Evaluation of the TRICARE Program:
Fiscal Year 2024 Report
Access, Cost, and Quality Data through Fiscal Year 2023

Improving Health and Building Readiness, Anytime, Anywhere — Always

27th Annual

TRICARE Evaluation Report and Data

Evaluation of the TRICARE Program:
Fiscal Year 2024 Report
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FEBRUARY 29, 2024

The *Evaluation of the TRICARE Program: Fiscal Year 2024 Report* is provided by the Defense Health Agency (DHA), Analytics and Evaluation Division, in the Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA]). The intent of this report is an annual evaluation of the TRICARE Program only and is not intended to cover the costs of care delivered to dual- eligible beneficiaries under the Veterans Administration. Once the Report has been approved, an interactive digital version with enhanced functionality and searchability will be available at: https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program.

The estimated cost of this report for the Department of Defense (DoD) is approximately $665,000.

Front cover photo descriptions:

A – U.S. sailors assigned to Naval Mobile Construction Battalion 133 finalize compaction and earthwork for a tension fabric structure project in Nutekpor, Ghana. (September 2023)

B – Robotic-assisted surgery milestone at Fort Belvoir Community Hospital is on full display during a robotic-assisted joint replacement surgery. The hospital is the first medical treatment facility in the DHA with this robotic-assisted platform, and the cutting-edge technology provides joint replacement surgeons an unparalleled amount of real-time surgical data. (February 2023)

C – U.S. Soldiers assigned to the 2nd Armored Brigade Combat Team, 1st Cavalry Division maneuver an M2 Bradley Fighting Vehicle during exercise Arrow 23 in Niinisalo, Finland. (May 2023)

D – A hospital corpsman from the aircraft carrier USS John F. Kennedy (CVN 79) performs a microscopic examination in the medical laboratory during Composite Training Unit Exercise. (March 2023)

E – Search and rescue Soldiers and Airmen attached to Hawaii National Guard CERF-P unit conduct search and recovery efforts to assist in the Lahaina wildfire response. (August 2023)

F – The Ohio-class ballistic missile submarine USS Maine (SSBN 741) surfaces to receive a vertical replenishment in the Philippine Sea. (May 2023)

G – U.S. Army Veteran from the Korean War attends a ceremony commemorating the 70th Anniversary of the Signing of the Korean War Armistice at the 3rd Infantry Division Monument in Section 46, Arlington National Cemetery. (March 2023)

H – Air Force orthopedic spine surgeon uses a robotic guidance system to perform spinal surgery on a patient at Brooke Army Medical Center, Fort Sam Houston, Texas. The robotic guidance system allows for preoperative or intraoperative planning, with features such as customizable implant selection, optimal implant trajectories, and 3-D analytics. (January 2023)

I – An MQ-9 Reaper, piloted by the 556th Test and Evaluation Squadron (TES), fires an Air-to-Ground Missile-114 Hellfire over the Nevada Test and Training Range. The 556th TES performs all software and physical testing to improve the combat capabilities of the MQ-9 Reaper. (August 2023)

J – Adapt and overcome: an Air Force Major competes in the wheelchair racing event during the 2023 Department of Defense (DoD) Warrior Games at Naval Base San Diego. Each Service provides newly enrolled wounded warriors with access to adaptive sports, allowing them to find new ways to enhance their recovery journey. (June 2023)

K – Space Force Sergeant from STARCOM's 527th Space Aggressor Squadron (SAS) conducts global positioning system (GPS) electromagnetic interference training with a GPS electromagnetic attack system at Schriever Space Force Base, Colo. The 527th SAS's mission is to know, teach, and replicate modern, emerging, and integrated space threats to prepare Service, joint, and coalition forces to fight in and through a Contested, Degraded, and Operationally Limited environment. (July 2023)

L – A U.S. Marine assigned to the Battalion Landing Team 1/6, 26th Marine Expeditionary Unit (Special Operations Capable) pilots a Skydio Unmanned Aerial System during an amphibious landing for Northern Coast 2023 (NOCO 23) in Ventspils, Latvia. (September 2023)

M – A hospital corpsman—a member of the Pacific Partnership medical staff, the largest annual multinational humanitarian assistance and disaster relief preparedness mission—demonstrates cardiopulmonary resuscitation (CPR) during first aid training to university staff at International Islamic University Malaysia, Kuantan Campus. (September 2023)

N – Walter Reed National Military Medical Center Interventional Pulmonology surgeon performs the first robotic bronchoscopy within the DHA. (August 2023)

O – Members with Maritime Security Response Team West hoist back into a Sector San Diego MH-60 Jayhawk helicopter from the flight deck of the Coast Guard Cutter Waesche (WMSL 751) off the coast of San Diego, Calif. (March 2023)

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

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BETTER HEALTH

LOWER COST

APPENDIX

DELIVERING ON THE DEFENSE HEALTH AGENCY (DHA) MISSION IN FISCAL YEAR (FY) 2023

The annual TRICARE Report serves as an essential resource for our Defense Health Agency team, our colleagues in military medicine, and our external stakeholders.

This annual report provides official information about who we serve, the choices our beneficiaries make in their TRICARE health plan, what health services they seek, their level of satisfaction, and the quality of care throughout our system—whether that care is delivered in military medical facilities or in the private sector.

This report is public, and we welcome the opportunity to share with every Service member and military family, Active Duty and retired, that we commit to meeting their health care needs anytime, anywhere—always.

This report also provides insight into how our resources are used in support of the DHA Strategic Plan. In 2024, we will be implementing a more comprehensive digital health strategy with a focus on improving our patients' experiences with seeking care and managing their health. We will change how care is delivered. We are privileged—and proud—to serve more than 9.5 million Americans who sacrifice so much to serve this nation. This annual TRICARE Report tells the story of how we are meeting this unique and indispensable mission.

Telita Crosland
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Director, Defense Health Agency

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KEY FINDINGS FOR FY 2023

Military Health System (MHS) Worldwide Summary

- The $58.7 billion Unified Medical Program (UMP) presented in the FY 2024 Enacted President's Budget, including estimated outlays from the Medicare-Eligible Retiree Health Care Fund (MERHCF), is 1.1 percent higher than the actual $58 billion FY 2023 expenditures and is about 7 percent of total FY 2024 estimated Department of Defense (DoD) outlays (ref. pages 22–23).
- In FY 2023, 9.4 million beneficiaries were eligible for DoD medical care. Of those, about 4.4 million (46 percent) were enrolled in TRICARE Prime (including TRICARE Young Adult [TYA] Prime and Uniformed Services Family Health Plan [USFHP]) (ref. pages 14–15).
- TYA enrollment decreased to just under 33,000 beneficiaries in FY 2023, from approximately 39,000 in FY 2021, with most enrolled in TRICARE Select (ref. pages 14–15).
- In FY 2023, there were 351,825 covered lives in the premium-based TRICARE Reserve Select (TRS), an increase from the previous year (342,256 covered lives in FY 2022). TRICARE Retired Reserve (TRR) had 12,468 covered lives in FY 2023, an increase from 12,365 in FY 2022 (ref. page 133).

MHS Workload and Cost Trends[1,2]

- The percentage of beneficiaries using Military Health System (MHS) services decreased from 86 percent in FY 2021 to 81 percent FY 2023 (ref. page 20).
- Excluding TRICARE for Life (TFL), total MHS workload (direct and private sector care combined) fell from FY 2021 to FY 2023 for inpatient care (6 percent) and prescription drugs (3 percent). Outpatient workload decreased by 5 percent over the same time period (ref. pages 25–26, 30).
- From FY 2021 to FY 2023, direct care workload decreased for inpatient care (16 percent), outpatient care (15 percent), and prescription drugs (9 percent). Over the same period, total direct care costs increased by 2 percent (ref. pages 25–26, 30, 35).
- Excluding TFL, private sector care workload decreased for inpatient care (1 percent), increased for outpatient care (3 percent) and increased for prescription drugs (1 percent). Overall, private sector care costs rose by 1 percent (ref. pages 25–26, 30, 35).
- The private sector care portion of total MHS health care expenditures rose from 60 percent in FY 2021 to 61 percent in FY 2023 (ref. page 35).
- In FY 2023, out-of-pocket costs for MHS beneficiary families under age 65 were between $7,300 and $8,000 lower than those for their civilian counterparts, while out-of-pocket costs for MHS senior families were $3,700 lower (ref. pages 169, 174).

Lower Cost

- MHS cost avoidance/recovery includes $1.4 billion in retail pharmacy refunds in FY 2023 and $184 million in Program Integrity activities in calendar year (CY) 2022 (ref. page 151).

Improved Readiness

- **Force Health Protection:** At the end of FY 2023, the overall medical readiness of the Total Force and the Active Component (AC) was at 92 percent and the Reserve Component (RC) was at 90 percent, both meeting the strategic goal of 90 percent. Dental readiness, at 89 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 37–42).

Better Care

- **Access to Care:** Patient-Centered Medical Home (PCMH) primary care administrative measures indicate that, in FY 2023, military medical treatment facility (MTF) enrollees saw their primary care provider 50 percent of the time. In FY 2023, there was an increase from the previous year in the average number of days to third next available 24-hour (2.7 days) and future (6.7 days) appointments. Network urgent care usage increased from 29.1 visits per 100 enrollees in FY 2022 to 30.6 visits per 100 enrollees in FY 2023. In FY 2023, the number of patient-initiated messages responded to within one business day was 71 percent. The Joint Outpatient Experience Survey (JOES) shows 59 to 73 percent of MTF users in FY 2023 reported they could get care when needed. Administrative data shows that 83 percent of non-Active Duty enrollees had at least one primary care visit in FY 2023 (ref. pages 49, 50, 55–56, 63, 66).
- **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 98–100).
- **Outpatient Care:** In FY 2023, MTF Healthcare Effectiveness Data and Information Set (HEDIS®) rates exceeded the national 90th percentile for appropriate treatment of pharyngitis, surpassed the national 75th percentile for mental health (MH) follow-up and colorectal cancer screening, and surpassed the national 50th percentile for appropriate treatment of URI (ref. pages 93–95).
- **Beneficiary Ratings of Inpatient Care—Overall Hospital Rating:** Direct care patient hospital ratings for FY 2023 met or exceeded the national Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) benchmark average in the medical and surgical product lines. Ratings in the obstetric product line increased by two percentage points from FY 2022 to FY 2023 but still fell below the HCAHPS benchmark (ref. page 121).
- **Patient Safety:** The MHS direct care system is focusing on reducing Wrong-Site Surgery (WSS) Reportable Events (REs) through education and leadership engagement, with a goal of zero events. The MHS experienced a significant drop in WSS REs from 2022 to 2023 (ref. page 75).
- **MHS Provider Trends:** The number of TRICARE network primary care providers increased by 18 percent from FY 2019 to FY 2023, while the number of specialists increased by 19 percent. The total number of participating primary care providers increased by 12 percent and by 16 percent for specialists since FY 2019 over the same time period (ref. page 136).
- **Access for TRICARE Select Users:** Results from the FY 2023 TRICARE Select Survey of Civilian Providers showed 84 percent of physicians and 34 percent of behavioral health (BH) providers accepted new TRICARE patients if they were accepting new patients at all (ref. page 137).

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

[2] By the end of FY 2023, the DoD's electronic health record, MHS GENESIS, had been deployed at 1,340 hospitals and clinics worldwide, including all within the United States. Because RVUs and cost data are currently unavailable for inpatient or outpatient care at MHS GENESIS facilities, we included estimates of those quantities in our totals.

WHAT IS TRICARE?

TRICARE is the worldwide health care program of the Department of Defense (DoD). It serves Uniformed Service members (Active and Guard/Reserve) on Active Duty (longer than 30 days) and their families; as well as retirees, their families, survivors, certain members of the selected/retired reserve and certain former spouses (www.tricare.mil). TRICARE brings together the military hospitals and clinics worldwide (military medical treatment facilities [MTFs] and military dental treatment facilities [DTFs], collectively called the "direct care system") with network and non-network TRICARE-authorized civilian health care professionals, institutions, pharmacies, and suppliers (collectively called "private sector care [PSC]") to provide access to the full array of high-quality health care services while maintaining the capability to support military operations.

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

- **TRICARE Select** requires enrollment and is comparable to preferred provider organization (PPO) health plans. It features access to both network and non-network TRICARE-authorized providers. Referrals are generally not required for coverage.
  - Beneficiaries other than Active Duty Service members (ADSMs) and other than TRICARE for Life (TFL) may qualify to enroll.
  - Retirees, their families, and certain survivors must pay enrollment fees to participate.
- **TRICARE Prime** requires enrollment and is comparable to health maintenance organization (HMO) plans. Each enrollee is assigned to a primary care manager (PCM). A PCM is a health care provider who is responsible for managing an enrollee's 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 a 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. However, POS deductibles and cost shares are significantly higher than TRICARE Select, and POS charges are not counted toward the enrollee's catastrophic cap.
  - **TRICARE Prime Remote (TPR)** enrollment is offered to certain Service members stationed remote from MTFs.
  - **TRICARE Prime Remote for Active Duty Family Members (TPRADFM)** enrollment is offered to qualified dependents of Service member sponsors, Active and Reserve, on Active Duty more than 30 days.
  - **Uniformed Services Family Health Plan (USFHP)** is a TRICARE Prime plan offered to non-Active Duty beneficiaries who live in one of six statutorily specified areas: Washington, Texas, Maine, Maryland, Massachusetts, and New York/New Jersey. Enrollees receive all services, including pharmacy, exclusively from their particular enrolled USFHP plan. Enrollees forfeit MTF services.
- **TRICARE for Life** offers wraparound coverage for TRICARE-eligible beneficiaries who have both Medicare Parts A and B, regardless of age or place of residence. Similar to Medigap policies, TFL pays secondary to Medicare for TRICARE-covered services. TFL started October 1, 2001.
- **Transitional Assistance Management Program (TAMP)** provides 180 days of premium-free coverage upon release from Active Duty served more than 30 days by certain Service member sponsors, Active or Reserve.
- **Other plans and programs:** Some beneficiaries may qualify for the following depending on their location, Active/Reserve status, and/or other factors:
  - Premium-based health plans, including:
    - **TRICARE Young Adult (TYA)** is available for purchase by qualified former dependent children up to the age of 26. They may choose TRICARE Prime, where offered locally, or TRICARE Select coverage. Cost-sharing level is dependent upon sponsor status.
    - **TRICARE Reserve Select (TRS)** is available for purchase by qualified Selected Reserve (SelRes) members and qualified survivors. TRS delivers TRICARE Select coverage with cost sharing at the Active Duty Family Member rate.
    - **TRICARE Retired Reserve (TRR)** is available for purchase by qualified Retired Reserve members with cost sharing at the retiree rate.
    - **TRICARE Dental Program (TDP)** is available for purchase by family members of ADSMs as well as Ready Reserve members and their family members.
    - **Continued Health Care Benefit Program** is comparable to Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage.
    - **Federal Employees Dental and Vision Insurance Program (FEDVIP)** offers dental plans for purchase by retirees, and offers vision plans for purchase by most non-Service member beneficiaries enrolled in a TRICARE health plan. FEDVIP is operated by the U.S. Office of Personnel Management, not DoD.
- **Other benefits and services, including:**
  - Dental benefits (DTFs and claims management for Active Duty using civilian dental services)
  - Pharmacy: MTFs, TRICARE retail network pharmacies, and TRICARE Pharmacy Home Delivery Program
  - Overseas private sector care, customer service, and claims processing services
  - Women, Infants, and Children Overseas Program (www.tricare.mil/wic)
  - Extended Care Health Option (ECHO): nonmedical benefits available to qualified Active Duty family members (ADFMs) with special needs (www.tricare.mil/echo).

MILITARY HEALTH SYSTEM STRATEGY FOR FYs 2024–2029

The MHS fosters, protects, sustains, and restores health of active duty and Reserve Component forces to support the mission. The MHS provides the direction, resources, health care personnel, and other means necessary for promoting and improving the health of our country's fighting forces, their families, and those who served and retired.

OUR MISSION

To enable the Department of Defense to provide medically ready and ready medical forces by improving the health of all those entrusted to our care.

OUR VISION

To become the world's role model of an integrated military system of health and readiness delivering technology enabled, innovative, and Service-focused care in support of our nation's military mission – anytime, anywhere.

Source: MHS Strategy: Fiscal Years 2024–2029

MILITARY HEALTH SYSTEM STRATEGY FOR FYs 2024–2029 *(CONT.)*

The MHS strategy aligns to and supports the National Defense Strategy, the National Military Strategy, and the National Biodefense Strategy and Implementation Plan. This strategy orients the MHS and its resourcing and planning processes to the rest of DoD, serving as a roadmap to becoming a requirements-driven organization and guide the system into the next Future Years Defense Program. To do so effectively and accomplish our mission, the MHS strategy builds on three fundamental and interrelated pillars:

- **Medically Ready Force.** A force composed of individuals with the mental, physical, and cognitive strength and resilience to engage in sustained combat operations; meets DoD and Military Service medical requirements for deployment; and partners with health care delivery to create health and well-being.
- **Ready Medical Force.** Deployable operational and tactical medical forces (Role 1–3) that provide a joint network of integrated health support delivering prevention, protection, and treatment. Operational and tactical medical forces provide three of five core joint health service capabilities: forward resuscitative care; enroute care; and theater hospitalization. Strategic medical forces (Role 4) sustain, prepare, generate, and regenerate medically ready and ready medical forces and provide the joint health service core capability of definitive care, up to and including, in support of large-scale combat operations.
- **Health Care Delivery.** A health delivery system is the combination of people, systems, policies, and resources which provide services to promote, improve, conserve, or restore behavioral and physical health and well-being. Military health care delivery produces medically ready and ready medical forces.

Strategic Goals

Our strategic goals describe how the MHS will become the world's role model for an integrated military system of health and medical readiness. These four goals provide an actionable roadmap to effectively deliver required MHS capabilities. Each goal is defined and supported by strategic objectives that outline what resources the DoD needs to provide to achieve the goals and accomplish the medical mission.

1. **Take Care of Our People.** Healthy, educated, and trained people take better care of people. We must restore the well-being of our health care personnel so that they are ready to provide the best care and the best support for those who go into harm's way. To advance this goal, we will:
    - 1.1. Invest In Our Workforce by providing complete lifecycle support for health professionals, including education, training, and skills sustainment for the uniformed and civilian workforce. The MHS develops leaders in health and medicine; respects and reveres Military Service cultures; and supports a robust, strong civilian workforce.
    - 1.2. Deploy Ready Reliable Care to improve safety and standardize processes for less variability; reduce errors in clinical and non-clinical areas; encourage and celebrate transparency and accountability; and value everyone's input, regardless of rank.
    - 1.3. Empower Our Workforce by providing safe, supportive environments and encouraging healthy behaviors by leadership engagement at all levels to promote well-being and reduce burnout.
2. **Stabilize the MHS.** The realignment of medical personnel, coupled with a volatile health care economy and a new electronic health record, created challenges to care for our beneficiaries and impacted our ability to efficiently generate and sustain medically ready and ready medical forces. To advance this goal, we will:
    - 2.1. Increase Capacity and Capability to Care for Complex Patients by realigning capability to better meet demand for care from our patients and mitigate risks. This requires the MHS to optimize military medical personnel availability in coordination with the Military Departments; improve civilian personnel hiring and retention; sustain clinical competencies; and strategically reinvest in MTFs and DTFs.
    - 2.2. Improve Experience of Care by first and foremost improving access to primary and specialty care, and delivering services that are patient centered, recognizing the unique needs of each person and their right to make informed choices to achieve health and well-being.
    - 2.3. Attract and Reattract Beneficiaries to MTFs to improve efficiency and enrich clinical experiences for the Ready Medical Force, and consciously fulfill the promise our nation makes to care for our beneficiaries.

Source: MHS Strategy: Fiscal Years 2024–2029

MILITARY HEALTH SYSTEM STRATEGY FOR FYs 2024–2029 *(CONT.)*

Strategic Goals *(cont.)*

3. **Modernize the MHS.** Health systems worldwide must transform to keep up with the pace of rapid innovation. A complex and challenging national security landscape requires us to streamline and reform health care delivery to make the best, most effective use of our nation's resources. To advance this goal, we will:

    3.1. Implement Digital Health to integrate advanced technology from home to the clinic to the battlefield and back. Timely, accurate, and useful information gives medical personnel a vast array of focused knowledge to enable state-of-the-art care and afford patients more choice in access and power over their health decisions.

    3.2. Prioritize Medical Research and Development investments in blood and blood products, pharmaceuticals, vaccines, biomedical equipment, and new pathways of care to save future lives on the battlefield, restore the Warfighter, and aid military responses to national emergencies.

    3.3. Expand Biodefense surveillance and response capabilities to assess, prevent, protect against, respond to, and recover from biological threats; strengthen the national medical readiness posture; and improve global health security.

    3.4. Deliver Value-Based Care to ensure that we optimize resources to capitalize on our structure and capabilities to deliver high quality, safe, equitable, and resource responsible outcomes that matter to patients.

4. **Integrate MHS Capabilities.** Resources must be strategically applied to effectively and efficiently deliver the five integrated military health service capabilities: first responder care; forward resuscitative care; enroute care; theater hospitalization; and definitive care.

    4.1. Define Health Care Requirements across the MHS from unit-level medical care (Role 1); forward trauma management and emergency medical treatment (Role 2); theater hospitalization (Role 3); and definitive care (Role 4) to plan, program manpower and resources, sustain clinical competencies, and mitigate risk to other military requirements.

    4.2. Facilitate Interoperability in the MHS by strengthening links and relationships between system components to ensure safe, high-quality care across all installations and missions, responsibly manage resources, and limit unwarranted duplication.

    4.3. Reinforce Partnerships with other federal agencies, allies and partners, and civilian health systems to support military missions and efficiently generate, sustain, and rebuild health readiness worldwide.

    4.4. Reinvest in MTFs critical to medical force generation, sustainment, casualty reception, and centers of excellence.

Source: MHS Strategy: Fiscal Years 2024–2029

DEFENSE HEALTH AGENCY (DHA) MISSION, VISION, AND PRIORITIES, FYs 2023–2028 STRATEGIC PLAN

Mission

The Defense Health Agency supports our Nation by improving health and building readiness—making extraordinary experiences ordinary and exceptional outcomes routine.

Vision

Unrelenting pursuit of excellence as we care for our joint force and those that we are privileged to serve. Anytime, Anywhere—Always.

Priorities

Enabling Combat Support to the Joint Force in Competition, Crisis, or Conflict

Deliver agile and scalable combat support capabilities to the Combatant Commanders (CCDRs) and Joint Force through operation of agreed upon clearly defined functions in competition, crisis, or conflict. Listen better, address comprehensively, and respond with urgency to challenges—and bring flexible solutions, to any place around the globe that our mission requires.

Building a Modernized, Integrated, and Resilient Healthcare Delivery System

Achieve new levels of excellence by fully leveraging emerging scientific and technological advancements, expanding partnerships, and adopting new models of health and wellness to optimize the health and care experience of our beneficiaries while improving preparedness of our medical teams. Use authorities to continuously pilot demonstration projects that reward outcomes over production, value over volume, and optimize delivery options to provide information, care, and transparency using the most appropriate venues for our beneficiaries, patients, and stakeholders.

Dedicated and Inspired Teams of Professionals Driving Military Health's Next Evolution

Create a fulfilling and revitalizing workplace where purpose drives performance, people are the primary focus, and the principles of high reliability nurture and energize each individual, driving the entire organization in support of our pursuit of excellence.

Source: DHA Strategic Plan: Fiscal Year 23–28

DHA ADVANCEMENT

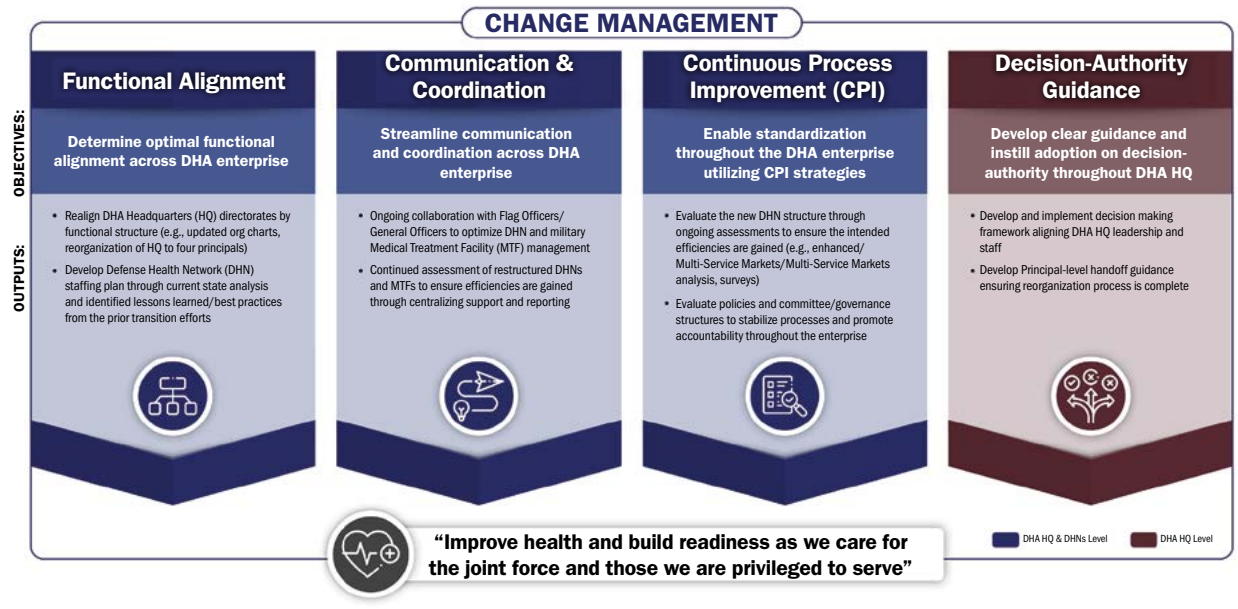
Military hospitals and clinics are organized into one of nine Defense Health Networks (DHNs), enabling the Defense Health Agency to deliver high-quality health care for those we are privileged to serve. A DHN is a group of military medical and dental facilities that operates as a coordinated system and improves the delivery and continuity of your health services.

DEFENSE HEALTH NETWORKS

Source: https://health.mil/About-MHS/Defense-Health-Networks

THE PILLARS OF DHA ADVANCEMENT SUCCESS

Functional Alignment, Communication & Coordination, Continuous Process Improvement, and Decision-Authority Guidance are the four key pillars enabling effective outcomes and instilling our Mission and Vision through the success of the Defense Health Agency (DHA) Advancement



Source: DHA Advancement Initiative Sharepoint, 2024

MHS PERFORMANCE MANAGEMENT

Private Sector Care Performance Management

In FY 2023, DHA continued value-based demonstrations and pilots to meet the requirements of National Defense Authorization Act (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 Low Back Pain (LBP) and Physical Therapy (PT) Demonstration and the Hospital Value-Based Purchasing (HVBP) Program. A new project, the Child Birth and Breast Feeding Support Demonstration, began in FY 2022. This nationwide initiative is designed to measure maternal and fetal outcomes for beneficiaries who receive support services from doulas and/or lactation counselors/consultants, as compared with those who do not.

DHA started a three-year LBP and PT demonstration January 2021 in 10 states: Arizona, California, Colorado, Florida, Georgia, Kentucky, North Carolina, Ohio, Tennessee, and Virginia. The demonstration tests whether incentivizing participation in PT by waiving copayments increases the use of appropriate PT services and reduces potentially unnecessary and harmful care to the beneficiary, such as unnecessary imaging, surgery, and opioid prescribing. 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. This demonstration will conclude at the end of this year, after which the DHA will evaluate the results to see if permanent benefit changes are warranted.

DHA implemented Medicare's HVBP Program on January 1, 2020. The 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. TRICARE hospitals are not subjected to any additional reporting, as they are already participating in the Medicare HVBP Program.

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.

HOW TRICARE OPERATES

TRICARE consists of both care in the private sector (as administered by TRICARE contractors) and in the direct care system (MTFs and DTFs).

The DHA is responsible for the administration, direction, and control (ADC) of MTFs and DTFs as required by Section 1073c of Title 10, United States Code. DHA exercises ADC of the direct care system through enterprise-wide guidance, reporting relationships, and named direct-care Network offices worldwide.

The DHA Health Care Operations (HCO) directorate supports the optimization of MTFs/DTFs and the Network through its various divisions. HCO includes the Health Care Optimization division, which focuses on direct care operations and optimization in primary care, specialty care, referral management, appointing, DoD and Veterans Health Administration (VHA) integration, patient experience, and virtual health (VH) execution. Other HCO divisions include Health Care Operations Support, Health Care Optimization, Pharmacy Operations, Laboratory Management, Joint Trauma System (JTS), TRICARE Health Plan (THP), Patient Administration, Armed Services Blood Program, and Network Integration.

Within HCO, the Pharmacy Operations division oversees the TRICARE retail pharmacy contract currently operated by Express Scripts, Inc.

The THP division in HCO oversees performance of the other TRICARE contracts that administer coverage of private sector care. Humana Government Business (HGB) operates the TRICARE East Region contract in the United States, and Health Net Federal Services (HNFS) operates the TRICARE West Region contract. Wisconsin Physician Services operates the contract that administers TFL. Each of the six USFHP contracts is operated by a different contractor.

The TRICARE Overseas Program (TOP) section oversees the TOP contract, which is currently operated by International SOS. TOP supplements the direct care system by providing private sector care services through networks with host nation providers. TOP supports the Combatant Commands in delivery of comprehensive health services in remote locations and performs aeromedical evacuations when military assets are not available.

CONTINUAL EXPANSION, EVOLUTION, AND OPTIMIZATION OF THE TRICARE BENEFIT

Since the TRICARE brand name was first applied to the MHS enterprise in 1995, the TRICARE benefit has continued to expand and evolve for Uniformed Services members, retirees, and their families. Even as the MHS aggressively works to optimize the TRICARE Program through good fiscal stewardship, it also refines and enhances the benefits and programs in a manner consistent with statutes and federal regulation to stay abreast of industry standard of care and best practices (see “TRICARE Program and Benefits Evolution over the Years” in the Appendix).

BENEFICIARY TRENDS AND DEMOGRAPHICS

System Characteristics

TRICARE FACTS AND FIGURES—PROJECTED FOR FISCAL YEAR (FY) 2024

	PROJECTED FOR FY 2024[a]	FY 2023 ACTUALS
Total Beneficiaries	**9.5 million worldwide[b]**	9.4 million worldwide[b]
MILITARY FACILITIES—DIRECT CARE SYSTEM[c]		
Inpatient Hospitals and Medical Centers	**45 (32 in U.S.)**	45 (32 in U.S.)
Ambulatory Care and Occupational Health Clinics[d]	**572 (481 in U.S.)**	574 (481 in U.S.)
Dental Clinics	**115 (88 in U.S.)**	117 (88 in U.S.)
Military Health System (MHS) Defense Health Program Personnel	**129,853**	123,164
Military	**72,544**	68,260
	26,771 Officers	25,340 Officers
	45,773 Enlisted	42,920 Enlisted
Civilian (including Foreign National)	**57,309**	54,904
CIVILIAN RESOURCES—PRIVATE SECTOR CARE SYSTEM[e]		
Network Primary Care, Behavioral Health (BH), and Specialty Care Providers (i.e., individual, not institutional, providers)	**931,679**	932,091
Network BH Providers (shown separately, but included in above)	**182,006**	181,437
TRICARE Network Acute Care Hospitals	**4,158**	4,626
BH Facilities	**2,148**	2,221
Contracted (Network) Retail Pharmacies	**41,500**	41,874[f]
Contracted Worldwide Pharmacy Home Delivery Vendor	**1**	1
TRICARE Dental Program (TDP) (for Active Duty families, Reserve members and their families)	**Approximately 2 million covered lives**	Approximately 2 million covered lives
TDP Network Dentists	**105,000 total dentists, including: 80,000 general dentists and 25,000 specialty dentists**	100,520 total dentists, including: 76,721 general dentists and 23,799 specialty dentists
Total Requested FY 2023 Unified Medical Program (UMP) (including Projected Trust Fund Receipts)	**$58.38 billion[g]**	$55.41 billion[g]
Projected Receipts from Medicare-Eligible Retiree Health Care Fund (MERHCF) Trust Fund	**$9.74 billion**	$9.34 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 the end of FY 2023 is 9,446,069, rounded to 9.4 million. This projection is based on the DoD Comptroller's Budget End Strength, the DoD Actuary's forecast of the retiree population, and the family members per sponsor from the Defense Manpower Data Center Defense Enrollment Eligibility Reporting System (DEERS) as of January 2024.

[c] Military medical treatment facility (MTF) clinic count includes occupational health, community-based, embedded behavioral health, Active Duty troop, centers of excellence, and joint DoD-Department of Veterans Affairs (VA) clinics, and excludes leased/contracted facilities and Aid Stations. Military facility counts are that of the number of facilities based on the Defense Medical Information System Identifiers ID, not clinical functions Source: Defense Health Agency (DHA)/Resources & Management (J-1/J-8)/Budget and Execution and Programming Divisions, 12/12/2023.

[d] The projected increase in ambulatory clinics for FY 2023 is largely administrative in nature to ensure system alignment with MHS GENESIS Patient Care locations. The policy reinforcement has come from two different directions: (1) Defense Medical Information System Identifiers (DMIS IDs) table alignment with MHS GENESIS to resolve issues in clerk/patient appointing and (2) aligning overhead costs to a building or function to better reflect the cost of care (delineating buildings on the DMIS table that don't fall under a campus concept).

[e] As reported by the managed care support contractors (MCSCs) for contracted network provider and hospital data, 12/19/2022; and TRICARE Dental Program Section, Health Plan Execution and Operations for dental provider data, 3/1/2023.

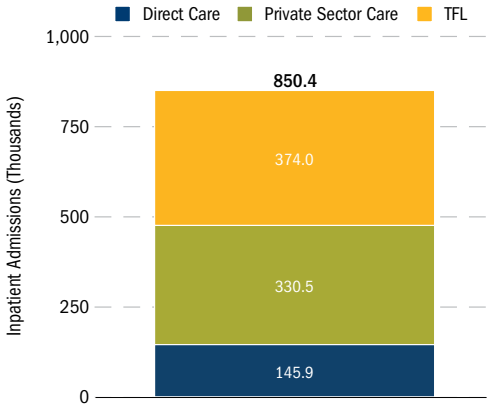
[f] This number is only accurate at the time of the data pull (9/30/2023).

[g] 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, as of FY 2023 Request.

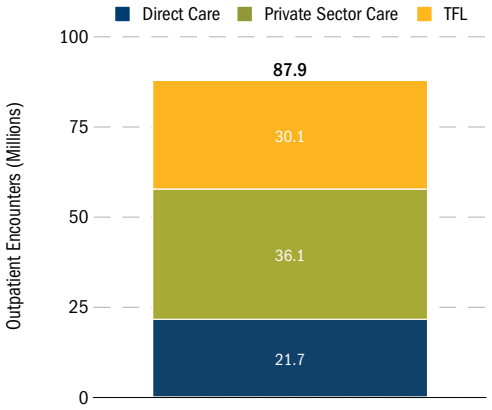
BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

FY 2023 TRICARE Workload and Population Summary

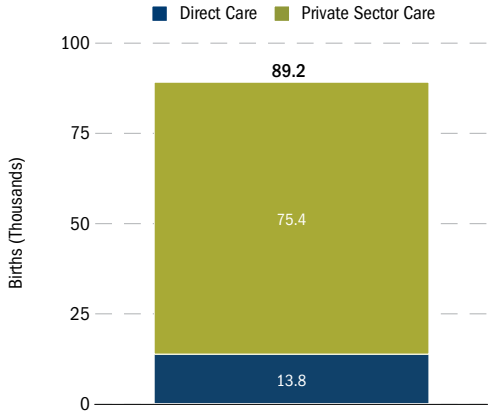
INPATIENT ADMISSIONS[a]



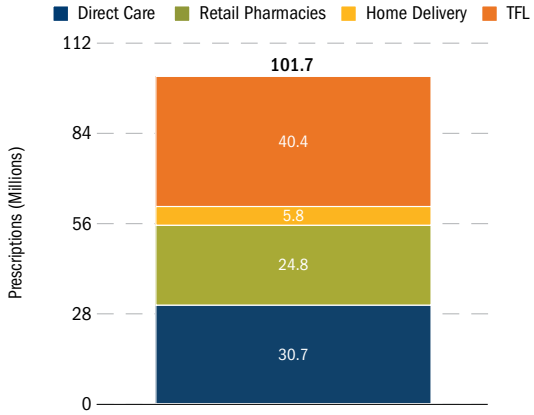
OUTPATIENT ENCOUNTERS[a]



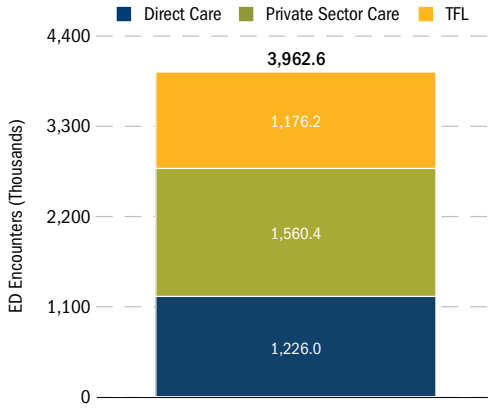
BIRTHS[a]



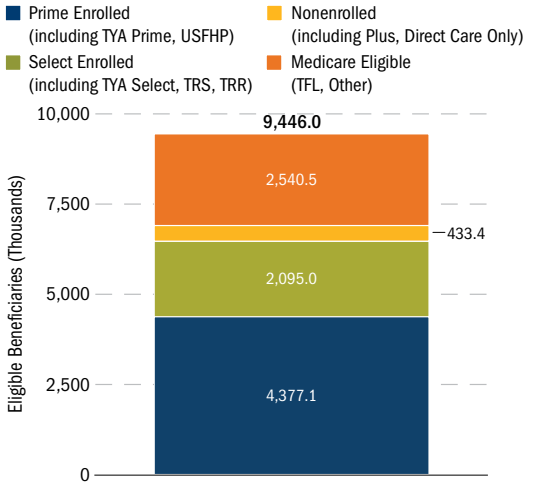
PRESCRIPTIONS[a]



EMERGENCY DEPARTMENT (ED) ENCOUNTERS[a]



ELIGIBLE BENEFICIARIES



Sources: MHS administrative data, 1/4/2024, and DEERS, 1/4/2024

[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.

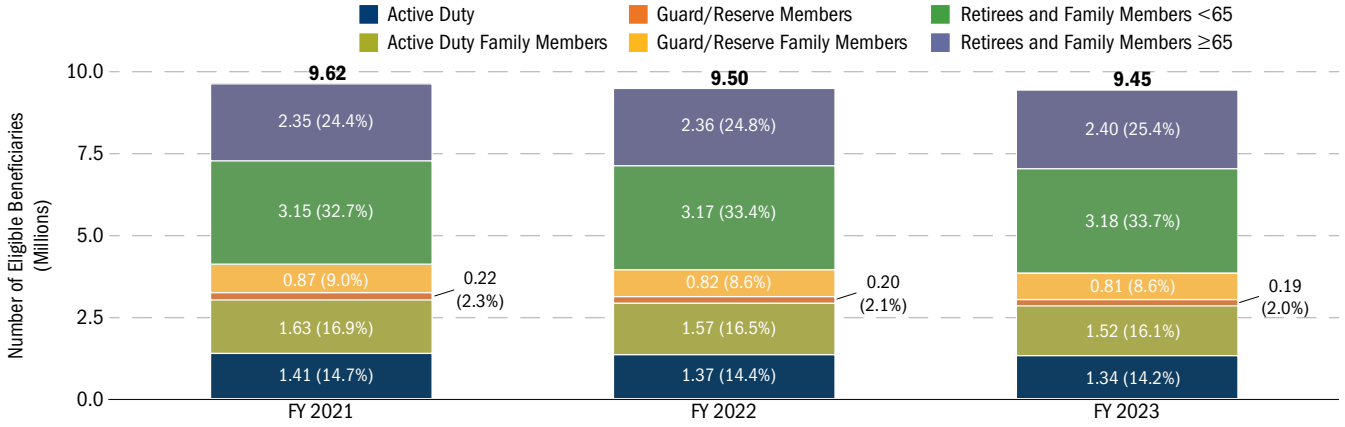
– Numbers may not sum to bar totals due to rounding.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Number of Eligible and Enrolled Beneficiaries between FY 2021 and FY 2022

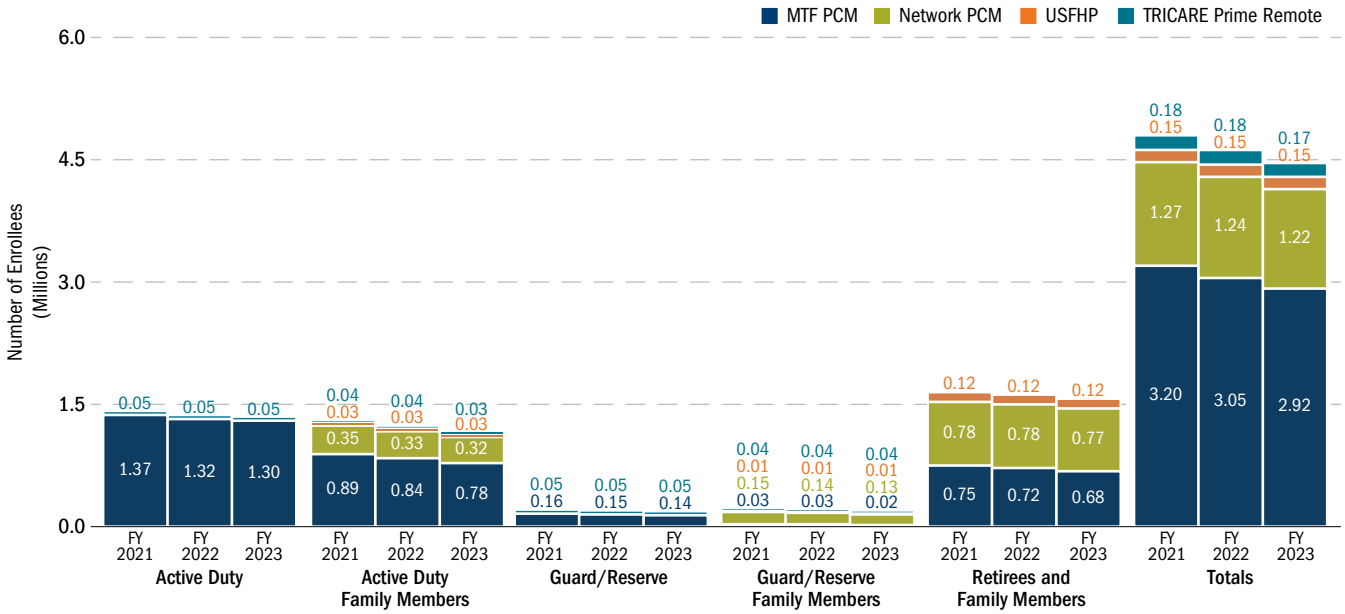
The number of beneficiaries eligible for DoD medical care (including TRR, TRS, and TYA) declined by 2 percent from 9.62 million in FY 2021 to 9.45 million in FY 2023.[1] Active Duty Service members (ADSMs) decreased by 5 percent; the number of Active Duty family members (ADFMs) decreased by 7 percent. The number of retirees and family members (RETFMs) under age 65 increased by 1 percent, but the number of RETFMs aged 65 and older increased by 2 percent.

TRENDS IN THE END-YEAR NUMBER OF ELIGIBLE BENEFICIARIES BY BENEFICIARY GROUP, FYs 2021–2023



- From FY 2021 to FY 2023, ADFMs experienced declines in Prime enrollment with both MTF and network primary care managers (PCMs). However, this is largely due to an overall decline in the ADFM population. Prime enrollment by Guard/Reserve members and their families remained about the same.
- The trend in RETFM Prime enrollments was similar to that of ADFMs, with the number of beneficiaries having either an MTF or network PCM decreasing. The number of RETFMs enrolled with a network PCM continued to exceed the number of those with an MTF PCM, with the gap widening further in FY 2023.
- TRICARE Prime Remote (TPR) displayed a 7.9 percent decline, while USFHP enrollment remained about the same from FY 2021 to FY 2023.

TRENDS IN THE END-YEAR NUMBER OF PRIME-ENROLLED BENEFICIARIES BY BENEFICIARY GROUP, FYs 2021–2023



Source: DEERS, 1/4/2024

[1] This number should not be confused with the one displayed under TRICARE Facts and Figures on page 11. The population figure on page 11 is a projected FY 2024 total, whereas the population reported on this page is the actual for the end of FY 2023.

Notes:

– The RETFMs 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 2023

PLAN TYPE	0–17	18–24	25–44	45–64	≥65	TOTAL[a]
Prime Enrolled	1,134,969	808,036	1,477,964	948,941	7,282	4,377,192
Prime: MTF PCM	648,128	667,930	1,162,533	484,831	1,282	2,964,704
Prime: Network PCM	407,489	111,974	205,037	401,198	560	1,126,258
Prime Remote	42,908	16,852	90,634	16,521	57	166,972
USFHP	36,444	9,008	19,112	46,391	5,383	116,338
TYA Prime	0	2,272	648	0	0	2,920
Select Enrolled	713,545	213,444	544,772	622,142	1,073	2,094,976
TRICARE Select	542,745	151,027	349,016	572,069	998	1,615,855
TRS	162,994	35,651	186,482	32,914	34	418,075
TYA Select	0	24,121	5,776	0	0	29,897
TRICARE Plus	3,946	1,188	2,008	10,844	41	18,027
TRR	3,860	1,457	1,490	6,315	0	13,122
Nonenrolled	71,041	55,999	90,614	185,128	30,661	433,443
Direct Care Only	71,016	55,988	90,593	184,463	29,846	431,906
TRICARE Plus	25	11	21	665	815	1,537
Medicare-Eligible	18	807	31,181	141,498	2,366,954	2,540,458
TFL	6	428	15,974	77,411	2,058,656	2,152,475
TRICARE Plus[b]	0	2	120	928	186,961	188,011
Direct Care Only	0	25	4,268	13,538	84,950	102,781
USFHP	0	14	320	1,597	35,831	37,762
Prime: Network PCM	5	123	5,517	25,329	5	30,979
Prime: MTF PCM	3	129	4,263	21,932	1	26,328
Other	4	86	719	763	550	2,122
Total	**1,919,573**	**1,078,286**	**2,144,531**	**1,897,709**	**2,405,970**	**9,446,069**

Source: DEERS, 1/4/2024

[a] The totals 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, 184,966 with TRICARE Plus also have TFL. These numbers are not included in the TFL row.

- About 27 percent of USFHP enrollees are seniors (aged 65 and older), and about 24 percent are children (aged 0–17).
- The vast majority of those aged 65 and older are enrolled in Medicare Part B and are covered by TFL as their supplemental plan. About 9 percent of seniors covered by TFL are also enrolled in TRICARE Plus, the primary care–only plan available at selected MTFs.
- Medicare-eligible beneficiaries younger than 65 years have a choice between TRICARE Prime (including the USFHP) and TFL. About 60 percent choose TFL and 40 percent choose Prime.
- Beneficiaries aged 45–64 had the lowest TRICARE Prime enrollment rate, at 50 percent. Enrollment rates for the other age groups were 59 percent for 0–17, 75 percent for 18–24, and 69 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 2023

PLAN TYPE	AD	ADFM	GR	GRFM	IGR	IGRFM	OTH	RET	RETFM	SRV	TOTAL[a]
Prime Enrolled	1,343,107	1,164,287	189,085	185,689	4,117	13,997	1,777	520,516	920,477	34,140	4,377,192
Prime: MTF PCM	1,296,554	816,547	140,190	55,117	2,178	3,894	1,096	244,676	390,572	13,880	2,964,704
Prime: Network PCM	0	288,040	0	85,733	557	8,669	554	246,793	478,093	17,819	1,126,258
Prime Remote	46,553	33,305	48,895	36,861	994	364	0	0	0	0	166,972
USFHP	0	26,155	0	7,923	388	1,068	127	29,047	49,245	2,385	116,338
TYA Prime	0	240	0	55	0	2	0	0	2,567	56	2,920
Select Enrolled	0	322,113	0	95,023	178,990	293,723	12,429	378,669	771,718	42,311	2,083,229
TRICARE Select	0	319,760	0	93,978	21,260	33,272	11,997	367,355	727,080	41,153	1,615,855
TRS	0	1	0	248	157,730	259,515	421	33	86	41	418,075
TYA Select	0	2,126	0	750	0	936	11	0	25,269	805	29,897
TRICARE Plus	0	226	0	47	0	0	0	6,823	10,649	282	18,027
TRR	0	0	0	0	0	0	0	4,458	8,634	30	13,122
Nonenrolled	0	31,706	0	7,895	22,857	3,594	19,208	124,828	196,076	27,279	433,443
Direct Care Only	0	30,924	0	7,866	22,857	3,594	19,208	124,693	195,551	27,213	431,906
TRICARE Plus	0	782	0	29	0	0	0	135	525	66	1,537
Medicare-Eligible	0	1,920	0	641	129	792	2,311	1,236,146	789,243	509,276	2,540,458
TFL	0	0	0	0	0	0	2,025	1,025,659	675,183	449,608	2,152,475
TRICARE Plus[b]	0	280	0	31	0	0	31	95,745	60,162	31,762	188,011
Direct Care Only	0	1,110	0	277	10	31	213	60,750	23,067	17,323	102,781
USFHP	0	0	0	0	0	0	25	18,138	12,112	7,487	37,762
Prime: Network PCM	0	0	0	0	0	0	9	19,525	9,935	1,510	30,979
Prime: MTF PCM	0	0	0	0	0	0	0	16,212	8,565	1,551	26,328
Other	0	530	0	333	119	761	8	117	219	35	2,122
Total	**1,343,107**	**1,520,026**	**189,085**	**289,248**	**206,093**	**312,106**	**35,725**	**2,260,159**	**2,677,514**	**613,006**	**9,446,069**

Source: DEERS, 1/4/2024

[a] The totals 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, 188,186 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 7 percent of non-Medicare-eligible beneficiaries were not enrolled in any TRICARE plan (i.e., they used space-available care or TRICARE Plus at MTFs or other health insurance [OHI]) in FY 2023.
- 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 9 percent in FY 2023.
- About 70 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 2021–2023

PLAN TYPE	FY 2021		FY 2022		FY 2023	
	POPULATION	% OF TOTAL	POPULATION	% OF TOTAL	POPULATION	% OF TOTAL
Prime Enrolled	4,701,360	48.9%	4,537,128	47.8%	4,377,192	46.3%
Prime: MTF PCM	3,235,054	33.6%	3,100,140	32.6%	2,964,704	31.4%
Prime: Network PCM	1,165,835	12.1%	1,139,643	12.0%	1,126,258	11.9%
Prime Remote	180,088	1.9%	178,650	1.9%	166,972	1.8%
USFHP	114,223	1.2%	114,643	1.2%	116,338	1.2%
TYA Prime	6,160	0.1%	4,052	0.0%	2,920	0.0%
Select Enrolled	2,053,179	21.3%	2,072,022	21.8%	2,094,976	22.2%
TRICARE Select	1,595,731	16.6%	1,598,613	16.8%	1,615,855	17.1%
TRS	392,636	4.1%	410,272	4.3%	418,075	4.4%
TYA Select	33,305	0.3%	31,823	0.3%	29,897	0.3%
TRICARE Plus	19,331	0.2%	18,172	0.2%	18,027	0.2%
TRR	12,176	0.1%	13,142	0.1%	13,122	0.1%
Nonenrolled	366,570	3.8%	377,666	4.0%	433,443	4.6%
Direct Care Only	365,023	3.8%	376,077	4.0%	431,906	4.6%
TRICARE Plus	1,547	0.0%	1,589	0.0%	1,537	0.0%
Medicare-Eligible	2,502,188	26.0%	2,508,706	26.4%	2,540,458	26.9%
TFL	2,111,286	21.9%	2,118,309	22.3%	2,152,475	22.8%
TRICARE Plus	186,087	1.9%	187,880	2.0%	188,011	2.0%
Direct Care Only	99,777	1.0%	100,342	1.1%	102,781	1.1%
USFHP	39,782	0.4%	38,541	0.4%	37,762	0.4%
Prime: Network PCM	33,022	0.3%	33,003	0.3%	30,979	0.3%
Prime: MTF PCM	29,644	0.3%	28,331	0.3%	26,328	0.3%
Other/Unknown	2,590	0.0%	2,300	0.0%	2,122	0.0%
Total	**9,623,297**		**9,495,522**		**9,446,069**	

Source: DEERS, 1/4/2024

- The open season model went into full effect for coverage beginning in calendar year (CY) 2019. Since then, beneficiaries can no longer change their TRICARE coverage outside open season unless they have a TRICARE-recognized qualifying life event.
- As a percentage of the total eligible population, the number of Prime-enrolled beneficiaries declined by almost 3 percentage points from FY 2021 to FY 2023. Most of the decline occurred among beneficiaries with an MTF PCM.
- As a percentage of the total eligible population, the number of beneficiaries with TRICARE Select plans increased slightly from FY 2021 to FY 2023. Over the same time period, the percentage of beneficiaries with direct-care-only coverage increased, with most of the increase occurring in FY 2023.

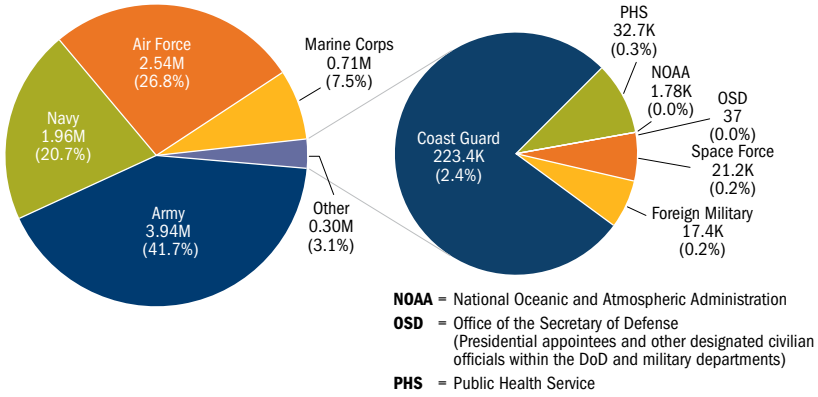
BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Eligible Beneficiaries in FY 2023

- There were a total of 9.45 million beneficiaries eligible for some form of DoD health care benefits at the end of FY 2023. 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 overseas as they are in the U.S. (see beneficiary breakout by U.S. and overseas at bottom of this page).
- Retirees, their family members, and survivors constitute the largest percentage of the eligible beneficiary population (53 percent). The U.S. MHS population is presented at the state level on page 21, reflecting those enrolled in the Prime benefit and the total population, enrolled and nonenrolled.
- Mirroring trends in the civilian sector, the MHS is confronted with an aging beneficiary population (see the chart at the top of the next page). About 28 percent of female beneficiaries and 23 percent of male beneficiaries are seniors (age ≥65).

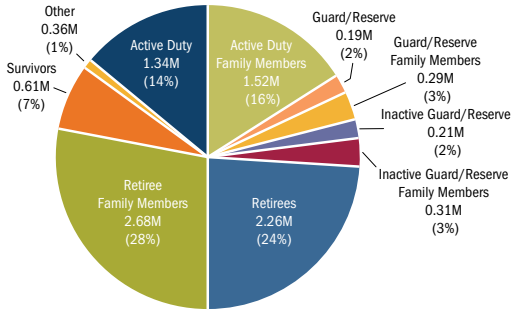
WORLDWIDE BENEFICIARIES ELIGIBLE FOR DoD HEALTH CARE BENEFITS, END OF FY 2023

BY SERVICE BRANCH



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

BY BENEFICIARY CATEGORY

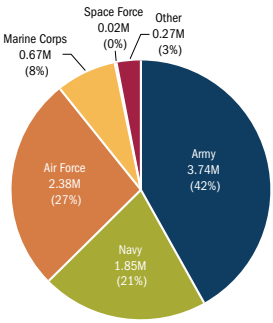


TOTAL: 9.45 Million

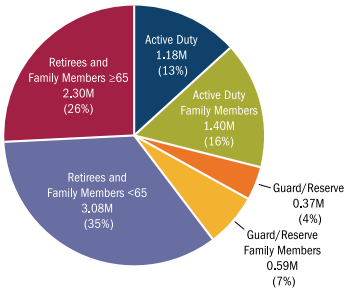
U.S. AND OVERSEAS BENEFICIARIES ELIGIBLE FOR DoD HEALTH CARE BENEFITS, END OF FY 2023

U.S.

BY SERVICE BRANCH



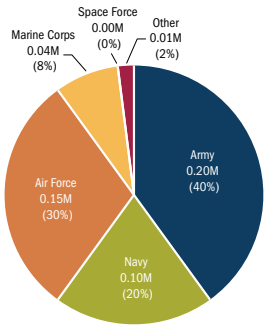
BY BENEFICIARY CATEGORY



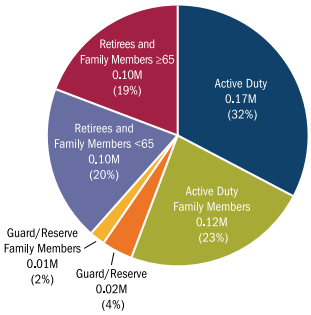
U.S. TOTAL: 8.93 Million

OVERSEAS

BY SERVICE BRANCH



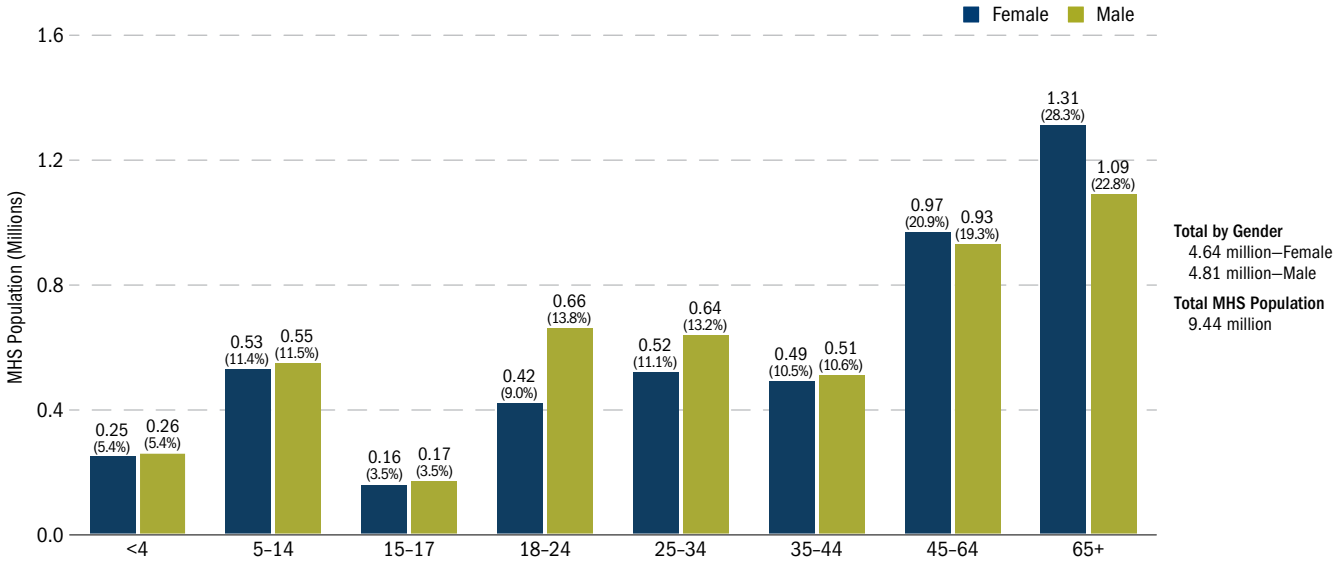
BY BENEFICIARY CATEGORY



OVERSEAS TOTAL: 0.51 Million

Source: DEERS, 1/4/2024
Note: Percentages may not sum to 100 percent due to rounding.

ELIGIBLE BENEFICIARIES BY AGE GROUP AND GENDER, END OF FY 2023



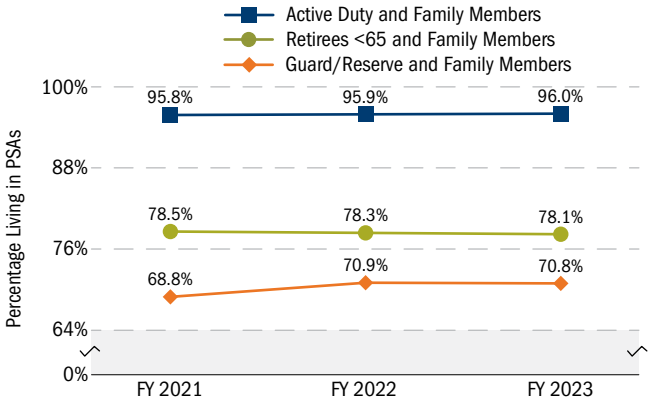
Source: DEERS, 1/4/2024
Note: Numbers may not sum to population totals due to rounding.

Beneficiary Access to 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.

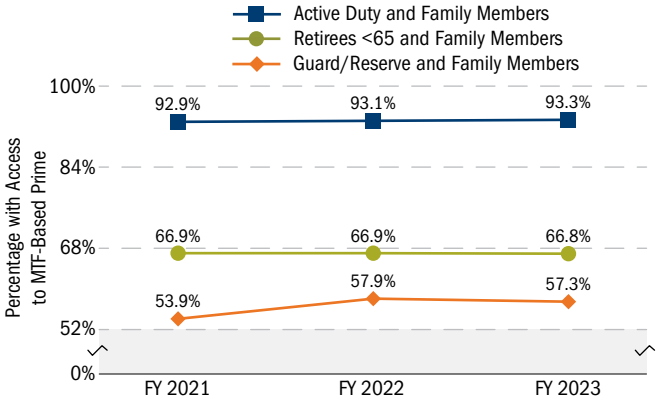
The left chart below shows the percentage of beneficiaries living in PSAs (defined only in the U.S.). The right chart below shows the percentage of the eligible population in the U.S. with access to MTF-based Prime. The latter is defined as the percentage living in both a PSA and an MTF Service Area (defined by ZIP code centroids that are within a 40-mile radius of an active MTF hospital or clinic, subject to overlap rules, barriers, and other policy overrides).

TREND IN ELIGIBLE POPULATION LIVING IN PSAs, FYs 2021–2023



- Between FY 2021 and FY 2023, the percentage of Guard/Reserve and family members living in PSAs increased, while the percentage for the other beneficiary groups remained about the same.
- As determined by residence in an MTF PSA, access to MTF-based Prime for Guard/Reserve and family members increased from FY 2021 to FY 2023, whereas it remained about the same for the other beneficiary groups.

TREND IN ELIGIBLE POPULATION WITH ACCESS TO MTF-BASED PRIME, FYs 2021–2023



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

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

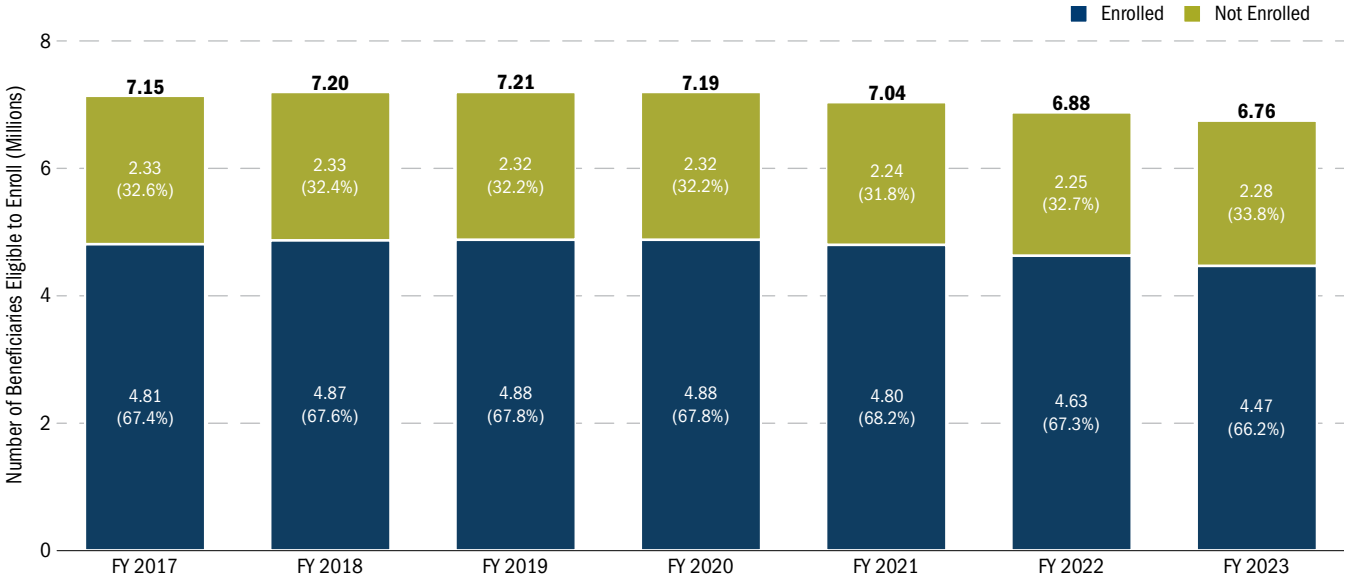
Eligibility and Enrollment in TRICARE Prime

Eligibility for and enrollment in TRICARE Prime was determined from DEERS. For the purpose of this report, all AD 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 nonenrolled beneficiaries (direct care only) are included in the non-Prime-enrolled counts.

- The number of beneficiaries enrolled in TRICARE Prime was roughly flat between FY 2017 and FY 2020 but since dropped through FY 2023. As a percentage of the beneficiary population, TRICARE Prime enrollment exhibited a similar pattern.
- By the end of FY 2023, about 66 percent of all eligible beneficiaries were enrolled in Prime (4.47 million enrolled of the 6.76 million eligible).

HISTORICAL END-YEAR PRIME ENROLLMENT NUMBERS, FYs 2017–2023



Source: DEERS, 1/4/2024

Note: Numbers may not sum to bar totals due to rounding. Detailed MHS enrollment data by state can be found on page 21.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Recent Three-Year Trend in Eligibles and Users

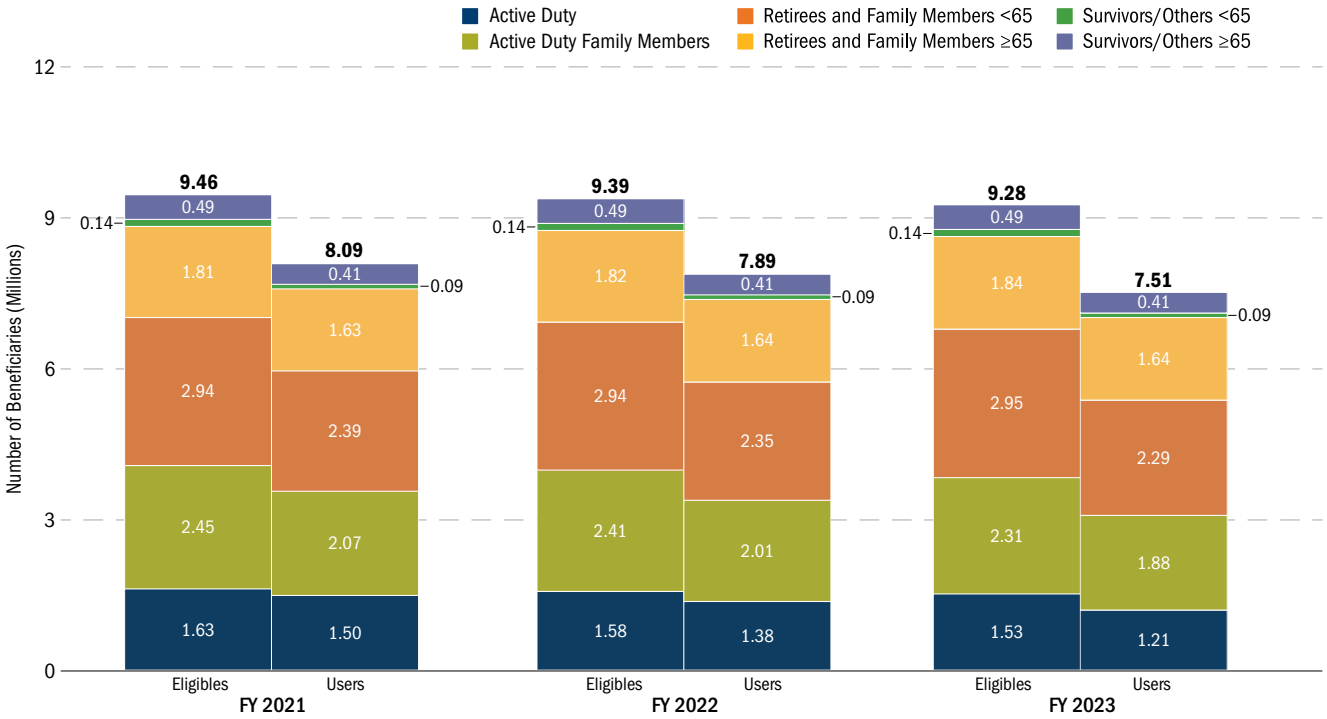
This section compares the number of users of MHS services with the numbers of eligibles. Because beneficiaries eligible for any part of the year can be users, average (rather than end-year) beneficiary counts were used for all calculations.

The average numbers of eligibles by beneficiary category[1] from FY 2021 to FY 2023 were determined from DEERS data. The eligible counts include all beneficiaries eligible for some form of the military health care benefit.

No distinction is made here between users of direct and private sector care. The union of the two types of users is equal to the number of beneficiaries who had any MHS utilization.

The overall user rate decreased from 85.5 percent FY 2021 to 81.0 percent in FY 2023.

RECENT THREE-YEAR TREND IN ELIGIBLES AND USERS, FYs 2020–2023



Sources: DEERS and MHS administrative data, 1/4/2024

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

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	82,129	1,532	23,581	22,091	4,406	8,011	58,089
AL	210,814	9,563	11,979	20,340	17,585	30,886	80,790
AR	84,966	5,108	6,482	7,929	4,709	8,266	27,386
AZ	207,606	9,329	21,278	24,658	15,444	27,677	89,057
CA	736,142	22,095	173,455	130,345	36,124	69,386	409,310
CO	246,079	11,286	43,071	41,064	16,678	29,958	130,771
CT	47,178	2,916	8,169	6,565	2,076	3,494	20,304
DC	23,685	852	13,183	2,854	733	828	17,598
DE	33,789	1,863	4,439	4,366	2,509	3,844	15,158
FL	746,581	27,943	73,798	79,294	59,542	99,904	312,538
GA	438,751	16,542	73,582	64,402	34,995	62,210	235,189
HI	148,625	2,046	46,825	40,329	4,950	8,323	100,427
IA	48,352	5,328	2,311	3,175	760	1,476	7,722
ID	57,550	4,238	5,055	5,556	2,966	5,425	19,002
IL	146,667	9,412	26,888	15,808	8,174	14,231	65,101
IN	96,422	10,522	4,535	7,380	4,260	8,254	24,429
KS	117,931	5,735	22,966	23,064	6,061	12,133	64,224
KY	144,028	6,381	35,412	20,608	7,261	12,960	76,241
LA	115,878	6,633	18,284	17,774	6,351	11,071	53,480
MA	68,209	5,802	6,275	7,115	5,606	8,881	27,877
MD	239,184	8,499	38,096	41,617	26,485	40,159	146,357
ME	38,641	2,331	1,427	3,060	6,981	10,111	21,579
MI	102,537	6,332	5,044	6,743	3,596	6,125	21,508
MN	70,533	9,576	3,747	3,828	96	304	7,975
MO	156,336	12,121	20,039	17,393	8,031	15,058	60,521
MS	111,412	6,748	15,879	11,914	5,724	9,494	43,011
MT	37,881	2,539	4,335	3,961	862	1,498	10,656
NC	505,647	14,934	98,099	89,654	27,457	49,258	264,468
ND	32,969	2,334	8,195	6,561	1,136	1,973	17,865
NE	60,541	4,638	7,727	7,875	3,480	6,336	25,418
NH	31,266	2,008	2,376	2,324	4,488	6,721	15,909
NJ	84,899	6,123	11,654	13,059	4,906	9,786	39,405
NM	80,208	2,173	14,722	12,733	5,105	8,483	41,043
NV	106,666	3,974	13,504	13,774	7,691	12,608	47,577
NY	172,540	7,453	30,063	27,245	9,353	16,807	83,468
OH	173,967	13,225	12,611	14,285	6,927	12,426	46,249
OK	155,524	6,267	26,711	21,666	10,201	18,620	77,198
OR	63,549	3,186	3,490	3,573	961	1,651	9,675
PA	161,950	9,898	7,217	10,869	7,392	13,045	38,523
RI	24,678	1,263	5,156	3,705	1,435	2,327	12,623
SC	262,466	10,512	50,156	28,612	16,079	27,648	122,495
SD	35,734	4,469	4,400	4,253	1,305	2,266	12,224
TN	203,731	12,567	6,367	21,092	10,782	19,342	57,583
TX	937,830	49,617	127,466	127,024	78,697	145,596	478,783
UT	78,472	9,464	7,037	9,972	4,472	9,247	30,728
VA	730,479	17,081	135,995	123,725	50,092	80,447	390,259
VT	13,094	1,146	887	1,204	1,290	1,866	5,247
WA	328,896	8,941	62,131	58,652	24,646	42,195	187,624
WI	77,056	8,622	3,321	4,754	1,017	1,723	10,815
WV	36,529	2,835	1,934	2,036	1,050	1,669	6,689
WY	23,755	1,628	3,735	3,506	1,183	1,999	10,423
Subtotal	**8,940,352**	**417,630**	**1,355,089**	**1,245,386**	**574,110**	**1,004,006**	**4,178,591**
Overseas	**505,717**	**2,622**	**177,103**	**104,590**	**281**	**11,696**	**293,670**
Total	**9,446,069**	**420,252**	**1,532,192**	**1,349,976**	**574,391**	**1,015,702**	**4,472,261**

Source: MHS administrative data systems, as of 1/4/2024 for end of FY 2023

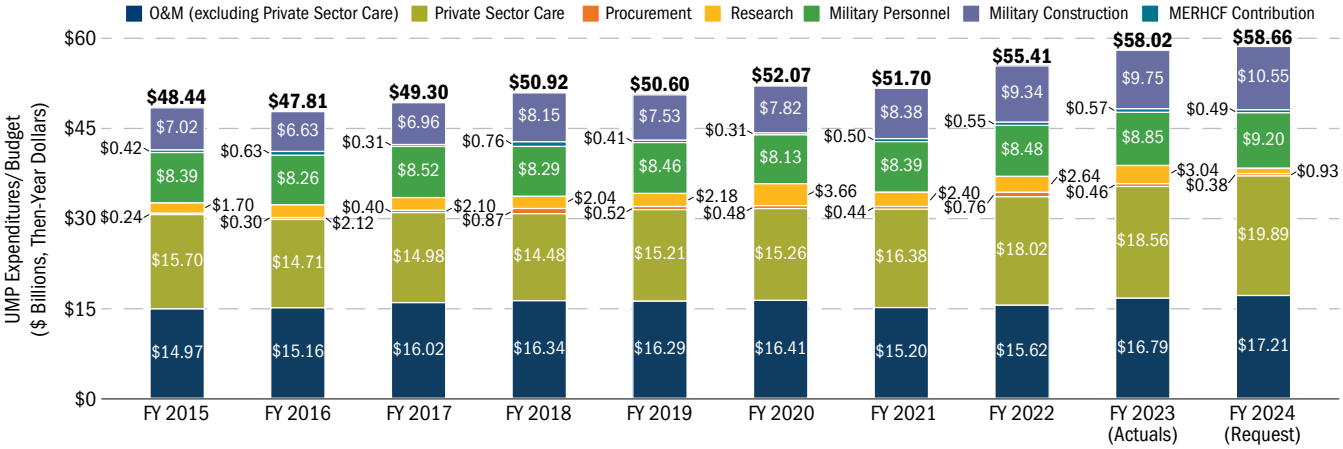
Note: Prime Enrolled includes Prime (MTF and network PCMs), TRICARE Prime Remote (and Overseas equivalent), TYA Prime, and USFHP; and excludes members in TRICARE Select, TYA Select, TRS, TRR, TRICARE Plus, and TFL.

UNIFIED MEDICAL PROGRAM FUNDING

The Department of Defense's FY 2024 Budget Request for health care services is $58.7 billion. In nominal terms, this is about 1.1 percent higher than the actual $58 billion FY 2023 expenditures.

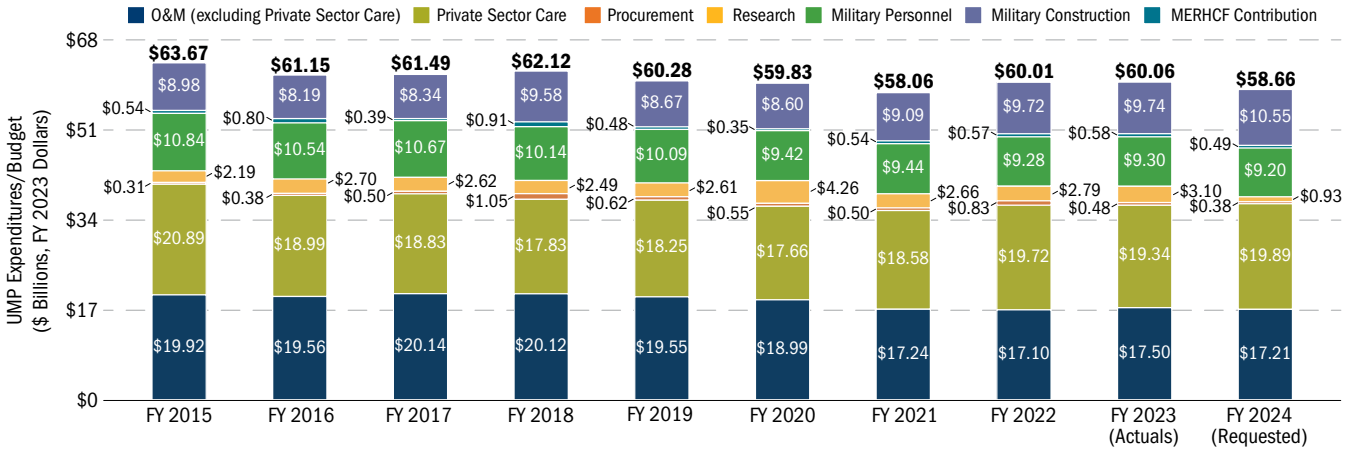
The FY 2024 Budget Request has three components. The first is the DHP appropriation, which is a unique three-in-one appropriation consisting of funds for operation and maintenance (O&M); procurement; and research, development, test, and evaluation (RDT&E), and totaling $38 billion. Of that amount, $19.9 billion (nearly 54 percent) is partitioned off for TRICARE/private sector care. The second component is composed of military personnel (MILPERS) and military construction (MILCON), which total $9.7 billion. Amounts for MILPERS are retained within the Military Department MILPERS appropriations and amounts for MILCON are retained within the MILCON appropriation. The third component is the MERHCF, totaling $10.6 billion. The MERHCF is a trust fund established to pay for the costs of health care (both direct and private sector care) for military Medicare-eligible retirees, retiree family members, and survivors.

UMP FUNDING AND TRUST FUND CONTRIBUTIONS ($ BILLIONS) IN CURRENT (THEN-YEAR) DOLLARS, FYs 2015–2024



Using constant dollars, the FY 2024 request is about $5.0 billion (7.9 percent) less than real FY 2015 expenditures.

UMP FUNDING AND TRUST FUND CONTRIBUTIONS ($ BILLIONS) IN CONSTANT 2023 DOLLARS, FYs 2015–2024



Source: UMP cost and budget estimates, DHA/Resources Management Directorate (J-8)/Budget & Execution Division, 01/16/2024

Notes:

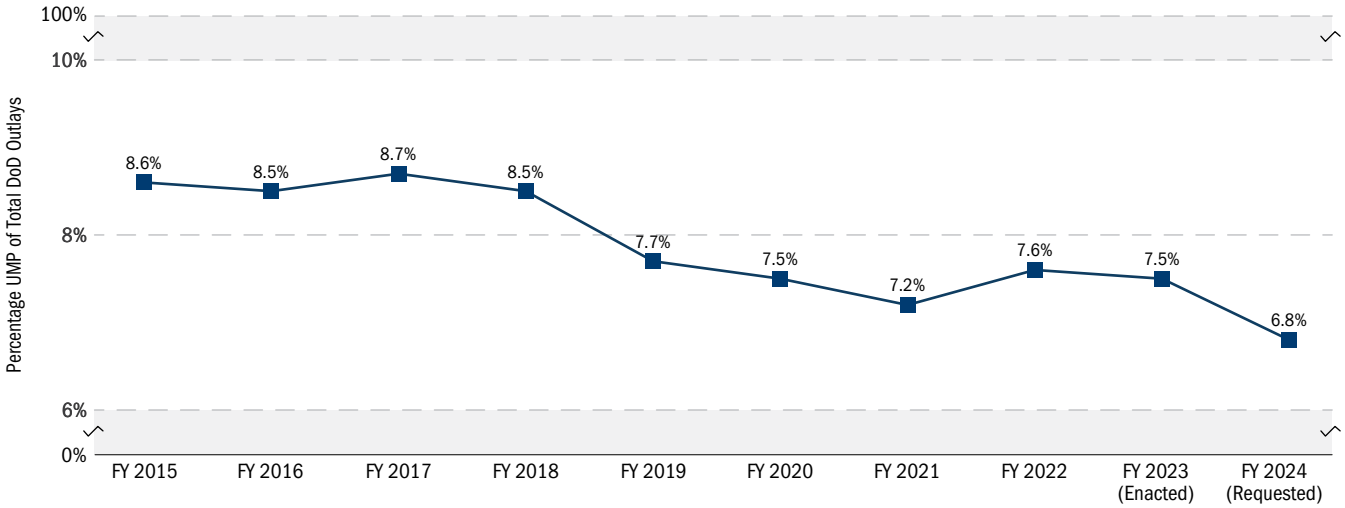
– FYs 2015–2023 reflect Comptroller Information System actual execution.
– FY 2024 reflects the DHP Budget Request.
– Source of data for deflators (MILPERS, DHP, Procurement, RDT&E, and MILCON) is Table 5-5, Department of Defense Deflators—TOA by Category–TOA, National Defense Budget Estimates for FY 2024 (Green Book).
– Medicare Eligible Retiree Health Care Fund Deflator computed using a combination of MILPERS (5%) and DHP factors (95%).
– FY 2015 actuals includes $344.645M for Overseas Contingency Operations (OCO).
– FY 2016 actuals includes $285.032M for OCO.
– FY 2017 actuals includes $332.603M for OCO.
– FY 2018 actuals includes $405.856M for OCO.
– FY 2019 actuals includes $349.422M for OCO.
– FY 2020 includes $2.503B Coronavirus Aid, Relief, and Economic Security (CARES) Act Supplemental and $347.746M OCO supplemental funding enacted for O&M.
– FY 2021 actuals includes $354.322M OCO supplemental funding execution. It also includes $663M reprogrammed into O&M.
– FY 2022 actuals includes $228.412M for Overseas Operations Costs (OOC) and $429.415M for enduring COVID-19 requirements.
– FY 2023 actuals includes $500.817M for COVID-19 requirements and $110.426M for OOC. It also includes $108.333M reprogrammed into O&M.
– FY 2024 President's Budget Request includes $92.2M for COVID-19 requirements and $230.885M for OOC.

UNIFIED MEDICAL PROGRAM FUNDING *(CONT.)*

UMP Share of Defense Budget

The UMP funding share of total DoD expenditures remains below FY 2015 levels.

UMP EXPENDITURES AS A PERCENTAGE OF TOTAL DoD OUTLAYS, FYs 2015–2024 (EST.)

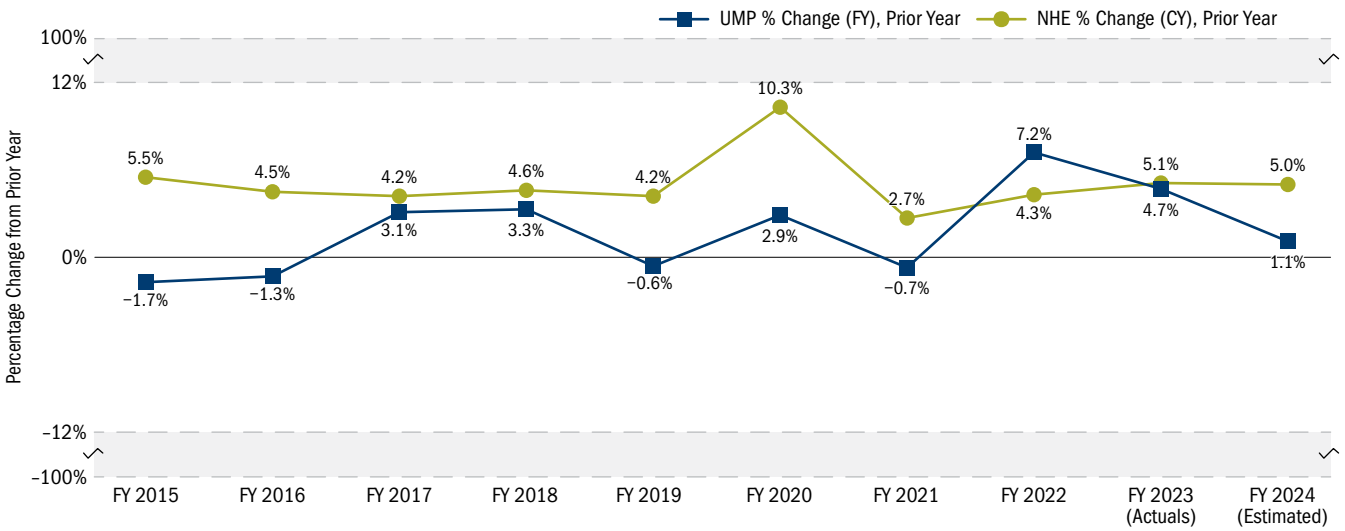


Source: UMP cost and budget estimates, DHA/Financial Operations Directorate (J-8)/DHP Budget and Execution Division, 1/16/2024
Note: Percentages are estimates of total DoD outlays reflected in the FY 2024 President's Budget request.

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 MERHCF distributions) has fluctuated from a high of 7.2 percent in FY 2022 to 1.1 percent projected in FY 2024. By comparison, the National Health Expenditures (NHE) series compiled by the Centers for Medicare & Medicaid Services (CMS) has grown at about 5.0 percent year-over-year for the same period.

COMPARISON OF CHANGE IN ANNUAL UMP (INCLUDING MERHCF OUTLAYS) AND NHE ESTIMATED EXPENDITURES OVER TIME (UNADJUSTED THEN-YEAR DOLLARS): 2015–2024 (EST.)



