Evaluation of the TRICARE Program:
Access, Cost, and Quality

Fiscal Year 2016 Report to Congress

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February 24, 2016

The Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2016 Report to Congress is provided by the Defense Health Agency (DHA), Decision Support Division, in the Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]). Once the Report has been sent to Congress, an interactive digital version with enhanced functionality and searchability will be available at: http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program.

Front cover photo descriptions:

A – A Marine salutes during a wreath-laying ceremony commemorating the 70th anniversary of the battle of Iwo Jima at the Marine Corps War Memorial in Washington, D.C. (March 2015)

B – A Soldier from 3rd Brigade Combat Team "Rakkasans," 101st Airborne Division (Air Assault) provides security escort at Tactical Base Gamberi in Afghanistan. (February 2015)

C – Sailors direct an E-2C Hawkeye on the flight deck aboard aircraft carrier USS Harry S. Truman (CVN 75). (September 2015)

D – A Petty Officer and a Staff Sergeant of the 3rd Marine Regiment brace for Marine Heavy Helicopter Squadron 366 to take off at the Marine Corps Air Ground Combat Center, Twentynine Palms, Calif. (July 2015)

E – A Sailor works with engineers from the Philippine army 53rd Engineering Brigade to construct school houses designed to serve more than 2,000 students in Cebu, Philippines. (July 2015)

F – World War II Veterans salute the parade of colors kicking off Legacy Week and Memorial Day weekend during a wreath ceremony aboard the USS Midway Museum. (May 2015)

G – A U.S. Air Force F-16 Fighting Falcon from the 480th Fighter Squadron, Spangdahlem Air Base, Germany, participates in a training sortie with F-22 Raptors. (September 2015)

H – The crew of U.S. Coast Guard Cutter Healy supports the Geotraces science team in studying the geochemistry of the world's oceans at the North Pole. (September 2015)

I – An F-22 Raptor from the 95th Fighter Squadron from Tyndall Air Force Base, Fla., flies over Tallinn, Estonia. (September 2015)

J – A 78th Air Base Wing Commander greets an Army Veteran during a reception at the Museum of Aviation in Warner Robins, Ga. (August 2015)

K – Guided missile destroyer USS Russel (DDG 59) follows aircraft carrier USS John C. Stennis (CVN 74) during a show of force transit. (August 2015)

L – A patient and Soldier in transition checks a service dog in training for potential health concerns during a Wounded Warrior Service Dog Training session. (August 2015)

M – Two Army Officers become the first women to receive their Ranger tab during graduation from U.S. Army Ranger School at Fort Benning, Ga. (August 2015)

N – Army Rangers from the U.S. 1st Battalion, 75th Ranger Regiment join Ranger units from Italy and Germany to train together in Hohenfels, Germany, as part of exercise Swift Response. (August 2015)

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

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A MESSAGE FROM JONATHAN WOODSON, M.D., ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

I am honored to provide the Congress our annual assessment of the effectiveness of TRICARE, the Department's premier health benefits program. While this report responds to both recent and long-standing congressional reporting requirements,[1] it also represents our commitment to transparency—with those we serve, with our military and civilian leaders, and with the American people.

This report highlights our performance on important measures of access, quality, and patient safety across the Military Health System (MHS). This report expands upon previous annual reports that depicted enterprise-wide measures, and includes hyperlinks to our Web portal that will provide measures of access, quality, and patient safety and satisfaction at the military treatment facility (MTF) level.

Our $48 billion fiscal year (FY) 2016 Unified Medical Program (UMP) budget supports the physical and mental health of our 9.4 million beneficiaries worldwide. This budget is 1 percent lower than actual FY 2014 expenditures, and almost $5 billion (over 9 percent) less than our peak expenditures of $53 billion in FY 2012. The UMP continues to represent about 8 percent of the total Department of Defense (DoD) outlays.

The FY 2015 eligible population is slightly less than in FY 2014, as Active Duty Service members and their families depart the military and Reservists return to non-Active status in their civilian lives. The population decline is moderated by about 360,000 Reservists and their families who have foregone private insurance and opted instead to purchase the premium-based TRICARE Reserve Select and TRICARE Retired Reserve (TRR) benefits, as well as over 45,000 young adults taking advantage of TRICARE Young Adult (TYA) coverage, developed in response to the Affordable Care Act.

MHS continues to implement major structural reforms in how we govern and manage our global health operations, ensuring the medical readiness of our forces and the readiness of our medical personnel. On October 1, 2015, one of the cornerstones of our organizational reform—the establishment of the Defense Health Agency (DHA)—reached full operational capability. We also have continued to mature joint health care delivery models in our six enhanced Multi-Service Market Areas, or eMSMs: the Washington, D.C. area; the Tidewater area of Virginia; San Antonio, Texas; Colorado Springs, Colorado; the Puget Sound region of Washington state; and Oahu Island in Hawaii.

MHS is also implementing a broad set of improvements directed by the Secretary of Defense on October 1, 2014, in the areas of access, quality, and patient safety, which follows from the internal "MHS Review" conducted by our military medical leaders and esteemed, independent national experts in safety and quality. We established an MHS High Reliability Organization (HRO) Task Force, and we have implemented a number of actions to address outliers, highlight successful practices, and increase both internal and external transparency. The concept of high reliability is characterized by a single-minded focus by the entire workforce to identify potential problems and high-risk situations before they lead to an adverse event. This year's report begins to reflect MHS's initial efforts in our HRO journey with data and metrics.

MHS leadership has established an enterprise-wide performance dashboard that identifies critical measures aligned with our strategic plan and priorities: Improved Readiness, Better Health, Better Care, and Lower Costs. Our "Partnership for Improvement" (P4I) system pinpoints those areas that offer the greatest opportunity to further improve our system.

I am proud of the accomplishments of MHS and the TRICARE program, and inspired by the focus of leadership on efforts to continuously improve the TRICARE program and the delivery of care. Once this report has been sent to the Congress, an interactive digital version with enhanced functionality and searchability will be available at: http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program.

—Jonathan Woodson, M.D.

[1] National Defense Authorization Act (NDAA) for FY 1996 (Section 717); NDAA for FY 2013 (Section 714); NDAA for FY 2016 (Sections 712 and 713).

MHS PURPOSE, MISSION, VISION, AND STRATEGY

The purpose, mission, vision, and overall strategy of senior Department of Defense (DoD) and Military Health System (MHS) leadership are focused on the core business of creating an integrated medical team that provides optimal health services in support of our nation's military mission—anytime, anywhere. We are ready to go into harm's way to meet our nation's challenges at home or abroad, and to be a national leader in health education, training, research, and technology.

Our ability to provide the continuum of health services across the range of military operations is contingent upon the ability to create and sustain a healthy, fit, and protected force. Key MHS mission elements of research and innovation, medical education and training, and a uniformed sustaining base and platform are interdependent and cannot exist alone. A responsive capacity for research, innovation, and development is essential to achieve improvements in operational care and evacuation.

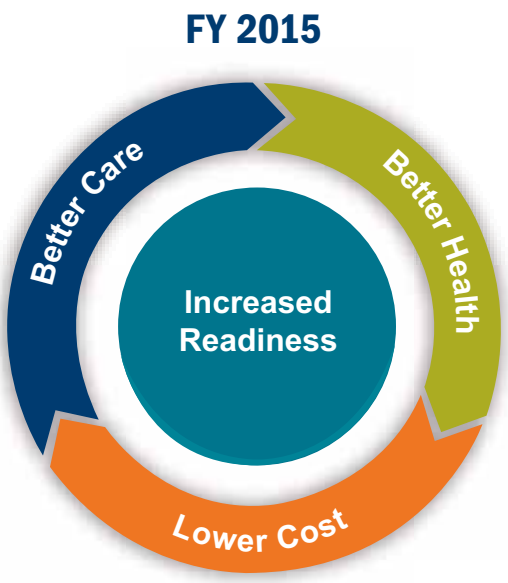
MHS is a global system delivering health services—anytime, anywhere. In everything we do, we adhere to common principles that are essential for accomplishing our mission and achieving our vision.

MHS QUADRUPLE AIM—STRATEGIC DIRECTION AND PRIORITIES

The MHS Quadruple Aim has served as the MHS strategic framework since the fall of 2009, and continues to remain relevant in describing our priorities and strategies for the coming years. This framework was adopted from the unifying construct of the Triple Aim from the Institute for Healthcare Improvement (IHI; http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx). Senior MHS leaders modified the Quadruple Aim in FY 2013 by explicitly emphasizing the desired direction of improvement: toward increased readiness, better care, better health in our population, and at lower costs to the Department.

MHS Quadruple Aim

- **Increased Readiness**
  Readiness means ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health care anytime, anywhere in support of the full range of military operations, including humanitarian missions.
- **Better Care**
  We are proud of our track record, but there is more to accomplish. We will provide a care experience that is safe, timely, effective, efficient, equitable, and patient- and family-centered.



- **Better Health**
  Our goal is to reduce the frequency of visits to our military hospitals and clinics by keeping the people we serve healthy. We are moving "from health care to health" by reducing the generators of ill health, by encouraging healthy behaviors, and by decreasing the likelihood of illness through focused prevention and the development of increased resilience.
- **Lower Cost**
  To lower costs, we will create value by focusing on quality, eliminating waste, and reducing unwarranted variation; we will consider the total cost of care over time, not just the cost of an individual health care activity. There are both near-term opportunities to become more agile in our decision-making and longer-term opportunities to change the trajectory of cost growth through a healthier population.

MHS QUADRUPLE AIM—STRATEGIC DIRECTION AND PRIORITIES *(CONT.)*

Leading into FY 2015, the former Defense Secretary identified six "priorities" to the Military Department Secretaries and Chiefs as well as combatant commanders as the Pentagon prepares to move ahead with living under sequestration:

1. **Institutional reform:** Cut the Defense Department's administrative "back office" and apply as much of the savings as possible to "real military capabilities."
2. **Force sizing and planning:** Service leaders should change the calculus by which they organize, train, and equip their forces to "better reflect our goals in the shifting strategic environment."
3. **Preparing for a prolonged military readiness challenge:** Services should assume that shrinking budgets mean they will have to prioritize some units—likely an unpopular goal within the military.
4. **Protecting investments in emerging military capabilities:** Fencing off space, cyber, and special operations forces and "intelligence, surveillance and reconnaissance" from cuts could preserve the U.S. edge.
5. **Balancing capacity and capability across the Services:** Cuts should not come at the expense of any one Service or capability—perhaps keep heavy Army tank units, for example, but move more of them to the Guard and Reserve.
6. **Balancing personnel responsibilities with a sustainable compensation policy:** Congress should help the Pentagon reform pay, benefits, health care, and other costly areas of the personnel side of the budget, but lawmakers in the past have not been keen to go along.

MHS OBJECTIVES

1. Promote more effective and efficient health operations through enhanced enterprise-wide shared services.
2. Deliver more comprehensive primary care and integrated health services using advanced patient-centered medical homes.
3. Coordinate care over time and across treatment settings to improve outcomes in the management of chronic illness, particularly for patients with complex medical and social problems.
4. Match personnel, infrastructure, and funding to current missions, future missions, and population demand.
5. Establish more inter-Service standards/metrics, and standardize processes to promote learning and continuous improvement.
6. Create enhanced value in military medical markets using an integrated approach in five-year business plans.
7. Align incentives with health and readiness outcomes to reward value creation.

DHA VISION AND MISSION

A joint, integrated, premier system of health, supporting those who serve in defense of our country.

"A premier workplace delivering world-class customer service."

"Provide the foundation for the mission success of the Defense Health Agency by delivering enterprise-wide customer-focused support services."

The DHA Mission and Objectives Align with the MHS Objectives That Support the Secretary of Defense's Priorities

The DHA is a Combat Support Agency supporting the Military Services. The DHA supports the delivery of integrated, affordable, and high-quality health services to beneficiaries of MHS, and executes responsibility for shared services, functions, and activities of MHS and other common clinical and business processes in support of the Military Services. The DHA serves as the program manager for the TRICARE health plan and medical resources, and as market manager for the National Capital Region (NCR) enhanced Multi-Service Market. The DHA manages the execution of policy as issued by the Assistant Secretary of Defense for Health Affairs and exercises authority, direction, and control over the inpatient facilities and their subordinate clinics assigned to the DHA in the NCR Directorate.

Goal 1: Improve customer service and satisfaction by identifying and managing needs and expectations.

Goal 2: Acquire, shape, and retain a diverse workforce.

Goal 3: Make processes more lean, efficient, and standardized.

Goal 4: Improve internal and external communications.

Goal 5: More effectively generate, capture, and transfer knowledge.

Goal 6: Incorporate resource stewardship in all decision-making.

http://www.tricare.mil/About.aspx

EXECUTIVE SUMMARY: KEY FINDINGS FOR FY 2015

MHS Worldwide Summary

- The $48 billion Unified Medical Program (UMP) authorized in fiscal year (FY) 2016 is slightly more than 1 percent lower than actual expenditures of $48.7 billion in FY 2015, and is currently at 7.8 percent of the overall Defense budget (ref. pages 20–21).
- The number of beneficiaries eligible for Department of Defense (DoD) medical care fell slightly, from 9.58 million in FY 2013 to 9.44 million in FY 2015 (ref. page 14). The number of Prime-enrolled beneficiaries has decreased annually since 2011 and reached just under 5 million in FY 2015, corresponding to a drop in the eligible population (ref. page 17).
- **TRICARE Young Adult (TYA):** Just over 45,000 young adults under age 26 enrolled in TYA in FY 2015, with 60 percent selecting the Prime option (ref. page 68).
- **Reserve Component (RC) Enrollment in TRICARE Plans:** Enrollment for Selected Reserve members and their families in TRICARE Reserve Select (TRS) increased to 132,000 plans/351,000 covered lives, and to nearly 2,200 plans/5,600 covered lives for retired Reservists and their families in TRICARE Retired Reserve (TRR) (ref. pages 66–68).

MHS Workload and Cost Trends[1]

- The percentage of beneficiaries using MHS services remained about the same between FY 2013 and FY 2015, at just under 85 percent (ref. page 18).
- Excluding TRICARE for Life (TFL), total MHS workload (direct and purchased care combined) fell from FY 2013 to FY 2015 for inpatient care (–5 percent), outpatient care (–7 percent), and prescription drugs (–3 percent) (ref. pages 23, 24, 26).
- Direct care workload decreased for inpatient care (–3 percent), outpatient care (–7 percent), and prescription drugs (–2 percent) from FY 2013 to FY 2015. Despite the decreases in workload, direct care costs rose by 1 percent, driven primarily by new drugs to market, especially high-cost specialty drugs. Excluding TFL, purchased care workload fell for inpatient care (–6 percent), outpatient care (–6 percent), and prescription drugs (–3 percent). Overall, purchased care costs rose by 11 percent, driven by sharp increases in compound drug expenditures (ref. pages 23, 24, 26, 30).
- The purchased care portion of total MHS health care expenditures increased from 50 percent in FY 2013 to 52 percent in FY 2015 (ref. page 30).
- In FY 2015, out-of-pocket costs for MHS beneficiary families under age 65 were between $5,000 and $5,500 lower than those for their civilian counterparts, while out-of-pocket costs for MHS senior families were $2,900 lower (ref. pages 101, 103, 106).

Lower Cost

- MHS estimated savings include $1.1 billion in retail pharmacy refunds in FY 2015 and $22 million in Program Integrity (PI) activities in calendar year (CY) 2014 (ref. page 83).

Increased Readiness

- **Force Health Protection:** In FY 2015, the Active Component (88 percent) and Reserve Component (85 percent) each met or exceeded the strategic goals of 85 percent Total Force medically ready to deploy, for an overall readiness status of 86 percent. Dental readiness remained high in FY 2015, at 94 percent (ref. pages 33–34).

Better Care

- **Access to Care:** In FY 2015, about 85 percent of Prime enrollees reported at least one outpatient visit, comparable to the civilian benchmark. Administrative data also show 86 percent of non-Active Duty had at least one recorded primary care visit. Patient-Centered Medical Home (PCMH) primary care administrative measures remained constant in provider and team continuity; favorably declined in average days to third next 24-hour or acute appointments, but still remained higher than the 24-hour standard; continued to meet the seven-day standard for future appointments; and improved in reduced inpatient bed days per 1,000 enrollees. DHA and Service surveys of beneficiary outpatient experience generally show strong and stable ratings of access to care. Population-based surveys indicate that, between FY 2013 and FY 2015, ratings for getting referrals to specialists improved and remained stable for getting needed care, but declined for getting care quickly and getting timely appointments, as did the civilian benchmarks (ref. pages 35, 37–44).
  - **MHS Provider Trends:** The number of TRICARE network providers increased by 19 percent from FY 2011 to FY 2015. The total number of participating providers increased by 10 percent over that same time period (ref. page 69).
  - **Access for TRICARE Standard/Extra Users:** Eight of 10 physicians accept new TRICARE Standard patients, a higher acceptance than reported for behavioral health providers (ref. page 70).
- **Quality of Care—National Hospital Quality Measures:** Military treatment facility (MTF)- and MHS-supporting civilian hospitals report many Joint Commission quality measures that are comparable to the national standards (ref. pages 47–60).
- **Beneficiary Ratings of Inpatient and Outpatient Care:** MHS beneficiaries generally rate the TRICARE health plan higher than the average civilian benchmark CAHPS rating, while lagging average civilian ratings for providers of overall care (ref. page 52).
- **Patient Safety:** Accepting the challenge set by the Partnerships for Patients (PfP) Initiative in 2011, MHS reduced hospital-acquired conditions by a cumulative 17 percent by the end of CY 2014 (ref. pages 61–63).

Better Health

- MHS continues to exceed some population health measures, such as Healthy People (HP) 2020 goals for mammograms for women, obesity, prenatal exams, and the non-smoking rate (ref. pages 73–74).

[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.

WHAT IS TRICARE?

TRICARE is the DoD health care program serving 9.5 million Active Duty Service members (ADSMs), National Guard and Reserve members, retirees, their families, survivors, and certain former spouses worldwide (http://www.tricare.mil/Welcome.aspx?sc_database=web). As a major component of the Military Health System (MHS; www.health.mil), TRICARE brings together the worldwide health care resources of the Uniformed Services (often referred to as "direct care," usually in military treatment facilities, or MTFs) and supplements this capability with network and non-network participating civilian health care professionals, institutions, pharmacies, and suppliers (often referred to as "purchased care") to provide access to high-quality health care services while maintaining the capability to support military operations.

In addition to providing care from MTFs, where available, TRICARE offers beneficiaries a family of health plans, based on three primary options:

- **TRICARE Standard** is the non-network benefit, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), open to all eligible DoD beneficiaries, except ADSMs. Beneficiaries who are eligible for Medicare Part B are also covered by TRICARE Standard for any services covered by TRICARE but not covered by Medicare. An annual deductible (individual or family) and cost shares are required.
- **TRICARE Extra** is the network benefit for beneficiaries eligible for TRICARE Standard. When non-enrolled beneficiaries obtain services from TRICARE network professionals, hospitals, and suppliers, they pay the same deductible as TRICARE Standard; however, TRICARE Extra cost shares are reduced by 5 percent. TRICARE network providers file claims for the beneficiary.
- **TRICARE Prime** is the health maintenance organization-like benefit offered in many areas. Each enrollee chooses or is assigned a primary care manager (PCM), a health care professional who is responsible for helping the patient manage his or her care, promoting preventive health services (e.g., routine exams, immunizations), and arranging for specialty provider services as appropriate. Access standards apply to waiting times to get an appointment and waiting times in doctors' offices. A point-of-service (POS) option permits enrollees to seek care from providers other than the assigned PCM without a referral, but with significantly higher deductibles and cost shares than those under TRICARE Standard.
- **Other plans and programs:** Some beneficiaries may qualify for other benefit options depending on their location, Active/Reserve status, and/or other factors. These plans and programs provide additional benefits or offer benefits that are a blend of the Prime and Standard/Extra options with some limitations. Some examples are:
  - The premium-based TRICARE Young Adult (TYA) Program available to qualified dependents up to the age of 26;
  - Dental benefits (military dental treatment facilities, claims management for Active Duty using civilian dental services, as well as the premium-based TRICARE Dental Program [TDP] and the TRICARE Retiree Dental Program [TRDP]);
  - Pharmacy benefits in MTFs, via TRICARE retail network pharmacies, and through the TRICARE Pharmacy Home Delivery program (formerly called TRICARE Mail Order Pharmacy);
  - Overseas purchased care and claims processing services;
  - Programs supporting the Reserve Components (RCs), including the premium-based TRICARE Reserve Select (TRS) or TRICARE Retired Reserve (TRR) for those who are retired from Reserve status but not yet eligible for the TRICARE benefits as a military retiree;
  - Supplemental programs including TRICARE Prime Remote (TPR) in the United States and overseas, DoD-Veterans Affairs (VA) sharing arrangements, and joint services;
  - Designated Provider/Uniformed Services Family Health Plan (USFHP), which provides the full TRICARE Prime benefit, including pharmacy, under capitated payment to non-Active Duty MHS enrollees at six statutorily specified locations: Washington, Texas, Maine, Massachusetts, Maryland, and New York;
  - Clinical and educational services demonstration programs (e.g., chiropractic care, autism services, and TRICARE Assistance Program); and
  - Other programs, including the premium-based Continued Health Care Benefit Program, providing a Consolidated Omnibus Budget Reconciliation Act-like benefit, and the Transitional Assistance Management Program, which allows RC members who have served more than 30 consecutive days in support of a Contingency Operation, or certain Active Component members separating from Active Duty, continued access to the TRICARE benefit for 180 days after release from Active Duty.

HOW TRICARE IS ADMINISTERED

TRICARE is administered on a regional basis, with three regional contractors in the United States and an overseas contractor working with their TRICARE Regional Offices (TROs) to manage purchased care operations and coordinate medical services available through civilian providers with the MTFs. The TROs do the following:

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

NEW BENEFITS AND PROGRAMS IN FY 2015 SUPPORTING THE MHS QUADRUPLE AIM

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

DHA Reaches Full Operating Capability on Its Two-Year Anniversary

On October 1, 2015, two years after the agency was first established, the DHA celebrated its achievement of full operating capability. The DHA's combat support mission is to have a medically ready force and a ready medical force at all times, fully supported by a better, stronger, more relevant MHS. The results so far include improved delivery of services with substantial savings to DoD and the taxpayer—$350 million in FY 2014, and nearly $3.5 billion in savings projected over the next four years. The agency was built, and is staffed, by dedicated professionals from the Services and from career civilian staff who are determined to see this agency succeed.

The last offices to be added, on August 23, 2015, were the National Museum of Health and Medicine (NMHM), the Armed Forces Health Surveillance Center (AFHSC), and the Armed Forces Medical Examiner System (AFMES). NMHM and AFMES are now part of the Research, Development & Acquisition Directorate, and AFHSC is part of the Healthcare Operations Directorate.

NMHM, founded as the Army Medical Museum in 1862, is home to a National Historic Landmark collection of more than 25 million objects. It was instituted as a center for the study of battlefield medicine during the Civil War, and has made several historic contributions to the field of military medicine since that time, including the x-ray. AFMES provides worldwide comprehensive medicolegal services and investigations, with Board-certified forensic pathologists, forensic anthropologists, medical-legal death investigators, and photographers conducting forensic investigations into military deaths throughout the world. AFHSC became the Armed Forces Health Surveillance Branch, and serves as a central, integrated, and customer-focused epidemiological resource for DoD, and as a global health surveillance resource for the U.S. Armed Forces.

Managed Care Support (MCS) Contracts

DHA Proposes Cutting TRICARE Regions from Three to Two

DHA is proposing to cut the number of TRICARE regions from three to two, a cost-saving plan that would sharply increase competition for the next round of lucrative Pentagon health care contracts.

DoD released a solicitation in April 2015 with plans to change the contract regions from the current configuration of North, South, and West to just East (combining the prior North and South regions) and West, with the two regions managed under different companies. The proposals are due in February 2016 for the next generation of TRICARE contracts, which will likely begin a base period of performance that year.

DHA Launches the Fourth Generation Pharmacy Contract

The fourth generation TRICARE pharmacy contract, or "TPharm4," kicked off on May 1, 2015. The contractor, Express Scripts, Inc. (ESI), provides pharmacy benefits management services, including administering a retail pharmacy network, mail order pharmacy operations, claims processing, and beneficiary support services. Under TPharm4, ESI for the first time provides a number of support functions to the direct care system. ESI now processes pharmacy claims at MTF pharmacies for improved integration between direct care and purchased care, as well as brings an enhanced, industry-standard drug-interaction screening capability, which improves patient safety standards. The deployment prescription program is also now managed by the contractor, providing prescription drugs to deployed Service members and beneficiaries through the mail order pharmacy program.

DoD Contracts Leidos to Improve Interagency Operations

DoD awarded a $4.3 billion contract to Leidos, Inc., to improve current interoperability among DoD, VA, and private sector health-care providers, and to enable each to access and update health records.

The new contract will cover more than 9.4 million DoD beneficiaries and the more than 205,000 care providers that support them. It is based on protocols established by the Office of the National Coordinator for Health IT and the DoD/VA interagency program office. It will operate in DoD hospitals and clinics as well as remote places such as Afghanistan, and will replace up to 50 legacy systems.

The contract ensures that DoD and VA will continue to be interoperable by including future software upgrades. It also includes training to ensure staff are prepared to use it effectively.

The next step is to test the software to ensure it is secure and does what is needed. The contractor will begin fielding the system at eight locations in the

Pacific Northwest covering each of the Services in late 2016. Ultimately, it will be fielded at more than 1,000 worldwide locations. The cost over 18 years will be between $9 billion and $11 billion.

TRICARE Coverage and the Affordable Care Act (ACA)

For the first time, all U.S. citizens, including Service members, their families, and military retirees were required to self-attest health care coverage on their 2014 taxes. The Services' pay centers issued forms reflecting medical coverage, much the same way employees receive their W2s. TRICARE coverage meets the ACA criteria for minimum essential coverage for the majority of service members and their families.

QUADRUPLE AIM: INCREASED READINESS

U.S. Response at Home and Abroad

In September 2014, the U.S. military sent assistance to combat the Ebola outbreak in West Africa. The U.S. sent nearly 3,000 troops, trained more than 1,500 health care workers, built 10 Ebola Treatment Units (ETUs) in the region, and helped with the construction of four others in West Africa. DoD leadership created comprehensive pre- and post-deployment screening guidance, and military personnel coming home from affected areas were placed into a 21-day controlled monitoring regimen.

QUADRUPLE AIM: BETTER CARE

Improving Communication and Reducing Errors

An estimated 80 percent of serious medical errors involve miscommunication between caregivers during the transfer of patients. In addition to causing patient harm, this can lead to delays in treatment, inappropriate treatment, and increased length of stay in the hospital. To combat this problem, Walter Reed National Military Medical Center (WRNMMC) and the Uniformed Services University of Health Sciences (USU) were part of the team developing I-PASS—"Illness severity, Patient summary, Action list, Situational awareness and contingency planning, and Synthesis"—a system of bundled communication and team-training tools for the handoff of patient care between providers. WRNMMC is the first military hospital to adopt this system, and a WRNMMC and USU study showed a 30 percent reduction in injuries due to medical errors after implementation.

DHA Gives Separating Service Members and Their Families More Time to Access Important Medical Information

TRICARE sponsors, spouses, and dependents 18 years and older have access to their personal information, health care enrollments, eligibility, and other information through MilConnect, an online resource provided by the Defense Manpower Data Center (DMDC). Although separating Service members lose their Common Access Card and account access to MilConnect upon separation, their DoD Self-Service (DS) Logon does not expire and can still be used to access MilConnect. As of December 2014, DMDC is giving prior eligible family members six additional months to sign up for a DS Logon for use in accessing MilConnect after their sponsor's separation.

MHS Partners with Civilian and Sports Traumatic Brain Injury Programs

According to the Centers for Disease Control and Prevention, each year 1.7 million people are diagnosed with a brain injury. The most common form of traumatic brain injury (TBI), even for the military, is mild TBI (also referred to as a concussion), and the vast majority occur at home. The Defense and Veterans Brain Injury Center reports that from 2000 to 2014, more than 313,000 Service members were diagnosed with TBI, most of which were mild.

The National Collegiate Athletic Association (NCAA) and DoD are currently sponsoring the Mind Matters Challenge, a landmark initiative to enhance the safety of student-athletes and Service members. The partnership is the most comprehensive study of concussion and head impact exposure ever conducted.

For TBI patients, TRICARE covers rehabilitative services, and DoD offers a variety of products, such as clinical recommendations, tool kits, and mobile applications to assist health care providers in the diagnosis, evaluation, and treatment of patients with mild TBI. Early diagnosis of TBI, as well as evaluation and treatment, can shorten return-to-duty time and lead to the best possible outcome for those entrusted to our care.

MHS Deploys Electronic Prescribing in Military Pharmacies in the United States, including Guam and Puerto Rico

MHS has deployed electronic prescribing in military pharmacies in the United States, including Guam and Puerto Rico. This capability allows civilian providers to send prescriptions for noncontrolled substances electronically to military pharmacies, reducing the need for handwritten prescriptions, just as in MTFs. Electronic prescriptions allow the pharmacist to resolve issues before the patient arrives.

State of Emergency

When a state of emergency is declared in a region, emergency prescription refill procedures are put into place. To get an emergency refill, beneficiaries may take their prescription bottle to any TRICARE retail network pharmacy.

The following table lists the states that declared a state of emergency (in at least part of the state) during the past year and the time in which it applied. For more information, please see the TRICARE Web site.

California (Wildfires)	Sept. 11–Oct. 11, 2015 July 31–Aug. 29, 2015
Washington (Wildfires)	Aug. 21–Sept. 20, 2015
Iowa (Severe Weather)	June 24–July 24, 2015
Florida (Tropical Storm Erika)	Aug. 28–Sept. 27, 2015
Missouri (Flooding)	June 18–July 18, 2015
Alaska (Wildfires)	June 16–July 16, 2015
Oklahoma (Severe Weather and Flooding)	May 26–June 25, 2015
Texas (Severe Weather and Flooding)	May 26–June 25, 2015

TRICARE Outpatient Behavioral Health Care Available for Beneficiaries

TRICARE Prime beneficiaries can get routine primary care appointments to assess behavioral health within seven calendar days and within 30 minutes' travel time. They can use their primary care manager, a mental health provider at their primary care clinic, a behavioral health care provider in the MTF, or a TRICARE-authorized provider in the community. Following the initial behavioral health assessment, referrals for additional care are provided within four weeks or 28 days, unless the referring provider determines more urgent care is needed.

All other beneficiaries can schedule an appointment with any TRICARE-authorized provider. Beneficiaries do not need referrals for mental health care appointments; however, after the eighth outpatient visit, they will need prior authorization. For more information about TRICARE's mental health resources, visit http://www.tricare.mil/mentalhealth. To download the Behavioral Health Care Services Fact Sheet, go to http://www.tricare.mil/~/media/Files/TRICARE/Publications/FactSheets/Mental_Health_FS.pdf.

QUADRUPLE AIM: BETTER HEALTH

New TRICARE Lactation Policy

On July 1, 2015, TRICARE's new lactation policy was implemented. The new provision stems from the National Defense Authorization Act (NDAA) FY 2015, and provides for cost-sharing and copays to be waived for eligible beneficiaries. The legislation fixed a discrepancy between coverage for breast-feeding expenses in the ACA (which requires insurers to cover the full cost of renting or providing pumps as well as counseling and support) and those of TRICARE, which previously paid only for hospital-quality breast pumps for use in medical facilities and under certain conditions for premature infants. The cost for a manual or standard electric breast pump, related pump supplies, and up to six one- to two-hour lactation counseling sessions, will be covered, retroactive to December 19, 2014, when the act was signed into law.

Webinars

One method TRICARE uses to reach out to beneficiaries is through Webinars. Webinars allow participants to listen to featured speakers and ask questions, no matter their location. Over the past year, TRICARE and Military OneSource have hosted the following Webinars:

- Overview of Childhood and Adolescent Immunizations
- Women's Health
- Mental Health Benefits and Autism Care Demonstration
- Health Care Options when TRICARE Eligibility Ends
- Military Health Systems Health Innovations
- TRICARE Pharmacy Options
- Moving Made Easy
- Spring Forward but Stay Rested
- Using TRICARE and Other Health Insurance
- TRICARE Dental Options
- TRICARE Dental Options for Children
- TRICARE and the Affordable Care Act
- Suicide Prevention

TRICARE Coverage for Applied Behavior Analysis (ABA) Pilot Transitions to New TRICARE Autism Care Demo (ACD)

TRICARE extended the coverage for the TRICARE ABA Pilot until December 31, 2014, when beneficiaries transitioned to the new TRICARE ACD. The law creating the TRICARE ABA Pilot expired on July 24, 2014, and ACD technically kicked off on July 25, but did not go into effect until the end of the year. TRICARE used the time to flesh out all the details of the program and fully educate affected beneficiaries about the new benefit. The delay also allowed beneficiaries in each of the three current ABA programs to transition to this single unified benefit.

Beneficiaries covered under the ABA Pilot, the ABA Demo, and TRICARE Basic coverage of ABA did not need to do anything to continue their coverage. They, as well as any new enrollees, transitioned seamlessly to the ACD, and TRICARE worked with their ABA providers to get new referrals and authorization when needed. More info is at www.tricare.mil/ACD.

QUADRUPLE AIM: LOWER COST

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

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

TRICARE Prime Enrollment Fees Frozen for Certain Beneficiary Categories

Effective October 30, 2014, there is an exception to the rule that TRICARE Prime enrollment fees are uniform for all retirees and their dependents.

Survivors of Active Duty Deceased Sponsors and Medically Retired Uniformed Services Members and their dependents are part of the retiree group under TRICARE rules. In acknowledgment and appreciation of the sacrifices of these two beneficiary categories, the Secretary of Defense exempted them and their dependents enrolled in TRICARE Prime from paying future increases to the TRICARE Prime annual enrollment fees.

Beneficiaries who enrolled in TRICARE Prime will have their annual enrollment fee frozen at the appropriate fiscal year rate: FY 2011 rate of $230 per single or $460 per family; FY 2012 rate of $260 or $520; FY 2013 rate of $269.38 or $538.56; or FY 2014 rate of $273.84 or $547.68. Future beneficiaries added to these categories will have their fee frozen at the rate in effect at the time they are classified and the rate in effect at the time of enrollment. The fee remains frozen as long as at least one family member remains enrolled in TRICARE Prime and there is not a break in enrollment. The fee charged for the dependent(s) of a Medically Retired Uniformed Services Member would not change if the dependent(s) was later re-classified a Survivor.

TRICARE Dental Program (TDP) Fees Increase

The annual increases for the TDP went into effect on February 1, 2015. Under the TDP, there is a $1,300 annual maximum benefit per beneficiary, per plan year for nonorthodontic services. The TDP monthly premium rates for Active Duty are (http://www.tricare.mil/Costs/DentalCosts/TDP/Premiums.aspx):

	ENROLLED BETWEEN FEBRUARY 2015 AND JANUARY 2016	ENROLLED BETWEEN FEBRUARY 2016 AND JANUARY 2017
Individual	$11.30	$11.68
Family	$33.88	$34.68

Small Increase to TRICARE Pharmacy Copays

New copayments for prescription drugs covered by TRICARE went into effect February 1, 2015. The FY 2015 NDAA required TRICARE to increase most pharmacy copays by $3. Drugs from military pharmacies and generic drugs from TRICARE Pharmacy Home Delivery still cost beneficiaries $0.

TRICARE pharmacy copays vary based on a three-tier formulary placement system (generally classified as generic, brand, and non-formulary). Home Delivery copays for formulary brand name drugs went from $13 to $16, and for non-formulary from $43 to $46. Beneficiaries can get up to a 90-day supply of drugs through Home Delivery. At the retail pharmacy network, copays for generic formulary drugs went from $5 to $8, brand name formulary from $17 to $20, and non-formulary from $44 to $47. Beneficiaries can get up to a 30-day supply of drugs at retail pharmacies for each copay amount.

New Pharmacy Policy

Under an interim rule published by DoD in August 2015, following the change mandated in the FY 2015 NDAA, TRICARE began requiring beneficiaries to use the mail order system or a military pharmacy to refill select non-generic prescription maintenance medications. In September, Express Scripts notified beneficiaries taking an affected drug that beginning October 1, they would no longer be able to fill maintenance drug prescriptions at retail pharmacies unless they wished to pay the full cost, and explaining their options. After October 1, beneficiaries still filling an affected drug at a retail pharmacy received additional notification of the change and one final "courtesy" fill before having to pay 100 percent of the cost of their medication. The DoD estimates this program could save the government at least $88 million a year, but will help beneficiaries as well, with an estimated beneficiary savings of $176 per year. The law does not apply to short-term prescriptions or other special needs. For more information about this change to TRICARE's pharmacy benefit, visit www.tricare.mil/RxNewRules.

DHA Promotes Capital Area MHS Beneficiaries' Enrollment in MTFs

There are 450,000 TRICARE-eligible beneficiaries residing in the Washington, D.C., area, of which about 250,000 are enrolled in Prime. Enrolling beneficiaries in MTF-based Prime reduces their out-of-pocket costs, increases productivity of MTF providers, enhances medical research and graduate education, and hones their medical skills with a broad range of patient needs, while reducing purchased care costs. The first phase of the effort began with 57,000 military households in the National Capital Region receiving information promoting the facilities, features, and services available at military hospitals and clinics in the area. DHA plans to roll out similar initiatives in cities with significant military populations tailored to the military health care market in those regions.

DHA Reminds Beneficiaries with Commercial Insurance to Provide Policy Information to TRICARE Providers

DHA released an announcement to remind its health care beneficiaries who carry commercial health insurance to provide their policy information to their TRICARE providers. By law, commercial health care insurance companies pay first and TRICARE pays second on medical bills. When commercial health

care insurers pay first, it saves DoD and insured patients money, because beneficiaries will have little to no copayment.

DoD surveys show that about 14 percent of retirees and spouses who work receive employer-sponsored coverage.

Preventing Fraud and Abuse

DHA Acts to Counter Increases in Deceptive Compounding Drug Claims

DHA announced it was taking aggressive action to counter huge increases in deceptive compounding drug claims. On May 1, 2015, TRICARE's pharmacy benefits manager, Express Scripts, began a new screening process of all ingredients in compound drugs. This follows a policy change allowing DHA to determine whether prescriptions meet coverage criteria by requiring all ingredients in compounded medications to be approved by the U.S. Food and Drug Administration (FDA). This ensures that TRICARE pays only for compounds proven to be safe and effective, and complies with policy prohibiting TRICARE from paying for procedures and medications not approved by the FDA. The DHA saw reimbursements for approved compounds drop from over $1 billion in the first four months of 2015 to a monthly average of around $9 million for the last four months of the fiscal year.

If a compound does not pass an initial screening, the pharmacist can switch a nonapproved ingredient with an approved one, or request the doctor write a new prescription. Beneficiaries whose compounded medications are rejected by the system are able to request prior authorization or, if they are denied, appeal the decision. Beneficiaries using a compound drug likely to be impacted by the change received notification explaining the new process and steps to be followed.

Many private insurers, as well as Medicare and the VA, either do not cover compounded medications or cover only those that are in their unique formulary list of covered drugs.

Leading up to the new TRICARE policy on compounding medications, aggressive marketing campaigns by some compounding pharmacy companies cold-called TRICARE beneficiaries or contacted them directly to collect their personal information and sell them specialty prescriptions for ailments such as pain, skin disorders, and erectile dysfunction. Once they had the information, it was used to bill TRICARE as much as $15,000 for a single compound prescription. Several Web sites were falsely created to look like TRICARE Web sites, in order to get the information. TRICARE began warning beneficiaries of these practices at the end of 2014, and advised beneficiaries to notify the Express Scripts fraud line if they were contacted.

Fraudulent Secret Shopper Offer

The DHA, Office of Program Integrity (DHA-PI) has received a significant number of return envelopes from mailings by a bogus organization identifying themselves as TRICARE SURVEY INC., to TRICARE beneficiaries across the country and attempting to solicit beneficiaries to be "Secret Shoppers" for TRICARE. TRICARE does not employ "Secret Shoppers." Enclosed in the mailing is a form letter claiming to be a solicitation for a position as a Trainee Independent Private Evaluator, a counterfeit TRICARE WPS check for $3,775, and an instruction/survey form on how the beneficiary gets the check authorized through the company's agent via phone. Beneficiaries are directed to cash the check at their local bank, retain a percentage of the money, and utilize the remaining amount to purchase six "Vanilla Reload" cards at $500 apiece at various stores across the country. The "Secret Shopper" is instructed to provide the company agent with the card numbers once they are bought, complete the survey and mail it, and wait for the next assignment. Once money has been loaded onto the card, however, they are immediately available for transfer and the bogus company zeros out the monies on the cards. TRICARE will identify the checks as counterfeit through a positive check controls process and return them to the bank in which they were drawn from as non-cashable. Potential exists for the beneficiary to be personally liable for the entire $3,775 in restitution to the bank.

Access our Fraud Reporting by clicking the "Report Health Care Fraud" button at www.health.mil/fraud.

Nationwide Telephone Scam

TRICARE beneficiaries need to be aware of a telephone scam affecting beneficiaries over the age of 65 and on Medicare nationwide.

Callers will usually identify themselves as being an official Medicare vendor, and will then offer to sell back braces. The caller is hoping to get social security numbers and additional personal information such as birth date or banking information. TRICARE never asks beneficiaries for this information when calling for an official Department of Defense survey.

For more information on fraud and abuse reporting, visit http://www.tricare.mil/fraud.

BENEFICIARY TRENDS AND DEMOGRAPHICS

System Characteristics

TRICARE FACTS AND FIGURES—PROJECTED FOR FY 2016[a]

	PROJECTED FOR FY 2016	FY 2015 (AS PROJECTED LAST YEAR)
Total Beneficiaries	**9.4 million[b]**	**9.5 million**
MILITARY FACILITIES—DIRECT CARE SYSTEM	TOTAL[c,d] U.S.	TOTAL U.S.
Inpatient Hospitals and Medical Centers	**55 (41 in U.S.)**	55 (41 in U.S.)
Ambulatory Care and Occupational Health Clinics	**373 (315 in U.S.)**	373 (315 in U.S.)
Dental Clinics	**251 (201 in U.S.)**	264 (210 in U.S.)
Veterinary Facilities	**253 (198 in U.S.)**	253 (198 in U.S.)
Military Health System (MHS) Defense Health Program–Funded Personnel	**149,116[e]**	151,785
Military	**84,104**	84,564
	31,396 Officers	31,500 Officers
	52,708 Enlisted	53,064 Enlisted
Civilian	**65,012**	67,221
CIVILIAN RESOURCES—PURCHASED CARE SYSTEM[f]		
Network Primary Care, Behavioral Health, and Specialty Care Providers (i.e., individual, not institutional, providers)	**554,439**	550,194
Network Behavioral Health Providers (shown separately, but included in above)	**81,780**	68,465
TRICARE Network Acute Care Hospitals	**3,789**	3,812
Behavioral Health Facilities	**803**	1,757
Contracted (Network) Retail Pharmacies	**58,142**	59,670
Contracted Worldwide Pharmacy Home Delivery Vendor	**1**	1
TRICARE Dental Program (TDP) (for Active Duty families, Reservists and families)	**Over 1.8 million covered lives, in almost 790,000 contracts**	About 2.0 million covered lives, in over 790,000 contracts
TDP Network Dentists	**Over 95,000 total dentists, including:**	90,901 total dentists
	76,000 general dentists	72,484 general dentists
	19,000 specialists	18,437 specialists
TRICARE Retiree Dental Program (for retired Uniformed Services members and families)	**Over 1.4 million covered lives, in over 758,000 contracts**	Over 1.4 million covered lives, in over 721,000 contracts
Total Unified Medical Program (UMP)	**$48.0 billion[e]**	**$48.5 billion**
(Includes FY 2016 Normal Cost Contribution)	**$6.6 billion**	**$7 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.

[b] Department of Defense (DoD) health care beneficiary population projected for mid–fiscal year (FY) 2016 is 9,427,000, rounded to 9.4 million, and is based on Director, Defense Health Agency (DHA) Memo dated January 7, 2016, "Estimate of Beneficiaries Eligible for Health Care in Fiscal Year 2016."

[c] Military treatment facility (MTF) data includes 13 Occupational Health Clinics and is as of December 2015 from DHA Business Support Directorate, Facility Planning, 12/30/2015

[d] Excludes leased/contracted facilities and Aid Stations, but does include Active Duty (AD) troop clinics and Occupational Health Clinics.

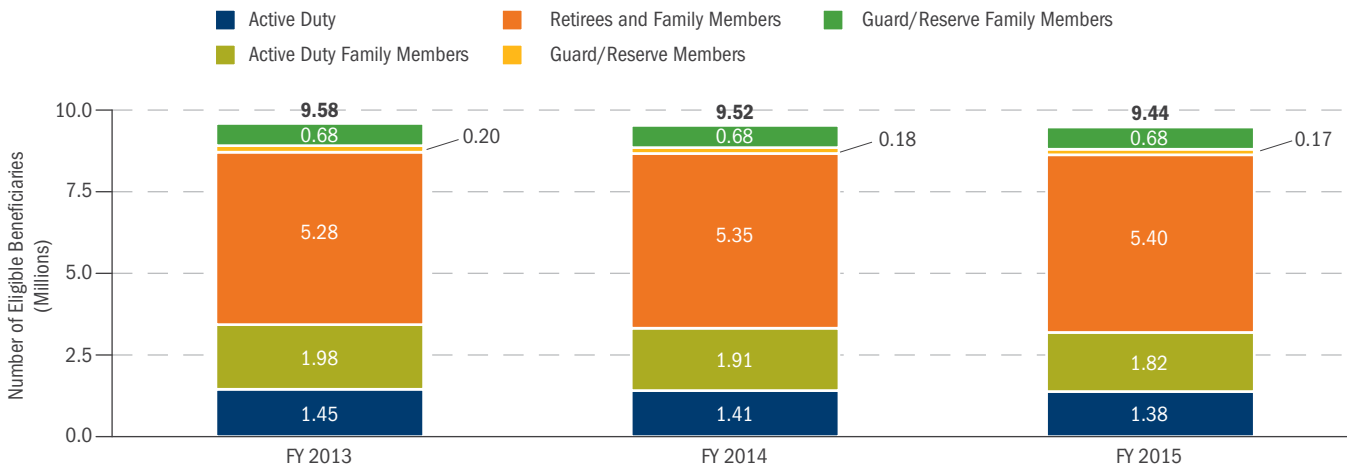
[e] Includes direct and private-sector care funding, military personnel, military construction, and the Medicare-Eligible Retiree Health Care Fund (MERHCF) ("Accrual Fund"). DoD Normal Cost Contribution paid by the U.S. Treasury, as of 11/25/2015. Defense Health Program–funded MHS personnel from DHA Business Support Directorate, 12/3/2015, reflecting FY 2016 President's Budget.

[f] As reported by TRICARE Regional Offices (TROs) for contracted network provider and hospital data (10/26/2015), and by TRICARE Dental Office, Health Plan Execution and Operations for dental provider data (12/14/2015).

Number of Eligible and Enrolled Beneficiaries Between FY 2013 and FY 2015

The number of beneficiaries eligible for DoD medical care (including TRICARE Reserve Select [TRS], TRICARE Young Adult [TYA], and TRICARE Retired Reserve [TRR]) fell from 9.58 million at the end of FY 2013 to 9.44 million[1] at the end of FY 2015. The decline was primarily due to a drawdown in the number of Active Duty and Guard/Reserve personnel, with a consequent decline in the number of family members.[2] Compensating somewhat for the downturn in the latter beneficiary groups was an increase in the number of retirees and family members (RETFMs), especially those age 65 and older (numbers included but not shown separately in the chart below).

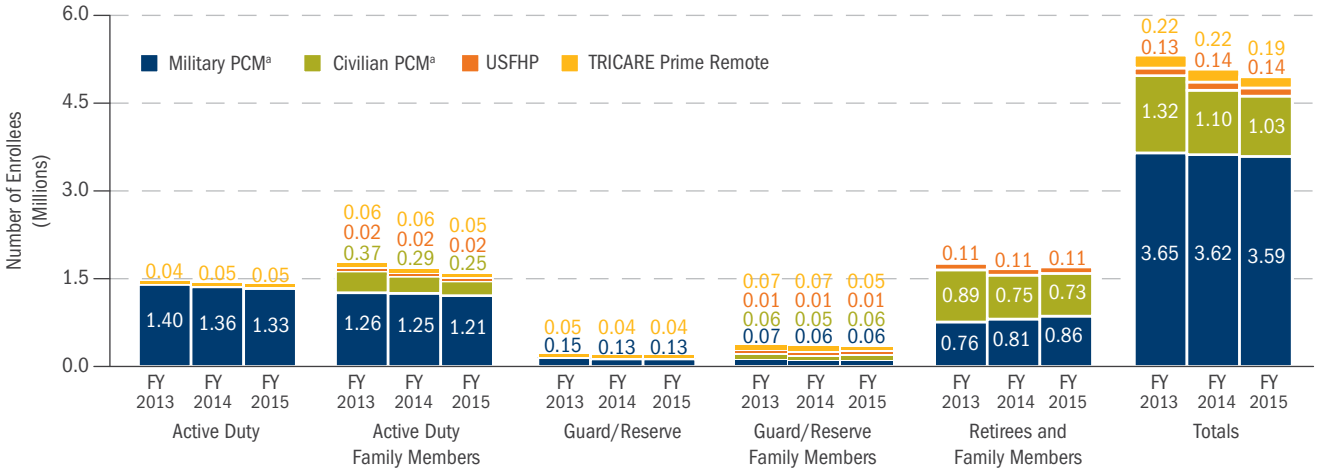
TRENDS IN THE END-YEAR NUMBER OF ELIGIBLE BENEFICIARIES BY BENEFICIARY GROUP



Source: Defense Enrollment Eligibility Reporting System (DEERS), 1/6/2016

- Declines in Prime and TRICARE Prime Remote (TPR) enrollment are due primarily to corresponding declines in the Active Duty and Guard/Reserve populations and their family members.
- Uniformed Services Family Health Plan (USFHP) enrollment increased slightly, overall and across beneficiary groups, from FY 2013 to FY 2015.

TRENDS IN THE END-YEAR NUMBER OF ENROLLED BENEFICIARIES BY BENEFICIARY GROUP



Source: DEERS, 1/6/2016

[a] Primary care manager

[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 2016 total, whereas the population reported on this page is the actual for the end of FY 2015.

[2] In this year's report, both inactive Guard/Reserve members and their families are included under Guard/Reserve Family Members because their benefits are similar to that of family members. This differs from previous reports, in which they were included under Guard/Reserve Members and Guard/Reserve Family Members, respectively.

Beneficiary Plan Choice by Age Group and Beneficiary Category

Although Prime and Standard/Extra are the primary choices for most TRICARE beneficiaries, several other options are available to those who do not qualify for those benefits. Of the 9.4 million eligible beneficiaries, approximately 7.5 million (or 79 percent) were enrolled in one or more of the plans below.[1] Plan choice varied by age group and beneficiary category.

PLAN CHOICE BY AGE GROUP (END OF FY 2015)

PLAN TYPE	0–17	18–24	25–44	45–64	≥65	TOTAL[a]
Prime	1,316,894	895,761	1,535,455	1,055,700	2,278	4,806,088
USFHP	28,949	7,501	15,238	45,210	45,772	142,670
TRS	135,110	32,705	157,862	31,619	125	357,421
TRR	1,475	808	463	3,390	13	6,149
TFL	0	0	0	0	2,103,868	2,103,868
Plus	5,554	1,770	3,152	16,796	170,103	197,375
TYA Prime	0	23,272	5,448	0	0	28,720
TYA Standard	0	15,228	3,555	0	0	18,783
Multiple Plans	0	–874	–159	0	–207,996	–209,029
Total Enrolled	1,487,982	976,171	1,721,014	1,152,715	2,114,163	7,452,045
Non-Enrolled	472,299	186,670	316,872	928,280	81,957	1,986,078
Total	**1,960,281**	**1,162,841**	**2,037,886**	**2,080,995**	**2,196,120**	**9,438,123**

Source: DEERS, 1/6/2016

- About one-third of USFHP enrollees are seniors (age ≥65), and one-fifth are children (age 0–17).
- The vast majority of those age 65 and above are enrolled in Medicare Part B and are covered by TRICARE for Life (TFL) as their supplemental plan. About 8 percent of seniors covered by TFL are also enrolled in TRICARE Plus, the primary care–only plan available at selected MTFs.
- Beneficiaries aged 45 to 64 had the lowest TRICARE enrollment rate, at 55 percent. Enrollment rates for the other age groups were 76 percent for 0–17, 85 percent for 18–24, 84 percent for 25–44, and 96 percent for 65 and older.

PLAN CHOICE BY BENEFICIARY CATEGORY (END OF FY 2015)

PLAN TYPE	AD/GRD	ADFM/GRDFM[b]	RET/RETFM <65	RET/RETFM ≥65[c]	TOTAL[a]
Prime	1,542,202	1,676,578	1,585,728	1,580	4,806,088
USFHP	91	30,467	66,352	45,760	142,670
TRS	352	355,882	1,187	–	357,421
TRR	3	5	6,128	13	6,149
TFL	0	0	0	2,103,868	2,103,868
Plus	27	3,069	24,965	169,314	197,375
TYA Prime	0	3,685	25,035	0	28,720
TYA Standard	0	2,608	16,175	0	18,783
Multiple Plans	0	–864	–169	–207,996	–209,029
Total Enrolled	1,542,675	2,071,430	1,725,401	2,112,539	7,452,045
Non-Enrolled	0	428,328	1,478,619	79,131	1,986,078
Total	**1,542,675**	**2,499,758**	**3,204,020**	**2,191,670**	**9,438,123**

Source: DEERS, 1/6/2016

[a] The totals in the right-hand columns of the above tables 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] Inactive Guard/Reserve and their family members eligible for TRICARE are included in the Active Duty family member (ADFM)/Guard/Reserves and Family Members (GRDFM) group.

[c] This column total does not match the "≥65" total in the top table because the latter includes a small number of Active Duty family members age 65 and older.

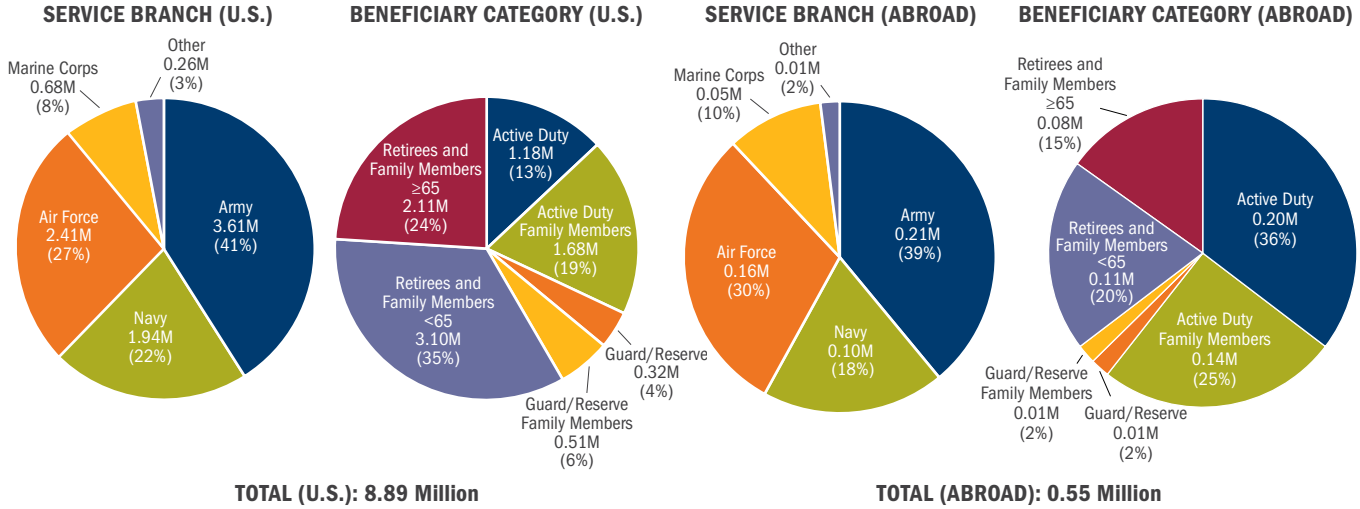
- Three percent of RETFMs under the age of 65 are enrolled in plans other than Prime or Standard/Extra (including TYA Prime and Standard).
- Sixteen percent of ADFM/GRDFMs are enrolled in plans other than Prime or Standard/Extra. The vast majority are inactive Guard/Reserves and family members enrolled in TRS.
- The large majority of beneficiaries enrolled in TYA are children of retirees under the age of 65 (most Active Duty members are not old enough to have children in the requisite age group). TYA Prime is the favored plan for those enrolled in TYA.
- About 80 percent of beneficiaries enrolled in the USFHP are RETFMs, most of whom are under age 65. The USFHP is available at only six sites nationwide, so enrollment is low relative to Prime.

[1] Some beneficiaries use more than one plan (e.g., some TFL-eligible beneficiaries are also enrolled in TRICARE Plus). To avoid double-counting when summing beneficiary counts over plan types, the numbers with multiple plans are displayed as negatives so that the totals equal the number of unique beneficiaries.

Eligible Beneficiaries in FY 2015

- Of the 9.44 million eligible beneficiaries at the end of FY 2015, 8.89 million (94 percent) were stationed or resided in the United States (U.S.), and 0.55 million were stationed or resided abroad. The Army has the most beneficiaries eligible for Uniformed Services health care benefits, followed (in order) by the Air Force, Navy, Marine Corps, and other Uniformed Services (Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration). Although the proportions are different, the Service rankings (in terms of eligible beneficiaries) are the same abroad as they are in the U.S.
- Whereas retirees and their family members constitute the largest percentage of the eligible population (59 percent) in the U.S., Active Duty personnel (including Guard/Reserve Component [RC] members on Active Duty for at least 30 days) and their family members make up the largest percentage (65 percent) of the eligible population abroad. The U.S. MHS population is presented at the state level on page 19, reflecting those enrolled in the Prime benefit and the total population, enrolled and non-enrolled.
- Mirroring trends in the civilian population, MHS is confronted with an aging beneficiary population.

