Defense Health Program
Fiscal Year (FY) 2013 Budget Estimates
Defense Health Program
Appropriation Highlights

($ in Millions)

Appropriation Summary:	FY 2011[1] Actuals	Price Growth	Program Growth	FY 2012[2] Estimate	Price Growth	Program Growth	FY 2013[3] Estimate
Operation & Maintenance[4]	29,953.5	721.7	-89.0	30,586.2	859.6	-96.6	31,349.2
RDT&E	1,205.8	22.9	38.1	1,266.8	22.8	-616.6	673.0
Procurement	546.7	12.4	73.4	632.5	14.2	-140.2	506.5
Total, DHP	**31,706.0**	**757.0**	**22.5**	**32,485.5**	**896.6**	**-853.4**	**32,528.7**
MERHCF Receipts[5]	8,600.0			9,470.6			9,727.1
Total Health Care Costs	**40,306.0**			**41,956.1**			**42,255.8**

[1/] FY 2011 actuals include Operation and Maintenance (O&M) funding of $1,394.0 million and Research and Development funding of $24.0 million for Overseas Contingency Operations (OCO) under the FY 2011 Department of Defense Appropriations Act, Public Law 112-10.
[2/] FY 2012 current estimate excludes $1,215.3 million for OCO.
[3/] FY 2013 request excludes $993.9 million for OCO.
[4/] The Department of Defense projects O&M funding of $132.2 million in FY 2011, $135.6 million in FY 2012, and $139.2 million in FY 2013 should transfer to the Joint Department of Defense – Department of Veterans Affairs Medical Facility Demonstration Fund established by section 1704 of Public Law 111-84 (National Defense Authorization Act for FY 2010).
[5/] Reflects DoD Medicare-Eligible Retiree Health Care Fund (MERHCF) O&M Receipts for FY 2011, FY 2012, and FY 2013.

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Description of Operations Financed:

The medical mission of the Department of Defense (DoD) is to enhance DoD and our Nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care. The Defense Health Program (DHP) appropriation funding provides for worldwide medical and dental services to active forces and other eligible beneficiaries, veterinary services, medical command headquarters, specialized services for the training of medical personnel, and occupational and industrial health care. Included are costs associated with provisions of the TRICARE benefit which provides for the health care of eligible active duty family members, retired members and their family members, and the eligible surviving family members of deceased active duty and retired members. The FY 2013 Defense Health Program budget request of $32,528.7 million includes realistic cost growth for pharmacy, managed care support contracts, and other health care services either provided in the Military Treatment Facility or purchased from the private sector. This budget includes funding for continued support of Traumatic Brain Injury and Psychological Health (TBI/PH) and Wounded, Ill and Injured (WII) requirements. It complies with Congressional mandate related to support of Centers of Excellence (COE) and Secretary of Defense's initiative for operations efficiencies, including assumed savings for proposed military healthcare reform initiatives. Operation and Maintenance (O&M) funding is divided into seven major areas: In-House Care, Private Sector Care, Information Management, Education and Training, Management Activities, Consolidated Health Support, and Base Operations. The DoD Medicare Eligible Retiree Health Care Fund (MERHCF) is an accrual fund to pay for DoD's share of health care costs for Medicare-eligible retirees, retiree family members and survivors. MERHCF receipts fund applicable In-House and Private Sector Care operation and maintenance health care costs.

The Defense Health Program appropriation also funds the Research, Development, Test and Evaluation (RDT&E) program for medical Information Management/Information Technology (IM/IT), medical research to reduce capability gaps, support to medical laboratory facilities, and the Armed Forces Radiobiological Research Institute (AFRRI). The Defense Health Program appropriation Procurement program funds acquisition of capital equipment

in Military Treatment Facilities and other selected health care activities which include equipment for initial outfitting of newly constructed, expanded, or modernized health care facilities; equipment for modernization and replacement of worn-out, obsolete, or uneconomically reparable items; equipment supporting programs such as pollution control, clinical investigation, and occupational/environmental health; and Military Health System information technology (IT) requirements.