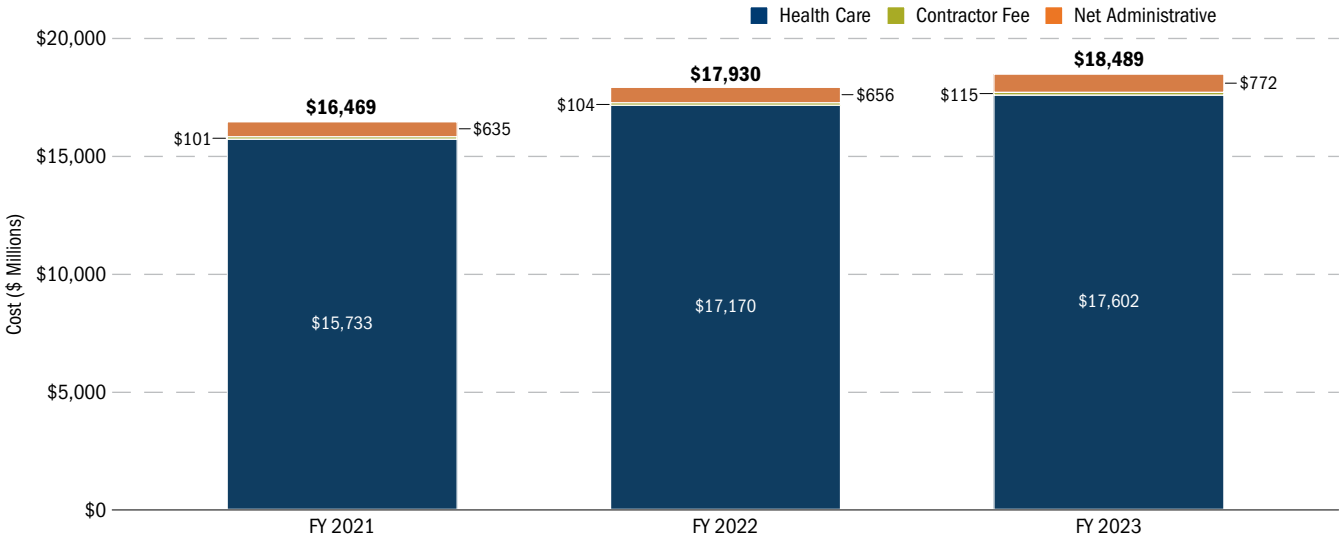
Source: UMP cost and budget estimates, DHA/Financial Operations Directorate (J-8)/DHP Budget and Execution Division, 1/16/2024, using NHE data from CMS, Office of the Actuary, NHE Projections 2019–2030, Tables Table 02, National Health Expenditure Amounts and Annual Percent Change by Type of Expenditure: Calendar Years 2012–2030; 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 (PSC) Budget Activity Group 2 (BAG 2) provides for all medical and dental care plus pharmaceuticals received by MHS-eligible beneficiaries using health care services offered in the private sector.[1] BAG 2 excludes costs for non-DoD beneficiaries and MERHCF expenses. The totals in the graph below differ from the BAG 2 because the former excludes settlements paid in prior years, undefinitized change-order costs, and certain DoD internal/overhead costs but includes funds authorized and executed under the DHP carryover authority.[2]

- PSC costs increased from $16,469 million in FY 2021 to $18,489 million (12 percent) in FY 2023. Costs increased by 9 percent in FY 2022 and by another 3 percent in FY 2023.
- On January 1, 2021, DHA began collecting Select enrollment fees for Group A retirees (those whose initial enlistment or appointment or that of the Uniformed Services sponsor began before January 1, 2018). As a result, DHA saw an increase in its enrollment fee collections from $363 million in FY 2021 to $400 million in FY 2022, when it collected a full year of enrollment fees. Growth continued in FY 2023 to $421 million.
- Net of Prime/Select enrollment fees, PSC administrative costs increased by 22 percent from $635 million in FY 2021 to $772 million in FY 2023.
- Excluding contractor fees, net administrative expenses increased from 3.9 percent of total PSC costs in FY 2021 ($635 million of $16,469 million) to 4.2 percent in FY 2023 ($772 million of $18,489 million). Including contractor fees (in both administrative and total costs), net administrative expenses increased from 4.5 percent of total PSC costs in FY 2021 ($736 million of $16,469 million) to 4.8 percent in FY 2023 ($887 million of $18,489 million).
- Contractor fees increased by 14 percent between FY 2021 and FY 2023, although they remained roughly the same as a proportion of total PSC health care costs.

TRENDS IN PRIVATE SECTOR CARE COSTS, FYs 2021–2023



Source: DHA/Resources & Management (J-1/J-8)/CRM (Administrative Costs), 10/30/2023

[1] Defense Budget Materials FY 2023, Defense Wide Budget Documentation, Defense Health Program (Vol. 1, Sec 6B (Retrieved from https://comptroller.defense.gov/Budget-Materials/FY2023BudgetJustification/#defhealthprog)

[2] 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 $313 million in FY 2021, $98 million in FY 2022, and $75 million in FY 2023.

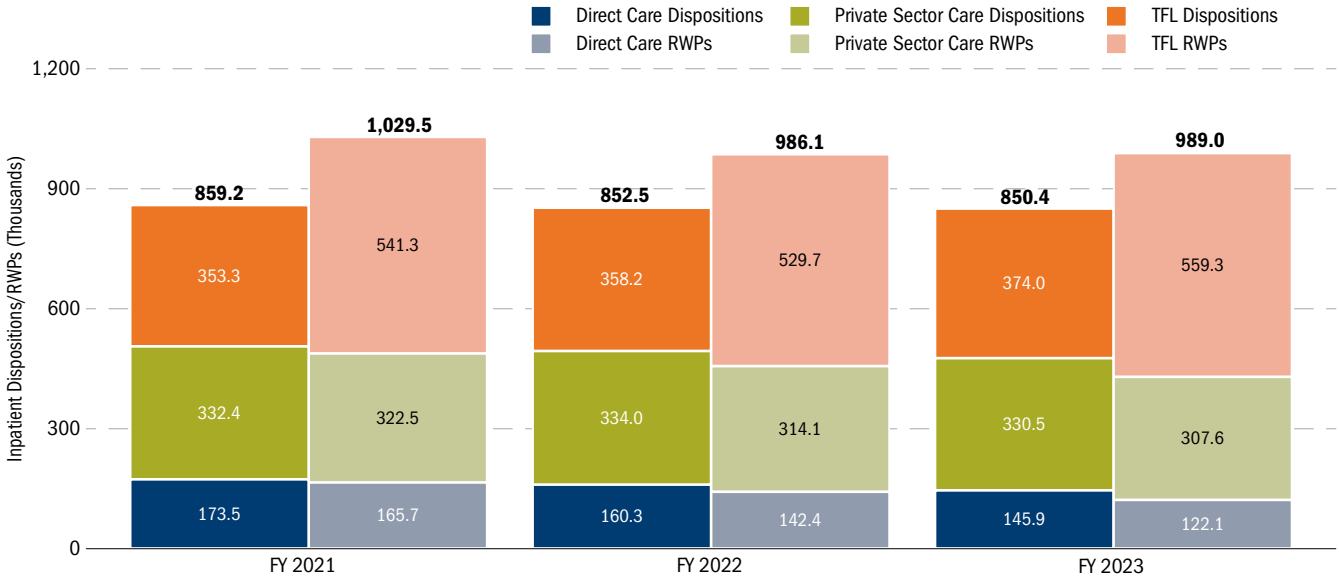
MHS WORKLOAD TRENDS (DIRECT AND PRIVATE SECTOR CARE)

MHS Inpatient Workload

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

- Total inpatient dispositions (direct and private sector care combined) declined by 6 percent and RWPs by 12 percent between FY 2021 and FY 2023, excluding the effect of TFL.[1]
- Direct care inpatient dispositions decreased by 16 percent and RWPs by 26 percent over the past three years. Possible reasons for the large drop in direct care dispositions is the downsizing of three MHS hospitals to clinics and the impact of the COVID-19 pandemic.[2]
- Excluding TFL workload,[1] private sector care inpatient dispositions decreased by 1 percent with RWPs decreasing by 5 percent between FY 2021 and FY 2023.
- Including TFL workload, private sector care dispositions increased by 3 percent, while RWPs increased by less than 1 percent between FY 2021 and FY 2023.
- Although not shown, about 10 percent of direct care inpatient workload (dispositions) was performed abroad in FY 2023. Private sector care and TFL inpatient workload performed abroad accounted for about 2 percent of the worldwide total.

TRENDS IN MHS INPATIENT WORKLOAD, FYs 2021–2023



Source: MHS administrative data, 1/24/2024

[1] 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.

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

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

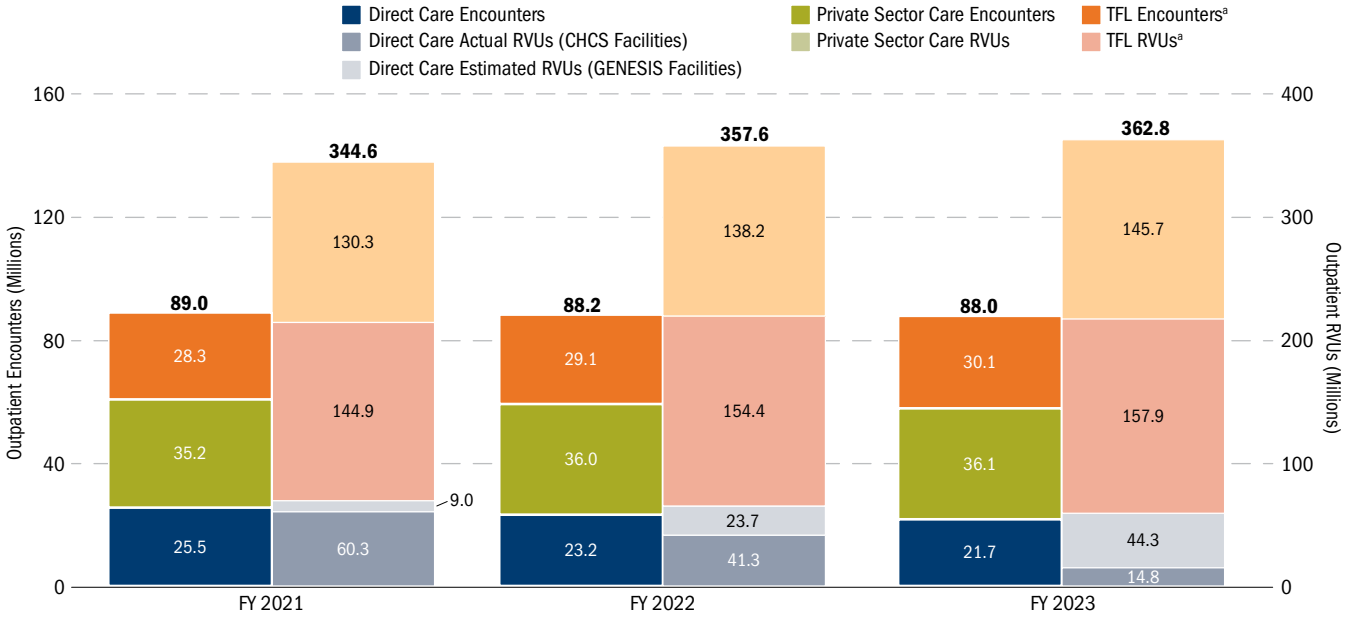
MHS WORKLOAD TRENDS (DIRECT AND PRIVATE SECTOR CARE) *(CONT.)*

MHS Outpatient Workload

Total MHS outpatient workload is measured two ways: as the number of encounters (outpatient visits and ambulatory procedures) and as the number of relative value units (RVUs). Because encounters do not appear on private sector care claims, they are calculated using a DHA-developed algorithm. RVUs reflect the relative resources consumed by a single encounter compared with the average of those consumed by all encounters (see the Appendix (pages 179–180) for a more detailed description of the RVU measure). Note that direct care RVUs at Composite Health Care System (CHCS), the MHS's legacy electronic health record (EHR) facilities are actuals, whereas RVUs at GENESIS facilities are estimates. Also note that, since MHS GENESIS records do not include telephone consults, those encounters have been excluded from the CHCS records as well for consistency.

- Total outpatient encounters (direct and private sector care combined) decreased by 5 percent, while RVUs increased by 1 percent between FY 2021 and FY 2023, excluding the effect of TFL.
- Direct care outpatient encounters and RVUs both decreased by 15 percent over the past three years.
- Excluding TFL workload, private sector care outpatient encounters increased by 3 percent and RVUs by 9 percent. Including TFL workload, private sector care outpatient encounters increased by 4 percent and RVUs by 10 percent.[1]
- Although not shown, about 11 percent of direct care outpatient workload (encounters) were performed abroad. Private sector care and TFL outpatient workload performed abroad accounted for less than 1 percent of the worldwide total.

TRENDS IN MHS OUTPATIENT WORKLOAD, FYs 2021–2023



Source: MHS administrative data, 1/24/2024

[a] Private sector care only

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

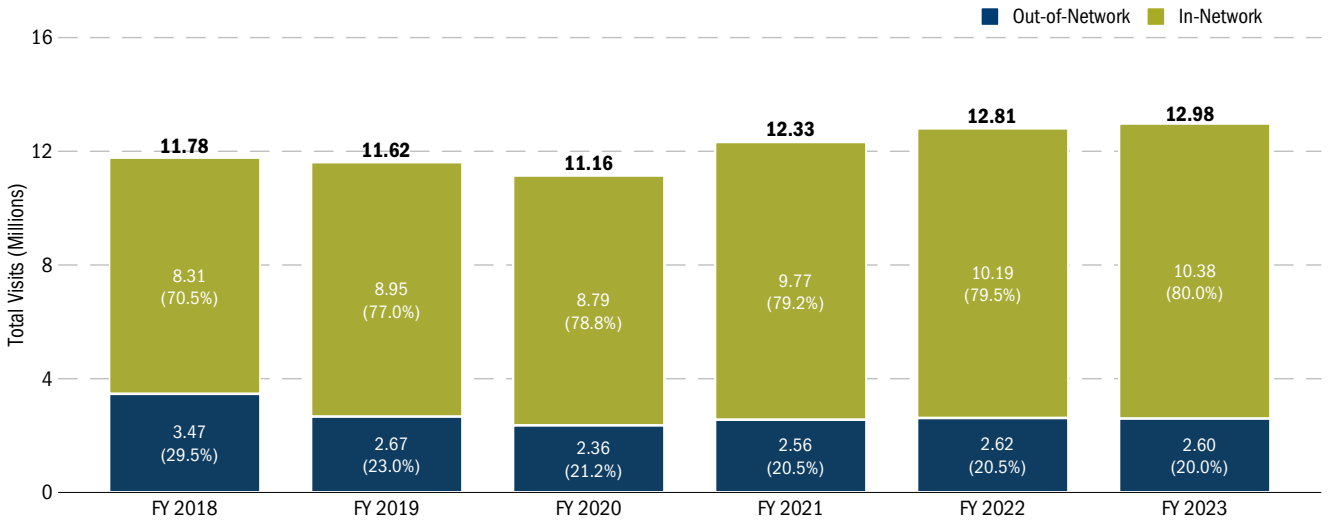
Note: Numbers may not sum to bar totals due to rounding.

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

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

For beneficiaries not enrolled in Prime, the ratio of in-network to out-of-network visits has steadily increased. In FY 2008, in-network visits accounted for only 46 percent of all non-Prime visits. By FY 2009, the number of in-network visits exceeded the number of out-of-network visits for the first time (51 percent). In FY 2023, 80 percent of all non-Prime visits were to in-network providers. One likely reason for the increasing use of in-network providers is the expansion of the TRICARE provider network (see page 136).

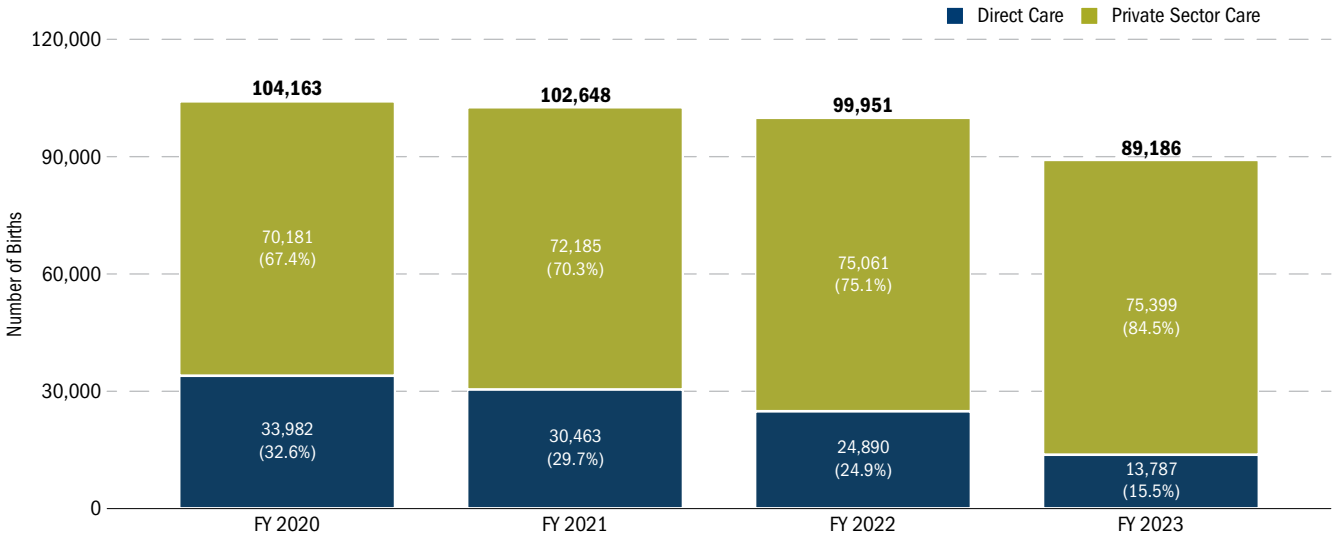
TRENDS IN OUT-OF-NETWORK VS. IN-NETWORK VISITS, FYs 2018–2023



MTF Market Share for Childbirths

Overall MTF obstetric market share decreased from 33 percent to 15 percent between FY 2020 and FY 2023. This trend is likely due, at least in part, to the migration of Prime enrollees from MTF to network PCMs (see the table on page 16) and the downsizing of four MTF hospitals in the U.S. to clinics during that time period. However, even within MTF hospital service areas, the MTF obstetric market share was only 30 percent in FY 2023.

TRENDS IN MTF MARKET SHARE FOR CHILDBIRTHS, FYs 2020–2023



Source: MHS administrative data, 1/4/2024

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

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

Urgent Care (UC) Utilization

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

- UC encounters increased 130 percent from FY 2017 to FY 2023, while RVUs increased by 203 percent (FY 2017 not shown).
- The government share of the cost for UC increased by $136 million (206 percent) from FY 2017 to FY 2023 (FY 2017 not shown).
- UC utilization and costs increased steadily from FY 2017 to FY 2019 but leveled off in FY 2020 (possibly due to COVID-19). However, they began to rise again in FY 2021 (24 percent for encounters, 43 percent for RVUs, and 59 percent for government costs) with smaller increases in FY 2022. In FY 2023, UC utilization and costs decreased by 2 percent for encounters and RVUs, with costs declining by 11 percent compared to FY 2022.
- ADFMs with an MTF PCM constitute by far the largest share of total UC utilization and government cost.

TRENDS IN UC UTILIZATION, FYs 2021–2023

BENEFICIARY CATEGORY	ENROLLMENT STATUS	FY	ENCOUNTERS	RVUs	GOVERNMENT COST
Active Duty	All	2021	234,411	701,463	$31,608,325
		2022	246,637	839,724	$36,005,864
		2023	209,803	713,136	$29,062,786
Active Duty Family Members	MTF PCM	2021	310,491	917,679	$39,138,168
		2022	365,678	1,212,943	$50,077,396
		2023	381,243	1,258,601	$49,804,824
	Network PCM	2021	168,492	501,730	$22,139,888
		2022	179,098	591,119	$25,204,116
		2023	181,905	601,509	$24,661,642
	Nonenrolled	2021	295,758	871,268	$31,796,701
		2022	317,826	1,036,487	$35,193,655
		2023	327,414	1,069,889	$32,294,392
Retirees and Family Members <65	MTF PCM	2021	194,970	567,786	$20,732,660
		2022	198,875	669,062	$23,649,635
		2023	182,244	608,293	$18,587,481
	Network PCM	2021	229,547	682,766	$25,802,784
		2022	228,717	766,031	$27,467,893
		2023	216,076	727,631	$22,947,985
	Nonenrolled	2021	269,556	785,117	$25,957,387
		2022	277,220	899,605	$27,715,116
		2023	279,120	908,911	$23,956,476
Retirees and Family Members ≥65	All	2021	423	1,078	$197,741
		2022	560	1,495	$268,489
		2023	417	1,249	$329,312
Total	**All**	**2021**	**1,703,648**	**5,028,886**	**$197,373,655**
		2022	**1,814,611**	**6,016,466**	**$225,582,163**
		2023	**1,778,222**	**5,889,219**	**$201,644,899**

Source: MHS administrative data, 1/24/2024

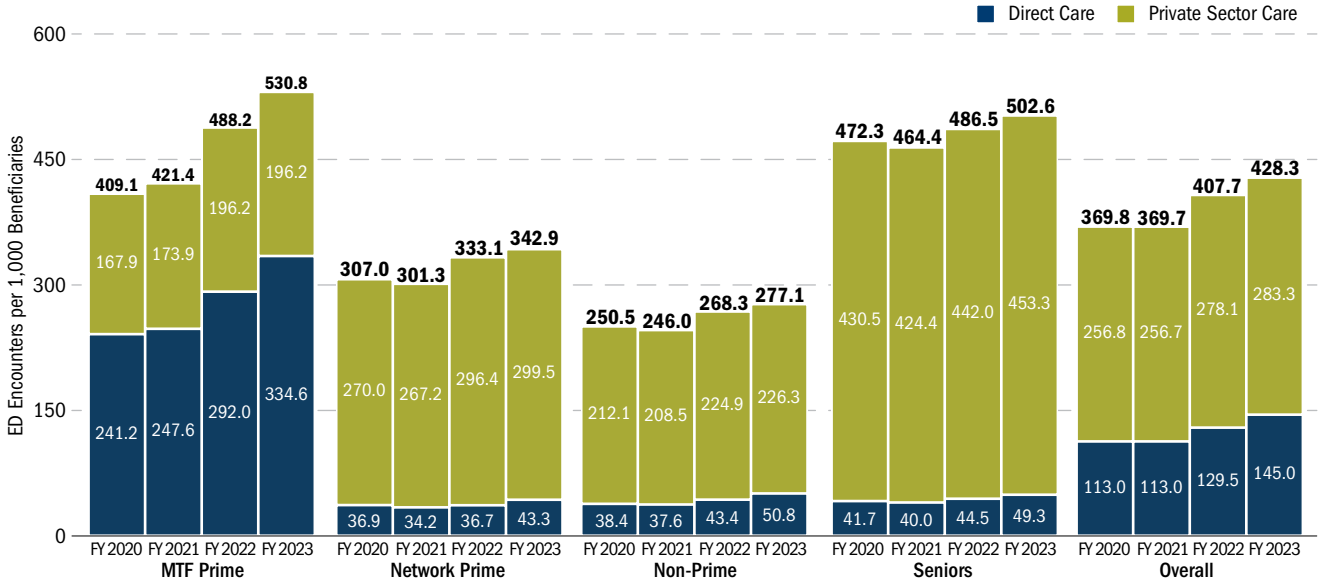
MHS WORKLOAD TRENDS (DIRECT AND PRIVATE SECTOR CARE) *(CONT.)*

Emergency Department (ED) Utilization

ED utilization is sometimes used as an indirect measure of access to care, particularly for Prime enrollees. Using data from the National Health Interview Survey, the National Center for Health Statistics (NCHS) reports that almost 80 percent of civilians who use the ED do so because of lack of access to other providers.[1] Although not equivalent, it is reasonable to ask whether a similar situation occurs in the MHS, in particular whether Prime enrollees excessively use EDs as a source of care if they cannot get timely access to their PCMs under the normal appointment process. To provide a preliminary evaluation of this issue, direct and private sector care ED utilization rates were compared across three enrollment groups: MTF enrollees, network enrollees, and nonenrollees. 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 for MTF Prime enrollees increased by 30 percent (from 409 to 531 encounters per 1,000 beneficiaries) over FY 2020 to FY 2023 while Network Prime enrollees increased by 12 percent over the same period.
- The rate for non-Prime enrollees increased by 11 percent from FY 2020 to FY 2023. One possible reason for the lower growth rate is increased access to urgent care by TRICARE beneficiaries (see page 28).
- In FY 2023, MTF Prime enrollees had an ED utilization rate 55 percent higher than that of network Prime enrollees and 92 percent higher than that of nonenrollees. Network Prime enrollees had an ED utilization rate 24 percent higher than that of nonenrollees.
- For MTF Prime enrollees, 37 percent of ED encounters were in private sector care facilities (not necessarily in network) in FY 2023.
- Children under five years old had the highest ED utilization rate for all enrollment groups (not shown).
- The FY 2021 MHS rate of 370 encounters per 1,000 beneficiaries is 15 percent lower than the civilian rate of 436 per 1,000 reported in the same year.[2] (CY 2021 is the most recent year for which civilian data are available.)

ED UTILIZATION BY ENROLLMENT STATUS AND SOURCE OF CARE (ENCOUNTERS PER 1,000 BENEFICIARIES), FYs 2020–2023



Source: MHS administrative data, 1/9/2024

[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] CDC, "National Hospital Ambulatory Medical Care Survey: 2021 Emergency Department Summary Tables," Table 1, https://www.cdc.gov/nchs/data/nhamcs/web_tables/2021-nhamcs-ed-web-tables-508.pdf. The civilian ED rate reported on this page is somewhat higher than the rate reported by the CDC because we adjust the rate for the age/sex distribution of the military population.

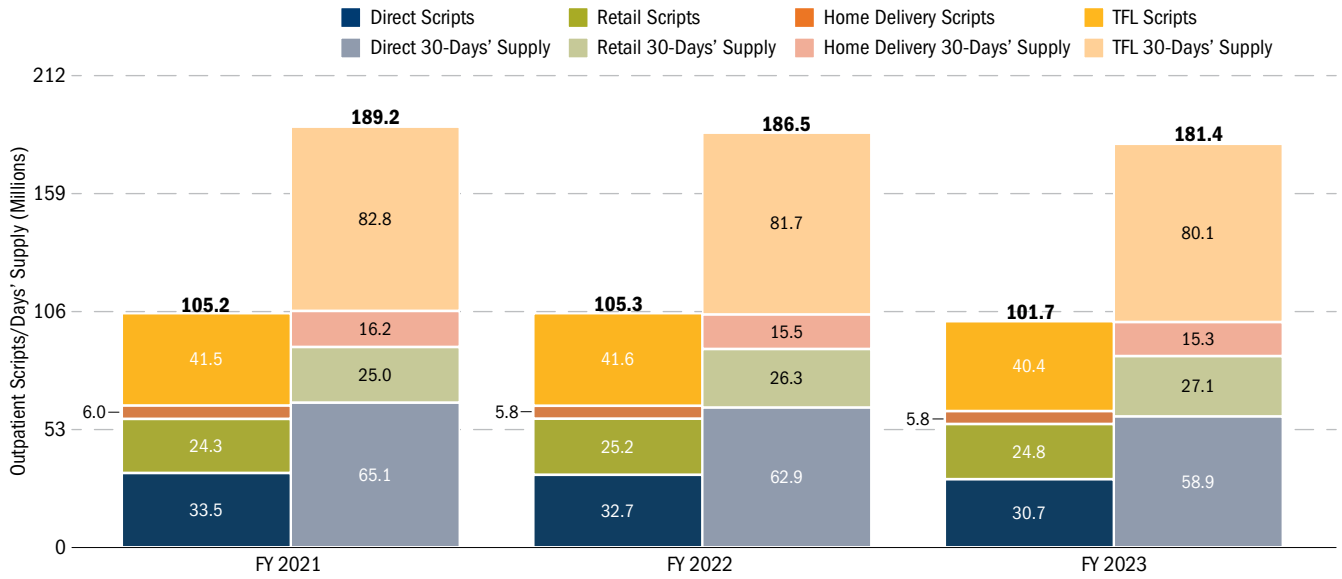
Note: Numbers may not sum to bar totals due to rounding.

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

MHS Prescription Drug Workload

TRICARE beneficiaries can fill prescription medications at MTF and private sector care pharmacies (including retail network and non-network pharmacies and through home delivery). Total outpatient prescription workload is measured two ways: as the number of prescriptions and as the number of days' supply (in 30-day increments). Total prescription drug workload (all sources combined) decreased between FY 2021 and FY 2023 (prescriptions fell by 3 percent and days' supply by 5 percent), excluding the effect of TFL private sector care pharmacy usage.

TRENDS IN MHS PRESCRIPTION WORKLOAD, FYs 2021–2023



Source: MHS administrative data, 1/10/2024

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

- Direct care prescriptions decreased by 9 percent, while days' supply declined by 10 percent between FY 2021 and FY 2023.
- Private sector care prescriptions (retail and home delivery combined) increased by 1 percent and days' supply by 3 percent from FY 2021 to FY 2023, excluding TFL utilization. Including TFL utilization, private sector care prescriptions and days' supply both decreased by 1 percent.
- Although not shown, about 8 percent of direct care prescriptions were issued abroad in FY 2023. Private sector care prescriptions issued abroad accounted for 5 percent of the worldwide total.

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

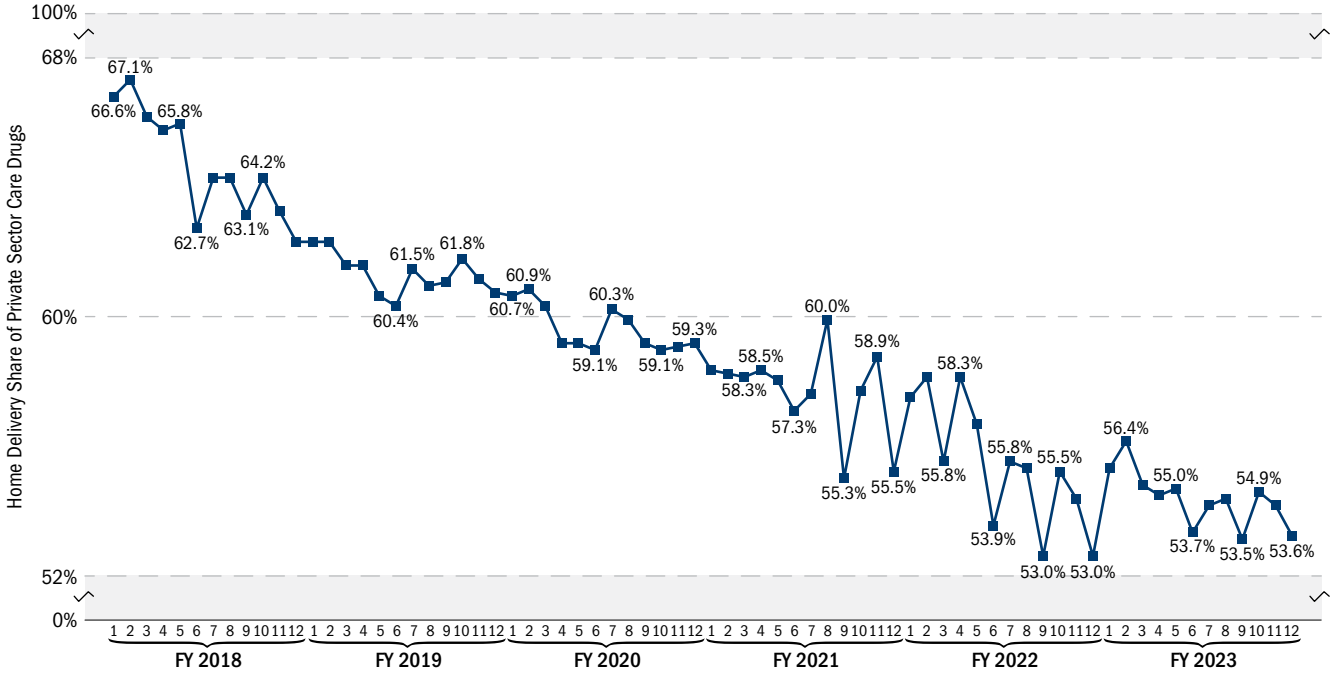
MHS Prescription Drug Workload *(cont.)*

Home delivery of prescription medications offers benefits to both the DoD and its beneficiaries. The DoD negotiates home delivery prescription prices that are considerably lower than those for retail drugs.

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

The home delivery share of total private sector care utilization had been on the rise since the DoD changed the copayment structure for retail/home delivery drugs at the beginning of FY 2012. From FY 2016 to FY 2017, the home delivery share of private sector care pharmacy utilization (as measured by days' supply) increased from 63 percent to 67 percent (not shown).[1] However, in FY 2018, the home delivery copayment for a 90-day supply of generic formulary drugs rose from $0 to $7 (versus $11 for a 30-day supply at retail pharmacies). By 2023, the home delivery copayment had risen to $12 (versus $14 for a 30-day supply at retail pharmacies), further reducing the disparity in copayments between home delivery and retail drugs. This likely contributed to the decrease in the home delivery share of total private sector care utilization from 65 percent in FY 2018 to 55 percent in FY 2023. Another possible explanation for the decline in the home delivery share is that because the copayment for retail generic drugs is the lower of the statute copayment and the actual government cost (after rebates), the average retail generic drug copayment is less than that for home delivery drugs (albeit for a lower average days' supply).

TREND IN HOME DELIVERY UTILIZATION (DAYS' SUPPLY) AS A SHARE OF TOTAL PRIVATE SECTOR CARE UTILIZATION, FYs 2018–2023



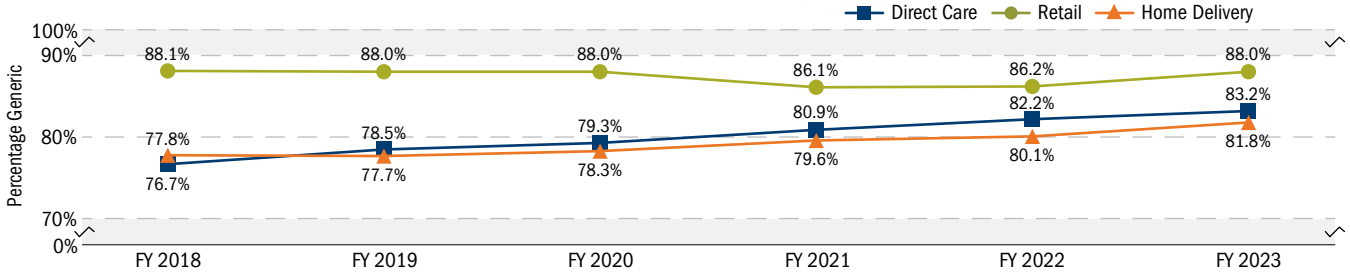
Source: MHS administrative data, 1/10/2024

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

COST SAVINGS EFFORTS IN DRUG DISPENSING

- The rate of generic drug dispensing has been increasing for both direct and home delivery pharmacies. Direct care pharmacies have seen the larger increase, from 77 percent in FY 2018 to 83 percent in FY 2023. Home delivery pharmacies dispensed generic drugs at approximately the same rate, from 78 percent in FY 2018 to 82 percent in FY 2023. Retail pharmacies continued to dispense the highest percentage of generic drugs in FY 2023 (88 percent).
- The direct and PSC generic drug dispensing rates in FY 2023 were both lower than that of the civilian sector (91 percent).[1,2]
- The average cost to the DoD for a 30-day supply of a brand versus generic drug in FY 2023 was as follows: direct care (MTF): $104 versus $18; retail network: $807 (net of manufacturer refunds) versus $9, and home delivery: $207 versus $11. Note that costs are not adjusted for differences in drug types or drug mix between brand and generic at the three pharmacy points of service.

TRENDS IN GENERIC DRUG DISPENSING, FYs 2018–2023

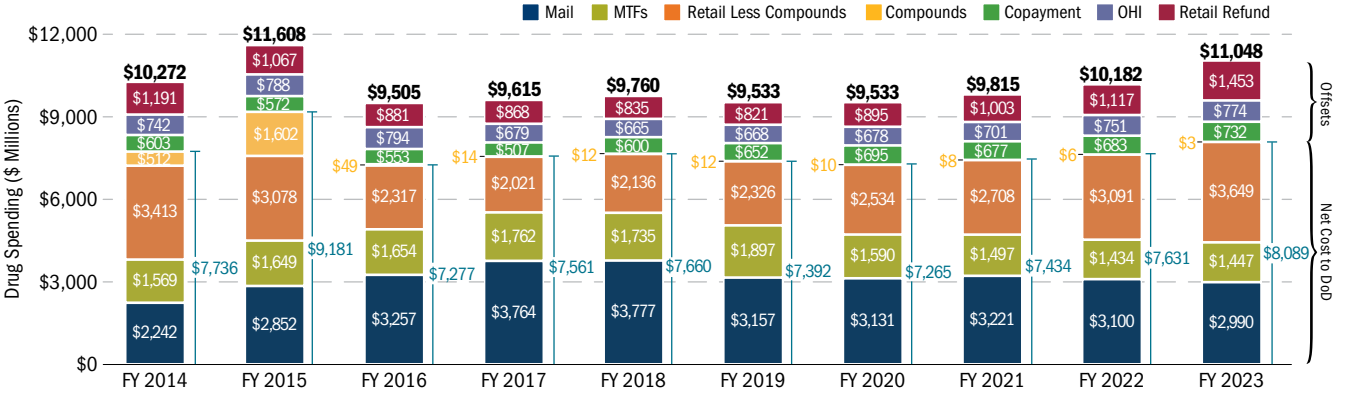


Source: MHS administrative data, 1/10/2024

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 2023, the refunds are estimated to have saved the DoD $1.5 billion. After rising an average of only 2.7 percent per year from FY 2008 to FY 2014, net DoD costs rose by 19 percent in FY 2015 alone, driven largely by a threefold increase in expenditures for compound drugs. After the DoD was able to control compound drug prices, net DoD costs fell by 21 percent in FY 2016 with steady increases in retail spending through FY 2023.

MHS OUTPATIENT DRUG SPENDING, FYs 2014–2023



Source: Pharmacy Data Transaction Service (PDTS) Data Warehouse, 12/5/2023; DHA Pharmacy Operations Division (refunds), 12/28/2023

[1] Association for Accessible Medicines, "The U.S. Generic & Biosimilar Medicines Savings Report," September 2022, https://accessiblemeds.org/sites/default/files/2022-09/AAM-2022-Generic-Biosimilar-Medicines-Savings-Report.pdf.

[2] The direct care generic dispensing rate may be lower than in the private sector because the MHS can frequently buy a branded drug at a lower cost, either under contract or at federal pricing, than the generic drug. (This occurs during the 180-day exclusivity period when there is only one generic drug competing against the branded drug.) This is not the case for most commercial plans. The MHS is also forbidden by law to purchase generic drugs from countries that do not comply with the requirements established by the Trade Agreements Act. 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 copays, OHI, and retail refunds invoiced.
– Mail Order admin fees are included; however, other retail/mail contract costs and MTF cost of dispensing (overhead costs) are not included.
– Retail refunds are 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.
– Total expenditures do NOT include costs associated with pharmacy contracts (e.g., Express Scripts).

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

DoD/VA Pharmacy Contracting Initiatives

The Departments continued to maximize efficiencies through joint efforts when possible. There were 198 national contracts active at the end of FY 2023. In FY 2023, the VA spent $535 million on joint national contracts, and the DoD spent $135 million over the same period.

SPECIALTY DRUG COST TRENDS

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

No national standard definition of a specialty drug exists and definitions vary across health plans. The DoD has adopted the following guidelines in order to designate a medication as a specialty drug: (1) one or more of the following clinical factors: difficult to administer, special handling or storage, intense monitoring, high risk of adverse drug events, frequent dose adjustments, Risk Evaluation and Mitigation Strategy Programs in place, benefits of ongoing training for patients, class not widely used in practice, other drugs in the class are designated as specialty; (2) the cost of the medication to DoD falls in the top 1 percent of spend (cost per 30-day supply); and (3) on further review, designation of the medication as specialty continues to provide value to the patient and/or DoD.

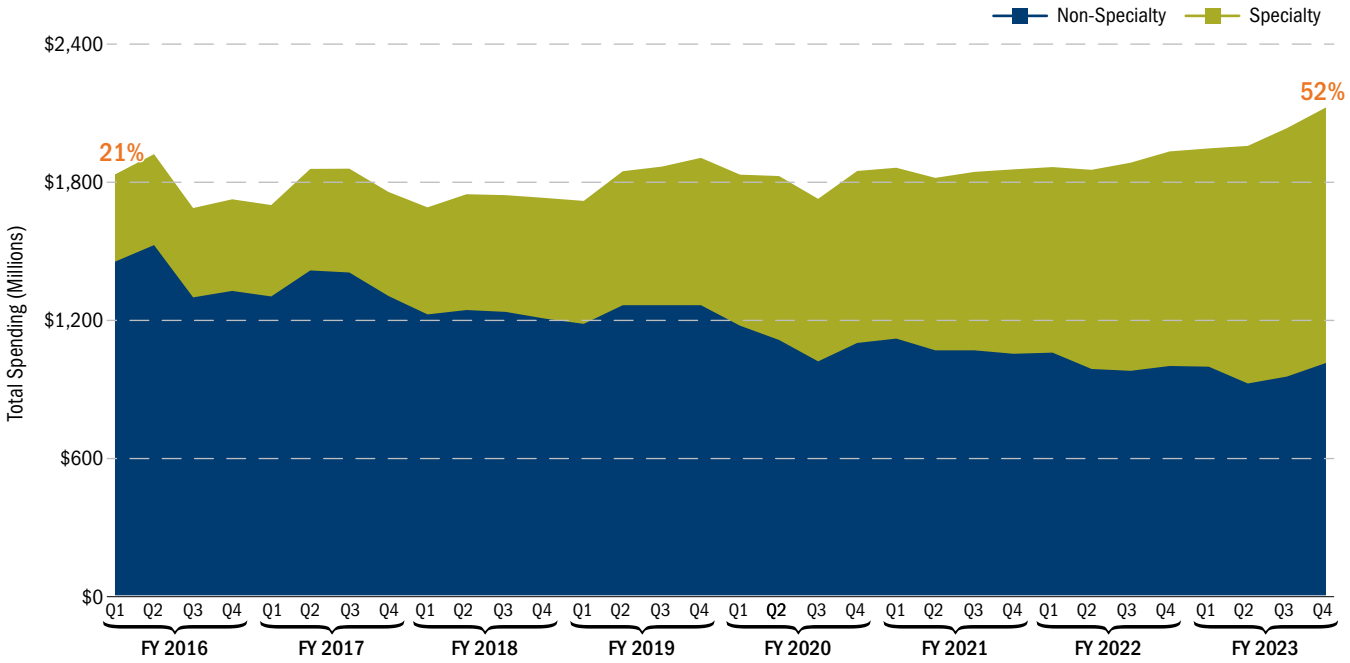
By spending, the top five specialty classes as defined by the DoD Pharmacy & Therapeutics (P&T) Committee are oncological agents (excluding leukemia/lymphoma and breast cancer agents), targeted immunological biologics (TIBs), atopy agents (asthma/atopic dermatitis), breast cancer agents, and multiple sclerosis 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.

- In FY 2023, specialty drugs accounted for less than 1 percent of total MHS prescription drug utilization (30-day equivalents), but for 52 percent of total spending.
- As a percentage of total drug costs, specialty drug costs continued to increase from FY 2013 to FY 2023. A large proportion of specialty spend comes from retail prescriptions, reflecting the manufacturers' imposed limited distribution mechanisms in place for many of these agents. This limits availability at mail order and MTFs, which are generally lower cost points of service.
- The highest spend specialty drugs were the oncological agents. Overall, oncological agents accounted for about $1,523 million in drug spend in FY 2023, up from $1,322 million in FY 2022 and $1,189 million in FY 2021. TIBs (primarily self-administered injectables for the treatment of rheumatoid arthritis, psoriasis, Crohn's disease, and other autoimmune disorders) accounted for another $928 million in FY 2023, followed by the atopy agents (including medications for atopic dermatitis and/or asthma), at $346 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.

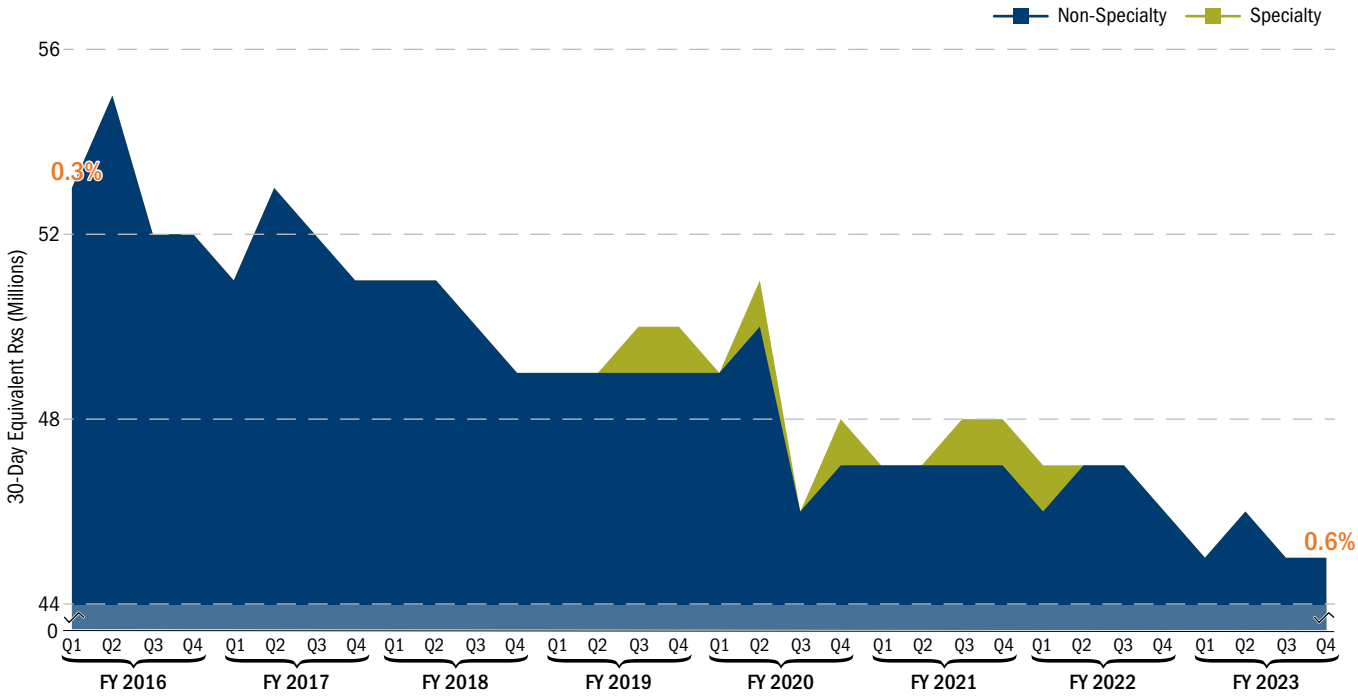
SPECIALTY DRUG COST TRENDS *(CONT.)*

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

FY 2016–2023 TOTAL SPENDING



FY 2016–2023 30-DAY EQUIVALENT PRESCRIPTIONS



Source: Pharmacy Operations Division, Defense Health Agency, 1/4/2024 based on Specialty Agent Reporting List for applicable quarters; totals adjusted for retail refunds, copayments, and against prime vendor cost per unit for MTF and home delivery drugs.

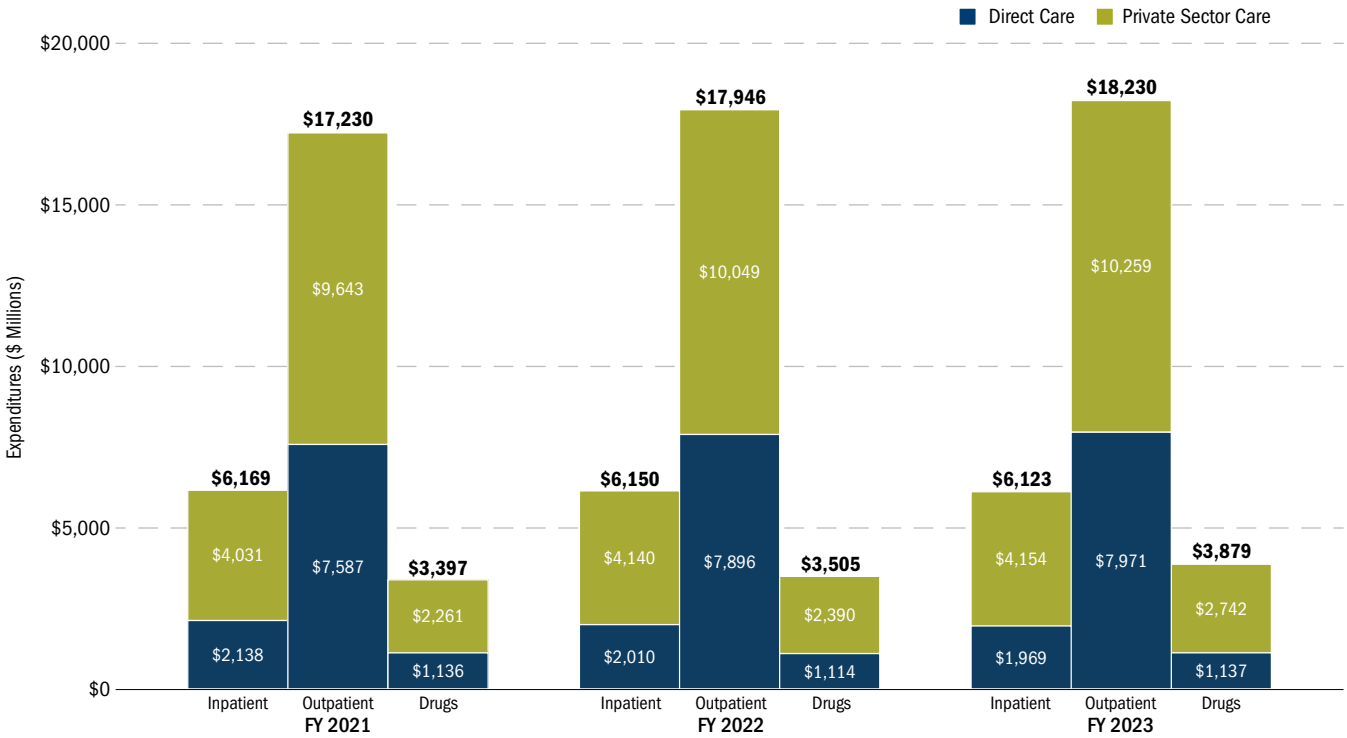
[a] Percentage Specialty excludes compounds, paper claims, and OHI.

MHS COST TRENDS

Total DoD health care costs include three components: (1) payments made to PSC institutions and providers for services rendered in hospitals (inpatient) or in an office or virtual setting (outpatient), (2) expenditures for direct care at MTFs that are attributed to either inpatient or outpatient care based on a workload-based allocation model, and (3) payments made for prescription drugs (whether via PSC or MTF).

- Excluding drug costs, about 75 percent of health care cost is for outpatient care in FY 2023.
- In FY 2023, the DoD spent $2.98 on outpatient care for every $1 spent on inpatient care.

TRENDS IN DoD EXPENDITURES FOR HEALTH CARE (EXCLUDING MERHCF), FYs 2021–2023

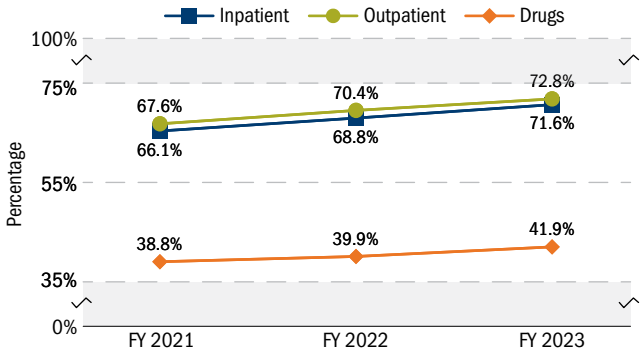


Note: Numbers may not sum to bar totals due to rounding.

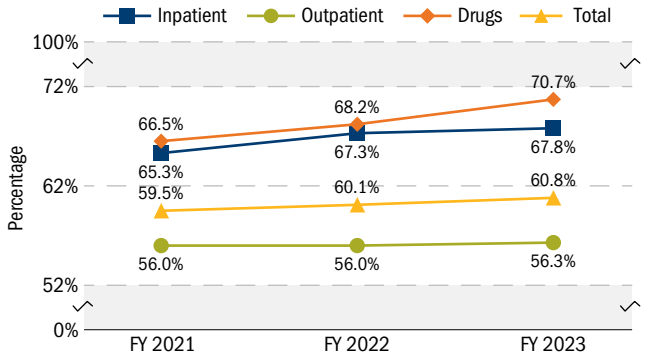
The charts below show the trends in the percentage of health care that is provided via the private sector.

- The trend for both utilization (a separate analysis) and cost is increasing. However, PSC utilization appears to have increased by approximately 5 percent from FY 2021 to FY 2023, while total costs increased by approximately 1 percent over the same this time period.
- For example, the percentage of total cost that is due to PSC rose from about 60 percent in FY 2021 to about 61 percent in FY 2023.

TRENDS IN PRIVATE SECTOR CARE UTILIZATION[a] AS PERCENTAGE OF MHS TOTAL BY TYPE OF SERVICE, FYs 2021–2023



TRENDS IN PRIVATE SECTOR CARE COST AS PERCENTAGE OF MHS TOTAL BY TYPE OF SERVICE, FYs 2021–2023



Source: DHA/Resources & Management Directorate (J-8)/Business Integration Division, 2/9/2024

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

MHS COST TRENDS *(CONT.)*

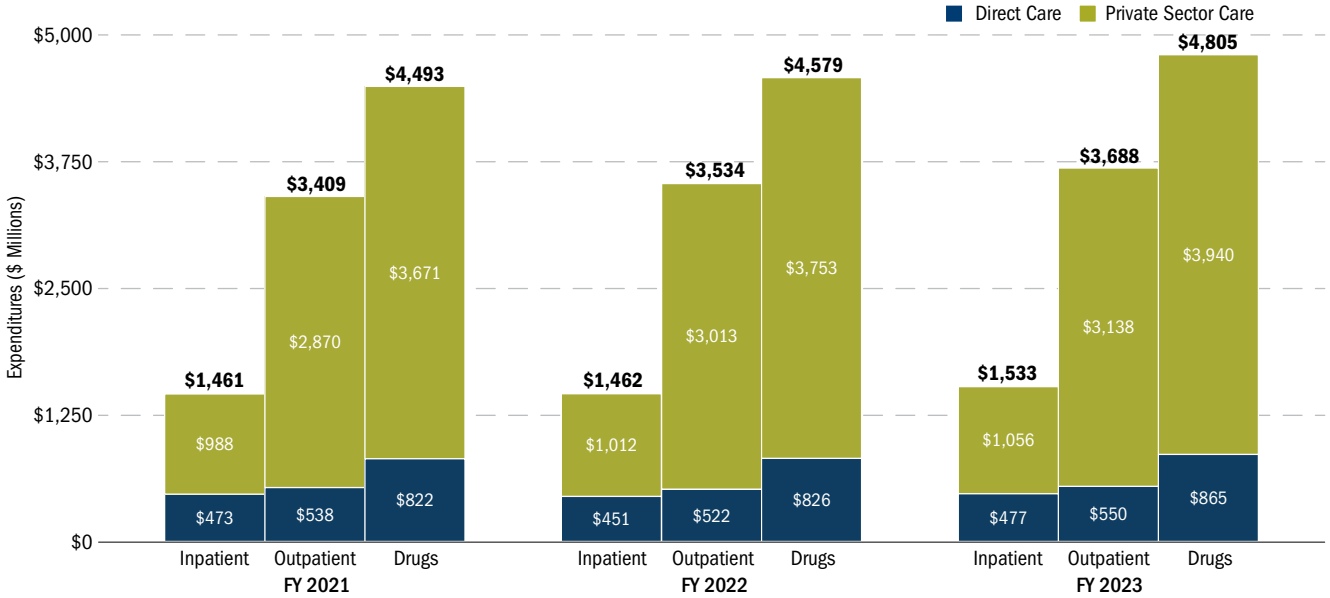
MERHCF Expenditures for Medicare-Eligible Beneficiaries

The MERHCF covers Medicare-eligible retirees, retiree family members, and survivors only, regardless of age or Part B enrollment status. The MERHCF is not identical to TFL, which covers Medicare-eligible non-Active Duty beneficiaries who have Medicare Parts A and B. For example, the MERHCF covers MTF care and USFHP costs, whereas TFL does not.

Total MERHCF expenditures include actual direct care expenditures at non-GENESIS facilities, estimated expenditures at GENESIS facilities, and private sector care costs. Total MERHCF expenditures increased from $9,363 million in FY 2021 to $10,026 million in FY 2023 (7 percent), net of manufacturer refunds on retail prescription drugs.

- Total DoD direct care expenses for MERHCF-eligible beneficiaries increased by 3 percent from FY 2021 to FY 2023. Inpatient rose by 1 percent, outpatient costs rose by 2 percent, and prescription drug costs increased by 5 percent.
- In FY 2021, TRICARE Plus enrollees accounted for 71 percent of DoD direct care inpatient and outpatient expenditures on behalf of MERHCF-eligible beneficiaries (not shown). That percentage increased to 74 percent by FY 2023.
- Including prescription drugs, TRICARE Plus enrollees accounted for 55 percent of total DoD direct care expenditures on behalf of MERHCF-eligible beneficiaries in FY 2021. That percentage increased slightly to 56 percent by FY 2023.
- Total private sector care MERHCF expenditures increased by 8 percent from FY 2021 to FY 2023. Inpatient and prescription drug expenditures both increased by 7 percent; outpatient expenditures rose by 9 percent.

MERHCF EXPENDITURES BY TYPE OF SERVICE, FYs 2021–2023



Source: DHA/Resources & Management Directorate (J-8)/Business Integration Division, 2/9/2024
Note: Numbers may not sum to bar totals due to rounding.

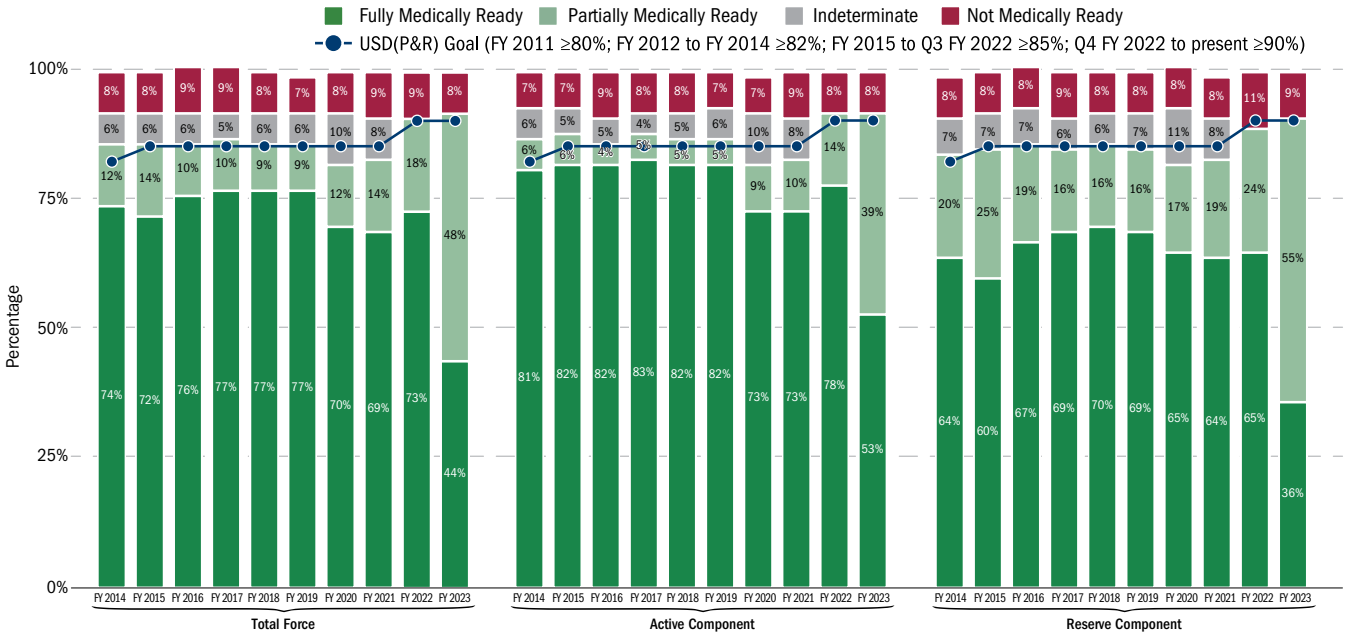
MEDICAL READINESS OF THE FORCE

The Department of Defense (DoD) Individual Medical Readiness (IMR) Program assesses individual Service members' compliance with established medical readiness elements. The IMR metric enables commanders to monitor and sustain Service members' and units' medical, dental, and other 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. DoD Instruction 6025.19 "Individual Medical Readiness Program" was revised and published on July 13, 2022. Changes to this issuance include removal of the Medical Readiness Indeterminate category and subsequent inclusion of overdue Periodic Health Assessment and Dental Readiness Classification 4 into the Partially Medically Ready (PMR) category. It also established a Total Force Medically Ready goal of 90 percent or greater, and PMR goals of 15 percent or less for AC and 25 percent or less for RC. The six requirements tracked are 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 medical readiness compliance of the total force since FY 2014 increased by 6 percentage points (from 86 percent in FY 2014 to 92 percent in FY 2023). The AC and RC medical readiness compliance remained steady from FY 2014 to FY 2019. In 2020, compliance dropped 5 percentage points for AC and 3 percentage points for RC, but climbed 10 percentage points and 9 percentage points, respectively, in 2023. The IMR chart below illustrates that by the end of fiscal year 2023, the AC (39 percent) and RC (55 percent) did not meet their respective PMR goals, but both components surpassed the total force goal of 90 percent. The FY 2023 total force compliance was 92 percent, with the AC at 92 percent and RC at 91 percent. It is important to note that the readiness data fluctuates daily and is pulled from multiple medical readiness systems.

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

OVERALL INDIVIDUAL MEDICAL READINESS STATUS (ALL COMPONENTS NOT DEPLOYED), FY 2014 TO FY 2023



Source: Defense Health Agency (DHA), Public Health, 11/28/2023

Notes:

– USD(P&R) = Under Secretary of Defense for Personnel and Readiness

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

HEALTHY, FIT, AND PROTECTED FORCE

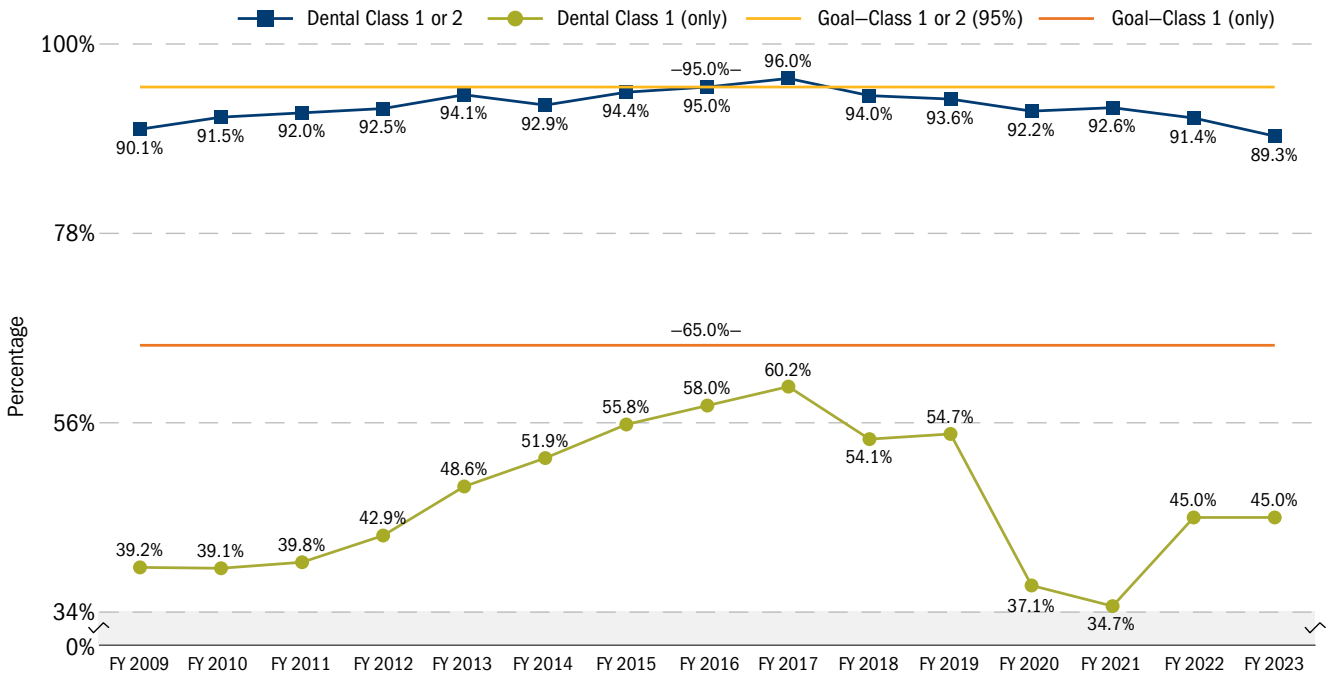
Key among the measures of performance related to providing an efficient and effective deployable medical capability and offering force medical readiness are those related to how well we: (1) maintain the worldwide deployment capability of our Service members, as in dental readiness and immunization rates 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 (AD) 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 AD 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 2009, the combined Classes 1 and 2 percentage fell in FY 2018 just under 94 percent and in FY 2023 fell to 89.3 percent, down from 96 percent in FY 2017, falling short of the long-standing MHS goal of 95 percent.
- The rate for AD personnel in Dental Class 1 had risen steadily since FY 2010 (39.1 percent), but fell from 60.2 percent in FY 2017 to 45.0 percent in FY 2023—20 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 2009–2023



Source: The Services' Dental Corps–DoD Dental Readiness Classifications, 12/15/23

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.

SUSTAINING EXPEDITIONARY MEDICAL SKILLS

Measuring Clinical Readiness through the Joint Knowledge, Skills, and Abilities Program Management Office (JKSA PMO)

The MHS is unique in that it must create a framework supporting both the delivery of health care and military department (MILDEP) clinical readiness requirements. In April 2022, the DHA was delegated the authority by the Assistant Secretary of Defense for Health Affairs (ASD[HA]) to formally stand up the JKSA PMO within the DHA. The PMO will manage the sustainment and development of clinical readiness metrics for wartime specialties. Through the development of these metrics, the JKSA PMO will help inform and recommend best practices as to how the MHS can sustain clinical readiness of military medical personnel 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 personnel are proficient in those areas. While there are many components comprising readiness, the basis of the DoD's expeditionary medical system rests on individual clinical proficiency. An MHS-wide strategic approach must be adopted to support the DoD requirements to optimize health care delivery and the sustainment of the ready medical force. As part of the MHS optimization efforts, the DHA is evaluating Veterans Affairs (VA) Resource Sharing Agreements as a mutually beneficial effort to provide health care and clinical readiness workload opportunities. Additionally, the DHA is improving the evaluation mechanisms and establishing a measure of effectiveness for military-civilian partnerships (MCPs) to leverage the expertise, acuity, and patient volume of civilian medical systems to maximize clinical readiness opportunities for military medical personnel. The JKSA PMO provides an innovative approach to measuring, evaluating, and sustaining individual clinical proficiency, with a focus on the metric-based specialties below. Although these processes are applied to assess individual clinical readiness, these metrics are also used to evaluate the ability of an MTF or VA/MCP to support clinical readiness and overall skills sustainment.

JKSA PMO METRIC-BASED SPECIALTIES			
1	General Surgery (and Colorectal Surgery)	9	Plastic Surgery
2	Orthopedic Surgery	10	Neurosurgery
3	Critical Care	11	Oral Maxillofacial Surgery (OMS)
4	Emergency Medicine	12	Otorhinolaryngology (ENT)
5	Anesthesiology (and Certified Registered Nurse Anesthetists)	13	Urology
6	Trauma Surgery	14	Vascular Surgery
7	Ophthalmology	15	Obstetrics/Gynecology (OB/GYN)
8	Cardiothoracic Surgery		

Clinical Currency

The JKSAs comprise the specialty-specific expeditionary skill sets used by military medical personnel, reflecting both clinical currency and competency. The JKSA PMO methodology is based on a continuous cycle of clinical currency through periodic knowledge assessments, clinical practice (JKSA clinical activity metrics), and the procedural skills assessments through specialty-specific implementation of the Emergency War Surgery Courses (e.g., Advanced Surgical Skills for Exposure in Trauma+ [ASSET+], Joint Operational Trauma Surgical Skills [JOTS+], etc.). JKSAs are developed using a standardized process and create the ability to assess the wartime medical readiness value derived from each clinician's peacetime workload. They also provide detailed descriptions of the knowledge and skills needed in their specialty-specific expeditionary environment and help inform knowledge and skills degradation, which can guide training/retraining timelines in support of deployment readiness.

SUSTAINING EXPEDITIONARY MEDICAL SKILLS *(CONT.)*

Clinical Currency Metric

To date, 15 metric-based Joint Expeditionary Scopes of Practice (ESPs) and dashboard methodologies have been developed. The clinical activity measures and thresholds have been finalized for 13 of the metric-based specialties, and their dashboards are accessible through the JKSA PMO SharePoint site (https://info.health.mil/hco/JKSA/Pages/Home.aspx) via common access card (CAC)–enabled CarePoint for use in Service, Defense Health Network, and facility decision making. The remaining two specialties are in late-stage development for implementation and are expected to be completed in summer of 2024. The JKSA PMO Chartered Working Group (WG), in collaboration with the Tri-Service clinical communities, will be responsible for managing the sustainment and development of these clinical readiness metrics and for additional specialties. Clinical practice metrics and assessments for Operational Medical Officers and operating room nurses and technicians are included within this group, and several other nonprovider specialties are also being considered. Through the JKSA Chartered WG, the JKSA PMO team is reviewing and revalidating the other 47 checklist-based specialty ESPs that were completed in 2019. These ESPs delineate shared specialty requirements related to both occupational currency and completion of designated training.

Knowledge Assessment

Periodic knowledge assessments ensure the sustainment of clinical proficiencies by identifying knowledge gap areas that may challenge military medical personnel and inform the requirements for focused training resources to ensure ongoing clinical readiness. Knowledge assessments are specialty specific and supported through Tri-Service development and implementation, with support from professional organizations, such as the American College of Surgeons (ACS), American Society of Anesthesiologists, and Society for Critical Care Medicine.

Implementation outcomes for general surgery and orthopedic surgery yielded rigorous high-reliability exams with strong psychometric integrity covering the expeditionary surgical domains for each surgical specialty. Test outcomes documented performance gaps in multiple domains, as well as differentiated between subspecialty training and deployment experience.

Test forms of 200 items each were completed by 273 general surgeons and 112 orthopedic surgeons of varying experience levels, and the consensus-derived benchmark score for both exams is 80 percent. The baseline mean scores for general surgeons and orthopedic surgeons were 72 percent and 68 percent, respectively.

Knowledge tests are fully developed for Critical Care and Trauma Surgery, and exams are currently available for use by all of these specialties. Test development and implementation for the remaining specialties are in progress, with ongoing Tri-Service engagement.

Completion of knowledge tests provides the MHS and the JKSA PMO with critical information about capability gaps and facilitates development of focused resources designed to close those gaps through easily accessible training mechanisms. These training resources are available through the Joint Trauma System (JTS) Deployed Medicine portal, which directly links to vetted clinical resources and on-demand multimedia-supported training resources developed in partnership with the ACS. Test takers earn 60 continuing medical education credits through Navy Mods for completing the knowledge tests and associated training content for identified gap areas. Knowledge tests will be implemented every three years to identify areas of knowledge decay and inform ongoing training refreshment intervals. They may be completed as often as desired at any time to support pre-deployment preparations.

SUSTAINING EXPEDITIONARY MEDICAL SKILLS *(CONT.)*

Procedural Skills Assessments

Current training and practice environments do not fully prepare military medical personnel and treatment teams to perform vital life-, limb-, and eyesight-saving procedures. The existing Emergency War Surgical Courses (EWSCs) are an inconsistently funded and nominally enforced "mandate" that suffer from lack of standardization. The JKSA PMO, in collaboration with the Uniformed Services University of the Health Sciences (USUHS) Clinical Readiness Program have developed and validated standardized procedural skills courses utilizing best- in-class educational principles to teach and robustly assess more than 50 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 courses, participants receive one-on-one hands-on training with four experienced trauma surgical specialists and selected subspecialists who provide real-time assessment and individualized feedback. Rigorous assessment measures, captured over four years of these courses, demonstrated significant improvements for all participants in the integration of knowledge, skills, decision making, and confidence to handle injuries likely to be seen in the expeditionary environment. Course instructors and surgical technician team members have also found the course to be extremely valuable as preparation for expeditionary care and civilian trauma care. This focused, structured, and efficient assessment-driven training paradigm is applicable to all clinical skills requirements. The outcomes underscore the critical need to identify and address clinical readiness capability gaps prior to deployment through focused performance assessment and essential retraining to ensure clinical competency and currency.

ASSET+ and Combat Orthopedic Trauma Skills outcomes from 2020–2021 confirmed that, at baseline, less than 3 percent of surgeons were able to meet the established benchmark performance score of 90/100 for the identified surgical procedures. After focused training, 99 percent of surgeons met or exceeded the performance benchmarks and 85 percent were able to do so independently. This underscores the need for these programs to ensure clinical competency and currency ahead of deployment and on an ongoing basis to manage casualties resulting from theater operations and natural disasters. Importantly, outcomes from the first year of skills assessment implementation demonstrate significant correlation between individual JKSA 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.

These procedural skills assessment courses have replaced the existing emergency war surgery courses as a doctrinally mandated and centrally funded effort intended to be delivered to all military surgeons either every two years or in a pre-deployment window. This approach is scalable, cost effective, and, with future expansion, will enable predictable performance capabilities for surgeons and expeditionary team members as a component of the clinical readiness lifecycle. Currently, there are active emergency war surgery courses for trauma (ASSET+), orthopedic trauma (JOTS+), and ocular trauma; all of which support life-, limb-, and eyesight-saving procedures. Orthopedic trauma remains a primary injury pattern for both combat and civilian occurrences of terrorism and other mass casualty events. EWSCs for craniomaxillofacial, otolaryngology, and plastic surgeons (Combat Craniomaxillofacial Trauma Surgery) are in the late stages of development, with implementation scheduled for 2024. Courses for critical care physicians and operational medical officers (Critical Skills for Expeditionary Medicine) are in the early stages of development, with anticipated completion in 2024. Development for skills assessment courses for anesthesiology, emergency medicine, and nursing (critical care and emergency medicine) has begun and will continue through 2024.

SUSTAINING EXPEDITIONARY MEDICAL SKILLS *(CONT.)*

JKSA Integration with Enterprise Planning

Throughout the implementation process for the JKSA PMO, coordination with the Services and their support has been a critical aspect of the development and improvement of the assessments and clinical currency metrics. These assessments and metrics are currently being incorporated into relevant Service-readiness constructs (Army Individual Critical Task Lists, Naval Readiness Criteria, and Air Force Comprehensive Medical Readiness Program). Services are utilizing JKSA metrics in their Readiness Demand Signal determinations, informing their readiness planning and support of the DHA's Performance Planning processes. To successfully transition the MHS from solely an economic-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 activity scores, outlined as follows:

Recapture: By aligning daily peacetime health care delivery activities 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 clinical readiness value across the enterprise. This can involve efforts to recapture high-acuity cases through shaping referral management, delivering strategic communications with specific patient populations, and focusing on policies that support bringing high-readiness-value cases back into the MTFs. JKSA methodologies are already in use to support recapture, and the JKSA activity scores for specific procedure groups have been included in the development of the new TRICARE contract.

Expand: MTFs can expand services to beneficiaries other than DoD to increase JKSA clinical workload opportunities. Partnering with the VA, optimizing subspecialty care within the MHS, and caring for local civilian trauma patients can all expand volume, acuity, and complexity of cases performed within the MTF.

Partner: MCPs create opportunities for individuals and teams to embed part-time or full-time in civilian trauma centers. The Joint Trauma Education and Training Branch, guided by National Defense Authorization Act (NDAA) Fiscal Year (FY) 2017, Section 717, has established a working group composed of representatives from the Services to facilitate and coordinate these efforts. This working group, having supported development of the ACS "Blue Book: Military-Civilian Partnerships for Trauma Training, Sustainment, and Readiness," has continued to review current MCP efforts and determined ways to support Service usage of partnerships for clinical readiness attainment and sustainment. Currently, external workload is captured in a fractured, inconsistent manner; however, initial efforts have begun to standardize and streamline this for the MHS. Once data capture is standardized, JKSA metrics will be leveraged to assess the effectiveness of these partnerships over time.

This three-pronged approach within the ready medical force functional review of the Performance Planning process helps inform leadership's prioritization of proposed initiatives and approval of projects based on the anticipated clinical readiness impacts. Ultimately, this supports a ready medical force with the knowledge, skills, and abilities—the highly perishable mission-essential medical skills in particular—required for the execution of military operations worldwide.

ACCESS, QUALITY, SAFETY, AND PATIENT ENGAGEMENT

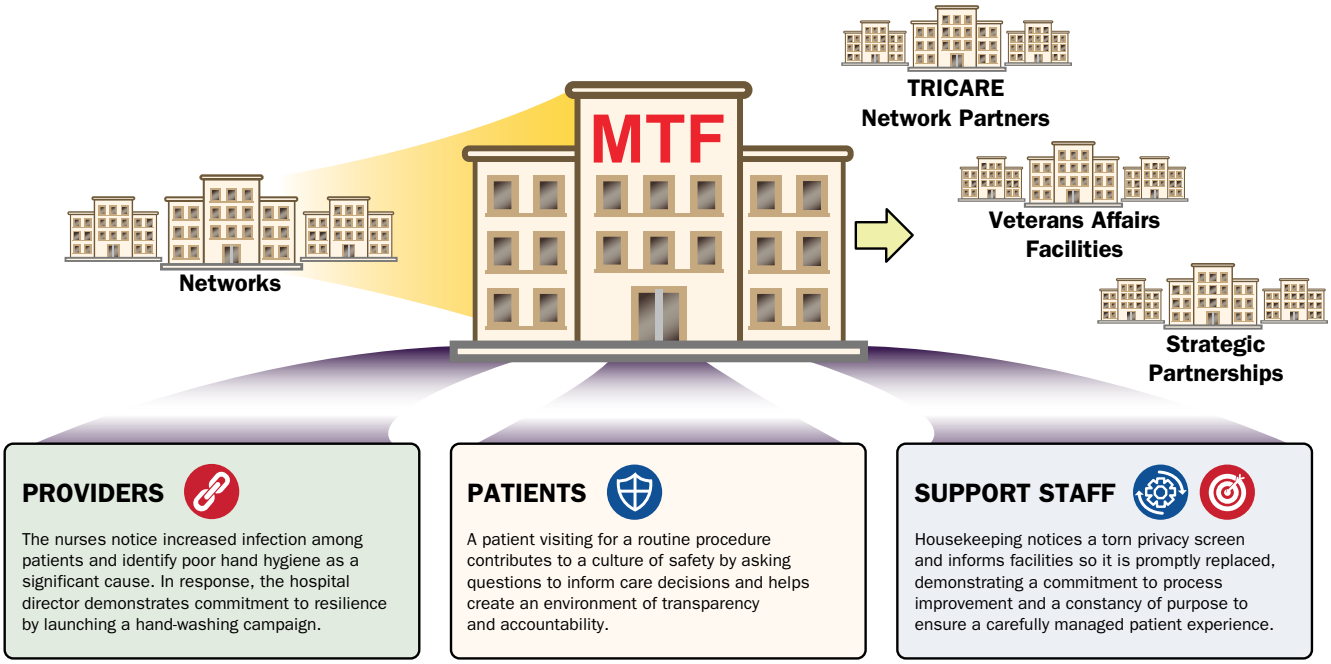
High Reliability Organization (HRO) Journey

The Military Health System (MHS) has continued incorporating the principles of high reliability while completing the Congressionally mandated transition of operational control of the military medical treatment facilities (MTFs) from the military Services to the Defense Health Agency (DHA). An HRO achieves top outcomes despite operating in complex or high-risk environments. HROs, commonly seen in aviation and nuclear industries, achieve top outcomes by: improving standardization and reducing variability; mitigating errors to achieve zero harm; embracing transparency and accountability; and valuing the contributions of all individuals, regardless of rank. The graphic below illustrates how HRO represents an organizational culture change throughout the entire MHS. In the DHA, this journey to HRO is called Ready Reliable Care (RRC).

DRIVING HIGH RELIABILITY AT MTFs AND WITH OUR PARTNERS

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

Here are just a few examples:



The DHA Strategic Plan FY 2023–2028 includes a portfolio of multiple initiatives that support the HRO journey. The strategy leverages the collective expertise of the DHA Medical Affairs Directorate, Clinical Communities, Clinical Management Teams, Clinical Quality Management (CQM), and Clinical Support Services efforts to accelerate high reliability across the MHS and deliver continuous process improvement (CPI) in clinical practice. This strategy will scale and spread leading clinical process improvements across the MHS for appropriate standardization to minimize or avoid system failures, prevent harm, reduce unwarranted variation, and eliminate waste. It aims to establish and monitor metrics that measure adoption of evidence-based leading practices, monitor effectiveness, and evaluate the performance outcomes of process improvement efforts across the MHS. This maximizes value by embedding exemplary standards of care as well as effective and efficient patient-centered solutions. Specific projects include the following:

- Centers of Excellence Development and Implementation
- Top 10 CPG Implementation in MHS GENESIS
- Improve Medication Safety
- Military Orthopedics Tracking Injuries Outcomes Network/Musculoskeletal Triage Continuous Quality Improvement Program
- Direct Access to Physical Therapy
- Acute Concussion Care Pathway
- Behavioral Health Treatment and Outcomes Monitoring
- Standardization of Depression and Suicide Risk Screening in Primary Care
- Postpartum Hemorrhage Bundle DHA-PI 6025.35 Compliance
- Opioid Overdose Education and Naloxone Distribution
- Operationalizing Pharmacogenomics Testing for Comprehensive Medication Management

These improvement efforts support quality and patient safety and drive DHA's strategic goal of an integrated, highly reliable health care delivery system focused on casualty reception, medically ready force, medical force generation, and delivery of excellent patient-centered and evidence-based care.

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

High Reliability Organization Journey *(cont.)*

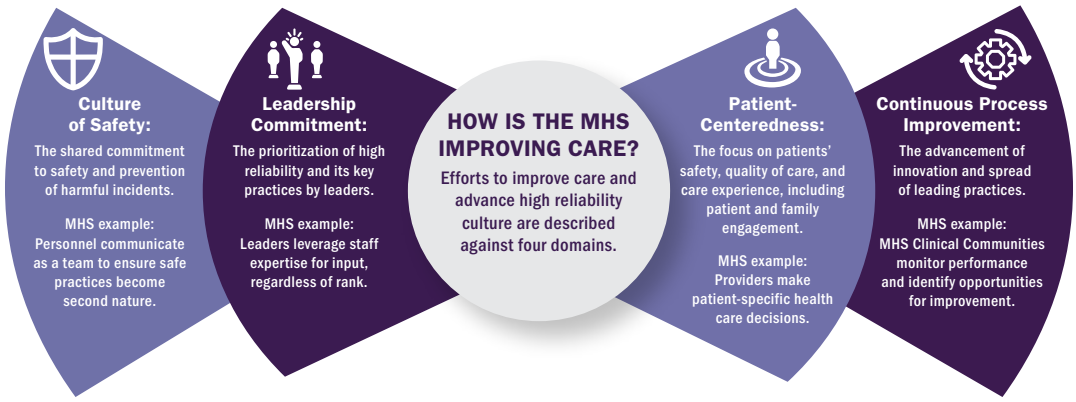
Ready Reliable Care

Since 2014, the Services and DHA have been taking action to improve health care access, quality, safety, transparency, and patient engagement. Following completion of the MHS Transition in October 2022 and the transfer of military MTFs to the authority direction and control of the DHA, the DHA is working to standardize and expand these efforts in a coordinated approach to high reliability for the entire MHS. It will enable the MHS to manage system-wide processes to root out potential for error and sources of waste and identify tools to deliver better care. Increasing standardization will deliver consistent high-quality care from one facility to the next, one patient to the next. These efforts are motivated by three key drivers: promoting the integration of HRO across the MHS, establishing an MHS-wide culture of safety focused on achieving zero harm, and enhancing the MHS through CPI.

RRC Next Steps:

- Develop MHS HRO education and training program
- Develop MHS HRO assessment strategy and tools aligned to the domains of change
- Establish a formal recognition program for highly reliable behaviors and activities to be acknowledged at headquarters (HQ), Network, and MTF levels
- Understand and address contributing factors to staff burnout and well-being
- Incentivize a just culture and a culture of life-long learning and transparency
- Develop, standardize, integrate, and mature CPI and change management capabilities across the MHS
- Implement leading practices
- Implement daily management system

MHS READY RELIABLE CARE DOMAINS OF CHANGE



HRO PRINCIPLES

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

MHS Data Transparency

The MHS data transparency framework was established to support a culture of safety by enabling transparency throughout the organization. The framework addresses the four domains of transparency as identified by the National Patient Safety Foundation (transparency between clinician and patient; transparency between health care organizations; transparency between clinicians themselves; and transparency between clinicians, health care organizations, and the public) and integrates the domains into the daily work of work groups, programs, and activities across the organization. The National Patient Safety Foundation is currently incorporated into the Institute for Healthcare Improvement.

In alignment with the National Defense Authorization Act (NDAA) FY 2017, Section 728, incorporation and public reporting of appropriate core measures from the Core Quality Measures Collaborative (CQMC) continues to advance.

- Public reporting of CQMC measures continues in prescribed phases as measures are developed, tested, and completed via the approval process.
  - Data for 14 measures relating to primary care, obstetrics and gynecology, behavioral health (BH), and pediatrics are available on the MHS Transparency site for public access.
  - Measures for orthopedics, cardiovascular, gastroenterology, neurology, and HIV/hepatitis C are in the measurement implementation phase. The oncology measure is in the measure specification phase. Delays in measure development have been associated with changes in selected measure methodology by the measure steward, loss of National Quality Forum (NQF) endorsement for selected measures, and transition of the responsibility for management of CQMC measures.

Additionally, the MHS is furthering its data transparency efforts in alignment with Section 1073b of Title 10, United States Code: recurring reports and publication of certain data.

With respect to each MTF, this includes reporting of the following data and/or data sets:

- **The current accreditation status, including recommendations for corrective action (CA).** Accredited organizations, including DoD inpatient and freestanding ambulatory clinic MTFs, can be found on The Joint Commission (TJC) website at www.qualitycheck.org. The Joint Commission is the current health care accrediting organization for the DHA. 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 (RFI) to meet full accreditation are found in the downloadable report at www.health.mil/AccreditationStatus (ref. pages 82–86).
- **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 Secretary of Defense (SECDEF).** 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 43, 72).
- **Data on surgical and maternity care outcomes during the year.** MHS-level data are presented in this report (ref. pages 98–100, 107–108). 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 50–51), including MHS-wide and MTF-specific analyses 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 Centers for Medicare & Medicaid (CMS) Care Compare website.

To the extent that information in this report contains medical quality assurance (QA) 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.)*

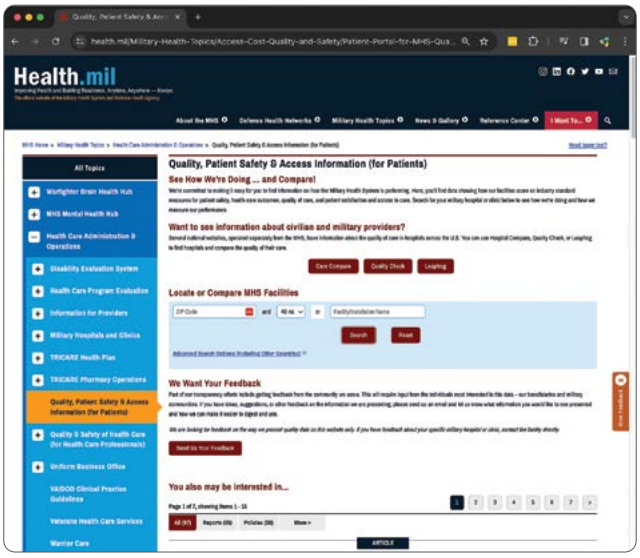
After the MHS Transition in 2021, the responsibility for public reporting functions of MHS measures on the www.health.mil/transparency website transitioned to the CQM Clinical Measurement (CM) Program. Through collaboration, the CM Program continues to review and iterate on the approach and display of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

In 2018, the DHA began participation in Leapfrog surveys with one pilot site, Walter Reed National Military Medical Center. Leveraging lessons learned from this pilot, in 2023, DHA expanded the program to include 48 MTFs, 40 hospitals (including eight outside the contiguous United States [OCONUS]), and eight ambulatory survey centers. All results from the survey are reported publicly on Leapfrog's website (leapfroggroup.org). In 2024, DHA plans to expand the program to incorporate all OCONUS facilities and participate in Leapfrog's Hospital Safety Grade. Webpage example is shown at right.

