. pages 111, 135–139, and 146–147). 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 75–79), including MHS-wide and MTF-specific analysis of variability. MTF-level data over time are reported on www.health.mil/transparency.
- **Data on patient safety, quality of care, and access to care, as compared with standards established by the DoD.** In addition to the MHS-level data presented in this report, the individual MTF-level data are presented in the www.health.mil/transparency public-facing website.
- **Data on patient experience and satisfaction.** MTF-level data are presented in the www.health.mil public-facing website and on the CMS Care Compare website.

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

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

MHS Data Transparency *(cont.)*

The Tri-Service Transparency Initiative Group (TIG) and Clinical Quality Management Clinical Measurement Program maintain responsibility for public reporting efforts of MHS measures on the www.health.mil/transparency website. The TIG continues to review and iterate on the approach and display of publicly reported information, to include enhancements in search functionality, improved measure visualization, and development of plain language measure descriptions to facilitate end user value. In addition to enhancements to the patient safety (PS) information, in 2020, the TIG has focused efforts on providing additional measures to the website related to patient experience (provider communication), access to specialty care, and quality of care for women and infants. The MHS publication of data and patient information on patient safety, quality of care, patient experience and satisfaction, and health outcomes is available on www.health.mil/transparency. Web page example is shown below.

VISIT HEALTH.MIL/TRANSPARENCY

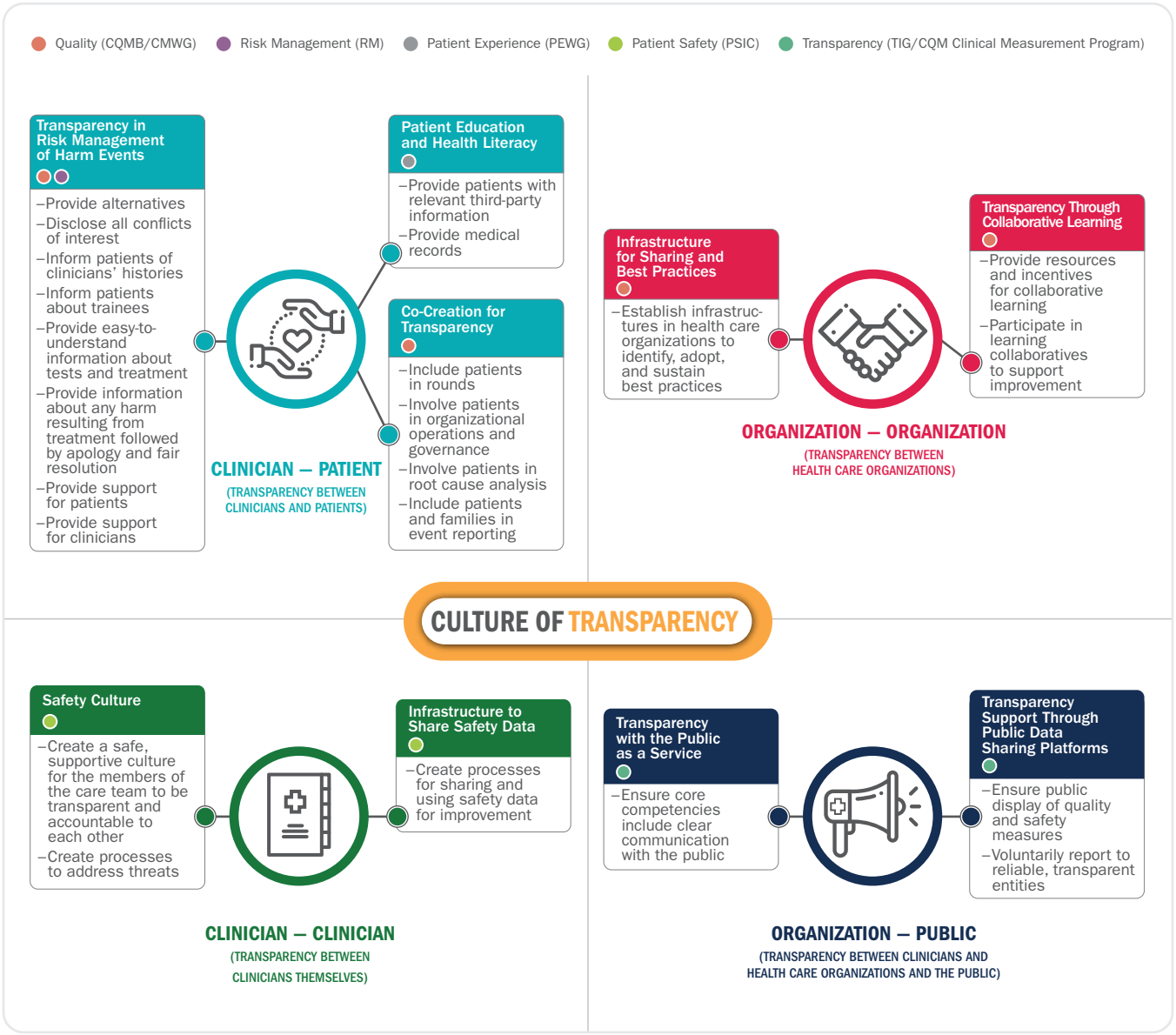
MHS clinical measurement results data are found on the following websites: Leapfrog (https://www.leapfroggroup.org); Care Compare (https://www.medicare.gov/care-compare); Health.mil (https:// health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Patient-Portal-for-MHS-Quality-Patient-Safety-and-Access-Information); and TJC Quality Check (https://www.qualitycheck.org).

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

MHS Transparency Framework

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

MHS TRANSPARENCY FRAMEWORK



ACCESS TO MHS CARE

Access to Outpatient Care in the MHS

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

In the last year, the direct care system has continued improving access to care performance and reducing variance among MTFs. This is especially noteworthy given the direct care system rapidly responded to the COVID-19 pandemic by leveraging existing standard processes in DHA guidance. DHA issued extensive and responsive guidance to MTFs and markets on access to care, supporting health care operations activities and the use of virtual health, which enabled the direct care system to provide medically necessary care throughout the pandemic. As the MTFs began resuming full operations while continuing to minimize risk of infection for patients and staff, the direct care system implemented processes to catch up on delayed chronic and preventive care, with strong emphasis on cancer screening. Direct care system access to care efforts gained momentum after the SECDEF-directed 2014 MHS review of quality, safety, and access through robust Tri-Service collaboration, development of standard processes, and implementation of an MHS performance management system.

In FY 2020, the direct care system continued optimization efforts to enhance access, improve patient experience, and eliminate unwarranted variance among MTFs. The direct care system improved access, particularly in primary care, by implementing standard appointing and capacity processes codified in DHA policy to meet requirements in the NDAA for FY 2017. The NDAA FY 2017, Section 704 directed MTFs to improve access to urgent care (UC) by expanding operating hours in MTF PCMHs, implementing additional MTF UC clinics at locations where sufficient patient demand existed to justify operating costs, and integrating the nurse advice line (NAL) UC and appointing processes. The NDAA FY 2017, section 709 also directed the MHS to implement standard appointing processes and procedures and to develop productivity standards on the expected number of patient encounters for each health care provider in both primary and specialty care. The direct care system is currently implementing standard appointing and procedures to improve access, increase direct care system capacity, enhance patient experience, and eliminate variance among MTFs. Standard processes and procedures include:

1. Optimization of the PCMH model of primary care
2. Simplified appointing to reduce template complexity and improve access
3. Use of standard screening tools and clinical practice guidelines (CPGs) in the Tri-Service Workflow templates in the MHS EHR
4. Implementation of enhanced access initiatives, including team-based care, integrated specialists, and nurse-run walk-in clinics for common acute conditions
5. Standard First Call Resolution processes in both primary and specialty care to ensure beneficiaries' needs are met the first time they call for an appointment
6. Use of DHA-developed centralized data and standard tools to better match appointment supply to patient demand by day of week and hour of day. The MHS also established productivity standards on the expected number of encounters per provider to meet the congressional intent of the NDAA FY 2017, section 709. Finally, the MHS has established standard primary care empanelment goals per provider and MTF to optimize direct care system capacity and provide a basis for primary care staff resource allocation across the direct care system based on patient demand.

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

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

ACCESS TO MHS CARE *(CONT.)*

Patient-Centered Medical Home Primary Care

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

MTF PCMHs employ processes to ensure each routine, follow-up, or urgent medical appointment is focused on prevention and future medical needs. For example, if a patient is seen for an acute medical need, the PCMH also addresses needed preventive services, renews medications, and meets as many of the patient's other medical needs as possible during the same visit. In support of medical readiness, the Uniformed Services continue to implement operational medical homes through the Marine-centered, Soldier-centered, Fleet-centered, and submarine-centered medical home programs.

ACCESS TO MHS CARE *(CONT.)*

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

PCM and PCMH Team Continuity

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

Description of Box and Whisker Plots

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

- As shown in the tables, in FY 2020 enrollees saw their own PCM during primary care visits approximately as frequently as prior years. PCMH team continuity improved from 2019 to be consistent with prior years of PCMH team continuity. MTFs are to maximize continuity of care by optimizing provider availability, templating appointments 180 days in advance, expanding clinic hours, and maintaining adequate team size (DHA-Interim Procedures Memorandum [DHA-IPM] 18-001).

PCM AND PCMH TEAM CONTINUITY, FYs 2013–2020

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
PCM Continuity	58%	60%	60%	60%	59%	57%	57%	56%
PCMH Team Continuity	90%	91%	91%	92%	92%	92%	83%	91%

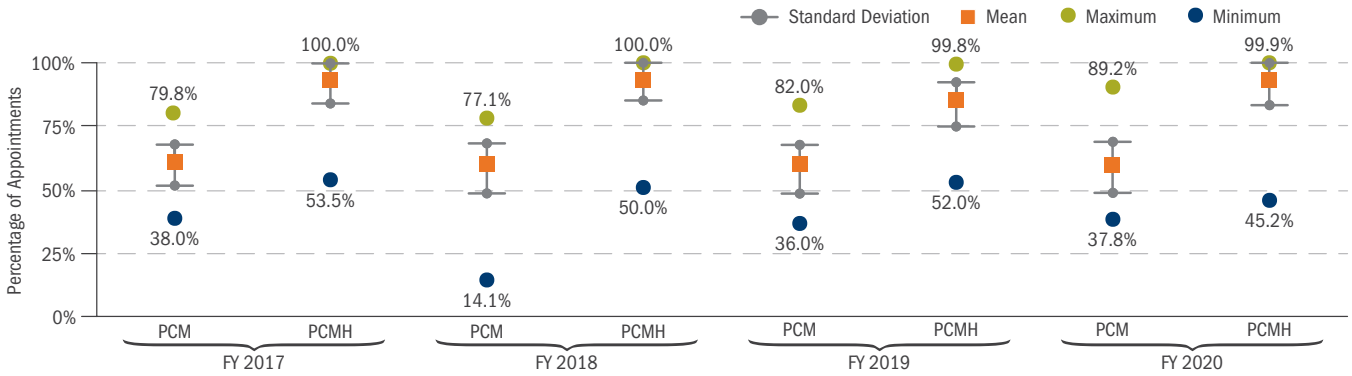
PCM CONTINUITY, FYs 2017–2020

	FY 2017	FY 2018	FY 2019	FY 2020
Mean	60%	58%	58%	59%
Standard Deviation	7.9%	9.4%	9.6%	10.0%
Median	60%	58%	58%	59%
75th Percentile	65%	64%	65%	65%
25th Percentile	55%	53%	52%	51%
Maximum	80%	77%	82%	89%
Minimum	38%	14%	36%	38%
Range	42%	63%	46%	51%

PCMH TEAM CONTINUITY, FYs 2017–2020

	FY 2017	FY 2018	FY 2019	FY 2020
Mean	92%	93%	84%	92%
Standard Deviation	7.5%	7.9%	8.3%	8.8%
Median	93%	94%	85%	94%
75th Percentile	96%	97%	90%	97%
25th Percentile	90%	91%	81%	90%
Maximum	100%	100%	99%	100%
Minimum	54%	50%	52%	45%
Range	46%	50%	47%	55%

PCM AND PCMH TEAM CONTINUITY, FYs 2017–2020



Source: MHS administrative data (MHS Data Repository [MDR]); DHA/HCO/Healthcare Optimization Division, 10/11/2020

Notes:

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

– Data include MHS GENESIS sites beginning August 2019.

ACCESS TO MHS CARE *(CONT.)*

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

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

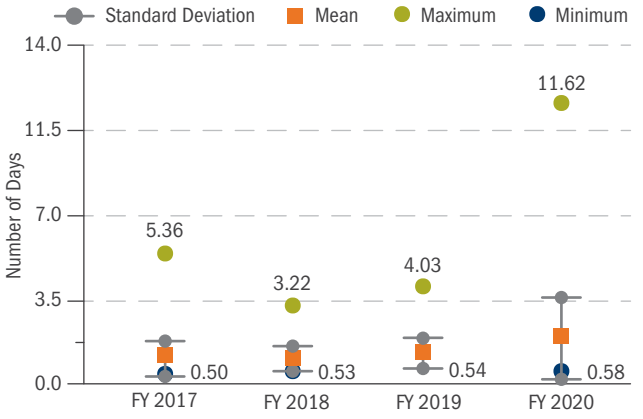
The direct care system prospectively measures access to primary care by evaluating the average number of days to the third next available 24-hour or acute appointment and third next available future appointment against the MHS goals of 1.0 and 7.0 days, respectively. Measuring third next for a prospective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

In FY 2020, there was an increase in the average number of days to third next available 24-hour (2.0 days) and future (6.95 days) appointments, with greater variation in appointment availability due to COVID-19. This has resulted in performance above the one-day standard for third next available 24-hour appointments in FY 2020; future appointments remained below the seven-day standard.

DAYS TO THIRD NEXT AVAILABLE 24-HOUR APPOINTMENT, FYs 2017–2020

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2017–FY 2020 CHANGE
Mean	1.14	1.12	1.33	2.00	0.85
Standard Deviation	0.72	0.46	0.64	1.70	0.98
Median	0.92	1.01	1.21	1.54	0.61
75th Percentile	7.34	7.55	7.67	8.42	1.08
25th Percentile	4.05	4.07	4.51	4.67	0.62
Maximum	5.36	3.22	4.03	11.62	6.26
Minimum	0.50	0.53	0.54	0.58	0.08
Range	4.86	2.69	3.49	11.04	6.19

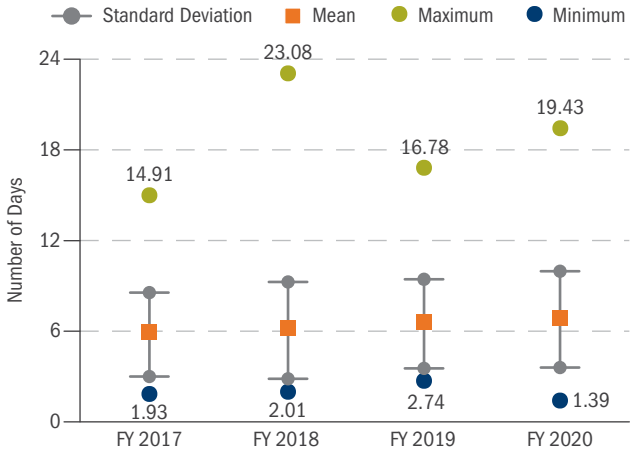
DAYS TO THIRD NEXT AVAILABLE 24-HOUR APPOINTMENT, FYs 2017–2020



DAYS TO THIRD NEXT AVAILABLE FUTURE APPOINTMENT, FYs 2017–2020

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2017–FY 2020 CHANGE
Mean	5.89	6.16	6.60	6.95	1.07
Standard Deviation	2.75	3.19	2.87	3.19	0.45
Median	4.82	5.23	6.24	6.22	1.39
75th Percentile	1.25	1.24	1.55	2.13	0.88
25th Percentile	0.75	0.83	0.90	1.02	0.27
Maximum	14.91	23.08	16.78	19.43	4.52
Minimum	1.93	2.01	2.74	1.39	–0.54
Range	12.98	21.07	14.04	18.04	5.06

DAYS TO THIRD NEXT AVAILABLE FUTURE APPOINTMENT, FYs 2017–2020



Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 10/14/2020

Notes:

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

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

TOL Patient Portal Automatic Appointment Reminders

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

Access to Integrated Specialists in the PCMH

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

ACCESS TO MHS CARE *(CONT.)*

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

Dispositions and Bed-Days per 1,000 MTF Enrollees

By focusing on prevention, proactive care coordination, and improving outcomes for common conditions, MTF PCMHs focus on reducing the incidence of dispositions (admissions) and bed-days per 1,000 MTF enrollees. PCMH teams continue efforts to reduce the number of times MTF enrollees are admitted to hospitals and medical centers in both the direct and purchased care sectors, and the length of time they spend as inpatients if they are admitted, which is measured by bed-days (number of dispositions multiplied by the length of stay [LOS]). The average monthly disposition count per 1,000 MTF enrollees was 4.51 in FY 2020 (based on Q1–Q3 data); there was also a projected decrease in the bed days per 1,000 enrollees. The top five reasons for admissions remain childbirth, musculoskeletal, circulatory, digestive, and respiratory conditions.

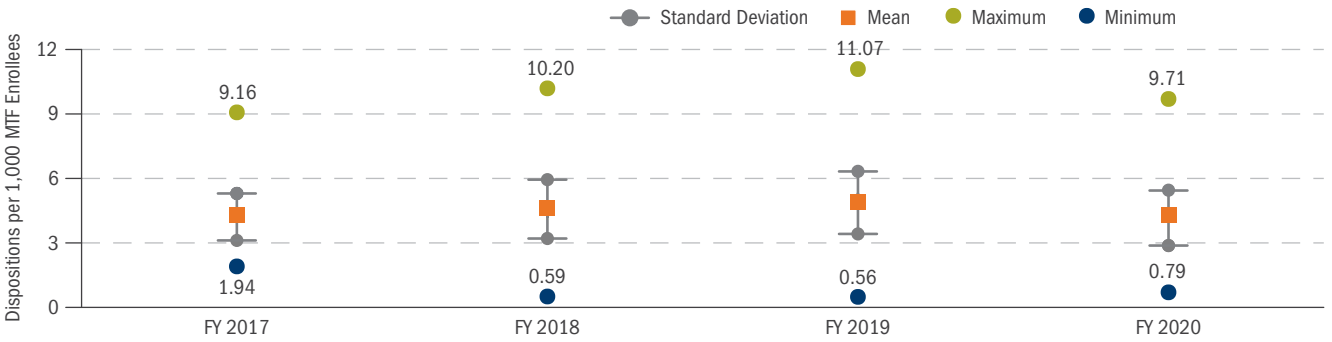
AVERAGE MONTHLY DISPOSITIONS AND BED-DAYS PER 1,000 MTF ENROLLEES, FYs 2017–2020

	FY 2017	FY 2018	FY 2019	FY 2020
Average Monthly Dispositions per 1,000 MTF Enrollees	4.67	4.92	5.15	4.51
Average Monthly Bed-Days per 1,000 MTF Enrollees	14.63	15.62	16.78	15.27

AVERAGE MONTHLY DISPOSITIONS PER 1,000 MTF ENROLLEES, FYs 2017–2020

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2017–FY 2020 CHANGE
Mean	4.28	4.61	4.91	4.27	-0.01
Standard Deviation	1.09	1.34	1.42	1.24	0.15
Median	4.10	4.53	4.68	4.24	0.14
75th Percentile	4.61	5.17	5.61	4.79	0.18
25th Percentile	3.65	4.00	4.15	3.63	-0.02
Maximum	9.16	10.20	11.07	9.71	0.55
Minimum	1.94	0.59	0.56	0.79	-1.16
Range	7.21	9.61	10.51	8.92	1.71

AVERAGE MONTHLY DISPOSITIONS PER 1,000 MTF ENROLLEES, FYs 2017–2020



Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 10/27/2020

Notes:

– Parent facility scores were used to describe variability in the results above.
– Months with fewer than 50 enrollees for a given parent facility were removed from the analysis.
– FY 2020 average monthly dispositions were based on FY 2020 Q1–Q3 data.
– Data exclude MHS GENESIS sites.
– Numbers may not sum due to rounding.

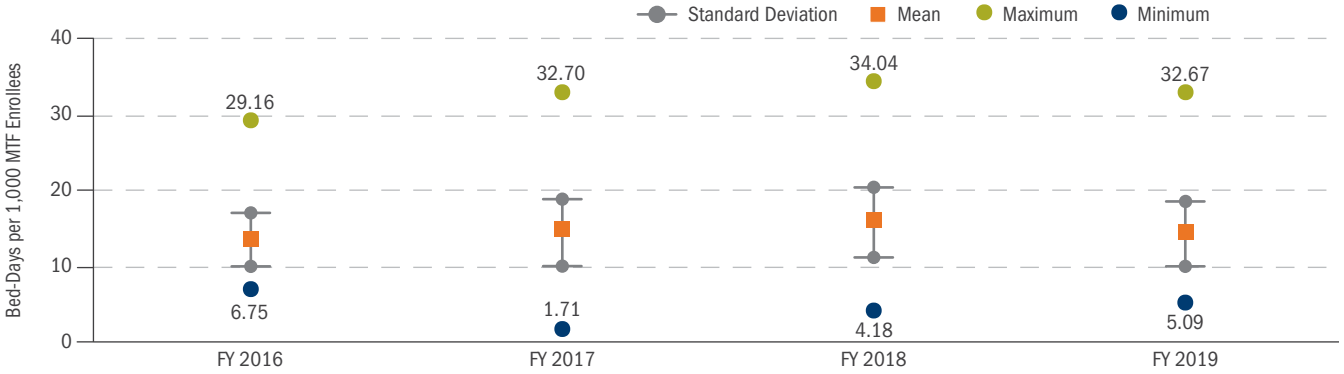
ACCESS TO MHS CARE *(CONT.)*

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

AVERAGE MONTHLY BED-DAYS PER 1,000 MTF ENROLLEES, FYs 2017–2020

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2017–FY 2020 CHANGE
Mean	13.51	14.55	15.91	14.25	0.74
Standard Deviation	3.42	4.40	4.57	4.28	0.86
Median	13.18	14.32	15.49	14.06	0.87
75th Percentile	14.89	16.54	18.54	16.15	1.26
25th Percentile	11.11	12.18	13.10	11.91	0.80
Maximum	29.16	32.70	34.04	32.67	3.51
Minimum	6.75	1.71	4.18	5.09	–1.65
Range	22.41	30.98	29.86	27.58	5.17

AVERAGE MONTHLY BED-DAYS PER 1,000 MTF ENROLLEES, FYs 2017–2020



Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 10/27/2020

Notes:

– Parent facility scores were used to describe variability in the results above.
– Months with fewer than 50 enrollees for a given parent facility were removed from the analysis.
– FY 2020 average monthly dispositions were based on FY 2020 Q1–Q3 data.
– Data excludes MHS GENESIS sites.
– Numbers may not sum due to rounding.

ACCESS TO MHS CARE *(CONT.)*

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

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

The ED utilization rate is projected to decrease in FY 2020 from 18.2 visits per 100 enrollees to 16.9 visits per 100 enrollees. ED visits for primary care reasons are a small percentage of all ED visits and are defined by the Tri-Service Emergency Medicine consultants and industry as evaluation and management codes 99281 and 99282. The rate of network ED visits for primary care reasons is projected to decrease 15 percent from FY 2019 to FY 2020. MTF efforts to reduce ED visits include better access to 24-hour care in PCMH, walk-in clinics for common acute conditions, PCMH team-based care to meet patients' needs, and the NAL and secure messaging.

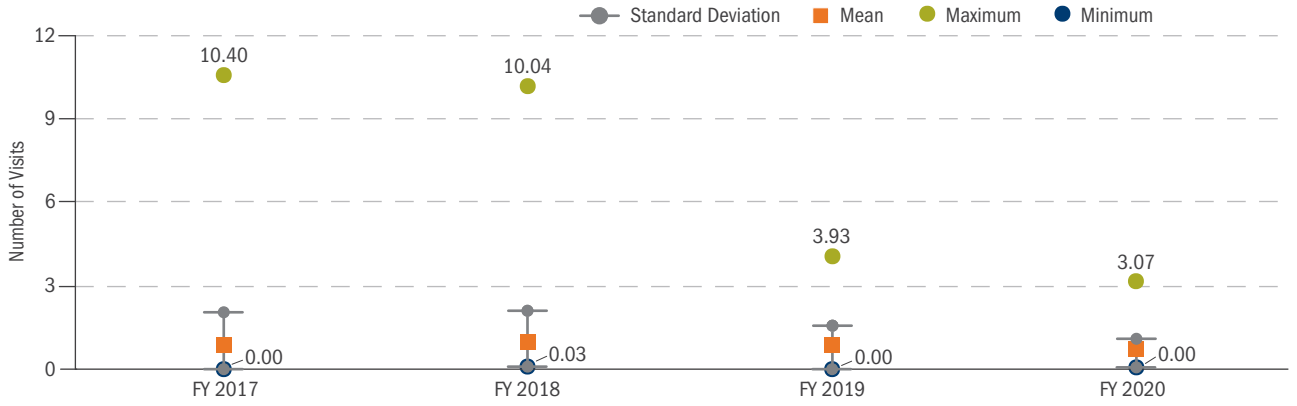
AVERAGE NETWORK ED VISITS PER 100 MTF ENROLLEES, FYs 2016–2020

	AVERAGE NETWORK ED VISITS PER 100 MTF ENROLLEES (INCLUDING TRUE EMERGENCIES)	AVERAGE NETWORK ED VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS
FY 2016	18.14	0.65
FY 2017	17.66	0.62
FY 2018	18.11	0.64
FY 2019	18.20	0.60
FY 2020	16.86	0.51

NETWORK ED VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS, FYs 2017–2020

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2017–FY 2020 CHANGE
Mean	0.79	0.82	0.76	0.57	–0.21
Standard Deviation	1.02	1.06	0.76	0.54	–0.49
Median	0.54	0.54	0.56	0.41	–0.12
75th Percentile	1.02	1.00	0.93	0.80	–0.22
25th Percentile	0.30	0.31	0.28	0.24	–0.05
Maximum	10.40	10.04	3.93	3.07	–7.32
Minimum	0.00	0.03	0.00	0.00	0.00
Range	10.40	10.04	3.93	3.07	–7.32

NETWORK ED VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS, FYs 2017–2020



Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 10/22/2020

Notes:

– Parent facility scores were used to describe variability in the results above.
– Months with fewer than 50 enrollees for a given parent facility were removed from the analysis.
– ED visits were projected based on 2020 averages to account for visits during July–September 2020.
– Numbers may not sum due to rounding.

ACCESS TO MHS CARE *(CONT.)*

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

Network UC Visits per 100 Enrollees

As shown in the table below, the rate of network UC visits by MTF enrollees has continued to increase in FY 2020 compared to previous years, timed with the change to allow unlimited network UC visits. The majority of network UC visits were for upper respiratory illness. That most network UC visits are for upper respiratory illnesses or colds is consistent with industry results that unlimited self-referred UC visits increase demand for care for self-limiting or low-acuity issues beyond that which occurred in a given population previously. In FY 2021, the MHS will continue to evaluate this data and recommend additional expanded hours or direct care UCs to increase convenience for enrolled beneficiaries and optimize direct care resources.

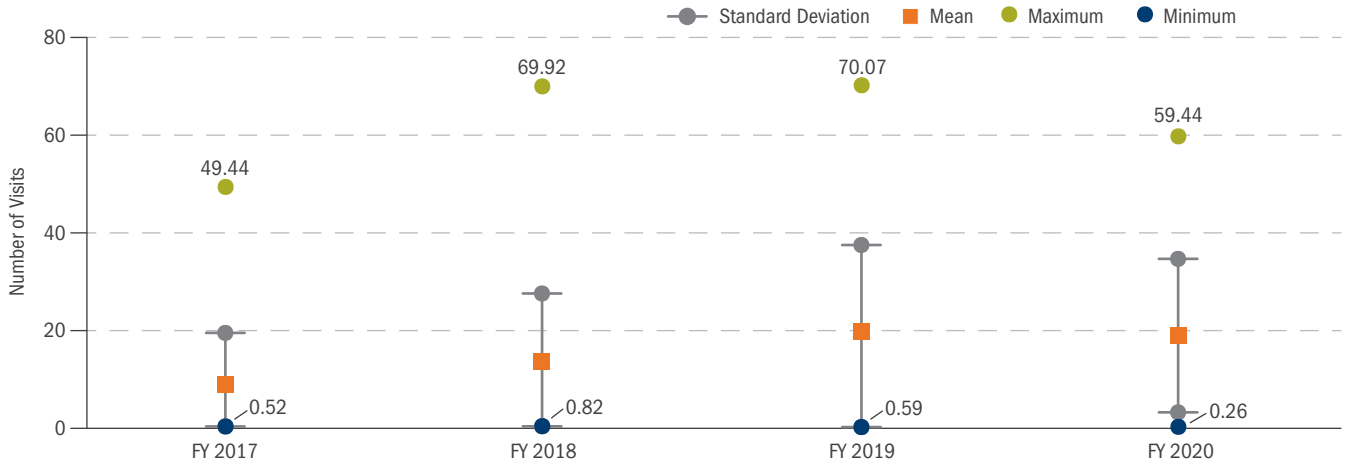
AVERAGE NETWORK UC VISITS PER 100 MTF ENROLLEES, FYs 2017–2020

	AVERAGE NETWORK UC VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS
FY 2017	8.07
FY 2018	13.03
FY 2019	18.34
FY 2020	18.45

NETWORK UC VISITS PER 100 MTF ENROLLEES, FYs 2017–2020

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2017–FY 2020 CHANGE
Mean	9.07	13.93	19.86	19.01	9.94
Standard Deviation	9.75	13.73	17.67	15.77	6.01
Median	5.08	9.25	15.71	16.19	11.12
75th Percentile	11.90	21.70	32.18	30.05	18.15
25th Percentile	2.12	2.80	2.96	2.99	0.87
Maximum	49.44	69.92	70.07	59.44	10.01
Minimum	0.52	0.82	0.59	0.26	-0.26
Range	48.92	69.11	69.48	59.18	10.27

NETWORK UC VISITS PER 100 MTF ENROLLEES, FYs 2017–2020



Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 10/28/2020

Notes:

– Parent facility scores were used to describe variability in the results above.
– Months with fewer than 50 enrollees for a given parent facility were removed from the analysis.
– UC visits were projected based on 2019 averages to account for visits during August–September 2019.
– Numbers may not sum due to rounding.

ACCESS TO MHS CARE *(CONT.)*

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

Secure Messaging

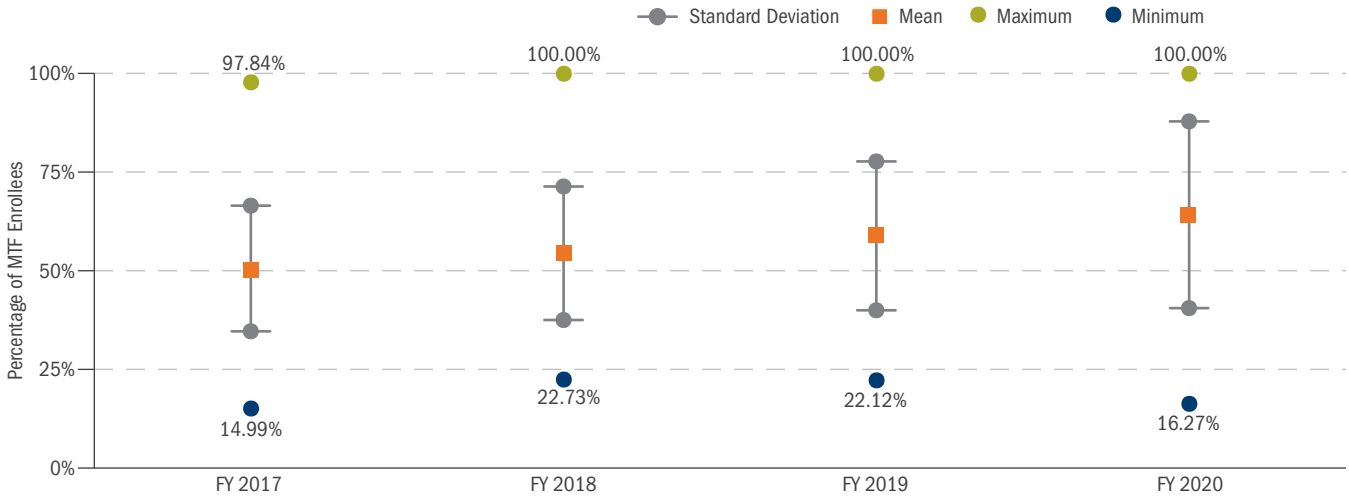
Percentage of Enrollees Registered to Use Secure Messaging: The direct care system offers enhanced access to care through the use of a commercially available secure messaging system. Secure messaging allows MTF enrollees to communicate directly with their PCMs and care teams to ask questions about their health or medical tests and to arrange referrals or appointments. In FY 2020, secure messaging was particularly important to maintain communication between the provider and patient while preventing the spread of COVID-19. The proportion of beneficiaries registered to use secure messaging at parent facilities has increased with each fiscal year, with an average of 64 percent of beneficiaries registered to use secure messaging for FY 2020. The MHS prioritized enrollment in secure messaging starting in FY 2017. Analysis of the primary reasons that patients initiate messages include: asking a medical question (72 percent), arranging appointments/referrals (15 percent), and renewing medications (11 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. There was a significant jump in the number of patient-initiated messages before and after the onset of COVID-19 (October–February: 97,000 messages per month on average; March–September: 137,000 messages per month on average). Despite the large increase of messages, over 80 percent were responded to within one business day—an even stronger performance than the previous year.

PERCENTAGE OF MTF ENROLLEES REGISTERED TO USE SECURE MESSAGING, FYs 2017–2020

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2017–FY 2020 % POINT CHANGE
Mean	50.40%	54.33%	58.89%	64.16%	13.76
Standard Deviation	15.89%	16.91%	18.83%	23.67%	7.78
Median	49.57%	53.57%	56.57%	62.40%	12.83
75th Percentile	58.44%	65.59%	70.40%	76.17%	17.72
25th Percentile	39.02%	43.42%	46.44%	49.00%	9.98
Maximum	97.84%	100.00%	100.00%	100.00%	2.16
Minimum	14.99%	22.73%	22.12%	16.27%	1.27
Range	82.85%	77.27%	77.88%	83.73%	0.88

PERCENTAGE OF MTF ENROLLEES REGISTERED TO USE SECURE MESSAGING, FYs 2017–2020



Source: MHS administrative data; DHA/HCO/Healthcare Optimization Division, 10/12/2020

Notes:

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

– Data exclude MHS GENESIS sites.

– Numbers may not sum due to rounding.

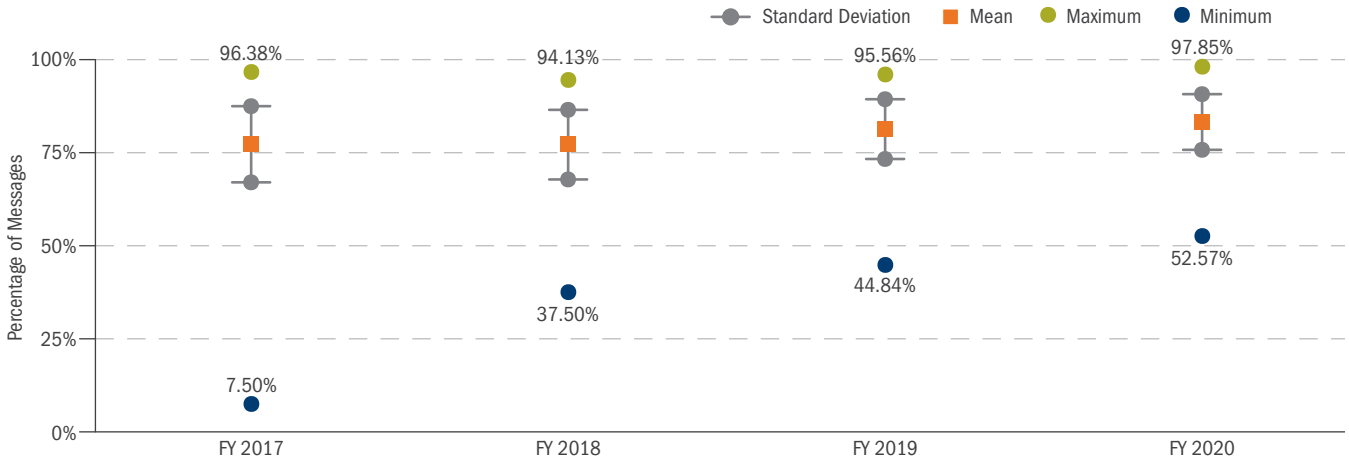
ACCESS TO MHS CARE *(CONT.)*

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

PERCENTAGE OF SECURE MESSAGES RESPONDED TO WITHIN ONE BUSINESS DAY, FYs 2017–2020

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2017–FY 2020 % POINT CHANGE
Mean	77.08%	77.09%	81.27%	83.28%	6.20
Standard Deviation	10.33%	9.41%	8.14%	7.36%	–2.97
Median	78.74%	79.06%	82.18%	84.15%	5.41
75th Percentile	83.55%	84.06%	86.74%	87.40%	3.85
25th Percentile	73.07%	72.56%	77.94%	79.91%	6.85
Maximum	96.38%	94.13%	95.56%	97.85%	1.47
Minimum	7.50%	37.50%	44.84%	52.57%	45.07
Range	88.88%	56.63%	50.73%	45.28%	–43.60

PERCENTAGE OF SECURE MESSAGES RESPONDED TO WITHIN ONE BUSINESS DAY, FYS 2017–2020



Source: MHS administrative data; DHA/HCO/Healthcare Optimization Division, 10/12/2020

Notes:

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

– Data exclude MHS GENESIS sites.

ACCESS TO MHS CARE *(CONT.)*

Nurse Advice Line

The MHS NAL continues to provide valuable, quality, and convenient nurse triage and care coordination services to our MHS beneficiaries 24 hours a day, seven days a week, directing over half a million callers per year to the most clinically appropriate level of care. Since implementation in late FY 2014, the NAL has provided access to registered nurses (RNs) who address health concerns, offer self-care advice, and answer general health questions. The NAL received approximately 2,300 calls per day with the overall call volume increasing by 25 percent from FY 2019.

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

In FY 2020, the NAL played a vital role in the COVID-19 crisis. During the onset in March 2020, call volumes to the advice line increased over four times, with the highest day seeing more than 10,000 calls. As a foundational component of the DHA response, the NAL was quickly able to streamline processes to meet the surge demand. The NAL adjusted its triage protocols in real time according to guidelines from the Centers for Disease Control and Prevention (CDC). The NAL booked virtual visits made available by military hospitals and clinics. This allowed the clinical team to provide care to the patient while minimizing risk of exposure to both the beneficiaries and MTF staff. Patients were brought in on a case-by-case basis as clinically indicated.

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

The percentage of NAL callers who intended to seek care in a network ED was significantly reduced. The NAL recaptured nearly 42 percent of care back to the MTF, while almost of half of callers did not seek follow-on care and instead used self-care advice provided by the RN. Patient satisfaction with the NAL remains over 92 percent, based on responses from a sample of beneficiaries who are surveyed by the DHA following the call.

NAL CALLER INFORMATION FOR MTF ENROLLEES, FY 2020

NAL DISPOSITION	CALLER'S PRE-INTENT	NURSE ADVICE	CALLER'S ACTION WITHIN 24 HOURS
Network ED	24%	9%	4%
Network UC	14%	17%	18%
MTF Care	26%	40%	29%
Self-Care	19%	26%	49%
General Health and Other Miscellaneous Questions	17%	9%	0%
Total	100%	100%	100%

Source: NAL Program and administrative data (M2/MDR): DHA/HCO/Healthcare Optimization Division, 11/30/2020

ACCESS TO MHS CARE *(CONT.)*

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

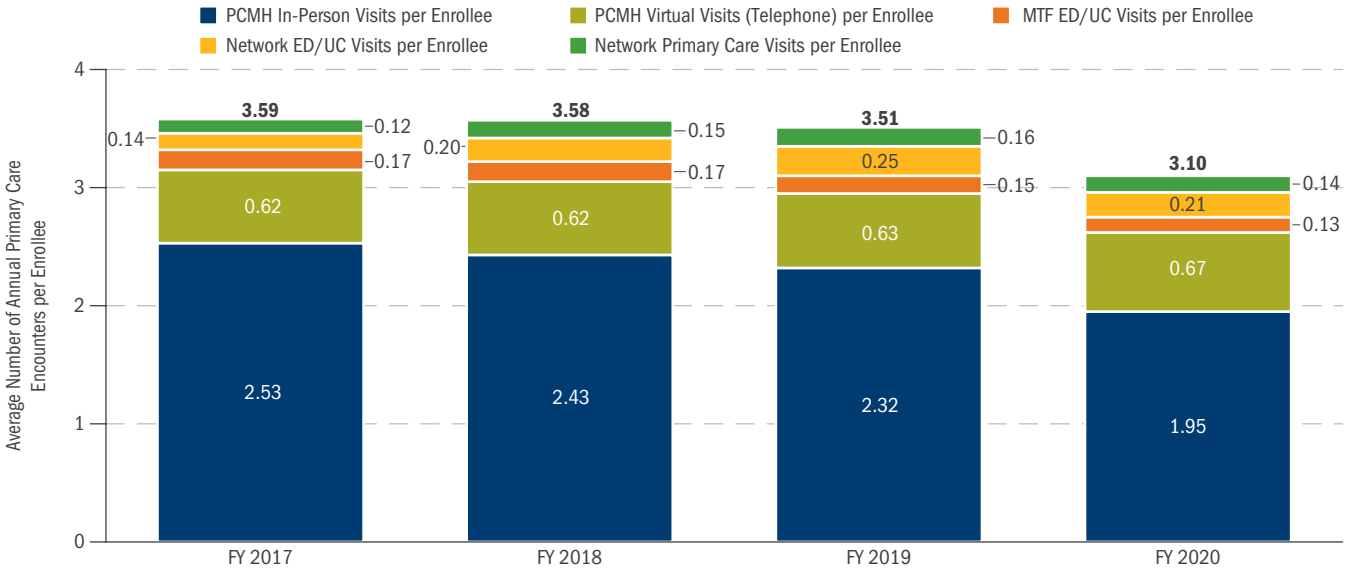
Primary care utilization decreased in FY 2020 with the onset of COVID-19. Overall primary care visits decreased to 3.1 visits per enrollee in FY 2020 from 3.5 visits in 2019. Telephone visits increased slightly as beneficiaries reduced in-person visits (true for ED/UC visits and in-person primary care visits). Market share remained generally consistent with prior years' rates. Primary care leakage to the network is 11 percent for FY 2020, with additional purchased care claims expected to be processed for FY 2020.

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

PRIMARY CARE UTILIZATION, PCMH MARKET SHARE, AND NETWORK LEAKAGE OF ENROLLEES' PRIMARY CARE NEEDS, FYs 2017–2020

	PCMH IN-PERSON VISITS PER ENROLLEE	PCMH VIRTUAL VISITS (TELEPHONE) PER ENROLLEE	MTF ED/UC VISITS PER ENROLLEE	NETWORK ED/UC VISITS PER ENROLLEE	NETWORK PRIMARY CARE VISITS PER ENROLLEE	TOTAL ANNUAL PRIMARY CARE VISITS PER ENROLLEE	PERCENT PCMH MARKET SHARE	PERCENT NETWORK PRIMARY CARE LEAKAGE
FY 2017	2.53	0.62	0.17	0.14	0.12	3.59	87.9%	7.3%
FY 2018	2.43	0.62	0.17	0.20	0.15	3.58	85.3%	9.9%
FY 2019	2.32	0.63	0.15	0.25	0.16	3.51	84.0%	11.7%
FY 2020	1.95	0.67	0.13	0.21	0.14	3.10	84.4%	11.4%

AVERAGE NUMBER OF ANNUAL PRIMARY CARE ENCOUNTERS PER ENROLLEE, FYs 2017–2020



Source: MHS administrative data; DHA/HCO/Healthcare Optimization Division, 10/29/2020

Notes:

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

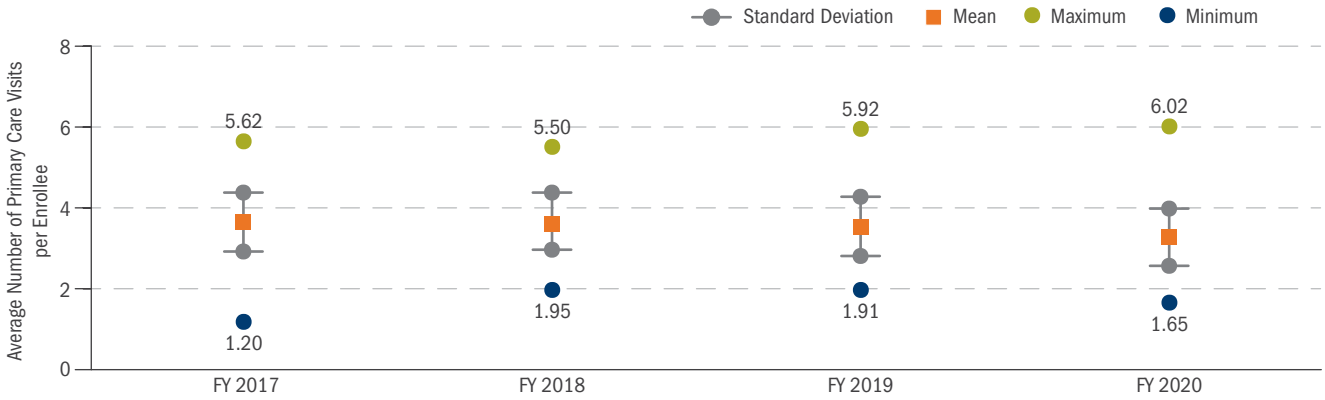
– Purchased care data may not be complete for up to one year due to claims processing.

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

AVERAGE NUMBER OF ANNUAL MTF ENROLLEE VISITS FOR PRIMARY CARE OVERALL, FYs 2017–2020

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2017–FY 2020 CHANGE
Mean	3.64	3.58	3.54	3.27	–0.38
Standard Deviation	0.73	0.62	0.74	0.71	–0.03
Median	3.58	3.46	3.40	3.09	–0.49
75th Percentile	4.11	3.93	4.03	3.78	–0.33
25th Percentile	3.21	3.20	3.07	2.77	–0.44
Maximum	5.62	5.50	5.92	6.02	0.40
Minimum	1.20	1.95	1.91	1.65	0.44
Range	4.42	3.55	4.01	4.38	–0.05

AVERAGE NUMBER OF ANNUAL MTF ENROLLEE VISITS FOR PRIMARY CARE OVERALL, FYs 2017–2020



Source: MHS administrative data; DHA/HCO/Healthcare Optimization Division, 10/29/2020

Notes:

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

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

Improvement Tools

In FY 2020, the MHS continued expanding the centralized performance report capabilities in the Direct Access Reporting Tool (DART) on the CarePoint Information Portal to provide additional tools for MTFs to adjust supply to meet beneficiary demand. In FY 2020, the DART also released new reports to measure MTF compliance with DHA policies on expanded hours and standardized appointing. Additional dashboards are available on the CarePoint Information Portal. The tools below will be expanded to report and predict unexpected events, including missed appointments and cancellations by beneficiary age and category and by type of care. Finally, all tools will be expanded to show specialty care and inpatient data to support market optimization efforts.

Template Optimization Tool

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

Build or Buy Tool on CarePoint

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

ACCESS TO MHS CARE *(CONT.)*

Specialty Care Access

In FY 2020, the MHS continued monitoring specialty care performance for several reasons: most purchased care costs for MTF enrollees are due to specialty deferrals to purchased care; patient feedback indicated dissatisfaction with the decentralized specialty care processes and variance among MTFs; and capturing specialty care workload delivered in the MTF enhances clinical currency and a ready medical force, which includes both providers and clinical support staff. In FY 2018, the MHS codified specialty care standards in the DHA-IPM 18-001 on standard appointing processes and productivity. To measure compliance with the policy, enhance patient experience, and eliminate unwarranted variance among MTFs, a new measure was implemented—the percentage of referrals dispositioned within one business day—to complement the existing measure on the number of days between the appointment creation date and the appointment date. DHA-IPM 18-001 identifies standard MTF and market processes to improve both measures.

Percentage of Referrals Dispositioned within One Business Day

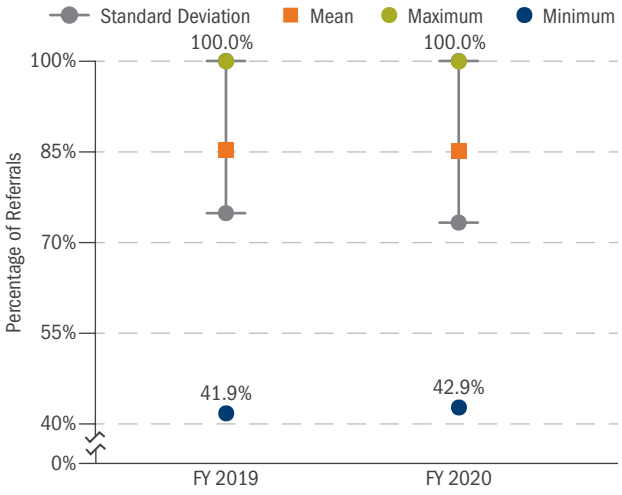
To "disposition" a referral is to determine whether the patient will be seen at the MTF, in the network, or if no appointment is required. Survey and qualitative data demonstrate a longer wait to obtain a scheduled appointment is a source of patient dissatisfaction and also delays needed care. DHA-IPM 18-001 identified standard processes to centralize referral review and appointing at the MTF or market level compared to existing decentralized and time-consuming processes in which each specialty clinic reviewed referrals and scheduled appointments. As stated in DHA-IPM 18-001, MTFs are required to implement processes to ensure that the MTF decides to accept or defer the referral to the network within 24 hours and subsequently to schedule the beneficiary's appointment within two business days; the MHS goal is for the entire process to be accomplished in three business days or fewer.

In FY 2020 85 percent of referrals were dispositioned within one business day, which is consistent with FY 2019 rates. The MHS has a standard of 90 percent of referrals being dispositioned within one business day. As the MHS is now monitoring this metric, we expect performance to improve to meet the standard in FY 2021.

PERCENTAGE OF REFERRALS DISPOSITIONED WITHIN ONE BUSINESS DAY FYs 2019–2020

	FY 2019	FY 2020
Mean	85.2%	85.3%
Standard Deviation	10.4%	12.0%
Median	87.3%	88.7%
75th Percentile	93.3%	94.3%
25th Percentile	80.8%	80.8%
Maximum	100.0%	100.0%
Minimum	41.9%	42.9%
Range	58.1%	57.1%

PERCENTAGE OF REFERRALS DISPOSITIONED WITHIN ONE BUSINESS DAY FYs 2019–2020



Source: MHS Administrative Data; DHA/HCO/Healthcare Optimization Division, 10/30/2020
Notes:
– Parent facility scores were used to describe variability in the results above.
– Parent facilities with fewer than 10 referrals issued were not included in the results.
– Results continue to be revised for four months after referral issuance.
– Data exclude MHS GENESIS results.

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. The direct care system has been meeting this goal since January 2020 (not displayed), which has led to an overall average of 14 days for FY 2020—a large improvement from the performance in FY 2019.

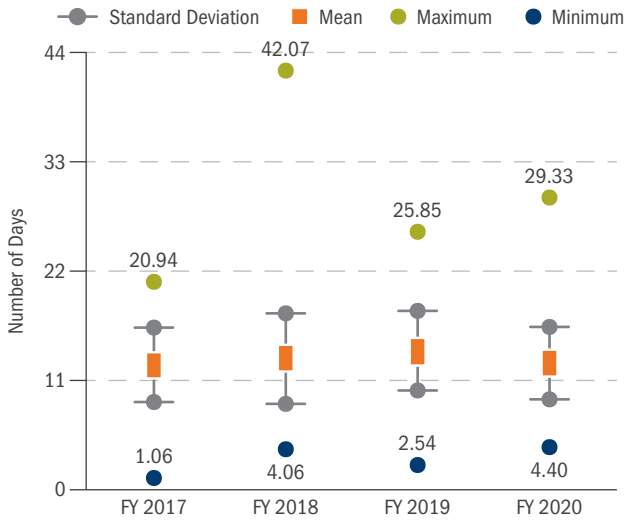
AVERAGE NUMBER OF DAYS FROM MTF BOOKED TO MTF APPOINTMENT, FYs 2017–2020

	FY 2017	FY 2018	FY 2019	FY 2020
Days from MTF Booked to MTF Appt.	14.88	15.30	16.38	14.31

AVERAGE NUMBER OF DAYS FROM MTF BOOKED TO MTF APPOINTMENT, FYs 2017–2020

	FY 2017	FY 2018	FY 2019	FY 2020	FY 2017–FY 2020 CHANGE
Mean	12.49	13.23	13.93	12.68	0.19
Standard Deviation	3.83	4.56	4.01	3.58	–0.25
Median	12.24	12.81	14.00	12.71	0.46
75th Percentile	15.31	14.79	16.57	14.94	–0.37
25th Percentile	9.97	10.91	11.56	10.51	0.54
Maximum	20.94	42.07	25.85	29.33	8.39
Minimum	1.06	4.06	2.54	4.40	3.34
Range	19.88	38.00	23.31	24.93	5.05

AVERAGE NUMBER OF DAYS FROM MTF BOOKED TO MTF APPOINTMENT, FYs 2017–2020



Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 10/29/2020
Notes:
– Parent facility scores were used to describe variability in the results above.
– Data exclude MHS GENESIS sites.
– FY 2020 results exclude August–September 2020.
– Results include referrals filled up to seven months after referral issuance.

Specialty Care Ambulatory Leakage

In FY 2020 (September 2019–June 2020), the MHS had elevated specialty care leakage above previous years at 14.4 percent. The MHS goal is to reduce this leakage to 10.7 percent. In FY 2021, the MHS will further analyze performance variance at each MTF and by product lines to identify reasons for and solutions to improve direct care system capacity.

AVERAGE AMBULATORY SPECIALTY CARE LEAKAGE, FYs 2014–2020

	ANNUAL AVERAGE
FY 2014	13.5%
FY 2015	13.2%
FY 2016	13.1%
FY 2017	13.5%
FY 2018	13.4%
FY 2019	13.7%
FY 2020	14.4%

Source: MHS administrative data; DHA/HCO/Healthcare Optimization Division, 10/30/2020
Notes: FY 2020 excludes July–September 2020 records.

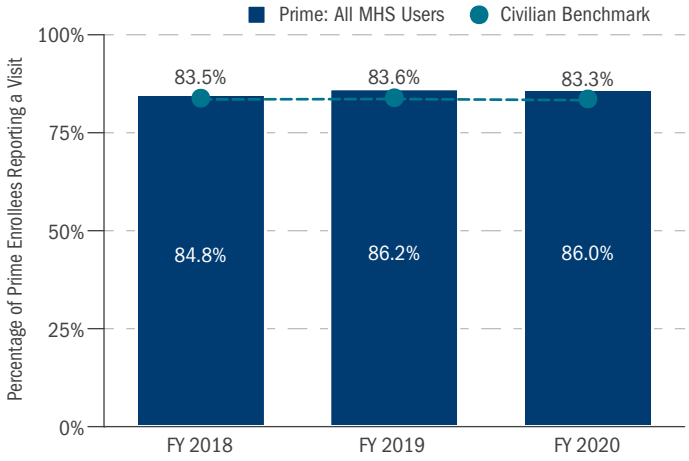
ACCESS TO MHS CARE *(CONT.)*

Measures of Availability and Ease of Access

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

- **Self-Reported Access:** The ability to see a doctor reflects one measure of successful access to the health care system. Prime enrollees were asked whether they had at least one outpatient visit during the past year. As shown in the chart (at right), access to and use of outpatient services remain high among Prime enrollees (with either an MTF or network PCM), with 86 percent reporting at least one visit in FY 2020. MHS results remain statistically comparable to the civilian benchmark of just over 83 percent. Actual administrative data demonstrate 85 percent of direct care system (non-Active Duty) enrollees had at least one primary care encounter in FY 2020.

TRENDS IN PRIME ENROLLEES HAVING AT LEAST ONE OUTPATIENT VISIT DURING THE YEAR, FYs 2018–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, Health Care Survey of DoD Beneficiaries (HCSDB) data, adjusted for age and health status, as of 10/15/2020

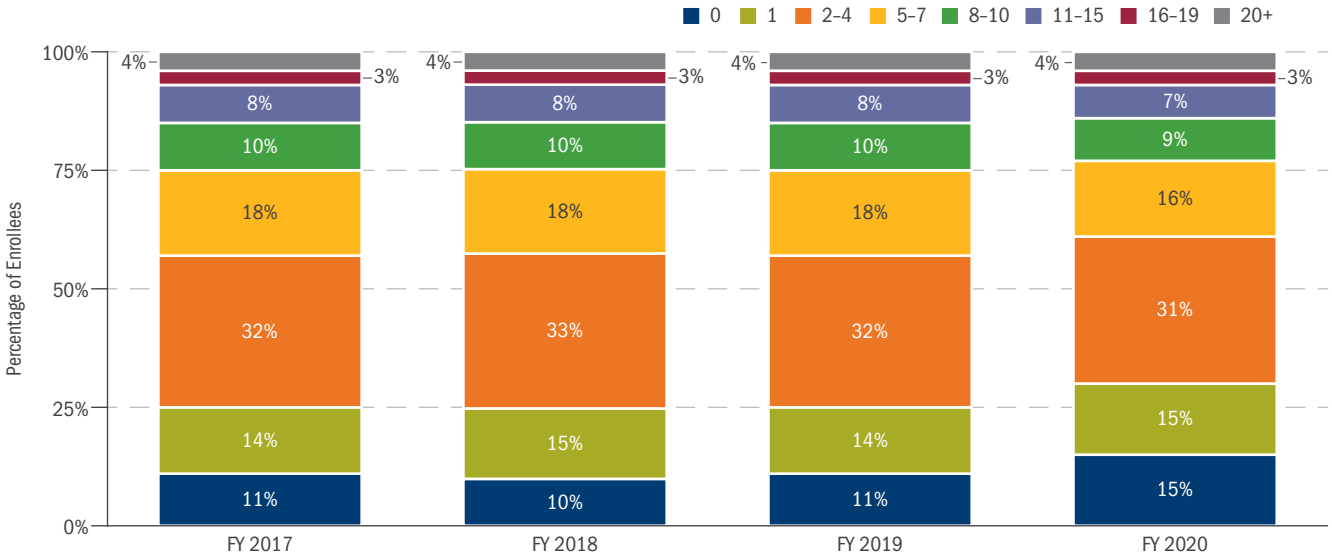
Note: "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the National Committee for Quality Assurance (NCQA) by commercial plans. Benchmarks used in 2018, 2019, and 2020 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.)*

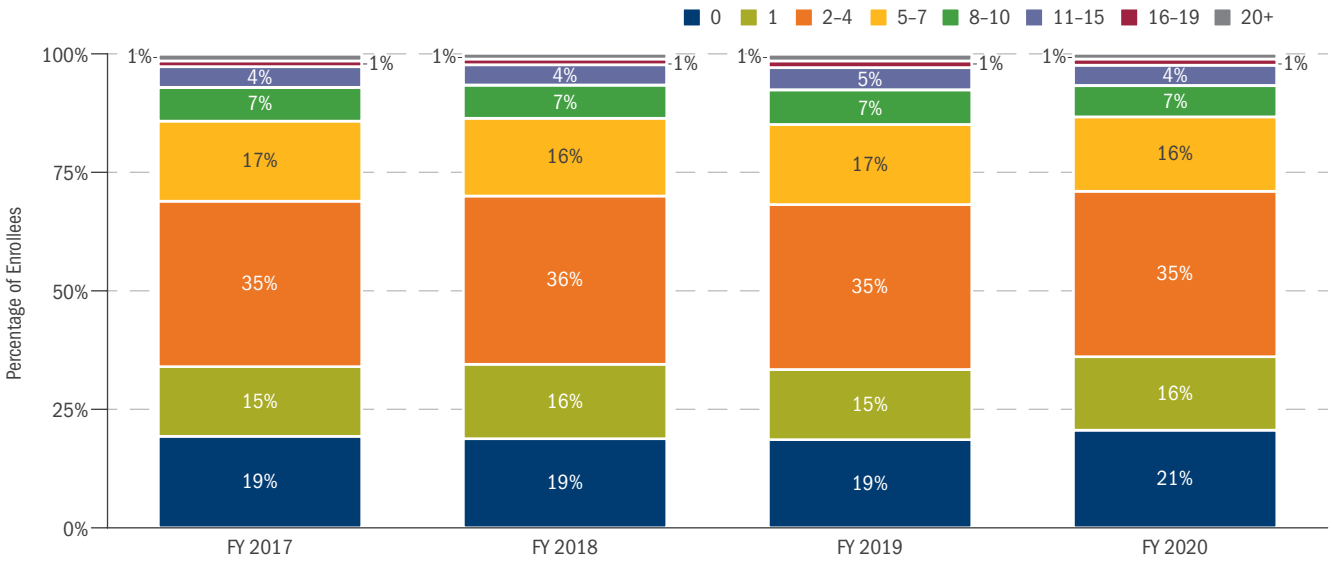
- **Direct Care Enrollee Access:** Based on administrative utilization data shown in the chart below, 85 percent of all non-Active Duty MTF enrollees under age 65 had at least one recorded outpatient visit for primary care reasons in FY 2020 (i.e., 15 percent did not have at least one visit). This access has been relatively stable since 2014. In FY 2020, 46 percent had between one and four visits, and 39 percent had five or more visits.

PERCENTAGE OF NON-ACTIVE DUTY ENROLLEES <65, BY NUMBER OF ANNUAL VISITS FOR MTF PRIMARY CARE (ANY VENUE), FYs 2017–2020



- **Purchased Care Enrollee Access:** Based on administrative claims utilization data, the chart below shows that 79 percent of all non-Active Duty managed care support contractor (MCSC) Network Prime enrollees under age 65 had at least one recorded outpatient visit for primary care reasons in FY 2020 (i.e., 21 percent had no visits). Fifty-one percent of non-Active Duty MCSC Network Prime enrollees had between one and four visits, and 29 percent had five or more visits in FY 2020.

PERCENTAGE OF NON-ACTIVE DUTY ENROLLEES <65, BY NUMBER OF ANNUAL VISITS FOR MCSC/NETWORK PRIMARY CARE (ANY VENUE), FYs 2017–2020



Source: MHS administrative data Systems (M2), DHA/SP&FI (J-5)/Analytics and Evaluation Division, 12/16/2020

Notes:

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

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

ACCESS TO MHS CARE *(CONT.)*

Exploring Patterns of Urgent Care Use among TRICARE Beneficiaries

Urgent care centers (also called walk-in, immediate, and convenient care) provide immediate attention to patients with a non-emergency illness or injury. They play an important and expanding role in American health care, with a growth rate of nearly 20 percent from 2015 to 2018.[1] Convenience (after-hours options) and low out-of-pocket costs (generally about the same as primary care visits and less expensive than emergency room visits[2]) make urgent care appealing to patients. Many urgent care centers also offer patients the convenience of getting primary care services, such as vaccinations and physicals, which can be valuable to patients without a personal doctor. The Urgent Care Association estimates that urgent care centers handle more than 29 percent of all primary care visits in the country.[1]

Getting prompt access to care, including urgent care, is a DHA priority for TRICARE beneficiaries. To help beneficiaries get prompt access to care, TRICARE allows beneficiaries to use urgent care centers associated with any TRICARE-authorized center or network provider without a referral. Because urgent care centers are increasingly offering primary care, it is important to know which TRICARE beneficiaries are using urgent care centers and why.

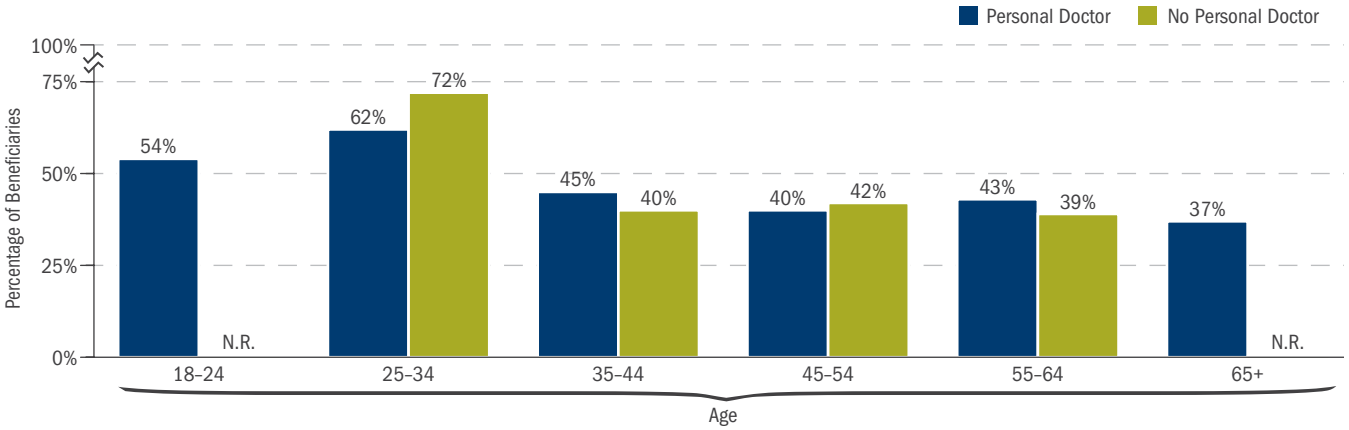
For this analysis, HCSDB respondents were organized into three groups: beneficiaries without a personal doctor; beneficiaries with a personal doctor whose availability was unknown or whose office was closed at the time of the urgent care visit; and beneficiaries with a personal doctor whose office was open.

Who Uses Urgent Care

More than two in five (43 percent) of non-Active Duty (non-AD) beneficiaries who needed immediate care within the past six months used an urgent care center (not shown). Most non-AD beneficiaries who needed immediate care had a personal doctor (92 percent, not shown), but this varied significantly by age. Nearly all beneficiaries (99 percent, not shown) 65 or older who needed immediate care indicated they had a personal doctor, compared to roughly 75 percent of beneficiaries aged 25–34 (not shown). After controlling for age, there was no difference in utilization rates of urgent care centers between beneficiaries with and without a personal doctor.

Urgent care centers were the most popular among younger beneficiaries, particularly those aged 25–34. Seventy-two percent of beneficiaries in this age group who did not have a personal doctor and 62 percent of beneficiaries who did used an urgent care center. In comparison, about 40 percent of beneficiaries 35 and older visited an urgent care center, regardless of whether they had a personal doctor or not.

USE OF URGENT CARE CENTERS BY BENEFICIARIES WITH IMMEDIATE CARE NEEDS, BY HAVING A PERSONAL DOCTOR AND AGE, OCTOBER 2019–JANUARY 2020



Source: FY 2020 Q1 HCSDB. N = 8,395. The response rate is 8.4 percent. The survey was fielded from October 9, 2019, to January 31, 2020.

N.R. = Not reported due to small sample size.

[1] Alkon, C., "What's Behind the Growth of Urgent Care Clinics?" Medical Economics, vol. 95, no. 17, August 29, 2019, https://www.medicaleconomics.com/business/whats-behind-growth-urgent-care-clinics, accessed February 27, 2020.

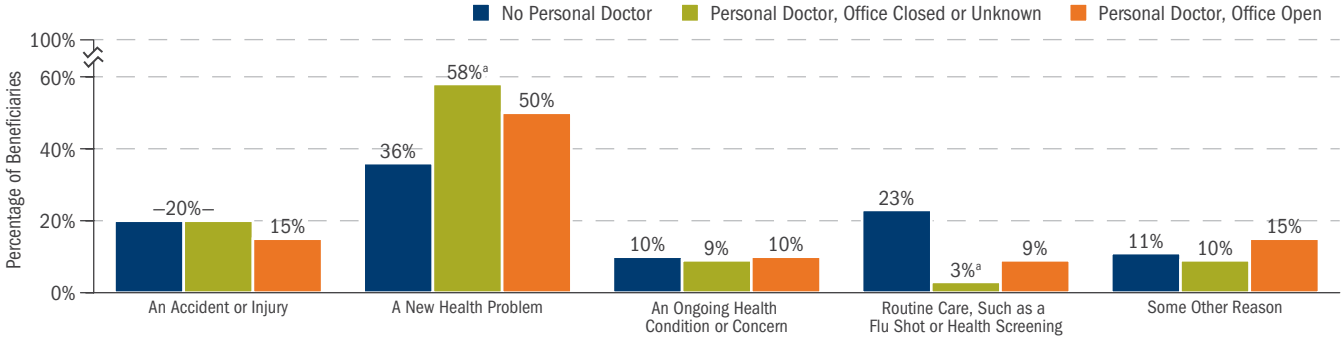
[2] Yee, T., et al., "The Surge in Urgent Care Centers: Emergency Department Alternative or Costly Convenience," HSC Research Brief No. 26, National Institute for Health Care Reform, July 2013, https://www.nihcr.org/analysis/improving-care-delivery/urgent-care-centers/, accessed February 27, 2020.

Exploring Patterns of Urgent Care Use among TRICARE Beneficiaries *(cont.)*

Why People Use Urgent Care

The main reason given for using an urgent care center was a new health problem, regardless of whether the person had access to a personal doctor. Over half of beneficiaries who did have a personal doctor—and over one-third of those who did not have one—went to an urgent care center for a new health problem. For beneficiaries without a personal doctor, the second most popular reason for using an urgent care center was routine care, such as a flu shot or health screening (23 percent). In comparison, only 9 percent of beneficiaries with a personal doctor who was available—and 3 percent of beneficiaries with a personal doctor who was not available—used urgent care centers for this reason. Only about 10 percent of all beneficiaries, regardless of their access to a personal doctor, used urgent care for an ongoing health problem.

REASONS FOR SEEKING URGENT CARE, BY HAVING A PERSONAL DOCTOR AND DOCTOR AVAILABILITY, OCTOBER 2019–JANUARY 2020



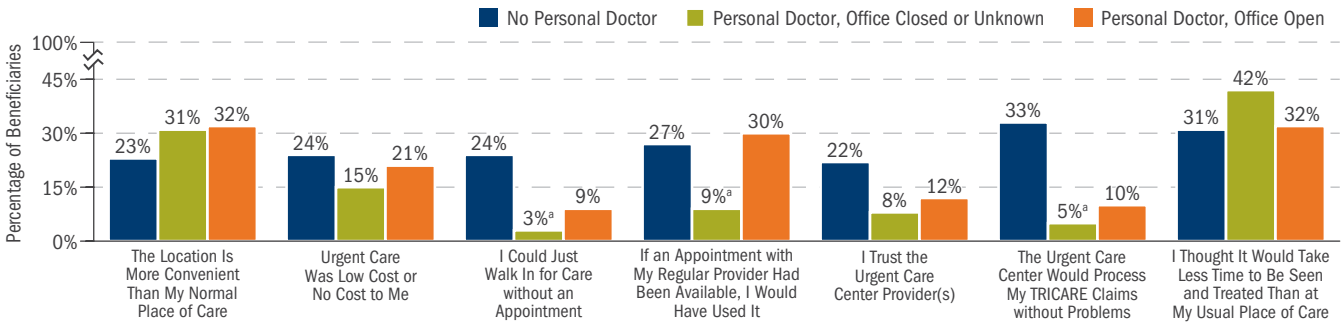
Source: FY 2020 Q1 HCSDB. N = 8,395. The response rate is 8.4 percent. The survey was fielded from October 9, 2019, to January 31, 2020.

[a] Significantly different from beneficiaries without a personal doctor ($p < 0.05$).

Beneficiaries were asked whether they agreed or strongly agreed with statements about their most recent visit. Many beneficiaries agreed that using urgent care would take less time than going to their usual place of care (32 percent of beneficiaries with a personal doctor whose office was open, 42 percent of beneficiaries with a personal doctor whose office was closed, and 31 percent of beneficiaries without a personal doctor). Approximately 32 percent of beneficiaries with a personal doctor and 23 percent without agreed that the location of urgent care is more convenient than their usual place of care.

The three groups had different attitudes on the importance of the walk-in option and the expected ease of processing TRICARE claims. Nearly one-quarter of beneficiaries without a personal doctor cited the ability to walk in without an appointment as a reason for going to urgent care, compared with 3 percent of those whose personal doctor was unavailable at the time. One-third of beneficiaries without a personal doctor also expected that the urgent care center would process their TRICARE claim without, while 5 to 10 percent with a personal doctor agreed with this statement. Beneficiaries with a personal doctor who was unavailable were less likely than those without a personal doctor to say that they would have gone to their regular provider if an appointment had been available, suggesting that they went directly to an urgent care center when they knew their personal doctor was unavailable. Almost one-third of beneficiaries without a personal doctor agreed that they would have gone to their regular provider if an appointment had been available; however, we do not know who these beneficiaries are referring to as their regular provider because they said they did not have a personal doctor.

AGREEMENT WITH STATEMENTS ABOUT THE RECENT URGENT CARE CENTER VISIT, BY HAVING A PERSONAL DOCTOR AND DOCTOR AVAILABILITY, OCTOBER 2019–JANUARY 2020



Source: FY 2020 Q1 HCSDB. N = 8,395. The response rate is 8.4 percent. The survey was fielded from October 9, 2019, to January 31, 2020.

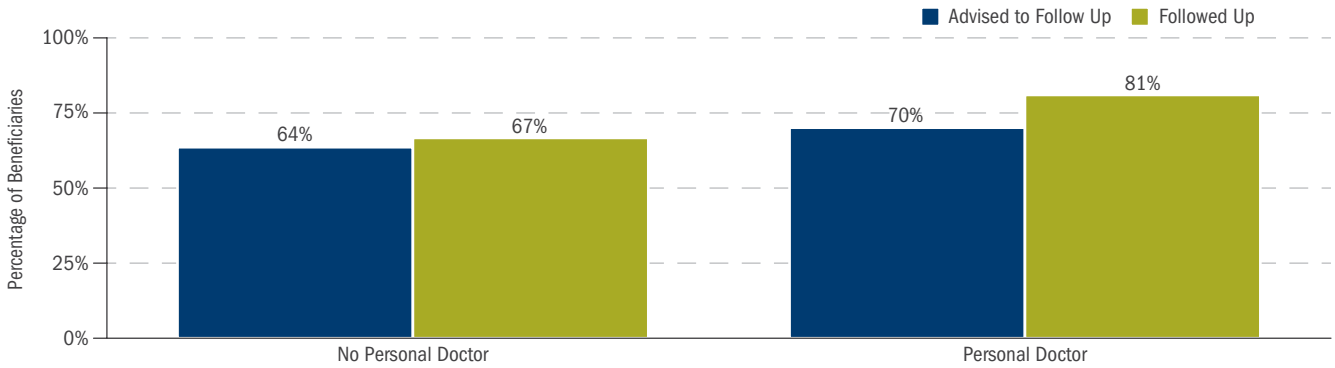
[a] Significantly different from beneficiaries without a personal doctor ($p < 0.05$).

Exploring Patterns of Urgent Care Use among TRICARE Beneficiaries *(cont.)*

Following Up with a Personal Doctor

Urgent care physicians often reinforce the importance of continuity of care, even for people without a personal doctor. During the urgent care visit, 64 percent of beneficiaries without a personal doctor and 70 percent of beneficiaries with a personal doctor were advised to follow up with their personal doctor. For beneficiaries without a personal doctor, 67 percent said they did seek follow-up care. Eighty-one percent of those beneficiaries with a personal doctor said they did seek follow-up care.

BENEFICIARIES ADVISED TO FOLLOW UP AND RECEIVING FOLLOW-UP CARE, BY HAVING A PERSONAL DOCTOR, OCTOBER 2019–JANUARY 2020

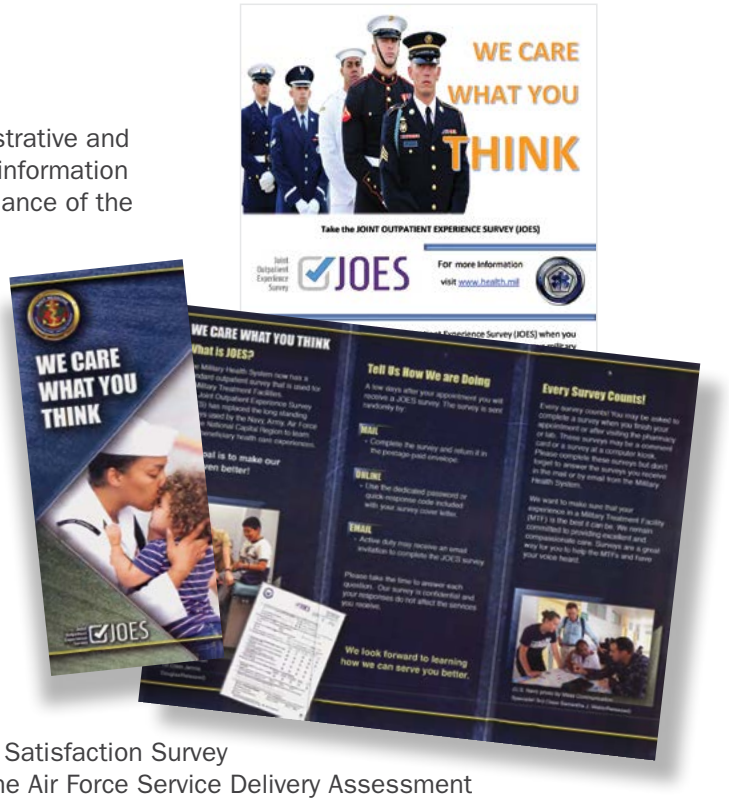


Source: FY 2020 Q1 HCSDB. N = 8,395. The response rate is 8.4 percent. The survey was fielded from October 9, 2019, to January 31, 2020.

Conclusion

Beneficiaries agreed urgent care centers were appealing due to their convenience, but there were differences in who was using them and how they were used. Urgent care center use was more popular among younger beneficiaries, particularly those aged 25–34, compared to older beneficiaries. Among beneficiaries aged 25–34, using an urgent care center was 10 percentage points higher for those without a personal doctor than those with one; however, no significant difference was detected, possibly due to a low number of respondents. Beneficiaries without a personal doctor were more likely to go to an urgent care center for routine care, compared to beneficiaries with a personal doctor. The fact that many beneficiaries without a personal doctor appreciated the quick processing of claims and the relatively inexpensive treatment could mean that urgent care centers are filling a critical access need.

ACCESS TO MHS CARE *(CONT.)*



Patient-Centered, Self-Reported Measures

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

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

The goal of MHS outpatient surveys is to monitor and report on the experience and satisfaction of MHS beneficiaries who have received outpatient care in an MTF or civilian provider office. FY 2020 marks the fourth complete year that the Joint Outpatient Experience Survey (JOES) has been fielded to replace the Army Provider Level Satisfaction Survey (APLSS), the Navy Patient Satisfaction Survey (PSS), and the Air Force Service Delivery Assessment (SDA). Almost 500,000 JOES were returned during FY 2020, providing targeted areas for improvement in outpatient care at military facilities. As shown below, JOES results are comparable between each Service and have varied only minimally over time.

