Fiscal Year 2024 TRICARE Program Evaluation Report

Produced by the:
Chief Data and Analytics Office
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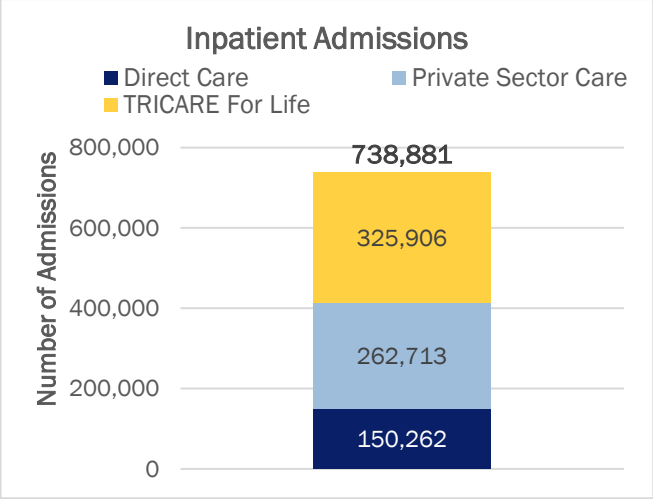
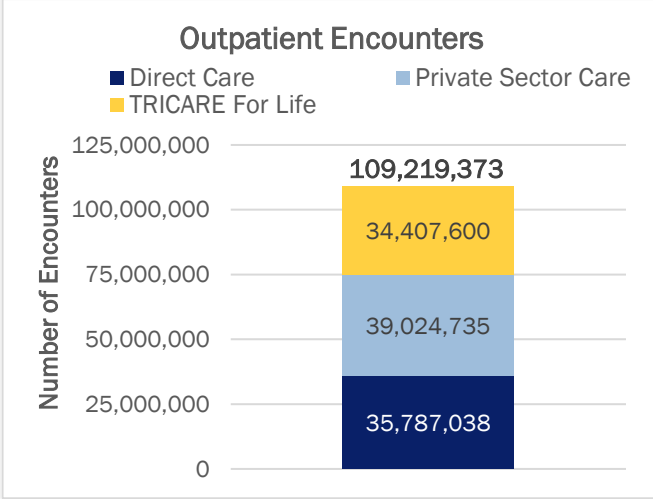
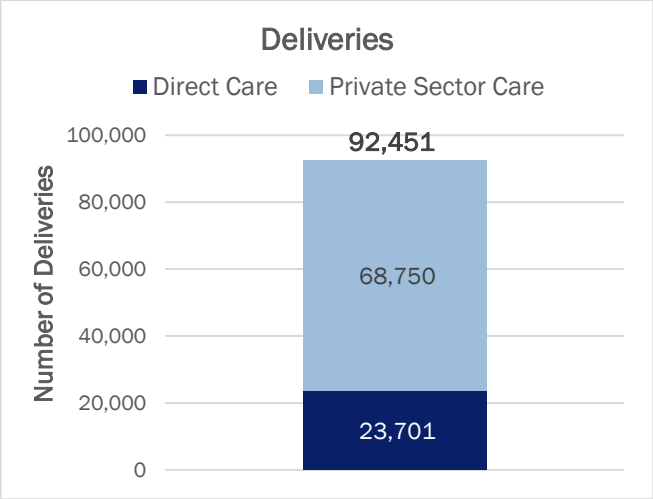
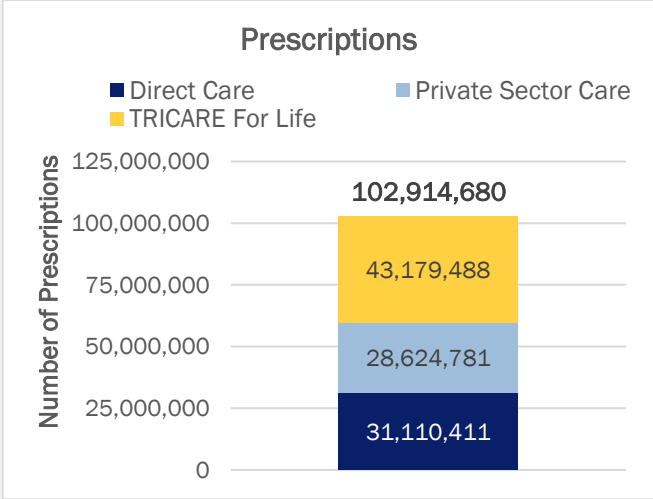
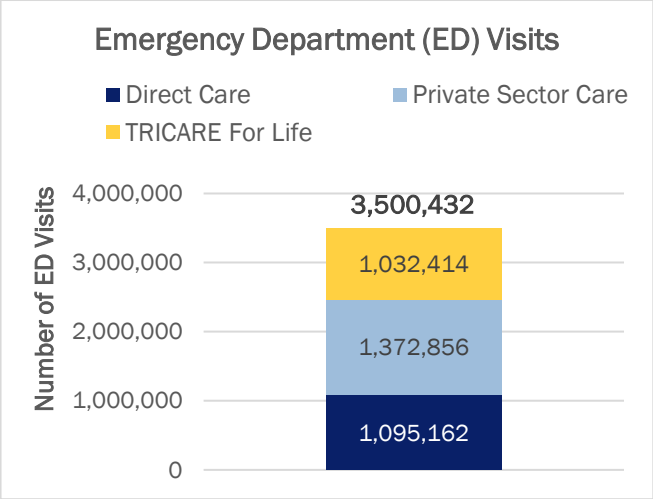
WORKLOAD AND POPULATION SUMMARY FOR FY 2024

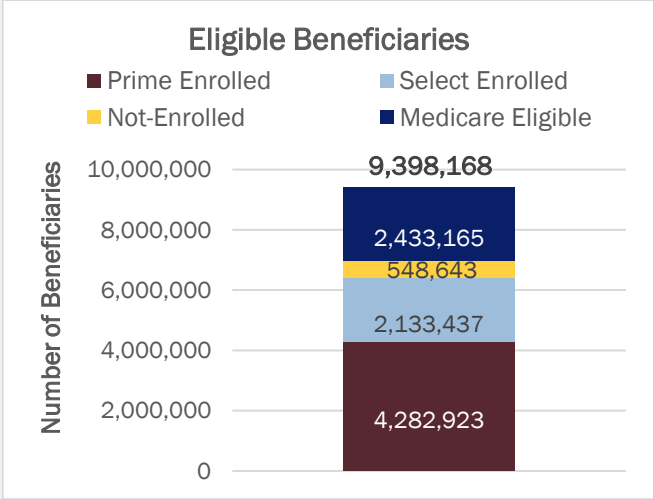












Source: MHS administrative data and DEERS.
Notes: TRICARE For Life is from private sector care only. Admissions to non-acute care hospitals in private sector care and TRICARE For Life are not counted since all MTF hospitals are acute care facilities. Percentages may not sum to 100 due to rounding.

KEY FINDINGS FOR FY 2024

Military Health System (MHS) Worldwide Summary

- The $61.4 billion Unified Medical Program (UMP) presented in the FY 2025 Enacted President's Budget, including estimated outlays from the Medicare-Eligible Retiree Health Care Fund (MERHCF), is 2.4 percent higher than the actual $59.9 billion FY 2024 expenditures and is about 7 percent of total FY 2025 estimated Department of Defense (DoD) outlays.
- In FY 2024, 9.4 million beneficiaries were eligible for DoD medical care. Of those, about 4.3 million (46 percent) were enrolled in TRICARE Prime.

Utilization Rates and Workload

- Urgent care utilization and emergency department utilization each remained relatively the same in FY 2024 as they did the previous two years.

Access to MHS Care

- Primary Care Manager (PCM) patient relationship remains a driving force to improve access and quality and to deliver better health outcomes for military medical treatment facility (MTF) beneficiaries. In FY 2024, enrollees saw their PCM during primary care visits 48 percent of the time. In FY 2024, there was an increase in the average number of days to third next available 24-hour (2.8 days) and future (9.6 days) appointments from the previous year. The rate of network urgent care visits by MTF enrollees decreased in FY 2024 from the previous year.
- The Joint Outpatient Experience Survey (JOES) shows 73 to 75 percent of MTF users indicated they were able to see a provider when needed (based on quarterly data) in FY 2024.

Patient Safety

- The DHA requires MTF Directors and staff to report all patient safety events that reach the patient (i.e., harm and no-harm events) and those that do not reach the patient (i.e., near-miss events) to the greatest extent possible through the Joint Patient Safety Reporting (JPSR) system. In FY 2024, a total of 68,125 patient safety reports were submitted from direct care.

Hospital Quality of Care/Healthcare Effectiveness Data and Information Set (HEDIS®)

- The HEDIS rate for DoD colorectal cancer screening improved by 7.1 percentage points; all sectors (MTFs, private sector care, DoD overall) were above the 75th percentile in FY 2024. The HEDIS measure for a mental health follow up within 30-days after hospitalization increased for MTFs from FY 2023 to FY 2024 and was above the 90th percentile.
- DoD breast cancer screening rates decreased slightly and were below the 50th percentile. Cervical cancer screening rates have noted improvements, however, remain below the 50th percentile across all sectors of care.
- Glycemic status assessment for patients with diabetes is a two-component measure. The diabetes control measure (HbA1c<8) for MTFs has steadily increased and was above the 75th percentile. The measure for poor diabetes control (HbA1c>9) for MTFs improved (lower score is better) and continues to perform above the 50th percentile.
- The well-child visit HEDIS measure was below the 50th percentile for all venues in FY 2024.

Patient Experience

- Patient satisfaction with their health plan for those with Select and Prime Network PCM were above the civilian benchmark in FY 2024, but below the benchmark for enrollees in Prime MTF PCM (from the Health Care Survey of Beneficiaries [HCSDB]).
- Satisfaction with outpatient care was between 86 and 89 percent in FY 2024, consistent with the three previous years (JOES).
- Overall hospital rating for direct care medical and surgical product lines were above the civilian benchmark in FY 2024, while obstetric product line was below the benchmark.

WHAT IS TRICARE?

TRICARE is the worldwide health care program of the Department of Defense (DoD). It serves uniformed service members (active and guard/reserve) on active duty (longer than 30 days) and their families; as well as retirees, their families, survivors, certain members of the selected/retired reserve and certain former spouses (www.tricare.mil). TRICARE brings together the military hospitals and clinics worldwide (MTFs and military dental treatment facilities [DTFs], collectively called "direct care") 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 PCM. A PCM is a health care provider who is responsible for managing an enrollee's care, promoting preventive health services (e.g., routine exams and immunizations), and arranging for specialty provider services as indicated.
  - TRICARE Prime access standards apply to the drive time to reach a provider, waiting times to get an appointment, and waiting times in provider offices.
  - TRICARE Prime's point-of-service (POS) feature offers enrollees freedom to obtain care from TRICARE-authorized providers other than their assigned PCM without a referral. However, POS deductibles and cost shares are significantly higher than TRICARE Select, and POS charges are not counted toward the enrollee's catastrophic cap.
- TRICARE Prime Remote (TPR) enrollment is offered to certain Service members stationed remote from MTFs.
- TRICARE Prime Remote for Active Duty Family Members (TPRADFM) enrollment is offered to qualified dependents of service member sponsors, active and reserve, on active duty more than 30 days.
- Uniformed Services Family Health Plan (USFHP) is a TRICARE Prime plan offered to non-active duty beneficiaries who live in one of six statutorily specified areas: Washington, Texas, Maine, Maryland, Massachusetts, and New York/New Jersey. Enrollees receive all services, including pharmacy, exclusively from their particular enrolled USFHP plan. Enrollees forfeit MTF services.
  - TRICARE for Life offers wraparound coverage for TRICARE-eligible beneficiaries who have both Medicare Parts A and B, regardless of age or place of residence. Similar to Medigap policies, TFL pays secondary to Medicare for TRICARE-covered services. TFL started October 1, 2001.
  - Transitional Assistance Management Program (TAMP) provides 180 days of premium-free coverage upon release from Active Duty served more than 30 days by certain service member sponsors, active or reserve.
- Other plans and programs: Some beneficiaries may qualify for the following depending on their location, Active/Reserve status, and/or other factors; premium-based health plans, including:
  - TRICARE Young Adult (TYA) is available for purchase by qualified former dependent children up to the age of 26. They may choose TRICARE Prime, where offered locally, or TRICARE Select coverage. Cost-sharing level is dependent upon sponsor status.
  - TRICARE Reserve Select (TRS) is available for purchase by qualified Selected Reserve members and qualified survivors. TRS delivers TRICARE Select coverage with cost sharing at the active duty family member rate.
  - TRICARE Retired Reserve (TRR) is available for purchase by qualified Retired Reserve members with cost sharing at the retiree rate.
  - TRICARE Dental Program (TDP) is available for purchase by family members of ADSMs as well as Ready Reserve members and their family members.

  - Continued Health Care Benefit Program is comparable to Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage.
  - Federal Employees Dental and Vision Insurance Program (FEDVIP) offers dental plans for purchase by retirees, and offers vision plans for purchase by most non-Service member beneficiaries enrolled in a TRICARE health plan. FEDVIP is operated by the U.S. Office of Personnel Management, not DoD.
- Other benefits and services, including:
  - Dental benefits (DTFs and claims management for active duty using civilian dental services)
  - Pharmacy: MTFs, TRICARE retail network pharmacies, and TRICARE Pharmacy Home Delivery Program
  - Overseas private sector care, customer service, and claims processing services
  - Women, Infants, and Children Overseas Program (www.tricare.mil/wic)
  - Extended Care Health Option (ECHO): nonmedical benefits available to qualified Active Duty family members (ADFMs) with special needs (www.tricare.mil/echo).

BENEFICIARY TRENDS AND CHARACTERISTICS

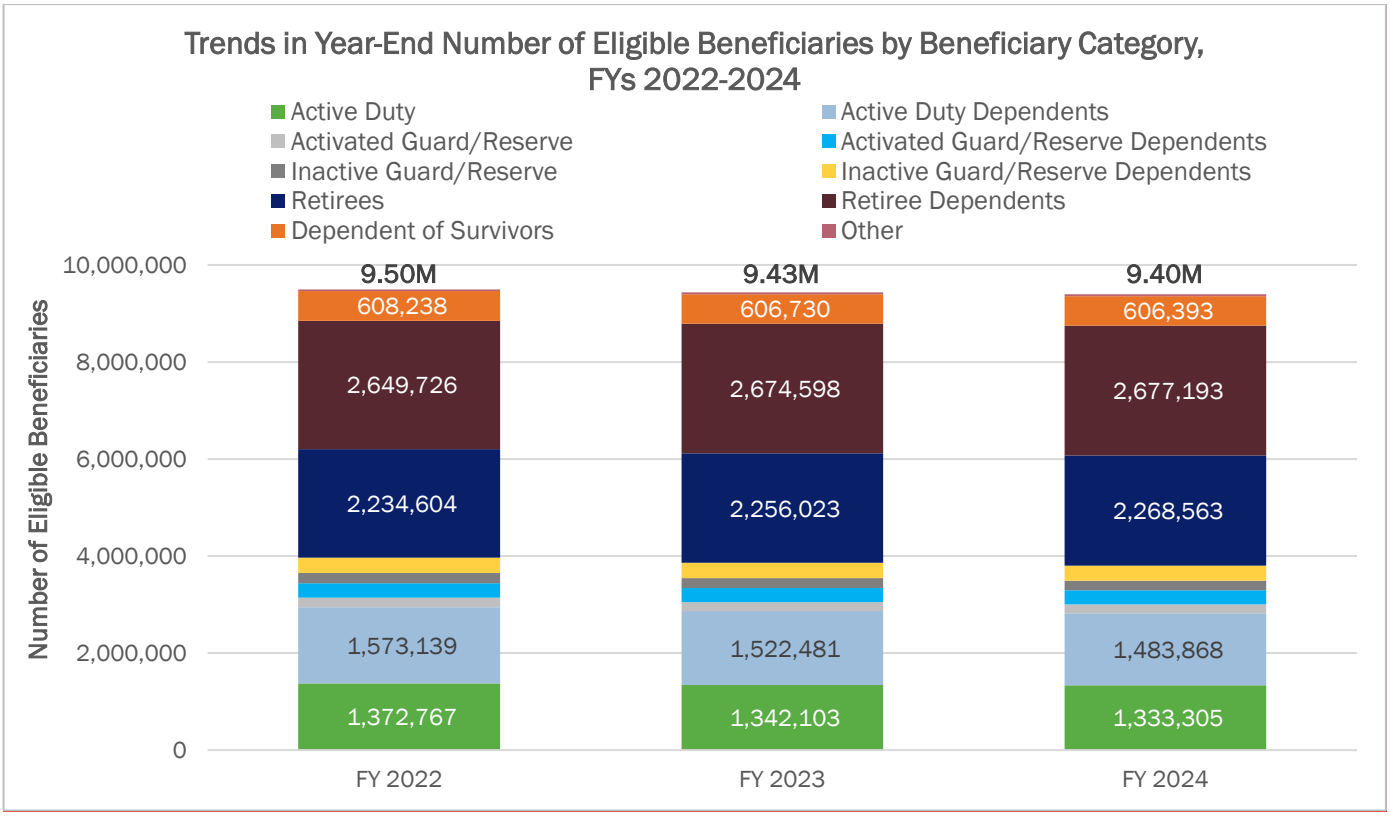
System Characteristics – TRICARE Facts and Figures Projected for FY 2024 and Projected FY 2025

	Projected For FY 2025[1]	FY 2024 Actuals
Total Beneficiaries	9.5 million worldwide[2]	9.4 million worldwide[2]
MILITARY FACILITIES—DIRECT CARE SYSTEM		
Inpatient Hospitals and Medical Centers	45 (33 in U.S.)[3]	45 (30 in U.S.)[3]
Ambulatory Care and Occupational Health Clinics	592 (486 in U.S.)[4]	606 (496 in U.S.)[4]
Dental Clinics	110 (91 in U.S.)	113 (93 in U.S.)
MHS Defense Health Program Personnel	125,788	124,764
Military	72,561	72,337
	26,791 Officers	*26,733 Officers*
	45,770 Enlisted	*45,604 Enlisted*
Civilian (including Foreign National)	53,227	52,427
CIVILIAN RESOURCES—PRIVATE SECTOR CARE SYSTEM[5]		
Network Primary Care, Behavioral Health, & Specialty Care Providers (i.e., individual, not institutional, providers)	1,161,027	1,070,660
Network Behavioral Health Providers (shown separately, but included in above)	230,748	210,240
TRICARE Network Acute Care Hospitals	4,451	4,394
Behavioral Health Facilities	5,487	5,200
Contracted (Network) Retail Pharmacies	41,000	41,762[6]
Contracted Worldwide Pharmacy Home Delivery Vendor	1	1
TRICARE Dental Program (TDP) (for active duty families, reserve members, and their families)	Approximately 2 million covered lives	Approximately 2 million covered lives
TDP Network Dentists	115,000 total dentists, including: 85,829 general dentists & 29,208 specialty dentists	114,037 total dentists, including: 85,329 general dentists & 28,708 specialty dentists
Total Requested FY 2024 Unified Medical Program (UMP) (including Projected trust Fund Receipts)	$61.36 billion[7]	$59.95 billion[7]
Projected Receipts from Medicare-eligible Retiree Health Care Fund (MeRHCF) trust Fund	$11.05 billion	$10.53 billion

[1] 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.
[2] DoD health care beneficiary population projected for the end of FY 2024 is 9,398,168 rounded to 9.4 million. This projection is based on the DoD Comptroller's Budget End Strength, DoD Actuary's forecast of the retiree population, and family members per sponsor from DEERS as of April 2025.
[3] "Inpatient Hospitals and Medical Centers" includes 36 hospitals and 9 medical centers for FY 2024. The 45 MTF count excludes a joint VA-DoD facility (James A. Lovell FHCC) and a birthing center (Iwakuni is part of the Yokosuka Organization, so is not delineated out as a stand-alone hospital). In FY 2025, the definition of CONUS/OCONUS facilities was updated, resulting in reclassification of the three sites located in Alaska and Hawaii reclassified as "OCONUS" to "CONUS," resulting in the change of 30 MTFs in U.S. in FY 2024 to 33 in FY 2025. Source: DHA. J-8, Cost Accounting Division, 6/10/2025; updated 1/20/2026.
[4] "Ambulatory Care and Occupational Health Clinics" includes community-based clinics, embedded behavioral health, centers of excellence, and occupational health clinics, and excludes joint DoD-VA clinics 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: DHA. J-8, Cost Accounting Division, 6/10/2025; updated 1/20/2026.
[5] As reported by the managed care support contractors (MCSCs) for contracted network provider and hospital data, 5/12/2025; and TRICARE Dental Program Section, Health Plan Execution and Operations for dental provider data, 11/1/2024.
[6] This number is only accurate at the time of the data pull (November 2024).
[7] 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, 11/19/2024.

Number of Eligible and Enrolled Beneficiaries Between FY 2022 and FY 2024

The number of beneficiaries eligible for DoD medical care declined slightly from FY 2022 to FY 2023, and again in FY 2024. The percentage of the eligible population by beneficiary category remains relatively the same for the past three years with approximately half of eligible beneficiaries being retirees and their dependents.



Source: DEERS, 4/16/2025
Note: Data labels for beneficiary categories representing small percentages have been removed from the figure for ease of reading. Percentages may not sum to 100 due to rounding.

Trends in Year-End Number of Eligible Beneficiaries by Beneficiary Category, FYs 2022-2024

	FY 2022	FY 2022	FY 2023	FY 2023	FY 2024	FY 2024
Beneficiary Category	**Population**	**Percent of Total**	**Population**	**Percent of Total**	**Population**	**Percent of Total**
Active Duty	1,372,767	14.5%	1,342,103	14.2%	1,333,305	14.2%
Active Duty Dependents	1,573,139	16.6%	1,522,481	16.1%	1,483,868	15.8%
Activated Guard/Reserve	197,147	2.1%	188,100	2.0%	188,185	2.0%
Activated Guard/Reserve Dependents	299,168	3.2%	289,339	3.1%	286,402	3.0%
Inactive Guard/Reserve	207,457	2.2%	205,853	2.2%	203,212	2.2%
Inactive Guard/Reserve Dependents	315,890	3.3%	312,275	3.3%	308,987	3.3%
Retirees	2,234,604	23.5%	2,256,023	23.9%	2,268,563	24.1%
Retiree Dependents	2,649,726	27.9%	2,674,598	28.4%	2,677,193	28.5%
Dependents of Survivors	608,238	6.4%	606,730	6.4%	606,393	6.5%
Other	37,096	0.4%	36,680	0.4%	42,060	0.4%
TOTAL	**9,495,232**		**9,434,182**		**9,398,168**	

Source: DEERS, 4/16/2025
Percentages may not sum to 100 due to rounding.

Plan Type by Beneficiary Category

Plan Type by Beneficiary Category, FY 2024

Plan Type	AD	DA	GR	GRD	IGR	IGRD	RET	RETD	DS	OTH	TOTAL
Prime Enrolled	**1,333,305**	**1,118,018**	**188,185**	**182,745**	**4,324**	**11,351**	**505,588**	**901,593**	**33,068**	**4,746**	**4,282,923**
Prime MTF PCM	1,284,409	803,529	139,310	56,022	2,128	3,827	238,326	385,445	13,461	1,936	2,928,393
Prime Network PCM	0	257,385	0	83,191	525	6,315	238,092	463,787	16,701	2,309	1,068,305
Prime Remote	48,896	32,587	48,875	35,489	1,235	361	23	12	481	53	168,012
Prime TYA	0	195	0	21	0	0	0	1,840	55	1	2,112
Prime USFHP	0	24,322	0	8,022	436	848	29,147	50,509	2,370	447	116,101
Select Enrolled	**0**	**332,222**	**0**	**93,959**	**179,889**	**294,437**	**385,677**	**791,936**	**41,264**	**14,053**	**2,133,437**
Select	0	330,184	0	93,135	22,361	34,722	374,472	749,234	40,193	13,174	1,657,475
Select TYA	0	1,855	0	639	0	813	0	23,317	709	38	27,371
TRR (Select)	0	0	0	0	1	3	4,385	8,717	40	2	13,148
TRS (Select)	0	6	0	161	157,527	258,899	37	85	41	804	417,560
TRICARE Plus	0	177	0	24	0	0	6,783	10,583	281	35	17,883
Not-Enrolled	**0**	**32,478**	**0**	**9,634**	**18,994**	**3,183**	**195,120**	**223,041**	**45,441**	**20,752**	**548,643**
Not-enrolled (MTF Only)	0	32,478	0	9,634	18,994	3,183	195,120	223,041	45,441	20,752	548,643
Medicare-Eligible	**0**	**1,150**	**0**	**64**	**5**	**16**	**1,182,178**	**760,623**	**486,620**	**2,509**	**2,433,165**
Prime MTF PCM	0	0	0	0	0	0	15,650	8,172	1,482	25	25,329
Prime Network PCM	0	0	0	0	0	0	18,878	9,466	1,465	52	29,861
Prime USFHP	0	0	0	0	0	0	17,272	11,450	7,403	46	36,171
TFL	0	0	0	0	5	16	1,033,246	670,597	444,533	2,273	2,150,670
TRICARE Plus	0	1,150	0	64	0	0	97,132	60,938	31,737	113	191,134
TOTAL	**1,333,305**	**1,483,868**	**188,185**	**286,402**	**203,212**	**308,987**	**2,268,563**	**2,677,193**	**606,393**	**42,060**	**9,398,168**

Source: DEERS, 4/16/2025

Beneficiary Categories
AD = Active Duty
DA = Active Duty Dependents
GR = Activated Guard/Reserve
GRD = Activated Guard/Reserve Dependents
IGR = Inactive Guard/Reserve
IGRD = Inactive Guard/Reserve Dependents
RET = Retirees
RETD = Retiree Dependents
DS = Dependents of Survivors
OTH = Other

Plan Type Acronyms
TYA = TRICARE Young Adult
USFHP = Uniformed Services Family Health Plan
TRR = TRICARE Retired reserve
TRS = TRICARE Reserve Select
TFL = TRICARE For Life

Plan Type by Age Group

Plan Type by Age Group, FY 2024

Plan Type	Age 0-17	Age 18-24	Age 25-44	Age 45-64	Age 65+	TOTAL
Prime Enrolled	**1,061,438**	**777,962**	**1,487,429**	**928,226**	**27,868**	**4,282,923**
Prime MTF PCM	620,043	631,422	1,189,039	477,070	10,819	2,928,393
Prime Network PCM	365,447	117,612	187,490	387,425	10,331	1,068,305
Prime Remote	41,141	16,976	91,990	17,845	60	168,012
Prime TYA	0	1,373	739	0	0	2,112
Prime USFHP	34,807	10,579	18,171	45,886	6,658	116,101
Select Enrolled	**707,645**	**225,532**	**559,048**	**620,769**	**20,443**	**2,133,437**
Select	541,690	168,382	359,753	567,799	19,851	1,657,475
Select TYA	0	18,790	8,581	0	0	27,371
TRR (Select)	3,736	1,648	1,370	6,340	54	13,148
TRS (Select)	158,602	35,233	187,566	35,874	285	417,560
TRICARE Plus	3,617	1,479	1,778	10,756	253	17,883
Not-Enrolled	**69,867**	**57,962**	**101,416**	**197,525**	**121,873**	**548,643**
Not-Enrolled (MTF Only)	69,867	57,962	101,416	197,525	121,873	548,643
Medicare-Eligible	**46**	**617**	**23,451**	**111,448**	**2,297,603**	**2,433,165**
Prime MTF PCM	3	121	3,760	20,476	969	25,329
Prime Network PCM	4	111	4,841	23,848	1,057	29,861
Prime USFHP	0	14	303	1,376	34,478	36,171
TFL	10	353	14,423	64,417	2,071,467	2,150,670
TRICARE Plus	29	18	124	1,331	189,632	191,134
TOTAL	**1,838,996**	**1,062,073**	**2,171,344**	**1,857,968**	**2,467,787**	**9,398,168**

Source: DEERS, 4/16/2025

Plan Type Acronyms
TYA = TRICARE Young Adult
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Trends in Plan Type

As a percentage of total eligible population, the number of TRICARE Prime-enrolled beneficiaries declined by two percentage points from FY 2022 to FY 2024 (48 percent to 46 percent). Prime-enrolled beneficiaries make up nearly half (45.6) of all beneficiaries in FY 2024, followed by 25.9 percent enrolled in Medicare-eligible plans, and 22.7 percent enrolled in TRICARE Select plans.

Trends in Plan Type and Percentage of Total Enrollment, FYs 2022-2024

	FY 2022	FY 2022	FY 2023	FY 2023	FY 2024	FY 2024
Plan Type	**Population**	**Percent of Total**	**Population**	**Percent of Total**	**Population**	**Percent of Total**
Prime Enrolled	**4,530,232**	**47.7%**	**4,376,230**	**46.4%**	**4,282,923**	**45.6%**
Prime MTF PCM	3,105,260	32.7%	2,973,898	31.5%	2,928,393	31.2%
Prime Network PCM	1,127,683	11.9%	1,115,415	11.8%	1,068,305	11.4%
Prime Remote	178,793	1.9%	167,770	1.8%	168,012	1.8%
Prime TYA	3,747	0.0%	2,710	0.0%	2,112	0.0%
Prime USFHP	114,749	1.2%	116,437	1.2%	116,101	1.2%
Select Enrolled	**2,065,068**	**21.7%**	**2,095,867**	**22.2%**	**2,133,437**	**22.7%**
Select	1,599,803	16.8%	1,618,395	17.2%	1,657,475	17.6%
Select TYA	31,823	0.3%	29,922	0.3%	27,371	0.3%
TRR (Select)	13,324	0.1%	13,288	0.1%	13,148	0.1%
TRS (Select)	402,063	4.2%	416,258	4.4%	417,560	4.4%
TRICARE Plus	18,055	0.2%	18,004	0.2%	17,883	0.2%
Not-Enrolled	**487,845**	**5.1%**	**536,580**	**5.7%**	**548,643**	**5.8%**
Not-enrolled (MTF Only)	487,845	5.1%	536,580	5.7%	548,643	5.8%
Medicare-Eligible	**2,412,087**	**25.4%**	**2,425,505**	**25.7%**	**2,433,165**	**25.9%**
Prime MTF PCM	28,433	0.3%	26,387	0.3%	25,329	0.3%
Prime Network PCM	33,021	0.3%	30,968	0.3%	29,861	0.3%
Prime USFHP	38,548	0.4%	37,621	0.4%	36,171	0.4%
TFL	2,122,664	22.4%	2,142,002	22.7%	2,150,670	22.9%
TRICARE Plus	189,421	2.0%	188,527	2.0%	191,134	2.0%
TOTAL	**9,495,232**		**9,434,182**		**9,398,168**	

Source: DEERS, 4/16/2025
Note: Percentages may not sum to 100 due to rounding.

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TYA = TRICARE Young Adult
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Eligible TRICARE Beneficiaries in FY 2024

There were 9.40 million beneficiaries eligible for some form of DoD health care benefits at the end of FY 2024. The Army has the most beneficiaries eligible for uniformed services health care benefits, followed (in order) by the Air Force, Navy, Marine Corps, Coast Guard, Public Health Service, Space Force, Foreign Military, and the National Oceanic and Atmospheric Administration.

Beneficiaries Eligible for DoD Health Care Benefits by Service Branch, FY 2024

Service Branch	Population Counts	Percent of Total
Army	3,927,699	41.8%
Air Force	2,513,814	26.7%
Navy	1,941,367	20.7%
Marine Corps	714,596	7.6%
Coast Guard	225,404	2.4%
Public Health Service	32,414	0.3%
Space Force	23,075	0.2%
Foreign Military	17,999	0.2%
NOAA	1,800	0.0%
TOTAL	**9,398,168**	

Source: DEERS, 4/16/2025
Notes:
- NOAA = National Oceanic and Atmospheric Administration
- Percentages may not sum to 100 to due to rounding.

Retirees and their family members constituted the largest percentages of the eligible beneficiary population (24.1 percent and 28.5 percent, respectively) in FY 2024. Active duty and their dependents constituted approximately 30 percent of the total eligible beneficiary population.

Beneficiaries Eligible for DoD Health Care Benefits by Beneficiary Category, FY 2024

Beneficiary Category	Population Counts	Percent of Total
Active Duty	1,333,305	14.2%
Active Duty Dependents	1,483,868	15.8%
Activated Guard/Reserve	188,185	2.0%
Activated Guard/Reserve Dependents	286,402	3.0%
Inactive Guard/Reserve	203,212	2.2%
Inactive Guard/Reserve Dependents	308,987	3.3%
Retirees	2,268,563	24.1%
Retiree Dependents	2,677,193	28.5%
Dependents of Survivor	606,393	6.5%
Other	42,060	0.4%
TOTAL	**9,398,168**	

Source: DEERS, 4/16/2025
Note: Percentages may not sum to 100 due to rounding.

