Department of Defense
INSTRUCTION

NUMBER 6000.14
September 26, 2011
Incorporating Change 2, Effective April 3, 2020

USD(P&R)

SUBJECT: DoD Patient Bill of Rights and Responsibilities in the Military Health System (MHS)

References: See Enclosure 1

1. PURPOSE. In accordance with the authority in DoD Directive 5124.02 (Reference (a)), this Instruction:

a. Reissues DoD Instruction (DoDI) 6000.14 (Reference (b)) to establish policy, assign responsibilities, and provide procedures for implementation of the Consumer Bill of Rights and Responsibilities (commonly referred to as the "Patient's Bill of Rights") (Reference (c)).

b. Incorporates and cancels Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)) policy 98-010 (Reference (d)).

2. APPLICABILITY. This Instruction applies to the OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD (hereinafter referred to collectively as the "DoD Components").

3. DEFINITIONS. See Glossary.

4. POLICY. It is DoD policy that:

a. MHS patients have explicit rights about information disclosure; choice of providers; health plans; access to emergency services; participation in treatment decisions; respect and nondiscrimination; privacy and security of personally identifiable information (PII), complaints, and appeals; as well as specific responsibilities to participate in their own health decisions.

b. This Instruction does NOT expand the scope of benefits or create any entitlement inconsistent with chapter 55 of title 10, United States Code (U.S.C.) (Reference (e)); part 199 of title 32, Code of Federal Regulations (CFR) (Reference (f)); or other applicable law or regulation. Additionally, deviation from the guidelines in this Instruction does not result in a legal cause of action. Failure of a patient to adhere to the responsibilities listed in Enclosure 2 will not by itself result in a loss of benefits or other adverse action.

5. RESPONSIBILITIES

a. Assistant Secretary of Defense for Health Affairs (ASD(HA)). The ASD(HA), under the authority, direction, and control of the Under Secretary of Defense for Personnel and Readiness (USD(P&R)), shall exercise oversight to ensure standardization of the Patient's Bill of Rights (see Enclosure 2) and compliance with this Instruction.

b. Director, Defense Health Agency (DHA). The Director, DHA, under the authority, direction, and control of the USD(P&R), through the ASD(HA), shall serve as the program manager for TRICARE health and medical resources, supervising and administering TRICARE programs and other resources within the DoD.

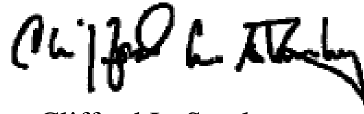
c. Secretaries of the Military Departments. The Secretaries of the Military Departments shall oversee Service compliance with this Instruction through the Surgeons General of the Military Departments and military treatment facility and dental treatment facility (MTF/DTF) commanders.

6. PROCEDURES. Procedures and compliance guidelines are contained in Enclosure 3.

7. RELEASABILITY. UNLIMITED. This Instruction is approved for public release and is available on the Directives Division Website at https://www.esd.whs.mil/DD/.

8. SUMMARY OF CHANGE 2. The change to this issuance updates references and removes expiration language in accordance with current Chief Management Officer of the Department of Defense direction.

9. EFFECTIVE DATE. This Instruction is effective September 26, 2011.



Clifford L. Stanley
Under Secretary of Defense for
Personnel and Readiness

Enclosures
1. References
2. DoD Patient Bill of Rights and Responsibilities
3. Procedures and Compliance Guidelines

Glossary

ENCLOSURE 1

REFERENCES

(a) DoD Directive 5124.02, "Under Secretary of Defense for Personnel and Readiness USD(P&R))", June 23, 2008
(b) DoD Instruction 6000.14, "Patient Bill of Rights and Responsibilities in the Military Health System (MHS)," September 5, 2007 (hereby cancelled)
(c) President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, "Consumer Bill of Rights and Responsibilities," November 1997
(d) Office of the Assistant Secretary of Defense for Health Affairs Policy 98-010, "Policy for Improving Access and Quality in the Military System," January 8, 1998 (hereby cancelled)
(e) Chapters 47[1] and 55 of title 10, United States Code
(f) Part 199 of title 32, Code of Federal Regulations
(g) DoD 5400.11-R, "Department of Defense Privacy Program," May 14, 2007
(h) Public Law 104-191, "Health Insurance Portability and Accountability Act of 1996," August 21, 1996
(i) Section 552a of title 5, United States Code
(j) Executive Order 13410, "Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs," August 22, 2006
(k) Joint Commission Accreditation Manual for Hospitals, current edition[2]
(l) Parts 160 and 164 of title 45, Code of Federal Regulations (also known as the "HIPAA Privacy, Security and Breach Rules")
(m) DoD Manual 6025.18, "Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DOD Health Care Programs," March 13, 2019
(n) DoD Medical Management Guide, January 2009[3]
(o) DoD Instruction 8500.01, "Cybersecurity," March 14, 2014, as amended
(p) DoD Instruction 5025.01, "DoD Issuances Program," August 1, 2016, as amended