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

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

Additionally, more surveys are now being completed by Service members stationed overseas, providing invaluable feedback on their care. The results of the JOES and JOES-C measures are published to the JOES/JOES-C reporting website that allows users to examine the quality of care across the MHS. Some of these measures are routinely reported to senior MHS leadership as core measures on various dashboards, including the MHS Dashboard, TRICARE Health Plan Enterprise Support Activity Purchased Care Dashboard, Vital Signs Dashboard, and the QPP 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 HCSDB, are also included in the findings reported here, where appropriate, as a comparison against outpatient surveys that are administered following receipt of care. The HCSDB, based on the CAHPS Health Plan Survey, is administered quarterly to a sample of the approximately 9.4 million members of the eligible MHS population, irrespective of where they might have received care and uses a 12-month recall period for most questions (i.e., "In the last 12 months..."). Both the HCSDB and CAHPS Health Plan Surveys focus on the performance of the health plan over time from the beneficiary's perspective. The JOES-C is focused on health care received over the past six months following a specific outpatient visit, while the JOES pertains solely to a specifically referenced visit. The comparison of these surveys provides a more comprehensive understanding of the experiences of beneficiaries, regardless of the survey that they are completing or the care that they may or may not have received.

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

Privacy of Adolescents

In support of state and federal statutes, the MHS respects and upholds the privacy 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 TRICARE Inpatient Satisfaction Survey (TRISS), JOES-C, or HCSDB. The MHS protected the privacy rights of adolescents when administering the JOES by only sending a survey to Service members responding to a child's care for children aged 0–10. The following patient-centered, self-reported results are based on the ages included in the sample.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule and Adolescents[1]

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

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

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

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

ACCESS TO MHS CARE *(CONT.)*

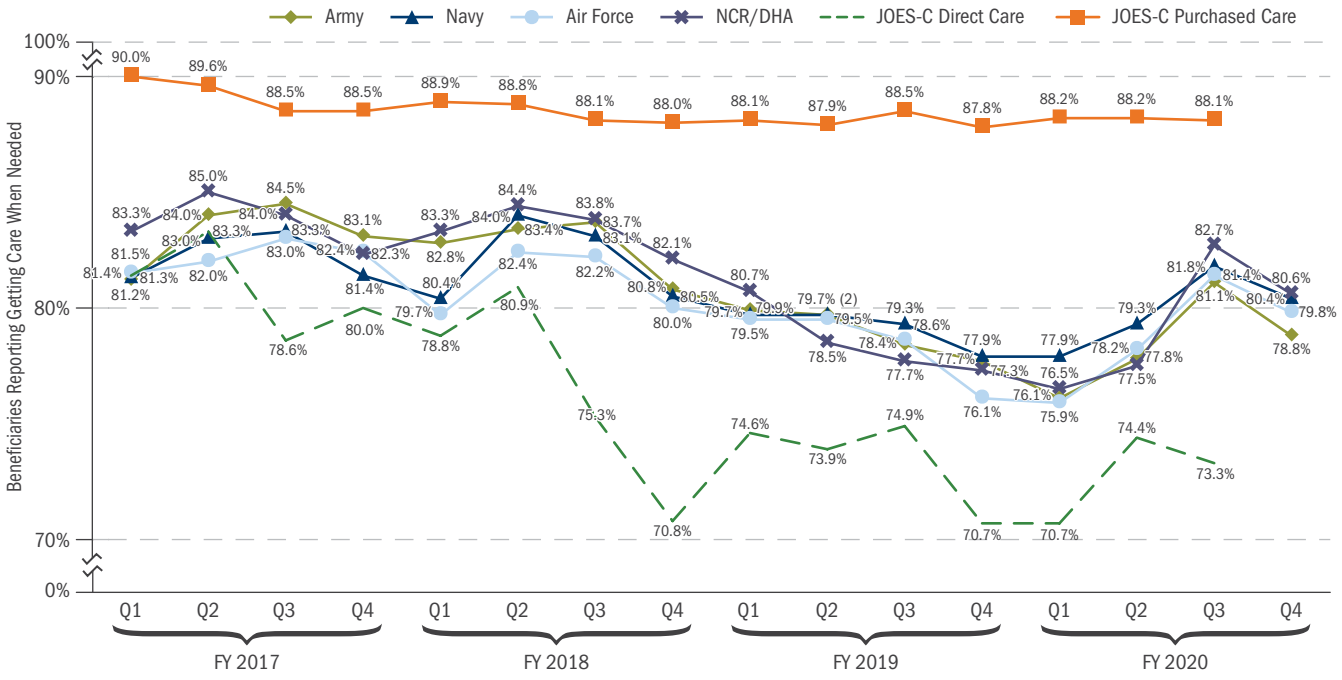
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care

Ratings of Getting Care When Needed

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

- Since the introduction of JOES in the second half of FY 2016, Service results for Getting Care When Needed are now comparable and have converged.
- For Getting Care When Needed, the lowest scores were present in FY 2020 Q1 for all Services. The highest scores were present in FY 2017 Q2 & Q3 for Army, Air Force, and National Capital Region (NCR)/ DHA. FY 2018 Q2 presented the highest score for Navy. Score ranges for each Service remain largely consistent from FY 2017 to FY 2020.
  - Air Force from 76 percent to 83 percent
  - Army from 76 percent to 85 percent
  - Navy from 78 percent to 84 percent
  - NCR/DHA from 77 percent to 85 percent
- Service scores for JOES-C purchased care have been steady from FY 2017 to FY 2020. There has been a slight decrease in scores beginning FY 2018 Q4 for all Services. JOES-C direct care scores are the lowest compared to all other surveys for Getting Care When Needed.

JOES GETTING CARE WHEN NEEDED, FYs 2017–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES, weighted data, compiled 1/13/2021

Notes:

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

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

– The NCR category is represented by FY 2017 Q1 through FY 2019 Q1 data points and is made up of parent facilities Fort Belvoir Community Hospital (FBCH) and Walter Reed National Military Medical Center (WRNMMC). Parent facilities FBCH, WRNMMC, 81st Medical Group at Keesler Air Force Base, Womack Army Medical Center, Naval Hospital Jacksonville, 4th Medical Group at Seymour Johnson Air Force Base, and 628th Medical Group at Joint Base Charleston compose the DHA category from FY 2019 Q2 through FY 2020 Q4, and includes Kimbrough Ambulatory Center at Fort Meade for FY 2020.

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

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

Extent of Change in Variability in Patient Ratings Over Time

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

JOES Getting Care When Needed—Variability Over Time

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

- From FY 2019 to FY 2020, the mean scores increased between 1 to 2 percent for Air Force, Navy, and NCR/DHA. Army had a decrease of 0.1 percent over the same period. Changes to the median from FY 2019 to FY 2020 were less than 1 percent for all branches of Service. On average, standard deviation dispersion indicated that data remained close to the mean for all Services from FY 2019 to FY 2020.
- The 25th percentile increased for all Services, with Air Force having an increase of approximately 2 percentage points. The 75th percentile decreased for Air Force and Army, while Navy increased by 2.3 percent over the same time period. Dispersion, in terms of the range between the highest- and lowest-scoring parent facility, decreased for all Service branches from FY 2019 to FY 2020.

ACCESS TO MHS CARE *(CONT.)*

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

VARIABILITY IN JOES GETTING CARE WHEN NEEDED, FYs 2019–2020

	FY 2019 Q1 & Q2	FY 2019 Q3 & Q4	FY 2020 Q1 & Q2	FY 2020 Q3 & Q4	% POINT CHANGE (FY 2019 Q1 & Q2 TO FY 2020 Q3 & Q4)
ARMY					
Number of Respondents	103,099	93,689	80,755	74,532	-27.7%
Service Score (Mean)	79.8%	78.8%	77.0%	79.9%	0.1
Standard Deviation	4.9%	5.9%	4.9%	4.1%	-0.8
Median	80.5%	78.9%	76.9%	80.1%	-0.4
75th Percentile	83.4%	82.3%	80.6%	83.6%	0.2
25th Percentile	77.1%	76.4%	74.9%	78.1%	1.0
Maximum	93.4%	85.3%	91.0%	88.4%	-5.0
Minimum	70.4%	57.7%	69.1%	69.7%	-0.7
Range	23.0%	27.5%	21.9%	18.7%	-4.3
AIR FORCE					
Number of Respondents	63,964	56,979	58,525	50,700	-20.7%
Service Score (Mean)	79.5%	78.0%	77.0%	80.6%	1.1
Standard Deviation	8.7%	7.9%	7.6%	6.3%	-2.4
Median	81.0%	77.3%	78.3%	81.1%	0.1
75th Percentile	85.7%	83.1%	82.2%	85.3%	-0.4
25th Percentile	75.7%	73.1%	73.4%	77.6%	1.9
Maximum	100.0%	98.0%	97.3%	100.0%	0.0
Minimum	58.2%	58.4%	59.9%	69.2%	11.0
Range	41.8%	39.6%	37.4%	30.8%	-11.0
NAVY					
Number of Respondents	52,215	48,378	41,319	39,591	-24.2%
Service Score (Mean)	79.7%	79.1%	78.7%	81.0%	1.3
Standard Deviation	5.1%	5.3%	6.1%	4.2%	-0.9
Median	81.2%	80.7%	81.3%	81.7%	0.5
75th Percentile	83.8%	84.6%	86.5%	86.1%	2.3
25th Percentile	79.4%	76.9%	76.7%	80.2%	0.8
Maximum	98.5%	90.7%	90.8%	90.5%	-8.0
Minimum	73.2%	69.9%	69.2%	73.7%	0.5
Range	25.2%	20.8%	21.8%	16.8%	-8.4
NCR/DHA					
Number of Respondents	31,244	39,350	41,930	39,863	27.6%
Service Score (Mean)	79.2%	77.9%	77.1%	81.9%	2.3

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES, weighted data, compiled 1/13/2021

Notes:

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

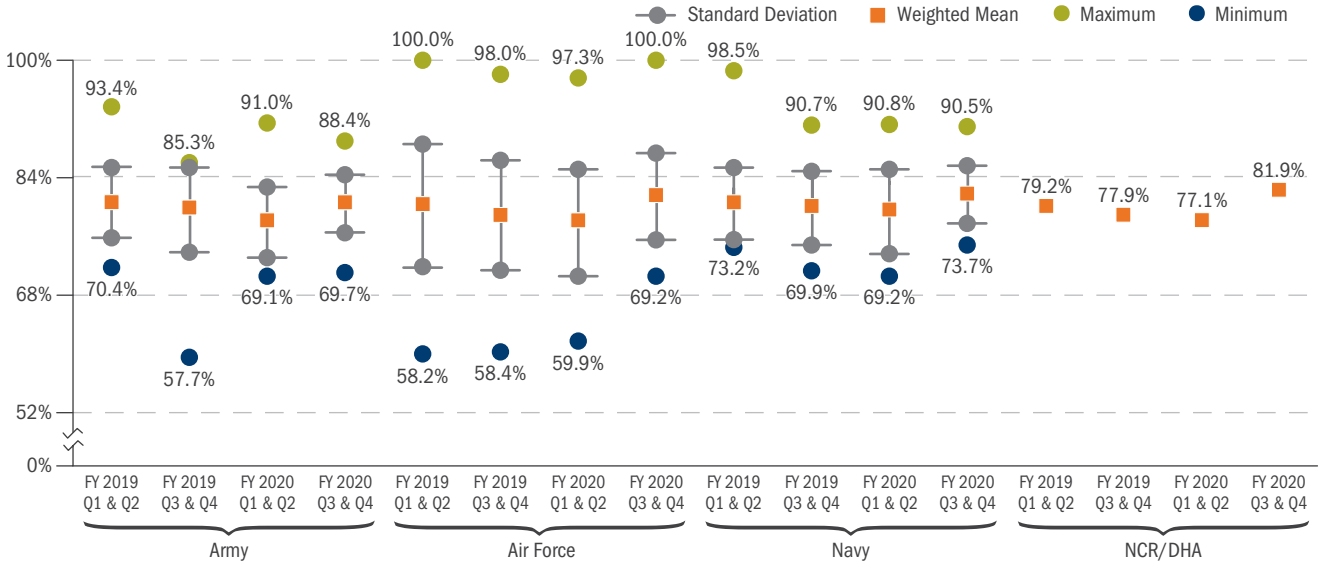
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration.

– The NCR category is represented by FY 2019 Q1 data points and is made up of parent facilities FBCH and WRNMMC. Parent facilities FBCH, WRNMMC, 81st Medical Group at Keesler Air Force Base, Womack Army Medical Center, Naval Hospital Jacksonville, 4th Medical Group at Seymour Johnson Air Force Base, and 628th Medical Group at Joint Base Charleston compose the DHA category from FY 2019 Q2 through FY 2020 Q4, and includes Kimbrough Ambulatory Center at Fort Meade for FY 2020.

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 2019–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES, weighted data, compiled 1/13/2021

Notes:

– Parent facility scores were used above, and those reporting fewer than 10 responses in the time period were excluded from analyses.
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration.
– The box plot shows the Service score (weighted mean) with the standard deviation, minimum, and maximum scores for each Service.
– The NCR category is represented by FY 2019 Q1 data points and is made up of parent facilities FBCH and WRNMMC. Parent facilities FBCH, WRNMMC, 81st Medical Group at Keesler Air Force Base, Womack Army Medical Center, Naval Hospital Jacksonville, 4th Medical Group at Seymour Johnson Air Force Base, and 628th Medical Group at Joint Base Charleston compose the DHA category from FY 2019 Q2 through FY 2020 Q4, and includes Kimbrough Ambulatory Center at Fort Meade for FY 2020.

ACCESS TO MHS CARE *(CONT.)*

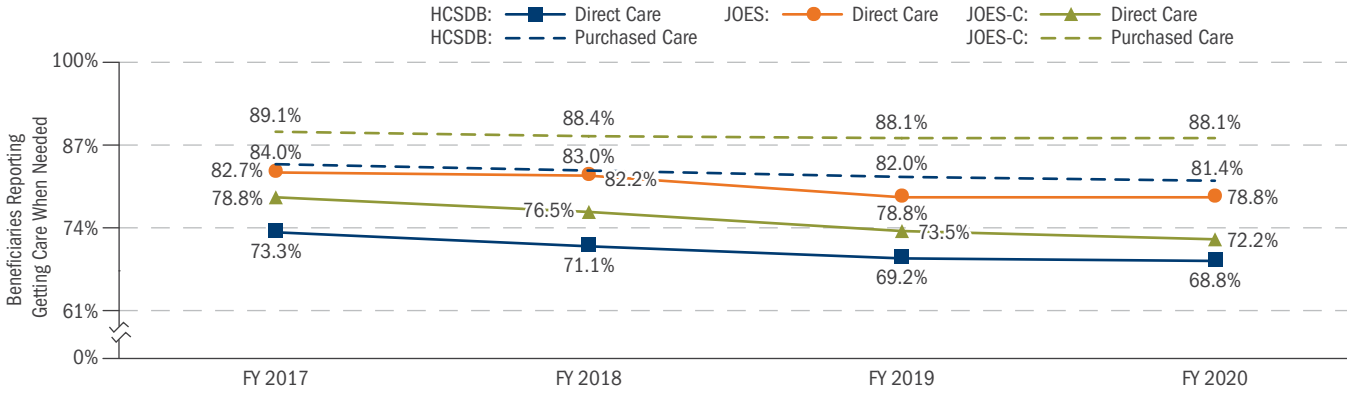
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care *(cont.)*

Comparison of Multiple Surveys—Getting Care When Needed

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

- Beneficiaries who utilize or are assigned to purchased care report greater access to their provider than those who utilize or are assigned to direct care, regardless of the time period. For JOES-C, scores for purchased care are 16 points higher than those for direct care in FY 2020. Purchased care scores for HCSDB are 13 percentage points higher than their direct care counterpart scores in FY 2020.
- Beneficiaries who completed JOES-C reported greater access to care than beneficiaries who completed HCSDB, over time, for direct care and purchased care, respectively. This may be because beneficiaries who complete JOES-C are beneficiaries who responded to a survey after having received care, while those who complete the HCSDB may not have received care or may not have received care as needed over the previous 12 months.
- Ratings of Getting Care When Needed have declined over time for all surveys from FY 2017 to FY 2020. JOES-C direct care rating for Getting Care When Needed decreased by less than 2 percentage points from FY 2019 to FY 2020. JOES-C purchased care and JOES direct care have both leveled off in FY 2020. HCSDB direct care and purchased care decreased less than 1 percent from FY 2019 to FY 2020.

HCSDB, JOES, AND JOES-C RATINGS OF GETTING CARE WHEN NEEDED, FYs 2017–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB, JOES, and JOES-C, weighted data, compiled 1/13/2021

Notes:

– Results for each survey above are weighted to appropriately represent the composition of the MHS population.
– Results for JOES-C FY 2020 direct care and purchased care include data from September 2019 to June 2020.
– Results for HCSDB are for Prime enrollees only. "HCSDB Direct Care" represents care received as Active Duty or through a military PCM for individuals under 65 and who have been enrolled for at least 6 months. "HCSDB Purchased Care" is defined as care received from civilian PCM for individuals under 65 who were enrolled in the following healthcare plans for at least six months: TRICARE Select, TRICARE Reserve Select, TRICARE Retired Reserve, or TRICARE Young Adult Select.
– "Getting Care When Needed" is assessed in each survey as an agreement to the following statement: "In general, I am able to see my provider when needed." The five-point scale for this question ranges from "Strongly Disagree" to "Strongly Agree." The results provided above are for those beneficiaries who reported either "Somewhat Agree" or "Strongly Agree."
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration, respective to the JOES and JOES-C.
– HCSDB data were derived from the FYs 2017–2020 HCSDB, as of 11/1/2020, and adjusted for age and health status. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology.

ACCESS TO MHS CARE *(CONT.)*

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

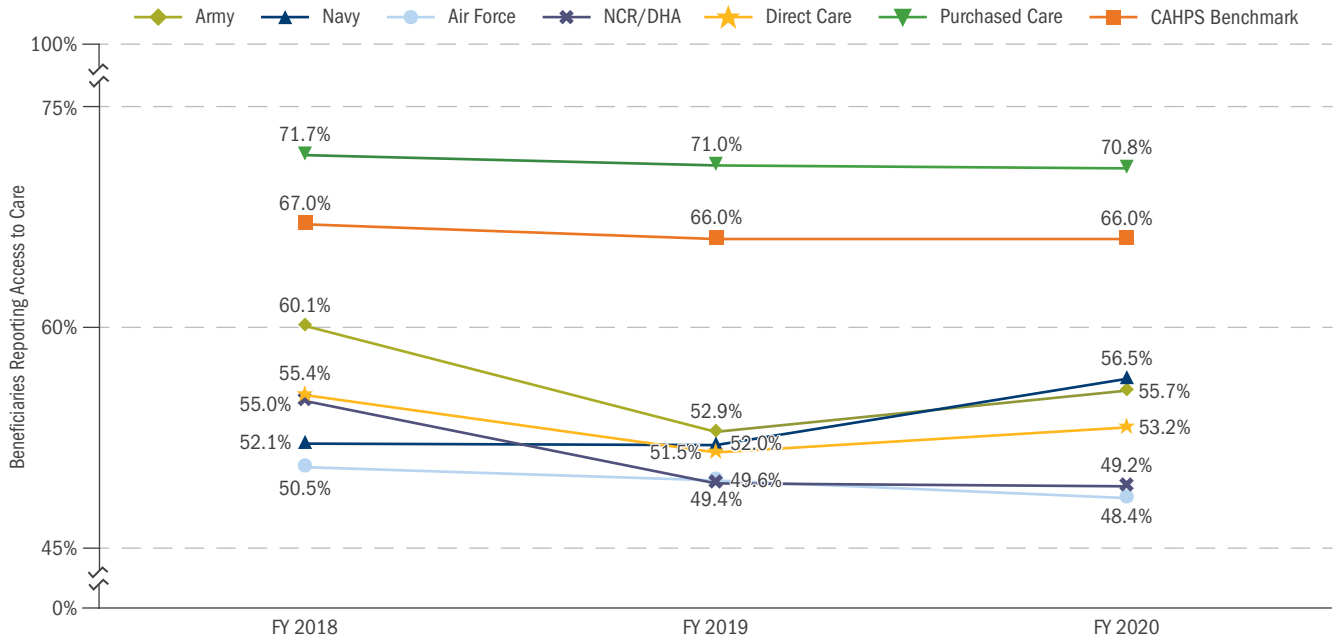
JOES-C Access to Care Composite

The Access to Care composite differs from the Getting Care When Needed measure because it is based on guidelines from AHRQ's CG-CAHPS. Additionally, the Access to Care composite is calculated based on multiple questions that are included in the results, and the reference ("look-back") period is six months compared to 24–48 hours for JOES. Component questions that are part of the Access to Care composite include whether the patient was able to be seen for routine and urgent appointments and if the patient received an answer to a question within an appropriate time.

- The Access to Care composite ratings for beneficiaries receiving outpatient care at civilian facilities (purchased care) are higher than for those receiving care from MTFs (direct care).
- With the introduction of JOES-C in FY 2016, overall scores for purchased care have slightly 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 2018 to FY 2020, there was a decrease in scores for the Army, Air Force, and NCR/DHA, while Navy scores improved.

BETTER CARE

JOES-C ACCESS TO CARE COMPOSITE, FYs 2018–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES-C, weighted data, compiled 12/7/2020

Notes:

- Results displayed above were weighted to represent the composition of the MHS population receiving care.
- FY 2020 data were incomplete at time of publication. Direct scores include data through July 2020. Purchase care scores include data through June 2020.
- Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration.
- The NCR category is represented by the FY 2018 Q1 through FY 2019 Q1 data points and is made up of parent facilities FBCH and WRNMMC. Parent facilities FBCH, WRNMMC, 81st Medical Group at Keesler Air Force Base, Womack Army Medical Center, Naval Hospital Jacksonville, 4th Medical Group at Seymour Johnson Air Force Base, and 628th Medical Group at Joint Base Charleston compose the DHA category from FY 2019 Q2 through FY 2020 Q4, and includes Kimbrough Ambulatory Center at Fort Meade for FY 2020.
- CAHPS benchmarks are the 50th percentiles from the respective 2017 and 2018 CG-CAHPS national civilian scores.

ACCESS TO MHS CARE *(CONT.)*

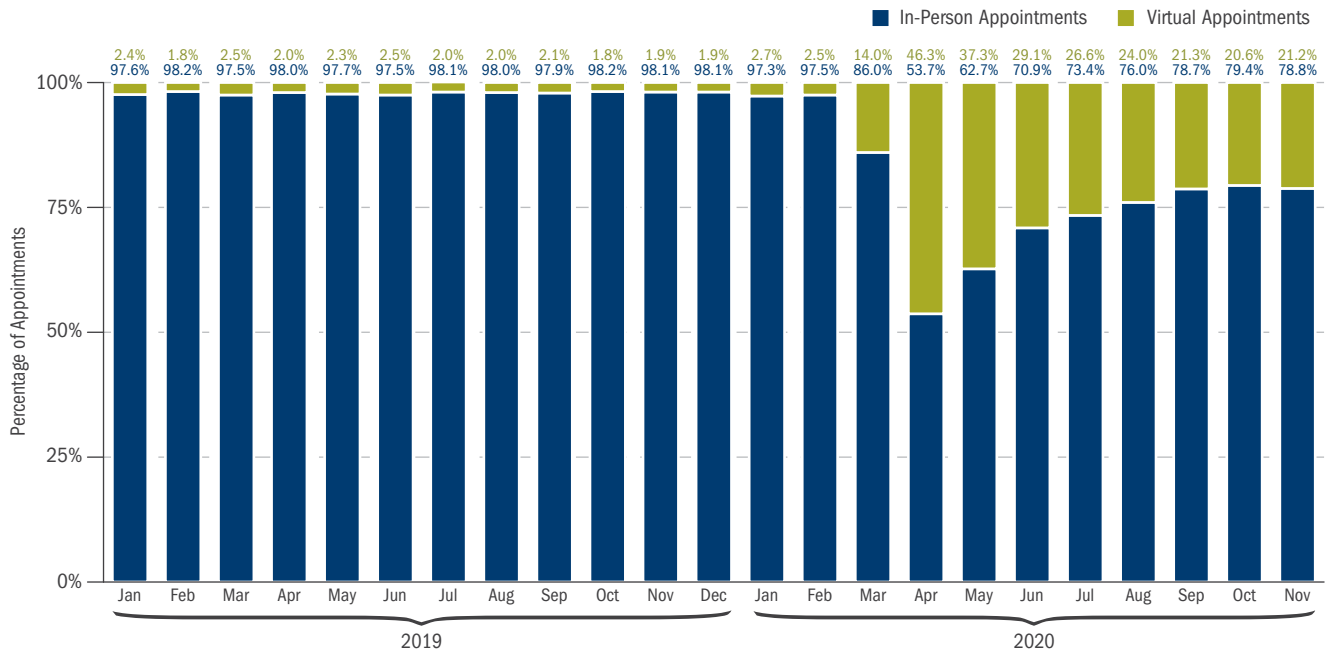
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care *(cont.)*

Impact of COVID-19 on Patient Experience

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

- Based on self-reported survey data from the JOES, the vast majority (approximately 98 percent) of outpatient appointments were in person from January 2019 through February 2020 with the combined virtual appointments accounting for approximately 2 percent of appointment types.
- In March 2020, virtual appointments accounted for 14 percent of outpatient appointments (an increase from 2.5 percent in February 2020).
- April 2020 had the largest percentage of virtual outpatient appointments for the year at 46.3 percent.
- The majority of virtual appointments are phone appointments during both CY 2019 and 2020; video appointments were less than 0.5 percent through February 2020, then increased slightly to about 3–4 percent from March through November 2020. E-mail/secure messaging has been less than 1 percent of virtual appointments through CY 2019 and 2020.
- From April 2020 through November 2020, the percentage of in-person outpatient appointments has remained at least 20 percentage points lower than this time frame in the previous year (2019). During the same time, virtual appointments account for between 20 and 46 percent of all outpatient appointments.

SELF-REPORTED PROPORTION OF OUTPATIENT VISITS BY APPOINTMENT TYPE, CY 2019–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, compiled 12/17/2020

Notes:

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

– Data were available through November 2020 at time of analysis.

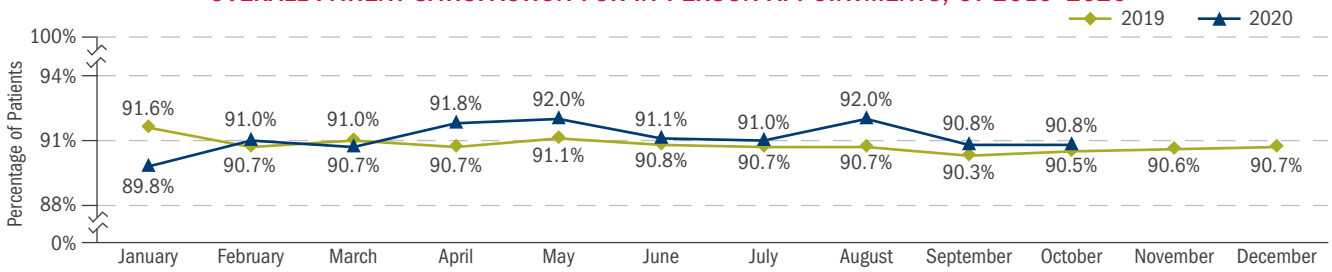
ACCESS TO MHS CARE *(CONT.)*

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

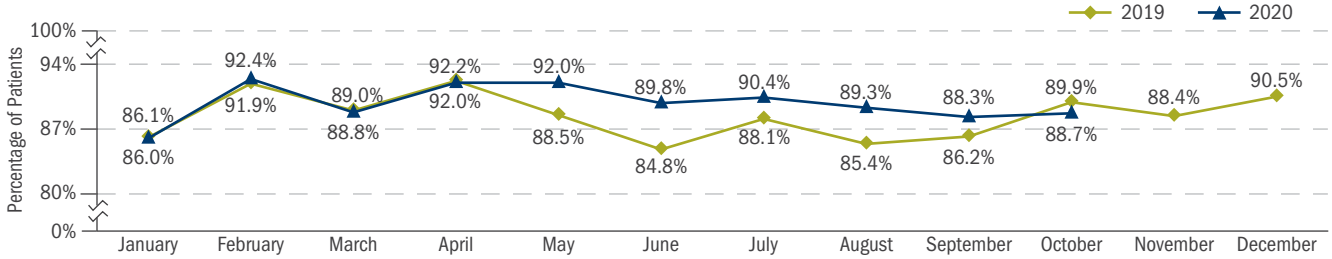
Impact of COVID-19 on Patient Experience *(cont.)*

The charts below show overall patient satisfaction by appointment type (in-person or virtual) for CY 2019 and CY 2020 to compare if satisfaction scores have changed during the COVID-19 pandemic. Patient satisfaction for in-person appointments remained stable in both CY 2019 and 2020 (90–91 percent in 2019 and 91–92 percent in 2020). Virtual appointments in CY 2019 had more fluctuation in scores, likely due to the lower number of surveys. Comparing virtual appointments from CY 2019 to CY 2020, satisfaction tends to be higher in CY 2020. In April 2020 when virtual appointments increased, there was a slight increase in patient satisfaction (from 88.8 percent in March to 92 percent), which remained above 88 percent through the rest of the year.

OVERALL PATIENT SATISFACTION FOR IN-PERSON APPOINTMENTS, CY 2019–2020

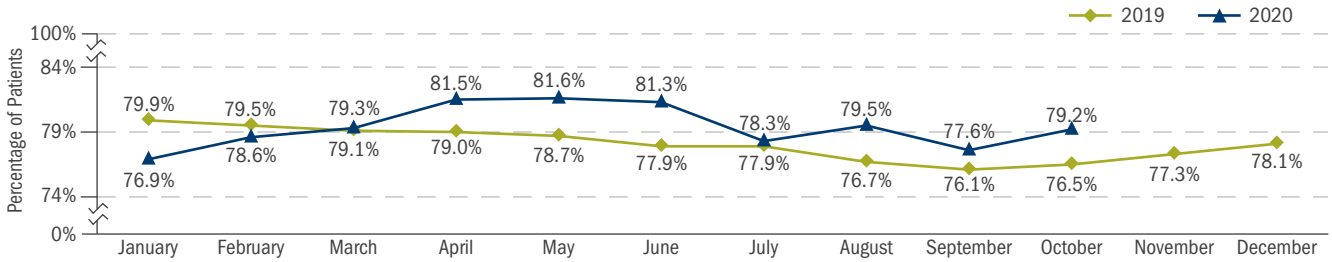


OVERALL PATIENT SATISFACTION FOR VIRTUAL APPOINTMENTS, CY 2019–2020

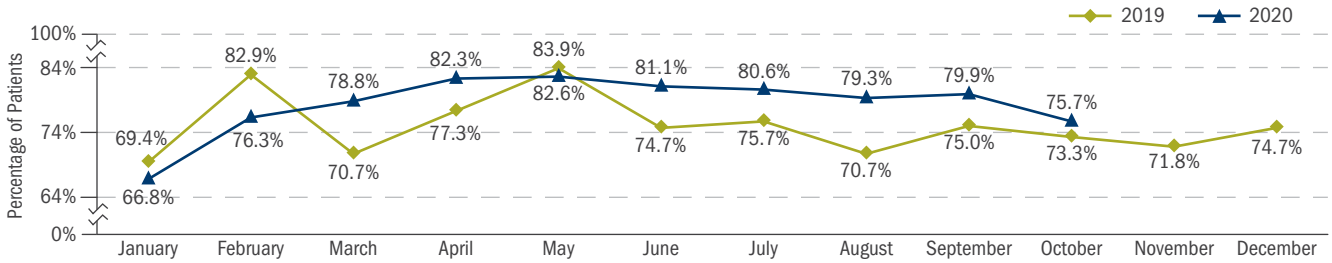


The graphs below display access to care (see provider when needed) scores for in-person and virtual appointments that follow similar trends as overall patient satisfaction. In CY 2019 and 2020, scores remained stable for "able to see provider when needed" for in-person appointments, with scores generally slightly higher in 2020. This would indicate that COVID-19 did not impact access to in-person care. For virtual appointments, CY 2020 scores are generally higher than CY 2019. There is also a slight increase from January 2020 through April 2020 for virtual appointments on the "able to see provider" measure. This coincides with the increase in virtual appointments due to the pandemic.

SEE PROVIDER WHEN NEEDED BY IN-PERSON APPOINTMENTS, CY 2019–2020



SEE PROVIDER WHEN NEEDED BY VIRTUAL APPOINTMENTS, CY 2019–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, compiled 12/17/2020

Notes:

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

– Data were available through October 2020 at time of analysis.

ACCESS TO MHS CARE *(CONT.)*

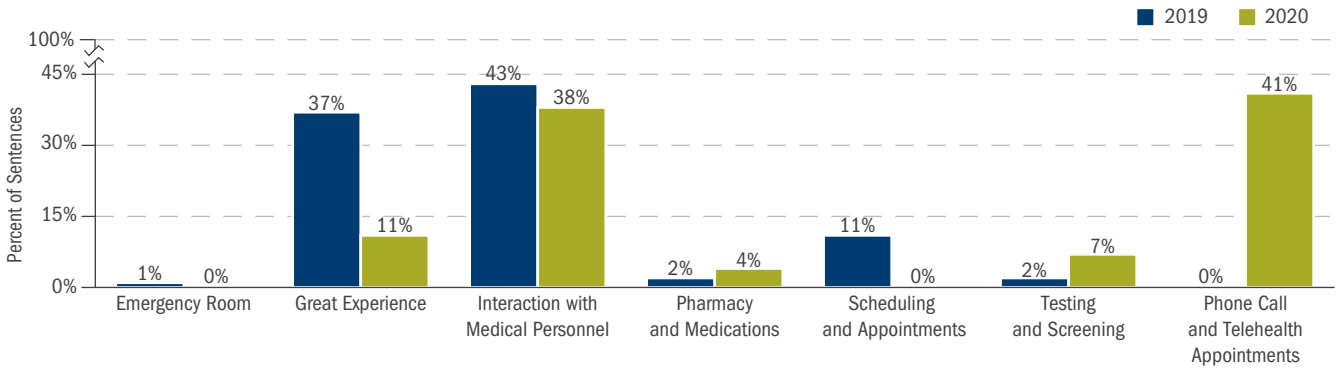
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care *(cont.)*

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

A qualitative analysis of open-ended survey comments from JOES was conducted using comments from April to July 2019 (sample of comments) and April to July 2020 (comments that mention COVID) to compare how the pandemic affected patient experience through patient comments. Approximately 130,000 comments were analyzed. Analysis was conducted at the sentence level and sentences were coded into themes based on key words and phrases that were associated with each theme. Depending on its length and content, a sentence could have been assigned zero or multiple themes.

- Between 2019 and 2020, seven themes were identified related to feedback about the provider visit. The most frequently mentioned theme in 2019 was interaction with medical personnel (43 percent), which is consistent with the 2020 data (38 percent in 2020).
- The second most frequently mentioned theme in 2019 was great experience (37 percent), whereas phone call and telehealth appointments (41 percent) was more frequently cited in 2020. This aligns with the COVID-19 pandemic where many appointments were changed from in-person to virtual (via phone or video) in 2020.

JOES COMMENTS THEMES FOR "VISIT" QUESTION



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES, compiled 11/19/2020

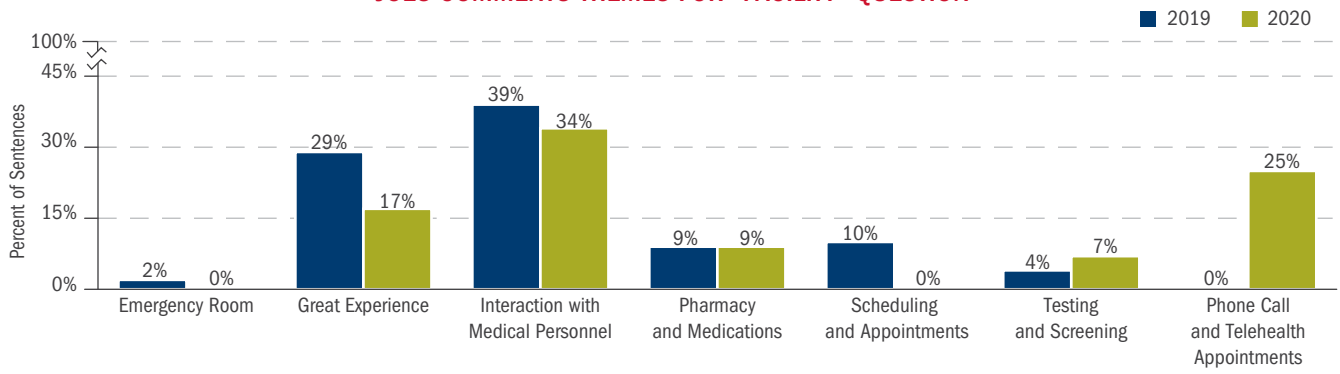
Notes:

– JOES "Visit" question is question #11: Please provide any comments about your visit with the provider that you would like to share.

– Percentages do not sum to 100 because some sentences were coded only as a sentiment and did not fit into a theme. Emergency Room, Scheduling and Appointments, and Phone Call and Telehealth Appointments do not include comparisons as they are unique to one year.

- The same seven themes were identified related to experiences in the facility as with the provider question in 2019 and 2020. Consistent with the "Visit" question, the most frequently mentioned theme in 2019 was Interaction with Medical Personnel (39 percent), which is consistent with the 2020 data (34 percent in 2020).
- The second most frequently mentioned theme in 2019 was Great Experience (29 percent), whereas Phone Call and Telehealth Appointments (25 percent) was more frequently cited in 2020.

JOES COMMENTS THEMES FOR "FACILITY" QUESTION



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES, compiled 11/19/2020

Notes:

– JOES "Facility" question is question #29: Please provide any comments about the facility that you would like to share.

– Percentages do not sum to 100 because some sentences were coded only as a sentiment and did not fit into a theme. Emergency Room, Scheduling and Appointments, and Phone Call and Telehealth Appointments do not include comparisons as they are unique to one year.

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

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

Overall, comments in 2019 and 2020 were thematically similar. Emergency room and scheduling and appointments were unique themes to 2019, whereas phone and telehealth appointments were a unique themeto 2020. With changes in patient needs during the pandemic in 2020, this shift in patient comments was expected. Comment sentiment was generally more positive in 2019 (not shown). Positive sentiment was greater in 2019 than in 2020 for interaction with medical personnel, great experience, and testing and screening (for both the "Facility" and "Visit" questions). Positive sentiment was greater in 2020 than in 2019 for the pharmacy and medications theme for the "Facility" question.

Additionally, 2019 respondents wanted wait-time improvements; 2020 respondents were concerned with appointment availability and COVID-19 (not shown). Recommendations from 2019, based on patient comments, centered mainly on wait times (pharmacy wait time, appointment wait time, and scheduling wait time) and interpersonal interactions with staff (politeness of front desk staff and bedside manner of medical staff). For 2020, recommendations focused on appointments (ease of telehealth appointments and availability of in-person appointments) and COVID-19 (safety protocols, testing availability, and communications).

ACCESS TO MHS CARE *(CONT.)*

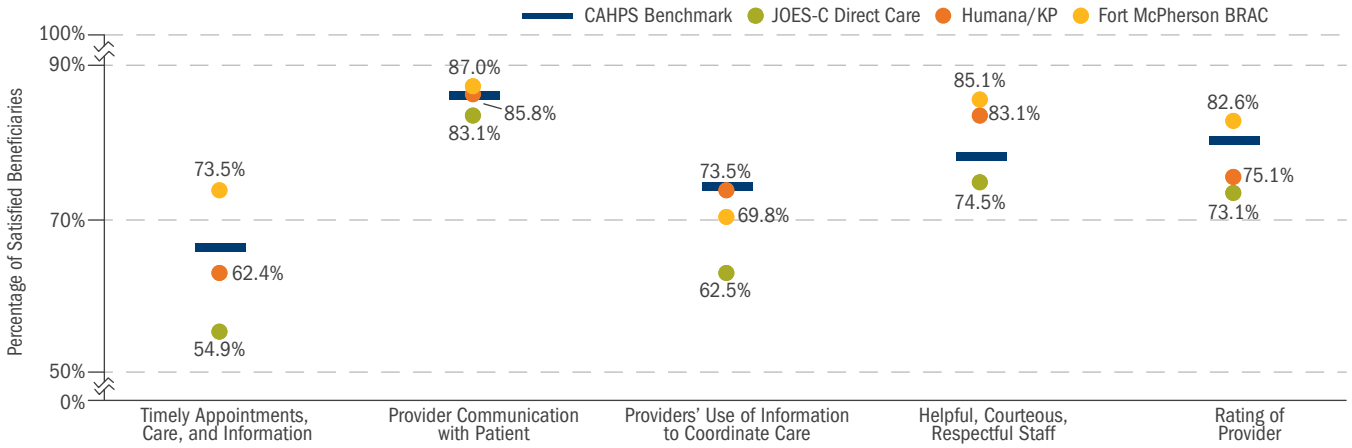
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care *(cont.)*

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

In FY 2020, DHA implemented an Accountable Care Organization (ACO) demonstration in the Atlanta market area in partnership with Humana and Kaiser Permanente (KP). Enrollment in the Humana/KP demonstration was offered to TRICARE Prime and Select members in the Atlanta Prime Service Area during the 2019 Open Enrollment Season. Care delivery began January 1, 2020, and will continue for three years. As of October 2020, KP beneficiary enrollment is 1,775. This section compares patient experience scores of participants in the Humana/KP pilot and TRICARE beneficiaries in the Atlanta area (Fort McPherson BRAC) from JOES-C Direct Care and Purchased Care during January to June 2020.

- Humana/KP pilot participant ratings were above direct care ratings for all measures over the period of January to June 2020. Humana/KP ratings were generally below those in the Atlanta area (Fort McPherson BRAC) and at or above the civilian CAHPS benchmark for provider communication, use of information to provide care, and helpful, courteous staff.

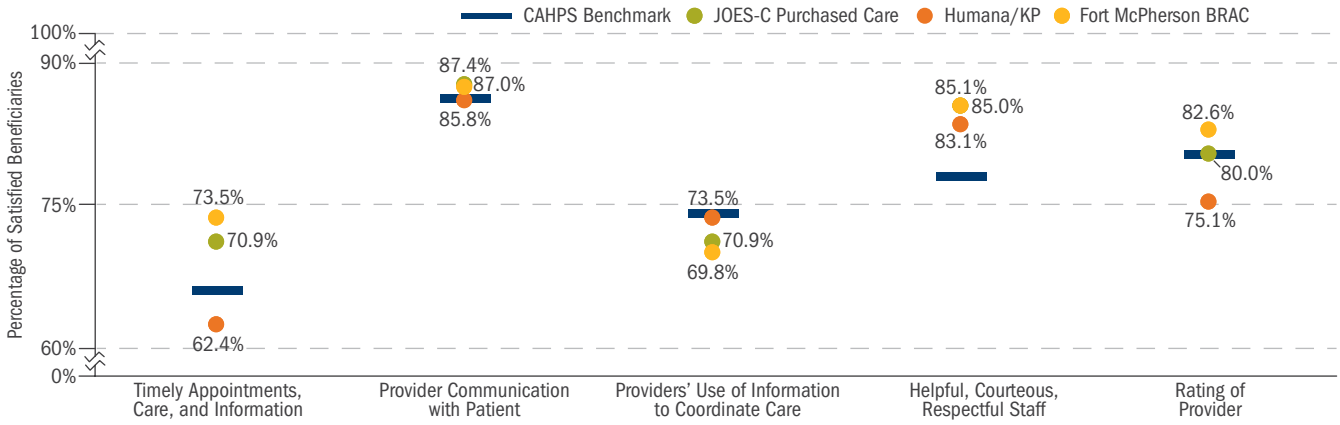
CAHPS COMPOSITE SCORES COMPARED TO DIRECT CARE, JANUARY–JUNE 2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES-C, weighted data, compiled 12/8/2020
Note: Humana/KP N=280

- Humana/KP pilot scores were comparable to Atlanta area scores for provider communication, use of information, and helpful, courteous staff during January to June 2020. Humana/KP pilot scores were below purchased care scores and the CAHPS benchmark for two of the five measures (timely appointments and rating of provider scores).

CAHPS COMPOSITE SCORES COMPARED TO PURCHASED CARE, JANUARY–JUNE 2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES-C, weighted data, compiled 12/8/2020
Note: Humana/KP N=280

For four of the five measures (all except use of information composite), scores for Humana/KP participants decreased from January to June 2020 when examining scores per month (not shown). Respondent numbers also decreased over this period, ranging from 10 to 98 per month; results for this small sample size pilot population should be interpreted with caution.

ACCESS TO MHS CARE *(CONT.)*

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

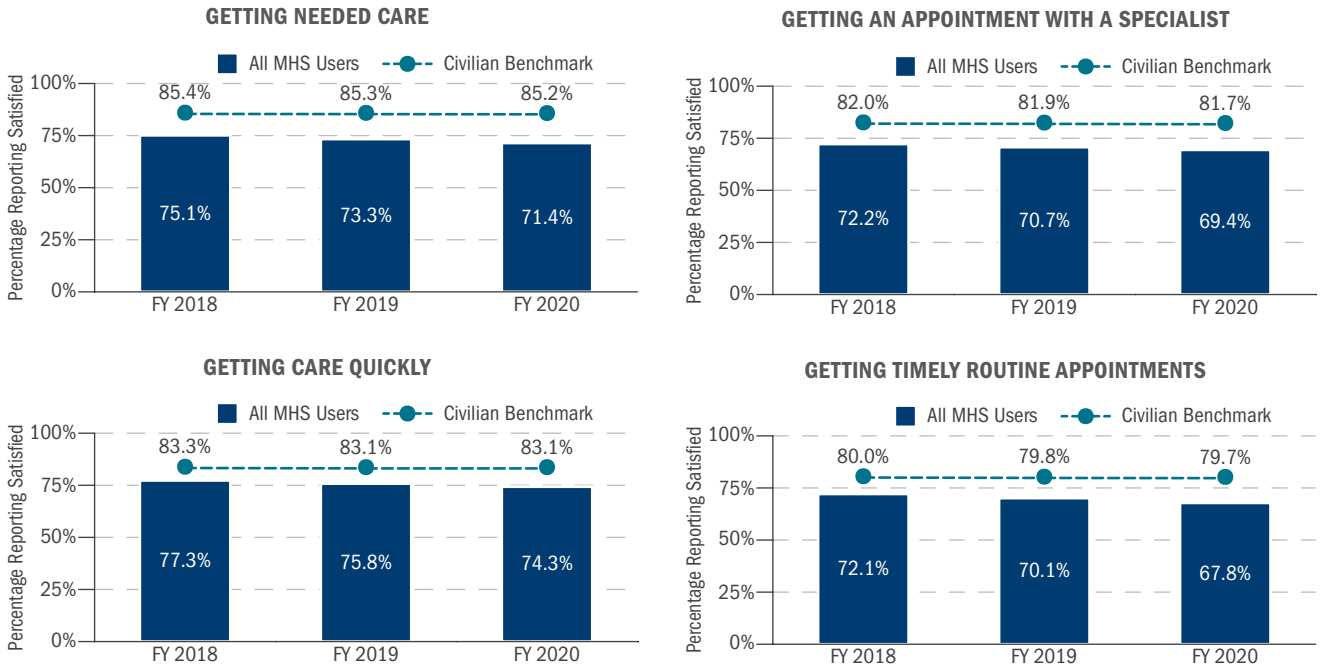
Instead of focusing on a specific health care event to assess patient experience with care, population surveys are designed to sample populations based on the demographics being considered (e.g., a survey of all ADSMs about their health behaviors, or a survey of all MHS beneficiaries to assess their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

Availability and Ease of Obtaining Care

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

- Overall, MHS beneficiary ratings for all measures declined from FY 2018 to FY 2020. 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 2018 and FY 2020.

TRENDS IN MEASURES OF ACCESS FOR ALL MHS BENEFICIARIES (ALL SOURCES OF CARE), FYs 2018–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 10/15/2020

Note: "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used in 2017 come from NCQA's 2015 data, while the benchmarks used in 2018, 2019, and 2020 come from NCQA's 2017 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

CLINICAL QUALITY MANAGEMENT IN THE MHS

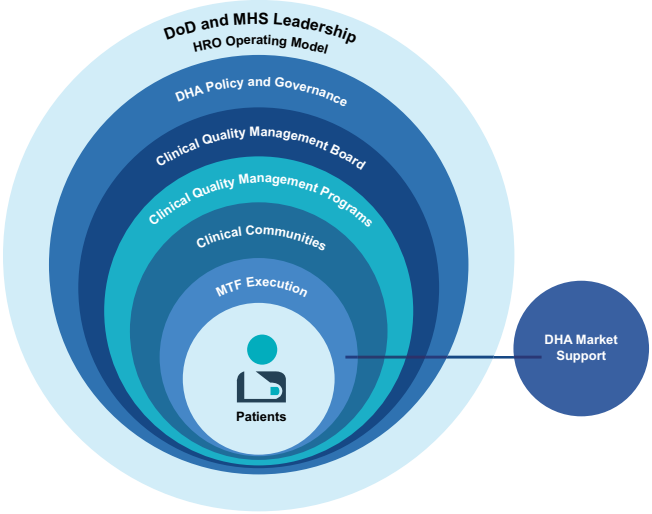
Clinical Quality Management Oversight

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

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

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

MHS GOVERNANCE OF CLINICAL QUALITY MANAGEMENT



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

Healthcare Resolutions Program

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

Healthcare Resolutions

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

Disclosure Training

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

Peer Support

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

Healthcare Resolutions Program *(cont.)*

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

Patient Safety: Program to Prevent Harm

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

In collaboration with the Services and established markets, the DoD PSP focuses on three functional areas:

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

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

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

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

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

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

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

1. Joint Patient Safety Reporting

The MHS directs MTF commanders and staff to report all patient safety events reaching the patient and to report near-miss events to the greatest extent possible through JPSR. JPSR is a standardized, anonymous, and voluntary web-based reporting system that was implemented in 2011 across the MHS to capture patient safety events. As a result, DoD PSP has seen increased collaboration on improvement efforts, knowledge exchange, and solutions. In FY 2020, a total of 81,281 patient safety reports were submitted from the direct care system. Near-miss JPSR events, which did not reach a patient, accounted for 51 percent of all JPSR events reported in FY 2020. Where feasible, the operational environment also reports patient safety events using the JPSR system.

The table below compares FY 2016 to FY 2020 patient safety reporting, stratified by degree of harm. Harm is defined as events that reach a patient and result in harm, including death; no harm is defined as events that reach a patient and do not result in harm; near miss is defined as events that do not reach a patient.

JOINT PATIENT SAFETY EVENTS REPORTED, FYs 2016–2020

HARM GROUP	FY 2016		FY 2017		FY 2018		FY 2019		FY 2020	
	#	%	#	%	#	%	#	%	#	%
Harm	10,065	10%	10,446	11%	9,963	10%	9,751	10%	8,482	10%
No Harm	37,041	38%	39,075	39%	40,523	39%	38,634	38%	31,159	38%
Near Miss	49,347	51%	49,468	50%	54,181	52%	53,432	52%	41,640	51%
Total	**96,453**	**100%**	**98,989**	**100%**	**104,667**	**100%**	**101,817**	**100%**	**81,281**	**100%**

Source: DHA/Medical Affairs/CSD, 12/8/2020. Data as of 12/4/2020

Note:

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

– Due to rounding, percentages may not equal 100.

2. DoD Reportable Events

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

DoD REs REPORTED, FYs 2016–2020

EVENT TYPE	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
	#	#	#	#	#
Wrong-Site Surgery: Wrong Patient, Wrong Site, Wrong Procedure	38	27	46	27	21
Unintended Retained Foreign Object	18	25	27	20	17
Delay in Treatment: Lab, Path, Radiology, Referral, Treatment Order	25	20	25	15	15
Maternal (≥20 Week Gestational Age–42 Days Postpartum): Hemorrhage, Hysterectomy	28	9	11	<4[a]	10
Intraoperative or Immediate Post-Op/Post-Procedure or Surgery	25	13	11	<4[a]	<4[a]

Source: DHA/Medical Affairs/CSD, 11/30/2020. Data reported as of 11/19/2020

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

- **Wrong-Site Surgery (WSS):** WSS is a preventable DoD RE involving surgeries on the wrong site, wrong side, wrong person, or wrong procedure in the system. The MHS goal for WSS is zero events. In FY 2020, the MHS saw a 22 percent decrease from FY 2019 in the number of reported WSS DoD REs (from 27 to 21). Efforts to prevent WSS include the development of concise incident analysis (CIA). Initially intended for dental WSS events, DoD PSP is developing and piloting the CIA methodology to determine its utility more broadly and facilitate quicker learning and development.
- **Unintended Retained Foreign Object (URFO):** An URFO event that occurs after an invasive medical or surgical procedure causes patient harm and significantly increases the cost of patient care. In FY 2020, the number of reported URFO DoD REs decreased 15 percent from FY 2019 (from 20 to 17).

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

- **Delay in Treatment:** Delay in treatment events can be the result of a misdiagnosis, delay in diagnosis, or failure to follow up or communicate test results. These events can be serious DoD REs that ultimately result in serious harm or patient death. To bring greater awareness to leading practices for prevention in FY 2019, DHA published a focused review on delay in treatment.
- **Maternal:** Maternal DoD REs include events where the mother receives more than four units of blood, is transferred to a higher level of care, or receives a hysterectomy due to hemorrhage. To address maternal events, the DoD PSP partners with the WICC to improve the safety of women and infants.
- **Intraoperative:** Intraoperative events include serious events that occur during a surgery or procedure, or immediately post-operative or post-procedure. There was a decrease in reported intraoperative events from FY 2019 to FY 2020. The decrease in reporting of these events continues from the clarification of the definition of these events through the publication of the CQM policy DHA-PM 6025.13, Volume 2. These events are reported under a different event type.

In addition to capturing patient safety events through DoD REs, per policy, MTFs must submit a comprehensive systematic analysis (CSA) for every DoD RE that occurs within their facility. In addition to mandatory completion, the Services/markets may also voluntarily elect to complete a CSA for events that do not meet the threshold of a DoD RE, representing an opportunity for learning and improvement for the MTF. In total, 108 CSAs were received for TJC reportable DoD REs in FY 2020, representing a 19 percent decrease from FY 2019 (not shown). For each CSA received, the DoD PSP reviews the strength of corrective actions (CAs) and submits a review back to the Service/market. The DoD PSP's corrective rating system is based on the Department of Veterans Affairs (VA) Action Hierarchy of Corrective Actions, which breaks down actions by strength based on likelihood of preventing the event from happening again. The actions can be strong, intermediate, or weak. Stronger actions focus on a system change and are not reliant on individual memory or vigilance. Through this process, the DoD PSP guides MTFs in implementing strong CAs that are more likely to prevent a similar event from happening again. In FY 2020, the percentage of CSAs received for TJC reportable DoD REs that included at least one strong or intermediate CA increased by 5 percent over FY 2019 (not shown).

Preventing Harm Events – Service Example

Prevention Steps

The Air Force has focused on improving patient safety, even for deployed MTFs. Prior to deployment, patient safety professionals are paired with a garrison mentor or coach. CSAs among deployed MTFs and continued involvement with patient safety throughout the deployment has led to zero serious harm events from 2017 to present, decreasing from an average of two per year for six deployed MTFs from 2012–2016.

Adapting During COVID-19 to Prevent Harm – Service Example

Navy Drive-Thru Pharmacies

The Navy emphasized improving patient safety at all MTFs. During the COVID-19 pandemic, the Navy focused its efforts on many areas, including pharmacy. One example is by making the traditional pharmacy process more accessible and efficient by implementing a drive-thru pharmacy model, which would make it possible for patients to pick up prescriptions without leaving their cars. Each MTF focused on tailoring its approach to include consideration of traffic flow, designating the drive-thru at different routes, and standardizing and updating SOPs and procedures to address the rapidly changing environment. Implementing a drive-thru pharmacy minimizes foot traffic, which helps mitigate the spread of the virus and enables staff to better preserve the health and well-being of all patients. At NMRTC (Naval Medical Readiness and Training Command), the SOP was updated in a matter of days by coordinating across pharmacy, primary care, specialty care, and the watch bill coordinator. The SOP includes updates to patient safety risks, safe medication distribution, increased communication between pharmacy and providers, operational risk management, and patient and staff satisfaction. By focusing on patient safety, most Commands found that patient satisfaction levels increased significantly from past experiences.

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

3. CDC National Healthcare Safety Network

The reduction and prevention of HAIs, improved antibiotic stewardship, and reduction of multidrug-resistant organisms (MDROs) remain as top priorities for the DoD PSP. To ensure standardization of reporting practices across the health care system, the MHS continues to participate in the CDC NHSN reporting system. NHSN participation directly aligns with the MHS goal of achieving zero harm by allowing for the implementation of targeted process improvement initiatives based on standardized measures and benchmarks. The MHS continues to participate in the NHSN device-associated module, which includes submission of central line–associated blood stream infection (CLABSI) and catheter-associated urinary tract infection (CAUTI) data for all ICUs and wards. The MHS also expanded NHSN data submission in FY 2020, with all inpatient facilities now participating in the the Lab ID Event, Facility-Wide Inpatient module for *Clostridioides difficile* infection. The standardized infection ratio (SIR) continues to serve as the primary source for benchmarking and comparison of internal data against national benchmarks.

To facilitate integration of leading practices, the DHA developed and distributed a comprehensive CLABSI Toolkit and a CAUTI Implementation Guide for HAI Prevention. These two critical documents provide frontline staff with evidence-based resources and serve to advance DHA's role in supporting standardization across the health care system. The table below shows where the MHS performed in comparison to the national benchmark for both CAUTIs and CLABSIs. The MHS performed better than or the same as the national benchmark if the value shown is 1.0 or less.

HAIS, FY 2016 Q1–FY 2020 Q3, STANDARDIZED INFECTION RATIO

	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3
CLABSIs	1.4	0.7	1.3	1.2	0.9	0.5	0.7	0.8	0.6	0.5	0.8	0.7	1.4	0.8	1.0	0.5	0.6	0.3	0.9
CAUTIs	0.6	0.7	1.2	1.1	1.1	1.0	0.9	1.0	0.8	0.8	0.5	0.8	0.4	0.5	0.5	0.6	0.3	0.2	0.6

Source: DHA/Medical Affairs/CSD, 11/30/2020. Data are as of 10/19/2020.

Infection Prevention and Control (IPC) COVID-19 Response

In response to the COVID-19 pandemic, the DHA established an IPC Tiger Team consisting of Tri-Service IPC experts from a variety of fields (e.g., dentistry, medical logistics, pharmacy) to provide agile responses to IPC-related inquiries from the field. The team developed and distributed key deliverables (including personal protective equipment [PPE] conservation and reuse, exam room turnover, and post-pandemic recovery) in alignment with identified critical COVID-19 management and response needs. Since setting up the DHA IPC Tiger Team in March 2020, the team responded to more than 120 requests for information to support frontline providers at 475 MHS facilities.

4. Global Trigger Tool

In FY 2018, MHS completed the implementation of the GTT, which is based on the Institute for Healthcare Improvement (IHI) methodology. Voluntary reporting methods detect only a fraction of AEs that cause patient harm. However, GTT uses a standardized process shown to detect AEs not otherwise reported. It is a validated, objective, and consistent retrospective method for medical record review. The tool is used to determine and monitor rates of patient harm over time and supplements other reporting systems to help direct resources and monitor impact. The IHI methodology recommends a minimum of 12 months of data collection to determine a baseline; therefore, FY 2019 was the first year where GTT data were reportable. The table below shows GTT statistics from FY 2019 to FY 2020 Q3.

GLOBAL TRIGGER TOOL ADVERSE EVENTS, FY 2019 Q1–FY 2020 Q3

	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3
Adverse Events per 100 Admissions	7.1	8.2	6.9	7.9	6.0	6.1	6.5

Source: DHA/Medical Affairs/CSD, 11/30/2020
Note: There is a four-month lag in data, data received in November are through July.

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

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

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

Engage

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

Patient Safety Awareness Week (PSAW): This week is a multiorganizational effort that serves as a national education campaign for promoting patient safety practices. The DoD PSP collaborates with external organizations, including AHRQ and IHI, on this awareness initiative. In FY 2020, PSAW efforts included hosting 13 webinars on leading practices and efforts from across the organization; engaging our MTFs through daily activities such as quizzes; and providing PSAW kits such as posters, badges, and other patient safety–related materials. PSAW is a consistent way that DoD PSP reaches into all areas of the organization to promote and encourage the adoption of leading safety practices.

COVID-19 Response – Ready and Resilient Award Program: The Ready and Resilient Award program is a new peer-to-peer recognition mechanism that allows staff of military hospitals and clinics to recognize their peers during the difficulties of the COVID-19 pandemic. With more than 500 submissions since the program's inception, the Ready and Resilient Award program displayed how our professionals are going above and beyond to improve patient and staff safety at such a critical time.

Clinical Communities: Clinical Communities improve patient safety and quality of care by engaging appropriate clinical experts, enabling process improvement, promoting collaboration, expanding knowledge sharing, setting the standard of care, and defining practice guidelines to bolster force readiness and support our clinicians and staff in delivering the best health outcomes for all our recipients of care. As the DHA Clinical Communities have been established in FY 2019, DoD PSP has engaged with these groups and has provided enabling expertise to the communities. For example, this year, the PSP partnered with Clinical Communities, enabling expertise for an initiative to further target zero harm by eliminating wrong-site, wrong-person, and wrong-side surgeries. Together, PSP and the Clinical Communities are developing a standardized policy to implement the Universal Protocol Checklist for surgical and invasive procedures performed in MTFs. A multidisciplinary work group with Tri-Service representation is developing the DHA Universal Protocol Policy, which will include implementation of the Universal

Ready and Resilient Award – Service Example

TRANSCOM's Response to COVID-19

TRANSCOM Patient Movement Requirements Center-EAST (TPMRC-E) validates, coordinates, and executes strategic aeromedical evacuation, through fixed-wing patient movement, for every ill and injured service member in Europe, Africa, Middle East, and Central Asia to a higher echelon of care at Landstuhl Regional Medical Center (LRMC), Germany; partner nation facilities; Walter Reed National Military Medical Center (WRNMMC) in Bethesda, Md.; and beyond in the CONUS. Since January 2020, TPMRC-E implemented a COVID-19 screening questionnaire for every patient entering and moving in the aeromedical evacuation system to mitigate the risk of spread and to protect all garrison and expeditionary forces. After moving their first COVID-19 patient in March, TPMRC-E, a C-17, Transport Isolation System (TIS), and 16-person Force Package—which included an augmented seven-person aeromedical evacuation team, a three-person critical care air transport team (CCATT), a public health officer, and infectious diseases doctor, and additional support technicians—were rapidly deployed to Ramstein within two weeks from Joint Base Charleston. Since then, TPMRC-E has successfully tracked and processed more than 381 patient movement requests and have expedited the regulation, validation, and execution of the movement of over 253 COVID-19 patients out of 14 MTFs across eight countries for care, isolation, quarantine, and return to duty or onward movement from LRMC.

Responding to the COVD-19 Pandemic – Service Example

Javits Center in New York City

All branches of the military, federal, and civilian agencies came together at the Javits Convention Center in New York City to provide care during the COVID-19 pandemic. One highlight was the Army responders, designated Task Force Silver Dragons, as the command and control element. Their mission was to come together with other responders to build a complex health care delivery system in the Javits Center. The plan was developed to house 2,800 patients if needed. Upon arrival, the Army immediately coordinated efforts with federal, state, and local authorities, Active Duty and Reserve military personnel, all Services, the Navy USS Comfort, New York City Police Department, New York State Troopers, Federal Emergency Management Agency, the Army Corps of Engineers, United States Public Health Services, New York Department of Health, New York Fire Safety, and civilian hospital partners. The Javits Center Medical Station establishment and operational mission was one of the most complex multipartner efforts because it required intense collaboration of resources between a team of 1,300 personnel that had never worked together previously. In approximately three days, the team transformed an empty slate nonmedical facility into a fully functioning medical center that ultimately provided care to more than 1,090 patients in a 50-day period. The systems and care processes developed in the Javits Center were an amazing feat of how coordinated efforts between multiple agencies resulted in the largest successful collaborative effort our country has ever seen. Many of the personnel brought back the Javits Center mission best practices to their own MTFs to continue refining COVID care processes for maximum success.

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

Protocol Checklists for the operating room and ambulatory areas. By establishing Universal Protocol processes in accordance with TJC requirements, we aim to continue to standardize the processes that allow the MHS to deliver high-quality care and prevent harm to patients.

Educate

The HRO journey is leading the MHS to a learning organization, where organizations use learning to reach its goals; create, acquire, and transfer knowledge; and change behavior based on that knowledge. To that end, DoD PSP has developed and implemented multiple evidence-based learning resources designed and developed to eliminate patient harm. These include learning systems designed to establish a common knowledge base for entry level patient safety professionals, identify opportunities to assist these professionals to advance from the entry-level to intermediate and advanced levels, enhance communication and teamwork, address any new regulations and protocols, and identify learning needs or educational gaps based on patient safety data and changes in the environment. The DoD PSP uses a competency-based model to identify gaps in learning and develops an education and training strategy plan to address those gaps. In addition to identifying learning gaps and developing curriculum, the DoD PSP uses a blended learning approach for successful implementation and long-term sustainment of structured training. In addition to structured learning, examples of this approach include micro-learning, coaching, office hours, apps, simulation, tool kits and guidebooks, networking opportunities, access to real-time data, SharePoint sites, and Communities of Practice. The DoD PSP has multiple tools and materials to supplement learning. During FY 2020, there were over 1,200 materials disseminated to the MTFs/DTFs. These included TeamSTEPPS instructor guides, pocket guides, badge cards, and posters.

The DoD supports the Services/markets and MTF teams by providing the infrastructure to obtain continuing education (CE) for multiple training courses, offering one-on-one team coaching, and evaluating the system's effectiveness. In FY 2020, there were 5,127 leaders, providers, and staff trained in various courses; 560 courses held; and 2,577 CE credits awarded through the DoD PSP accreditation partner, the Postgraduate Institute of Medicine (PIM). Because of the COVID-19 virus, many classes were canceled; however, the DoD is leveraging various learning platforms to host training in the virtual learning environment. Our MHS staff completed training in a variety of areas, including:

- Patient Safety Professional Course (PSPC)
- TeamSTEPPS Train the Trainer 2.0
- TeamSTEPPS Train the Staff 2.0
- TeamSTEPPS Scenario-Based Train the Staff 2.0
- TeamSTEPPS Simulation-Based Train the Staff 2.0
- Root Cause Analysis (RCA)

PSPC: A key learning resource in the patient safety inventory is the PSPC. Patient safety professionals obtain their initial training through the PSPC, which they complete within the first year of assuming their role in an MTF. It is a week-long course hosted four times a year and provides them with evidence-based knowledge, skills, and tools to implement patient safety initiatives at their facility. The PSPC offers an award-winning, state-of-the-art learning system with a prework module, five days of face-to-face training, including two days of TapRooT® training, post-training virtual coaching, and opportunities for continued development through a Patient Safety Manager Ongoing Learning Certificate. The PSPC curriculum is regularly updated to integrate HRO principles and foundational knowledge within the course content, to reflect the MHS transition and policy changes, and to keep attendees trained on the latest innovative health care information and resources. In FY 2020, the PSPC was conducted virtually for participants across the globe for the first time in response to COVID-19 with great success. The PSPC has had proven success in training patient safety professionals. For example, in FY 2020, prior to completing the course, 23 percent of the participating patient safety professionals highly or very highly believed they could apply MHS HRO guiding principles at their facility. After the course, the percentage increased to 73 percent.

TeamSTEPPS: Teamwork failures are substantial contributors to 68 percent of patient harm events according to TJC, making them a major source of preventable medical errors. Developed by the DoD PSP in collaboration with AHRQ, TeamSTEPPS is an evidence-based, teamwork development system designed to improve health care team communication techniques and produce teams that optimize the use of information, people, and resources to achieve the best clinical outcomes. TeamSTEPPS has been adopted worldwide with leadership engagement, training, implementation, and sustainment of TeamSTEPPS done at the local level. Though structured training has its place, the focus is turning more toward implementation and sustainment of the concepts and tools. In FY 2020, there were 549 TeamSTEPPS classes with 4,928 participants and 2,455 CE credits awarded. Due to the COVID-19 virus, numerous classes were cancelled. Since May 2020, the Service Headquarters and MTFs have held 12 virtual courses. In FY 2020, the DoD PSP led an effort to update the TeamSTEPPS pocket guide and begin development of an app that includes all tools and links to articles and scenarios for real-time micro-learning. The DHA-PM identifies TeamSTEPPS as foundational to

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

patient safety and is the MHS standard for maximally integrating teamwork principles into practice. For a blended learning approach, the DoD PSP supports the MTFs with several adjuncts to learning, to include coaching, questionnaires, badge cards, posters, pocket guides, and tips and scenarios. Since 2009, the DoD PSP has sponsored Active Duty and DoD civilian government employees to participate in the National TeamSTEPPS conference, sponsored by the American Hospital Association, which includes a DoD breakout session. The conference was cancelled in FY 2020 due to the COVID-19 pandemic.

Equip

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

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

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

MHS GENESIS and Patient Safety: The MHS is in the process of deploying the new EHR, MHS GENESIS. The DoD PSP engaged with the EHR team early in the deployment in FY 2019, resulting in the development and release of several materials, including a job aid, training deck, practice exercises, and communication materials that target patient safety professionals transitioning to the new system. In FY 2020, DoD PSP participated in deployment training with the MHS GENESIS sites to educate around the appropriate and timely reporting and resolution of any patient safety issues that may arise due to EHR deployment.

High Reliability and Readiness – Service Example

Ready and Resilient Award: Brooke Army Medical Center

During the COVID-19 pandemic, Brooke Army Medical Center (BAMC) was resilient and steadfast while caring for patients on the hospital's Medical/Surgical COVID-19 unit. The unit comprises more than 80 personnel from the Army and Air Force, and has 30 patient beds. Additionally, the unit supports 700–1,000 patient admissions and transfers per month. In March 2020, BAMC leadership made the decision to transition the unit's primary mission to care for COVID-19 patients. The unit leadership and staff have remained flexible and accepted the mission of caring for COVID patients without hesitation. Despite the multiple changes in unit mission, personnel—including nurses, physicians, and ancillary staff—built their foundation of care on the principles of an HRO and TeamSTEPPS. Staff members continually researched COVID care best practices and maintained a rigorous sustainment training program to ensure the highest quality and safest medical care was delivered around the clock. In fact, due to their training program, the team completed over 5,600 successful donning and doffing procedures in a five-month time period with zero employee infections incurred. Because of the exceptional team work and dedication to creating an environment of safe clinical practice, this unit has been spotlighted across the MHS as a team with celebrated best practices during COVID care delivery.

Transparency

Transparency is key to patient safety improvement. The DoD PSP is making strides in increasing and improving the transparency of patient safety care and data for Service members and their families. Data transparency has been a big focus as DHA moves forward to stand up the markets and centralizes the MTFs under a unified and centralized structure, data transparency promises open communication between the organization and its employees and customers on common quality metrics that affect patient outcomes. MHS transparency efforts are described below and on pages 70 and 124.

Safety Event and Root Cause Analysis (SERCA): To share lessons learned and data from four data sources (JPSR, DoD REs, CDC NHSN, and GTT) between Services/markets and MTFs, the DoD has implemented the DHA SERCA tool. This tool allows designated users to view data for their own facilities and others across the MHS and access all CAs implemented for safety events across the DoD. This provides enhanced transparency, and MTFs have real-time visibility into what other facilities in the DoD are doing to prevent events and improve safety. The SERCA tool has over 100 active users and over 10,500 views since initial deployment in FY 2017.

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

MHS Patient Safety Culture Survey

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

The DoD PSP most recently administered the MHS Patient Safety Culture Survey from April 2019 to June 2019. For the 2019 survey, the DoD PSP added questions to assess associations of staff burnout and resilience with safety culture and to further inform improvement strategies. As with previous culture survey iterations, the DoD PSP provided MTFs with multiple resources, including a guidebook, learning webinars, and SME office hours, to help frontline staff members interpret their results and use them to advance their local safety culture toward high reliability.

Respondents to the 2019 MHS Patient Safety Culture Survey identified opportunities for improvements in our culture, including high rates of perceived burnout across the MHS workforce, ranging from 33 percent to 48 percent reported overall. Survey analyses additionally revealed that higher burnout rates and higher reported workplace chaos were associated with lower teamwork within and across units. To address burnout, the DoD PSP is developing an HRO Safety Practice Communication Bundle, consisting of six practices that address leadership engagement, teamwork, and the Universal Protocol. In addition to policy and guidance, the DoD PSP will develop and execute blended strategies to support the implementation, including webinars, microlearning, coaching, office hours, safety forums, and an app.

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

HRO Awards Program to Promote a Culture of Safety

The HRO Awards Program raises awareness, rewards successful efforts, inspires organizations, and communicates successes throughout the MHS. Ultimately, these awards support DoD on its journey to transform the MHS into an HRO. One quality of an HRO is a single-minded focus on identifying potential problems and high-risk situations before they lead to AEs. The PSP encourages and engages field members through the facilitation of the HRO Awards Program on a yearly basis. The award identifies those who have shown innovation and commitment to the development of systems and processes focused on patient needs, eliminating preventable harm, and enhancing the integration of nationally recognized standards of care. In 2020, the PSP organized the award disciplines to align with the HRO principles and received 96 highly competitive submissions for consideration. By award discipline, these included 17 for Leadership Commitment, 24 for Culture of Safety, 31 for Continuous Process Improvement, and 24 for Patient Centeredness. See below for the full breakdown of submissions across Army, Navy, Air Force, and the markets.

This year's award winners have been selected from various MTFs across the country. There were four winners selected for the Leadership Commitment Award and seven winners selected for the Culture of Safety Award. In addition, several of the winning submissions were aligned with the Clinical Communities. Below is a short summary of the winning Leadership Commitment and Culture of Safety Award submissions.

2020 LEADERSHIP COMMITMENT AND CULTURE OF SAFETY AWARD WINNERS

MILITARY MEDICAL TREATMENT FACILITY/TRICARE REGIONAL OFFICE	AWARD-WINNING INITIATIVE
Carl R. Darnall Army Medical Center	Optimizing Emergency Department Transfer Decisions
U.S. Naval Hospital Rota	COVID Combat Outside the Contiguous United States (OCONUS) MTF
Carl R. Darnall Army Medical Center	Highlighting Quality as a High Priority: Seizing the Opportunities of a Pandemic through Preventive Care and Vulnerable Population Outreach
U.S. Naval Hospital Okinawa	Respiratory Clinic Implementation and Continuous Process Improvement at an Overseas Military Treatment Facility
Brooke Army Medical Center	CODE STROKE: Improved Radiology Turnaround Times following Modification to Radiologist User Interface
Naval Medical Readiness and Training Command Yokosuka	Reducing Opioid Use in Post-Cesarean Deliveries
Spangdahlem Air Base	Provider Recharge Initiative to Decrease Provider Burnout
Brooke Army Medical Center	Creating Patient Safety Team Leaders through a Simulation-Based Interprofessional RCA Course
Naval Medical Readiness and Training Unit Sasebo	The Impact of Risk and Safety Awareness in Reducing the Risk of Sharps Injuries and the Exposure to Bloodborne Pathogens during the Sterilization Process
Naval Medical Readiness and Training Command Okinawa	Develop MICC RN Perioperative Training Plan
Vance Air Force Base Clinic	Culture of Safety

Total submissions received: 96

- **Leadership Commitment: 17**
  - Army: 7
  - Navy: 7
  - Air Force: 3
  - NCR: 0
- **Continuous Process Improvement: 31**
  - Army: 10
  - Navy: 15
  - Air Force: 5
  - NCR: 1
- **Culture of Safety: 24**
  - Army: 4
  - Navy: 7
  - Air Force: 10
  - NCR: 3
- **Patient Centeredness: 24**
  - Army: 5
  - Navy: 11
  - Air Force: 5
  - NCR: 3

Healthcare Risk Management: Program to Address Risk

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

The MHS Healthcare Risk Management (HRM) Program promotes accountability, transparency, and standardization through support of the MHS strategy for managing clinical, operational, human capital, technical, and corporate compliance risks. Oversight of health care risk management processes in the MHS is the responsibility of the DoD RMWG, led by the Office of the Assistant Secretary of Defense for Health Affairs. This governance body is directed by the Department of Defense Instruction (DoDI) 6025.13 and the DHA-PM 6025.13, and is the primary body for oversight of health care risk management processes and reporting to the NPDB, states of licensure, and other regulatory/certifying bodies. Reporting to NPDB includes paid malpractice tort claims, Active Duty death and disabilities associated with health care when the standard of care is breached, adverse privileging actions, and administrative/criminal actions related to health care following required due process procedures. The RMWG provides a forum to discuss relevant risk management topics, share clinical lessons learned from reported adverse events within the MHS, identify variance in health care delivery, apply effective risk reduction strategies, and promote uniform implementation of healthcare risk management processes across the MHS.

Reporting to the NPDB. In FY 2020, 116 practitioners confirmed by Risk Management providing health care in MTFs worldwide were reported to the NPDB (reported by the Services to the MHS RMWG). In 2019, 115 reports were made, and 113 practitioners were reported in 2018.

Credentialing and Privileging: Program to Assure Appropriate Credentials and Privileges

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

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

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

Accreditation and Compliance Program

MTF/TJC Accreditation, Top Five TJC Standards

The MHS is committed to the provision of safe, quality care to all beneficiaries. Utilization of health care industry standards to continually assess the care provided in the MHS serves as a foundation of CQM. The nationally recognized accreditation standards for health care organizations provide guidance for the development of policies and practices at MTFs. Civilian network health care facilities are contractually required to maintain accreditation by an approved accrediting organization. Accreditation and certification by external organizations provide the MHS with valuable information to validate compliance with national quality and safety standards and to identify opportunities for improvement.

MTF-specific hospital and clinic accreditation status is available publicly on the accreditation organization website TJC Quality Check (www.qualitycheck.org). MTF survey completion dates and requirements for improvement to meet full accreditation are displayed at the Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA]) public-facing web portal, www.health.mil/AccreditationStatus. This transparency is consistent with standardized management across an enterprise journeying toward high reliability, and supports NDAA FY 2016, section 713 requirements.

DHA is establishing the DHA Accreditation and Compliance (AC) Program to manage and administer accreditation and compliance activities in its markets and MTFs formerly aligned with the Services. To establish the DHA AC Program, Service and DHA SMEs are working in close collaboration to develop program procedures based on the successes of the Service accreditation programs. The Services continue to support MTF accreditation activities during the transition-related development and

Accreditation and Compliance Program *(cont.)*

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

Accreditation and Compliance is a new program under development at DHA as the Service Headquarters have traditionally administered and managed the accreditation programs for their individual MTFs. The recently published DHA Procedural Manual 6025.13, *Clinical Quality Management in the Military Health System Volume 5: Accreditation and Compliance,* provided direction and guidance for the development of a robust program. DHA continues to work in close collaboration with the Services during this time of transition. The Services provide direct support for accreditation activities to DHA and the MTFs as the DHA capability develops. The goal is to jointly build a program based on the successes and lessons learned from the well-established Service accreditation programs.

