Defense Health Program
Fiscal Year (FY) 2017 Budget Estimates
Operation and Maintenance
Introductory Statement

($ in Millions)

Appropriation Summary:	FY 2015[1] Actuals	Price Growth	Program Growth	FY 2016[2] Estimate	Price Growth	Program Growth	FY 2017[3] Estimate
Operation & Maintenance[4]	30,669.5	900.4	-1,782.9	29,787.0	870.8	1,573.6	32,231.4
RDT&E	1,698.6	27.2	395.7	2,121.5	38.2	-1,336.8	822.9
Procurement	238.6	5.0	121.8	365.4	10.5	37.3	413.2
Total, DHP	**32,606.7**	**932.6**	**-1,265.4**	**32,273.9**	**919.5**	**274.1**	**33,467.5**
MERHCF Receipts[5]	9,466.1			9,310.7			9,797.1
Total Health Care Costs	**42,072.8**			**41,584.6**			**43,264.6**

1/ FY 2015 actuals includes $344.645 million for OCO.

2/ FY 2016 estimate excludes $272.704 million for OCO.

3/ FY 2017 request excludes $331.800 million for OCO.

4/ The Department of Defense transferred O&M funding of $117.1 million in FY 2015 and will transfer $120.4 million in FY 2016 and up to $122.4 million in FY 2017 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). Additionally, the Department transferred $15 million of O&M funding in FY 2015 and will transfer the same amount in FY 2016 to the DoD-VA Health Care Joint Incentive Fund (JIF) as required by Section 8111 of Title 38 of the United States Code (USC) and Section 721 of Public Law 107-314 (National Defense Authorization Act for 2003). For FY 2017 $15 million will be transferred to JIF.

5/ Reflects DoD Medicare-Eligible Retiree Health Care Fund (MERHCF) O&M Receipts for FY 2015, FY 2016, and FY 2017.

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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) Operation and Maintenance (O&M) appropriation funding provides for worldwide medical and dental services to active forces and other eligible beneficiaries, veterinary services, occupational and industrial health care, specialized services for the training of medical personnel, and medical command headquarters. Included are costs associated with the delivery 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 2017 budget request of $32,231.4 million includes realistic cost growth for health care services either provided in the Military Treatment Facilities (MTFs) or purchased from the private sector through the managed care support contracts, and for pharmaceuticals. 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 the Congressional mandate related to support of Centers of Excellence (COE) and Department 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 applicable Direct Care and Private Sector Care operation and maintenance health care costs for Medicare-eligible retirees, retiree family members and survivors.

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The DHP appropriation also funds the Research, Development, Test and Evaluation (RDT&E) program for medical Information Management/Information Technology (IM/IT), research to reduce medical capability gaps, and support to both Continental United States and (CONUS) and Outside the Continental United States (OCONUS) medical laboratory facilities. The DHP appropriation Procurement program funds acquisition of capital equipment in MTFs 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 uneconomically reparable items; equipment supporting programs such as pollution control, clinical investigation, and occupational/environmental health; and Military Health System (MHS) information technology (IT) requirements.

Narrative Explanation of FY 2016 and FY 2017 Operation and Maintenance (O&M) Changes:

The DHP O&M funding reflects an overall increase of $2,444.4 million between FY 2016 and FY 2017, consisting of $870.8 million in price growth and a net program increase of $1,573.6 million. Program increases include:

- $1,013.4 million for support of direct and private sector healthcare services
- $262.8 million for facility restoration and modernization projects at Military Treatment Facilities (MTF)
- $225.9 million for FY 2016 National Defense Authorization Act (NDAA) and the Department of Defense Health Benefit Proposals
- $106.8 million for replacement of medical equipment that will meet their life cycle expectancy for utilization
- $43.6 million for Department of Defense Healthcare Management System Modernization (DHMSM)

- $41.7 million to transform the Military Health System to a High Reliability Organization which will promote identifying problems and high-risk situations before they lead to an adverse event
- $30.1 million for Defense Information Systems Network (DISN) Cost Recovery Model Consumption Adjustment
- $25.5 million for Secretary of Defense Performance measures and monitoring compliance
- $15.5 million for mission and student travel
- $9.2 million for Defense Information Systems Agency (DISA) circuit, Defense Enterprise Email (DEE) transition and website consolidation
- $7.5 million for net functional transfers for Armed Forces DNA Identification Laboratory (AFDIL), service treatment records and other activities
- $5.5 million for Health Artifact and Image Management Solution (HAIMS)
- $5.3 million for targeted medical education and training
- $5.0 million for Defense Health Headquarters (DHHQ) telephone and video teleconferencing
- $4.4 million for MHS facilities sustainment
- $4.3 million for Military Health Information Technology (HIT) Optimization
- $4.0 million for occupational and environmental health readiness, safety and compliance
- $3.8 million for Office of the Electronic Health Record Transition Management (OETM)
- $3.7 million for facilities support to the Medical Services, National Capital Region (NCR) and Defense Health Agency (DHA)
- $3.2 million for Armed Forces Billing and Collection Utilization Solution (ABACUS) transition to cloud-based platform and sustainment
- $3.1 million for contract support services for the DHA
- $3.0 million for DHHQ rents for co-locating shared services staff
- $2.3 million for readiness pre- and post-deployment training and support