Beneficiaries Access to Prime

A beneficiary is considered to have access to Prime if he or she resides within a Prime Service Area (PSA). PSAs are designated ZIP codes in which the TRICARE Prime benefit is offered by enrolling to (1) an MTF, (2) the Tricare Network (provided by the two Managed Care Support Contractors [MCSC]), or (3) to the Uniformed Services Family Health Plan. TRICARE Prime is available at MTFs, in areas around most MTFs (MTF PSAs), in areas where an MTF was eliminated in the Base Realignment and Closure (BRAC) process (BRAC PSAs), and by designated providers through the USFHP as of October 1, 2013.

The first table below shows the percentage of beneficiaries living in PSAs (defined only in the U.S.) compared to those living outside of PSAs. The second table shows the percentage of the eligible population in the U.S. with access to MTF-based Prime. The latter is defined as the percentage living in both a PSA and an MTF Service Area (defined by ZIP code centroids that are within a 40-mile radius of an active MTF hospital or clinic, subject to overlap rules, barriers, and other policy overrides). In FY 2024, 80 percent of eligible beneficiaries lived within a PSA with the largest percentages being retirees and their dependents. Additionally, 66 percent of eligible beneficiaries lived within an MTF Service Area.

Eligible Population Living in PSAs vs Outside PSAs, by Beneficiary Category, FY 2024

Beneficiary Category	Prime Service Area (PSA)	Percent of Total	Outside PSA	Percent of Total	TOTAL
Active Duty	1,157,978	98.2%	21,007	1.8%	1,178,985
Active Duty Dependents	1,288,554	94.3%	78,582	5.7%	1,367,136
Activated Guard/Reserve	140,845	77.1%	41,879	22.9%	182,724
Activated Guard/Reserve Dependents	199,410	71.2%	80,748	28.8%	280,158
Inactive Guard/Reserve	142,217	71.0%	58,146	29.0%	200,363
Inactive Guard/Reserve Dependents	199,023	65.0%	107,166	35.0%	306,189
Retirees	1,965,445	76.7%	596,219	23.3%	2,221,247
Retiree Dependents	429,257	72.9%	159,367	27.1%	2,561,664
Dependents of Survivor	34,737	90.2%	3,786	9.8%	588,624
Other	1,658,633	74.7%	562,614	25.3%	38,523
TOTAL	**7,216,099**	**80.8%**	**1,709,514**	**19.2%**	**8,925,613**

Source: DEERS, 4/16/2025
Note: Percentages may not sum to 100 due to rounding

Eligible Population Living in MTF Service Area vs Outside MTF Service Area, by Beneficiary Category, FY 2024

Beneficiary Category	MTF Service Area	Percent of Total	Non-MTF Service Area	Percent of Total	Total
Active Duty	1,130,786	95.9%	48,199	4.1%	1,178,985
Active Duty Dependents	1,193,488	87.3%	173,648	12.7%	1,367,136
Activated Guard/Reserve	110,367	60.4%	72,357	39.6%	182,724
Activated Guard/Reserve Dependents	139,492	49.8%	140,666	50.2%	280,158
Inactive Guard/Reserve	101,654	50.7%	98,709	49.3%	200,363
Inactive Guard/Reserve Dependents	128,987	42.1%	177,202	57.9%	306,189
Retirees	1,237,945	55.7%	983,302	44.3%	2,221,247
Retiree Dependents	1,503,181	58.7%	1,058,483	41.3%	2,561,664
Dependents of Survivor	304,188	51.7%	284,436	48.3%	588,624
Other	31,282	81.2%	7,241	18.8%	38,523
TOTAL	**5,881,370**	**65.9%**	**3,044,243**	**34.1%**	**8,925,613**

Source: DEERS, 4/16/2025
Note: Percentages may not sum to 100 due to rounding.

MHS Population: Enrollees and Total Population by State, FY 2024

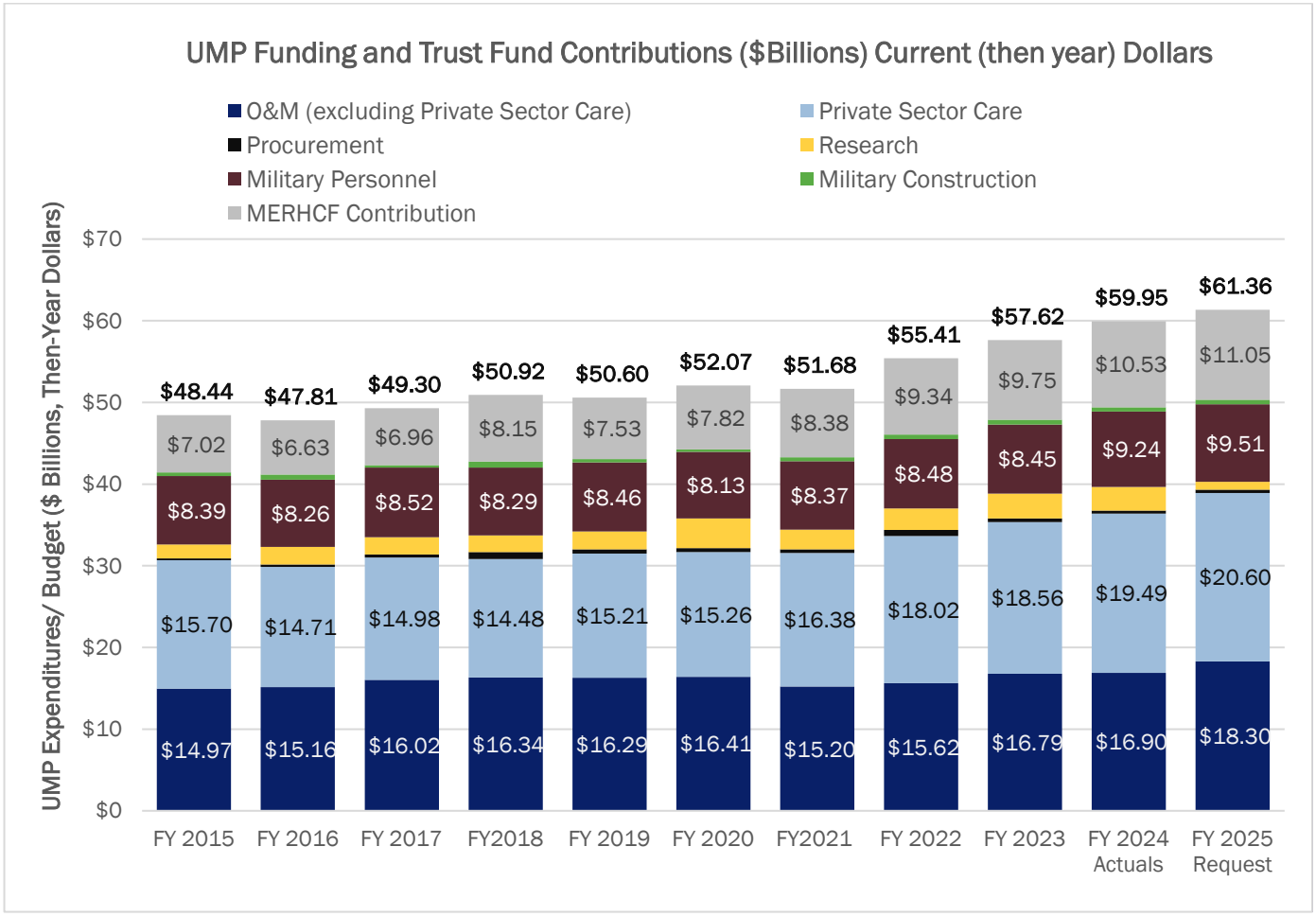
State	Prime	Select	Medicare	Not Enrolled	TOTAL
AL	80,873	47,437	72,574	11,891	212,775
AK	55,278	12,291	8,689	3,709	79,967
AZ	86,843	39,015	68,263	11,679	205,800
AR	25,945	21,459	31,704	4,975	84,083
CA	399,491	118,123	165,552	46,455	729,621
CO	127,829	55,119	51,202	11,509	245,659
CT	20,536	12,131	11,829	3,213	47,709
DE	14,482	5,919	10,914	2,034	33,349
DC	25,599	2,744	1,994	1,511	31,848
FL	306,401	171,218	235,563	37,410	750,592
GA	235,191	82,356	102,548	22,187	442,282
HI	97,503	22,965	18,464	7,425	146,357
ID	18,233	18,433	17,902	2,944	57,512
IL	65,518	37,625	35,378	10,551	149,072
IN	24,323	35,162	30,014	6,711	96,210
IA	7,297	23,303	15,339	2,833	48,772
KS	62,463	24,928	23,712	5,593	116,696
KY	73,622	31,306	31,163	6,579	142,670
LA	51,404	28,256	28,333	6,515	114,508
ME	20,601	6,639	9,116	2,029	38,385
MD	144,130	37,108	42,659	16,155	240,052
MA	28,033	15,242	19,223	6,003	68,501
MI	20,688	39,107	34,888	8,302	102,985
MN	8,055	34,285	23,964	4,449	70,753
MS	40,467	28,887	33,498	5,969	108,821
MO	61,897	44,688	44,409	8,283	159,277
MT	10,302	14,416	11,114	2,078	37,910
NE	24,273	18,320	15,351	2,509	60,453
NV	46,231	20,572	32,723	6,825	106,351
NH	15,098	6,158	7,999	1,884	31,139
NJ	40,383	15,968	20,955	6,787	84,093
NM	39,946	12,253	22,804	4,497	79,500
NY	81,211	33,569	40,371	15,432	170,583
NC	262,433	118,063	107,944	20,976	509,416
ND	17,466	8,308	5,630	1,183	32,587
OH	44,897	66,642	51,868	11,669	175,076
OK	74,869	32,552	39,422	8,169	155,012
OR	10,057	21,509	26,748	5,351	63,665
PA	39,769	48,460	60,860	13,783	162,872
RI	11,582	4,630	6,026	1,762	24,000
SC	122,542	56,821	75,165	12,164	266,692
SD	11,637	12,850	9,906	1,537	35,930
TN	55,444	73,235	65,641	11,544	205,864
TX	468,776	193,229	209,555	51,788	923,348
UT	30,703	25,092	20,407	3,745	79,947
VT	5,267	2,794	4,118	1,056	13,235
VA	372,841	169,481	144,994	33,615	720,931
WA	180,838	51,347	75,089	16,404	323,678
WV	6,909	14,682	12,785	2,731	37,107
WI	10,712	35,299	26,299	5,273	77,583
WY	10,661	6,523	5,923	1,280	24,387
US Territories	12,260	16,772	19,500	8,994	57,526
APO Americas	2,146	405	110	292	2,953
APO Europe	117,850	20,172	3,806	6,305	148,133
APO Pacific	118,501	14,349	2,902	4,576	140,328
Missing or Bad Zip	25,978	23,220	46,895	27,520	123,613
TOTAL	**4,374,284**	**2,133,437**	**2,341,804**	**548,643**	**9,398,168**

Source: MHS administrative data systems, 3/6/2025

UNIFIED MEDICAL PROGRAM FUNDING

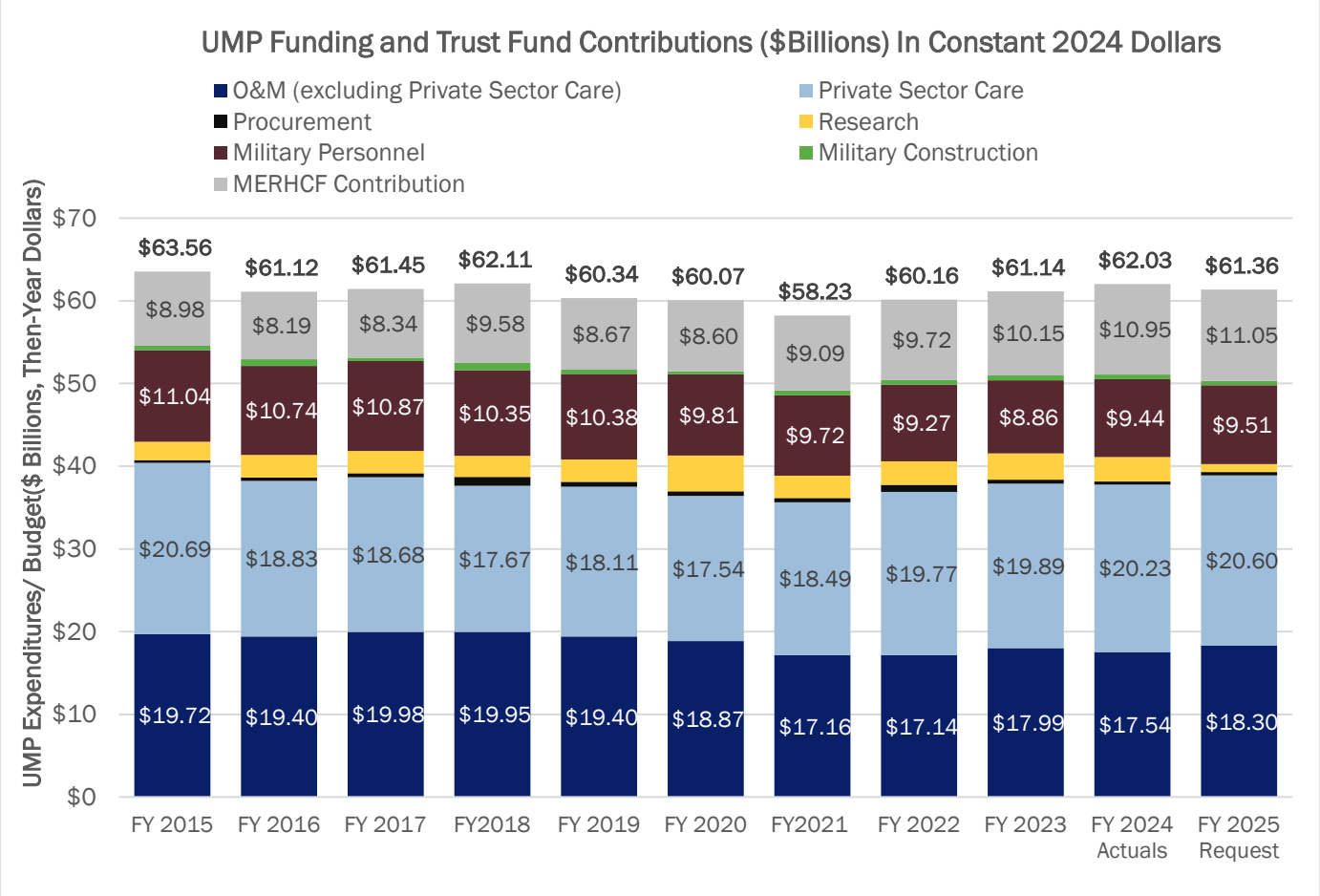
The DoD's FY 2025 Budget Request for health care services is $61.4 billion. In nominal terms, this is about 2.4 percent higher than the actual $59.9 billion FY 2024 expenditures.

The FY 2025 Budget Request has three components. The first is the DHP appropriation, which is a unique three-in-one appropriation consisting of funds for operation and maintenance (O&M); procurement; and research, development, test, and evaluation (RDT&E), and totaling $40.3 billion. Of that amount, $20.6 billion (51.1 percent) is partitioned off for TRICARE/private sector care. The second component is composed of military personnel (MILPERS) and military construction (MILCON), which total $10 billion. Amounts for MILPERS are retained within the Military Department MILPERS appropriations and amounts for MILCON are retained within the MILCON appropriation. The third component is the MERHCF, totaling $11 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.



Source: UMP cost and budget estimates, DHA/Resources Management Directorate (J-8)/Budget & Execution Division, 11/19/2024
Additional notes on the following page.

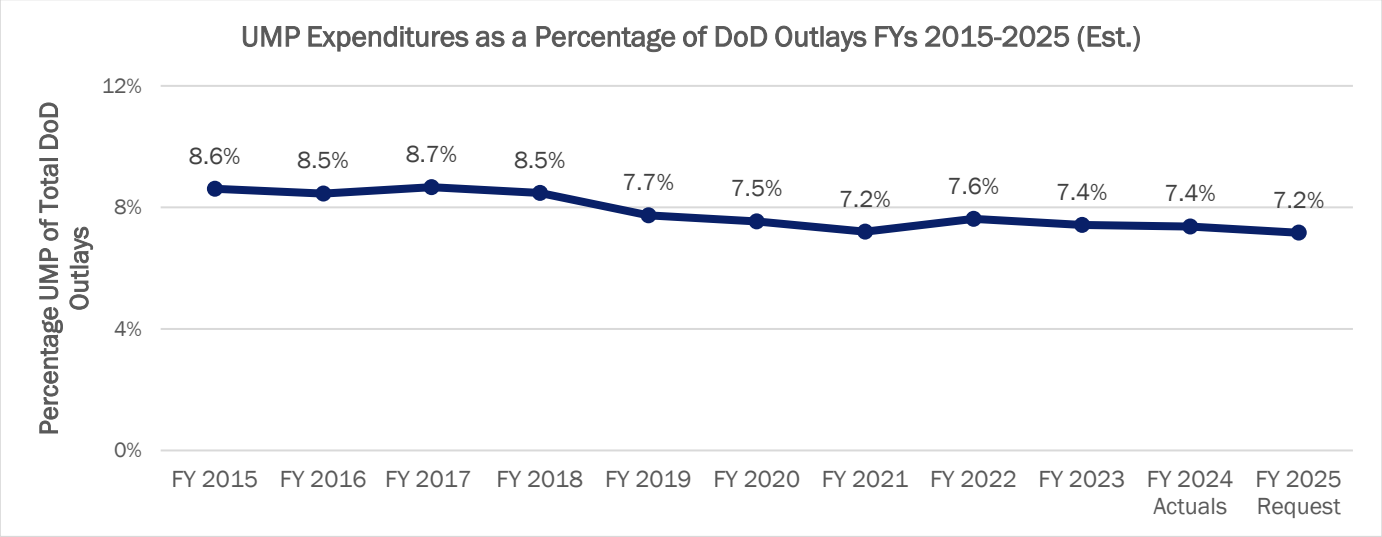
Using constant dollars, the FY 2025 request is about $2.2 billion (3.5 percent) less than real FY 2015 expenditures.



Source: UMP cost and budget estimates, DHA/Resources Management Directorate (J-8)/Budget & Execution Division, 11/19/2024
Notes:
- FYs 2016–2024 reflect Comptroller Information System actual execution.
- FY 2025 reflects the DHP Budget Request.
- Source of data for deflators (MILPERS, DHP, Procurement, RDT&E, and MILCON) is Table 5-5, Department of Defense Deflators—TOA by Category--TOA, National Defense Budget Estimates for FY 2025 (Green Book).
- Medicare Eligible Retiree Health Care Fund Deflator computed using a combination of MILPERS (5%) and DHP factors (95%).
- FY 2016 actuals includes $285.032M for OCO.
- FY 2017 actuals includes $332.603M for OCO.
- FY 2018 actuals includes $405.856M for OCO.
- FY 2019 actuals includes $349.422M for OCO.
- FY 2020 includes $2.503B Coronavirus Aid, Relief, and Economic Security (CARES) Act Supplemental and $347.746M OCO supplemental funding enacted for O&M.
- FY 2021 actuals includes $354.322M OCO supplemental funding execution. It also includes $663M reprogrammed into O&M.
- FY 2022 actuals includes $228.412M for Overseas Operations Costs (OOC) and $429.415M for enduring COVID-19 requirements.
- FY 2023 actuals includes $500.817M for COVID-19 requirements and $110.426M for OOC. It also includes $108.333M reprogrammed into O&M.
- FY 2024 actuals includes $212.383M for OOC.
- FY 2025 President's Budget request includes $220.5M for OOC.

UMP Share of Defense Budget

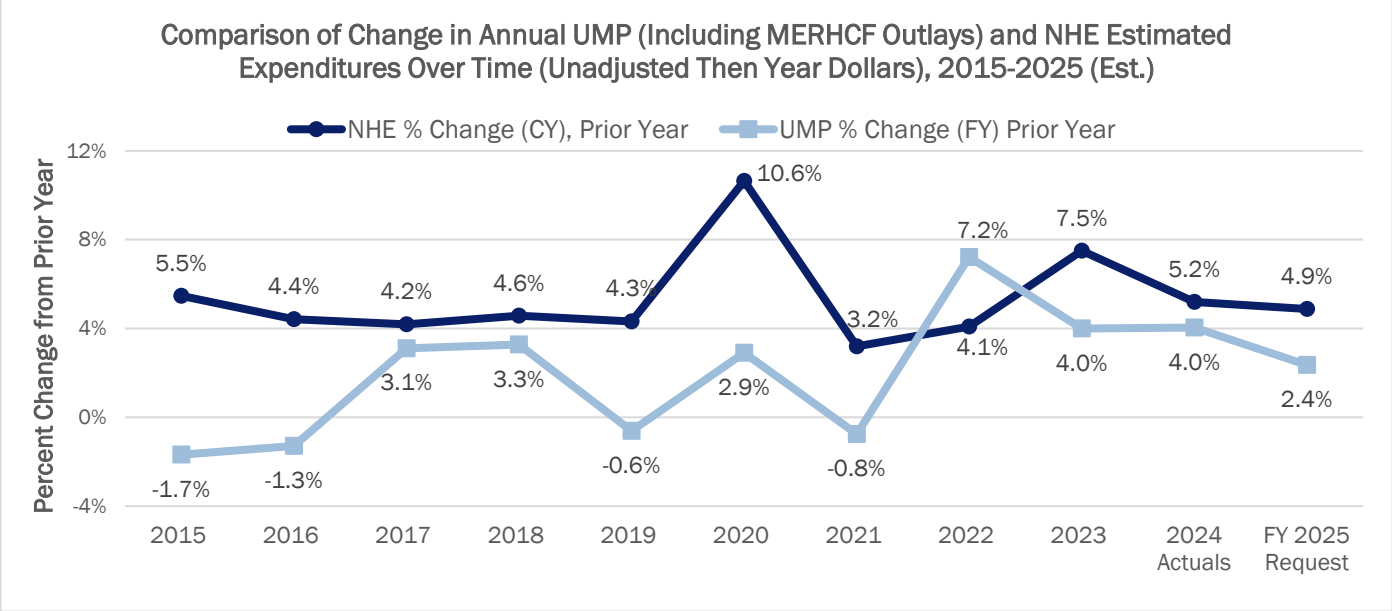
The UMP funding share of total DoD expenditures remains below FY 2015 levels.



Source: UMP cost and budget estimates, DHA/Financial Operations Directorate (J-8)/DHP Budget and Execution Division, 11/19/2024
Note: Percentages are estimates of total DoD outlays reflected in the FY 2025 President's Budget request.

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

As shown in the chart below, the annual rate of growth in the UMP (in then-year dollars, including MERHCF distributions) has fluctuated from a high of 7.2 percent in FY 2022 to 2.4 percent projected in FY 2025. By comparison, the National Health Expenditures (NHE) series compiled by the Centers for Medicare & Medicaid Services (CMS) has grown at an average of 5.4 percent year-over-year for the same period.



Source: UMP cost and budget estimates, DHA/Financial Operations Directorate (J-8)/DHP Budget and Execution Division, 11/19/2024, using NHE data from CMS, Office of the Actuary, NHE Projections 2019–2030, Tables Table 02, National Health Expenditure Amounts and Annual Percent Change by Type of Expenditure: Calendar Years 2016–2032; 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.

MHS WORKLOAD TRENDS

Urgent Care (UC) Utilization and Costs

Urgent Care Utilization by Plan and Beneficiary Category, FYs 2022-2024

Plan	Beneficiary Category	FY	Encounter	RVU	Paid
Prime MTF PCM	Active Duty	2022	214,470	722,724	$30,937,999
		2023	186,659	628,484	$25,513,468
		2024	191,925	674,053	$26,439,068
	Active Duty Dependents	2022	379,525	1,229,445	$50,233,339
		2023	400,442	1,291,130	$50,685,329
		2024	380,582	1,285,754	$50,560,469
	Retirees and Dependents	2022	202,636	670,952	$23,696,968
		2023	188,277	618,591	$18,911,341
		2024	227,117	766,279	$22,348,060
Prime Network PCM	Active Duty Dependents	2022	156,385	505,225	$21,533,711
		2023	161,233	522,813	$21,423,824
		2024	156,987	523,222	$20,926,639
	Retirees and Dependents	2022	233,305	760,784	$27,258,819
		2023	222,826	729,689	$23,005,549
		2024	227,117	766,279	$22,348,060
Prime Remote	Active Duty	2022	37,123	120,072	$5,166,999
		2023	29,970	97,413	$4,042,427
		2024	31,557	106,950	$4,306,584
	Active Duty Dependents	2022	24,546	76,583	$3,149,895
		2023	24,422	75,190	$3,004,693
		2024	24,195	77,495	$3,019,246
Prime TYA	Active Duty Dependents	2022	261	840	$36,180
		2023	130	413	$17,509
		2024	87	274	$11,396
	Retirees and Dependents	2022	1,740	5,460	$197,509
		2023	1,146	3,665	$116,620
		2024	855	2,834	$82,205
Select	Active Duty Dependents	2022	142,602	445,480	$14,680,912
		2023	157,043	495,536	$14,708,140
		2024	164,450	533,155	$15,428,234
	Inactive Guard/Reserve	2022	182,167	577,195	$19,797,009
		2023	174,183	553,577	$16,805,749
		2024	179,247	588,559	$16,312,312
	Retirees and Dependents	2022	276,454	870,342	$26,682,081
		2023	281,356	888,529	$23,300,788
		2024	302,983	996,664	$23,436,372
Medicare-TFL	Retirees and Dependents	2022	10,546	1,776	$252,117
		2023	12,795	1,630	$319,188
		2024	15,755	1,564	$409,537
TOTAL	**All Plans**	**2022**	**1,861,760**	**5,986,878**	**$223,623,538**
		2023	**1,840,482**	**5,906,660**	**$201,854,625**
		2024	**1,863,270**	**6,202,671**	**$201,581,910**

Source: MHS administrative data, 4/21/2025

MHS WORKLOAD TRENDS

Emergency Department (ED) Utilization

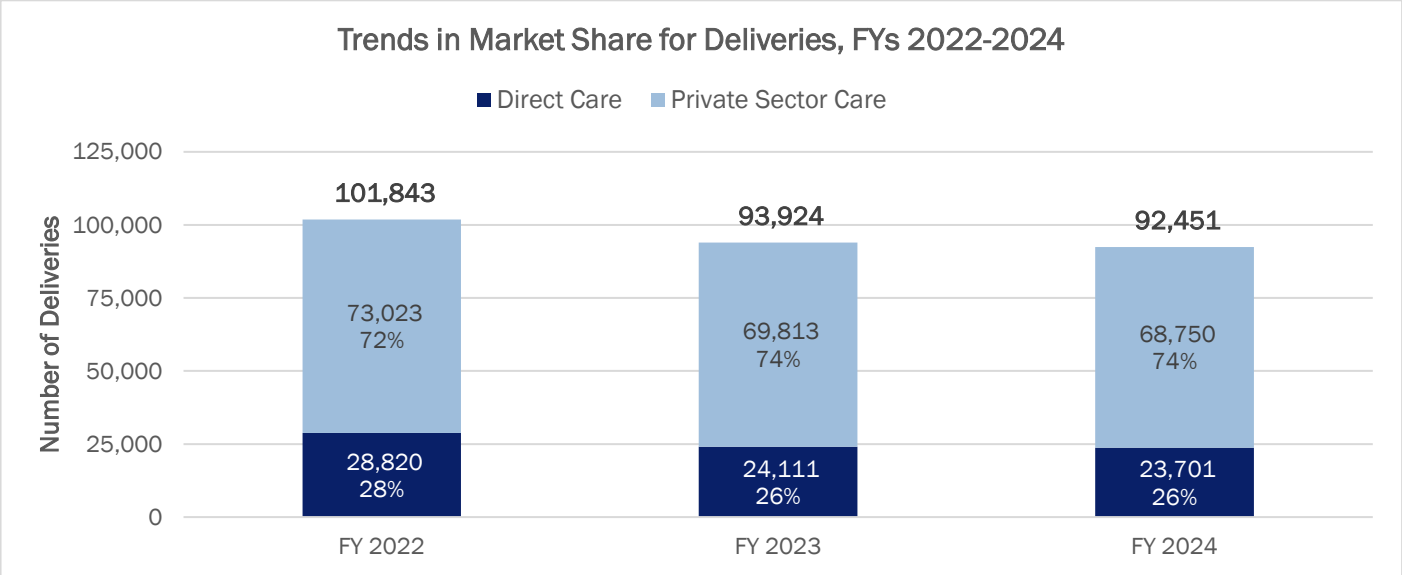
ED Utilization By Plan and Beneficiary Category, Encounters Per 1,000 Beneficiaries, FYs 2022-2024

Plan	Beneficiary Category	FY	Direct Care (MTF)	Private Sector Care	Total	Percentage of Care Provided in Direct Care
Prime MTF PCM	Active Duty and Activated Guard/Reserve	2022	247	125	371	66.4%
		2023	252	127	378	66.6%
		2024	261	129	390	66.9%
	Active Duty Dependents and Activated Guard/Reserve Dependents	2022	228	227	455	50.1%
		2023	243	236	479	50.8%
		2024	255	228	483	52.7%
	Retirees, Dependents of Retirees, and Dependents of Survivors	2022	185	181	366	50.5%
		2023	191	187	377	50.5%
		2024	195	184	379	51.3%
Prime Network PCM	Active Duty Dependents and Activated Guard/Reserve Dependents	2022	65	267	332	19.4%
		2023	71	279	350	20.4%
		2024	76	280	356	21.3%
	Retirees, Dependents of Retirees, and Dependents of Survivors	2022	20	248	268	7.5%
		2023	20	254	274	7.4%
		2024	21	256	278	7.7%
Select	Active Duty Dependents and Activated Guard/Reserve Dependents	2022	57	234	291	19.5%
		2023	63	248	311	20.2%
		2024	70	249	319	21.9%
	Retirees, Dependents of Retirees, and Dependents of Survivors	2022	12	199	211	5.7%
		2023	13	207	220	6.0%
		2024	14	209	223	6.4%
TRICARE Plus	Retirees, Dependents of Retirees, and Dependents of Survivors	2022	349	288	637	54.8%
		2023	354	313	667	53.1%
		2024	364	338	702	51.9%
Medicare-TFL	Retirees, Dependents of Retirees, and Dependents of Survivors	2022	11	372	383	2.8%
		2023	11	405	415	2.6%
		2024	12	434	445	2.6%

Source: MHS administrative data, 5/7/2025
Note: Data excludes the following beneficiary categories: Direct Care Only (Not Enrolled); TRS, TRR, TRP enrollees; foreign military; Inactive Guard/reserve

Market Share for Deliveries

While the overall number of deliveries has decreased by approximately 9,000 from FY 2022 to FY 2024, the MTF (direct care) market share for deliveries has remained about the same during this time period (28 percent in FY 2022 to 26 percent in FY 2024).



Source: MHS administrative data, 4/30/2025

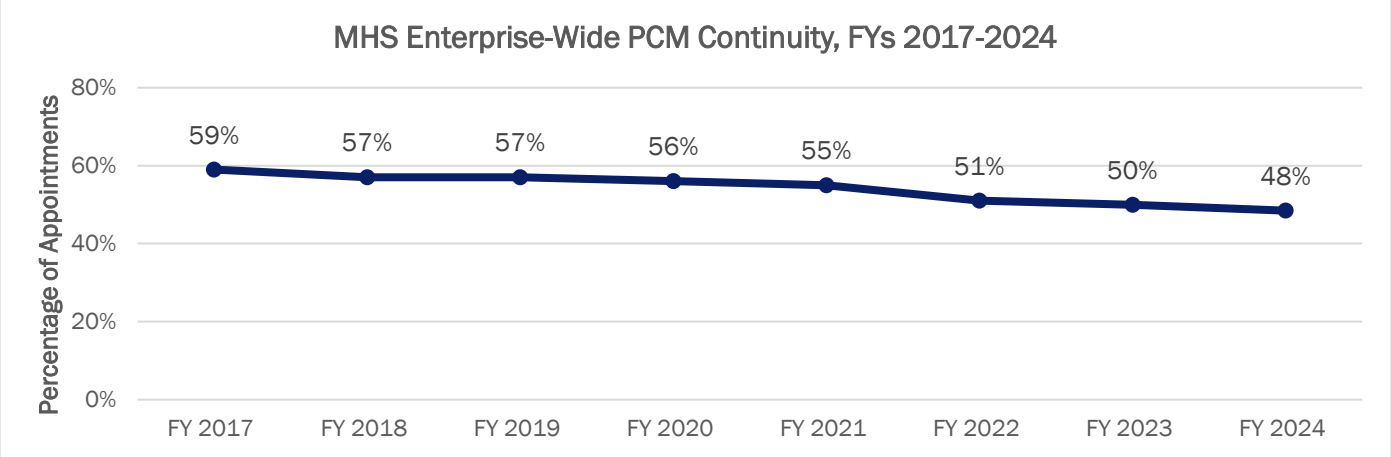
ACCESS TO MHS CARE

Military Medical Treatment Facility (MTF)/Defense Health Network (DHN) Primary Care

Primary Care Manager (PCM) MTF/DHN Team Continuity

The PCM-patient relationship remains the driving force to improve access and quality and deliver better health outcomes for MTF 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 DHA values MTF continuity first and will offer appointments with other to keep care within the MTF.