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[1] Chapter 47 of title 10 is also known as "The Uniform Code of Military Justice."
2 http://www.jointcommission.org/accreditation/accreditation_main.aspx
[3] http://www.tricare.mil/ocmo/download/MMG_v3_2009.pdf

ENCLOSURE 2

DOD PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

1. PATIENT RIGHTS

a. Medical Care. Patients have the right to quality care and treatment that is consistent with available resources and generally accepted standards, including access to specialty care and to pain assessment and management.

b. Respectful Treatment. Patients have the right to considerate and respectful care, with recognition of personal dignity, psychosocial, spiritual, and cultural values and belief systems.

c. Privacy and Security. Patients have rights, defined by Federal law, DOD 5400.11-R (Reference (g)), Public Law 104-191 (Reference (h)), and section 552a of title 5 U.S.C. (also known as "The Privacy Act of 1974, as amended") (Reference (i)), to reasonable safeguards for the confidentiality, integrity, and availability of their protected health information, and similar rights for other PII, in electronic, written, and spoken form. These rights include the right to be informed when breaches of privacy occur, to the extent required by Federal law.

d. Provider Information. Patients have the right to receive information about the individual(s) responsible for, as well as those providing, his or her care, treatment, and services. The hospital may inform the patient of the names, and as requested, the professional credentials of the individual(s) with primary responsibility for, as well as those providing, his or her care, treatment, and services.

e. Explanation of Care. Patients have the right to an explanation concerning their diagnosis, treatment, procedures, and prognosis of illness in terms that are easily understood. The specific needs of vulnerable populations in the development of the patient's treatment plan shall be considered when applicable. Such vulnerable populations shall include anyone whose capacity for autonomous decision making may be affected. When it is not medically advisable to give such information to the patient due to vulnerabilities or other circumstances, the information should be provided to a designated representative.

f. Informed Consent. Patients have the right to any and all necessary information in non-clinical terms to make knowledgeable decisions on consent or refusal for treatments, or participation in clinical trials or other research investigations as applicable. Such information is to include any and all complications, risks, benefits, ethical issues, and alternative treatments as may be available.

g. Filing Grievances. Patients have the right to make recommendations, ask questions, or file complaints to the MTF/DTF Patient Relations Representative or to the Patient Relations Office. If concerns are not adequately resolved, patients have the right to contact The Joint Commission at 1-800-994-6610.

h. Research Projects. Patients have the right to know if the MTF/DTF proposes to engage in or perform research associated with their care or treatment. The patient has the right to refuse to participate in any research projects.

i. Safe Environment. Patients have the right to care and treatment in a safe environment.

j. MTF/DTF Rules and Regulations. Patients have the right to be informed of the facility's rules and regulations that relate to patient or visitor conduct.

k. Transfer and Continuity of Care. When medically permissible, a patient may be transferred to another MTF/DTF only after he or she has received complete information and an explanation concerning the needs for and alternatives to such a transfer.

l. Charges for Care. Patients have the right to understand the charges for their care and their obligation for payment.

m. Advance Directive. Patients have the right to make sure their wishes regarding their healthcare are known even if they are no longer able to communicate or make decisions for themselves.