- $1.0 million for Joint Knowledge Online (JKO) Training System for consolidating on-line training systems
- $0.5 million for Tricare Prime Clinic (TPC) utilities and maintenance services

Program decreases include:

- $105.8 million for Civilian Pay Reductions due to hiring lag during the past two FYs
- $40.5 million for HIT Infrastructure, network operations, and support
- $23.7 million for reduced Initial Outfitting and Transition (IO&T) requirements for MILCON and Restoration and Modernization projects
- $19.8 million to comply with the Secretary of Defense efficiency to reduce Management Headquarters
- $11.6 million for Health Professions Scholarship Program (HPSP)/Health Professions Loan Repayment Program (HPLRP) based upon decreasing tuition costs and lower student levels
- $9.6 million for reduced Defense Health Medical Systems (DHMS) modernization estimates
- $8.6 million to comply with other Secretary of Defense Directed Efficiencies
- $8.0 million for audit and program integrity programs
- $7.2 million for contract services review initiative for base operations activities
- $6.0 million for consolidation of shared health facilities services
- $5.9 million for supplies inventory consolidation initiative
- $5.2 million for Wounded, Ill and Injured and Traumatic Brain Injury (WII/TBI) Programs
- $3.8 million for lower training demand for Extension of Community Health Outcomes (ECHO)
- $1.3 million for improved building security operational practices
- $0.5 million for initial outfitting and transition portfolio realigned to Procurement and Research, Development, Testing and Evaluation (RDT&E)

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Continuing in FY 2017, the Department projects that up to $122.4 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.

Continuing in FY 2017, the Department will transfer $15 million to the DoD-VA Health Care Joint Incentive Fund (JIF). Authority for the JIF is established by Section 8111, Title 38, of the United States Code (USC) and Section 721 of Public Law 107-314(National Defense Authorization Act for 2003. This fund combines the resources of the DoD and VA to implement, fund, and evaluate creative coordination and sharing initiatives at the facility, intraregional, and nationwide levels.

Narrative Explanation of FY 2016 and FY 2017 Research Development Test & Evaluation (RDT&E) Changes:

The DHP RDT&E Program reflects a net decrease of $1,298.6 million between FY 2016 and FY 2017. This includes price growth of $38.2 million and a net program decrease of $1,336.8 million.

Program increases include:

- $22.1 million realignment to the new Program Element for Joint Operational Medicine Information Systems (JOMIS). Funding will support engineering design, integration, development and operational testing of the DoD-Healthcare Management System Modernization (DHMSM) release with legacy operational medicine software capabilities
- $6.5 million in support of the Breast, Prostate, and Gynecological Cancer Centers of Excellence

- $4.9 million to support development of critical user enhancements and Hazmat Material Safety Data Sheets (Phase I) within the Defense Occupational and Environmental Health Readiness System - Industrial Hygiene (DOEHRS-IH)
- $1.4 million related to the transfer of Defense Center of Excellence (DCoE) development activities from US Army Medical Command to the DHA
- $0.7 million to support roll out of the Patient Assessment Screening Tool Outcome Registry (PASTOR) to the remaining Military Treatment Facilities
- $0.4 million in minor miscellaneous adjustments

Program decreases include:

- $1,147.9 million in FY 2016 one-time Congressional adjustments and General Provisions
- $139.8 million to the DHMSM based upon the completion of the test and evaluation plan in anticipation of reaching Initial Operating Capability (IOC)
- $42.0 million in medical research efforts coinciding with a reduction in capability gaps
- $17.3 million for reduced IO&T requirements as a result of the completion of the construction of the new US Army Medical Research Institute of Chemical Defense (USAMRICD)
- $11.0 million related to the planned completion of DHMSM IOC integration and testing in Pacific Northwest, as well as, upgraded data terminology service to support objective data sharing architecture and DHMSM
- $7.0 million in savings related to research efforts focused on concept technology development, prototyping and, piloting IM/IT products identified as part of the zero-based review of MHS information technology and management portfolio
- $2.1 million due to planned mobility innovations development activities accomplished with FY 2016 funding from Navy Medical IM/IT
- $5.7 million for minor miscellaneous adjustments

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Narrative Explanation of FY 2016 and FY 2017 Procurement Changes:

The DHP Procurement Program has a net increase of $47.8 million between FY 2016 and FY 2017. This consists of $10.5 million in price growth and a net program increase of $37.3 million.