As shown below, in FY 2024, enrollees saw their own PCM during primary care visits 48 percent of the time. MTFs are to maximize continuity of care by optimizing provider availability, templating appointments 180 days in advance, planning appointments at times and on days convenient to patients and offering virtual health options to keep care within the MTF.



MTF Distribution, PCM Continuity, FYs 2021-2024

	FY 2021	FY 2022	FY 2023	FY 2024	FY 2021 - FY 2024 Percentage Change
Mean	52.3%	52.6%	52.2%	48.8%	-6.7%
Standard Deviation	10.3%	9.8%	11.3%	10.6%	2.5%
Median	51.5%	52.1%	53.3%	48.7%	-5.4%
Maximum	84.2%	75.9%	89.5%	79.0%	-6.2%
Minimum	30.0%	30.5%	21.8%	22.7%	-24.3%

Source: MHS administrative data (Tricare Operations Center, MHS Data Repository); DHA/Health Care Operations (HCO)/Health Care Optimization Division, 11/20/2024
- Parent facility scores were used to describe variability in the results above.
- Data include MHS GENESIS sites beginning August 2019.

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. The third next available 24-hour appointment standard is 1.0 days or less and the third next available future appointment is 7.0 days. The Third Next Available measure is considered a more sensitive and accurate measure of access than retrospective measures as it indicates what appointment timeframes are being offered to patients at the point of request.

In FY 2024, there was an increase in the average number of days to third next available 24-hour (2.8 days) and future (9.6 days) appointments. Optimization efforts aim to comply with the established targets of 1.0 day or less to the average third next available 24-hour appointment and 7.0 days or less to the average third next available future appointment. Efforts include planning templates with the recommended ratios of 24-hour and future appointments based on retrospective analysis of patient demand for care.

MTF Distribution, Days to Third Next Available 24-Hour Appointment, FYs 2021-2024

	FY 2021	FY 2022	FY 2023	FY 2024	FY 2021 – FY 2024 Percentage Change
Mean	1.8	2.0	2.7	2.8	57.1%
Standard Deviation	1.2	2.4	3.4	6.3	428.5%
Median	1.4	1.4	1.9	1.8	30.6%
Maximum	9.6	16.5	32.3	60.0	525.0%
Minimum	0.6	0.1	0.6	0.4	-31.3%

MTF Distribution, Days to Third Next Available Future Appointment, FYs 2021-2024

	FY 2021	FY 2022	FY 2023	FY 2024	FY 2021 – FY 2024 Percentage Change
Mean	5.5	5.9	6.7	9.6	42.4%
Standard Deviation	2.4	2.3	3.5	5.7	57.6%
Median	4.9	5.5	6.0	8.7	43.9%
Maximum	10.9	11.6	15.0	47.3	77.0%
Minimum	1.1	1.9	1.5	0.2	-563.4%

Source: MHS administrative data (Tricare Operations Center, MHS Data Repository); DHA/Health Care Operations (HCO)/Health Care Optimization Division, 11/20/2024
- Parent facility scores were used to describe variability in the results above.
- Data include MHS GENESIS sites beginning January 2022.
- Data quality note: There is an identified issue related to auto-releasing feature in GENESIS resulting in unexpectedly high 3NAA Scores (24HR & FTR slot types) between mid-December 2023 to early January 2024, between early February 2024 to mid-February 2024, and early August 2024 to late September 2024.

Beneficiary Access to Integrated Specialists

The most common reason enrollees sought direct care in FY 2024 was for musculoskeletal issues and routine screenings. Otherwise, the most common conditions were behavioral health (BH)-related, mental health (MH)–related, pediatrics-related, hypertension-related, and diabetes-related. To improve access and outcomes for the beneficiaries affected by these conditions, the direct care system continues optimizing the use and integration of specialists to provide more continuous, comprehensive care in the primary care setting and to facilitate coordinated care.

FY 2024 Most Common Reasons Why Enrollees Sought Direct Care

	FY 2024 Number of Encounters
Musculoskeletal	1,550,674
Routine Screening / PC	1,480,511
Mental and Behavioral Health	733,535
Pediatrics	330,482
Hypertension	209,841
Diabetes	145,489

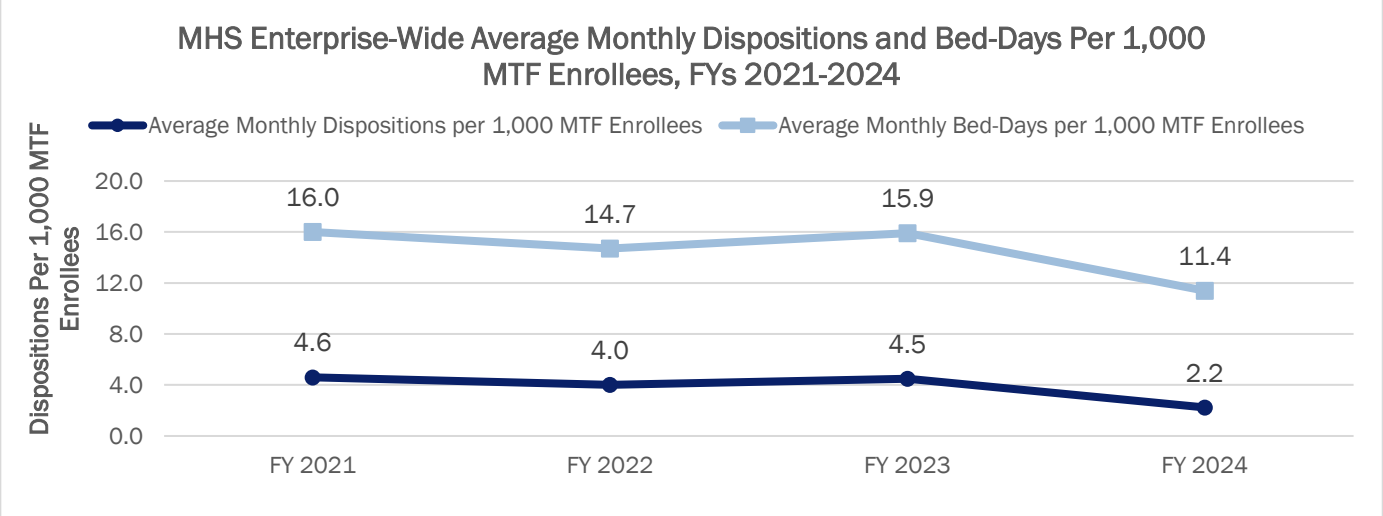
Source: M2 Data; DHA/Health Care Operations (HCO)/Health Care Optimization Division, 11/21/2024

Currently, the majority of MTFs serving adult enrollees have integrated BH specialists who provide treatment for MH and BH issues. Directly integrating BH providers ensures the integrated specialists can work closely in partnership with the patient and PCM team; moreover, because the specialties share a location, it helps to destigmatize the care received. The Uniformed Services University for the Health Sciences (USUHS) determined that being seen by a BH specialist integrated within a care team results in a statistically significant improvement in MH status. MTF and DHN 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 across MTF and DHNs. A 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 MTFs and DHNs 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.

Dispositions and Bed-Days per 1,000 MTF Enrollees

By focusing on prevention, proactive care coordination, and improving outcomes for common conditions, MTFs focus on reducing the incidence of dispositions (admissions) and bed-days per 1,000 MTF enrollees. MTFs continue efforts to reduce the number of times 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 2.2 in FY 2024; the average number of monthly bed-days was 11.4 per 1,000 enrollees. The top five reasons for admissions are childbirth, infectious diseases, mental health conditions, cardiac conditions, and digestive conditions.



MTF Distribution, Average Monthly Dispositions per 1,000 MTF Enrollees, FYs 2021-2024

	FY 2021	FY 2022	FY 2023	FY 2024	FY 2021 - FY 2024 Change
Mean	3.6	4.0	4.1	2.6	-1.0
Standard Deviation	1.5	3.2	0.1	1.6	0.1
Median	3.7	3.7	3.9	2.4	-1.3
Maximum	9.9	35.0	10.5	7.2	-2.7
Minimum	0.3	0.0	2.5	0.0	-0.3

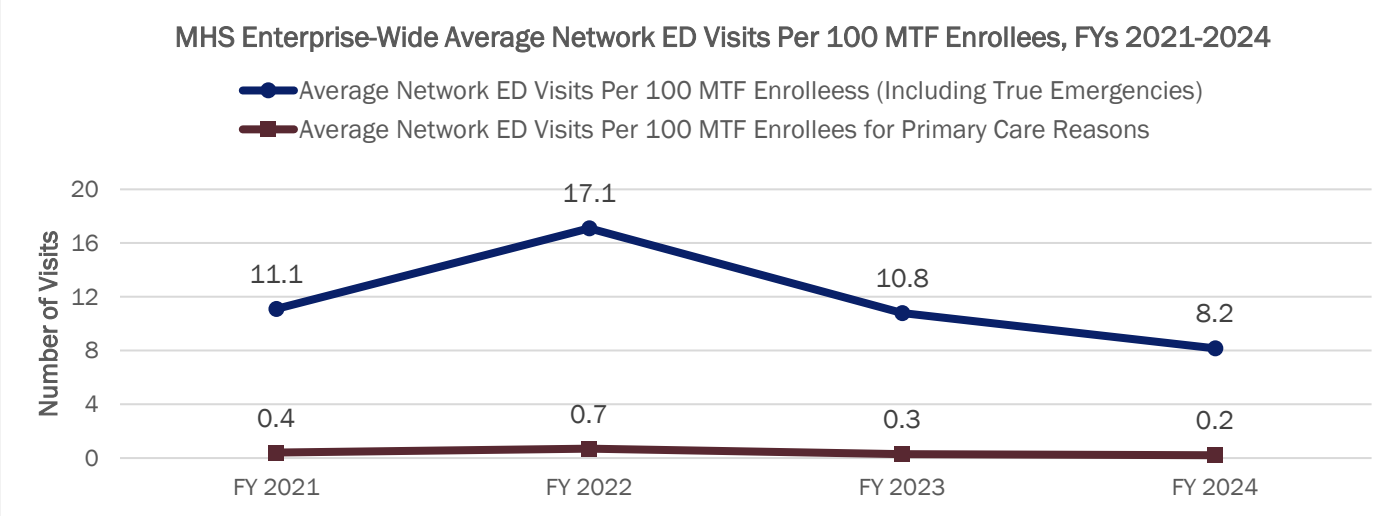
MTF Distribution, Average Monthly Bed-Days per 1,000 MTF Enrollees, FYs 2021-2024

	FY 2021	FY 2022	FY 2023	FY 2024	FY 2021 - FY 2024 Change
Mean	12.0	13.0	14.3	14.6	2.6
Standard Deviation	4.9	6.8	0.7	9.4	4.5
Median	12.3	12.5	13.2	14.4	2.1
Maximum	30.8	70.1	96.8	51.0	20.2
Minimum	0.9	0.5	6.6	0.1	-0.8

Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 11/6/2024
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 2024.
- Parent Facilities with fewer than 20 average enrollees per year were excluded.

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

The ED utilization rate decreased from 10.8 visits per 100 enrollees in FY 2023 to 8.2 visits per 100 enrollees in FY 2024. ED visits for primary care reasons are a small percentage of all ED visits and are defined by Emergency Medicine consultants and industry as evaluation and management codes 99281 and 99282. The rate of network ED visits for primary care reasons decreased from 0.3 to 0.2 visits per 100 enrollees in FY 2024. Efforts to reduce ED visits include better access to 24-hour care across MTFs and DHNs, walk-in services for common acute conditions, the Nurse Advice Line (NAL), and increasing virtual health offerings to meet patients where they want to be seen.



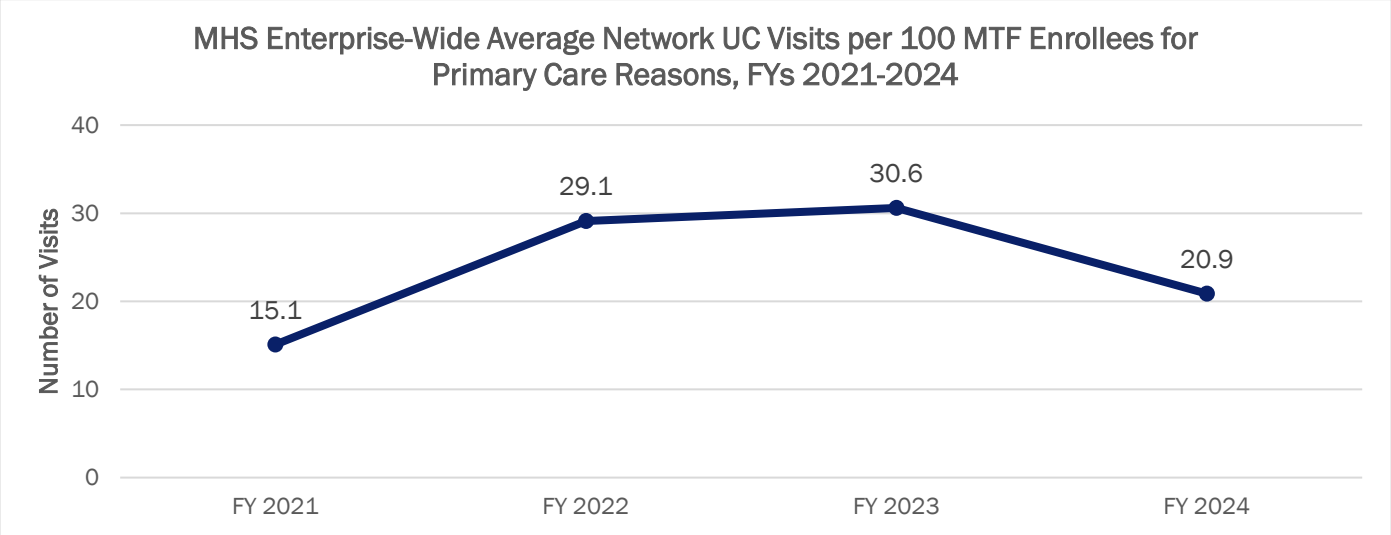
MTF Distribution, Average Network ED Visits Per 100 MTF Enrollees for Primary Care Reasons, FYs 2021-2024

	FY 2021	FY 2022	FY 2023	FY 2024	FY 2021 - FY 2024 Change
Mean	0.6	0.9	0.8	0.3	0.3
Standard Deviation	0.7	1.2	0.8	0.3	0.4
Median	0.4	0.6	0.6	0.2	0.2
Maximum	3.9	9.3	6.4	1.8	2.1
Minimum	0.0	0.0	0.0	0.0	0.0

Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 11/27/2024
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.

Network Urgent Care (UC) Visits per 100 Enrollees

The rate of network UC visits by MTF enrollees has decreased in FY 2024 compared with the previous two years. The most common reason why beneficiaries went to network UCs in FY 2024 was for respiratory illnesses and other infections. In FY 2025, the DHA will continue to promote MTF services and encourage MTFs to be conducive to patient schedules.



MTF Distribution, Network UC Visits Per 100 MTF Enrollees, FYs 2021-2024

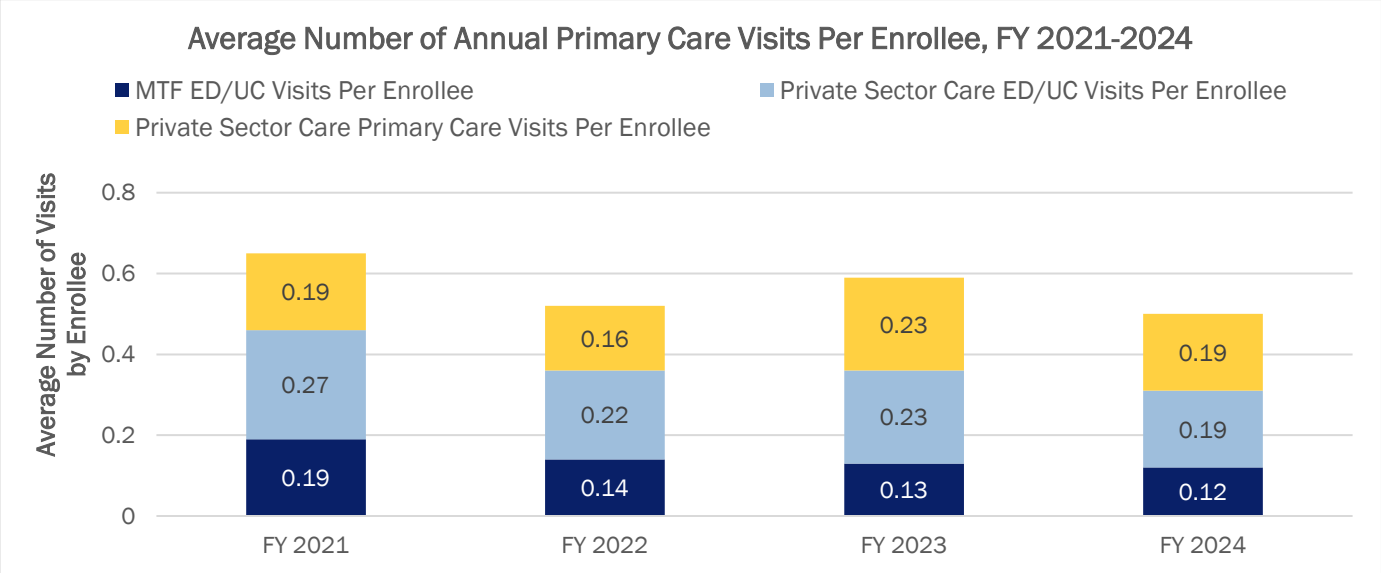
	FY 2021	FY 2022	FY 2023	FY 2024	FY 2021 - FY 2024 Change
Mean	20.3	27.8	27.4	25.7	-5.4
Standard Deviation	17.8	20.4	20.8	20.9	-3.1
Median	16.6	25.1	28.3	23.8	-7.2
Maximum	73.9	99.1	82.5	71.8	2.1
Minimum	0.6	1.2	1.4	0.0	0.6

Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 11/27/2024
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.

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

In FY 2024, primary care utilization was 3.28 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 11.1 percent for FY 2024, with additional private sector care claims expected to be processed for FY 2024.

A major goal of the MHS 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 virtual health 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 the MTFs. In FY 2025, the MHS will continue efforts to reduce unnecessary health care utilization and capture a greater proportion of MTF enrollees' primary care needs within the MTFs through care delivery modernization and leveraging technology to meet patients where they want to be seen.



MHS Enterprise-Wide Primary Care Utilization, MTF Market Share, and Network Leakage of Enrollee's Primary Care Needs, FYs 2021-2024

	MTF Primary Care 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 MTF Market Share	Percent Network Primary Care Leakage
FY 2021	2.95	0.19	0.27	0.19	3.59	87.5%	12.5%
FY 2022	2.15	0.14	0.22	0.16	2.67	85.7%	14.3%
FY 2023	2.62	0.13	0.23	0.23	3.17	85.7%	14.3%
FY 2024	2.91	0.12	0.19	0.19	3.41	88.9%	11.1%

Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 10/31/2024
Notes:
- Data includes Prime and Plus empaneled to an MTF
- Private sector care data may not be complete for up to one year due to claims processing.
- MTF Primary Care Visits per Enrollee is inclusive of care delivered both in person and virtually.

Specialist Care Access

In FY 2024, the MHS continued monitoring specialty care performance for several reasons: most private sector care costs for MTF enrollees are due to specialty referrals to private sector care, patient feedback indicated dissatisfaction with the decentralized specialty care processes and variance among MTFs, and capturing specialty care workload delivered in the MTF enhances clinical currency and medical force generation, which includes both providers and clinical support staff. The MHS codified specialty care standards in the DHA-IPM 18-001 (February 2020) on standard appointing processes and productivity. To measure compliance with the policy, enhance patient experience, and eliminate unwarranted variance among MTFs, a new measure was implemented—the percentage of referrals dispositioned within one business day—to complement the existing measure on the number of days between the appointment creation date and the appointment date.

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 DHN level compared with existing decentralized and time- consuming processes in which each specialty clinic reviewed referrals and scheduled appointments. As stated in DHA-IPM 18-001, MTFs are required to implement processes to ensure that the MTF decides to accept or defer the referral to the network within 24 hours and subsequently to schedule the beneficiary's appointment within two business days; the MHS goal is for the entire process to be accomplished in three business days or fewer.

In FY 2024, an average of 86 percent of referrals were dispositioned within one business day, which is higher than FY 2023 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 2025.

MTF Distribution, Percentage of Referrals Dispositioned within One Business Day, FYs 2021-2024

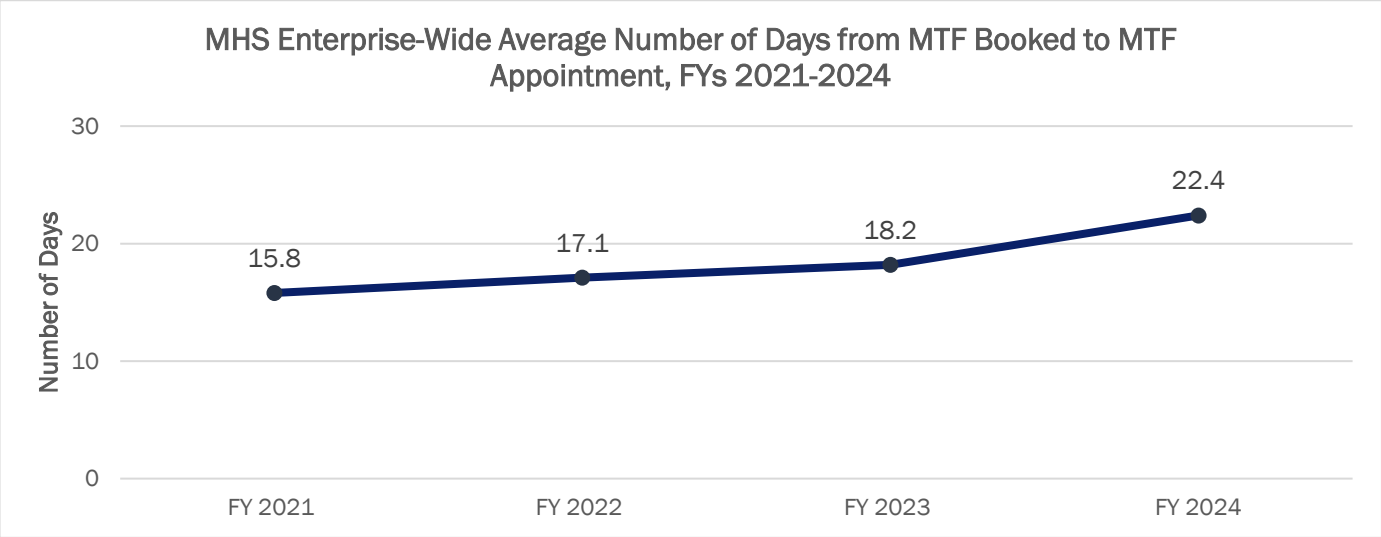
	FY 2021	FY 2022	FY 2023	FY 2024	FY 2021 - FY 2024 Change
Mean	85.5%	85.7%	80.0%	86.3%	-0.8%
Standard Deviation	11.2%	11.6%	14.2%	14.4%	-3.2%
Median	86.9%	88.0%	84.2%	92.4%	-5.5%
Maximum	99.7%	99.7%	100.0%	99.5%	0.2%
Minimum	54.4%	54.1%	51.7%	32.1%	22.3%

Source: MHS administrative data (MDR); DHA/HCO/Healthcare Optimization Division, 11/12/2024
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.

Average Number of Days from Booking to Appointment

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

The standard for a beneficiary to receive an initial, specialty care appointment is 28 days or less. Many MTFs met this goal in FY 2024, but as an enterprise, beneficiaries waited 22.4 days on average for a specialty care appointment requiring a referral. This is expected to be associated with staffing challenges in certain specialties, limiting provider availability. With improved referral processes and template optimization, performance is expected to improve in FY 2025



MTF Distribution, Average Number of Days from MTF Booked to MTF Appointment, FYs 2021-2024

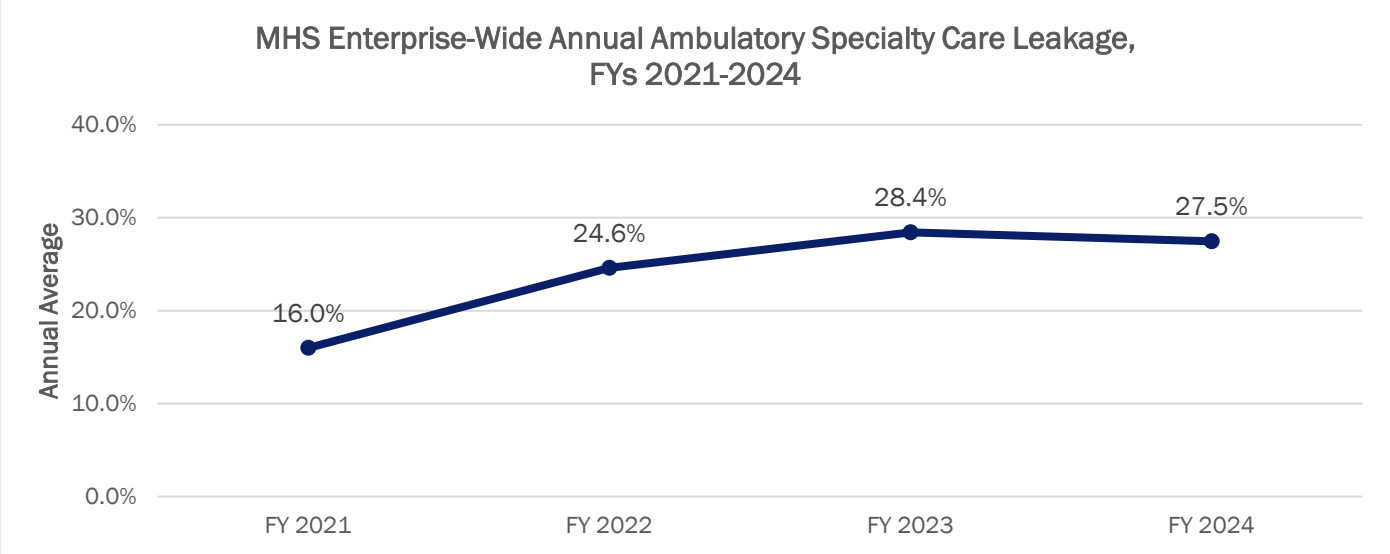
	FY 2021	FY 2022	FY 2023	FY 2024	FY 2021 - FY 2024 Percentage Change
Mean	12.2	15.7	16.9	20.4	40.2%
Standard Deviation	4.1	5.4	6.4	5.1	19.3%
Median	12.1	15.8	16.5	20.7	41.5%
Maximum	23.7	32.9	71.7	35.0	32.3%
Minimum	0.7	1.0	1.0	8.1	91.4%

Source: MHS administrative data (Tricare Operations Center, MHS Data Repository); DHA/HCO/Health Care Optimization Division, 11/20/2024

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

Specialty Care Ambulatory Leakage

In FY 2024, the MHS had elevated specialty care leakage above previous years at 27.5 percent but lower than FY 2023. 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 2025, 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.



Source: MHS administrative data (M2); DHA/HCO/ Health Care Optimization Division, 11/25/2024
Note: Between FY 2021 and FY 2022, the methodology for this metric changed, resulting in different inclusion criteria and an uptick in Specialty Care Leakage, which continued through FY 2023.

Nurse Advice Line (NAL)

The MHS NAL continues to provide valuable, quality, and convenient nurse triage and care coordination services to our MHS beneficiaries 24 hours a day, seven days a week, directing over 530,000 callers per year to the most clinically appropriate level of care. Since implementation in late FY 2014, the NAL has provided access to registered nurses (RNs) who address health concerns, offer self-care advice, and answer general health questions. The NAL received approximately 1,400 calls per day, with the overall call volume less than thirteen percent lower than FY 2023. Total call volume remains 17 percent higher than pre-COVID-19 levels.

The NAL falls under the DHA Health Care Optimization Program organizationally and is fully integrated with the MTF primary care clinics to support enhanced access strategies. MTF enrollees make up 82 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 appointments, warm transfer the beneficiary directly to his or her care team 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. MTFs 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 MTFs and DHNs to monitor utilization and adjust future appointing templates to accommodate changes in demand.

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

The percentage of NAL callers who intended to seek care in a network ED was significantly reduced by 89 percent. Twenty-one percent of the callers did not seek follow-on care and instead used self-care advice provided by the nurse. Patient satisfaction with the NAL remains above 91 percent, based on responses from a sample of beneficiaries who were surveyed by the DHA following their call.

NAL Caller Information for MTF Enrollees, FY 2024

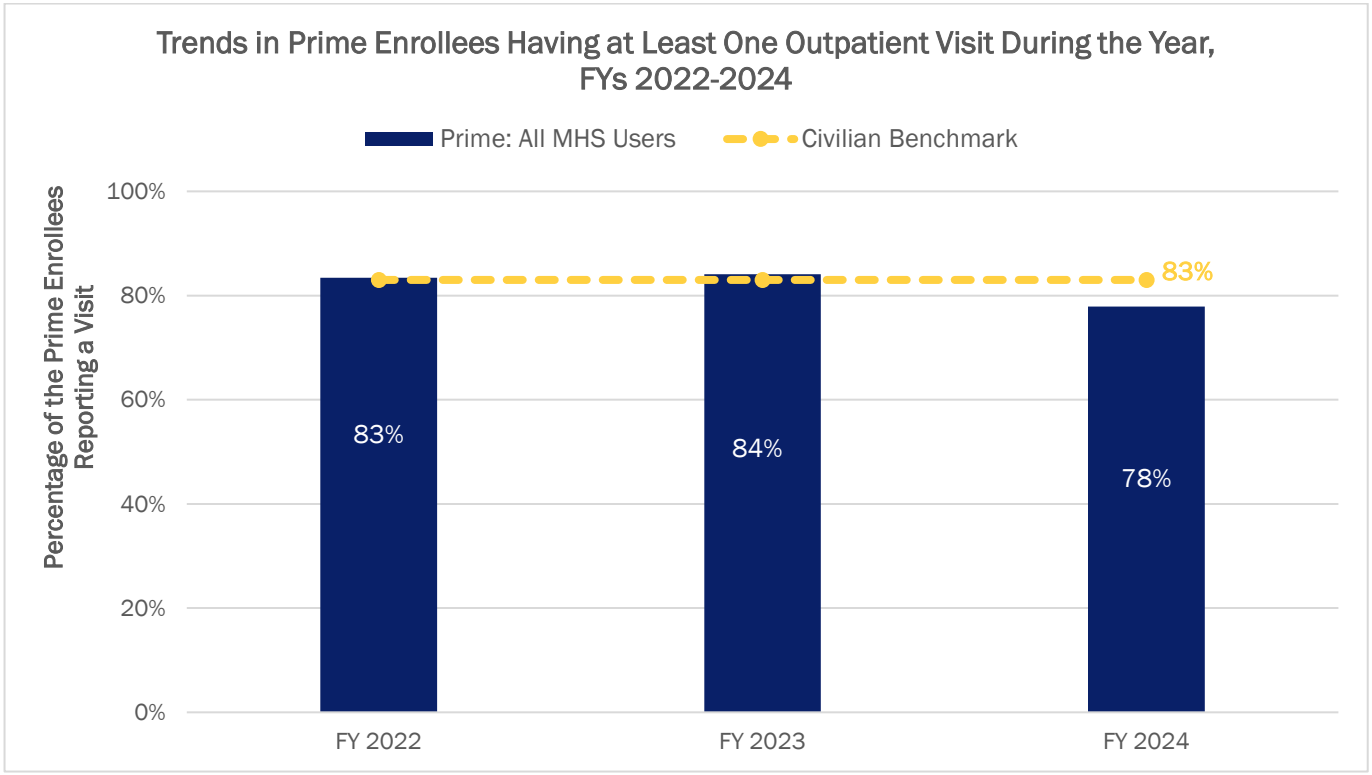
NAL Dispositions	Caller's Pre-Intent	Nurse Advice	Caller's Agreement with Nurse Recommendation
Network ED	31%	10%	97%
Network UC	24%	27%	97%
MTF Care	24%	32%	99%
Self-Care	21%	30%	99%
General Health and Other Misc. Questions	0%	1%	99%
Total	100%	100%	--

Source: NAL Program and administrative data (NAL Management System): DHA/HCO/ Health Care Optimization Division, 11/26/2024

Measure of Outpatient Visit

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.