BENEFICIARIES ELIGIBLE FOR DoD HEALTH CARE BENEFITS AT THE END OF FY 2015

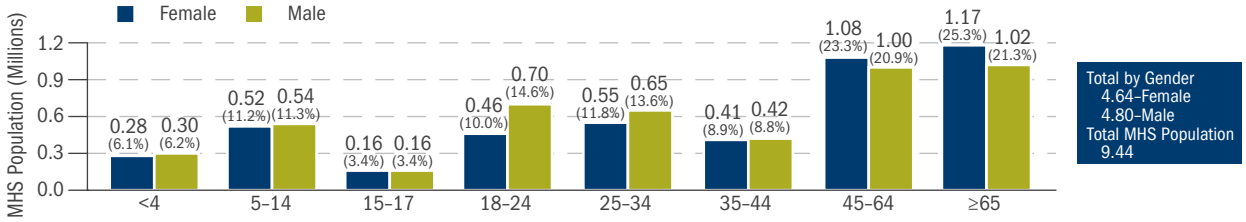


TOTAL (U.S.): 8.89 Million **TOTAL (ABROAD): 0.55 Million**

Source: DEERS, 1/6/2016

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

FY 2015 MHS END-YEAR POPULATION BY AGE GROUP AND GENDER



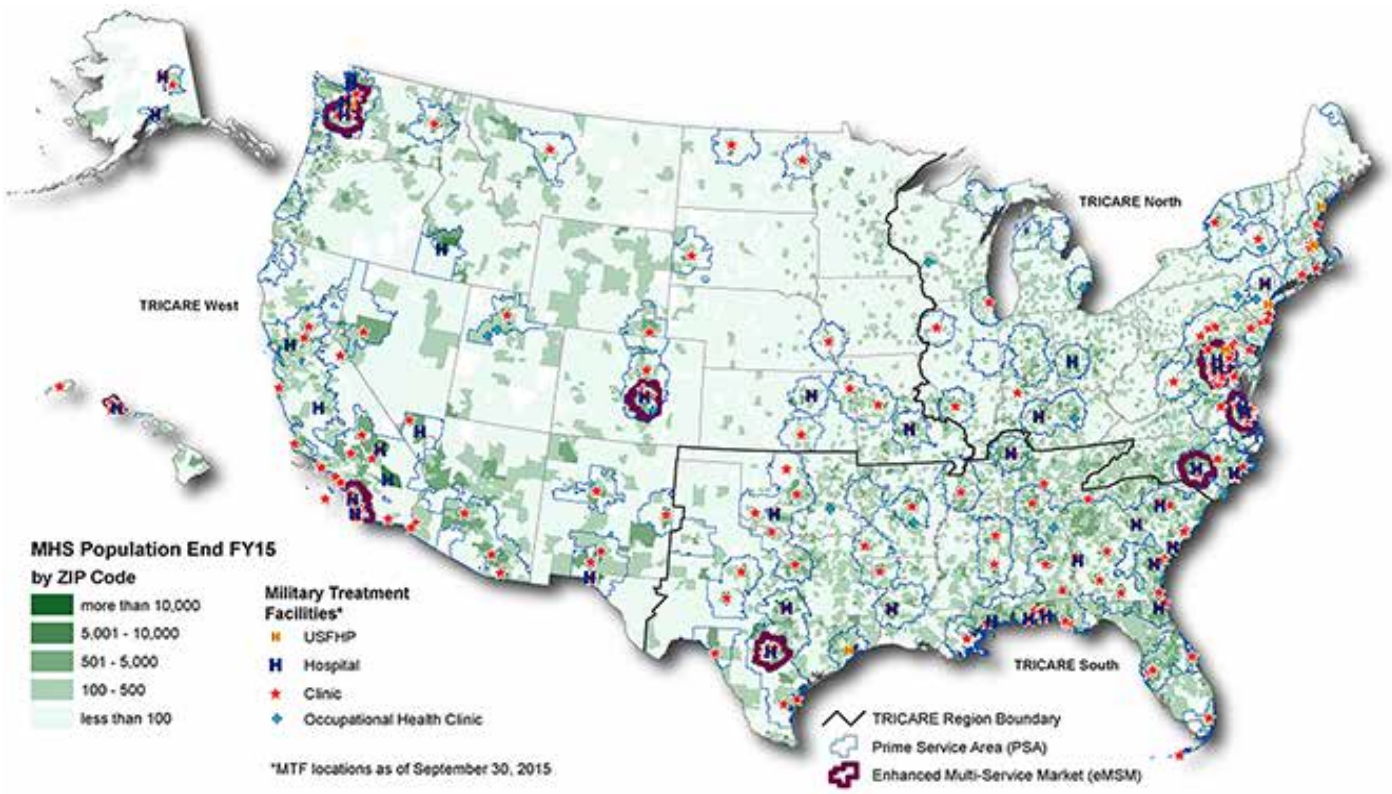
PROJECTED END-YEAR MHS POPULATIONS (MILLIONS) BY BENEFICIARY CATEGORY

BENEFICIARY CATEGORY	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Active Duty	1.36	1.34	1.33	1.34	1.34	1.34	1.34	1.34
Active Duty Family Members	1.80	1.77	1.76	1.76	1.76	1.76	1.76	1.76
Guard/Reserve	0.17	0.17	0.17	0.17	0.17	0.17	0.17	0.17
Guard/Reserve Family Members	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26
Inactive Guard/Reserve	0.16	0.16	0.16	0.16	0.16	0.16	0.16	0.16
Inactive Guard/Reserve Family Members	0.26	0.26	0.26	0.26	0.26	0.26	0.26	0.26
Retirees	2.18	2.19	2.20	2.21	2.22	2.23	2.25	2.26
Retiree Family Members	2.58	2.59	2.60	2.60	2.61	2.62	2.63	2.64
Survivors	0.60	0.61	0.61	0.61	0.62	0.62	0.62	0.63
Other	0.05	0.05	0.05	0.05	0.05	0.05	0.05	0.05
Total	**9.42**	**9.40**	**9.40**	**9.42**	**9.44**	**9.46**	**9.49**	**9.51**

Sources: FY 2015 actuals from DEERS as of 1/6/2016 and FYs 2016–2023 estimates from DHA Projections of Eligible Population (PEP) model as of 12/22/2015

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

MHS POPULATION DISTRIBUTION IN THE U.S. RELATIVE TO MTFs AT THE END OF FY 2015



Sources: DHA/Decision Support Division, 12/22/2015; MHS population as of 9/30/2015, pulled 12/1/2015; and VHA population as of 9/30/2015, provided 11/18/2015.

Notes:

[a] Eligible MHS beneficiary data from the MHS Data Repository (MDR) DEERS, effective 9/30/2015. For Active Duty and Guard/Reserve members, unit ZIP code was used for location; for all other beneficiaries, residential ZIP code was used.

[b] Location information determined by DHA Catchment Area Directory (CAD) database, September 2015.

[c] TRICARE medically eligible Guard/Reserve beneficiaries, including those who have opted into TRS/TRR.

Definitions:

– See page 16 for definitions of Geographic Areas: Catchments, Provider Requirement Integrated Specialty Model (PRISM), MTF Service Area, Prime Service Areas (PSAs), and enhanced multi-Service market (eMSM)

MILITARY HEALTH SYSTEM ELIGIBLE BENEFICIARY PROXIMITY TO MILITARY TREATMENT FACILITIES, END OF FY 2015[a]

BENEFICIARY GROUP[b]	POPULATION TOTAL (FY 2015)	POPULATION IN PSAs	% IN PSAs	% IN CATCHMENTS	% IN PRISMs	% IN MTF SERVICE AREAS	% IN eMSMs
Active Duty and Their Families	2,859,032	2,730,509	95.5%	70.3%	88.2%	92.7%	38.3%
Guard/Reserves and Their Families	829,510	568,229	68.5%	24.4%	39.3%	53.8%	13.1%
Retirees, Their Families, Survivors, and Other Eligibles[c]	5,211,055	3,980,634	76.4%	36.0%	50.0%	64.1%	20.4%
Total MHS Eligibles, U.S.	8,899,597	7,279,372	81.8%	45.9%	61.3%	72.4%	25.5%
MHS Eligibles, Overseas	538,933						
Total MHS Eligibles, Worldwide	9,438,530						
VETERANS HEALTH ADMINISTRATION PRIORITY BENEFICIARIES							
Eligible Veterans without TRICARE Eligibility	7,253,958	4,275,155	58.9%	16.2%	23.7%	42.3%	6.8%
Dual TRICARE-Eligible and VHA-Eligible Veterans	1,511,988	1,134,953	75.1%	35.2%	49.5%	62.7%	18.5%
Total VHA Priority Veterans U.S.	8,765,946	5,410,108	61.7%	19.5%	28.1%	45.8%	8.8%
VHA Veterans Overseas	199,976						
Total Worldwide	8,965,922						

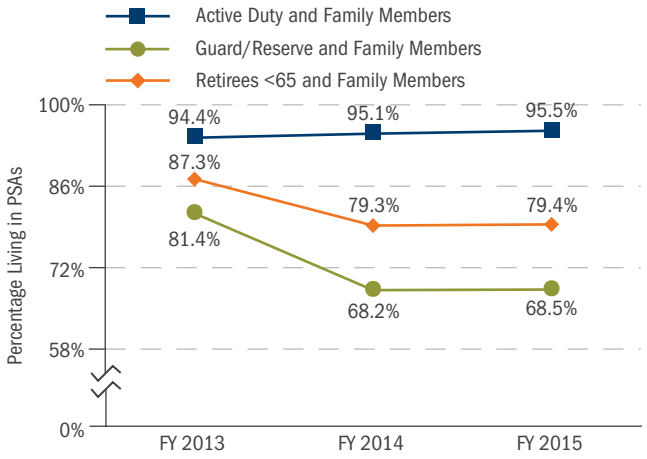
Locations of MTFs (Hospitals and Ambulatory Care Clinics) at the End of FY 2015

The map on the previous page shows the geographic dispersion of the almost 9 million beneficiaries eligible for the TRICARE benefit residing within the United States (94 percent of the 9.4 million eligible beneficiaries described on the previous pages). An overlay of the major DoD MTFs (medical centers and community hospitals, as well as medical clinics) reflects the extent to which the MHS population has access to TRICARE Prime. A beneficiary is considered to have access to Prime if he or she resides within a PSA. PSAs are geographic areas in which the TRICARE managed care support contractors (MCSCs) offer the TRICARE Prime benefit through established networks of providers. TRICARE Prime is available at MTFs, in areas around most MTFs ("MTF PSAs"), in areas where an MTF was eliminated in the Base Realignment and Closure (BRAC) process ("BRAC PSAs"), and by designated providers through the USFHP as of October 1, 2013. The overlay of MTF and BRAC PSAs on the previous map shows the eligible beneficiary population.

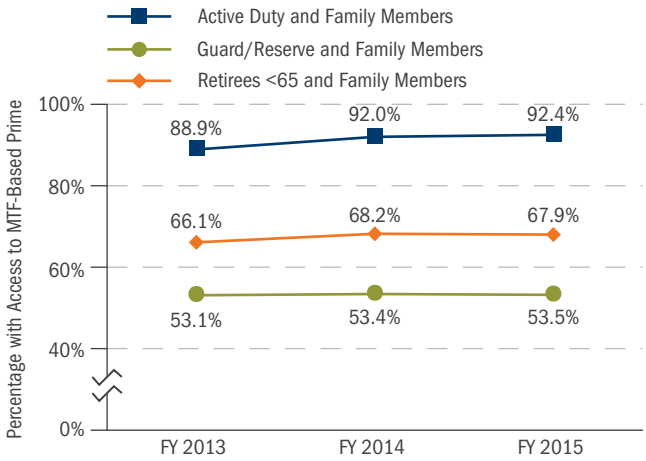
Beneficiary Access to Prime

Effective October 1, 2013, DoD reduced the number of locations designated as PSAs to those within a 40-mile radius of existing MTFs or designated BRAC locations (closed MTFs). The left chart below shows the effect of the reduction on the percentage of beneficiaries living in PSAs (defined only in the U.S.). The right chart below shows the percentage of the eligible population in the U.S. with access to MTF-based Prime. The latter is defined as the percentage living in both a PSA and an MTF Service Area (see the notes to the right of the map on the previous page for the definition of an MTF Service Area).

TREND IN ELIGIBLE POPULATION LIVING IN PSAs



TREND IN ELIGIBLE POPULATION WITH ACCESS TO MTF-BASED PRIME



Source: DEERS, 1/6/2016

- The reduction in the number of PSAs in FY 2014 had no effect on the access to Prime by Active Duty members and their families. However, the percentage of Guard/Reserve and family members (including those in a pre- and post-mobilization status) and retirees and family members living in PSAs each declined substantially in FY 2014. The percentage living in PSAs in FY 2015 was about the same as in FY 2014 for all beneficiary groups.
- As determined by residence in an MTF PSA, access to MTF-based Prime increased slightly from FY 2013 to FY 2014 for all beneficiary groups but declined slightly in FY 2015 for retirees and family members.
- As expected, Active Duty and their families have the highest level of access to MTF-based Prime, whereas Guard/Reserve members and their families have the lowest. Retirees, some of whom move to locations near an MTF to gain access to care in military facilities, fall in between.

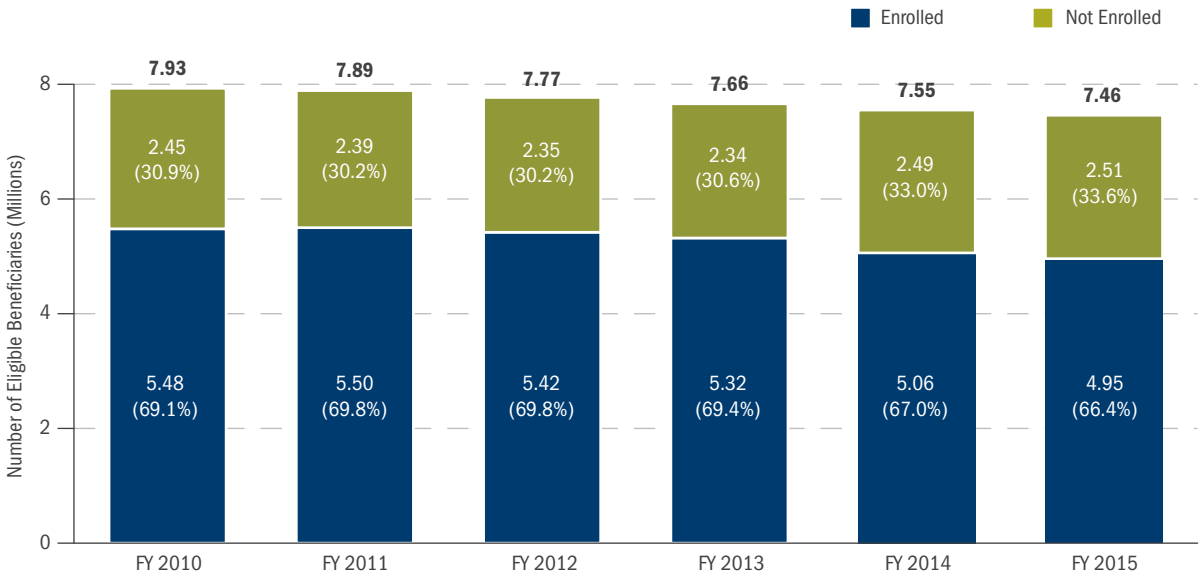
Eligibility and Enrollment in TRICARE Prime

Eligibility for and enrollment in TRICARE Prime was determined from DEERS. For the purpose of this report, all Active Duty personnel are considered to be enrolled. The eligibility counts exclude most beneficiaries age 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 TPR (including Global Remote), TYA Prime, and the USFHP are included in the enrollment counts below. Beneficiaries enrolled in TRICARE Plus (a primary care enrollment program offered at selected MTFs), TRS, TYA Standard, and TRR are excluded from the enrollment counts below; they are included in the non-enrolled counts.

- After peaking in FY 2011, the number of beneficiaries enrolled in TRICARE Prime has continued to drop. As a percentage of the beneficiary population, TRICARE Prime enrollment remained level from FY 2011 to FY 2013 but dropped significantly in FY 2014, largely due to a reduction in Active Duty end-strength.
- By the end of FY 2015, about 66 percent of all eligible beneficiaries were enrolled (4.95 million enrolled of the 7.46 million eligible to enroll).

HISTORICAL END-YEAR ENROLLMENT NUMBERS



Source: DEERS, 1/6/2016

Note: Numbers may not sum to bar totals due to rounding. Detailed MHS enrollment data by state can be found on page 19.

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

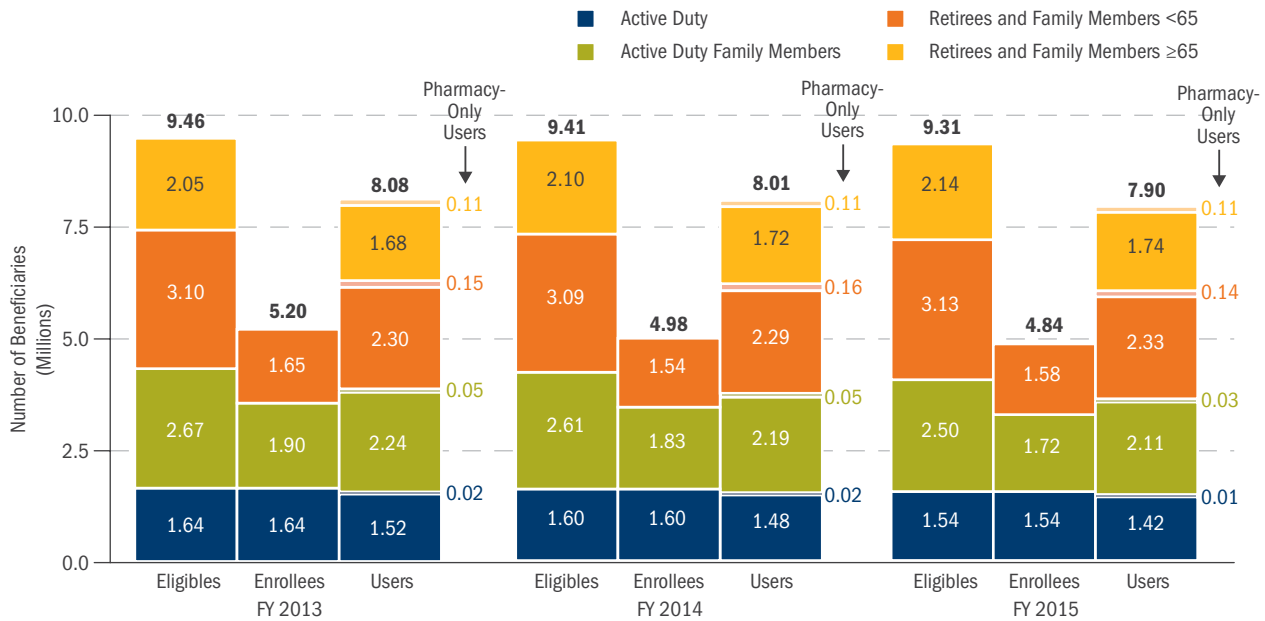
This section compares the number of users of MHS services with the numbers of eligibles and enrollees. Because beneficiaries eligible for any part of the year can be users, average (rather than end-year) beneficiary counts were used for all calculations.

The average numbers of eligibles and TRICARE Prime enrollees by beneficiary category from FY 2013 to FY 2015 were determined from DEERS data. The eligible counts include all beneficiaries eligible for some form of the military health care benefit and, therefore, include those who may not be eligible to enroll in Prime. TRICARE Plus and Reserve Select enrollees are not included in the enrollment counts. USFHP enrollees are excluded from both the eligible and enrollment counts because information about users of that plan was not available.

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

- The number of Active Duty and eligible family members declined by 6 percent between FY 2013 and FY 2015. The number of RETFMs under age 65 increased by 1 percent, while the number of RETFMs age 65 and older increased by 5 percent.
- The percentage of ADFMs enrolled in TRICARE Prime declined from 71 percent in FY 2013 to 69 percent in FY 2015.[1] The percentage of RETFMs under age 65 enrolled in Prime decreased from 53 percent in FY 2013 to 51 percent in FY 2015 partly because of the reduction in PSAs in FY 2014.
- The overall user rate remained about the same between FY 2013 and FY 2015 at just under 85 percent. Although the user rates (including pharmacy-only users) decreased slightly for all beneficiary groups, the declines were too small to affect the overall user rate (rounded to two digits).
- RETFMs under age 65 constitute the greatest number of MHS users but have the lowest user rate. Their MHS user rate is lower because some of them have other health insurance (OHI).

AVERAGE NUMBERS OF FY 2013 TO FY 2015 ELIGIBLES, ENROLLEES, AND USERS BY BENEFICIARY CATEGORY



Sources: DEERS and MHS administrative data, 1/6/2016

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

[1] In previous reports, inactive Guard/Reserves and family members were included with retirees and family members because they are grouped that way in the MHS administrative data. In this year's report, however, we grouped inactive Guard/Reserves and their family members with ADFMs because their TRICARE benefits are more alike. The shift between groups affects the enrollment percentages of both groups because most inactive Guard/Reserves and family members are not enrolled (mostly in TRICARE Reserve Select).

MHS POPULATION: ENROLLEES AND TOTAL POPULATION BY STATE

STATE	TOTAL POPULATION	PRIME ENROLLED	TRS ENROLLED
AK	84,934	63,302	1,419
AL	207,196	89,004	8,059
AR	87,903	31,894	4,773
AZ	201,248	96,703	7,923
CA	813,472	466,451	22,518
CO	247,071	151,093	8,466
CT	48,323	21,865	1,947
DC	22,052	16,231	503
DE	33,195	15,997	1,513
FL	696,064	329,944	21,274
GA	438,869	267,326	12,987
HI	164,713	124,061	2,061
IA	43,910	8,228	4,815
ID	50,455	18,859	3,968
IL	147,659	69,751	8,243
IN	89,486	23,401	8,438
KS	126,499	76,096	5,791
KY	145,865	84,081	6,063
LA	127,142	64,385	7,990
MA	69,353	29,311	5,446
MD	245,735	162,157	6,075
ME	39,266	23,249	2,339
MI	97,159	22,740	5,992
MN	65,489	9,145	10,066
MO	152,381	64,264	11,754
MS	110,125	47,604	7,169
MT	34,707	11,869	2,312
NC	506,399	300,360	12,024
ND	32,128	19,633	2,382
NE	61,278	29,390	4,156
NH	30,921	16,393	1,621
NJ	84,684	39,884	4,355
NM	84,616	46,321	1,641
NV	102,637	51,184	3,037
NY	176,293	87,823	6,850
OH	163,628	50,569	11,208
OK	155,991	83,396	6,489
OR	68,759	11,831	3,165
PA	159,810	40,695	9,630
RI	24,636	12,365	1,108
SC	245,058	125,911	9,572
SD	33,502	13,682	4,352
TN	195,335	69,733	10,990
TX	882,261	510,914	31,231
UT	73,896	31,601	8,191
VA	753,702	449,117	12,575
VT	13,000	5,282	1,170
WA	348,106	215,718	7,989
WI	69,961	12,387	6,958
WV	35,716	6,724	2,469
WY	22,658	11,303	1,334
Subtotal	**8,915,246**	**4,631,227**	**354,401**
Overseas	**522,877**	**318,550**	**3,020**
Total	**9,438,123**	**4,949,777**	**357,421**

Source: MHS administrative data systems, as of 1/6/2016 for end of FY 2015

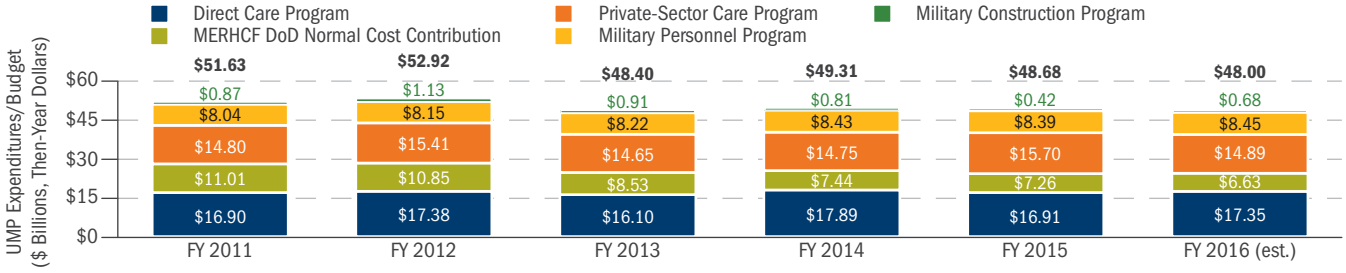
Note: "Prime Enrolled" includes Prime (military and civilian primary care managers), TRICARE Prime Remote (and Overseas equivalent), TYA Prime, and Uniformed Services Family Health Plan; and excludes members in TFL, TRICARE Plus, TYA Standard, and TRS.

UMP FUNDING

The UMP, estimated at $48.0 billion for FY 2016, or slightly more than 1 percent lower than the $48.7 billion in actual expenditures in FY 2015 and 9 percent lower than the peak of almost $53 billion in FY 2012 (unadjusted, then-year dollars). The UMP shown includes the normal DoD cost contribution to the MERHCF (the "Accrual Fund"). This fund (effective October 1, 2002) pays the cost of DoD health care programs (both direct and purchased care) for Medicare-eligible retirees, retiree family members, and survivors. The majority of Accrual Fund payments for health care provided to Medicare-eligible beneficiaries are for purchased care pharmacy and outpatient care.

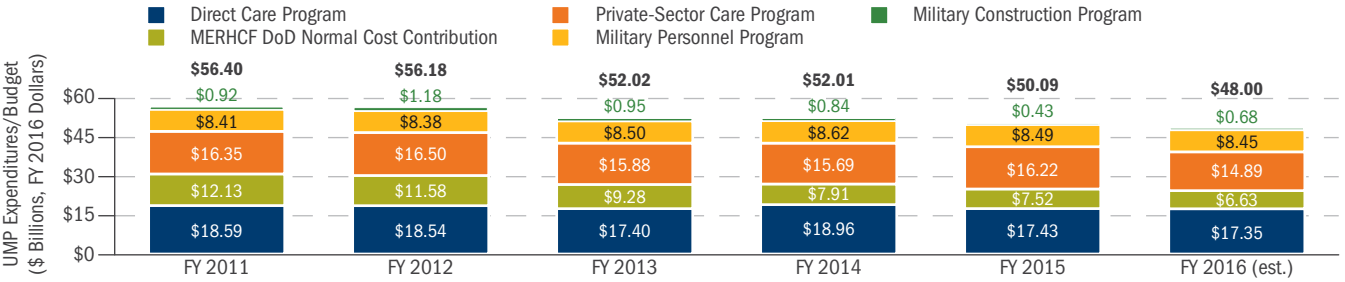
At $17.35 billion estimated for FY 2016, direct care expenditures represent the largest sector of the UMP (36 percent), followed by the private sector program ($14.89 billion, 31 percent) and estimated military personnel costs ($8.45 billion, almost 18 percent). Accrual Fund contributions declined from a high of $11.01 billion in FY 2011 to under $7 billion estimated for FY 2016. Military construction, small relative to other UMP sectors, increased from $0.42 billion in FY 2015 to almost $0.7 billion in FY 2016.

FY 2011 TO FY 2016 (EST.) UMP FUNDING ($ BILLIONS) IN UNADJUSTED, THEN-YEAR DOLLARS



In constant FY 2016 dollar funding, when actual expenditures or projected funding are adjusted for inflation as estimated by the Department, the FY 2016 $48.0 billion estimated budget in purchasing value is currently programmed to be $2 billion (4 percent) less in purchasing value than actual expenditures in FY 2015 and almost $8.4 billion (almost 15 percent) less than the peak in FY 2011 of $56.4 billion in constant FY 2016 dollars.

FY 2011 TO FY 2016 (EST.) UMP FUNDING ($ BILLIONS) IN CONSTANT FY 2016 DOLLARS



Source: Cost and budget estimates, DHA Business Support Directorate, Program, Budget, and Execution (PB&E), 11/20/2015

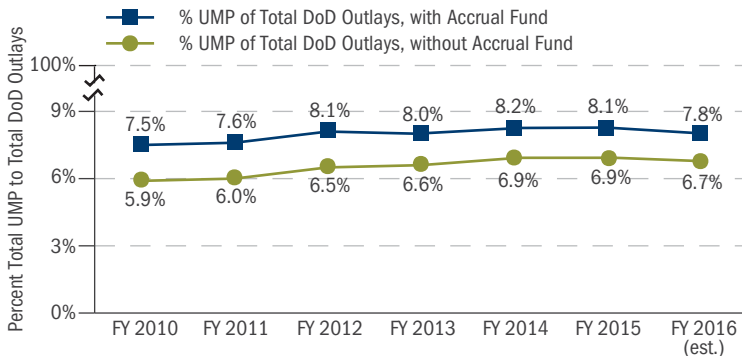
Notes: For the charts above and the "UMP Expenditures" chart on the next page:

- The DoD MERHCF, also referred to herein as the "Accrual Fund," implemented in FY 2003, is an accrual fund that pays for health care provided in DoD/Coast Guard facilities to DoD retirees, dependents of retirees, and survivors who are Medicare-eligible beneficiaries. The fund also supports purchased care payments through the TFL benefit first implemented in FY 2002. There are three sources of revenue for Defense health care that make up the projected total FY 2016 MERHCF outlays: (1) The Accrual Fund ($6.63 billion), reflected in the charts and discussion above, is the DoD normal cost contribution funded by the UMP at the beginning of each fiscal year. This fund is paid by the military Services for future health care liability accrued since October 1, 2002, for Active Duty, Guard, and Reserve beneficiaries and their family members when they become retired and Medicare-eligible; (2) $3.3 billion is paid by the Treasury to fund future health care liability accrued prior to October 1, 2002 for retired, Active Duty, Guard, and Reserves and their family members when they become retired and Medicare-eligible; and (3) revenue gained from return on the two investments noted above. Projected outlays for FY 2016 are programmed to be $10.14 billion to pay for health care benefits provided during FY 2016 to current Medicare-eligible retirees, family members, and survivors (i.e., actual projected outlays from the trust fund). Most of the programmed $10.14 billion in expected outlays in FY 2016 are for purchased care ($8.15 billion, comprising $3.6 billion for TFL, $0.72 billion for USFHP, and $3.83 billion for retail and home delivery pharmacy) and $1.99 billion for direct (MTF) care ($1.53 billion for Operations and Maintenance [O&M] and $0.46 billion for Military Personnel).
- The MERHCF funding presented in the above charts reflects the programmed normal cost contribution at the beginning of each fiscal year; actual MERHCF expenditures by the end of each year are as follows (in $ billions):

FY 2010	FY 2011	FY 2012	FY 2013	FY 2014
$8.9	$8.7	$8.85	$8.63	$9.42

- FYs 2010–2014 reflect Comptroller Information System actual execution.
- FY 2010 current estimate includes O&M funding of $1.2567 billion in support of Overseas Contingency Operations (OCO) requirements and $140.0 million ($132.0 million for O&M and $8.0 million for Research, Development, Test, and Evaluation [RDT&E]) transferred from the Department of Health and Human Services (DHHS) for Pandemic Influenza Preparedness and Response.
- FY 2011 includes $1.4 billion OCO supplemental funding for O&M and $23.4 million in OCO funding for RDT&E.
- FY 2012 includes $1.2 billion OCO supplemental funding for O&M and reductions for DoD efficiency initiatives (FY 2012 OCO includes $452 million in Private Sector; $765 million in direct care).
- FY 2013 includes $966.022 million in OCO. Reflects reductions for Sequestration, National Defense Authorization Act (NDAA) 2013 Sections 3001, 3004, and 8123.
- FY 2014 includes $715.484 million in OCO supplemental funding for O&M, plus congressional additions and statutory reductions as reflected in Public Law 113-76.
- FY 2015 includes $300.531 million in OCO supplemental funding for O&M, plus congressional additions and statutory reductions as reflected in Public Law 113-64.
- FY 2016 reflects Base President's Budget Request to the Office of Management and Budget (OMB)/Congress.

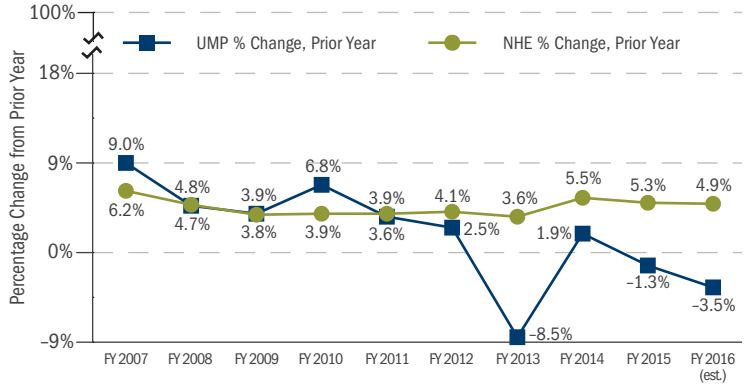
UMP EXPENDITURES AS A PERCENTAGE OF TOTAL DoD OUTLAYS: FY 2010 TO FY 2016 (EST.)



Source: UMP Data come from DHA Business Support Directorate, PB&E, 11/19/2015

Note: FY 2015–FY 2016 percentages are estimates of total DoD outlays reflected as of the writing of this report.

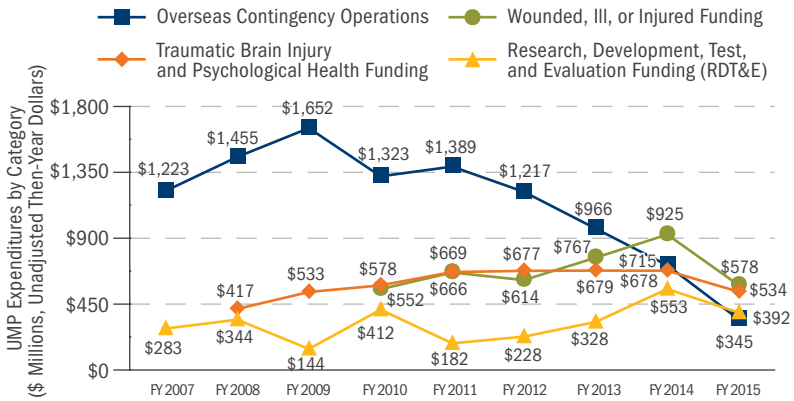
COMPARISON OF CHANGE IN ANNUAL UMP AND NHE EXPENDITURES OVER TIME: FY 2007 TO FY 2016 (EST.)



Sources:

- UMP Data come from DHA Business Support Directorate, PB&E, 11/19/2015
- NHE Data from CMS Office of the Actuary, Table 2, National Health Expenditure Amounts and Annual Percent Change by Type of Expenditure: Calendar Years 2008–2024; table modified 7/22/2015, accessed 10/15/2015
- http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html (NHE Projections 2014–2024, Tables [zip])

MEDICAL COST OF WAR—CARING FOR OUR WOUNDED, ILL, OR INJURED



Source: DHA Business Support Directorate, PB&E, 11/19/2015

Notes:

- TBI and PH expenditures shown for FY 2008 include FY 2007 and FY 2006.
- The Wounded, Ill, or Injured Funding line is included in overall OCO funding from FY 2007 to FY 2009 but is identified separately beginning in FY 2010.

UMP Share of Defense Budget

UMP expenditures (including the Accrual Fund) as a percentage of total DoD expenditures (outlays), has fluctuated around 8 percent since FY 2012, and is currently estimated at 7.8 percent in FY 2016—or at 6.7 percent if the Accrual Fund is excluded. These proportions may increase in the future as the FY 2016 DoD budget is fully appropriated and/or to the extent that medical costs (i.e., the numerator) to care for returning forces continue to increase due to inflationary pressures, and the Department's overall budget (i.e., the denominator) is constrained or reduced due to fiscal pressures and the return of operationally deployed forces to U.S. bases.

Comparison of UMP and National Health Expenditures over Time

As noted in the middle chart at left, the annual rate of growth in the UMP (in then-year dollars) declined from a high of 9 percent in FY 2007 and has steadily declined almost every year since, except for a spike in 2010 and a deep drop in FY 2013 (–8.5 percent). After an increase to almost 2 percent growth in FY 2014, the UMP is projected to decline by 3.5 percent from FY 2015 to FY 2016. In comparison, the Centers for Medicare & Medicaid Services (CMS) estimates that annual percentage changes in National Health Expenditures (NHE) have fluctuated between 3.6 and 6.2 percent since FY 2007, with expenditures reaching an estimated $3.4 trillion in FY 2016, for an increase of 4.9 percent over FY 2015. These increases are expected due to the major coverage expansion legislated by the Affordable Care Act (ACA), which may have been moderated by the recession (ref. source notes at left).

Medical Cost of War—Caring for Our Wounded, Ill, or Injured

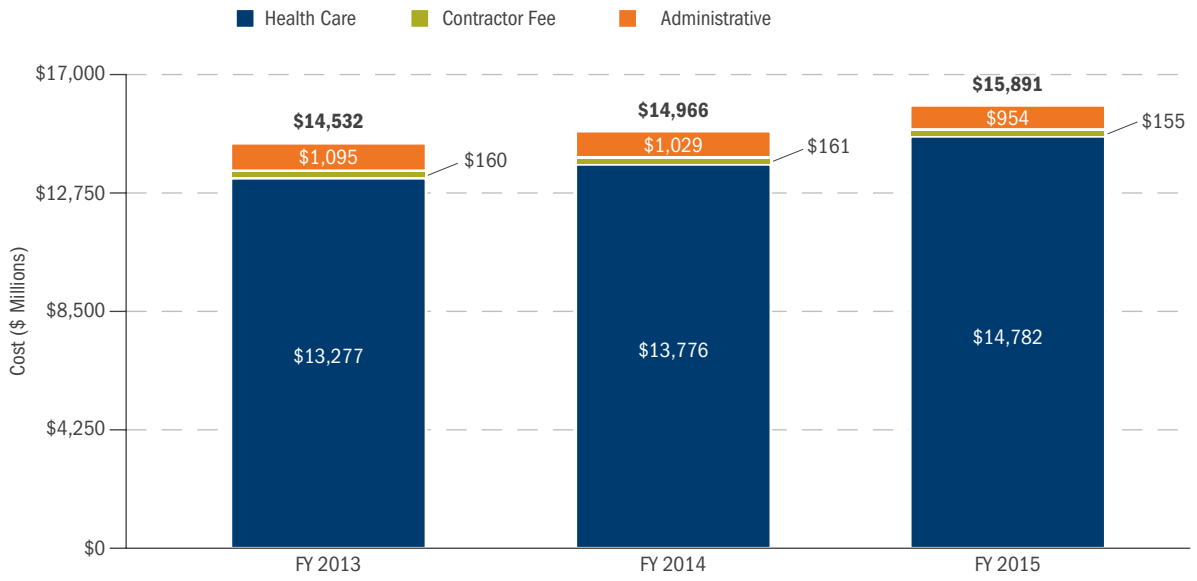
The graph at left reflects the total actual DHP funding for OCO and resultant care for wounded, ill, or injured since FY 2007. Total annual DHP expenditures have ranged from a low of $1.51 billion in FY 2007, to a high of $2.9 billion in FY 2011 in then-year dollars. FY 2015 expenditures totaled $1.85 billion. These overall expenses are the sum of OCO operations; care for traumatic brain injury (TBI); wounded, ill, or injured; and psychological health (PH), as well as research and development shown as separate expense lines in the chart. These funds are within the DHP (O&M) funding line and are reflected in the earlier budget charts.

PRIVATE-SECTOR CARE ADMINISTRATIVE COSTS

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

- Total private-sector care costs rose from $14,532 million in FY 2013 to $15,891 million in FY 2015, an increase of over 9 percent.
- Private-sector health care costs increased by 11 percent, due mostly to rising compound pharmacy costs.
- Administrative costs declined by 13 percent from FY 2013 to FY 2015. In April of FY 2015, the negotiated North Region contract extension began, which lowered administrative costs by $40 million.
- Excluding contractor fees, administrative expenses decreased from 7.6 percent of total private-sector care costs in FY 2013 ($1,095 million of $14,372 million) to 6.1 percent in FY 2015 ($954 million of $15,736 million). Including contractor fees (in both administrative and total costs), administrative expenses decreased from 8.6 percent of total private-sector care costs in FY 2013 ($1,255 million of $14,532 million) to 7.0 percent in FY 2015 ($1,109 million of $15,891 million).
- Contractor fees decreased by 3 percent from FY 2013 to FY 2015.

TREND IN PRIVATE-SECTOR CARE COSTS



Source: DHA, Contract Resource Management, 10/29/2015

[1] DHA has congressional authority to carry over 1 percent of its O&M funding into the following year. The amounts carried forward from the prior-year appropriation were $308 million in FY 2014 and $307 million in FY 2015. There was no funding carried over from FY 2012 to FY 2013 because of sequestration.

MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE)

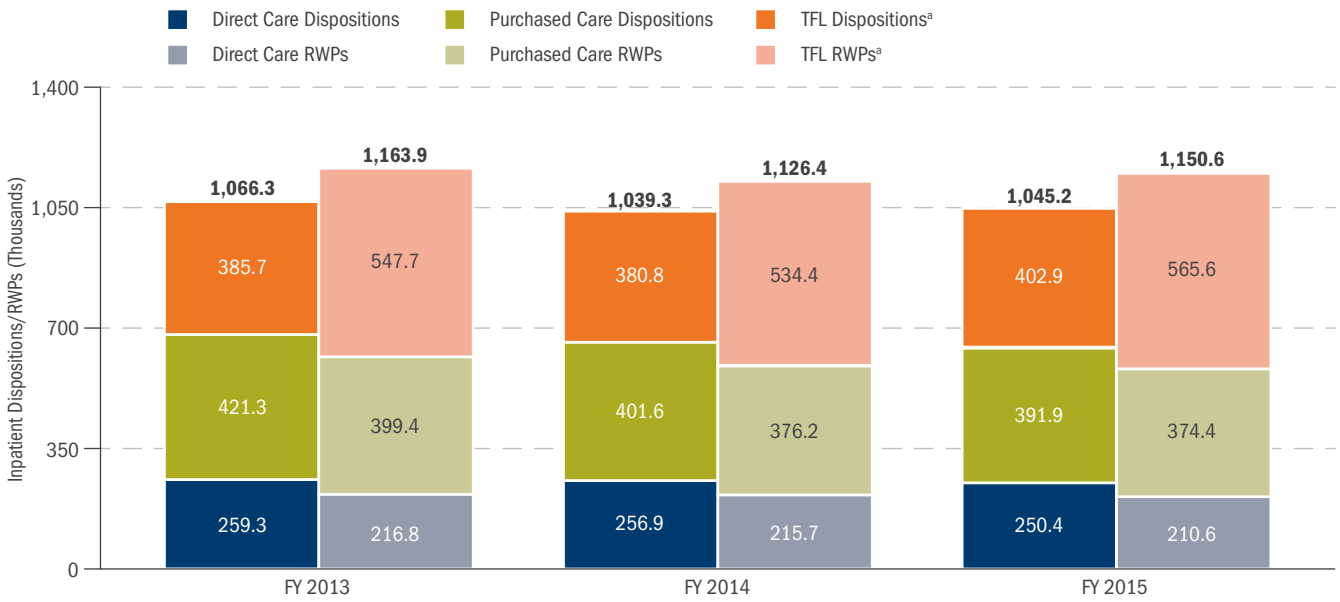
MHS Inpatient Workload

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

Total inpatient dispositions (direct and purchased care combined) declined by 6 percent and total RWPs declined by 5 percent between FY 2013 and FY 2015, excluding the effect of TRICARE for Life (TFL).[1]

- Direct care inpatient dispositions and RWPs each decreased by 3 percent over the past three years.
- Excluding TFL workload, purchased care inpatient dispositions decreased by 7 percent, while RWPs decreased by 6 percent between FY 2013 and FY 2015.
- Including TFL workload, purchased care dispositions decreased by 2 percent, while RWPs decreased by 1 percent between FY 2013 and FY 2015.
- Although not shown, about 7 percent of direct care inpatient workload (dispositions) was performed abroad in FY 2015. Purchased care and TFL inpatient workload performed abroad accounted for about 2 percent of the worldwide total.

TRENDS IN MHS INPATIENT WORKLOAD



Source: MHS administrative data, 1/19/2016

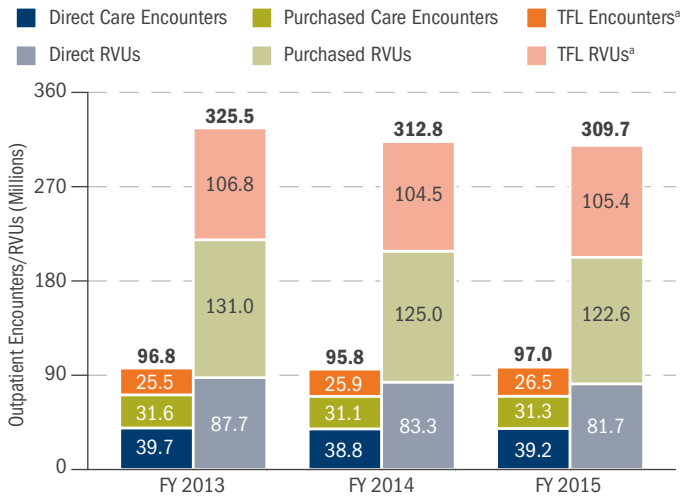
[a] Purchased care only

[1] Although TFL claims are not technically MHS workload (i.e., 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 MHS if they were excluded.

MHS Outpatient Workload

Total MHS outpatient workload is measured two ways: as the number of encounters (outpatient visits and ambulatory procedures) and as the number of relative value units (RVUs). Because encounters do not appear on purchased care claims, they are calculated using a DHA-developed algorithm. RVUs reflect the relative resources consumed by a single encounter as compared with the average of those consumed by all encounters. In FY 2010, TRICARE developed an enhanced measure of RVUs that accounts for units of service (e.g., 15-minute intervals of physical therapy) and better reflects the resources expended to produce an encounter. The enhanced RVU measures have been applied to the data from FY 2013 to FY 2015. The RVU measure used in this year's report is the sum of the Physician Work and Practice Expense RVUs (called "Total RVUs"). See the Appendix for a detailed description of the latter RVU measures.

TRENDS IN MHS OUTPATIENT WORKLOAD



Source: MHS administrative data, 1/19/2016

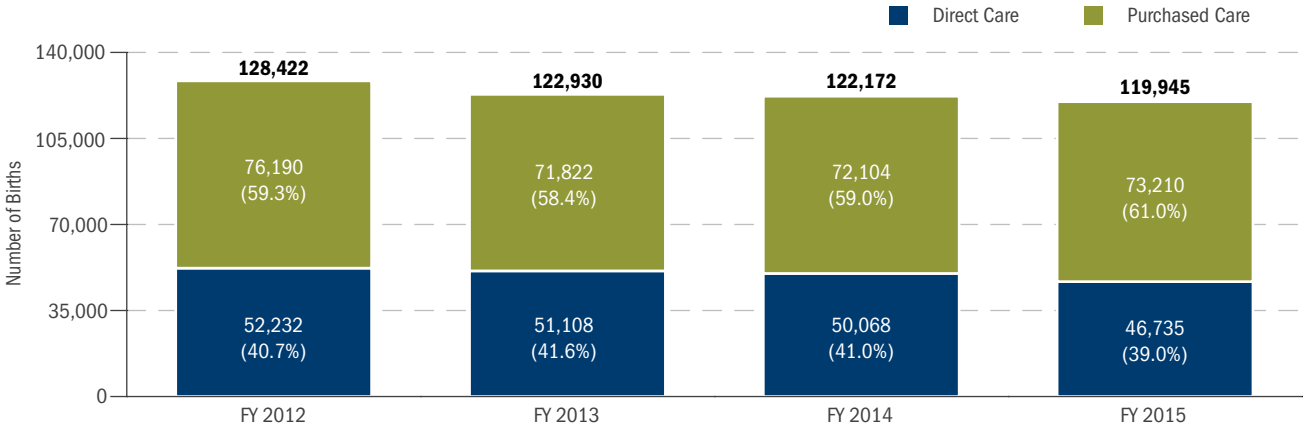
[a] Purchased care only

- Total outpatient workload (direct and purchased care combined) decreased between FY 2013 and FY 2015 (encounters decreased by 1 percent and RVUs by 7 percent), excluding the effect of TFL.[1]
- Direct care outpatient encounters decreased by 1 percent and RVUs by 7 percent over the past three years.
- Excluding TFL workload, purchased care outpatient encounters decreased by 1 percent and RVUs by 6 percent. Including TFL workload, encounters increased by 1 percent and RVUs decreased by 4 percent.
- Although not shown, about 8 percent of direct care outpatient workload (encounters) was performed abroad. Purchased care and TFL outpatient workload performed abroad accounted for less than 1 percent of the worldwide total.

MTF Market Share for Childbirths

A 2011–2012 DHA survey of MTF obstetric (OB) patients measured satisfaction with various aspects of their care. Moderate correlations were found between some survey satisfaction levels and MTF market shares for childbirths (i.e., the percentage of total OB workload [direct plus purchased] performed in direct care facilities). MTF OB market shares in the U.S. ranged from 7 percent to 88 percent. From the chart below, overall MTF OB market share increased modestly between FY 2012 and FY 2013, but then dropped slightly in FY 2014 and then by a larger amount in FY 2015. The decreasing trend in MTF market share suggests that satisfaction with MTF OB care may be declining as well.

TREND IN MTF MARKET SHARE FOR CHILDBIRTHS



Source: MHS administrative data, 1/19/2016

[1] Although TFL claims are not technically MHS workload (i.e., 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 MHS if they were excluded.

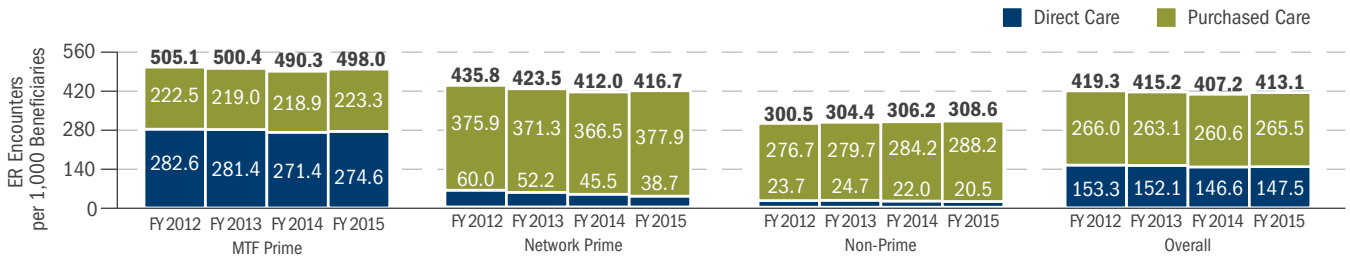
MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE) *(CONT.)*

Emergency Room Utilization

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

- ER utilization per capita declined for Prime enrollees from FY 2012 to FY 2015 (4 percent for network Prime enrollees and 1 percent for MTF Prime enrollees). The rate for non-Prime enrollees was essentially flat over the same time period.
- In FY 2015, MTF Prime enrollees had an ER utilization rate 20 percent higher than that of network Prime enrollees and 61 percent higher than that of non-enrollees. Network Prime enrollees had an ER utilization rate 35 percent higher than that of non-enrollees.
- For MTF Prime enrollees, 45 percent of ER encounters were in purchased care facilities (not necessarily in-network).
- Children under five years old had the highest ER utilization rate for all enrollment groups (not shown).
- The FY 2015 overall MHS ER utilization rate of 413 encounters per 1,000 beneficiaries is 7 percent lower than the civilian rate of 445 per 1,000 reported in calendar year (CY) 2011, the most recent year for which data are available.[2]

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

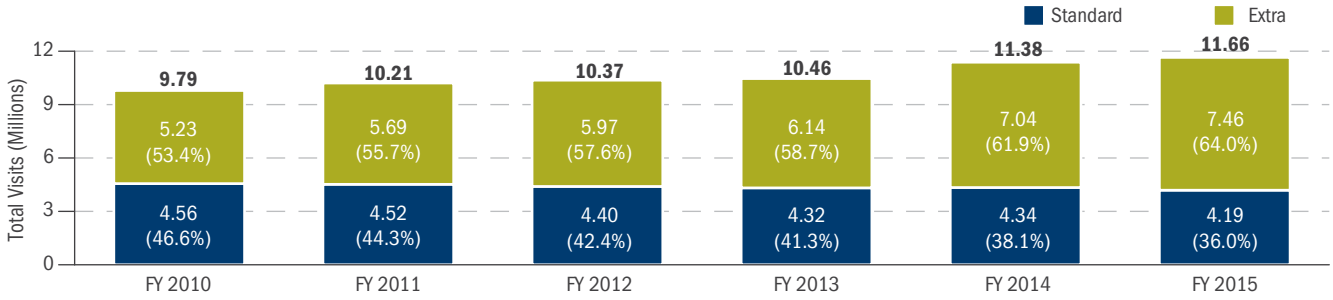


Source: MHS administrative data, 1/19/2016

Extra vs. Standard Non-Prime Visits

For beneficiaries not enrolled in Prime, the ratio of Extra to Standard visits has been steadily increasing. In FY 2008, Extra visits (calculated using the new methodology mentioned above) accounted for only 46 percent of all non-Prime visits. By FY 2009, the number of Extra visits exceeded the number of Standard visits for the first time (51 percent). In FY 2015, 64 percent of all non-Prime visits were to Extra providers. One reason for the increasing usage of Extra providers is the expansion of the TRICARE provider network (see page 69).

TRENDS IN EXTRA VS. STANDARD VISITS



Source: MHS administrative data, 1/19/2016

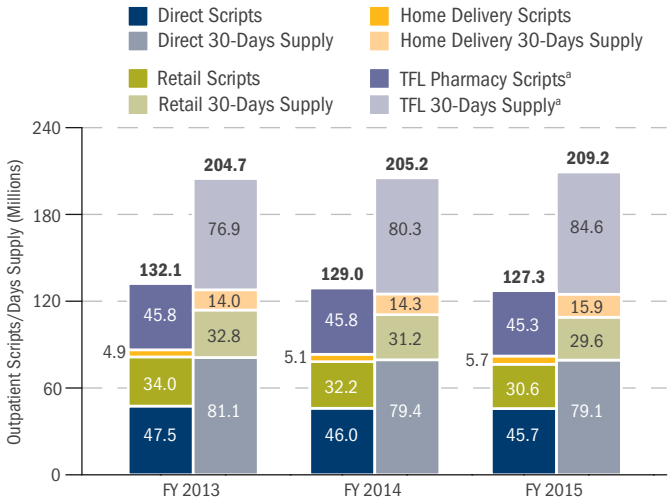
[1] Gindi, R. M., et al., "Emergency Room Use Among Adults Aged 18–64: Early Release of Estimates from the National Health Interview Survey, January–June 2011," (National Center for Health Statistics: May 2012), http://www.cdc.gov/nchs/nhis/releases.htm

[2] Centers for Disease Control and Prevention, "National Hospital Ambulatory Medical Care Survey: 2010 Emergency Department Summary Tables," Table 1, http://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/2011_ed_web_tables.pdf

MHS Prescription Drug Workload

TRICARE beneficiaries can fill prescription medications at MTF pharmacies, through home delivery (mail order), at TRICARE retail network pharmacies, and at non-network pharmacies. Total outpatient prescription workload is measured two ways: as the number of prescriptions and as the number of days supply (in 30-day increments). Total prescription drug workload (all sources combined) decreased between FY 2013 and FY 2015 (prescriptions decreased by 5 percent and days supply by 2 percent), excluding the effect of TFL purchased care pharmacy usage.

TRENDS IN MHS PRESCRIPTION WORKLOAD



Source: MHS administrative data, 1/19/2016

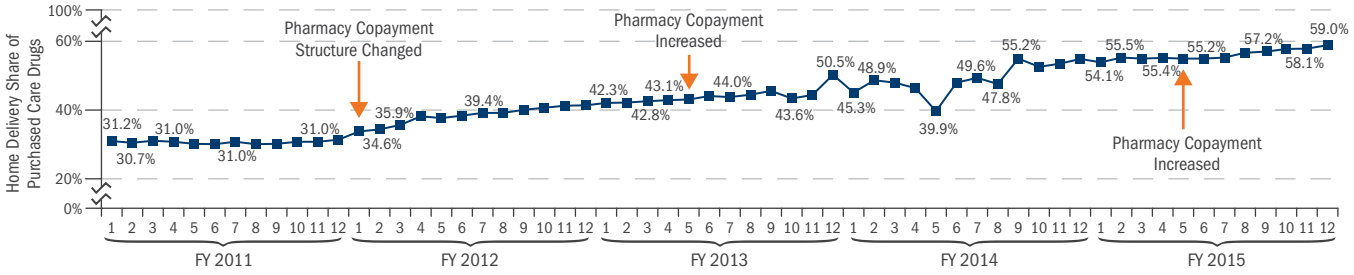
[a] Home delivery workload for TFL-eligible beneficiaries is included in the TFL total.

- Direct care prescriptions decreased by 4 percent and days supply by 2 percent between FY 2013 and FY 2015.
- Purchased care prescriptions (retail and home delivery combined) decreased by 7 percent and days supply by 3 percent from FY 2013 to FY 2015, excluding TFL utilization. Including TFL utilization, purchased care prescriptions decreased by 4 percent and days supply increased by 5 percent. The discrepancy in trends between purchased care prescription counts and days supply is due to increased beneficiary utilization of home delivery services, which are dispensed for up to a 90-day supply.
- Although not shown, about 5 percent of direct care prescriptions were issued abroad. Purchased care prescriptions issued abroad accounted for less than 1 percent of the worldwide total.

Although TRICARE pharmacy home delivery services have been available to DoD beneficiaries since the late 1990s, they have not been heavily used until recently. Home delivery of prescription medications offers benefits to both DoD and its beneficiaries, because DoD negotiates prices that are considerably lower than those for retail drugs and the beneficiary receives up to a 90-day supply for the same copay as a 30-day supply at a retail pharmacy. In November 2009, DoD consolidated its pharmacy services under a single contract (called TPharm) and launched an intensive campaign to educate beneficiaries on the benefits of home delivery services. As an additional incentive for beneficiaries to use home delivery services, effective October 1, 2011, TRICARE eliminated home delivery beneficiary copayments for generic drugs while at the same time increasing retail pharmacy copayments. Furthermore, the NDAA for FY 2013 mandated that DoD implement a five-year pilot program requiring TFL beneficiaries to obtain all refill prescriptions for select non-generic maintenance medications from the TRICARE home delivery program or MTF pharmacies. The pilot program went into effect on February 14, 2014. The NDAA for FY 2015 ended the pilot program on September 30, 2015, and expanded the program to all non-Active Duty beneficiaries beginning October 1, 2015.

The home delivery share of total purchased care utilization has been on the rise since DoD changed the copayment structure for retail/home delivery drugs at the beginning of FY 2012. Since that time, the home delivery share of purchased care pharmacy utilization (as measured by days supply) has increased almost linearly, from 32 percent at the end of FY 2011 to 59 percent at the end of FY 2015.

TREND IN HOME DELIVERY UTILIZATION (DAYS SUPPLY) AS A SHARE OF TOTAL PURCHASED CARE UTILIZATION[b]



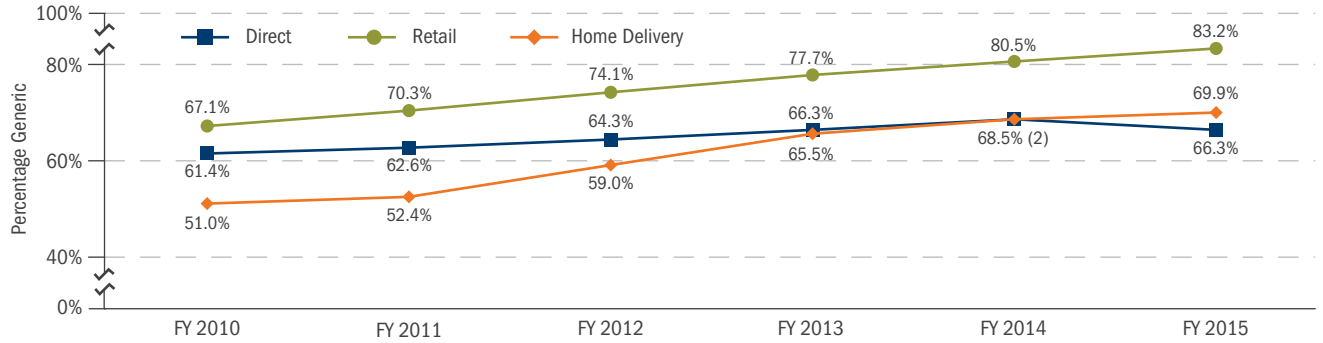
Source: MHS administrative data, 1/19/2016

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

COST SAVINGS EFFORTS IN DRUG DISPENSING

- The rate of generic drug dispensing has been increasing for all sources: direct, retail, and home delivery. Home delivery pharmacies have seen the greatest increase, from 51 percent in FY 2010 to 70 percent in FY 2015. However, retail pharmacies dispensed the highest percentage of generic drugs in FY 2015 (83 percent).
- Although the rate of generic drug dispensing is increasing in MHS, it still lags the private sector. In 2013, approximately 81 percent of new and refilled private-sector prescriptions were filled with generics,[1] compared with 72 percent overall (direct plus retail) in MHS.[2] The use of generics in lieu of brand-name drugs is expected to grow, since the patent protection of a sizable number of brand-name drugs will expire in the coming years.
- The average cost to DoD for a 30-day supply of a brand versus generic drug in FY 2015 was $50 versus $14 for direct care, $379 (net of manufacturer refunds) versus $21 for retail pharmacies, and $95 versus $16 for home delivery (costs are not adjusted for differences in drug types between brand and generic). Therefore, all other factors being equal, the trend toward greater generic drug dispensing is likely to lower DoD costs for prescription drugs.

TRENDS IN GENERIC DRUG DISPENSING

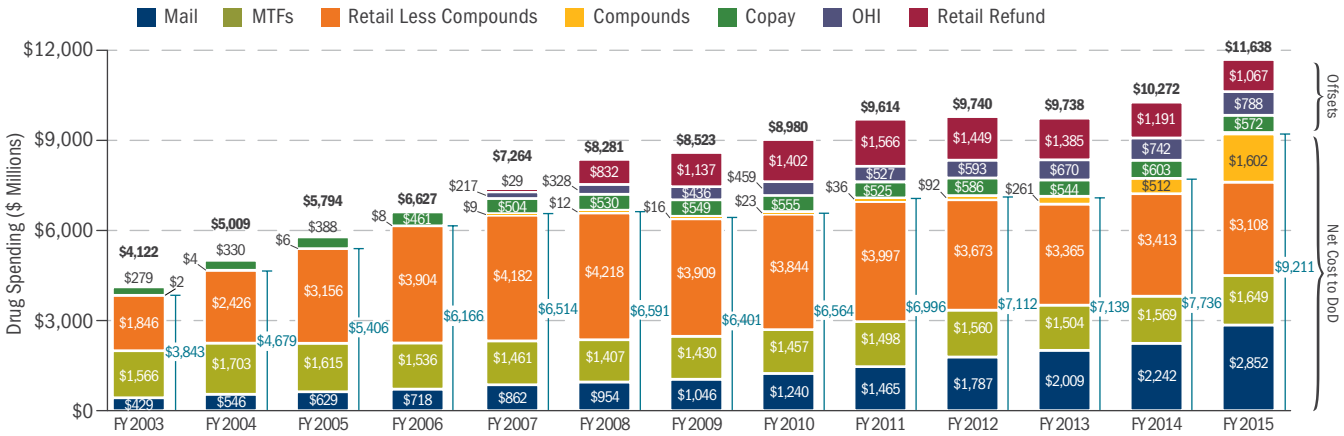


Source: MHS administrative data, 12/17/2015

The NDAA for FY 2008 mandated that the TRICARE retail pharmacy program be treated as an element of 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 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 DoD. In FY 2015, the refunds are estimated to have saved DoD almost $1.1 billion. After rising an average of only 2.7 percent per year since FY 2008, net DoD costs rose by 19 percent in FY 2015 alone, driven largely by a threefold increase in expenditures for compound drugs.