Program to Monitor and Support MTF Accreditation

MTFs are required to maintain facility accreditation by an external nationally recognized AO based on the health care services provided at the facility. The accreditation programs required by the MTFs include hospital, ambulatory, behavioral health and home health.The same AO, TJC, is currently utilized across the direct care system to reduce variation in the accreditation standards and survey process, supporting high reliability efforts.

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

CHAPTERS IN TJC ACCREDITATION MANUALS

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

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

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

Accreditation and Compliance Program *(cont.)*

MHS HEALTH CARE ACCREDITATION SURVEYS COMPLETED, BY TYPE AND YEAR

YEAR	HOSPITAL	AMBULATORY	BEHAVIORAL HEALTH	HOME CARE
2015	24	14	5	1
2016	17	35	10	0
2017	12	24	4	0
2018	20	21	17	1
2019	19	35	22	0

Source: DHA/Medical Affairs/CSD, 9/30/2020

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

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

TOP 5 TJC AMBULATORY STANDARDS CITED BY CHAPTER IN MTF SURVEYS, CYs 2014–2019

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

TOP 5 TJC HOSPITAL STANDARDS CITED BY CHAPTER IN MTF SURVEYS, CYs 2014–2019

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

Source: DHA/Medical Affairs/CSD, 9/30/2020

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

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

Accreditation and Compliance Program *(cont.)*

In addition to the survey process for accreditation, TJC requires accredited hospitals to submit national clinical quality measures data to TJC on a quarterly basis. Each inpatient MTF selects the measures for data submission. Trained abstractors collect data centrally and report to the MTFs for analysis and improvement as indicated. As an example, the perinatal care measures are included in the WICC quality measures section of this report (see pages 135–139).

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

Clinical Laboratory Services Accreditation

Regulatory Compliance

Standards for the regulatory compliance of clinical laboratories in the MHS are established by DoDI and DoD Manual (DoDM) 6440.02, titled *Clinical Laboratory Improvement Program (CLIP)*, and *CLIP* Procedures, respectively, dated May 29, 2014. The CLIP conditions and standards are federal laboratory/Clinical Laboratory Improvement Amendments (CLIA) comparable. Memorandum of Understanding (MOU) 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. The regulatory compliance of clinical laboratories in the MHS is, in part, evaluated through inspections conducted by an accreditation organization that has been granted deeming authority by CMS's Division of Clinical Laboratory Improvement and Quality, such as the College of American Pathologists (CAP), Commission on Laboratory Accreditation (COLA), TJC, American Society for Histocompatibility and Immunogenetics, American Association for Laboratory Accreditation, as well as through periodic self-inspections.

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

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

Accreditation Performance

The DoDM currently specifies key conditions that place more stringent requirements on DoD's clinical laboratories, such as requiring the performance of proficiency testing for all laboratory tests, to include those in the waived complexity category. The DoDM also requires accreditation inspections of DoD's clinical laboratories that operate under the authority of waived or provider-performed microscopy (PPM) certificates.

At present, CMS does not require inspection of their waived- or PPM-certificate laboratories, nor does it require proficiency testing for tests conducted within those laboratories. The application of these more stringent requirements within the DoD means that more of the MHS's clinical laboratories are assessed and accredited for proficiency testing when compared to the U.S. civilian-sector clinical laboratories.

In FY 2020, CLMS concluded the process of reviewing the DoDM to assure the DoD's policies, conditions, and standards regarding clinical laboratory regulatory compliance were current and updated as compared to CLIA, as implemented by Title 42, Code of Federal Regulations, Part 493. MOU 15-46 was also reviewed and revised. The updated documents are under review by the Division of Clinical Laboratory Improvement and Quality at DHHS to ensure the CLIP standards and requirements are essentially equivalent to those in CLIA and to facilitate renewal of the MOU between DoD and DHHS, respectively.

In CY 2020, 172 DoD laboratories worldwide were due for their biennial CAP re-accreditation inspections. The COVID-19 pandemic caused delays for 52 (30 percent) of those laboratories that were past their inspection anniversary dates. In September, the CAP rolled out a plan to begin virtual inspections for the DoD clinical laboratories whose inspections were postponed, as well as for the remaining 54 laboratories that had upcoming inspections. Scores for accreditation and proficiency testing of DoD clinical laboratories are summarized on the following page.

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

Accreditation and Compliance Program *(cont.)*

MHS CLINICAL LABORATORY ACCREDITATION SCORES, BY SERVICE, FY 2020

SERVICE	# OF LABORATORIES INSPECTED	ACCREDITATION SCORE AVG.	PROFICIENCY TESTING SCORE
Army	21	99.4%	99.1%
Air Force	17	99.5%	98.6%
Navy	28	99.0%	98.1%

Source: College of American Pathologists, 9/24/2020

Overall, the performance of the MHS laboratories regarding inspection accreditation rating and average proficiency testing scores is on par with the 2020 national average. CAP national average scores are 99.1 percent for accreditation inspections and 98.6 percent for proficiency testing scores.

Blood Bank Services Accreditation

The regulatory compliance of Blood Bank Services in the MHS is, in part, evaluated through inspections conducted by an accreditation organization that has been granted deeming authority by CMS's Division of Clinical Laboratory Improvement and Quality. Blood Bank Services in the MTFs are surveyed by external organizations based on the services provided. For MTFs with blood collection operations, U.S. Food and Drug Administration (FDA) registration and standards compliance demonstrated through an inspection process is required, as well as AABB (formerly known as the American Association of Blood Banks) inspection and CAP. If the MTF has blood transfusion operations, the Transfusion Service is registered with the FDA, and inspections are performed based on the services provided. All MTFs that perform transfusion operations are mandated to be accredited by CAP and AABB, and inspections are performed based on the services provided. Additionally, Blood Bank Services are assessed under relevant TJC standards during the survey process and annual self-assessments. AABB, CAP, and the FDA inspect and assess the Blood Bank Donor Centers and Transfusion Services (BDC) biennially.

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

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

INSPECTION	2019 INSPECTIONS	2020 INSPECTIONS
FDA	31	1
AABB/CAP	31	16

In May 2020, the ASBP BDC were tasked to obtain 10,000 units of COVID Convalescent Plasma (CCP) as a therapeutic treatment for COVID-19 disease by September 30, 2020. The CCP Campaign kicked off in June 2020 and the ASBP BDC were successful in obtaining the 10,000 CCP units—4,500 units were procured from the Blood Center of America and the ASBP BDC collected 5,500 units of CCP—by implementing three FDA regulatory requirements for the collection and manufacturing of CCP.

The ASBP Division (at DHA) established a QA and Regulatory Branch. The QA and Regulatory Branch Chief will create a portal for submission of all FDA, CAP and AABB inspections and assessments. The submitted inspection and assessment findings and/or citations will provide an enterprise quality assessment of the Blood Donor Center and Transfusion Service Activities and will identify repeat citations and nonconformances. The ASBP QA and Regulatory Branch Chief will provide guidance for corrective actions to be taken and monitor continual process improvement. An ASBP Quality Plan will be created and published as a reference for the Service Blood Programs and Combatant Command Joint Blood Program Officers for implementation. The ASBP QA and Regulatory Branch Chief will establish metrics to monitor overall QA in the Blood Donor Centers and Transfusion Service Activities.

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

Clinical Measurement

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

CM activities include internal assessment of quality care delivered, identification of improvement actionable information, performance monitoring, and providing clinical measure education to markets and MTFs.

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

CM data are displayed throughout the CQM section and in various other sections included in this report.

National (External) Clinical Quality Programs and Databases

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

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

The DoD currently participates in 11 clinical quality programs and databases:

- American College of Surgeons (ACS) NSQIP Adult Program
- ACS NSQIP Pediatric Program
- ACS Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP)
- ACS Trauma Verification, Review, and Consultation (VRC) Program; and Trauma Quality Improvement Program (TQIP)
- National Cardiovascular Data Registry (NCDR)
- American Society of Clinical Oncology (ASCO) Quality Oncology Practice Initiative
- National Perinatal Information Center (NPIC) Database
- National Healthcare Safety Network (NHSN)
- CMS Care Compare (formerly Hospital Compare)
- Targeted Solutions Tool
- The Joint Commission (TJC) National Hospital Measure

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

MHS Data Transparency

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

Leapfrog: The MHS continues to focus on clinical quality, safety, and transparency, putting the power of knowledge into the hands of the patient through participation in the Leapfrog Group's surveys.

DHA began the first federal multifacility participation in the Leapfrog Group's Hospital Survey when five pilot inpatient MTFs submitted survey data in November 2019. These facilities' data are now publicly reported on the Leapfrog website (www.leapfroggroup.org), allowing

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

Clinical Measurement *(cont.)*

comparison of standard clinical quality and patient safety measures across both direct and purchased care. This new partnership will provide visibility to empower our Service members and their families to make the best decisions for their health care. It is anticipated that all CONUS MTFs with inpatient capability, including those in Alaska and Hawaii, will submit responses to the Leapfrog Hospital Survey in December 2020.

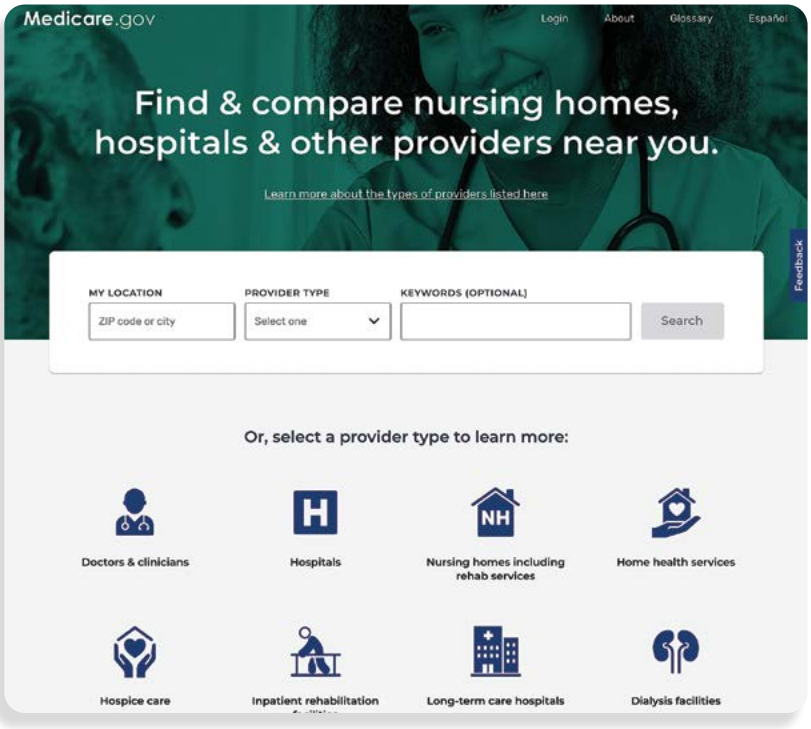
Health.mil: The health.mil website is designed for patients to assess how the facilities at which they receive care are performing in terms of quality, safety, and access. There are more than 60 metrics reported on health.mil.

MHS Transparency on CMS Care Compare (formerly Hospital Compare)

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

The TRISS and Timely and Effective Care results are publicly posted on Care Compare for all military hospitals in the United States. TRISS is based on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and is administered following inpatient discharge to assess the patient's perceptions of staff communication/responsiveness, facility cleanliness/quietness, provision of discharge information, and whether they would recommend the hospital. Timely and Effective Care measures are process of care measures that show the percentage of hospitals that gave treatments for certain conditions/procedures, how quickly hospitals treat patients with certain emergencies, and how well hospitals perform in offering and providing preventive services. An example of these measures would include average time for an EKG in the emergency department and patient experience with staff responsiveness. The MHS will add a Sepsis measure and an additional emergency department (ED) measure to its public reporting on Care Compare in January 2021. The Sepsis measure will assess facilities' appropriate early management of severe sepsis and septic shock and the additional ED measure will report facilities' percentage of patients who left the ED without being seen. The MHS continues to develop plans to expand reporting of measures on Care Compare. MTFs can be searched by ZIP code or hospital name and compared with civilian facilities in the same location. Visit https://www.medicare.gov/care-compare/ for more information.

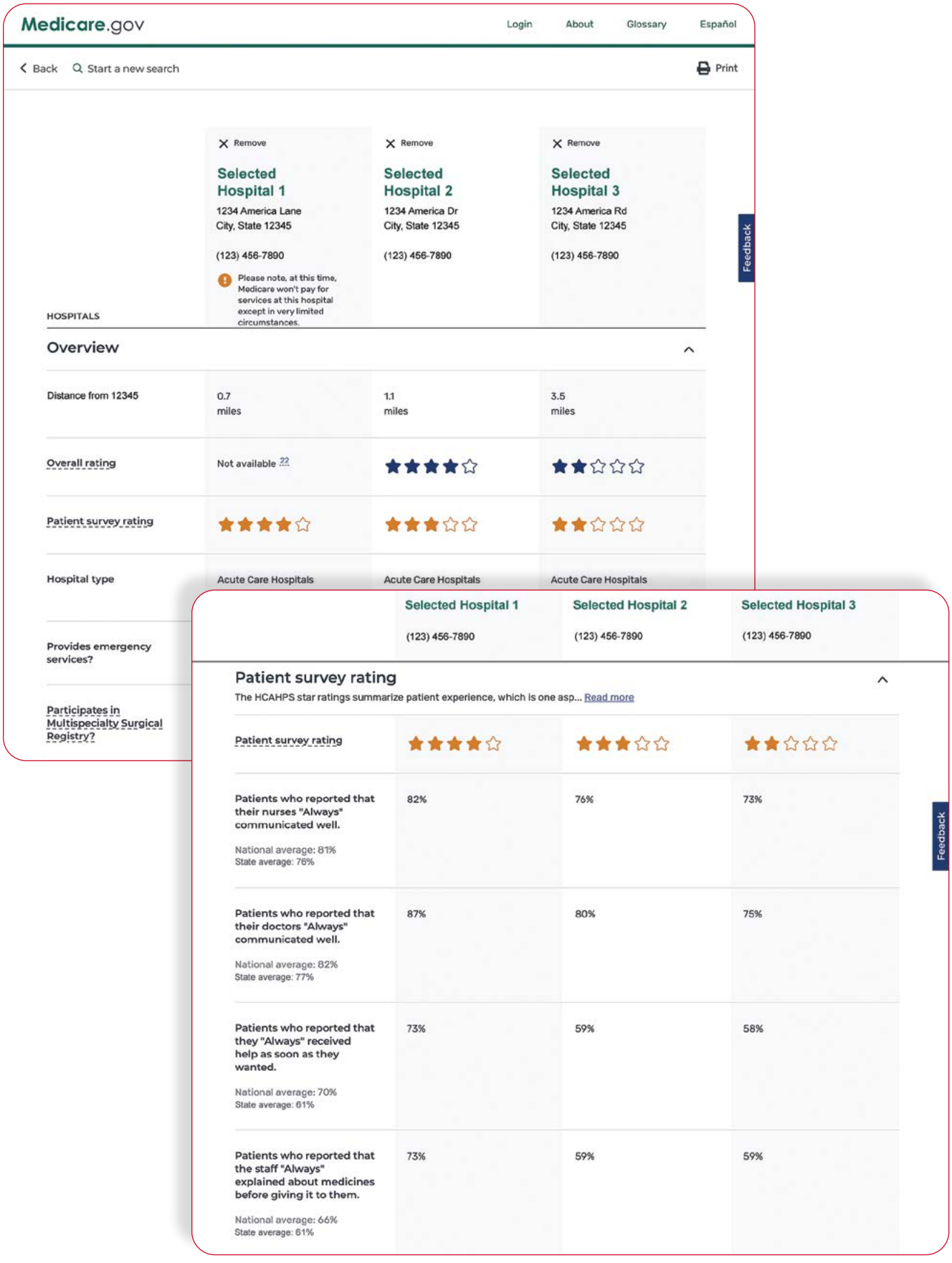
THE MHS COLLABORATES WITH CMS TO POST MTF HOSPITAL RESULTS ON THE CARE COMPARE WEBSITE



BETTER CARE

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

MHS Transparency on CMS Care Compare (formerly Hospital Compare) *(cont.)*



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

Clinical Quality Improvement (CQI)

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

CQI activities include strategic quality improvement planning, CQM training and education, and CQI studies.

Strategic Quality Improvement Planning

The CQI program continues to lead strategic quality improvement planning with its close collaboration with the QPP. Briefly, the QPP is the enterprise-wide planning process that integrates capabilities in strategic planning, performance planning, financial operations, performance improvement, and decision making. QPP supports alignment of the market and MTF activities to the Quadruple Aim of Improved Readiness, Better Care, Better Health, and Lower Cost. The CQI program organized the review of more than 60 different QPP improvement initiatives from the MTF and identified several potential improvement opportunities that will be further studied for possible system-wide improvement efforts. Most recently, the CQI program defined new quality improvement priorities in the QPP supplemental guidance that will further align clinical quality improvement efforts from the headquarters down to the MTFs.

CQM Training and Education

The CQI program is responsible for the development of a workforce equipped with core competencies in health care quality, patient safety, and quality improvement. Empowering individuals to use evidence-based tools and improvement science to help identify improvement opportunities and promote data-driven improvement behaviors throughout the system is necessary in our HRO journey. In collaboration with the Services, the CQI program completed development of CQM competencies and is planning to pilot new DHA learning resources for the general workforce and CQM professionals.

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

Clinical Quality Improvement Studies (CQIS)

The MHS is also involved in conducting CQIS designed to validate and improve processes and outcomes of the care delivered to beneficiaries, to include the analysis and comparison of the performance of MHS direct care and purchased care with civilian national benchmarks, whenever available. The completed FY 2018 CQIS result is as follows:

- **Opioid Overdose Risk Assessment and Repeat Overdose Risk Reduction Strategies, FY 2018–FY 2019**

  Using administrative claims records and chart abstractions, this study examined (1) providers' actions to lower the risk of an opioid overdose event and (2) whether these actions had an effect on preventing a repeat overdose. The results, based on a full year of observation following the index (initial) overdose, found no repeat opioid overdoses among patients treated at military facilities only. For TRICARE patients with repeat overdoses treated in non-military settings, three distinct groups emerged for those at risk for second overdoses: patients with a history of chronic pain managed with long-term opioid therapy, those with acute pain who were prescribed opioids or those prescribed opioids for non-specific use, and those who were using heroin or illicit drugs. The most common risk reduction actions by providers were discussions with the patient about pain treatment, strategies for treating pain, risk of overdose, and setting functional goals. There was no evidence that these risk reduction actions, consistent with VA/DoD CPGs for Management of Opioid Therapy for Chronic Pain, mitigated second overdoses, which primarily occurred among family members aged 18–34 of military retirees, those who relied on emergency departments for their health care, and those with a history of heroin or illicit drug use. Recommendations to MHS clinicians include using the VA Risk Index for Overdose or Serious Opioid-induced Respiratory Depression for all patients prescribed opioids, and offering naloxone for high-risk patients.

Future Alignment of DoD Program Management Office supporting the VA/DoD CPG

The CQI program will assume the DoD program management of the joint VA/DoD Evidence-Based Practice Work Group (EBPWG), which is chartered through the Health Executive Committee (HEC) Clinical Care Business Line reporting to the Joint Executive Committee. The EBPWG is responsible for using clinical and epidemiological evidence to improve the health of the population across the Veterans Health Administration (VHA) and MHS. This partnership facilitates the development of both CPGs and tool kits for clinicians and patients to promote continuous learning. In FY 2019, five CPGs were developed: hypertension; dyslipidemia; headache; and obesity and overweight; osteoarthritis of the hip and knees. In 2020, five additional CPGs are being updated to include: chronic obstructive pulmonary disease; chronic multisymptom illness; mild traumatic brain injury; upper extremity and amputation and rehabilitation; and substance use disorder. VA/DoD CPGs consistently receive national recognition, including the ECRIs Guidelines Trust approval.

HIGH RELIABILITY OPERATING MODEL/CLINICAL COMMUNITIES

Primary Care Clinical Community

Primary Care Services

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

VA and DoD CPG collaboration has established a rigorous systematic review of medical evidence to help primary care providers and health care teams deliver consistent high-quality health care to beneficiaries. CPGs are developed by multidisciplinary clinical experts and are based on unbiased clinical research studies and literature reviews. Multiple CPGs have been developed and updated to provide practitioners with information and tool kits to support evidence-based practice. VA/DoD CPGs are available at www.healthquality.va.gov/. To enhance its availability and use, CPG information is embedded into the EHR as clinical decision support. The goal was to incorporate the CPGs into the clinician's workflow to ensure ease of use. Information on assessment, diagnosis, and recommendations for treatment were literally placed at the providers' fingertips.

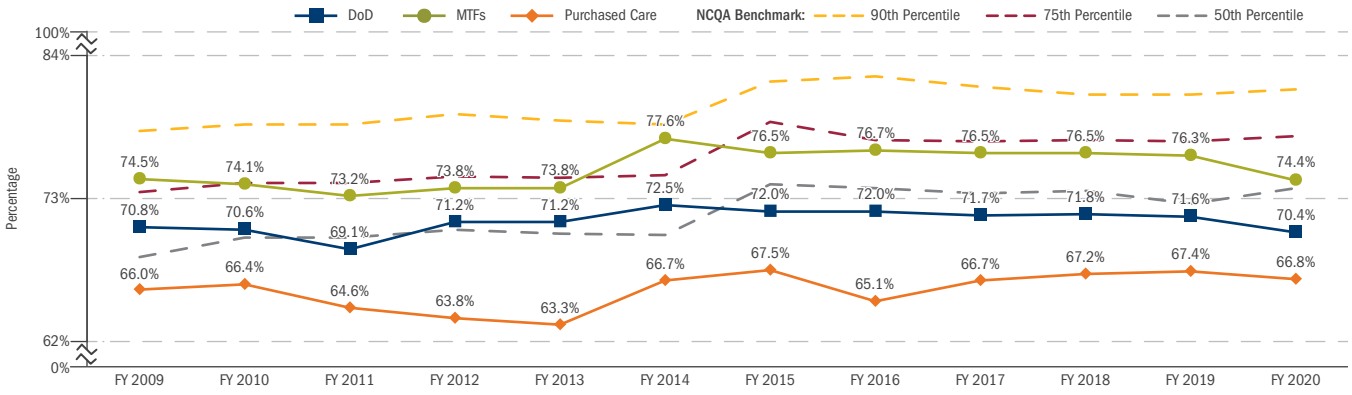
Additionally, the MHS monitors the performance of primary care services with a variety of nationally recognized quality measures. The NCQA Healthcare Effectiveness Data and Information Set (HEDIS) includes primary care–focused health plan measures with methodologies. HEDIS is a tool used by America's health plans to measure performance on important dimensions of care and service. HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. MHS data can be compared with the NCQA annual benchmark results. The MHS Population Health Portal CarePoint application provides measure methodology, as well as performance data at the system, Service, region, clinic, and provider level. The HEDIS methodologies used by CarePoint are reviewed annually by an NCQA HEDIS auditor for validation and certification.

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

Adult HEDIS Measures

- **Breast and Cervical Cancer Screening:** HEDIS measure focused on cancer screening for early detection and treatment to maximize the potential for a cure. Breast cancer screening is above NCQA's 50th percentile in direct care. Cervical cancer screening is within 1.5 percentage points of the 75th percentile for direct care. Purchased care increased slightly in cervical cancer screenings, while all other rates decreased for both cervical and breast cancer screenings, compared with FY 2019. COVID-19 impacts are likely contributing to the decreased rates seen in these two screening measures. For cervical cancer screening, major measure specification changes in FY 2014 resulted in a break in benchmark applicability, which led to the absence of a benchmark for FY 2015, as reflected in the graph.

HEDIS MEASURE: BREAST CANCER SCREENING

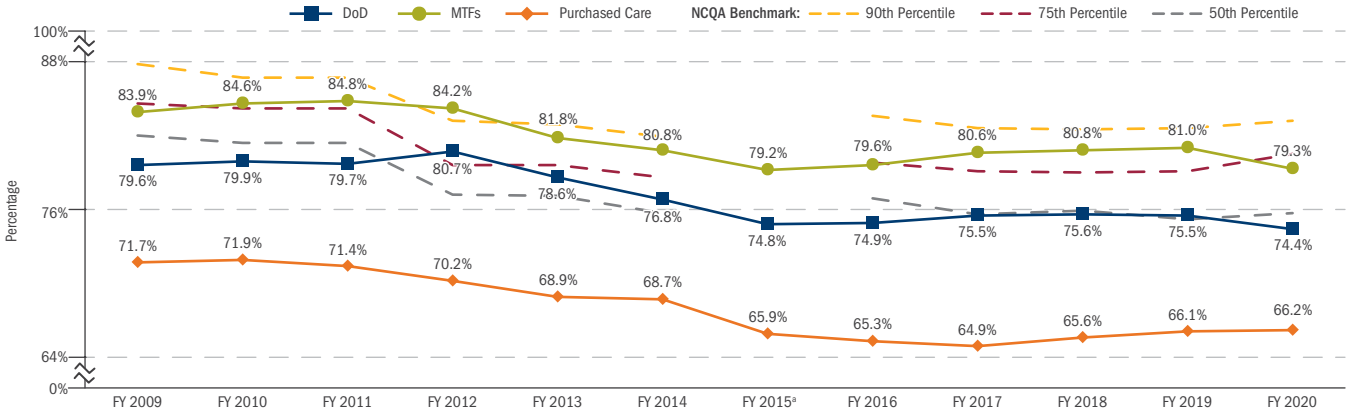


Source: DHA/Medical Affairs/CSD, 2/24/2021
Note: Data for FY 2020 are through May 2020.

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

Primary Care Clinical Community *(cont.)*

HEDIS MEASURE: CERVICAL CANCER SCREENING



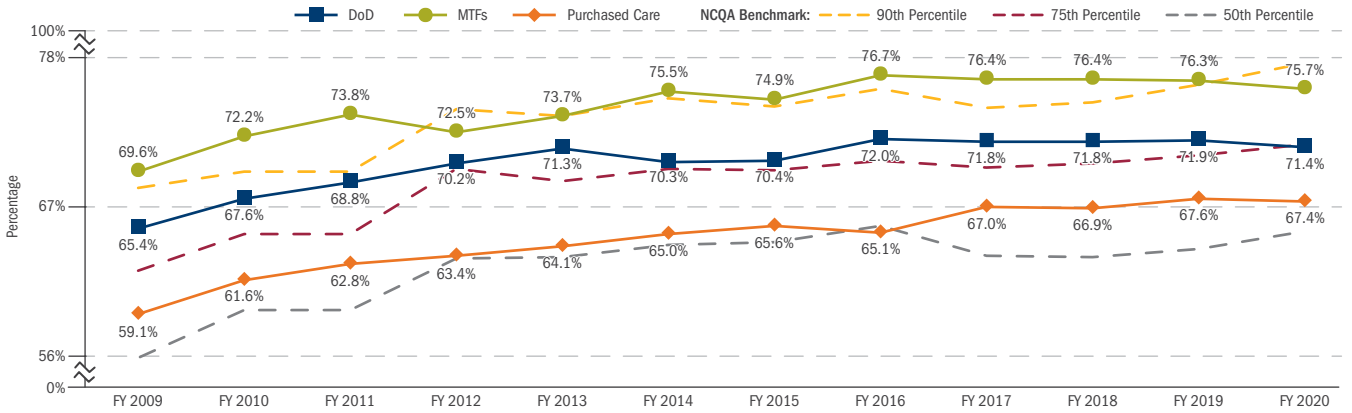
Source: DHA/Medical Affairs/CSD, 2/24/2021

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

Note: Data for FY 2020 are through May 2020.

- **Colorectal Cancer Screening:** HEDIS measure focused on detecting colorectal cancer as well as screening for premalignant polyps to prevent cancer. Current MHS direct care rates are within two percentage points of the NCQA 90th percentile, and purchased care rates are above the NCQA 50th percentile. Decreased rates, compared to FY 2019, in both purchased and direct care for this screening measure are likely due to impacts from COVID-19.

HEDIS MEASURE: COLORECTAL CANCER SCREENING

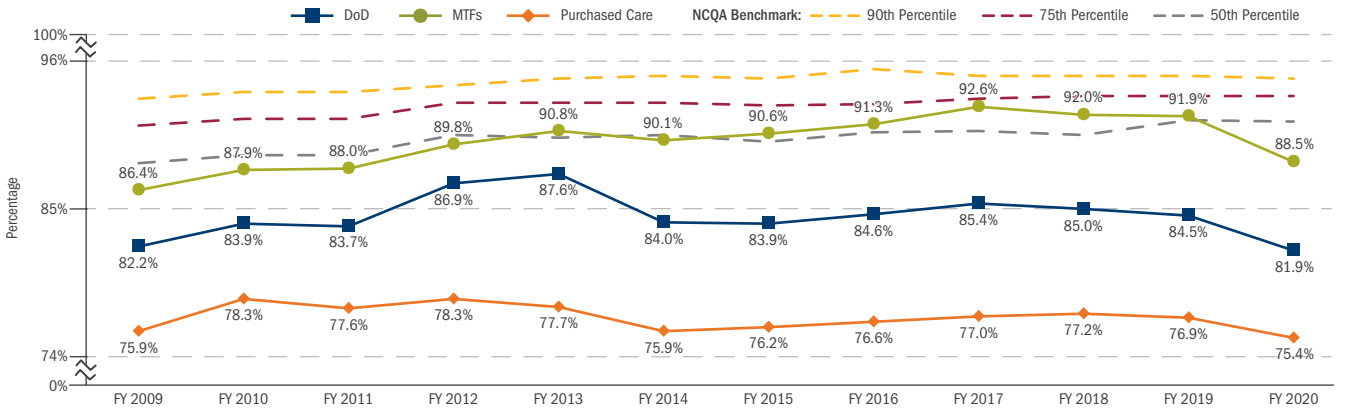


Source: DHA/Medical Affairs/CSD, 2/24/2021

Note: Data for FY 2020 are through May 2020.

- **Diabetes HbA1c Screening:** HEDIS measure focused on annual testing to help health care providers with care for the common and serious chronic disease of diabetes. The MHS continues to work to improve the management of diabetic patients. The 2020 rate of performance for direct care facilities fell below the NCQA 50th percentile. The 2020 rates in both purchased and direct care were likely negatively impacted by COVID-19 for this screening measure.

HEDIS MEASURE: DIABETES HbA1c SCREENING



Source: DHA/Medical Affairs/CSD, 2/24/2021

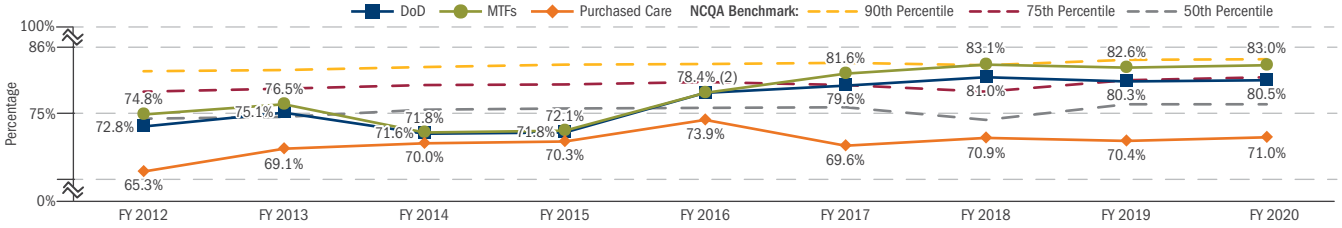
Note: Data for FY 2020 are through May 2020.

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

Primary Care Clinical Community *(cont.)*

- **Low Back Pain Imaging:** HEDIS measure focused on overuse of imaging for acute low back pain. MHS has integrated the VA/DoD low back pain CPG into the EHR to support providers with improvement initiatives. Performance reporting capabilities were developed for each level of care, MTF, provider team, and individual provider to support feedback. The MHS continues to demonstrate improvement in this measure over the years. The 2020 rate of performance for direct care facilities is consistent with the NCQA 75th percentile and is within one percentage point of the 90th percentile. Both direct and purchased care saw improved rates during 2020, compared with FY 2019.

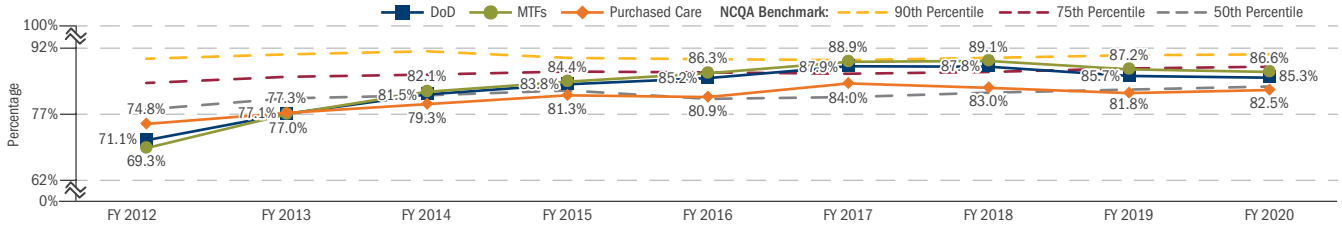
HEDIS MEASURE: LOW BACK PAIN IMAGING



Source: DHA/Medical Affairs/CSD, 2/24/2021
Note: Data for FY 2020 are through May 2020.

- **Well-Child Visits:** HEDIS measure focused on the adequacy of well-child care for infants, as demonstrated by children having six visits within the first 15 months of life. Direct care facilities are in the NCQA 50th percentile in 2020 and are within 1.5 percentage points from the 75th percentile. The purchased care providers are within one percentage point of the 50th percentile.

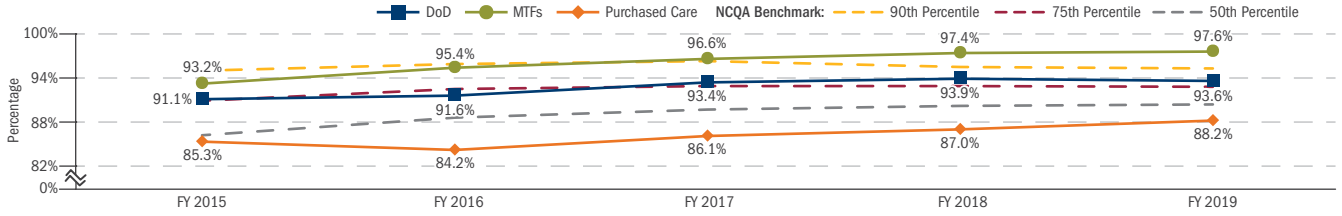
HEDIS MEASURE: WELL-CHILD VISITS



Source: DHA/Medical Affairs/CSD, 2/24/2021
Note: Data for FY 2020 are through May 2020.

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

HEDIS MEASURE: CHILDREN WITH URI



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

- **Appropriate Treatment of URI:** HEDIS measure focused on the avoidance of antibiotic prescribing for anyone three months of age or older diagnosed with a URI. This measure increases awareness of the importance of antibiotic stewardship among children and adults to prevent antibiotic resistance. This is a new measure for 2020; therefore, NCQA has yet to establish benchmarks for comparison. This new measure is not comparable to the NCQA Appropriate Treatment of Children with URI measure from previous years due to significant measure specification changes.

APPROPRIATE TREATMENT OF URI (AGE ≥3 MONTHS)

	DoD	MTFs	PURCHASED CARE
FY 2020	88.2%	95.0%	78.9%

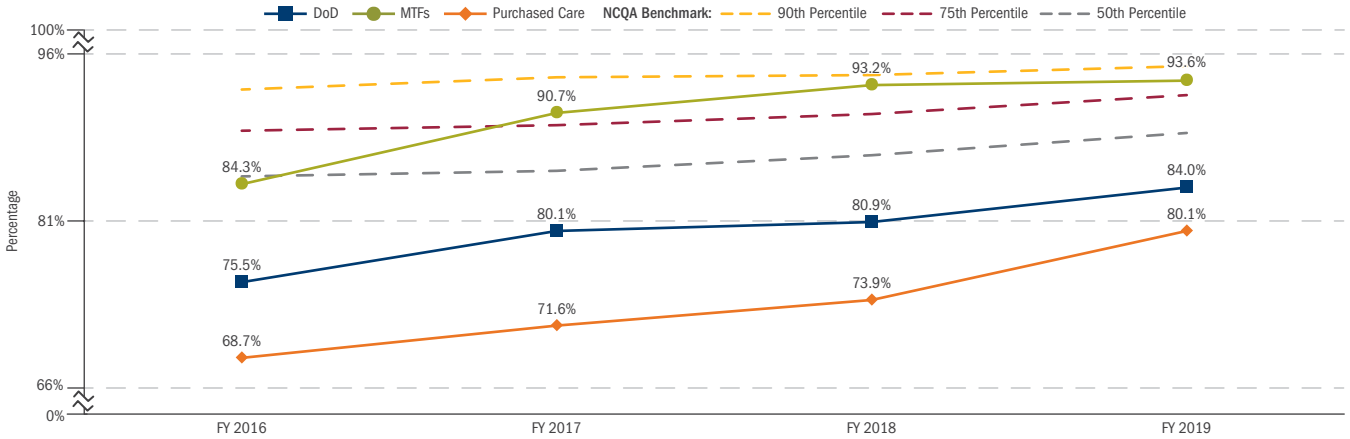
Source: DHA/Medical Affairs/CSD, 2/24/2021
Note: Data for FY 2020 are through May 2020.

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

Primary Care Clinical Community *(cont.)*

- **Children with Pharyngitis:** HEDIS measure focused on appropriate use of antibiotics for children diagnosed with pharyngitis based on laboratory data. Pharyngitis diagnosis can be easily and objectively validated through administration of a group A strep test at the point of care. Validation of the diagnosis prevents unnecessary use of antibiotics. A higher rate indicates appropriate laboratory testing confirmation prior to prescribing antibiotics for pharyngitis. Due to significant changes, measure specifications are not comparable in 2020 to prior years. Data through FY 2019 are provided in the graph below for historical purposes. Please refer to the new measure, Appropriate Treatment for Pharyngitis, in the table below for 2020 data. In the graph below, rates for children with pharyngitis are available for previous years; however, prior to FY 2016, rates were aggregated based on MTF enrollment and not by treatment place of care. The graph below reflects the transition to place of care attribution for data reporting in FY 2016 and in subsequent years following the attribution change.

HEDIS MEASURE: CHILDREN WITH PHARYNGITIS



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

- **Appropriate Treatment of Pharyngitis:** HEDIS measure focused on appropriate use of antibiotics for anyone three months of age or older diagnosed with pharyngitis, based on laboratory data. This measure increases awareness of the importance of laboratory testing and confirmation prior to prescribing antibiotics for pharyngitis. This is a new measure for 2020; therefore, NCQA has yet to establish benchmarks for comparison. This new measure is not comparable to the NCQA Appropriate Testing for Children with Pharyngitis measure from previous years due to significant measure specification changes.

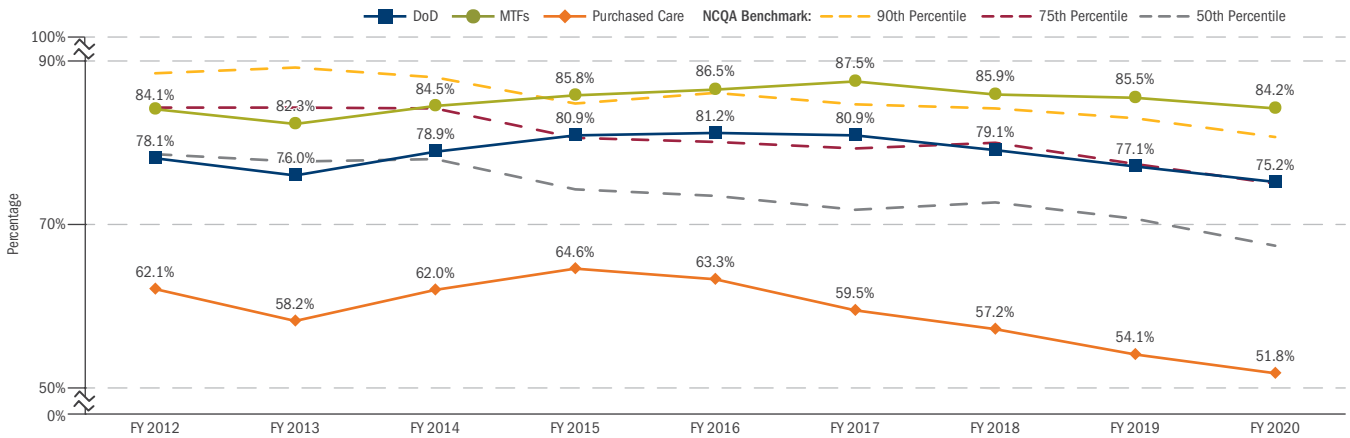
APPROPRIATE TREATMENT OF PHARYNGITIS (AGE ≥3 MONTHS)

	DoD	MTFs	PURCHASED CARE
FY 2020	76.4%	84.2%	73.2%

Source: DHA/Medical Affairs/CSD, 2/24/2021
Note: Data for FY 2020 are through May 2020.

- **Mental Health (MH) Follow-Up:** This HEDIS measure examines 30-day MH follow-up care in the MHS MTF and purchased care venues. The direct care rates continue to exceed the NCQA 90th percentile, while purchased care rates continue to decline, falling below the 50th percentile. The MHS overall is consistent with the 75th percentile.

HEDIS MEASURE: MENTAL HEALTH 30-DAY FOLLOW-UP



Source: DHA/Medical Affairs/CSD, 2/15/2021
Note: Data for FY 2020 are through May 2020.

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

Primary Care Clinical Community *(cont.)*

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

MHS performed fairly well compared with national HEDIS benchmarks, obtaining the 75th percentile for MH Follow-Up (7 and 30 day) and Chlamydia Screening. Low Back Pain Imaging measure results for the MHS were within one-half percentage point of the 75th percentile. COVID-19 negatively impacted the availability of onsite clinical services and caused a positive shift in the use of telehealth across the MHS. These impacts are suspected to have played a role in the rate decreases seen across the MHS for most of the HEDIS measures in 2020. Measure results are available through May FY 2020 due to necessary data platform changes and system security updates. These influences may have impacted the rates reported for 2020. Future reports will likely shed light on the degree to which these prevailing factors ultimately impacted HEDIS FY 2020 rates. Overall MHS performance shown below includes TRICARE Prime enrollees to facilities containing an Army, Navy, Air Force, or DHA facility service codes, along with TRICARE Prime enrollees to Defense Medical Information System Identifiers (DMIS IDs) associated with an MCSC, Uniformed Services Family Health Plan (USFHP), or Coast Guard facility service code. Direct care, purchased care, and DoD performance calculations (pages 129–132) only include TRICARE Prime beneficiaries and do not include Coast Guard facilities.

MHS HEDIS BENCHMARK PERFORMANCE, JUNE 2014–MAY 2020

HEDIS MEASURE	2014	2015	2016	2017	2018	2019	2020	2014 TO 2015 CHANGE	2015 TO 2016 CHANGE	2016 TO 2017 CHANGE	2017 TO 2018 CHANGE	2018 TO 2019 CHANGE	2019 TO 2020 CHANGE	HEDIS BENCHMARK STATUS (2020)
Mental Health														
Mental Health Follow-Up: 30 Days	78.10	78.86	81.08	80.90	77.68	77.05	75.20	0.76	2.22	–0.18	–3.23	–0.63	–1.85	★★★★
Mental Health Follow-Up: 7 Days	62.41	64.01	68.03	69.03	61.31	59.34	58.04	1.60	4.01	1.01	–7.73	–1.97	–1.29	★★★★
Pediatric														
Well-Child: 6 or More Visits	80.85	83.09	84.09	87.09	88.25	85.95	85.28	2.24	1.01	2.99	1.16	–2.30	–0.67	★★★
Children with Pharyngitis[a]	76.04	73.04	74.91	79.31	80.89	83.76		–3.00	1.87	4.41	1.57	2.87		
Children with Upper Respiratory Infection[a]	89.07	90.48	91.32	93.32	93.79	93.64		1.42	0.84	2.00	0.47	–0.15		
PCMH														
Treatment for Pharyngitis[b]							76.38							–
Treatment for Upper Respiratory Infection[b]							88.17							–
Breast Cancer Screening	72.65	72.27	72.08	71.59	71.84	71.70	70.37	–0.38	–0.19	–0.49	0.24	–0.14	–1.33	★★
Cervical Cancer Screening	77.13	74.38	74.73	75.24	75.32	75.38	74.39	–2.75	0.35	0.51	0.08	0.06	–0.98	★★
Colorectal Cancer Screening	70.64	70.91	71.81	73.27	72.18	72.36	71.37	0.27	0.91	1.46	–1.09	0.18	–1.00	★★★
Chlamydia Screening	58.33	62.36	64.43	65.41	65.68	66.50	64.13	4.03	2.07	0.97	0.27	0.82	–2.37	★★★★
Low Back Pain Imaging	71.49	71.38	76.36	78.70	80.56	80.48	80.54	–0.11	4.98	2.34	1.86	–0.07	0.05	★★★
Diabetes Screening	84.24	83.68	84.30	84.94	85.31	84.60	81.86	–0.57	0.62	0.65	0.37	–0.71	–2.74	★
Diabetes A1c Level <7%	50.21	48.52	48.33	46.82	47.29	46.80	42.71	–1.69	–0.18	–1.51	0.47	–0.49	–4.09	–
Diabetes A1c Level <8%	68.10	67.69	67.87	66.90	67.75	67.62	63.19	–0.40	0.17	–0.96	0.84	–0.13	–4.43	★★★
Diabetes A1c Level ≤9%	76.71	76.77	77.31	76.70	77.93	77.21	73.52	0.06	0.54	–0.61	1.22	–0.71	–3.69	–

Source: MHS Population Health Portal, May 2020

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

[b] New measure in 2020

Notes:

– The data are June–June look-backs for the given year. Data for 2020 are through May 2020.
– Rates include TRICARE Prime enrollees to Army, Air Force, Navy, DHA, MCSCs, Coast Guard, and associated USFHP DMIS IDs.
– Statistical Testing: Two-sample Z test; Green or Red: statistically significant at p=0.05 level.
– 2017 and 2018 data exclude the MHS GENESIS initial operating capability (IOC) sites.
– Sites that have transitioned to MHS GENESIS use as of June 2019 were removed for 2017–2020.
– 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
– Purchased Care measure results are derived from TRICARE Encounter Data and other administrative data.

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

Neuromusculoskeletal Clinical Community

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

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

The NMSKCC is fielding the Patient Reported Outcomes Clinical Record (PROCR) system on the DHA Survey Portal. NMSK adoption of the PROCR on the DHA Survey Portal is a DHA enterprise FY 2022 supplemental QPP metric that will be assessed quarterly with the DHA Regional Directors. Enterprise PROCR use in the NMSK community will provide unprecedented clinical insight, accelerate continuous process improvement and has the potential to establish the Military Health System as the world leader in NMSK care. Merging patient reported outcomes with all available clinical data will enable increasingly sophisticated predicted and prescriptive analysis that will drive adherence to clinically based guidelines and leading processes. The end state will support both improved military medical readiness and value-based care, and support the FY 2021 Senate Armed Services Committee (SASC) NDAA Report priority to improve musculoskeletal injury prevention and the NDAA FY 2017, Section 726, directive to establish best practices for the delivery of healthcare services, incorporate best practices and eliminate variability in health outcomes in MTFs.

The NMSKCC is also working to implement a Low Back Pain Clinical Pathway to decrease care variability and return Soldiers to duty faster. The pathway focuses on patient outcomes, in line with high reliability principles. The pathway seeks to facilitate early access to physical therapy, which has been shown to improve patient outcomes and reduce cost and additional utilization of health care resources. The pathway aims to improve pain management and the patient experience through the reduction of unnecessary imaging, opioid prescriptions, and pain-related disability. Pilot sites are currently being determined, with anticipated initial data collection in the first quarter of 2021.

With the onset of the COVID-19 pandemic, emphasis was placed on increased readiness training, focusing on rehabilitation foundation skills for the acute hospital setting. The Acute and Critical Care Rehabilitation Working Group (ACCRWG) established the DHA Rehabilitation clinical practice guidelines for the acute care setting for use throughout the enterprise. Within the first month of known cases, Acute Inpatient Rehabilitation personnel consisting of physical and occupational therapists, physical medicine and rehabilitation physiatrists, and speech-language pathologists from across the enterprise trained more than 280 rehabilitation staff in basic skills for providing care within the acute and critical care setting for both the traditional MTF and forward deployed in support of nontraditional settings such as the USS Mercy and the Javits Center. These personnel also trained almost 500 nursing staff in early mobility, transfers, basic exercises using handouts, gait training, fall prevention, and use of lift systems and additional equipment commonly used for safe patient handling to help minimize the use of critical PPE at a time of known shortages. With a renewed awareness for the need of acute rehabilitation skills, the ACCRWG has set priorities to be the key driver in moving enterprise health care delivery to a value-based system, decrease risk of harm to hospitalized patients, and support the DoD's readiness mission by providing critical war time and pandemic skills training and sustainment for our deployable medical force. Three focused areas are: (1) staffing aligned with the American College of Surgeons Trauma Center Verification Rehabilitation Requirements as established in the ACS's Orange book, chapter 12; (2) establish access to data from validated outcome measures, decision support tools, and programs, such as the Activity and Mobility Promotions initiative with Johns Hopkins Hospital, to drive clinical decision making, streamline practices, and promote wise use of resources; and (3) develop the Acute and Critical Care Foundations Course to ensure the safe provision of acute and critical care at a moment's notice anywhere we are called to go, including our home facilities as casualty receiving centers.

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

Women and Infant Clinical Community

Women and Infant Initiatives

The WICC promotes readiness, process improvement, maximum value, and desired patient outcomes, while catalyzing innovation and eliminating preventable harm and waste. It is organized by readiness-critical or high-volume, high-risk, high-variability groups of interrelated processes related to the care of women and infants, and aligns related clinical specialty work.

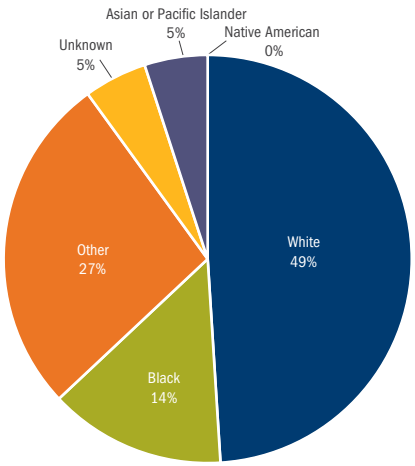
The WICC utilizes available evidence and community practices to support standardization to avoid unwarranted variation in clinical processes and reviews MTF and market data and clinical outcomes that impact women's health, perinatal (maternity), and infant (birth to one year of age) care. WICC collaboration is internal to MHS (within clinical communities) and external to the DoD with the Veterans Administration and national organizations such as American College of Obstetricians and Gynecologists (ACOG), the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN), and the Alliance for Innovation on Maternal Health (AIM). In addition, the WICC utilizes national collaboratives to leverage existing processes to expand quality of care transparency and transform leading practices. Examples include: an initial framework for severe maternal morbidity and mortality reviews; capacity for same day or walk-in contraception appointments; adoption of a Navy handbook, Deployment Readiness Education for Service Women, into a Tri-Service mobile application; MHS-wide documentation standardization, in both legacy (Essentris) and MHS GENESIS electronic health systems; and alignment with AIM bundles to decrease adverse events for families.

Perinatal Care Measures

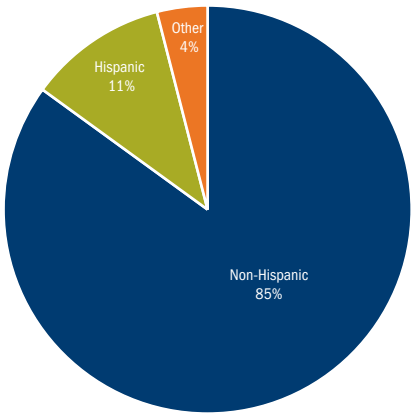
Perinatal care is an MHS high-volume specialty. Nationally recognized measures are continually monitored at the enterprise, community, and MTF levels to assess the quality and safety of perinatal care provided across the system for both community-based and MTF-based care. Data available through the NPIC provide quality data and benchmarks for perinatal care in both community-based and MTF-based care. MHS reports multiple perinatal metrics externally to beneficiaries and interested parties to demonstrate quality of care. Increasing transparency to MHS beneficiaries, and the public at large, continues to expand with the addition of the five Leapfrog maternity care measures to the previously existing measures from the NQF, TJC, and the Agency for Health Research and Quality (AHRQ), providing a basis for comparison of MHS performance and quality care. The Leapfrog Group sets performance targets to assist health care organizations identify top performance for patient safety and quality.

Each year across the MHS, more than 30,000 babies are born in MTF-based care, representing a wide variety of races/ethnicities, shown below. Tracking maternal and neonatal outcome measures by race and ethnicity will be a focus for the WICC in 2021.

DELIVERIES IN DIRECT CARE, BY RACE, APRIL 2019–MARCH 2020



DELIVERIES IN DIRECT CARE, BY ETHNICITY, APRIL 2019–MARCH 2020



Source: NPIC

Note that all data provided above and hereafter represents MTFs utilizing the legacy electronic medical record (EMR), Essentris. Data from MTFs utilizing the new EMR, MHS GENESIS, are not available for aggregation and analysis at this time. MTF rollout of MHS GENESIS is based on an MHS implementation plan that began in the Northwest United States and includes: Madigan Army Medical Center (Joint Base Lewis McCord, Wash.), Naval Hospital Bremerton (Wash.), and Travis Air Force Base Hospital (Calif.).

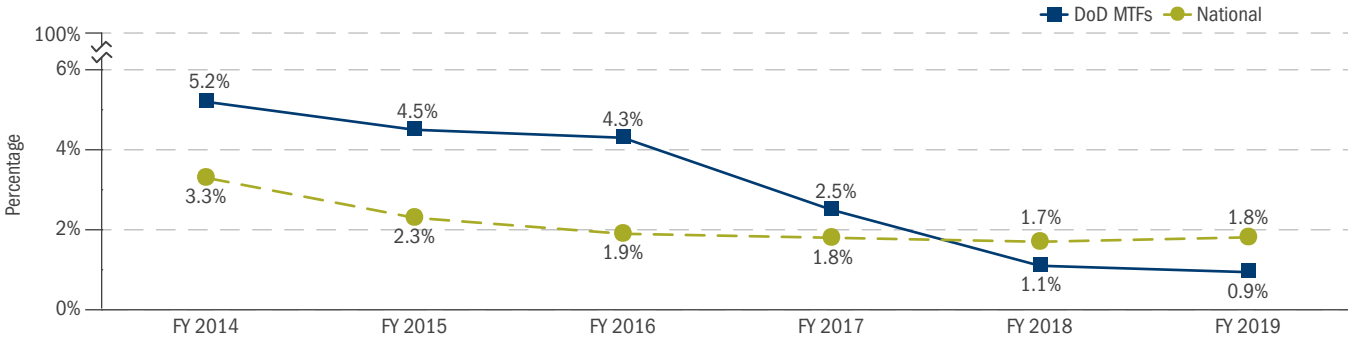
HIGH RELIABILITY OPERATING MODEL/CLINICAL COMMUNITIES *(CONT.)*

Women and Infant Clinical Community *(cont.)*

TJC has six perinatal core (PC) measures the MHS tracks at the MTF and MHS level.

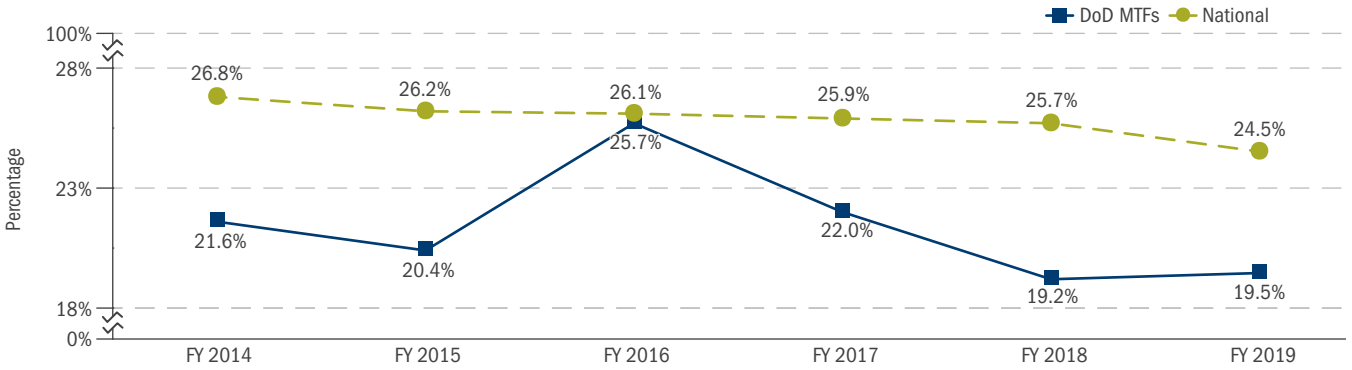
- **Elective Delivery:** This measure (PC-01) focuses on improving the health and outcomes of infants and mothers by avoiding non-medically indicated early elective births (before 39 weeks gestation). Elective inductions result in more cesarean births, longer maternal length of stay, and increased short-term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

DoD HOSPITAL QUALITY MEASURE: ELECTIVE DELIVERY PC-01, FYs 2014–2019



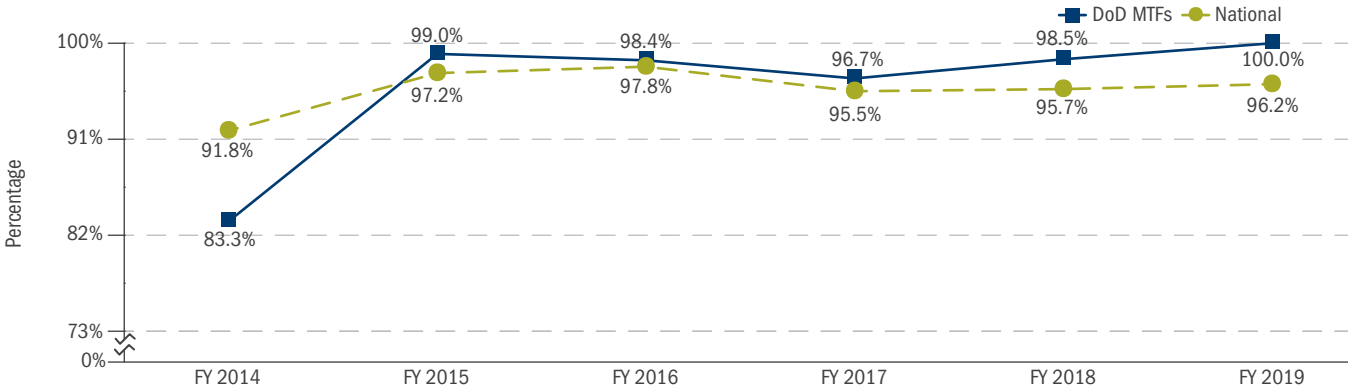
- **Cesarean Rates:** This measure (PC-02) focuses on safe and appropriate use of cesarean delivery for women who have not previously given birth and have a nulliparous, term (39 weeks), singleton, vertex cesarean delivery. The goal of the measure is to reduce risk and increase safety for mothers and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

DoD HOSPITAL QUALITY MEASURE: CESAREAN SECTION PC-02, FYs 2014–2019



- **Antenatal Steroids:** This measure (PC-03) focuses on providing mothers at risk of preterm delivery (≥24 and <34 weeks gestation) with steroids prior to delivering preterm newborns. The steroids improve the lung function in premature infants. DoD MTF rates for the past five years are slightly better than the national rate and achieved 100 percent in FY 2019 (higher is better).

DoD HOSPITAL QUALITY MEASURE: ANTENATAL STEROIDS PC-03, FYs 2014–2019



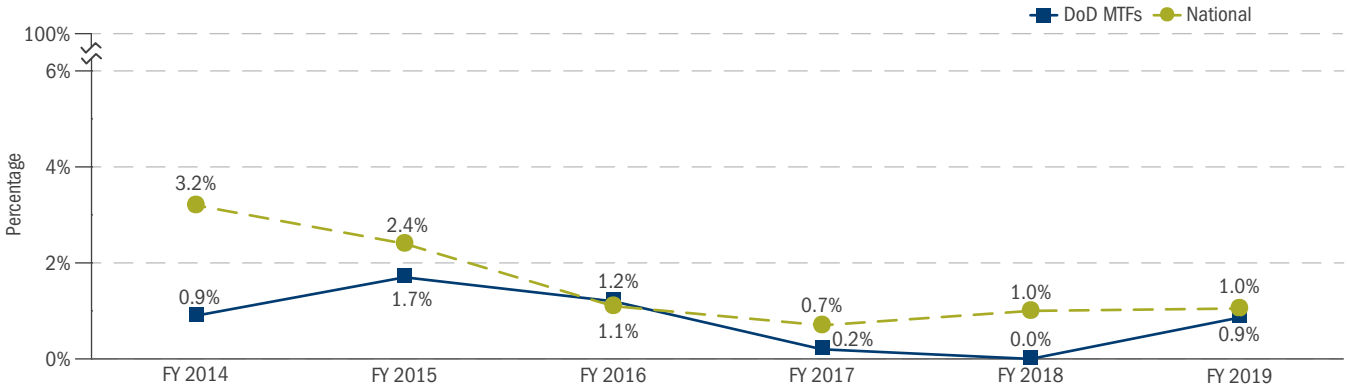
Sources: for DoD MTFs, DHA/Medical Affairs/CSD, 12/10/2020; for National, TJC/TJC Connect/Performance Measurement System Extranet Track (PET), 12/14/2020

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

Women and Infant Clinical Community *(cont.)*

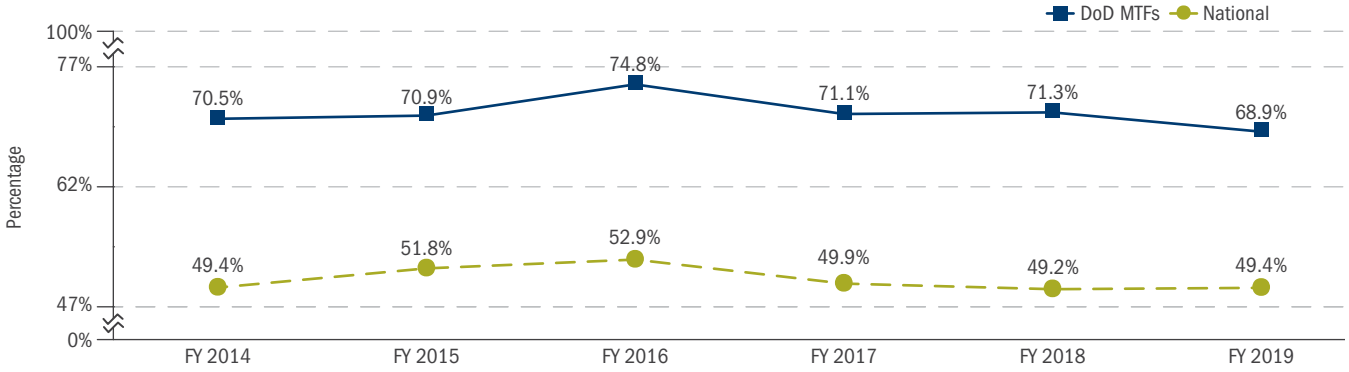
- **Newborn Bloodstream Infections:** This measure (PC-04) focuses on monitoring healthcare-associated bloodstream infections in newborns to identify opportunities for improvement. The DoD continually strives to eliminate HAIs through the use of evidence-based preventive measures. The DoD MTF rate has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

DoD HOSPITAL QUALITY MEASURE: HEALTHCARE-ASSOCIATED BLOODSTREAM INFECTIONS IN NEWBORNS PC-04, FYs 2014–2019



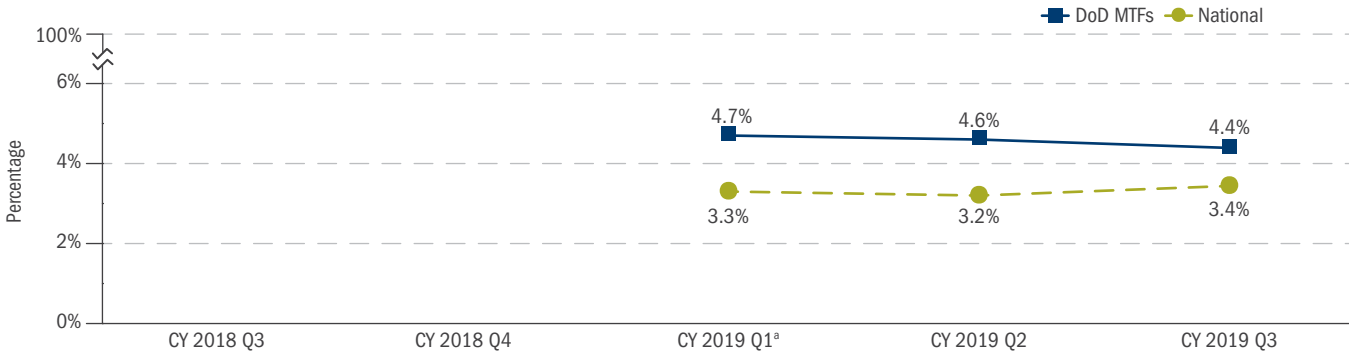
- **Breastfeeding:** This measure (PC-05) focuses on exclusive breastfeeding for newborns during the entire hospitalization. The World Health Organization and national leaders in pediatric and obstetric care note the benefits of breastfeeding an infant for the first six months of life. Early initiation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

DoD HOSPITAL QUALITY MEASURE: EXCLUSIVE BREASTFEEDING PC-05, FYs 2014–2019



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

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



Sources: for DoD MTFs, DHA/Medical Affairs/CSD, 12/11/2020; for National, TJC/TJC Connect/PET, 12/14/2020

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

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

Women and Infant Clinical Community *(cont.)*

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

NATIONAL PERINATAL INFORMATION CENTER COMPARATIVE DATA ALL SERVICES COMBINED, CY 2019 Q2–CY 2020 Q1

	CY 2019 Q2			CY 2019 Q3			CY 2019 Q4			CY 2020 Q1		
Total Deliveries	8,068			8,729			7,755			8,084		
Maternal Outcome Measures	**MHS Avg**	**NPIC Avg**		**MHS Avg**	**NPIC Avg**		**MHS Avg**	**NPIC Avg**		**MHS Avg**	**NPIC Avg**	
Inpatient Quality Indicator (IQI) 33 Primary Cesarean Delivery Rate	13.4%	18.6%	●	14.5%	17.7%	●	15.9%	18.1%	●	14.6%	18.2%	●
Postpartum Hemorrhage (PPH) Rate	4.2%	4.4%	●	4.6%	5.0%	●	5.0%	5.0%	●	5.3%	5.0%	●
Severe Maternal Morbidity Overall Rate	2.3%	2.1%	●	2.1%	2.2%	●	2.1%	2.2%	●	2.4%	2.3%	●
Maternal Readmit Rate to Delivery Hospital	1.8%	1.3%	●	2.2%	1.5%	●	2.2%	1.6%	●	2.0%	1.4%	●
Total Neonates	8,508			9,168			8,223			8,635		
Neonatal Outcome Measures	**MHS Avg**	**NPIC Avg**		**MHS Avg**	**NPIC Avg**		**MHS Avg**	**NPIC Avg**		**MHS Avg**	**NPIC Avg**	
Inborn Readmit Rate to Delivery Hospital	4.3%	0.9%	●	3.5%	0.9%	●	3.9%	1.1%	●	4.0%	0.9%	●
Inborn Mortality ≥2,000 Grams (Per 1,000 births)	0.123	0.703	●	0.000	0.714	●	0.876	0.676	●	0.486	0.597	●

Note: For all measures, lower rates/scores are better.
RED indicates the MHS average rate is significantly ABOVE the NPIC Database Rate.
GREEN indicates the MHS average rate is either significantly BELOW or not significantly different from the NPIC Average Database Rate.

NUMBER OF MTF NPIC MEASURE OUTLIERS, CY 2019 Q4 & CY 2020 Q1

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

Source: DHA/Medical Affairs/CSD, 12/10/2020
RED indicates the number of Service-aligned MTFs that performed worse (higher) than the NPIC database average for the two consecutive quarters shown (CY 2019 Q4 and CY 2020 Q1).
MHS Average and NPIC Average Database Rates for IQI 33 are the sum of all numerators/sum of all denominators (case level rates). For all other measures, the MHS Average NPIC and Average 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/Quality Analytic Service (QAS) civilian hospitals in the database.
IQI 33 Primary Cesarean Delivery Rate: Overall rate of cesarean deliveries, regardless of the number of deliveries a woman has had; MHS continues to have lower rates of cesarean sections than the NPIC benchmark.
PPH Rate: (based on ACOG and the members of the Women's Health Registry Alliance standardized definition). The MHS average continues to be lower than the NPIC benchmark. The MHS continues to focus its attention on PPH and is actively working to implement the Alliance for Innovation on Maternal Health Patient Safety Bundle on Obstetric Hemorrhage at select MTFs. The MHS has added the metric of Severe Maternal Morbidity to align with national concerns in the multiple conditions that can impact a mother's health during pregnancy and delivery.
Readmissions may be aligned with MHS role to support families who don't have local support or whose spouse is deployed.
Readmission work continues to be reviewed in collaboration with MHS's overall readmission project.

- **Maternal Readmit Rate to Delivery Hospital:** Based on the NPIC benchmark, the National and MHS most common reason for readmission (within 30–42 days of delivery) is hypertension. This accounts for 40 percent of MHS readmissions.
- **Inborn Readmit Rate to Delivery Hospital:** Based on the NPIC benchmark, the National and MHS most common reason for newborn readmission to delivery hospital is jaundice. This accounts for 43 percent of MHS readmissions.

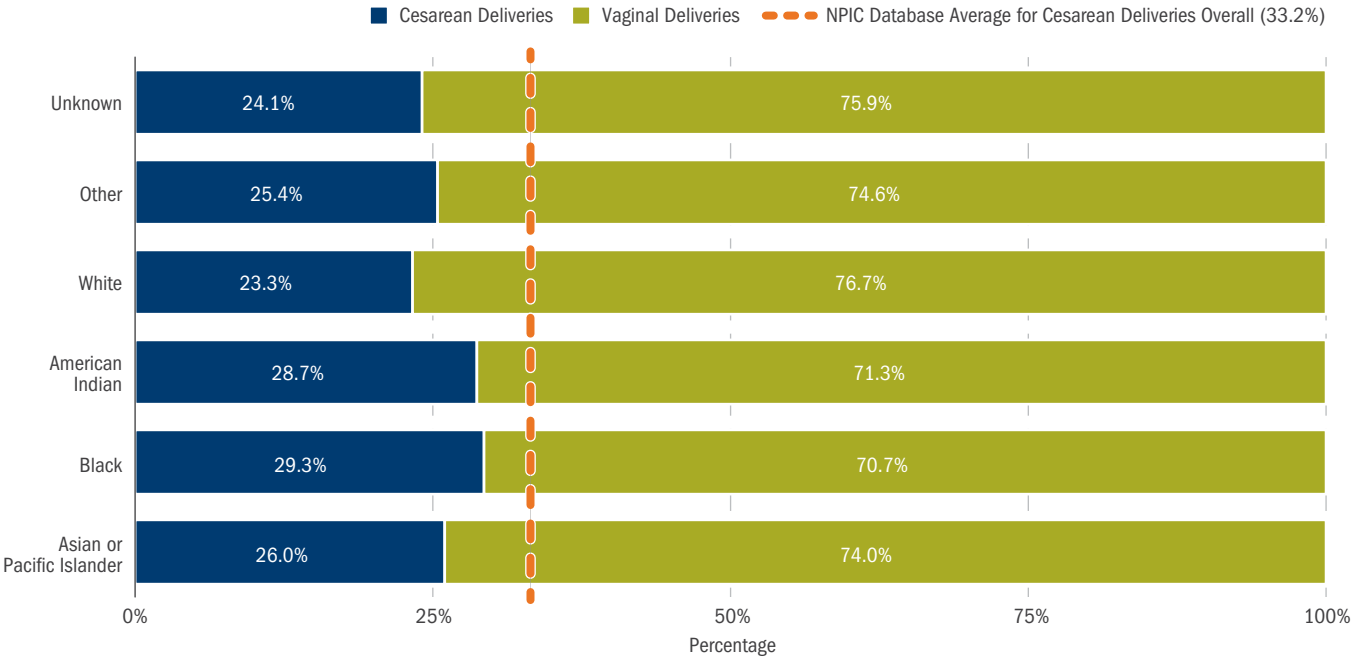
Inborn Mortality ≥2,000 Grams (per 1,000 births) remains lower than the benchmark for term (2,000 g) infants born in MTFs.

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

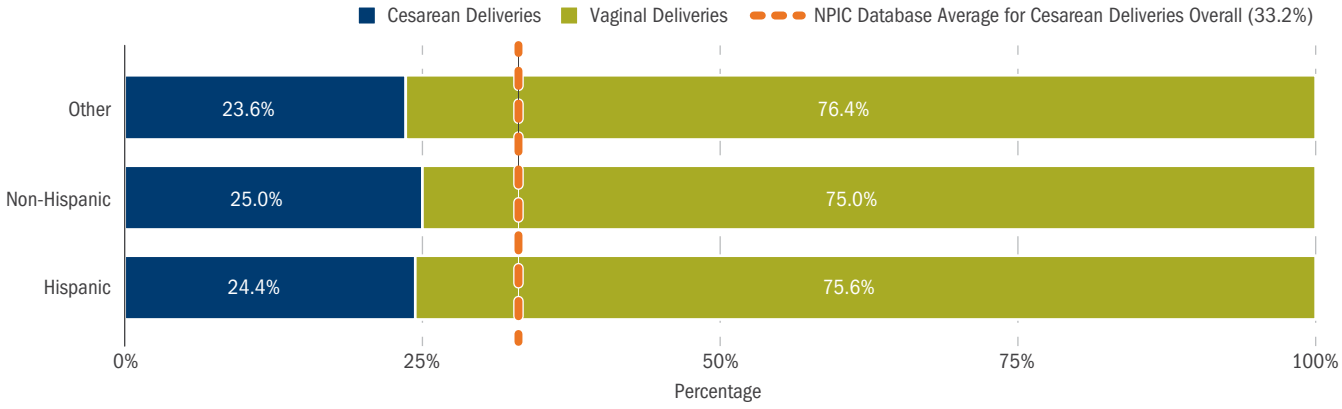
Women and Infant Clinical Community *(cont.)*

Additionally, NPIC has been responsive to congressional reports and requests for information related to perinatal outcomes, with data on racial and ethnic subgroups reporting. WICC began adding racial and ethnic subgroups to identify disparities among the data. Future reports will include additional findings related to race and ethnicity in the perinatal population (lower is better).

DELIVERIES IN DIRECT CARE, BY RACE, APRIL 2019–MARCH 2020



DELIVERIES IN DIRECT CARE, BY ETHNICITY, APRIL 2019–MARCH 2020



Source: Standard Inpatient Data Record (SIDR), NPIC

BETTER CARE

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

Behavioral Health Clinical Community

Developing the Behavioral Health HROM

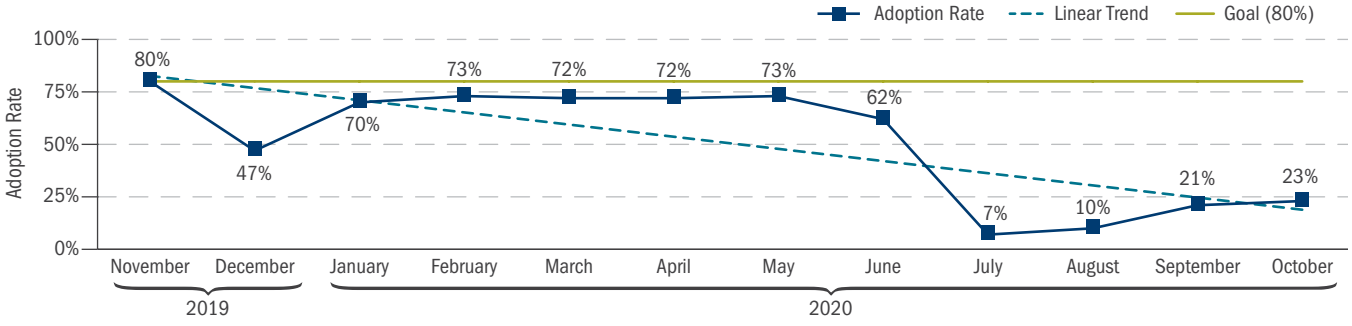
The BHCC was chartered under DHA Healthcare Operations on November 8, 2017, and meets biweekly, with executive sessions including only core members in the off-weeks followed by backbriefs to the entire group. The BHCC Chair and other voting members are Directors of Psychological Health from Army, Air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

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

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

1. **Behavioral Health Treatment and Outcomes Monitoring:** The NDAA FY 2016, section 729 and a 2013 Assistant Secretary of Defense Memorandum, "Military Treatment Facility Mental Health Clinical Outcomes Guidance," required the DoD to collect behavioral health (BH) treatment-specific outcome measurements, and assess behavioral health outcomes, variations, and barriers to VA/DoD CPGs. To meet these requirements, the DHA published DHA-PI 6490.02, "Behavioral Health Treatment and Outcomes Monitoring." DHA-PI 6490.02 sets outcome monitoring requirements in specialty care behavioral health, substance use disorder (SUD), and primary care clinics at MTFs. The types of metrics required by DHA-PI 6490.02 for collection, reporting, and analysis include: structure (equipment and training compliance); process (treatment dosage rate, evidence-based treatment rates); and clinical outcome metrics (improvement and/or remission in MDD and PTSD).
2. **BHDP Implementation:** BHDP is an enterprise-wide web application that enables standardized behavioral health assessments and outcome tracking in behavioral health clinics. Use of BHDP allows for real-time graphing of outcome measures for clinical care, consolidation of data from multiple sources into one clinician dashboard, and aggregation of data for meaningful program evaluation. Improving performance on the metrics for BHDP Adoption Rate, Behavioral Health Treatment Dosage Rate, and Positive Outcome Rate are DHA FY 2021 QPP initiatives. Enterprise-wide, the BHDP Adoption Rate was trending upward since BHDP inception, but the MHS met two critical incidents in FY 2020 that significantly impacted BHDP Adoption Rate (see chart below). The first impediment, which caused a temporary drop in BHDP Adoption Rate scores, was the move in late FY 2019 and early FY 2020 to a new server. During and shortly following this transition, BHDP was not available in many BH clinics, causing a drop in BHDP Adoption Rate. The rate was back on track until impacted more significantly and longer term by the COVID-19 pandemic. While MTFs were quickly able to adapt to virtual BH visits, the MHS did not have a mechanism in place that allowed patients to enter BHDP data from home that would be counted as a completed survey. From March through August 2020, BHDP Adoption Rate was higher for in-person visits compared to virtual but still much below previous levels, due to continued safety precautions in clinics around sharing equipment and maintaining social distancing. BHCC efforts are underway to continue improving performance on this metric through development of a remote-access BHDP tool and continued staff training.

