Defense Health Program
Operation and Maintenance, Defense-Wide
Fiscal Year (FY) 2024 Budget Estimates
Introductory Statement

Appropriation Summary

Appropriation Summary	FY 2022 Actuals	Price Change	Program Change	FY 2023 Enacted	Price Change	Program Change	FY 2024 Request
Operation & Maintenance	33,640.8	1,501.4	466.9	35,609.1	1,406.0	85.20	37,100.3
RDT&E	2,638.5	14.6	388.3	3,041.4	18.4	-2,128.00	931.8
Procurement	758.7	23.2	-211.8	570.1	16.3	-204.50	381.9
Total DHP	**37,038.0**	**1,539.2**	**643.4**	**39,220.6**	**1,440.7**	**-2,247.30**	**38,414.0**
MERHCF Receipts	11,393.8			11,846.6			12,291.6
Total Health Care Costs	**48,431.8**			**51,067.2**			**50,705.6**

Notes:

1. FY 2022 actuals include $227.726 million for Overseas Operations Costs, and excludes funds transferred to VA for Lovell FHCC and the DoD-VA Joint Incentive Fund ($152.0 million).
2. FY 2023 enacted includes $116.171 million for Overseas Operations Costs, $14.1 million for Ukraine Supplemental, $5.0 million for Fisher House, $168 million for transfer to VA for Lovell FHCC, and $15 million for transfer to Joint Incentive Fund.
3. FY 2024 request includes $230.885 million for Overseas Operations Costs, $172.0 million for transfer to VA for Lovell FHCC and $15 million for transfer to the DoD-VA Joint Incentive Fund.
4. Reflects DoD Medicare-Eligible Retiree Health Care Fund (MERHCF) O&M transfer Receipts for FY 2022, FY 2023 and FY 2024 that support 2.5 million Medicare-eligible retirees and their family members.

Description of Operations Financed:

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, occupational and industrial health care, and specialized services for the training of medical personnel. The MHS provides care in government owned and operated medical treatment facilities focused on sustaining readiness of the medical force and the medical readiness of deployable forces. Additionally, the MHS purchases more than 65 percent of the total care provided for beneficiaries through tailored contracts, such as Managed Care Support Contracts responsible for the administration of the TRICARE benefit. 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.

In FY 2024, we are anticipating COVID costs to continue to come down, driving a reduction in the DHP budget in Direct Care and Private Sector Care for costs attributed directly to COVID. The Department continues to invest in testing, Bio-surveillance, genomic sequencing, and integrating health information technology systems to protect against and treat COVID-19 and prepare for new variants, while applying lessons learned to prepare for future biological threats and other major public health emergencies.

The National Defense Authorization Acts (NDAAs) for FY 2017, FY 2019, and FY 2020 contained language to drive a wide range of structural and management reforms within the MHS. These adjustments have been catalysts for the transformation of the MHS into a more integrated system of readiness and health. As we develop new ways of doing business, our commitment is to build an improved system of military health. This system will continuously improve, ensuring success in supporting service members that are fit to fight; medical professionals are ready to support them in training and on the battlefield; and our great outcomes for all those who serve. The MHS is laser-focused on three key areas of organizational reform; integrated management of care provided in the direct care and purchased care systems, a reinvigorated approach to readiness within the direct care system, and optimizing the recruitment, education, training, and sustainment of talented and committed service members with size, quality, and composition to deliver care, anywhere, anytime in support of our service members. The FY 2024 budget continues the MHS reform efforts underway by focusing on improving access to services for our patients by better integrating the direct and purchased care systems. Standardization will lead to improved safety and the availability of options for patients to manage their health care more easily. As of FY2022, the Defense Health Agency (DHA) has completed the transition of all Military Medical Treatment Facilities (MTF) to DHA in accordance with the Department's approved conditions-based execution plan (Plan 3 version 6) for critical milestones.