The NDAA FY 2021, Section 744, identified specific requirements for the MHS CQM Program. This includes the systematic measurement of indicators of health care quality, emphasizing clinical outcome measures; comparison of such indicators with benchmarks from leading health care quality improvement organizations; and transparency with the public of appropriate clinical measurements for MTFs.

Furthering MHS transparency efforts, the NDAA FY 2023, Section 706, required an analysis of the quality and patient safety review process for health provided under the direct care component of the TRICARE Program to be conducted by a federally funded research and development center and to include recommendations. Included in this assessment is the evaluation and publication of clinical quality metrics (at the level of the MTFs and other operational medical units of the DoD) and a comparison with similar metrics for non-DoD health care entities.

VISIT HEALTH.MIL/TRANSPARENCY



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

ACCESS TO MHS CARE

Access to Outpatient Care in the MHS

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

In the last year, the direct care system has continued improving access to care performance and reducing variance among MTFs. This is especially noteworthy given that the direct care system continued to adapt to changes in demand and care-seeking behaviors post-pandemic as well as enduring staffing shortages and challenges related to the wake of COVID-19. The 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 (VH), which enabled the direct care system to provide medically necessary care throughout the pandemic. As the MTFs began resuming full operations while continuing to minimize risk of infection for patients and staff, the direct care system implemented processes to catch up on delayed chronic and preventive care, with strong emphasis on cancer screening. Direct care system access-to-care efforts gained momentum after the SECDEF-directed 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 2023, the direct care system continued optimization efforts to enhance access, improve patient experience, and eliminate unwarranted variance among MTFs. The direct care system improved access, particularly in primary care, by implementing standard appointing and capacity processes codified in DHA policy to meet requirements in the NDAA for FY 2017. The NDAA FY 2017, Section 704, directed MTFs to improve access to urgent care (UC) by expanding operating hours in MTF Patient-Centered Medical Homes (PCMHs), implementing additional MTF UC clinics at locations where sufficient patient demand existed to justify operating costs, and integrating the NAL UC and appointing processes. The NDAA FY 2017, Section 709, also directed the MHS to implement standard appointing processes and procedures and to develop productivity standards on the expected number of patient encounters for each health care provider in both primary and specialty care. The direct care system is currently implementing standard appointing and procedures to improve access, increase direct care system capacity, enhance patient experience, and eliminate variance among MTFs. Standard processes and procedures include:

1. Optimization of the PCMH model of primary care
2. Simplified appointing to reduce template complexity and improve access
3. Use of standard screening tools and clinical practice guidelines (CPGs) in the Tri-Service Workflow templates in the MHS electronic health record (EHR)
4. Implementation of enhanced access initiatives, including team-based care, integrated specialists, and nurse-run walk-in clinics for common acute conditions
5. Standard First Call Resolution processes in both primary and specialty care to ensure beneficiaries' needs are met the first time they call for an appointment
6. Use of DHA-developed centralized data and standard tools to better match appointment supply to patient demand by day of week and hour of day

The MHS also established productivity standards on the expected number of encounters per provider to meet the congressional intent of the NDAA FY 2017, Section 709. Finally, the MHS has established standard primary care empanelment goals per provider and MTF to optimize direct care system capacity and provide a basis for primary care staff resource allocation across the direct care system based on patient demand.

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

ACCESS TO MHS CARE *(CONT.)*

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

The Patient Centered Care Operations Board (PCCOB), which is organized under the flag-level Enterprise Solutions Board, 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 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. Subject-matter experts (SMEs) evaluate performance and variance among MTFs on every measure, relative to past performance and compared with MHS goals. Performance is reported on the R&A dashboard, with monthly reporting to the Assistant Director, Health Care Administration for DHA.

Patient-Centered Medical Home Primary Care

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

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

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

Primary Care Manager (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 2023, enrollees saw their own PCM during primary care visits 50 percent of the time. MTFs are to maximize continuity of care by optimizing provider availability, templating appointments 180 days in advance, expanding clinic hours, and maintaining adequate team size (DHA-Interim Procedures Memorandum [DHA-IPM] 18-001).

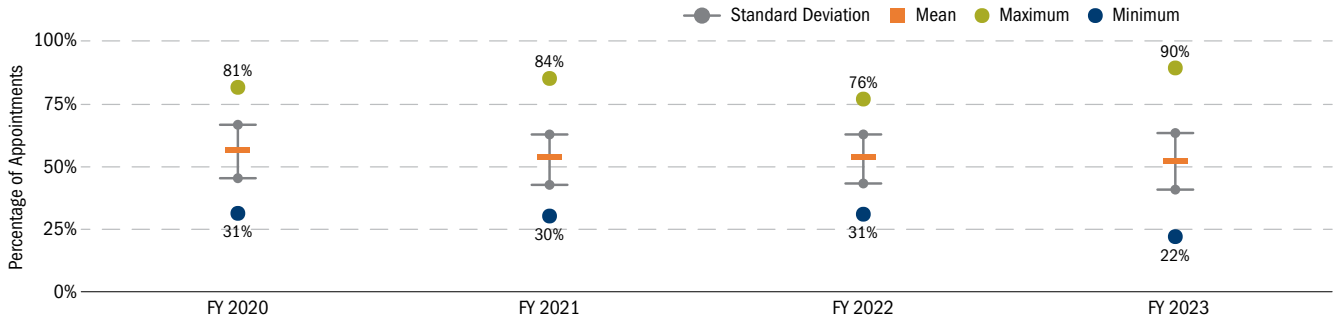
PCM CONTINUITY, FYs 2016–2023

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
PCM Continuity	60%	59%	57%	57%	56%	55%	51%	50%

PCM CONTINUITY, FYs 2020–2023

	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020–FY 2023 PERCENTAGE CHANGE
Mean	55.4%	52.3%	52.6%	52.2%	-5.1%
Standard Deviation	10.2%	10.3%	9.8%	11.3%	10.6%
Median	55.1%	51.5%	52.1%	53.3%	-3.0%
75th Percentile	65.0%	62.0%	59.0%	59.0%	-8.9%
25th Percentile	51.0%	49.0%	47.0%	44.0%	-13.1%
Maximum	80.7%	84.2%	75.9%	89.5%	10.5%
Minimum	31.2%	30.0%	30.5%	21.8%	-29.6%
Range	49.5%	54.2%	45.3%	67.7%	38.1%

PCM CONTINUITY, FYs 2020–2023



Source: MHS administrative data (MHS Data Repository [MDR]); DHA/Health Care Operations (HCO)/Health Care Optimization Division, 12/8/2023
Notes:
– Parent facility scores were used to describe variability in the results above.
– Data include MHS GENESIS sites beginning August 2019.
– Numbers may not sum due to rounding.

ACCESS TO MHS CARE *(CONT.)*

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

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

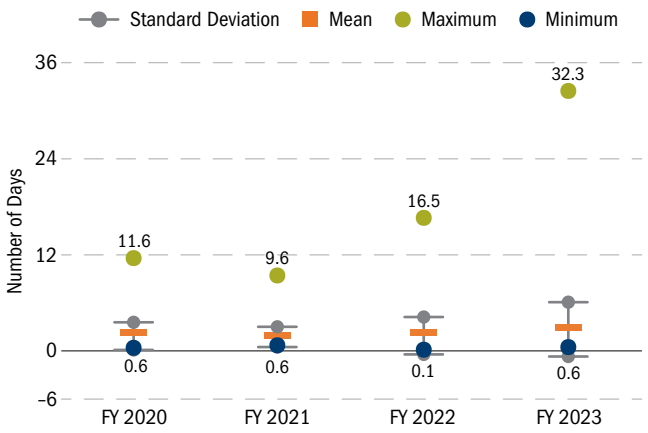
The direct care system prospectively measures access to primary care by evaluating the average number of days to the third next available 24-hour appointment and third next available future appointment against the MHS goals of 1.0 and 7.0 days, respectively. Measuring third next for a prospective measurement 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 2023, there was an increase in the average number of days to third next available 24-hour (2.7 days) and future (6.7 days) appointments. Future appointments remain within the seven-day standard in FY 2023; we aim to meet the 24-hour target of one day as we continue to adapt to post-pandemic conditions.

DAYS TO THIRD NEXT AVAILABLE 24-HOUR APPOINTMENT, FYs 2020–2023

	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020–FY 2023 CHANGE
Mean	2.0	1.8	2.0	2.7	0.7
Standard Deviation	1.7	1.2	2.4	3.4	1.7
Median	1.5	1.4	1.4	1.9	0.3
75th Percentile	2.1	2.1	2.8	2.5	0.4
25th Percentile	1.0	1.0	1.3	1.1	0.1
Maximum	11.6	9.6	16.5	32.3	20.7
Minimum	0.6	0.6	0.1	0.6	0.0
Range	11.0	9.0	16.5	31.8	20.7

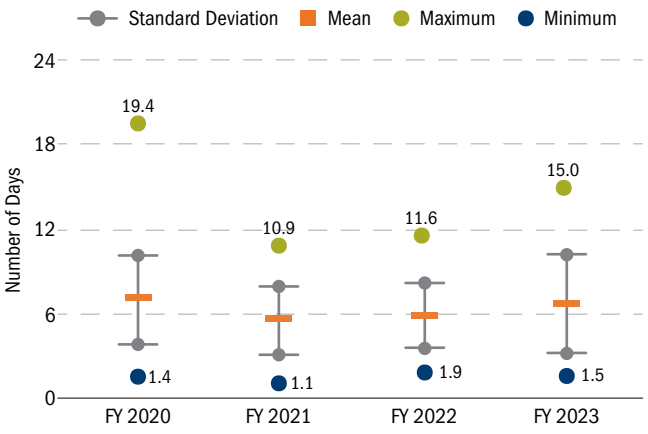
DAYS TO THIRD NEXT AVAILABLE 24-HOUR APPOINTMENT, FYs 2020–2023



DAYS TO THIRD NEXT AVAILABLE FUTURE APPOINTMENT, FYs 2020–2023

	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020–FY 2023 CHANGE
Mean	7.0	5.5	5.9	6.7	–0.3
Standard Deviation	3.2	2.4	2.3	3.5	0.3
Median	6.2	4.9	5.5	6.0	–0.2
75th Percentile	8.4	7.2	8.9	6.1	–2.3
25th Percentile	4.7	3.7	4.0	3.7	–1.0
Maximum	19.4	10.9	11.6	15.0	–4.4
Minimum	1.4	1.1	1.9	1.5	0.1
Range	18.0	9.8	9.7	13.5	–4.6

DAYS TO THIRD NEXT AVAILABLE FUTURE APPOINTMENT, FYs 2020–2023



Source: MHS administrative data (MDR); DHA/HCO/Health Care Optimization Division, 12/8/2023
Notes:
– Parent facility scores were used to describe variability in the results above.
– GENESIS data are included beginning in January 2022.
– Numbers may not sum due to rounding.

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

TRICARE for Life (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 and also lets the patient know if it is an in-person or virtual appointment. The reminders also provide information on how to cancel the appointment, if necessary.

There are three different types of notifications in TOL Patient Portal, all reported separately.

- Appointment confirmation, cancellation, and reminders (e-mail/text)
- Refill request confirmation (e-mail/text)
- Lab result notification (e-mail/text)—implemented during COVID; TOL sends a notification to patients when a new lab result has been posted

During FY 2023, TOL sent an average of 37,000 e-mail and 23,000 text appointment reminders per week.

TOL PATIENT PORTAL AUTOMATIC APPOINTMENT REMINDERS

	FY 2021	FY 2022	FY 2023
Total number of reminders	28.3M	27.9M	3.1M
Average number of e-mail reminders sent per week	319K	318K	37K
Average number of text reminders sent per week	226K	218K	23K

TOL Patient Portal Health Record

The TOL Health Record provides patients secure and easy access to their health information. On TOL, patients can access Health Record to view, print, save, and/or download their personal health data. The Health Record includes laboratory results, medications, radiology results, immunizations, problem list, encounters, documents, vitals, and allergies. TOL provides patients with e-mail and/or text alerts when COVID test results and/or new laboratory results are posted. The Health Record is helpful for the patient's own personal record-keeping, for partnering with their provider(s), and the care of their family. Easy access to health records on TOL also assists in applying for Veterans Affairs (VA) and Social Security benefits. Health Record views for FY 2023 totaled over 35.6 million with the highest number in October 2023 at 4.1 million views.

Once MTF transitions to MHS GENESIS, patients will view all new Health Record data using the MHS GENESIS Patient Portal. Patients can continue to view historical Health Record data using TOL until it ultimately retires in FY 2024.

Access to Integrated Specialists in the PCMH

The most common reason enrollees sought direct care in FY 2023 was for routine screenings and musculoskeletal issues. Otherwise, the most common conditions, excluding pregnancy, were BH-related, mental health (MH)–related, infectious disease screening and immunizations, and miscellaneous conditions, such as hypertension, vision, 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 BH specialists who provide treatment for MH and BH issues. Directly integrating BH 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 (USUHS) determined that being seen by a BH specialist integrated in a PCMH results in a statistically significant improvement in MH status. PCMH Clinical Pathways are being optimized by incorporating multidisciplinary specialties for BH-related issues prevalent in the MTF Prime population, including alcohol misuse, anxiety, depression, diabetes, obesity, chronic pain, sleep problems, and tobacco use. The MHS is also implementing integrated clinical pharmacists in PCMHs. An FY 2016 independent analysis demonstrated that the use of integrated clinical pharmacists resulted in a statistically significant improvement in diabetes, hypertension, and hyperlipidemia outcomes. Finally, the MHS is implementing integrated physical therapists in PCMHs to address highly prevalent musculoskeletal issues, such as low back pain. Where implemented, integrated physical therapists continue to achieve improved outcomes and reduced MTF enrollee private sector care costs.

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

Dispositions and Bed-Days per 1,000 MTF Enrollees

By focusing on prevention, proactive care coordination, and improving outcomes for common conditions, MTF PCMHs focus on reducing the incidence of dispositions (admissions) and bed-days per 1,000 MTF enrollees. PCMH teams continue efforts to reduce the number of times MTF enrollees are admitted to hospitals and medical centers in both the direct and private sector care sectors, and the length of time they spend as inpatients if admitted, which is measured by bed-days (number of dispositions multiplied by the length of stay [LOS]). The average monthly disposition count per 1,000 MTF enrollees was 4.5 in FY 2023; the average number of monthly bed-days was 15.9 per 1,000 enrollees. The top five reasons for admissions are childbirth, mental health conditions, digestive conditions, behavioral health conditions, and reproductive system conditions.

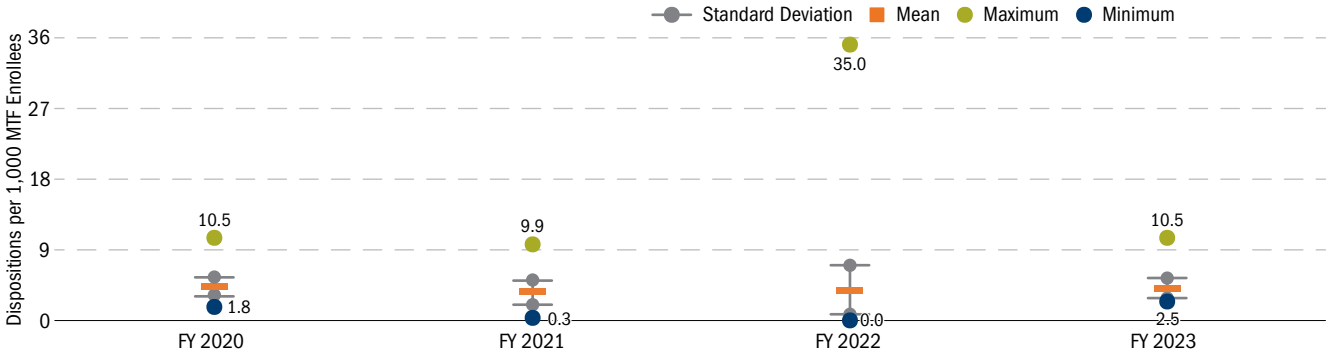
AVERAGE MONTHLY DISPOSITIONS AND BED-DAYS PER 1,000 MTF ENROLLEES, FYs 2020–2023

	FY 2020	FY 2021	FY 2022	FY 2023
Average Monthly Dispositions per 1,000 MTF Enrollees	4.5	4.6	4.0	4.5
Average Monthly Bed-Days per 1,000 MTF Enrollees	14.8	16.0	14.7	15.9

AVERAGE MONTHLY DISPOSITIONS PER 1,000 MTF ENROLLEES, FYs 2020–2023

	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020–FY 2023 CHANGE
Mean	4.3	3.6	4.0	4.1	-0.2
Standard Deviation	1.2	1.5	3.2	0.1	-1.1
Median	4.1	3.7	3.7	3.9	-0.2
75th Percentile	4.8	4.4	4.4	4.6	-0.3
25th Percentile	3.6	3.0	3.0	3.4	-0.2
Maximum	10.5	9.9	35.0	10.5	0.0
Minimum	1.8	0.3	0.0	2.5	0.7
Range	8.8	9.6	35.0	8.1	-0.7

AVERAGE MONTHLY DISPOSITIONS PER 1,000 MTF ENROLLEES, FYs 2020–2023



Source: MHS administrative data (MDR); DHA/HCO/Health Care Optimization Division, 12/8/2023

Notes:

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

– Private sector care claims may take up to a year to be finalized and are not complete for FY 2023.

– Numbers may not sum due to rounding.

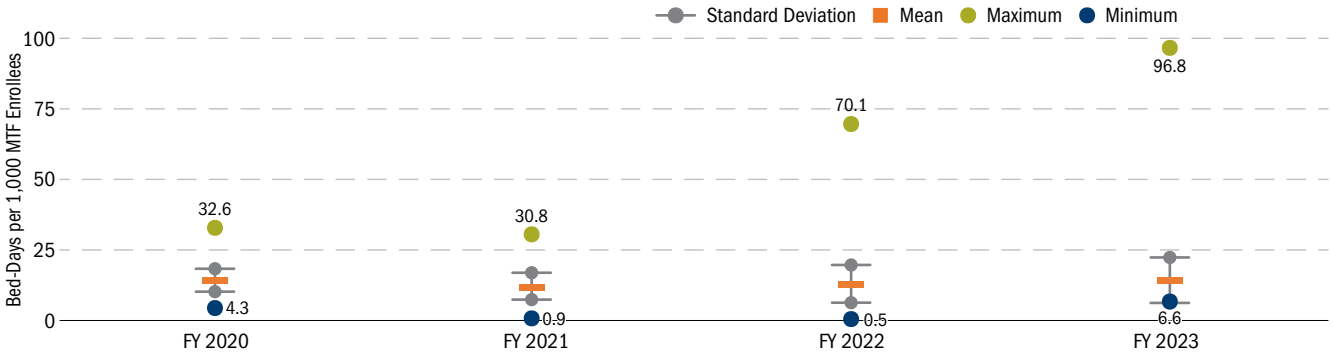
ACCESS TO MHS CARE *(CONT.)*

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

AVERAGE MONTHLY BED-DAYS PER 1,000 MTF ENROLLEES, FYs 2020–2023

	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020–FY 2023 CHANGE
Mean	14.2	12.0	13.0	14.3	0.2
Standard Deviation	4.0	4.9	6.8	0.7	-3.3
Median	13.5	12.3	12.5	13.2	-0.3
75th Percentile	15.7	14.7	15.4	15.5	-0.2
25th Percentile	12.1	9.6	10.2	11.5	-0.5
Maximum	32.6	30.8	70.1	96.8	64.2
Minimum	4.3	0.9	0.5	6.6	2.2
Range	28.3	29.9	69.6	90.2	61.9

AVERAGE MONTHLY BED-DAYS PER 1,000 MTF ENROLLEES, FYs 2020–2023



Source: MHS administrative data (MDR); DHA/HCO/Health Care Optimization Division, 12/8/2023

Notes:

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

– Private sector care claims may take up to a year to be finalized and are not complete for FY 2023.

– 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 decreased from 17.1 visits per 100 enrollees in FY 2022 to 10.8 visits per 100 enrollees in FY 2023. ED visits for primary care reasons are a small percentage of all ED visits and are defined by the Tri-Service Emergency Medicine consultants and industry as evaluation and management codes 99281 and 99282. The rate of network ED visits for primary care reasons decreased from 0.7 to 0.3 visits per 100 enrollees in FY 2023. MTF efforts to reduce ED visits include better access to 24-hour care in PCMH, walk-in clinics for common acute conditions, PCMH team-based care to meet patients' needs, the NAL, and secure messaging.

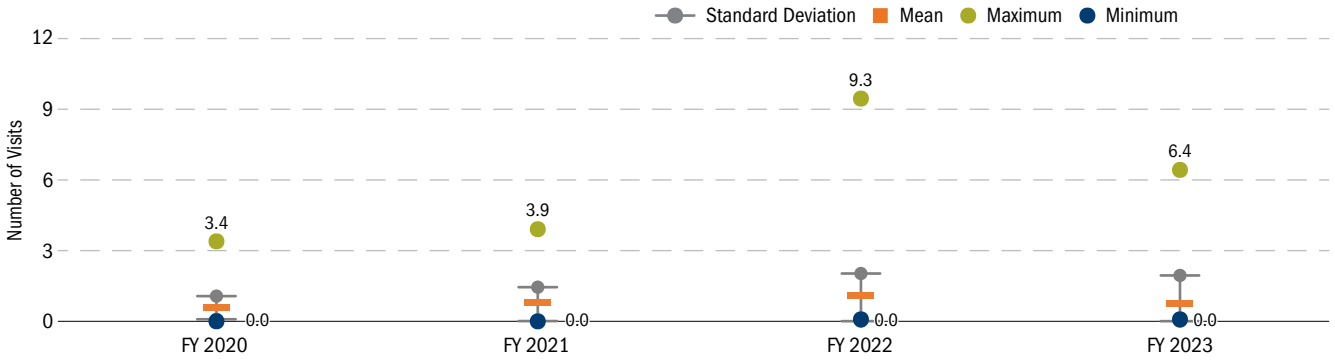
AVERAGE NETWORK ED VISITS PER 100 MTF ENROLLEES, FYs 2020–2023

	AVERAGE NETWORK ED VISITS PER 100 MTF ENROLLEES (INCLUDING TRUE EMERGENCIES)	AVERAGE NETWORK ED VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS
FY 2020	16.5	0.5
FY 2021	11.1	0.4
FY 2022	17.1	0.7
FY 2023	10.8	0.3

NETWORK ED VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS, FYs 2020–2023

	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020–FY 2023 CHANGE
Mean	0.6	0.6	0.9	0.8	0.2
Standard Deviation	0.6	0.7	1.2	0.8	0.2
Median	0.5	0.4	0.6	0.6	0.1
75th Percentile	0.8	0.8	1.1	1.0	0.2
25th Percentile	0.3	0.2	0.3	0.3	0.1
Maximum	3.4	3.9	9.3	6.4	3.1
Minimum	0.0	0.0	0.0	0.0	0.0
Range	3.4	3.9	9.3	6.4	3.1

NETWORK ED VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS, FYs 2020–2023



Source: MHS administrative data (MDR); DHA/HCO/Health Care Optimization Division, 12/8/2023

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

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 2023 compared with previous years, timed with the change to allow unlimited network UC visits. The most common reason why beneficiaries went to network UCs in FY 2023 was for respiratory illnesses and other infections. In FY 2024, the DHA will continue to promote MTF services and encourage MTFs to be conducive to patient schedules.

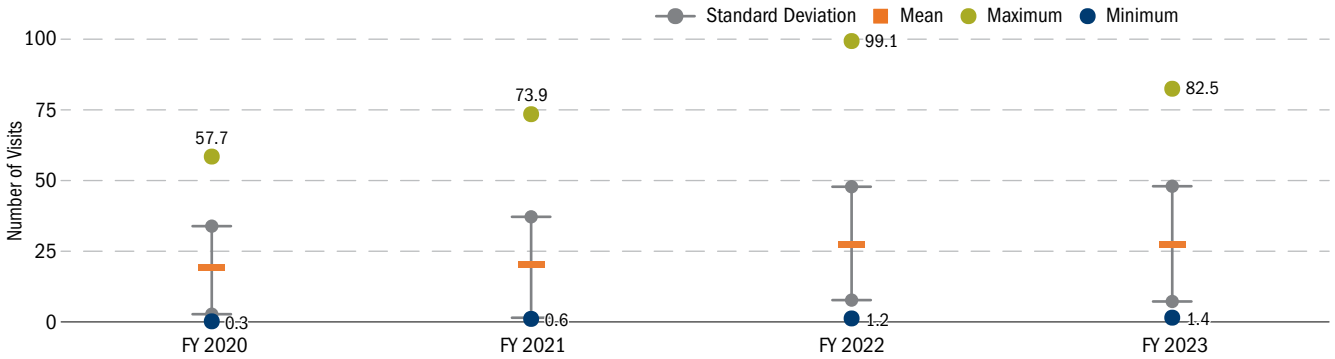
AVERAGE NETWORK UC VISITS PER 100 MTF ENROLLEES, FYs 2020–2023

	AVERAGE NETWORK UC VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS
FY 2020	18.4
FY 2021	15.1
FY 2022	29.1
FY 2023	30.6

NETWORK UC VISITS PER 100 MTF ENROLLEES, FYs 2020–2023

	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020–FY 2023 CHANGE
Mean	19.0	20.3	27.8	27.4	8.4
Standard Deviation	15.6	17.8	20.4	20.8	5.2
Median	17.0	16.6	25.1	28.3	11.3
75th Percentile	30.1	29.2	40.7	43.5	13.4
25th Percentile	3.4	4.9	9.0	5.1	1.6
Maximum	57.7	73.9	99.1	82.5	24.7
Minimum	0.3	0.6	1.2	1.4	1.1
Range	57.4	73.4	97.9	81.0	23.6

NETWORK UC VISITS PER 100 MTF ENROLLEES, FYs 2020–2023



Source: MHS administrative data (MDR); DHA/HCO/Health Care Optimization Division, 12/8/2023

Notes:

– Parent facility scores were used to describe variability in the results above.
– Months with fewer than 50 enrollees for a given parent facility were removed from the analysis.
– Numbers may not sum due to rounding.

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

TOL Secure Messaging

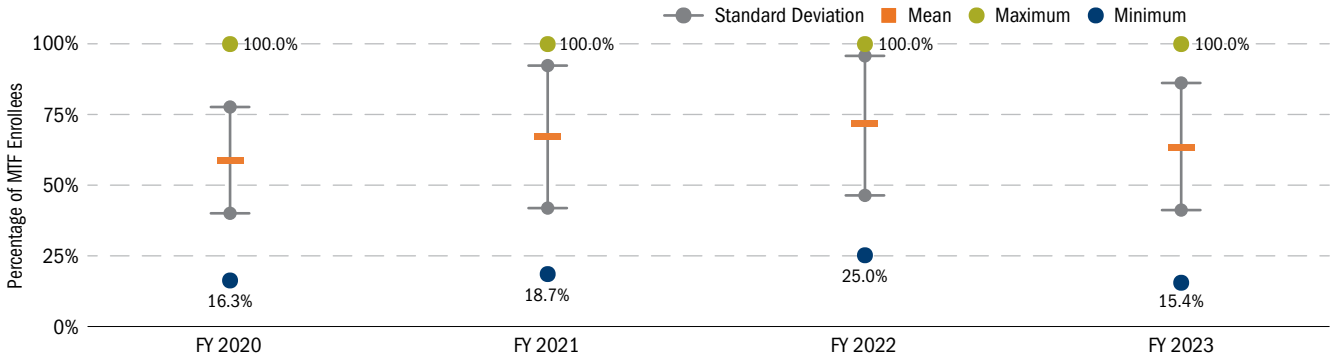
Percentage of Enrollees Registered to Use TOL Secure Messaging: The direct care system offers enhanced access to care using a commercially available secure messaging system. TOL Secure Messaging allows MTF enrollees to communicate directly with their PCMs and care teams to ask questions about their health or medical tests and to arrange referrals or appointments. The MHS prioritized enrollment in secure messaging starting in FY 2017. In FYs 2020 and 2021, secure messaging was particularly important to maintain communication between the provider and patient while preventing the spread of COVID-19. The proportion of beneficiaries registered to use secure messaging at parent facilities has increased from FY 2020 to FY 2023, with an average with an average of 64 percent of beneficiaries registered to use secure messaging for FY 2023. Analysis of the primary reasons that patients initiate messages for FY 2023 include: messaging a provider (68 percent), referrals (10 percent), renewing a prescription (9 percent), and message to office (6 percent). Use of broadcast messaging as a way to keep beneficiaries informed (especially helpful in informing beneficiaries of upcoming transition to MHS GENESIS) decreased from 6.59 million broadcast/blast messages sent in FY 2022 to 1.71 million for FY 2023—a decrease of 4.88 million messages. Most sites/MTFs had transitioned to MHS GENESIS in FY 2023 and no longer had access to or used TOL Secure Messaging. Broadcast messaging allows clinic administrators to send a mass message to all online secure messaging patients or to a select group based on clinic population. Broadcast messaging is also used to inform patient populations on COVID-19 booster/flu vaccination information as well as provide information for upcoming MHS GENESIS deployments. While MHS GENESIS completed over 90 percent deployment throughout the MHS in 2023, the DHA saw a strong return on investment through continued patient usage of the TOL patient portal consisting of secure messaging and TRICARE Online application, proportionately commensurate with sites awaiting transition.

Percentage of Patient-Initiated TOL Secure Messages Responded to within One Business Day: To improve the patient experience, satisfaction with secure messaging, and the likelihood of patients to use secure messaging again to meet health care needs in the future, the MHS also prioritized responding to secure messages within one business day. For FY 2023, the number of patient-initiated messages responded to within one business day decreased to 70.9 percent.

PERCENTAGE OF MTF ENROLLEES REGISTERED TO USE SECURE MESSAGING, FYs 2020–2023

	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020–FY 2023 % POINT CHANGE
Mean	58.9%	67.2%	71.3%	63.6%	4.7
Standard Deviation	18.8%	25.2%	25.0%	22.6%	3.8
Median	56.6%	64.3%	68.7%	66.4%	9.8
75th Percentile	70.4%	80.3%	89.0%	79.6%	9.2
25th Percentile	46.4%	51.2%	54.1%	45.3%	-1.1
Maximum	100.0%	100.0%	100.0%	100.0%	0.0
Minimum	16.3%	18.7%	25.0%	15.4%	-0.9
Range	83.7%	81.3%	75.0%	84.6%	0.9

PERCENTAGE OF MTF ENROLLEES REGISTERED TO USE SECURE MESSAGING, FYs 2020–2023



Source: MHS administrative data; DHA/HCO/Health Care Optimization Division, 12/8/2023

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.

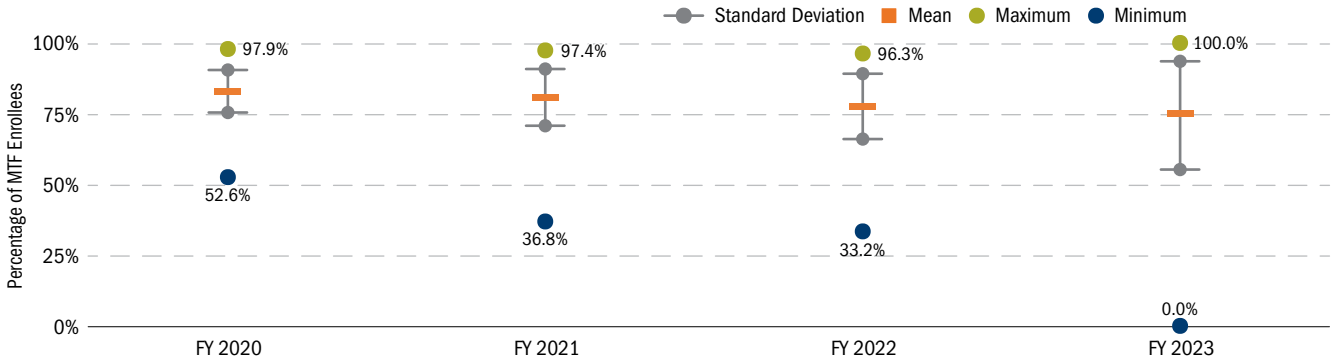
ACCESS TO MHS CARE *(CONT.)*

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

PERCENTAGE OF SECURE MESSAGES RESPONDED TO WITHIN ONE BUSINESS DAY, FYs 2020–2023

	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020–FY 2023 % POINT CHANGE
Mean	83.3%	81.0%	77.7%	74.9%	-8.4
Standard Deviation	7.4%	9.9%	11.6%	19.0%	11.6
Median	84.2%	83.0%	79.3%	79.4%	-4.8
75th Percentile	87.5%	87.7%	85.5%	86.7%	-0.8
25th Percentile	79.9%	77.2%	74.2%	70.2%	-9.7
Maximum	97.9%	97.4%	96.3%	100.0%	2.1
Minimum	52.6%	36.8%	33.2%	0.0%	-52.6
Range	45.3%	60.6%	63.1%	100.0%	54.7

PERCENTAGE OF SECURE MESSAGES RESPONDED TO WITHIN ONE BUSINESS DAY, FYs 2020–2023



Source: MHS administrative data; DHA/HCO/Health Care Optimization Division, 12/8/2023

Notes:

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

Nurse Advice Line (NAL)

The MHS NAL continues to provide valuable, quality, and convenient nurse triage and care coordination services to our MHS beneficiaries 24 hours a day, seven days a week, directing over 610,000 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 1,700 calls per day, with the overall call volume less than twelve percent lower than FY 2022. Total call volume remains 17 percent higher than pre-COVID-19 levels.

The NAL falls under the DHA Health Care Optimization Program organizationally and is fully integrated with the MTF PCMH primary care clinics to support enhanced access strategies. MTF enrollees make up 84 percent of all NAL calls. If the RN determines that the beneficiary needs to be seen within 24 hours, the NAL staff can search the NAL Management System for MTF walk-in capabilities, schedule MTF PCMH appointments, warm transfer the beneficiary directly to his or her PCMH via telephone, provide information about MTF UC and ED Fast Track options, and/or generate civilian UC referrals in the EHR for Active Duty personnel. PCMH teams have access to NAL encounter information through the NAL Management System; teams use NAL data to conduct appropriate follow-up with their patients and coordinate care, if clinically indicated. The NAL Management System also includes performance data, which allow PCMH teams to monitor utilization and adjust future appointing templates to accommodate changes in demand.

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

The percentage of NAL callers who intended to seek care in a network ED was significantly reduced by 78 percent. Fifteen percent of the callers did not seek follow-on care and instead used self-care advice provided by the nurse. Patient satisfaction with the NAL remains above 91 percent, based on responses from a sample of beneficiaries who were surveyed by the DHA following their call.

NAL CALLER INFORMATION FOR MTF ENROLLEES, FY 2023

NAL DISPOSITION	CALLER'S PRE-INTENT	NURSE ADVICE	CALLER'S AGREEMENT WITH NURSE RECOMMENDATION
Network ED	35%	13%	97%
Network UC	22%	25%	97%
MTF Care	22%	38%	98%
Self-Care	21%	15%	99%
General Health and Other Miscellaneous Questions	0%	9%	99%
Total	100%	100%	

Source: NAL Program and administrative data (NAL Management System): DHA/HCO/Health Care Optimization Division, 12/13/2023

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

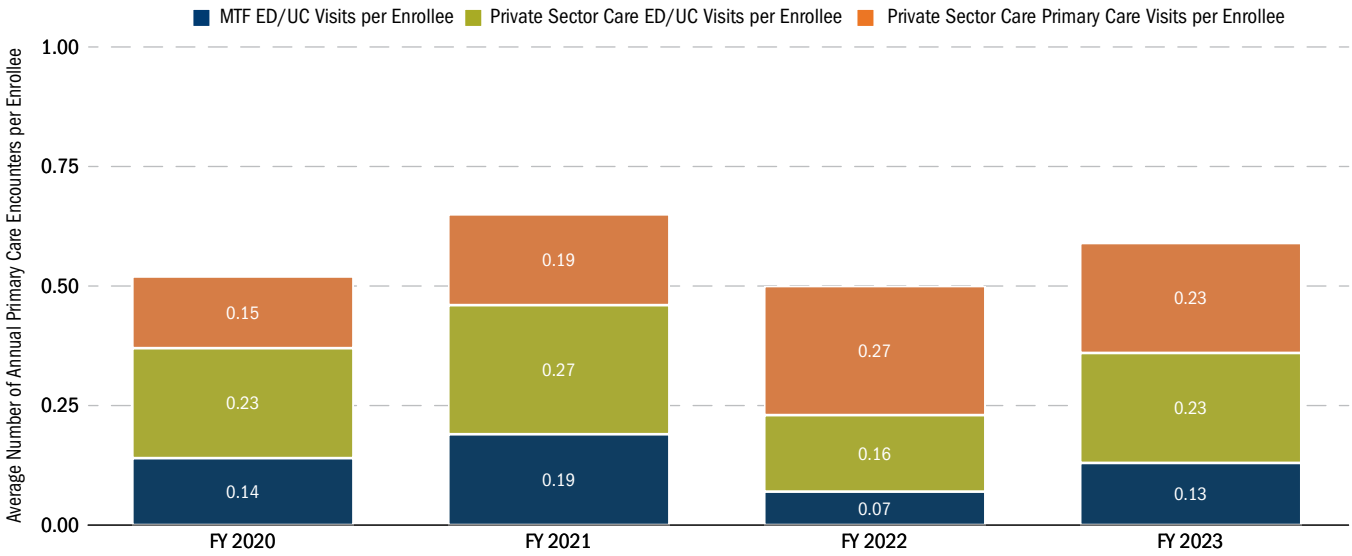
In FY 2023, primary care utilization was 3.15 visits per enrollee. In FY 2021, network ED and UC rates increased disproportionately to care provided by the MTF, resulting in the lowest direct care market share since the primary care leakage to the network metric began. Primary care leakage to the network is 11.3 percent for FY 2023, with additional private sector care claims expected to be processed for FY 2023.

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 2024, 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 2019–2023

	PCMH IN-PERSON VISITS 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 2019	2.32	0.15	0.25	0.16	3.51	84.0%	11.7%
FY 2020	2.05	0.14	0.23	0.15	3.28	84.0%	11.8%
FY 2021	2.20	0.19	0.27	0.19	3.59	82.0%	12.6%
FY 2022		0.07	0.16	0.27	2.11	83.1%	11.3%
FY 2023		0.13	0.23	0.23	3.15	82.5%	11.3%

AVERAGE NUMBER OF ANNUAL PRIMARY CARE ENCOUNTERS PER ENROLLEE, FYs 2020–2023



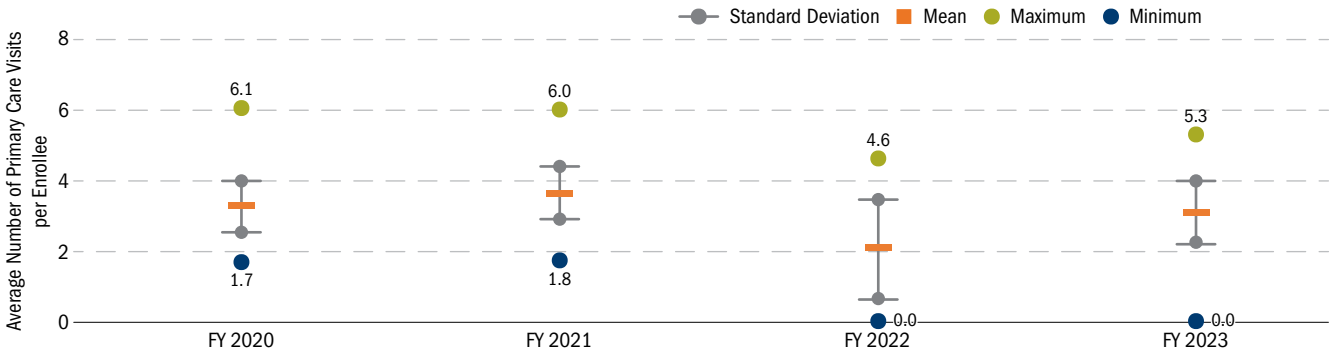
Source: MHS administrative data; DHA/HCO/Health Care Optimization Division, 12/8/2023
Notes:
– Data exclude MHS GENESIS sites, and only include Prime, Plus, and Reliant enrollments.
– FY 2022 data exclude August and September 2022.
– Private sector care data may not be complete for up to one year due to claims processing.
– PCMH In-Person Visits per Enrollee data unavailable after FY 2021.

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 2020–2023

	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020–FY 2023 CHANGE
Mean	3.3	3.7	2.1	3.1	–0.2
Standard Deviation	0.7	0.8	1.4	0.9	0.1
Median	3.1	3.5	2.5	3.2	0.1
75th Percentile	3.8	4.3	3.3	3.6	–0.2
25th Percentile	2.8	3.2	0.3	2.8	0.0
Maximum	6.1	6.0	4.6	5.3	–0.8
Minimum	1.7	1.8	0.0	0.0	–1.7
Range	4.4	4.3	4.6	5.3	0.9

AVERAGE NUMBER OF ANNUAL MTF ENROLLEE VISITS FOR PRIMARY CARE OVERALL, FYs 2020–2023



Source: MHS administrative data; DHA/HCO/Health Care Optimization Division, 12/8/2023

Notes:

– Parent facility scores were used to describe variability in the results above.
– Results exclude MHS GENESIS sites, and only include Prime, Plus, and Reliant enrollments.
– Private sector care data may take up to a year to be finalized and are not complete for FY 2023.
– Numbers may not sum due to rounding.

Improvement Tools

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

Template Optimization Tool

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

Build or Buy Tool on CarePoint

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

Specialty Care Access

In FY 2023, the MHS continued monitoring specialty care performance for several reasons: most private sector care costs for MTF enrollees are due to specialty referrals to private sector care; patient feedback indicated dissatisfaction with the decentralized specialty care processes and variance among MTFs; and capturing specialty care workload delivered in the MTF enhances clinical currency and a ready medical force, which includes both providers and clinical support staff. The MHS codified specialty care standards in the DHA-IPM 18-001 (February 2020) 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 identified standard MTF and Market processes to improve both measures.

Percentage of Referrals Dispositioned within One Business Day

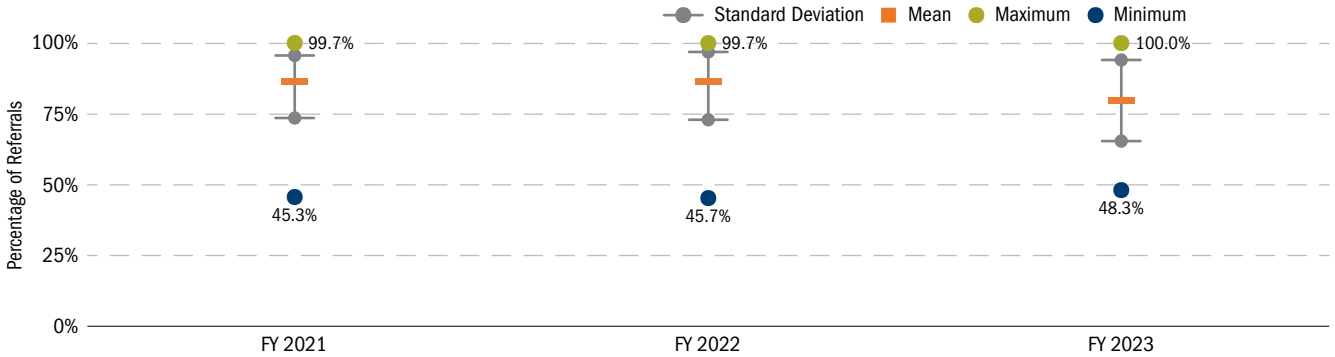
To "disposition" a referral is to determine whether the patient will be seen at the MTF, in the Network, or if no appointment is required. Survey and qualitative data demonstrate a longer wait to obtain a scheduled appointment is a source of patient dissatisfaction and also delays needed care. DHA-IPM 18-001 identified standard processes to centralize referral review and appointing at the MTF or Market level compared with 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 2023, an average of 80 percent of referrals were dispositioned within one business day, which is lower than FY 2022 rates. The MHS has a standard of 90 percent of referrals being dispositioned within one business day. As the MHS is continuing to monitor performance with this metric, performance is expected to improve to meet the standard in FY 2024.

PERCENTAGE OF REFERRALS DISPOSITIONED WITHIN ONE BUSINESS DAY, FYs 2021–2023

	FY 2021	FY 2022	FY 2023	FY 2021–FY 2023 PERCENTAGE CHANGE
Mean	85.5%	85.7%	80.0%	-6.4%
Standard Deviation	11.2%	11.6%	14.2%	27.0%
Median	86.9%	88.0%	84.2%	-3.1%
75th Percentile	94.6%	94.7%	91.2%	-3.6%
25th Percentile	81.5%	80.3%	66.4%	-18.5%
Maximum	99.7%	99.7%	100.0%	0.3%
Minimum	45.3%	45.7%	48.3%	6.5%
Range	54.4%	54.1%	51.7%	-4.9%

PERCENTAGE OF REFERRALS DISPOSITIONED WITHIN ONE BUSINESS DAY, FYs 2021–2023



Source: MHS Administrative Data; DHA/HCO/Health Care Optimization Division, 12/8/2023

Notes:

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

ACCESS TO MHS CARE *(CONT.)*

Specialty Care Access *(cont.)*

Average Number of Days from Booking to Appointment

The average number of days from booking to appointment measures how long the patient waits for a scheduled appointment from the time the appointment was scheduled for appointments requiring referrals. DHA-IPM 18-001 identified standard processes and specialty provider productivity requirements in order to increase the number of available specialty care appointments, standardize appointment templates, and optimize direct care system specialty care capacity.

The goal is for beneficiaries to have a specialty care appointment within 15 days of being scheduled for the appointment. Many MTFs met this goal in FY 2023, but as an enterprise, beneficiaries waited 18.2 days on average for a specialty care appointment requiring a referral. This is expected to be associated with the return to post-pandemic demand as well as staffing challenges in certain specialties, limiting provider availability. With improved referral processes and appointing expected with the new MHS GENESIS rollout and enforced DHA policy, performance is expected to improve in FY 2024.

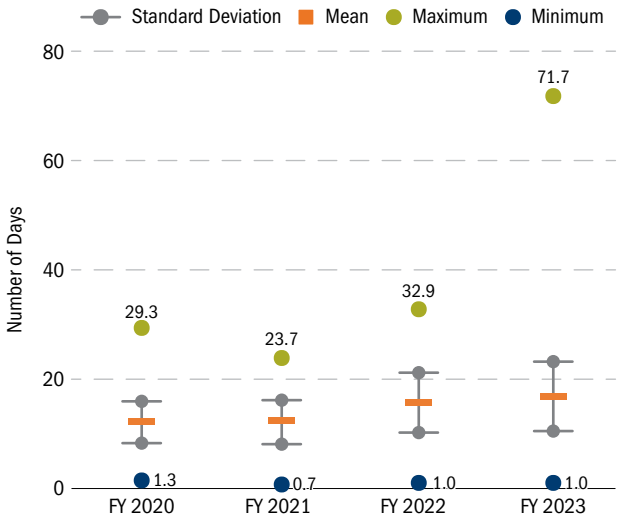
AVERAGE NUMBER OF DAYS FROM MTF BOOKED TO MTF APPOINTMENT, FYs 2020–2023

	FY 2020	FY 2021	FY 2022	FY 2023
Days from MTF Booked to MTF Appt.	14.2	15.8	17.1	18.2

AVERAGE NUMBER OF DAYS FROM MTF BOOKED TO MTF APPOINTMENT, FYs 2020–2023

	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020–FY 2023 CHANGE
Mean	12.1	12.2	15.7	16.9	4.8
Standard Deviation	3.7	4.1	5.4	6.4	2.7
Median	12.0	12.1	15.8	16.5	4.5
75th Percentile	14.1	14.5	18.9	19.4	5.3
25th Percentile	10.1	9.4	12.1	13.7	3.6
Maximum	29.3	23.7	32.9	71.7	42.4
Minimum	1.3	0.7	1.0	1.0	-0.3
Range	28.1	23.1	31.9	70.7	42.6

AVERAGE NUMBER OF DAYS FROM MTF BOOKED TO MTF APPOINTMENT, FYs 2020–2023



Source: MHS administrative data (MDR); DHA/HCO/Health Care Optimization Division, 12/7/2023

Notes:

– Parent facility scores were used to describe variability in the results above.
– Data exclude MHS GENESIS sites prior to FY 2023
– FY 2020 results exclude August–September 2020.
– FY 2021 results exclude September 2021.
– FY 2022 results exclude August–September 2022.
– Results include referrals filled up to seven months after referral issuance.

Specialty Care Ambulatory Leakage

In FY 2023, the MHS had elevated specialty care leakage above previous years at 37.3 percent. The MHS goal is to reduce this leakage to 10.7 percent. The increase in the percentage is in part due to post-pandemic demand increases, also reflected in the increase in the average days to booking for specialty care within the direct care system, as well as methodology changes that began including provider specialties not previously measured. In FY 2024, 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 2016–2023

	ANNUAL AVERAGE
FY 2016	13.1%
FY 2017	13.5%
FY 2018	13.4%
FY 2019	13.7%
FY 2020	14.7%
FY 2021	15.7%
FY 2022	27.3%
FY 2023	37.3%

Source: MHS administrative data; DHA/HCO/Health Care Optimization Division, 12/8/2023

Note: Between FY 2021 and FY 2022, the methodology for this metric changed, resulting in different inclusion criteria and an uptick in Specialty Care Leakage, which continued through FY 2023.

ACCESS TO MHS CARE *(CONT.)*

Virtual Health (VH)

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

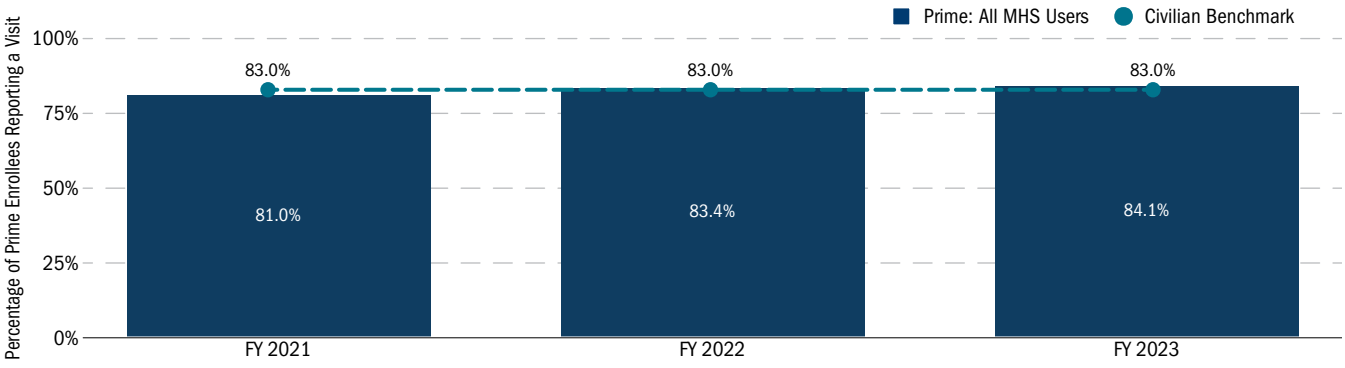
The 2018 MHS VH strategic plan was the initial effort to combine military department (MILDEP) and DHA VH efforts into a coordinated global MHS VH strategy. With the transition of all MTFs and Markets to DHA's authority, DHA's oversight of all VH capabilities and the Virtual Medical Center construct is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

Measures of Availability and Ease of Access

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

- **Self-Reported Access:** The ability to see a doctor reflects one measure of successful access to the health care system. Prime enrollees were asked whether they had at least one outpatient visit during the past year. As shown in the graph, access to and use of outpatient services increased among Prime enrollees (with either a military or civilian PCM), with 84 percent reporting at least one visit in FY 2023, compared with 83 percent in FY 2022. 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 under age 65 had at least one primary care encounter in FY 2023.

TRENDS IN PRIME ENROLLEES HAVING AT LEAST ONE OUTPATIENT VISIT DURING THE YEAR, FYs 2021–2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, Health Care Survey of DoD Beneficiaries (HCSDB) data, adjusted for age and health status, as of 12/8/2023

Notes:

– All MHS Users applies to survey respondents in the 50 United States and the District of Columbia. Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the National Committee for Quality Assurance (NCQA) by commercial plans.

– Benchmarks come from NCQA's 2019 data.

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 2023 marks the seventh complete year that the Joint Outpatient Experience Survey (JOES) has been fielded to replace the Army Provider Level Satisfaction Survey (APLSS), the Navy Patient Satisfaction Survey (PSS), and the Air Force Service Delivery Assessment (SDA).

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

Approximately 306,000 JOES/JOES-C were returned during FY 2023 (241,000 JOES and 65,000 JOES-C), providing targeted areas for improvement in outpatient care for MHS beneficiaries.

The JOES and JOES-C have improved in efficiency and representation, demonstrated through the collection of web-based surveys by Active Duty Service members (ADSMs) in FY 2019 in response to e-mailed invitations. In FY 2020, a pilot program began to send the JOES via text message to beneficiaries at select MTFs and continued to expand to additional MTFs in 2023. 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. In FY 2023, the Tricare Online Portal provided a means for patients to provide direct consent to receive short message service (SMS) surveys. This new consent process resulted in a large increase in SMS surveys.

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, which allows users to examine the quality of care across the MHS. Some of these measures are routinely reported to senior MHS leadership as core measures on various dashboards and are reported publicly on the transparency website of www.health.mil.

Results from the MHS population survey, the HCSDB, are also included in the findings reported here, where appropriate, as a comparison against outpatient surveys that are administered following receipt of care. The HCSDB, based on the CAHPS Health Plan Survey, is administered quarterly to a sample of the eligible MHS population, irrespective of where they might have received care, and uses a 12-month recall period for most questions (i.e., "In the last 12 months..."). Both the HCSDB and CAHPS Health Plan Surveys focus on the performance of the health plan over time from the beneficiary's perspective. The JOES-C is focused on health care received over the past six months following a specific outpatient visit, while the JOES pertains solely to a specifically referenced visit. The comparison of these surveys provides a more comprehensive understanding of the experiences of beneficiaries, regardless of the survey that they are completing or the care that they may or may not have received.

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

Privacy of Adolescents

In support of state and federal statutes, the MHS respects and upholds the privacy rights of adolescents to protect teen confidentiality for specific services—particularly with respect to reproductive and sexual health, MH, 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) Adult, JOES-C, or HCSDB. The TRISS Child provides for the surveying of the parent/guardian of minor children who have received care at MHS facilities. 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[1,2]

The Privacy Rule allows a parent to have access to protected health information (PHI) about his or her child as the minor child's personal representative when such access is not inconsistent with state or other law. Exceptions to the Privacy Rule apply when the parent, guardian, or person acting as the parent may not be a personal representative of the minor. In such situations, the minor has the authority to act as "the individual" in regards to his or her PHI. A minor is considered "the individual" who can exercise rights under the rule in one of three circumstances[2]:

1. The minor provides informed consent to a health care service; no other informed consent to such health care service is required by law, regardless of whether the informed consent of another person has also been obtained; and the minor has not requested that such person be treated as the personal representative.
2. The minor may lawfully obtain such health care service without the consent of a parent, guardian, or other person acting in the place of a parent assents to an agreement of confidentiality between a covered health care provider and the minor with respect to such health care service.
3. A parent, guardian, or other person acting in the place of a parent assents to an agreement of confidentiality between the covered health care provider and the minor with respect to such health care service.

[1] Adapted from https://www.hhs.gov/hipaa/for-professionals/faq/227/can-i-access-medical-record-if-i-have-power-of-attorney/index.html.
[2] Adapted from DoD Manual (DoDM) 6025.18, "Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs," March 13, 2019.

ACCESS TO MHS CARE *(CONT.)*

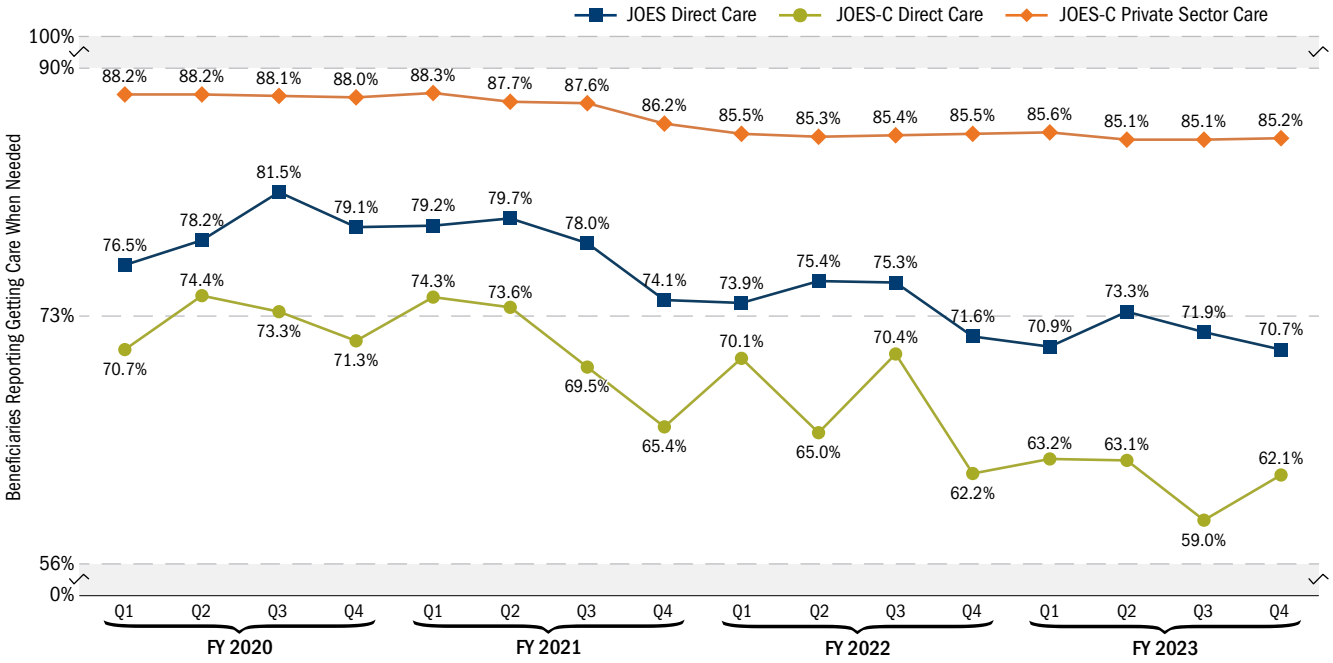
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care

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 (TRISS, JOES, JOES-C, HCSDB) since FY 2012. This question allows a patient to provide feedback on his or her ability to access care after care has been received.

- JOES-C private sector care scores for Getting Care When Needed have been above JOES-C direct care and JOES direct care for the last four years. JOES-C private sector care scores for Getting Care When Needed have been relatively unchanged from FY 2022 to FY 2023, at about 85 percent.
- JOES direct care scores for Getting Care When Needed have declined since FY 2021, from 79.2 percent in FY 2021 Q1 to 70.7 percent in FY 2023 Q4.
- JOES-C direct care scores for Getting Care When Needed remained below JOES direct care scores for the past four years. In FY 2023, scores ranged from 59.0 to 63.2 percent by quarter.

JOES AND JOES-C GETTING CARE WHEN NEEDED, FYs 2020–2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, JOES, weighted data, compiled 12/8/2023

Notes:

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

– FY 2023 is from October 2022 to August 2023 for JOES-C direct care and from October 2022 to July 2023 for JOES-C private sector care.

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

Extent of Change in Variability in Patient Ratings over Time

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

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

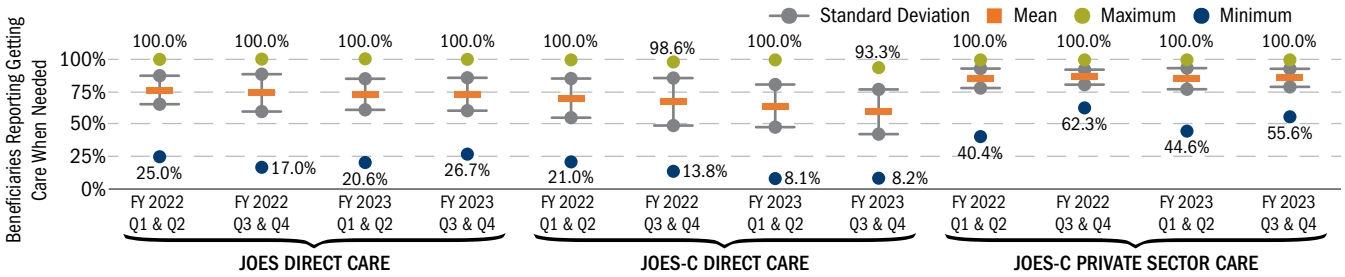
The table below displays the extent to which the measure of Getting Care When Needed changed over time in terms of improvement (increasing mean or median) or decreased dispersion (reduced range or standard deviation).

- From FY 2022 Q1 & Q2 to FY 2023 Q3 & Q4, the mean scores for Getting Care When Needed decreased by 3.4 percentage points for JOES direct care and 10.1 percentage points for JOES-C direct care.
- JOES-C private sector care increased by 0.6 percentage points over the same time period for Getting Care When Needed.

VARIABILITY IN JOES GETTING CARE WHEN NEEDED, FYs 2022–2023

	FY 2022 Q1 & Q2	FY 2022 Q3 & Q4	FY 2023 Q1 & Q2	FY 2023 Q3 & Q4	% POINT CHANGE (FY 2022 Q1 & Q2 TO FY 2023 Q3 & Q4)
JOES DIRECT CARE					
Number of Respondents	148,334	93,545	128,693	137,406	
Service Score (Mean)	76.1%	73.9%	73.0%	72.7%	-3.4
Standard Deviation	11.3%	14.4%	12.3%	12.6%	1.3
Median	76.8%	75.5%	73.2%	73.1%	-3.7
75th Percentile	82.7%	83.4%	81.6%	80.8%	1.9
25th Percentile	69.7%	66.8%	65.5%	65.9%	-3.8
Maximum	100.0%	100.0%	100.0%	100.0%	0.0
Minimum	25.0%	17.0%	20.6%	26.7%	1.7
Range	75.0%	83.0%	79.4%	73.3%	-1.7
JOES-C DIRECT CARE					
Number of Respondents	6,578	6,383	6,989	4,207	
Service Score (Mean)	69.5%	67.1%	63.5%	59.4%	-10.1
Standard Deviation	15.0%	18.6%	16.3%	17.3%	2.3
Median	71.4%	70.8%	64.3%	60.9%	-10.5
75th Percentile	78.3%	78.6%	74.7%	73.1%	-5.2
25th Percentile	61.9%	55.8%	53.8%	49.4%	-12.5
Maximum	100.0%	98.6%	100.0%	93.3%	-6.7
Minimum	21.0%	13.8%	8.1%	8.2%	-12.8
Range	79.0%	84.8%	91.9%	85.1%	6.1
JOES-C PRIVATE SECTOR CARE					
Number of Respondents	28,313	27,407	27,060	18,397	
Service Score (Mean)	84.9%	86.2%	84.9%	85.5%	0.6
Standard Deviation	7.4%	5.7%	8.0%	6.7%	-0.7
Median	86.2%	86.9%	86.0%	85.4%	-0.8
75th Percentile	89.2%	89.4%	89.4%	89.3%	0.1
25th Percentile	81.8%	83.6%	82.5%	81.7%	-0.1
Maximum	100.0%	100.0%	100.0%	100.0%	0.0
Minimum	40.4%	62.3%	44.6%	55.6%	15.2
Range	59.6%	37.7%	55.4%	44.4%	-15.2

VARIABILITY IN BENEFICIARY RATINGS: GETTING CARE WHEN NEEDED, FY 2022–2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, JOES, weighted data, compiled 12/8/2023

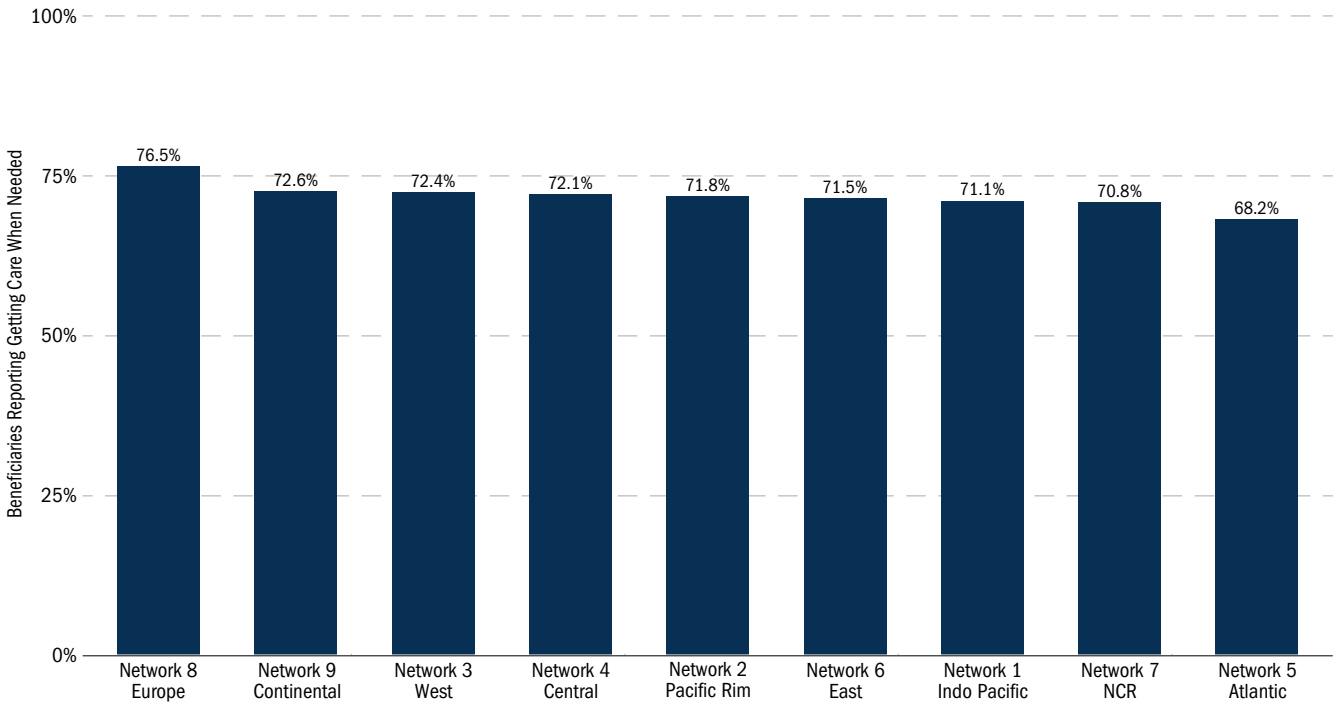
Note: FY 2023 is from October 2022 to August 2023 for JOES-C direct care and from October 2022 to July 2023 for JOES-C private sector care.

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

JOES Getting Care When Needed—By Networks

The chart below shows JOES scores for Getting Care When Needed for FY 2023 for the new Defense Health Networks (DHNs). Network 8–Europe was the highest scoring Network, with 76.5 percent of respondents indicating satisfaction with Getting Care When Needed. The lowest scoring Network for Getting Care When Needed in FY 2023 was Network 5–Atlantic at 68.2 percent satisfaction.

JOES GETTING CARE WHEN NEEDED BY NETWORK, FY 2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, JOES, weighted data, compiled 12/8/2023

Notes:

– NCR = National Capital Region

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

ACCESS TO MHS CARE *(CONT.)*

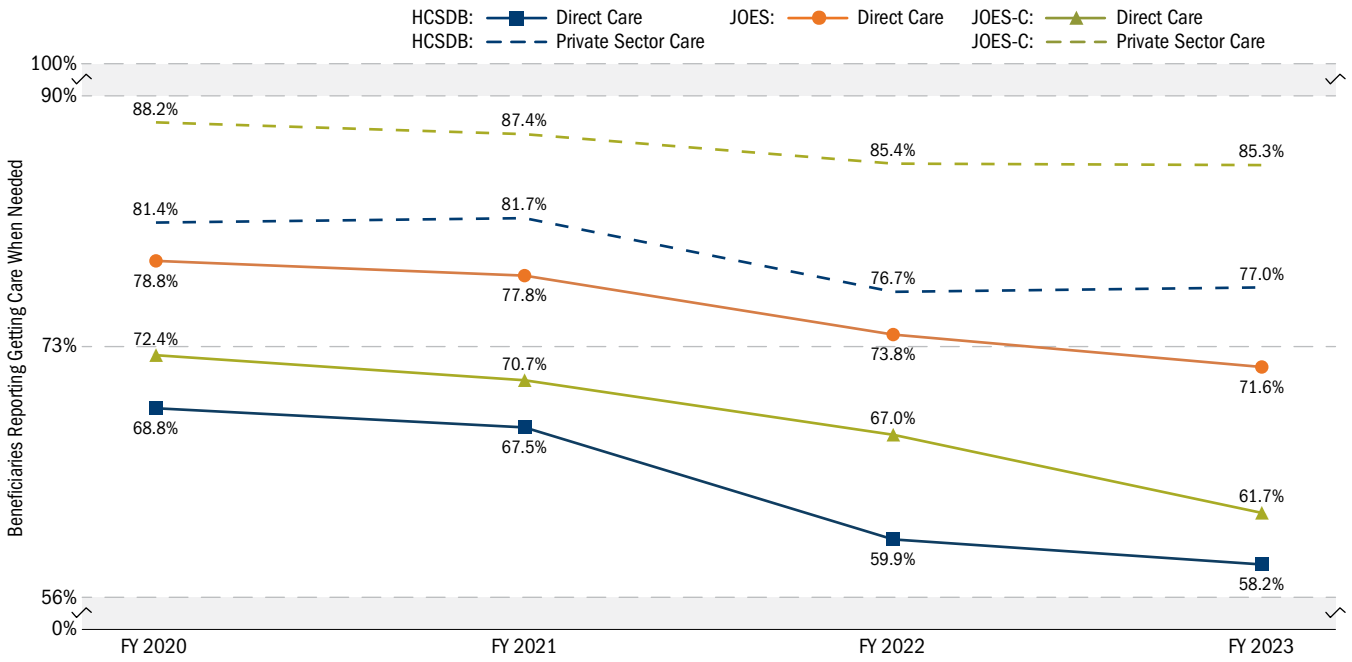
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care *(cont.)*

Comparison of Multiple Surveys—Getting Care When Needed

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

- Beneficiaries who utilize or are assigned to private sector care report greater access to their provider than those who utilize or are assigned to direct care, regardless of the time period or the survey. For JOES-C, scores for private sector care are 23.6 percentage points higher than those for direct care in FY 2023.
- Ratings of Getting Care When Needed have declined over time for all surveys from FY 2020 to FY 2023.
- Beneficiaries who completed JOES-C reported greater access to care than beneficiaries who completed HCSDB, over time, for direct care and private sector care, respectively. This may be because beneficiaries who complete JOES-C are beneficiaries who responded to a survey after having received care, while those who complete the HCSDB may not have received care or may not have received care as needed over the previous 12 months.

HCSDB, JOES, AND JOES-C RATINGS OF GETTING CARE WHEN NEEDED, FYs 2020–2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, HCSDB, JOES, and JOES-C, weighted data, compiled 12/8/2023

Notes:

– FY 2023 is from October 2022 to August 2023 for JOES-C direct care and from October 2022 to July 2023 for JOES-C private sector care.

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

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

ACCESS TO MHS CARE *(CONT.)*

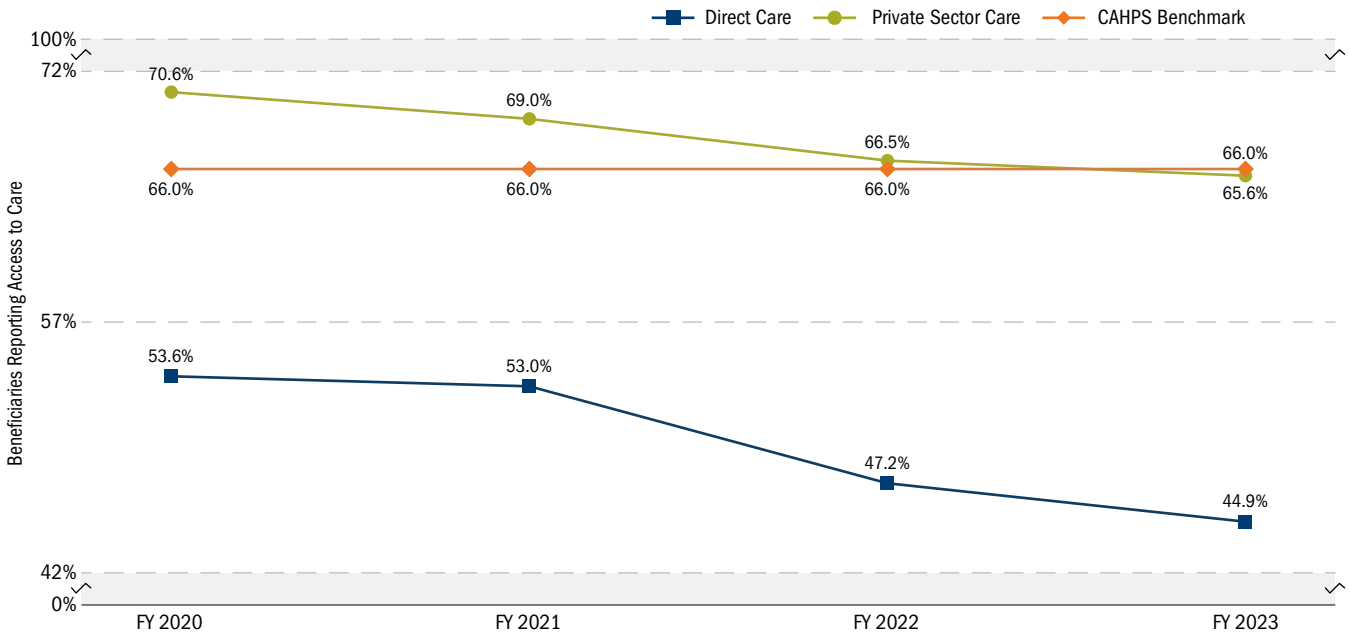
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care *(cont.)*

JOES-C Access to Care Composite

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

- The Access to Care composite ratings for beneficiaries receiving outpatient care at civilian facilities (private sector care) are higher than for those receiving care from MTFs (direct care).
- From FY 2020 through FY 2021, JOES-C Access to Care scores for private sector care were above the CAHPS benchmark by 3 to 4 percentage points. In 2022, the private sector score narrowed to half a percentage point above the benchmark and fell to just below the benchmark in 2023. In the same period, JOES-C direct care scores ranged from 12.4 to 21 percentage points below the CAHPS benchmark.

JOES-C ACCESS TO CARE COMPOSITE, FYs 2020–2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, JOES-C, weighted data, compiled 12/8/2023

Notes:

– FY 2023 is from October 2022 to August 2023 for JOES-C direct care and from October 2022 to July 2023 for JOES-C private sector care.

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

ACCESS TO MHS CARE *(CONT.)*

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

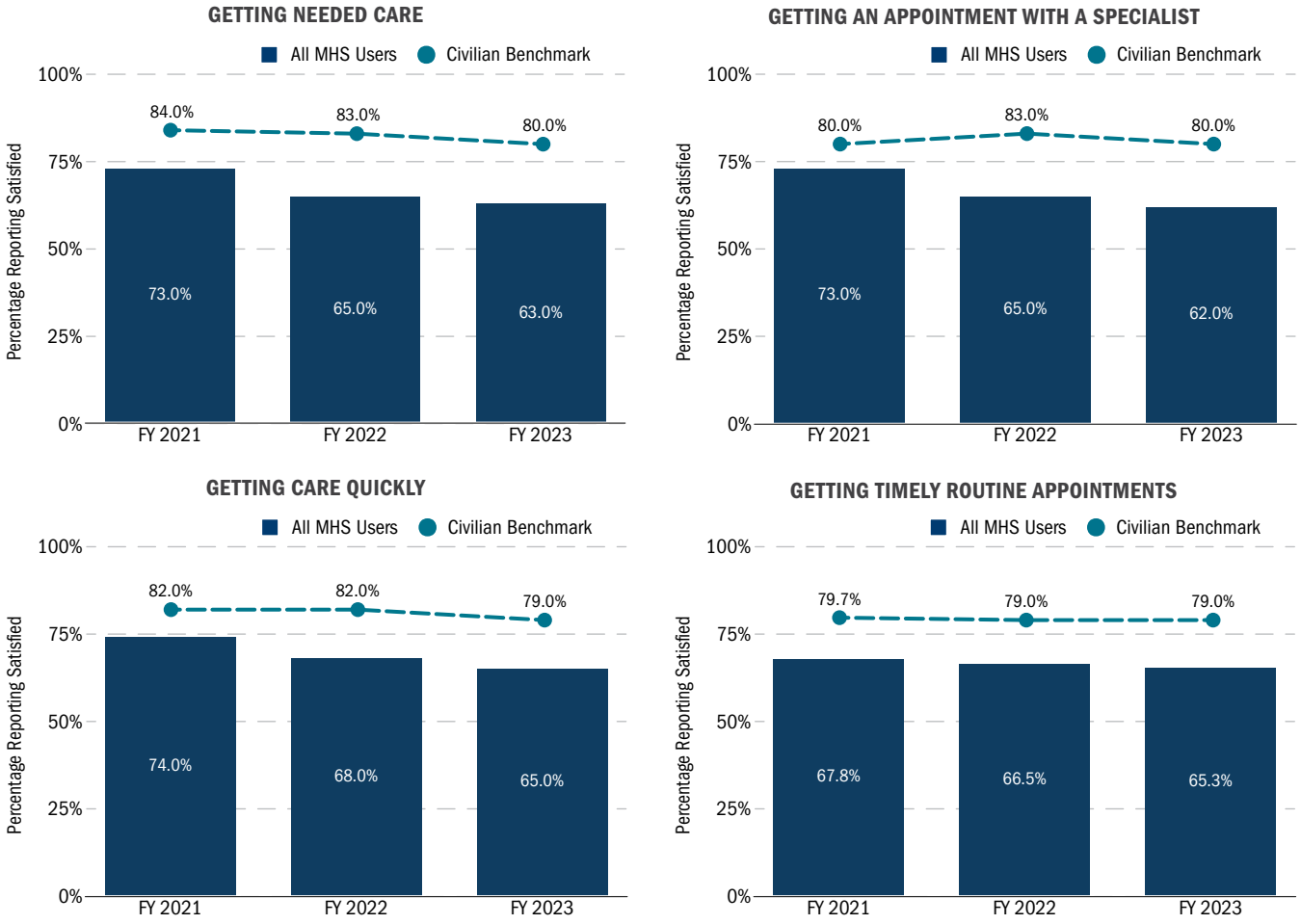
Instead of focusing on a specific health care event to assess patient experience with care, population surveys are designed to sample populations based on the demographics being considered (e.g., a survey of all ADSMs about their health behaviors, or a survey of all MHS beneficiaries to assess their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

Availability and Ease of Obtaining Care

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

- MHS beneficiary ratings for Getting Care Quickly, Getting Needed Care, Getting an Appointment with a Specialist, and Getting Timely Routine Appointments declined from FY 2021 to FY 2023.
- MHS beneficiary satisfaction with all four access measures was lower than the comparable civilian benchmarks in each year between FY 2021 and FY 2023.

TRENDS IN MEASURES OF ACCESS FOR ALL MHS BENEFICIARIES (ALL SOURCES OF CARE), FYs 2021–2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 12/7/2023

Notes:

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

– Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks come from NCQA's 2019 data.

CLINICAL QUALITY MANAGEMENT IN THE MHS

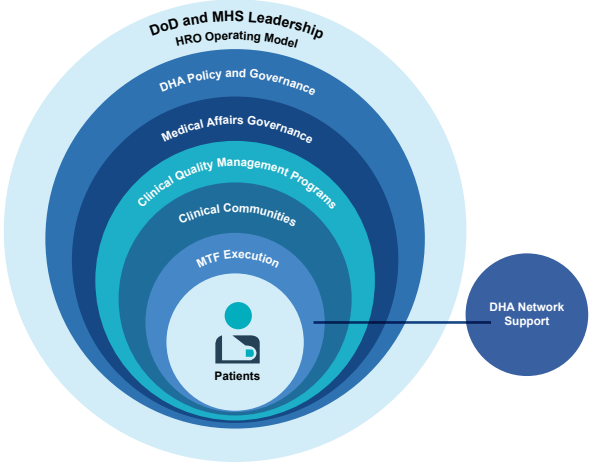
Clinical Quality Management (CQM) Oversight

CQM and its programs embody HRO principles and strive to continually incorporate them in their daily work. The CQM functional capability affirms its unwavering commitment to provide health care of the highest quality and value to all beneficiaries. Recent NDAAs and the update to the Department of Defense Instruction 6025.13 "Clinical Quality Management in the Military Health System" have enacted significant TRICARE and MHS reforms, including changes to the administration and management structure, and specific requirements for CQM across the MHS. These reforms are collectively transforming the MHS into an integrated system of readiness and health. The prescribed changes enable DHA and the MHS to act as one enterprise, delivering improved results. These changes provide the opportunity to integrate and standardize quality improvement and patient safety efforts through the elimination of unwarranted duplication and reduce variation in execution through consolidation of management authority focused on safe, high-quality health care.

In this work, CQM partners with the military departments and is fully committed to reaching our shared vision of a better MHS. CQM seeks to foster a culture of safety, collaboration, and high reliability that will accelerate the evolution of health care in the MHS. Leveraging the most advantageous practices of the industry, the Services, and DHA, the requirements to fulfill this promise have been established. The vision is to integrate CQM in the MHS through structure, process, and function to improve the readiness mission while delivering world-class, efficient, and accessible health care for all beneficiaries. The future CQM operating environment will feature strong partnerships with stakeholders across the enterprise to responsively and effectively advance the DoD's operational and medical missions and to deliver on DHA priorities. Priorities include enabling combat support to the Joint Force in competition, crisis, or conflict; building a modernized, integrated, and resilient health delivery system; and ensuring dedicated and inspired teams of professionals driving military health's next evolution. The release of the DHA Procedural Manual 6025.13 "Clinical Quality Management in the Military Health System" in 2019 facilitates CQM work. This procedural manual supersedes existing Service policy and integrates the MHS's approach to clinical quality under a singular organizational construct that provides a framework of interdependent programs at each organizational level. Furthermore, it seeks to objectively define, measure, improve, and ensure the quality of care in the MHS. CQM work is furthered by the CQM Strategy and its four strategic goals to drive zero harm, decrease clinical variation, increase accountability in the health care system, and optimize CQM activities to improve value. The MHS's HRO journey includes regular assessments of health care safety culture. CQM is augmenting its assessment capability for the safety and quality of care in its private sector care network and fully participating in the NDAA FY 2023, Section 706. This NDAA required external assessment of quality and patient safety review processes to further drive transparency, accountability, standardization, prevention, and improvement across all care continuum environments.

The National Defense Authorization Act of 2021, Section 744, required DHA to implement a comprehensive program, known as the "Military Health System Clinical Quality Management Program." The sections that follow provide additional details on the DHA approach to implementing this program.

MHS GOVERNANCE OF CLINICAL QUALITY MANAGEMENT



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

Healthcare Resolutions Program

Healthcare Resolutions is a nonlegal venue to resolve clinically complex health care issues following unanticipated/adverse outcomes of care or quality-of-care concerns starting at the time of service delivery at MHS-operated medical centers, hospitals, clinics, and/or operational medicine platforms. The program incorporates five core principles of high reliability: preoccupation with failure, reluctance to simplify, sensitivity to operations, commitment to resilience, and deference to expertise. The three primary components of the MHS Healthcare Resolutions Program are: (1) detailed fact-finding, consultation with experts, and facilitated dialogue with involved patients and providers; (2) promotion of process improvement efforts with involved clinicians; and (3) a resilience program for providers. The MHS Healthcare Resolutions Program is based in large MTFs, with each assigned Special Assistant for Healthcare Resolutions at these large MTFs and supporting all smaller MTFs.

Healthcare Resolutions

The Healthcare Resolutions 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 QA processes. Arrangements may be made for patients to provide their perspectives to QA 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 QA reviews may not be released per federal regulations. Interventions in Healthcare Resolutions are prelegal claim discussions; the filing of a claim transitions the process into a formal legal venue and out of the Healthcare Resolutions Program. 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-PI (DHA-PI 6025.17), titled "Healthcare Resolutions, Disclosure, Clinical Conflict Management and Healthcare Provider Resiliency and Support in the Military Health System," signed in June 2019. Healthcare Resolutions has also been endorsed by the Assistant Secretary of Defense for Health Affairs in support of transparency and full disclosure following unanticipated or adverse medical events and is referenced in the revised DHA-PM.

Disclosure Training

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

Peer Support

Healthcare Resolutions is involved with providers who are often second victims following adverse outcomes of care, knowing that the most devastating impact for providers is to feel responsible for causing harm, permanent injury, or death to a patient. Many feel that they have failed the patient and second-guess their clinical skills, knowledge base, and career choice. 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 engagement following AEs, with an emphasis on emotional recovery and psychosocial support in a blame-free environment.

Healthcare Resolutions Program *(cont.)*

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 QA or legal processes. Peer Supporters are volunteer providers who receive training and coaching on the fundamentals of this critical intervention, as well as guidance regarding when formal clinical referrals should be sought. This initiative supports providers (staff providers, fellows, residents, interns), enhances provider recovery, contributes to quality-of-care improvements, allows providers to contribute to the event investigation, increases teamwork, enhances productivity, and reduces medical errors that are often associated with nonsupported providers. Peer Support is a critical component of military medicine's commitment to its providers and to firmly establishing itself as an HRO.

Patient Safety: Program to Prevent Harm

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

The PSP focuses on four functional areas:

1. Managing Patient Safety Events: Eliminating harm through the identification, investigation, and mitigation of patient safety events
2. Supporting a Learning Organization: Designing and identifying integrated solutions to engage, educate, and equip
3. Fostering a Culture of Safety: Fostering a culture in which mistakes lead to sustainable, positive change and safety of patients, and the workforces are both highly valued and ardently protected
4. Infection Prevention and Control (IPC): Focusing on reducing harm events in the areas of health care–associated infections (HAIs) and supporting leading practices through the Antimicrobial Stewardship Program (ASP)

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

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

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

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

1. Joint Patient Safety Reporting (JPSR), a self-reporting system that allows staff to report safety issues in either identified or anonymous mode
2. DoD Reportable Events (REs), the most severe events from across the organization
3. HAIs, which are tracked through the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN)
4. Global Trigger Tool (GTT), which measures AEs collected through a sampling methodology from patient records
5. Administrative data, such as coding data used for Patient Safety Indicators

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

1. Joint Patient Safety Reporting (JPSR) System

The DHA requires Networks, MTF Directors, and staff to report all patient safety events that reach the patient (i.e., harm and no-harm events) and do not reach the patient (i.e., near-miss events) to the greatest extent possible through JPSR. JPSR is a standardized, voluntary web-based reporting system that allows for anonymous or reporter-identified reporting and was implemented in 2011 across the DHA to capture patient safety events. The system is jointly used with the Veterans Health Administration (VHA) effective 2017. Additionally, the U.S. Transportation Command (USTRANSCOM) patient movement system, operational medical units deployed to the U.S. Central Command, and the Navy fleet have adopted the JPSR database for global use. In 2023, a Joint Incentive Fund (JIF) award was granted to allow modernization of the current web-based JPSR version for the three user groups to close a critical capability gap and add a higher-level harm incident investigation module. This module will be standardized across the DHA, VHA, and USTRANSCOM enterprise in FY 2026. This will simultaneously enable the VHA to sunset a legacy database, automate antiquated manual DHA/USTRANSCOM processes, make initial reporting for frontline staff more efficient, and create a shared data set, with a leading practice library from corrective action plans. One of the key objectives with this JIF project is to mitigate future patient harm and share lessons learned from all types of patient safety reports to strengthen clinical processes.

