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About IDA

IDA is a private, nonprofit corporation that manages three Federally Funded Research and Development Centers. Our mission is to answer the most challenging U.S. security and science policy questions with objective analysis leveraging extraordinary scientific, technical, and analytic expertise.

This newsletter is prepared by IDA's health research team. For more information, visit https://www.ida.org/research-and-publications/research/health-research or email healthteam@ida.org.

Research Spotlight #1

RESTRUCTURING THE MILITARY HEALTH SYSTEM TO MEET THE NEEDS OF THE FORCE

W. Patrick Luan

Over the past 11 years since the establishment of the Defense Health Agency (DHA), the Department of Defense (DOD) and Congress have taken a perennial interest in reforming the Military Health System (MHS). Legislation has focused on form and function but rarely both in a systematic way — a casualty of the legislative cycle. As a result, reforms have largely been incremental and reactionary, with stakeholders tinkering with one cog at a time in a complex and dynamic system. Furthermore, subsequent provisions fail to account for the impact of prior years' reforms. In fact, rarely is the dust allowed to settle for effects to have time to manifest. Now, however, financial realities coupled with an acceleration of geopolitical events have brought a renewed sense of urgency.

What Is the Function of the MHS?

In layman's terms, the intended function of the MHS is easy to define. The MHS has three primary missions:

- Ensure that uniformed personnel are healthy to execute their missions (be a medically ready force).
- Ensure that uniformed medical personnel are trained to support operational forces (be a ready medical force).
- Deliver a health benefit to beneficiaries across the globe.

> "Form follows function — that has been misunderstood. Form and function should be one, joined in a spiritual union."
>
> — Frank Lloyd Wright

Function — especially intended function — is obscured when ideas are translated into requirements about, for example, how many medics and facilities are needed, or what capabilities and platforms are needed, and where.

This type of analysis is dynamic and complex. It is also mired in politics and parochialism. Objectively and systematically working through both form and function would require an end-to-end analysis of the core requirements of today's mission, future requirements for the next fight and how much excess capacity is necessary to account for unknown unknowns. These requirements would then be compared against the existing system. How does the existing health system support operational plans of the combatant commanders? How does it support force generation and sustainment? How does it support training, education and currency of the medical force? How should we provide public and private care to balance operational needs with delivering a

health benefit ? The MHS is not intended to be economically efficient. Nevertheless, leadership should set a threshold of how much slack health care capacity the DOD is willing to carry for national contingencies. Once requirements are understood, leadership should overlay existing resources against where those resources are needed most. Medical support to operational plans and combatant commands (COCOMs) should take priority over all else.

What Form Could the MHS Take?

The section that follows outlines an approach proposed by IDA for realigning MHS support to combatant commanders and the military components across the globe. At its most basic, this approach calls for a triage of existing health capabilities, capacity and personnel into four levels of military treatment facilities (MTFs):

- Priority 1 MTFs — those essential for operational medical requirements to maintain casualty evacuation from the COCOMs (medical hubs).
- Priority 2 MTFs — those necessary for force generation and sustainment (spokes).
- Priority 3 MTFs — those that fulfill unique operational requirements or serve geographically remote populations (requiring alignment of readiness and business cases).
- Priority 4 MTFs — those that should be considered for consolidation or closure.

Priority 1 – Academic Medical Center Hubs at Points of Disembarkation

Under this proposed realignment, Priority 1 MTFs are large medical centers that anchor the MHS at receiving hubs critical to medical evacuation. They also have large populations of beneficiaries enrolled in TRICARE, the military's healthcare program. These MTFs align to U.S. Transportation Command (USTRANSCOM) plans for ports of disembarkation. As such, it is important that these facilities be staffed to cover operational requirements with the necessary number and mix of clinical specialists. Medical billets at these facilities should receive priority fill designations by the armed services. Recent National Defense Authorization Act (NDAA) conference legislation from the Senate Armed Services Committee has called for identifying "four military medical treatment facilities as Core Casualty Receiving Facilities to