MHS OUTPATIENT DRUG SPENDING, FYs 2003–2015



Sources: Pharmacy Data Transaction Service (PDTS) Data Warehouse; DHA Pharmacy Operations Division (refunds) as of 12/4/2015

Notes: Net cost to DoD represents total prescription expenditures minus copays, coverage by other health insurance (OHI), and retail refunds invoiced. Mail Order dispensing fees are included; however, other retail/mail contract costs and MTF cost of dispensing are not included. Retail refunds are reported on an accrual rather than a cash basis, corresponding to the original prescription claim data and updated refund adjustments. Retail Compound spending, broken out separately, is not adjusted for any recoveries or settlements with compound pharmacies outside of claims reversals.

[1] CVS/Caremark, Insights 2014: 7 Sure Things, http://info.cvscaremark.com/insights2014/INSIGHTS%20Trend%202014-v2.pdf

[2] The MHS generic dispensing rate may be lower than in the private sector because 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. MHS is also forbidden by law to purchase generic drugs from countries that do not comply with the requirements established by the Trade Agreements Act.

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

DoD-VA Pharmacy Contracting Initiatives

The Departments continued to maximize efficiencies through joint efforts when possible. National contracts are at an all-time high with 138 existing contracts, of which 52 were new in FY 2015. There are currently 22 joint contracts pending at the National Acquisition Center and 18 pending at the Defense Logistics Agency. The VA/DoD pharmacy team identified 40 commonly used pharmaceutical products and manufacturers for potential joint contracting action and continued to seek new joint contracting opportunities where practicable. Through the third quarter of FY 2015, VA had spent $260 million on joint national contracts, and DoD had spent $132 million. Over the same time period, VA joint national contract prime vendor purchases represented 6.3 percent of total prime vendor purchases; DoD purchases represented 3.8 percent.

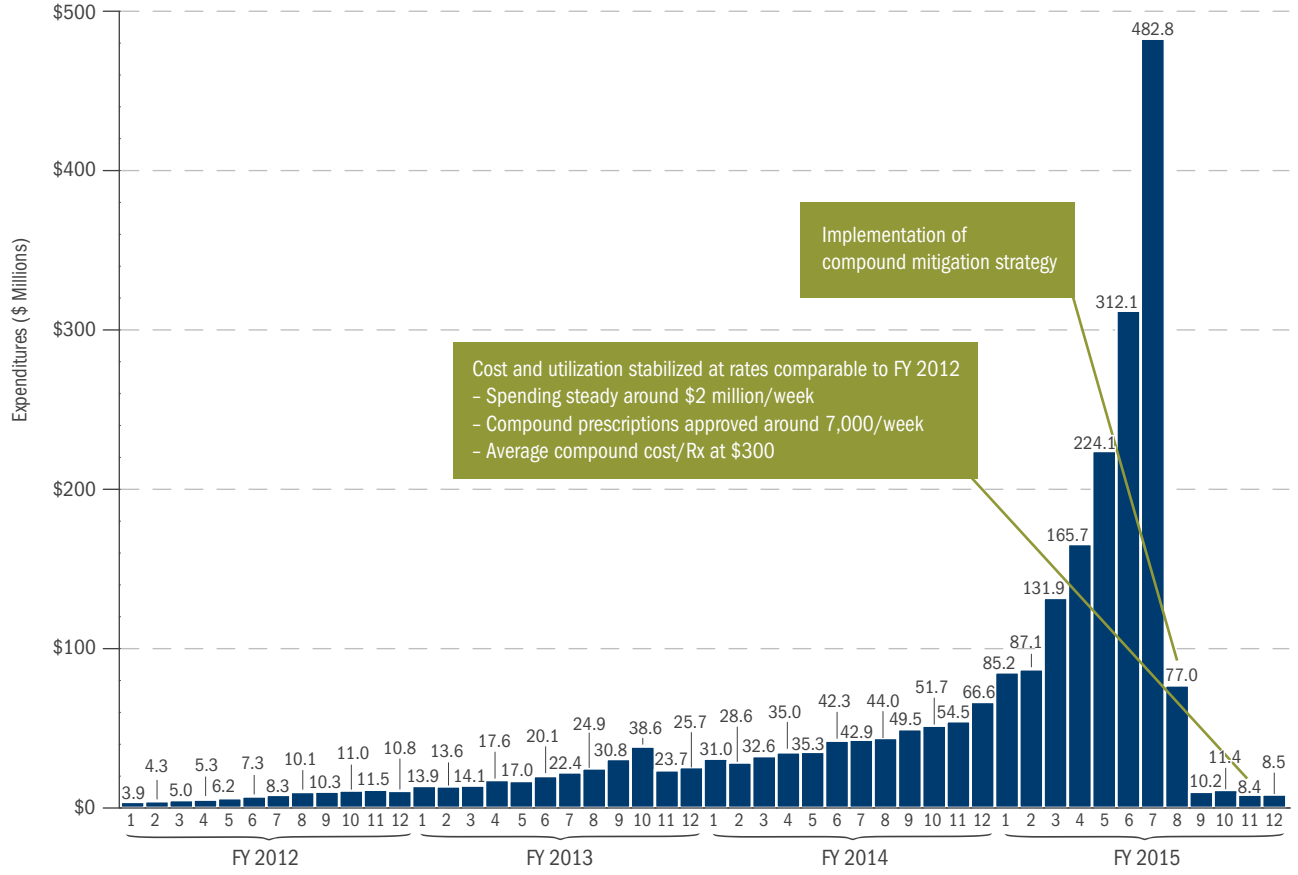
COMPOUND DRUG COST TRENDS

Compound drugs are a combination of two or more drugs prepared by a pharmacist for a patient's individual needs. Unlike traditional medications, compounded products are not regulated by the U.S. Food and Drug Administration (FDA), and therefore lack evidence of safety, efficacy, strength, quality, or purity. Intense marketing and drastic increases in compound ingredient costs led to significant increases in retail compound drug spending and utilization in FY 2015.

From FY 2012 to FY 2015, the average cost for a compounded prescription increased from $170 to $2,135. Compound utilization peaked in April 2015, with 95,228 prescriptions, at a cost of $483 million per month. As a result of nefarious and questionable compound pharmacy practices, DoD costs for compounds rose tenfold in two years. In response to this dramatic increase in compound spending, on May 1, 2015, TRICARE began actively screening all compound prescriptions. This screening process aligned DoD practices with those of commercial health plans. By June 1, 2015, compound spending normalized and returned to pre–FY 2014 levels.

Had the Department not implemented corrective action, which included partnering with the Department of Justice, the compound spending would have exceeded $2 billion in FY 2015. Efforts to manage spending and utilization of compounds are ongoing.

MONTHLY COMPOUND DRUG EXPENSES, FYs 2012–2015



Source: Pharmacy Data Transaction Service (PDTS) Data Warehouse, 12/17/2015

Note: Detailed information regarding the compound approval process can be found at http://tricare.mil/CoveredServices/Pharmacy/Drugs/CompoundDrugs.aspx.

SPECIALTY DRUG COST TRENDS

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

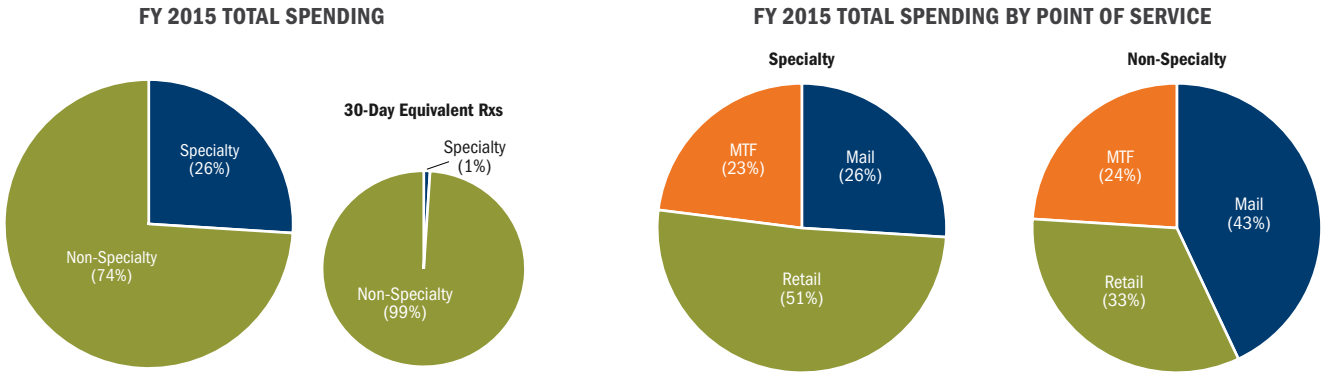
Although the definition of a specialty drug varies across insurers, the DoD has adopted the following guidelines in order to designate a medication as a specialty drug: (1) cost is greater than or equal to $500 per dose or greater than or equal to $6,000 per year; (2) has difficult or unusual process of delivery; (3) requires patient management beyond traditional dispensing practices; or (4) as defined by DoD.

By spending, the top five specialty classes as defined by the Pharmacy & Therapeutics (P&T) committee are oncological agents, targeted immunological biologics, multiple sclerosis agents, Hepatitis C agents, and antihemophilic agents. The DoD P&T committee continually monitors specialty pharmaceutical utilization.

TOP FIVE SPECIALTY CLASSES ($ MILLIONS), AS DEFINED BY P&T COMMITTEE

	FY 2014	FY 2015
Oncological Agents	$414	$502
Targeted Immunological Biologics	$266	$294
Multiple Sclerosis Agents	$192	$205
Hepatitis C Agents	$108	$195
Antihemophilic Agents	$62	$99

MHS SPENDING: SPECIALTY VS. NON-SPECIALTY DRUG SPENDING (EXCLUDING COMPOUNDS)



SPENDING BY QUARTER, FYs 2013–2015

	FY 2013 ($ MILLION)				FY 2014 ($ MILLION)				FY 2015 ($ MILLION)			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Non-Specialty	$1,331	$1,349	$1,348	$1,388	$1,335	$1,335	$1,399	$1,364	$1,368	$1,430	$1,355	$1,350
Specialty	$299	$304	$315	$332	$332	$372	$413	$425	$465	$488	$482	$491
Percentage Specialty[a]	18.3%	18.4%	18.9%	19.3%	19.9%	21.8%	22.8%	23.8%	25.4%	25.4%	26.2%	26.7%

Source: FY 2013 and FY 2014 Specialty Agent Reporting List; FY 2015 spending based on the same list updated Q4 FY 2015 to account for new drugs; totals are adjusted for refunds and copays.

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

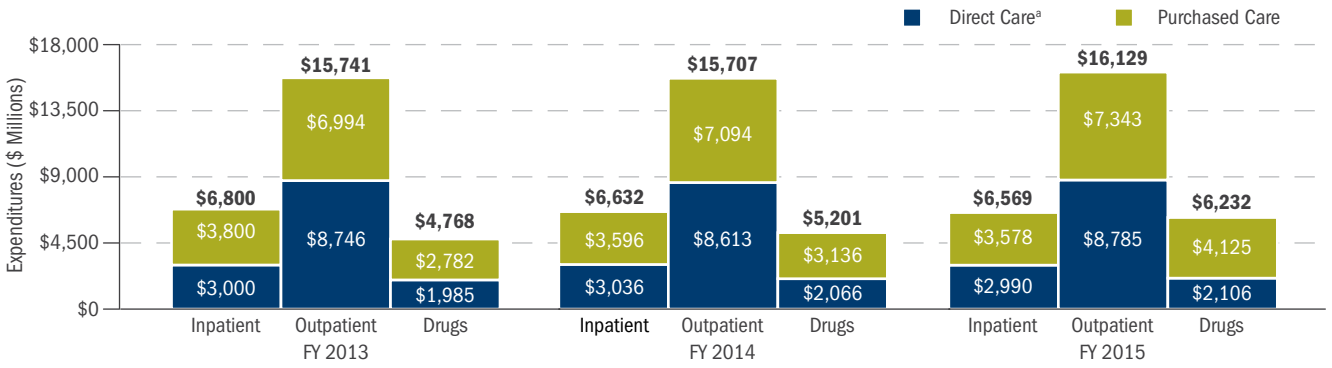
- As a percentage of total drug costs, specialty drug costs increased from FY 2013 to FY 2015.
- In FY 2015, specialty drugs accounted for approximately 1 percent of total MHS prescription drug utilization (30-day equivalents) but for 26 percent of total spending.
- As a potential cost-saving effort, the Services are able to leverage DHA-generated reports to identify and recapture high-cost specialty medications from retail and benefit from more advantageous pharmaceutical pricing at MTFs.
- 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 our beneficiaries.

MHS COST TRENDS

Net of MERHCF costs, total DoD expenditures for health care increased by 6 percent between FY 2013 and FY 2015, driven largely by an increase in prescription drug expenses (31 percent). Outpatient costs increased by 3 percent, while inpatient costs fell by 3 percent.

- The share of DoD expenditures for outpatient care relative to total expenditures for inpatient and outpatient care increased slightly from 70 percent in FY 2013 to 71 percent in FY 2015. For example, in FY 2015, DoD expenses for inpatient and outpatient care totaled $22,698 million, of which $16,129 million was for outpatient care, for a ratio of $16,129/$22,698 = 71 percent.
- Purchased care drug costs shown below have been reduced by manufacturer refunds for retail name brand drugs accrued to the years in which the drugs were dispensed.
- In FY 2015, DoD spent $2.46 on outpatient care for every $1 spent on inpatient care.

TRENDS IN DoD EXPENDITURES FOR HEALTH CARE (EXCLUDING MERHCF)



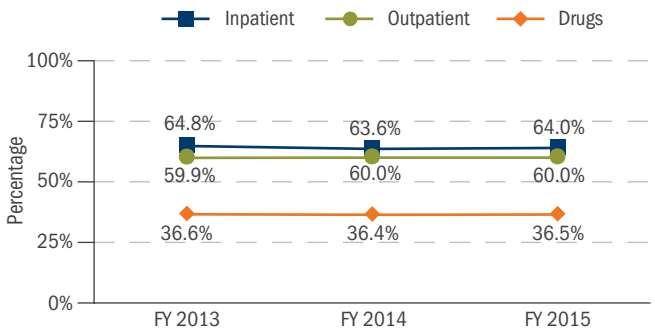
Source: MHS administrative data, 1/19/2016

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

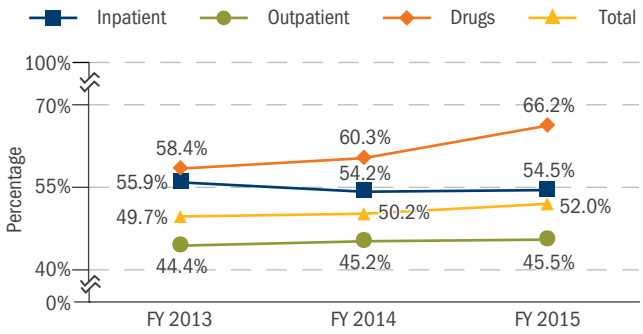
Note: Numbers may not sum to bar totals due to rounding.

- The purchased care share of total inpatient utilization fell by about 1 percentage point from FY 2013 to FY 2015. The purchased care share of outpatient and prescription drug utilization remained unchanged over that time period.
- The purchased care share of total MHS costs increased by 2 percentage points between FY 2013 and FY 2015. The purchased care share of inpatient costs declined, but the share increased significantly for prescription drug costs despite a decline in the share of purchased care utilization.

TRENDS IN PURCHASED CARE UTILIZATION[a] AS PERCENTAGE OF MHS TOTAL BY TYPE OF SERVICE



TRENDS IN PURCHASED CARE COST AS PERCENTAGE OF MHS TOTAL BY TYPE OF SERVICE



Source: MHS administrative data, 1/19/2016

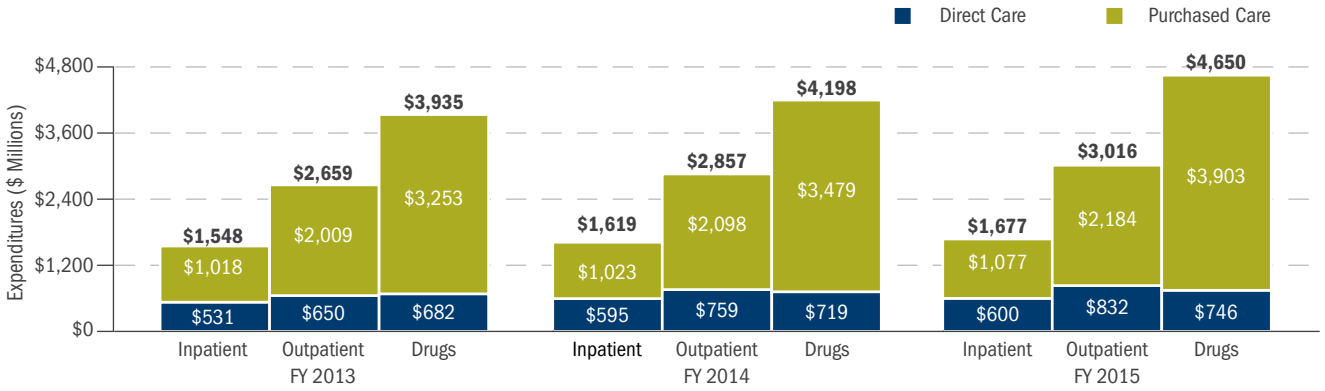
[a] Utilization is measured as RWPs for inpatient care (acute care hospitals only), RVUs for outpatient care, and days supply for prescription drugs. Purchased care drugs include both retail and home delivery.

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 age 65 and above enrolled in Part B. For example, the MERHCF covers MTF care and USFHP costs, whereas TFL does not. Total MERHCF expenditures increased from $8,142 million in FY 2013 to $9,342 million in FY 2015 (15 percent), including manufacturer refunds on retail prescription drugs. The percentage of TFL-eligible beneficiaries who filed at least one claim remained at about 83 percent.

- Total DoD direct care expenses for MERHCF-eligible beneficiaries increased by 17 percent from FY 2013 to FY 2015. The largest increase was for outpatient services, which grew by 28 percent, followed by inpatient services at 13 percent and prescription drugs at 10 percent.
  - In FY 2013, TRICARE Plus enrollees accounted for 72 percent of DoD direct care inpatient and outpatient expenditures on behalf of MERHCF-eligible beneficiaries. By FY 2015, the TRICARE Plus share had grown slightly to 73 percent.
  - Including prescription drugs, TRICARE Plus enrollees accounted for 56 percent of total DoD direct care expenditures on behalf of MERHCF-eligible beneficiaries in FY 2013. By FY 2015, that figure had risen to 59 percent.
- Total purchased care MERHCF expenditures increased by 14 percent from FY 2013 to FY 2015. Inpatient expenditures rose by 6 percent, outpatient expenditures by 9 percent, and prescription drug expenditures by 20 percent.

MERHCF EXPENDITURES FYs 2013–2015 BY TYPE OF SERVICE



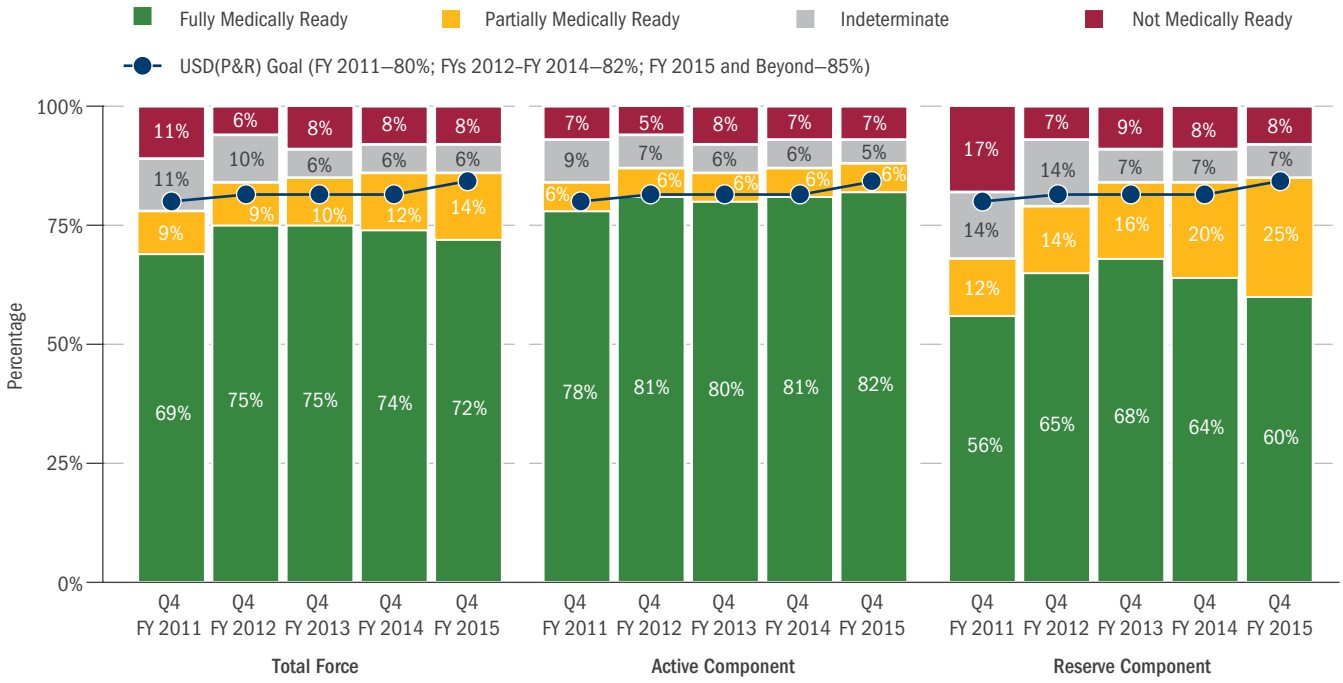
Source: MHS administrative data, 1/19/2016

MEDICAL READINESS OF THE FORCE

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

The IMR chart below shows that by the end of fiscal year (FY) 2015, the total force overall (at 86 percent), the AC (at 88 percent), and the RC (at 85 percent) met or surpassed the Under Secretary of Defense for Personnel and Readiness (USD[P&R]) goal of 85 percent medically ready (shown as the sum of the percentages in the green and yellow sections). Similarly, by the end of FY 2014, the total force overall (at 86 percent), the AC (at 87 percent), and the RC (at 84 percent) exceeded the 82 percent goal for that year. The total force medically ready rate reflects continued Department efforts to improve the overall readiness of the total force. As the total force has improved, the USD(P&R) medical readiness goal has increased, from 80 percent in FY 2011, to 82 percent from FY 2012 to FY 2014, to 85 percent in FY 2015. The IMR status is a component of the MHS Partnership for Improvement (P4I) dashboard and is monitored by the Surgeons General and the Office of the Assistant Secretary of Defense (Health Affairs), in the Quarterly metrics Review and Analysis Forum.

OVERALL INDIVIDUAL MEDICAL READINESS STATUS: Q4 FY 2011 TO Q4 FY 2015
(ALL COMPONENTS NOT DEPLOYED)



Source: Defense Health Agency (DHA), Healthcare Operations Directorate, Public Health Division, 10/26/2015

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

HEALTHY, FIT, AND PROTECTED FORCE

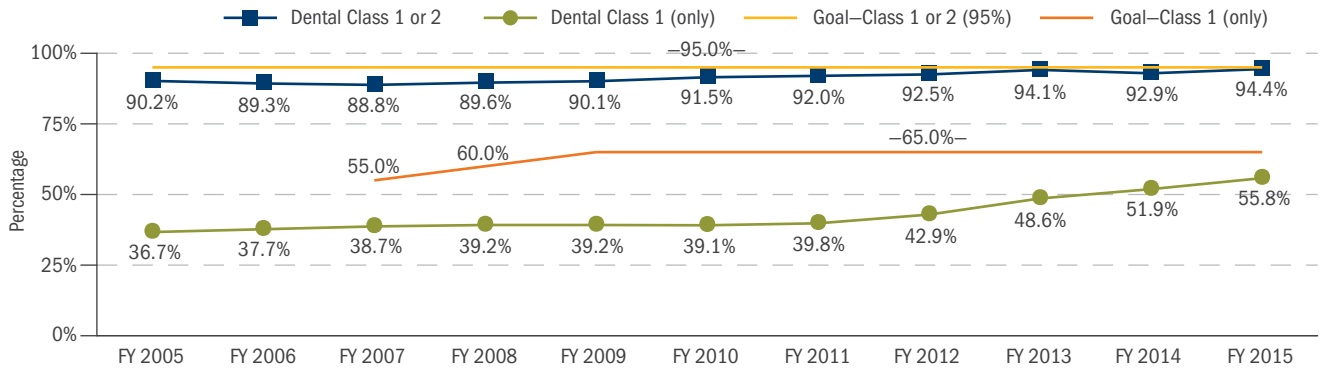
Key among the measures of performance related to providing an efficient and effective deployable medical capability and offering force medical readiness are those related to how well we (1) maintain the worldwide deployment capability of our Service members, as in dental readiness and immunization rates; 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).

DENTAL READINESS

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

- Overall MHS dental readiness in the combined Classes 1 and 2 remains high. Following a generally steady annual increase since FY 2007, the combined Classes 1 and 2 percentage rose again in FY 2015 to 94.4 percent, from 92.9 percent in FY 2014, but remained just below the long-standing MHS goal of 95 percent.
- The rate for Active Duty personnel in Dental Class 1 has increased in the past six years, from about 39 percent (FY 2010) to nearly 56 percent in FY 2015—or nine percentage points short of the MHS goal of 65 percent. The MHS goal of 65 percent was increased in FY 2009 from the 55 percent goal established in FY 2007.

ACTIVE DUTY DENTAL READINESS: PERCENT CLASS 1 OR 2



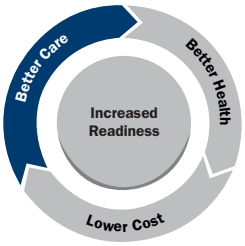
Source: The Services' Dental Corps–DoD Dental Readiness Classifications, 12/14/2015

Definitions:

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

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

ACCESS TO MHS CARE: SELF-REPORTED MEASURES OF AVAILABILITY AND EASE OF ACCESS



In response to the comprehensive review of the Military Health System (MHS) directed in May 2014 by former Secretary of Defense Hagel, MHS has focused on (1) improving access to medical care to meet defined standards; (2) ensuring that the quality of its health care meets or exceeds defined benchmarks; and (3) creating a culture of safety with effective processes for ensuring safe and reliable care of beneficiaries. In this review, key staff from all three Services and the Defense Health Agency (DHA) conducted site visits at selected military hospitals in the United States (U.S.) and one overseas. The review examined existing measures used to assess access, quality, and patient safety in military treatment facilities (MTFs). Data were also provided by three top-performing civilian health care medical centers to establish a benchmark for what great performance looks like. The report concluded that, although MHS is meeting the standards set by the Department of Defense (DoD), further work is required to exceed the U.S. average.

Building on last year's report, the following summarizes key action plan initiatives for direct care accomplished in fiscal year (FY) 2015 and targeted for FY 2016.

Access to Care

2015	2016
Deployed nurse advice line (NAL) across MHS	Streamlining specialty appointing and referral management
Ensured "First Call Resolution," no call-back policies	Continuing to expand and promote use of secure messaging
Introduced Simplified Appointing	Optimizing Patient-Centered Medical Home (PCMH)
Expanded availability of TRICARE Online (TOL) and secure messaging	

Quality of Care

2015	2016
Expanded National Surgical Quality Improvement Program (NSQIP)	Continuing to expand NSQIP; adding ambulatory surgery benchmarking program
Deployed Essentris® 2.0 (Partnership for Patients requirements)	Enhancing data transparency
Developed and implemented Essentris Newborn Note 1.0	Developing perinatal dashboard of quality metrics
Prioritized DoD/VA clinical practice guidelines for MHS direct care	Developing career path for quality experts
Contracted the Joint Commission "High Reliability Self-Assessment Tool" (HRST) pilot (at four MTFs)	Implementing educational module on Prevention Quality Indicators (PQIs)

Patient Safety

2015	2016
Published interim sentinel event policy	Implementing sentinel event policy
Approved hiring of an infection preventionist position for each Service and DHA	Implementing infection control plan
Developed Root Cause Analysis (RCA) Toolkit and Web-based repository of RCA lessons learned	Implementing Leadership Engagement Strategies Toolkit
Developed Leadership Engagement Strategies Toolkit	Acquiring and deploying Institute for Healthcare Improvement (IHI) Global Trigger Tool (GTT)
Identified role-based competencies and education for patient S/Q/PI	Developing strategies for S/Q/PI education as a learning organization
Acquired postpartum hemorrhage operative simulator	Acquiring clinical obstetric emergency simulator; standardizing obstetric simulation training across MHS

Purchased Care

2015	2016
Standardized TRICARE regional office (TRO) reporting to the Services	Improving assessment of quality and safety in the purchased care sector
Studied purchased care access and patient satisfaction in the direct and purchased care systems	Ensuring T-17 managed care support contractors monitor access to care relative to the 32 CFR standards
	Improving the quality of administrative data used by the MHS Population Health Portal to report HEDIS measures for purchased care
	Introducing changes to the current contracts and TRICARE operations manual
	Continuing efforts to pursue Joint Outpatient Experience Survey
	Conducting a study to further understand reasons for patient satisfaction and dissatisfaction with access to care in both direct and purchased care

ACCESS TO MHS CARE: SELF-REPORTED MEASURES OF AVAILABILITY AND EASE OF ACCESS *(CONT.)*

In addition to Department efforts to assess and improve MHS access, quality, and safety, Section 713 of the National Defense Authorization Act (NDAA) for FY 2016 also requires MHS to incorporate into this annual Evaluation of the TRICARE Program measures of access, quality, and patient safety at the MTF level. Section 712 further requires the Department, within 180 days of enactment of the NDAA, to provide results of these measures at the MTF level on publicly available Web sites. Because of the timing of the legislation and the immense amount of detail that is required on the access, quality, and safety at each MTF, this report seeks to meet the intent of Congress by addressing many of the access, quality, and patient safety measures at the MHS enterprise level, and providing the Internet hyperlink to the official website of the Military Health System and the Defense Health Agency, which will be modified in FY 2016 in response to Section 712. While enterprise-level reports on access, quality, safety, and patient satisfaction are currently available through the publicly facing Web portal at www.health.mil (and then by clicking the link circled below), this link will be expanded to present data at the MTF level as well, provided by the Military Departments. The Department will notify Congress in a supplemental report when the Web site has been modified to reflect MTF-level data.

Section 713 of NDAA 2016 specifically requires MHS to address patient safety, quality of care, and access to care at military medical treatment facilities. These requirements include the following:

a. An identification of the number of practitioners providing health care in military medical treatment facilities that were reported to the National Practitioner Data Bank during the year preceding the evaluation; and

b. With respect to each military medical treatment facility, an assessment of:

   i. The current accreditation status of such facility, including any recommendations for corrective action made by the relevant accrediting body;

   ii. Any policies or procedures implemented during such year by the Secretary of the military department concerned that were designed to improve patient safety, quality of care, and access to care at such facility;

   iii. Data on surgical and maternity care outcomes during such year;

   iv. Data on appointment wait times during such year; and

   v. Data on patient safety, quality of care, and access to care as compared with standards established by DoD with respect to patient safety, quality of care, and access to care.

Beginning with last year's report, the following sections address many aspects of MHS access, quality, and patient safety, and have been modified in response to the current legislation.

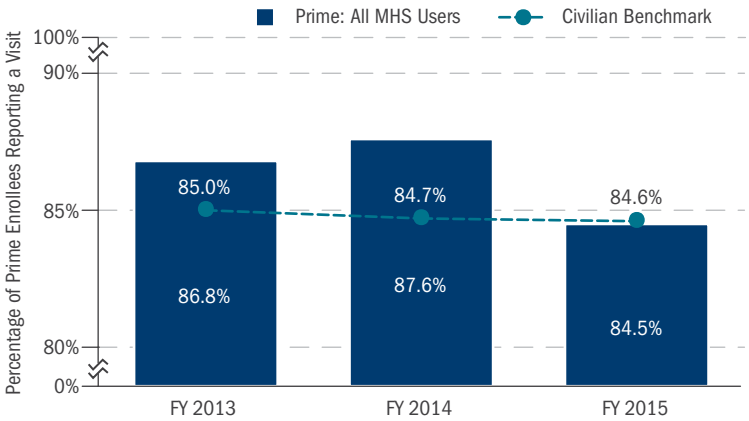
ACCESS TO MHS CARE: SELF-REPORTED MEASURES OF AVAILABILITY AND EASE OF ACCESS *(CONT.)*

Overall Outpatient Access

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

- The ability to see a doctor reflects one measure of successful access to the health care system. Prime enrollees were asked whether they had at least one outpatient visit during the past year. As shown in the chart (at right), access to and use of outpatient services remains high among Prime enrollees (with either a military or civilian primary care manager [PCM]), with about 85 percent reporting at least one visit in FY 2015, a decrease from almost 87 percent in FY 2013 but comparable to the civilian benchmark.

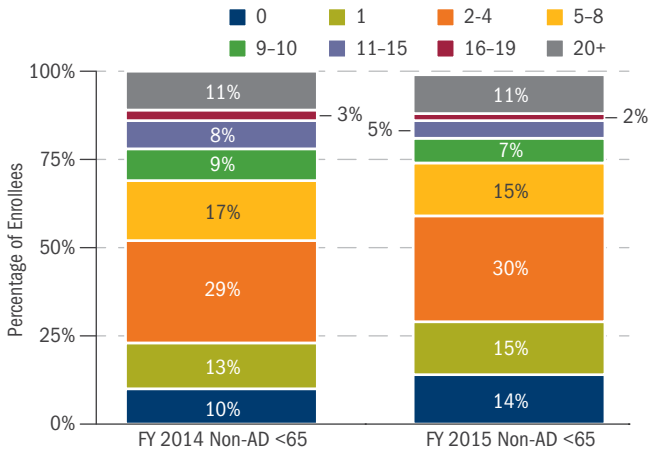
TRENDS IN PRIME ENROLLEES HAVING AT LEAST ONE OUTPATIENT VISIT DURING THE YEAR



Note: DoD data were derived from the FYs 2013–2015 Health Care Survey of DoD Beneficiaries (HCSDB), as of 10/19/2015, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 4.0, used in the 2013 survey, and CAHPS Version 5.0 for the 2014 and 2015 surveys. CAHPS results come from the National CAHPS Benchmarking Database (NCBD) for commercial health plans and from survey results submitted to the National Committee for Quality Assurance (NCQA) by commercial plans. Benchmarks used in 2013 come from the 2011 NCBD, while benchmarks for 2014 and 2015 come from NCQA's 2013 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

- Based on administrative utilization data shown in the chart (at right), 86 percent of all non-Active Duty MTF enrollees had at least one recorded outpatient visit for primary care reasons in FY 2015 (i.e., through July 2015, all but 14 percent had at least one visit), while most (45 percent) had between one and four visits in FY 2015, 25 percent had nine or more visits, and 11 percent had 20 or more visits.

PERCENTAGE OF MTF NON-ACTIVE DUTY <65 BY NUMBER OF ANNUAL VISITS (ANY VENUE)



Source: MHS administrative data systems (M2), DHA/Healthcare Operations (HCO)/PCMH, 11/10/2015

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

ACCESS TO CARE: PATIENT-CENTERED MEDICAL HOME (PCMH) PRIMARY CARE

As of September 2015, almost 3.6 million beneficiaries were enrolled to MTF primary care clinics, which have transformed to a PCMH model of primary care. More than 85 percent of the direct care system's family medicine, internal medicine, pediatrics, and operational medicine clinics have achieved formal PCMH recognition from the NCQA. MHS expects to complete initial NCQA PCMH recognition of all primary care clinics by the end of calendar year (CY) 2016. 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.[1] Improvement in PCM continuity reinforces a central strategy of the PCMH model—to support a continuous relationship between a patient and his or her provider.[2]

Access to Care: PCM and PCMH Team Continuity

The PCM-patient relationship continues to be the driving force to improve quality and better health outcomes for MTF-enrolled beneficiaries. Based on MTF administrative appointment tracking (consolidated in the TRICARE Operations Center), in FY 2015, enrollees saw their own PCMs during primary care visits 60 percent of the time, and 91 percent of the time from their own PCM or a fellow PCMH team provider.

	FY 2012	FY 2013	FY 2014	FY 2015
PCM Continuity	55%	58%	60%	60%
PCMH Team Continuity	86%	90%	91%	91%

Source: MHS Administrative Data (M2); Tri-Service Primary Care PCMH Advisory Board, DHA/HCO/PCMH, 11/6/2015

Access to Care—Appointment Wait Times: Average Number of Days to Acute and Future Appointments

The direct care system prospectively measures access to primary care by evaluating the average number of days to the third next 24-hour or acute appointment and third next future appointment against the MHS goal of 1.0 and 7.0 days, respectively. Prospective measurement of access to care is considered a more sensitive and accurate measure of access compared with retrospective analysis of when the appointment was booked. For access to acute care appointments, the MHS average is improving, but, on average, remains higher than the 24-hour standard. In FY 2015, the average number of days to a third next acute appointment was 1.72 days, a 9 percent improvement over the 1.89 days average for FY 2014 and a 17 percent improvement over the 2.07 days average for FY 2013. However, the MHS met the standard of 7.0 days for future appointments since FY 2012; and, in FY 2015, the MHS averaged 6.85 days to a third next future appointment. The 2014 MHS Review of Quality, Safety, and Access determined that while, on average, access to care meets the identified MHS standards, performance varies across the system. In FY 2015, the variance among MTF access to care performance improved 27 percent in the average number of days to the third next acute appointments and 3 percent in the average number of days to the third next future appointments, as compared with FY 2014, with more MTFs performing better than the MHS access goals. In late FY 2015, the direct care system began implementing several new processes to further improve access to care. The direct care system's new Simplified Appointing policy reduces the number of appointment types used to increase the number of appointments available for acute and routine medical needs, as well as to change the focus to better support patient preference for scheduling an appointment.

	FY 2012	FY 2013	FY 2014	FY 2015
Avg. # Days to Third Next 24-Hour Appointment	2.09	2.07	1.89	1.72
Avg. # Days to Third Next Future Appointment	6.62	6.51	6.38	6.85

Source: TRICARE Operations Center data evaluated and modified by Tri-Service Primary Care PCMH Advisory Board, DHA/HCO/PCMH, 11/06/2015

Access to Integrated Specialists in the PCMH

The direct care system has made efforts to provide better access to comprehensive, coordinated care in the PCMH and to improve outcomes by embedding specialty providers based on MTF enrollees' most common medical conditions. As of the end of FY 2015, embedded behavioral health (BH) specialists are available in 81 percent of applicable PCMHs. Integrated BH providers address both behavioral health and health for all direct care system enrollees aged 18 years or older. PCMH clinical pathways have been developed and are being implemented for BH-related issues prevalent in the MTF Prime population, including alcohol misuse, anxiety, depression, diabetes, obesity, chronic pain, sleep problems, and tobacco use. Data through the first quarter of FY 2015 indicate that PCMH enrollees with at least two integrated BH specialist appointments showed statistically significant improvement from their first to last appointment in global mental health, as measured by the Behavioral Health Measure 20. The global mental health score is a composite that includes life satisfaction, psychological symptoms, social relations, and life functioning. The direct care system also has begun implementation of integrated physical therapists and integrated clinical pharmacists to address and improve a variety of common medical conditions in the enrolled population.

[1] Source: Tri-Service Primary Care PCMH Advisory Board

[2] Source: MHS Administrative Data

Dispositions and Bed-Days per 1,000 MTF Enrollees

PCMH goals include reducing dispositions (admissions) and bed-days per 1,000 MTF enrollees by proactively addressing and coordinating MTF enrollee comprehensive care in the PCMH setting. PCMH teams are working to reduce the number of times MTF enrollees are admitted to hospitals and medical centers in both the direct and purchased care sectors, and the length of time they spend as inpatients if they are admitted, which is measured by bed-days (number of dispositions multiplied by the length of stay). The dispositions per 1,000 MTF enrollees averaged 21.0 in FY 2015 through the second quarter, a reduction of 7 percent from the 22.6 dispositions per 1,000 in FY 2013, with a commensurate reduction in the number of bed-days per 1,000 MTF enrollees from 121.2 bed-days in FY 2013 to 113.5 bed-days per 1,000 enrollees in FY 2015 (a reduction of 6 percent).[1]

	FY 2012	FY 2013	FY 2014	FY 2015
Dispositions per 1,000 Enrollees	24.6	22.6	21.0	21.0
Bed-Days per 1,000 Enrollees	130.4	121.2	115.6	113.5

Source: MHS Administrative Data (M2); Tri-Service Primary Care PCMH Advisory Board, DHA/HCO/PCMH, 11/6/2015

Recapturable Emergency Room Visits in the Private Sector per 100 Enrollees

The direct care system continues to reduce primary care–recapturable emergency room (ER) visits to the private sector in order to reduce fragmented, episodic, and expensive care. Efforts to reduce ER visits include better access to 24-hour care in PCMH, walk-in clinics for common acute conditions, the use of PCMH team members to meet patients' needs, and the use of the Nurse Advice Line and Secure Messaging. As of July 31, 2015, the average number of primary care network ER visits per 100 MTF enrollees for primary care reasons decreased 23 percent compared to the FY 2013 average. In FY 2015, 14 percent of all network ER visits by MTF enrollees were for primary care reasons. Due to the direct care system's efforts to provide more continuous care overall in the MTF, overall network ER visits for all reasons, including true emergencies, declined 5 percent over the same period.

YEAR	AVERAGE NETWORK ER VISITS PER 100 MTF ENROLLEES (INCLUDING TRUE EMERGENCIES)	AVERAGE NETWORK ER VISITS PER 100 MTF ENROLLEES FOR POTENTIALLY PRIMARY CARE REASONS
FY 2012	23.01	13.77
FY 2013	22.27	13.30
FY 2014	22.19	12.94
FY 2015 (through July 31, 2015)	21.06	11.99
Two-Year Improvement	–5%	–10%

Source: MHS Administrative Data (M2); Tri-Service Primary Care PCMH Advisory Board, DHA/HCO/PCMH, 11/6/2015

Enhanced Access to Care: Nurse Advice Line (NAL)

MHS also implemented the continental United States (CONUS) NAL in FY 2014 to provide MHS beneficiaries with access to a team of registered nurses who offer advice and help beneficiaries decide what type of health care is needed to address their medical condition. The NAL is also able to make PCMH appointments for the beneficiary if he or she is enrolled in the direct care system. If the NAL is unable to arrange care for direct care system enrollees in the MTF, the NAL helps the caller obtain urgent care in the network. Since implementation in late March 2014, the NAL has received almost one million calls, 94 percent of which are from direct care system enrollees. Current call volume is over 1,700 calls per day. The direct care system analyzed 400,000 FY 2015 calls from direct care system enrollees to compare patient pre-intent with NAL advice and what action the patient took following the call. The NAL demonstrated it was able to safely and cost-effectively direct patients to the most clinically appropriate level of care. Overall, 33 percent of callers originally intended to seek network ER care; after calling the NAL, only 11 percent did so. In FY 2015, callers were able to obtain needed care in their own MTF 44 percent of the time.

DISPOSITION	CALLER'S PRE-INTENT	NURSE ADVICE	CALLER'S ACTION WITHIN 24 HOURS
Network ER	33%	9%	11%
Network Urgent Care	25%	31%	14%
Direct Care MTF	31%	26%	44%
Self-Care at Home	7%	33%	30%
Other	4%	1%	1%

Source: HCO/PCMH from NAL, 11/6/2015

Enhanced Access to Care: Secure Messaging

The direct care system continues to offer enhanced access to care through the use of a commercially available secure messaging system. Secure messaging allows MTF enrollees to communicate directly with their PCMs and PCMH teams to ask questions about their health or medical tests and to arrange referrals or appointments. As of the end of FY 2015, over 1.3 million MTF enrollees were registered in secure messaging (or 37 percent of all MTF Prime and TRICARE Plus [seniors] enrollees), an increase of about 319,000 potential users. As to actual usage, in FY 2015, 9 percent of registered patients initiated a secure message with their PCM team each month. Although not shown in the table (at right), analysis of the primary reasons patients initiate messages include: asking a medical question (56 percent), arranging primary care appointments (15 percent), or renewing medications (12 percent). The direct care system is developing a campaign to increase the utilization of secure messaging by registered enrollees. In FY 2015, the direct care system changed the response time goal to 24 hours or one business day, from the previous goal of 72 hours. By the end of FY 2015, 78 percent of patient-initiated messages were responded to within one business day, compared to 68 percent at the beginning of FY 2015.

	FY 2014	FY 2015
Percent of MTF Enrollees Registered in Secure Messaging	28%	37%
Percent of Patient-Initiated Messages per Registered User	10%	9%
Enrollees Registered	999,297	1,318,169
Patient-Initiated Messages	112,128	114,912

Source: Secure Messaging Program Office; DHA/Defense Health Services Systems (DHSS), 11/6/2015

Primary Care Utilization

The direct care system has made progress in reducing unnecessary primary care office visits per enrollee by meeting patient needs in more convenient ways, including telephone visits, walk-in clinics for common acute conditions, and secure messaging. Office visits for primary care conditions, delivered in the direct care system or in network ERs or urgent care, decreased 4 percent in FY 2014 compared with FY 2012. Direct care primary care utilization is significantly higher than the national average of 1.43 visits per year among an insured population in a 2013 report from the Health Care Cost Institute[1] and 1.66 visits per year among an insured population in a 2010 report from the Centers for Disease Control.

	FY 2012	FY 2013	FY 2014	FY 2012–2014 CHANGE
Direct Care Enrollee Annual Primary Care Utilization Rate (Face-to-Face Visits per Enrollee per Year)	4.02	4.00	3.87	–3.7%

Source: MHS Administrative Data (M2); Tri-Service Primary Care PCMH Advisory Board, DHA/HCO/PCMH, 11/6/2015

[1] 2013 Health Care Cost and Utilization Report; Health Care Cost Institute; October 2014

ACCESS TO CARE: PATIENT-CENTERED, SELF-REPORTED MEASURES

In addition to tracking patient care using administrative and provider-centric data, including patient self-reported information provides a more complete assessment of the performance of the health care system, from the nonmedical user's perspective. There are a number of methods for evaluating the patient's experience: face-to-face encounters, complaint and suggestion programs, focus groups, and surveys. Within surveys, patients can be asked about their experience following a specific event and time, as in event-based surveys after an outpatient visit or discharge from a hospital.

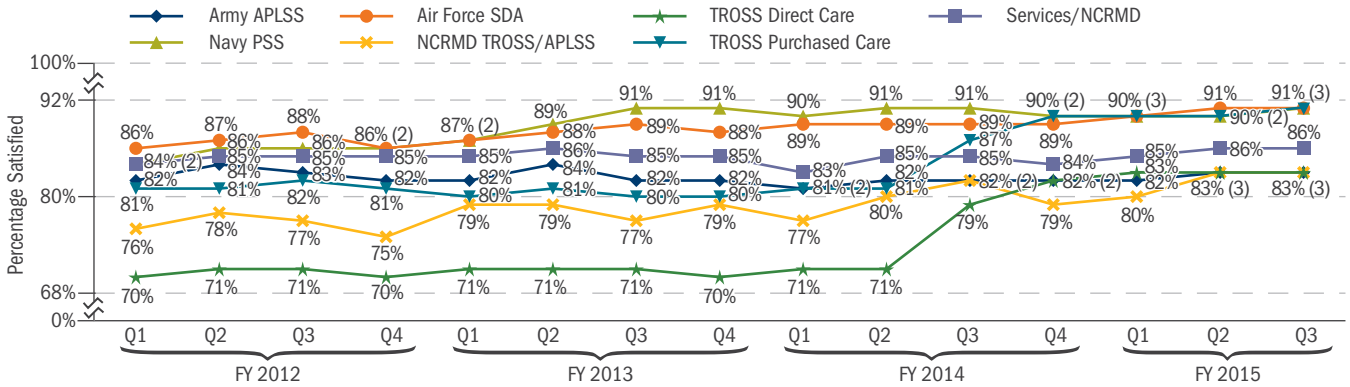
The goal of MHS outpatient surveys is to monitor and report on the experience and satisfaction of MHS beneficiaries who have received outpatient care in an MTF or civilian provider office. The TRICARE Outpatient Satisfaction Survey (TROSS) is based on the Agency for Healthcare Research and Quality (AHRQ) CAHPS Clinician and Group questionnaire (CAHPS® C&G). The TROSS instrument also includes MHS-specific questions that measure satisfaction with various aspects important to MHS. The TROSS supports standardized comparison of beneficiary experiences across different Service Departments, between direct and purchased care, and with civilian benchmarks using the same survey.

The Army, Navy, and Air Force also field individual outpatient Service satisfaction surveys: the Army Provider Level Satisfaction Survey (APLSS), the Navy Patient Satisfaction Survey (PSS), and the Air Force Service Delivery Assessment (SDA). Service surveys focus on MTF care within each Service and provide extensive detailed data for each MTF, for clinics within MTFs, and down to the individual providers. Service surveys provide transparency across a Service's MTFs and allow providers to understand beneficiary perceptions of the care they provide.

Beneficiary Ratings of Access to Care Following Outpatient Treatment

- Combining DHA and Service Surveys: The measure **Getting Care When Needed** is a common item across all outpatient Service surveys, APLSS, PSS, SDA, and TROSS direct care and purchased care. The chart below presents overall ratings of this access measure for FY 2012 to FY 2015 Q3. Navy PSS beneficiary ratings and Air Force SDA beneficiary ratings are consistently above the Service average (Services/National Capital Region Medical Directorate [NCRMD]) across time. TROSS beneficiary ratings are higher for beneficiaries receiving outpatient care at civilian facilities than for beneficiaries receiving care at MTFs. In the most recent quarter, FY 2015 Q3, the TROSS rating rose to 91 percent for beneficiaries within the purchased care system and remained at 83 percent for beneficiaries within the direct care system. Note: The TROSS instrument was changed during this time, and the new TROSS survey was fielded in May 2014. This results in a change in the satisfaction score starting in FY 2014 Q3.

RATING OF GETTING CARE WHEN NEEDED, USING MULTIPLE SURVEYS



Source: OASD(HA)/DHA Decision Support TROSS, Air Force SDA, Army APLSS, and Navy PSS results as of FY 2015 Q3 (June 2015), compiled 12/1/2015

Notes:

– Satisfied respondents for Getting Health Care When Needed are identified by those who responded with "Somewhat Agree" or "Strongly Agree" on the scale "Strongly Disagree, Somewhat Disagree, Neither Agree nor Disagree, Somewhat Agree, and Strongly Agree."

– FY 2014 Q3 data include May and June data only because the new TROSS instrument was fielded in May 2014.

– "Direct Care" refers to MTF-based care; "Purchased Care" refers to care provided in the private sector through the claims-based reimbursement process.

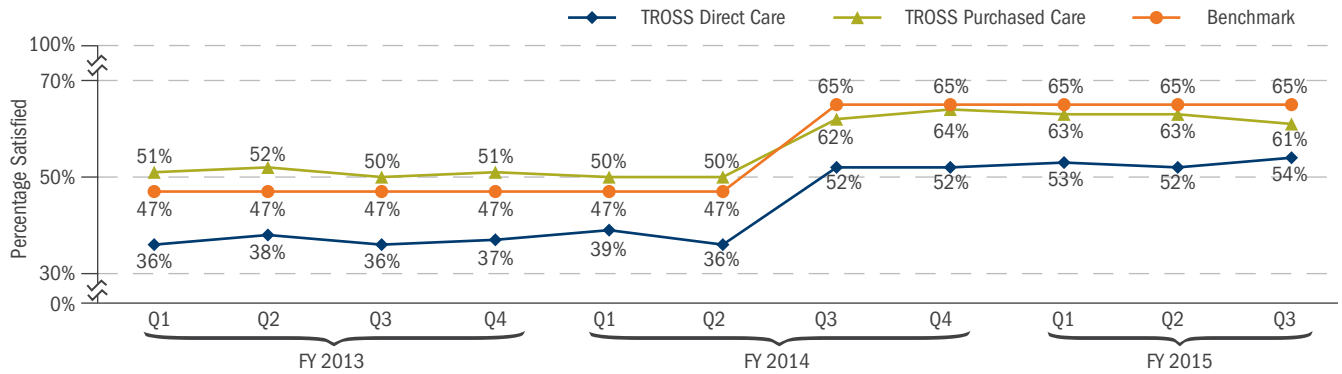
– All MHS Direct Care data are adjusted for selection, nonresponse, gender, beneficiary category, and TRICARE region.

– All MHS civilian Purchased Care data are adjusted for selection, nonresponse, gender, beneficiary category, age, and TRICARE region.

Beneficiary Ratings of Access to Care Following Outpatient Treatment *(cont.)*

- Using the TROSS instrument only, MHS beneficiary overall ratings of **Access to Care** for FY 2013 to FY 2015 Q3 are shown below. This measure is based on the CAHPS C&G survey and has a comparable CAHPS 50th percentile benchmark as noted in the legend. Access to Care ratings for beneficiaries receiving outpatient care at civilian facilities are higher than for those receiving care from MTFs. In the most recent quarter, FY 2015 Q3, the beneficiary rating in the direct care system was 54 percent, while the rating for beneficiaries in the purchased care system was 61 percent. Beneficiary ratings within both the direct care and purchased care systems were statistically significantly below the benchmark in FY 2015 Q3. As noted above, the TROSS instrument was changed during this period, and the new TROSS survey was fielded in May 2014 (i.e., partway through FY 2014 Q3).

TROSS ACCESS TO CARE COMPOSITE



Source: OASD(HA)/DHA Decision Support TROSS survey results as of FY 2015 Q3 (June 2015), compiled 12/1/2015

Notes:

- Percentage satisfied for the "Access to Care" composite is scored as "Always" on the scale of "Never, Sometimes, Usually, Always."
- FY 2014 Q3 data include May and June data only because the new TROSS instrument was fielded in May 2014.
- This measure is based on the CAHPS C&G and has a comparable CAHPS 50th percentile benchmark as noted in the graph.
- "Direct Care" refers to MTF-based care; "Purchased Care" refers to care provided in the private sector through the claims-based reimbursement process.
- All MHS direct care data are adjusted for selection, nonresponse, gender, beneficiary category, and TRICARE region.
- All MHS civilian purchased care data are adjusted for selection, nonresponse, gender, beneficiary category, age, and TRICARE region.

Availability of Mental Health Providers for Active Duty and Families

Given the tremendous growth in DoD mental health staffing since early FY 2002, the current level of behavioral health resourcing appears adequate to serve all Active Duty and eligible Reserve Component members and their families, as well as retirees and their dependents. Since 9/11, with the support of Congress, DoD has increased the outlays for mental health care by a 10 percent compounded annual rate from FY 2002 through FY 2014.

Approximately 21 percent of the Active Duty force was seen by a mental health professional in 2015, averaging just under nine visits per Service member seeking care. In addition, care is embedded into both primary care clinics and fighting units. The number of mental health providers in MHS has risen to 9,295, an increase of 42 percent from FY 2009 through FY 2015. Further, TRICARE network assets have been bolstered to better serve Reservists, dependents, and retirees, with a total of 81,780 mental health providers available in the purchased care network. Finally, DoD provides state-of-the-art substance abuse care, including medical therapies for addiction and confidential alcohol abuse treatment, as well as some of the most comprehensive benefits for autism spectrum disorders in the nation, including care to provide early intervention.

Health Care and Related Support for Children of Members of the Armed Forces

As the MHS tackles the challenges of lack of readily comparable data between direct and private sector care, and within the direct care system, more comprehensive data should become available to demonstrate the excellent care provided for all beneficiaries, including children. Additionally, TRICARE continues to evaluate statutory authority and benefit alignment with the Affordable Care Act for pediatric well-child and preventive care. Benefits for certain eligible Extended Care Health Option (ECHO) beneficiaries changed in 2015 to receive incontinence supplies based on the Military Compensation and Reimbursement Commission report. Additionally benefit changes are in process for the inpatient psychiatric length of stay and residential treatment facilities for substance abuse for children. The newly chartered Pediatric Advisory Working Group will focus on pediatric priorities in the MHS. TRICARE continues to evaluate and adjust benefits within the statutory and regulatory authority granted by Congress.

ACCESS TO CARE: BENEFICIARY RATINGS BASED ON POPULATION-WIDE SURVEYS

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 Active Duty Service members about their health behaviors, or a survey of all MHS beneficiaries to assess their use of preventive services and access to primary and specialty care), as in the case of the DHA Health Care Survey of DoD Beneficiaries (HCSDB).

This section begins with an assessment of beneficiary access to care based on a population survey, and compares with national benchmarks; then it presents the results of beneficiary access to care based on several different surveys following beneficiaries' outpatient visit.

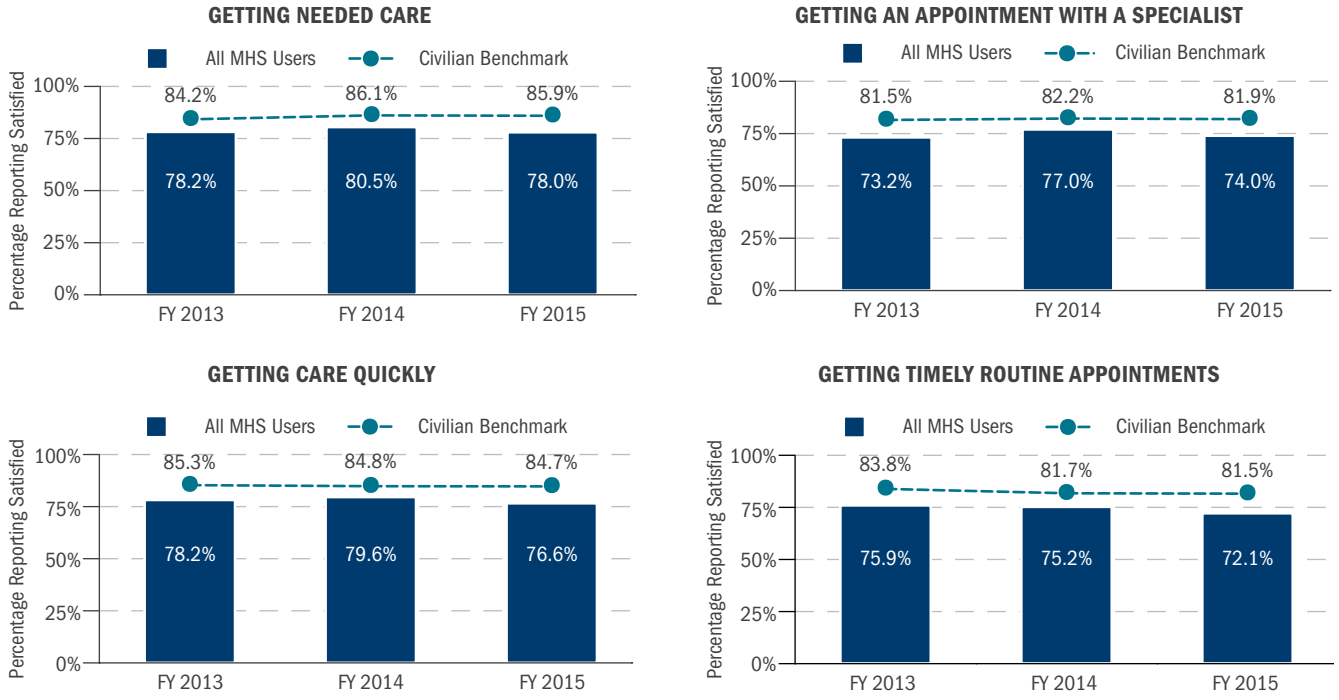
Availability and Ease of Obtaining Care

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 Needed Care** (composite) remained stable from FY 2013 to FY 2015, while ratings for getting referrals to specialists improved. Ratings for **Getting Care Quickly** and **Getting Timely Routine Appointments** both declined slightly over the three-year period, as did the civilian benchmarks.
- All MHS access measures continued to lag the comparable civilian benchmarks.