2. PATIENT RESPONSIBILITIES

a. Providing Information. Patients are responsible for providing accurate and complete information about complaints, past illnesses, hospitalizations, medications, and other matters relating to their health to the best of their knowledge. Patients are responsible for letting their healthcare provider know whether they understand the diagnosis, treatment plan, and expectations.

b. Respect and Consideration. Patients are responsible for being considerate of the rights of other patients and MTF/DTF healthcare personnel. Patients are responsible for being respectful of the property of other persons and of the MTF/DTF.

c. Adherence with Medical Care. Patients are responsible for adhering to the medical and nursing treatment plan, including follow-up care, recommended by healthcare providers. This includes keeping appointments on time and notifying MTF/DTF when appointments cannot be kept.

d. Medical Records. Patients are responsible for returning medical records promptly to the MTF/DTF for appropriate filing and maintenance if records are transported by the patients for the purpose of medical appointments, consultations, or changes of duty location. All medical records documenting care provided by any MTF/DTF are the property of the U.S. Government.

e. MTF/DTF Rules and Regulations. Patients are responsible for following MTF/DTF rules and regulations affecting patient care and conduct.

f. Refusal of Treatment. Patients are responsible for their actions if they refuse treatment or do not follow the practitioner's instructions.

g. Healthcare Charges. Patients are responsible for meeting financial obligations incurred for their healthcare as promptly as possible.

ENCLOSURE 3

PROCEDURES AND MHS COMPLIANCE GUIDELINES

1. GENERAL. The DoD Patient Bill of Rights and Responsibilities in Enclosure 2 is intended to accomplish three major goals:

a. To strengthen patient confidence by assuring the healthcare system is fair and responsive to patients' needs, provides patients with credible and effective mechanisms to address their concerns, and encourages patients to take an active role in improving and assuring their health.

b. To reaffirm the importance of a strong relationship between patients and their healthcare professionals.

c. To reaffirm the critical role patients play in safeguarding their own health by establishing both rights and responsibilities for all participants in improving health status.

2. GUIDELINES

a. Information Sharing. Each MTF/DTF shall provide patients with accurate, easily understood information and assistance in making informed healthcare decisions about their health plans, providers, and facilities. DoD facilities will promote quality and efficient healthcare through the use of health information technology; transparency regarding healthcare quality and price; and better incentives for patients and providers in accordance with Executive Order 13410 (Reference (j)) and in accordance with specifications established by the ASD(HA).

(1) Each MTF/DTF shall provide patients accurate, understandable, and timely information about the TRICARE program in accordance with Reference (f), including details of the covered health benefit, access standards, the various health plan options, and applicable cost-sharing arrangements.

(2) Each MTF/DTF shall make every reasonable effort to maintain scheduled appointments. This includes providers keeping appointments on time and notifying the patient when appointments cannot be kept.

(3) Each MTF/DTF shall maintain and have available a staff provider directory, including information regarding each provider's name, degree, licensure, specialty in which privileges have been granted, and board certification. The directory shall be updated as required to ensure a current listing of staff providers and be available to assist beneficiaries in the selection of their Primary Care Manager (PCM).

(4) Directory information shall not be pulled from the Centralized Credentials and Quality Assurance System or other quality assurance systems.

(5) To promote quality and efficient delivery of healthcare, each MTF/DTF shall provide beneficiaries with information on how to access publicly available facility performance data as appropriate.

(6) Upon enrollment to the MTF/DTF, patients shall be informed how to access facility compliance data on the Joint Commission Quality Check® Website (http://www.jointcommission.org) to include quality goals (ORYX measures), patient safety goals, and Joint Commission accreditation status according to the Joint Commission Accreditation Manual for Hospitals (Reference (k)). MTF/DTFs shall publish the Joint Commission Quality Check® Website address in MTF/DTF communication or marketing materials for beneficiaries.

(7) MTF/DTFs accredited by organizations other than the Joint Commission shall provide beneficiaries with information similar to that described in subparagraph 2.a.(6) of this enclosure in printed literature and facility Internet Websites as appropriate.

(8) All TRICARE regional offices will have full-time dedicated Beneficiary Counseling and Assistance Coordinators (BCAC), and MTF/DTFs will have either full-time or collateral duty BCAC positions. The BCACs are subject matter experts available to explain the TRICARE health plan and options available to assist beneficiaries in their healthcare decisions.