DoD BHDP ADOPTION RATE, NOVEMBER 2019–OCTOBER 2020



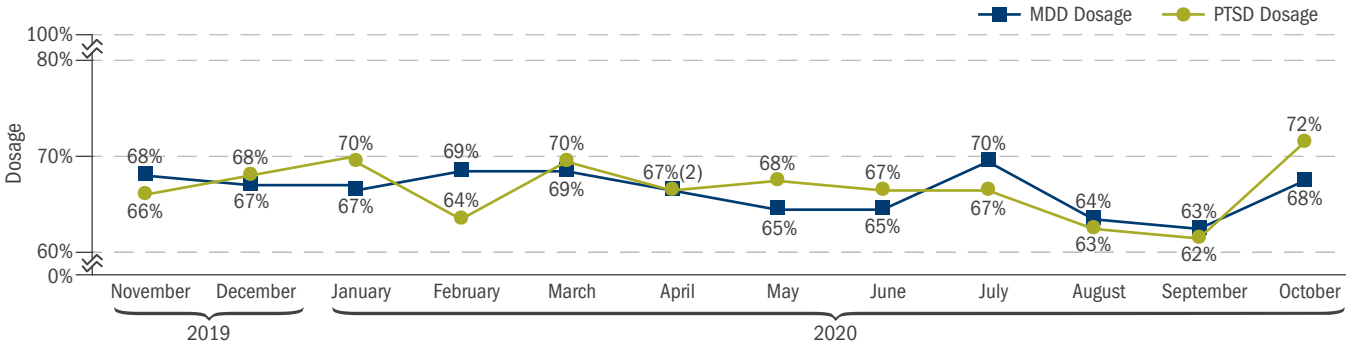
Source: DHA/Medical Affairs/CSD, 11/30/2020

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

Behavioral Health Clinical Community *(cont.)*

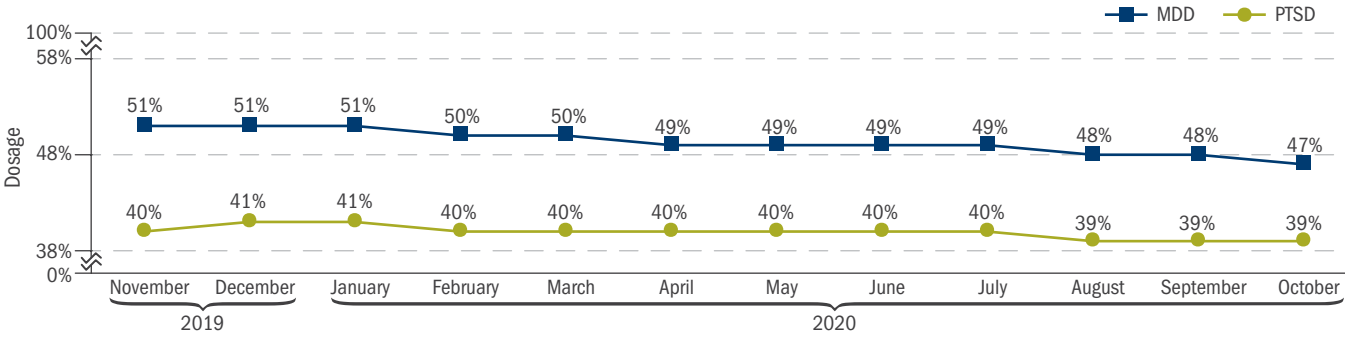
3. **Treatment Dosage for MDD and PTSD:** As described in DHA-PI 6490.02, Treatment Dosage Rate is the percentage of patients with new diagnosis of PTSD or MDD who receive at least three follow-up appointments within 90 days of diagnosis. While three visits within 90 days is not adequate care according to VA/DoD clinical practice guidelines, Army studies showed this dosage was associated with better outcomes, compared with fewer than three follow-up visits. Receiving adequate frequency of care improves outcomes over a shorter period of time, returning the patient to well-being and higher functioning more quickly. Despite challenges due to COVID-19 to usual clinic workflows, the MHS was able to largely maintain good performance on this metric (see graph below).

TREATMENT DOSAGE FOR MDD AND PTSD, NOVEMBER 2019–OCTOBER 2020



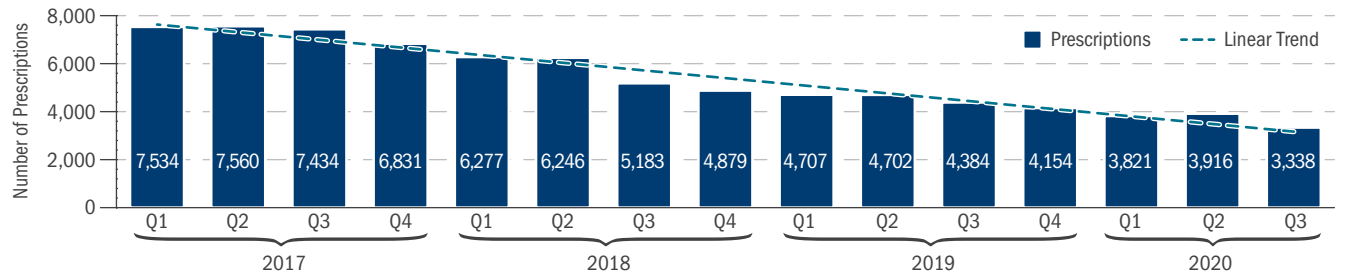
4. **MDD and PTSD Positive Outcomes:** DHA-PI 6490.02 requires MTFs to monitor patient-reported outcomes for PTSD and MDD using standardized assessments mandated by ASD(HA) memorandum. The BHCC set current targets for patient improvement or remission at 47 percent for MDD and 36 percent for PTSD. The graph below shows outcomes for both disorders. As Treatment Dosage Rate and Evidence-Based Treatment (EBT) Utilization Rate improve, it is expected positive outcome rates will also improve.

MDD AND PTSD POSITIVE OUTCOMES, NOVEMBER 2019–OCTOBER 2020



5. **PTSD Prescriber Tool:** NDAA FY 2017, section 745, required the DoD to implement a process to monitor MTF prescribing practices of pharmaceutical agents that are discouraged from use under the VA/DoD CPG for the Management of PTSD and Acute Stress Disorder, such as benzodiazepines (BZDs). BHCC developed a PTSD Prescriber Profile that identifies, on a quarterly basis, individual providers who write a high number of BZD prescriptions to patients with PTSD. The overall number of BZD prescriptions written to patients with PTSD declined almost every quarter in FY 2018, FY 2019, and FY 2020, resulting in a 56 percent reduction in BZD prescriptions over this time period (see chart below). Given the success of monitoring and discouraging use of BZDs in beneficiaries with PTSD, DHA continues to monitor but will no longer report on this metric unless the trend reverses.

NUMBER OF PRESCRIPTIONS FOR BZD TO BENEFICIARIES DIAGNOSED WITH PTSD, FY 2017 Q1–FY 2020 Q3



Source: DHA/Medical Affairs/CSD, 11/30/2020

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

Behavioral Health Clinical Community *(cont.)*

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

Utilization of behavioral health services continues to increase in both direct and purchased care MH and SUD services. The 2016 final rule, "TRICARE; Mental Health and Substance Use Disorder Treatment," contained comprehensive revisions to the TRICARE regulation to reduce administrative barriers to accessing MH benefit coverage and to improve access to SUD treatment for all TRICARE beneficiaries. In FY 2019, increases in utilization and cost were seen in beneficiary category, sector of care (direct/private sector), and provider type (inpatient/outpatient services).

Total MHS expenditures for MH and SUD care increased by 6 percent from FY 2018 to FY 2019. Notably, spending for non-pharmacy outpatient care increased by 13 percent—partly due to increases in autism expenditures (16 percent increase) and SUD expenditures (18 percent increase); both private sector and direct care non-pharmacy expenditures increased (12 and 8 percent respectively). MH pharmacy expenditures decreased by 16 percent in FY 2019 after decreasing by 11 percent in FY 2018. MHS behavioral health care costs for children increased by 9 percent compared with an increase of 4 percent for adults. The 9 percent increase in costs for children is primarily due to an increase in autism expenditures.

Outpatient MH visits, excluding autism encounters, increased for TRICARE beneficiaries from 8.2 million encounters in 2018 to 8.7 million encounters, 7 percent of which occurred in private sector care. Specific observations include:

- For inpatient MH services, 78 percent of all inpatient stays occurred in private-sector care.
- In FY 2019, the number of inpatient MH stays (including residential treatment center [RTC] care) decreased slightly (by 2 percent), while inpatient mental health users decreased (by 1 percent). The decrease in both utilization and users was primarily due to a decrease in Active Duty family member (ADFM) and non-Active Duty family member (NADFM) use in the private sector. The number of ADSM inpatient stays and users increased in FY 2019 by 4 and 5 percent, respectively.
- Inpatient SUD stays (including SUD rehabilitation facility [SUDRF] care) increased by 5 percent in FY 2019. There was an increase in ADSM SUD stays in both direct and purchased care (17 and 5 percent respectively). SUD users also increased by 4 percent, entirely driven by a 12 percent increase in ADSM users in FY 2019.
- Thirty-three percent of all inpatient MH encounters were for a primary diagnosis of major depressive disorder in both FY 2018 and FY 2019.
- In FY 2019, there was a 5 percent increase in MH encounters and a 4 percent increase in users (excluding autism, but including partial hospitalization program [PHP] and intensive outpatient program [IOP]). All three major beneficiary categories (ADSM, ADFM, and non-Active Duty dependents [NADD]) had an increase in private-sector MH care encounters and an increase in non-autism MH users.
- There was a 23 percent increase in private-sector outpatient SUD encounters (including IOP, PHP, and opioid treatment program [OTP]). However, because over half of all SUD outpatient encounters are in direct care for ADSMs, which decreased by four percent, total non-autism SUD encounters only increased by three percent. Total ADSM SUD users remained unchanged in FY 2019.
- The number of mental health PHP encounters increased by 7 percent in FY 2019, while MH IOP users and encounters increased by almost 50 percent from about 15,000 encounters in FY 2018 to about 23,000 in FY 2019. Continued growth in IOP encounters may be a result of allowing increased access due to the provisions in the TRICARE Final Rule implemented in October 2016.
- In FY 2019, the number of RTC stays decreased by 6 percent after increasing by 165 percent (from 2,700 to 5,100 RTC stays) in FY 2018.
- The seven most common outpatient MH diagnoses accounted for 75 percent of all MHS MH outpatient expenditures (autism alone accounted for 23 percent and PTSD accounted for 6 percent of total outpatient expenditures, ranking first and seventh, respectively).
- Alcohol-related disorders accounted for over 75 percent of both the number of SUD inpatient stays and outpatient encounters. Additionally alcohol-related disorders were one of the only conditions that were more commonly treated in direct care. There were over 404,000 encounters for outpatient alcohol treatment in direct care in FY 2019 and these visits accounted for 75 percent of all SUD outpatient costs across both direct and private-sector care.
- Although outpatient SUD encounters decreased in FY 2019 due primarily to a decline in ADSM direct care encounters, NADD SUD encounters continued to increase, and NADD SUD care in IOP, OTP, PHP, and SUDRF care also increased in FY 2019. In particular, IOP care increased for all beneficiary types, from 8,846 encounters in FY 2018 to 22,886 encounters in FY 2019. The number of SUD IOP users also increased by more than 100 percent in FY 2019, although there is very little use of SUD IOP care.
- While the number of PHP MH encounters remained fairly flat in FY 2019, PHP encounters for SUD increased by 21 percent to 72,530 encounters in FY 2019. The number of unique PHP SUD users only increased by 7 percent, which means unique users had more PHP services on average. SUDRF stays increased by 50 percent in FY 2019, with increases for all beneficiary categories.
- OTP visits increased from 969 encounters in FY 2018 to 1,157 encounters in FY 2019, although in FY 2019 there were less than 100 OTP users. About 80 percent of all OTP users were NADDs.

Behavioral Health Clinical Community *(cont.)*

Pharmacy utilization is defined as MH medications by therapeutic class and included drugs used for medication-assisted treatment (MAT) for opioid dependence and abuse. Pharmacy utilization is most common among NADDs and in the private sector. Private-sector scripts for NADFM accounted for 88 percent of all MH prescriptions and 82 percent of MHS expenditures for MH prescription drugs in FY 2019 (up from 76 and 77 percent respectively in FY 2018). Pharmacy utilization has decreased the last few years, with a 1 percent decrease in MH medications observed in FY 2019, following a 3 percent decrease in FY 2018. The number of unique pharmacy users, however, remained almost constant in FY 2019. Pharmacy utilization is more common among older populations. NADDs had the largest number of unique pharmacy users among all beneficiary categories (1.4 million in FY 2019 in comparison to ADSMs with 255,000 and ADFMs with 272,000). Eighty-eight percent of all MH prescriptions are for adults and 62 percent of those adult prescriptions are for adults age 45 and older.

The most common therapeutic class of MH prescriptions was antidepressants, which made up 52 percent of all prescriptions, 30 percent of total expenditures, and 46 percent of all prescription users (1.3 million of 2.8 million users). Although the number of prescriptions for antidepressants remained fairly similar in FY 2019, the total cost fell by 23 percent, indicating a significant drop in the unit price for these drugs.

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

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

Applied behavior analysis (ABA) services are covered by TRICARE as part of a demonstration project for beneficiaries with ASD. All ABA services are provided through the private-sector care network. Other services covered for beneficiaries with ASD include, but are not limited to, speech and language therapy, occupational therapy, physical therapy, medications, and psychotherapy.

In June 2014, TRICARE published the Comprehensive Autism Care Demonstration (ACD) Notice in the Federal Register on the approval of the Office of Management and Budget, and in compliance with the regulations that govern TRICARE demonstration projects. Based on limited demonstration authority, in July 2014, the ACD consolidated the three previous ABA programs into a single program for eligible TRICARE beneficiaries. This consolidated demonstration ensures consistent ABA coverage for all TRICARE beneficiaries—including ADFMs and non-ADFMs diagnosed with ASD. ABA services are not limited by the beneficiary's age, the dollar amount spent, or the number of services provided, and there are no annual caps of government cost shares. ABA services are authorized based on the clinical necessity and appropriateness of the individual beneficiary's needs. These changes attempt to strike a balance that maximizes access while ensuring care at the highest level of quality for our beneficiaries. An extension through December 31, 2023, for the demonstration was approved via a Federal Register Notice on December 11, 2017. The Notice stated that additional analysis and experience is required to determine the appropriate characterization of ABA services as a medical treatment, or other modality, under the TRICARE program coverage requirements.

By extending the demonstration, the government is (1) gaining additional information about what services TRICARE beneficiaries are receiving under the ACD; (2) determining how to most effectively target services that will have the most benefit; (3) collecting more comprehensive outcomes data; and (4) gaining greater insight and understanding of the diagnosis of ASD in the TRICARE population.The most recent full-year fiscal data available, FY 2019, show that all services for the diagnosis of ASD, including ABA services, had a total program expenditure of $439 million, with ABA services accounting for $377 million (86 percent of the total cost for ASD treatments). The total number of ADFM autism encounters increased by 8 percent to reach almost 1.2 million encounters in FY 2019. NADD encounters increased by 9 percent in FY 2019 to nearly 500,000 encounters. ABA services are not provided at MTFs but rather through the ACD in the private sector 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.

In November 2017, Fort Belvoir Community Hospital (FBCH) created the FBCH Autism Clinic that includes four components: Autism and Communication Diagnostic Clinic (a multidisciplinary clinic for newly diagnosed beneficiaries and their families); Autism Clinic (a new evaluation clinic for previously diagnosed beneficiaries and their families); Autism Resource Clinic (a clinic designed to connect families with local resources and provide support); and an Autism Follow-Up Clinic. Once per month, the Autism Resource Clinic hosts a four-hour session featuring 15–20 speakers where families learn about medical and nonmedical resources available on the installation, as well as obtain information regarding local area school programs and support, community resources, and other nonmilitary activities that support children diagnosed with ASD and their families. Subsequently, two additional MTFs have established Autism Resource Clinics following the FBCH model (Walter Reed National Military Medical Center [WRNMMC] in 2018 and Naval Medical Center [NMC] Portsmouth in 2019), with more installations gaining interest. To date, 748 beneficiaries and their families have participated in the FBCH diagnostic clinic and 215 families have participated in the FBCH Autism Resource Clinic.

At Madigan Army Medical Center, Joint Base Lewis McCord (JBLM), the Center for Autism Resources, Education, and Services (CARES) program is a military family readiness framework that opened in 2017. JBLM CARES delivers specialty care and family services/education, and establishes advocates for families affected by ASD or a related disorder who relocate to the Pacific Northwest.

Behavioral Health Clinical Community *(cont.)*

JBLM CARES brings together medical, installation, community, and education resources, and weaves together fragmented efforts from family and medical services. JBLM CARES has served over 1,000 families per year since its opening.

As evidenced in previous reports, participation in the ACD by beneficiaries and ABA providers is growing. By the end of FY 2019, the number of beneficiaries participating in the ACD who had filed claims for ABA services was 15,928.

TRICARE continues to measure outcomes for children enrolled in the ACD, to ensure they are receiving the maximum possible benefit from services, and to help guide future planning for ACD services in TRICARE. These measures include the Pervasive Developmental Disorder Behavior Inventory (PDDBI), administered every six months, and the Social Responsiveness Scale and Vineland Adaptive Behavior Scale, administered every two years. The most current results from the PDDBI are reported in the Annual 2020 TRICARE Report to Congress. While these results should be interpreted with caution as this is just one of three outcome measures, the findings from this analysis continue to demonstrate concern with overall outcomes of beneficiaries participating in the ACD. While the report noted some improvements after 12 and 18 months of rendered ABA services for some beneficiaries, the changes are small and may not be clinically significant. In addition, the change did not appear to be associated with applied behavior analysis service utilization.

Additional information and details are available at: https://health.mil/About-MHS/OASDHA/Defense-Health-Agency/Congressional-Relations/Reports-to-Congress.

As a result of the ongoing lack of overall positive outcomes and the goal of providing clinically meaningful interventions to these beneficiaries, DHA plans to revise the ACD policy, to include specialized case management, increased oversight and management, and greater support to the family. These changes are anticipated to be effective in 2021.

In summary, the DoD has implemented a robust benefit that serves all eligible TRICARE beneficiaries diagnosed with ASD. Unlike many civilian insurance plans, the TRICARE benefit has no limits on medically necessary hours of ABA services or cost per beneficiary. In addition, other services, such as occupational therapy and speech and language therapy, are available to beneficiaries with ASD. MCSCs continue to recruit new providers to expand the network, especially in areas with longer access to care times. The TRICARE benefit is one of the best in the nation, particularly considering that network ABA providers never have to collect a copayment, deductible, or any other payment from Active Duty families, who have 100 percent coverage. Retirees have nominal out-of-pocket costs and are protected by TRICARE's catastrophic coverage cap. The Department continues to review the ACD and make changes as needed to help ensure that our beneficiaries and their families receive the best evidence-based support to help our beneficiaries with ASD reach their maximum potential.

Child and Adolescent MH and SUD Treatment

The final rule changes, implemented in 2017, are especially important to the pediatric population, as they expanded the array of TRICARE-authorized MH and SUD providers across the full continuum of care in alignment with civilian behavioral health treatment industry standards. The goal of these changes was to continue to modernize access, safety, and quality health care options to strengthen our families' resilience.

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

TRICARE has a robust MH and SUD provider network across the continuum of MH and SUD care to meet the needs of approximately 2 million pediatric beneficiaries. Specific observations include:

- The most common principal diagnoses in terms of both encounters and users for children aged 1–4 were speech and language disorders. There were more encounters for ASD for children age 5–8, 9–12, and 13–17, but there were more children (unique users) with ADHD in these age categories.
- Dependent children age 18–21 most commonly had principal diagnoses for anxiety disorders or MDD.
- The number of encounters for children age 1–12 vastly exceeded the number for older children (age 13–21), in large part because of the number of encounters related to ASD. ASD diagnoses accounted for 42 percent of all MH encounters for children age 1–12, and 17 percent for children over the age of 12. The higher number of encounters for children age 1–12 also reflects that the eligible population aged 1–12 is about 55 percent larger than the population of TRICARE eligible dependent children aged 13–21.
- In FY 2019, 57 percent of all inpatient MH stays for children were for ages 13–17. This same group had more inpatient stays for MH care than any other age group.
- The number of outpatient MH encounters, excluding ASD, were fairly evenly distributed among the four age groups (23 percent for ages 1–4; 27 percent for ages 5–8; 20 percent for ages 9–12; and 22 percent for ages 13–17).

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

Child and Adolescent MH and SUD Treatment *(cont.)*

- The outpatient utilization rate (excluding ASD) was higher for children (9.1 average visits per person per year) than for adults (6.3 visits).
- Psychiatric RTC care is most common in the pediatric adolescent population, especially for ages 13–17. Adolescents aged 13–17 also had nearly 20 percent of the total IOP care and 17 percent of the total PHP MH encounters in FY 2019.
- SUD treatment is not common for beneficiaries under age 21 in the MHS. This age group accounted for approximately 4 percent of total encounters of SUD inpatient stays, and 2 percent for SUD outpatient care for all beneficiaries.
- Pharmacy prescriptions for pediatric beneficiaries totaled 20 percent of the total in FY 2019.

Dental Clinical Community

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

The DCC milestones for FYs 2019 and 2020 include the following actions:

- The dental SMEs continue using teamwork and continue to receive training in HRO models, key process analysis, and the MHS requirements submission portal; additional nonvoting members are included in the DCC to support numerous strategic dental health initiatives.
- Revised DCC governance charter, accepted by the CCAC, and signed in October 2019 by the Chief Medical Officer.
- A new DCC Chair was selected by the DCC Core Members in August 2020 as per the guidance set forth by the DCC charter.
- Established working groups to develop enterprise-wide guidance to the military dental enterprise during the COVID-19 pandemic to include: (1) suspension of routine dental care amid COVID-19; (2) teledentistry instructions; (3) testing dental patients for SARS-CoV-2; and (4) resumption of routine dental care amid COVID-19 pandemic.
- Established working groups to develop the following DHA procedural instructions: (1) dental sedation medical management; (2) processes and procedures for implementation of standardized dental cone beam computed tomography (CBCT) operations and training; and (3) dental universal protocol.
- Established a working group to develop a standardized set of dental metrics that support the Quadruple Aim.

Ongoing Quality Initiatives: Surgical Services

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

NSQIP Quality Outcomes

The ACS NSQIP remains one of the most mature quality improvement programs utilized throughout the MHS in MTFs with inpatient surgery. It is the primary method to continuously monitor surgical outcomes through morbidity and mortality data. In February 2018, the MHS reached its NSQIP Adult Program expansion goal of 100 percent participation (48 MTFs). At the end of FY 2018, the total number of participating MTFs decreased to 46 with the transition of two hospitals to stand-alone ambulatory surgical centers. DoD NSQIP collaborates closely with the new DHA Surgical Services Clinical Community (S2C2) to provide surgical quality benchmarking with high-fidelity data and guidance on the development of standardized pathways for improvement of care in the MTFs.

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

Focused Quality Initiatives

The 2019 mortality data indicated that all MTFs reporting data met the expected performance level, including two facilities that were "exemplary" (results in the top quartile of hospitals). No facilities were in the "needs improvement" category (results in the bottom quartile of hospitals) for mortality. The morbidity data indicated that of the 46 sites reporting data for CY 2019, 35 MTFs met expected performance levels while seven were exemplary (results in the top quartile of hospitals). Four MTFs were in the "needs improvement" category (results in the bottom quartile of hospitals). Falling in the "needs improvement" category rarely connotes a persistent deficiency unless recurrent on multiple reports, but it does enable the hospitals to recognize areas of potential concern and dive deeper to improve the quality of their surgical care (see table below).

MTF MORTALITY AND MORBIDITY PERFORMANCE, CYs 2014–2019

			CY 2014		CY 2015		CY 2016		CY 2017		CY 2018		CY 2019	
			MORTALITY	MORBIDITY	MORTALITY	MORBIDITY	MORTALITY	MORBIDITY	MORTALITY	MORBIDITY	MORTALITY	MORBIDITY	MORTALITY	MORBIDITY
MEDICAL CENTERS	ARMY	AMC BAMC (SAN ANTONIO)					★						★	
		AMC DARNALL (HOOD)								★		★		★
		AMC EISENHOWER (GORDON)		★	★	★		★		★	★	★		★
		AMC LANDSTUHL (GERMANY)										★		
		AMC MADIGAN (LEWIS)												
		AMC TRIPLER (SHAFTER)												
		AMC WILLIAM BEAUMONT (BLISS)		★								★		
		AMC WOMACK (BRAGG)												
	NAVY	NMC PORTSMOUTH								★		★		★
		NMC SAN DIEGO										★		★
		NMC CAMP LEJEUNE												
	AIR FORCE	99th MED GROUP (NELLIS)						★						
		60th MED GROUP (TRAVIS)	★		★	★	★		★		★		★	
		88th MED GROUP (WRIGHT PATTERSON)					★							
		96th MED GROUP (EGLIN)												
		81st MED GROUP (KEESLER)						★						
	NCR	WALTER REED NMMC (BETHESDA)						★		★		★		★
COMMUNITY HOSPITALS	ARMY	ACH BASSETT (WAINWRIGHT)												
		ACH BAYNE-JONES (POLK)												
		ACH BLANCHFIELD (CAMPBELL)		★				★						
		ACH BRIAN ALLGOOD (SEOUL)												
		ACH EVANS (CARSON)								★		★		
		ACH GENERAL LEONARD WOOD (WOOD)												
		ACH IRWIN (RILEY)								★				
		ACH KELLER (WEST POINT)												
		ACH MARTIN (BENNING)												
		ACH WEED (IRWIN)												
		ACH WINN (STEWART)												
	NAVY	NH BREMERTON										★		
		NH CAMP PENDLETON												
		NH GUAM												
		NH GUANTANAMO BAY												
		NH JACKSONVILLE		★						★		★		★
		NH OKINAWA												
		NH PENSACOLA				★		★						
		NH TWENTYNINE PALMS												★
		NH YOKOSUKA												
		NH SIGONELLA												
		NH NAPLES												
		NH ROTA												
	AIR FORCE	31st MED GROUP (AVIANO)												
		35th MED GROUP (MISAWA)												
		48th MED GROUP (RAF LAKENHEATH)												
		51st MED GROUP (OSAN)												
		633rd MED GROUP (JB LANGLEY-EUSTIS)										★		
		673rd MED GROUP (JB ELMENDORF-RICHARDSON)												
		374th MED GROUP (YOKOTA)												
	NCR	FT BELVOIR COMMUNITY HOSP								★				

★ EXEMPLARY AS EXPECTED NEEDS IMPROVEMENT DATA UNAVAILABLE

Source: DHA/OPS Medical Affairs/CSD, 10/5/2020

Note: Data unavailable may be due to loss of Surgical Clinical Reviewer, site transitioned to ambulatory care, or in initial data collection.

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

Focused Quality Initiatives *(cont.)*

The most recent DoD collaborative report demonstrates that MHS surgical performance meets or exceeds most performance standards relative to the NSQIP population reference rate (719 hospitals across the United States currently participate in the ACS NSQIP Adult Program). According to the report, DoD collaborative performance was "exemplary" in nine of 14 statistical models, exceeding expected performance even after adjustments for patient risk profiles. One area that needs improvement, as noted in the DoD collaborative report, was All Cases Return to Operating Room (ROR). The NSQIP Steering Panel is currently collaborating with the Surgical Services Clinical Community to understand these issues and develop strategies to improve performance. Improvements are often highly influenced by drivers specific to each MTF. While there is rarely a one-size-fits-all solution, interfacility collaboration drives the sharing of problem-solving strategies.

DoD COLLABORATIVE JULY 2020 SUMMARY (SURGERY DATES JANUARY 1, 2019, TO DECEMBER 31, 2019)

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	44,793	69	0.15%	0.67%	0.52%	0.84%	Low	0.70	0.95%
All Cases Morbidity	44,793	1,235	2.76%	5.82%	5.51%	6.13%		0.98	5.94%
All Cases Cardiac	44,793	45	0.10%	0.34%	0.22%	0.47%	Low	0.54	0.62%
All Cases Pneumonia	44,781	87	0.19%	0.62%	0.48%	0.78%	Low	0.69	0.90%
All Cases Unplanned Intubation	44,793	54	0.12%	0.44%	.032%	0.57%	Low	0.69	0.63%
All Cases Ventilator >48 Hours	44,788	48	0.11%	0.47%	0.34%	0.63%	Low	0.71	0.66%
All Cases VTE	44,793	158	0.35%	0.74%	0.63%	0.86%		0.94%	0.79%
All Cases Renal Failure	44,793	39	0.09%	0.31%	0.21%	0.43%	Low	0.71%	0.44%
All Cases Urinary Tract Infection (UTI)	44,724	285	0.64%	1.10%	0.98%	1.22%		1.03%	1.06%
All Cases Surgical Site Infection (SSI)	44,660	664	1.49%	2.62%	2.43%	2.81%		1.04%	2.53%
All Cases Sepsis	44,741	99	0.22%	0.65%	0.52%	0.81%	Low	0.72	0.91%
All Cases C. Diff Colitis	44,793	33	0.07%	0.22%	0.14%	0.32%	Low	0.65	0.34%
All Cases ROR	44,793	619	1.38%	2.60%	2.42%	2.80%	High	1.13	2.30%
All Cases Readmission	44,793	1,132	2.53%	4.59%	4.33%	4.86%	Low	0.93	4.89%

EXEMPLARY AS EXPECTED NEEDS IMPROVEMENT

Source: ACS NSQIP DoD Collaborative Report, released July 2020

[a] Adjusted Rate is the risk-adjusted smoothed rate.

[b] Outlier status is determined by the risk-adjusted smoothed rate confidence interval relative to the NSQIP population reference rate.

Note: "CL" means confidence limit, and "OR" means odds ratio.

Focused Quality Initiatives *(cont.)*

Surgical Quality Program Expansion

The MHS expanded its surgical quality improvement programs in 2019 to include the ACS NSQIP Pediatric Program, the ACS MBSAQIP, the ACS Trauma VRC Program, and the ACS TQIP.

The ACS NSQIP Pediatric Program is a multispecialty national database to measure pediatric surgical outcomes. The data are risk adjusted and case-mix adjusted. There are currently 127 hospitals participating across the nation. Naval Medical Center (NMC) Portsmouth has been participating in the program since May 2019. In June 2020, NMC San Diego and Tripler Army Medical Center (TAMC) also began participating in the program. Plans are in development to expand the program to other sites in 2021.

The ACS MBSAQIP provides a quality improvement program for patients suffering from severe obesity. Bariatric surgery is considered a low-volume, high-risk procedure and is one of the few foregut procedures currently available to surgeons that offer wartime surgical skill experience. There are 21 MTFs performing bariatric procedures on a regular basis. Six MTFs are currently participating in MBSAQIP, with 15 sites interested in MBSAQIP membership.

The ACS Trauma VRC Program was launched in 1987 to evaluate and validate resources at trauma centers. TQIP was established in 2009 by the ACS and provides risk-adjusted outcome measures for trauma patients. In January 2017, the ACS Committee on Trauma (COT) mandated that all trauma centers use a quality improvement program. Participation in TQIP will meet this requirement and assist the Joint Trauma System (JTS) Director with the directive to "develop evidence-based practice trauma care guidelines for clinical practice and program improvement processes," as directed by DoDI 6040.47 Joint Trauma System. There are currently 12 MTFs designated as or pursuing designation as trauma centers, with seven additional sites interested in pursuing trauma center designation.

Hospital enrollment in these programs depends on dedicated data abstractors trained to ensure data quality, but not all facilities that would qualify for participation have the available manpower to support participation.

ACS NSQIP CY 2019 Meritorious Award

The annual ACS Meritorious Award is presented to top-performing hospitals, recognizing the quality of surgical care provided to their beneficiaries. There are two categories of meritorious hospitals recognized: the All Cases Meritorious List and the High-Risk Meritorious List. The criteria for selection is based upon composite quality scores for surgical care provided in CY 2019 in eight All Cases outcome areas: mortality, cardiac (cardiac arrest and myocardial infarction), pneumonia, unplanned intubation, ventilator >48 hours, renal failure, UTI, and surgical site infection. The MTFs below were recognized by the ACS NSQIP as meritorious hospitals for CY 2019:

All Cases Meritorious List:

- Brooke Army Medical Center
- Dwight D. Eisenhower Army Medical Center
- Naval Hospital Jacksonville
- Womack Army Medical Center
- Carl R. Darnall Army Medical Center
- Walter Reed National Military Medical Center

High-Risk Meritorious List:

- Brooke Army Medical Center
- 60th MED GROUP (David Grant, Travis)

These sites are among the 89 facilities representing the top 10 percent of all NSQIP participating hospitals worldwide in 2019.

Surgical Care Performance

The ACS NSQIP continues to be a critical cornerstone for surgical quality improvement in the MHS. Implementation of NSQIP at all military inpatient surgical facilities has fostered the development of a formal quality collaborative. The DoD collaborative unites surgical SMEs across the enterprise with a single focus—surgical excellence. The collaborative assists with identifying enterprise trends, educating and building new quality leaders in program surgeon champions, and promoting collaboration with civilian experts. It also strengthens our culture of vigilance with surgical outcomes and providing quality surgical care across the MHS. Prior to the COVID-19 pandemic, this collaborative met in person twice a year for professional development and cross-pollination of ideas. These face-to-face opportunities are critical to the rapid on-boarding of personnel new to NSQIP and help ensure sustained return on investment by mitigating impacts of turnover inherent to military practice. The current pandemic has resulted in a pivot toward virtual meetings to sustain a rhythm of training.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES

Medical Management

The DHA is dedicated to improving the health of all MHS beneficiaries. In support of this mission, ongoing collaboration to promote a fully integrated clinical and nonclinical evidence-based approach to improve care across all treatment settings is underway. Medical Management (MM) within the MHS has made great progress in the provision and standardization of services, resulting in high reliability in healthcare delivery and clinical processes within MTFs. Expanded engagement and collaboration between DHA and the military departments (MILDEPs), as a result of the required transition of MTFs to DHA, enabled improvement efforts. Together, the development and implementation of dedicated policies and standardized procedures resulted in reduced practice variation, decreased fragmentation in care processes, and enhanced delivery of an integrated enterprise-wide approach.

One area within the MHS Medical Management program that has continued to make programmatic improvements in alignment with industry best practices is case management (CM). There has been significant progress toward developing dedicated processes and evidence-based tools aimed at reducing practice variance and improving the effectiveness of CM. Specifically, the MHS has developed and implemented standardized guidance and processes aligned with industry-based best practices to support consistent care delivery across the enterprise. These efforts aim to deliver reliable, high-quality patient experiences in CM to ensure improved patient outcomes within the MHS.

Historically, case managers targeted populations or diagnostic conditions where there was evidence of costly, high-risk, and high-resource consumption. Today, the MHS has transitioned and expanded its capabilities using predictive analytics in support of case finding and proactive patient engagement to address the needs of Service members, Veterans, and their families. Specifically, DHA has developed a CM registry (leveraging the Johns Hopkins Adjusted Clinical Groupings [ACG] System), which is now available to facilities across the MHS down to the point of care. Through a population-based approach established on patterns of morbidity, rather than any single condition or diagnosis, the ACG system-based tool provides case managers the ability to identify and proactively engage with persons in need of CM intervention (Johns Hopkins, 2015).

The MHS system as an HRO is moving beyond a stand-alone MM approach. Today, MM teams leverage technology for proactive case finding and engagement. In addition, efforts continue toward MHS-wide programmatic standardization along with evidence-based practice on a journey targeted to reduce unnecessary duplication and transform MHS MM from a series of independent elements to an integrated system.

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

Pain Management

During FYs 2019 and 2020, the 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) resulted in several advances in pain management policy, clinical care, and fielding of innovative education, training products, and clinical tools, including:

- Continued implementation of the Defense and Veterans Pain Rating Scale (DVPRS), an innovative pain scale that was developed by the DoD to improve assessment of the impact of pain on a person's function and quality of life.
- Continued MHS implementation of the Stepped Care Model of Pain Management to ensure the appropriate level of pain care is available and delivered to patients throughout the continuum of acute and chronic pain.
- Continued implementation of pain-related CPGs, as well as continued identification of requirements for updated CPGs by using resources available through the Pain Management Clinical Support Service, Clinical Communities, and VA/DoD Health Executive Committee (HEC) Work Groups.
- Increasing pain telehealth integration in NCR primary care by both direct care visits and provider webinar case-based education. This was greatly enhanced with the 2020 public health crisis (COVID-19).
- Continued primary care pain skills training offered annually by the NCR Pain Care Initiative. In 2020 and for the foreseeable future, Pain Skills has been moved to virtual online forum. Three hundred providers registered and participated in 2020.
- Expansion of pilot in-home telehealth visits to transitioning and rural Service members and beneficiaries. Enhanced by DHA Connected Health and HEC Pain Management Wording Group regarding COVID-related virtual health support for pain management and opioid safety.
- Continued development and deployment of the Pain Assessment Screening Tool and Outcome Registry (PASTOR), the MHS pain outcome registry and clinical decision-making tool. PASTOR is one of a growing number of use cases within the MHS PROCR that leverage the National Institutes of Health (NIH) Patient Reported Outcomes Measurement Information System (PROMIS).
- Established Opioid Prescribers Trend Report that displays data and provides ability to visualize comparisons within and between clinics and providers. Used to support Stepped Care Model Implementation, CPG adherence, and monitoring out-of-norm prescribing practices, supports local QI efforts.
- Continued execution of the Joint Pain Education Project in disseminating a standardized VA/DoD pain management curriculum and supplemental pain videos for widespread use in education and training programs.
- Participation in research efforts offered by DoD, VA, and NIH to examine nonpharmacological treatments for acute and chronic pain, and also complex pain syndromes experienced by military populations.
- Publication of DHA-Procedural Instruction (DHA-PI) 6025.33, "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.
- Opioid Education and Naloxone Distribution program being implemented throughout the MHS. Educating patients and families on opioid risks and dispensing the overdose antidote naloxone.
- Naloxone metric established as QPP metric for FY 2021 will be percentage of at-risk population receiving naloxone prescription in past year.
- Reductions in number of opioid prescriptions, number on long-term opioid therapy, those prescribed high doses Morphine Equivalent Daily Dose (MEDD>90), and those prescribed BZDs continues. Also broadened the MEDD metric to MEDD≥50 MEDD.
- Opioid Prescriber Safety Training refreshed for January 2021.
- Pain Management Clinical Support Service (PMCSS) is developing recommendations for opioid prescribing safety alerts to be integrated into the new electronic health record, MHS GENESIS.

Preventing Opioid Misuse by Military Service Members

DHA-PI 6025.04, "Pain Management and Opioid Safety in the MHS," published June 8, 2018, institutes DHA's procedures to:

- Establish the MHS Stepped Care Model as the comprehensive standardized pain management model for MHS to provide consistent, quality, and safe care for patients experiencing pain, with an emphasis on nonpharmacological treatments
- Educate patients in effective self-management of pain and injury rehabilitation
- Educate clinicians regarding effective pain management and optimal opioid safety consistent with VA/DoD and CDC CPGs
- Provide tools, including those through MHS GENESIS and legacy EHRs, to assist clinicians in evidence-based and patient-centered pain management
- 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 MAT for those with opioid use disorders; and providing naloxone (opioid reversal) for those at higher risk for overdose. It also provides guidance for the TRICARE health plan to partner with MCSCs to minimize inappropriate opioid prescribing and conduct value-based pilots of nonpharmacologic pain treatments.

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

Patient-Centered Care/Experience

Satisfaction with Provider

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

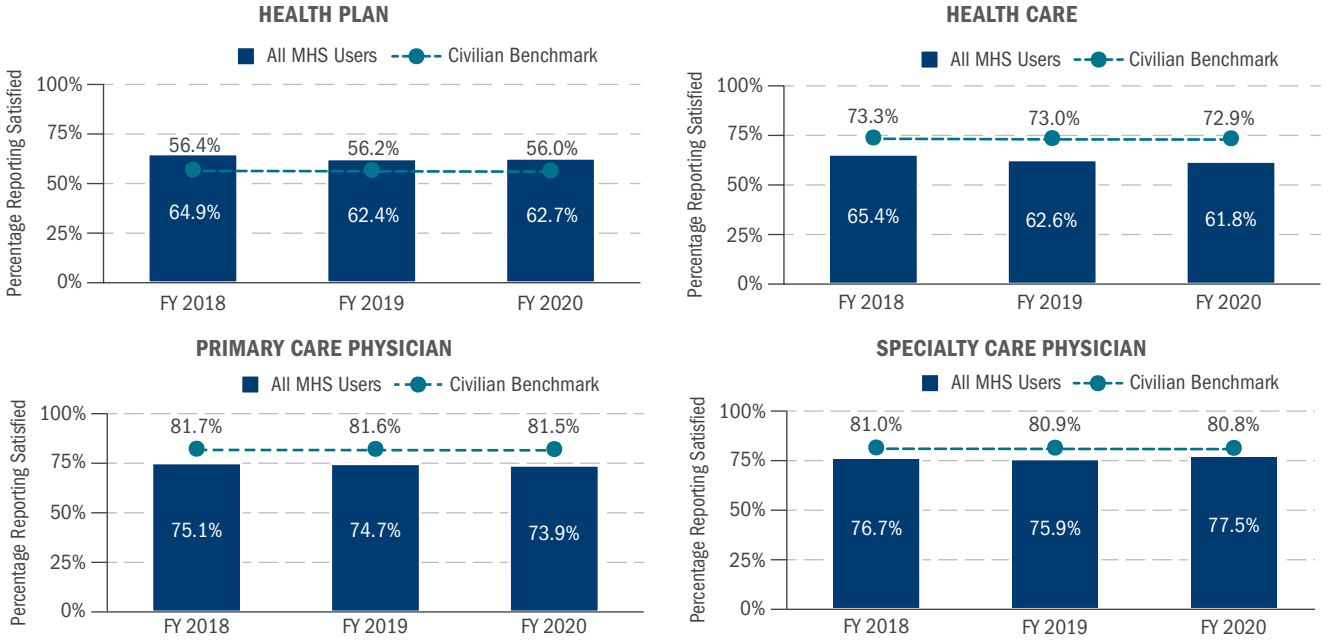
In this section, MHS beneficiaries in the U.S. who have used TRICARE are compared with the civilian benchmark with respect to ratings of (1) the health plan in general; (2) health care; (3) their personal physician; and (4) specialty care. Health plan ratings depend on access to care and how the plan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

Beneficiary Ratings of Their Health Plan through Population-Based Surveys

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

- MHS beneficiary satisfaction with their health plan, health care, and primary care decreased from FY 2018 to FY 2020. There were no significant trends for the remaining aspect of care. However, MHS beneficiary satisfaction with specialty care increased slightly from FY 2018 to FY 2020.
- MHS beneficiary satisfaction with their health plan exceeded that of the civilian benchmark in each year between FY 2018 and FY 2020. 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 2018–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 10/15/2020

Note: "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used in 2018, 2019, and 2020 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.)*

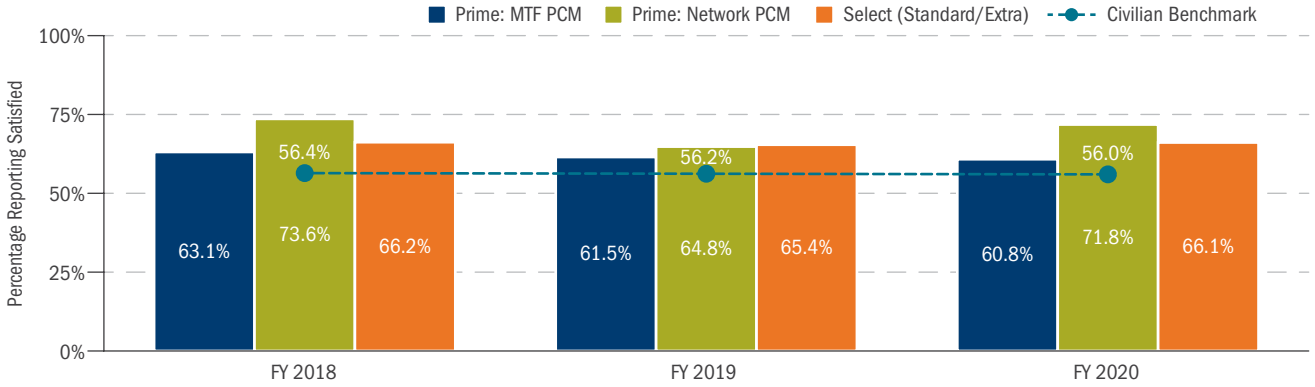
Patient-Centered Care/Experience *(cont.)*

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 Select in FYs 2018–2020). Satisfaction levels with one's health plan across the TRICARE options are compared with commercial plan counterparts.

- Satisfaction with the TRICARE health plan decreased from FY 2018 to FY 2020 for Prime enrollees with both an MTF and a network PCM, and remained stable for non-enrollees.
- For each year between FY 2018 and FY 2020, all MHS enrollment groups reported higher levels of satisfaction with their health plan than did their civilian counterparts.

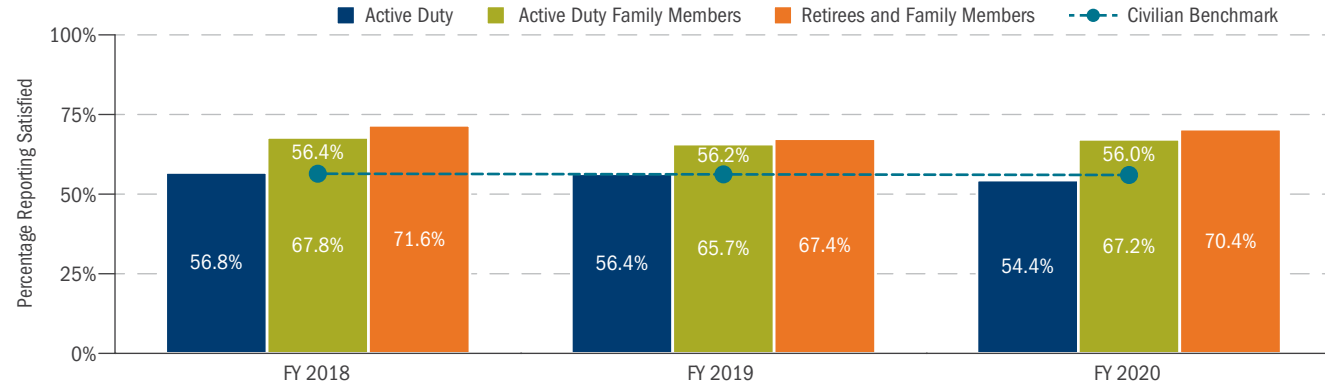
TRENDS IN SATISFACTION WITH THE HEALTH PLAN BY ENROLLMENT STATUS, FYs 2018–2020



Beneficiary Ratings of Their Health Plan Based on Beneficiary Category

- Satisfaction with the TRICARE health plan declined by 2.4 percentage points from FY 2018 to FY 2020 for Active Duty. The corresponding civilian benchmark also declined slightly over the same time period.
- Active Duty satisfaction was nearly the same as the civilian benchmark for FY 2018 and FY 2019, but was below the benchmark in FY 2020. Satisfaction levels for ADFMs and retirees and family members (RETFMs) were higher than the civilian benchmark in each year from FY 2018 to FY 2020.

TRENDS IN SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY, FYs 2018–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 10/15/2020

Note: "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used in 2018, 2019, and 2020 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.)*

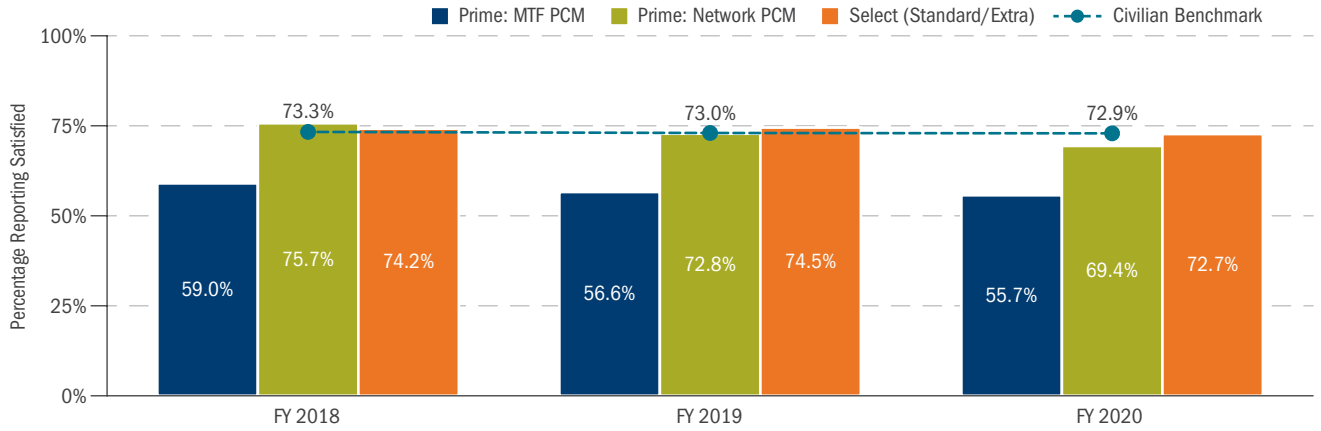
Patient-Centered Care/Experience *(cont.)*

Beneficiary Ratings of Satisfaction with Health Care by Enrollment Status and Beneficiary Category

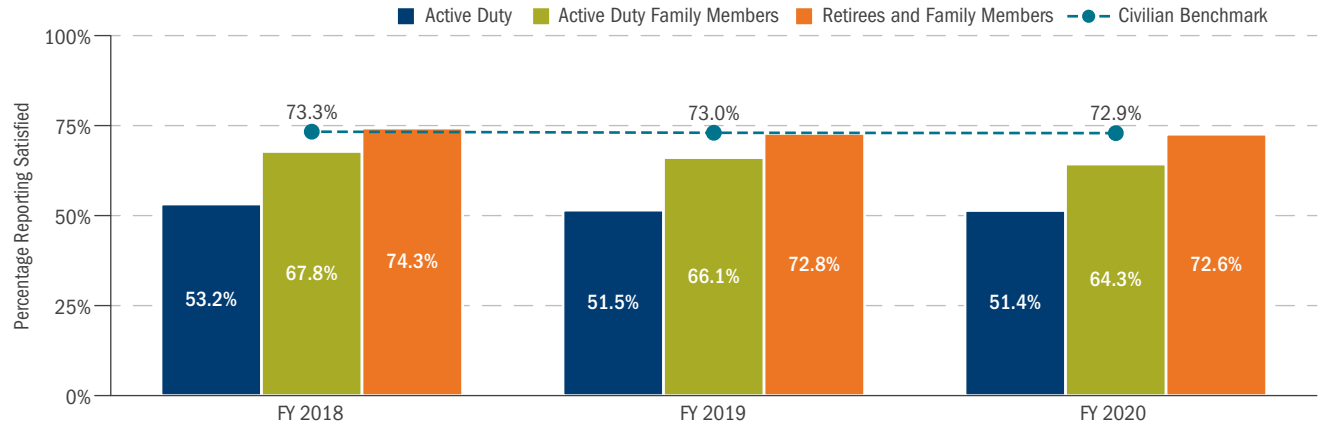
Similar to satisfaction with the TRICARE health plan, satisfaction levels with the health care received differ by beneficiary category and enrollment status.

- Beneficiary satisfaction with their health care declined between FY 2018 and FY 2020 for Prime enrollees with both an MTF PCM and a network PCM and remained the same for non-enrollees. The civilian benchmark was also stable over the same time period.
- Satisfaction with health care for beneficiaries with a MTF PCM was significantly lower than the civilian benchmark in each year between FY 2018 and FY 2020. Satisfaction levels for the other enrollment groups were about the same as the civilian benchmark.
- Beneficiary satisfaction with their health care by beneficiary category remained about the same between FY 2018 and FY 2020. The civilian benchmark was stable over the same time period.
- Satisfaction with health care for Active Duty and ADFMs was well below the civilian benchmark for each year between FY 2018 and FY 2020. Satisfaction for RETFMs was about the same as the civilian benchmark.

TRENDS IN SATISFACTION WITH TRICARE HEALTH CARE BY ENROLLMENT STATUS, FYs 2018–2020



TRENDS IN SATISFACTION WITH TRICARE HEALTH CARE BY BENEFICIARY CATEGORY, FYs 2018–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 10/15/2020

Note: "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used used in 2018, 2019, and 2020 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.)*

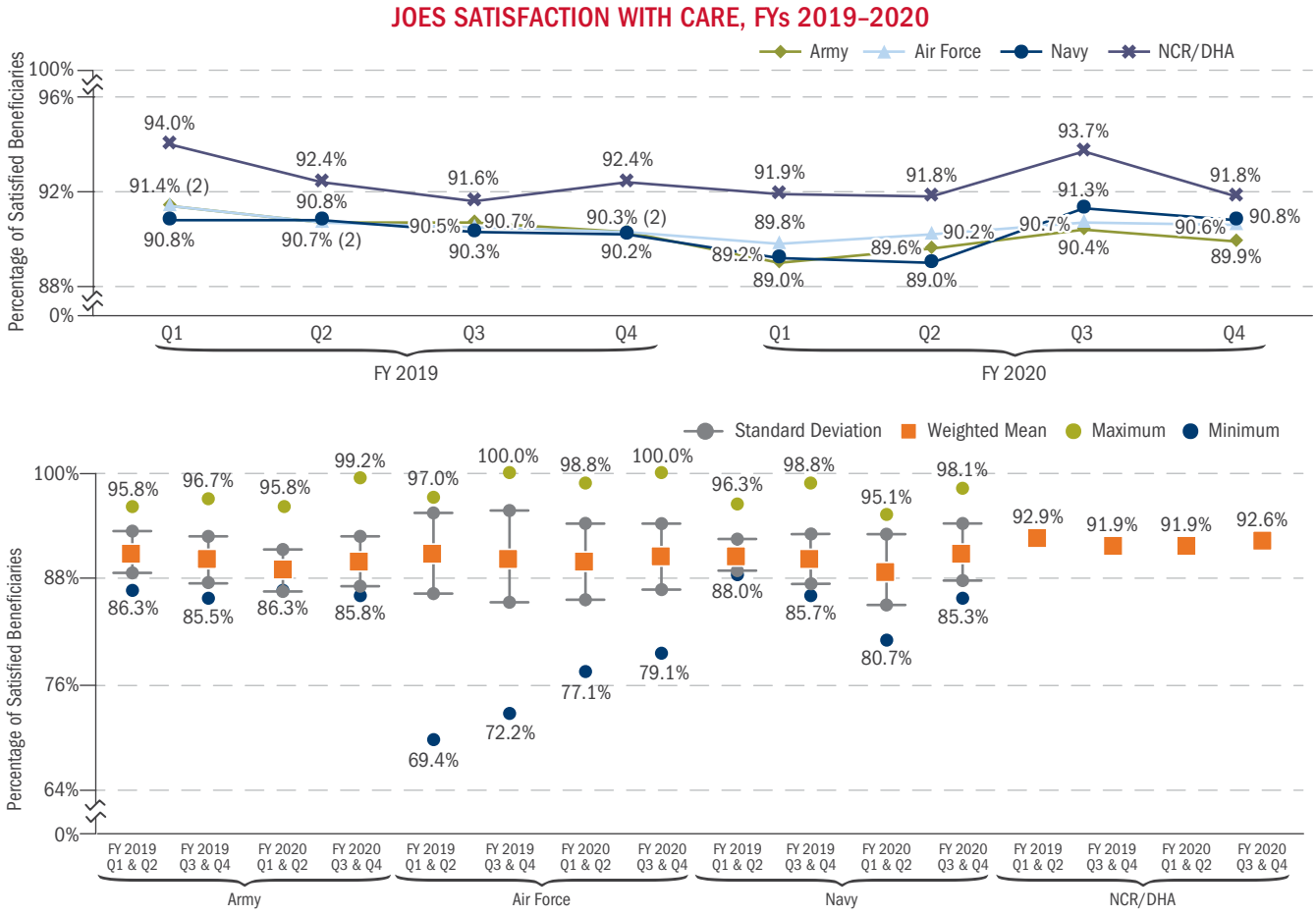
Patient-Centered Care/Experience *(cont.)*

Beneficiary Ratings of Satisfaction with Care Following Outpatient Treatment

Since FY 2017, the JOES and the JOES-C have measured various aspects of patient experience with MHS care. Some factors reported on by the beneficiary include: their experience with the pharmacy, laboratory, or radiology department (JOES); the communication of receptionists and providers (JOES, JOES-C); how care was received (JOES); and if the provider knew and communicated information about the beneficiary's medical history and prescription medicines (JOES, JOES-C). During and prior to FY 2016, similar aspects were captured in Service-specific surveys and in TROSS.

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 on pages 170–171.

Rating of Satisfaction with Care (JOES): The scores for each Service are tightly grouped together and are around 90 percent—indicating that a large proportion of individuals are "Somewhat Satisfied" or "Very Satisfied" with the care that they received. Scores have slightly decreased over time for all Services from FY 2019 Q1 through FY 2020 Q2. In FY 2020 Q3, there was a small increase, but scores trended downward again by FY 2020 Q4. JOES is fielded to beneficiaries using direct care only, so purchased care results are not available for display below.



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES, weighted data compiled 1/13/2021

Notes:

– Parent facility scores were used above, and those reporting fewer than 10 responses in the time period were excluded from analyses.
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration.
– Satisfaction with Care is assessed in each survey as an agreement to the following statement: Overall, I am satisfied with the health care I received on this visit." The five-point scale response for this question ranges from "Strongly Disagree" to "Strongly Agree." The results provided above are for those beneficiaries who reported either "Somewhat Agree" or "Strongly Agree."
– The NCR category is represented by FY 2019 Q1 data points and is made up of parent facilities FBCH and WRNMMC. Parent facilities FBCH, WRNMMC, 81st Medical Group at Keesler Air Force Base, Womack Army Medical Center, Naval Hospital Jacksonville, 4th Medical Group at Seymour Johnson Air Force Base, and 628th Medical Group at Joint Base Charleston compose the DHA category from FY 2019 Q2 through FY 2020 Q4, and includes Kimbrough Ambulatory Center at Fort Meade for FY 2020.
– For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

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

Patient-Centered Care/Experience *(cont.)*

JOES Satisfaction with Care—Variability Over Time

The table below displays the extent to which the ratings of satisfaction with care changed over time in terms of improvement (increasing mean or median) or decreased dispersion (reduced range or standard deviation).

- From FY 2019 to FY 2020, Army, Air Force, and Navy worsened in terms of the mean demonstrating a slight decrease in satisfaction ratings. The median ratings decreased by less than two percentage points for all Service branches. The standard deviation shows that the data is concentrated around the mean for Army, Air Force, and Navy. This dispersion was less than one percentage point from FY 2019 to FY 2020.
- Dispersion, in terms of the range between the lowest- and highest-performing parent facilities, increased overall, from FY 2019 to FY 2020 for Army and Navy. The difference between the highest and lowest for Air Force decreased by 6.6 percentage points over the same period.

VARIABILITY IN JOES RATINGS: SATISFACTION WITH CARE, FYs 2019–2020

	FY 2019 Q1 & Q2	FY 2019 Q3 & Q4	FY 2020 Q1 & Q2	FY 2020 Q3 & Q4	% POINT CHANGE (FY 2019 Q1 & Q2 TO FY 2020 Q3 & Q4)
ARMY					
Number of Respondents	104,190	94,509	81,458	75,100	-27.9%
Service Score (Mean)	91.0%	90.5%	89.3%	90.1%	-0.9
Standard Deviation	2.3%	2.4%	2.2%	2.8%	0.5
Median	91.0%	90.4%	89.4%	90.6%	-0.4
75th Percentile (Q3)	92.5%	92.0%	90.7%	92.6%	0.1
25th Percentile (Q1)	89.7%	89.2%	88.0%	89.0%	-0.7
Maximum	95.8%	96.7%	95.8%	99.2%	3.4
Minimum	86.3%	85.5%	86.3%	85.8%	-0.5
Range	9.5%	11.2%	9.5%	13.4%	3.9
AIR FORCE					
Number of Respondents	64,425	57,388	58,897	51,018	-20.8%
Service Score (Mean)	91.0%	90.5%	90.0%	90.6%	-0.4
Standard Deviation	4.6%	5.2%	4.2%	3.8%	-0.8
Median	91.7%	90.4%	89.6%	89.9%	-1.8
75th Percentile (Q3)	93.2%	93.2%	92.0%	92.6%	-0.6
25th Percentile (Q1)	89.6%	87.5%	87.1%	87.8%	-1.8
Maximum	97.0%	100.0%	98.8%	100.0%	3.0
Minimum	69.4%	72.2%	77.1%	79.1%	9.7
Range	27.5%	27.8%	21.7%	20.9%	-6.6
NAVY					
Number of Respondents	52,624	48,748	41,644	39,876	-24.2%
Service Score (Mean)	90.8%	90.3%	89.1%	91.0%	0.2
Standard Deviation	1.9%	2.8%	4.0%	3.3%	1.4
Median	91.3%	91.0%	90.3%	91.1%	-0.2
75th Percentile (Q3)	92.2%	92.4%	93.3%	91.8%	-0.4
25th Percentile (Q1)	90.6%	89.2%	87.4%	89.0%	-1.6
Maximum	96.3%	98.8%	95.1%	98.1%	1.8
Minimum	88.0%	85.7%	80.7%	85.3%	-2.7
Range	8.3%	13.0%	14.3%	12.8%	4.5
NCR/DHA					
Number of Respondents	31,549	39,793	42,315	25,499	-19.2%
Service Score (Mean)	92.9%	91.9%	91.9%	92.6%	-0.3

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES, weighted data, compiled 1/13/2021

Notes:

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

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

– The NCR category is represented by FY 2019 Q1 data points and is made up of parent facilities FBCH and WRNMMC. Parent facilities FBCH, WRNMMC, 81st Medical Group at Keesler Air Force Base, Womack Army Medical Center, Naval Hospital Jacksonville, 4th Medical Group at Seymour Johnson Air Force Base, and 628th Medical Group at Joint Base Charleston compose the DHA category from FY 2019 Q2 through FY 2020 Q4, and includes Kimbrough Ambulatory Center at Fort Meade for FY 2020.

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

Patient-Centered Care/Experience *(cont.)*

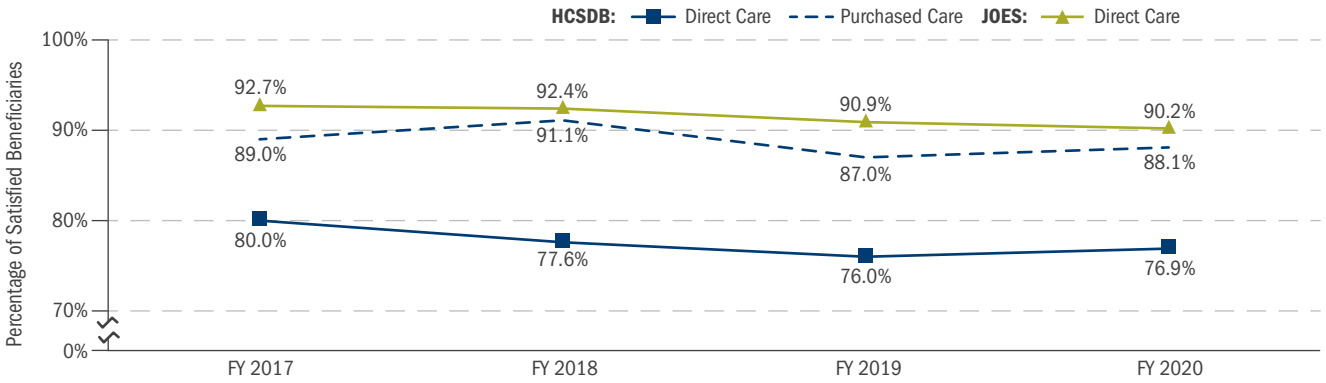
DHA Surveys—Satisfaction with Care and Health Care Rating

In addition to JOES and JOES-C, the population-based HCSDB survey also reports results for the Satisfaction with Care measure. Including this same item in each survey provides important information about the differences between surveys and the beneficiaries who answer them.

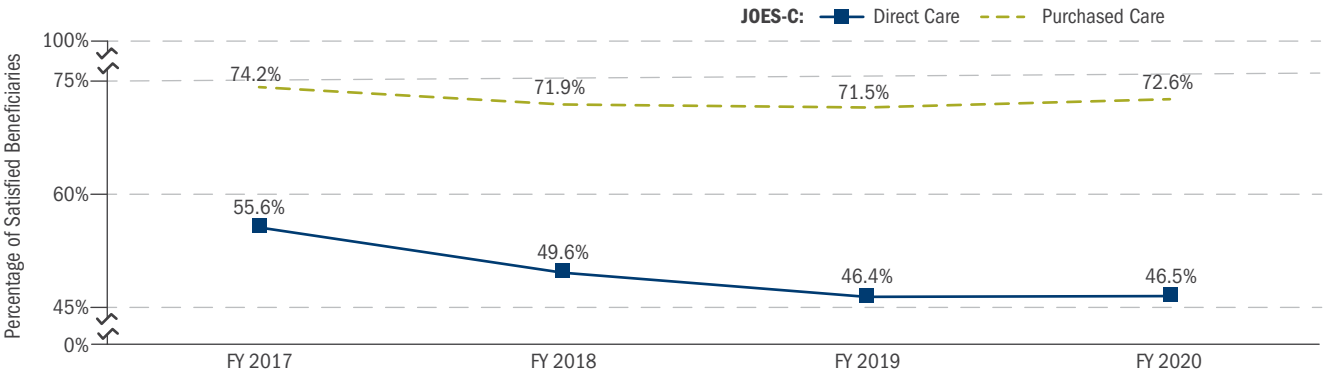
- From FY 2017 to FY 2020, JOES direct care beneficiaries reported the greatest satisfaction with care. Beneficiaries completing JOES-C health care rating for purchased care reported higher ratings as compared to JOES-C direct care from FY 2017 to FY 2020. By year, the range is approximately 19 to 26 percentage points between JOES-C direct care and purchased care. HCSDB purchased care users reported greater satisfaction with care than those using HCSDB direct care from FY 2017 through FY 2020.
- Trends for health care rating have generally remained fairly steady for both HCSDB direct care and purchased care from FY 2017 to 2020. JOES direct care rating has decreased over the same period. Health care rating trends decreased for both JOES-C direct care and purchased care after FY 2017, with ratings becoming steady from FY 2019 to FY 2020.

BETTER CARE

HCSDB AND JOES RATINGS OF SATISFACTION WITH CARE, FYs 2017–2020



JOES-C HEALTH CARE RATING, FYs 2017–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB JOES, and JOES-C, compiled 1/13/2021

Notes:

– Results for each survey above are weighted to appropriately represent the composition of the MHS population.
– Results for HCSDB are for Prime enrollees only. "HCSDB Direct Care" represents care received as Active Duty or through a military PCM for individuals under 65 and who have been enrolled for at least six months. "HCSDB Purchased Care" is defined as care received from civilian PCM for individuals under 65 who were enrolled in the following healthcare plans for at least six months: TRICARE Select, TRICARE Reserve Select, TRICARE Retired Reserve, or TRICARE Young Adult Select.
– Results for JOES-C direct care and JOES-C purchased care representing FY 2020 are from September 2019 to June 2020.
– "Satisfaction with Care" is worded very similarly in JOES and HCSDB surveys as the following statement: "Overall, I am satisfied with the health care I received on this visit." The five-point scale response for this question ranges from "Strongly Disagree" to "Strongly Agree." The results provided above are for those beneficiaries who reported either "Somewhat Agree" or "Strongly Agree."
– "Health Care Rating" in JOES-C is worded as the following statement: "Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate your health care?" The results reported above are for those beneficiaries who provided a rating of 9 or 10.
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration, respective to the JOES and JOES-C.

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

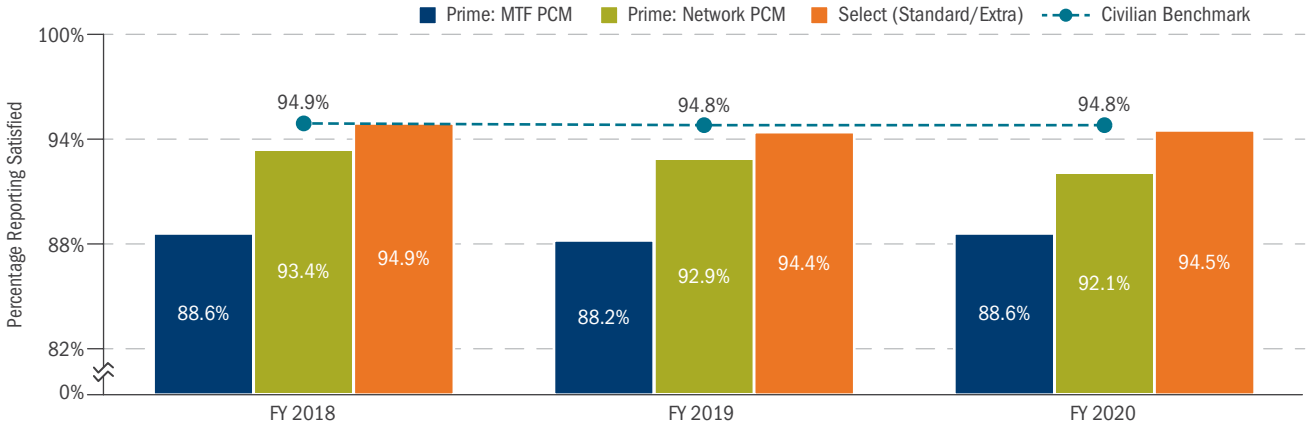
Patient-Centered Care/Experience *(cont.)*

Satisfaction with Doctors' Communication

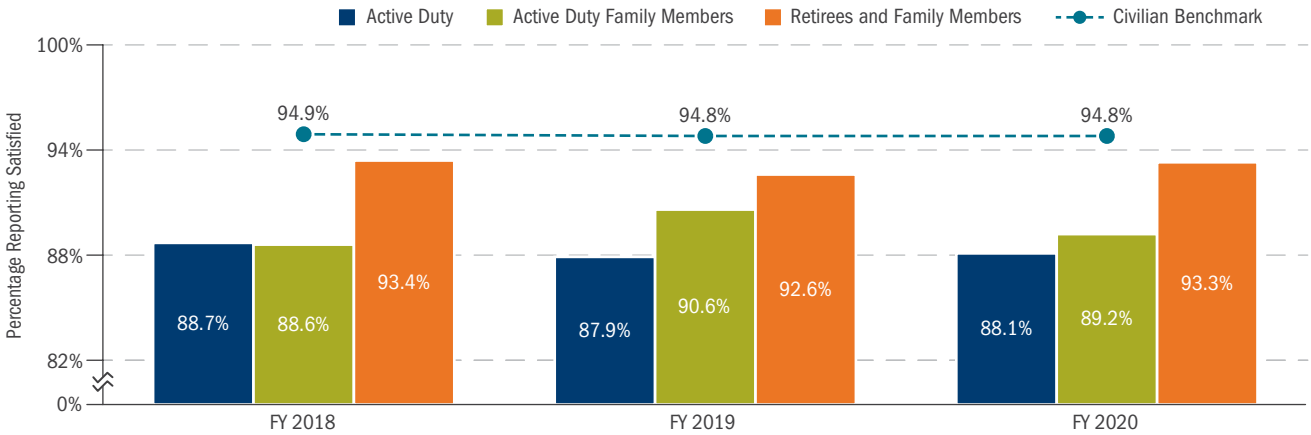
Communication between doctors and patients is an important factor in beneficiaries' satisfaction and their ability to obtain appropriate care. The following charts present beneficiary-reported perceptions of how well their doctor communicates with them.

- Beneficiary satisfaction with their doctors' communication remained stable between FY 2018 and FY 2020, regardless of their enrollment status. The civilian benchmark also remained stable over the same time period.
- Satisfaction with doctors' communication was below the benchmark for Prime enrollees with an MTF PCM and a network PCM for all years between FY 2018 and FY 2020.
- Satisfaction with doctors' communication remained stable between FY 2018 and FY 2020 for all beneficiary groups except for ADFMs, who saw a modest increase. The civilian benchmark also remained stable over the same time period.
- Satisfaction with doctors' communication was lower than the civilian benchmark for all beneficiary groups in FY 2020.

TRENDS IN SATISFACTION WITH DOCTORS' COMMUNICATION BY ENROLLMENT STATUS, FYs 2018–2020



TRENDS IN SATISFACTION WITH DOCTORS' COMMUNICATION BY BENEFICIARY CATEGORY, FYs 2018–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 10/15/2020

Note: "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used in 2018, 2019, and 2020 come from NCQA's 2015 data, while the benchmarks used in 2018 and 2019 come from NCQA's 2017 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

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

Patient-Centered Care/Experience *(cont.)*

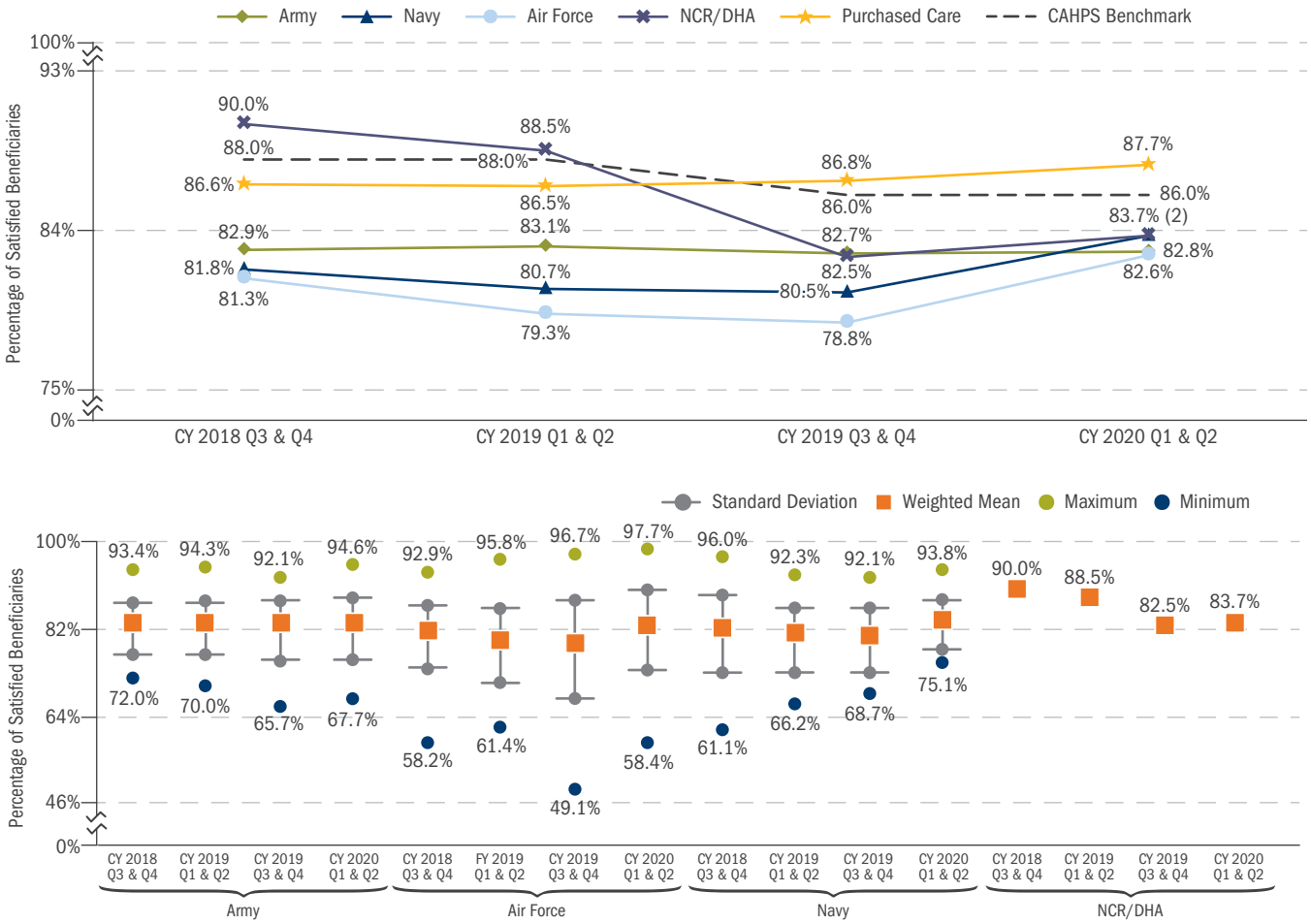
Provider Communication

As detailed in "Drivers of Patient Experience Ratings" on pages 170–171, communication between the beneficiary and their provider is one of the leading drivers of overall patient satisfaction across care settings, in both outpatient and inpatient care, and is cross-validated by the core surveys (JOES, JOES-C, TRISS, and HCSDB). The TRISS, JOES-C, and HCSDB surveys measure provider communication (or doctor and nurse communication) from the beneficiary's perspective, and it remains vitally important to quality of care ratings. Some of the questions in these surveys ask: if the provider was understandable, if the provider listened, if the provider was respectful, and if the provider spent enough time with the patient. The results of these questions make up the score for the Provider Communication composite measure. These results can be compared to nationally representative civilian and military benchmarks, and can be compared across all levels of the MHS.

- JOES-C was introduced in June 2016 for direct care and May 2017 for purchased care. Provider communication scores for the Army, Navy, and Air Force have remained relatively stable from CY 2019 Q3 & Q4 to CY 2020 Q1 & Q2 but have remained below the civilian CG-CAHPS benchmark.
- Scores for the NCR/DHA have declined over the same period. Purchased care scores exceeded the civilian benchmark in CY 2019 Q3 & Q4 as well as CY 2020 Q1 & Q2.
- There is a slight variation in the direct care scores, as reflected by the box and whisker plot (shown below).

BETTER CARE

JOES-C PROVIDER COMMUNICATION, CY 2018 Q3 & Q4 TO CY 2020 Q1 & Q2



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES-C, weighted data, compiled 12/07/2020

Notes:

– Parent facility scores were used above, and those reporting fewer than 10 responses within the time period were excluded from analyses.
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration.
– The box shows the interquartile range (IQR) (25th to 75th percentiles) with the Service score (weighted mean) highlighted.
– The NCR category is represented by the CY 2018 Q3 and CY 2018 Q4 data point and is made up of parent facilities FBCH and WRNMMC. Parent facilities FBCH, WRNMMC, 81st Medical Group at Keesler Air Force Base, Womack Army Medical Center, Naval Hospital Jacksonville, 4th Medical Group at Seymour Johnson Air Force Base, and 628th Medical Group at Joint Base Charleston compose the DHA category from CY 2019 Q1 through CY 2020 Q2, and includes Kimbrough Ambulatory Center at Fort Meade for CY 2020 Q1 & Q2.
– CAHPS benchmarks are the 50th percentiles from the respective 2017 and 2018 CG-CAHPS national civilian scores.

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

Patient-Centered Care/Experience *(cont.)*

Provider Communication

The table below displays the extent to which the ratings of the Provider Communication composite changed over time in terms of improvement (increasing mean or median) or decreased dispersion (reduced range or standard deviation).