Narrative Explanation of FY 2012 and FY 2013 Operation and Maintenance (O&M) Changes:

The Defense Health Program O&M funding reflects an overall increase of $763.0 million between FY 2012 and FY 2013, consisting of $859.6 million in price growth and net program decrease of $96.6 million. Program increases include: $272.1 million for Private Sector Care net changes in benefits and utilization; $263.7 million for increased healthcare provided in Military Treatment Facilities; $104.4 million for initial outfitting in support of MILCON and Restoration and Modernization projects net of savings from better management and standardization; $43.0 million for Non-Electronic Health Record (EHR) information systems support; $34.1 million for Integrated Disability Evaluation System support; $28.2 million for facilities operations and Sustainment, Restoration and Modernization (FSRM); $25.5 million for Nurse Advice Line (NAL)implementation; $25.1 million for Integrated Electronic Health Record; $19.3 million for one additional civilian paid day in FY 2013; $16.4 million for Defense Health Headquarters Anti-Terrorism and Force Protection compliance and lease transfer; $13.4 million for DoD/VA Integrated Project Office (IPO) transfer from Defense Human Resource Activity; $11.2 million for Joint Theater Trauma System (JTTS); and $4.3 million for effectiveness tracking in support of Psychological Health. Program decreases include: $452.0 million for Secretary of Defense FY 2013 Proposal for Military Healthcare Reform *(includes $273.0 million for increased enrollment fees and $179.0 million for increased pharmacy co-pays)* $226.7 million for Federal Ceiling Pricing revised cost savings projections; $123.6 million for incremental Secretary of Defense Efficiencies *(includes $38.9 million for Medicare reimbursement rates for Critical Access Hospital services; $33.8 million for Reducing Reliance on DoD Service Support Contractors; $25.7 million for pharmacy co-pay; $18.9 million for enrollment fees; $6.1 million for Medical Supply Chain Sourcing*

Optimization; and $.2 million for Civilian Senior Executive Staff reduction); $61.6 million for incremental restoral of military to civilian conversions; $56.0 million for facilities and base operations net one-time funding for Central Utility Plant for the National Interagency Bio-Defense Campus at Ft. Detrick; $30.5 million for reversal of FY 2012 one-time Congressional program adds; and $6.9 million for Computer/Electronics Accommodation Program (CAP) transfer from the Defense Human Resource Activity (DHRA).

Continuing in FY 2013, the Department projects $139.2 million should transfer to the Joint Department of Defense (DoD) - Department of Veterans Affairs (VA) Medical Facility Demonstration Fund established by section 1704 of Public Law 111-84, (National Defense Authorization Act for FY 2010). This fund combines the resources of DoD and VA to operate the first totally integrated Federal Health Care Facility in the country by the total integration of the North Chicago VA Medical Center and the Navy Health Clinic Great Lakes.

Narrative Explanation of FY 2012 and FY 2013 Research Development Test & Evaluation (RDT&E) Changes:

The Defense Health Program RDT&E Program reflects a net decrease of $593.8 million between FY 2012 and FY 2013. This includes price growth of $22.8 million and a net program decrease of $616.6 million. Program increases include: $35.5 million for medical/health research to reduce capability gap requirements; $15.0 million associated with updates to the Medical Situational Awareness Tool (MSAT) to include information from the Defense Occupational and Environmental Health Readiness - Industrial Hygiene (DOEHRS-IH) system and continued integration development efforts including interfaces for: *enabling the use of Electronic Data Interchange Person Number vice the use of Social Security Number for identification; the inclusion of International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10); extended use of Public Key Infrastructure and Common Access Card; and increased use of virtualization technologies*; $9.6 million clinical trial laboratory support at military treatment facilities (MTFs); $4.2 million increase for laboratory operating costs for the Biological Defense Research Directorate (BDRD) relocation to the National Interagency

Biodefense Campus (NIBC) at Fort Detrick; $3.9 million for Army medical overseas research laboratory support of existing OCONUS laboratories and the new laboratory in the Republic of Georgia; $2.7 million increase associated with the realignment of funds from operation and maintenance (O&M) for proper execution of Army information management and information technology (IM/IT) projects; and $2.9 million in miscellaneous enhancements/realignments (net of increases and decreases).

