Evaluation of the TRICARE Program:
Fiscal Year 2023 Report to Congress
Access, Cost, and Quality Data through Fiscal Year 2022

Anytime. Anywhere. *Keeping Warfighters Ready. For Life.*

26th Annual

TRICARE Evaluation Report and Data

Evaluation of the TRICARE Program:

Fiscal Year 2023 Report to Congress

Access, Cost, and Quality Data through Fiscal Year 2022

FEBRUARY 28, 2023

The *Evaluation of the TRICARE Program: Fiscal Year 2023 Report to Congress* is provided by the Defense Health Agency (DHA), Analytics and Evaluation Division, in the Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA]). The intent of this report is an annual evaluation of the TRICARE Program only and is not intended to cover the costs of care delivered to dual-eligible beneficiaries under the Veterans Administration. Once the Report has been sent to Congress, an interactive digital version with enhanced functionality and searchability will be available at: http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program.

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

Front cover photo descriptions:

A – A hospital corpsman explains the capabilities of a portable x-ray machine to medical professionals from the National Referral Hospital in Honiara during training aboard the Military Sealift Command hospital ship USNS Mercy (T-AH 19) during Pacific Partnership 2022. Now in its 17th year, Pacific Partnership is the largest annual multinational humanitarian assistance and disaster relief preparedness mission conducted in the Indo-Pacific. (September 2022)

B – U.S. Air Force cardiologists from the 81st Medical Group (MDG) work at Keesler Air Force Base, Miss. (August 2022)

C – Soldiers assigned to the 7th Infantry Regiment conduct live-fire exercises at the Grafenwoehr Training Area in Germany. (May 2022)

D – World War II veterans attend a ceremony at the Eternal Heroes Memorial in Normandy, France, to honor fallen paratroopers who liberated Ravenoville in June 1944. (June 2022)

E – A respiratory therapist performs intrapulmonary percussive ventilation for a pediatric patient at Brooke Army Medical Center, Fort Sam Houston, Texas. (September 2022)

F – An aviation boatswain's mate (equipment) observes an F/A-18E Super Hornet, attached to the "Blue Blasters" of Strike Fighter Squadron 34, launch from the flight deck of the Nimitz-class aircraft carrier USS Harry S. Truman (CVN 75) during a Carrier Air Wing (CVW) 1 flyoff. (September 2022)

G – A Warrior Games athlete on Team Air Force high-fives a Team Navy athlete during a wheelchair rugby game at the 2022 Department of Defense Warrior Games in Orlando, Fla. The DoD Warrior Games feature a variety of adaptive sports for all wounded, ill, and injured Service members to improve their quality of life throughout the continuum of recovery and transition. (August 2022)

H – U.S. Navy hospitalmen conduct dental examinations on local children at Francis Primary School during Pacific Partnership 2022. (September 2022)

I – U.S. Marines assigned to the 31st Marine Expeditionary Unit disembark an MV-22 Osprey tiltrotor aircraft assigned to Marine Medium Tiltrotor Squadron (VMM) 262 (Reinforced) onto amphibious assault carrier USS Tripoli (LHA 7). (August 2022)

J – A dentist assigned to Navy Medicine Readiness and Training Command Pearl Harbor performs a dental exam on the Mobile Dental Unit on Joint Base Pearl Harbor-Hickam, Hawaii. (August 2022)

K – U.S. Navy Lieutenant Commander performs surgery aboard the Military Sealift Command hospital ship USNS Mercy (T-AH 19) during Pacific Partnership 2022. (August 2022)

L – U.S. Air Force F-15E Strike Eagles assigned to the 335th Expeditionary Fighter Squadron fly alongside Saudi Arabian Air Force F-15E aircraft during an Agile Combat Employment exercise within the U.S. Central Command area of responsibility. (September 2022)

M – A South Dakota Army National Guard medic tests the blood pressure of a woman in Suriname, South Africa. (April 2022)

N – An 81st MDG radiation therapist operates radiation equipment for a patient at Keesler Air Force Base, Miss. (August 2022)

O – The USCGC Oliver Henry (WPC 1140) gets underway from Guam for a patrol headed south to assist partner nations in upholding and asserting their sovereignty while protecting U.S. national interests. (August 2022)

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

CONTENTS

BETTER CARE

BETTER HEALTH

LOWER COST

APPENDIX

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

This annual report on the TRICARE Program is filled with important information and is a visual presentation about the current state of the program.

In the pages that follow, you will better understand who we serve, the choices our beneficiaries make in their TRICARE health plan, what health services they seek, their level of satisfaction, the quality throughout our system—whether that care is delivered in military medical facilities or in the private sector—and what this indispensable health system costs.

This report provides a window into how well we are living up to the standards we set for quality, safety, and satisfaction. The standards that we share with every Service member and military family, Active and retired, and that we commit to meeting anytime, anywhere—always.

We believe deeply in transparency, letting everyone—our patients, our leaders, our stakeholders in Congress, and the American public—know how well we are doing across a wide range of measures. This annual report delivers on that commitment and on these principles.

And this report signals our commitment to continuously get better. We use information contained in these pages to identify where we can improve, every day, every year.

I hope that this report on the state of our TRICARE Program supplies you with the information you need in assessing the value that TRICARE, and our larger Military Health System (MHS), provides to 10 million Americans who sacrifice so much on behalf of this nation.

– Telita Crosland
LTG, USA
Director, Defense Health Agency

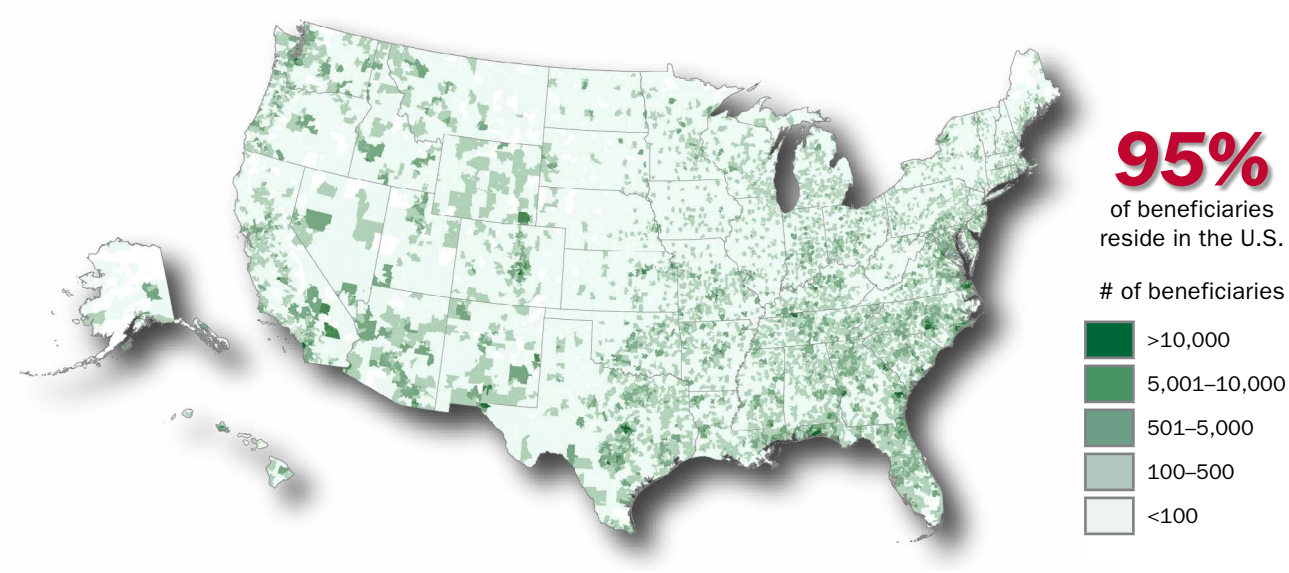
Evaluation of the TRICARE Program: Report to Congress
Executive Summary: Key Findings for FY 2022

The Defense Health Agency (DHA), a Combat Support Agency, leads the Military Health System (MHS) integrated system of readiness and health to deliver:

The Quadruple Aim

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

Beneficiary Population (pages 36–37)



95% of beneficiaries reside in the U.S.

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

Enrollment (page 34)

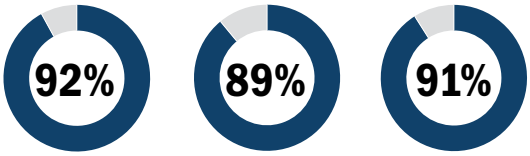
Prime Enrolled:
4.5 million beneficiaries
- ⬇ **3,100,000 Prime:** MTF PCM
- ⬇ **1,140,000 Prime:** Network PCM
- ⬇ **179,000 Prime:** Prime Remote
- ⬆ **115,000 Prime:** USFHP
- ⬇ **4,000 Prime:** TYA Prime

Select Enrolled/Non-Enrolled:
2.4 million beneficiaries
- ⬆ **1,599,000** TRICARE Select
- ⬆ **410,000** TRS
- ⬆ **376,000** Direct Care Only
- ⬇ **32,000** TYA Select
- ⬆ **20,000** TRICARE Plus
- ⬆ **13,000** TRR

Medicare-Eligible:
2.5 million beneficiaries
- ⬆ **2,118,000** TFL
- ⬆ **188,000** TRICARE Plus
- ⬆ **100,000** Direct Care Only
- ⬇ **38,000** USFHP
- = **33,000** Prime: Network PCM
- ⬇ **28,000** Prime: MTF PCM
- ⬇ **2,000** Other

** Numbers rounded to the nearest thousand; ⬆ Increase from FY 2021; ⬇ Decrease from FY 2021; = Same as FY 2021*

Readiness (pages 57–58)



Active Duty Strategic Goal: 90%

Reserve Strategic Goal: 90%

Dental Strategic Goal: 95%

COVID-19 (pages 13–23)

- Further developed and enhanced portfolio of COVID-19 tools, including COVID-19 Current Operations Dashboard
- Continued the COVID-19 Registry with more than 897,000 COVID-positive patients in the registry, and full manual data abstraction completed on 21,000 patients
- Total completed vaccination of 4,969,613

Pharmacy (page 187)

$1 billion
pharmacy retail refunds

Hospital Ratings (page 155)

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

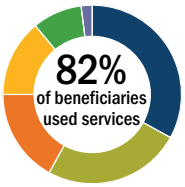
KEY FINDINGS FOR FY 2022 *(CONT.)*

Budget (page 41)

FY 2022 Expenditures → FY 2023 Budget

$55.4 B → $58.4 B

Beneficiary Categories (pages 31, 39)



- 33% Retirees and Family Members <65
- 25% Retirees and Family Members ≥65
- 17% Active Duty Family Members
- 14% Active Duty
- 9% Guard/Reserve Family Members
- 2% Guard/Reserve Members

Utilization & Expenditures (pages 44–45, 49, 54)

DIRECT CARE		PRIVATE SECTOR CARE*
↓ 16% decrease	Inpatient Care	↑ 1% increase
↓ 1% decrease	Outpatient Care	↑ 24% increase
↓ 11% decrease	Prescription Drugs	↑ 6% increase

Increase/decrease is from FY 2020 to FY 2022

* Excludes TRICARE for Life

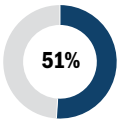
Total MHS Health Care Expenditures

Private sector care portion of total MHS health care expenditures increased from 58% in FY 2020 to 60% in FY 2022

Total Network Providers (pages 171–172)

25% ↑ increase in network **primary care providers** since FY 2018

23% ↑ increase in network **specialists** since FY 2018



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

FY 2022 MTF HEDIS Scores (page 127)

Low Back Pain Imaging	30-Day Mental Health Follow-Up	Well-Child Visits: 15 Months
78% ↓ 0.3%	**78%** ↓ 5%	**80%** ↑ 3%

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

FY 2022 Perinatal Care Measures (pages 130–131)

	MTFs	National
Elective Delivery	2.8%	2.2%
Cesarean Section	22.1%	25.4%
Exclusive Breastfeeding	61.5%	49.9%

Direct Care Hospital Ratings (page 155)

Obstetric	Surgical	Medical
65% FY 2020 → 62% FY 2022	79% FY 2020 → 77% FY 2022	77% FY 2020 → 74% FY 2022

Urgent Access (pages 72, 76–79)

In direct care, there was a **decrease** in the average number of days to third next available 24-hour (1.04 days) and future (3.36 days) appointments in FY 2022.

The rate of network urgent care visits by MTF enrollees has **continued to increase** in FY 2022. Emergency department utilization rate also slightly **increased** in FY 2022.

- **71% of beneficiaries enrolled in secure messaging** in FY 2022.
- **Over 77%** of patient messages **were responded to within one business day**.

Access Ratings (pages 81, 93)

Overall network leakage of MTF enrollees' primary care needs **decreased** from 12.6% in FY 2021 to 11.3% in FY 2022.

In FY 2022, **74%** reported via JOES they **can get care when needed** (outpatient) in direct care, a **decrease of 4 percentage points** from FY 2021.

KEY FINDINGS FOR FY 2022 *(CONT.)*

Military Health System (MHS) Worldwide Summary

- The $58.4 billion Unified Medical Program (UMP) presented in the FY 2023 Enacted President's Budget, including estimated outlays from the Medicare-Eligible Retiree Health Care Fund (MERHCF), is 5.37 percent higher than the $55.4 billion in expenditures in FY 2022 and is about 8 percent of total FY 2023 estimated Department of Defense (DoD) outlays (ref. pages 41–42).
- In FY 2022, 9.5 million beneficiaries were eligible for DoD medical care. Of those, about 4.5 million (48 percent) were enrolled in TRICARE Prime (including TRICARE Young Adult [TYA] Prime and Uniformed Services Family Health Plan [USFHP]) (ref. pages 31–32).
- TYA enrollment decreased to just under 36,000 beneficiaries in FY 2022, from about 40,000 in FY 2020, with most enrolled in TRICARE Select (ref. pages 32–33).
- In FY 2022, there were 342,256 covered lives in the premium-based TRICARE Reserve Select (TRS), an increase from the previous year (326,867 covered lives in FY 2021). Retired Reserve (TRR) had 12,365 covered lives in FY 2022, an increase from 11,519 in FY 2021 (ref. page 167).

MHS Workload and Cost Trends[1,2]

- The percentage of beneficiaries using Military Health System (MHS) services remained at 85 percent from FY 2020 to FY 2022 (ref. page 39).
- Excluding TRICARE for Life (TFL), total MHS workload (direct and private sector care combined) fell from FY 2020 to FY 2022 for inpatient care (5 percent) and prescription drugs (5 percent). Outpatient care workload increased by 13 percent over the same time period (ref. pages 44–45, 49).
- From FY 2020 to FY 2022, direct care workload decreased for inpatient care (16 percent), outpatient care (1 percent), and prescription drugs (11 percent). Over the same period, total direct care costs fell by 6 percent (ref. pages 44–45, 49, 54).
- Excluding TFL, private sector care workload increased for inpatient care (1 percent), outpatient care (24 percent) and prescription drugs (6 percent). Overall, private sector care costs rose by 14 percent (ref. pages 44–45, 49, 54).
- The private sector care portion of total MHS health care expenditures rose from 59 percent in FY 2020 to 63 percent in FY 2022 (ref. page 54).
- In FY 2022, out-of-pocket costs for MHS beneficiary families under age 65 were between $6,900 and $7,500 lower than those for their civilian counterparts, while out-of-pocket costs for MHS senior families were $3,800 lower (ref. pages 205, 210).

Lower Cost

- MHS cost avoidance/recovery includes $1 billion in retail pharmacy refunds in FY 2022 and $556 million in Program Integrity activities in calendar year (CY) 2021 (ref. page 187).

Improved Readiness

- **Force Health Protection:** At the end of FY 2022, the overall medical readiness of the Total Force and the Active Component was at 92 percent, meeting the strategic goal of 90 percent. However, the Reserve Component, at 89 percent, did not meet the goal. Dental readiness, at 91 percent, was below the MHS goal of 95 percent. The MHS surgical community is leading the way in identifying and enumerating critical clinical readiness skill sets (ref. pages 57–61).

Better Care

- **Access to Care:** Patient-Centered Medical Home (PCMH) primary care administrative measures indicate that, in FY 2022, military medical treatment facility (MTF) enrollees saw their primary care provider 51 percent of the time. In FY 2022, there was an improvement in the average number of days to third next available 24-hour (1.04 days) and future (3.36 days) appointments. Network urgent care usage increased substantially from 15.1 visits per 100 enrollees in FY 2021 to 21.4 visits per 100 enrollees in FY 2022 due to confluence of COVID-19, influenza, and respiratory syncytial virus (RSV) infections and immunizations. MTF responsiveness to secure messaging was 78 percent. The Joint Outpatient Experience Survey (JOES) shows 63 to 75 percent of MTF users in FY 2022 reported they could get care when needed. Administrative data shows that 86 percent of non-Active Duty enrollees had at least one primary care visit in FY 2022 (ref. pages 71–72, 77, 79, 86, 90).
- **Hospital Quality of Care:** MTFs and MHS civilian network hospital performance perinatal quality measures are comparable to The Joint Commission® (TJC) hospital benchmarks. MHS civilian network hospitals and inpatient MTFs are required to maintain accreditation by a recognized external accreditation organization to demonstrate compliance with national standards of care (ref. pages 129–133).
- **Outpatient Care:** In FY 2022, MTF Healthcare Effectiveness Data and Information Set (HEDIS®) rates exceed the national 90th percentile for mental health (MH) follow-up, surpass the national 75th percentile for colorectal cancer screening, and surpass the national 50th percentile for breast cancer screening and lower back pain imaging (ref. pages 122–127).
- **Beneficiary Ratings of Inpatient Care—Overall Hospital Rating:** Direct care has shown improved patient hospital ratings from FY 2020 to FY 2022, meeting or exceeding the national Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) benchmark average in the medical and surgical product lines. Ratings in the obstetric product line fell from FY 2021 to FY 2022 and are below the HCAHPS benchmark (ref. page 155).
- **Patient Safety:** The MHS direct care system is focusing on reducing Wrong-Site Surgery (WSS) Reportable Events (REs) through education and leadership engagement, with a goal of zero events. The MHS experienced a significant drop in WSS REs from 2019 to 2020 due to the pandemic and subsequently returned to and remained at 2019 levels from 2021 to 2022 as surgical volumes returned to pre-pandemic levels (ref. page 102).
- **MHS Provider Trends:** The number of TRICARE network primary care providers increased by 25 percent from FY 2018 to FY 2022, while the number of specialists increased by 23 percent. The total number of participating primary care providers increased by 10 percent and by 12 percent for specialists since FY 2018 over the same time period (ref. page 171).
- **Access for TRICARE Select Users:** Results from the FY 2022 congressionally mandated four-year survey of civilian providers show 87 percent of physicians and 51 percent of behavioral health (BH) providers accept new TRICARE patients (ref. page 172).

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

[2] By the end of FY 2022, the DoD's new electronic health record, MHS GENESIS, had been deployed at 838 military hospitals and clinics worldwide. Because RVUs and cost data are currently unavailable for outpatient care at MHS GENESIS facilities, we included estimates of those quantities in our totals for the first time this year.

WHAT IS TRICARE?

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

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

- **TRICARE Select** requires enrollment and is comparable to preferred provider organization (PPO) health plans. It features access to both network and non-network TRICARE-authorized providers. Referrals are generally not required for coverage.
  - Beneficiaries other than Active Duty Service members (ADSMs) and other than TRICARE for Life (TFL) may qualify to enroll.
  - Retirees, their families, and certain survivors must pay enrollment fees to participate.
- **TRICARE Prime** requires enrollment and is comparable to health maintenance organization (HMO) plans. Each enrollee is assigned to a primary care manager (PCM). A PCM is a health care provider who is responsible for managing an enrollee's care, promoting preventive health services (e.g., routine exams and immunizations), and arranging for specialty provider services as indicated.
  - TRICARE Prime access standards apply to the drive time to reach a provider, waiting times to get an appointment, and waiting times in provider offices.
  - TRICARE Prime's point-of-service (POS) feature offers enrollees freedom to obtain care from TRICARE-authorized providers other than their assigned PCM without a referral. However, POS deductibles and cost shares are significantly higher than TRICARE Select, and POS charges are not counted toward the enrollee's catastrophic cap.
  - **TRICARE Prime Remote (TPR)** enrollment is offered to certain Service members stationed remote from MTFs.
  - **TRICARE Prime Remote for Active Duty Family Members (TPRADFM)** enrollment is offered to qualified dependents of Service member sponsors, Active and Reserve, on Active Duty more than 30 days.
  - **Uniformed Services Family Health Plan (USFHP)** is a TRICARE Prime plan offered to non-Active Duty beneficiaries who live in one of six statutorily specified locations areas: Washington, Texas, Maine, Maryland, Massachusetts, and New York/New Jersey. Enrollees receive all services, including pharmacy, exclusively from their particular enrolled USFHP plan. Enrollees forfeit MTF services.
- **TRICARE for Life** offers wraparound coverage for TRICARE-eligible beneficiaries who have both Medicare Parts A and B, regardless of age or place of residence. Compare to Medigap policies. TFL pays secondary to Medicare for TRICARE-covered services. TFL started October 1, 2001.
- **Transitional Assistance Management Program (TAMP)** plan provides 180 days of premium-free coverage upon release from Active Duty served more than 30 days by certain Service member sponsors, Active or Reserve.
- **Other plans and programs:** Some beneficiaries may qualify for the following depending on their location, Active/Reserve status, and/or other factors:
  - Premium-based health plans, including:
    - **TRICARE Young Adult (TYA)** is available for purchase by qualified former dependent children up to the age of 26. They may choose TRICARE Prime, where offered locally, or TRICARE Select coverage. Cost-sharing level is dependent upon sponsor status.
    - **TRICARE Reserve Select (TRS)** is available for purchase by qualified Selected Reserve members and qualified survivors. TRS delivers TRICARE Select coverage with cost sharing at the Active Duty Family Member rate.
    - **TRICARE Retired Reserve (TRR)** is available for purchase by qualified Retired Reserve members with cost sharing at the retiree rate.
    - **TRICARE Dental Program (TDP)** is available for purchase by family members of ADSMs as well as Ready Reserve members and their family members.
    - **Continued Health Care Benefit Program** is comparable to Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage.
    - **Federal Employees Dental and Vision Insurance Program (FEDVIP)** offers dental plans for purchase by retirees, and offers vision plans for purchase by most non-Service member beneficiaries enrolled in a TRICARE health plan. FEDVIP is operated by the U.S. Office of Personnel Management, not DoD.
- **Other benefits and services, including:**
  - Dental benefits (DTFs and claims management for Active Duty using civilian dental services)
  - Pharmacy: MTFs, TRICARE retail network pharmacies, and TRICARE Pharmacy Home Delivery program
  - Overseas private sector care, customer service, and claims processing services
  - Women, Infants, and Children Overseas Program (www.tricare.mil/wic)
  - Extended Care Health Option (ECHO): nonmedical benefits available to qualified Active Duty family members with special needs (www.tricare.mil/echo).

MHS PURPOSE, MISSION, VISION, AND STRATEGY

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

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

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

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

MHS QUADRUPLE AIM—STRATEGIC DIRECTION AND PRIORITIES

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

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

MHS QUADRUPLE AIM

DHA VISION AND MISSION FOR FYs 2021–2022

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

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

Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA]) Intent

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

DHA Director's Intent and the MHS Transformation

The DHA's priority effort continues to be the implementation of the provisions of National Defense Authorization Act (NDAA) FY 2017, section 702. In October 2019, the DHA undertook administration and management of all MTFs within the contiguous United States (CONUS). The DHA was establishing a Market-based structure to manage the hospitals and clinics within a region. The Deputy Secretary of Defense paused the MTF transition in early 2020 to allow the Military Medical Departments (MILDEPs) and the DHA to focus on the COVID-19 pandemic response efforts. In December 2020, the DHA resumed the transition, which was scheduled to be completed in October 2022. In July 2022, the MHS Executive Review Committee, chaired by OUSD(P&R), directed a study of the MHS to determine if it was appropriately funded. The results of the study will determine the most optimal infrastructure and operating model to efficiently execute the DHA's mission.

Phased Implementation of NDAA FY 2017, Section 702

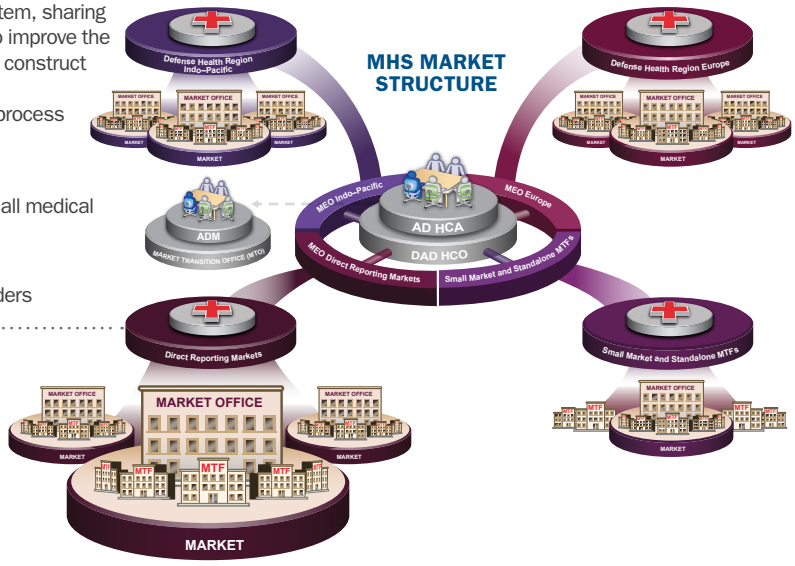
MHS Market Construct Overview

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

At the center of this organizational design is the health care Market. A Market is a group of MTFs in a geographic area that operate as a system, sharing patients, providers, functions, and budgets across facilities to improve the coordination and delivery of health care services. This market construct stand up is a criteria-based and data driven model that expands on the existing eMSM concept in order to drive process standardization, reduce variability, and generate efficiencies.

A Market will:

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



Market Benefits

READINESS

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

PATIENT EXPERIENCE

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

STAFF EXPERIENCE

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

RESOURCES

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

RESOURCES

Market Information

Transition MilSuite Site

DHA Launchpad

Core Market Functions

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

CLINICAL

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

ADMINISTRATIVE

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

EXECUTIVE SUPPORT

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

ANALYTICS

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

Our Definition of Success

GREAT OUTCOMES

Our most important outcome is a medically ready force

READY MEDICAL FORCE

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

SATISFIED PATIENTS

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

FULFILLED STAFF

Our staff feel joy and purpose working in the MHS

MHS PERFORMANCE MANAGEMENT

Governance

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

MHS Governance is composed of three councils and one board. The Council of Colonels and Captains, chaired by the Director for MHS Governance, acts as an intake point for all governance topics. Once vetted by the Council, issues are presented to the Deputy Military Medical Action Council (DMMAC), chaired by the Principal Deputy ASD(HA). Issues that cannot be resolved by the DMMAC are elevated to the Senior Military Medical Advisory Council (SMMAC), chaired by the ASD(HA). The SMMAC serves as an advisory council to the ASD(HA). When a decision cannot be made by the SMMAC, the ASD(HA) brings these concerns or issues to the MHS Executive Review Board. The Deputy Secretary of Defense (DSD) also has a governance structure to elevate MHS topics. The Workforce Management Group (WMG), chaired by the USD(P&R), receives regular updates on issues concerning MHS performance and MHS transformation. Once topics are addressed at the WMG, they are then briefed at the Deputy's Workforce Council (DWC), chaired by the DSD. Decisions are made and actions are tasked by the DWC to senior leaders of the MHS and their stakeholders to improve the policy, processes, and performance of the MHS.

Monitoring Strategic Performance

The ASD(HA) began building and testing a set of measures in FY 2021 to provide concise insight to senior DoD leadership and policymakers. The set of measures balances need for robust information with clarity. These measures align to the MHS Quadruple Aim to help target improvement across MTFs, the private sector care network, and military medical operations. The DSD endorsed a set of 10 measures that are reported on quarterly.

- Deployment Limiting Medical Conditions
- Access to Primary Care for ADSM
- Access to Specialty Care for ADSM
- Overall Health (Health-Related Quality of Life [HRQOL])
- Surgical Morbidity (National Surgical Quality Improvement Program [NSQIP])
- Satisfaction with Health Care
- Value of MTFs as Readiness Platforms
- MTF Personnel Availability
- Year-to-Date Budget Execution and Projection
- Knowledge, Skills, and Abilities Generated and Achieved

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

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

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

MHS PERFORMANCE MANAGEMENT *(CONT.)*

Monitoring Strategic Performance *(cont.)*

CASCADING PERFORMANCE MANAGEMENT

Tactical KPIs

Tactical KPIs are managed by the Market Directors and Assistant Director for Health Care Administration. They are key drivers of operational KPIs within the Market's control.

Operational KPIs

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

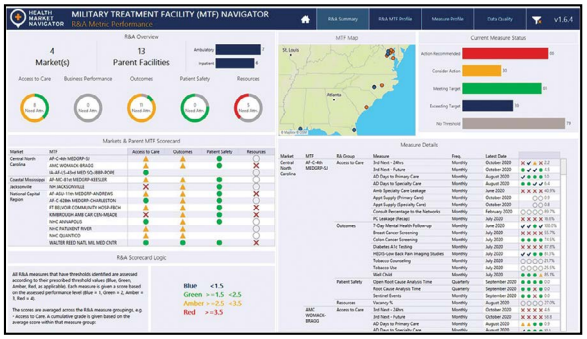
Strategic KPIs

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

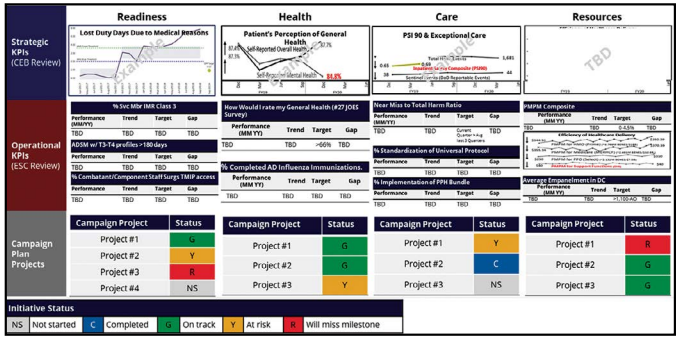
OSD Oversight

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

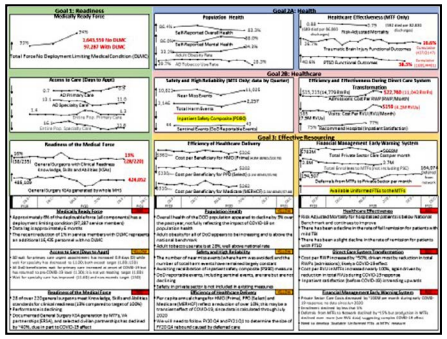
Market Dashboard



DHA Campaign Plan Dashboard (In Development)



ASD(HA) Dashboard



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

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

Campaign Plan Initiatives and Projects

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

Oversight Measures

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

Management and Execution | **Oversight**

MHS PERFORMANCE MANAGEMENT *(CONT.)*

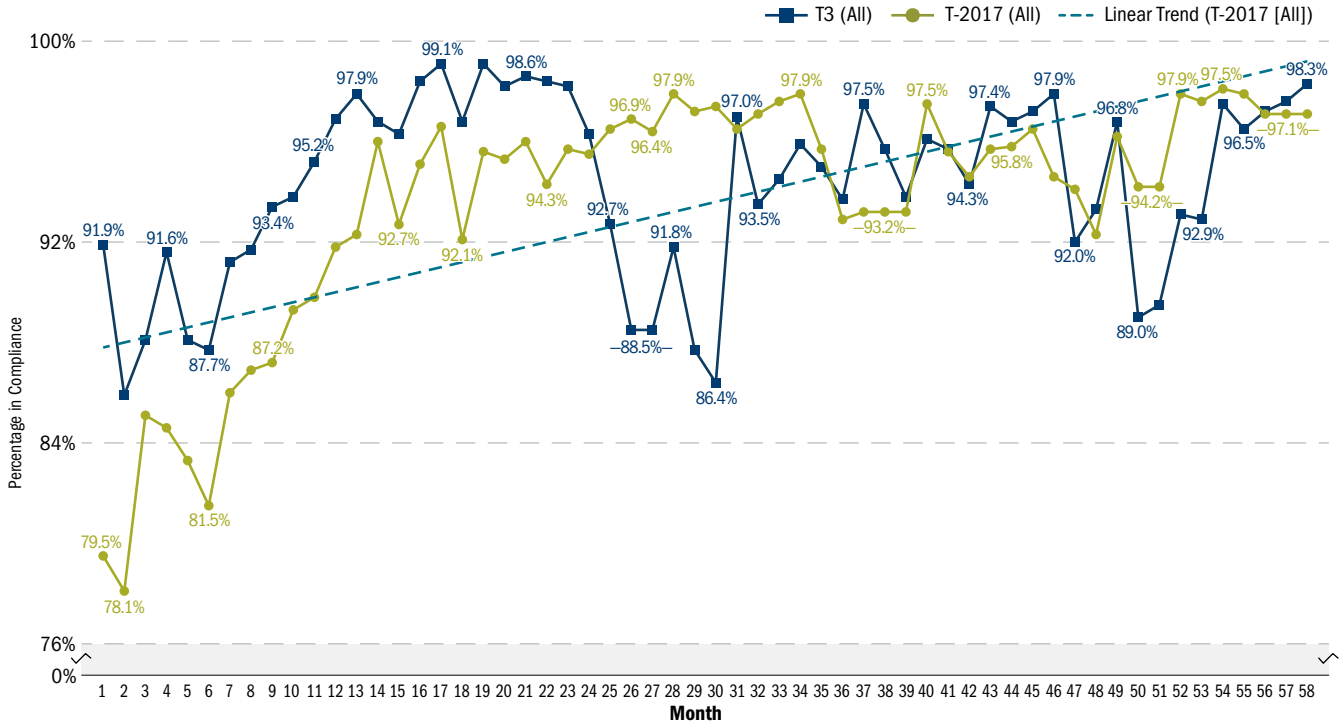
Private Sector Care Performance Management

To better synchronize clinical quality monitoring across the MHS, and compare data outcomes and promote system integration, direct and private sector care continue to collaborate to align clinical quality metrics where possible within current and future contracts. Ongoing combined direct and private sector quality data reviews during Clinical Quality Summits offer useful information and recommendations for updating health care performance data monitored across the enterprise. A joint effort between direct care and the private sector continues to improve the accuracy and completeness of enterprise Healthcare Effectiveness Data and Information Set (HEDIS) metrics. This work will lead to increased transparency and efficient and effective mechanisms to acquire, process, report, and store clinical data necessary for assessing and improving the quality of health care delivery to TRICARE beneficiaries.

The TRICARE (T2017) contractors started health care delivery on January 1, 2018. In comparing T2017 contract performance with the previous generation of TRICARE contract (T3) during the first 47 months of performance and after some initial challenges, T2017 compliance was similar to T3 across more than 20 contract requirements in seven critical areas. In FY 2020, T2017 compliance steadily improved and exceeded performance under T3 in months 24–35. In FYs 2021 and 2022, significant outages and challenges with the Defense Enrollment Eligibility Reporting System (DEERS) and DEERS Online Enrollment System impacted both contractors' performance related to customer service and call center requirements. Both received waivers from the contract standards for the affected performance periods.

In the fifth year of T2017 performance, the contractors' performance overall is stable. The managed care support contractors (MCSCs) continue to experience challenges meeting the standard for provider directory accuracy, but both improved their directories and maintain accuracy rates of 80 percent. In the East Region, Humana Military continues to work on improving claims systems and processing.

PERCENTAGE OF CONTRACTS IN COMPLIANCE, OPTION PERIODS 1 THROUGH 5



Source: Requirements from the Contract Quality Assurance Surveillance Plan, 11/17/2022

MHS PERFORMANCE MANAGEMENT *(CONT.)*

Private Sector Care Performance Management *(cont.)*

In FY 2022, DHA continued numerous value-based demonstrations and pilots to meet the requirements of NDAA FY 2016, Section 726 and NDAA FY 2017, Sections 701(h), 704(a), 705(a), and 729 (a)(b) and (c). These projects included the Medication Adherence Demonstration, Low Back Pain (LBP) and Physical Therapy (PT) Demonstration, the Accountable Care Organization (ACO) Demonstration, and the Buckley Prime Service Area (PSA) Pilot. A new project, the Child Birth and Breast Feeding Support Demonstration, began in FY 2022. This nationwide initiative is designed to measure maternal and fetal outcomes for beneficiaries who receive support services from doulas and/or lactation counselors/consultants, as compared with those who do not.

The Medication Adherence demonstration, launched nationwide January 1, 2018, was designed to reduce or eliminate copayments for high-value drugs to encourage patient adherence to these medications. This program impacted approximately 136,000 users per quarter with a copayment savings for users of approximately $4.9 million per year.

DHA started a three-year LBP and PT demonstration January 2021 in 10 states: Arizona, California, Colorado, Florida, Georgia, Kentucky, North Carolina, Ohio, Tennessee, and Virginia. The demonstration will test whether incentivizing participation in PT by waiving copayments will increase the use of appropriate PT services and reduce potentially unnecessary and harmful care to the beneficiary, such as unnecessary imaging, surgery, and opioid prescribing. Moreover, by incentivizing the use of PT, DHA may see a decrease in the overall cost of care for participating beneficiaries and a reduction in the number of beneficiaries who transition from acute to chronic LBP.

In January 2020, DHA implemented a three-year ACO Demonstration in the Atlanta, Ga., PSA in partnership with Humana Government Business (HGB) and Kaiser Permanente (KP). Enrollment in the ACO Demonstration was offered to TRICARE Prime and Select members during the 2019 Open Enrollment Season. The DHA implemented the demonstration to evaluate value-driven initiatives to move from a volume-based reimbursement system to a value-based reimbursement system for health care services. The ACO Demonstration ended in December 2022 and a program evaluation is underway.

In January 2021, DHA implemented a two-year Buckley Space Force Base (SFB) PSA pilot in partnership with Health Net Federal Services (HNFS) under the T-2017 West region contract. The pilot ended in December 2022. During the two years of the pilot, the DHA and HNFS explored alternative payment models (APMs) with providers in the PSA and gathered knowledge through initiatives designed to improve beneficiary access to care, beneficiary and provider satisfaction, and quality of care. Lessons learned from the pilot will drive future TRICARE value-based care models.

DHA implemented Medicare's Hospital Value-Based Purchasing (HVBP) program on January 1, 2020. The HVBP program provides incentives to hospitals that show improvement in areas of health care delivery, process improvement, and increased patient satisfaction. The program offers incentive payments based on the hospital's Total Performance Score. TRICARE hospitals are not subjected to any additional reporting, as they are already participating in the Medicare HVBP program.

The value-based project Performance-Based Maternity Payment Pilot, launched in FY 2018, has been completed. The pilot was designed to provide incentives to hospitals that achieve and maintain excellence in maternity care quality. Data from this pilot are currently being analyzed.

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

MHS RESPONSE TO COVID-19 PANDEMIC

COVID-19 Registry

The DHA established the COVID-19 Registry to provide a centralized DoD COVID-19 data collection platform to support clinical performance improvement. The purpose of the COVID-19 Registry is to (1) support clinical performance improvement for COVID-19 casualties, which requires detailed information verified and coded by registrars (for example, tracking the hospitalization of patients who receive outpatient medications compared to those with similar risk factors who do not); and (2) track the epidemiology of disease, which requires large quantities of synchronized data, such as identifying the vaccine breakthrough rates among the DoD population.

As of November 29, 2022, there were more than 897,000 COVID-positive patients in the registry, and full manual data abstraction had been completed on 21,000 patients, with data automation applied to improve the ability to rapidly track trends for all patients. Registry records currently include patients treated in the direct care system only. The COVID-19 Registry does not include detailed data on all COVID cases in the DoD. Due to a large population needing abstraction into the Registry, the Joint Trauma System (JTS) developed a list of patient abstraction priorities.

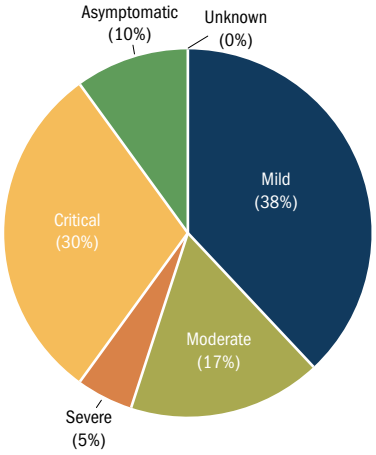
Patients are abstracted into the COVID-19 Registry in the following order:

1. All inpatients
2. Vaccine breakthrough cases
3. Outpatient treatment recipients
4. Persistent viremia and possible second infection
5. Multisystem inflammatory syndrome in children (MISC)
6. Burn-pit exposed patients
7. Other outpatients

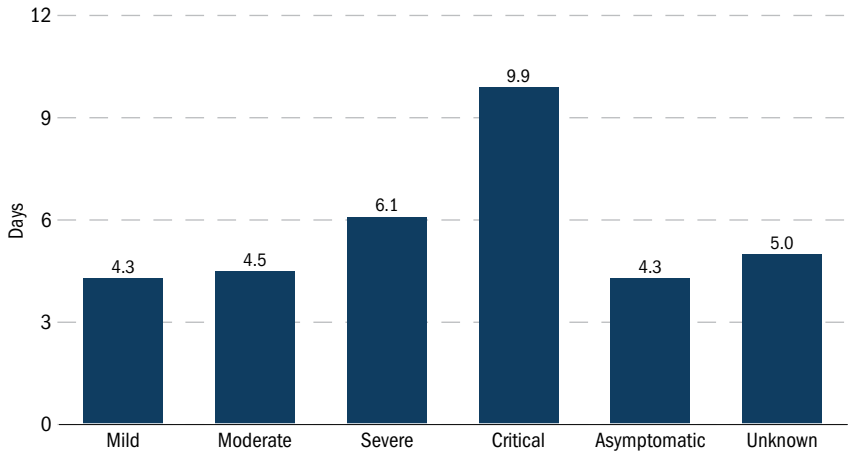
COVID-19 Registry Data Overview, February 2020–November 2022

Determining COVID-19 illness severity requires the detailed information provided by the registry.

SEVERITY OF HOSPITALIZED PATIENTS, 2022



AVERAGE HOSPITALIZATION DAYS BY SEVERITY, 2022



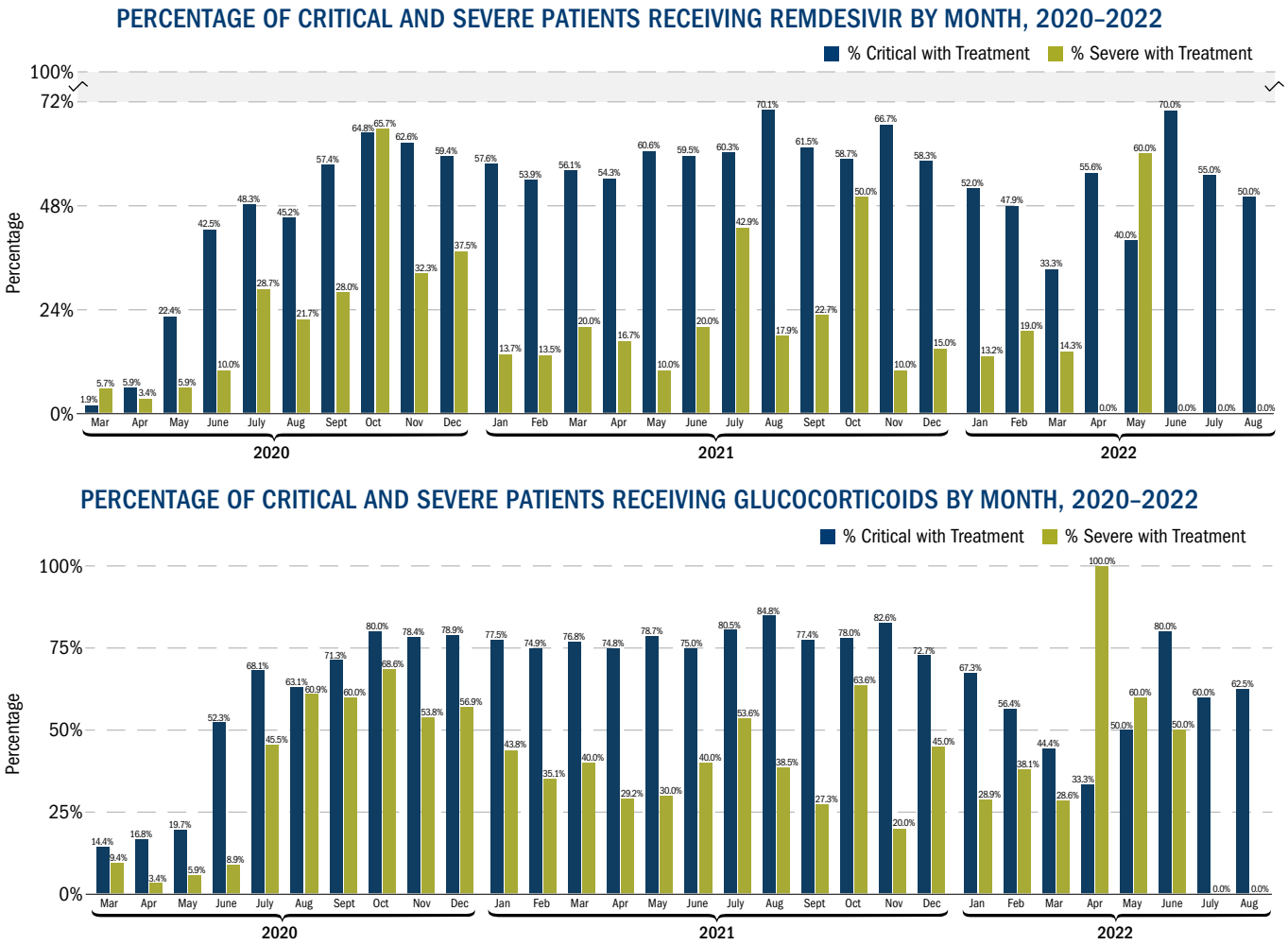
Source: DHA Combat Support, JTS/COVID-19 Registry, 11/3/2022
Note: N=20,567 total patients in registrar-abstracted population with detailed chart review from February 2, 2020–November 3, 2022

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

COVID-19 Registry *(cont.)*

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

2020–2022 Critical and Severe Patients Receiving Remdesivir and Glucocorticoids



Source: DHA Combat Support, JTS/COVID-19 Registry, 11/3/2022

Note: N=20,567 total patients in registrar-abstracted population with detailed chart review from February 2, 2020–November 3, 2022

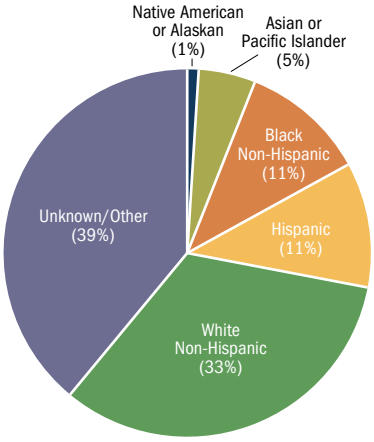
MHS RESPONSE TO COVID-19 PANDEMIC *(CONT.)*

COVID-19 Registry *(cont.)*

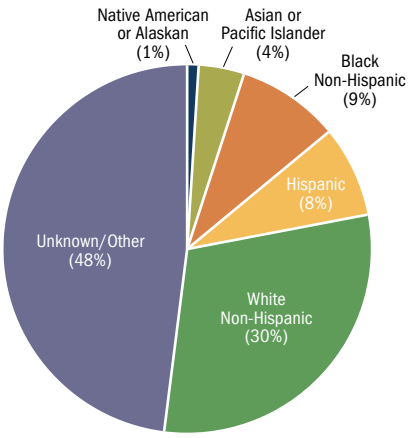
Overview of Race/Ethnicity of COVID Patients

There is a slightly higher incidence of COVID-19 positive compared with negative for Hispanic, Black, and White non-Hispanic ethnicities within the DoD population tested in the direct care system. The Unknown/Other percentage is per DEERS documentation. (See Race/Ethnicity of COVID-Positive/-Negative Patients below.) Within the registrar-abstracted population, there was no significant difference detected for average age, average intensive care unit (ICU) days, and average days from positive COVID tests to hospitalization for any ethnicity.

RACE/ETHNICITY OF COVID-POSITIVE PATIENTS, 2022

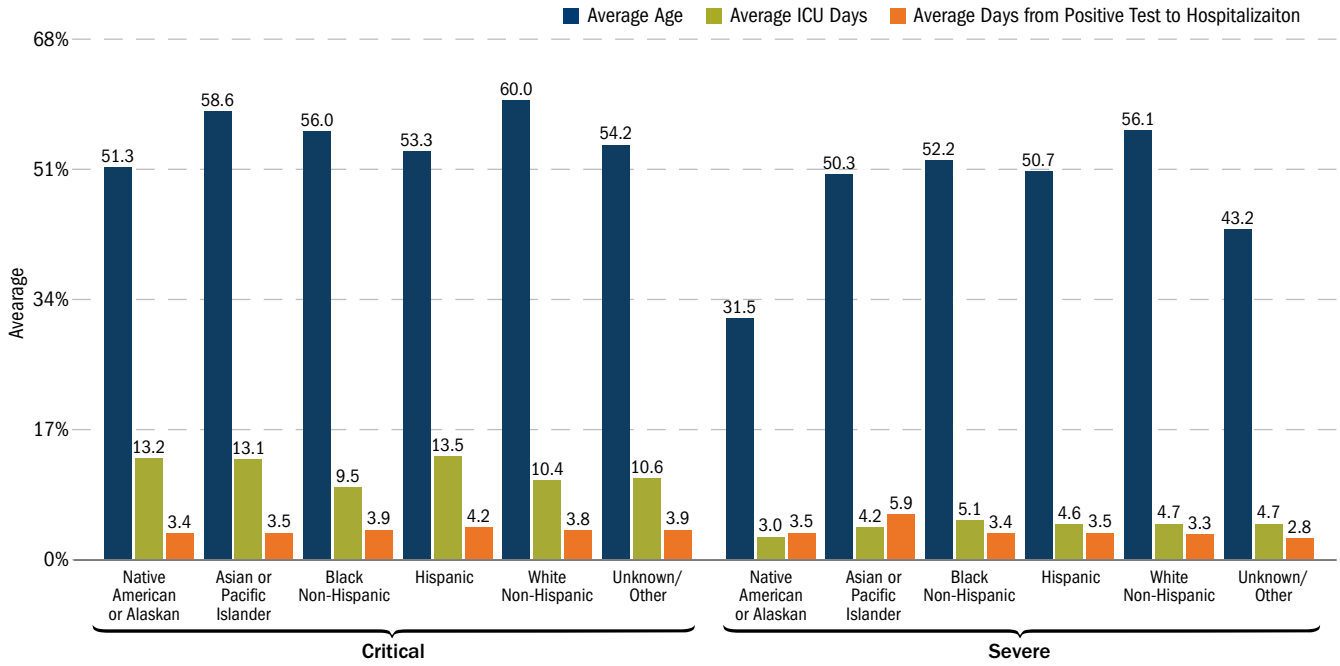


RACE/ETHNICITY OF COVID-NEGATIVE PATIENTS, 2022



Source: DHA Combat Support, JTS/COVID-19 Registry, 11/3/2022
Note: Patients treated in the direct care system February 2, 2020–November 3, 2022

AGE, SEVERITY, AND HOSPITALIZATION, BY RACE, 2022



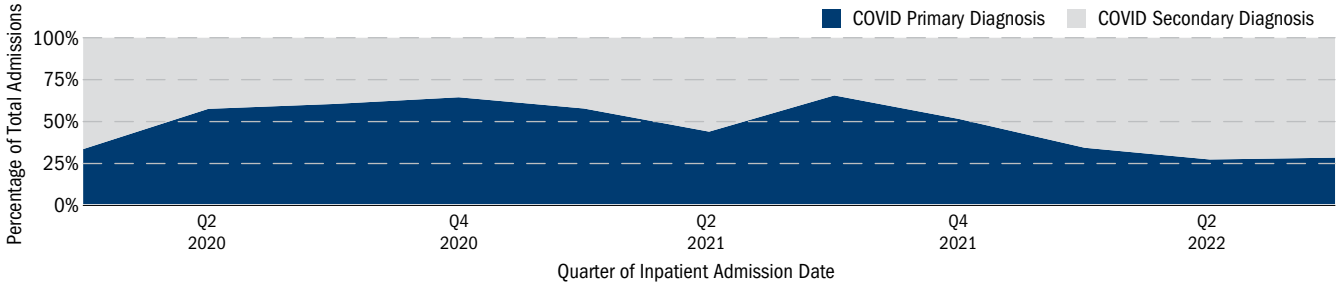
Source: DHA Combat Support, JTS/COVID-19 Registry, 11/3/2022
Note: N=20,567 total patients in registrar-abstracted population with detailed chart review from February 2, 2020–November 3, 2022

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

COVID-19 Registry *(cont.)*

COVID-19-Related Hospitalizations: Admissions with COVID-19 as the Primary vs. Secondary Diagnosis

A total of 17,016 COVID-positive DoD beneficiaries were admitted to the hospital during the pandemic, including both direct and private sector care. This graph shows the percentage with COVID as the primary diagnosis (admitted "for" COVID in blue) compared with those with COVID as the secondary diagnosis (admitted "with" COVID in gray).



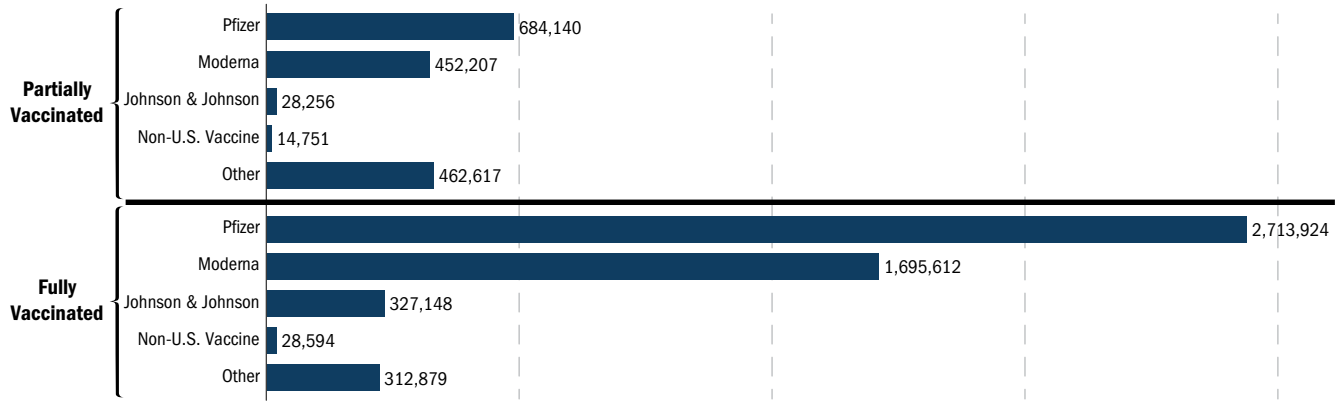
Vaccination and Vaccine Breakthrough Cases, by Manufacturer

TOTAL COMPLETELY VACCINATED	
Boosted	41,837
Non-Boosted	4,927,776

VACCINE BREAKTHROUGH SUMMARY

	INPATIENT	GRAND TOTAL
Fully Vaccinated	2,002	361,567
Partially Vaccinated	441	85,672

VACCINES BY BRAND AND DOSE SEQUENCE



Source: DHA Combat Support, JTS/COVID-19 Registry, 11/3/2022

The COVID-19 registry tracks vaccination and vaccine breakthrough cases using MHS Information Portal (MIP) data. As of November 3, 2022, almost 5 million patients were fully vaccinated (defined as having both doses of the Pfizer or Moderna series, or single dose of the Johnson & Johnson vaccine, plus 14 days after the final vaccination). Boosted patients are those who have received a dose of vaccine over the series count at least 30 days after the initial vaccine series. Breakthrough cases are defined as any new cases of COVID-19 that are confirmed by PCR lab test greater than 14 days after the administration of the final (or only) dose in the vaccine series. Over 2 million patients were vaccinated using the Pfizer series. The cumulative breakthrough rate for all fully vaccinated patients is 6.97 percent, with the highest breakthrough rate being 9.87 percent for those who received the Johnson & Johnson vaccine.

COVID-19 Registry Timeline

The COVID-19 Registry is temporarily housed in the DoD Trauma Registry platform because it was most readily available. The enduring COVID Registry capability is being built within the MIP and will support manual and automated electronic health record (EHR) data mapping. Transition to MIP via Initial Operational Capability (IOC) is projected to be completed in FY 2023 Q1. The Registry dashboard prototype is established and capable of expanding to incorporate more demographics as well as performance improvement indicators and outcomes.

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

COVID-19 Vaccine Administration

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

The DHA has rapidly gotten vaccines into arms with minimal waste throughout vaccine administration. By actively tracking vaccine administration, the DHA closely monitors breakthrough cases and adverse reactions, enabling leaders to have visibility of vaccine safety and efficacy. An agile team was required to respond to the evolving COVID-19 climate to develop scalable, intuitive views with powerful data visualizations, statistical models, and machine learning algorithms. The DHA J-5 team was able to help agency leaders understand trends and make informed decisions backed by data. To date, the DoD has administered more than 6.7 million doses of the COVID-19 vaccine, with 98 percent of the Active Duty population vaccinated, compared with 91.1 percent of adults fully vaccinated across the U.S.

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

As the COVID-19 pandemic persists, the MHS response continues to be agile and focused. The MHS monitors COVID-19 progression and provides leadership with early indicators, enabling MHS leadership to make critical decisions while maintaining the health and safety of all DoD beneficiaries and the communities MHS serves.

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

Overview of Private Sector Care during the COVID-19 Pandemic

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

- TRICARE aligned with the Families First Coronavirus Response Act and the Coronavirus Aid, Relief, and Economic Security (CARES) Act, including waiving cost-sharing associated with medically necessary testing. TRICARE aligned as a matter of policy with what the rest of the industry was required to do
- Provider licensing flexibility during the national emergency
- Ensured that beneficiaries would have coverage under the medical program for investigational new drugs, like monoclonal antibodies and COVID Convalescent Plasma (CCP)
- Changes that ensured appropriate reimbursement of health care facilities during the national emergency and Department of Health and Human Services' Public Health Emergency
- Addition of COVID-19 clinical trials sponsored by the National Institute of Allergy and Infectious Diseases (NIAID) during the national emergency
- Waived certain acute care hospital requirements for temporary hospitals and freestanding ambulatory surgery centers that enroll with Medicare's Hospitals Without Walls initiatives to ensure patients had access to acute care facilities
- Expanded access for overseas telehealth
- Made coverage of certain telephonic office visits permanent
- Added permanent coverage of certain telephonic monitoring services and supplies
- Waived the Skilled Nursing Facility three-day hospital stay prior to admission during the national emergency
- Clarified that TRICARE coverage of Food and Drug Administration (FDA)-approved drugs includes drugs with an emergency use authorization
- Clarified coverage of behavioral telehealth, specifically intensive outpatient programs, medication assisted treatment, opioid treatment programs, and certain other behavior health care that may be covered when rendered via telehealth
- Allowed coverage of Applied Behavior Analysis (ABA) parent or caregiver guidance services delivered via telehealth

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

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

Intentions to Vaccinate by Beneficiary Characteristics and Beliefs

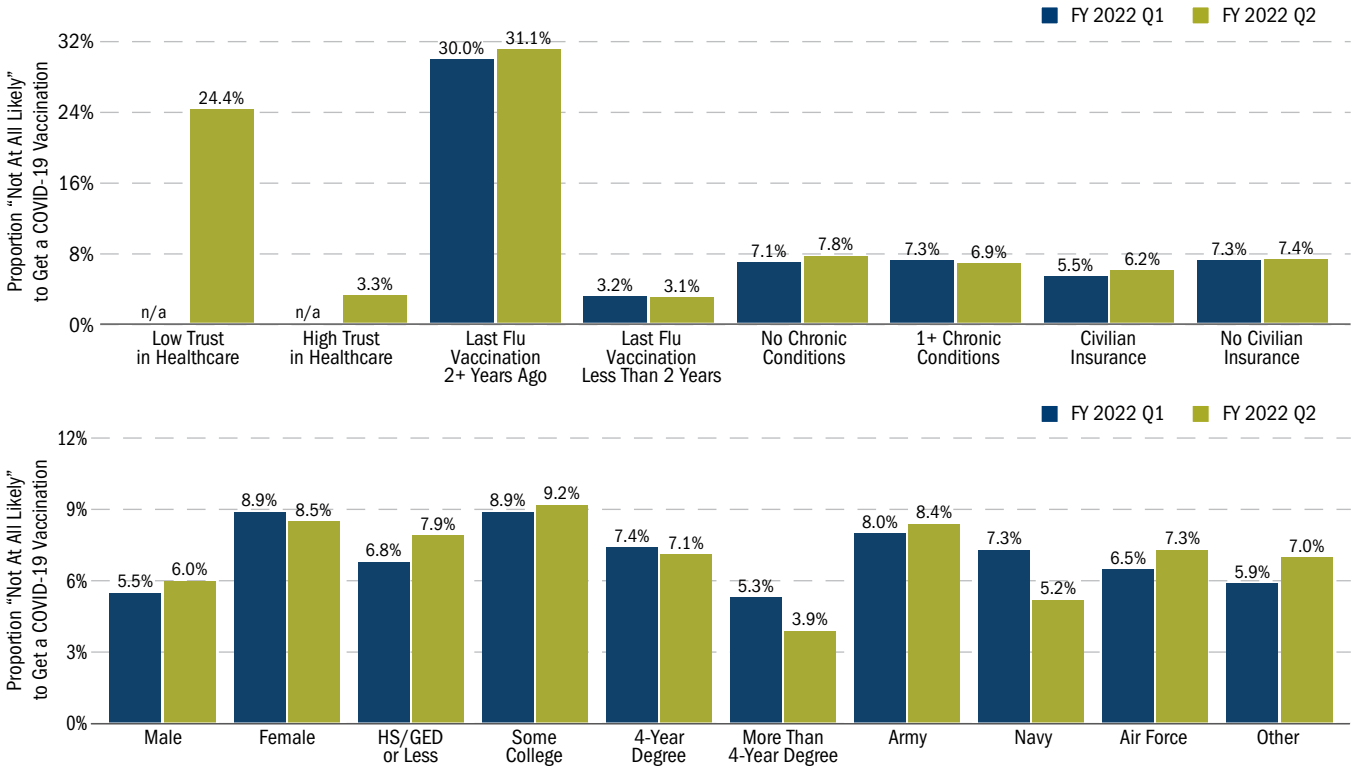
This analysis examines changes in intentions to vaccinate for COVID-19 over time and differences in vaccination beliefs among TRICARE beneficiaries from the FY 2022 Quarter 1 (Q1) and Quarter 2 (Q2) Health Care Survey of DoD Beneficiaries (HCSDB).

Vaccine intentions were measured with questions about actual vaccination status and if unvaccinated, with the question "How likely are you to get vaccinated?" Response options of "very likely" and "somewhat likely" were counted as intending to vaccinate. A response of "not at all likely" was counted as not intending to vaccinate. Results are based on 8,065 completed FY 2022 Q1 surveys and 7,913 FY 2022 Q2 surveys and are weighted to match the TRICARE beneficiary population characteristics. The Q1 survey was conducted between January and March 2022, and the Q2 survey was conducted between March and May 2022. These surveys were conducted after Secretary of Defense Lloyd J. Austin III issued a memo directing mandatory COVID-19 vaccinations for all uniformed Service members on August 24, 2021.

Overall, vaccine refusal intentions decreased from 18 percent in FY 2021 Q2 to 15 percent in FY 2021 Q3 to 8 percent in both FY 2022 Q1 and Q2. This decrease was driven by increased vaccinations among service members following the vaccination mandate in August 2021. Personal beliefs, such as trust in the health care system, were strongly associated with intentions to vaccinate, as was having a recent flu vaccination.

Examining the rate of COVID-19 vaccination refusal among demographic characteristics in the FY 2022 Q1 to FY 2022 Q2 surveys found several trends. There were few differences by having a chronic condition or civilian insurance. Women were more likely to refuse a COVID-19 vaccination, but this was driven by men being more likely to be Service members with a vaccination mandate. Education was also related to vaccination with those with some college most likely to refuse vaccination and those with more than a four-year degree least likely to refuse vaccination. Older beneficiaries were least likely to refuse vaccination. Asian, Black, and Hispanic beneficiaries were also less likely to refuse vaccination. Among beneficiary categories, family of ADSM and Reservists were most likely to refuse vaccination. Among health plan options, those with a military PCM or Medicare were least likely to refuse vaccination. Those who were overseas were also much less likely to refuse vaccination. Several of these factors are driven by the high proportion of ADSM who have a vaccination mandate in these categories, such as having a military PCM or being overseas.

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



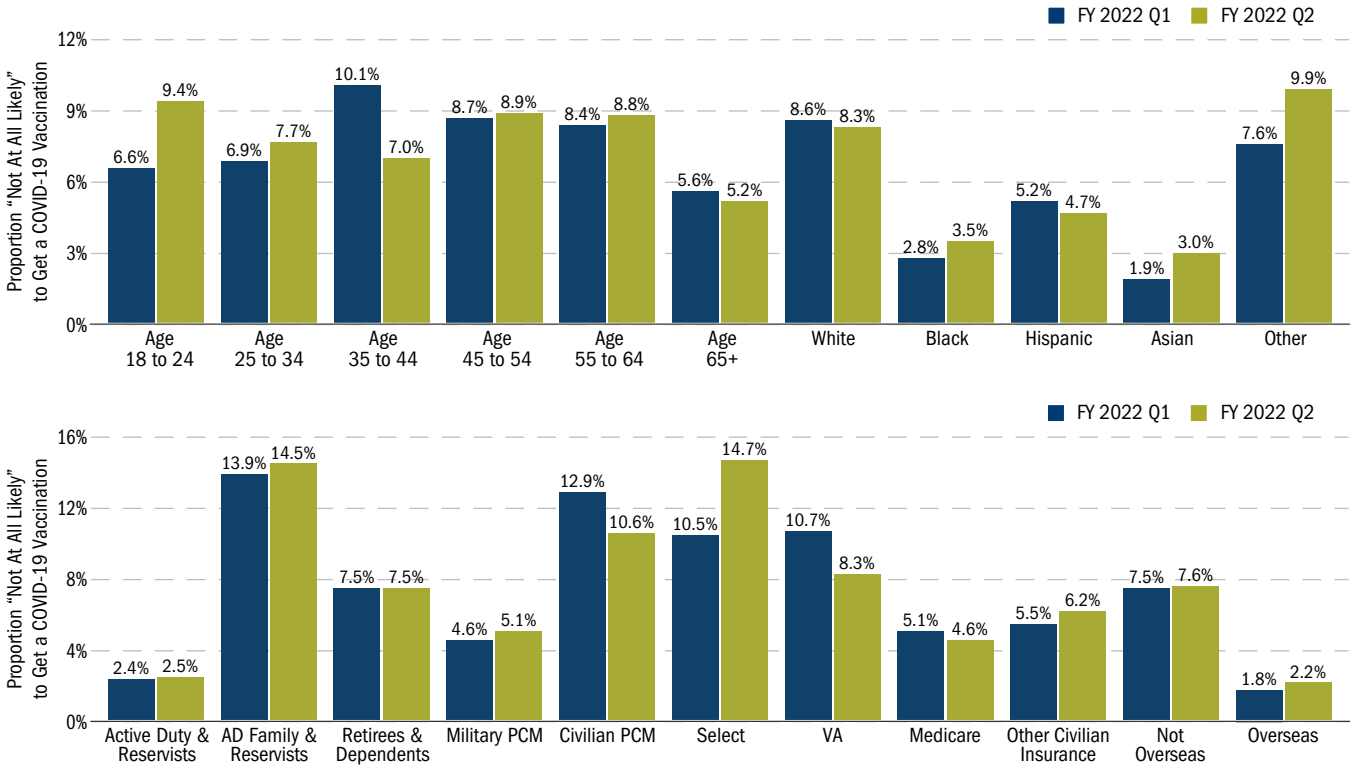
Source: DHA/Strategy, Plans, and Functional Integration (SP&FI) (J-5)/Analytics and Evaluation Division, HCSDB data, 8/20/2022

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

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

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

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



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, 8/20/2022

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

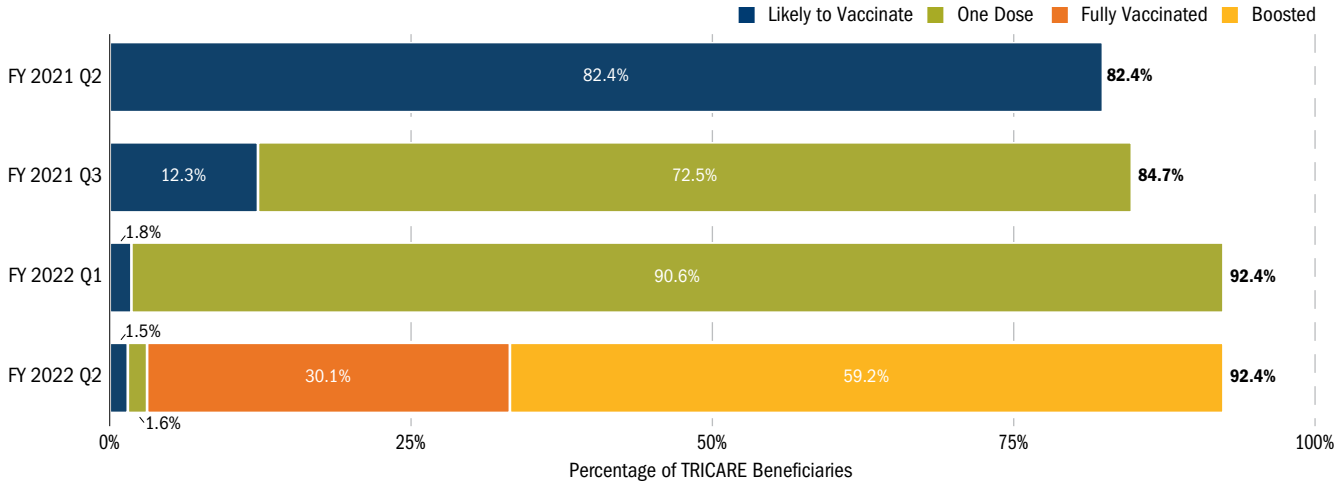
MHS RESPONSE TO COVID-19 PANDEMIC *(CONT.)*

Vaccination Status for COVID-19 among TRICARE Beneficiaries

From FY 2021 Q2 through FY 2022 Q1, the HCSDB included several questions about COVID-19 vaccination status, beliefs, and experiences related to COVID-19.

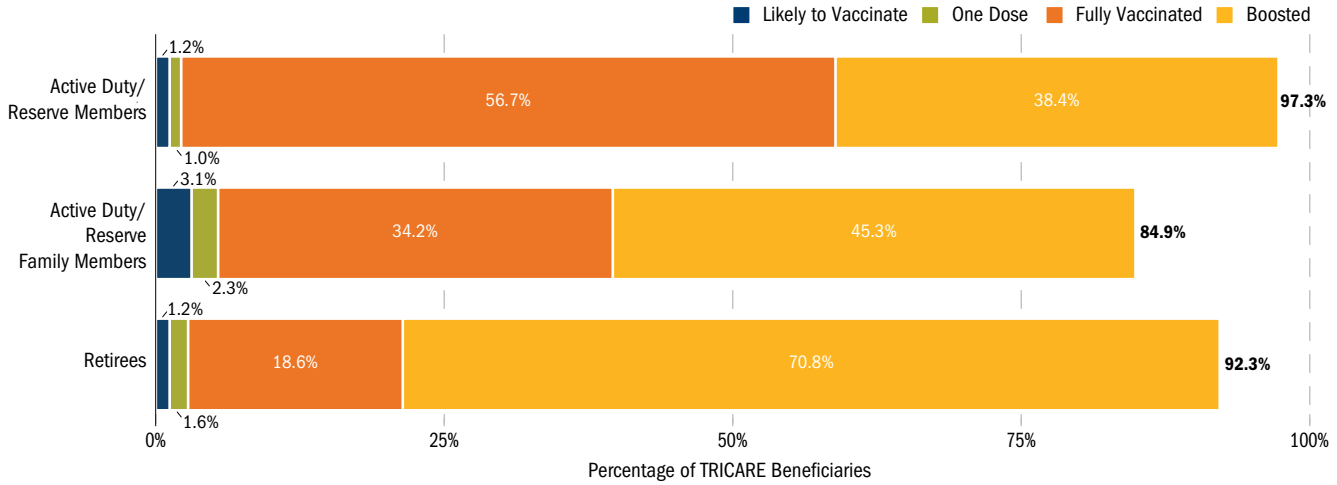
In FY 2021 Q2, vaccinations were not yet publicly available, and the survey asked about intention to vaccinate. At that time, 82.4 percent of TRICARE beneficiaries intended to vaccinate for COVID-19. By FY 2021 Q3, public vaccination had started, and the survey included a question about receiving at least one dose of vaccination. At that time, 84.7 percent had either receive a dose or intended to. At the next survey in FY 2022 Q1, the vaccination mandate for Service members had come into force; 92.4 percent of beneficiaries had received a vaccination or intended to. At FY 2022 Q2, the survey included options for full vaccination and receiving a booster. The same proportion was vaccinated or intended to (92.4 percent) as the prior quarter. Nearly all of these were fully vaccinated and 59.2 percent had also received the booster.

COVID-19 VACCINATION STATUS OF TRICARE BENEFICIARIES OVER TIME, HCSDB



Using the FY 2022 Q2 HCSDB survey data, vaccination status by beneficiary category was examined. These results shows Active Duty and Reserve were most likely to be vaccinated or intending to (97.3 percent), followed by Retirees (92.3 percent), and then Active Duty/Reserve Family Members (84.9 percent). Service members had a mandate for COVID-19 vaccination. Retirees were most likely to be boosted (70.8 percent), while Service members were least likely to be boosted (38.4 percent).

COVID-19 VACCINATION STATUS BY TRICARE BENEFICIARY CATEGORY, HCSDB, FY 2022 Q2



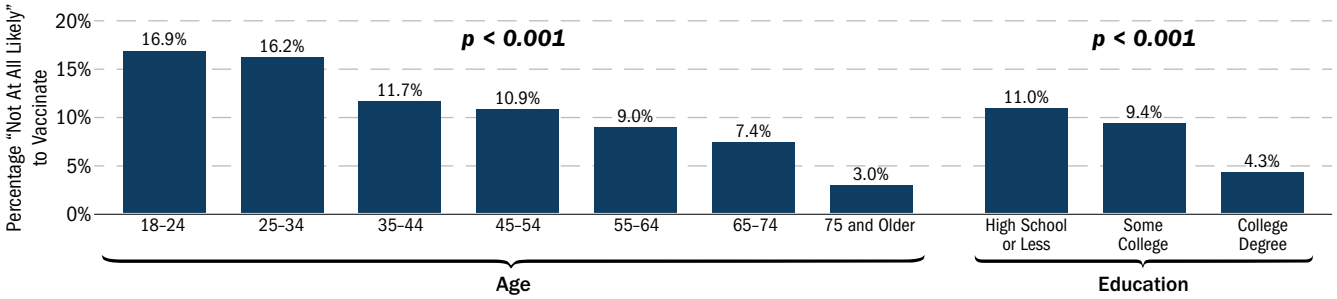
Source: DHA/SP&FI (J5)/Analytics and Evaluation Division, HCSDB data, 12/20/2022
Note: Numbers may not sum to bar totals due to rounding.

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

Vaccination Status for COVID-19 among TRICARE Beneficiaries *(cont.)*

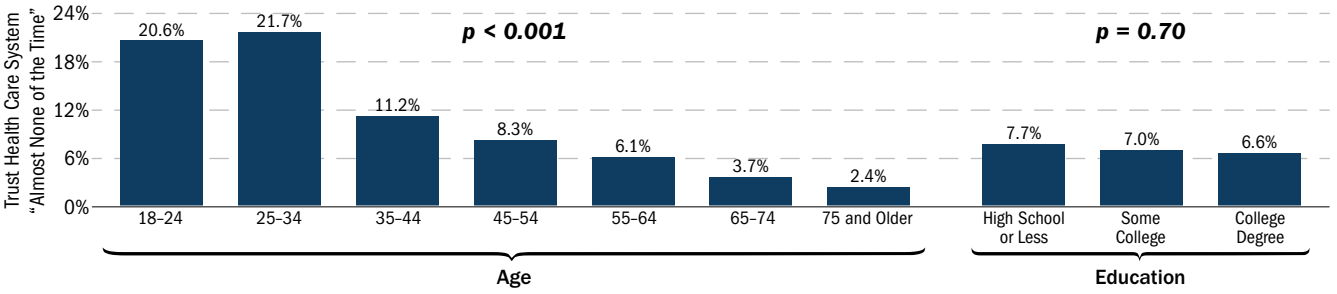
Several demographic comparisons were made among those who said they were "not at all likely" to vaccinate. These comparisons were made among dependents and retirees because Service members were mandated for vaccination. The two demographic variables with the largest differences in vaccination intent were age group and education (both $p < 0.001$). Beneficiaries under the age of 35 were five times as likely to say they will not be vaccinated (16.5 percent) than those over the age of 75 (3.0 percent). Those with a high school degree or less were almost three times as likely to say they will not vaccinate (11.0 percent) than those with a college degree (4.3 percent).

LIKELIHOOD TO NOT VACCINATE, BY AGE AND EDUCATION, NON-SERVICE MEMBERS, HCSDB, FY 2022 Q2



A prior HCSDB analysis had shown trust in the health care system played a strong role in predicting COVID-19 vaccination intent. The share of non-Service members who trust the health care system "almost none of the time" were compared across age group and education level. This showed a strong difference by age group, with those under 35 more than eight times as likely to not trust the health care system (21.1 percent) than those over the age of 75 (2.4 percent), which was highly significant ($p < 0.001$). Education did not show any significant differences by trust ($p = 0.70$).

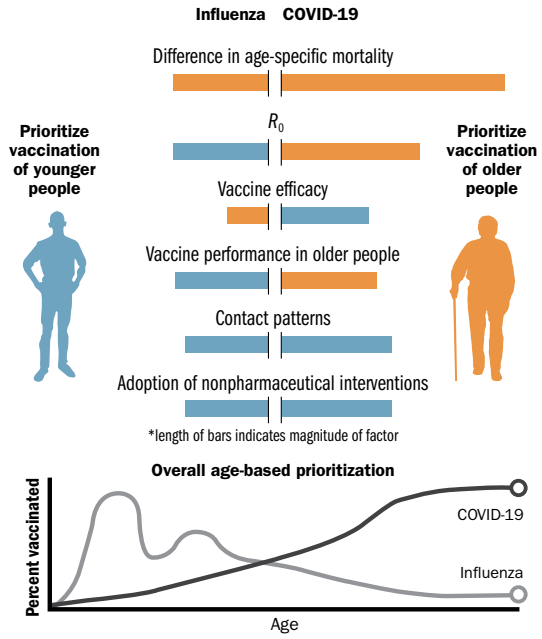
TRUST IN HEALTH CARE SYSTEM BY AGE GROUP AND EDUCATION LEVEL, HCSDB, FY 2022 Q2



Because of the strong interrelationships between age group, trust in health care, and vaccination status, statistical mediation was explored. This considers how much of the main effect (age group) can be explained by controlling for the mediator (trust in health care) in predicting the outcome (vaccination status). Education level was used as a covariate. The mediation model found the standardized beta of age group on vaccination status decreased from 0.23 to 0.13 when controlling for trust in health care, which was a highly significant mediation ($p < 0.001$). The odds ratio of age decreased from 1.34 to 1.18 when controlling for trust. This indicates almost half of the effect of age group on vaccination status can be explained by controlling for trust in health care. This mediation model diagram is shown at right.

KEY DETERMINANTS OF AGE-BASED VACCINATION

Epidemiological factors drive age-based vaccine optimization for influenza and COVID-19 with varying influence according to the mechanism and magnitude of the factor. When there are stark differences in mortality risk with age, or when the reproductive number R_0 is high, older people are more likely to be prioritized for vaccination. By contrast, high vaccine efficacy, the amount of social contact among younger people, and widespread adherence to nonpharmaceutical interventions can shift prioritization toward younger age.



Sources:

– DHA/SP&FI (J5)/Analytics and Evaluation Division, HCSDB data, 12/20/2022

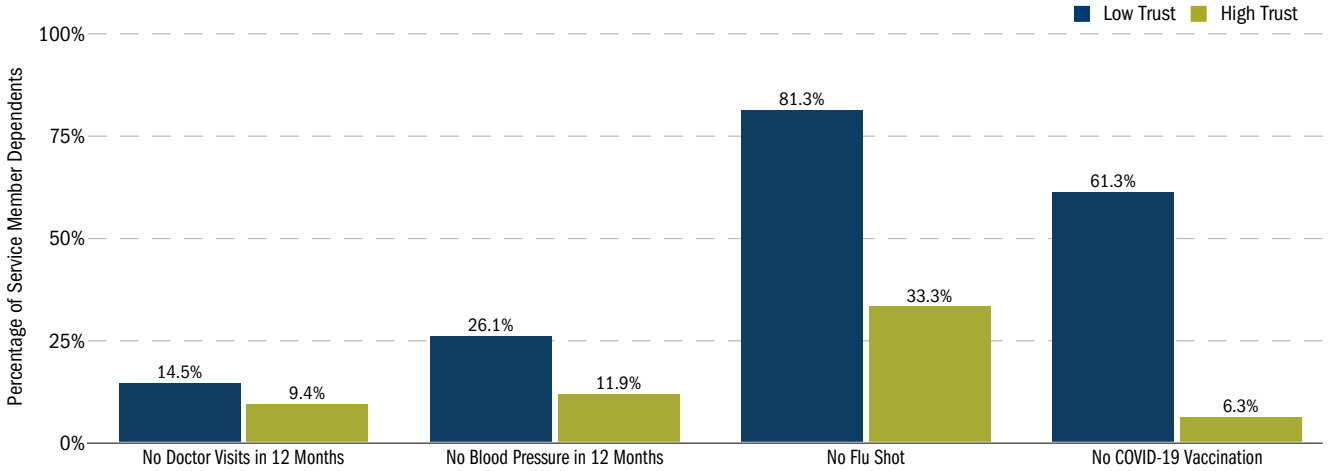
– Optimizing age-specific vaccination, Volume: 371, Issue: 6532, Pages 890-891, DOI; (10.1126/science.abg2334)

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

Vaccination Status for COVID-19 among TRICARE Beneficiaries *(cont.)*

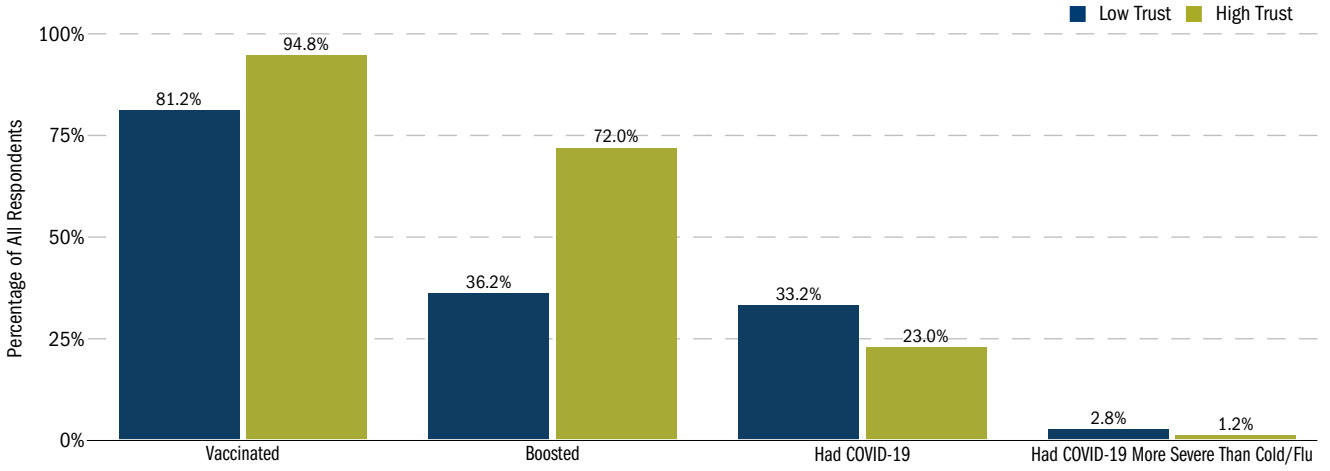
The strong mediating effect of trust on vaccination status raised questions about how much other preventive health behaviors differed by trust levels. Dependents of Service members were compared by trust level across several preventive care behaviors, including not visiting the doctor in the past 12 months, not having a blood pressure check in 12 months, not having a flu shot in 12 months, and not having a COVID-19 vaccination. All behaviors differed by trust level, with those low in trust 0.5 times more likely to have not seen a doctor in 12 months (14.5 percent to 9.4 percent), 1.2 times as likely to not have a blood pressure check in 12 months (26.1 percent to 11.9 percent), and 1.4 times as likely to not have a flu shot in 12 months (81.3 percent to 33.3 percent). While each of these effects were strong, the effect of COVID-19 vaccination was by far the strongest, with those low in trust 8.7 times as likely to be unvaccinated with no intention to do so (61.3 percent to 6.3 percent). This suggests COVID-19 vaccination is far more polarized by trust level than other preventive care behaviors.

PREVENTIVE CARE BEHAVIORS BY TRUST IN HEALTH CARE, HCSDB, FY 2022 Q2



Several COVID-19-related outcomes were compared by trust level, including vaccination status, receiving a booster vaccination, testing positive for COVID-19, and having COVID-19 symptoms more severe than a cold or flu. This analysis included all respondents, including Service members who had a vaccination mandate. Of those who were low in trust, 81.2 percent were vaccinated, compared with 94.8 percent among those high in trust; 36.2 percent of those low in trust had received a booster vaccination, compared with 72.0 percent of those high in trust. Of those low in trust, 33.2 percent had tested positive, compared with 23.0 percent who were high in trust. Of those who had tested positive, those who were low in trust were more likely to have severe symptoms (2.8 percent) than those high in trust (1.2 percent). This suggests trust has a strong effect in both preventive care behaviors and outcomes, including disease incidence and disease severity.

COVID-19 OUTCOMES BY TRUST LEVEL, HCSDB, FY 2022 Q2



Source: DHA/SP&FI (J5)/Analytics and Evaluation Division, HCSDB data, 12/20/2022

HOW TRICARE OPERATES

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

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

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

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

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

The THP TRICARE Overseas Program (TOP) section oversees the TOP contract currently operated by International SOS. TOP supports the Combatant Commands in delivery of health care in remote locations and during natural disasters when military assets are not available.

CONTINUAL EXPANSION, EVOLUTION, AND OPTIMIZATION OF THE TRICARE BENEFIT

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

NEW BENEFITS AND PROGRAMS IN FY 2022 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT

Quadruple Aim: Improved Readiness

DHA Launched App Addressing Service Women's Health Care Needs – Deployment Readiness Education for Service (DRES)

The app is a one-stop resource that covers the full scope of military women's health care topics like menstrual management, injury prevention, intimate partner violence, returning to duty postpartum, and family planning. The app covers topics that affect all Service members and is also a resource for male and nonbinary service members. Users can find the free web app at mobile.health.mil/dres.

Uniformed Services University's Center for Neuroscience and Regenerative Medicine (CNRM) Launched Multisite Study on Post-Traumatic Headaches (PTHs)

CNRM is a randomized, placebo-controlled, multisite study to test the safety and efficacy of using erenumab to treat PTHs. PTH is a secondary headache disorder that develops within seven days after a head and/or neck injury. It is frequently experienced after a mild traumatic brain injury (TBI). Erenumab treatments may reduce or eliminate PTHs. No approved treatments for PTH currently exist.

Researchers aim to enroll a total of 404 participants at Naval Medical Center Camp Lejeune, Brooke Army Medical Center (AMC), Womack Army Medical Center, and William Beaumont Army Medical Center. Findings from this study could identify a solution to PTH and support the return of Service members with mild TBIs to duty faster than current therapies.

DHA Regions (DHARs) Established in the Indo Pacific and Europe

On September 27, 2022, DHA established DHAR-Indo Pacific (DHAR-IP) under the leadership of U.S. Army Major General Joseph Heck. DHAR-IP oversees health care delivery for more than 234,000 beneficiaries enrolled in 45 military treatment facilities in Hawaii, Guam, Japan, and the Republic of Korea. Almost a month later, DHAR-Europe was formally established. Led by U.S. Army Brig. General Clinton K. Murray, the region oversees health care delivery for over 135,000 beneficiaries enrolled in MTFs in Iceland, the United Kingdom, Belgium, Germany, Spain, Italy, Greece, Turkey, Bahrain, and Kuwait. Launching the DHARs will improve readiness and the health care of beneficiaries.

Quadruple Aim: Better Care

Improvements to the TRICARE Autism Care Demonstration (ACD) Provides More Help to Enrollees

TRICARE assigned an autism services navigator (ASN) to every ACD participant who enrolled in the program in FY 2022. ASNs helped participants:

- Identify care and services for their child
- Document outcome measures, track timelines, and help ensure families get the measures they need when the time comes
- Document PCS timelines or other transitions, where applicable
- Develop a care management discharge and transition plan

Latest information on the ACD updates can be found here: https://newsroom.tricare.mil/Articles/Article/2554995/dha-improves-tricarecomprehensive-autism-care-demonstration-program

TRICARE Updated Retail Pharmacy Network Options

About 15,000 independent pharmacies departed the TRICARE retail pharmacy network, including Walmart and SAM's Club. TRICARE still offers over 42,000 pharmacies in the network with the addition of CVS Pharmacy.

TRICARE Expanded Childbirth and Breastfeeding Benefits for Expecting Parents

TRICARE launched the Childbirth and Breastfeeding Support Demonstration (CBSD) to TRICARE Prime and Select beneficiaries under one of its regional contractors. The five-year study will cover the services of certified labor doulas, certified lactation consultants, and certified lactation counselors. The CBSD will expand to overseas and U.S. territories in January 2025.

TRICARE Included Coverage of Continuous Glucose Monitors (CGMs) under the TRICARE Pharmacy Program

Two brands of CGMs—Abbott FreeStyle Libre 2 and Dexcom G6—are now available under the TRICARE Pharmacy Benefit. Previously, both CGMs were only covered as durable medical equipment under the TRICARE medical benefit.

NEW BENEFITS AND PROGRAMS IN FY 2022 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

Quadruple Aim: Better Care *(cont.)*

TRICARE Announced Policy Changes Telehealth Services

During the COVID-19 pandemic, DHA made temporary updates to the TRICARE telehealth benefit. Some of these policy changes expired such as the temporary waiver on costs. Beneficiaries are required to again pay cost shares and copayments for telehealth services. Effective July 1, 2022, audio-only telehealth appointments became a permanent benefit.

DHA Launched the First of Four Ocular Trauma Centers

The first Ocular Trauma Center opened April 19, 2022, at Brooke Army Medical Center, Fort Sam Houston, Texas. DHA's Vision Center of Excellence supports the establishment of the four centers. Each center will provide a full range of eye injury care—from initial medical/surgical management through visual rehabilitation and follow-on care. Remaining centers are anticipated to open at Walter Reed National Military Medical Center/Fort Belvoir Community Hospital; Madigan Army Medical Center, Joint Base Lewis-McChord, Washington; and Naval Medical Center San Diego, California.

MHS Employed New Pain Management Scale at MTFs

The Defense and Veterans Pain Rating Scale (DVPRS), developed by a DOD pain management task force, combined several validated pain assessment tools with some additions. The DVPRS incorporates functional descriptions to the traditional 0–10 levels of pain scale. The DVPRS is in use at all MTFs and was adopted by the West Virginia University Health System for use in its hospitals and clinics.

DHA Introduced the new Electronic Caregiver Resource Directory (eCRD)

The directory rolled out in May 2022 to more than 300,000 caregivers of wounded warriors and veterans. The eCRD has a database of over 2,000 resources that supports recovery, rehabilitation, and reintegration for Service members, Veterans, family members, and caregivers. The library of resources is accessible on mobile phones, computers, or tablets. Jointly developed by the DoD, Department of Veterans Affairs and Department of Labor, the eCRD is an updated version of the downloadable PDF.

DHA Expanded Walk-In Contraceptive Care Services

On September 27, 2022, the DHA issued an Administrative Instruction directing the expansion of walk-in contraception services across the MHS. No appointments or referrals are needed to access the services. Patients receive care to support family planning, menstrual health, pregnancy prevention, and readiness.

92 Military Hospitals and Clinics Actively Use MHS GENESIS

In 2022, MHS GENESIS deployed in eight waves at 45 military hospitals and clinics in Arkansas, Oklahoma, Texas, New Mexico, Louisiana, Florida, Alabama, Mississippi, South Carolina, North Carolina, and Georgia. The DHA in partnership with Oracle Cerner and Leidos enhanced MHS GENESIS in June 2022 to improve beneficiary user experience.

The DHA works in close coordination with the Program Executive Office, Defense Healthcare Management Systems to deploy this new electronic health record (EHR) across the MHS. By the end of 2023, MHS GENESIS will have deployed to 138 hospitals and clinic commands worldwide.

DoD Ensured Access to Reproductive Health Care

On October 20, 2022, Secretary of Defense Lloyd J. Austin III issued a memo directing for improved access and awareness of reproductive health care.

NEW BENEFITS AND PROGRAMS IN FY 2022 SUPPORTING THE MHS QUADRUPLE AIM, MILITARY DEPARTMENTS, AND TRICARE BENEFIT *(CONT.)*

Quadruple Aim: Better Health

TRICARE Launched a New Podcast – Getting Care with TFL

The new podcast series was designed to provide helpful conversations around pertinent TFL topics. The first episode of the series, "What Is and Isn't Covered by TRICARE for Life," featured an interview with Anne Beslin, the TFL program manager at the DHA.

The podcast is available on Apple Podcasts and Spotify.

Extremity Trauma and Amputation Center of Excellence (EACE) Transitioned to DHA

The DHA added EACE, its fifth center of excellence within the DHA Research and Engineering Directorate, on October 23, 2022. The EACE leads the advancement of extremity trauma research and clinical practice innovations to optimize outcomes of Service members and Veterans. Since 2017, the EACE has received over $30 million in research funding and currently executes over 60 research projects focused on five core areas of investigation:

- Optimizing post-musculoskeletal injury time to return to duty
- Exoskeletons to enable Service member lethality during prolonged care
- Acute care therapeutics for enhancing outcomes of neuromusculoskeletal trauma
- Enhancing musculoskeletal rehabilitation outcomes within the MHS
- Epidemiology and surveillance of the extremity trauma and amputation population

Latest Study Supports Evidence of New Sleep Disorder

Researchers at the San Antonio Market Sleep Disorders Center at Wilford Hall Ambulatory Surgical Center performed the largest study to date of Service members who had experienced combat-related trauma and were acting out dreams physically or verbally (or dream enactment). The five-year study established trauma-associated sleep disorder (TSD) as a distinct sleep-related disorder. TSD includes dream enactment, symptoms of autonomic hyperarousal, and vivid, repeating nightmares about the individual's trauma. More details about the study titled "Clinical and Polysomnographic Features of Trauma-Associated Sleep Disorder" is in the December 2022 issue of the *Journal of Clinical Sleep Medicine*.

Quadruple Aim: Lower Cost

Premiums for TRICARE Dental Program (TDP) Coverage Increased

New premium rates went into effect on May 1, 2022. Rate increases differed for each premium group, depending on the sponsor's military service status and the number of family members. The TDP is a voluntary dental plan that is available to Active Duty family members, as well as National Guard and Reserve members and their family members. TDP Active Duty premiums increased to $11.94 (up from $11.65) for single members and $31.04 (up from $30.28) for coverage including family members.

TRICARE Waived Cost Shares and Copayments on Contraceptive Services

Beginning July 28, 2022, TRICARE beneficiaries no longer have to pay cost shares or copayments for all TRICARE-covered reversible medical contraceptives. These include IUDs, hormonal shots, and slow-release hormonal rods.

For a list of TRICARE-covered contraceptive services, see https://newsroom.tricare.mil/Articles/Article/3174941/tricare-offers-contraceptive-care-to-support-you-your-family-and-your-readiness.

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BENEFICIARY TRENDS AND DEMOGRAPHICS

System Characteristics

TRICARE FACTS AND FIGURES—PROJECTED FOR FISCAL YEAR (FY) 2023

	PROJECTED FOR FY 2023[a]	FY 2022 ACTUALS
Total Beneficiaries	**9.5 million worldwide[b]**	9.6 million worldwide[b]
MILITARY FACILITIES—DIRECT CARE SYSTEM[c]		
Inpatient Hospitals and Medical Centers	**45 (31 in U.S.)**	45 (31 in U.S.)
Ambulatory Care and Occupational Health Clinics[d]	**566 (466 in U.S.)**	525 (458 in U.S.)
Dental Clinics	**117 (94 in U.S.)**	138 (115 in U.S.)
Military Health System (MHS) Defense Health Program Personnel	**127,511**	123,794
Military	**70,116**	70,422
	26,404 Officers	26,371 Officers
	44,914 Enlisted	43,995 Enlisted
Civilian (including Foreign National)	**57,395**	58,163
CIVILIAN RESOURCES—PRIVATE SECTOR CARE SYSTEM[e]		
Network Primary Care, Behavioral Health (BH), and Specialty Care Providers (i.e., individual, not institutional, providers)	**1,163,560**	1,121,377
Network BH Providers (shown separately, but included in above)	**164,245**	156,270
TRICARE Network Acute Care Hospitals	**4,880**	5,599
BH Facilities	**2,295**	1,311
Contracted (Network) Retail Pharmacies	**42,500**	56,129
Contracted Worldwide Pharmacy Home Delivery Vendor	**1**	1
TRICARE Dental Program (TDP) (for Active Duty families, Reserve members and their families)	**Over 1.79 million covered lives in 756,000 contracts**	Over 1.79 million covered lives in 771,000 contracts
TDP Network Dentists	**Over 80,300 total dentists, including: 62,144 general dentists and 18,191 specialty dentists**	79,935 total dentists, including: 61,744 general dentists over 18,191 specialty dentists
Total Requested FY 2023 Unified Medical Program (UMP) (including Projected Trust Fund Receipts)	**$58.38 billion[f]**	$55.41 billion[f]
Projected Receipts from Medicare-Eligible Retiree Health Care Fund (MERHCF) Trust Fund	**$9.74 billion**	$9.34 billion

[a] Unless specified otherwise, this report presents budgetary, utilization, and cost data for the Defense Health Program (DHP)/UMP only, not those related to deployment or funded by the "Line" of the Services.

[b] Department of Defense (DoD) health care beneficiary population projected for the end of FY 2022 is 9,489,182, rounded to 9.5 million. This projection is based on the DoD Comptroller's Budget End Strength, the DoD Actuary's forecast of the retiree population, and the family members per sponsor from the Defense Manpower Data Center Defense Enrollment Eligibility Reporting System (DEERS) as of January 2023.

[c] Military medical treatment facility (MTF) clinic count includes occupational health, community-based, embedded behavioral health, Active Duty troop, centers of excellence, and joint DoD-Department of Veterans Affairs (VA) clinics, and excludes leased/contracted facilities and Aid Stations. Military facility counts are that of the number of facilities based on the Defense Medical Information System Identifiers ID, not clinical functions Source: Defense Health Agency (DHA)/Resources & Management (J-1/J-8)/Budget and Execution and Programming Divisions, 1/26/2023.

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

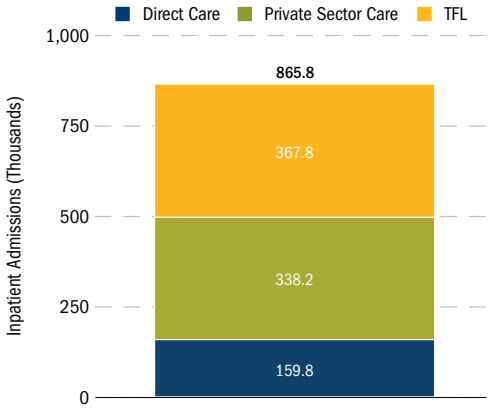
[e] As reported by the managed care support contractors (MCSCs) for contracted network provider and hospital data, 12/19/2022; and TRICARE Dental Program Section, Health Plan Execution and Operations for dental provider data, 3/1/2023.

[f] UMP presented here includes direct and private sector care funding, military personnel, military construction, and the MERHCF ("Accrual Fund"). Budget and expense data from DHA/Resources & Management Directorate (J-8)/Budget & Execution Division, as of FY 2023 Request.

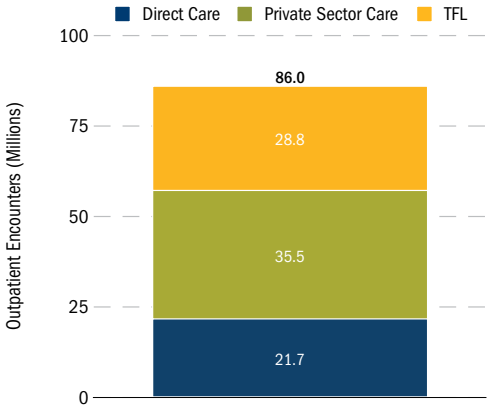
BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

FY 2022 TRICARE Workload and Population Summary

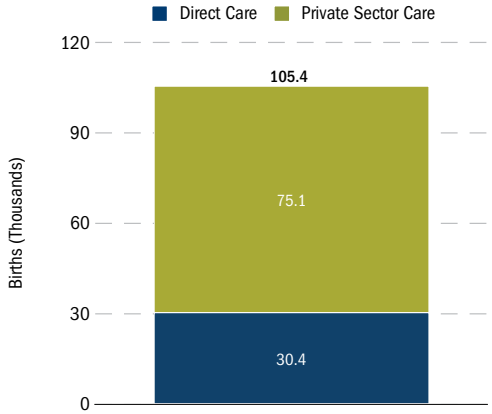
INPATIENT ADMISSIONS[a]



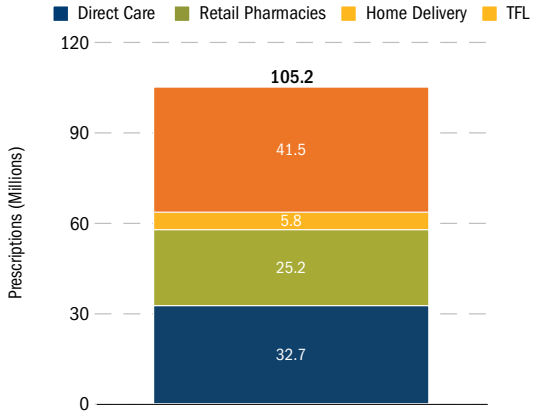
OUTPATIENT ENCOUNTERS[a]



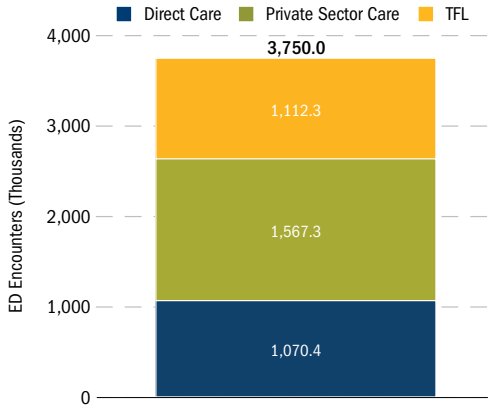
BIRTHS[a]



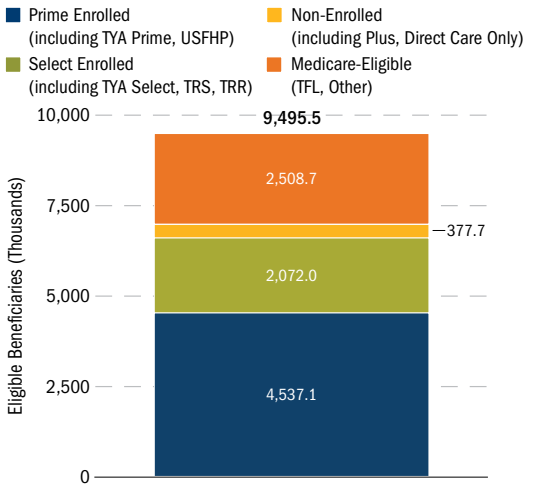
PRESCRIPTIONS[a]



EMERGENCY DEPARTMENT (ED) ENCOUNTERS[a]



ELIGIBLE BENEFICIARIES



Sources: MHS administrative data, 1/20/2023, and DEERS, 12/30/2022

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

Notes:

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

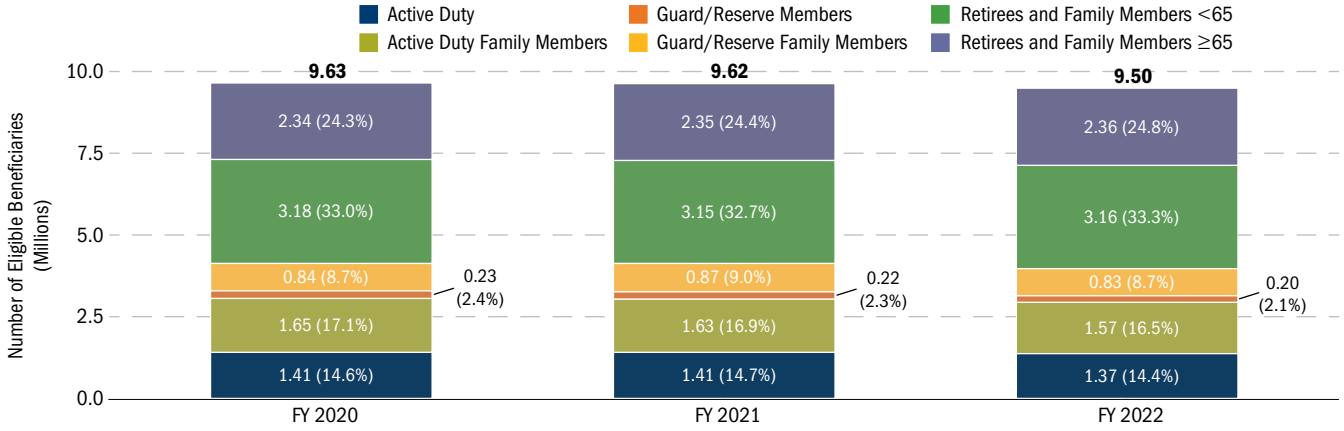
– Numbers may not sum to bar totals due to rounding.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Number of Eligible and Enrolled Beneficiaries Between FY 2020 and FY 2022

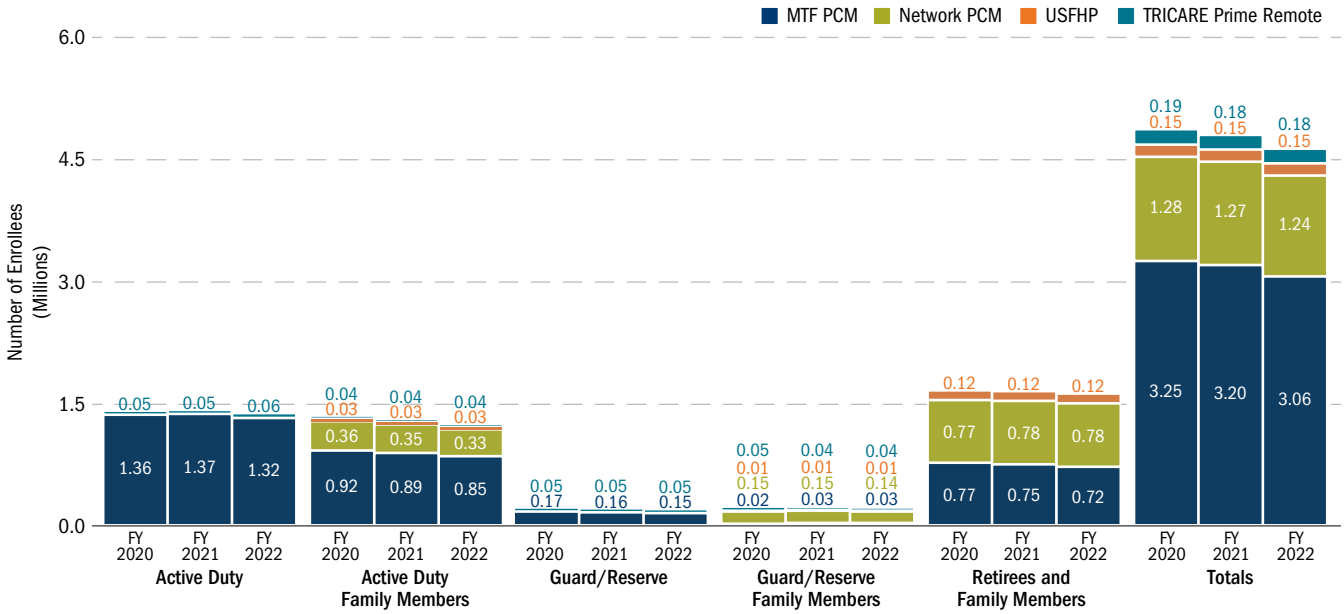
The number of beneficiaries eligible for DoD medical care (including TRR, TRS, and TYA) declined by 1 percent from 9.63 million in FY 2020 to 9.50 million in FY 2022.[1] Although the number of Active Duty Service members (ADSMs) decreased by only 2.8 percent, the number of Active Duty family members (ADFMs) decreased by 5 percent. The number of retirees and family members (RETFMs) under age 65 decreased by 1 percent, but the number of RETFMs aged 65 and older increased by 1 percent.