- From CY 2018 Q3 & Q4 to CY 2020 Q1 & Q2, the median score and weighted mean for Air Force and Navy increased, the Army's mean score decreased slightly (0.1 percentage point) while its median score increased. The mean score for DHA facilities decreased by 6.3 percentage points.
- Dispersion, in terms of the range between the lowest- and highest-performing parent facilities, decreased significantly from CY 2018 Q3 & Q4 to CY 2020 Q1 & Q2 for Navy while increasing for Army and Air Force.

JOES-C: PROVIDER COMMUNICATION COMPOSITE, CY 2018 Q3 & Q4 TO CY 2020 Q1 & Q2

	CY 2018 Q3 & Q4	CY 2019 Q1 & Q2	CY 2019 Q3 & Q4	CY 2020 Q1 & Q2	% POINT CHANGE (CY 2018 Q3 & Q4 TO CY 2020 Q1 & Q2)
ARMY					
Number of Respondents	2,455	3,364	3,219	3,180	29.5%
Service Score (Mean)	82.9%	83.1%	82.7%	82.8%	–0.1
Standard Deviation	5.1%	5.3%	6.3%	6.4%	1.3
Median	82.8%	84.0%	81.0%	84.8%	2.1
75th Percentile (Q3)	86.9%	86.4%	86.5%	87.7%	0.9
25th Percentile (Q1)	79.5%	80.8%	76.6%	78.7%	–0.8
Maximum	93.4%	94.3%	92.1%	94.6%	1.2
Minimum	72.0%	70.0%	65.7%	67.7%	–4.3
Range	21.4%	24.3%	26.4%	26.9%	5.5
AIR FORCE					
Number of Respondents	4,947	4,255	2,450	2,438	–50.7%
Service Score (Mean)	81.3%	79.3%	78.8%	82.6%	1.3
Standard Deviation	6.3%	7.7%	10.2%	8.2%	1.9
Median	80.2%	78.4%	80.6%	82.9%	2.7
75th Percentile (Q3)	83.7%	83.5%	84.6%	88.0%	4.3
25th Percentile (Q1)	76.3%	71.9%	73.1%	75.0%	–1.3
Maximum	92.9%	95.8%	96.7%	97.7%	4.8
Minimum	58.2%	61.4%	49.1%	58.4%	0.2
Range	34.7%	34.4%	47.6%	39.3%	4.7
NAVY					
Number of Respondents	1,489	1,721	1,605	1,507	1.2%
Service Score (Mean)	81.8%	80.7%	80.5%	83.7%	1.9
Standard Deviation	8.0%	6.7%	6.5%	5.2%	–2.7
Median	83.3%	79.8%	80.9%	83.9%	0.6
75th Percentile (Q3)	87.3%	87.7%	87.7%	88.2%	0.9
25th Percentile (Q1)	79.3%	76.7%	77.3%	79.6%	0.3
Maximum	96.0%	92.3%	92.1%	93.8%	–2.2
Minimum	61.1%	66.2%	68.7%	75.1%	14.0
Range	34.9%	26.1%	23.4%	18.7%	–16.2
NCR/DHA					
Number of Respondents	402	1,238	1,622	1,650	310.4%
Service Score (Mean)	90.0%	88.5%	82.5%	83.7%	–6.3

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES-C, weighted data, compiled 12/7/2020

Notes:

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

– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 and FY 2020 after migration.

– The NCR category is represented by the CY 2018 Q3 and CY 2018 Q4 data point and is made up of parent facilities FBCH and WRNMMC. Parent facilities FBCH, WRNMMC, 81st Medical Group at Keesler Air Force Base, Womack Army Medical Center, Naval Hospital Jacksonville, 4th Medical Group at Seymour Johnson Air Force Base, and 628th Medical Group at Joint Base Charleston compose the DHA category from CY 2019 Q1 through CY 2020 Q2, and includes Kimbrough Ambulatory Center at Fort Meade for CY 2020 Q1 & Q2.

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

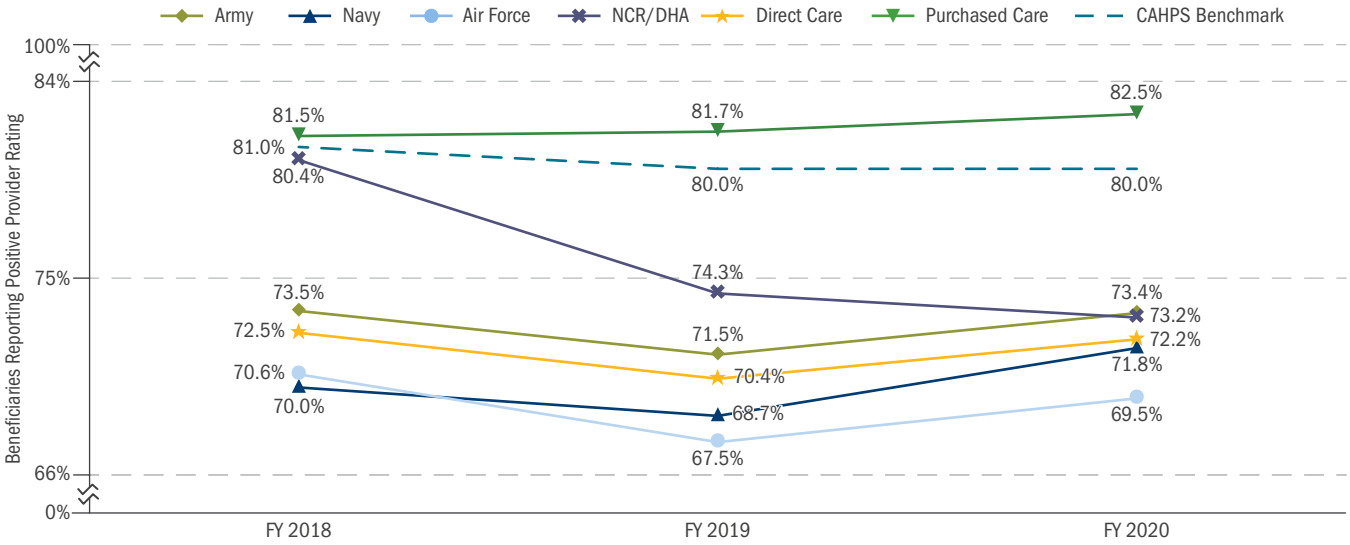
Patient-Centered Care/Experience *(cont.)*

Beneficiary Ratings of Provider Following Outpatient Treatment

In the JOES-C, beneficiaries are also asked to provide an overall rating for their provider, based on a scale from zero (worst provider possible) to 10 (best provider possible). The percentages of beneficiaries rating their provider a nine or 10 are provided in the following graph. The results to this question are comparable to civilian results, and the civilian 50th percentile score is used as the CAHPS benchmark.

- Provider ratings were captured by JOES-C from FY 2018 to FY 2020. The annual aggregated rating from FY 2018 to FY 2020 declined by approximately one and seven percentage points for Air Force and NCR/DHA, respectively. Provider ratings for Navy increased by almost two percentage points over this same period, while Army remained steady.
- Direct care scores remained relatively steady between FY 2018 and FY 2020, while purchased care scores increased by one percentage point.
- The graph shows that all of the Services and direct care are below the national CAHPS 50th percentile as of FY 2020, with the exception of the purchased care scores, which are above the benchmark.

JOES-C RATING OF PROVIDER, FYs 2018–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES-C weighted data, compiled 12/7/2020

Notes:

- Results displayed above were weighted to represent the composition of the MHS population.
- CAHPS benchmarks are the 50th percentiles from the respective 2017 and 2018 CG-CAHPS national civilian scores.
- Results for JOES-C FY 2020 direct care include data from September 2019 to July 2020. Results for purchased care include data from September 2019 to June 2020.
- The NCR category is represented by the FY 2018 Q1 through FY 2019 Q1 data points and is made up of parent facilities FBCH and WRNMMC. Parent facilities FBCH, WRNMMC, 81st Medical Group at Keesler Air Force Base, Womack Army Medical Center, Naval Hospital Jacksonville, 4th Medical Group at Seymour Johnson Air Force Base, and 628th Medical Group at Joint Base Charleston compose the DHA category from FY 2019 Q2 through FY 2020 Q4, and includes Kimbrough Ambulatory Center at Fort Meade for FY 2020 Q1–Q3.
- Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 and FY 2020 after migration.

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

Patient-Centered Care/Experience *(cont.)*

Beneficiary Ratings of Care Following Inpatient Treatment

TRISS: The purpose of the TRISS is to monitor and report on the perceptions and experiences of MHS beneficiaries who have been admitted to MTF and civilian hospitals. The survey instrument incorporates the questions developed by AHRQ and CMS for the HCAHPS initiative. Additional information on HCAHPS, including the protocols for sampling, data collection, and coding can be found in the HCAHPS Quality Assurance Guidelines manual on the official HCAHPS website, www.hcahpsonline.org, as well as information on recent changes, star ratings, and other updates to publicly reported data such as that on the Hospital Compare website. The TRISS follows the HCAHPS protocols developed by CMS and endorsed by the NQF.

The goal of the HCAHPS initiative is to measure uniformly and report publicly on inpatient care experiences using a standardized survey instrument and data collection methodology. The information derived from the survey can provide feedback to providers and patients, valuable insight for internal quality improvement initiatives, and an assessment of the impact of changes in operating procedures.

Comparison of these data with the results from previous surveys, as well as comparisons to civilian benchmark data, enable the DoD to measure progress in meeting its goals and objectives of high-quality health care. The TRISS compares care across all Services and across venues (i.e., direct MTF-based care and private-sector/purchased care) including inpatient surgical, medical, and obstetric care. The TRISS continues to update and change as new HCAHPS requirements are tested and implemented, and these changes over time have resulted in more reliable measures and higher response rates. Data collected by the TRISS includes but is not limited to:

- Overall rating of hospital and recommendation of hospital to others
- Nursing care (care, respect, listening, and explanations)
- Physician care (care, respect, listening, and explanations)
- Communication (with nurses and doctors, and regarding medications)
- Responsiveness of staff
- Hospital environment (cleanliness and quietness)
- Post-discharge (such as written directions for post-discharge care)

In addition to the above TRISS measures from the HCAHPS survey instrument, TRISS also includes DoD supplemental measures unique to the military population including, but not limited to, education on breastfeeding and repeat obstetrics care, nurse hourly rounding, and nurse leader visit. Beginning in FY 2020, TRISS expanded on the HCAHPS hospital environment measures to seven additional metrics (variety of food options, temperature of food, mattress comfort, room temperature, room privacy, hospital signage and directions, and adequacy of parking).

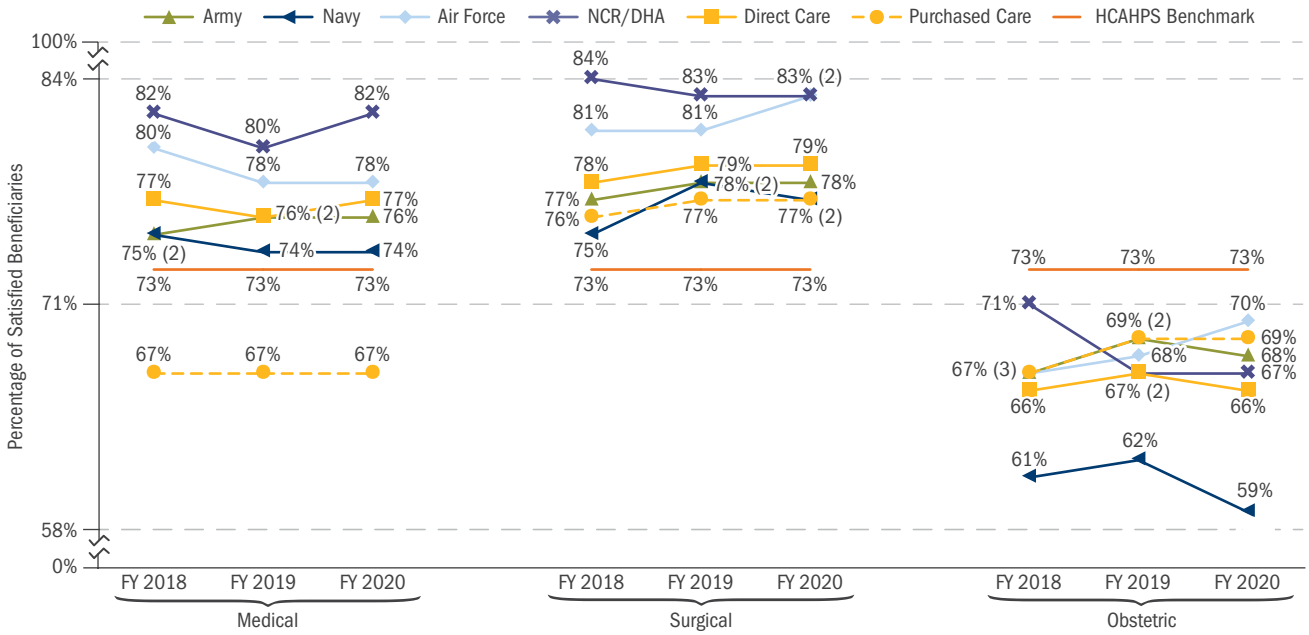
In the following sections, we detail specific findings focused primarily on two measures of patient experience: overall rating of the hospital and willingness to recommend the hospital to others. These results are produced by the DHA J-5 Analytics and Evaluation Division and do not represent official HCAHPS results. Official HCAHPS results are published on the Hospital Compare website (www.medicare.gov/hospitalcompare).

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

Patient-Centered Care/Experience *(cont.)*

Overall Hospital Rating: Overall, direct care has remained consistent in patient satisfaction over time in each inpatient product line from FY 2018 to FY 2020. With the exception of purchased care in the medical product line, each of the Services met or exceeded the national HCAHPS benchmark in FY 2020 in the medical and surgical product lines, with the surgical product line for the Air Force improving in FY 2020. Although the obstetric product line results for all Services and purchased care are below the HCAHPS benchmark, scores trended downward overall in FY 2020; the Air Force showed a noticeable increase in patient satisfaction in the obstetric product line in FY 2018 to FY 2020.

TRISS OVERALL HOSPITAL RATING TRENDS, FYs 2018–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/16/2020

Notes:

– FY 2020 includes results from FY 2020 Q1–Q3 for direct care and the Services and FY 2020 Q1–Q2 for purchased care.

– HCAHPS benchmarks are the U.S. scores from the October 2018, July 2019, July 2020, and October 2020 HCAHPS Public Reports. More information about these scores can be found at: https://www.hcahpsonline.org/en/summary-analyses/.

– The NCR category is represented by the FY 2018 data points and is made up of parent facilities FBCH and WRNMMC. Parent facilities FBCH, WRNMMC, 81st Medical Group at Keesler Air Force Base, Womack Army Medical Center, and Naval Hospital Jacksonville compose the DHA category from FY 2019 Q1 through FY 2020 Q3.

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

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

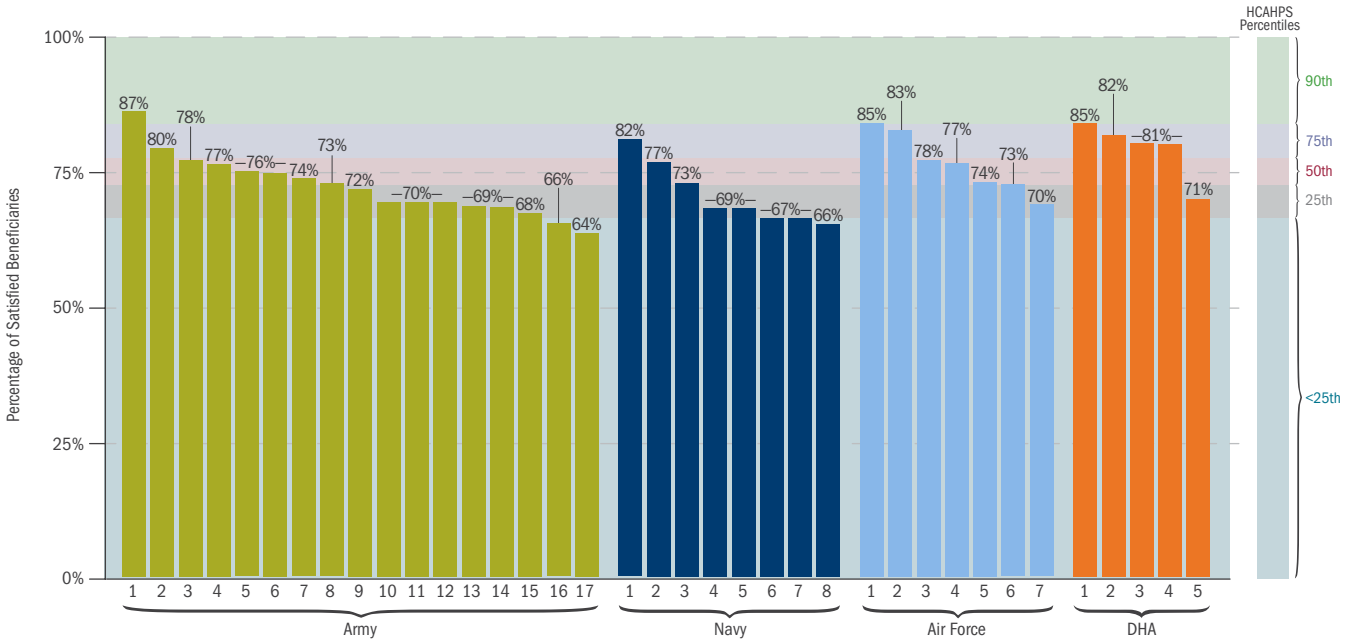
HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient-Centered Care/Experience *(cont.)*

The facilities in both TRISS histogram charts have been de-identified within their respective Service. The de-identified labels (e.g., Army 1, Army 2, etc.) in Overall Hospital Ratings correspond with the same facilities in the Recommend Hospital histogram chart on page 167.

The chart below shows the distribution for Overall Hospital Ratings of direct care inpatient facilities, and how they compared with the national HCAHPS percentiles. Three facilities had ratings in the HCAHPS 90th percentile: one Army, one Air Force, one DHA; six facilities had ratings in the HCAHPS 75th percentile; and 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 2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/16/2020

Notes:

– FY 2020 includes results from FY 2020 Q1–Q3 for direct care and the Services.
– Facilities that have fewer than 25 responses do not have a score displayed above.
– Sites that migrated to MHS GENESIS were sampled in FY 2019 Q4 after migration.
– The increment of the above percentiles was set at <25th, 25th, 50th, 75th, and 90th. Percentiles are based on nationally representative civilian and military facility scores (July 2020 Public Report: October 2018–September 2019 discharges). More information about these percentiles can be found at: https://www.hcahpsonline.org/en/summary-analyses/.

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

Patient-Centered Care/Experience *(cont.)*

The table below displays the extent to which the Overall Hospital Rating scores changed over time in terms of improvement (increasing mean or median) or decreased dispersion (reduced range).

- From FY 2017 to FY 2020, direct care improved by approximately two percentage points with regard to the mean; median ratings remained consistent, decreasing by less than one percentage point between FY 2017 and FY 2020.
- Dispersion of direct care decreased in terms of the range from FY 2017 to FY 2020; the range between the lowest- and highest-performing MTFs decreased by seven percentage points from FY 2017 to FY 2020.
- From FY 2017 to FY 2020, purchased care scores have changed minimally in terms of the mean and median ratings. The range between the lowest- and highest-performing civilian hospital shows an increase of seven percentage points.

TRISS OVERALL HOSPITAL RATING: FYs 2017–2020

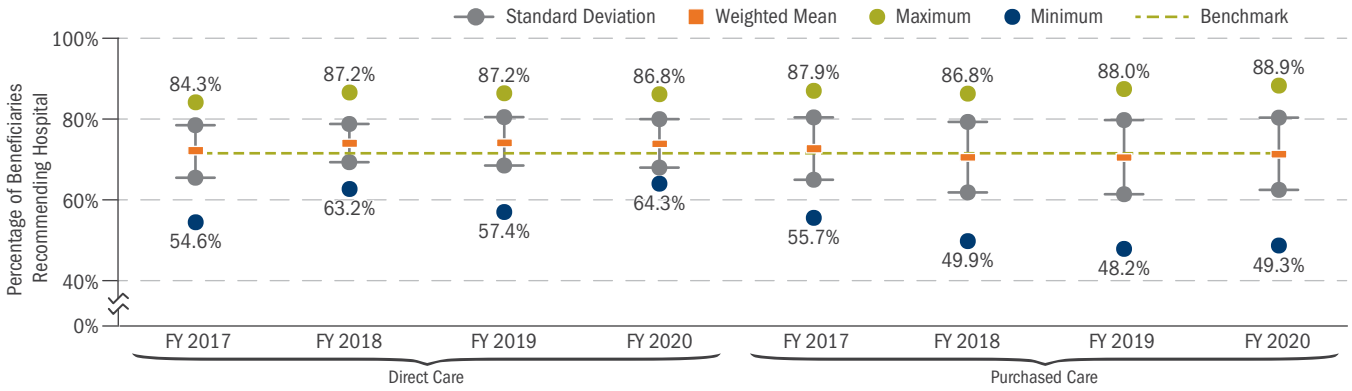
	FY 2017	FY 2018	FY 2019	FY 2020	% POINT CHANGE (FY 2017–FY 2020)
DIRECT CARE					
Number of Respondents	45,109	39,209	36,860	23,995	
Weighted Mean	72.5%	74.4%	74.4%	74.2%	1.7
Standard Deviation	6.6%	4.9%	6.0%	6.1%	–0.5
Median	73.5%	74.3%	73.9%	73.3%	–0.2
75th Percentile (Q3)	76.8%	76.9%	77.3%	78.9%	2.1
25th Percentile (Q1)	68.1%	70.0%	72.4%	69.2%	1.1
Maximum	84.3%	87.2%	87.2%	86.8%	2.5
Minimum	54.6%	63.2%	57.4%	64.3%	9.7
Range	29.7%	24.0%	29.8%	22.4%	–7.3
PURCHASED CARE					
Number of Respondents	21,142	20,966	20,644	20,035	
Weighted Mean	73.0%	70.8%	70.9%	71.7%	–1.3
Standard Deviation	7.7%	8.7%	9.2%	8.9%	1.2
Median	72.3%	71.7%	71.5%	73.4%	1.1
75th Percentile (Q3)	78.7%	76.8%	77.5%	78.5%	–0.2
25th Percentile (Q1)	67.0%	65.2%	65.2%	64.6%	–2.4
Maximum	87.9%	86.8%	88.0%	88.9%	1.0
Minimum	55.7%	49.9%	48.2%	49.3%	–6.4
Range	32.3%	36.9%	39.8%	39.6%	7.3

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/16/2020

Notes:

– Inpatient facilities scores were used in the table above, and facilities reporting fewer than 25 respondents were excluded from analyses.
– FY 2020 includes results from FY 2020 Q1–Q3 for direct care and FY 2020 Q1–Q2 for purchased care. Percentage change is not calculated for number of respondents due to FY 2020 not including four quarters of data.
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration.

VARIABILITY IN TRISS OVERALL HOSPITAL RATINGS, FYs 2017–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/16/2020

Notes:

– Inpatient facility scores were used above, and facilities reporting fewer than 25 responses in the time period were excluded from analyses.
– FY 2020 includes Q1–Q3 for direct care and Q1–Q2 for purchased care results.
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration.
– HCAHPS benchmarks are U.S. scores from the October 2017 (72 percent), October 2018 (73 percent), October 2019 (73 percent), and October 2020 (73 percent) HCAHPS Public Reports. More information about these benchmarks can be found at: https://hcahpsonline.org/en/summary-analyses/.

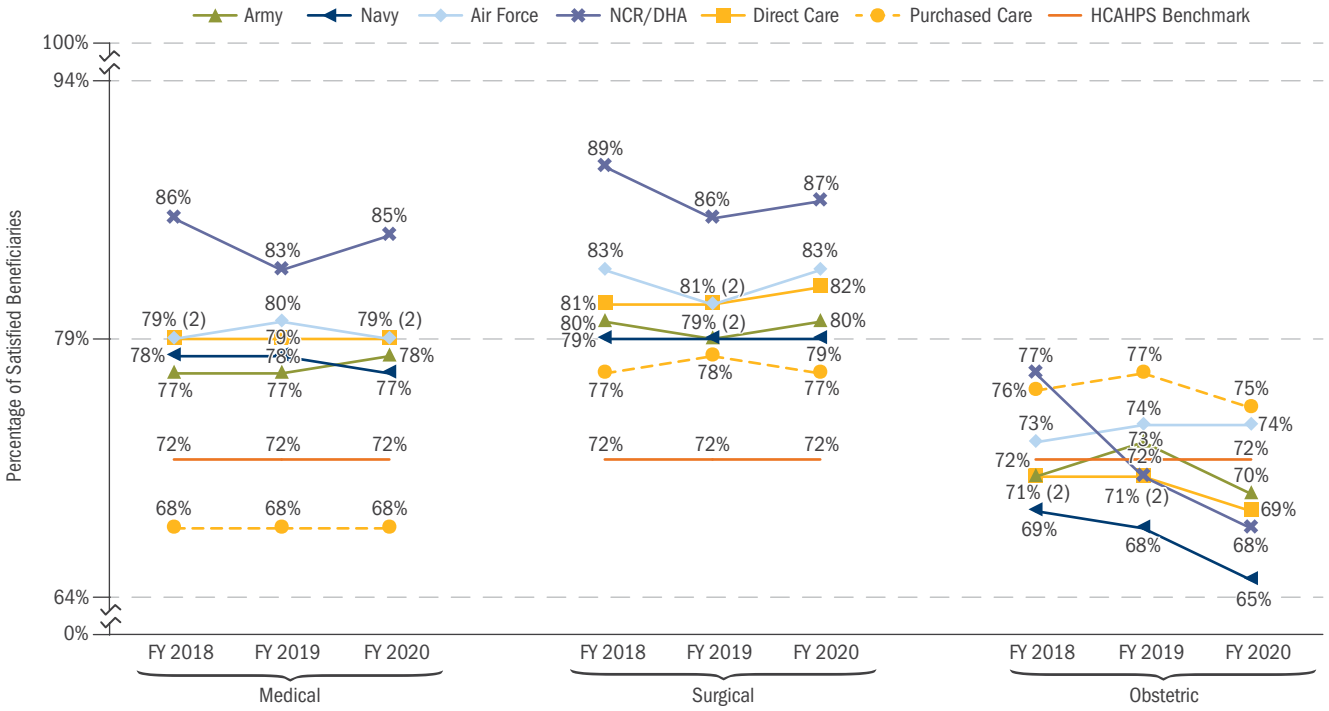
HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient-Centered Care/Experience *(cont.)*

Beneficiary Recommendation of Hospital Following Inpatient Treatment

Results for Recommend Hospital follow similar trends to those for Overall Hospital Rating from FY 2018 to FY 2020. Both the medical and surgical product lines remain above the HCAHPS benchmarks, with the exception of purchased care scores for the medical product line. For the obstetric product line, purchased care and Air Force scores remain steadily above the benchmark. Although NCR/DHA scores were well above the benchmark in FY 2018 for the obstetric product line, there has been a steady decline in inpatient recommendation scores from FY 2019 to FY 2020.

TRISS RECOMMEND HOSPITAL TRENDS, FYs 2018–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/16/2020

Notes:

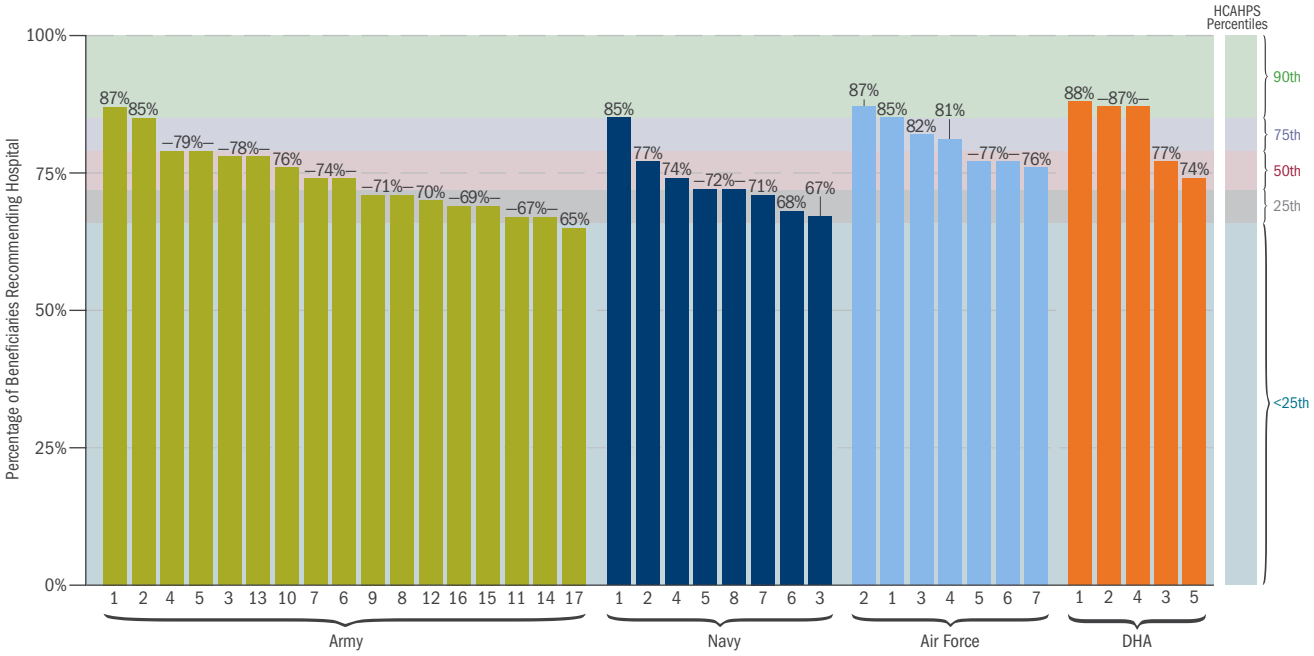
– FY 2020 includes results from FY 2020 Q1–Q3 for direct care and the Services and Q1–Q2 for purchased care.
– HCAHPS benchmarks are the U.S. scores from the October 2018, July 2019, and July 2020 HCAHPS Public Reports. More information about these scores can be found at: https://www.hcahpsonline.org/en/summary-analyses/.
– The NCR category is represented by the FY 2018 data points and is made up of parent facilities FBCH and WRNMMC. Parent facilities FBCH, WRNMMC, 81st Medical Group at Keesler Air Force Base, Womack Army Medical Center, and Naval Hospital Jacksonville compose the DHA category from FY 2019 Q1 through FY 2020 Q3.
– Sites that migrated to MHS GENESIS were sampled in FY 2018 Q3 after migration and in FY 2019 Q4 after migration.
– For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

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

Patient-Centered Care/Experience *(cont.)*

The chart below shows the distribution for Recommend Hospital of direct care inpatient facilities and how these ratings compared with the national HCAHPS percentiles. Eight facilities had ratings that reached the HCAHPS 90th percentile: two Army, two Air Force, one Navy, and three DHA. Four facilities had ratings in the HCAHPS 75th percentile; 14 facilities had ratings in the HCAHPS 50th percentile. The remaining facilities were below the HCAHPS 50th percentile.

TRISS RECOMMEND HOSPITAL: DIRECT CARE, FY 2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/16/2020

Notes:

- FY 2020 includes results from FY 2020 Q1–Q3 for direct care and the Services.
- Facilities that have fewer than 25 responses do not have a score displayed above.
- Sites that migrated to MHS GENESIS were sampled in FY 2019 Q4 after migration.
- The increment of the above percentiles was set at <25th, 25th, 50th, 75th, and 90th. Percentiles are based on nationally representative civilian and military facility scores (July 2020 Public Report: October 2018–September 2019 discharges). More information about these percentiles can be found at: https://www.hcahpsonline.org/en/summary-analyses/.

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

Patient-Centered Care/Experience *(cont.)*

The table below displays the extent to which the ratings of Recommend Hospital changed over time in terms of improvement (increasing mean or median) or decreased dispersion (reduced range).

- From FY 2017 to FY 2020, direct care reflects a slight decrease in the mean, and a decrease of almost two percentage points in the median ratings.
- Scores in the 25th percentile decreased by two percentage points with a slight improvement seen in the 75th percentile with an increase of less than one percentage point.
- There was a decrease of four percentage points in the range between the lowest- and highest-performing inpatient facilities for direct care.
- From FY 2017 to FY 2020, purchased care scores have changed minimally in terms of the mean and median ratings. The range between the lowest- and highest-performing civilian hospital shows an increase of approximately one percentage point.

TRISS RECOMMEND HOSPITAL RATING: FYs 2017–2020

	FY 2017	FY 2018	FY 2019	FY 2020	% POINT CHANGE (FY 2017–FY 2020)
DIRECT CARE					
Number of Respondents	45,109	39,209	36,860	23,995	
Weighted Mean	76.6%	77.8%	77.5%	76.3%	–0.3
Standard Deviation	6.1%	6.3%	6.0%	6.7%	0.6
Median	77.7%	76.2%	76.2%	76.1%	–1.6
75th Percentile	81.8%	81.3%	80.6%	82.0%	0.2
25th Percentile	73.2%	73.0%	73.4%	70.8%	–2.4
Maximum	90.4%	98.0%	94.4%	87.5%	–2.9
Minimum	64.4%	60.0%	67.5%	65.1%	0.7
Range	26.0%	37.9%	26.8%	22.3%	–3.7
PURCHASED CARE					
Number of Respondents	21,142	20,966	20,644	20,035	
Weighted Mean	75.3%	73.4%	73.5%	73.5%	–1.8
Standard Deviation	7.6%	9.6%	10.0%	9.4%	1.8
Median	76.0%	73.9%	73.7%	74.5%	–1.5
75th Percentile (Q3)	81.6%	79.8%	81.2%	81.8%	0.2
25th Percentile (Q1)	68.9%	67.9%	68.3%	67.7%	–1.2
Maximum	88.5%	89.4%	89.2%	89.7%	1.2
Minimum	52.4%	47.8%	48.2%	52.3%	–0.1
Range	36.1%	41.6%	41.1%	37.4%	1.3

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/16/2020

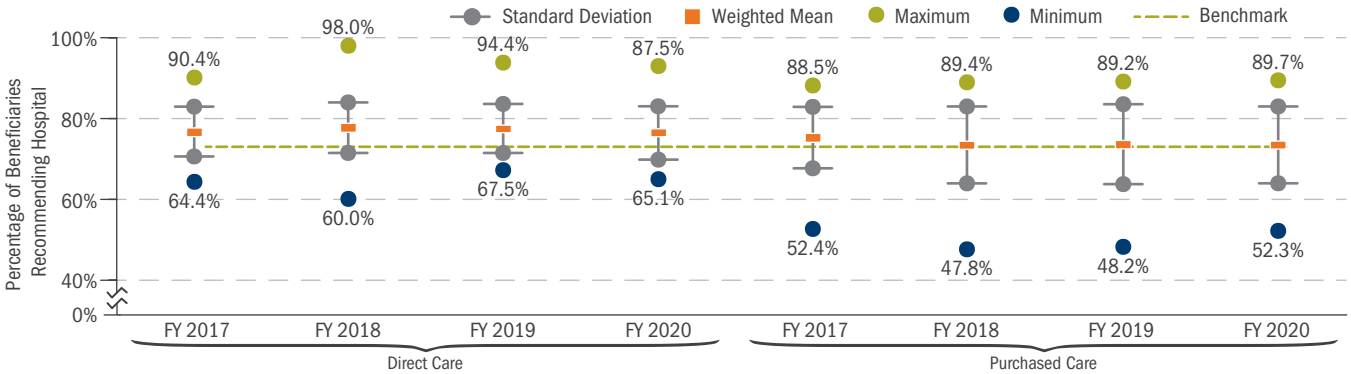
Notes:

– Inpatient facilities scores were used in the table above, and facilities reporting fewer than 25 respondents were excluded from analyses.

– FY 2020 includes results from FY 2020 Q1–Q3 for direct care and Q1–Q2 for purchased care. Percentage change is not calculated for number of respondents due to FY 2020 not including four quarters of data.

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

VARIABILITY IN TRISS RECOMMEND HOSPITAL RATINGS, FYs 2017–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/16/2020

Notes:

– Inpatient facility scores were used above, and facilities reporting fewer than 25 responses in the time period were excluded from analyses.

– FY 2020 includes results from FY 2020 Q1–Q3 for direct care and Q1–Q2 for purchased care.

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

– HCAHPS benchmarks are U.S. scores from the October 2017 (72 percent), October 2018 (72 percent), October 2019 (73 percent), and July 2020 (72 percent) HCAHPS Public Reports. More information about these benchmarks can be found at: https://hcahpsonline.org/en/summary-analyses/.

Patient-Centered Care/Experience *(cont.)*

Patient Experience Star Ratings—Inpatient Facilities

Star ratings are used by CMS to enable consumers to assess patients' experience of care across health care facilities. The summary star rating for patient experience takes into account all 10 publicly reported HCAHPS measures, referenced on page 162, including Overall Hospital Rating and Recommend Hospital as components. Official star ratings for CY 2019, including for military hospitals in the United States, are posted publicly on the CMS Care 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 2019 Q4 to FY 2020 Q3. Three stars can be considered an "average" patient experience; therefore, most of the MHS facilities are performing above average in terms of patient care, with 28 four-star-rated facilities and four facilities rated as five-star.

PATIENT EXPERIENCE STAR RATINGS, FY 2019 Q4–FY 2020 Q3

★★★★★	★★★★	★★★
4 FACILITIES	28 FACILITIES	4 FACILITIES

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/23/2020
Note: One hundred responses to TRISS within the year were required to receive a summary star rating.

Patient-Centered Care/Experience *(cont.)*

Drivers of Patient Experience Ratings

Results from patient surveys have become increasingly important in measuring health plan performance, directing action to improve the beneficiary experience, and improving the quality of services provided by health care facilities. Patient surveys provide key insights into the patient's perception of the health care they received, as well as the importance of different aspects of their care in determining their overall experience, satisfaction, and ratings of hospital facilities.

As stated previously, three key beneficiary surveys measure self-reported access to and satisfaction with MHS direct and purchased care experiences:

- TRISS—event-based after a discharge from a hospital (based on HCAHPS)
- JOES-C—event-based following an outpatient visit, asking about health care plan rating (based on CG-CAHPS)
- HCSDB—population-based quarterly survey sampling MHS-eligible beneficiaries who may use the MHS or their own health insurance, asking about care received in the preceding 12 months (based on the CAHPS Health Plan Survey)

Results from these surveys for FY 2019 and FY 2020 (using all data available at the time of analysis) were modeled to identify key drivers of satisfaction. Drivers of satisfaction for all surveys of the direct care system were determined by examining the effects of composite scores on outcome variables. The models controlled for all composites and patient demographic variables, including beneficiary category, gender, Service, health status, and region. The statistical significance and effect size of odds ratios were used to rank drivers of satisfaction.

The table below shows that beneficiary satisfaction with health care provided in MTFs was driven primarily by communication between patients and providers, and getting care when needed. In addition to the above, use of information to coordinate care and treatment by staff were also important to beneficiary satisfaction. Results suggest that improving communication between beneficiaries and health care providers, ensuring hospital cleanliness, and providing care at the right time and location have the potential to influence a patient's health care experience and hospital satisfaction ratings.

TOP THREE DRIVERS OF SATISFACTION BY SURVEY: DIRECT CARE, FYs 2019–2020

	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 2019	#1	Communication with Nurses	How Well Providers Communicate with Patients	Provider Communication
	#2	Communication with Doctors	Helpful, Courteous, and Respectful Office Staff	Getting Needed Care
	#3	Cleanliness of Hospital Environment	Providers' Use of Information to Coordinate Care	Customer Service
FY 2020	#1	Communication with Nurses	How Well Providers Communicate with Patients	Provider Communication
	#2	Communication with Doctors	Helpful, Courteous, and Respectful Office Staff	Getting Needed Care
	#3	Cleanliness of Hospital Environment	Providers' Use of Information to Coordinate Care	Customer Service

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS results, compiled 12/16/2020, JOES-C results, compiled 12/16/2020, and HCSDB, FYs 2019–2020 (Q1–Q3 only for TRISS and JOES-C)

Notes:

– Composite measure generation followed guidelines established by AHRQ.
– TRISS followed HCAHPS composite construction found at: https://www.hcahpsonline.org/
– JOES-C followed CG-CAHPS version 3.0 guidelines detailed at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/cg/about/cg_3-0_overview.pdf
– HCSDB followed CAHPS guidelines provided at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/hp/about/measures_hp50_2109.pdf

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

Patient-Centered Care/Experience *(cont.)*

Drivers of Patient Experience Ratings—JOES

In addition to the TRISS, JOES-C, and HCSDB, the MHS also fields the JOES survey, which combined and standardized previous surveys used by the Army, Navy, Air Force, and NCR/DHA to learn about beneficiary health care experiences. The JOES aims to more efficiently gather beneficiary health care experiences so that the information obtained can be better utilized to improve care within and across the Services.

Respondent data from the JOES for FY 2019 and FY 2020 (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 2019–2020

	RANKING	SATISFACTION WITH HEALTH CARE	SATISFACTION WITH PROVIDER
FY 2019	#1	Provider Explained Things in a Way That Was Easy to Understand	Provider Explained Things in a Way That Was Easy to Understand
	#2	Provider Knew Important Medical History	Provider Knew Important Medical History
	#3	Provider Treated Patient with Courtesy and Respect	Provider Treated Patient with Courtesy and Respect
FY 2020	#1	Provider Explained Things in a Way That Was Easy to Understand	Provider Explained Things in a Way That Was Easy to Understand
	#2	Provider Knew Important Medical History	Provider Knew Important Medical History
	#3	Ease of Making an Appointment	Provider Treated Patient with Courtesy and Respect

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES results, FYs 2019–2020, compiled 12/16/2020
Note: JOES questions continue to be updated over time; drivers analysis was based on the most recent survey questions.

Patient-Centered Care/Experience *(cont.)*

Best Practices to Foster Positive Patient Experience

In addition to the patient experience quantitative survey analyses in the preceding pages (pages 94–106; 162–171), the DHA also frequently conducts special qualitative analyses and interviews with MTF staff and leadership to identify potential leading practices that foster positive patient experience across the MHS. The following section highlights findings of best practices from interviews with various MTFs that scored high on patient experience measures from the JOES, JOES-C, or TRISS.

Best Practices to Improve Laboratory Patient Experience

The DHA is prioritizing standardizing laboratory practices across the MHS using "best practices" models. Three facilities with the highest patient experience scores for laboratory were interviewed to identify leading practices—Farrelly Army Medical Hospital (AMH), Naval Hospital (NH) Sigonella, and Air Force 325th Medical Group (MDG) Tynall. Best practices identified include:

- Providing patient-centered care focused on increased accessibility (e.g., walk-in lab testing, proximity of services, minimizing wait times, providing Wi-Fi while waiting)
- Utilizing effective communication between patient and staff to explain processes and set patient expectations
- Ensuring leadership is approachable and able to engage with patients, and empowering staff to work autonomously

Best Practices to Improve Pharmacy Patient Experience

The DHA is also prioritizing standardizing pharmacy practices across the MHS. Three facilities with the highest patient experience scores for pharmacy were interviewed to identify leading practices—Keller Army Community Hospital (ACH), NH Naples, and Air Force 14th MDG Columbus. Best practices identified include:

- Providing patient-centered care focused on customer service (e.g., anticipating patient needs and proactively reaching out to patients)
- Utilizing effective communication between staff members with daily huddles and regular check-ins to track obstacles and encourage team learning
- Implementation and utilization of hospital systems that allow pharmacists to easily connect with physicians and other MTF staff

Best Practices for Hospital Environment

Beginning in FY 2020, TRISS added seven hospital environment metrics (food variety/temperature, mattress comfort, room temperature/privacy, hospital signage, parking). Keller ACH was the highest scoring MTF for food variety/temperature and mattress comfort in FY 2020 Q1. Best practices from Keller ACH for food quality include:

- Utilization of a room-service dining model with patient choice and flexibility in food selections
- Focus on customer service during dining with weekly test meal inspections and face-to-face staff rounding

Best practices for mattress comfort include:

- Advanced research and a close working relationship with the regional medical materials office and SMEs to ensure the mattresses meet patient needs (specific bed types for post-surgical patients, etc.)

Best Practices for Discharge Information and Hospital Cleanliness for Obstetrics Patients

NH Bremerton often scores high on discharge information and hospital cleanliness compared to the civilian benchmark and other MTFs. Best practices at NH Bremerton for discharge information include:

- "What to Expect" handout given before surgery
- Customized, detailed obstetrics booklet distributed to all new parents
- Discharge occurs across several hours so staff and patients do not feel rushed
- Comprehensive training and daily staff huddles

Best practices for hospital cleanliness include:

- Multiuse items have visible green tape noting when the item was cleaned and by whom
- Cleaning schedules documented for every room
- Following delivery, housekeeping is available to clean room as soon as patient is comfortable

Patient-Centered Care/Experience *(cont.)*

Overall Outpatient Clinic Best Practices

In FY 2020 Q2, one of the highest scoring outpatient clinics in the MHS was 60th MDG Travis Oncology Clinic. Best practices from the 60th MDG for overall patient satisfaction include:

- Enforcing a proactive customer service–driven environment, including focus on front desk staff, creating a positive patient experience
- Providing patient-centered care with longer appointment times, covering several areas of health care

In FY 2020 Q2, Naval Hospital Center (NHC) Camp Lejeune was also one of the highest scoring outpatient clinics in the MHS. Best practices from NHC Camp Lejeune for overall patient satisfaction include:

- Providing community-centered care including strong relationship between the base and MTF as well as strong civilian community support and working relationships (e.g., Level III Trauma Center)
- Patient satisfaction recognized at all levels, including from leadership and community members, with ongoing and regular monitoring of patient feedback

In FY 2020 Q3, 48th MDG Lakenheath Internal Medicine Clinic was one of the highest scoring outpatient clinics in the MHS. Best practices from the 48th MDG for overall patient satisfaction include:

- Providing comprehensive, personalized patient care with longer appointments to address all patient concerns including preventative care as well as strong patient-provider continuity
- Utilizing TRICARE Online services to increase patient involvement and promote transparency and patient education
- Providing flexible, often same-day appointments and using telehealth, especially during the COVID-19 pandemic

In FY 2020 Q3, 375th MDG Scott Pediatric Clinic was also one of the highest scoring outpatient clinics in the MHS. Best practices from the 375th MDG for overall patient satisfaction include:

- Promoting a culture of dignity and respect across the facility that fosters open communication among staff, a positive quality of work life, and strong leadership engagement
- Focusing on high-quality care and open dialogue with patients, including continuity of care during the pandemic
- Collaborating and communicating with staff from various clinics

Factors Influencing the Experience of Obstetric Care Patients

In addition to specific MTF leading practices, inpatient survey comments for obstetric care patients were analyzed to identify factors influencing their experiences. Historically, obstetric care scores have been lower than patient experience scores for other product lines; thus, it is important to understand why in order for the DHA to understand and improve the patient experience for obstetric patients. This analysis of obstetrics patient comments is done annually and the results are from the most recently conducted analysis. By analyzing TRISS patient comments, we found:

- Patients felt engaged in decision making and that their birth plans were respected.
- Patients felt well-informed when engagement was prioritized.
- Staff were described as caring, helpful, supportive, attentive, knowledgeable, and professional.

Potential areas for improvement included:

- Amenities: cleanliness of patient rooms, unavailable accommodations for spouses, and food service/quality
- Provider-patient communication issues, specifically related to pain management and admitting patients in (possibly early) labor
- Discharge issues (e.g., being rushed, no wheelchairs, paperwork mishaps)
- Limited availability of lactation consultants

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

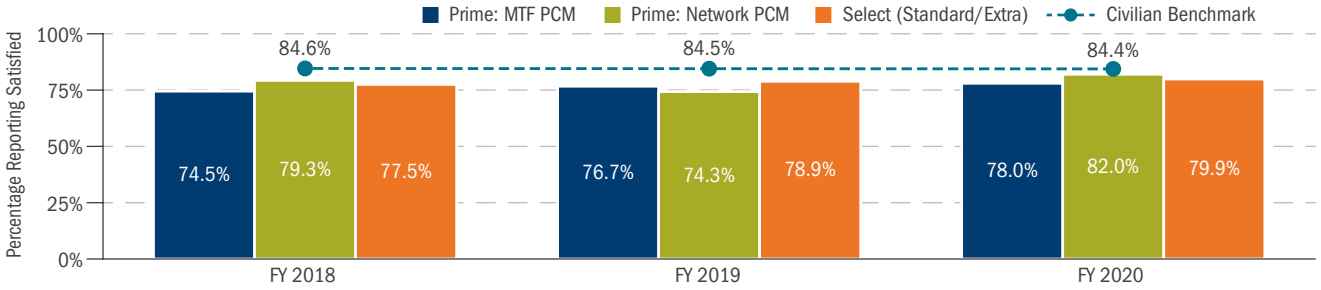
Patient-Centered Care/Experience *(cont.)*

Satisfaction with Customer Service

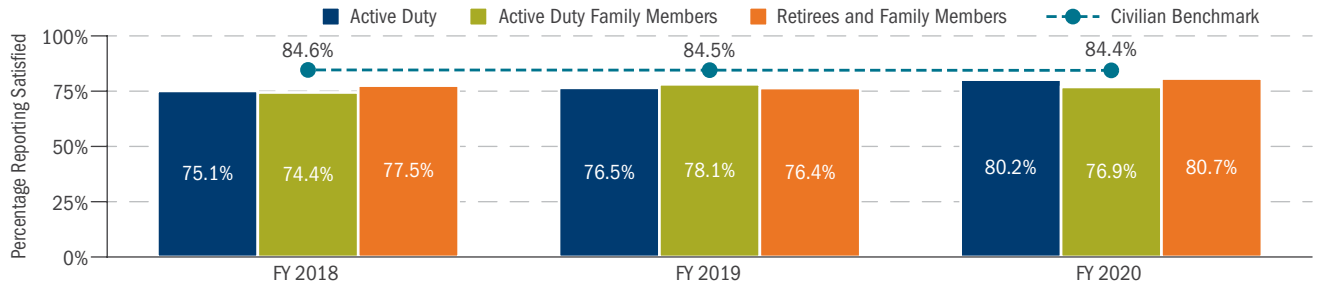
Most DoD health care beneficiaries participate in TRICARE in one of two ways: by enrolling in the Prime option or by using the traditional indemnity option for seeing participating or network providers (TRICARE Select in FYs 2018–2020). Access to and understanding written materials about one's health plan are important determinants of overall satisfaction with the plan.

- MHS beneficiary satisfaction with customer service in terms of understanding written material, getting customer assistance, and dealing with paperwork improved for Prime enrollees with an MTF PCM and for non-enrolled beneficiaries from FY 2018 to FY 2020 and improved for Prime enrollees with a network PCM from FY 2019 to FY 2020. The civilian benchmark remained steady over the same period.
- Satisfaction with customer service for all enrollment groups was lower than the civilian benchmark in FY 2020.
- MHS beneficiary satisfaction with customer service improved for Active Duty and remained stable for ADFMs and RETFMs between FY 2018 and FY 2020. 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 2020.

TRENDS IN RESPONSIVE CUSTOMER SERVICE: COMPOSITE MEASURE OF FINDINGS (UNDERSTANDING WRITTEN MATERIAL, GETTING CUSTOMER ASSISTANCE, AND DEALING WITH PAPERWORK) BY ENROLLMENT STATUS, FYs 2018–2020



TRENDS IN RESPONSIVE CUSTOMER SERVICE: COMPOSITE MEASURE OF FINDINGS (UNDERSTANDING WRITTEN MATERIAL, GETTING CUSTOMER ASSISTANCE, AND DEALING WITH PAPERWORK) BY BENEFICIARY CATEGORY, FYs 2018–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 10/15/2020

Note: "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used in 2018–2020 come from NCQA's 2017 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends

OTHER PLANS AND PROGRAMS

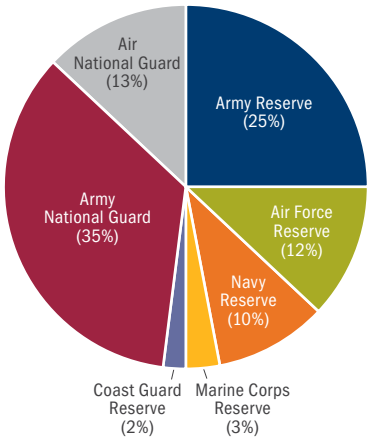
TRICARE Benefits for the Reserve Component

TRICARE offers a broad array of benefits coverage for Reserve Component (RC) members who qualify and their eligible family members pre-deployment, during deployment, post-deployment, and into retirement.

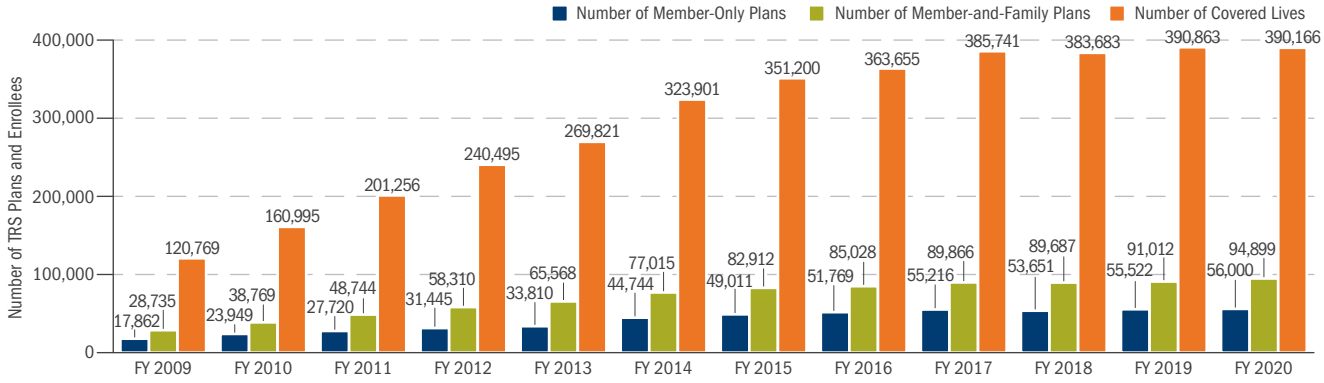
TRICARE Reserve Select (TRS). The premium-based TRS health plan features TRICARE Select coverage for purchase by qualified members of the Selected Reserve. TRS plateaued over the last three years at around 146,000 plans before dropping in 2020 to 111,000 plans. The chart below shows TRS enrollment since October 1, 2007, when the NDAA FY 2007 enacted current TRS qualifications.

- As shown in the pie chart at right, Army National Guard and Army Reserve combined constitute 60 percent of the 335,241 TRS members.
- The 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).

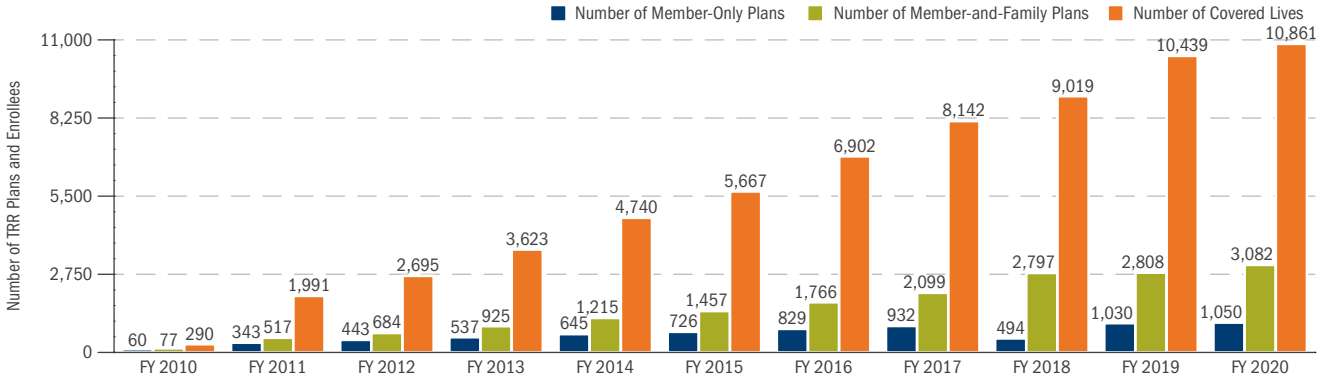
TRICARE RESERVE SELECT: POPULATION BY COMPONENT (335,241 SPONSORS AND FAMILY MEMBERS AS OF SEPTEMBER 2020)



TRENDS IN RC ENROLLMENT IN TRS, SEPTEMBER 2009–SEPTEMBER 2020



TRENDS IN ENROLLMENT IN TRR, OCTOBER 2010–SEPTEMBER 2020



Source: Defense Manpower Data Center (DMDC)/Defense Enrollment Eligiblity Reporting System (DEERS) Medical Policy Report, September 2020
Note: For FY 2020, individual plans are an estimate based on prior year, due to changes in how the data are recorded in the M2 database.

OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Benefits for the Reserve Component *(cont.)*

TRICARE Retired Reserve (TRR). Qualified members of the Retired Reserve may purchase full-cost, premium-based coverage under TRR until they reach age 60. Upon reaching age 60 and receiving retired pay, they and their eligible family members may enroll in an available TRICARE health plan for retirees.

TRR enrollment continued to grow in a linear fashion. By the end of FY 2020, TRR covered over 10,800 Retired Reserve members and their families in 3,900 member-only and member-and-family plans.

TRS and TRR Costs. Both TRS and TRR adopted the new TRICARE Select cost-sharing structure (Group B) on January 1, 2018.

TRR members pay the full cost of the premium unlike TRS, where the member's share of the premium is only 28 percent, with the Department absorbing the rest. Premiums are calculated annually for both TRS and TRR and are derived from actual prior year costs. Premium rates for CY 2020 are as follows:

MONTHLY PREMIUMS FOR TRS AND TRR, CYs 2020–2021

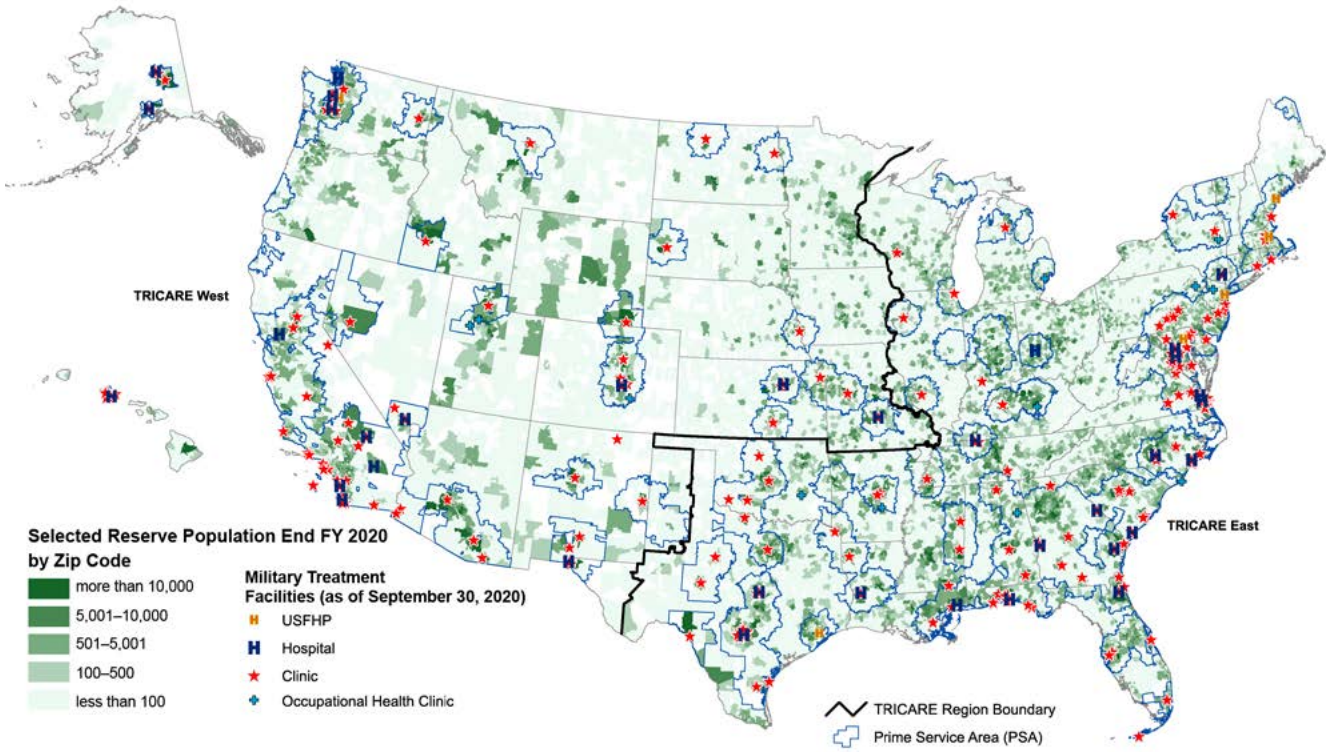
TYPE OF COVERAGE	CY 2020 MONTHLY	CY 2021 MONTHLY	% CHANGE
TRS Member Only	$44.17	$47.20	6.4%
TRS Member and Family	$228.27	$238.99	4.5%
TRR Member Only	$444.37	$484.83	8.4%
TRR Member and Family	$1,066.26	$1,165.01	8.5%

Source: TRS and TRR data from https://tricare.mil/Costs/Compare, accessed 12/23/2020

OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Benefits for the Reserve Component *(cont.)*

SELECTED RESERVE POPULATION IN THE U.S. RELATIVE TO MTF, PRIME, AND NON-PRIME SERVICE AREAS (PSAs), END OF FY 2020



COMPARISON OF SELECTED RESERVE AND ACTIVE DUTY SPONSORS AND FAMILY MEMBER PROXIMITY TO MTFs, END OF FY 2020[a]

BENEFICIARY GROUP[b]	POPULATION TOTAL	POPULATION IN PSAs	POPULATION IN MTF SERVICE AREAS	% IN MTF SERVICE AREAS
Active Duty and Their Families	3,310,902	3,021,955	2,877,306	87%
Selected Reserve and Their Families	1,903,412	1,300,277	1,039,135	52%
Select Reserve and Their Families, Overseas or Unknown	119,217			
Total Select Reserve and Their Families, Worldwide	2,022,629			

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, population as of 1/19/2021

Notes:

[a] Eligible MHS beneficiary data from the MDR DEERS, as of 9/30/2020. Residential ZIP code was used as the location for all beneficiaries.

[b] Location information determined by DHA Catchment Area Directory database, September 2020.

Definitions:

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

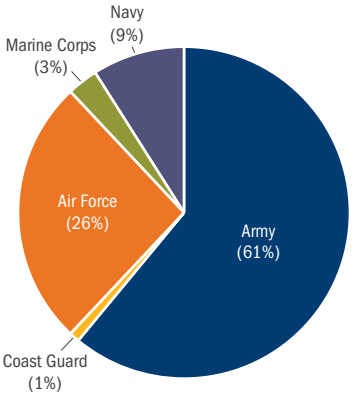
– MTF Service Area is defined by ZIP code (centroids), which are within a 40-mile radius of an active MTF (inpatient or outpatient), subject to overlap rules, barriers, and other policy overrides.

OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Benefits for the Reserve Component *(cont.)*

- As of August 30, 2020, there were more than 2 million Selected Reserve members and their families (2,143,444), of which 801,630 were sponsors and 1,341,808 were family members.
- Over 68 percent of Selected Reserve and their family members (almost 96 percent for Active Duty and their family members) in the U.S. lived in localities where TRICARE Prime was offered (see table on page 177). Slightly more than half (almost 55 percent) of this population lived near an MTF, compared with 93 percent of Active Duty and their family members.
- As shown in the pie chart, almost two-thirds (61 percent) of the worldwide Selected Reserve population of 2 million sponsors and their family members are Army National Guard (39 percent) and Army Reserve (24 percent).

SELECTED RESERVE POPULATION (2,143,444): SPONSORS AND FAMILY MEMBERS BY SERVICE (SEPTEMBER 2020)



Source: DEERS Database Extract

TRS TAKE RATE

	TOTAL
Selected Reserve End Strength	**801,630**
Federal Employees Health Benefits Plan (FEHBP)	(113,121)
On Active Duty (AD)	(72,218)
On Early Identification or Early Eligibility (E-ID)	(28,644)
On TAMP	(49,262)
Adjusted TRS Eligible Population	**493,658**
Enrolled TRS Sponsors	126,980
Take Rate for Eligible Population	**25.72%**

Source: ODASD/MPP eligibility data as of 12/30/2014, provided 12/10/2015 and M2, November 2020.

Notes:

– Data in table are unchanged since being provided in the FY 2016 TRICARE Evaluation report (page 66); Office of Personnel Management (OPM) data unavailable for updating as of this writing.

– Selected Reserve end strength subcategories are mutually exclusive counts based on precedence of category (e.g., FEHBP, then AD, then E-ID, then TAMP). End of CY 2014 data are the latest available match results for the DoD-OPM match to identify RC members with FEHBP.

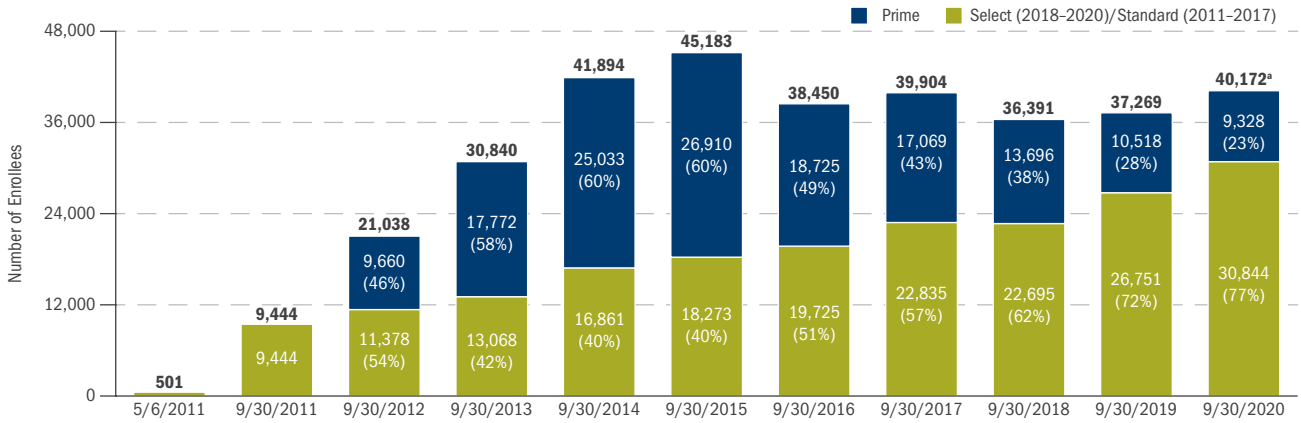
OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Young Adult

The TRICARE Young Adult (TYA) program is a premium-based TRICARE plan available for purchase by qualified adult-age children who lose eligibility for TRICARE due to age. TYA offers Prime and Select coverage across all TRICARE plans (Prime, Prime Remote ADFM, Prime Overseas, Prime Overseas Remote, Select, Select Overseas, TRR, TRS, and USFHP). Monthly premiums cover the full cost of the coverage with no government contribution. TYA meets the minimum essential coverage requirements of the Patient Protection and Affordable Care Act.

- As shown in the chart below, enrollment rose from over 37,000 in FY 2019 to over 40,000 in FY 2020. Enrollment in the TRICARE Select option accounted for 77 percent of total TYA enrollment.
- Based on actual prior year costs, TYA monthly premiums increased for CY 2021 from $376 to $459 per month for Prime and from $228 to $257 per month for Select (table below; see tricare.mil/Costs/HealthPlanCosts/TYA).
- Most TYA enrolled (89 percent) are family members of those who are not Active Duty. A detailed tabulation of enrollment by plan and beneficiary category is on page 35.

TRENDS IN TYA ENROLLMENT SINCE INCEPTION (MAY 2011–SEPTEMBER 2020)



[a] The number of FY 2020 TYA Select enrollees on this chart is slightly larger than the one shown on pages 34 and 35. There are 57 Medicare-eligible TYA Select enrollees that are included in the "Other" group on those pages because their number is too small to merit breaking them out separately.

MONTHLY TYA PREMIUMS, CYs 2017–2021

	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021
Prime	$319	$324	$358	$376	$459
Select (Standard)	$216	$225	$214	$228	$257

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, 1/20/2021

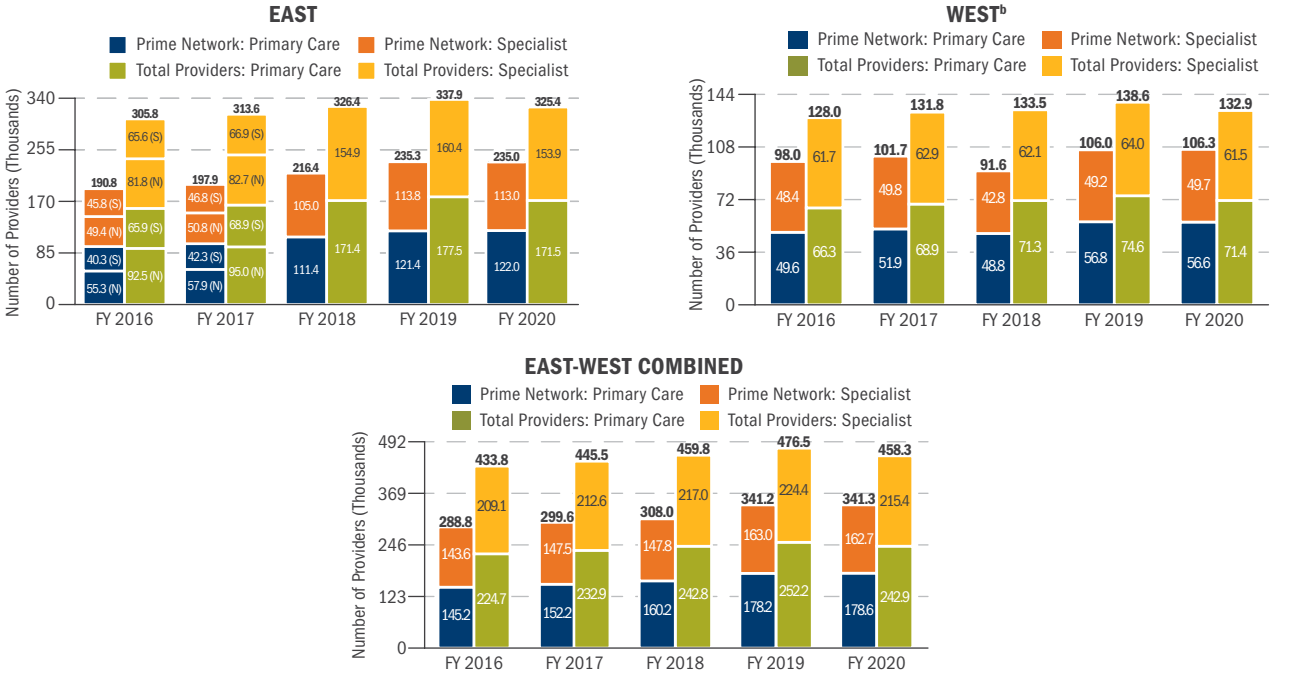
OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Provider Participation

The National Provider Identifier (NPI) is a unique identification number issued to health care providers in the U.S. by CMS. All HIPAA-covered individual health care providers and organizations must obtain an NPI for use in all HIPAA standard transactions. In this report, providers are counted using the NPI. The number of TRICARE-participating providers was determined by the number of unique providers filing TRICARE (excluding TRICARE for Life [TFL]) claims.[1] Providers were counted in terms of full-time equivalent (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 2016, the number of network primary care providers has increased at a higher rate (23 percent) than that of specialists (13 percent), and the total number of participating primary care providers has increased at a higher rate (8 percent) than that of total participating specialists (3 percent).[2]

- Between FY 2016 and FY 2020, the East Region saw an increase of 6 percent in the total number of TRICARE providers (4 percent in the former North Region and 10 percent in the former South Region), while the West Region saw an increase of 3 percent.
- The East Region saw an increase of 23 percent in the total number of network providers (24 percent in the former North Region and 22 percent in the former South Region), while the West Region saw an increase of 9 percent.
- The total number of TRICARE providers increased by 7 percent in PSAs and by 3 percent in non-PSAs (not shown).
- The number of network providers increased by 17 percent in PSAs and by 21 percent in non-PSAs (not shown).
- In FY 2020, 67 percent of all network providers and 66 percent of all participating providers were in PSAs (not shown).

TRENDS IN NETWORK AND TOTAL PARTICIPATING PROVIDER FTEs, FYs 2016–2020[a]



Source: MHS administrative data, 1/21/2021

[a] Network providers are TRICARE-authorized providers who have a signed agreement with the regional contractors to provide care at a negotiated rate. Participating providers include network providers and those non-network providers who have agreed to file claims for beneficiaries, to accept payment directly from TRICARE, and to accept the TRICARE allowable charge, less any applicable cost shares paid by beneficiaries, as payment in full for their services.

[b] The West Region includes Alaska.

Notes: The source for the provider counts shown above was the TRICARE purchased care claims data for each of the years shown, in which a provider was counted if he or she was listed as a TRICARE-participating provider. The claims also explicitly identify network providers. Numbers may not sum to bar totals due to rounding.

[1] Providers include physicians, physician assistants, nurse practitioners, and select other health professionals. Providers of support services (e.g., nurses, laboratory technicians) were not counted.

[2] Primary care providers were defined as general practice, family practice, internal medicine, obstetrics/gynecology, pediatrics, physician assistant, nurse practitioner, and clinic or other group practice.

OTHER PLANS AND PROGRAMS *(CONT.)*

Civilian Provider Acceptance of, and Beneficiary Access to, TRICARE Select

The DoD has completed a congressionally mandated four-year survey (2017–2020) of civilian providers and MHS non-enrolled beneficiaries, designed to determine civilian provider acceptance of, and beneficiary access to, the TRICARE Select benefit option. This survey complies with the requirements of NDAA FY 2015, section 712 (Public Law 113-291). This four-year survey is required as a follow-on to two previous four-year surveys completed from 2008 to 2011 (NDAA FY 2008, section 711, Public Law 110-181) and 2012 to 2015 (NDAA FY 2012, section 721, Public Law 112). The survey is licensed by the Office of Management and Budget (provider survey) and Washington Headquarters Service (beneficiary survey) and has been reviewed by the Government Accountability Office (GAO) as required by the guiding legislation.

- **Provider survey results and key points after four years:**
  - Over five of 10 providers overall (54 percent of physicians and nonphysician behavioral health providers) and eight of 10 physicians (75 percent) accept new TRICARE Select patients if they accept new patients of any insurance. These acceptance rates are statistically similar to the 2012–2015 benchmark survey for physicians (76 percent), and lower for all providers (59 percent).
  - Over eight of 10 providers (84 percent) and over nine of 10 physicians (93 percent) are aware of the TRICARE program in general (similar to the 2012–2015 benchmark, respectively, 84 percent for all providers and 93 percent for physicians).
  - Similar to the 2012–2015 and 2008–2011 benchmark surveys, behavioral health providers (including psychiatrists, psychologists, and nonphysician providers) report lower rates than physicians for awareness (76 percent) and acceptance (37 percent), pulling down the all-provider acceptance rates.
  - Primary care and specialist physicians report similar rates of awareness, while specialists report higher rates of acceptance. Specialists' acceptance (77 percent) is less than the 2012–2015 benchmark (80 percent).
  - Providers in non-PSAs report greater awareness and acceptance of new TRICARE Select and Medicare patients than do PSA providers.
- **Beneficiary survey results and key points after four years:**
  - Compared with the civilian benchmark, MHS non-enrolled beneficiaries who use TRICARE Select rate their care experience and access to care higher than or comparable to the civilian benchmarks (higher for two of four global measures; higher for one of four access measures). Access of TRICARE Select users to personal doctors and specialists is lower than civilian benchmarks.
  - Beneficiaries in non-PSAs reported higher rates of finding a personal doctor than those in PSAs. Other access measures do not differ significantly between PSAs and non-PSAs.
  - Provider and beneficiary results vary among PSAs, non-PSAs, and Health Service Areas, offering opportunities for improvement in some local areas for certain provider types (e.g., primary care in Portland and Eugene, Ore., or mental health care in the Bronx and Brooklyn, N.Y.).

During the time of this study, section 701 of NDAA FY 2017 replaced the non-enrolled TRICARE Standard program with the new enrollment-based TRICARE Select benefits program, effective January 1, 2018. Thus, these results combine experience of the new TRICARE Select program with the original TRICARE Standard program. This survey is useful in supporting evaluation of the effectiveness of TRICARE Select as it continues to mature.

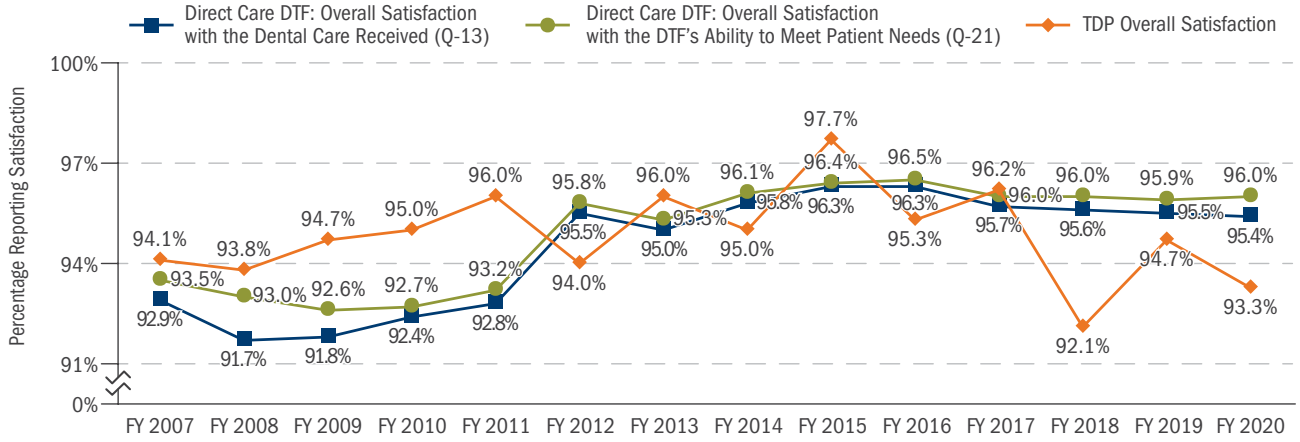
OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Dental Programs Customer Satisfaction

The overall TRICARE dental benefit is composed of several delivery programs serving the MHS beneficiary population. Consistent with other benefit programs, beneficiary satisfaction is routinely measured for each of these important dental programs.

- **Military Dental Treatment Facilities (DTFs)** are responsible for the dental care of about 1.64 million ADSMs worldwide and eligible family members residing OCONUS. The Tri-Service Center for Oral Health Studies (TSCOHS) completed 78,616 surveys in FY 2020. This is a substantial decrease from 131,059 completed surveys in FY 2019, potentially due to the COVID-19 pandemic. Reports of overall satisfaction have remained at around 96 percent since FY 2014.
- The **TRICARE Dental Program (TDP)** is a voluntary, premium-sharing dental insurance program available to eligible ADFMs, Selected Reserve and Individual Ready Reserve members, and their families. The TDP composite overall average enrollee satisfaction decreased from FY 2019 (94.7 percent) to FY 2020 (93.3 percent). As of September 30, 2019, TDP enrollment totaled 1,839,495 contracts, covering almost 2 million lives (1,858,526), 94 percent of which were in the U.S. The TDP network has 71,206 total dentists, a decline from the 73,085 in FY 2019—of which 56,865 are general dentists and 14,341 are specialists.

