Defense Health Program
Fiscal Year (FY) 2012 Budget Estimates
Defense Health Program
Appropriation Highlights

($ in Millions)

Appropriation Summary:	FY 2010[1] Actuals	Price Growth	Program Growth	FY 2011[2] Estimate	Price Growth	Program Growth	FY 2012[3] Estimate
Operation & Maintenance[4]	28,423.7	719.3	772.3	29,915.3	785.7	201.6	30,902.5
RDT&E	1,443.6	20.2	-963.9	499.9	7.5	156.3	663.7
Procurement	524.7	11.8	-16.6	519.9	12.1	100.5	632.5
FY 2011 Annual CR Total[5]				***30,534.3***			
Total, DHP	30,392.0	751.3	-208.2	30,935.1	805.3	458.4	32,198.7
MERHCF Receipts[6]	8,026.7			8,998.9			9,448.0
Total Health Care Costs	38,418.7			39,934.0			41,646.7

[1/] FY 2010 actuals include Operation and Maintenance (O&M) funding of $1,289.2 million for Overseas Contingency Operations (OCO) under the FY 2010 Department of Defense Appropriations Act, Public Law 111-118 and $33.4 million for Department of Defense Supplemental, FY 2010, Public Law 111-212. Additionally, FY 2010 includes $132.0 million O&M and $8.0 million RDT&E funding transferred from Health and Human Services for H1N1 in the Supplemental Appropriations Act of 2009, Public Law 111-32.

[2/] FY 2011 President's Budget Request estimate excludes $1,398.1 million for OCO.

[3/] FY 2012 request excludes $1,228.3 million for OCO.

[4/] The Department of Defense projects $132.2 million O&M funding should transfer in FY 2011, and $135.6 million in FY 2012 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]/FY 2011 reflects DHP annualized Continuing Resolution funding.

[6/] Reflects Departmental DoD Medicare-Eligible Retiree Health Care Fund (MERHCF) for FY 2010, FY 2011, and FY 2012 O&M only. FY 2012 MERHCF includes Department of Defense healthcare reform initiatives.

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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 2012 Defense Health Program budget request of $32,198.7 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 also complies with Congressional mandate related to support of Centers of Excellence (COE) and Secretary of Defense's initiative for operations efficiencies. 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 laboratory research, 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 processing requirements.

Narrative Explanation of FY 2011 and FY 2012 Operation and Maintenance (O&M) Changes:

The Defense Health Program O&M funding reflects an overall increase of $987.3 million between FY 2011 and FY 2012, consisting of $785.7 million in price growth and net program increase of $201.6 million. Program increases include: $379.1 million for Federal Ceiling Pricing revised reimbursement projections; $205.9 million for increased healthcare provided in Military Treatment Facilities; $151.1 million for Facilities Sustainment, Restoration and Modernization (FSRM); $137.8 million for initial outfitting in support of MILCON and Restoration and Modernization projects; $137.4 million for TRICARE Reserve Select enrollment increase; $87.2 million for Warrior Transition Command (WTC) transfer and other Wounded Warrior support; $83.8 million for readiness enhancements for bio-defense vaccines, pandemic influenza and surveillance; $71.6 million for fact of life funding realignment and adjustments; $66.3 million for medical education collocation, Tri-Service Nurse Academic Partnership, and other programs enhancements; $50.2 million National Interagency Bio-Defense Campus (NIBC) Central Utility Plan project and lease costs increases; $40.7 million for Navy Individual Augmentees; $30.6 million for collocated medical headquarters transition and sustainment; $29.9 million for Military Health System innovation, strategic communications, and other headquarters and oversight activities; $14.3 million for Hearing and Vision Centers of Excellence enhancements; $6.5 million for Non- Electronic Health Record (EHR) information systems support; $4.6 million for EHR planning, acquisition and oversight activities; and $2.3 million for West Point Medical Facilities transfer from Army Installation Command (IMCOM). Program decreases include: $511.9 million for Private Sector Care net changes in benefits and utilization; $316.8 million for Secretary of Defense Efficiencies which include: *Pharmacy Co-Pay for Non-Medicare Eligible ($95.0 million); Reducing Reliance on DoD Service Support Contractors ($67.6 million); TMA Baseline Review to Consolidate*

Headquarters' Activities ($51.4 million); Prime enrollment fees increase ($31.4 million); Medicare reimbursement rates for Critical Access Hospital services ($31.0 million); Reports, Studies, Boards and Commissions Review to reduce reliance on Advisory and Assistance Service ($27.4 million); Medical Supply Chain Sourcing Optimization ($12.9 million); DFAS Baseline Review ($0.9 million), and net Civilian Manpower Freeze and Exceptions (+$0.8 million); $146.7 million for Civilian in-sourcing and other civilian pay adjustments to include one less pay day in FY 2012; $81.6 million for installations transfer to Army Installation Command (IMCOM)and Network Enterprise Technology Command (NETCOM); $68.7 million for military to civilian conversions restoral; $62.0 million for medical installation transfer to Navy; $31.1 million for Army Substance Abuse Program (ASAP) transfer to Army Installation Command (IMCOM); $25.6 million for Patient Centered Medical Home investment's net impact on private sector care requirements; $21.8 million for Military Health System savings initiatives: $14.6 million for Fraud, Waste and Abuse cost savings initiatives; $9.1 million for State Directors of Psychological Health Transfer to Army National Guard; and $7.6 million for Managed Care Support Contract (T3 version) automated eligibility systems support.