(9) The MTF/DTF Commander shall ensure sustained, effective, two-way communication exists between the medical facility and its beneficiary population through meetings, publications, and various other media, as appropriate. Not only is it vital to keep beneficiaries informed about access to care issues, service interruptions, new programs, and other aspects of medical operations, but the Commander shall also have a mechanism(s) in place to provide information upon request (e.g., provider credentials, patient satisfaction, accreditation survey results, and procedures to register complaints).

b. Choice of Providers and Plans. Each MTF/DTF shall provide beneficiaries with the right to a choice of healthcare providers that is sufficient to ensure access to appropriate, high-quality healthcare.

(1) TRICARE Prime provider networks, coupled with the MTF/DTF capabilities, shall provide access to sufficient numbers and types of providers to ensure that all covered services are accessible within the TRICARE Prime access standards.

(2) TRICARE Prime access standards include emergency care 24 hours per day and 7 days per week, urgent care within 24 hours, routine primary care within 7 days, wellness and health promotion within 28 days, and specialty care within 28 days.

(3) MHS beneficiaries entitled under law to the Civilian Health and Medical Program of the Uniformed Services have a right to choose TRICARE Standard, which permits access to all authorized providers within guidelines of the TRICARE program.

(4) All active duty members and Prime enrollees will be assigned or allowed to select a PCM pursuant to a system established by the MTF/DTF Commander. The enrollee will be given the opportunity to register a preference for a PCM from a list of choices provided by the MTF/DTF. To the extent available, preference requests shall be honored, matching patient medical needs with the appropriate level of healthcare provider, and other operational requirements established by the MTF/DTF Commander.

(5) The MHS shall promote the availability of providers who have special training in women's health issues to serve as PCMs for female Prime enrollees. To the extent available, female enrollees should have the option to choose a PCM who has advanced training in women's health issues.

(6) Prime enrollees shall obtain all primary healthcare from the PCM or from another provider to which the enrollee is referred by the PCM. For any necessary specialty care and non-emergency inpatient care, the PCM will assist in making an appropriate referral.

(7) Beneficiaries undergoing a course of treatment for a chronic or disabling condition or who are in the second or third trimester of a pregnancy at the time there is an involuntary change in coverage of the specialty services being provided shall, to the extent possible and legally permissible, be able to continue seeing their current specialty provider for up to 90 days (or through completion of postpartum care) to preserve continuity of care and allow for transition of care.

(8) In the case of an involuntary loss of eligibility for the MHS, the continued transitional access to healthcare shall be through the Transition Assistance Management Program or the Continued Health Benefit Program in accordance with Reference (f). They may also seek continued care under applicable procedures for the Secretarial Designee Program.

(9) In the case of an involuntary loss of other health insurance coverage coincident with the continuation or initiation of MHS eligibility, continued transitional coverage of the specialty care involved shall be through TRICARE, in accordance with section 199.17 of Reference (f).

(10) In the case of a termination of the provider involved (for other than quality concerns) or a change in the applicable Managed Care Support Contractor (MCSC) affecting a TRICARE Prime enrollee, continued transitional coverage of the specialty care involved shall be in accordance with appropriate TRICARE policies and procedures (if the beneficiary remains enrolled in TRICARE Prime) with applicable TRICARE Prime cost-sharing amounts applied.

c. Access to Emergency Services. Each MTF/DTF shall provide MHS beneficiaries with information regarding their right to access emergency healthcare services when and where the need arises. Emergency services are covered in circumstances where acute symptoms are of sufficient severity that a "prudent layperson" could reasonably expect the absence of medical attention would result in serious health risks or death.

(1) There is no requirement for preauthorization for emergency services.

(2) Providers and facilities are subject to payment limits because of either network agreements or regulations on balance billing.

(3) Each MTF/DTF shall provide MHS beneficiaries information on the location, availability, and appropriate use of emergency services, cost sharing, provisions for civilian emergency services, and availability of care outside of an emergency department.

d. Participation in Treatment Decisions. Each MTF/DTF shall ensure that MHS beneficiaries have the right and opportunity to participate fully in all decisions related to their healthcare, subject to readiness requirements for active duty Service members.

(1) To the extent practical, MTF/DTF and TRICARE Prime network healthcare professionals shall:

(a) Provide patients with easily understood information and the opportunity to decide among treatment options consistent with the informed consent process.

(b) Discuss all treatment options, including the option of no treatment at all with a patient in a culturally sensitive manner.

(c) Ensure that patients with disabilities have effective communications with members of the health system in making such decision.