BETTER CARE

TRENDS IN MEASURES OF ACCESS FOR ALL MHS BENEFICIARIES (ALL SOURCES OF CARE)



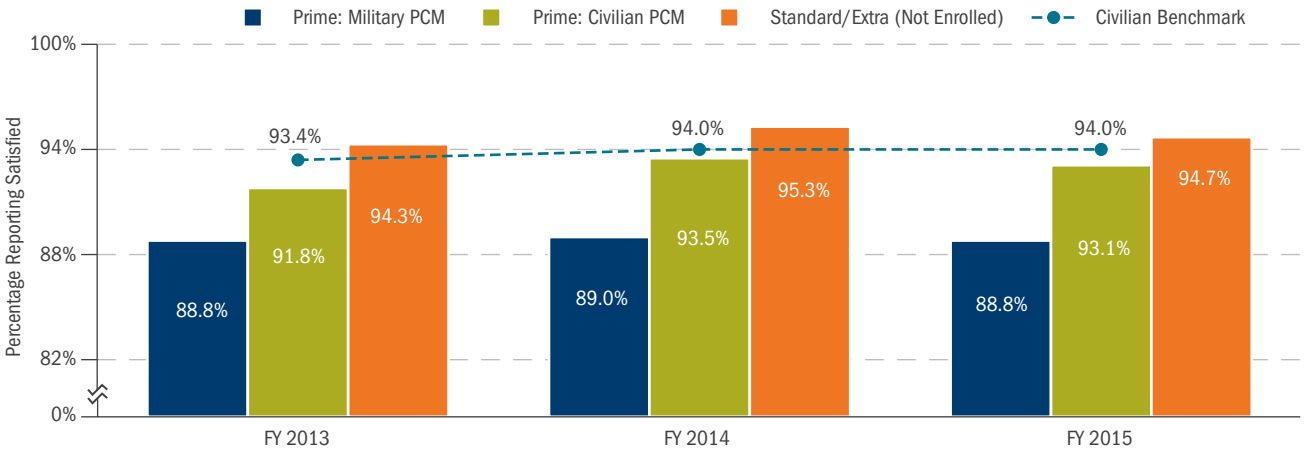
Note: DoD data were derived from the FYs 2013–2015 HCSDB, as of 10/19/2015, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for more a detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 4.0, used in the 2013 survey, and CAHPS Version 5.0 for the 2014 and 2015 surveys. CAHPS results come from the National CAHPS Benchmarking Database (NCBD) for commercial health plans and from survey results submitted to the National Committee for Quality Assurance (NCQA) by commercial plans. Benchmarks used in 2013 come from the 2011 NCBD, while benchmarks for 2014 and 2015 come from NCQA's 2013 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

Satisfaction with Doctors' Communication

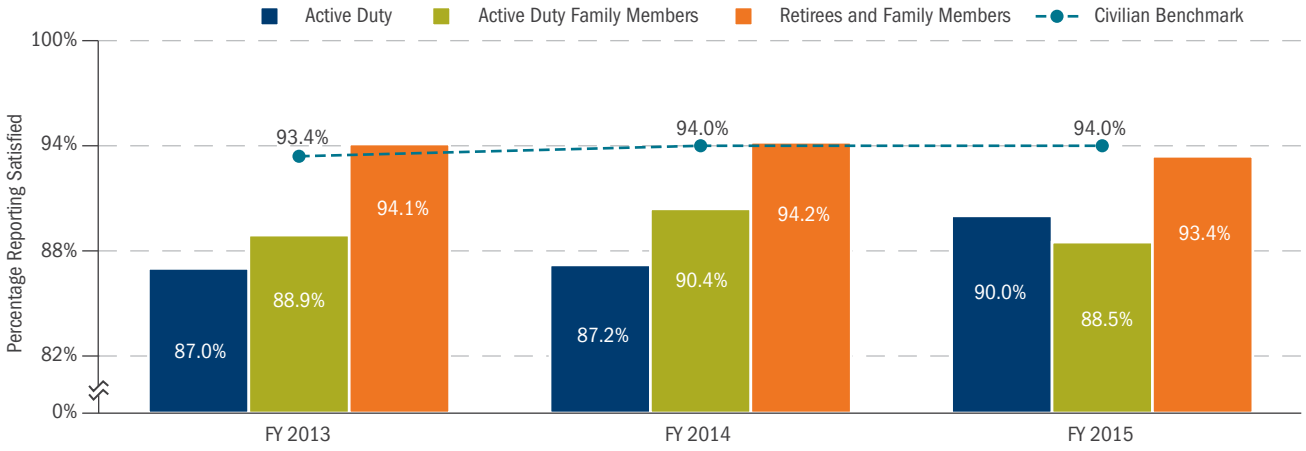
Communication between doctors and patients is an important factor in beneficiaries' satisfaction and their ability to obtain appropriate care. The following charts present beneficiary-reported perceptions of how well their doctor communicates with them.

- Prime enrollee and non-enrollee satisfaction levels with their doctors' communication remained stable between FY 2013 and FY 2015. Satisfaction levels for those with a civilian PCM were higher than for those with a military PCM. Satisfaction ratings in the civilian benchmark increased slightly.
- The civilian benchmark for satisfaction with doctors' communication was not significantly different from any of the satisfaction ratings by enrollment status.
- The levels of satisfaction with doctors' communication remained stable for Active Duty family members (ADFMs) and retirees and family members, but increased for Active Duty.
- Satisfaction with doctors' communication lagged the civilian benchmark for Active Duty, ADFMs, and retirees and family members.

TRENDS IN SATISFACTION WITH DOCTORS' COMMUNICATION BY ENROLLMENT STATUS



TRENDS IN SATISFACTION WITH DOCTORS' COMMUNICATION BY BENEFICIARY CATEGORY



Note: DoD data were derived from the FYs 2013–2015 HCSDB, as of 10/19/2015, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for more a detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 4.0, used in the 2013 survey, and CAHPS Version 5.0 for the 2014 and 2015 surveys. CAHPS results come from the NCBD for commercial health plans and from survey results submitted to the NCQA by commercial plans. Benchmarks used in 2013 come from the 2011 NCBD, while benchmarks for 2014 and 2015 come from NCQA's 2013 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

ACCESS TO MHS CARE AND SERVICES FOR FAMILY MEMBERS OF ACTIVE DUTY AND NON-ACTIVE DUTY WITH AUTISM SPECTRUM DISORDER

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

Effective July 25, 2014, the Department created the Comprehensive Autism Care Demonstration (ACD) to provide all TRICARE-covered applied behavior analysis (ABA) services under one new demonstration. This demonstration encompasses all ABA services previously provided under a patchwork combination of the TRICARE Basic Program, the Extended Care Health Option (ECHO) Enhanced Access to Autism Services Demonstration, and the ABA Pilot. The key feature of ABA services is the delivery of "sole" or "tiered" model services. In the sole provider delivery model, ABA services are provided by health care professionals certified as "authorized ABA supervisors" (e.g., Board Certified Behavior Analyst [BCBA] or BCBA-Doctoral certified by the Behavior Analyst Certification Board [BACB]) or by other TRICARE-authorized ABA providers practicing within the scope of their state licensure or state certification. These providers are authorized to provide ABA services independently under the ACD. Under the tiered model, assistant behavior analysts and behavior technicians (BTs) who are certified or credentialed by the BACB, the Qualified Applied Behavior Analysis Certification Board, or the Behavioral Intervention Certification Council can provide ABA services under the supervision of an authorized ABA supervisor.

TRICARE ASD Benefit History. The MHS provides one of the most comprehensive sets of specialized services for children with a diagnosis of autism spectrum disorder (ASD) in the U.S., including the provision of ABA. TRICARE first began covering ABA services for Active Duty family members (ADFMs) with ASD under the Program for Persons with Disabilities in 2001. In 2005, the ECHO program covered ABA services as a nonmedical intervention for those enrolled in the Exceptional Family Member Program (EFMP). The ECHO Enhanced Access to Autism Services Demonstration (or ECHO Autism Demonstration) for ADFMs was implemented on March 15, 2008, in response to section 717 of NDAA FY 2007. The primary goal of this Demonstration was to evaluate the effective use of tiered-model ABA services, thereby improving access to ABA services for military families by expanding the pool of ABA providers. That change was implemented on April 1, 2009. Sole provider model ABA was added to the TRICARE Basic Program in 2012 as a benefit for both ADFMs and Non-ADFMs.

The NDAA FY 2013 authorized TRICARE to provide the type of ABA service delivery model used in the ECHO Autism Demonstration to non-Active Duty family members (NADFMs, including retiree dependents and participants in TRICARE Reserve Select [TRS], TRICARE Retired Reserve [TRR], TRICARE Young Adult [TYA], TRICARE for Life [TFL], and the Continued Health Care Benefit Program) under the authority of a one-year pilot project. The ABA Pilot was implemented July 25, 2013, through July 24, 2014, as a benefit separate from the medical coverage provided under the TRICARE Basic Program to NADFMs who are diagnosed with ASD, and separate also from the ECHO Autism Demonstration services available by law to ADFMs.

Faced with various temporary authorities and the resulting complexity of interim TRICARE policies concerning coverage of ABA for ASD, the Department created the ACD to provide all TRICARE-covered ABA services under one demonstration that began July 25, 2014. The ACD preserves most of the terms and conditions of coverage under the previous patchwork of ABA services and programs provided by TRICARE, while incorporating lessons learned. Coverage of ABA under this demonstration applies to all TRICARE-eligible dependents with a diagnosis of ASD. The term "eligible dependent" means the dependent of a beneficiary defined under sections 1079 and 1086 of chapter 55 of title 10, U.S. Code, and includes dependents of Active Duty, retired, TRICARE-eligible Reserve Component (RC), and certain other non-Active Duty members. This demonstration consolidates TRICARE coverage of ABA services based on the Department's demonstration authority in section 1092 of title 10, U.S. Code, to improve the quality, efficiency, convenience, and cost-effectiveness of those autism-related services that do not constitute the proven medical care provided under the medical benefit coverage requirements that govern TRICARE Basic.

The ACD demonstration's goals are as follows:

- Analyze and evaluate the appropriateness of the ACD under TRICARE in light of current and future editions of BACB's *Applied Behavior Analysis Treatment of Autism Spectrum Disorder: Practice Guidelines for Healthcare Funders and Managers*.
- Determine the appropriate provider qualifications for the proper diagnosis of ASD and for the provision of ABA, and assess the added value of assistant behavior analysts and BTs providing ABA services beyond those provided by BCBAs.
- Assess, across the three TRICARE regions and overseas locations (where only the sole provider model is available), the ASD beneficiary characteristics associated with full utilization of the ACD's tiered delivery model versus utilization of sole provider services only (or nonutilization of

any ABA services) as well as any isolating factors contributing to significant variations across TRICARE regions and overseas locations in delivery of ABA.

- Determine what beneficiary age groups utilize and benefit most from ABA interventions.
- Assess the relationships between receipt of ABA services and utilization of established medical interventions for children with ASD (e.g., speech language pathology services, occupational therapy, physical therapy, and pharmacotherapy).
- Evaluate the feasibility and advisability of establishing a beneficiary cost-share for the treatment of ASD.

Since implementation of the ACD, several roundtable and information sessions were held with various stakeholders, with the goal of improving the ABA benefit to all TRICARE-eligible beneficiaries. The most significant changes and improvements include: allowing all ABA services to accrue to the catastrophic cap, implementing geographic adjustments to reimbursement rates to ensure equitable and fair payment of ABA services, implementing the BT certification/credentialing criteria, improved supervision requirements, aligning the authorization benefits with the industry standards, and implementing the Basic Life Support or Cardiopulmonary Pulmonary Resuscitation certification equivalent for all providers.

As shown in the table below, which reflects both ADFM and NADFM program users, in the first half of FY 2014 there were a total of 7,105 ADFM beneficiaries and 889 NADFM beneficiaries using TRICARE's ABA programs; by the first half of FY 2015, there were 7,877 unique ADFM users and 1,720 unique NADFM users of TRICARE ABA services. This is a 20.1 percent increase in the number of unique users of ABA services.

ECHO TUTOR DEMO, ECHO ABA, ABA PILOT PROGRAM, AND ACD USERS BY BENEFICIARY CATEGORY FOR THE FIRST HALF OF FY 2014 AND THE FIRST HALF OF FY 2015

(INCLUDES ALL CLAIMS PROCESSED THROUGH AUGUST 1, 2015)

ACTIVE DUTY FAMILY MEMBERS		RETIREE DEPENDENTS < AGE 65		TOTAL ADFMs & RETIREE DEPENDENTS < AGE 65	
FY 2014 First Half	**Total**	**FY 2014 First Half**	**Total**	**FY 2014 First Half**	**Total**
ECHO ABA Users	449	ECHO ABA Users	–	**Total (Unique Users)**	**7,994**
ECHO Tutor Users	5,484	ECHO Tutor Users	–		
TRICARE Basic ABA Users	2,661	TRICARE Basic ABA Users	831		
ABA Pilot Users	0	ABA Pilot Users	170		
Total (Unique Users)	**7,105**	**Total (Unique Users)**	**889**		
FY 2015 First Half	**Total**	**FY 2015 First Half**	**Total**	**FY 2015 First Half**	**Total**
ECHO ABA Users	147	ECHO ABA Users	–	**Total (Unique Users)**	**9,597**
ECHO Tutor Users	4,870	ECHO Tutor Users	–		
TRICARE Basic ABA Users	2,308	TRICARE Basic ABA Users	897		
ABA Pilot Users	0	ABA Pilot Users	388		
Autism Care Demo Users	7,094	Autism Care Demo Users	1,540		
Total (Unique Users)	**7,877**	**Total (Unique Users)**	**1,720**		

Note: Although not shown, in FY 2014 expenditures for ADFMs using TRICARE's ASD programs totaled $143.4 million, of which $94.4 million (or 66 percent) was for ADFMs using the ECHO tutor demo program, $9.2 million (or 6 percent) was for the ECHO ABA program, and $39.8 million (or 28 percent) was for the TRICARE Basic ABA program. The average ADFM user had $15,955 in ASD expenditures during FY 2014, and $9,091 for the first six months of FY 2015.

QUALITY OF MHS CARE

MHS Hospital Quality Measures—DoD Military and Contracted Civilian Hospitals Compared with National Civilian Hospitals, FYs 2011–2014

MHS assesses the quality of clinical care through analysis of process and outcome measures for both the inpatient and outpatient settings. Standardized, nationally recognized, consensus-based metrics are used to ensure consistency in methodology and to facilitate comparison with civilian-sector care. Although the sources of data vary, the performance in MTFs and by contracted civilian health care inpatient institutions is reviewed. The measures data provide essential information for leaders and stakeholders who are focused on evaluating and improving the quality of health care delivered to MHS beneficiaries.

Extensive data and analysis on the quality of care in MHS have been provided in previous reports to Congress. This report has been expanded to address the 2014 Secretary of Defense–directed MHS review and subsequent October 1, 2014, Secretary's Action Plan with corrective strategies. This report also responds to data required in Section 713 of NDAA 2016. Data are presented at the MHS level, in anticipation of Web-based MTF reporting in response to Section 712 of the NDAA requiring Web-based reporting of access, quality, and safety at the MTF level within 180 days of enactment of the law.

In response to Section 713 of NDAA 2016:

1. **Reporting to the National Practitioner Data bank (NPDB):** In FY 2015, 127 practitioners providing health care in MTFs worldwide were reported to the NPDB (reported by the Services to the DoD Risk Management Committee) for activities including malpractice claims, Active Duty death and disability cases, Adverse Privileging actions, and Adverse administrative actions.
2. **Accreditation Status of MTFs:** DoD Instruction 6025.13 requires all MTFs, as well as hospitals and other facilities used by managed care support contractors, to meet or exceed the standards of appropriate external accrediting bodies. Military hospitals and clinics are accredited by several external, independent health care quality and accreditation organizations. All DoD military hospitals (inpatient facilities) are accredited by The Joint Commission (TJC). An independent, not-for-profit organization, TJC accredits and certifies more than 20,500 health care organizations and programs in the United States. TJC accreditation and certification are recognized nationwide as symbols of quality that reflect an organization's commitment to meeting health care performance standards. Accredited hospitals can be found on TJC's Web site at: http://www.qualitycheck.org/consumer/searchQCR.aspx.

   All uniquely governed, free-standing ambulatory clinic MTFs are accredited by either TJC (same site as above) or the Accreditation Association for Ambulatory Health Care (AAAHC; http://www.aaahc.org/). As of the end of FY 2015, 65 Air Force clinics were accredited by AAAHC, and Army and Navy clinic MTFs were accredited by TJC (10 and 9, respectively). Air Force clinics will transition back to TJC accreditation beginning in FY 2016. All other clinics are subordinate to MTF hospitals and included in TJC accreditation.

   Specific MTF-level data will be provided via the central Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]) Web portal within 180 days of enactment of NDAA 2016 as required by Section 712 of the NDAA. As a result of the MHS Review and HRO task force, MTF hospital findings by TJC and responding action plans are being consolidated at a central protected site in FY 2016, consistent with standardized management across an enterprise journeying toward an HRO.
3. **Policies or procedures implemented during such year** were designed to improve patient safety, quality of care, and access to care at such facility. The ASD(HA) provided the Memorandum to the Military Department Assistant Secretaries (Manpower and Reserve Affairs), dated March 12, 2015: "Medical Quality Assurance and Clinical Quality Management in the Military Health System Sentinel Event and Root Cause Analysis Process Improvements." This policy provided guidance and directed Service MTFs to actively identify all sentinel events in their facilities, conduct root cause analysis, form corrective action plans for each event, and promptly report results through higher headquarters to the ASD(HA).
4. **Data on Surgical and Maternity Care Outcomes:** The Surgical Care Improvement Project (SCIP) and mother and newborn measures presented on pages 50–51 show MHS MTF results compared with national rates at the 90th percentile, and are process-focused measures. The MHS initiated participation in the American College of Surgeons (ACS) NSQIP to validate the quality of surgical care and identify opportunities to enhance surgical outcomes. The ACS NSQIP evaluates outcome measures associated with surgical mortality and morbidity, and is a nationally benchmarked, clinical, risk-adjusted, and outcomes-based program. During FY 2015, 17 MTFs participated in NSQIP. The MHS 90-day Review included a recommendation to expand participation in ACS NSQIP to include all inpatient MTFs.
5. **Data on patient safety, quality of care, and access to care,** as compared with standards established by DoD based on nationally recognized quality standards, are presented in the Better Care and Better Health sections of this report.

MHS Hospital Quality Measures—DoD Military and Contracted Civilian Hospitals Compared with National Civilian Hospitals, FYs 2011–2014 *(Cont.)*

MHS Hospital Quality of Care and National Standards

The performance of hospitals in MHS is, in part, evaluated through measure sets for the following: acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN), Surgical Care Improvement Project (SCIP), perinatal care (PC), and children's asthma care (CAC). In direct care MTFs, the data for the hospital quality measures are abstracted by trained specialists, reported to TJC to meet hospital accreditation requirements, and presented to facility leadership for analysis and identification of improvement opportunities. Data on the same measure sets for hospitals enrolled in a managed care support contractor (MCSC) network are obtained from the files posted by the Centers for Medicare & Medicaid Services (CMS) on the Hospital Compare Web site: http://www.hospitalcompare.hhs.gov. Quarterly, the Hospital Compare data file is downloaded, and the participating purchased care network hospitals are identified. These data reflect the overall performance of the network hospitals for the measures and include both TRICARE-reimbursed patients as well as all others reported by the civilian hospital (the Department does not have access to data based solely on TRICARE patients).

The display of MTF and network facility data provides a systemwide view of the performance of health care facilities available to beneficiaries. MHS subject matter experts for both direct care and purchased care review the data and work collaboratively to identify and communicate performance excellence and improvement opportunities. The data file is available publicly on the MHS Clinical Quality Management Web site, at: https://www.mhs-cqm.info.

DoD data displayed in the following charts include all patients who meet the National Hospital Measures technical specifications for the 54 inpatient MTFs and 2,026 civilian hospitals participating in contracted care networks. As noted in last year's report, TJC, consistent with guidance from CMS, continues to retire a number of clinical measures where national rates are consistently above top performance of 95 percent or better. Other measures were continued, and some were added this year (e.g., Cesarean rates) to core sets to better focus on areas that require improvement. Also, several measures reflected in this year's report have been scheduled for retirement in 2015 and will not be reported next year. The national trend toward using electronic measure collection and submission will challenge the existing MHS system until the new electronic health record is deployed.

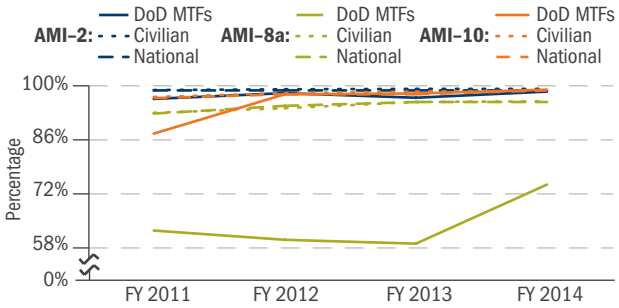
Adult Quality Measures

- **Acute Myocardial Infarction (AMI):** DoD MTF performance for the AMI measures is improving relative to the national benchmark, especially in closing the gap in giving percutaneous coronary intervention (PCI) and prescribing statins. One measure with noted opportunity for continued improvement is AMI–8a for MTFs. A performance improvement review to analyze the process and timeline for PCI in the MTFs is underway.

	FY 2011	FY 2012	FY 2013	FY 2014
AMI–2 HEART ATTACK PATIENTS GIVEN ASPIRIN AT DISCHARGE				
Military/Civilian Hospitals Treating DoD Patients	99.1%	99.3%	99.4%	99.4%
DoD MTFs	96.8%	98.3%	97.1%	98.7%
Civilian Hospitals Treating DoD Pts.	99.1%	99.3%	99.4%	99.4%
National	99.0%	99.0%	99.0%	99.0%
AMI–8a HEART ATTACK PATIENTS GIVEN PCI WITHIN 90 MINUTES OF ARRIVAL				
Military/Civilian Hospitals Treating DoD Patients	93.1%	94.4%	96.0%	96.2%
DoD MTFs	62.7%	60.3%	59.3%	74.6%
Civilian Hospitals Treating DoD Pts.	93.2%	94.4%	96.0%	96.2%
National	93.0%	95.0%	96.0%	96.0%
AMI–10 STATINS PRESCRIBED AT DISCHARGE				
Military/Civilian Hospitals Treating DoD Patients	97.3%	98.3%	98.7%	98.9%
DoD MTFs	87.8%	98.0%	98.2%	99.2%
Civilian Hospitals Treating DoD Pts.	97.3%	98.3%	98.7%	98.9%
National	97.0%	98.0%	98.0%	99.0%

Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 12/9/2015

DoD HOSPITAL QUALITY MEASURE: AMI

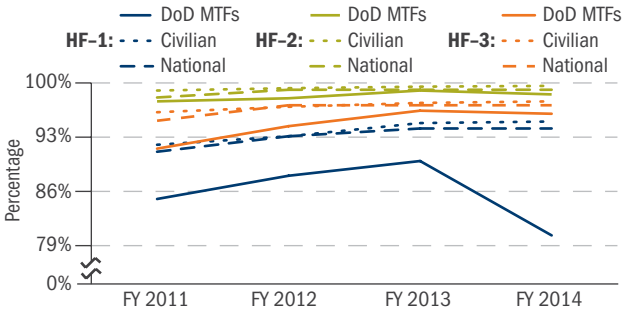


MHS Hospital Quality Measures—DoD Military and Contracted Civilian Hospitals Compared with National Civilian Hospitals, FYs 2011–2014 *(Cont.)*

- **Heart Failure (HF):** DoD performance for the HF measures continues to improve, while lagging the national rates. TJC is planning to retire the HF measure set in 2015.

	FY 2011	FY 2012	FY 2013	FY 2014
HF–1 HEART FAILURE PATIENTS GIVEN DISCHARGE INSTRUCTIONS				
Military/Civilian Hospitals Treating DoD Patients	91.9%	92.9%	94.7%	94.8%
DoD MTFs	84.9%	87.9%	89.8%	80.2%
Civilian Hospitals Treating DoD Pts.	91.9%	93.0%	94.7%	94.9%
National	91.0%	93.0%	94.0%	94.0%
HF–2 HEART FAILURE PATIENTS GIVEN AN EVALUATION OF LEFT VENTRICULAR SYSTOLIC (LVS) FUNCTION				
Military/Civilian Hospitals Treating DoD Patients	98.9%	99.2%	99.4%	99.5%
DoD MTFs	97.5%	97.9%	98.9%	98.4%
Civilian Hospitals Treating DoD Pts.	98.9%	99.2%	99.4%	99.5%
National	98.0%	99.0%	99.0%	99.0%
HF–3 HEART FAILURE PATIENTS GIVEN ACE INHIBITOR OR ARB FOR LVSD[a]				
Military/Civilian Hospitals Treating DoD Patients	96.1%	96.7%	97.3%	97.4%
DoD MTFs	91.4%	94.3%	96.3%	95.9%
Civilian Hospitals Treating DoD Pts.	96.1%	96.8%	97.3%	97.5%
National	95.0%	97.0%	97.0%	97.0%

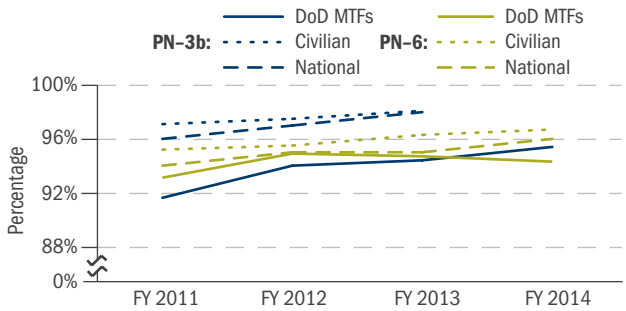
DoD HOSPITAL QUALITY MEASURE: HEART FAILURE



- **Pneumonia (PN):** DoD performance on the pneumonia measures is consistent with the average performance across the nation. TJC is planning to retire the PN measure set in 2015.

	FY 2011	FY 2012	FY 2013	FY 2014
PN–3b PNEUMONIA PATIENTS WHOSE INITIAL EMERGENCY ROOM BLOOD CULTURE WAS PERFORMED PRIOR TO THE ADMINISTRATION OF THE FIRST HOSPITAL DOSE OF ANTIBIOTICS				
Military/Civilian Hospitals Treating DoD Patients	97.0%	97.5%	98.1%	95.4%
DoD MTFs	91.6%	94.0%	94.4%	95.4%
Civilian Hospitals Treating DoD Pts.	97.1%	97.5%	98.1%	–
National	96.0%	97.0%	98.0%	–
PN–6 PNEUMONIA PATIENTS GIVEN THE MOST APPROPRIATE INITIAL ANTIBIOTIC(S)				
Military/Civilian Hospitals Treating DoD Patients	95.2%	95.5%	96.3%	96.7%
DoD MTFs	93.1%	94.9%	94.7%	94.3%
Civilian Hospitals Treating DoD Pts.	95.2%	95.5%	96.3%	96.7%
National	94.0%	95.0%	95.0%	96.0%

DoD HOSPITAL QUALITY MEASURE: PNEUMONIA



Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 12/9/2015

[a] Angiotensin II Receptor Blocker; Left Ventricular Systolic Dysfunction

Note: No data were available for PN–3b for FY 2014 national rates or civilian hospitals treating DoD patients.

MHS Hospital Quality Measures—DoD Military and Contracted Civilian Hospitals Compared to National Civilian Hospitals, FYs 2011–2014 *(Cont.)*

	FY 2011	FY 2012	FY 2013	FY 2014
SCIP INF–1[a] SURGERY PATIENTS WHO WERE GIVEN AN ANTIBIOTIC AT THE RIGHT TIME (WITHIN ONE HOUR BEFORE SURGERY) TO HELP PREVENT INFECTION				
Military/Civilian Hospitals Treating DoD Patients	98.1%	98.4%	98.9%	99.1%
DoD MTFs	95.5%	96.3%	98.1%	98.8%
Civilian Hospitals Treating DoD Pts.	98.1%	98.4%	98.9%	99.1%
National	98.0%	98.0%	99.0%	99.0%
SCIP INF–2[a] SURGERY PATIENTS WHO WERE GIVEN THE RIGHT KIND OF ANTIBIOTIC TO HELP PREVENT INFECTION				
Military/Civilian Hospitals Treating DoD Patients	98.3%	98.6%	99.1%	98.9%
DoD MTFs	95.8%	96.5%	97.4%	97.9%
Civilian Hospitals Treating DoD Pts.	98.4%	98.6%	99.1%	98.9%
National	98.0%	99.0%	99.0%	99.0%
SCIP INF–3[a] SURGERY PATIENTS WHOSE PREVENTIVE ANTIBIOTICS WERE STOPPED AT THE RIGHT TIME (WITHIN 24 HOURS AFTER SURGERY)				
Military/Civilian Hospitals Treating DoD Patients	96.8%	97.3%	98.2%	98.4%
DoD MTFs	94.6%	96.1%	96.5%	96.8%
Civilian Hospitals Treating DoD Pts.	96.8%	97.3%	98.2%	98.4%
National	96.0%	97.0%	98.0%	98.0%
SCIP INF–9[a] URINARY CATHETER REMOVED ON POD1 OR POD2 WITH DAY OF SURGERY BEING DAY ZERO				
Military/Civilian Hospitals Treating DoD Patients	93.0%	95.9%	97.6%	98.3%
DoD MTFs	92.9%	97.4%	98.4%	98.7%
Civilian Hospitals Treating DoD Pts.	93.0%	95.8%	97.6%	98.3%
National	93.0%	96.0%	97.0%	98.0%

- **Perinatal Care (PC):** These measures focus on the care of mother and infant while in the hospital. PC–1 focuses on decreasing the rate of early elective deliveries.

	FY 2011	FY 2012	FY 2013	FY 2014
PC–1 ELECTIVE DELIVERY[c]				
DoD MTFs	8.8%	6.1%	4.6%	5.2%
National	15.0%	9.1%	5.0%	3.5%

- **Cesarean Rates:** Because Cesarean section is major surgery and increases the likelihood of many short- and longer-term adverse effects in mothers and babies, this measure focuses on reducing this delivery method where appropriate. While DoD MTF rates continue below the national rate, they are slowly rising.

	FY 2011	FY 2012	FY 2013	FY 2014
PC–2 CESAREAN SECTION[c]				
DoD MTFs	20.7%	21.6%	21.8%	21.6%
National	26.3%	26.5%	26.1%	26.7%

Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 12/9/2015

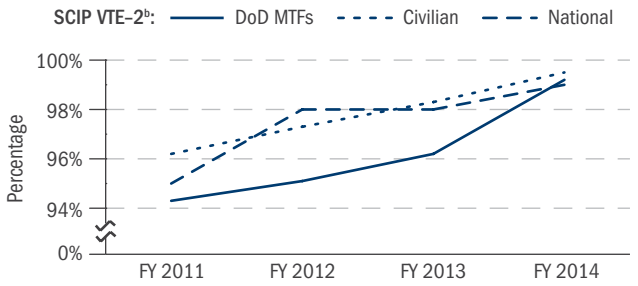
[a] Surgical Care Improvement Project–Infection

[b] Surgical Care Improvement Project–Venous, Thromboembolism, Prophylaxis

[c] Lower rates are better.

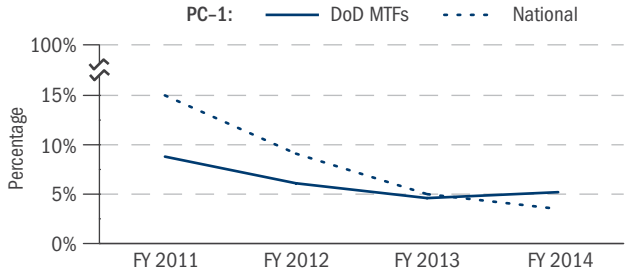
- **Surgical Care Improvement Project (SCIP):** DoD performance on SCIP measures is consistent with the average performance across the nation, with all measures above 95 percent—the benchmark used by TJC to identify top-performing hospitals.

DoD HOSPITAL QUALITY MEASURE: SCIP VTE–2[b]

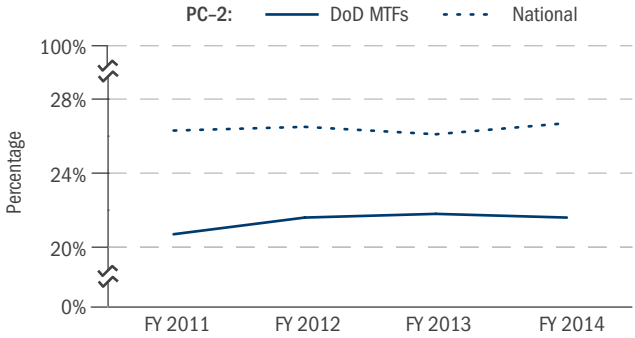


	FY 2011	FY 2012	FY 2013	FY 2014
SCIP VTE–2[b] PATIENTS WHO GOT TREATMENT AT THE RIGHT TIME (WITHIN 24 HOURS BEFORE OR AFTER THEIR SURGERY) TO HELP PREVENT BLOOD CLOTS AFTER CERTAIN TYPES OF SURGERY				
Military/Civilian Hospitals Treating DoD Patients	96.2%	97.3%	98.3%	99.5%
DoD MTFs	94.3%	95.1%	96.2%	99.2%
Civilian Hospitals Treating DoD Pts.	96.2%	97.3%	98.3%	99.5%
National	95.0%	98.0%	98.0%	99.0%

DoD HOSPITAL QUALITY MEASURE: ELECTIVE DELIVERY PC–1[c]



DoD HOSPITAL QUALITY MEASURE: CESAREAN SECTION PC–2[c]

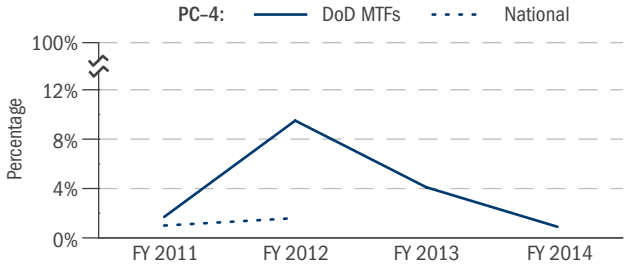


MHS Hospital Quality Measures—DoD Military and Contracted Civilian Hospitals Compared to National Civilian Hospitals, FYs 2011–2014 *(Cont.)*

- **Newborn Bloodstream Infections:** DoD continues to strive to reduce its rates, and, in 2014, may be approaching the national rate.

	FY 2011	FY 2012	FY 2013	FY 2014
PC–4 HEALTH CARE–ASSOCIATED BLOODSTREAM INFECTIONS IN NEWBORNS[a]				
DoD MTFs	1.7%	9.5%	4.1%	0.9%
National	1.0%	1.6%	–	–

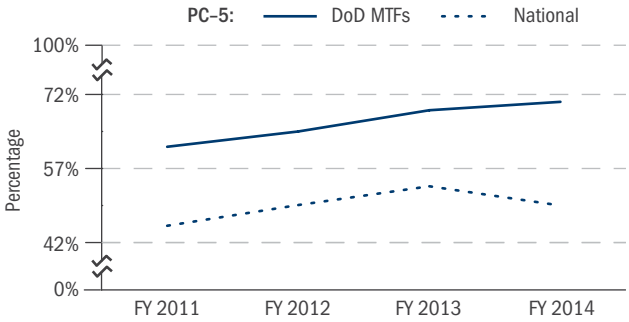
DoD HOSPITAL QUALITY MEASURE: HEALTH CARE–ASSOCIATED BLOODSTREAM INFECTIONS IN NEWBORNS PC–4[a]



- **Breastfeeding:** The benefits of breastfeeding a baby, especially in the days after birth, are internationally recognized. DoD MTFs have seen success with this program relative to the national rates, improving incrementally over each of the past three years.

	FY 2011	FY 2012	FY 2013	FY 2014
PC–5 EXCLUSIVE BREASTFEEDING				
DoD MTFs	61.4%	64.5%	68.8%	70.5%
National	45.4%	49.6%	53.4%	49.5%

DoD HOSPITAL QUALITY MEASURE: EXCLUSIVE BREASTFEEDING PC–5



Children's Quality Measures

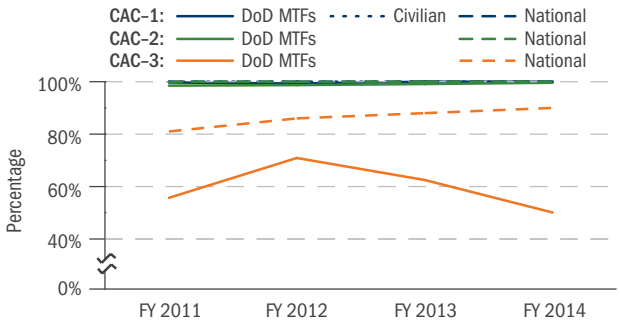
	FY 2011	FY 2012	FY 2013	FY 2014
CAC–1 CHILDREN WHO RECEIVED RELIEVER MEDICATION WHILE HOSPITALIZED FOR ASTHMA				
Military/Civilian Hospitals Treating DoD Patients	100.0%	99.9%	100.0%	100.0%
DoD MTFs	99.7%	99.3%	100.0%	100.0%
Civilian Hospitals Treating DoD Pts.	100.0%	100.0%	100.0%	100.0%
Hospital Compare National Rate	100.0%	100.0%	100.0%	100.0%
CAC–2 CHILDREN WHO RECEIVED SYSTEMIC CORTICOSTEROID MEDICATION (ORAL AND IV MEDICATION THAT REDUCES INFLAMMATION AND CONTROLS SYMPTOMS) WHILE HOSPITALIZED FOR ASTHMA				
Military/Civilian Hospitals Treating DoD Patients	99.7%	99.6%	99.9%	99.8%
DoD MTFs	98.5%	98.7%	99.1%	99.6%
Civilian Hospitals Treating DoD Pts.	99.7%	99.7%	99.9%	99.8%
Hospital Compare National Rate	100.0%	100.0%	100.0%	100.0%
CAC–3 CHILDREN AND THEIR CAREGIVERS WHO RECEIVED A HOME MANAGEMENT PLAN OF CARE DOCUMENT WHILE HOSPITALIZED FOR ASTHMA				
Military/Civilian Hospitals Treating DoD Patients	83.3%	85.4%	87.1%	89.5%
DoD MTFs	55.7%	70.9%	62.5%	50.1%
Civilian Hospitals Treating DoD Pts.	84.7%	86.1%	88.1%	91.0%
Hospital Compare National Rate	81.0%	86.0%	88.0%	90.0%

Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 12/9/2015

[a] Lower rates are better.

- **Children's Asthma Care (CAC):** MTFs providing care to DoD beneficiaries are 100 percent for CAC–1 and above 99 percent for CAC–2, which focus on medications for asthma patients. CAC–3 focuses on the transition of care from the inpatient to the outpatient setting and is an area for improvement for both DoD and the nation. While a standardized note for the electronic medical record has been developed to support MTF performance for this measure, more work needs to be done to keep pace with the national improvement.

DoD HOSPITAL QUALITY MEASURE: CAC

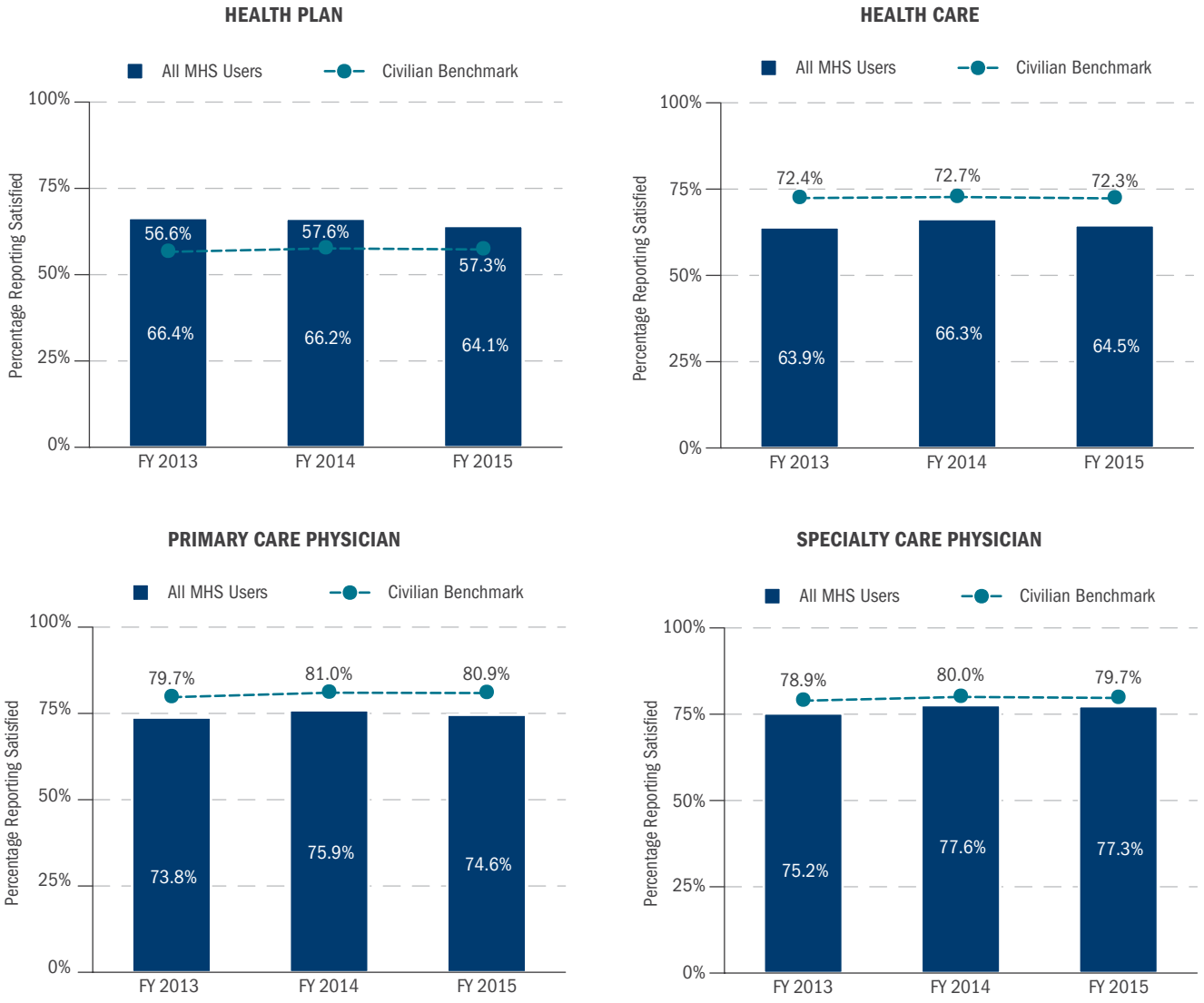


Beneficiary Ratings of Experience and Satisfaction with Key Aspects of TRICARE

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) 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 satisfaction with health care quality and with primary care physicians remained stable from FY 2013 to FY 2015. Satisfaction with specialty care physicians increased while satisfaction with the health plan decreased slightly over the same period.
- MHS beneficiary satisfaction with the health plan continues to exceed that of the civilian benchmark. However, satisfaction with health care quality and with primary and specialty care physicians lagged the civilian benchmarks.

TRENDS IN SATISFACTION RATINGS OF KEY HEALTH PLAN ASPECTS



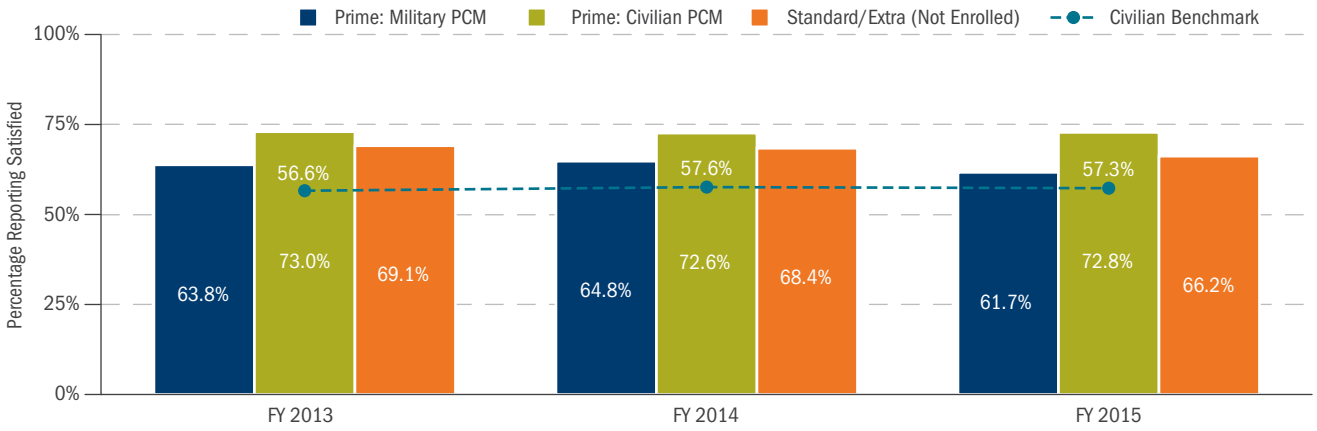
Note: DoD data were derived from the FYs 2013–2015 HCSDB, as of 10/19/2015, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 4.0, used in the 2013 survey, and CAHPS Version 5.0 for the 2014 and 2015 surveys. CAHPS results come from the NCBD for commercial health plans and from survey results submitted to the NCQA by commercial plans. Benchmarks used in 2013 come from the 2011 NCBD, while benchmarks for 2014 and 2015 come from NCQA's 2013 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

Beneficiary Ratings of Satisfaction with Health Plan Based on Enrollment Status

DoD health care beneficiaries can participate in TRICARE in two ways: by enrolling in the Prime option, or by not enrolling and using the traditional indemnity option for seeing participating providers (Standard) or network providers (Extra). Satisfaction levels with one's health plan across the TRICARE options are compared with commercial plan counterparts.

- Satisfaction with the TRICARE health plan decreased from FY 2013 to FY 2015 for Prime enrollees with a military PCM. Satisfaction levels for Prime enrollees with a civilian PCM and for non-enrollees remained stable.
- For each of the past three years (FY 2013 to FY 2015), all beneficiary groups reported higher levels of satisfaction with their health plan than did their civilian counterparts.

TRENDS IN SATISFACTION WITH HEALTH PLAN BY ENROLLMENT STATUS

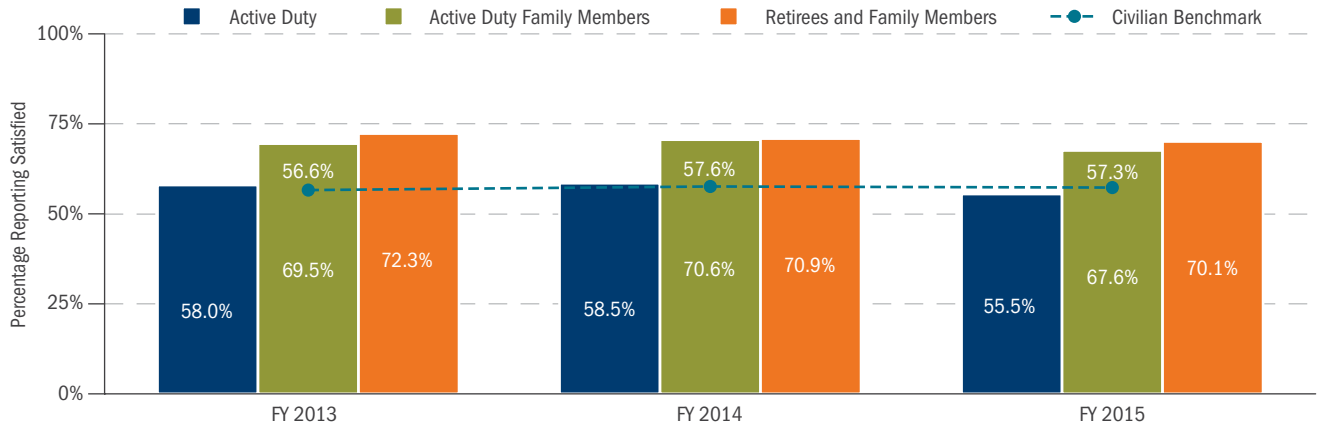


Beneficiary Ratings of Satisfaction with Health Plan by Beneficiary Category

Satisfaction levels of different beneficiary categories are examined to identify any diverging trends among groups.

- Satisfaction with the TRICARE health plan declined from FY 2013 to FY 2015 for Active Duty and ADFMs, but remained unchanged for retirees and family members.
- Active Duty satisfaction was not significantly different from the civilian benchmark. However, satisfaction levels for ADFMs and non-enrollees were above the civilian benchmarks.

TRENDS IN SATISFACTION WITH HEALTH PLAN BY BENEFICIARY CATEGORY



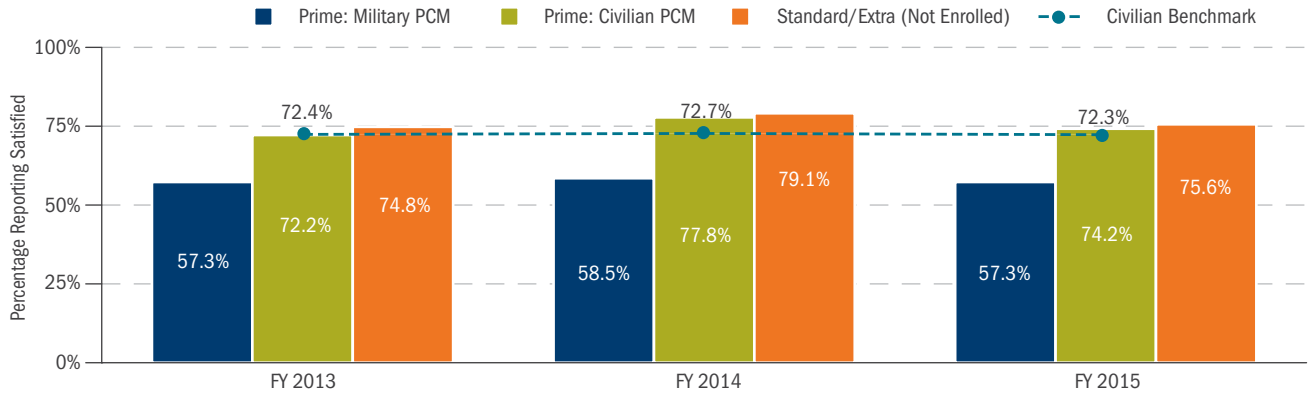
Note: DoD data were derived from the FYs 2013–2015 HCSDB, as of 10/19/2015, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 4.0, used in the 2013 survey, and CAHPS Version 5.0 for the 2014 and 2015 surveys. CAHPS results come from the NCBD for commercial health plans and from survey results submitted to the NCQA by commercial plans. Benchmarks used in 2013 come from the 2011 NCBD, while benchmarks for 2014 and 2015 come from NCQA's 2013 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

Beneficiary Ratings of Satisfaction with Health Care Based on Enrollment or Beneficiary Category

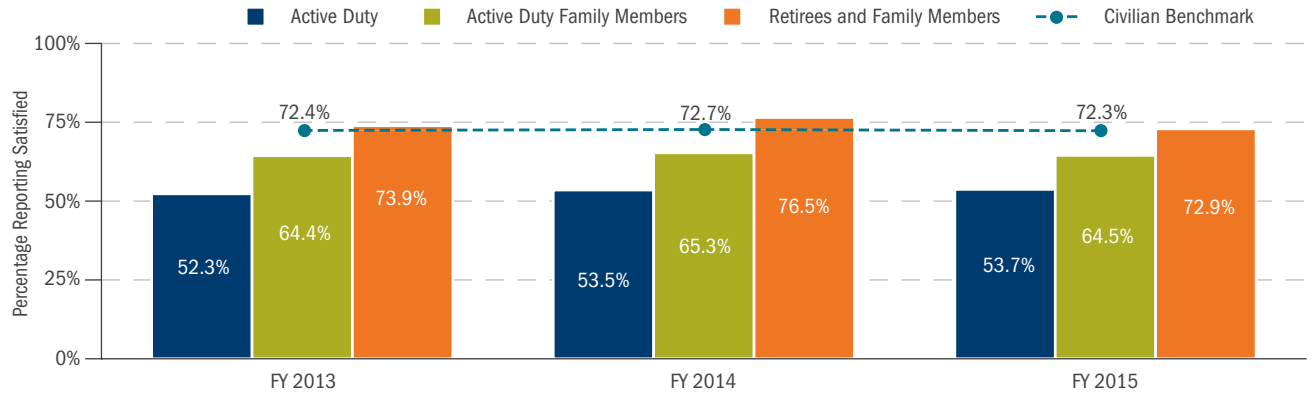
Similar to satisfaction with the TRICARE health plan, satisfaction levels with the health care received differ by beneficiary category and enrollment status:

- Satisfaction with health care remained stable from FY 2013 to FY 2015 for Prime enrollees and non-enrollees.
- The satisfaction levels of Prime enrollees with a military PCM lagged the civilian benchmark. Satisfaction levels for the other enrollment groups exceeded the civilian benchmark in FY 2014 (and in FY 2015 for non-enrollees).
- Satisfaction with health care remained stable for all beneficiary groups.
- The satisfaction levels of Active Duty and ADFMs lagged the civilian benchmarks. Satisfaction levels for retirees and family members exceeded the civilian benchmark in FY 2014.

TRENDS IN SATISFACTION WITH TRICARE HEALTH CARE BY ENROLLMENT STATUS



TRENDS IN SATISFACTION WITH TRICARE HEALTH CARE BY BENEFICIARY CATEGORY



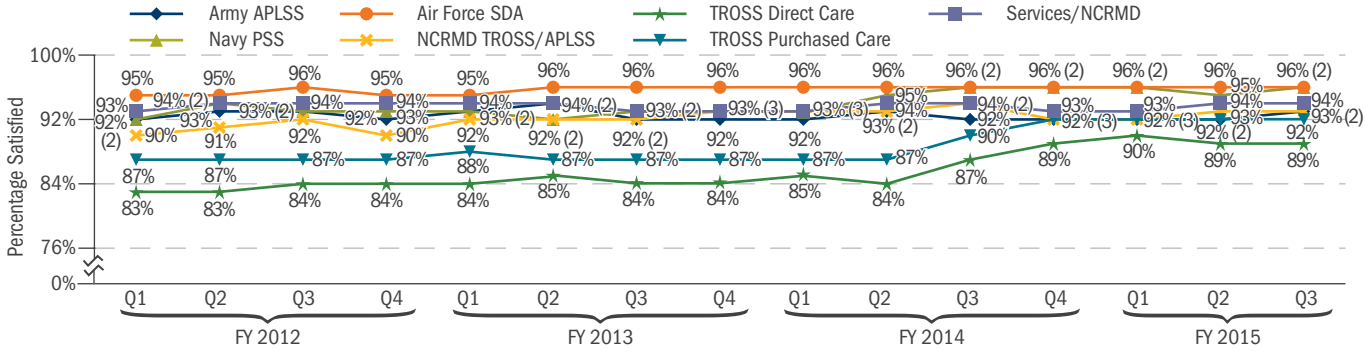
Note: DoD data were derived from the FYs 2013–2015 HCSDB, as of 10/19/2015, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for a more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 4.0, used in the 2013 survey, and CAHPS Version 5.0 for the 2014 and 2015 surveys. CAHPS results come from the NCBD for commercial health plans and from survey results submitted to the NCQA by commercial plans. Benchmarks used in 2013 come from the 2011 NCBD, while benchmarks for 2014 and 2015 come from NCQA's 2013 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

Beneficiary Ratings of Care Following Outpatient Treatment Using Multiple DHA and Service Outpatient Surveys

The Army, Navy, Air Force, and DHA measure various aspects of the patient experience with MHS care. The Services focus on MHS beneficiaries using their MTFs for outpatient care, and design their surveys with sufficient power to be able to drill down to examine each MTF, as well as individual providers within each MTF. The focus of DHA surveys, on the other hand, is to use a standardized instrument and survey methodology to effectively examine beneficiary experience of care across the Services and between the direct and purchased care venues, as well as to compare to civilian CAHPS benchmarks, but are not designed to examine the performance of individual providers within MTFs.

- The measure Overall Satisfaction with Care is another common item across all outpatient surveys, APLSS, PSS, SDA, and TROSS direct care purchased care. Overall ratings from FY 2012 to FY 2015 Q3 are shown in the chart below. Navy PSS and Air Force SDA beneficiary ratings were consistently above the Services average across time. TROSS ratings are slightly higher for beneficiaries receiving outpatient care at civilian facilities than beneficiaries receiving care at MTFs. TROSS ratings remain at 92 percent within the purchased care system and 89 percent within the direct care system in the most recent quarter, FY 2015 Q3. Note: There was a change in the TROSS instrument, and the new TROSS survey was fielded in May 2014. This results in a change in the satisfaction score starting in FY 2014 Q3.

RATINGS OF OVERALL SATISFACTION WITH CARE USING MULTIPLE OUTPATIENT SURVEYS

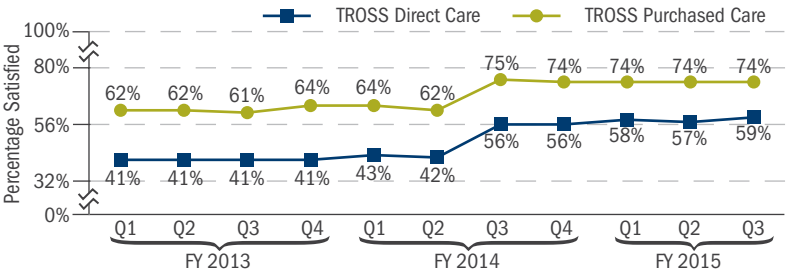


Source: OASD(HA)/DHA Decision Support. TROSS, Air Force SDA, Army APLSS, and Navy PSS results are as of FY 2015 Q3 (June 2015), compiled 12/1/2015

Notes:

- Percentage satisfied for Overall Satisfaction with Care are responses of "Somewhat Satisfied" or "Completely Satisfied" on the scale "Completely Dissatisfied, Somewhat Dissatisfied, Neither Satisfied nor Dissatisfied, Somewhat Satisfied, and Completely Satisfied."
- FY 2014 Q3 data include May and June data only because the new TROSS instrument was fielded in May 2014.
- "MHS Overall" refers to the users of both direct and purchased care components; "Direct Care" refers to MTF-based care, and "Purchased Care" refers to care provided in the private sector through the claims-based reimbursement process.
- All MHS direct care data are adjusted for selection, nonresponse, gender, beneficiary category, and TRICARE region.
- All MHS civilian purchased care data are adjusted for selection, nonresponse, gender, beneficiary category, age, and TRICARE region.

TROSS OVERALL RATING OF HEALTH CARE



Source: OASD(HA)/DHA Decision Support TROSS survey results as of FY 2015 Q3 (June 2015), compiled 12/1/2015

Notes:

- Percentage satisfied for Overall Rating of Health Care is a score of 9 or 10 on a 0–10 scale where 10 is best.
- FY 2014 Q3 data include May and June data only because the new TROSS instrument was fielded in May 2014.
- "MHS Overall" refers to the users of both direct and purchased care components; "Direct Care" refers to MTF-based care, and "Purchased Care" refers to care provided in the private sector through the claims-based reimbursement process.
- All MHS direct care data are adjusted for selection, nonresponse, gender, beneficiary category, and TRICARE region.
- All MHS civilian purchased care data are adjusted for selection, nonresponse, gender, beneficiary category, age, and TRICARE region.

Ratings of Health Care: Overall ratings of outpatient health care based on the TROSS from FY 2013 to FY 2015 Q3 were higher at civilian facilities than the ratings of such care at MTFs. Although both direct and purchased care results increased between Q2 and Q3 in FY 2014 with the TROSS instrument change, direct care ratings continued to increase from the FY 2014 Q4 to FY 2015 Q3. Beneficiary ratings within the purchased care system remained stable after the TROSS survey change at 74 percent.

Beneficiary Ratings of Care Following Inpatient Treatment

TRICARE Inpatient Satisfaction Survey (TRISS)

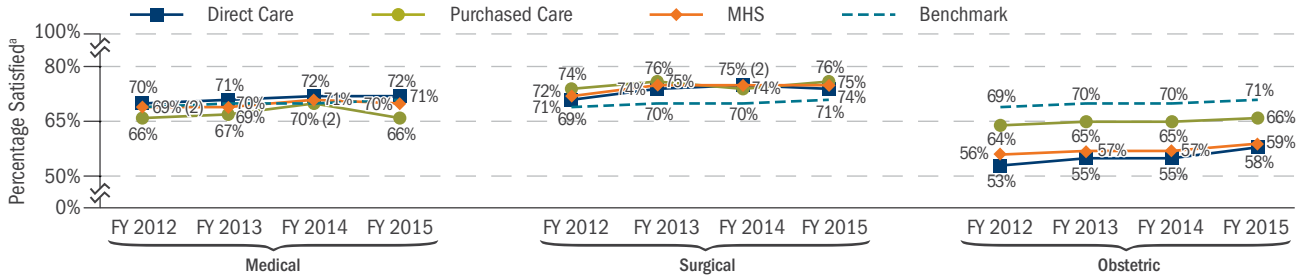
The purpose of the OASD(HA)/DHA TRICARE Inpatient Satisfaction Survey (TRISS) is to monitor and report on the experience and satisfaction of MHS beneficiaries who have been admitted to MTF and civilian hospitals. The survey instrument incorporates the questions developed by the Agency for Healthcare Research and Quality (AHRQ) and CMS for the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS®) initiative. The goal of the HCAHPS initiative is to measure uniformly and report publicly patients' 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 operating procedures, and to provide feedback to providers and patients. The TRISS survey follows the HCAHPS protocols developed by CMS, which are endorsed by the National Quality Forum. The HCAHPS protocols for sampling, data collection, and coding can be found in the HCAHPS Quality Assurance Guidelines manual on the official HCAHPS Web site, www.hcahpsonline.org.