In response to Section 741 of the NDAA for FY 2023, the FY 2024 President's Budget suspends planned clinical medical military end strength divestitures. The Department will use this directed pause to conduct an assessment of current military medical end strength to match operational requirements and enable the MHS to increase the medical readiness of the force, as well as the readiness of our medical force. Following this assessment, the Department will submit a report to the House and Senate Armed Services Committees that certifies the completion of a comprehensive review of the military medical manning and justification for any proposed changes to the composition of the military medical end strength and the plan to address civilian backfill and persistent civilian vacancies or risks associated with the planned reductions.

Private Sector Care continues to be a vital part of the Military Health System in FY 2024 and represents over half of the Operations and Maintenance requirement. Over the period of FY 2012 to FY 2018, both private health insurance premiums and National Health Expenditures per capita rose 25% (or 3.7% annually). The

Private Sector Care budget should have continued to rise but the Department, with concurrence from Congress, instituted a series of initiatives that bent the cost curve. A combination of benefit changes, payment savings initiatives, contract changes, and population reductions offset underlying increases in health care costs, which is estimated to have saved $3.5 billion over a six-year period. Beginning toward the end of FY 2019 and continuing into FY 2020, the Department began to experience significant growth without the benefit of new reforms to offset the increases. In FY 2022, the Department focused on re-baselined funding for Private Sector Care healthcare requirements using the latest execution data, National Health Expenditure rates, beneficiary population forecasts, and current policy/compensation assumptions. Based on FY 2021 execution and FY 2022 execution, the much higher PSC baseline update was valid. In FY 2024, the Department is making additional investments in Private Sector Care based on the previous year's execution trends and the FY 2024 request fully funds the Department's anticipated PSC requirements to reduce risk to other DoD programs. Private Sector Care will continue to represent an important part of the overall health system in FY 2024 and beyond.

Mental Health continues to be an area of emphasis across the DoD. The FY 2024 budget invests $1.4 billion in clinical mental health programs and initiatives include those which evaluate, treat, and follow-up with patients with a variety of mental health issues. These programs leverage evidence-based best practices and treatment, practical problem resolution, case management and crisis management to support positive health outcomes. Ongoing mental health efforts within the Department include Primary Care Behavioral Health, Tele-Behavioral Health, National Intrepid Center of Excellence and Intrepid Spirit Centers, Substance Abuse Program, as well as research on mental health aimed to accelerate the innovation and delivery of preventive interventions and treatments for TBI, PTSD, and other mental health conditions.

The DoD and the Department of Veteran's Affairs continue to progress in the establishment of the unified Electronic Health Record. In FY 2024, the DoD continues funding the clinical application, HealtheIntent, which provides a platform for population health and analytic tools and offers a seamless longitudinal record between the DoD and VA that will grant providers and beneficiaries' access to detailed medical histories.

The FY 2024 budget supports the completion of MHS GENESIS deployment Outside the Continental United States with the following waves slated to go live within FY 2024: Waves LANDSTUHL, LAKENHEATH, OKINAWA, AND GUAM/SOUTH KOREA. This is all part of the Defense Healthcare Management System Modernization Program (DHMSM) Program Management Office's (PMO) deployment schedule and incorporates lessons learned from prior deployments completed to date. In addition, the FY 2024 budget supports MHS GENESIS moving to full sustainment of all sites post deployment as well as critical enhancements to the original MHS GENESIS capabilities. These enhancements include tele-health initiatives, interfaces between MHS GENESIS and the Patient Queuing & Notification System (PQNS) and the General Fund Enterprise Business System (GFEBS), and product improvement engineering to support agile development, configuration, and test of new capabilities for MHS GENESIS.