The ability to see a doctor reflects one measure of successful access to the health care system. Prime enrollees were asked on the Health Care Survey of DoD Beneficiaries (HCSDB) whether they had at least one outpatient visit during the past year. As shown in the graph, access to and use of outpatient services decreased among Prime enrollees (with either a military or civilian PCM), with 84 percent reporting at least one visit in FY 2023, compared with 78 percent in FY 2024.

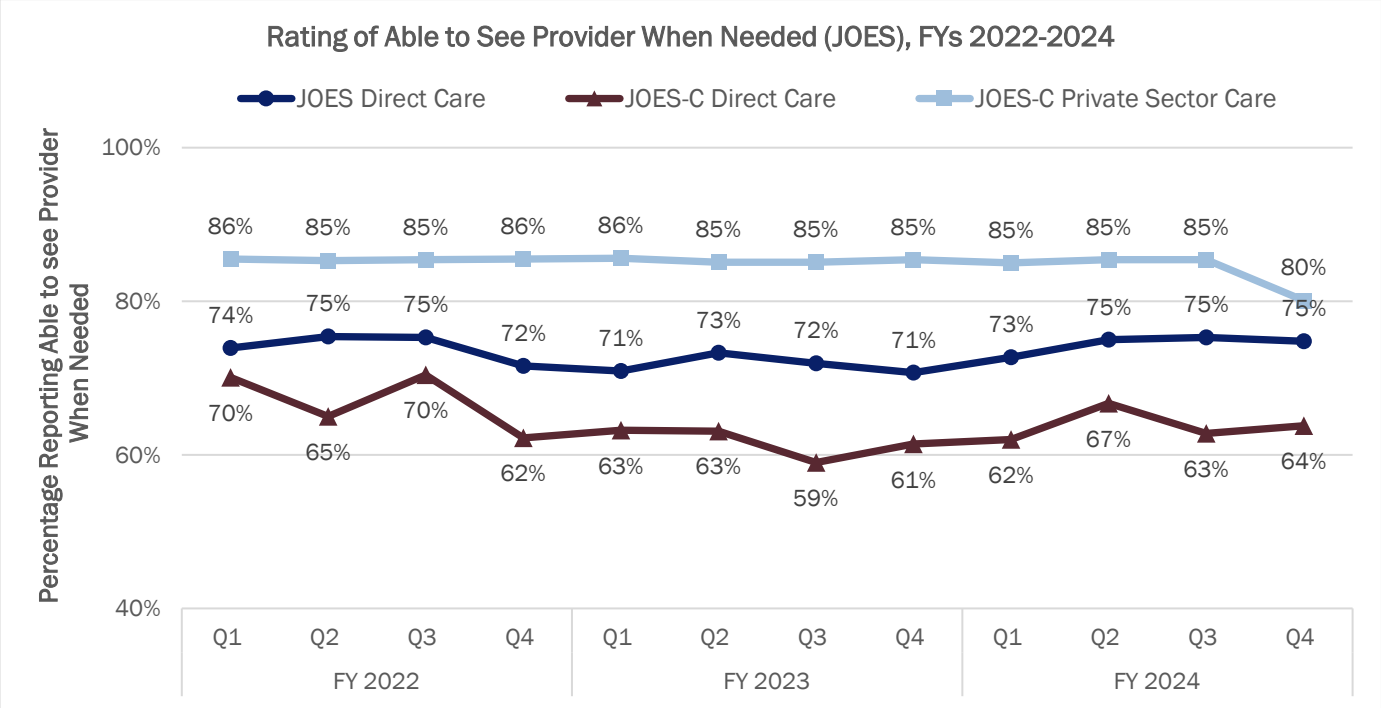


Source: DHA Chief Data and Analytics Office, Health Care Survey of DoD Beneficiaries (HCSDB) data, adjusted for age and health status, as of 11/18/2024
Note: All MHS Users applies to survey respondents in the 50 United States and the District of Columbia. Rates are compared with the most recent benchmarks 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.

Beneficiary Rating of Able to See Provider When Needed

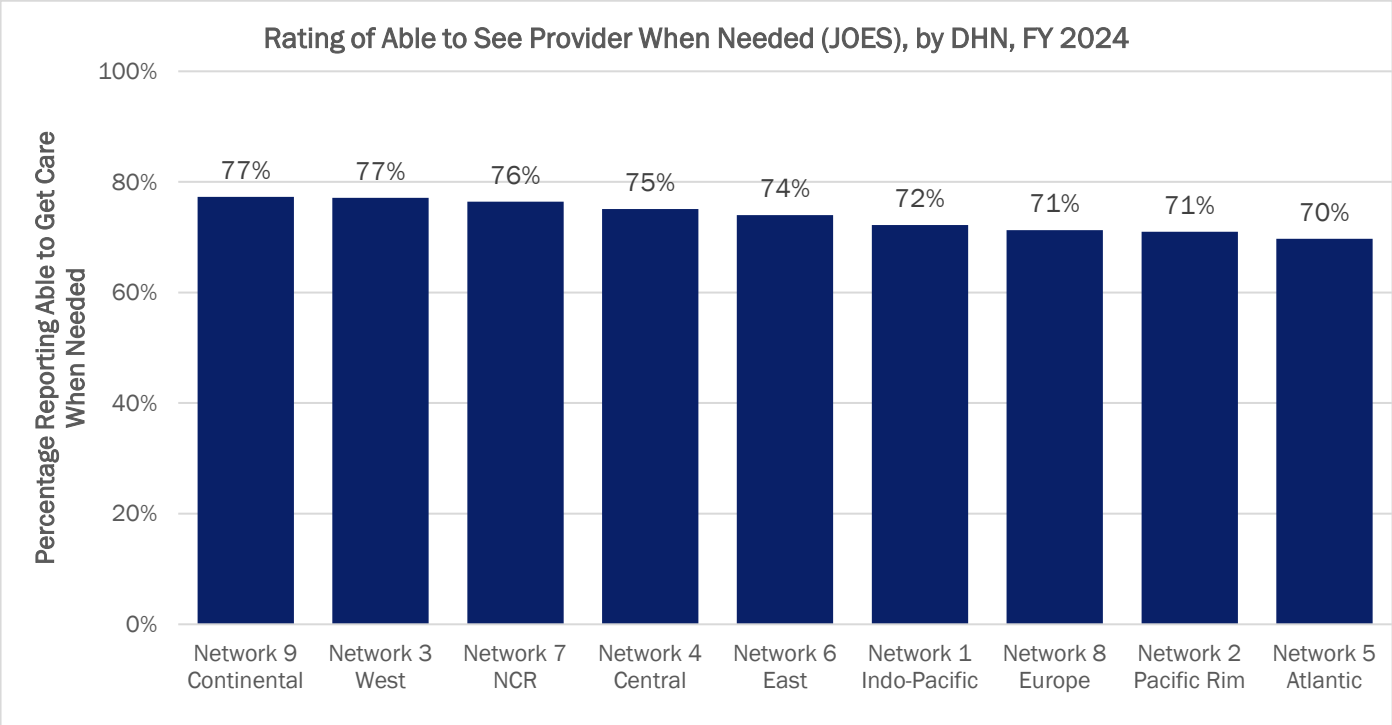
The below chart shows data from the Joint Outpatient Experience Survey (JOES) and JOES-C, (the Clinician and Group CAHPS [Consumer Assessment of Healthcare Providers and Systems]) for the survey question, "In general, I am able to see my provider when needed." Scores are shown for the top two positive responses of "strongly agree" and "somewhat agree."

- JOES-C private sector care scores for *able to see provider when needed* have been above JOES-C direct care and JOES direct care for the past three years. JOES-C private sector care scores for *able to see provider when needed* have been relatively unchanged from FY 2022 through FY 2024, at about 85 percent, with the exception of FY 2024 Q4 score of 80 percent.
- JOES direct care scores for *able to see provider when needed* have also remained relatively stable over the past three years, ranging from 71 percent to 75 percent quarterly.
- JOES-C direct care scores for *able to see provider when needed* remained below JOES direct care scores for the past three years.



Source: DHA Chief Data and Analytics Office, JOES, weighted data, compiled 4/8/2025
Note: *Getting Care When Needed* is assessed in each survey as an agreement to the following statement: "In general, I am able to see my provider when needed." The five-point scale for this question ranges from "strongly disagree" to "strongly agree." The results provided above are for those beneficiaries who reported either "somewhat agree" or "strongly agree."

The chart below shows FY 2024 JOES scores for *able to see provider when needed* by DHN. DHN Continental and DHN West had the highest scores of beneficiaries indicating satisfaction with *able to see provider when needed* (77 percent) in FY 2024.



Source: DHA Chief Data and Analytics Office, JOES, weighted data, compiled 12/6/2024
Note: *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."

CLINICAL QUALITY MANAGEMENT IN THE MHS

Clinical Quality Management Strategy 2025-2030

Mission: Provide an organized structure for an integrated framework of programs to define, measure, assure, and improve the quality and safety of care provided to beneficiaries. This framework is guided by Clinical Quality Management (CQM) strategic elements and supported by CQM functions and programs to ensure:

- Support of the DHA mission, vision, core values, and strategy
- Delivery of safe, timely, effective, efficient, and patient-centered health care
- Seamless and agile support for clinical quality through centralized programs, capabilities, resources and expertise-advancing force readiness and combat support by enabling high-quality, reliable healthcare delivery
- Promotion of a learning health care system, a safety culture, and a workplace free of violence

Vision: To advance optimal health outcomes through a culture of accountability, transparency, prevention, and standardization in quality and patient safety in all dimensions of care.

Goals

Improve Clinical Quality and Safety of Care	Increase CQM Accountability in the Direct Care System	Improve and Optimize the DHA CQM Functions	Sustain and Mature CQM Capabilities Across DHA

Objectives

1. Improve the workflows and outcomes for quality and safety for MTFs/DTFs. 2. Improve the implementation and monitoring of evidence-based clinical practice guidelines.	1. Ensure all healthcare facilities maintain full accreditation and compliance. 2. Streamline health risk management processes while maintaining quality standards and compliance.	1. Publish, monitor, and evaluate the implementation of DHA-PM 6025.13. 2. Optimize credentialing, privileging, and processes for providers across the MHS.	1. Increase the knowledge and experience of CQM capabilities across the DHA. 2.Increase the utilization of CQM measures, tools and expertise to support Networks/MTFs/DTFs.

CQM Strategic Measures

- DHA-PM 6025.13 training: >75 percent of MTF and Network staff in CQM roles demonstrate competency in quality and patient safety post-training (collective six programs)
- Publish and implement DHA Deployed Operational Clinical Services (OCS) Memorandum of Agreement (MOAs) for each of the Services
- The Joint Commission (TJC) Accreditation Compliance Rate: 100 percent accreditation status
- Provider Credentialing Compliance Rate: Timeliness of Credentialing Process: <60 days for initial; <30 days for re-credentialing
- Healthcare Risk Management (HRM) Adverse Action Case Process Cycle Time: 130 days for non-appeals; 180 days for appeals
- 100 percent compliance Leapfrog Safety Grade Compliance: >90 percent of MTFs achieving “A” grades
- Patient Safety Indicator (PSI) 90 Score: 10 percent lower than baseline

Patient Safety: Program to Prevent Harm

Joint Patient Safety Reporting (JPSR) System

The DHA requires DHNs, MTF Directors, and staff to report all patient safety events that reach the patient (i.e., harm and no-harm events) and do not reach the patient (i.e., near-miss events) to the greatest extent possible through JPSR. The JPSR system is a standardized, voluntary web-based reporting system that allows for anonymous reporting and was implemented in 2011 across the DHA to capture patient safety events. The system is jointly used with the Veterans Health Administration (VHA) and the U.S. Transportation Command (USTRANSCOM) Patient Movement (PM) system effective 2017-2018. The operational Medical units deployed to the U.S. Central Command and the Navy fleet have adopted the JPSR system, as well. In 2023, a Joint Incentive Fund (JIF) award was granted to allow modernization of the current web-based JPSR version for all user groups to close a critical capability gap by adding a comprehensive higher-level incident investigation module. This module is planned to be launched across the DHA, VHA, and USTRANSCOM PM enterprise in FY 2026. This will simultaneously enable the VHA to sunset a legacy root cause analysis system/database, and for DoD to automate legacy manual DHA/USTRANSCOM processes for DoD Reportable Events. This investigation module aims to make initial reporting for frontline staff more efficient, and create a shared data set, with a leading practice library from corrective action plans. Two key objectives for this JIF project are to mitigate future patient harm and share lessons learned from all types of patient safety reports strengthening clinical processes.

As a result of JPSR reporting, the Patient Safety Program has seen increased collaboration on improvement efforts, knowledge exchange, and the development of broad-based solutions. In FY 2024, a total of 68,125 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 2024. In the deployed environment, JPSR has become an important tool in delivering safer care in austere environments where extraordinary care is taken to stabilize and safely transport wounded warriors back to the contiguous United States (CONUS) in the global Aeromedical Evacuation system.

The table below compares FY 2020 through FY 2024 patient safety reporting, stratified by degree of harm. Harm is defined as events that reach a patient and result in harm, including death; no-harm events that reach a patient and do not result in harm; and near-miss events (or close calls) that do not reach a patient.

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

Joint Patient Safety Events Reported, FYs 2020-2024

Harm Group	FY 2020	FY 2020	FY 2021	FY 2021	FY 2022	FY 2022	FY 2023	FY 2023	FY 2024	FY 2024
	#	%	#	%	#	%	#	%	#	%
Harm	9,517	10.7%	9,214	10.5%	7,598	10.3%	6,793	10.0%	6,446	9.4%
No Harm	34,746	39.0%	44,422	50.7%	29,837	40.3%	27,390	40.5%	27,915	41.0%
Near Miss	44,784	50.3%	34,016	38.8%	36,679	49.4%	33,566	49.5%	33,764	49.6%
Total	89,047	100%	87,652	100%	74,113	100%	67,749	100%	68,125	100%

Source: DHA/Medical Affairs/Clinical Support Division (CSD), 12/17/2024. Data reported as of 12/16/2024.
Note: Due to the process of event investigation and resolution, data may shift slightly from year to year as the JPSR system closes out the event.

Department of Defense Reportable Events (DoD REs)

DoD REs are an important part of patient safety. DoD REs are defined as any patient safety event resulting in death, permanent harm (regardless of the level of severity), or severe harm as per the Agency for Healthcare Research and Quality (AHRQ) Net Harm Scale; or meeting The Joint Commission's (TJC) sentinel event or the National Quality Forum's serious reportable event definitions. The table below provides the most common medical and dental DoD REs that DHA reported to TJC from FY 2020-2024.

Top Five DoD REs Reported to TJC, FYs 2020-2024

Event Type	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Wrong Site Surgery: Wrong-Patient, Wrong-Site, Wrong-Procedure	22	28	28	21	29
Patient Fall	13	22	17	26	31
Delay in Treatment: Lab, Path, Radiology, Referral, TX Order	15	22	14	10	24
Unintended Retained Foreign Object	18	15	12	18	20
General Care Management*	9	11	16	9	25

Source: DHA/Medical Affairs/CSD, 12/17/2024. Data reported as of 12/16/2024.
* Any patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm, or permanent harm.

Policy mandates that MTFs must submit a comprehensive systematic analysis (CSA) for each DoD RE. In FY 2024, MTFs submitted 176 CSAs to DHA and TJC, a 39 percent increase from FY 2023. For each CSA received, the Patient Safety Program reviews the strength of corrective actions (CAs) and guides MTFs in implementing strong CAs that are more likely to prevent a similar event from reoccurring.

Top Five DoD REs Categories for FY 2024

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

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

Fall
A fall is considered a DoD RE when it occurs while the patient is being cared for in a health care setting and results in death or serious injury, such as a fracture, neurological injury, or internal injury.

Delay in Treatment
Delay in treatment events can be the result of a misdiagnosis, delay in diagnosis, or failure to follow up or communicate test results. These are DoD REs that ultimately result in serious harm or patient death.

Unintended Retained Foreign Object (URFO)
An event that occurs after skin closure for an invasive or surgical procedure that results in an object unintentionally remaining in the patient.

Global Trigger Tool (GTT)

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

The table below shows the rate of AEs per 100 admissions as measured by GTT decreasing from 6.1 in FY 2020 Q1 to 0.0 in FY 2024 Q3 (a statistically significant downward trend).

Global Trigger Tool Adverse Events, FY 2020-2024

	FY 2020				FY 2021				FY 2022				FY 2023				FY 2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
AEs per 100 Admissions	6.1	6.4	6.6	7.1	6.5	6.7	5.7	5.1	5.8	6.1	5.0	4.6	3.7	3.5	3.0	3.2	3.1	0.1	0	N/A

Source: DHA/Medical Affairs/CSD, 10/28/2024
Note: There is a lag in data due to a delay in coding and reviewing medical records.

CDC National Healthcare Safety Network (NHSN)

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

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

The Patient Safety Program analyzes DHA data and conforms to national standards. The standardized infection ratio (SIR) and the standardized antibiotic administration ratio (SAAR) are the two primary measures used to benchmark and compare internal DHA data to national benchmarks. DHA is actively engaged in improvement efforts where performance is worse than the national benchmark. For both measures, the benchmark is 1.0 and takes into consideration the statistical significance when comparing to the national benchmark. For both SIR and SAAR, a value of 1.0 or less and a statistically significant ($p<=0.05$) difference means performance is consistent with or better than the national benchmark. A value greater than 1.0 and a statistically significant ($p<=0.05$) difference means performance is worse than the national benchmark.

The table below demonstrates how the DHA performed in comparison with the national benchmark for both CLABSI and CAUTI SIRs.

Health Care-Associated Infections (HAI), FY 2020-2024, Standardized Infection Ratio (SIR)

	FY 2020				FY 2021				FY 2022				FY 2023				FY 2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
CLABSI	0.7	0.3	0.9	1.6	1.2	1.2	0.7	1.4	1.0	0.6	0.6	0.9	0.9	0.8	0.3	0.7	0.6	0.7	0.3	0.7
CAUTI	0.5	0.1	0.7	0.6	0.6	0.5	0.6	1.3	1.0	1.3	1.1	0.6	0.5	0.9	1.0	0.6	0.7	0.6	1.2	0.8

Source: DHA/Medical Affairs/CSD, 1/6/2025
Note: These data are inclusive of all 26 locations reported in NHSN: six intensive care units (ICUs), 15 wards, two Step Down Units, two Mixed Acuity Units, and one Chronic Care Unit.

The table below displays the Standardized Antimicrobial Administrative Ratio (SAAR) for all antibiotics for both adults and pediatrics from FY 2020 through FY 2024.

Antimicrobial Use, FY 2020-2024, Standardized Antimicrobial Administrative Ratio (SAAR)

	FY 2020				FY 2021				FY 2022				FY 2023				FY 2024			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
All Antibiotics – All Adult Wards	0.9	1.1	1.1	1.1	1.2	1.1	1.0	1.1	1.1	1.0	1.0	0.9	1.0	1.1	1.2	1.2	1.2	1.2	1.2	1.2
All Antibiotics – All Pediatric Wards	0.8	1.1	1.3	0.9	1.0	0.6	0.7	0.7	0.6	0.8	0.9	0.8	0.7	0.7	0.9	0.9	0.9	1.1	1.0	0.9

Source: DHA/Medical Affairs/CSD, 1/6/2025
Note: These data are inclusive of all 26 locations reported in NHSN: six intensive care units (ICUs), 15 wards, two Step Down Units, two Mixed Acuity Units, and one Chronic Care Unit.

HIGH RELIABILITY OPERATING MODEL

Primary Care Clinical Community

Primary Care Services

MHS primary care services are driven by evidence-based clinical practices. MHS primary care includes standardized processes and procedures, integrated and coordinated care, and development of 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 primary care teams in meeting the care needs of beneficiaries.

VA and DoD Clinical Practice Guidelines (CPG) collaboration has established a rigorous systematic review of medical evidence to help primary care providers and health care teams deliver consistent high-quality health care to beneficiaries. CPGs are developed by multidisciplinary clinical experts and are based on clinical research studies and literature reviews. Multiple CPGs have been developed and updated to provide practitioners with information and tool kits to support evidence-based practice. VA/DoD CPGs are available at www.healthquality.va.gov/. To enhance its availability and use, CPG information is embedded into the EHR as clinical decision support. The goal is to incorporate the CPGs into the clinician's workflow to ensure ease of use with information on assessment, diagnosis, and recommendations for treatment literally placed at the providers' fingertips.

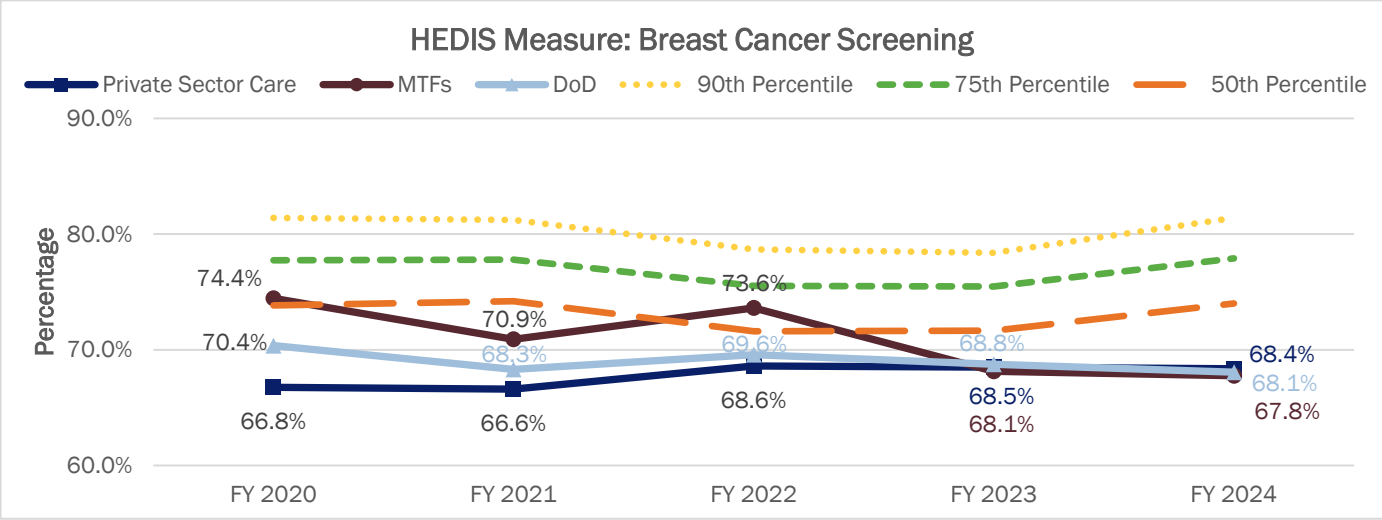
Additionally, the MHS monitors the performance of primary care services with a variety of nationally recognized quality measures. The National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) includes primary care–focused health plan measures with standardized methodologies. HEDIS is a tool used by America's health plans to measure performance on important dimensions of care and service. HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. MHS data can be compared with the NCQA annual benchmark results. The MHS Population Health Portal CarePoint application provides measure methodology and performance data at the enterprise, Network, clinic, and provider levels. The HEDIS methodologies used by CarePoint are reviewed annually by an NCQA HEDIS auditor for validation and certification.

MHS leadership, from MTF staff through the Networks to DHA and the Surgeons General and OASD(HA) leadership, routinely monitor HEDIS performance at all levels of the MHS. HEDIS performance measures are included in the MHS performance management system. The measures are presented in dynamically linked dashboards at the MTF level and aggregated to Networks, and the MHS as a whole. MHS leadership formally reviews and assesses select measures on a quarterly basis, including HEDIS, with discussion on efforts to improve performance.

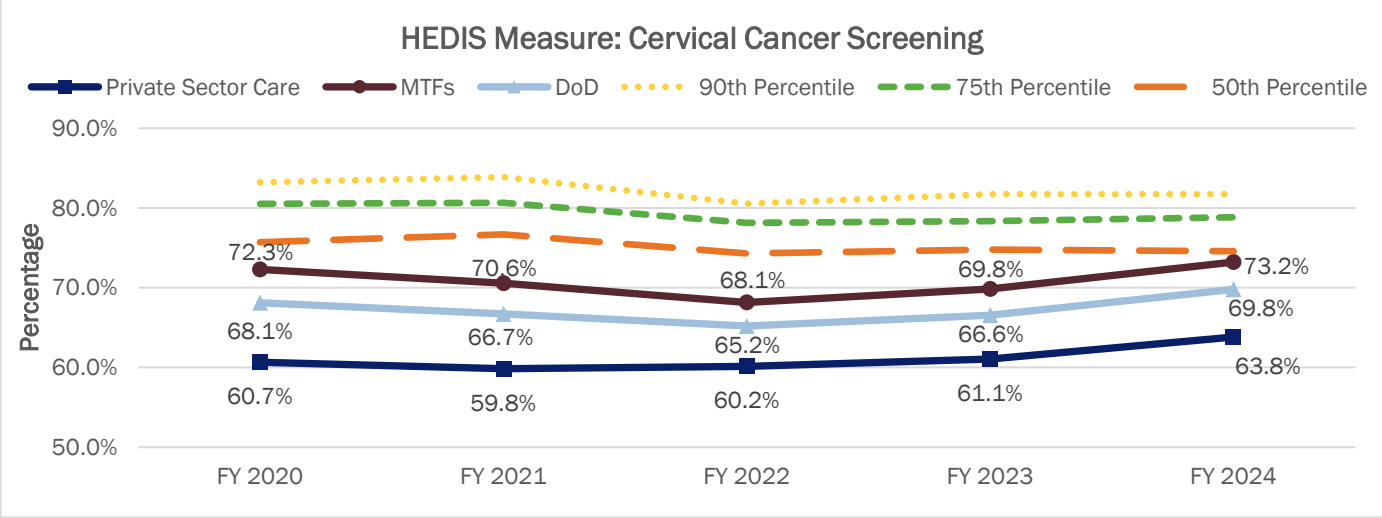
Adult HEDIS Measures

For direct care, data completeness has been negatively impacted by the MHS Genesis implementation. Improvements in the FY 2023 data are related to new data capture from the VHA and other supplemental data sources. Data labels are displayed for private sector care, MTFs, and DoD on each chart.

Breast and Cervical Cancer Screening: HEDIS measures focused on cancer screening for early detection and treatment to maximize the potential for a cure. DoD breast cancer screening rates decreased slightly and continue to be below the 50th percentile in FY 2024. Cervical cancer screening rates have noted improvements, however, remain below the 50th percentile across all sectors of care. The DoD improved by 3.2 percentage points, MTFs saw a 3.4 percentage point increase from the previous year, while private sector care improved by 2.7 percentage points. Improvement is attributed to additional data capture from VHA and other supplemental data sources. Screenings that are completed with other health insurance (OHI) are not included in this figure, which may impact reported metrics.

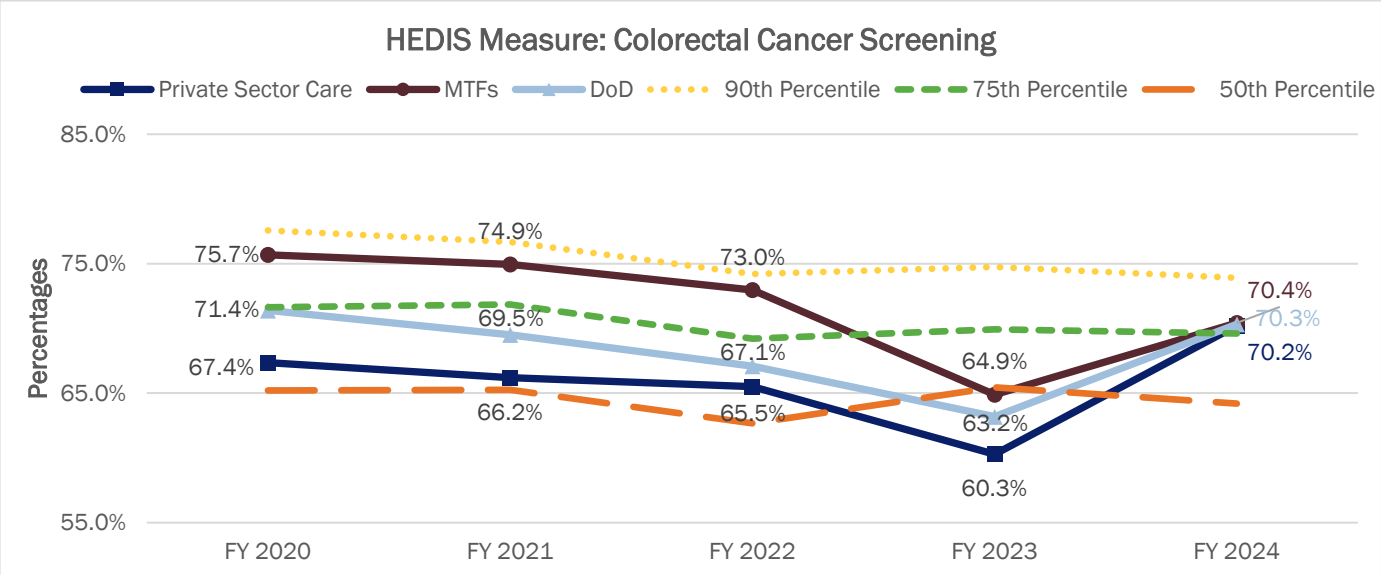


Source: MDR (MHS Data Repository), 3/20/2025.
Note: Data for FY 2020 are through May 2020.



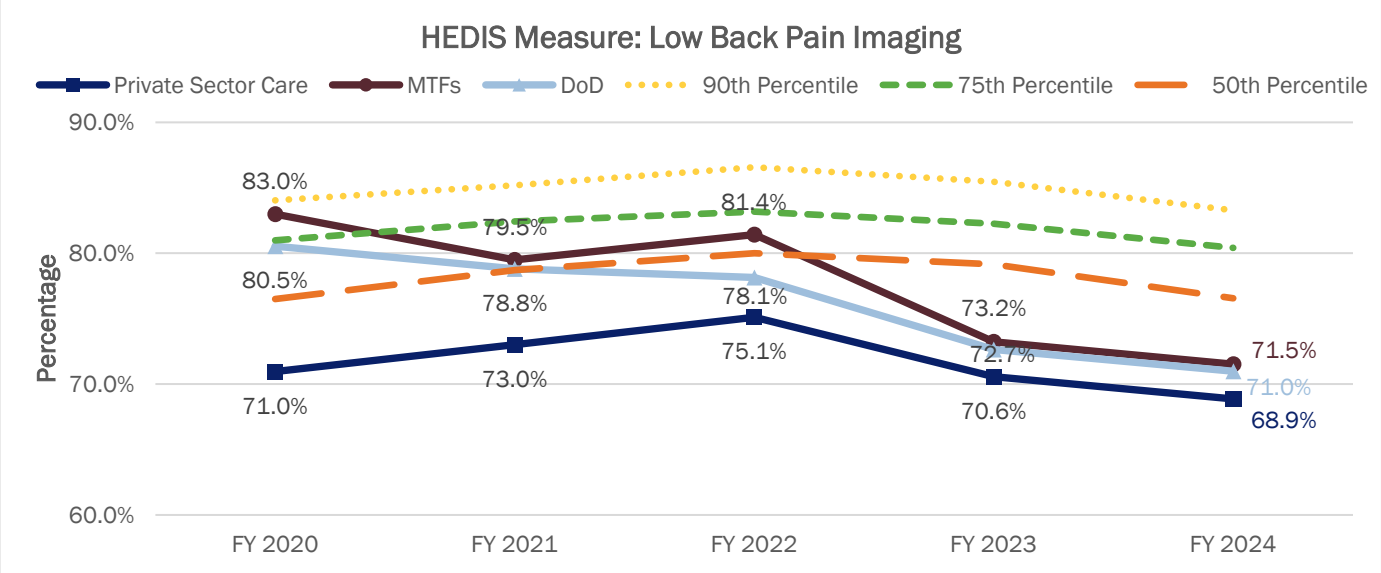
Source: MDR, 3/20/2025.
Note: Data for FY 2020 are through May 2020.

Colorectal Cancer Screening: HEDIS measure focused on detecting colorectal cancer as well as screening for premalignant polyps to prevent cancer. In FY 2024 the DoD rate improved by 7.1 percentage points. The MTF and Private Sector Care rates increased by 5.5 and 9.9 percentage points respectively. All sectors of care are now above the 75th percentile. Improvement is attributed to additional data capture from VHA and other supplemental data sources.