SATISFACTION WITH TRICARE DENTAL CARE: MILITARY AND CONTRACT SOURCES, FYs 2007–2020



Sources: TRICARE Dental Care Section, Health Plan Execution and Operations; Tri-Service Center for Oral Health Studies; and DoD Dental Patient Satisfaction Reporting website (Trending Reports), 12/9/2020

Notes:
– The dental satisfaction surveys are displayed above for ease of reference, but are not directly comparable because they are based on different survey instruments and methodologies.
– For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

OTHER PLANS AND PROGRAMS *(CONT.)*

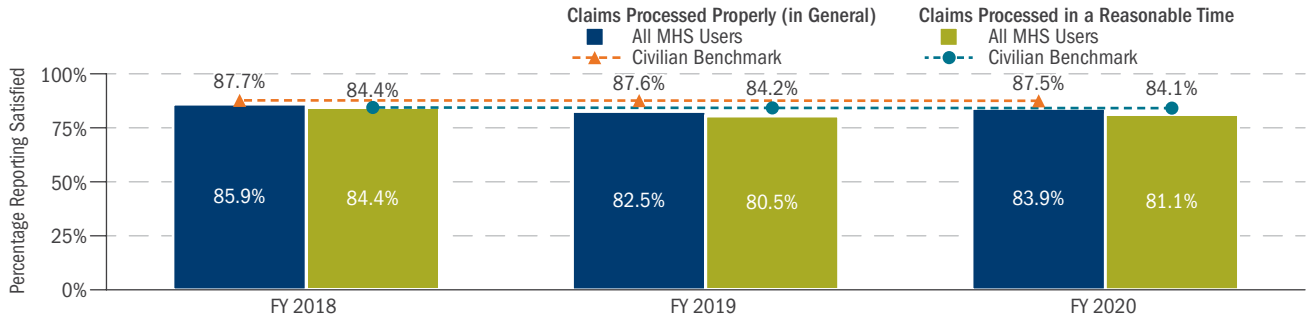
Customer Service, Claims Processing

Beneficiaries and their providers alike have an interest in the promptness and accuracy of claims processing and payment. The MHS monitors the performance of TRICARE claims processing through surveys of beneficiary perceptions and administrative tracking.

Beneficiary Perceptions of Claims Filing Process

- Satisfaction both with claims being processed properly and with processing speed decreased from FY 2018 to FY 2020. The civilian benchmarks remained stable over the same time period.
- MHS satisfaction levels with both the accuracy and the speed of claims processing were lower than the civilian benchmarks for FY 2020.

TRENDS IN SELF-REPORTED ASPECTS OF CLAIMS PROCESSING (ALL SOURCES OF CARE), FYs 2018–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 10/15/2020

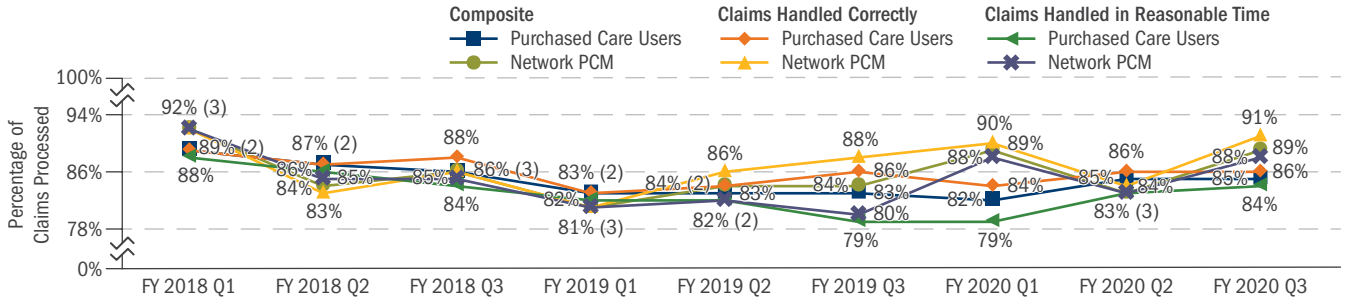
Note: "All MHS Users" applies to survey respondents in the 50 United States and the District of Columbia. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used in 2018–2020 come from NCQA's 2017 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

Trends in Claims Filing Process

TRICARE monitors claims processing to ensure compliance with contractual requirements and to ensure that our participating providers are paid on a timely basis. Claims processing for purchased care comprises three intervals: claims submission, claims processing, and transmission acceptance.

- **Claims Submission:** The claims submission interval is the time from the patient's last date of care to the date that the treating provider files a claim for payment with the Purchased Care Processing Contractor.
- **Claims Processing:** The Purchased Care Processing Contractor adjudicates the claim and sends a TRICARE Encounter Data (TED) record to DHA requesting payment. Claims processing includes the time needed for the Purchased Care Processing Contractor to ensure that the TED records pass all TRICARE validation edits (services are "Accepted").
- **Transmission Acceptance:** The transmission acceptance interval is the time between when DHA takes an "Accepted" TED record and when it identifies the appropriate program cost fund for payment. The accept date is defined as the "Last Update Date" in the TED record by current contracts. Contracts between DHA and MCSCs require that TED records be received by 10 AM Eastern time for DHA to accept the same day; otherwise, the cutoff moves the TED "Accepted" record to the next day.

TRENDS IN PURCHASED CARE/NETWORK PCM CLAIMS PROCESSING, FY 2018 Q1–FY 2020 Q3



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division; HCSDB, current as of FY 2020 Q3

Notes:

– Purchased care users are beneficiaries who rely on civilian care financed by TRICARE through Prime or Select.

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

OTHER PLANS AND PROGRAMS *(CONT.)*

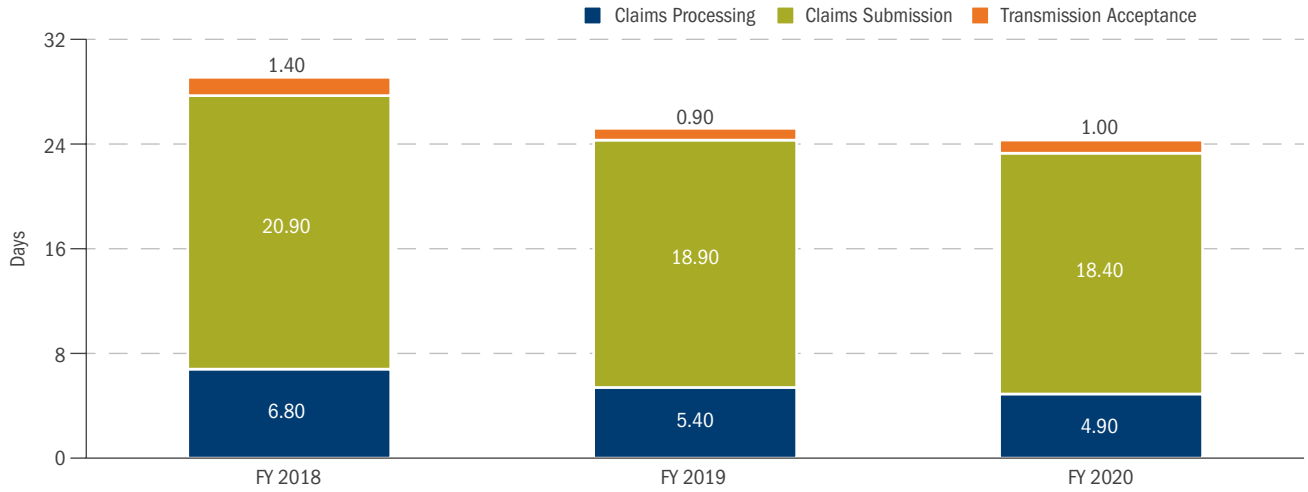
Customer Service, Claims Processing *(cont.)*

DHA pays MCSCs within seven days of the later of "Transmission Receive Date" or "Last Update Date," in compliance with contractual language. The chart below shows that TRICARE payments met time requirements, complying with managed care support contracts. It excludes paper claims and claims from OHI, pharmacy, TRICARE Dual Eligible Fiscal Intermediary Contract, and TRICARE Overseas Program contracts.

The most recent fiscal year continues the trend of decreases in overall processing times, with a 3.5 percent decrease from FY 2019. The lengthiest portion of claims processing consistently is claims submission—the time it takes for the treating provider to submit claims.

The chart shows results of analyses of claims counts of 38.6 million, 41.8 million, and 41.8 million for FY 2018, FY 2019, and FY 2020, respectively.

AVERAGE INTERVAL (DAYS) FOR CLAIMS PROCESSING, FYs 2018–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, MHS administrative data, 10/23/2020

POPULATION HEALTH

The Military Health System (MHS) is dedicated to Population Health management and engagement. Although this concept is generally associated with managing the clinical risks associated with patients, the MHS has extended this concept to include helping the population manage their own health and creating an environment where the healthy choice is the easy choice. The MHS model continues to evolve to include strategies such as strengthening the connections between our military medical treatment facilities (MTFs) and regional managed care support contractor (MCSC) engagement.

HEALTH PROMOTION AND DISEASE PREVENTION EFFORTS

This section presents efforts toward meeting the MHS aim of "Better Health," part of the Quadruple Aim, to include preventive care, population health, tobacco cessation, and obesity and condition management. This section also provides selected measures benchmarked to the Healthy People 2020 (HP 2020) goals. The HP 2020 goals are national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce those threats; these goals have been embraced by the Department of Defense (DoD).

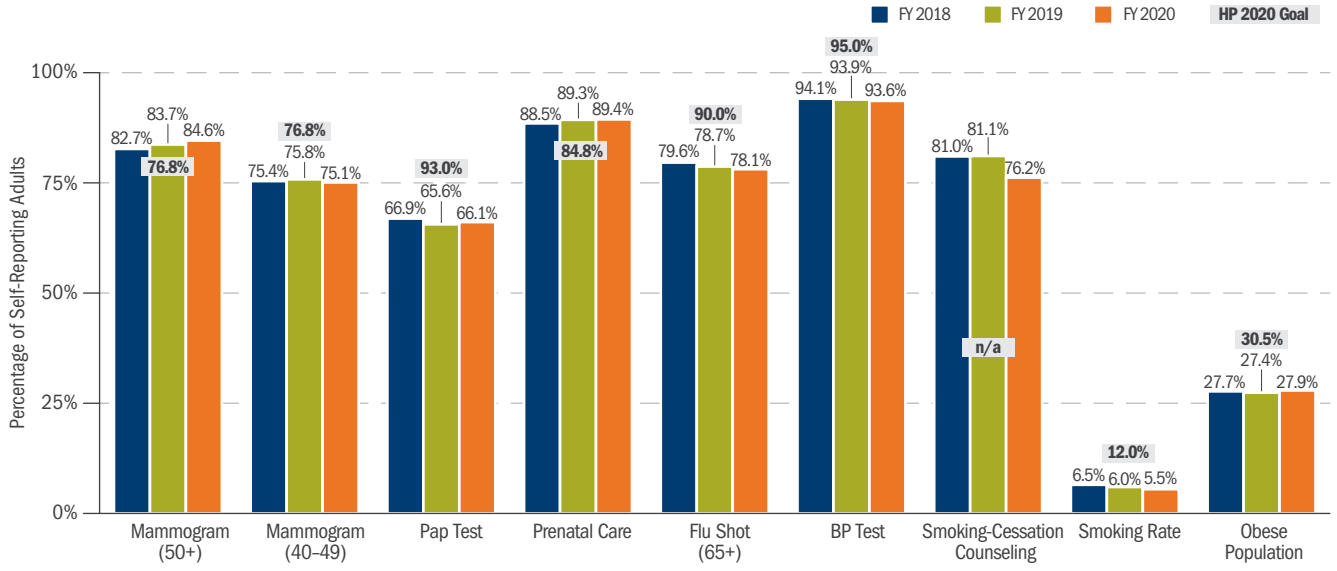
The MHS strategic goals go beyond those for primary health and wellness. The graphs on pages 186–190 reflect secondary prevention efforts via self-reported responses from all eligible MHS beneficiaries within the categories shown (e.g., all adult women over the age of 40 for mammography, all adult pregnant women for prenatal care, etc.). The graphs on pages 191–193 show Better Health Measures that are housed on the MHS Dashboard and use clinical records to track and assess enterprise performance on obesity/overweight prevalence and tobacco use/cessation counseling.

It should also be noted there were limitations imposed on preventive health care due to the COVID-19 national health pandemic, specifically for 2020 scores shown in the following section.

- 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:** According to self-reported Health Care Survey of DoD Beneficiaries (HCSDB) data, the percentage of age of MHS female beneficiaries receiving Pap tests remained stable from about 67 percent in fiscal year (FY) 2018 to about 66 percent in FY 2020. 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 5.5 percent in FY 2020, more than six percentage points below the HP 2020 goal of 12 percent for adults aged 18 years and over. Smoking-cessation counseling has decreased from 81 percent in FY 2018 to just over 76 percent in FY 2020 (pages 186–188). MHS Dashboard. MHS Dashboard measure data for tobacco use and counseling are available on page 191. These measures apply to the direct care population only and use different sources and methods. Therefore, the results differ from the survey-based measures. As of FY 2020 Q3, 22.3 percent of direct care beneficiaries screened for tobacco use were current users based on data from the MHS Dashboard.
- **Obesity:** Based on self-reported survey data, the overall proportion of MHS beneficiaries identified as obese held constant at slightly under 28 percent. This is below the HP 2020 goal of 31 percent (revised from 34 percent in 2012, consistent with reporting from the National Health and Nutrition Examination Survey [NHANES]) and below the most recently identified U.S. population average of 33.9 percent from 2005 to 2008 (Centers for Disease Control and Prevention [CDC] National Center for Health Statistics [NCHS], 2012; not shown). MHS Dashboard measure data for overweight and obesity are available on pages 192–193. These measures apply to the direct care population only and use different sources and methods. Therefore, the results differ from the survey-based measures.

HEALTH PROMOTION AND DISEASE PREVENTION EFFORTS *(CONT.)*

TRENDS IN MEETING PREVENTIVE CARE STANDARDS, FYs 2018–2020



Sources: Defense Health Agency (DHA)/Strategy, Plans, and Functional Integration (SP&FI) (J-5)/Analytics and Evaluation Division, 2018–2020 HCSDB http://www.tricare.mil/survey/hcsdbsurvey/home/z_reports.cfm, results provided 1/10/2020, NHANES; CDC, NCHS http://www.healthypeople.gov/2020/Data/SearchResult.aspx?ztopicid=29&topic=Nutrition+and+Weight+Status&objective=NWS-9&anchor=141.

Notes:

– The Trends in Meeting Preventative Care Standards estimates are for TRICARE users (i.e., enrollees of Prime, Select, or Retired Reserve) who are younger than 65.
– Unlike the objective for all other categories, the objective for Smoking Rate and Obese Population is for actual rates to be below the HP 2020 goals.
– The goal for Prenatal Care was revised from 77.6 percent to 84.8 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.

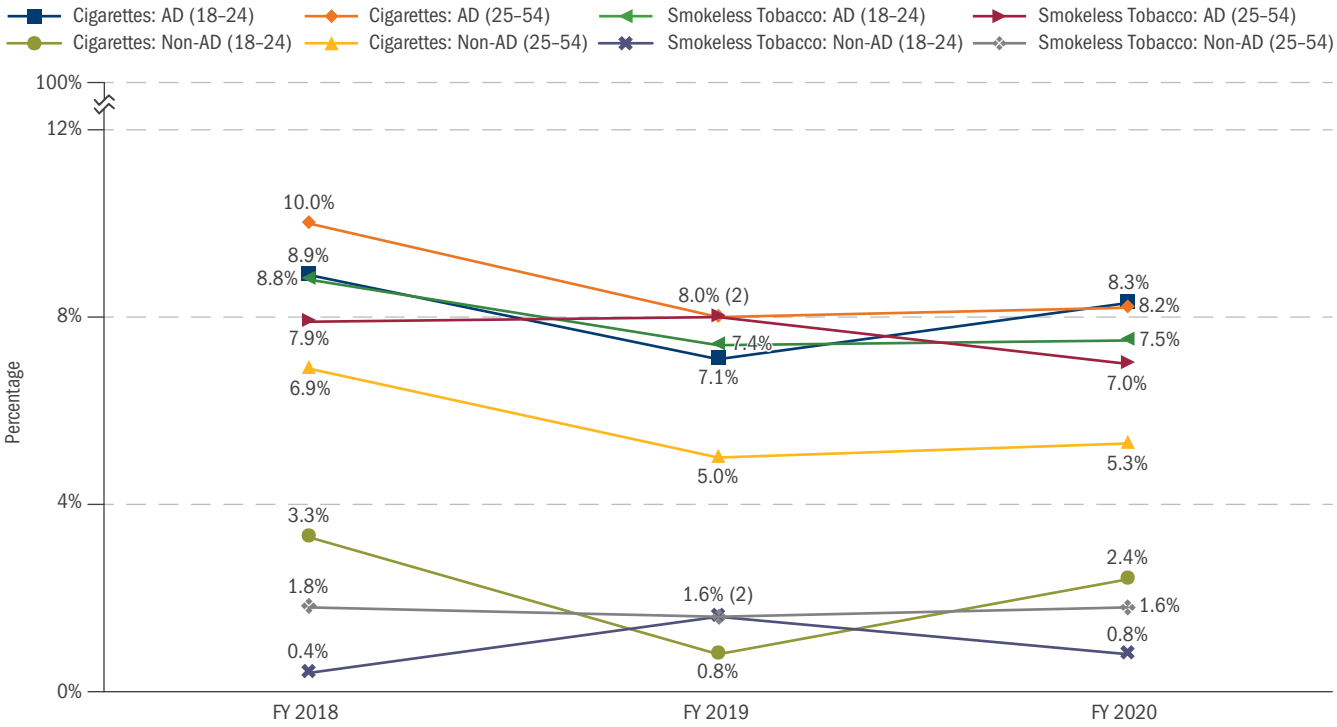
SELF-REPORTED PREVENTATIVE HEALTH MEASURE

Tobacco Cessation

Tobacco continues to be the leading cause of preventable death, according to the CDC, and smoking rates in the military remain higher than desired. Military personnel who smoke experience reduced physical performance capability, impaired night vision, increased risk of respiratory illnesses and surgical complications, delayed wound healing, and accelerated age-related hearing loss. Furthermore, there are negative impacts on dental readiness, and long-term effects of tobacco use often include cancer, stroke, emphysema, and heart disease.

- Based on self-reported usage, cigarette smoking for Active Duty Service members (ADSMs) of all ages statistically declined over the past six years: from 16 percent in FY 2013, leveling to 8 percent in FY 2020 (not shown). This trend in lower Active Duty (AD) cigarette usage is most pronounced in the 18- to 24-year-old age range (8 percent in FY 2020, compared with 7.8 percent in the U.S. among the same age group). Use of smokeless tobacco products in the 25- to 54-year-old age range by AD (7 percent) decreased by one percentage point from FY 2018 to FY 2020, but remained stable for non-Active Duty (non-AD) (2 percent). Non-AD appear to smoke cigarettes (5 percent in FY 2020) and use smokeless tobacco (1 percent) at lower rates than AD (not shown). AD and non-AD rates are lower than the reported U.S. national average for smoking cigarettes (13.7 percent, reported in 2018), while the non-AD smokeless tobacco rate is comparable to, or lower than, the national average (3.4 percent).

MHS CIGARETTE AND SMOKELESS TOBACCO USE RATES AMONG ACTIVE DUTY AND NON-ACTIVE DUTY, FYs 2018–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, 10/15/2020

Notes:

– Percentages are weighted for the probability of selection and nonresponse; variation in quarterly estimates may not be significant and should not be assumed as such without appropriate tests of significance.

– U.S. adult cigarette smoking rate of 13.7 percent, 7.8 percent for adults aged 18–24 from https://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/, accessed 1/10/2020.

– U.S. adult smokeless tobacco rate of 3.4 percent in 2016 from http://www.cdc.gov/tobacco/data_statistics/fact_sheets/smokeless/use_us/index.htm, accessed 1/10/2020.

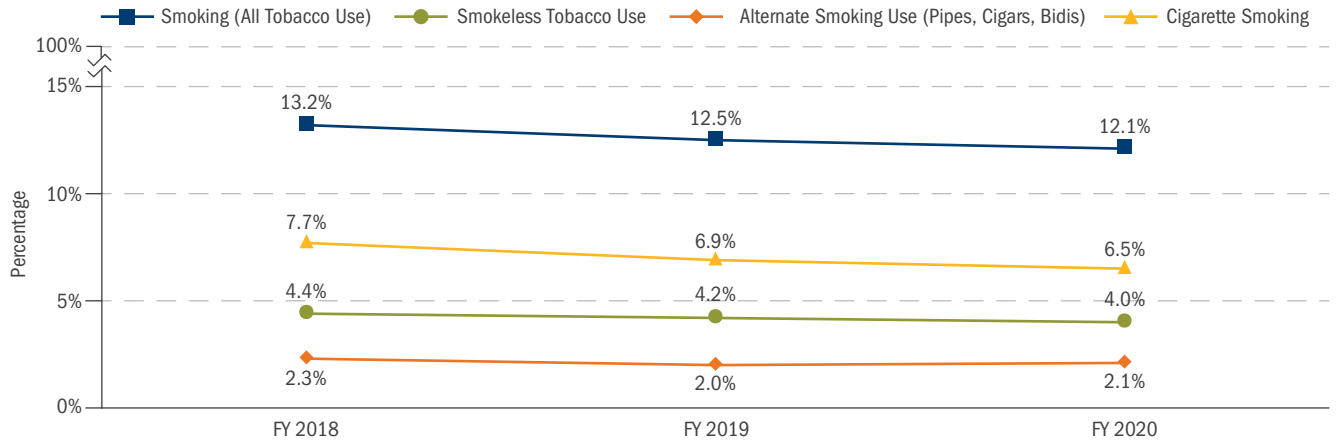
– For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

SELF-REPORTED PREVENTATIVE HEALTH MEASURE *(CONT.)*

Tobacco Cessation *(cont.)*

- **MHS Prime Enrollee Use of Any Tobacco Products:** Although attention has historically been focused on cigarette smoking, the HCSDB has also been directed to assess the use of various tobacco products across the MHS. The chart below presents the self-reported estimates of the prevalence of MHS Prime enrollees using different tobacco products (cigars, pipes, bidis, or kreteks). Prime enrollee use of tobacco in one form or another declined from 19 percent in FY 2013 to 12 percent in FY 2020.
- Cigarette smoking, which is the most used form of tobacco among Prime enrollees, declined from 13 percent in FY 2013 to 6 percent in FY 2020 (and statistically decreased over the past three years), while smokeless tobacco and alternate smoking use have remained nearly unchanged from FY 2018 to FY 2020 (at 4 percent and 2 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.

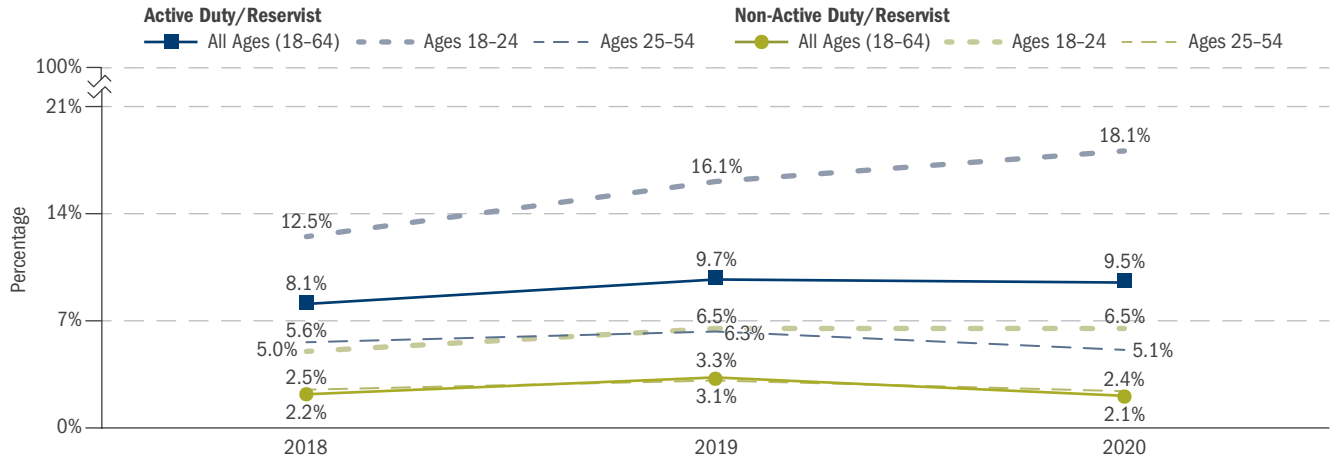
MHS PRIME ENROLLEE USE OF TOBACCO PRODUCTS, BY TYPE OF TOBACCO USE: CIGARETTES, ALTERNATE SMOKING TOBACCO, AND SMOKELESS TOBACCO, FYs 2018–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, 10/15/2020
Notes:
– Smokeless tobacco may include dip, snuff, snus, chew, etc., while alternate smoking tobacco may include cigars, pipes, hookahs, bidis, or kreteks.
– Percentages are weighted for the probability of selection and nonresponse; variation in quarterly estimates may not be significant and should not be assumed as such without appropriate tests of significance.

- Self-reported use of e-cigarette or vaping products in the 18 to 64 age range by AD (9.5 percent) increased by 1.4 percentage points from FY 2018 to FY 2020 but remained mostly flat for non-AD (2.4 percent) individuals in the same age range with a 0.1 percentage point decrease. The increase in reported usage among AD members is driven by the 18 to 24 age range where use rose from 12.5 percent in FY 2018 to 18.1 percent in FY 2020. AD reported higher use than non-AD for each age group.

E-CIGARETTE USAGE AMONG SELECT COHORTS, FYs 2018–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, 12/8/2020

SELF-REPORTED PREVENTATIVE HEALTH MEASURE *(CONT.)*

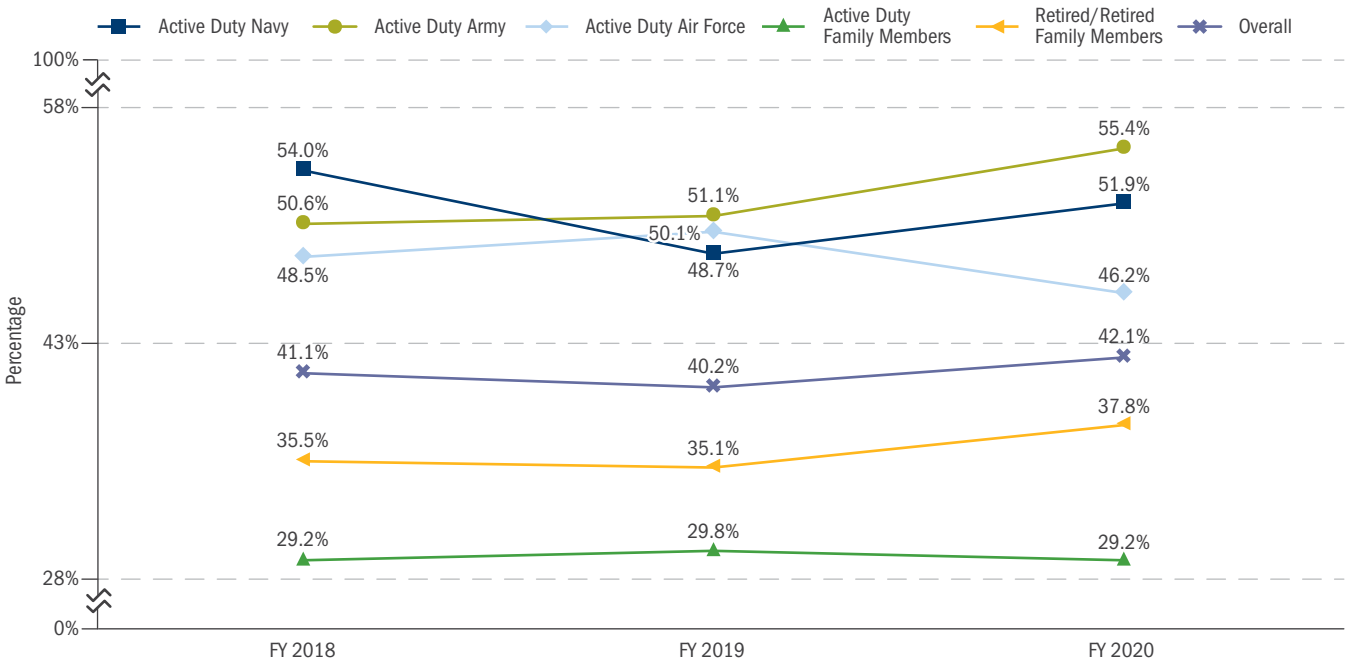
MHS Adult Obesity

This measure provides important information about the overall health of DoD beneficiaries for use by MHS leadership to help promote military initiatives that encourage exercise and healthy nutritional habits. These data can also shape the need for, and development of, medical interventions or modalities that are effective in maintaining healthy weights for all age groups.

The 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 chart below, 42.1 percent of all MHS beneficiaries were overweight in FY 2020. 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 37.8 percent. Calculated BMI rates reflecting overweightness may not be reflective of AD fitness without consideration of muscle mass, and may explain why AD appear to have high prevalence rates of being overweight but low obesity rates (14 to 15 percent), as shown in the second chart.

MHS OVERWEIGHT RATE (BMI 25–29.9), FYs 2018–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, 3/19/2021

Notes:

– BMI is defined as the individual's body weight divided by the square of his or her height. The formula universally used in medicine produces a unit of measure of kg/m^2. Because the HCSDB collects height and weight in inches and pounds, BMI is calculated as lb/in^2 x 703. A BMI of 18.5 to 25 may indicate optimal weight; a BMI lower than 18.5 suggests the person is underweight, while a number above 25 may indicate the person is overweight; a number of 30 or above suggests the person is obese (Division of Nutrition, Physical Activity and Obesity, National Center for Chronic Disease Prevention and Health Promotion, CDC).

– Since the data are self-reported, they are subject to recall bias, while provider measurements are subject to instrument error (e.g., lack of calibration of weight scales) and inconsistency in recording (e.g., asking patient's height or weight versus measuring). Self-reported scores are adjusted for user characteristics that allow comparison with civilian benchmarks. No objective validation tool is used to verify accuracy of BMI results.

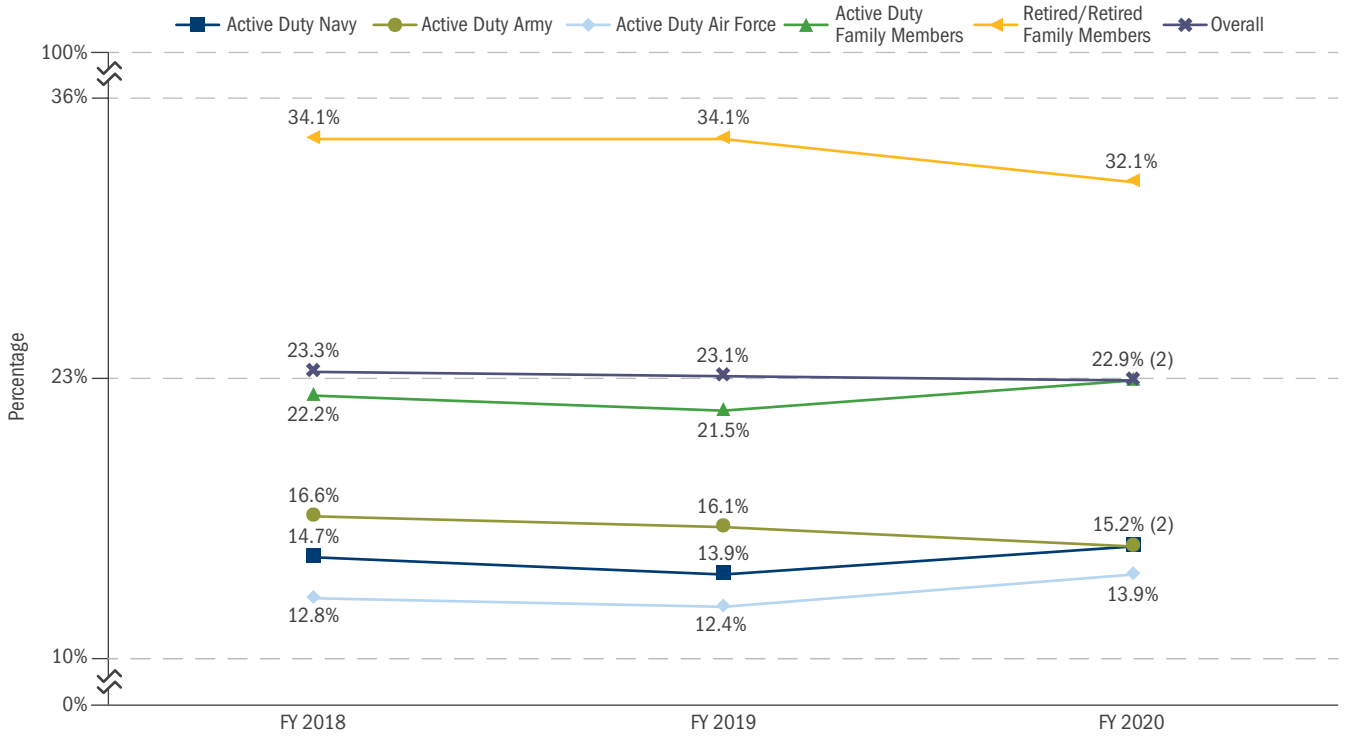
– CDC-reported obesity (39.8 percent) and combined overweight plus obesity (71.6 percent) rates for U.S. adults aged 20 and over: http://www.cdc.gov/nchs/fastats/obesity-overweight.htm, accessed 11/12/2020.

SELF-REPORTED PREVENTATIVE HEALTH MEASURE *(CONT.)*

MHS Adult Obesity *(cont.)*

- The chart below displays the prevalence of obesity in the MHS population (i.e., a calculated BMI of 30 or higher based on self-reported height and weight). AD present the lowest rates (between approximately 14 and 15 percent) in FY 2020. The overall MHS obesity rate has been unchanged from FY 2018 to FY 2020 (about 23 percent), as well as obesity rates for ADFMs (22 to 23 percent) and the retired and their family members (32 to 34 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 2018 to FY 2020 (i.e., there was no statistically significant difference, although numerically the numbers appear different).

MHS OBESITY RATE (BMI 30 OR HIGHER), FYs 2018–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, 3/9/2021

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.

– Estimates are based on all those eligible for military health, including those who are 65+ and those who use other civilian coverage or Department of Veterans Affairs (VA) health, and those with no response to the health plan question on the HCSDB.

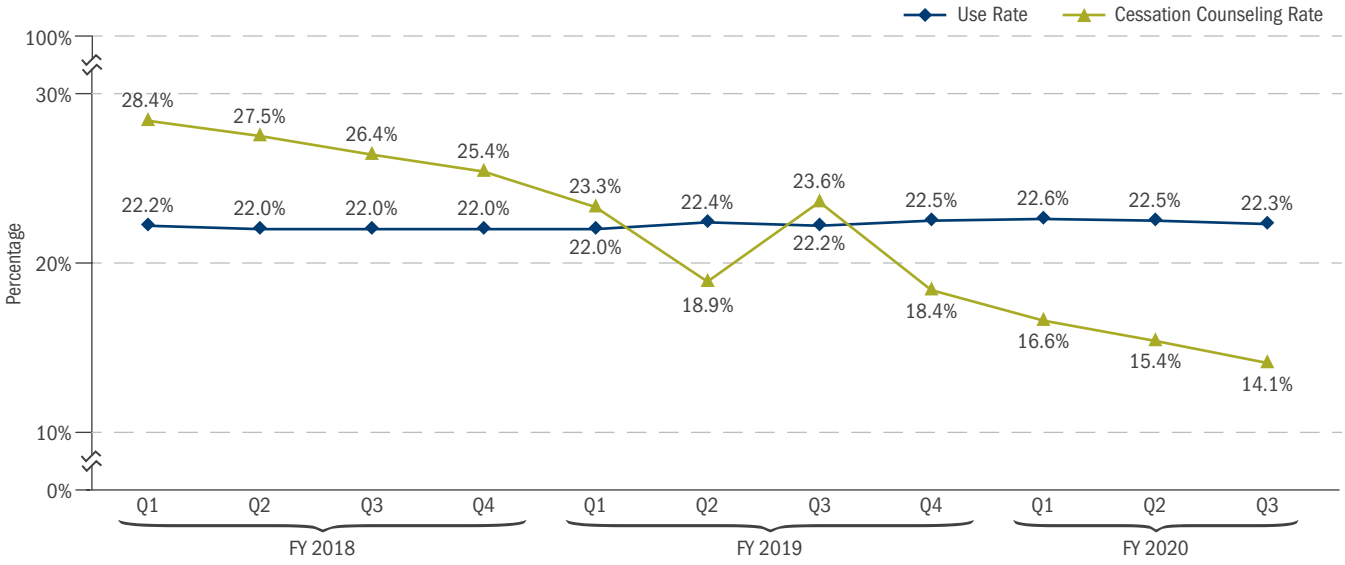
MHS DASHBOARD BETTER HEALTH MEASURES

Better Health Measures housed on the MHS Dashboard use clinical records to track and assess enterprise performance on obesity/overweight prevalence and tobacco use/cessation counseling. These measures are enrollment-based indicators of performance among the direct care population with health care encounters in MHS facilities.

Tobacco Use and Cessation Counseling

The MHS retired the Tobacco Use Assessment measure, replacing it with Tobacco Use and establishing an age-adjusted performance target of 18.2 percent by January 1, 2021 (pending visual integration into the Dashboard). As of FY 2020 Q3, 22.3 percent of direct care beneficiaries screened for tobacco use were current users. Documentation in encounter records for provision of cessation counseling among beneficiaries with indications of tobacco use in the 12-month measure look-back period has steadily declined since the measure's inception (to 14.1 percent as of FY 2020 Q3). This record-based measure is drastically different, performance-wise, than the survey-based counterpart. Population Health is engaged with Clinical Communities and clinician stakeholders to explore ways to improve coding practices and performance on the cessation counseling measure.

MHS DASHBOARD TOBACCO MEASURES, FYs 2018–2020



Source: CarePoint (available only on the MHS intranet), MHS Dashboard, data accessed 9/20/2020

Notes:

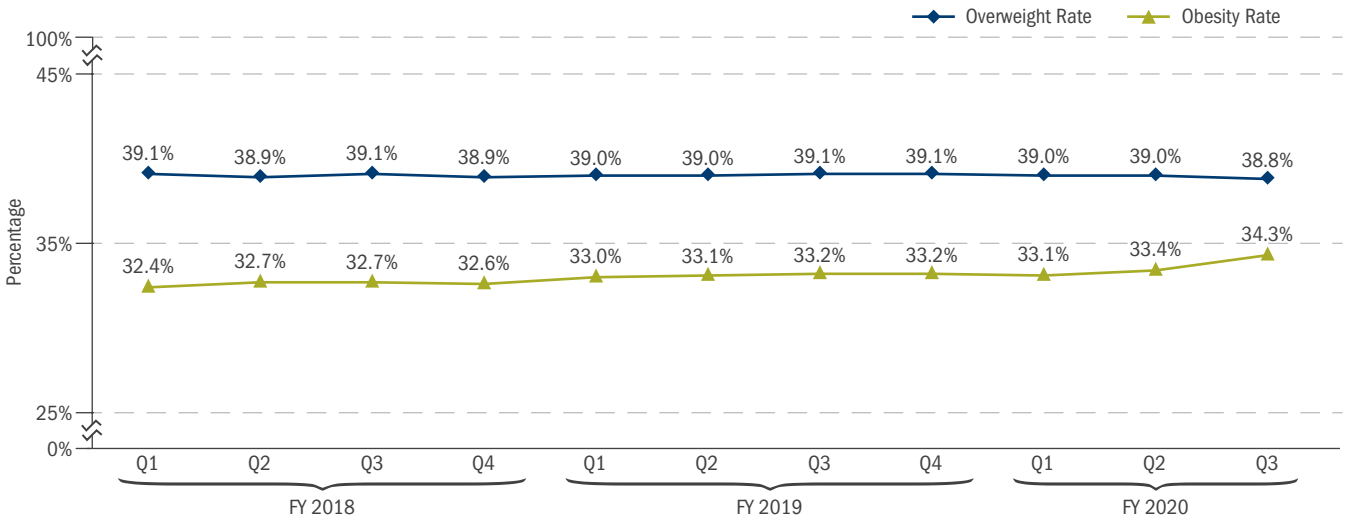
- Reflects rate during last month of each quarter.
- Tobacco dashboard measure includes beneficiaries 18 years of age and up, or pregnant at any age, continuously enrolled (11 months) to TRICARE Prime or Plus, with a primary care MTF encounter in the last 12 months.
- The tobacco use rate measure does not distinguish among use modalities and is presumed to include traditional tobacco products as well as newer products such as e-cigarettes.
- The tobacco counseling dashboard measure data are presumed objective clinical observations. The survey-derived use and cessation statistics, described earlier, are self-reported data, which are subject to recall bias, while clinical records based data are subject to variances in clinical coding habits, policies, and practice patterns across the enterprise.

MHS DASHBOARD BETTER HEALTH MEASURES *(CONT.)*

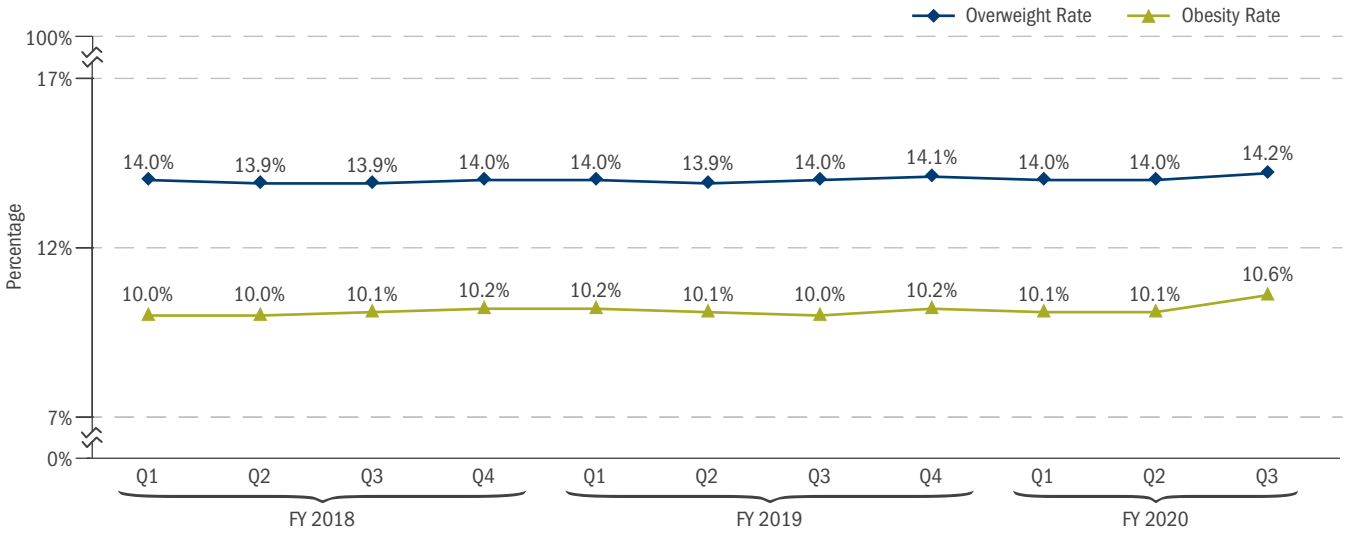
Obesity and Overweight Prevalence

Trends in obesity and overweight prevalence among youth and adult direct-care beneficiaries in the MHS have continued to mirror those in the general population. Overall, as of FY 2020 Q3, the MHS adult population is less burdened with obesity (34.3 percent, adjusted for age and sex) than the general U.S. population, as estimated by the 2015–2016 NHANES measurement cycle (39.5 percent, adjusted for age and sex, not shown). Using the same comparator data source for overweight burden, adjusted prevalence among adults (38.8 percent, adjusted) is higher than the national average (31.5 percent, adjusted, not shown). Youth estimates of obesity and overweight prevalence (10.6 percent and 14.2 percent respectively, both adjusted) in the MHS population FY 2020 Q3 remain below the national average (18.4 percent and 16.6 percent respectively, both adjusted, not shown).

MHS DASHBOARD ADULT OBESITY AND OVERWEIGHT RATE, FYs 2018–2020



MHS DASHBOARD YOUTH OBESITY AND OVERWEIGHT RATE, FYs 2018–2020



Source: CarePoint (available only on the MHS intranet), MHS Dashboard, data accessed 9/20/2020

Notes:

– Reflects rate during last month of each quarter.

– Adult dashboard measure includes beneficiaries 20 years of age and up, continuously enrolled (three months) in TRICARE Prime or Plus, with an MTF encounter in the last 12 months. Rates shown are age and sex adjusted (to the 2000 U.S. Census population). Crude obesity and overweight prevalence for FY 2020 Q3 are 31.4 percent and 41.0 percent respectively. Obesity and overweight in adults are defined as having a BMI ≥30.0 kg/m^2 and at least 25.0 kg/m^2 but less than 30.0 kg/m^2, respectively.

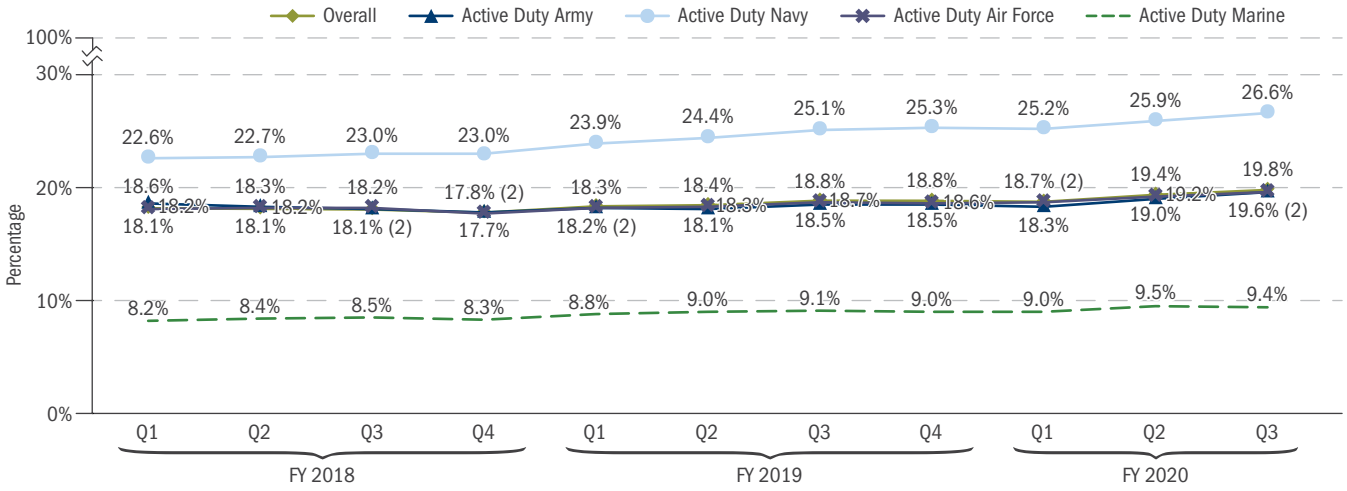
– Youth dashboard measure includes beneficiaries aged 3 years to 19 years, continuously enrolled (3 months) in TRICARE Prime or Plus, with an MTF encounter in the last 12 months. Rates shown are age adjusted (to the 2000 U.S. Census Population). Crude obesity and overweight prevalence for FY 2020 Q3 are 10.6 pecent and 14.2 percent respectively. Obesity and overweight among youth is defined as having a BMI ≥95th or ≥85th and <95th percentile of the CDC's sex-specific BMI for age growth chart, respectively.

– The obesity and overweight dashboard measure data are presumed objective clinical measurements. The survey-derived obesity statistics, described earlier, are self-reported data, which are subject to recall bias, while provider measurements are subject to instrument error (e.g., lack of calibration of weight scales) and inconsistency in recording (e.g., asking patient's height or weight versus measuring).

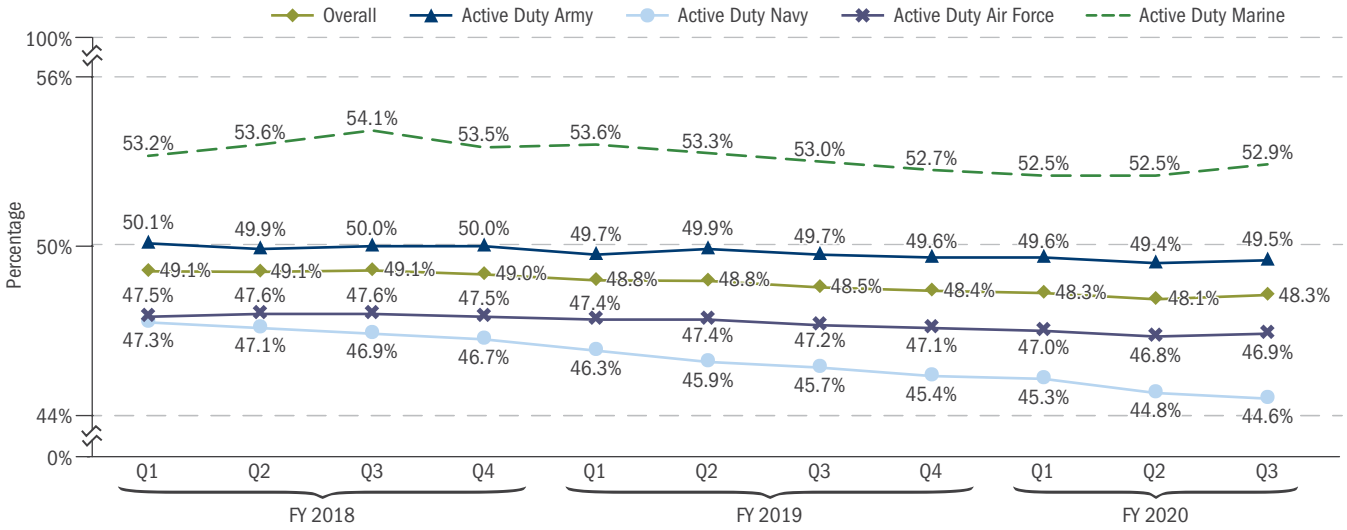
MHS DASHBOARD BETTER HEALTH MEASURES *(CONT.)*

Obesity and overweight rates among Active Duty Service members (ADSMs) has continued along similar trends as the general population. While obesity remains relatively low in comparison with other MHS beneficiaries, it continues to increase as the rate of overweight ADSMs declines. When stratified by Service Branch, obesity is highest among Navy SMs (26.6 percent) and lowest among Marines (9.4 percent). The opposite is true for overweight rates (Marines – 52.9 percent, Army – 49.5 percent, Air Force – 46.9 percent, Navy – 44.6 percent). BMI may not be an accurate indicator of adiposity, and higher rates of overweight among ADSMs may be partially biased by muscularity and hyper fitness.

MHS DASHBOARD ACTIVE DUTY SERVICE MEMBER OBESITY RATE, FYs 2018–2020



MHS DASHBOARD ACTIVE DUTY SERVICE MEMBER OVERWEIGHT RATE, FYs 2018–2020



Source: CarePoint (available only on the MHS intranet), MHS Dashboard, data accessed 9/20/2020

Notes:

– Reflects rate during last month of each quarter.
– ADSM Dashboard measure includes Active Duty beneficiaries 17 years of age and up, continuously enrolled (three months) in TRICARE Prime or Plus, with an MTF encounter in the last 12 months.
– Obesity and overweight are defined as described for youth and adults, depending on the age of the ADSM.
– The obesity and overweight dashboard measure data are presumed objective clinical measurements. The survey-derived obesity statistics, described earlier, are self-reported data, which are subject to recall bias, while provider measurements are subject to instrument error (e.g., lack of calibration of weight scales) and inconsistency in recording (e.g., asking patient's height or weight versus measuring).

HEALTH-RELATED QUALITY OF LIFE

Using CDC's Health-Related Quality of Life Questions as a Proxy Measure of "Better Health"

During FY 2018, senior DHA and Service medical leadership directed adding an overall measure of our MHS population health. Ultimately, it was proposed to assess and trend the overall health of the MHS population using the same Health-Related Quality of Life (HRQOL) measurement as the CDC's state-based Behavioral Risk Factor Surveillance System (BRFSS). Self-perceived health status is considered a valid proxy measure for the state of U.S. national health; research has shown that people's perception of their health is highly correlated with their actual health, and can be used at the population level.

HRQOL refers to the perceived physical and mental health of an individual or group over a period of time. The standard four-item set of Healthy Days core questions (CDC HRQOL–4) has been in the State-based BRFSS since 1993 (see the BRFSS website at https://www.cdc.gov/brfss).

- From 2000 to 2012, the CDC HRQOL–4 has been in the NHANES for persons aged 12 and older.
- Since 2003, the CDC HRQOL–4 has been in the Medicare Health Outcomes Survey (HOS)—a measure in the Healthcare Effectiveness Data and Information Set (HEDIS) of the National Committee for Quality Assurance (NCQA) (https://www.cdc.gov/HRQOL/HRQOL14_measure.htm).

The HRQOL–4 questions are:

1. **Self-rated health:** In general, how would you rate your overall health? (Respondents have five choices: poor, fair, good, very good, or excellent. "Good health" is coded as the proportion of those rating their overall health as good, very good, or excellent.)
2. **Number of recent days physical health not good:** Thinking about your physical health, including physical illness and injury, how many days during the past 30 days was your physical health not good? (Referred to as "poor physical health.")
3. **Number of recent days mental health not good:** Thinking about your mental health—including stress, depression, and problems with emotions—how many days during the past 30 days was your mental health not good? (Referred to as "poor mental health.")
4. **Number of recent days limited due to poor physical/mental health:** During the past 30 days, how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? (Referred to as "limited by poor health.")

Although the CDC currently reports BRFSS data from 2010 on its website, and these results are used to inform the HP 2020 Goals, HCSDB HRQOL results are compared to norms calculated from 2017 BRFSS micro data, which are not currently reported in summary like 2010, but rather containing responses from approximately 440,000 respondents in 53 states/territories, and reweighted to match our MHS population. Mode differences between the BRFSS and HCSDB may result in mode effects and make comparison more difficult.

Because the MHS population differs from the U.S. population in age, gender, and ethnic composition, BRFSS rates were reweighted to match MHS users' characteristics in those areas. However, the populations may differ in other ways that complicate the comparisons between estimates from the BRFSS and HCSDB—for example, employment, education, and access to health care.

After examining both the HP and BRFSS benchmarks, the MHS established a performance target of 90.5 percent (the highest current beneficiary category score of Active Duty for FY 2019) by January 1, 2021.

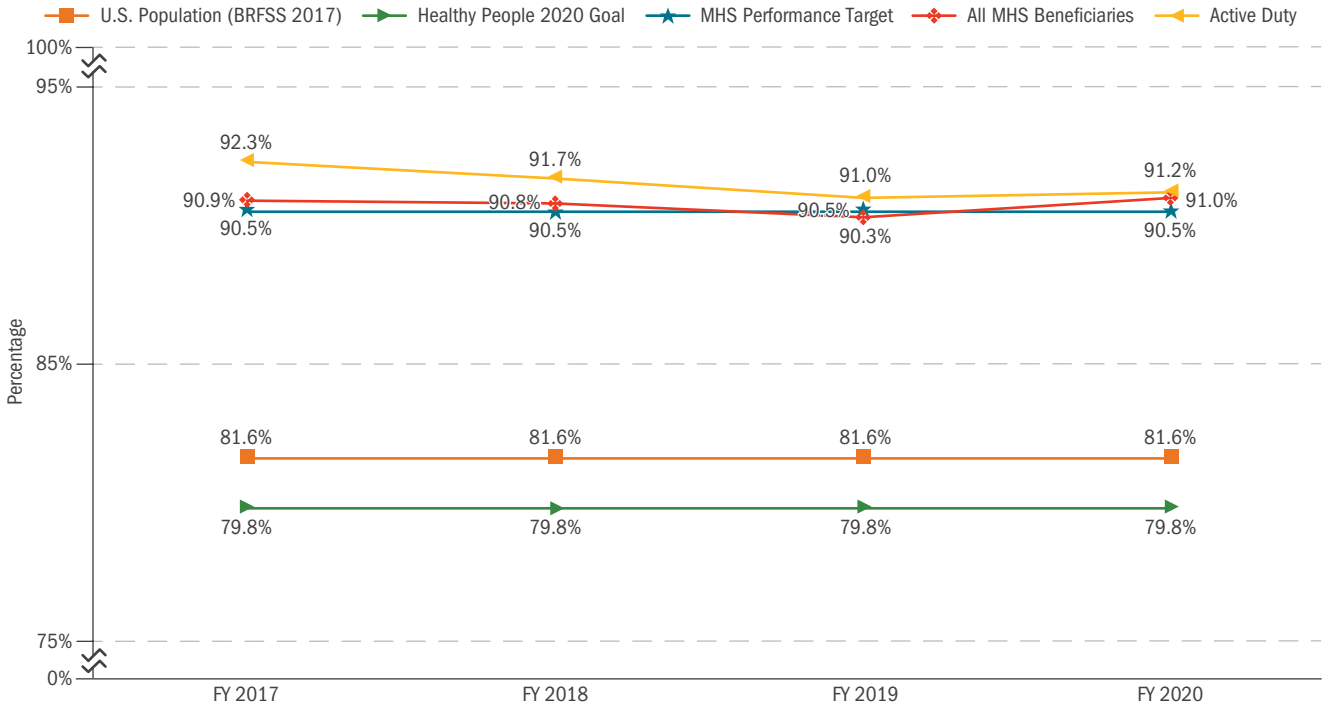
As shown in the following graphs, the overall MHS population in general, including ADSM rate their health status higher than the general U.S. population did in 2017, and both are higher than the HP 2020 goal of 79.8 percent.

- The overall MHS population rating of good or better health appears to have remained about the same from FY 2017 through FY 2020 at approximately 91 percent. ADSM rating their health as good or better declined slightly between FY 2017 and FY 2020 by about one percentage point.
- All Services far exceed the HP 2020 goal and are above the U.S. 2017 population by at least 10 percentage points. By Service, Air Force members rating of good or better health is highest from FY 2017 through FY 2020 and is 93 percent for FY 2020. The Air Force is also the only Service to meet or exceed the MHS performance target in FY 2020.

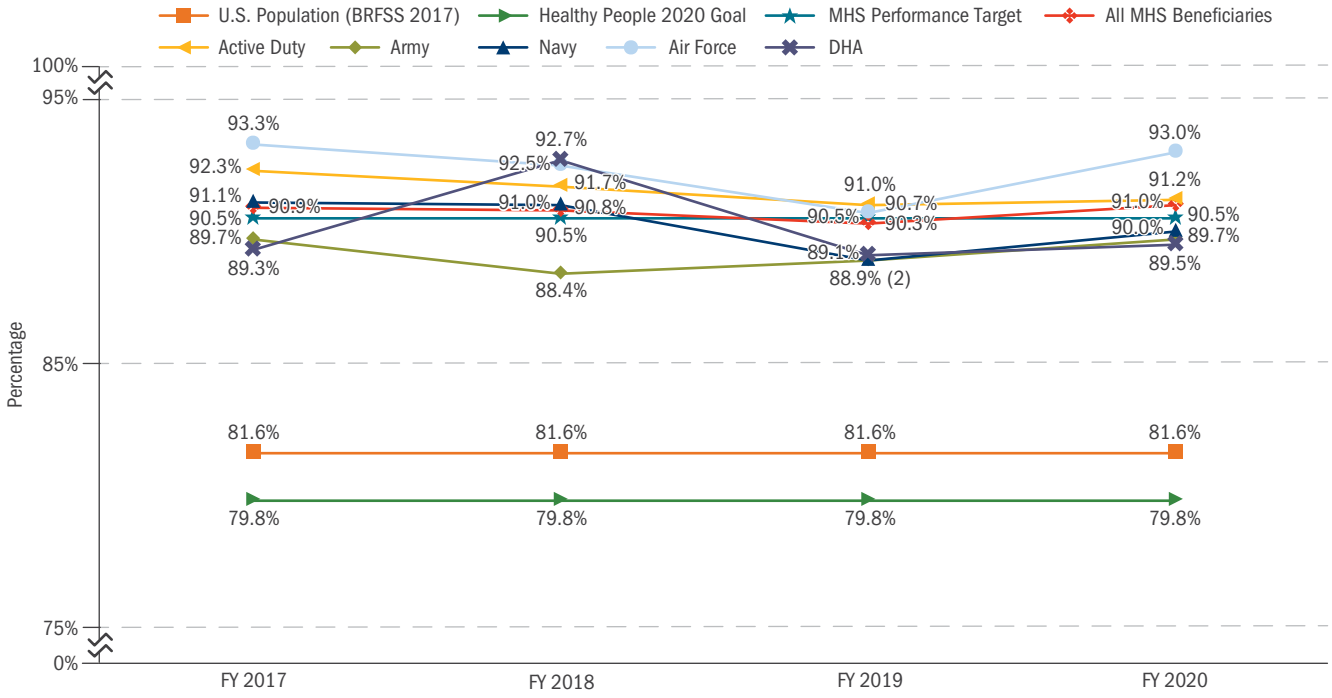
HEALTH-RELATED QUALITY OF LIFE *(CONT.)*

Using CDC's Health-Related Quality of Life Questions as a Proxy Measure of "Better Health" *(cont.)*

PERCENTAGE OF MILITARY BENEFICIARIES SELF-RATING HEALTH STATUS AS GOOD OR BETTER, BASED ON BRFSS, FYs 2017–2020



PERCENTAGE OF ACTIVE DUTY SERVICE MEMBERS BY SERVICE SELF-RATING HEALTH STATUS AS GOOD OR BETTER, BASED ON BRFSS, FYs 2017–2020



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, 11/18/2020

Notes:

- BRFSS results are from the 2017 survey conducted by CDC, reweighted to match the 2017 MHS population; DHA results for FYs 2016–2019 are recalculated to accommodate the transitional Intermediate Management Organization (tIMO) as of October 1, 2018.
- FY 2016 (Q2 and Q3), FY 2017 (Q3), FY 2018 (Q3), FY 2019 (Q3), and FY 2020 (Q2) 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 sent to Active Duty members; response by Internet for all, and paper questionnaire mailed to a sample of all nonresponding Active Duty family members, retirees, and their family members living in the United States.

SAVINGS AND RECOVERIES

Pharmacy Retail Refunds

The District Court's 2008 decision granted the Department of Defense (DoD) the authority to require refunds from drug manufacturers, a decision upheld by the U.S. Court of Appeals in 2013.

There are two main drivers for the decline in rebates on retail drugs: (1) the implementation of the maintenance drugs benefit program influenced beneficiaries to purchase maintenance drugs through mail order rather than retail pharmacies; and (2) many drugs included under the TRICARE Retail Refund Program have patents expiring and therefore are no longer included in the program.

PHARMACY RETAIL REFUNDS ($ MILLIONS), FYs 2016–2020

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Total Receivables	$929.44	$850.71	$841.78	$836.01	$859.28
Total Collections	$982.73	$847.40	$853.44	$860.82	$824.89

Source: DHA Business Support Directorate, Contract Resource Management, 9/30/2020

Note: Refund amounts are netted out of pharmacy costs provided within this report. The refunds in the table above are categorized in the fiscal year (FY) they were validated and billed to the manufacturers.

Program Integrity Activities

The Defense Health Agency (DHA) Office of Program Integrity (PI) is responsible for health care anti-fraud to safeguard beneficiaries and protect benefit dollars. DHA PI develops and executes anti-fraud and abuse policies and procedures, provides oversight of contractor program integrity activities, and coordinates investigative activities. DHA PI also develops cases for criminal prosecutions, civil litigations, and initiates administrative measures. Through a Memorandum of Understanding (MOU), DHA PI refers its fraud cases to the Defense Criminal Investigative Services. DHA PI also coordinates investigative activities with Military Criminal Investigative Offices, as well as other federal, state, and local agencies.

PROGRAM INTEGRITY RECOVERIES/COST AVOIDANCE ($ MILLIONS), CYs 2017–2019

	CY 2017	CY 2018	CY 2019
Total Recoveries	$88.8	$149.4	$363.6
Court-Ordered Fraud Judgments/Settlements	$66.3	$125.9	$328.2
PI Contractor Administrative Recoupment/Offsets (Received)	$22.5	$23.5	$34.4
Total PI Contractors Cost Avoidance	$55.0	$48.9	$67.5
Contractor Prepayment Reviews	$53.6	$48.5	$67.5
Excluded Providers	$1.4	$0.4	$0.1

Sources: 2019 Annual Program Integrity Operational Report/Contractor Submitted Fraud and Abuse Reports, CY 2017–CY 2019; CY 2019 data are the latest reported as of 9/24/2020.

SAVINGS AND RECOVERIES *(CONT.)*

Program Savings and Claim Recoveries

New reimbursement approaches are continually evaluated for potential savings to TRICARE. As new programs are established, savings are estimated and monitored.

Claim recoveries result from identified overpayments adjusted in TRICARE Encounter Data (TED), and the differences are recouped.

Recovery A—Post-Payment Duplicate Claim Recoveries: A post-payment duplicate claims system was developed by the DHA Healthcare Operations Directorate/TRICARE Health Plan Division for use by TRICARE purchased care contractors. The system was designed as a retrospective auditing tool and facilitates the identification of actual duplicate claim payments and the initiation and tracking of recoupments. The table below provides the historical recovery of duplicate claims payments. Duplicate claim recoveries show an increase in duplicate claims due to a new regional contractor that experienced claims processing issues.

RECOVERIES ($ MILLIONS), FYs 2018–2020

RECOVERIES	FY 2018	FY 2019	FY 2020
Post-Payment Duplicate Claim Recoveries	$4.5	$20.2	$21.1

Recovery B—Improper Payment Recoveries: The DHA is vigilant in ensuring the accuracy of health care claim payments within the military health benefits program. The DHA has contracted with an external independent contractor (EIC) who is responsible for conducting post-payment accuracy reviews of TRICARE health benefit claims. The EIC is responsible for identifying improper payment made by TRICARE purchased care contractors as a result of contractor noncompliance with TRICARE policy, benefit, and/or reimbursement requirements.

OVERPAYMENTS RECAPTURED OUTSIDE OF PAYMENT RECAPTURE AUDITS ($ MILLIONS), FY 2020

ACTUAL OVERPAYMENT DOLLARS IDENTIFIED VIA RANDOM SAMPLES[a]	AMOUNT RECAPTURED (REFUNDS THROUGH FY 2020)
$13.85	$295.86

Sources: DHA/R&M (J-1/J-8)/Trust Fund and Revenue Cycle Management Improper Payment Evaluation Branch, 10/23/2020; Operational Reports and Quarterly Fraud and Abuse Reports

[a] "Actual overpayment dollars identified via random samples" in FY 2018 represents the total overpayment dollars from sampled claims.

Notes:

– DHA modified the methodology to calculate recoveries for this AFR (FY 2020). The methodology used in prior years could have overcounted refunds that were subsequently repaid. The modified methodology takes into consideration subsequent repayments and nets them against refunds, which lowered overall refunds.

– These numbers include recoupments for overpayments identified in audits as well as refunds occurring in the course of routine claim adjustments (for claims initially paid in FY 2018 and other fiscal years). DHA has no way to distinguish overpayment recoupments from routine claim adjustments.

– The Active Duty Dental Program (ADDP) refunds were calculated differently. The amount recovered in FY 2018 figure for ADDP represents refunds shown on contractor invoices to DHA. ADDP data is not included in the TED system, thus contractor invoices were used because TED transactions are not available.

In addition to the EIC post-payment reviews, DHA requires TRICARE purchased care contractors to use industry best business practice when processing TRICARE claims. Contractors are required to use claims auditing software and develop prepayment initiatives that are manual and/or automated to avoid or prevent improper payments. The above table provides FY 2020 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)

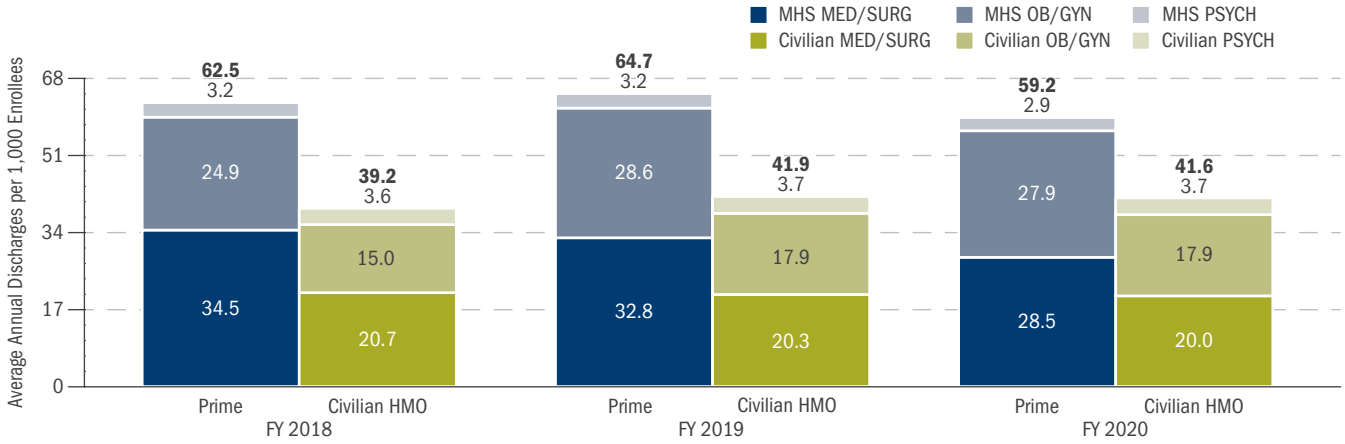
TRICARE Prime Enrollees

This section compares the inpatient utilization of TRICARE Prime enrollees (including TRICARE Young Adult [TYA] Prime) with that of enrollees in civilian employer-sponsored health maintenance organization (HMO) plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. Inpatient utilization is measured as the total number of dispositions (i.e., the sum of direct and purchased care dispositions) because relative weighted products (RWPs) are not available in the civilian-sector data.

Dispositions are computed for three broad product lines—obstetrics/gynecology (OB/GYN), mental health (PSYCH), and other medical/surgical (MED/SURG)—and compared for acute care facilities only. The comparisons exclude beneficiaries aged 65 and older because very few are covered by employer-sponsored plans. The Military Health System (MHS) data further exclude beneficiaries enrolled in the Uniformed Services Family Health Plan (USFHP) and TRICARE Plus.

- The TRICARE Prime inpatient utilization rate decreased by 5 percent between FY 2018 and FY 2020, while the civilian HMO rate increased by 6 percent. The decrease in the Prime inpatient utilization rate was driven largely by a 17 percent decline in MED/SURG utilization, offset partially by a 12 percent increase in OB utilization. In FY 2020, the TRICARE Prime inpatient utilization rate (direct and purchased care combined) was 42 percent higher than the civilian HMO utilization rate (59.2 discharges per 1,000 Prime enrollees compared with 41.6 per 1,000 civilian HMO enrollees).
- In FY 2020, the TRICARE Prime inpatient utilization rate was 42 percent higher than the civilian HMO rate for MED/SURG procedures, 56 percent higher for OB/GYN procedures, and 22 percent lower for PSYCH procedures.
- The average length of stay (LOS) for MHS Prime enrollees (direct and purchased care combined) increased slightly from 3.3 days in FY 2018 to 3.4 days in FY 2020, whereas the average LOS for civilian HMO enrollees declined slightly from 3.8 days to 3.7 days. In FY 2020, the average LOS for MHS Prime enrollees was 9 percent lower than that of civilian HMO enrollees (not shown).

INPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK, FYs 2018–2020



Sources: MHS administrative data, 2/5/2021, and IBM Watson Health, MarketScan® Commercial Claims and Encounters (CCAE) database, 1/15/2021

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2020 civilian benchmarks are based on two quarters of data, which were seasonally adjusted and annualized.

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

LOWER COST

INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

TRICARE Inpatient Utilization Rates Compared with Civilian Benchmarks (U.S. Only) *(cont.)*

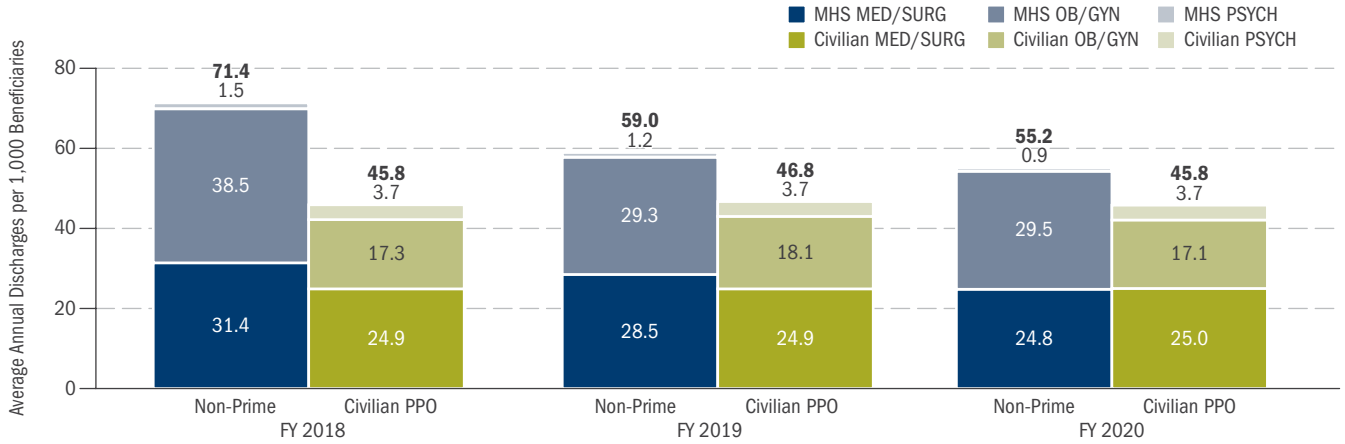
Non-Prime-Enrolled Beneficiaries

This section compares the inpatient utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored preferred provider organization (PPO) plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. Inpatient utilization is measured as the total number of dispositions (i.e., the sum of direct and purchased care dispositions) because RWPs are not available in the civilian-sector data.

Dispositions are computed for three broad product lines—OB/GYN, PSYCH, and other MED/SURG procedures—and compared for acute care facilities only. The comparisons exclude beneficiaries aged 65 and older because very few are covered by employer-sponsored plans. To make the utilization rates of MHS and civilian beneficiaries more comparable, non-Prime-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Although most beneficiaries who fail to file a TRICARE claim have private health insurance, we estimate that about 18 percent do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable with the civilian rates, which also include non-users.

- Between FY 2018 and FY 2020, the TRICARE non-Prime utilization rate decreased by 23 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 2020, the inpatient utilization rate (direct and purchased care combined) for non-Prime-enrolled beneficiaries was 21 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 2018 to FY 2020, the MHS OB/GYN disposition rate decreased by 23 percent, whereas it decreased by 1 percent in the civilian sector. Despite the precipitous drop in the MHS non-Prime OB/GYN disposition rate, it was still 73 percent higher than the corresponding civilian PPO rate in FY 2020.
- 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) decreased from 3.7 days in FY 2018 to 3.5 days in FY 2020, whereas the average LOS for civilian PPO participants remained unchanged at 3.8 days. As a result, the average LOS for MHS non-Prime beneficiaries was 7 percent lower than that of civilian PPO participants in FY 2020 (not shown).

INPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK, FYs 2018–2020



Sources: MHS administrative data, 2/5/2021, and IBM Watson Health, MarketScan® CCAE database, 1/15/2021

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2020 civilian benchmarks are based on two quarters of data, which were seasonally adjusted and annualized.

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

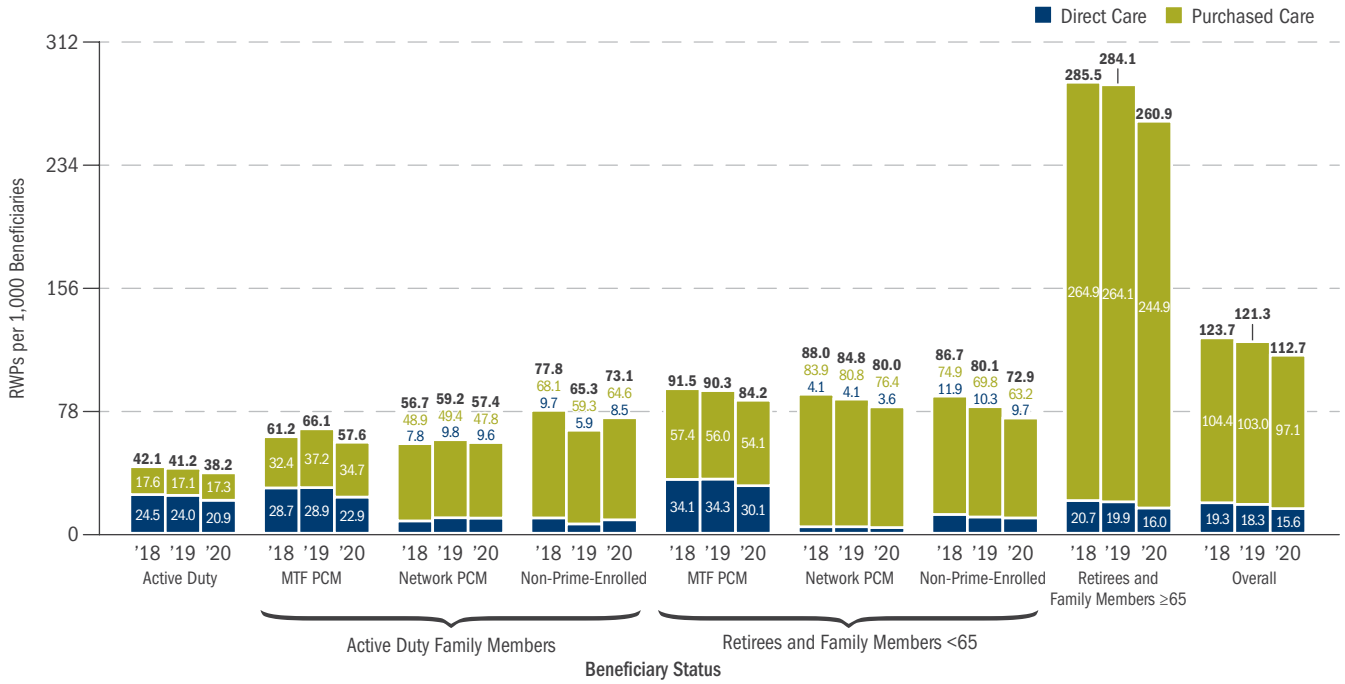
INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Inpatient Utilization Rates by Beneficiary Status (U.S. Only)

When breaking out inpatient utilization by beneficiary group, RWPs per capita more accurately reflect differences across beneficiary groups than do discharges per capita. MHS RWPs are based on the Medicare Severity Diagnosis Related Group (MS-DRG) system of classifying inpatient hospital cases under the Medicare Prospective Payment System and are relevant only for acute care hospitals.