TRENDS IN THE END-YEAR NUMBER OF ELIGIBLE BENEFICIARIES BY BENEFICIARY GROUP, FYs 2020–2022



- From FY 2020 to FY 2022, ADFMs experienced declines in Prime enrollment with both MTF and network primary care managers (PCMs). However, this is largely due to an overall decline in the ADFM population. Prime enrollment by Guard/Reserve members and their families remained about the same.
- The trend in RETFM Prime enrollments was similar to that of ADFMs, with the number of beneficiaries having either an MTF or network PCM decreasing. In FY 2021, for the first time, the number of RETFMs enrolled with a network PCM exceeded the number enrolled with an MTF PCM. That trend continued in FY 2022, with the gap widening further.
- TRICARE Prime Remote (TPR) and USFHP enrollment remained about the same from FY 2020 to FY 2022.

TRENDS IN THE END-YEAR NUMBER OF PRIME-ENROLLED BENEFICIARIES BY BENEFICIARY GROUP, FYs 2020–2022



Source: DEERS, 12/30/2022

[1] This number should not be confused with the one displayed under TRICARE Facts and Figures on page 29. The population figure on page 29 is a projected FY 2023 total, whereas the population reported on this page is the actual for the end of FY 2022.

Notes:

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

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

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Beneficiary Plan Choice by Age Group and Beneficiary Category

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

PLAN CHOICE BY AGE GROUP, END OF FY 2022

PLAN TYPE	0–17	18–24	25–44	45–64	≥65	TOTAL[a]
Prime Enrolled	1,190,562	845,123	1,514,188	979,990	7,265	4,537,128
Prime: MTF PCM	695,933	700,045	1,193,148	509,802	1,212	3,100,140
Prime: Network PCM	412,694	112,843	206,626	406,879	601	1,139,643
Prime Remote	46,234	20,502	94,814	17,050	50	178,650
USFHP	35,701	8,661	18,620	46,259	5,402	114,643
TYA Prime	0	3,072	980	0	0	4,052
Select Enrolled	695,454	216,852	536,042	622,549	1,125	2,072,022
TRICARE Select	527,471	153,164	344,229	572,688	1,061	1,598,613
TRS	160,239	35,186	182,317	32,504	26	410,272
TYA Select	0	25,836	5,987	0	0	31,823
TRICARE Plus	3,973	1,187	2,067	10,907	38	18,172
TRR	3,771	1,479	1,442	6,450	0	13,142
Nonenrolled	58,141	48,060	71,864	170,963	28,638	377,666
Direct Care Only	58,121	48,047	71,843	170,277	27,789	376,077
TRICARE Plus	20	13	21	686	849	1,589
Medicare-Eligible	16	832	32,777	144,594	2,330,487	2,508,706
TFL	2	428	16,185	77,733	2,023,961	2,118,309
TRICARE Plus[b]	0	5	125	991	186,759	187,880
Direct Care Only	3	26	4,346	13,335	82,632	100,342
USFHP	0	15	323	1,600	36,603	38,541
Prime: Network PCM	4	140	6,164	26,687	8	33,003
Prime: MTF PCM	2	137	4,839	23,353	0	28,331
Other	5	81	795	895	524	2,300
Total	**1,944,173**	**1,110,867**	**2,154,871**	**1,918,096**	**2,367,515**	**9,495,522**

Source: DEERS, 12/30/2022

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

[b] Among Medicare eligibles, 184,966 with TRICARE Plus also have TFL. These numbers are not included in the TFL row.

- About 27 percent of USFHP enrollees are seniors (aged 65 and older), and about 23 percent are children (aged 0–17).
- The vast majority of those aged 65 and older are enrolled in Medicare Part B and are covered by TFL as their supplemental plan. About 8 percent of seniors covered by TFL are also enrolled in TRICARE Plus, the primary care–only plan available at selected MTFs.
- Medicare-eligible beneficiaries younger than 65 years have a choice between TRICARE Prime (including the USFHP) and TFL. About 60 percent choose TFL and 40 percent choose Prime.
- Beneficiaries aged 45–64 had the lowest TRICARE Prime enrollment rate, at 55 percent. Enrollment rates for the other age groups were 61 percent for 0–17, 76 percent for 18–24, and 71 percent for 25–44. Beneficiaries aged 65 and older predominantly use TFL.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

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

PLAN CHOICE BY BENEFICIARY CATEGORY, END OF FY 2022

PLAN TYPE	AD	ADFM	GR	GRFM	IGR	IGRFM	OTH	RET	RETFM	SRV	TOTAL[a]
Prime Enrolled	1,373,463	1,240,264	198,073	197,126	4,252	10,637	1,533	536,206	939,759	35,815	4,537,128
Prime: MTF PCM	1,318,366	882,529	151,519	59,923	1,886	3,053	744	257,995	409,498	14,627	3,100,140
Prime: Network PCM	0	295,309	0	89,697	753	6,503	686	249,364	478,616	18,715	1,139,643
Prime Remote	55,097	35,782	46,554	39,782	1,083	352	0	0	0	0	178,650
USFHP	0	26,263	0	7,671	530	729	101	28,847	48,101	2,401	114,643
TYA Prime	0	381	0	53	0	0	2	0	3,544	72	4,052
Select Enrolled	0	308,276	0	95,969	190,133	303,252	14,852	369,768	746,068	43,704	2,072,022
TRICARE Select	0	305,603	0	94,965	35,780	46,789	14,594	358,281	700,112	42,489	1,598,613
TRS	0	6	0	106	154,353	255,452	244	18	48	45	410,272
TYA Select	0	2,385	0	842	0	1,011	11	0	26,697	877	31,823
TRICARE Plus	0	282	0	56	0	0	0	6,933	10,636	265	18,172
TRR	0	0	0	0	0	0	3	4,536	8,575	28	13,142
Nonenrolled	0	19,650	0	5,211	17,488	2,830	17,390	108,961	180,026	26,110	377,666
Direct Care Only	0	18,834	0	5,177	17,488	2,830	17,390	108,821	179,489	26,048	376,077
TRICARE Plus	0	816	0	34	0	0	0	140	537	62	1,589
Medicare-Eligible	0	1,961	0	673	128	895	2,263	1,219,226	780,985	502,575	2,508,706
TFL	0	0	0	0	0	0	1,922	1,007,750	665,603	443,034	2,118,309
TRICARE Plus[b]	0	311	0	33	0	0	40	95,513	60,293	31,690	187,880
Direct Care Only	0	1,128	0	278	2	33	229	59,073	22,564	17,035	100,342
USFHP	0	0	0	0	0	0	23	18,584	12,445	7,489	38,541
Prime: Network PCM	0	0	0	0	0	0	22	20,736	10,610	1,635	33,003
Prime: MTF PCM	0	0	0	0	0	0	9	17,441	9,251	1,630	28,331
Other	0	522	0	362	126	862	18	129	219	62	2,300
Total	**1,373,463**	**1,570,151**	**198,073**	**298,979**	**212,001**	**317,614**	**36,038**	**2,234,161**	**2,646,838**	**608,204**	**9,495,522**

Source: DEERS, 12/30/2022

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

[b] Among Medicare eligibles, 184,966 with TRICARE Plus also have TFL. These numbers are not included in the TFL row.

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

- Only 5 percent of non-Medicare-eligible beneficiaries were not enrolled in any TRICARE plan (i.e., they used space-available care or TRICARE Plus at MTFs or other health insurance [OHI]) in FY 2022.
- The large majority of beneficiaries enrolled in TYA are children of retirees under the age of 65 (most Active Duty members are not old enough to have children in the requisite age group). TYA Prime enrollment has declined from 58 percent of total TYA enrollment in FY 2015 to 11 percent in FY 2022.
- About 77 percent of beneficiaries enrolled in the USFHP are retirees and family members (including survivors), most of whom are under age 65. The USFHP is available at only six sites nationwide, so enrollment is low relative to Prime.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Trends in Plan Choice

PLAN CHOICE AND PERCENTAGE OF TOTAL ENROLLMENT, END OF FYs 2020–2022

PLAN TYPE	FY 2020		FY 2021		FY 2022	
	POPULATION	% OF TOTAL	POPULATION	% OF TOTAL	POPULATION	% OF TOTAL
Prime Enrolled	4,775,013	49.6%	4,701,360	48.9%	4,537,128	47.8%
Prime: MTF PCM	3,300,114	34.3%	3,235,054	33.6%	3,100,140	32.6%
Prime: Network PCM	1,163,573	12.1%	1,165,835	12.1%	1,139,643	12.0%
Prime Remote	189,717	2.0%	180,088	1.9%	178,650	1.9%
USFHP	112,300	1.2%	114,223	1.2%	114,643	1.2%
TYA Prime	9,309	0.1%	6,160	0.1%	4,052	0.0%
Select Enrolled	2,127,596	22.1%	2,053,179	21.3%	2,072,022	21.8%
TRICARE Select	1,684,706	17.5%	1,595,731	16.6%	1,598,613	16.8%
TRS	377,119	3.9%	392,636	4.1%	410,272	4.3%
TYA Select	30,765	0.3%	33,305	0.3%	31,823	0.3%
TRICARE Plus	23,572	0.2%	19,331	0.2%	18,172	0.2%
TRR	11,434	0.1%	12,176	0.1%	13,142	0.1%
Nonenrolled	233,146	2.4%	366,570	3.8%	377,666	4.0%
Direct Care Only	231,516	2.4%	365,023	3.8%	376,077	4.0%
TRICARE Plus	1,630	0.0%	1,547	0.0%	1,589	0.0%
Medicare Eligible	2,495,294	25.9%	2,502,188	26.0%	2,508,706	26.4%
TFL	2,104,327	21.8%	2,111,286	21.9%	2,118,309	22.3%
TRICARE Plus	185,897	1.9%	186,087	1.9%	187,880	2.0%
Direct Care Only	98,587	1.0%	99,777	1.0%	100,342	1.1%
USFHP	40,722	0.4%	39,782	0.4%	38,541	0.4%
Prime: Network PCM	32,541	0.3%	33,022	0.3%	33,003	0.3%
Prime: MTF PCM	30,434	0.3%	29,644	0.3%	28,331	0.3%
Other/Unknown	2,786	0.0%	2,590	0.0%	2,300	0.0%
Total	**9,631,049**		**9,623,297**		**9,495,522**	

Source: DEERS, 12/30/2022

- After a year of grace in calendar year (CY) 2018, the open season model went into full effect for coverage beginning in CY 2019. Since then, beneficiaries can no longer change their TRICARE coverage outside open season unless they have a TRICARE-recognized qualifying life event. As a result, plan enrollment has been relatively stable the past three years.
- As a percentage of the total eligible population, the number of Prime-enrolled beneficiaries declined by almost 2 percentage points from FY 2020 to FY 2022. Most of the decline occurred among beneficiaries with an MTF PCM.
- As a percentage of the total eligible population, the number of beneficiaries with TRICARE Select plans declined slightly from FY 2020 to FY 2022. Over the same time period, the percentage of beneficiaries with direct-care-only coverage increased, with most of the increase occurring in FY 2021.

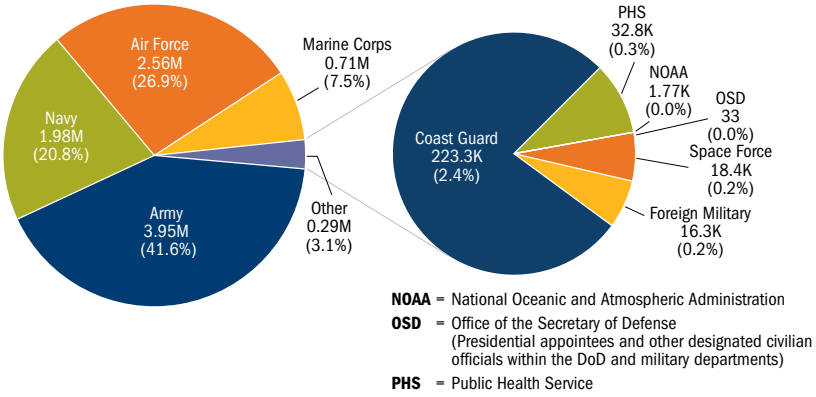
BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Eligible Beneficiaries in FY 2022

- There were a total of 9.5 million beneficiaries eligible for some form of DoD health care benefits at the end of FY 2022. The Army has the most beneficiaries eligible for Uniformed Services health care benefits, followed (in order) by the Air Force, Navy, Marine Corps, and other Uniformed Services (Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration). Although the proportions are different, the Service rankings (in terms of eligible beneficiaries) are the same abroad as they are in the U.S.
- Retirees, their family members, and survivors constitute the largest percentage of the eligible beneficiary population (51.42 percent). The U.S. MHS population is presented at the state level on page 40, reflecting those enrolled in the Prime benefit and the total population, enrolled and nonenrolled.
- Mirroring trends in the civilian population, the MHS is confronted with an aging beneficiary population.

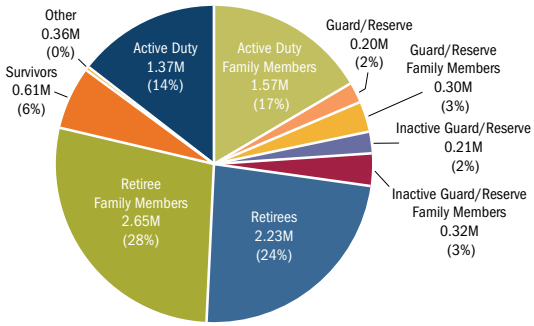
WORLDWIDE BENEFICIARIES ELIGIBLE FOR DoD HEALTH CARE BENEFITS, END OF FY 2022

BY SERVICE BRANCH



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

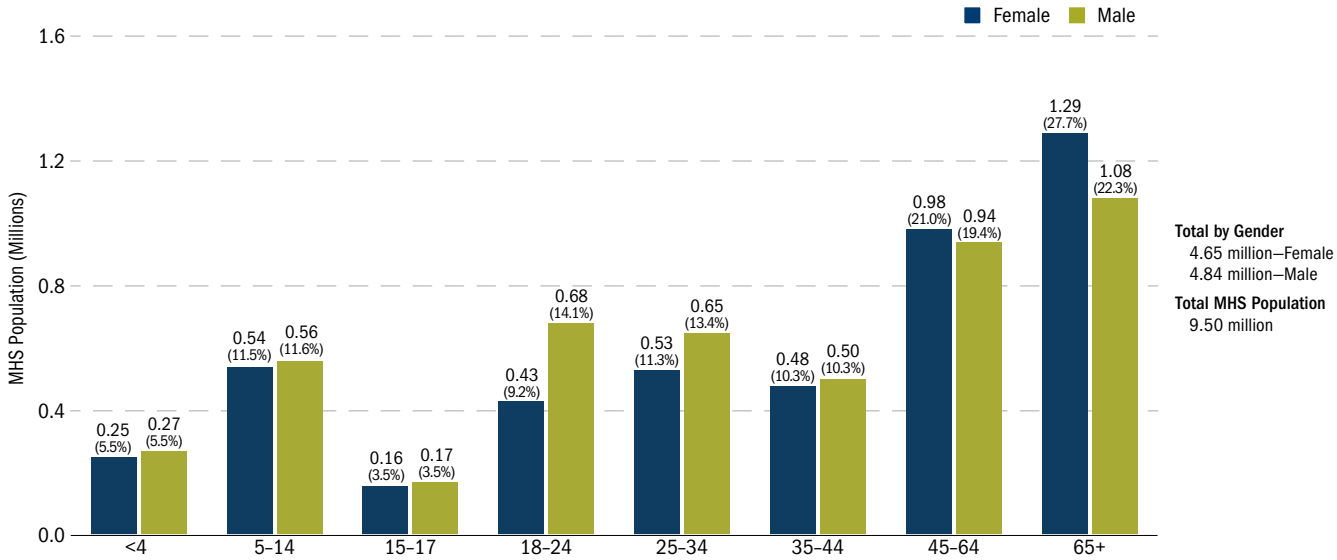
BY BENEFICIARY CATEGORY



TOTAL: 9.50 Million

Source: DEERS, 12/30/2022
Note: Percentages may not sum to 100 percent due to rounding.

MHS POPULATION BY AGE GROUP AND GENDER, END OF FY 2022



Source: FY 2022 actuals from DEERS as of 12/30/2022
Note: Numbers may not sum to population totals due to rounding.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Locations of MTFs (Hospitals and Ambulatory Care Clinics) at the End of FY 2022

The map on the following page shows the geographic dispersion of the 9 million beneficiaries eligible for the TRICARE benefit residing within the United States (95 percent of the 9.5 million eligible beneficiaries). An overlay of the major DoD MTFs (medical centers and community hospitals, as well as medical clinics) reflects the extent to which the MHS population has access to TRICARE Prime. The map also shows the recently established 20 direct reporting DHA Markets.

A beneficiary is considered to have access to Prime if he or she resides within a Prime Service Area (PSA). PSAs are geographic areas in which the TRICARE MCSCs offer the TRICARE Prime benefit through established networks of providers. TRICARE Prime is available at MTFs, in areas around most MTFs (MTF PSAs), in areas where an MTF was eliminated in the Base Realignment and Closure (BRAC) process (BRAC PSAs), and by designated providers through the USFHP as of October 1, 2013.

MHS ELIGIBLE BENEFICIARY PROXIMITY TO MTFs, END OF FY 2022[a]

BENEFICIARY GROUP[b]	POPULATION TOTAL	POPULATION IN PSAs	% IN PSAs	POPULATION IN MTF SERVICE AREA	% IN MTF SERVICE AREAS
Active Duty and Their Families	3,123,016	2,887,907	92%	2,761,224	88%
Inactive Guard/Reserve and Their Families[c]	501,536	345,807	69%	278,360	56%
Retirees, Their Families, Survivors, and Other Eligibles	5,325,831	4,030,253	76%	3,381,812	63%
Total MHS Eligibles, U.S.	8,950,383	7,263,967	81%	6,421,396	72%
MHS Eligible, Overseas and Unknown	538,799				
Total MHS Eligibles, Worldwide	9,489,182				

Source: DHA/Strategy, Plans, and Functional Integration (SP&FI) (J-5)/Analytics and Evaluation Division, population as of 1/18/2023

Notes:

[a] Eligible MHS beneficiary data from the MHS Data Repository (MDR) DEERS, as of 1/18/2023. Residential ZIP code was used as the location for all beneficiaries.

[b] Location information determined by DHA Catchment Area Directory database, September 2022.

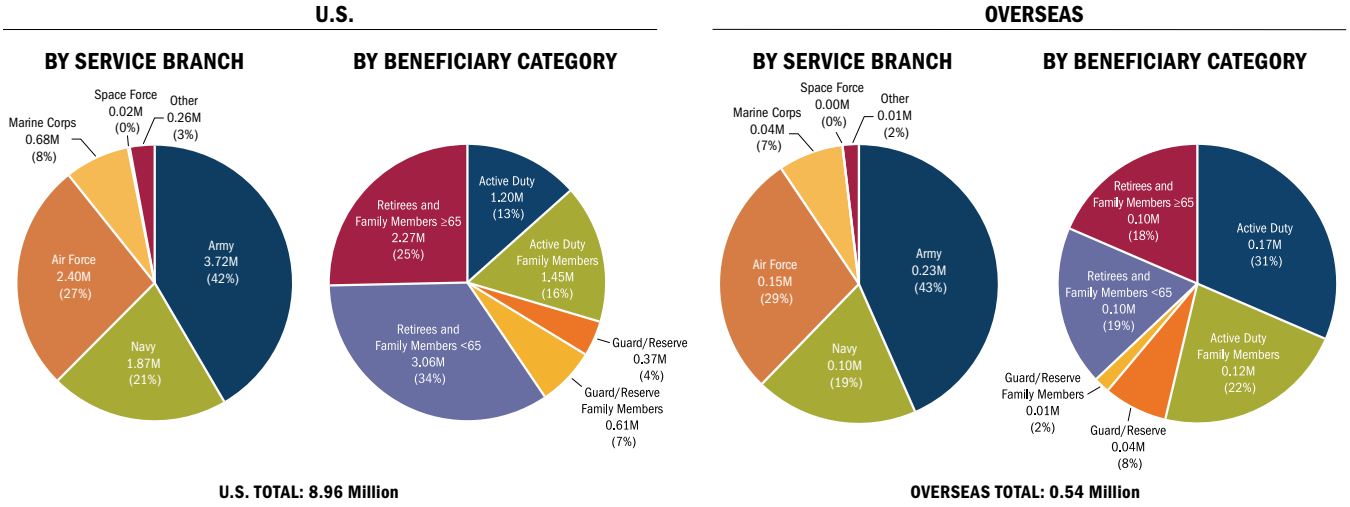
[c] TRICARE medically eligible Guard/Reserve beneficiaries, including those who have enrolled in TRS, TRR, or TYA (does not include all Select Reserve).

Definitions:

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

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

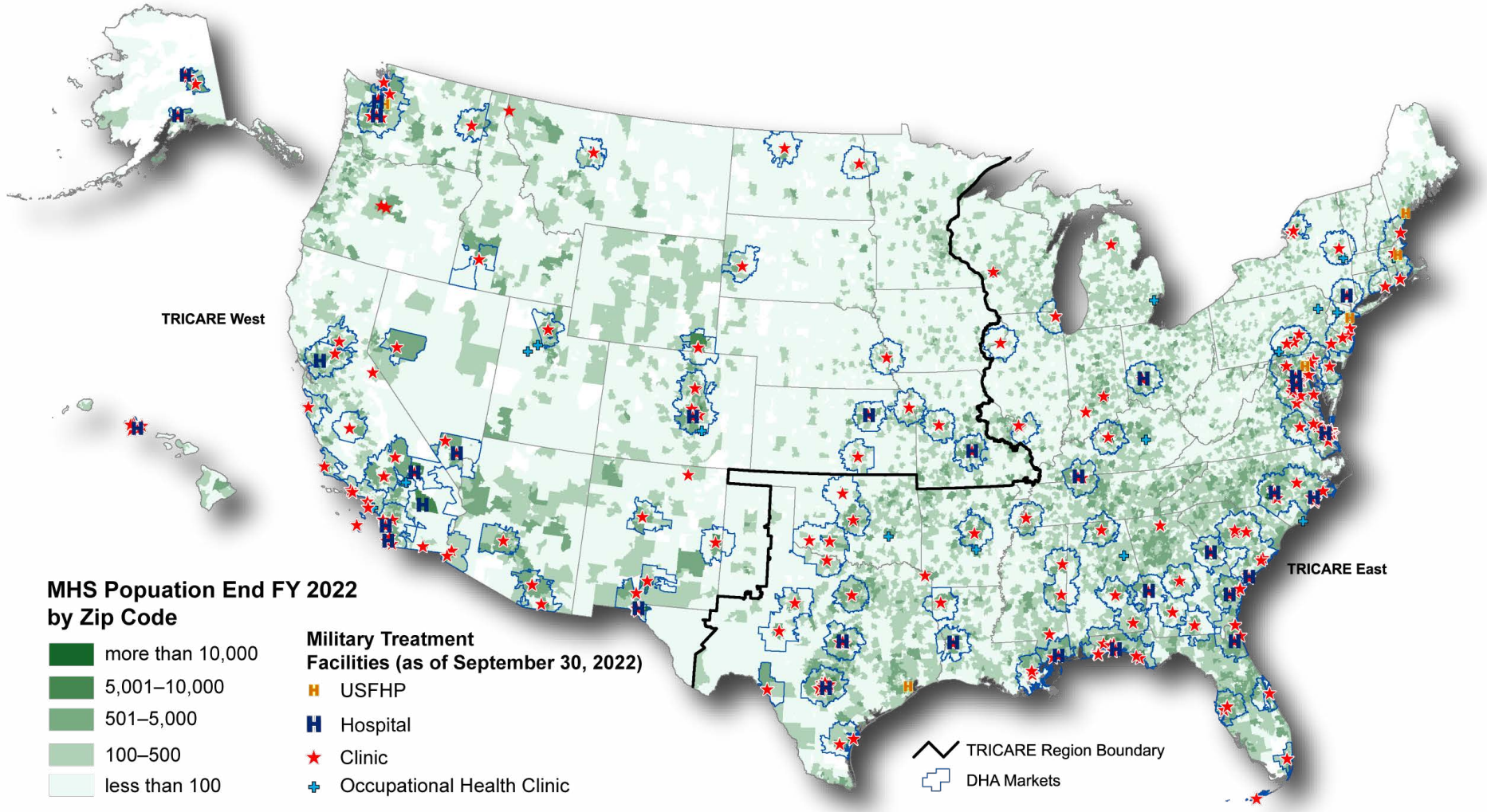
BENEFICIARIES ELIGIBLE FOR DoD HEALTH CARE BENEFITS, END OF FY 2022



Source: DEERS, 12/30/2022

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

MHS POPULATION DISTRIBUTION IN THE U.S. RELATIVE TO MTFs, END OF FY 2022



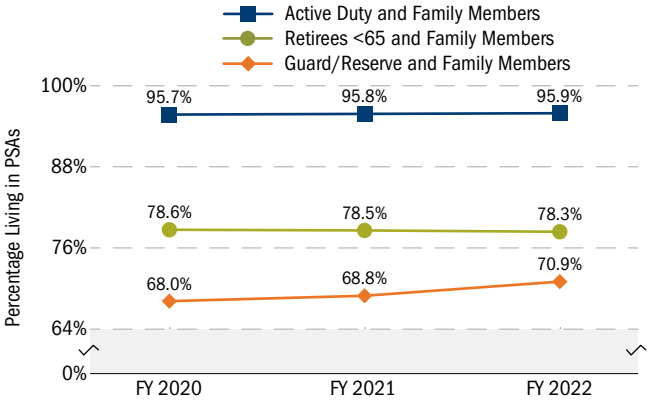
Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, population as of 9/30/2022
Note: For in-depth market area maps, visit https://info.health.mil/staff/analytics/decsupmp/gismaps (a DoD-issued Common Access Card [CAC] is required for access).

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

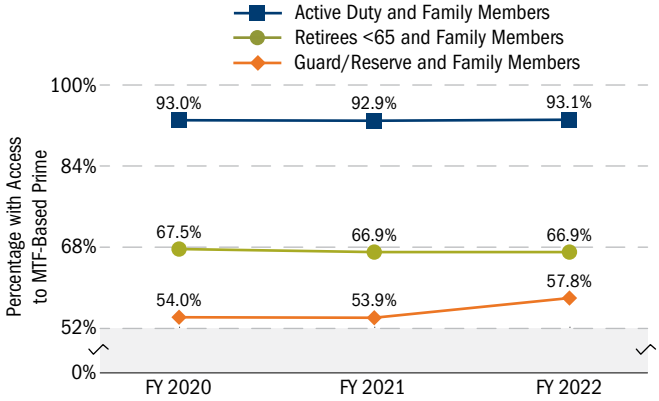
Beneficiary Access to Prime

The left chart below shows the percentage of beneficiaries living in PSAs (defined only in the U.S.). The right chart below shows the percentage of the eligible population in the U.S. with access to MTF-based Prime. The latter is defined as the percentage living in both a PSA and an MTF Service Area (see the last remark below the table on page 36 for the definition of an MTF Service Area).

TREND IN ELIGIBLE POPULATION LIVING IN PSAs, FYs 2020–2022



TREND IN ELIGIBLE POPULATION WITH ACCESS TO MTF-BASED PRIME, FYs 2020–2022



- Between FY 2020 and FY 2022, the percentage of Guard/Reserve and family members living in PSAs increased, while the percentage for the other beneficiary groups remained about the same.
- As determined by residence in an MTF PSA, access to MTF-based Prime for Guard/Reserve and family members increased from FY 2020 to FY 2022, whereas it remained about the same for the other beneficiary groups.
- As expected, Active Duty and their families have the highest level of access to MTF-based Prime, and Guard/Reserve members and their families have the lowest. Retirees, some of whom move to locations near an MTF to gain access to care in military facilities, fall in between.

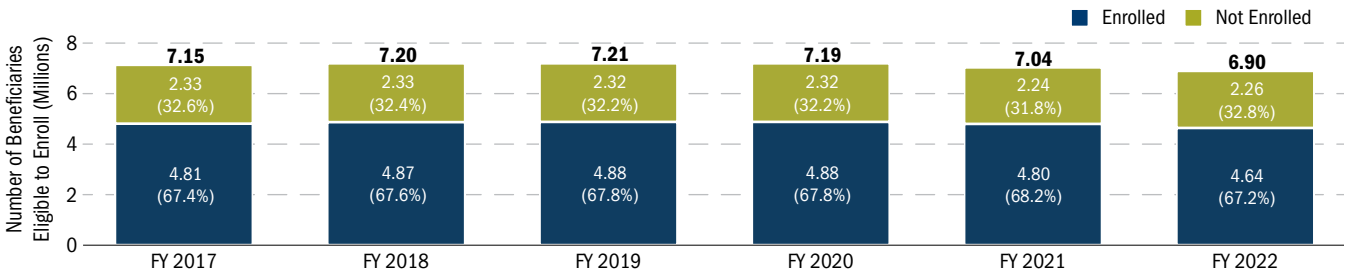
Eligibility and Enrollment in TRICARE Prime

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

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

- The number of beneficiaries enrolled in TRICARE Prime was roughly flat between FY 2017 and FY 2021 but dropped in FY 2022. As a percentage of the beneficiary population, TRICARE Prime enrollment exhibited a similar pattern.
- By the end of FY 2022, about 67 percent of all eligible beneficiaries were enrolled in Prime (4.63 million enrolled of the 6.89 million eligible).

HISTORICAL END-YEAR PRIME ENROLLMENT NUMBERS, FYs 2017–2022



Source: DEERS, 12/30/2022

Note: Numbers may not sum to bar totals due to rounding. Detailed MHS enrollment data by state can be found on page 40.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Recent Three-Year Trend in Eligibles and Users

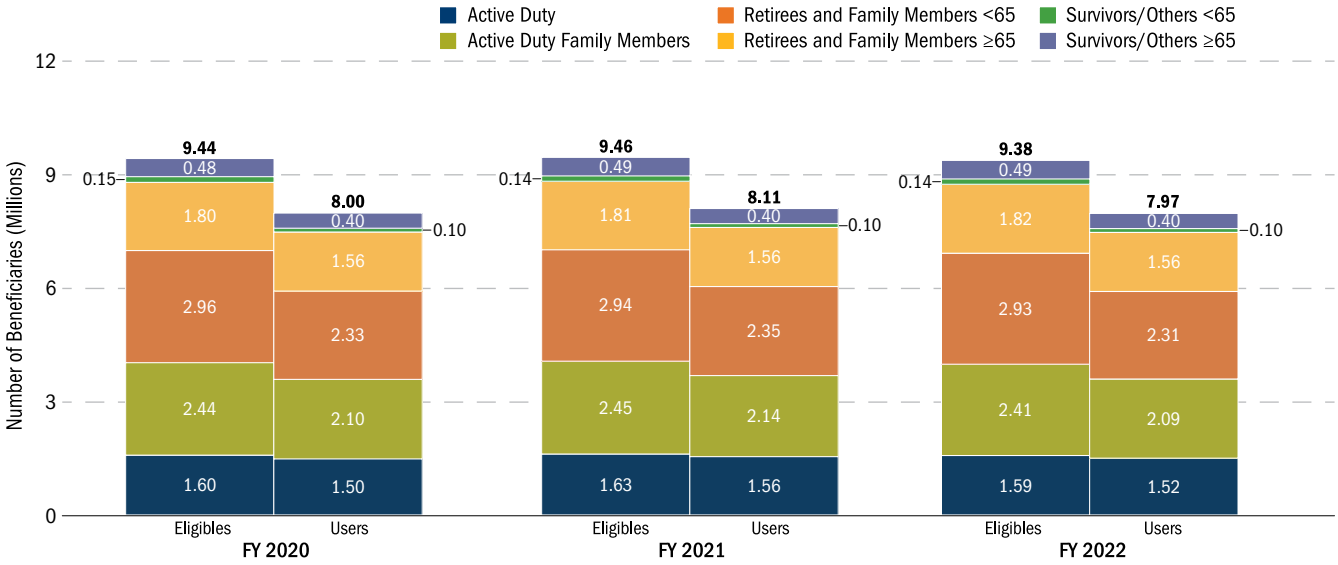
This section compares the number of users of MHS services with the numbers of eligibles. Because beneficiaries eligible for any part of the year can be users, average (rather than end-year) beneficiary counts were used for all calculations.

The average numbers of eligibles by beneficiary category[1] from FY 2020 to FY 2022 were determined from DEERS data. The eligible counts include all beneficiaries eligible for some form of the military health care benefit.

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

The overall user rate remained at about 85 percent from FY 2020 to FY 2022.

RECENT THREE-YEAR TREND IN ELIGIBLES AND USERS, FYs 2020–2022



Sources: DEERS and MHS administrative data, 12/30/2022

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

MHS POPULATION: ENROLLEES AND TOTAL POPULATION BY STATE

STATE	TOTAL POPULATION	TRS ENROLLED	PRIME ENROLLED				
			ACTIVE DUTY AND GUARD/RESERVE ON ACTIVE DUTY	DEPENDENTS OF ACTIVE DUTY AND GUARD/RESERVE ON ACTIVE DUTY	RETIRED	RETIRED FAMILY MEMBERS/ OTHERS	TOTAL
AK	81,063	1,527	22,591	23,024	4,493	8,066	58,174
AL	208,863	9,301	12,099	22,225	18,019	31,393	83,736
AR	84,350	5,097	5,994	8,108	4,859	8,515	27,476
AZ	207,503	9,494	21,518	25,938	16,006	27,985	91,447
CA	746,603	21,427	175,509	138,414	37,375	71,259	422,557
CO	248,732	10,275	44,485	44,189	17,275	30,954	136,903
CT	47,299	2,469	8,081	6,904	2,090	3,463	20,538
DC	23,461	797	13,029	2,973	764	847	17,613
DE	33,850	1,585	4,287	4,535	2,637	4,121	15,580
FL	740,541	26,523	75,878	85,273	62,030	102,112	325,293
GA	436,170	17,283	71,054	69,957	36,511	63,486	241,008
HI	145,286	2,138	43,751	42,072	5,037	8,473	99,333
IA	47,218	4,839	2,132	3,373	771	1,398	7,674
ID	57,323	3,860	5,146	5,958	3,045	5,508	19,657
IL	148,337	9,167	28,271	17,288	8,478	14,529	68,566
IN	98,811	10,087	5,846	8,064	4,345	8,672	26,927
KS	117,904	5,842	23,809	24,756	6,228	11,908	66,701
KY	147,988	5,984	38,999	21,518	7,468	13,019	81,004
LA	118,770	6,102	18,935	18,973	6,554	11,596	56,058
MA	68,751	5,303	6,814	7,569	5,869	9,106	29,358
MD	239,763	7,887	37,616	44,573	27,291	40,588	150,068
ME	38,915	1,871	1,607	3,288	7,104	10,430	22,429
MI	101,500	6,142	4,775	7,276	3,682	6,243	21,976
MN	70,497	9,044	3,590	4,051	134	348	8,123
MO	152,989	11,334	17,236	18,702	8,282	15,233	59,453
MS	114,253	8,423	17,372	12,581	5,982	10,038	45,973
MT	37,750	2,192	4,531	4,347	910	1,528	11,316
NC	507,456	14,796	102,074	95,874	27,944	49,262	275,154
ND	33,326	2,014	8,475	7,100	1,139	1,982	18,696
NE	60,524	3,970	7,817	8,362	3,542	6,506	26,227
NH	31,075	1,922	2,102	2,228	4,597	6,842	15,769
NJ	85,678	7,259	12,520	13,814	5,035	8,840	40,209
NM	80,662	1,935	14,552	13,198	5,387	8,798	41,935
NV	107,252	3,601	13,827	14,528	8,052	13,053	49,460
NY	170,976	6,924	28,628	28,982	9,529	16,542	83,681
OH	172,314	12,144	12,526	15,030	7,187	12,799	47,542
OK	153,683	6,412	25,349	23,146	10,514	18,960	77,969
OR	65,853	2,832	3,728	3,919	972	1,677	10,296
PA	161,572	9,543	7,855	12,007	7,602	13,117	40,581
RI	24,186	1,188	4,723	3,537	1,466	2,414	12,140
SC	249,140	10,048	41,552	29,842	16,523	28,025	115,942
SD	35,593	4,130	4,365	4,634	1,402	2,335	12,736
TN	203,218	11,702	6,560	23,662	11,188	19,874	61,284
TX	968,807	56,452	149,392	135,795	80,291	147,934	513,412
UT	78,067	9,586	7,136	10,767	4,534	9,170	31,607
VA	731,708	15,470	136,033	133,212	52,296	83,441	404,982
VT	13,515	919	944	1,279	1,307	1,981	5,511
WA	340,062	8,808	66,895	63,103	25,407	43,212	198,617
WI	77,794	8,094	4,191	5,071	1,058	1,861	12,181
WV	36,261	2,307	1,941	2,149	1,098	1,676	6,864
WY	23,988	1,563	3,892	3,924	1,215	1,978	11,009
Subtotal	**8,977,200**	**409,612**	**1,382,032**	**1,331,092**	**592,524**	**1,023,097**	**4,328,745**
Overseas	**518,322**	**2,681**	**189,504**	**106,298**	**443**	**12,013**	**308,258**
Total	**9,495,522**	**412,293**	**1,571,536**	**1,437,390**	**592,967**	**1,035,110**	**4,637,003**

Source: MHS administrative data systems, as of 12/30/2022 for end of FY 2022

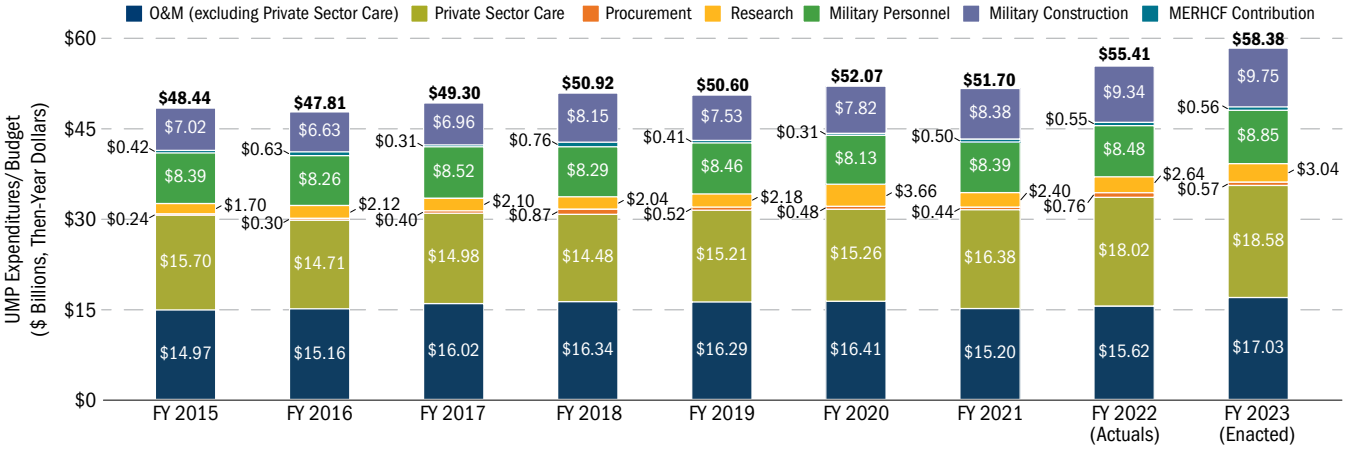
Note: Prime Enrolled includes Prime (MTF and network PCMs), TRICARE Prime Remote (and Overseas equivalent), TYA Prime, and USFHP; and excludes members in TRICARE Select, TYA Select, TRS, TRR, TRICARE Plus, and TFL.

UNIFIED MEDICAL PROGRAM FUNDING

The Defense Department's FY 2023 Enacted Budget for health care services is $58.4 billion. In nominal terms, this is about 5.37 percent higher than the actual $55.4 billion FY 2022 expenditures.

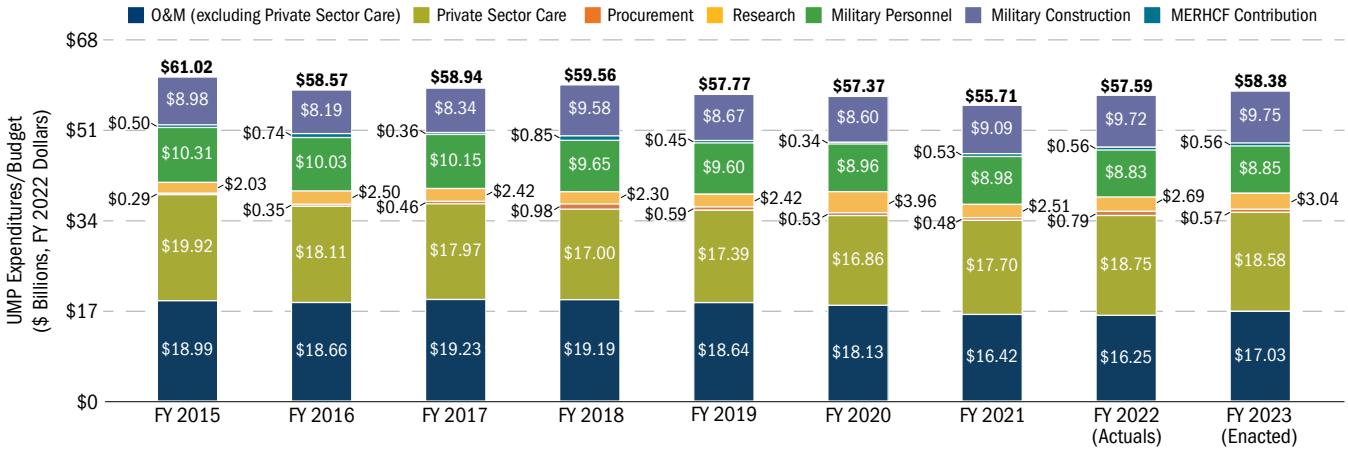
The FY 2023 Enacted Budget has three components. The first is the Defense Health Program (DHP) appropriation, which is a unique three-in-one appropriation consisting of funds for operation and maintenance (O&M); procurement; and research, development, test, and evaluation (RDT&E), and totaling $39.2 billion. Of that amount, $18.6 billion (nearly 50 percent) is partitioned off for TRICARE/private sector care. The second component is composed of military personnel (MILPERS) and military construction (MILCON), which total $9.4 billion. Amounts for MILPERS are retained within the Military Department MILPERS appropriations and amounts for MILCON are retained within the MILCON appropriation. The third component is the Medicare-Eligible Retiree Health Care Fund (MERHCF), totaling $9.7 billion. The MERHCF is a trust fund established to pay for the costs of health care (both direct and private sector care) for military Medicare-eligible retirees, retiree family members, and survivors.

UMP FUNDING AND TRUST FUND CONTRIBUTIONS ($ BILLIONS) IN CURRENT (THEN-YEAR) DOLLARS, FYs 2015–2023



Using constant dollars, the FY 2023 request is about $5.4 billion (9.7 percent) less than real FY 2015 expenditures.

UMP FUNDING AND TRUST FUND CONTRIBUTIONS ($ BILLIONS) IN CONSTANT 2021 DOLLARS, FYs 2015–2023



Source: UMP cost and budget estimates, DHA/Resources Management Directorate (J-8)/Budget & Execution Division, 11/7/2022

Notes:

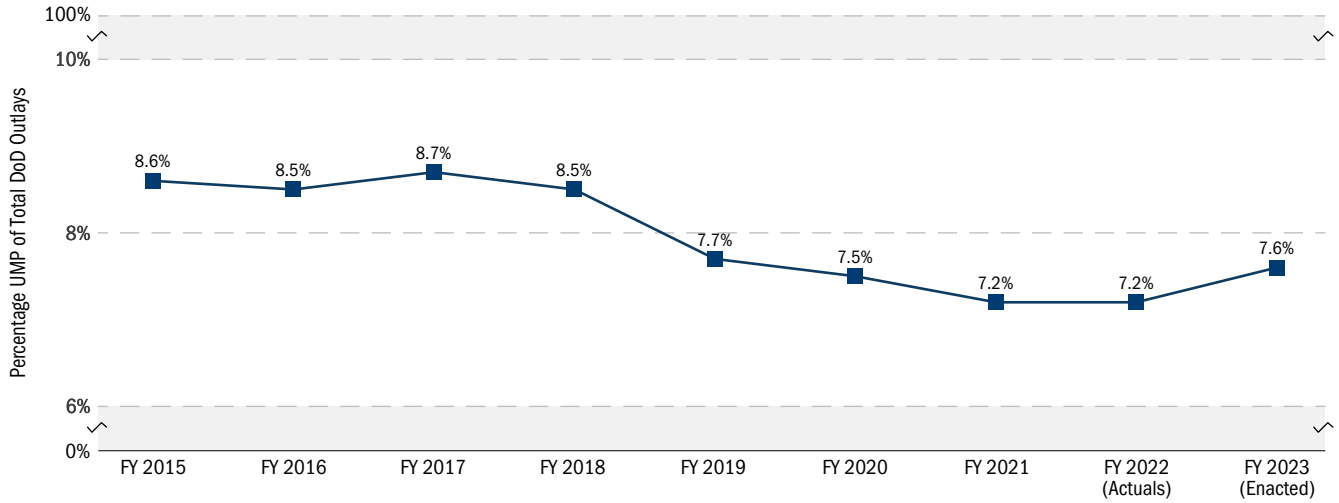
– FYs 2015–2021 reflect Comptroller Information System actual execution.
– FY 2022 reflects the DHP Enacted Budget.
– Source of data for deflators (MILPERS, DHP, Procurement, RDT&E, and MILCON) is Table 5-5, Department of Defense Deflators—TOA by Category–TOA, National Defense Budget Estimates for FY 2023 (Green Book).
– Medicare Eligible Retiree Healthcare Fund Deflator computed using a combination of MILPERS (5%) and DHP factors (95%).
– FY 2015 actuals includes $344.645M for Overseas Contingency Operations (OCO).
– FY 2016 actuals includes $285.032M for OCO.
– FY 2017 actuals includes $332.603M for OCO.
– FY 2018 actuals includes $405.856M for OCO.
– FY 2019 actuals includes $349.422M for OCO.
– FY 2020 includes $2.503B Coronavirus Aid, Relief, and Economic Security (CARES) Act Supplemental and $347.746M OCO supplemental funding enacted for O&M.
– FY 2021 actuals includes $354.322M OCO supplemental funding execution. It also includes $663M reprogrammed into O&M.
– FY 2022 actuals includes $228.412M for Overseas Operations Costs (OOC) and $429.415M for enduring COVID-19 requirements.
– FY 2023 Enacted President's Budget includes $197.1M for COVID-19 requirements and $116.171M for OOC.

UNIFIED MEDICAL PROGRAM FUNDING *(CONT.)*

UMP Share of Defense Budget

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

UMP EXPENDITURES AS A PERCENTAGE OF TOTAL DoD OUTLAYS, FYs 2015–2023

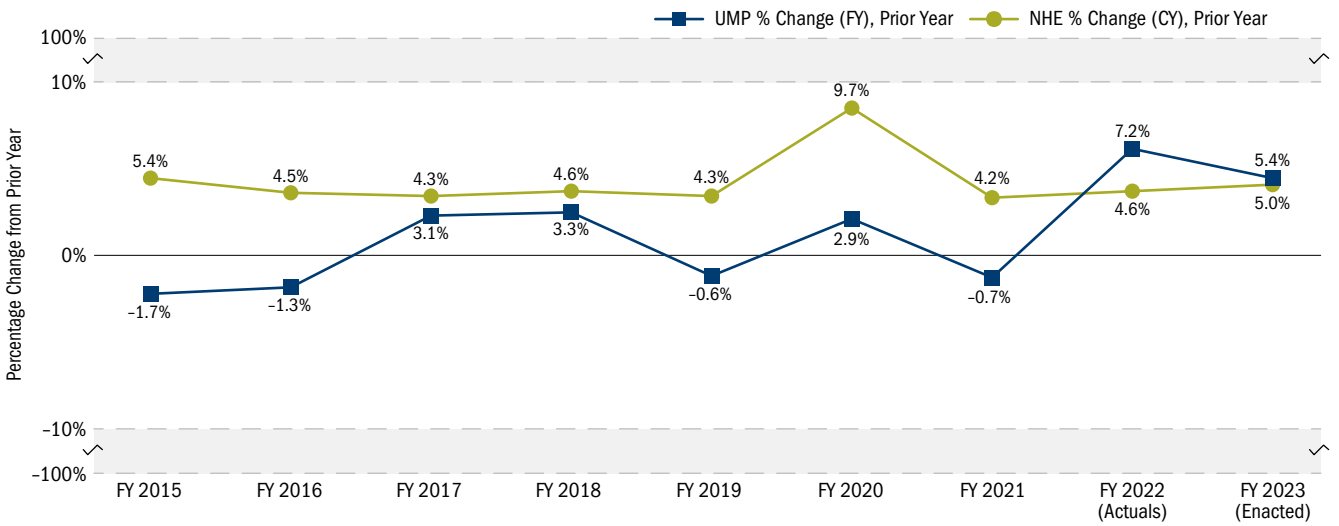


Source: UMP cost and budget estimates, DHA/Financial Operations Directorate (J-8)/DHP Budget and Execution Division, 02/28/2023
Note: Percentages are estimates of total DoD outlays reflected in the FY 2023 Enacted President's Budget.

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

As shown in the chart below, the annual rate of growth in the UMP (in then-year dollars, including MERHCF distributions) has fluctuated from a high of 7.2 percent in FY 2022 to 5.4 percent projected in FY 2023. By comparison, the NHE series compiled by the Centers for Medicare & Medicaid Services (CMS) has grown at about 5.0 percent year-over-year for the same period.

COMPARISON OF CHANGE IN ANNUAL UMP (INCLUDING MERHCF OUTLAYS) AND NHE ESTIMATED EXPENDITURES OVER TIME (UNADJUSTED, THEN-YEAR DOLLARS): 2015–2023



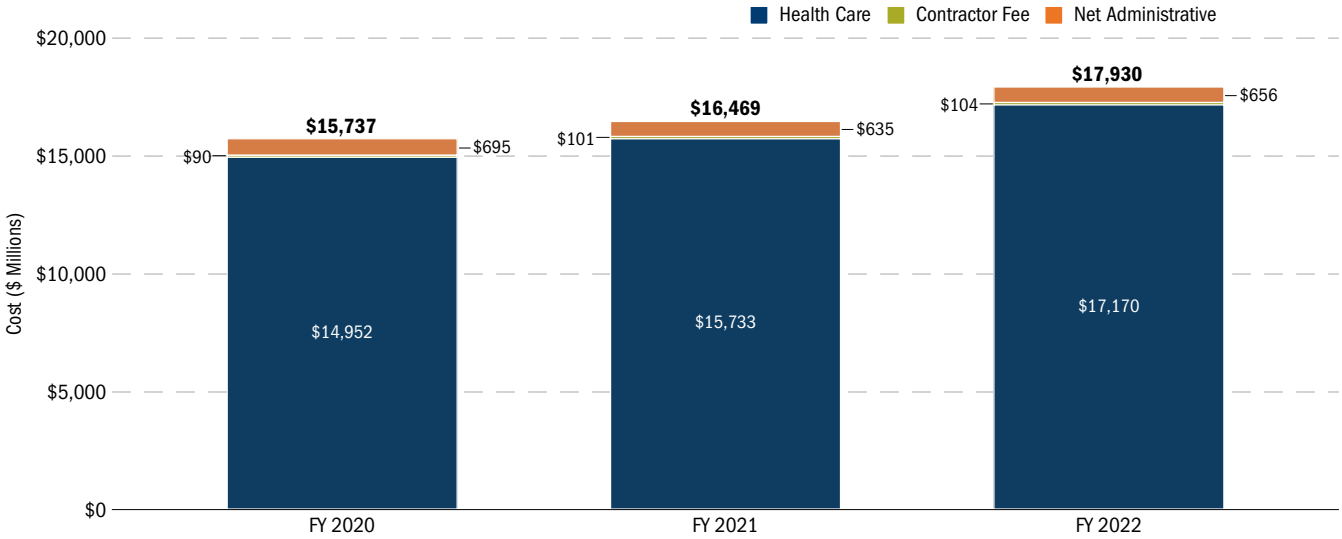
Source: UMP cost and budget estimates, DHA/Financial Operations Directorate (J-8)/DHP Budget and Execution Division, 02/28/2023, using NHE data from CMS, Office of the Actuary, NHE Projections 2019–2030, Tables Table 02, National Health Expenditure Amounts and Annual Percent Change by Type of Expenditure: Calendar Years 2012–2030; https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html
Note: DoD UMP data are in fiscal years; CMS NHE data are in calendar years.

PRIVATE SECTOR CARE ADMINISTRATIVE COSTS

The Private Sector Care Budget Activity Group (PSC BAG) includes underwritten health, pharmacy, AD 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 graph below differ from the PSC BAG because the former excludes settlements paid in prior years, undefinitized change-order costs, and certain DoD internal/overhead costs, but includes funds authorized and executed under the DHP carry-over authority.[1]

- Private sector care (PSC) costs increased from $15,737 million in FY 2020 to $17,930 million (14 percent) in FY 2022. Costs increased by 5 percent in FY 2021 and by another 9 percent in FY 2022.
- On January 1, 2018, DHA began collecting Prime enrollment fees that were previously held by the contractors to offset their administrative costs. DHA collected $293 million in Prime enrollment fees in FY 2021.
- On January 1, 2021, DHA began collecting Select enrollment fees as well for Group A retirees (those whose initial enlistment or appointment or that of the uniformed services sponsor began before January 1, 2018). As a result, DHA saw an increase in its enrollment fee collections to $363 million in FY 2021 and to $400 million in FY 2022, when it collected a full year of enrollment fees.
- Net of Prime/Select enrollment fees, PSC administrative costs decreased by 9 percent in FY 2021 but increased by 3 percent in FY 2022.
- Excluding contractor fees, net administrative expenses decreased from 4.4 percent of total PSC costs in FY 2020 ($695 million of $15,647 million) to 3.7 percent in FY 2022 ($656 million of $17,826 million). Including contractor fees (in both administrative and total costs), net administrative expenses decreased from 5.0 percent of total PSC costs in FY 2020 ($785 million of $15,737 million) to 4.2 percent in FY 2022 ($760 million of $17,930 million).
- Contractor fees increased by 16 percent between FY 2020 and FY 2022, although they remained roughly the same as a proportion of total PSC health care costs.

TRENDS IN PRIVATE SECTOR CARE COSTS, FYs 2020–2022



Source: DHA/Resources & Management (J-1/J-8)/CRM (Administrative Costs), 11/4/2022

[1] DHA has congressional authority to carry over 1 percent of its O&M funding into the following year. The amount carried forward from the prior-year appropriation was $0 in FY 2020, $313 million in FY 2021, and $98 million in FY 2022.

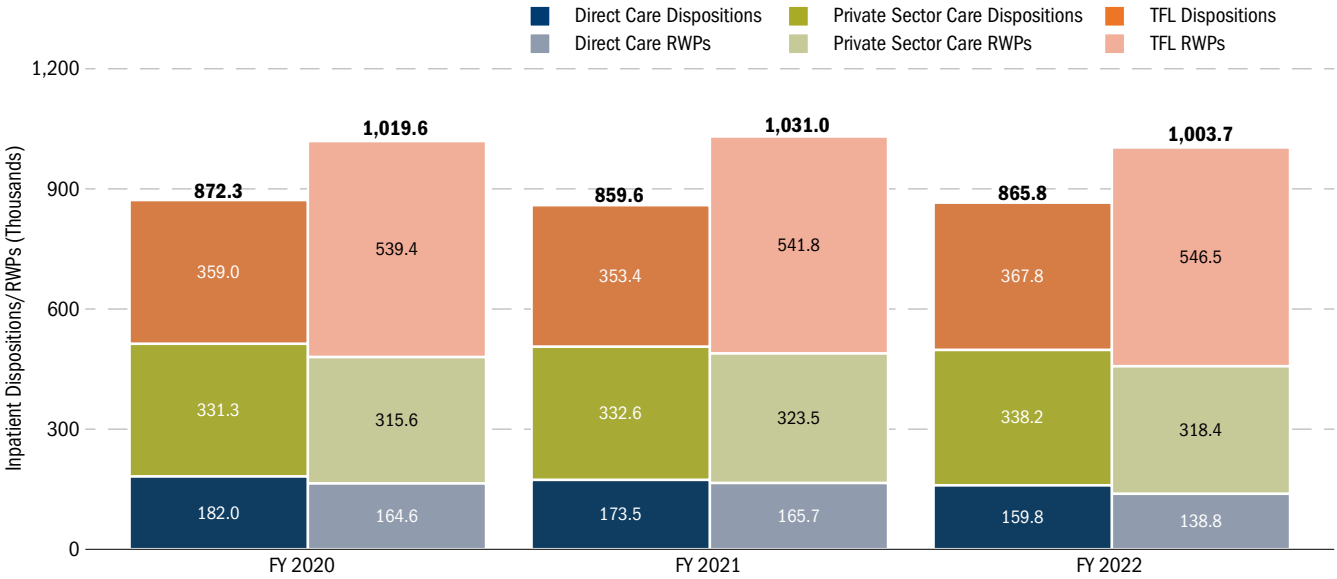
MHS WORKLOAD TRENDS (DIRECT AND PRIVATE SECTOR CARE)

MHS Inpatient Workload

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

- Total inpatient dispositions (direct and private sector care combined) declined by 3 percent and RWPs by 5 percent between FY 2020 and FY 2022, excluding the effect of TFL.[1]
- Direct care inpatient dispositions decreased by 12 percent and RWPs by 16 percent over the past three years. Possible reasons for the large drop in direct care dispositions is the downsizing of three MHS hospitals to clinics and the impact of the COVID-19 pandemic.
- Excluding TFL workload,[2] private sector care inpatient dispositions increased by 2 percent, while RWPs increased by 1 percent between FY 2020 and FY 2022.
- Including TFL workload, private sector care dispositions increased by 2 percent, while RWPs increased by 1 percent between FY 2020 and FY 2022.
- Although not shown, about 9 percent of direct care inpatient workload (dispositions) was performed abroad in FY 2022. Private sector care and TFL inpatient workload performed abroad accounted for about 2 percent of the worldwide total.

TRENDS IN MHS INPATIENT WORKLOAD, FYS 2020–2022



Source: MHS administrative data, 1/20/2023

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

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

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

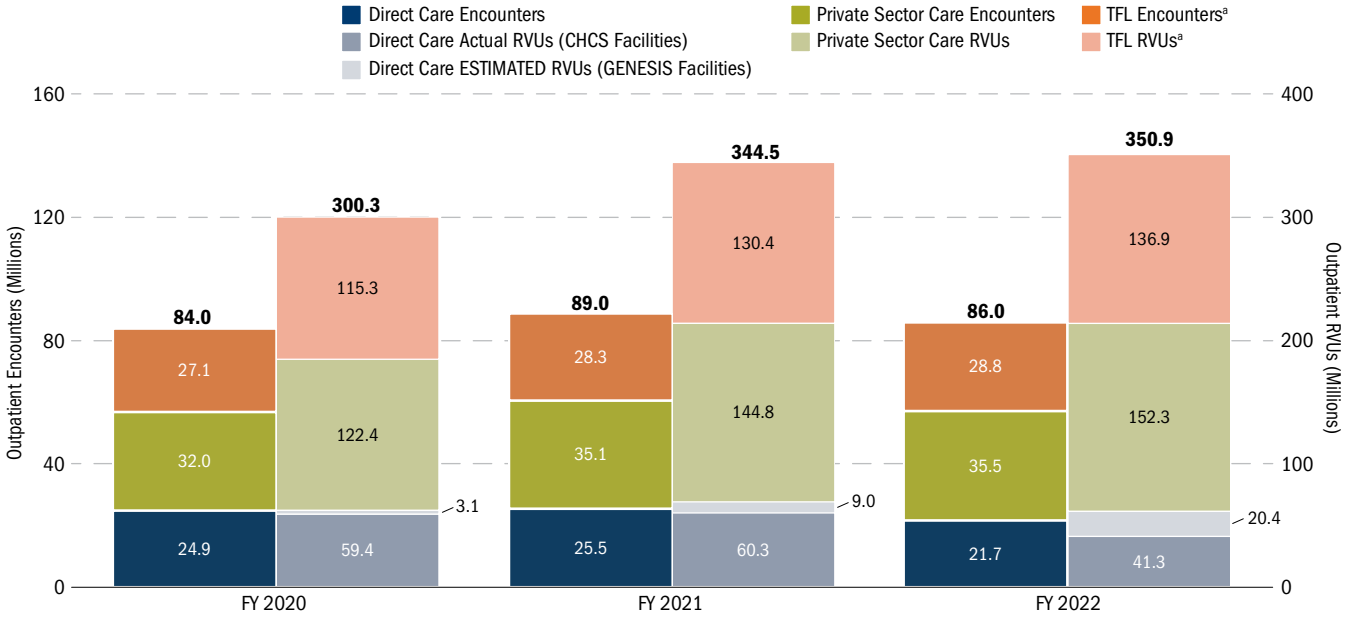
MHS WORKLOAD TRENDS (DIRECT AND PRIVATE SECTOR CARE) *(CONT.)*

MHS Outpatient Workload

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

- Total outpatient encounters (direct and private sector care combined) increased by less than 1 percent, while RVUs increased by 16 percent between FY 2020 and FY 2022, excluding the effect of TFL.
- Direct care outpatient encounters decreased by 13 percent and RVUs decreased by 1 percent over the past three years.
- Excluding TFL workload, private sector care outpatient encounters increased by 11 percent and RVUs by 24 percent. Including TFL workload, private sector care outpatient encounters increased by 9 percent and RVUs by 22 percent.[1]
- Although not shown, about 10 percent of direct care outpatient workload (encounters) was performed abroad. Private sector care and TFL outpatient workload performed abroad accounted for less than 1 percent of the worldwide total.

TRENDS IN MHS OUTPATIENT WORKLOAD, FYs 2020–2022



Source: MHS administrative data, 1/20/2023

[a] Private sector care only

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

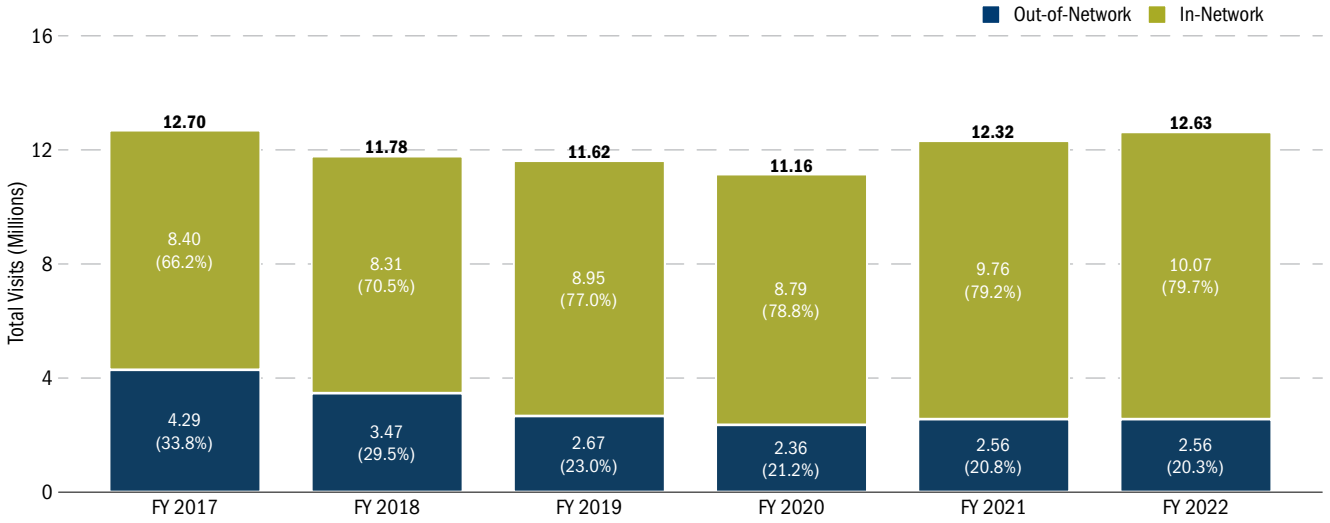
Note: Numbers may not sum to bar totals due to rounding.

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

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

For beneficiaries not enrolled in Prime, the ratio of in-network to out-of-network visits has steadily increased. In FY 2008, in-network visits accounted for only 46 percent of all non-Prime visits. By FY 2009, the number of in-network visits exceeded the number of out-of-network visits for the first time (51 percent). In FY 2022, 80 percent of all non-Prime visits were to in-network providers. One likely reason for the increasing use of in-network providers is the expansion of the TRICARE provider network (see page 172).

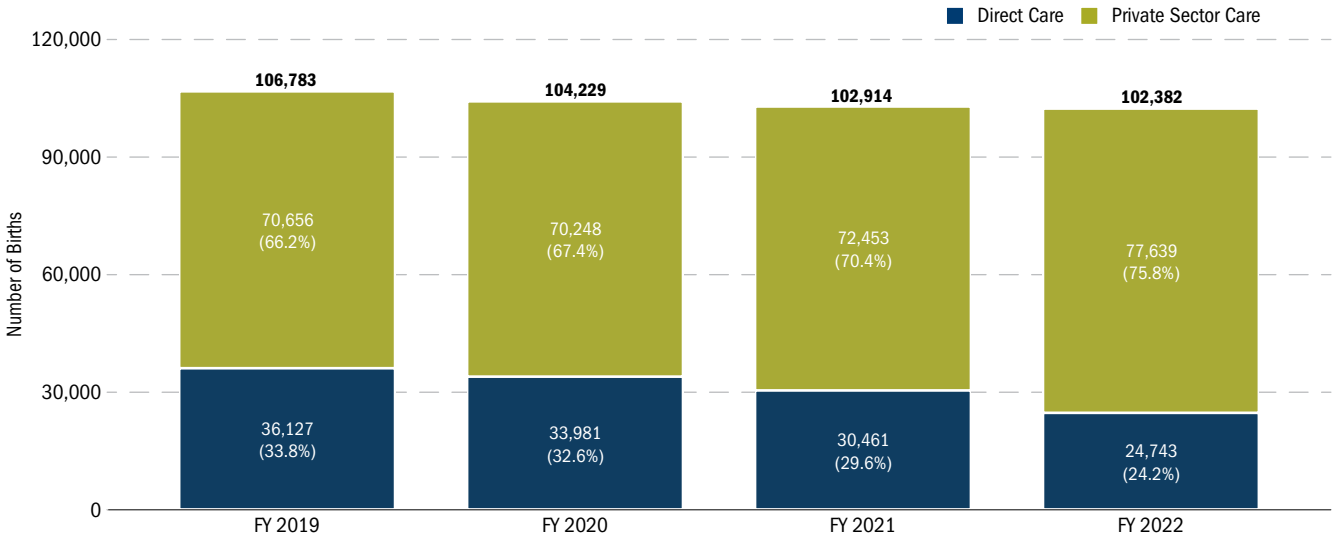
TRENDS IN OUT-OF-NETWORK VS. IN-NETWORK VISITS, FYs 2017–2022



MTF Market Share for Childbirths

Overall MTF obstetric market share decreased from 34 percent to 24 percent between FY 2019 and FY 2022. This trend is likely due, at least in part, to the migration of Prime enrollees from an MTF to a network PCM (see the table on page 34) and the downsizing of four MTF hospitals to clinics during that time period. In FY 2022, individual MTF shares in the U.S. ranged from 39 percent to 99 percent.

TRENDS IN MTF MARKET SHARE FOR CHILDBIRTHS, FYs 2019–2022



Source: MHS administrative data, 1/20/2023

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

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

Urgent Care (UC) Utilization

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

- UC encounters increased 131 percent from FY 2017 to FY 2022, while RVUs increased by 205 percent (FY 2017 not shown).
- The government share of the cost for UC increased by $156 million (236 percent) from FY 2017 to FY 2022 (FY 2017 not shown).
- UC utilization and costs increased steadily from FY 2017 to FY 2019 but leveled off in FY 2020 (possibly due to COVID-19). However, they began to rise again in FY 2021 (24 percent for encounters, 42 percent for RVUs, and 59 percent for government costs) and continued to rise in FY 2022.
- ADFMs with an MTF PCM constitute by far the largest share of total UC utilization and government cost.

TRENDS IN UC UTILIZATION, FYs 2020–2022

BENEFICIARY CATEGORY	ENROLLMENT STATUS	FY	ENCOUNTERS	RVUs	GOVERNMENT COST
Active Duty	All	2020	128,029	333,997	$14,709,270
		2021	233,497	698,464	$31,480,349
		2022	242,936	826,522	$35,392,037
Active Duty Family Members	MTF PCM	2020	314,254	809,060	$33,867,781
		2021	309,827	915,551	$39,045,191
		2022	360,775	1,195,446	$49,242,161
	Network PCM	2020	143,022	367,838	$15,959,246
		2021	168,164	500,655	$22,057,900
		2022	177,017	583,357	$24,795,814
	Nonenrolled	2020	238,166	607,597	$18,308,532
		2021	294,915	868,474	$31,658,662
		2022	313,161	1,020,357	$34,468,071
Retirees and Family Members <65	MTF PCM	2020	157,722	401,400	$12,540,651
		2021	194,479	566,279	$20,668,181
		2022	196,503	660,545	$23,217,390
	Network PCM	2020	174,265	448,145	$14,773,245
		2021	229,157	681,450	$25,748,041
		2022	225,958	756,056	$27,047,257
	Nonenrolled	2020	219,338	554,400	$13,623,992
		2021	268,723	782,380	$25,829,351
		2022	272,624	884,828	$27,142,934
Retirees and Family Members ≥65	All	2020	263	572	$233,004
		2021	430	1,078	$197,977
		2022	552	1,468	$266,840
Total	**All**	**2020**	**1,375,059**	**3,523,008**	**$124,015,721**
		2021	**1,699,192**	**5,014,331**	**$196,685,653**
		2022	**1,789,526**	**5,928,579**	**$221,572,503**

Source: MHS administrative data, 1/20/2023

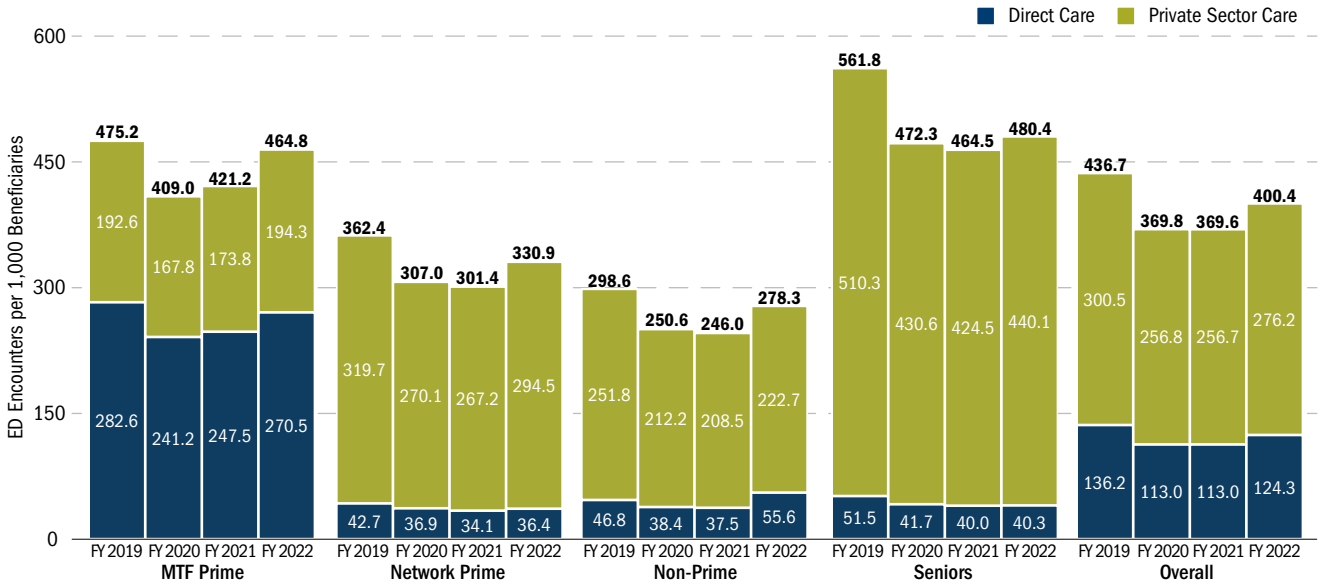
MHS WORKLOAD TRENDS (DIRECT AND PRIVATE SECTOR CARE) *(CONT.)*

ED Utilization

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

- ED utilization per capita for MTF Prime enrollees declined in FYs 2020 and 2021 but rebounded in FY 2022 to a level 2 percent lower than it was in FY 2019. A similar pattern was observed for Network Prime enrollees, but the rebound was smaller (to 9 percent below the FY 2019 level). One likely reason for the sudden drop in MHS ED encounters in FYs 2020 and 2021 is the impact of the COVID-19 pandemic.[2,3]
- The rate for non-Prime enrollees declined by 7 percent over the same time period. One possible reason for the decline is increased access to urgent care by TRICARE beneficiaries (see page 47).
- In FY 2022, MTF Prime enrollees had an ED utilization rate 40 percent higher than that of network Prime enrollees and 67 percent higher than that of nonenrollees. Network Prime enrollees had an ED utilization rate 19 percent higher than that of nonenrollees.
- For MTF Prime enrollees, 42 percent of ED encounters were in private sector care facilities (not necessarily in network) in FY 2022.
- Children under five years old had the highest ED utilization rate for all enrollment groups (not shown).
- The FY 2019 MHS rate of 437 encounters per 1,000 beneficiaries is 8 percent lower than the civilian rate of 475 per 1,000 reported in the same year.[4] (CY 2019 is the most recent year for which civilian data are available.)

ED UTILIZATION BY ENROLLMENT STATUS AND SOURCE OF CARE (ENCOUNTERS PER 1,000 BENEFICIARIES), FYs 2019–2022



Source: MHS administrative data, 1/20/2023

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

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

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

[4] CDC, "National Hospital Ambulatory Medical Care Survey: 2019 Emergency Department Summary Tables," Table 2, https://www.cdc.gov/nchs/data/nhamcs/web_tables/2019-nhamcs-ed-web-tables-508.pdf. The civilian ED rate reported on this page is somewhat lower than the rate reported by the CDC because we adjust the rate for the age/sex distribution of the military population.

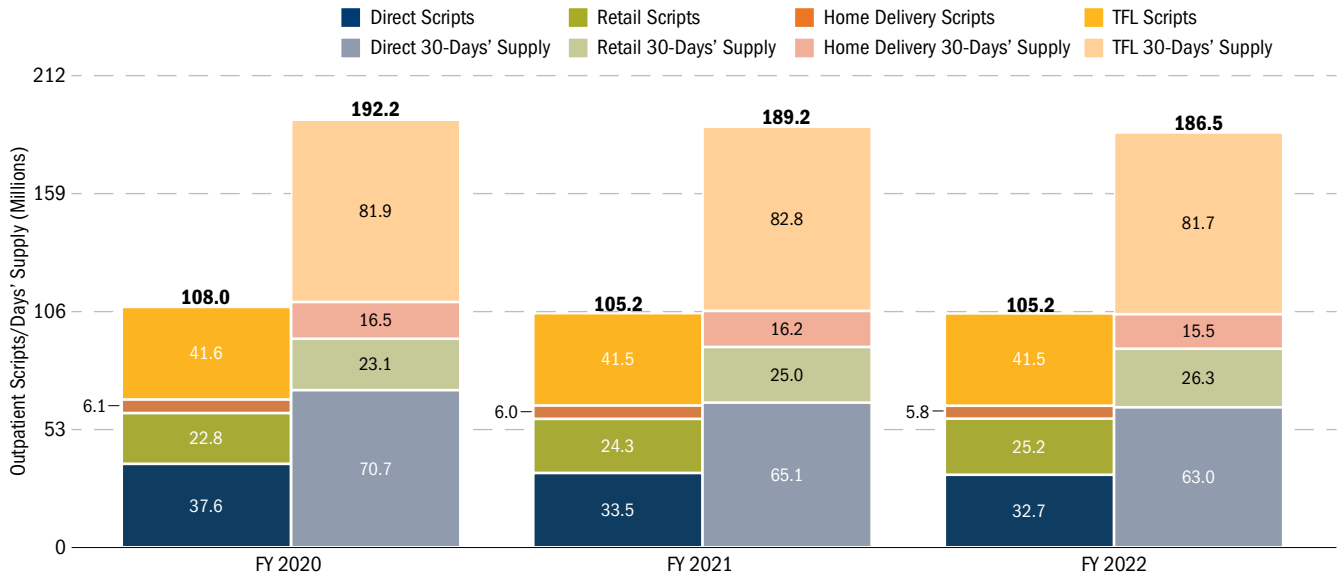
Note: Numbers may not sum to bar totals due to rounding.

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

MHS Prescription Drug Workload

TRICARE beneficiaries can fill prescription medications at MTF and private sector care pharmacies (including retail network and non-network pharmacies and through home delivery). Total outpatient prescription workload is measured two ways: as the number of prescriptions and as the number of days' supply (in 30-day increments). Total prescription drug workload (all sources combined) decreased between FY 2020 and FY 2022 (prescriptions fell by 4 percent and days' supply by 5 percent), excluding the effect of TFL private sector care pharmacy usage.

TRENDS IN MHS PRESCRIPTION WORKLOAD, FYs 2020–2022



Source: MHS administrative data, 1/20/2023

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

- Direct care prescriptions decreased by 13 percent, while days' supply declined by 11 percent between FY 2020 and FY 2022.
- Private sector care prescriptions (retail and home delivery combined) increased by 7 percent and days' supply by 6 percent from FY 2020 to FY 2022, excluding TFL utilization. Including TFL utilization, private sector care prescriptions increased by 3 percent and days' supply by 2 percent.
- Although not shown, about 7 percent of direct care prescriptions were issued abroad in FY 2022. Private sector care prescriptions issued abroad accounted for 2 percent of the worldwide total.

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

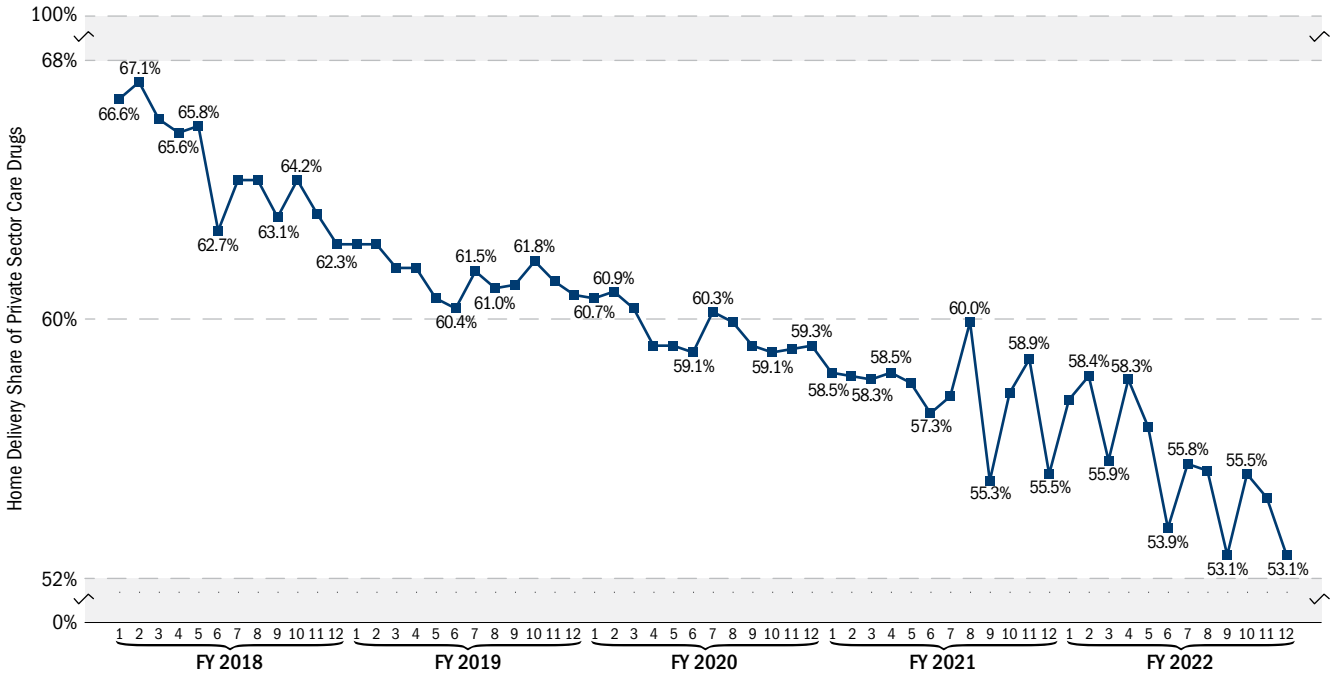
MHS Prescription Drug Workload *(cont.)*

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

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

The home delivery share of total private sector care utilization had been on the rise since the DoD changed the copayment structure for retail/home delivery drugs at the beginning of FY 2012. From FY 2016 to FY 2017, the home delivery share of private sector care pharmacy utilization (as measured by days' supply) increased from 63 percent to 67 percent (not shown).[1] However, in FY 2018, the home delivery copayment for a 90-day supply of generic formulary drugs rose from $0 to $7 (versus $11 for a 30-day supply at retail pharmacies). By FY 2022, the home delivery copayment had risen to $12 (versus $14 for a 30-day supply at retail pharmacies), further reducing the disparity in copayments between home delivery and retail drugs. This likely contributed to the decrease in the home delivery share of total private sector care utilization from 65 percent in FY 2018 to 56 percent in FY 2022. Another possible explanation for the decline in the home delivery share is that because the copayment for retail generic drugs is the lower of the statute copayment and the actual government cost (after rebates), the average retail generic drug copayment is less than that for home delivery drugs (albeit for a lower average days' supply).

TREND IN HOME DELIVERY UTILIZATION (DAYS' SUPPLY) AS A SHARE OF TOTAL PRIVATE SECTOR CARE UTILIZATION, FYs 2018–2022



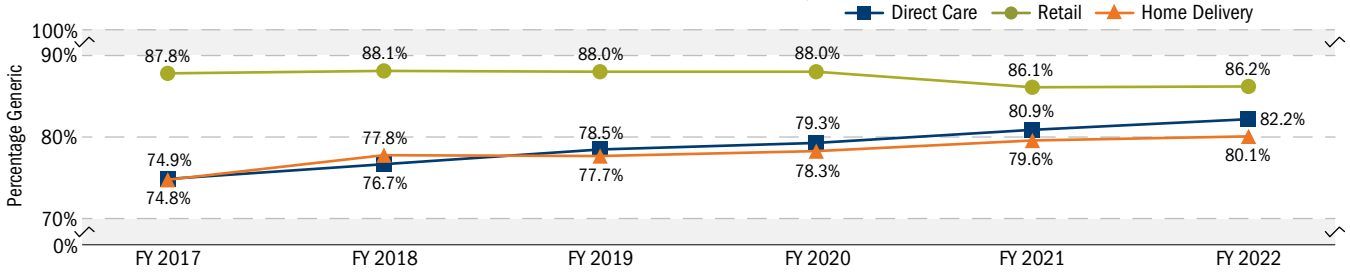
Source: MHS administrative data, 1/20/2023

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

COST SAVINGS EFFORTS IN DRUG DISPENSING

- The rate of generic drug dispensing has been increasing for both direct and home delivery pharmacies. Direct care pharmacies have seen the larger increase, from 75 percent in FY 2017 to 82 percent in FY 2022. Home delivery pharmacies dispensed generic drugs at a slightly lower rate, from 75 percent in FY 2017 to 80 percent in FY 2022. Retail pharmacies continued to dispense the highest percentage of generic drugs in FY 2022 (86 percent).
- The direct and PSC generic drug dispensing rates in FY 2022 were both lower than that of the civilian sector (91 percent).[1,2]
- The average cost to the DoD for a 30-day supply of a brand versus generic drug in FY 2022 was as follows: direct care (MTF): $95 versus $15; retail network: $680 (net of manufacturer refunds) versus $8, and home delivery: $190 versus $9. Note that costs are not adjusted for differences in drug types or drug mix between brand and generic at the three pharmacy points of service.

TRENDS IN GENERIC DRUG DISPENSING, FYs 2017–2022

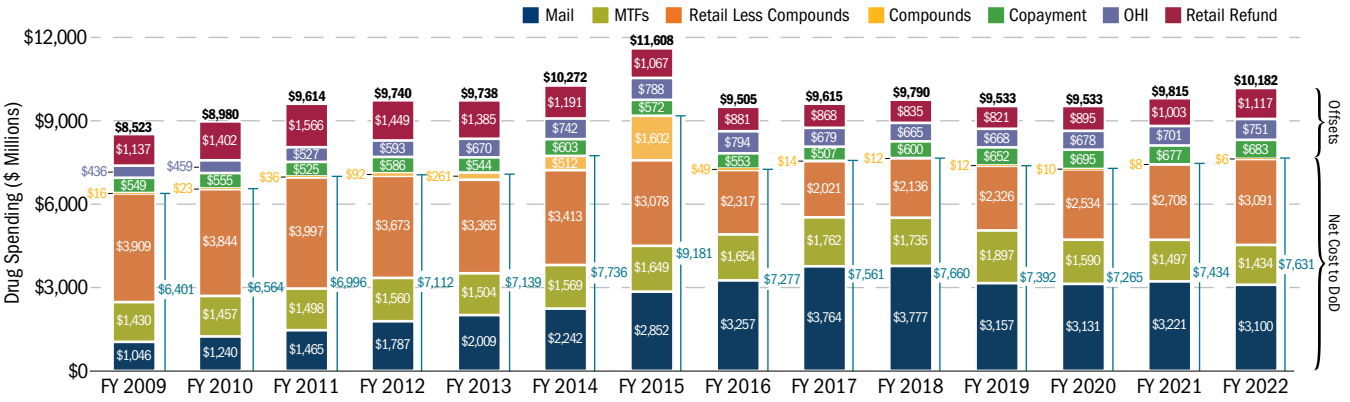


Source: MHS administrative data, 1/20/2023

The NDAA for FY 2008 mandated that the TRICARE retail pharmacy program be treated as an element of the DoD and, as such, be subject to the same pricing standards as other federal agencies. As a result, beginning in FY 2008, drug manufacturers began providing refunds to the DoD on most brand-name retail drugs.

- Although total drug costs have consistently increased over the past decade, retail drug refunds have stemmed the increase in the cost to the DoD. In FY 2022, the refunds are estimated to have saved the DoD $1.1 billion. After rising an average of only 2.7 percent per year from FY 2008 to FY 2014, net DoD costs rose by 19 percent in FY 2015 alone, driven largely by a threefold increase in expenditures for compound drugs. After the DoD was able to control compound drug prices, net DoD costs fell by 21 percent in FY 2016 and have increased only slightly since then.

MHS OUTPATIENT DRUG SPENDING, FYs 2009–2022



Source: Pharmacy Data Transaction Service (PDTS) Data Warehouse, 1/17/2023; DHA Pharmacy Operations Division (refunds), 12/21/2022

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

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

Notes:

– Net cost to DoD represents total prescription expenditures minus copays, OHI, and retail refunds invoiced.
– Mail Order admin fees are included; however, other retail/mail contract costs and MTF cost of dispensing (overhead costs) are not included.
– Retail refunds are reported on an accrual rather than a cash basis, based on original prescription claim data and updated refund adjustments.
– Retail compound spend is not adjusted for any recoveries or settlements with compound pharmacies outside of claims reversals.
– Total expenditures do NOT include costs associated with pharmacy contracts (e.g., Express Scripts).

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

DoD/VA Pharmacy Contracting Initiatives

The Departments continued to maximize efficiencies through joint efforts when possible. National contracts were at a high with 211 existing contracts, of which 42 became effective in FY 2022. There are currently 15 joint contracts pending at the National Acquisition Center and 12 pending at the Defense Logistics Agency. The DoD/VA pharmacy team identified 26 commonly used pharmaceutical products and manufacturers for potential joint contracting action and continues to seek new joint contracting opportunities where possible. In FY 2022, the VA spent $490 million on joint national contracts, and the DoD spent $161 million over the same period.

SPECIALTY DRUG COST TRENDS

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

Although the definition of a specialty drug varies across insurers, the DoD has adopted the following guidelines in order to designate a medication as a specialty drug: (1) one or more of the following clinical factors: difficult to administer, special handling or storage, intense monitoring, high risk of adverse drug events, frequent dose adjustments, Risk Evaluation and Mitigation Strategy (REMS) programs in place, benefits of ongoing training for patients, class not widely used in practice, other drugs in the class are designated as specialty; (2) the cost of the medication to DoD falls in the top 1 percent of spend (cost per 30-day supply); (3) on further review, designation of the medication as specialty continues to provide value to the patient and/or DoD.

By spending, the top five specialty classes as defined by the DoD Pharmacy & Therapeutics (P&T) committee are oncological agents (excluding leukemia/lymphoma and breast cancer agents), targeted immunological biologics (TIBs), atopy agents (asthma/atopic dermatitis), leukemia/lymphoma agents, and multiple sclerosis agents. The DoD P&T Committee continually reviews new specialty medications as part of its new drug review process, with a particular focus on the large number of new oncological agents being introduced to the market.

TOP 20 SPECIALTY CLASSES ($ MILLIONS), AS DEFINED BY P&T COMMITTEE, FYs 2020–2022

FY 2021 RANK	SPECIALTY CLASS	FY 2020	FY 2021	FY 2022	FYs 2021–2022 % CHANGE[a]
1	Oncological	$832	$916	$1,015	11%
2	Targeted Immunomod Biologics	$610	$654	$753	15%
3	Atopy (e.g., dupilumab)	$103	$156	$212	36%
4	Leukemia and Lymphoma (e.g., ibrutinib)	$126	$144	$161	11%
5	Multiple Sclerosis	$178	$152	$149	–2%
6	Pulmonary Arterial Hypertension	$130	$134	$138	3%
7	Breast Cancer	$102	$116	$136	18%
8	Antiretrovirals	$143	$139	$130	–7%
9	Immunological Misc (Immune globulins)	$93	$108	$124	15%
10	Cystic Fibrosis	$99	$100	$111	12%
11	Neurological Misc	$60	$83	$108	29%
12	Pulmonary-1 (e.g., nintedanib, pirfenidone)	$60	$69	$79	16%
13	Sleep Disorders (e.g., sodium oxybate)	$63	$55	$61	12%
14	Corticosteroid-Immune Modulators	$43	$44	$57	30%
15	Metabolic Misc	$46	$50	$56	12%
16	Antihemophilic Factors	$66	$60	$51	–16%
17	Hematological Factors	$34	$40	$47	19%
18	Gastrointestinal-2 Agents	$30	$33	$37	11%
19	Endocrine Misc	$32	$31	$30	–5%
20	Anticonvulsants–Antimania	$18	$19	$25	31%

Source: PDTS Data Warehouse, 12/21/2022

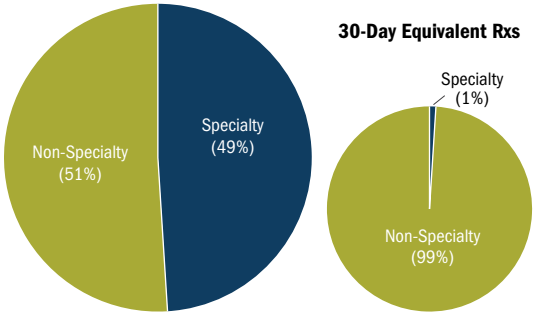
[a] The percentage changes are based on the original unrounded numbers.

Note: Includes only specialty agents in given classes; total classes; total costs in $ millions, adjusted for retail refunds; Q4 FY 2022 Specialty Agent Reporting list applied to all data.

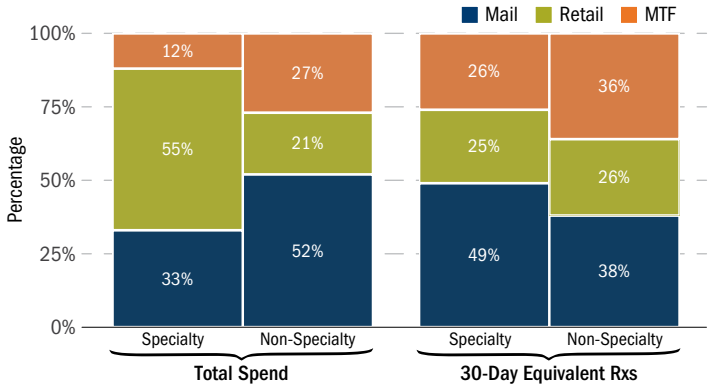
SPECIALTY DRUG COST TRENDS *(CONT.)*

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

FY 2022 TOTAL SPENDING



FY 2022 TOTAL SPENDING BY POINT OF SERVICE



Source: PDTS Data Warehouse, 12/21/2022

TOTAL ESTIMATED SPENDING ($ MILLIONS) BY QUARTER, FYs 2019–2022

	FY 2019				FY 2020				FY 2021				FY 2022			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Non-Specialty	$1,058	$1,126	$1,130	$1,128	$1,050	$980	$899	$982	$1,008	$949	$954	$948	$960	$885	$884	$901
Specialty	$612	$665	$685	$729	$739	$794	$788	$828	$819	$825	$853	$872	$873	$928	$959	$984
Percentage Specialty[a]	36.7%	37.1%	37.7%	39.3%	41.3%	44.8%	46.7%	45.7%	44.8%	46.5%	47.2%	47.9%	47.6%	51.2%	52.0%	52.2%

Source: As of 12/21/2022, based on Specialty Agent Reporting List for applicable quarters; totals adjusted for retail refunds, copayments, and against prime vendor cost per unit for MTF and home delivery drugs.

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

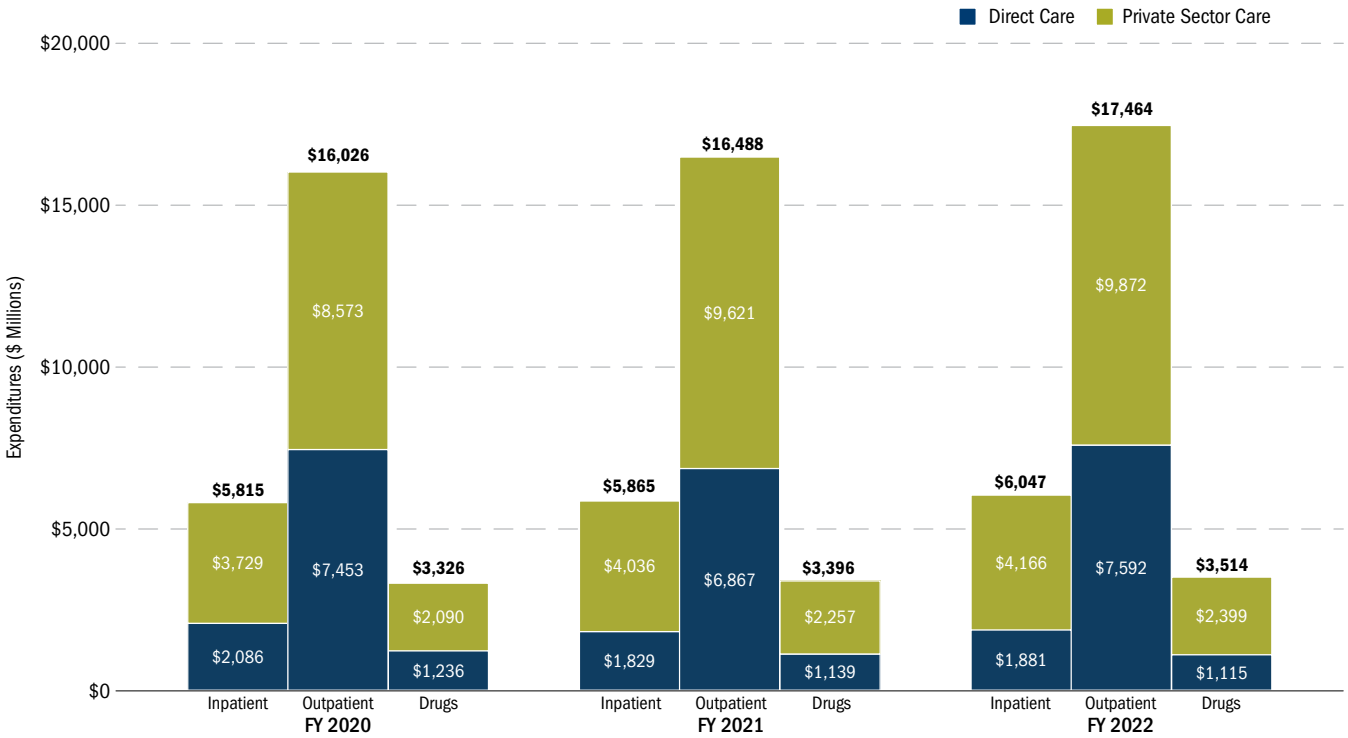
- In FY 2022, specialty drugs accounted for less than 1 percent of total MHS prescription drug utilization (30-day equivalents), but for 51 percent of total spending.
- As a percentage of total drug costs, specialty drug costs continued to increase from FY 2013 to FY 2022. A large proportion of specialty spend comes from retail prescriptions, reflecting the limited distribution mechanisms in place for many of these agents. This limits availability at mail order and MTFs, which are generally lower cost points of service.
- The highest spend specialty drugs were the oncological agents. Overall, oncological agents accounted for about $1,322 million in drug spend in FY 2022, up from $1,189 million in FY 2021 and $1,075 million in FY 2020. The Targeted Immunomodulatory Biologics (primarily self-administered injectables for the treatment of rheumatoid arthritis, psoriasis, Crohn's disease, and other autoimmune disorders) accounted for another $753 million in FY 2022, followed by the atopy agents (including medications for atopic dermatitis and/or asthma), at $212 million.
- The top five oncological classes or subclasses (by total FY 2022 spend) were multiple myeloma ($316 million), leukemia/lymphoma ($161 million), breast cancer ($136 million), second-generation antiandrogens ($112 million), and renal cell carcinoma ($112 million). Other oncological agents accounted for an additional $485 million.
- The DoD P&T Committee considers the clinical and cost effectiveness of reviewed specialty agents with the end goal of selecting safe, efficacious, and cost-effective treatments for beneficiaries. The Committee reviews new drugs shortly after Food and Drug Administration (FDA) approval, including all new specialty agents, in order to promote appropriate use through formulary management tools such as prior authorization and to evaluate ongoing strategies for drug class evaluations in classes where two or more agents compete for the same clinical niche.

MHS COST TRENDS

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

- Excluding drug costs, about three-quarters of health care cost is for outpatient care.
- In FY 2022, the DoD spent $2.90 on outpatient care for every $1 spent on inpatient care.

TRENDS IN DoD EXPENDITURES FOR HEALTH CARE (EXCLUDING MERHCF), FYs 2020–2022

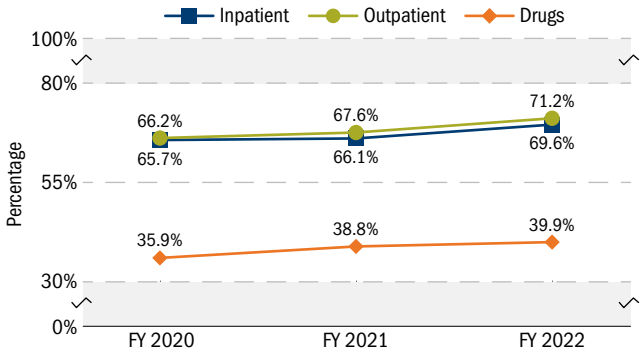


Note: Numbers may not sum to bar totals due to rounding.

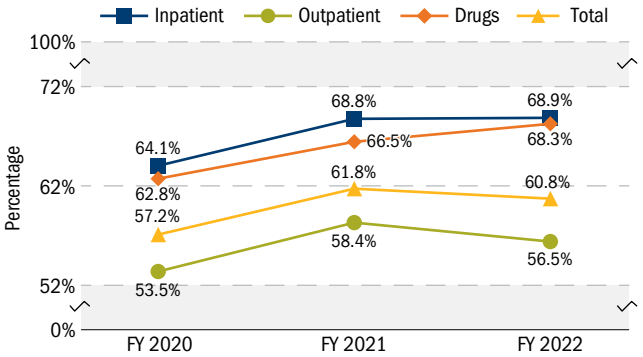
The charts below show the trends in the percentage of health care that is provided via the private sector.

- The trend for both utilization (a separate analysis) and cost is increasing; they each rose by about four percentage points over this time period.
- For example, the percentage of total cost that is due to PSC rose from about 57 percent in FY 2020 to about 61 percent in FY 2022.

TRENDS IN PRIVATE SECTOR CARE UTILIZATION[a] AS PERCENTAGE OF MHS TOTAL BY TYPE OF SERVICE, FYs 2020–2022



TRENDS IN PRIVATE SECTOR CARE COST AS PERCENTAGE OF MHS TOTAL BY TYPE OF SERVICE, FYs 2020–2022



Source: DHA/Resources & Management Directorate (J-8)/Business Integration Division, 5/17/2023

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

MHS COST TRENDS *(CONT.)*

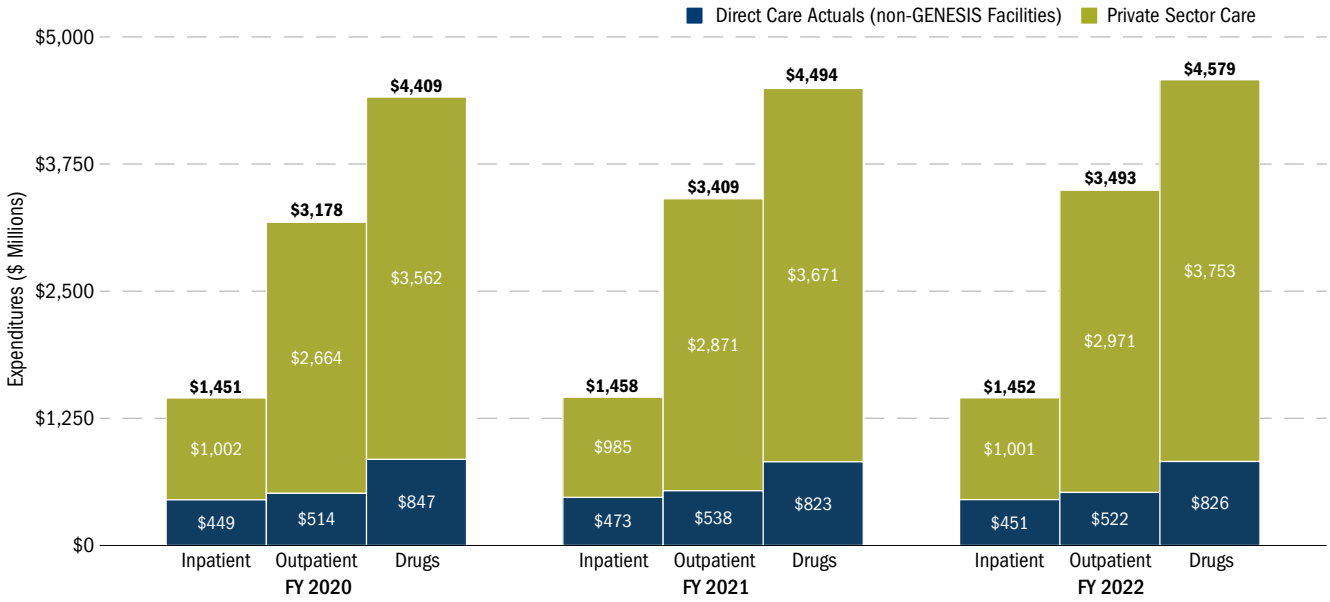
MERHCF Expenditures for Medicare-Eligible Beneficiaries

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

Total MERHCF expenditures include actual direct care expenditures at non-GENESIS facilities, estimated expenditures at GENESIS facilities, and private sector care costs. Total MERHCF expenditures increased from $9,038 million in FY 2020 to $9,524 million in FY 2022 (5 percent), net of manufacturer refunds on retail prescription drugs.