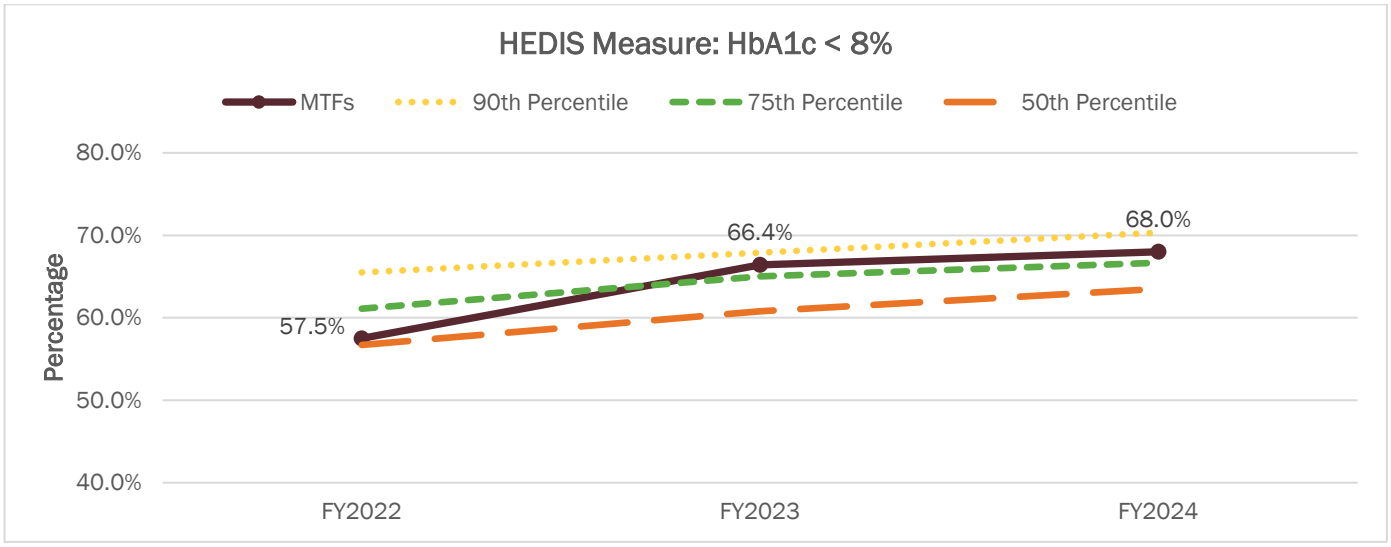
Source: MDR, 3/20/2025.
Note: Data for FY 2020 are through May 2020.

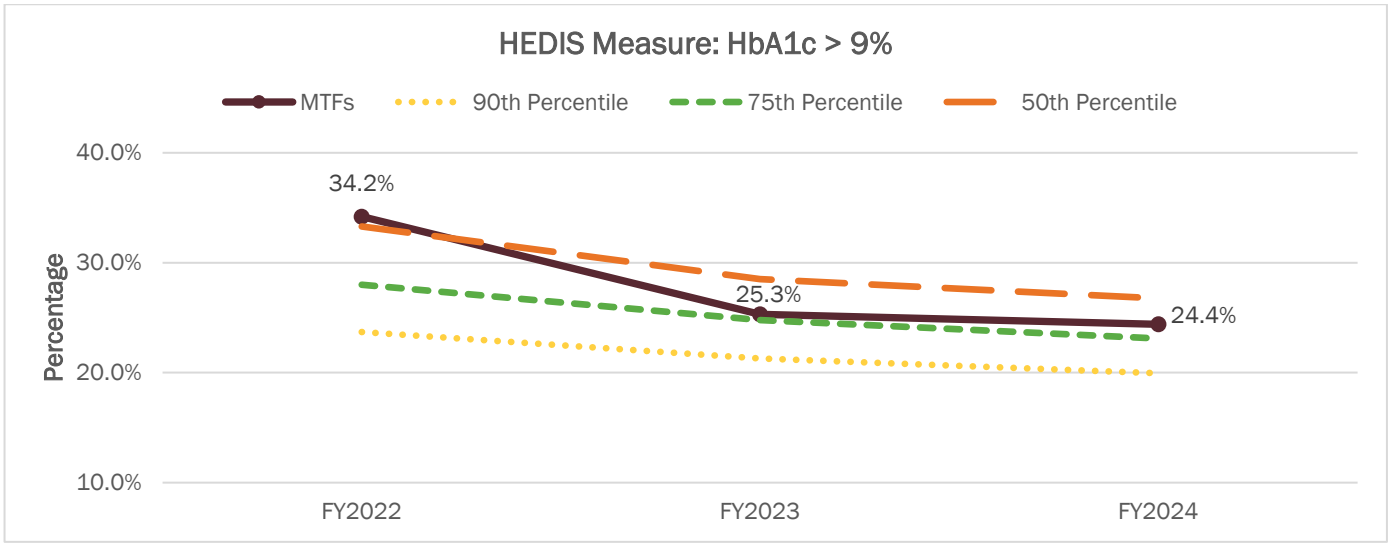
Low Back Pain (LBP) Imaging: HEDIS measure focused on decreasing the overuse of imaging for acute LBP. Rates reflect avoidance of imaging within 28 days of an LBP diagnosis. MHS is integrating the VA/DoD LBP CPG into the EHR to support providers with improvement initiatives. MTFs and private sector care continue to see declines in this measure with scores below the 50th percentile in all sectors. For direct care, this may be related to data completeness issues associated with the new electronic healthcare record data capture.



Source: MDR, 3/20/2025. Note: Data for FY 2020 are through May 2020.

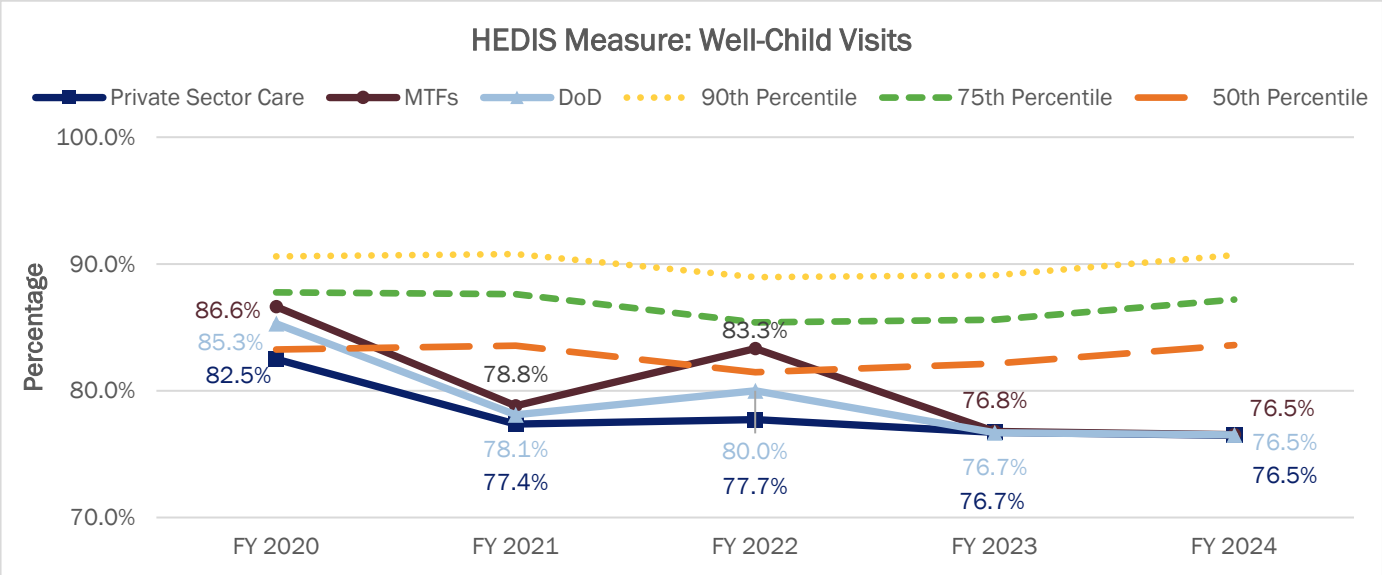
Glycemic Status Assessment for Patients With Diabetes: This measure has two components. The first component measures diabetes control and includes patients with an HbA1c <8. The second component measures diabetes poor control and includes patients with an HbA1c>9 and patients who have not received testing during the measurement period. For HbA1c control (<8), MTFs have steadily increased their performance and are now above the 75th percentile. For HbA1c poor control (<9), MTFs have also improved their performance (lower is better) and continue to be above the 50th percentile. Laboratory results data for private sector care are not available for this measure.





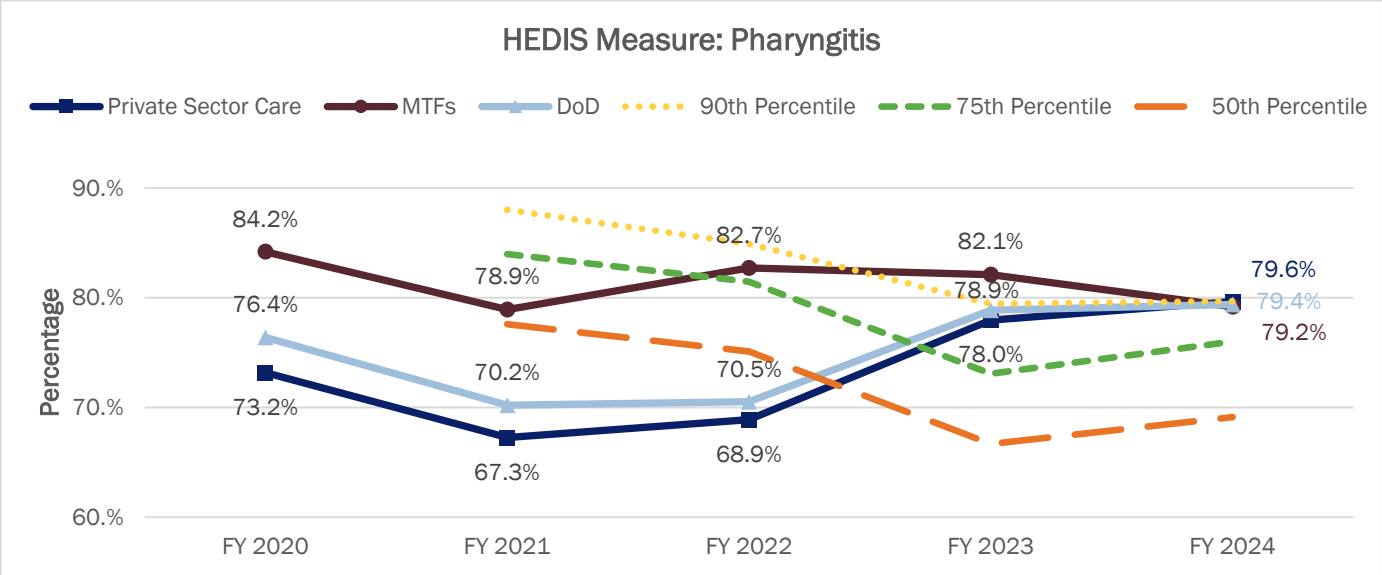
Source: MDR, 3/20/2025.

Well-Child Visits: HEDIS measure focused on the adequacy of well-childcare for infants, as demonstrated by children having six visits within the first 15 months of life. Over the last year, rates have declined, with scores remaining below the 50th percentile across all sectors of care.



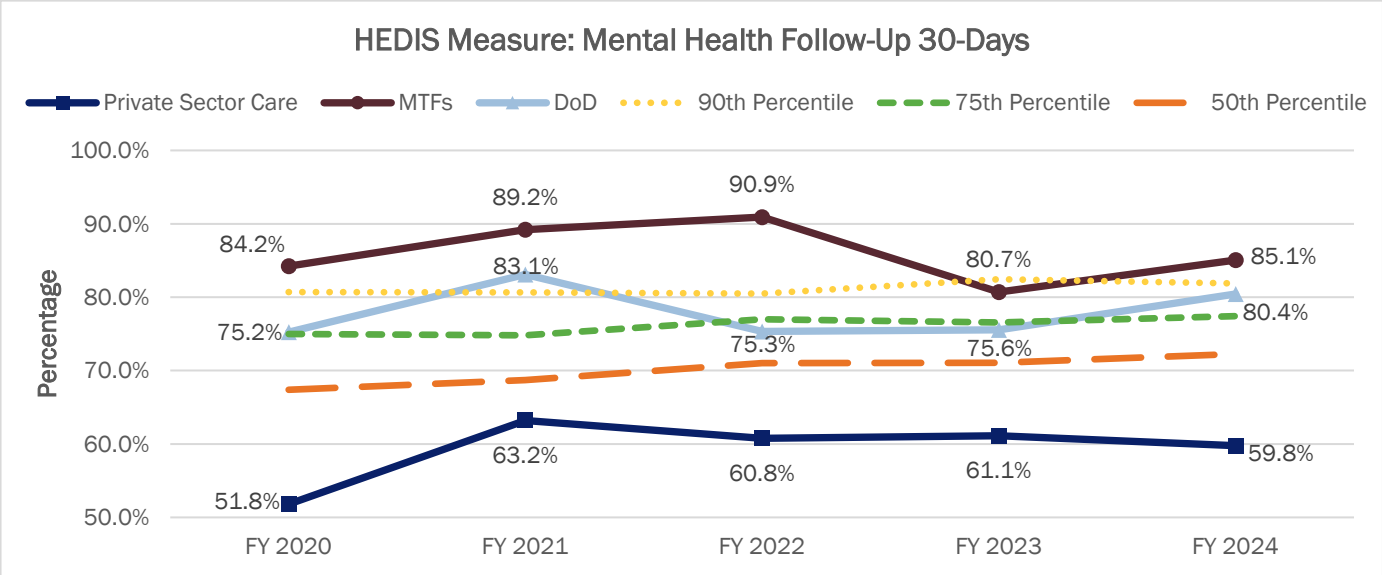
Source: MDR, 3/20/2025.
Note: Data for FY 2020 are through May 2020.

Appropriate Treatment of Pharyngitis: HEDIS measure focused on appropriate use of antibiotics for anyone three months of age or older diagnosed with pharyngitis, based on laboratory data. This measure increases awareness of the importance of laboratory testing and confirmation prior to prescribing antibiotics for pharyngitis. This was a new measure as of 2020. New measure benchmarks became available in 2021. In 2024, DoD continued to perform between the 75th and 90th percentiles.



Source: MDR, 3/20/2025.
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 MTFs and private sector care venues. The overall DoD rate increased by 4.8 percentage point, with 2024 performance between the 75th and 90th percentiles. While MTFs performed above the 90th percentile, private sector care performed below the 50th percentile.



Source: MDR, 3/20/2025.
Note: Data for FY 2020 are through May 2020.

Behavioral Health Clinical Community (BHCC)

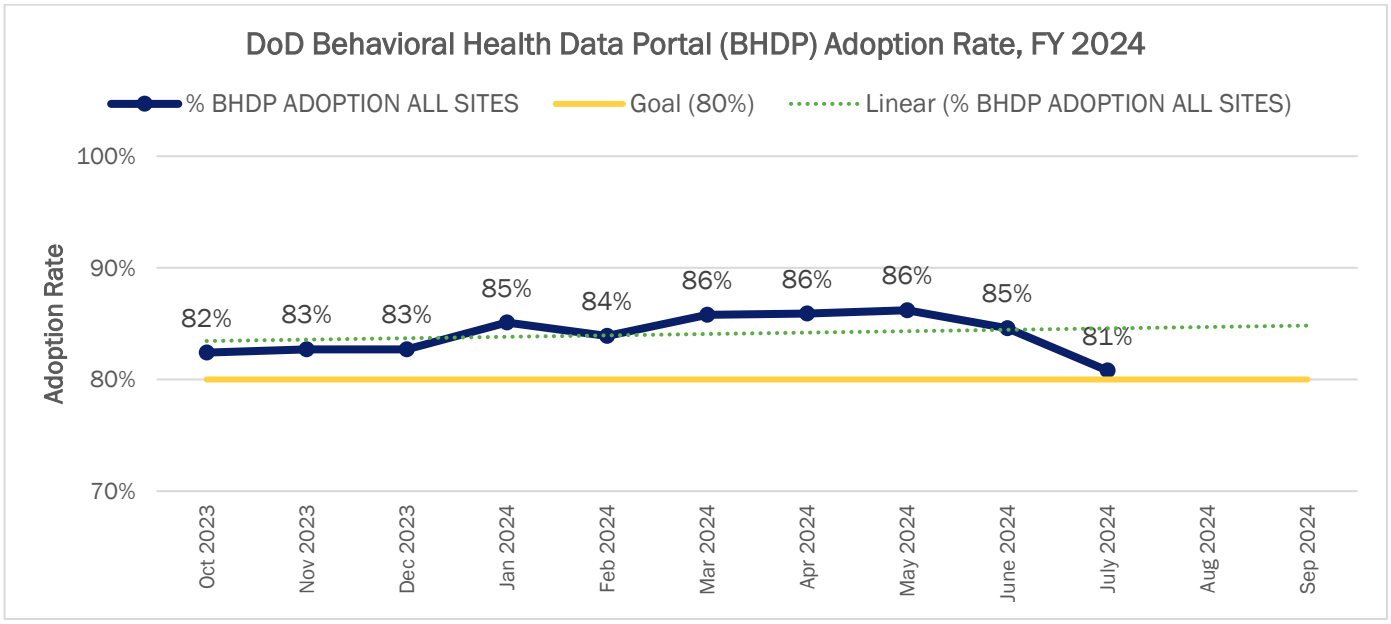
The mission of the BHCC is to promote safe, effective BH care that integrates full spectrum care delivery and community resources through standardized BH programs and procedures, partnerships, engagement with staff and patients, and state of the science research. The BHCC was established in November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

To attain its objectives, BHCC maintains working relationships with persons and entities with the following types of enabling expertise: analytics, change management, clinical informatics, education and training, health information technology, process improvement, clinical quality, public health and patient safety. Strategic partners include DoD Psychological Health Center of Excellence, Uniformed Services University, TRICARE, and VA. The BHCC also coordinates closely and partners with the BH Clinical Management Team, which oversees implementation of process improvement initiatives and programmatic management and execution.

Through FY 2024, the BHCC and BH Clinical Management Team advanced on the following significant initiatives:

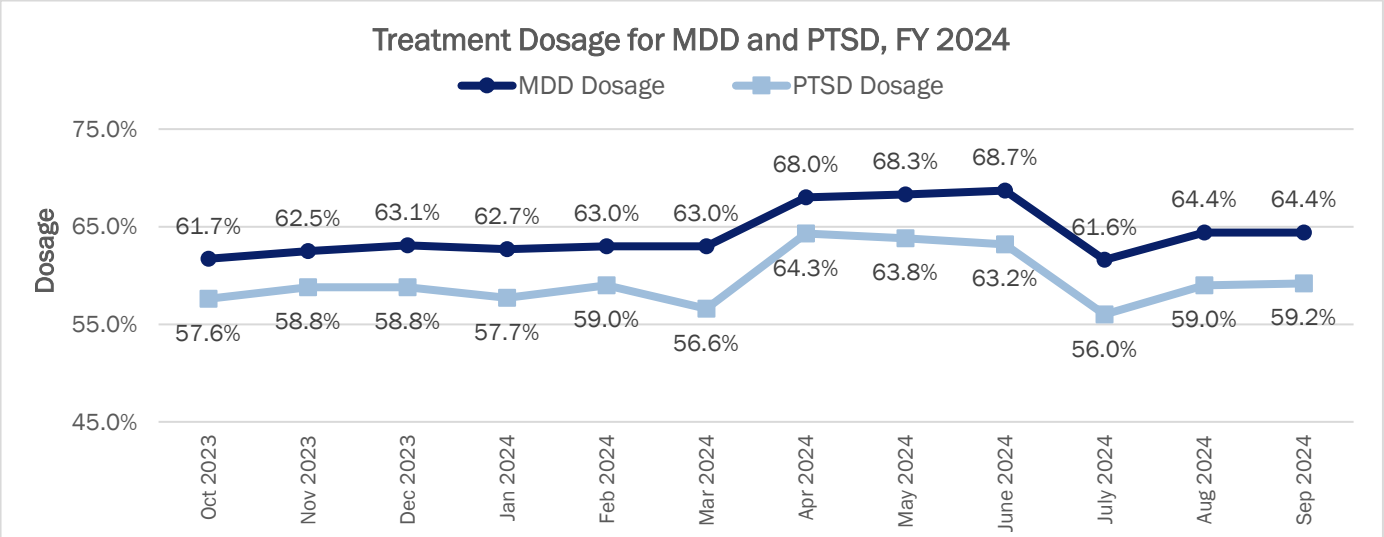
1. **BH Treatment and Outcomes Monitoring:** NDAA FY 2016, Section 729, and a 2013 Assistant Secretary of Defense Memorandum, "Military Treatment Facility Mental Health Clinical Outcomes Guidance," required the DoD to collect BH treatment-specific outcome measurements, and assess BH outcomes, variations, and barriers to VA/DoD CPGs. To meet these requirements, the DHA published DHA-PI 6490.02 "Behavioral Health Treatment and Outcomes Monitoring" on July 12, 2018. DHA-PI 6490.02 sets outcome monitoring requirements in specialty care BH, substance use disorder, and primary care clinics at MTFs. The types of metrics required by DHA-PI 6490.02 for collection, reporting, and analysis include: structure (equipment and training compliance); process (treatment dosage rate, evidence-based treatment rates); and clinical outcome metrics (improvement and/or remission in major depressive disorder [MDD] and post-traumatic stress disorder [PTSD]).

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 averages above 80% for in-person and virtual visits. In FY 2023 remote access was implemented to allow patients to complete BHDP virtually, which had significant positive impacts on BHDP adoption in FY24. The MHS-wide BHDP Adoption Rate has steadily improved through FY 2024 and has stayed consistently above the DHA goal of 80%. Beginning in FY 2024 the BHDP PMO in conjunction with the BHCC began developing a Groups encounter Survey and an abbreviated version of the Tri-Service Adult BH/SUD Survey. The intent of these surveys will be to better support the providers and ultimately the patient experience. The BHCC supports efforts to further improve the BHDP Adoption Rate through education, training, and sharing of best practices.

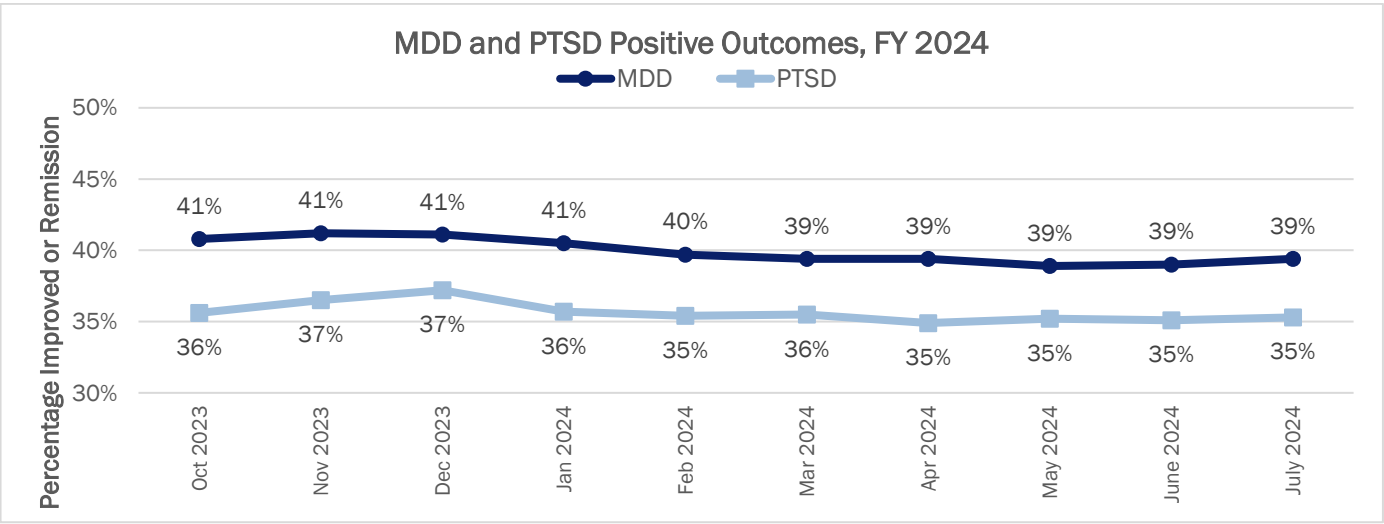


Source: DHA/Medical Affairs/CSD, 1/8/2025
Note: BHDP data was unavailable for August and September 2024 due to MODS migration.

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



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 are expected to improve.



Source: DHA/Medical Affairs/CSD, 1/8/2025
Note: BHDP data were unavailable for August 2024 and September 2024 due to MODS migration.

5. **Procedural Guidance on the Behavioral Health System of Care:** DHA Administrative Instruction 6490.01, published in February 2023, establishes the DHA Behavioral Health System of Care within the DHA's Direct Care System, utilizing a system of care model to promote efficient and effective BH care for MHS beneficiaries by standardizing program requirements, assessment and treatment services, documentation, coordination processes, training requirements, and outcomes measurement.

6. **My Military Health (MMH):** Beginning in 2023, five MTF's behavioral health clinics participated in a pilot to implement the processes that became MMH. This initiative strove to better match the 40 percent of individuals who present to specialty BH who do not require medical intervention or have a diagnosable condition with the resource that best addresses the individual's need. These resources include those beyond the BH clinic and involve other clinical resources, such as PCBH, along with nonclinical resources including military and family life counselors, chaplains, or other available helping resource on the installation. The pilot program found that leveraging behavioral health clinic changes that included use of groups and technician-driven care enabled an increase in specialty appointments by 60 percent and improved patient access to care. This resulted in reattraction of care from the network and reduced patient wait times by 46 percent. MMH was then rolled out to DHN Atlantic, DHN East, and DHN National Capital Region in the fourth quarter of CY 2024.

ENTERPRISE QUALITY AND SAFETY IMPROVEMENT INITIATIVES

To strengthen quality of care and promote patient safety and medical readiness, the Deputy Assistant Director for Medical Affairs (DAD-MA) has prioritized a series of enterprise-level initiatives. These projects support DHA's strategic goals by standardizing evidence-based practices, improving clinical outcomes, and reducing preventable harm for ADSMs and all TRICARE beneficiaries.

National Surgical Quality Improvement Program (NSQIP)

DHA participates in the American College of Surgeons (ACS) National Surgical Quality Improvement Program (NSQIP), which provides risk-adjusted, benchmarked data to evaluate surgical quality across more than 700 hospitals internationally. The most recent DoD NSQIP Collaborative report, covering surgeries from July 2023 through June 2024, includes performance data from 45 MTFs.

DoD Collaborative January 2025 Semiannual Report (Surgery Dates July 1, 2023 to June 30, 2024)

	Collaborative								NSQIP
Model Name	Total Case	Observed Events	Observed Rate	Adjusted Rate*	95% Lower CL	95% Upper CL	Outlier**	Estimated OR	Population Rate
ALLCASES Mortality	38,434	64	0.17%	0.75%	0.59%	0.94%		0.80	0.94%
ALLCASES Morbidity	38,434	1,118	2.91%	5.90%	5.55%	6.25%	Low	0.91	6.46%
ALLCASES Cardiac	38,434	39	0.10%	0.35%	0.23%	0.50%	Low	0.58	0.61%
ALLCASES Pneumonia	38,430	76	0.20%	0.68%	0.52%	0.85%	Low	0.76	0.88%
ALLCASES Unplanned Intubation	38,434	38	0.10%	0.39%	0.28%	0.53%		0.76	0.51%
ALLCASES Ventilator > 48 Hours	38,429	34	0.09%	0.43%	0.30%	0.59%		0.74	0.59%
ALLCASES VTE	38,434	150	0.39%	0.80%	0.68%	0.93%		1.00	0.80%
ALLCASES Renal Failure	38,426	46	0.12%	0.46%	0.32%	0.62%	Low	0.72	0.64%
ALLCASES UTI	38,392	250	0.65%	1.09%	0.96%	1.23%		0.98	1.12%
ALLCASES SSI	38,302	650	1.70%	2.84%	2.62%	3.06%		0.94	3.01%
ALLCASES Sepsis	38,397	63	0.16%	0.50%	0.35%	0.67%	Low	0.53	0.94%
ALLCASES C.diff Colitis	38,434	29	0.08%	0.22%	0.15%	0.30%		0.89	0.24%
ALLCASES Unplanned Reoperation	38,434	608	1.58%	2.96%	2.76%	3.17%	High	1.25	2.38%
ALLCASES Unplanned Readmission	38,434	920	2.39%	4.68%	4.40%	4.97%		1.02	4.58%

Source: American College of Surgeons National Surgical Quality Improvement Program DoD Collaborative Report, released January 2025
*Adjusted Rate is the risk-adjusted smoothed rate. **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.

Overall, the MHS continues to demonstrate strong surgical quality, with performance meeting or exceeding 13 of 14 benchmarked measures. The DoD Collaborative received "exemplary" ratings in five statistical models. However, All Cases Morbidity remains a top enterprise priority, as it encompasses a wide range of preventable post-operative complications that directly affect patient outcomes and system-level performance, and the collaborative rate is trending in the wrong direction. Notably, Surgical Site Infections (SSIs) and Urinary Tract Infections (UTIs) together account for approximately 75 percent of All Cases Morbidity across the MHS surgical population, and SSIs are also a common driver for Unplanned Reoperations.

To address this, DHA launched a targeted NSQIP improvement initiative focused on reducing SSIs and UTIs. In FY24, the DHA published formal Practice Recommendations (PRs) for both SSIs and UTIs and engaged 17 MTFs with elevated infection rates in a focused effort to standardize evidence-based prevention practices.

This initiative includes the use of MHS GENESIS–integrated workflows, site-specific process improvements, and strengthened data monitoring. While SSIs are more frequently associated with Return to Operating Room (ROR), both infections significantly impact patient safety, length of stay, and readmission risk. The overarching goal of the initiative is to reduce All Cases Morbidity by driving down the most common and preventable post-surgical complications across the enterprise.

The NSQIP Steering Panel and the MHS Strategic Partnership with ACS (MHSSPACS) support this initiative through quarterly collaborative learning sessions and customized analytic tools. Additionally, the DHA Surgical Services Clinical Community Quality and Safety Subcommittee is partnering with NSQIP sites to implement the ACS Optimal Resources for Quality and Safety, advancing a standardized surgical quality infrastructure.

Notably, three DHA hospitals were nationally recognized by the ACS for superior performance in both "All Cases" and "High-Risk" surgical care categories—an honor awarded to only 77 hospitals nationwide. These achievements reflect the MHS's commitment to surgical safety, continuous learning, and improved patient outcomes.

Leapfrog Safety Grade Improvement

The Leapfrog Safety Grade Improvement project advances DHA's strategic commitment to high reliability, patient safety, and transparency. It is one of several efforts with the DHA Strategy's Optimize Healthcare Delivery strategic initiative, under the Culture of Wellness and Health driver. In 2024, for the first time, all DHA hospitals (including OCONUS facilities) participated in the Leapfrog Safety Grade Survey, aligning the MHS with a nationally recognized, independent standard for hospital safety. This initiative complements broader enterprise efforts such as Improve Medication Safety and NSQIP, while specifically leveraging Leapfrog's publicly reported performance framework to benchmark MTF progress in areas like medication safety, infection prevention, intensive care, and harm reduction practices.

The results demonstrate substantial improvement. As shown in the table below, DHA MTFs outperformed national averages in the Fall 2024 Leapfrog Safety Grade, with 75 percent achieving an "A" compared to 32 percent of participating civilian hospitals nationwide. These results underscore the success of enterprise-wide implementation and DHA's continued commitment to patient safety, accountability, and high reliability across the global MHS.

2024 Leapfrog Hospital Safety Grades	**A**	**B**	**C**	**D**	**F**
Percentage of MTFs Achieving Fall 2024 Grade	75%	25%	0	0	0
Percentage of MTFs Achieving Spring 2024 Grade	43%	43%	14%	0	0
Percentage of Participating Facilities Nationwide (Fall 2024 Grade)	32%	24%	36%	7%	<1%

Improve Medication Safety

The Improve Medication Safety project is a major enterprise initiative designed to reduce preventable harm through standardized, system-wide improvements in medication management processes. It supports DHA's broader patient safety strategy and directly aligns with national benchmarks such as the Leapfrog Hospital Survey, The Joint Commission standards, and the agency's commitment to zero preventable harm.