In addition, the FY24 budget supports MHS strategic goals and facilitates informed decision-making through the delivery of vital information services and data in a timely, relevant, and actionable manner via Enterprise Intelligence & Data Solutions (EIDS). EIDS has become the nexus of all Military Health System (MHS) secondary data and the core data broker and provider for most clinical and operational medical systems across the enterprise. The EIDS PMO strives to execute the DHA Data Vision of providing seamless data services and decision support for clinicians, patients, beneficiaries, analysts, researchers, and DoD leadership to improve patient care through the MIP. EIDS Military Health System Information Platform (MIP) enclave integrates over 130 data sources, 50+ clinical registries and rationalized over 22 data warehouses, 18 applications over the last 4 years. In addition, it supports a set of DoD legacy systems and projects that aim to increase data interoperability and access to electronic health data via digital health hub serving up health care data to DoD and Federal partners. The MIP provides a core

clinical research platform for self-service business intelligence and is building an artificial intelligence and machine learning workbench. Additionally, EIDS is building the first secure cloud-based genomics platform for the DoD. An inability to fully fund the EIDS initiative would result in an enterprise loss of value in bringing together data, information technology, and data science, delivering analytics-driven insights for customers driving towards prescriptive analytics, as well as delay the ability of the Departments to meet the Congressional intent of a fully interoperable health record.

The DHP appropriation funds the Research, Development, Test and Evaluation (RDT&E) program developed in response to the needs of the National Defense Strategy and Joint Capabilities Integration and Development System (JCIDS). The goal is to advance the state of medical science in those areas of most pressing need and relevance to today's battlefield experience and emerging threats. The objectives are to discover and explore innovative approaches to protect, support, and advance the health and welfare of military personnel and individuals eligible for care in the MHS; to accelerate the transition of medical technologies into deployed products; and to accelerate the translation of advances in knowledge into new standards of care for injury prevention, treatment of casualties, rehabilitation, and training systems that can be applied in theater or in military medical treatment facilities.

The DHP 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; and MHS information technology (IT) requirements.

O&M Changes

Narrative Explanation of FY 2023 and FY 2024 Operation and Maintenance (O&M) Changes:

The DHP O&M funding reflects an overall increase of $1,491.2 million between FY 2023 and FY 2024, consisting of $1,406.0 million in price growth and a net program increase of $85.2 million. $230.9 million of Overseas Operations Costs is included in the base request.

Program **increases** include:

- $402.8 million increase is based on beneficiary population forecasts, policy changes and significantly increasing healthcare costs. The increase is fueled by higher Medicare reimbursement rates set by the Centers for Medicare and Medicaid Services (CMS), which statutorily determine the TRICARE reimbursement rates for PSC providers and facilities.
- $78.2 million to address the estimated impacts of Executive Order 14026, Increasing the Minimum Wage for Federal Contractors, dated April 27, 2021 (BAG 1 $46.2M, BAG 3 $30.6M, BAG 6 $1.4M).
- $73.4 million provides funds for Joint Operational Medicine Information Systems requirements, the increase is largely due to the realignment of funding from RDT&E to O&M to reflect the new Acquisition Strategy approved January 2021, including: 1) continued funding of software development that will occur beyond the first MVCR; 2) funding of IT Management and testing support for software development beyond the first MVCR. Additionally, increase funding is required to maintain new capabilities that are added to the suite of Operational Medicine Information Systems (OpMed IS) as part of the

program's Capability Roadmap. The newly deployed capabilities include Medical Common Operating Picture, Healthcare Delivery, Operational Medicine Data Service, and Theater Blood.

- $54.5 million funds increase in supplemental health care program due to increased utilization of the Private Sector Care network for Active Duty care not available in the Military Treatment facilities.
- $46.6 million increase to Retail and Mail Order Scripts attributed to more patients being seen in the Private Sector Care and filling prescriptions in Mail Order and Retail, following patient preference and behavior inducted by COVID.
- $46.5 million funds increased utilization of Private Sector Care mental health treatment by Active Duty.
- $39.1 million to improve the ability to prevent, detect, and respond to biological incidents and biological threats as highlighted in the Biodefense Posture Review.
- $32.7 million one-time increase for Microsoft 365 Enterprise E5 licensing upgrades for improved Zero Trust capabilities.
- $23.7 million increase based on transfer of full-time equivalents, civilian pay and non-pay funding from the Department of the Army and the Department of the Air Force to complete the Department of Defense Public Health consolidation at the Defense Health Agency in accordance with Section 711 of the National Defense Authorization Act of FY 2019.
- $4.6 million increase is based on a Managed Care Support Contract revision to expand on existing two-region structure by implementing demonstrations permitting the DoD to test the efficacy of offering beneficiaries access to multiple networks in the same geographic area.
- $3.6 million transfer of civilian pay funds, full-time equivalents, and associated programming resources to the Defense Health Agency from the Department of the Army for the Initial Entry Training Reception Battalion Medical Support function.
- $2.1 million increase in supports the FY 2017 NDAA note on the national security challenges posed by anomalous health incidents (P. L. 114-328, 10 U. S. C. 111 note) and ensures that individuals affected by anomalous health incidents receive timely and comprehensive health care and treatment.