- Total DoD direct care expenses for MERHCF-eligible beneficiaries decreased by 1 percent from FY 2020 to FY 2022. Inpatient costs remained about the same, outpatient costs rose by 2 percent, and prescription drug costs fell by 2 percent.
- In FY 2020, TRICARE Plus enrollees accounted for 71 percent of DoD direct care inpatient and outpatient expenditures on behalf of MERHCF-eligible beneficiaries (not shown). That percentage increased to 74 percent by FY 2022.
- Including prescription drugs, TRICARE Plus enrollees accounted for 54 percent of total DoD direct care expenditures on behalf of MERHCF-eligible beneficiaries in FY 2020. That percentage increased to 56 percent by FY 2022.
- Total private sector care MERHCF expenditures increased by 7 percent from FY 2020 to FY 2022. Inpatient expenditures remained the same, outpatient expenditures rose by 12 percent, and prescription drug expenditures rose by 5 percent.

MERHCF EXPENDITURES BY TYPE OF SERVICE, FYs 2020–2022



Source: DHA/Resources & Management Directorate (J-8)/Business Integration Division, 1/20/2023
Note: Numbers may not sum to bar totals due to rounding.

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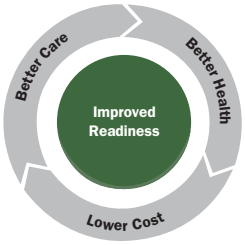
MEDICAL READINESS OF THE FORCE

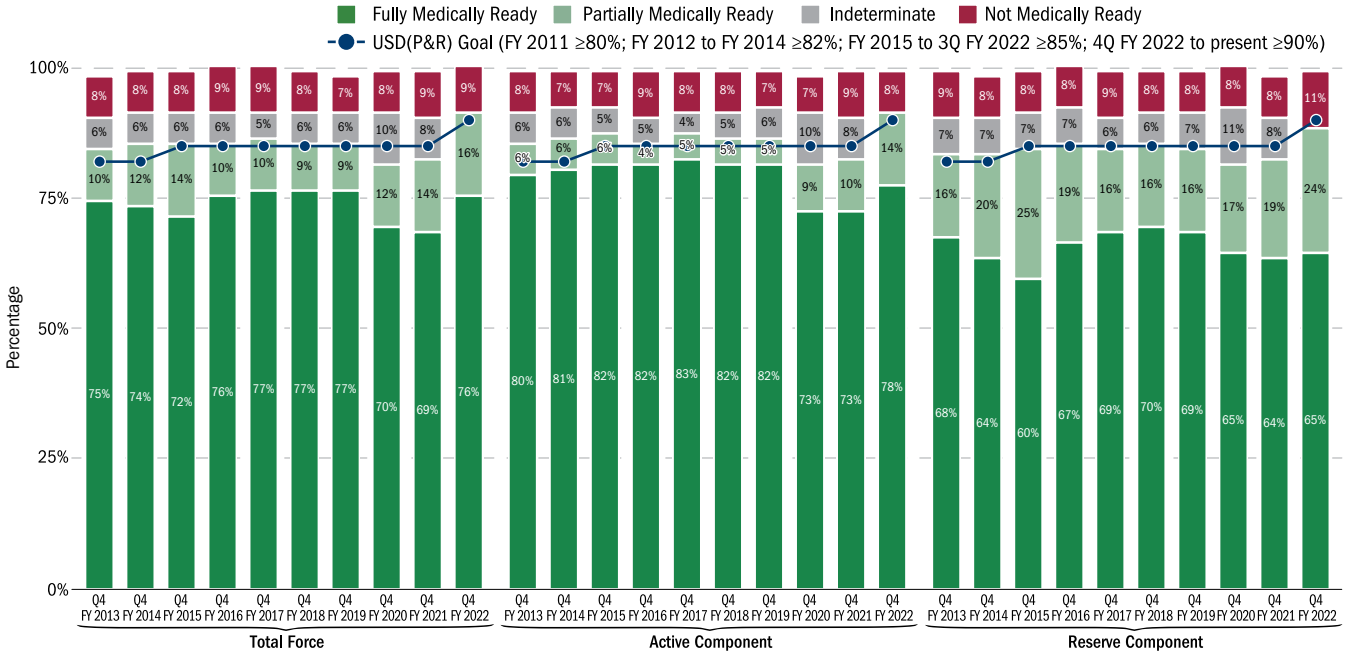


The Department of Defense (DoD) Individual Medical Readiness (IMR) program assesses individual Service members' compliance with established medical readiness elements and determines medical deployability in support of military operations. The IMR metric enables commanders to monitor and sustain Service members' and units' medical, dental, and other health requirements necessary to perform their assigned missions. The DoD began tracking IMR status in 2003 to help ensure that Service members, both Active Component (AC) and Reserve Component (RC), were medically ready to deploy when required. DoD Instruction 6025.19 "Individual Medical Readiness" was revised and published on July 13, 2022. Changes to this issuance include removal of the Medical Readiness Indeterminate "MRI" category and subsequent inclusion of overdue PHA and Dental Readiness Assessment 4 (DRC 4) into the "Partially Medically Ready" (PMR) category. It also established a Total Force Medically Ready (TFMR) goal of 90 percent or greater, and PMR goals of 15 percent or less for AC and 25 percent or less for RC. The six requirements tracked include: Completion of Dental Readiness Assessments with Satisfactory Dental Health, Completion of Periodic Health Assessments, Deployment-Limiting Medical Conditions Status, Current Immunization Status, Completion of Required Medical Readiness Laboratory Tests, and Possession of Required Individual Medical Equipment.

The IMR chart below shows that by the end of fiscal year (FY) 2022, the TFMR, at 92 percent, exceeded the Office of the Under Secretary of Defense for Personnel and Readiness (OUSD[P&R]) goal of 90 percent, as well as the AC at 92 percent. The RC, at 89 percent, did not meet the OUSD[P&R] goal of 90 percent (these percentages are shown as the sum of the percentages in the dark and light green sections). In addition, the AC and RC met their respective PMR goals. The overall medical readiness of the total force since FY 2013 has increased by 7 percentage points (from 85 percent in FY 2013 to 92 percent in FY 2022). The AC medical readiness remained steady from FY 2013 to FY 2019 (between 86 and 88 percent), but then decreased 5 percentage points in FY 2020 (from 87 percent to 82 percent), and the RC also decreased from 85 percent in FY 2019 to 82 percent in FY 2020. This decrease is most likely due to the onset of the COVID-19 pandemic and the temporary pause to some medical services that occurred during this time.

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

OVERALL INDIVIDUAL MEDICAL READINESS STATUS (ALL COMPONENTS NOT DEPLOYED), FY 2013 Q4 TO FY 2022 Q4



Source: Defense Health Agency (DHA), Public Health, 11/16/2022
Note: Percentages may not sum to 100 percent due to rounding.

HEALTHY, FIT, AND PROTECTED FORCE

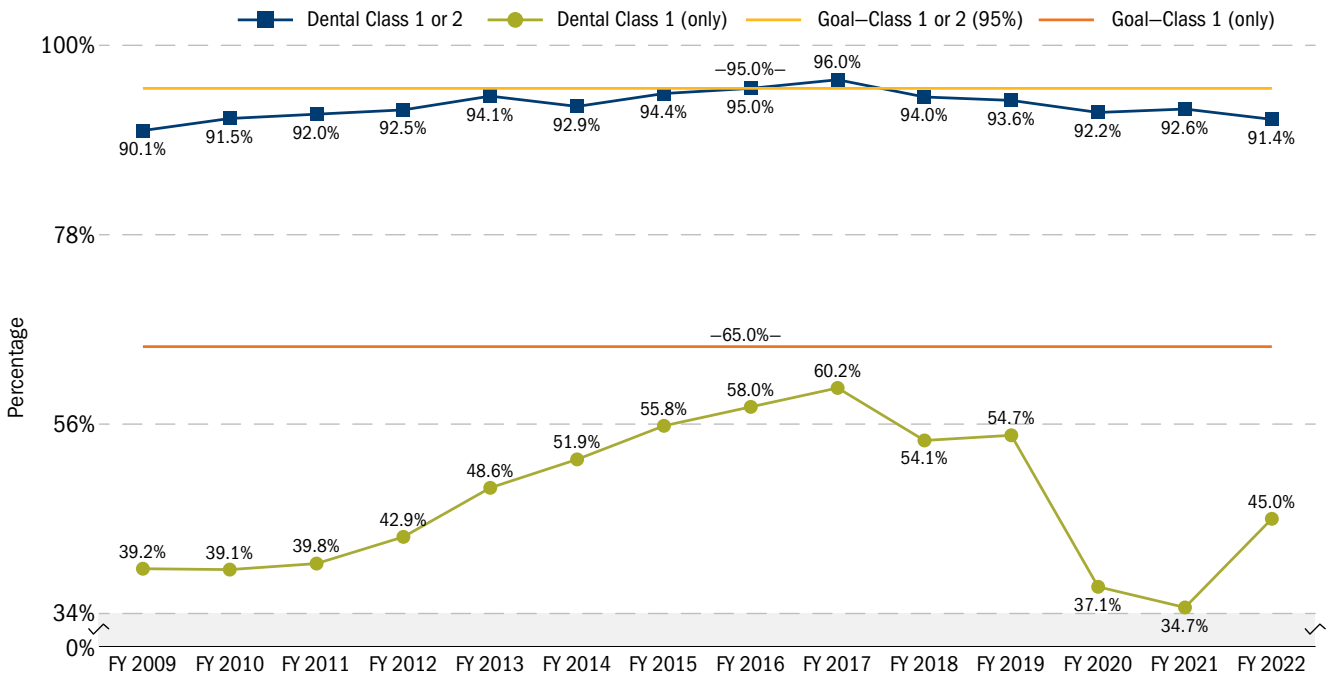
Key among the measures of performance related to providing an efficient and effective deployable medical capability and offering force medical readiness are those related to how well we: (1) maintain the worldwide deployment capability of our Service members, as in dental readiness and immunization rates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

DENTAL READINESS

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

- Overall MHS dental readiness in the combined Classes 1 and 2 remains high. Following a generally steady annual increase since FY 2007, the combined Classes 1 and 2 percentage fell in FY 2018 just under 94 percent and in FY 2022 fell to 91.4 percent, down from 96 percent in FY 2017, falling short of the long-standing MHS goal of 95 percent.
- The rate for Active Duty personnel in Dental Class 1 had risen steadily since FY 2010 (39.1 percent), but fell from 60.2 percent in FY 2017 to 45.0 percent in FY 2022—20 percentage points short of the MHS goal. The MHS goal of 65 percent was increased in FY 2009 from the 55 percent goal established in FY 2007.

ACTIVE DUTY DENTAL READINESS: PERCENT CLASS 1 OR 2, FYs 2009–2022



Source: The Services' Dental Corps–DoD Dental Readiness Classifications, 10/27/22

Definitions:

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

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

SUSTAINING EXPEDITIONARY MEDICAL SKILLS

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

The MHS is unique in that it must create a framework supporting both the delivery of health care and military department (MILDEP) clinical readiness requirements. In April 2022, the DHA was delegated the authority by the Assistant Secretary of Defense for Health Affairs (ASD[HA]) to formally stand up the JKSA PMO within the DHA. The PMO will manage the sustainment and development of clinical readiness metrics for wartime specialties. Through the development of these metrics, the JKSA PMO will help inform and recommend best practices as to how the MHS can sustain clinical readiness of military medical personnel through routine medical practice, particularly in military medical treatment facilities (MTFs). The key to the military mission is identifying which aspects of care are relevant to clinical "readiness" and ensuring that military personnel are proficient in those areas. While there are many components comprising readiness, the basis of the DoD's expeditionary medical system rests on individual clinical proficiency. The DHA's campaign plan includes the JKSA PMO's clinical measures as one of the five workstreams within the Sustainment of Expeditionary Medical Skills (SEMS) Strategic Initiative. The SEMS Strategic Initiative also supports the DoD requirement to optimize trauma care delivery and the sustainment of the ready medical force. Furthermore, the SEMS Strategic Initiative establishes key performance indicators to measure progress and places an enhanced focus on Role 4 Casualty Care facilities. As part of the MHS optimization efforts, the DHA is evaluating Veterans Affairs (VA) Resource Sharing Agreements as a mutually beneficial effort to provide health care and clinical readiness workload opportunities. Additionally, the DHA is improving the evaluation mechanisms and establishing a measure of effectiveness for military-civilian partnerships (MCPs) to leverage the expertise, acuity, and patient volume of civilian medical systems to maximize clinical readiness opportunities for military medical personnel. The JKSA PMO provides an innovative approach to measuring, evaluating, and sustaining individual clinical proficiency, with a focus on the metric-based specialties below. Although these processes are applied to assess individual clinical readiness, these metrics are also used to evaluate the ability of an MTF or VA/MCP to support clinical readiness and overall skills sustainment.

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

Clinical Currency

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

SUSTAINING EXPEDITIONARY MEDICAL SKILLS *(CONT.)*

Clinical Currency Metric

To date, 15 metric-based Joint Expeditionary Scopes of Practice (ESPs) and dashboard methodologies have been developed and are expected to be completed in July 2023. The clinical activity measures and thresholds have been finalized for seven of the metric-based specialties, and their dashboards are accessible via common access card (CAC)-enabled CarePoint for use in Service, Market, and facility decision making. The remaining eight specialties are in late-stage development for implementation. The JKSA PMO Chartered Working Group, in collaboration with the tri-Service clinical communities, will be responsible for managing the sustainment and development of these clinical readiness metrics and for additional specialties; clinical practice metrics and assessments for Operational Medical Officers, and operating room nurses and technicians are tentatively planned for inclusion within this group. The JKSA PMO team is reviewing and revalidating the other 47 checklist-based specialty ESPs that were completed in 2019. These ESPs delineate shared specialty requirements related to both occupational currency and completion of designated training.

Knowledge Assessment

Periodic knowledge assessments ensure the sustainment of clinical proficiencies by identifying knowledge gap areas that may challenge military medical personnel and inform the requirements for focused training resources to assure ongoing clinical readiness. Knowledge assessments are specialty-specific and supported through Tri-Service development and implementation, with support from professional organizations, such as the American College of Surgeons (ACS), American Society of Anesthesiologists, and Society for Critical Care Medicine. Implementation outcomes for general surgery and orthopedic surgery yielded rigorous, high-reliability exams with strong psychometric integrity covering the expeditionary surgical domains for each surgical specialty. Test outcomes documented performance gaps in multiple domains, as well as differentiated between subspecialty training and deployment experience. Test forms of 200 items each were completed by 238 general surgeons and 104 orthopedic surgeons of varying experience levels, and the consensus-derived benchmark score for both exams is 70 percent. The baseline mean scores for general surgeons and orthopedic surgeons were 73 percent and 68 percent, respectively. Knowledge tests are fully developed for Critical Care and Trauma Surgery, and exams are currently available for use by all four of these specialties.

Test development and implementation for the remaining specialties are in process, with ongoing Tri-Service engagement. Knowledge tests for Anesthesiology and Plastic Surgery, OMS, and ENT will be completed in 2022 and released in 2023. The development of knowledge tests for both critical care and emergency nursing will be also completed in 2022, with implementation slated for early 2023. Knowledge tests for operational medical officers, emergency medicine, urology, and ophthalmology will begin development in 2023.

Completion of knowledge tests provides the MHS and the JKSA PMO with critical information about capability gaps and facilitates development of focused resources designed to close those gaps through easily accessible training mechanisms. These training resources are available through the Joint Trauma System (JTS) Deployed Medicine portal, which directly links to vetted clinical resources and on-demand, multimedia-supported training resources developed in partnership with the ACS. Test takers earn 60 continuing medical education through DHA J-7 for completing the knowledge tests and associated training content for identified gap areas. Knowledge tests will be implemented every three years to identify areas of knowledge decay and inform ongoing training refreshment intervals, but may be completed as often as desired at any time to support pre-deployment preparations.

SUSTAINING EXPEDITIONARY MEDICAL SKILLS *(CONT.)*

Procedural Skills Assessments

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

ASSET+ and COTS+ outcomes from 2020–2021 confirmed that, at baseline, less than 3 percent of surgeons were able to meet the established benchmark performance score of 90/100 for the identified surgical procedures. After focused training, 99 percent of surgeons met or exceeded the performance benchmarks and 85 percent were able to do so independently. This underscores the need for these programs to ensure clinical competency and currency ahead of deployment and on an ongoing basis to manage casualties resulting from terrorism and natural disasters. Importantly, outcomes from the first year of skills assessment implementation demonstrate significant correlation between individual JKSA metric values and performance of critical trauma surgical procedures, such as control of bleeding from major blood vessels. This underscores the link between ongoing complex elective and emergency surgical care and the key skills needed during deployment.

These procedural skills assessment courses are designed to fully replace the existing emergency war surgery courses as a doctrinally mandated and centrally funded effort intended to be delivered to all military surgeons either every two years or in a pre-deployment window. This approach is scalable, cost effective, and with future expansion, will enable predictable performance capabilities for surgeons and expeditionary team members as a component of the Clinical Readiness Lifecycle. Currently, there are active emergency war surgery courses for trauma (ASSET+), orthopedic trauma (COTS+), and ocular trauma (OTSL); all of which support life-, limb-, and eyesight-saving procedures. Orthopedic trauma remains a primary injury pattern for both combat and civilian occurrences of terrorism and other mass casualty events. EWSCs for craniomaxillofacial, otolaryngology, and plastic surgeons (Combat Craniomaxillofacial Trauma Surgery) are in the late stages of development, with implementation scheduled for 2023. Courses for critical care physicians and operational medical officers (Critical Skills for Expeditionary Medicine) are in the early stages of development, with anticipated completion in 2023. Development for skills assessment courses is planned to begin in 2023 for anesthesiology, emergency medicine, and nursing (critical care and emergency medicine).

SUSTAINING EXPEDITIONARY MEDICAL SKILLS *(CONT.)*

JKSA Integration with Enterprise Planning

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

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

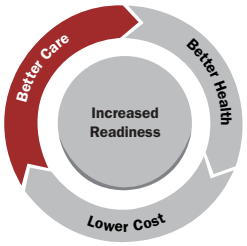
Expand: MTFs can expand services to beneficiaries other than DoD to increase JKSA clinical workload opportunities. Partnering with the VA, optimizing subspecialty care within the MHS, and caring for local civilian trauma patients can all expand volume, acuity, and complexity of cases performed within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

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

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

ACCESS, QUALITY, SAFETY, AND PATIENT ENGAGEMENT

MHS Review—Status Update



The Secretary of Defense (SECDEF) directed a review of the Military Health System (MHS) in 2014, focused on safety, quality of care, and access to care. To fully address all the recommendations from the MHS review, 41 action plans were developed.

As of November 18, 2019, all 41 action plans, comprising 264 milestones, have been approved by MHS Governance and completed. While the milestones fulfilled the intent of the MHS review and warranted action plan closure, the enduring work of these improvement initiatives continues, captured as standard work throughout the MHS. In addition, the MHS continues to pursue its organizational goal of becoming a high reliability organization (HRO).

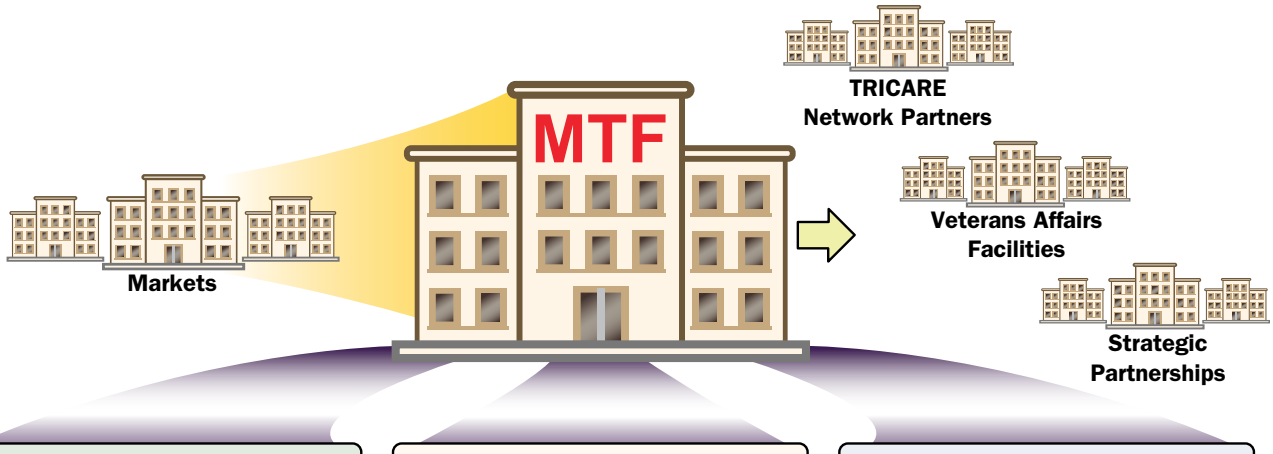
High Reliability Organization Journey

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

DRIVING HIGH RELIABILITY AT MTFs AND WITH OUR PARTNERS

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

Here are just a few examples:



PROVIDERS

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

PATIENTS

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

SUPPORT STAFF

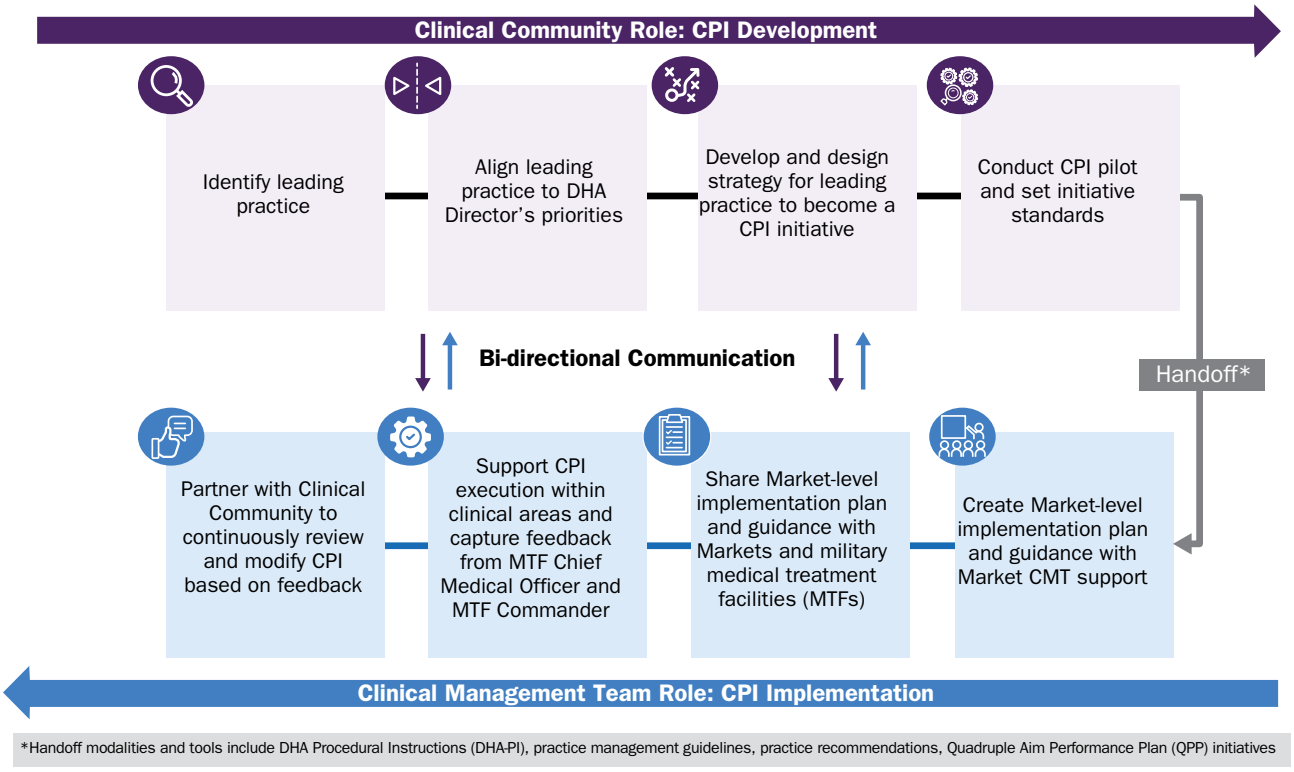
Housekeeping notices a torn privacy screen and informs facilities so it is promptly replaced, demonstrating a commitment to process improvement and a constancy of purpose to ensure a carefully managed patient experience.

High Reliability Organization Journey *(cont.)*

MHS Clinical Communities

The MHS Clinical Communities are a key driver promoting HRO and continuous process improvement (CPI) in health care delivery across the MHS. Clinical Communities are interdisciplinary networks of MHS providers who advise the DHA on how to optimize health care delivery for every patient across the MHS. Clinical Communities now include: Behavioral Health (BH), Neuromusculoskeletal, Primary Care, Women and Infant, Dental, Critical Care/Trauma, Surgical Services, Oncology, Cardiovascular, Complex Pediatrics, and Military-Specific Care. In fiscal year (FY) 2022, these communities were actively supported by Clinical Support Services and Enabling Expertise to drive enterprise-wide clinical quality improvement (CQI). Additionally, the DHA established Clinical Management Teams at the Headquarters and Market levels to implement CPI initiatives developed and promoted by the Clinical Communities. The graphic below depicts the CPI development and implementation process.

MHS CPI INITIATIVE PROCESS FLOW



*Handoff modalities and tools include DHA Procedural Instructions (DHA-PI), practice management guidelines, practice recommendations, Quadruple Aim Performance Plan (QPP) initiatives

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

High Reliability Organization Journey *(cont.)*

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

- Optimize Low Back Pain Care
- Musculoskeletal Triage Decision Support Tool
- Direct Access to Physical Therapy
- Breast Cancer Screening for All Department of Defense (DoD) Beneficiaries
- Lung Cancer Screening (Work Flow Development)
- Screening for Colorectal Cancer with Fecal Immunochemical Test
- Measurement of Patient Reported Outcomes
- Standardization of Depression and Suicide Risk Screening in Primary Care
- Opioid Overdose Education and Naloxone Distribution
- Pain Assessment Screening Tool and Outcomes Registry (PASTOR) Adoption
- Acute Concussion Care Pathway
- BH Treatment and Outcomes Monitoring
- Standardized Automated Universal Protocol Compliance Reporting
- Postpartum Hemorrhage (PPH) Bundle DHA-PI 6025.35 Compliance
- Musculoskeletal Treatment and Outcomes Monitoring Adoption
- Bar Code Medication Administration Compliance

These improvement efforts support and drive the MHS transition by standardizing the best care approaches across the system and leading initiatives to support the QPP. The MHS Clinical Communities are vital to ensuring a consistent level of excellence in patient care at every MTF. We will continuously assess our performance throughout the year and will refresh the plan at the close of each year.

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

High Reliability Organization Journey *(cont.)*

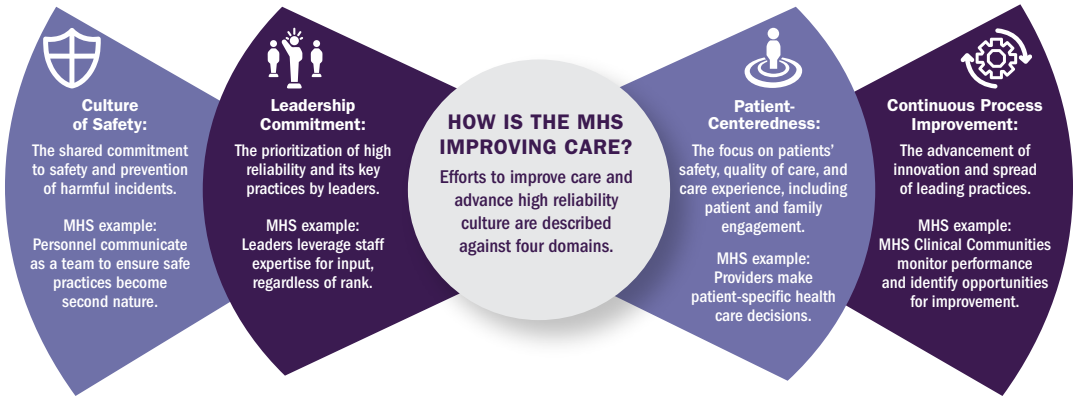
Ready Reliable Care (RRC)

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

RRC Next Steps:

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

MHS READY RELIABLE CARE DOMAINS OF CHANGE



HRO PRINCIPLES

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

MHS Data Transparency

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

The National Defense Authorization Act (NDAA) FY 2017, Section 728 required incorporation and public reporting of Core Quality Measures Collaborative (CQMC) core measures, MHS reporting on the Centers for Medicare & Medicaid Services (CMS) Care Compare website, and development of a framework for evolving MHS transparency.

- Public reporting of CQMC measures continues in prescribed phases as measures are developed and complete the approval process.
  - Data for 15 measures relating to primary care, obstetrics and gynecology, BH, and pediatrics are available on the MHS Transparency site for public access.
  - Measures for cardiovascular, orthopedics, gastroenterology, and HIV/hepatitis C are currently under development.
  - Original measures selected for oncology and neurology lost National Quality Forum (NQF) endorsement. A new measure has been selected for oncology, which is pending development, and MHS clinical teams are currently reviewing the available neurology measures to determine which would best represent the MHS.

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

1. Reporting to the National Practitioner Data Bank (NPDB). This is reported in the Healthcare Risk Management section under Clinical Quality Management of this report (ref. page 112).

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

- **The current accreditation status, including recommendations for corrective action (CA).** Accredited organizations, including DoD inpatient and freestanding ambulatory clinic MTFs, can be found on The Joint Commission (TJC) website at www.qualitycheck.org. Other associated clinics subordinate to one of these MTFs are included in the respective facility TJC accreditation. Additionally, MTF-specific hospital and clinic accreditation status, accreditation organization, completed survey dates, and requirements for improvement (RFI) to meet full accreditation are found in the downloadable report at www.health.mil/AccreditationStatus (ref. pages 112–116).
- **Policies or procedures concerned with or designed to improve patient safety, quality of care, and access to care that were implemented during the year by the SECDEF.** A consolidated summary of relevant Health Affairs and Service policies is provided at www.health.mil/AccreditationStatus. The DHA is currently in the process of developing and publishing publications to supersede both DoD- and Service-level policies (where appropriate) in support of management and administration of MTFs in accordance with NDAA FY 2017, section 702. Relevant Health Affairs, DHA, and Service policies can be found in their associated subject areas related to access, patient safety, and quality of care at www.health.mil (ref. pages 63, 99).
- **Data on surgical and maternity care outcomes during the year.** MHS-level data are presented in this report (ref. pages 129–133, 140–141). MTF-level data over time are publicly presented at www.health.mil/transparency.
- **Data on access and appointment wait times at the MTF level.** MHS-level data are presented in this report (ref. pages 72–73), including MHS-wide and MTF-specific analyses of variability. MTF-level data over time are reported on www.health.mil/transparency.
- **Data on patient safety, quality of care, and access to care, as compared with standards established by the DoD.** In addition to the MHS-level data presented in this report, the individual MTF-level data are presented in the www.health.mil/transparency public-facing website.
- **Data on patient experience and satisfaction.** MTF-level data are presented in the www.health.mil public-facing website and on the CMS Care Compare website.

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

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

MHS Data Transparency *(cont.)*

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

VISIT HEALTH.MIL/TRANSPARENCY

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

ACCESS TO MHS CARE

Access to Outpatient Care in the MHS

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

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

In FY 2022, the direct care system continued optimization efforts to enhance access, improve patient experience, and eliminate unwarranted variance among MTFs. The direct care system improved access, particularly in primary care, by implementing standard appointing and capacity processes codified in DHA policy to meet requirements in the NDAA for FY 2017. The NDAA FY 2017, Section 704 directed MTFs to improve access to urgent care (UC) by expanding operating hours in MTF Patient-Centered Medical Homes (PCMHs), implementing additional MTF UC clinics at locations where sufficient patient demand existed to justify operating costs, and integrating the nurse advice line (NAL) UC and appointing processes. The NDAA FY 2017, section 709 also directed the MHS to implement standard appointing processes and procedures and to develop productivity standards on the expected number of patient encounters for each health care provider in both primary and specialty care. The direct care system is currently implementing standard appointing and procedures to improve access, increase direct care system capacity, enhance patient experience, and eliminate variance among MTFs. Standard processes and procedures include:

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

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

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

ACCESS TO MHS CARE *(CONT.)*

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

Patient-Centered Medical Home Primary Care

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

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

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

PCM and PCMH Team Continuity

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

Description of Box and Whisker Plots

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

- As shown in the tables, in FY 2022, enrollees saw their own PCM during primary care visits 51 percent of the time. MTFs are to maximize continuity of care by optimizing provider availability, templating appointments 180 days in advance, expanding clinic hours, and maintaining adequate team size (DHA-Interim Procedures Memorandum [DHA-IPM] 18-001).

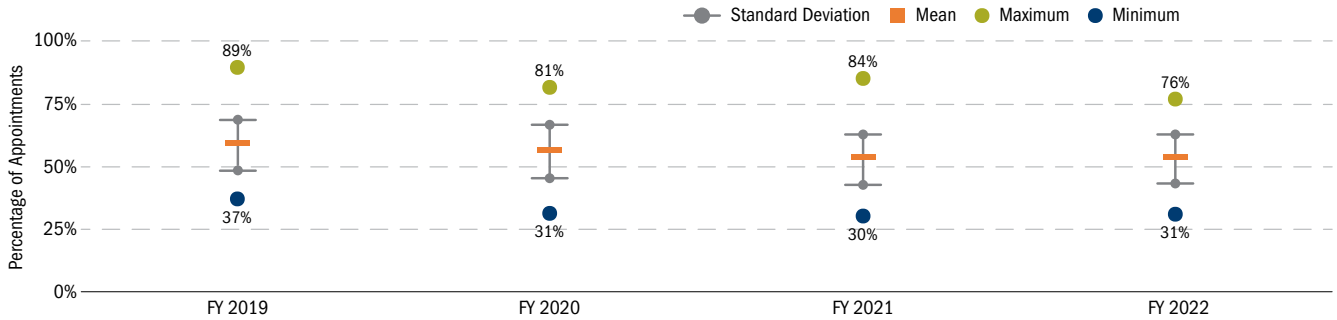
PCM CONTINUITY, FYs 2015–2022

	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
PCM Continuity	60%	60%	59%	57%	57%	56%	55%	51%

PCM CONTINUITY, FYs 2019–2022

	FY 2019	FY 2020	FY 2021	FY 2022	FY 2019–FY 2022 % POINT CHANGE
Mean	58%	55%	52%	53%	–5
Standard Deviation	10.1%	10.2%	10.3%	9.8%	–0.3
Median	58%	55%	52%	52%	–6
75th Percentile	65%	65%	62%	59%	–6
25th Percentile	52%	51%	49%	47%	–5
Maximum	89%	81%	84%	76%	–13
Minimum	37%	31%	30%	31%	–6
Range	52%	49%	54%	45%	–7

PCM CONTINUITY, FYs 2019–2022



Source: MHS administrative data (MHS Data Repository [MDR]); DHA/Health Care Operations (HCO)/Health Care Optimization Division, 11/10/2022

Notes:

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

ACCESS TO MHS CARE *(CONT.)*

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

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

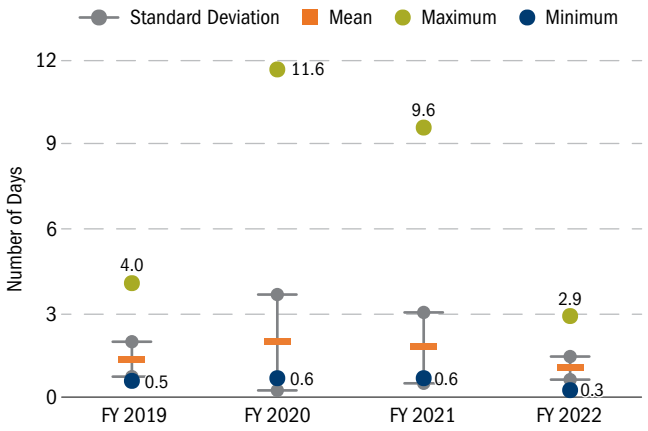
The direct care system prospectively measures access to primary care by evaluating the average number of days to the third next available 24-hour appointment and third next available future appointment against the MHS goals of 1.0 and 7.0 days, respectively. Measuring third next for a prospective measurement of access to care is considered a more sensitive and accurate measure of access than retrospective analysis of when the appointment was booked.

In FY 2022, there was a decrease in the average number of days to third next available 24-hour (1.04 days) and future (3.36 days) appointments, which is partially due to clinics' increased adoption of telehealth services and improved access to in-person appointments since the height of the pandemic. Future appointments remain within the seven-day standard in FY 2022; we aim to meet the 24-hour target of one day as we continue to adapt to post-pandemic conditions.

DAYS TO THIRD NEXT AVAILABLE 24-HOUR APPOINTMENT, FYs 2019–2022

	FY 2019	FY 2020	FY 2021	FY 2022	FY 2019–FY 2022 CHANGE
Mean	1.3	2.0	1.8	1.0	–0.3
Standard Deviation	0.6	1.7	1.2	0.4	–0.2
Median	1.2	1.5	1.4	0.9	–0.3
75th Percentile	1.6	2.1	2.1	1.2	–0.3
25th Percentile	0.9	1.0	1.0	0.8	–0.1
Maximum	4.0	11.6	9.6	2.9	–1.1
Minimum	0.5	0.6	0.6	0.3	–0.3
Range	3.5	11.0	9.0	2.6	–0.9

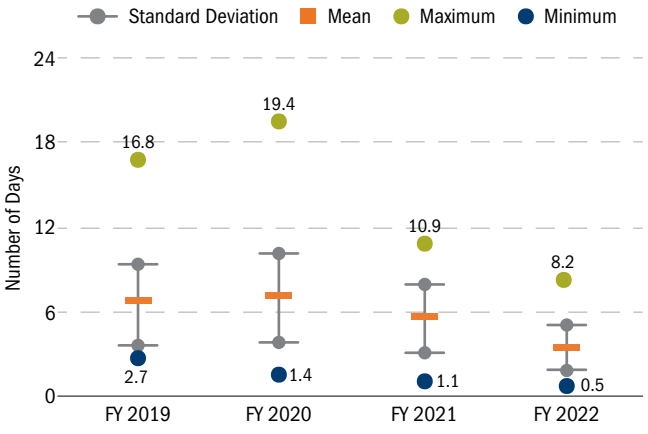
DAYS TO THIRD NEXT AVAILABLE 24-HOUR APPOINTMENT, FYs 2019–2022



DAYS TO THIRD NEXT AVAILABLE FUTURE APPOINTMENT, FYs 2019–2022

	FY 2019	FY 2020	FY 2021	FY 2022	FY 2019–FY 2022 CHANGE
Mean	6.6	7.0	5.5	3.4	–3.2
Standard Deviation	2.9	3.2	2.4	1.6	–1.3
Median	6.2	6.2	4.9	3.2	–3.1
75th Percentile	7.7	8.4	7.2	4.3	–3.4
25th Percentile	4.5	4.7	3.7	2.4	–2.2
Maximum	16.8	19.4	10.9	8.2	–8.6
Minimum	2.7	1.4	1.1	0.5	–2.2
Range	14.0	18.0	9.8	7.7	–6.3

DAYS TO THIRD NEXT AVAILABLE FUTURE APPOINTMENT, FYs 2019–2022



Source: MHS administrative data (MDR); DHA/HCO/Health Care Optimization Division, 11/10/2022
Notes:
– Parent facility scores were used to describe variability in the results above.
– Data excludes MHS GENESIS results.
– Numbers may not sum due to rounding.

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

TOL Patient Portal Automatic Appointment Reminders

The TOL Patient Portal added the capability to allow beneficiaries to select the option of receiving reminders of upcoming MTF primary or specialty appointments by text message and/or e-mail. Once the beneficiary provides a preferred telephone number and/or e-mail address, the beneficiary receives several reminders of each upcoming appointment, regardless of whether the appointment was scheduled on TOL, by calling an appointment center, or in person. The appointment reminders are sent at least one week in advance, three days in advance, one day in advance, and then several hours in advance, depending how far in advance the appointment was scheduled. Each reminder notifies the beneficiary of the appointment date, time, provider, clinic, and MTF and also lets the patient know if it is an in-person or virtual appointment. The reminders also provide information on how to cancel the appointment, if necessary.

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

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

During FY 2022, TOL sent an average of 317,863 e-mail and 217,813 text appointment reminders per week.

TOL PATIENT PORTAL AUTOMATIC APPOINTMENT REMINDERS

	FY 2020	FY 2021	FY 2022
Total number of reminders	18.1M	28.3M	27.9M
Average number of e-mail reminders sent per week	205K	319K	318K
Average number of text reminders sent per week	143K	226K	218K

TOL Patient Portal Health Record

The TOL Health Record provides patients secure and easy access to their health information. On TOL, patients can access Health Record to view, print, save, and/or download their personal health data. The Health Record includes laboratory results, medications, radiology results, immunizations, problem list, encounters, documents, vitals, and allergies. TOL provides patients with e-mail and/or text alerts when COVID test results and/or new laboratory results are posted. The Health Record is helpful for the patient's own personal record-keeping, for partnering with their provider(s), and the care of their family. Easy access to health records on TOL also assists in applying for Veterans Affairs (VA) and Social Security benefits. Health Record views for FY 2022 totaled over 78.8 million with the highest number in January 2022 at 13.69 million views.

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

Access to Integrated Specialists in the PCMH

The most common reason why enrollees sought direct care in FY 2022 was for infectious disease screening and immunizations. Otherwise, the most common conditions, excluding pregnancy, are routine screenings, musculoskeletal issues, BH-related, mental health (MH)–related, and miscellaneous conditions, such as skin disorders, hypertension, vision, and diabetes. To improve access and outcomes for the beneficiaries affected by these conditions, the direct care system continues optimizing the use and integration of specialists in PCMHs to provide more continuous, comprehensive care in the primary care setting and to facilitate coordinated care. Currently, the majority of PCMHs serving adult enrollees have integrated BH specialists who provide treatment for MH and BH issues. Directly integrating BH providers ensures the integrated specialists are able to work closely in partnership with the patient, PCM, and PCMH team; moreover, because the specialties share a location, it helps to destigmatize the care received. The Uniformed Services University for the Health Sciences determined that being seen by a BH specialist integrated in a PCMH results in a statistically significant improvement in MH status. PCMH Clinical Pathways are being optimized by incorporating multidisciplinary specialties for BH-related issues prevalent in the MTF Prime population, including alcohol misuse, anxiety, depression, diabetes, obesity, chronic pain, sleep problems, and tobacco use. The MHS is also implementing integrated clinical pharmacists in PCMHs. An FY 2016 independent analysis demonstrated that the use of integrated clinical pharmacists resulted in a statistically significant improvement in diabetes, hypertension, and hyperlipidemia outcomes. Finally, the MHS is implementing integrated physical therapists in PCMHs to address highly prevalent musculoskeletal issues, such as low back pain. Where implemented, integrated physical therapists continue to achieve improved outcomes and reduced MTF enrollee private sector care costs.

ACCESS TO MHS CARE *(CONT.)*

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

Dispositions and Bed-Days per 1,000 MTF Enrollees

By focusing on prevention, proactive care coordination, and improving outcomes for common conditions, MTF PCMHs focus on reducing the incidence of dispositions (admissions) and bed-days per 1,000 MTF enrollees. PCMH teams continue efforts to reduce the number of times MTF enrollees are admitted to hospitals and medical centers in both the direct and private sector care sectors, and the length of time they spend as inpatients if admitted, which is measured by bed-days (number of dispositions multiplied by the length of stay [LOS]). The average monthly disposition count per 1,000 MTF enrollees was 4.7 in FY 2022; the average number of monthly bed-days was 15.7 per 1,000 enrollees. The top five reasons for admissions are childbirth, digestive conditions, musculoskeletal conditions, respiratory conditions, and circulatory conditions.

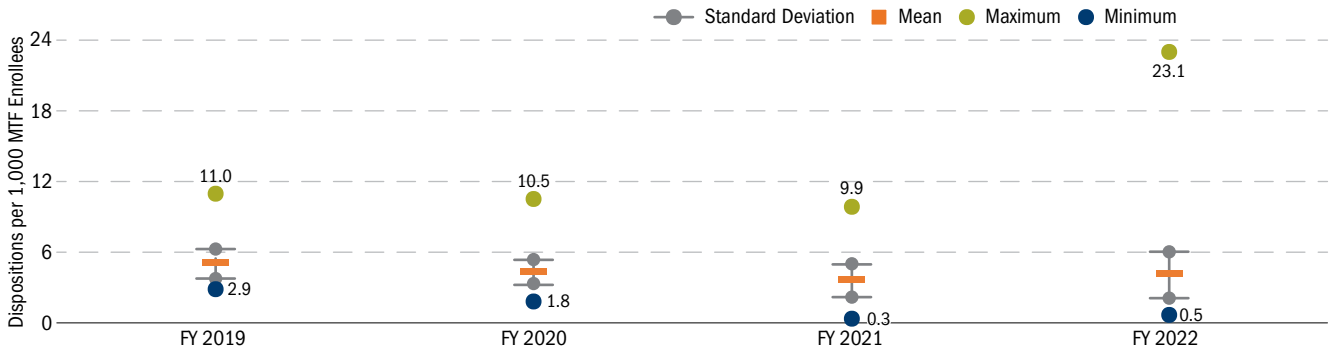
AVERAGE MONTHLY DISPOSITIONS AND BED-DAYS PER 1,000 MTF ENROLLEES, FYs 2019–2022

	FY 2019	FY 2020	FY 2021	FY 2022
Average Monthly Dispositions per 1,000 MTF Enrollees	5.2	4.5	4.6	4.7
Average Monthly Bed-Days per 1,000 MTF Enrollees	16.7	14.8	16.0	15.7

AVERAGE MONTHLY DISPOSITIONS PER 1,000 MTF ENROLLEES, FYs 2019–2022

	FY 2019	FY 2020	FY 2021	FY 2022	FY 2019–FY 2022 CHANGE
Mean	5.0	4.3	3.6	4.2	-0.9
Standard Deviation	1.3	1.2	1.5	2.0	0.7
Median	4.8	4.1	3.7	4.2	-0.6
75th Percentile	5.7	4.8	4.4	4.9	-0.7
25th Percentile	4.2	3.6	3.0	3.2	-1.0
Maximum	11.0	10.5	9.9	23.1	12.1
Minimum	2.9	1.8	0.3	0.5	-2.4
Range	8.1	8.8	9.6	22.6	14.5

AVERAGE MONTHLY DISPOSITIONS PER 1,000 MTF ENROLLEES, FYs 2019–2022



Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 11/10/2022

Notes:

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

– Private sector care claims may take up to a year to be finalized and are not complete for FY 2022.

– Numbers may not sum due to rounding.

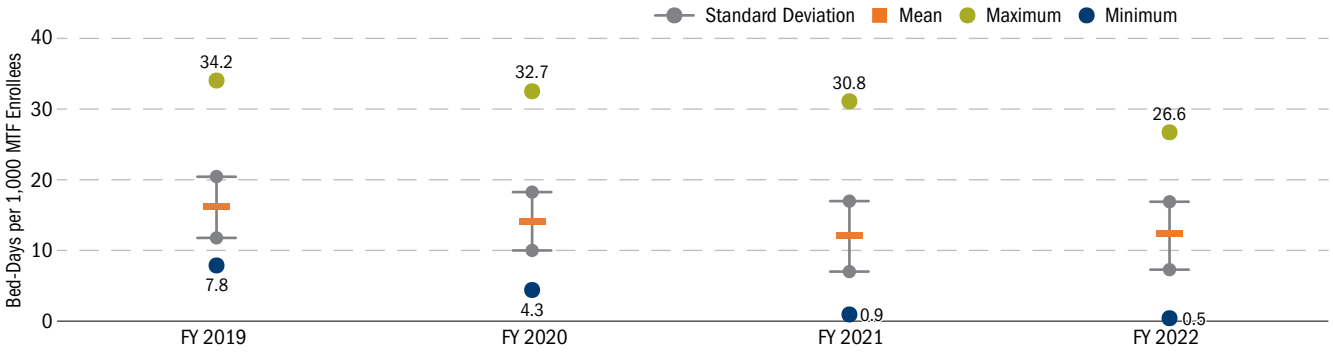
ACCESS TO MHS CARE *(CONT.)*

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

AVERAGE MONTHLY BED-DAYS PER 1,000 MTF ENROLLEES, FYs 2019–2022

	FY 2019	FY 2020	FY 2021	FY 2022	FY 2019–FY 2022 CHANGE
Mean	16.2	14.2	12.0	12.4	-3.8
Standard Deviation	4.2	4.0	4.9	4.8	0.6
Median	15.8	13.5	12.3	13.1	-2.8
75th Percentile	18.5	15.7	14.7	15.7	-2.9
25th Percentile	13.6	12.1	9.6	9.8	-3.8
Maximum	34.2	32.7	30.8	26.6	-7.6
Minimum	7.8	4.3	0.9	0.5	-7.3
Range	26.3	28.3	29.9	26.1	-0.2

AVERAGE MONTHLY BED-DAYS PER 1,000 MTF ENROLLEES, FYs 2019–2022



Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 11/10/2022

Notes:

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

– Private sector care claims may take up to a year to be finalized and are not complete for FY 2022.

– Numbers may not sum due to rounding.

ACCESS TO MHS CARE *(CONT.)*

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

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

The ED utilization rate increased from 11.12 visits per 100 enrollees in FY 2021 to 17.09 visits per 100 enrollees in FY 2022. ED visits for primary care reasons are a small percentage of all ED visits and are defined by the Tri-Service Emergency Medicine consultants and industry as evaluation and management codes 99281 and 99282. The rate of network ED visits for primary care reasons increased from 0.43 to 0.68 visits per 100 enrollees in FY 2022. MTF efforts to reduce ED visits include better access to 24-hour care in PCMH, walk-in clinics for common acute conditions, PCMH team-based care to meet patients' needs, the Nurse Advice Line, and secure messaging.

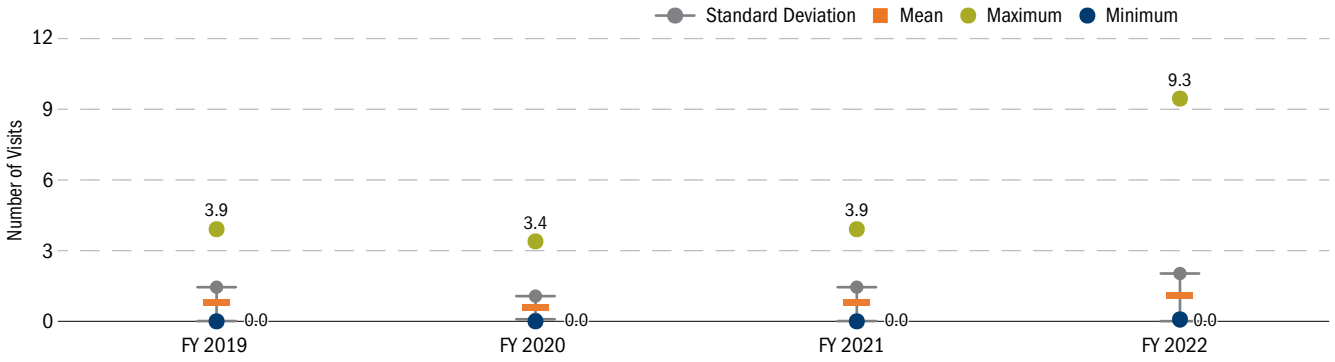
AVERAGE NETWORK ED VISITS PER 100 MTF ENROLLEES, FYs 2019–2022

	AVERAGE NETWORK ED VISITS PER 100 MTF ENROLLEES (INCLUDING TRUE EMERGENCIES)	AVERAGE NETWORK ED VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS
FY 2019	18.2	0.6
FY 2020	16.5	0.5
FY 2021	11.1	0.4
FY 2022	17.1	0.7

NETWORK ED VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS, FYs 2019–2022

	FY 2019	FY 2020	FY 2021	FY 2022	FY 2019–FY 2022 CHANGE
Mean	0.8	0.6	0.6	0.9	0.2
Standard Deviation	0.8	0.6	0.7	1.2	0.4
Median	0.6	0.5	0.4	0.6	0.0
75th Percentile	0.9	0.8	0.8	1.1	0.2
25th Percentile	0.3	0.3	0.2	0.3	0.0
Maximum	3.9	3.4	3.9	9.3	5.3
Minimum	0.0	0.0	0.0	0.0	0.0
Range	3.9	3.4	3.9	9.3	5.3

NETWORK ED VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS, FYs 2019–2022



Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 11/10/2022

Notes:

– Parent facility scores were used to describe variability in the results above.
– Months with fewer than 50 enrollees for a given parent facility were removed from the analysis.
– ED values are projections due to maturing private sector care claims.
– Numbers may not sum due to rounding.

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

Network UC Visits per 100 Enrollees

As shown in the table below, the rate of network UC visits by MTF enrollees has continued to increase in FY 2022 compared with previous years, timed with the change to allow unlimited network UC visits. The most common reason why beneficiaries went to network UCs in FY 2022 was for respiratory illnesses or immunizations. Although this contributed to high immunization rates among beneficiaries, the preferable option is for this care to be administered by MTF staff. In FY 2023, the DHA will continue to promote MTF services and encourage MTFs to be conducive to patient schedules.

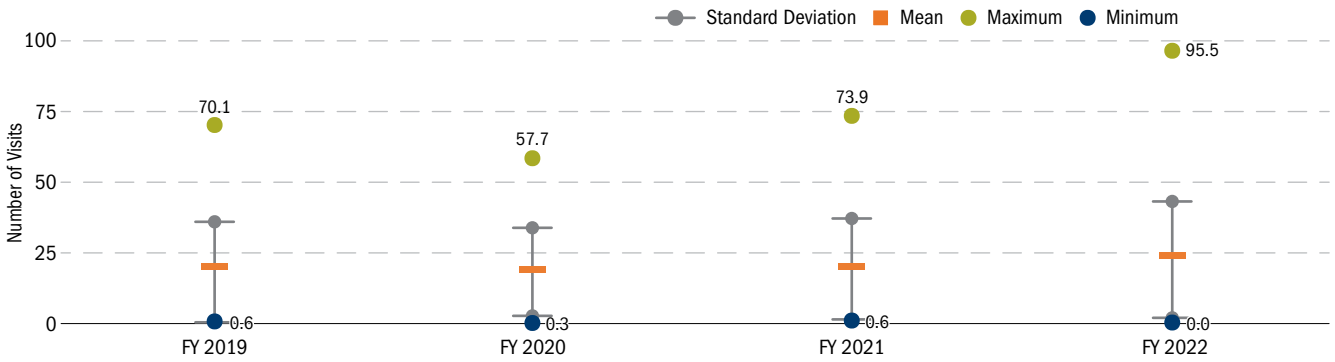
AVERAGE NETWORK UC VISITS PER 100 MTF ENROLLEES, FYs 2019–2022

	AVERAGE NETWORK UC VISITS PER 100 MTF ENROLLEES FOR PRIMARY CARE REASONS
FY 2019	18.3
FY 2020	18.4
FY 2021	15.1
FY 2022	21.4

NETWORK UC VISITS PER 100 MTF ENROLLEES, FYs 2019–2022

	FY 2019	FY 2020	FY 2021	FY 2022	FY 2019–FY 2022 CHANGE
Mean	19.9	19.0	20.3	23.3	3.5
Standard Deviation	17.7	15.6	17.8	20.2	2.5
Median	15.7	17.0	16.6	19.2	3.4
75th Percentile	32.2	30.1	29.2	31.9	–0.3
25th Percentile	3.0	3.4	4.9	6.4	3.4
Maximum	70.1	57.7	73.9	95.5	25.5
Minimum	0.6	0.3	0.6	0.0	–0.6
Range	69.5	57.4	73.4	95.5	26.0

NETWORK UC VISITS PER 100 MTF ENROLLEES, FYs 2019–2022



Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 11/10/2022

Notes:

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

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

TOL Secure Messaging

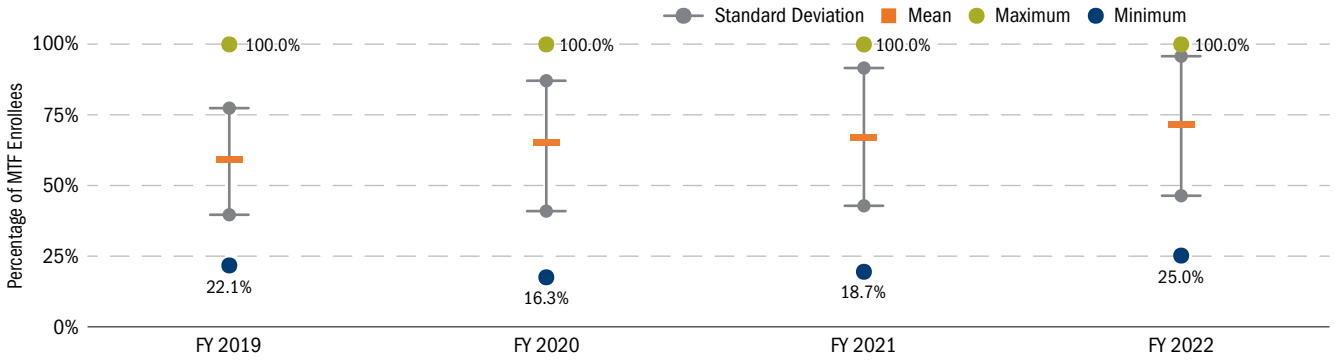
Percentage of Enrollees Registered to Use TOL Secure Messaging: The direct care system offers enhanced access to care using a commercially available secure messaging system. TOL Secure Messaging allows MTF enrollees to communicate directly with their PCMs and care teams to ask questions about their health or medical tests and to arrange referrals or appointments. The MHS prioritized enrollment in secure messaging starting in FY 2017. In FYs 2020 and 2021, secure messaging was particularly important to maintain communication between the provider and patient while preventing the spread of COVID-19. The proportion of beneficiaries registered to use secure messaging at parent facilities has increased with each fiscal year, with an average of 71 percent of beneficiaries registered to use secure messaging for FY 2022. Analysis of the primary reasons that patients initiate messages include: messaging a provider (67 percent), referrals (11 percent) and renewing a prescription (9 percent). Use of broadcast messaging as a way to keep beneficiaries informed decreased from 9.95 million broadcast/blast messages sent in FY 2021 to 6.59 million for FY 2022—a decrease of 3.35 million broadcast messages. Broadcast messaging allows clinic administrators to send a mass message to all online secure messaging patients or to a select group based on clinic population. Broadcast messaging is also used to inform patient populations on COVID-19 booster/flu vaccination information as well as provide information for upcoming MHS GENESIS deployments. While MHS GENESIS completed 60 percent deployment throughout the MHS in 2022, the DHA saw a strong return on investment (ROI) through continued patient usage of TOL PP, consisting of secure messaging and TRICARE Online application, proportionately commensurate with sites awaiting transition.

Percentage of Patient-Initiated TOL Secure Messages Responded to within One Business Day: To improve the patient experience, satisfaction with secure messaging, and the likelihood of patients to use secure messaging again to meet health care needs in the future, the MHS also prioritized responding to secure messages within one business day. For FY 2022, the number of patient-initiated messages responded to within one business day decreased to 78 percent.

PERCENTAGE OF MTF ENROLLEES REGISTERED TO USE SECURE MESSAGING, FYs 2019–2022

	FY 2019	FY 2020	FY 2021	FY 2022	FY 2019–FY 2022 % POINT CHANGE
Mean	54.3%	58.9%	67.2%	71.3%	17.0
Standard Deviation	16.9%	18.8%	25.2%	25.0%	8.1
Median	53.6%	56.6%	64.3%	68.7%	15.1
75th Percentile	65.6%	70.4%	80.3%	89.0%	23.4
25th Percentile	43.4%	46.4%	51.2%	54.1%	10.7
Maximum	100.0%	100.0%	100.0%	100.0%	0.0
Minimum	22.1%	16.3%	18.7%	25.0%	2.3
Range	77.9%	83.7%	81.3%	75.0%	-2.3

PERCENTAGE OF MTF ENROLLEES REGISTERED TO USE SECURE MESSAGING, FYs 2019–2022



Source: MHS administrative data; DHA/HCO/Healthcare Optimization Division, 11/10/2022

Notes:

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

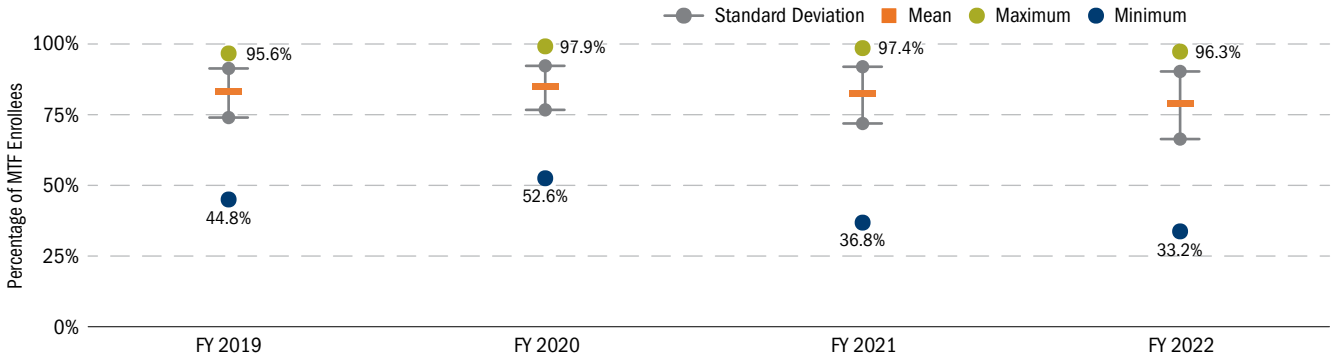
ACCESS TO MHS CARE *(CONT.)*

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

PERCENTAGE OF SECURE MESSAGES RESPONDED TO WITHIN ONE BUSINESS DAY, FYs 2019–2022

	FY 2019	FY 2020	FY 2021	FY 2022	FY 2019–FY 2022 % POINT CHANGE
Mean	81.3%	83.3%	81.0%	77.7%	-3.6
Standard Deviation	8.1%	7.4%	9.9%	11.6%	3.5
Median	82.2%	84.2%	83.0%	79.3%	-2.9
75th Percentile	86.8%	87.5%	87.7%	85.5%	-1.3
25th Percentile	77.7%	79.9%	77.2%	74.2%	-3.5
Maximum	95.6%	97.9%	97.4%	96.3%	0.7
Minimum	44.8%	52.6%	36.8%	33.2%	-11.8
Range	50.7%	45.3%	60.6%	63.1%	12.4

PERCENTAGE OF SECURE MESSAGES RESPONDED TO WITHIN ONE BUSINESS DAY, FYs 2019–2022



Source: MHS administrative data; DHA/HCO/Healthcare Optimization Division, 11/10/2022

Notes:

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

ACCESS TO MHS CARE *(CONT.)*

Nurse Advice Line

The MHS NAL continues to provide valuable, quality, and convenient nurse triage and care coordination services to our MHS beneficiaries 24 hours a day, seven days a week, directing over 700,000 callers per year to the most clinically appropriate level of care. Since implementation in late FY 2014, the NAL has provided access to registered nurses (RNs) who address health concerns, offer self-care advice, and answer general health questions. The NAL received approximately 2,000 calls per day, with the overall call volume less than one percent lower than FY 2021. Total call volume remains 16 percent higher than pre-COVID-19 levels.

The NAL falls under the DHA Healthcare Optimization program organizationally and is fully integrated with the MTF PCMH primary care clinics to support enhanced access strategies. MTF enrollees make up 83 percent of all NAL calls. If the RN determines that the beneficiary needs to be seen within 24 hours, the NAL staff can search the NAL Management System for MTF walk-in capabilities, schedule MTF PCMH appointments, warm transfer the beneficiary directly to his or her PCMH via telephone, provide information about MTF UC and ED Fast Track options, and/or generate civilian UC referrals in the EHR for Active Duty personnel. PCMH teams have access to NAL encounter information through the NAL Management System; teams use NAL data to conduct appropriate follow-up with their patients and coordinate care, if clinically indicated. The NAL Management System also includes performance data, which allow PCMH teams to monitor utilization and adjust future appointing templates to accommodate changes in demand.

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

The percentage of NAL callers who intended to seek care in a network ED was significantly reduced by 72 percent. Over half of the callers did not seek follow-on care and instead used self-care advice provided by the RN. Patient satisfaction with the NAL remains above 92 percent, based on responses from a sample of beneficiaries who were surveyed by the DHA following their call.

NAL CALLER INFORMATION FOR MTF ENROLLEES, FY 2022

NAL DISPOSITION	CALLER'S PRE-INTENT	NURSE ADVICE	CALLER'S ACTION WITHIN 24 HOURS
Network ED	24%	9%	7%
Network UC	16%	19%	11%
MTF Care	22%	32%	30%
Self-Care	17%	28%	53%
General Health and Other Miscellaneous Questions	21%	12%	0%
Total	100%	100%	100%

Source: NAL Program and administrative data (M2/MDR): DHA/HCO/Healthcare Optimization Division, 11/30/2022

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

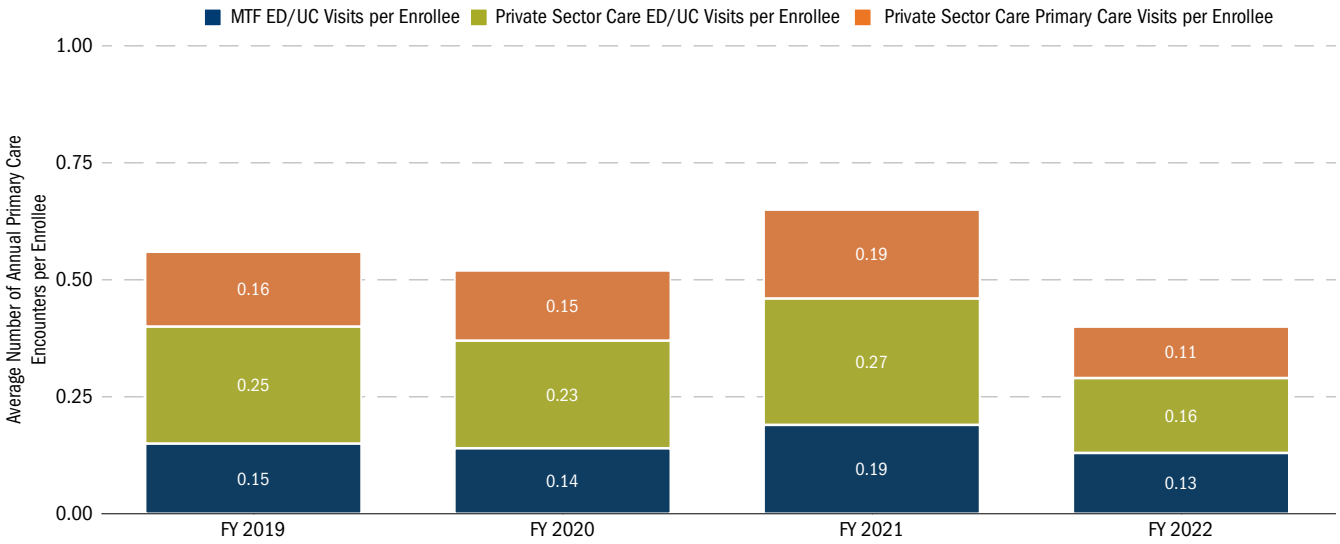
In FY 2022, primary care utilization was 2.38 visits per enrollee. In FY 2021, network ED and UC rates increased disproportionately to care provided by the MTF, resulting in the lowest direct care market share since the primary care leakage to the network metric began. Primary care leakage to the network is 11.3 percent for FY 2022, with additional private sector care claims expected to be processed for FY 2022.

A major goal of the MHS's PCMH program is to reduce unnecessary health care utilization by maximizing PCM ability to meet beneficiary health care needs during each visit and by using team-based care to better meet beneficiary health care needs outside of in-person or telephone visits with the beneficiary's PCM. Any ED care referenced below was for low-acuity needs occurring Monday through Saturday (excluding federal holidays)—this is care that could be resolved by PCMHs. In FY 2023, the MHS PCMHs will continue efforts to reduce unnecessary health care utilization and capture a greater proportion of MTF enrollees' primary care needs in the PCMH.

PRIMARY CARE UTILIZATION, PCMH MARKET SHARE, AND NETWORK LEAKAGE OF ENROLLEES' PRIMARY CARE NEEDS, FYs 2018–2022

	PCMH IN-PERSON VISITS PER ENROLLEE	MTF ED/UC VISITS PER ENROLLEE	NETWORK ED/UC VISITS PER ENROLLEE	NETWORK PRIMARY CARE VISITS PER ENROLLEE	TOTAL ANNUAL PRIMARY CARE VISITS PER ENROLLEE	PERCENT PCMH MARKET SHARE	PERCENT NETWORK PRIMARY CARE LEAKAGE
FY 2018	2.43	0.17	0.20	0.15	3.58	85.3%	10.0%
FY 2019	2.32	0.15	0.25	0.16	3.51	84.0%	11.7%
FY 2020	2.05	0.14	0.23	0.15	3.28	84.0%	11.8%
FY 2021	2.20	0.19	0.27	0.19	3.59	82.0%	12.6%
FY 2022		0.13	0.16	0.11	2.38	83.1%	11.3%

AVERAGE NUMBER OF ANNUAL PRIMARY CARE ENCOUNTERS PER ENROLLEE, FYs 2019–2022



Source: MHS administrative data; DHA/HCO/Healthcare Optimization Division, 11/10/2022

Notes:

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

– FY 2022 data exclude August and September 2022.

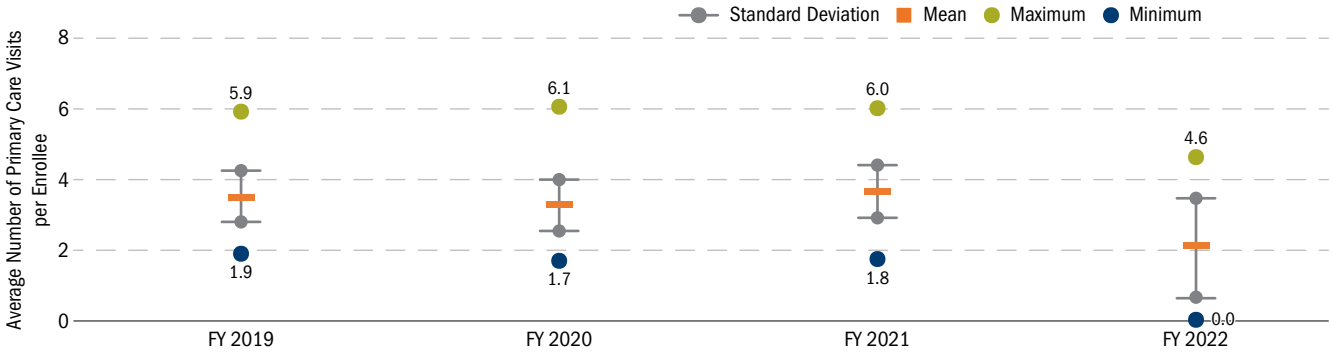
– Private sector care data may not be complete for up to one year due to claims processing.

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

AVERAGE NUMBER OF ANNUAL MTF ENROLLEE VISITS FOR PRIMARY CARE OVERALL, FYs 2019–2022

	FY 2019	FY 2020	FY 2021	FY 2022	FY 2019–FY 2022 CHANGE
Mean	3.5	3.3	3.7	2.1	–1.4
Standard Deviation	0.7	0.7	0.8	1.4	0.7
Median	3.4	3.1	3.5	2.5	–0.9
75th Percentile	4.0	3.8	4.3	3.3	–0.8
25th Percentile	3.1	2.8	3.2	0.3	–2.7
Maximum	5.9	6.1	6.0	4.6	–1.3
Minimum	1.9	1.7	1.8	0.0	–1.9
Range	4.0	4.4	4.7	4.6	0.6

AVERAGE NUMBER OF ANNUAL MTF ENROLLEE VISITS FOR PRIMARY CARE OVERALL, FYs 2019–2022



Source: MHS administrative data; DHA/HCO/Healthcare Optimization Division, 11/10/2022
Notes:
– Parent facility scores were used to describe variability in the results above.
– Results exclude MHS GENESIS sites, and only include Prime, Plus, and Reliant enrollments.
– Private sector care data may take up to a year to be finalized and are not complete for FY 2022.
– Numbers may not sum due to rounding.

Improvement Tools

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

Template Optimization Tool

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

Build or Buy Tool on CarePoint

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

Specialty Care Access

In FY 2022, the MHS continued monitoring specialty care performance for several reasons: most private sector care costs for MTF enrollees are due to specialty deferrals to private sector care; patient feedback indicated dissatisfaction with the decentralized specialty care processes and variance among MTFs; and capturing specialty care workload delivered in the MTF enhances clinical currency and a ready medical force, which includes both providers and clinical support staff. In FY 2018, the MHS codified specialty care standards in the DHA-IPM 18-001 on standard appointing processes and productivity. To measure compliance with the policy, enhance patient experience, and eliminate unwarranted variance among MTFs, a new measure was implemented—the percentage of referrals dispositioned within one business day—to complement the existing measure on the number of days between the appointment creation date and the appointment date. DHA-IPM 18-001 identifies standard MTF and Market processes to improve both measures.

Percentage of Referrals Dispositioned within One Business Day

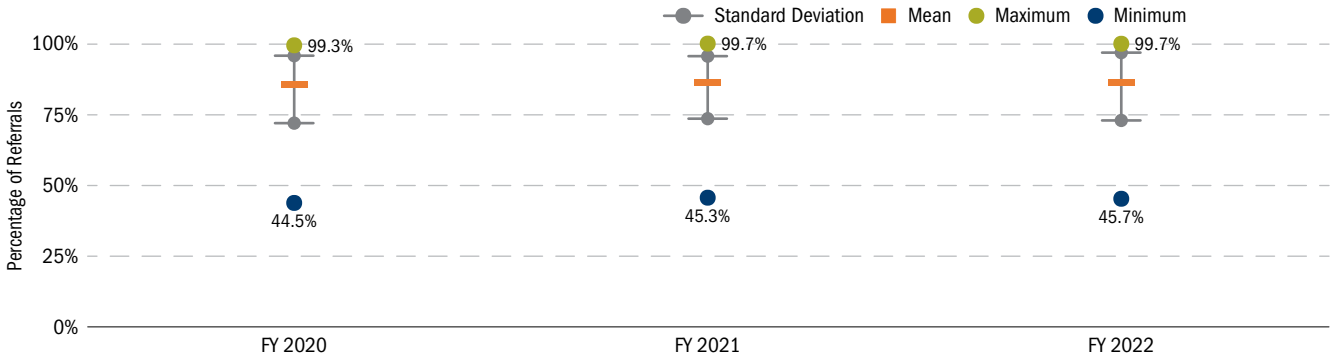
To "disposition" a referral is to determine whether the patient will be seen at the MTF, in the network, or if no appointment is required. Survey and qualitative data demonstrate a longer wait to obtain a scheduled appointment is a source of patient dissatisfaction and also delays needed care. DHA-IPM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

In FY 2022, an average of 85.7 percent of referrals were dispositioned within one business day, which is consistent with FY 2021 rates. The MHS has a standard of 90 percent of referrals being dispositioned within one business day. As the MHS is continuing to monitor performance with this metric, performance is expected to improve to meet the standard in FY 2023.

PERCENTAGE OF REFERRALS DISPOSITIONED WITHIN ONE BUSINESS DAY FYs 2020–2022

	FY 2020	FY 2021	FY 2022	FY 2020–FY 2022 % POINT CHANGE
Mean	84.8%	85.5%	85.7%	0.9
Standard Deviation	11.8%	11.2%	11.6%	–0.2
Median	87.7%	86.9%	88.0%	0.2
75th Percentile	94.0%	94.6%	94.7%	0.7
25th Percentile	78.6%	81.5%	80.3%	1.7
Maximum	99.3%	99.7%	99.7%	0.4
Minimum	44.5%	45.3%	45.7%	1.2
Range	54.9%	54.4%	54.1%	–0.8

PERCENTAGE OF REFERRALS DISPOSITIONED WITHIN ONE BUSINESS DAY FYs 2020–2022



Source: MHS Administrative Data; DHA/HCO/Healthcare Optimization Division, 11/10/2022

Notes:

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

ACCESS TO MHS CARE *(CONT.)*

Specialty Care Access *(cont.)*

Average Number of Days from Booking to Appointment

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

The goal is for beneficiaries to have a specialty care appointment within 15 days of being scheduled for the appointment. Many MTFs met this goal in FY 2022, but as an enterprise, beneficiaries waited 21.6 days on average for a specialty care appointment requiring a referral. This is expected to be associated with the return to post-pandemic demand as well as staffing challenges in certain specialties limiting provider availability. With improved referral processes and appointing expected with the new MHS GENESIS rollout and enforced DHA policy performance is expected to decrease in FY 2023.

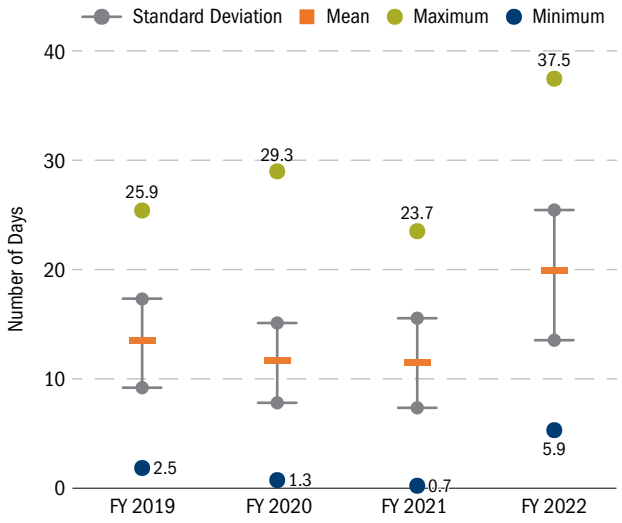
AVERAGE NUMBER OF DAYS FROM MTF BOOKED TO MTF APPOINTMENT, FYs 2019–2022

	FY 2019	FY 2020	FY 2021	FY 2022
Days from MTF Booked to MTF Appt.	16.4	14.2	15.8	21.6

AVERAGE NUMBER OF DAYS FROM MTF BOOKED TO MTF APPOINTMENT, FYs 2019–2022

	FY 2019	FY 2020	FY 2021	FY 2022	FY 2019–FY 2022 CHANGE
Mean	13.3	12.1	12.2	20.1	6.8
Standard Deviation	4.0	3.7	4.1	5.9	1.9
Median	14.0	12.0	12.1	19.9	5.9
75th Percentile	16.6	14.1	14.5	23.9	7.3
25th Percentile	11.6	10.1	9.4	16.4	4.8
Maximum	25.9	29.3	23.7	37.5	11.7
Minimum	2.5	1.3	0.7	5.9	3.3
Range	23.3	28.1	23.1	31.7	8.4

AVERAGE NUMBER OF DAYS FROM MTF BOOKED TO MTF APPOINTMENT, FYs 2019–2022



Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 11/10/2022

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

Specialty Care Ambulatory Leakage

In FY 2022 (September 2021–June 2022), the MHS had elevated specialty care leakage above previous years at 24.2 percent. The MHS goal is to reduce this leakage to 10.7 percent. The increase in the percentage is in part due to post-pandemic demand increases also reflected in the increase in the average days to booking for specialty care within the direct care system as well as methodology changes that began including provider specialties not previously measured. In FY 2023, the MHS will further analyze performance variance at each MTF and by product lines to identify reasons for and solutions to improve direct care system capacity.

AVERAGE AMBULATORY SPECIALTY CARE LEAKAGE, FYs 2016–2022

	ANNUAL AVERAGE
FY 2016	13.1%
FY 2017	13.5%
FY 2018	13.4%
FY 2019	13.7%
FY 2020	14.7%
FY 2021	15.7%
FY 2022	24.2%

Source: MHS administrative data; DHA/HCO/Healthcare Optimization Division, 11/10/2022
Note: FY 2022 excludes September 2022 records. Between FY 2021 and FY 2022, there was a change in methodology for this metric, which partially explains this uptick.

ACCESS TO MHS CARE *(CONT.)*

Virtual Health

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

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

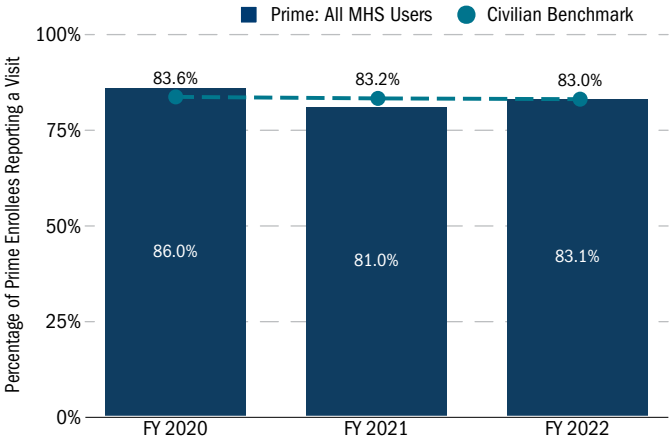
ACCESS TO MHS CARE *(CONT.)*

Measures of Availability and Ease of Access

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

- **Self-Reported Access:** The ability to see a doctor reflects one measure of successful access to the health care system. Prime enrollees were asked whether they had at least one outpatient visit during the past year. As shown in the graph, access to and use of outpatient services declined among Prime enrollees (with either a military or civilian PCM), with 83 percent reporting at least one visit in FY 2022, compared with 81 percent in FY 2021. MHS results remain statistically comparable to the civilian benchmark of just over 83 percent. Actual administrative data demonstrate 86 percent of direct care system (non-Active Duty) enrollees under age 65 had at least one primary care encounter in FY 2022.

TRENDS IN PRIME ENROLLEES HAVING AT LEAST ONE OUTPATIENT VISIT DURING THE YEAR, FYs 2020–2022



Source: DHA/Strategy, Plans, and Functional Integration (SP&FI) (J-5)/Analytics and Evaluation Division, Health Care Survey of DoD Beneficiaries (HCSDB) data, adjusted for age and health status, as of 12/15/2022

Notes:

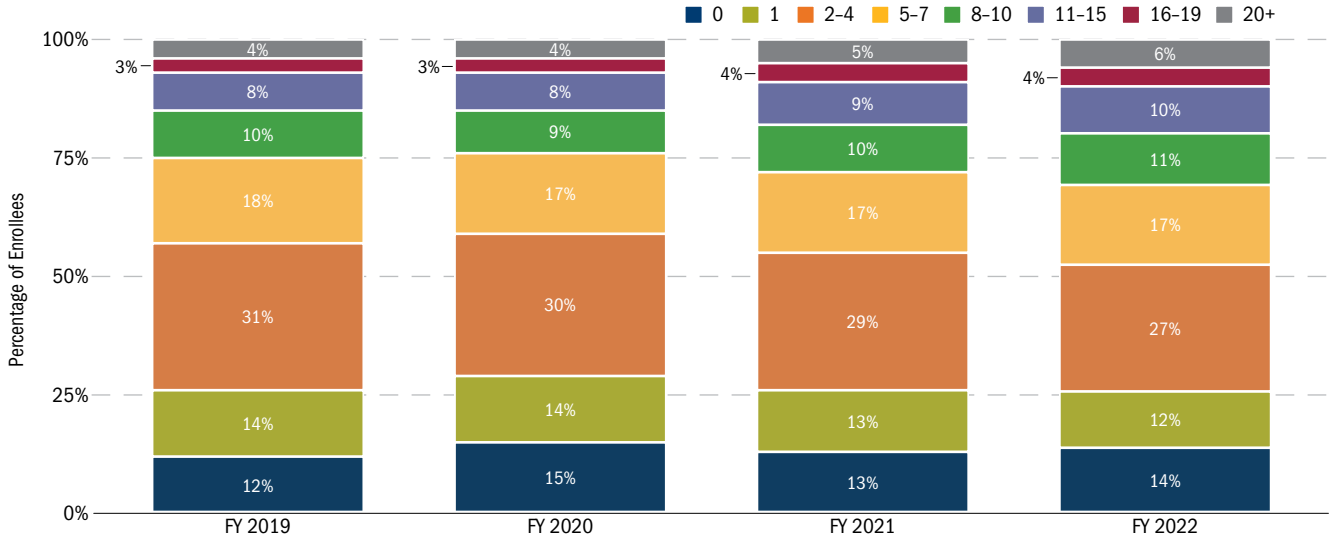
– All MHS Users applies to survey respondents in the 50 United States and the District of Columbia. Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric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

ACCESS TO MHS CARE *(CONT.)*

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

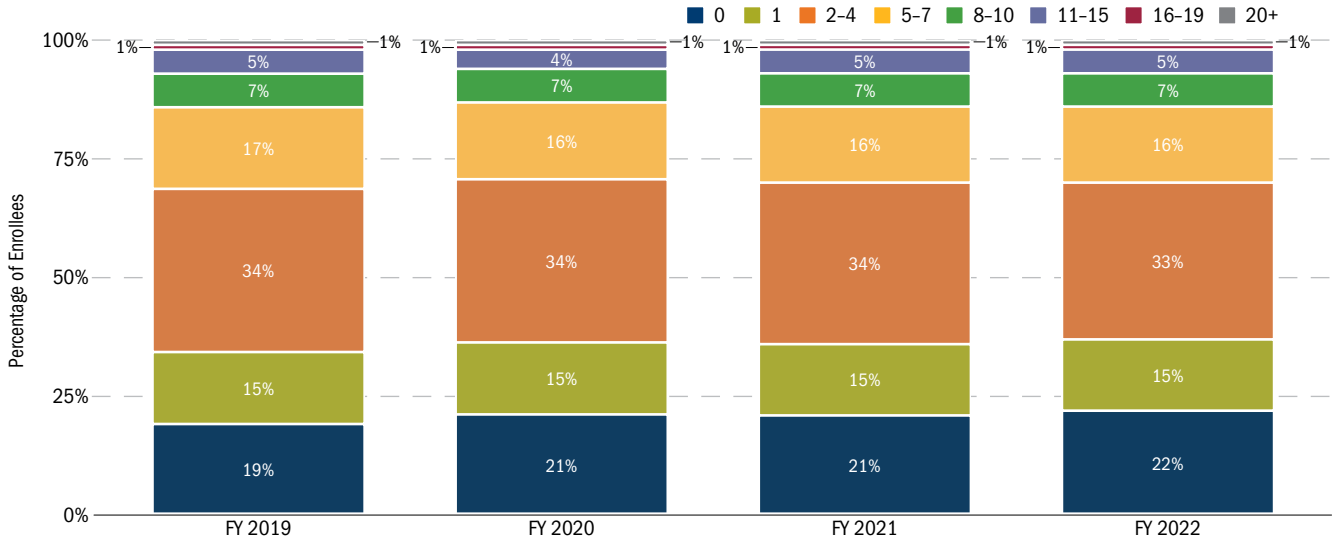
- **Direct Care Enrollee Access:** Based on administrative utilization data shown in the chart below, 86 percent of all non-Active Duty MTF enrollees under age 65 had at least one recorded outpatient visit for primary care reasons in FY 2022 (i.e., 14 percent did not have at least one visit). This access has been relatively stable since 2014. In FY 2022, 39 percent had between one and four visits, and 48 percent had five or more visits.

PERCENTAGE OF NON-ACTIVE DUTY ENROLLEES <65 YEARS, BY NUMBER OF ANNUAL VISITS FOR MTF PRIMARY CARE (ANY VENUE), FYs 2019–2022



- **Private Sector Care Enrollee Access:** Based on administrative claims utilization data, the chart below shows that 78 percent of all non-Active Duty managed care support contractor (MCSC) Network Prime enrollees under age 65 had at least one recorded outpatient visit for primary care reasons in FY 2022 (i.e., 22 percent had no visits). Forty-eight percent of non-Active Duty MCSC Network Prime enrollees had between one and four visits, and 30 percent had five or more visits in FY 2022.

PERCENTAGE OF NON-ACTIVE DUTY ENROLLEES <65 YEARS, BY NUMBER OF ANNUAL VISITS FOR MCSC/NETWORK PRIMARY CARE (ANY VENUE), FYs 2019–2022



Source: MDR, DHA/SP&FI (J-5)/Analytics and Evaluation Division, 12/23/2022

Notes:

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

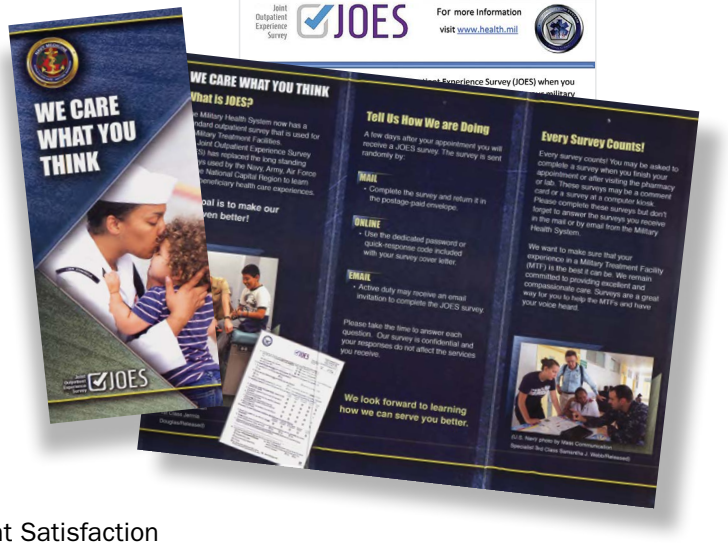
– Percentages may not sum to 100 percent due to rounding.

ACCESS TO MHS CARE *(CONT.)*

Patient-Centered, Self-Reported Measures

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

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



The goal of MHS outpatient surveys is to monitor and report on the experience and satisfaction of MHS beneficiaries who have received outpatient care in an MTF or civilian provider office. FY 2022 marks the sixth complete year that the Joint Outpatient Experience Survey (JOES) has been fielded to replace the Army Provider Level Satisfaction Survey (APLSS), the Navy Patient Satisfaction Survey (PSS), and the Air Force Service Delivery Assessment (SDA).

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

Approximately 318,000 JOES/JOES-C were returned during FY 2022, including 249,000 JOES and 69,000 JOES-C, providing targeted areas for improvement in outpatient care for MHS beneficiaries.

The JOES and JOES-C have improved in efficiency and representation, demonstrated through the collection of web-based surveys by Active Duty Service members (ADSMs) in FY 2019 in response to e-mailed invitations. In FY 2020, a pilot program began to send the JOES via text message to beneficiaries at select MTFs and continued to expand to additional MTFs in 2022. A text was sent to consenting beneficiaries with a link to complete the JOES online. Early analyses found response rates were higher for text message recipients and the data was comparable to mail and e-mail survey responses.

Additionally, more surveys are now being completed by Service members stationed overseas, providing invaluable feedback on their care. The results of the JOES and JOES-C measures are published to the JOES/JOES-C reporting website that allows users to examine the quality of care across the MHS. Some of these measures are routinely reported to senior MHS leadership as core measures on various dashboards and are reported publicly on the transparency website of www.health.mil.

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

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

Privacy of Adolescents

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule and Adolescents[1,2]

The Privacy Rule allows a parent to have access to protected health information (PHI) about his or her child, as the minor child's personal representative when such access is not inconsistent with state or other law. Exceptions to the Privacy Rule apply when the parent, guardian, or person acting as the parent may not be a personal representative of the minor. In such situations, the minor has the authority to act as "the individual" in regards to his or her PHI.

A minor is considered "the individual" who can exercise rights under the rule in one of three circumstances[2]:

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

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

ACCESS TO MHS CARE *(CONT.)*

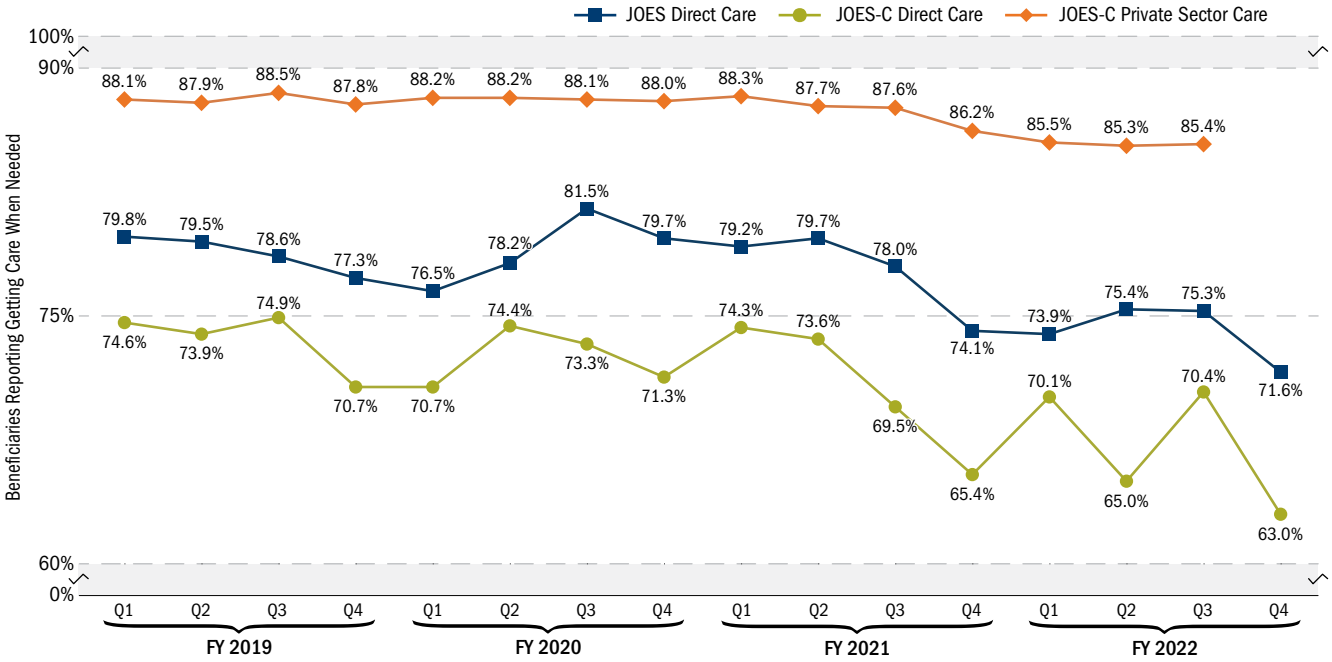
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care

Ratings of Getting Care When Needed

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

- JOES-C private sector care scores for Getting Care When Needed have been above JOES-C direct care and JOES direct care for the last four years.
- JOES-C private sector care Getting Care When Needed scores were relatively stable from the beginning of FY 2019 through FY 2021, followed by a slight decrease in FY 2022.
- JOES direct care scores for satisfaction with Getting Care When Needed were on the decline since FY 2021, from 79.2 percent in FY 2021 Q2 to 71.6 percent in FY 2022 Q4.
- JOES-C direct care scores for Getting Care When Needed fluctuated in FY 2022, ranging from a score of 70.4 percent to 63.0 percent.

JOES AND JOES-C GETTING CARE WHEN NEEDED, FYs 2019–2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES, weighted data, compiled 12/6/2022

Notes:

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

– FY 2022 is from October 2021 to July 2022 for JOES-C direct care and from October 2021 to June 2022 for JOES-C private sector care.

ACCESS TO MHS CARE *(CONT.)*

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

Extent of Change in Variability in Patient Ratings over Time

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

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

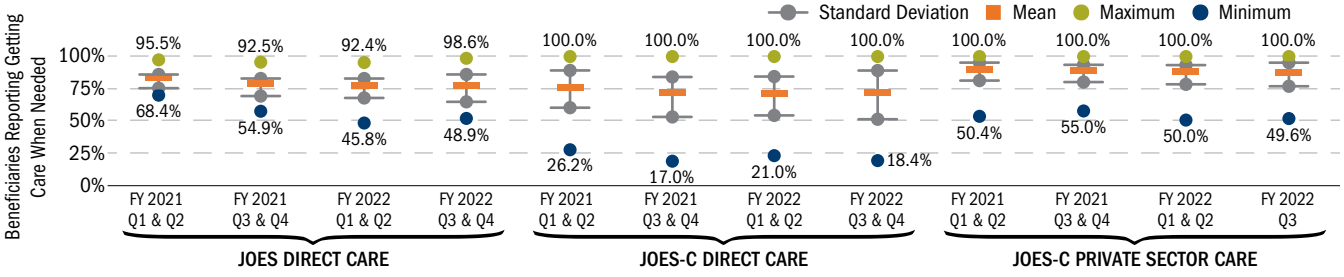
The table below displays the extent to which the measure of Getting Care When Needed changed over time in terms of improvement (increasing mean or median) or decreased dispersion (reduced range or standard deviation).

- From FY 2021 to FY 2022, the mean scores decreased by 4.6 percentage points for JOES-C direct care and 5.7 percentage points for JOES direct care.
- JOES-C private sector care decreased by 2.1 percentage points over the same time period.

VARIABILITY IN JOES GETTING CARE WHEN NEEDED, FYs 2021–2022

	FY 2021 Q1 & Q2	FY 2021 Q3 & Q4	FY 2022 Q1 & Q2	FY 2022 Q3 & Q4	% POINT CHANGE (FY 2021 Q1 & Q2 TO FY 2022 Q3 & Q4)
JOES DIRECT CARE					
Number of Respondents	188,985	156,185	148,334	93,545	
Service Score (Mean)	80.4%	76.0%	74.6%	74.7%	-5.7
Standard Deviation	5.4%	7.0%	7.8%	10.3%	4.9
Median	80.3%	75.7%	75.3%	74.1%	-6.2
75th Percentile	83.5%	80.8%	79.4%	82.8%	-0.7
25th Percentile	77.2%	72.1%	70.3%	68.2%	-9.0
Maximum	95.5%	92.5%	92.4%	98.6%	3.1
Minimum	68.4%	54.9%	45.8%	48.9%	-19.6
Range	27.0%	37.6%	46.6%	49.7%	22.7
JOES-C DIRECT CARE					
Number of Respondents	7,416	7,228	6,578	2,758	
Service Score (Mean)	73.9%	68.3%	69.5%	69.3%	-4.6
Standard Deviation	13.9%	15.7%	15.0%	19.1%	5.2
Median	74.4%	68.6%	71.4%	70.4%	-4.0
75th Percentile	83.0%	77.8%	78.3%	82.2%	-0.9
25th Percentile	64.1%	61.4%	61.9%	59.0%	-5.1
Maximum	100.0%	100.0%	100.0%	100.0%	0.0
Minimum	26.2%	17.0%	21.0%	18.4%	-7.8
Range	73.8%	83.0%	79.0%	81.6%	7.8
JOES-C PRIVATE SECTOR CARE					
Number of Respondents	30,794	28,732	28,313	13,958	
Service Score (Mean)	87.1%	86.5%	84.8%	85.0%	-2.1
Standard Deviation	7.0%	6.9%	7.4%	8.9%	1.9
Median	88.1%	87.7%	85.8%	86.6%	-1.5
75th Percentile	91.0%	91.1%	89.5%	90.8%	-0.1
25th Percentile	84.5%	83.9%	81.2%	80.9%	-3.6
Maximum	100.0%	100.0%	100.0%	100.0%	0.0
Minimum	50.4%	55.0%	50.0%	49.6%	-0.8
Range	49.6%	45.0%	50.0%	50.4%	0.8

VARIABILITY IN BENEFICIARY RATINGS: GETTING CARE WHEN NEEDED, FY 2021–2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES, weighted data, compiled 12/2022

Note: FY 2022 is from October 2021 to July 2022 for JOES-C direct care and from October 2021 to June 2022 for JOES-C private sector care.

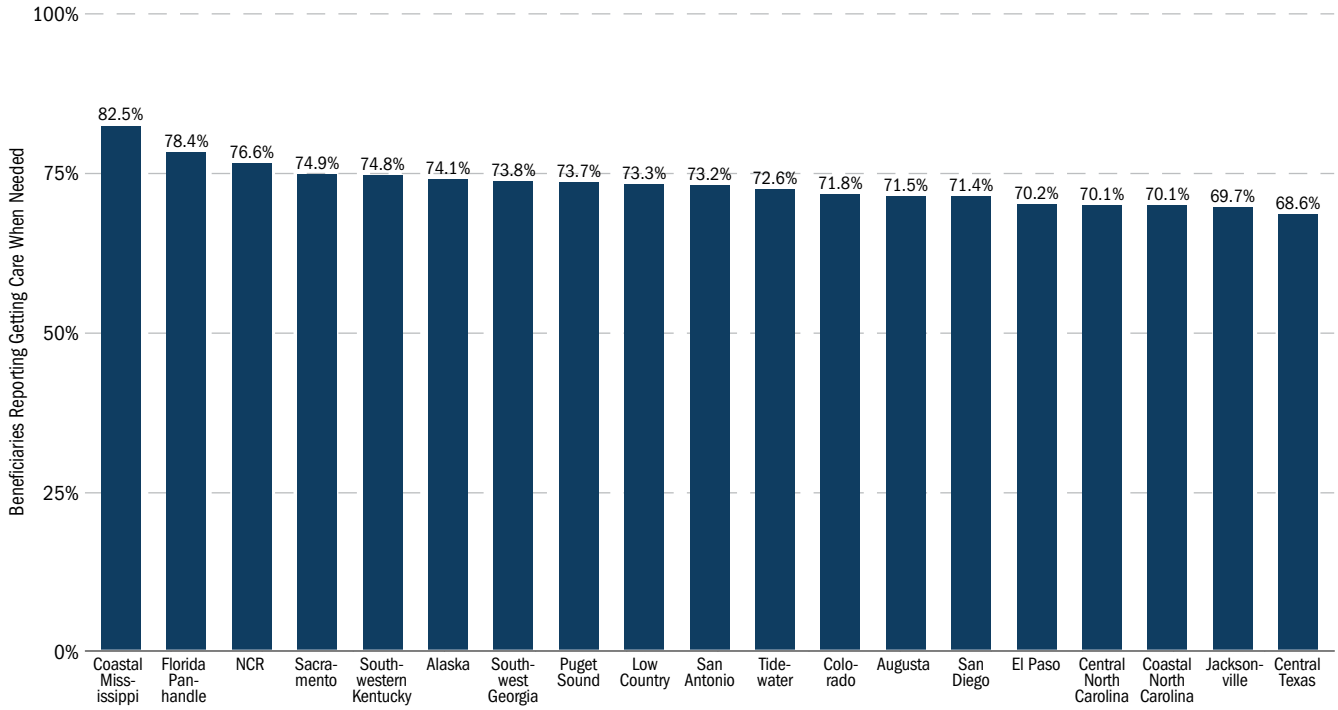
ACCESS TO MHS CARE *(CONT.)*

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

JOES Getting Care When Needed—By Markets

The chart below shows JOES scores for Getting Care When Needed for FY 2022 for the DHA Direct Reporting Markets. Coastal Mississippi was the highest scoring Market, with 82.5 percent of respondents indicating satisfaction with Getting Care When Needed. The lowest scoring Market for Getting Care When Needed in FY 2022 was Central Texas at 68.6 percent satisfaction.

JOES GETTING CARE WHEN NEEDED BY MARKET, FY 2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES, weighted data, compiled 12/7/2022

Notes:

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

– This analysis only includes the large health care markets that report directly to DHA.