- The overall (direct and purchased care combined) inpatient utilization rate (RWPs per 1,000 beneficiaries) decreased by 9 percent from FY 2018 to FY 2020.
- Between FY 2018 and FY 2020, the direct care inpatient utilization rate decreased by 19 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. Retirees and family members aged 65 and older experienced the largest decline (23 percent). Active Duty family members (ADFMs) with a military medical treatment facility (MTF) primary care manager (PCM) also experienced a large decline (20 percent) as did non-Prime-enrolled retirees and family members under age 65 (19 percent). The only group with an increase in utilization was ADFMs with a network PCM (23 percent), but that is based on a low direct care utilization level.
- The overall purchased acute care inpatient utilization rate decreased by 7 percent between FY 2018 and FY 2020, but there was a great deal of variation across beneficiary groups. ADFMs with an MTF PCM experienced a 7 percent increase while the remaining beneficiary groups experienced declines. The largest decline was experienced by non-Prime-enrolled retirees and family members (RETFMs) under age 65 (16 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 74 percent in FY 2018 to 76 percent in FY 2020 (the MHS GENESIS issue likely played a role in this result).
- From FY 2018 to FY 2020, the percentage of per capita inpatient workload referred to the network on behalf of beneficiaries enrolled with an MTF PCM (including Active Duty personnel) rose from 54 percent to 57 percent (again, the MHS GENESIS issue likely had an effect).

AVERAGE ANNUAL INPATIENT RWPs PER 1,000 BENEFICIARIES, FYs 2018–2020



Sources: MHS administrative data, 2/5/2021

Notes:

– The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere.

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

LOWER COST

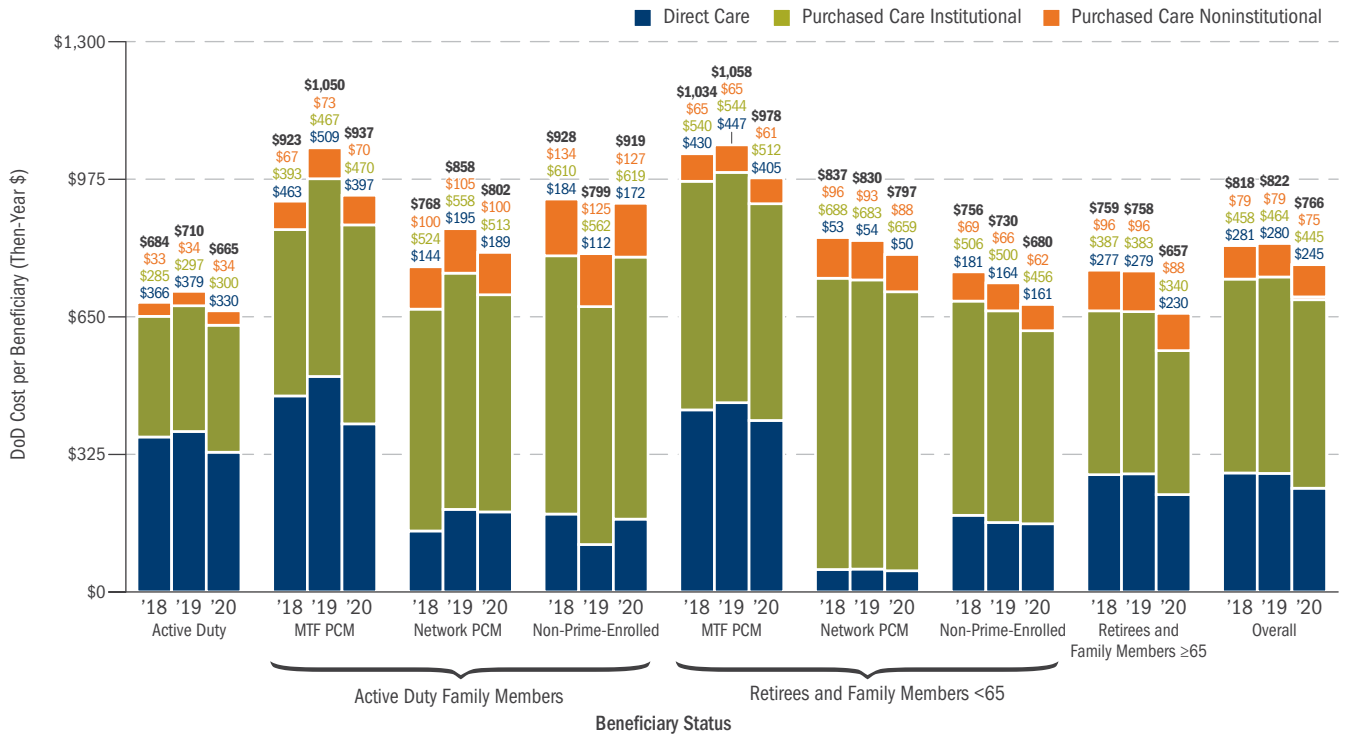
INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Inpatient Cost by Beneficiary Status (U.S. Only)

MHS costs for inpatient care include costs incurred in both acute and non-acute care facilities. They also include the cost of inpatient professional services (i.e., noninstitutional charges [e.g., physician, lab, anesthesia]) associated with a hospital stay. The overall MHS inpatient cost (in then-year dollars) per beneficiary (far-right columns below), including TRICARE for Life (TFL), decreased by 6 percent between FY 2018 and FY 2020.

- Most beneficiary groups experienced modest declines in total (direct plus purchased care) per capita inpatient costs. Non-Prime-enrolled RETFMs aged 65 and over experienced the largest decline (13 percent). The only group to experience an increase was enrolled ADFMs (1 percent for those with an MTF PCM and 4 percent for those with a network PCM).
- Direct care inpatient costs per capita decreased by 13 percent between FY 2018 and FY 2020. Purchased care inpatient costs (institutional plus noninstitutional) per capita decreased by 3 percent over the same time period.
- The direct care cost per RWP increased from $14,574 in FY 2018 to $15,706 in FY 2020 (8 percent).
- Exclusive of TFL, DoD purchased care cost (institutional plus noninstitutional) per RWP in acute care facilities increased from $7,776 in FY 2018 to $9,005 in FY 2020 (16 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 from $9,233 in FY 2018 to $9,967 (8 percent) in FY 2020, exclusive of TFL.

AVERAGE ANNUAL DoD INPATIENT COSTS PER BENEFICIARY, FYs 2018–2020



Sources: MHS administrative data, 2/5/2021

Notes:

– The reader should exercise caution when comparing the direct versus purchased care costs per RWP. The data on this page are unadjusted for differences in beneficiary mix, enrollment status, geographical location of care, etc. They represent DoD health care costs only, and specifically exclude beneficiary cost shares, administrative costs, and overhead expenses.

– The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere.

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

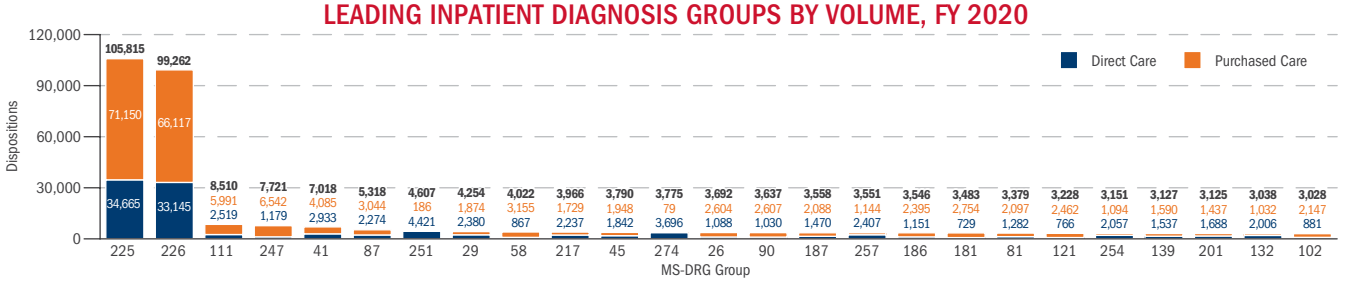
INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Leading Inpatient Diagnosis Groups (U.S. Only)

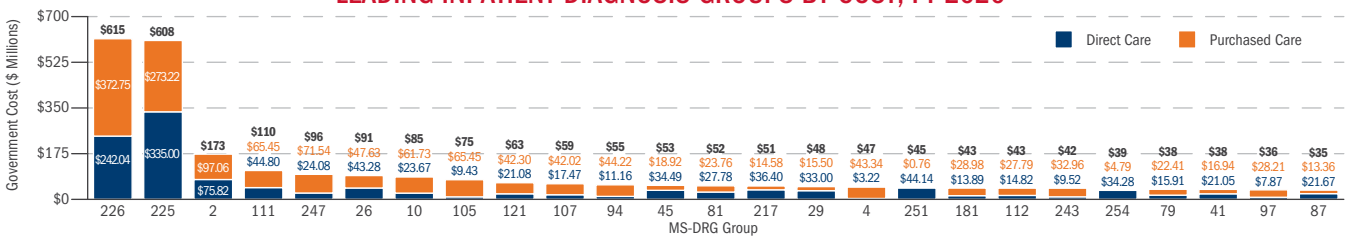
The MHS uses the MS-DRG system to classify acute care hospital inpatient cases into clinically related categories having similar treatment costs. For the purpose of this section, MS-DRGs exhibiting variations in complications and comorbidities were grouped into like categories[1] and numbered sequentially. The category numbers have no significance other than to identify the DRG groups on the horizontal axes in the charts below. See the Appendix for additional detail on the DRG grouping methodology.

The top 25 MS-DRG groups in terms of volume in FY 2020 accounted for 69 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 2020 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 2020 accounted for 58 percent of total inpatient costs (direct and purchased care combined) in acute care hospitals. TFL admissions and observation stays are excluded from the calculations for both volume and cost.

LEADING INPATIENT DIAGNOSIS GROUPS BY VOLUME, FY 2020



LEADING INPATIENT DIAGNOSIS GROUPS BY COST, FY 2020



Source: MHS administrative data, 2/5/2021

MS-DRG Groups

2	ECMO or Tracheostomy
4	Bone Marrow Transplant
10	Craniotomy
26	Major Small and Large Bowel Procedures
29	Appendectomy
41	Esophagitis, Gastroenteritis, and Miscellaneous Digestive Disorders
45	Cholecystectomy
58	Seizures and Headaches
79	Respiratory System with Ventilator Support
81	Respiratory Infections and Inflammations
87	Simple Pneumonia and Pleurisy
90	Bronchitis and Asthma
94	Cardiac Valve and Other Major Cardiothoracic Procedures
97	Coronary Bypass
102	Disorder of Pancreas Except Malignancy
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
181	Operating Room Procedures for Obesity
186	Diabetes
187	Nutritional and Miscellaneous Metabolic Disorders
201	Kidney and Urinary Tract Infections
217	Uterine and Adnexal Procedures for Non-Malignancy
225	Pregnancy, Childbirth, and the Puerperium
226	Newborns and Other Neonates with Condition Originating in Perinatal Period
243	Infectious and Parasitic Diseases with Operating Room Procedure
247	Septicemia or Severe Sepsis
251	Neuroses Except Depressive
254	Psychoses
257	Alcohol/Drug Abuse or Dependence
274	Other Factors Influencing Health Status

- The top two procedures by volume are related to childbirth, accounting for 47 percent of all hospital admissions and 27 percent of total hospital costs (not just among the top 25).
- Procedures performed in private-sector acute care hospitals account for 64 percent of the total volume of the top 25 MS-DRG groups and 56 percent of the total cost.
- Admissions in direct care facilities exceed those in purchased care facilities for only eight of the top 25 MS-DRG groups, whereas expenditures in direct care facilities exceed those in purchased care facilities for nine of the top 25 MS-DRG groups (not all the DRG groups based on cost are the same as those for admissions).
- Surgical procedures for obesity rank 18th in both volume and cost among the top 25 MS-DRG groups. Thus, the obesity epidemic in the civilian sector (as per the Centers for Disease Control and Prevention [CDC]) appears to be mirrored to an extent in the DoD population as well.

[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.

LOWER COST

OUTPATIENT UTILIZATION RATES AND COSTS

TRICARE Outpatient Utilization Rates Compared with Civilian Benchmarks (U.S. Only)

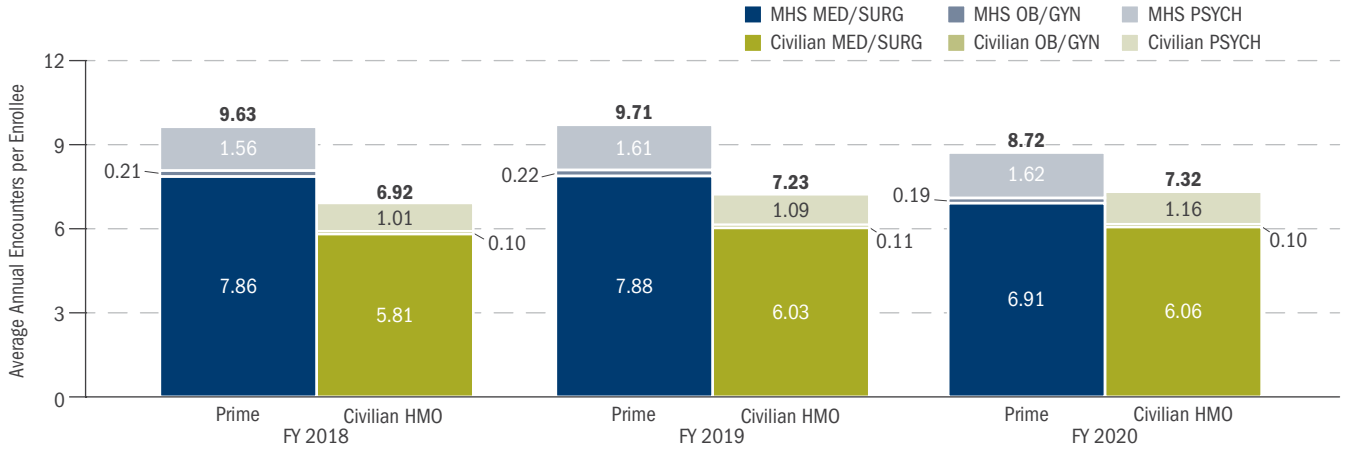
TRICARE Prime Enrollees

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 9 percent between FY 2018 and FY 2020. The civilian HMO outpatient utilization rate increased by 6 percent over the same period.
- In FY 2020, the overall Prime outpatient utilization rate was 19 percent higher than the civilian HMO rate.
- In FY 2020, the Prime outpatient utilization rate for MED/SURG procedures was 14 percent higher than the civilian HMO rate.
- The Prime outpatient utilization rate for OB/GYN procedures fell by 10 percent between FY 2018 and FY 2020 (albeit from a low base rate) but still remained 90 percent higher than for civilian HMOs in FY 2020. 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 40 percent higher than the corresponding rate for civilian HMOs in FY 2020. This disparity, though based on relatively low MHS and civilian mental health utilization rates, may reflect the more stressful environment that many ADSMs and their families endure.

OUTPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK, FYs 2018–2020



Sources: MHS administrative data, 2/5/2021, and IBM Watson Health, MarketScan® CCAE database, 1/15/2021

[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.

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2020 civilian benchmarks are based on two quarters of data, which were seasonally adjusted and annualized.

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

OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

TRICARE Outpatient Utilization Rates Compared with Civilian Benchmarks (U.S. Only) *(cont.)*

Non-Prime-Enrolled Beneficiaries

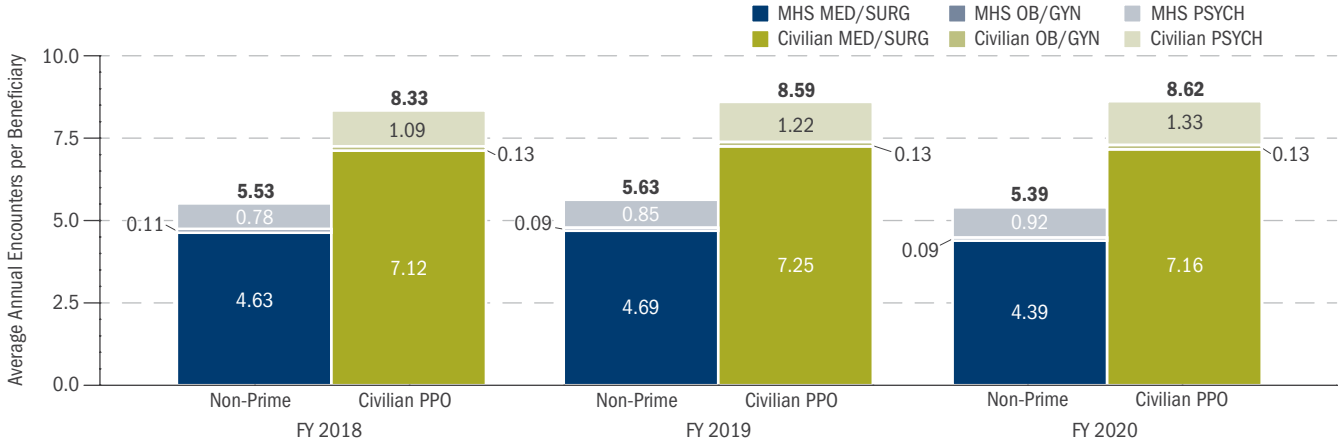
This section compares the outpatient utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored PPO plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. Outpatient utilization is measured in terms of encounters because the civilian-sector data used in the comparisons do not contain a measure of RVUs. However, there is no fixed definition for what constitutes a "face-to-face" encounter with a physician. TRICARE and the private sector may therefore use varying methodologies to calculate the number of encounters.

Encounters are computed for three broad product lines: OB/GYN, PSYCH, and other MED/SURG. The comparisons are made for beneficiaries under age 65 only. To make the utilization rates of MHS and civilian beneficiaries more comparable, non-Prime-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Because telephone consults are routinely recorded in direct care data, but appear very infrequently in private-sector claims, they are also excluded from the direct care utilization computations. Although most beneficiaries who fail to file a TRICARE claim have private health insurance, we estimate that about 18 percent do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable to the civilian rates, which also include non-users.

- The overall TRICARE outpatient utilization rate (direct and purchased care combined) for non-Prime-enrolled beneficiaries decreased by 2 percent between FY 2018 and FY 2020. 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 2020, TRICARE non-Prime outpatient utilization was 37 percent lower than in civilian PPOs.
- In FY 2020, the non-Prime outpatient utilization rate for MED/SURG procedures was 39 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 18 percent between FY 2018 and FY 2020 and was 31 percent below the rate for civilian PPO participants in FY 2020.
- The PSYCH outpatient utilization rate for non-Prime-enrolled MHS beneficiaries increased by 18 percent from FY 2018 to FY 2020; the rate increased by 22 percent for civilian PPO participants. In FY 2020, the PSYCH outpatient utilization rate for non-Prime-enrolled beneficiaries was 31 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 Active Duty Service members (ADSMs) and their families) are more likely to enroll in Prime.

LOWER COST

OUTPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK, FYs 2018–2020



Sources: MHS administrative data, 2/5/2021, and IBM Watson Health, MarketScan® CCAE database, 1/15/2021

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2020 civilian benchmarks are based on two quarters of data, which were seasonally adjusted and annualized.

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

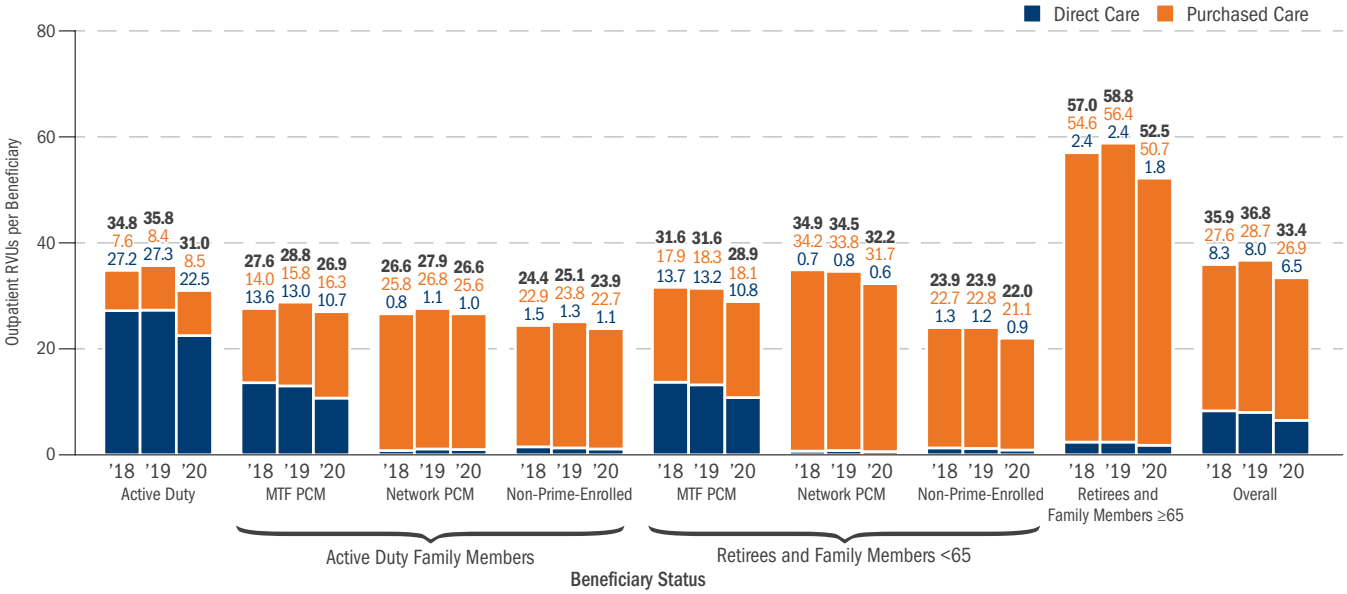
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Outpatient Utilization Rates by Beneficiary Status (U.S. Only)

When breaking out outpatient utilization by beneficiary group, RVUs per capita more accurately reflect differences across beneficiary groups than encounters per capita. The RVU measure used in this report is the sum of the Physician Work and Practice Expense RVUs (see the Appendix for a detailed description of the Physician Work and Practice Expense RVU measures).

- Total per capita MHS utilization (direct plus purchased care) decreased by 7 percent from FY 2018 to FY 2020.
- Overall direct care outpatient utilization decreased by 22 percent from FY 2018 to FY 2020. With the exception of ADFMs with a network PCM (20 percent increase), large declines were experienced by every beneficiary group, ranging from 18 percent for Active Duty members to 28 percent for non-Prime-enrolled RETFMs under age 65.
- From FY 2018 to FY 2020, purchased care outpatient utilization decreased by 3 percent overall. ADFMs with an MTF PCM experienced a 16 percent increase, while Active Duty members experienced a 12 percent increase. The largest declines occurred for RETFMs age 65 and older, RETFMs under age 65 with a network PCM, and non-Prime-enrolled RETFMs under age 65 (7 percent each). The other beneficiary groups experienced small declines in purchased care outpatient utilization.

AVERAGE ANNUAL OUTPATIENT RVUs PER BENEFICIARY, FYs 2018–2020



Source: MHS administrative data, 2/5/2021

Notes:

– The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere.

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

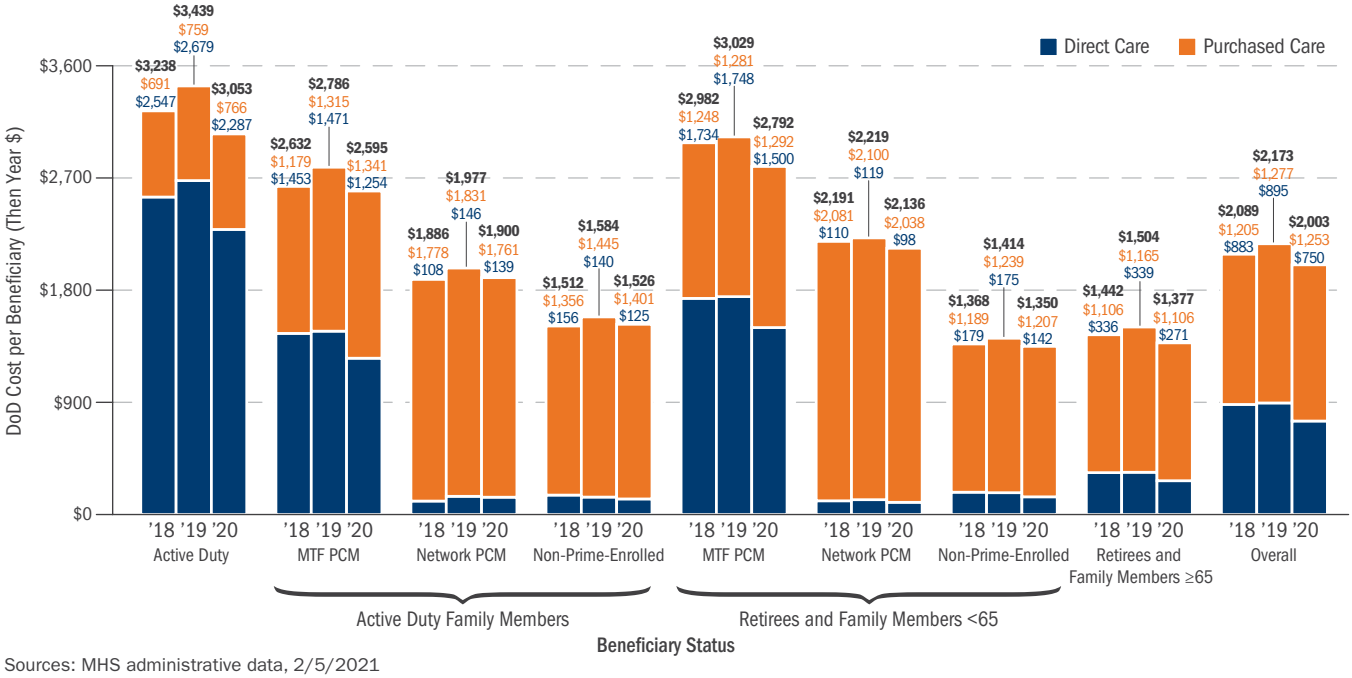
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Outpatient Costs by Beneficiary Status (U.S. Only)

Overall MHS outpatient costs (in then-year dollars) per beneficiary (far-right columns below), including TFL, decreased by 4 percent from FY 2018 to FY 2020. This was moderately less than the corresponding decrease in overall outpatient utilization (7 percent).

- The direct care cost per beneficiary decreased by 15 percent overall from FY 2018 to FY 2020. All beneficiary groups except ADFMs with a network PCM (29 percent increase) experienced a decline. Non-Prime-enrolled ADFMs and RETFMs under age 65 experienced the largest declines (20 percent each). Government expenditures on those beneficiary groups, however, were relatively small compared to beneficiaries enrolled with an MTF PCM.
- Excluding TFL, the per capita DoD purchased care outpatient cost increased by 4 percent overall. Every beneficiary group except those with a network PCM (decreases of 1 percent for ADFMs and 2 percent for RETFMs under age 65) experienced an increase. Increases ranged from 1 percent for non-Prime-enrolled RETFMs under age 65 to 13 percent for ADFMs with an MTF PCM.
- The TFL (purchased care) outpatient cost per beneficiary remained essentially unchanged between FY 2018 and FY 2020.[1]

AVERAGE ANNUAL DoD OUTPATIENT COSTS PER BENEFICIARY, FYs 2018–2020



Sources: MHS administrative data, 2/5/2021

[1] The basis for this statement is the collection of stacked bars labeled "Retirees and Family Members ≥65." Although the vast majority of TFL-eligible beneficiaries are retirees and family members ≥65, there is a small number who are not.

Notes:

– The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere.

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

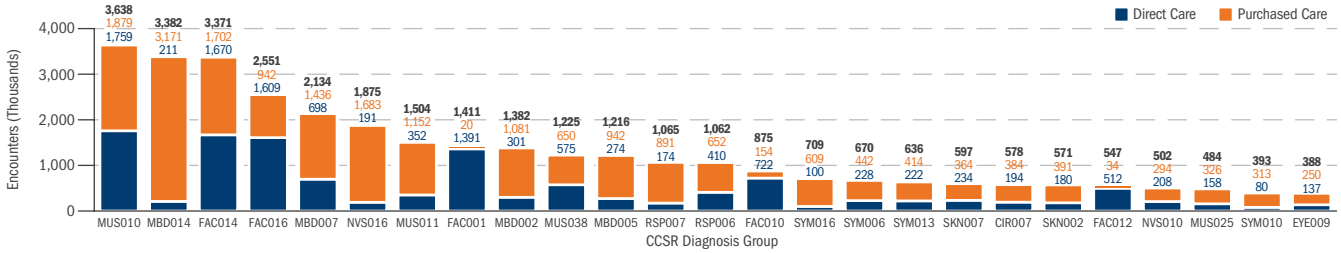
LOWER COST

OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

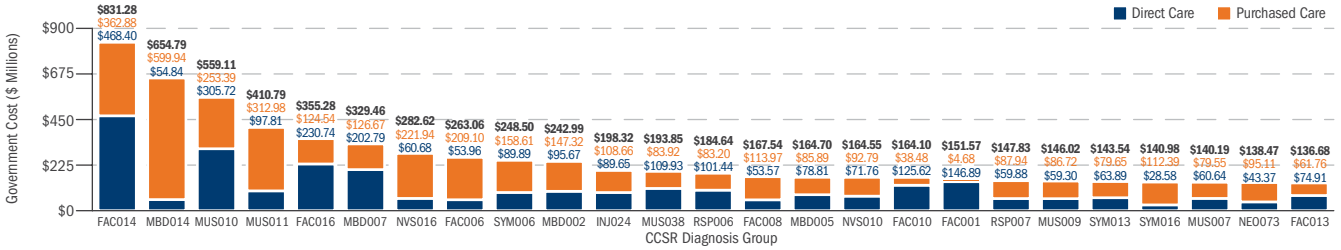
Leading Outpatient Diagnosis Groups (U.S. Only)

Leading outpatient diagnoses were determined by grouping ICD-10-CM primary diagnosis codes into like categories using the Clinical Classifications Software Refined (CCSR) tool developed through a federal-state-industry partnership sponsored by the Agency for Healthcare Research and Quality (AHRQ). The CCSR replaces the Clinical Classifications Software tool used in previous reports and takes advantage of the specificity of ICD-10-CM diagnoses to create new clinical categories. The top 25 outpatient diagnosis groups in FY 2020 accounted for 61 percent of all outpatient encounters (direct care and purchased care combined) and 46 percent of total outpatient costs.[1] Direct care drug expenses, which are included in outpatient costs in the direct care administrative data, are excluded from the cost totals in this section. TFL encounters and telephone consults are excluded from the calculations for both volume and cost.

LEADING OUTPATIENT DIAGNOSIS GROUPS BY VOLUME, FY 2020



LEADING OUTPATIENT DIAGNOSIS GROUPS BY COST, FY 2020



Sources: MHS administrative data, 2/5/2021

CCSR Diagnosis Groups

CIR007 Essential Hypertension
EYE009 Refractive Error
FAC001 Encounter for Administrative Purposes
FAC006 Encounter for Antineoplastic Therapies
FAC008 Neoplasm-Related Encounters
FAC010 Other Aftercare Encounter
FAC012 Other Specified Encounters and Counseling
FAC013 Contraceptive and Procreative Management
FAC014 Medical Examination/Evaluation
FAC016 Exposure, Encounters, Screening, or Contact with Infectious Disease
INJ024 Sprains and Strains, Initial Encounter
MBD002 Depressive Disorders
MBD005 Anxiety and Fear-Related Disorders
MBD007 Trauma- and Stressor-Related Disorders
MBD014 Neurodevelopmental Disorders
MUS007 Other Specified Joint Disorders
MUS009 Tendon and Synovial Disorders
MUS010 Musculoskeletal Pain, Not Low Back Pain
MUS011 Spondylopathies/Spondyloarthropathy (Including Infective)
MUS025 Other Specified Connective Tissue Disease
MUS038 Low Back Pain
NEO073 Benign Neoplasms
NVS010 Headache; Including Migraine
NVS016 Sleep Wake Disorders
RSP006 Other Specified Upper Respiratory Infections
RSP007 Other Specified and Unspecified Upper Respiratory Disease
SKN002 Other Specified Inflammatory Condition of Skin
SKN007 Other Specified and Unspecified Skin Disorders
SYM006 Abdominal Pain and Other Digestive/Abdomen Signs and Symptoms
SYM010 Nervous System Signs and Symptoms
SYM013 Respiratory Signs and Symptoms
SYM016 Other General Signs and Symptoms

- The top three diagnosis groups in terms of volume are the same, but in reverse order, as those in terms of cost. Those diagnosis groups are musculoskeletal pain (not low back pain), neurodevelopmental disorders, and medical examination/evaluation.
- Negative or unknown test results for COVID-19 are included in CCSR category FAC016 but cannot be separately identified. Positive test results are included in a CCSR category of its own, but it is not one of the top 25 in terms of volume or cost.
- Diagnoses treated in purchased care facilities account for 62 percent of the total volume of the top 25 diagnosis groups and 57 percent of the total cost.
- Encounters in direct care facilities exceed those in purchased care facilities for only four of the 25 top diagnosis groups. However, expenditures in direct care facilities exceed those in purchased care facilities for nine of the top 25 diagnosis groups.

[1] All costs were aggregated based on the primary diagnosis. Although some costs may be attributable to additional diagnoses on the record, there is no easy way to allocate the total cost to multiple diagnoses on the same record.

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

PRESCRIPTION DRUG UTILIZATION RATES AND COSTS

TRICARE Prescription Drug Utilization Rates Compared with Civilian Benchmarks (U.S. Only)

Prescription utilization is difficult to quantify since prescriptions come in different forms (e.g., liquid or pills), quantities, and dosages. Moreover, home delivery and MTF prescriptions can be filled for up to a 90-day supply, whereas retail prescriptions are usually based on 30-day increments for copayment purposes. Prescription counts from all sources (including civilian) were normalized by dividing the total days supply for each by 30 days.

Direct care pharmacy data differ from private-sector claims in that they include over-the-counter medications. To make the utilization rates of MHS and civilian beneficiaries more comparable, over-the-counter medications were backed out of the direct care data using factors provided by the DHA Pharmacy Operations Division.

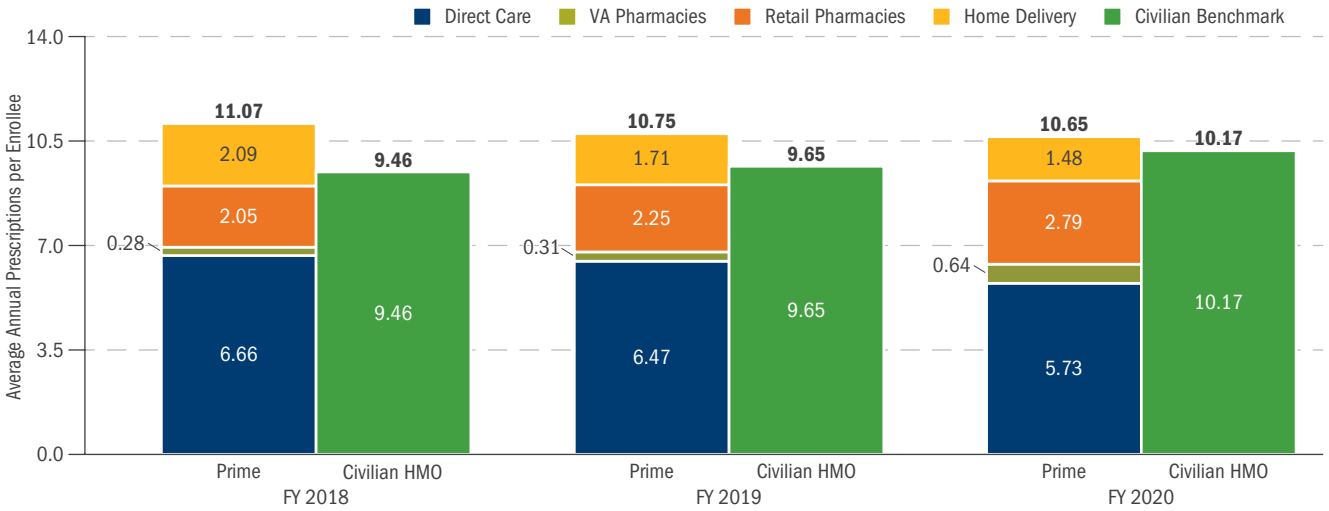
TRICARE Prime Enrollees

This section compares the outpatient prescription drug utilization of TRICARE Prime enrollees with that of enrollees in civilian employer-sponsored HMO plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. To give a more complete picture of total prescription drug utilization by TRICARE beneficiaries, prescriptions filled at Department of Veterans Affairs (VA) pharmacies as part of a beneficiary's VA benefit (and paid for by VA) are included. Prescriptions filled at VA pharmacies under the TRICARE benefit have always been included with retail pharmacy prescriptions. Comparisons are made for beneficiaries under age 65 only. The MHS data exclude beneficiaries enrolled in the USFHP and TRICARE Plus.

- The overall prescription utilization rate (direct care, VA, and purchased care combined) for TRICARE Prime enrollees decreased by 4 percent between FY 2018 and FY 2020, while the civilian HMO benchmark rate increased by 8 percent. In FY 2020, the TRICARE Prime prescription utilization rate was 5 percent higher than the civilian HMO rate.
- Prescription utilization rates for Prime enrollees at DoD pharmacies decreased by 14 percent between FY 2018 and FY 2020, whereas the utilization rate at retail pharmacies increased by 37 percent.
- Although the number of prescriptions is small, prescription utilization rates for Prime enrollees at VA pharmacies increased by 129 percent between FY 2018 and FY 2020.
- 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 2018 and FY 2020, enrollee home delivery prescription utilization decreased by 29 percent, likely due, at least in part, to a sharp increase in copayments for home delivery drugs. In FY 2020, home delivery accounted for 35 percent of per capita purchased care prescription utilization by Prime enrollees (as measured by 30-day supply), which is down from 51 percent in FY 2018. The overall purchased care share of prescription utilization for Prime enrollees increased from 38 percent in FY 2018 to 43 percent in FY 2020.

LOWER COST

PRESCRIPTION UTILIZATION RATES BY SOURCE OF CARE[a]: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK, FYs 2018–2020



Sources: MHS administrative data, 2/5/2021, and IBM Watson Health, MarketScan® CCAE database, 1/15/2021

[a] Source of care (direct, VA, retail, or home delivery) is based solely on where the prescriptions were filled, not on where the prescribing services were provided.

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2020 civilian benchmarks are based on two quarters of data, which were seasonally adjusted and annualized.

PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT.)*

TRICARE Prescription Drug Utilization Rates Compared with Civilian Benchmarks (U.S. Only) *(cont.)*

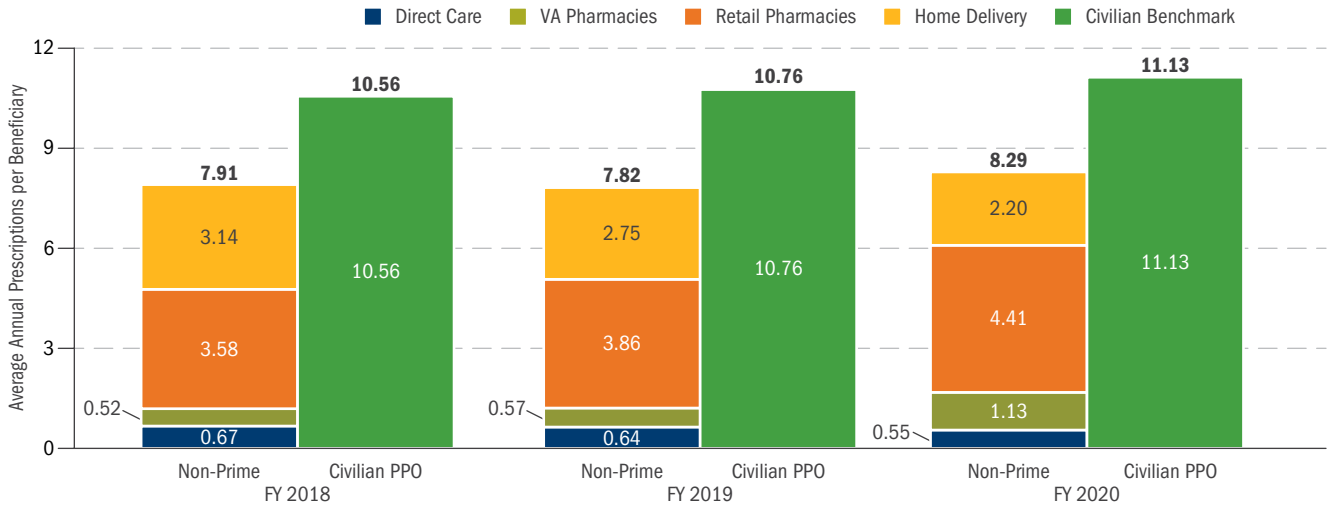
Non-Prime-Enrolled Beneficiaries

This section compares the outpatient prescription drug utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored PPO plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. To give a more complete picture of total prescription drug utilization by TRICARE beneficiaries, prescriptions filled at VA pharmacies as part of a beneficiary's VA benefit (and paid for by VA) are included. Prescriptions filled at VA pharmacies under the TRICARE benefit have always been included with retail pharmacy prescriptions. The comparisons are made for beneficiaries under age 65 only.

To make the utilization rates of MHS and civilian beneficiaries more comparable, non-Prime-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Although most beneficiaries who fail to file a TRICARE claim have private health insurance, we estimate that about 18 percent do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable to the civilian rates, which also include non-users.

- The overall prescription utilization rate (direct care, VA, and purchased care combined) for non-Prime-enrolled beneficiaries increased by 5 percent between FY 2018 and FY 2020. During the same period, the civilian PPO benchmark rate also increased by 5 percent. In FY 2020, the TRICARE prescription utilization rate for non-Prime enrollees was 26 percent lower than the civilian PPO rate.
- The direct care prescription utilization rate for non-Prime-enrolled beneficiaries decreased by 18 percent from FY 2018 to FY 2020, whereas the utilization rate at retail pharmacies increased by 23 percent.
- Prescription utilization rates for non-Prime enrollees at VA pharmacies increased by 117 percent between FY 2018 and FY 2020.
- Home delivery prescription utilization had been on the upswing since the DoD began increasing the disparity in copayments between retail andhome delivery drugs in FY 2012. However, between FY 2018 and FY 2020, non-Prime-enrollee home delivery prescription utilization decreased by 30 percent, likely due, at least in part, to a sharp increase in copayments for home delivery drugs. In FY 2020, home delivery accounted for 33 percent of per capita purchased care prescription utilization by non-Prime enrollees (as measured by 30-day supply), which is down from 47 percent in FY 2018. The overall purchased care share of prescription utilization for non-Prime enrollees increased slightly from 91 percent in FY 2018 to 92 percent in FY 2020.

PRESCRIPTION UTILIZATION RATES BY SOURCE OF CARE[a]: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK, FYs 2018–2020



Sources: MHS administrative data, 2/5/2021, and IBM Watson Health, MarketScan® CCAE database, 1/15/2021

[a] Source of care (direct, VA, retail, or home delivery) is based solely on where the prescriptions were filled, not on where the prescribing services were provided.
Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2020 civilian benchmarks are based on two quarters of data, which were seasonally adjusted and annualized.

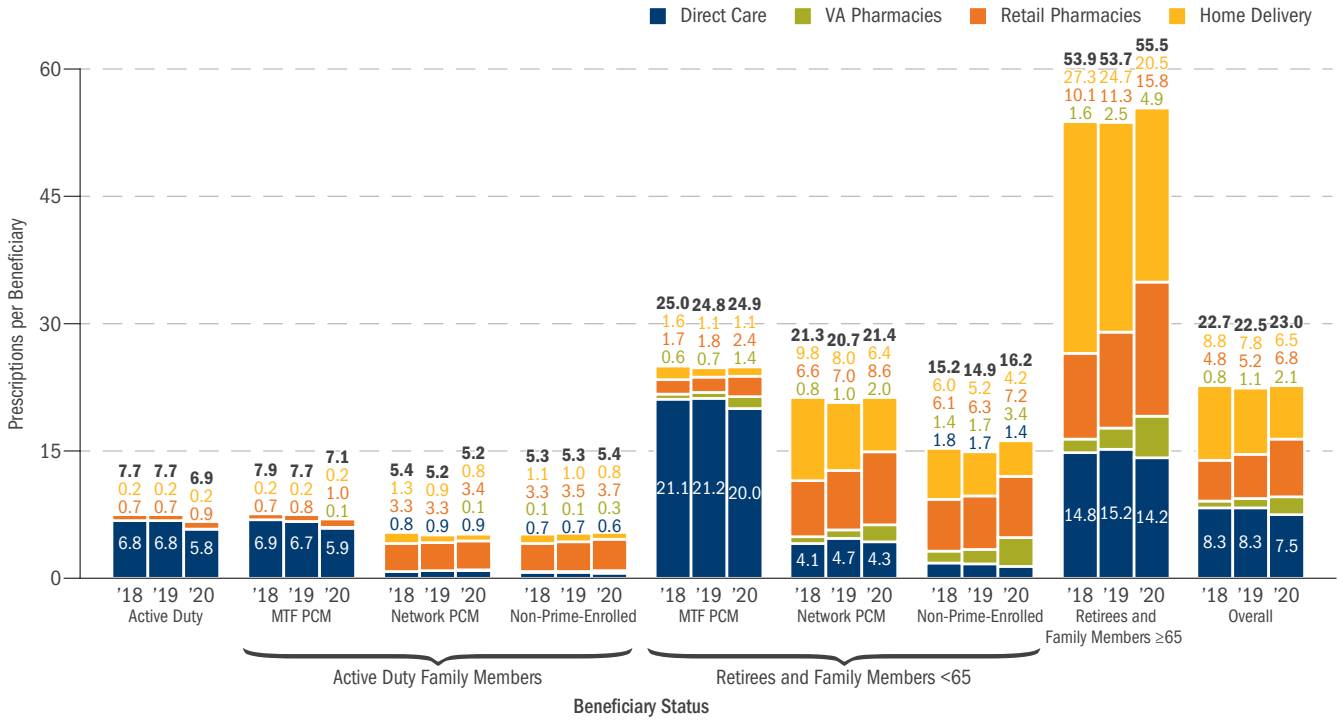
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT.)*

TRICARE Prescription Drug Utilization Rates by Beneficiary Status (U.S. Only)

Prescriptions include all initial and refill prescriptions filled at military pharmacies, VA pharmacies (for DoD/VA dual-eligible beneficiaries), retail pharmacies, and home delivery. VA prescriptions include those filled as part of a beneficiary's VA benefit and paid for by VA. Prescriptions filled at a VA pharmacy under the TRICARE benefit are included with retail pharmacy prescriptions. Prescription counts from all sources were normalized by dividing the total days supply for each by 30 days.

- The total (direct, VA, retail, and home delivery) number of prescriptions per beneficiary decreased by 2 percent from FY 2018 to FY 2020, exclusive of the TFL benefit. Including TFL, the total number of prescriptions increased by 1 percent.
- The overall direct care prescription utilization rate declined by 10 percent between FY 2018 and FY 2020. Declines were experienced by all beneficiary groups except those enrolled with a network PCM (13 percent increase for ADFMs and 5 percent increase for RETFMs). The largest decline was experienced by non-Prime-enrolled ADFMs (14 percent) followed by non-Prime-enrolled RETFMs under age 65 (22 percent), and ADFMs with an MTF PCM (14 percent).
- Average per capita VA pharmacy prescription utilization increased by 163 percent from FY 2018 to FY 2020.
- Average per capita prescription utilization through retail pharmacies increased by 42 percent overall, despite the congressionally mandated requirement for non-Active Duty beneficiaries to refill prescriptions for select nongeneric maintenance medications at TRICARE home delivery or MTF pharmacies and an increase in copayments for retail drugs. Increases occurred for every beneficiary group, ranging from 3 percent for ADFMs with a network PCM to 56 percent for RETFMs age 65 or older.
- Home delivery utilization, which had been on the rise until FY 2017, reversed course in FY 2018 and continued to drop in FY 2019 and again in FY 2020 (for a cumulative drop of 26 percent between FY 2018 and FY 2020). The drop is likely due to a large increase in copayments for home delivery drugs mandated by the National Defense Authorization Act (NDAA) for FY 2018. In FY 2020, home delivery drugs accounted for 49 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 34 percent of total purchased care prescription drug utilization, whereas for seniors it accounts for 56 percent.

AVERAGE ANNUAL PRESCRIPTION UTILIZATION PER BENEFICIARY, FYs 2018–2020



Source: MHS administrative data, 2/5/2021

Notes:

– The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere.

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

LOWER COST

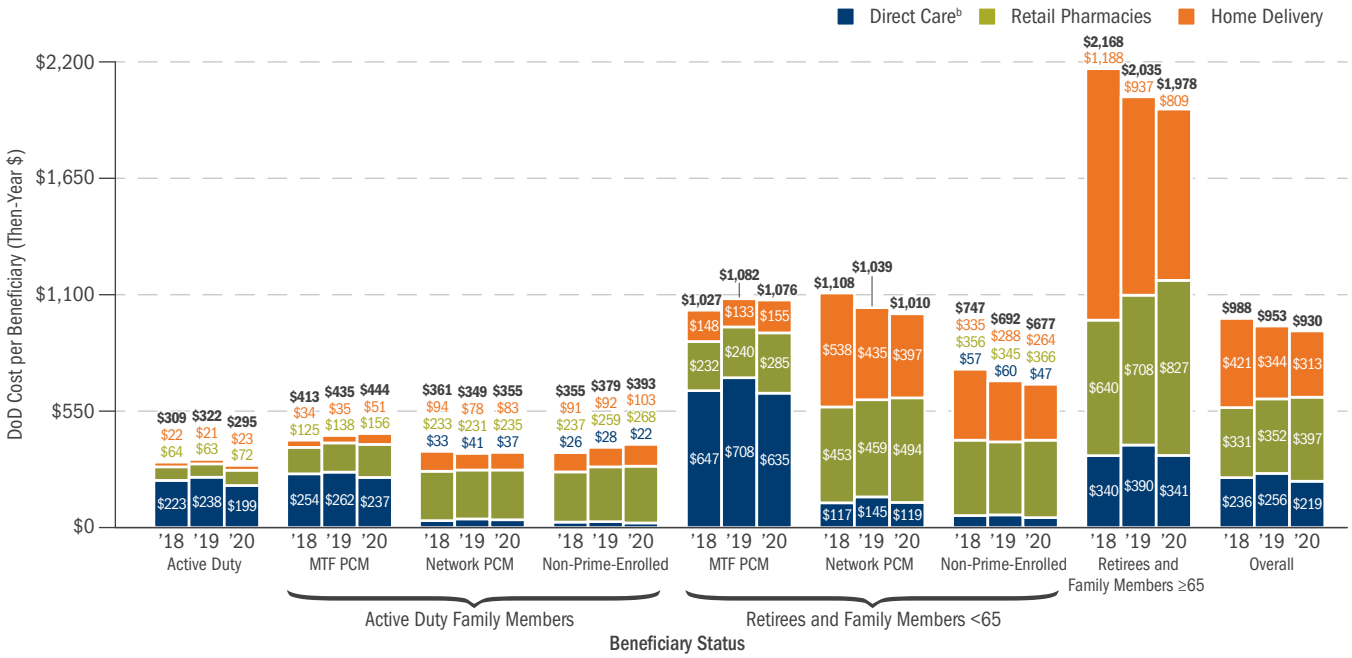
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT.)*

Prescription Drug Cost by Beneficiary Status

Although the drug refunds referenced on page 53 have slowed the overall growth of retail prescription drug costs, the refunds are not reflected in the chart below because they cannot be attributed to specific beneficiary groups. Exclusive of refunds, overall MHS prescription drug costs (in then-year dollars) per beneficiary (far-right columns below), including TFL, decreased by 6 percent from FY 2018 to FY 2020. 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 3 percent between FY 2018 and FY 2020.
- Declines ranged from 2 percent for ADFMs with a network PCM to 9 percent for non-Prime-enrolled RETFMs. The only groups to experience increases were non-Prime-enrolled ADFMs (11 percent) and beneficiaries with an MTF PCM (8 percent for ADFMs and 5 percent for RETFMs under age 65).
- Direct care costs per beneficiary decreased by 7 percent, while retail pharmacy costs increased by 11 percent excluding TFL and by 20 percent including TFL.
- Home delivery costs per beneficiary decreased by 13 percent excluding TFL and by 26 percent including TFL. RETFMs age 65 and older experienced the largest decline (32 percent) while ADFMs with an MTF PCM experienced the largest increase.

AVERAGE ANNUAL DoD PRESCRIPTION COSTS PER BENEFICIARY, FYs 2018–2020[a]



Source: MHS administrative data, 2/5/2021

[a] Excludes retail drug refunds.

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

Notes:

– The "Retirees and Family Members" groups include survivors and others not explicitly identified elsewhere.

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

BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65)

Out-of-pocket costs are computed for Active Duty and retiree families in the U.S. grouped by sponsor age: (1) under 65; and (2) 65 and older (seniors). Costs include deductibles and copayments for medical care and drugs, TRICARE enrollment fees, and insurance premiums. Costs are compared with those of civilian counterparts (i.e., civilian families with the same demographics as the typical MHS family). For beneficiaries under age 65, civilian counterparts are assumed to be covered by employer-sponsored OHI.

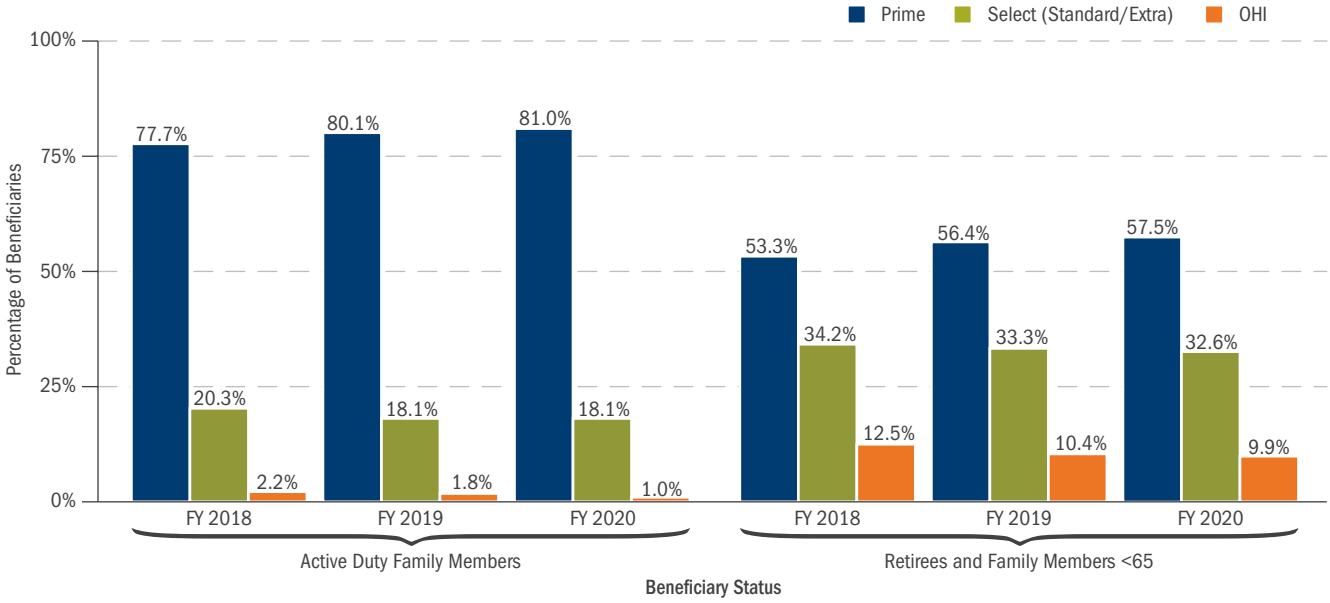
Health Insurance Coverage of MHS Beneficiaries Under Age 65

MHS beneficiaries have a choice of (1) TRICARE Prime, including TYA Prime and USFHP; (2) TRICARE Select, including TYA Select, TRICARE Reserve Select (TRS), and TRICARE Retired Reserve (TRR); (3) direct care only (space-available care); and (4) OHI. Many beneficiaries with OHI have no TRICARE utilization; however, some use TRICARE as a second payer.

Beneficiaries are grouped by their primary health plan:

- **TRICARE Prime:** Family enrolled in TRICARE Prime (including a small percentage who also have OHI coverage). In FY 2020, 81 percent of Active Duty families and 58 percent of retiree families were in this group.
- **TRICARE Select (Standard/Extra):** Family enrolled in TRICARE Select (or Standard/Extra in early FY 2018) or relying on space-available MTF care in FYs 2018–2020 and who do not have OHI coverage. In FY 2020, 18 percent of Active Duty families and 33 percent of retiree families were in this group.
- **OHI:** Family covered by OHI. In FY 2020, 1 percent of Active Duty families and 10 percent of retiree families were in this group.

HEALTH INSURANCE COVERAGE OF BENEFICIARIES UNDER AGE 65, FYs 2018–2020



Source: Insurance coverage in FYs 2018–2020 based on Defense Enrollment Eligibility Reporting System (DEERS) and Health Care Survey of DoD Beneficiaries (HCSDB) responses; as of 12/31/2020

Notes:

- The Prime group includes HCSDB respondents enrolled in Prime based on DEERS plus enrollees in the USFHP. The Select (Standard/Extra) group includes HCSDB respondents without OHI who are not enrolled in Prime based on DEERS. The OHI group includes HCSDB respondents with private health insurance (i.e., Federal Employees Health Benefits Plan [FEHBP]), a civilian HMO such as Kaiser, or other civilian insurance such as Blue Cross. A small percentage of Prime enrollees are also covered by OHI; these beneficiaries are included in the Prime group.
- Percentages may not sum to 100 percent due to rounding.
- Numbers for FYs 2018 and 2019 may differ slightly from last year's report. FY 2020 HCSDB data showed a higher sampling of Inactive Guard/Reserve family members by nearly a factor of 10 compared to previous years. To account for this discrepancy, we excluded Inactive Guard/Reserve family members for all years to avoid biasing the calculations.

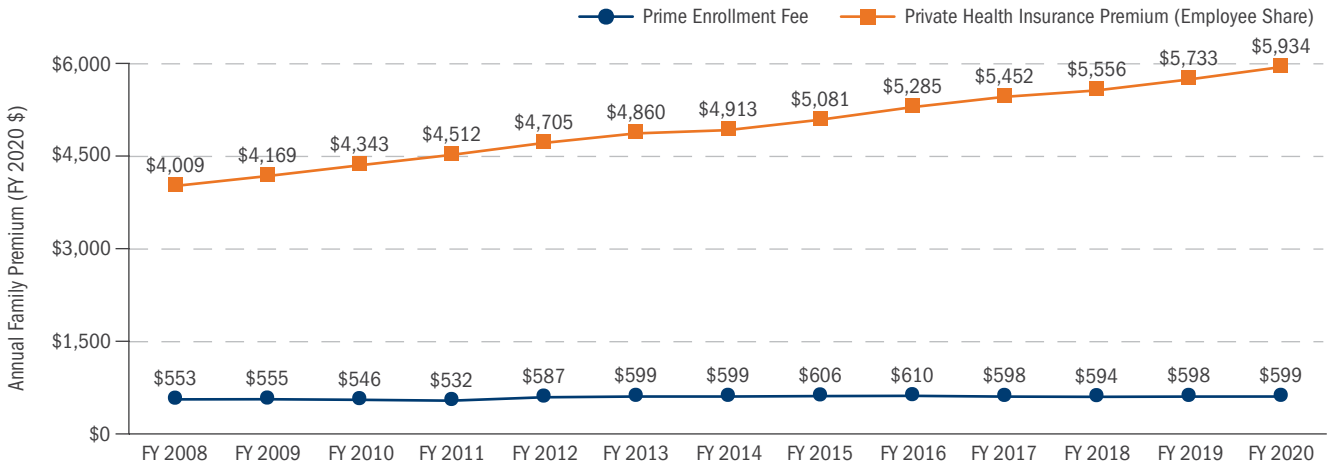
LOWER COST

BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Retirees and Family Members Under Age 65 Returning to the MHS

From FY 2008 to FY 2020, the average private health insurance family premium has increased, whereas the TRICARE Prime enrollment fee remained essentially flat. In FY 2020 dollars, private health insurance premiums increased by $1,925 (48 percent) over this period, whereas the TRICARE Prime enrollment fee increased by only $46 (8 percent).

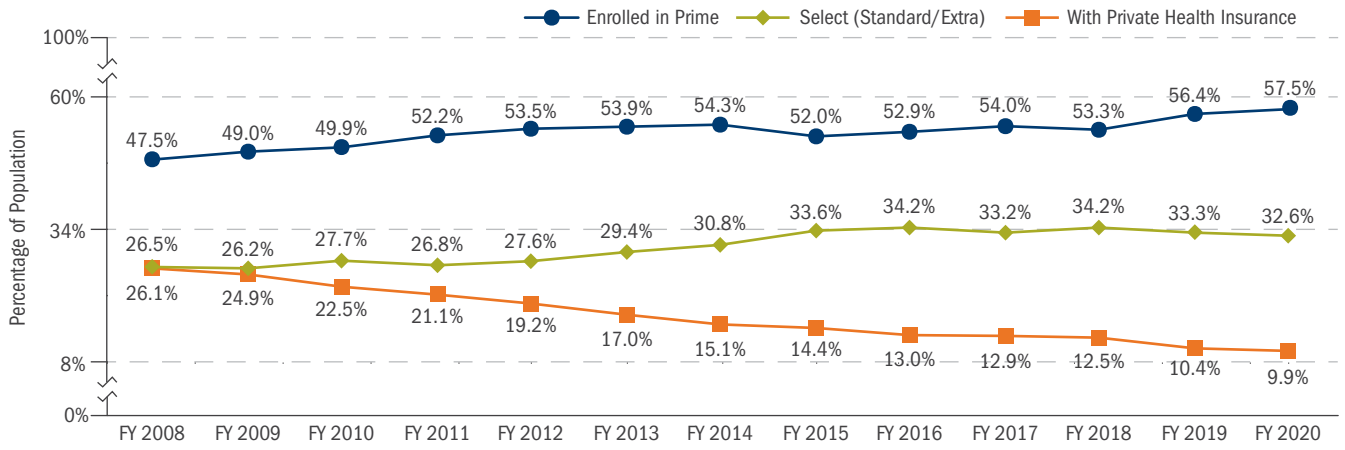
TRENDS IN PRIVATE INSURANCE PREMIUMS VS. TRICARE PRIME ENROLLMENT FEE, FYs 2008–2020



Sources: The employee share of insurance premium for a typical employer-sponsored family health plan in FYs 2008–2020 from the Insurance Component of the Medical Expenditure Panel Survey (MEPS) 2006–2018; OHI premiums in FY 2020 projected by the Institute for Defense Analyses (IDA) based on the average growth rate of premiums in FYs 2014–2018; There is mixed evidence of the impact of the COVID-19 pandemic's impact on health insurance premiums. The Kaiser Family Foundation's analysis of ACA Marketplace plans shows that premium rate changes ranged from –3.5 percent to 4.6 percent. Plans that directly cite COVID-19 impacts reported increases in premiums from 0 percent to 2 percent due to the effects of the pandemic. https://www.kff.org/private-insurance/issue-brief/2021-premium-changes-on-aca-exchanges-and-the-impact-of-covid-19-on-rates/ as of 12/31/2020.

Between FY 2010 and FY 2020, 12 percent of retirees switched from private health insurance to TRICARE. Most switched because of an increasing disparity in premiums and out-of-pocket expenses; some lost coverage due to above-average unemployment in FYs 2009–2014.[1] As a result of declines in private insurance coverage, about 500,000 more retirees and family members under age 65 in the U.S. are now relying primarily on TRICARE instead of on private health insurance.

TRENDS IN RETIREE (<65) HEALTH INSURANCE COVERAGE, FYs 2008–2020



Sources: Insurance coverage in FYs 2008–2020 based on DEERS and HCSDB responses in FYs 2008–2020; as of 12/31/2020

Note: The Prime enrollment rates above include about 4 percent of retirees who also have private health insurance.

[1] For an analysis of retirees' switching from OHI to TRICARE, see Goldberg et al., "Demand for Health Insurance by Military Retirees," IDA Document D-5098, May 2015, Alexandria, Va.: IDA.

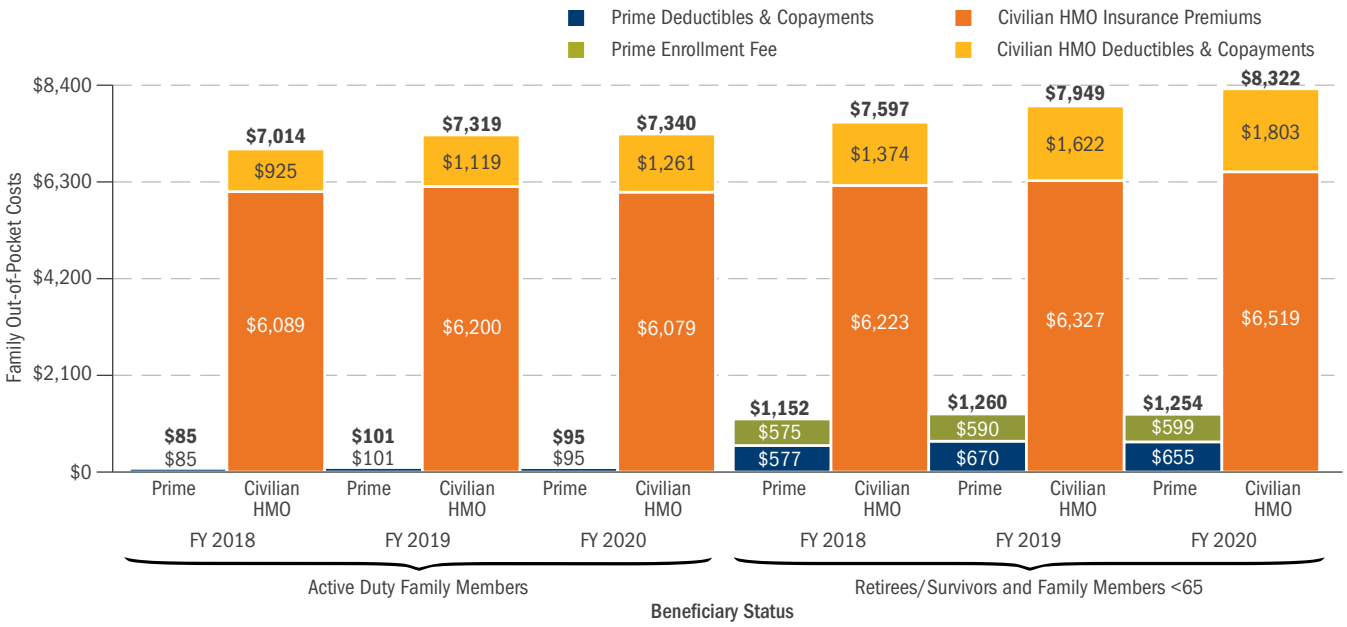
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Out-of-Pocket Costs for Families Enrolled in TRICARE Prime vs. Civilian HMO Counterparts

In FYs 2018–2020, civilian counterpart families enrolled in HMO plans had substantially higher out-of-pocket costs than TRICARE Prime enrollees.

- Civilian HMO counterparts paid more for insurance premiums, deductibles, and copayments.
- In FY 2020, costs for civilian HMO counterparts were:
  - $7,200 more than those incurred by Active Duty families enrolled in Prime
  - $7,100 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 2018–2020



Sources: TRICARE beneficiary expenditures for deductibles and copayments in FYs 2018–2020 from MHS administrative data for all families enrolled in Prime without OHI payments, 12/31/2020; civilian benchmark expenditures for deductibles and copayments from IBM Watson Health, MarketScan® CCAE database, 1/5/2021; civilian benchmark insurance premiums from the Insurance Component of the MEPS (actuals in FYs 2018, projected in FY 2019 and 2020), 12/31/2020

Notes:

– Estimates are for a demographically typical family. For Active Duty dependents, a family includes a spouse and 1.54 children, on average. For retirees, a family includes a sponsor, spouse, and 0.65 children.

– The Peterson Center on Healthcare and Kaiser Family Foundation's Health System Tracker has published estimates of the impacts to spending and utilization during the COVID-19 pandemic. They estimate that health services spending in 2020 has fallen by 2.4 percent as compared to the previous year. Furthermore, they publish quarterly estimates of spending growth. At the height of the pandemic during the second quarter of 2020, health spending fell by 8.6 percent. As the data used to calculate civilian comparisons has a lag time to publication, IDA uses the Peterson/Kaiser Family Foundation report to adjust civilian estimates of spending and utilization to account for the short-term impacts of the COVID pandemic. Source: https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/#item-covidhealthspendingutilizationcollection_1

– MarketScan data cover a full four quarters in FYs 2018 and 2019. Only two quarters of data were available for FY 2020. The remaining quarters were projected with year-on-year quarterly estimates from the Peterson/Kaiser Family Foundation report.

– Some dual-eligible retirees receive care from the VA, which is not included in MHS administrative data. Using regression analyses, we estimated utilization at VA facilities in FYs 2018–2020 for retirees enrolled in Prime and included those estimates in total utilization (e.g., $461 per retiree family in FY 2019).

– Civilian expenditures for deductibles and copayments are somewhat higher than in previous reports. Our previous source was the MEPS, which marginally understates those expenditures relative to MarketScan (see Zuvekas, S. "Comparing MEPS Use and Expenditure Estimates for the Privately Insured to Truven MarketScan® and OptumLabs™ Claims Data, 2008–2013." Center for Financing, Access and Cost Trends, AHRQ. October 2017).

LOWER COST

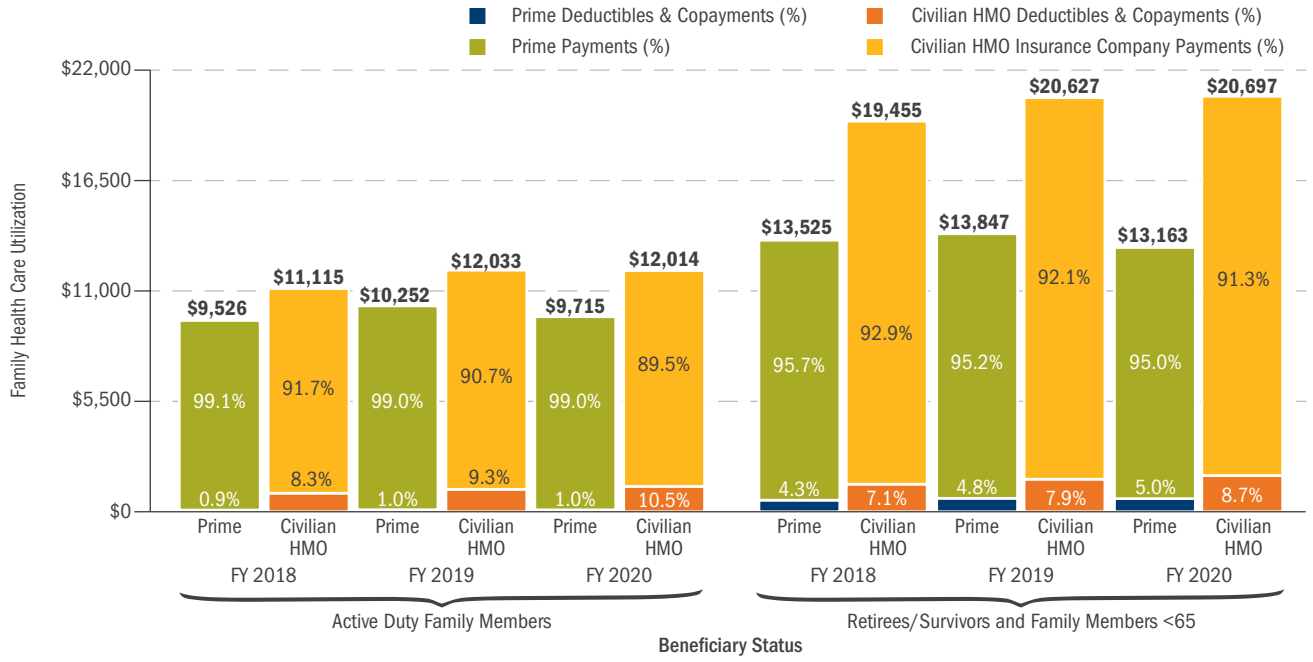
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Coinsurance and Health Care Utilization for Families Enrolled in TRICARE Prime vs. Civilian HMO Counterparts

In FYs 2018–2020, TRICARE Prime enrollees had lower coinsurance rates (deductibles and copayments per dollar of utilization) and less utilization than their civilian HMO counterparts.

- In FYs 2018–2020, TRICARE Prime enrollees had coinsurance rates that were 3 to 10 percentage points below those of their civilian HMO counterparts.
  - In FY 2020, the coinsurance rate for Active Duty families was 1 percent—10 percentage points lower than civilian HMO counterparts (11 percent).
  - In FY 2020, the coinsurance rate for retiree families was 5 percent—4 percentage points lower than civilian HMO counterparts (9 percent).
- In FYs 2018–2020, TRICARE Prime enrollees had lower health care utilization than their civilian HMO counterparts.
  - In FY 2020, Active Duty families consumed $9,700 of medical services—$2,300 less than civilian HMO counterparts ($12,000).
  - In FY 2020, retiree families consumed $13,200 in medical services—$7,500 less than civilian HMO counterparts ($20,700).

COINSURANCE AND HEALTH CARE UTILIZATION FOR FAMILIES ENROLLED IN TRICARE PRIME VS. CIVILIAN HMO COUNTERPARTS, FYs 2018–2020



Sources: TRICARE health care utilization expenditures by both the government and beneficiaries in FYs 2018–2020 from MHS administrative data for all families enrolled in Prime without OHI payments for TRICARE utilization, 12/31/2020; civilian insurance company and beneficiary benchmark expenditures from IBM Watson Health, MarketScan® CCAE database, 1/5/2021

Notes:

– The Peterson Center on Healthcare and Kaiser Family Foundation's Health System Tracker has published estimates of the impacts to spending and utilization during the COVID-19 pandemic. They estimate that health services spending in 2020 has fallen by 2.4 percent as compared to the previous year. Furthermore, they publish quarterly estimates of spending growth. At the height of the pandemic during the second quarter of 2020, health spending fell by 8.6 percent. As the data used to calculate civilian comparisons has a lag time to publication, IDA uses the Peterson/Kaiser Family Foundation report to adjust civilian estimates of spending and utilization to account for the short-term impacts of the COVID pandemic. Source: https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/#item-covidhealthspendingutilizationcollection_1

– MarketScan data cover a full four quarters in FYs 2018 and 2019. Only two quarters of data were available for FY 2020. The remaining quarters were projected with year-on-year quarterly estimates from the Peterson/Kaiser Family Foundation report.

– Some dual-eligible retirees receive care from the VA, which is not included in MHS administrative data. Using regression analyses, we estimated utilization at VA facilities in FYs 2018–2020 for retirees enrolled in Prime and included those estimates in total utilization (e.g., $613 per retiree family in FY 2020).

– Civilian benchmark total utilization expenditures (i.e., beneficiary plus insurance company payments) are notably higher than those in previous reports. Our previous source for civilian benchmark expenditures was the MEPS, which has been found to significantly understate actual expenditures relative to MarketScan (see Zuvekas, S. "Comparing MEPS Use and Expenditure Estimates for the Privately Insured to Truven MarketScan® and OptumLabs™ Claims Data, 2008–2013." Center for Financing, Access and Cost Trends, AHRQ. October 2017).

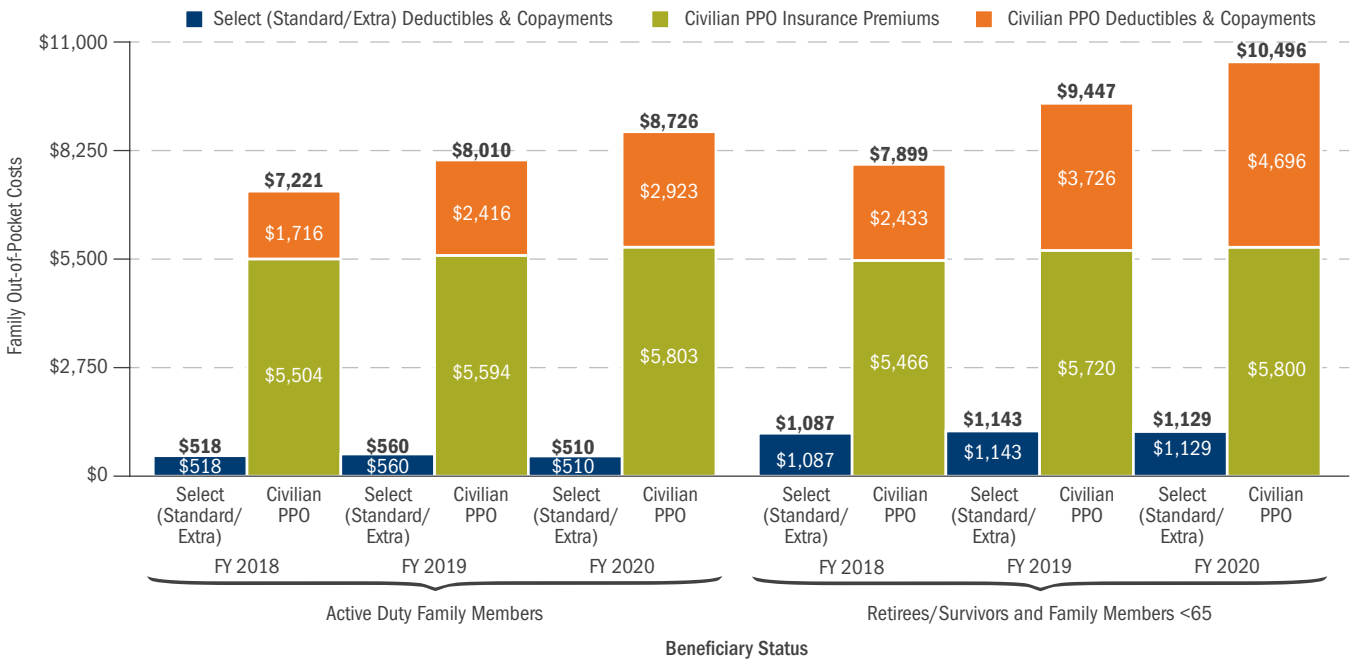
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Out-of-Pocket Costs for Families Who Rely on TRICARE Select (Standard/Extra) or Direct Care vs. Civilian PPO Counterparts

In FYs 2018–2020, civilian counterpart families enrolled in PPO plans had much higher out-of-pocket costs than TRICARE Select (Standard/Extra) users.