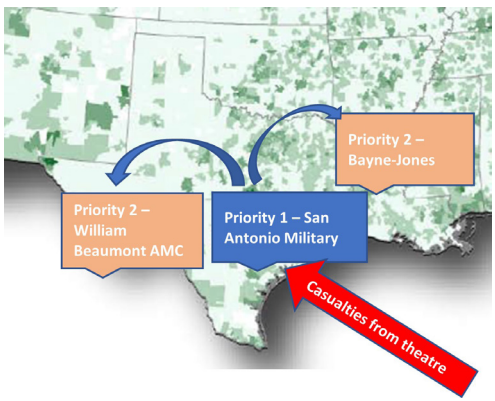
facilitate aeromedical evacuation of casualties from military operational theaters." Earlier versions of the legislation from the House further specified that Core Casualty Receiving Facilities be "manned at no less than 90% of the staffing level required to maintain bed capacities to support operational planning requirements." Other legislation has focused on establishing an academic health system in the National Capital Region. Establishing academic health systems at all Priority 1-designated facilities would concentrate medical capabilities to not only better support operational plans but also advance military medicine through research, education, clinical care delivery and collaboration with military and civilian medical institutions. These facilities could also support the hospital network within the National Disaster Medical System. The San Antonio Military Medical Center (SAMMC) is a leading example of this principle. It has collocated and coordinated:

- Research capability: U.S. Army Institute of Surgical Research, Naval Medical Research Unit – San Antonio, collaboration with The University of Texas Health at San Antonio.
- Medical education: San Antonio Uniformed Services Health Education Consortium for graduate medical education and the Medical Education and Training Campus for enlisted medical education.
- Clinical care delivery in coordination with the local civilian health system: SAMMC is the designated Level-1 trauma center for the community, accepting both military and civilian patients.

Priority 2 – Supporting Community Hospital Spokes

Priority 2 military treatment facilities are smaller community hospitals that support military academic health systems through a hub-and-spoke network. During contingencies, these MTFs support the redistribution of patients to provide care to lower-acuity triaged patients and by offering longer-term rehabilitation and stabilization for casualties. These facilities support the load management of casualty streams across the MHS. During peacetime, Priority 2 MTFs provide medical care to maintain force generation and sustainment at collocated training platforms and surrounding TRICARE beneficiary populations. These facilities should align Graduate Medical Education (GME) offerings to support this construct with a greater emphasis on primary care.

Priority 3 – Supporting Unique Operational Requirements and Remote Populations



Priority 3 facilities support unique operational requirements that cannot be met by the civilian sector. These requirements include assisting geographically remote or operational platforms that require dedicated medical support. MHS investments in telemedicine expand the suite of specialty services and consults available to smaller facilities. Given the nature of these missions and locations, patient volumes tend to be low. These facilities should pursue military-civilian partnerships to augment caseload and keep military medics clinically current. While the readiness of the force is the primary concern, the business and readiness cases should align to warrant continued operation of these facilities.

Priority 4 – Closure and Consolidation

Facilities that are deemed to be Priority 4 should be tagged for closure or consolidation with other MTFs. These facilities are likely affected by smaller beneficiary populations, misalignment of medical infrastructure and operational needs, or are areas with a robust civilian health care system that can absorb the additional caseload with improved efficiency.

Facility Triage	Atributes
Priority 1	• Medical hubs aligned to aeromedical evacuation plans and USTRANSCOM. • disembarkation ports. • Established as military academic health centers. • Consolidate GME and clinical research programs and shared services. • Priority fill for medical billets at 90% of personnel requirements. • Aligned to National Disaster Medical System. • Supported by large TRICARE beneficiary populations.
Priority 2	• Supporting spokes to Priority 1 medical hubs. • Affiliated foundational GME programs. • Support to patient redistribution and rehabilitation. • Support force generation and sustainment during peacetime – align staffing requirements to this construct.
Priority 3	• Meet unique operational requirements. • Support local beneficiary populations. • Supported by telehealth for specialty consults. • Augment caseload and case mix with military-civilian partnerships to maintain currency of medical personnel.
Priority 4	• Consider closure, consolidation or downsizing if business and readiness cases do not align.

Conclusions

The DHA should refocus on aligning form and function. Instead, it is restructuring around its existing set of chess pieces, trying to optimize the system it has rather than the system that is needed. Objective analysis is required to inform these decisions. However, time is of the essence as global conflict will not wait for internal departmental reform.