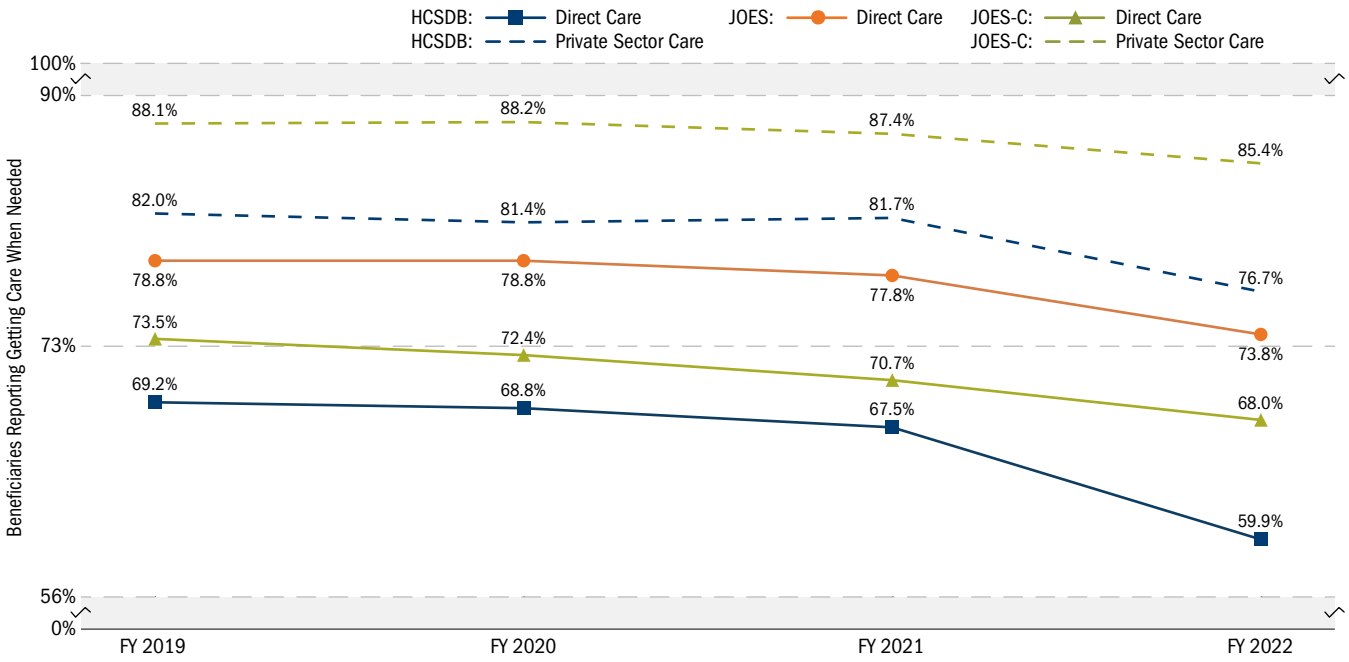
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care *(cont.)*

Comparison of Multiple Surveys—Getting Care When Needed

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

- Beneficiaries who utilize or are assigned to private sector care report greater access to their provider than those who utilize or are assigned to direct care, regardless of the time period or the survey. For JOES-C, scores for private sector care are 17 percentage points higher than those for direct care in FY 2022. Private sector care scores for HCSDB are almost 17 percentage points higher than their direct care counterpart scores in FY 2022.
- Ratings of Getting Care When Needed have declined over time for all surveys from FY 2019 to FY 2022.
- Beneficiaries who completed JOES-C reported greater access to care than beneficiaries who completed HCSDB, over time, for direct care and private sector care, respectively. This may be because beneficiaries who complete JOES-C are beneficiaries who responded to a survey after having received care, while those who complete the HCSDB may not have received care or may not have received care as needed over the previous 12 months.

HCSDB, JOES, AND JOES-C RATINGS OF GETTING CARE WHEN NEEDED, FYs 2019–2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB, JOES, and JOES-C, weighted data, compiled 12/22/2022

Notes:

– FY 2022 is from October 2021 to July 2022 for JOES-C direct care and from October 2021 to June 2022 for JOES-C private sector care.

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

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

ACCESS TO MHS CARE *(CONT.)*

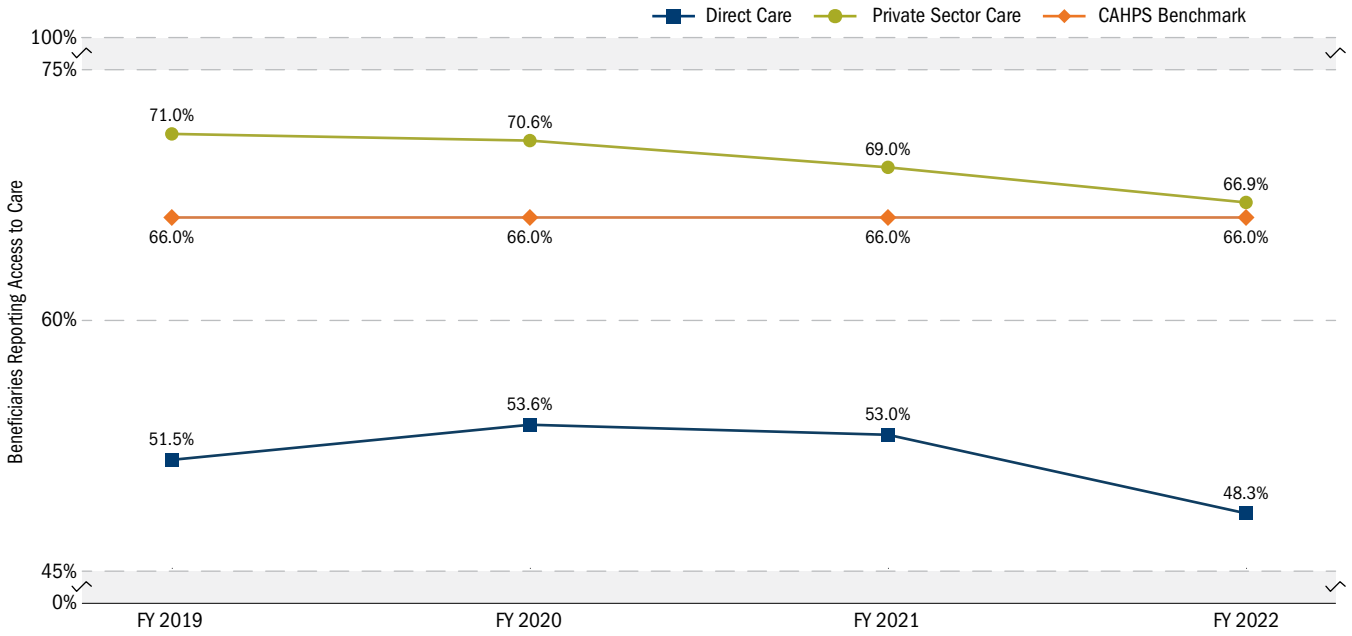
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care *(cont.)*

JOES-C Access to Care Composite

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

- The Access to Care composite ratings for beneficiaries receiving outpatient care at civilian facilities (private sector care) are higher than for those receiving care from MTFs (direct care).
- From FY 2019 through FY 2021, JOES-C Access to Care scores for private sector care were above the CAHPS benchmark by 4 to 5 percentage points. In 2022, the private sector score narrowed to less than 1 percentage point above the benchmark. In the same period, JOES-C direct care scores ranged from 12 to 18 percentage points below the CAHPS benchmark.

JOES-C ACCESS TO CARE COMPOSITE, FYs 2019–2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES-C, weighted data, compiled 12/8/2022

Notes:

– FY 2022 is from October 2021 to July 2022 for JOES-C direct care and from October 2021 to June 2022 for JOES-C private sector care.

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

ACCESS TO MHS CARE *(CONT.)*

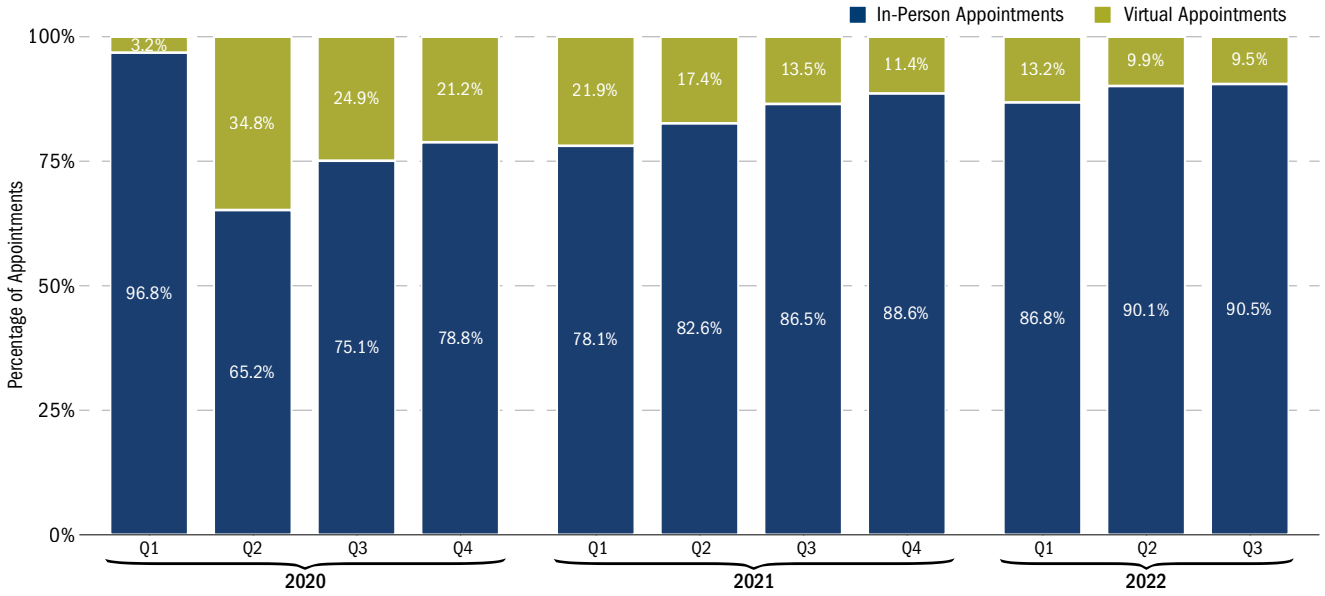
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care *(cont.)*

Impact of COVID-19 on Patient Experience

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

- Based on self-reported survey data from the JOES, the vast majority (approximately 97 percent) of outpatient appointments were in person prior to the pandemic (until March 2020) with the combined virtual appointments accounting for approximately 3 percent of appointment types during this time.
- The second quarter of CY 2020 had the largest percentage of virtual outpatient appointments for the past three years at 34.8 percent.
- The majority of virtual appointments were phone appointments during CYs 2020–2022.
- Virtual care has steadily decreased from each quarter from the beginning of the pandemic in March 2020 through September 2022 but still remains at approximately 10 percent, which is much higher than before the pandemic.

SELF-REPORTED PROPORTION OF OUTPATIENT VISITS BY APPOINTMENT TYPE, CYs 2020–2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, compiled 12/28/2022

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

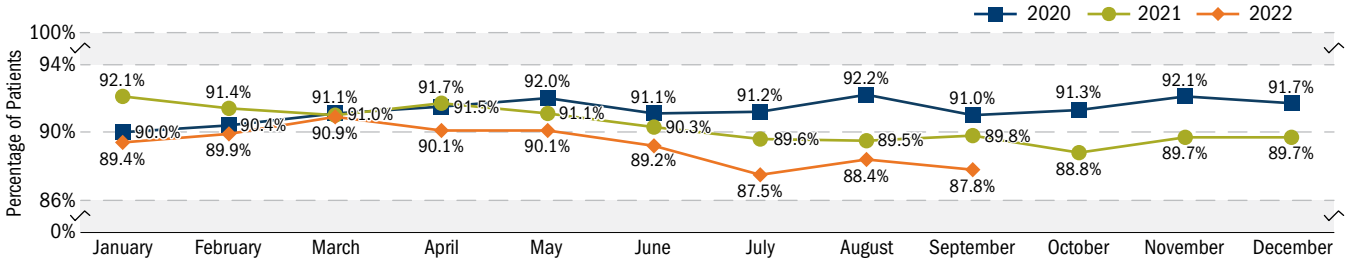
ACCESS TO MHS CARE *(CONT.)*

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

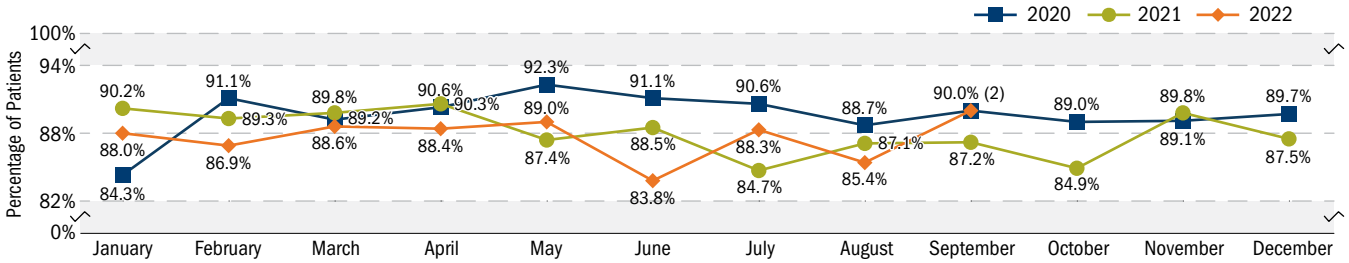
Impact of COVID-19 on Patient Experience *(cont.)*

The graphs below display Access to Care (See Provider When Needed) scores (in-person or virtual) for CYs 2020–2022 to compare if satisfaction scores have changed during the COVID-19 pandemic. Patient satisfaction for in-person appointments remained relatively stable during this period. Virtual appointments over the past three years had more fluctuation in scores. In general, comparing by month, 2021 scores were lower than 2022 and 2020 for the respective month, ranging from 83.8 percent to 90 percent.

OVERALL PATIENT SATISFACTION FOR IN-PERSON CARE, CYs 2020–2022

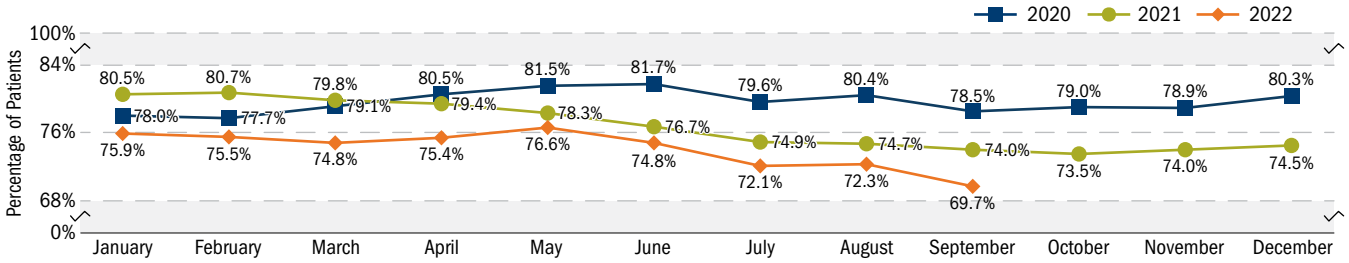


OVERALL PATIENT SATISFACTION FOR VIRTUAL CARE, CYs 2020–2022

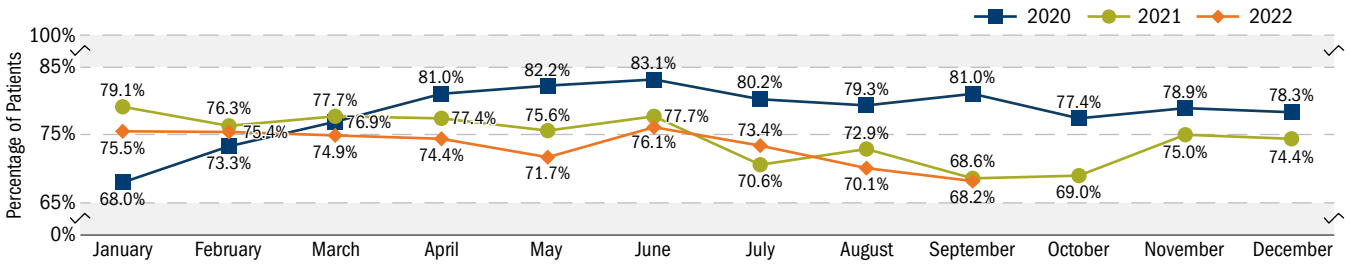


The graphs below display Access to Care (See Provider When Needed) scores for in-person and virtual appointments that follow similar trends as overall patient satisfaction. In CY 2020, scores remained stable for Able to See Provider When Needed for in-person appointments, but 2021 and 2022 scores started declining in the month of May. Moreover, from January 2021 to September 2022, Access to Care for in-person appointments decreased by approximately 11 percentage points. For virtual appointments, scores for CYs 2021 and 2022 are generally lower than CY 2020 when comparing by month.

SEE PROVIDER WHEN NEEDED BY IN-PERSON APPOINTMENTS, CYs 2020–2022



SEE PROVIDER WHEN NEEDED BY VIRTUAL APPOINTMENTS, CYs 2020–2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, compiled 1/5/2023

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

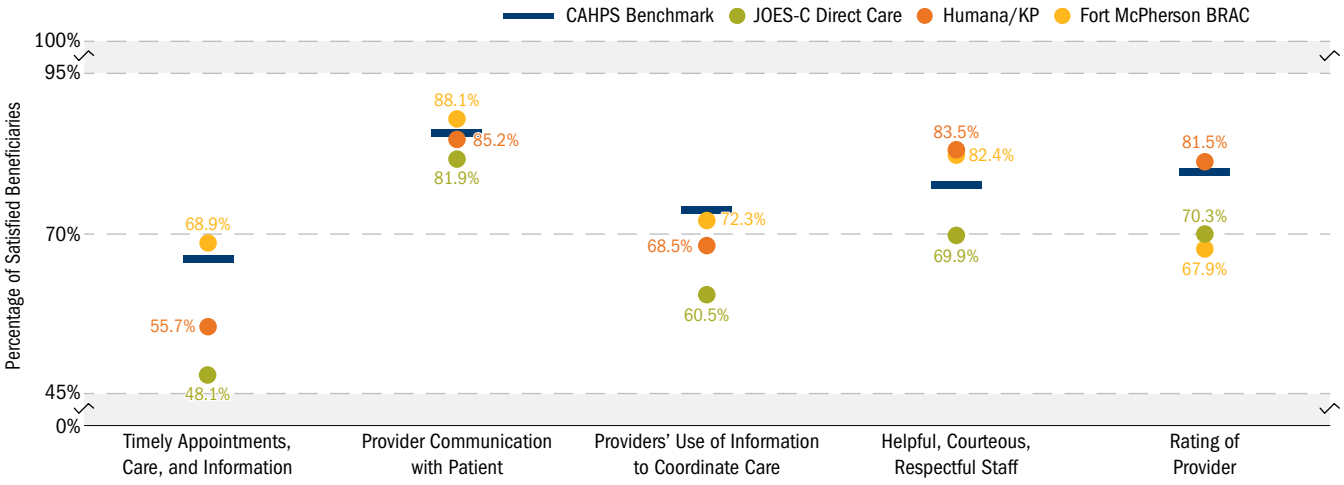
Beneficiary Ratings of Access to Care Following Outpatient Primary and Specialty Care *(cont.)*

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

In FY 2020, DHA implemented an accountable care organization (ACO) demonstration in the Atlanta Market area in partnership with Humana and Kaiser Permanente (KP). Enrollment in the Humana/KP demonstration was offered to TRICARE Prime and Select members in the Atlanta Prime Service Area during the 2019 Open Enrollment Season (January 1, 2020, start). Care delivery began January 1, 2020, and continued for three years. From October 2021 to June 2022, KP beneficiary enrollment was 2,869. This section compares patient experience scores of participants in the Humana/KP pilot and TRICARE beneficiaries in the Atlanta area (Fort McPherson BRAC) from JOES-C direct care and private sector care during October 2021 to June 2022.

- Humana/KP pilot participant ratings were above direct care ratings for all measures from October 2021 to June 2022. Humana/KP ratings were below those in the Atlanta area (Fort McPherson BRAC) and below the civilian CAHPS benchmark for Timely Appointments, Care, and Information, Provider Communication with Patient, and Providers' Use of Information to Coordinate Care measures during the same period.

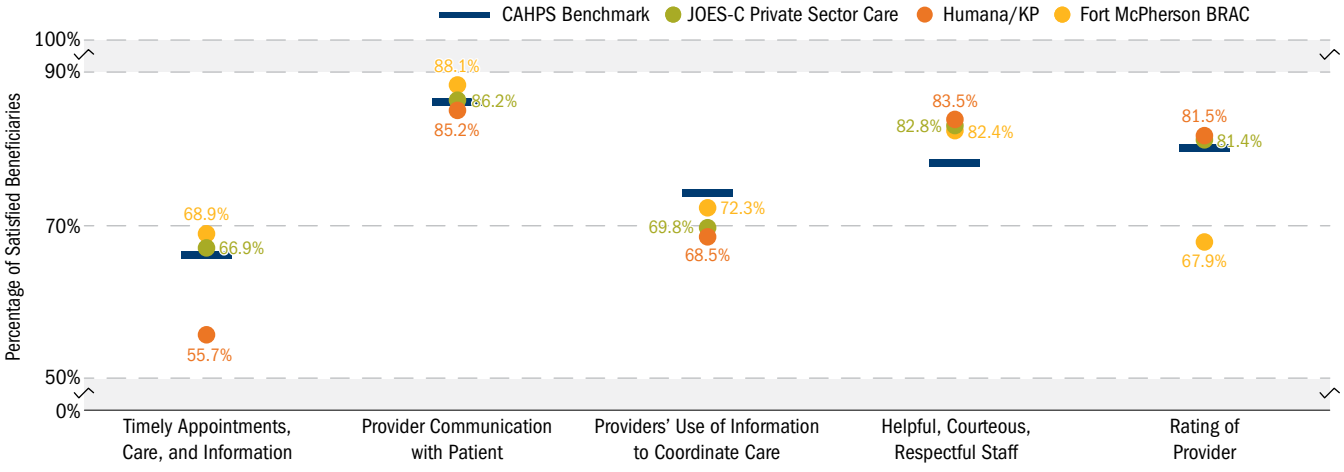
CAHPS COMPOSITE SCORES COMPARED WITH DIRECT CARE, OCTOBER 2021–JUNE 2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES-C, weighted data, compiled 12/23/2022
Note: Humana/KP N=396

- Humana/KP pilot participant ratings were above the private sector care Helpful, Courteous, Respectful Staff and Rating of Provider scores during the period of October 2021 through June 2022.
- Results should be interpreted with caution due to the small sample size for the Humana/KP pilot survey respondents.

CAHPS COMPOSITE SCORES COMPARED WITH PRIVATE SECTOR CARE, OCTOBER 2021–JUNE 2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES-C, weighted data, compiled 12/23/2022
Note: Humana/KP N=396

ACCESS TO MHS CARE *(CONT.)*

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

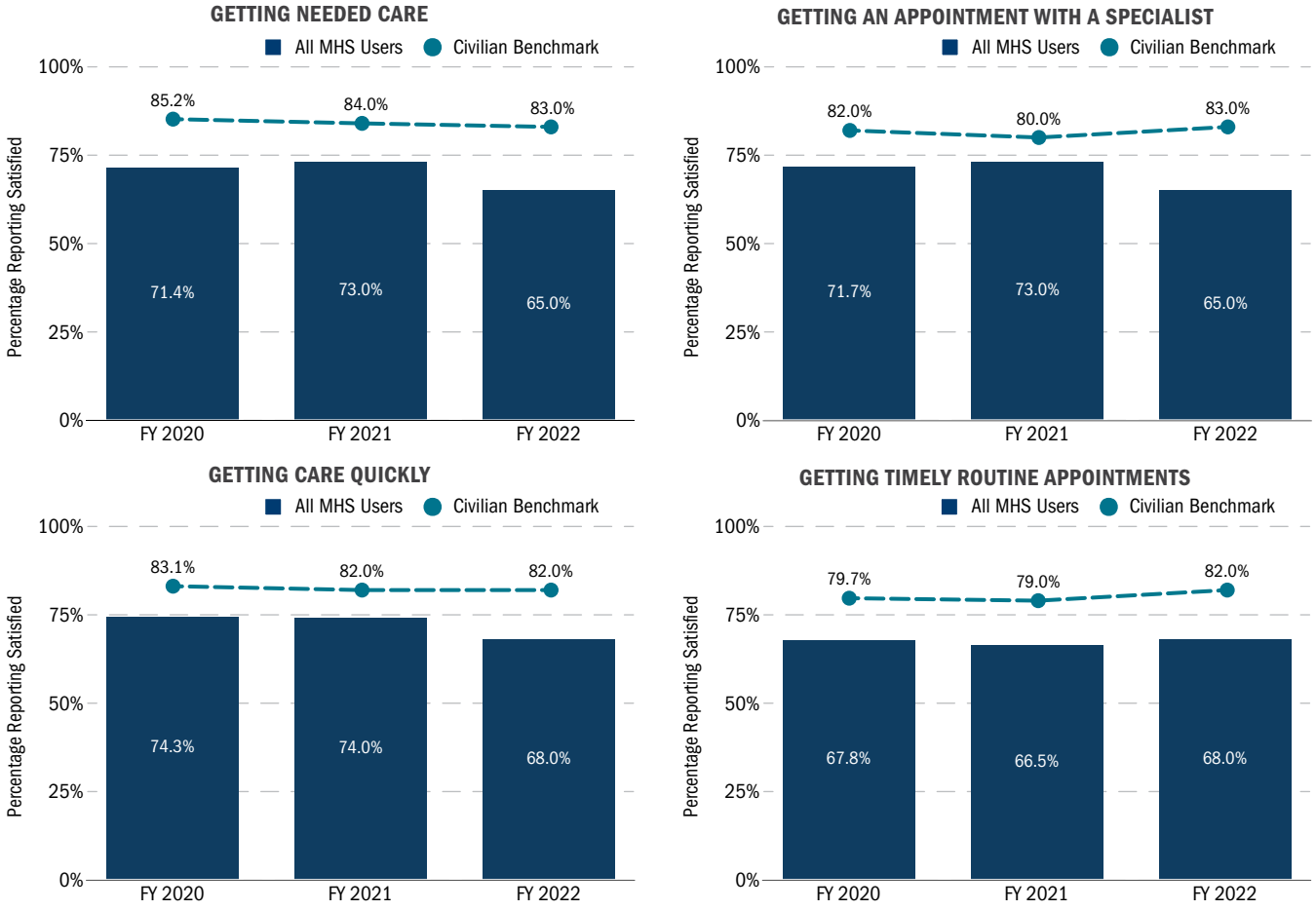
Instead of focusing on a specific health care event to assess patient experience with care, population surveys are designed to sample populations based on the demographics being considered (e.g., a survey of all ADSMs about their health behaviors, or a survey of all MHS beneficiaries to assess their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

Availability and Ease of Obtaining Care

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

- MHS beneficiary ratings for Getting Care Quickly, Getting Needed Care, and Getting an Appointment with a Specialist declined from FY 2020 to FY 2022. MHS beneficiary satisfaction with Getting Timely Routine Appointments remained about the same from FY 2020 to FY 2022.
- MHS beneficiary satisfaction with all four access measures was lower than the comparable civilian benchmarks in each year between FY 2020 and FY 2022.

TRENDS IN MEASURES OF ACCESS FOR ALL MHS BENEFICIARIES (ALL SOURCES OF CARE), FYs 2020–2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 12/15/2022

Notes:

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

– Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used in 2020 come from NCQA's 2017 data and in 2021–2022 from NCQA's 2019 data.

CLINICAL QUALITY MANAGEMENT IN THE MHS

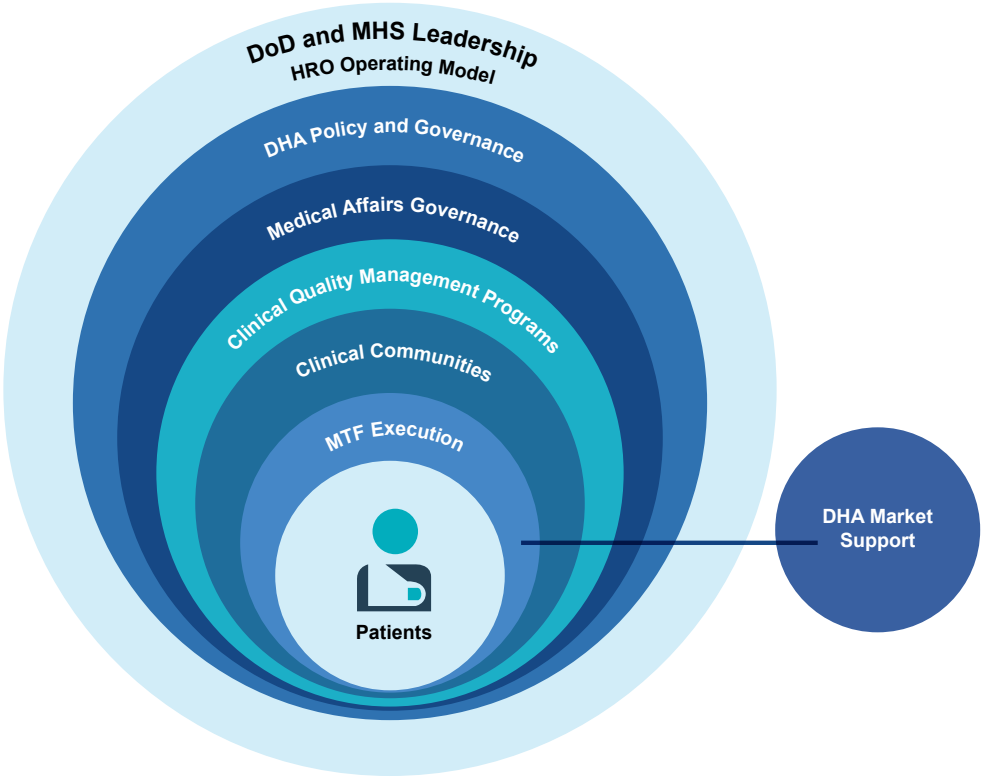
Clinical Quality Management Oversight

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

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

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

MHS GOVERNANCE OF CLINICAL QUALITY MANAGEMENT



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

Healthcare Resolutions Program

Healthcare Resolutions is a 24/7/365 non-legal venue to resolve complex health care issues following unanticipated/adverse outcomes of care or quality-of-care concerns starting at the time of service delivery at medical centers, hospitals, clinics, and/or operational medicine platforms. The program incorporates five core principles of high reliability: preoccupation with failure, reluctance to simplify, sensitivity to operations, commitment to resilience, and deference to expertise. The three primary components of the MHS Healthcare Resolution Program are: (1) detailed fact-finding, consultation with experts, and facilitated dialogue with involved patients and providers; (2) promotion of process improvement efforts with involved clinicians; and (3) a resilience program for providers. The MHS Healthcare Resolutions Program is based in large MTFs, with each assigned Special Assistant for Healthcare Resolutions at these large MTFs supporting select smaller MTFs.

Healthcare Resolutions

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

Disclosure Training

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

Peer Support

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

Healthcare Resolutions Program *(cont.)*

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

Patient Safety: Program to Prevent Harm

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

In collaboration with DHA Markets, the Small Market and Stand-Alone MTF Office (SSO), Defense Health Agency Regions (DHARs), MTFs, and the Services, the PSP focuses on five functional areas:

1. Managing Patient Safety Events: Eliminating harm through the identification, investigation, and mitigation of patient safety events
2. Supporting a Learning Organization: Designing and identifying integrated solutions to engage, educate, and equip
3. Fostering a Culture of Safety: Fostering a culture in which mistakes lead to sustainable, positive change and safety of patients, and the workforces are both highly valued and ardently protected
4. Infection Prevention and Control (IPC): Focusing on reducing harm events in the areas of healthcare-associated infections (HAIs) and including the Antimicrobial Stewardship Program (ASP)
5. Pharmacovigilance: Focusing on medication safety through proactive medication safety surveillance and usage analysis, supporting the ASP, and sharing best practices and lessons learned across the enterprise

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

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

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

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

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

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

1. Joint Patient Safety Reporting (JPSR)

The MHS requires Markets, SSO, DHARs, and MTF Directors and staff to report all patient safety events reaching the patient and to report near-miss events to the greatest extent possible through JPSR. JPSR is a standardized, anonymous, and voluntary web-based reporting system that was implemented in 2011 across the MHS to capture patient safety events and jointly used with the Veterans Health Administration (VHA) effective 2017.

As a result, the PSP has seen increased collaboration on improvement efforts, knowledge exchange, and the development of enterprise solutions. In FY 2022, a total of 73,025 patient safety reports were submitted from the direct-care system. Near-miss events, which did not reach a patient, accounted for 50 percent of all JPSR events reported in FY 2022. Across the deployed environment, JPSR has become an important tool in delivering safer care in austere environments where extraordinary care is taken to stabilize and safely transport wounded warriors back to contiguous United States (CONUS) in the global Aeromedical Evacuation system.

The table below compares FY 2018 through FY 2022 patient safety reporting, stratified by degree of harm. Harm is defined as events that reach a patient and result in harm, including death; no harm is defined as events that reach a patient and do not result in harm; and near miss is defined as events that do not reach a patient. A culture of self-reporting is critical to advance Ready Reliable Care in order to learn from patient safety events.

JOINT PATIENT SAFETY EVENTS REPORTED, FYs 2018–2022

HARM GROUP	FY 2018		FY 2019		FY 2020		FY 2021		FY 2022	
	#	%	#	%	#	%	#	%	#	%
Harm	10,034	10%	10,333	10%	9,517	11%	9,215	11%	7,476	10%
No Harm	40,975	39%	41,004	38%	34,737	39%	34,003	39%	29,410	40%
Near Miss	54,445	52%	55,373	52%	44,768	50%	44,371	51%	36,139	49%
Total	105,454	100%	106,710	100%	89,022	100%	87,589	100%	73,025	100%

Source: DHA/Medical Affairs/Clinical Support Division (CSD), 1/17/2023. Data reported as of 1/12/2023
Notes:
– Due to the process of event investigation and resolution, data may shift slightly from year to year as the JPSR system closes out the event.
– Percentages may not sum to 100 percent due to rounding.

2. DoD Reportable Events

DoD REs are an important part of patient safety. DoD REs are defined as any patient safety event resulting in death, permanent harm, or severe temporary harm, and encompass The Joint Commission (TJC) Sentinel Events and National Quality Forum (NQF) Serious Reportable Events. The table below provides the most common medical and dental DoD REs that the MHS reported to TJC from FY 2018–2022.

DoD REs REPORTED, FYs 2018–2022

EVENT TYPE	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
	#	#	#	#	#
Wrong-Site Surgery: Wrong Patient, Wrong Site, Wrong Procedure	46	27	21	28	28
Maternal (≥20 Week Gestational Age–42 Days Postpartum): Hemorrhage, Hysterectomy	11	<4[a]	10	9	14
Fall	8	6	12	22	17
Delay in Treatment: Lab, Path, Radiology, Referral, Treatment Order	25	15	15	22	14
Unintended Retained Foreign Object	27	20	18	15	12

Source: DHA/Medical Affairs/CSD, 1/17/2023. Data reported as of 1/12/2023
[a] Contents confidential and privileged in accordance with 10 U.S.C. §1102. Data include only TJC reportable events.

- **Wrong-Site Surgery (WSS):** WSS is a preventable DoD RE involving surgeries on the wrong site, wrong side, wrong person, or performance of the wrong procedure. The MHS goal for WSS is zero events. In FY 2022, the MHS did not report changes from FY 2021 in the number of reported WSS DoD REs. The DHA has developed policy in recent years specifically aimed at surgical and procedural error prevention through standardization. In January 2022, the Deputy Assistant Director of Medical Affairs (DAD-MA) published the Procedural Instruction (PI) 6025.44: Surgical and Procedural Patient Safety Practices with the purpose to improve quality and safety of medical care through standardization with a focus on Universal Protocol (UP). Additionally, PSP published a Surgical and Procedural Errors in the Operating Room Focused Review in October 2022.
- **Unintended Retained Foreign Object (URFO):** An URFO event that occurs after an invasive medical or surgical procedure causes patient harm and significantly increases the cost of patient care. In FY 2022, the number of reported URFO DoD REs decreased 20 percent from FY 2021 (from 15 to 12).

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

- **Delay in Treatment:** Delay in Treatment events can be the result of a misdiagnosis, delay in diagnosis, or failure to follow up or communicate test results. These can be serious DoD REs that ultimately result in serious harm or patient death. In FY 2022, the MHS saw a 36 percent decrease in the number of reported Delay in Treatment DoD REs (from 22 to 14). DoD, in collaboration with the AHRQ developed TeamSTEPPS, an evidence-based set of communication and teamwork tools used by health care professionals. In 2022, AHRQ developed a tool kit for engaging patients to address diagnostic safety designed to improve diagnostic skills and avoid diagnostic errors, such as delay in treatment, by improving collaboration and communication. Additionally, PSP published a focused review on Delay in Treatment in August 2022 to bring greater awareness to leading practices for preventing delays in treatment.
- **Fall:** A fall is considered a DoD RE when the fall occurs while the patient is being cared for in a health care setting and causes death or serious injury. In FY 2022, the MHS saw a 23 percent decrease in the number of reported fall DoD REs (from 22 to 17). To bring greater awareness to practices for prevention, DHA published a tool kit that offers guidance on education, assessment, reassessment, intervention, and continuous improvement.
- **Maternal:** Maternal DoD REs include events during which the mother receives more than four units of blood, is transferred to a higher level of care, or undergoes a hysterectomy due to hemorrhage. To address maternal events, the PSP partners with the Women and Infant Clinical Community (WICC) to improve the safety of women and infants. In FY 2022, the MHS saw a 56 percent increase in the number of reported maternal events (from 9 to 14) resulting in hemorrhage or hysterectomy. The DHA has developed and implemented DHA-PI 6025.35: Guidance for Implementation of the Postpartum Hemorrhage Bundle, which established DHA protocols for all MTFs to implement standardized PPH practices. Additionally, PSP published a PPH Focused Review in March 2022 to bring greater awareness to leading practices for preventing PPH events.

Policy mandates that MTFs must submit a comprehensive systematic analysis (CSA) for each DoD RE that occurs in the facility. In addition to mandatory completion, the Services/Markets may also voluntarily elect to complete a CSA for events that do not meet the threshold of a DoD RE, which provides an opportunity for learning and improvement for the MTF. In total, the DHA submitted 153 CSAs for DoD REs to TJC in FY 2022, representing a 23 percent increase from FY 2021 (not shown). For each CSA received, the PSP reviews the strength of CA and provides feedback review to the applicable Market, SSO, DHAR, or MTF. The PSP's corrective action rating system is based on the VA Action Hierarchy of Corrective Actions, which breaks down actions by strength based on likelihood of preventing the event from happening again.

The actions can be strong, intermediate, or weak. Strong actions focus on a system change and are not reliant on individual memory or vigilance. Through this process, the PSP guides MTFs in implementing strong CAs that are more likely to prevent a similar event from occurring.

3. CDC National Healthcare Safety Network (NHSN)

The reduction and prevention of HAIs, improved antibiotic stewardship, and reduction of multidrug-resistant organisms remain top priorities for the PSP. To ensure standardization of reporting practices across the health care system, the MHS participates in the CDC's NHSN, the nation's most widely used HAI tracking system. NHSN participation directly aligns with the MHS goal of achieving zero harm by allowing the tracking of data needed to identify problem areas, measuring progress, and ultimately eliminating HAIs through implementation of targeted process improvement initiatives based on standardized measures and benchmarks. The MHS participates in the NHSN device-associated module and the antimicrobial use and resistance module. The device-associated module includes submission of central line–associated blood stream infection (CLABSI) and catheter-associated urinary tract infection (CAUTI) data for all intensive care units (ICUs) and units while the AUR modules include submission of antimicrobial administration and resistance data for all inpatient military treatment facilities. It is important to note that the deployment of MHS GENESIS and transfer of NHSN data (AUR, device days, ICD-10 coding) has affected the ability to mine data by MTFs and other PSP workstreams.

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

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

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

HAIs, FY 2019 Q1–FY 2022 Q3, STANDARDIZED INFECTION RATIO

	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2	2022 Q3
CLABSIs	1.4	0.8	1.0	0.5	0.6	0.3	0.9	1.5	1.3	1.4	0.5	1.5	1.1	0.8	0.5
CAUTIs	0.4	0.5	0.5	0.6	0.3	0.1	0.6	0.6	0.8	0.5	0.6	1.3	1.0	1.3	1.3

Source: DHA/Medical Affairs/CSD, 11/1/2022

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

To facilitate dissemination and access to antimicrobial use data to all inpatient MTFs, the Patient Safety Program publishes quarterly reports and dashboard metrics that enable each facility to monitor its data. Additional SAAR statistics for 22 antimicrobial categories and 17 inpatient location types are also available for review. The table below displays the two primary SAARs for adults and pediatrics. For FY 2019 Q1 to FY 2022 Q4, the MHS performed better or the same as the national benchmark if the value shown is 1.0 or less.

ANTIMICROBIAL USE, FY 2019 Q1–FY 2022 Q4, STANDARDIZED ANTIMICROBIAL ADMINISTRATION RATIO

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

Source: DHA/Medical Affairs/CSD, 11/2/2022

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

IPC COVID-19 Response

In response to the COVID-19 pandemic, the DHA established an IPC Tiger Team that consisted of multidisciplinary Tri-Service experts. The IPC Tiger Team contributed to the DOD COVID-19 Practice Management Guide. The team has now transitioned into the DHA IPC Standardization and Advisory Group and continues to provide agile responses to IPC-related inquiries received from the field. The group supports Public Health Emergency/Event Management Working Group for Monkey Pox and Ebola in its efforts for the prevention and education related to the emergence of infectious diseases, provides consultative services for COVID-19 to include other variants and respiratory pathogens, and enhances disease surveillance utilizing data provided by Integrated Biosurveillance Branch, Armed Forces Health Surveillance Division, Multidrug-Resistant Organism Repository and Surveillance Network (MRSN), the Navy EpiData Center (EDC), and Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE).

4. Global Trigger Tool (GTT)

The MHS implemented the GTT in FY 2018, leveraging methodology gleaned from the Institute for Healthcare Improvement (IHI). Voluntary reporting methods detect only a fraction of adverse events (AEs) that cause patient harm. However, GTT uses a standardized process to detect AEs not otherwise reported. It is a validated, objective, and consistent retrospective method for medical record review. The DHA uses the GTT to determine and monitor rates of patient harm over time and supplements other reporting systems to help direct resources and monitor impact. The IHI methodology recommends a minimum of 12 months of data collection to determine a baseline; therefore, FY 2019 was the first year when GTT data were reportable. The table below shows GTT statistics from FY 2019 to FY 2022 Q3.

GLOBAL TRIGGER TOOL ADVERSE EVENTS, FY 2019 Q1–FY 2022 Q3

	2019 Q1	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2	2022 Q3
AEs per 100 Admissions	7.1	8.2	6.9	7.9	6.0	6.4	6.6	7.1	6.5	6.7	5.5	4.9	5.7	6.2	7.9

Source: DHA/Medical Affairs/CSD, 11/1/2022

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

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

Throughout the MHS transformation, the PSP continued work toward patient safety, quality, and process improvement. Over the past year, the PSP has focused on engaging, educating, and equipping our MTFs and their leadership teams. This focus includes collaboration with the Services and Clinical Communities to document patient safety concerns, assist with analysis of patient safety events, and implement CA. The sections below describe examples of patient safety solutions.

Engage

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

Patient Safety Awareness Week (PSAW): This week is a multiorganizational effort that serves as a national education campaign for promoting patient safety practices. The PSP collaborates with external organizations, including AHRQ and IHI, on this awareness initiative. In FY 2022, the PSAW theme was "Uniting for Ready Reliable Care," and included 15 webinars on leading practices and efforts from across the organization; engaging our MTFs through daily activities such as quizzes; and providing PSAW kits such as posters, badges, and other patient safety–related materials. PSAW is a consistent way that the PSP reaches into all areas of the organization to promote and encourage the adoption of leading safety practices.

RRC Safety Communication Bundle: To help the MHS reach the goal of zero preventable patient harm, the Patient Safety Program has collaborated with the Markets, SSO, DHARs and Markets, along with Clinical Communities to implement the RRC Safety Communication Bundle's (SCB) six standardized safety communication practices:

- Leader Daily Safety Briefs
- Safety Leadership Rounds
- Unit-Based Huddles
- I-PASS for Patient Handoff
- Surgical Briefs and Debriefs
- Universal Protocol

The RRC SCB also focuses on improving culture and reducing staff burnout. Incorporated into the Campaign Plan under the Implementing Ready Reliable Care strategic initiative, RRC SCB directly aims to improve several culture-related workplace stressors found in both the 2019 and 2022 culture surveys to be associated with increased reported burnout—i.e., poor teamwork and communication, low staff empowerment to improve. More information about the RRC Safety Communication Bundle is available in this introductory video (https://www.dvidshub.net/video/814600/introduction-safety-communication-bundle) and at RRC Safety Communication Bundle: (https://health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Ready-Reliable-Care/Safety-Communication-Bundle).

Patient Safety Champion Recognition Program: The PSP created the Patient Safety Champion Recognition Program to encourage peer-to-peer acknowledgement and celebration of patient safety innovations across the MHS. Each year more than 100 individuals are recognized for their contributions. In CY 2022, 123 PS Champion certificates were awarded.

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

Healthcare Event Analysis Response Team (HEART): The HEART consists of a team of experts with specialized training in investigation and support of patient safety investigations. The team includes physicians, nurses, Human Factors SMEs, and other patient safety experts. The PSP launches HEART missions to complete a full investigative analysis, which identifies clinical process failures and latent vulnerabilities, recognizes human factor contributions, and determines CA to mitigate future risk. HEART leverages SME input and coordinates with the appropriate Clinical Communities to assess enterprise-level challenges to find effective system-level solutions. HEART engages MTFs via direct investigation activity and provides coaching support to MTFs who are completing independent comprehensive systematic analyses internally. HEART Mission statistics and results are in Figures 1 and 2.

FIGURE 1: HEART MISSION OVERVIEW

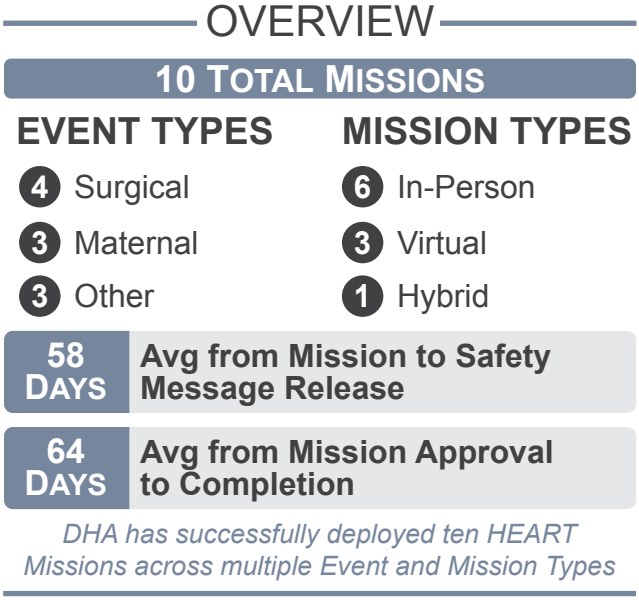
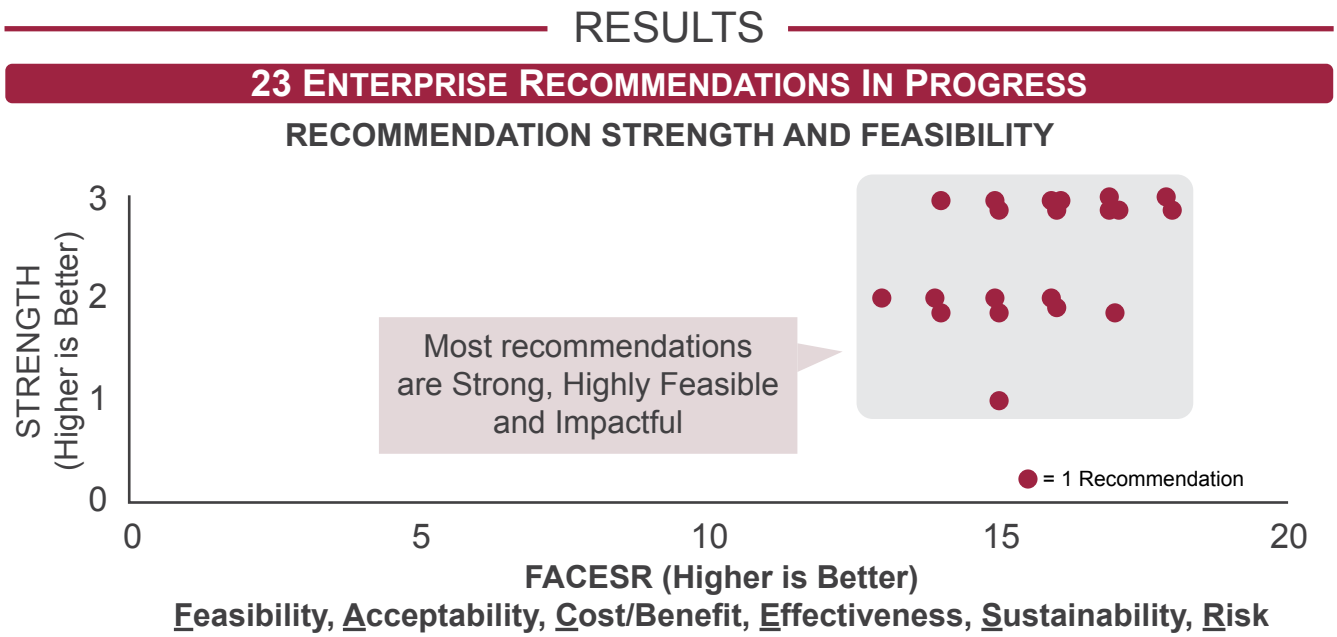


FIGURE 2: HEART MISSION RESULTS



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

Educate

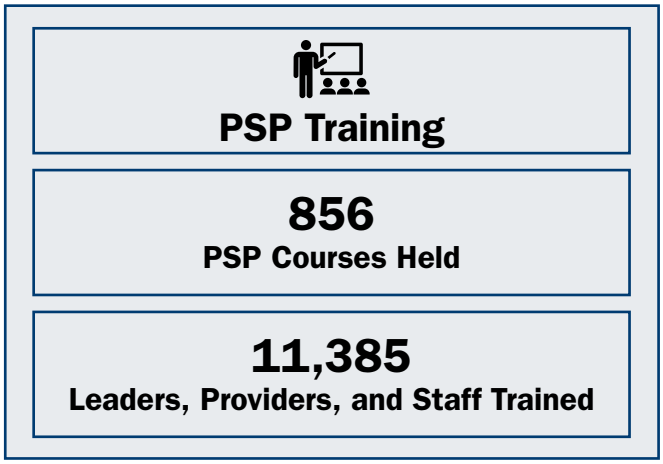
The DHA's RRC approach strives for zero preventable harm and remains committed to continuous learning and improvement, despite operating in complex or high-risk environments. RRC is the DHA approach to increasing high reliability across the MHS. It builds on the existing work and best practices of the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

The PSP uses a competency-based model to identify gaps in learning and develops an education and training strategy plan to address those gaps. The PSP uses a blended learning approach for successful implementation and long-term sustainment of learning. This includes structured training, social interaction, and experiential learning. The PSP has developed and sustained resources in all three categories to include live webinars, on-demand videos, coaching, office hours, apps, simulation, tool kits and guidebooks, networking opportunities, access to real-time data, SharePoint sites, and Communities of Practice. The PSP supports the Markets, SSO, DHARs and MTF teams by providing the infrastructure to obtain continuing education for multiple training courses, offering one-on-one team coaching and evaluating the system's effectiveness. From January through November 2022, the PSP held 856 courses and trained 11,385 leaders, providers, and staff. Our MHS staff completed training in a variety of areas, including:

- Patient Safety Professional Course (PSPC)
- TeamSTEPPS® Train the Trainer 2.0
- TeamSTEPPS® Train the Staff 2.0
- TeamSTEPPS® Scenario-Based Train the Staff 2.0
- TeamSTEPPS® Train the Staff Simulation Based 2.0
- Comprehensive Systematic Analysis
- Bias
- Human Factors Analysis and Classification System Case Review

PSPC: A key learning resource in the patient safety inventory is the PSPC. Patient safety professionals obtain their initial training through the PSPC, which is completed within the first year of assuming their role in an MTF. Four times a year, this week-long course provides them with evidence-based knowledge, skills, and tools to implement patient safety initiatives at their facilities. The PSPC offers an award-winning, state-of-the-art learning system with a pre-work module, approximately 40 hours of virtual training, including two days of CSA training, post-training virtual coaching, and other opportunities for continued development. The PSP regularly updates the PSPC curriculum to integrate HRO principles and foundational knowledge within the course content, to reflect the MHS transition and policy changes, and to keep attendees trained on the latest innovative health care information and resources. The PSPC determines success in educating patient safety professionals to the knowledge, skill, insight, and confidence essential to perform by the triangulation of select data. Data are derived from (1) participant evaluation data including a self-evaluation of pre-post course knowledge and confidence in ability to perform; (2) interview data gathered during three-, six-, and 12-month post-Course Coaching Sessions; and (3) anecdotal self-reports regarding the impact of the course and coaching on the success of individual practices.

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



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

PSPC *(cont.)*

Of the 115 respondents in FY 2022, 92 percent indicated that they agree or strongly agree with the statement "I am confident I can use the knowledge I learned during training to perform more effectively as a PS professional on the job."

PSPC faculty review and analyze all data for the opportunity to innovate and improve upon the experience, transfer of knowledge, and application of practice into performance excellence for the patient safety professional.

TeamSTEPPS: Teamwork failures are substantial contributors to 68 percent of patient-harm events according to TJC, making them a major source of preventable medical errors. TeamSTEPPS is an evidence-based, teamwork development system that the MHS has adopted worldwide. The program provides leadership engagement, training, implementation, and sustainment on the local level at each MTF. Though structured training has its place, the focus is turning more toward implementation and sustainment of the concepts and tools. In CY 2022, the PSP continued to sustain a mobile and web-based TeamSTEPPS application, available on all platforms at https://mobile.health.mil/teamstepps/.

DHA-PM 6025.13 Volume 2 identifies TeamSTEPPS as foundational to patient safety and the MHS standard for maximally integrating teamwork principles into practice. For a blended learning approach, the PSP supports the MTFs with several adjuncts to learning, to include coaching, questionnaires, badge cards, posters, pocket guides, and tips and scenarios.

Equip

The PSP provides several resources, including guidebooks, implementation guides, and job aids to equip MTFs with the tools needed to improve patient safety. Several examples are included here.

The DHA has made great strides in developing a formal IPC structure, and efforts continue to be leveraged to drive progress through the DHA IPC Standardization and Advisory Group. Key deliverables and initiatives have focused on the development and MHS-wide implementation of evidence-based guidance for critical IPC processes. This included the completion of the High-Level Disinfection Implementation Guide leveraging standardized tracers, as well as the CLABSI and CAUTI Implementation Guides.

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

The DHA Antimicrobial Stewardship Program (ASP) was formally aligned under the PSP in 2021. In 2022, the ASP developed an ASP Fundamentals Guide and an ASP Annual Summary template for use by MTF antimicrobial stewardship teams. The ASP continues to enhance the ASP mobile app to assist frontline providers with antimicrobial decision-making by maintaining up to date clinical practice guidelines for common infectious syndromes. The ASP also established routine MTF Brief Sessions to disseminate headquarters-level information to Market and MTF antimicrobial stewardship teams.

Success Story: Perioperative Antibiotics: A Quality Improvement and Patient Safety Project at Brooke Army Medical Center (AMC)

Even with appropriate antimicrobial prophylaxis, 2 to 5 percent of surgeries are complicated by infection. Perioperative antibiotics require ideal timing, regular re-dosing to maintain adequate tissue levels of the medication, and continuation of antibiotics following surgery. Brooke AMC undertook a multidisciplinary approach to improve adherence with antibiotic standards. Interventions included Surgical Grand Rounds, dissemination of department-specific results, development of clinical practice guidelines to guide antibiotic dosing, benchmarked feedback to departments, and tailored presentations on this project and available literature. One year after intervention, Brooke AMC was able to demonstrate significant improvements in compliance, including a 28.9 percent increase in intraoperative re-dosing and 12.5 percent increase in post-operative administration. Next steps for this project include maintaining clinical practice guidelines and targeted interventions to address prophylactic antibiotic choice.

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

MHS GENESIS and Patient Safety: The MHS is in the last critical phase in deploying the new MHS GENESIS EHR across 450 MTFs. We are now 75 percent completed on the journey to delivering an end-to-end EHR with MHS in concert with VHA facilities globally. The PS Program has employed a strong clinical review process in concert with a robust incident response and change request process to ensure the safest rollout possible. No EHR rollout is risk free, so due diligence is required to mitigate risk as the new system is employed. The PSP is sharing lessons learned with VHA partners that are just beginning their journey with the same vendor to leverage opportunities for improved safety with this major change. The PSP engaged with the EHR team early in the deployment in FY 2022, resulting in the development and release of a new job aid. Resources include a sustainment training supplement with DoD Healthcare Management System Modernization Operations and Support webinars prior to each go-live site, practice exercises, and communication materials that target patient safety professionals transitioning to the new system. In FY 2022, the PSP were invited to conduct deployment training with over 60 sites to educate around the appropriate and timely reporting and resolution of any patient safety issues that may arise due to EHR deployment. During FY 2023, the IT workstream has updated the Operating Room (OR) Debrief tool (ORDIT) and installed an online Carepoint site to 54 MTFs across the MHS to capture lessons learned during OR procedures, collate important issues, and resolve any discrepancies and share leading practices.

Additionally, the ASP is collaborating with DHA Health Informatics and the EHR team to enhance the clinical decision support and reporting capabilities to improve antimicrobial use.

Success Story: MHS GENESIS Site Visits, Pre-Go-Live and Sustainment Training for MTF Staff

Over the past 12 months, patient safety managers and site integrators at more than 65 MTFs have been trained on patient safety reporting system roles and responsibilities. The MHS has fostered relationships with the MTF Informatics steering committees and Patient Safety professional staff. Staff now know how to engage effectively with the MHS Service Help Desk trouble ticket systems that capture new EHR MHS GENESIS issues to ensure safe rollout of the new federal health care electronic record. The teams have traveled to 25 sites, providing on-hand support and post-go-live forums are held weekly to share lessons learned and to elevate concerns to get resolution for MTFs. PSP has partnered with VHA/DHA teams to drive Bar Code Medication Administration performance to higher levels as an additional safety measure in medication administration safety as a key component of the new EHR capability.

Transparency

Transparency is key to patient safety improvement. The PSP is making strides in increasing and improving the transparency of patient safety care and data for Service members and their families. The DHA has focused on data transparency while standing up the Markets and centralizing the MTFs under a unified structure. Data transparency promises open communication among the organization, its employees, and its customers on common quality metrics that affect patient outcomes. Pages 67 and 119 further describe the MHS transparency efforts.

Safety Event and Root Cause Analysis (SERCA): The MHS has implemented the DHA SERCA tool to share lessons learned and data from four data sources (JPSR, DoD REs, CDC NHSN, and GTT), between Markets, SSO, DHARs, and MTFs. This tool allows designated users to view data for their own facilities and others across the MHS and access all CAs implemented for safety events across the DoD. Enhanced transparency affords MTFs real-time visibility into what other facilities in the DoD are doing to prevent events and improve safety. The SERCA tool has more than 500 active users and over 19,100 views since initial deployment in FY 2017.

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

MHS Patient Safety Culture Survey

Since 2005, the PSP has administered the MHS Patient Safety Culture Survey approximately every three years across the MHS direct care system, and most recently in 2022. Adapted from the nationally recognized Surveys on Patient Safety Culture developed by AHRQ, the MHS Patient Safety Culture Survey is an anonymous, web-based, self-reported questionnaire designed to assess staff perceptions of patient safety within their MTF and work units. The survey evaluates culture across several key dimensions, including leadership support, teamwork, staff empowerment, trust, reporting and learning from errors. The PSP administers the survey across all DoD hospitals, outpatient clinics, and dental facilities to all staff members, including Active Duty and Reserve personnel, contractors, government employees, and volunteers. The PSP uses the data to define the current state of safety culture across the MHS, track trends and advancements over time, and identify opportunities for improvement.

The PSP most recently administered the MHS Patient Safety Culture Survey from January 2022 to March 2022. For the 2022 survey, all inpatient MTFs completed Hospital Survey (HSOPS 2.0) and all ambulatory clinics completed Medical Office Survey. HSOPS 2.0 is AHRQ's updated version of HSOPS, integrating current science of PS culture. It is a different survey from HSOPS 1.0, and results cannot be compared. DoD transitioned to HSOPS 2.0 to stay current with the science of culture measurement and maintain ability to benchmark results to national database as AHRQ discontinued HSOPS 1.0 database.

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

Between October 2019 and January 2020, the main pharmacy of Walter Reed National Military Medical Center's three outpatient pharmacies had 16 medication errors, 13 of which were incorrect medication and incorrect patient errors that reached patients. Medication errors undermine the hospital's mission to provide quality care and ensure patient safety. A Lean Six Sigma team identified two root causes: lack of standardization and lack of a dedicated floor supervisor. Countermeasures were implemented in August 2020 and outcomes monitored through May 2021. Medication errors that reached patients (per 100,000 prescriptions) reported a 77 percent decrease. Near misses, which do not reach the patient and are quantified as a percentage of total medication errors, increased 468 percent. On the path to Six Sigma, the team improved from 5.2 Sigma to 5.6 Sigma. This project demonstrated the value of checklists, adherence to policies, and importance of annual/refresher training. This project was shared with other pharmacies who sustained this success with 97 percent adherence in random daily observations.

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

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

Ready Reliable Care (RRC) HRO Awards

The RRC HRO Awards is an annual event that began in Patient Safety to recognize improvements and innovation efforts in military health care. Over the years, these submission categories have evolved from a patient safety focus to encompass the broader DHA priorities associated with the Quadruple Aim, and they have been expanded to incorporate clinical as well as nonclinical projects. All submissions were evaluated using an internal board review composed of DHA SMEs in a variety of disciplines and specialties.

There were 79 highly competitive submissions this year, and 20 winners were selected from around the globe. Out of nine submissions, one winner was selected for the Leadership Commitment Award. Out of 18 submissions, two winners were selected for Culture of Safety. Out of 33 submissions, nine winners were selected for Continuous Process Improvement. Out of 19 submissions, eight winners were selected for Patient Centeredness. Submissions are aligned with Clinical Communities where it makes sense, while other submissions may be associated with a clinical support service. The following table summarizes the winning organizations and their respective submissions.

2022 RRC HRO AWARD WINNERS

MILITARY MEDICAL TREATMENT FACILITY (MTF)/ TRICARE REGIONAL OFFICE	AWARD-WINNING INITIATIVE
Leadership Commitment	
Joint Base Elmendorf-Richardson	CPI Manager – Build a Competitive Edge
Culture of Safety	
Naval Medical Center Portsmouth	Enhanced Recovery after Surgery Protocol Implementation for Breast Surgery Patients to Reduce Post-Operative Opiate Use
377th Medical Group, Kirtland Air Force Base	First Five Minutes Drill Program
Continuous Process Improvement	
Brooke Army Medical Center	A Quality Improvement Project Rapid Response EEG Headset Reduces Time to Determination of Non-Convulsive Status Epilepticus at a Level 1 Trauma Center in the DoD
U.S. Naval Hospital Okinawa Japan	Depression Screening Initiative in Military NICU Parents
Brooke Army Medical Center	Determining Progesterone Threshold for Fresh IVF Cycles in a Military Facility
39th Medical Group, Incirlik	Education and Training SharePoint Project
Brooke Army Medical Center	High Fidelity Simulation of Acute Neurology Enhances Rising Resident Confidence: Results from a Multicohort Study
Brooke Army Medical Center	Implementation of a Rapid HIV Screening Program in the Emergency Department
Navy Medicine Readiness & Training Command Camp Pendleton	Improving Point-of-Use Decontamination
U.S. Naval Hospital Okinawa Japan	Standardized Enteral Feeding Protocol: Impact on Growth, Central Line, and TPN Days in Very Low Birthweight Infants
Navy Medicine Readiness & Training Command Iwakuni Japan	Streamlining Training Records
Patient Centeredness	
Naval Health Clinic Oak Harbor	Increasing Virtual Women's Health Appointments
Naval Medical Center Portsmouth	Penicillin Allergy Testing and Clearance: Patient-Centered Readiness Initiative through Non-Allergist Engagement
Brooke Army Medical Center	Rapid Initiation of Antiretroviral Therapy by Virtual Health in Service Members Newly Diagnosed with HIV Infection
Naval Health Clinic Hawaii	Improving Physical Therapy Purchased Care Recapture of Low Back Pain Encounters
Joint Base Elmendorf-Richardson	Optimization of Patient Centeredness, Education, and Access to Neurologic Care in Alaska: An Underserved Market
Joint Base Elmendorf-Richardson	Point of Service Vaccine Administration During Routine Obstetric and Gynecologic Clinic Care
45th Medical Group, Patrick Air Force Base	Leveraging a Virtual Check-In Queue to Decrease Patient Wait Times and Increase Patient Satisfaction in the Pharmacy
Walter Reed National Military Medical Center	Tele-Pain and Patient-Centeredness

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

Healthcare Risk Management (HRM): Addressing Enterprise Risk

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

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

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

Reporting to the NPDB and Regulatory Agencies. HRM confirmed that for FY 2022, 201 practitioners were reported to the NPDB and regulatory agencies for risk management–related events or actions occurring within the MHS (source: Services' quarterly report to DoD RMWG). In FY 2021, 134 reports were made, and 116 practitioners were reported in FY 2020.

Credentialing and Privileging: Program to Ensure Appropriate Credentials and Privileges

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

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

For example, the DHA has recently established a centralized credentials verification service whose purpose is to standardize and optimize prime source verification of provider credentials upon request by the MTF to help ensure that clinical staff are qualified and competent to deliver safe, high-quality care to patients across the MHS. In addition, we have instituted a centralized surveillance and monitoring program to identify areas for improvement with compliance with standardized credentialing processes including reporting and documentation of credentials verification and ongoing and focused professional provider performance evaluations. In addition, we have further developed and standardized the DHA's Impaired Healthcare Provider Program, which is designed to provide support for rehabilitation of health care personnel who suffer from a condition that negatively influences or has the potential to negatively influence optimal clinical performance.

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

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

MTF Accreditation

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

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

Program to Monitor and Support MTF Accreditation

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

The AC Program has focused its efforts on the establishment of the Accreditation Assist Visit (Mock Survey) Program. The Accreditation Assist Visit Program provides a comprehensive systematic review of routine operations and ongoing quality improvement efforts 12–18 months prior to an MTF's projected accreditation survey date. The MTF Assist Visit is performed by a contracted vendor and simulates a full accreditation survey event. The vendor-performed Accreditation Assist Visit allows MTFs to demonstrate their ability to meet DoD policy mandates, regulatory requirements, and nationally recognized health care standards. Action plans and milestones are developed by MTF personnel for identified noncompliance.

Achieving and maintaining accreditation by a recognized external AO provides benchmarks for measuring standards compliance and builds stakeholder confidence in the quality of health care delivered. The mandate to accredit MTFs by an external AO demonstrates DoD's commitment to the provision of safe, quality care to all beneficiaries and supports the DHA HRO journey. Private sector TRICARE network health care facilities are mandated to meet contractual requirements for accreditation by an approved AO. Accreditation by external organizations provides the MHS with valuable information to validate compliance with standards and to identify opportunities for improvement.

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

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

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

CHAPTERS IN TJC ACCREDITATION MANUALS

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

TJC's accreditation process includes a triennial on-site survey. During the survey process, compliance with the applicable accreditation program standards based on the services provided at the facility is assessed. A total of 131 MTFs are accredited by TJC. Eighty-four of the MTFs require accreditation under the ambulatory program. Forty-seven MTFs are accredited through the hospital program. Forty-nine of the ambulatory or hospital surveys include BH units that require accreditation utilizing additional BH program standards. Only one inpatient MTF requires home care accreditation due to the geographical location. As shown in the following table, 19 inpatient MTFs, 36 ambulatory care MTFs, and 23 BH units underwent health care accreditation surveys in CY 2022. All the facilities successfully achieved the outcome of fully accredited status.

MHS HEALTH CARE ACCREDITATION SURVEYS COMPLETED, BY TYPE AND YEAR

YEAR	HOSPITAL	AMBULATORY	BEHAVIORAL HEALTH	HOME CARE
2015	24	14	5	1
2016	17	35	10	0
2017	12	24	4	0
2018	20	21	17	1
2019	19	35	22	0
2020	1	9	0	0
2021	15	27	15	0
2022	19	36	23	0

Source: DHA/Medical Affairs/CSD, 12/31/2022

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

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

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

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

TOP 5 TJC AMBULATORY STANDARDS CITED BY CHAPTER IN MTF SURVEYS, CYs 2015–2022

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

TOP 5 TJC HOSPITAL STANDARDS CITED BY CHAPTER IN MTF SURVEYS, CYs 2015–2022

CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022
Environment of Care	Life Safety	Environment of Care	Environment of Care	Environment of Care	Environment of Care	National Patient Safety Goals	Infection Prevention and Control
Life Safety	Environment of Care	Life Safety	Life Safety	Life Safety	Infection Prevention and Control	Infection Prevention and Control	National Patient Safety Goals
Infection Prevention and Control	Provision of Care, Treatment, and Services	Provision of Care, Treatment, and Services	Provision of Care, Treatment, and Services	Provision of Care, Treatment, and Services	Medication Management	Environment of Care	Environment of Care
Provision of Care, Treatment, and Services	Infection Prevention and Control	Infection Prevention and Control	Infection Prevention and Control	Infection Prevention and Control	National Patient Safety Goals	Life Safety	Life Safety
Medication Management	Medication Management	Medication Management	Medication Management	Medication Management	Provision of Care, Treatment, and Services	Medication Management	Provision of Care

Source: DHA/Medical Affairs/CSD, 12/4/2022

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

In addition to the survey process for accreditation, TJC requires accredited hospitals to submit national clinical quality measures data to TJC on a quarterly basis. Each inpatient MTF selects the measures for data submission. Trained abstractors collect data centrally and report to the MTFs for analysis and improvement as indicated. As an example, the perinatal care (PC) measures are included in the WICC quality measures section of this report (see pages 129–133).

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

Clinical Laboratory Services Accreditation

Regulatory Compliance

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

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

The Joint-Service Center for Laboratory Medicine Services (CLMS), which was established in 1992, provides regulatory oversight for all DoD clinical laboratories and provides reports to CMS' CLIA Office, the Deputy Assistant Director, Health Care Operations, DHA, and the Services' Surgeons General, on a periodic basis and when requested. The office also manages a DoD contract with the Clinical and Laboratory Standards Institute, providing access to consensus-based standards regarding the management and operation of clinical laboratories.

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

Non-MTF clinical laboratories are inspected by CAP or one of the other deemed accreditation organizations, or their regulatory compliance is assessed via an alternative inspection method as determined by CLMS. In FY 2022, CLMS performed inspections at six nonclinical sites, and coordinated assessments at three others.

Accreditation Performance

The DoDM currently specifies key conditions that place more stringent requirements on DoD's clinical laboratories, such as requiring the performance of proficiency testing for all laboratory tests, to include those in the waived complexity category. The DoDM also requires accreditation inspections of DoD's clinical laboratories that operate under the authority of waived or provider-performed microscopy (PPM) certificates.

At present, CMS does not require inspection of their waived- or PPM-certificate laboratories, nor does it require proficiency testing for tests conducted within those laboratories. The application of these more stringent requirements within the DoD means that more of the MHS's clinical laboratories are assessed and accredited against laboratory standards when compared with the U.S. civilian-sector clinical laboratories.

COVID-19 and Accreditation Inspections

Many accreditation inspections were delayed due to COVID travel restrictions in 2020 and 2021. As a result, CAP chose to provide alternate accreditation solutions, including hybrid inspections, which are a combination of in-person and virtual inspections, and accreditation extensions for low-risk laboratories. With the collaborative efforts of CLMS and CAP, the backlog of inspections from 2020 and 2021 has now been resolved.

MHS CLINICAL LABORATORY CAP ACCREDITATIONS, BY SERVICE, FY 2022

SERVICE	COMPLIANCE RATE	% ABOVE CAP AVERAGE	COMPLETED CAP INSPECTIONS	COMPLETED SITE SELF-INSPECTIONS[a]	TOTAL
Army	99.42	0.18%	51	47	98
Air Force	99.55	0.31%	68	36	104
Navy	99.48	0.24%	120	48	168
Total			239	131	370

Source: CAP, 11/15/2022

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

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

Blood Bank Services Accreditation

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

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

There are approximately 72 BDCs and Transfusion Service activities. As in FY 2021, 100 percent of the ASBP centers maintained FDA licensure and registration, as well as AABB and CAP accreditation.

Inspections and assessments began to increase in 2021 as COVID-19 restrictions were reduced. The Service Blood Program QA Managers also performed inspections during 2021. In 2022, inspection and assessment began to return to normal.

INSPECTION	2020 INSPECTIONS	2021 INSPECTIONS	2022 INSPECTIONS
FDA	1	1	17
AABB/CAP	16	55	45
Blood Programs	n/a	10	15

In 2021, the ASBP BDCs were ordered to maintain a sustainment level of 1,000 units of COVID-19 Convalescent Plasma (CCP) as a therapeutic treatment for COVID-19 infections. The ASBP BDCs were successful in maintaining at least 1,800 units of CCP and supported our civilian partners with CCP when requests were received. In January 2022, the FDA changed the requirements for manufacturing CCP and clarified the use of CCP as a COVID-19 therapeutic treatment. Currently, ASBP BDCs no longer maintain an inventory of CCP and no longer maintain the ability to manufacture CCP.

The first ever Quality Management Plan for the ASBP has been developed. The draft is being prepared for submission to the DHA publication office for review and coordination.

The ASBP QA Management Team is actively supporting the MHS transition to the electronic system of record for patient health care. Twenty-nine ASBP Transfusion Service activities have transitioned from the ASBP Enterprise Blood Management System of record to the MHS Genesis PathNet, Blood Bank Transfusion system of record for patient transfusion testing and transfusion history. Brooke Army Medical Center is DoD's largest transfusing facility that transitioned to MHS Genesis PathNet-BBT in January 2022 with no period of adverse impact to blood services availability.

The ASBP provides technical bulletin updates to all MHS GENESIS Transfusion Services to ensure all sites are formally notified of any MHS Genesis PathNet-BBT system configuration changes. These updates are necessary to ensure patient testing documentation and blood product management reflect current practices and meet the desired outcome.

The ASBP Quality Management Team is providing support with the validation of moving the transfusion patient history legacy data from Enterprise Blood Management System to the Health Information Achieve System to ensure historical information is accurate when a patient or product lookback is needed. Once all data have been moved and verified, transfusion service personnel will only have to use one system to find historical patient information.

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

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

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

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

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

National (External) Clinical Quality Programs and Databases

On October 1, 2014, the Access, Quality of Care, and Patient Safety Memorandum was signed by the SECDEF. This memorandum directed the DHA to establish an MHS performance management system. The objective was to drive improvement throughout the enterprise for identified common executable goals and develop dashboard measures that address all areas covered by the MHS review. Participation in strategically selected national databases, such as the National Surgical Quality Improvement Program (NSQIP), was identified as a means to significantly contribute to meeting this requirement.

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

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

- American College of Surgeons (ACS) NSQIP Adult Program
- ACS NSQIP Pediatric Program
- ACS Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP)
- ACS Trauma Verification, Review, and Consultation (VRC) Program; and Trauma Quality Improvement Program (TQIP)
- American Society of Clinical Oncology (ASCO) Quality Oncology Practice Initiative
- National Perinatal Information Center (NPIC) Database
- NHSN
- CMS Care Compare (formerly Hospital Compare)
- The Joint Commission (TJC) National Hospital Measure
- Leapfrog Hospital Survey
- Leapfrog Ambulatory Surgery Center Survey

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

MHS Data Transparency

Since the 2014 MHS review, NDAA FY 2016 requirement to report MTF-level clinical quality data, NDAA FY 2017, section 728 requirement to use CQMC Core Measure sets, and MHS transparency efforts have continued to evolve.

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

These facilities' data are now publicly reported on the Leapfrog website (www.leapfroggroup.org), allowing comparison of industry-standard clinical quality and patient safety measures across both direct and private sector care. This partnership provides visibility to empower our Service members and their families to make the best decisions for their health care. All 33 CONUS inpatient facilities and one outside the contiguous United States (OCONUS) (Yokosuka) inpatient facility submitted the Leapfrog Hospital Survey in 2022. In addition, all eight ambulatory surgery centers submitted Leapfrog's ambulatory surgery center survey in 2022. It is anticipated that all OCONUS MTFs will participate in Leapfrog in 2023.

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

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

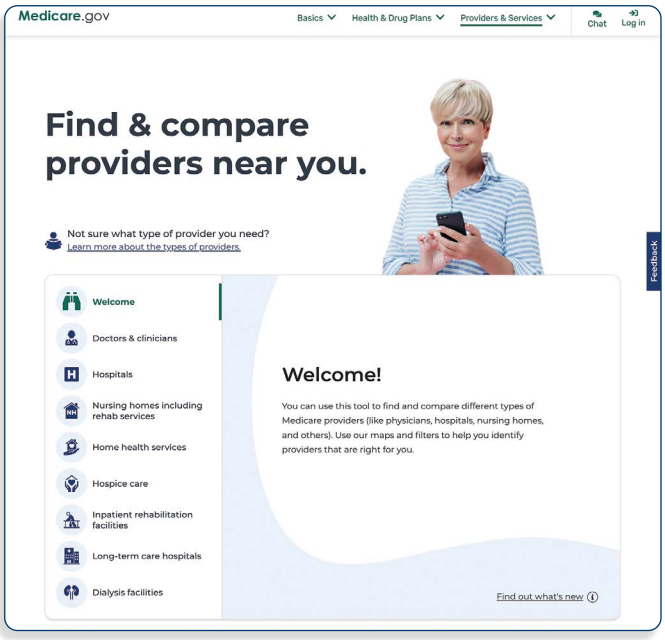
Health.mil: In response to the 2014 MHS Review, the health.mil website was designed as the first step for the MHS in providing data to patients to assess how the facilities at which they receive care are performing in terms of quality, safety, and access. There are more than 40 metrics reported on health.mil.

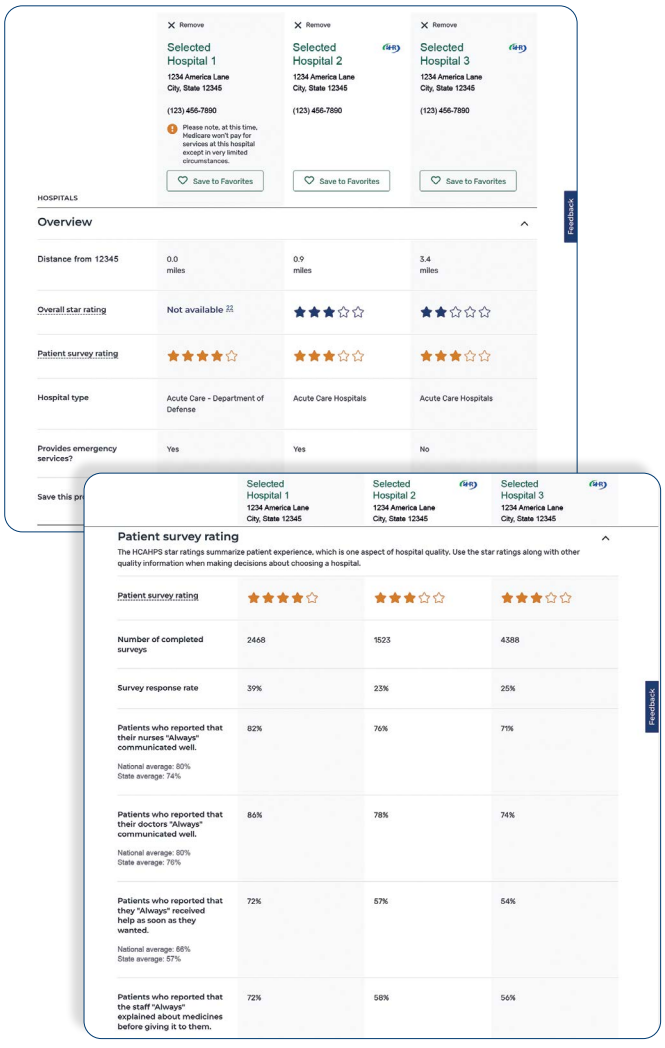
MHS Transparency on CMS Care Compare (formerly Hospital Compare)

The MHS provides patient experience, timely and effective care, and HAI measurement data to CMS for public reporting on Care Compare, formerly Hospital Compare. Care Compare is a consumer-oriented website providing information on how hospitals perform on quality measures, with more than 4,000 U.S. hospitals participating. The information on Care Compare helps patients make decisions about where to get health care and encourages hospitals to improve the quality of care they provide.

The TRISS, Timely and Effective Care, and HAI results are publicly posted on Care Compare for all military hospitals in the United States. TRISS is based on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and is administered following inpatient discharge to assess the patient's perceptions of staff communication/responsiveness, facility cleanliness/quietness, provision of discharge information, and whether they would recommend the hospital. Timely and Effective Care measures are process of care measures that show the percentage of hospitals that gave treatments for certain conditions/procedures, how quickly hospitals treat patients with certain emergencies, and how well hospitals perform in offering and providing preventive services. HAIs are infections people get while they are receiving care for another condition. As part of the evolution of MHS transparency efforts, the CM Program continues to develop plans to expand reporting of measures on Care Compare. MTFs can be searched by ZIP code or hospital name and compared with civilian facilities in the same location. Visit https://www.medicare.gov/care-compare/ for more information.

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





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

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

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

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

Improvement Initiative Planning

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

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

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

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

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

Evidence-Based Practice

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

As of October 2022, there are 24 VA/DoD CPGs completed or in the update/development process. The four FY 2022–2023 CPGs being updated are Management of Type 2 Diabetes Mellitus in Primary Care, Management of Post-Traumatic Stress Disorder and Acute Stress Disorder, Management of Pregnancy, and Primary Care Management of Headache. There are also two MH CPGs under development in FY 2022–2023: Schizophrenia and Bipolar Disorder. Projected CPG updates for FY 2023 include the Assessment and Management of Patients at Risk for Suicide, Management of Stroke Rehabilitation, and the development of a CPG on tinnitus.

Clinical Quality Improvement Studies

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

In FYs 2022 and 2023, three clinical quality improvement studies were ongoing. These were quality improvement studies on Maternal Hypertension, Quality of Care in the Virtual Environment, and Access to Nutrition Services.

HIGH RELIABILITY OPERATING MODEL/CLINICAL COMMUNITIES

Primary Care Clinical Community

Primary Care Services

MHS primary care services are driven by evidence-based clinical practices. The MHS PCMH practice model provides the essential structure to establish standardized processes and procedures, integrate and coordinate care, and develop the cohesive team of health care professionals required to provide consistent, safe, quality care. The MHS has developed a variety of tools to support the PCMH teams in meeting the care needs of beneficiaries.

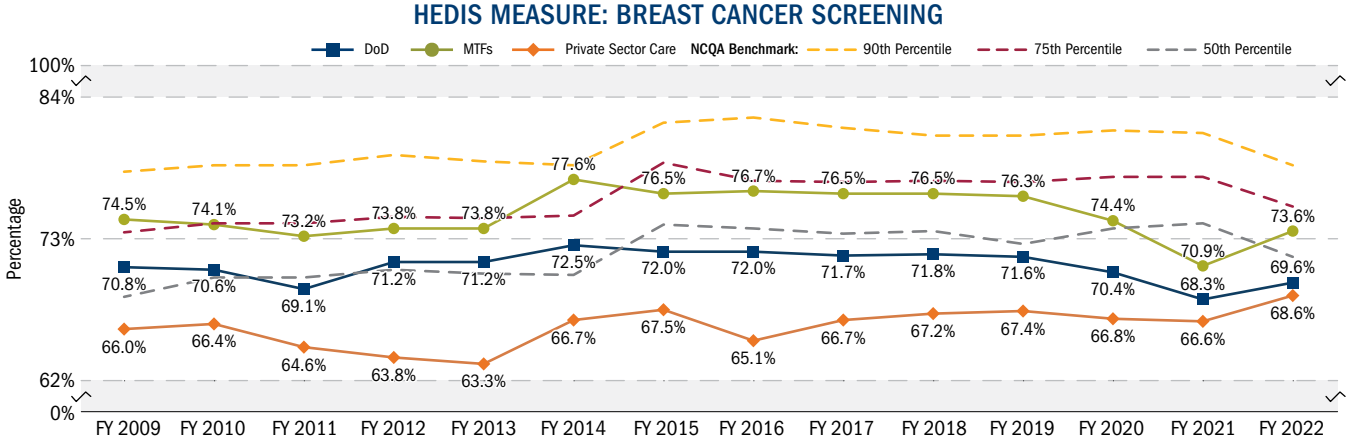
VA and DoD CPG collaboration has established a rigorous systematic review of medical evidence to help primary care providers and health care teams deliver consistent high-quality health care to beneficiaries. CPGs are developed by multidisciplinary clinical experts and are based on unbiased clinical research studies and literature reviews. Multiple CPGs have been developed and updated to provide practitioners with information and tool kits to support evidence-based practice. VA/DoD CPGs are available at www.healthquality.va.gov/. To enhance its availability and use, CPG information is embedded into the EHR as clinical decision support. The goal was to incorporate the CPGs into the clinician's workflow to ensure ease of use. Information on assessment, diagnosis, and recommendations for treatment were literally placed at the providers' fingertips.

Additionally, the MHS monitors the performance of primary care services with a variety of nationally recognized quality measures. The NCQA Healthcare Effectiveness Data and Information Set (HEDIS) includes primary care–focused health plan measures with standardized methodologies. HEDIS is a tool used by America's health plans to measure performance on important dimensions of care and service. HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. MHS data can be compared with the NCQA annual benchmark results. The MHS Population Health Portal (MHSPHP) CarePoint application provides measure methodology and performance data at the enterprise, Market, clinic, and provider levels. The HEDIS methodologies used by CarePoint are reviewed annually by an NCQA HEDIS auditor for validation and certification.

MHS leadership, from MTF staff through the Markets to DHA and the Surgeons General and OASD(HA) leadership, routinely monitor HEDIS performance at all levels of the MHS. HEDIS performance measures are included in the MHS performance management system. The measures are presented in dynamically linked dashboards at the MTF level and aggregated to Markets, and the MHS as a whole. MHS leadership formally reviews and assesses select measures on a quarterly basis, including HEDIS, with discussion on efforts to improve performance.

Adult HEDIS Measures

- **Breast and Cervical Cancer Screening:** HEDIS measures focused on cancer screening for early detection and treatment to maximize the potential for a cure. Breast cancer screening rates improved in FY 2022 likely due to rebound from the previous year's COVID-19 impact, though DoD and private sector care rates still remain below the 50th percentile. The MTFs saw the largest improvements with a 2.7 percentage point increase from the previous year. Cervical cancer screening rates remain below the 50th percentile across all sectors of care, possibly influenced by the American Cancer Society's new recommendations last year for women under 30 to get HPV tests every five years. For cervical cancer screening, major measure specification changes in FY 2014 resulted in a break in benchmark applicability, which led to the absence of a benchmark for FY 2015, as reflected in the graph. Measure methodology for cervical cancer screening was updated in FY 2018, which accounts for the shift seen in results from FY 2017.

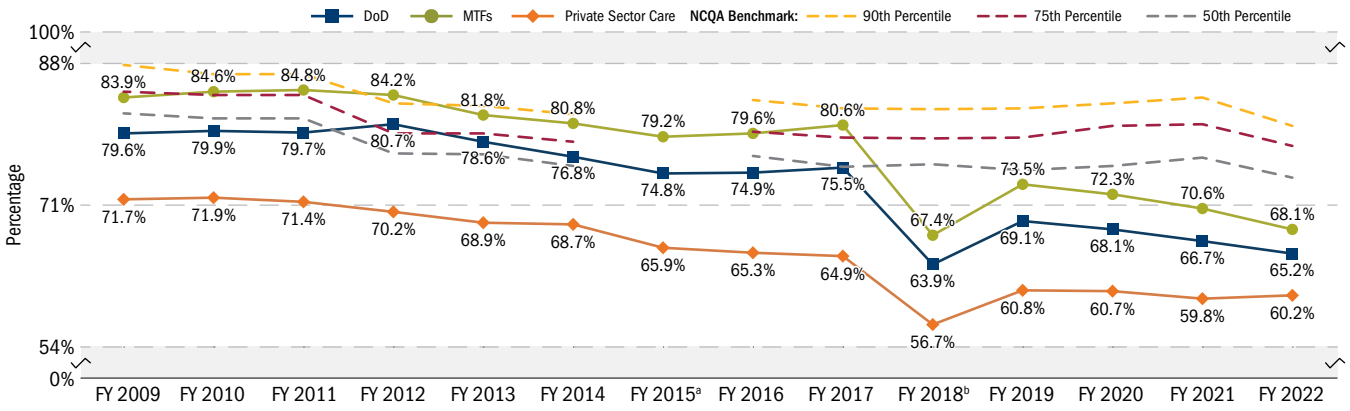


Source: DHA/Medical Affairs/CSD, 12/19/2022
Note: Data for FY 2020 are through May 2020.

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

Primary Care Clinical Community *(cont.)*

HEDIS MEASURE: CERVICAL CANCER SCREENING



Source: DHA/Medical Affairs/CSD, 12/19/2022

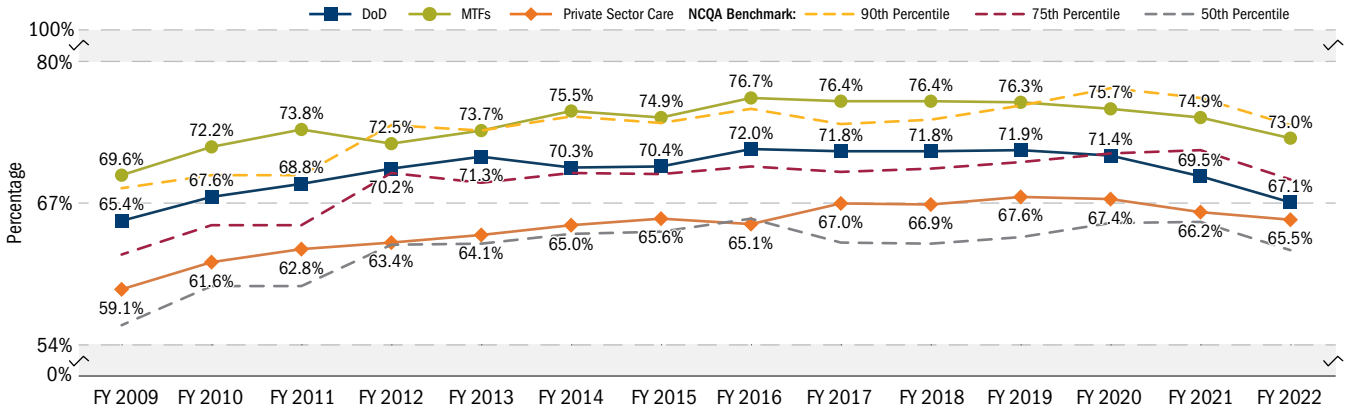
[a] No benchmark for 2015 due to methodology change.

[b] Methodology updated

Note: Data for FY 2020 are through May 2020.

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

HEDIS MEASURE: COLORECTAL CANCER SCREENING

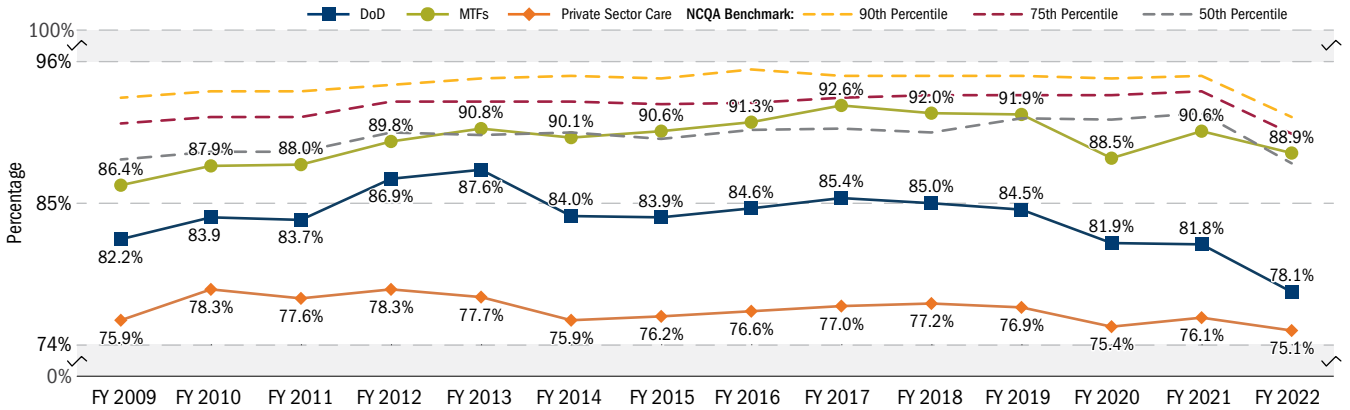


Source: DHA/Medical Affairs/CSD, 12/19/2022

Note: Data for FY 2020 are through May 2020.

- **Diabetes HbA1c Screening:** HEDIS measure focused on annual testing to help health care providers with care for the common and serious chronic disease of diabetes. The MTF and private sector care rates saw slight rate declines in FY 2022. The overall DoD rate declined at a rate similar to the decline seen in the national benchmarks.

HEDIS MEASURE: DIABETES HbA1c SCREENING



Source: DHA/Medical Affairs/CSD, 12/19/2022

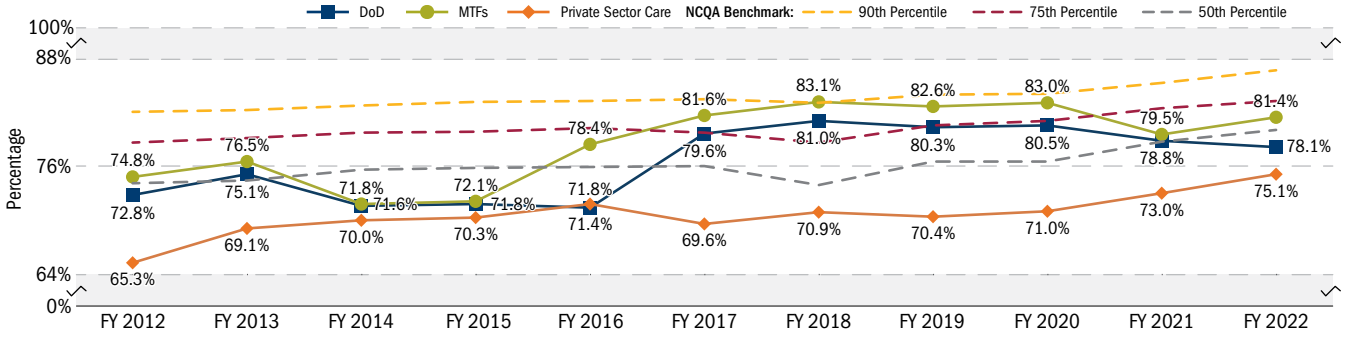
Note: Data for FY 2020 are through May 2020.

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

Primary Care Clinical Community *(cont.)*

- **Low Back Pain (LBP) Imaging:** HEDIS measure focused on decreasing the overuse of imaging for acute LBP. Rates reflect avoidance of imaging within 28 days of an LBP diagnosis. MHS has integrated the VA/DoD LBP CPG into the EHR to support providers with improvement initiatives. Performance reporting capabilities were developed for each level of care, MTF, provider team, and individual provider to support feedback. MTFs and private sector care saw slight improvements with the MTF rates remaining slightly above the 50th percentile. The DoD rate decreased by 0.7 percentage points from FY 2021 due to measure results being more greatly impacted by the larger volume in private sector care and the MTF data only reflecting facilities with the legacy electronic health record.

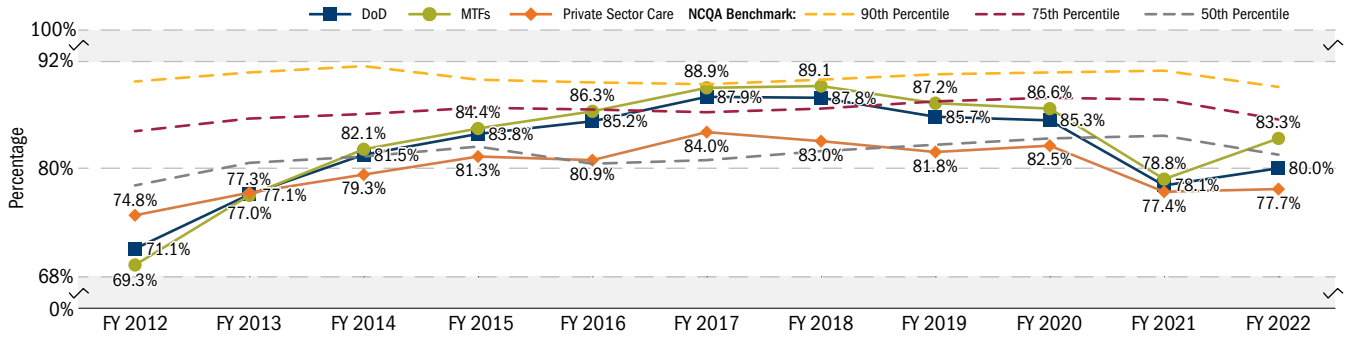
HEDIS MEASURE: LOW BACK PAIN IMAGING



Source: DHA/Medical Affairs/CSD, 12/19/2022
Note: Data for FY 2020 are through May 2020.

- **Well-Child Visits:** HEDIS measure focused on the adequacy of well-child care for infants, as demonstrated by children having six visits within the first 15 months of life. Although national benchmarks declined, all MHS sectors of care showed improvements. The MTF rate increased 4.5 percentage points, which resulted in surpassing the 50th percentile.

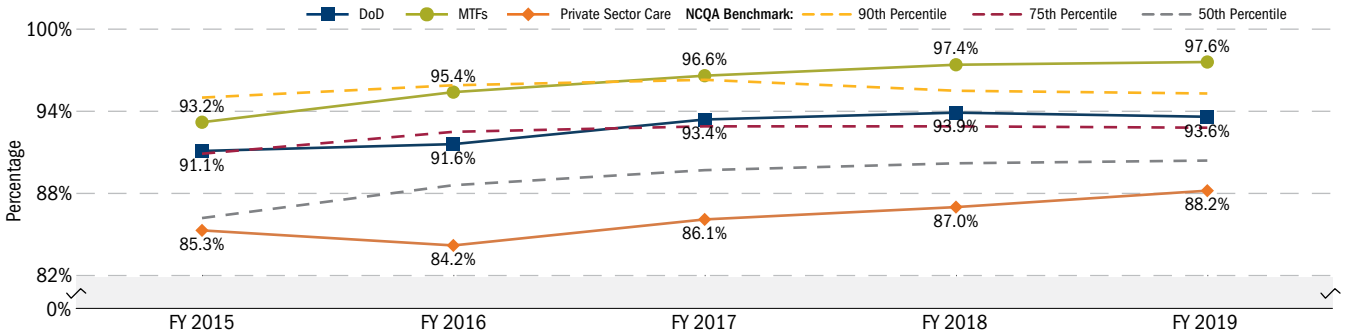
HEDIS MEASURE: WELL-CHILD VISITS



Source: DHA/Medical Affairs/CSD, 12/19/2022
Note: Data for FY 2020 are through May 2020.

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

HEDIS MEASURE: CHILDREN WITH URI

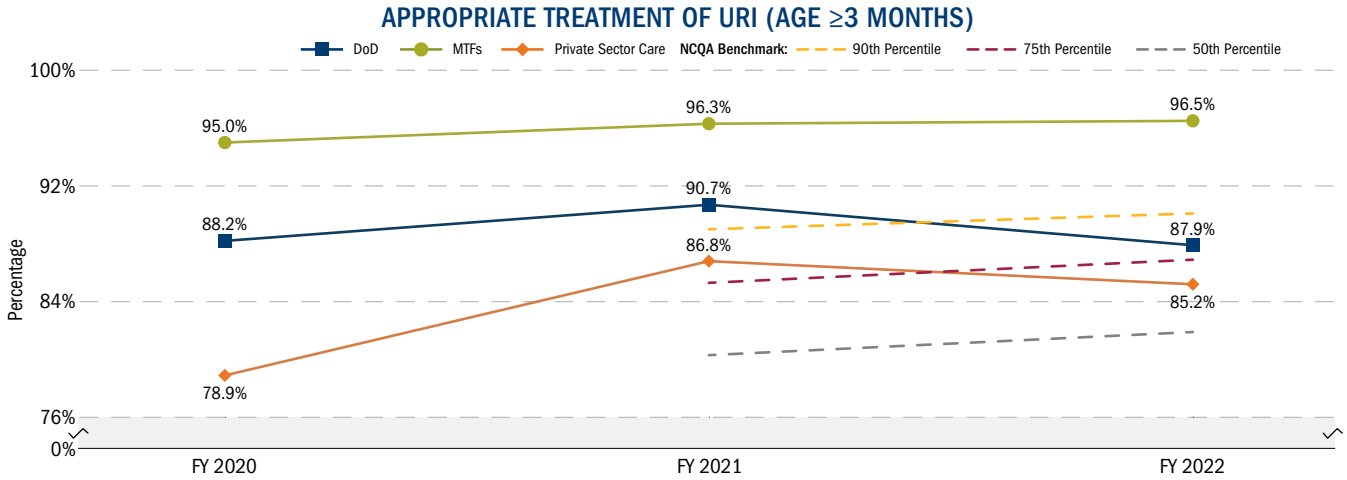


Source: DHA/Medical Affairs/CSD, 12/7/2021

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

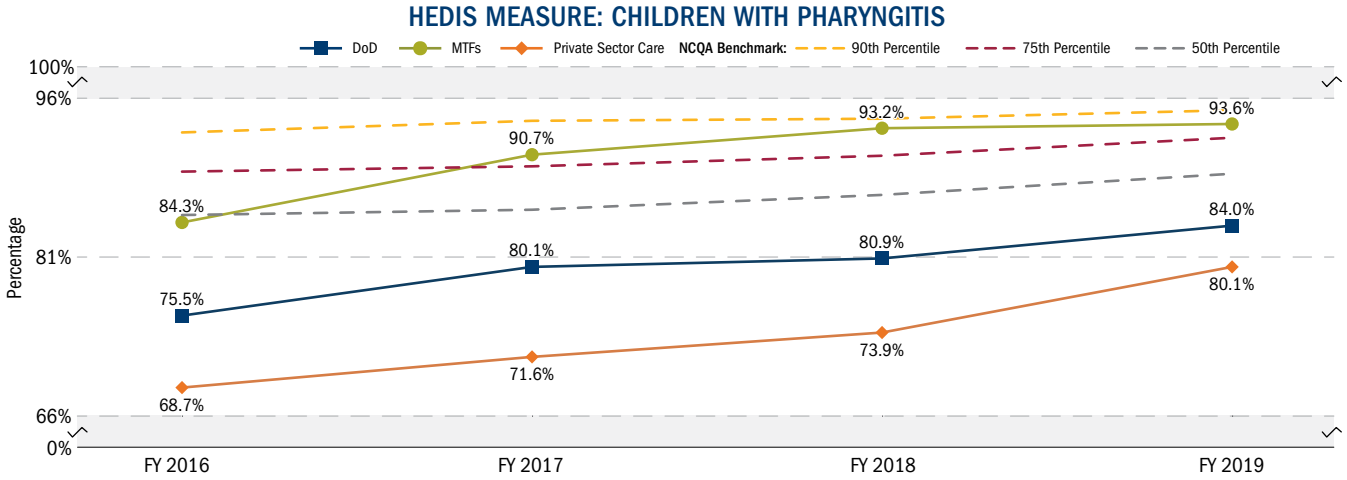
Primary Care Clinical Community *(cont.)*

- **Appropriate Treatment of URI:** HEDIS measure focused on the avoidance of antibiotic prescribing for anyone three months of age or older diagnosed with a URI. This measure increases awareness of the importance of antibiotic stewardship among children and adults to prevent antibiotic resistance. This is a new measure as of 2020. New measure benchmarks became available in 2021. MTFs remain above the 90th percentile, while DoD is between the 75th and 90th percentiles and private sector care is between the 50th and 75th percentiles. This new measure is not comparable to the NCQA Appropriate Treatment of Children with URI measure from previous years due to significant measure specification changes.



Source: DHA/Medical Affairs/CSD, 12/19/2022
Note: Data for FY 2020 are through May 2020.

- **Children with Pharyngitis:** HEDIS measure focused on appropriate use of antibiotics for children diagnosed with pharyngitis based on laboratory data. Pharyngitis diagnosis can be easily and objectively validated through administration of a group A strep test at the point of care. Validation of the diagnosis prevents unnecessary use of antibiotics. A higher rate indicates appropriate laboratory testing confirmation prior to prescribing antibiotics for pharyngitis. Due to significant changes, measure specifications are not comparable to prior years starting in 2020. Data through FY 2019 are provided in the graph below for historical purposes. Please refer to the new measure Appropriate Treatment for Pharyngitis on the following page for data starting in 2020. In the graph below, rates for children with pharyngitis are available for previous years; however, prior to FY 2016, rates were aggregated based on MTF enrollment and not by treatment place of care. The graph below reflects the transition to place of care attribution for data reporting in FY 2016 and in subsequent years following the attribution change.