Program **decreases** include:

- $200.0 million decrease in Direct Care Pharmaceuticals due to the decline in Military Treatment Facility Pharmacy utilization observed since FY2020.
- $118.3 million decrease in the Military Health System Information Management/Information Technology Legacy sustainment funding as the Defense Health Agency implements consolidation measures to reduce infrastructure costs at the Military Treatment Facilities and the Defense Health Agency.
- $95.2 million decrease in COVID funding assumes that future outbreaks in COVID variants will be less severe due to increased vaccination/natural immunity, requiring fewer hospitalization costs and more outpatient care. (BAG 1 $72.3M, BAG 3 $22.9M).
- $83.8 million decrease for the transfer of the Service's Medical Readiness activities which occur outside of the Military Treatment Facilities to the Military Departments (BAG 1 $55.8M, BAG 3 $11.7M, BAG 4 $899K, BAG 5 $463K BAG 6 $10.3M, BAG 7 $4.6M).
- $68.9 million decrease in Budget Activity Group 7 based on contract consolidation and efficiencies gained as DHA implements standardization of contract management for the Military Treatment Facilities.
- $47.5 million decrease in Department of Defense Healthcare Management System Modernization (DHMSM) due to the reduction in management oversight and travel required to support deployment in FY 2024. Deployment efforts for MHS GENESIS will complete in the first half of FY 2024 in accordance with the approved deployment schedule.

- $31.9 million decrease to facility sustainment funding based on the facility sustainment model for non-critical facilities funded at 85 percent in accordance with current strategy to maintain facilities sustainment costs.
- $15.0 million adjustment to reverse one-time funding of Telehealth for Military Children and Families to improve access to care through telehealth opportunities.
- $15.0 million adjustment to reverse one-time funding of Therapeutic Service Dog Training to determine the measurable effects of Therapeutic Service Dog Training program as a therapeutic intervention for Service Members with posttraumatic stress disorder.
- $10.0 million adjustment to reverse one-time funding of Uniformed Services University of the Health Sciences' (USUHS) for management and administration of the USUHS academic programs.
- $7.0 million adjustment to reverse one-time funding of the Tri-Service Nursing Research Program.
- $6.5 million decrease in Management Activities contract funding based on consolidation of contracts and increased contract standard standardization to achieve purchasing efficiencies.
- $5.0 million adjustment to reverse one-time funding of Armed Outdoor Recreation and Education Activities funding to establish an outdoor recreation wellness program for military families in conjunction with vetted non-governmental partners.
- $5.0 million adjustment to reverse one-time funding for Fisher House.
- $5.0 million adjustment to reverse one-time funding of Fetal Alcohol Spectrum Disorders Prevention and Clinical Guidelines.
- $4.0 million adjustment to reverse one-time funding of Armed Forces Medical Examiner DNA testing funding increase to support the Prisoner of War/Missing in Action efforts.
- $2.5 million adjustment to reverse one-time funding of Specialized Medical Pilot Program for military orthopedic surgeons advanced arthroscopy skills course.
- $2.2 million decrease in Education and Training travel and equipment requirements at the Defense Health Agency through consolidation of education and training programs.