(d) Discuss all current treatments a patient may be undergoing, including those alternative treatments that are self-administered.

(e) Discuss all risks, benefits, and consequences to treatment or non-treatment.

(f) Give competent patients the opportunity to refuse treatment and to express preferences about future treatment.

(g) Discuss the use of advance directives—both living wills and durable medical powers of attorney—with patients and their designated representatives and abide by all decisions made by their patients or their designated representatives. A provider who disagrees with a patient's wishes as a matter of conscience shall arrange for transfer of care to another qualified provider willing to proceed according to the patient's wishes within the limits of the law and medical ethics. Signed advance directives shall become a part of the patient's medical record.

(2) MTF/DTF and MCSC providers and medical facilities shall disclose to patients financial arrangements, contractual restrictions, ownership of or interest in healthcare facilities, matters of conscience, or other factors that could influence medical advice or treatment decisions. MCSC contracts shall not contain any so-called "gag clauses" or other contractual mechanisms that restrict the healthcare provider's ability to communicate with and advise patients about medically necessary treatment options.

(3) The MHS shall not penalize or seek retribution against healthcare professionals or other health workers for advocating on behalf of their patients.

(4) For active duty Service members, rights under paragraph 2.d. of this enclosure are subject to responsibilities of the member to comply with Service requirements for military readiness and the chapter 47 of Reference (e) (also known as "The Uniform Code of Military Justice").

e. Respect and Nondiscrimination. Each MTF/DTF shall provide the right to considerate, respectful care from all members of the MHS at all times and under all circumstances in an environment of mutual respect and free from discrimination. Subject to eligibility and other requirements of law and DoD regulations, including Chapter 55 of Reference (e) and Reference (f), the MHS does not discriminate in the delivery of healthcare services or in information and enrollment practices based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, genetic information, sexual orientation, or source of payment.

f. Privacy and Security of Health Information. Each MTF/DTF shall provide MHS beneficiaries with the right to communicate with healthcare providers in confidence, to have the privacy and security of their protected health information maintained, to review and copy their own medical records, and to request amendments to their records, subject to limited exceptions for which there is a clear legal basis(parts 160 and 164 of title 45, CFR (Reference (l)); DoD Manual 6025.18 (Reference (m)); DoD Medical Management Guide (Reference (n)); and DoDI 8500.01 (Reference (o)).

g. Complaints and Appeals. Each MTF/DTF shall provide MHS beneficiaries with the right to a fair and efficient process for resolving differences with their healthcare providers, MTF/DTF, or MCSC, including a rigorous system of internal review and an independent system of external review.

(1) When healthcare services are denied by an MTF/DTF (which will neither provide nor authorize TRICARE payment for the services) or an MCSC (which will not authorize TRICARE payment for the services) based on a determination that the services are not medically necessary, the beneficiary has the right to internal and external appeals.

(2) Appeals at the MTF/DTF subject to subparagraph 2.g.(1) of this enclosure shall follow appeal procedures in accordance with the most recent edition of Reference (n). Internal appeals for purchased care subject to subparagraph 2.g.(1) of this enclosure shall follow reconsideration procedures in accordance with paragraphs (f) through (h) of section 199.15 of Reference (f). Appeals procedures shall include written notification of the decision, the reasons for the decision, and appeal procedures; timely resolution, including expedited consideration for decisions involving concurrent review and preadmission or preprocedure cases; use of credentialed providers not involved in the initial decision; and written notification of the reconsideration decision, the reasons for it, and the external appeal procedures.

(3) External appeals for purchased care follow when all levels of internal appeals have been exhausted. External appeals subject to subparagraph 2.g.(1) of this enclosure shall follow

the procedures established pursuant to paragraphs (f) through (i) of section 199.15 of Reference (f), including reconsideration by the independent national quality monitoring contractor (NQMC) and a hearing before DHA. NQMC procedures shall include written notification of the decision, the reasons for the decision, and appeal procedures; timely resolution, including expedited consideration for decisions involving concurrent review and preadmission or preprocedure cases; use of credentialed providers; and written notification of the reconsideration decision, the reasons for it, and the right to request a hearing.