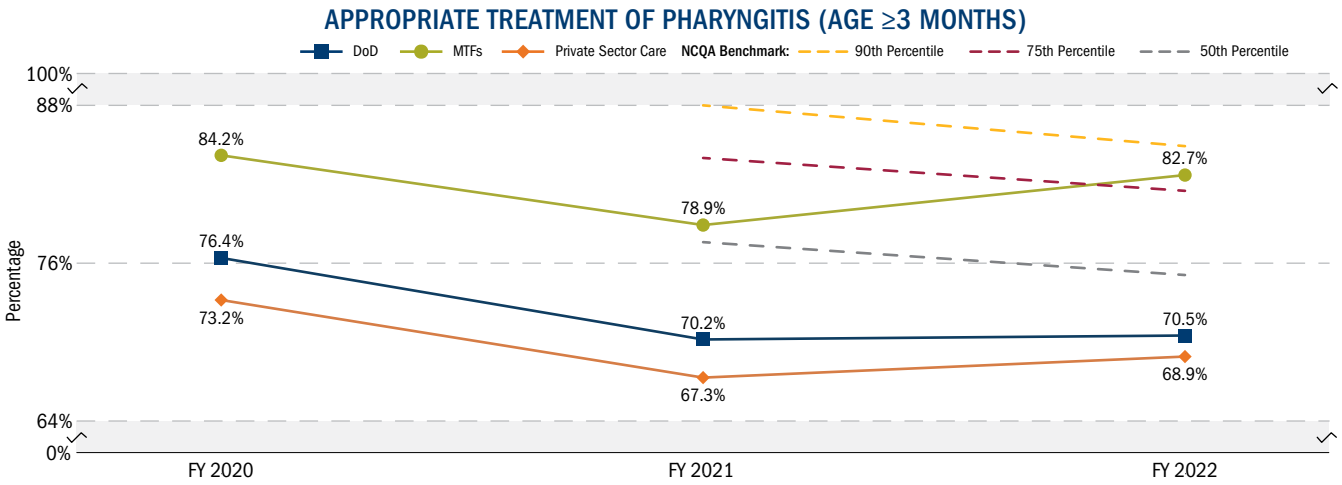
Source: DHA/Medical Affairs/CSD, 12/7/2021

BETTER CARE

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

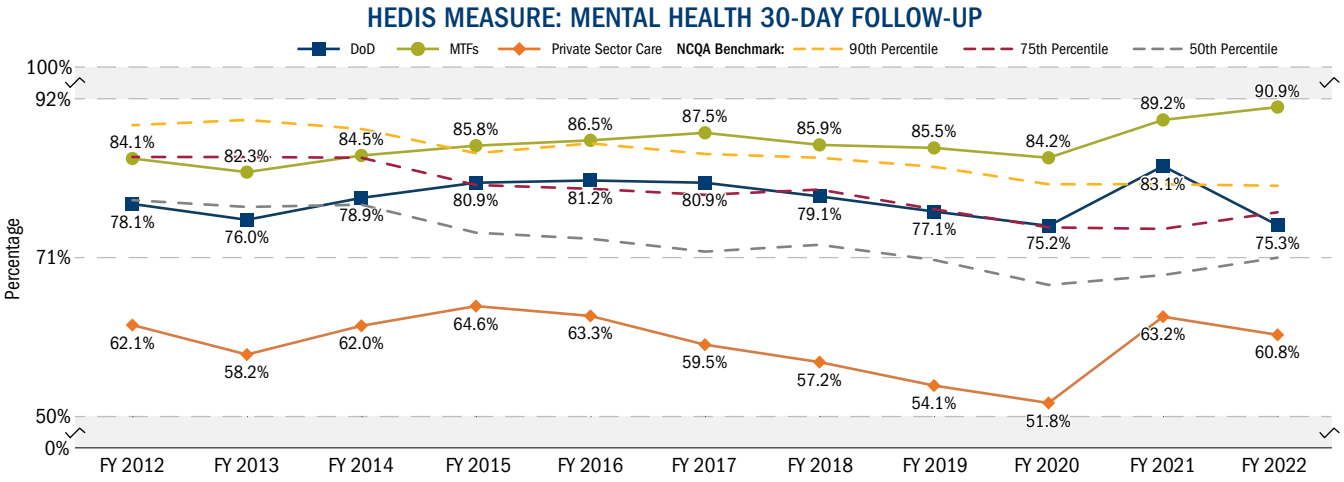
Primary Care Clinical Community *(cont.)*

- **Appropriate Treatment of Pharyngitis:** HEDIS measure focused on appropriate use of antibiotics for anyone three months of age or older diagnosed with pharyngitis, based on laboratory data. This measure increases awareness of the importance of laboratory testing and confirmation prior to prescribing antibiotics for pharyngitis. This is a new measure as of 2020. New measure benchmarks became available in 2021. Improvements in rates were seen in all MHS sectors of care in FY 2022. The MTF rate increased 3.8 percentage points, placing them between the 75th and 90th percentiles. This new measure is not comparable to the NCQA Appropriate Testing for Children with Pharyngitis measure from previous years due to significant measure specification changes.



Source: DHA/Medical Affairs/CSD, 12/19/2022
Note: Data for FY 2020 are through May 2020.

- Mental Health (MH) Follow-Up: This HEDIS measure examines 30-day MH follow-up care in the MHS MTF and private sector care venues. The private sector care rate decreased slightly by 2.4 percentage points and MTF scores improved by 1.7 percentage points. The overall DoD rate decreased 7.8 percentage points, largely due to measure results being greatly impacted by the larger number of follow-up visits in private sector care and the MTF data only reflecting facilities with the legacy electronic health record.



Source: DHA/Medical Affairs/CSD, 12/19/2022
Note: Data for FY 2020 are through May 2020.

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

Primary Care Clinical Community *(cont.)*

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

The MHS performed well compared with national HEDIS benchmarks. Mental Health Follow-Up (7 and 30 Days) and Treatment for URI remain the highest performing measures for the MHS, falling between the 75th and 90th percentiles for 2022. Of the 14 measures reported below in 2022, the MHS saw rates improve in four measures: Well-Child (15 and 30 Months), Breast Cancer Screening, and Diabetes A1c <8, with the largest rate change seen in the diabetes measure with a 6 percent increase. The MHS is above the 50th percentile for half of the 2022 reported measures in the table below and only three measures fall below the 25th percentile. On-site clinical services were negatively impacted by COVID-19, resulting in a positive shift in the use of VH across the MHS. These impacts are suspected to have played a role in the rate decreases seen across the MHS for most of the HEDIS measures in 2020 and continuing into 2022, especially for acute care and screening measures dependent on in-person tests and evaluations. Measures with longer look-back periods (e.g., Colorectal Cancer Screening) tend to be less acutely impacted by COVID-19. Measure results for 2020 may have also been impacted by a necessary data platform change and system security update midway through the year. Overall MHS performance, shown below, includes TRICARE Prime enrollees to facilities containing Army, Navy, Air Force, or DHA facility service codes, along with TRICARE Prime enrollees to Defense Medical Information System Identifiers (DMIS IDs) associated with an MCSC, Uniformed Services Family Health Plan (USFHP), or Coast Guard facility service code. Direct care, private sector care, and DoD performance calculations (pages 122–126) only include TRICARE Prime beneficiaries and do not include Coast Guard facilities. All direct care data reflect only facilities utilizing the legacy EHR.

MHS HEDIS BENCHMARK PERFORMANCE, JUNE 2015–MAY 2022

HEDIS MEASURE	2015	2016	2017	2018	2019	2020	2021	2022	2018 TO 2019 CHANGE	2019 TO 2020 CHANGE	2020 TO 2021 CHANGE	2021 TO 2022 CHANGE	HEDIS BENCHMARK STATUS 2022
Mental Health													
Mental Health Follow-Up: 30 Days	78.86	81.08	80.90	77.68	77.05	75.20	83.46	78.33	-0.63	-1.85	8.26	-5.13	★★★★
Mental Health Follow-Up: 7 Days	64.01	68.03	69.03	61.31	59.34	58.04	69.36	61.46	-1.97	-1.29	11.32	-7.90	★★★★
Pediatric													
Well-Child: 15 Months	83.09	84.09	87.09	88.25	85.95	85.28	77.01	79.59	-2.30	-0.67	-8.28	2.58	★★
Well-Child: 30 Months							74.63	75.60				1.24	★
Children with Pharyngitis[a]	73.04	74.91	79.31	80.89	83.76				2.87				
Children with Upper Respiratory Infection[a]	90.48	91.32	93.32	93.79	93.64				-0.15				
PCMH													
Treatment for Pharyngitis[b]						76.38	70.07	69.82			-6.30	-0.25	★★
Treatment for Upper Respiratory Infection[b]						88.17	91.38	89.20			3.21	-2.18	★★★★
Breast Cancer Screening	72.27	72.08	71.59	71.84	71.70	70.37	67.99	68.61	-0.14	-1.33	-2.37	0.61	★★
Cervical Cancer Screening	74.38	74.73	75.24	75.32	75.38	69.25	67.56	66.29	0.06	-6.13	-1.69	-1.27	★
Colorectal Cancer Screening	70.91	71.81	73.27	72.18	72.36	71.37	69.79	68.43	0.18	-1.00	-1.58	-1.36	★★★
Chlamydia Screening in Women	62.36	64.43	65.41	65.68	66.50	64.13	52.29	49.99	0.82	-2.37	-11.85	-2.29	★★★
Low Back Pain Imaging	71.38	76.36	78.70	80.56	80.48	80.54	77.92	77.63	-0.07	0.05	-2.62	-0.28	★★
Diabetes Screening	83.68	84.30	84.94	85.31	84.60	81.86	81.77	80.39	-0.71	-2.74	-0.08	-1.38	★
Diabetes A1c Level <7%	48.52	48.33	46.82	47.29	46.80	42.71			-0.49	-4.09			
Diabetes A1c Level <8%	67.69	67.87	66.90	67.75	67.62	63.19	54.91	60.91	-0.13	-4.43	-8.28	6.00	★★★
Diabetes A1c Level ≤9%	76.77	77.31	76.70	77.93	77.21	73.52	64.06		-0.71	-3.69	-9.46		
Diabetes A1c Level >9%[c]								29.34					★★★

Source: MHS Population Health Portal, May 2022
[a] Significant methodology change, break in trending in 2020
[b] New measure in 2020
[c] New measure in 2022
Notes:
– The data are June–May look-backs for the given year.
– Rates include TRICARE Prime enrollees to Army, Air Force, Navy, DHA, MCSCs, Coast Guard, and associated USFHP DMIS IDs.
– Statistical Testing: Two-sample test; Green or Red: statistically significant at p=0.05 level.
– Data exclude sites that have transitioned to MHS GENESIS.
– HEDIS Benchmark Status:
  • 1 star: Below 25th percentile
  • 2 stars: Between 25th and 49th percentile
  • 3 stars: Between 50th and 74th percentile
  • 4 stars: Between 75th and 89th percentile
  • 5 stars: At or above 90th percentile
– Private sector care measure results are derived from TRICARE encounter data (TED) and other administrative data.

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

Neuromusculoskeletal Clinical Community (NMSKCC)

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

The NMSKCC, via the Traumatic Brain Injury Advisory Committee, developed the Acute Concussion Care Clinical Pathway in September 2018. The primary foci of the pathway are: (1) early identification, assessment, and management of acute concussion; (2) patient and provider education on screening procedures and tools; and (3) progressive return to activity. Early identification and treatment of concussions can prevent long-term negative consequences to cognitive, psychological, and physical functions. Referral to a concussion clinic, such as the National Intrepid Center of Excellence, is also an option for Service members with delayed recovery. The Services' TBI leads and the Traumatic Brain Injury Center of Excellence worked to modernize an acute concussion screening tool (Military Acute Concussion Evaluation version 2 [MACE2]) and updated the Progressive Return to Activity (PRA) Clinical Recommendation. The MACE2 incorporates state-of-the-science advances in concussion evaluation, with particular focus on vestibular and oculomotor areas. The PRA has been revised and integrates the previous concussion management tool to simplify care and further drive modernized concussion management. In early 2021, the pathway was implemented at four Market sites. Data collection shows an incremental increase in Markets meeting the goal of early identification, assessment, and management of acute concussion.

The NMSKCC is also working to implement a Direct Access to Physical Therapy initiative. The initiative seeks to facilitate early access to physical therapy, which has been shown to improve patient outcomes and reduce cost and additional utilization of health care resources. The Phase 1 Pilot site in Puget Sound Market is ongoing. The workgroup has formalized documents and procedures to assist with implementation. The Phase 2 sites are meeting to facilitate implementation in other markets.

The NMSKCC is also engaged with multiple areas across the enterprise. The Pelvic Rehabilitation Workgroup researched, authored, and published a practice recommendation for Pelvic Health Pregnancy and Post-Partum Rehabilitation Services. Further work continues for a comprehensive document encompassing all pelvic health rehabilitation services.

The NMSKCC has initiated a low back pain initiative to reinforce recent evidence-based practice clinical practice guidelines for LBP. This project has multiple stakeholders with much interest in addressing this high volume musculoskeletal condition. The initiative is beginning by identifying the current state, and the strong recommendations for LBP care.

Finally, the NMSKCC initiated standards and guidance for multiple clinical areas, including dry needling, credentialing of athletic trainers, acute care staffing, and consistency in MHS GENESIS note format. Additionally, the Amputee Care Advisory Committee initiated a DHAPI and staffing through NMSKCC.

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

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

Women and Infant Initiatives

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

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

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

The WICC and WHCMT also utilize national collaboratives and existing processes to expand quality of care transparency and transform leading practices. The focus for FY 2023 will be the refinement and evaluation of outcomes for the MHS-wide implementation of the Postpartum Hemorrhage bundle campaign, which provided a framework for the reduction of severe maternal morbidity and mortality across the MHS, using structures developed by the AIM, CDC, and ACOG. Efforts are underway to expand capacity for same-day, full scope walk-in contraception services, to standardize MHS-wide documentation in both legacy (Essentris) and MHS GENESIS electronic health systems, and to align practice with AIM bundles to decrease adverse events for families.

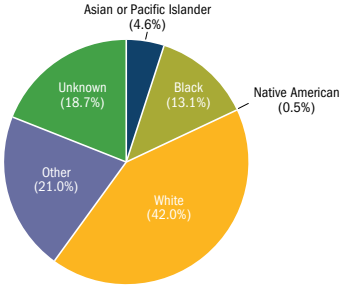
Perinatal Care Measures

Perinatal Care (PC) is an MHS high-volume specialty. The MHS utilizes nationally recognized clinical quality measures (CQMs) and benchmarks from the NPIC and The Joint Commission (TJC) to assess internal performance outcomes for MHS care delivered at the enterprise, Market, and MTF levels. To determine if the MHS's quality and safety of care meets national benchmarks, the data and information from MHS providers (DoD, MTF, and private sector care) is routinely compared with civilian community-based health care providers (obtained from NPIC and TJC) to identify best practices, address issues, and mitigate risks to patients.

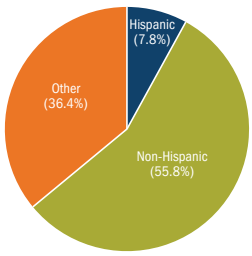
To demonstrate the quality of care delivered by the MHS, multiple PC CQMs are reported externally to beneficiaries and interested parties. The MHS is increasing its transparency to beneficiaries and the public at large. For example, in 2021, the MHS released the metric results of five additional Leapfrog maternity care measures alongside previously available metric results from the NQF, TJC, and AHRQ. These results provide a basis for comparing the MHS performance to national quality care performance outcomes.

Each year across the MHS, more than 100,000 babies are born, of which about 30,000 babies are born in MTFs. As shown below, these newborns represent a wide variety of races and ethnicities. In 2021, the MHS began tracking maternal and neonatal metric results by race and ethnicity. In 2022, the WICC will continue to analyze MHS care delivery practices that influence patient outcomes in an effort to decrease health disparities across patient populations.

DELIVERIES IN DIRECT CARE, BY RACE, APRIL 2021–MARCH 2022



DELIVERIES IN DIRECT CARE, BY ETHNICITY, APRIL 2021–MARCH 2022



Source: NPIC, 9/30/2022
Notes:
– Data provided above include both Essentris and MHS GENESIS facilities.
– Percentages may not sum to 100 percent due to rounding.

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

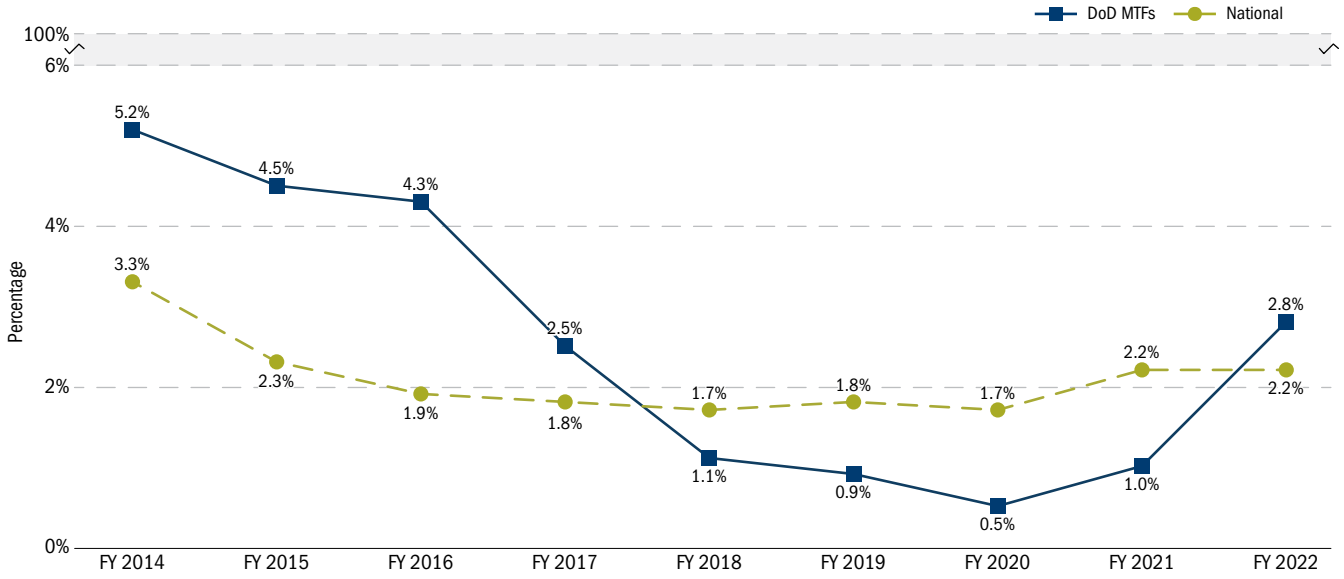
Women and Infant Clinical Community (WICC) and Women's Health Clinical Management Team (WHCMT) *(cont.)*

TJC

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

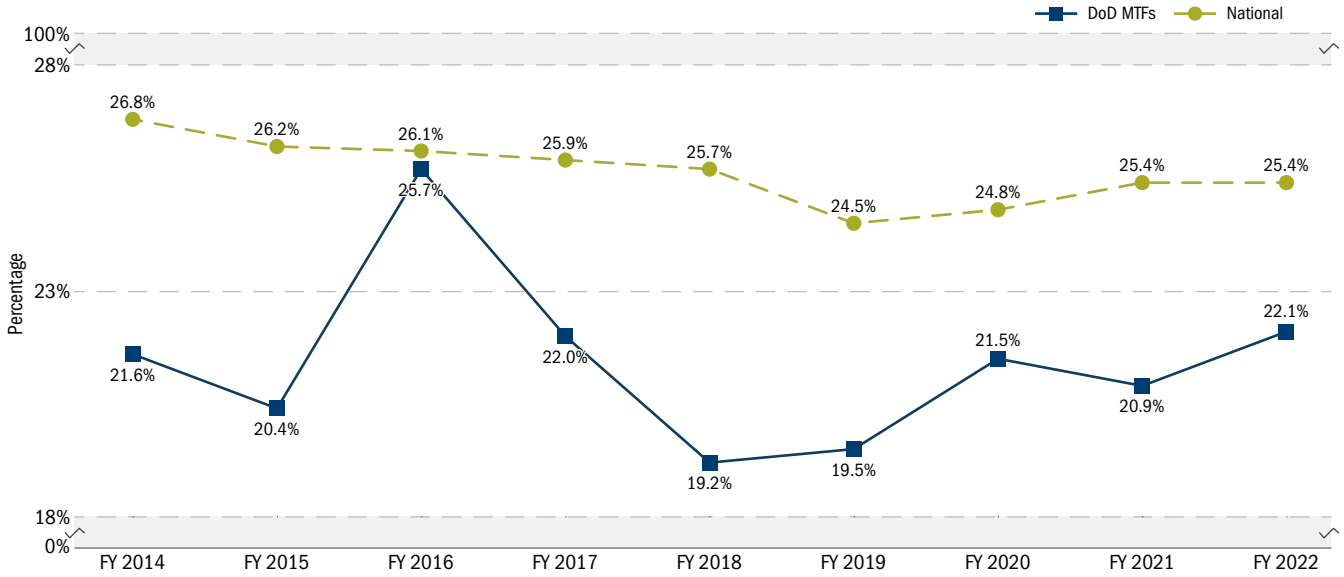
- **Elective Delivery:** This measure (PC-01) focuses on improving the health and outcomes of infants and mothers by avoiding non-medically indicated early elective births (before 39 weeks gestation). Elective inductions result in more cesarean births, longer maternal length of stay, and increased short-term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

DoD HOSPITAL QUALITY MEASURE: ELECTIVE DELIVERY PC-01, FYs 2014–2022



- **Cesarean Rates:** This measure (PC-02) focuses on safe and appropriate use of cesarean delivery for women who have not previously given birth and have a nulliparous, term (39 weeks), singleton, vertex cesarean delivery. The goal of the measure is to reduce risk and increase safety for mothers and infants. DoD MTF rates continue to remain below the national rates (lower is better).

DOD HOSPITAL QUALITY MEASURE: CESAREAN SECTION PC-02, FYs 2014–2022



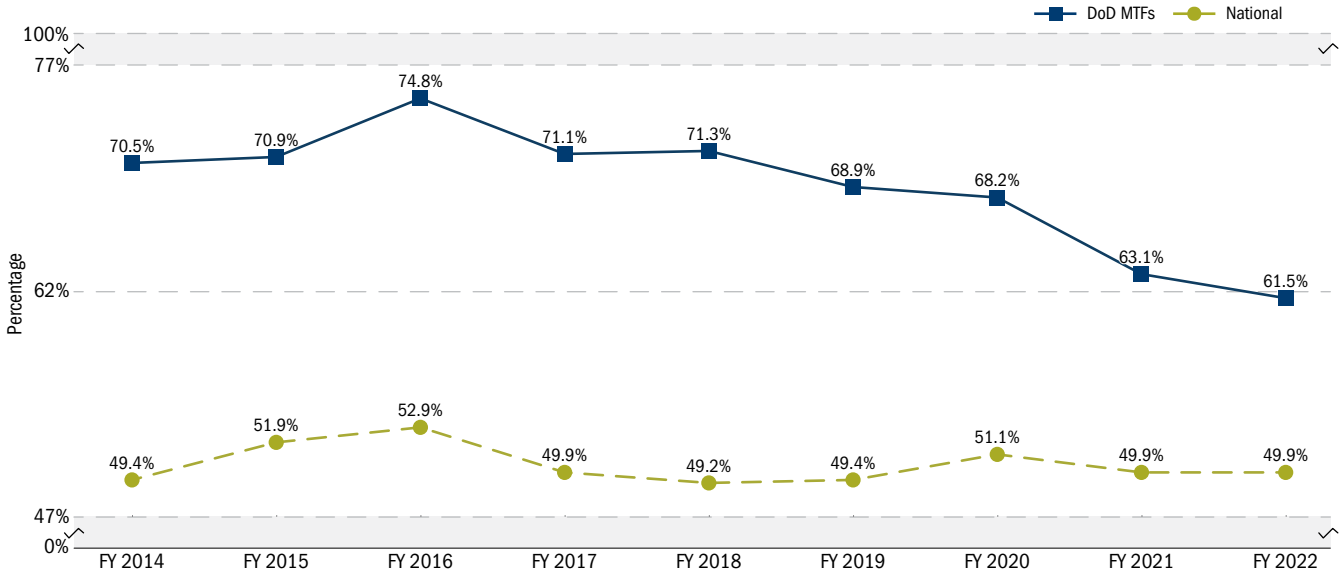
Sources: for DoD MTFs, DHA/Medical Affairs/CSD, 12/5/2022; for National, TJC/TJC Connect/Performance Measurement System Extranet Track (PET), 12/5/2022

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

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

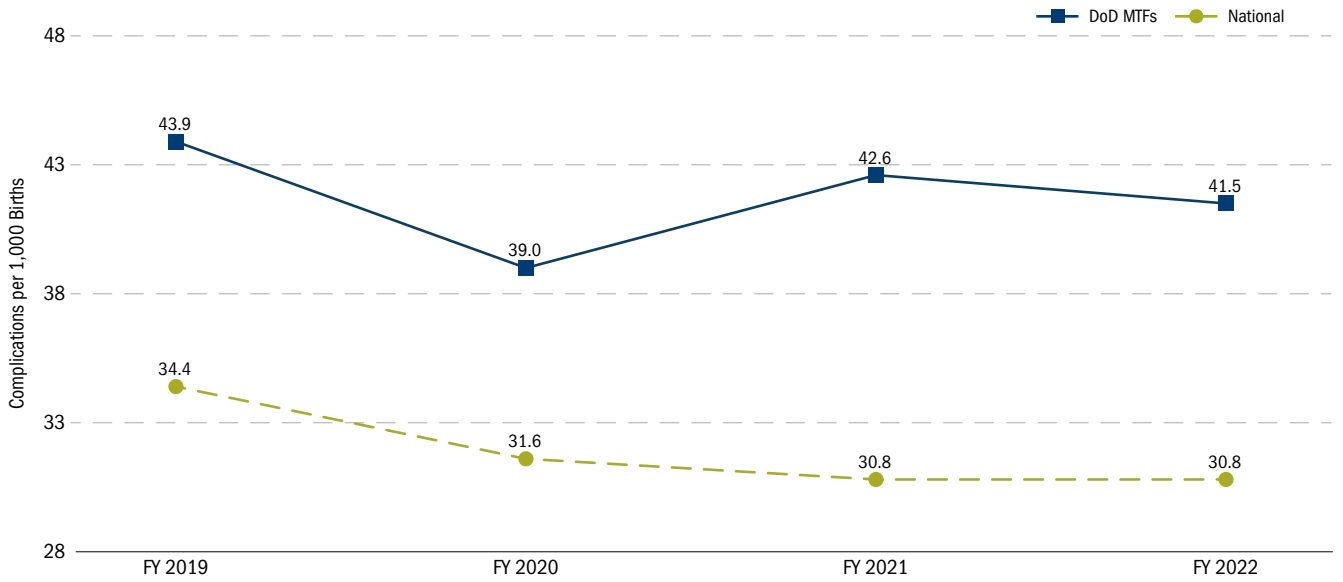
- **Breastfeeding:** This measure (PC-05) focuses on exclusive breastfeeding for newborns during the entire hospitalization. The World Health Organization and national leaders in pediatric and obstetric care note the benefits of breastfeeding an infant for the first six months of life. Early initiation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

DoD HOSPITAL QUALITY MEASURE: EXCLUSIVE BREASTFEEDING PC-05, FYs 2014–2022



- **Unexpected Complications in Term Newborns:** This measure (PC-06), which began January 1, 2019, focuses on complications that would prevent families from bringing home a healthy baby. This metric combines many potential complications to assess the health outcomes of term infants with no preexisting conditions, who represent over 90 percent of all births. DoD MTF performance improved slightly in FY 2022, but still remains above the national rate (lower is better).

DoD HOSPITAL QUALITY MEASURE: UNEXPECTED COMPLICATIONS IN TERM NEWBORNS PC-06, FYs 2019–2022[a]



Sources: for DoD MTFs, DHA/Medical Affairs/CSD, 12/5/2022; for National, TJC/TJC Connect/PET, 12/5/2022

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

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

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

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

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

NATIONAL PERINATAL INFORMATION CENTER COMPARATIVE DATA ALL SERVICES COMBINED, CY 2021 Q2–CY 2022 Q1

	CY 2021 Q2			CY 2021 Q3			CY 2021 Q4			CY 2022 Q1		
Total Deliveries	5,910			7,878			7,081			6,233		
Maternal Outcome Measures	**MHS Avg**	**NPIC Database Rate**		**MHS Avg**	**NPIC Database Rate**		**MHS Avg**	**NPIC Database Rate**		**MHS Avg**	**NPIC Database Rate**	
Inpatient Quality Indicator (IQI) 33 Primary Cesarean Delivery Rate	15.2%	17.6%	●	14.7%	17.6%	●	14.4%	18.0%	●	14.5%	18.2%	●
PPH Rate	6.5%	5.4%	●	7.1%	5.6%	●	6.0%	5.8%	●	6.8%	5.8%	●
Severe Maternal Morbidity Overall Rate	2.5%	2.7%	●	2.7%	3.0%	●	2.8%	3.1%	●	3.2%	2.9%	●
Maternal Readmit Rate to Delivery Hospital	2.2%	1.7%	●	2.1%	1.6%	●	2.1%	1.7%	●	1.7%	1.6%	●
Total Neonates	6,237			8,756			7,703			7,046		
Neonatal Outcome Measures	**MHS Avg**	**NPIC Database Rate**		**MHS Avg**	**NPIC Database Rate**		**MHS Avg**	**NPIC Database Rate**		**MHS Avg**	**NPIC Database Rate**	
Inborn Readmit Rate to Delivery Hospital	3.0%	0.9%	●	3.4%	1.0%	●	3.7%	1.0%	●	3.5%	1.0%	●
Inborn Mortality ≥2,000 Grams (Per 1,000 births)	0.333	0.800	●	0.360	0.568	●	0.273	0.595	●	0.749	0.592	●

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

RED indicates the MHS average rate is significantly ABOVE the NPIC database rate.

GREEN indicates the MHS average rate is either significantly BELOW or not significantly different from the NPIC database average rate.

MHS Average and NPIC Database Average Rates are the sum of all numerators/sum of all denominators (case level rates).

NPIC Average is a weighted average from all NPIC/Quality Analytic Service civilian hospitals in the database.

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

PPH Rate: (based on American College of Obstetrics and Gynecology and the members of the Women's Health Registry Alliance standardized definition.) The MHS average is above the NPIC benchmark. The MHS continues to focus its attention on PPH with full implementation of the Alliance for Innovation on Maternal Health patient safety Bundle on Obstetric Hemorrhage. The MHS has added the metric of Severe Maternal Morbidity to align with national concerns in the multiple conditions that can impact a mother's health during pregnancy and delivery.

Higher readmissions may be aligned with MHS role to support families who don't have local support or whose spouse is deployed.

- **Maternal Readmit Rate to Delivery Hospital:** Remains above the NPIC benchmark. Both National and MHS most common reason for readmission (within 30–42 days of delivery) is hypertension.
- **Inborn Readmit Rate to Delivery Hospital:** Remains above on the NPIC benchmark. Both National and MHS most common reason for newborn readmission to delivery hospital is jaundice.

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

MTF OUTLIERS FOR NPIC MEASURES, CY 2021 Q4–CY 2022 Q1

NPIC MEASURE OUTLIER	ARMY	NAVY	AIR FORCE	NATIONAL CAPITAL REGION (NCR)
Severe Maternal Morbidity Overall Rate	0	0	0	0
Maternal Readmit Rate to Delivery Hospital	0	0	0	1
Inborn Readmit Rate to Delivery Hospital	7	2	3	1

Source: DHA/Medical Affairs/CSD, 9/29/2022

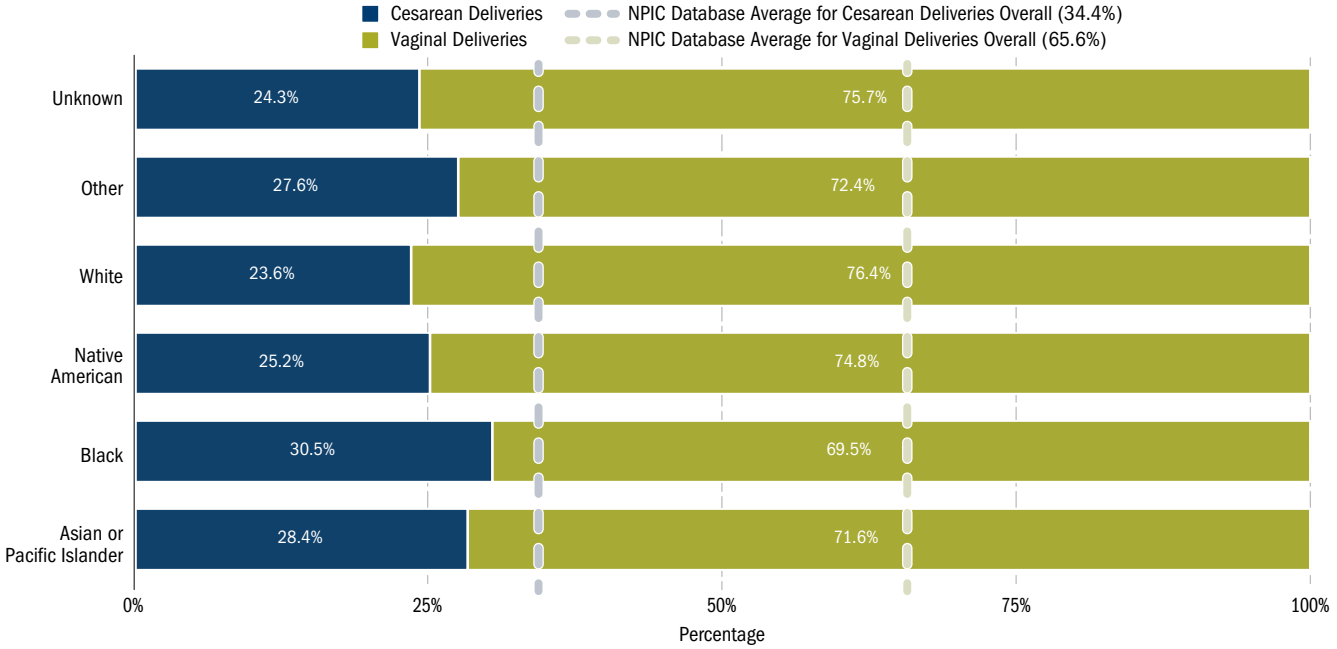
RED indicates number of Service aligned MTFs with rates significantly above NPIC database average for two consecutive quarters (lower is better).

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

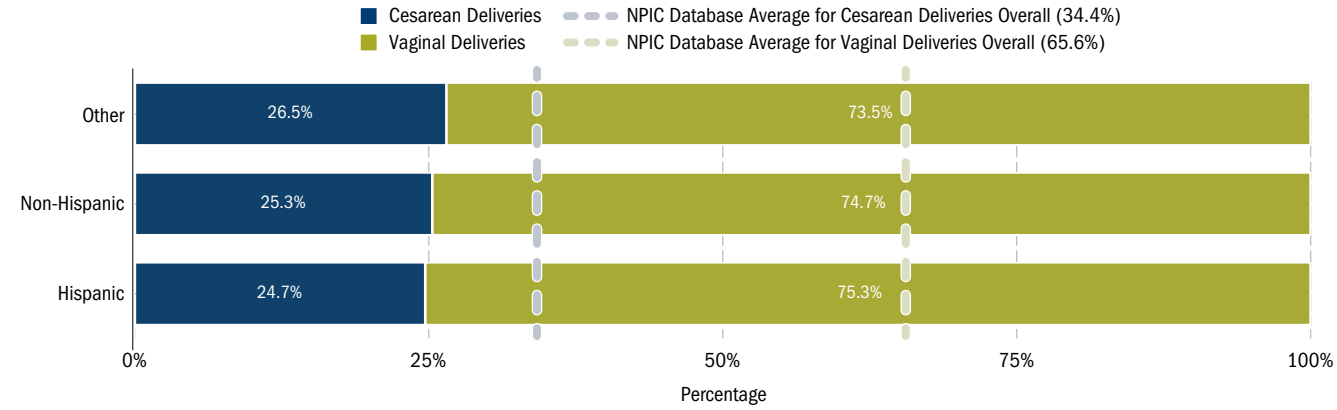
Women and Infant Clinical Community (WICC) and Women's Health Clinical Management Team (WHCMT) *(cont.)*

Additionally, NPIC has been responsive to congressional reports and requests for information related to perinatal outcomes, with data on racial and ethnic subgroups. WICC began adding racial and ethnic subgroups to identify disparities among the populations. Future reports will include additional findings related to race and ethnicity in the perinatal population.

DELIVERIES IN DIRECT CARE, BY RACE, APRIL 2021–MARCH 2022



DELIVERIES IN DIRECT CARE, BY ETHNICITY, APRIL 2021–MARCH 2022



Source: Standard Inpatient Data Record (SIDR), NPIC

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

Behavioral Health Clinical Community (BHCC)

Developing the Behavioral Health High Reliability Operating Model

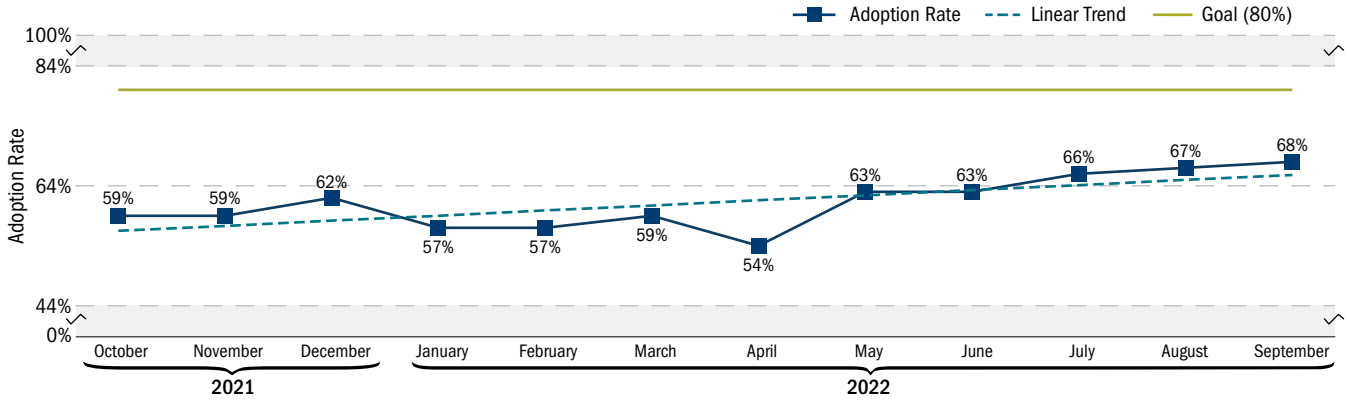
The mission of the BHCC is to promote safe, effective BH care that integrates full spectrum care delivery and community resources through standardized BH programs and procedures, partnerships, engagement with staff and patients, and state of the science research. The BHCC was established in November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

To attain its objectives, BHCC maintains working relationships with persons and entities with the following types of enabling expertise: analytics, change management, clinical informatics, education and training, health information technology, process improvement, quality, and patient safety. Strategic partners include DoD Psychological Health Center of Excellence, Uniformed Services University, Military Operational Medicine Research Program, TRICARE, and VA. The BHCC also coordinates closely and partners with the BH Clinical Management Team, which oversees implementation of process improvement initiatives and programmatic execution.

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

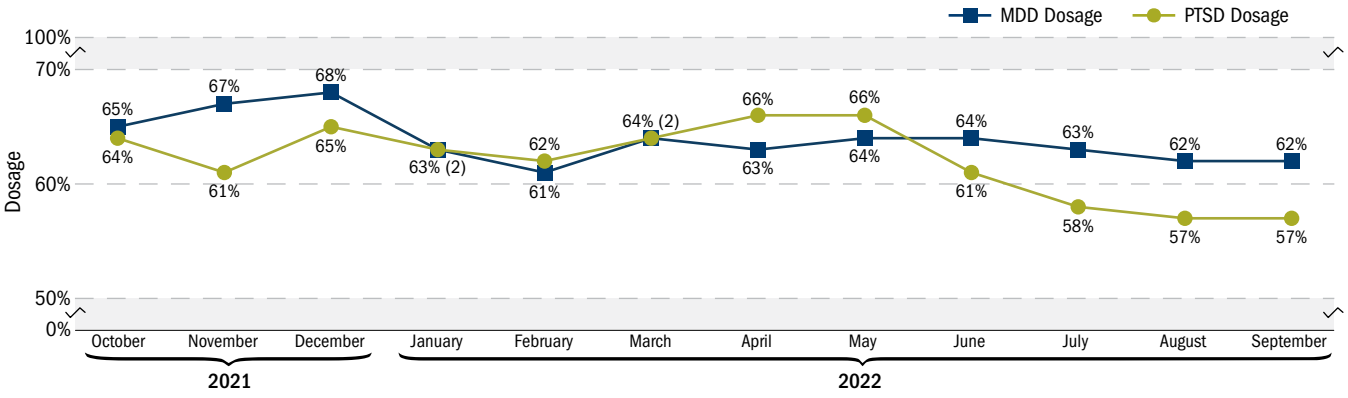
Behavioral Health Clinical Community (BHCC) *(cont.)*

DoD BHDP ADOPTION RATE, ALL SITES, OCTOBER 2021–SEPTEMBER 2022

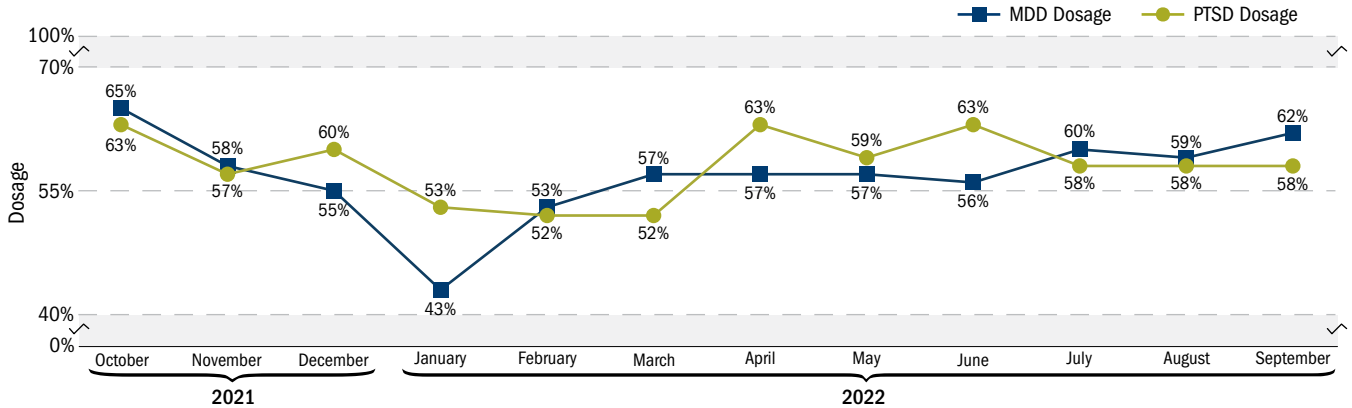


3. **Treatment Dosage for MDD and PTSD:** As described in DHA-PI 6490.02, Treatment Dosage Rate is the percentage of patients with a new diagnosis of PTSD or MDD who receive at least three follow-up appointments within 90 days of diagnosis. While three visits within 90 days is not optimal care, according to VA/DoD clinical practice guidelines, Army studies showed this dosage was associated with better outcomes, compared with fewer than three follow-up visits. Receiving adequate frequency of care improves outcomes over a shorter period of time, returning the patient to well-being and higher functioning more quickly. The BHCC's support of virtual BH care allowed the MHS to maintain good performance on this metric for the duration of the COVID-19 epidemic.

TREATMENT DOSAGE FOR MDD AND PTSD, ALL SITES, OCTOBER 2021–SEPTEMBER 2022



TREATMENT DOSAGE FOR MDD AND PTSD, MHS GENESIS SITES, OCTOBER 2021–SEPTEMBER 2022



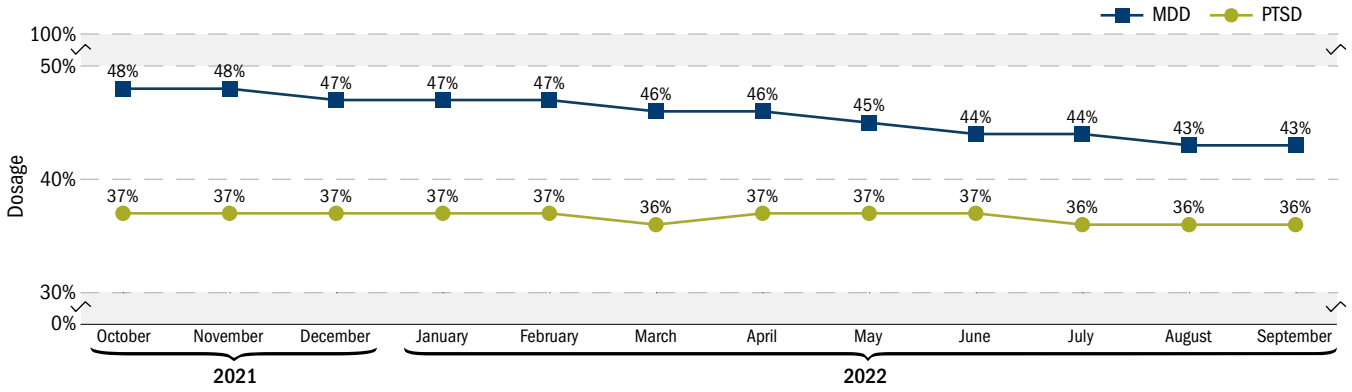
Source: DHA/Medical Affairs/CSD, 11/3/2022

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

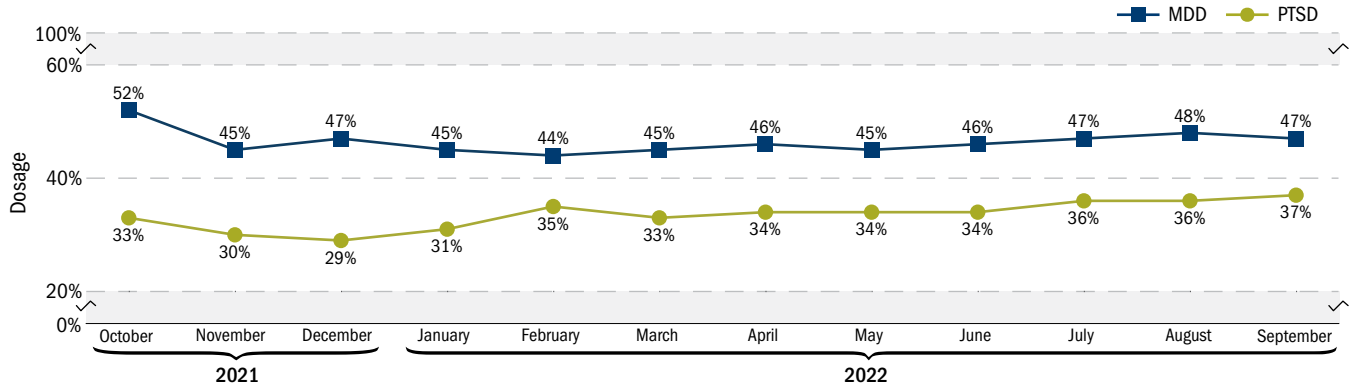
Behavioral Health Clinical Community (BHCC) *(cont.)*

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

MDD AND PTSD POSITIVE OUTCOMES, ALL SITES, OCTOBER 2021–SEPTEMBER 2022

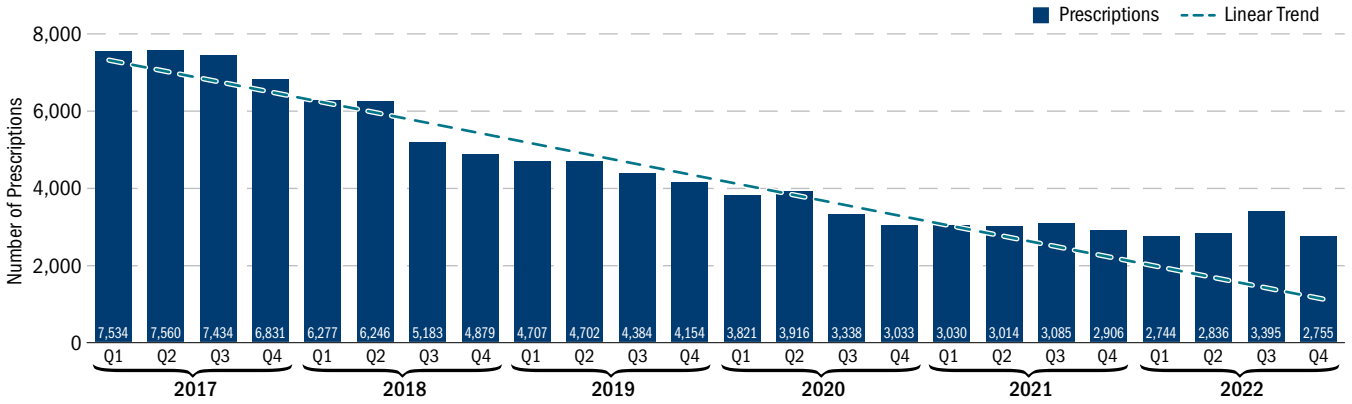


MDD AND PTSD POSITIVE OUTCOMES, MHS GENESIS SITES, OCTOBER 2021–SEPTEMBER 2022



5. **PTSD Prescriber Tool:** NDAA FY 2017, section 745, required DoD to implement a process to monitor MTF prescribing practices of pharmaceutical agents that are not recommended under the VA/DoD CPG for the Management of PTSD and Acute Stress Disorder, such as benzodiazepines (BZDs). BHCC developed a PTSD Prescriber Profile that identifies, on a quarterly basis, individual providers who write a high number of BZD prescriptions to patients with PTSD. The overall number of BZD prescriptions written to patients with PTSD declined almost every quarter in FY 2017 through FY 2021, resulting in a 61 percent reduction in BZD prescriptions over this time period. The rate of progress has slowed during FYs 2021 and 2022, and the BHCC is implementing a targeted initiative to educate those providers who continue to write significantly more BZD prescriptions than the majority of their colleagues.

NUMBER OF PRESCRIPTIONS FOR BZD TO BENEFICIARIES DIAGNOSED WITH PTSD, FY 2017 Q1–FY 2022 Q4



Source: DHA/Medical Affairs/CSD, 11/3/2022

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

6. **Publication of Procedural Guidance on Suicide Risk Care Pathway for Adult Patients in the DHA:** DHA Administrative Instruction 6025.06, published in August 2022, establishes the DHA's procedures to screen and comprehensively assess patients in the DHA for suicide risk; manage and treat patients at risk for suicide using evidence-based and evidence-informed practices; track at-risk patients during periods of increased risk; train the DHA workforce on suicide-risk care procedures; measure outcomes for suicide-risk care in the DHA; and report suicide deaths and attempts identified in ADSMs and Reserve Component Service members on Active Duty for a period of more than 30 days.

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

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

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

In June 2014, TRICARE published the Comprehensive Autism Care Demonstration (ACD) Notice in the Federal Register, on approval of the Office of Management and Budget and in compliance with the regulations that govern TRICARE demonstration projects. Based on limited demonstration authority, in July 2014, the ACD consolidated the three previous ABA programs into a single program for eligible TRICARE beneficiaries. This consolidated demonstration ensures consistent ABA coverage for all TRICARE beneficiaries, including Active Duty family members (ADFMs) and non-ADFMs diagnosed with ASD. ABA services are not limited by the beneficiary's age, the dollar amount spent, or the number of services provided, and there are no annual caps on government cost shares. ABA services are authorized based on the clinical necessity and appropriateness of the individual beneficiary's needs. The program provisions attempt to strike a balance that maximizes access while ensuring care at the highest level of quality for our beneficiaries. An extension for the demonstration through December 31, 2028, was approved via a Federal Register Notice on August 4, 2022. In addition to continuing the analysis and evaluating the goals of the demonstration, the Notice states that additional time is required for the ACD evaluation due to the pending Congressionally Directed Medical Research Program study and the Congressionally directed National Academies of Sciences, Engineering, and Medicine analysis (Section 737, NDAA FY 2022).

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

In March 2021, the DHA published policy revisions to the ACD with the focus on providing enhanced beneficiary and family support, improving outcomes, encouraging parental involvement, and improving utilization management controls. These revisions become effective over a 270-day implementation plan. Data collection and subsequent analyses are under way regarding the impact of the policy update.

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

Dental Clinical Community (DCC)

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

The DCC milestones include the following actions:

- DCC members and dental SMEs continue using teamwork, HRO models, key process analysis, and the DHA submission portal; additional nonvoting members are included in the DCC to support numerous strategic dental health initiatives.
- A new DCC DHA member was selected by the DCC Core Members in January 2021, as per the guidance set forth by the DCC charter.
- Biweekly core member meetings and quarterly enterprise-wide dental SME and Service representative meetings are held.
- A working group continued to develop standardized dental performance and outcome metrics that support the Quadruple Aim.
- SMEs have been established to develop standardized enterprise-wide Dental Infection Control guidance.
- Working groups developed enterprise-wide guidance and updates to the military dental enterprise to ensure safe and effective care during the COVID-19 pandemic in line with CDC, OSH, American Dental Association, and other applicable local, state and federal guidance.
- Working groups developed, drafted, coordinated, and aided the publishing of the following DHA procedural instructions: (1) DHA-PI 6410.01 Dental Sedation Medical Management, published May 4, 2021; (2) DHA-PI 6410.02 Dental Universal Protocol, published May 21, 2021; and (3) DHA-PI 6410.03 Processes and Procedures for Implementation of Standardized Dental Cone Beam Computed Tomography Operations and Training, published August 23, 2021.

Ongoing Quality Initiatives: Surgical Services

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

NSQIP Quality Outcomes

The ACS NSQIP remains one of the most mature quality improvement programs utilized throughout the MHS in MTFs with inpatient surgery. It is the primary method to continuously monitor surgical outcomes through morbidity and mortality data. In February 2018, the MHS reached its NSQIP Adult Program expansion goal of 100 percent participation (48 MTFs). Currently, at the end of FY 2022, the total number of participating MTFs has decreased to 45 with the transition of several hospitals to stand-alone ambulatory surgical centers. DoD NSQIP collaborates closely with the DHA Surgical Services Clinical Community (S2C2), DHA Women and Infant Clinical Community, and other DHA Clinical Communities with relevant overlapping outcomes data to provide surgical quality benchmarking with high-fidelity data and guidance on the development of standardized pathways for improvement of care in the MTFs.

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

Focused Quality Initiatives

The 2021 mortality data indicated that all MTFs reporting data (data provided from 40,003 assessed surgeries) met the expected performance level, including two facilities that were "exemplary" (results in the top quartile of hospitals). No facilities were in the "needs improvement" category (results in the bottom quartile of hospitals) for mortality. The morbidity data indicated that of the 42 sites reporting data for CY 2021, 26 MTFs met expected performance levels, while 11 were "exemplary." Five MTFs were in the "needs improvement" category. Falling in the "needs improvement" category rarely connotes a persistent deficiency unless recurrent on multiple reports, but it does enable the hospitals to recognize areas of potential concern and dive deeper to improve the quality of their surgical care (see table below). Additionally, the DoD NSQIP Steering Panel has a process by which any MTF falling in the "needs improvement" categories are provided oversight and opportunity for collaboration with an "exemplary" site.

MTF MORTALITY AND MORBIDITY PERFORMANCE, CYs 2015–2021

			CY 2015		CY 2016		CY 2017		CY 2018		CY 2019		CY 2020		CY 2021	
			MORTALITY	MORBIDITY	MORTALITY	MORBIDITY	MORTALITY	MORBIDITY	MORTALITY	MORBIDITY	MORTALITY	MORBIDITY	MORTALITY	MORBIDITY	MORTALITY	MORBIDITY
MEDICAL CENTERS	ARMY	AMC BAMC (SAN ANTONIO)			★						★		★		★	★
		AMC DARNALL (HOOD)						★		★		★		★		★
		AMC EISENHOWER (GORDON)	★	★		★		★	★	★		★				
		AMC LANDSTUHL (GERMANY)								★				★		★
		AMC MADIGAN (LEWIS)														
		AMC TRIPLER (SHAFTER)														★
		AMC WILLIAM BEAUMONT (BLISS)								★				★		★
		AMC WOMACK (BRAGG)														
	NAVY	NMC PORTSMOUTH						★		★		★				★
		NMC SAN DIEGO								★		★		★		
		NMC CAMP LEJEUNE														
	AIR FORCE	99th MED GROUP (NELLIS)				★										
		60th MED GROUP (TRAVIS)	★	★	★		★		★		★				★	
		88th MED GROUP (WRIGHT PATTERSON)			★											
		96th MED GROUP (EGLIN)														
		81st MED GROUP (KEESLER)				★										★
	NCR	WALTER REED NMMC (BETHESDA)				★		★		★		★		★		★
COMMUNITY HOSPITALS	ARMY	ACH BASSETT (WAINWRIGHT)														
		ACH BAYNE-JONES (POLK)														
		ACH BLANCHFIELD (CAMPBELL)				★										
		ACH BRIAN ALLGOOD (SEOUL)														
		ACH EVANS (CARSON)						★		★				★		★
		ACH GENERAL LEONARD WOOD (WOOD)														
		ACH IRWIN (RILEY)						★								
		ACH KELLER (WEST POINT)														
		ACH MARTIN (BENNING)														
		ACH WEED (IRWIN)														
		ACH WINN (STEWART)														
	NAVY	NH BREMERTON								★						
		NH CAMP PENDLETON														
		NH GUAM														
		NH GUANTANAMO BAY														
		NH JACKSONVILLE						★		★		★		★		★
		NH OKINAWA														
		NH PENSACOLA		★		★										
		NH TWENTYNINE PALMS										★				
		NH YOKOSUKA														★
		NH SIGONELLA														
		NH NAPLES														
		NH ROTA														
	AIR FORCE	31st MED GROUP (AVIANO)														
		35th MED GROUP (MISAWA)														
		48th MED GROUP (RAF LAKENHEATH)														
		51st MED GROUP (OSAN)														
		633rd MED GROUP (JB LANGLEY-EUSTIS)								★						
		673rd MED GROUP (JB ELMENDORF-RICHARDSON)														
		374th MED GROUP (YOKOTA)														
	NCR	FT BELVOIR COMMUNITY HOSP						★								

★ EXEMPLARY AS EXPECTED NEEDS IMPROVEMENT DATA UNAVAILABLE

Source: DHA/OPS Medical Affairs/CSD, 11/28/2022

Note: Data unavailable may be due to loss of Surgical Clinical Reviewer, site transitioned to ambulatory care, or in initial data collection.

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

Focused Quality Initiatives *(cont.)*

The most recent DoD collaborative report demonstrates that MHS surgical performance meets or exceeds most performance standards relative to the NSQIP population reference rate (704 hospitals both internationally and across the United States currently participate in the ACS NSQIP Adult Program). The DoD Collaborative performed "exemplary" in eight of 14 statistical models, exceeding expected performance even after adjustments for patient risk profiles. One area that needs improvement, as noted in the DoD collaborative report, was All Cases Return to Operating Room (ROR). The NSQIP Steering Panel is currently collaborating with the Surgical Services Clinical Community to understand these issues and develop strategies to improve performance. Improvements are often highly influenced by drivers specific to each MTF. While there is rarely a one-size-fits-all solution, interfacility collaboration drives the sharing of problem-solving strategies.

DoD COLLABORATIVE JULY 2022 SUMMARY (SURGERY DATES JANUARY 1 TO DECEMBER 31, 2021)

MODEL NAME	COLLABORATIVE								NSQIP
	TOTAL CASES	OBSERVED EVENTS	OBSERVED RATE	ADJUSTED RATE[a]	95% LOWER CL	95% UPPER CL	OUTLIER[b]	ESTIMATED OR	POPULATION RATE
All Cases Mortality	40,003	68	0.17%	0.74%	0.58%	0.92%	Low	0.76	0.97%
All Cases Morbidity	40,003	1,132	2.83%	5.72%	5.39%	6.05%	Low	0.93	6.23%
All Cases Cardiac	40,003	33	0.08%	029%	0.17%	0.44%	Low	0.46	0.63%
All Cases Pneumonia	39,993	63	0.16%	0.53%	0.38%	0.70%	Low	0.59	0.90%
All Cases Unplanned Intubation	40,003	33	0.08%	0.33%	0.21%	0.47%	Low	0.57	0.58%
All Cases Ventilator >48 Hours	39,993	38	0.10%	0.45%	0.31%	0.61%	Low	0.71	0.62%
All Cases VTE	40,003	145	0.36%	0.75%	0.64%	0.88%		0.95	0.79%
All Cases Renal Failure	39,999	26	0.07%	0.26%	0.16%	0.39%	Low	0.57	0.46%
All Cases Urinary Tract Infection (UTI)	39,947	244	0.61%	1.05%	0.92%	1.19%		0.97	1.08%
All Cases Surgical Site Infection	39,881	689	1.73%	2.89%	2.68%	3.09%		1.05	2.74%
All Cases Sepsis	39,936	92	0.23%	0.67%	0.52%	0.83%	Low	0.75	0.89%
All Cases C. Diff Colitis	40,003	38	0.09%	0.28%	0.20%	0.37%		0.95	0.29%
All Cases ROR	40,003	658	1.64%	3.09%	2.89%	3.29%	High	1.31	2.38%
All Cases Readmission	40,003	980	2.45%	4.85%	4.56%	5.14%		1.02	4.75%

EXEMPLARY AS EXPECTED NEEDS IMPROVEMENT

Source: American College of Surgeons National Surgical Quality Improvement Program DoD Collaborative Report, released July 2022

[a] Adjusted Rate is the risk-adjusted smoothed rate.

[b] Outlier status is determined by the risk-adjusted smoothed rate confidence interval relative to the NSQIP population reference rate.

Note: "CL" means confidence limit, and "OR" means odds ratio.

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

Focused Quality Initiatives *(cont.)*

Surgical Quality Program Expansion

The MHS expanded its surgical quality improvement programs in 2019 to include the ACS NSQIP Pediatric Program, the ACS MBSAQIP, the ACS Trauma VRC Program, and the ACS TQIP.

The ACS NSQIP Pediatric Program is a multispecialty national database to measure pediatric surgical outcomes. The data are risk adjusted and case-mix adjusted. There are currently 148 hospitals participating across the nation. Naval Medical Center (NMC) Portsmouth has been participating in the program since May 2019. In June 2020, NMC San Diego and Tripler Army Medical Center (AMC) also began participating in the program. Plans are in development to expand the program to other sites in 2023.

The ACS MBSAQIP provides a quality improvement program for patients suffering from severe obesity. Bariatric surgery is a procedure group with studied relationships between procedural volume and surgical outcomes and features frequently in discussions of high-risk procedures performed at low-volume facilities. These are also one of the few foregut procedures currently available to a broad range of surgeons that can offer surgical skill experience referable to deployment-relevant knowledge, skills, and abilities (KSAs). There are 21 MTFs performing bariatric procedures on a regular basis. Six MTFs are currently participating in MBSAQIP, with 15 sites interested in MBSAQIP membership.

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

Hospital enrollment in these programs depends on dedicated data abstractors trained to ensure data quality, but not all facilities that would qualify for participation have the available manpower to support participation.

ACS NSQIP CY 2021 Meritorious Award

The annual ACS Meritorious Award is presented to recognize top-performing hospitals for the quality of surgical care provided to their beneficiaries. There are two categories of meritorious hospitals recognized: the All Cases Meritorious List and the High-Risk Meritorious List. The criteria for selection is based upon composite quality scores for surgical care provided in CY 2021 in eight All Cases outcome areas: mortality, cardiac (cardiac arrest and myocardial infarction), pneumonia, unplanned intubation, ventilator >48 hours, renal failure, UTI, and surgical site infection. The MTFs below were recognized by the ACS NSQIP as meritorious hospitals for CY 2021:

All Cases Meritorious List:

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

High-Risk Meritorious List:

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

These sites are among the 78 facilities representing the top 10 percent of all NSQIP participating hospitals worldwide in 2021. Of note, each of these facilities have received meritorious recognition on multiple occasions in past years.

Surgical Care Performance

The ACS NSQIP continues to be a critical cornerstone for surgical quality improvement in the MHS. Implementation of NSQIP at all military inpatient surgical facilities has fostered the development of a formal quality collaborative. The DoD collaborative unites surgical SMEs across the enterprise with a single focus—surgical excellence. The collaborative assists with identifying enterprise trends, educating and building new quality leaders in program surgeon champions, and promoting collaboration with civilian experts. It also strengthens our culture of vigilance with surgical outcomes and providing quality surgical care across the MHS. Prior to the COVID-19 pandemic, this collaborative met in person twice a year for professional development and cross-pollination of ideas. These face-to-face opportunities are critical to the rapid on-boarding of personnel new to NSQIP and help ensure sustained return on investment by mitigating impacts of turnover inherent to military practice. The pandemic has driven a pivot toward quarterly virtual meetings to sustain a rhythm of training.

HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES

The National Clinical Quality Database

On October 1, 2014, the MHS action plan for Access, Quality of Care, and Patient Safety Memorandum was signed by the Secretary of Defense. This memorandum directed the DHA to establish an MHS performance management system. The objective was to drive improvement throughout the enterprise for identified common executable goals and develop dashboard measures that address all areas covered by the MHS Review. Participation in strategically selected national databases, such as NSQIP, was identified as a means to significantly contribute to meeting this requirement.

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

The DoD currently participates in 11 clinical quality databases:

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

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

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

Medical Management (MM)

The MHS is engaging in an organizational health care transformation, including the delivery of MM services to members of the Armed Forces and other covered beneficiaries. In direct support of this mission, the DHA MM program is focused on the development and integration of standardized clinical and business processes to support improved patient outcomes. To achieve this mission, the MHS MM program has integrated use of technology, tools, and industry evidence-based best practices to support higher reliability in health care delivery and uniformity of MM clinical processes within military treatment facilities (MTFs). As a result of the transition of MTF authority, direction, and control (ADC) to DHA, the DHA MM program has expanded engagement and collaboration between DHA, the MTFs, and the Markets to ensure improved standardization of clinical practice efforts. The DHA and the MILDEPs also collaborate regularly as it relates to care delivery associated with medical readiness of the ADSM. Through these ongoing transition efforts, the DHA will continue to reduce practice variation, decrease fragmentation in care processes, enhance MM delivery of services, while contributing to individual and service level readiness through an integrated and enterprise-wide approach.

An example of MM improvements include efforts to support improved Case Management (CM) services. Case managers support the identification of individuals with chronic, complex, high-risk, and/or high-cost conditions that would benefit from engagement and coordination with dedicated health care teams. This effort reduces fragmentation in care and aligns with the MHS Quadruple Aim to optimize health system performance. MM continues to standardize practice across the MHS.

CM within the MHS continues to apply evidence-based tools, proactively identifying at-risk beneficiaries utilizing predictive analytics. The MHS leverages the Johns Hopkins Adjusted Clinical Groupings (ACG) as an evidence-based tool. The use of ACGs to identify patients through a comprehensive population-based approach based on clustering of morbidity, surpasses other methodologies that look exclusively at diagnosis. High-risk patients are listed on the web-based MHSPHP utilized by CM personnel at the point of care. The MHSPHP tool provides CM personnel the capability to identify and proactively intervene for at-risk populations. “Unlike many traditional methods for case identification (such as hospital concurrent review and ED utilization reports), the ACG Predictive Model identifies individuals in need of care management intervention before they become high utilizers” (Johns Hopkins, 2015).

The MHS MM strategy is built around core concepts of a shared vision for patient-centric care, evidence-based management, and a commitment to quality, which fully supports DHA’s priorities: great outcomes, ready medical force, satisfied patients, and fulfilled staff. The DHA MM program remains committed to these priorities in the execution of MHS MM policies and procedures.

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

Pain Management

During FYs 2021 and 2022, the MHS continued to mature pain management capabilities and resources for our beneficiaries and health care workforce. Improved coordination and collaboration across the Services, DHA, USU, and VHA resulted in continued advances in pain management policy, clinical care, and fielding of innovative education, training products, and clinical tools, including:

- Continued implementation of the Defense and Veterans Pain Rating Scale (DVPRS), an innovative pain scale that was developed by the DoD to improve assessment of the impact of pain on a person's function and quality of life.
- Continued MHS implementation of the Stepped Care Model of Pain Management to ensure the appropriate level of pain care is available and delivered to patients throughout the continuum of acute and chronic pain.
- Published updates to the DoD/VA CPG "Use of Opioids in the Management of Chronic Pain," as well as continued identification of required updates to other pain-related guidelines using resources available through the Pain Management Clinical Support Service, Clinical Communities, and VA/DoD HEC Work Groups.
- Increasing pain VH integration in NCR primary care by both direct care visits and provider webinar case-based education. This was greatly enhanced with COVID-19. There were 271 attendees at the Substance Use Disorder Symposium for 2022.
- Continued primary care pain skills training offered annually by the NCR Pain Care Initiative. Since 2020, Pain Skills moved to a virtual online forum. There were 326 participants for the training in 2022. The virtual portion of the training consisted of one half-day plenary session on the Brain SPECT Imaging, Pain, and Implications for Treatment, Autoimmune and Pain, Biomarkers and Predictors for Pain, and Women and Pain. This was followed by 19 workshops—three 2-hour, eight 3-hour, and eight 4-hour sessions—that attendees could select from. The in-person portion of the training consisted of two full days of workshops, with the option of selecting two workshops per day from 13 different workshops. All in-person workshops were at least either three hours or four hours long.
- Expansion of pilot in-home VH visits to transitioning and rural Service members and beneficiaries. Enhanced by DHA Connected Health and HEC Pain Management Work Group regarding COVID-related VH support for pain management and opioid safety. Examples include integration of virtual pain assessment utilization of the DVPRS and establishing DoD access to VA virtual functional restoration programs for chronic pain conditions.
- Continued deployment of the PASTOR, the MHS pain outcome registry and clinical decision-making tool. PASTOR is one of a growing number of use cases within the MHS Patient-Reported Outcomes Clinical Record that leverage the National Institutes of Health (NIH) Patient Reported Outcomes Measurement Information System.
- Enhanced integration of the Opioid Prescribers Trend Report, which gives providers and pain leaders insights about opioid prescribing trends at the Market, MTF, clinic, and provider levels. This tool is used to support Stepped Care Model Implementation, CPG adherence, and local QI efforts and provider peer review.
- Updated components of the Joint Pain Education Project (JPEP), a standardized VA/DoD pain management curriculum, and supplemental pain videos for joint use across DoD and VA education and training programs.
- Participation in research efforts under the NIH/DoD/VA Pain Management Collaboratory to examine the effectiveness of nonpharmacological treatments for acute and chronic pain and complex pain syndromes experienced by military and Veteran populations.
- Continued standardization of acupuncture practice in the MHS following the 2020 Publication of DHA-PI 6025.33 Acupuncture Practice in Medical Treatment Facilities.

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

Pain Management *(cont.)*

- Opioid Education and Naloxone Distribution program continued implementation throughout the MHS. Educating patients and families on opioid risks and dispensing the overdose antidote naloxone.
- Continued Naloxone metric as a QPP metric for FY 2023; percentage of at-risk population receiving naloxone prescription in past year.
- Reductions in number of opioid prescriptions, number on long-term opioid therapy those prescribed high doses Morphine Equivalent Daily Dose (MEDD>50), and those co-prescribed BZDs continue.
- Completed full review and update of content and transition to Joint Knowledge Online (JKO) platform for the DoD Opioid Prescriber Safety Training, a requirement for all MHS prescribers. More than 13,500 providers completed this training in 2022.
- Pain Management Clinical Support Service is developing recommendations for opioid prescribing safety alerts to be integrated into the new electronic health record, MHS GENESIS.

Preventing Opioid Misuse by Military Service Members

DHA-PI 6025.04 Pain Management and Opioid Safety in the MHS, originally published June 8, 2018, and revised in 2022 to DHA-Administrative Instruction 6025.08:

- Establish the MHS Stepped Care Model as the comprehensive standardized pain management model for MHS to provide consistent, quality, and safe care for patients experiencing pain, with an emphasis on nonpharmacological treatments.
- Educate patients in effective self-management of pain and injury rehabilitation.
- Provide MHS providers with clear guidance regarding standards, processes, and decision support tools for safe and effective opioid prescribing.
- Educate clinicians regarding effective pain management and optimal opioid safety consistent with VA/DoD and CDC CPGs.
- Provide tools, including those through MHS GENESIS and legacy EHRs, to assist clinicians in evidence-based and patient-centered pain management.
- Conduct pain research to continuously improve the MHS approach to pain management.

The DHA-AI provides specific guidelines on opioid prescribing for MTF providers, consistent with VA/DoD CPGs, including: documentation of informed consent for patients who require long-term opioid therapy; guidance on the recommended days supply, dosage, and refill procedures for opioid prescribing; provision of Medication for Opioid Use Disorder; and provision of naloxone (opioid reversal medication) for those at higher risk for overdose. It also provides guidance for the TRICARE health plan to partner with MCSCs to minimize inappropriate opioid prescribing and conduct value-based pilots of nonpharmacologic pain treatments.

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

Patient-Centered Care/Experience

Satisfaction with Provider

Patient experience is important because it is a unique indicator of health facility performance in the critical areas of safety, access, and quality of care. There is a growing body of evidence that shows that better patient experiences are closely related to patients adhering to preventive measures and treatment protocols, better patient safety within hospitals, less need to seek further treatment after an encounter, better quality of care from hospital staff, and overall better patient outcomes, including both medical and surgical care.

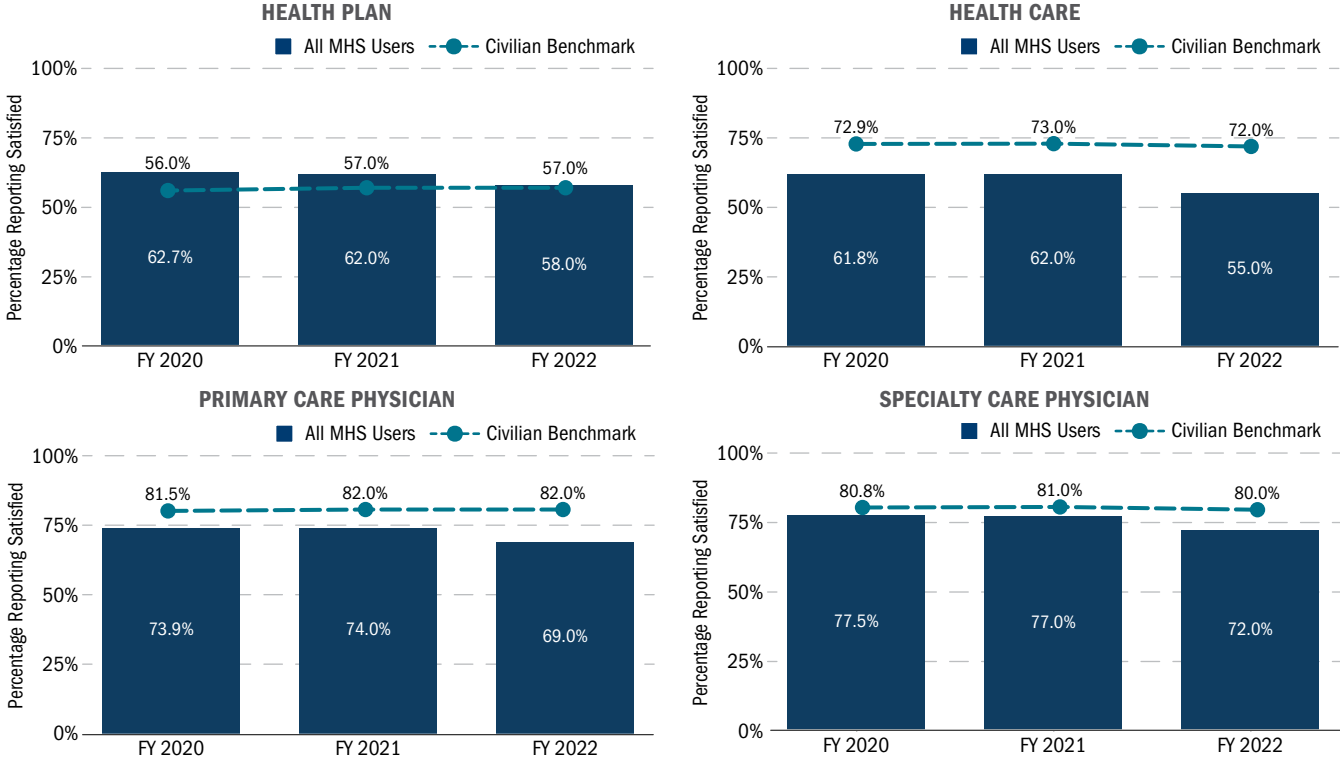
In this section, MHS beneficiaries in the U.S. who have used TRICARE are compared with the civilian benchmark with respect to ratings of (1) the health plan in general; (2) health care; (3) their personal physician; and (4) specialty care. Health plan ratings depend on access to care and how the plan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

Beneficiary Ratings of Their Health Plan through Population-Based Surveys

The population-based HCSDB is based on the CAHPS Health Plan survey and is used to routinely assess MHS beneficiary experience with health care, whether in the direct or private sector care systems or with other health insurance (OHI). Unlike JOES and JOES-C, which follow an outpatient visit, or the TRISS, which follows a discharge from a hospital, the HCSDB is based on a sample of all MHS-eligible beneficiaries worldwide who may or may not have had an outpatient or inpatient encounter in the previous year. Results from the HCSDB can be compared with civilian health plans, providing a good benchmark for MHS performance measurement. Results of the HCSDB for the past three years on key aspects of a health plan are presented below.

- MHS beneficiary satisfaction with their health plan, health care, primary care physician (i.e., personal doctor), and specialty care physician remained relatively the same in FYs 2020 and 2021, but showed a significant decline in FY 2022.
- MHS beneficiary satisfaction with their health plan exceeded that of the civilian benchmark in each year from FY 2020 to FY 2022. However, MHS beneficiary satisfaction with health care quality, their personal doctor, and specialty care physicians were lower than the comparable civilian benchmarks.

TRENDS IN SATISFACTION RATINGS OF KEY HEALTH PLAN ASPECTS, FYs 2020–2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 12/15/2022

Notes:

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

– Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used in 2020 come from NCQA's 2017 data and in 2021–2022 from NCQA's 2019 data.

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

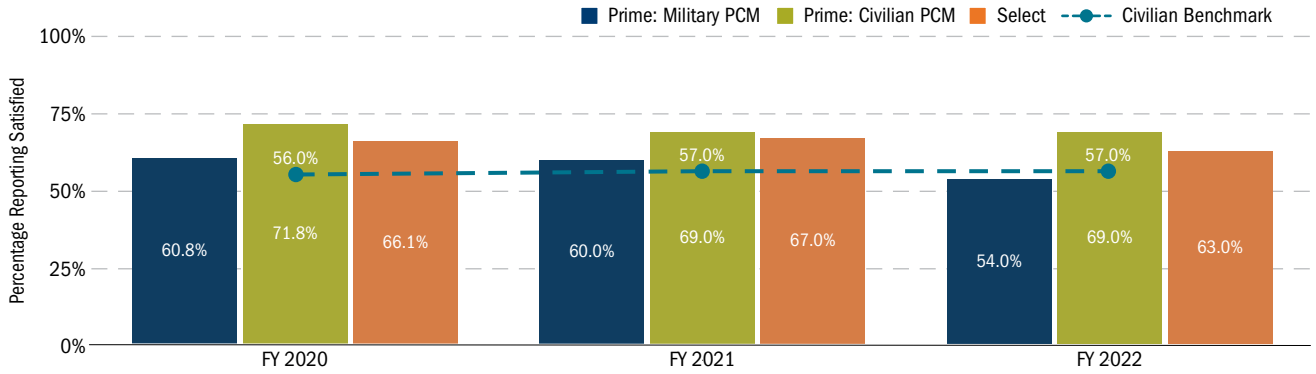
Patient-Centered Care/Experience *(cont.)*

Beneficiary Ratings of Their Health Plan Based on Enrollment Status

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

- Satisfaction with the TRICARE health plan decreased by 4 percentage points for Select enrollees from FY 2021 to FY 2022 and by 6 percentage points for Prime enrollees with a military PCM. Prime enrollees with a civilian PCM remained the same for the same time period.
- For each year between FY 2020 and FY 2022, all MHS enrollment groups reported higher levels of satisfaction with their health plan than the civilian benchmark with the exception of the Prime enrollees with a military PCM in FY 2022.

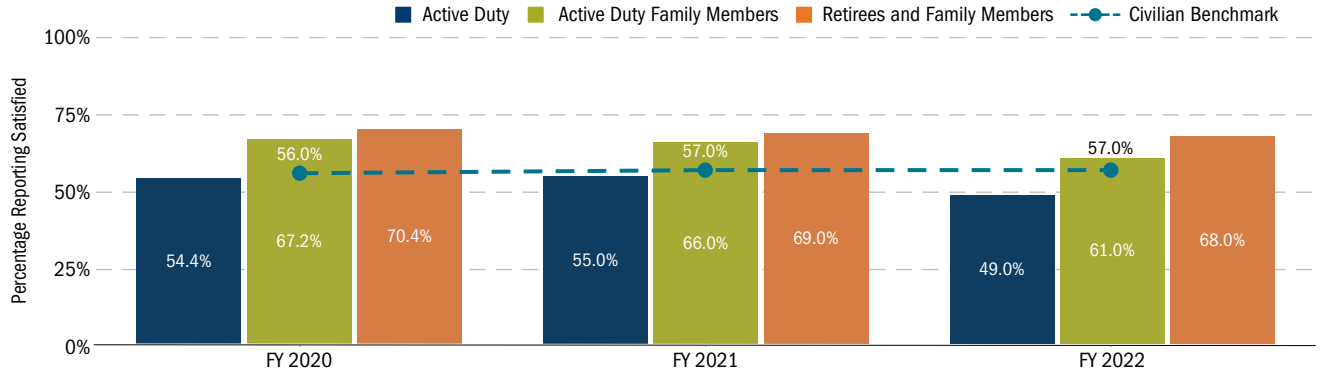
TRENDS IN SATISFACTION WITH THE HEALTH PLAN BY ENROLLMENT STATUS, FYs 2020–2022



Beneficiary Ratings of Their Health Plan Based on Beneficiary Category

- Satisfaction with the TRICARE health plan declined by 5 percentage points from FY 2020 to FY 2022 for Active Duty, 6 percentage points for ADFMs, 2 percentage points for retirees and their families.
- Satisfaction with health plan scores for Active Duty was below the benchmark in FY 2022.

TRENDS IN SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY, FYs 2020–2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 12/15/2022

Note: Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used in 2020 come from NCQA's 2017 data and in 2021–2022 from NCQA's 2019 data.

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

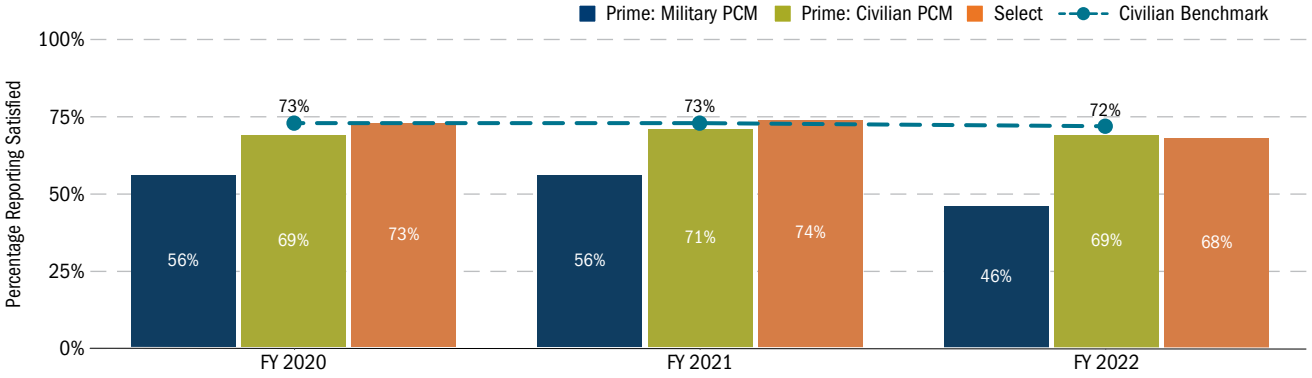
Patient-Centered Care/Experience *(cont.)*

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

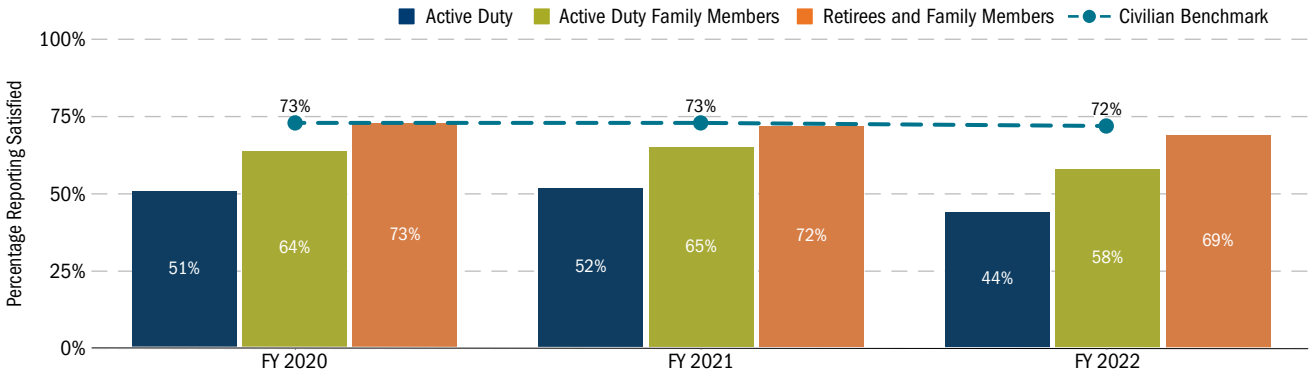
Similar to satisfaction with the TRICARE health plan, satisfaction levels with the health care received differ by beneficiary category and enrollment status.

- Beneficiary satisfaction with their health care declined slightly between FY 2021 and FY 2022 by enrollment status.
- In FY 2022, satisfaction with health care for beneficiaries with military and civilian PCMs were lower than the civilian benchmark.
- Satisfaction with health care for Active Duty and ADFMs were below the civilian benchmark for each year between FY 2020 and FY 2022 and decreased by approximately 8 percentage points between FY 2021 and FY 2022.

TRENDS IN SATISFACTION WITH TRICARE HEALTH CARE BY ENROLLMENT STATUS, FYs 2020–2022



TRENDS IN SATISFACTION WITH TRICARE HEALTH CARE BY BENEFICIARY CATEGORY, FYs 2020–2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 12/15/2022

Note: Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used in 2020 come from NCQA's 2017 data and in 2021–2022 from NCQA's 2019 data.

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

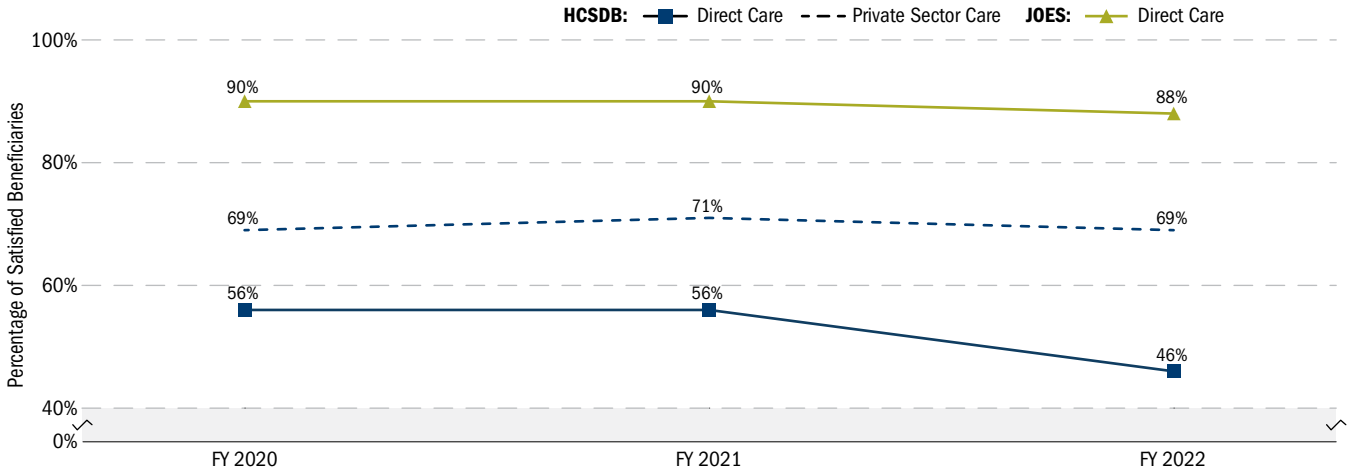
Patient-Centered Care/Experience *(cont.)*

DHA Surveys—Satisfaction with Care and Health Care Rating

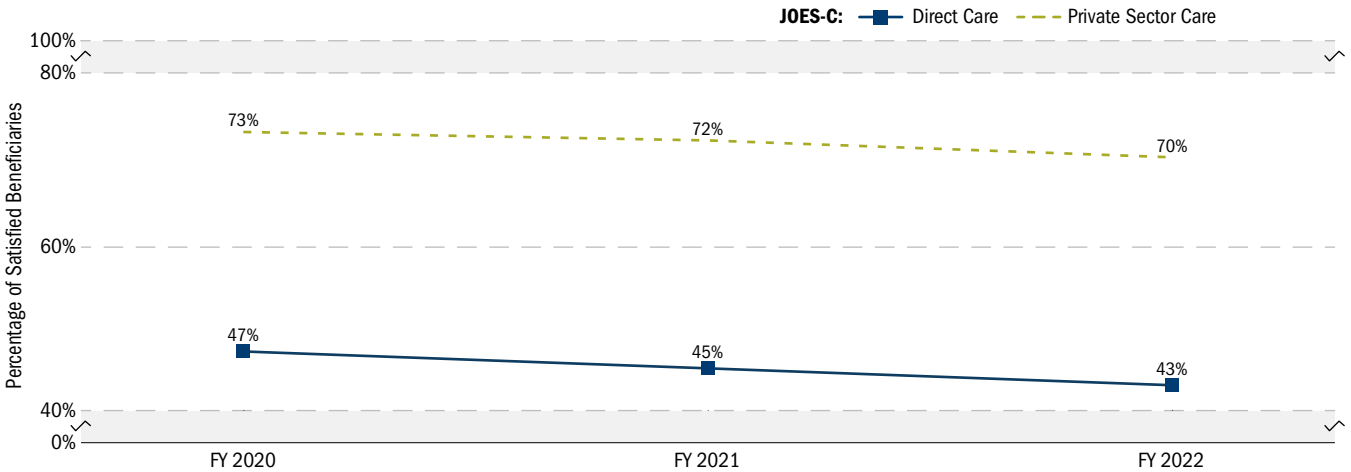
In addition to JOES and JOES-C, the population-based HCSDB survey also reports results for the Satisfaction with Care measure. Including this same item in each survey provides important information about the differences between surveys and the beneficiaries who answer them.

- From FY 2020 to FY 2022, JOES direct care beneficiaries reported the greatest satisfaction with care when compared with beneficiaries responding to HCSDB direct care or private sector care. HCSDB private sector care users reported greater satisfaction with care than those using direct care from FY 2020 through FY 2022.
- HCSDB private sector care scores for satisfaction with care were relatively stable from FY 2020 to FY 2022, while HCSDB direct care decreased by 10 percentage points.
- JOES-C health care rating scores for private sector care decreased by 3 percentage points from FY 2020 to FY 2022, while still above those for JOES-C direct care.

HCSDB AND JOES RATINGS OF SATISFACTION WITH CARE, FYs 2020–2022



JOES-C HEALTH CARE RATING, FYs 2020–2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB, JOES, and JOES-C, compiled 1/6/2023

Notes:

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

– The data above reflects the HCSDB Health Care Rating for 2019–2022: "Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate your health care?" The results reported above are for those beneficiaries who provided a rating of 8, 9, or 10.

– Results for JOES-C FY 2022 is from October 2021 to July 2022 for direct care and from October 2021 to June 2022 for private sector care. Satisfaction with Care is worded similarly in JOES and HCSDB surveys as the following statement: "Overall, I am satisfied with the health care I received on this visit." The five-point scale response for this question ranges from "strongly disagree" to "strongly agree." The results provided above are for those beneficiaries who reported either "somewhat agree" or "strongly agree."

– Health Care Rating in JOES-C is worded as the following statement: "Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate your health care?" The results reported above are for those beneficiaries who provided a rating of 9 or 10.

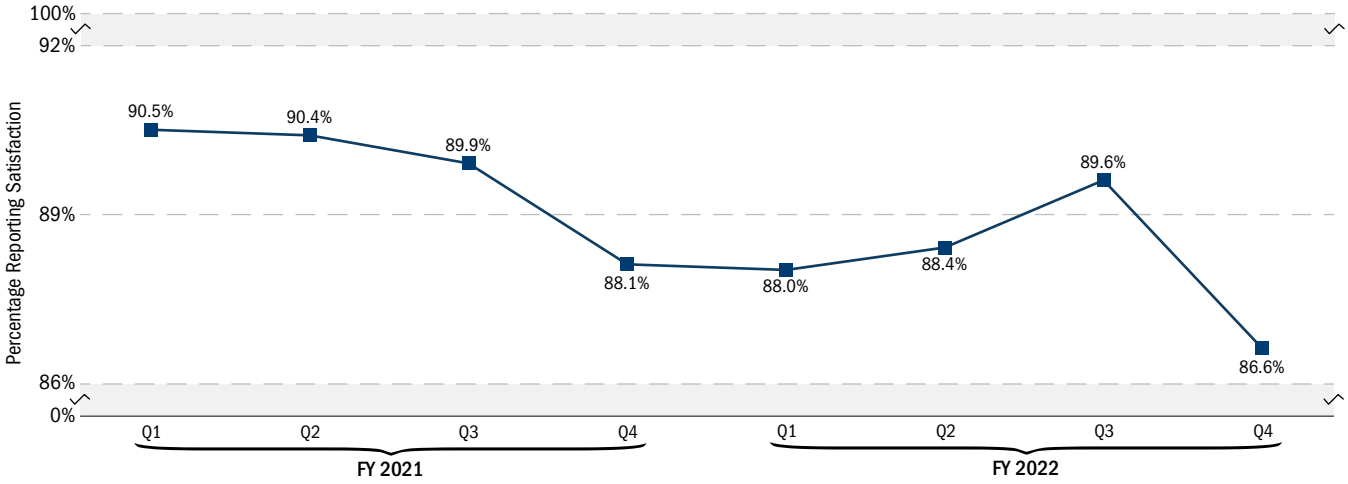
HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

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

JOES Satisfaction with Care

From FY 2021 Q1 through FY 2022 Q4, Satisfaction with Care scores from JOES dropped by approximately 4 percentage points.

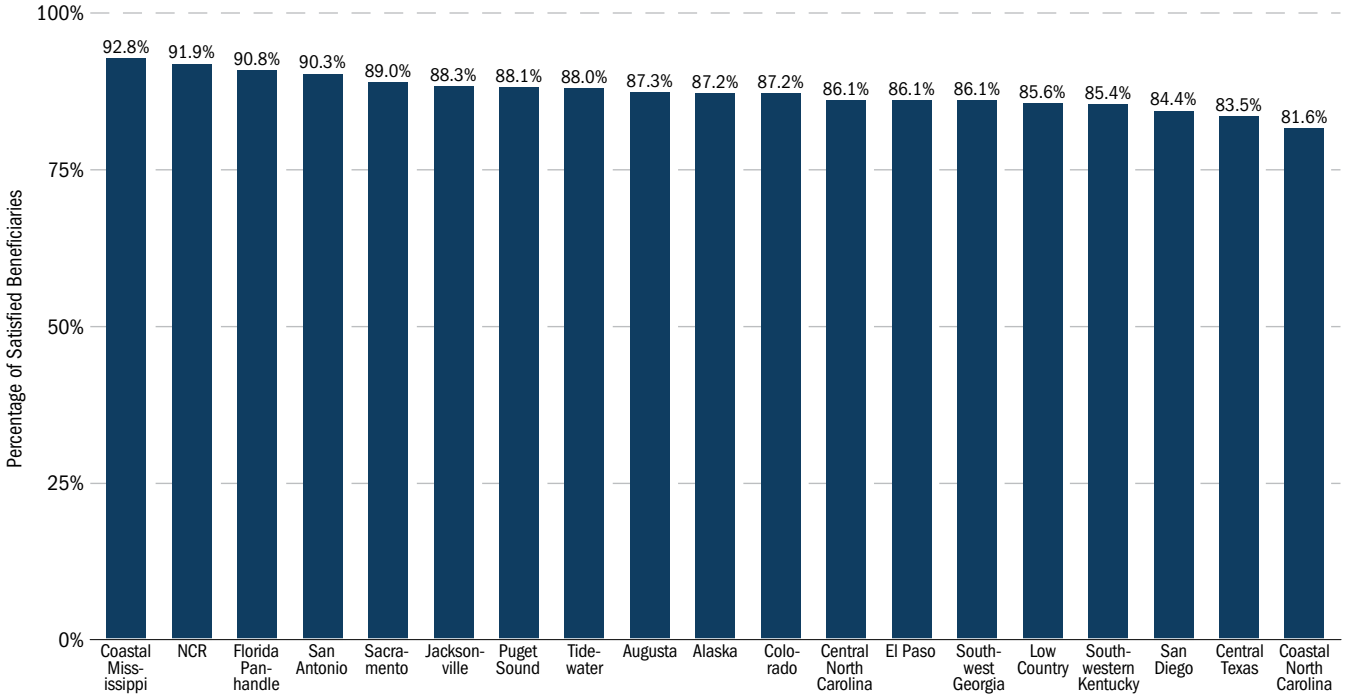
JOES SATISFACTION WITH CARE, FYs 2021–2022



The chart below shows JOES Satisfaction with Care by DHA Markets in FY 2022.

- At the end of FY 2022, Coastal Mississippi was the highest scoring Market for Satisfaction with Care at 92.8 percent, while Coastal North Carolina was the lowest at 81.6 percent satisfaction.

JOES SATISFACTION WITH CARE BY MARKET, FY 2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES, weighted data compiled 1/6/2023

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

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

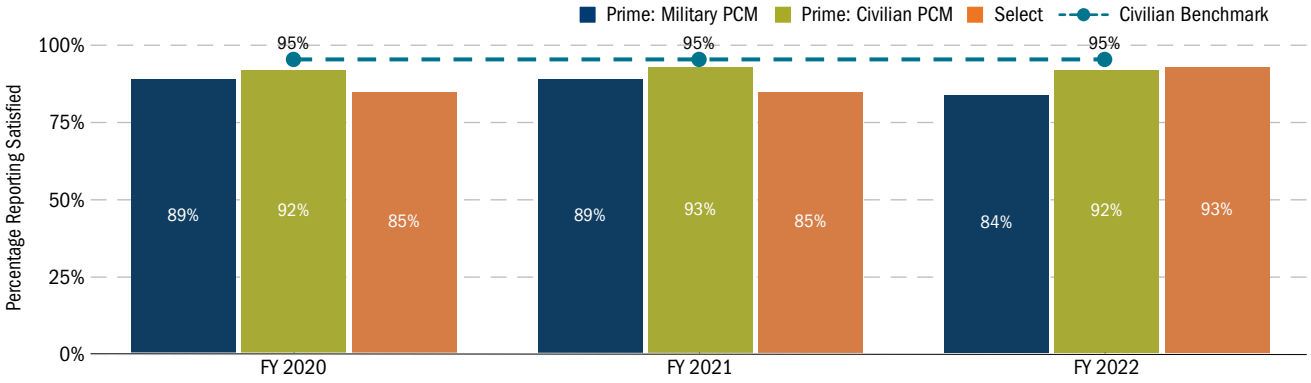
Patient-Centered Care/Experience *(cont.)*

Satisfaction with Doctors' Communication

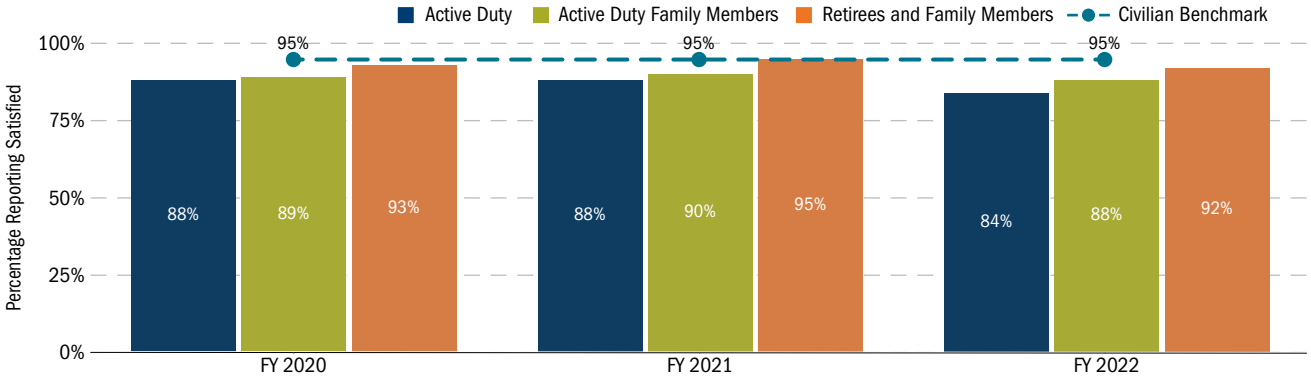
Communication between doctors and patients is an important factor in beneficiaries' satisfaction and their ability to obtain appropriate care. The following charts present beneficiary-reported perceptions of how well their doctor communicates with them.

- Between FY 2020 and FY 2022, satisfaction with doctors' communication decreased by 5 percentage points for Prime enrollees with a military PCM, while satisfaction for Tricare Select enrollees increased by 8 percentage points. Prime enrollees with a civilian PCM remained relatively stable for all three years.
- Satisfaction with doctors' communication was below the benchmark for Prime enrollees with a military or civilian PCM for all three years.
- Satisfaction with doctors' communication showed a slight decline between FY 2021 and FY 2022 for Active Duty, ADFMs, and retirees and family members (RETFMs).
- Satisfaction with doctors' communication was lower than the civilian benchmark for Active Duty and ADFMs in FY 2022.

TRENDS IN SATISFACTION WITH DOCTORS' COMMUNICATION BY ENROLLMENT STATUS, FYs 2020–2022



TRENDS IN SATISFACTION WITH DOCTORS' COMMUNICATION BY BENEFICIARY CATEGORY, FYs 2020–2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 12/15/2022

Note: Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used in 2020 come from NCQA's 2017 data and in 2021 and 2022 from NCQA's 2019 data.

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

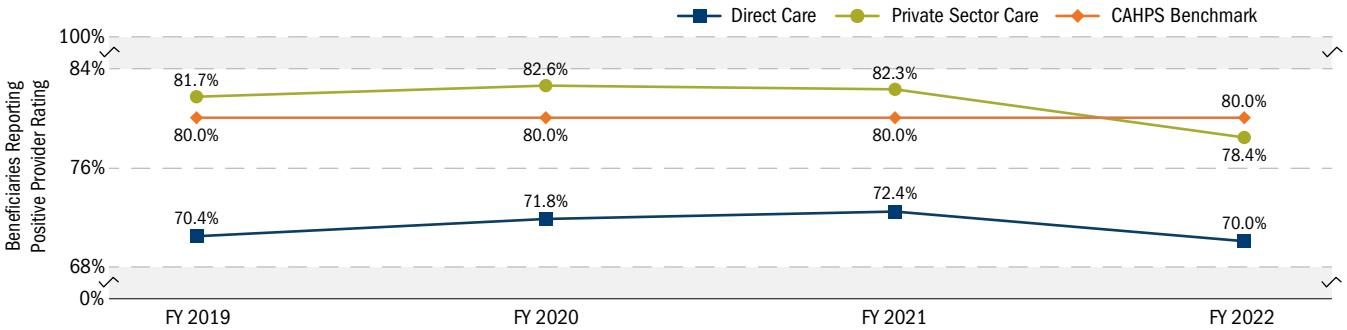
Patient-Centered Care/Experience *(cont.)*

Beneficiary Ratings of Provider Following Outpatient Treatment

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

- The rating of provider from FY 2019 to FY 2022 remained relatively constant for JOES-C direct care. From FY 2019 to FY 2022, scores remained below the civilian CAHPS benchmark for direct care.
- Rating of provider scores for JOES-C private sector care have remained about the same from FY 2019 to FY 2021 at 82 percent, with a slight decline in FY 2022 at 78.4 percent. Scores were above the civilian CAHPS benchmark except in FY 2022.

JOES-C RATING OF PROVIDER, FYs 2019–2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES-C weighted data, compiled 1/6/2023

Notes:

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

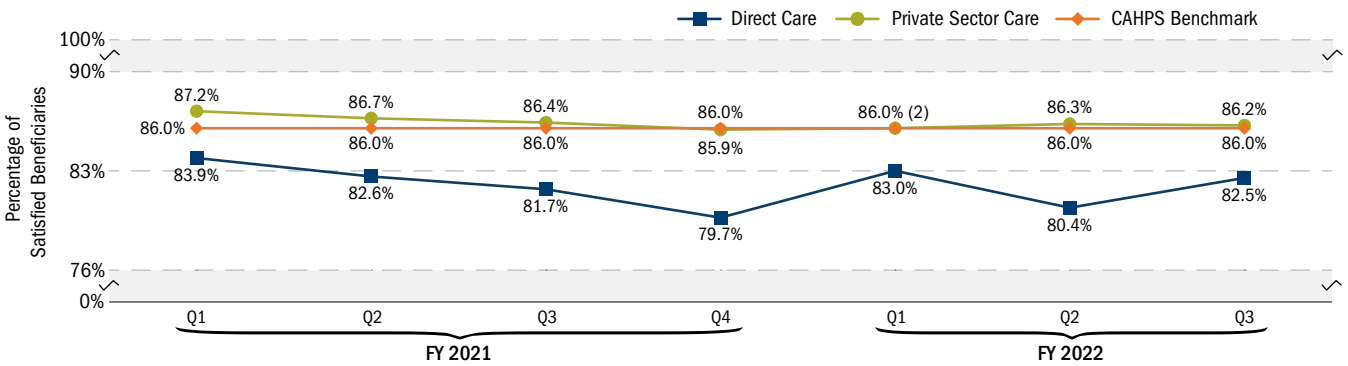
– Results for JOES-C FY 2022 is from October 2021 to July 2022 for direct care and from October 2021 to June 2022 for private sector care.