Program decreases include: $603.6 million decrease related to one-time Congressional adds; $23.2 million decrease in Electronic Health Record (EHR) funding due to revised planned development schedule to incorporate the needs of the Department of Defense (DoD) and the Department of Veterans Affairs (VA); $11.2 million associated with FY 2012 Information Management/Information Technology (IM/IT) rebaselining efforts; $7.1 million decrease in Hyperbaric Oxygen (HBO2) Therapy for Traumatic Brain Injury (TBI) clinical trial support; $4.9 million related to Virtual Lifetime Electronic Record (VLER) start up to support the planned series of pilots at 4 separate sites with increasing functionality installed and tested sequentially per site before proceeding to next site, in preparation for a Go/No Go decision nationwide in FY 2012; $4.2 million for initial outfitting and transition for the new US Army Medical Research Institute of Infectious Disease (USAMRIID), the US Army Medical Research Institute of Chemical Defense (USAMRICD); $3.2 million related to the realignment of funding to operation and maintenance (O&M) for the proper execution of research support at the Armed Forces Radiobiology Research Institute (AFRRI); $2.2 million for the development of new injury metrics related to Underbody Blast; $0.7 for the Secretary of Defense Efficiency to reduce reliance on DoD Service Support Contractors; $0.5 million Department directed reduction to support Federally Funded Research and Development Center (FFRDC) projects within the Department; $0.2 million for improving testing protocols related to hard body armor; and $29.4 million in miscellaneous enhancements/realignments (net of increases and decreases).

Narrative Explanation of FY 2012 and FY 2013 Procurement Changes:

The Defense Health Program Procurement Program has a net decrease of $126.0 million between FY 2012 and FY 2013. This consists of $14.2 million in price growth and decreased program growth of $140.2 million. Program increases include: $15.7 million increase associated with the realignment of funds from operation and maintenance (O&M) for proper execution of Army information management and information technology (IM/IT) projects; $6.2 million for initial outfitting of accelerated military construction (MILCON) projects; $3.3 million due to refresh of Healthcare Artifact and Image Management Solution (HAIMS) hardware; $2.6 million increase for hardware upgrades to additional Service sites for the Clinical Information System (CIS); and $2.4 million in miscellaneous enhancements/realignments (net of increases and decreases).

Program decreases include: $133.0 million decrease associated with adjustments to the planned Electronic Health Record Way Ahead (EHRWA) implementation schedule; $19.8 million decrease attributable infrastructure program replacement cycles, and to the infrastructure's departmentally directed efficiencies of End User Devices (EUDs) and Local Area Network (LAN) Upgrades; $6.9 million associated with the one-time deployment of JXP interfaces to the Clinical Information System at 56 inpatient sites, planned to be accomplished with FY 2012; $5.7 million due to one-time funding for Radio Frequency Identification (RFID) deployment at 200 sites for the Defense Medical Logistics Standard System (DMLSS) to be accomplished in FY 2012; $2.6 million related to fact-of-life changes in Navy equipment purchases; $1.4 million in military construction initial outfitting and transition (IO&T) due to the acceleration of the Medical/Dental Clinic at RAF Croughton into FY 2012; and $1.0 million in miscellaneous enhancements/realignments (net of increases and decreases).

President’s Management Plan – Performance Metrics Requirements:

The Defense Health Program continues to refine existing performance measures and develop specific criterion to determine and measure outputs/outcomes as compared with initial

goals. Over the past year the DHP has transitioned to the Quadruple Aim that is focused on a balanced approach to overall performance to include not only production but outcome measures related to medical readiness, a healthy population, positive patient experiences and responsible management of health care costs.

- **Individual Medical Readiness** - This measure provides operational commanders, Military Department leaders and primary care managers the ability to monitor the medical readiness status of their personnel, ensuring a healthy and fit fighting force medically ready to deploy. This represents the best-available indicator of the medical readiness of the Total Force, Active Components and Reserve Components prior to deployment.