(4) Beneficiaries with grievances about specific treatment or coverage decisions (e.g., decisions related to experimental, investigational, or unproven procedures) other than those covered by subparagraph 2.g.(1) of this enclosure shall have an opportunity to seek resolution through established MTF/DTF or MCSC grievance procedures.

(5) Paragraph 2.g. of this enclosure does not apply to beneficiary disagreements with eligibility requirements or other matters established by law or regulation, including Chapter 55 of Reference (e) and Reference (f), or MTF/DTF determinations of space available care (including the availability of services, pharmaceuticals, equipment, or other items from MTF/DTFs).

h. Patient Responsibilities. Each MTF/DTF shall facilitate, promote, and encourage MHS patients to assume reasonable responsibility for their health. This increases the likelihood of achieving the best outcomes and supports quality improvement and a cost-conscious environment. Such responsibilities include:

(1) Maximizing healthy habits, such as exercising, not smoking, eating a healthful diet, and not knowingly spreading disease.

(2) Becoming involved in specific healthcare decisions, working collaboratively with healthcare providers in developing and carrying out agreed-upon treatment plans, disclosing relevant information, and clearly communicating wants and needs.

(3) Recognizing the risks and limits of the science of medical care and the human fallibility of the healthcare profession and being aware of a healthcare provider’s obligation to be reasonably efficient and equitable in providing care to other patients.

(4) Becoming knowledgeable about MHS and TRICARE coverage, options, and rules and abiding by applicable procedures.

(5) Showing respect for other patients and health workers and making a good-faith effort to meet financial obligations.

(6) Reporting wrongdoing and fraud to appropriate authorities.

GLOSSARY

PART I. ABBREVIATIONS AND ACRONYMS

ASD(HA)	Assistant Secretary of Defense for Health Affairs
BCAC	Beneficiary Counseling and Assistance Coordinators
CFR	Code of Federal Regulations
DHA	Defense Health Agency
DoDI	DoD instruction
MCSC	Managed Care Support Contractor
MHS	Military Health System
MTF/DTF	medical treatment facility/dental treatment facility
NQMC	national quality monitoring contractor
OASD(HA)	Office of the Assistant Secretary of Defense for Health Affairs
PCM	Primary Care Manager
PII	personally identifiable information
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
U.S.C.	United States Code

PART II. DEFINITIONS

These terms and their definitions are for the purpose of this Instruction.

beneficiary, medical. A person eligible for health care services under chapter 55 of Reference (e).

external appeal. An appeal that has been elevated to the external chain of responsibility at the NQMC and DHA levels, to provide an independent review. An external appeal may be exercised when the internal appeal process does not provide a resolution for the beneficiary.

internal appeal. An administrative review of program determinations regarding medical necessity that is internal to the MTF/DTF (for direct care) or to the MCSC (for purchased care). Progression through the successive levels of appeal occurs when the reviewing authority upholds the initial denial and the beneficiary, dissatisfied with the denial decision, files the next level of appeal.

involuntary change. Includes an involuntary loss of eligibility for the MHS, an involuntary loss of other health insurance coincident with the initiation or continuation of MHS eligibility, or termination of the provider by the MCSC for other than cause or a change in the applicable MCSC.

MHS. The combination of military and civilian medical systems used to provide healthcare to DoD medical beneficiaries.

MTF/DTFs. Those inpatient and outpatient facilities owned, staffed, and managed by the Military Departments.

NQMC. A contract peer review organization that monitors the quality of MHS-delivered care and serves the OASD(HA) as the external peer reviewer for medical necessity determination appeals.

patient. A sick, injured, wounded, or other person requiring medical or dental care or treatment.

PCM. Licensed and credentialed healthcare providers privileged to provide primary and preventive care services and to facilitate appropriate referrals for other services, including specialty services, for all active duty members and TRICARE Prime enrollees. PCMs may include physicians specialized in Family Practice, Internal Medicine, Pediatrics, and Obstetrics and Gynecology. Certified and privileged Adult, Family, Pediatric or Women's Health Nurse Practitioners, Nurse Midwives, and Physicians Assistants may also serve as PCMs.

transparency. A broad-scale initiative enabling consumers to compare the quality and price of healthcare services, so they can make informed choices among providers and facilities.

TRICARE. The DoD-managed healthcare program for active duty military, active duty service families, retirees and their families, and other beneficiaries.