Provider Communication

As detailed in Drivers of Patient Experience Ratings on pages 164–165, communication between the beneficiary and their provider is one of the leading drivers of overall patient satisfaction across care settings, in both outpatient and inpatient care, and is cross-validated by the core surveys (JOES, JOES-C, TRISS, and HCSDB). The patient experience surveys measure provider communication (or doctor and nurse communication) from the beneficiary's perspective, and it remains vitally important to quality of care ratings. Some of the questions in these surveys ask: was the provider understandable, did the provider listen, was the provider respectful, and did the provider spend enough time with the patient. The results of these questions make up the score for the provider communication composite measure. These results can be compared with nationally representative civilian and military benchmarks, and can be compared across all levels of the MHS.

- For FY 2021 and FY 2022, private sector care scores for provider communication were at or exceeded the benchmark, while direct care scores have fallen below.
- Provider communication scores for direct care range from 80 to 84 percent satisfaction in FY 2021 and FY 2022. Private sector care scores range from 86 to 88 percent for the same period.

JOES-C PROVIDER COMMUNICATION, FY 2021 Q1–FY 2022 Q3



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES-C, weighted data, compiled 1/6/2023

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

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

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

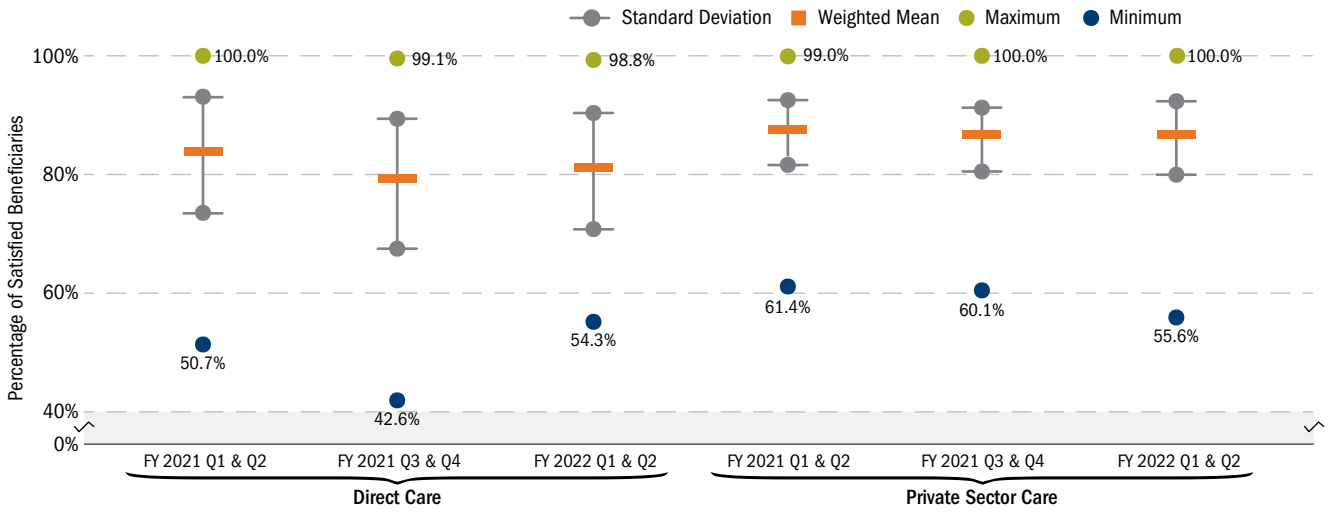
Provider Communication

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

- From FY 2021 Q1 & Q2 to FY 2022 Q1 & Q2, the median score and weighted mean for the provider communication composite direct care decreased by 4.5 percentage points and 3 percentage points, respectively.
- For private sector care from FY 2021 Q1 & Q2 to FY 2022 Q1 & Q2, the median score and weighted mean for the provider communication composite decreased slightly at less than 1 percentage point each.

JOES-C: PROVIDER COMMUNICATION COMPOSITE, FY 2021 Q1 & Q2 TO FY 2022 Q1 & Q2

	FY 2021 Q1 & Q2	FY 2021 Q3 & Q4	FY 2022 Q1 & Q2	% POINT CHANGE FY 2021 Q1 & Q2 TO FY 2022 Q1 & Q2
JOES-C DIRECT CARE				
Number of Respondents	5,901	5,896	5,506	
Service Score (Mean)	83.4%	78.5%	80.4%	-2.9
Standard Deviation	9.7%	11.0%	9.7%	0.0
Median	85.8%	79.8%	81.2%	-4.5
75th Percentile	89.4%	86.2%	87.8%	-1.6
25th Percentile	78.3%	74.1%	76.1%	-2.2
Maximum	100.0%	99.1%	98.8%	-1.2
Minimum	50.7%	42.6%	54.3%	3.6
Range	49.3%	56.5%	44.5%	-4.8
JOES-C PRIVATE SECTOR CARE				
Number of Respondents	27,182	25,466	25,019	
Service Score (Mean)	87.0%	86.0%	86.2%	-0.8
Standard Deviation	5.6%	5.3%	6.1%	0.5
Median	87.5%	86.6%	86.6%	-0.9
75th Percentile	90.0%	89.3%	90.0%	-0.1
25th Percentile	84.8%	83.6%	83.1%	-1.7
Maximum	99.0%	100.0%	100.0%	1.0
Minimum	61.4%	60.1%	55.6%	-5.8
Range	37.6%	39.9%	44.4%	6.8



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES-C, weighted data, compiled 12/19/22

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

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

Beneficiary Ratings of Care Following Inpatient Treatment

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

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

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

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

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

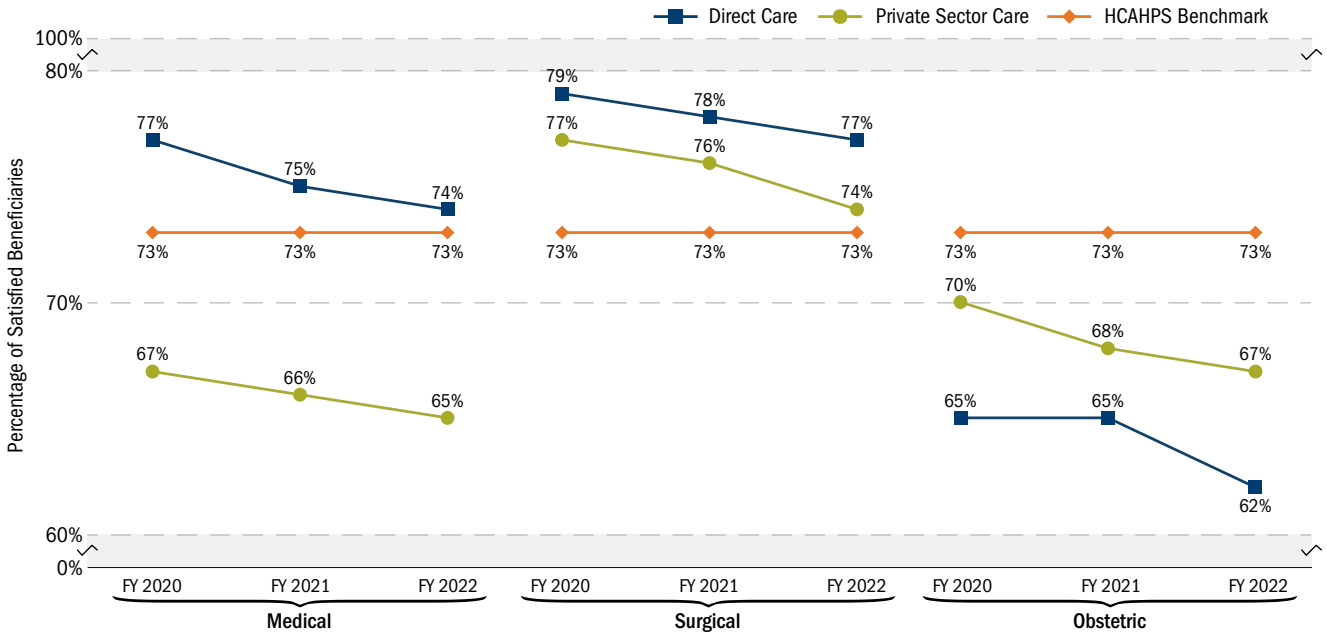
In the following sections, we detail specific findings focused primarily on two measures of patient experience: overall rating of the hospital and willingness to recommend the hospital to others. Inpatient facilities with fewer than 25 responses are not included in the analyses. These results are produced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

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

Overall Hospital Rating

Overall hospital rating is measured by the TRISS question "Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?" Scores are shown for those who indicated 9 or 10. Overall, the medical and surgical product lines of direct care have exceeded the national HCAHPS benchmark in overall hospital rating from FY 2020 to FY 2022, while the obstetric product line of direct care is below the national HCAHPS benchmark during the same time period. The surgical product lines of private sector care has exceeded the national HCAHPS benchmark in overall hospital rating from FY 2020 to FY 2022. However, the medical and obstetric product lines of private sector care are below the national HCAHPS benchmark in overall hospital rating from FY 2020 to FY 2022.

TRISS OVERALL HOSPITAL RATING BY PRODUCT LINE, FYs 2020–2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 1/6/2023

Notes:

– FY 2022 includes results from FY 2022 Q1–Q3 for direct care and FY 2022 Q1–Q2 for private sector care.

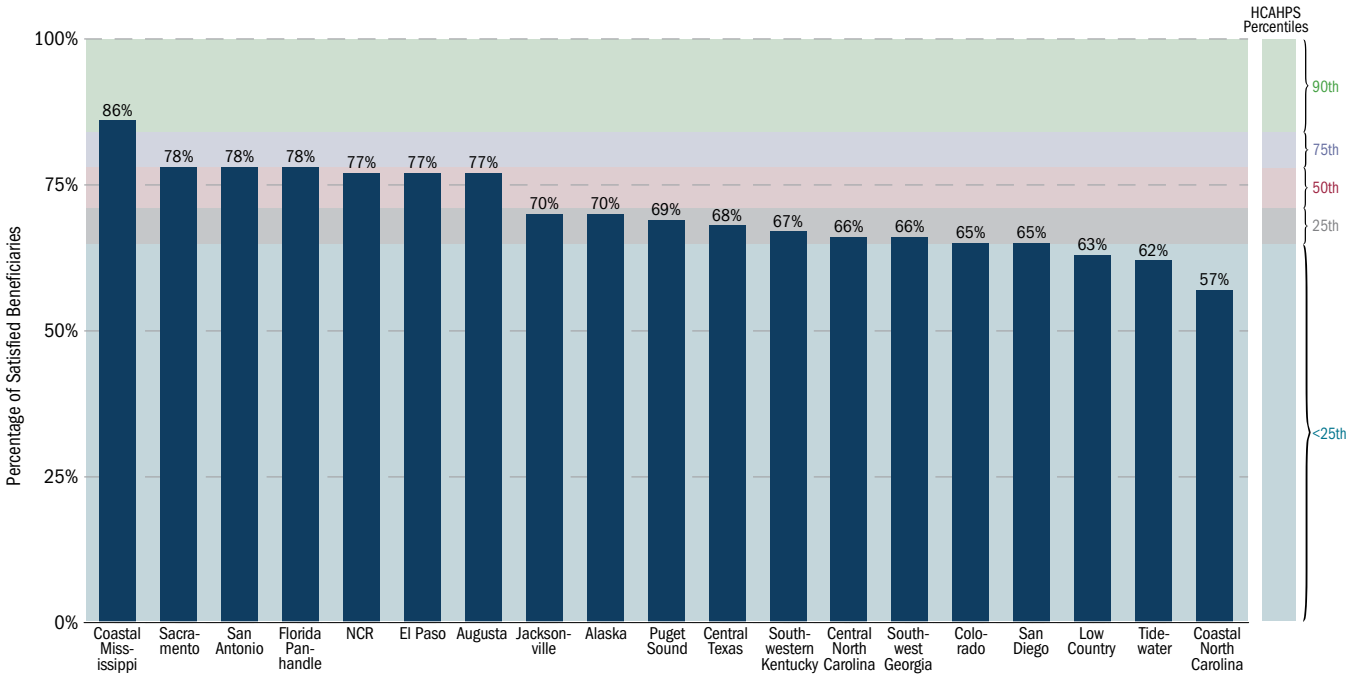
– HCAHPS benchmarks are the U.S. scores from the October 2020, October 2021, and October 2022 HCAHPS Public Reports.

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

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

The chart below shows the distribution for overall hospital ratings by Market for FY 2022. The Coastal Mississippi Market has the highest overall rating of the hospital at 86 percent satisfaction, while the Coastal North Carolina Market is lowest at 57 percent overall hospital rating.

TRISS OVERALL HOSPITAL RATING BY MARKET: DIRECT CARE, FY 2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 1/9/2023

Notes:

– FY 2022 includes results from FY 2022 Q1–Q3.

– The increment of the above percentiles was set at <25th, 25th, 50th, 75th, and 90th. HCAHPS percentiles are based on the October 2022 Public Report. More information about these percentiles can be found at: https://www.hcahpsonline.org/en/summary-analyses/.

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

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

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

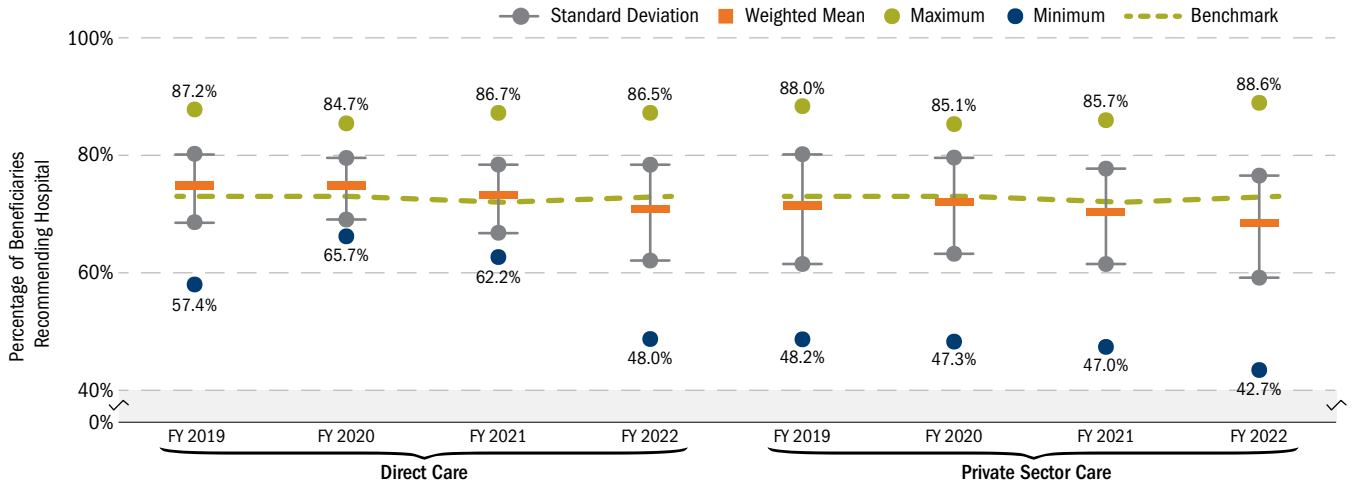
- From FY 2019 to FY 2022, direct care decreased by 4.0 percentage points with regard to the mean; median ratings decreased by 4.9 percentage points between FY 2019 and FY 2022.
- From FY 2019 to FY 2022, private sector care scores decreased in terms of the mean by 2.9 percentage points and median by 3.6 percentage points.

TRISS OVERALL HOSPITAL RATING: FYs 2019–2022

	FY 2019	FY 2020	FY 2021	FY 2022	% POINT CHANGE (FY 2019–FY 2022)
DIRECT CARE					
Number of Respondents	36,678	32,309	32,097	17,347	
Weighted Mean	74.4%	74.3%	72.6%	70.4%	-4.0
Standard Deviation	6.0%	5.3%	5.8%	8.2%	2.2
Median	73.9%	74.9%	72.2%	69.0%	-4.9
75th Percentile (Q3)	77.3%	77.8%	75.4%	77.0%	-0.3
25th Percentile (Q1)	72.4%	70.0%	69.5%	65.9%	-6.5
Maximum	87.2%	84.7%	86.7%	86.5%	-0.7
Minimum	57.4%	65.7%	62.2%	48.0%	-9.3
Range	29.8%	19.1%	24.5%	38.5%	8.7
PRIVATE SECTOR CARE					
Number of Respondents	20,502	21,003	22,435	10,544	
Weighted Mean	70.9%	71.6%	69.7%	68.0%	-2.9
Standard Deviation	9.2%	8.2%	8.4%	9.0%	-0.2
Median	71.5%	72.9%	70.7%	67.9%	-3.6
75th Percentile (Q3)	77.5%	77.7%	76.4%	75.0%	-2.5
25th Percentile (Q1)	65.2%	66.6%	63.6%	62.7%	-2.5
Maximum	88.0%	85.1%	85.7%	88.6%	0.6
Minimum	48.2%	47.3%	47.0%	42.7%	-5.5
Range	39.8%	37.8%	38.7%	45.9%	6.1

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/20/2022
Note: FY 2022 includes results from Q1–Q3 for direct care and Q1–Q2 for private sector care.

VARIABILITY IN TRISS OVERALL HOSPITAL RATINGS, FYs 2019–2022



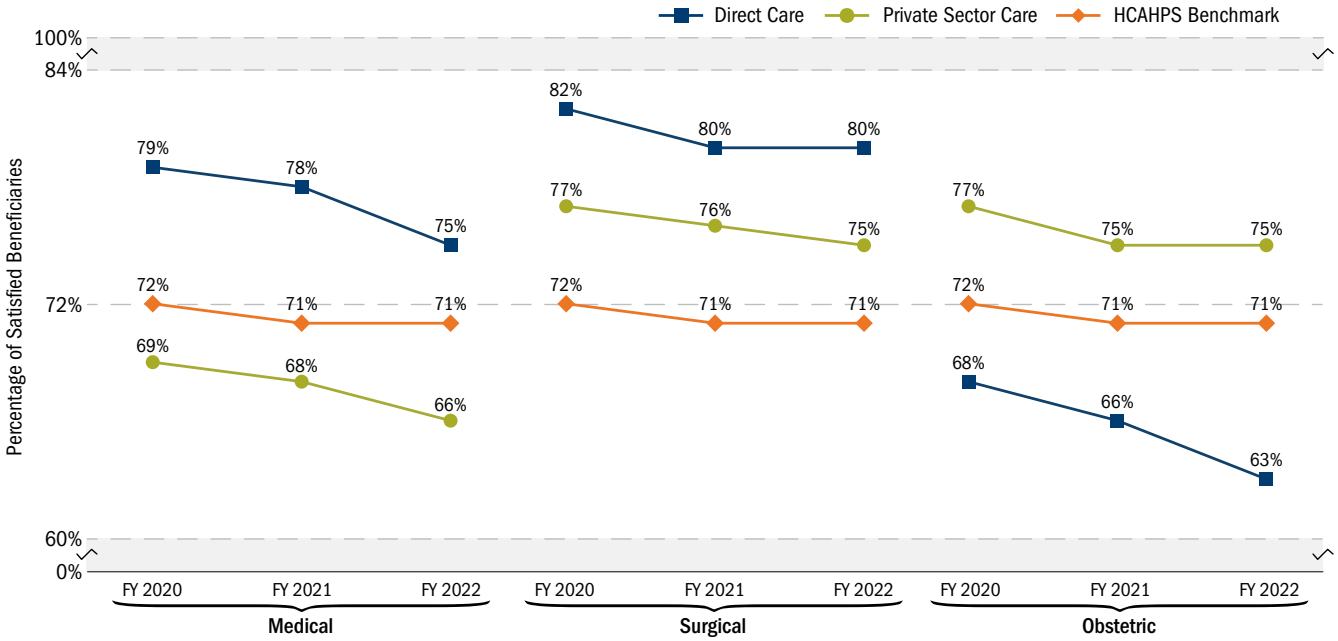
Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/20/2022
Notes:
– FY 2022 includes Q1–Q3 for direct care and Q1–Q2 for private sector care results.
– HCAHPS benchmarks are U.S. scores from the October 2019, July 2020, and October 2021 HCAHPS Public Reports.

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

Beneficiary Recommendation of Hospital Following Inpatient Treatment

Hospital recommendation is measured by the TRISS question "Would you recommend this hospital to your friends and family?" with response options of definitely no, probably no, probably yes, definitely yes. Scores are shown for those who indicated definitely yes. The medical and surgical product lines of direct care have exceeded the national HCAHPS benchmark in recommending the hospital from FY 2020 to FY 2022. The obstetric product line of direct care is below the national HCAHPS benchmark during this time period and has fallen from 68 percent in FY 2020 to 63 percent in FY 2022. The surgical and obstetric product lines of private sector care have exceeded the national HCAHPS benchmark in recommending the hospital from FY 2020 to FY 2022; however, the medical product line of private sector care is below the national HCAHPS benchmark.

TRISS RECOMMEND HOSPITAL RATING BY PRODUCT LINE, FYs 2020–2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 1/10/2023

Notes:

– FY 2022 includes results from FY 2022 Q1–Q3 for direct care and Q1–Q2 for private sector care.

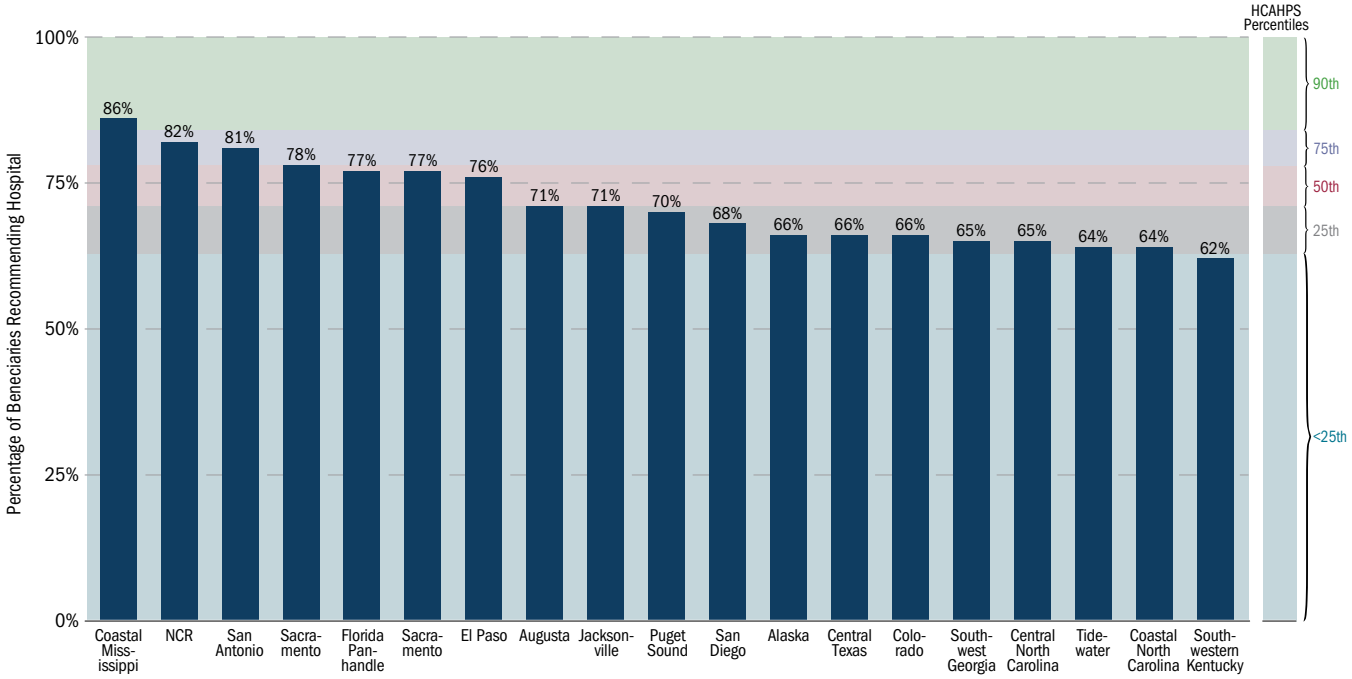
– HCAHPS benchmarks are the U.S. scores from the July 2020, October 2021, October 2022 HCAHPS Public Reports.

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

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

The chart below shows the distribution for recommend hospital scores of the DHA Markets for FY 2022. The Coastal Mississippi Market has the highest rating at 86 percent satisfaction, followed by the NCR Market at 82 percent. The Southwestern Kentucky Market is the lowest scoring Market for recommend the hospital at 62 percent.

TRISS RECOMMEND HOSPITAL BY MARKET, FY 2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 1/10/2023

Notes:

– FY 2021 includes results from FY 2022 Q1–Q3.

– The increment of the above percentiles was set at <25th, 25th, 50th, 75th, and 90th. HCHAPS percentiles are based on the October 2022 Public Report. More information about these percentiles can be found at: https://www.hcahpsonline.org/en/summary-analyses/.

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

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

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

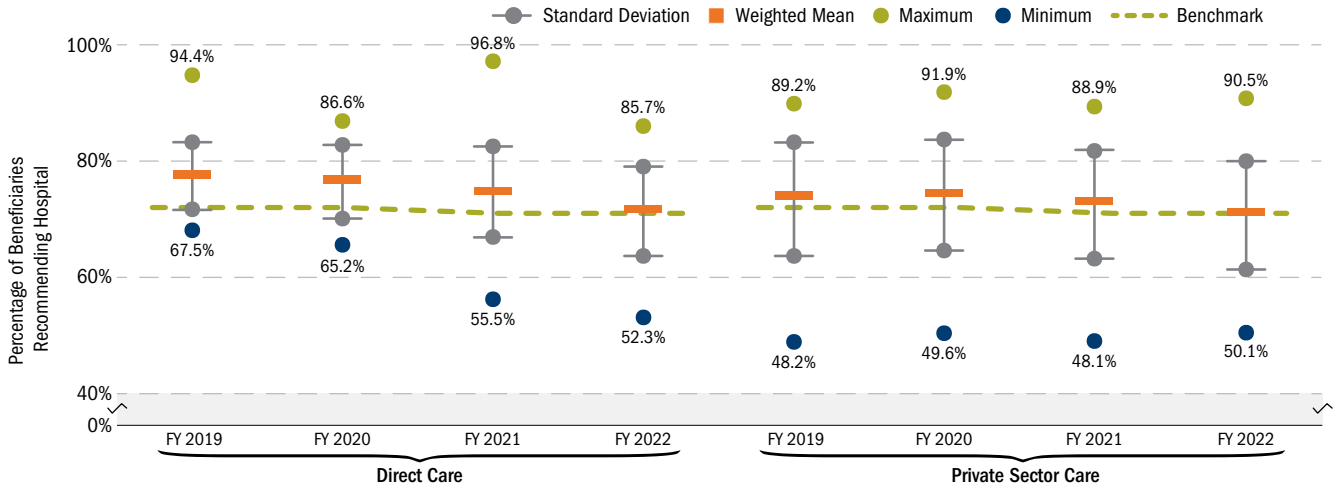
- From FY 2019 to FY 2022, direct care decreased by 6.1 percentage points with regard to the mean; median ratings decreased by 5.6 percentage points between FY 2019 and FY 2022.
- From FY 2019 to FY 2022, private sector care mean and median scores both decreased by 2.7 percentage points.

TRISS RECOMMEND HOSPITAL RATING: FYs 2019–2022

	FY 2019	FY 2020	FY 2021	FY 2022	% POINT CHANGE (FY 2019–FY 2022)
DIRECT CARE					
Number of Respondents	36,581	32,192	31,991	17,258	
Weighted Mean	77.5%	76.3%	74.5%	71.3%	-6.1
Standard Deviation	6.0%	6.3%	7.7%	7.6%	1.6
Median	76.2%	76.3%	73.2%	70.6%	-5.6
75th Percentile	80.6%	79.1%	78.5%	76.9%	-3.7
25th Percentile	73.4%	71.2%	70.6%	65.5%	-7.9
Maximum	94.4%	86.6%	96.8%	85.7%	-8.7
Minimum	67.5%	65.2%	55.5%	52.3%	-15.2
Range	26.8%	21.4%	41.2%	33.4%	6.6
PRIVATE SECTOR CARE					
Number of Respondents	20,473	20,939	22,403	10,488	
Weighted Mean	73.5%	74.2%	72.4%	70.8%	-2.7
Standard Deviation	10.0%	9.4%	9.3%	9.4%	-0.6
Median	73.7%	74.8%	73.7%	71.0%	-2.7
75th Percentile (Q3)	81.2%	82.2%	79.2%	77.9%	-3.3
25th Percentile (Q1)	68.3%	68.6%	65.7%	64.5%	-3.7
Maximum	89.2%	91.9%	88.9%	90.5%	1.3
Minimum	48.2%	49.6%	48.1%	50.1%	2.0
Range	41.1%	42.4%	40.7%	40.4%	-0.6

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/20/2022
Note: FY 2022 includes results from Q1–Q3 for direct care and Q1–Q2 for private sector care.

VARIABILITY IN TRISS RECOMMEND HOSPITAL RATINGS, FYs 2019–2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/20/2022
Notes:
– FY 2022 includes results from FY 2022 Q1–Q3 for direct care and Q1–Q2 for private sector care.
– HCAHPS benchmarks are U.S. scores from the October 2019, July 2020, and October 2021 HCAHPS Public Reports.

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

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

Patient Experience Star Ratings—Inpatient Facilities

Star ratings are used by CMS to enable consumers to assess patients' experience of care across health care facilities. The summary star rating for patient experience takes into account all 10 publicly reported HCAHPS measures, referenced on page 154, including Overall Hospital Rating and Recommend Hospital as components. Official star ratings, including for military hospitals in the United States, are posted publicly on the CMS Care Compare website. The MHS calculates star ratings similar to the method employed by CMS using the most recently available civilian benchmarks, and these results are published on the TRISS reporting website.

The MHS performed very well as measured by star ratings from FY 2021 Q4 to FY 2022 Q3. Three stars can be considered an "average" patient experience; therefore, most of the MHS facilities are performing above average in terms of patient care, with 18 four-star-rated facilities and one facility rated as five-star.

PATIENT EXPERIENCE STAR RATINGS, FY 2021 Q4–FY 2022 Q3

★★★★★	★★★★	★★★
1 FACILITY	18 FACILITIES	13 FACILITIES

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 12/19/2022
Note: One hundred responses to TRISS within the year were required to receive a summary star rating.

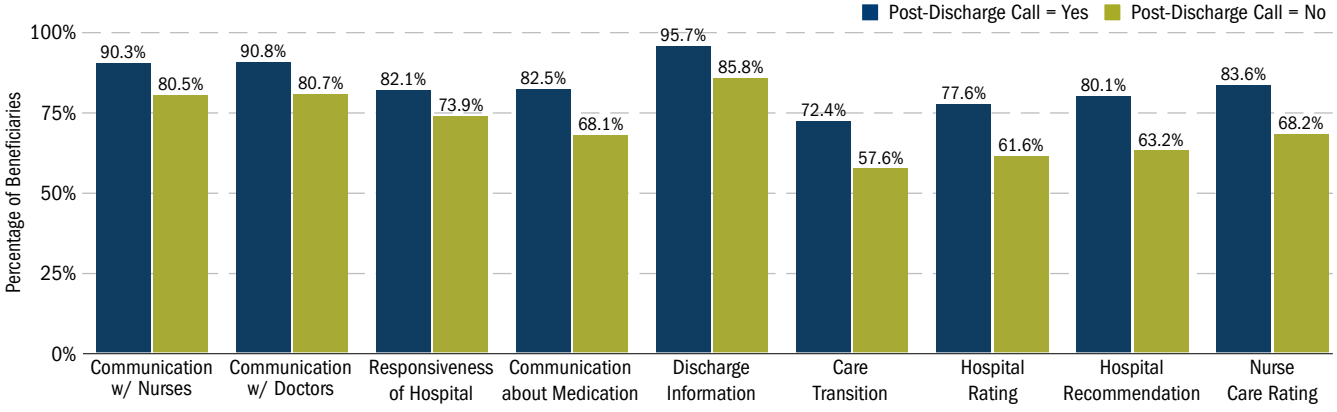
Leading Nurse Engagement Practices

Across the care continuum, strong nurse-patient relationships are critical to positively impacting patient experience and clinical outcomes and reducing hospital costs.[1,2] The MHS assesses the relationship between nurses and MHS beneficiaries by collecting data on the use of evidence-based nurse engagement practices—nurse hourly rounding, nurse leader visits, post-discharge staff phone calls, and care planning—with beneficiaries at MTFs and civilian hospitals. The TRISS questionnaire collects information on nurse engagement practices in addition to the core set of patient experience measures adopted from HCAHPS (ref. page 154). The Huron Consulting Group, formerly Studer Group, developed the nurse engagement questions as a part of its effort to improve health care outcomes and the HCAHPS.[2]

Hospitals that focused on engagement of staff and patients through prioritized implementation of leading nurse engagement practices report improved patient experience scores.[3] Hourly rounds with patients are associated with raised patient satisfaction and safety and decreased use of call lights, patient falls, and skin breakdown. Nurse leader visits provide leadership opportunities to recognize nursing staff members, assess staff needs, and improve patients' perception of care. Routine nurse calls to patients following discharge reduces the risk of medication errors, procedure-related injuries, and readmissions. Patients included in the planning of care are observed to have greater trust in staff and a better perception of their care.[4] Analysis of the TRISS MTF results show that incorporating these leading practices in the inpatient care setting has highly significant, positive impacts on patient satisfaction. The next four exhibits show TRISS results for FY 2022 (through Q3) for each Huron-Studer question. Ratings of the top two most positive response options for each patient experience composite or single-item measure are assessed in relation to the individual nurse engagement practice measures.

- For all leading nurse engagement practices, MHS beneficiaries admitted at MTFs who reported receiving a leading practice rated their patient experience more positively than those who did not.
- Discharge information was the most positively rated patient experience among the groups of beneficiaries who reported receiving or not receiving a leading practice.
- Communication with Nurses and Communication with Doctors measures rated positively by 90 percent or more beneficiaries for all leading nurse engagement practices except nurse leader visit.

TRISS RATINGS OF PATIENT EXPERIENCE WHEN BENEFICIARIES REPORTED RECEIVING OR NOT RECEIVING A POST-DISCHARGE STAFF PHONE CALL, FY 2022



Source: DHA/SP& FI (J5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 1/13/2023

[1] Calvin Chou, "Time to Start Using Evidence-Based Approaches to Patient Engagement," *New England Journal of Medicine Catalyst* 2018, https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0220.

[2] Improving HCAHPS: A Guide to Increasing Patient Satisfaction Scores, Huron Consulting Group Blog, accessed January 18, 2022. https://www.huronconsultinggroup.com/insights/improving-hcahps.

[3] Judy Morton, Jodi Brekhus, Megan Reynolds, Anna Kay Dykes, "Improving the Patient Experience through Nurse Leader Rounds," *Patient Experience Journal* 2014 1:2.

[4] Lauri Littleton, Laura A. Fennimore, Catherine Shull Fernald, Judith Zedreck Gonzalez, "Effective Nurse Leader Rounding Improves Patient Experience," Nursing Management 2019 50:10, doi:10.1097/01.NUMA.0000580620.45628.cd

Notes:

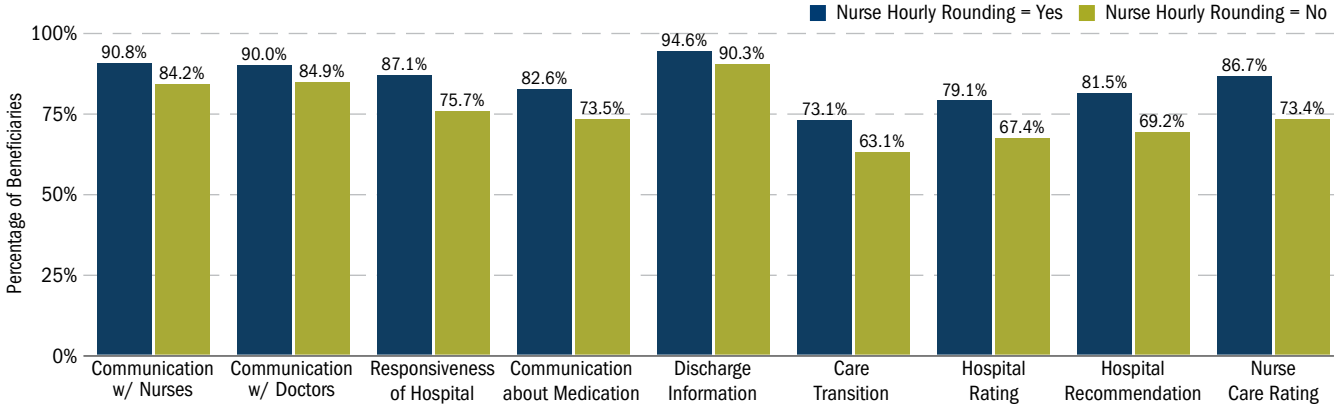
– FY 2022 includes results from FY 2022 Q1–Q3

– Post-Discharge Staff Phone Call in TRISS is worded as the following statement: "After discharge, did you receive a phone call from a hospital staff member regarding recovery at home?" The response options for this question are "yes" and "no."

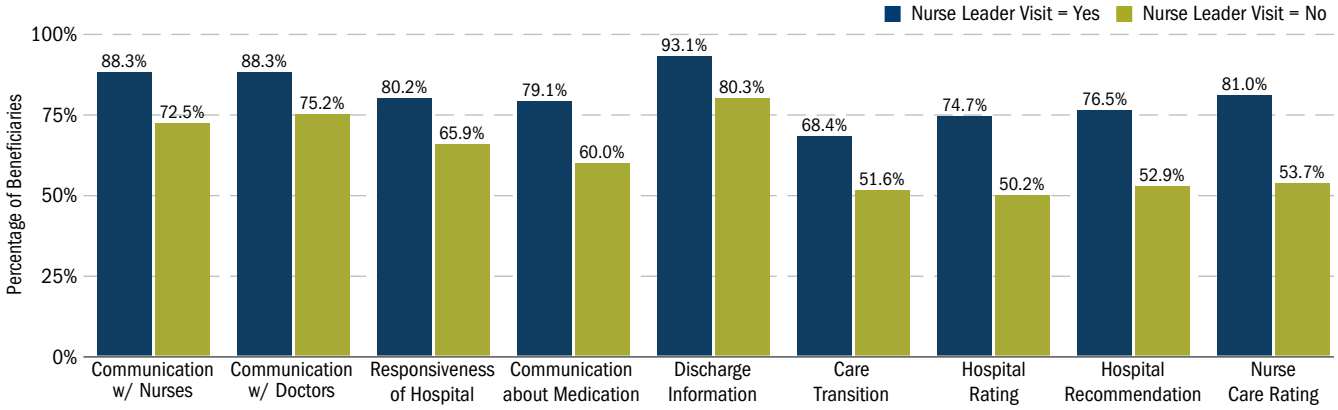
HIGH RELIABILITY OPERATING MODEL/CLINICAL SUPPORT SERVICES *(CONT.)*

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

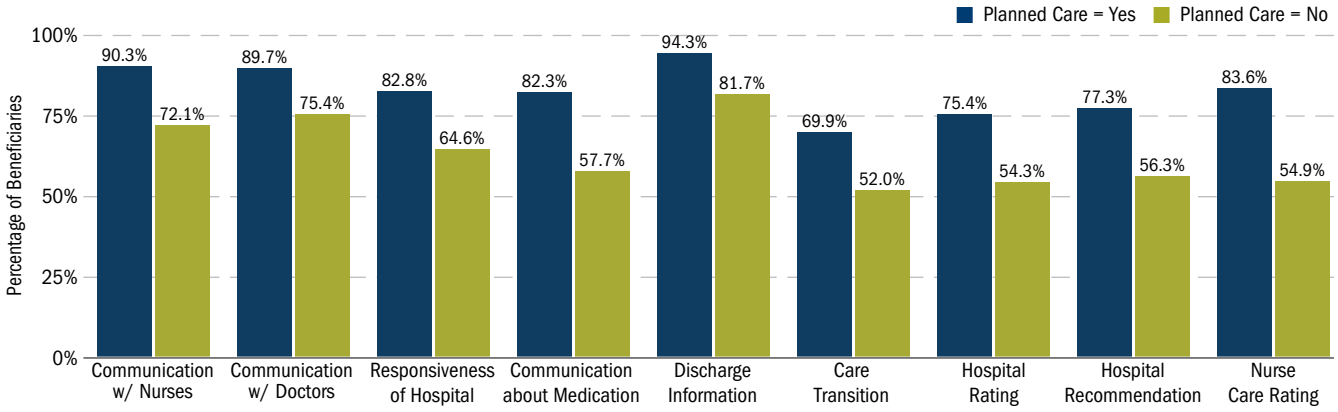
TRISS RATINGS OF PATIENT EXPERIENCE WHEN BENEFICIARIES REPORTED RECEIVING OR NOT RECEIVING NURSE HOURLY ROUNDING, FY 2022



TRISS RATINGS OF PATIENT EXPERIENCE WHEN BENEFICIARIES REPORTED RECEIVING OR NOT RECEIVING NURSE LEADER VISIT, FY 2022



TRISS RATINGS OF PATIENT EXPERIENCE WHEN BENEFICIARIES REPORTED RECEIVING OR NOT RECEIVING PLANNED CARE, FY 2022



Source: DHA/SP& FI (J5)/Analytics and Evaluation Division, TRISS, weighted data, compiled 1/13/2023

Notes:

– FY 2022 includes results from FY 2022 Q1–Q3.

– Nurse Hourly Rounding is worded in TRISS to capture the frequency to the following statement: "How often did nursing staff come into your room to check or round on you during the day? The four response options for this question are "every hour," "every two hours," "every few hours," and "a couple times a day." The "yes" results provided above are for those beneficiaries who reported "every hour" and the "no" results for those beneficiaries who reported "every two hours," "every few hours," and "a couple times a day."

– Nurse Leader Visit in TRISS is worded as the following statement: "Did a nurse leader visit you during your stay?" The response options for this question are "yes" and "no."

– Planned Care in TRISS is worded as the following statement: "At shift change, did the nurses include you in their conversation regarding your plan of care?" The response options for this question are "yes" and "no."

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

Drivers of Patient Experience Ratings

Results from patient surveys have become increasingly important in measuring health plan performance, directing action to improve the beneficiary experience, and improving the quality of services provided by health care facilities. Patient surveys provide key insights into the patient's perception of the health care they received, as well as the importance of different aspects of their care in determining their overall experience, satisfaction, and ratings of hospital facilities.

As stated previously, three key beneficiary surveys measure self-reported access to and satisfaction with MHS direct and private sector care experiences:

- TRISS—event-based after a discharge from a hospital (based on HCAHPS)
- JOES-C—event-based following an outpatient visit, asking about health care plan rating (based on CAHPS-CG)
- HCSDB—population-based quarterly survey sampling MHS-eligible beneficiaries who may use the MHS or their own health insurance, asking about care received in the preceding 12 months (based on the CAHPS Health Plan Survey)

Results from these surveys for FYs 2021 and 2022 (using all data available at the time of analysis) were modeled to identify key drivers of satisfaction. Drivers of satisfaction for all surveys of the direct care system were determined by examining the effects of composite scores on outcome variables. The models controlled for all composites and patient demographic variables, including beneficiary category, gender, Service, health status, and region. The statistical significance and effect size of odds ratios were used to rank drivers of satisfaction.

The table below shows that beneficiary satisfaction with health care provided in MTFs was driven primarily by communication between patients and providers, and getting care when needed. In addition to the above, use of information to coordinate care and treatment by staff were also important to beneficiary satisfaction. Results suggest that improving communication between beneficiaries and health care providers, ensuring hospital cleanliness, and providing care at the right time and location have the potential to influence a patient's health care experience and hospital satisfaction ratings.

TOP THREE DRIVERS OF SATISFACTION BY SURVEY: DIRECT CARE, FYs 2021–2022

	RANKING	TRISS DIRECT CARE MHS RATING OF HOSPITAL	JOES-C DIRECT CARE MHS HEALTH CARE RATING	HCSDB DIRECT CARE U.S. SATISFACTION WITH HEALTH CARE
FY 2021	#1	Care Transition	How Well Providers Communicate with Patients	Provider Communication
	#2	Communication with Nurses	Helpful, Courteous, and Respectful Office Staff	Getting Needed Care
	#3	Communication with Doctors	Providers' Use of Information to Coordinate Care	Claim Handling
FY 2022	#1	Communication with Nurses	How Well Providers Communicate with Patients	Provider Communication
	#2	Communication with Doctors	Helpful, Courteous, and Respectful Office Staff	Getting Needed Care
	#3	Cleanliness of Hospital Environment	Providers' Use of Information to Coordinate Care	Customer Service

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, TRISS results, JOES-C results, and HCSDB, FYs 2021–2022 (Q1–Q3 only for TRISS and JOES-C), compiled 12/23/2022

Notes:

– Composite measure generation followed guidelines established by AHRQ.

– TRISS followed HCAHPS composite construction found at: https://www.hcahpsonline.org/

– JOES-C followed CAHPS-CG version 3.0 guidelines detailed at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/cg/about/cg_3-0_overview.pdf

– HCSDB followed CAHPS guidelines provided at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/surveys-guidance/hp/about/measures_hp50_2109.pdf

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

Drivers of Patient Experience Ratings—JOES

In addition to the TRISS, JOES-C, and HCSDB, the MHS also fields the JOES survey, which combined and standardized previous surveys used by the Army, Navy, Air Force, and NCR/DHA to learn about beneficiary health care experiences. The JOES aims to more efficiently gather beneficiary health care experiences so that the information obtained can be better utilized to improve care within and across the Services.

Respondent data from the JOES for FYs 2021 and 2022 (using all data available at the time of analysis) were modeled to identify key drivers of a patient's satisfaction with health care and their provider. Drivers for these two types of patient experience for the direct care system were determined by analyzing the effect of individual aspects of the patient care experience on outcome variables. The models assessed the ease of making an appointment for care, the helpfulness and courteousness of both staff and providers, whether or not a provider knew the patient's medical history and reviewed current and/or new medications, as well as whether the provider team considered the patient's values and opinions when devising a care plan. Results took into account patient demographic variables, including beneficiary category, gender, Service, health status, and region.

The statistical significance and effect size of odds ratios were used to rank drivers of satisfaction.

The table below shows that overall satisfaction with health care and providers in MTFs was driven primarily by clear and understandable provider communication and the provider knowing the patient's medical history. Results suggest that treating patients with courtesy and respect, provider review of patient data before or during the exam, and ensuring an easy appointment scheduling process have the potential to positively influence health care experiences for patients.

TOP THREE DRIVERS OF SATISFACTION FROM JOES: DIRECT CARE, FYs 2021–2022

	RANKING	SATISFACTION WITH HEALTH CARE	SATISFACTION WITH PROVIDER
FY 2021	#1	Provider Knew Important Medical History	Provider Knew Important Medical History
	#2	Provider Explained Things in a Way That Was Easy to Understand	Provider Explained Things in a Way That Was Easy to Understand
	#3	Ease of Making an Appointment	Provider Treated Patient with Courtesy and Respect
FY 2022	#1	Provider Explained Things in a Way That Was Easy to Understand	Provider Explained Things in a Way That Was Easy to Understand
	#2	Provider Knew Important Medical History	Provider Knew Important Medical History
	#3	Ease of Making an Appointment	Provider Treated Patient with Courtesy and Respect

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, JOES results, FYs 2021–2022, compiled 12/23/2022
Note: JOES questions continue to be updated over time; drivers analysis was based on the most recent survey questions.

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

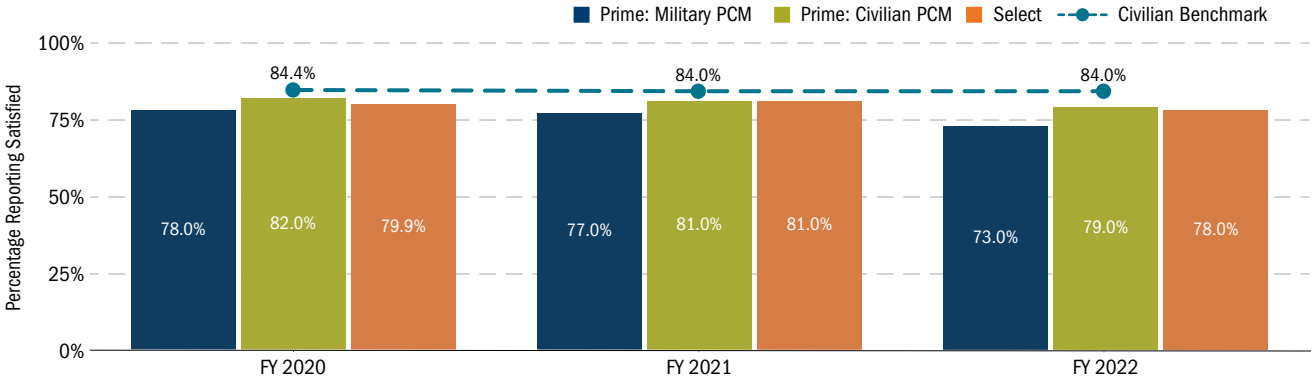
Patient-Centered Care/Experience *(cont.)*

Satisfaction with Customer Service

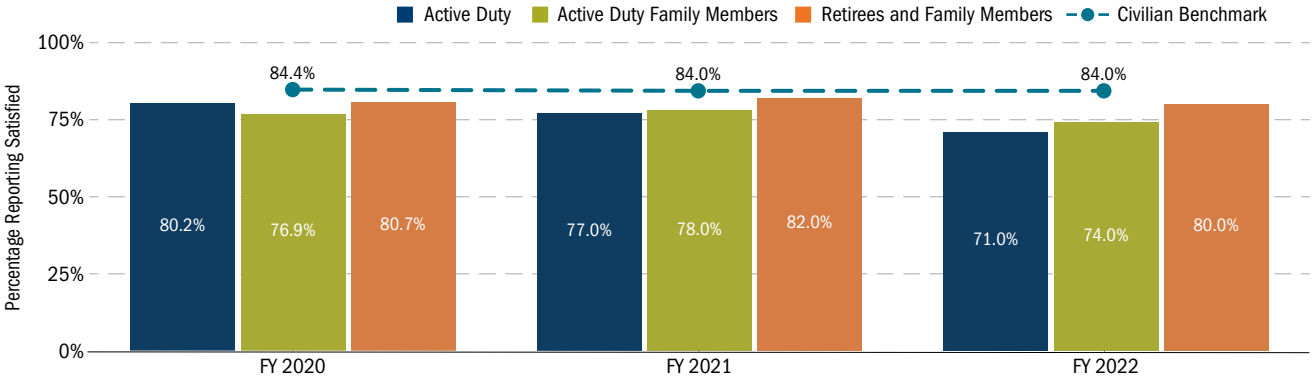
Most DoD health care beneficiaries participate in TRICARE in one of two ways: by enrolling in the Prime option or enrolling in the Select option. Access to and understanding written materials about one's health plan are important determinants of overall satisfaction with the plan.

- MHS beneficiary satisfaction with customer service in terms of understanding written material, getting customer assistance, and dealing with paperwork declined between FY 2020 and FY 2022 for all enrollment groups.
- Satisfaction with customer service for all enrollment groups was also lower than the civilian benchmark in FY 2022. MHS beneficiary satisfaction with customer service decreased by 9 percentage points for Active Duty (AD) from FY 2020 to FY 2022 and remained relatively stable for retirees and their family members over the same time period.

TRENDS IN RESPONSIVE CUSTOMER SERVICE: COMPOSITE MEASURE (UNDERSTANDING WRITTEN MATERIAL, GETTING CUSTOMER ASSISTANCE, AND DEALING WITH PAPERWORK) BY ENROLLMENT STATUS, FYs 2020–2022



TRENDS IN RESPONSIVE CUSTOMER SERVICE: COMPOSITE MEASURE (UNDERSTANDING WRITTEN MATERIAL, GETTING CUSTOMER ASSISTANCE, AND DEALING WITH PAPERWORK) BY BENEFICIARY CATEGORY, FYs 2020–2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 12/15/2022

Note: Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used in 2020 come from NCQA's 2017 data and in 2021 and 2022 from NCQA's 2019 data.

OTHER PLANS AND PROGRAMS

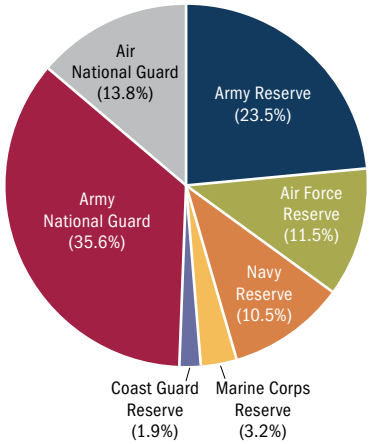
TRICARE Benefits for the Reserve Component

TRICARE offers a broad array of health care coverage and benefits for Reserve Component (RC) members who qualify, and their eligible family members, during active Guard or Reserve status, pre-deployment, deployment, post-deployment, and into retirement.

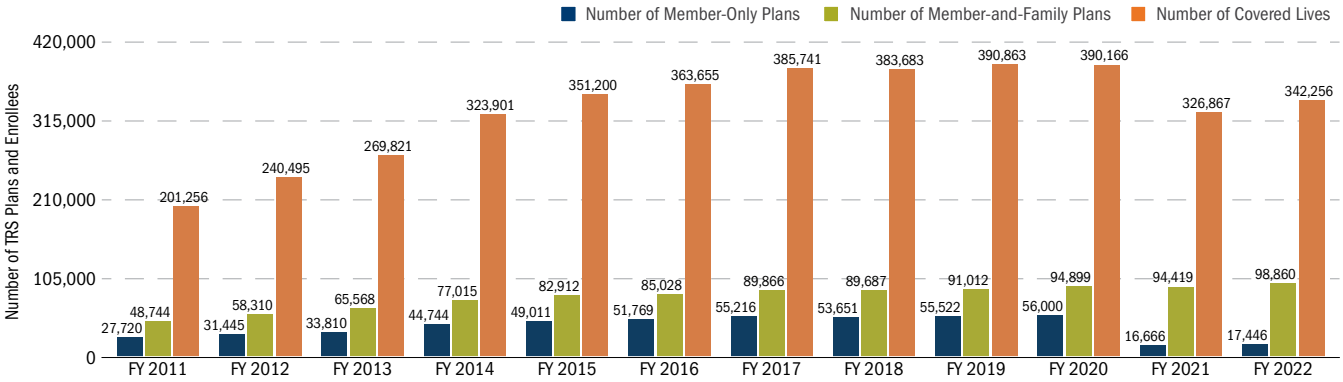
TRICARE Reserve Select (TRS). The subsidized premium-based TRS health plan provides TRICARE Select coverage for purchase by qualified members of the Selected Reserve (SelRes). TRS plans have plateaued and continue to fluctuate, where the significant gap remains between Member-Only and Member-and-Family plans. The pie chart to the right reflects the latest TRS enrollment by Component as of September 30, 2022.

- As shown in the pie chart at right, Army Reserve and Army National Guard combined constitute 59 percent of the 116,306 total TRS plans.
- The NDAA FY 2020, Section 701, removed the exclusion to those SelRes members eligible for or enrolled in Federal Employees Health Benefits Program (FEHB) from purchasing TRS coverage, to be effective January 1, 2030.

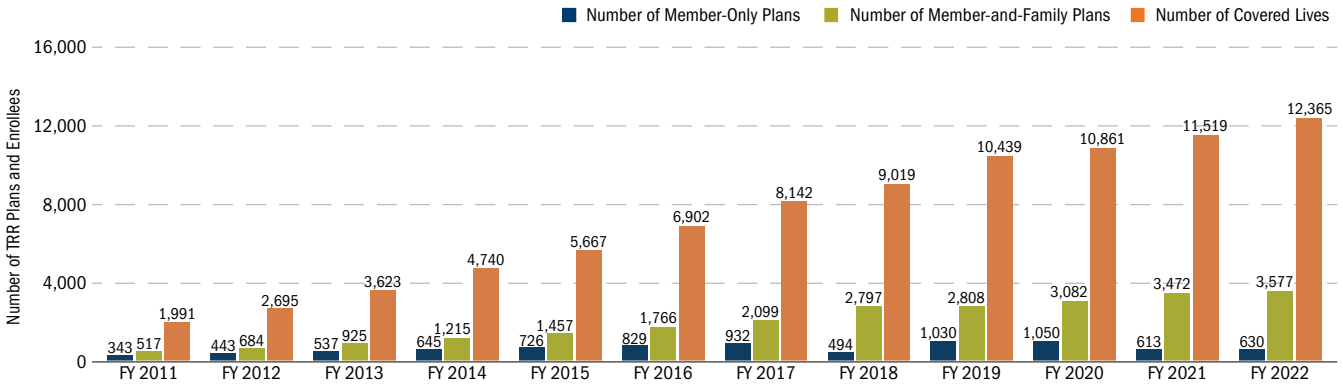
TRS: POPULATION BY COMPONENT (342,256 SPONSORS AND FAMILY MEMBERS AS OF SEPTEMBER 2022)



TRENDS IN RC ENROLLMENT IN TRS, FYs 2011–2022



TRENDS IN ENROLLMENT IN TRICARE RETIRED RESERVE (TRR), FYs 2011–2022



Source: Defense Manpower Data Center/Defense Enrollment Eligibility Reporting System (DEERS) Medical Policy Report, September 2022

OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Benefits for the Reserve Component *(cont.)*

TRICARE Retired Reserve (TRR). Qualified members of the Retired Reserve may purchase full-cost premium-based health care coverage under TRR until they reach age 60. Upon reaching age 60 and receiving retired pay, they and their eligible family members may enroll in premium-free TRICARE health plan options available for retirees.

TRR enrollment has also stabilized, with Member and Family plans still the majority of plans purchased.

TRS and TRR Costs. Both TRS and TRR adopted the new TRICARE Select cost-sharing structure (Group B) on January 1, 2018.

TRR enrollees pay the full cost of the premium, unlike TRS, where the enrolled's share of the premium is 28 percent, with the Department subsidizing the rest. Premiums are calculated annually for both TRS and TRR and are derived from actual prior year costs. Premium rates for CYs 2022–2023 are shown below.

MONTHLY PREMIUMS FOR TRS AND TRR, CYs 2022–2023

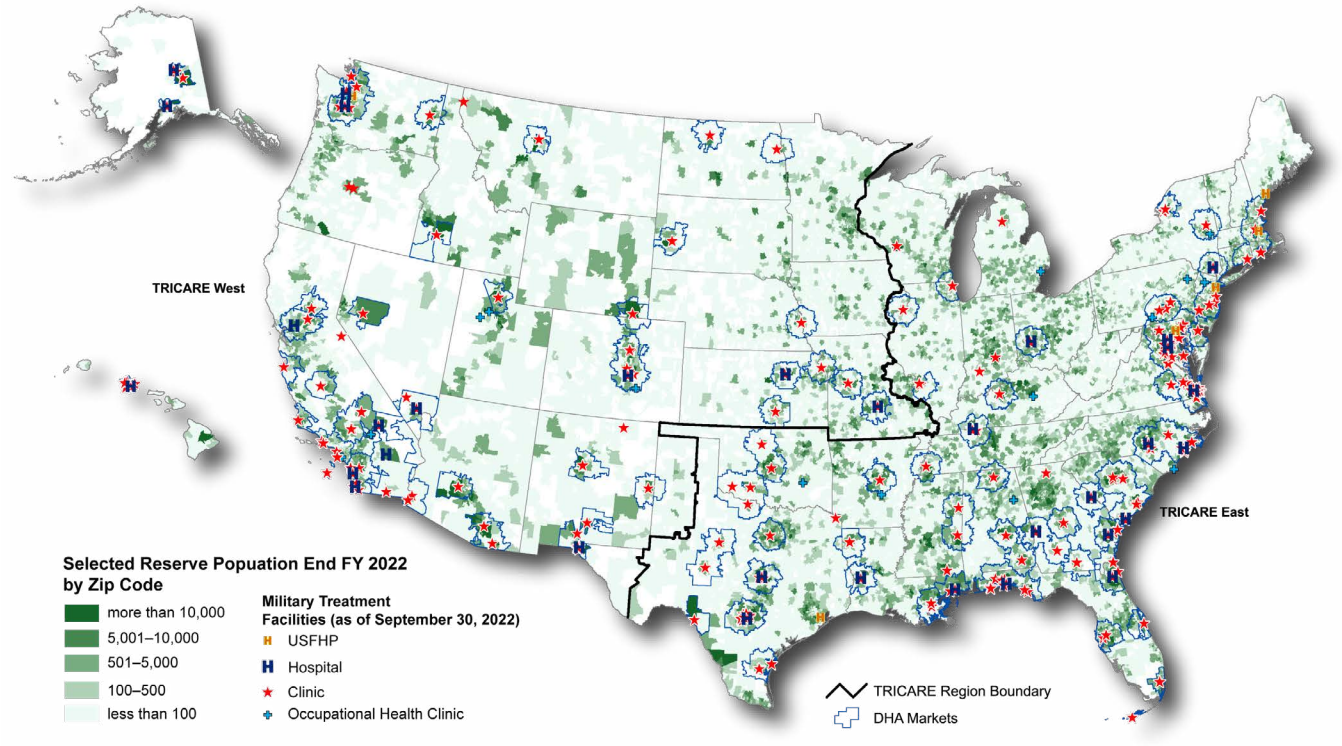
TYPE OF COVERAGE	CY 2022 MONTHLY	CY 2023 MONTHLY	% CHANGE
TRS Member Only	$46.70	$48.47	3.8%
TRS Member and Family	$229.99	$239.69	4.2%
TRR Member Only	$502.32	$549.35	9.4%
TRR Member and Family	$1,206.59	$1,320.76	9.5%

Source: TRS and TRR data from https://tricare.mil/Costs/Compare, accessed 10/21/2022

OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Benefits for the Reserve Component *(cont.)*

SELECTED RESERVE POPULATION IN THE U.S. RELATIVE TO MTF, PRIME, AND NON-PRIME SERVICE AREAS (PSAs), END OF FY 2022



COMPARISON OF SELECTED RESERVE AND ACTIVE DUTY SPONSORS AND FAMILY MEMBER PROXIMITY TO MTFs, END OF FY 2022[a]

BENEFICIARY GROUP[b]	POPULATION TOTAL	POPULATION IN PSAs	% IN PSAs	POPULATION IN MTF SERVICE AREAS	% IN MTF SERVICE AREAS
Active Duty and Their Families	3,123,016	2,887,907	92%	2,761,224	88%
Selected Reserve and Their Families	1,842,893	1,269,212	69%	1,012,635	55%
Select Reserve and Their Families, Overseas or Unknown	100,112				
Total Select Reserve and Their Families, Worldwide	1,943,005				

Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, population as of 9/30/2022

Notes:

[a] Eligible MHS beneficiary data from the MDR DEERS, as of 9/30/2022. Residential ZIP code was used as the location for all beneficiaries.

[b] Location information determined by DHA Catchment Area Directory database, September 2022.

Definitions:

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

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

- As of September 2022, there were almost 2 million SelRes and their family members (1,943,005).
- Approximately 69 percent of SelRes and their family members (about 92 percent for Active Duty and their family members) in the U.S. lived in localities where TRICARE Prime was offered. Slightly more than half (approximately 55 percent) of this population lived near an MTF, compared with 88 percent of Active Duty and their family members.
- Section 733 of NDAA FY 2021 authorized Transitional Assistance Management Program (TAMP) benefits to National Guard members coming off active service in support of the Government's response to COVID-19.

OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Young Adult

The TRICARE Young Adult (TYA) program is a premium-based TRICARE plan available for purchase by qualified adult-age children who would otherwise lose eligibility for TRICARE due to age. TYA offers Prime and/or Select coverage based on sponsor status and beneficiary location. Monthly premiums cover the full cost of the coverage with no government contribution. TYA meets the minimum essential coverage requirements of the Patient Protection and Affordable Care Act.

- TYA Prime premiums increased by 50 percent from $319 in CY 2017 to $512 in CY 2022, whereas TYA Select premiums increased by only 13 percent (from $216 to $265) over the same period (see table below). The increasing disparity in premiums between TYA Prime and Select likely explains the shift in enrollment from the former plan to the latter.
- TYA monthly premiums increased for CY 2023 from $512 to $570 per month for Prime and from $265 to $291 per month for Select (table below; tricare.mil/Costs/HealthPlanCosts/TYA). The continuing increase in premiums suggests that the shift in enrollment is likely to continue.

MONTHLY TYA PREMIUMS, CYs 2017–2023

	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Prime	$319	$324	$358	$376	$459	$512	$570
Select (Standard)	$216	$225	$214	$228	$257	$265	$291

Source: DHA/TRICARE Health Plan (THP) (J-10)/Health Plan Design Branch, Policy & Program Section, 6/15/2022

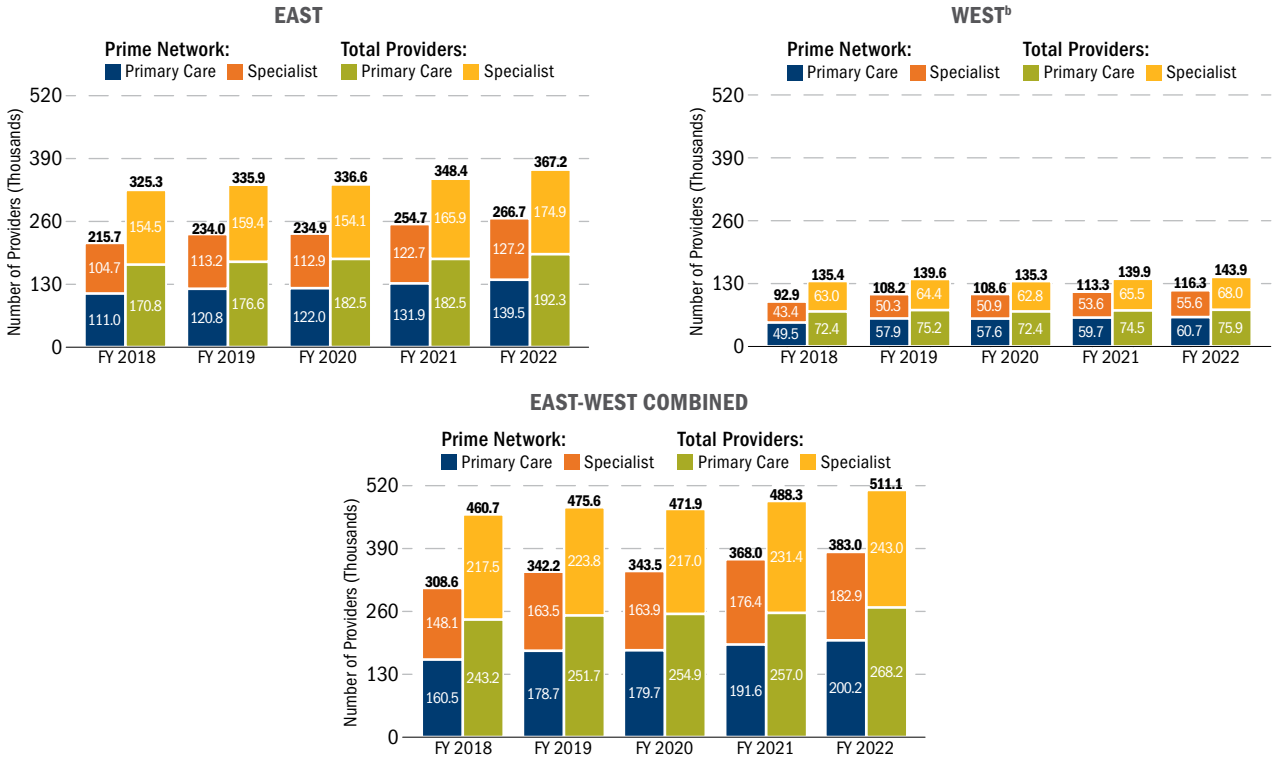
OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Provider Participation

The National Provider Identifier (NPI) is a unique identification number issued to health care providers in the U.S. by CMS. All HIPAA-covered individual health care providers and organizations must obtain an NPI for use in all HIPAA standard transactions. In this report, providers are counted using the NPI. The number of TRICARE-participating providers was determined by the number of unique providers filing TRICARE (excluding TRICARE for Life [TFL]) claims.[1] Providers were counted in terms of full-time equivalent units (1/12 of a provider for each month the provider saw at least one MHS beneficiary). The total number of participating providers has been rising steadily for more than a decade. The trend is due exclusively to an increase in the number of network providers; the number of non-network providers has actually slightly declined. Since FY 2018, the number of network primary care providers has increased at a somewhat higher rate (25 percent) than that of specialists (23 percent), and the total number of participating primary care providers has increased at a slightly lower rate (10 percent) than that of total participating specialists (12 percent).[2]

- Between FY 2018 and FY 2022, the East Region saw an increase of 13 percent in the total number of TRICARE providers, while the West Region saw an increase of 6 percent.
- Between FY 2018 and FY 2022, the East Region saw an increase of 24 percent in the total number of network providers, while the West Region saw an increase of 25 percent.
- The total number of TRICARE providers increased by 13 percent in PSAs and by 7 percent in non-PSAs (not shown).
- The number of network providers increased by 26 percent in PSAs and by 20 percent in non-PSAs (not shown).
- In FY 2022, 68 percent of all network providers and 66 percent of all participating providers were in PSAs (not shown).

TRENDS IN NETWORK AND TOTAL PARTICIPATING PROVIDER FTEs, FYs 2018–2022[a]



Source: MHS administrative data, 1/20/2022

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

[b] The West Region includes Alaska.

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

[2] Primary care providers were defined as general practice, family practice, internal medicine, obstetrics/gynecology, pediatrics, physician assistant, nurse practitioner, and clinic or other group practice.

Notes:

– The source for the provider counts shown above was the TRICARE private sector care claims data for each of the years shown, in which a provider was counted if he or she was listed as a TRICARE-participating provider. The claims also explicitly identify network providers.

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

OTHER PLANS AND PROGRAMS *(CONT.)*

Civilian Provider Acceptance of, and Beneficiary Access to, TRICARE Select

The TRICARE Select Survey (TSS) evaluates access to care and patient experience for TRICARE Select beneficiaries and awareness and acceptance of TRICARE Select among providers nationwide. It does this through two surveys: a beneficiary survey (TSS-B) and a provider survey (TSS-P).

- **Results from the FY 2022 Beneficiary Survey (TSS-B):**
  - **Reasons for Not Using TRICARE.** Fifteen percent of TSS beneficiaries reported not using TRICARE in the last 12 months and were asked why. The top reasons for not using TRICARE are "I have not needed health care" (38 percent) and "another reason" (33 percent). Beneficiaries in a PSA are more likely to say they get a greater choice of providers with a civilian plan (17 percent versus 9 percent not in a PSA), and they did not want to pay the TRICARE premium (3.3 percent versus 2.6 percent not in a PSA). Beneficiaries in a non-PSA were much more likely to say there was no military facility nearby compared with those in a PSA (24 percent versus 8 percent).
  - **Access to Care.** In FY 2022, 81 percent of TSS beneficiaries indicated satisfaction with Getting Needed Care CAHPS composite (below the 87 percent benchmark). However, 86 percent of beneficiaries indicated satisfaction with Getting Care Quickly CAHPS composite, meeting the benchmark. Access to personal doctor or BH were statistically the same as FY 2021. There were few differences between PSA and non-PSA in access to care except for travel time, where 87 percent of beneficiaries within a PSA reported a travel time of 30 minutes or less to a personal doctor, compared with 85 percent in a non-PSA. Similarly, 92 percent of those within a PSA reported a travel time of 60 minutes or less to a specialist, compared with 85 percent of those in a non-PSA.
  - **Global Patient Experience Ratings.** Global ratings for Health Care (78 percent) and Health Plan (70 percent) were both above CAHPS benchmarks. Global ratings for Personal Doctor (83 percent) and Specialist (81 percent) were both at CAHPS benchmarks. There were few differences between beneficiaries in PSAs and those not in PSAs.
  - **Problems Finding a Personal Doctor.** Twenty-four percent of TSS beneficiaries reported a problem finding a personal doctor. The top reasons were "doctors not accepting TRICARE" (55 percent) and "doctors not accepting new TRICARE patients" (49 percent). Twenty-six percent of beneficiaries say the wait for an appointment was too long. Beneficiaries outside of PSAs were more likely to say personal doctors did not accept TRICARE (57 percent versus 53 percent) and the travel distance was too long (38 percent versus 27 percent).
  - **Problems Finding a Specialist.** Twenty-seven percent of TSS beneficiaries reported a problem finding a specialist. The top reasons were "specialists not accepting TRICARE" (53 percent) and "specialists not accepting new TRICARE patients" (37 percent). Beneficiaries outside of PSAs were more likely to say the travel distance was too long 33 percent versus 29 percent).
  - **Problems Finding Mental Health Care.** Forty-three percent of TSS beneficiaries reported a problem finding MH care. The top reasons were "mental health providers not taking new patients" (43 percent) and "not accepting TRICARE payments" (42 percent). Beneficiaries outside of PSAs were more likely to say MH providers did not accept TRICARE (43 percent versus 42 percent). Beneficiaries within PSAs were more likely to say the wait was too long (38 percent versus 30 percent).
- **Results from the FY 2022 Provider Survey (TSS-P):**
  - **TRICARE Acceptance.** Eighty-two percent of physicians and 60 percent of BH providers were aware of TRICARE Select. Eighty-seven percent of physicians and 51 percent of BH providers accept new TRICARE patients if they were accepting new patients at all.
  - **Reasons for Not Accepting TRICARE.** Of the 42 percent of providers who do not accept TRICARE Select, the top reasons were "other" (25 percent), "not aware of TRICARE Select" (20 percent), and "not accepting new patients" (20 percent). Physicians were more likely to not accept TRICARE Select because they were not accepting new patients. BH providers were more likely to not accept TRICARE Select because of "other"—they were not aware of it, they had problems being accepted, or they only took private insurance. Open text analysis revealed many BH providers were not eligible to be credentialed or worked in facilities or positions that did not accept insurance, such as in schools, in prisons, or as social workers. Some providers stopped accepting TRICARE Select because of nonpayment of claims.

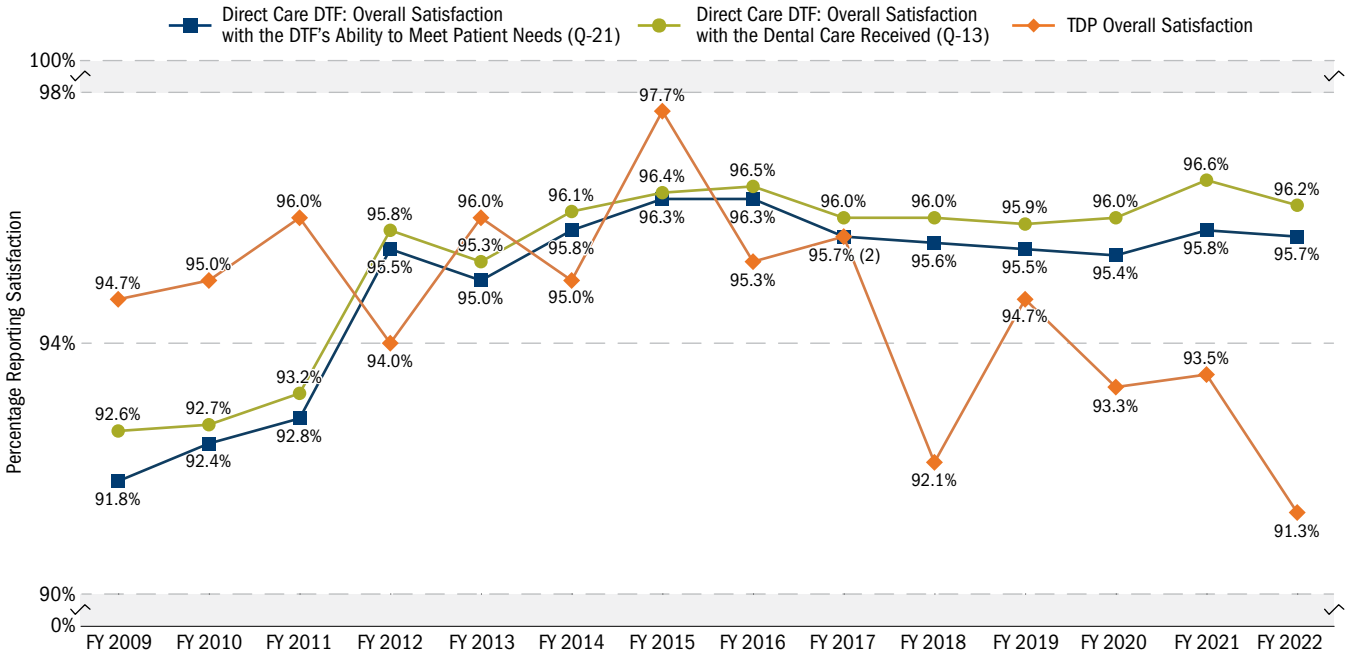
OTHER PLANS AND PROGRAMS *(CONT.)*

TRICARE Dental Programs Customer Satisfaction

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

- **Military DTFs** are responsible for the dental care of about 1.64 million ADSMs worldwide and eligible family members residing outside the contiguous United States. The Tri-Service Center for Oral Health Studies completed 84,000 surveys in FY 2022. This is a substantial decrease from 131,059 completed surveys in FY 2019, potentially due to the COVID-19 pandemic. Reports of overall satisfaction have remained at around 96 percent since FY 2014.
- The **TRICARE Dental Program (TDP)** is a voluntary, premium-sharing dental insurance program available to eligible ADFMs, Selected Reserve and Individual Ready Reserve members, and their families. The TDP composite overall average enrollee satisfaction for FY 2022 is 91.3 percent. This is a decrease from the previous year of 92.8 percent. It should be noted that the survey does not allow for questions to improve quality. As of November 1, 2022, TDP enrollment totaled 1,791,682 contracts, covering almost 2 million lives, 98 percent of which were in the U.S. The TDP network has 79,935 total dentists in FY 2022—61,744 are general dentists and 18,191 are specialists.

SATISFACTION WITH TRICARE DENTAL CARE: MILITARY AND CONTRACT SOURCES, FYs 2009–2022



Sources: TRICARE Dental Care Section, Health Plan Execution and Operations; Tri-Service Center for Oral Health Studies; and DoD Dental Patient Satisfaction Reporting website (Trending Reports), 12/5/2022

Note: The dental satisfaction surveys are displayed above for ease of reference, but are not directly comparable because they are based on different survey instruments and methodologies.

OTHER PLANS AND PROGRAMS *(CONT.)*

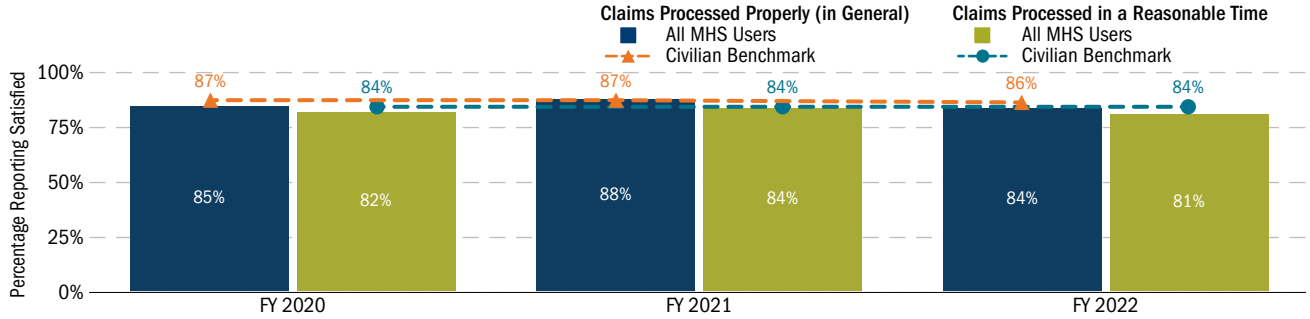
Customer Service, Claims Processing

Beneficiaries and their providers alike have an interest in the promptness and accuracy of claims processing and payment. The MHS monitors the performance of TRICARE claims processing through surveys of beneficiary perceptions and administrative tracking.

Beneficiary Perceptions of Claims Filing Process

- Satisfaction with claims being processed both properly and in a reasonable time slightly decreased from FY 2020 to FY 2022.
- MHS satisfaction levels with the accuracy of claims processing were higher than the civilian benchmarks from FY 2021, but lower in FY 2020 and FY 2022. Satisfaction with processing time was at benchmark in FY 2021 but lower in FY 2020 and FY 2022.

TRENDS IN SELF-REPORTED ASPECTS OF CLAIMS PROCESSING (ALL SOURCES OF CARE), FYs 2020–2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, adjusted for age and health status, as of 12/15/2022

Notes:

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

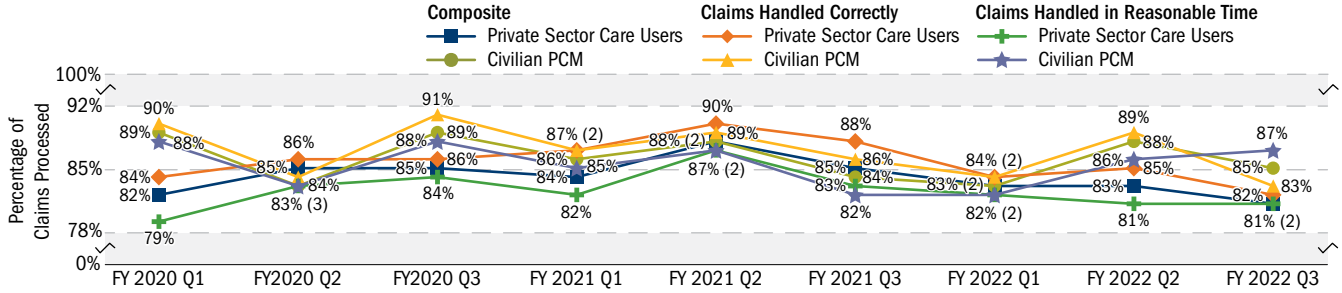
– Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans. Benchmarks used in 2020 come from NCQA's 2017 data and in 2021 and 2022 from NCQA's 2019 data.

Trends in Claims Filing Process

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

- **Claims Submission:** The claims submission interval is the time from the patient's last date of care to the date that the treating provider files a claim for payment with the Private Sector Care Processing Contractor.
- **Claims Processing:** The Private Sector Care Processing Contractor adjudicates the claim and sends a TRICARE Encounter Data (TED) record to DHA requesting payment. Claims processing includes the time needed for the Private-Sector Processing Contractor to ensure that the TED records pass all TRICARE validation edits (services are "Accepted").
- **Transmission Acceptance:** The transmission acceptance interval is the time between when DHA takes an "Accepted" TED record and when it identifies the appropriate program cost fund for payment. The accept date is defined as the "Last Update Date" in the TED record by current contracts. Contracts between DHA and MCSCs require that TED records be received by 10 AM Eastern time for DHA to accept the same day; otherwise, the cutoff moves the TED "Accepted" record to the next day.

TRENDS IN PRIVATE SECTOR CARE/CIVILIAN PCM CLAIMS PROCESSING, FY 2020 Q1–FY 2022 Q3



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division; HCSDB, current as of FY 2022 Q3

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

OTHER PLANS AND PROGRAMS *(CONT.)*

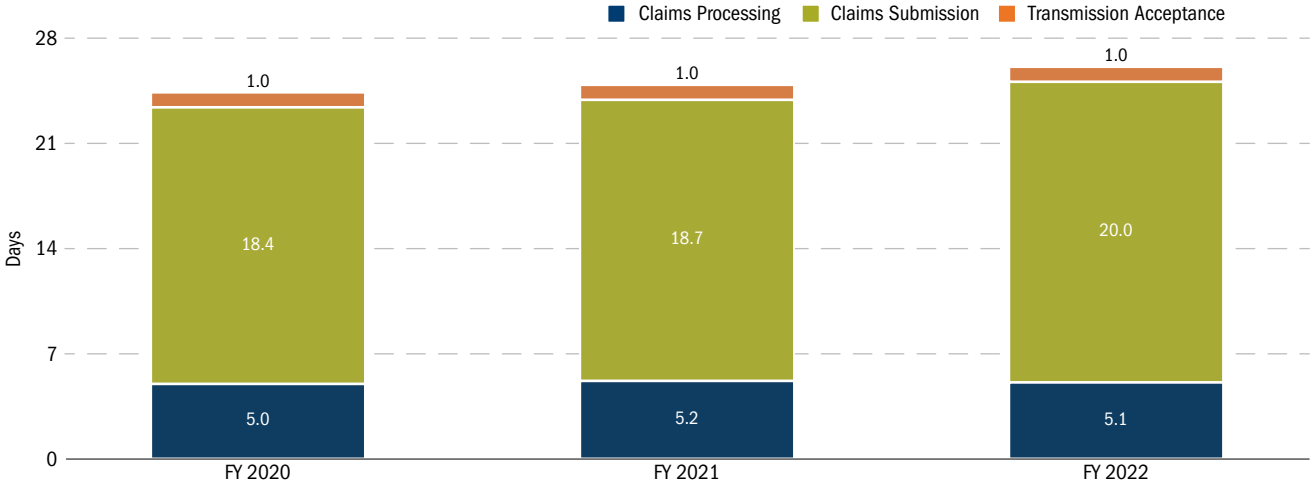
Customer Service, Claims Processing *(cont.)*

DHA pays MCSCs within seven days of the later of "Transmission 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 graph below excludes paper claims and claims from other health insurance, pharmacy, TRICARE Dual Eligible Fiscal Intermediary Contract, and TRICARE Overseas Program contracts.

This fiscal year showed a statistically insignificant increase in overall processing times, driven by small increases in average Claim Submission times from FY 2022. The lengthiest portion of claims processing consistently is Claims Submission—the time it takes for the treating provider to submit claims. The graph shows results of analysis of claims counts of 41.6 million, 46.2 million, and 48.7 million for FY 2020, FY 2021, and FY 2022, respectively.

AVERAGE INTERVAL (DAYS) FOR CLAIMS PROCESSING, FYs 2020–2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, MHS administrative data, 11/16/2022

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POPULATION HEALTH

The Military Health System (MHS) is dedicated to Population Health management and engagement. Although this concept is generally associated with managing the clinical risks associated with patients, the MHS has extended this concept to include helping the population manage their own health and creating an environment where the healthy choice is the easy choice. The MHS model continues to evolve to include strategies such as strengthening the connections between our military medical treatment facilities (MTFs) and regional managed care support contractor (MCSC) engagement.

HEALTH PROMOTION AND DISEASE PREVENTION EFFORTS

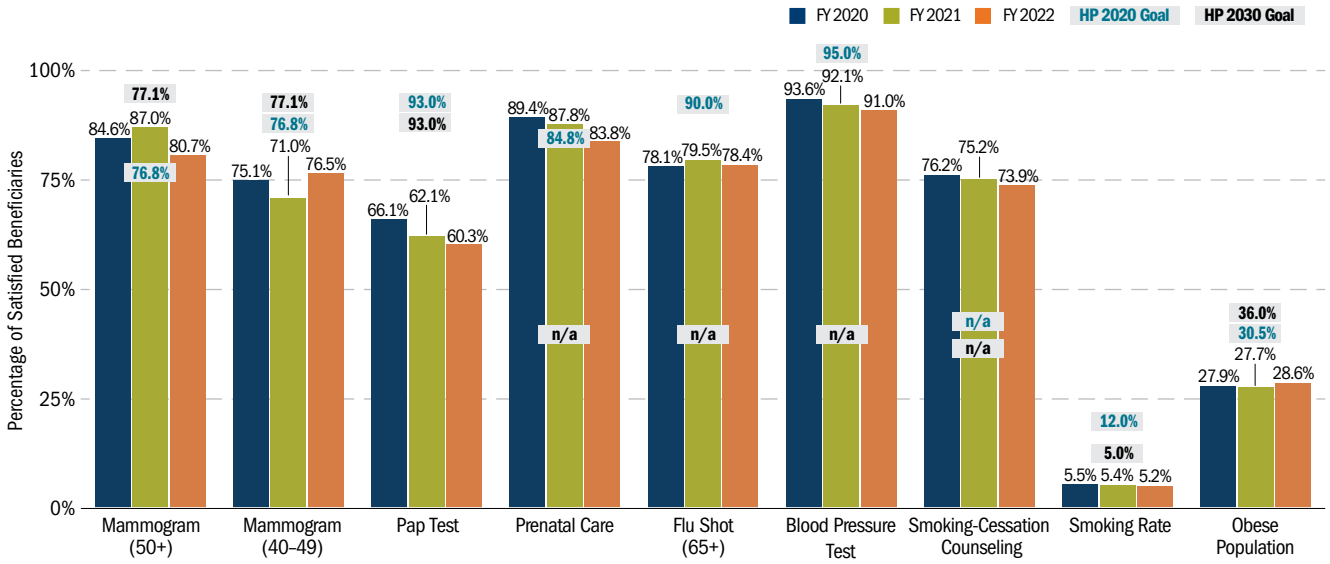
This section presents efforts toward meeting the MHS aim of "Better Health," part of the Quadruple Aim, to include preventive care, population health, tobacco cessation, and obesity and condition management. This section also provides selected measures benchmarked to the Healthy People 2020 (HP 2020) and Healthy People 2030 (HP 2030) goals. The HP goals are national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce those threats; these goals have been embraced by the Department of Defense (DoD).

The MHS strategic goals go beyond those for primary health and wellness. The graphs on pages 122–126 reflect secondary prevention efforts via self-reported responses from all eligible MHS beneficiaries within the categories shown (e.g., all adult women over the age of 40 for mammography, all adult pregnant women for prenatal care, etc.). The graphs on pages 181–184 show Better Health Measures that are housed on the MHS Dashboard and use clinical records to track and assess enterprise performance on obesity/overweight prevalence and tobacco use/cessation counseling.

- The MHS has set as goals a subset of the health promotion and disease prevention objectives specified by the Department of Health and Human Services in HP 2020 (through 2020) and HP 2030 (beginning in 2021). Over the past three years, the MHS has exceeded or was about equal to targeted HP goals for providing mammograms (ages 50 and over) and prenatal care for women, as well as for rates of smoking and obesity.
- Pap Test: According to self-reported Health Care Survey of DoD Beneficiaries (HCSDB) data, the percentage of MHS female beneficiaries receiving Pap tests increased in FY 2022 to 72 percent from 62 percent in the previous year but still below targeted HP goal by 21 percentage points. In March 2012, the U.S. Preventive Services Task Force offered an updated "Final Recommendation Statement: Cervical Cancer Screening" (https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/cervical-cancer-screening), which may have contributed to the decline in Pap tests.
- Tobacco Use: The overall self-reported smoking rate among all MHS beneficiaries has declined slightly over the past three years. Smoking-cessation counseling has decreased from 76 percent in FY 2020 to 74 percent in FY 2022 (page 178). MHS Dashboard measure data for tobacco use and counseling are available on pages 178–180 and 182. These measures apply to the direct care population only and use different sources and methods. Therefore, the results differ from the survey-based measures. As of FY 2022 Q4, 23 percent of direct care beneficiaries screened for tobacco use were current users based on data from the MHS Dashboard.
- Obesity: Based on self-reported survey data, the overall proportion of MHS beneficiaries identified as obese ranged from 23 percent to 26 percent for the past three years. This is below the HP 2020 goal of 30.5 percent and the HP 2030 goal of 36 percent. MHS Dashboard measure data for overweight and obesity are available on pages 181 and 183–184. These measures apply to the direct care population only and use different sources and methods. Therefore, the results differ from the survey-based measures. In FY 2022 Q3, the MHS adult obesity rate per the MHS Dashboard was 36.1 percent.

HEALTH PROMOTION AND DISEASE PREVENTION EFFORTS *(CONT.)*

TRENDS IN MEETING PREVENTIVE CARE STANDARDS, FYs 2020–2022



Sources: Defense Health Agency (DHA)/Strategy, Plans, and Functional Integration (SP&FI) (J-5)/Analytics and Evaluation Division, results provided 12/15/2022

Notes:

– The Trends in Meeting Preventative Care Standards estimates are for TRICARE users (i.e., enrollees of Prime, Select, or Retired Reserve) who are younger than 65.

– Unlike the objective for all other categories, the objective for Smoking Rate and Obese Population is for actual rates to be below the HP 2020 goals.

– The Healthy People 2020 goals are for data through 2020. Healthy People 2030 goals were released in late 2021 and should be used for 2021–2022 data.

MHS-TARGETED PREVENTIVE CARE MEASURES

Mammogram: Women aged 50 or older who had a mammogram in the past year; women aged 40–49 who had a mammogram in the past two years. **Pap Test:** All women who had a Pap test in the last three years. **Prenatal Care:** Women pregnant in the last year who received care in the first trimester. **Flu Shot:** People aged 65 and older who had a flu shot in the last 12 months. **Blood Pressure Test:** People who had a blood pressure check in the last two years and know the results. **Obese:** Obesity is defined as a body mass index (BMI) of 30 or above, which is calculated from self-reported data from the HCSDB. An individual's BMI is calculated using height and weight (BMI = 703 times weight in pounds, divided by height in inches squared). Although BMI is a risk measure, it does not measure actual body fat; as such, it provides a preliminary indicator of possible excess weight, which in turn provides a preliminary indicator of risk associated with excess weight. It should therefore be used in conjunction with other assessments of overall health and body fat. **Smoking-Cessation Counseling:** People advised to quit smoking in the last 12 months.

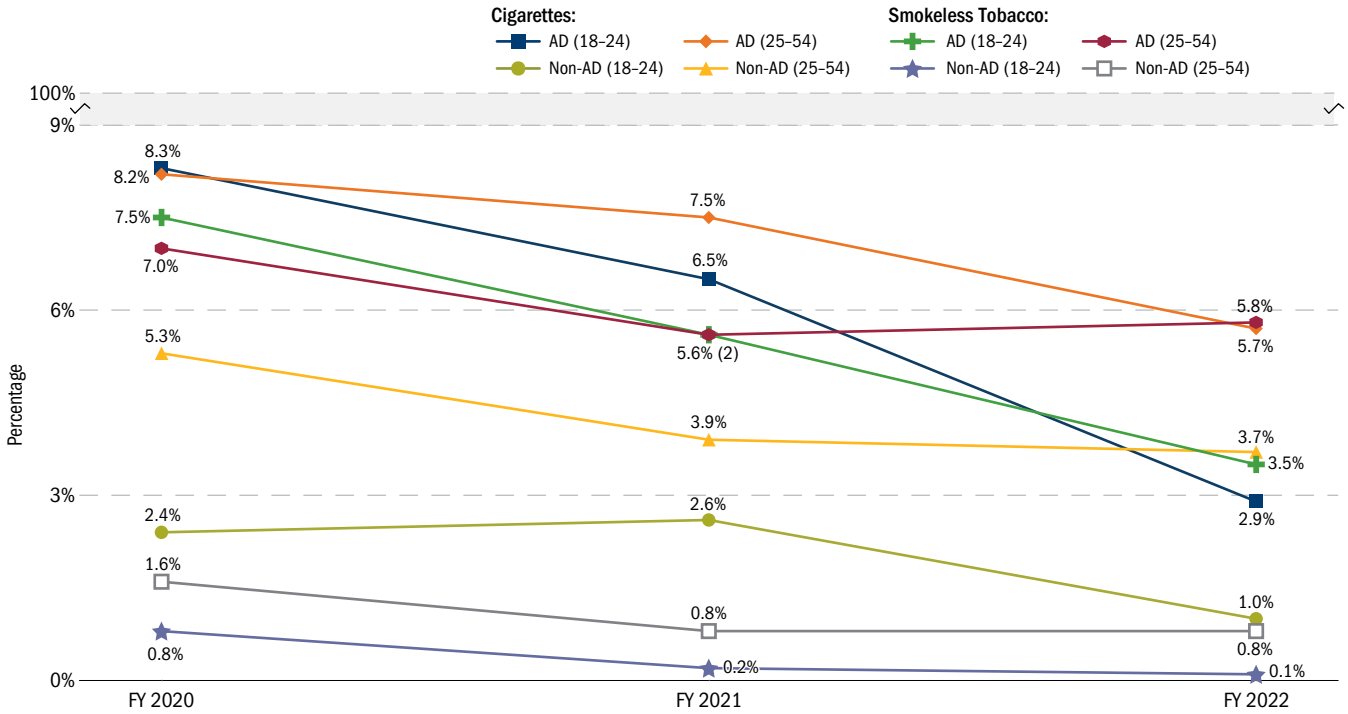
SELF-REPORTED PREVENTATIVE HEALTH MEASURES

Tobacco Cessation

Tobacco continues to be the leading cause of preventable death, according to the Centers for Disease Control and Prevention (CDC), and smoking rates in the military remain higher than desired. Military personnel who smoke experience reduced physical performance capability, impaired night vision, increased risk of respiratory illnesses and surgical complications, delayed wound healing, and accelerated age-related hearing loss. Furthermore, there are negative impacts on dental readiness, and long-term effects of tobacco use often include cancer, stroke, emphysema, and heart disease.

- Based on self-reported usage, cigarette smoking and smokeless tobacco use for Active Duty Service members (ADSMs) of all ages declined from FY 2020 to FY 2022.
- Cigarette smoking and smokeless tobacco use for non-Active Duty of all ages also decreased over the same time period.
- Cigarette smoking for MHS beneficiaries is well below the U.S. average of 12.5 percent (reported in 2020 from the CDC).

SELF-REPORTED CIGARETTE AND SMOKELESS TOBACCO USE RATES AMONG ACTIVE DUTY (AD) AND NON-ACTIVE DUTY, FYs 2020–2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, 12/15/2022

Notes:

– Percentages are weighted for the probability of selection and nonresponse; variation in quarterly estimates may not be significant and should not be assumed as such without appropriate tests of significance.

– The U.S. adult cigarette smoking rate in 2020 was 12.5 percent, https://www.cdc.gov/tobacco/data_statistics/fact_sheets/index.htm?s_cid=osh-stu-home-spotlight-001, accessed 12/15/2022.

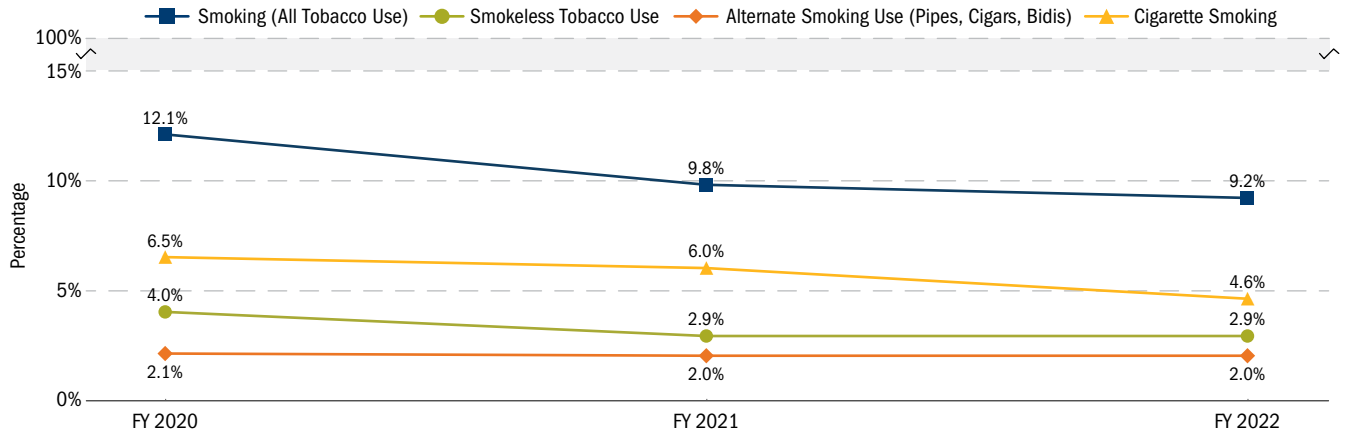
– For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

SELF-REPORTED PREVENTATIVE HEALTH MEASURES *(CONT.)*

Tobacco Cessation *(cont.)*

- **MHS Prime Enrollee Use of Any Tobacco Products:** In addition to cigarette smoking, the HCSDB assesses the use of various tobacco products across the MHS. The chart below presents the self-reported estimates of the prevalence of MHS Prime enrollees using different tobacco products (cigars, pipes, bidis, or kreteks). Prime enrollee use of tobacco in one form or another declined from 12.1 percent in FY 2020 to 9.2 percent in FY 2022.
- Cigarette smoking, which is the most used form of tobacco among Prime enrollees, remained about the same between FY 2021 and FY 2022. Smokeless tobacco use decreased from 4.0 percent in FY 2020 to 2.9 percent in FY 2022.

SELF-REPORTED MHS PRIME ENROLLEE USE OF TOBACCO PRODUCTS, BY TYPE OF TOBACCO USE: CIGARETTES, ALTERNATE SMOKING TOBACCO, AND SMOKELESS TOBACCO, FYs 2020–2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, 2/15/2022

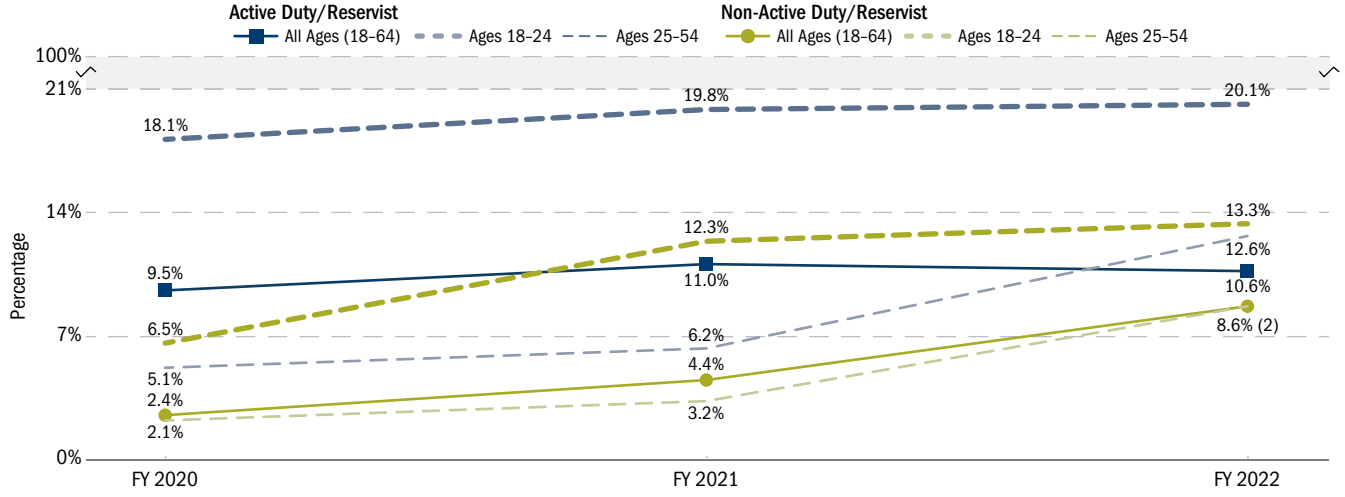
Notes:

– Smokeless tobacco may include dip, snuff, snus, chew, etc., while alternate smoking tobacco may include cigars, pipes, hookahs, bidis, or kreteks.

– Percentages are weighted for the probability of selection and nonresponse; variation in quarterly estimates may not be significant and should not be assumed as such without appropriate tests of significance.

- Self-reported use of e-cigarette or vaping products among the AD/Reservists aged 18–64 slightly increased by one percentage point from FY 2020 to FY 2021, and less than one percentage point from FY 2021 to FY 2022. AD reported higher use than non-AD for each age group.
- Non-AD/Reservists e-cigarette use among those 18–64 years old nearly doubled during the past two years, increasing from 4.4 percent in FY 2021 to 8.6 percent in FY 2022. E-cigarette use among AD/Reservists aged 25–54 and non-AD/Reservists aged 25–54 showed a similar trend.

SELF-REPORTED E-CIGARETTE USAGE AMONG SELECT COHORTS, FYs 2020–2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data, 12/15/2022

Note: Data are derived from the HCSDB question "Do you now vape or use e-cigarettes every day, some days, or not at all?" with scores shown for those indicated "every day."

SELF-REPORTED PREVENTATIVE HEALTH MEASURES *(CONT.)*

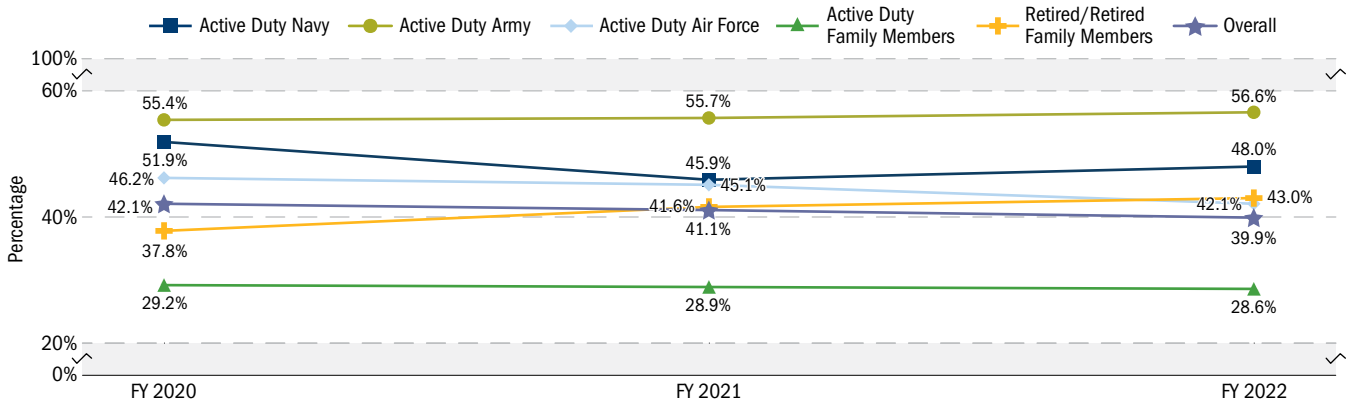
MHS Adult Obesity

This measure provides important information about the overall health of DoD beneficiaries for use by MHS leadership to help promote military initiatives that encourage exercise and healthy nutritional habits. These data can also shape the need for, and development of, medical interventions or modalities that are effective in maintaining healthy weights for all age groups.

The charts below display the percentage of the population reporting in the HCSDB a height and weight that, when used in calculating BMI, result in a measurement of 25 or higher (30 is the threshold for obesity).