Continuing in FY 2012, the Department projects $135.631 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 2011 and FY 2012 Research Development Test & Evaluation (RDT&E) Changes:

The Defense Health Program RDT&E Program reflects a net increase of $163.8 million between FY 2011 and FY 2012. This includes price growth of $7.5 million and a net program increase of $156.3 million. Program increases include: $46.6 million for medical research to reduce capability gap requirements; $44.4 million for Electronic Health

Record(EHR)funding that will support enhanced speed, reliability, and user interface, as well as improve security of protected information and data integrity; $19.5 million for initial outfitting and transition for the new US Army Medical Research Institute of Infectious Disease (USAMRIID) and the US Army Medical Research Institute of Chemical Defense (USAMRICD); $15.6 million for Hyperbaric Oxygen (HBO2) Therapy for Traumatic Brain Injury (TBI) clinical trial support; $15.2 million for the development of new injury metrics related to Underbody Blast; $11.9 million for Defense Occupational and Environmental Health Readiness-Industrial Hygiene (DOEHRS-IH) RDT&E associated with enhancements to improve data sharing across DOEHRS modules, ergonomics, hazmat product hazard data, interface with current DoD EHR applications, risk assessment, and the completion of veterinary; $7.7 million increase for operations support for the Pacific Based Joint Information Technology Center - Maui (JITC- Maui); $7.1 million increase to research programs in support of high-interest projects and enhance competitiveness; $4.0 million clinical trial laboratory support at CONUS laboratories and Military Treatment Facilities; $3.1 million for Army medical overseas research laboratory support of existing OCONUS laboratories and the new laboratory in the Republic of Georgia; $2.2 million for continued testing and evaluation of Patient Safety Record (PSR) System evaluations and system refresh; $2.0 million increase associated with the Theater Medical information Program-Joint (TMIP-J) associated with AHLTA Theater enhancements for aeromedical evacuation and pharmacy functionality, continued performance improvements of administrative functions within the TMIP-J framework and interfaces with the Services Joint Theater Trauma Registry (JTTR) applications; $0.9 million for improving testing protocols related to hard body armor; $0.4 million for information technology support related to the transfer of the US Army Warrior Transition Command (WTC) to the DHP; and $1.6 million in miscellaneous enhancements/realignments (net of increases and decreases).

Program decreases include: $10.1 million for the planned completion of medical logistics capabilities and evolving wireless technology in FY 2011 offset by continued migration of Defense Medical Logistics Standard System (DMLSS) into net-centric, service oriented architecture and development of enhanced functionality to include federated medical logistics capabilities and evolving wireless technology; $4.6 million decrease associated with information management and technology development within the DHP Components; $2.9

million decrease due to the completion of spiral development of Wounded Warrior requirements in support of Traumatic Brain Injury and Psychological Health (TBI/PH) specifically the Neuro Cognitive Assessment Tool (NCAT) allowing data to be available to the Bi-Directional Health Information Exchange (BHIE) network which will assist the Services in detecting, evaluating, and monitoring all TBI cases; $2.5 million for decreases in AHLTA associated with the current timeline for patient safety enhancements; $2.3 million for reductions in e-Commerce development; $2.0 million decrease due to the completed integration required for development of two new blood management COTS products in FY 2011; $0.6 for the Secretary of Defense Efficiency to reduce reliance on DoD Service Support Contractors; and $0.9 million in miscellaneous enhancements/realignments (net of increases and decreases).

Narrative Explanation of FY 2011 and FY 2012 Procurement Changes:

The Defense Health Program Procurement Program has a net increase of $112.6 million between FY 2011 and FY 2012. This consists of $12.1 million in price growth and an increased program growth of $100.5 million. Program increases include: $90.4 million for the Electronic Health Record (EHR) to support enhanced speed, reliability, and user interface, as well as, improve security of protected information and data integrity; $18.0 million due to replacement cycles of End User Devices (EUDs) and Local Area Network (LAN) Upgrades; $10.3 million for initial outfitting of military construction (MILCON) projects accelerated due to one-time Congressional adds, Base Realignment and Closure (BRAC), American Recovery and Reinvestment Act (ARRA), and Supplemental funding increases; and $0.8 million in miscellaneous enhancements/realignments (net of increases and decreases).

Program decreases include: $7.0 million decrease due to completed implementation of COTS solutions providing donor and transfusion tracking for blood management; $3.8 million due to completion of the Defense Occupational and Environmental Health Readiness-Industrial Hygiene (DOEHRS-IH) Mobile PC tablets deployment to the Air Force and Navy in FY 2011 offset by increased requirements for server storage associated with DOEHRS data warehouse

in FY 2012; $3.6 million associated with the completion of hardware refresh for the Clinical Information System initiative in FY 2011; and $4.6 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 seven treatment protocols related to: Appropriate Asthma Medication Use; Breast Cancer Screening; Cervical Cancer Screening; Colorectal Cancer Screening; and Diabetic Care. The selected measures 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 2010 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 2010 exceeded the goal of 58 percent during each quarter for the year, with an aggregate score of 64 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 2010, the MHS produced 214 thousand RWPs against a target of 215 thousand RWPs. These numbers are based on the records reported to date, and will increase slightly as all records are completed. While care for Active Duty continues at high levels due to care for Wounded Warriors, 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 2010, the system produced 71.2 million relative value units versus a goal of 67.0 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** – Through the most recent reporting timeframe the Military Health System achieved the goal for the annual cost growth related to Medical Cost per Member per Month. For FY 2010, the annual cost

growth rate was 5 percent, compared with the goal for the year of 6 percent. The primary reason for the improvement is related to changes made with respect to the outpatient prospective payments in Purchased Care. Performance improved with each quarter, and should continue into FY 2011 where the measure will continue to be reported.