- In FYs 2018–2020, civilian PPO counterparts paid $6,500 to $9,000 more for insurance premiums, deductibles, and copayments.
- In FY 2020, costs for civilian PPO counterparts were:
  - $8,200 more than those incurred by Active Duty families who relied on TRICARE Select
  - $9,400 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 2018–2020



Sources: TRICARE health care utilization expenditures by both the government and beneficiaries in FYs 2018–2020 from MHS administrative data for all families enrolled in Prime without OHI payments for TRICARE utilization, 12/31/2020; civilian insurance company and beneficiary benchmark expenditures from IBM Watson Health, MarketScan® CCAE database, 1/5/2021

Notes:

– The Peterson Center on Healthcare and Kaiser Family Foundation's Health System Tracker has published estimates of the impacts to spending and utilization during the COVID-19 pandemic. They estimate that health services spending in 2020 has fallen by 2.4 percent as compared to the previous year. Furthermore, they publish quarterly estimates of spending growth. At the height of the pandemic during the second quarter of 2020, health spending fell by 8.6 percent. As the data used to calculate civilian comparisons has a lag time to publication, IDA uses the Peterson/Kaiser Family Foundation report to adjust civilian estimates of spending and utilization to account for the short-term impacts of the COVID pandemic. Source: https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/#item-covidhealthspendingutilizationcollection_1

– MarketScan data cover a full four quarters in FYs 2018 and 2019. Only two quarters of data were available for FY 2020. The remaining quarters were projected with year-on-year quarterly estimates from the Peterson/Kaiser Family Foundation report.

– Some dual-eligible retirees receive care from the VA, which is not included in MHS administrative data. Using regression analyses, we estimated utilization at VA facilities in FYs 2018–2020 for retirees enrolled in Prime and included those estimates in total utilization (e.g., $613 per retiree family in FY 2020).

– Civilian benchmark total utilization expenditures (i.e., beneficiary plus insurance company payments) are notably higher than those in previous reports. Our previous source for civilian benchmark expenditures was the MEPS, which has been found to significantly understate actual expenditures relative to MarketScan (see Zuvekas, S. "Comparing MEPS Use and Expenditure Estimates for the Privately Insured to Truven MarketScan® and OptumLabs™ Claims Data, 2008–2013." Center for Financing, Access and Cost Trends, AHRQ. October 2017).

LOWER COST

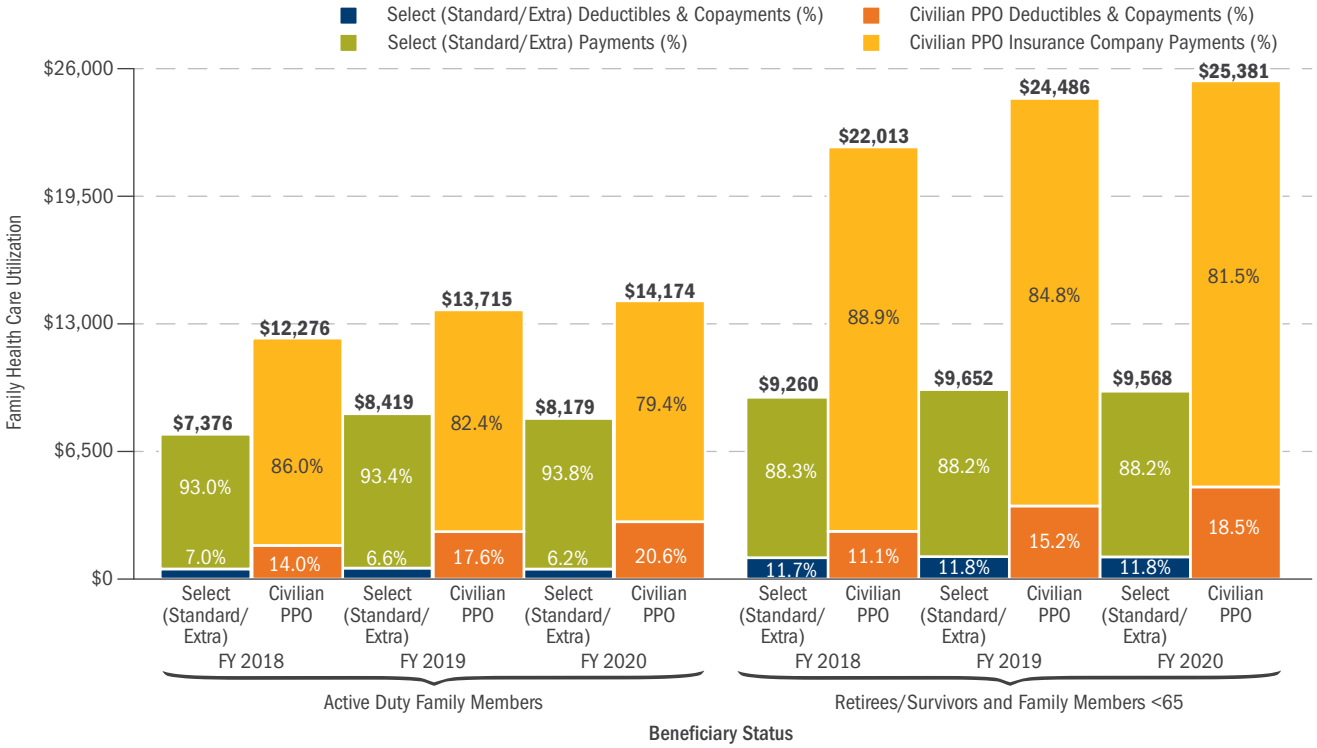
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Coinsurance and Health Care Utilization for Families Who Rely on TRICARE Select (Standard/Extra) or Direct Care vs. Civilian PPO Counterparts

Active Duty families who relied on TRICARE Select had lower coinsurance rates (deductibles and copayments per dollar of utilization) and lower health care utilization (dollar value of health care services consumed) than their civilian counterparts enrolled in PPO plans. Retiree families have seen their coinsurance rates remain relatively stable while their civilian counterparts have faced rising rates. Retiree families exhibited substantially lower utilization.

- In FY 2020 for Active Duty families:
  - Coinsurance rates were 6 percent versus 21 percent for civilian PPO counterparts (15 percentage points lower).
  - Health care utilization was $8,200 versus $14,200 for civilian PPO counterparts ($6,000 less).
- In FY 2020 for retiree families:
  - Coinsurance rates were 12 percent versus 19 percent for civilian PPO counterparts (seven percentage points lower).
  - Health care utilization was $9,600 versus $25,400 for civilian PPO counterparts ($15,800 less).

COINSURANCE AND HEALTH CARE UTILIZATION FOR FAMILIES WHO RELY ON TRICARE SELECT (STANDARD/EXTRA) OR DIRECT CARE VS. CIVILIAN PPO COUNTERPARTS, FYs 2018–2020



Sources:TRICARE health care utilization expenditures by both the government and beneficiaries in FYs 2018–2020 from MHS administrative data for all families enrolled in Prime without OHI payments for TRICARE utilization, 12/31/2020; civilian insurance company and beneficiary benchmark expenditures from IBM Watson Health, MarketScan® CCAE database, 1/5/2021

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BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES)

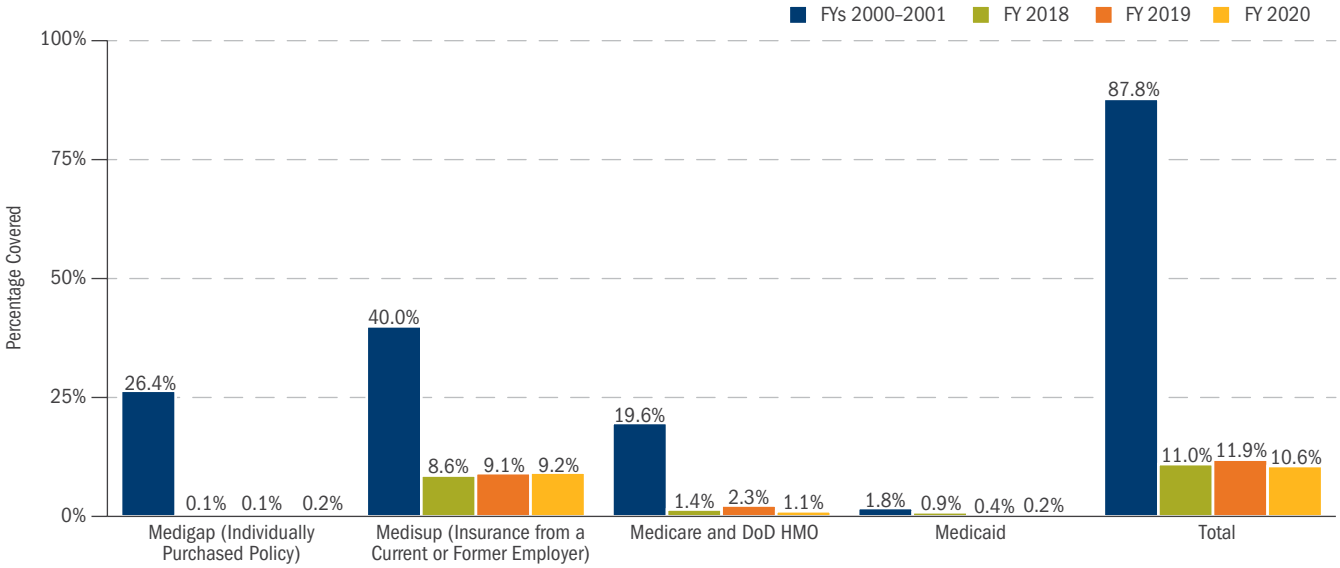
Out-of-pocket costs for retirees aged 65 and older (seniors) and their families include deductibles and copayments for medical care and drugs, TRICARE enrollment fees, and insurance premiums. In April 2001, the DoD expanded drug benefits for seniors; on October 1, 2001, the DoD implemented the TFL program, 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), 88 percent of MHS seniors had Medicare supplemental insurance or were covered by Medicaid. After TFL, the percentage of MHS seniors with supplemental insurance or Medicaid fell sharply. It was about 11 percent in FY 2020.
- Why do some seniors retain supplemental insurance, especially a Medisup policy, when they can use TFL for free? Some possible reasons are:
  - A lack of awareness of the TFL benefit.
  - A desire for dual coverage.
  - Higher family insurance costs if a spouse is not yet Medicare-eligible. Dropping a non-Medicare-eligible spouse from an employer-sponsored plan can result in higher family costs if the spouse must purchase a nonsubsidized individual policy.

MEDICARE SUPPLEMENTAL INSURANCE COVERAGE OF MHS SENIORS, FYs 2000–2001 VS. FYs 2018–2020



Source: FYs 2000–2001 and FYs 2018–2020 HCSDB, as of 12/31/2020

[1] Medigap is an individually purchased policy that covers Medicare deductibles and copayments. Medisup is group insurance from a current or former employer (or a union). It includes those with Medicare who are covered either by FEHBP, a civilian HMO such as Kaiser, or other civilian health insurance such as Blue Cross. Individually obtained HMO policies include Medicare Advantage, USFHP, and TRICARE Senior Prime (until December 2001). Almost all TRICARE seniors are covered by Medicare and are enrolled in Parts A and B; only 1.3 percent have just Part A. About 1 percent of TRICARE seniors are covered by government-sponsored Medicaid. About 1 percent of TRICARE seniors have OHI and are not covered by Medicare; these are excluded from the above figure; as of 12/31/2020.

LOWER COST

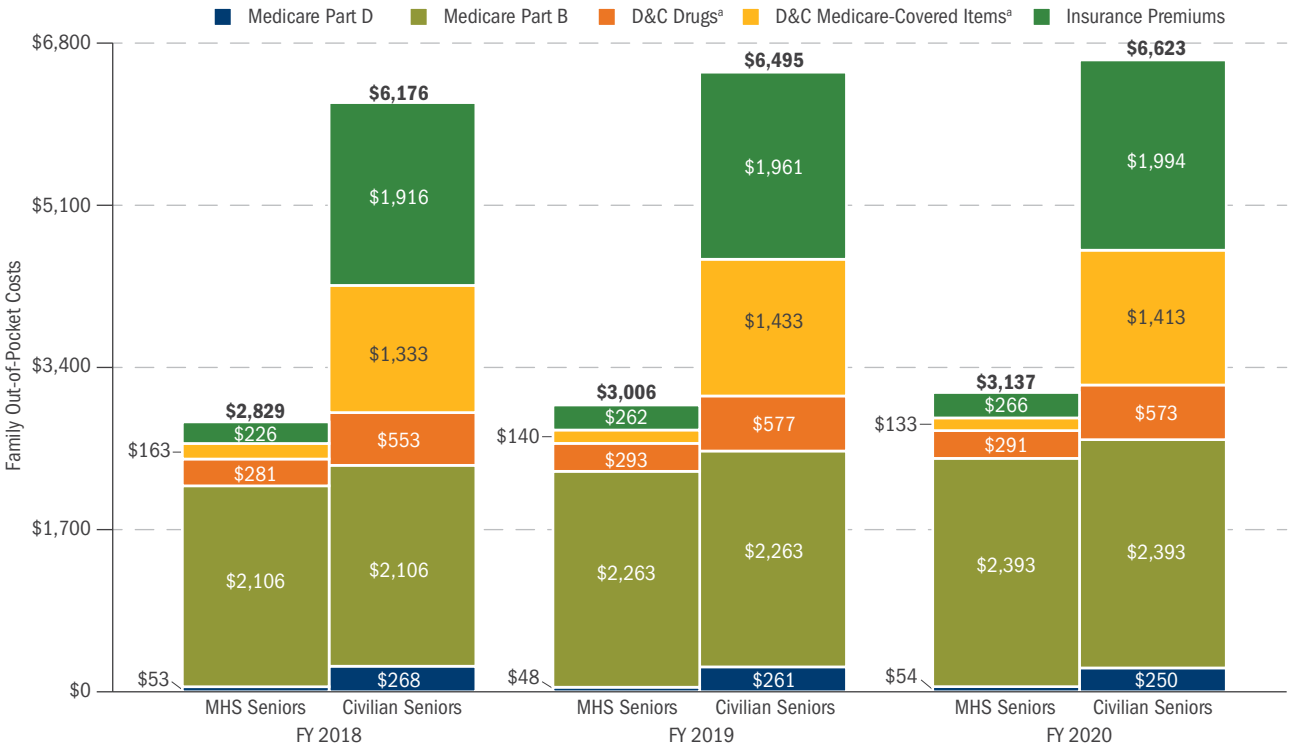
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT.)*

Out-of-Pocket Costs for MHS Senior Families Before and After TFL

About 87 percent of TRICARE senior families use MHS health care. TFL and added drug benefits have enabled MHS seniors to reduce their out-of-pocket costs for deductibles/copayments and supplemental insurance. The costs for a typical TRICARE senior family after TFL, including MHS users and non-users, are compared with those of their civilian counterparts having supplemental insurance coverage similar to TRICARE senior families in FYs 2000–2001 (before TFL).

- In FY 2020, out-of-pocket costs for MHS senior families were 47 percent less than those of their "before TFL" civilian counterparts.
- In FY 2020, MHS senior families saved about $3,500 as a result of TFL and added drug benefits.

OUT-OF-POCKET COSTS OF MHS SENIOR FAMILIES AFTER TFL VS. CIVILIAN COUNTERPARTS, FYs 2018–2020



Sources: TRICARE senior family deductibles and copayments for MHS users in FYs 2018–2020 from MHS administrative data, 12/31/2020; for MHS non-users and civilian benchmark senior families, deductibles and copayments by type of Medicare supplemental coverage in FYs 2018–2020 projected from the Household Component of the MEPS; Medicare Part B and Medicare HMO premiums in FYs 2018–2020 from the Centers for Medicare & Medicaid Services (CMS); Medigap premiums in FYs 2018–2020 from Weiss Research, Inc.; Medigap enrollment distribution is taken from America's Health Insurance Plans report entitled "The State of Medigap 2019"; Medisup premiums from Towers Watson Health Care Cost Surveys in 2013–2014 projected to FYs 2018–2020 based on their long-run growth rates; Medicare Part D premiums in FYs 2018–2020 from Kaiser Family Foundation Surveys; Medicare supplemental insurance coverage, before and after TFL, from HCSDB, FYs 2000–2001, 2018–2020, as of 12/31/2020

[a] "D&C" is deductibles and copayments.

Notes:

– Estimates are for a demographically typical senior family. On average, this consists of 0.7 men and 0.7 women over the age of 65.

– There are three limitations of the MEPS utilization expenditures data for seniors. First, they are known to understate expenditures for inpatient and outpatient services by about 19 percent (see Zuvekas and Olin. Accuracy of Medicare Expenditures in the Medical Expenditure Panel Survey. *Inquiry* 46: 92–108 [Spring 2009]). Expenditures for inpatient and outpatient services were adjusted upward to account for the bias. Second, the data are volatile due to small samples; the data were smoothed to mitigate the effects of volatility. Third, the sample is not up to date; the last observation period is CY 2017. The long-run growth rate between FY 2007 and FY 2017 was used to project utilization expenditures in FYs 2018–2020.

– The Peterson Center on Healthcare and Kaiser Family Foundation's Health System Tracker has published estimates of the impacts to spending and utilization during the COVID-19 pandemic. They estimate that health services spending in 2020 has fallen by 2.4 percent as compared to the previous year. Furthermore, they publish quarterly estimates of spending growth. At the height of the pandemic during the second quarter of 2020, health spending fell by 8.6 percent. As the data used to calculate civilian comparisons has a lag time to publication, IDA uses the Peterson-KFF's report to adjust civilian estimates of spending and utilization to account for the short-term impacts of the COVID pandemic. Source: https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/#item-covidhealthspendingutilizationcollection_1

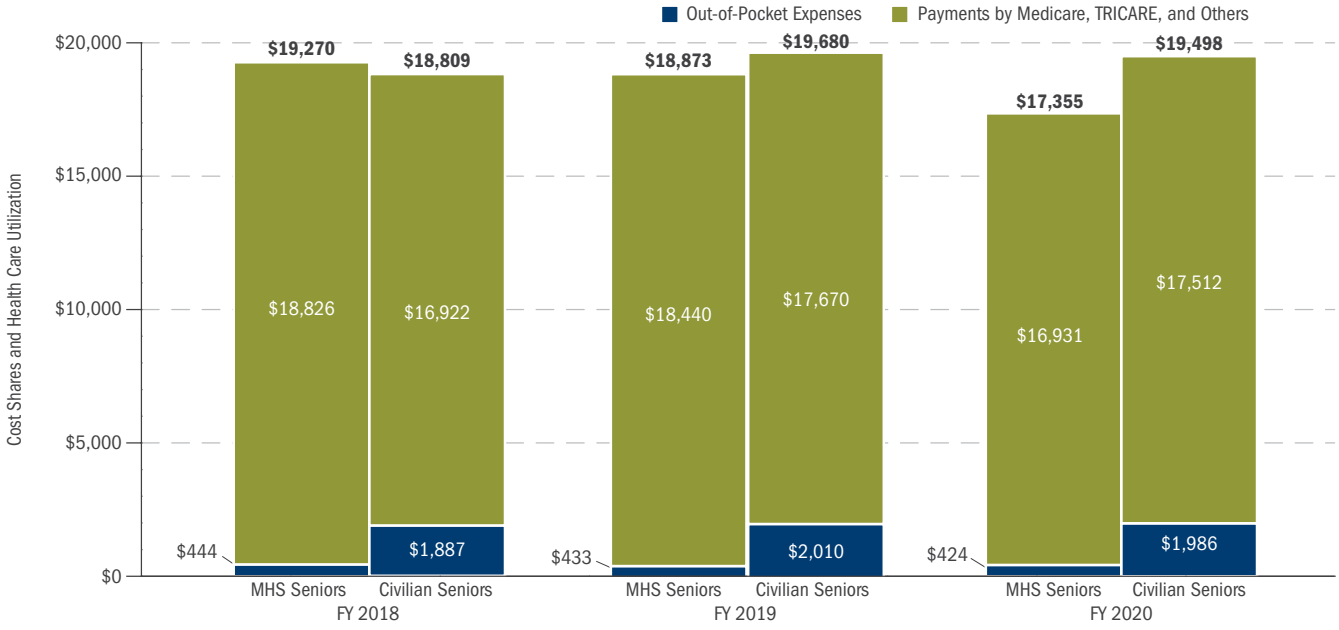
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT.)*

Coinsurance and Health Care Utilization for MHS vs. Civilian Senior Families

TRICARE senior families have lower coinsurance rates (deductibles and copayments per dollar of utilization) than their "before TFL" civilian counterparts. Utilization is similar for both groups.

- MHS senior families have relatively low coinsurance rates.
  - In FY 2020, the coinsurance rate for civilian senior counterparts was 10 percent; it was 2 percent for MHS seniors (8 percentage points lower).
- MHS senior families have slightly lower utilization than civilian senior families.
  - In FY 2020, civilian senior counterparts consumed $19,500 in medical services; MHS senior families consumed $17,400 ($2,100 less).

COINSURANCE AND HEALTH CARE UTILIZATION FOR SENIOR FAMILIES VS. CIVILIAN COUNTERPARTS, FYs 2018–2020



Sources: TRICARE senior family utilization, deductibles, and copayments for MHS users in FYs 2018–2020 from MHS administrative data, 12/31/2020; for MHS non-users and civilian benchmark senior families, utilization, deductibles, and copayments by type of Medicare supplemental coverage in FYs 2018–2020 projected from the Household Component of the MEPS in FYs 2007–2017; Medicare supplemental insurance coverage, before and after TFL, from HCSDB, FYs 2000–2001 and 2018–2020, as of 12/31/2020

Notes:

– The Peterson Center on Healthcare and Kaiser Family Foundation's Health System Tracker has published estimates of the impacts to spending and utilization during the COVID-19 pandemic. They estimate that health services spending in 2020 has fallen by 2.4 percent as compared to the previous year. Furthermore, they publish quarterly estimates of spending growth. At the height of the pandemic during the second quarter of 2020, health spending fell by 8.6 percent. As the data used to calculate civilian comparisons has a lag time to publication, IDA uses the Peterson/Kaiser Family Foundation report to adjust civilian estimates of spending and utilization to account for the short-term impacts of the COVID pandemic. Source: https://www.healthsystemtracker.org/chart-collection/how-have-healthcare-utilization-and-spending-changed-so-far-during-the-coronavirus-pandemic/#item-covidhealthspendingutilizationcollection_1

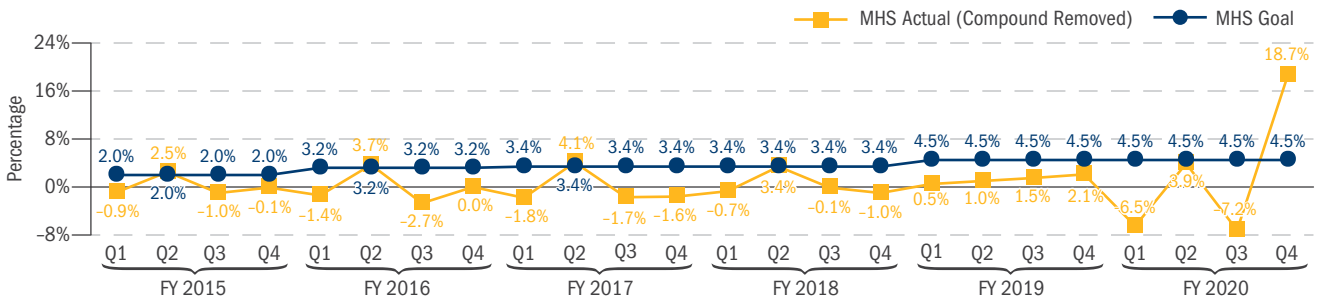
LOWER COST

SYSTEM PRODUCTIVITY: MHS MEDICAL COST PER PRIME ENROLLEE

The goal in using this financial and productivity metric is to support the Quadruple Aim of lower costs. This measure focuses on the annual overall cost growth for TRICARE Prime enrollees and includes all costs related to health care delivered to enrollees. The objective is to keep the rate of cost growth for Prime enrollees to a level at or below the increases for the civilian health care plans at the national level. Currently, the measure provides insight to issues regarding unit cost, utilization management, and purchased care management. The metric has been enhanced to properly account for differences in population demographics and health care requirements of the enrolled population. During FY 2018 and FY 2019, 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 2019, the MHS sustained growth in provider productivity, demonstrating that improvement processes continue to work. During FY 2020, provider efficiency has declined due to the COVID-19 pandemic. 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 NDAA 2015 maintenance medication and operational changes. Under the NDAA for FY 2015, maintenance medications were redirected from the retail pharmacy to either TRICARE Home Delivery or MTFs, which resulted in significant reduction in pharmacy costs to the government. Additionally, further reductions in overall pharmacy costs were achieved through the Pharmacy & Therapeutics Committee explicit formulary management and actionable Prime enrollee leakage reports for nonmaintenance medication. The impact of these actions resulted in achievement of the goal through FY 2016.
- The MHS continues to expand the Patient-Centered Medical Home (PCMH) strategy, a practice model in which a team of health care professionals, coordinated by a personal physician, work collaboratively to provide high levels of care, access, and communication; care coordination and integration; and care quality and safety. Care delivered in a PCMH is meant to produce better outcomes; reduce mortality, unnecessary emergency department visits, and preventable hospital admissions for patients with chronic diseases; lower overall utilization; and improve patient compliance with recommended care, resulting in lower spending for the same population.
- The MHS goal in percentage change in medical costs from the prior year is based on the annual national survey of nonfederal private and public employers with three or more workers, conducted by the Kaiser Family Foundation and the Health Research and Educational Trust. From this survey, the MHS rate is set, based on the average annual premiums for employer-sponsored health insurance for family coverage. For the time period from FY 2014 to FY 2016, the MHS goal was set at one percentage point below the survey. Starting in FY 2017, the goal reverted back to the actual survey result.
- Due to the COVID-19 pandemic, FY 2020, the direct care MTFs experienced significant decreases in workload while their expenses did not during FY 2020. This is causing the significant fluctuations in percentage change. Additionally, FY 2020 MEPRS expenses are not complete as of the time of this report and a rolling algorithm is used to populate the missing expenses for those months.

PERCENTAGE CHANGE IN MEDICAL COST PER PRIME EQUIVALENT LIFE (FROM PRIOR YEAR), FYs 2015–2020



Sources: DHA, Analytics and Evaluation Division, 1/4/2021. Data are as of December 2020, and MHS administrative data MHS Management Analysis and Reporting Tool (M2); Standard Inpatient Data Record/ Standard Ambulatory Data Record/Comprehensive Ambulatory/Professional Encounter Record/TED Institutional/TED Non-institutional; Pharmacy Data Transaction Service; and Expense Assignment System IV.

Notes:

– Enrollees are adjusted for health risk status.

– FY 2020 data are reported through FY 2020 Q4, and data from this time period should be considered preliminary.

– Once a site implements MHS GENESIS, their data stops.

GENERAL METHOD

This report presents the overall performance of the TRICARE program with respect to the Military Health System (MHS) Quadruple Aim of Improved Readiness, Better Care, Better Health, and Lower Cost. The MHS monitors various metrics to assess performance and, where possible, tries to compare MHS performance with relevant civilian health care performance. This report examines the effects of TRICARE on beneficiary utilization of inpatient, outpatient, and prescription services, as well as on MHS and beneficiary costs. Wherever feasible, the report contrasts various aspects of TRICARE and national health care trends. These include comparison of TRICARE utilization and cost measures with comparable civilian sector benchmarks derived from the MarketScan® Commercial Claims and Encounters (CCAE) database provided by IBM Watson Health, trended changes in medical costs based on the national survey of nonfederal health plans and public employers conducted by the Kaiser Family Foundation and the Health Research and Education Trust (HRET), and national patient survey results from the consortium of the Agency for Healthcare Research and Quality (AHRQ) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS), to include CAHPS Health Plan Survey, Hospital CAHPS (HCAHPS), and CAHPS Clinician & Group Survey (CG-CAHPS).

Notes on Methodology

- Numbers in charts or text may not sum to the expressed totals due to rounding.
- Unless otherwise indicated, all years referenced are federal fiscal years (FYs; October 1–September 30).
- Unless otherwise indicated, all dollar amounts are expressed in then-year dollars for the fiscal year represented.
- All photographs in this document were obtained from websites accessible by the public. The photos have not been tampered with other than to mask an individual's name.
- Differences between MHS survey-based data and the civilian benchmark, or the MHS over time, were considered statistically significant if the significance level was less than or equal to 0.05.
- All workload and costs are estimated to completion based on separate factors derived from MHS administrative data for direct care and recent claims experience for purchased care.
- Data were current as of:
  - Surveys—Health Care Survey of DoD Beneficiaries (HCSDB) (10/15/2020); Joint Outpatient Experience Survey (JOES)/Joint Outpatient Experience-CAHPS (JOES-C) (12/7/2020); TRICARE Inpatient Satisfaction Survey (TRISS) (12/16/2020)
  - Eligibility/enrollment data—1/12/2021
  - MHS workload/costs—2/5/2021
- The Defense Health Agency (DHA) regularly updates its encounters and claims databases as more current data become available. It also periodically "retrofits" its databases as errors are discovered. The updates and retrofits can sometimes have significant impacts on the results reported in this and previous documents if they occur after the data collection cutoff date. The reader should keep this in mind when comparing this year's results with those from previous reports.

DATA SOURCES

HCSDB

The HCSDB was developed by the DHA and its predecessor, the TRICARE Management Activity, to fulfill the 1993 National Defense Authorization Act (NDAA) requirements and to provide a routine mechanism to assess TRICARE-eligible beneficiary access to and experience with the MHS or with alternate health plans. Conducted continuously since 1995, the HCSDB was designed to provide a comprehensive look at beneficiary opinions about their Department of Defense (DoD) health care benefits. The HCSDB provides information on a wide range of health care issues, such as beneficiaries' ease of access to health care, preventive care services, and healthy behaviors.

The worldwide, multiple-mode Adult HCSDB has been conducted on a quarterly basis (three FY 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).

The CAHPS is a nationally recognized set of standardized questions and reporting formats that has been used to collect and report meaningful and reliable information about the health care experiences of consumers. It was developed by a consortium of research institutions and sponsored by AHRQ. It has been tested in the field and evaluated for validity and reliability. The questions and reporting formats have been tested to ensure that the answers can be compared across plans and demographic groups.

About three-fourths of HCSDB questions are closely modeled on the CAHPS Health Plan Survey in wording, response choices, and sequencing. The other one-fourth of HCSDB questions are designed to obtain information unique to TRICARE benefits or operations, and to solicit information about healthy lifestyles or health promotion, often based on other nationally recognized health care survey questions (e.g., the Centers for Disease Control and Prevention [CDC] Behavioral Risk Factor Surveillance System [BRFSS], National Health Interview Survey, or the National Health and Nutrition Examination Survey). Supplemental questions are added on a quarterly basis to explore specific topics of interest, such as the acceptance and prevalence of preventive services, including colorectal cancer screening and annual influenza immunizations; availability of other non-DoD health insurance; use of urgent care centers; and measures of Health-Related Quality of Life (HRQOL).

Because the HCSDB uses CAHPS questions, TRICARE can be benchmarked to civilian managed care health plans reporting CAHPS Health Plan results. More information on CAHPS can be obtained at www.cahps.ahrq.gov.

The survey request is sent by postal mail to all beneficiaries and also by e-mail to Active Duty members, with responses accepted via web and, for a random sample of initial nonrespondents, by postal mail. The HCSDB is fielded to a stratified random sample of beneficiaries. In order to calculate representative rates and means from their responses, sampling weights are used to account for different sampling rates and different response rates in different sample strata. Beginning with the FY 2006 report, weights were adjusted for factors such as age, sex, and rank that do not define strata, but make some beneficiaries more likely to respond than others. Because of the adjustment, rates calculated from the same data differ from past evaluation reports and are more representative of the population of TRICARE users.

The DHA HCSDB is sent to a random sample of all MHS-eligible users and non-users. Survey results are reported quarterly, with about 27,500 respondents from about 301,500 beneficiaries sampled in FY 2020 (about a 9.2 percent raw response and a 15.8 percent weighted response rate, compared to a 8.9 percent raw response rate in FY 2019). 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 2018–2020 were based on questions taken from the CAHPS Version 5.0. As CAHPS versions change, the HCSDB results will be compared to the like-CAHPS version results each year because changes in the questionnaires and changes in rates are only meaningful when compared with changes in the relevant benchmark. CAHPS Version 5.0 benchmark microdata were obtained from the National Committee for Quality Assurance (NCQA).

NCQA collects responses to the survey from a national sample of health plans that serve the civilian population. Results from each plan for beneficiaries who responded by mail or Internet are averaged together, weighted equally. The benchmarks are adjusted to correspond to the age and health status of TRICARE users.

Differences between the MHS and civilian benchmark were considered significant at less than or equal to 0.05, using the normal approximation. The significance test for a change between years is based on the change in the MHS estimate minus the change in the benchmark, which is adjusted for age and health status to match the MHS. T-tests measure the probability that the difference between the change in the MHS estimate and the change in the benchmark occurred by chance.

Tests are performed using a Z-test, and standard errors are calculated using SUDAAN® to account for the complex stratified sample and unequal weights. If p is less than 0.05, the difference is significant.

Within the context of the HCSDB, Prime enrollees are defined as those enrolled at least six months.

TRISS

The purpose of the Office of the Assistant Secretary of Defense for Health Affairs TRISS is to monitor and report on the experience and satisfaction of MHS beneficiaries who have been admitted to military medical treatment facilities (MTFs) and civilian hospitals. The survey instrument incorporates the questions developed by AHRQ and the Centers for Medicare & Medicaid Services (CMS) for the HCAHPS initiative. The goal of the HCAHPS initiative is to measure uniformly and report publicly patient experiences with inpatient care through the use of a standardized survey instrument and data collection methodology. The information derived from the survey can be useful for internal quality improvement initiatives, to assess the impact of changes in policy, and to provide feedback to providers and patients.

The TRISS is a 44-item survey instrument. The survey includes HCAHPS questions asking how often or whether patients experienced a critical aspect of hospital care, rather than whether they were "satisfied" with their care, and DoD-specific questions, including an open-ended question to solicit location-specific comments from our beneficiaries.

The TRISS questionnaire is sent to all (census) adult MTF inpatients worldwide between 48 hours and six weeks after discharge. The TRISS survey is also administered to a random sample of adult MHS inpatients discharged from civilian network/purchased care hospitals. The TRISS follows the HCAHPS protocols developed by CMS. HCAHPS protocols for sampling, data collection, and coding can be found in the HCAHPS Quality Assurance Guidelines manual on the official HCAHPS website, www.hcahpsonline.org. The overall FY 2020 Q1–Q3 response rate for direct care was 31 percent and 34 percent for purchased care.

JOES/JOES-C

The JOES continues to focus on the beneficiary experience with care received in MTFs, and is centrally managed under the direction of Service and DHA survey leads. JOES results are reported centrally, and reported for each Service, multi-Service market area, and down to each MTF and provider. The JOES-C is a companion survey to the JOES, measuring outpatient care at military and civilian facilities. The JOES-C is based on the CG-CAHPS, as was the predecessor to the JOES-C: the TRICARE Outpatient Satisfaction Survey (TROSS). JOES-C allows the MHS to compare beneficiary results to the civilian benchmark results.

Quality

Military hospital inpatient quality measures were abstracted from clinical records by trained specialists and reported to the Joint Commission (TJC) for national benchmarking. The data for direct care hospitals participating in the National Surgical Quality Improvement Program (NSQIP) are abstracted by trained surgical case reviewers and submitted to the American College of Surgeons (ACS). The perinatal data are obtained from the electronic data system through an administrative data pull and are submitted to the National Perinatal Information Center (NPIC) to support comparison with other participating organizations across the nation. The availability of data for MHS providers continues to increase through the MHS Population Health Portal in CarePoint, via a streamlined access process, registry development for population management, and improved data displays. The MHS Dashboard in CarePoint provides views for all measures as well as executive and improvement priorities. The CarePoint portal includes a discharge tool to ensure that patients at high risk for readmission are identified during hospitalization. This facilitates continuity of care and provides caregivers with time for patient education and follow-up appointment scheduling to reduce the risk of readmissions.

Utilization and Costs

Data on MHS and beneficiary utilization and costs came from several sources. We obtained the health care experience of eligible beneficiaries by aggregating Standard Inpatient Data Records (SIDRs—MTF hospitalization records), Comprehensive Ambulatory/ Professional Encounter Records (CAPERs—MTF outpatient records), TRICARE Encounter Data (TED—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

DATA SOURCES *(CONT.)*

RVUs are also part of the formula used to determine physician reimbursement rates, but since military physicians are not subject to malpractice claims, they are excluded from Total RVUs to make the direct and purchased care workload measures more comparable. For a more complete description of enhanced as well as other RVU measures, see https://www.milsuite.mil/video/watch/video/9653 (a milSuite account and DoD-issued Common Access Card [CAC] are required to access this site).

Costs recorded on TEDs were broken out by source of payment (DoD, beneficiary, or private insurer). Although SIDR and CAPER data indicate the enrollment status of beneficiaries, the Defense Enrollment Eligibility Reporting System (DEERS) enrollment file is considered to be more reliable. We therefore classified MTF discharges as Prime or space-available by matching the discharge dates to the DEERS enrollment file. Final data pulls used for this report were completed in January 2021, as referenced above.

The CCAE database contains the health care experience of several million individuals (annually) covered under a variety of health plans offered by large employers, including preferred provider organization (PPO) plans, point-of-service (POS) plans, health maintenance organization (HMO) plans, and indemnity plans. The database links inpatient services and admissions, outpatient claims and encounters, and, for most covered lives, outpatient pharmaceutical drug data and individual-level enrollment information.

We tasked IBM Watson Health to compute quarterly benchmarks for HMOs and PPOs, broken out by product line (i.e., medical/surgical [MED/SURG], obstetrics/gynecology [OB/GYN], mental health [PSYCH]) and several sex/age group combinations. The quarterly breakout, available through the second quarter of FY 2020, allowed us to derive annual benchmarks by fiscal year and to estimate FY 2020 data to completion. Product lines were determined by aggregating Major Diagnostic Categories (MDCs) as follows: OB = MDC 14 (Pregnancy, Childbirth, and Puerperium) and MDC 15 (Newborns and Other Neonates with Conditions Originating in Perinatal Period), PSYCH = MDC 19 (Mental Diseases and Disorders) and MDC 20 (Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders), and MED/SURG = all other MDCs. The breakouts by gender and age group allowed us to apply DoD-specific population weights to the benchmarks and aggregate them to adjust for differences in DoD and civilian beneficiary populations. We excluded individuals aged 65 and older from the calculations because most of them are covered by Medicare and Medigap policies rather than by a present or former employer's insurance plan.

DRG Grouping Methodology

In the section that displays the "Top 25" inpatient diagnosis groups, diagnosis related groups (DRGs) are grouped into descriptively (but not necessarily clinically) similar categories using a code set available on http://www.findacode.com/code-set.php?set=DRG, an online database of medical billing codes and information. The site lists DRGs within each MDC, with headings above diagnostically related DRGs. These headings provide a broad description of the DRGs underneath and distinguish between medical and surgical DRGs, but do not distinguish among DRGs with different (or any) levels of complications and comorbidities. For the purposes of this report, the DRGs were too detailed and the MDCs too broad to provide the reader with a general sense of the most common inpatient diagnoses the MHS confronts; therefore, the headings were used as the basis for broadening the groupings in this report into descriptively related categories, without regard for whether they are medical or surgical, whether there are complications, or which parts of the body are affected. For example, the "ECMO or Tracheostomy" group includes DRGs 003, 004, 011, 012, and 013. The description for each of those DRGs includes the words "ECMO" or "Tracheostomy"—some with complications, some without; some for face, mouth, and neck; and some for other parts of the body. Once all the groups were formed, they were numbered sequentially following the order in which they were presented on the website. This resulted in a reduction from 818 DRGs to 284 DRGs.

ABBREVIATIONS

AABB	American Association of Blood Banks | 123
ABA	applied behavior analysis | 27
AC	Active Component | 59
AC	Accreditation and Compliance | 119
ACCRWG	Acute and Critical Care Rehabilitation Working Group | 134
ACD	Autism Care Demonstration | 27
ACG	Adjusted Clinical Groupings | 149
ACGME	Accreditation Council for Graduate Medical Education | 9
ACH	Army Community Hospital | 172
ACO	Accountable Care Organization | 14
ACOG	American College of Obstetricians and Gynecologists | 135
ACS	American College of Surgeons | 62
ADC	authority, direction, and control | 7
ADDP	Active Duty Dental Program | 233
ADFM	Active Duty family member | 24
ADSM	Active Duty Service member | 68
AE	adverse event | 109
AHRQ	Agency for Healthcare Research and Quality | 9
AIM	Alliance for Innovation on Maternal Health | 68
AMC	Army Medical Center | 46
AMH	Army Medical Hospital | 172
AO	accrediting organization | 120
AP	Action Plan | 69
APLSS	Army Provider Level Satisfaction Survey | 94
ASBP	Armed Services Blood Program | 22
ASD	autism spectrum disorder | 143
ASD(HA)	Assistant Secretary of Defense for Health Affairs | 9
ASV	Adaptive Servo-Ventilation | 26
AWHONN	Association of Women's Health, Obstetric and Neonatal Nurses | 135
BDC	Blood Bank Donor Centers and Transfusion Services | 123
BH	behavioral health | 140
BHCC	Behavioral Health Clinical Community | 68
BHDP	Behavioral Health Data Portal | 68
BMI	body mass index | 186
BP	blood pressure | 186
BRAC	Base Realignment and Closure | 38
BRFSS	Behavioral Risk Factor Surveillance System | 194
BZD	benzodiazepine | 141
CA	corrective action | 112
CAC	Common Access Card | 10
CAHPS	Consumer Assessment of Healthcare Providers and Systems | 73
CAMIC	COVID-19 Airway Management Isolation Chamber | 28
CAP	College of American Pathologists | 9
CAPER	Comprehensive Ambulatory/Professional Encounter Record | 225
CARES	Center for Autism Resources, Education, and Services | 143
CARES Act	Coronavirus Aid, Relief, and Economic Security Act | 23
CAUTI	catheter-associated UTI | 9
CCAC	Clinical Communities Advisory Council | 67
CCAE	Commercial Claims and Encounters | 199
CCCT	Combat Casualty Care Team | 61
CCP	COVID Convalescent Plasma | 18
CCQAS	Centralized Credentialing and Quality Assurance System | 119
CCSR	Clinical Classifications Software Refined | 208
CDC	Centers for Disease Control and Prevention | 50
CE	continuing education | 115
CG-CAHPS	CAHPS Clinician & Group Survey | 94
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services | 229
CHCBP	Continued Health Care Benefit Program | 24
CIA	concise incident analysis | 111
CLABSI	central line–associated bloodstream infection | 9
CLIA	Clinical Laboratory Improvement Amendment | 122
CLIP	Clinical Laboratory Improvement Program | 122
CLMS	Joint-Service Center for Laboratory Medicine Services | 122
CM	clinical measurement | 124
CM	case management | 149
CMS	Centers for Medicare & Medicaid Services | 23
CMWG	Clinical Measurement Work Group | 70
COBRA	Consolidated Omnibus Budget Reconciliation Act | 24
COLA	Commission on Laboratory Accreditation | 122
CONUS	contiguous United States | 7
COT	Committee on Trauma | 148
COTS	Combat Orthopedic Trauma Skills | 62
CP	Credentialing and Privileging | 119
CPAP	continuous positive airway pressure | 26
CPG	clinical practice guideline | 73
CPI	continuous process improvement | 67
CQI	clinical quality improvement | 67
CQIS	CQI studies | 128
CQM	clinical quality management | 108
CQMB	Clinical Quality Management Board | 72
CQMC	Core Quality Measures Collaborative | 70
CSA	comprehensive systematic analysis | 112
CSD	Clinical Support Division | 65
CUOP	Current Operation Dashboard | 16
CY	calendar year | 4
DART	Direct Access Reporting Tool | 86
DBT	digital breast tomosynthesis | 27
DCC	Dental Clinical Community | 145
DEERS	Defense Enrollment Eligibility Reporting System | 20
DHA	Defense Health Agency | 5
DHA-IPM	DHA Interim Procedures Memorandum | 75
DHA-PM	DHA Procedures Manual | 70
DHHS	Department of Health and Human Services | 122
DHP	Defense Health Program | 31
DoD	Department of Defense | 1
DoDI	DoD Instruction | 119
DoDM	DoD Manual | 122
DoDTR	DoD temporary registry location | 21
DRG	diagnosis-related group | 226
DRRS	Defense Readiness Reporting System | 9
DSD	Deputy Secretary of Defense | 16
DTF	dental treatment facility | 24
DVPRS	Defense and Veterans Pain Rating Scale | 150
EBPWG	Evidence-Based Practice Work Group | 128
EBT	Evidence-Based Treatment | 141
ECHO	Extended Care Health Option | 24
ED	emergency department | 27
EHR	electronic health record | 4
EIC	external independent contractor | 198
ESB	Enterprise Solutions Board | 67
ESC	Evidence of Standards Compliance | 122
ESI	Express Scripts, Inc. | 25
ESP	Expeditionary Scope of Practice | 61
EWSC	Emergency War Surgery Course | 62
FBCH	Fort Belvoir Community Hospital | 26
FDA	Food and Drug Administration | 22
FEDVIP	Federal Employees Dental and Vision Insurance Program | 24
FTE	full-time equivalents | 180
FY	fiscal year | 1
GAO	Government Accountability Office | 181
GTT	Global Trigger Tool | 110
HAI	healthcare-associated infection | 110
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems | 4
HCO	Health Care Operations | 25
HCSDB	Health Care Survey of DoD Beneficiaries | 89
HEC	Health Executive Committee | 128
HEDIS	Healthcare Effectiveness Data and Information Set | 4
HGB	Humana Government Business | 15
HHVBP	Home Health Value-Based Purchasing | 14
HIE	Health Information Exchange | 28
HIPAA	Health Insurance Portability and Accountability Act | 95
HMO	health maintenance organization | 24
HNFS	Health Net Federal Services | 25
HP	Healthy People | 185
HPCON	Health Protection Condition | 26
HRM	Healthcare Risk Management | 119
HRO	high reliability organization | 66
HROM	high reliability operating model | 66
HRQOL	Health-Related Quality of Life | 9
HVBP	Hospital Value-Based Purchasing | 14
ICTLs	Individual Critical Task Lists | 63
ICU	intensive care unit | 9
IDA	Institute for Defense Analyses | 214
IHI	Institute for Healthcare Improvement | 113
IMR	Individual Medical Readiness | 9
IOP	intensive outpatient program | 142
IPC	Infection Prevention and Control | 113
IQI	inpatient quality indicator | 138
IQR	interquartile range | 159
ISO	in support of | 9
JBLM	Joint Base Lewis McCord | 143
JKSA PMO	Joint Knowledge, Skills, and Abilities Program Management Office | 61
JOES	Joint Outpatient Experience Survey | 4
JOES-C	Joint Outpatient Experience Survey-CAHPS | 94
JPSR	Joint Patient Safety Reporting | 110
JTET	Joint Trauma Education and Training | 63
JTS	Joint Trauma System | 18
KP	Kaiser Permanente | 15
KSAs	knowledge, skills, and abilities | 9
LBP	Low Back Pain | 15
LEJR	Lower Extremity Joint Replacement/Reattachment | 14
LOS	length of stay | 78
M&RA	Manpower and Reserve Affairs | 61

APPENDIX

ABBREVIATIONS *(CONT.)*

M2	MHS Management Analysis and Reporting Tool | 84
MAT	medication-assisted treatment | 143
MBSAQIP	Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program | 124
MCSC	managed care support contractor | 11
MDD	major depressive disorder | 68
MDG	Medical Group | 172
MDR	MHS Data Repository | 38
MEDD	morphine equivalent daily dose | 150
MED/SURG	medical/surgical product line | 199
MEPS	Medical Expenditure Panel Survey | 214
MERHCF	Medicare-Eligible Retiree Health Care Fund | 4
MH	mental health | 9
MHS	Military Health System | 1
MILDEP	military department | 7
MIP	MHS Information Portal | 21
MM	Medical Management | 149
MOU	Memorandum of Understanding | 122
MS	multiple sclerosis | 54
MS-DRG	Medicare Severity Diagnosis Related Group | 201
MTF	military medical treatment facility | 4
NADD	non-Active Duty dependents | 142
NADFM	non-Active Duty family member | 142
NAL	nurse advice line | 26
NAS	Non-Availability Statement | 229
NCHS	National Center for Health Statistics | 50
NCI	National Cancer Institute | 230
NCQA	National Committee for Quality Assurance | 89
NCR	National Capital Region | 96
NDAA	National Defense Authorization Act | 1
NH	Naval Hospital | 46
NHANES	National Health and Nutrition Examination Survey | 165
NHC	Naval Hospital Center | 185
NHE	National Health Expenditures | 44
NHSN	National Healthcare Safety Network | 110
NIAID	National Institute of Allergy and Infectious Diseases | 23
NIH	National Institutes of Health | 150
NMC	Naval Medical Center | 143
NMSKCC	Neuromusculoskeletal Clinical Community | 68
NPDB	National Practitioner Data Bank | 70
NPI	National Provider Identifier | 180
NPIC	National Perinatal Information Center | 124
NQF	National Quality Forum | 111
NSQIP	National Surgical Quality Improvement Program | 9
OASD(HA)	Office of the Assistant Secretary of Defense for Health Affairs | 7
OB/GYN	obstetrics/gynecology product line | 199
OCONUS	outside the contiguous United States | 118
OCO	overseas contingency operations | 43
OHI	other health insurance | 35
O&M	operations and maintenance | 43
OPM	Office of Personnel Management | 178
OTP	opioid treatment programs | 142
OUSD(P&R)	Office of the Under Secretary of Defense for Personnel and Readiness | 7
P-BMP	Performance-Based Maternity Payment | 14
P4I	Partnership for Improvement | 12
PAH	pulmonary arterial hypertension | 54
PASTOR	Pain Assessment Screening Tool and Outcome Registry | 150
PC	perinatal core | 136
PCCC	Primary Care Clinical Community | 68
PCCOB	Patient-Centered Care Operations Board | 73
PCM	primary care manager | 9
PCMH	Patient-Centered Medical Home | 4
PDTS	Pharmacy Data Transaction Service | 53
PEP	Projection of Eligible Population | 37
PEWG	Patient Experience Work Group | 72
PFPWD	Program for Persons with Disabilities | 230
PHP	partial hospitalization program | 142
PI	Program Integrity | 4
PIM	Postgraduate Institute of Medicine | 115
PMCSS	Pain Management Clinical Support Service | 150
PMPM	per member per month | 9
POS	point of service | 24
PPE	personal protective equipment | 16
PPH	postpartum hemorrhage | 68
PPM	provider-performed microscopy | 122
PPO	preferred provider organization | 24
PROCR	Patient-Reported Outcomes Clinical Record | 134
PROMIS	Patient Reported Outcomes Measurement Information System | 150
PS	patient safety | 71
PSA	prime service area | 38
PSAW	Patient Safety Awareness Week | 114
PSC BAG	Private-Sector Care Budget Activity Group | 45
PSIC	Patient Safety Improvement Collaborative | 72
PSP	Patient Safety Program | 110
PSPC	Patient Safety Professional Course | 115
PSS	Navy Patient Satisfaction Survey | 94
PSYCH	mental health product line | 199
P&T	Pharmacy & Therapeutics | 54
PT	physical therapy | 15
PTSD	posttraumatic stress disorder | 68
PV	prime vendor | 54
QA	quality assurance | 123
QLE	qualifying life event | 36
QPP	Quadruple Aim Performance Plan | 7
R&A	review and analysis | 73
RC	Reserve Component | 59
RCA	root cause analysis | 115
RE	reportable event | 4
RETFM	retiree and family member | 33
RFI	Requirements for Improvement | 121
RME	reportable medical events | 28
RMG	Reform Management Group | 9
RMWG	Risk Management Work Group | 72
RN	registered nurse | 84
RTC	residential treatment center | 142
RVU	relative value unit | 4
RWP	relative weighted product | 4
S2C2	Surgical Services Clinical Community | 145
SDA	Air Force Service Delivery Assessment | 94
SE	sentinel event | 68
SECDEF	Secretary of Defense | 7
SERCA	Safety Event and Root Cause Analysis | 116
SIDR	Standard Inpatient Data Record | 139
SIR	standardized infection ratio | 9
SME	subject matter expert | 16
SNF	skilled nursing facility | 23
SP&FI	Strategy, Plans, and Functional Integration | 16
SRV/OTHs	survivors and others | 41
SSO	Small-Market and Stand-Alone Organization | 7
STDs	sexually transmitted diseases | 95
SUD	substance use disorder | 140
SUDRF	substance use disorder rehabilitation facility | 142
TAC	Traumatic Brain Injury Advisory Committee | 68
TAMP	Transitional Assistance Management Program | 24
TATRC	Telemedicine and Advanced Technology Research Center | 28
TBI	traumatic brain injury | 68
TDP	TRICARE Dental Program | 24
TeamSTEPPS	Team Strategies and Tools to Enhance Performance and Patient Safety | 69
TED	TRICARE Encounter Data | 183
TFL	TRICARE for Life | 4
TFMR	Total Force Medical Readiness | 59
THP	TRICARE Health Plan | 12
TIB	targeted immunological biologic | 54
TIG	Transparency Initiative Group | 71
tIMO	transitional Intermediate Management Organization | 16
TJC	The Joint Commission | 4
TOL	TRICARE Online | 74
TOP	TRICARE Overseas Program | 13
TPR	TRICARE Prime Remote | 24
TPRADFM	TRICARE Prime Remote for Active Duty Family Members | 24
TQIP	Trauma Quality Improvement Program | 124
TRDP	TRICARE Retiree Dental Program | 236
TRISS	TRICARE Inpatient Satisfaction Survey | 95
TROSS	TRICARE Outpatient Satisfaction Survey | 94
TRR	TRICARE Retired Reserve | 4
TRS	TRICARE Reserve Select | 4
TYA	TRICARE Young Adult | 4
UC	urgent care | 49
UMP	Unified Medical Program | 1
URFO	unintended retained foreign object | 9
URI	upper respiratory infection | 131
USD(P&R)	Under Secretary of Defense for Personnel and Readiness | 9
USFHP	Uniformed Services Family Health Plan | 4
USUHS	Uniformed Services University of the Health Sciences | 150
UTI	urinary tract infection | 147
VA	Department of Veterans Affairs | 28
VHA	Veterans Health Administration | 128
VPAP	variable positive airway pressure | 26
VRC	Verification, Review, and Consultation | 124
WICC	Women and Infant Clinical Community | 68
WPS	Wisconsin Physician Services | 25
WRNMMC	Walter Reed National Military Medical Center | 26
WSS	wrong-site surgery | 4

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS

1988–1995

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Era Leading to TRICARE

- Managed care demonstrations—mental health review, contracted provider arrangement for mental health, home health care/case management, catchment area management projects including the Tri-Service TRICARE Tidewater demonstration, the inaugural use of TRICARE branding
- CHAMPUS Reform Initiative demonstration contract for California and Hawaii offered CHAMPUS Prime, CHAMPUS Extra, and standard CHAMPUS (basis of later TRICARE triple option)

1993–1994

TRICARE Managed Care Legislation

- Administered under CHAMPUS fiscal intermediary contracts with oversight by the Office of CHAMPUS at Fitzsimmons Army Hospital installation in Aurora, Colo.
- Non-availability statements (NASs) for civilian inpatient care in MTF catchment areas
- Program for Persons with Handicaps supplements basic program with nonmedical benefits for Active Duty family members (ADFMs) with serious disabilities
- Demonstration program to cover CHAMPUS Breast Cancer Treatment Clinical Trial; access to high-dose chemotherapy with stem-cell rescue; beginning of a partnership between CHAMPUS and the National Cancer Institute
- Added coverage of screening mammography and Papanicolaou (Pap) tests, added Certified Marriage and Family Therapists as TRICARE-authorized providers
- Added Continued Health Care Benefit Program for certain former DoD beneficiaries at full-cost premiums, providing beneficiaries with an option comparable to COBRA coverage to continue health care coverage for a limited period after leaving military service
- Reduced the catastrophic cap from $10,000 to $7,500 per year for retirees and their family members, capping their out-of-pocket expenses for any given fiscal year

1995

- Provided beneficiaries with greater choice, access to care, and coverage of preventive services through restructuring the MHS with publication of the TRICARE final rule (October 5, 1995; 60 FR 52078-52103) to implement managed care legislation of 1993
- TRICARE overlaid the CHAMPUS program established in 1966
- Established cost-neutral TRICARE triple option (TRICARE Prime, Extra, and Standard)
- Started nationwide rollout of managed care support contracts (seven contracts) across 12 regions, each headed by a lead agent (five Army, two Navy, four Air Force, one rotating)
- Built a TRICARE provider network to wrap around the MTFs
- Increased beneficiary access to pharmacy options by adding home delivery and retail pharmacy points of service as a result of Base Realignment and Consolidation (BRAC) commission
- Preventive services first offered exclusively under TRICARE Prime
- Reduced catastrophic cap for non-Active Duty enrollees from $7,500 to $3,000
- Expanded Active Duty Dental Benefit Plan begins

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS *(CONT.)*

- Expanded beneficiary access to additional options for cancer treatment with a demonstration
  - Expanded coverage to all Phase II and III cancer clinical trials sponsored by the National Cancer Institute (NCI)
  - Widened access to promising cancer therapies, and contributed to the NCI's efforts to further the science of cancer treatment
  - Eventually became a permanent TRICARE Basic benefit available to all beneficiaries

1996

- Dropped requirement for outpatient NAS
- Increased beneficiary access to preventive services by expanding access in TRICARE Standard/Extra (expanded further in 1997 to be very similar to TRICARE Prime)
- Launched TRICARE website

1997

- Began National Mail Order Pharmacy program
- Improved access to services for families with a disabled family member through the implementation of the Program for Persons with Disabilities (PFPWD), simplifying the process and making access easier for families
- Expanded comprehensive preventive benefits to TRICARE Standard/Extra
- Began TRICARE Retiree Dental Program—full-cost premiums with no DoD subsidy

1998

- Completed TRICARE rollout with 11 regions operational (regions 7 and 8 consolidated)
- Removed TRICARE Prime copayments for ancillary services (radiology, laboratory, and diagnostic testing) conducted as a result of an outpatient visit
- Began TRICARE Senior Prime demonstration

1999

- Increased beneficiary access to more providers by adding Corporate Services Provider Class
  - Allowed provider groups and foundations to become TRICARE-authorized providers; the care rendered by these providers was previously not cost-shared
  - Included freestanding corporations or foundations that rendered professional ambulatory care (e.g., physical therapy), in-home care, or technical diagnostic procedures
- Began TRICARE Prime Remote benefit
- NASs are required for maternity care

2000

- The DoD waives charges for Active Duty Prime Remote family members through August 31, 2000
- Expanded TRICARE benefits to cover school physicals

- 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

2001

- Eliminated TRICARE Prime copayments for ADFMs
- Began TRICARE for Life (TFL) benefit, superseding TRICARE Senior Prime Demonstration; TFL is Medicare wraparound coverage for TRICARE beneficiaries who have Medicare Part A and Medicare Part B; TRICARE pays after Medicare and other health insurance for TRICARE-covered health care services
- Began TRICARE Senior Pharmacy (TSRx) benefit, adding pharmacy benefits for retirees over 65 years of age who formerly lost all TRICARE benefits upon becoming eligible for Medicare at age 65
- Reduced and simplified TRICARE copayment structure for prescription drugs
- Began permanent chiropractic care benefit in MTFs for Active Duty Service members (ADSMs)
- Began TRICARE Prime travel benefit to reimburse travel expenses when an enrollee has to travel more than 100 miles for referred specialty care

- Improved beneficiary access to needed care by revising the Coverage Criteria for Transplants and Cardiac and Pulmonary Rehabilitation
  - Added coverage of heart-lung, single or double lung, and combined liver-kidney transplants
  - Added coverage of pulmonary rehabilitation
  - Enhanced access to life-saving treatments for seriously ill TRICARE beneficiaries
  - Expanded coverage for pulmonary rehabilitation services to additional diagnoses as determined by the Director or designee
- Demonstration that waived NASs and annual TRICARE Standard/Extra deductible for family of mobilized Reserve Component (RC) sponsor (extended five times until made permanent in 2008)
- Deployed Pharmacy Data Transaction Service (PDTS)—improving patient safety—an online, real-time worldwide prospective drug utilization review (clinical screening) against a patient's complete medication history for each new or refilled prescription; these clinical screenings identify potential medication issues, which are immediately resolved to ensure the patient receives safe and quality care

2002

- Began TRICARE Prime Remote for Active Duty family members (TPRADFM) benefit
- Awarded TRICARE Mail Order Pharmacy (TMOP) contract (formerly managed by Defense Logistics Agency [DLA] as the National Mail Order Program)
- Began TRICARE Global Remote Overseas (TGRO) contract, providing cashless/claimless health care to overseas ADSMs/ADFMs assigned to Prime Remote locations

- Created Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC)—a discretionary program for beneficiaries with extraordinary medical or psychological conditions, providing coverage of care normally excluded by law or regulation, as long as the benefit was cost effective
- Created Custodial Care Transition Policy (CCTP) to cover new cases of custodial care for beneficiaries entitled to expanded benefits

2003

- Modified TPRADFM to allow family members residing in Prime Remote locations to remain enrolled when sponsors undergo Permanent Change of Station on unaccompanied tour
- Began requirement for RC sponsor's activation orders for TRICARE Global Remote Overseas benefit

- Eliminated NAS requirement for TRICARE Standard, except for mental health
- Awarded TRICARE Retail Pharmacy contract (TRRx), carving the benefit out of the managed care support contracts into a single program

APPENDIX

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS *(CONT.)*

2004

- Expanded Transitional Assistance Management Program (TAMP) coverage temporarily to 180 days for all participants (made permanent in 2005)
- Began early eligibility for RC members activated for more than 30 days in support of a contingency operation (made permanent in 2005)
- Consolidated managed care support contracts and 11 TRICARE Regions to three (North, South, and West)

2005

- Began premium-based TRICARE Reserve Select (TRS) benefit for certain Reserve Component members
- Superseded the PFPWD with Extended Health Care Option/Home Health Care (ECHO/EHHC) program, including 16 hours of respite care per month
- Improved beneficiary access to needed medications and, in many cases, decreased beneficiary cost share, by implementing the DoD Pharmacy Uniform Formulary/three-tier cost-share system
- Implemented the Uniform Formulary three-tier copayment, administered by the DoD Pharmacy & Therapeutics (P&T) committee under the Pharmacy Program

2006

- Expanded TRS to all members of the Selected Reserve by adding two premium tiers
- Expanded TRICARE coverage to gastric bypass, gastric stapling, or gastroplasty
- Gave family members a 30-day period to submit a TRICARE Prime enrollment form
- Added transitional TRICARE survivor coverage for dependents whose sponsor dies on Active Duty (greater than 30 days)
- Expanded coverage to certain direct commission reserve officers awaiting Active Duty

2007

- Expanded TRICARE coverage to anesthesia and other costs for dental care for certain children and other beneficiaries
- Standardized claims processing under TRICARE program and Medicare program
- Enhanced mental health screening and services for members of the Armed Forces
- Simplified TRS—superseded three-tier TRS with a single 28 percent premium tier; opened to all Selected Reserve members other than those eligible for, or enrolled in, Federal Employees Health Benefits (FEHB) program

- Included mental health care program in definition of health care
- Implemented the Enhanced Access to Autism Care Demonstration (ACD) through the ECHO for ADFMs
- Improved the care provided to Wounded Warriors by adding numerous benefits, including:
  - Expanded ECHO services to Service members with respite care added
  - Added retiree combat-related disability travel
  - Added transitional care for service-related conditions first identified during TAMP for RC members

2008

- Began Integrated disability evaluation system—ensured DoD disability ratings and Department of Veterans Affairs (VA) disability ratings were established prior to medical retirement from Active Duty

2009

- Started Active Duty Dental Program (ADDP)
- Eased the potential burden on families with special needs by increasing the ECHO cap to $36,000 per year for certain services
- Increased access to care by expanding the TAMP program:
  - Separated Active Duty members who affiliate with the Selected Reserve
  - Members in receipt of a sole survivorship discharge
- Improved beneficiary access to behavioral health care by allowing a streamlined certification for Hospital-Based Psychiatric Partial Hospitalization Programs
- Established TRICARE Pharmacy manufacturer refunds (retroactive to January 2008)
- Implemented Outpatient Prospective Payment System (OPPS)
- Improved beneficiary access to vaccines by expanding coverage under pharmacy benefit for H1N1 at retail pharmacies at zero copayment

2010

- Began TRICARE Overseas Program health care delivery
- Launched premium-based TRICARE Retired Reserve (TRR) program—TRICARE Standard/Extra coverage offered for purchase by Retired Reserve members (gray area) for themselves and eligible family members
- Expanded ADDP to Reserve members during TAMP

2011

- Launched premium-based TRICARE Young Adult (TYA)—TRICARE Standard/Extra coverage offered for purchase for certain adult children up to age 26
- Increased access to support services by expanding the ACD
- Increased access to needed treatment by expanding coverage of the available surgical options for morbid obesity
- Decreased copayment for TRICARE Pharmacy Home Delivery, coinciding with increases to copayments for retail pharmacy purchases
- Adjusted TRICARE Prime enrollment fee and began option for annual collection (frozen for survivors and certain significantly injured or ill retirees)
- Increased beneficiary access to behavioral health services by adding Certified Mental Health Counselors as independent practitioners

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS *(CONT.)*

2012

- Eliminated TRICARE Standard/Extra cost shares for authorized preventive services (always free of cost-sharing in TRICARE Prime)
- Expanded TYA to offer TRICARE Prime coverage
- Revised TRICARE compound drug coverage by adopting a more rigorous screening process to ensure they are safe and effective, and covered by TRICARE
- Decreased beneficiary cost by freezing TRICARE Prime enrollment fees at rate effective when first enrolled for survivors of Active Duty deceased sponsors and medically retired members and dependents
- Added coverage for off-label uses of devices if reliable evidence indicates it is safe, effective, and in accordance with nationally accepted standards of practice in the medical community
- Added assisted reproductive services for seriously or severely ill or injured service members

2013

- Reduction in Prime services areas (PSAs; closed all those not built around an MTF or BRAC site)
- TRS termination date delayed 180 days for Selected Reserve members involuntarily separated under honorable conditions (expired in 2018 by law)
- Expanded Autism Care Demonstration to include retiree family members
- Restricted U.S. Family Health Plan enrollment to beneficiaries (65 years and younger)
- Permanent authority to include certain OTC drugs under Uniform Formulary based on P&T recommendation
- Modified Over-the-Counter Demonstration project to include Plan B One-Step (levonorgestrel) without prescription requirement
- Added coverage for abortions for rape or incest and brought coverage into conformance with existing federal statutory laws, including the Hyde Amendment, the Affordable Care Act, and President's Executive Order #13535
- Added coverage of hippotherapy under ECHO (horseback riding as a therapeutic or rehabilitative treatment)
- Defense Health Agency (DHA) became initially operational under authority of the Assistant Secretary of Defense for Health Affairs (ASD[HA]) and designated as a Combat Support Agency with oversight from the Chairman of the Joint Chiefs

2014

- Reinstated Prime eligibility for some beneficiaries
- Launched Laboratory-Developed Test demonstration—authority to determine whether tests not yet approved by the FDA are safe and effective for use and thus eligible for TRICARE coverage
- Expanded TRICARE coverage to single-level cervical total disc replacement
- Increased access to TRICARE mental health counselors
- Expanded available treatments for substance abuse
- Began TFL Pharmacy Pilot, requiring TFL beneficiaries living in the U.S. and the U.S. territories to fill select maintenance medications through TRICARE Pharmacy Home Delivery or at a military pharmacy
- Extended the TRICARE Over-the-Counter demonstration, which permits beneficiaries to fill prescriptions for certain OTC drugs, from network pharmacies and through home delivery for free
- Added Certified Mental Health Counselors as authorized TRICARE providers
- Eliminated day limits for inpatient mental health stays
- Closed U.S.-based TRICARE Service Centers
- Expanded breast pump (and supplies) coverage to all TRICARE beneficiaries
- Expanded TRICARE coverage to same-sex spouses and their family members
- Clarified the Unfortunate Sequelae policy, ensuring that treatment of complications or medically necessary follow-on care that occurs subsequent to noncovered initial surgery/treatment at an MTF is covered

2015

- Changed TRICARE Prime access to allow beneficiaries to enroll in a region where their desired primary care manager (PCM) is located (cross-region enrollment)
- Launched fourth-generation pharmacy contract
- Added requirement for all beneficiaries (other than Service members) to receive maintenance drugs via mail-order or at MTFs only
- Awarded second-generation TRICARE Overseas Program contract
- Coverage of Transitional Care Management Services—includes services provided to beneficiaries with moderate or complex medical needs and who are transitioning from the inpatient setting to their community setting (e.g., home)

2016

- Implemented first Value-Based Demonstration—lower extremity joint replacement
- Launched network Urgent Care Pilot Program—up to four visits per year without referral or prior authorizations for non-ADSM Prime enrollees in contiguous United States
- Improved mental health access and parity with lower out-of-pocket expense
  - Expanded inpatient mental health hospital services coverage
  - Reduced cost shares for all applied behavior analysis services under Comprehensive Autism Care Demonstration
  - Expanded opioid treatment
- Improved TRICARE pharmacy benefit
  - Safe disposal of unwanted medications
  - Medication Therapy Management Pilot
  - DoD/VA Continuity of Care Drug List
  - Required brand name maintenance drug fills through either TRICARE Pharmacy Home Delivery or from a military pharmacy
  - Increased copayments slightly for Home Delivery and retail network pharmacies
  - Expanded over-the-counter drug coverage permanently
- Added reimbursement for end-of-life care beneficiary planning consultations
- Enhanced preventive services and eliminated some cost share/copayments
- Introduced provisional coverage for emerging treatments and technologies
- Expanded TRICARE Basic Program to cover:
  - Surgery for femoroacetabular impingement
  - Transcranial magnetic stimulation (TMS) for treatment of major depressive order and two-level cervical disc replacement
  - Nonsurgical treatment of gender dysphoria for all MHS beneficiaries; gender reassignment surgery only for ADSMs
- Began U.S.-based pilot to encourage MHS beneficiaries seen in civilian emergency rooms (in designated markets) to voluntarily transfer to a participating MTF if an inpatient admission is needed and if determined safe for transfer
- Started second-generation TRICARE Overseas Program contract
  - 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

2017

- Initial deployment of MHS GENESIS to four MTFs and their child sites

2018

- Replaced TRICARE Standard/Extra with TRICARE Select, with grace transition period in 2018
- Extended Autism Care Demonstration for five years, through 2023, providing Applied Behavior Analysis coverage
- First annual TRICARE Open Season; coincided with the annual open season by U.S. Office of Personnel Management (OPM)
- Enhanced TRICARE Coverage for Guard and Reserve members:
  - Extended TRICARE coverage to National Guard members and their eligible family members on 502(f) orders under Title 32 and called to state disaster response duty
  - Extended pre-deployment/early TRICARE eligibility and transitional coverage to Reserve Component members and eligible family members in receipt of 12304b orders for pre-planned missions under Title 10

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS *(CONT.)*

2019

- Ended TRICARE Retiree Dental Program (TRDP)
- OPM welcomed beneficiaries previously eligible for TRDP to enroll in a dental plan under their Federal Employees Dental and Vision Insurance Program (FEDVIP)
- Opened FEDVIP vision enrollment to ADFMs, retirees and their families, as well as TRS and TRR members
- Assigned administration, direction, and control (ADC) of MTFs in U.S. to DHA (Deputy Secretary of Defense memo October 25, 2019)
- Offered TRICARE Prime enrollment in a Kaiser Permanente demonstration to beneficiaries in the Atlanta region
- Updated coverage of breastfeeding supplies and equipment
- Continued rollout of MHS GENESIS, the electronic health record (EHR) to MTFs

2020

- Operation Warp Speed for COVID-19 vaccine development—massive HHS/DoD joint project; DoD phased vaccine administration began December 2020
- MTF COVID-19 adaptations included telemedicine
- Temporary TRICARE adaptations for COVID-19
  - Asymptomatic testing for Service members
  - Expanded telemedicine to audio only, eliminated Prime/Select cost shares, and authorized interstate or international practice
  - Expanded coverage to investigational drugs and emerging treatments, including vaccines and NIAID-sponsored clinical trials
  - Increased certain hospital payments by 20 percent
  - Relaxed criteria for skilled nursing facility care
  - Relaxed certification of temporary hospital facilities and free-standing surgical centers
- MHS transformation—MTF transition to DHA
  - Resumed after a pause for COVD-19 response
  - A number of Service medical department staff transferred to DHA
  - MHS GENESIS rollout to MTFs continued
- Added occupational therapy assistants (OTAs) and physical therapist assistants (PTAs) as TRICARE authorized providers; podiatrists can refer to PT and OT
- Enhanced TRICARE Pharmacy Benefits Program; encouraged use of high-value products
- Extended TRICARE demonstration project for Laboratory Developed Tests by three years
- Adopted Medicare's authority for Hospital Value Based Purchasing (HVBP) program
- Fourth Annual Open Season—new for 2021, TRICARE Select enrollment fees. 900,000 grandfathered retirees, their family, and survivors completed arrangements for fee collection with contractors

The **Evaluation of the TRICARE Program: Fiscal Year 2021 Report to Congress** is provided by the Defense Health Agency, Analytics and Evaluation Division, in the Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]). Once the Report has been sent to Congress, an interactive digital version with enhanced functionality and searchability will be available at: http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program.

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ASD = Office of the Assistant Secretary of Defense
CRM = Contract Resource Management
CSD = Clinical Support Division
HA = Health Affairs
KSA = Knowledge, Skills, and Abilities
OPS = Operations
OSD = Office of the Secretary of Defense
PCMH = Patient-Centered Medical Home
PHD = Public Health Division
P&R = Personnel & Readiness
R&M = Resources & Management
SP&FI = Strategy, Plans, & Functional Integration
THP = TRICARE Health Plan

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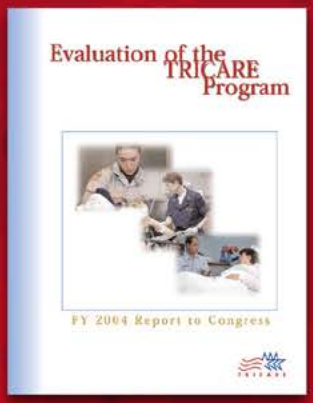
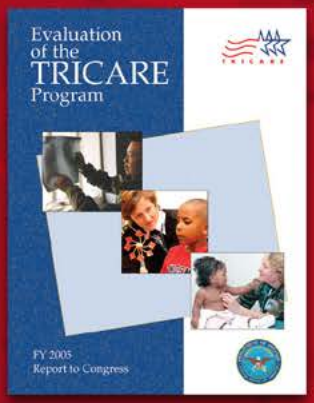
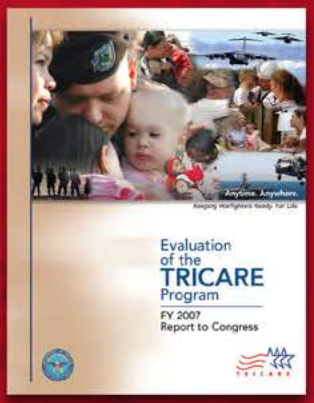
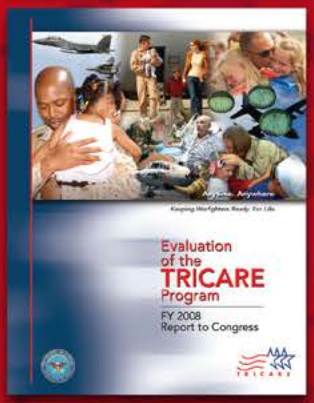
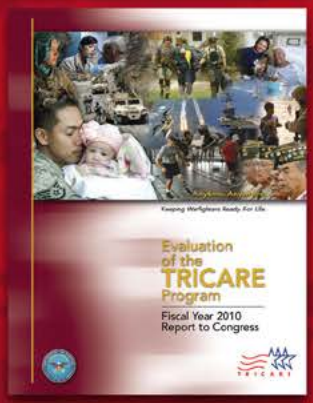
DHA
Defense Health Agency

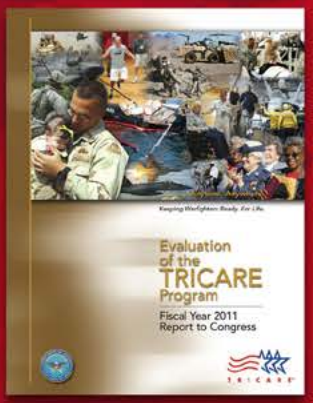


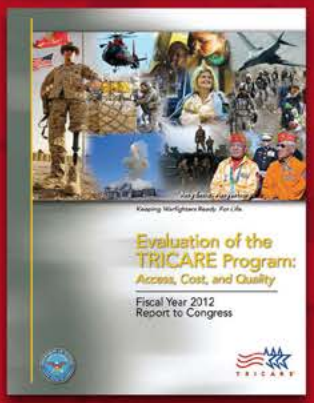


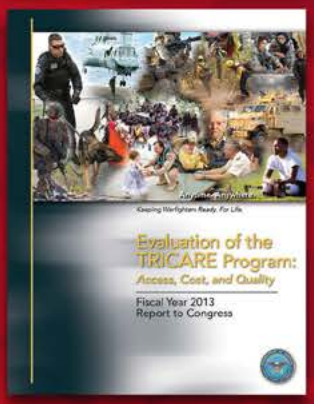


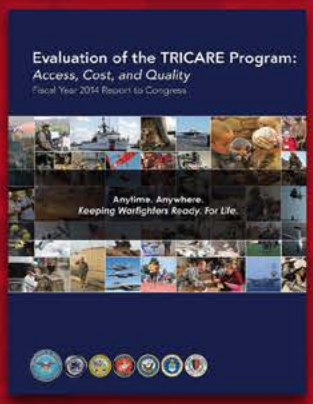


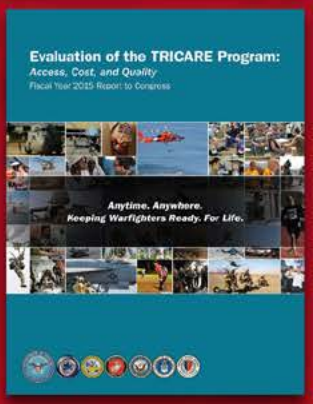


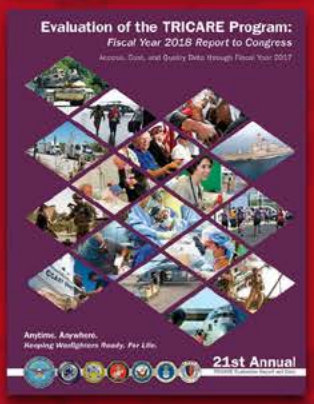


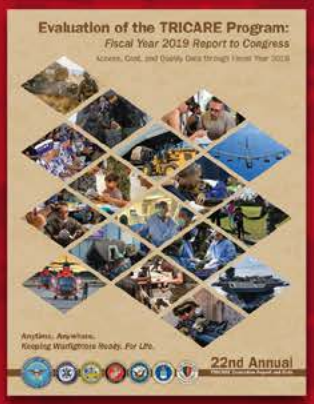












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TRICARE Evaluation Report and Data