Comparison of these data with the results from previous surveys, as well as comparisons with civilian benchmark data, enable DoD to measure progress in meeting its goals and objectives of high-quality inpatient health care. The TRISS compares care across all Services and across venues (i.e., direct MTF-based care and private-sector, or purchased care), including comparisons of inpatient surgical, medical, and obstetric care. The survey covers a number of domains, including:

- Overall rating of hospital and recommendation 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
- Pain control
- Hospital environment (cleanliness and quietness)
- Post-discharge (e.g., written directions for post-discharge care)

Rating of Hospital: Overall, MHS beneficiaries receiving surgical care, whether discharged from MTF or civilian hospitals, rated their hospital stay statistically significantly higher than users that make up the HCAHPS benchmark. Beneficiaries who received medical services in military facilities rated their hospital higher compared with the civilian benchmark, and higher than did MHS beneficiaries receiving care from civilian hospitals. Beneficiaries who received obstetric care rated the hospital lower than those who received surgical and medical care. Beneficiaries who received care within the purchased care system for surgical and obstetric care rated their hospital higher than did those in the direct care system. Direct care satisfaction ratings for obstetric patients show a statistically significant positive trend from FY 2012 through Q3 FY 2015.

TRISS RATING OF HOSPITAL TREND, FYs 2012–2015



Source: OASD(HA)/DHA Decision Support TRISS survey results for FY 2015 as of June 2015, compiled 12/1/2015

[a] Percentage satisfied for "Rating of Hospital" is a score of 9 or 10 on a 0–10 scale where 10 is best.

Notes:

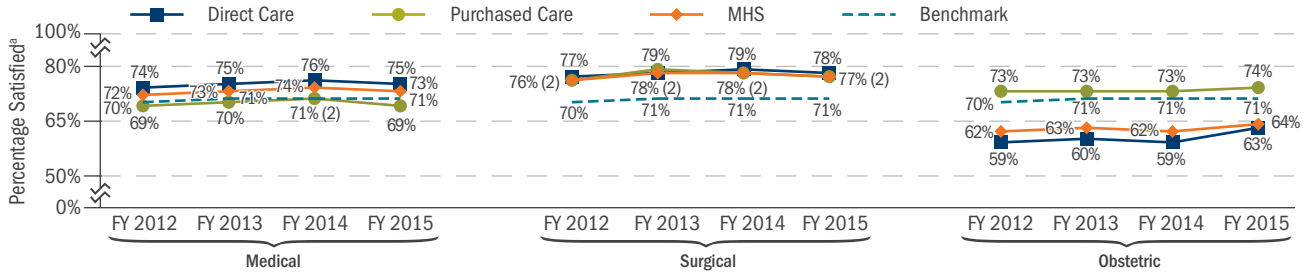
- "MHS Overall" refers to the users of both direct and purchased care components; "Direct Care" refers to MTF-based care; and "Purchased Care" refers to care provided in the private sector through the claims-based reimbursement process.
- The years depicted align with the fiscal year. Direct care 2015 results are based on discharges from Q1 2015 through Q3 2015. Purchased care 2015 results are based on discharges from Q1 2015 through Q2 2015.
- All MHS military facility data are adjusted for selection, nonresponse, beneficiary category, age, and MTF Service branch.
- All MHS civilian purchased-care data are adjusted for selection, nonresponse, gender, beneficiary category, age, and TRICARE region.
- TRISS data have not been case-mix adjusted, limiting comparability with CMS benchmarks.
- CMS benchmarks for civilian providers represent three product lines combined (medical, surgical, and obstetrics) and are case-mix adjusted. These benchmarks are the latest published from Medicare Hospital Survey of Patients' Hospital Experience (www.hospitalcompare.hhs.gov).

Beneficiary Ratings of Care Following Inpatient Treatment *(Cont.)*

TRICARE Inpatient Satisfaction Survey (TRISS) *(Cont.)*

Recommendation of Hospital: Beneficiaries who received medical and surgical care in military facilities were more likely to recommend their hospital than the civilian benchmark. MHS beneficiaries using purchased care facilities for medical and obstetric services rated their willingness to recommend the hospital higher than the civilian benchmark, and higher than users of military facilities for obstetric services. Although lagging, beneficiary ratings in military hospitals have improved since FY 2014 for users of obstetric care.

TRISS RECOMMENDATION OF HOSPITAL TREND, FYs 2012–2015



Source: OASD(HA) DHA/Decision Support TRISS survey results for FY 2015 as of June 2015, compiled 12/1/2015

[a] Percentage satisfied for "Recommendation of Hospital" is a response of "Definitely Yes" when asked if one would recommend their hospital to family or friends.

Note: Please refer to notes accompanying "Overall Rating of Hospital" for more detail regarding this analysis.

Drivers of Patient Satisfaction/Experience Ratings

Top Three Drivers of Satisfaction by Survey

Results of customer surveys have become increasingly important in measuring health plan performance and in directing action to improve the beneficiary experience and quality of services provided.

- Three key beneficiary surveys measure self-reported access to and satisfaction with MHS direct and purchased care experiences:
  - TRISS—event-based after a discharge from a hospital (based on HCAHPS);
  - TROSS—event-based following an outpatient visit (based on Clinician and Group [C&G] CAHPS);
  - HCSDB—population-based quarterly survey sampling MHS-eligible beneficiaries who may use MHS or their own health insurance (based on CAHPS Plan).

Results from these three surveys for FYs 2014 and 2015 (using all data available at the time of analysis) were modeled to identify key drivers of satisfaction. Drivers of satisfaction for all surveys, for the direct care system, were determined by examining the effects of composite scores on outcome variables. The models controlled for all composites and demographic variables, including beneficiary category, gender, Service, health status, and region. The statistical significance and effect size of odds ratios were used to rank drivers of satisfaction.

- As shown in the table below, beneficiary ratings of satisfaction with inpatient health care provided in MTFs are driven by communication between patients, doctors, and nurses, and the cleanliness of the patient room/bathroom (based on the TRISS). Beneficiary satisfaction with outpatient care (TROSS) and for care in general across the MHS population (HCSDB) is driven by access (getting needed care and getting care quickly), provider communications, and helpful office staff. Perceptions of the MHS (a DoD-specific composite for TROSS) are also important to beneficiary satisfaction with outpatient care.
- These results suggest that improving communication between respondents and health care providers, patient room/bathroom cleanliness, and overall perceptions of the MHS have the potential to influence a patient's satisfaction with their health care and their hospital.

TOP THREE DRIVERS OF SATISFACTION BY SURVEY: DIRECT CARE, FYs 2014–2015

FISCAL YEAR	RANKING	TRISS DIRECT CARE MHS RATING OF HOSPITAL	TROSS DIRECT CARE MHS SATISFACTION WITH HEALTH CARE	HCSDB DIRECT CARE U.S. SATISFACTION WITH HEALTH CARE
FY 2014	#1	Communication with Nurses	Communication with Doctors	Communication with Doctors
	#2	Communication with Doctors	Perceptions of MHS[a]	Getting Needed Care
	#3	Cleanliness of Room/Bathroom	Office Staff	Getting Care Quickly
FY 2015	#1	Communication with Nurses	Communication with Doctors	Communication with Doctors
	#2	Communication with Doctors	Perceptions of MHS[a]	Getting Care Quickly
	#3	Cleanliness of Room/Bathroom	Office Staff	Getting Needed Care

Sources: OASD(HA)/DHA TRISS, TROSS, and HCSDB, FYs 2014–2015 (Q1–Q3 only for TRISS and TROSS), compiled 12/1/2015

[a] DoD composite

Note: TROSS data are reported for May through September 2014 due to an instrument change in May 2014.

DoD/Department of Veterans Affairs (VA) Interagency Care Coordination Committee (IC3): One Mission—One Policy—One Plan

The DoD/VA IC3 oversees implementation of the November 2012 Secretaries' Intent memorandum to achieve: One Mission–One Policy–One Plan. The goal of the IC3 is to streamline, synchronize, coordinate, and integrate the full spectrum of complex care, benefits, and services provided to Service members and Veterans (SM/Vs) and their families as they transition from military service to civilian status.

One Mission

During FY 2015, IC3 advanced the implementation of a standard model of care coordination for SM/Vs with complex care needs by operationalizing key initiatives within the IC3 Community of Practice Work Group (CoP WG). A key component of this effort is the Lead Coordinator (LC) concept. The CoP WG developed and fielded LC training, a program exploration tool for care coordinators, in addition to kicking off the national rollout of the LC role.

The IC3 CoP WG, comprising leaders from more than 50 care, benefits, and services coordination programs across DoD and VA, continued to drive key IC3 initiatives, focusing on member engagement, communications, and creating common tools and shared resources. In January 2015, the CoP WG facilitated two LC "refresh" trainings in the Walter Reed National Military Medical Center and San Antonio Military Medical Center for care coordinator staff. The refresh trainings were based on lessons learned from the FY 2014 feasibility assessment and were the precursors to the launch of the LC training national rollout in July 2015. The training provides two components: LC training (for individuals who will likely serve in the role of LC) and LC awareness training (for individuals who provide services to SM/Vs and work with LCs, but will not be assigned as LCs). These two complementary curricula are targeted to meet the differing needs of the LCs and the other supportive services and programs.

National rollout of the LC training and the LC awareness training began in July 2015, beginning with 10 U.S. locations for joint DoD and VA training by the end of FY 2015, with others scheduled for completion by the end of calendar year 2015.

CoP WG leaders are supporting the LC implementation and other IC3 efforts by:

- Engaging and communicating with their CoP colleagues and staff;
- Developing internal and external communications to promulgate awareness of upcoming changes and expectations about IC3 and complex care coordination; and
- Using Co-Lab, a Personal Identity Verification (PIV) card and Common Access Card (CAC) secure Web site for interagency care coordinators to connect, learn more about one another's programs, and find one another through a master directory.

Over the past year, based on feedback from Co-Lab users, CoP WG members improved Co-Lab search functionality and began the development of a care coordination benefits and services exploration tool. Through coordinated communications and the use of common tools, the CoP WG strives to make it easier for care management team members to navigate care for SM/Vs to allow the SM/Vs and their families to focus on recovery.

One Plan

During FY 2015, IC3 continued to ensure effective development and utilization of a single, shared comprehensive plan for SM/Vs in need of complex coordination for care, benefits, and services. The Interagency Comprehensive Plan (ICP) covers the full range of services and benefits needed by SM/Vs as they progress in their rehabilitation. This includes benefits and services encompassing eight domains: Career, Daily Living, Family, Finances, Health, Legal, Military, and Spirituality. The ICP is a plan developed and updated by an LC, and follows the SM/V through the continuum of care. LCs are being trained on the ICP and using it to adopt a standardized plan for SM/Vs' recovery, rehabilitation, and reintegration across both Departments.

The Departments have agreed to pursue a technical solution using existing VA and DoD systems (VA's Federal Case Management Tool [FCMT] and DoD's Case Management System [DoD-CMS]). The IC3 Technology, Tools, and Change Work Group is planning for a full-scale, interoperable, electronic ICP. The electronic ICP will improve coordination, transparency, and interoperability across programs by allowing VA and DoD care coordinators to view and share client data. Technical requirements were gathered in a joint effort between DoD and VA in April 2015 to determine the best path forward, and both DoD and VA awarded contracts to execute the development of the electronic ICP.

One Policy

Subsequent to the VA/DoD Memorandum of Understanding (MOU) for Interagency Complex Care Coordination Requirements for SM/Vs signed on July 29, 2014, a VA Directive and a DoD Instruction were released to their respective Departments. These governing documents establish the MOU as policy for processes and assigning responsibilities in accordance with the overarching guidance, and give it the force of policy across both Departments. Ongoing efforts continue to identify, review, revise, and sunset (as necessary) any VA and DoD policies with any connection to care coordination and to ensure alignment with the MOU.

Additionally, IC3 has developed methodologies to quantify the VA and DoD complex care coordination population. This population includes all SM/Vs who meet the criteria for complex care coordination for LC assignment and is estimated to include approximately 14,000 Service members from DoD and 40,000 veterans from VA. These may include SM/Vs who are represented in both the DoD and VA estimates; a data match effort is underway to compare data and identify duplicates. Also, progress toward implementing an oversight process and mechanism to track IC3 performance and outcomes has been made, and interim performance metrics have been identified. Metrics will begin to be reported in FY 2016.

PATIENT SAFETY IN MHS

The aim of the MHS Patient Safety Program (PSP) is to prevent harm to patients through evidence-based system and process improvements. In the MHS direct care system, DoD PSP focuses efforts to guide improvements targeting opportunities identified through reported patient safety events. DoD PSP coordinates across Services to implement improvements and offer resources and tools.

As part of the comprehensive May 2014 MHS Review, the MHS demonstrated its commitment to continuous improvement, focusing on high reliability and the delivery of safe, high-quality health care. To support this goal, DoD PSP, in collaboration with Service leadership, focused efforts in FY 2014 on continuing to advance a culture of safety and the data-driven establishment of effective, standardized processes in promoting safe and reliable care.

Patient Safety Reporting

Reporting patient safety events is one of the key components in the MHS's effort to achieve high reliability, continuously improve, and provide the safest patient care possible. The reporting of patient safety events, including those that did not reach the patient (i.e., Near Miss events), allows DoD PSP to "Focus on Failure" by analyzing the sequence of events that potentially leads to errors, identifying trends in patient harm across the MHS direct care system and sharing lessons learned to prevent harm events. The Patient Safety Reporting (PSR) system is a standardized, anonymous, Web-based reporting system that was implemented across the MHS direct care system in FY 2011 to capture patient safety events.[1]

The MHS leadership has encouraged MTF commander and staff to report on all patient safety events. The table below compares FYs 2013–2014 patient safety reporting as stratified by harm classification. In FY 2014, a total of 81,433 patient safety event reports were submitted, which was a 1.3 percent increase from FY 2013. Although Near Miss events reported in FY 2014 showed a 5 percent increase over FY 2013 reporting, they continued to represent about one half of the total reported events. Events reporting harm to patients accounted for 8.4 percent of the total reports for FY 2014, an increase of 6.5 percentage points from FY 2013.

HARM GROUP STRATIFICATION	EVENT REPORTS, FY 2014		RESULTS, FYs 2013–2014
	NUMBER	PERCENTAGE	PERCENTAGE CHANGE
Overall			
Events Reached Patient, Harm	6,847	8.4%	6.5%
Events Reached Patient, No Harm	33,679	41.4%	–3.9%
Events Did Not Reach Patient, Near Miss	40,907	50.2%	5.1%
Total	**81,433**	**100.0%**	**1.3%**
Medication (38.7% of all reports)			
Events Reached Patient, Harm	1,662	5.3%	2.7%
Events Reached Patient, No Harm	9,400	29.8%	–17.5%
Events Did Not Reach Patient, Near Miss	20,475	64.9%	–12.3%
Total	**31,537**	**100.0%**	**–13.2%**
Non-Medication (61.3% of all reports)			
Events Reached Patient, Harm	5,185	10.4%	7.8%
Events Reached Patient, No Harm	24,279	48.7%	2.7%
Events Did Not Reach Patient, Near Miss	20,432	40.9%	31.0%
Total	**49,896**	**100.0%**	**13.3%**

Source: DHA/Health Care Operations Directorate, Clinical Support Division, 11/10/2015

In addition to capturing patient safety events reported through PSR, DoD PSP receives root cause analyses (RCAs), which MTFs are required to report for every sentinel event that occurs within a facility. Similar to prior years, of the RCAs received for FY 2014, the associated leading event categories included: Wrong Site/Person/Procedure Surgery, Unintended Retention of Foreign Object, Delay in Treatment, Operative/Post-Operative Complication, and Patient Suicide/Suicide Attempt. DoD PSP reviews the RCAs submitted and determines appropriate mechanisms to communicate trends, lessons learned, and/or recommended actions. Examples include recommending enterprise-wide system/process redesign, issuing patient safety notices, developing new policies, and offering focused training or education.

As the MHS continues on its path toward high reliability, the Assistant Secretary of Defense (Health Affairs) and the DoD PSP have clarified enterprise-wide definitions, reporting requirements and improvements in the performance and sharing of RCAs. The PSP continues to advance the high-reliability organization (HRO) principle of being reluctant to simplify complex issues by diving deeply into patient safety events to identify underlying problems that increase the likelihood of errors, contributing factors/root causes, and recommended corrective actions. These actions will be supplemented by ongoing guidance, training, and educational resources for MTF leaders and staff.

[1] Although PSR is currently used to capture only patient safety events in MHS direct care facilities, starting in FY 2014, DoD PSP began assisting the Department of Veterans Affairs (VA) with piloting the PSR for future use across the VA. In addition to this Joint-PSR effort, DoD PSP and VA National Patient Safety Center continue to explore additional opportunities for collaboration and data sharing to improve patient care.

Engagement in Targeted Patient Safety Improvement Initiatives

In June 2011, MHS direct care facilities accepted the challenge set by the National Partnership for Patients (PfP) Initiative: to reduce preventable hospital-acquired conditions (HACs) in nine identified areas of harm by 40 percent, and to facilitate better care transitions to reduce hospital readmissions by 20 percent by the end of 2013.

PfP set a foundation for ongoing cross-Service collaboration on large-scale patient safety improvement efforts, an approach that is now informing the MHS's plans and approaches toward high reliability. PfP was the first major enterprise-wide approach to patient safety, with a learning-based initiative focused on implementing clinical evidence-based practices (EBPs) across the MHS. This transformative, cross-Service approach applied standardized, structured tools and processes across the enterprise to effect change for our patients.

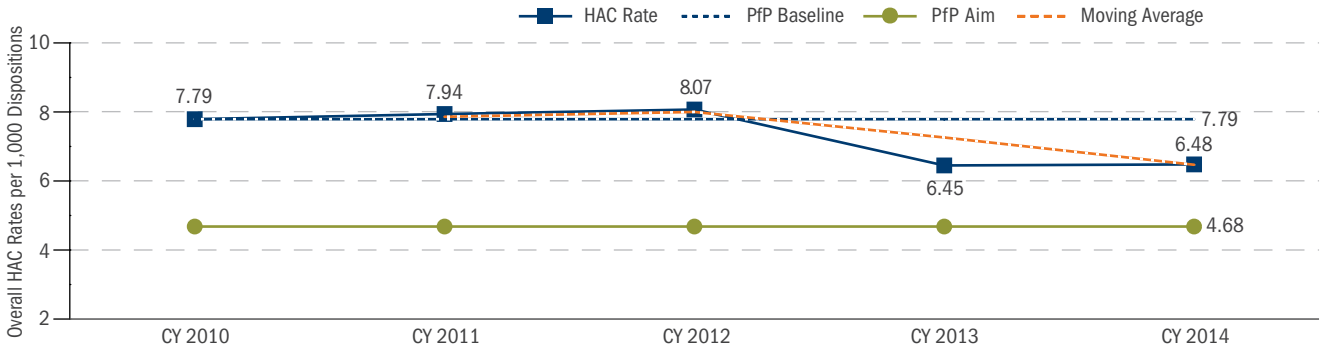
During the DoD PfP Initiative (October 1, 2012, through December 31, 2013), MHS direct care hospitals prevented HACs for approximately 500 patients and avoided $13.5 million in HAC treatment costs (based on national estimates for direct medical costs for HAC treatment).[1] With an estimated $5.46 million investment in the PfP Initiative, MHS achieved an $8 million return on investment. During that same time, the MHS also realized a reduction of 15.8 percent in the harm rate: 7.96 harms per 1,000 dispositions (cumulative from CY 2010 Q1 to CY 2012 Q3) to the current rate of 6.70 harms per 1,000 dispositions (cumulative from CY 2012 Q4 to CY 2013 Q4). By the end of CY 2014, the MHS achieved a 17 percent cumulative improvement in the harm rate.[2]

The HAC improvements of note were in Central Line-Associated Bloodstream Infections (CLABSIs), Pressure Ulcers, Potential/Probable Ventilator Associated Pneumonia (PVAP), and Venous Thromboembolisms (VTEs), as the MHS exceeded the 40 percent reduction goal in those HACs. Adverse Drug Events (ADEs) and Falls with Harm increased in their rates; however, since they are self-reported, it is possible that their increase is partially due to increased reporting.

The trend chart below depicts efforts to reduce preventable HACs by accelerating the spread of EBPs throughout the MHS. Variation is shown in the HAC Rate ([HACs x 1,000]/dispositions) across the MHS relative to the PfP aim of 4.68, a rate that is based on a 40 percent reduction from the MHS baseline rate of 7.79 (CY 2010). The moving average for HAC rates, shown below, reflects a favorably declining trend from the time of program implementation in October 2012.

The Learning Circles and Communities of Practice (CoPs) were designed to support MTF implementation teams and were instrumental in sharing best practices, preventing harm and improving care for beneficiaries. Ninety percent of the participants who attended the CoPs found them useful. More than 6,000 learning hours were tracked centrally throughout 171 CoP sessions, in which improvement coaches facilitated ongoing learning for and leading by MTF champions and teams as well as external subject matter experts. To date, all Services have implemented PfP EBPs. The ongoing sustainment of PfP activities and accountability for tracking results is managed at the Service level, with responsibility at the MTF level.

TOTAL PARTNERSHIP FOR PATIENTS: HOSPITAL-ACQUIRED CONDITION (HAC) RATE PROGRESS (PER 1,000 DISPOSITIONS) BY YEAR, CYs 2010–2014



Source: DHA/Health Care Operations Directorate, Clinical Support Division, 11/10/2015

[1] As of January 2013, the definition for ventilator-associated pneumonia (VAP) changed to a ventilator-associated event (VAE) algorithm. VAE is a three-tiered approach to identifying (1) ventilator-associated conditions (VACs), (2) infection-related ventilator-associated complications (IVACs), and (3) possible or probable VAP (PVAP or PRVAP), allowing facilities to more accurately assess all VAEs instead of just VAP. As of May 2015, PVAP is included in the MHS rate from CY 2013 Q1–CY 2014 Q4.

[2] Improvement rate calculation is based on harms that have been reported within five months of the quarter's closing.

The MHS continues to integrate PfP efforts into ongoing, enterprise-wide improvement activities by leveraging lessons learned from this initiative and determining how they can be applied to other areas of care and/or patient safety and quality initiatives. As part of the 2014 Secretary of Defense's 90-Day Review of Quality, Access to Care, and Patient Safety in the MHS and the journey toward high reliability, PfP efforts were leveraged in the development of recommendations to refine and strengthen a comprehensive infection prevention and control program across the MHS, to include standardized requirements for monitoring device-related infections, tracking infection rates at the unit level beyond intensive care, and continued improvements in HAC rates across the MHS.

The annual DoD Quality and Patient Safety Award recognizes efforts designed to decrease harm and improve the care delivered within the MHS. The award identifies those who have shown initiative and commitment to the development of systems and processes that are tightly organized around patients' needs and demonstrate improvement. In FY 2014, 41 applications highlighting innovative MTF-level initiatives were received and a total of seven awards were presented across five categories:

- Enhancing Culture and Leadership
- Reducing Harm and Healthcare Acquired Conditions
- Improvements Across the Continuum of Care and Readmissions
- Patient and Family Activation and Engagement
- Clinical Improvements through the Use of Evidence-Based Practices

Training and Education to Improve Performance and Patient Safety

Staff-to-staff communication breakdowns remain frequently cited as a primary factor contributing to patient safety events across the nation. Included among the many resources and solutions the PSP offers is the Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS®), a system whose purpose is to improve communication techniques within health care teams. TeamSTEPPS is an evidence-based teamwork development system designed to produce highly effective medical teams that optimize the use of information, people, and resources to achieve the best clinical outcomes. Throughout the MHS direct care system, TeamSTEPPS has been trained at our MTFs, with follow-on coaching to facilitate ongoing sustainment.

Further targeted training is offered for Patient Safety Managers (PSMs), who serve as local champions within MTFs. DoD PSP conducts a Basic Patient Safety Manager (BPSM) course to provide new PSMs with standardized knowledge, skills, and tools to implement patient safety initiatives at their facility. Blending traditional industry-standard training strategies with creative methodologies, this course is founded on the latest predictors of workforce training success research. The BPSM course offers an award-winning, state-of-the-art learning system with a pre-work module, five days of face-to-face training, 12 months of post-training virtual coaching, and opportunities for continued development through a PSM Ongoing Learning Certificate. Before BPSM, trainees reported an average confidence level of 18 percent across all aspects of their role; after course completion, this increased to an average of 80 percent. After 12 months of coaching, PSM confidence continued to grow, with nearly 100 percent of those surveyed expressing high confidence in their understanding and abilities.

To further build on the standardized patient safety knowledge, skills, and tools facilitated through the BPSM Course, in FY 2014, DoD PSP began working towards developing comprehensive quality, safety, and performance improvement-focused competencies for various target audiences across the MHS, from the general non-clinical workforce to MTF senior leadership. To accompany these competencies, currently available education and training curricula and learning resources are being mapped to each competency to help MTF staff identify ways to build capacity and to highlight areas where the MHS may need to focus curriculum development in the future. This also ties to the MHS's HRO focus by encouraging alignment and consistency in building staff skill sets.

In addition to educating frontline workers and PSMs, DoD PSP is undertaking the development of tools and resources to engage leadership in advancing quality and patient safety and provide them with the competencies and resources needed to facilitate large-scale change. Leadership commitment is the keystone to an HRO, and therefore must be the first step in the journey to high reliability, serving as the basis for continuous process improvement and a culture of safety.

Patient Safety in the Purchased Care System

All TRICARE contractors continue to monitor their networks using the National Quality Forum Serious Reportable Events criteria and to analyze administrative data using the AHRQ indicators. Occurrences are thoroughly reviewed with follow-up in an effort to learn from errors and prevent future harm events.

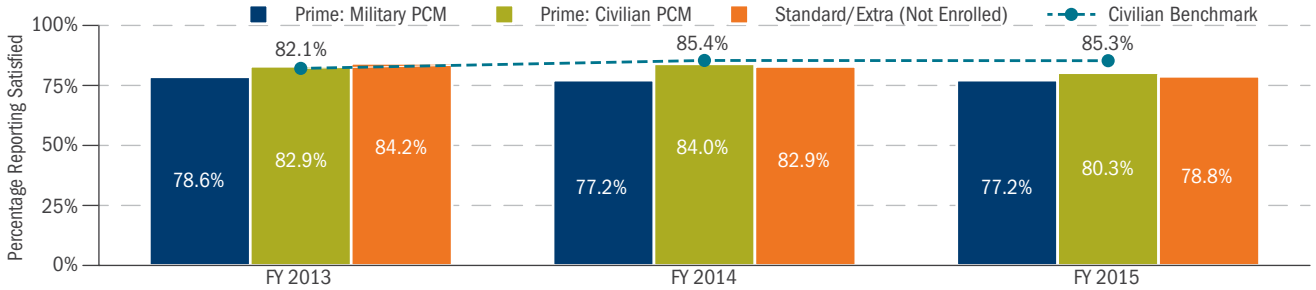
CUSTOMER SERVICE

Satisfaction with Customer Service

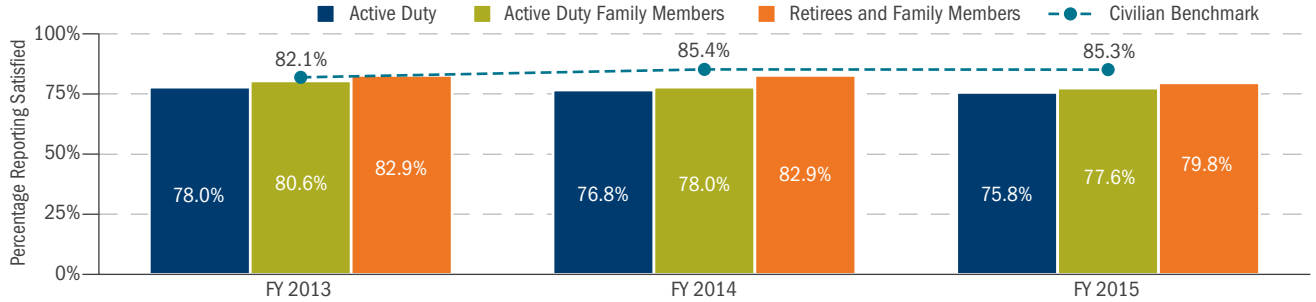
Access to and understanding written materials about one's health plan are important determinants of overall satisfaction with the plan.

- MHS beneficiaries' reported satisfaction with customer service in terms of understanding written material, getting customer assistance, and dealing with paperwork declined from FY 2013 to FY 2015. Reported satisfaction in the civilian benchmark rose over this period.
- Satisfaction for Prime enrollees with a military PCM lagged the civilian benchmark over all three years. Satisfaction levels for Prime enrollees with a civilian PCM and for non-enrolled beneficiaries lagged the civilian benchmark in FY 2015.
- Satisfaction levels for all beneficiary groups declined from FY 2013 to FY 2015, while the civilian benchmark increased.
- In FY 2014 and FY 2015, satisfaction levels for all beneficiary groups lagged the civilian benchmark.

TRENDS IN RESPONSIVE CUSTOMER SERVICE: COMPOSITE MEASURE OF FINDINGS (UNDERSTANDING WRITTEN MATERIAL, GETTING CUSTOMER ASSISTANCE, AND DEALING WITH PAPERWORK) BY ENROLLMENT STATUS



TRENDS IN RESPONSIVE CUSTOMER SERVICE: COMPOSITE MEASURE OF FINDINGS (UNDERSTANDING WRITTEN MATERIAL, GETTING CUSTOMER ASSISTANCE, AND DEALING WITH PAPERWORK) BY BENEFICIARY CATEGORY



Note: DoD data were derived from the FYs 2013–2015 HCSDB, as of 10/19/2015, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for more a detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 4.0, used in the 2013 survey, and CAHPS Version 5.0 for the 2014 and 2015 surveys. CAHPS results come from the NCBD for commercial health plans and from survey results submitted to the NCQA by commercial plans. Benchmarks used in 2013 come from the 2011 NCBD, while benchmarks for 2014 and 2015 come from NCQA's 2013 data. In this and all discussions of the HCSDB results, the terms "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests for significance of differences or trends.

CLAIMS PROCESSING

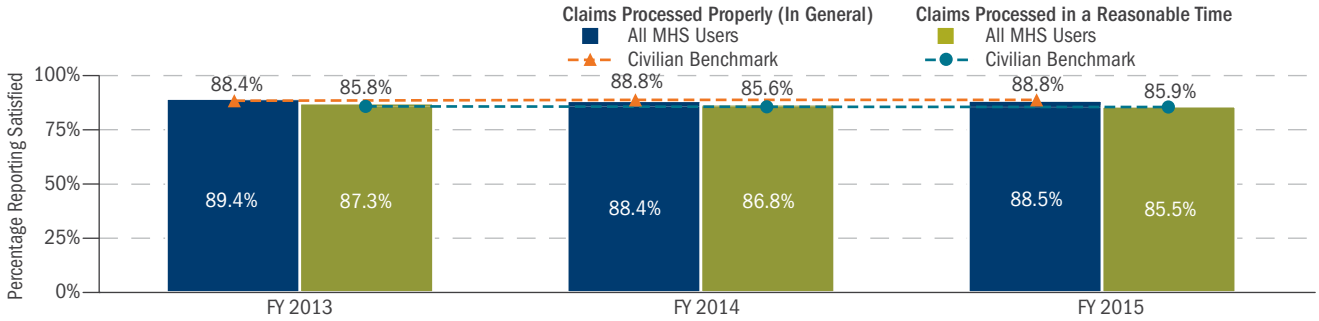
Both beneficiaries and their providers have an interest in the promptness and accuracy of claims processing and payment. MHS monitors the performance of TRICARE claims processing through surveys of beneficiary perceptions and administrative tracking. The overall number of claims processed decreased from 194 million in FY 2013 to 190 million in FY 2014 and 189 million in FY 2015. The number of claims is decreasing at a rate consistent with the decrease in population. Overall utilization has decreased over the three years reported.

Beneficiary Perceptions of Claims Filing Process

- Satisfaction with claims being processed accurately remained stable from FY 2013 to FY 2015. Satisfaction with processing speed also remained stable during that time period.
- MHS satisfaction levels with both the accuracy and the speed of claims processing were not significantly different from the civilian benchmarks in FY 2014 or FY 2015.

Beneficiary Perceptions of Claims Filing Process

TRENDS IN SELF-REPORTED ASPECTS OF CLAIMS PROCESSING (ALL SOURCES OF CARE)



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Trends in Claims Filing Process

TRICARE monitors claims processing to ensure compliance with contractual requirements and to ensure our participating providers are paid on a timely basis. Claims processing for purchased care comprises three intervals: claims submission, claims processing, and transmission acceptance.

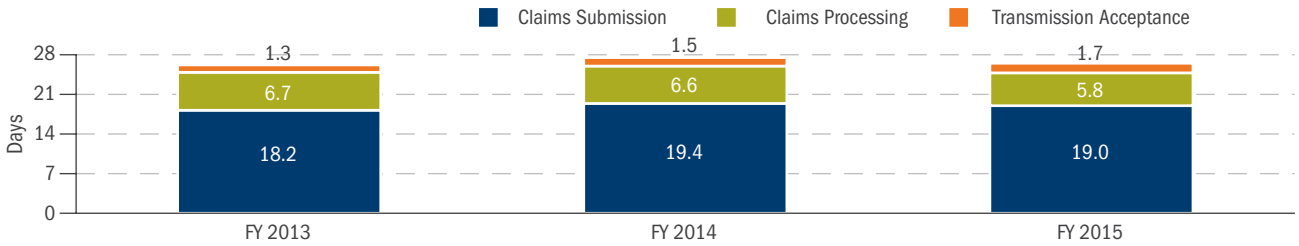
- **Claims Submission:** The claims submission interval is the time from the patient's last date of care to the date that the treating provider files a claim for payment with the Purchased Care Processing Contractor.
- **Claims Processing:** The Purchased Care Processing Contractor adjudicates the claim and sends a TRICARE Encounter Data (TED) record to DHA requesting payment. Claims processing includes the time needed for the Purchased Care Processing Contractor to ensure 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 by current contracts. Contracts between DHA and MCSCs require that TED records be received by 10 AM Eastern time for DHA to accept same day; otherwise, the cutoff moves the TED "Accept" record to the next day.

DHA pays MCSCs within seven days of the later of "Transmission Receive Date" or "Last Update Date," in compliance with contractual language. The graph below shows that TRICARE payments met time requirements, complying with managed care support contracts.

The below graph excludes paper claims and claims from other health insurance, pharmacy, TRICARE Dual Eligible Fiscal Intermediary Contract, and TRICARE Overseas Program contracts. From FY 2011 to FY 2013, three new contracts were implemented, and these changes affected provider networks and their claims submission processes. The West Region contract caused an overall increase during FY 2014. The lengthiest portion of claims processing consistently is claims submission—the time it takes for the treating provider to submit claims. Since institutional claims are less than 5 percent of the total claims, the claims submission time is not affected by this claim type.

The chart below shows results of analysis of claims counts of 37.5 million, 37.4 million, and 38.3 million for FY 2013, FY 2014, and FY 2015, respectively.

AVERAGE INTERVAL (DAYS) FOR CLAIMS PROCESSING



Source: MHS Administrative data, 11/3/2015

TRICARE BENEFITS FOR THE RESERVE COMPONENT

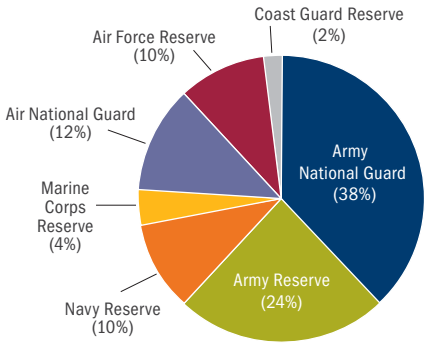
TRICARE offers a broad array of benefits coverage for RC members and their families, from pre-deployment and during mobilization to post-deployment and into retirement from the Selected Reserve.

TRICARE Reserve Select (TRS). The premium-based TRS health plan offers comprehensive TRICARE Standard and Extra coverage for purchase by qualified members of the Selected Reserve. TRS had grown to nearly 132,000 plans with more than 351,000 covered lives by the end of FY 2015. The chart below shows TRS enrollment growth since the NDAA FY 2007 enacted current member qualifications, effective October 1, 2007.

- As shown in the pie chart at right, Army National Guard and Army Reserve combined constitute 62 percent of the 351,200 TRS covered lives.
- The Department has been asked previously to estimate the "take rate"—the share of members of the Reserve and Guard who could qualify for TRS that actually hold coverage. As shown in the table on the right, almost 127,000 Reserve and Guard members held TRS coverage by the end of CY 2014 of the almost 494,000 qualified Selected Reservists at the time, for an estimated "take rate" of almost 26 percent. (The take rate methodology was validated by the Government Accountability Office [GAO], GAO-11-151, June 2011, pages 11–12.)
- TRS monthly premiums are derived from actual prior year costs. Member-only rates will decrease by $2.85, from $50.75 in CY 2015 to $47.90 in CY 2016. Member-and-family rates will increase by $5.21, from $205.62 in CY 2015 to $210.83 in CY 2016, as follows (10/19/2015; see http://tricare.mil/Costs/HealthPlanCosts/TRS.aspx):

MONTHLY PREMIUMS	CY 2014	CY 2015	CY 2016
TRS Member Only	$51.68	$50.75	$47.90
TRS Member and Family	$204.29	$205.62	$210.83

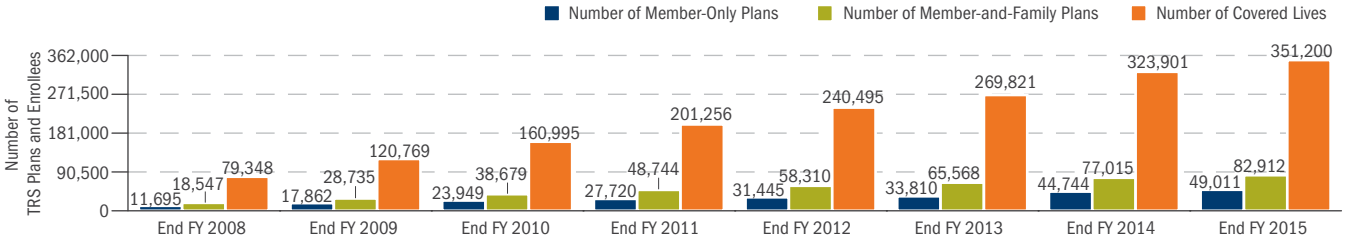
TRICARE RESERVE SELECT: POPULATION BY COMPONENT (351,200 SPONSORS AND FAMILY MEMBERS AS OF SEPTEMBER 2015)



	TOTAL
Selected Reserve Members/Sponsors	826,848
Federal Employees Health Benefits Program (FEHBP)	(113,121)
On Active Duty	(147,792)
Early Identification (EID) Eligibility	(12,599)
On Transitional Assistance Management Program (TAMP)	(59,678)
Adjusted TRS-Qualified Population	493,658
Enrolled TRS Sponsors	126,980
Take Rate for Eligible Population	25.72%

Source: ODASD (MPP) eligibility data as of 12/30/2014, provided 12/10/2015
Note: Selected Reserve end strength subcategories are mutually exclusive counts based on precedence of category (e.g., FEHBP, then AD, then EID, then TAMP). End of CY 2014 data are the latest available match results for the DoD-OPM match to identify reserve component members with FEHBP.

TREND IN RESERVE COMPONENT ENROLLMENT IN TRS (SEPTEMBER 2008–END FY 2015)



TREND IN ENROLLMENT IN TRR (OCTOBER 2010–SEPTEMBER 2015)

Source for TRR and TRS data: Defense Manpower Data Center (DMDC)/DEERS Medical Policy Report, 10/14/2015

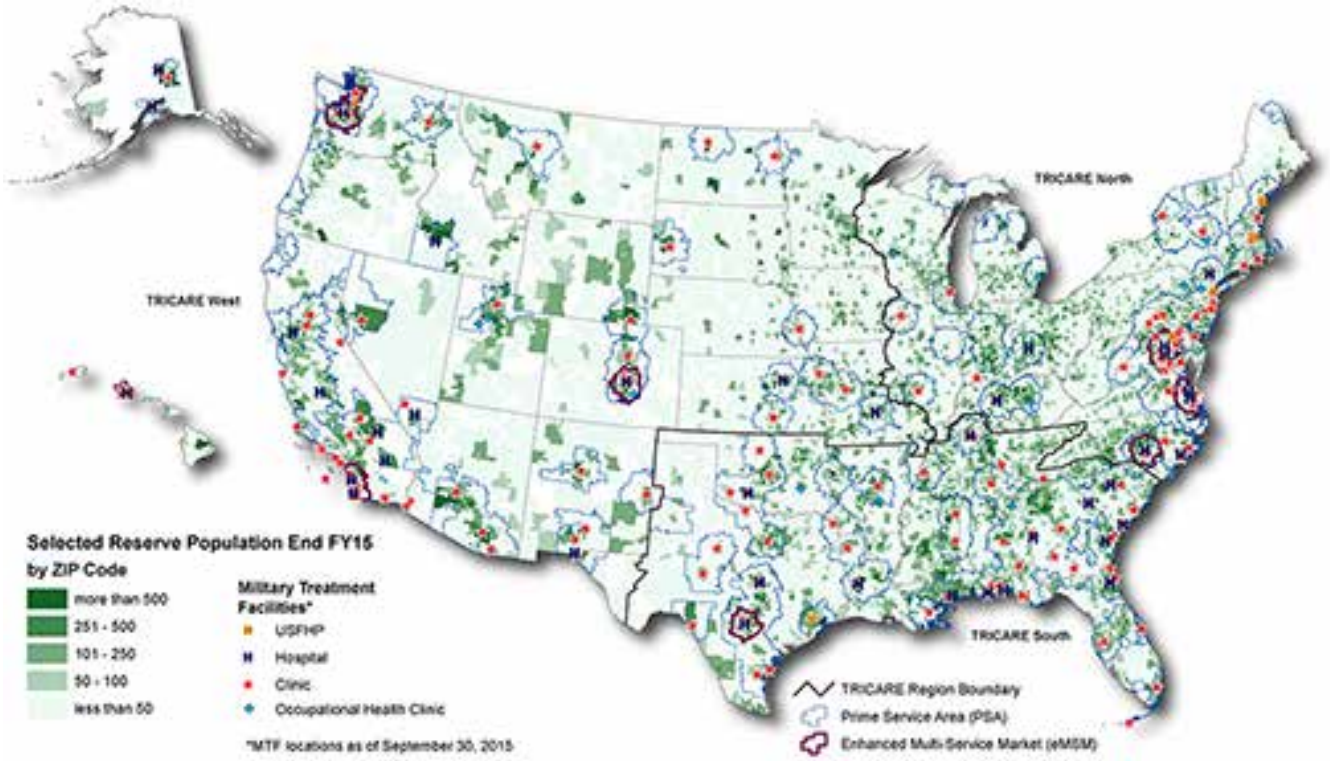
TRICARE Retired Reserve (TRR). Coverage under the TRR premium-based health plan began on October 1, 2010 (NDAA for FY 2010, section 705 and encoded at 10 U.S.C. 1076e). The law allows qualified members of the Retired Reserve to purchase full-cost, premium-based coverage under TRR until they reach age 60, when they receive premium-free TRICARE coverage for themselves as retirees and their eligible family members.

Although coverage under TRR is similar to TRS, it differs in the cost contribution. Unlike TRS, where the Department and member share in the cost of the premium, in TRR the member pays the full cost of the premium. Premiums are calculated annually for both.

- By the end of FY 2015, over 5,600 retired Reservists and their families were covered by TRR in 2,183 member-only and member-and-family plans.
- TRR monthly premiums, based on actual prior year costs, will decrease by $2.10 in member-only plans, from $390.89 in CY 2015 to $388.79 in CY 2016, and the member-and-family plans will decrease by $3.91, from $961.35 in CY 2015 to $957.44 in CY 2016, as follows (9/14/2015; see http://tricare.mil/Costs/HealthPlanCosts/TRR.aspx):

MONTHLY PREMIUMS	CY 2014	CY 2015	CY 2016
TRR Member Only	$390.99	$390.89	$388.79
TRR Member and Family	$956.65	$961.35	$957.44

SELECTED RESERVE POPULATION IN THE U.S. RELATIVE TO MTF, PRIME, AND NON-PRIME SERVICE AREAS IN FY 2015



COMPARISON OF SELECTED RESERVE AND ACTIVE DUTY SPONSORS AND FAMILY MEMBER PROXIMITY TO MILITARY TREATMENT FACILITIES AND NETWORK PROVIDERS IN THE U.S. (SEPTEMBER 30, 2015)

BENEFICIARY GROUP	POPULATION TOTALS (END FY 2015)	POPULATION IN PSAs	% IN PSAs	POPULATION IN CATCHMENTS	% IN CATCHMENTS	POPULATION IN PRISMs	% IN PRISMs	POPULATION IN MTF SERVICE AREAS	% IN MTF SERVICE AREAS	POPULATION IN MULTI-SERVICE MARKET AREAS	% IN MULTI-SERVICE MARKET AREAS
Active Duty and Their Families	2,859,032	2,730,509	96%	2,008,925	70%	2,521,498	88%	2,651,322	93%	1,096,150	38%
Selected Reservists and Their Families	1,969,083	1,342,433	68%	483,288	25%	733,050	37%	1,058,949	54%	243,835	12%

Sources: MTF information from DHA Business Support Directorate, Facility Planning 10/21/2015, and geospatial representation by DHA/Decision Support Division, 12/22/2015; Populations: Selected Reserve and family member data provided by OASD/RAS Reserve Components Common Personnel Data System (RCCPDS) and Defense Enrollment Eligibility Reporting System (DEERS) database extract as of 9/30/2015, provided 11/17/2015; Active Duty and their families from MHS Data Repository (MDR) DEERS extract as of 9/30/2015, provided 11/18/2015.

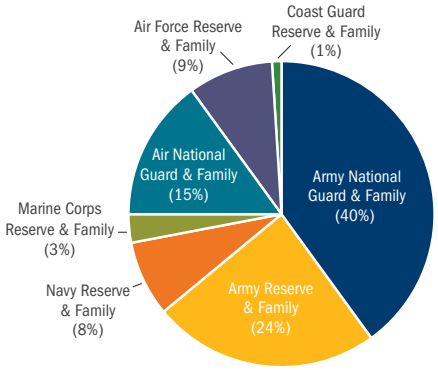
Notes:

– Percentages are rounded to the nearest whole number.
– MTF Service Areas are 40-mile circles around inpatient and outpatient MTFs, rounded to include all complete and partial ZIP codes, subject to overlap rules, barriers, and other policy overrides.
– Prime Service Areas are MTF Service Areas and similar geographies around closed MTFs (Base Realignment and Closure [BRAC] Prime Service Areas), effective October 1, 2013.
– Multi-Service market areas are the six enhanced multi-Service market (eMSM) areas used in the MHS strategy and metrics calculations (i.e., National Capital Region, Puget Sound, Colorado Springs, San Antonio, Tidewater, and Hawaii areas) and two densely populated multiple-market areas in San Diego and Fort Bragg.

TRICARE BENEFITS FOR THE RESERVE COMPONENT *(CONT.)*

- As of September 30, 2015, there were more than 2 million Selected Reserve Service members and their families (2,094,570), of which 826,002 were sponsors and 1,268,568 were family members. Approximately 96 percent were identified as residing in the U.S.
- The map on page 67 depicts where Selected Reservists and their family members reside in the U.S., relative to the direct care MTFs, and also to all areas where TRICARE Prime networks are available. As shown in the accompanying table, by September 30, 2015, 68 percent of Selected Reservists and their family members (96 percent for Active Duty and their family members) in the U.S. live within the area covered by the TRICARE network (PSAs). Slightly more than half (54 percent) of this population resides near a clinic or inpatient MTF, compared with 93 percent of Active Duty and their family members.
- As shown below, almost two-thirds (64 percent) of the worldwide Selected Reserve population of 2 million sponsors and their family members are Army National Guard (40 percent) and Army Reserve (24 percent), similar to the 62 percent enrolled in TRICARE Reserve Select.

SELECTED RESERVE POPULATION: SPONSORS AND FAMILY MEMBERS BY SERVICE (SEPTEMBER 2015)



Source: OUSD(RA) (M&P), as of 9/30/2015, 11/17/2015

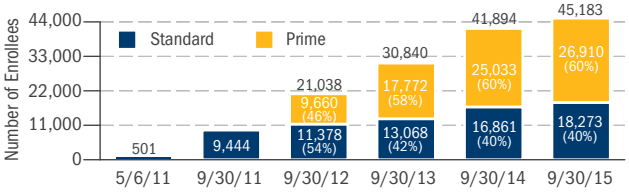
TRICARE YOUNG ADULT

The TRICARE Young Adult (TYA) program offers optional premium-based TRICARE plan coverage up to the age of 26 for former dependent children who lose their entitlement to TRICARE coverage due to reaching a statutory age limit at age 21 or up to age 23. TYA Standard plans began in May 2011 and expanded to TYA Prime plans in January 2012. Monthly premiums are established to actuarially cover the full cost of the coverage. Coverage options and costs depend on the Uniformed Service sponsor's status and where the former dependent child desires coverage. When purchased, TYA meets the minimum essential coverage requirements of the Patient Protection and Affordable Care Act.

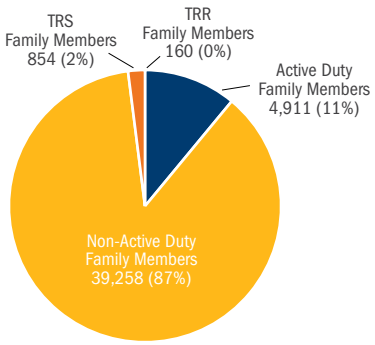
- As shown in the chart at right, enrollment went from almost 42,000 in FY 2014 to just over 45,000 in FY 2015. Also, although TYA began with the Standard option, Prime now accounts for about 60 percent of total TYA enrollment.
- As shown in the accompanying pie chart, most TYA enrolled (87 percent) are family members of those who are not Active Duty (e.g., dependents of retirees and others).
- Based on actual prior year costs, TYA monthly premiums for Prime plans will be $306 per month for Prime and $228 per month for Standard in CY 2016 (table below; see http://tricare.mil/Costs/HealthPlanCosts/TYA.aspx [last updated 10/28/2015]).

MONTHLY TYA PREMIUMS	CY 2013	CY 2014	CY 2015	CY 2016
Prime	$176	$180	$208	$306
Standard	$152	$156	$181	$228

TREND IN TYA ENROLLMENT SINCE INCEPTION (MAY 2011–SEPTEMBER 2015)



TYA ENROLLMENT BY FAMILY MEMBER CAREER STATUS



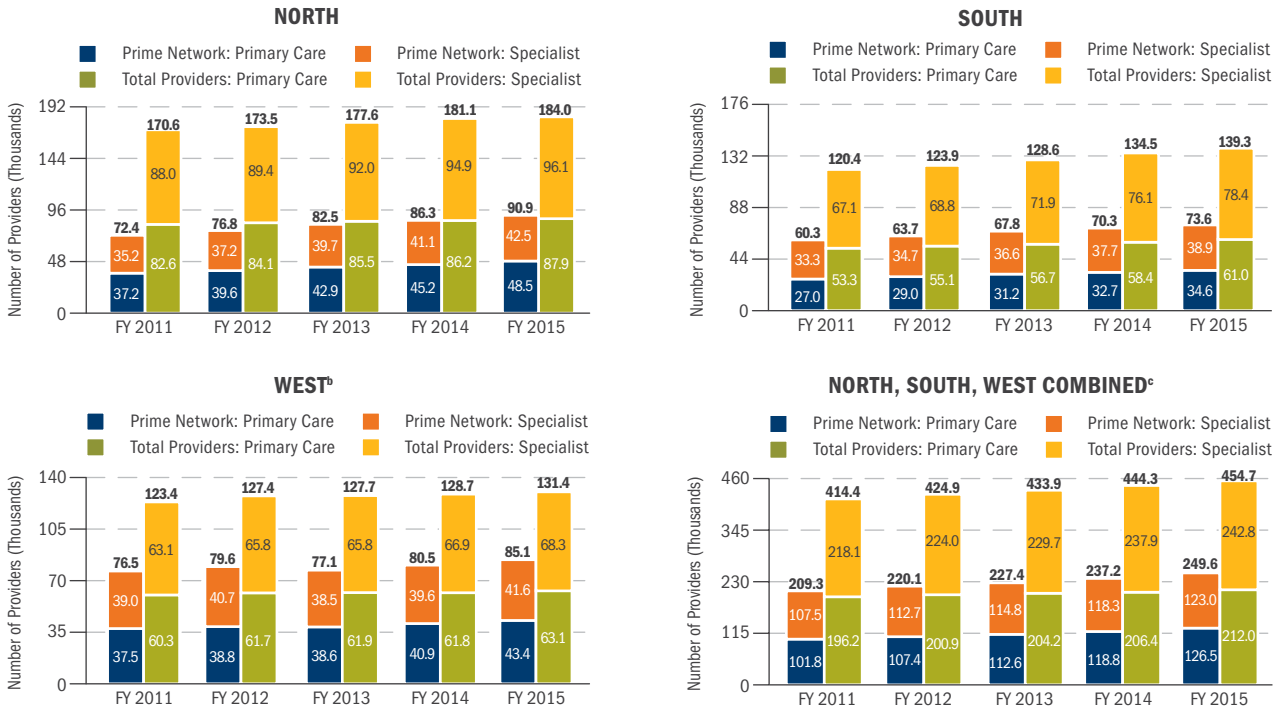
Source: DHA/Healthcare Operations Directorate, TRICARE Health Plan Division, 9/30/2015

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 Health Insurance Portability and Accountability Act (HIPAA)-covered individual health care providers and organizations must obtain an NPI for use in all HIPAA standard transactions. In this report, providers are counted using the NPI. The number of TRICARE participating providers was determined by the number of unique providers filing TRICARE (excluding TFL) claims.[1] Providers were counted in terms of full-time equivalent (FTE) units (1/12 of a provider for each month the provider saw at least one MHS beneficiary). The total number of participating providers has been rising steadily for more than a decade. The trend is due exclusively to an increase in the number of network providers; the number of Standard providers has actually declined slightly. Furthermore, the number of network primary care providers has increased at a higher rate than that of specialists but the total number of participating primary care providers has increased at a slightly lower rate than that of total participating specialists.[2]

- Between FY 2011 and FY 2015, the South Region saw the largest increase in the total number of TRICARE providers (16 percent), while the North Region saw an increase of 8 percent and the West Region an increase of 6 percent.
- The North Region saw the largest increase in the number of network providers (26 percent), followed by the South at 22 percent and the West at 11 percent.
- The total number of TRICARE providers decreased by 13 percent in PSAs and increased by 106 percent in non-PSAs (not shown). This pattern is not due to any fundamental shift in where providers practice but rather to the reduction in the number of PSAs in FY 2014.
- The number of network providers decreased by 5 percent in PSAs and increased by 163 percent in non-PSAs, also due to the reduction in the number of PSAs in FY 2014.
- In FY 2015, 68 percent of all network providers and 64 percent of all participating providers were in PSAs.

TRENDS IN NETWORK AND TOTAL PARTICIPATING PROVIDER FTEs[a]



Source: MHS administrative data, 1/22/2016

Notes: The source for the provider counts shown above was the TRICARE purchased care claims data for each of the years shown, in which a provider was counted if he or she was listed as a TRICARE participating provider. From FY 2005 forward, the claims explicitly identify network providers. Numbers may not sum to bar totals due to rounding.

[a] Network providers are TRICARE-authorized providers who have a signed agreement with the regional contractors to provide care at a negotiated rate. Participating providers include network providers and those non-network providers who have agreed to file claims for beneficiaries, to accept payment directly from TRICARE, and to accept the TRICARE allowable charge, less any applicable cost shares paid by beneficiaries, as payment in full for their services.

[b] The West Region includes Alaska.

[c] Numbers may not sum to regional totals due to rounding.

[1] Providers include physicians, physician assistants, nurse practitioners, and select other health professionals. Providers of support services (e.g., nurses, laboratory technicians) were not counted.

[2] Primary care providers were defined as General Practice, Family Practice, Internal Medicine, Obstetrics/Gynecology, Pediatrics, Physician's Assistant, Nurse Practitioner, and clinic or other group practice.

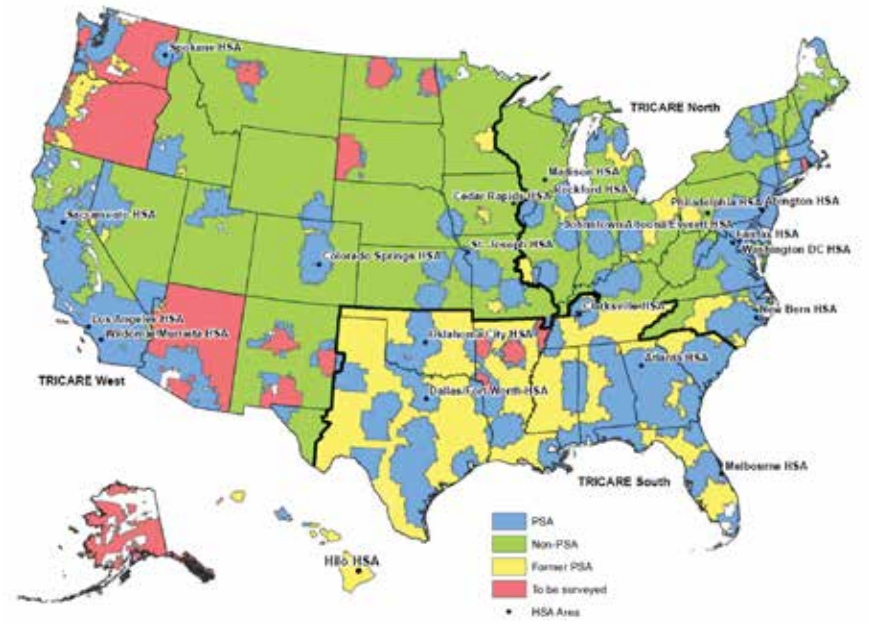
CIVILIAN PROVIDER ACCEPTANCE OF, AND BENEFICIARY ACCESS TO, TRICARE STANDARD AND EXTRA

DoD has completed the third year of a congressionally mandated four-year survey of civilian providers and MHS non-enrolled beneficiaries, designed to determine civilian provider acceptance of, and beneficiary access to, the TRICARE Standard benefit option. This survey complies with the requirements of Section 721, NDAA FY 2012, Public Law (PL) 112-81. This four-year survey is required as a follow-on to a previous four-year survey completed from 2008 to 2011 (Section 711, NDAA 2008 PL 110-181). The survey is licensed by the Office of Management and Budget (provider survey) and Washington Headquarters Service (beneficiary survey), and has been reviewed by the GAO as required by the guiding legislation.

◆ **Results and key points:**

- Provider survey results after three years:
  - About six of 10 providers overall (60 percent of physicians and nonphysician behavioral health providers) and eight of 10 physicians (76 percent) accept new TRICARE Standard patients if they accept new patients of any insurance. These acceptance rates are statistically similar to the 2008–2011 benchmark survey for all providers (61 percent) and are higher for physicians (74 percent).
  - Almost nine of 10 providers (84 percent) and over nine of 10 physicians (93 percent) are aware of the TRICARE program in general (greater than the 2008–2011 benchmarks of 82 percent and 91 percent, respectively).
  - Similar to the 2008–2011 benchmark survey, behavioral health providers (including psychiatrists, psychologists, and nonphysician providers) report lower rates of awareness (73 percent) and acceptance (39 percent), pulling down the all-provider acceptance rates.
  - Primary care and specialist physicians report similar rates of awareness, while specialists report higher acceptance rates than primary care providers for any new patients, new TRICARE Standard patients, and new Medicare patients.
  - Prime and non-Prime Service Area differences: Responding to guiding legislation to assess differences between areas where Prime is offered (Prime Service Areas [PSAs]) and where it is not (non-PSAs), provider acceptance of new TRICARE Standard patients is higher in non-PSAs than in PSAs, while provider awareness is comparable in these locations.
- Beneficiary survey results, after two years:
  - MHS non-enrolled Standard/Extra-eligible beneficiaries rate their care experience and access to care similarly to, or higher than, the benchmark standardized CAHPS Plan survey used by Medicare, Medicaid, and commercial health plans, and health plan accrediting agencies.
  - Standard/Extra beneficiaries residing in PSAs and non-PSAs rate most of their care experience similarly. However, Standard/Extra beneficiaries in non-PSAs report higher ratings of access to TRICARE personal doctors and specialists than beneficiaries in PSAs.
- Provider and beneficiary results vary among PSAs, non-PSAs, and Health Service Areas (HSAs), offering opportunities for improvement in some local areas, such as the boroughs of New York City, N.Y., and Sacramento and Los Angeles, Cali.