As a result, the PSP has seen increased collaboration on improvement efforts, knowledge exchange, and the development of broad-based solutions. In FY 2023, a total of 67,749 patient safety reports were submitted from the direct-care system. Near-miss events, which did not reach a patient, accounted for 50 percent of all JPSR events reported in FY 2023. In significant elements of the deployed environment, JPSR has become an important tool in delivering safer care in austere environments where extraordinary care is taken to stabilize and safely transport wounded warriors back to the contiguous United States (CONUS) in the global Aeromedical Evacuation system.

The table below compares FY 2019 through FY 2023 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 events that reach a patient and do not result in harm; and near-miss events (or close calls) that do not reach a patient.

A strong culture of self-reporting is critical to organizational learning to advance ready reliable care. The JPSR system is agile in allowing anyone with a DoD CAC or VHA Personal Identity Verification card to report all categories of events for process improvement purposes. The DHA strongly encourages a nonpunitive transparent culture of reporting.

JOINT PATIENT SAFETY EVENTS REPORTED, FYs 2019–2023

HARM GROUP	FY 2019		FY 2020		FY 2021		FY 2022		FY 2023	
	#	%	#	%	#	%	#	%	#	%
Harm	10,335	9.7%	9,517	10.7%	9,214	10.5%	7,598	10.3%	6,793	10.0%
No Harm	41,014	38.4%	34,746	39.0%	44,422	50.7%	29,837	40.3%	27,390	40.5%
Near Miss	55,385	51.9%	44,784	50.3%	34,016	38.8%	36,679	49.4%	33,566	49.5%
Total	106,734	100.0%	89,047	100.0%	87,652	100.0%	74,113	100.0%	67,749	100.0%

Source: DHA/Medical Affairs/Clinical Support Division (CSD), 11/29/2023. Data reported as of 11/28/2023
Note: Due to the process of event investigation and resolution, data may shift slightly from year to year as the JPSR system closes out the event.

2. Department of Defense Reportable Events (DoD REs)

DoD REs are an important part of patient safety. DoD REs are defined as any patient safety event resulting in death, permanent harm (regardless of the level of severity), or severe harm as per the Agency for Healthcare Research and Quality (AHRQ) Net Harm Scale; or meeting TJC's sentinel event or the NQF's serious reportable event definitions. The table below provides the most common medical and dental DoD REs that the DHA reported to TJC from FY 2019–2023.

DoD REs REPORTED TO TJC, FYs 2019–2023

EVENT TYPE	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
	#	#	#	#	#
Wrong-Site Surgery: Wrong Patient, Wrong Site, Wrong Procedure	29	22	28	28	21
Patient Fall	6	13	22	17	26
Unintended Retained Foreign Object	21	18	15	12	18
Delay in Treatment: Lab, Pathology, Radiology, Referral, TX Order	19	15	22	14	10
General Care Management[a]	9	9	11	16	9

Source: DHA/Medical Affairs/CSD, 11/30/2023. Data reported as of 11/23/2023
[a] Any patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm, or permanent harm.

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

Wrong-Site Surgery (WSS)
Preventable DoD RE involving surgeries on wrong site, wrong side, wrong person, or performance of the wrong procedure.

General
Any patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm).

Fall
A fall is considered a DoD RE when it occurs while the patient is being cared for in a health care setting and causes death or serious injury.

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 can be serious DoD REs that ultimately result in serious harm or patient death.

Unintended Retained Foreign Object (URFO)
An URFO event that occurs after an invasive medical or surgical procedure causes patent harm and significantly increases the cost of patient care.

Policy mandates that MTFs must submit a comprehensive systematic analysis (CSA) for each DoD RE. In FY 2023, MTFs submitted 127 CSAs to DHA, a 17 percent decrease from FY 2022. For each CSA received, the PSP reviews the strength of CAs and guides MTFs in implementing strong CAs that are more likely to prevent a similar event from reoccurring.

3. CDC National Healthcare Safety Network (NHSN)

The reduction and prevention of HAIs, improved antibiotic stewardship, and reduction of multidrug-resistant organisms remain top priorities for the PSP. To ensure standardization of reporting practices across the health care system and to align with the DHA goal of zero preventable harm, the DHA participates in the CDC's NHSN tracking system.

The DHA participates in several modules within the NHSN patient safety component. Inpatient MTFs submit data for central line–associated blood stream infection (CLABSI), catheter-associated urinary tract infection (CAUTI), Clostridioides difficile (C. diff), methicillin-resistant Staphylococcus aureus (MRSA), surgical-site infection (colon), and antimicrobial use and resistance (AUR) data. As MHS GENESIS rolls out, the PSP is developing improved solutions for accessing and downloading NHSN data (AUR, device days, ICD-10 coding) within the new system.

The PSP analyzes DHA data and conforms to national standards. The standardized infection ratio and the standardized antibiotic administration ratio (SAAR) are the two primary measures the PSP uses to benchmark and compare internal DHA data to national benchmarks. For both measures, a value of 1.0 or less indicates that the DHA performs the same or better than the national benchmark. The table below demonstrates how the DHA performed in comparison with the national benchmark for both CLABSIs and CAUTIs.

HAIs, FY 2019 Q1–FY 2023 Q4, STANDARDIZED INFECTION RATIO

	2019				2020				2021				2022				2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CLABSIs	1.6	0.8	1.1	0.7	0.7	0.3	0.9	1.6	1.2	1.2	0.7	1.4	1.0	0.6	0.6	0.9	1.0	0.7	0.4	0.7
CAUTIs	0.6	0.6	0.5	0.6	0.5	0.1	0.7	0.6	0.7	0.5	0.6	1.3	1.0	1.3	1.1	0.6	0.5	0.9	1.1	0.6

Source: DHA/Medical Affairs/CSD, 1/31/2024
Note: These data are inclusive of all 26 locations reported in NHSN: six intensive care units (ICUs), 15 wards, two Step Down Units, two Mixed Acuity Units, and one Chronic Care Unit.

The table below displays the SAAR for all antibiotics for both adults and pediatrics.

ANTIMICROBIAL USE, FY 2019 Q1–FY 2023 Q4, STANDARDIZED ANTIMICROBIAL ADMINISTRATION RATIO

	2019				2020				2021				2022				2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
All Antibiotics – All Adult Wards	0.9	1.0	0.9	0.9	0.9	1.1	1.1	1.1	1.2	1.1	1.0	1.0	1.1	0.8	0.8	0.7	1.0	1.1	1.2	1.2
All Antibiotics – All Pediatric Wards	1.0	0.9	0.7	0.9	0.8	1.1	1.3	1.0	1.0	0.6	0.7	0.7	0.6	0.6	0.8	0.7	0.7	0.8	1.0	0.9

Source: DHA/Medical Affairs/CSD, 1/30/2024
Note: These data are inclusive of 12 locations: six ICUs and six wards. ICUs: Burn, Medical/Surgical, Medical, Trauma, Pediatrics Medical/Surgical, and Surgical. Wards: Burn; Medical/Surgical; Medical; Surgical; Labor, Delivery, Recovery and Postpartum Suite; and Oncology/Hematology.

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

4. Global Trigger Tool (GTT)

The DHA implemented the GTT in FY 2018, leveraging methodology from the Institute for Healthcare Improvement (IHI). Voluntary reporting methods detect only a fraction of AEs that cause patient harm. However, GTT uses a standardized process to sample medical records and detect AEs not otherwise reported. It is a validated, objective, and consistent retrospective method for medical record review. The DHA uses the GTT to determine and monitor rates of patient harm over time and supplements other reporting systems to help direct resources and monitor impact. The IHI methodology recommends a minimum of 12 months of data collection to determine a baseline; therefore, FY 2019 was the first year when GTT data were reportable. The table below shows GTT data from FY 2019 to FY 2023 Q3.

GLOBAL TRIGGER TOOL ADVERSE EVENTS, FY 2019 Q1–FY 2023 Q4

	2019				2020				2021				2022				2023			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
AEs per 100 Admissions	7.1	8.2	6.9	7.9	6.0	6.4	6.6	7.1	6.5	6.7	5.6	5.1	5.6	6.0	5.0	4.6	3.7	3.6	2.9	4.2

Source: DHA/Medical Affairs/CSD, 2/6/2024

Note: There is a four-month lag in data. FY 2023 Q4 data include data through September 2023.

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

Over the past year, the PSP continues to focus on engaging, educating, and equipping MTFs and their leadership teams in patient safety, quality, and process improvement efforts. This focus includes collaboration with the Services and Clinical Management Teams to document patient safety concerns, assist with analysis of patient safety events, and implement CA. The sections below describe examples of patient safety solutions.

Engage

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

Patient Safety Awareness Week (PSAW): This week is a national education campaign to promote patient safety practices. In FY 2023, the PSAW theme was "Be a Patient Safety Hero: Anytime, Anywhere — Always." During this week, the PSP engaged our MTFs through a themed video challenge and recorded Culture of Safety presentations from the annual Ready Reliable Care High Reliability Organization (RRC HRO) Awards Program. Additionally, Patient Safety Managers could download a PSAW tool kit for materials and creative activities to further engage staff and patients in patient safety awareness efforts. The PSP uses PSAW to promote discussion and action to improve patient safety practices.

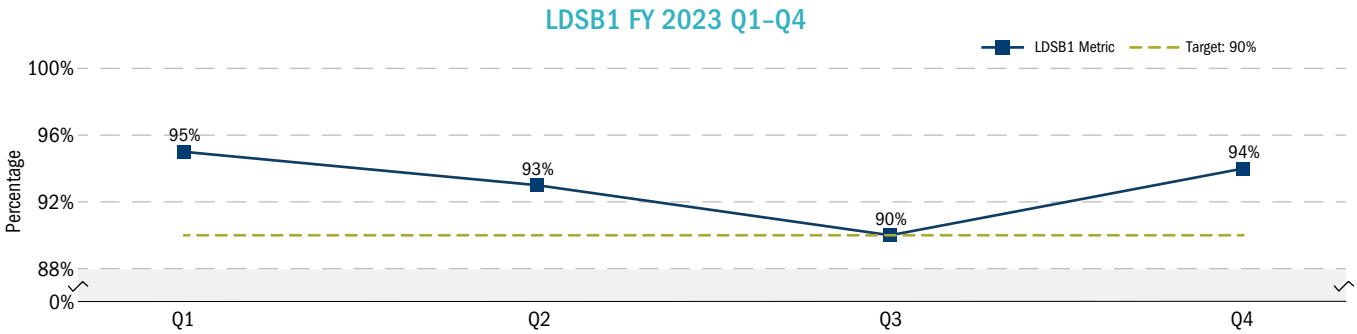
RRC Safety Communication Bundle (SCB): To help the DHA reach the goal of zero preventable patient harm, the Patient Safety Program sponsored the release of the DHA-PI 6025.45 "Ready Reliable Care Safety Communication Bundle" on January 3, 2022, and collaborated with the MTFs, former Markets, SSO, DHA regions, and Clinical Communities to implement the RRC Safety Communication Bundle's six standardized safety communication practices:

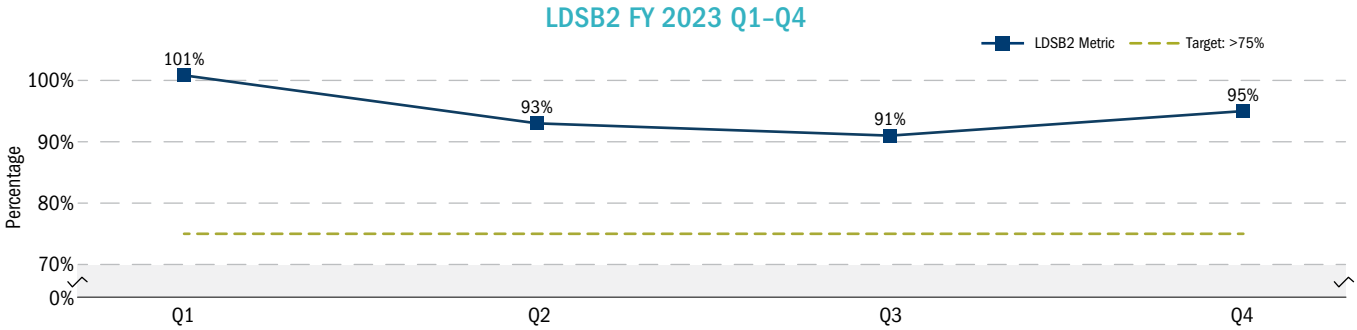
- Leader Daily Safety Briefs
  - Safety Messages (LDSB1)
  - Safety Alerts (LDSB2)
- Safety Leadership Rounds (SLR)
- Unit-Based Huddles (UBH)
- I-PASS for Patient Handoff
- Surgical Briefs and Debriefs Using the Operating Room Debrief Issue Tracker (ORDIT)
- Universal Protocol (UP)

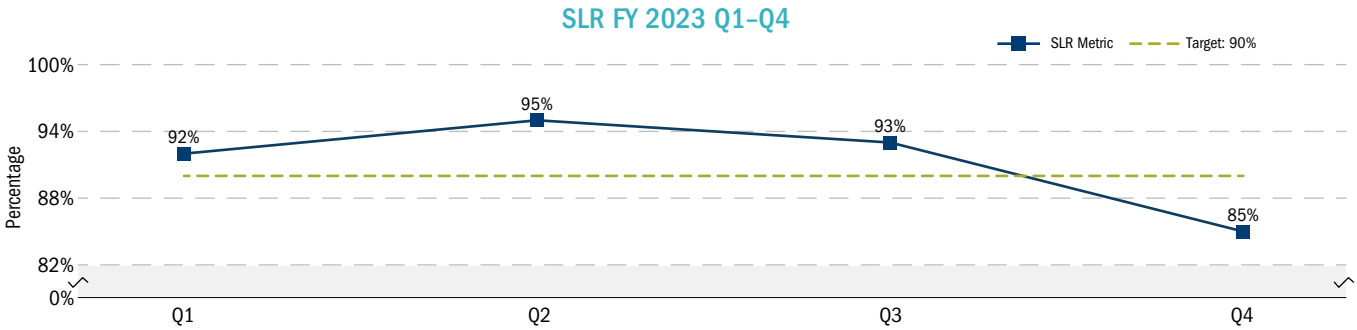
CLINICAL QUALITY MANAGEMENT IN THE MHS *(CONT.)*

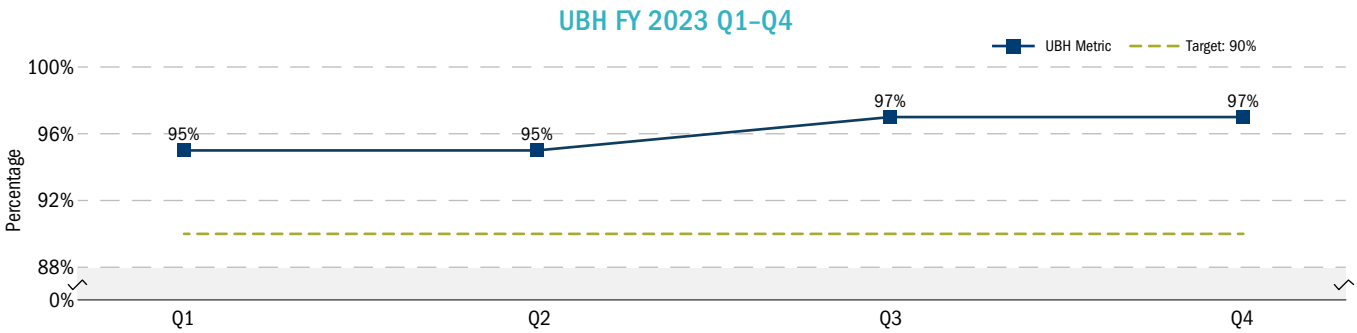
Patient Safety: Program to Prevent Harm *(cont.)*

The RRC SCB Dashboard on Safety Event and Root Cause Analysis (SERCA) contains performance data on the six safety practices at the MTF, parent facility, and former Market levels. The graphs below indicate performance over time in FY 2023. As shown in the graphs below, for every quarter of FY 2023, the LDSB1, LDSB2, and UBH metrics met or exceeded their respective targets. In addition, the I-PASS metric has consistently increased each quarter in FY 2023 and is approaching the current target of 100 percent. The SLR and UP metrics have both remained within a range of ±5 percent of their respective targets.









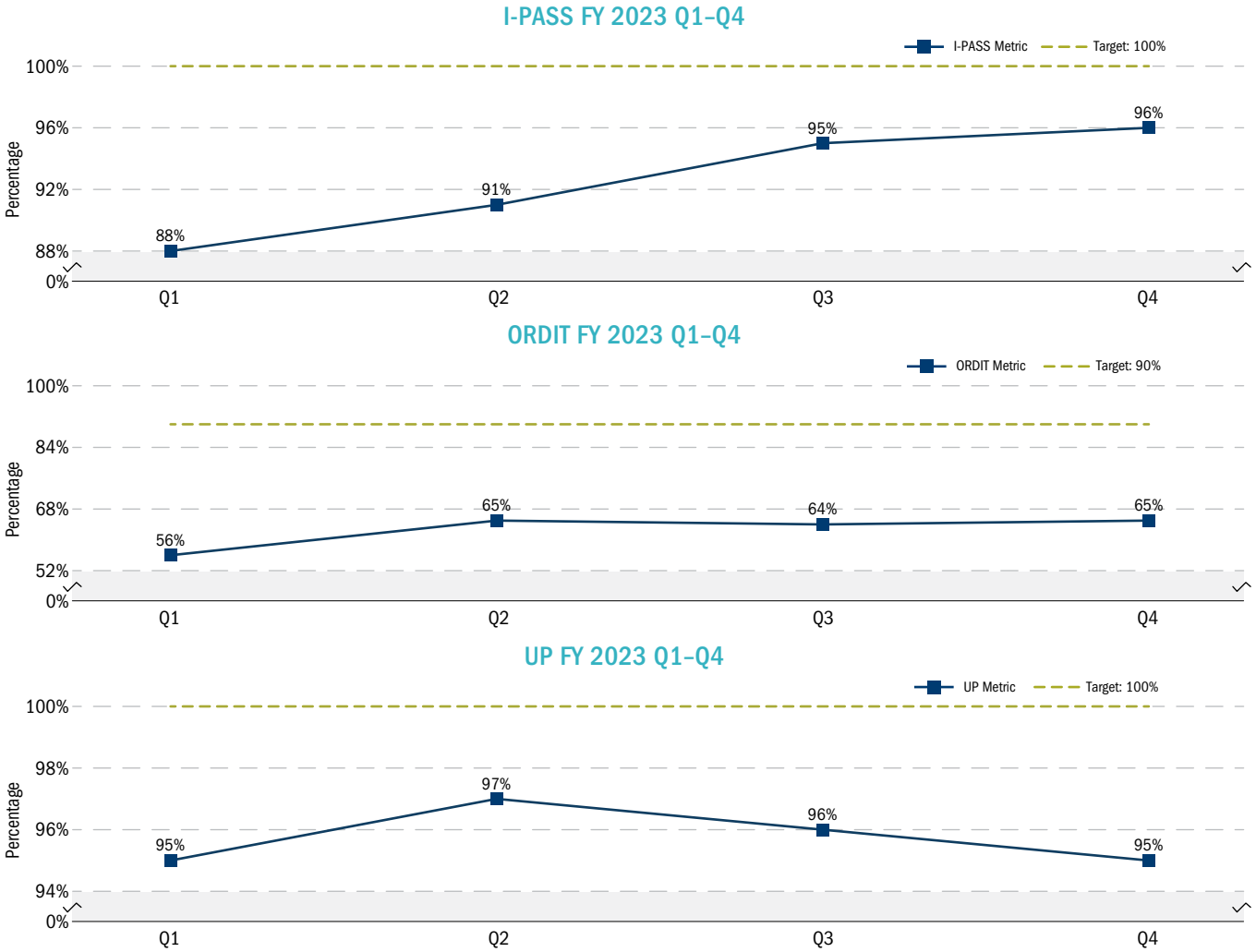
Source: SERCA, 1/22/2024.

Notes:

– LDSB1: There was a 4 percentage-point increase from FY 2023 Q3 to Q4.
– LDSB2: There was a 4 percentage-point increase from FY 2023 Q3 to Q4. This metric may have numerators larger than their denominators due to some safety issues being resolved in the following quarter. This may lead to some percentages being slightly over 100%.
– SLR: There was a 8 percentage-point decrease from FY 2023 Q3 to Q4.
– UBH: There was no change from FY 2023 Q3 to Q4.

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

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



Source: SERCA, 1/22/2024. The data were published on SERCA as of 1/22/2024.

Notes:

– I-PASS and ORDIT: There was a 1 percentage-point increase from FY 2023 Q3 to Q4.

– UP: There was a 1 percentage-point drop from FY 2023 Q3 to Q4.

All six of these metrics were designed and adopted to improve patient safety across the DHA. For example, improved performance for LDSB1 and LDSB2 can improve patient safety as any safety issues discussed during the LDSB might become the focus of SLR, providing an opportunity for leaders to learn from the front lines of care and identify potential opportunities for improvement. Overall, the RRC SCB has the potential to reduce staff burnout through reduction of culture-related workplace stressors. These stressors—poor teamwork, poor communication, and low staff empowerment—were identified in the 2019 and 2022 culture surveys.

Patient Safety Champion Recognition Program: The PSP created the Patient Safety Champion Recognition Program to encourage peer-to-peer acknowledgement and celebration of patient safety innovations across the DHA. Each year more than 100 individuals are recognized for their contributions. In calendar year (CY) 2023, 182 PS Champion certificates were awarded.

182
PS Champion Certificates Awarded in CY 2023

158
Students Trained in TeamSTEPPS® Deployment Course in CY 2023

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

Healthcare Event Analysis Response Team (HEART): The HEART is a team of experts with specialized training in investigation and support of patient safety investigations. The DHA launches HEART missions to complete a full investigative analysis, which identifies clinical process failures and latent vulnerabilities and assesses enterprise-level challenges to find effective system-level solutions and disseminates a corresponding safety message to all DHA facilities. DHA has successfully deployed 18 HEART missions since April 2021, which have generated 51 DHA-wide recommendations for improvement actions. The majority of these recommendations have been strong, feasible, and impactful.

Educate

The DHA's RRC approach strives for zero preventable harm and remains committed to continuous learning and improvement. To that end, the PSP has developed and implemented multiple evidence-based learning resources. The resources focus on enhancing communication and teamwork, addressing new regulations and protocols, and identifying learning needs or educational gaps with the goal of successful implementation and long-term sustainment of learning. Between January and November 2023, there were 876 courses conducted with 14,296 graduates.

Patient Safety Professional Course (PSPC): Patient safety professionals complete this course within one year of onboarding at an MTF. This three-week-long course features a comprehensive learning approach that provides them with evidence-based knowledge, skills, and tools to implement patient safety initiatives at their facilities. PSP staff establish regular touchpoints with patient safety professionals to promote role socialization and ensure the course continues to meet the needs of the field.

Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS): According to TJC's Sentinel Event Data 2022 Annual Review, failures in communication, teamwork and consistently following policies were leading causes for reported sentinel events. TeamSTEPPS is an evidence-based teamwork development system that the DHA has adopted worldwide to prevent these failures and increase patient safety.

Equip

The PSP provides several resources, including guidebooks, implementation guides, and job aids to equip MTFs and their patient safety managers with the tools needed to improve patient safety.

Key deliverables and initiatives have focused on the development and DHA-wide implementation of evidence-based guidance for critical IPC processes. This included the completion of the High-Level Disinfection Implementation Guide, leveraging standardized tracers, as well as the CLABSI and CAUTI Implementation Guides.

Additionally, the ASP established new policy and developed an ASP Fundamentals Guide and an ASP Annual Summary template for use by MTF antimicrobial stewardship teams. The ASP continues to enhance the ASP mobile app to assist frontline providers with antimicrobial decision-making by maintaining up-to-date clinical practice guidelines for common infectious syndromes.

MHS GENESIS and Patient Safety: No EHR rollout is risk free, so the PSP has employed a strong clinical review process in concert with a robust incident response and change request process to ensure continued delivery of safe patient care.

Transparency

Transparency is key to patient safety improvement. The PSP contributes to transparency of patient safety care and data for Service members, their families, and all eligible beneficiaries. The DHA has focused on data transparency while standing up the Networks and centralizing the MTFs under an integrated structure. Data transparency promises open communication among the organization, its employees, and its customers on common quality metrics that affect patient outcomes. Pages 45–46 and 88–90 further describe the DHA transparency efforts.

Safety Event and Root Cause Analysis (SERCA): PSP has implemented the DHA SERCA tool to share lessons learned and patient safety data from four data sources—JPSR, DoD REs, CDC NHSN, and GTT—between Networks and MTFs enhanced transparency affords MTFs real-time visibility into what other facilities in the DHA are doing to prevent events and improve safety. The SERCA tool has more than 547 active users and over 21,500 views.

MHS Patient Safety Culture Survey

The PSP administers the Patient Safety Culture Survey approximately every three years to evaluate culture and assess staff perceptions of patient safety within their MTF and work units. The PSP uses the data to define the current state of safety culture across the organization, track trends and advancements over time, and continue to strategically implement opportunities for improvement. The last Patient Safety Culture Survey was administered from January 2022 to March 2022. The next Patient Safety Culture Survey will launch in September 2024 and will use the same AHRQ survey to allow MTFs to compare their results between 2022 and 2024.

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

Ready Reliable Care High Reliability Organization (RRC HRO) Awards

The RRC HRO Awards is an annual event that began in Patient Safety to recognize improvements and innovation efforts in military health care. Over the years, these submission categories have evolved from a patient safety focus to encompass the broader DHA priorities associated with Ready Reliable Care Domains of Change and Principles. Recently, categories have been expanded to incorporate clinical as well as nonclinical projects. All submissions are evaluated using an internal board review composed of DHA subject-matter experts (SMEs) in a variety of disciplines and specialties.

There were 52 highly competitive submissions this year, and 13 winners were selected from around the globe. Out of nine submissions, two winners were selected for the Leadership Commitment Award. Out of 12 submissions, four winners were selected for Culture of Safety. Out of 21 submissions, three winners were selected for Continuous Process Improvement. Out of 10 submissions, four winners were selected for Patient Centeredness. Submissions are aligned with Clinical Communities where it makes sense, while other submissions may be associated with a clinical support service. The following table summarizes the winning organizations and their respective submissions.

2023 RRC HRO AWARD WINNERS

MTF/TRICARE REGIONAL OFFICE	AWARD-WINNING INITIATIVE
Leadership Commitment	
U.S. Naval Hospital Guantanamo Bay, Cuba	Refusal to Accept Lapses in Whole Blood Availability in an Austere OCONUS Military Treatment Facility
Brooke Army Medical Center	Behavioral Health Data Platform Adoption & Utilization
Culture of Safety	
Walter Reed National Military Medical Center	Reduction of Hospital-Acquired Pressure Injuries
Small Market & Stand-Alone MTF Organization (SSO)	IMO Good Catch Program
U.S. Naval Hospital Rota, Spain	Implement Skin to Skin Protocol to Prevent Newborn Hypothermia
U.S. Naval Hospital Rota, Spain	Increase Helicopter Maritime Strike Squadron Eye Exam Readiness
Continuous Process Improvement	
Institute of Surgical Research	Foundations for Barcode Medication Administration Rate Improvement
Joint Base Elmendorf-Richardson	Using Rapid Response EEG Technology in Simulated Austere Environments
Naval Health Clinic Oak Harbor	Increasing Schedule Utilization Through Use of Dental Hygiene Standby Patients
Patient Centeredness	
Joint Base Elmendorf-Richardson	Advanced Nutrition Assessments
377th Medical Group, Kirtland Air Force Base	Patient Experience
45th Medical Group, Patrick Air Force Base	One Stop Readiness Construct
U.S. Naval Hospital Rota, Spain	Optimize ENT Circuit Rider Visits

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

Healthcare Risk Management (HRM): Addressing Enterprise Risk

The overarching goal of the HRM Program is to protect patient safety, mitigate risks and harm within our health care delivery system, improve the reliability of our health care, and protect the reputation and financial assets of the MHS. HRM manages the required clinical quality management review of medical malpractice claims, Active Duty death and disability cases when the death or disability is associated with health care delivery, potentially compensable events, and the required due process procedures for clinical adverse actions taken against privileged and nonprivileged health care providers. The HRM Program also is the responsive office for official requests for information regarding these processes.

The HRM Program promotes accountability, transparency, standardization, and improvement through support of the MHS strategy for managing clinical, operational, human capital, technical, and corporate compliance risks. To execute this mission, the HRM Program works in close collaboration with other CQM Programs, Networks, MTFs, the Services, and Health Affairs to ensure a robust risk management capability.

The DoD Risk Management Working Group (RMWG), led by the Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA]), is responsible for overseeing HRM processes in the MHS. HRM is directed by the Department of Defense Instruction (DoDI) 6025.13 and executes through the DHA-PM 6025.13 for HRM processes and, where required, reporting to the National Practitioner Data Bank (NPDB), states of licensure, and other regulatory/certifying bodies.

Reporting to NPDB occurs for paid malpractice and tort cases, as well as Active Duty death and disability cases associated with health care when the standard of care is breached. Reporting also occurs to NPDB and/or regulatory agencies for adverse privileging/practice actions, and administrative/criminal actions with nexus to health care delivery, following required due process procedures. The HRM Program supports the RMWG as a forum to discuss relevant risk management topics, share clinical lessons learned from reported adverse events within the MHS, identify variance in health care delivery, apply effective risk reduction strategies, and promote uniform implementation of HRM processes across the MHS.

The HRM program confirmed that for FY 2023, 379 practitioners were reported to the NPDB and regulatory agencies for risk management–related events and actions occurring within the MHS (source: Services' quarterly report to DoD RMWG). In FY 2022, 201 providers were reported, and in FY 2021, 134 providers were reported. This trend reflects the phased increase in case processing responsibilities associated with the change in policy and regulatory requirements.

The HRM Program goals for CY 2024 include updating HRM procedures in DHA-PM 6025.13 to comply with newly released DoDI 6025.13 and the reorganization of the MHS since last publication, updating information systems for improved tracking and trending of HRM data for transparency and organizational learning, continuing robust educational efforts for MTF and Network HRM proficiency, and improving standardization of HRM processes within DHA.

Credentialing and Privileging: Program to Ensure Appropriate Credentials and Privileges

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

The primary tool for CP Program mission execution is the DoD's Centralized Credentialing and Quality Assurance System (CCQAS), a web-based application that serves as the DoD global application for CP of MHS providers. Under the leadership of the DHA CP Program managers and in collaboration with key stakeholders, required CCQAS system updates that support the MHS Transition have been enabled and continue to promote increased transparency, accountability, and standardization. The CP Program also continues to establish and refine capabilities to regulate and enhance quality and safety throughout the DHA through structured centrally managed processes.

As part of DHA CP efforts to streamline, promote transparency and standardize efforts across the DHA enterprise, several centralized functions have been established to support health care quality and patient safety. The DHA CP Program has recently established a centralized credentials verification service whose purpose is to standardize and optimize prime source verification of provider credentials upon request by the MTF to help ensure that clinical staff are qualified and competent to deliver safe, high-quality care to patients across the MHS.

A centralized verification function provides primary source verification to reflect the appointment dates, specialty of a provider, and relevant information regarding whether a provider was in good standing with all associated organizations within DoD. This service provides transparency to stakeholders, such as licensing boards and future employers. In the last year, the service has provided over 18,000 primary source credentials verifications to MTFs across the DHA enterprise. DHA CP is currently enrolling nurses and privileged providers in the NPDB Continuous Query, which provides 24/7 monitoring and notification of

Credentialing and Privileging: Program to Ensure Appropriate Credentials and Privileges *(cont.)*

reports to the NPDB for any enrolled MHS providers. This improves health care quality, efficiency, and system responsiveness to protect patients from harm.

In addition, DHA CP has implemented a centralized surveillance and monitoring program for MTFs to identify areas for improvement in compliance with standardized credentialing processes, including reporting and documentation of credentials verification, and ongoing and focused professional provider performance evaluations. DHA CP will coordinate this work with Networks to ensure an integrated oversight system. Additionally, the CP Program has developed and standardized the DHA's Impaired Healthcare Provider Program, which provides nonpunitive support for rehabilitation of health care personnel who suffer from a condition that negatively influences or has the potential to negatively influence optimal clinical performance.

In the past year, CP has made significant strides in standardizing and consolidating this new DHA capability to reduce unwarranted variation and improve compliance across the DHA along with a robust education program.

To further support MTF credentialing and privileging processes, the CP Program has established a centralized provider affiliation cell, which has assumed the responsibility for verification of provider affiliations with MTFs across DHA, alleviating MTF personnel of this responsibility while ensuring standardization and compliance with applicable regulatory guidance.

The CP Program has a robust training and education plan that provides education at all levels, including mentorship program for new credentials personnel, CCQAS training, and a "Credentials 101" credentialing and privileging refresher. The DHA CP Program will continue its efforts in standardization of credentialing and privileging processes. We are actively engaged in leading the effort for a modernized consolidated credentialing and privileging/health care risk management system of record to replace CCQAS with a goal of better meeting the needs of a rapidly changing and dynamic health care system. In a significant restructuring effort, the CP Program realigned more than 2,400 dental providers to the MTF privileging authority, further consolidating and standardizing CP activities across DHA.

Looking ahead, the DHA CP Program will continue its efforts in standardization in the interest of quality, patient safety, and high reliability.

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

MTF Accreditation

The DHA is committed to providing safe, quality care to all beneficiaries. Utilization of health care industry standards to continually assess the care provided in the DHA serves as a foundation of CQM. The DHA Accreditation and Compliance (AC) Program enables the application of nationally recognized accreditation standards for health care delivery organizations to provide guidance for the development of policies and practices that ensure quality and safe care delivery in the DHA direct care system. Further, civilian network health care facilities are contractually required to maintain accreditation by an approved health care accrediting organization (AO). Accreditation and certification by external organizations provide the DHA with valuable information to validate compliance with national quality and safety standards and to identify opportunities for improvement and to further affirm the DHA's commitment to high reliability and providing the best care to all our beneficiaries.

Maintaining national health care quality and safety standards through a rigorous self- and external assessment program with benchmarking and public reporting is foundational to high reliability in health care. The AC Program enables this through support for the requirements in NDAAs 2016 through 2021. MTF health care accreditation survey completion dates and associated RFIs to meet full accreditation are displayed at the OASD(HA) public-facing web portal, www.health.mil/AccreditationStatus.

Program to Monitor and Support MTF Accreditation

MTFs are required to maintain facility health care accreditation by an external nationally recognized AO based on the health care services provided at the facility. The comprehensive MTF-level accreditation programs required include hospital, ambulatory, BH, and home health. Currently, the same AO, TJC, is utilized across the direct care system to reduce variation in the accreditation standards and survey process. This uniformity of effort is critical for supporting the DHA's HRO journey.

The AC Program has continued to focus on building a robust Accreditation Assist Visit (Mock Survey) Program. Recently, the DHA AC Program established the procedures and created the infrastructure to support the addition of 139 unaccredited Army and Marine Corps Battalion Dental Treatment Facilities (DTFs) to the DHA Accreditation Program and included them in the Accreditation Assist Visit schedule. The Accreditation Assist Visit workstream within the AC Program executes a simulated survey event and allows MTFs and DTFs to demonstrate their ability to meet DoD policy mandates, regulatory requirements, and nationally recognized health care standards. Like an actual survey event, the Accreditation Assist Visit Program requires that a Plan of Action and Milestones (POAM) are developed by MTF personnel for identified areas of noncompliance. Once POAMs and associated corrective actions are completed, the finalized POAM is submitted to the Network and DHA HQs. The POAM is monitored by the Network to ensure closure of requirements for

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

improvement, sustainment activities continue, and standards compliance with standards is maintained.

The mandate to accredit MTFs by an external health care AO demonstrates DoD's commitment to the provision of safe, quality care to all beneficiaries, and supports the DHA HRO journey.

The DHA Procedural Manual 6025.13 "Clinical Quality Management in the Military Health System Volume 5: Accreditation and Compliance" provides the procedures, direction, and guidance for the development of an integrated, robust accreditation program. DHA AC continues to work toward standardizing processes, capturing leading practices, disseminating accreditation compliance data trends, and leveraging lessons learned.

While anticipating future health care challenges, changing accreditation standards, and evolving law and regulation, the DHA's AC Program remains committed to proactively advancing accreditation processes to fostering system and MTF innovation to ensure optimal care delivery for military personnel and beneficiaries. The AC Program's primary goal is to successfully achieve and consistently maintain accreditation of all MTFs from an established, nationally recognized, external AO. In CY 2024, the AC Program will focus on advancing measures to continually ensure all health care staff are well informed and engaged in accreditation processes, fostering a culture of compliance and quality improvement. Additional activities will include ensuring accreditation program goals align with the broader organizational mission, vision, and strategic objectives, identifying potential system risks to patient safety and accreditation status, implementing proactive measures to mitigate risk, and instill a culture of continuous improvement and commitment to quality throughout the health care system.

CHAPTERS IN TJC ACCREDITATION MANUALS

HOSPITAL CHAPTERS	AMBULATORY CHAPTERS	BEHAVIORAL HEALTH CHAPTERS	HOME CARE CHAPTERS
Emergency Management	Emergency Management	Emergency Management	Emergency Management
Environment of Care	Environment of Care	Environment of Care	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. All 131 DHA MTFs are accredited by TJC. Eighty-six of the MTFs require accreditation under the ambulatory program. Forty-five MTFs are accredited through the hospital program. Forty-nine of the ambulatory or hospital surveys include BH units that require accreditation utilizing additional BH program standards. Only one inpatient MTF requires home care accreditation due to the geographical location. As shown in the following table, 11 inpatient MTFs, 16 ambulatory care MTFs, and 11 BH units, and one home care program underwent health care accreditation surveys in CY 2023. All the facilities successfully achieved the outcome of fully accredited status.

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

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

DHA HEALTH CARE ACCREDITATION SURVEYS COMPLETED, BY TYPE AND YEAR

YEAR	HOSPITAL	AMBULATORY	BEHAVIORAL HEALTH	HOME CARE
2016	17	35	10	0
2017	12	24	4	0
2018	20	21	17	1
2019	19	35	22	0
2020	1	9	0	0
2021	15	27	15	0
2022	19	36	23	0
2023	11	16	11	1

Source: DHA/Medical Affairs/CSD, 12/8/2023

The triennial accreditation surveys provide MTFs, Networks, 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 are 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 POAMs with CAs as evidence of standards compliance within prescribed time frames are required for noncompliant standards identified as RFIs in the final formal survey report. Once this process is successfully completed, the MTF is provided with their effective date for successfully achieving the health care accreditation standard and is awarded the Gold Seal by TJC.

According to TJC, nationally, the top five accreditation standards chapters most frequently cited for RFIs at ambulatory MTF surveys remained fairly consistent over the past six years. Among DHA MTFs, the top five accreditation standards chapters most frequently cited for RFIs at inpatient MTF surveys remained consistent over the past seven years and only change in sequence. The chapters cited most frequently in the MTFs are consistent with the standards chapters identified by TJC as most challenging for the nation during the annual review of the previous year's findings.

The DHA Accreditation and Compliance Program supports a centralized continuous survey readiness program through the following activities:

1. Oversees the evaluation of MTF's processes, safety protocols, staff qualifications, and overall compliance with industry health care standards through self- and external evaluation.
2. Monitors MTF accreditation programs to ensure adherence to accreditation standards, laws, and regulations.
3. Oversees the documentation process to provide evidence of standards compliance.
4. Assists with MTF corrective action development and implementation.
5. Coordinates a centralized external Accreditation Assist Visit Program (Mock Survey Program) to identify areas of noncompliance and address any deficiencies.
6. Develops education products and conducts training to educate staff on accreditation requirements and procedures.
7. Assists in identifying areas for improvement and executing strategies to enhance the quality of health care.
8. Serves as the DHA liaison between the health system and AO, facilitating communication and resolving issues.
9. Collaborates with leaders to develop and update policies that align with accreditation standards.
10. Analyzes data related to quality metrics and ensures data-driven improvements.
11. Develops internal auditing tools (tracers) to assess standards compliance.
12. Coaches, teaches, and mentors new accreditation personnel throughout the health care system.
13. Provides consultative guidance to DHA HQ leaders, MTF Directors, and MTF staff.
14. Manages daily oversight of AO stipulations to ensure MTF compliance with accreditation participation requirements.

Highlighting DHA's commitment to transparency as an HRO, 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 RFIs required to meet full accreditation are displayed at the OASD(HA) public-facing web portal, https://health.mil/AccreditationStatus. The public display of accreditation information aligns with the MHS initiative to enhance transparency and supports compliance with NDAA FY 2021, Section 744, requirements.

In addition to the survey process for accreditation, TJC requires accredited hospitals to submit national clinical quality measures data to TJC on a quarterly basis. Each inpatient MTF selects the measures for data submission. Trained abstractors collect data centrally and report to the MTFs for analysis and improvement as indicated. As an example, the perinatal care (PC) measures are included in the WICC quality measures section of this report (see pages 98–100).

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

TOP 5 TJC AMBULATORY STANDARDS CITED BY CHAPTER IN MTF SURVEYS, CYs 2016–2023

CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Environment of Care	Environment of Care	Provision of Care, Treatment, and Services	Environment of Care	Infection Prevention and Control	Infection Prevention and Control	Infection Prevention and Control	Environment of Care
Medication Management	Medication Management	Infection Prevention and Control	Medication Management	Environment of Care	Environment of Care	Environment of Care	Infection Prevention and Control
Infection Prevention and Control	Infection Prevention and Control	Medication Management	Infection Prevention and Control	Medication Management	National Patient Safety Goals	National Patient Safety Goals	Medication Management
Provision of Care, Treatment, and Services	Provision of Care, Treatment, and Services	Provision of Care, Treatment, and Services	Medication Management	Provision of Care, Treatment, and Services	Medication Management	Life Safety	National Patient Safety Goals
National Patient Safety Goals	Record of Care, Treatment, and Services	Leadership	Leadership	Record of Care, Treatment, and Services	Provision of Care, Treatment, and Services	Provision of Care, Treatment, and Services	Life Safety

TOP 5 TJC HOSPITAL STANDARDS CITED BY CHAPTER IN MTF SURVEYS, CYs 2016–2023

CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Life Safety	Environment of Care	Environment of Care	Environment of Care	Environment of Care	National Patient Safety Goals	Infection Prevention and Control	Environment of Care
Environment of Care	Life Safety	Life Safety	Life Safety	Infection Prevention and Control	Infection Prevention and Control	National Patient Safety Goals	Life Safety
Provision of Care, Treatment, and Services	Provision of Care, Treatment, and Services	Provision of Care, Treatment, and Services	Provision of Care, Treatment, and Services	Medication Management	Environment of Care	Environment of Care	Provision of Care, Treatment, and Services
Infection Prevention and Control	Infection Prevention and Control	Infection Prevention and Control	Infection Prevention and Control	National Patient Safety Goals	Life Safety	Life Safety	Infection Prevention and Control
Medication Management	Medication Management	Medication Management	Medication Management	Provision of Care, Treatment, and Services	Medication Management	Provision of Care	Medication Management and Services

Source: DHA/Medical Affairs/CSD, 12/8/2023

Continuous compliance with health care accreditation standards contributes to the maintenance of safe, quality patient care; improved performance; and consistent survey readiness. 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 live process audits known as 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.

In addition to self-assessment and tracer activity, each MTF received a DHA-sponsored onsite Accreditation Assist Visit (Mock Survey). The visit is a systematic review of routine operations and ongoing quality improvement efforts at the MTF, supporting continuous compliance with accreditation standards. The Accreditation Assist Visit is usually conducted 12 to 18 months prior to the projected accreditation survey date. A report containing an overview of the Accreditation Assist Visit team, activities completed during the visit, identified areas of excellence, and opportunities for improvement is created and provided to the MTF and Network within 30 business days of the onsite visit. MTFs are responsible for developing and submitting POAMs for identified areas of noncompliance with laws, regulations, policies, and standards to the respective Network and DHA HQs within 30 business days of receiving the visit report. Once corrective actions are completed, the finalized POAM and associated documents will be monitored by the Network to ensure sustainment activities continue and standards compliance is maintained.

Clinical Laboratory Services Accreditation

Regulatory Compliance

Standards for the regulatory compliance of clinical laboratories in the MHS are established by DoDI and DoD Manual (DoDM) 6440.02 "Clinical Laboratory Improvement Program (CLIP) and CLIP Procedures," respectively, dated May 29, 2014. The CLIP conditions and standards are federal laboratory/Clinical Laboratory Improvement Amendments (CLIA) comparable.

Memorandum of Understanding (MOU) 21–48, between the DoD and the Department of Health and Human Services, recognizes that certain unique mission requirements exist within the DoD that are not found within the civilian sector and authorizes the establishment of comparable, but not necessarily identical, CLIA regulations within the DoD. The regulatory compliance of clinical laboratories in the MHS is, in part, evaluated through inspections conducted by an AO that has been granted deeming authority by CMS's Division of Clinical Laboratory Improvement and Quality, such as the College of American Pathologists (CAP), Commission on Laboratory Accreditation, TJC, American Society for Histocompatibility and Immunogenetics, American Association for Laboratory Accreditation, as well as through periodic self-inspections.

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

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 CMS' CLIA Office, the Deputy Assistant Director, Health Care 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.

Most MTF-based clinical laboratories are accredited by CAP per requirements in the DoDI and DoDM, and all MTF-based laboratories are projected to align under CAP accreditations by 2024. Accreditation inspections are unannounced for the majority of the clinical laboratories and are conducted on a two-year (biennial) cycle.

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. In FY 2023, CLMS performed inspections at 13 nonclinical sites, and coordinated assessments at two others.

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 against laboratory standards when compared with the U.S. civilian-sector clinical laboratories.

COVID-19 and Accreditation Inspections

Many accreditation inspections were delayed due to COVID travel restrictions in 2020 and 2021. With the collaborative efforts of CLMS and CAP, the backlog of inspections from 2020 and 2021 has now been resolved; however, CLMS remains prepared to re-establish virtual and/or hybrid inspections should the need arise again.

MHS CLINICAL LABORATORY CAP ACCREDITATIONS, BY SERVICE, FY 2023

SERVICE	COMPLIANCE RATE	% ABOVE CAP AVERAGE	COMPLETED CAP INSPECTIONS	COMPLETED SITE SELF-INSPECTIONS[a]	TOTAL
Army	99.31	0.14%	54	45	99
Air Force	99.45	0.28%	54	38	92
Navy	99.28	0.11%	56	51	107
Total			164	134	298

Source: CAP, 12/4/2023

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

Blood Bank Services Accreditation

The regulatory compliance of Blood Bank Services in the MHS is, in part, evaluated through inspections conducted by an accreditation organization that has been granted deeming authority by the CMS Division of Clinical Laboratory Improvement and Quality. Blood Bank Services in MTFs are surveyed by external organizations based on the services provided. For MTFs with blood collection and blood product manufacturing operations, registration and regulatory compliance is demonstrated through an inspection process required by the U.S. Food and Drug Administration (FDA), as well as inspection by accreditation organizations like the CAP and the Association for the Advancement of Blood and Biotherapies (AABB). 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 Joint Commission standards during the survey process and annual self-assessments. AABB, CAP, and the FDA inspect and assess the Armed Services Blood Program (ASBP) Blood Donor Centers (BDCs) and Transfusion Service activities biennially.

Blood Bank Services Accreditation *(cont.)*

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

There are approximately 72 BDCs and Transfusion Service activities. As in FY 2022, 100 percent of the facilities maintained FDA licensure and registration, as well as AABB and CAP accreditation.

Inspections and assessments have returned to normal frequency with the conclusion of the COVID-19 pandemic.

INSPECTION	2022 INSPECTIONS	2023 INSPECTIONS
FDA	17	22
AABB/CAP	45	67
Blood Programs	15	15

Fifty-one DoD Transfusion Service sites have decommissioned Wellsky® HCLL™ and implemented MHS GENESIS PathNet Blood Bank Transfusion (PathNet BBT) as the system for the Enterprise Blood Management System. All historical transfusion records previously contained in HCLL have been transferred to a new web-based health information archive called DataArk® to assist with regulatory requirements and accreditation standards related to patient safety.

The ASBP QA Management Team established end-user training, systems validation plans, and validation documentation to support the change.

The DoD Transfusion Services share the MHS GENESIS platform with the VA. In coordination with the VA, the ASBP publishes technical guidance to ensure all sites are formally notified of any MHS GENESIS PathNet-BBT system configuration changes. These updates ensure patient testing documentation and blood product management reflect current practices and meet the desired outcome.

In February 2023, 21 ASBP BDCs implemented Wellsky Blood Centers 2019, which is an upgrade to the Enterprise Blood Management System for Donor, FDA 510(k) management system that provides streamlined operations for donor recruitment, manufacturing, testing, and distribution. In December 2023, the ASBP BDCs also implemented FDA's revised recommendations for evaluating donor eligibility using the Individual Donor Assessment. The ASBP QA team directed an enterprise-wide implementation strategy to include donor staff training, computer system validation plans, standard operation procedures, and policy development. ASBP BDCs now utilize the Health History Questionnaire 4.0 to determine donor eligibility, which is in compliance with AABB accreditation standards and FDA regulations. This new screening process expands donor eligibility and maintains reduced risk of transmission of HIV through blood and blood products.

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

CM is an integral part of the CQM framework with a goal to objectively define and measure the quality of care provided in DHA. CM activities include assessment of quality care delivered, identification of improvement opportunities, comparative analysis with benchmarks from professional organizations, facilitation of participation in external quality programs, and fulfillment of the DHA Transparency Program. In 2024, CM will continue to work on clinical measure trending and outlier identification to recommend quality improvement efforts across the health care delivery system. CM will continue to provide point of care providers, clinical support staff, and MHS leadership with the data, information, clinical measurement education, mentoring, and coaching needed to assess clinical quality processes, outcomes, patient perceptions, organizational structure and systems, and electronic clinical quality measures. The CM Program is composed of three distinct functional areas: internal quality, external quality, and transparency.

Internal Clinical Quality Programs

Internal quality includes ongoing assessment of the quality of care delivered, identification of actionable information for improvement, performance monitoring, and clinical measurement support and education to Networks and MTFs.

To fulfill its mission, the CM Program utilizes a variety of external and internal clinical health care measure sets. The use of nationally recognized, endorsed measures provides a consistent methodology and enables risk-adjusted results and comparison with established benchmarks. Where no nationally recognized consensus measures exist, CM develops measures to support strategic priorities and to provide insight into a variety of care functions and settings. CM data are displayed throughout the CQM section and in various other sections included in this report.

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

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

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 performance management system to drive enterprise-wide improvement for identified common executable goals and develop dashboard measures that address all areas covered by the review. Participation in strategically selected national databases, such as the National Surgical Quality Improvement Program (NSQIP), was identified 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. This use of data from multiple sources provides a broader range of information and increases opportunities for national comparison, greater performance improvement analysis, and tailored quality/safety measurements.

The DHA currently participates in 11 clinical quality programs and databases:

- National Committee for Quality Assurance (NCQA)
- 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)
- ACS Commission on Cancer Programs
- National Perinatal Information Center (NPIC) Database
- CDC National Healthcare Safety Network (NHSN)
- CMS Care Compare
- TJC National Hospital Measures
- Leapfrog Hospital Survey, Leapfrog Ambulatory Surgery Center (ASC) Survey, and the Leapfrog Safety Grade

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

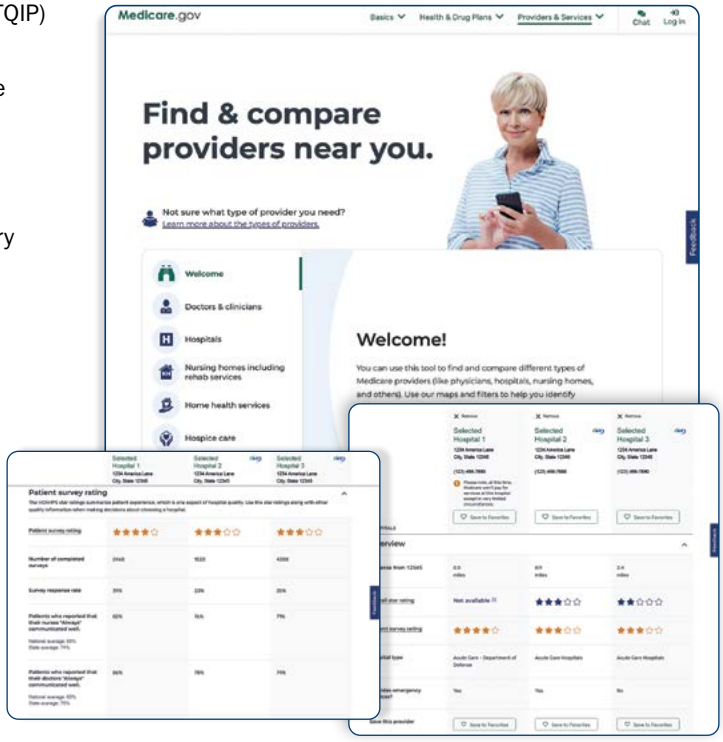
MHS Data Transparency

The DHA continues to focus on the needs of our stakeholders by modernizing and standardizing transparency efforts. In order to place meaningful, user-friendly, and actionable clinical quality and safety information in the hands of patients and decision makers, the DHA began the first federal multifacility participation in the Leapfrog Group's Hospital Survey with the submission of survey data from five pilot inpatient MTFs in November 2019. In CY 2023, all 32 inpatient MTFs in the CONUS and eight inpatient facilities OCONUS participated in Leapfrog. In addition, all eight of our ASCs participated in Leapfrog's ASC survey.

Data for these facilities are now publicly reported on the Leapfrog website (www.leapfroggroup.org), allowing comparison of industry-standard clinical quality and patient safety measures across both direct and private sector care. This partnership provides visibility to empower our Service members and their families to make the best decisions for their health care. It is anticipated that all OCONUS MTFs will participate in Leapfrog in CY 2024.

Health.mil: In response to the 2014 MHS Review, the health.mil website was designed as the first step for the MHS in providing data to patients to assess how the facilities at which they receive care are performing in terms of quality, safety, and access. There are 38 metrics reported on health.mil.

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



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

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

MHS Transparency on CMS Care Compare (formerly Hospital Compare)

The MHS provides patient experience, timely and effective care, and HAI measurement data to CMS for public reporting on Care Compare. 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.

Patient experience data come from the TRISS. 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.

As part of the evolution of DHA transparency efforts, the CM Program continues to develop and review the expansion of reporting of measures on Care Compare. HAIs are often preventable infections that patients get in a health care facility while receiving medical care. These infections are reported to Care Compare directly from CDC's NHSN. 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.

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

The DHA supports MTFs and Networks with a CQI Program responsible for establishing an infrastructure that enables MTFs, Networks, and HQs to systematically identify, implement, and sustain data-driven and evidence-based quality improvement initiatives. The objective of the CQI Program is to ensure that clinical quality improvement activities are strategically aligned to support the goals of CQM and fulfill the promise of an integrated system of readiness and health with optimized patient outcomes. The CQI Program is integrated within the CQM functional capability and supported by each of the CQM Programs and the DHA performance improvement capability to ensure that improvement opportunities are identified, capitalized upon, and sustained through planning, education guideline development, and knowledge management.

CQI activities include improvement initiative planning, implementation and sustainment, education and training activities for all of CQM, evidence-based practice guideline and clinical tool development, clinical quality improvement studies, and knowledge management activities across CQM. In 2024, the CQI Program will be focusing on incorporation of CPGs into MHS GENESIS workflows, which will allow for monitoring of MTF implementation and adherence. In addition, the CQI Program plans to support the rebuilding of the Leading Practices Program and partner with the DHA Education and Training Directorate on the development of training initiatives for MTFs and the Director's DHA Academy initiative.

Improvement Initiative Planning

The CQI Program works closely with the Clinical Measurement Program and the Clinical Communities to identify, plan, implement, measure, and sustain improvement initiatives. This includes collaboration with the DHA Performance Planning (PP) efforts. PP is the DHA planning process that integrates capabilities in strategic planning, performance planning, financial operations, performance improvement, and decision making. CQI ensures that CQM and all its capabilities are represented in the DHA PP process and have a voice in this process, aligning Network and MTF activities to DHA CQM priorities.

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

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

Clinical Quality Management Education and Training (CQM E&T)

The CQM E&T capability within CQI assists the CQM programs in developing a DHA CQM workforce equipped with core competencies in health care quality, patient safety, and quality improvement. As a critical foundational element, CQI supports value generation from quality improvement efforts through the development of a competent and educated CQM staff DHA-wide. In this role, CQI sets the conditions for successful improvement and sustainment by ensuring DHA enterprise CQM staff have access to training and education that lead to competence in their organizational roles. CQM E&T and CQM programs empower individuals to use evidence-based tools and improvement science to help identify improvement opportunities and promote data-driven improvement behaviors throughout the system in alignment with the MHS HRO journey. In collaboration with the Services, CQM E&T developed applicable CQM competencies and piloted new DHA learning resources for the general workforce. CQM E&T also created, piloted, and implemented a Foundational Concepts for Entry-Level Clinical Quality Management (all CQM) Professionals Course. They also drafted a Training and Development Standard Operating Procedure (SOP), documenting and codifying how education and training will be developed and maintained across CQM. To support implementation of the Training and Development SOP and associated tasks, CQM E&T stood up and manages the Education and Training Working Group. CQM E&T continues to advocate for this critical infrastructure capability to better support DHA enterprise clinical quality improvement and high reliability.

Evidence-Based Practice

The CQI Program assumed the DoD program management of the joint VA/DoD Evidence-Based Practice Work Group (EBPWG), which is chartered through the Health Executive Committee (HEC) Clinical Care Business Line reporting to the Joint Executive Committee. The EBPWG is responsible for using clinical and epidemiological evidence to improve the health of the population across the VHA and DoD. The VA and DHA collaborate to update and develop new CPGs that are nationally and internationally recognized and meet the needs of the military and veterans' health care systems. VA/DoD CPGs consistently receive national recognition, including the ECRI Guidelines Trust approval. The VA/DoD partnership facilitates the development of both CPGs and clinical support tools for clinicians and patients to promote continuous learning. The choice of guidelines to update or develop is determined by the VA/DoD EBPWG and is based on careful consideration of the readiness needs of the military, beneficiaries served, and the continued care of the Veteran population. In addition, considerations take into account high-volume and high-cost health conditions treated within the VHA and DHA. Congress can also mandate the development and/or update of a CPG.

At the close of FY 2023, there were 25 VA/DoD CPGs completed or undergoing update/development. There are three CPGs still under development from FY 2023: Management of Stroke Rehabilitation, Assessment and Management of Patients at Risk for Suicide, and Tinnitus. Six CPGs are projected to enter the update cycle in FY 2024: Rehabilitation of Lower Limb Amputation, Chronic Insomnia Disorder/ Obstructive Sleep Apnea, Asthma, Chronic Kidney Disease, Obesity, and Dyslipidemia. Development of two new CPGs are also anticipated to begin in FY 2024: Tobacco Cessation and Pressure Injury Prevention.

Clinical Quality Improvement Studies

The CQI Program conducts clinical quality improvement studies designed to validate and improve both processes and outcomes of the health care delivered to DHA beneficiaries. These studies utilize clinical and administrative data, comparing the performance of MHS direct care and private sector care with civilian national benchmarks. To direct these investigations, the CQI Program has established a Clinical Quality Improvement Studies (CQIS) Working Group, which serves as the DHA lead for such improvement and safety studies. This working group consists of multiple stakeholders across CQM and Medical Affairs.

CQIS Working Group studies in FY 2023 included Maternal Hypertension, Quality of Care in the Virtual Environment, and an evaluation of DHA's Standardized Mortality Ratio.

HIGH RELIABILITY OPERATING MODEL/CLINICAL COMMUNITIES

Primary Care Clinical Community

Primary Care Services

MHS primary care services are driven by evidence-based clinical practices. The MHS PCMH practice model provides the essential structure to establish standardized 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.

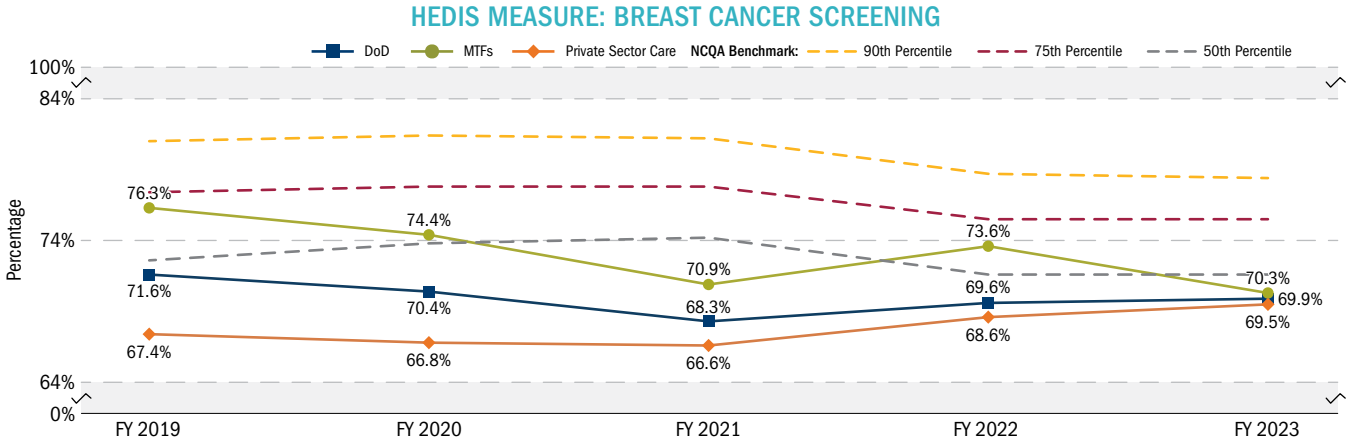
VA and DoD CPG collaboration has established a rigorous systematic review of medical evidence to help primary care providers and health care teams deliver consistent high-quality health care to beneficiaries. CPGs are developed by multidisciplinary clinical experts and are based on clinical research 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 is to incorporate the CPGs into the clinician's workflow to ensure ease of use with information on assessment, diagnosis, and recommendations for treatment 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 standardized 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 and performance data at the enterprise, Network, clinic, and provider levels. 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 networks 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 dynamically linked dashboards at the MTF level and aggregated to Networks, and the MHS as a whole. MHS leadership formally reviews and assesses select measures on a quarterly basis, including HEDIS, with discussion on efforts to improve performance.

Adult HEDIS Measures

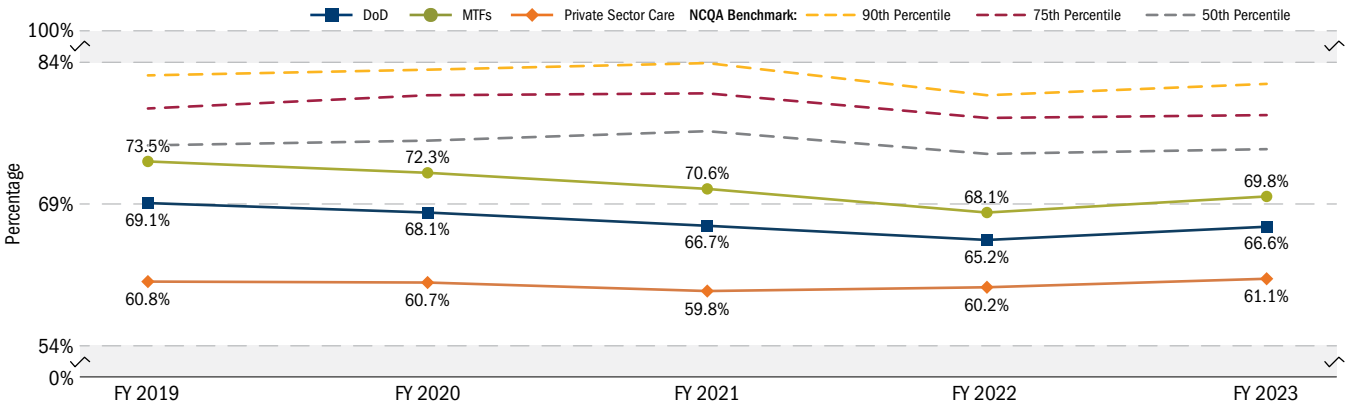
- **Breast and Cervical Cancer Screening:** HEDIS measures focused on cancer screening for early detection and treatment to maximize the potential for a cure. DoD breast cancer screening rates remained slightly below the 50th percentile in 2023. MTFs saw a 3.3 percentage point decrease from the previous year, while private sector care improved by 0.9 percentage points. Cervical cancer screening rates remain below the 50th percentile across all sectors of care. For direct care, this may be related to incomplete laboratory data being captured in MHS GENESIS.



Source: MDR (MHS Data Repository)
Note: Data for FY 2020 are through May 2020.

Primary Care Clinical Community *(cont.)*

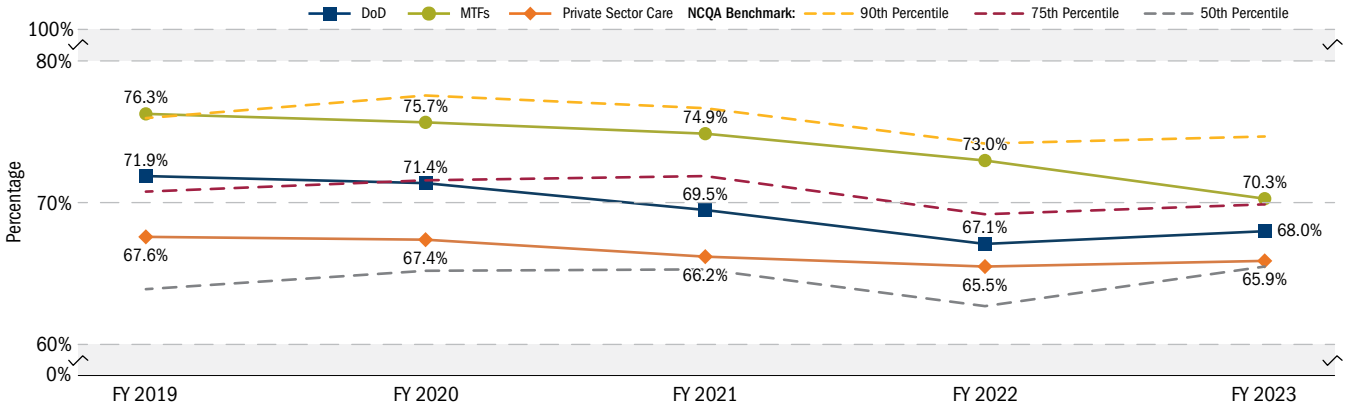
HEDIS MEASURE: CERVICAL CANCER SCREENING



Source: MDR
Note: Data for FY 2020 are through May 2020.

- **Colorectal Cancer Screening:** HEDIS measure focused on detecting colorectal cancer as well as screening for premalignant polyps to prevent cancer. The MTF rate has continued to decrease since 2019. Last year, it decreased by 2.7 percentage points, but it remains above the 75th percentile. The DoD and private sector care rates remain between the 50th and 75th percentiles.

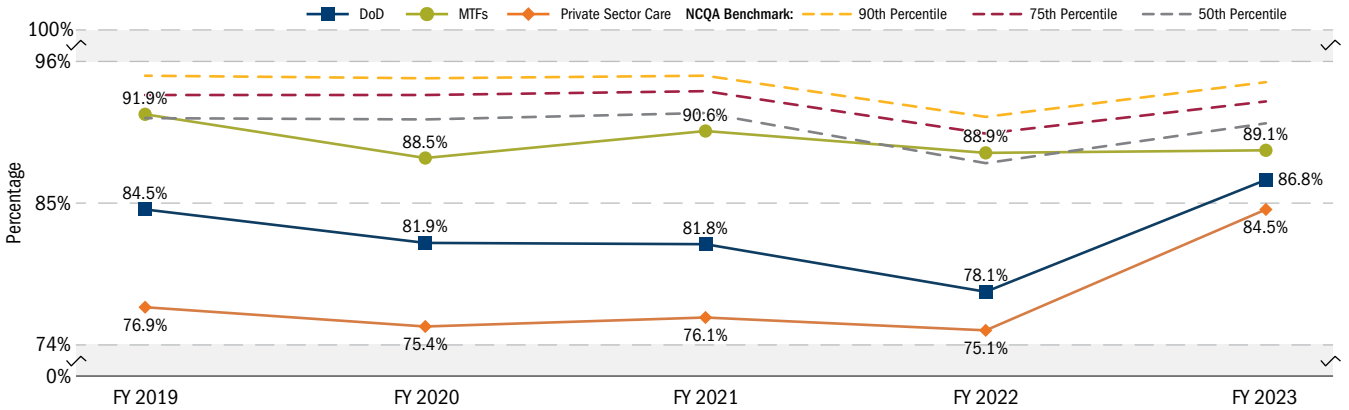
HEDIS MEASURE: COLORECTAL CANCER SCREENING



Source: MDR
Note: Data for FY 2020 are through May 2020.

- **Diabetes HbA1c Screening:** HEDIS measure focused on annual testing for the common and serious chronic disease of diabetes. The overall DoD rate increase of 8.7 percentage points over the last year based mainly on improvements in private sector care. All sectors continue to perform below the 50th percentile.

HEDIS MEASURE: DIABETES HbA1c SCREENING

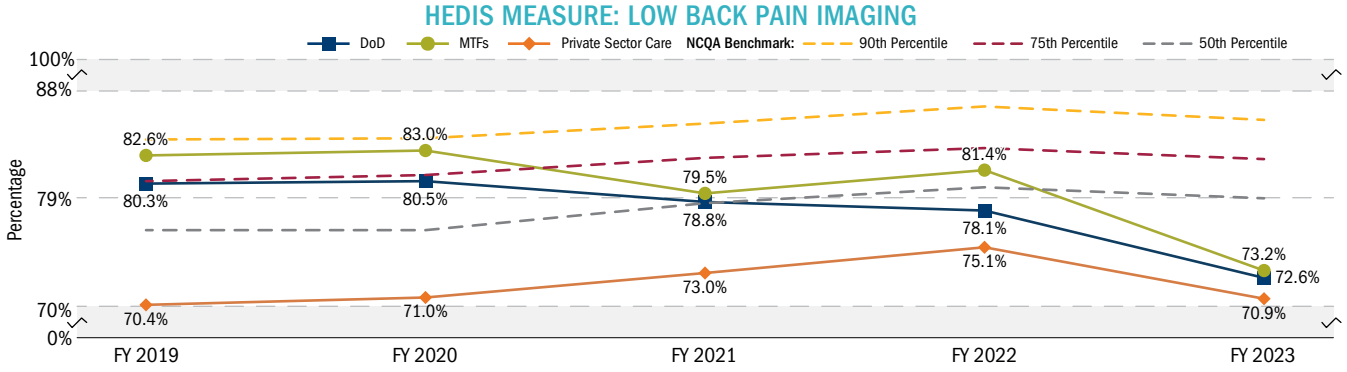


Source: MDR, May 2023
Note: Data for FY 2023 are through May 2023.

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

Primary Care Clinical Community *(cont.)*

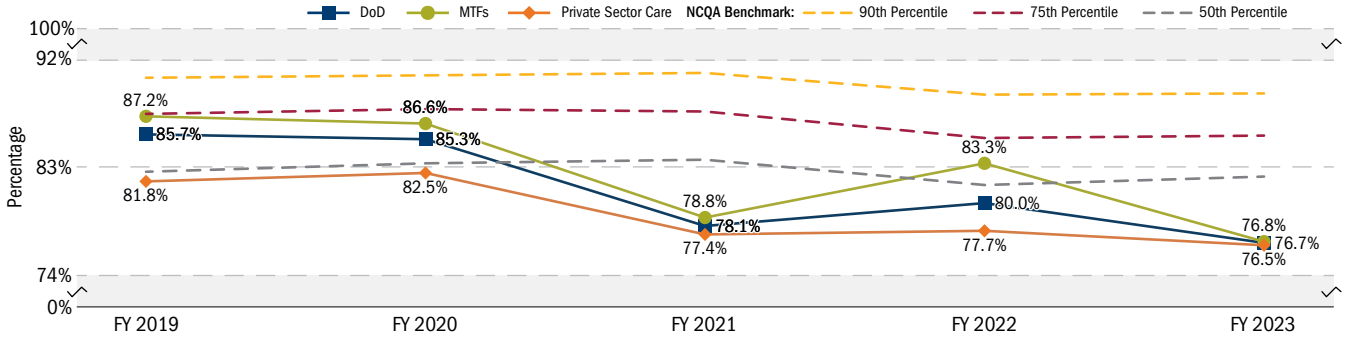
- **Low Back Pain (LBP) Imaging:** HEDIS measure focused on decreasing the overuse of imaging for acute LBP. Rates reflect avoidance of imaging within 28 days of an LBP diagnosis. MHS has integrated the VA/DoD LBP CPG into the EHR to support providers with improvement initiatives. Performance reporting capabilities were developed for each level of care, MTF, provider team, and individual provider to support feedback. MTFs and private sector care saw declines in this measure over the last year with scores below the 50th percentile in all sectors. For direct care, this may be related to data quality issues associated with the MHS GENESIS implementation.



Source: MDR

Note: Data for FY 2020 are through May 2020.

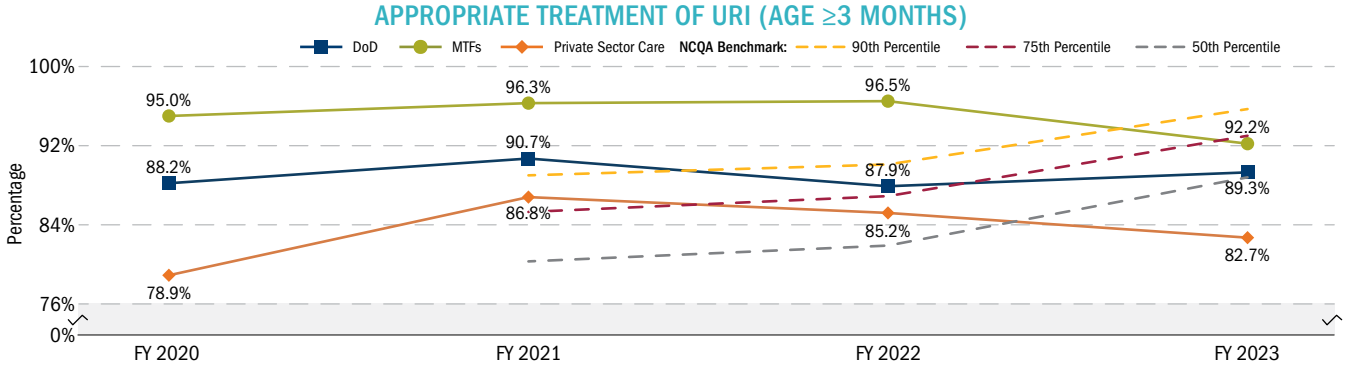
- **Well-Child Visits:** HEDIS measure focused on the adequacy of well-child care for infants, as demonstrated by children having six visits within the first 15 months of life. Over the last year, the MTF rate decreased 6.5 percentage points, which resulted in scores below the 50th percentile across all sectors of care. For direct care, this may be related to data quality issues associated with the MHS GENESIS implementation.



Source: MDR

Note: Data for FY 2020 are through May 2020.

- **Appropriate Treatment of Upper Respiratory Infection (URI):** HEDIS measure focused on the avoidance of antibiotic prescribing for anyone three months of age or older diagnosed with a URI. This measure increases awareness of the importance of antibiotic stewardship among children and adults to prevent antibiotic resistance. This is a new measure as of 2020. New measure benchmarks became available in 2021. DoD has improved slightly in the measure, maintaining a performance above the 50th percentile, with MTFs above and private sector care below the 50th percentile.



Source: MDR

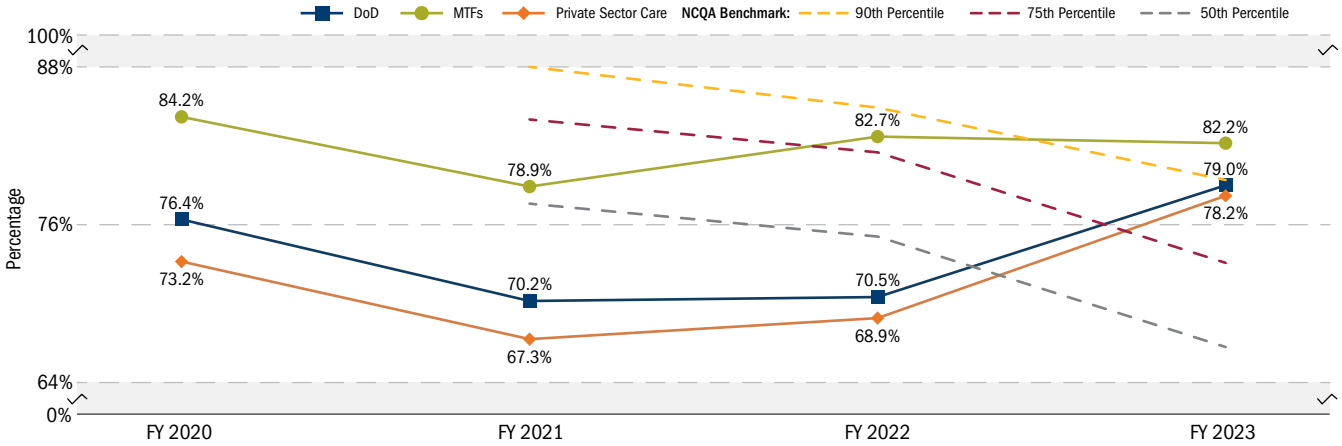
Note: Data for FY 2020 are through May 2020.

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

Primary Care Clinical Community *(cont.)*

- **Appropriate Treatment of Pharyngitis:** HEDIS measure focused on appropriate use of antibiotics for anyone three months of age or older diagnosed with pharyngitis, based on laboratory data. This measure increases awareness of the importance of laboratory testing and confirmation prior to prescribing antibiotics for pharyngitis. This was a new measure as of 2020. New measure benchmarks became available in 2021. In 2023, DoD performed between the 75th and 90th percentiles.

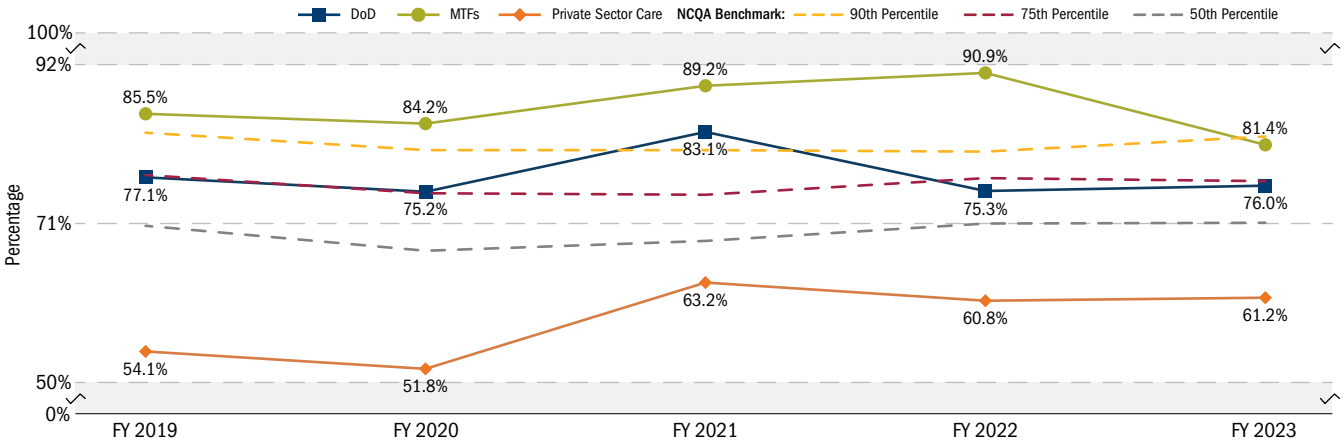
APPROPRIATE TREATMENT OF PHARYNGITIS



Source: MDR
Note: Data for FY 2020 are through May 2020.

- **Mental Health (MH) Follow-Up:** This HEDIS measure examines 30-day MH follow-up care in the MHS MTF and private sector care venues. The overall DoD rate increased slightly by 0.7 percentage point, with 2023 performance falling between the 50th and 75th percentiles.
- While MTFs performed slightly below the 90th percentile, private sector care performed below the 50th percentile. Drops in MTF performance may be related to data quality issues associated with MHS GENESIS.

HEDIS MEASURE: MENTAL HEALTH 30-DAY FOLLOW-UP



Source: MDR
Note: Data for FY 2020 are through May 2020.

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

Primary Care Clinical Community *(cont.)*

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

The MHS performed well compared with national HEDIS benchmarks. Treatment for URI, Treatment for Pharyngitis, Mental Health Follow-Up: 7 Days, and Diabetes Control <8% fell between the 75th and 90th percentiles. Of the 13 measures reported in 2023, the MHS saw rates improve in five measures: Well-Child: 30 Months, Treatment for Pharyngitis, Treatment for Upper Respiratory Infection, Breast Cancer Screening, and Diabetes A1c Level <8%. The MHS is above the 50th percentile for seven of the 2023 reported measures and only three measures fall below the 25th percentile. Overall MHS performance, shown below, includes TRICARE Prime enrollees to all current DHA facilities, along with TRICARE Prime enrollees to Defense Medical Information System Identifiers (DMIS IDs) associated with a managed care support contractor (MCSC) and Uniformed Services Family Health Plan (USFHP). MHS GENESIS data are included for transitioned facilities starting in June 2022.

MHS HEDIS BENCHMARK PERFORMANCE, JUNE 2019–MAY 2023

HEDIS MEASURE	2019	2020	2021	2022	2023	2019 TO 2020 CHANGE	2020 TO 2021 CHANGE	2021 TO 2022 CHANGE	2022 TO 2023 CHANGE	HEDIS BENCHMARK STATUS 2023
Mental Health										
Mental Health Follow-Up: 30 Days	77.05	75.20	83.46	78.33	75.84	-1.85	8.26	-5.13	-2.49	★★★
Mental Health Follow-Up: 7 Days	59.34	58.04	69.36	61.46	58.44	-1.29	11.32	-7.90	-3.02	★★★★
Pediatric										
Well-Child: 15 Months	85.95	85.28	77.01	79.59	77.84	-0.67	-8.28	2.58	-1.75	★★
Well-Child: 30 Months			74.63	75.60	75.90			1.24	0.30	★
Children with Pharyngitis[a]	83.76									
Children with Upper Respiratory Infection[a]	93.64									
PCMH										
Treatment for Pharyngitis[b]		76.38	70.07	69.82	76.91		-6.30	-0.25	7.09	★★★★
Treatment for Upper Respiratory Infection[b]		88.17	91.38	89.20	95.31		3.21	-2.18	6.11	★★★★
Breast Cancer Screening	71.70	70.37	67.99	68.61	70.19	-1.33	-2.37	0.61	1.58	★★
Cervical Cancer Screening	75.38	69.25	67.56	66.29	62.90	-6.13	-1.69	-1.27	-3.39	★
Colorectal Cancer Screening	72.36	71.37	69.79	68.43	68.07	-1.00	-1.58	-1.36	-0.36	★★★
Chlamydia Screening in Women	66.50	64.13	52.29	49.99	46.18	-2.37	-11.85	-2.29	-3.81	★★
Low Back Pain Imaging	80.48	80.54	77.92	77.63	74.58	0.05	-2.62	-0.28	-3.05	★
Diabetes Screening	84.60	81.86	81.77	80.39		-2.74	-0.08	-1.38		
Diabetes A1c Level <7%	46.80	42.71				-4.09				
Diabetes A1c Level <8%	67.62	63.19	54.91	60.91	66.45	-4.43	-8.28	6.00	5.54	★★★★
Diabetes A1c Level ≤9%	77.21	73.52	64.06			-3.69	-9.46			
Diabetes A1c Level >9%[c]				29.34	24.98				-4.36	★★★

Source: MHS Population Health Portal, May 2023

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

[b] New measure in 2020

[c] New measure in 2022

Notes:

– The data are June–May look-backs for the given year.

– Rates include TRICARE Prime enrollees to Army, Air Force, Navy, DHA, MCSCs, and associated USFHP DMIS IDs.

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

– 2023 data include sites that have transitioned to MHS GENESIS.

– HEDIS Benchmark Status:

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

– Private sector care measure results are derived from TRICARE encounter data (TED) and other administrative data.

Neuromusculoskeletal Clinical Community (NMSKCC)

The mission of the NMSKCC is to optimize the neuromusculoskeletal health and readiness of the force by enabling efficient business practices and data-driven decisions to decrease clinical practice variation, improving outcomes, and ensuring a high-quality, consistent patient experience. The NMSKCC provides leadership to the patient-centered, clinician-led neuromusculoskeletal networks that span all Service components, environments, and care, impacting areas from headquarters through MTFs. The NMSKCC is the MHS proponent for improving readiness through comprehensive neuromusculoskeletal, traumatic brain injury (TBI), and amputation/extremity trauma care standardizing care of common conditions, such as pelvic health rehabilitation, 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), reviewed and updated guidance to the Acute Concussion Care (ACC) Clinical Pathway, originally published 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. The ACC Pathway guidance update directs the administration of state-of-the-science clinical tools such as the Military Acute Concussion Evaluation version 2 (MACE 2) for ADSMs and adult beneficiaries, the Acute Concussion Evaluation (ACE) screening tool for the pediatric population, and the Progressive Return to Activity (PRA) protocol. Moreover, the revised administrative instruction specifies a 72-hour follow-up appointment requirement. The TAC collaborated with the National Intrepid Center of Excellence to develop specialty care referral guidelines to ensure timely and appropriate care after sustaining a concussion, to optimize access to specialty brain health care for Service members and other beneficiaries with delayed recovery. The DHA TBI Program Manager and the TBI Center of Excellence staff worked to create and streamline access to acute concussion screening tools (MACE 2 and ACE) and PRA Clinical Recommendation in MHS GENESIS' electronic health record. Additionally, the team collaborated with DHA Health Informatics to create a concussion report in GENESIS to assist MTFs identify patients diagnosed with concussion to receive a follow-up appointment within 72 hours after the patient's initial visit. Data show an incremental increase in MTFs meeting the goal of early identification, assessment, and management of acute concussion.

The NMSKCC is also working to implement a direct access to physical therapy initiative. The initiative seeks to facilitate early access to physical therapy, which has been shown to improve patient outcomes and reduce cost and additional utilization of health care resources. The NMSKCC is currently assessing the effectiveness of this initiative through a three-phased implementation pilot program. Phase A of the pilot program started in June 2022 with six MTFs in the Network–Indo-Pacific. Phase B consists of 25 additional MTFs divided into two cohorts. Eight of the Phase B MTFs implemented direct access to physical therapy (PT) in January 2023, with an additional 17 MTFs in June 2023. Phase C will begin pre-implementation in October 2023, and is scheduled to conclude in December 2025.

The NMSKCC is also engaged with multiple areas across the enterprise. The Pelvic Rehabilitation Workgroup continues to develop a comprehensive document encompassing all pelvic health rehabilitation services. The Dry Needling Workgroup completed the administrative instruction providing guidance on the indications, procedures, training, and privileging for the implementation of dry needling in the MHS. They subsequently developed a continuing education unit–awarding course to provide evidence-based pain management techniques to effectively treat acute and chronic myofascial pain without the use of pharmacologic treatments within a multimodal treatment plan. The Athletic Training Workgroup continued to make progress to standardize credentialing and privileging of athletic trainers operating in DHA facilities. The Amputee Care Advisory Committee continues to staff a procedural instruction providing guidance for care management of DoD beneficiaries with amputation.

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

Women and Infant Initiatives

The Women's Health team promotes readiness and process improvement and maximum value by catalyzing innovation to achieve optimal patient outcome by minimizing preventable harm. The optimal way to improve patient outcomes is to identify and minimize disparities by decreasing unwarranted variation in clinical processes. Standardization in direct care utilizes evidence-based standardization for clinical assessment, responses, and evaluation of care. Women's Health uses national collaboratives and processes to expand quality of care, add transparency, and transform leading practice. Bidirectional communication from DHA to the DHNs and coaching at the MTF level ensure consistent outcome reviews for clinical standardization.