Continuing in FY 2024, the Department projects that up to $172.0 million should transfer to the Joint DoD -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 Center in the country by the total integration of the North Chicago VA Medical Center and the Navy Health Clinic Great Lakes, IL.

Continuing in FY 2024, 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.

RDT&E Changes

Narrative Explanation of FY 2023 and FY 2024 Research Development Test & Evaluation (RDT&E) Changes:

The DHP RDT&E Program reflects a net decrease of $2,109.6 million between FY 2023 and FY 2024. This includes a price growth of $18.4 million and a program decrease of $2,128.0 million.

Program **increases** include:

- $10.0 million increase associated with the internal realignment of funding for the APOLLO (Applied Proteogenomics Organizational Learning and Outcome) project to accelerate and broaden the successful research efforts in the development of new cancer treatments.
- $2.4 million increase associated with the programmatic transfer in accordance with the 711/737 US Army Medical Research and Development Command transfer to Defense Health Agency in support of Medical Products Support and Advanced Concept Development from Army PE 0604110A.

Program **decreases** include:

- $2,121.5 million decrease for FY 2023 one-time Congressional adjustments for congressional special interest.
- $10.0 million decrease associated with the internal realignment of funding for the APOLLO (Applied Proteogenomics Organizational Learning and Outcome) project to accelerate and broaden the successful research efforts in the development of new cancer treatments.
- $5.9 million decrease associated with the programmatic transfer in accordance with the 711/737 US Army Medical Research and Development Command transfer to Defense Health Agency in support of Medical Products and Support Systems Development from Army PE 0605145A.
- $2.1 million decrease associated with the realignment of funding to Information Technology Development – Defense Medical Information Exchange (DMIX) (PE 0605039DHA) from BA-08 Software & Digital Technology Pilot Program.
- $0.9 million decrease in miscellaneous adjustments related to DoD Healthcare Management System Modernization (DHMSM) and Medical Products and Capabilities Enhancement Activities.

Procurement Changes

Narrative Explanation of FY 2023 and FY 2024 Procurement Changes:

The DHP Procurement Program has a net decrease $188.2 million between FY 2023 and FY 2024. This includes price growth of $16.3 million and a net program decrease of $204.5 million.

Program **increases** include:

- $28.0 million increase to Joint Operational Medicine Information Systems (JOMIS) program per rephasing of activities to align with the program's new Acquisition Strategy and Capability Roadmap signed by Milestone Decision Authority (MDA) Jan 2021. Funding will be used for initial system implementation and fielding of JOMIS programs, to include new equipment training (NET) as well as procurement of hardware and software which is required to build out the infrastructure of JOMIS's hosting requirement. Deployment activities include purchasing required commercial software user license and site visits, localized configuration, on-site deployment support to include "over-the shoulder" support to approximately 450+ forward and resuscitative sites, 300+ ships, 2 hospital ships, 6 theater hospitals, and 3 aeromedical staging units deployed across all geographic combatant commands environments while providing access to authoritative sources of clinical data.

Program **decreases** include:

- $227.5 million decrease in Department of Defense Healthcare Management System Modernization (DHMSM) due to the planned completion of MHS GENESIS wave deployments in the first half of FY 2024.
- $5.0 million decrease for the replacement of medical equipment across the Military Health System for Medical/Surgical, Preventive Medicine/Pharmacy, and Radiographic programs.

President's Management Plan - Performance Metrics Requirements:

The Military Health System (MHS) continues to refine existing performance measures and develop specific criteria to determine and measure outputs/outcomes as compared with initial goals. The Quadruple Aim provides a focused and balanced approach to overall performance. This approach includes outcome measures related to medical readiness, a healthy population, positive patient experiences and the responsible management of health care costs.

- **Individual Medical Readiness** – This measure provides operational commanders, Military Department leaders and primary care managers use a measure 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 Component and Reserve Component) prior to deployment.