The project focuses on three interdependent pillars:

1. Bar Code Medication Administration (BCMA)
2. Medication Reconciliation (MR)
3. Computerized Provider Order Entry (CPOE)

BCMA compliance has steadily improved across the enterprise. As of May 2025, Leapfrog-designated units (ICU, Med-Surg, Labor & Delivery, Pre-Op, and PACU) achieved a sustained compliance rate of > 95 percent, exceeding Leapfrog's top benchmark. Ambulatory Surgical Centers (ASCs) also improved from 69 percent to 80 percent over the past year. Sustained gains have been driven by leadership engagement, staff education, and unit-level compliance monitoring. A BCMA Coordinator Resource Guide is set for release in July 2025 to support sustainment across MTFs.

Medication Reconciliation is a key area of focus, with known vulnerabilities in transitions of care. A Plan of Action and Milestones (POAM) was developed outlining six enterprise-level priorities: establishing DHA-wide policy, implementing updated training, defining standardized metrics and performance goals, revising workflows, developing accountability mechanisms, and instituting a sustainment plan. A new DHA Medication Reconciliation Policy is expected to be fully drafted by July 2025, with publication anticipated in the months that follow. Once finalized, it will standardize expectations and procedures across inpatient, outpatient, and emergency settings.

CPOE optimization efforts aim to improve medication safety through enhanced clinical decision support. As of 2025, nearly all MTFs exceed the 85 percent usage benchmark for CPOE inpatient medications. However, clinical decision support (CDS) alert compliance remains below the 60 percent Leapfrog benchmark, and multiple updates are pending with Oracle/Multum to improve alert functionality and reduce alert fatigue. In parallel, efforts are underway to incorporate high-alert medication lists, BEERs® criteria, and FDA boxed warning alerts to strengthen prescribing safety and align with national standards.

Collectively, the Improve Medication Safety initiative addresses some of the most common and preventable causes of harm across the MHS. It reduces adverse drug events, strengthens care transitions, improves provider decision-making, and ensures medication accuracy across all care settings—directly enhancing the safety and quality of care delivered to ADSMs and beneficiaries.

Implement and Monitor Top 10 Clinical Practice Guidelines (CPGs) in MHS GENESIS

The DHA continues to advance implementation of the top 10 VA/DoD Clinical Practice Guidelines within the MHS GENESIS electronic health record. These guidelines promote evidence-based care in high-impact areas such as asthma, opioid therapy, low back pain, insomnia, and obesity. Enhanced clinical decision support tools and workflow integration enable providers to deliver consistent, high-quality care. Current efforts focus on increasing CPG adherence rates through standardized workflows, performance dashboards, and end-user training, directly improving outcomes and supporting continuity of care across the MHS.

Primary Care Cancer Screening

Enterprise-wide initiatives targeting colorectal, breast, cervical, and lung cancer screenings have significantly expanded access and early detection. Notable accomplishments include the mailing of over 16,000 fecal

immunochemical test (FIT) kits across 110 MTFs, contributing to a 7.1 percentage point increase in DoD colorectal cancer screening rates.

Comprehensive Sepsis Strategy

The Sepsis Strategy Project supports the implementation of consistent, evidence-based practices across MTFs to improve the recognition and management of sepsis and septic shock. Guided by DHA Policy Memorandum 25-005 (5 Feb 2025), the initiative directs MTFs to establish interdisciplinary teams and enhance clinical workflows to strengthen inpatient sepsis care. Each MTF team must include members from key disciplines – physicians, nurses, pharmacists, infection prevention, quality services, and MHS GENESIS trainers.

The project focuses on five strategic pillars: prevention, early detection, timely management, quality improvement, and provider education. It uses the CMS SEP-1 bundle as a quality benchmark, allowing comparisons of MTF performance with private-sector hospitals via CMS Care Compare. The National Early Warning Score (NEWS) embedded within MHS GENESIS, aids in early identification and escalation of suspected sepsis.

Quarterly SEP-1 data is reviewed through the Clinical Measures Work Group, and MTFs report semiannual updates to the DHA Sepsis Working Group. The project advances DHA's goal of improving patient outcomes and patient safety through coordinated, data-informed quality improvement efforts.

Operationalizing Pharmacogenomics Testing for Comprehensive Medication Management (OPTIMM)

OPTIMM is a DAD-MA project designed to enhance prescribing safety and medication effectiveness through the integration of pharmacogenomics (PGx) into clinical care. Funded with a $4 million allocation from the DoD Appropriations Act, the project supports medical readiness by enabling personalized medication management – particularly for medications used in pain management, behavioral health, and other mission-critical conditions. DHA is required to submit 12- and 24-month progress updates to the House and Senate Armed Services Committees (HASC/SASC), underscoring its strategic importance.

The project is being implemented at the DHA Genetics Reference Lab (DHAGRL) and includes the development of military-relevant PGx testing panels, with initial focus on medications with FDA Boxed Warnings. A complementary provider education module (JKO Course DHA US1209) was launched to prepare clinicians and pharmacists for broader adoption. OPTIMM also supports enhanced clinical decision-making by informing efforts to integrate PGx-based prescribing recommendations and drug alerts into MHS GENESIS. Future work includes potential development of "hard stop" alerts for specific high-risk medications and seamless incorporation of PGx results into the electronic health record. The project positions DHA to advance precision medicine across the MHS – reducing adverse drug reactions, improving therapeutic outcomes, and supporting the readiness and safety of Active-Duty Service Members and beneficiaries through more tailored, data-driven prescribing practices.

All-Cause Readmissions

The All-Cause Readmission project is a DAD-MA initiative focused on reducing unplanned hospital readmissions across the MHS. These readmissions are a critical indicator of care quality and care transition effectiveness and contribute to increased cost, patient burden, and risk of preventable harm. The initiative supports DHA's goals to improve continuity of care, reduce preventable hospital readmissions, and strengthen force medical readiness.

To drive improvement in the All-Cause Readmission rate, DHA is implementing four enterprise driver measures in MHS GENESIS that target key pre- and post-discharge processes:

1. Medication Reconciliation – ensuring medications are accurately reviewed, reconciled, and documented prior to discharge.
2. Multidisciplinary Rounds – focused team reviews to promote safe and effective transitions, documented prior to discharge.
3. Primary Care Follow-Up Appointment Scheduling – ensuring follow-up appointments are scheduled with patient or caregiver input prior to discharge.
4. Post-Discharge Follow-Up Within 72 Hours – documenting contact with the patient or caregiver within 72 hours of discharge.

These interventions are grounded in evidence-based best practices endorsed by organizations such as the Joint Commission, AHRQ, CMS, and Society of Hospital Medicine. They have been shown to reduce readmission risk, improve care transitions, and support better patient outcomes across a range of healthcare systems.

The process measures are being implemented across participating MTFs with defined FY 2025 performance targets, and user feedback is helping refine workflows and documentation tools. Importantly, a draft DHA Medical Management Program Policy is currently in coordination, which will require compliance with these measures as part of inpatient pre- and post-discharge processes. Once finalized, the policy will further standardize expectations and reinforce accountability across the enterprise.

Collectively, these interventions strengthen discharge planning, improve care coordination, and reduce avoidable hospital returns – supporting patient safety and force medical readiness.

Musculoskeletal Treatment and Outcomes Monitoring (MOTION)

MOTION is a DAD-MA project that improves musculoskeletal (MSK) care by leveraging a digital triage and outcomes platform. It aims to reduce unwanted variation, enhance care quality, and improve patient-reported outcomes through standardized clinical pathways and treatment tracking over time. The platform supports appropriate triage, evidence-based care, and informed referral decisions – all integrated within MHS GENESIS.

Pilot implementation has exceeded expectations, with ≥ 80 percent adoption at select sites such as NHC Cherry Point, Fort Liberty (Robinson Clinic), and AHC Baumholder, compared to a 40 percent enterprise target. Continued rollout will support DHA's goals to enhance conservative MSK management, reduce unnecessary specialty referrals, and improve warfighter readiness by minimizing avoidable disability and lost duty-time.

Inpatient Falls Reduction Initiative

To address patient falls—the most frequently reported DoD Reportable Event in 2023—the DAD-MA Clinical Quality Implementation and Optimization Workgroup launched a system-wide initiative aligned with DHA-AI 6025.34. A new Inpatient Falls Analysis Tool has been developed to track compliance with four required interventions: Falls Risk Assessment on Admission, High-Risk Interdisciplinary Plan of Care (IPOC) Utilization, Nurse Shift Change Communication, and Inpatient Transfers. This tool standardizes data collection and enables MTFs to monitor adherence to evidence-based fall prevention practices. Initial Operating Capability (IOC) is targeted for mid-2025, supporting reduced harm from falls and improved patient safety across the MHS.

Behavioral Health Treatment and Outcomes Monitoring

The Behavioral Health Treatment and Outcomes Monitoring project is a DAD-MA initiative focused on strengthening the Military Health System's ability to assess and improve the effectiveness of behavioral health (BH) care. The project supports enterprise efforts to develop more reliable and actionable metrics, improve patient outcomes, and ensure behavioral health services are aligned with medical readiness objectives.

This effort addresses long-standing challenges with legacy measures, such as those for major depressive disorder (MDD) and post-traumatic stress disorder (PTSD), by refining data sources, expanding the use of

patient-reported outcomes, and standardizing evaluation methods across MTFs. It emphasizes the need for metrics that reflect meaningful improvements in functioning, treatment engagement, and quality of care.

The project also supports enhanced stratification of BH outcome data, allowing for more targeted analysis of population subgroups and enabling performance comparisons across the enterprise. These improvements will strengthen DHA's ability to evaluate the impact of BH services on patient recovery, system performance, and force readiness – ensuring that behavioral health care delivered through the TRICARE system remains effective, responsive, and mission-aligned.

Lifestyle Medicine

The DHA is integrating Lifestyle Medicine principles as part of the Optimize Healthcare Delivery Strategic Initiative, aligned with the Culture of Wellness and Health driver. This effort supports DHA's strategy to deliver whole-person, proactive care by addressing root causes of chronic disease and promoting sustainable behavior change.

This initiative has developed and prepared web-based resources for TRICARE beneficiaries, with new content pending implementation on TRICARE.mil, and aims to increase utilization of Armed Forces Wellness Centers (AFWC). Lifestyle Medicine aligns with social determinants of health and DHA's wellness-focused strategic objectives, advancing preventive care through focus areas such as nutrition, physical activity, stress reduction, and sleep hygiene.

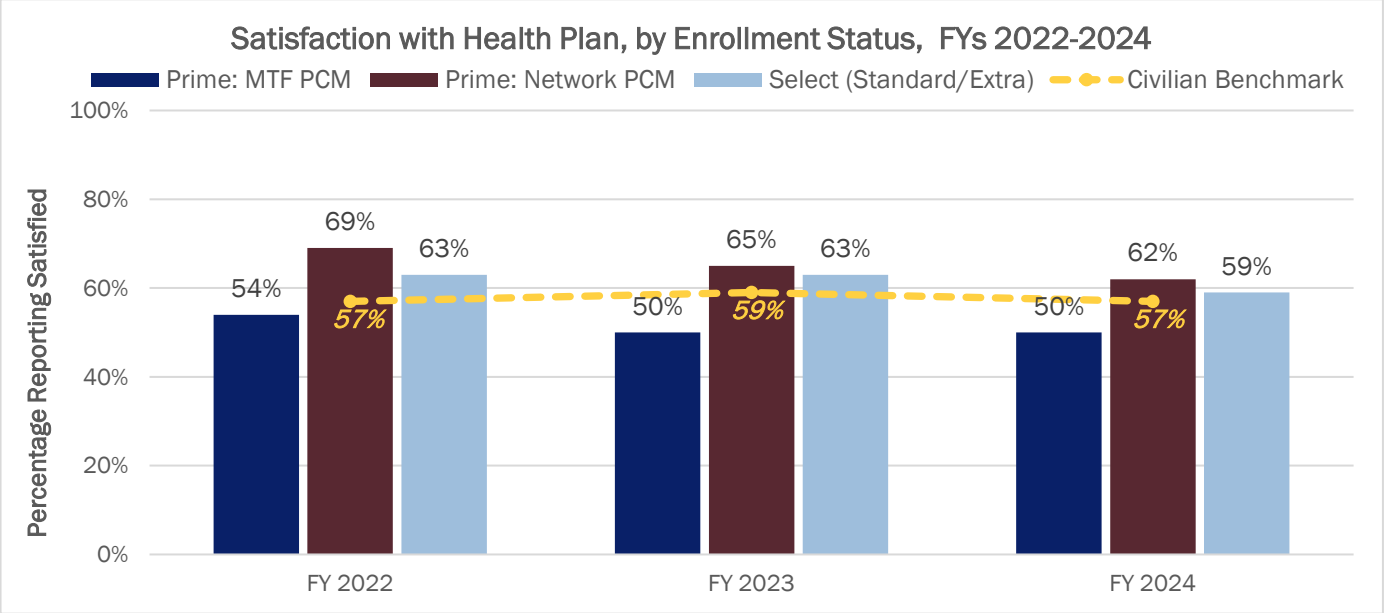
PATIENT-CENTERED CARE AND PATIENT EXPERIENCE

Beneficiary Rating of Satisfaction with TRICARE Health Plan

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 with one's health plan across the TRICARE options are compared with commercial plan counterparts. *Satisfaction with TRICARE health plan* scores come from the Health Care Survey of DoD Beneficiaries (HCSDB). The HCSDB is the only population-based survey administered to a statistically representative sample of DoD beneficiaries. It is based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey and allows for comparison to civilian benchmarks. The survey has run continuously since 1995 supporting various DHA offices.

Beneficiary satisfaction scores with TRICARE health plan are shown by beneficiary enrollment status.

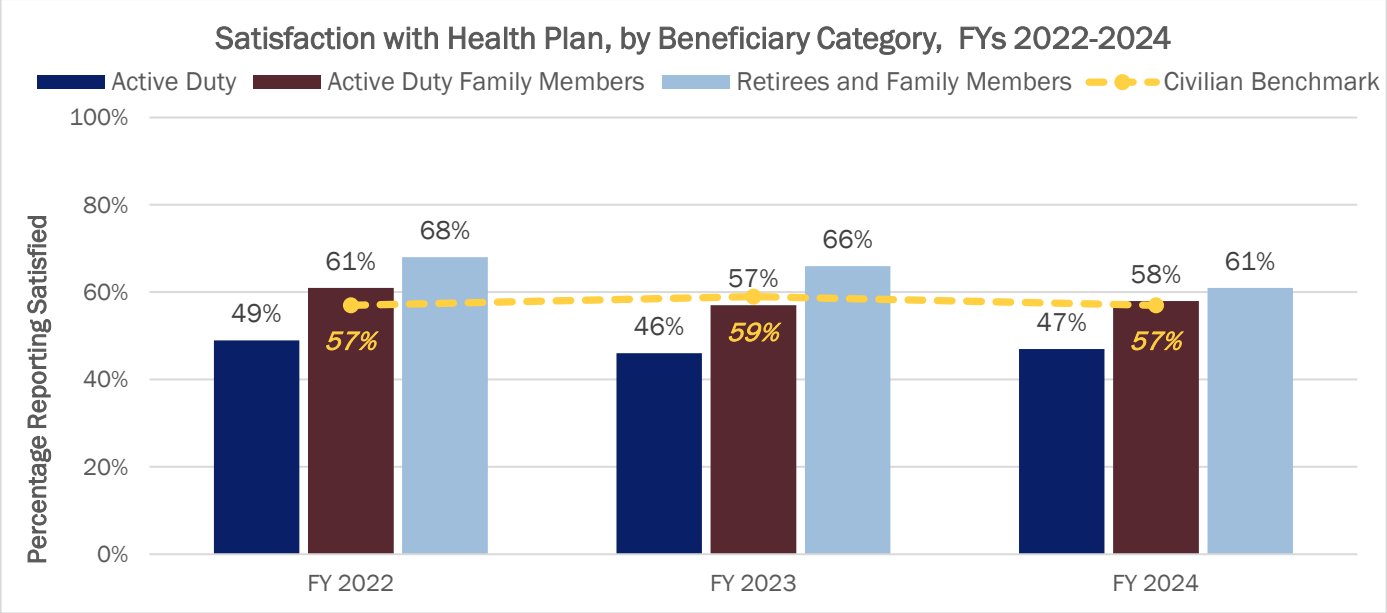
- *Satisfaction with health plan* decreased slightly for all three enrollment categories from FY 2022 to FY 2024.
- Enrollees in Prime with Network PCM and Select enrollees indicated higher satisfaction with their health plan than the civilian benchmark for the past three years while enrollees in Prime with MTF PCM fell under the civilian benchmark.
- Beneficiaries with Prime Network PCM reported higher levels of satisfaction than those with Prime MTF PCM and those with Select (Standard/Extra) TRICARE health plans.



Source: DHA Chief Data and Analytics Office, HCSDB data, adjusted for age and health status, as of 11/18/2024
Notes:
–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.
– *Satisfaction with Health Plan* is assessed from HCSDB question: "Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?" Response options are a scale of 0 = worst health plan possible to 10 = best health plan possible. The results provided above are for those beneficiaries who reported "8," "9," or "10."

The figure below shows trends in *satisfaction with health plan*, by beneficiary category.

- Overall, retirees and their dependents report higher *satisfaction with health plan* than the other beneficiary categories across the past three years.
- For FY 2024, active duty was the only beneficiary category that is below the civilian benchmark for *satisfaction with health plan*.



Source: DHA Chief Data and Analytics Office, HCSDB data, adjusted for age and health status, as of 11/18/2024
Notes:
– 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.
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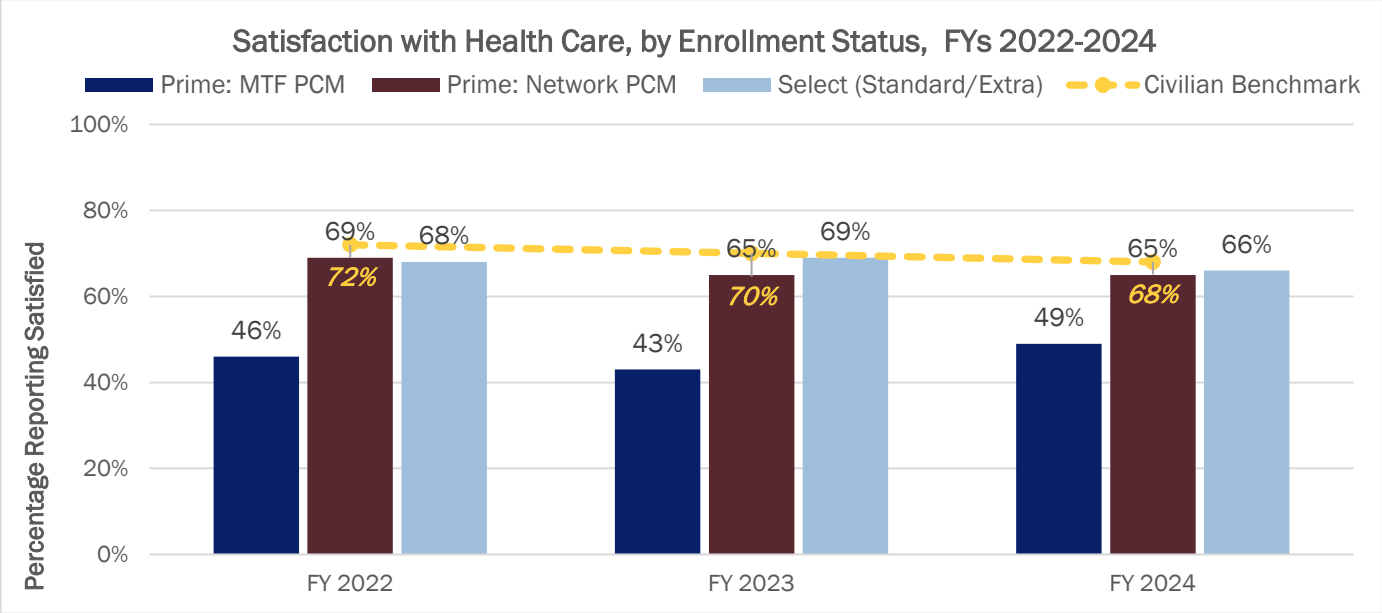
Beneficiary Rating of Satisfaction with TRICARE Health Care

Also from the HCSDB, beneficiary satisfaction levels with TRICARE health care by beneficiary category and enrollment status are shown below for FY 2022 through FY 2024.

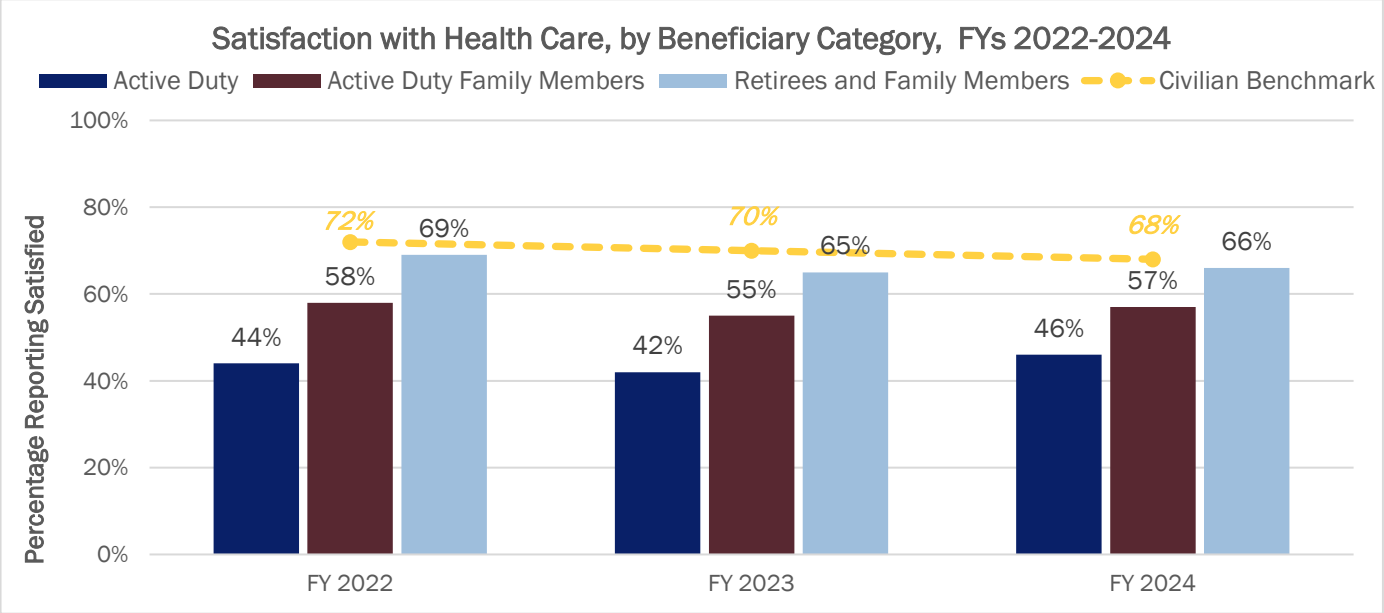
- Beneficiary *satisfaction with health care* increased for those with Prime MTF PCM from 46% satisfaction in FY 2022 to 49% satisfaction in FY 2024.
- *Satisfaction with health care* for enrollees in Select was higher than the other two enrollment categories (Prime MTF PCM and Prime Network PCM) in FY 2023 and FY 2024.
- *Satisfaction with health care* for all beneficiaries was below the civilian benchmark during the past three years.



Source: DHA Chief Data and Analytics Office, HCSDB data, adjusted for age and health status, as of 11/18/2024
Notes:
– 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.
– *Satisfaction with Health Care* is assessed from HCSDB question: "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 all your health care in the last 12 months?" Response options are a scale of 0 = worst health care possible to 10 = best health care possible. The results provided above are for those beneficiaries who reported "8," "9," or "10."

The figure below shows beneficiary trends in *satisfaction with health care*, by beneficiary category.

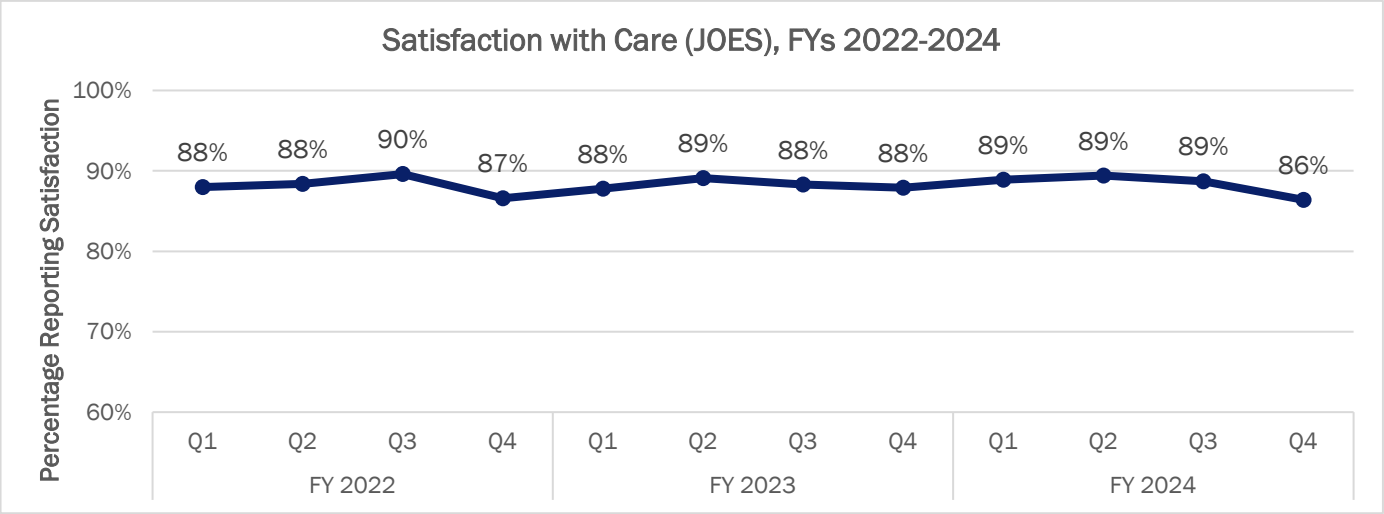
- *Satisfaction with the health care* for active duty was consistently lower than the other beneficiary categories for the past three years.
- All beneficiary categories indicated lower levels of *satisfaction with health care* than the civilian benchmark during FY 2022 through FY 2024.

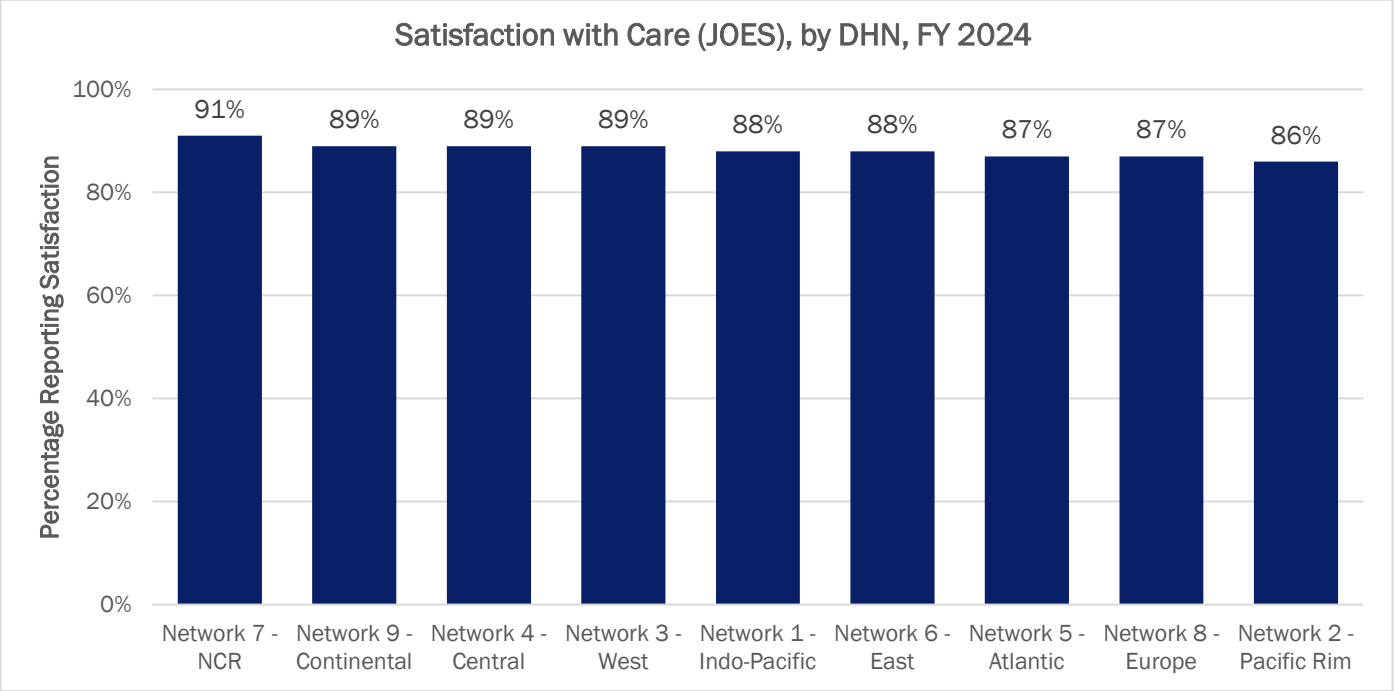


Source: DHA Chief Data and Analytics Office, HCSDB data, adjusted for age and health status, as of 11/18/2024
Notes:
– Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans.
– *Satisfaction with Health Care* is assessed from HCSDB question: "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 all your health care in the last 12 months?" Response options are a scale of 0 = worst health care possible to 10 = best health care possible. The results provided above are for those beneficiaries who reported "8," "9," or "10."

The below chart shows direct care *satisfaction with care* scores from the outpatient satisfaction survey (JOES) for FY 2022 through FY 2024. Quarterly *satisfaction with care* scores was relatively unchanged over the past three years, ranging from 86% to 90% satisfied.

Satisfaction with care is also shown by DHN for FY 2024. The DHN with the highest *satisfaction with care* is Network 7 National Capital Region (NCR) with 91% reporting *satisfaction with care*.



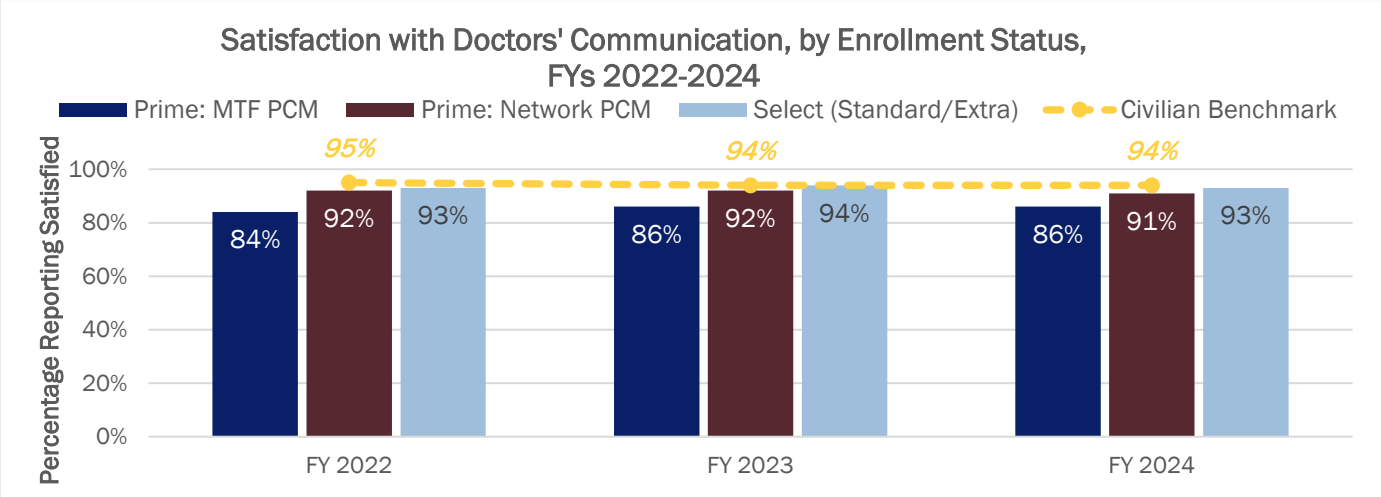


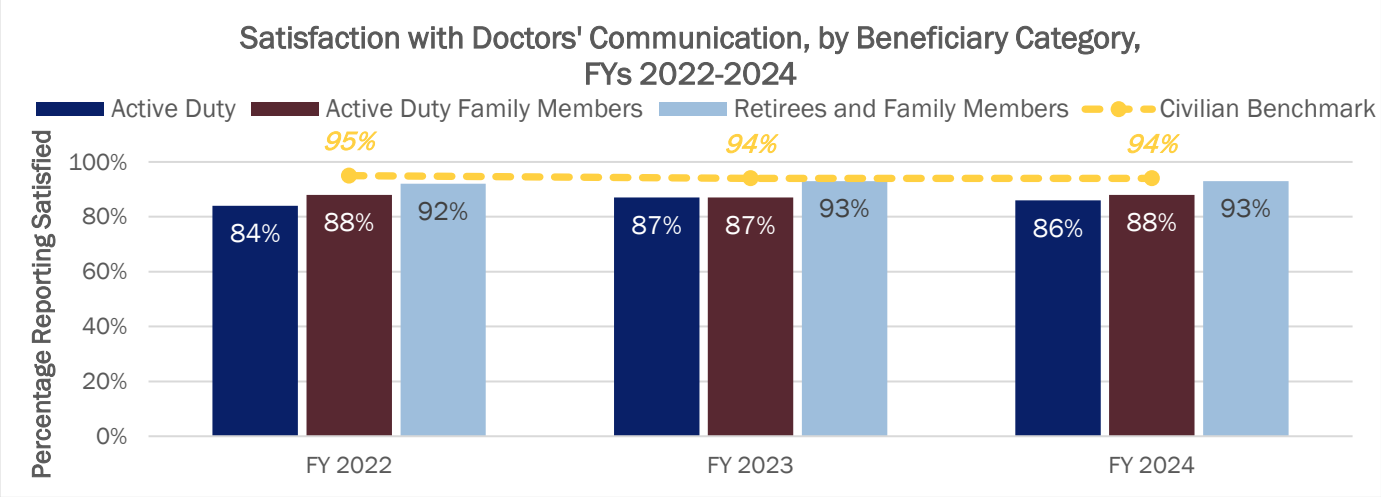
Source: DHA Chief Data and Analytics Office, JOES, weighted data, compiled 12/6/2024
Note: *Satisfaction with Care* is assessed by the JOES question: "Overall, I am satisfied with the healthcare I received on this visit." The five-point scale for this question ranges from "strongly disagree" to "strongly agree." The results provided above are for those beneficiaries who reported either "somewhat agree" or "strongly agree."