TRICARE STANDARD SURVEYS



TRICARE DENTAL PROGRAMS CUSTOMER SATISFACTION

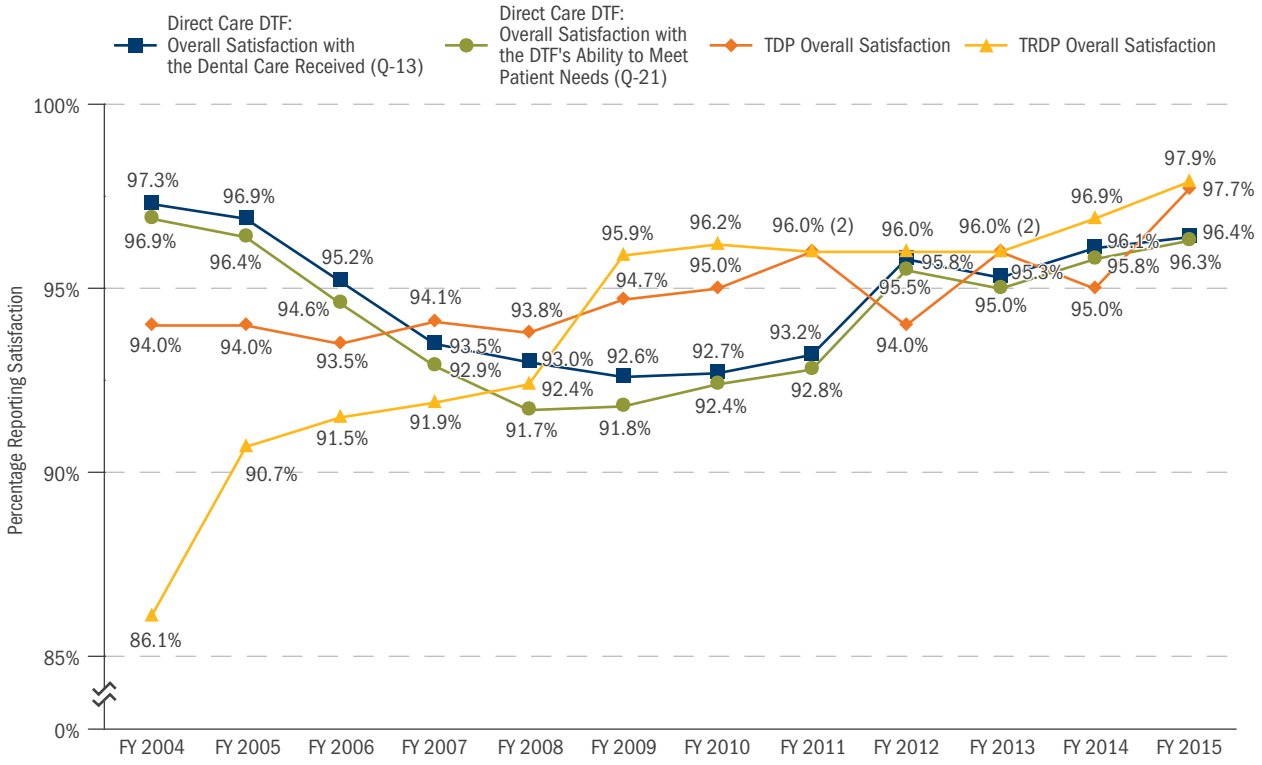
Dental Customer Satisfaction

The overall TRICARE dental benefit is composed of several delivery programs serving the MHS beneficiary population. Consistent with other benefit programs, beneficiary satisfaction is routinely measured for each of these important dental programs.

- **Military Dental Treatment Facilities (DTFs)** are responsible for the dental care of about 1.55 million Active Duty Service members and eligible family members residing outside the continental U.S. (OCONUS). The Tri-Service Center for Oral Health Studies completed almost 178,360 surveys in FY 2015. Continuing the upward trend from last year, overall satisfaction with the dental care received and patient ratings of the ability of the DTFs to meet their dental needs rose again in FY 2015.
- The **TRICARE Dental Program (TDP)** composite overall average enrollee satisfaction increased from 95 percent in FY 2014 to almost 98 percent in FY 2015. The TDP is a voluntary, premium-sharing dental insurance program available to eligible ADFMs, Selected Reserve and Individual Ready Reserve members, and their families. As of September 30, 2015, the TDP enrollment totaled 786,679 contracts, covering almost 2 million lives (1,826,080), 95 percent of which were in the U.S. The TDP network has 95,345 total dentists—or 5 percent more than the 90,901 in FY 2014—of which 76,043 are general dentists and 19,302 are specialists.
- The **TRICARE Retiree Dental Program (TRDP)** overall retired enrollee satisfaction rate rose again from 97 percent in FY 2014 to 98 percent in FY 2015, after remaining steady at 96 percent for the five years prior, from FY 2009 to FY 2013. The TRDP is a full premium insurance program open to retired Uniformed Services members and their families. TRDP enrollment at the end of FY 2015 was higher by 19 percent than in FY 2010, with over 1.491 million total covered lives in over 758,000 contracts in FY 2015, compared with about 1.25 million lives in over 606,000 contracts in FY 2010.

BETTER CARE

SATISFACTION WITH TRICARE DENTAL CARE: MILITARY AND CONTRACT SOURCES, FYs 2004–2015



Sources: TRICARE Dental Office, Health Plan Execution and Operations; Tri-Service Center for Oral Health Studies; and DoD Dental Patient Satisfaction Reporting Web site (Trending Reports), 12/14/2015

Note: The three dental satisfaction surveys (Direct Care, TDP, and TRDP) are displayed above for ease of reference, but are not directly comparable because they are based on different survey instruments and methodologies. For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

HEALTHY AND RESILIENT INDIVIDUALS, FAMILIES, AND COMMUNITIES

This section presents the Military Health System (MHS) Quadruple Aim of "Better Health" and efforts to move "from health care to health" by making the healthy choice the easy choice. This transition is focused on addressing health determinants across the organization, which includes the military health community and places where beneficiaries live, learn, work, and play.

ENGAGING PATIENTS IN HEALTHY BEHAVIORS

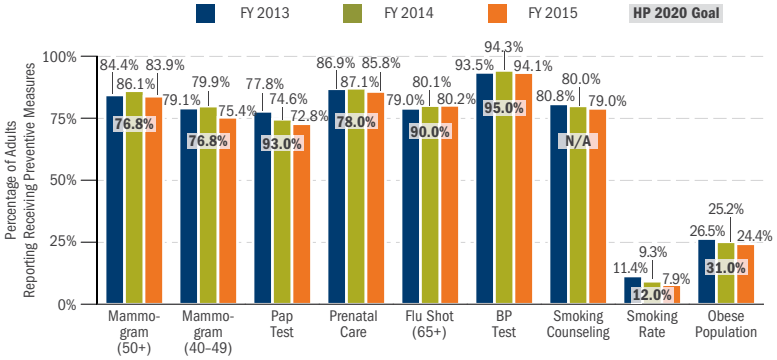
The Healthy People (HP) 2020 goals are national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce those threats; these goals have been embraced by the Department of Defense (DoD) along with the National Prevention Council (NPC). The NPC comprises twenty federal departments, agencies, and offices, and developed the National Prevention Strategy (NPS), America's plan for improving health and well-being. An additional paradigm guiding our efforts within DoD is Total Force Fitness (TFF). This paradigm focuses on several domains that address the NPS, encompassing mind and body. Adoption of these concepts in support of DoD's prevention strategy supports continuous optimal performance, resilience, and recovery for our Service members and their families through the increased coordination of clinical and community prevention services, and by empowering beneficiaries, creating healthier communities, and eliminating health disparities.

In response to health concerns regarding Service members and their families, DoD launched Operation Live Well (OLW) in 2013. This initiative brings together the resources and capabilities of the entire military community to focus on the best ways to promote health and wellness for all beneficiaries. A major focus in 2014 and 2015 has been on demonstration projects that leverage community to inform OLW.

The Health Base Initiative (HBI) is one demonstration project that will inform OLW. The focus of the demonstration is on select initiatives that support improving nutritional choices, increasing physical activity, reducing obesity, and decreasing tobacco use.

HBI was only a first step in DoD's long-term effort to address a core challenge to America's military strength and readiness in the years to come. As a demonstration project, HBI showed that, although there is no simple strategy for improving health and wellness in the military community, and although DoD has much to learn about designing and implementing effective programs for healthy eating, active living, and tobacco cessation, the interest and opportunity exist to make substantial progress in all of these areas. Leveraging that opportunity will require leadership at all levels, increased collaboration within DoD and with outside organizations, and a commitment to applying robust measurement and evaluation tools to continually identify gaps, track outcomes, and refine future efforts. The Department looks forward to exploring this and other partnerships to support Service members and their families in areas where they live, learn, work, and play.

TRENDS IN MEETING PREVENTIVE CARE STANDARDS, FYs 2013–2015



Sources: Defense Health Agency (DHA)/Decision Support Division 2015 Health Care Survey of DoD Beneficiaries (HCSDB) results, provided 10/14/2015, the NCBD http://www.tricare.mil/Survey/HCSDBSurvey/home/abr_region_components.cfm?comp=Healthy Behaviors&period=2015&grp=All Users&region=USA MHS&mainperiod=FY2015A and the National Health and Nutrition Examination Survey (NHANES); Centers for Disease Control and Prevention, National Center for Health Statistics (CDC/NCHS) http://www.healthypeople.gov/2020/Data/SearchResult.aspx?ztopicid=29&topic=Nutrition+and+Weight+Status&objective=NWS-9&anchor=141

Notes:

- Unlike the objective for all other categories, the objective for Smoking Rate and Obese Population is for actual rates to be below the HP 2020 goals.
- The goal for Prenatal Care was revised down from 90 percent in the HP 2010 goals to 78 percent in the HP 2020 goals.
- The goal for Obese Population was revised up from 15 percent in the HP 2010 goals to 31 percent in the HP 2020 goals (see http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx for more information).

MHS-TARGETED PREVENTIVE CARE MEASURES

Mammogram: Women aged 50 or older who had a mammogram in the past year; women age 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: Women pregnant in the last year who received care in the first trimester.
Flu Shot: People aged 65 and older who had a flu shot in the last 12 months.
Blood Pressure (BP) Test: People who had a blood pressure check in the last two years and know the results.
Obese: Obesity is defined as a Body Mass Index (BMI) of 30 or above, which is calculated from self-reported data from the HCSDB. An individual's BMI is calculated using height and weight (BMI = 703 times weight in pounds, divided by height in inches squared). While 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.

ENGAGING PATIENTS IN HEALTHY BEHAVIORS *(CONT.)*

The MHS strategic goals go beyond those for primary health and wellness. The chart on the right reflects secondary-prevention efforts via self-reported responses from all eligible MHS beneficiaries within the categories shown (e.g., all adult women for mammography, all adult pregnant women for prenatal care, etc.).

- MHS has set as goals a subset of the health-promotion and disease-prevention objectives specified by the Department of Health and Human Services (DHHS) in HP 2020. Over the past 10 years (only the most recent three years are reported here), MHS has exceeded targeted HP 2020 goals in providing mammograms for women aged 40–49 years as well as those aged 50+ (except in FY 2015) and prenatal care (see note on page 73). MHS providers will modify protocols as mammography guidelines change.
- Efforts continue toward achieving HP 2020 standards for Pap smears and blood pressure screenings. The percentage of MHS female beneficiaries receiving Pap tests declined from 78 percent in FY 2013 to 73 percent in FY 2015 and is well below the HP 2020 goal of 93 percent. Conversely, the percentage of MHS beneficiaries having BP screenings has risen to the point where it is less than 1 percent short of the HP 2020 standard.
- **Tobacco Use:** The overall self-reported smoking rate among all MHS beneficiaries has declined for the past 5 years, decreasing from almost 15 percent in 2010 (not shown) to just under 8 percent in FY 2015, four percentage points below the HP 2020 goal of 12 percent. Smoking-cessation counseling has decreased slightly from 81 percent in FY 2013 to 79 percent in FY 2015.
- **Obesity:** The overall proportion of MHS beneficiaries identified as obese declined from about 27 percent in FY 2012 to about 25 percent in FY 2015. This is below the HP 2020 goal of 30.5 percent (revised from 34 percent in 2012, consistent with reporting from the National Health and Nutrition Examination Survey [NHANES]) and below the most recently identified U.S. population average of 35 percent (CDC National Center for Health Statistics, 2012, not shown). See other charts on the following pages, which distinguish obesity rates by beneficiary category.

POPULATION HEALTH

Population Health is dedicated to proactively managing the health care of patient populations based on predictable patterns of behavior. Although this concept is generally associated with managing the clinical risks associated with patients, through OLW and the HBI, 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 has evolved to better address the determinants of health through strategies such as strengthening the connections between community-based wellness and prevention programs, strategically communicating through a dedicated MHS campaign (e.g., OLW), and collaborating with ongoing initiatives that support patient-centered care through Patient-Centered Medical Home (PCMH) teams.

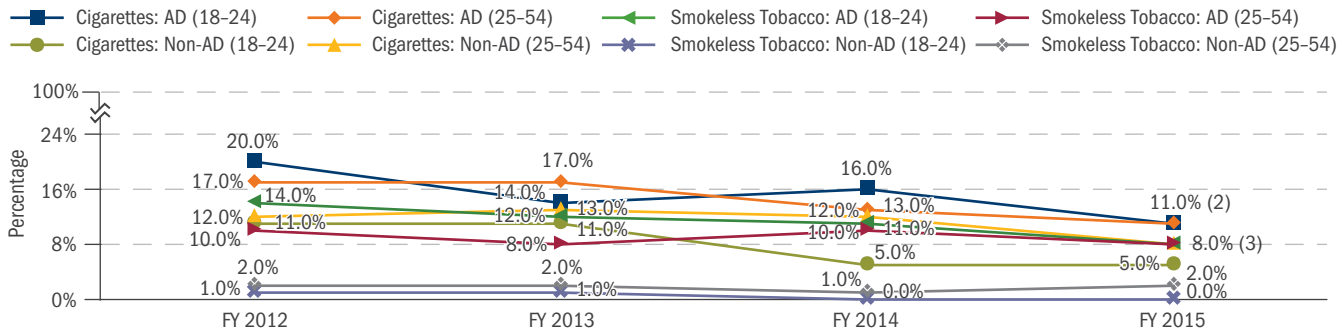
Aligning with participation in the NPC, MHS continues to implement recommendations for the nation's first NPS. These actions are intended to target initiatives that effectively promote health, well-being, and resiliency in support of MHS beneficiaries. Collectively, these efforts will help our health system move from one based on sickness and disease to one based on wellness and prevention.

TOBACCO CESSATION

Tobacco use is the leading cause of death in the U.S., and rates of smoking in the military remain higher than desired. In addition, the costs of tobacco use to DoD in medical care, hospitalizations, and lost work days has been estimated to exceed $1.5 billion annually. 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.

Cigarette smoking and smokeless tobacco usage have declined for Active Duty Service members (ADSMs) the past four years. Self-reported cigarette smoking declined from 20 percent in FY 2012 to 11 percent in FY 2015 for young Active Duty aged 18–24, and from 17 percent to 11 percent for older Active Duty (aged 25–54), both of which are lower than the national civilian adult average of just under 18 percent in 2013 (down from 21 percent in 2005). Cigarette smoking among Active Duty family members (ADFMs) in both age groups has also declined over this same time period, although Active Duty smoking remains higher than that of family members. Active Duty use of smokeless tobacco has also declined for both the younger and older age groups, down to an estimated 8 percent by 2015, but is still higher than the civilian average of almost 4 percent.

MHS CIGARETTE AND SMOKELESS TOBACCO USE RATES AMONG ACTIVE DUTY AND FAMILY MEMBERS: FYs 2012–2015



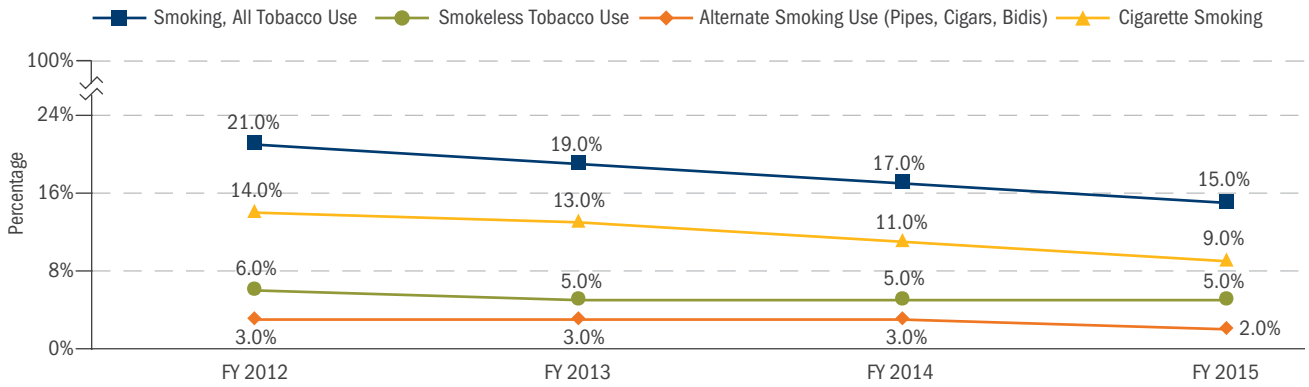
Source: Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]) DHA/Decision Support Division survey, 10/14/2015, HCSDB

Notes:

- For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.
- Percentages are weighted for the probability of selection and nonresponse; variation in quarterly estimates may not be significant and should not be assumed as such without appropriate tests of significance.
- U.S. adult smoking rate of 17.8 percent from http://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/, accessed November 4, 2015
- U.S. adult smokeless tobacco rate of 3.7 percent in 2013, from: http://www.cdc.gov/tobacco/data_statistics/fact_sheets/smokeless/use_us/index.htm, accessed November 4, 2015

- **MHS Prime Enrollee Use of Any Tobacco Products:** Although attention has historically been focused on cigarette smoking, the HCSDB has also been directed to assess the use of various tobacco products across MHS. The chart below presents the self-reported estimates of the prevalence of MHS Prime enrollees using different tobacco products (cigars, pipes, bidis, or kreteks). Based on the survey, Prime enrollee use of tobacco in one form or another has had a statistically significant decline from 21 percent in FY 2012 to 15 percent in FY 2015. Cigarette smoking, which is the most-used form of tobacco among Prime enrollees, has declined from 14 percent to 9 percent over the same time period, while smokeless tobacco and alternative tobacco usage have each declined by 1 percent. Usage of various tobacco products shown in the chart are not mutually exclusive (e.g., a cigarette smoker may also report being a snuff user [smokeless tobacco] or a pipe smoker [alternate smoking tobacco]) and thus are not additive).

MHS PRIME ENROLLEE USE OF TOBACCO PRODUCTS, BY TYPE OF TOBACCO USE: CIGARETTES, ALTERNATE SMOKING TOBACCO, AND SMOKELESS TOBACCO



Source: OASD(HA) DHA/Decision Support Division, HCSDB survey, 12/5/2014

Notes:

- Smokeless tobacco may include dip, snuff, snuss, 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.

Parity Pricing

When HBI started—that is, prior to the FY 2015 National Defense Authorization Act (NDAA)—the policy of selling tobacco at the most competitive price in the local community (instead of at 5 percent less) was already being implemented by Navy and Marine installations across DoD. This change was implemented DoD-wide in accordance with the 2015 NDAA.

Defense Advisory Committee on Tobacco (DACT)

The Secretary of Defense (SecDef) charged his Under Secretary of Defense for Personnel and Readiness (USD[P&R]) to charter a committee to review the DoD's policy on tobacco use and sales. This effort supports sound policy considerations. In support of this effort, the SecDef requested that the USD(P&R) provide him with a range of options developed by an inclusive committee. The DACT, established June 2014, explored options for tobacco policy in DoD that are consistent with national objectives and are based on the CDC's Best Practices for Comprehensive Tobacco Control Programs (2014).

These options will provide the SecDef with an opportunity to review and select tobacco policies that provide a strategic way forward to address DoD tobacco policy. The DoD continues to support tobacco-free living through working with the Military Services to encourage tobacco-free campus policies for military treatment facilities (MTFs).

The ultimate goal of the DACT is to develop a comprehensive tobacco policy that helps prevent the initiation of tobacco use, assists those who want to quit using tobacco, and reduces exposure to second-hand smoke for the entire DoD community. The Committee brought together representatives from each of the Services, as well as key stakeholders from DoD components, to develop policy options with respect to tobacco sales, designated tobacco use areas, and tobacco use in uniform, among other topics, for consideration by senior leaders. The Advisory Committee's plan is currently being reviewed by the SecDef, who is expected to issue a decision about whether and how to proceed with the plan following an effort to collect input from the broader DoD community. This process will take time due to coordination through a large number of stakeholders.

Tobacco Cessation Resources

TRICARE covers smoking-cessation products, including prescriptions and over-the-counter (OTC) drugs, for beneficiaries aged 18 to 65 in the U.S. In addition, the TRICARE smoking-cessation program for ADSMs and Active Duty dependents residing overseas—including the U.S. territories of Guam, Puerto Rico, and the Virgin Islands who are enrolled in TRICARE Prime at an MTF—may have access to those services that the ASD(HA) has determined may be reasonably provided overseas under the authority of 32 CFR 199.17. Covered smoking-cessation products may be obtained at no cost at military pharmacies and through TRICARE Pharmacy Home Delivery, where available. Beneficiaries must have a prescription from a TRICARE-authorized provider for any smoking-cessation medication, including OTCs, and the beneficiary does not need to be diagnosed with a related illness.

Access to online and print tobacco-cessation material remains available through "Quit Tobacco—UCanQuit2.org," an initiative informed by extensive research and testing that was launched by the TRICARE Management Activity (TMA) in 2006. The https://www.UCanQuit2.org Web site supports the Quit Tobacco program and continues to provide 24/7 live chat staffed by trained coaches/mentors who can help participants identify smoking-cessation resources and provide tips and encouragement. Quit Tobacco—UCanQuit2.org also provides SmokefreeMIL, a text message–based tobacco-cessation tool, and Ready2Quit, an interactive quit plan. The Quit Tobacco program distributes materials, including promotional materials for five tobacco-cessation events each year, to tobacco-cessation partners on military installations worldwide who can then provide these materials in-person to Service members and other beneficiaries.

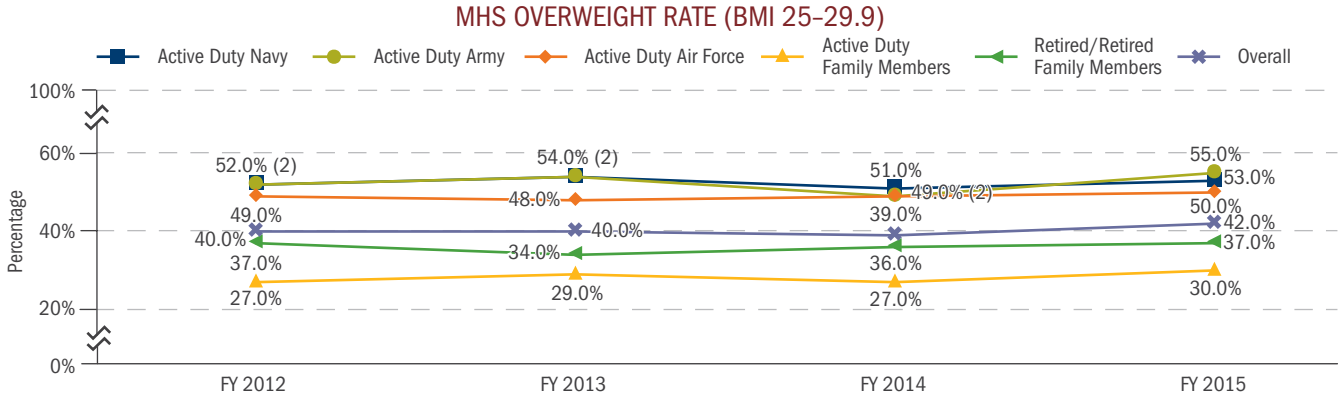
In 2015, the Quit Tobacco program executed a seven-month digital media campaign targeting ADSMs. This campaign integrated Facebook, Google ads, mobile advertising, and other digital media strategies to increase awareness of Quit Tobacco tools and resources. The number of impressions gained in these seven months was 28,987,855. This campaign increased use of our UCanQuit2.org cessation resources, including live chat, SmokefreeMIL, and Ready2Quit.

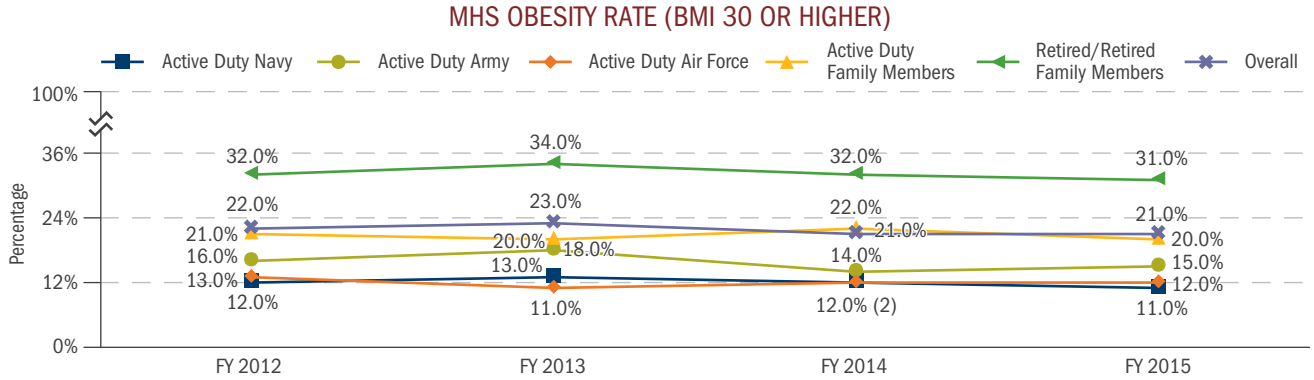
MHS ADULT OBESITY

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 also can shape the need for, and development of, medical interventions or modalities that are effective in maintaining healthy weights for all age groups.

The chart below displays the percentage of the population reporting in the HCSDB a height and weight that, when used in calculating BMI, result in a measurement of 30 or higher (30 is the threshold for obesity).

- As shown in the first chart below, 42 percent of all MHS beneficiaries were overweight in FY 2015, lower than the overall U.S. rate of 69 percent (CDC's NCHS 2011–2012). ADFMs appear to have the lowest rate of being overweight (30 percent), but still represent over one-fourth of the MHS-eligible population. Calculated BMI rates reflecting overweightness may not be reflective of Active Duty fitness without consideration of muscle mass, and may explain why Active Duty appears to have high prevalence rates of being overweight but low obesity rates, as shown in the second chart.
- The second chart displays the prevalence of obesity in the MHS population (i.e., a calculated BMI of 30 or higher based on self-reported height and weight). Active Duty present the lowest rates (between 11 and 15 percent) in FY 2015. The overall MHS obesity rate in FY 2015 (21 percent) as well as obesity rates for family members (20 percent) and retired and their family members (31 percent) are lower than the NHANES rates for adults ages 18–42 (32 percent), ages 43–64 (38 percent), and ages 65 and over (37 percent). Overweight and obesity rates did not change appreciably from FY 2012 to FY 2015.





Source: DHA/Decision Support Division, HCSDB, 10/14/2015

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 $lb/in^2 \times 703$. A BMI of 18.5 to 25 may indicate optimal weight; a BMI lower than 18.5 suggests the person is underweight, while a number above 25 may indicate the person is overweight; a number of 30 or above suggests the person is obese (Division of Nutrition, Physical Activity and Obesity, National Center for Chronic Disease Prevention and Health Promotion, CDC).

– Since the data are self-reported, they are subject to recall bias, while provider measurements are subject to instrument error (e.g., lack of calibration of weight scales) and inconsistency in recording (e.g., asking patient's height or weight versus measuring). Self-reported scores are adjusted for user characteristics that allow comparison with civilian benchmarks. No objective validation tool is used to verify accuracy of BMI results.

– CDC-reported obesity and overweight rates in U.S. adults: http://www.cdc.gov/nchs/fastats/obesity-overweight.htm, accessed November 4, 2015.

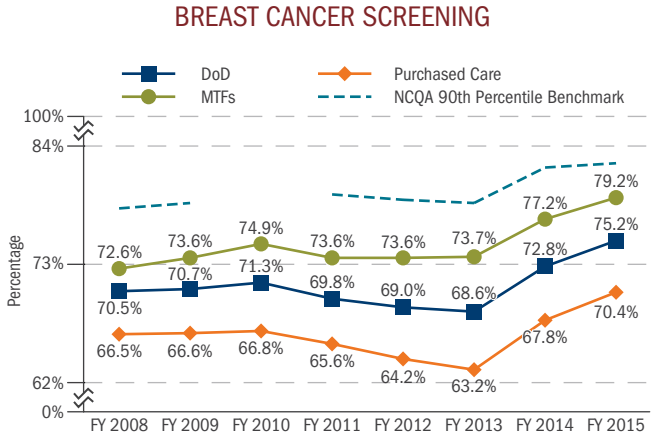
In an effort to capture objective administration data on obesity prevalence among the MHS population, an MHS guideline was developed to support the documentation of BMI with all direct care patient encounters. This documentation is intended to support the capture of information concerning the overall health of DoD beneficiaries for use by MHS leadership to help promote military initiatives that encourage exercise and healthy nutritional habits. These data also can shape the need for, and development of, medical interventions or modalities that are effective in maintaining healthy weights for all age groups.

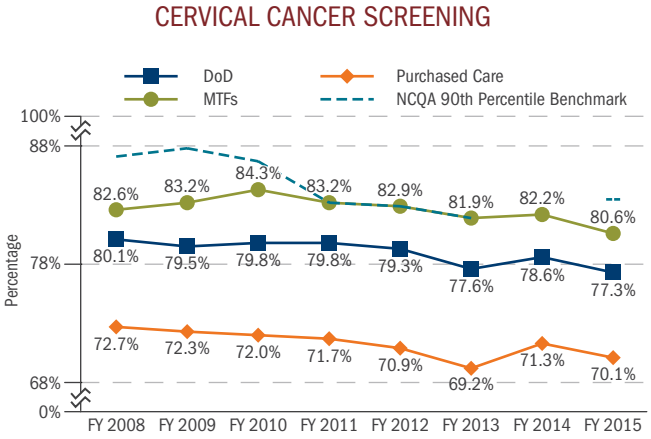
HEDIS MEASURES FOR MHS 2008–2015

MHS collects health plan measures using the Healthcare Effectiveness Data and Information Set (HEDIS) methodologies. HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis (http://www.ncqa.org/HEDISQualityMeasurement.aspx, 10/22/2015) and consists of 81 measures across eight domains of care. The DHA Tri-Service Clinical Measures Steering Panel (CMSP) selects measures for development on an annual basis. The Population Health Portal maintains data and reports these measures for the Services and for the regional managed care support contractors (MCSCs). There are currently 24 measures available for MTFs derived from administrative and Armed Forces Health Longitudinal Technology Application data, and six measures available for purchased care derived from administrative data sources. Other measures are under development to support the HBI, disease management (DM), and PCMH programs. MHS collects and trends metrics for adults (breast, cervical, and colorectal cancer screening; diabetes management; use of imaging studies for lower back pain; and follow-up after hospitalization for mental illness) and children (asthma care [for ages 5–65], well-child care, and use of antibiotics for pharyngitis and upper respiratory infection). These available data can be compared with the National Committee for Quality Assurance (NCQA) annual benchmark results. The HEDIS methodologies used by the Portal to calculate HEDIS measures have been reviewed for the past three years by an NCQA HEDIS auditor to validate that the portal methodology is appropriately implemented.

HEDIS performance is monitored quarterly through the CMSP, with discussion of Service or contractor efforts to improve performance on particular measures. Pay-for-performance programs in the Services encourage MTF compliance with measures. There are also specific clinical incentives in the managed care support contracts that encourage performance improvement on select measures and that are evaluated annually.

Adult HEDIS Measures





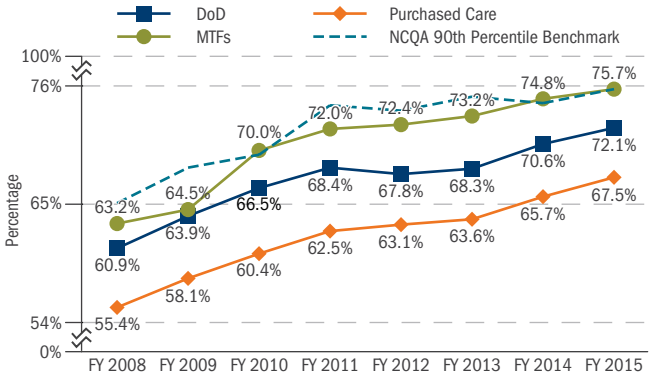
Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 12/15/2015

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

- **Breast and Cervical Cancer Screening:** There have been concerns raised in the last three years regarding the U.S. Preventive Services Task Force recommendations for breast and cervical cancer screening. The recommendations have been reviewed and updated to reflect current evidence-based practice. These changes will affect trending of the data for the near future.
- Other methods of engaging patients and families are under consideration to improve compliance with these important clinical service screening and care management recommendations.

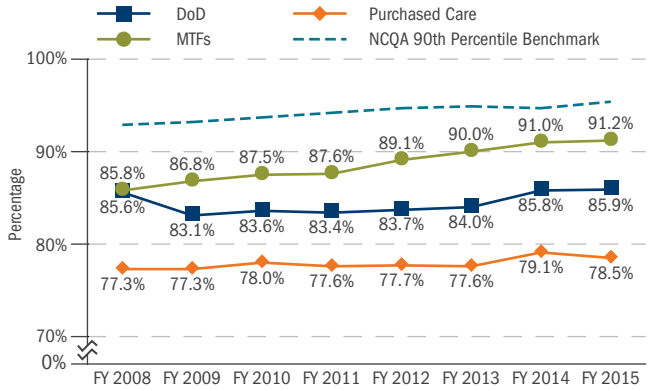
Adult HEDIS Measures *(cont.)*

COLORECTAL CANCER SCREENINGBREAST CANCER SCREENING

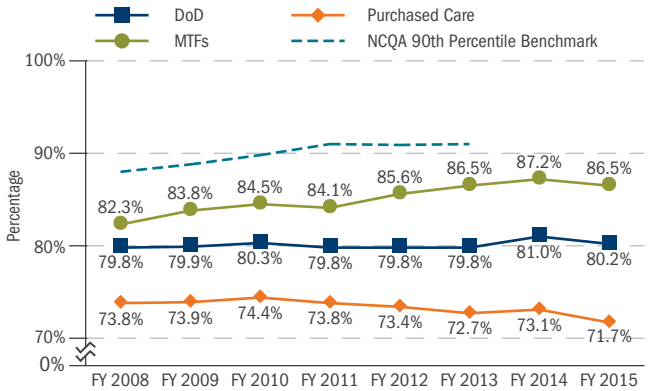


- **Colorectal Cancer Screening:** Similar to the national rates, MHS direct and purchased care rates have improved in colorectal cancer screening. MHS direct care MTF rates reached the NCQA 90th percentile, while purchased care rates continue to lag.

DIABETES HbA1c SCREENING

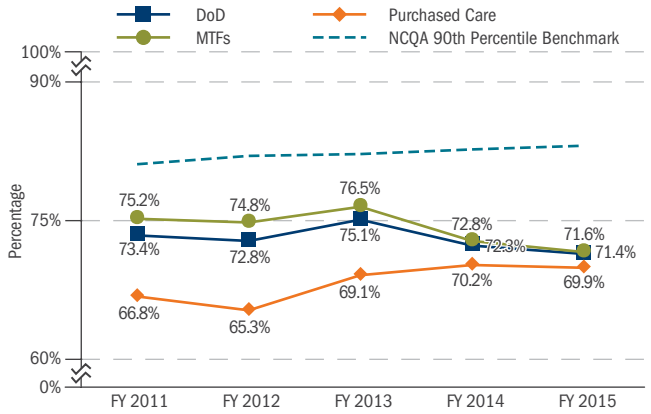


DIABETES LDL SCREENING

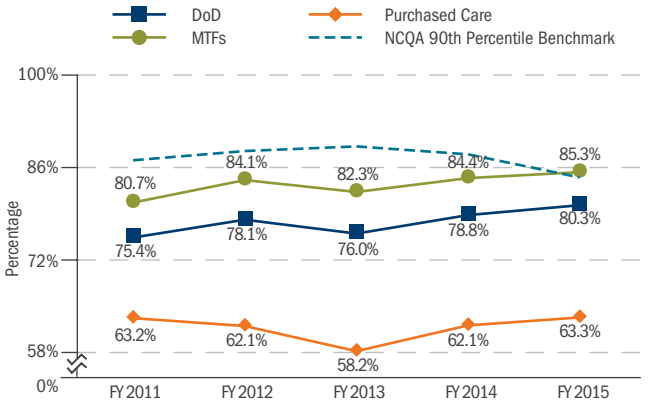


- **Diabetes HbA1c and LDL Screening:** Diabetes screening just for HbA1c and LDL are presented here, because these rates are determined from administrative data only. MHS continues to work to improve diabetic management.

LOW BACK PAIN IMAGING



MENTAL HEALTH FOLLOW-UP

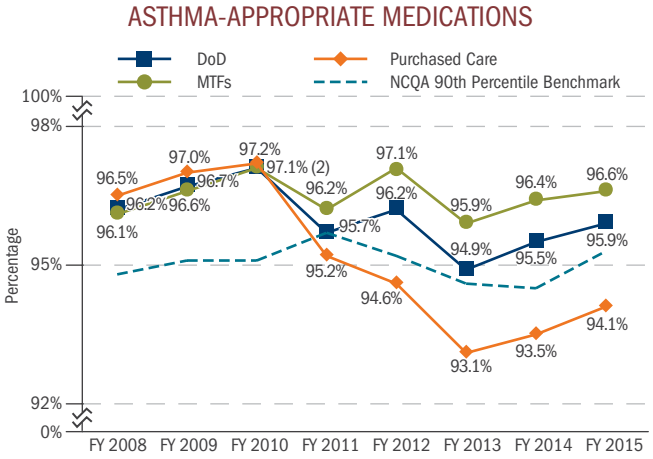


Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 12/15/2015

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

- **Low Back Pain:** Focused on overuse of imaging for acute back pain, MHS is working to integrate the DoD-VA clinical practice guideline into the electronic medical record to support improvement in this measure.
- **Mental Health Follow-Up 30 Days Post-Hospitalization:** MHS is addressing cross-venue communications to enhance transition of care between the MTF and purchased care venues.

Adult and Pediatric HEDIS Measures

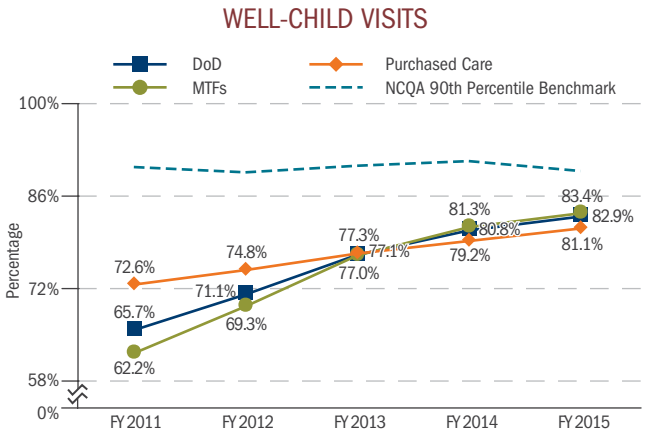


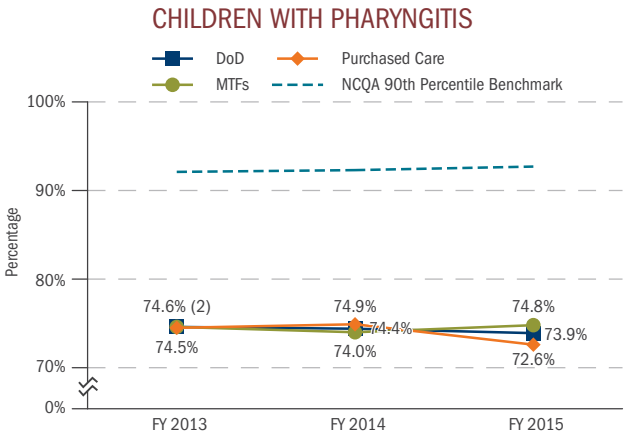
Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 12/15/2015

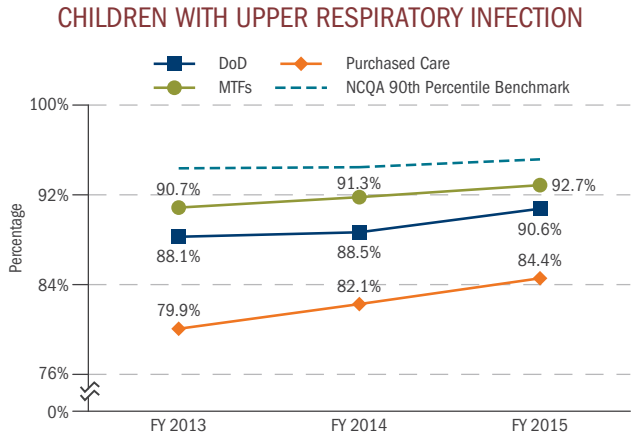
For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

- **Asthma-Appropriate Medications:** MHS direct care MTF adherence to guidelines for appropriate medications for asthma (ages 5–65 years) exceeds the HEDIS 90th percentile.

Pediatric HEDIS Measures







Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 12/15/2015

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

- **Well-Child Visits:** The MHS is reviewing administrative processes to support improvement in this measure, which focuses on children having six visits within the first 18 months of life.

- **HEDIS Measures for Children with Pharyngitis and Upper Respiratory Illness:** These two measures compare MHS children with the 90th percentile across the U.S. Although MHS results fall below the 90th percentile, the MTF care and purchased care results are similar.

ALCOHOL-REDUCTION MARKETING AND EDUCATION CAMPAIGN

The DoD has several educational initiatives promoting the reduction of alcohol consumption that address providers as well as beneficiaries. Efforts targeting providers are focused on facilitating the use of evidence-based screening tools across the Military Services and educating them on new developments in the field of addiction medicine.

DoD's integrated marketing campaign, "That Guy," continues to target military enlisted personnel ages 18–24. This campaign was launched in December 2006 across all branches of Service. It leverages a multimedia, peer-to-peer social marketing approach for this age group to increase awareness of the negative, short-term social consequences of excessive drinking.

This campaign includes an award-winning Web site (https://www.thatguy.com), online and offline public service announcements, social media channels (e.g., Facebook and YouTube), a mobile site and game app, funded and pro bono billboard and print advertising, a turnkey implementation plan and schedule for installation project officers, centrally funded promotional materials, and centralized support for special events. Installation leaders consistently support campaign efforts, as they believe alcohol-related incidents have a negative impact on readiness. To that end, in 2014, a focus group was formed to evaluate the "That Guy" campaign and develop a strategic way forward.

Between 2006 and 2015, the "That Guy" campaign conducted 77 in-person focus groups with 621 junior Service members at 21 DoD installations to ensure the campaign's continued efficacy with the E1–E4 target audience. The campaign has achieved a 64 percent awareness rate among the target audience to date and analysis of the 2008 DoD Survey of Health-Related Behaviors indicated a statistical correlation between installations consistently implementing "That Guy" and lower rates of binge drinking. Most recently, two separate two-year quantitative studies have been launched to explore the potential connection between "That Guy" and lower rates of alcohol-related incidents.

DISEASE MANAGEMENT

Improving the health and quality of life for MHS beneficiaries living with chronic conditions is an ongoing effort. Identifying those at highest risk, who would benefit most from a structured disease management program, has long been a challenge.

More recent endeavors include the development of patient registries in the MHS Population Health Portal (MHSPHP). The registries are created by using direct care and purchased care information, and enhanced using the Johns Hopkins Adjusted Clinical Groups® (ACG®) System. The MHSPHP registries stratify beneficiaries with select chronic conditions by identifying morbidity patterns, which can then be utilized by military treatment facility disease management staff to target specific high-risk populations for interventions.

The program emphasis continues to be on patient-centered and coordinated care that is proactive and promotes patient engagement and self-management. These elements will drive the ongoing program development and improvements in order to achieve the Quadruple Aim goals of Better Health, Better Care, Lower Cost, and Increased Readiness.

PREVALENCE OF MHS BENEFICIARIES WITH CHRONIC MEDICAL CONDITIONS

MHS Chronic Conditions FY 2015

Many TRICARE beneficiaries of all ages suffer from chronic conditions, which may result in poor health outcomes and high health care utilization and costs. This section presents rates of chronic condition diagnoses within the MHS population. This information offers policymakers a better understanding of the burden of chronic conditions among the military population and provides preliminary insights into possible targets for prevention, as well as management strategies to improve care, care coordination, and the quality of life and health of the MHS population, while potentially reducing costs through effective care management.

Methods: The analysis follows similar methods as those in the FY 2014 report. In order to provide some context to these statistics, the chronic conditions presented here are consistent with a set of 25 select chronic conditions reported by the Centers for Medicare and Medicaid Services (CMS) Chronic Condition Data Warehouse (CCW). All unique MHS beneficiaries alive, eligible, and in the U.S. during FY 2015 were included.

The following two tables highlight the overall prevalence of one or more chronic conditions in the MHS population and present the top five prevalent chronic conditions within the Prime direct care and Prime purchased care populations for Active Duty and Active Duty family members (ADFMs) and retirees and their family members.

- Almost half of all MHS retirees and their family members (49 percent) have one or more chronic diseases, compared to about one-fifth (22 percent) of all Active Duty and ADFMs. Prime enrolled retirees and their family members also show a higher prevalence of chronic disease than their Active Duty and family member counterparts (37 and 23 percent, respectively).
- Prevalence rates in the direct care Prime enrollee beneficiary population are higher than for purchased care Prime enrollees (within both the Active Duty/ADFM and retiree segments).
- Attention-deficit/conduct/disruptive behavior and mood disorders are the top two prevalent conditions for Active Duty and ADFMs, whether enrolled in direct or purchased care venues, or not enrolled.
- Diabetes mellitus without complication is the top condition for retirees and retiree family, affecting 6 percent of those who use direct care Prime, compared with 3 percent of those who use purchased care Prime.

TOP FIVE PREVALENT CHRONIC CONDITIONS AMONG ACTIVE DUTY AND FAMILY MEMBERS

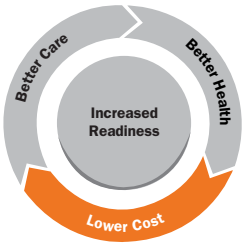
Active Duty and Family Members	DIRECT CARE PRIME ENROLLEES (24%)	PURCHASED CARE ENROLLEES (20%)	ALL PRIME ENROLLEES (23%)	NON-ENROLLED (17%)	ALL PRIME AND NON-ENROLLED (22%)
1	Attention-deficit/conduct/disruptive behavior (4%)	Attention-deficit/conduct/disruptive behavior (3%)	Attention-deficit/conduct/disruptive behavior (3%)	Mood disorders (2%)	Attention-deficit/conduct/disruptive behavior (3%)
2	Mood disorders (3%)	Mood disorders (3%)	Mood disorders (3%)	Attention-deficit/conduct/disruptive behavior (2%)	Mood disorders (3%)
3	Anxiety disorders (3%)	Adjustment disorders (2%)	Adjustment disorders (2%)	Adjustment disorders (2%)	Adjustment disorders (2%)
4	Adjustment disorders (2%)	Anxiety disorders (2%)	Anxiety disorders (2%)	Anxiety disorders (2%)	Anxiety disorders (2%)
5	Asthma (1%)	Asthma (1%)	Asthma (1%)	Menstrual-related problems (2%)	Asthma (1%)

TOP FIVE PREVALENT CHRONIC CONDITIONS AMONG RETIREES AND FAMILY MEMBERS

Retirees and Family Members	DIRECT CARE PRIME ENROLLEES (41%)	PURCHASED CARE ENROLLEES (33%)	ALL PRIME ENROLLEES (37%)	NON-ENROLLED (56%)	ALL PRIME AND NON-ENROLLED (49%)
1	Diabetes Mellitus without complication (6%)	Mood disorders (3%)	Hypertension (4%)	Cataract (9%)	Hypertension (7%)
2	Hypertension (5%)	Hypertension (3%)	Diabetes Mellitus without complication (4%)	Hypertension (9%)	Cataract (6%)
3	Mood disorders (4%)	Back problem (3%)	Mood disorders (4%)	Glaucoma (7%)	Diabetes Mellitus without complication (5%)
4	Back problem (3%)	Osteoarthritis (3%))	Back problem (3%)	Osteoarthritis (6%)	Osteoarthritis (5%)
5	Osteoarthritis (3%)	Diabetes Mellitus without complication (2%)	Osteoarthritis (3%)	Diabetes Mellitus without complication (6%)	Glaucoma (5%)

Source: DHA Administrative data, 1/5/2016

SAVINGS AND RECOVERIES



Pharmacy Retail Refunds

With the District Court's decision that the Department of Defense (DoD) has the authority to require refunds from manufacturers going back to January 29, 2008, affirmed by the U.S. Court of Appeals on January 4, 2013, the Defense Health Agency (DHA) produced retroactive refunds for the calendar years (CYs) 2008 Q1 through 2009 Q2 bill quarters during fiscal year (FY) 2012.

Due to enhancements in the Retail Refund Calculation process and improvements in communication of eligible products among manufacturers, the Department of Veterans Affairs (VA), and DoD, utilization data/refund recalculations were performed to ensure accuracy of the data reported to manufacturers, as well as refunds due to DoD, since the inception of the Final Rule. Recalculations were conducted for CY 2009 Q3 through CY 2011 Q4 bill quarters during FY 2013 and FY 2014. Receivables are consistent with previous years.

PHARMACY RETAIL REFUNDS ($ MILLIONS)

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Total Receivables	$1,862.81	$3,143.53	$1,491.06	$1,319.28	$1,068.04
Routine	$1,862.81	$1,509.28	$1,370.80	$1,280.96	$1,068.04
Retroactive (CY 2008 Q1–CY 2009 Q2)	–	$1,634.25	–	–	–
Additional from Recalculations (CY 2009 Q3–CY 2011 Q4)	–	–	$120.26	$38.32	–
Total Collections	$1,816.50	$1,516.41	$2,359.77	$1,496.25	$1,117.14

Source: DHA Business Support Directorate, Contract Resource Management, 9/30/2015

Notes: Refund amounts are netted out of pharmacy costs provided within this report. The refunds in the chart above are categorized in the FY they were validated and billed to the manufacturers.

Program Integrity Activities

The DHA Program Integrity (PI) Office is responsible for all antifraud and abuse activities worldwide for the DHA to protect benefit dollars and safeguard beneficiaries. The PI develops and executes antifraud and abuse policies and procedures, provides oversight of contractor program integrity activities, coordinates investigative activities, develops cases for criminal prosecutions and civil litigations, and initiates administrative measures. DHA PI develops areas of focus and analyzes claims data to identify outliers. Through a Memorandum of Understanding, DHA PI refers its fraud cases to the Defense Criminal Investigative Services and coordinates investigative activities with Military Criminal Investigative Offices, as well as other federal, state, and local agencies.

PROGRAM INTEGRITY RECOVERIES/COST AVOIDANCE ($ MILLIONS)

	CY 2012	CY 2013	CY 2014
Total Recoveries	$121.9	$182.1	$21.6
Court-Ordered Fraud Judgments/Settlements	$118.5	$175.6	$15.5
PI Contractor Administrative Recoupment/Offsets (Received)	$3.4	$6.5	$6.1
Total PI Contractors Cost Avoidance	$17.7	$16.5	$18.1
Contractor Prepayment Reviews	$16.2	$15.4	$17.7
Excluded Providers	$1.5	$1.1	$0.4

Sources: TRICARE Program Integrity Operational Reports and Quarterly Fraud and Abuse Reports, CY 2012–CY 2014. CY 2014 data are latest reported as of this writing.

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 TED, and the differences are recouped.

Recovery A—Post-Payment Duplicate Claim Recoveries: A post-payment duplicate claims system was developed by the DHA Healthcare Operations Directorate/TRICARE Health Plan Division for use by TRICARE purchased care contractors. The system was designed as a retrospective auditing tool and facilitates the identification of actual duplicate claim payments and the initiation and tracking of recoupments. The table below provides the historical recovery of duplicate claims payments. Duplicate Claim recoveries are consistent with previous years.

RECOVERIES ($ MILLIONS)

	FY 2013	FY 2014	FY 2015
Recovery A—Post-Payment Duplicate Claim Recoveries	$8.3	$9.0	$7.4

Recovery B—Improper Payment Recoveries: The DHA is vigilant in ensuring the accuracy of health care claims payment within the military health benefits program. The DHA has contracted with an External Independent Contractor (EIC) who is responsible for conducting post-payment accuracy reviews of TRICARE health benefit claims. The EIC is responsible for identifying improper payment made by TRICARE purchased care contractors as a result of contractor noncompliance with TRICARE policy, benefit, and/or reimbursement requirements.

RECOVERY B: OVERPAYMENTS RECAPTURED THROUGH PAYMENT RECAPTURE AUDITS ($ MILLIONS)			
PROGRAM OR ACTIVITY	ACTUAL OVERPAYMENT DOLLARS IDENTIFIED VIA RANDOM SAMPLES	TOTAL AMOUNT EXTRAPOLATED (ESTIMATED THROUGHOUT TOTAL OUTLAYS)	AMOUNT RECAPTURED[a] (REFUNDS THROUGHOUT FY 2014)
Total	$2.51	$74.2	$334.75

[a] "Amount Recaptured" dollars represent recoveries from specific overpayments identified via samples as well as dollars paid back to DHA in the course of other routine claim adjustments.

In addition to the EIC post-payment reviews, DHA requires TRICARE purchased care contractors to use industry best business practice when processing TRICARE claims. Contractors are required to use claims auditing software and develop prepayment initiatives that are manual and/or automated to avoid or prevent improper payments. The above table provides FY 2014 improper payment recoveries of medical care as a result of the EIC compliance reviews and ongoing purchased care contractor efforts to identify and recover improper payments. Recovery amounts in FY 2014 are higher than in previous years due to an increase in the scope of the analysis.

INPATIENT UTILIZATION RATES AND COSTS

TRICARE Inpatient Utilization Rates Compared with Civilian Benchmarks

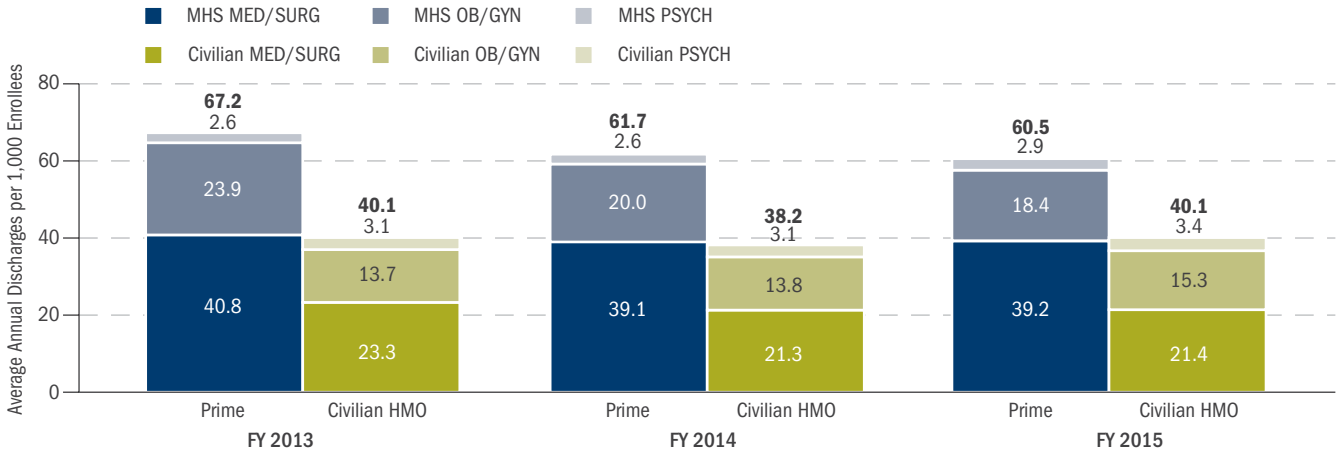
TRICARE Prime Enrollees

This section compares the inpatient utilization of TRICARE Prime enrollees with that of enrollees in civilian employer-sponsored health maintenance organization (HMO) plans. Inpatient utilization is measured as the total number of dispositions (i.e., the sum of direct and purchased care dispositions) because relative weighted products (RWPs) are not available in the civilian-sector data.

Dispositions are computed for three broad product lines—Obstetrician/Gynecologist (OB/GYN), mental health (PSYCH), and other Medical/Surgical (MED/SURG)—and compared for acute care facilities only. The comparisons exclude beneficiaries age 65 and older because very few are covered by employer-sponsored plans. The Military Health System (MHS) data further exclude beneficiaries enrolled in the Uniformed Services Family Health Plan (USFHP) and TRICARE Plus.

- TRICARE Prime inpatient utilization rates declined between FY 2013 and FY 2015, while the civilian HMO rates remained about the same. In FY 2015, the TRICARE Prime inpatient utilization rate (direct and purchased care combined) was 51 percent higher than the civilian HMO utilization rate (60.5 discharges per 1,000 Prime enrollees compared with 40.1 per 1,000 civilian HMO enrollees).
- In FY 2015, the TRICARE Prime inpatient utilization rate was 83 percent higher than the civilian HMO rate for MED/SURG procedures, 20 percent higher for OB/GYN procedures, and 17 percent lower for PSYCH procedures.
- The average length of stay (LOS) for MHS Prime enrollees (direct and purchased care combined) remained at about 3.2 days between FY 2013 and FY 2015, whereas the average LOS for civilian HMO enrollees declined slightly from 3.6 to 3.5 days. In FY 2015, the average LOS for MHS Prime enrollees was 9 percent lower than that of civilian HMO enrollees (not shown).

INPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK



Sources: MHS administrative data, 1/19/2016, and Truven Health Analytics Inc., MarketScan® Commercial Claims and Encounters (CCAE) database, 12/8/2015

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2015 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

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

LOWER COST

TRICARE Inpatient Utilization Rates Compared with Civilian Benchmarks *(Cont.)*

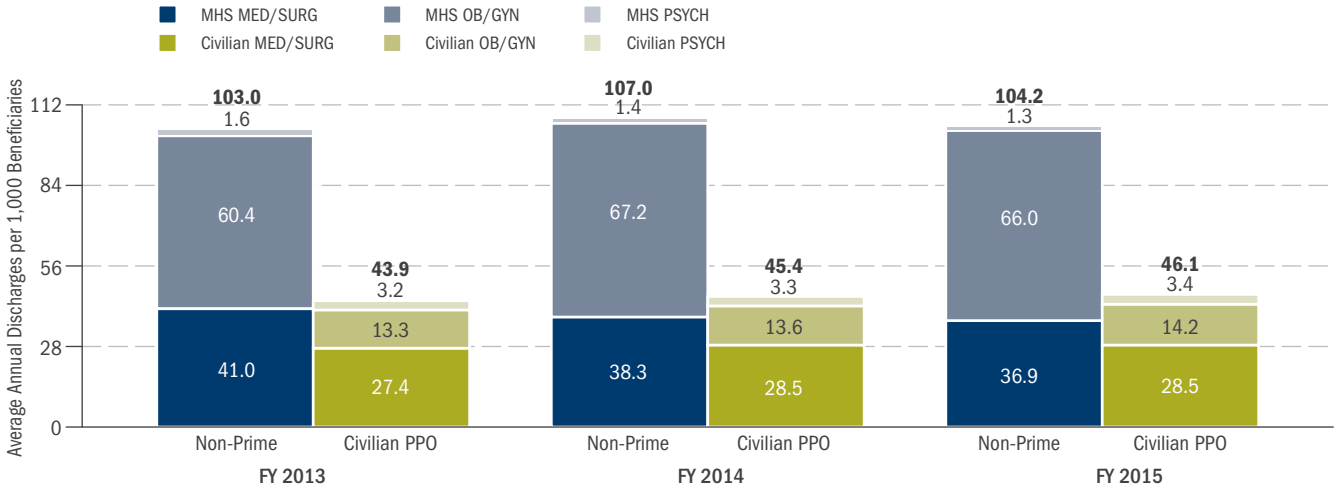
Non-Enrolled Beneficiaries

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. Inpatient utilization is measured as the total number of dispositions (i.e., the sum of direct and purchased care dispositions) because RWPs are not available in the civilian-sector data.