The Women's Health team collaborates both internally within MHS as well as externally with the VA and national organizations to optimize care and outcomes.

Perinatal Care Measures

A component of women's health care is perinatal care. Mother and infant care is a high-volume specialty in both direct care (MTF) and private sector care. To demonstrate the quality of care delivered by the MHS, multiple clinical quality measures are reported externally to regulatory bodies, beneficiaries, and interested parties. The MHS utilizes nationally recognized benchmarks and processes from TJC; CDC; the American College of Obstetricians and Gynecologists (ACOG); the Association of Women's Health, Obstetric and Neonatal Nurses; and the Alliance for Innovation on Maternal Health (AIM) to assess performance outcomes for MHS care delivered within the enterprise, direct care, and private sector care. Evaluation of process, outcome, and trends assists the MHS to improve the quality and safety of care.

Metrics and benchmarks help to identify best practices, address issues, identify/decrease disparities, and mitigate patient risks.

The full implementation of the post-partum hemorrhage bundle was the FY 2023 focus. This bundle implemented and adapted existing valid processes from AIM, CDC, and ACOG to reduce severe maternal morbidity and mortality across direct care. An additional direct care focus for FY 2023 was to establish 130 walk-in contraception services (WiCS) locations. WiCS provides same-day, full-scope, no-appointment access for menstrual management and contraception for ADSMs and other TRICARE-eligible beneficiaries on a space-available basis. The Women's Health team continues to evaluate and implement standardized tools and outcome metrics for perinatal clinicians in direct care.

MHS GENESIS, the new electronic health system, allows for the ability to review near-time data to align practice and evaluate outcomes. MHS GENESIS as an enterprise system, linking all facilities in direct care, provides a platform for data and metrics to evaluate outcomes and care more astutely.

Each year across the MHS, more than 100,000 babies are born, of which about 30,000 are born in MTFs. These beneficiaries represent a wide variety of races and ethnicities, each with unique challenges and opportunities. As data become more clear, the ability to evaluate the outcomes of standardization and optimization of care will improve.

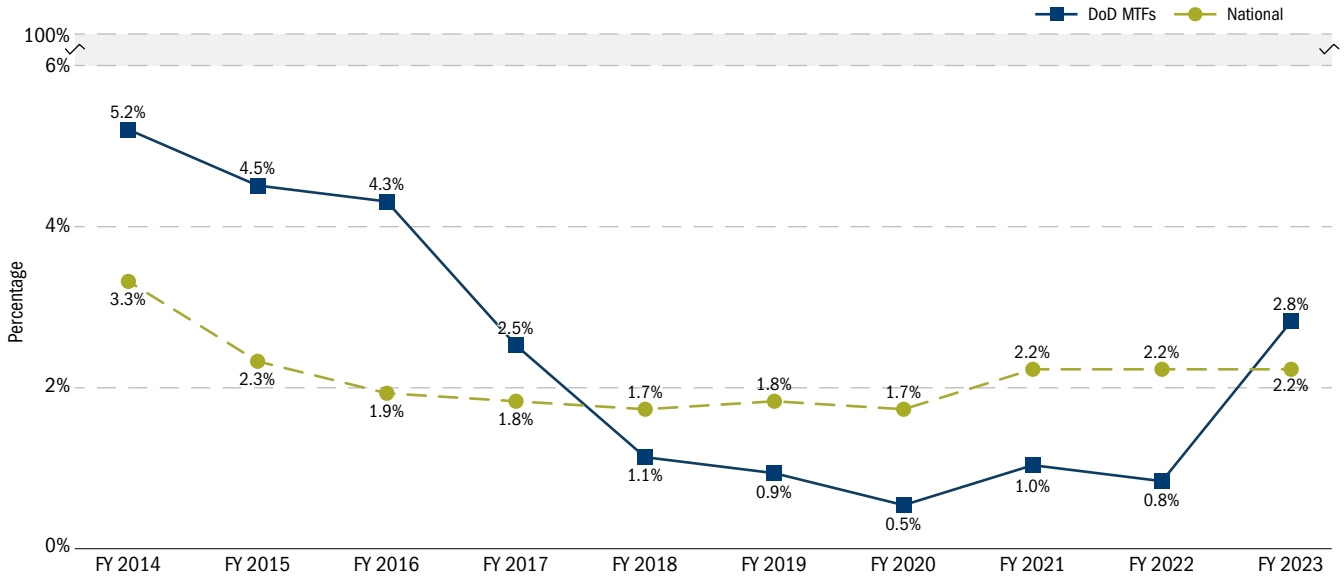
Women and Infant Clinical Community (WICC) and Women's Health Clinical Management Team (WHCMT) *(cont.)*

TJC

The MHS currently tracks metric outcomes for four TJC PC measures at the MHS enterprise, DHN, and MTF levels.

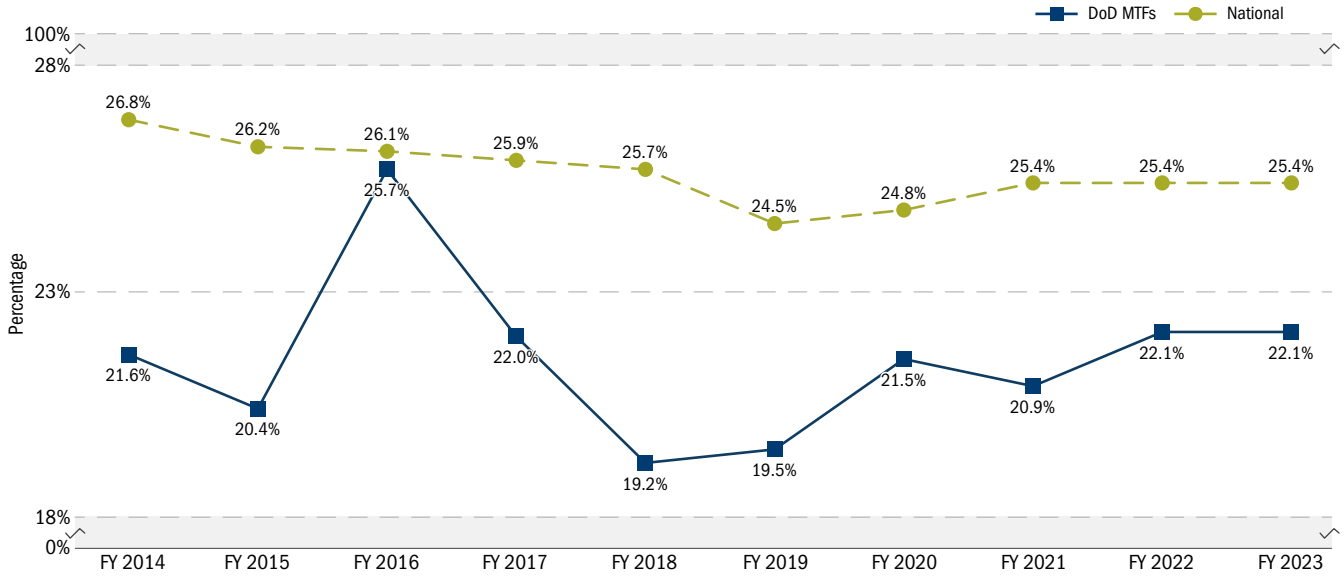
- **Elective Delivery:** This measure (PC-01) focuses on improving the health and outcomes of infants and mothers by avoiding nonmedically indicated early elective births (before 39 weeks gestation). Elective inductions result in more cesarean births, longer maternal length of stay, and increased short-term neonatal morbidity. DoD MTF rates have varied: since FY 2021, they decreased in FY 2022 and increased in FY 2023 (lower is better).

DoD HOSPITAL QUALITY MEASURE: ELECTIVE DELIVERY PC-01, FYs 2014–2023



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

DoD HOSPITAL QUALITY MEASURE: CESAREAN SECTION PC-02, FYs 2014–2023



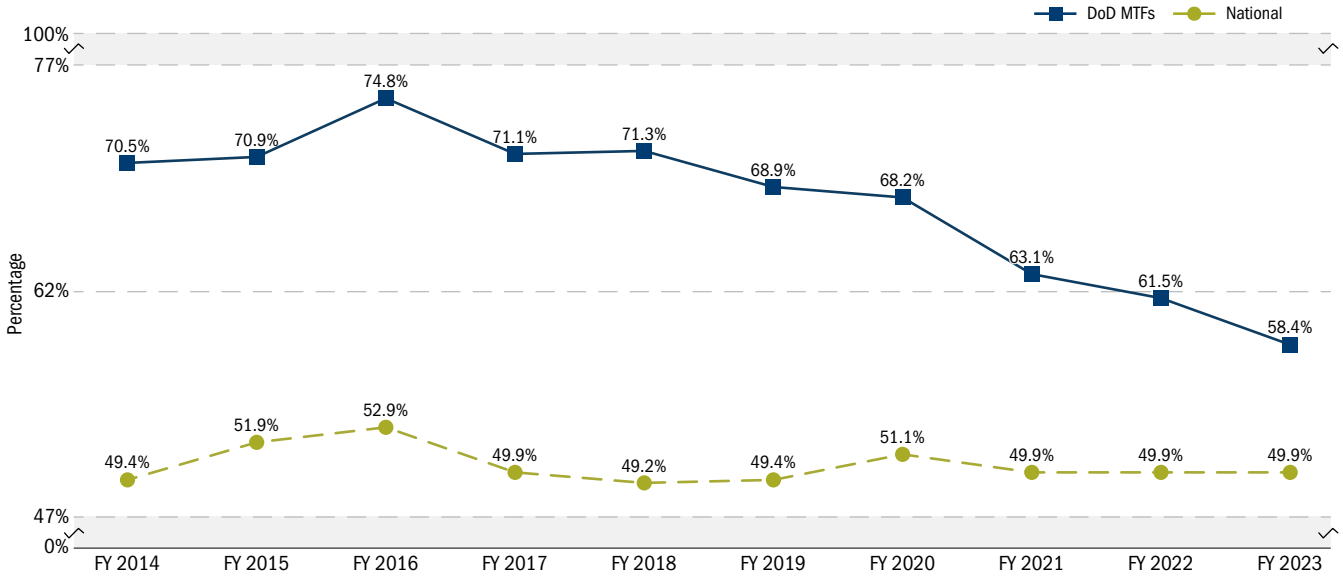
Sources: for DoD MTFs, DHA/Medical Affairs/CSD, 12/5/2023; for National, TJC/TJC Connect/Performance Measurement System Extranet Track (PET), 12/5/2023

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

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

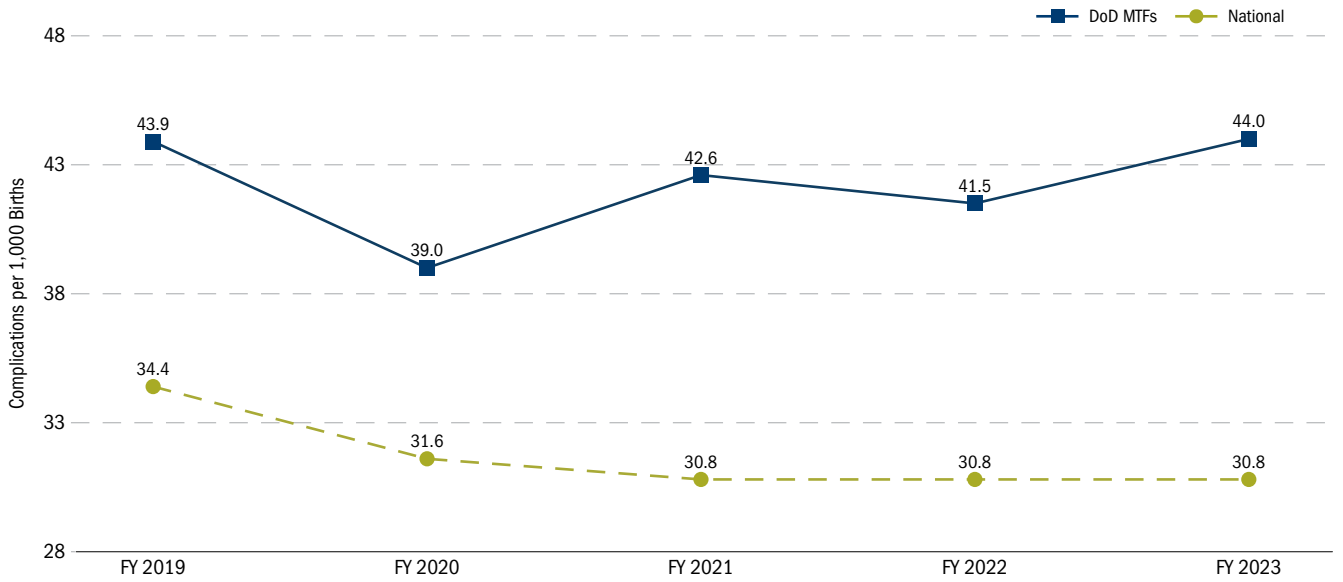
- **Breastfeeding:** This measure (PC-05) focuses on exclusive breastfeeding for newborns during the entire hospitalization. The World Health Organization and national leaders in pediatric and obstetric care note the benefits of breastfeeding an infant for the first six months of life. Early initiation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

DoD HOSPITAL QUALITY MEASURE: EXCLUSIVE BREASTFEEDING PC-05, FYs 2014–2023



- **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. DoD MTF performance still remains above the national rate (lower is better).

DoD HOSPITAL QUALITY MEASURE: UNEXPECTED COMPLICATIONS IN TERM NEWBORNS PC-06, FYs 2019–2023[a]



Sources: for DoD MTFs, DHA/Medical Affairs/CSD, 12/5/2023; for National, TJC/TJC Connect/PET, 12/5/2023

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

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

Behavioral Health Clinical Community (BHCC)

Developing the Behavioral Health High Reliability Operating Model

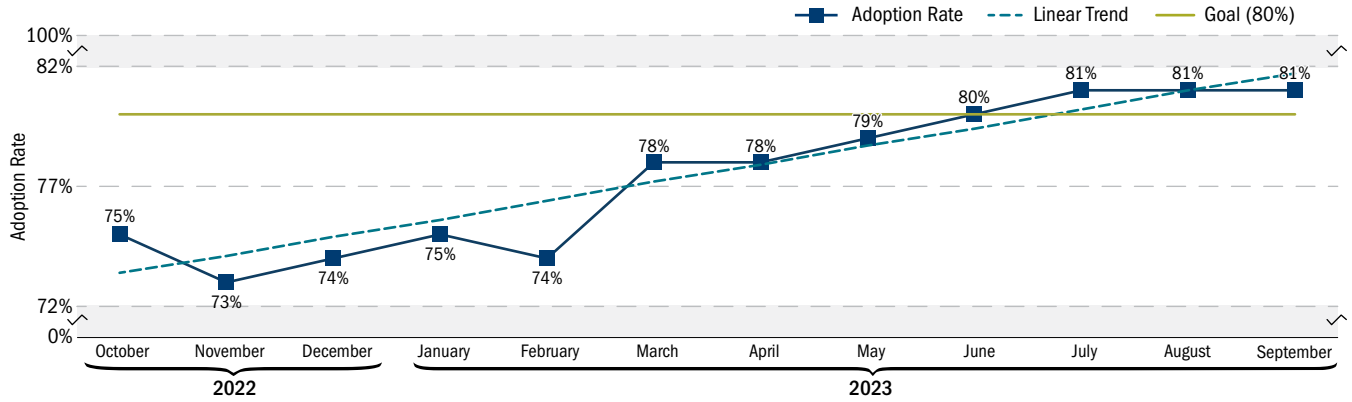
The mission of the BHCC is to promote safe, effective BH care that integrates full spectrum care delivery and community resources through standardized BH programs and procedures, partnerships, engagement with staff and patients, and state of the science research. The BHCC was established in November 2017 and comprises a combination of core voting members, program management, consulting members, and invited participants from across the DHA enterprise. Core members include Directors of Psychological Health from Army, Air Force, and Navy; and a representative from one of the DHA networks—all are active in clinical practice. Consulting members include DoD stakeholder offices whose missions pertain to BH. Clinicians from the fields of psychiatry, psychology, and clinical social work are all represented within BHCC's membership to inform multidisciplinary decision making. The BHCC also invites BH leaders from across the nine Defense Health Networks to promote a shared enterprise-wide awareness of BH challenges and initiatives. The BHCC meets biweekly, immediately followed by an executive session with core members and relevant standing advisors only.

To attain its objectives, BHCC maintains 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, TRICARE, and VA. The BHCC also coordinates closely and partners with the BH Clinical Management Team, which oversees implementation of process improvement initiatives and programmatic execution.

1. **BH Treatment and Outcomes Monitoring:** NDAA FY 2016, Section 729, and a 2013 Assistant Secretary of Defense Memorandum, "Military Treatment Facility Mental Health Clinical Outcomes Guidance," required the DoD to collect BH treatment-specific outcome measurements, and assess BH outcomes, variations, and barriers to VA/DoD CPGs. To meet these requirements, the DHA published DHA-PI 6490.02 "Behavioral Health Treatment and Outcomes Monitoring" on July 12, 2018. DHA-PI 6490.02 sets outcome monitoring requirements in specialty care BH, substance use disorder, and primary care clinics at MTFs. The types of metrics required by DHA-PI 6490.02 for collection, reporting, and analysis include: structure (equipment and training compliance); process (treatment dosage rate, evidence-based treatment rates); and clinical outcome metrics (improvement and/or remission in major depressive disorder [MDD] and post-traumatic stress disorder [PTSD]). Currently, the BHCC is revising DHA-PI 6490.02 to capitalize on the opportunity presented by the MTFs' transition to DHA and further standardize responsibilities and procedures; publication is expected by end of FY 2024.
2. **Behavioral Health Data Portal (BHDP) Implementation:** BHDP is an enterprise-wide web application that enables standardized BH assessments and outcome tracking in BH 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 have been DHA QPP initiatives since FY 2022. Enterprise-wide, the BHDP Adoption Rate has improved since BHDP inception until the COVID-19 pandemic significantly affected MTF performance on this metric. While MTFs quickly adapted to virtual BH visits, the MHS did not have a mechanism in place to enable patients to enter BHDP data from home. Currently, BHDP Adoption Rate remains significantly higher for in-person visits compared with virtual visits and the BHCC continues efforts to improve the ease of use and utilization rate for the remote-access BHDP tool, which was released in April 2022. The MHS-wide BHDP Adoption Rate has steadily improved through FY 2023, reaching and staying at or above the DHA goal since June 2023. The BHCC supports efforts to further improve the BHDP Adoption Rate through education, training, and sharing of best practices.

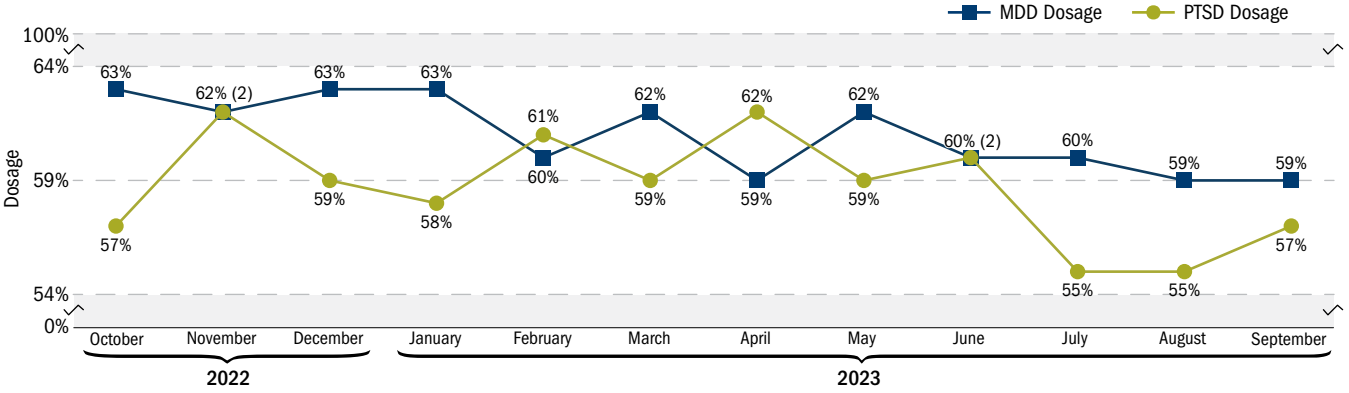
Behavioral Health Clinical Community (BHCC) *(cont.)*

DoD BHDP ADOPTION RATE, OCTOBER 2022–SEPTEMBER 2023



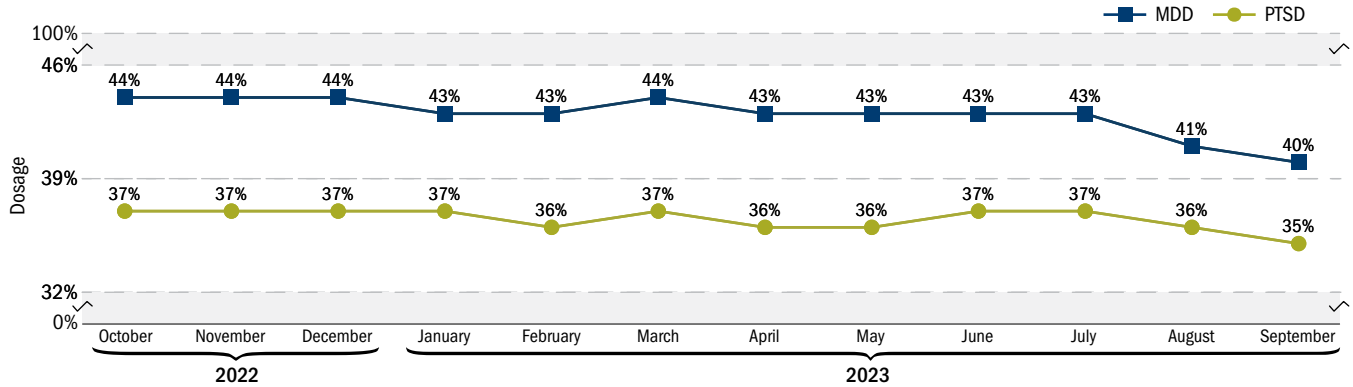
3. **Treatment Dosage for MDD and PTSD:** As described in DHA-PI 6490.02, Treatment Dosage Rate is the percentage of patients with a new diagnosis of PTSD or MDD, or new episode of care (greater than six months since last treatment for PTSD or MDD), who receive at least three follow-up appointments within 90 days of diagnosis. While three visits within 90 days is not optimal care, according to VA/DoD clinical practice guidelines, Army studies showed this dosage was associated with better outcomes, compared with fewer than three follow-up visits. Receiving adequate frequency of care improves outcomes over a shorter period of time, returning the patient to well-being and higher functioning more quickly.

TREATMENT DOSAGE FOR MDD AND PTSD, OCTOBER 2022–SEPTEMBER 2023



4. **MDD and PTSD Positive Outcomes:** DHA-PI 6490.02 requires MTFs to monitor patient-reported outcomes for PTSD and MDD using standardized assessments mandated by Assistant Secretary of Defense for Health Affairs (ASD[HA]) memorandum. The BHCC set current targets for patient improvement or remission at 47 percent for MDD and 36 percent for PTSD. The graph below shows outcomes for both disorders. As Treatment Dosage Rate and Evidence-Based Treatment Utilization Rate improve, positive outcome rates will also improve.

MDD AND PTSD POSITIVE OUTCOMES, OCTOBER 2022–SEPTEMBER 2023



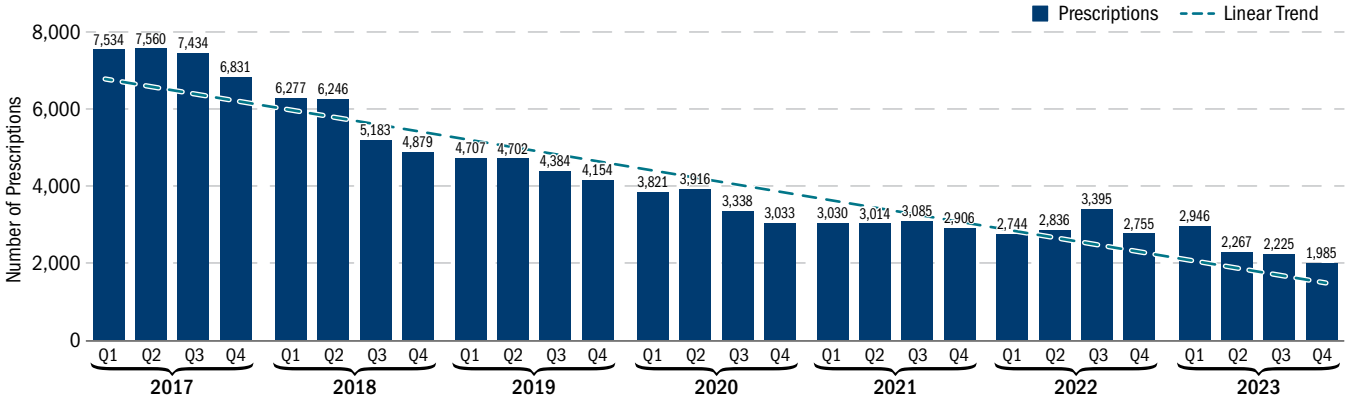
Source: DHA/Medical Affairs/CSD, 12/8/2023

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

Behavioral Health Clinical Community (BHCC) *(cont.)*

5. **PTSD Prescriber Tool:** NDAA FY 2017, Section 745, required DoD to implement a process to monitor MTF prescribing practices of pharmaceutical agents that are not recommended under the VA/DoD CPG for the management of PTSD and acute stress disorder, such as benzodiazepines (BZDs). BHCC developed a PTSD Prescriber Profile that identifies, on a quarterly basis, individual providers who write a high number of BZD prescriptions to patients with PTSD. The overall number of BZD prescriptions written to patients with PTSD declined almost every quarter in FY 2017 through FY 2021, resulting in a 61 percent reduction in BZD prescriptions over this time period. The rate of progress has slowed since FY 2021 but continues to show an improving trend, which the BHCC is reinforcing by educating providers on best practices for PTSD management, leveraging the electronic health record to inform providers on potentially inappropriate prescriptions at the point of care, and by continued quarterly monitoring.

NUMBER OF PRESCRIPTIONS FOR BZD TO BENEFICIARIES DIAGNOSED WITH PTSD, FY 2017 Q1–FY 2023 Q4



Source: DHA/Medical Affairs/CSD, 12/8/2023

6. **Procedural Guidance on the Behavioral Health System of Care:** DHA Administrative Instruction 6490.01, published in February 2023, establishes the DHA Behavioral Health System of Care within the DHA's Direct Care System, utilizing a system of care model to promote efficient and effective BH care for MHS beneficiaries by standardizing program requirements, assessment and treatment services, documentation, coordination processes, training requirements, and outcomes measurement.
7. **Targeted Care (TC):** TC is a workflow process that involves matching individuals who present to specialty BH with the resource that best addresses the individual's need. The resource the individual is matched to can extend beyond the BH clinic and involve other clinical resources, such as Primary Care Behavioral Health, along with nonclinical resources such as military and family life counselors (MFLC), chaplains, or other available helping resource on the installation. Nine MTFs volunteered to participate in the DHA TC pilot over a six-month timeframe from May to November 2023. Preliminary results indicated that, on average, 40 percent of the individuals who presented to the outpatient BH clinics did not require medical intervention or have a diagnosable condition. Sites also reported that approximately 2,650 individuals were successfully connected to other medical or nonmedical counseling resources with the MFLCs as the highest referred resource. This led to increased ability in BH clinics to book multiple follow-up appointments after intake and allowed providers to better focus on empirically based treatments. Further data analyses and expansion of this program are pending in FY 2024.
8. **Implementation of Public Law 1178-81, Section 704 (Brandon Act):** DHA collaborated with OASD(HA) and the Military Department BH leadership to provide information and guidance on MTF procedures that enable Service members to trigger a referral on their own for a mental health evaluation through a commanding officer or supervisor in a grade above E-5. DoD Directive-Type Memorandum (DTM) 23-005 "Self-Initiated Referral Process for Mental Health Evaluations of Service Members," published on May 5, 2023, formalized this DoD requirement.

Behavioral Health Clinical Community (BHCC) *(cont.)*

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

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

Applied behavior analysis (ABA) services are covered by TRICARE as part of a demonstration project for eligible beneficiaries diagnosed with ASD through December 31, 2028. All ABA services are provided through the private sector care network. Other medically necessary and appropriate services covered for beneficiaries diagnosed with ASD include, but are not limited to, speech and language therapy, occupational therapy, physical therapy, medication-based treatment, and psychotherapy.

In June 2014, TRICARE published the Comprehensive Autism Care Demonstration (ACD) Notice in the Federal Register, on approval of the Office of Management and Budget and in compliance with the regulations that govern TRICARE demonstration projects. Based on limited demonstration authority, in July 2014, the ACD consolidated the three previous ABA programs into a single program for eligible TRICARE beneficiaries. This consolidated demonstration ensures consistent ABA coverage for all TRICARE beneficiaries, including Active Duty family members (ADFMs) and non-ADFMs diagnosed with ASD. ABA services are not limited by the beneficiary's age, the dollar amount spent, or the number of services provided, and there are no annual caps on government cost shares. ABA services are authorized based on the clinical necessity and appropriateness of the individual beneficiary's needs. The program provisions attempt to strike a balance that maximizes access while ensuring care at the highest level of quality for our beneficiaries.

The most recent full-year fiscal data available, FY 2021, show that ABA services had a total program expenditure of $452.4 million. The total number of beneficiaries participating in the ACD increased by only 2 percent. By the end of FY 2021, the total number of beneficiaries participating in the ACD who had filed claims for ABA services was 16,657.

In March 2021, the DHA published policy revisions to the ACD with the focus on providing enhanced beneficiary and family support, improving outcomes, encouraging parental involvement, and improving utilization management controls. DHA continues to report on the program and its analyses.

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

Dental Clinical Community (DCC)

The MHS-level 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 DHA's Strategic Plan FY 2023–FY 2028, HRO domains of change, and HRO principles, and is the primary mechanism for improving patient outcomes and embedding learning and safety culture about dental-related clinical practices across the MHS global integrated delivery system. The DCC pays particular attention to the patient's experience in navigating care throughout the spectrum of austere military operations, direct care, and private sector care.

The DCC milestones include the following actions:

- DCC members and dental SMEs continue using teamwork, HRO models, key process analysis, and the DHA submission portal; additional nonvoting members are included in the DCC to support numerous strategic dental health initiatives.
- Weekly core member meetings with the Chief of the Dental Clinical Management Team are held.
- DCC continues to work with the Dental Clinical Management Team and DHA senior leaders to develop standardized dental health care performance and outcome measures/metrics that support the Quadruple Aim.
- Working groups continue to develop enterprise-wide guidance and updates in support of the Chief of the Clinical Management Team to the military dental enterprise. Multiple policy initiatives are being adjudicated.

Ongoing Quality Initiatives: Surgical Services

Surgical Services across the system focus on providing quality surgical care to our beneficiaries. The DHA 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

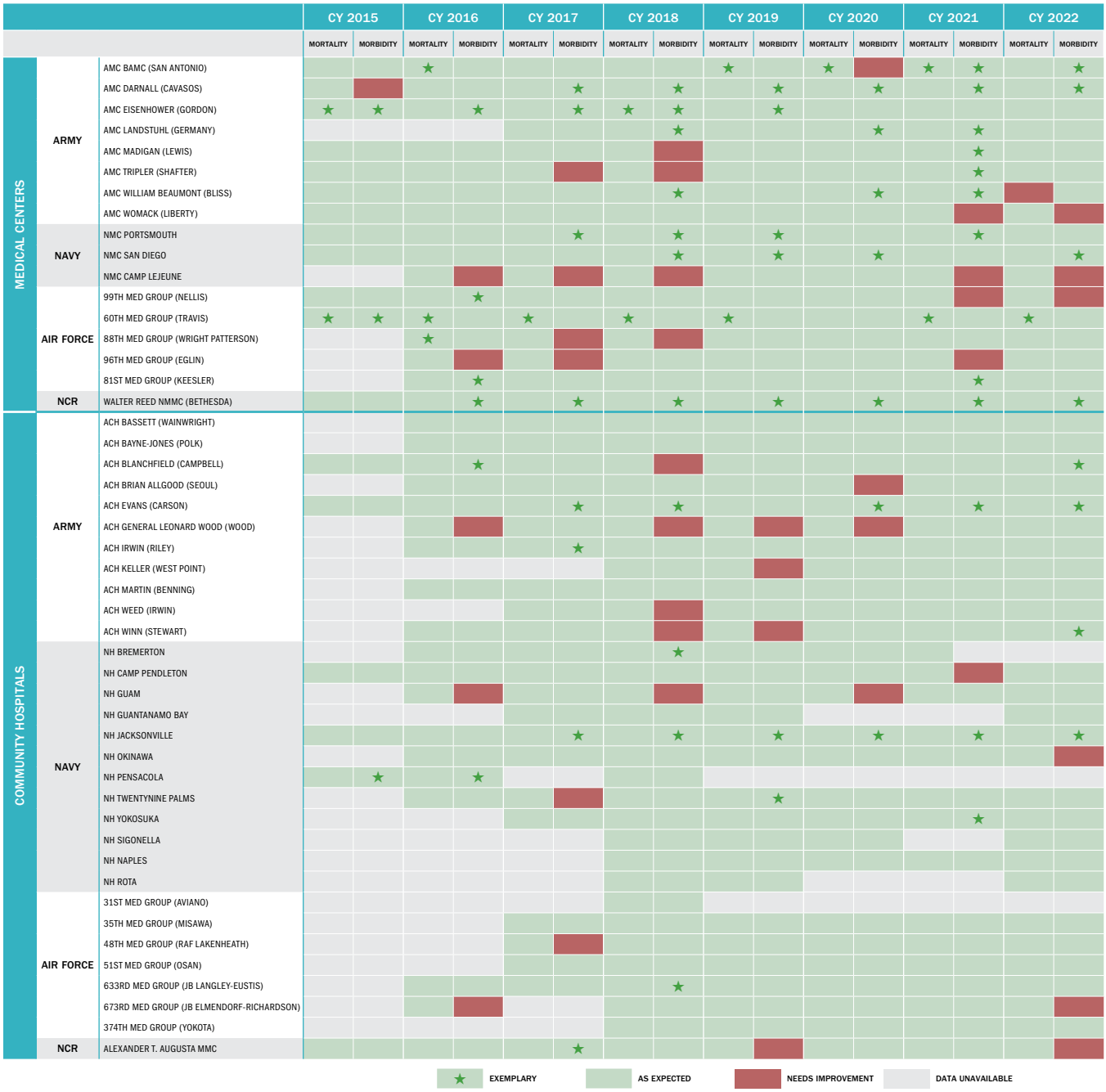
American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP) quality outcomes remain one of the most mature quality improvement programs utilized throughout the MHS in MTFs with inpatient surgery. It is the primary method to continuously monitor surgical outcomes through morbidity and mortality data. In February 2018, the MHS reached its NSQIP Adult Program expansion goal of 100 percent participation (48 MTFs). Currently, at the end of FY 2023, the total number of participating MTFs has decreased to 45 with the transition of several hospitals to stand-alone ambulatory surgical centers. Expansion to other ACS programs include three NSQIP Pediatric Program and seven Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP). DoD NSQIP collaborates closely with the DHA Surgical Services Clinical Community (S2C2), DHA Women and Infant Clinical Community, and other DHA Clinical Communities with relevant overlapping outcomes data 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 2022 mortality data indicated that 43 of 45 MTFs reporting data (data provided from 35,946 assessed surgeries) met the expected performance level, including one facility that was "exemplary" (results in the top quartile of hospitals). One facility was in the "needs improvement" category (results in the bottom quartile of hospitals) for mortality. The morbidity data indicated that of the 45 sites reporting data for CY 2022, 31 MTFs met "as expected" performance levels, while eight were "exemplary." Six MTFs were in the "needs improvement" category. 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). The DoD NSQIP Steering Panel has a process by which any MTF falling in the "needs improvement" category are provided oversight and opportunity for collaboration with an "exemplary" site. Additional targeted improvement efforts have been implemented with Deputy Assistant Director – Medical Affairs (DAD – MA) direction through Corrective Action Plan memos and targeted improvement projects for MTFs designated "needs improvement" for all cases morbidity.

MTF MORTALITY AND MORBIDITY PERFORMANCE, CYs 2015–2022



Source: DHA/OPS Medical Affairs/CSD, 12/7/2023

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 (702) hospitals both internationally and across the United States currently participate in the ACS NSQIP Adult Program). The DoD Collaborative performed "exemplary" in five 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. As surgical site infections (SSI) are common ROR drivers, a DHA-directed improvement project has been chartered and includes development and distribution of evidence-based SSI Prevention Practice Recommendations (PR). Ongoing PR sustainment will be supported by a tailored MHS GENESIS PR workflow.

DoD COLLABORATIVE JULY 2023 SEMIANNUAL REPORT (SURGERY DATES JANUARY 1 TO DECEMBER 31, 2022)

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	35,946	65	0.18%	0.81%	0.64%	1.00%		0.84	0.97%
All Cases Morbidity	35,946	1,060	2.95%	6.03%	5.68%	6.39%		0.96	6.27%
All Cases Cardiac	35,946	41	0.11%	0.39%	0.26%	0.54%	Low	0.63	0.62%
All Cases Pneumonia	35,943	54	0.15%	0.52%	0.36%	0.71%	Low	0.59	0.89%
All Cases Unplanned Intubation	35,945	36	0.10%	0.38%	0.26%	0.53%	Low	0.70	0.55%
All Cases Ventilator >48 Hours	35,944	25	0.07%	0.33%	0.20%	0.50%	Low	0.55	0.61%
All Cases Venous Thromboembolism	35,946	154	0.43%	0.87%	0.75%	1.00%		1.10	0.79%
All Cases Renal Failure	35,940	42	0.12%	0.42%	0.30%	0.57%		0.80	0.53%
All Cases Urinary Tract Infection (UTI)	35,903	229	0.64%	1.09%	0.95%	1.23%		0.99	1.10%
All Cases Surgical Site Infection	35,838	635	1.77%	2.96%	2.74%	3.18%		1.03	2.87%
All Cases Sepsis	35,883	75	0.21%	0.61%	0.47%	0.78%	Low	0.70	0.88%
All Cases C. Diff Colitis	35,946	33	0.09%	0.27%	0.19%	0.36%		0.99	0.27%
All Cases ROR	35,946	611	1.70%	3.22%	3.01%	3.43%	High	1.36	2.39%
All Cases Readmission	35,946	857	2.38%	4.69%	4.39%	4.99%		1.01	4.66%

EXEMPLARY AS EXPECTED NEEDS IMPROVEMENT

Source: American College of Surgeons National Surgical Quality Improvement Program DoD Collaborative Report, released July 2023

[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 157 hospitals participating across the nation, as well as in seven other countries. Naval Medical Center (NMC) Portsmouth has been participating in the program since May 2019. In June 2020, NMC San Diego and Tripler Army Medical Center (AMC) also began participating in the program.

The ACS MBSAQIP provides a quality improvement program for patients suffering from severe obesity. Bariatric surgery is a procedure group with studied relationships between procedural volume and surgical outcomes and features frequently in discussions of high-risk procedures performed at low-volume facilities. These are also one of the few foregut procedures currently available to a broad range of surgeons that can offer surgical skill experience referable to deployment-relevant knowledge, skills, and abilities. There are 21 MTFs performing bariatric procedures on a regular basis. Seven MTFs are currently participating in MBSAQIP, with 10 sites interested in MBSAQIP membership.

The ACS Trauma VRC Program was launched in 1987 to evaluate and validate resources at trauma centers. TQIP was established in 2009 by the ACS and provides risk-adjusted outcome measures for trauma patients. In January 2017, the ACS Committee on Trauma mandated that all trauma centers use a quality improvement program. Participation in TQIP will meet this requirement and assist the Joint Trauma System (JTS) Director with the directive to "develop evidence-based practice trauma care guidelines for clinical practice and program improvement processes," as directed by DoDI 6040.47 "Joint Trauma System." There are currently 12 MTFs working on or designated trauma centers.

Hospital enrollment in these programs depends on dedicated trained and certified nurse reviewers to ensure data quality and integrity, but not all facilities that qualify for participation have the manpower to support participation.

ACS NSQIP CY 2022 Meritorious Award

The annual ACS Meritorious Award is presented to recognize top-performing hospitals for the quality of surgical care provided to their beneficiaries. There are two categories of meritorious hospitals recognized: the All Cases Meritorious List and the High-Risk Meritorious List. The criterion for selection is based upon composite quality scores for surgical care provided in CY 2022 in eight All Cases or High Risk category using a weighted formula combining the following outcomes: 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 2022:

All Cases Meritorious List:

- 60th Med Group (David Grant, Travis)
- Brooke Army Medical Center
- Blanchfield Army Community Hospital

High-Risk Meritorious List:

- 60th Med Group (David Grant, Travis)
- Brooke Army Medical Center

These sites are among the 78 facilities representing the top 10 percent of all NSQIP participating hospitals worldwide in 2022. Of note, each of these facilities have received meritorious recognition on multiple occasions in past years.

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. The COVID-19 pandemic led to using virtual meetings to sustain a rhythm of training. Beginning in July 2022, this collaborative successfully resumed in-person meetings 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 Military Health System Strategic Partnership American College of Surgeons launched in December 2014. This partnership facilitates collaboration and educational opportunities between the ACS and MHS to advance high-quality surgical care.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES

The National Clinical Quality Database

On October 1, 2014, the MHS action plan for Access, Quality of Care, and Patient Safety Memorandum was signed by the Secretary of Defense. This memorandum directed the DHA to establish 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 NSQIP, was identified as a means to significantly contribute to meeting this requirement.

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

The DoD currently participates in 11 clinical quality databases:

- ACS National Surgical Quality Improvement Program Adult Program
- ACS National Surgical Quality Improvement Program Pediatric Program
- ACS Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program
- ACS Trauma VRC and TQIPs
- American Society of Clinical Oncology Quality Oncology Practice Initiative
- National Perinatal Information Center Database
- National Healthcare Safety Network
- CMS Care Compare
- The Joint Commission National Hospital Measure
- Leapfrog Hospital Survey
- Leapfrog Ambulatory Surgery Center Survey

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

Pain Management

The MHS continues to highlight success for pain management with nonpharmacologic and pharmacologic modalities with an emphasis on opioid misuse. Multiple educational opportunities to enhance provider and patient awareness of pain management continue to shift the culture within the MHS regarding evidence-based practices and care.

During FYs 2021 to 2023, the MHS continued to advance pain management capabilities and resources for our beneficiaries and health care workforce. Improved coordination and collaboration across the Services, DHA, USUHS, and VHA resulted in continued 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 awareness and implementation of the DoD/VA CPG "Use of Opioids in the Management of Chronic Pain," as well as updates to other pain-related guidelines using resources available through the Pain Management Clinical Support Service, Clinical Communities, and VA/DoD HEC Work Groups.
- Increasing pain VH integration in MHS primary and specialty care by both direct care visits and provider webinar case-based education. The types of pain visits include evaluation and follow-up with pain specialists as well as behavioral health, pharmacy, and integrative medicine physicians. Patients are referred from locations throughout the MHS. Visits continue to increase, reaching 4,120 in 2022. In addition, five monthly webinars attract providers throughout the MHS for education in pain and addiction issues.
- Furthering health provider education in substance use disorder prevention, screening, diagnosis and treatment of ADSMs and beneficiaries was accomplished at the seventh Annual Substance Use Disorder Symposium. There were 257 attendees at the 2023 Substance Use Disorder Symposium.
- Continued primary care pain skills training offered annually by the National Capitol Region Pain Care Initiative. In 2023, Pain Skills moved to a hybrid format with a combination of both virtual live workshops, prerecorded plenary sessions, and live in-person workshops. There were 324 participants for the training in 2023. The virtual portion of the training consisted of one half-day plenary session followed by a choice of 22 workshops that attendees could select from. The in-person portion of the training consisted of two full days of workshops.
- Continued deployment of PASTOR—the MHS's pain assessment screening tool and outcome registry. PASTOR is one of a growing number of use cases within the MHS Patient-Reported Outcomes Clinical Record that leverage the National Institutes of Health (NIH) Patient Reported Outcomes Measurement Information System.
- Continued integration of the Opioid Prescribers Trend Report, which gives providers and pain leaders insights about opioid prescribing trends at the Market, MTF, clinic, and provider levels. This tool is used to support Stepped Care Model Implementation, CPG adherence, and local quality improvement efforts and provider peer review.
- Expanded awareness and access of the Joint Pain Education Project, a standardized VA/DoD pain management curriculum, and supplemental pain videos for joint use across DoD and VA education and training programs to all providers.
- Participation in research efforts under the NIH/DoD/VA Pain Management Collaboratory to examine the effectiveness of nonpharmacological treatments for acute and chronic pain and complex pain syndromes experienced by Active Duty and Veteran populations.
- Initiated the conversion of DHA-PI 6025.33 "Acupuncture Practice in Military Medical Treatment Facilities," originally published February 20, 2020, to an Administrative Instruction to further standardize acupuncture practice in the MHS.
- Developed recommendations for integrating opioid prescribing safety alerts into the MHS GENESIS electronic health record.

Pain Management *(cont.)*

Preventing Opioid Misuse by Military Service Members

- Opioid Education and Naloxone Distribution Program continued implementation throughout the MHS. Developed a plan to educate patients and families on opioid risks and how to dispense the overdose antidote naloxone.
- Continued naloxone metric for FY 2023; percentage of at-risk population receiving naloxone prescription in past year with increased awareness and prescribing of naloxone from 18 percent in FY 2021 to 79 percent currently for FY 2023.
- Reviewed and updated resource documents for the DoD Opioid Prescriber Safety Training, a tri-annual requirement for all MHS prescribers, on the Joint Knowledge Online platform to align with current guidelines and policies. More than 17,600 providers completed this training in 2023.
- Continued to reduce the number of opioid prescriptions from 8.6 million in 2013 to 2.5 million in 2023, number of patients on long-term opioid therapy from 193,000 in 2017 to 83,000 in 2023, those prescribed high Morphine Equivalent Daily Dose (MEDD>50) from 71,600 in 2017 to 31,000 in 2023, and those co-prescribed BZDs from 77,000 in 2017 to 25,400 in 2023.

DHA-PI 6025.04 "Pain Management and Opioid Safety in the MHS," originally published June 8, 2018, was converted to DHA-Administrative Instruction 6025.08, effective February 8, 2023:

- Establish the MHS Stepped Care Model as the comprehensive standardized pain management model for MHS to provide consistent, quality, and safe care for patients experiencing pain, with an emphasis on nonpharmacological treatments.
- Educate patients in effective self-management of pain and injury rehabilitation.
- Provide MHS providers with clear guidance regarding standards, processes, and decision support tools for safe and effective opioid prescribing.
- Provide guidance for the TRICARE health plan to partner with MCSCs to minimize inappropriate opioid prescribing and conduct value-based pilots of nonpharmacologic pain treatments.
- 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.

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. There is a growing body of evidence that shows that better patient experiences are closely related to patients adhering to preventive measures and treatment protocols, better patient safety within hospitals, less need to seek further treatment after an encounter, better quality of care from hospital staff, and overall better patient outcomes, including both medical and surgical care.

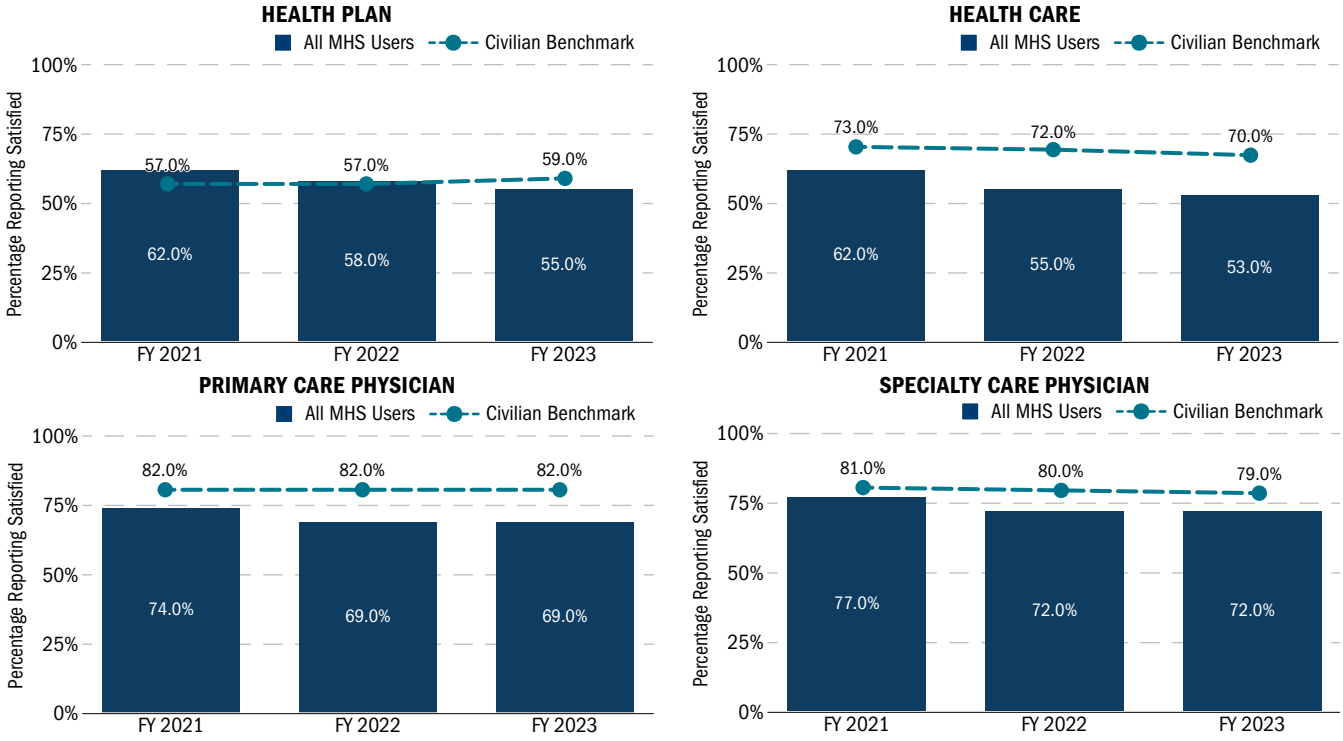
In this section, MHS beneficiaries in the U.S. who have used TRICARE are compared with the civilian benchmark with respect to ratings of (1) the health plan in general; (2) health care; (3) their personal physician; and (4) specialty care. Health plan ratings depend on access to care and how the plan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

Beneficiary Ratings of Their Health Plan through Population-Based Surveys

The population-based HCSDB is based on the CAHPS Health Plan survey and is used to routinely assess MHS beneficiary experience with health care, whether in the direct or private sector care systems or with other health insurance (OHI). Unlike JOES and JOES-C, which follow an outpatient visit, or the TRISS, which follows a discharge from a hospital, the HCSDB is based on a sample of all MHS-eligible beneficiaries worldwide who may or may not have had an outpatient or inpatient encounter in the previous year. Results from the HCSDB can be compared with 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 primary care physician (i.e., personal doctor) and specialty care physician remained relatively the same in FYs 2022 and 2023. MHS beneficiary satisfaction with their health plan and health care decreased by 3 percentage points and 2 percentage points, respectively, between FY 2022 and FY 2023, but declined significantly since FY 2021.
- MHS beneficiary satisfaction with their health plan exceeded that of the civilian benchmark in FY 2021 and FY 2022, but fell short in FY 2023. Additionally, MHS beneficiary satisfaction with health care quality, their personal doctor, and specialty care physicians were also lower than the comparable civilian benchmarks.

TRENDS IN SATISFACTION RATINGS OF KEY HEALTH PLAN ASPECTS, FYs 2021–2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 12/15/2023

Notes:

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

– Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks come from NCQA's 2019 data.

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

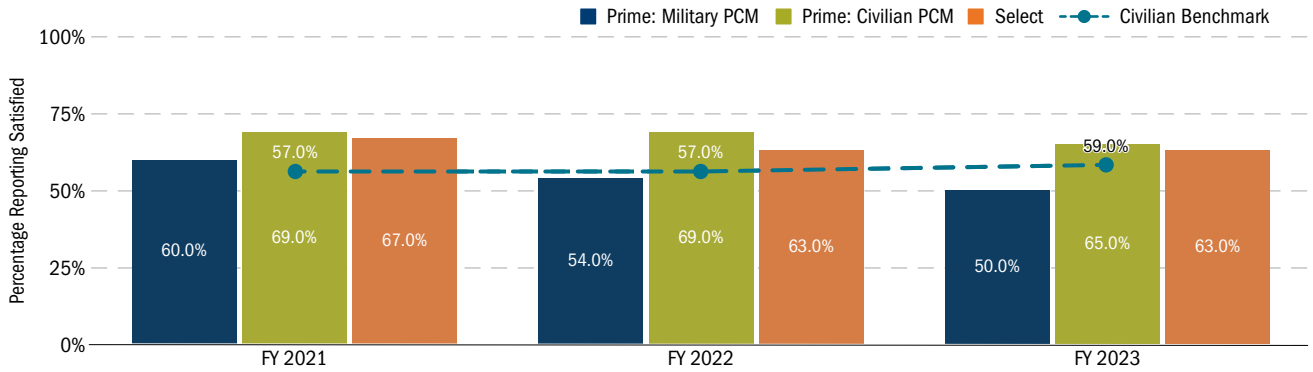
Patient-Centered Care/Experience *(cont.)*

Beneficiary Ratings of Their Health Plan Based on Enrollment Status

Most DoD health care beneficiaries participate in TRICARE in one of two ways: by enrolling in the Prime option or enrolling in the Select option. Satisfaction levels with one's health plan across the TRICARE options are compared with commercial plan counterparts.

- Satisfaction with the TRICARE health plan remained the same for Select enrollees between FY 2022 and FY 2023, and decreased by 4 percentage points for Prime enrollees with a military PCM and Prime enrollees with a civilian PCM for the same time period.
- All MHS enrollment groups reported higher levels of satisfaction with their health plan than the civilian benchmark each year between FY 2021 and FY 2023 with the exception of the Prime enrollees with a military PCM in FY 2022 and FY 2023.

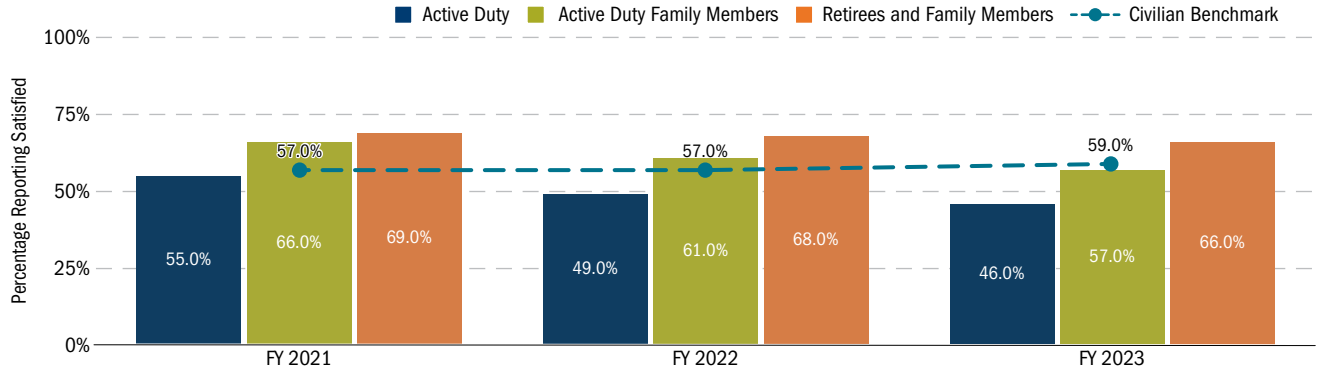
TRENDS IN SATISFACTION WITH THE HEALTH PLAN BY ENROLLMENT STATUS, FYs 2021–2023



Beneficiary Ratings of Their Health Plan Based on Beneficiary Category

- Satisfaction with the TRICARE health plan declined by 9 percentage points from FY 2021 to FY 2023 for Active Duty and ADFMs, and declined 3 percentage points for retirees and their families.
- Satisfaction with health plan scores for Active Duty and ADFMs were below the benchmark in FY 2023.

TRENDS IN SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY, FYs 2021–2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 12/7/2023

Note: Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans.

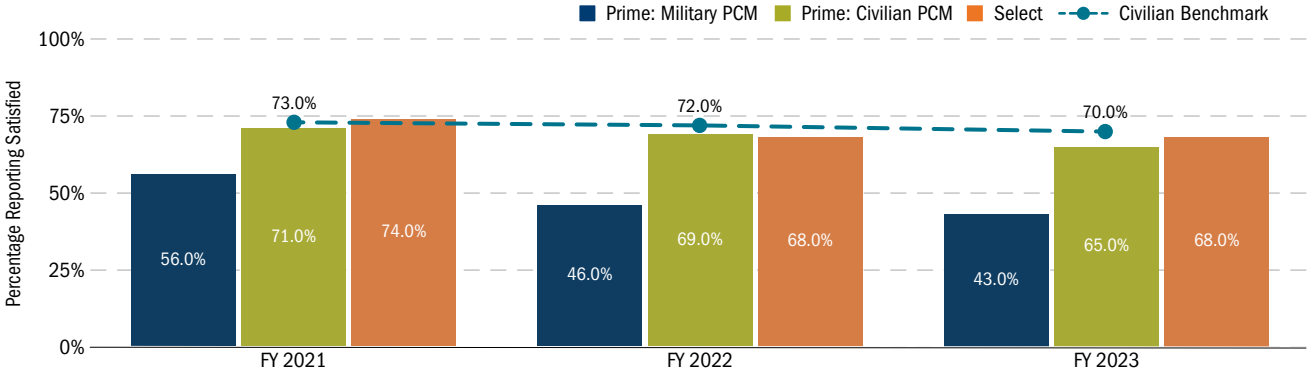
Patient-Centered Care/Experience *(cont.)*

Beneficiary Ratings of Satisfaction with Health Care by Enrollment Status and Beneficiary Category

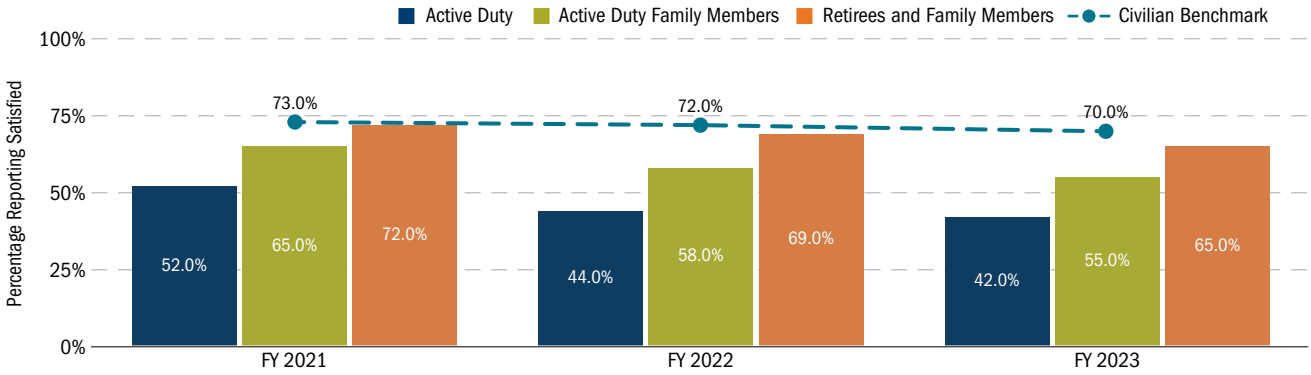
Similar to satisfaction with the TRICARE health plan, satisfaction levels with the health care received differ by beneficiary category and enrollment status.

- Beneficiary satisfaction with their health care declined for each year between FY 2021 and FY 2023 by enrollment status with the exception of Select enrollees where satisfaction with their health plan remained the same between FY 2022 and FY 2023.
- Satisfaction with health care for all beneficiaries were lower than the civilian benchmark in FY 2022 and FY 2023.

TRENDS IN SATISFACTION WITH TRICARE HEALTH CARE BY ENROLLMENT STATUS, FYs 2021–2023



TRENDS IN SATISFACTION WITH TRICARE HEALTH CARE BY BENEFICIARY CATEGORY, FYs 2021–2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 12/7/2023

Note: Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used come from NCQA's 2019 data.

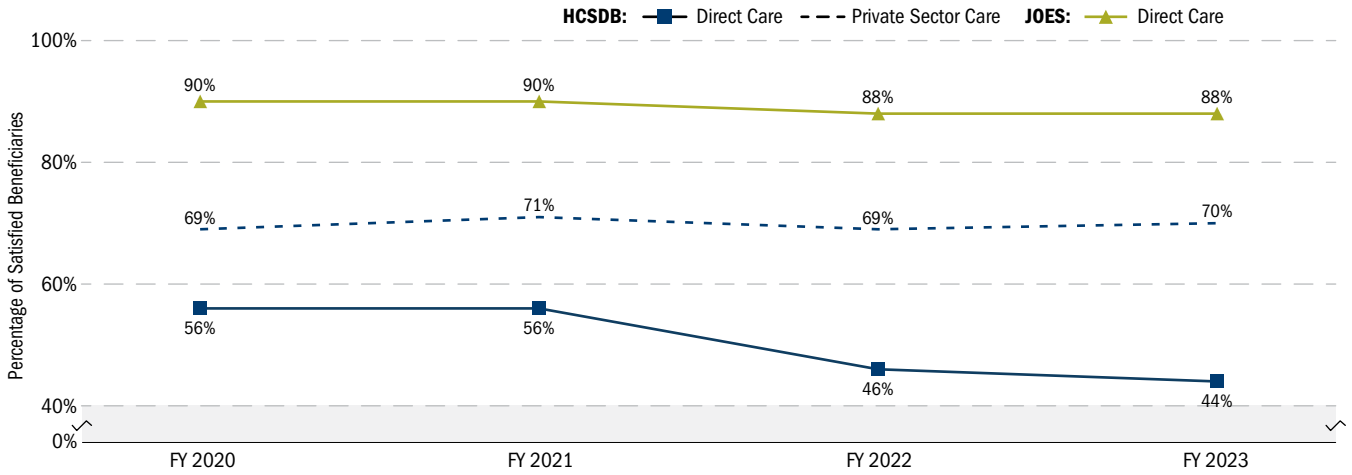
Patient-Centered Care/Experience *(cont.)*

DHA Surveys—Satisfaction with Care and Health Care Rating

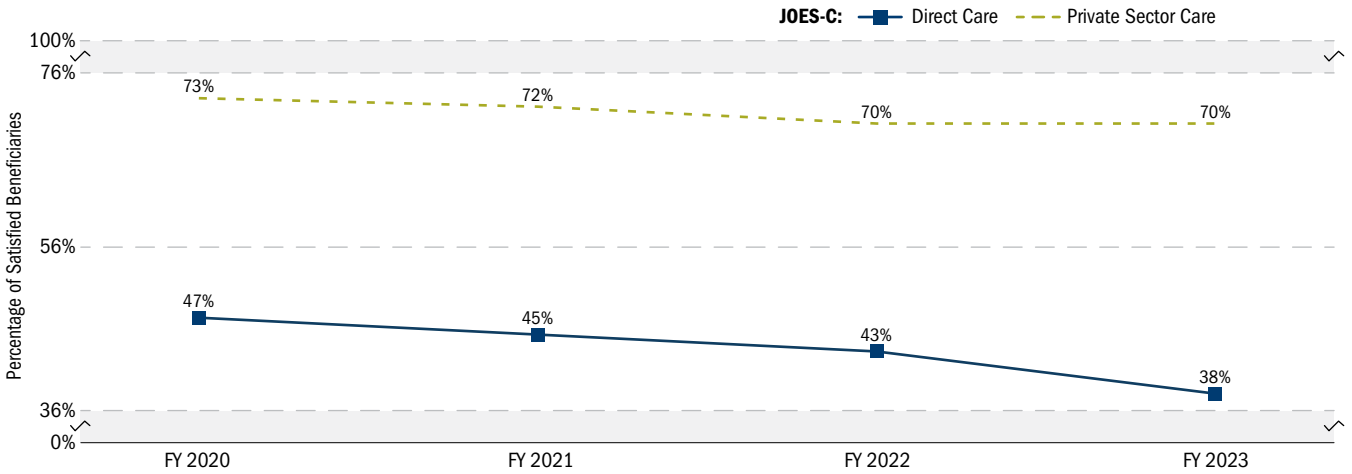
In addition to JOES and JOES-C, the population-based HCSDB survey also reports results for the Satisfaction with Care measure. Including this same item in each survey provides important information about the differences between surveys and the beneficiaries who answer them.

- From FY 2020 to FY 2023, JOES direct care beneficiaries reported the greatest satisfaction with care when compared with beneficiaries responding to HCSDB direct care or private sector care. HCSDB private sector care users reported greater satisfaction with care than those using direct care from FY 2020 through FY 2023.
- HCSDB private sector care scores for satisfaction with care were relatively stable from FY 2020 to FY 2023, while HCSDB direct care decreased by 12 percentage points.
- JOES-C health care rating scores for private sector care decreased by 3 percentage points from FY 2020 to FY 2023, while still above those for JOES-C direct care.

HCSDB AND JOES RATINGS OF SATISFACTION WITH CARE, FYs 2020–2023



JOES-C HEALTH CARE RATING, FYs 2020–2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, HCSDB, JOES, and JOES-C, compiled 12/8/2023

Notes:

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

– The data above reflects the HCSDB Health Care Rating for 2020–2023: "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 8, 9, or 10.

– Results for JOES-C FY 2023 is from October 2022 to August 2023 for direct care and from October 2022 to July 2023 for private sector care. Satisfaction with Care is worded 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.

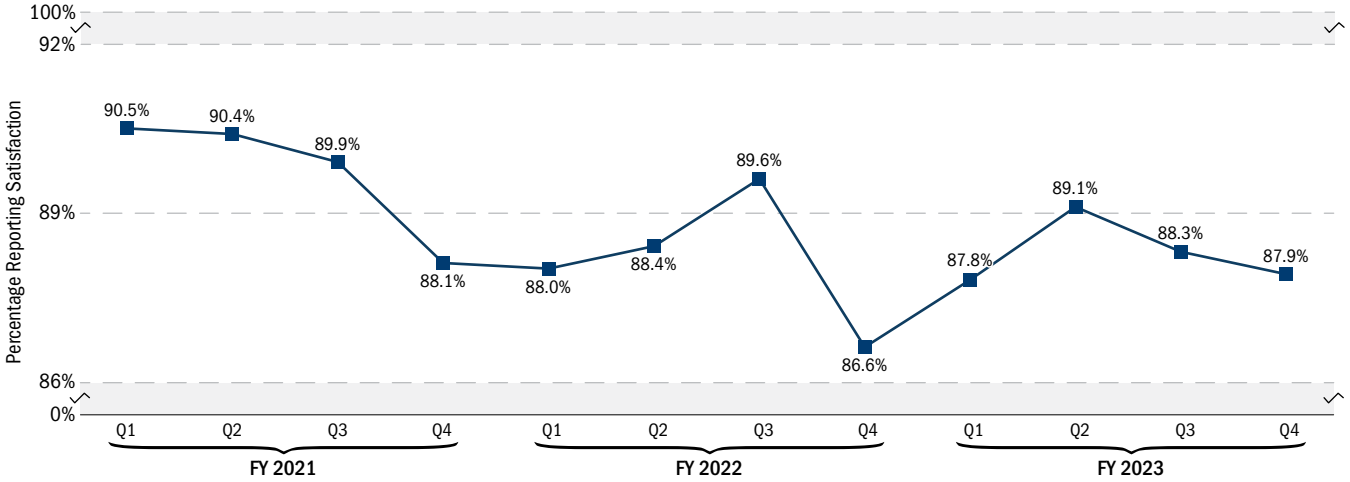
HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient-Centered Care/Experience *(cont.)*

JOES Satisfaction with Care

From FY 2021 Q1 through FY 2023 Q4, Satisfaction with Care scores from JOES dropped by 2.6 percentage points.

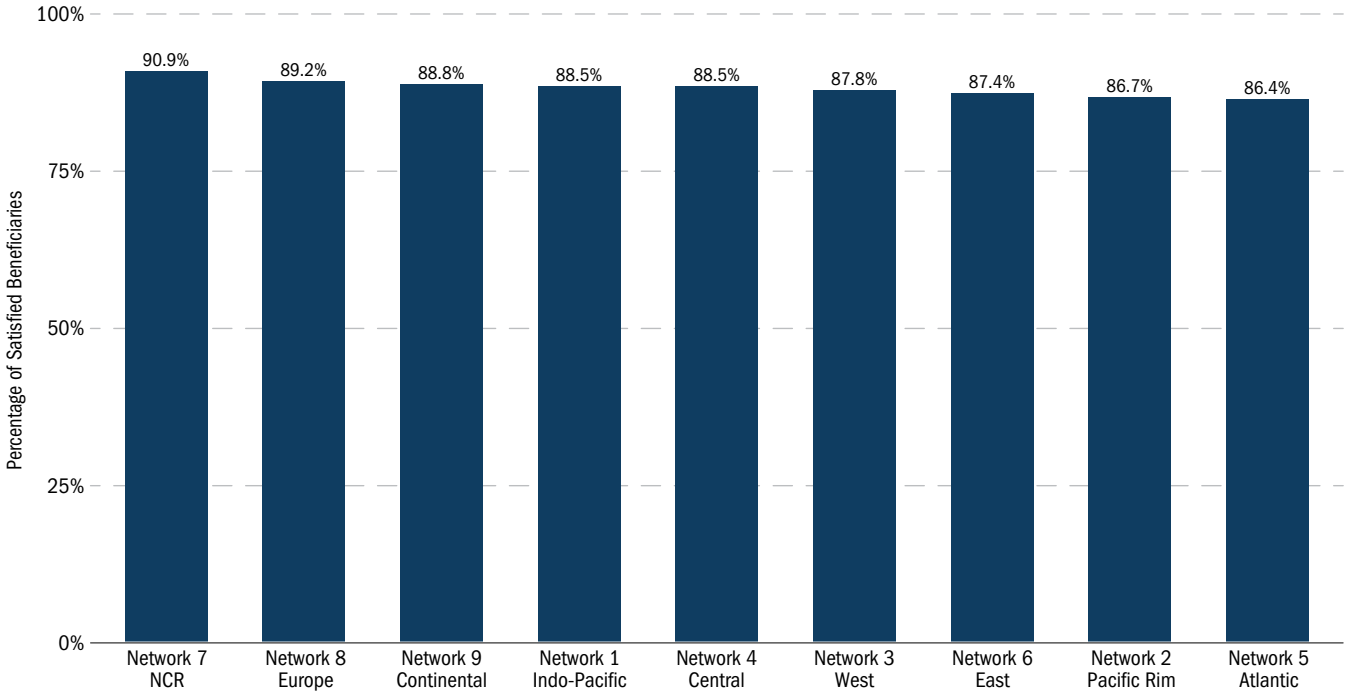
JOES SATISFACTION WITH CARE, FYs 2021–2023



The chart below shows JOES Satisfaction with Care by DHNs in FY 2023.

At the end of FY 2023, Network 7–NCR was the highest scoring Network for Satisfaction with Care at 90.9 percent, while Network 5–Atlantic was the lowest at 86.4 percent satisfaction.

JOES SATISFACTION WITH CARE BY MARKET, FY 2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, JOES, weighted data compiled 12/8/2023

Note: Satisfaction with Care is assessed in each survey as an agreement to the following statement: "Overall, I am satisfied with the health care I received on this visit." The five-point scale response for this question ranges from "strongly disagree" to "strongly agree." The results provided above are for those beneficiaries who reported either "somewhat agree" or "strongly agree."

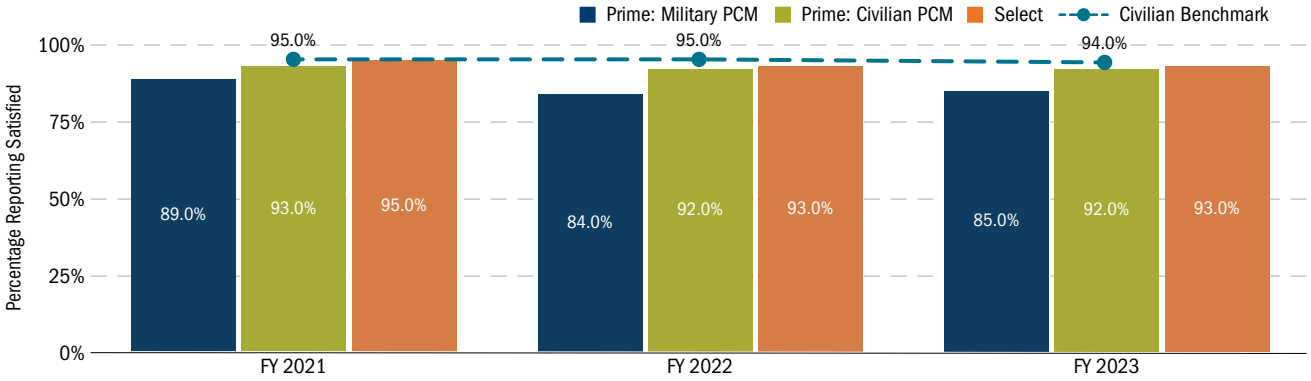
Patient-Centered Care/Experience *(cont.)*

Satisfaction with Doctors' Communication

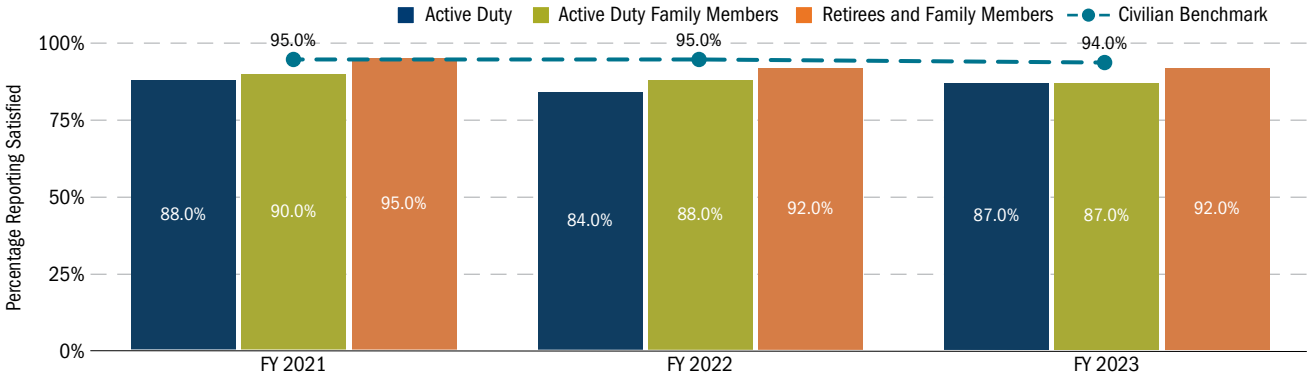
Communication between doctors and patients is an important factor in beneficiaries' satisfaction and their ability to obtain appropriate care. The following charts present beneficiary-reported perceptions of how well their doctor communicates with them.

- Between FY 2021 and FY 2023, satisfaction with doctors' communication decreased by 4 percentage points for Prime enrollees with a military PCM; Tricare Select enrollees decreased by 2 percentage points, and Prime enrollees with a civilian PCM decreased by 1 percentage point.
- Satisfaction with doctors' communication was below the benchmark for Prime enrollees with a military or civilian PCM for all three years.
- Satisfaction with doctors' communication showed an increase of 3 percentage points for Active Duty between FY 2022 and FY 2023, and remained the same for retirees and family members (RETFMs).
- Satisfaction with doctors' communication was lower than the civilian benchmark for Active Duty and ADFMs in FY 2023.

TRENDS IN SATISFACTION WITH DOCTORS' COMMUNICATION BY ENROLLMENT STATUS, FYs 2021–2023



TRENDS IN SATISFACTION WITH DOCTORS' COMMUNICATION BY BENEFICIARY CATEGORY, FYs 2021–2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 12/7/2023

Note: Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used come from NCQA's 2019 data.

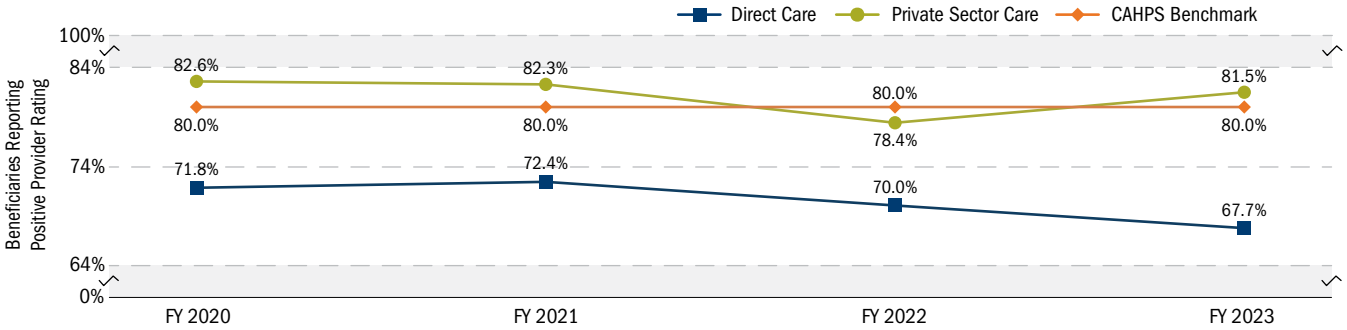
Patient-Centered Care/Experience *(cont.)*

Beneficiary Ratings of Provider Following Outpatient Treatment

In the JOES-C, beneficiaries are asked to provide an overall rating for their provider based on a scale from zero (worst provider possible) to 10 (best provider possible). The percentages of beneficiaries rating their provider a nine or 10 are provided in the following graph. The results to this question are comparable to civilian results and the civilian 50th percentile score is used as the CAHPS benchmark.

- The rating of provider scores from FY 2020 to FY 2023 remained relatively constant for JOES-C direct care, but were below the civilian CAHPS benchmark each year.
- Rating of provider scores for JOES-C private sector care have remained about the same from FY 2020 to FY 2023. Scores were above the civilian CAHPS benchmark except in FY 2022.

JOES-C RATING OF PROVIDER, FYs 2020–2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, JOES-C weighted data, compiled 12/8/2023

Notes:

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

– Results for JOES-C FY 2023 are from October 2022 to August 2023 for direct care and from October 2022 to June 2023 for private sector care.

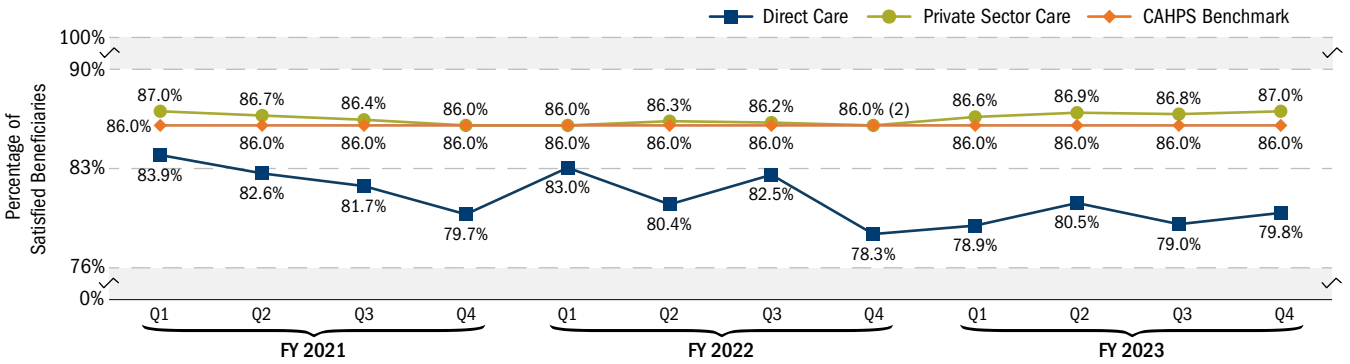
Provider Communication

As detailed in Drivers of Patient Experience Ratings on pages 130–131, 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, and TRISS).

The patient experience surveys measure provider communication (or doctor and nurse communication) from the beneficiary's perspective, and it remains vitally important to quality of care ratings. Some of the questions in these surveys ask: was the provider understandable, did the provider listen, was the provider respectful, and did the provider spend enough time with the patient. The results of these questions make up the score for the provider communication composite measure. These results can be compared with nationally representative civilian and military benchmarks, and can be compared across all levels of the MHS.

- For FY 2021 to FY 2023, private sector care scores for provider communication were at or exceeded the benchmark, while direct care scores have consistently remained below the benchmark.
- Provider communication scores for direct care range from 78.3 to 83.9 percent satisfaction in FY 2021 to FY 2023. Private sector care scores range from 86 to 87 percent for the same period.

JOES-C PROVIDER COMMUNICATION, FY 2022 Q1–FY 2023 Q3



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, JOES-C, weighted data, compiled 12/8/2023

Note: CAHPS benchmarks are the 50th percentiles from the 2018 CAHPS-CG national civilian scores. For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

Patient-Centered Care/Experience *(cont.)*

Provider Communication

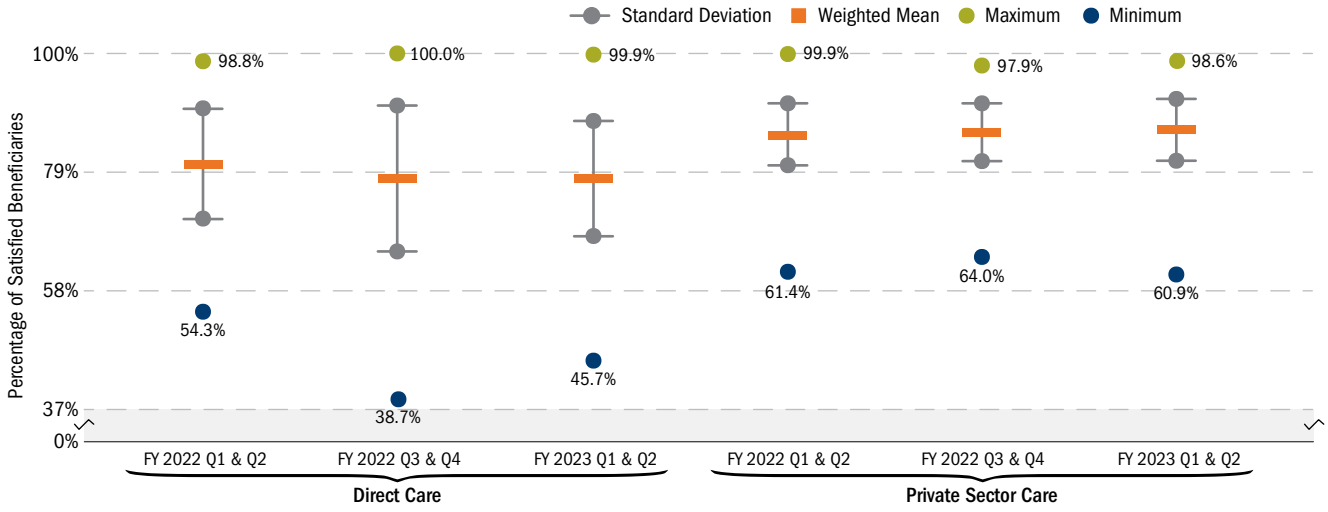
The table below displays the extent to which the ratings of the Provider Communication composite changed over time in terms of improvement (increasing mean or median) or decreased dispersion (reduced range or standard deviation).

- From FY 2022 Q1 & Q2 to FY 2023 Q1 & Q2, the median score and weighted mean for the provider communication composite direct care decreased by 2.1 percentage points and 2.6 percentage points, respectively.
- For private sector care from FY 2022 Q1 & Q2 to FY 2023 Q1 & Q2, the median score and weighted mean for the provider communication composite increased 1.0 points and 1.3 points, respectively.

JOES-C: PROVIDER COMMUNICATION COMPOSITE, FY 2022 Q1 & Q2 TO FY 2023 Q1 & Q2

	FY 2022 Q1 & Q2	FY 2022 Q3 & Q4	FY 2023 Q1 & Q2	% POINT CHANGE FY 2022 Q1 & Q2 TO FY 2023 Q1 & Q2
JOES-C DIRECT CARE				
Number of Respondents	5,506	5,474	5,941	
Service Score (Mean)	80.5%	77.9%	77.9%	-2.6
Standard Deviation	9.7%	13.1%	10.3%	0.6
Median	81.2%	79.9%	79.1%	-2.1
75th Percentile	87.8%	87.5%	84.0%	-3.8
25th Percentile	76.1%	70.9%	72.8%	-4.3
Maximum	98.8%	100.0%	99.9%	1.1
Minimum	54.3%	38.7%	45.7%	-8.6
Range	44.5%	61.3%	54.2%	9.7
JOES-C PRIVATE SECTOR CARE				
Number of Respondents	25,019	24,300	24,055	
Service Score (Mean)	85.6%	86.1%	86.6%	1.0
Standard Deviation	5.5%	5.2%	5.5%	0.0
Median	86.1%	86.5%	87.4%	1.3
75th Percentile	88.7%	89.3%	90.0%	1.3
25th Percentile	83.2%	83.7%	85.0%	1.8
Maximum	99.9%	97.9%	98.6%	-1.3
Minimum	61.4%	64.0%	60.9%	-0.5
Range	38.5%	33.9%	37.7%	-0.8

VARIABILITY IN JOES-C: PROVIDER COMMUNICATION COMPOSITE, FY 2022 Q1–FY 2023 Q1 & Q2



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, JOES-C, weighted data, compiled 12/8/2023

Patient-Centered Care/Experience *(cont.)*

Beneficiary Ratings of Care Following Inpatient Treatment

TRISS: The purpose of the TRISS is to monitor and report on the perceptions and experiences of MHS beneficiaries who have been admitted to military and civilian hospitals. The survey instrument incorporates the questions developed by AHRQ and CMS for the HCAHPS initiative. Additional information on HCAHPS, including the protocols for sampling, data collection, and coding can be found in the HCAHPS Quality Assurance Guidelines manual on the official HCAHPS website, www.hcahpsonline.org, as well as information on recent changes, star ratings, and other updates to publicly reported data such as that on the Hospital Compare website. The TRISS follows the HCAHPS protocols developed by CMS and endorsed by the NQF.

The goal of the HCAHPS initiative is to measure uniformly and report publicly on inpatient care experiences using a standardized survey instrument and data collection methodology. The information derived from the survey can provide feedback to providers and patients, valuable insight for internal quality improvement initiatives, and an assessment of the impact of changes in operating procedures.

Comparison of these data with the results from previous surveys, as well as comparisons to civilian benchmark data, enable the DoD to measure progress in meeting its goals and objectives of high-quality health care. The TRISS compares care across all Services and across venues (i.e., direct MTF-based care and private sector care) including inpatient surgical, medical, and obstetric care. The TRISS continues to update and change as new HCAHPS requirements are tested and implemented, and these changes over time have resulted in more reliable measures and higher response rates. Data collected by the TRISS includes but is not limited to:

- Overall rating of hospital and recommendation of hospital to others
- Nursing care (care, respect, listening, and explanations)
- Physician care (care, respect, listening, and explanations)
- Communication (with nurses and doctors, and regarding medications)
- Responsiveness of staff
- Hospital environment (cleanliness and quietness)
- Post-discharge (such as written directions for post-discharge care)

In addition to the above TRISS measures from the HCAHPS survey instrument, TRISS also includes DoD supplemental measures such as education on breastfeeding and repeat obstetrics care, nurse hourly rounding, and nurse leader visit.