Beneficiary Rating of 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. Data are from the HCSDB.

- Between FY 2022 and FY 2024, *satisfaction with doctors' communication* remained relatively stable for each enrollment status category and was below the benchmark in FY 2024. *Satisfaction with doctors' communication* was lowest for Prime MTF PCM compared to other enrollment statuses.
- Retirees and their dependents indicated higher levels of *satisfaction with doctors' communication* than Active Duty and their dependents for FY 2022 through FY 2024. All beneficiary categories fell below the civilian benchmark.



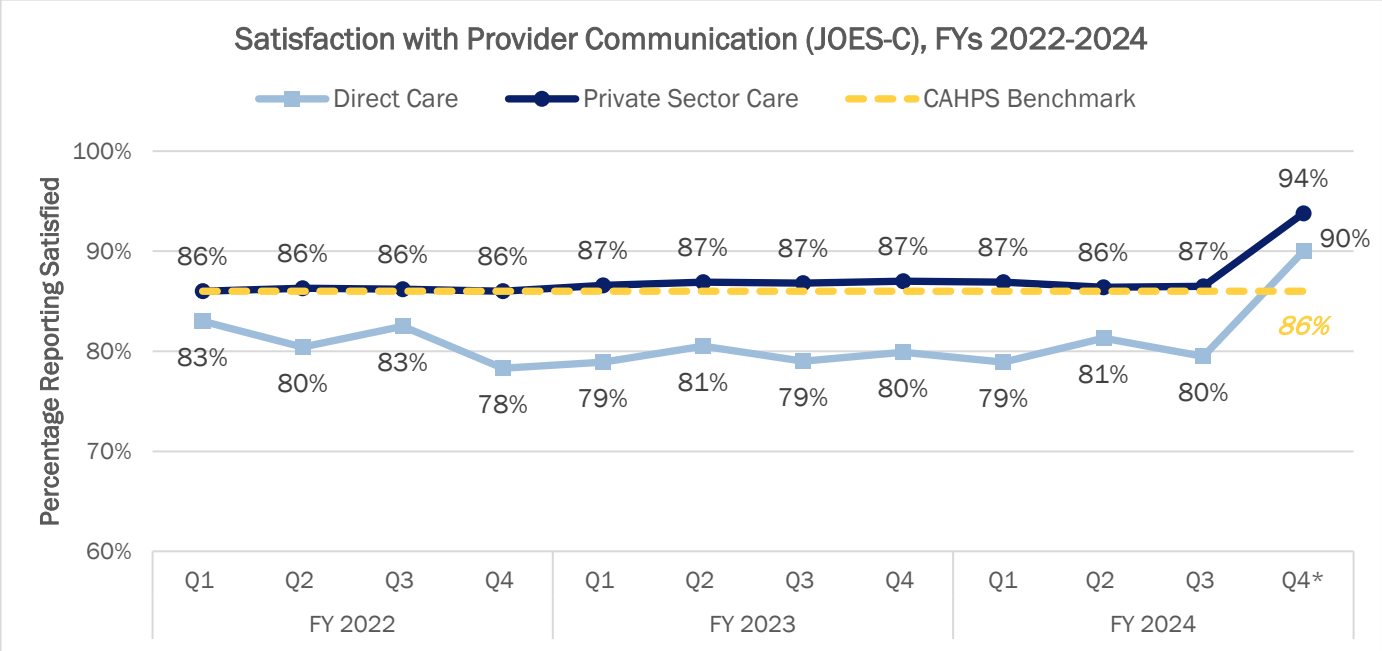


Source: DHA Chief Data and Analytics Office, HCSDB data, adjusted for age and health status, as of 11/18/2024
Notes:
– Rates are compared with the most recent benchmarks of the same CAHPS Health Plan adult survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 5.0. CAHPS results come from micro data submitted to the NCQA by commercial plans.
– *Satisfaction with Doctors' Communication* is assessed from HCSDB as a composite of four questions: "In the last 12 months, how often did your personal doctor: listen carefully to you, explain things in a way you could understand, show respect for what you had to say, and spend enough time with you?" Percent satisfied are those who indicated Always from options Never, Sometimes, Usually, and Always.

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.

Data below are from the outpatient survey JOES-C. Note DHA began administering the CAHPS version 4.0 in FY2024 Q4. This version of the survey changed from asking respondents about a six-month lookback to current appointment, which may explain the increase in scores for FY 2024 Q4 compared to the previous quarters.

- For FY 2022 to FY 2024, private sector care scores for *provider communication* were above scores for direct care.
- Also during the same time period, private sector care scores for *provider communication* were at or exceeded the benchmark, while direct care scores were below the benchmark.

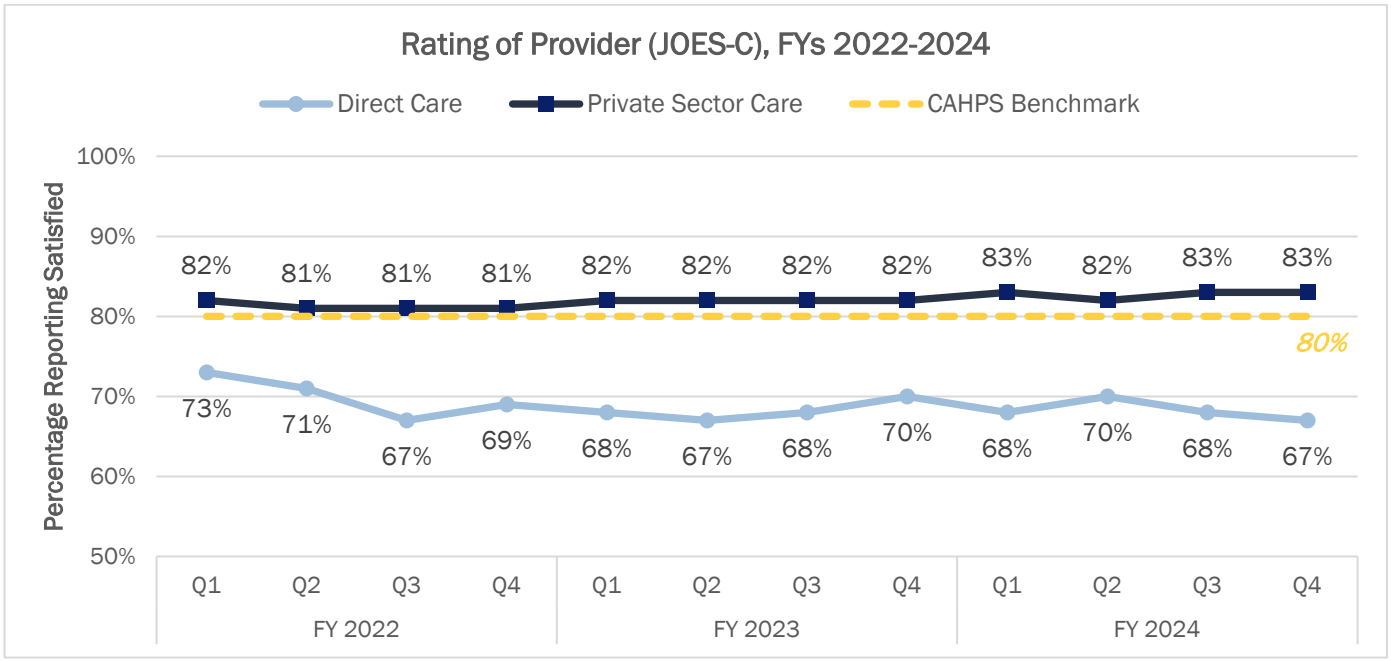


Source: DHA Chief Data and Analytics Office, JOES, weighted data, compiled 12/6/2024
Note: *Satisfaction with Provider Communication* is assessed by the JOES-C question: "In the last 6 months: did this provider explain things in a way that was easy to understand; did this provider listen carefully to you; did this provider show respect for what you had to say; did this provider spend enough time with you?" The results provided above are for those beneficiaries who reported either "Usually" or "Always" from response options Always, Usually, Sometimes, Never. Note the question stem changed from "in the last 6 months" to during your most recent visit" during FY 2024 Q4.

Beneficiary Rating of Provider

Similar to the above metric of provider communication, in the JOES-C, beneficiaries are asked to provide an *overall rating for their provider*. Note DHA began administering the CAHPS version 4.0 in FY2024 Q4. The equivalent question in FY 2024 Q4 rates the facility rather than the provider.

- *Rating of provider* scores from FY 2022 to FY 2024 remained relatively constant for JOES-C direct care, but were below the civilian CAHPS benchmark each year.
- *Rating of provider* scores for JOES-C private sector care have ranged from 81% to 83% over the last three years and were above the CAHPS benchmark of 80%.



Source: DHA Chief Data and Analytics Office, JOES, weighted data, compiled 4/11/2025
Note: *Rating of Provider* is assessed by the JOES-C question: "Using any number from 0 to 10, where 0 is the worst provider possible and 10 is the best provider possible, what number would you use to rate this provider?" The results provided above are for those beneficiaries who reported "9," or "10." As noted above, FY 2024 Q4 JOES-C equivalent question asks to rate the facility rather than the provider.

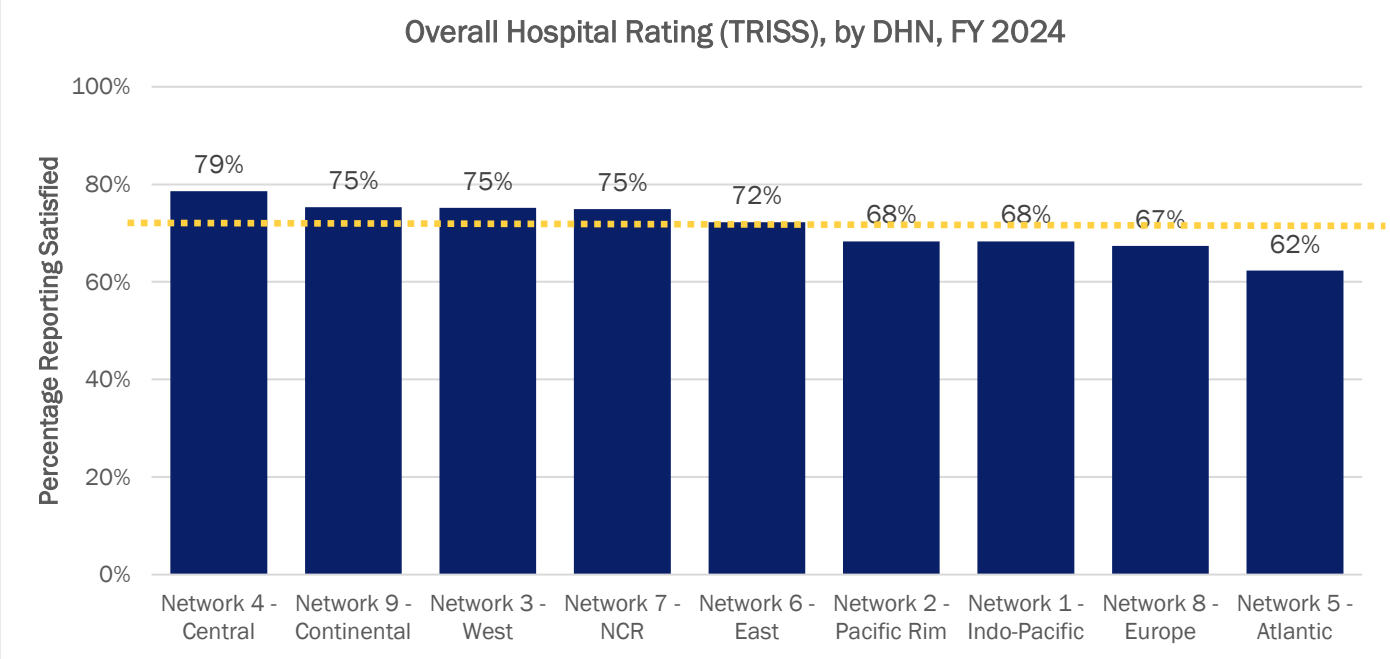
Beneficiary Rating of Inpatient Hospital Care

The purpose of the TRICARE Inpatient Satisfaction Survey (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 the Agency for Healthcare Research and Quality (AHRQ) and Centers for Medicare and Medicaid Services (CMS) for the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) initiative.

Comparison of TRISS 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 hospitals and across venues (i.e., direct MTF-based care and private sector care) including inpatient surgical, medical, and obstetric care. The TRISS continues to update and change as new HCAHPS requirements are tested and implemented, and these changes over time have resulted in more reliable measures and higher response rates.

The below chart shows *overall hospital rating* scores by DHN in FY 2024.

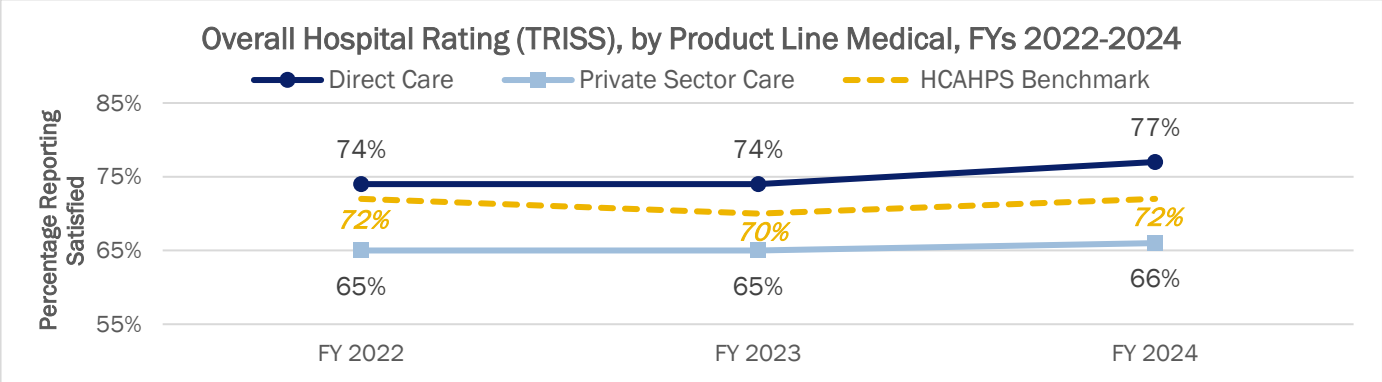
- The civilian HCAHPS benchmark is 72 percent, shown by the yellow dashed line.
- In FY 2024, five of the nine DHNs had scores at or above the benchmark for *overall hospital rating*.
- DHN 4 Central scored highest of the DHNs at 79 percent satisfaction with *overall hospital rating*.

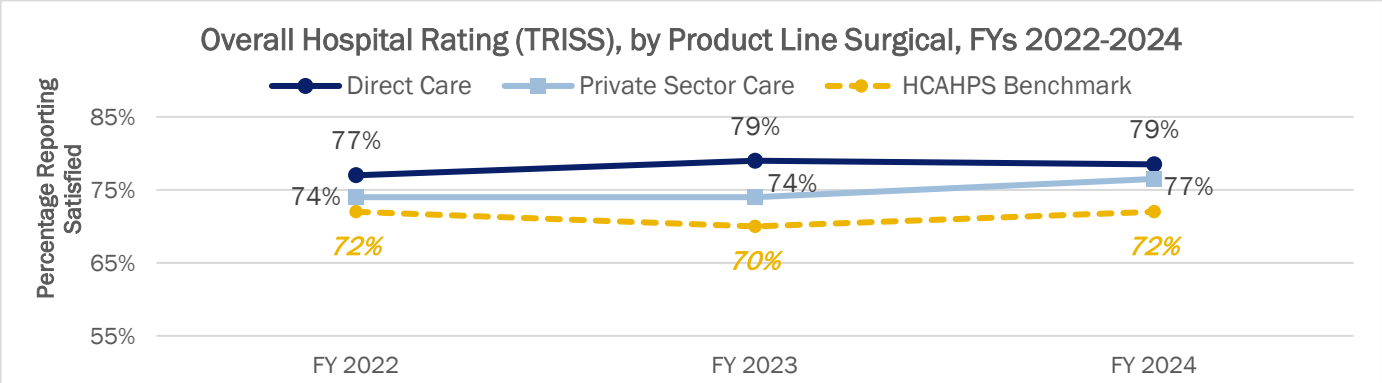


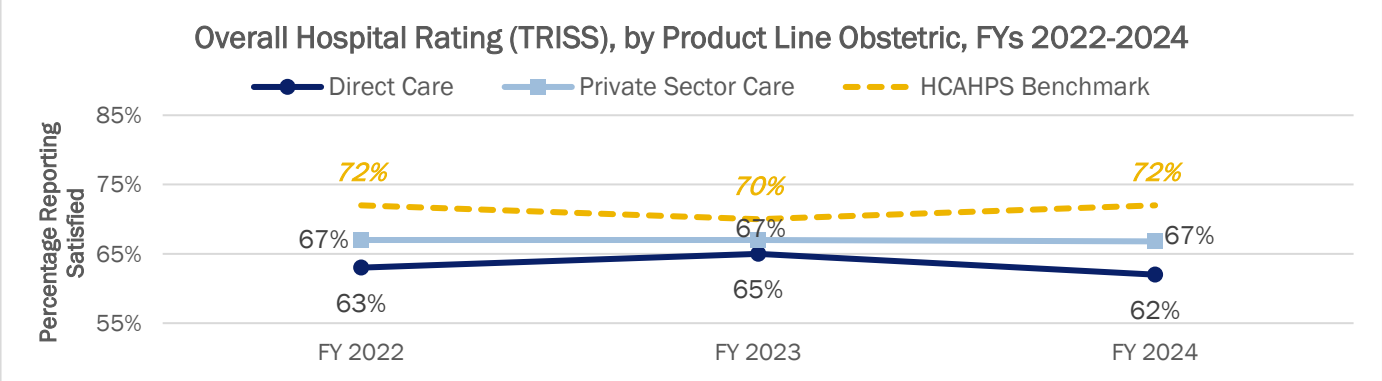
Source: DHA Chief Data and Analytics Office, TRISS, weighted data, compiled 7/15/2025
Note: *Overall hospital rating* is measured by the TRISS question "Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?" Scores are shown for those who indicated "9" or "10."

Below are trends for overall hospital rating by patient product line for direct care and private sector care.

- *Overall hospital rating* for medical direct care increased by three percentage points from FY 2022 to FY 2024 and was above the civilian benchmark.
- *Overall hospital rating* for surgical direct care and private sector care increased slightly and was above the civilian benchmark.
- Obstetric patients' *overall hospital rating* scores were below the civilian benchmark for the last three years and remained relatively unchanged.







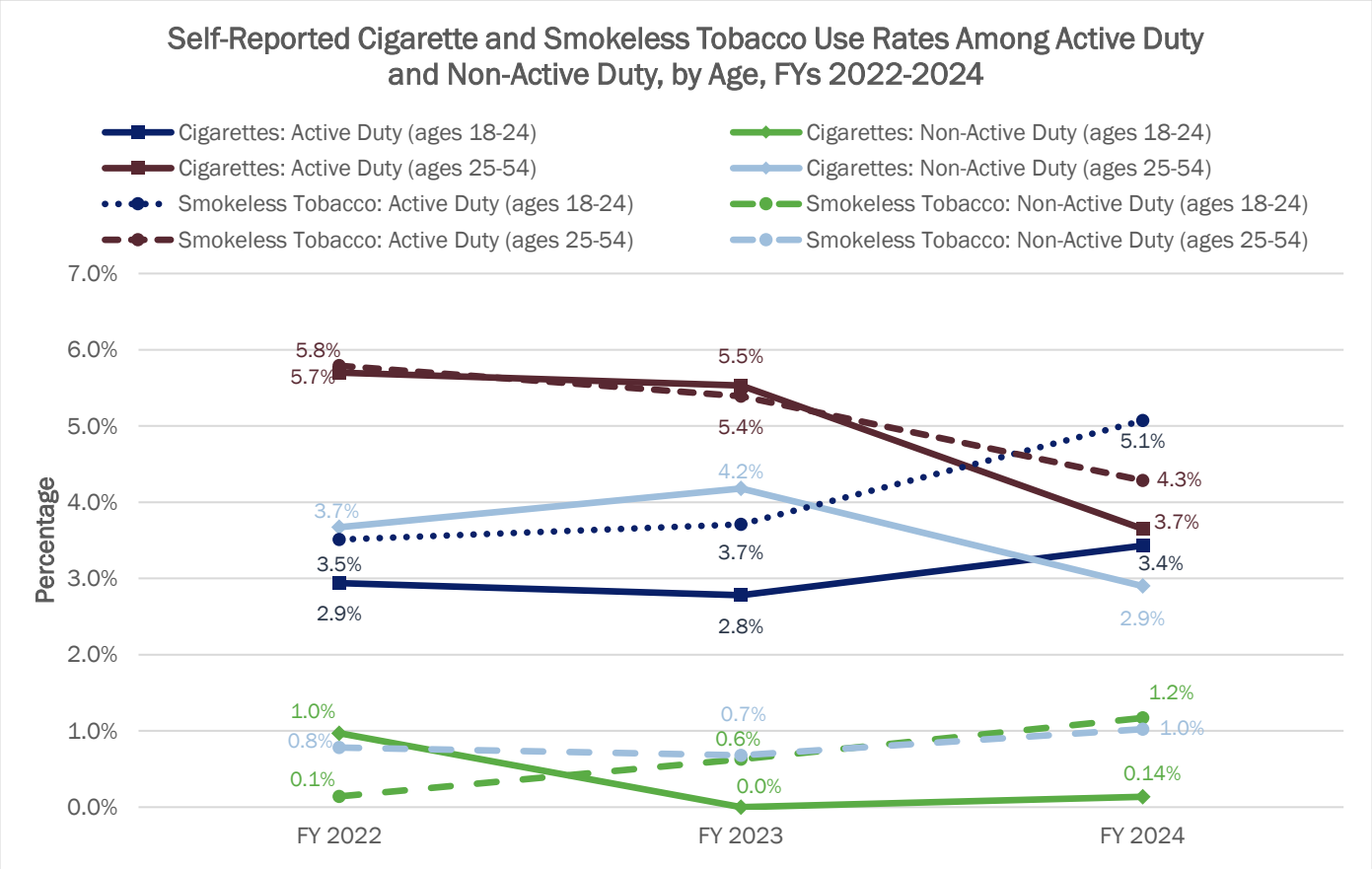
Source: DHA Chief Data and Analytics Office, TRISS, weighted data, compiled 7/15/2025
Note: *Overall hospital rating* is measured by the TRISS question "Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?" Scores are shown for those who indicated "9" or "10."

SELF-REPORTED HEALTH MEASURES

Tobacco Usage Rates

The HCSDB includes survey questions on various preventative health measures and health behaviors; one such measure is tobacco cessation. Tobacco continues to be the leading cause of preventable death, according to the Centers for Disease Control and Prevention (CDC). 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.

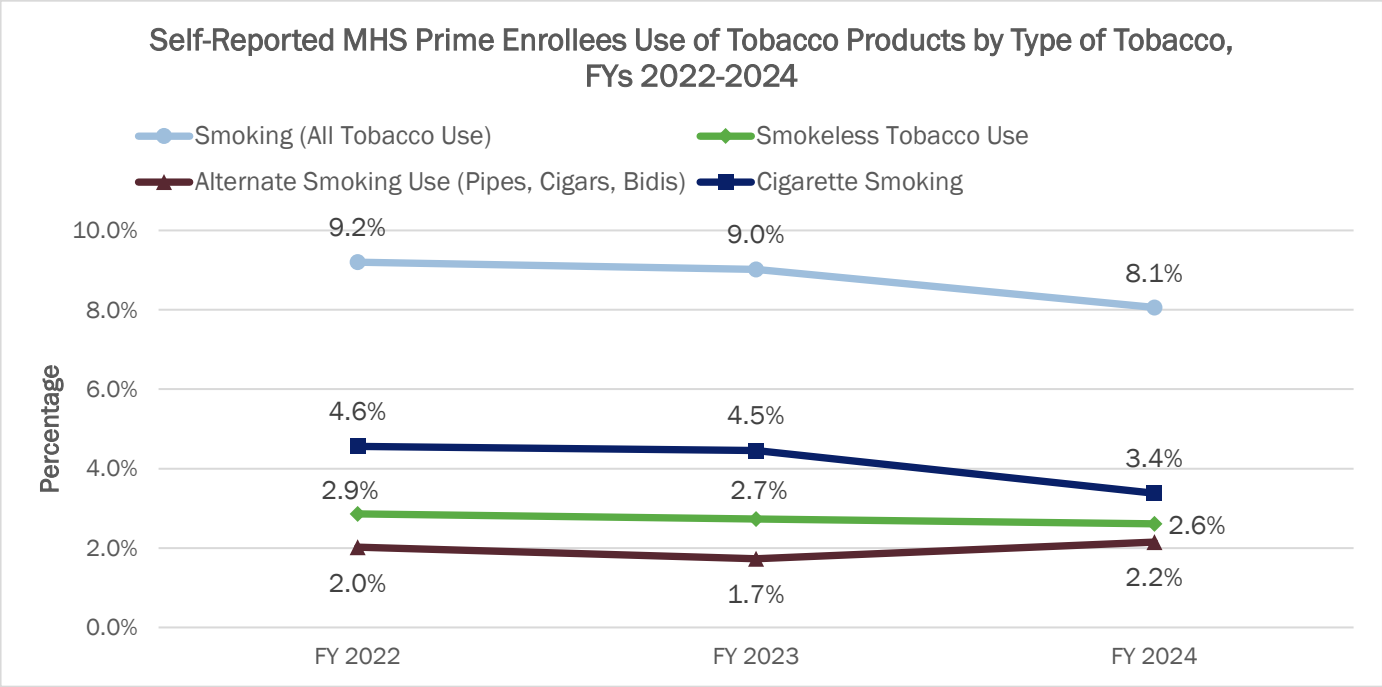
- Based on self-reported usage, cigarette smoking and smokeless tobacco use for active duty ages 25 or older years of age declined from FY 2022 to FY 2024. However, smokeless tobacco use for active duty 24 years of age or younger slightly increased during the last three years.



Source: DHA Chief Data and Analytics Office, HCSDB data, as of 11/18/2024
Note: 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.

In addition to cigarette smoking, the HCSDB assesses the use of various tobacco products across the MHS. The chart below shows the self-reported estimates of the prevalence of MHS Prime enrollees using different tobacco products (cigars, pipes, bidis, or kreteks).

- Prime enrollee use of tobacco in one form or another declined from 9.2 percent in FY 2022 to 8.1 percent in FY 2024.

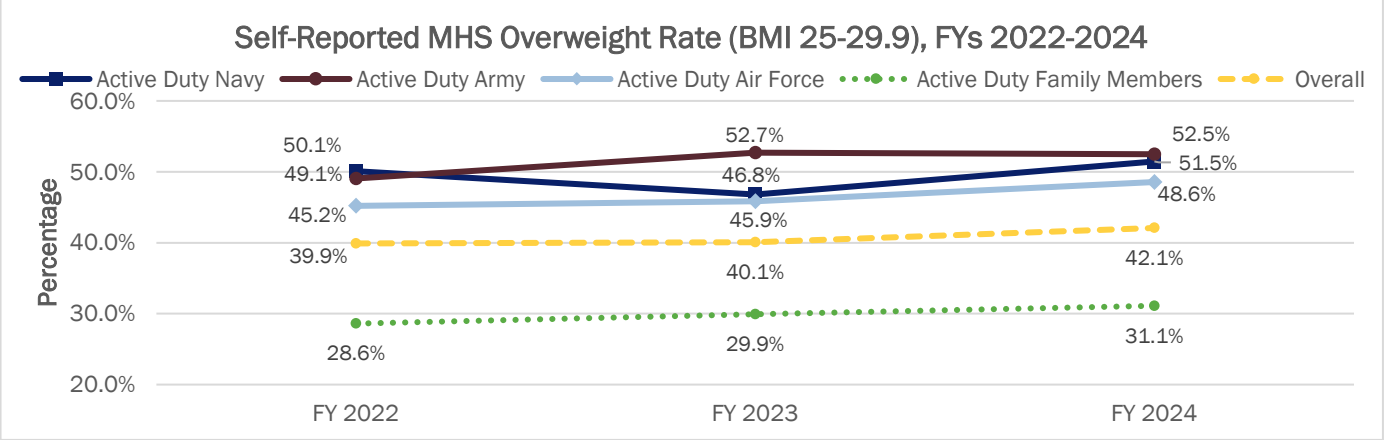


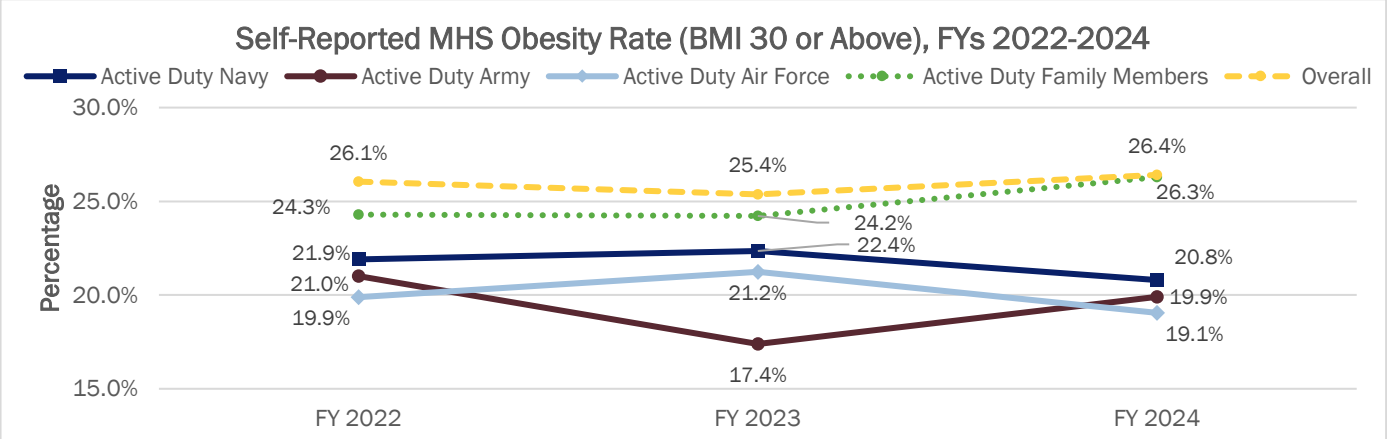
Source: DHA Chief Data and Analytics Office, HCSDB data, as of 11/18/2024
Notes:
- Percentages are weighted for the probability of selection and nonresponse; variation in quarterly estimates may not be significant and should not be assumed as such without appropriate tests of significance.
- Smokeless tobacco may include dip, snuff, snus, chew, etc., while alternate smoking tobacco may include cigars, pipes, hookahs, bidis, or kreteks.