- **Beneficiary Satisfaction with Health Plan** – Satisfaction is measured using a standard survey instrument comparable to those used by civilian plans. The goal is to improve MHS beneficiary overall satisfaction with TRICARE to a level at or above benchmark satisfaction with civilian plans utilizing the Consumer Assessment of Healthcare Providers and Systems survey. Increasing satisfaction with the Health Plan indicates that actions being taken are improving the overall functioning of the health plan from the beneficiary perspective. The MHS is modernizing and improving all its surveys to better assess beneficiary satisfaction. The MHS plans to resolve current known survey challenges by normalizing by demographics and volume to make the data more meaningful, improve result accuracy and performance assessment. The MHS also plans to improve the response rate, which is very low; low survey response rates overrepresents negative bias, per survey science and peer-reviewed literature.

- **Medical Cost Per Member Per Year** – This measure focuses on the annual overall cost growth for the Prime enrollees and includes all costs related to health care delivered to enrollees. The objective is to keep the rate of cost growth for TRICARE Prime enrollees to a level at or below the increases for the Civilian health care plans 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 enrollment site, 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 family members enroll, the overall average would likely decrease. Using adjustment factors, a comparison across enrolment locations and across time is made more meaningful.

  Below is reporting for FY 2022 performance measures related to the Quadruple Aim. Performance in general represents a return to more normal health care operations by the end of the fiscal year, following MHS supporting the Federal Emergency Management Agency (FEMA) as part of the whole-of-government response in confronting COVID-19. While most treatment operations have returned to a normal level, the impacts related to COVID-19 remain a significant health risk that likely will impact health care operations as more is understood regarding the long-term impacts of the virus. The overall success of each measure is discussed below:

- **Individual Medical Readiness** – The MHS achieved 91 percent for the Total Force Medical Readiness in the last quarter of FY 2022 versus the goal of 90 percent. The FY 2022 adjusted target is based on updated guidance signed out in July 2022, with respect to enhancing the performance levels and clarified reporting of individuals. In the past, individuals who were reported under Medically Ready Indeterminate and those currently deployed impacted the measure in a manner that would artificially lower the score because of administrative items easily resolved once members returned from deployments. The fourth quarter of FY 2022 was the first reporting period that exceeded the revised goal established in July of 2022. The key drivers for improved performance include: (1) reduced delinquent PHAs, (2) reduced Deployment-Limiting Medical Conditions, (3) reduced percentage of delinquent dental exams (Dental Class 4), and reduced percentage of non-deployable dental conditions (Dental Class 3).

- **Beneficiary Satisfaction with Health Plan** – Satisfaction with Health Care Plan performance for FY2022 matched or exceeding the benchmark for all quarters based on Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey for the fiscal year. Overall, there was a slight decrease in the satisfaction level related to the continued access issues related to COVID-19. It appears that the continued access restrictions at the MTFs related to force health protections related to COVID-19 drove part of the decrease along with deployments in support of FEMA and whole-of-government response in confronting COVID-19. With the dramatic reduction of COVID-19 related health care utilization, the MHS has efforts in place to improve access to the

MTFs which should improve the overall trend and maintain levels above the benchmark for future fiscal years. Major performance drivers for this measure are related to claims processing timeliness, interaction during health care encounter, and access to health care.

- **Medical Cost Per Member Per Year – Annual Cost Growth** – The performance estimate for the first 11 months of FY 2022 is a 1.9 percent growth vs goal of 4.1 percent growth. This represents a return to normal performance for the system and is primary attributable to the impacts of COVID-19 on the United States health care system during the pandemic. Overall, the entire health care system experienced a dramatic increase in utilization of health care services during FY 2021 as delayed care from COVID-19 returned. The return of normal growth in FY 2022 represents what is expected to be continued health care utilization for TRICARE Prime enrollees that should remain for the next couple of years.

- Note: Due to the deployment of MHS GENESIS and data availability issues, sites that have deployed the new Electronic Health Record are excluded from the Per Member Per Month measure. The 11-month timeframe is being utilized because of the deployment of MHS GENESIS to additional treatment facilities, and related data issues that are in the process of being resolved that link direct care costs and workload for multiple years to ensure that trend information is available.