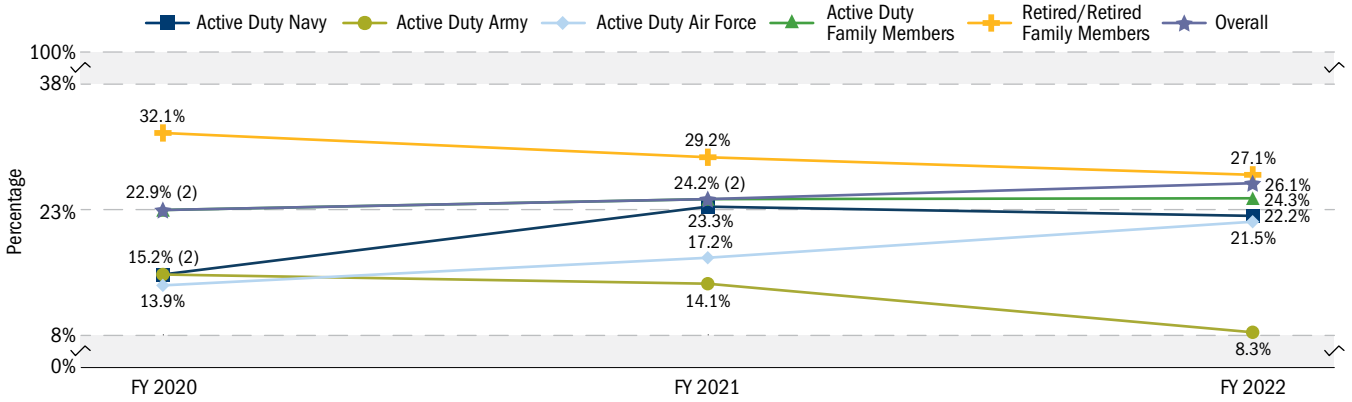
- As shown in the chart below, 39.9 percent of all MHS beneficiaries were overweight in FY 2022. Active Duty family members (ADFMs), on average, have the lowest rate of being overweight (28.6 percent). Calculated BMI rates reflecting overweightness may not be reflective of AD fitness without consideration of muscle mass, and may explain why AD appear to have high prevalence rates of being overweight but low obesity rates, as shown in the second chart.

SELF-REPORTED MHS OVERWEIGHT RATE (BMI 25–29.9), FYs 2020–2022



- The chart below displays the prevalence of obesity in the MHS population (i.e., a calculated BMI of 30 or higher) based on self-reported height and weight survey data from the HCSDB. The overall MHS obesity rate has been relatively unchanged from FY 2020 to FY 2022.
- In FY 2022, AD Army had the lowest obesity rates, compared with AD Navy and Air Force.
- AD Navy and AD Air Force obesity rates for FY 2022 increased by 7.0 and 7.6 percent, respectively, while overweight rates decreased by 3 percentage points for AD Air Force.

SELF-REPORTED MHS OBESITY RATE (BMI 30 OR HIGHER), FYs 2020–2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, HCSDB data 12/15/2022

Notes:

– BMI is defined as the individual's body weight divided by the square of his or her height. The formula universally used in medicine produces a unit of measure of kg/m^2. Because the HCSDB collects height and weight in inches and pounds, BMI is calculated as $lb/in^2 \times 703$. 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). No objective validation tool is used to verify accuracy of BMI results.

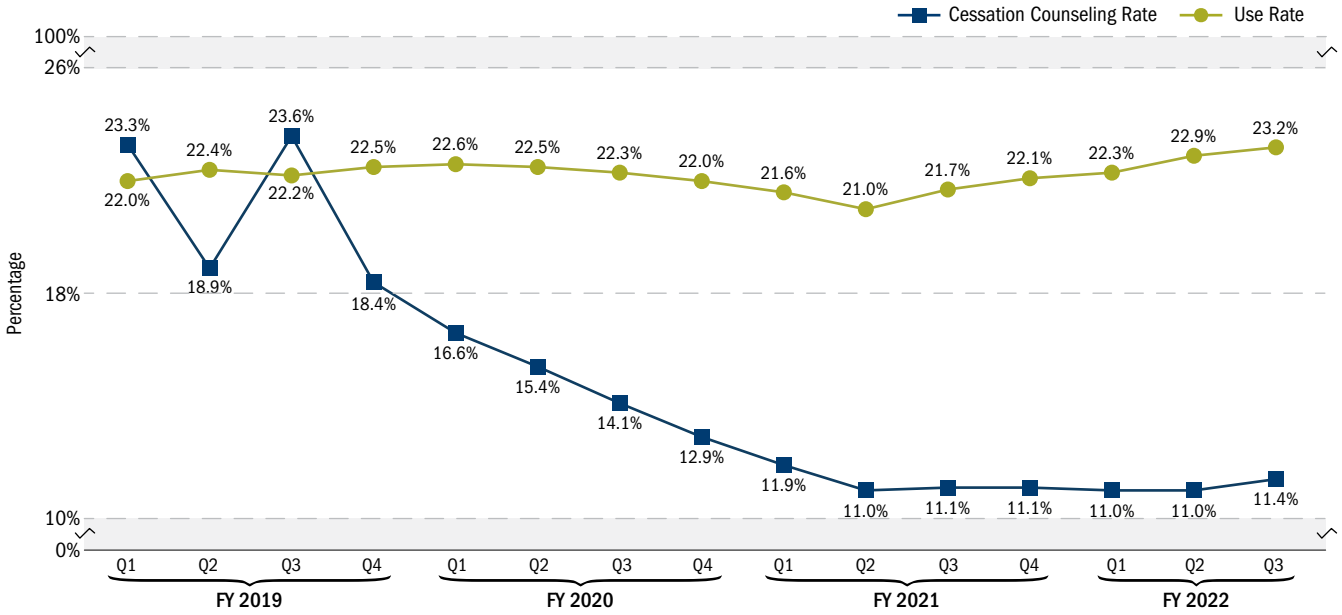
MHS DASHBOARD BETTER HEALTH MEASURES

Better Health Measures use clinical records to track and assess enterprise performance on tobacco use/cessation counseling and obesity/overweight prevalence. These measures are enrollment-based indicators of performance among the direct care population with health care encounters in MHS facilities.

Tobacco Use and Cessation Counseling

The use rate has remained largely unchanged from Q1 FY 2019 to Q3 FY 2022. The cessation counseling rate has more recently remained unchanged following a substantial decrease between Q3 FY 2019 and Q2 FY 2021. This large decrease is likely attributed to a steady decline in the documentation of encounter records for the provision of cessation counseling among beneficiaries with documented tobacco use in the 12-month measure look-back period. Additionally, the decline in documentation was further impacted by the decreased availability of cessation counseling data for MHS GENESIS transitioned sites during the phased rollout. Efforts are ongoing by Population Health to improve performance and to identify additional sources for data capture for the tobacco measures.

TOBACCO USE AND CESSATION COUNSELING MEASURES, FYs 2019–2022



Source: DHA/SP & F1 (J-5)/Analytics and Evaluation, DHA Measures Library, data accessed 8/17/2022

Notes:

– Reflects rate during last month of each quarter.

– Tobacco dashboard measure includes beneficiaries 18 years of age and up, or pregnant at any age, continuously enrolled (11 months) to TRICARE Prime or Plus, with a primary care MTF encounter in the last 12 months.

– The tobacco use rate measure does not distinguish among use modalities and is presumed to include traditional tobacco products as well as newer products such as e-cigarettes.

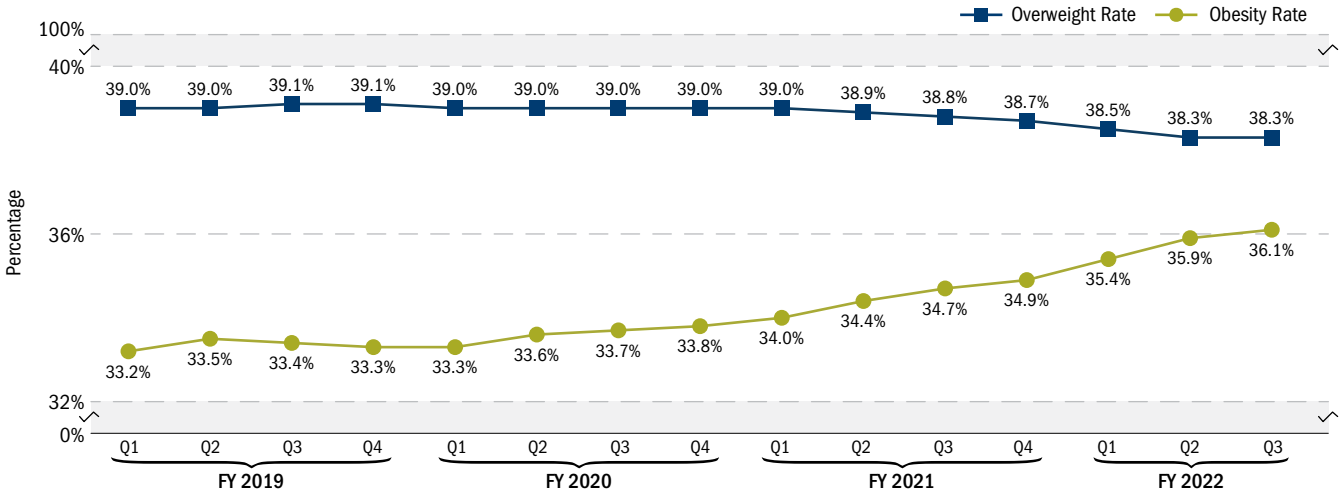
– The tobacco cessation counseling dashboard measure data are presumed objective clinical observations. The survey-derived use and cessation statistics, described earlier, are self-reported data, which are subject to recall bias, while clinical records based data are subject to variances in clinical coding habits, policies, and practice patterns across the enterprise.

MHS DASHBOARD BETTER HEALTH MEASURES *(CONT.)*

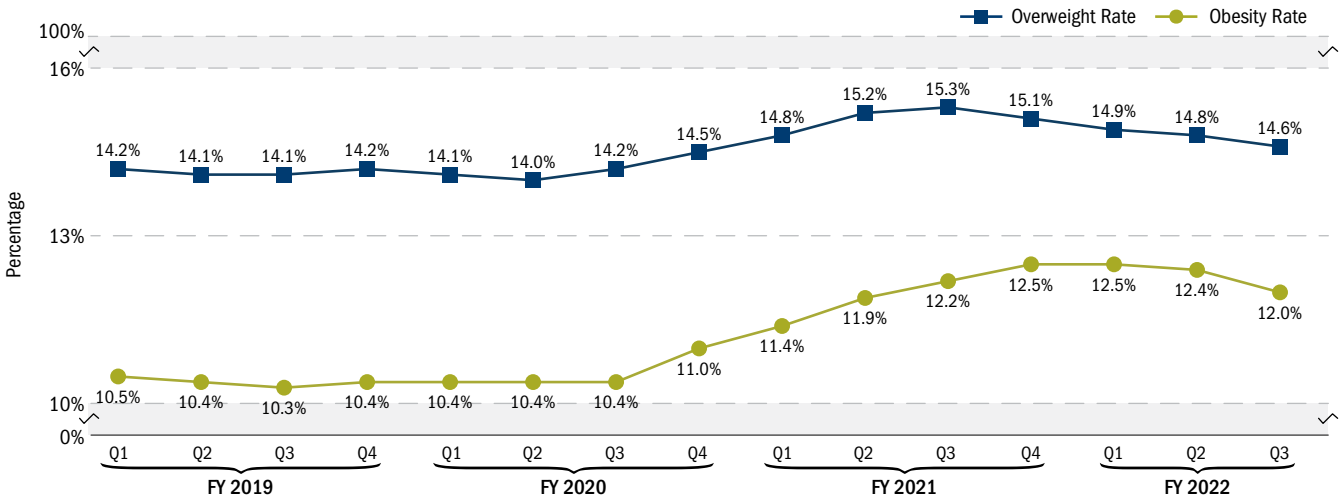
Obesity and Overweight Prevalence

Trends in obesity and overweight prevalence among youth and adult direct-care beneficiaries in the MHS are consistent with those in the general population in the National Health and Nutrition Examination Survey (NHANES). Overall, the MHS adult population obesity prevalence rate has increased during the time period; however, as of Q3 FY 2022, the rate (36.1 percent, adjusted for age and sex) remains less than that of the general U.S. population, as estimated by the 2017–2018 NHANES measurement cycle (42.4 percent, adjusted for age and sex). Using the same comparator data source for overweight burden, adjusted prevalence among MHS beneficiary adults (38.3 percent, adjusted for age and sex) has remained largely unchanged and is higher than the national average (31.1 percent, adjusted). Estimates of obesity and overweight prevalence in Q3 FY 2022 for MHS beneficiary youth (12.0 percent and 14.6 percent, respectively, both adjusted for age and sex) have declined slightly and remain below the national average (19.3 percent and 16.1 percent, respectively, both adjusted).

ADULT OBESITY AND OVERWEIGHT RATE, FYs 2019–2022



YOUTH OBESITY AND OVERWEIGHT RATE, FYs 2019–2022



Source: DHA/SP & F1 (J-5)/Analytics and Evaluation Division, DHA Measures Library, data accessed 8/17/2022

Notes:

– Reflects rate during last month of each quarter.

– Obesity and overweight in adults are defined as having a BMI ≥30.0 kg/m2 and at least 25.0 kg/m2 but less than 30.0 kg/m2, respectively. Adult dashboard measure includes beneficiaries 20 years of age and up, continuously enrolled (three months) in TRICARE Prime or Plus, with an MTF encounter in the last 12 months. Rates shown are age and sex adjusted (to the 2000 U.S. Census population).

– Obesity and overweight among youth is defined as having a BMI ≥95th or ≥85th and <95th percentile of the CDC's sex-specific BMI for age growth chart, respectively. Youth dashboard measure includes beneficiaries aged 3 years to 19 years, continuously enrolled (3 months) in TRICARE Prime or Plus, with an MTF encounter in the last 12 months. Rates shown are age adjusted (to the 2000 U.S. Census Population).

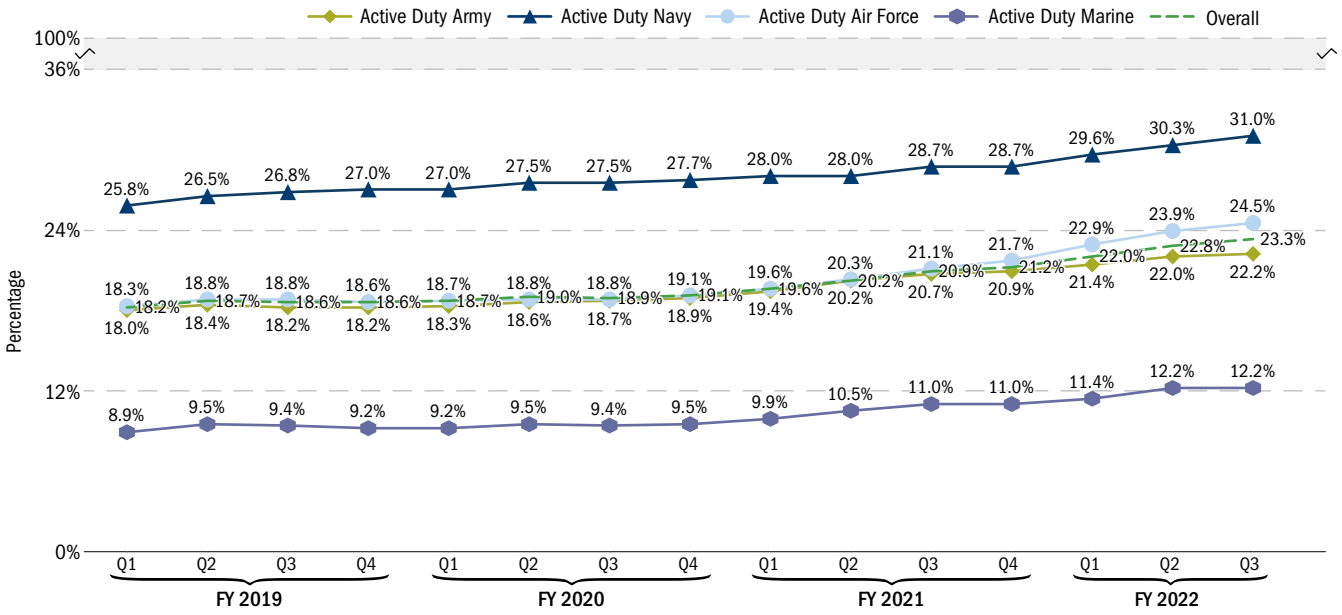
– The obesity and overweight dashboard measure data are presumed objective clinical measurements. The survey-derived obesity statistics, described earlier, are self-reported data, which are subject to recall bias, while provider measurements are subject to instrument error (e.g., lack of calibration of weight scales) and inconsistency in recording (e.g., asking patient's height or weight versus measuring).

MHS DASHBOARD BETTER HEALTH MEASURES *(CONT.)*

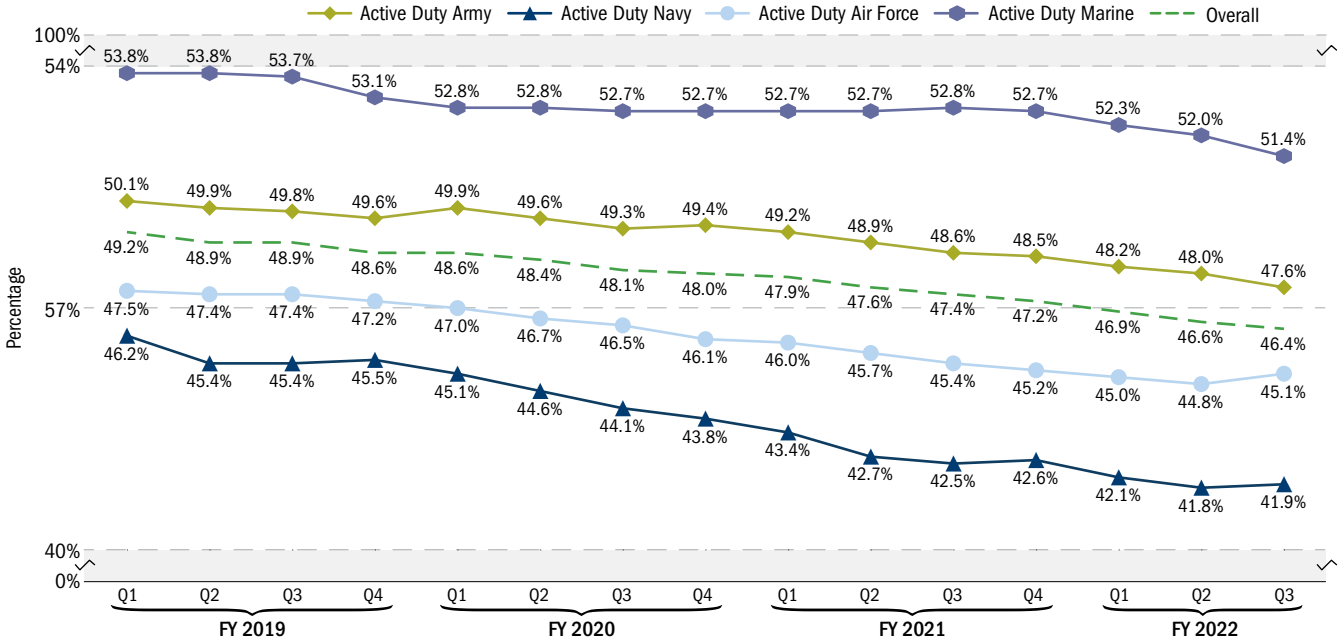
Obesity and Overweight Prevalence *(cont.)*

Obesity and overweight rates among ADSMs have continued along similar trends as the general population. While obesity prevalence remains relatively low in comparison with other MHS beneficiaries, it continues to increase as the rate of overweight ADSMs declines. When stratified by Service Branch, obesity is highest among Navy ADSMs (31.0 percent) and lowest among Marines (12.2 percent). The opposite is true for overweight rates (Marines – 51.4 percent, Army – 47.6 percent, Air Force – 45.1 percent, Navy – 41.9 percent). However, BMI may not be an accurate indicator of adiposity, and higher rates of overweight among ADSMs may be partially biased by muscularity and hyper fitness.

ACTIVE DUTY SERVICE MEMBER OBESITY RATE, FYs 2019–2022



ACTIVE DUTY SERVICE MEMBER OVERWEIGHT RATE, FYs 2019–2022



Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, DHA Measures Library, data accessed 8/17/2022

Notes:

– Reflects rate during last month of each quarter.

– ADSM obesity and overweight dashboard measure includes AD beneficiaries 17 years of age and up, continuously enrolled (three months) in TRICARE Prime or Plus, with an MTF encounter in the last 12 months.

– Obesity and overweight are defined as described for youth and adults, depending on the age of the ADSM.

– The obesity and overweight dashboard measure data are presumed objective clinical measurements. The survey-derived obesity statistics, described earlier, are self-reported data, which are subject to recall bias, while provider measurements are subject to instrument error (e.g., lack of calibration of weight scales) and inconsistency in recording (e.g., asking patient's height or weight versus measuring).

HEALTH-RELATED QUALITY OF LIFE (HRQOL)

Using CDC's Health-Related Quality of Life Questions as a Proxy Measure of "Better Health"

During FY 2018, senior DHA and Service medical leadership directed adding an overall measure of our MHS population health. Ultimately, it was proposed to assess and trend the overall health of the MHS population using the same HRQOL measurement as the CDC's state-based Behavioral Risk Factor Surveillance System (BRFSS). Self-perceived health status is considered a valid proxy measure for the state of U.S. national health; research has shown that people's perception of their health is highly correlated with their actual health, and can be used at the population level.

HRQOL refers to the perceived physical and mental health (MH) of an individual or group over a period of time. The standard four-item set of Healthy Days core questions (CDC HRQOL–4) has been in the state-based BRFSS since 1993 (see the BRFSS website at https://www.cdc.gov/brfss).

- From 2000 to 2012, the CDC HRQOL–4 has been in the NHANES for persons aged 12 and older.
- Since 2003, the CDC HRQOL–4 has been in the Medicare Health Outcomes Survey (HOS)—a measure in the Healthcare Effectiveness Data and Information Set (HEDIS) of the National Committee for Quality Assurance (NCQA) (https://www.cdc.gov/HRQOL/HRQOL14_measure.htm).

The HRQOL–4 questions are:

- **Self-rated health:** In general, how would you rate your overall health? (Respondents have five choices: poor, fair, good, very good, or excellent. "Good health" is coded as the proportion of those rating their overall health as good, very good, or excellent.)
- **Number of recent days physical health not good:** Thinking about your physical health, including physical illness and injury, how many days during the past 30 days was your physical health not good? (Referred to as "poor physical health.")
- **Number of recent days mental health not good:** Thinking about your mental health—including stress, depression, and problems with emotions—how many days during the past 30 days was your mental health not good? (Referred to as "poor mental health.")
- **Number of recent days limited due to poor physical/mental health:** During the past 30 days, how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? (Referred to as "limited by poor health.")

Although the CDC currently reports BRFSS data from 2010 on its website, and these results are used to inform the HP 2020 Goals, HCSDB HRQOL results are compared to norms calculated from 2017 BRFSS micro data, which are not currently reported in summary like 2010, but rather containing responses from approximately 440,000 respondents in 53 states/territories, and reweighted to match our MHS population. Mode differences between the BRFSS and HCSDB may result in mode effects and make comparison more difficult. Healthy People 2030 does not include HRQOL goals.

Because the MHS population differs from the U.S. population in age, gender, and ethnic composition, BRFSS rates were reweighted to match MHS users' characteristics in those areas. However, the populations may differ in other ways that complicate the comparisons between estimates from the BRFSS and HCSDB—for example, employment, education, and access to health care.

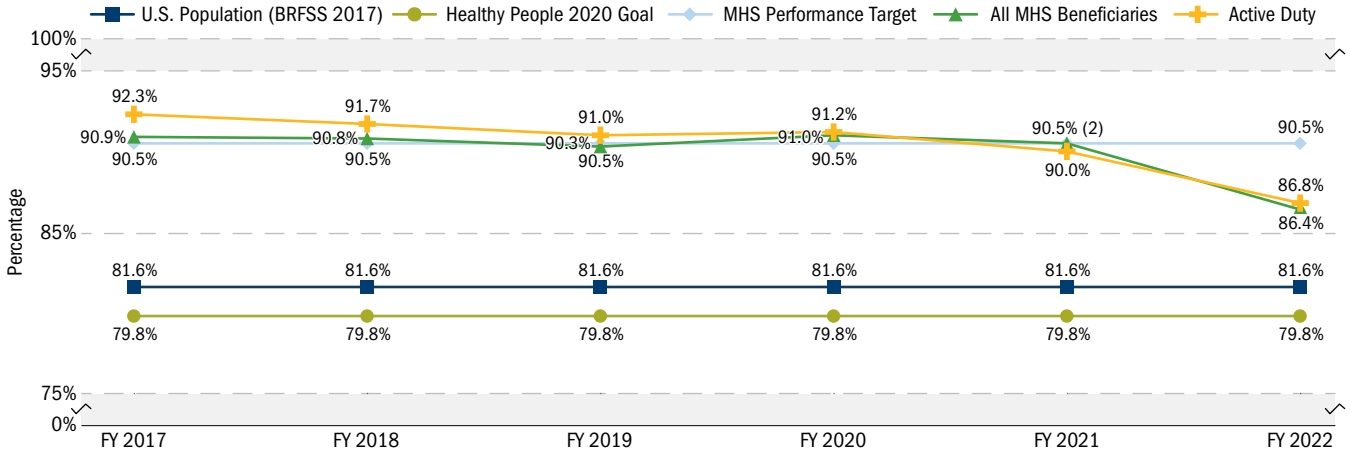
After examining both the HP and BRFSS benchmarks, the MHS established a performance target of 90.5 percent by January 1, 2021. As shown in the following graphs, the overall MHS population in general, including ADSM, rate their health status higher than the general U.S. population did in 2017, and both are higher than the HP 2020 goal of 79.8 percent.

- The overall MHS population rating of good or better health appears to have remained about the same from FY 2017 through FY 2021, ranging from 90 percent to 92 percent. However, scores for all MHS beneficiaries declined from 91 percent in FY 2021 to 86 percent in FY 2022. ADSMs rating their health as good or better declined from 90 percent to 87 percent for the same period.
- From FY 2021 to FY 2022, physically unhealthy days in the past 30 days increased from 3.7 to 5.3 for ADSM/Reservists, 2.9 to 3.5 for ADSM/Reservists dependents, and 4.2 to 4.7 for retirees and their dependents. Emotionally unhealthy days out of the past 30 increased from 4.5 in FY 2021 to 5.9 in FY 2022 for ADSM/Reservists and from 4.9 in FY 2021 to 5.5 for dependents of ADSM/Reservists. Retirees and their dependents saw almost no change in emotionally unhealthy days with 3.2 in FY 2021 and 3.3 in FY 2022.

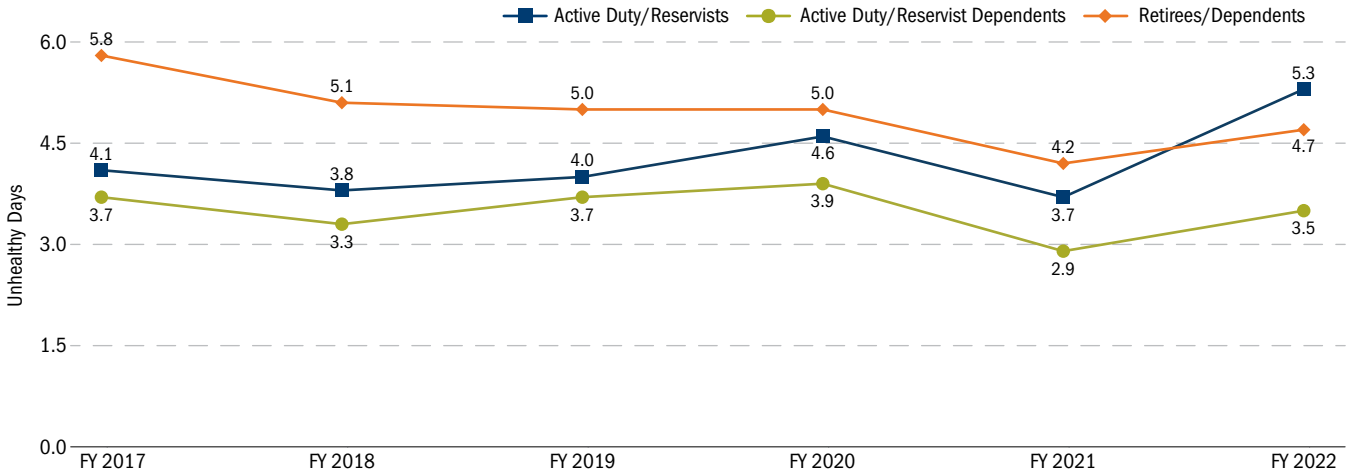
HEALTH-RELATED QUALITY OF LIFE (HRQOL) *(CONT.)*

Using CDC's Health-Related Quality of Life Questions as a Proxy Measure of "Better Health" *(cont.)*

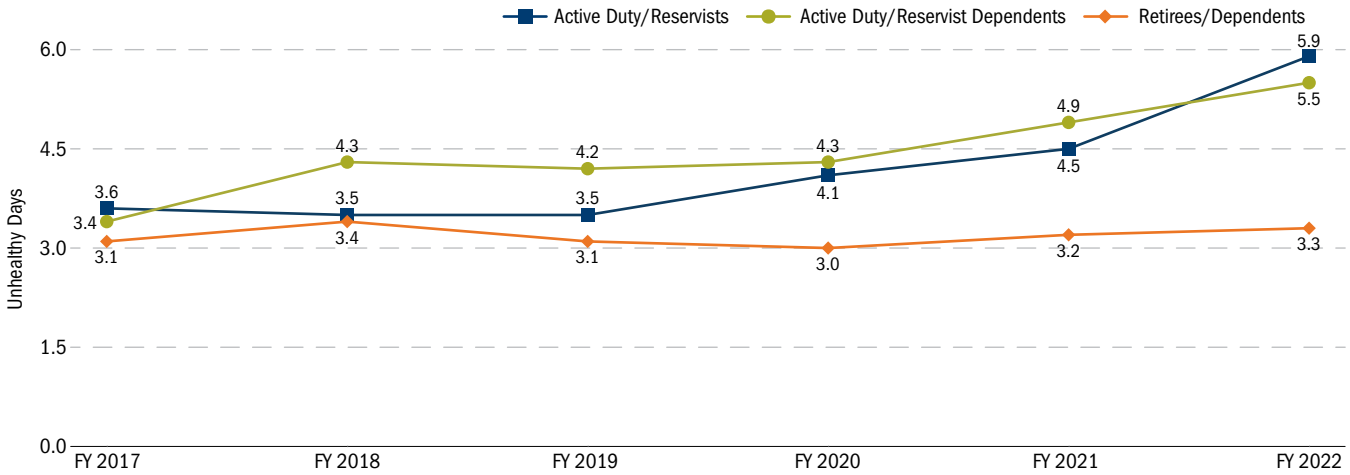
PERCENTAGE OF MILITARY BENEFICIARIES SELF-RATING HEALTH STATUS AS GOOD OR BETTER, FYs 2017–2022



PHYSICALLY UNHEALTHY DAYS FOR TRICARE BENEFICIARIES, FYs 2017–2022



EMOTIONALLY UNHEALTHY DAYS FOR TRICARE BENEFICIARIES, FYs 2017–2022



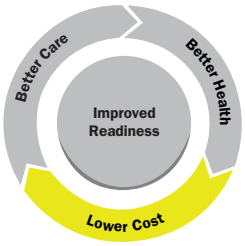
Source: DHA/SP&FI (J-5)/Analytics and Evaluation Division, 1/12/2023

Notes:

– BRFSS results are from the 2017 survey conducted by CDC, reweighted to match the 2017 MHS population.

– Unhealthy days are measured from 0 to 30 out of the last 30 days, as indicated in HRQOL questions 3 and 4 on the previous page.

SAVINGS AND RECOVERIES



Pharmacy Retail Refunds

The authority at 38 USC 8126 directly authorizes refunds when direct purchases of pharmaceuticals are made by the government (i.e., MTFs, TRICARE mail order pharmacy, etc.) and is made applicable to the TRICARE retail pharmacy program by the TRICARE Pharmacy Benefits Program statute at 10 U.S.C. 1074g(f) and the implementing TRICARE regulation.

The increase in refunds on drugs dispensed in retail is likely caused by several factors. Potential drivers include a shift of prescription volume from the military medical treatment facility (MTF) point of service to the retail point of service starting in early 2020 driven by the COVID-19 pandemic, cost increases for branded medications, increasing availability and use of costly specialty medications, and additional discounts offered by manufacturers through the Department of Defense (DoD) Pharmacy & Therapeutics (P&T) process.

PHARMACY RETAIL REFUNDS ($ MILLIONS), FYs 2018–2022

	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022
Total Receivables	$841.78	$836.01	$859.28	$986.97	$1,067.87
Total Collections	$853.44	$860.82	$824.89	$957.52	$1,019.70

Source: Defense Health Agency (DHA) Business Support Directorate, Contract Resource Management, 9/30/2022

Note: Refund amounts are netted out of pharmacy costs provided within this report. The refunds in the table above are categorized in the fiscal year (FY) they were validated and billed to the manufacturers.

Program Integrity Activities

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

PROGRAM INTEGRITY RECOVERIES/COST AVOIDANCE ($ MILLIONS), CALENDAR YEARS (CYs) 2019–2021

	CY 2019	CY 2020	CY 2021
Total Recoveries	$363.6	$509.2	$555.9
Court-Ordered Fraud Judgments/Settlements	$328.2	$493.1	$520.9
DHA PI Contractor Administrative Recoupment/Offsets (Received)	$34.4	$16.1	$35.1
Total DHA PI Contractors Cost Avoidance	$67.5	$41.2	$66.8
Contractor Prepayment Reviews	$67.5	$40.3	$66.7
Excluded Providers	$0.1	$0.9	$0.1

Source: 2021 Annual Program Integrity Operational Report/Contractor Submitted Fraud and Abuse Reporting, CY 2019–CY 2021. CY 2021 data are the latest reported as of 11/28/2022.

Note: Annual Reports are located here: https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Program-Integrity.

SAVINGS AND RECOVERIES *(CONT.)*

Program Savings and Claim Recoveries

New reimbursement approaches are continually evaluated for potential savings to TRICARE. As new programs are established, savings are estimated and monitored.

Claim recoveries result from identified overpayments adjusted in TRICARE Encounter Data (TED), and the differences are recouped.

Recovery A—Post-Payment Duplicate Claim Recoveries: A post-payment duplicate claims system was developed by the DHA Health Care Operations Directorate/TRICARE Health Plan Division for use by TRICARE private sector care contractors. The system was designed as a retrospective auditing tool and facilitates the identification of actual duplicate claim payments and the initiation and tracking of recoupments. The table below provides the historical recovery of duplicate claims payments. Duplicate claim recoveries show a decrease due to a regional contractor correcting claims processing issues.

RECOVERIES ($ MILLIONS), FYs 2020–2022

RECOVERIES	FY 2020	FY 2021	FY 2022
Post-Payment Duplicate Claim Recoveries	$21.1	$10.8	$8.9

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

OVERPAYMENTS RECAPTURED OUTSIDE OF PAYMENT RECAPTURE AUDITS ($ MILLIONS), FY 2022

ACTUAL OVERPAYMENT DOLLARS IDENTIFIED VIA RANDOM SAMPLES[a]	AMOUNT RECAPTURED (REFUNDS THROUGH FY 2022)
$8.9	$213.6

Sources: DHA/R&M (J-1/J-8)/Trust Fund and Revenue Cycle Management Improper Payment Evaluation Branch; Operational Reports and Quarterly Fraud and Abuse Reports

[a] "Actual overpayment dollars identified via random samples" represents the total overpayment dollars from sampled claims.

Notes:

– DHA's methodology to calculate recoveries takes into consideration subsequent repayments and nets them against refunds.

– These numbers include recoupments for overpayments identified in audits as well as refunds occurring in the course of routine claim adjustments. DHA has no way to distinguish overpayment recoupments from routine claim adjustments.

In addition to the EIC post-payment reviews, DHA requires TRICARE private sector care contractors to use industry best business 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 2022 improper payment recoveries of health care as a result of the EIC compliance reviews and ongoing private sector care contractor efforts to identify and recover improper payments.

INPATIENT UTILIZATION RATES AND COSTS

TRICARE Inpatient Utilization Rates Compared with Civilian Benchmarks (U.S. Only)

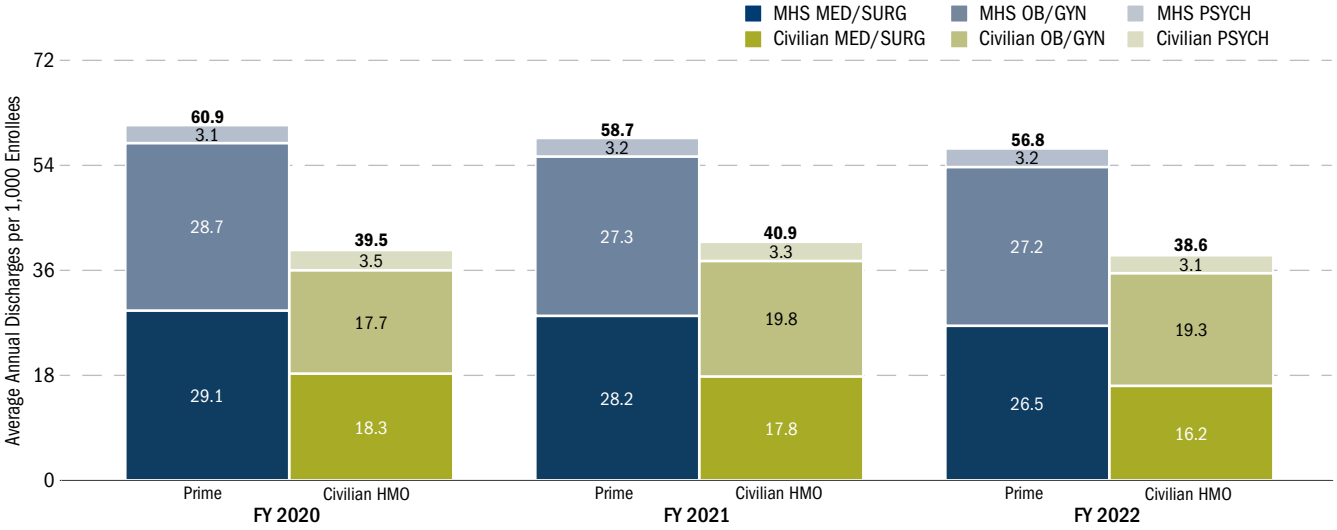
TRICARE Prime Enrollees

This section compares the inpatient utilization of TRICARE Prime enrollees (including TRICARE Young Adult [TYA] Prime but excluding the Uniformed Services Family Health Plan [USFHP]) with that of enrollees in civilian employer-sponsored health maintenance organization (HMO) plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. Inpatient utilization is measured as the total number of dispositions (i.e., the sum of direct and private sector care dispositions) because relative weighted products (RWPs) are not available in the civilian-sector data.

Dispositions are computed for three broad product lines—obstetrics/gynecology (OB/GYN), mental health (PSYCH), and other medical/surgical (MED/SURG)—and compared for acute care facilities only. The comparisons exclude beneficiaries aged 65 and older because very few are covered by employer-sponsored plans.

- The overall TRICARE Prime inpatient utilization rate decreased by 7 percent between FY 2020 and FY 2022, while the civilian HMO rate decreased by 2 percent. The overall TRICARE Prime decrease was driven by a 9 percent decline in MED/SURG utilization and a 5 percent decline in OB/GYN utilization. Although PSYCH utilization increased by 3 percent, it represents only a small fraction of total utilization.
- In FY 2022, the TRICARE Prime inpatient utilization rate (direct and private sector care combined) was 47 percent higher than the civilian HMO utilization rate (56.8 discharges per 1,000 Prime enrollees compared with 38.6 per 1,000 civilian HMO enrollees).
- In FY 2022, the TRICARE Prime inpatient utilization rate was 64 percent higher than the civilian HMO rate for MED/SURG procedures, 41 percent higher for OB/GYN procedures, and 3 percent higher for PSYCH procedures.
- The average length of stay (LOS) for MHS Prime enrollees (direct and private sector care combined) increased slightly from 3.4 days in FY 2020 to 3.7 days in FY 2022, whereas the average LOS for civilian HMOs remained steady at 3.8 days. In FY 2022, the average LOS for MHS Prime enrollees was 2 percent lower than that of civilian HMO enrollees (not shown).

INPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK, FYs 2020–2022



Sources: MHS administrative data, 1/20/2023, and Merative™ MarketScan® Commercial Database, 1/16/2023

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2022 civilian benchmarks are based on two quarters of data, which were seasonally adjusted and annualized.

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

LOWER COST

INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

TRICARE Inpatient Utilization Rates Compared with Civilian Benchmarks (U.S. Only) *(cont.)*

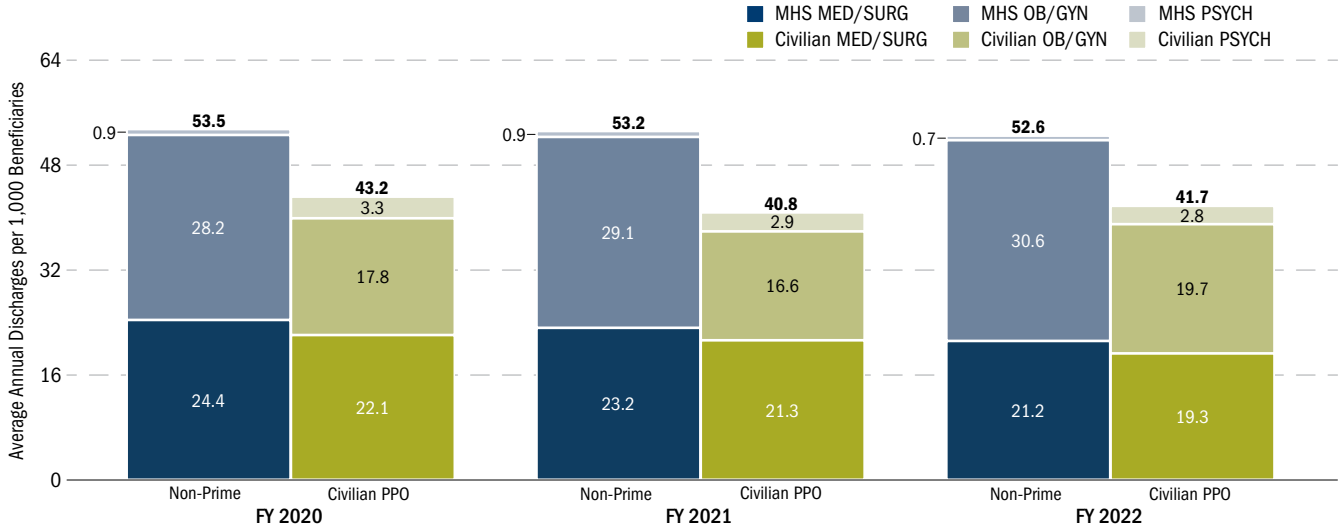
Non-Prime-Enrolled Beneficiaries

This section compares the inpatient utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored preferred provider organization (PPO) plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. Inpatient utilization is measured as the total number of dispositions (i.e., the sum of direct and private sector–care dispositions) because relative weighted products (RWPs) are not available in the civilian-sector data.

Dispositions are computed for three broad product lines—OB/GYN, PSYCH, and other MED/SURG procedures—and compared for acute care facilities only. The comparisons exclude beneficiaries aged 65 and older because very few are covered by employer-sponsored plans. To make the utilization rates of MHS and civilian beneficiaries more comparable, non-Prime-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Although most beneficiaries who fail to file a TRICARE claim have PHI, we estimate that about 20 percent do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable with the civilian rates, which also include non-users.

- Between FY 2020 and FY 2022, the overall TRICARE non-Prime utilization rate decreased by 2 percent, whereas the civilian PPO inpatient utilization rate declined by 4 percent. Despite the sharp overall decline, the TRICARE rate remains well above the civilian benchmark. In FY 2022, the inpatient utilization rate (direct and private sector care combined) for non-Prime-enrolled beneficiaries was 26 percent higher than that of civilian PPO participants.
- By far the largest discrepancy in utilization rates between the MHS and the private sector is for OB/GYN procedures. From FY 2020 to FY 2022, the MHS OB/GYN disposition rate increased by 8 percent, whereas it increased by 10 percent in the civilian sector. In FY 2022, the MHS OB/GYN disposition rate was 56 percent higher than the corresponding civilian PPO rate.
- Of the three product lines considered in this report, only PSYCH procedures had lower utilization in the MHS than in the civilian sector.
- The average LOS for MHS non-Prime-enrolled beneficiaries (direct and private sector care combined) remained unchanged at 3.6 days from FY 2020 to FY 2022, whereas the average LOS for civilian PPO participants remained unchanged at 3.8 days. As a result, the average LOS for MHS non-Prime beneficiaries was 4 percent lower than that of civilian PPO participants in FYs 2020–2022 (not shown).

INPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK, FYs 2020–2022



Sources: MHS administrative data, 1/20/2023, and Merative™ MarketScan® Commercial Database, 1/16/2023

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2022 civilian benchmarks are based on two quarters of data, which were seasonally adjusted and annualized.

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

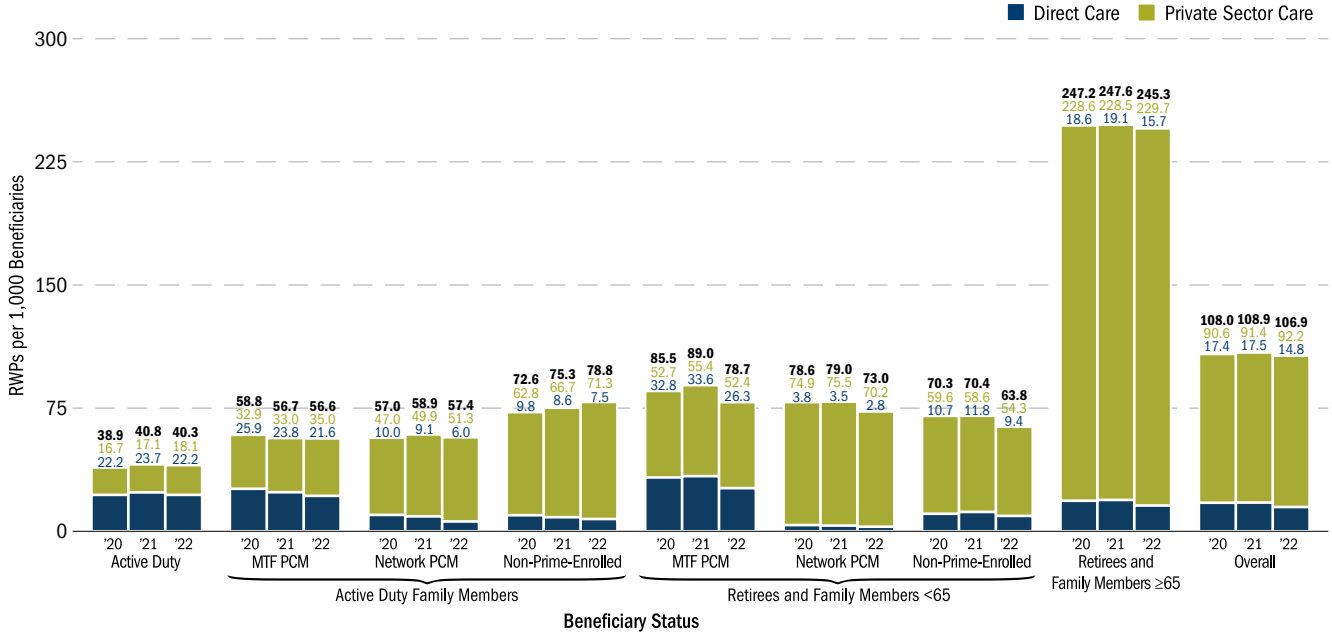
INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Inpatient Utilization Rates by Beneficiary Status

When breaking out inpatient utilization by beneficiary group, RWPs per capita more accurately reflect differences across beneficiary groups than do discharges per capita. MHS RWPs are based on the Medicare Severity Diagnosis Related Group (MS-DRG) system of classifying inpatient hospital cases under the Medicare Prospective Payment System and are relevant only for acute care hospitals.

- The overall (direct and private sector care combined) inpatient utilization rate (RWPs per 1,000 beneficiaries) fell by 1 percent from FY 2020 to FY 2022.
- Between FY 2020 and FY 2022, the direct care inpatient utilization rate decreased by 15 percent overall, due in part to the downsizing of three military hospitals to clinics over that time period and in part because of the adverse impact of the COVID-19 pandemic. The direct care inpatient utilization rate fell for all beneficiary groups, except Active Duty members, who experienced no change. Active Duty family members (ADFMs) with a network primary care manager (PCM) had the largest decline (40 percent). Retirees and family members (RETFMs) with a network PCM also saw a large decline (25 percent). The remaining beneficiary groups experienced declines ranging from 12 to 23 percent.
- The overall private-sector acute care inpatient utilization rate increased by 2 percent between FY 2020 and FY 2022, but there was variation across beneficiary groups. Non-Prime-enrolled ADFMs experienced a 14 percent increase, while smaller increases were experienced by Active Duty members (9 percent), ADFMs with a network PCM (9 percent), ADFMs with an MTF PCM (7 percent), and RETFMs age 65 and older (less than 1 percent). RETFMs under age 65 with an MTF PCM experienced no change and the remaining beneficiary groups experienced declines ranging from 6 to 9 percent.
- Excluding Medicare-eligible beneficiaries (for whom Medicare is likely their primary source of care and TRICARE is second payer), the percentage of per capita inpatient workload performed in private sector care facilities increased from 73 percent in FY 2020 to 77 percent in FY 2022.
- From FY 2020 to FY 2022, the percentage of per capita inpatient workload referred to the network on behalf of beneficiaries enrolled with an MTF PCM (including Active Duty personnel) rose from 54 percent to 57 percent.

AVERAGE ANNUAL INPATIENT RWPs PER 1,000 BENEFICIARIES, FYs 2020–2022



Source: MHS administrative data, 1/20/2023

Notes:

– The Retirees and Family Members groups include survivors and others not explicitly identified elsewhere.

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

LOWER COST

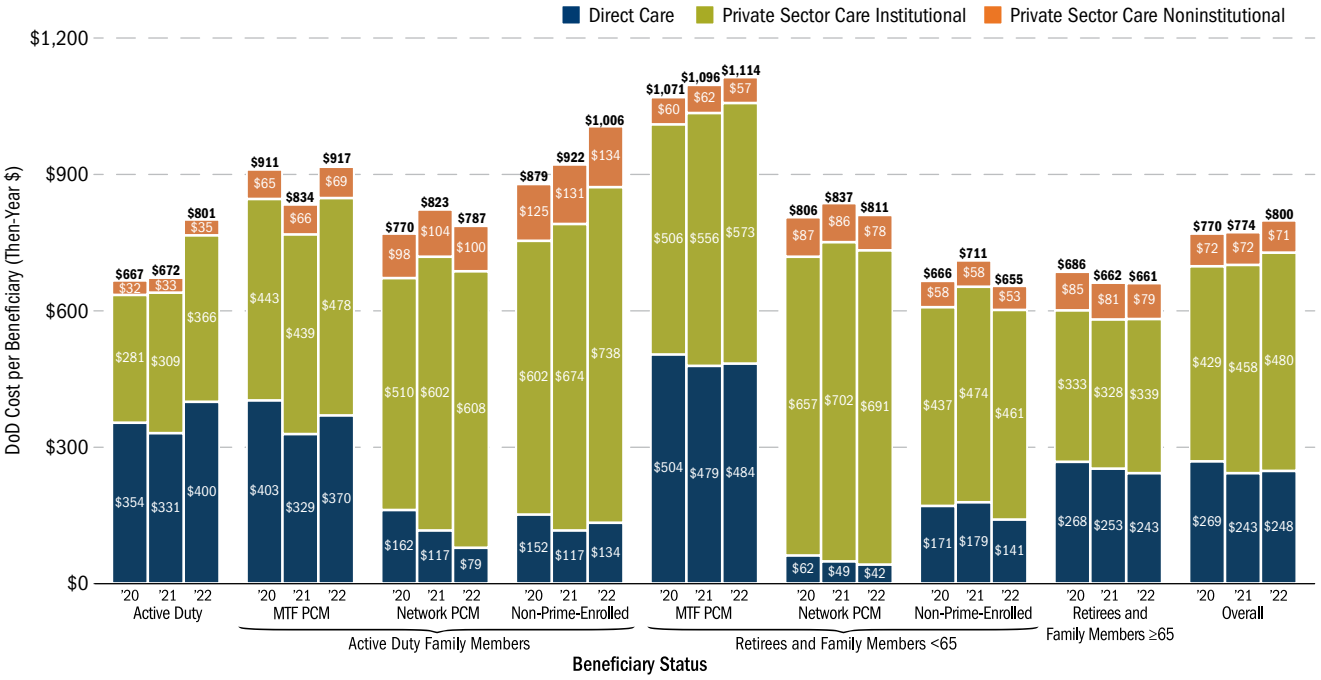
INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Inpatient Cost by Beneficiary Status

Total DoD in-patient costs include two components: (1) expenditures for direct care at MTFs that are attributed to inpatient care and (2) payments made to private sector care (PSC) institutions (and others) for services rendered in hospitals, both acute care and non-acute. PSC payments to "others" are for professional services that are associated with a hospital stay; e.g., provider visits, lab services, anesthesia, and other.

- The overall MHS inpatient cost per beneficiary increased by four percent between FY 2020 and FY 2022.
- By beneficiary group, the total inpatient cost per beneficiary increased most (20 percent) for Active Duty.
- For PSC, the inpatient cost per beneficiary increased by 10 percent between FY 2020 and FY 2022; however, for direct care, the inpatient cost per beneficiary actually decreased by eight percent over that same period.
- A separate analysis shows that the PSC cost per RWP increased from $9,170 to $9,950 between FY 2020 and FY 2022 and that the direct care cost per RWP increased from $15,400 to $16,800 over that same period.

AVERAGE ANNUAL DoD INPATIENT COSTS PER BENEFICIARY, FYs 2020–2022



Source: DHA/Resources & Management Directorate (J-8)/Business Integration Division, 5/17/2023

Notes:

– The reader should exercise caution when comparing the direct versus private sector care costs per RWP. The data on this page are unadjusted for differences in beneficiary mix, enrollment status, geographical location of care, etc. They represent DoD health care costs only and specifically exclude beneficiary cost shares, administrative costs, and overhead expenses.

– The Retirees and Family Members groups include survivors and others not explicitly identified elsewhere.

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

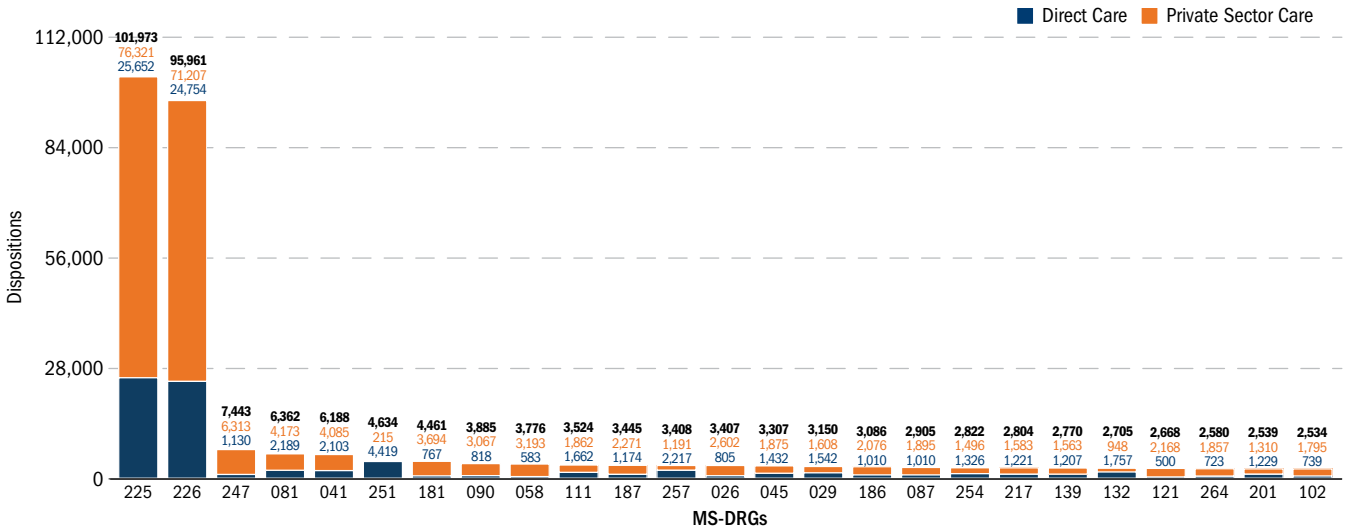
INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Leading Inpatient Diagnosis Groups (U.S. Only)

The MHS uses the MS-DRG system to classify acute care hospital inpatient cases into clinically related categories having similar treatment costs. For the purpose of this section, MS-DRGs exhibiting variations in complications and comorbidities were grouped into like categories[1] and numbered sequentially. The category numbers have no significance other than to identify the DRGs on the horizontal axes in the charts below. See the Appendix for additional detail on the DRG grouping methodology.

The top 25 MS-DRGs in terms of volume in FY 2022 accounted for 71 percent of all inpatient admissions (direct care and private sector care combined) in acute care hospitals. TFL admissions and observation stays are excluded from the calculations.

LEADING INPATIENT DIAGNOSIS GROUPS BY VOLUME, FY 2022



MS-DRGs

26 Major Small and Large Bowel Procedures
29 Appendectomy
41 Esophagitis, Gastroenteritis, and Miscellaneous Digestive Disorders
45 Cholecystectomy
58 Seizures and Headaches
81 Respiratory Infections and Inflammations
102 Disorders of Pancreas Except Malignancy
111 Major Joint Replacement or Reattachment of Lower Extremity
121 Percutaneous Cardiovascular Procedures with Coronary Artery Stent
132 Heart Failure and Shock
139 Cardiac Arrhythmia and Conduction Disorders
181 Operating Room Procedures for Obesity
186 Diabetes
187 Nutritional and Miscellaneous Metabolic Disorders
201 Kidney and Urinary Tract Infections
217 Uterine and Adnexal Procedures for Non-Malignancy
225 Pregnancy, Childbirth, and the Puerperium
226 Newborns and Other Neonates with Condition Originating in Perinatal Period
247 Septicemia or Severe Sepsis
250 Depressive Neuroses
251 Neuroses Except Depressive
254 Psychoses
257 Alcohol/Drug Abuse or Dependence
264 Poisoning and Toxic Effects of Drugs
274 Other Factors Influencing Health Status

- The top two procedures by volume are related to childbirth, accounting for 50 percent of all hospital admissions (not just among the top 25).
- Procedures performed in private-sector acute care hospitals account for 71 percent of the total volume of the top 25 MS-DRGs.
- Admissions in direct care facilities exceed those in private sector care facilities for only three of the top 25 MS-DRGs.
- Surgical procedures for obesity ranks 7th in volume among the top 25 MS-DRGs. Thus, the obesity epidemic in the civilian sector (as per the Centers for Disease Control and Prevention [CDC]) appears to be mirrored to an extent in the DoD population as well.

Source: MHS administrative data, 1/20/2023

[1] DRGs were grouped into like categories using a code set available on www.findacode.com/code-set.php?set=DRG, an online database of medical billing codes and information. The site lists surgical and medical DRGs within each Major Diagnostic Category with headings above diagnostically related DRGs. In some cases (e.g., DRGs related to pregnancy and childbirth), the headings were further grouped into larger, descriptively similar categories. The headings were then sequentially numbered, providing the basis for the DRG grouping methodology.

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

OUTPATIENT UTILIZATION RATES AND COSTS

TRICARE Outpatient Utilization Rates Compared with Civilian Benchmarks (U.S. Only)

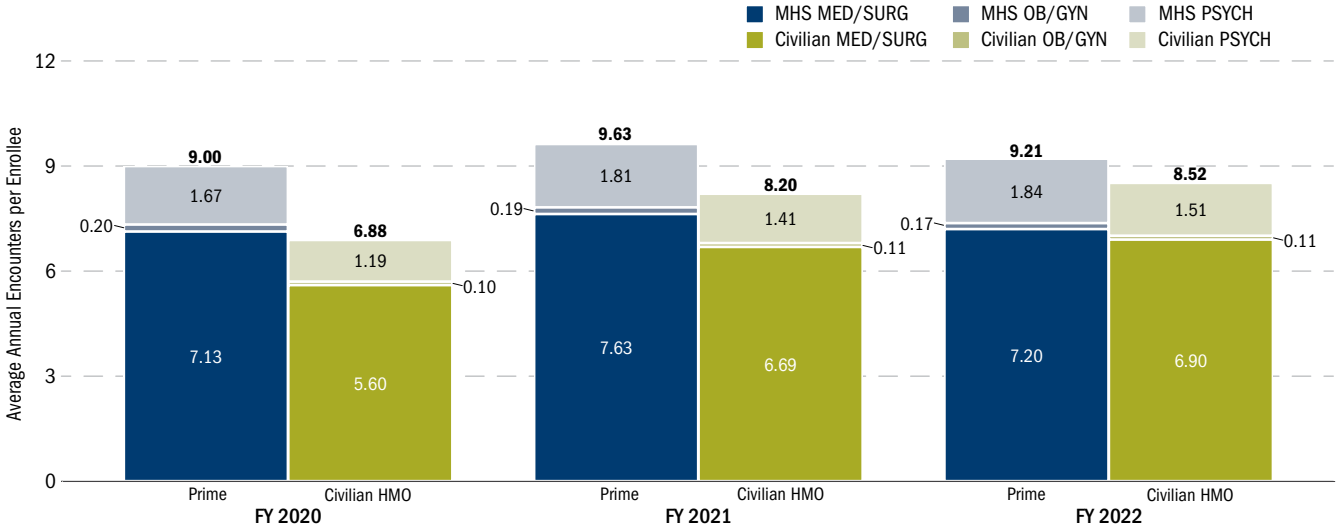
TRICARE Prime Enrollees

This section compares the outpatient utilization of TRICARE Prime enrollees (including TYA Prime but excluding the USFHP) with that of enrollees in civilian employer-sponsored HMO plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. Outpatient utilization is measured in terms of encounters because the civilian-sector data used in the comparisons do not contain a measure of relative value units (RVUs). However, there is no fixed definition for what constitutes a "face-to-face" encounter with a physician. TRICARE and the private sector may, therefore, use differing methodologies to calculate the number of encounters.

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

- The overall TRICARE Prime outpatient utilization rate (direct and private sector care combined) increased by 2 percent between FY 2020 and FY 2022. The civilian HMO outpatient utilization rate increased by 24 percent over the same period.
- In FY 2022, the overall Prime outpatient utilization rate was 8 percent higher than the civilian HMO rate.
- In FY 2022, the Prime outpatient utilization rate for MED/SURG procedures was 4 percent higher than the civilian HMO rate.
- The Prime outpatient utilization rate for OB/GYN procedures fell by 17 percent between FY 2020 and FY 2022 (albeit from a low base rate) but still remained 55 percent higher than for civilian HMOs in FY 2022. However, the disparity is due in part to how the direct care system records global procedures.[1]
- The Prime outpatient utilization rate for PSYCH procedures was 22 percent higher than the corresponding rate for civilian HMOs in FY 2022. This disparity, though based on relatively low MHS and civilian MH utilization rates, may reflect the more stressful environment that many Active Duty Service members (ADSMs) and their families endure.

OUTPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK, FYs 2020–2022



Sources: MHS administrative data, 1/20/2023, and Merative™ MarketScan® Commercial Database, 1/16/2023

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

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2022 civilian benchmarks are based on two quarters of data, which were seasonally adjusted and annualized.

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

OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

TRICARE Outpatient Utilization Rates Compared with Civilian Benchmarks (U.S. Only) *(cont.)*

Non-Prime-Enrolled Beneficiaries

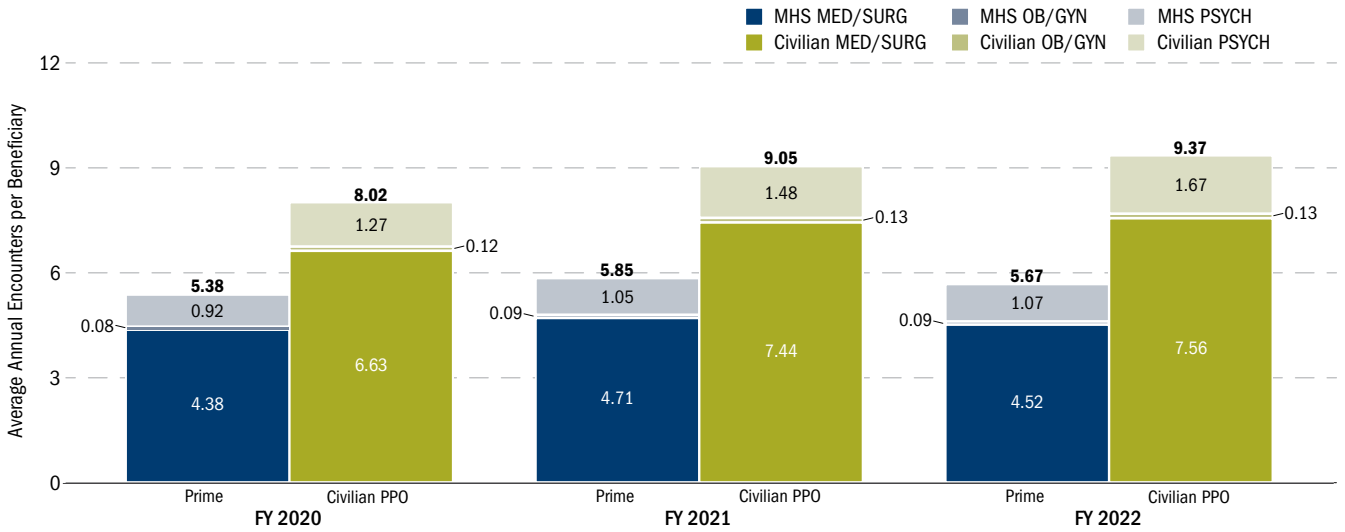
This section compares the outpatient utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored PPO plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. Outpatient utilization is measured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

Encounters are computed for three broad product lines: OB/GYN, PSYCH, and other MED/SURG. The comparisons are made for beneficiaries under age 65 only. To make the utilization rates of MHS and civilian beneficiaries more comparable, non-Prime-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Because telephone consults are routinely recorded in direct care data but appear very infrequently in private sector claims, they are also excluded from the direct care utilization computations. Although most beneficiaries who fail to file a TRICARE claim have PHI, we estimate that about 20 percent do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable to the civilian rates, which also include non-users.

- The overall TRICARE outpatient utilization rate (direct and private sector care combined) for non-Prime-enrolled beneficiaries increased by 5 percent between FY 2020 and FY 2022. The civilian PPO outpatient utilization rate increased by 17 percent over the same period.
- The overall TRICARE non-Prime outpatient utilization rate remained well below the level observed for civilian PPOs. In FY 2022, TRICARE non-Prime outpatient utilization was 39 percent lower than in civilian PPOs.
- In FY 2022, the non-Prime outpatient utilization rate for MED/SURG procedures was 40 percent lower than the civilian PPO rate. MED/SURG procedures account for roughly 80 percent of total outpatient utilization in both the military and civilian sectors.
- The TRICARE non-Prime outpatient utilization rate for OB/GYN procedures increased by 2 percent between FY 2020 and FY 2022 but was 35 percent below the rate for civilian PPO participants in FY 2022.
- The PSYCH outpatient utilization rate for non-Prime-enrolled MHS beneficiaries increased by 16 percent from FY 2020 to FY 2022, while the rate increased by 31 percent for civilian PPO participants. In FY 2022, the PSYCH outpatient utilization rate for non-Prime-enrolled beneficiaries was 36 percent below that of civilian PPO participants. The latter observation, together with the utilization exhibited by Prime enrollees, suggests that MHS beneficiaries in need of extensive PSYCH counseling (primarily ADSMs and their families) are more likely to enroll in Prime.

LOWER COST

OUTPATIENT UTILIZATION RATES BY PRODUCT LINE: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK, FYs 2020–2022



Sources: MHS administrative data, 1/20/2023, and Merative™ MarketScan® Commercial Database, 1/16/2023

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2022 civilian benchmarks are based on two quarters of data, which were seasonally adjusted and annualized.

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

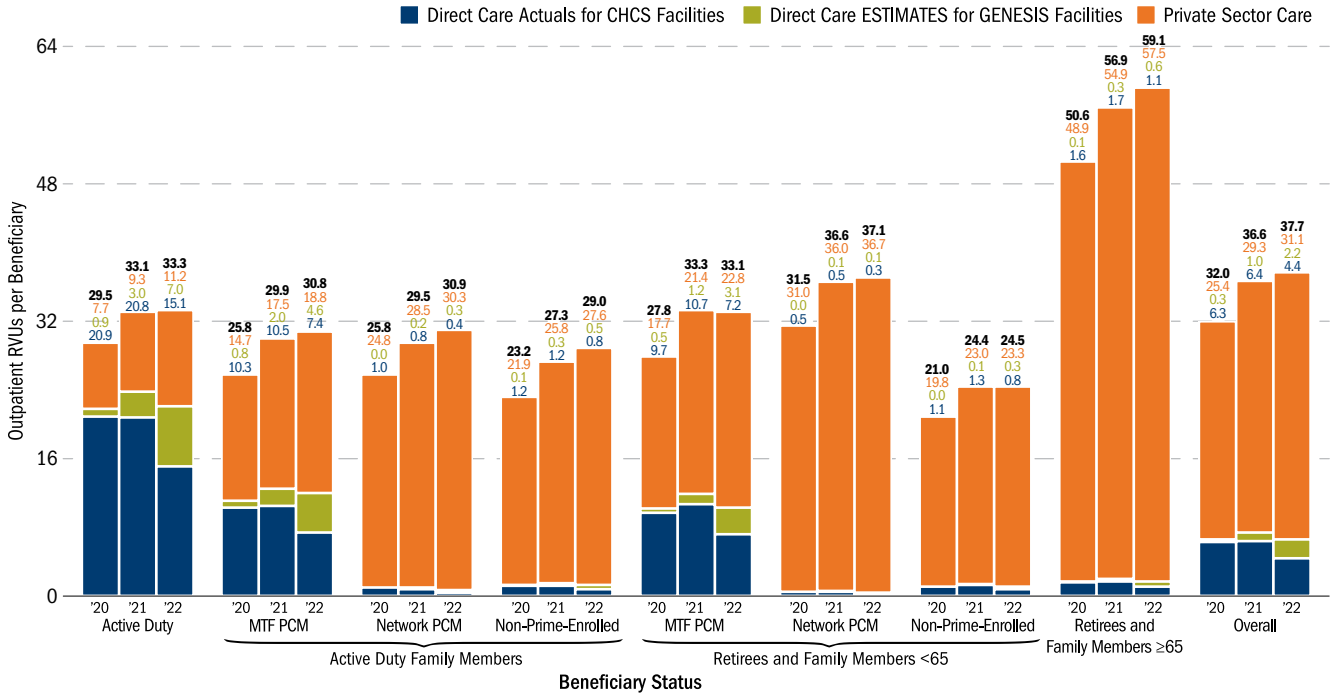
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Outpatient Utilization Rates by Beneficiary Status

When breaking out outpatient utilization by beneficiary group, RVUs per capita more accurately reflect differences across beneficiary groups than encounters per capita. The RVU measure used in this report is the sum of the Physician Work and Practice Expense RVUs (see the Appendix for a detailed description of the Physician Work and Practice Expense RVU measures). Note that direct care RVUs at non-GENESIS facilities are actuals, whereas RVUs at GENESIS facilities are estimates. Also note that since MHS GENESIS records do not include telephone consults, those encounters have been excluded from the Composite Health Care System (CHCS) records as well for consistency.

- Total per capita MHS outpatient utilization (direct plus private sector care) increased by 18 percent from FY 2020 to FY 2022.
- Overall direct care outpatient per capita utilization decreased by 1 percent from FY 2020 to FY 2022. Declines ranged from 3 percent for non-Prime enrolled RETFMs under age 65 to 31 percent for ADFMs with a network PCM. The largest increase was experienced by ADFMs with an MTF PCM (8 percent) with the remaining increases ranging from 1 to 2 percent.
- From FY 2020 to FY 2022, per capita private sector care outpatient utilization increased by 22 percent overall. Increases were experienced by every beneficiary group, ranging from 18 percent for nonenrolled RETFMs under age 65 and RETFMs age 65 and older, to 46 percent for Active Duty members.

AVERAGE ANNUAL OUTPATIENT RVUs PER BENEFICIARY, FYs 2020–2022



Source: MHS administrative data, 1/20/2023

Notes:

– The Retirees and Family Members groups include survivors and others not explicitly identified elsewhere.

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

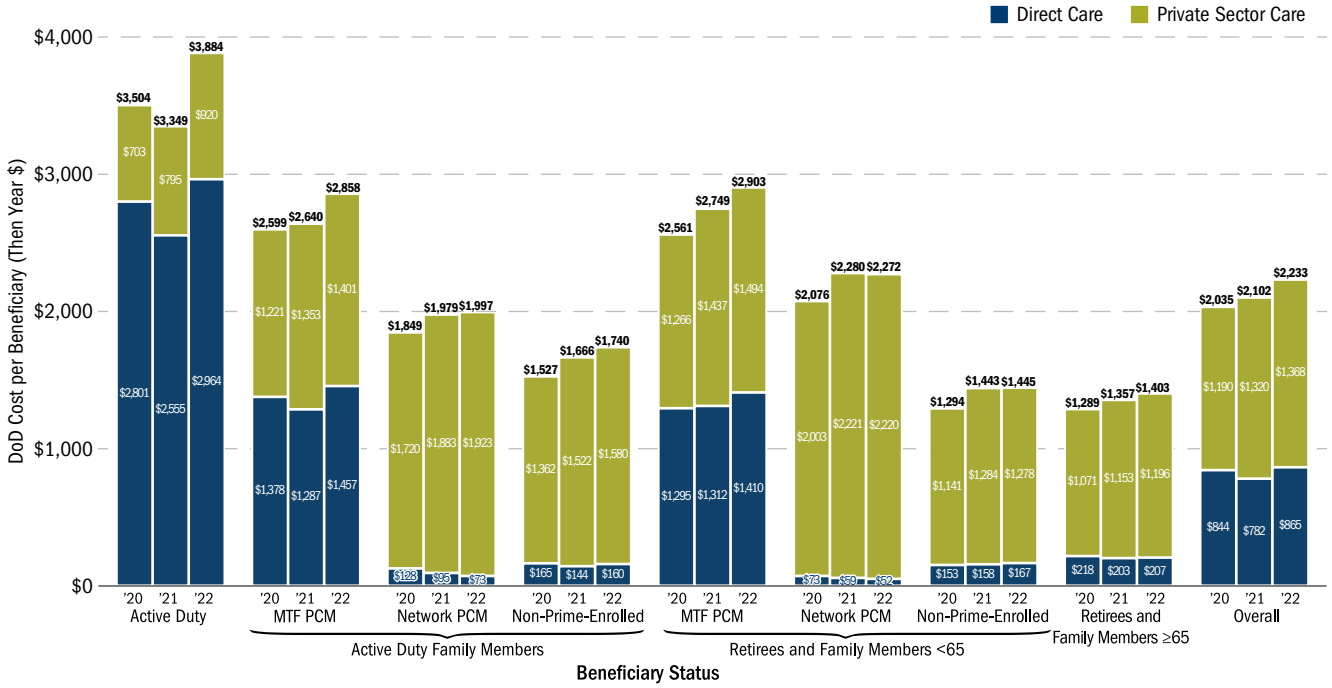
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Outpatient Costs by Beneficiary Status

Total DoD outpatient costs include two components: (1) expenditures for direct care at MTFs that are attributed to outpatient care and (2) payments made to PSC providers for services rendered in an outpatient setting, i.e., in an office or clinic, not in a hospital.

- The overall MHS outpatient cost per beneficiary increased by 10 percent between FY 2020 and FY 2022.
- Six of the eight beneficiary groups experienced a noticeable increase in total outpatient cost per beneficiary.
- For PSC, the cost per beneficiary for TRICARE for Life (TFL) persons increased about 12 percent between FY 2020 and FY 2022[1]; excluding TFL, the PSC outpatient cost per beneficiary increased by even more (16 percent).
- On the other hand, the direct care outpatient cost per beneficiary increased by just 2.5 percent over that same period.

AVERAGE ANNUAL DoD OUTPATIENT COSTS PER BENEFICIARY, FYs 2020–2022



Source: DHA/Resources & Management Directorate (J-8)/Business Integration Division, 5/17/2023

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

Notes:

– The Retirees and Family Members groups include survivors and others not explicitly identified elsewhere.

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

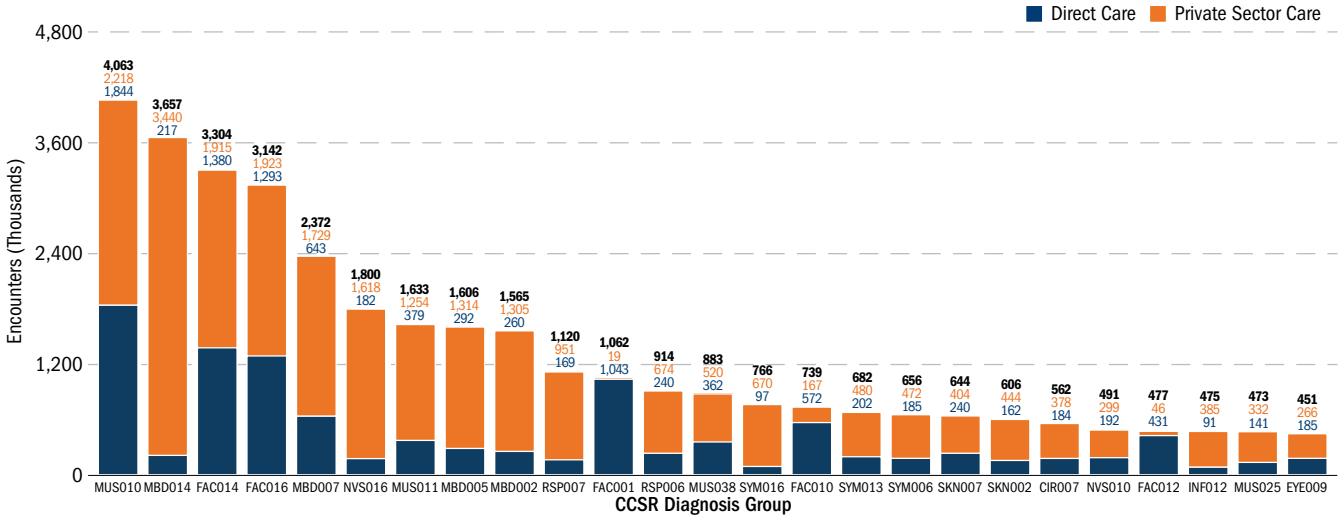
LOWER COST

OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Leading Outpatient Diagnosis Groups (U.S. Only)

Leading outpatient diagnoses were determined by grouping ICD-10-CM primary diagnosis codes into like categories using the Clinical Classifications Software Refined (CCSR) tool developed through a federal-state-industry partnership sponsored by the Agency for Healthcare Research and Quality (AHRQ). The CCSR replaces the Clinical Classifications Software tool and takes advantage of the specificity of ICD-10-CM diagnoses to create new clinical categories. The top 25 outpatient diagnosis groups in FY 2022 accounted for 62 percent of all outpatient encounters (direct care and private sector care combined). TFL encounters and telephone consults are excluded from the calculations.

LEADING OUTPATIENT DIAGNOSIS GROUPS BY VOLUME, FY 2022



CCSR Diagnosis Groups

CIR007	Essential Hypertension
EYE009	Refractive Error
FAC001	Encounter for Administrative Purposes
FAC010	Other Aftercare Encounter
FAC012	Other Specified Encounters and Counseling
FAC014	Medical Examination/Evaluation
FAC016	Exposure, Encounters, Screening, or Contact with Infectious Disease
INF012	COVID-19
MBD002	Depressive Disorders
MBD005	Anxiety and Fear-Related Disorders
MBD007	Trauma- and Stressor-Related Disorders
MBD014	Neurodevelopmental Disorders
MUS010	Musculoskeletal Pain, Not Low Back Pain
MUS011	Spondylopathies/Spondyloarthropathy (Including Infective)
MUS025	Other Specified Connective Tissue Disease
MUS038	Low Back Pain
NVS010	Headache; Including Migraine
NVS016	Sleep Wake Disorders
RSP006	Other Specified Upper Respiratory Infections
RSP007	Other Specified and Unspecified Upper Respiratory Disease
SKN002	Other Specified Inflammatory Condition of Skin
SKN007	Other Specified and Unspecified Skin Disorders
SYM006	Abdominal Pain and Other Digestive/Abdomen Signs and Symptoms
SYM013	Respiratory Signs and Symptoms
SYM016	Other General Signs and Symptoms

- The top diagnosis group in terms of volume is MUS010: musculoskeletal pain, not low back pain. This displaces the FY 2021 top diagnosis group FAC016: exposure, encounters, screening, or contact with infectious disease (now the fourth most frequent diagnosis), which was elevated in volume due to the COVID-19 pandemic.
- Positive test results for COVID-19 is in a CCSR category of its own (INF012) and is now the 23rd most common diagnosis.
- Diagnoses treated in private sector care facilities account for 68 percent of the total volume of the top 25 diagnosis groups.
- Encounters in direct care facilities exceed those in private sector care facilities for only three of the 25 top diagnosis groups.

Source: MHS administrative data, 1/20/2023
Note: Numbers may not sum to bar totals due to rounding.

PRESCRIPTION DRUG UTILIZATION RATES AND COSTS

TRICARE Prescription Drug Utilization Rates Compared with Civilian Benchmarks (U.S. Only)

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

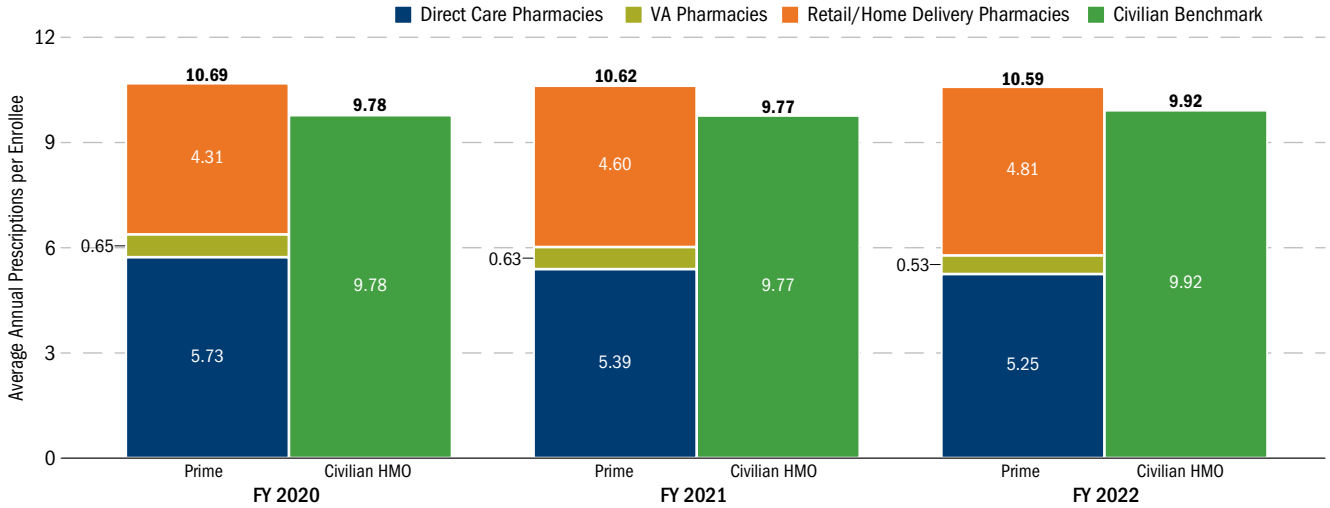
Direct care pharmacy data differ from private-sector claims in that they include over-the-counter medications. To make the utilization rates of MHS and civilian beneficiaries more comparable, over-the-counter medications were backed out of the direct care data using factors provided by the DHA Pharmacy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

TRICARE Prime Enrollees

This section compares the outpatient prescription drug utilization of TRICARE Prime enrollees (including TYA Prime but excluding the USFHP) with that of enrollees in civilian employer-sponsored HMO plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. To give a more complete picture of total prescription drug utilization by TRICARE beneficiaries, prescriptions filled at Department of Veterans Affairs (VA) pharmacies as part of a beneficiary's VA benefit (and paid for by VA) are included. Prescriptions filled at VA pharmacies under the TRICARE benefit have always been included with retail pharmacy prescriptions.

- The overall prescription utilization rate (direct care, VA, and private sector care combined) for TRICARE Prime enrollees decreased by 1 percent between FY 2020 and FY 2022, while the civilian HMO benchmark rate increased by 2 percent. In FY 2022, the TRICARE Prime prescription utilization rate was 7 percent higher than the civilian HMO rate.
- Prescription utilization rates for Prime enrollees at DoD pharmacies decreased by 8 percent between FY 2020 and FY 2022, whereas the utilization rate at private sector care pharmacies increased by 12 percent.
- Prescription utilization rates for Prime enrollees at VA pharmacies declined by 18 percent between FY 2020 and FY 2022, although the number of prescriptions is small.
- The overall private sector care share of per-capita prescription utilization for Prime enrollees increased from 46 percent in FY 2020 to 50 percent in FY 2022.

PRESCRIPTION UTILIZATION RATES BY SOURCE OF CARE[a]: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK, FYs 2020–2022



Sources: MHS administrative data, 1/20/2023, and Merative™ MarketScan® Commercial Database, 1/16/2023

[a] Source of care (direct, VA, retail, or home delivery) is based solely on where the prescriptions were filled, not on where the prescribing services were provided.

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2022 civilian benchmarks are based on two quarters of data, which were seasonally adjusted and annualized.

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

TRICARE Prescription Drug Utilization Rates Compared with Civilian Benchmarks (U.S. Only) *(cont.)*

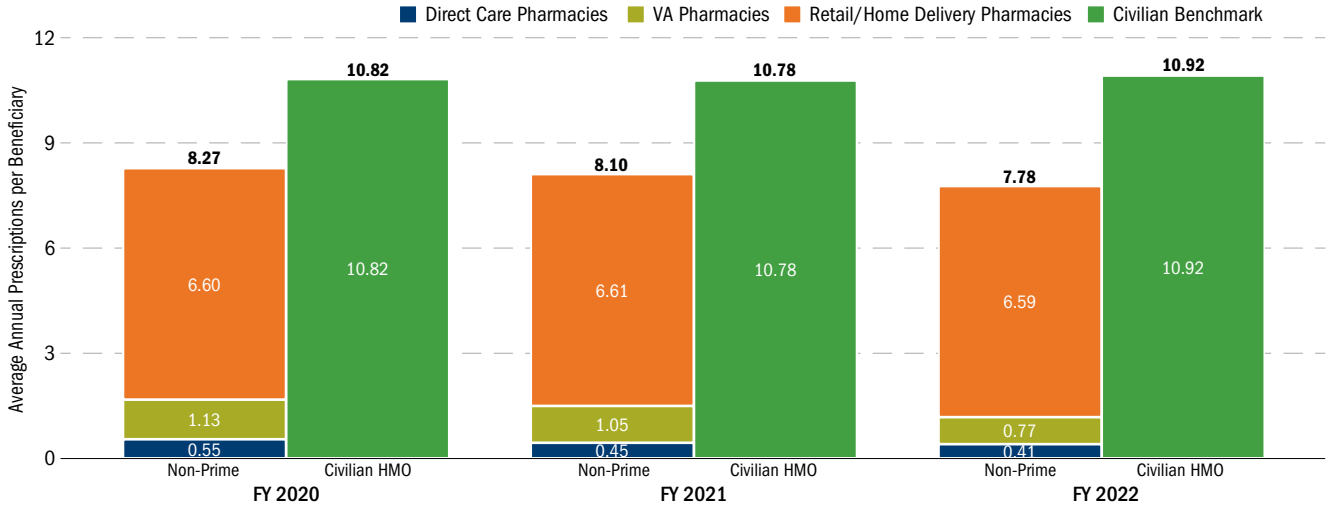
Non-Prime-Enrolled Beneficiaries

This section compares the outpatient prescription drug utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored PPO plans. The comparisons are limited to the U.S. because the civilian benchmark data cover domestic plans only. To give a more complete picture of total prescription drug utilization by TRICARE beneficiaries, prescriptions filled at VA pharmacies as part of a beneficiary's VA benefit (and paid for by VA) are included. Prescriptions filled at VA pharmacies under the TRICARE benefit have always been included with retail pharmacy prescriptions. The comparisons are made for beneficiaries under age 65 only.

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

- The overall prescription utilization rate (direct care, VA, and private sector care combined) for non-Prime-enrolled beneficiaries decreased by 6 percent between FY 2020 and FY 2022. During the same period, the civilian PPO benchmark rate increased by 1 percent. In FY 2022, the TRICARE prescription utilization rate for non-Prime enrollees was 29 percent lower than the civilian PPO rate.
- The direct care prescription utilization rate for non-Prime-enrolled beneficiaries decreased by 24 percent from FY 2020 to FY 2022, whereas the utilization rate at private sector care pharmacies remained unchanged.
- Prescription utilization rates for non-Prime enrollees at VA pharmacies declined by 31 percent between FY 2020 and FY 2022.
- The overall private sector care share of per-capita prescription utilization for non-Prime enrollees increased from 93 percent in FY 2020 to 95 percent in FY 2022.

PRESCRIPTION UTILIZATION RATES BY SOURCE OF CARE[a]: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK, FYs 2020–2022



Sources: MHS administrative data, 1/20/2023, and Merative™ MarketScan® Commercial Database, 1/16/2023

[a] Source of care (direct, VA, retail, or home delivery) is based solely on where the prescriptions were filled, not on where the prescribing services were provided

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2022 civilian benchmarks are based on two quarters of data, which were seasonally adjusted and annualized.

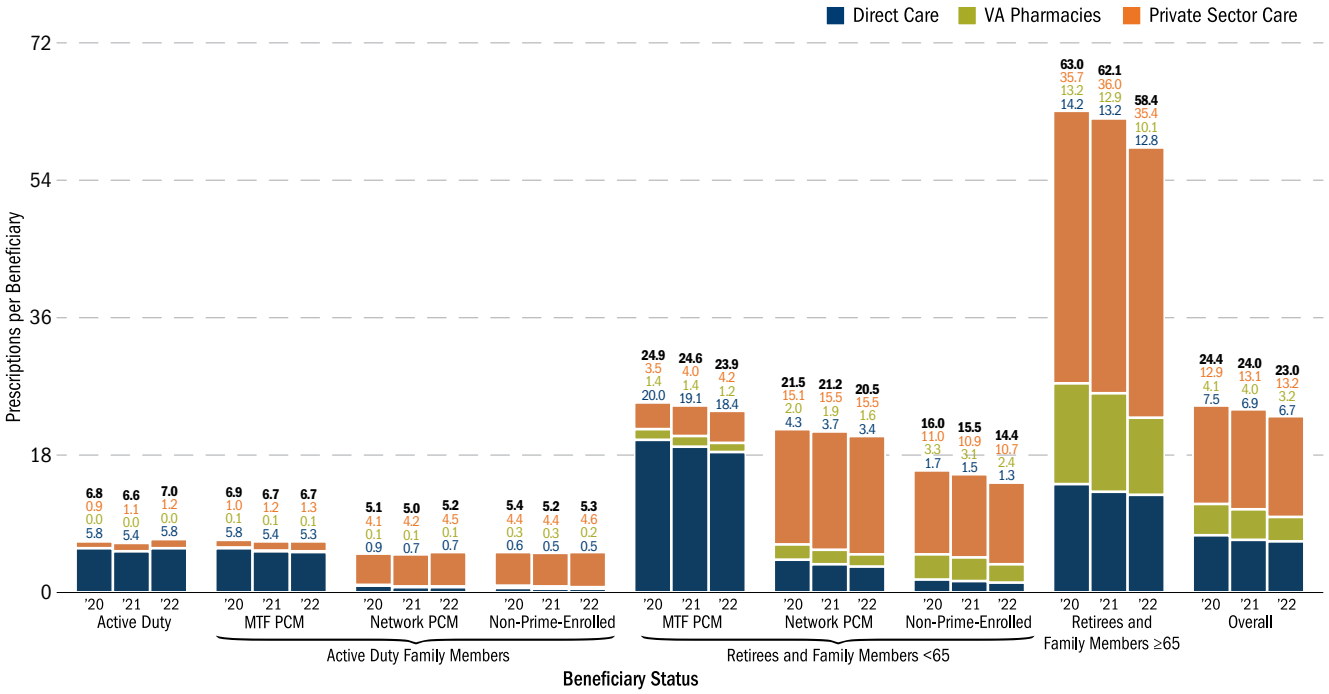
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT.)*

TRICARE Prescription Drug Utilization Rates by Beneficiary Status

Prescriptions include all initial and refill prescriptions filled at military pharmacies, VA pharmacies (for DoD/VA dual-eligible beneficiaries), retail pharmacies, and home delivery. VA prescriptions include those filled as part of a beneficiary's VA benefit and paid for by VA. Prescriptions filled at a VA pharmacy under the TRICARE benefit are included with retail pharmacy prescriptions. Prescription counts from all sources were normalized by dividing the total days' supply for each by 30 days.

- The total (direct, VA, retail, and home delivery) number of prescriptions per beneficiary decreased by 5 percent from FY 2020 to FY 2022, exclusive of the TFL benefit. Including TFL, the total number of prescriptions declined by 6 percent.
- The overall direct care prescription utilization rate declined by 10 percent between FY 2020 and FY 2022. Declines were experienced by all beneficiary groups, ranging from 1 percent for Active Duty members to 23 percent for nonenrolled RETFMs under age 65.
- Average per capita VA pharmacy prescription utilization decreased by 22 percent from FY 2020 to FY 2022.
- Overall per capita prescription utilization through private sector care pharmacies increased by 2 percent between FY 2020 and FY 2022. Increases occurred for every beneficiary group except non-Prime-enrolled RETFMs under age 65 (3 percent decline) and RETFMs age 65 and over (1 percent decline). Increases ranged from 2 percent for RETFMs under age 65 with a network PCM to 28 percent for ADFMs with an MTF PCM.

AVERAGE ANNUAL PRESCRIPTION UTILIZATION PER BENEFICIARY, FYs 2020–2022



Source: MHS administrative data, 1/20/2023

Notes:

– The Retirees and Family Members groups include survivors and others not explicitly identified elsewhere.

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

LOWER COST

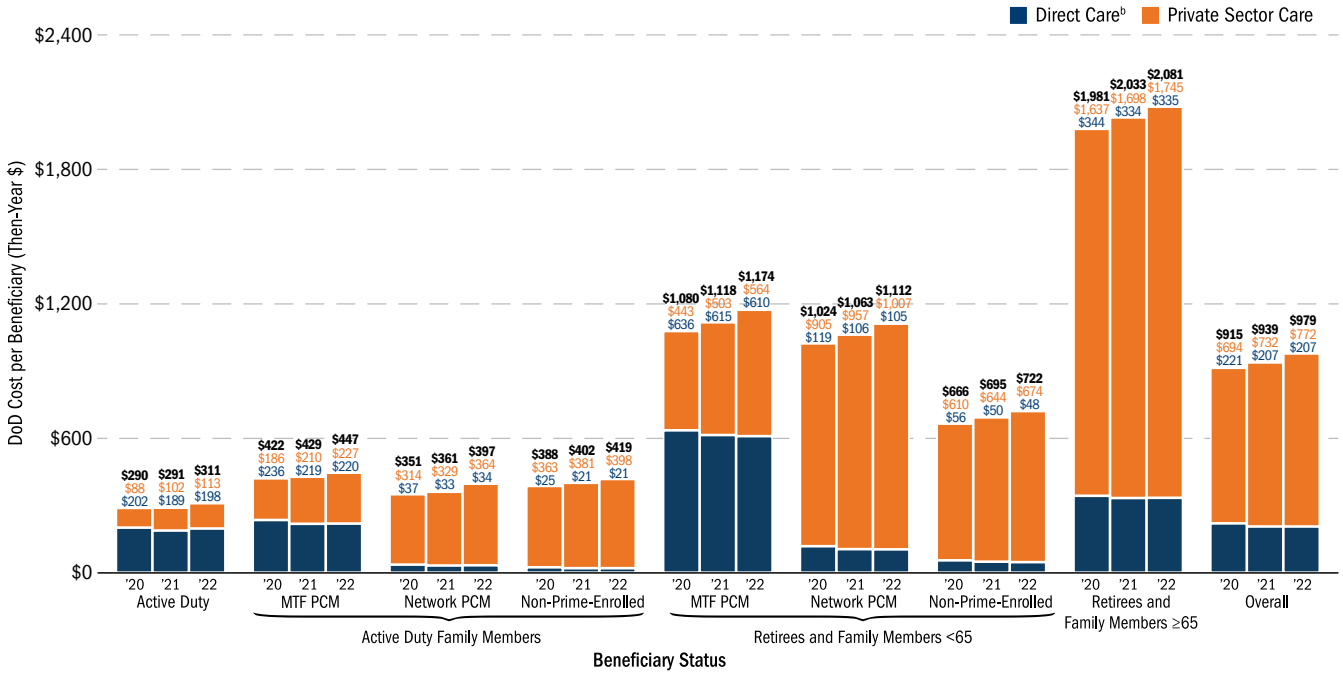
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT.)*

Prescription Drug Cost by Beneficiary Status

Although the drug refunds referenced on page 51 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 7 percent between FY 2020 and FY 2022. The annual pharmacy cost for non-Prime enrollees is diluted by the larger number of beneficiaries with OHI coverage where the DoD pays approximately 30 percent of their prescription coverage cost.

- Exclusive of TFL, overall per capita prescription drug costs increased by 8 percent between FY 2020 and FY 2022.
- Increases in overall per capita prescription drug costs were experienced by every beneficiary group, ranging from 5 percent for RETFMs age 65 and older to 13 percent for ADFMs with a network PCM.
- Overall direct care costs per beneficiary decreased by 6 percent, while private sector care pharmacy costs increased by 16 percent excluding TFL and by 11 percent including TFL.

AVERAGE ANNUAL DoD PRESCRIPTION COSTS PER BENEFICIARY, FYs 2020–2022[a]



Source: MHS administrative data, 1/20/2023

[a] Excludes retail drug refunds.

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

Notes:

– The Retirees and Family Members groups include survivors and others not explicitly identified elsewhere.

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

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

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

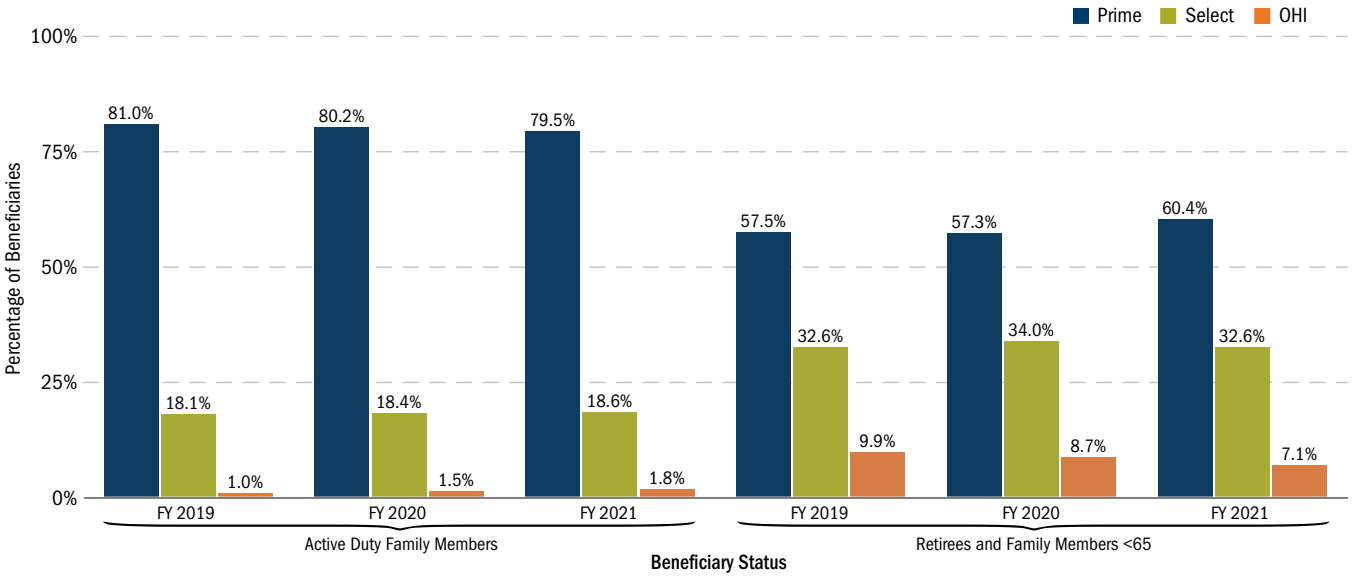
Health Plan Coverage of MHS Beneficiaries Under Age 65

MHS beneficiaries have a choice of (1) TRICARE Prime, including TYA Prime and USFHP; (2) TRICARE Select, including TYA Select, TRICARE Reserve Select (TRS), and TRICARE Retired Reserve (TRR); (3) direct care only (space-available care); and (4) OHI. Many beneficiaries with OHI have no TRICARE utilization; however, some use TRICARE as a second payer.

Beneficiaries are grouped by their primary health plan:

- **TRICARE Prime:** Family enrolled in TRICARE Prime (including a small percentage who also have OHI coverage). In FY 2022, 80 percent of Active Duty families and 60 percent of retiree families were in this group.
- **TRICARE Select:** Family enrolled in TRICARE Select or relying on space-available MTF care in FYs 2020–2022 and who do not have OHI coverage. In FY 2022, 19 percent of Active Duty families and 33 percent of retiree families were in this group.
- **OHI:** Family covered by OHI. In FY 2022, 2 percent of Active Duty families and 7 percent of retiree families were in this group.

HEALTH PLAN COVERAGE OF BENEFICIARIES UNDER AGE 65, FYs 2020–2022



Source: TRICARE and OHI coverage in FYs 2020–2022 based on Defense Enrollment Eligibility Reporting System (DEERS) and Health Care Survey of DoD Beneficiaries (HCSDB) responses; as of 12/31/2022

Notes:

– The Prime group includes HCSDB respondents enrolled in Prime based on DEERS plus enrollees in the USFHP. The Select group includes HCSDB respondents without OHI who are enrolled in a Select plan based on DEERS. The OHI group includes HCSDB respondents with private health insurance (e.g., the Federal Employees Health Benefits [FEHB] Program, a civilian HMO such as Kaiser, or other civilian insurance such as Blue Cross). A small percentage of Prime enrollees are also covered by OHI; these beneficiaries are included in the Prime group.

– Numbers for FYs 2020 and 2021 may differ slightly from prior reports. FYs 2020 and 2021 HCSDB data showed a higher sampling of Inactive Guard/Reserve family members by nearly a factor of 10 compared with previous years. To account for this discrepancy, we excluded Inactive Guard/Reserve family members for all years to avoid biasing the calculations.

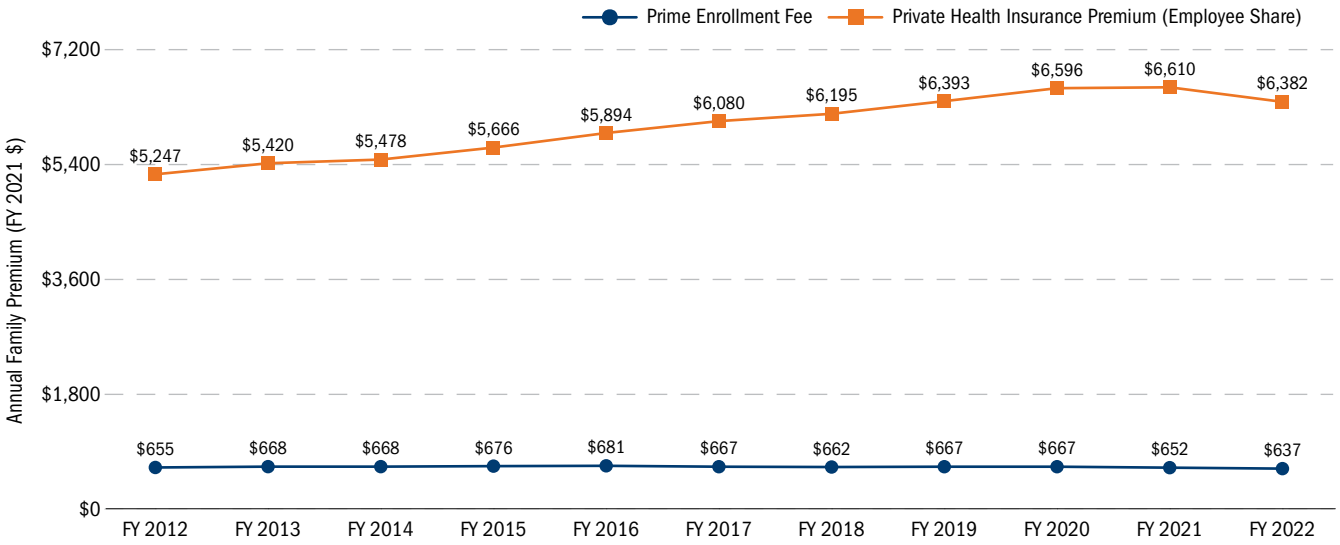
– Percentages may not sum to 100 percent due to rounding.