MHS Adult Overweight and Obesity

The charts below display self-reported adult overweight and obesity rates from the HCSDB. Rates are calculated by the percentage of the population reporting on the survey a height and weight that, when used in calculating BMI, result in a measurement of 25-29.9 for overweight and 30 or above for obesity. Calculated BMI rates reflecting overweightness may not be reflective of Active Duty fitness without consideration of muscle mass and may explain why active duty appear to have high prevalence rates of being overweight but low obesity rates, as shown in the second chart. Note "Other" respondent categories are excluded from the graphics.

- Approximately 42 percent of all MHS beneficiaries were overweight in FY 2024 and 26 percent were considered obese.
- Self-reported scores for both overweight rate and obesity rate have remained relatively consistent over the last three years.





Source: DHA Chief Data and Analytics Office, HCSDB data, as of 11/18/2024
Notes:
"Other" survey respondent category is excluded from the graphic, which explain how Overall rates of Obesity are higher than the other categories of AD and Active Duty family members shown.

- 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/m2. Because the HCSDB collects height and weight in inches and pounds, BMI is calculated as lb/in2 x 703. A BMI of 18.5 to 25 may indicate optimal weight; a BMI lower than 18.5 suggests the person is underweight, while a number above 25 may indicate the person is overweight; a number of 30 or above suggests the person is obese (CDC).
- Since the data are self-reported, they are subject to recall bias, while provider measurements are subject to instrument error and inconsistency in recording. No objective validation tool is used to verify accuracy of BMI results.

UTILIZATION RATES

Inpatient Utilization Rates by Plan and Beneficiary Category

Average Annual Inpatient RWPs Per 1,000 Beneficiary, FYs 2022-2024

Plan	Beneficiary Category	FY	Direct Care (MTF)	Private Sector Care	Total	Percentage of Care Provided in Direct Care
Prime MTF PCM	Active Duty and Activated Guard/Reserve	2022	22	15	37	58.7%
		2023	19	16	35	53.8%
		2024	17	16	34	52.0%
	Active Duty Dependents and Activated Guard/Reserve Dependents	2022	24	45	69	34.7%
		2023	21	44	65	32.9%
		2024	21	43	65	33.3%
	Retirees, Dependents of Retirees, and Dependents of Survivors	2022	28	53	81	35.0%
		2023	24	53	78	31.4%
		2024	21	53	74	28.7%
Prime Network PCM	Active Duty Dependents and Activated Guard/Reserve Dependents	2022	6	42	48	12.1%
		2023	5	40	45	11.5%
		2024	5	40	45	11.5%
	Retirees, Dependents of Retirees, and Dependents of Survivors	2022	3	69	72	4.1%
		2023	3	67	70	4.0%
		2024	2	66	69	3.4%
Select	Active Duty Dependents and Activated Guard/Reserve Dependents	2022	4	62	65	5.9%
		2023	4	61	65	6.3%
		2024	4	59	63	6.3%
	Retirees, Dependents of Retirees, and Dependents of Survivors	2022	1	56	57	2.3%
		2023	1	54	55	2.0%
		2024	1	52	53	2.0%
TRICARE Plus	Retirees, Dependents of Retirees, and Dependents of Survivors	2022	121	190	311	39.0%
		2023	112	192	304	36.8%
		2024	109	196	305	35.7%
Medicare-TFL	Retirees, Dependents of Retirees, and Dependents of Survivors	2022	4	230	234	1.5%
		2023	3	234	238	1.4%
		2024	3	238	241	1.2%

Source: MHS administrative data, 5/1/2025
Note: Percentages are based on unrounded Direct Care/Private Sector Care counts whereas whole numbers (rounded) are presented in the table.

Outpatients Utilization Rates by Plan and Beneficiary Category

Average Annual Outpatient RVUs Per Beneficiary, FYs 2022-2024

Plan	Beneficiary Category	FY	Direct Care (MTF)	Private Sector Care	Total	Percentage of Care Provided in Direct Care
Prime MTF PCM	Active Duty and Activated Guard/Reserve	2022	26	11	37	69.9%
		2023	28	13	41	69.3%
		2024	32	13	46	70.8%
	Active Duty Dependents and Activated Guard/Reserve Dependents	2022	13	23	36	37.1%
		2023	14	24	38	38.0%
		2024	17	33	50	34.5%
	Retirees, Dependents of Retirees, and Dependents of Survivors	2022	15	28	42	34.5%
		2023	17	29	46	37.9%
		2024	20	32	52	38.9%
Prime Network PCM	Active Duty Dependents and Activated Guard/Reserve Dependents	2022	2	33	35	5.9%
		2023	2	34	36	6.4%
		2024	3	42	45	6.7%
	Retirees, Dependents of Retirees, and Dependents of Survivors	2022	1	43	44	1.9%
		2023	1	44	45	2.1%
		2024	1	47	48	2.4%
Select	Active Duty Dependents and Activated Guard/Reserve Dependents	2022	1	33	34	3.9%
		2023	2	35	36	4.4%
		2024	2	40	42	4.9%
	Retirees, Dependents of Retirees, and Dependents of Survivors	2022	0	33	33	1.0%
		2023	0	34	34	1.2%
		2024	0	36	37	1.3%
TRICARE Plus	Retirees, Dependents of Retirees, and Dependents of Survivors	2022	28	68	96	29.2%
		2023	33	73	105	31.0%
		2024	37	77	115	32.6%
Medicare-TFL	Retirees, Dependents of Retirees, and Dependents of Survivors	2022	0	85	86	0.5%
		2023	1	90	91	0.6%
		2024	1	95	96	0.7%

Source: MHS administrative data, 5/1/2025
Note: Percentages are based on unrounded Direct Care/Private Sector Care counts whereas whole numbers (rounded) are presented in the table.

Prescription Drug Utilization Rates

Average Annual Prescription Utilization Per Beneficiary, FYs 2022-2024

Plan	Beneficiary Category	FY	MTF	Retail	Mail Order	Total	Percent from MTF
Prime MTF PCM	Active Duty and Activated Guard/Reserve	2022	4.5	0.8	0.1	5.4	83.6%
		2023	4.3	0.9	0.1	5.4	80.9%
		2024	4.5	1.0	0.1	5.6	79.6%
	Active Duty Dependents and Activated Guard/Reserve Dependents	2022	3.2	1.5	0.1	4.8	66.3%
		2023	3.1	1.6	0.1	4.7	64.5%
		2024	3.2	1.6	0.1	4.9	65.3%
	Retirees, Retiree Dependents, Dependents of Survivors	2022	8.9	3.2	0.6	12.7	70.4%
		2023	8.2	3.2	0.6	12.0	68.0%
		2024	8.4	3.4	0.6	12.5	67.5%
Prime Network PCM	Active Duty Dependents and Activated Guard/Reserve Dependents	2022	0.7	3.5	0.3	4.5	15.5%
		2023	0.7	3.5	0.3	4.5	15.7%
		2024	0.8	3.5	0.3	4.6	17.8%
	Retirees, Retiree Dependents, Dependents of Survivors	2022	1.6	7.2	2.7	11.4	13.7%
		2023	1.5	7.0	2.6	11.0	13.3%
		2024	1.5	7.2	2.5	11.2	13.6%
Select	Active Duty Dependents and Activated Guard/Reserve Dependents	2022	0.3	3.4	0.3	4.1	8.5%
		2023	0.4	3.5	0.3	4.2	9.1%
		2024	0.4	3.6	0.3	4.3	10.0%
	Retirees, Retiree Dependents, Dependents of Survivors	2022	0.5	6.2	2.0	8.7	5.7%
		2023	0.5	6.0	1.9	8.4	5.6%
		2024	0.5	6.1	1.8	8.4	5.7%
TRICARE Plus MTF	Retirees, Retiree Dependents, Dependents of Survivors	2022	21.8	5.2	2.5	29.5	73.8%
		2023	20.7	5.4	2.4	28.6	72.6%
		2024	21.2	5.7	2.3	29.2	72.5%
Medicare-TFL	Retirees, Retiree Dependents, Dependents of Survivors	2022	3.7	10.5	8.9	23.0	16.0%
		2023	3.6	10.1	8.6	22.3	16.0%
		2024	3.6	10.5	8.2	22.3	16.4%

Source: MHS administrative data, 5/27/2025
Notes:
- Percentages are based on counts whereas whole numbers (rounded) are presented in the table.
- Data excludes the following beneficiary categories: Direct Care Only (Not Enrolled); TRS, TRR, TRP enrollees; foreign military; Inactive Guard/reserve

Leading Inpatient Diagnosis Groups

The table below displays leading inpatient diagnosis groups by care venue (PSC, DC, and TFL). Ranking by PSC, DC, and TFL are displaying in the right three columns. Cells with a dash indicate the diagnosis grouping was not in the top 24 for that care venue. Births were the leading inpatient diagnosis group in both DC and PSC in FY 2024.

Leading Inpatient Diagnosis Group, FY 2024

	Diagnosis Group	Private Sector Care (PSC)	Direct Care (DC)	TRICARE for Life (TFL)	PSC Rank	DC Rank	TFL Rank
PNL1	Liveborn	29,347	7,402	-	1	1	-
MUS11	Spondylopathies/spondyloarthropathy (including infective)	14,316	2,840	30,088	2	6	2
PRG29	Uncomplicated pregnancy, delivery or puerperium	9,758	2,676	-	3	7	-
SYM6	Abdominal pain and other digestive/abdomen signs and symptoms	8,434	5,578	13,820	4	2	13
INF2	Septicemia	7,658	1,262	33,828	5	21	1
SYM13	Respiratory signs and symptoms	5,495	3,869	27,544	6	4	3
MAL1	Cardiac and circulatory congenital anomalies	4,763	-	-	7	-	-
END9	Obesity	4,571	1,406	-	8	17	-
CIR9	Acute myocardial infarction	4,350	-	16,284	9	-	6
PRG20	Hypertension and hypertensive-related conditions complicating pregnancy; childbirth; and the puerper	4,326	1,913	-	10	11	-
PRG16	Previous C-section	4,070	1,367	-	11	19	-
CIR12	Nonspecific chest pain	3,894	2,306	14,543	12	9	10
PNL2	Short gestation; low birth weight; and fetal growth retardation	3,574	-	-	13	-	-
PRG23	Complications specified during childbirth	3,533	1,996	-	14	10	-
RSP12	Respiratory failure; insufficiency; arrest	3,506	-	9,103	15	-	18
CIR11	Coronary atherosclerosis and other heart disease	3,305	-	15,375	16	-	8
PRG22	Prolonged pregnancy	3,194	1,232	-	17	23	-
MUS10	Musculoskeletal pain, not low back pain	3,091	2,989	11,988	18	5	14
DIG17	Biliary tract disease	3,041	1,831	-	19	13	-
NVS9	Epilepsy; convulsions	3,035	-	-	20	-	-
SYM10	Nervous system signs and symptoms	2,854	1,832	15,530	21	12	7
NEO73	Benign neoplasms	2,615	-	-	22	-	-
INJ5	Fracture of the lower limb (except hip), initial encounter	2,444	1,757	-	23	14	-
MUS6	Osteoarthritis	2,381	2,651	9,545	24	8	17
CIR17	Cardiac dysrhythmias	-	-	23,230	-	-	4
CIR3	Nonrheumatic and unspecified valve disorders	-	-	17,677	-	-	5
INJ6	Fracture of the neck of the femur (hip), initial encounter	-	-	14,601	-	-	9
CIR19	Heart failure	-	-	14,182	-	-	11
SYM7	Malaise and fatigue	-	1,462	13,913	-	16	12
CIR20	Cerebral infarction	-	-	11,795	-	-	15
RSP2	Pneumonia (except that caused by tuberculosis)	-	-	9,775	-	-	16
DIG21	Gastrointestinal hemorrhage	-	-	7,840	-	-	19
GEN4	Urinary tract infections	-	-	7,817	-	-	20
INJ35	Complication of internal orthopedic device or implant, initial encounter	-	-	7,763	-	-	21
END11	Fluid and electrolyte disorders	-	-	6,985	-	-	22
GEN2	Acute and unspecified renal failure	-	-	6,574	-	-	23
SYM1	Syncope	-	-	6,248	-	-	24
MBD12	Suicidal ideation/attempt/intentional self-harm	-	5,032	-	-	3	-
INJ8	Traumatic brain injury (TBI); concussion, initial encounter	-	1,469	-	-	15	-
DIG9	Appendicitis and other appendiceal conditions	-	1,376	-	-	18	-
MBD7	Trauma- and stressor-related disorders	-	1,267	-	-	20	-
MBD17	Alcohol-related disorders	-	1,255	-	-	22	-
SKN1	Skin and subcutaneous tissue infections	-	1,208	-	-	24	-
PNL1	Liveborn	29,347	7,402	-	1	1	-
MUS11	Spondylopathies/spondyloarthropathy (including infective)	14,316	2,840	30,088	2	6	2
PRG29	Uncomplicated pregnancy, delivery or puerperium	9,758	2,676	-	3	7	-
SYM6	Abdominal pain and other digestive/abdomen signs and symptoms	8,434	5,578	13,820	4	2	13

Source: MHS administrative data, 4/18/2025. Data include overseas encounters.
Note: Cells with a dash indicates the diagnosis grouping was not in the top 24 for that care venue.

Leading Outpatient Diagnosis Groups

The table below displays leading outpatient diagnosis groups by care venue (PSC, DC, and TFL). Ranking by PSC, DC, and TFL are displaying in the right three columns. Cells with a dash indicate the diagnosis grouping was not in the top 24 for that care venue (PSC, DC, or TFL). Musculoskeletal diagnoses (MUS) were the top-most common conditions addressed of the combined diagnosis groups, closely followed by mental and behavioral health (MBD), and the factors influencing health (FAC). FAC include well baby visits, routine pregnancy visits, vaccinations and physicals. The top diagnosis group for FY 2022 through FY 2024 was MUS010: musculoskeletal pain, not low back pain. Some groups are primarily one population: eye (cataracts, retinal conditions and glaucoma) and circulatory (hypertension, heart disease) are primarily TFL.

Leading Outpatient Diagnosis Group, FY 2024

	Diagnosis Group	Private Sector Care (PSC)	Direct Care (DC)	TRICARE for Life (TFL)	PSC Rank	DC Rank	TFL Rank
FAC14	Medical examination/evaluation	11,730,434	6,323,333	3,499,193	1	2	12
MUS10	Musculoskeletal pain, not low back pain	9,544,706	7,423,202	8,420,375	2	1	2
MBD14	Neurodevelopmental disorders	9,446,941	1,063,563	-	3	17	-
MBD7	Trauma- and stressor-related disorders	8,333,094	2,617,637		4	3	-
MUS11	Spondylopathies/spondyloarthropathy (including infective)	7,320,661	1,658,839	10,837,036	5	8	1
MBD5	Anxiety and fear-related disorders	6,558,999	1,415,072	-	6	12	-
MBD2	Depressive disorders	6,539,128	1,161,357	-	7	14	-
RSP6	Other specified upper respiratory infections	3,795,451	1,691,927	-	8	6	-
FAC8	Neoplasm-related encounters	3,728,874	-	-	9	-	-
RSP7	Other specified and unspecified upper respiratory disease	3,097,948	-	-	10	-	-
NVS16	Sleep wake disorders	3,019,847	940,604	2,522,421	11	19	21
SYM6	Abdominal pain & other digestive/abdomen signs & symptoms	2,996,116	1,472,612	-	12	11	-
PRG29	Uncomplicated pregnancy, delivery or puerperium	2,904,124	-	-	13	-	-
SYM16	Other general signs and symptoms	2,683,631	-	-	14	-	-
FAC16	Exposure, encounters, screening or contact with infectious disease	2,492,827	1,581,205	-	15	9	-
SYM13	Respiratory signs and symptoms	2,338,778	1,199,057	2,917,788	16	13	18
MUS38	Low back pain	2,246,580	1,921,504	2,491,667	17	4	22
NEO73	Benign neoplasms	2,232,397	-	2,794,632	18	-	19
SKN7	Other specified and unspecified skin disorders	2,181,778	993,338	4,541,983	19	18	8
INJ24	Sprains and strains, initial encounter	2,074,580	850,743	-	20	20	-
MUS6	Osteoarthritis	2,004,863	-	7,557,718	21	-	3
SKN2	Other specified inflammatory condition of skin	1,976,126	-	-	22	-	-
SYM17	Abnormal findings without diagnosis	1,895,346	-	3,202,600	23	-	13
MUS9	Tendon and synovial disorders	1,759,404	-		24	-	-
EYE2	Cataract and other lens disorders	-	-	5,917,340	-	-	4
CIR7	Essential hypertension	-	-	5,516,514	-	-	5
SYM10	Nervous system signs and symptoms	-	-	4,669,367	-	-	6
CIR17	Cardiac dysrhythmias	-	-	4,625,534	-	-	7
CIR11	Coronary atherosclerosis and other heart disease	-	-	4,198,192	-	-	9
END3	Diabetes mellitus with complication	-	-	4,192,828	-	-	10
EYE5	Retinal and vitreous conditions	-	-	3,628,569	-	-	11
FAC6	Encounter for antineoplastic therapies	-	-	3,106,267	-	-	14
GEN3	Chronic kidney disease	-	-	3,094,129	-	-	15
NEO26	Skin cancers - basal cell carcinoma	-	-	2,976,600	-	-	16
MUS26	Muscle disorders	-	-	2,942,640	-	-	17
NEO39	Male reproductive system cancers - prostate	-	-	2,643,135	-	-	20
NEO27	Skin cancers - squamous cell carcinoma	-	-	2,364,889	-	-	23
EYE3	Glaucoma	-	-	2,333,616	-	-	24
EYE9	Refractive error	-	1,790,039	-	-	5	-
FAC1	Encounter for administrative purposes	-	1,680,442	-	-	7	-
FAC10	Other aftercare encounter	-	1,576,132	-	-	10	-
NVS10	Headache; including migraine	-	1,097,326	-	-	15	-
MBD17	Alcohol-related disorders	-	1,079,885	-	-	16	-
FAC25	Other specified status	-	849,644	-	-	21	-
FAC19	Socioeconomic/psychosocial factors	-	844,003	-	-	22	-
FAC12	Other specified encounters and counseling	-	804,276	-	-	23	-
CIR12	Nonspecific chest pain	-	738,362	-	-	24	-

Source: MHS administrative data, 4/18/2025. Data include overseas encounters.
Note: Cells with a dash indicates the diagnosis grouping was not in the top 24 for that care venue.

DRUG COST TRENDS

The DoD and VA continued to maximize efficiencies through joint efforts when possible. There were 172 contracts active at the end of FY 2024. In FY 2024, DoD accumulated $269 million in cost-avoidance on joint national contract purchases for specialty and traditional pharmaceutical agents.

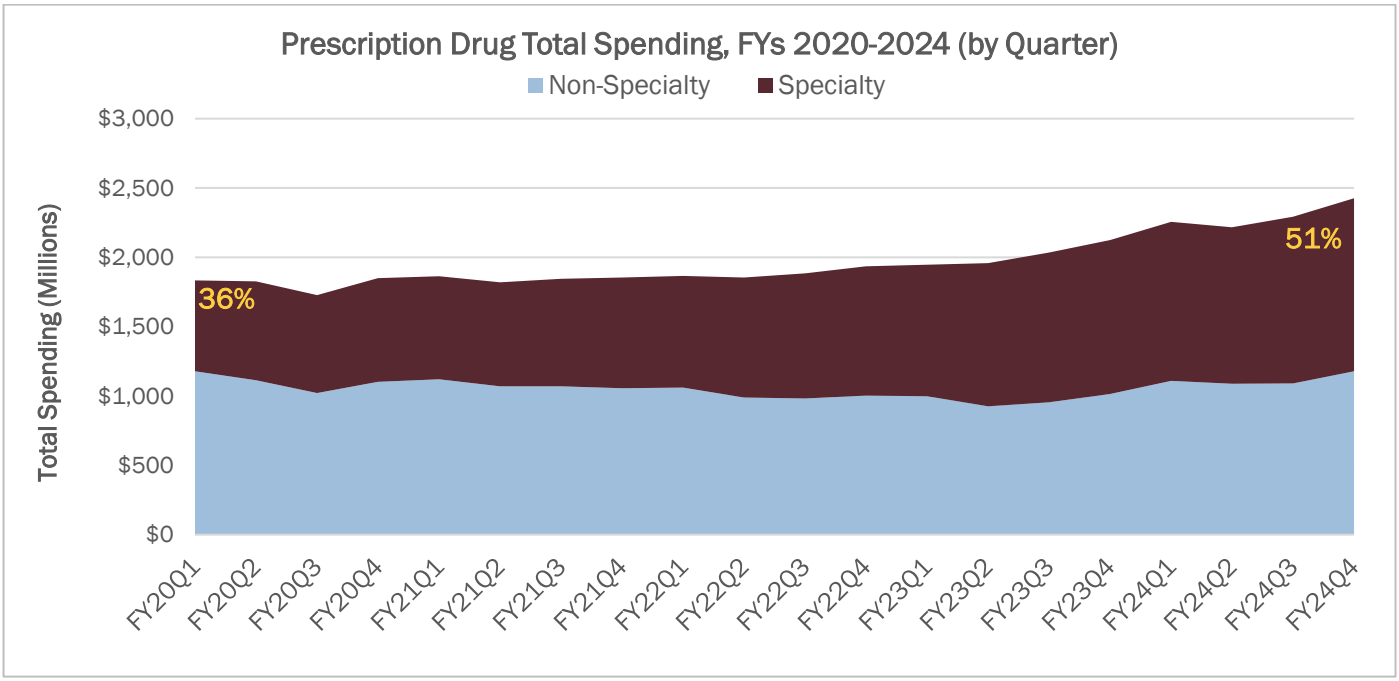
Specialty drugs are prescription medications that often require special handling, administration, or monitoring. Although the cost of specialty drugs is high, some represent significant advances in therapy and may be offset by decreases in future medical costs.

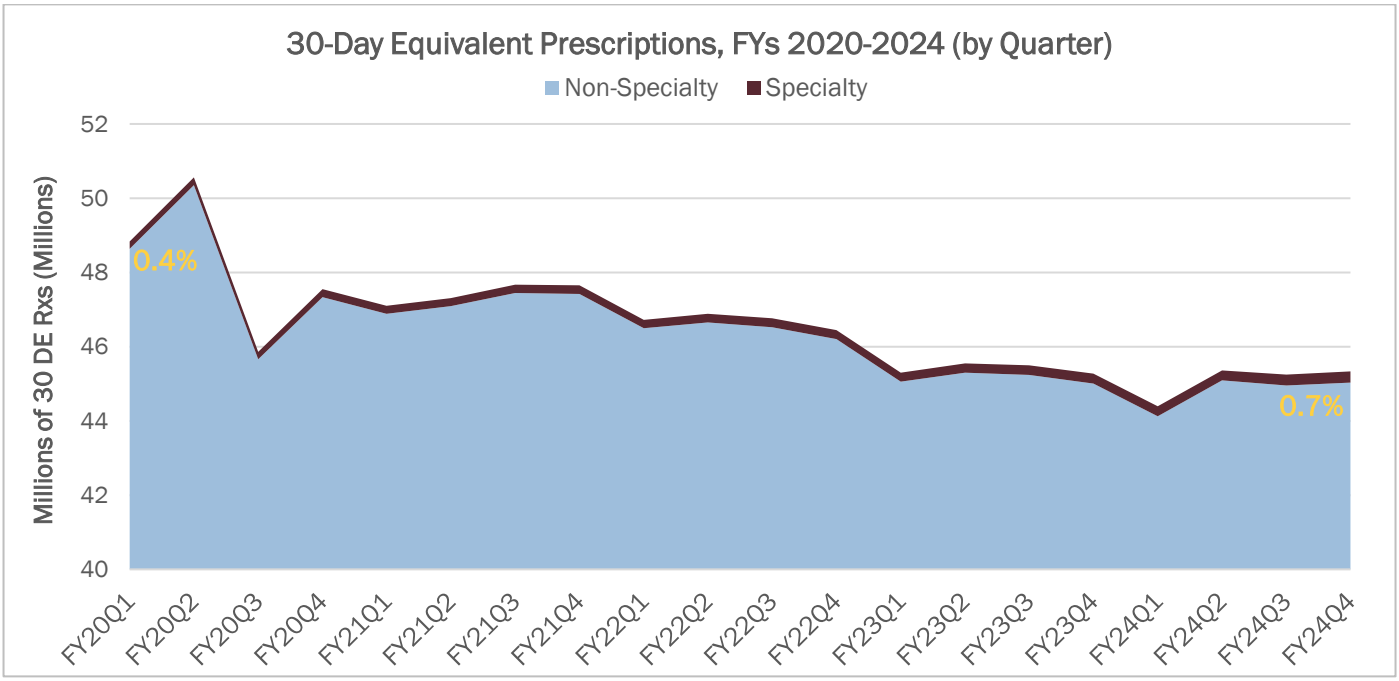
Although the definition of a specialty drug varies across insurers, the DoD has adopted the following guidelines in order to designate a medication as a specialty drug: 1) one or more of the following clinical factors: difficult to administer, special handling or storage, intense monitoring, high risk 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% 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, targeted immunomodulatory biologics (TIBs), atopy agents (asthma/atopic dermatitis), pulmonary arterial hypertension agents, and miscellaneous neurological 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 and orphan disease agents being introduced to the market.

- In FY 2024, specialty drugs accounted for less than 1 percent of total MHS prescription drug volume (in 30-day equivalent prescriptions), but for 51% percent of total spending.
- As a percentage of total drug costs, specialty drug costs continued to increase from FY 2013 (not shown) to FY 2023, with the percentage slightly decreasing in FY 2024 compared to FY 2023. A large proportion of specialty spend continues to come from retail prescriptions, reflecting limited distribution networks established by manufacturers for many of these agents that prevent availability at mail order and MTFs, generally lower cost points of service. However, FY 2024 saw a substantial increase in the percentage of specialty prescriptions filled at lower government prices (primarily at mail order) as a result of the March 2024 addition of a specialty pharmacy as a part of the TRICARE Mail Order Pharmacy. This lowers costs for patients due to lower copayments at mail order. As of the last quarter of FY 2024, retail pharmacies accounted for 41 percent of total specialty spend and 19 percent of volume, down from 65 percent of spend and 39 precent of volume in FY 2024 Quarter 1.
- The highest spend specialty drugs were the oncological agents. All oncological agents combined accounted for about $1.6B in drug spend in FY 2024, up from $1.5B in FY 2023 and $1.3B in FY 2022. The targeted immunomodulatory biologics (primarily self-administered injectables for the treatment of rheumatoid arthritis, psoriasis, Crohn's disease, and other autoimmune disorders) accounted for an additional $1.0B in FY 2024, followed by the atopy agents (including medications for atopic dermatitis and/or asthma), at $0.5B.
- The P&T Committee mission is to uniformly, consistently, and equitably provide appropriate drug therapy to meet the clinical needs of DoD beneficiaries in an effective, efficient, and fiscally responsible manner.
- In order to ensure cost-effective availability of pharmaceutical agents in a complete range of therapeutic classes, the physician-led DoD P&T Committee performs relative clinical and relative cost effectiveness reviews of both specialty and non-specialty drug classes and all drugs newly approved by the U.S. Food and Drug Administration (FDA) and recommends formulary status and use of formulary management tools to support appropriate use. DoD P&T Committee reviews also include a bid price negotiation process that

allows manufacturers to partner with DoD to provide the best value to the benefit. As part of ongoing utilization management, the DoD P&T Committee also continuously monitors for new evidence, new indications, changes to clinical practice guidelines, generic and biosimilar approvals, and other factors affecting availability, place in therapy, and relative value of currently existing drugs.





Source: Pharmacy Operations Division, 6/12/2025, 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.

NOTE: Percentage Specialty excludes compounds, paper claims, and OHI.

TRICARE PROGRAM AND BENEFITS EVOLUTION OVER THE YEARS

2024

- Started follow-on TRICARE contracts:
  - TRICARE Medicare Eligible Program (TMEP) by Wisconsin Physicians Service Insurance Corp
  - TRICARE Dental Program (TDP) by United Concordia Companies Inc
  - TRICARE home delivery of specialty meds by Accredo® specialty pharmacy services
- Authorized TRICARE contractors to reinstate (restore) health plan enrollment at beneficiary request beyond 90 days of last paid-through date due to disenrollment because of catastrophic cap recalculation
- Extended coverage of hearing aids to children of retired Service members
- Expanded coverage of Assisted Reproductive Technology (ART) for Service members with qualifying condition including embryo cryopreservation and storage
- Added coverage of fetal surgery: open, fetoscopic, and other minimally invasive fetal surgery for myelomeningocele (MMC), under certain qualifying conditions
- Added coverage of automatic blood pressure monitors for patients receiving covered Remote Physiologic Monitoring services, for medically necessary self-measured blood pressure monitoring
- Ended provisional coverage Platelet-Rich Plasma for Major Joint Treatment and Rehabilitation

2023

- Eliminated cost sharing for female tubal sterilization as a preventive care
- Added coverage for preconception and prenatal carrier screening
- Began cost sharing for breastfeeding supplies
- Extended the Laboratory Developed Test Demonstration through July 18, 2028

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

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

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–sponsored clinical trials
  - Increased certain hospital payments by 20 percent

2020 Continued

- 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

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

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 members in receipt of 12304b orders for pre-planned missions under Title 10

2017

- Initial deployment of MHS GENESIS to four MTFs and their child sites

2010s

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

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)

2010s

2014

- Reinstated Prime eligibility for some beneficiaries
- Launched Laboratory-Developed Test demonstration—authority to determine whether tests not yet approved by the FDA are safe and effective for use and thus eligible for TRICARE coverage
- Expanded TRICARE coverage to single-level cervical total disc replacement
- Increased access to TRICARE mental health counselors
- Expanded available treatments for substance abuse
- Began TFL Pharmacy Pilot, requiring TFL beneficiaries living in the U.S. and the U.S. territories to fill select maintenance medications through TRICARE Pharmacy Home Delivery or at a military pharmacy
- Extended the TRICARE Over-the-Counter demonstration, which permits beneficiaries to fill prescriptions for certain OTC drugs, from network pharmacies and through home delivery for free
- Added Certified Mental Health Counselors as authorized TRICARE providers
- Eliminated day limits for inpatient mental health stays
- Closed U.S.-based TRICARE Service Centers
- Expanded breast pump (and supplies) coverage to all TRICARE beneficiaries
- Expanded TRICARE coverage to same-sex spouses and their family members
- Clarified the Unfortunate Sequelae policy, ensuring that treatment of complications or
- medically necessary follow-on care that occurs subsequent to noncovered initial surgery/treatment at an MTF is covered

2013

- Reduction in Prime service areas (PSAs; closed all those not built around an MTF or BRAC site)
- TRS termination date delayed 180 days for Selected Reserve members involuntarily separated under honorable conditions (expired in 2018 by law)
- Expanded Autism Care Demonstration to include retiree family members
- Restricted Uniformed Services Family Health Plan (USFHP) enrollment to beneficiaries (65 years and younger)
- Permanent authority to include certain OTC drugs under Uniform Formulary based on P&T recommendation
- Modified Over-the-Counter Demonstration project to include Plan B One-Step (levonorgestrel) without prescription requirement
- Added coverage for abortions for rape or incest and brought coverage into conformance with existing federal statutory laws, including the Hyde Amendment, the Affordable Care Act, and President's Executive Order #13535
- Added coverage of hippotherapy under ECHO (horseback riding as a therapeutic or rehabilitative treatment)
- Defense Health Agency (DHA) became initially operational under authority of the Assistant Secretary of Defense for Health Affairs (ASD[HA]) and designated as a Combat Support Agency with oversight from the Chairman of the Joint Chiefs

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, 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

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

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

2009

- Started Active Duty Dental Program (ADDP)
- Eased the potential burden on families with special needs by increasing the ECHO cap to $36,000 per year for certain services
- Increased access to care by expanding TAMP:
  - Separated Active Duty members who affiliate with the Selected Reserve
  - Members in receipt of a sole survivorship discharge
- Improved beneficiary access to behavioral health care by allowing a streamlined certification for Hospital-Based Psychiatric Partial Hospitalization Programs
- Established TRICARE Pharmacy manufacturer refunds (retroactive to January 2008)
- Implemented Outpatient Prospective Payment System
- Improved beneficiary access to vaccines by expanding coverage under pharmacy benefit for H1N1 at retail pharmacies at zero copayment

2010s

2008

- 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 retiree combat-related disability travel and transitional care for service-related conditions first identified during TAMP for RC members
- 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

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

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

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

2004

- Expanded Transitional Assistance Management Program (TAMP) coverage temporarily to 180 days for all participants (made permanent in 2005)
- Began early eligibility for RC members activated for more than 30 days in support of a contingency operation (made permanent in 2005)
- Consolidated managed care support contracts and 11 TRICARE Regions to three (North, South, and West) care

2000s

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

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

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, combined liver-kidney transplants, and 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; made permanent in 2008)
- Deployed PDTS—improving patient safety—an online, real-time worldwide prospective drug utilization review (clinical screening) against 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

2000s

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

2000s