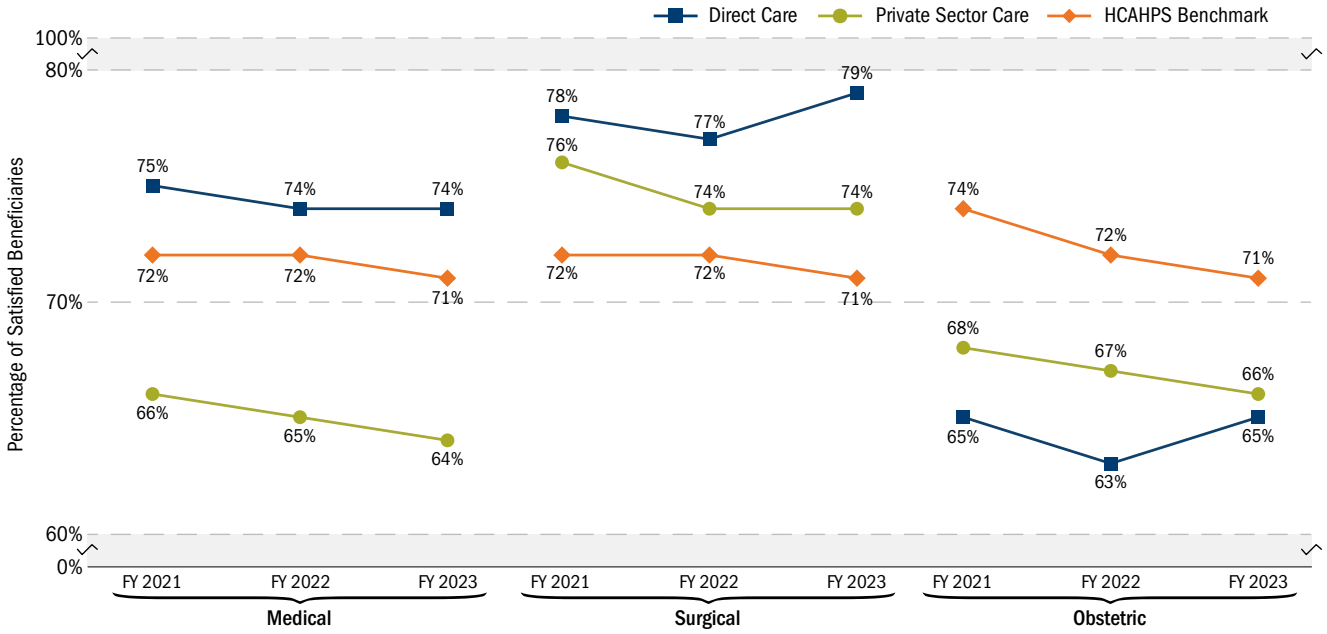
In the following sections, we detail specific findings focused primarily on two measures of patient experience: overall rating of the hospital and willingness to recommend the hospital to others. Inpatient facilities with fewer than 25 responses are not included in the analyses. These results are produced by the DHA J-5 Analytics and Evaluation Division and do not represent official HCAHPS results. Official HCAHPS results are published on the CMS Care Compare website (https://www.medicare.gov/care-compare).

Patient-Centered Care/Experience *(cont.)*

Overall Hospital Rating

Overall hospital rating is measured by the TRISS question "Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?" Scores are shown for those who indicated 9 or 10. Similar to previous years, the overall hospital rating for the direct care medical and surgical product lines are higher than the national HCAHPS benchmark for FY 2023, while the obstetric product line is lower than the national HCAHPS benchmark. For private sector care, only the surgical product line rating is greater than the national HCAHPS benchmark, while the medical and obstetric product lines are below the national HCAHPS benchmark. These results are in line with findings from previous fiscal years.

TRISS OVERALL HOSPITAL RATING BY PRODUCT LINE, FYs 2021–2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/8/2023

Notes:

– FY 2023 includes results from FY 2023 Q1–Q3 for direct care and FY 2023 Q1–Q2 for private sector care.

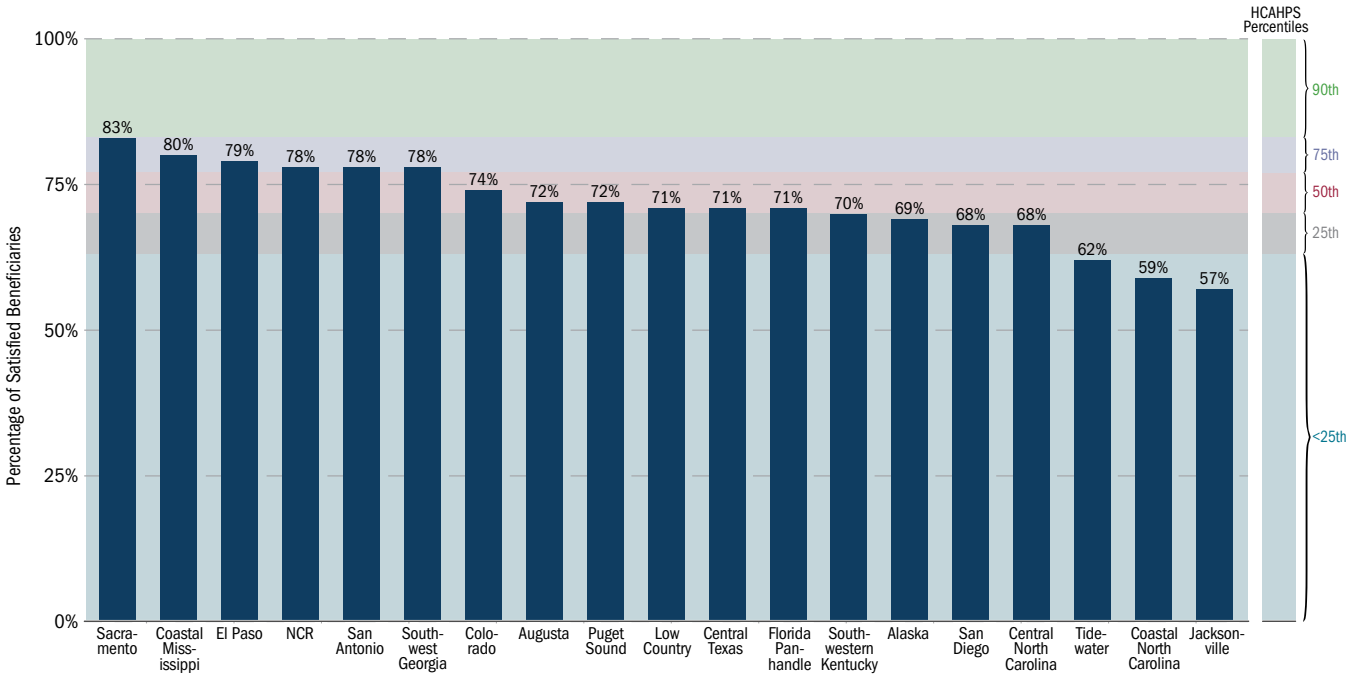
– HCAHPS benchmarks are the U.S. scores base on HCAHPS Public Reports.

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

Patient-Centered Care/Experience *(cont.)*

The chart below shows the distribution for overall hospital ratings by Market for FY 2023. The Sacramento Market has the highest overall hospital rating at 83 percent. The Jacksonville Market is lowest at 57 percent, a 13 percent decrease from FY 2022.

TRISS OVERALL HOSPITAL RATING BY MARKET: DIRECT CARE, FY 2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/8/2023

Notes:

– FY 2023 includes results from FY 2023 Q1–Q3.

– The increment of the above percentiles was set at <25th, 25th, 50th, 75th, and 90th. HCAHPS percentiles are based on the October 2023 Public Report. More information about these percentiles can be found at: https://www.hcahpsonline.org/en/summary-analyses/.

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

Patient-Centered Care/Experience *(cont.)*

The table below displays the extent to which the overall hospital rating scores changed over time in terms of improvement (increasing mean or median) or decreased dispersion (reduced range).

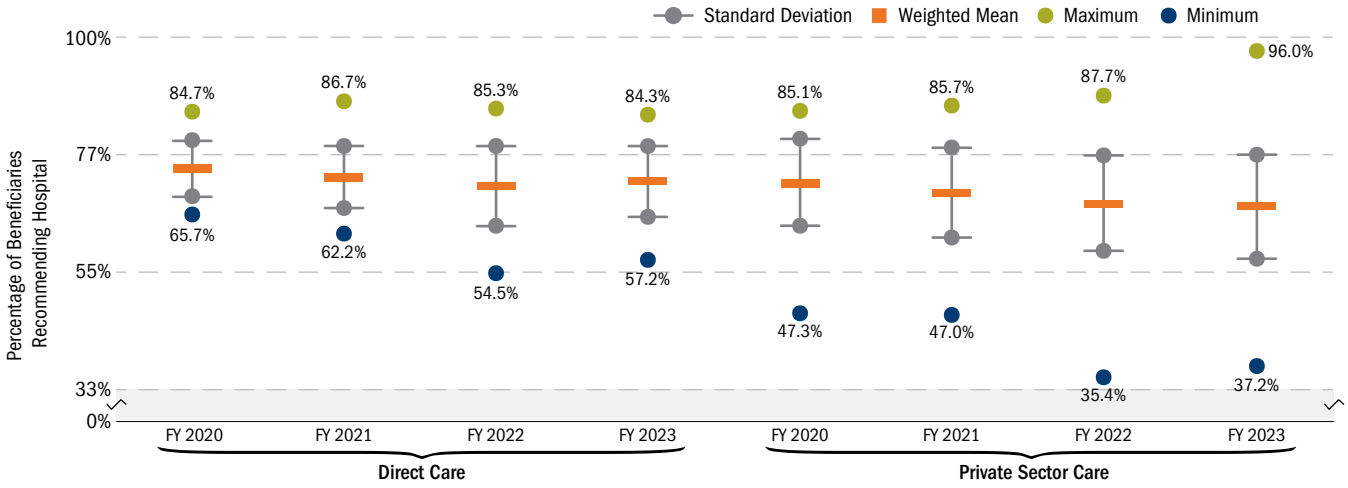
- From FY 2020 to FY 2023, direct care overall hospital rating scores decreased by 2.5 percentage points with regard to the mean, and median ratings decreased by 3.3 percentage points.
- From FY 2020 to FY 2023, private sector care mean score decreased by 4.3 percentage points and median ratings decreased by 6.4 percentage points.

TRISS OVERALL HOSPITAL RATING: FYs 2020–2023

	FY 2020	FY 2021	FY 2022	FY 2023	% POINT CHANGE (FY 2020–FY 2023)
DIRECT CARE					
Number of Respondents	32,309	32,097	23,654	16,973	
Weighted Mean	74.3%	72.6%	71.0%	71.8%	-2.5
Standard Deviation	5.3%	5.8%	7.5%	6.7%	1.4
Median	74.9%	72.2%	70.2%	71.6%	-3.3
75th Percentile	77.8%	75.4%	77.4%	76.6%	-1.2
25th Percentile	70.0%	69.5%	66.4%	68.7%	-1.3
Maximum	84.7%	86.7%	85.3%	84.3%	-0.4
Minimum	65.7%	62.2%	54.5%	57.2%	-8.5
Range	19.1%	24.5%	30.9%	27.1%	8.0
PRIVATE SECTOR CARE					
Number of Respondents	21,003	22,435	21,453	10,579	
Weighted Mean	71.6%	69.7%	67.6%	67.3%	-4.3
Standard Deviation	8.2%	8.4%	8.9%	9.8%	1.6
Median	72.9%	70.7%	67.5%	66.5%	-6.4
75th Percentile	77.7%	76.4%	74.0%	73.9%	-3.8
25th Percentile	66.6%	63.6%	61.7%	60.6%	-6.0
Maximum	85.1%	85.7%	87.7%	96.0%	10.9
Minimum	47.3%	47.0%	35.4%	37.2%	-10.1
Range	37.8%	38.7%	52.3%	58.7%	20.9

Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/8/2023
Note: FY 2023 includes results from Q1–Q3 for direct care and Q1–Q2 for private sector care.

VARIABILITY IN TRISS OVERALL HOSPITAL RATINGS, FYs 2020–2023



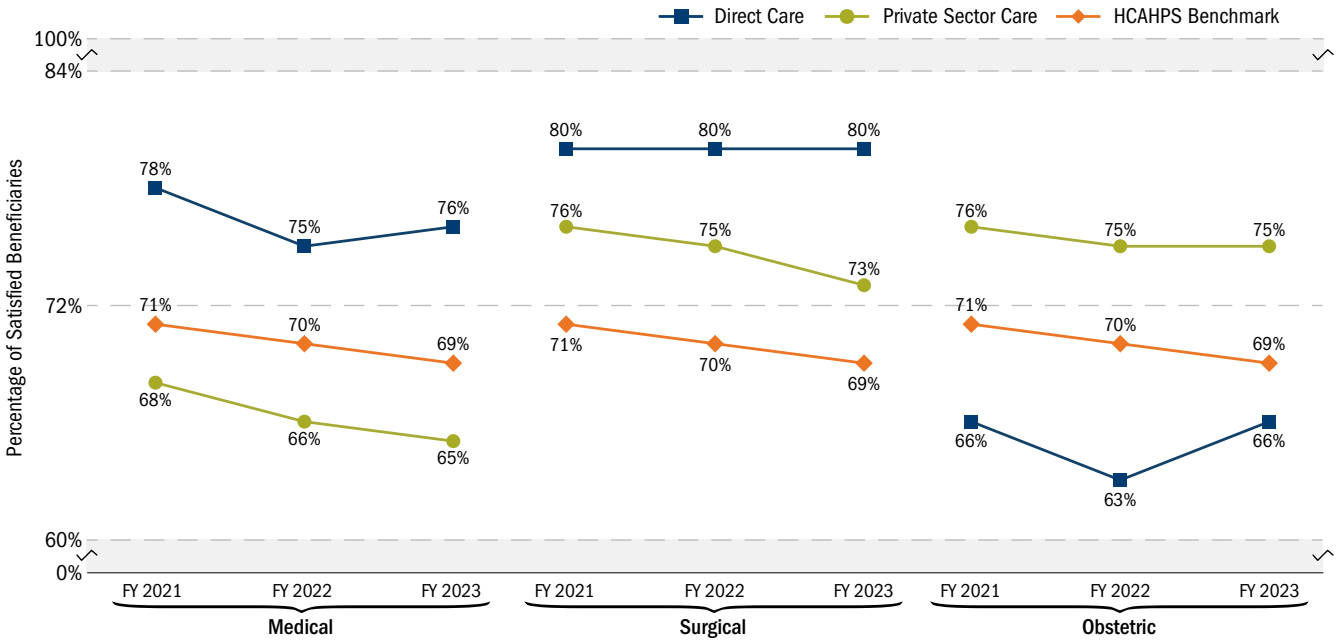
Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/8/2023
Notes:
– FY 2023 includes Q1–Q3 for direct care and Q1–Q2 for private sector care results.
– HCAHPS benchmarks are U.S. scores from the HCAHPS Public Reports.

Patient-Centered Care/Experience *(cont.)*

Beneficiary Recommendation of Hospital Following Inpatient Treatment

Hospital recommendation is measured by the TRISS question "Would you recommend this hospital to your friends and family?" with response options of "definitely no," "probably no," "probably yes," and "definitely yes." Scores are shown for those who indicated definitely yes. In FY 2023, the direct care medical and surgical product lines exceeded the national HCAHPS benchmark for the likelihood of recommending the hospital. The direct care obstetric product line continues to be below the national HCAHPS benchmark during this time period. However, it has increased from 63 percent in FY 2022 to 66 percent in FY 2023. For private sector care, the surgical and obstetric product lines exceeded the national HCAHPS benchmark for the likelihood of recommending the hospital in FY 2023. The private sector care medical product line is below the national HCAHPS benchmark. These findings are similar to those of previous fiscal years.

TRISS RECOMMEND HOSPITAL RATING BY PRODUCT LINE, FYs 2021–2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/8/2023

Notes:

– FY 2023 includes results from FY 2023 Q1–Q3 for direct care and Q1–Q2 for private sector care.

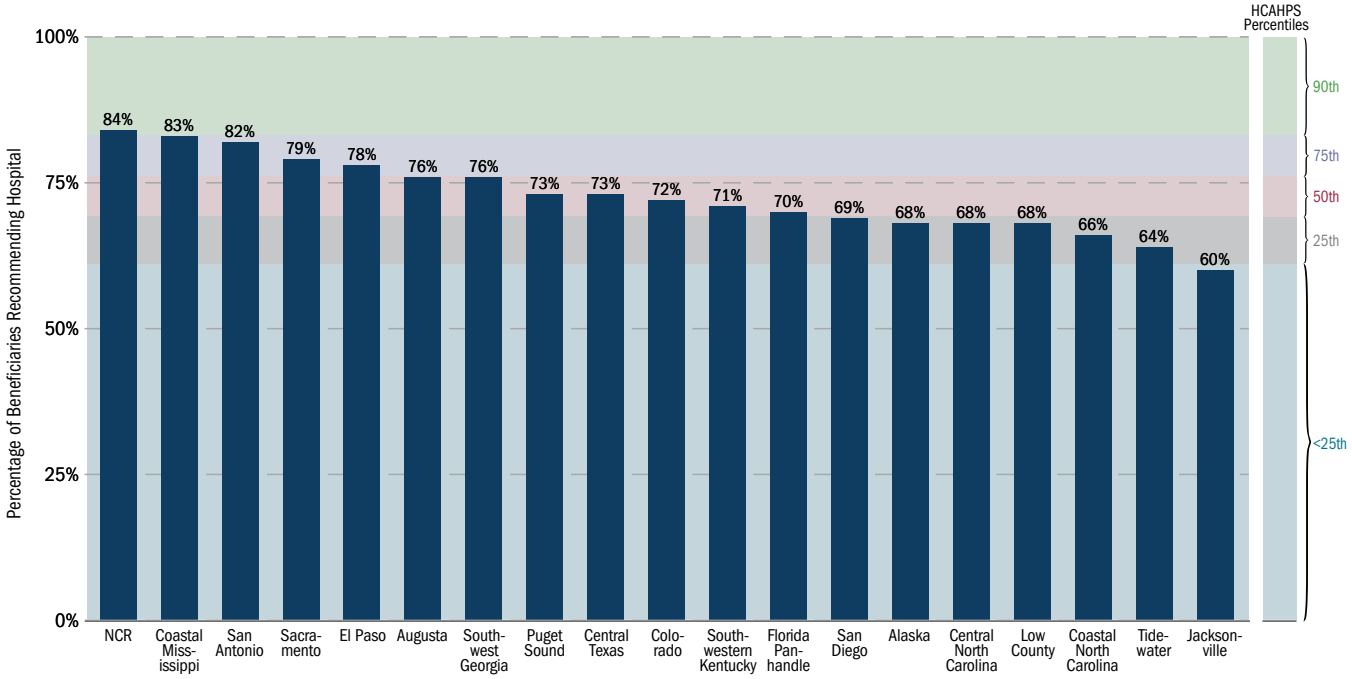
– HCAHPS benchmarks are the U.S. scores from the HCAHPS Public Reports.

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

Patient-Centered Care/Experience *(cont.)*

The chart below shows the distribution for likelihood to recommend the hospital scores by DHA Markets for FY 2023. The NCR Market has the highest rating at 84 percent. The Jacksonville Market is the lowest scoring Market for likelihood to recommend the hospital at 60 percent, a decrease of 11 percentage points from its FY 2022 score.

TRISS RECOMMEND HOSPITAL BY MARKET, FY 2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/8/2023

Notes:

– FY 2023 includes results from FY 2023 Q1–Q3.

– The increment of the above percentiles was set at <25th, 25th, 50th, 75th, and 90th. HCHAPS percentiles are based on the October 2023 Public Report. More information about these percentiles can be found at: https://www.hcahpsonline.org/en/summary-analyses/.

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

Patient-Centered Care/Experience *(cont.)*

The table below displays the extent to which the ratings of recommend hospital changed over time in terms of improvement (increasing mean or median) or decreased dispersion (reduced range).

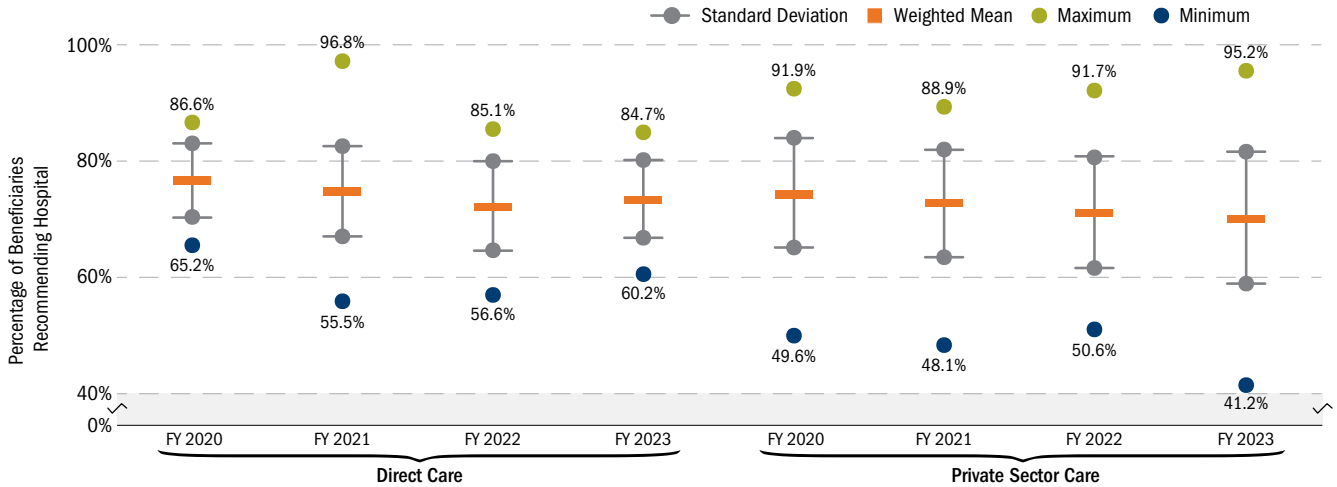
- From FY 2020 to FY 2023, direct care mean score decreased by 3.2 percentage points, and the median score decreased by 3.7 percentage points.
- From FY 2020 to FY 2023, private sector care score decreased 4.3 percent with regard to the mean, and the median score decreased by 4.4 percentage points.

TRISS RECOMMEND HOSPITAL RATING: FYs 2020–2023

	FY 2020	FY 2021	FY 2022	FY 2023	% POINT CHANGE (FY 2020–FY 2023)
DIRECT CARE					
Number of Respondents	32,192	31,991	23,542	16,909	
Weighted Mean	76.3%	74.5%	72.0%	73.1%	-3.2
Standard Deviation	6.3%	7.7%	7.6%	6.7%	0.4
Median	76.3%	73.2%	71.3%	72.6%	-3.7
75th Percentile	79.1%	78.5%	77.3%	78.4%	-0.7
25th Percentile	71.2%	70.6%	65.3%	68.0%	-3.2
Maximum	86.6%	96.8%	85.1%	84.7%	-1.9
Minimum	65.2%	55.5%	56.6%	60.2%	-5.0
Range	21.4%	41.2%	28.5%	24.5%	3.1
PRIVATE SECTOR CARE					
Number of Respondents	20,939	22,403	21,364	10,542	
Weighted Mean	74.2%	72.4%	70.8%	69.9%	-4.3
Standard Deviation	9.4%	9.3%	9.6%	11.3%	1.9
Median	74.8%	73.7%	71.0%	70.4%	-4.4
75th Percentile (Q3)	82.2%	79.2%	78.7%	77.2%	-5.0
25th Percentile (Q1)	68.6%	65.7%	63.9%	62.2%	-6.4
Maximum	91.9%	88.9%	91.7%	95.2%	3.3
Minimum	49.6%	48.1%	50.6%	41.2%	-8.4
Range	42.4%	40.7%	41.1%	54.8%	12.4

Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/8/2023
Note: FY 2023 includes results from Q1–Q3 for direct care and Q1–Q2 for private sector care.

VARIABILITY IN TRISS RECOMMEND HOSPITAL RATINGS, FYs 2020–2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/8/2023
Note: FY 2023 includes results from FY 2023 Q1–Q3 for direct care and Q1–Q2 for private sector care.

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 120, including Overall Hospital Rating and Recommend Hospital as components. Official star ratings, including for military hospitals in the United States, are posted publicly on the CMS Care Compare website. The MHS calculates star ratings similar to the method employed by CMS using the most recently available civilian benchmarks. These results are published on the TRISS reporting website.

The MHS performed very well as measured by star ratings from FY 2022 Q4 to FY 2023 Q3. As three stars is considered an "average" patient experience, all of the MHS facilities are performing above average in terms of patient experience, with 12 four-star-rated facilities and 19 facilities rated five stars. This is notable improvement from last year, as only one facility had a five-star rating and 13 facilities had three stars from FY 2021 Q4 to FY 2022 Q3.

PATIENT EXPERIENCE STAR RATINGS, FY 2022 Q4–FY 2023 Q3

★★★★★	★★★★	★★★
19 FACILITIES	12 FACILITIES	0 FACILITIES

Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/8/2023
Note: One hundred responses to TRISS within the year were required to receive a summary star rating.

Patient-Centered Care/Experience *(cont.)*

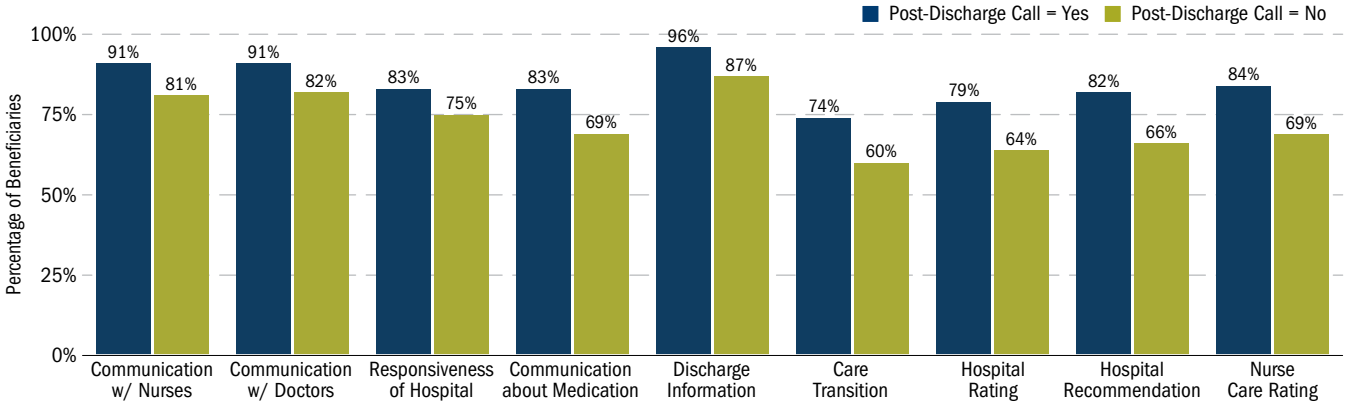
Leading Nurse Engagement Practices

Across the care continuum, strong nurse-patient relationships are critical to positively impacting patient experience and clinical outcomes and reducing hospital costs.[1,2] The MHS assesses the relationship between nurses and MHS beneficiaries by collecting data on the use of evidence-based nurse engagement practices—nurse hourly rounding, nurse leader visits, post-discharge staff phone calls, and care planning—with beneficiaries at MTFs and civilian hospitals. The TRISS questionnaire collects information on nurse engagement practices in addition to the core set of HCAHPS patient experience measures (ref. page 120). The Huron Consulting Group, formerly Studer Group, developed the nurse engagement questions as a part of its effort to improve health care outcomes and the HCAHPS.[2]

Hospitals that focus on engagement of staff and patients through prioritized implementation of leading nurse engagement practices report improved patient experience scores.[3] Hourly rounds with patients are associated with raised patient satisfaction and safety and decreased use of call lights, patient falls, and skin breakdown. Nurse leader visits provide leadership opportunities to recognize nursing staff members, assess staff needs, and improve patients' perception of care. Routine nurse calls to patients following discharge reduces the risk of medication errors, procedure-related injuries, and readmissions. Patients included in the planning of care are observed to have greater trust in staff and a better perception of their care.[4] Analysis of the TRISS MTF results shows that incorporating these leading practices in the inpatient care setting has positive impacts on patient experience. The next four exhibits show TRISS results for FY 2023 (through Q3) for each Huron-Studer question. Ratings of the top two most positive response options for each patient experience composite or single-item measure are assessed in relation to the individual nurse engagement practice measures.

- For all leading nurse engagement practices, MHS beneficiaries admitted at MTFs who reported receiving a leading practice rated their patient experience more positively than those who did not.
- Discharge information continues to be the most positively rated patient experience among the groups of beneficiaries who reported receiving or not receiving a leading practice.

TRISS RATINGS OF PATIENT EXPERIENCE WHEN BENEFICIARIES REPORTED RECEIVING OR NOT RECEIVING A POST-DISCHARGE STAFF PHONE CALL, FY 2023



Source: DHA/Strategy, Plans, and Analytics (J5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/8/2023

[1] Calvin Chou, "Time to Start Using Evidence-Based Approaches to Patient Engagement," *New England Journal of Medicine Catalyst* 2018. https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0220.

[2] Improving HCAHPS: A Guide to Increasing Patient Satisfaction Scores, Huron Consulting Group Blog, accessed January 18, 2022. https://www.huronconsultinggroup.com/insights/improving-hcahps.

[3] Judy Morton, Jodi Brekhus, Megan Reynolds, Anna Kay Dykes, "Improving the Patient Experience through Nurse Leader Rounds," *Patient Experience Journal* 2014 1:2.

[4] Lauri Littleton, Laura A. Fennimore, Catherine Shull Fernald, Judith Zedreck Gonzalez, "Effective Nurse Leader Rounding Improves Patient Experience," Nursing Management 2019 50:10, doi:10.1097/01.NUMA.0000580620.45628.cd

Notes:

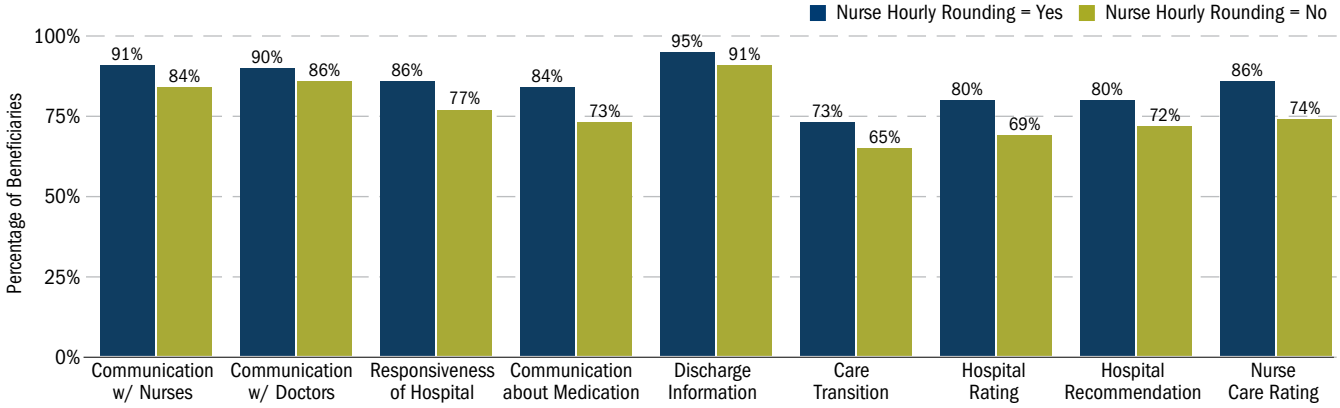
– FY 2023 includes results from FY 2023 Q1–Q3.

– Post-Discharge Staff Phone Call in TRISS is worded as the following statement: "After discharge, did you receive a phone call from a hospital staff member regarding recovery at home?" The response options for this question are "yes" and "no."

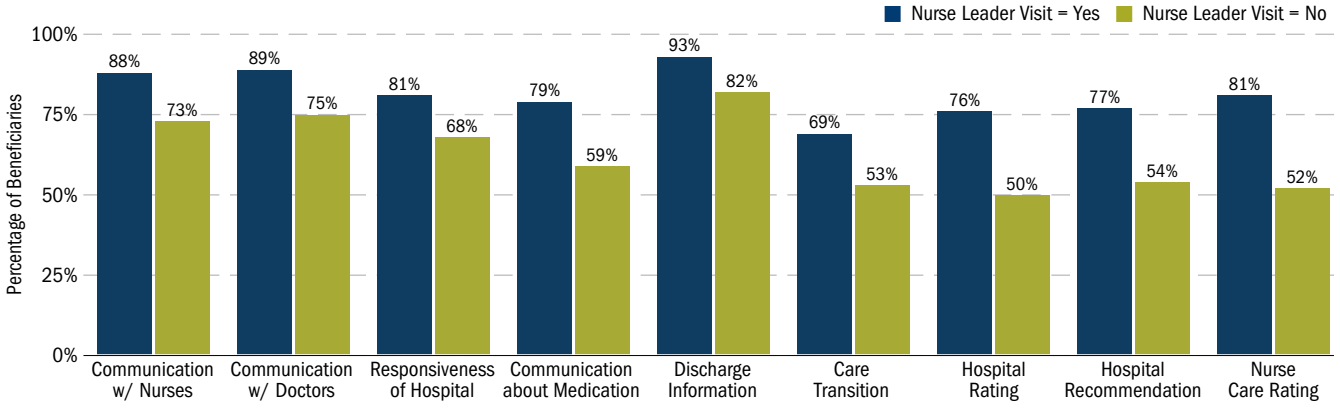
HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

Patient-Centered Care/Experience *(cont.)*

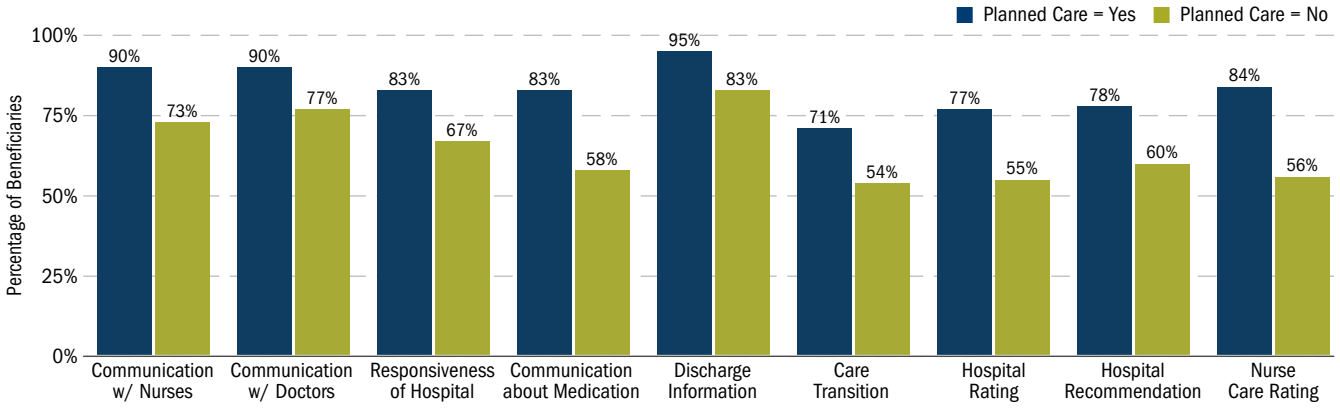
TRISS RATINGS OF PATIENT EXPERIENCE WHEN BENEFICIARIES REPORTED RECEIVING OR NOT RECEIVING NURSE HOURLY ROUNDING, FY 2023



TRISS RATINGS OF PATIENT EXPERIENCE WHEN BENEFICIARIES REPORTED RECEIVING OR NOT RECEIVING NURSE LEADER VISIT, FY 2023



TRISS RATINGS OF PATIENT EXPERIENCE WHEN BENEFICIARIES REPORTED RECEIVING OR NOT RECEIVING PLANNED CARE, FY 2023



Source: DHA/Strategy, Plans, and Analytics (J5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/8/2023

Notes:

– FY 2022 includes results from FY 2023 Q1–Q3.

– Nurse Hourly Rounding is worded in TRISS to capture the frequency to the following statement: "How often did nursing staff come into your room to check or round on you during the day? The four response options for this question are "every hour," "every two hours," "every few hours," and "a couple times a day." The "yes" results provided above are for those beneficiaries who reported "every hour" and the "no" results for those beneficiaries who reported "every two hours," "every few hours," and "a couple times a day."

– Nurse Leader Visit in TRISS is worded as the following statement: "Did a nurse leader visit you during your stay?" The response options for this question are "yes" and "no."

– Planned Care in TRISS is worded as the following statement: "At shift change, did the nurses include you in their conversation regarding your plan of care?" The response options for this question are "yes" and "no."

Patient-Centered Care/Experience *(cont.)*

Drivers of Patient Experience Ratings

Results from patient surveys have become increasingly important in measuring health plan performance, directing action to improve the beneficiary experience, and improving the quality of services provided by health care facilities. Patient surveys provide key insights into the patient's perception of the health care they received, as well as the importance of different aspects of their care in determining their overall experience, satisfaction, and ratings of hospital facilities.

As stated previously, three key beneficiary surveys measure self-reported access to and satisfaction with MHS direct and private sector care experiences:

- TRISS—event-based after a discharge from a hospital (based on HCAHPS)
- JOES-C—event-based following an outpatient visit, asking about health care plan rating (based on CAHPS-CG)

Results from these surveys for FYs 2022 and 2023 (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, overall health status, and region. The statistical significance and size of odds ratios derived from regression 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 2022–2023

	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 2022	#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 2023	#1	Communication with Nurses	How Well Providers Communicate with Patients	Getting Needed Care
	#2	Care Transition	Helpful, Courteous, and Respectful Office Staff	Getting Care as Soon as Needed
	#3	Communication with Doctors	Timely Appointments, Care, and Information	Customer Service

Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, TRISS results, and JOES-C results, FYs 2022 (Q1–Q3)–2023 (Q1–Q3 only for TRISS and October 2022–August 2023 for 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 CAHPS-CG version 3.0 guidelines detailed at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/cg/about/cg_3-0_overview.pdf

Patient-Centered Care/Experience *(cont.)*

Drivers of Patient Experience Ratings—JOES

In addition to TRISS and JOES-C, 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. Patient surveys provide key insights into their experiences and the information obtained can improve care within and across the Services.

Respondent data from the JOES for FYs 2022 and 2023 (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. The models also controlled for patient demographic variables, including beneficiary category, gender, health status, and region. The statistical significance and effect size of the 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 providers considering patients' values and opinions when creating care plans and the provider knowing the patient's medical history. Results also suggest that providers who clearly explain information to patients, treat patients with courtesy and respect, and ensure an easy appointment scheduling process will potentially positively influence patient experiences.

TOP THREE DRIVERS OF SATISFACTION FROM JOES: DIRECT CARE, FYs 2022–2023

	RANKING	SATISFACTION WITH HEALTH CARE	SATISFACTION WITH PROVIDER
FY 2022	#1	Provider Explained Things in a Way That Was Easy to Understand	Provider Explained Things in a Way That Was Easy to Understand
	#2	Provider Knew Important Medical History	Provider Knew Important Medical History
	#3	Ease of Making an Appointment	Provider Treated Patient with Courtesy and Respect
FY 2023	#1	Provider Considers Patient's Values and Opinions	Provider Considers Patient's Values and Opinions
	#2	Provider Knew Important Medical History	Provider Knew Important Medical History
	#3	Provider Explained Things in a Way That Was Easy to Understand	Provider Explained Things in a Way That Was Easy to Understand

Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, JOES results, FY 2022 (Q1–Q3 only) through FY 2023 (Q1–Q4).
Note: JOES questions continue to be updated over time; drivers analysis was based on the most recent survey questions.

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

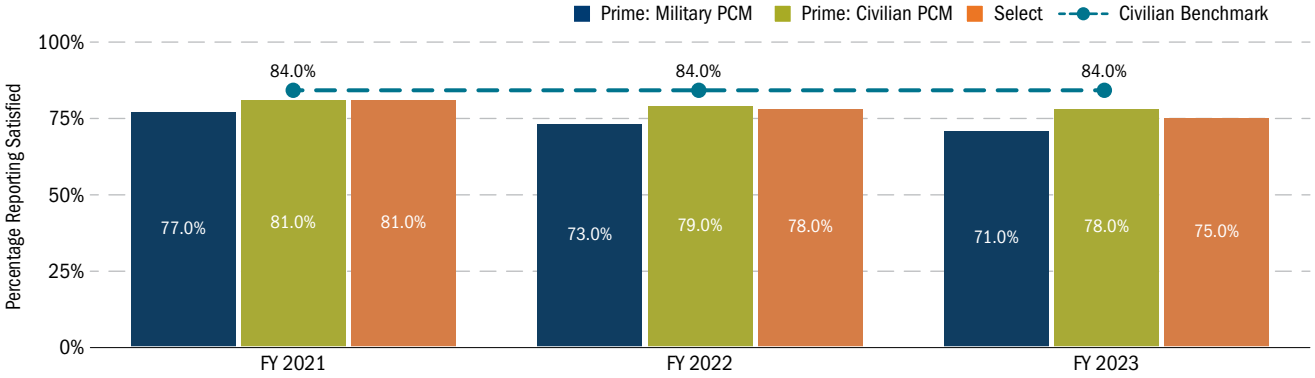
Patient-Centered Care/Experience *(cont.)*

Satisfaction with Customer Service

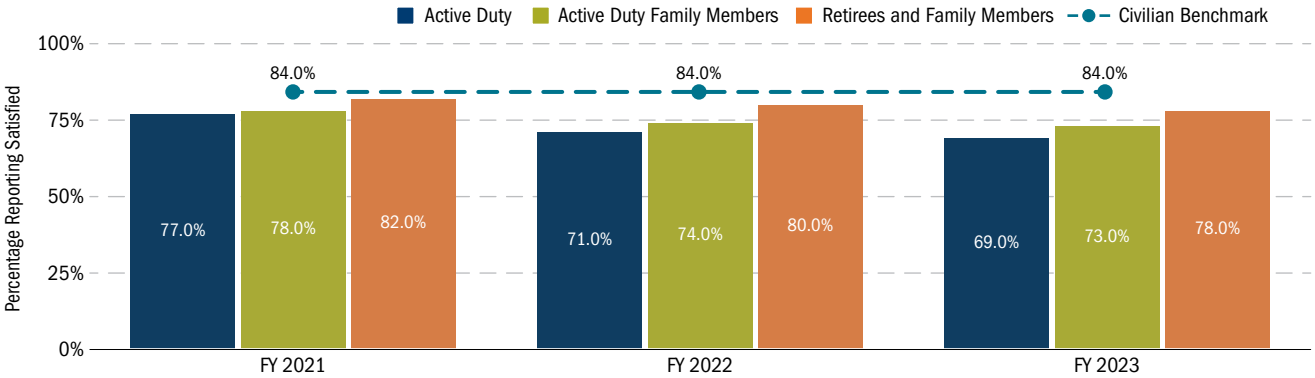
Most DoD health care beneficiaries participate in TRICARE in one of two ways: by enrolling in the Prime option or enrolling in the Select option. Access to and understanding written materials about one's health plan are important determinants of overall satisfaction with the plan.

- MHS beneficiary satisfaction with customer service in terms of understanding written material, getting customer assistance, and dealing with paperwork declined between FY 2021 and FY 2023 for all enrollment groups.
- Satisfaction with customer service for all enrollment groups was also lower than the civilian benchmark for each year between FY 2021 and FY 2023. MHS beneficiary satisfaction with customer service fell by 8 percentage points for Active Duty (AD) and by 5 percentage points for ADFMs from FY 2021 to FY 2023. Satisfaction for retirees and their family members decreased by 4 percentage points over the same time period.

TRENDS IN RESPONSIVE CUSTOMER SERVICE: COMPOSITE MEASURE (UNDERSTANDING WRITTEN MATERIAL, GETTING CUSTOMER ASSISTANCE, AND DEALING WITH PAPERWORK) BY ENROLLMENT STATUS, FYs 2021–2023



TRENDS IN RESPONSIVE CUSTOMER SERVICE: COMPOSITE MEASURE (UNDERSTANDING WRITTEN MATERIAL, GETTING CUSTOMER ASSISTANCE, AND DEALING WITH PAPERWORK) BY BENEFICIARY CATEGORY, FYs 2021–2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 12/7/2023

Note: Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used in 2020 come from NCQA's 2019 data.

OTHER PLANS AND PROGRAMS

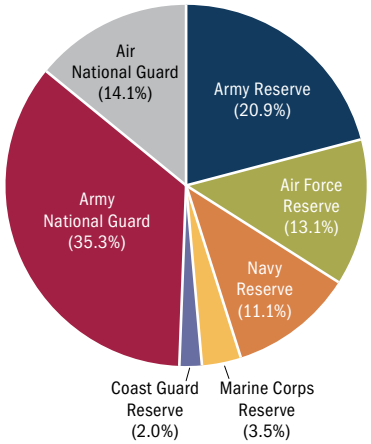
TRICARE Benefits for the Reserve Component

TRICARE offers a broad array of health care coverage and benefits for Reserve Component (RC) members who qualify, and their eligible family members, during active Guard or Reserve status, pre-deployment, deployment, post-deployment, and into retirement.

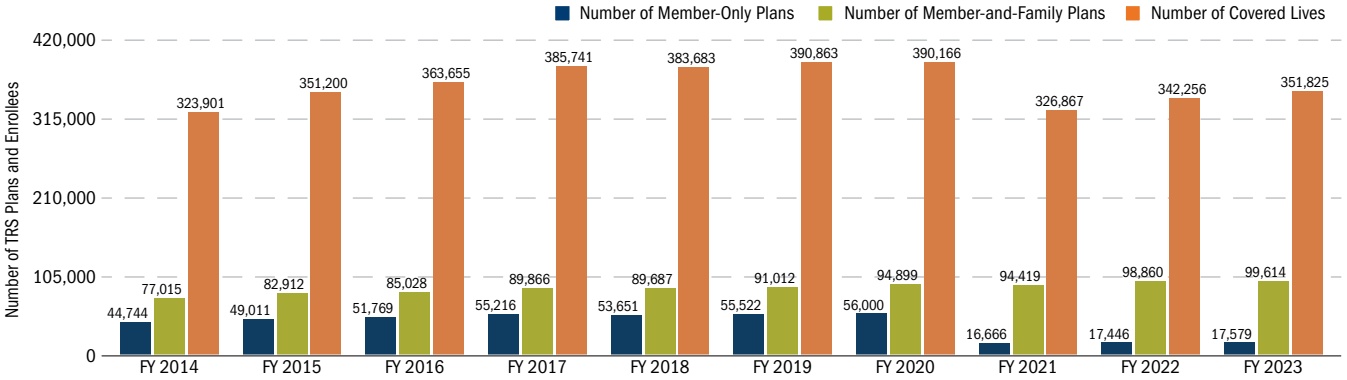
TRICARE Reserve Select (TRS). The subsidized premium-based TRS health plan provides TRICARE Select coverage for purchase by qualified members of the Selected Reserve (SelRes). TRS plans have plateaued and continue to fluctuate, where the significant gap remains between Member-Only and Member-and-Family plans. The pie chart to the right reflects the latest TRS enrollment by Component as of September 30, 2023.

- As shown in the pie chart at right, Army Reserve and Army National Guard combined constitute 56 percent of the 117,193 total TRS plans.
- The NDAA FY 2023, Section 702, authorized Transitional Assistance Management Program coverage to all Guard members on 502(f), Title 32 orders for more than 30 days, responding to a national emergency declared by the President.

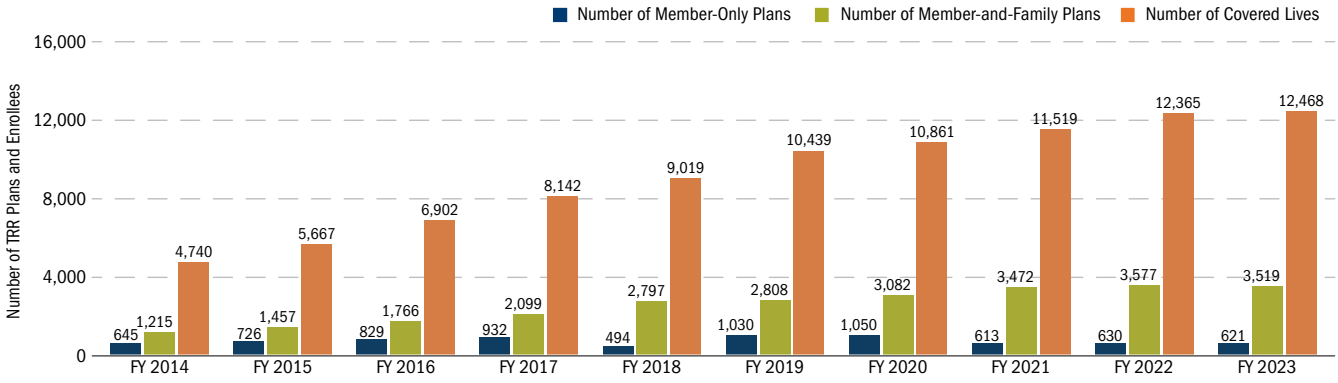
TRS: POPULATION BY COMPONENT (351,825 SPONSORS AND FAMILY MEMBERS AS OF SEPTEMBER 2023)



TRENDS IN RC ENROLLMENT IN TRS, FYs 2014–2023



TRENDS IN ENROLLMENT IN TRICARE RETIRED RESERVE (TRR), FYs 2014–2023



Source: Defense Manpower Data Center/Defense Enrollment Eligibility Reporting System (DEERS) Medical Policy Report, September 2023

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 health care coverage under TRR until they reach age 60. Upon reaching age 60 and receiving retired pay, they and their eligible family members may enroll in premium-free TRICARE health plan options available for retirees.

TRR enrollment has also stabilized, with Member and Family plans still the majority of plans purchased.

TRS and TRR Costs. Both TRS and TRR adopted the new TRICARE Select cost-sharing structure (Group B) on January 1, 2018.

TRR enrollees pay the full cost of the premium, unlike TRS, where the enrolled's share of the premium is 28 percent, with the Department subsidizing the rest. Premiums are calculated annually for both TRS and TRR and are derived from actual prior year costs. Premium rates for CYs 2023–2024 are shown below.

MONTHLY PREMIUMS FOR TRS AND TRR, CYs 2023–2024

TYPE OF COVERAGE	CY 2023 MONTHLY	CY 2024 MONTHLY	% CHANGE
TRS Member Only	$48.47	$51.95	7.2%
TRS Member and Family	$239.69	$256.87	7.2%
TRR Member Only	$549.35	$585.24	6.5%
TRR Member and Family	$1,320.76	$1,406.22	6.5%

Source: TRS and TRR data from https://tricare.mil/Costs/Compare, accessed 11/29/2023

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 would otherwise lose eligibility for TRICARE due to age. TYA offers Prime and/or Select coverage based on sponsor status and beneficiary location. Monthly premiums cover the full cost of the coverage with no government contribution. TYA meets the minimum essential coverage requirements of the Patient Protection and Affordable Care Act.

- TYA Prime premiums increased by 78 percent from $319 in CY 2017 to $570 in CY 2023, whereas TYA Select premiums increased by only 34 percent (from $216 to $291) over the same period (see table below). The increasing disparity in premiums between TYA Prime and Select likely explains the shift in enrollment from the former plan to the latter.
- TYA monthly premiums increased for CY 2024 from $570 to $637 per month for Prime and from $291 to $311 per month for Select (table below; tricare.mil/Costs/HealthPlanCosts/TYA). The continuing increase in premiums suggests that the shift in enrollment is likely to continue.

MONTHLY TYA PREMIUMS, CYs 2017–2024

	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023	CY 2024
Prime	$319	$324	$358	$376	$459	$512	$570	$637
Select (Standard)	$216	$225	$214	$228	$257	$265	$291	$311

Source: DHA/TRICARE Health Plan (THP) (J-10)/Health Plan Design Branch, Policy & Program Branch, 1/25/2024

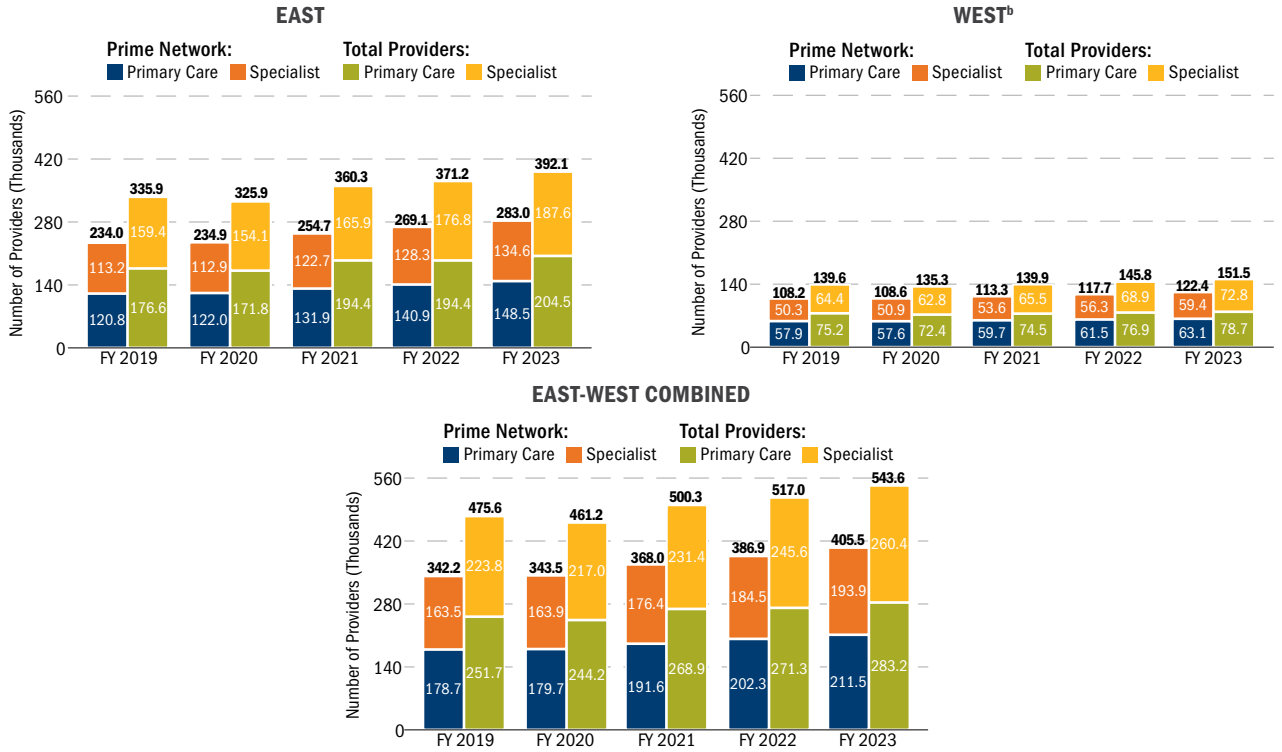
OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Provider Participation

The National Provider Identifier (NPI) is a unique identification number issued to health care providers in the U.S. by CMS. All HIPAA-covered individual health care providers and organizations must obtain an NPI for use in all HIPAA standard transactions. In this report, providers are counted using the NPI. The number of TRICARE-participating providers was determined by the number of unique providers filing TRICARE (excluding TRICARE for Life [TFL]) claims.[1] Providers were counted in terms of full-time equivalent units (1/12 of a provider for each month the provider saw at least one MHS beneficiary). The total number of participating providers has been rising steadily for more than a decade. The trend is due primarily to an increase in the number of network providers, which increased by 18 percent between FY 2019 and FY 2023. The number of non-network providers increased by only 4 percent over the same period. Since FY 2019, the number of network primary care providers has increased at a slightly lower rate (18 percent) than that of specialists (19 percent), and the total number of participating primary care providers has increased at a lower rate (12 percent) than that of total participating specialists (16 percent).[2]

- Between FY 2019 and FY 2023, the East Region saw an increase of 17 percent in the total number of TRICARE providers, while the West Region saw an increase of 9 percent.
- Between FY 2019 and FY 2023, the East Region saw an increase of 21 percent in the total number of network providers, while the West Region saw an increase of 13 percent.
- The total number of TRICARE providers increased by 17 percent in Prime Service Areas (PSAs) and by 10 percent in non-PSAs (not shown).
- The number of network providers increased by 22 percent in PSAs and by 13 percent in non-PSAs (not shown).
- In FY 2023, 68 percent of all network providers and 66 percent of all participating providers were in PSAs (not shown).

TRENDS IN NETWORK AND TOTAL PARTICIPATING PROVIDER FTEs, FYs 2019–2023[a]



Source: MHS administrative data, 1/20/2024

[a] Network providers are TRICARE-authorized providers who have a signed agreement with the regional contractors to provide care at a negotiated rate. Participating providers include network providers and those non-network providers who have agreed to file claims for beneficiaries, to accept payment directly from TRICARE, and to accept the TRICARE allowable charge, less any applicable cost shares paid by beneficiaries, as payment in full for their services.

[b] The West Region includes Alaska.

[1] Providers include physicians, physician assistants, nurse practitioners, and select other health professionals. Providers of support services (e.g., nurses, laboratory technicians) were not counted.

[2] Primary care providers were defined as general practice, family practice, internal medicine, obstetrics/gynecology, pediatrics, physician assistant, nurse practitioner, and clinic or other group practice.

Notes:

– The source for the provider counts shown above was the TRICARE private sector care claims data for each of the years shown, in which a provider was counted if he or she was listed as a TRICARE-participating provider. The claims also explicitly identify network providers.

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

Civilian Provider Acceptance of, and Beneficiary Access to, TRICARE Select

The TRICARE Select Survey (TSS) evaluates access to care and patient experience for TRICARE Select beneficiaries and awareness and acceptance of TRICARE Select among providers nationwide. It does this through two surveys: a beneficiary survey (TSS-B) and a provider survey (TSS-P).

- **Results from the FY 2023 Beneficiary Survey (TSS-B):**
  - **Reasons for Not Using TRICARE.** Thirteen percent of TSS beneficiaries reported not using TRICARE in the last 12 months and were asked why. The top reasons for not using TRICARE are "another reason" (38 percent) and "I have not needed health care" (31 percent). Beneficiaries in a PSA are more likely to say they get better customer service with a civilian plan (7 percent versus 1 percent not in a PSA). Beneficiaries in a non-PSA were much more likely to say there was no military facility nearby compared with those in a PSA (28 percent versus 9 percent), and they have to travel too far to see their TRICARE doctor (11 percent in a non-PSA compared with 5 percent in a PSA).
  - **Access to Care.** In FY 2023, 81 percent of TSS beneficiaries indicated satisfaction with Getting Needed Care CAHPS composite (below the 84 percent benchmark). However, 83 percent of beneficiaries indicated satisfaction with Getting Care Quickly CAHPS composite, meeting the benchmark. Access to personal doctor decreased from FY 2022, from 64 percent to 60 percent, as did BH, which was 57 percent in FY 2022 and 47 percent in FY 2023. There were several differences in access to care by PSA status, with those in a PSA more likely to have a personal doctor with 30 minutes (85 percent to 82 percent) and a specialist with 60 minutes (92 percent to 85 percent). However, those in a non-PSA had more access through Getting Needed Care (84 percent to 80 percent) and Getting Care Quickly (87 percent to 81 percent).
  - **Global Patient Experience Ratings.** Global ratings for Health Care (77 percent) and Health Plan (66 percent) were both above CAHPS benchmarks. Global ratings for Personal Doctor (82 percent) was at benchmark and Specialist (79 percent) was slightly below benchmark. Beneficiaries in non-PSAs gave higher ratings to their personal doctor (85 percent versus 80 percent) and health care (80 percent versus 75 percent).
  - **Problems Finding a Personal Doctor.** Twenty-seven percent of TSS beneficiaries reported a problem finding a personal doctor. The top reasons were "doctors not accepting TRICARE payments" (53 percent), "doctors not accepting any new patients" (43 percent), and doctors not accepting any new TRICARE patients (42 percent). Thirty-three percent of beneficiaries say the wait for an appointment was too long. Beneficiaries outside of PSAs were more likely to say personal doctors did not accept TRICARE payment (57 percent versus 52 percent) and the travel distance was too long (36 percent versus 29 percent).
  - **Problems Finding a Specialist.** In FY 2023, 27 percent of TSS beneficiaries reported a problem finding a specialist. The top reasons were "specialists not accepting TRICARE payments" (4 percent) and "wait for an appointment too long" (39 percent). Beneficiaries outside of PSAs were more likely to say the travel distance was too long (38 percent versus 27 percent).
  - **Problems Finding Mental Health Care.** Fifty-three percent of TSS beneficiaries reported a problem finding MH care. The top reasons were "not accepting TRICARE payments" (51 percent) and "wait for an appointment was too long" (41 percent).
  - Beneficiaries outside of PSAs were more likely to say the travel distance was too long (29 percent versus 19 percent). Beneficiaries within PSAs were more likely to say the wait was too long (44 percent versus 36 percent).
- **Results from the FY 2023 Provider Survey (TSS-P):**
  - **TRICARE Acceptance.** Eighty-one percent of physicians and 59 percent of BH providers were aware of TRICARE Select. Eighty-four percent of physicians and 34 percent of BH providers accept new TRICARE patients if they were accepting new patients at all.
  - **Reasons for Not Accepting TRICARE.** Of the 48 percent of providers who do not accept TRICARE Select, the top reasons were "other" (31 percent), "not accepting new patients" (30 percent), and "not aware of TRICARE Select" (21 percent). Physicians were more likely to not accept TRICARE Select because they were not accepting new patients. BH providers were more likely to not accept TRICARE Select because of they were not aware of it, the reimbursement was too low, or they only took private insurance. Some providers stopped accepting TRICARE Select because of nonpayment of claims.

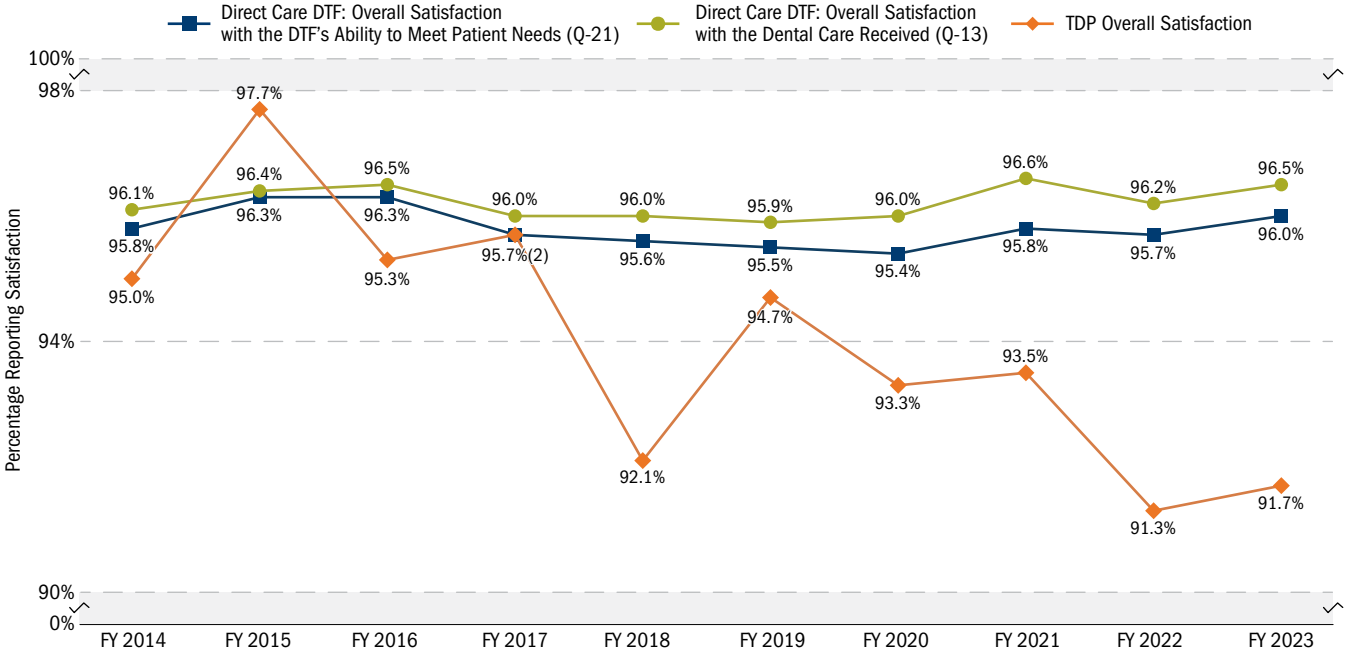
OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Dental Programs Customer Satisfaction

The overall TRICARE dental benefit is composed of several delivery programs serving the MHS beneficiary population. Consistent with other benefit programs, beneficiary satisfaction is routinely measured for each of these important dental programs.

- The Tri-Service Center for Oral Health Studies completed 36,603 surveys in FY 2023. This is a substantial decrease from 131,059 completed surveys in FY 2019, potentially due to the COVID-19 pandemic. Reports of overall satisfaction have remained at around 96 percent since FY 2014.
- The **TRICARE Dental Program (TDP)** is a voluntary, premium-sharing dental insurance program available to eligible ADFMs, Selected Reserve, and Individual Ready Reserve members and their families. The TDP composite overall average enrollee satisfaction for FY 2023 is 91.7 percent. It should be noted that the survey does not allow for questions to improve quality. As of November 1, 2023, TDP enrollment totaled 1,749,470 contracts, covering almost 2 million lives, 98 percent of which were in the U.S. The TDP network has 100,520 total dentists in FY 2023—76,721 are general dentists and 23,799 are specialists.

SATISFACTION WITH TRICARE DENTAL CARE: MILITARY AND CONTRACT SOURCES, FYs 2014–2023



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), 12/15/2023

Note: The dental satisfaction surveys are displayed above for ease of reference, but are not directly comparable because they are based on different survey instruments and methodologies.

OTHER PLANS AND PROGRAMS *(CONT.)*

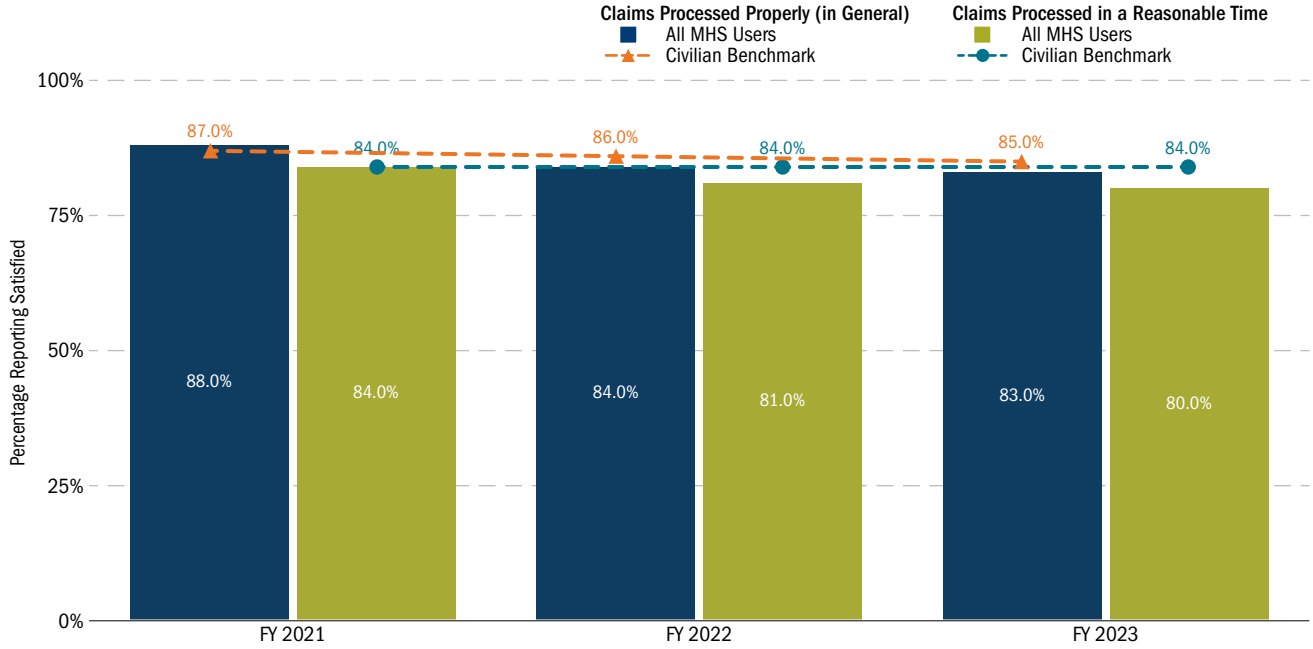
Customer Service, Claims Processing

Beneficiaries and their providers alike have an interest in the promptness and accuracy of claims processing and payment. The MHS monitors the performance of TRICARE claims processing through surveys of beneficiary perceptions and administrative tracking.

Beneficiary Perceptions of Claims Filing Process

- Satisfaction with claims being processed both properly and in a reasonable time decreased from FY 2021 to FY 2023.
- MHS satisfaction level with the accuracy of claims processing was higher than the civilian benchmark in FY 2021 but fell in FY 2022 and FY 2023. Satisfaction with processing time was at benchmark in FY 2021 but lower in FY 2022 and FY 2023.

TRENDS IN SELF-REPORTED ASPECTS OF CLAIMS PROCESSING (ALL SOURCES OF CARE), FYs 2021–2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 12/7/2023

Notes:

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

– Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks are based on NCQA's 2021 data.

OTHER PLANS AND PROGRAMS *(CONT.)*

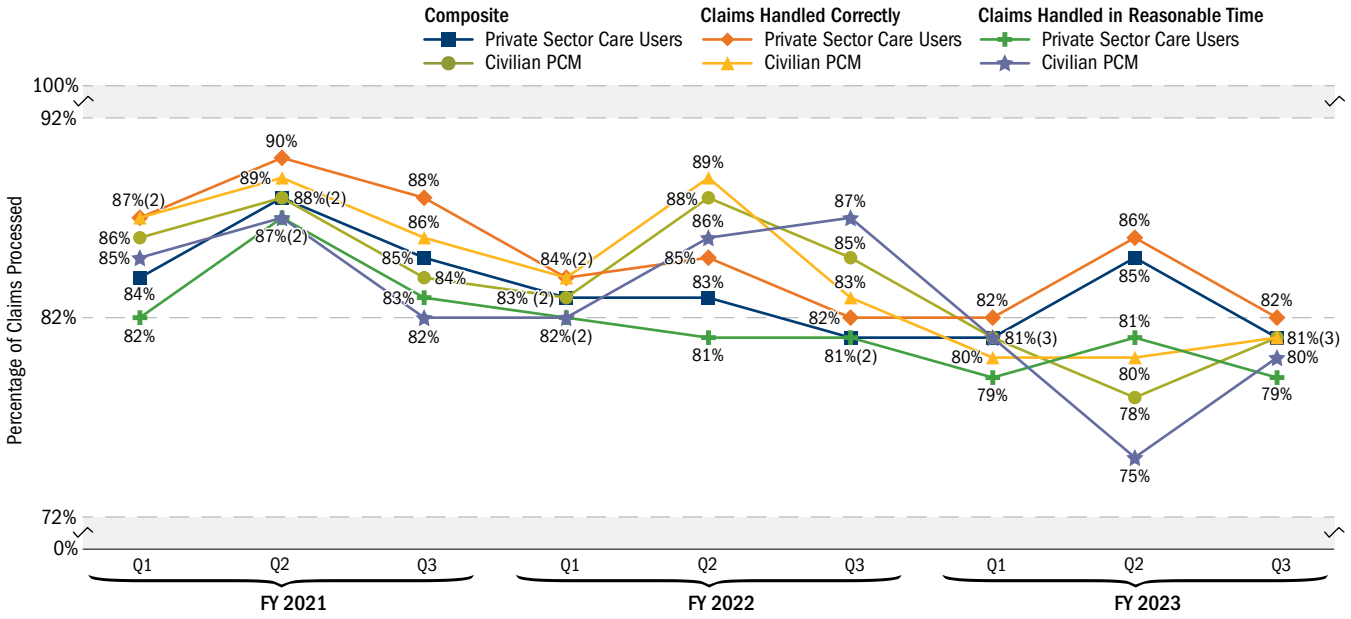
Customer Service, Claims Processing *(cont.)*

Trends in Claims Filing Process

TRICARE monitors claims processing to ensure compliance with contractual requirements and to ensure that our participating providers are paid on a timely basis. Claims processing for private sector care comprises three intervals: claims submission, claims processing, and transmission acceptance.

- **Claims Submission:** The claims submission interval is the time from the patient's last date of care to the date that the treating provider files a claim for payment with the Private Sector Care Processing Contractor.
- **Claims Processing:** The Private Sector Care Processing Contractor adjudicates the claim and sends a record to DHA, requesting payment. Claims processing includes the time needed for the Private Sector 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 PRIVATE SECTOR CARE/CIVILIAN PCM CLAIMS PROCESSING, FY 2021 Q1–FY 2023 Q3



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division; HCSDB, current as of FY 2023 Q3

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

OTHER PLANS AND PROGRAMS *(CONT.)*

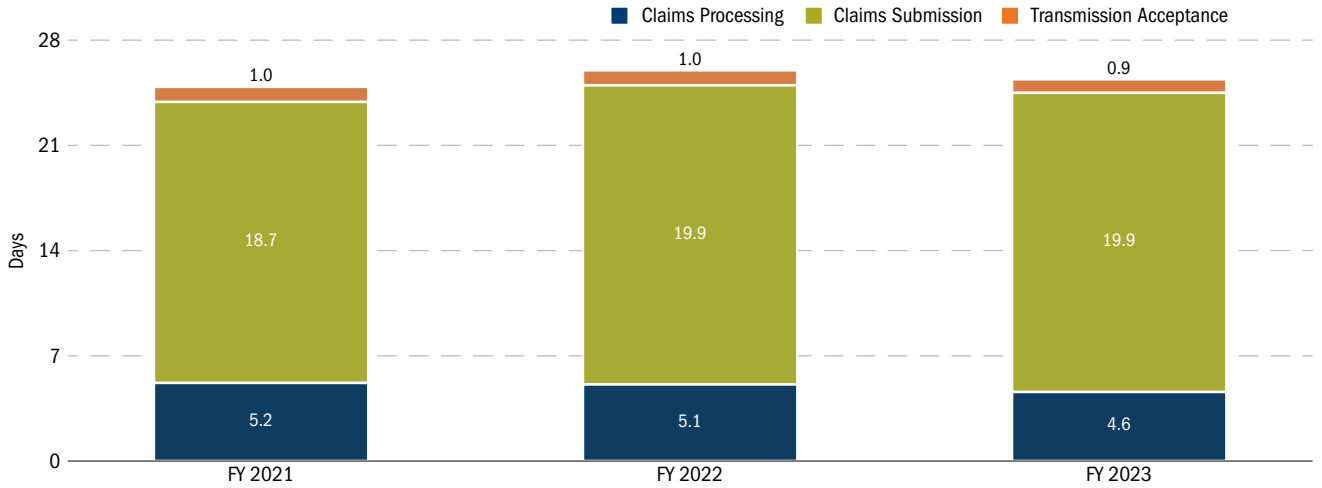
Customer Service, Claims Processing *(cont.)*

DHA pays MCSCs within seven days of the later of "transmission received date" or "last update date," in compliance with contractual language. The graph below shows that TRICARE payments met time requirements, complying with managed care support contracts.

The graph below excludes paper claims and claims from other health insurance, pharmacy, TRICARE Dual Eligible Fiscal Intermediary, and TRICARE Overseas Program contracts.

This fiscal year showed a statistically insignificant decrease in overall processing times, driven by a decrease in average Claims Processing times from FY 2023. The lengthiest portion of claims processing consistently is Claims Submission—the time it takes for the treating provider to submit claims. The chart below shows results of analysis of claims counts of 46.1 million, 48.6 million, and 49.0 million for FY 2021, FY 2022, and FY 2023 respectively.

AVERAGE INTERVAL (DAYS) FOR CLAIMS PROCESSING, FYs 2021–2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, MHS administrative data, 12/20/2023

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POPULATION HEALTH

The Military Health System (MHS) is dedicated to Population Health management and engagement. Although this concept is generally associated with managing the clinical risks associated with patients, the MHS has extended this concept to include helping the population manage their own health and creating an environment where the healthy choice is the easy choice. The MHS model continues to evolve to include strategies such as strengthening the connections between our military treatment facilities (MTFs) and regional managed care support contractor (MCSC) engagement.

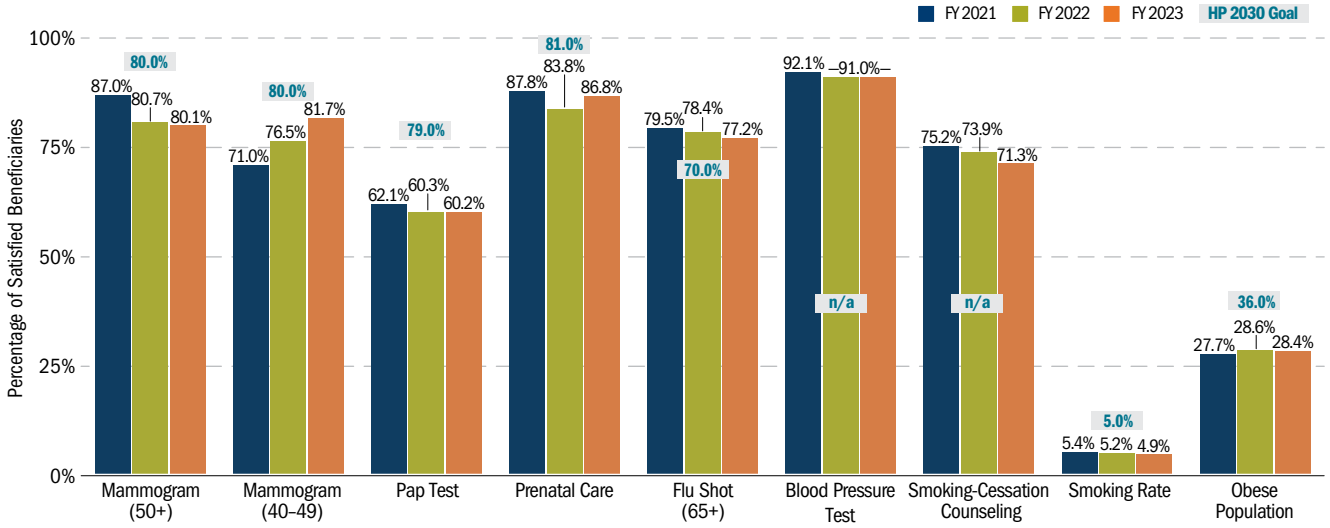
HEALTH PROMOTION AND DISEASE PREVENTION EFFORTS

The graphs on pages 92–95 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.). This section also provides selected measures benchmarked to the Healthy People 2030 (HP 2030) goals. The HP goals are national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce those threats; these goals have been embraced by the Department of Defense (DoD).

- The MHS has set as goals a subset of the health promotion and disease prevention objectives specified by the Department of Health and Human Services in HP 2030 (beginning in 2021). Over the past three years, the MHS has exceeded or was about equal to targeted HP goals for providing mammograms (ages 50 and older) and prenatal care for women, as well as for rates of smoking and obesity.
- Pap Test: According to self-reported Health Care Survey of DoD Beneficiaries (HCSDB) data, the percentage of MHS female beneficiaries receiving Pap tests decreased from 62.1 percent in fiscal year (FY) 2021 to 60.2 percent in FY 2023. Percentages remained relatively unchanged between FY 2022 (60.3 percent) and FY 2023, but still below targeted HP goal by approximately 19 percentage points.
- In March 2012, the U.S. Preventive Services Task Force offered an updated "Final Recommendation Statement: Cervical Cancer Screening" (https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/cervical-cancer-screening), which may have contributed to the decline in Pap tests.
- Tobacco Use: The overall self-reported smoking rate among all MHS beneficiaries has declined slightly over the past three years. Smoking-cessation counseling has decreased from 73.9 percent in FY 2022 to 71.3 percent in FY 2023 (page 144).
- Obesity: Based on self-reported survey data, the overall proportion of MHS beneficiaries identified as obese ranged from approximately 28 percent to 29 percent for the past three years. This is below the HP 2030 goal of 36 percent.

HEALTH PROMOTION AND DISEASE PREVENTION EFFORTS *(CONT.)*

TRENDS IN MEETING PREVENTIVE CARE STANDARDS, FYs 2021–2023



Sources: Defense Health Agency (DHA)/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, results provided 12/8/2023

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 2030 goals.
– Healthy People 2030 goals were released in late 2021 and should be used for 2021–2023 data.

MHS-TARGETED PREVENTIVE CARE MEASURES

Mammogram: Women aged 50 or older who had a mammogram in the past year; women aged 40–49 who had a mammogram in the past two years. **Pap Test:** All women who had a Pap test in the last three years. **Prenatal Care:** Women pregnant in the last year who received care in the first trimester. **Flu Shot:** People aged 65 and older who had a flu shot in the last 12 months. **Blood Pressure Test:** People who had a blood pressure check in the last two years and know the results. **Obese:** Obesity is defined as a body mass index (BMI) of 30 or above, which is calculated from self-reported data from the HCSDB. An individual's BMI is calculated using height and weight (BMI = 703 times weight in pounds, divided by height in inches squared). Although BMI is a risk measure, it does not measure actual body fat; as such, it provides a preliminary indicator of possible excess weight, which in turn provides a preliminary indicator of risk associated with excess weight. It should, therefore, be used in conjunction with other assessments of overall health and body fat. **Smoking-Cessation Counseling:** People advised to quit smoking in the last 12 months.

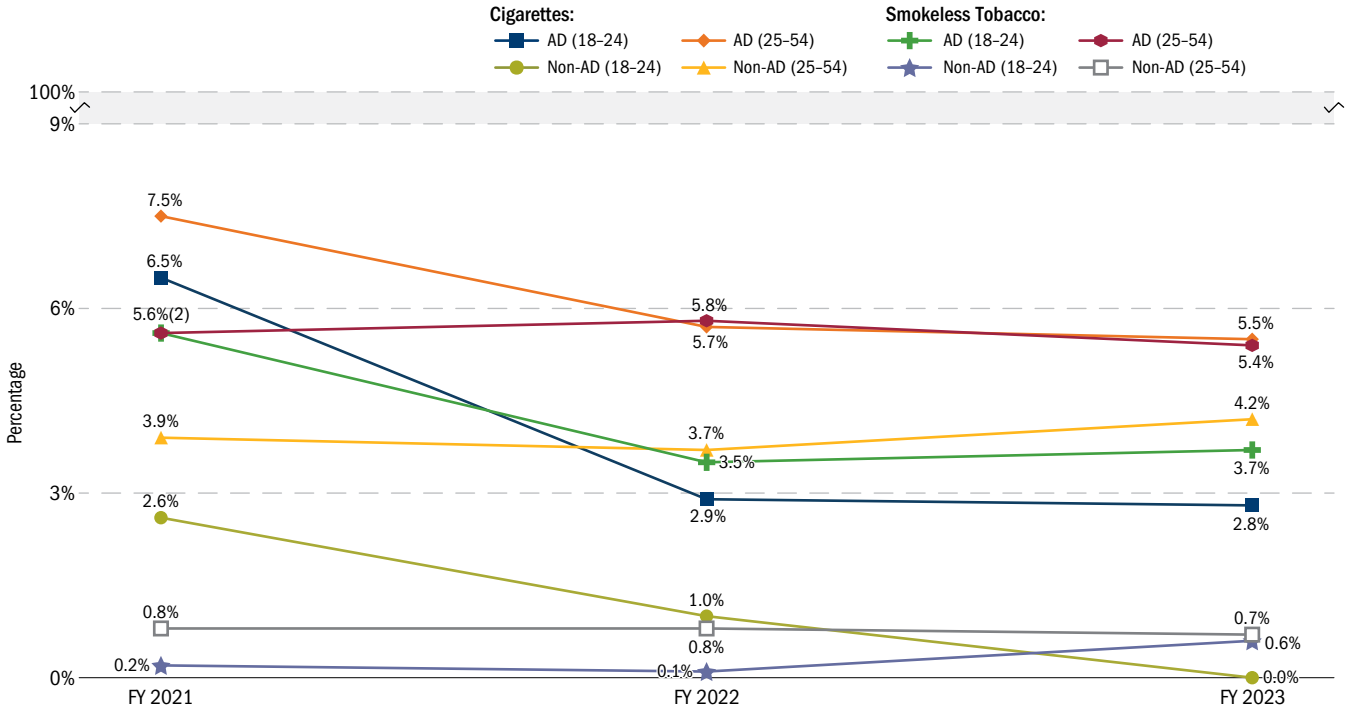
SELF-REPORTED PREVENTATIVE HEALTH MEASURES

Tobacco Cessation

Tobacco continues to be the leading cause of preventable death, according to the Centers for Disease Control and Prevention (CDC), and smoking rates in the military remain higher than desired. Military personnel who smoke experience reduced physical performance capability, impaired night vision, increased risk of respiratory illnesses and surgical complications, delayed wound healing, and accelerated age-related hearing loss. Furthermore, there are negative impacts on dental readiness, and long-term effects of tobacco use often include cancer, stroke, emphysema, and heart disease.

- Based on self-reported usage, cigarette smoking and smokeless tobacco use for Active Duty Service members (ADSMs) of all ages declined from FY 2021 to FY 2023.
- Cigarette smoking for non-Active Duty ages 18–24 declined from FY 2021 to FY 2023; however, smokeless tobacco use slightly increased for this population over the same time period. Cigarette smoking for non-Active Duty ages 24–54 slightly increased from FY 2021 to FY 2023 and smokeless tobacco use remained about the same.
- Cigarette smoking for MHS beneficiaries is well below the U.S. average of 11.5 percent (reported in 2021 from the CDC).

SELF-REPORTED CIGARETTE AND SMOKELESS TOBACCO USE RATES AMONG ACTIVE DUTY (AD) AND NON-ACTIVE DUTY, FYs 2021–2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, HCSDB data, 12/7/2023

Notes:

– Percentages are weighted for the probability of selection and nonresponse; variation in quarterly estimates may not be significant and should not be assumed as such without appropriate tests of significance.

– The U.S. adult cigarette smoking rate in 2021 was 11.5 percent, https://www.cdc.gov/tobacco/data_statistics/fact_sheets/index.htm?s_cid=osh-stu-home-spotlight-001, accessed 12/7/2023.

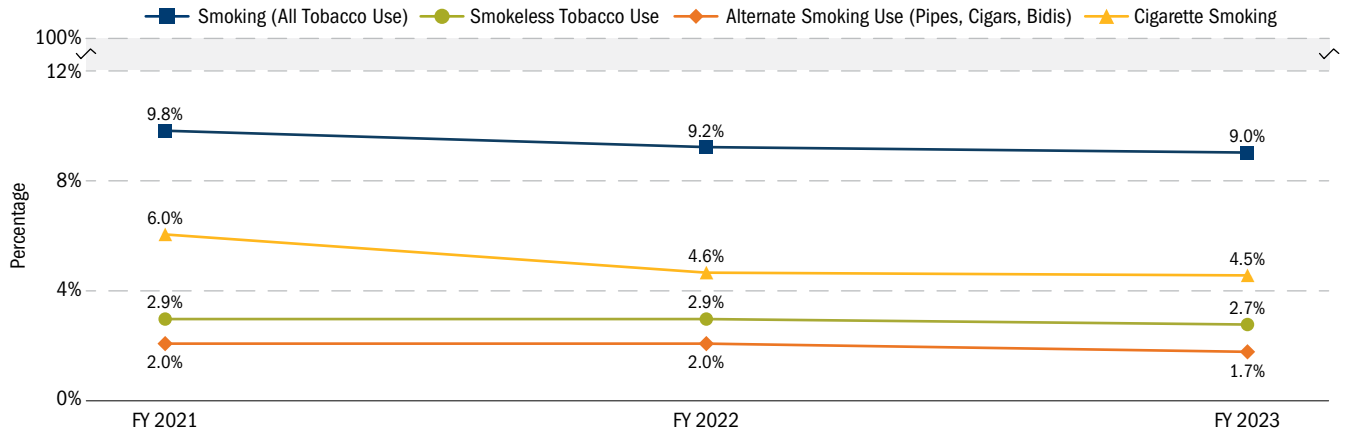
– For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

SELF-REPORTED PREVENTATIVE HEALTH MEASURES *(CONT.)*

Tobacco Cessation *(cont.)*

- **MHS Prime Enrollee Use of Any Tobacco Products:** In addition to cigarette smoking, the HCSDB assesses the use of various tobacco products across the MHS. The chart below presents the self-reported estimates of the prevalence of MHS Prime enrollees using different tobacco products (cigars, pipes, bidis, or kreteks). Prime enrollee use of tobacco in one form or another declined from 9.8 percent in FY 2021 to 9.0 percent in FY 2023.
- Cigarette smoking, which is the most used form of tobacco among Prime enrollees, decreased from 6 percent in FY 2021 to 4.5 percent in FY 2023. Smokeless tobacco use remained the same between FY 2021 and FY 2023.