Program increases include:

- $29.5 million for DoD-Healthcare Management System Modernization (DHMSM) progressing from the developmental stage to the deployment stage
- $28.2 million to support MHS Virtualization technical refresh of hardware/software for all designated MHS Application Access Gateway (MAAG) sites
- $16.2 million for 14 additional site surveys and installation of Local Area Network infrastructure upgrades planned in FY 2017, as well as, increases for other infrastructure equipment refresh
- $2.8 million for Health Artifact and Image Management Solution (HAIMS)software license refresh
- $2.4 million to support the initial phase of training and deployment of Joint Operational Medicine Information Systems (JOMIS) capabilities to Theater components
- $2.3 million to support MHS HIT Shared Services Portfolio Rationalization efforts to identify duplicative applications, consolidate requirements, evaluate solutions, and have functional users decide on a single solution
- $0.9 million to implement the Patient Assessment Screening Tool Outcome Registry (PASTOR) to the remaining Military Treatment Facilities

Program decreases include:

- $24.7 million due to completion of hardware upgrades to the Composite Health Care System (CHCS) Computerized Order Entry funded in FY 2016 to sustain the system until the modernized electronic health record will be the fully deployed in FY 2022
- $9.3 million to radiology equipment requirements due to prior year recapitalization
- $7.8 million in radiology equipment for Army Medical Department (AMEDD) Medical Care Support Equipment (MEDCASE) program
- $1.7 million to server hardware replacement for the Enterprise Blood Management System (EBMS) at the MHS Enterprise Service Operations Centers (MESOC) - San Antonio and Aurora - based on a 5-year hardware refresh cycle
- $1.5 million due to Departmental direction to transition funding from TMIP-J to the newly established JOMIS Program

President's Management Plan – Performance Metrics Requirements:

The Military Health System (MHS) 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 MHS continues the transition 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.

- **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 MHS. 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** (Medicare Severity Adjusted Relative Weighted Products, referred to as MS-RWPs) – 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 RVUs) – 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 reporting for FY 2015 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:

- **Individual Medical Readiness** – The Military Health System achieved the goal for the Total Force Medical Readiness for FY 2015 with a score of 86% compared to the goal of 85%. The MHS has managed to sustain this level of performance since last year, and will have to take significant steps to ensure that performance can be sustained over the long term. This measure will continue to be reported in support of the Quadruple Aim.

- **Beneficiary Satisfaction with Health Plan** – Satisfaction with Health Care Plan performance for FY 2015 exceeded the goal of 57 percent for the fiscal year. Continuous increases in percentage of eligible beneficiary enrolling in TRICARE Prime demonstrate progress for the program with respect to satisfying our beneficiaries. While achieving the goal for the year, there was a slight decrease in overall satisfaction for the year, and changes to the enrollment locations over the next couple of years may result in a further decrease over the next couple of years. This measure will continue to be reported in support of the Quadruple Aim.

- **Inpatient Production Target** (MS-RWPs) – Based on the most recently completed data for FY 2015, the MHS failed to achieve the performance target. Instead of increasing as expected during the last budget update, production actually decreased slightly. A significant reason for the decrease was related to the downsizing of

the Active Component which occurred faster than estimated. This decrease in population resulted in a decrease in the number of inpatient stays related to Pregnancy and Newborns. Overall this is the number one product line for the Military Health System, and resulted in 10% decrease for this product line. While there were some improvement in Musculoskeletal, it was not sufficient to offset the other decreases regarding inpatient care. These numbers are based on the records reported to date, and will increase slightly as all records are completed. This measure will continue to be reported as an output measure for the DHP.

- **Outpatient Production Target** (RVUs) – The Active Component downsizing also impacted the production of outpatient care, where the MHS fell short of obtaining its goal for FY 2015. Production levels actually remained steady with FY 2013, and fell short of the goal by approximately 6 percent. The MHS used statutory authority to migrate enrollees from purchased care back to the MTFs in a number of markets, but could not offset the decrease in Active Duty and Family members in the short run who decreased by almost 7 percent in MTF markets. Additionally, the MHS may be experiencing some of the declined utilization from the implementation of Patient Centered Medical Homes earlier than expected, with Primary Care workload declining by almost 11% percent as more care was shifted to virtual visits as opposed to face-to-face visits. Through the improved use of Secure Messaging and Nurse Advice Lines, the MHS is reducing utilization while still focusing on the entire patient instead of just throughput related to Primary Care. In general these virtual visits should result in more timely care and better patient satisfaction in the long run. This measure will continue to be reported as an output measure for the DHP.

- **Medical Cost Per Member Per Year – Annual Cost Growth** – The MHS is now experiencing a slightly higher cost growth than in the past couple of years. The largest growth factor involves Pharmacy compounded products. To contain the growth in this area, the MHS worked directly with MTF providers to ensure they understood the cost impact

of these types of prescriptions, to reduce the number to appropriate levels. Additionally, the MHS started an electronically screening process in May 2015 to ensure all ingredients are covered under the TRICARE pharmacy benefit and ensure the cost does not exceed the established pricing standard. This screening process is consistent with the pharmacy industry, and these efforts resulted in a decrease from a monthly high of $350M to $6M average per month for the last months of the year, but overall performance will exceed the yearly goal. The Year to Date performance estimate for FY 2015 is 7.3% vs goal of 2.0% (which is extremely low compared with normal health care cost growth). While final claims data are still lagging, the system will not be able to achieve the goal during the fiscal year and appears to be at an inflection point where both costs and utilization are growing at levels closer to traditional medical growth rates.