Dispositions are computed for three broad product lines—OB/GYN, PSYCH, and other MED/SURG procedures—and compared for acute care facilities only. The comparisons exclude beneficiaries age 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-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Although most beneficiaries who fail to file a TRICARE claim have private health insurance, we estimate that about 18 percent do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable with the civilian rates, which also include them.

- Between FY 2013 and FY 2015, both the TRICARE non-Prime and civilian PPO inpatient utilization rates increased. In FY 2015, the inpatient utilization rate (direct and purchased care combined) for non-enrolled beneficiaries was more than double the rate for civilian PPO participants.
- By far the largest discrepancy in utilization rates between MHS and the private sector is for OB/GYN procedures. From FY 2013 to FY 2015, the MHS OB/GYN disposition rate increased by 9 percent, whereas it increased by 7 percent in the civilian sector. In FY 2015, the MHS non-Prime OB/GYN disposition rate was almost five times as high as the corresponding civilian PPO rate.
- Of the three product lines considered in this report, only PSYCH procedures had lower utilization in MHS than in the civilian sector.
- The average LOS for MHS non-enrolled beneficiaries (direct and purchased care combined) declined from 3.6 days in FY 2013 to 3.5 days in FY 2015, whereas the average LOS for civilian PPO participants remained unchanged at 3.5 days. As a result, the average LOS for MHS non-Prime beneficiaries was the same as that of civilian PPO participants in FY 2015 (not shown).

INPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK



Sources: MHS administrative data, 1/19/2016, and Truven Health Analytics Inc., MarketScan® CCAE database, 12/8/2015

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2015 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

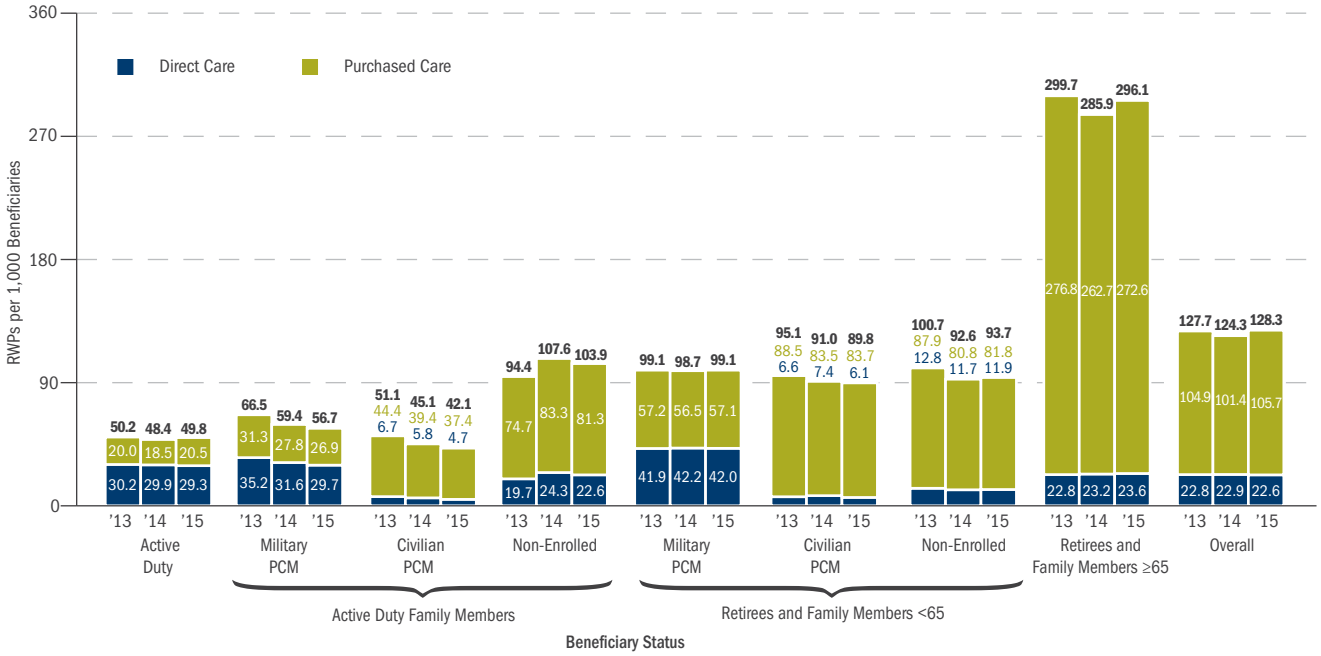
– Numbers may not sum to bar totals due to rounding.

Inpatient Utilization Rates by Beneficiary Status

When breaking out inpatient utilization by beneficiary group, RWPs per capita more accurately reflect differences across beneficiary groups than do discharges per capita. However, RWPs are relevant only for acute care hospitals. In FY 2009, TRICARE implemented the Medicare Severity Diagnosis Related Group (MS-DRG) system of classifying inpatient hospital cases to conform to changes made to the Medicare Prospective Payment System. The new MS-DRG classifications resulted in a corresponding change in the calculation of RWPs, which has been applied to the data from FY 2013 to FY 2015.

- The overall (direct and purchased care combined) inpatient utilization rate (RWPs per 1,000 beneficiaries) increased by less than 1 percent from FY 2013 to FY 2015.
- The direct care inpatient utilization rate decreased by 1 percent overall, but there was a great deal of variation across beneficiary groups. Enrolled Active Duty family members (ADFMs) experienced large declines (30 percent for those with a civilian primary care manager [PCM] and 16 percent for those with a military PCM), but non-enrolled ADFMs experienced an increase of 15 percent.
- Purchased acute care inpatient utilization rates decreased for all beneficiary groups except non-enrolled ADFMs (9 percent increase) and ADSMs (3 percent increase). Enrolled ADFMs experienced the largest declines (14 percent for those with a military PCM and 16 percent for those with a civilian PCM).
- Excluding Medicare-eligible beneficiaries (for whom Medicare is likely their primary source of care and TRICARE is second payer), the percentage of per capita inpatient workload performed in purchased care facilities remained at about 71 percent from FY 2013 to FY 2015.
- From FY 2013 to FY 2015, the percentage of per capita inpatient workload referred to the network on behalf of beneficiaries enrolled with a military PCM (including Active Duty personnel) remained at just under 50 percent.

AVERAGE ANNUAL INPATIENT RWPs PER 1,000 BENEFICIARIES (BY FY)



Source: MHS administrative data, 1/19/2016

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

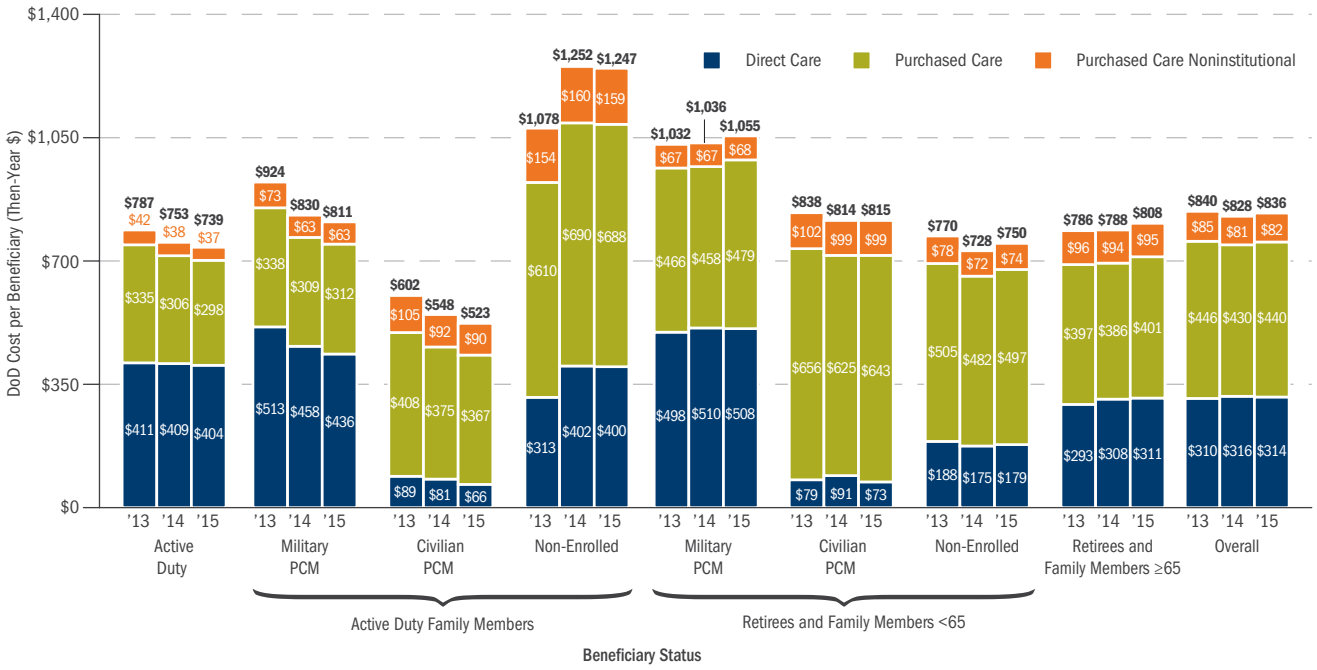
LOWER COST

Inpatient Cost by Beneficiary Status

MHS costs for inpatient care include costs incurred in both acute and non-acute care facilities. They also include the cost of inpatient professional services (i.e., noninstitutional charges [e.g., physician, lab, anesthesia]) associated with a hospital stay. The overall MHS inpatient costs (in then-year dollars) per beneficiary (far-right columns below), including TRICARE for Life (TFL), remained about the same from FY 2013 to FY 2015.

- Both direct and purchased care inpatient costs per capita remained roughly constant from FY 2013 to FY 2015.
- Non-enrolled ADFMs experienced an increase in MHS per capita inpatient cost (16 percent), while smaller increases were experienced by retirees and family members under age 65 with a military PCM (2 percent) and by seniors (3 percent). All other beneficiary groups experienced declines, with enrolled ADFMs having the largest (12 percent for those with a military PCM and 13 percent for those with a civilian PCM).
- The direct care cost per RWP increased from $13,573 in FY 2013 to $13,913 in FY 2015 (3 percent).
- Exclusive of TFL, DoD purchased care cost (institutional plus noninstitutional) per RWP in acute care facilities decreased from $7,440 in FY 2013 to $7,324 in FY 2015 (2 percent).
- The DoD purchased care cost per RWP is much lower than that for direct care partly because some beneficiaries have substantial cost shares (e.g., retirees) and may also have other health insurance (OHI). When beneficiaries have OHI, TRICARE becomes second payer, and the government pays a smaller share of the cost. If OHI claims are excluded, the DoD cost per RWP in acute care facilities decreased from $9,065 in FY 2013 to $8,776 in FY 2015 (3 percent, exclusive of TFL).
- Note: The reader should exercise caution when comparing the direct versus purchased care costs per RWP. The data on this page are unadjusted for differences in beneficiary mix, enrollment status, geographical location of care, etc.; represent DoD health care costs only; and specifically exclude beneficiary cost shares, administrative, and overhead expenses.

AVERAGE ANNUAL DoD INPATIENT COSTS PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/19/2016

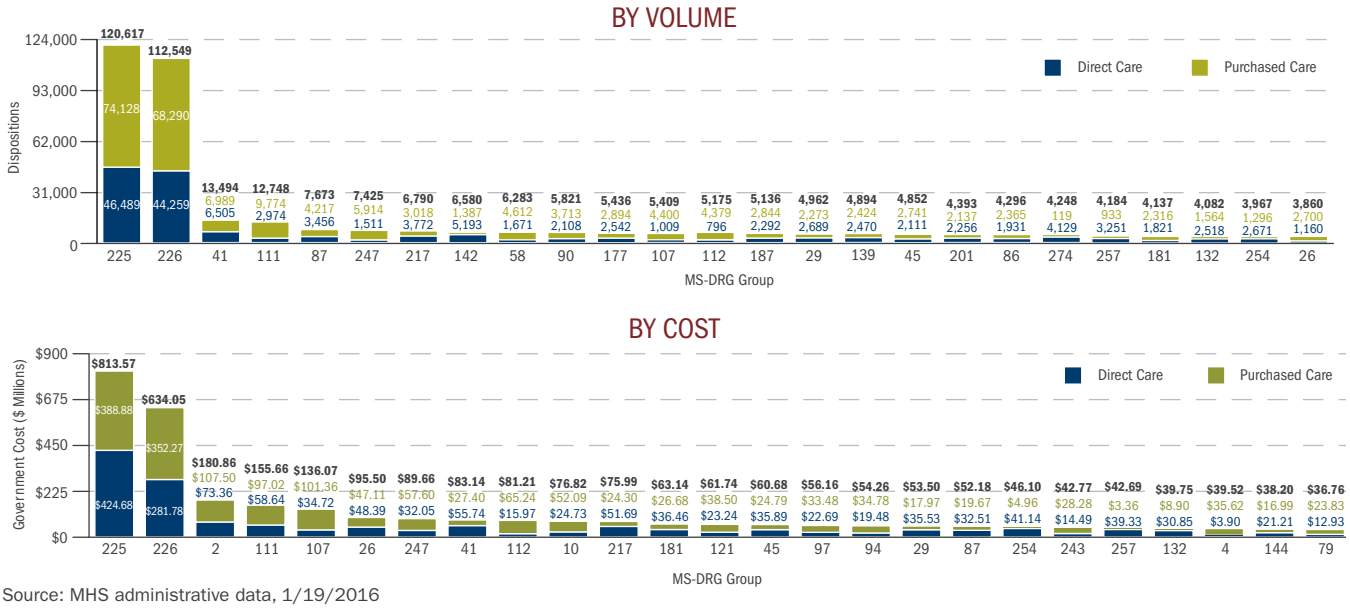
Note: Numbers may not sum to bar totals due to rounding.

INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Leading Inpatient Diagnosis Groups

In FY 2009, TRICARE implemented the MS-DRG system of classifying inpatient hospital cases to conform to changes made to the Medicare Prospective Payment System. The new system better captures variations in severity of illness and resource usage by reclassifying many diagnosis codes with regard to complication/comorbidity (CC) status. For the purpose of this section, MS-DRGs exhibiting variations in CC status were grouped into like categories[1] and numbered sequentially.

The top 25 MS-DRG groups in terms of volume in FY 2015 accounted for 67 percent of all inpatient admissions (direct care and purchased care combined) in acute care hospitals. The leading MS-DRG groups in terms of cost in FY 2015 include both institutional and noninstitutional claims (i.e., they include hospital, attendant physician, drug, and ancillary service charges). The top 25 MS-DRG groups in terms of cost in FY 2015 accounted for 58 percent of total inpatient costs (direct and purchased care combined) in acute care hospitals. TFL admissions are excluded from the calculations for both volume and cost.



Source: MHS administrative data, 1/19/2016

MS-DRG Groups

2 Ecmo or tracheostomy
4 Bone marrow transplant
10 Craniotomy
26 Major small and large bowel procedures
29 Appendectomy
41 Esophagitis, gastroenteritis, and miscellaneous digestive disorders
45 Cholecystectomy
58 Seizures and headaches
79 Respiratory system with ventilator support
86 Chronic obstructive pulmonary disease
87 Simple pneumonia and pleurisy
90 Bronchitis and asthma
94 Cardiac valve and other major cardiothoracic procedures
97 Coronary bypass
107 Spinal fusion except cervical
111 Major joint replacement or reattachment of lower extremity
112 Cervical spinal fusion
121 Percutaneous cardiovascular procedures with coronary artery stent
132 Heart failure and shock
139 Cardiac arrhythmia and conduction disorders
142 Chest pain
144 Lower extremity and humerus procedures except hip, foot, femur
177 Cellulitis
181 O.R. procedures for obesity
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 conditions originating in perinatal period
243 Infectious and parasitic diseases with O.R. Procedure
247 Septicemia or severe sepsis
254 Psychoses
257 Alcohol/drug abuse or dependence
274 Other factors influencing health status

- The top two procedures by volume are related to childbirth, accounting for 43 percent of all hospital admissions and 27 percent of total hospital costs (not just among the top 25).
- Procedures performed in private-sector acute care hospitals account for 59 percent of the total volume of the top 25 MS-DRG groups and 53 percent of the total cost.
- Admissions in direct care facilities exceed those in purchased care facilities for only nine of the top 25 MS-DRG groups. However, expenditures in direct care facilities exceed those in purchased care facilities for 12 of the top 25 MS-DRG groups.
- Surgical procedures for obesity rank 22nd in volume and 12th in cost among the top 25 MS-DRG groups. Thus, the obesity epidemic in the civilian sector appears to be mirrored to an extent in the DoD population as well.

[1] DRGs were grouped into like categories using a code set available on www.findacode.com/code-set.php?set=DRG, an online database of medical billing codes and information. The site lists surgical and medical DRGs within each Major Diagnostic Category (MDC) with headings above diagnostically related DRGs. In some cases (e.g., DRGs related to pregnancy and childbirth) the headings were further grouped into larger, descriptively similar categories. The headings were then sequentially numbered, providing the basis for the DRG grouping methodology. The numbers have no significance other than to identify the DRG groups on the horizontal axes in the charts above. See Appendix for additional detail on the DRG grouping methodology.

OUTPATIENT UTILIZATION RATES AND COSTS

TRICARE Outpatient Utilization Rates Compared with Civilian Benchmarks

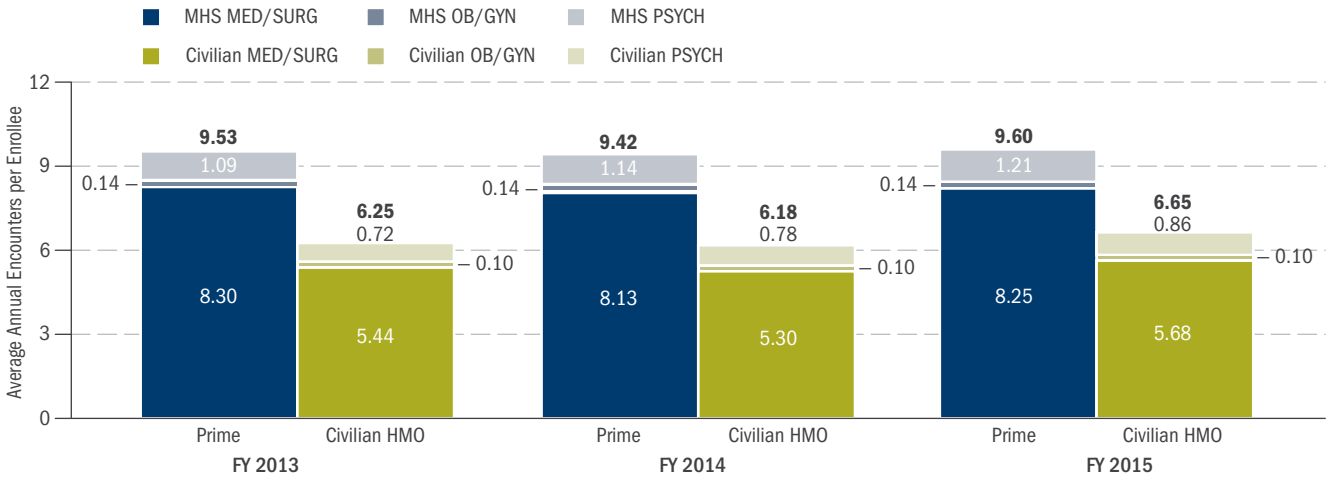
TRICARE Prime Enrollees

This section compares the outpatient utilization of TRICARE Prime enrollees with that of enrollees in civilian employer-sponsored HMO plans. Outpatient utilization is measured in terms of encounters because the civilian-sector data used in the comparisons do not contain a measure of relative value units (RVUs). However, there is no fixed definition for what constitutes a "face-to-face" encounter with a physician. TRICARE and the private sector may therefore use varying methodologies to calculate the number of encounters.

Encounters are computed for three broad product lines: OB/GYN, PSYCH, and other MED/SURG procedures. The comparisons are made for beneficiaries under age 65 only. The MHS data exclude beneficiaries enrolled in the USFHP and TRICARE Plus. Because telephone consults are routinely recorded in direct care data, but appear very infrequently in private-sector claims, they are also excluded from the direct care utilization computations.

- The overall TRICARE Prime outpatient utilization rate (direct and purchased care combined) increased by less than 1 percent between FY 2013 and FY 2015. The civilian HMO outpatient utilization rate increased by 6 percent over the same period.
- In FY 2015, the overall Prime outpatient utilization rate was 44 percent higher than the civilian HMO rate.
- In FY 2015, the Prime outpatient utilization rate for MED/SURG procedures was 45 percent higher than the civilian HMO rate.
- The Prime outpatient utilization rate for OB/GYN procedures was 30 percent higher than the corresponding rate for civilian HMOs in FY 2015, but that is due in part to how the direct care system records global procedures.[1]
- The Prime outpatient utilization rate for PSYCH procedures was 41 percent higher than the corresponding rate for civilian HMOs in FY 2015. This disparity, though based on relatively low MHS and civilian mental health utilization rates, may reflect the more stressful environment that many Active Duty Service members (ADSMs) and their families endure.

OUTPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK



Sources: MHS administrative data, 1/19/2016, and Truven Health Analytics Inc., MarketScan® CCAE database, 12/8/2015

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2015 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

[1] Outpatient encounters are not precisely comparable between the direct and private care sectors (including purchased care). In particular, services that are bundled in the private sector (such as newborn delivery, including prenatal and postnatal care) will not generate any outpatient encounters but will generate a record for each encounter in the direct care system. Because maternity care is a high-volume procedure, the disparity in utilization rates between the direct care and civilian systems will be exaggerated.

TRICARE Outpatient Utilization Rates Compared with Civilian Benchmarks *(Cont.)*

Non-Enrolled Beneficiaries

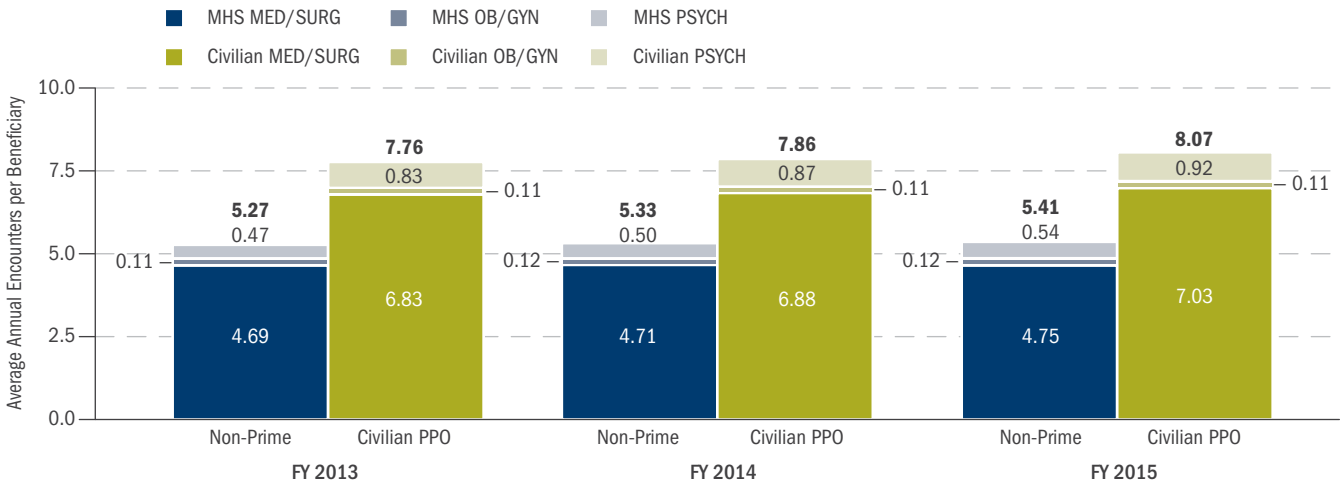
This section compares the outpatient utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored PPO plans. Outpatient utilization is measured in terms of encounters because the civilian-sector data used in the comparisons do not contain a measure of RVUs. However, there is no fixed definition for what constitutes a "face-to-face" encounter with a physician. TRICARE and the private sector may therefore use varying methodologies to calculate the number of encounters.

Encounters are computed for three broad product lines: OB/GYN, PSYCH, and other MED/SURG. The comparisons are made for beneficiaries under age 65 only. To make the utilization rates of MHS and civilian beneficiaries more comparable, non-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Because telephone consults are routinely recorded in direct care data, but appear very infrequently in private-sector claims, they are also excluded from the direct care utilization computations. Although most beneficiaries who fail to file a TRICARE claim have private health insurance, we estimate that about 18 percent do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable to the civilian rates, which also include them.

- The overall TRICARE outpatient utilization rate (direct and purchased care utilization combined) for non-enrolled beneficiaries increased from 5.3 encounters per participant in FY 2013 to 5.4 encounters in FY 2015 (3 percent). The civilian PPO outpatient utilization rate increased by 4 percent over the same period.
- The overall TRICARE non-Prime (space-available and Standard/Extra) outpatient utilization rate remained well below the level observed for civilian PPOs. In FY 2015, TRICARE non-Prime outpatient utilization was 33 percent lower than in civilian PPOs.
- In FY 2015, the non-Prime outpatient utilization rate for MED/SURG procedures was 33 percent lower than the civilian PPO rate. MED/SURG procedures account for almost 90 percent of total outpatient utilization in both the military and private sectors.
- The non-Prime outpatient utilization rate for OB/GYN procedures increased by 11 percent between FY 2013 and FY 2015. As a result, the MHS OB/GYN rate was 6 percent higher than the rate for civilian PPO participants in FY 2015.[1]
- The PSYCH outpatient utilization rate of non-enrolled MHS beneficiaries increased by 16 percent from FY 2013 to FY 2015; the rate increased by 12 percent for civilian PPO participants. In FY 2015, the PSYCH outpatient utilization rate for non-enrolled beneficiaries was 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



Sources: MHS administrative data, 1/19/2016, and Truven Health Analytics Inc., MarketScan® CCAE database, 12/8/2015

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2015 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

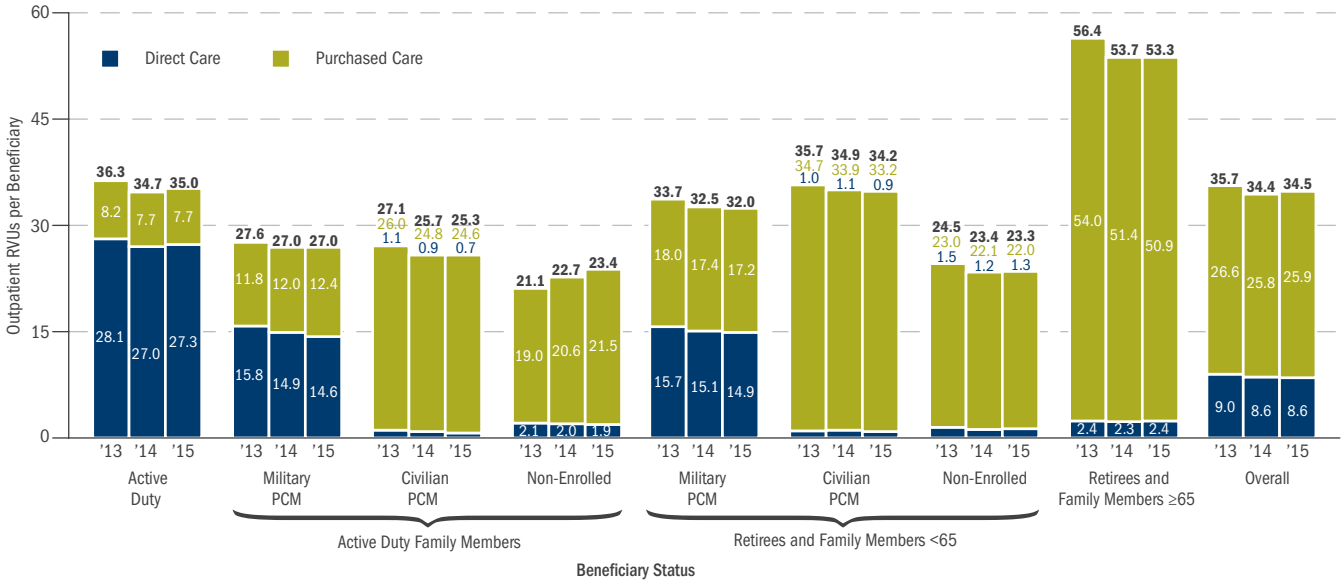
[1] The numbers on the chart are the same when rounded to two digits but are slightly different when unrounded.

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 year's report is the sum of the Physician Work and Practice Expense RVUs (called "Total RVUs"). See the Appendix for a detailed description of the Physician Work and Practice Expense RVU measures.

- Total per capita MHS utilization (direct plus purchased care) decreased by 3 percent from FY 2013 to FY 2015.
- All beneficiary groups experienced a decline in direct care outpatient utilization from FY 2013 to FY 2015. ADFMs with a civilian PCM experienced the largest decline, at 34 percent. Non-enrolled ADFMs experienced a 12 percent decline and non-enrolled retirees and family members experienced a 13 percent decline. However, none of the groups specified above has much direct care utilization to begin with.
- From FY 2013 to FY 2015, non-enrolled ADFMs experienced a 13 percent increase in per capita purchased care outpatient utilization, while ADFMs with a military PCM experienced a 5 percent increase. All other beneficiary groups experienced modest declines.
- The TFL outpatient utilization rate decreased by 6 percent from FY 2013 to FY 2015.[1]

AVERAGE ANNUAL OUTPATIENT RVUs PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/19/2016

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

[1] The basis for this statement is the collection of stacked bars labeled "Retirees and Family Members ≥65." Although the vast majority of TFL-eligible beneficiaries are retirees and family members ≥65, there is a small number who are not.

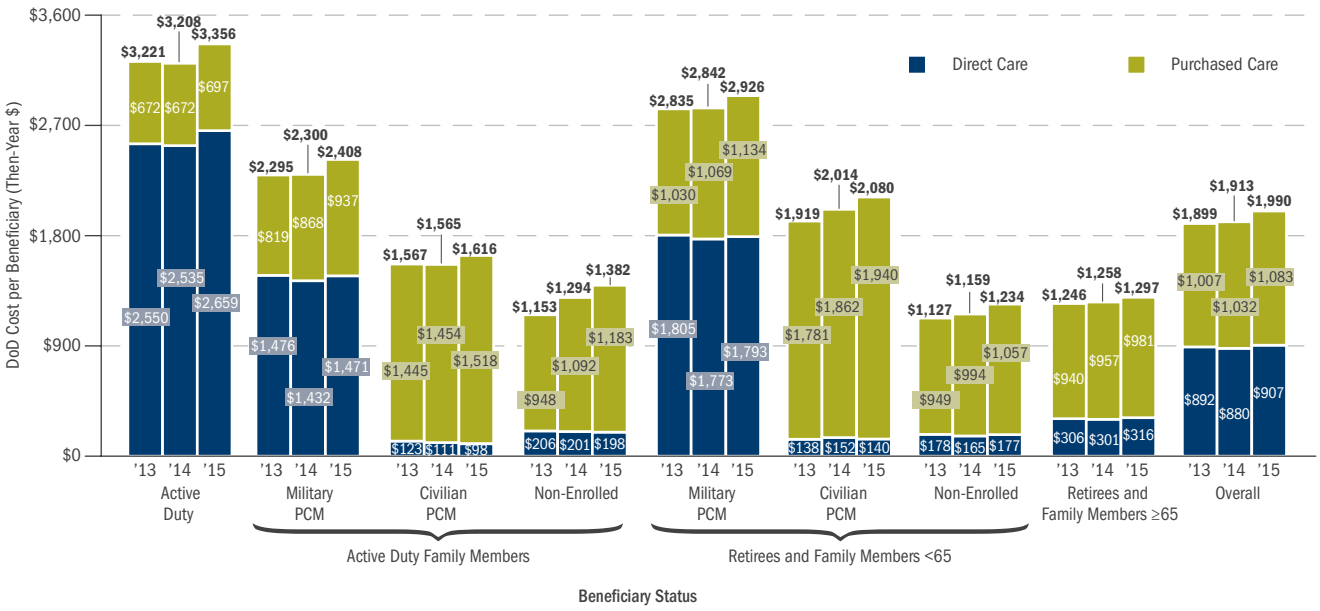
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Outpatient Costs by Beneficiary Status

Although outpatient utilization rates declined slightly, DoD outpatient costs continued to rise. Overall MHS outpatient costs (in then-year dollars) per beneficiary (far-right columns below), including TFL, increased by 5 percent from FY 2013 to FY 2015.

- The direct care cost per beneficiary increased by 2 percent overall from FY 2013 to FY 2015, although there was significant variation across beneficiary groups. Active Duty members experienced the largest increase, at 4 percent, whereas ADFMs with a civilian PCM experienced a 20 percent decline.
- Excluding TFL, the DoD purchased care outpatient cost per beneficiary increased by 9 percent from FY 2013 to FY 2015. Per capita costs increased for all beneficiary groups, especially for non-enrolled ADFMs (25 percent). Increases for other beneficiary groups ranged from 4 to 14 percent.
- The TFL outpatient cost per beneficiary increased by 4 percent between FY 2013 and FY 2015.[1]

AVERAGE ANNUAL DoD OUTPATIENT COSTS PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/19/2016

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

[1] The basis for this statement is the collection of stacked bars labeled "Retirees and Family Members ≥65." Although the vast majority of TFL-eligible beneficiaries are retirees and family members ≥65, there is a small number who are not.

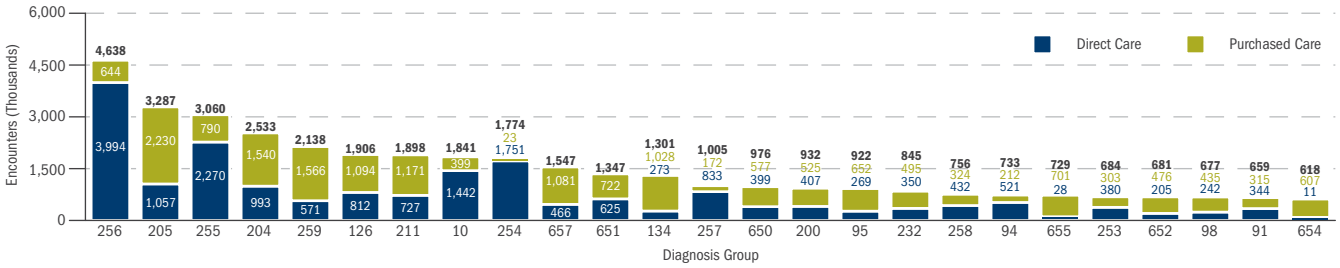
LOWER COST

OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

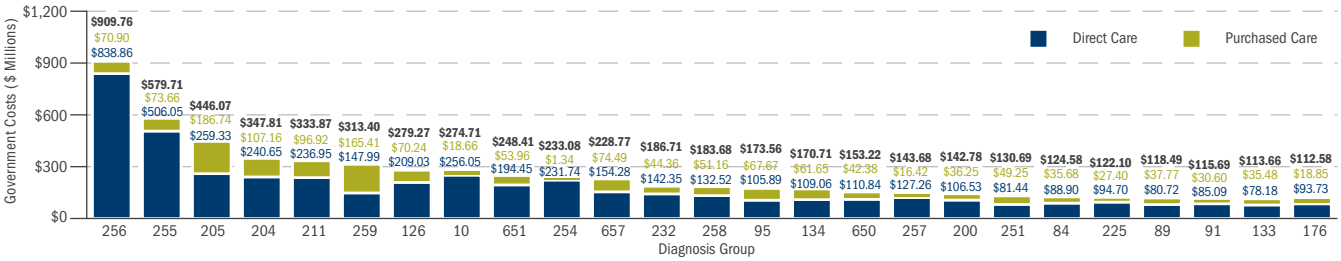
Leading Outpatient Diagnosis Groups

Leading outpatient diagnoses were determined by grouping ICD-9-CM primary diagnosis codes into like categories using the Clinical Classifications Software tool developed through a Federal-State-Industry partnership and sponsored by the Agency for Healthcare Research and Quality. The top 25 outpatient diagnosis groups in FY 2015 accounted for 64 percent of all outpatient encounters (direct care and purchased care combined) and 57 percent of total outpatient costs. Direct care drug expenses, which are included in outpatient costs in the direct care administrative data, are excluded from the cost totals in this section. TFL encounters and telephone consults are excluded from the calculations for both volume and cost.

BY VOLUME



BY COST



Source: MHS administrative data, 1/19/2016

Diagnosis Group

10 Immunizations and screening for infectious diseases
84 Headache, including migraine
89 Blindness and vision defects
91 Other eye disorders
94 Other ear and sense organ disorders
95 Other nervous system disorders
98 Essential hypertension
126 Other upper respiratory infections
133 Other lower respiratory disease
134 Other upper respiratory disease
176 Contraceptive and procreative management
200 Other skin disorders
204 Other non-traumatic joint disorders
205 Spondylosis, intervertebral disc disorders, and other back problems
211 Other connective tissue disease
225 Joint disorders and dislocations, trauma-related
232 Sprains and strains
251 Abdominal pain
253 Allergic reactions
254 Rehabilitation care, fitting of prostheses, and adjustment of devices
255 Administrative/social admission
256 Medical examination/evaluation
257 Other aftercare
258 Other screening for suspected conditions (not mental disorders or infectious disease)
259 Residual codes, unclassified
650 Adjustment disorders
651 Anxiety disorders
652 Attention-deficit, conduct, and disruptive behavior disorders
654 Developmental disorders
655 Disorders usually diagnosed in infancy, childhood, or adolescence
657 Mood disorders

- The top two diagnosis groups by volume are general health examinations (adults and children) and intervertebral disc disorders.
- Diagnoses treated in purchased care facilities account for 48 percent of the total volume of the top 25 diagnosis groups but only 24 percent of the total cost.
- Encounters in direct care facilities exceed those in purchased care facilities for only nine of the 25 top diagnosis groups. However, expenditures in direct care facilities exceed those in purchased care facilities for 24 of the top 25 diagnosis groups.

PRESCRIPTION DRUG UTILIZATION RATES AND COSTS

TRICARE Prescription Drug Utilization Rates Compared with Civilian Benchmarks

Prescription utilization is difficult to quantify since prescriptions come in different forms (e.g., liquid or pills), quantities, and dosages. Moreover, home delivery and military treatment facility (MTF) prescriptions can be filled for up to a 90-day supply, whereas retail prescriptions are usually based on 30-day increments for copay purposes. Prescription counts from all sources (including civilian) were normalized by dividing the total days supply for each by 30 days.

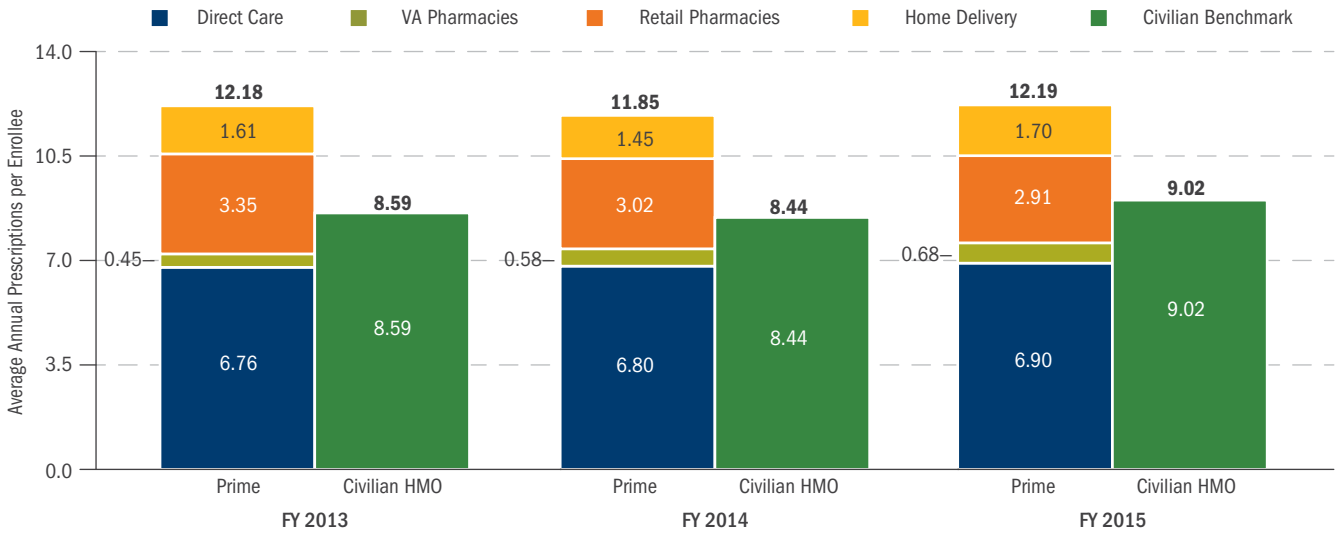
Direct care pharmacy data differ from private-sector claims in that they include over-the-counter medications. To make the utilization rates of MHS and civilian beneficiaries more comparable, over-the-counter medications were backed out of the direct care data using factors provided by the DHA Pharmacy Operations Division.

TRICARE Prime Enrollees

This section compares the prescription drug utilization of TRICARE Prime enrollees with that of enrollees in civilian employer-sponsored HMO plans. 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 the VA) are included. Prescriptions filled at VA pharmacies under the TRICARE benefit have always been included with retail pharmacy prescriptions. Comparisons are made for beneficiaries under age 65 only. The MHS data exclude beneficiaries enrolled in the USFHP and TRICARE Plus.

- The overall prescription utilization rate (direct care, VA, and purchased care combined) for TRICARE Prime enrollees remained about the same between FY 2013 and FY 2015, while the civilian HMO benchmark rate rose by 5 percent. In FY 2015, the TRICARE Prime prescription utilization rate was 35 percent higher than the civilian HMO rate.
- Prescription utilization rates for Prime enrollees at DoD pharmacies rose by 2 percent between FY 2013 and FY 2015, whereas the utilization rate at retail pharmacies decreased by 13 percent (due largely to greater reliance on home delivery services).
- Prescription utilization rates for Prime enrollees at VA pharmacies rose by 49 percent (although the number of prescriptions is small) between FY 2013 and FY 2015. Not all of the increase is a result of higher utilization—a portion is due to improved data sharing between the VA and DoD pharmacy systems.
- Enrollee home delivery prescription utilization increased by 5 percent from FY 2013 to FY 2015. Historically, home delivery utilization has been small compared with other sources of prescription services. However, in FY 2015, home delivery accounted for 37 percent of per capita purchased care prescription utilization by Prime enrollees (as measured by 30-day supply).

PRESCRIPTION UTILIZATION RATES BY SOURCE OF CARE[a]: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK



Sources: MHS administrative data, 1/19/2016, and Truven Health Analytics Inc., MarketScan® Commercial Claims and Encounters (CCAE) database, 12/8/2015

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2015 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

[a] Source of care (direct or purchased) is based solely on where care is received, not where beneficiaries are enrolled.

LOWER COST

TRICARE Prescription Drug Utilization Rates Compared with Civilian Benchmarks *(Cont.)*

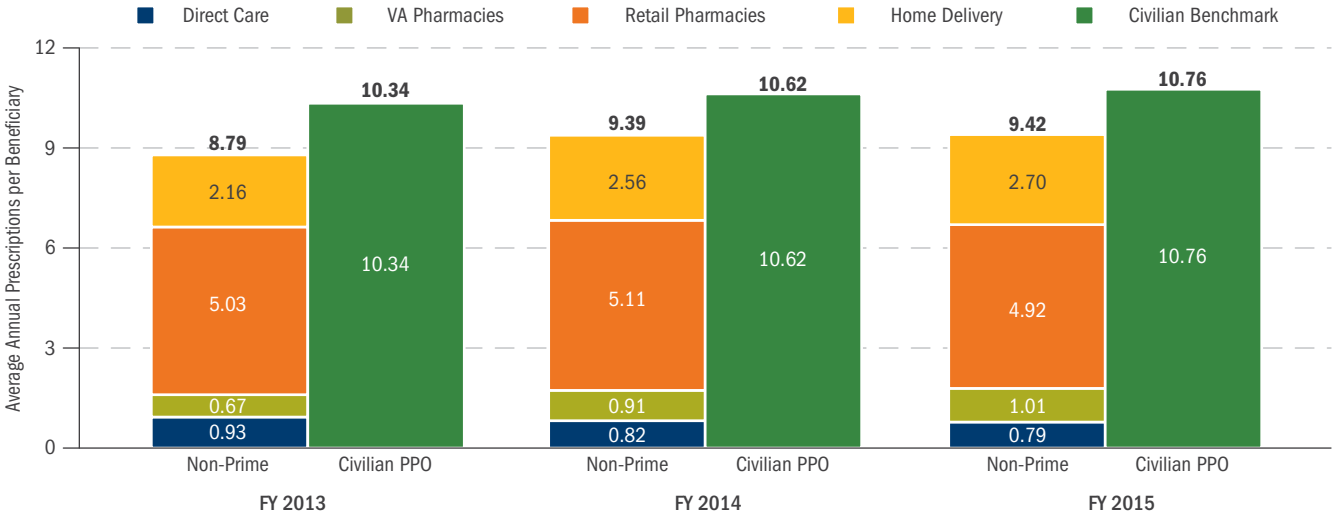
Non-Enrolled Beneficiaries

This section compares the prescription drug utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored PPO plans. 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 the 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-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Although most beneficiaries who fail to file a TRICARE claim have private health insurance, we estimate that about 18 percent do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable to the civilian rates, which also include them.

- The overall prescription utilization rate (direct care, VA, and purchased care combined) for non-enrolled beneficiaries increased by 7 percent between FY 2013 and FY 2015. During the same period, the civilian PPO benchmark rate increased by 4 percent. In FY 2015, the TRICARE prescription utilization rate for non-enrollees was 13 percent lower than the civilian PPO rate.
- The direct care prescription utilization rate for non-enrolled beneficiaries decreased by 15 percent from FY 2013 to FY 2015, whereas the utilization rate at retail pharmacies decreased by 2 percent (largely because of greater reliance on home delivery services).
- Prescription utilization rates for non-Prime enrollees at VA pharmacies increased by 50 percent between FY 2013 and FY 2015. Not all of the increase is a result of higher utilization—a portion is due to improved data sharing between the VA and DoD pharmacy systems.
- Non-enrollee home delivery prescription utilization increased by 25 percent from FY 2013 to FY 2015. Historically, home delivery utilization has been small compared with other sources of prescription services. However, in FY 2015, home delivery accounted for 35 percent of per capita purchased care prescription utilization by non-enrollees.

PRESCRIPTION UTILIZATION RATES BY SOURCE OF CARE[a]: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK



Sources: MHS administrative data, 1/19/2016, and Truven Health Analytics Inc., MarketScan® Commercial Claims and Encounters (CCAE) database, 12/8/2015

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2015 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

[a] Source of care (direct or purchased) is based solely on where care is received, not where beneficiaries are enrolled.

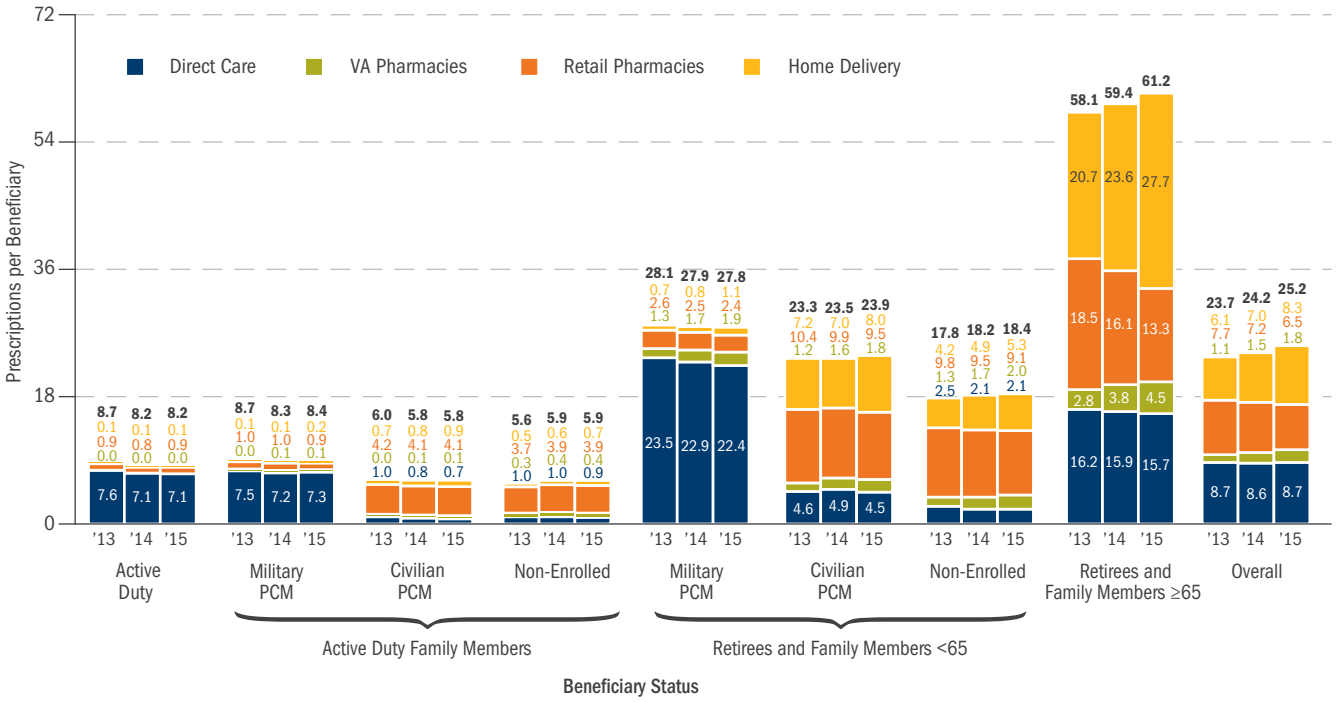
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT.)*

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 the VA. Prescriptions that were filled at a VA pharmacy under the TRICARE benefit have always been 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 increased by 2 percent from FY 2013 to FY 2015, exclusive of the TFL benefit. Including TFL, the total number of prescriptions increased by 7 percent.
- The overall direct care prescription utilization rate decreased by 1 percent between FY 2013 and FY 2015. Moreover, declines were experienced by all beneficiary groups.
- Average per capita prescription utilization through VA pharmacies increased by 64 percent from FY 2013 to FY 2015, but still accounted for only a small portion (7 percent) of total beneficiary utilization. Not all of the increase was a result of higher utilization—a portion was due to improved data sharing between the VA and DoD pharmacy systems.
- Average per capita prescription utilization through retail pharmacies decreased by 16 percent overall. Declines occurred for every beneficiary group except non-enrolled ADFMs, which had a 6 percent increase. The largest decline was for seniors (28 percent). The primary reason for the declines was the increase in copayments for retail drugs, which caused beneficiaries to migrate to home delivery for their maintenance drugs.
- Home delivery, which once accounted for only a small fraction of purchased care prescription drug utilization, grew by 36 percent between FY 2013 and FY 2015, to the point where it now accounts for 56 percent of total purchased care prescription drug utilization (as measured by 30-day supply) per capita. For beneficiaries under age 65, home delivery accounts for 35 percent of total purchased care prescription drug utilization, whereas for seniors it accounts for 68 percent.

AVERAGE ANNUAL PRESCRIPTION UTILIZATION PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/19/2016

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

LOWER COST

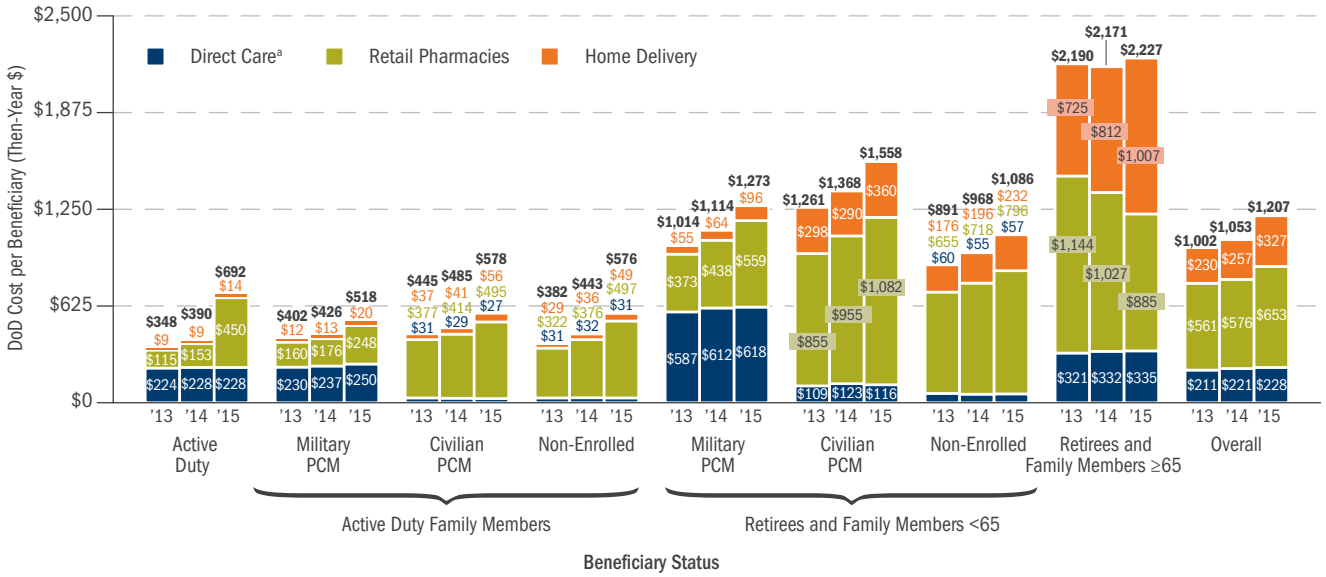
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT.)*

Prescription Drug Cost by Beneficiary Status

Although the drug refunds referenced on page 27 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 20 percent from FY 2013 to FY 2015.

- Exclusive of TFL, per capita prescription drug costs rose by 35 percent between FY 2013 and FY 2015. The largest increase (99 percent) occurred for ADSMs.
- Direct care costs per beneficiary increased by 8 percent, while retail pharmacy costs increased by 47 percent excluding TFL and by 16 percent including TFL.
- Home delivery costs per beneficiary increased by 32 percent excluding TFL and by 42 percent including TFL.
- The large increases in retail pharmacy costs are being driven by rising costs for specialty and compound drugs. Home delivery prescription drug costs per capita are increasing because of a shift away from retail pharmacy utilization to home delivery.

AVERAGE ANNUAL DoD PRESCRIPTION COSTS PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/19/2016

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

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

BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65)

Out-of-pocket costs are computed for Active Duty and retiree families in the U.S. grouped by sponsor age: (1) under 65, and (2) 65 and older (seniors). Costs include deductibles and copayments for medical care and drugs, TRICARE enrollment fees, and insurance premiums. Costs are compared with those of civilian counterparts (i.e., civilian families with the same demographics as the typical MHS family). For beneficiaries under age 65, civilian counterparts are assumed to be covered by other employer-sponsored group health insurance (OHI).

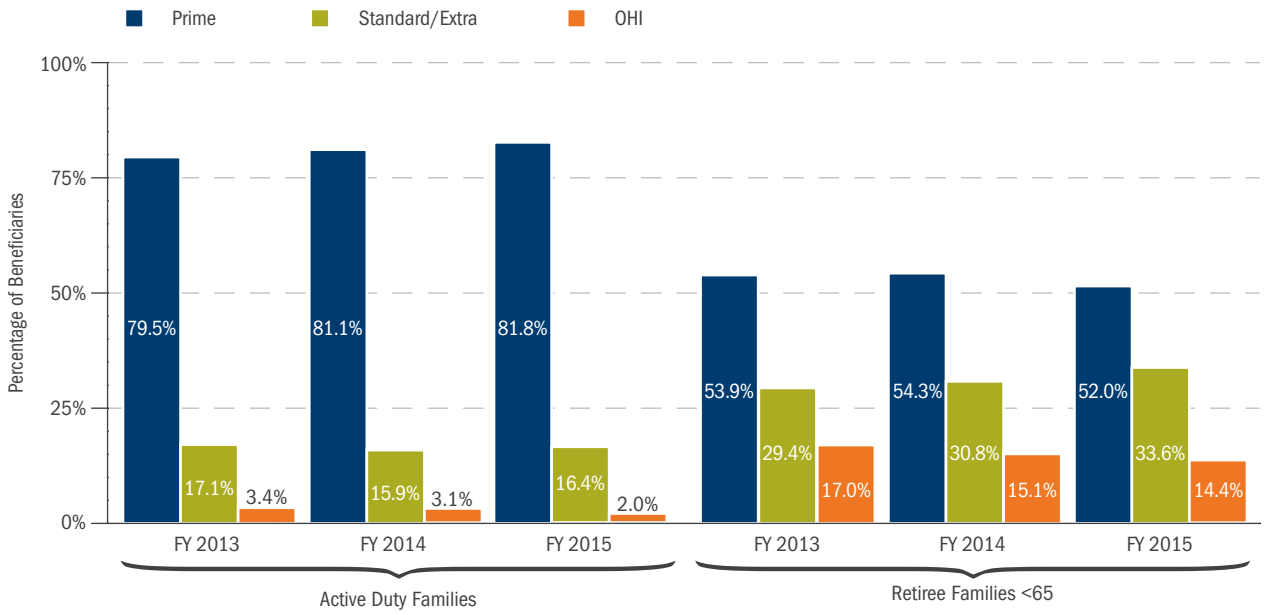
Health Insurance Coverage of MHS Beneficiaries Under Age 65

MHS beneficiaries have a choice of (1) TRICARE Prime, (2) TRICARE Standard/Extra, and (3) OHI. Many beneficiaries with OHI have no TRICARE utilization; however, some use TRICARE as a second payer.

Beneficiaries are grouped by their primary health plan:

- **TRICARE Prime:** Family enrolled in TRICARE Prime (including a small percentage who also have OHI coverage). In FY 2015, 81.8 percent of Active Duty families and 52.0 percent of retiree families were in this group.
- **TRICARE Standard/Extra:** Family not enrolled in TRICARE Prime and does not have OHI coverage. In FY 2015, 16.4 percent of Active Duty families and 33.6 percent of retiree families were in this group.
- **OHI:** Family covered by OHI. In FY 2015, 2.0 percent of Active Duty families and 14.4 percent of retiree families were in this group.

HEALTH INSURANCE COVERAGE OF BENEFICIARIES UNDER AGE 65



Source: Insurance coverage in FYs 2013–2015 based on DEERS and Health Care Survey of DoD Beneficiaries (HCSDB) responses; as of 12/31/2015

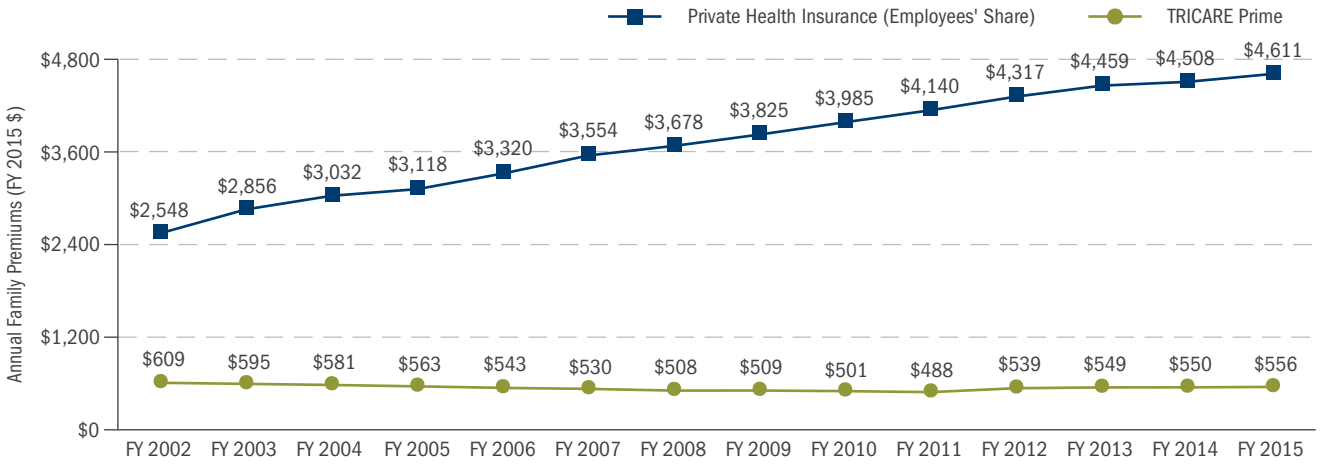
Note: The Prime group includes HCSDB respondents enrolled in Prime based on DEERS plus enrollees in the USFHP. The Standard/Extra group includes HCSDB respondents without OHI who are non-enrollees based on DEERS. The OHI group includes HCSDB respondents with private health insurance (i.e., Federal Employees Health Benefits Plan [FEHBP]), a civilian HMO such as Kaiser, or other civilian insurance such as Blue Cross. A small percentage of Prime enrollees are also covered by OHI; these beneficiaries are included in the Prime group. Percentages may not sum to 100 due to rounding.

BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Retirees and Family Members Under Age 65 Returning to MHS

From FY 2002 to FY 2015, the average private health insurance family premium increased substantially, whereas the TRICARE Prime enrollment fee declined slightly. In FY 2015 dollars, private health insurance premiums increased by $2,063 (81 percent); the TRICARE Prime enrollment fee declined by $53 (–9 percent).

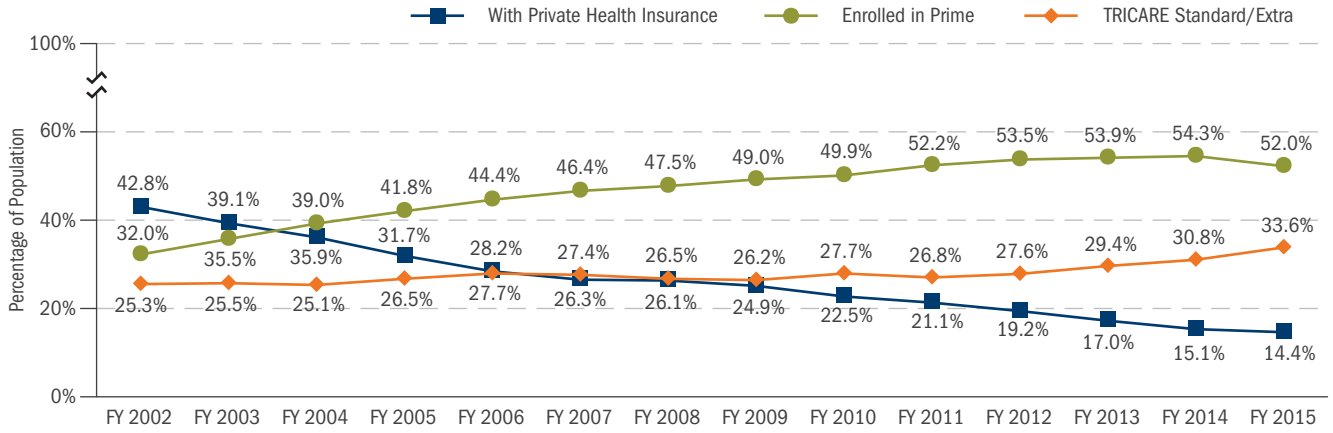
TREND IN PRIVATE INSURANCE PREMIUMS VS. TRICARE ENROLLMENT FEE



Sources: Employees' share of insurance premium for typical employer-sponsored family health plan in FYs 2002–2014 from the Insurance Component of the Medical Expenditure Panel Surveys (MEPS) 2001–2014; OHI premiums in FY 2015 forecasted by the Institute for Defense Analyses based on trends in premiums from Kaiser Family Foundation surveys; as of 12/31/2015

Between FY 2002 and FY 2015, 28.4 percent of retirees switched from private health insurance to TRICARE. Most switched because of an increasing disparity in premiums and out-of-pocket expenses; in the past few years, some lost coverage due to the recession.[1] As a result of declines in private insurance coverage, about 900,000 more retirees and family members under age 65 in the U.S. are now relying primarily on TRICARE instead of on private health insurance.

TREND IN RETIREE (<65) HEALTH INSURANCE COVERAGE



Sources: Insurance coverage in FYs 2002–2015 based on DEERS and HCSDB responses; as of 12/31/2015

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, Log: H14-001368, May 2015.

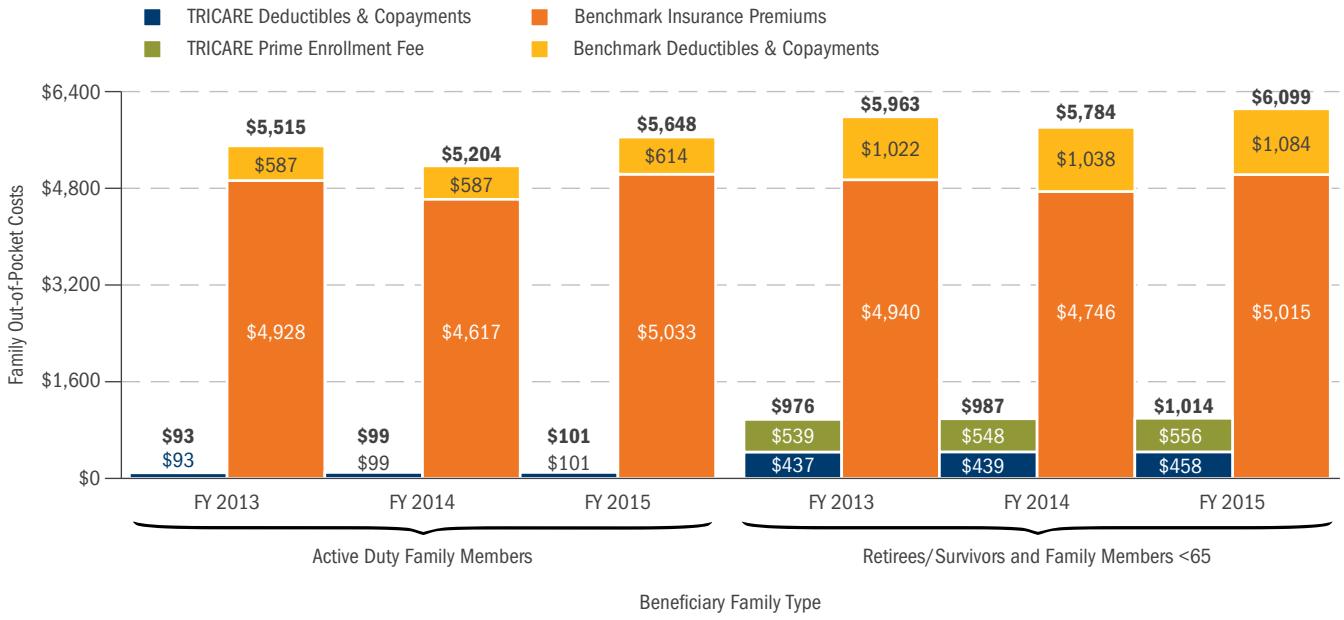
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Out-of-Pocket Costs for Families Enrolled in TRICARE Prime vs. Civilian HMO Counterparts

In FYs 2013–2015, civilian counterpart families had substantially higher out-of-pocket costs than TRICARE Prime enrollees.

- Civilian HMO counterparts paid more for insurance premiums, deductibles, and copayments.
- In FY 2015, costs for civilian counterparts were:
  - $5,500 more than those incurred by Active Duty families enrolled in Prime.
  - $5,100 more than those incurred by retiree families enrolled in Prime.

OUT-OF-POCKET COSTS FOR FAMILIES ENROLLED IN TRICARE PRIME VS. CIVILIAN HMO COUNTERPARTS



Sources: TRICARE beneficiary expenditures for deductibles and copayments in FYs 2013–2015 from MHS administrative data for all families enrolled in Prime without OHI payments; civilian benchmark expenditures for deductibles and copayments from the Household Component of the MEPS, actual MEPS in FY 2013 and projected MEPS in FYs 2014–2015; civilian benchmark insurance premiums in FYs 2013–2014 from the 2012–2014 Insurance Component of the MEPS; OHI premiums in FY 2015 forecasted by the Institute for Defense Analyses based on trends in premiums from Kaiser Family Foundation surveys; as of 12/31/2015

Note: Estimates are for a demographically typical family. For Active Duty dependents, the family includes a spouse and 1.54 children, on average. For retirees, a family includes a sponsor, spouse, and 0.65 children.

LOWER COST

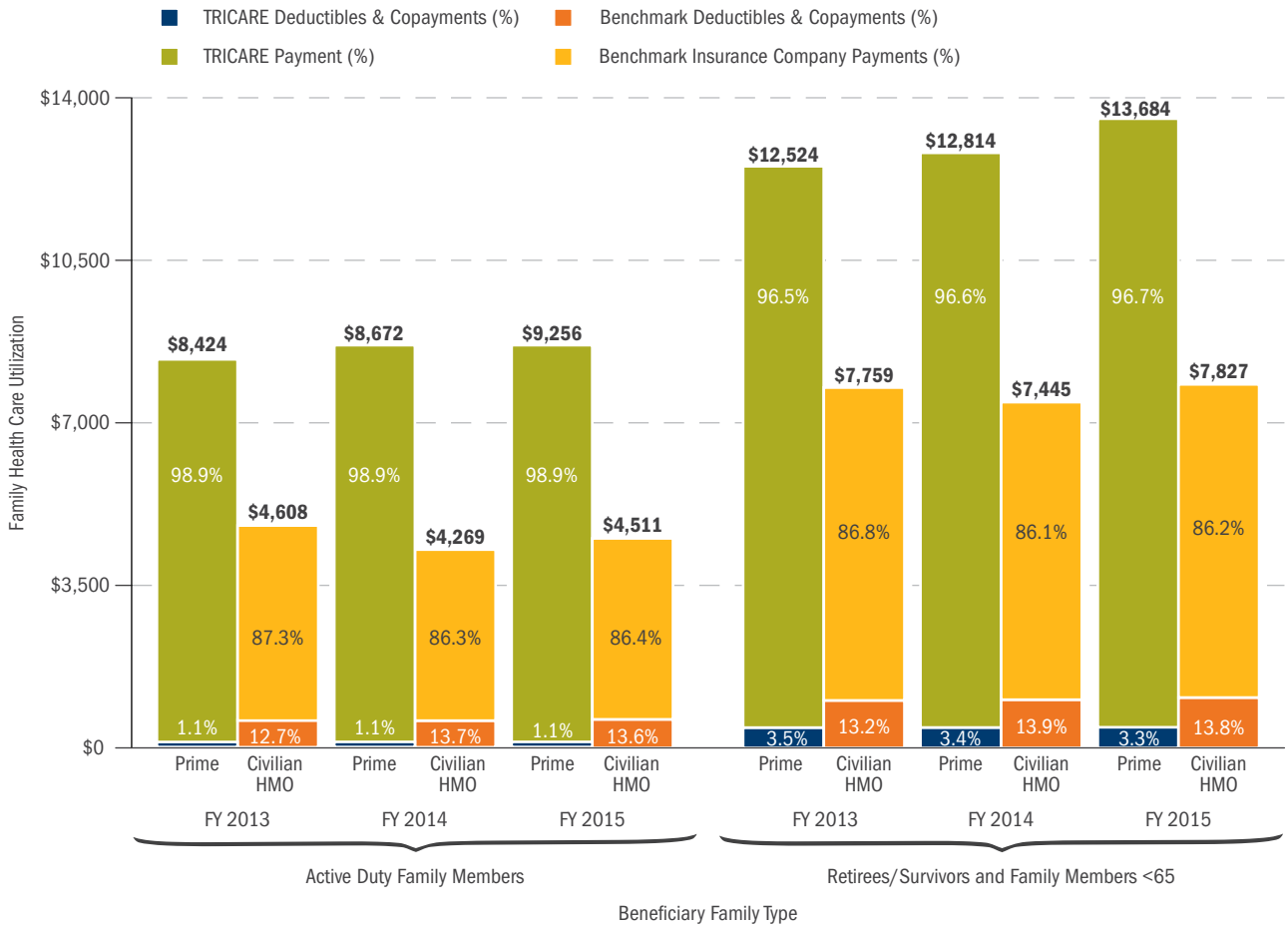
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Coinsurance and Health Care Utilization for Families Enrolled in TRICARE Prime vs. Civilian HMO Counterparts

Previous private-sector studies found that very low coinsurance rates increase health care utilization (dollar value of health care services).[1] In FYs 2013–2015, TRICARE Prime enrollees had negligible coinsurance rates (deductibles and copayments per dollar of utilization) and, not surprisingly, much higher utilization compared with civilian HMO counterpart families. Differences in coinsurance rates are a major reason for the higher utilization of health care services by Prime enrollees.

- TRICARE Prime enrollees had coinsurance rates that were 10.5 to 12.5 percentage points below those of civilian HMO counterparts.
  - In FY 2015, the coinsurance rate for Active Duty families was 1.1 percent versus 13.6 percent for civilian counterparts.
  - In FY 2015, the coinsurance rate for retiree families was 3.3 percent versus 13.8 percent for civilian counterparts.
- TRICARE Prime enrollees had substantially higher health care utilization than civilian HMO counterparts.
  - In FY 2015, Active Duty families consumed $9,300 of medical services versus $4,500 by civilian counterparts (105 percent higher).
  - In FY 2015, retiree families consumed $13,700 of medical services versus $7,800 by civilian counterparts (75 percent higher).

COINSURANCE AND HEALTH CARE UTILIZATION FOR FAMILIES ENROLLED IN TRICARE PRIME VS. CIVILIAN HMO COUNTERPARTS



Sources: TRICARE utilization expenditures by MHS and beneficiaries in FYs 2013–2015 from MHS administrative data for all families enrolled in Prime without OHI payments for TRICARE utilization; civilian benchmark utilization payments by insurance companies and families from the Household Component of the MEPS, actual MEPS in FY 2013, and projected MEPS in FYs 2014–2015; as of 12/31/2015. Dual-eligible retirees obtain some care at the Veterans Administration (VA), which is not included in MHS administrative data. Using regression analyses, the Institute for Defense Analyses estimated utilization at the VA in FYs 2013–2015 for retirees enrolled in Prime and included these estimates in total utilization (e.g., $474 per retiree family in FY 2015).

[1] Newhouse, Joseph P., and Insurance Experiment Group. *Free for All? Lessons from the RAND Health Insurance Experiment. A RAND Study.* Cambridge, MA: Harvard University Press, 1993.

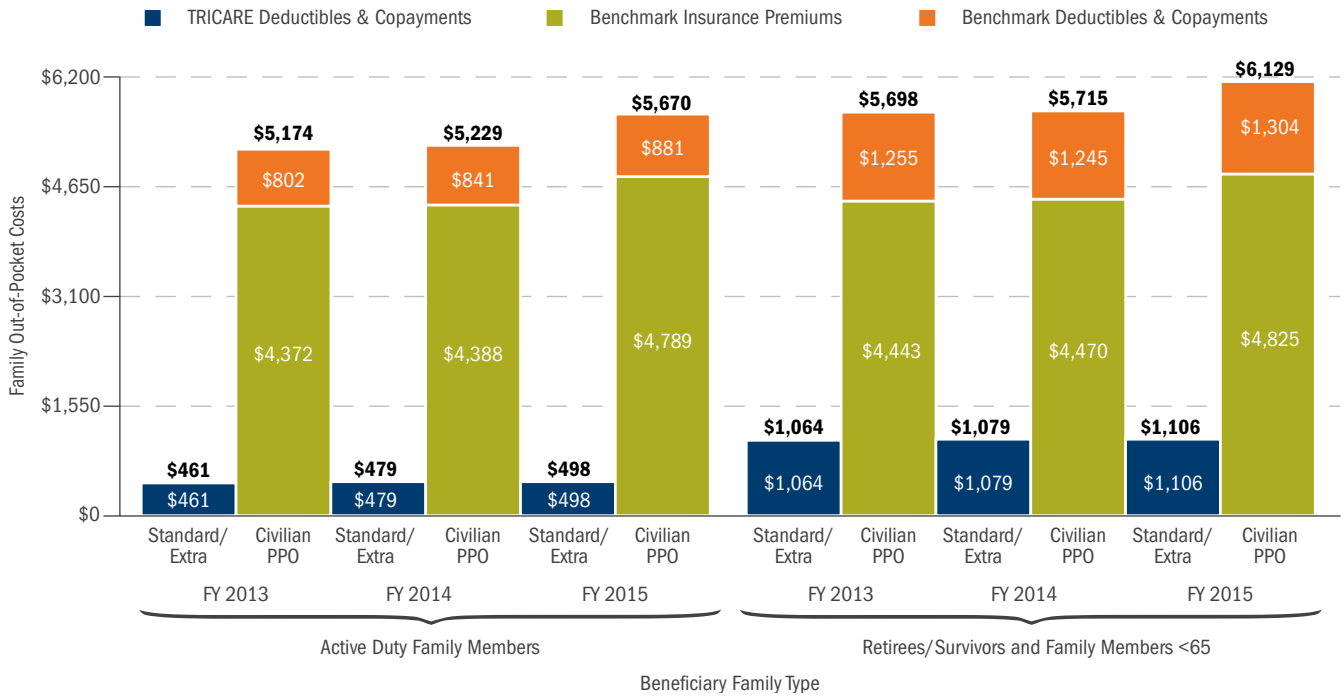
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Out-of-Pocket Costs for Families Who Rely on TRICARE Standard/Extra vs. Civilian PPO Counterparts

From FY 2013 to FY 2015, civilian counterparts had much higher out-of-pocket costs than did TRICARE Standard/Extra users.

- Civilian PPO counterparts paid more for insurance premiums, deductibles, and copayments.
- In FY 2015, costs for civilian counterparts were:
  - $5,200 more than those incurred by Active Duty families who relied on Standard/Extra.
  - $5,000 more than those incurred by retiree families who relied on Standard/Extra.

OUT-OF-POCKET COSTS FOR FAMILIES WHO RELY ON TRICARE STANDARD/EXTRA VS. CIVILIAN PPO COUNTERPARTS



Sources: TRICARE beneficiary expenditures for deductibles and copayments in FYs 2013–2015 from MHS administrative data for all Standard/Extra-reliant families without OHI payments for TRICARE utilization; civilian benchmark expenditures for deductibles and copayments from the Household Component of the MEPS, actual MEPS in FY 2013, and projected MEPS in FYs 2014–2015; civilian benchmark insurance premiums in FYs 2013–2014 from the 2012–2014 Insurance Component of the MEPS; OHI premiums in FY 2015 forecasted by the Institute for Defense Analyses based on trends in premiums from Kaiser Family Foundation surveys; insurance coverage from HCSDB, FYs 2013–2015; as of 12/31/2015

LOWER COST

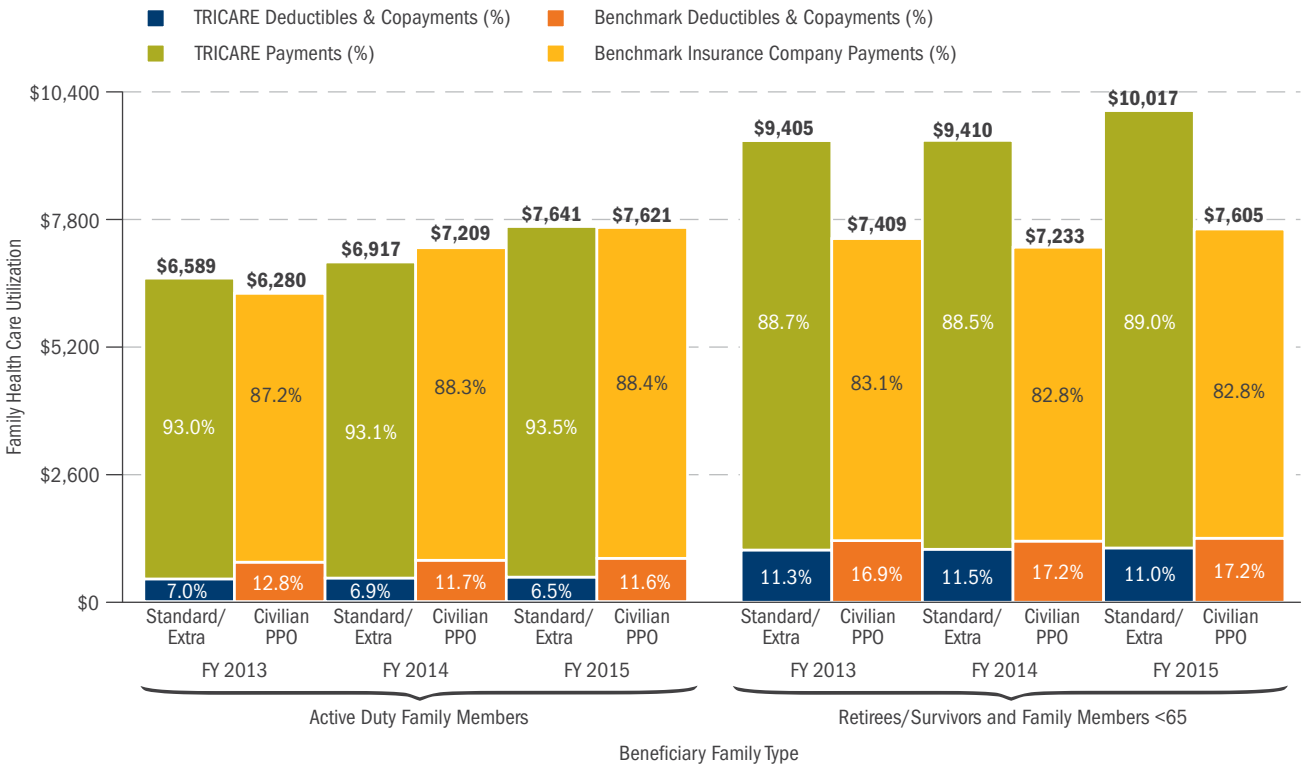
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Coinsurance and Health Care Utilization for Families Who Rely on TRICARE Standard/Extra vs. Civilian PPO Counterparts

In FYs 2013–2015, families who relied on TRICARE Standard/Extra had coinsurance rates (deductibles and copayments per dollar of utilization) that were only 5–6 percentage points below those of civilian counterparts. As a result, health care utilization (dollar value of health care services consumed) was fairly similar for TRICARE-reliant families and civilian counterparts.

- In FY 2015, Active Duty families had a coinsurance rate of 6.5 percent versus 11.6 percent for civilian counterparts.
- In FY 2015, the coinsurance rate for retiree families was 11.0 percent versus 17.2 percent for civilian counterparts.
- In FY 2015, both Active Duty families and civilian counterparts consumed $7,600 of medical services.
- In FY 2015, retiree families consumed $10,000 of medical services versus $7,600 for civilian counterparts (32 percent greater).

COINSURANCE AND HEALTH CARE UTILIZATION FOR FAMILIES WHO RELY ON TRICARE STANDARD/EXTRA VS. CIVILIAN PPO COUNTERPARTS



Sources: TRICARE utilization payments by MHS and beneficiaries in FYs 2013–2015 from MHS administrative data for all Standard/Extra-reliant families without OHI payments; civilian benchmark utilization payments by insurance companies and families from the Household Component of the MEPS, actual MEPS in FY 2013, and projected MEPS in FYs 2014–2015; as of 12/31/2015. Dual-eligible retirees obtain some care at the VA, which is not included in MHS administrative data. Using regression analyses, the Institute for Defense Analyses estimated utilization at the VA in FYs 2013–2015 for retirees not enrolled in Prime and included these estimates in total utilization (e.g., $480 per retiree family in FY 2015).

BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES)

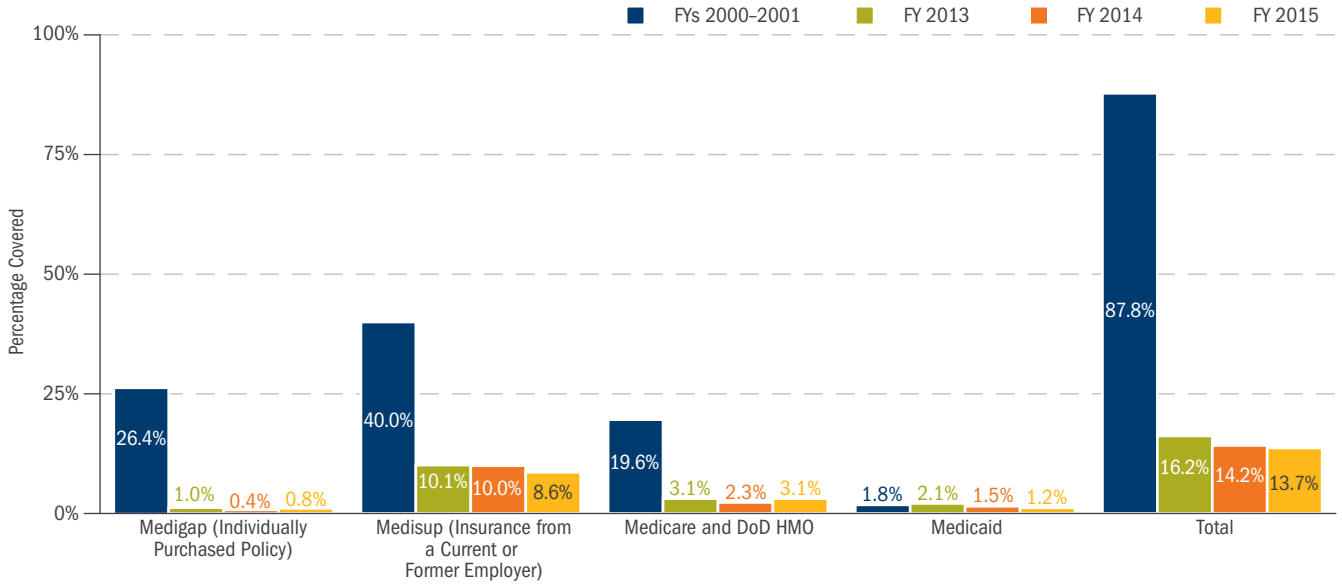
Out-of-pocket costs for retirees ages 65 and older (seniors) and their families include deductibles and copayments for medical care and drugs, TRICARE enrollment fees, and insurance premiums. In April 2001, DoD expanded drug benefits for seniors; on October 1, 2001, DoD implemented the TFL program, which provides Medicare wraparound coverage (i.e., TRICARE acts as second payer to Medicare, minimizing beneficiary out-of-pocket expenses). For seniors, costs are compared with civilian counterparts enrolled in Medicare having pre-TFL supplemental insurance coverage.

Health Insurance Coverage of MHS Senior Beneficiaries Before and After TFL

Although Medicare provides coverage for medical services, there are substantial deductibles and copayments. Until FY 2001, most MHS seniors purchased some type of Medicare supplemental insurance (e.g., Medigap, Medisup).[1] A small number were active employees with employer-sponsored insurance or were covered by Medicaid. Because of the improved drug and TFL benefits, most MHS seniors dropped their supplemental insurance.

- Before TFL (FYs 2000–2001), 87.8 percent of MHS seniors had Medicare supplemental insurance or were covered by Medicaid. After TFL, the percentage of MHS seniors with supplemental insurance or Medicaid fell sharply. It was 13.7 percent in FY 2015.
- Why do 13.7 percent of all seniors still 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



Source: FYs 2000–2001 and FYs 2013–2015 HCSDB; as of 12/31/2015

[1] Medigap is an individually purchased policy that covers Medicare deductibles and copays. Medisup is group insurance from a current or former employer: it includes those with Medicare who are covered either by FEHBP, a civilian HMO such as Kaiser, or other civilian health insurance such as Blue Cross. Individually obtained HMO policies include Medicare Advantage, USFHP, and TRICARE Senior Prime (until December 2001). Almost all TRICARE seniors are covered by Medicare and are enrolled in Parts A and B; only 1.3 percent have just Part A. About 2 percent of TRICARE seniors are covered by government-sponsored Medicaid. About 1 percent of TRICARE seniors have OHI and are not covered by Medicare; these are excluded from the above figure; as of 12/31/2015

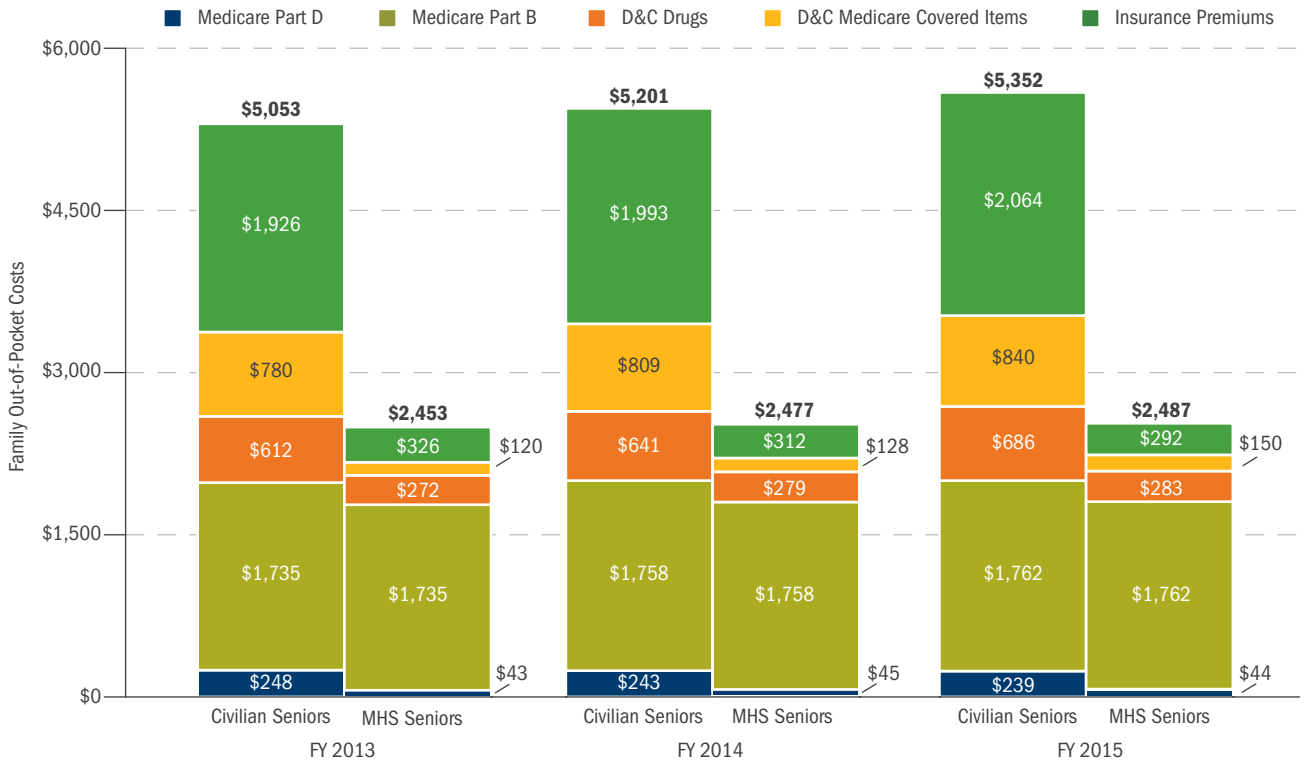
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT.)*

Out-of-Pocket Costs for MHS Senior Families Before and After TFL

About 87 percent of TRICARE senior families use MHS health care. TFL and added drug benefits have enabled MHS seniors to reduce their out-of-pocket costs for deductibles/copayments and supplemental insurance. The costs for a typical TRICARE senior family after TFL, including MHS users and non-users, are compared with those of civilian counterparts having the supplemental insurance coverage of TRICARE senior families before TFL in FYs 2000–2001.

- In FY 2015, out-of-pocket costs for MHS senior families were 54 percent less than those of their "before TFL" civilian counterparts.
- In FY 2015, MHS senior families saved about $2,900 as a result of TFL and added drug benefits.

OUT-OF-POCKET COSTS OF MHS SENIOR FAMILIES AFTER TFL VS. CIVILIAN COUNTERPARTS



Sources: TRICARE senior family deductibles and copayments for MHS users in FYs 2013–2015 from MHS administrative data on all TRICARE senior families. For MHS non-users and civilian benchmark senior families, deductibles and copayments by type of Medicare supplemental coverage from the Household Component of the MEPS, actual MEPS in FY 2013, and projected MEPS in FYs 2014–2015; Medicare Part B and Medicare HMO premiums in FYs 2013–2015 from the Centers for Medicare & Medicaid Services; Medigap premiums in FYs 2013–2015 from Weiss Research, Inc.; Medisup premiums in FYs 2013–2015 from Tower Perrin Health Care Cost Surveys; Medicare Part D premiums in FYs 2013–2015 from Kaiser Family Foundation Surveys; Medicare supplemental insurance coverage, before and after TFL from HCSDB, FYs 2000–2001, 2013–2015; as of 12/31/2015

Note: Estimates are for a demographically typical senior family. On average, this consists of 0.7 men and 0.7 women over the age of 65.

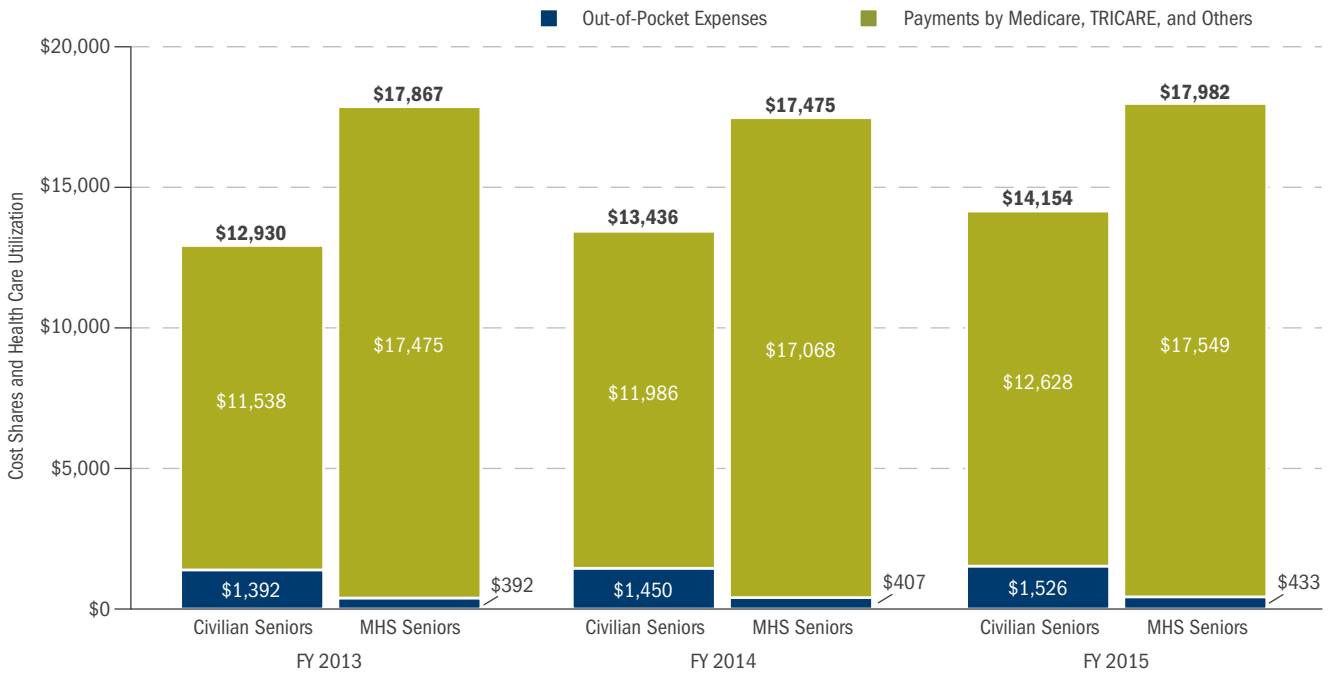
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT.)*

Coinsurance and Health Care Utilization for MHS vs. Civilian Senior Families

Medicare supplemental insurance lowers the coinsurance rate (deductibles and copayments per dollar of utilization), and previous studies find that this leads to more health care services consumed for seniors.[1] TFL and added drug benefits substantially lowered coinsurance rates, and, not surprisingly, utilization is higher for MHS seniors compared with "before TFL" civilian counterparts.

- TRICARE senior families have low coinsurance rates, 8.4 percentage points below those of civilian counterparts.
  - In FY 2015, the coinsurance rate for MHS seniors was 2.4 percent; it was 10.8 percent for civilian counterparts.
- TRICARE senior families have relatively high health care utilization.
  - In FY 2015, MHS senior families consumed $3,800 more medical services than their civilian counterparts (27 percent greater).

COINSURANCE AND HEALTH CARE UTILIZATION FOR SENIOR FAMILIES VS. CIVILIAN COUNTERPARTS



Sources: TRICARE senior family utilization, deductibles, and copayments for MHS users in FYs 2013–2015 from MHS administrative data. For MHS non-users and civilian benchmark senior families, utilization, deductibles and copayments by type of Medicare supplemental coverage from the Household Component of the MEPS, actual MEPS in FY 2013, and projected MEPS in FYs 2014–2015; Medicare supplemental insurance coverage, before and after TFL, from HCSDB, FYs 2000–2001 and 2013–2015; as of 12/31/2015

[1] Physician Payment Review Commission, "Private Secondary Insurance for Medicare Beneficiaries," in *Annual Report to Congress: Fiscal Year 1997* (Washington, D.C.: U.S. Government Printing Office, 1997), 27–28.

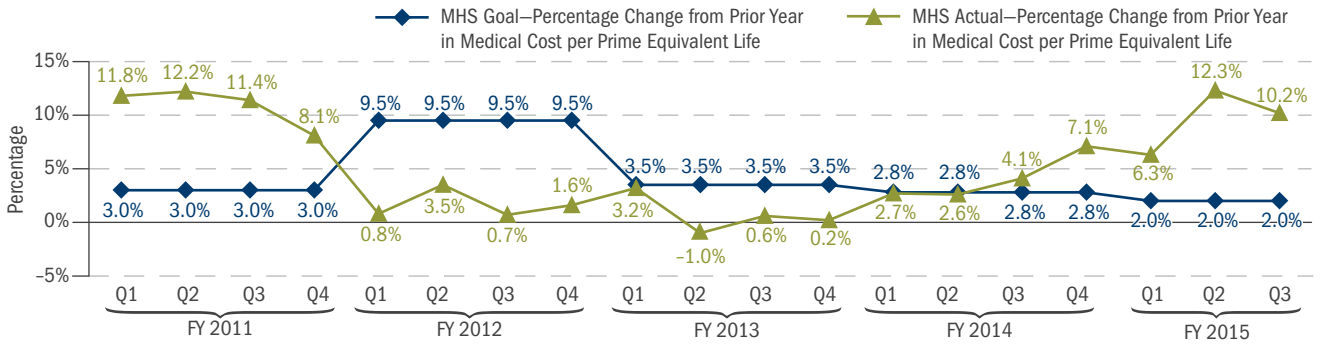
LOWER COST

SYSTEM PRODUCTIVITY: MHS MEDICAL COST PER PRIME ENROLLEE

The goal in using this financial and productivity metric is to support the Quadruple Aim of managing lower costs. This metric focuses on per capita costs to examine the extent to which MHS stays below a targeted annual rate of increase based on industry practice, including how well MHS manages the care for those individuals who have chosen to enroll in an HMO-type of benefit provided by MTFs. Designed to capture aspects of three major management issues, this metric measures (1) how efficiently MTFs provide care, (2) how efficiently MTFs manage the demand of their enrollees, and (3) how well MTFs determine which care should occur internally versus which should be purchased externally from a managed care support contractor.

- In the area of military health costs, MHS remained below the medical cost per equivalent life in FYs 2013 and 2014, and will exceed FY 2015 performance goals because it experienced higher-than-expected cost growth. The largest growth factor involved pharmacy compounded products. To contain the growth in this area, MHS worked directly with MTF providers to ensure they understood the cost impact of these types of prescriptions and to eliminate them when not required for the beneficiary. Most importantly, TRICARE began to actively screen all compound prescriptions. This screening process aligned DoD practices with those of commercial health plans. These efforts resulted in a decrease, for Prime enrollees, from a monthly high of $350 million to a $6 million average per month for the last months of the year; however, overall performance will exceed the yearly goal. Additionally, national health care utilization is starting to return to normal patterns, which will impact growth in future years.
- Through FY 2014, increases in purchased care outpatient costs were eased by DHA's implementation of the Outpatient Prospective Payment System (OPPS), beginning in May 2009 and completely phased in by May 2013, aligning TRICARE reimbursement with Medicare rates for hospital outpatient services. Pharmacy refunds continue to partially mitigate retail pharmacy costs—the highest-cost pharmacy venue. OPPS and refunds have provided short-term pricing decreases; however, as they have phased in fully, pricing has stabilized and utilization has again become a cost driver, as reflected in increases beginning in FY 2014.
- MHS continues to expand the Patient-Centered Medical Home (PCMH) strategy, a practice model in which a team of health care professionals, coordinated by a personal physician, works collaboratively to provide high levels of care, access, and communication; care coordination and integration; and care quality and safety. Care delivered in a PCMH is meant to produce better outcomes; reduce mortality, unnecessary emergency department visits, and preventable hospital admissions for patients with chronic diseases; lower overall utilization; and improve patient compliance with recommended care, resulting in lower spending for the same population.
- The MHS goal in percentage change in medical costs from 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 (HRET). From this survey, the MHS rate is set, based on the average annual premiums for employer-sponsored health insurance for family coverage. The FY 2012 goal of a 9.5 percent increase was much higher than previous years, based on expected higher average premiums under future implementation of the Affordable Care Act (ACA), which would limit the growth in premiums according to medical loss ratios. Starting in FY 2013, the MHS goal was 1 percentage point below the survey, which reduced the expected annual increase for FY 2013 to 3.5 percent, for FY 2014 to 2.8 percent, and for FY 2015 to 2.0 percent.

PERCENTAGE CHANGE IN MEDICAL COST PER PRIME EQUIVALENT LIFE (FROM PRIOR YEAR)



Source: Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA]) Health Budgets and Financial Policy, dated 11/9/2015, and MHS administrative data (M2: Standard Inpatient Data Record [SIDR]/Standard Ambulatory Data Record [SADR]/Comprehensive Ambulatory/Professional Encounter Record [CAPER]/TRICARE Encounter Data-Institutional [TED-I]/TED-Noninstitutional [-NI], Pharmacy Data Transaction Service [PDTS]; Expense Assignment System IV [EASIV]). Enrollees are adjusted for health risk status. FY 2015 data are reported through Q3 FY 2015, and data from this quarter should be considered preliminary.

GENERAL METHOD

This report presents the overall performance of the TRICARE program with respect to the Military Health System (MHS) Quadruple Aim of increased readiness, better care, better health, and lower cost. MHS monitors various metrics to assess performance and, where possible, tries to compare MHS performance with relevant civilian health care performance. This report examines the effects of TRICARE on beneficiary utilization of inpatient, outpatient, and prescription services, as well as on MHS and beneficiary costs. Wherever feasible, the report contrasts various aspects of TRICARE and national health care trends. These include comparison of TRICARE utilization and cost measures with comparable civilian sector benchmarks derived from the MarketScan® Commercial Claims and Encounters (CCAE) database provided by Truven Health Analytics Inc.; trended change in medical costs based on the national survey of nonfederal health plans and public employers conducted by the Kaiser Family Foundation and the Health Research and Education Trust (HRET); and national patient survey results from the consortium of the Agency for Healthcare Research and Quality (AHRQ) and the Consumer Assessment of Health Providers and Systems (CAHPS).

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 Web sites accessible by the public. These photos have not been tampered with other than to mask an individual's name.
- Differences between MHS survey-based data and the civilian benchmark, or MHS over time, were considered statistically significant if the significance level was less than or equal to 0.05.
- All workload and costs are estimated to completion based on separate factors derived from MHS administrative data for direct care and recent claims experience for purchased care.
- Data were current as of:
  - Surveys—HCSDB (10/19/2015); Service surveys: APLSS, PSS, and SDA (11/3/2015); and TROSS/TRISS (12/1/2015)
  - Eligibility/enrollment data—1/6/2016
  - MHS workload/costs—1/19/2016
  - Web site uniform resource locators—1/6/2016
- The Defense Health Agency (DHA) regularly updates its encounters and claims databases as more current data become available. It also periodically "retrofits" its databases as errors are discovered. The updates and retrofits can sometimes have significant impacts on the results reported in this and previous documents if they occur after the data collection cutoff date. The reader should keep this in mind when comparing this year's results with those from previous reports.

DATA SOURCES

Health Care Survey of DoD Beneficiaries (HCSDB)

The HCSDB was developed by the Defense Health Agency (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 MHS or with their 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 and preventive care services.

The worldwide, multiple-mode Adult HCSDB has been conducted on a quarterly basis (three fiscal year quarters: October, January, and April) since FY 2013, and reported quarterly on a publicly accessible Web site (http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/TRICARE-Patient-Satisfaction-Surveys/Health-Care-Survey-of-DoD-Beneficiaries).

The CAHPS is a nationally recognized set of standardized questions and reporting formats that has been used to collect and report meaningful and reliable information about the health care experiences of consumers. It was developed by a consortium of research institutions and sponsored by the AHRQ. It has been tested in the field and evaluated for validity and reliability. The questions and reporting formats have been tested to ensure that the answers can be compared across plans and demographic groups.

About three-fourths of HCSDB questions are closely modeled on the CAHPS program 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. 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, and indications of post-traumatic stress in the overall MHS population.

Because the HCSDB uses CAHPS questions, TRICARE can be benchmarked to civilian managed care health plans. More information on CAHPS can be obtained at https://www.cahps.ahrq.gov.

The survey request is sent by postal mail to all beneficiaries and also by e-mail to Active Duty members, with responses accepted via Web and, for a random sample of initial nonrespondents, by postal mail. The HCSDB is fielded to a stratified random sample of beneficiaries. In order to calculate representative rates and means from their responses, sampling weights are used to account for different sampling rates and different response rates in different sample strata. Beginning with the FY 2006 report, weights were adjusted for factors such as age and rank that do not define strata, but make some beneficiaries more likely to respond than others. Because of the adjustment, rates calculated from the same data differ from past evaluation reports and are more representative of the population of TRICARE users.

The DHA HCSDB is sent to a random sample of all MHS-eligible users and non-users. Survey results are reported quarterly, with almost 29,000 respondents from about 300,000 beneficiaries surveyed in FY 2015 (about a 10 percent raw response and 17 percent weighted response rate, down from an almost 18 percent raw response rate in FY 2013). Results can be estimated from the HCSDB for all beneficiary groups eligible for MHS benefits, whether they use direct care, purchased care, or other health insurance available to them, and are compared with benchmark results from a national sample of commercial civilian health plans administering the CAHPS Health Plan survey.

Results provided from HCSDB in FY 2013 were based on questions taken from the CAHPS Version 4.0 Questionnaire, while the FYs 2014 and 2015 fieldings of the HCSDB were based on CAHPS Version 5.0. The HCSDB results for FY 2013 (using CAHPS Version 4.0) were benchmarked to CAHPS Version 4.0 surveys conducted in 2011, and results for FYs 2014 and 2015 (using CAHPS Version 5.0) were benchmarked to CAHPS Version 5.0 surveys conducted in 2013 and 2014, respectively. Because of the changes in the questionnaire, changes in rates are only meaningful when compared with changes in the relevant benchmark. CAHPS Version 4.0 benchmarks were obtained from the National CAHPS Benchmarking Database (NCBD). CAHPS Version 5.0 benchmarks were obtained from the National Committee for Quality Assurance (NCQA).

Although the benchmark data files for CAHPS Versions 4.0 and 5.0 were obtained from different organizations, their contents and specifications are consistent, and the same selection criteria and methods were used to calculate benchmarks from both. The NCBD collects CAHPS results voluntarily submitted by participating health plans and is funded by the AHRQ and administered by a contractor. The NCQA's file also contains voluntarily submitted health plan survey results. Only health maintenance organization (HMO), preferred provider organization (PPO), and HMO/point-of-service (POS) plans from either source are used in the calculation of the benchmark scores. Both benchmarks and TRICARE results are adjusted for age and health status.

Differences between MHS and the 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 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. If P is less than 0.05, the difference is significant.

Within the context of the HCSDB, Prime enrollees are defined as those enrolled at least six months.

TRICARE Inpatient Satisfaction Survey (TRISS)

The purpose of the Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]) TRISS is to monitor and report on the experience and satisfaction of MHS beneficiaries who have been admitted to military treatment facilities (MTFs) and civilian hospitals. The survey instrument incorporates the questions developed by the AHRQ and Centers for Medicare & Medicaid Services (CMS) for the Hospital-CAHPS (HCAHPS®) initiative. The goal of the HCAHPS initiative is to measure uniformly and report publicly patient experiences with inpatient care through the use of a standardized survey instrument and data collection methodology. The information derived from the survey can be useful for internal quality improvement initiatives, to assess the impact of changes in policy, and to provide feedback to providers and patients.

The TRISS is a 43-item survey instrument, with 21 questions asking how often or whether patients

experienced a critical aspect of hospital care, rather than whether they were "satisfied" with their care, and 22 DoD-specific questions, including an open-ended question to solicit specific location-specific comments from our beneficiaries.

The TRISS questionnaire is sent to all (census) adult MTF inpatients worldwide between 48 hours and six weeks after discharge. The TRISS survey is also administered to a random sample of adult MHS inpatients discharged from civilian network/purchased care hospitals. The TRISS follows the HCAHPS protocols developed by the CMS. HCAHPS protocols for sampling, data collection, and coding can be found in the HCAHPS Quality Assurance Guidelines manual on the official HCAHPS Web site, http://www.hcahpsonline.org. The overall FY 2015 response rate for direct care was 39 percent and for purchased care was 45 percent.

TRICARE Outpatient Satisfaction Survey (TROSS) and Service Outpatient Surveys

This report presents beneficiary self-reported ratings of their outpatient experience from multiple sources, and, in so doing, offers different perspectives on how MHS assesses the outpatient beneficiary experience. These outpatient surveys are the TRICARE Outpatient Satisfaction Survey (TROSS), the Army Provider Level Satisfaction Survey (APLSS), the Navy Patient Satisfaction Survey (PSS), and the Air Force Service Delivery Assessment (SDA).

- **The DHA TROSS** is sent to a randomized sample of MHS beneficiaries following their outpatient encounter in either direct or purchased care. Survey results are reported monthly, with about 131,000 responses from about 590,000 annually surveyed in FY 2013 (22 percent raw annual response rate). Metric scores are compared with benchmarks established by the CAHPS Clinician and Group (C&G) Survey.
- **The APLSS** is sent by postal mail and e-mail to approximately 2.5 million beneficiaries annually who have used Army MTFs, receiving about 675,000 responses (27 percent response rate) via mail, Web, or telephone.
- **The Navy PSS** is sent by postal mail to about 1 million beneficiaries annually who have used Navy MTFs, with about 200,000 replying by mail or Web (20 percent response rate).
- **The Air Force SDA** surveys by telephone about 600,000 beneficiaries who have used Air Force MTFs, receiving about 189,000 responses (32 percent response rate).

The Service survey results are not easily comparable to one another because of differences in survey design, questionnaires, sampling, and mode of survey, but do provide a high volume of results for reporting at the MTF, clinic, and provider level important to the Service. The TROSS and the HCSDB Service surveys (APLSS, PSS, and SDA) have two questions in common, asking beneficiaries to rate their ability to get care when needed and the overall satisfaction with their care. Results from these surveys are used in the Performance for Improvement (P4I) metrics reviewed quarterly by senior MHS leadership.

Quality

Military hospital quality measures were abstracted from clinical records by trained specialists and reported to The Joint Commission. Preventable admission rates were calculated using both direct (MTF) care and purchased (civilian) care workload for adult patients aged 18 and older. Each admission was weighted by its relative weighted product (RWP), a prospective measure of the relative costliness of an admission. Rates were computed by dividing the total number of dispositions/admissions (direct care and Civilian Health and Medical Program of the Uniformed Services [CHAMPUS]) by the appropriate population. The results were then multiplied by 1,000 to compute an admission rate per 1,000 beneficiaries.

Utilization and Costs

Data on MHS and beneficiary utilization and costs came from several sources. We obtained the health care experience of eligible beneficiaries by aggregating Standard Inpatient Data Records (SIDRs—MTF hospitalization records), Comprehensive Ambulatory/Professional Encounter Records (CAPERs—MTF outpatient records), TRICARE Encounter Data (TED—purchased care claims information) for institutional and noninstitutional services, and Pharmacy Data Transaction Service (PDTS) claims within each beneficiary category.

Inpatient utilization was measured using dispositions (direct care)/admissions (purchased care) and Medical Severity Diagnosis Related Group (MS-DRG) RWPs, the latter being a measure of the intensity of hospital services provided. Outpatient utilization for both direct and purchased care was measured using encounters and an MHS-derived measure of intensity called Enhanced Total Relative Value Units (RVUs). MHS uses several different RVU measures to reflect the relative costliness of the provider effort for a particular procedure or service. Enhanced Total RVUs were introduced by MHS in FY 2010 (and retroactively applied to earlier years) to account for units of service (e.g., 15-minute intervals of physical therapy) and better reflect the resources expended to produce an encounter. The word "Total" in the name reflects that it is the sum of Work RVUs and Practice Expense RVUs. Work RVUs measure the relative level

of resources, skill, training, and intensity of services provided by a physician. Practice Expense RVUs account for nonphysician clinical labor (e.g., a nurse), medical supplies and equipment, administrative labor, and office overhead expenses. In the private sector, Malpractice RVUs are also part of the formula used to determine physician reimbursement rates, but since military physicians are not subject to malpractice claims, they are excluded from Total RVUs to make the direct and purchased care workload measures more comparable. For a more complete description of enhanced as well as other RVU measures, see http://www.tricare.mil/ocfo/_docs/R-6-1000_Using%20the%20M2%20to%20Identify%20and%20Manage%20MTF%20Data%20Quality_Redacted.pptx.

Costs recorded on TEDs were broken out by source of payment (DoD, beneficiary, or private insurer). Although the 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 2016, as referenced above.

The CCAE database contains the health care experience of several million individuals (annually) covered under a variety of health plans offered by large employers, including PPOs, POS plans, HMOs, and indemnity plans. The database links inpatient services and admissions, outpatient claims and encounters and, for most covered lives, outpatient pharmaceutical drug data and individual-level enrollment information. We tasked Truven Health Analytics Inc. to compute quarterly benchmarks for HMOs and PPOs, broken out by product line (MED/SURG, OB, PSYCH) and several sex/age group combinations. The quarterly breakout, available through the second quarter of FY 2015, allowed us to derive annual benchmarks by fiscal year and to estimate FY 2015 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 age 65 and older from the calculations because most of them are covered by Medicare and Medigap policies rather than by a present or former employer's insurance plan.

DRG Grouping Methodology

In the section that displays the "Top 25" inpatient diagnosis groups, Diagnosis Related Groups (DRGs) are grouped into descriptively (but not necessarily clinically) similar categories using a code set available on http://www.findacode.com/code-set.php?set=DRG, an online database of medical billing codes and information. The site lists DRGs within each Major Diagnostic Category (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 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 Web site. This resulted in a reduction from 818 DRGs to 284 DRG groups.

ABBREVIATIONS

ABA	applied behavior analysis	8
ACA	Affordable Care Act	7
ACD	Autism Care Demonstration	8
AD	Active Duty	22
ADE	adverse drug event	62
ADFM	Active Duty family member	13
ADSM	Active Duty Service member	5
AFHSC	Armed Forces Health Surveillance Center	6
AFMES	Armed Forces Medical Examiner System	6
AHRQ	Agency for Healthcare Research and Quality	41
APLSS	Army Provider Level Satisfaction Survey	41
ASD	autism spectrum disorder	45
BACB	Behavior Analyst Certification Board	45
BAG	Budget Activity Group	22
BCBA	Board Certified Behavior Analyst	45
BMI	body mass index	73
BRAC	Base Realignment and Closure	16
BT	behavior technician	45
CAD	Catchment Area Directory	15
CAHPS	Consumer Assessment of Healthcare Providers and Systems	37
CAHPS (C&G)	CAHPS Clinician and Group survey	41
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services	5
CDC	Centers for Disease Control and Prevention	73
CMS	Centers for Medicare & Medicaid Services	21
CMSP	Clinical Measures Steering Panel	78
CoP	Community of Practice	59
CY	calendar year	4
DACT	Defense Advisory Committee on Tobacco	76
DEERS	Defense Enrollment Eligibility Reporting System	12
DHA	Defense Health Agency	1
DHA-PI	Defense Health Agency, Office of Program Integrity	10
DHP	Defense Health Program	11
DHHS	Department of Health and Human Services	20
DM	disease management	78
DMDC	Defense Manpower Data Center	7
DoD	Department of Defense	1
DS	DoD self-service	7
EBP	evidence-based practice	62
ECHO	Extended Care Health Option	42
EFMP	Exceptional Family Member Program	45
eMSM	Enhanced Multi-Service Market	15
ER	emergency room	25
ESI	Express Scripts, Inc.	6
ETU	Ebola treatment unit	7
FDA	U.S. Food and Drug Administration	10
FTE	full-time equivalent	69
FY	fiscal year	1
GRDFM	Guard/Reserves and Family Members	13
HAC	hospital-acquired condition	62
HBI	Health Base Initiative	73
HCSDB	Health Care Survey of DoD Beneficiaries	37
HEDIS	Healthcare Effectiveness Data and Information Set	78
HIPAA	Health Insurance Portability and Accountability Act	69
HRO	High Reliability Organization	1
HP	Healthy People	73
I-PASS	Illness severity, Patient summary, Action list, Situational Awareness and contingency planning, and Synthesis	7
MCSC	Managed Care Support Contractor	16
MDR	MHS Data Repository	15
MERHCF	Medicare-Eligible Retiree Health Care Fund	
MHS	Military Health System	1
MHSPHP	MHS Population Health Portal	81
MTF	military treatment facility	1
NCAA	National Collegiate Athletic Association	7
NCHS	National Center for Health Statistics	73
NCQA	National Committee for Quality Assurance	78
NCRMD	National Capital Region Medical Directorate	41
NDAA	National Defense Authorization Act	1
NHANES	National Health and Nutritional Examination Survey	73
NHE	National Health Expenditures	21
NMHM	National Museum of Health and Medicine	6
NPC	National Prevention Council	73
NPI	National Provider Identifier	69
NPS	National Prevention Strategy	73
OB	obstetrics	24
OCO	Overseas Contingency Operations	20
OCONUS	outside the continental U.S.	71
OHI	other health insurance	18
OLW	Operation Live Well	73
OMB	Office of Management and Budget	20
O&M	Operations and Maintenance	20
OTC	over-the-counter	76
P4I	Performance for Improvement	1
PB&E	Program, Budget, and Execution	20
PCM	primary care manager	5
PCMH	Patient-Centered Medical Home	4
PDTS	Pharmacy Data Transaction Service	27
PfP	Partnerships for Patients	4
PH	psychological health	21
PI	Program Integrity	4
POS	point-of-service	5
PRISM	Provider Requirement Integrated Specialty Model	15
PSA	Prime Service Area	15
PSC	Private-Sector Care	22

ABBREVIATIONS *(CONT.)*

PSM	Patient Safety Manager | 63
PSP	Patient Safety Program | 61
PSR	Patient Safety Reporting | 61
PSS	Navy Patient Satisfaction Survey | 41
RC	Reserve Component | 4
RCA	root cause analysis | 35
RDT&E	Research, Development, Test, and Evaluation | 20
RETFM	Retirees and Family Member | 12
RVUs	relative value units | 24
RWPs	relative weighted products | 23
SDA	Air Force Service Delivery Assessment | 41
SecDef	Secretary of Defense | 76
TAMP	Transitional Assistance Management Program | 66
TBI	tramautic brain injury | 7
TDP	TRICARE Dental Program | 9
TeamSTEPPS	Team Strategies and Tools to Enhance Performance and Patient Safety | 63
TED	TRICARE Encounter Data | 65
TFF	Total Force Fitness | 73
TFL	TRICARE for Life | 4
TMA	TRICARE Management Activity | 76
TPharm4	fourth generation TRICARE pharmacy contract | 6
TPR	TRICARE Prime Remote | 5
TRDP	TRICARE Retiree Dental Program | 5
TRISS	TRICARE Inpatient Satisfaction Survey | 56
TROs	TRICARE Regional Offices | 5
TROSS	TRICARE Outpatient Satisfaction Survey | 41
TRR	TRICARE Retired Reserve | 1
TRS	TRICARE Reserve Select | 12
TYA	TRICARE Young Adult | 1
UMP	Unified Medical Program | 1
USFHP	Uniformed Services Family Health Plan | 5
USD(P&R)	Under Secretary of Defense for Personnel and Readiness | 33
USU	Uniformed Services University of Health Sciences | 7
VA	Veterans Affairs | 5
WRNMMC	Walter Reed National Military Medical Center | 7

The **Evaluation of the TRICARE Program: Fiscal Year 2016 Report to Congress** is provided by the Defense Health Agency, Decision Support Division, in the Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]). Once the Report has been sent to the Congress, an interactive digital version with enhanced functionality and searchability will be available at: http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program.

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APPENDIX

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Defense Health Agency