SELF-REPORTED MHS PRIME ENROLLEE USE OF TOBACCO PRODUCTS, BY TYPE OF TOBACCO USE: CIGARETTES, ALTERNATE SMOKING TOBACCO, AND SMOKELESS TOBACCO, FYs 2021–2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, HCSDB data, 12/7/2023

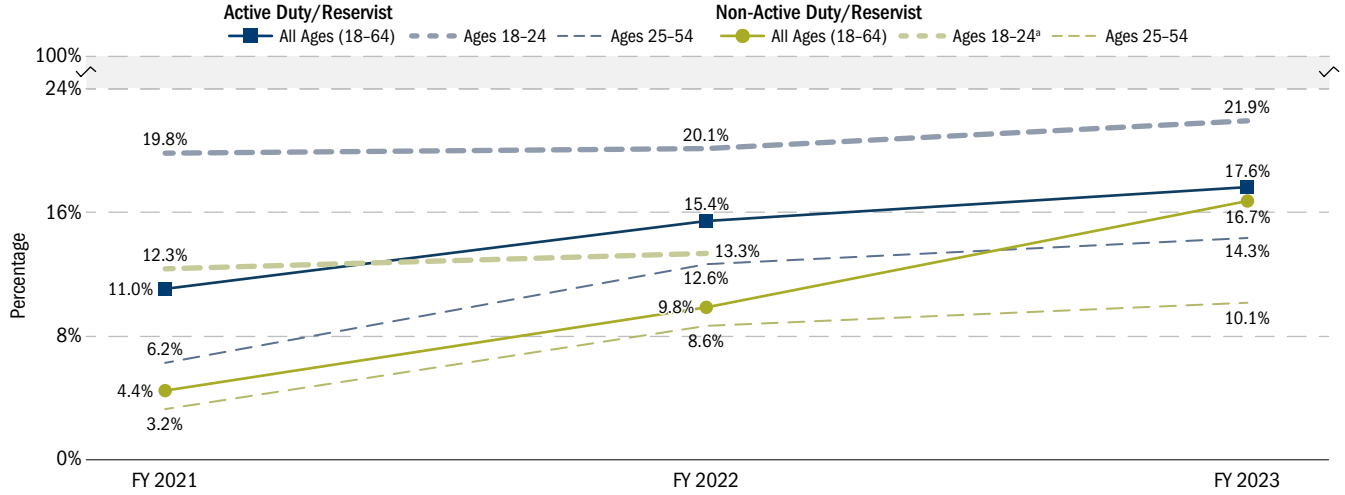
Notes:

– 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 among AD/Reservists (all ages) increased by 2.2 percentage points from FY 2022 to FY 2023. Non-AD/Reservists (all ages) self-reported use of e-cigarettes increased by nearly 7 percentage points during the same period.
- Self-reported use of e-cigarettes increased across all ages for both AD/Reservists and non-AD/Reservists for the past three years.

SELF-REPORTED E-CIGARETTE USAGE AMONG SELECT COHORTS, FYs 2021–2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, HCSDB data, 2/1/2024

[a] Due to small cell size, non-AD/Reservists ages 18–24 cannot be reported for FY 2023.

Note: Data are derived from the HCSDB question "Do you now vape or use e-cigarettes every day, some days, or not at all?" with scores shown for those who indicated "every day."

SELF-REPORTED PREVENTATIVE HEALTH MEASURES *(CONT.)*

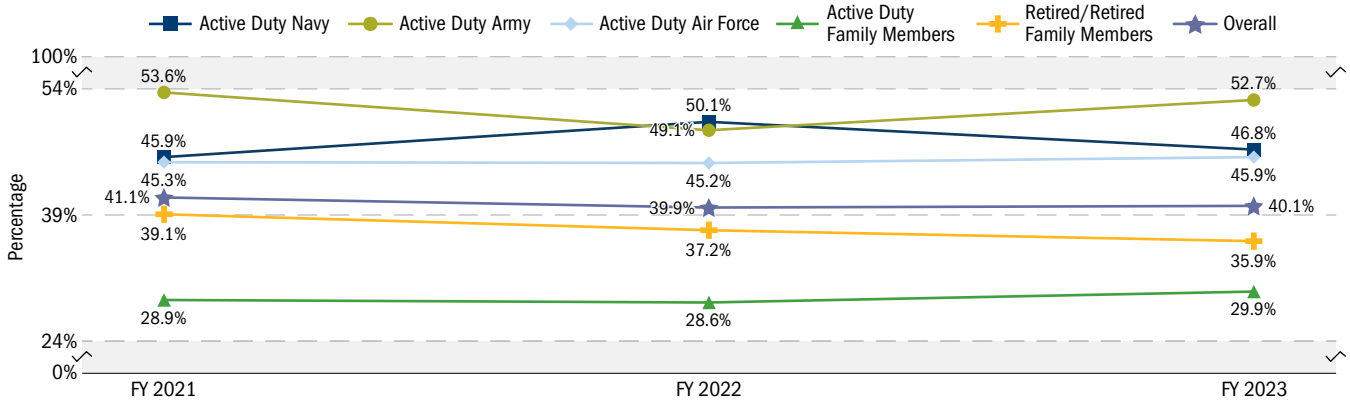
MHS Adult Obesity

This measure provides important information about the overall health of DoD beneficiaries for use by MHS leadership to help promote military initiatives that encourage exercise and healthy nutritional habits. These data can also shape the need for, and development of, medical interventions or modalities that are effective in maintaining healthy weights for all age groups.

The charts below display the percentage of the population reporting in the HCSDB a height and weight that, when used in calculating BMI, result in a measurement of 25 or higher (30 is the threshold for obesity).

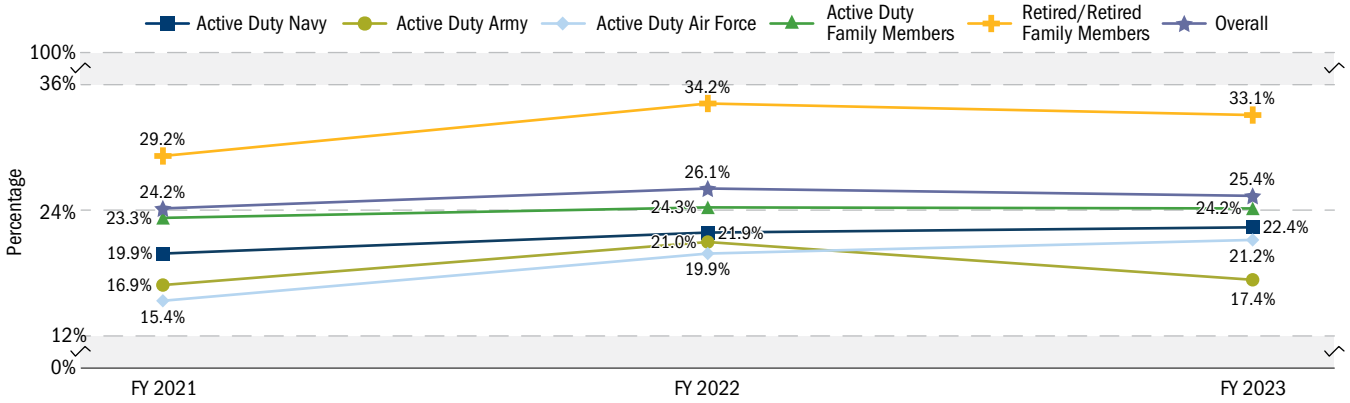
- As shown in the chart below, 40.1 percent of all MHS beneficiaries were overweight in FY 2023. Active Duty family members (ADFMs), on average, have the lowest rate of being overweight (29.9 percent). Calculated BMI rates reflecting overweightness may not be reflective of AD fitness without consideration of muscle mass, and may explain why AD appear to have high prevalence rates of being overweight but low obesity rates, as shown in the second chart.

SELF-REPORTED MHS OVERWEIGHT RATE (BMI 25–29.9), FYs 2021–2023



- The chart below displays the prevalence of obesity in the MHS population (i.e., a calculated BMI of 30 or higher) based on self-reported height and weight survey data from the HCSDB. The overall MHS obesity rate increased by 1.2 percentage points between FY 2021 and FY 2023 but decreased slightly by less than 1 percentage point between FY 2022 and FY 2023.
- In FY 2023, AD Army had the lowest obesity rates, compared with Navy and Air Force.
- AD Navy and Air Force obesity rates for FY 2023 increased by 2.5 and 5.8 percentage points since 2021, respectively, while overweight rates increased by less than 1 percentage point for Air Force.

SELF-REPORTED MHS OBESITY RATE (BMI 30 OR HIGHER), FYs 2021–2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, HCSDB data 2/1/2024

Notes:

– BMI is defined as the individual's body weight divided by the square of his or her height. The formula universally used in medicine produces a unit of measure of kg/m^2. Because the HCSDB collects height and weight in inches and pounds, BMI is calculated as lb/in^2 x 703. A BMI of 18.5 to 25 may indicate optimal weight; a BMI lower than 18.5 suggests the person is underweight, while a number above 25 may indicate the person is overweight; a number of 30 or above suggests the person is obese (Division of Nutrition, Physical Activity and Obesity, National Center for Chronic Disease Prevention and Health Promotion, CDC).

– Since the data are self-reported, they are subject to recall bias, while provider measurements are subject to instrument error (e.g., lack of calibration of weight scales) and inconsistency in recording (e.g., asking patient's height or weight versus measuring). No objective validation tool is used to verify accuracy of BMI results.

HEALTH-RELATED QUALITY OF LIFE (HRQOL)

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 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 (MH) of an individual or group over a period of time. The standard four-item set of Healthy Days core questions (CDC HRQOL–4) has been in the state-based BRFSS since 1993 (see the BRFSS website at https://www.cdc.gov/brfss).

- From 2000 to 2012, the CDC HRQOL–4 has been in the National Health and Nutrition Examination Survey for persons aged 12 and older.
- Since 2003, the CDC HRQOL–4 has been in the Medicare Health Outcomes Survey—a measure in the Healthcare Effectiveness Data and Information Set (HEDIS) of the National Committee for Quality Assurance (NCQA).

The HRQOL–4 questions are:

- **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.)
- **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.")
- **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.")
- **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 with norms calculated from 2017 BRFSS micro data, which are not currently reported in summary like 2010, but rather contain responses from approximately 440,000 respondents in 53 states/territories and are reweighted to match our MHS population. Mode differences between the BRFSS and HCSDB may result in mode effects and make comparison more difficult. Healthy People 2030 does not include HRQOL goals.

Because the MHS population differs from the U.S. population in age, gender, and ethnic composition, BRFSS rates were reweighted to match MHS users' characteristics in those areas. However, the populations may differ in other ways that complicate the comparisons between estimates from the BRFSS and HCSDB—for example, employment, education, and access to health care.

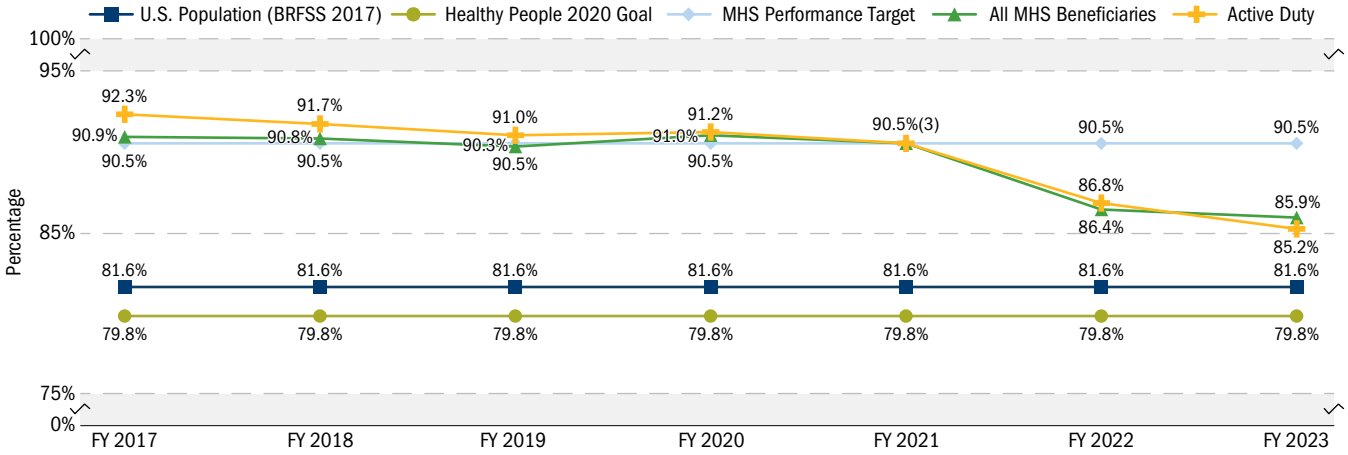
After examining both the HP 2020 and BRFSS benchmarks, the MHS established a performance target of 90.5 percent by January 1, 2021. As shown in the following graphs, the overall MHS population in general, including ADSM, rate their health status higher than the general U.S. population did in 2017, and both are higher than the HP 2020 goal of 79.8 percent.

- The overall MHS population rating of good or better health appears to have remained about the same from FY 2017 through FY 2021, ranging from 90 percent to 92 percent. However, scores for all MHS beneficiaries declined from 90.5 percent in FY 2021 to 86.4 percent in FY 2022 and FY 2023. ADSMs rating their health as good or better declined from 90.0 percent to 85.2 percent for the same period.
- From FY 2021 to FY 2023, physically unhealthy days in the past 30 days increased from 3.7 to 5.6 for AD/Reservists 2.9 to 4.1 for AD/Reservists dependents, and 4.2 to 5.0 for retirees and their dependents. Emotionally unhealthy days out of the past 30 increased from 4.5 in FY 2021 to 6.2 in FY 2023 for AD/Reservists and from 4.9 in FY 2021 to 6.0 for dependents of AD/Reservists. Retirees and their dependents saw less change in emotionally unhealthy days with 3.2 in FY 2021 and 3.8 in FY 2023.

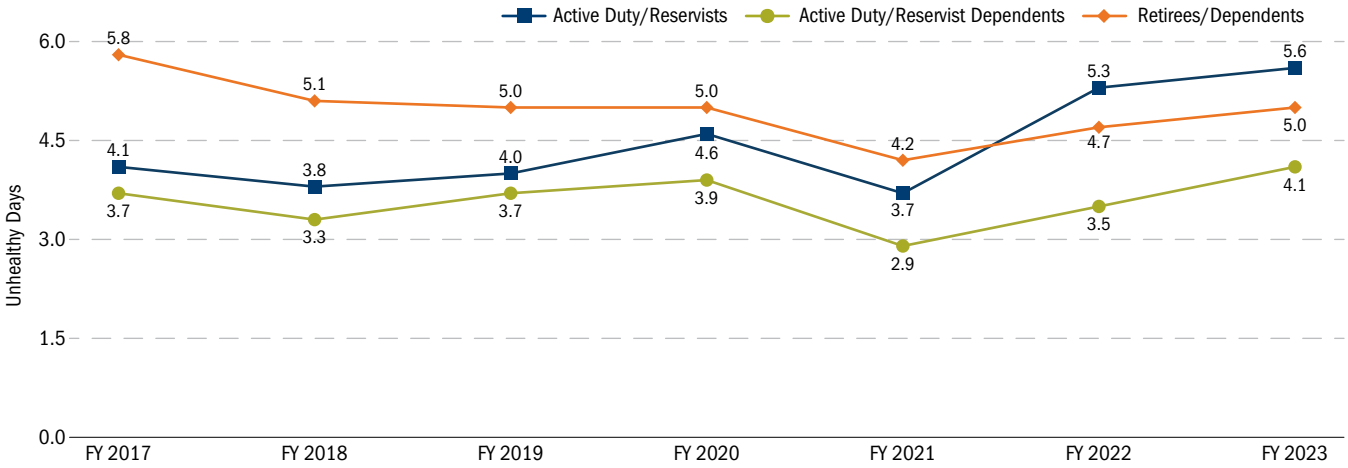
HEALTH-RELATED QUALITY OF LIFE (HRQOL) *(CONT.)*

Using CDC's Health-Related Quality of Life Questions as a Proxy Measure of "Better Health" *(cont.)*

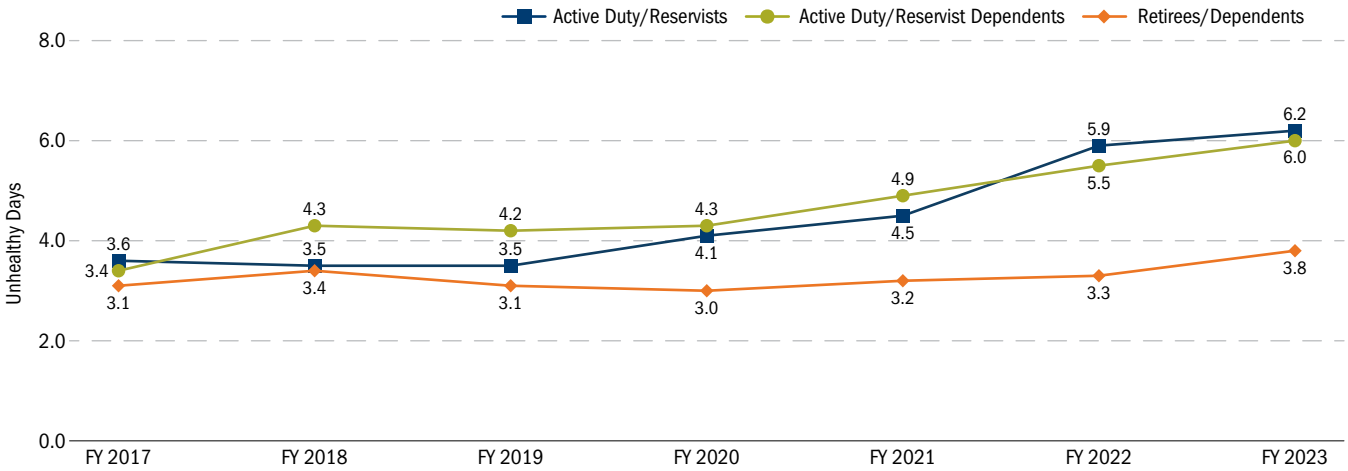
PERCENTAGE OF MILITARY BENEFICIARIES SELF-RATING HEALTH STATUS AS GOOD OR BETTER, FYs 2017–2023



PHYSICALLY UNHEALTHY DAYS FOR TRICARE BENEFICIARIES, FYs 2017–2023



EMOTIONALLY UNHEALTHY DAYS FOR TRICARE BENEFICIARIES, FYs 2017–2023



Source: DHA/Strategy, Plans, and Analytics (J-5)/Analytics and Evaluation Division, 12/8/2023

Notes:

– BRFSS results are from the 2017 survey conducted by CDC, reweighted to match the 2017 MHS population.

– Unhealthy days are measured from 0 to 30 out of the last 30 days, as indicated in HRQOL questions 3 and 4 on the previous page.

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SAVINGS AND RECOVERIES

Pharmacy Retail Refunds

The authority at 38 USC 8126 directly authorizes refunds when direct purchases of pharmaceuticals are made by the government (i.e., military medical treatment facility [MTF], TRICARE mail order pharmacy, etc.) and is made applicable to the TRICARE retail pharmacy program by the TRICARE Pharmacy Benefits Program statute at 10 U.S.C. 1074g(f) and the implementing TRICARE regulation.

The increase in refunds on drugs dispensed in retail is likely caused by several factors. Potential drivers include a shift of prescription volume from the MTF point of service to the retail point of service starting in early 2020 driven by the COVID-19 pandemic, cost increases for branded medications, increasing availability and use of costly specialty medications, and additional discounts offered by manufacturers through the Department of Defense (DoD) Pharmacy & Therapeutics (P&T) process.

PHARMACY RETAIL REFUNDS ($ MILLIONS), FISCAL YEARS (FYs) 2019–2023

	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Total Receivables	$836.01	$859.28	$986.97	$1,067.87	$1,364.80
Total Collections	$860.82	$824.89	$957.52	$1,019.70	$1,259.16

Source: Defense Health Agency (DHA) Business Support Directorate, Contract Resource Management, 11/30/2023

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 they were validated and billed to the manufacturers.

Program Integrity Activities

The DHA Office of Program Integrity (DHA PI) is responsible for health care antifraud to safeguard beneficiaries and protect benefit dollars. DHA PI develops and executes antifraud and abuse policies and procedures, provides oversight of contractor program integrity activities, and coordinates investigative activities. DHA PI also develops cases for criminal prosecutions and civil litigations, and initiates administrative measures. Through a Memorandum of Understanding, DHA PI refers its fraud cases to the Defense Criminal Investigative Services. DHA PI also coordinates investigative activities with Military Criminal Investigative Offices, as well as other federal, state, and local agencies.

PROGRAM INTEGRITY RECOVERIES/COST AVOIDANCE ($ MILLIONS), CALENDAR YEARS (CYs) 2020–2022

	CY 2020	CY 2021	CY 2022
Total Recoveries	$509.2	$555.9	$184.4
Court-Ordered Fraud Judgments/Settlements	$493.1	$520.9	$146.6
DHA PI Contractor Administrative Recoupment/Offsets (Received)	$16.1	$35.1	$37.8
Total DHA PI Contractors Cost Avoidance	$41.2	$66.8	$54.4
Contractor Prepayment Reviews	$40.3	$66.7	$54.3
Excluded Providers	$0.9	$0.1	$0.1

Source: 2022 Annual Program Integrity Operational Report/Contractor Submitted Fraud and Abuse Reporting, CY 2020–CY 2022. CY 2022 data are the latest reported as of 1/2/2024.

Note: Annual Reports are located here: https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Program-Integrity.

SAVINGS AND RECOVERIES *(CONT.)*

Program Savings and Claim Recoveries

New reimbursement approaches are continually evaluated for potential savings to TRICARE. As new programs are established, savings are estimated and monitored.

Claim recoveries result from identified overpayments adjusted in TRICARE Encounter Data (TED), and the differences are recouped.

Recovery A—Post-Payment Duplicate Claim Recoveries: A post-payment duplicate claims system was developed by the DHA Health Care Operations Directorate/TRICARE Health Plan Division for use by TRICARE private sector care contractors. The system was designed as a retrospective auditing tool and facilitates the identification of actual duplicate claim payments and the initiation and tracking of recoupments. The table below provides the historical recovery of duplicate claims payments. Duplicate claim recoveries show a decrease due to a regional contractor correcting claims processing issues.

RECOVERIES ($ MILLIONS), FYs 2021–2023

RECOVERIES	FY 2021	FY 2022	FY 2023
Post-Payment Duplicate Claim Recoveries	$10.8	$8.9	$26.7

Recovery B—Improper Payment Recoveries: The DHA is vigilant in ensuring the accuracy of health care claim payments within the military health benefits program. The DHA has contracted with an external independent contractor (EIC) who is responsible for conducting post-payment accuracy reviews of TRICARE health benefit claims. The EIC is responsible for identifying improper payment made by TRICARE private sector care contractors as a result of contractor noncompliance with TRICARE policy, benefit, and/or reimbursement requirements.

OVERPAYMENTS RECAPTURED OUTSIDE OF PAYMENT RECAPTURE AUDITS ($ MILLIONS), FY 2023

ACTUAL OVERPAYMENT DOLLARS IDENTIFIED VIA RANDOM SAMPLES[a]	AMOUNT RECAPTURED (REFUNDS THROUGH FY 2023)
$3.2	$311.9

Sources: DHA/R&M (J-1/J-8)/Trust Fund and Revenue Cycle Management Improper Payment Evaluation Branch; Operational Reports and Quarterly Fraud and Abuse Reports

[a] "Actual overpayment dollars identified via random samples" represents the total overpayment dollars from sampled claims.

Notes:

– DHA's methodology to calculate recoveries takes into consideration subsequent repayments and nets them against refunds.

– These numbers include recoupments for overpayments identified in audits as well as refunds occurring in the course of routine claim adjustments. DHA has no way to distinguish overpayment recoupments from routine claim adjustments.

In addition to the EIC post-payment reviews, DHA requires TRICARE private sector care contractors to use industry best business practices 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 2023 improper payment recoveries of health care as a result of the EIC compliance reviews and ongoing private sector care contractor efforts to identify and recover improper payments.

INPATIENT UTILIZATION RATES AND COSTS

TRICARE Inpatient Utilization Rates Compared with Civilian Benchmarks (U.S. Only)

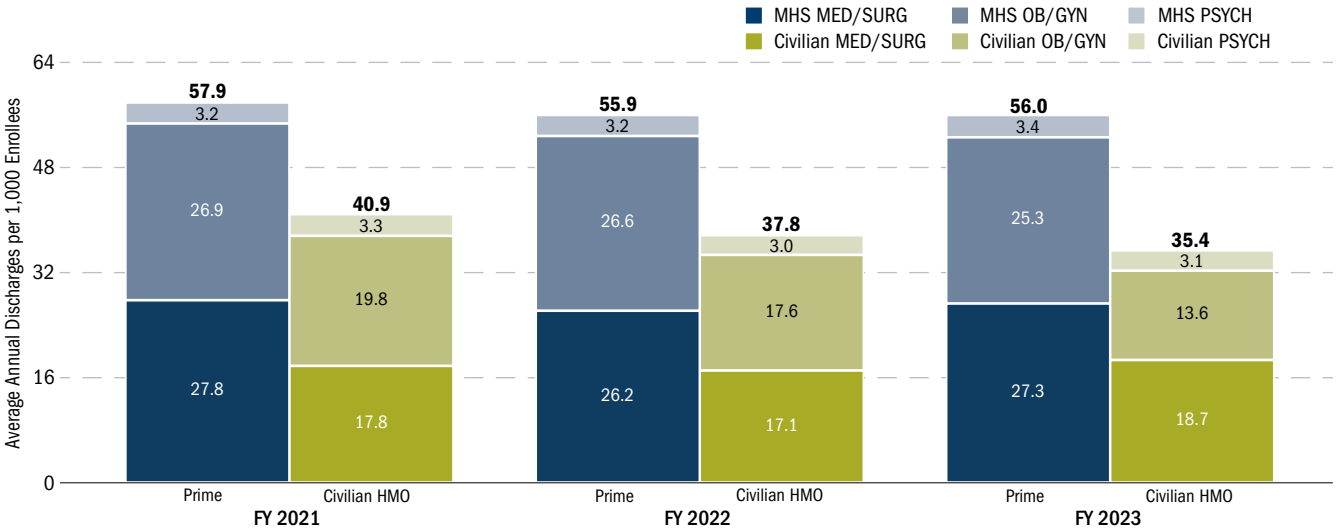
TRICARE Prime Enrollees

This section compares the inpatient utilization of TRICARE Prime enrollees (including TRICARE Young Adult [TYA] Prime but excluding the Uniformed Services Family Health Plan [USFHP]) with that of enrollees in civilian employer-sponsored health maintenance organization (HMO) plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. Inpatient utilization is measured as the total number of dispositions (i.e., the sum of direct and private sector care dispositions) because relative weighted products (RWPs) are not available in the civilian-sector data.

Dispositions are computed for three broad product lines—obstetrics/gynecology (OB/GYN), mental health (PSYCH), and other medical/surgical (MED/SURG)—and compared for acute care facilities only. The comparisons exclude beneficiaries aged 65 and older because very few are covered by employer-sponsored plans.

- The overall TRICARE Prime inpatient utilization rate decreased by 3 percent between FY 2021 and FY 2023, while the civilian HMO rate decreased by 14 percent. The overall TRICARE Prime decrease was driven by a 2 percent decline in MED/SURG utilization and a 6 percent decline in OB/GYN utilization. Although PSYCH utilization increased by 6 percent, it represents only a small fraction of total utilization.
- In FY 2023, the TRICARE Prime inpatient utilization rate (direct and private sector care combined) was 58 percent higher than the civilian HMO utilization rate (56 discharges per 1,000 Prime enrollees compared with 35.4 per 1,000 civilian HMO enrollees).
- In FY 2023, the TRICARE Prime inpatient utilization rate was 46 percent higher than the civilian HMO rate for MED/SURG procedures, 86 percent higher for OB/GYN procedures, and 9 percent higher for PSYCH procedures.
- The average length of stay (LOS) for Military Health Service (MHS) Prime enrollees (direct and private sector care combined) increased slightly from 3.55 days in FY 2021 to 3.57 days in FY 2023, whereas the average LOS for civilian HMOs decreased from 4.31 days to 3.88 days over the same period. In FY 2023, the average LOS for MHS Prime enrollees was 8 percent lower than that of civilian HMO enrollees (not shown).

INPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK, FYs 2021–2023



Sources: MHS administrative data, 1/19/2024, and Merative™ MarketScan® Commercial Database, 1/19/2024

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2023 civilian benchmarks are based on two quarters of data, which were seasonally adjusted and annualized.

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

LOWER COST

INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

TRICARE Inpatient Utilization Rates Compared with Civilian Benchmarks (U.S. Only) *(cont.)*

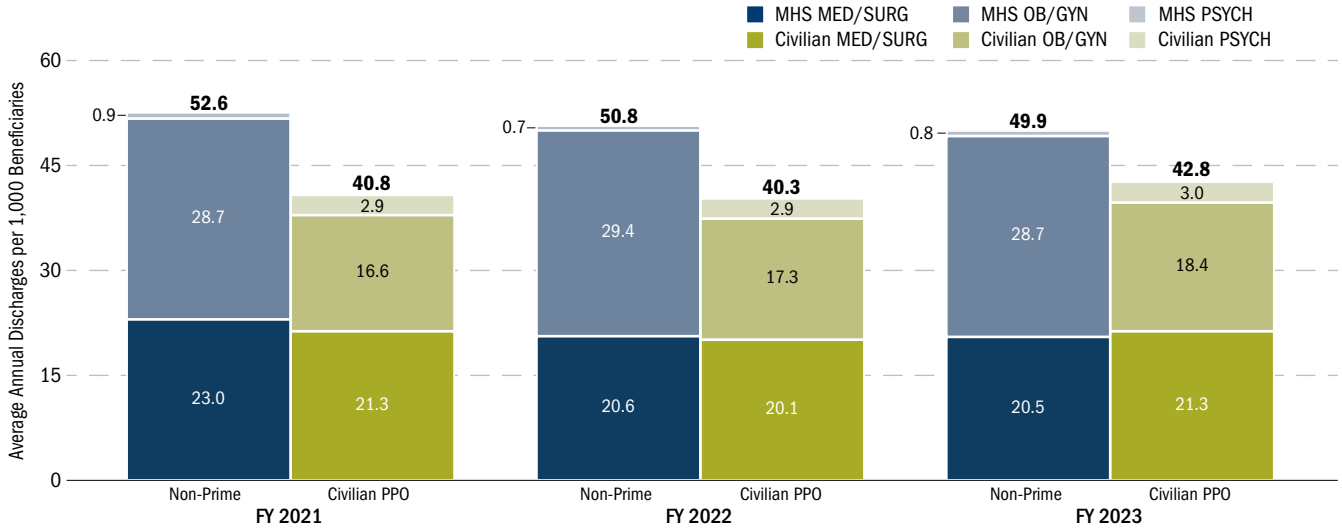
Non-Prime-Enrolled Beneficiaries

This section compares the inpatient utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored preferred provider organization (PPO) plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. Inpatient utilization is measured as the total number of dispositions (i.e., the sum of direct and private sector care dispositions) because RWPs are not available in the civilian-sector data.

Dispositions are computed for three broad product lines—OB/GYN, PSYCH, and other MED/SURG procedures—and compared for acute care facilities only. The comparisons exclude beneficiaries aged 65 and older because very few are covered by employer-sponsored plans. To make the utilization rates of MHS and civilian beneficiaries more comparable, non-Prime-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Although most beneficiaries who fail to file a TRICARE claim have private health insurance (PHI), we estimate that about 20 percent do not file because they have no utilization. The MHS utilization rates shown below include these nonusers to make them more comparable with the civilian rates, which also include nonusers.

- Between FY 2021 and FY 2023, the overall TRICARE non-Prime utilization rate decreased by 5 percent, whereas the civilian PPO inpatient utilization rate increased by 5 percent. Despite the overall decline, the TRICARE rate remains well above the civilian benchmark. In FY 2023, the inpatient utilization rate (direct and private sector care combined) for non-Prime-enrolled beneficiaries was 17 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 2021 to FY 2023, the MHS OB/GYN disposition rate held steady, whereas it increased by 11 percent in the civilian sector. In FY 2023, the MHS OB/GYN disposition rate was 55 percent higher than the corresponding civilian PPO rate.
- Of the three product lines considered in this report, only PSYCH procedures had lower utilization in the MHS than in the civilian sector.
- The average LOS for MHS non-Prime-enrolled beneficiaries (direct and private sector care combined) decreased to 3.60 days in FY 2023 from 3.78 days in FY 2021. The average LOS for civilian PPO participants decreased similarly from 4.17 days in FY 2021 to 3.99 days in FY 2023. In FY 2023, the average LOS for MHS non-Prime beneficiaries was 10 percent lower than that of civilian PPO participants (not shown).

INPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK, FYs 2021–2023



Sources: MHS administrative data, 1/19/2024, and Merative MarketScan Commercial Database, 1/19/2024

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2023 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.

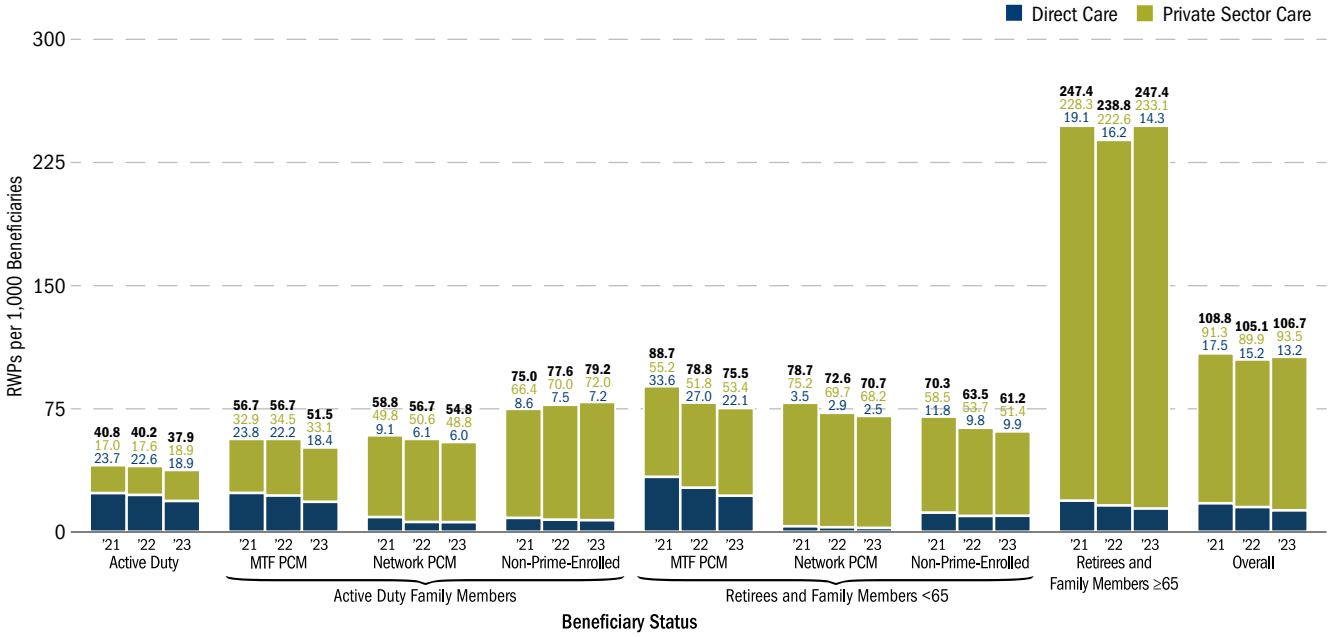
INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Inpatient Utilization Rates by Beneficiary Status

When breaking out inpatient utilization by beneficiary group, RWPs per capita more accurately reflect differences across beneficiary groups than discharges per capita do. MHS RWPs are based on the Medicare Severity Diagnosis Related Group (MS-DRG) system of classifying inpatient hospital cases under the Medicare Prospective Payment System and are relevant only for acute care hospitals.

- The overall (direct and private sector care combined) inpatient utilization rate (RWPs per 1,000 beneficiaries) fell by 2 percent from FY 2021 to FY 2023.
- Between FY 2021 and FY 2023, the direct care inpatient utilization rate decreased by 25 percent overall, due in part to the downsizing of three military hospitals to clinics over that time period.
- The direct care inpatient utilization rate fell for all beneficiary groups from FY 2021 to FY 2023. Active Duty family members (ADFMs) with a network primary care manager (PCM) had a decline of just over 34 percent. Retirees and family members (RETFMs) younger than age 65 with an MTF PCM also saw a 34 percent decrease in direct care inpatient utilization. RETFMs with a network PCM saw a decline of 29 percent. The remaining beneficiary groups experienced declines ranging from 16 to 25 percent.
- The overall private-sector acute care inpatient utilization rate increased by 2 percent between FY 2021 and FY 2023 with some variation across beneficiary groups. Active Duty (AD) experienced an 11 percent increase with nonenrolled ADFMs experiencing a similar 9 percent increase. ADFMs with an MTF PCM experienced no change. RETFMs under age 65 experienced declines in private-sector inpatient utilization ranging from 3 to 12 percent.
- Excluding Medicare-eligible beneficiaries (for whom Medicare is likely their primary source of care and TRICARE is second payer), the percentage of per capita inpatient workload performed in private sector care facilities increased from 74 percent in FY 2021 to 78 percent in FY 2023.
- From FY 2021 to FY 2023, 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 61 percent.

AVERAGE ANNUAL INPATIENT RWPs PER 1,000 BENEFICIARIES, FYs 2021–2023



Source: MHS administrative data, 1/19/2024

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

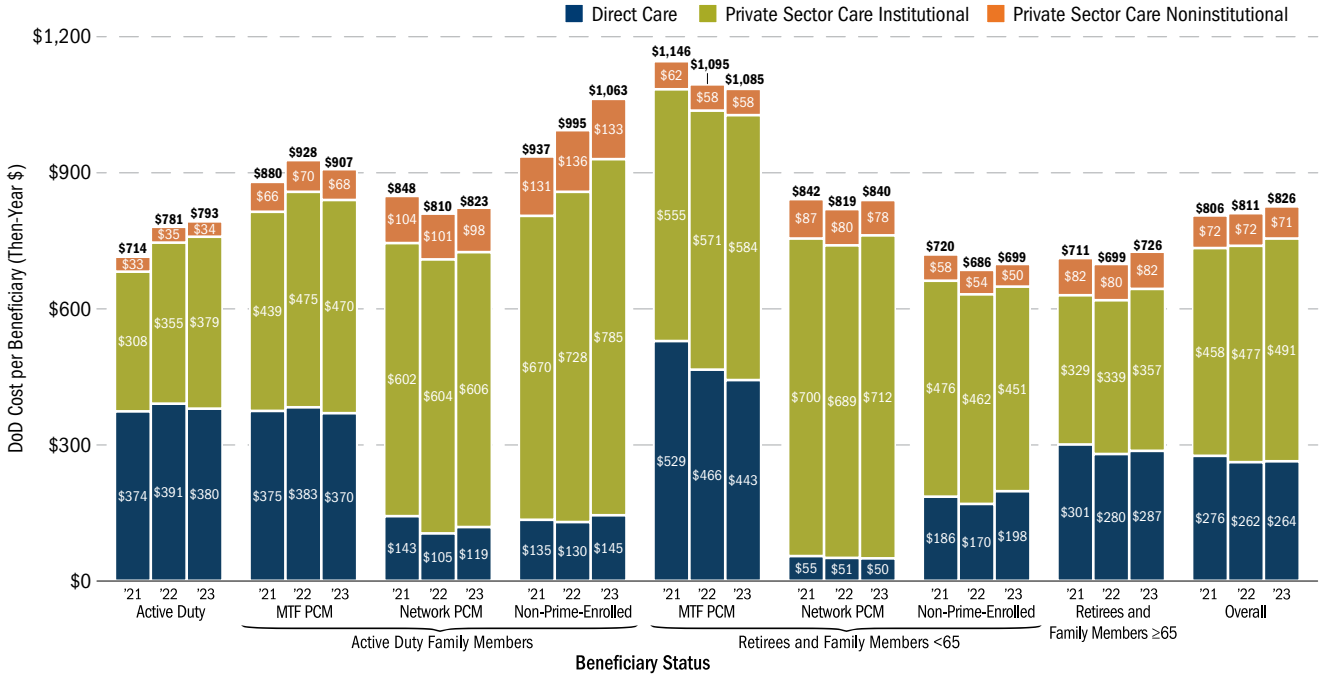
INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Inpatient Cost by Beneficiary Status

Total DoD inpatient costs include two components: (1) expenditures for direct care at MTFs that are attributed to inpatient care and (2) payments made to private sector care (PSC) institutions (and others) for services rendered in hospitals, both acute care and non-acute. PSC payments to "others" are for professional services that are associated with a hospital stay (e.g., provider visits, lab services, anesthesia, and other).

- The overall MHS inpatient cost per beneficiary increased by 2 percent between FY 2021 and FY 2023.
- By beneficiary group, the total inpatient cost per beneficiary increased most (13 percent) for nonenrolled ADFMs.
- For PSC, the inpatient cost per beneficiary increased by 6 percent between FY 2021 and FY 2023; however, for direct care, the inpatient cost per beneficiary actually decreased by 4 percent over that same period.
- A separate analysis shows that the PSC cost per RWP increased from $10,685 to $11,410 between FY 2021 and FY 2023 and that the direct care cost per RWP increased from $15,755 to $20,041 over the same period. The PSC costs exclude non-acute care hospitals and other health insurance and Medicare claims to make them more comparable to direct care costs (i.e., TRICARE is the primary payer in both instances).

AVERAGE ANNUAL DoD INPATIENT COSTS PER BENEFICIARY, FYs 2021–2023



Source: DHA/Resources & Management Directorate (J-8)/Business Integration Division, 2/9/2024

Notes:

– The reader should exercise caution when comparing the direct versus private sector care costs per RWP. The data on this page are unadjusted for differences in beneficiary mix, enrollment status, geographical location of care, etc. They represent DoD health care costs only and specifically exclude beneficiary cost shares, administrative costs, and overhead expenses.

– The Retirees and Family Members groups include survivors and others not explicitly identified elsewhere.

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

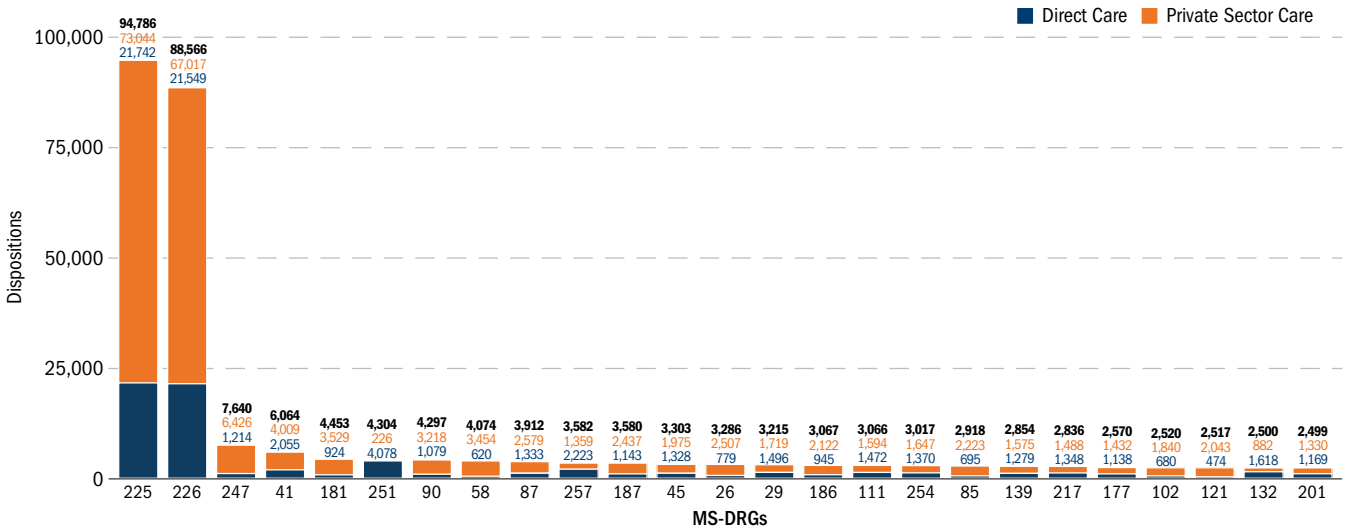
INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Leading Inpatient Diagnosis Groups (U.S. Only)

The MHS uses the MS-DRG system to classify acute care hospital inpatient cases into clinically related categories having similar treatment costs. For the purpose of this section, MS-DRGs exhibiting variations in complications and comorbidities were grouped into like categories[1] and numbered sequentially. The category numbers have no significance other than to identify the DRGs on the horizontal axes in the charts below. See the Appendix for additional detail on the DRG grouping methodology.

The top 25 MS-DRGs in terms of volume in FY 2023 accounted for 70 percent of all inpatient admissions (direct care and private sector care combined) in acute care hospitals. TRICARE for Life (TFL) admissions and observation stays are excluded from the calculations.

LEADING INPATIENT DIAGNOSIS GROUPS BY VOLUME, FY 2023



MS-DRGs

- 26 Major Small and Large Bowel Procedures
- 29 Appendectomy
- 41 Esophagitis, Gastroenteritis, and Miscellaneous Digestive Disorders
- 45 Cholecystectomy
- 58 Seizures and Headaches
- 85 Pulmonary Edema and Respiratory Failure
- 87 Simple Pneumonia and Pleurisy
- 90 Bronchitis and Asthma
- 102 Disorders of Pancreas Except Malignancy
- 111 Major Joint Replacement or Reattachment of Lower Extremity
- 121 Percutaneous Cardiovascular Procedures with Coronary Artery Stent
- 132 Heart Failure and Shock
- 139 Cardiac Arrhythmia and Conduction Disorders
- 177 Cellulitis
- 181 Operating Room Procedures for Obesity
- 186 Diabetes
- 187 Nutritional and Miscellaneous Metabolic Disorders
- 201 Kidney and Urinary Tract Infections
- 217 Uterine and Adnexal Procedures for Non-Malignancy
- 225 Pregnancy, Childbirth, and the Puerperium
- 226 Newborns and Other Neonates With Condition Originating in Perinatal Period
- 247 Septicemia or Severe Sepsis
- 251 Neuroses Except Depressive
- 254 Psychoses
- 257 Alcohol/Drug Abuse or Dependence

- The top two procedures by volume are related to childbirth, accounting for 48 percent of all hospital admissions (not just among the top 25).
- Procedures performed in private-sector acute care hospitals account for 72 percent of the total volume of the top 25 MS-DRGs.
- Admissions in direct care facilities exceed those in private sector care facilities for only three of the top 25 MS-DRGs.
- Surgery for obesity ranks fifth in volume among the top 25 MS-DRGs. Thus, the obesity epidemic in the civilian sector (as per the Centers for Disease Control and Prevention [CDC]) appears to be mirrored to an extent in the DoD population as well.

Source: MHS administrative data, 1/24/2024

[1] DRGs were grouped into like categories using a code set available on www.findacode.com/code-set.php?set=DRG, an online database of medical billing codes and information. The site lists surgical and medical DRGs within each Major Diagnostic Category with headings above diagnostically related DRGs. In some cases (e.g., DRGs related to pregnancy and childbirth), the headings were further grouped into larger, descriptively similar categories. The headings were then sequentially numbered, providing the basis for the DRG grouping methodology.

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

OUTPATIENT UTILIZATION RATES AND COSTS

TRICARE Outpatient Utilization Rates Compared with Civilian Benchmarks (U.S. Only)

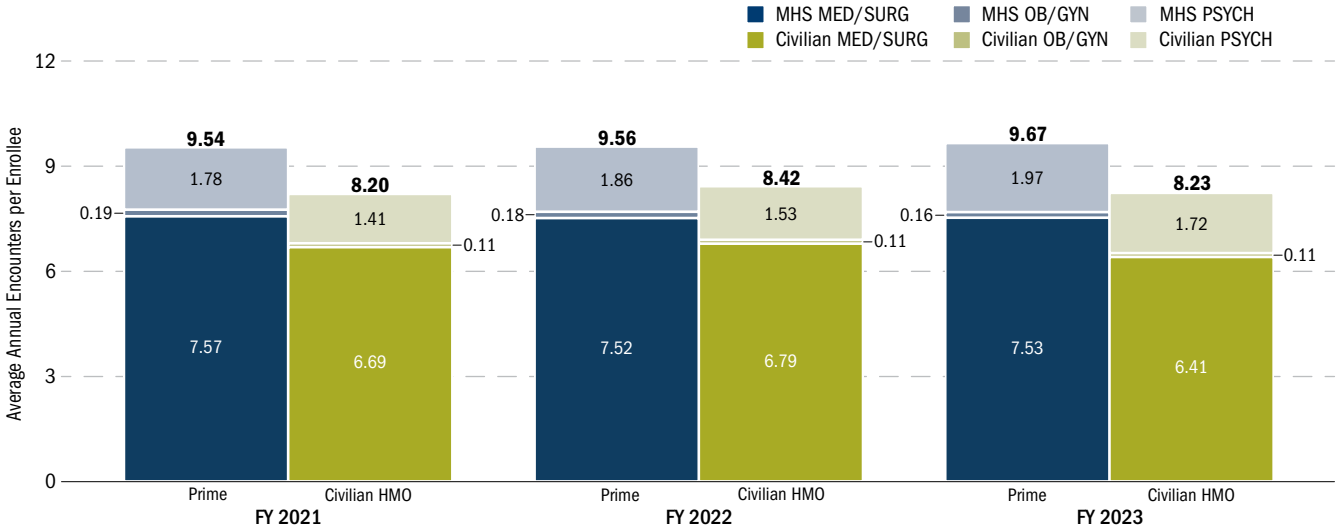
TRICARE Prime Enrollees

This section compares the outpatient utilization of TRICARE Prime enrollees (including TYA Prime but excluding the USFHP) with that of enrollees in civilian employer-sponsored HMO plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. Outpatient utilization is measured in terms of encounters because the civilian-sector data used in the comparisons do not contain a measure of relative value units (RVUs). However, there is no fixed definition for what constitutes a "face-to-face" encounter with a physician. TRICARE and the private sector may, therefore, use differing methodologies to calculate the number of encounters.

Encounters are computed for three broad product lines: OB/GYN, PSYCH, and other MED/SURG procedures. The comparisons are made for beneficiaries under age 65 only. Because telephone consults are routinely recorded in direct care data but appear very infrequently in private sector claims, they are also excluded from the direct care utilization computations.

- The overall TRICARE Prime outpatient utilization rate (direct and private sector care combined) increased by 1 percent between FY 2021 and FY 2023. The civilian HMO outpatient utilization rate remained flat over the same period.
- In FY 2023, the overall Prime outpatient utilization rate was 18 percent higher than the civilian HMO rate.
- In FY 2023, the Prime outpatient utilization rate for MED/SURG, the largest component of total outpatient utilization, procedures was 18 percent higher than the civilian HMO rate.
- The Prime outpatient utilization rate for OB/GYN procedures fell by 14 percent between FY 2021 and FY 2023 (albeit from a low base rate) but still remained 55 percent higher than for civilian HMOs in FY 2023. 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 15 percent higher than the corresponding rate for civilian HMOs in FY 2023. This disparity, though based on relatively low MHS and civilian MH utilization rates, may reflect the more stressful environment that many Active Duty Service members (ADSMs) and their families endure.

OUTPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK, FYs 2021–2023



Sources: MHS administrative data, 1/19/2024, and Merative MarketScan Commercial Database, 1/19/2024

[1] Outpatient encounters are not precisely comparable between the direct and private care sectors (including private sector care). In particular, services that are bundled in the private sector (such as newborn delivery, including prenatal and postnatal care) will not generate any outpatient encounters but will generate a record for each encounter in the direct care system. Because maternity care is a high-volume procedure, the disparity in utilization rates between the direct care and civilian systems will be exaggerated.

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2023 civilian benchmarks are based on two quarters of data, which were seasonally adjusted and annualized.

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

OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

TRICARE Outpatient Utilization Rates Compared with Civilian Benchmarks (U.S. Only) *(cont.)*

Non-Prime-Enrolled Beneficiaries

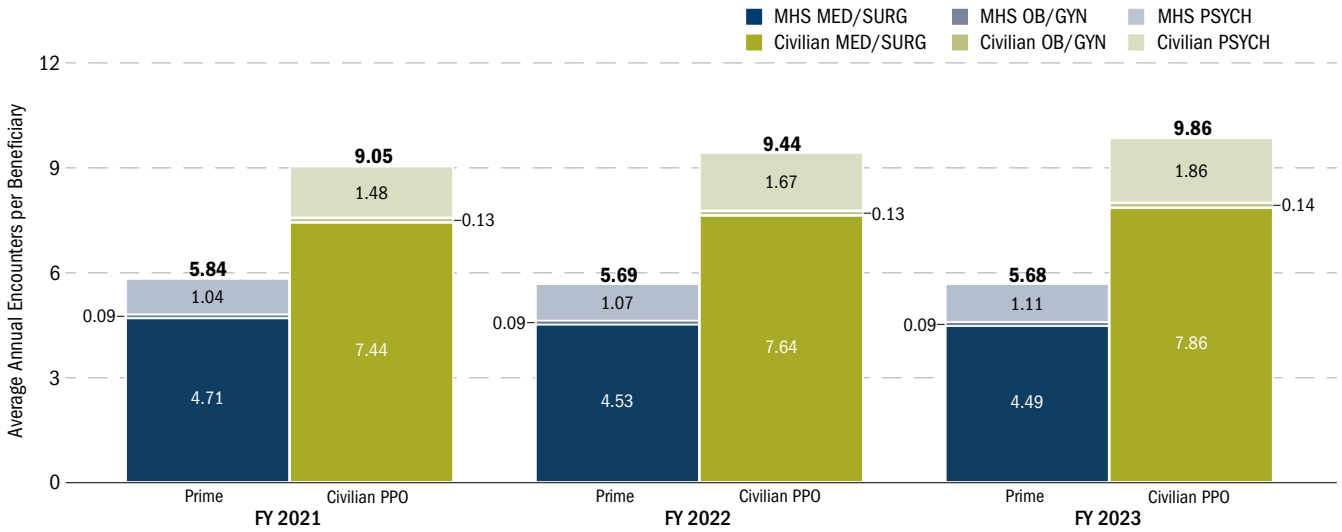
This section compares the outpatient utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored PPO plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. Outpatient utilization is measured in terms of encounters because the civilian-sector data used in the comparisons do not contain a measure of RVUs. However, there is no fixed definition for what constitutes a "face-to-face" encounter with a physician. TRICARE and the private sector may, therefore, use differing methodologies to calculate the number of encounters.

Encounters are computed for three broad product lines: OB/GYN, PSYCH, and other MED/SURG. The comparisons are made for beneficiaries under age 65 only. To make the utilization rates of MHS and civilian beneficiaries more comparable, non-Prime 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 PHI, we estimate that about 20 percent do not file because they have no utilization. The MHS utilization rates shown below include these nonusers to make them more comparable to the civilian rates, which also include nonusers.

- The overall TRICARE outpatient utilization rate (direct and private sector care combined) for non-Prime beneficiaries decreased by 3 percent between FY 2021 and FY 2023. The civilian PPO outpatient utilization rate increased by 9 percent over the same period.
- The overall TRICARE non-Prime outpatient utilization rate remained well below the level observed for civilian PPOs. In FY 2023, TRICARE non-Prime outpatient utilization was 42 percent lower than in civilian PPOs.
- In FY 2023, the non-Prime outpatient utilization rate for MED/SURG procedures was 43 percent lower than the civilian PPO rate. MED/SURG procedures account for roughly 80 percent of total outpatient utilization in both the military and civilian sectors.
- The TRICARE non-Prime outpatient utilization rate for OB/GYN procedures held steady between FY 2021 and FY 2023 but was 36 percent below the rate for civilian PPO participants in FY 2023.
- The PSYCH outpatient utilization rate for non-Prime MHS beneficiaries increased by 6 percent from FY 2021 to FY 2023, while the rate increased by 26 percent for civilian PPO participants. In FY 2023, the PSYCH outpatient utilization rate for non-Prime beneficiaries were 41 percent below that of civilian PPO participants. The latter observation, together with the utilization exhibited by Prime enrollees, suggests that MHS beneficiaries in need of extensive PSYCH counseling (primarily ADSMs and their families) are more likely to enroll in Prime.

LOWER COST

OUTPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK, FYs 2021–2023



Sources: MHS administrative data, 1/19/2024, and Merative MarketScan Commercial Database, 1/19/2024

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2023 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.

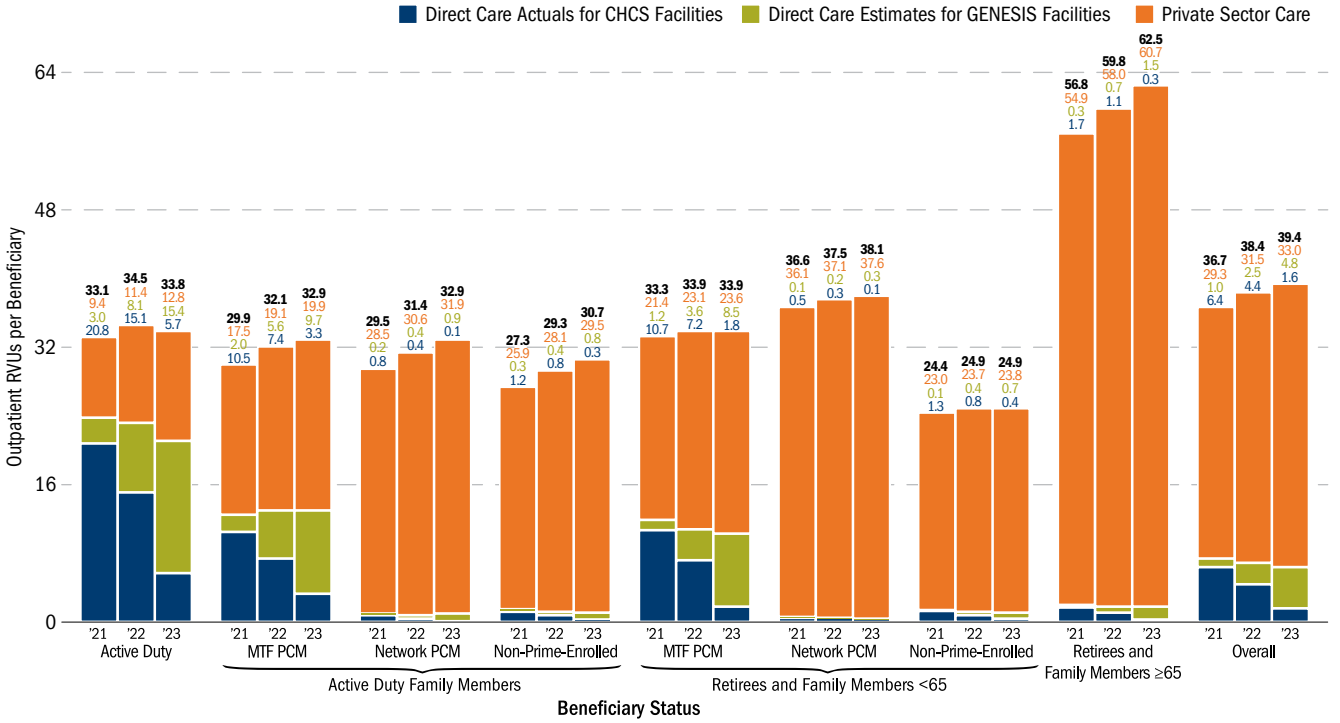
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Outpatient Utilization Rates by Beneficiary Status

When breaking out outpatient utilization by beneficiary group, RVUs per capita more accurately reflect differences across beneficiary groups than encounters per capita. The RVU measure used in this report is the sum of the Physician Work and Practice Expense RVUs (see the Appendix for a detailed description of the Physician Work and Practice Expense RVU measures). Note that direct care RVUs at non-GENESIS facilities are actuals, whereas RVUs at GENESIS facilities are estimates. Also note that since MHS GENESIS records do not include telephone consults, those encounters have been excluded from the Composite Health Care System (CHCS) records as well for consistency.

- Total per capita MHS outpatient utilization (direct plus private sector care) increased by 8 percent from FY 2021 to FY 2023.
- Overall direct care outpatient per capita utilization decreased by 13 percent from FY 2021 to FY 2023. Declines ranged from 24 percent for RETFMs enrolled to a network PCM under age 65 to 8 percent for all Medicare-eligible beneficiaries. ADFMs with a network PCM saw a 6 percent increase, while those with an MTF PCM saw a similar 5 percent gain. AD personnel experienced a 12 percent decline in direct care outpatient per capita utilization from FY 2021 to FY 2023.
- From FY 2021 to FY 2023, per capita private sector care outpatient utilization increased by 13 percent overall. Increases were experienced by every beneficiary group, ranging from 4 percent for nonenrolled RETFMs under age 65 to 37 percent for Active Duty members.

AVERAGE ANNUAL OUTPATIENT RVUs PER BENEFICIARY, FYs 2021–2023



Source: MHS administrative data, 1/19/2024

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.

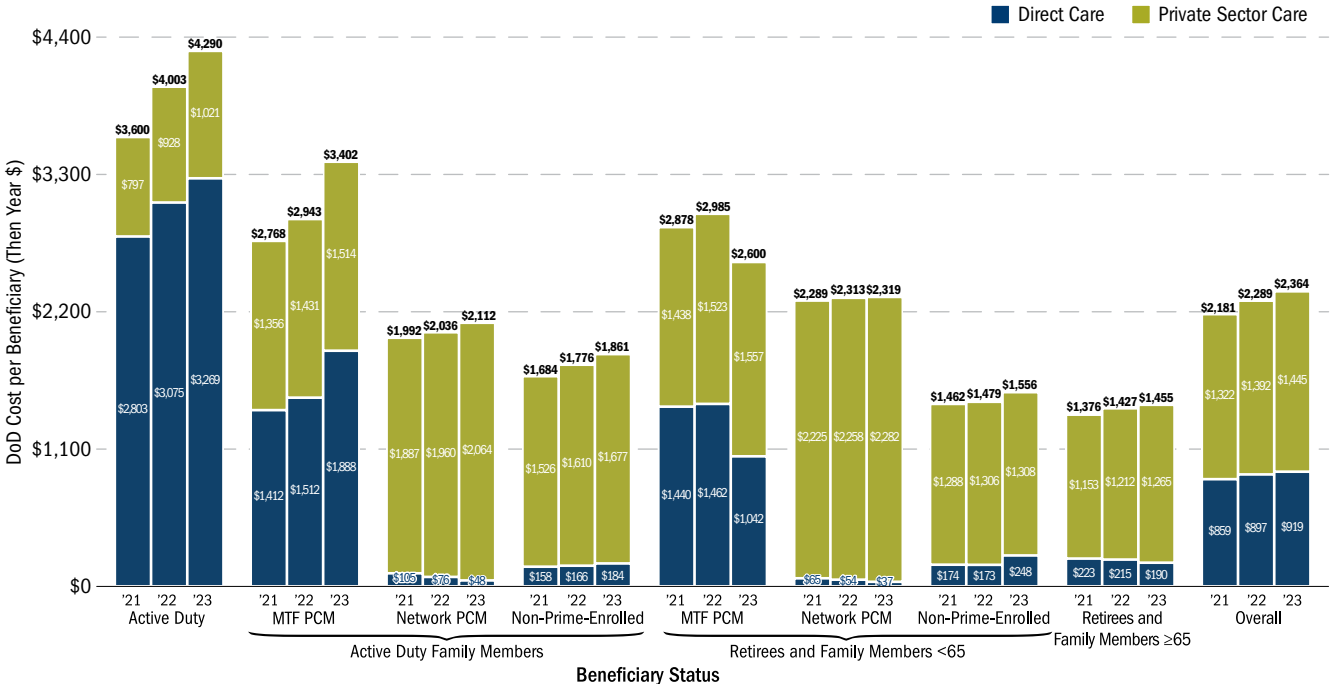
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Outpatient Costs by Beneficiary Status

Total DoD outpatient costs include two components: (1) expenditures for direct care at MTFs that are attributed to outpatient care and (2) payments made to PSC providers for services rendered in an outpatient setting, i.e., in an office or clinic, not in a hospital.

- The overall MHS outpatient cost per beneficiary increased by 8 percent between FY 2021 and FY 2023.
- Six of the eight beneficiary groups experienced a noticeable increase in total outpatient cost per beneficiary. One exception was RETFMs enrolled in MTFs, who experienced a 10 percent decline in overall cost per beneficiary.
- For PSC, the cost per beneficiary for TFL persons increased about 10 percent between FY 2021 and FY 2023.[1] Excluding TFL, the overall PSC outpatient cost per beneficiary increased by slightly less (9 percent).
- Similarly, the overall direct care outpatient cost per beneficiary increased by 7 percent over that same period.

AVERAGE ANNUAL DoD OUTPATIENT COSTS PER BENEFICIARY, FYs 2021–2023



Source: DHA/Resources & Management Directorate (J-8)/Business Integration Division, 2/9/2024

[1] The basis for this statement is the collection of stacked bars labeled Retirees and Family Members ≥65. Although the vast majority of TFL-eligible beneficiaries are retirees and family members ≥65, there is a small number who are not.

Notes:

– The Retirees and Family Members groups include survivors and others not explicitly identified elsewhere.

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

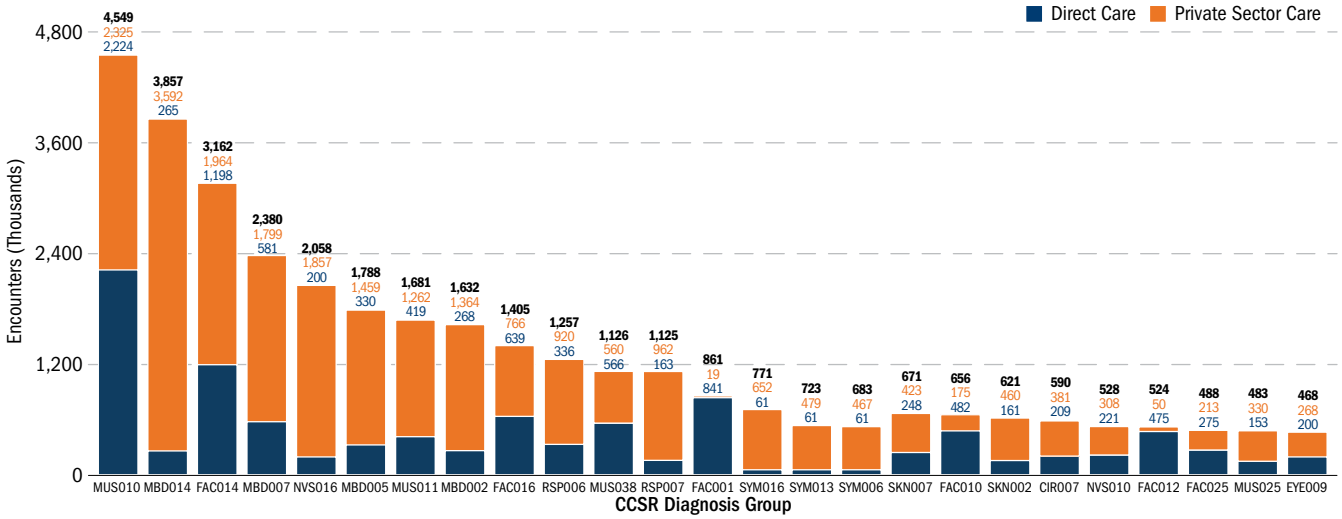
LOWER COST

OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Leading Outpatient Diagnosis Groups (U.S. Only)

Leading outpatient diagnoses were determined by grouping ICD-10-CM primary diagnosis codes into like categories using the Clinical Classifications Software Refined (CCSR) tool developed through a federal-state-industry partnership sponsored by the Agency for Healthcare Research and Quality (AHRQ). The CCSR replaces the Clinical Classifications Software tool and takes advantage of the specificity of ICD-10-CM diagnoses to create new clinical categories. The top 25 outpatient diagnosis groups in FY 2023 accounted for 61 percent of all outpatient encounters (direct care and private sector care combined). TFL encounters and telephone consults are excluded from the calculations.

LEADING OUTPATIENT DIAGNOSIS GROUPS BY VOLUME, FY 2023



CCSR Diagnosis Groups

CIR007	Essential Hypertension
EAR001	Otitis Media
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
MUS006	Osteoarthritis
MUS010	Musculoskeletal Pain, Not Low Back Pain
MUS011	Spondylopathies/Spondyloarthropathy (Including Infective)
MUS025	Other Specified Connective Tissue Disease
MUS038	Low Back Pain
NVS010	Headache; Including Migraine
NVS016	Sleep Wake Disorders
RSP006	Other Specified Upper Respiratory Infections
RSP007	Other Specified and Unspecified Upper Respiratory Disease
SKN002	Other Specified Inflammatory Condition of Skin
SKN007	Other Specified and Unspecified Skin Disorders
SYM006	Abdominal Pain and Other Digestive/Abdomen Signs and Symptoms
SYM010	Nervous System Signs and Symptoms
SYM013	Respiratory Signs and Symptoms
SYM016	Other General Signs and Symptoms
SYM017	Abnormal Findings Without Diagnosis

- The top diagnosis group for FY 2023 in terms of volume is MUS010: musculoskeletal pain, not low back pain. This was the same top diagnosis group as in FY 2022. This displaced FAC016: exposure, encounters, screening, or contact with infectious disease (now the ninth most frequent diagnosis), which was elevated in volume for FY 2021 due to the COVID-19 pandemic.
- Diagnoses treated in private sector care facilities account for 68 percent of the total volume of the top 25 diagnosis groups.
- Encounters in direct care facilities exceed those in private sector care facilities for only five of the 25 top diagnosis groups.

Source: MHS administrative data, 1/24/2024

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

PRESCRIPTION DRUG UTILIZATION RATES AND COSTS

TRICARE Prescription Drug Utilization Rates Compared with Civilian Benchmarks (U.S. Only)

Prescription utilization is difficult to quantify since prescriptions come in different forms (e.g., liquid or pills), quantities, and dosages. Moreover, home delivery and MTF prescriptions can be filled for up to a 90-day supply, whereas retail prescriptions are usually based on 30-day increments for copayment purposes. Prescription counts from all sources (including civilian) were normalized by dividing the total days' supply for each by 30 days.

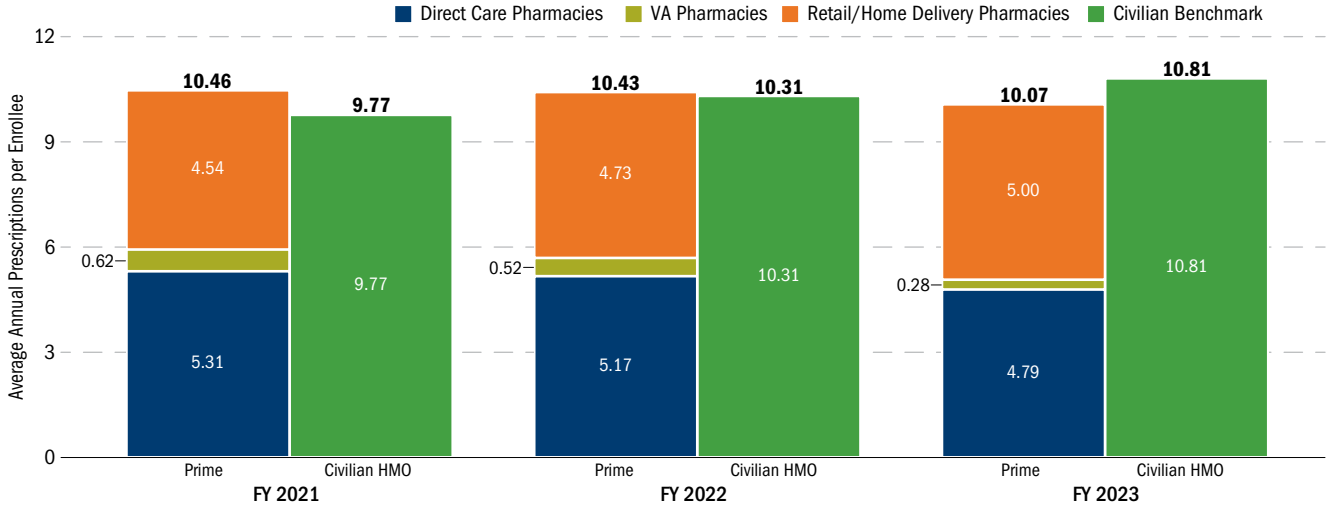
Direct care pharmacy data differ from private-sector claims in that they include over-the-counter medications. To make the utilization rates of MHS and civilian beneficiaries more comparable, over-the-counter medications were backed out of the direct care data using factors provided by the DHA Pharmacy Operations Division.

TRICARE Prime Enrollees

This section compares the outpatient prescription drug utilization of TRICARE Prime enrollees (including TYA Prime but excluding the USFHP) with that of enrollees in civilian employer-sponsored HMO plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. To give a more complete picture of total prescription drug utilization by TRICARE beneficiaries, prescriptions filled at Department of Veterans Affairs (VA) pharmacies as part of a beneficiary's VA benefit (and paid for by VA) are included. Prescriptions filled at VA pharmacies under the TRICARE benefit have always been included with retail pharmacy prescriptions.

- The overall prescription utilization rate (direct care, VA, and private sector care combined) for TRICARE Prime enrollees decreased by 4 percent between FY 2021 and FY 2023, while the civilian HMO benchmark rate increased by 11 percent. In FY 2023, the TRICARE Prime prescription utilization rate was 7 percent lower than the civilian HMO rate.
- Prescription utilization rates for Prime enrollees at DoD pharmacies decreased by 10 percent between FY 2021 and FY 2023, whereas the utilization rate at private sector care pharmacies increased by 10 percent.
- Prescription utilization rates for Prime enrollees at VA pharmacies declined by 55 percent between FY 2021 and FY 2023, although the total number of prescriptions is very small.
- The overall private sector care share of per-capita prescription utilization for Prime enrollees increased from 43 percent in FY 2021 to 50 percent in FY 2023.

PRESCRIPTION UTILIZATION RATES BY SOURCE OF CARE[a]: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK, FYs 2021–2023



Sources: MHS administrative data, 1/19/2024, and Merative MarketScan Commercial Database, 1/19/2024

[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 2023 civilian benchmarks are based on two quarters of data, which were seasonally adjusted and annualized.

LOWER COST

PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT.)*

TRICARE Prescription Drug Utilization Rates Compared with Civilian Benchmarks (U.S. Only) *(cont.)*

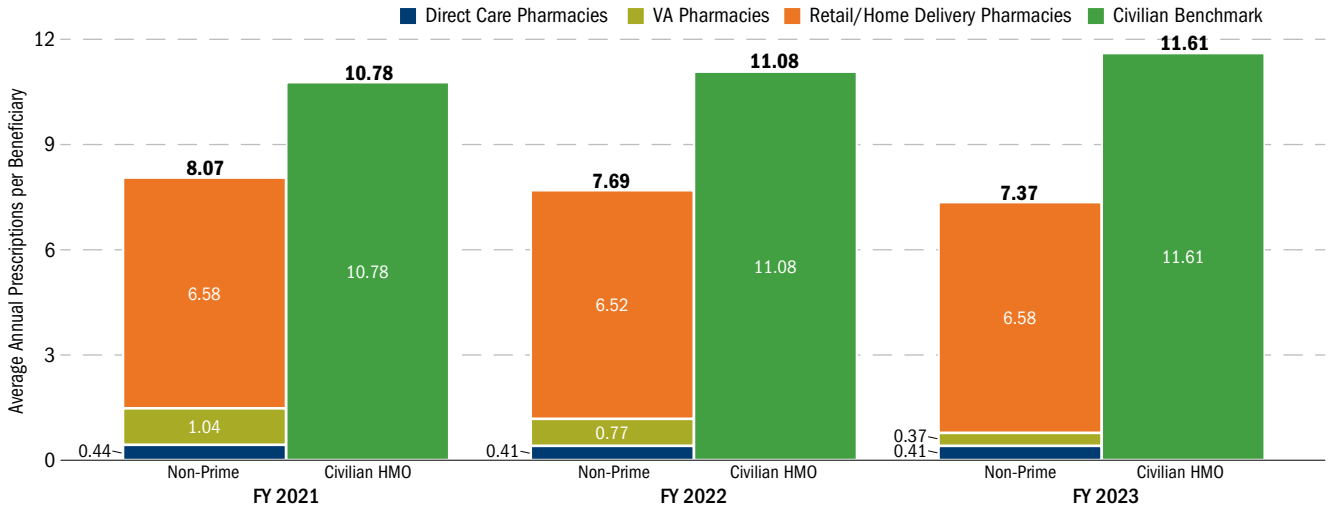
Non-Prime-Enrolled Beneficiaries

This section compares the outpatient prescription drug utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored PPO plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. To give a more complete picture of total prescription drug utilization by TRICARE beneficiaries, prescriptions filled at VA pharmacies as part of a beneficiary's VA benefit (and paid for by VA) are included. Prescriptions filled at VA pharmacies under the TRICARE benefit have always been included with retail pharmacy prescriptions. The comparisons are made for beneficiaries under age 65 only.

To make the utilization rates of MHS and civilian beneficiaries more comparable, non-Prime 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 nonusers to make them more comparable to the civilian rates, which also include nonusers.

- The overall prescription utilization rate (direct care, VA, and private sector care combined) for non-Prime-enrolled beneficiaries decreased by 9 percent between FY 2021 and FY 2023. During the same period, the civilian PPO benchmark rate increased by 8 percent. In FY 2023, the TRICARE prescription utilization rate for non-Prime enrollees was 37 percent lower than the civilian PPO rate.
- The direct care prescription utilization rate for non-Prime beneficiaries decreased by 6 percent from FY 2021 to FY 2023, whereas the utilization rate at private sector care pharmacies remained unchanged.
- Prescription utilization rates for non-Prime beneficiaries at VA pharmacies declined by 64 percent between FY 2021 and FY 2023, although the total number of prescriptions is very small
- The overall private sector care share of per-capita prescription utilization for non-Prime beneficiaries increased from 82 percent in FY 2021 to 89 percent in FY 2023.

PRESCRIPTION UTILIZATION RATES BY SOURCE OF CARE[a]: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK, FYs 2021–2023



Sources: MHS administrative data, 1/19/2024, and Merative MarketScan Commercial Database, 1/19/2024

[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 2023 civilian benchmarks are based on two quarters of data, which were seasonally adjusted and annualized.

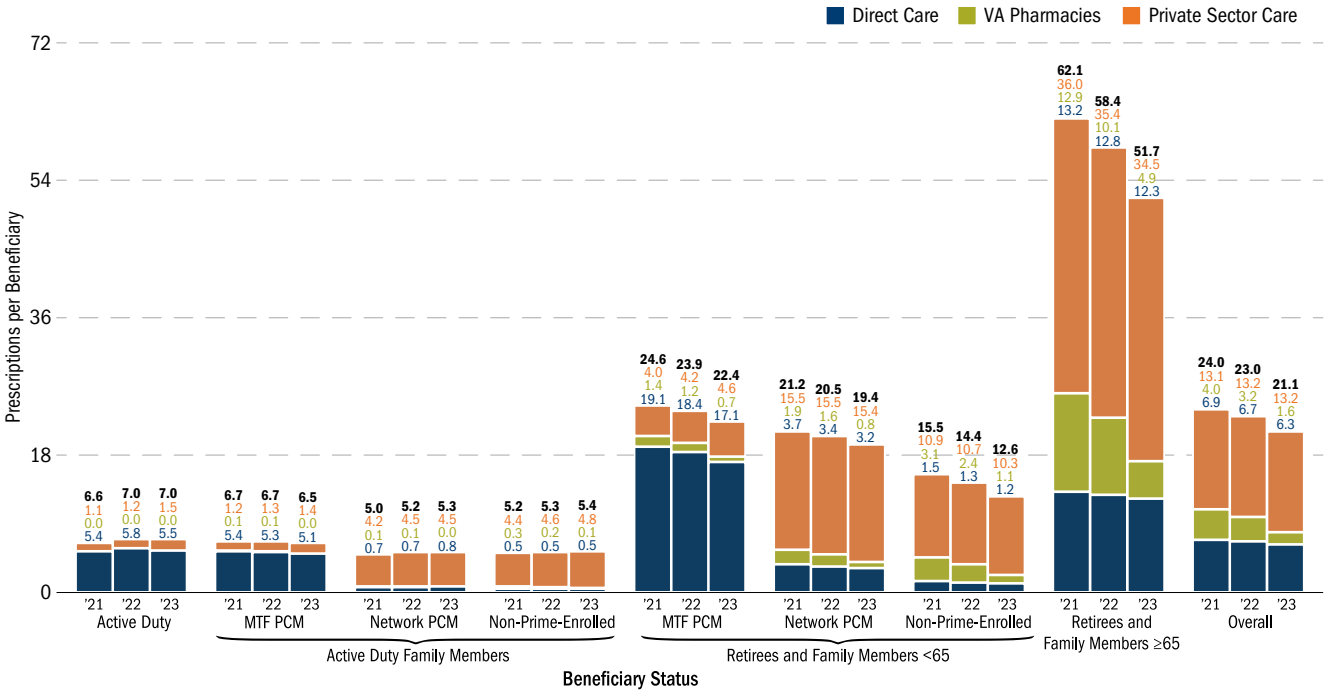
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT.)*

TRICARE Prescription Drug Utilization Rates by Beneficiary Status

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 8 percent from FY 2021 to FY 2023, exclusive of the TFL benefit. Including TFL, the total number of prescriptions declined by 12 percent.
- The overall direct care prescription utilization rate declined by 8 percent between FY 2021 and FY 2023. AD and ADFMs enrolled to network PCMs increased by 1 percent. Declines were experienced by all other beneficiary groups, ranging from 5 percent for nonenrolled ADFMs to 15 percent for nonenrolled RETFMs under age 65.
- Average per capita VA pharmacy prescription utilization decreased by 60 percent from FY 2021 to FY 2023 from a small starting utilization rate.
- Overall per capita prescription utilization through private sector care pharmacies increased by 1 percent between FY 2021 and FY 2023. Increases occurred for every beneficiary group except non-Prime RETFMs under age 65 (6 percent decline), RETFMs age 65 and over (4 percent decline), and RETFMs with a network PCM (1 percent decline). Increases ranged from 6 percent for ADFMs with a network PCM to 35 percent for AD.

AVERAGE ANNUAL PRESCRIPTION UTILIZATION PER BENEFICIARY, FYs 2021–2023



Source: MHS administrative data, 1/19/2024

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

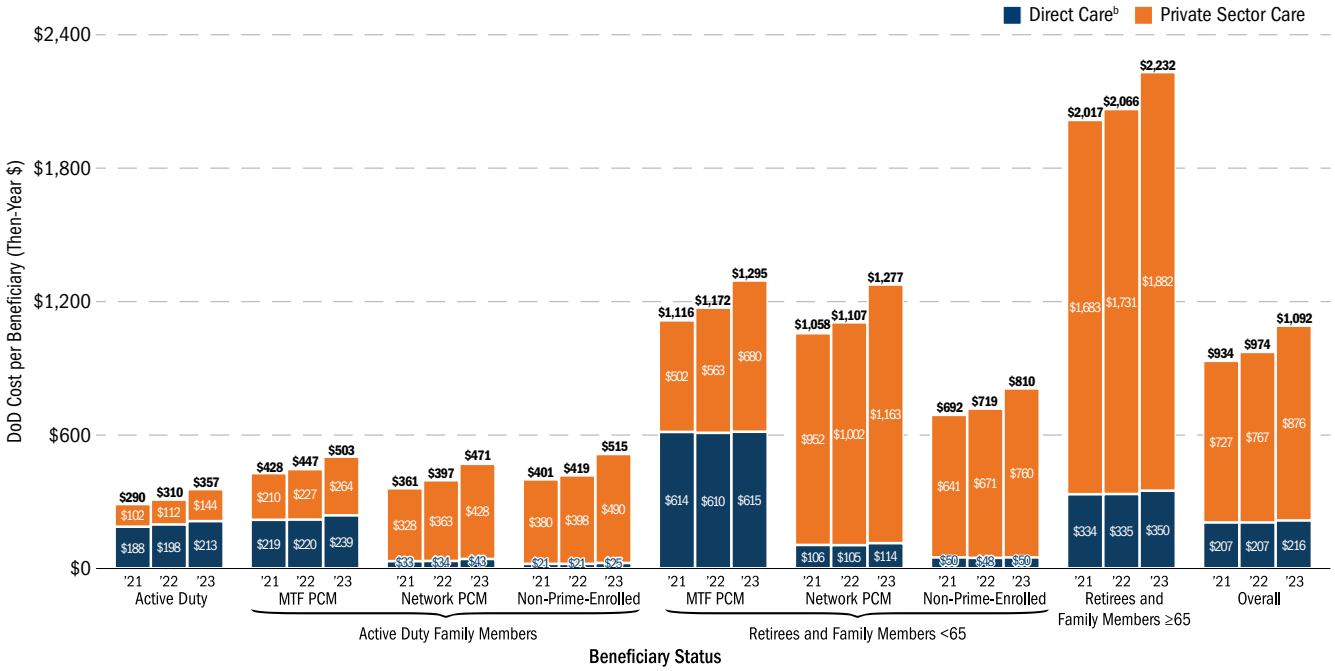
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT.)*

Prescription Drug Cost by Beneficiary Status

Although the drug refunds referenced on page 151 have slowed the overall growth of retail prescription drug costs, the refunds are not reflected in the chart below because they cannot be attributed to specific beneficiary groups. Exclusive of refunds, overall MHS prescription drug costs (in then-year dollars) per beneficiary (far-right columns below), including TFL, increased by 17 percent between FY 2021 and FY 2023. The annual pharmacy cost for non-Prime enrollees is diluted by the larger number of beneficiaries with OHI coverage where the DoD pays approximately 30 percent of their prescription coverage cost.

- Exclusive of TFL, overall per capita prescription drug costs increased by 21 percent between FY 2021 and FY 2023.
- Increases in overall per capita prescription drug costs were experienced by every beneficiary group, ranging from 11 percent for RETFMs age 65 and older to 31 percent for ADFMs with a network PCM.
- Overall direct care costs per beneficiary increased by 4 percent, while private sector care pharmacy costs increased by 28 percent excluding TFL and by 20 percent including TFL.

AVERAGE ANNUAL DoD PRESCRIPTION COSTS PER BENEFICIARY, FYs 2021–2023[a]



Source: MHS administrative data, 1/19/2024

[a] Excludes retail drug refunds.

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

Notes:

– The Retirees and Family Members groups include survivors and others not explicitly identified elsewhere.

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

BENEFICIARY FAMILY HEALTH PLAN COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65)

Out-of-pocket costs are computed for Active Duty and retiree families in the U.S. grouped by sponsor age: (1) under 65 and (2) 65 and older (seniors). Costs include deductibles and copayments for medical care and drugs, TRICARE enrollment fees, and private insurance premiums. Costs are compared with those of civilian counterparts (i.e., civilian families with the same demographics as the typical MHS family). For beneficiaries under age 65, civilian counterparts are assumed to be covered by employer-sponsored OHI.