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

Retirees and Family Members under Age 65 Returning to the MHS

From FY 2012 to FY 2022, the average private health insurance family premium increased, whereas the TRICARE Prime enrollment fee remained essentially flat. In FY 2022 dollars, private health insurance premiums increased by $1,135 (22 percent) over this period, whereas the TRICARE Prime enrollment fee actually decreased in constant dollar terms by $18 (3 percent).

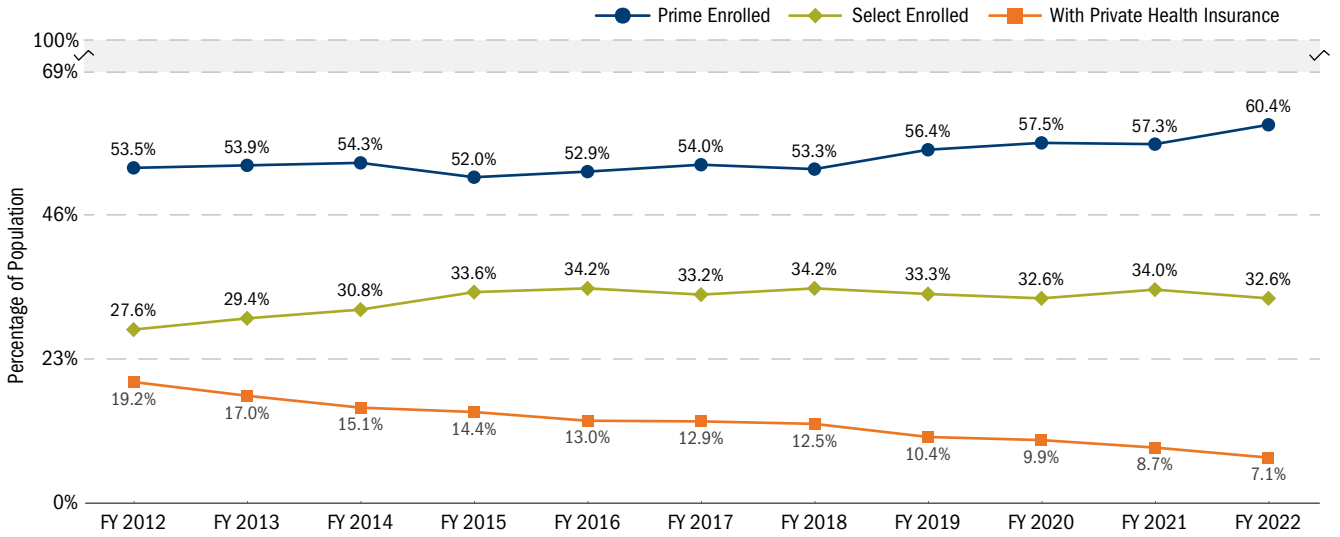
TRENDS IN PRIVATE INSURANCE PREMIUMS VS. TRICARE PRIME ENROLLMENT FEE, FYs 2012–2022



Sources: The employee share of insurance premiums for a typical employer-sponsored family health plan in FYs 2012–2021 from the Insurance Component of the Medical Expenditure Panel Survey (MEPS) 2010–2021; OHI premiums in FY 2022 projected by the Institute for Defense Analyses (IDA) based on the average growth rate of premiums in FYs 2015–2021. Data from the Kaiser Family Foundation (KFF) are used to account for pandemic-related changes to health care spending. KFF found that on average, spending remains 7.1 percent below the pre-pandemic trend. IDA used KFF's data to construct monthly growth rates to adjust spending. https://www.healthsystemtracker.org/brief/early-2021-data-show-no-rebound-in-health-care-utilization/ as of 1/31/2023.

Between FY 2012 and FY 2022, 12 percent of retirees switched from private health insurance to TRICARE. Most likely switched because of an increasing disparity in premiums and out-of-pocket expenses.[1]

TRENDS IN RETIREE (<65) HEALTH PLAN COVERAGE, FYs 2012–2022



Source: TRICARE and private health insurance coverage in FYs 2012–2022 based on DEERS and HCSDB responses in FYs 2012–2022; as of 12/31/2022
Note: The Prime enrollment rates above include about 4 percent of retirees who also have private health insurance.

[1] For an analysis of retirees switching from OHI to TRICARE, see Goldberg et al., "Demand for Health Insurance by Military Retirees," IDA Document D-5098, May 2015, Alexandria, Va.: IDA.

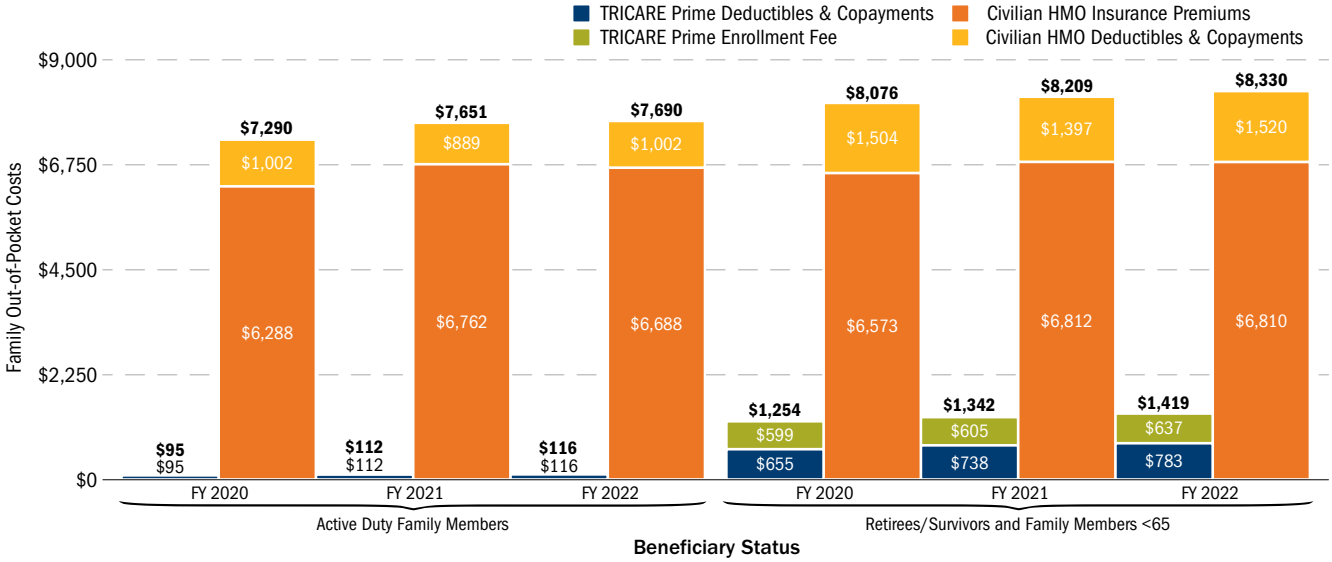
BENEFICIARY FAMILY HEALTH PLAN COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

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

In FYs 2020–2022, civilian counterpart families enrolled in HMO plans had substantially higher out-of-pocket costs than TRICARE Prime enrollees.

- Civilian HMO counterparts paid more for insurance premiums, deductibles, and copayments.
- In FY 2022, costs for civilian HMO counterparts were:
  - $7,500 more than those incurred by Active Duty families enrolled in Prime
  - $6,900 more than those incurred by retiree families enrolled in Prime

OUT-OF-POCKET COSTS FOR FAMILIES ENROLLED IN TRICARE PRIME VS. CIVILIAN HMO COUNTERPARTS, FYs 2020–2022



Sources: TRICARE beneficiary expenditures for deductibles and copayments in FYs 2020–2022 from MHS administrative data for all families enrolled in Prime without OHI payments, 12/31/2022; civilian benchmark expenditures for deductibles and copayments from IBM Watson Health, MarketScan® Commercial Claims and Encounters (CCAE) database, 1/31/2023; civilian benchmark insurance premiums from the Insurance Component of the MEPS (projected from FY 2020 data), 12/31/2022

Notes:

– Estimates are for a demographically typical family. For Active Duty dependents, a family includes a spouse and 1.54 children, on average. For retirees, a family includes a sponsor, spouse, and 0.65 children.
– The Peterson Center on Healthcare and KFF's Health System Tracker has published estimates of the impacts to spending and utilization during the COVID-19 pandemic. As the data used to calculate civilian comparisons have a lag time to publication, IDA uses the Peterson/KFF report to adjust civilian estimates of spending and utilization to account for the impacts of the COVID-19 pandemic. https://www.healthsystemtracker.org/brief/the-state-of-the-u-s-health-system-in-2022-and-the-outlook-for-2023/
– MarketScan data cover a full four quarters in FYs 2020 and 2021. Only two quarters of data were available for FY 2022. The remaining quarters were projected with year-on-year quarterly estimates from the Peterson/KFF report.
– Civilian expenditures for deductibles and copayments are somewhat higher than in previous reports. Our previous source was the MEPS, which marginally understates those expenditures relative to MarketScan (see Zuvekas, S. "Comparing MEPS Use and Expenditure Estimates for the Privately Insured to Truven MarketScan® and OptumLabs™ Claims Data, 2008–2013." Center for Financing, Access, and Cost Trends, AHRQ. October 2017).
– Currently, there is no cost information for MHS GENESIS records. While direct care cost shares are relatively uncommon, this will slightly underestimate out-of-pocket costs particularly as more sites deploy the new electronic health record (EHR).
– Numbers may not sum to bar totals due to rounding.

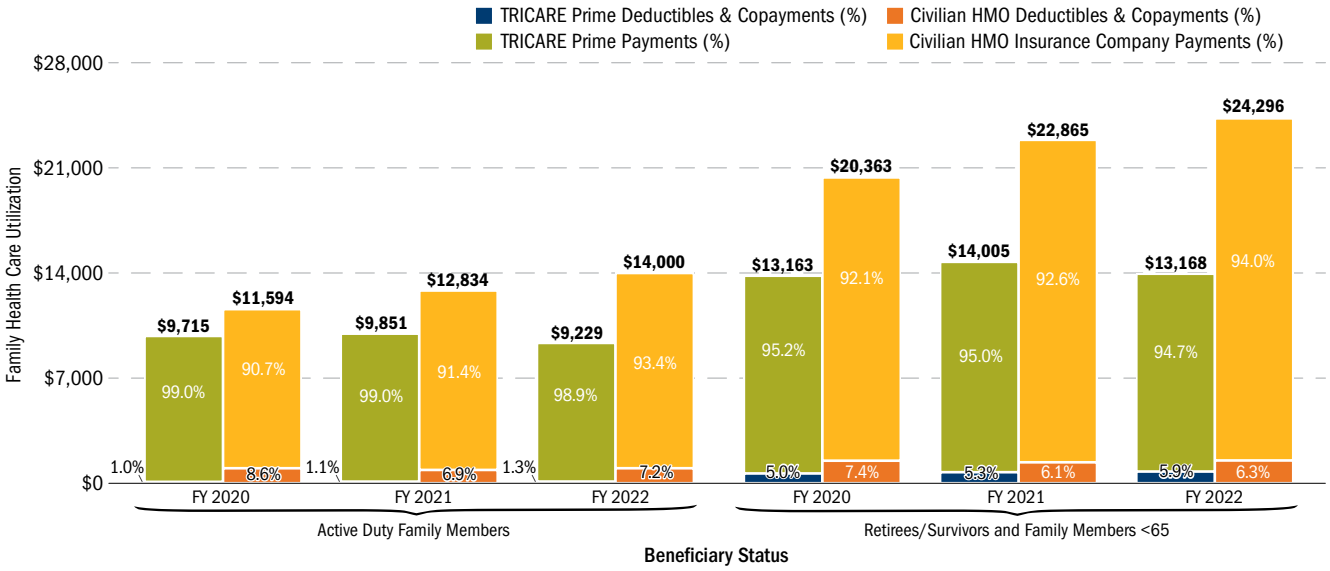
BENEFICIARY FAMILY HEALTH PLAN COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

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

In FYs 2020–2022, TRICARE Prime enrollees had lower coinsurance rates (deductibles and copayments per dollar of utilization) and less utilization than their civilian HMO counterparts.

- In FYs 2020–2022, TRICARE Prime enrollees had coinsurance rates that were 0 to 6 percentage points below those of their civilian HMO counterparts.
  - In FY 2022, the coinsurance rate for Active Duty families was 1 percent—6 percentage points lower than civilian HMO counterparts (7 percent).
  - In FY 2022, the coinsurance rate for retiree families was 6 percent—about the same as civilian HMO counterparts (6 percent).
- In FYs 2020–2022, TRICARE Prime enrollees had lower health care utilization than their civilian HMO counterparts.
  - In FY 2022, Active Duty families consumed $9,100 of medical services—$4,900 less than civilian HMO counterparts ($14,000).
  - In FY 2022, retiree families consumed $12,400 in medical services—$11,900 less than civilian HMO counterparts ($24,300).

COINSURANCE AND HEALTH CARE UTILIZATION FOR FAMILIES ENROLLED IN TRICARE PRIME VS. CIVILIAN HMO COUNTERPARTS, FYs 2020–2022



Sources: TRICARE health care utilization expenditures by both the government and beneficiaries in FYs 2020–2022 from MHS administrative data for all families enrolled in Prime without OHI payments for TRICARE utilization, 12/31/2022; civilian insurance company and beneficiary benchmark expenditures from IBM Watson Health, MarketScan® CCAE database, 1/31/2023

Notes:

– The Peterson Center on Healthcare and KFF's Health System Tracker has published estimates of the impacts to spending and utilization during the COVID-19 pandemic. As the data used to calculate civilian comparisons have a lag time to publication, IDA uses the Peterson/KFF report to adjust civilian estimates of spending and utilization to account for the impacts of the COVID-19 pandemic. https://www.healthsystemtracker.org/brief/the-state-of-the-u-s-health-system-in-2022-and-the-outlook-for-2023/

– MarketScan data cover a full four quarters in FYs 2020 and 2021. Only two quarters of data were available for FY 2022. The remaining quarters were projected with year-on-year quarterly estimates from the Peterson/KFF report.

– Civilian expenditures for deductibles and copayments are somewhat higher than in previous reports. Our previous source was the MEPS, which marginally understates those expenditures relative to MarketScan (see Zuvekas, S. "Comparing MEPS Use and Expenditure Estimates for the Privately Insured to Truven MarketScan® and OptumLabs™ Claims Data, 2008–2013." Center for Financing, Access, and Cost Trends, AHRQ. October 2017).

– Currently, there is no cost information for MHS GENESIS records. This will impact both out-of-pocket costs paid by beneficiaries and utilization costs paid by TRICARE.

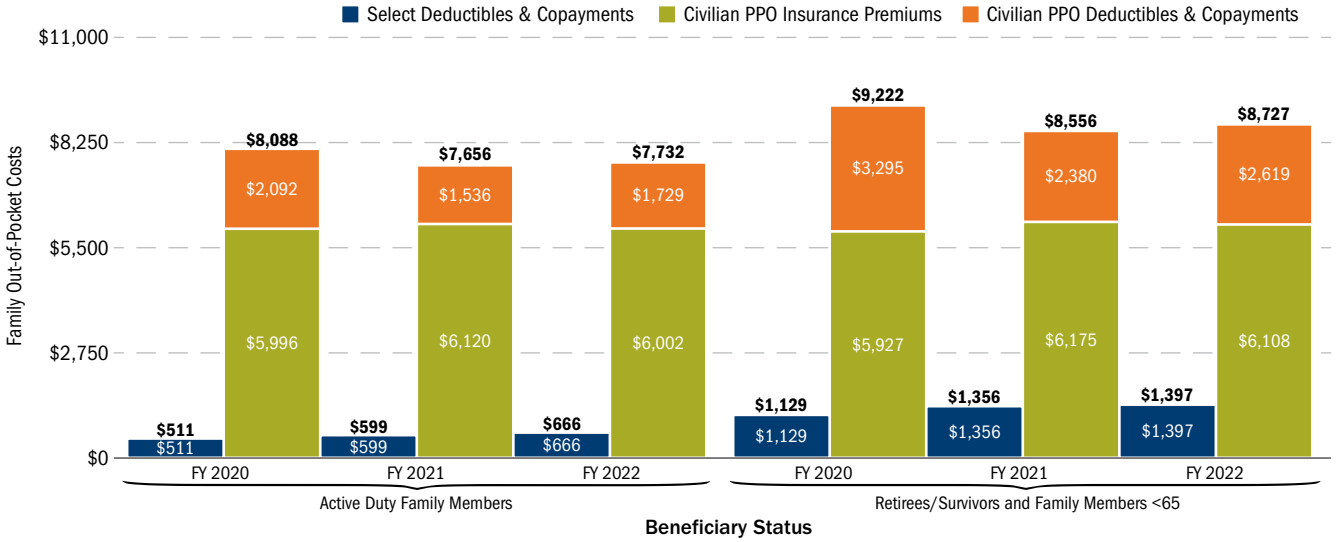
BENEFICIARY FAMILY HEALTH PLAN COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Out-of-Pocket Costs for Families Who Rely on TRICARE Select or Direct Care vs. Civilian PPO Counterparts

In FYs 2020–2022, civilian counterpart families enrolled in PPO plans had much higher out-of-pocket costs than TRICARE Select users.

- In FYs 2020–2022, civilian PPO counterparts paid $7,000 to $8,000 more for insurance premiums, deductibles, and copayments.
- In FY 2022, costs for civilian PPO counterparts were:
  - $7,100 more than those incurred by Active Duty families who relied on TRICARE Select
  - $7,300 more than those incurred by retiree families who relied on TRICARE Select

OUT-OF-POCKET COSTS FOR FAMILIES WHO RELY ON TRICARE SELECT OR DIRECT CARE VS. CIVILIAN PPO COUNTERPARTS, FYs 2020–2022



Sources: TRICARE health care utilization expenditures by both the government and beneficiaries in FYs 2020–2022 from MHS administrative data for all families enrolled in Select without OHI payments for TRICARE utilization, 12/31/2022; civilian insurance company and beneficiary benchmark expenditures from IBM Watson Health, MarketScan® CCAE database, 1/31/2023

Notes:

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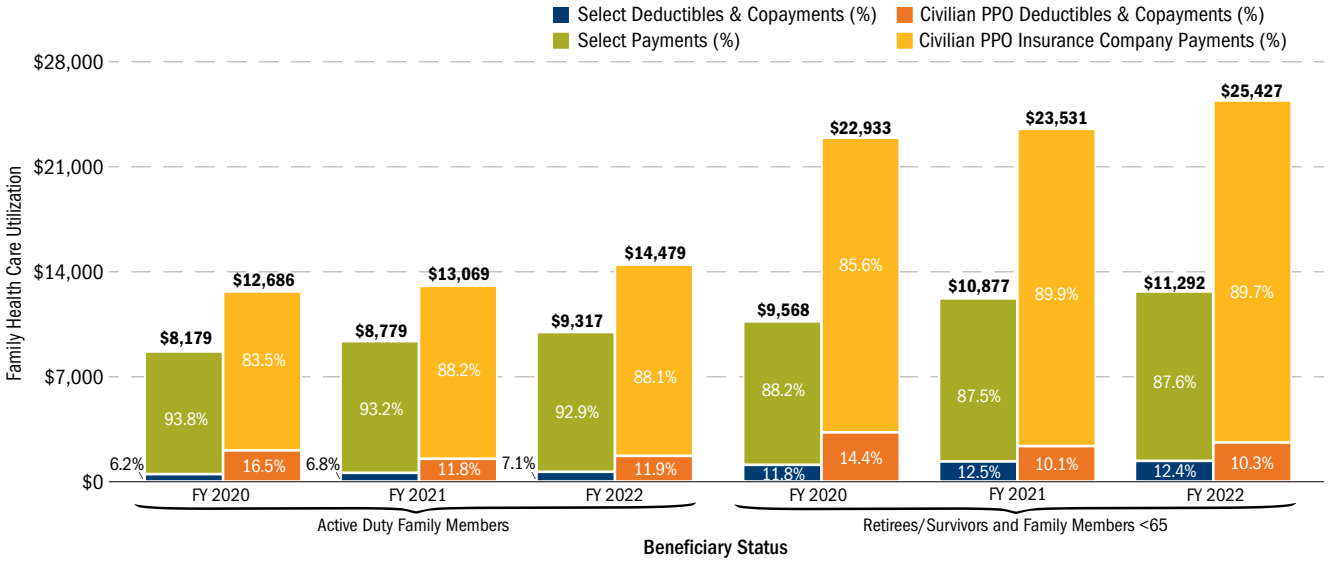
BENEFICIARY FAMILY HEALTH PLAN COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

Coinsurance and Health Care Utilization for Families Who Rely on TRICARE Select or Direct Care vs. Civilian PPO Counterparts

Active Duty families who relied on TRICARE Select had lower coinsurance rates (deductibles and copayments per dollar of utilization) and lower health care utilization (dollar value of health care services consumed) than their civilian counterparts enrolled in PPO plans. Retiree families have seen their coinsurance rates remain relatively stable, while their civilian counterparts have faced rising rates. Retiree families exhibited substantially lower utilization.

- In FY 2022, for Active Duty families:
  - Coinsurance rates were 7 percent versus 12 percent for civilian PPO counterparts (5 percentage points lower).
  - Health care utilization was $9,300 versus $14,400 for civilian PPO counterparts ($5,100 less).
- In FY 2022, for retiree families:
  - Coinsurance rates were 12 percent versus 10 percent for civilian PPO counterparts (2 percentage points higher). This reversal in prior year trends is due to the decline in civilian utilization attributable to the pandemic.
  - Health care utilization was $11,300 versus $25,400 for civilian PPO counterparts ($14,100 less).

COINSURANCE AND HEALTH CARE UTILIZATION FOR FAMILIES WHO RELY ON TRICARE SELECT OR DIRECT CARE VS. CIVILIAN PPO COUNTERPARTS, FYs 2020–2022



Sources: TRICARE health care utilization expenditures by both the government and beneficiaries in FYs 2020–2022 from MHS administrative data for all families enrolled in Select without OHI payments for TRICARE utilization, 12/31/2022; civilian insurance company and beneficiary benchmark expenditures from Merative™ MarketScan® Commercial Database, 1/16/2023

Notes:

– The Peterson Center on Healthcare and KFF's Health System Tracker has published estimates of the impacts to spending and utilization during the COVID-19 pandemic. As the data used to calculate civilian comparisons have a lag time to publication, IDA uses the Peterson/KFF report to adjust civilian estimates of spending and utilization to account for the impacts of the COVID-19 pandemic https://www.healthsystemtracker.org/brief/the-state-of-the-u-s-health-system-in-2022-and-the-outlook-for-2023/

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– Currently, there is no cost information for MHS GENESIS records. This will impact both out-of-pocket costs paid by beneficiaries and utilization costs paid by TRICARE.

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

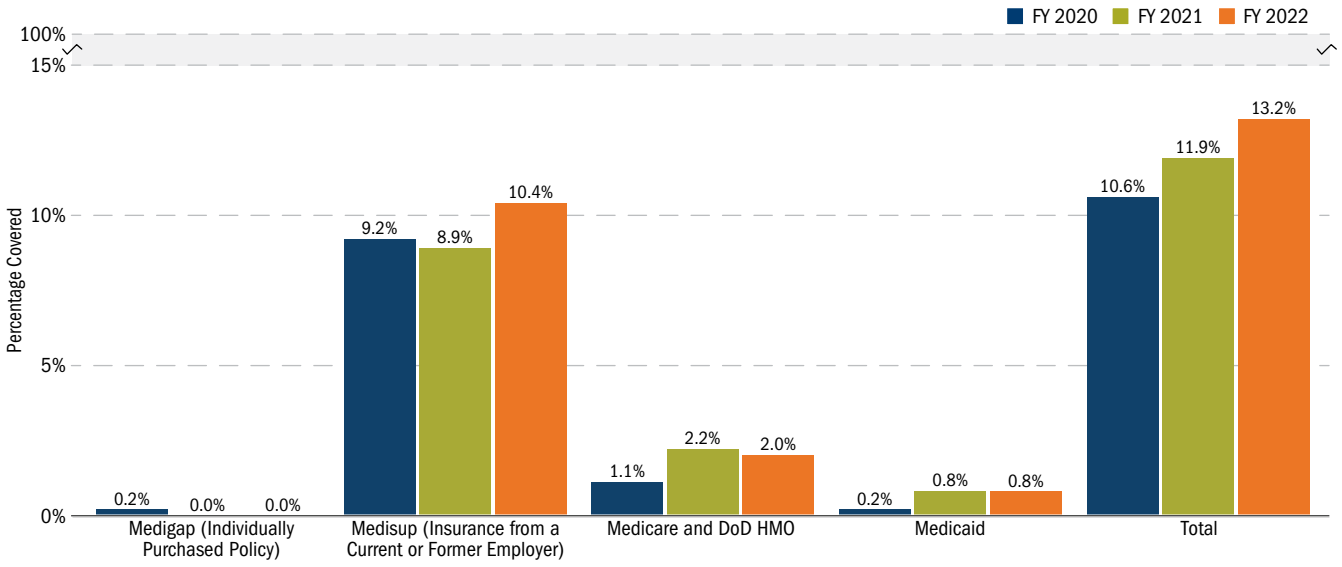
Out-of-pocket costs for retirees aged 65 and older (seniors) and their families include deductibles and copayments for medical care and drugs, TRICARE enrollment fees, and private insurance premiums. In April 2001, the DoD expanded drug benefits for seniors; on October 1, 2001, the DoD implemented the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

Supplemental Health Insurance Coverage of MHS Senior Beneficiaries

Although Medicare provides coverage for medical services, there are substantial deductibles and copayments. Until FY 2001, 88 percent of MHS seniors purchased some type of Medicare supplemental insurance (e.g., Medigap, Medisup).[1] A small number were active employees with employer-sponsored insurance or were covered by Medicaid. Because of the improved drug and TFL benefits, most MHS seniors dropped their supplemental insurance.

- In FY 2022, nearly 13 percent of MHS seniors retained some form of supplemental insurance. While still a small percentage overall, the number of MHS seniors with Medicaid coverage significantly increased relative to pre-pandemic levels (0.2 percent in FY 2020 vs. 0.8 percent in FY 2022).
- Why do some seniors retain supplemental insurance, especially a Medisup policy, when they can use TFL for free? Some possible reasons are:
  - A lack of awareness of the TFL benefit
  - A desire for dual coverage
  - Higher family insurance costs if a spouse is not yet Medicare-eligible. Dropping a non-Medicare-eligible spouse from an employer-sponsored plan can result in higher family costs if the spouse must purchase a nonsubsidized individual policy.

MEDICARE SUPPLEMENTAL INSURANCE COVERAGE OF MHS SENIORS, FYs 2020–2022



Source: FYs 2020–2022 HCSDB, as of 12/31/2022

[1] Medigap is an individually purchased policy that covers Medicare deductibles and copayments. Medisup is group insurance from a current or former employer (or a union). It includes those with Medicare who are covered either by FEHBP, a civilian HMO such as Kaiser, or other civilian health insurance such as Blue Cross. Individually obtained HMO policies include Medicare Advantage and USFHP. Almost all TRICARE seniors are covered by Medicare and are enrolled in Parts A and B; only 1.3 percent have just Part A. About 1 percent of TRICARE seniors are covered by government-sponsored Medicaid. About 1 percent of TRICARE seniors have OHI and are not covered by Medicare; as of 12/31/2022.

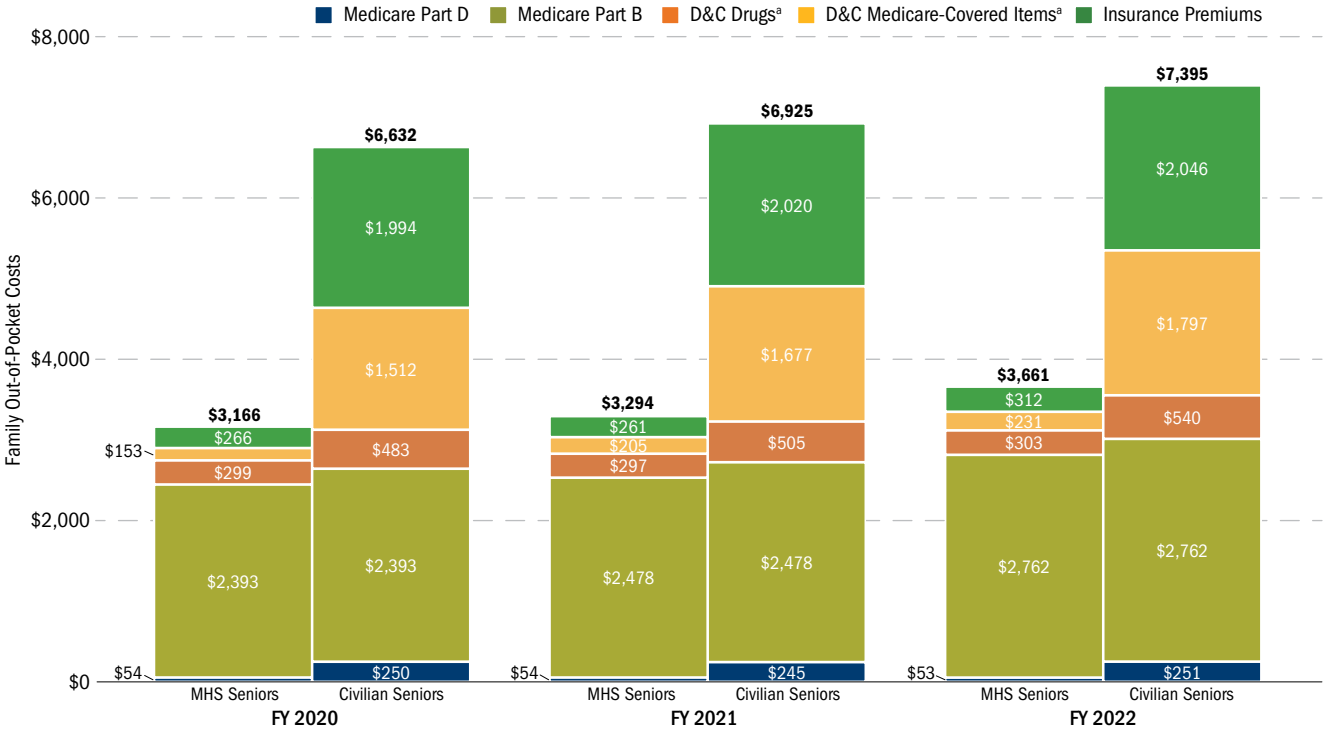
BENEFICIARY FAMILY HEALTH PLAN COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT.)*

Out-of-Pocket Costs for MHS Senior Families

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

- In FY 2022, out-of-pocket costs for MHS senior families were 50 percent less than those of their civilian counterparts.
- In FY 2022, MHS senior families saved about $3,800 as a result of TFL and added drug benefits.

OUT-OF-POCKET COSTS OF MHS SENIOR FAMILIES AFTER TFL VS. CIVILIAN COUNTERPARTS, FYs 2020–2022



Sources: TRICARE senior family deductibles and copayments for MHS users in FYs 2020–2022 from MHS administrative data, 12/31/2022; for MHS non-users and civilian benchmark senior families, deductibles and copayments by type of Medicare supplemental coverage in FYs 2020–2022 projected from the Household Component of the MEPS; Medicare Part B and Medicare HMO premiums in FYs 2020–2022 from the Centers for Medicare & Medicaid Services (CMS); Medigap premiums in FYs 2020–2022 from Weiss Research, Inc.; Medicare supplemental insurance coverage from the HCSDB, FYs 2020–2022, as of 1/31/2023

[a] "D&C" is deductibles and copayments.

Notes:

– Estimates are for a demographically typical senior family. On average, this consists of 0.7 men and 0.7 women over the age of 65.
– There are three limitations of the MEPS utilization expenditures data for seniors. First, they are known to understate expenditures for inpatient and outpatient services by about 19 percent (see Zuvekas and Olin. Accuracy of Medicare Expenditures in the Medical Expenditure Panel Survey. Inquiry 46: 92–108 [Spring 2009]). Expenditures for inpatient and outpatient services were adjusted upward to account for the bias. Second, the data are volatile due to small samples; the data were smoothed to mitigate the effects of volatility. Third, the sample is not up to date; the last observation period is CY 2017. The long-run growth rate between FY 2007 and FY 2017 was used to project utilization expenditures in FYs 2020–2022.
– The Peterson Center on Healthcare and KFF's Health System Tracker has published estimates of the impacts to spending and utilization during the COVID-19 pandemic. As the data used to calculate civilian comparisons has a lag time to publication, IDA uses the Peterson/KFF report to adjust civilian estimates of spending and utilization to account for the impacts of the COVID-19 pandemic. https://www.healthsystemtracker.org/brief/the-state-of-the-u-s-health-system-in-2022-and-the-outlook-for-2023/
– Currently, there is no cost information for MHS GENESIS records. While direct care cost shares are relatively uncommon, this will slightly underestimate out-of-pocket costs, particularly as more sites deploy the new EHR.
– Numbers may not sum to bar totals due to rounding.

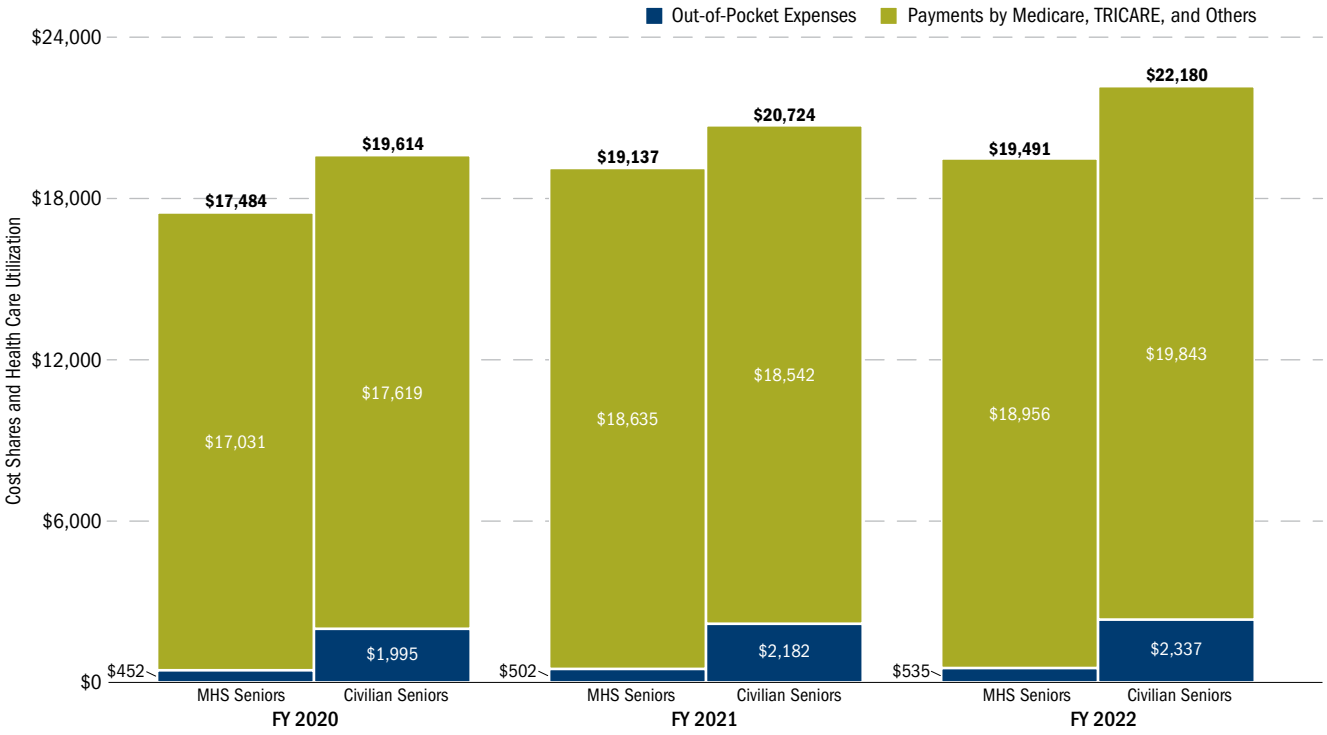
BENEFICIARY FAMILY HEALTH PLAN COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT.)*

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

TRICARE senior families have lower coinsurance rates (deductibles and copayments per dollar of utilization) than their civilian counterparts. Utilization is also slightly lower for MHS senior families.

- MHS senior families have relatively low coinsurance rates.
  - In FY 2022, the coinsurance rate for civilian senior counterparts was 11 percent; it was 3 percent for MHS seniors (8 percentage points lower).
- MHS senior families have slightly lower utilization than civilian senior families.
  - In FY 2022, civilian senior counterparts consumed $22,200 in medical services; MHS senior families consumed $19,500 ($2,700 less).

COINSURANCE AND HEALTH CARE UTILIZATION FOR SENIOR FAMILIES VS. CIVILIAN COUNTERPARTS, FYs 2020–2022



Sources: TRICARE senior family utilization, deductibles, and copayments for MHS users in FYs 2020–2022 from MHS administrative data, 12/31/2022; for MHS non-users and civilian benchmark senior families, utilization, deductibles, and copayments by type of Medicare supplemental coverage in FYs 2020–2022 projected from the Household Component of the MEPS; Medicare supplemental insurance coverage, before and after TFL, from HCSDB, FYs 2000–2001 and 2019–2021, as of 12/31/2022

Notes:

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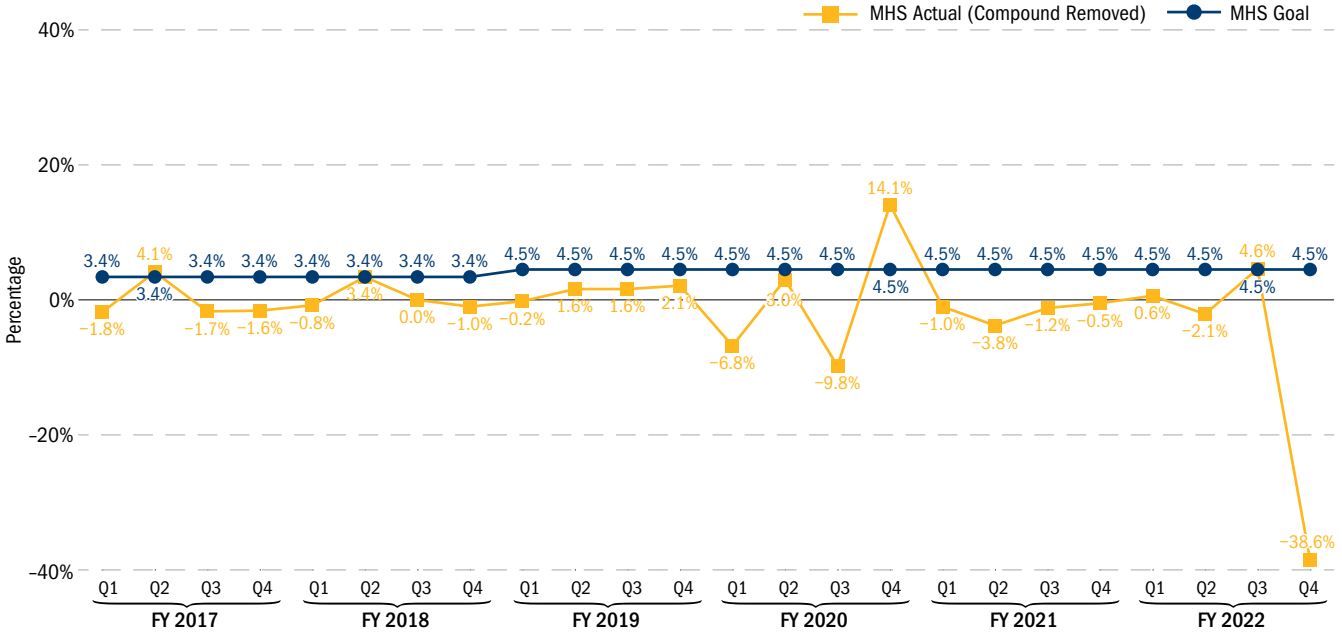
SYSTEM PRODUCTIVITY: MHS MEDICAL COST PER PRIME ENROLLEE

The goal in using this financial and productivity metric is to support the Quadruple Aim of lower costs. This measure focuses on the annual overall cost growth for TRICARE Prime enrollees and includes all costs related to health care delivered to enrollees. The objective is to keep the rate of cost growth for Prime enrollees to a level at or below the increases for the civilian health care plans at the national level. Currently, the measure provides insight on issues regarding unit cost, utilization management, and private sector care management. The metric has been enhanced to properly account for differences in population demographics and health care requirements of the enrolled population. During FY 2020 and FY 2021, the DoD Components focused on improvements in provider productivity through improved access standards, MTF site visits, effective use of resources, capturing of inpatient RVUs, and optimization of referral management. In FY 2020, provider efficiency declined due to the COVID-19 pandemic, resulting in a decrease in utilization without a corresponding decrease in expenses. In FY 2021, the MHS re-established growth in provider efficiency after COVID-19 protocols allowed for health care encounters to return to some level of normalcy, demonstrating that improvement processes continue to work. With productivity improvements, the MHS will need to ensure that ambulatory care utilization remains under control.

- The MHS continues to expand the Patient-Centered Medical Home (PCMH) strategy, a practice model in which a team of health care professionals, coordinated by a personal physician, work collaboratively to provide high levels of care, access, and communication; care coordination and integration; and care quality and safety. Care delivered in a PCMH is meant to produce better outcomes; reduce mortality, unnecessary emergency department visits, and preventable hospital admissions for patients with chronic diseases; lower overall utilization; and improve patient compliance with recommended care, resulting in lower spending for the same population.
- The MHS goal in percentage change in medical costs from the prior year is based on the annual national survey of nonfederal private and public employers with three or more workers, conducted by the KFF and the Health Research and Educational Trust. From this survey, the MHS rate is set, based on the average annual premiums for employer-sponsored health insurance for family coverage. For the time period from FY 2014 to FY 2016, the MHS goal was set at one percentage point below the survey. Starting in FY 2017, the goal reverted back to the actual survey result.
- Due to the COVID-19 pandemic in FY 2020, MTFs experienced significant decreases in workload while their expenses did not. This caused significant fluctuations in percentage change. FY 2022 Medical Expense and Performance Reporting System (MEPRS) expenses are not complete as of the time of this report and a rolling algorithm is used to populate the missing expenses for those months.

PERCENTAGE CHANGE IN MEDICAL COST PER PRIME EQUIVALENT LIFE (FROM PRIOR YEAR), FYs 2017–2022



Sources: DHA, Analytics and Evaluation Division, 10/19/2022. Data are as of October 2022, MHS Management Analysis and Reporting Tool (M2); Standard Inpatient Data Record/Standard Ambulatory Data Record/Comprehensive Ambulatory/Professional Encounter Record/TED Institutional/TED Non-institutional; Pharmacy Data Transaction Service; and Expense Assignment System IV

Notes:

– Enrollees are adjusted for health risk status.

– FY 2022 data are reported through FY 2022 Q4 but only FM 10 is included in FY 2022 Q4, and data from this time period should be considered preliminary.

– For sites that have implemented MHS GENESIS, their encounter data do not currently have the requisite information needed to compute the cost per Prime enrollee. Those sites are therefore excluded from the calculations.

GENERAL METHOD

This report presents the overall performance of the TRICARE Program with respect to the Military Health System (MHS) Quadruple Aim of Improved Readiness, Better Care, Better Health, and Lower Cost. The MHS monitors various metrics to assess performance and, where possible, tries to compare MHS performance with relevant civilian health care performance. This report examines the effects of TRICARE on beneficiary utilization of inpatient, outpatient, and prescription services, as well as on MHS and beneficiary costs. Wherever feasible, the report contrasts various aspects of TRICARE and national health care trends. These include comparison of TRICARE utilization and cost measures with comparable civilian sector benchmarks derived from the Merative™ MarketScan® Commercial Database, trended changes in medical costs based on the national survey of nonfederal health plans and public employers conducted by the Kaiser Family Foundation and the Health Research and Education Trust, and national patient survey results from the consortium of the Agency for Healthcare Research and Quality (AHRQ) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS), to include CAHPS Health Plan Survey, Hospital CAHPS (HCAHPS), and CAHPS Clinician & Group Survey (CAHPS-CG).

Notes on Methodology

- Numbers in charts or text may not sum to the expressed totals due to rounding.
- Unless otherwise indicated, all years referenced are federal fiscal years (FYs; October 1–September 30).
- Unless otherwise indicated, all dollar amounts are expressed in then-year dollars for the fiscal year represented.
- All photographs in this document were obtained from websites accessible by the public. The photos have not been tampered with other than to mask an individual's name.
- Differences between MHS survey-based data and the civilian benchmark, or the MHS over time, were considered statistically significant if the significance level was less than or equal to 0.05.
- All workload and costs are estimated to completion based on separate factors derived from MHS administrative data for direct care and recent claims experience for private sector care.
- Data were current as of:
  - Surveys—Health Care Survey of Department of Defense (DoD) Beneficiaries (HCSDB) (12/15/2022); Joint Outpatient Experience Survey (JOES)/Joint Outpatient Experience-CAHPS (JOES-C) (12/8/2022); TRICARE Inpatient Satisfaction Survey (TRISS) (1/9/2023)
  - Eligibility/enrollment data—12/30/2022
  - MHS workload/costs—1/20/2023
- The Defense Health Agency (DHA) regularly updates its encounters and claims databases as more current data become available. It also periodically "retrofits" its databases as errors are discovered. The updates and retrofits can sometimes have significant impacts on the results reported in this and previous documents if they occur after the data collection cutoff date. The reader should keep this in mind when comparing this year's results with those from previous reports.

DATA SOURCES

HCSDB

The HCSDB was developed by the DHA and its predecessor, the TRICARE Management Activity, to fulfill the 1993 National Defense Authorization Act (NDAA) requirements and to provide a routine mechanism to assess TRICARE-eligible beneficiary access to and experience with the MHS or with alternate health plans. Conducted continuously since 1995, the HCSDB was designed to provide a comprehensive look at beneficiary opinions about their Department of Defense (DoD) health care benefits. The HCSDB provides information on a wide range of health care issues, such as beneficiaries' ease of access to health care, preventive care services, and healthy behaviors.

The worldwide multiple-mode Adult HCSDB has been conducted on a quarterly basis, three times a fiscal year, since FY 2013, and reported on a publicly accessible website (https://health.mil/hcsdb).

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

About three-fourths of HCSDB questions are closely modeled on the CAHPS Health Plan Survey in wording, response choices, and sequencing. The other one-fourth of HCSDB questions are designed to obtain information unique to TRICARE benefits or operations, and to solicit information about healthy lifestyles or health promotion, often based on other nationally recognized health care survey questions (e.g., the Centers for Disease Control and Prevention [CDC] Behavioral Risk Factor Surveillance System [BRFSS], National Health Interview Survey, or the National Health and Nutrition Examination Survey). Supplemental questions are added on a quarterly basis to explore specific topics of interest, such as the acceptance and prevalence of preventive services, including colorectal cancer screening and annual influenza immunizations; availability of other non-DoD health insurance; use of urgent care centers; and measures of Health-Related Quality of Life (HRQOL); and special timely topics such as COVID-19 vaccination opinions.

Because the HCSDB uses CAHPS questions, TRICARE can be benchmarked to civilian managed care health plans reporting CAHPS Health Plan results. More information on CAHPS can be obtained at www.cahps.ahrq.gov.

The HCSDB is sent by postal mail to all beneficiaries and also by e-mail to Active Duty members, with responses accepted via web and, for a random sample of initial nonrespondents, by postal mail. The HCSDB is fielded to a stratified random sample of beneficiaries. In order to calculate representative rates and means from their responses, sampling weights are used to account for different sampling rates and different response rates in different sample strata. Beginning with the FY 2006 report, weights were adjusted for factors such as age, sex, and rank that do not define strata, but make some beneficiaries more likely to respond than others. Because of the adjustment, rates calculated from the same data differ from past evaluation reports and are more representative of the population of TRICARE users. The DHA HCSDB is sent to a random sample of all MHS-eligible users and non-users. In FY 2022, there were approximately 23,562 annual responses from the sample of 301,500, resulting in a raw response rate of 7.8 percent. This is a slight decline from 8.6 percent raw response rate the previous year. Results can be estimated from the HCSDB for all beneficiary groups eligible for MHS benefits, whether they use direct care, private sector care, or other health insurance available to them, and are compared with benchmark results from a national sample of commercial civilian health plans administering the CAHPS Health Plan Survey.

Results provided from HCSDB in FYs 2019–2022 were based on questions taken from the CAHPS Version 5.0. As CAHPS versions change, the HCSDB results will be compared to the like-CAHPS version results each year because changes in the questionnaires and changes in rates are only meaningful when compared with changes in the relevant benchmark. CAHPS Version 5.0 benchmark microdata were obtained from the National Committee for Quality Assurance (NCQA).

NCQA collects responses to the survey from a national sample of health plans that serve the civilian population. Results from each plan for beneficiaries who responded by mail or Internet are averaged together, weighted equally. The benchmarks are adjusted to correspond to the age and health status of TRICARE users.

Differences between the MHS and civilian benchmark were considered significant at less than or equal to 0.05, using the normal approximation. The significance test for a change between years is based on the change in the MHS estimate minus the change in the benchmark, which is adjusted for age and health status to match the MHS. T-tests measure the probability that the difference between the change in the MHS estimate and the change in the benchmark occurred by chance.

Tests are performed using a Z-test, and standard errors are calculated using SUDAAN® to account for the complex stratified sample and unequal weights. If p is less than 0.05, the difference is significant.

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

DATA SOURCES *(CONT.)*

TRISS

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

The TRISS is a 41-item survey instrument. The survey includes HCAHPS questions asking how often or whether patients experienced a critical aspect of hospital care, rather than whether they were "satisfied" with their care, and DoD-specific questions, including an open-ended question to solicit location-specific comments from our beneficiaries.

The TRISS questionnaire is sent to all (census) adult MTF inpatients worldwide between 48 hours and six weeks after discharge. The TRISS survey is also administered to a random sample of adult MHS inpatients discharged from civilian network/private sector care hospitals. The TRISS follows the HCAHPS protocols developed by CMS. HCAHPS protocols for sampling, data collection, and coding can be found in the HCAHPS Quality Assurance Guidelines manual on the official HCAHPS website, www.hcahpsonline.org. The overall FY 2022 Q1–Q3 response rate for direct care was 32 percent and 30 percent for private sector care.

JOES/JOES-C

The JOES continues to focus on the beneficiary experience with care received in MTFs, and is centrally managed under the direction of Service and DHA survey leads. JOES results are reported centrally, and reported for each Service, multi-Service Market area, and down to each MTF and provider. The JOES-C is a companion survey to the JOES, measuring outpatient care at military and civilian facilities. The JOES-C is based on the CAHPS-CG, as was the predecessor to the JOES-C: the TRICARE Outpatient Satisfaction Survey (TROSS). JOES-C allows the MHS to compare beneficiary results to the civilian benchmark results.

Quality

Military hospital inpatient quality measures were abstracted from clinical records by trained specialists and reported to the Joint Commission (TJC) for national benchmarking. The data for direct care hospitals participating in the National Surgical Quality Improvement Program (NSQIP) are abstracted by trained surgical case reviewers and submitted to the American College of Surgeons (ACS). The perinatal data are obtained from the electronic data system through an administrative data pull and are submitted to the National Perinatal Information Center (NPIC) to support comparison with other participating organizations across the nation. The availability of data for MHS providers continues to increase through the MHS Population Health Portal in CarePoint, via a streamlined access process, registry development for population management, and improved data displays. The MHS Dashboard in CarePoint provides views for all measures as well as executive and improvement priorities. The CarePoint portal includes a discharge tool to ensure that patients at high risk for readmission are identified during hospitalization. This facilitates continuity of care and provides caregivers with time for patient education and follow-up appointment scheduling to reduce the risk of readmissions.

Utilization and Costs

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

Inpatient utilization was measured using dispositions (direct care)/admissions (private sector care) and Medical Severity Diagnosis Related Group (MS-DRG) relative weighted products (RWPs), the latter being a measure of the intensity of hospital services provided. Outpatient utilization for both direct and private sector care was measured using encounters and an MHS-derived measure of intensity called Enhanced Total Relative Value Units (RVUs).

The MHS uses several different RVU measures to reflect the relative costliness of the provider effort for a particular procedure or service. Enhanced Total RVUs were introduced by the MHS in FY 2010 and subsequently revised in FY 2016 (in both cases, they were retroactively applied to earlier years) to account for units of service (e.g., 15-minute intervals of physical therapy) and better reflect the resources expended to produce an encounter. The word "Total" in the name reflects that it is the sum of Work RVUs and Practice Expense RVUs. Work RVUs measure the relative level of resources, skill, training, and intensity of services provided by a physician. Practice Expense RVUs account for nonphysician clinical labor (e.g., a nurse), medical supplies and equipment, administrative labor, and office overhead expenses. In the private sector, Malpractice RVUs are also part of the formula used to determine physician reimbursement rates, but since military

physicians are not subject to malpractice claims, they are excluded from Total RVUs to make the direct and private sector care workload measures more comparable. For a more complete description of enhanced as well as other RVU measures, see https://www.milsuite.mil/video/watch/video/9653 (a milSuite account and DoD-issued Common Access Card [CAC] are required to access this site).

By the end of FY 2022, the DoD's new electronic health record, MHS GENESIS, had been deployed at 102 military hospitals and clinic commands worldwide. The data feed from MHS GENESIS does not currently include the information needed (which provider worked on which procedure) to compute RVUs. Additionally, the algorithms and data needed by the MEPRS Program Office to allocate costs within its data capture system are not built into MHS GENESIS, which is based on a commercial off-the-shelf product. Consequently, patient-level costs are currently unavailable for GENESIS facilities. However, the DHA Resources & Management Directorate (J-8)/Business Integration Division was able to provide total DoD inpatient costs and total outpatient costs for all facilities, which were allocated to beneficiary groups where necessary.

In the past, we simply excluded MHS GENESIS facilities from most of our direct care utilization and cost analyses because their impact was only modest. However, because more and larger facilities are transitioning to GENESIS each year, excluding those facilities is no longer tenable. Consequently, we developed algorithms to estimate outpatient RVUs (inpatient RWPS are available for GENESIS facilities) for the period of time each facility was under the GENESIS regime. Prior to transitioning to MHS GENESIS, actual RVUs and costs were available and reported for each facility under the legacy system (the Composite Health Care System).

Costs recorded on TEDs were broken out by source of payment (DoD, beneficiary, or private insurer). Although SIDR and CAPER data indicate the enrollment status of beneficiaries, the Defense Enrollment Eligibility Reporting System (DEERS) enrollment file is considered to be more reliable. We therefore classified MTF discharges as Prime or space-available by matching the discharge dates to the DEERS enrollment file. Final data pulls used for this report were completed in January 2021, as referenced above.

The Merative database contains the health care experience of several million individuals (annually) covered under a variety of health plans offered by large employers, including preferred provider organization (PPO) plans, point-of-service (POS) plans, health maintenance organization (HMO) plans, and indemnity plans.

The database links inpatient services and admissions, outpatient claims and encounters, and, for most covered lives, outpatient pharmaceutical drug data and individual-level enrollment information.

We tasked Merative to compute quarterly benchmarks for HMOs and PPOs, broken out by product line (i.e., medical/surgical [MED/SURG], obstetrics/gynecology [OB/GYN], mental health [PSYCH]), and several sex/age group combinations. The quarterly breakout, available through the second quarter of FY 2022, allowed us to derive annual benchmarks by fiscal year and to estimate FY 2022 data to completion. Product lines were determined by aggregating Major Diagnostic Categories (MDCs) as follows: OB = MDC 14 (Pregnancy, Childbirth, and Puerperium) and MDC 15 (Newborns and Other Neonates with Conditions Originating in Perinatal Period), PSYCH = MDC 19 (Mental Diseases and Disorders) and MDC 20 (Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders), and MED/SURG = all other MDCs. The breakouts by gender and age group allowed us to apply DoD-specific population weights to the benchmarks and aggregate them to adjust for differences in DoD and civilian beneficiary populations.

We excluded individuals aged 65 and older from the calculations because most of them are covered by Medicare and Medigap policies rather than by a present or former employer's insurance plan.

DRG Grouping Methodology

In the section that displays the "Top 25" inpatient diagnosis groups, diagnosis related groups (DRGs) are grouped into descriptively (but not necessarily clinically) similar categories using a code set available on http://www.findacode.com/code-set.php?set=DRG, an online database of medical billing codes and information. The site lists DRGs within each MDC, with headings above diagnostically related DRGs. These headings provide a broad description of the DRGs underneath and distinguish between medical and surgical DRGs, but do not distinguish among DRGs with different (or any) levels of complications and comorbidities. For the purposes of this report, the DRGs were too detailed and the MDCs too broad to provide the reader with a general sense of the most common inpatient diagnoses the MHS confronts; therefore, the headings were used as the basis for broadening the groupings in this report into descriptively related categories, without regard for whether they are medical or surgical, whether there are complications, or which parts of the body are affected. For example, the "ECMO or Tracheostomy" group includes DRGs 003, 004, 011, 012, and 013. The description for each of those DRGs includes the words "ECMO" or "Tracheostomy"—some with complications, some without; some for face, mouth, and neck; and some for other parts of the body. Once all the groups were formed, they were numbered sequentially following the order in which they were presented on the website. This resulted in a reduction from 818 DRGs to 284 DRGs.

ABBREVIATIONS

AABB	American Association of Blood Banks | 117
ABA	applied behavior analysis | 18
AC	Accreditation and Compliance | 113
AC	Active Component | 4
ACD	Autism Care Demonstration | 137
ACG	Adjusted Clinical Groupings | 143
ACH	Army Community Hospital | 139
ACO	Accountable Care Organization | 12
ACOG	American College of Obstetricians and Gynecologists | 129
ACS	American College of Surgeons | 60
AD	Active Duty | 33
ADC	administration, direction, and control | 24
ADDP	Active Duty Dental Program | 223
ADFM	Active Duty family member | 31
ADHCA	Assistant Director for Health Care Administration | 10
ADSM	Active Duty Service member | 5
AE	adverse event | 100
AHRQ	Agency for Healthcare Research and Quality | 88
AIM	Alliance for Innovation on Maternal Health | 129
AMC	Army Medical Center | 25
AO	accrediting organization | 113
APLSS	Army Provider Level Satisfaction Survey | 88
ASBP	Armed Services Blood Program | 117
ASCO	American Society of Clinical Oncology | 118
ASD	autism spectrum disorder | 137
ASD(HA)	Assistant Secretary of Defense for Health Affairs | 9
ASSET+	Advanced Surgical Skills for Exposure in Trauma+ | 59
AUR	antimicrobial use and resistance | 103
BDC	blood donor centers | 117
BH	behavioral health | 4
BHCC	Behavioral Health Clinical Community | 134
BHDP	Behavioral Health Data Portal | 134
BMI	body mass index | 178
BRAC	Base Realignment and Closure | 97
BRFSS	Behavioral Risk Factor Surveillance System | 185
BZD	benzodiazepine | 136
CA	corrective action | 67
CAC	Common Access Card | 60
CAHPS	Consumer Assessment of Healthcare Providers and Systems | 69
CAHPS-CG	CAHPS Clinician & Group Survey | 88
CAP	College of American Pathologists | 116
CARES Act	Coronavirus Aid, Relief, and Economic Security Act | 18
CAUTI	catheter-associated urinary tract infection | 103
CCAE	Commercial Claims and Encounters | 205
CCP	COVID Convalescent Plasma | 18
CCQAS	Centralized Credentialing and Quality Assurance System | 112
CCSR	Clinical Classifications Software Refined | 198
CDC	Centers for Disease Control and Prevention | 17
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services | 219
CHCS	Composite Health Care System | 45
CLABSI	central line–associated bloodstream infection | 103
CLIA	Clinical Laboratory Improvement Amendment | 116
CLIP	Clinical Laboratory Improvement Program | 116
CLMS	Joint-Service Center for Laboratory Medicine Services | 116
CM	clinical measurement | 68
CM	case management | 143
CMS	Centers for Medicare & Medicaid Services | 42
COBRA	Consolidated Omnibus Budget Reconciliation Act | 5
CONUS	contiguous United States | 7
COTS+	Combat Orthopedic Trauma Skills | 59
CP	Credentialing and Privileging | 112
CPG	clinical practice guideline | 69
CPI	continuous process improvement | 64
CQI	clinical quality improvement | 64
CQM	clinical quality management | 65
CQM E&T	Clinical Quality Management Education and Training | 120
CQMC	Core Quality Measures Collaborative | 67
CSA	comprehensive systematic analysis | 103
CSD	Clinical Support Division | 102
CY	calendar year | 4
DART	Direct Access Reporting Tool | 82
DCC	Dental Clinical Community | 138
DEERS	Defense Enrollment Eligibility Reporting System | 11
DHA	Defense Health Agency | b
DHA PI	DHA Office of Program Integrity | 187
DHA-IPM	DHA Interim Procedures Memorandum | 71
DHA-PI	DHA Procedural Instructions | 64
DHA-PM	DHA Procedures Manual | 67
DHARs	Defense Health Agency Regions | 101
DHP	Defense Health Program | 29
DMIS	Defense Medical Information System Identifiers | 29
DMMAC	Deputy Military Medical Action Council | 9
DoD	Department of Defense | b
DoDI	Department of Defense Instruction | 112
DoDM	DoD Manual | 89
DTF	dental treatment facility | 5
DVPRS	Defense and Veterans Pain Rating Scale | 144
EBPWG	Evidence-Based Practice Work Group | 121
ECHO	Extended Care Health Option | 5
ED	emergency department | 47
EHR	electronic health record | 26
EIC	external independent contractor | 188
FDA	Food and Drug Administration | 18
FEDVIP	Federal Employees Dental and Vision Insurance Program | 5
FEHB	Federal Employees Health Benefits Program | 167
FY	fiscal year | 1
GTT	Global Trigger Tool | 101
HAI	healthcare-associated infection | 101
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems | 4
HCO	Health Care Operations | 24
HCSDB	Health Care Survey of DoD Beneficiaries | 19
HEART	Healthcare Event Analysis Response Team | 106
HEC	Health Executive Committee | 121
HEDIS	Healthcare Effectiveness Data and Information Set | 4
HGB	Humana Government Business | 12
HIPAA	Health Insurance Portability and Accountability Act | 89
HMO	health maintenance organization | 5
HNFS	Health Net Federal Services | 12
HRM	healthcare risk management | 112
HRO	high reliability organization | 63
HRQOL	Health-Related Quality of Life | 9
HVBP	Hospital Value-Based Purchasing | 12
ICU	intensive care unit | 15
IDA	Institute for Defense Analysis | 204
IHI	Institute for Healthcare Improvement | 104
IMR	Individual Medical Readiness | 57
IPC	Infection Prevention and Control | 101
IQI	inpatient quality indicator | 132
JKSA PMO	Joint Knowledge, Skills, and Abilities Program Management Office | 59
JOES	Joint Outpatient Experience Survey | 4
JOES-C	Joint Outpatient Experience Survey-CAHPS | 88
JPSR	Joint Patient Safety Reporting | 102
JTS	Joint Trauma System | 13
KFF	Kaiser Family Foundation | 204
KP	Kaiser Permanente | 12
KPIs	key performance indicators | 9
LBP	low back pain | 12
LOS	length of stay | 74
M2	MHS Management Analysis and Reporting Tool | 80
MACE2	Military Acute Concussion Evaluation | 128

ABBREVIATIONS *(CONT.)*

MBSAQIP	Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program | 118
MCP	military-civilian partnership | 59
MCSC	managed care support contractor | 11
MDD	major depressive disorder | 134
MDG	Medical Group | b
MED/SURG	medical/surgical | 189
MEPRS	Medical Expense and Performance Reporting System | 212
MEPS	Medical Expenditure Panel Survey | 204
MERHCF	Medicare-Eligible Retiree Health Care Fund | 4
MH	mental health | 4
MHS	Military Health System | 1
MHSPHP	MHS Population Health Portal | 122
MILDEP	military department | 7
MIP	MHS Information Portal | 16
MM	Medical Management | 143
MOU	Memorandum of Understanding | 116
MS-DRG	Medicare Severity Diagnosis Related Group | 191
MTF	military medical treatment facility | 4
NAL	nurse advice line | 47
NAS	Non-Availability Statement | 219
NCHS	National Center for Health Statistics | 48
NCQA	National Committee for Quality Assurance | 86
NCR	National Capital Region | 132
NDAA	National Defense Authorization Act | 7
NH	Naval Hospital | 139
NHANES	National Health and Nutrition Examination Survey | 183
NHE	National Health Expenditures | 42
NHSN	National Healthcare Safety Network | 101
NIAID	National Institute of Allergy and Infectious Diseases | 18
NIH	National Institutes of Health | 144
NMSKCC	Neuromusculoskeletal Clinical Community | 128
NPDB	National Practitioner Data Bank | 67
NPI	National Provider Identifier | 171
NPIC	National Perinatal Information Center | 118
NQF	National Quality Forum | 102
NSQIP	National Surgical Quality Improvement Program | 9
O&M	operation and maintenance | 41
OASD(HA)	Office of the Assistant Secretary of Defense for Health Affairs | b
OB/GYN	obstetrics/gynecology | 189
OCO	overseas contingency operations | 41
OCONUS	outside the contiguous United States | 118
OHI	other health insurance | 33
OPM	Office of Personnel Management | 225
OTH	other | 33
OUSD(P&R)	Office of the Under Secretary of Defense for Personnel and Readiness | 7
P&T	Pharmacy & Therapeutics | 52
PASTOR	Pain Assessment Screening Tool and Outcome Registry | 65
PC	perinatal care | 115
PCCOB	Patient Centered Care Operations Board | 70
PCM	primary care manager | 5
PCMH	Patient-Centered Medical Home | 4
PDTS	Pharmacy Data Transaction Service | 51
PFPWD	Program for Persons with Disabilities | 220
POS	point of service | 5
PPH	postpartum hemorrhage | 65
PPM	provider-performed microscopy | 116
PPO	preferred provider organization | 5
PRA	Progressive Return to Activity | 128
PSA	Prime Service Area | 12
PSAW	Patient Safety Awareness Week | 105
PSC	private sector care | 5
PSC BAG	Private Sector Care Budget Activity Group | 43
PSP	Patient Safety Program | 101
PSPC	Patient Safety Professional Course | 107
PSS	Navy Patient Satisfaction Survey | 88
PSYCH	mental health | 189
PT	physical therapy | 12
PTSD	posttraumatic stress disorder | 134
PV	prime vendor | 53
QA	quality assurance | 67
QPP	Quadruple Aim Performance Plan | 10
RC	Reserve Component | 57
RDT&E	research, development, test, and evaluation | 41
RE	reportable event | 4
RETFM	retiree and family member | 31
RFI	Requirements for Improvement | 67
RMWG	Risk Management Working Group | 112
RN	registered nurse | 80
ROR	Return to Operating Room | 140
RRC	Ready Reliable Care | 66
RVU	relative value unit | 4
RWP	relative weighted product | 4
SAAR	standardized antibiotic administration ratio | 103
SDA	Air Force Service Delivery Assessment | 88
SECDEF	Secretary of Defense | 7
SelRes	Selected Reserve | 167
SERCA	Safety Event and Root Cause Analysis | 109
SIDR	Standard Inpatient Data Record | 133
SIR	standardized infection ratio | 103
SME	subject-matter expert | 70
SMMAC	Senior Military Advisory Council | 9
SP&FI	Strategy, Plans, and Functional Integration | 19
SRV	survivors | 33
SSO	Small-Market and Stand-Alone MTF Office | 101
TAMP	Transitional Assistance Management Program | 5
TBI	traumatic brain injury | 25
TCC	Tele-Critical Care | 85
TDP	TRICARE Dental Program | 5
TeamSTEPPS	Team Strategies and Tools to Enhance Performance and Patient Safety | 66
TED	TRICARE Encounter Data | 127
TFL	TRICARE for Life | 4
TFMR	Total Force Medically Ready | 57
THP	TRICARE Health Plan | 24
TJC	The Joint Commission | 4
TOL	TRICARE Online | 70
TPR	TRICARE Prime Remote | 5
TPRADFM	TRICARE Prime Remote for Active Duty Family Members | 5
TQIP	Trauma Quality Improvement Program | 118
TRDP	TRICARE Retiree Dental Program | 220
TRISS	TRICARE Inpatient Satisfaction Survey | 89
TRR	TRICARE Retired Reserve | 4
TRS	TRICARE Reserve Select | 4
TSS	TRICARE Select Survey | 172
TYA	TRICARE Young Adult | 4
UC	urgent care | 47
UMP	Unified Medical Program | 4
URFO	unintended retained foreign object | 102
URI	upper respiratory infection | 124
USD(P&R)	Under Secretary of Defense for Personnel and Readiness | 9
USFHP	Uniformed Services Family Health Plan | 4
USU	Uniformed Services University of the Health Sciences | 25
UTI	urinary tract infection | 140
VA	Department of Veterans Affairs | 29
VH	virtual health | 24
VHA	Veterans Health Administration | 102
VRC	Verification, Review, and Consultation | 118
WHCMT	Women's Health Clinical Management Team | 129
WICC	Women and Infant Clinical Community | 103
WSS	wrong-site surgery | 4

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS

1988–1995

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Era Leading to TRICARE

- Managed care demonstrations—mental health review, contracted provider arrangement for mental health, home health care/case management, catchment area management projects including the Tri-Service TRICARE Tidewater demonstration, the inaugural use of TRICARE branding
- CHAMPUS Reform Initiative demonstration contract for California and Hawaii offered CHAMPUS Prime, CHAMPUS Extra, and standard CHAMPUS (basis of later TRICARE triple option)

1993–1994

TRICARE Managed Care Legislation

- Administered under CHAMPUS fiscal intermediary contracts with oversight by the Office of CHAMPUS at Fitzsimmons Army Hospital installation in Aurora, Colo.
- Non-availability statements (NASs) for civilian inpatient care in MTF catchment areas
- Program for Persons with Handicaps supplements basic program with nonmedical benefits for Active Duty family members (ADFMs) with serious disabilities
- Demonstration program to cover CHAMPUS Breast Cancer Treatment Clinical Trial; access to high-dose chemotherapy with stem-cell rescue; beginning of a partnership between CHAMPUS and the National Cancer Institute
- Added coverage of screening mammography and Papanicolaou (Pap) tests, added Certified Marriage and Family Therapists as TRICARE-authorized providers
- Added Continued Health Care Benefit Program for certain former Department of Defense (DoD) beneficiaries at full-cost premiums, providing beneficiaries with an option comparable to COBRA coverage to continue health care coverage for a limited period after leaving military service
- Reduced the catastrophic cap from $10,000 to $7,500 per year for retirees and their family members, capping their out-of-pocket expenses for any given fiscal year

1995

- Provided beneficiaries with greater choice, access to care, and coverage of preventive services through restructuring the MHS with publication of the TRICARE final rule (October 5, 1995; 60 FR 52078-52103) to implement managed care legislation of 1993
- TRICARE overlaid the CHAMPUS program established in 1966
- Established cost-neutral TRICARE triple option (TRICARE Prime, Extra, and Standard)
- Started nationwide rollout of managed care support contracts (seven contracts) across 12 regions, each headed by a lead agent (five Army, two Navy, four Air Force, one rotating)

- Built a TRICARE provider network to wrap around the MTFs
- Increased beneficiary access to pharmacy options by adding home delivery and retail pharmacy points of service as a result of Base Realignment and Consolidation (BRAC) commission
- Preventive services first offered exclusively under TRICARE Prime
- Reduced catastrophic cap for non-Active Duty enrollees from $7,500 to $3,000
- Expanded Active Duty Dental Benefit Plan begins

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS *(CONT.)*

- Expanded beneficiary access to additional options for cancer treatment with a demonstration
  - Expanded coverage to all Phase II and III cancer clinical trials sponsored by the National Cancer Institute
  - Widened access to promising cancer therapies, and contributed to the NCI's efforts to further the science of cancer treatment
  - Eventually became a permanent TRICARE Basic benefit available to all beneficiaries

1996

- Dropped requirement for outpatient non-availability statement (NAS)
- Increased beneficiary access to preventive services by expanding access in TRICARE Standard/Extra (expanded further in 1997 to be very similar to TRICARE Prime)
- Launched TRICARE website

1997

- Began National Mail Order Pharmacy program
- Improved access to services for families with a disabled family member through the implementation of the Program for Persons with Disabilities (PFPWD), simplifying the process and making access easier for families
- Expanded comprehensive preventive benefits to TRICARE Standard/Extra
- Began TRICARE Retiree Dental Program (TRDP)—full-cost premiums with no DoD subsidy

- Completed TRICARE rollout with 11 regions operational (regions 7 and 8 consolidated)
- Removed TRICARE Prime copayments for ancillary services (radiology, laboratory, and diagnostic testing) conducted as a result of an outpatient visit

1998

- Began TRICARE Senior Prime demonstration

1999

- Increased beneficiary access to more providers by adding Corporate Services Provider Class
  - Allowed provider groups and foundations to become TRICARE-authorized providers; the care rendered by these providers was previously not cost-shared
  - Included freestanding corporations or foundations that rendered professional ambulatory care (e.g., physical therapy), in-home care, or technical diagnostic procedures
- Began TRICARE Prime Remote benefit
- NASs are required for maternity care

2000

- Expansion of TRDP to dependents begins
- Reduced catastrophic cap for retirees, their family members, and survivors under TRICARE Standard/Extra from $7,500 to $3,000
- The DoD waives charges for Active Duty Prime Remote family members through August 31, 2000
- Expanded TRICARE benefits to cover school physicals

2001

- Eliminated TRICARE Prime copayments for ADFMs
- Began TRICARE for Life (TFL) benefit, superseding TRICARE Senior Prime Demonstration; TFL is Medicare wraparound coverage for TRICARE beneficiaries who have Medicare Part A and Medicare Part B; TRICARE pays after Medicare and other health insurance for TRICARE-covered health care services
- Began TRICARE Senior Pharmacy benefit, adding pharmacy benefits for retirees over 65 years of age who formerly lost all TRICARE benefits upon becoming eligible for Medicare at age 65
- Reduced and simplified TRICARE copayment structure for prescription drugs
- Began permanent chiropractic care benefit in MTFs for Active Duty Service members (ADSMs)
- Began TRICARE Prime travel benefit to reimburse travel expenses when an enrollee has to travel more than 100 miles for referred specialty care
- Improved beneficiary access to needed care by revising the Coverage Criteria for Transplants and Cardiac and Pulmonary Rehabilitation
  - Added coverage of heart-lung, single or double lung, and combined liver-kidney transplants
  - Added coverage of pulmonary rehabilitation
  - Enhanced access to life-saving treatments for seriously ill TRICARE beneficiaries
  - Expanded coverage for pulmonary rehabilitation services to additional diagnoses as determined by the Director or designee
- Demonstration that waived NASs and annual TRICARE Standard/Extra deductible for family of mobilized Reserve Component (RC) sponsor (extended five times until made permanent in 2008)
- Deployed PDTS—improving patient safety—an online, real-time worldwide prospective drug utilization review (clinical screening) against a patient's complete medication history for each new or refilled prescription; these clinical screenings identify potential medication issues, which are immediately resolved to ensure the patient receives safe and quality care

2002

- Began TRICARE Prime Remote for Active Duty family members (TPRADFM) benefit
- Awarded TRICARE Mail Order Pharmacy contract (formerly managed by Defense Logistics Agency as the National Mail Order Program)
- Began TRICARE Global Remote Overseas contract, providing cashless/claimless health care to overseas ADSMs/ADFMs assigned to Prime Remote locations
- Created Individual Case Management Program for Persons with Extraordinary Conditions—a discretionary program for beneficiaries with extraordinary medical or psychological conditions, providing coverage of care normally excluded by law or regulation, as long as the benefit was cost effective
- Created Custodial Care Transition Policy to cover new cases of custodial care for beneficiaries entitled to expanded benefits

2003

- Modified TPRADFM to allow family members residing in Prime Remote locations to remain enrolled when sponsors undergo Permanent Change of Station on unaccompanied tour
- Began requirement for RC sponsor's activation orders for TRICARE Global Remote Overseas benefit
- Eliminated NAS requirement for TRICARE Standard, except for mental health
- Awarded TRICARE Retail Pharmacy contract, carving the benefit out of the managed care support contracts into a single program

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS *(CONT.)*

- Expanded Transitional Assistance Management Program (TAMP) coverage temporarily to 180 days for all participants (made permanent in 2005)
- Began early eligibility for RC members activated for more than 30 days in support of a contingency operation (made permanent in 2005)

2004

- Consolidated managed care support contracts and 11 TRICARE Regions to three (North, South, and West)

2005

- Began premium-based TRICARE Reserve Select (TRS) benefit for certain Reserve Component members
- Superseded the PFPWD with Extended Health Care Option/Home Health Care (ECHO/EHHC) program, including 16 hours of respite care per month
- Improved beneficiary access to needed medications and, in many cases, decreased beneficiary cost share, by implementing the DoD Pharmacy Uniform Formulary/three-tier cost-share system
- Implemented the Uniform Formulary three-tier copayment, administered by the DoD Pharmacy & Therapeutics (P&T) committee under the Pharmacy Program

2006

- Expanded TRS to all members of the Selected Reserve by adding two premium tiers
- Expanded TRICARE coverage to gastric bypass, gastric stapling, or gastroplasty
- Gave family members a 30-day period to submit a TRICARE Prime enrollment form
- Added transitional TRICARE survivor coverage for dependents whose sponsor dies on Active Duty (greater than 30 days)
- Expanded coverage to certain direct commission reserve officers awaiting Active Duty

2007

- Expanded TRICARE coverage to anesthesia and other costs for dental care for certain children and other beneficiaries
- Standardized claims processing under TRICARE Program and Medicare program
- Enhanced mental health screening and services for members of the Armed Forces
- Simplified TRS—superseded three-tier TRS with a single 28 percent premium tier; opened to all Selected Reserve members other than those eligible for, or enrolled in, Federal Employees Health Benefits (FEHB) program

- Included mental health care program in definition of health care
- Implemented the Enhanced Access to Autism Care Demonstration (ACD) through the ECHO for ADFMs
- Improved the care provided to Wounded Warriors by adding numerous benefits, including:
  - Expanded ECHO services to Service members with respite care added
  - Added retiree combat-related disability travel
  - Added transitional care for service-related conditions first identified during TAMP for RC members

2008

- Began integrated disability evaluation system—ensured DoD disability ratings and Department of Veterans Affairs (VA) disability ratings were established prior to medical retirement from Active Duty

2009

- Started Active Duty Dental Program (ADDP)
- Eased the potential burden on families with special needs by increasing the ECHO cap to $36,000 per year for certain services
- Increased access to care by expanding the TAMP program:
  - Separated Active Duty members who affiliate with the Selected Reserve
  - Members in receipt of a sole survivorship discharge
- Improved beneficiary access to behavioral health care by allowing a streamlined certification for Hospital-Based Psychiatric Partial Hospitalization Programs
- Established TRICARE Pharmacy manufacturer refunds (retroactive to January 2008)
- Implemented Outpatient Prospective Payment System
- Improved beneficiary access to vaccines by expanding coverage under pharmacy benefit for H1N1 at retail pharmacies at zero copayment

2010

- Began TRICARE Overseas Program health care delivery
- Launched premium-based TRICARE Retired Reserve (TRR) program—TRICARE Standard/Extra coverage offered for purchase by Retired Reserve members (gray area) for themselves and eligible family members
- Expanded ADDP to Reserve members during TAMP

2011

- Launched premium-based TRICARE Young Adult (TYA)—TRICARE Standard/Extra coverage offered for purchase for certain adult children up to age 26
- Increased access to support services by expanding the ACD
- Increased access to needed treatment by expanding coverage of the available surgical options for morbid obesity
- Decreased copayment for TRICARE Pharmacy Home Delivery, coinciding with increases to copayments for retail pharmacy purchases
- Adjusted TRICARE Prime enrollment fee and began option for annual collection (frozen for survivors and certain significantly injured or ill retirees)
- Increased beneficiary access to behavioral health services by adding Certified Mental Health Counselors as independent practitioners

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS *(CONT.)*

2012

- Eliminated TRICARE Standard/Extra cost shares for authorized preventive services (always free of cost-sharing in TRICARE Prime)
- Expanded TYA to offer TRICARE Prime coverage
- Revised TRICARE compound drug coverage by adopting a more rigorous screening process to ensure they are safe and effective, and covered by TRICARE
- Decreased beneficiary cost by freezing TRICARE Prime enrollment fees at rate effective when first enrolled for survivors of Active Duty deceased sponsors and medically retired members and dependents
- Added coverage for off-label uses of devices if reliable evidence indicates it is safe, effective, and in accordance with nationally accepted standards of practice in the medical community
- Added assisted reproductive services for seriously or severely ill or injured Service members

- Modified Over-the-Counter Demonstration project to include Plan B One-Step (levonorgestrel) without prescription requirement
- Added coverage for abortions for rape or incest and brought coverage into conformance with existing federal statutory laws, including the Hyde Amendment, the Affordable Care Act, and President's Executive Order #13535
- Added coverage of hippotherapy under ECHO (horseback riding as a therapeutic or rehabilitative treatment)
- Defense Health Agency (DHA) became initially operational under authority of the Assistant Secretary of Defense for Health Affairs (ASD[HA]) and designated as a Combat Support Agency with oversight from the Chairman of the Joint Chiefs

2013

- Reduction in Prime service areas (PSAs; closed all those not built around an MTF or BRAC site)
- TRS termination date delayed 180 days for Selected Reserve members involuntarily separated under honorable conditions (expired in 2018 by law)
- Expanded Autism Care Demonstration to include retiree family members
- Restricted Uniformed Services Family Health Plan (USFHP) enrollment to beneficiaries (65 years and younger)
- Permanent authority to include certain OTC drugs under Uniform Formulary based on P&T recommendation

- Reinstated Prime eligibility for some beneficiaries
- Launched Laboratory-Developed Test demonstration—authority to determine whether tests not yet approved by the FDA are safe and effective for use and thus eligible for TRICARE coverage
- Expanded TRICARE coverage to single-level cervical total disc replacement
- Increased access to TRICARE mental health counselors
- Expanded available treatments for substance abuse
- Began TFL Pharmacy Pilot, requiring TFL beneficiaries living in the U.S. and the U.S. territories to fill select maintenance medications through TRICARE Pharmacy Home Delivery or at a military pharmacy

2014

- Extended the TRICARE Over-the-Counter demonstration, which permits beneficiaries to fill prescriptions for certain OTC drugs, from network pharmacies and through home delivery for free
- Added Certified Mental Health Counselors as authorized TRICARE providers
- Eliminated day limits for inpatient mental health stays
- Closed U.S.-based TRICARE Service Centers
- Expanded breast pump (and supplies) coverage to all TRICARE beneficiaries
- Expanded TRICARE coverage to same-sex spouses and their family members
- Clarified the Unfortunate Sequelae policy, ensuring that treatment of complications or medically necessary follow-on care that occurs subsequent to noncovered initial surgery/treatment at an MTF is covered

2015

- Changed TRICARE Prime access to allow beneficiaries to enroll in a region where their desired primary care manager (PCM) is located (cross-region enrollment)
- Launched fourth-generation pharmacy contract
- Added requirement for all beneficiaries (other than Service members) to receive maintenance drugs via mail-order or at MTFs only
- Awarded second-generation TRICARE Overseas Program contract
- Coverage of Transitional Care Management Services—includes services provided to beneficiaries with moderate or complex medical needs and who are transitioning from the inpatient setting to their community setting (e.g., home)

2016

- Implemented first Value-Based Demonstration—lower extremity joint replacement
- Launched network Urgent Care Pilot Program—up to four visits per year without referral or prior authorizations for non-ADSM Prime enrollees in contiguous United States
- Improved mental health access and parity with lower out-of-pocket expense
  - Expanded inpatient mental health hospital services coverage
  - Reduced cost shares for all applied behavior analysis services under Comprehensive Autism Care Demonstration
  - Expanded opioid treatment
- Improved TRICARE pharmacy benefit
  - Safe disposal of unwanted medications
  - Medication Therapy Management Pilot
  - DoD/VA Continuity of Care Drug List
  - Required brand name maintenance drug fills through either TRICARE Pharmacy Home Delivery or from a military pharmacy
  - Increased copayments slightly for Home Delivery and retail network pharmacies
  - Expanded over-the-counter drug coverage permanently
- Added reimbursement for end-of-life care beneficiary planning consultations
- Enhanced preventive services and eliminated some cost share/copayments
- Introduced provisional coverage for emerging treatments and technologies
- Expanded TRICARE Basic Program to cover:
  - Surgery for femoroacetabular impingement
  - Transcranial magnetic stimulation for treatment of major depressive order and two-level cervical disc replacement
  - Nonsurgical treatment of gender dysphoria for all MHS beneficiaries; gender reassignment surgery only for ADSMs
- Began U.S.-based pilot to encourage MHS beneficiaries seen in civilian emergency rooms (in designated Markets) to voluntarily transfer to a participating MTF if an inpatient admission is needed and if determined safe for transfer
- Started second-generation TRICARE Overseas Program contract
  - Translation of medical documentation for all TOP Prime and Prime Remote beneficiaries
  - Implemented CHAMPUS Maximum Allowable Charges rates for professional services in all U.S. territories

2017

- Initial deployment of MHS GENESIS to four MTFs and their child sites

2018

- Replaced TRICARE Standard/Extra with TRICARE Select, with grace transition period in 2018
- Extended Autism Care Demonstration for five years, through 2023, providing Applied Behavior Analysis coverage
- First annual TRICARE Open Season; coincided with the annual open season by U.S. Office of Personnel Management (OPM)
- Enhanced TRICARE Coverage for Guard and Reserve members:
  - Extended TRICARE coverage to National Guard members and their eligible family members on 502(f) orders under Title 32 and called to state disaster response duty
  - Extended pre-deployment/early TRICARE eligibility and transitional coverage to Reserve Component members and eligible family members in receipt of 12304b orders for pre-planned missions under Title 10

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS *(CONT.)*

2019

- Ended TRDP
- OPM welcomed beneficiaries previously eligible for TRDP to enroll in a dental plan under their Federal Employees Dental and Vision Insurance Program (FEDVIP)
- Opened FEDVIP vision enrollment to ADFMs, retirees and their families, as well as TRS and TRR members
- Assigned administration, direction, and control (ADC) of MTFs in U.S. to DHA (Deputy Secretary of Defense memo October 25, 2019)
- Offered TRICARE Prime enrollment in a Kaiser Permanente demonstration to beneficiaries in the Atlanta region
- Updated coverage of breastfeeding supplies and equipment
- Continued rollout of MHS GENESIS, the electronic health record (EHR) to MTFs

2020

- Operation Warp Speed for COVID-19 vaccine development—massive HHS/DoD joint project; DoD phased vaccine administration began December 2020
- MTF COVID-19 adaptations included telemedicine
- Temporary TRICARE adaptations for COVID-19
  - Asymptomatic testing for Service members
  - Expanded telemedicine to audio only, eliminated Prime/Select cost shares, and authorized interstate or international practice
  - Expanded coverage to investigational drugs and emerging treatments, including vaccines and National Institute of Allergy and Infectious Diseases (NIAID)-sponsored clinical trials
  - Increased certain hospital payments by 20 percent
  - Relaxed criteria for skilled nursing facility care
  - Relaxed certification of temporary hospital facilities and free-standing surgical centers
- MHS transformation—MTF transition to DHA
  - Resumed after a pause for COVID-19 response
  - A number of Service medical department staff transferred to DHA
  - MHS GENESIS rollout to MTFs continued
- Added occupational therapy assistants and physical therapist assistants as TRICARE-authorized providers; podiatrists can refer to physical therapy (PT) and OT
- Enhanced TRICARE Pharmacy Benefits Program; encouraged use of high-value products
- Extended TRICARE demonstration project for Laboratory Developed Tests by three years
- Adopted Medicare's authority for Hospital Value-Based Purchasing (HVBP) program
- Fourth Annual Open Season—new for 2021, TRICARE Select enrollment fees. About 900,000 grandfathered retirees, their families, and survivors completed arrangements for fee collection with contractors

2021

- Completed transfer of stateside MTFs to DHA
- Started TRICARE Overseas Program follow-on contract. Enhancements included:
  - Started Near Patient Program
  - Improved Clinical Quality Program
  - Facilitated medical document collection
- Clarified COVID-19–related TRICARE coverage
  - Covered testing with provider's order, including in-home test kits
  - Covered vaccine with zero cost share
  - Covered vaccine from retail pharmacies
- Adjusted TRICARE policies temporarily for COVID-19 patients during declared public health emergency
  - Increased inpatient payment by 20 percent
  - Relaxed long-term care hospital admission requirements
  - Covered skilled nursing facility services for COVID-19 transfer patients without the usual prior three-day qualifying hospital stay
- Started TRICARE pilot programs to test innovations
  - Ten states – waive cost shares on up to three physical therapy visits for low back pain through December 31, 2023
  - Metro Denver – test value-based care through December 31, 2022
- Added remote physiologic monitoring coverage for acute and chronic conditions
- Added laser treatment provisional coverage for symptomatic scars from burns and other trauma
- Eliminated concurrent ECHO benefits as a qualification to receive respite care
- Started allowing Active Duty members to file medical malpractice claims as the patient against military MTFs
- Reduced reimbursable costs for certain durable medical equipment, prosthetics/orthotics, and supplies
- Adopted Medicare's HVBP for the TRICARE Program
  - Incentivizes health care providers to improve service delivery and quality
- Adopted Medicare's special "New Technology Add-On Payments"
  - Increases payments for new medical services/technologies until standardized rates can be adjusted accordingly
  - Promises to improve clinical outcomes while modernizing the TRICARE benefit
- Amended federal regulation to repeal Federal Employees Health Benefits eligibility as a disqualification for TRICARE Reserve Select effective January 1, 2030

2022

- Transferred overseas MTFs to DHA
- Started follow-on TRICARE contracts
  - TRICARE Medicare Eligible Program (TMEP) by Wisconsin Physicians Service Insurance Corp.
  - ADDP by United Concordia Companies Inc.
  - Women, Infants, and Children (WIC) Overseas Program Support Services by Cherokee Nation Aerospace & Defense, LLC
- Permanently expanded coverage of audio-only telemedicine
- Waived cost sharing for certain contraceptive methods
- TRICARE demonstrations to test innovations
  - Nationwide: certified doulas and certified lactation consultants/counselors are covered through December 31, 2026
  - Metro Atlanta: TRICARE Prime operated by Kaiser Permanente. No military hospitals or clinics in the area
- Added new reimbursement methodology for New Technology Add-On Payments (NTAPs) for pediatric beneficiaries and authorized creation of TRICARE NTAPs for new medical technologies
- Expanded temporary COVID-19 waiver of acute-care hospital requirements to include any entity that temporarily enrolls with Medicare as a hospital

KEY AGENCY AND INDIVIDUAL CONTRIBUTORS

The **Evaluation of the TRICARE Program: Fiscal Year 2023 Report to Congress** is provided by the Defense Health Agency, Analytics and Evaluation Division, in the Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]). Once the Report has been sent to Congress, an interactive digital version with enhanced functionality and searchability will be available at: https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program.

Key agency and individual contributors to this analysis (and their areas of expertise):

Government DHA/Analytics and Evaluation Division Project Director and Lead Researcher:

Melissa D. Gliner, Ph.D.; DHA/SP&FI (J-5)

Senior Health Analyst and Lead Contributing Analyst:

Chizoba Chukwura, M.P.H.

Government Agency Analysts and Reviewers: OASD(HA) and DHA

Beth A. Adoue-Polk, M.S.; DHA/Healthcare Optimization/Health Care Operations/Patient Experience (Access to MHS Care)
Kimberley A. Aiyelawo, Ph.D.; DHA/SP&FI (J-5)/Analytics and Evaluation (JOES, JOES-C, TRISS Surveys)
Timothy J. Anderson, Lt Col; DHA/Financial Operations (DHP Personnel)
Raul L. Barrientos, CAPT, D.D.S.; DHA/Health Care Operations/THP (Dental Service)
Robert D. Barrientos, Lt Col, M.B.A.; DHA/DHP Budget and Execution (Budget)
William E. Bolduc, CAPT, L.C.S.W.; DHA/Medical Affairs/MHS Clinical Communities/Policy Support (Clinical Communities)
Joseph T. Cabell, R.N., Ph.D., MSN, MBA; DHA/Medical Affairs/CSD (Accreditation and Compliance)
Selina Carr-McEwen, M.B.A., M.A.; Military Operational Art and Science/Studies; DHA/Financial Operations(J-8)/DHP Programming (DHP Personnel)
Thomas N. Cheatham, Col; DHA/Healthcare Optimization (Access to MHS Care)
Warren G. Conrow, Lt Col; DHA/Health Care Operations (Accreditation and Compliance Program)
Tanya L. Carrere-Cooper; DHA/SP&FI (J-5)/Analytics and Evaluation (Operations)
Meghan L. Corso, CAPT, Psy.D.; DHA/Medical Affairs/CSD (Behavioral Health)
Tina R. Czopek, M.S., R.N.; DHA/Medical Affairs/Clinical Support/Clinical Quality Management (Clinical Communities)
John W. Davison, M.B.A., Ph.D.; DHA/Medical Affairs/CSD (Clinical Communities and HRO Journey)
Robert E. DeMartino, CAPT, M.D.; DHA/Medical Affairs/CSD (Pain Management)
Chris Diaz, M.H.I.M.; TRICARE Health Plan (Private Sector Care System)
Michael P. Dinneen, Ph.D., M.D.; OUSD(PR)/Strategy Management (Performance Management)
Paul S. Doan, M.D.; DHA/Medical Affairs/CSD (Surgical Quality)
Jody W. Donehoo, Ph.D.; DHA/THP (Customer Support Branch)
Darrell D. Dorrian; DHA Financial Operations (J-8)/Cost Accounting (Facilities)
John J. Felicio, M.H.A.; Health Care Operations (Demonstrations/Pilots)
Debra L. Fisher, B.S.; DHA/THP/TRICARE Policy and Programs (TRICARE Young Adult)
Melissa C. Fraine, M.P.H.; DHA/Medical Affairs/CSD (Transparency)
Sharon A. Francois, CPCS, CPMSM; DHA/Medical Affairs/CSD (Credentialing and Privileging)
Julia F. Gannon, M.H.A., R.Ph.; DHA/Medical Affairs/Clinical Support (Patient Safety Program)
Tad Gow, DEL, R.N.; DHA/Medical Affairs (J-3)/Clinical Support/Population Health and Medical Management (Better Health Measures)
Todd S. Gibson, M.A.; DHA Financial Operations (J-8)/Facilities Enterprise (Facilities)
Elan P. Green, M.P.P., M.P.H.; THP/Medical Benefits and Reimbursement (Private Sector Care)
Jennifer Gurney, COL; DHA/Health Care Operations/Joint Trauma System (COVID-19 Registry)
Brittany Haden, LCDR; Directors Action Group (DHA Vision and Mission)
Richard C. Hart; DHA/Health Care Operations/THP/Health Plan Design (Plans and Benefits)
Theresa A. Hart, R.N.; DHA/Medical Affairs/CSD (Women and Infant)
Rosemarie M. Hirata, B.S.; OUSD(P&R)/OASD(HA) (Performance Management)
Christopher L. Hunter, CAPT, Ph.D., ABPP; DHA/Medical Affairs/CSD (Primary Care)
Danita F. Hunter; DHA/THP (TRICARE Young Adult)
Kathleen M. Hutchinson, M.S.; DHA/SP&FI (J-5)/Analytics and Evaluation (System Productivity)
Chester C. Jean, COL, M.D.; DHA/Medical Affairs (Behavioral Health Clinical Community)
Stefanie S. Johnson, Maj, MSC, FACHE; DHA/Optimization Support (Access to MHS Care)
Regina M. Julian, M.H.A., M.B.A.; DHA/Health Care Operations/Chief, Clinical Business Operations (PCMH/Access/Experience)
Kevin J. Kaps, D.O.; DHA/SP&FI (J-5) (Chief of Medical Services)
Heidi B. King, M.S.; DHA/Medical Affairs/CSD (Patient Safety)
Richard T. Kollar, Business Administration and Management, General; DHA/JKSA Program Management Office (Clinical Readiness Project)
John P. Kugler, M.D.; DHA/Medical Affairs/CSD (Medical Management)
Patti A. Lederer, R.N., M.S.N.; DHA/Medical Affairs/CSD (Clinical Quality Management)
Frank K. Lee; DHA/Health Care Operations/THP (Private Sector Care Performance Management)
Stephen L. Lewis, CDR; Directors Action Group (DHA Vision and Mission)
Karla H. Loper, D.B.A., R.N.; DHA/Medical Affairs/CSD (Clinical Measurement)
Marybeth E. Luna, Lt Col (Ret.), M.P.A.; DHA/Health Care Operations (Clinical Laboratory Services and Accreditation)
Molly R. Maxim, M.P.H.; DHA/SP&FI (J-5)/Analytics and Evaluation (Claims Processing)
Douglas L. McAllaster, M.S.; DHA/SP&FI (J-5)/Analytics and Evaluation (Population and Workload/Cost QC)
Sharon P. McKiernan, M.A., M.D.; DHA (Healthcare Resolutions Program)
Mitchell A. Mismash, M.P.H.; DHA/Health Care Operations (PCMH/Access to Care)
Susan M. Moon, M.D.; DHA/Medical Affairs/CSD (Health Care Risk Management)
Mollie Mullen, CAPT (Ret.), M.B.A., R.N.; NMRTC/NMCSD Directorate for Surgical Services (Focused Quality Initiatives)
Mariana Munante, M.D.; DHA/Medical Affairs/Clinical Support (Clinical Measurement)
P. Thien Nguyen, CDR, Pharm.D.; DHA/Health Care Operations (Pharmacy Operations)

KEY AGENCY AND INDIVIDUAL CONTRIBUTORS *(CONT.)*

Government Agency Analysts and Reviewers: OASD(HA) and DHA *(cont.)*

Marjorie Faye Olger; DHA/Health Care Operations/THP (Private Sector Care Performance Management)
Janet A. Papazis, D.P.T.; DHA/Clinical Support (NMSK Clinical Community)
Todd W. Poindexter, Col, M.D.; DHA/Medical Affairs/Clinical Support (Clinical Quality Management)
Ginnean C. Quisenberry, M.S.N.; DHA/Medical Affairs/CSD (Population Health and Medical Management)
Lisa D. Regulus, CDFM-A; DHA/DHP Budget and Execution (Budget)
Leslie Edward Riggs, CAPT; DHA/Health Care Operations (Blood Bank Services Accreditation)
Margaret A. Rincon, CDR, Pharm.D.; DHA/Medical Affairs/CSD (Clinical Measurement)
Duneley A. Rochino, CAPT, D.Sc.; DHA/Medical Affairs/CSD (NMSK)
Scottie B. Roofe, COL, M.D.; DHA/Clin Spt/Credentialing and Privileging (Healthcare Risk Management)
Daniel J. Ross, M.D., D.D.S.; DHA/Medical Affairs/CSD (Clinical Quality Management Branch Chief)
Karen A. Royster, B.S.; DHA/Armed Service Blood Program Division (Blood Bank Services Accreditation)
Stacy A. Shackelford, Col, M.D.; DHA/Combat Support/Joint Trauma System (COVID-19 Registry)
Tammy K. Shaw, Maj; DHA/Health Care Operations (Accreditation and Compliance Program)
Jasmine Simmons, Maj; DHA/Public Health/Health Readiness Support/Individual Medical Readiness (Medical Readiness of the Force)
Bryce J. Slinger, M.P.H.; OASD(HA) (Performance Management)
Brian D. Smith, M.H.S.A; DHA/THP/Health Care Operations (Select Reserve)
Mark J. Stevenson, M.A., M.S., M.H.A., FACHE, CHIE; DHA/THP (Private Sector Care Performance Management)
Justin A. Sweetman, M.F.A.; DHA/SP&FI (J-5)/Analytics and Evaluation (COVID-19 Vaccine Administration)
Bobby G. Taylor Jr., LT, R.N.; DHA/PCMH (Nurse Advice Line)
Jennifer L. Varney, Lt Col, NC, M.S.N., D.N.P.; DHA/Medical Affairs/CSD (Pain Management)
Eric R. Vazquez; DHA/Financial Operations (MHS DHP Personnel)
John J. Verghese, COL; DHA/THP (Private Sector Care Performance Management)
Kristen M. Zottola, B.S.; DHA Financial Operations (J-8)/Cost Accounting (Facilities)

Lead Analytic Support:

Institute for Defense Analyses

Philip Lurie, Ph.D.
William Patrick Luan, Dr.P.H.
Maggie X. Li
Jamie Lindly, M.S. (Operations Research)

Contributing Analysts:

Altarum Institute

Cristine Battick, B.S.
Christopher Duke, Ph.D.
Sean Flowers, M.A.
Matt Michaelson, G.I.S.P.
Jennifer Peterson, B.A.
Danielle Hurdle Rabb, M.A.
Joe Swedorske, M.S.

W2 Consulting Corporation

Chizoba Chukwura, M.P.H.

Deloitte

Sarah Godby, Ph.D.
Michelle Strickland, M.P.A
Lauren D. Winslow, B.A.

IPSOS

Timothy Amsbary, M.S.
Randall Goldammer, B.S.

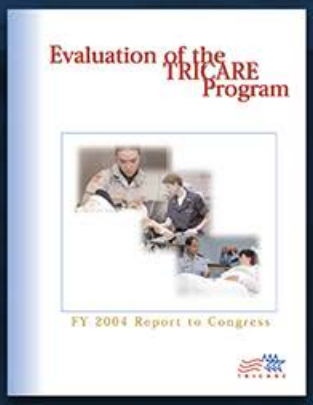
Final Report Production:

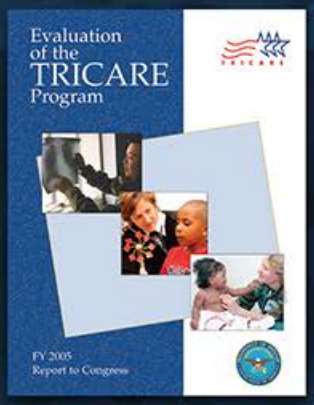
Forte Analytics, Denver, CO

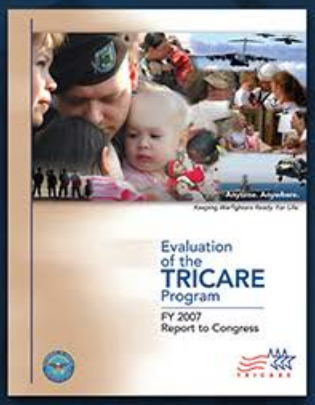
Terminology:

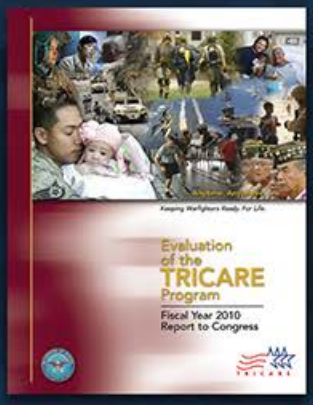
CSD = Clinical Support Division
DHP = Defense Health Program
HRO = High Reliability Organization
JKSA = Joint Knowledge, Skills, and Abilities
NMCSD = Naval Medical Center San Diego
NMRTC = Navy Medicine Readiness and Training Command
NMSK = Neuromusculoskeletal
OASD(HA) = Office of the Assistant Secretary of Defense for Health Affairs
OUSD(PR) = Office of the Under Secretary of Defense for Personnel and Readiness
PCMH = Patient-Centered Medical Home
SP&FI = Strategy, Plans, and Functional Integration
THP = TRICARE Health Plan

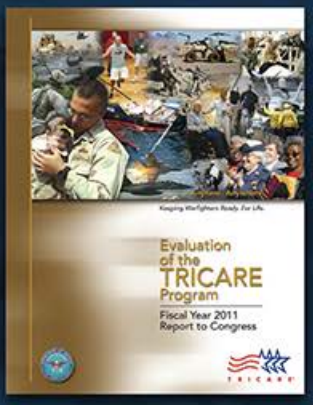
DHA
Defense Health Agency

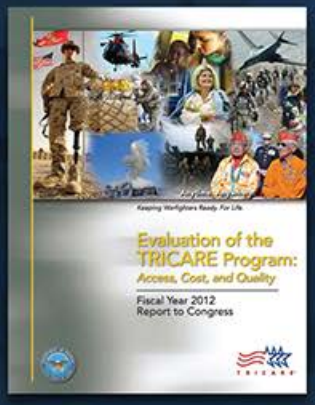


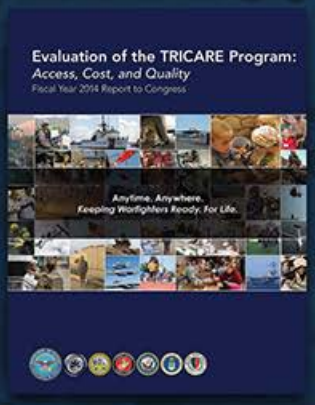


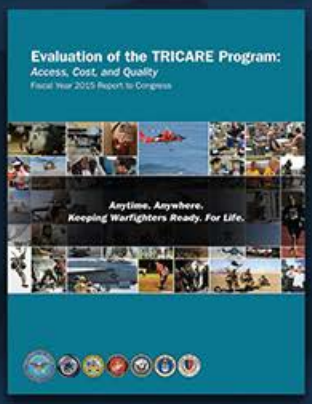


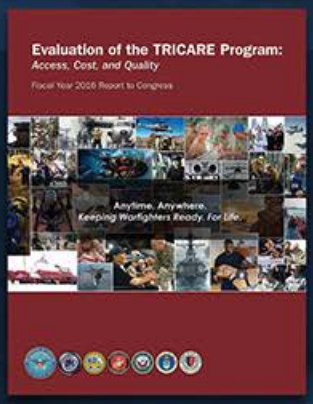


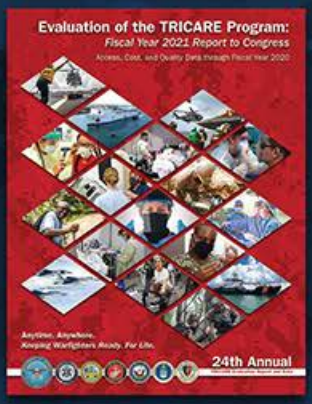












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