- **TRICARE Prime Enrollee Preventive Health Quality Inde**x - The National Committee for Quality Assurance (NCQA) established the Healthcare Effectiveness Data and Information Set (HEDIS) to provide the health care system with regular statistical measurements to track the quality of care delivered by the nation's health plans with a goal of improving the overall health of the population. This composite index scores Prime enrollee population for compliance with HEDIS like measures on selected measures to support an evidence-based approach to population health and quality assessment. It also provides a direct comparison with civilian health plans and a means of tracking improvements in disease screening and treatment. Improved scores in this measure should translate directly to a healthier beneficiary population, reduced acute care needs, and reduced use of integrated health system resources.

- **Beneficiary Satisfaction with Health Plan** – An increase in the satisfaction with the Health Plan indicates that actions being taken are improving the overall functioning of the plan from the beneficiary perspective. Improvements represent positive patient experiences with the health care benefit and services they receive through the system. The goal is to improve overall satisfaction level to that of civilian plans using a standard survey instrument.

- **Medical Cost Per Member Per Year** – Annual Cost Growth – The medical cost per member per year looks at the overall cost of the Prime enrollees for the DHP. This tracks all costs related to care delivered to enrollees. The objective is to keep the rate of cost growth for the treatment of TRICARE enrollees to a level at or below the civilian health care plans rate increases at the national level. Currently the measure provides insight to issues regarding unit cost, utilization management, and purchased care management. The metric has been enhanced to properly account for differences in population demographics and health care requirements of the enrolled population. Since enrollment demographics can vary significantly by Service, and across time, it is important to adjust the measure. For example, as increasing numbers of older individuals enroll, the overall average medical expense per enrollee would likely increase. Conversely, as younger, healthy active duty enroll, the overall average would likely decrease. Through the use of adjustment factors, a comparison across Services and across time is made more meaningful.

  Output related measures that influence Medical Cost Per Member Per Year:
  - **Inpatient Production Target** (Relative Weighted Products, referred to as RWP) – Achieving the production targets ensures that the initial plan for allocation of personnel and resources are used appropriately in the production of inpatient workload.
  - **Outpatient Production Target** (Relative Value Units, referred to as RVU) – Achieving the production targets ensures that the initial plans for allocation of personnel and resources are used appropriately in the production of outpatient workload.

Below is final reporting for FY 2011 related to the prior performance measure goals. The next reporting period will focus on the measures related to the Quadruple Aim, and two output measures related to production plan targets. The overall success of each area measured is discussed below along with information related to continuation of reporting in future documents:

- **Beneficiary Satisfaction with Health Plan** – Satisfaction with Health Care Plan performance for FY 2011 exceeded the goal of 56 percent during each quarter for the year, with an aggregate score of 65 percent for the year. Continuous increases in enrollment and improvement in the score demonstrates real progress for the program with respect to satisfying our beneficiaries. This measure will continue to be reported in support of the Quadruple Aim.

- **Inpatient Production Target** (Relative Weighted Products) – For the most recent reported monthly data for FY 2011, the MHS produced 216 thousand RWPs against a target of 217 thousand RWPs just slightly missing the target. These numbers are based on the records reported to date, and will increase slightly as all records are completed. With the focus on early ambulatory care to prevent inpatient admissions, there was a drop in the overall utilization from prior years that was not properly accounted for in the plan. This measure will continue to be reported as an output measure for the DHP.

- **Outpatient Production Target** (Relative Value Units) – With an increased emphasis on paying for performance, the system has seen a renewed focus on production of outpatient care. For FY 2011, the system produced 75.9 million relative value units versus a goal of 71.8 million relative value units. The MHS achieved the goal for the year. This measure will continue to be reported as an output measure for the DHP.

- **Medical Cost Per Member Per Year – Annual Cost Growth** – The Year to Date performance through the first three quarters of FY11 is 3.7% vs goal of 3.1%. While the system was not able to achieve the goal during the first three quarters, we continue to see improvements related to changes made with respect to the outpatient prospective payments in Purchased Care and Patient Centered Medical Home. Performance improved with each quarter, and should continue into FY 2012 where the measure will continue to be reported.