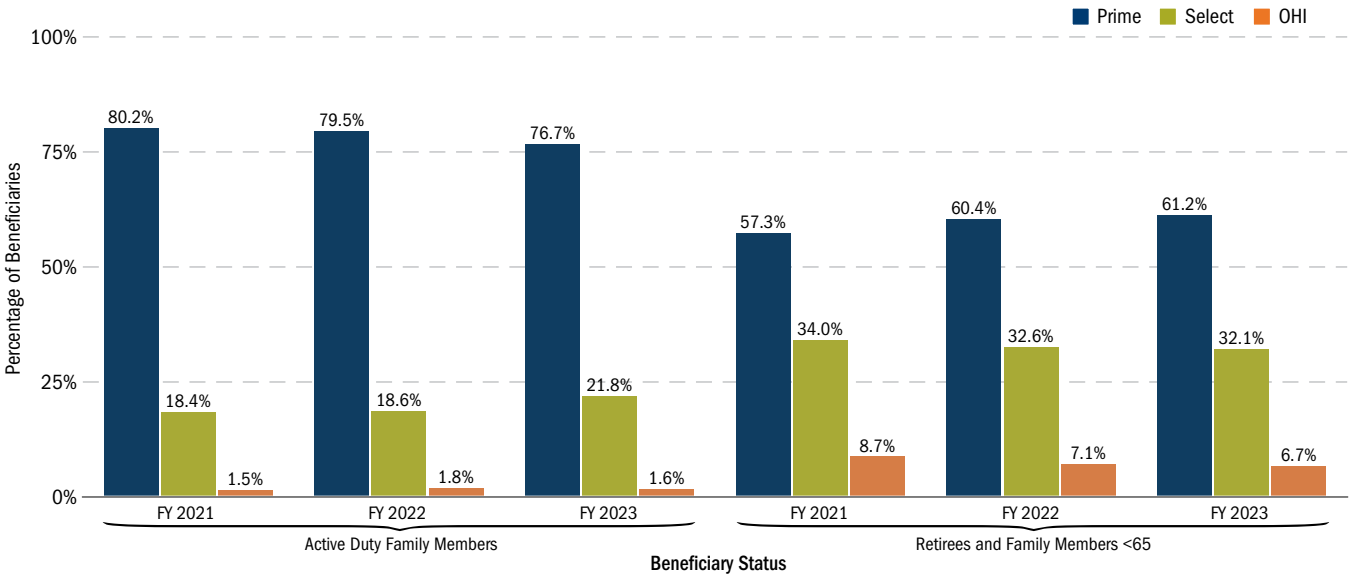
Health Plan Coverage of MHS Beneficiaries Under Age 65

MHS beneficiaries have a choice of (1) TRICARE Prime, including TYA Prime and USFHP; (2) TRICARE Select, including TYA Select, TRICARE Reserve Select (TRS), and TRICARE Retired Reserve (TRR); (3) direct care only (space-available care); and (4) OHI. Many beneficiaries with OHI have no TRICARE utilization; however, some use TRICARE as a second payer.

Beneficiaries are grouped by their primary health plan:

- **TRICARE Prime:** Family enrolled in TRICARE Prime (including a small percentage who also have OHI coverage). Seventy-seven percent of ADFMs and 61 percent of RETFMs were in this group in FY 2023.
- **TRICARE Select:** Family enrolled in TRICARE Select or relying on space-available MTF care in FYs 2021–2023 and who do not have OHI coverage. In FY 2023, 22 percent of ADFMs and 32 percent of RETFMs were in this group.
- **OHI:** Family covered by OHI. Only 1 percent of ADFMs and 7 percent of RETFMs were in this group in FY 2023.

HEALTH PLAN COVERAGE OF BENEFICIARIES UNDER AGE 65, FYs 2021–2023



Source: TRICARE and OHI coverage in FYs 2021–2023 based on Defense Enrollment Eligibility Reporting System (DEERS) and Health Care Survey of DoD Beneficiaries (HCSDB) responses; as of 12/31/2023

Notes:

– The Prime group includes HCSDB respondents enrolled in Prime based on DEERS plus enrollees in the USFHP. The Select group includes HCSDB respondents without OHI who are enrolled in a Select plan based on DEERS. The OHI group includes HCSDB respondents with private health insurance (e.g., the Federal Employees Health Benefits [FEHB] Program, a civilian HMO such as Kaiser, or other civilian insurance such as Blue Cross). A small percentage of Prime enrollees are also covered by OHI; these beneficiaries are included in the Prime group.

– Numbers for prior FYs may differ slightly from prior reports. FYs 2020 HCSDB data showed a higher sampling of Inactive Guard/Reserve family members by nearly a factor of 10 compared with previous years. To account for this discrepancy, we excluded Inactive Guard/Reserve family members for all years to avoid biasing the calculations.

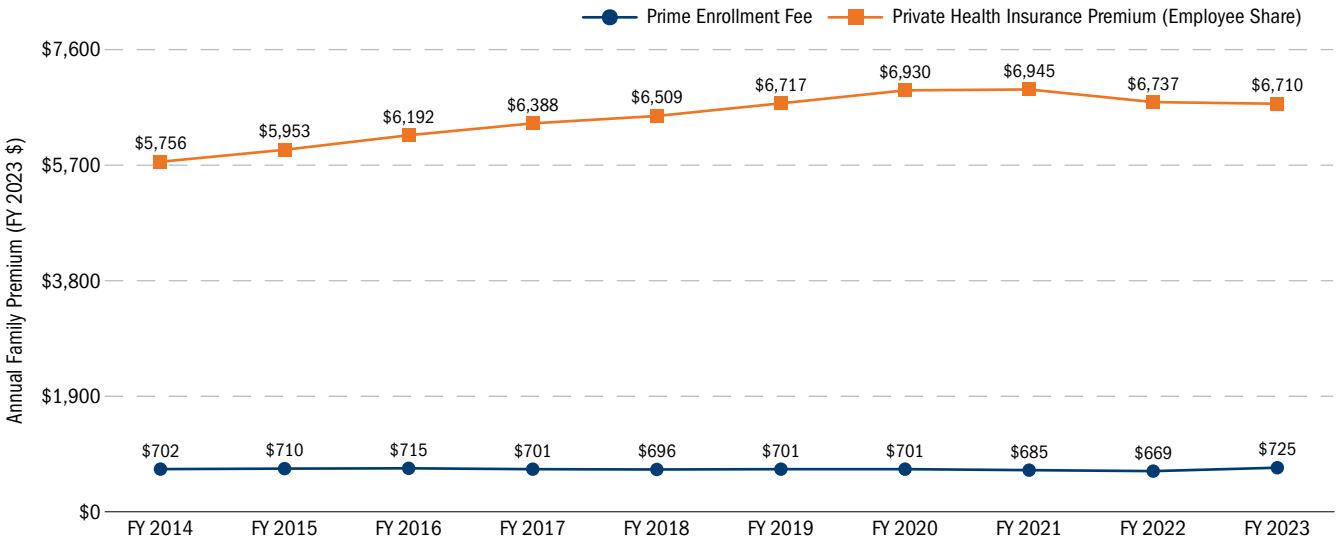
– Percentages may not sum to 100 percent due to rounding.

BENEFICIARY FAMILY HEALTH PLAN COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Retirees and Family Members under Age 65 Returning to the MHS

From FY 2014 to FY 2023, the average private health insurance family premium increased, whereas the TRICARE Prime enrollment fee remained essentially flat. In FY 2023 dollars, private health insurance premiums increased by $1,000 (17 percent) over this period, whereas the TRICARE Prime enrollment fee increased by $23 (3 percent).

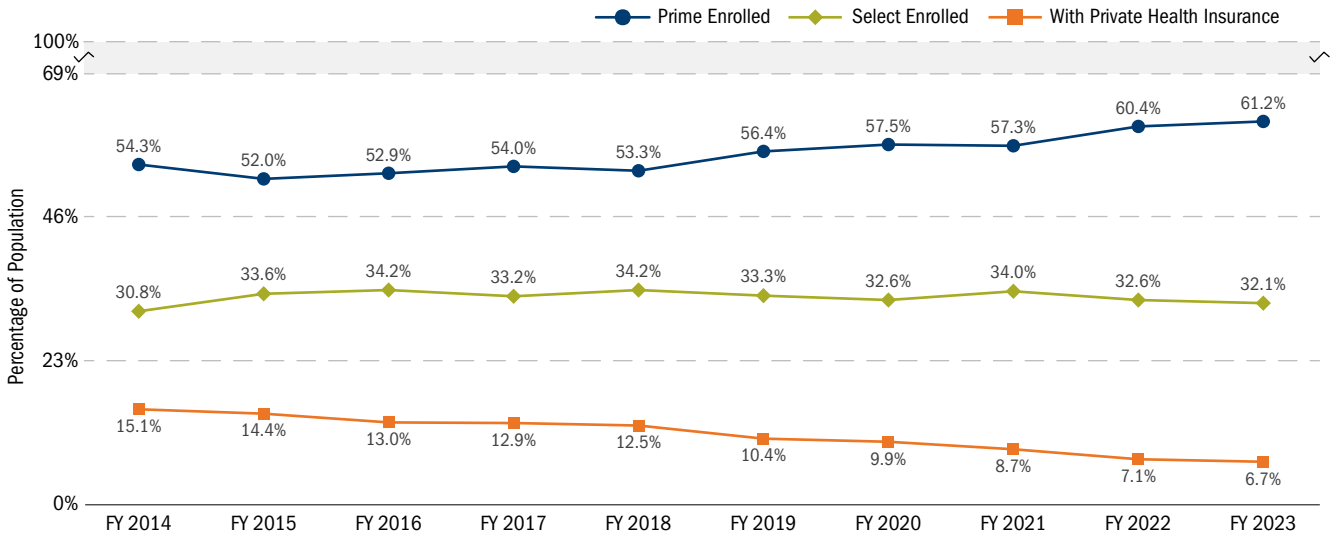
TRENDS IN PRIVATE INSURANCE PREMIUMS VS. TRICARE PRIME ENROLLMENT FEE, FYs 2014–2023



Sources: The employee share of insurance premiums for a typical employer-sponsored family health plan in FYs 2014–2023 from the Insurance Component of the Medical Expenditure Panel Survey (MEPS) 2010–2021; OHI premiums in FY 2023 projected by the Institute for Defense Analyses (IDA) based on the average growth rate of premiums in FYs 2021–2023; as of 1/31/2024.

Between FY 2014 and FY 2023, 10 percent of retirees switched from private health insurance to TRICARE. Most of them likely switched because of an increasing disparity in premiums and out-of-pocket expenses.[1]

TRENDS IN RETIREE (<65) HEALTH PLAN COVERAGE, FYs 2014–2023



Source: TRICARE and private health insurance coverage in FYs 2014–2023 based on DEERS and HCSDB responses in FYs 2014–2023; as of 12/31/2023

Note: The Prime enrollment rates above include about 4 percent of retirees who also have private health insurance.

[1] For an analysis of retirees switching from OHI to TRICARE, see Goldberg et al., "Demand for Health Insurance by Military Retirees," IDA Document D-5098, May 2015, Alexandria, Va.: IDA.

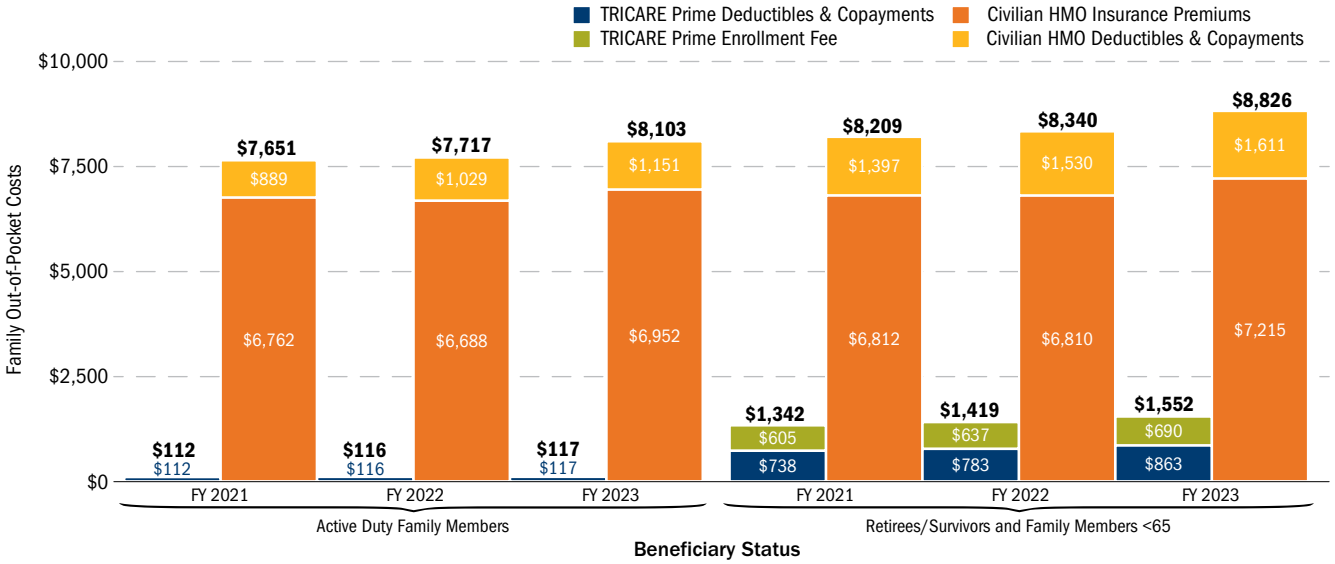
BENEFICIARY FAMILY HEALTH PLAN COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Out-of-Pocket Costs for Families Enrolled in TRICARE Prime vs. Civilian HMO Counterparts

In FYs 2021–2023, 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 2023, costs for civilian HMO counterparts were:
  - $8,000 more than those incurred by ADFMs enrolled in Prime
  - $7,300 more than those incurred by RETFMs enrolled in Prime

OUT-OF-POCKET COSTS FOR FAMILIES ENROLLED IN TRICARE PRIME VS. CIVILIAN HMO COUNTERPARTS, FYs 2021–2023



Sources: TRICARE beneficiary expenditures for deductibles and copayments in FYs 2021–2023 from MHS administrative data for all families enrolled in Prime without OHI payments, 12/31/2023; civilian benchmark expenditures for deductibles and copayments from Merative MarketScan Commercial Database, 1/19/2024; civilian benchmark insurance premiums from the Insurance Component of the MEPS (projected from FY 2021 data), 12/31/2023

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.
– For this year's report, IDA removed all COVID-19 pandemic-related adjustments to spending. Instead, IDA used its historical method of calculating multiyear growth rates using historical data to project forward for missing quarters.
– MarketScan data cover a full four quarters in FYs 2021 and 2022. Only two quarters of data were available for FY 2023. The remaining quarters were projected with multiyear growth rates.
– Civilian expenditures for deductibles and copayments are somewhat higher than in previous reports. Our previous source was the MEPS, which marginally understates those expenditures relative to MarketScan (see Zuvekas, S. "Comparing MEPS Use and Expenditure Estimates for the Privately Insured to Truven MarketScan and OptumLabs™ Claims Data, 2008–2013." Center for Financing, Access, and Cost Trends, AHRQ. October 2017).
– Currently, there is no cost information for MHS GENESIS records. While direct care cost shares are relatively uncommon, this will slightly underestimate out-of-pocket costs particularly as more sites deploy the new electronic health record (EHR).
– Numbers may not sum to bar totals due to rounding.

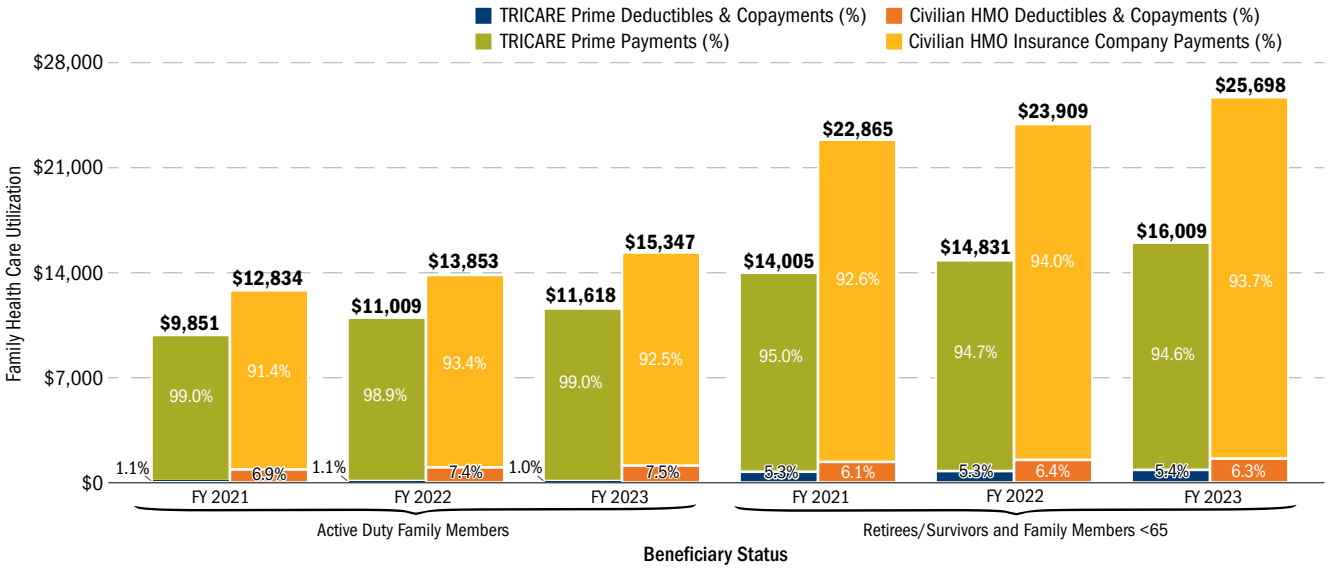
BENEFICIARY FAMILY HEALTH PLAN COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Coinsurance and Health Care Utilization for Families Enrolled in TRICARE Prime vs. Civilian HMO Counterparts

In FYs 2021–2023, TRICARE Prime enrollees had lower coinsurance rates (deductibles and copayments per dollar of utilization) and less utilization than their civilian HMO counterparts.

- TRICARE Prime enrollees had coinsurance rates that were 0 to 6 percentage points below those of their civilian HMO counterparts in FYs 2021–2023.
  - In FY 2023, the coinsurance rate for ADFMs was 1 percent, 6.5 percentage points lower than civilian HMO counterparts (7.5 percent).
  - That same year, the coinsurance rate for RETFMs was 5 percent, about the same as civilian HMO counterparts (6 percent).
- In FYs 2021–2023, TRICARE Prime enrollees had lower health care utilization than their civilian HMO counterparts.
  - ADFMs consumed $11,600 of medical services—$3,700 less than civilian HMO counterparts ($15,300)—in FY 2023.
  - RETFMs consumed $16,000 in medical services, which was $9,700 less than civilian HMO counterparts ($25,700), during that same period.

COINSURANCE AND HEALTH CARE UTILIZATION FOR FAMILIES ENROLLED IN TRICARE PRIME VS. CIVILIAN HMO COUNTERPARTS, FYs 2021–2023



Sources: TRICARE health care utilization expenditures by both the government and beneficiaries in FYs 2021–2023 from MHS administrative data for all families enrolled in Prime without OHI payments for TRICARE utilization, 12/31/2023; civilian insurance company and beneficiary benchmark expenditures from Merative MarketScan Commercial Database, 1/19/2024

Notes:

– For this year's report, IDA removed all COVID-19 pandemic-related adjustments to spending. Instead, IDA used its historical method of calculating multiyear growth rates using historical data to project forward for missing quarters.
– MarketScan data cover a full four quarters in FYs 2021 and 2022. Only two quarters of data were available for FY 2023. The remaining quarters were projected with multiyear growth rates.
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– Numbers may not sum to bar totals due to rounding.

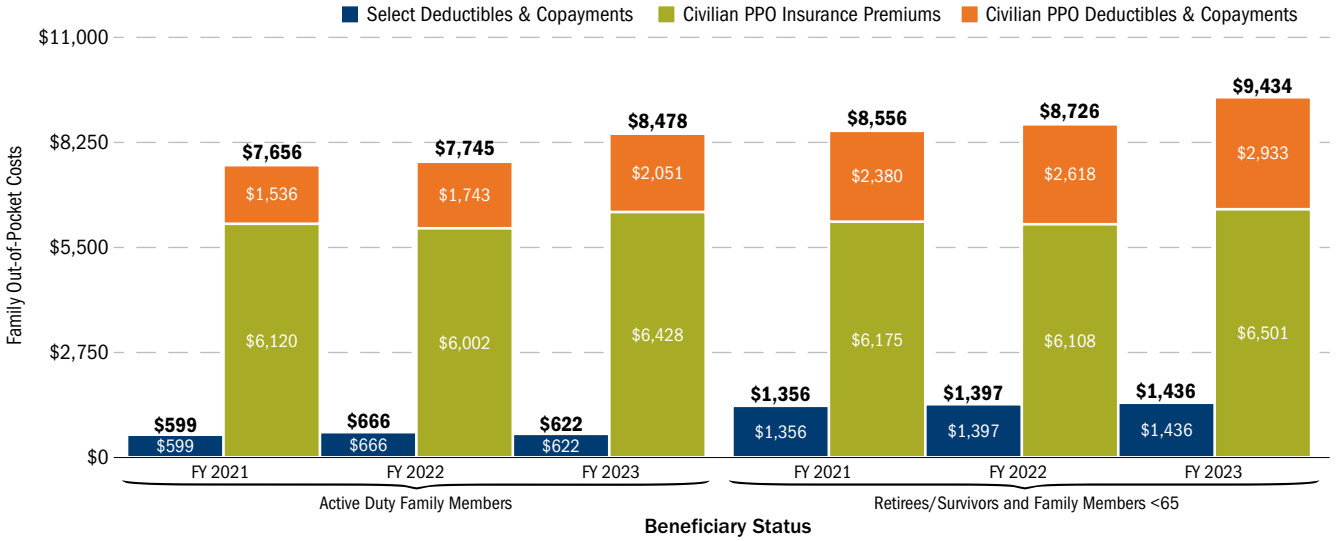
BENEFICIARY FAMILY HEALTH PLAN COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Out-of-Pocket Costs for Families Who Rely on TRICARE Select or Direct Care vs. Civilian PPO Counterparts

Civilian counterpart families enrolled in PPO plans had much higher out-of-pocket costs in FYs 2021–2023 than TRICARE Select users.

- In FYs 2021–2023, civilian PPO counterparts paid $7,000 to $8,000 more for insurance premiums, deductibles, and copayments.
- Costs for civilian PPO counterparts in FY 2023 were:
  - $7,800 more than those incurred by ADFMs who relied on TRICARE Select
  - $8,000 more than those incurred by RETFMs who relied on TRICARE Select

OUT-OF-POCKET COSTS FOR FAMILIES WHO RELY ON TRICARE SELECT OR DIRECT CARE VS. CIVILIAN PPO COUNTERPARTS, FYs 2021–2023



Sources: TRICARE health care utilization expenditures by both the government and beneficiaries in FYs 2021–2023 from MHS administrative data for all families enrolled in Select without OHI payments for TRICARE utilization, 12/31/2023; civilian insurance company and beneficiary benchmark expenditures from Merative MarketScan Commercial Database, 1/19/2024

Notes:

– For this year's report, IDA removed all COVID-19 pandemic-related adjustments to spending. Instead, IDA used its historical method of calculating multiyear growth rates using historical data to project forward for missing quarters.
– MarketScan data cover a full four quarters in FYs 2021 and 2022. Only two quarters of data were available for FY 2023. The remaining quarters were projected with multiyear growth rates.
– Civilian expenditures for deductibles and copayments are somewhat higher than in previous reports. Our previous source was the MEPS, which marginally understates those expenditures relative to MarketScan (see Zuvekas, S. "Comparing MEPS Use and Expenditure Estimates for the Privately Insured to Truven MarketScan and OptumLabs Claims Data, 2008–2013." Center for Financing, Access, and Cost Trends, AHRQ. October 2017).
– Currently, there is no cost information for MHS GENESIS records. While direct care cost shares are relatively uncommon, this will slightly underestimate out-of- pocket costs particularly as more sites deploy the new EHR.
– Numbers may not sum to bar totals due to rounding.

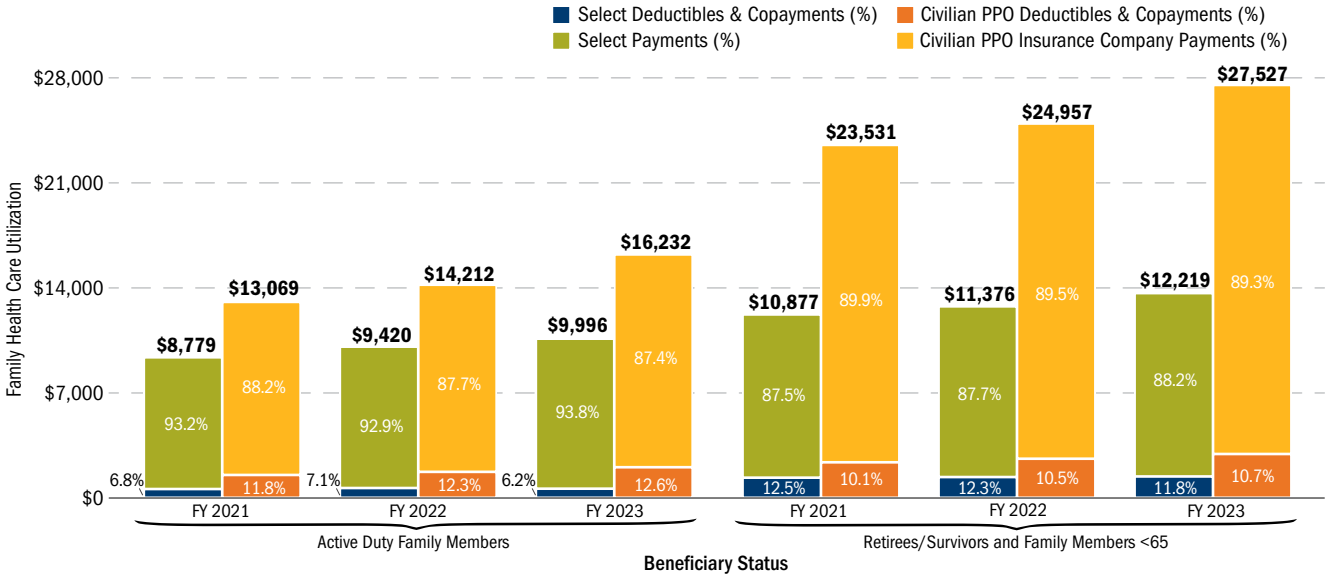
BENEFICIARY FAMILY HEALTH PLAN COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Coinsurance and Health Care Utilization for Families Who Rely on TRICARE Select or Direct Care vs. Civilian PPO Counterparts

Active Duty families who relied on TRICARE Select had lower coinsurance rates (deductibles and copayments per dollar of utilization) and lower health care utilization (dollar value of health care services consumed) than their civilian counterparts enrolled in PPO plans. Retiree families have seen their coinsurance rates remain relatively stable, while their civilian counterparts have faced rising rates. Retiree families exhibited substantially lower utilization.

- In FY 2023, for Active Duty families:
  - Coinsurance rates were 6 percent versus 13 percent for civilian PPO counterparts (7 percentage points lower).
  - Health care utilization was $10,000 versus $16,200 for civilian PPO counterparts ($6,200 less).
- In FY 2023, for retiree families:
  - Coinsurance rates were 12 percent versus 11 percent for civilian PPO counterparts (1 percentage point higher). Health care utilization was $12,200 versus $27,500 for civilian PPO counterparts ($15,300 less).

COINSURANCE AND HEALTH CARE UTILIZATION FOR FAMILIES WHO RELY ON TRICARE SELECT OR DIRECT CARE VS. CIVILIAN PPO COUNTERPARTS, FYs 2021–2023



Sources: TRICARE health care utilization expenditures by both the government and beneficiaries in FYs 2021–2023 from MHS administrative data for all families enrolled in Select without OHI payments for TRICARE utilization, 12/31/2023; civilian insurance company and beneficiary benchmark expenditures from Merative MarketScan Commercial Database, 1/16/2024

Notes:

– For this year's report, IDA removed all COVID-19 pandemic-related adjustments to spending. Instead, IDA used its historical method of calculating multi-year growth rates using historical data to project forward for missing quarters.

– MarketScan data cover a full four quarters in FYs 2021 and 2022. Only two quarters of data were available for FY 2023. The remaining quarters were projected with multi-year growth rates.

– Civilian expenditures for deductibles and copayments are somewhat higher than in previous reports. Our previous source was the MEPS, which marginally understates those expenditures relative to MarketScan (see Zuvekas, S. "Comparing MEPS Use and Expenditure Estimates for the Privately Insured to Truven MarketScan and OptumLabs Claims Data, 2008–2013." Center for Financing, Access, and Cost Trends, AHRQ. October 2017).

– Currently, there is no cost information for MHS GENESIS records. While direct care cost shares are relatively uncommon, this will slightly underestimate out-of- pocket costs particularly as more sites deploy the new EHR.

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

BENEFICIARY FAMILY HEALTH PLAN COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES)

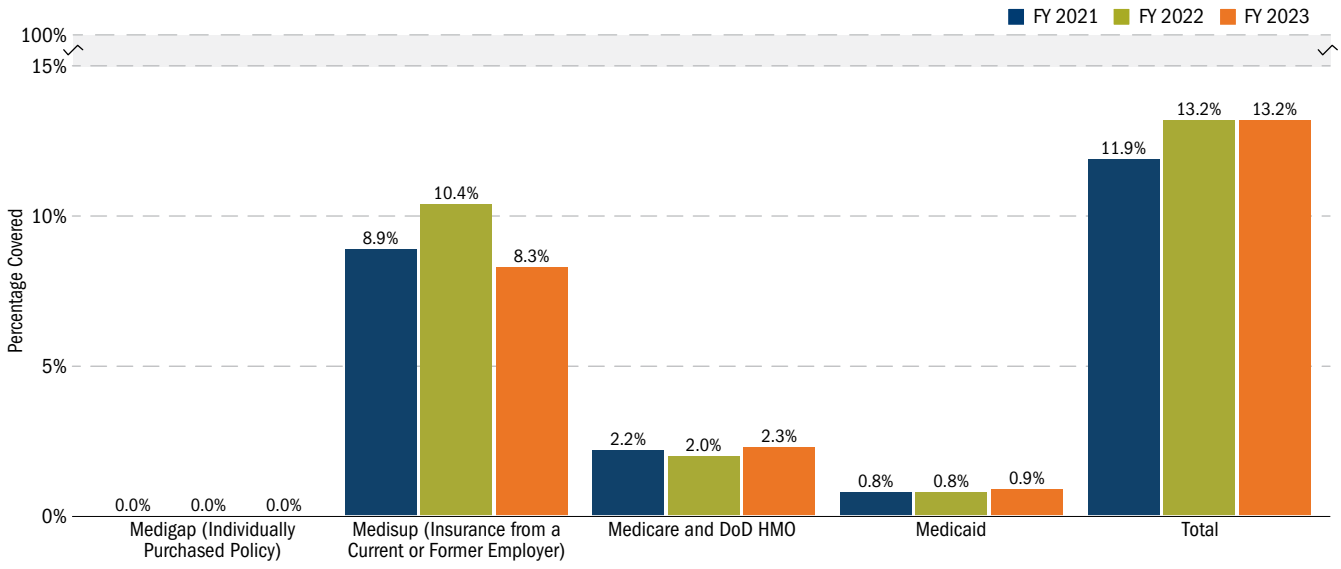
Out-of-pocket costs for retirees aged 65 and older (seniors) and their families include deductibles and copayments for medical care and drugs, TRICARE enrollment fees, and private insurance premiums. In April 2001, the DoD expanded drug benefits for seniors; on October 1, 2001, the DoD implemented the TFL Program which provides Medicare wraparound coverage (i.e., TRICARE acts as second payer to Medicare, minimizing beneficiary out-of-pocket expenses). For seniors, costs are compared with civilian counterparts enrolled in Medicare with supplemental insurance coverage.

Supplemental Health Insurance Coverage of MHS Senior Beneficiaries

Although Medicare provides coverage for medical services, there are substantial deductibles and copayments. Until FY 2001, 88 percent of MHS seniors purchased some type of Medicare supplemental insurance (e.g., Medigap, Medisup).[1] A small number were active employees with employer-sponsored insurance or were covered by Medicaid. Because of the improved drug and TFL benefits, most MHS seniors dropped their supplemental insurance.

- In FY 2023, nearly 12 percent of MHS seniors retained some form of supplemental insurance. The number of MHS seniors with Medicaid coverage has remained constant at less than 1 percent since the pandemic.
- 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 2021–2023



Source: FYs 2021–2023 HCSDB, as of 12/31/2023

[1] Medigap is an individually purchased policy that covers Medicare deductibles and copayments. Medisup is group insurance from a current or former employer (or a union). It includes those with Medicare who are covered either by FEHBP, a civilian HMO such as Kaiser, or other civilian health insurance such as Blue Cross. Individually obtained HMO policies include Medicare Advantage and USFHP. Almost all TRICARE seniors are covered by Medicare and are enrolled in Parts A and B; only 1.3 percent have just Part A. About 1 percent of TRICARE seniors are covered by government-sponsored Medicaid. About 1 percent of TRICARE seniors have OHI and are not covered by Medicare; as of 12/31/2023.

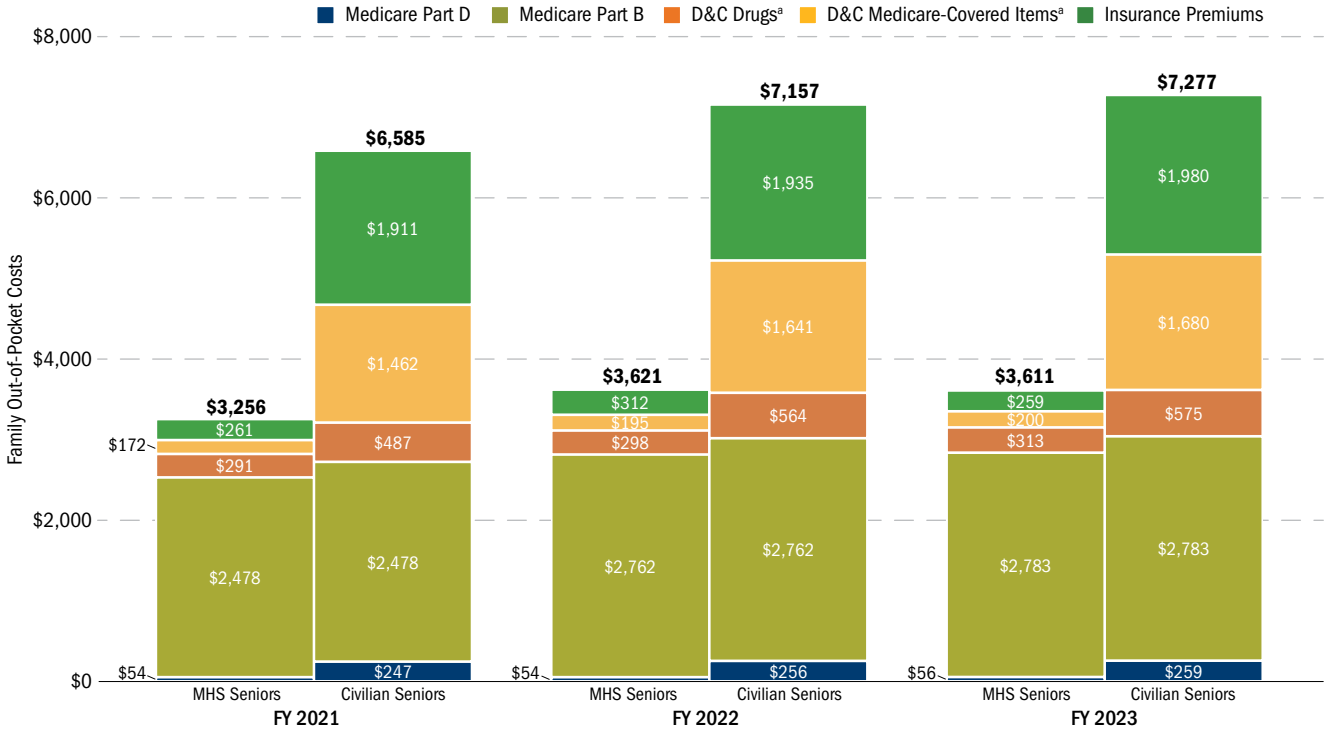
BENEFICIARY FAMILY HEALTH PLAN COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT.)*

Out-of-Pocket Costs for MHS Senior Families

About 87 percent of TRICARE senior families use MHS health care. TFL and added drug benefits have enabled MHS seniors to reduce their out-of-pocket costs for deductibles/copayments and supplemental insurance. The costs for a typical TRICARE senior family after TFL, including MHS users and nonusers, are compared with their civilian counterparts.

- In FY 2023, out-of-pocket costs for MHS senior families were 50 percent less than those of their civilian counterparts.
- MHS senior families saved about $3,700 as a result of TFL and added drug benefits in FY 2023.

OUT-OF-POCKET COSTS OF MHS SENIOR FAMILIES AFTER TFL VS. CIVILIAN COUNTERPARTS, FYs 2021–2023



Sources: TRICARE senior family deductibles and copayments for MHS users in FYs 2021–2023 from MHS administrative data, 12/31/2023; for MHS nonusers and civilian benchmark senior families, deductibles and copayments by type of Medicare supplemental coverage in FYs 2021–2023 projected from the Household Component of the MEPS; Medicare Part B and Medicare HMO premiums in FYs 2021–2023 from the Centers for Medicare & Medicaid Services (CMS); Medigap premiums in FYs 2021–2023 from Weiss Research, Inc.; Medicare supplemental insurance coverage from the HCSDB, FYs 2021–2023, as of 1/31/2024

[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 2021. The long-run growth rate between was used to project utilization expenditures in FYs 2021–2023.
– Numbers may not sum to bar totals due to rounding.

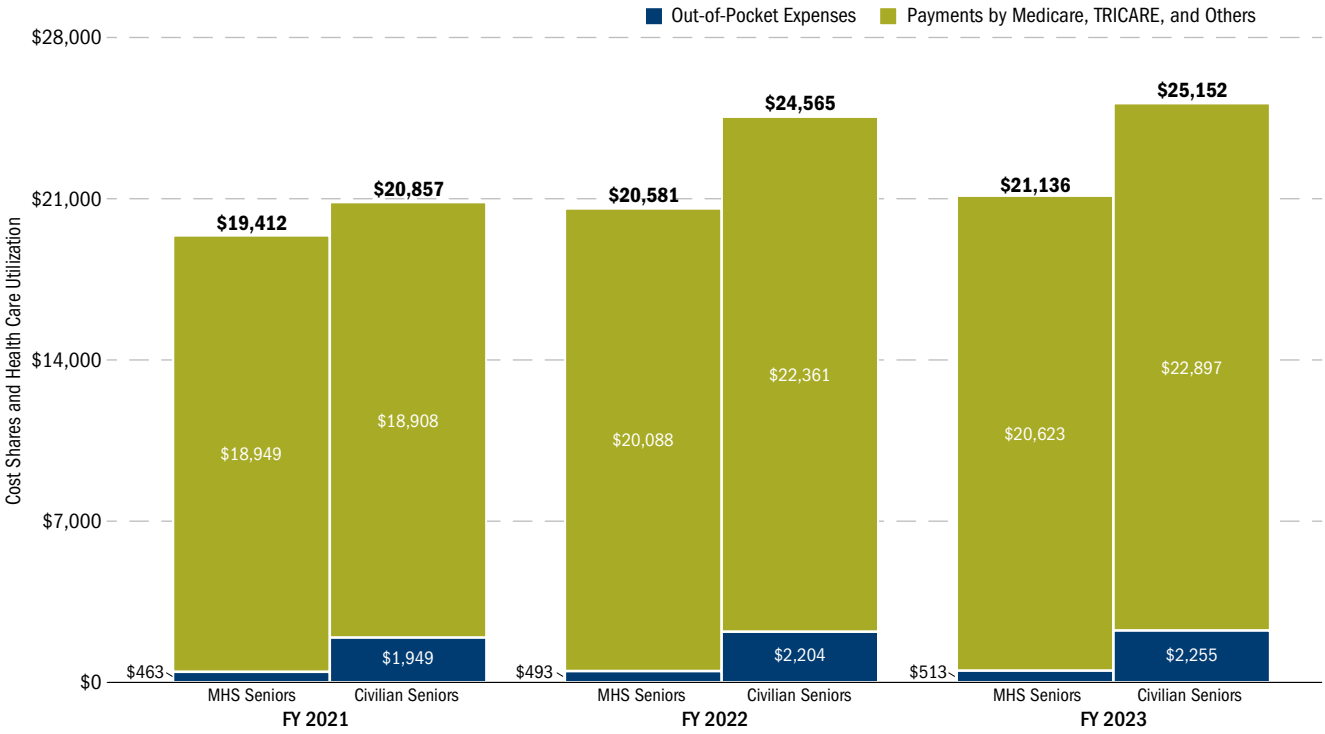
BENEFICIARY FAMILY HEALTH PLAN COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT.)*

Coinsurance and Health Care Utilization for MHS vs. Civilian Senior Families

TRICARE senior families have lower coinsurance rates (deductibles and copayments per dollar of utilization) than their civilian counterparts. Utilization is also slightly lower for MHS senior families.

- MHS senior families have relatively low coinsurance rates.
  - In FY 2023, the coinsurance rate for civilian senior counterparts was 9 percent; it was 2 percent for MHS seniors (7 percentage points lower).
- MHS senior families have slightly lower utilization than civilian senior families.
  - In FY 2023, civilian senior counterparts consumed $25,200 in medical services; MHS senior families consumed $21,100 ($4,100 less).

COINSURANCE AND HEALTH CARE UTILIZATION FOR SENIOR FAMILIES VS. CIVILIAN COUNTERPARTS, FYs 2021–2023



Sources: TRICARE senior family utilization, deductibles, and copayments for MHS users in FYs 2021–2023 from MHS administrative data, 12/31/2023; for MHS nonusers and civilian benchmark senior families, utilization, deductibles, and copayments by type of Medicare supplemental coverage in FYs 2021–2023 projected from the Household Component of the MEPS; Medicare supplemental insurance coverage, before and after TFL, from HCSDB, FYs 2019–2021, as of 12/31/2023

Notes:

– Currently, there is no cost information for MHS GENESIS records. This will impact both out-of-pocket costs paid by beneficiaries and utilization costs paid by TRICARE.

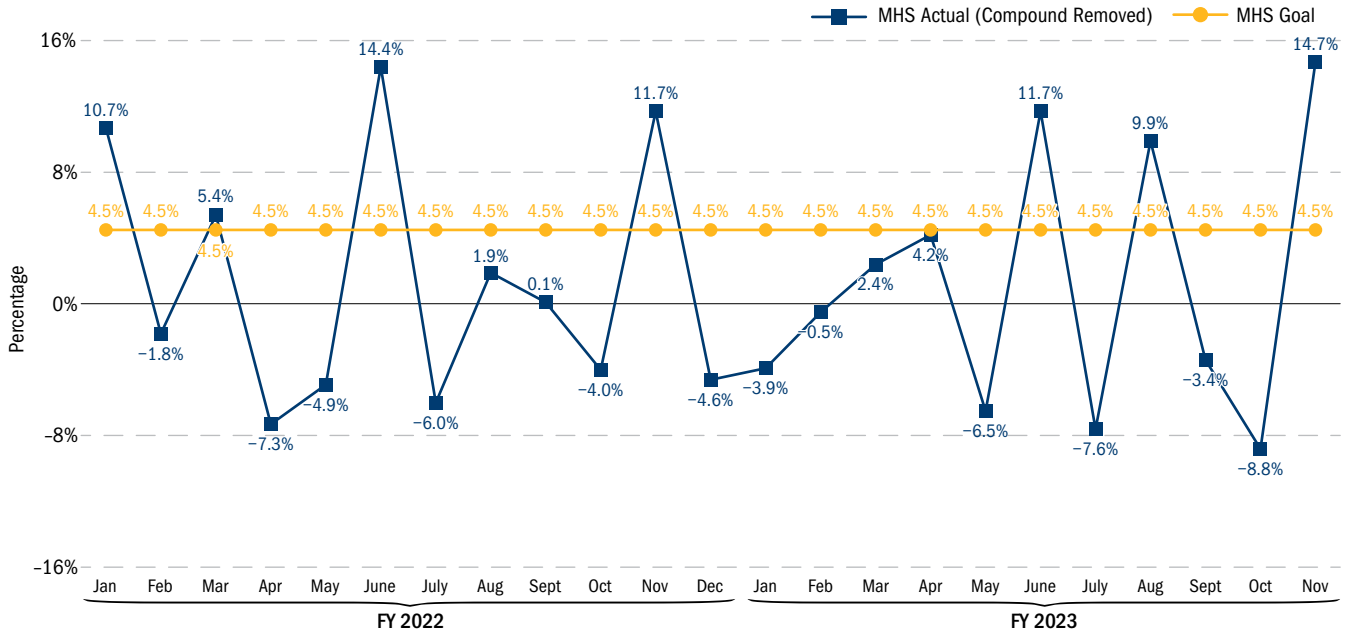
– Numbers may not sum to bar totals due to rounding

SYSTEM PRODUCTIVITY: MHS MEDICAL COST PER PRIME ENROLLEE

The goal in using this financial and productivity metric is to support the Quadruple Aim of lower costs. This measure focuses on the annual overall cost growth for TRICARE Prime enrollees and includes all costs related to health care delivered to enrollees. The objective is to keep the rate of cost growth for Prime enrollees to a level at or below the increases for the civilian health care plans at the national level. Currently, the measure provides insight on issues regarding unit cost, utilization management, and private sector care management. The metric has been enhanced to properly account for differences in population demographics and health care requirements of the enrolled population. DoD components focus on improvements in provider productivity through access standards, MTF site visits, effective use of resources, and optimization of referral management. With the implementation of MHS GENESIS, the per-member per-month for Prime enrollees results incorporate both CHCS and MHS GENESIS workload and expenses.

- The MHS continues to expand the Patient-Centered Medical Home (PCMH) strategy, a practice model in which a team of health care professionals, coordinated by a personal physician, work collaboratively to provide high levels of care, access, and communication; care coordination and integration; and care quality and safety. Care delivered in a PCMH is meant to produce better outcomes; reduce mortality, unnecessary emergency department visits, and preventable hospital admissions for patients with chronic diseases; lower overall utilization; and improve patient compliance with recommended care, resulting in lower spending for the same population.
- The MHS goal in percentage change in medical costs from the prior year is based on the annual national survey of nonfederal private and public employers with three or more workers, conducted by the Kaiser Family Foundation and the Health Research and Educational Trust. From this survey, the MHS rate is set, based on the average annual premiums for employer-sponsored health insurance for family coverage. For the time period from FY 2014 to FY 2016, the MHS goal was set at one percentage point below the survey. Starting in FY 2017, the goal reverted back to the actual survey result.

PERCENTAGE CHANGE IN MEDICAL COST PER PRIME EQUIVALENT LIFE (FROM PRIOR YEAR), FYs 2022–2023



Sources: DHA, Analytics and Evaluation Division, 12/11/2023. Data are as of November 2023, 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 2023 data are reported through November 2023 and data from this time period should be considered preliminary.

GENERAL METHOD

This report presents the overall performance of the TRICARE Program with respect to the Military Health System (MHS) Quadruple Aim of Improved Readiness, Better Care, Better Health, and Lower Cost. The MHS monitors various metrics to assess performance and, where possible, tries to compare MHS performance with relevant civilian health care performance. This report examines the effects of TRICARE on beneficiary utilization of inpatient, outpatient, and prescription services, as well as on MHS and beneficiary costs. Wherever feasible, the report contrasts various aspects of TRICARE and national health care trends. These include comparison of TRICARE utilization and cost measures with comparable civilian sector benchmarks derived from the Merative™ MarketScan® Commercial Database, trended changes in medical costs based on the national survey of nonfederal health plans and public employers conducted by the Kaiser Family Foundation and the Health Research and Education Trust, and national patient survey results from the consortium of the Agency for Healthcare Research and Quality (AHRQ) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS), to include CAHPS Health Plan Survey, Hospital CAHPS (HCAHPS), and CAHPS Clinician & Group Survey (CAHPS-CG).

Notes on Methodology

- Numbers in charts or text may not sum to the expressed totals due to rounding.
- Unless otherwise indicated, all years referenced are federal fiscal years (FYs; October 1–September 30).
- Unless otherwise indicated, all dollar amounts are expressed in then-year dollars for the fiscal year represented.
- All photographs in this document were obtained from websites accessible by the public. The photos have not been tampered with other than to mask an individual's name.
- Differences between MHS survey-based data and the civilian benchmark, or the MHS over time, were considered statistically significant if the significance level was less than or equal to 0.05.
- All workload and costs are estimated to completion based on separate factors derived from MHS administrative data for direct care and recent claims experience for private sector care.
- Data were current as of:
  - Surveys—Health Care Survey of Department of Defense (DoD) Beneficiaries (HCSDB) (11/17/2023); Joint Outpatient Experience Survey (JOES)/Joint Outpatient Experience-CAHPS (JOES-C) (12/8/2023); TRICARE Inpatient Satisfaction Survey (TRISS) (12/8/2023)
  - Eligibility/enrollment data—1/4/2024
  - MHS workload/costs—1/24/2024
- 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 DoD health care benefits. The HCSDB provides information on a wide range of health care issues, such as beneficiaries' ease of access to health care, preventive care services, and healthy behaviors.

The worldwide multiple-mode Adult HCSDB has been conducted on a quarterly basis, three times a fiscal year, since FY 2013, and reported on a publicly accessible website (https://health.mil/hcsdb).

The CAHPS is a nationally recognized set of standardized questions and reporting formats that has been used to collect and report meaningful and reliable information about the health care experiences of consumers. It was developed by a consortium of research institutions and sponsored by AHRQ. It has been tested in the field and evaluated for validity and reliability. The questions and reporting formats have been tested to ensure that the answers can be compared across plans and demographic groups.

About three-fourths of HCSDB questions are closely modeled on the CAHPS Health Plan Survey in wording, response choices, and sequencing. The other one-fourth of HCSDB questions are designed to obtain information unique to TRICARE benefits or operations, and to solicit information about healthy lifestyles or health promotion, often based on other nationally recognized health care survey questions (e.g., the Centers for Disease Control and Prevention [CDC] Behavioral Risk Factor Surveillance System [BRFSS], National Health Interview Survey, or the National Health and Nutrition Examination Survey). Supplemental questions are added on a quarterly basis to explore specific topics of interest, such as the acceptance and prevalence of preventive services, including colorectal cancer screening and annual influenza immunizations; availability of other non-DoD health insurance; use of urgent care centers; Health-Related Quality of Life (HRQOL) measures; and special timely topics, such as COVID-19 vaccination opinions.

Because the HCSDB uses CAHPS questions, TRICARE can be benchmarked to civilian managed care health plans reporting CAHPS Health Plan results. More information on CAHPS can be obtained at www.cahps.ahrq.gov.

The HCSDB is sent by postal mail to all beneficiaries and also by e-mail to Active Duty members, with responses accepted via web and, for a random sample of initial nonrespondents, by postal mail. The HCSDB is fielded to a stratified random sample of beneficiaries. In order to calculate representative rates and means from their responses, sampling weights are used to account for different sampling rates and different response rates in different sample strata. Beginning with the FY 2006 report, weights were adjusted for factors such as age, sex, and rank that do not define strata but make some beneficiaries more likely to respond than others. Because of the adjustment, rates calculated from the same data differ from past evaluation reports and are more representative of the population of TRICARE users. The DHA HCSDB is sent to a random sample of all MHS-eligible users and nonusers. In FY 2023, there were 23,198 annual responses from the sample of 301,500, resulting in a raw response rate of 7.7 percent. This is relatively unchanged from FY 2022. Results can be estimated from the HCSDB for all beneficiary groups eligible for MHS benefits, whether they use direct care, private sector care, or other health insurance available to them, and are compared with benchmark results from a national sample of commercial civilian health plans administering the CAHPS Health Plan Survey.

Results provided from HCSDB in FYs 2020–2023 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 micro data were obtained from the National Committee for Quality Assurance (NCQA).

NCQA collects responses to the survey from a national sample of health plans that serve the civilian population. Results from each plan for beneficiaries who responded by mail or Internet are averaged together, weighted equally. The benchmarks are adjusted to correspond to the age and health status of TRICARE users.

Differences between the MHS and civilian benchmark were considered significant at less than or equal to 0.05, using the normal approximation. The significance test for a change between years is based on the change in the MHS estimate minus the change in the benchmark, which is adjusted for age and health status to match the MHS. T-tests measure the probability that the difference between the change in the MHS estimate and the change in the benchmark occurred by chance.

Tests are performed using a Z-test, and standard errors are calculated using SUDAAN® to account for the complex stratified sample and unequal weights. If p is less than 0.05, the difference is significant.

Within the context of the HCSDB, Prime enrollees are defined as those enrolled at least six months.

TRISS

The purpose of the TRISS is to monitor and report on the experience and satisfaction of MHS beneficiaries who have been admitted to military medical treatment facilities (MTFs) and civilian hospitals. The survey instrument incorporates the questions developed by AHRQ and the Centers for Medicare & Medicaid Services (CMS) for the HCAHPS initiative. The goal of the HCAHPS initiative is to measure uniformly and report publicly patient experiences with inpatient care through the use of a standardized survey instrument and data collection methodology. The information derived from the survey can be useful for internal quality improvement initiatives, to assess the impact of changes in policy, and to provide feedback to providers and patients.

The TRISS is a 41-item survey instrument. The survey includes HCAHPS questions asking how often or whether patients experienced a critical aspect of hospital care, rather than whether they were "satisfied" with their care, and DoD-specific questions, including an open-ended question to solicit location-specific comments from our beneficiaries.

The TRISS questionnaire is sent to all (census) adult MTF inpatients worldwide between 48 hours and six weeks after discharge. The TRISS survey is also administered to a random sample of adult MHS inpatients discharged from civilian network/private sector care hospitals. The TRISS follows the HCAHPS protocols developed by CMS. HCAHPS protocols for sampling, data collection, and coding can be found in the HCAHPS Quality Assurance Guidelines manual on the official HCAHPS website, www.hcahpsonline.org. The overall FY 2023 Q1–Q3 response rate for direct care was 31 percent and 29 percent for private sector care.

JOES/JOES-C

The JOES continues to focus on the beneficiary experience with care received in MTFs, and is centrally managed under the direction of Service and DHA survey leads. JOES results are reported centrally, and reported for each Service, multi-Service Market area, and down to each MTF and provider. The JOES-C is a companion survey to the JOES, measuring outpatient care at military and civilian facilities. The JOES-C is based on the CAHPS-CG, 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 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 beneficiary utilization came from several sources. We obtained the health care experience of eligible beneficiaries by aggregating Standard Inpatient Data Records (SIDRs—MTF hospitalization records), Comprehensive Ambulatory/Professional Encounter Records (CAPERs—MTF outpatient records), TRICARE Encounter Data (TED—private sector care claims information) for institutional and noninstitutional services, and Pharmacy Data Transaction Service (PDTS) claims within each beneficiary category.

Inpatient utilization was measured using dispositions (direct care)/admissions (private sector care) and Medical Severity Diagnosis Related Group (MS-DRG) relative weighted products (RWPs), the latter being a measure of the intensity of hospital services provided. Outpatient utilization for both direct and private sector care was measured using encounters and an MHS-derived measure of intensity called Enhanced Total Relative Value Units (RVUs).

The 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 the MHS in FY 2010 and subsequently revised in FY 2016 to account for units of service (e.g., 15-minute intervals of physical therapy) and better reflect the resources expended to produce an encounter. The word "Total" in the name reflects that it is the sum of Work RVUs and Practice Expense RVUs. Work RVUs measure the relative level of resources, skill, training, and intensity of services provided by a physician. Practice Expense RVUs account for nonphysician clinical labor (e.g., a nurse), medical supplies and equipment, administrative labor, and office overhead expenses. In the private sector, Malpractice RVUs are also part of the formula used to determine physician reimbursement rates, but since military physicians are not subject to malpractice claims, they are excluded from Total RVUs

to make the direct and private sector care workload measures more comparable. For a more complete description of enhanced as well as other RVU measures, see https://www.milsuite.mil/video/watch/video/9653 (a milSuite account and DoD-issued Common Access Card [CAC] are required to access this site).

By the end of FY 2023, the DoD's new electronic health record, MHS GENESIS, had been deployed at all military hospitals and clinics in the United States. The data feed from MHS GENESIS does not currently include the information needed (which provider worked on which procedure) to compute RVUs. Additionally, the algorithms and data needed by the Medical Expense and Performance Reporting System Program Office to allocate costs within its data capture system are not built into MHS GENESIS, which is based on a commercial off-the-shelf product. Consequently, patient-level costs are currently unavailable for GENESIS facilities. However, the DHA Resources & Management Directorate (J-8)/Business Integration Division was able to provide total DoD inpatient costs and total outpatient costs for all facilities, which were allocated to beneficiary groups where necessary.

In the past, we simply excluded MHS GENESIS facilities from most of our direct care utilization and cost analyses because their impact was only modest. However, because all stateside MTFs had transitioned to GENESIS by the end of FY 2023, excluding GENESIS facilities was no longer tenable. Consequently, we developed algorithms to estimate outpatient RVUs (inpatient RWPs are available for GENESIS facilities) for the period of time each facility was utilizing MHS GENESIS regime. Prior to transitioning to MHS GENESIS, actual RVUs and costs were available and reported for each facility under the legacy system (the Composite Health Care System).

Costs recorded on TEDs were broken out by source of payment (DoD, beneficiary, or private insurer). Although SIDR and CAPER data indicate the enrollment status of beneficiaries, the Defense Enrollment Eligibility Reporting System (DEERS) enrollment file is considered to be more reliable. We therefore classified MTF discharges as Prime or space-available by matching the discharge dates to the DEERS enrollment file. Final data pulls used for this report were completed in January 2024, as referenced above.

The Merative 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 Merative 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 2023, allowed us to derive annual benchmarks by fiscal year and to estimate FY 2023 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.

Diagnosis Related Group (DRG) Grouping Methodology

In the section that displays the "Top 25" inpatient diagnosis groups, DRGs are grouped into descriptively (but not necessarily clinically) similar categories using a code set available on http://www.findacode.com/code-set.php?set=DRG, an online database of medical billing codes and information. The site lists DRGs within each MDC, with headings above diagnostically related DRGs. These headings provide a broad description of the DRGs underneath and distinguish between medical and surgical DRGs, but do not distinguish among DRGs with different (or any) levels of complications and comorbidities. For the purposes of this report, the DRGs were too detailed and the MDCs too broad to provide the reader with a general sense of the most common inpatient diagnoses the MHS confronts; therefore, the headings were used as the basis for broadening the groupings in this report into descriptively related categories, without regard for whether they are medical or surgical, whether there are complications, or which parts of the body are affected. For example, the "ECMO or Tracheostomy" group includes DRGs 003, 004, 011, 012, and 013. The description for each of those DRGs includes the words "ECMO" or "Tracheostomy"—some with complications, some without; some for face, mouth, and neck; and some for other parts of the body. Once all the groups were formed, they were numbered sequentially following the order in which they were presented on the website. This resulted in a reduction from 818 DRGs to 284 DRG groups.

ABBREVIATIONS

AABB	American Association of Blood Banks | 87
ABA	applied behavior analysis | 104
AC	Active Component | 2
AC	Accreditation and Compliance | 83
ACC	Acute Concussion Care | 97
ACD	Autism Care Demonstration | 104
ACE	Acute Concussion Evaluation | 97
ACOG	American College of Obstetricians and Gynecologists | 98
ACS	American College of Surgeons | 40
AD	Active Duty | 15
ADC	administration, direction, and control | 10
ADDP	Active Duty Dental Program | 188
ADFM	Active Duty family member | 3
ADSM	Active Duty Service member | 3
AE	adverse event | 73
AHRQ	Agency for Healthcare Research and Quality | 75
AIM	Alliance for Innovation on Maternal Health | 98
AMC	Army Medical Center | 108
AO	accrediting organization | 83
APLSS	Army Provider Level Satisfaction Survey | 64
ASBP	Armed Services Blood Program | 87
ASC	ambulatory surgery center | 89
ASD	autism spectrum disorder | 104
ASD(HA)	Assistant Secretary of Defense for Health Affairs | 39
ASP	Antimicrobial Stewardship Program | 74
ASSET+	Advanced Surgical Skills for Exposure in Trauma+ | 39
AUR	antimicrobial use and resistance | 76
BDC	blood donor centers | 87
BH	behavioral health | 2
BHCC	Behavioral Health Clinical Community | 101
BHDP	Behavioral Health Data Portal | 101
BMI	body mass index | 144
BRAC	Base Realignment and Closure | 18
BRFSS	Behavioral Risk Factor Surveillance System | 148
BZD	benzodiazepine | 103
CA	corrective action | 45
CAC	common access card | 40
CAHPS	Consumer Assessment of Healthcare Providers and Systems | 47
CAHPS-CG	CAHPS Clinician & Group Survey | 64
CAP	College of American Pathologists | 86
CAPER	Comprehensive Ambulatory/Professional Encounter Record | 179
CAUTI	catheter-associated urinary tract infection | 76
CCDR	Combatant Commander | 7
CCQAS	Centralized Credentialing and Quality Assurance System | 82
CCSR	Clinical Classifications Software Refined | 162
CDC	Centers for Disease Control and Prevention | 74
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services | 184
CHCS	Composite Health Care System | 26
CLABSI	central line–associated bloodstream infection | 76
CLIA	Clinical Laboratory Improvement Amendment | 86
CLIP	Clinical Laboratory Improvement Program | 86
CLMS	Joint-Service Center for Laboratory Medicine Services | 87
CM	clinical measurement | 46
CMS	Centers for Medicare & Medicaid Services | 23
COBRA	Consolidated Omnibus Budget Reconciliation Act | 3
CONUS	contiguous United States | 75
CP	Credentialing and Privileging | 82
CPG	clinical practice guideline | 47
CPI	continuous process improvement | 8
CQI	clinical quality improvement | 90
CQIS	Clinical Quality Improvement Studies | 91
CQM	clinical quality management | 43
CQM E&T	Clinical Quality Management Education and Training | 91
CQMC	Core Quality Measures Collaborative | 45
CSA	comprehensive systematic analysis | 76
CSD	Clinical Support Division | 75
CY	calendar year | 2
DART	Direct Access Reporting Tool | 60
DCC	Dental Clinical Community | 105
DEERS	Defense Enrollment Eligibility Reporting System | 11
DHA	Defense Health Agency | b
DHA PI	DHA Office of Program Integrity | 151
DHA-IPM	DHA Interim Procedures Memorandum | 49
DHA-PI	DHA Procedural Instructions | 43
DHA-PM	DHA Procedures Manual | 45
DHN	Defense Health Network | 8
DHP	Defense Health Program | 11
DMIS	Defense Medical Information System Identifiers | 11
DoD	Department of Defense | b
DoDI	Department of Defense Instruction | 82
DoDM	DoD Manual | 65
DTF	dental treatment facility | 3
DTM	Directive-Type Memorandum | 103
DVPRS	Defense and Veterans Pain Rating Scale | 110
EBPWG	Evidence-Based Practice Work Group | 91
ECHO	Extended Care Health Option | 3
ED	emergency department | 12
EHR	electronic health record | 26
EIC	external independent contractor | 152

ABBREVIATIONS *(CONT.)*

ESP	Expeditionary Scope of Practice | 40
EWSC	Emergency War Surgical Course | 41
FDA	Food and Drug Administration | 33
FEDVIP	Federal Employees Dental and Vision Insurance Program | 3
FEHB	Federal Employees Health Benefits | 167
FY	fiscal year | 1
GPS	global positioning system | b
GTT	Global Trigger Tool | 74
HAI	health care–associated infection | 74
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems | 2
HCO	Health Care Operations | 10
HCSDB	Health Care Survey of DoD Beneficiaries | 63
HEART	Healthcare Event Analysis Response Team | 80
HEC	Health Executive Committee | 91
HEDIS	Healthcare Effectiveness Data and Information Set | 2
HGB	Humana Government Business | 10
HIPAA	Health Insurance Portability and Accountability Act | 65
HMO	health maintenance organization | 3
HNFS	Health Net Federal Services | 10
HQ	headquarters | 8
HRM	Healthcare Risk Management | 82
HRO	high reliability organization | 43
HRQOL	Health-Related Quality of Life | 148
HVBP	Hospital Value-Based Purchasing | 9
ICU	intensive care unit | 76
IDA	Institute for Defense Analyses | 168
IHI	Institute for Healthcare Improvement | 77
IMR	Individual Medical Readiness | 37
IPC	Infection Prevention and Control | 74
JIF	Joint Incentive Fund | 75
JKSA PMO	Joint Knowledge, Skills, and Abilities Program Management Office | 39
JOES	Joint Outpatient Experience Survey | 2
JOES-C	Joint Outpatient Experience Survey-CAHPS | 64
JOTS+	Joint Operational Trauma Surgical Skills | 39
JPSR	Joint Patient Safety Reporting | 74
JTS	Joint Trauma System | 10
LBP	low back pain | 9
LDSB1	Leader Daily Safety Briefs – Safety Messages | 77
LDSB2	Leader Daily Safety Briefs – Safety Alerts | 77
LOS	length of stay | 52
M2	MHS Management Analysis and Reporting Tool | 58
MACE2	Military Acute Concussion Evaluation | 97
MBSAQIP	Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program | 89
MCP	military-civilian partnership | 39
MCSC	managed care support contractor | 11
MDC	major diagnositc category | 180
MDD	major depressive disorder | 101
MDR	MHS Data Repository | 49
MED/SURG	medical/surgical | 153
MEPS	Medical Expenditure Panel Survey | 168
MERHCF	Medicare-Eligible Retiree Health Care Fund | 2
MFLC	military and family life counselors | 103
MH	mental health | 2
MHS	Military Health System | 2
MILCON	military construction | 22
MILDEP	military department | 39
MILPERS	military personnel | 22
MOU	Memorandum of Understanding | 86
MRI	Medical Readiness Indeterminate | 37
MS-DRG	Medicare Severity Diagnosis Related Group | 155
MTF	military medical treatment facility | 2
NAL	nurse advice line | 28
NAS	non-availability statement | 184
NCHS	National Center for Health Statistics | 29
NCQA	National Committee for Quality Assurance | 63
NCR	National Capital Region | 68
NDAA	National Defense Authorization Act | 9
NH	Naval Hospital | 106
NHE	National Health Expenditures | 23
NHSN	National Healthcare Safety Network | 74
NIH	National Institutes of Health | 110
NMC	Naval Medical Center | 108
NMSKCC	Neuromusculoskeletal Clinical Community | 97
NPDB	National Practitioner Data Bank | 82
NPI	National Provider Identifier | 136
NPIC	National Perinatal Information Center | 89
NQF	National Quality Forum | 45
NSQIP	National Surgical Quality Improvement Program | 89
O&M	operation and maintenance | 22
OASD(HA)	Office of the Assistant Secretary of Defense for Health Affairs | b
OB/GYN	obstetrics/gynecology | 39
OCO	overseas contingency operations | 22
OCONUS	outside the contiguous United States | 46
OHI	other health insurance | 15
OOC	overseas operations costs | 22
OPM	Office of Personnel Management | 191
ORDIT	Operating Room Debrief Issue Tracker | 77
P&T	Pharmacy & Therapeutics | 33
PASTOR	Pain Assessment Screening Tool and Outcome Registry | 110
PC	perinatal care | 85
PCCOB	Patient Centered Care Operations Board | 48
PCM	primary care manager | 3
PCMH	Patient-Centered Medical Home | 2

ABBREVIATIONS *(CONT.)*

PDTS	Pharmacy Data Transaction Service | 179
PFPWD	Program for Persons with Disabilities | 185
PHI	protected health information | 65
PHI	private health insurance | 154
PMR	Partially Medically Ready | 37
POAM	Plan of Action and Milestones | 83
POS	point of service | 3
PP	Performance Planning | 90
PPM	provider-performed microscopy | 87
PPO	preferred provider organization | 3
PR	practice recommendations | 107
PSA	Prime Service Area | 18
PSAW	Patient Safety Awareness Week | 77
PSC	private sector care | 3
PSC BAG	Private Sector Care Budget Activity Group | 24
PSP	Patient Safety Program | 74
PSPC	Patient Safety Professional Course | 80
PSS	Navy Patient Satisfaction Survey | 64
PSYCH	mental health | 153
PT	physical therapy | 9
PTSD	post-traumatic stress disorder | 101
QA	quality assurance | 45
R&A	review and analysis | 48
RC	Reserve Component | 2
RDT&E	research, development, test, and evaluation | 22
RE	reportable event | 2
RETFM	retiree and family member | 13
RFI	requirements for improvement | 45
RMWG	Risk Management Working Group | 82
RN	registered nurse | 58
ROR	Return to Operating Room | 107
RRC	Ready Reliable Care | 43
RVU	relative value unit | 2
RWP	relative weighted product | 2
SAAR	standardized antibiotic administration ratio | 76
SAS	Space Aggressor Squadron | b
SCB	Safety Communication Bundle | 77
SDA	Air Force Service Delivery Assessment | 64
SECDEF	Secretary of Defense | 45
SelRes	Selected Reserve | 3
SERCA	Safety Event and Root Cause Analysis | 78
SIDR	Standard Inpatient Data Record | 179
SLR	Safety Leadership Rounds | 77
SME	subject-matter expert | 48
SMS	short message service | 64
SOP	standard operating procedure | 91
SRV	survivors | 33
SSI	surgical site infections | 107
SSO	Small Market and Stand-Alone MTF Office | 81
TAC	TBI Advisory Committee | 97
TAMP	Transitional Assistance Management Program | 3
TBI	traumatic brain injury | 97
TC	targeted care | 103
TCC	Tele-Critical Care | 63
TDP	TRICARE Dental Program | 3
TeamSTEPPS	Team Strategies and Tools to Enhance Performance and Patient Safety | 80
TED	TRICARE Encounter Data | 96
TES	Test and Evaluation Squadron | b
TFL	TRICARE for Life | 2
THP	TRICARE Health Plan | 10
TIB	targeted immunological biologic | 33
TJC	The Joint Commission | 2
TOL	TRICARE Online | 48
TOP	TRICARE Overseas Program | 10
TPR	TRICARE Prime Remote | 3
TPRADFM	TRICARE Prime Remote for Active Duty Family Members | 3
TQIP	Trauma Quality Improvement Program | 89
TRDP	TRICARE Retiree Dental Program | 185
TRISS	TRICARE Inpatient Satisfaction Survey | 65
TRR	TRICARE Retired Reserve | 2
TRS	TRICARE Reserve Select | 2
TSS	TRICARE Select Survey | 137
TYA	TRICARE Young Adult | 2
UBH	Unit-Based Huddles | 77
UC	urgent care | 28
UMP	Unified Medical Program | 2
UP	Universal Protocol | 77
URFO	unintended retained foreign object | 76
URI	upper respiratory infection | 94
USD(P&R)	Under Secretary of Defense for Personnel and Readiness | 37
USFHP	Uniformed Services Family Health Plan | 2
USTRANSCOM	U.S. Transportation Command | 75
USUHS	Uniformed Services University of the Health Sciences | 41
UTI	urinary tract infection | 107
VA	Department of Veterans Affairs | 11
VH	virtual health | 10
VHA	Veterans Health Administration | 10
VRC	Verification, Review, and Consultation | 89
WG	working group | 40
WHCMT	Women's Health Clinical Management Team | 98
WICC	Women and Infant Clinical Community | 98
WiCS	walk-in contraception services | 98
WSS	wrong-site surgery | 2

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS

1988–1995

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Era Leading to TRICARE

- Managed care demonstrations—mental health review, contracted provider arrangement for mental health, home health care/case management, catchment area management projects including the Tri-Service TRICARE Tidewater demonstration, the inaugural use of TRICARE branding
- CHAMPUS Reform Initiative demonstration contract for California and Hawaii offered CHAMPUS Prime, CHAMPUS Extra, and standard CHAMPUS (basis of later TRICARE triple option)

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 Pap tests, added Certified Marriage and Family Therapists as TRICARE-authorized providers
- Added Continued Health Care Benefit Program for certain former Department of Defense (DoD) beneficiaries at full-cost premiums, providing beneficiaries with an option comparable to COBRA coverage to continue health care coverage for a limited period after leaving military service
- Reduced the catastrophic cap from $10,000 to $7,500 per year for retirees and their family members, capping their out-of-pocket expenses for any given fiscal year

1995

- Provided beneficiaries with greater choice, access to care, and coverage of preventive services through restructuring the MHS with publication of the TRICARE final rule (October 5, 1995; 60 FR 52078-52103) to implement managed care legislation of 1993
- TRICARE overlaid the CHAMPUS Program established in 1966
- Established cost-neutral TRICARE triple option (TRICARE Prime, Extra, and Standard)
- Started nationwide rollout of managed care support contracts (seven contracts) across 12 regions, each headed by a lead agent (five Army, two Navy, four Air Force, one rotating)

- Built a TRICARE provider network to wrap around the MTFs
- Increased beneficiary access to pharmacy options by adding home delivery and retail pharmacy points of service as a result of Base Realignment and Consolidation (BRAC) commission
- Preventive services first offered exclusively under TRICARE Prime
- Reduced catastrophic cap for non-Active Duty enrollees from $7,500 to $3,000
- Expanded Active Duty Dental Benefit Plan begins

- 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
  - Widened access to promising cancer therapies, and contributed to the NCI's efforts to further the science of cancer treatment
  - Eventually became a permanent TRICARE Basic benefit available to all beneficiaries

1996

- Dropped requirement for outpatient non-availability statement (NAS)
- Increased beneficiary access to preventive services by expanding access in TRICARE Standard/Extra (expanded further in 1997 to be very similar to TRICARE Prime)
- Launched TRICARE website

1997

- Began National Mail Order Pharmacy Program
- Improved access to services for families with a disabled family member through the implementation of the Program for Persons with Disabilities (PFPWD), simplifying the process and making access easier for families

- Expanded comprehensive preventive benefits to TRICARE Standard/Extra
- Began TRICARE Retiree Dental Program (TRDP)—full-cost premiums with no DoD subsidy

- Completed TRICARE rollout with 11 regions operational (regions 7 and 8 consolidated)
- Removed TRICARE Prime copayments for ancillary services (radiology, laboratory, and diagnostic testing) conducted as a result of an outpatient visit

1998

- Began TRICARE Senior Prime demonstration

1999

- Increased beneficiary access to more providers by adding Corporate Services Provider Class
  - Allowed provider groups and foundations to become TRICARE-authorized providers; the care rendered by these providers was previously not cost-shared
  - Included freestanding corporations or foundations that rendered professional ambulatory care (e.g., physical therapy), in-home care, or technical diagnostic procedures

- Began TRICARE Prime Remote benefit
- NASs are required for maternity care

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS *(CONT.)*

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 TRDP 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 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 PDTS—improving patient safety—an online, real-time worldwide prospective drug utilization review (clinical screening) against a patient's complete medication history for each new or refilled prescription; these clinical screenings identify potential medication issues, which are immediately resolved to ensure the patient receives safe and quality care

2002

- Began TRICARE Prime Remote for Active Duty family members (TPRADFM) benefit
- Awarded TRICARE Mail Order Pharmacy contract (formerly managed by Defense Logistics Agency as the National Mail Order Program)
- Began TRICARE Global Remote Overseas contract, providing cashless/claimless health care to overseas ADSMs/ADFMs assigned to Prime Remote locations

- Created Individual Case Management Program for Persons with Extraordinary Conditions—a discretionary program for beneficiaries with extraordinary medical or psychological conditions, providing coverage of care normally excluded by law or regulation, as long as the benefit was cost effective
- Created Custodial Care Transition Policy to cover new cases of custodial care for beneficiaries entitled to expanded benefits

- 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

2003

- Eliminated NAS requirement for TRICARE Standard, except for mental health
- Awarded TRICARE Retail Pharmacy contract, carving the benefit out of the managed care support contracts into a single program

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)

- 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

2005

- 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

- 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

2007

- 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

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS *(CONT.)*

- 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 TAMP:
  - Separated Active Duty members who affiliate with the Selected Reserve
  - Members in receipt of a sole survivorship discharge

- Improved beneficiary access to behavioral health care by allowing a streamlined certification for Hospital-Based Psychiatric Partial Hospitalization Programs
- Established TRICARE Pharmacy manufacturer refunds (retroactive to January 2008)
- Implemented Outpatient Prospective Payment System
- Improved beneficiary access to vaccines by expanding coverage under pharmacy benefit for H1N1 at retail pharmacies at zero copayment

- 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

2010

- 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

- 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

2012

- Decreased beneficiary cost by freezing TRICARE Prime enrollment fees at rate effective when first enrolled for survivors of Active Duty deceased sponsors and medically retired members and dependents
- Added coverage for off-label uses of devices if reliable evidence indicates it is safe, effective, and in accordance with nationally accepted standards of practice in the medical community
- Added assisted reproductive services for seriously or severely ill or injured Service members

2013

- Reduction in Prime service areas (PSAs; closed all those not built around an MTF or BRAC site)
- TRS termination date delayed 180 days for Selected Reserve members involuntarily separated under honorable conditions (expired in 2018 by law)
- Expanded Autism Care Demonstration to include retiree family members
- Restricted Uniformed Services Family Health Plan (USFHP) 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

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS *(CONT.)*

- 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

2015

- Awarded second-generation TRICARE Overseas Program contract
- Coverage of Transitional Care Management Services—includes services provided to beneficiaries with moderate or complex medical needs and who are transitioning from the inpatient setting to their community setting (e.g., home)

2016

- Implemented first Value-Based Demonstration—lower extremity joint replacement
- Launched network Urgent Care Pilot Program—up to four visits per year without referral or prior authorizations for non-ADSM Prime enrollees in contiguous United States
- Improved mental health access and parity with lower out-of-pocket expense
  - Expanded inpatient mental health hospital services coverage
  - Reduced cost shares for all applied behavior analysis services under Comprehensive Autism Care Demonstration
  - Expanded opioid treatment
- Improved TRICARE pharmacy benefit
  - Safe disposal of unwanted medications
  - Medication Therapy Management Pilot
  - DoD/VA Continuity of Care Drug List
  - Required brand name maintenance drug fills through either TRICARE Pharmacy Home Delivery or from a military pharmacy
  - Increased copayments slightly for Home Delivery and retail network pharmacies
  - Expanded over-the-counter drug coverage permanently
- Added reimbursement for end-of-life care beneficiary planning consultations
- Enhanced preventive services and eliminated some cost share/copayments
- Introduced provisional coverage for emerging treatments and technologies
- Expanded TRICARE Basic Program to cover:
  - Surgery for femoroacetabular impingement
  - Transcranial magnetic stimulation for treatment of major depressive order and two-level cervical disc replacement
  - Nonsurgical treatment of gender dysphoria for all MHS beneficiaries; gender reassignment surgery only for ADSMs
- Began U.S.-based pilot to encourage MHS beneficiaries seen in civilian emergency rooms (in designated Markets) to voluntarily transfer to a participating MTF if an inpatient admission is needed and if determined safe for transfer
- Started second-generation TRICARE Overseas Program contract
  - Translation of medical documentation for all TOP Prime and Prime Remote beneficiaries
  - Implemented CHAMPUS Maximum Allowable Charges rates for professional services in all U.S. territories

2017

- Initial deployment of MHS GENESIS to four MTFs and their child sites

- Replaced TRICARE Standard/Extra with TRICARE Select, with grace transition period in 2018
- Extended Autism Care Demonstration for five years, through 2023, providing Applied Behavior Analysis coverage
- First annual TRICARE Open Season; coincided with the annual open season by U.S. Office of Personnel Management (OPM)

2018

- Enhanced TRICARE Coverage for Guard and Reserve members:
  - Extended TRICARE coverage to National Guard members and their eligible family members on 502(f) orders under Title 32 and called to state disaster response duty
  - Extended pre-deployment/early TRICARE eligibility and transitional coverage to Reserve Component members and eligible family members in receipt of 12304b orders for pre-planned missions under Title 10

2019

- Ended 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

- 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 National Institute of Allergy and Infectious Diseases–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

2020

- MHS transformation—MTF transition to DHA
  - Resumed after a pause for COVID-19 response
  - A number of Service medical department staff transferred to DHA
  - MHS GENESIS rollout to MTFs continued
- Added occupational therapy assistants and physical therapist assistants as TRICARE-authorized providers; podiatrists can refer to physical therapy (PT) and OT
- Enhanced TRICARE Pharmacy Benefits Program; encouraged use of high-value products
- Extended TRICARE demonstration project for Laboratory Developed Tests by three years
- Adopted Medicare's authority for Hospital Value-Based Purchasing (HVBP) Program
- Fourth Annual Open Season—new for 2021, TRICARE Select enrollment fees. About 900,000 grandfathered retirees, their families, and survivors completed arrangements for fee collection with contractors

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS *(CONT.)*

- Completed transfer of stateside MTFs to DHA
- Started TRICARE Overseas Program follow-on contract. Enhancements included:
  - Started Near Patient Program
  - Improved Clinical Quality Program
  - Facilitated medical document collection
- Clarified COVID-19–related TRICARE coverage
  - Covered testing with provider's order, including in-home test kits
  - Covered vaccine with zero cost share
  - Covered vaccine from retail pharmacies
- Adjusted TRICARE policies temporarily for COVID-19 patients during declared public health emergency
  - Increased inpatient payment by 20 percent
  - Relaxed long-term care hospital admission requirements
  - Covered skilled nursing facility services for COVID-19 transfer patients without the usual prior three-day qualifying hospital stay
- Started TRICARE pilot programs to test innovations
  - Ten states – waive cost shares on up to three physical therapy visits for low back pain through December 31, 2023
  - Metro Denver – test value-based care through December 31, 2022

2021

- Added remote physiologic monitoring coverage for acute and chronic conditions
- Added laser treatment provisional coverage for symptomatic scars from burns and other trauma
- Eliminated concurrent ECHO benefits as a qualification to receive respite care
- Started allowing Active Duty members to file medical malpractice claims as the patient against military MTFs
- Reduced reimbursable costs for certain durable medical equipment, prosthetics/orthotics, and supplies
- Adopted Medicare's HVBP for the TRICARE Program
  - Incentivizes health care providers to improve service delivery and quality
- Adopted Medicare's special "New Technology Add-On Payments"
  - Increases payments for new medical services/technologies until standardized rates can be adjusted accordingly
  - Promises to improve clinical outcomes while modernizing the TRICARE benefit
- Amended federal regulation to repeal Federal Employees Health Benefits eligibility as a disqualification for TRICARE Reserve Select effective January 1, 2030

- Transferred overseas MTFs to DHA
- Started follow-on TRICARE contracts
  - TRICARE Medicare Eligible Program (TMEP) by Wisconsin Physicians Service Insurance Corp.
  - ADDP by United Concordia Companies Inc.
  - Women, Infants, and Children (WIC) Overseas Program Support Services by Cherokee Nation Aerospace & Defense, LLC
- Permanently expanded coverage of audio-only telemedicine
- Waived cost sharing for certain contraceptive methods

2022

- TRICARE demonstrations to test innovations
  - Nationwide: certified doulas and certified lactation consultants/counselors are covered through December 31, 2026
  - Metro Atlanta: TRICARE Prime operated by Kaiser Permanente. No military hospitals or clinics in the area
- Added new reimbursement methodology for New Technology Add-On Payments (NTAPs) for pediatric beneficiaries and authorized creation of TRICARE NTAPs for new medical technologies
- Expanded temporary COVID-19 waiver of acute-care hospital requirements to include any entity that temporarily enrolls with Medicare as a hospital

2023

- Began cost sharing for breastfeeding supplies
- Extended the Laboratory Developed Test Demonstration through July 18, 2028
- Eliminated cost sharing for female tubal sterilization as a preventive care
- Added coverage for preconception and prenatal carrier screening

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The **Evaluation of the TRICARE Program: Fiscal Year 2024 Report** 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 approved, an interactive digital version with enhanced functionality and searchability will be available at: https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care- Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program.

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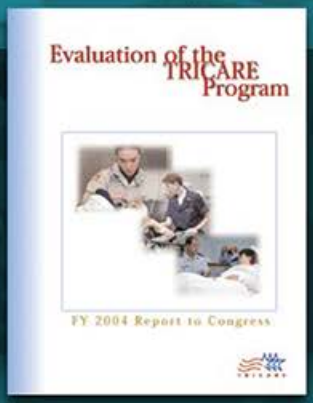
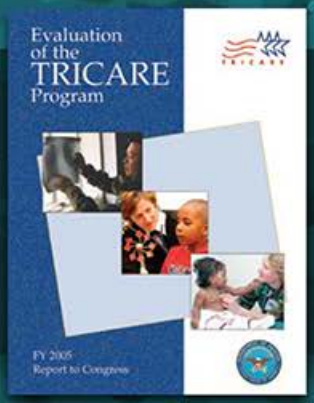
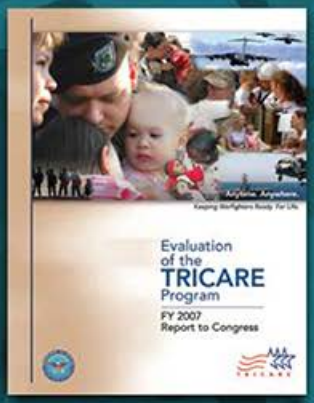
Terminology:

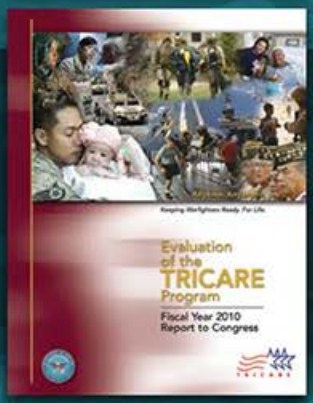
CQM = Clinical Quality Management
CSD = Clinical Support Division
DHP = Defense Health Program
HRO = High Reliability Organization
JKSA = Joint Knowledge, Skills, and Abilities
NMCSD = Naval Medical Center San Diego
NMRTC = Navy Medicine Readiness and Training Command
OASD(HA) = Office of the Assistant Secretary of Defense for Health Affairs
PCMH = Patient-Centered Medical Home
QC = Quality Control
THP = TRICARE Health Plan

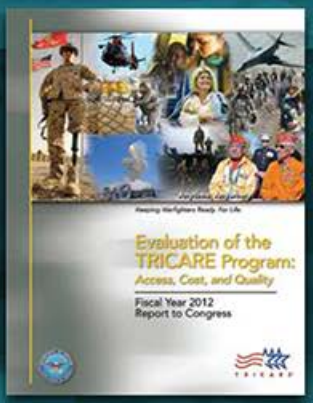
DHA
Defense Health Agency ®

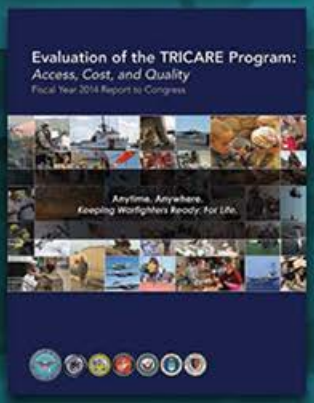


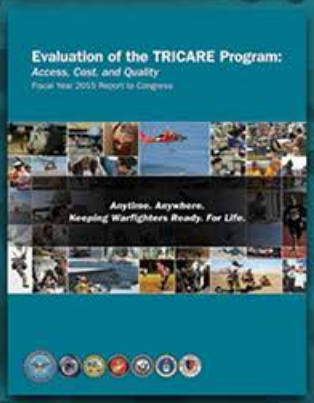


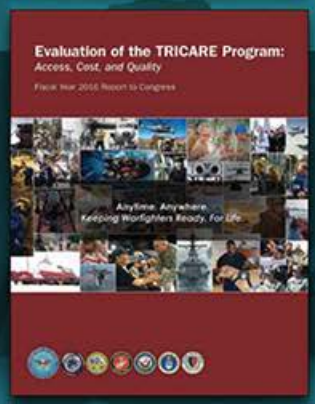


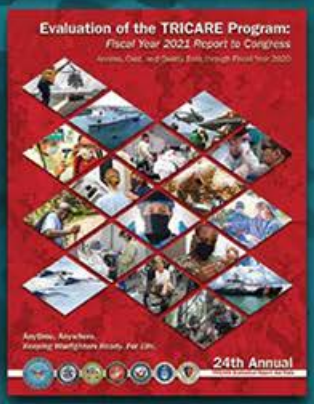












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TRICARE Evaluation Report and Data