Research Spotlight #2

THREE POLICY INITIATIVES TO IMPROVE THE MILITARY HEALTH SYSTEM'S DIRECT-CARE SYSTEM

Jamie M. Lindly

While right-sizing the direct-care footprint will drive structural changes, the Department of Defense (DOD) should focus simultaneously on operational improvements to bolster the direct-care system. Any recommendations to improve how the military health system (MHS) uses military treatment facilities (MTFs) to support our nation's defense must start by recognizing that optimizing a system of 600 MTFs to simultaneously deliver comprehensive beneficiary care and maintain medical force readiness is a difficult challenge.

Many aspects of this dual mission are complementary, and the DOD should reinforce those features. However, many other aspects are not. This strategic paradox allows MHS leadership to vacillate between prioritizing medical force readiness over beneficiary care (or vice versa), depending on the broader DOD policy priorities of the moment, which have eroded both mission sets over time. While a comprehensive solution is beyond the scope of this article, the following sections details three practical policy initiatives that better align mission sets to accountability in the MHS.

Demand Leadership Continuity and Accountability

Policy Recommendation 1: Direct MTF succession policy where the XO assumes responsibility as CO at the end of the command tour.

The MHS has consistently advocated for better care, better health, improved readiness and lower cost as strategic priorities. Applying these goals to local, health care support operations across a wide range of military unit and beneficiary stakeholders is complex and time consuming. MTF commanding officers (COs) and executive officers (XOs) rotate independently every 24 months, with extended periods of nonavailability in reporting, detaching or both. Leaders need time to familiarize with their command – things such as site-specific MTF service lines and operating constraints, network care partners and medical referral availability, and overall medical and support staff teams. MTF COs and XOs typically have 18 months or less of actual effective site presence. New COs (every two years) often revisit MTF mission, vision, goals and strategic objectives at some point early in their tour, only for a succeeding commander to change or reprioritize them. Instead, MTF succession policy should have the XO assume responsibility as the CO at the end of the command tour.

This policy change will place the XO in a leadership role at the MTF for four years, during which they will have the opportunity to better understand and execute on the health care priorities of local stakeholders, beneficiaries and mission partners.

High-reliability organizations in military aviation, nuclear power and others have adopted such policies to reinforce safe, effective and reliable mission accomplishment. However, military medicine accepts leadership churning, which can mask accountability and lead to poor long-term strategic choices at the local level. With this policy change, MTF leaders would have to live by their decisions for more than six to 12 months before rotating to a completely different MTF, making them more likely to thoroughly develop, monitor and responsively adjust operating practices.

Link Medical Specialty Pay to Provider Readiness and Currency

Policy Recommendation 2: Link active-duty medical specialty pays to basic levels of annual medical caseload to reinforce medical currency and readiness.

Military medical professionals are kept in uniform to support the medical needs of deployed forces around the globe. During peacetime, these uniformed providers deliver beneficiary care in MTFs, support medical education and training programs or work in a variety of medical support functions often unrelated to their primary professional training. If military physicians choose to take multiple positions outside of their primary medical specialty, with no external practice caseload to maintain proficiency and currency, these providers become decoupled from the operational medical mission.

Even when practicing in MTFs, many critical-care or surgical specialties fail to achieve minimum caseload levels relative to their private sector peers due to the fewer cases generated from the generally younger and medically screened beneficiary population served by MTFs. These providers are "demand bound" in that their medical or surgical specialty is necessary to be in uniform to support casualties generated in contingency operations, even as they are expected to stay current with a patient population less likely to need their critical care services.

In either case (choosing positions outside of their practice specialty or working in MTFs with little demand for their services), military medical providers are often unprepared for combat operations while continuing to collect military medical specialty pay. Thus, a second suggested policy initiative is needed to more closely link what the DOD expends in medical specialty pays to basic levels of annual medical caseload. Such an initiative would reinforce medical currency and readiness. By focusing on medical specialty pays, which differ by specialty type, the MHS can best target compensation incentives to those medical or surgical currency and readiness requirements most closely related to future contingency-support demands.

This policy change for such a linkage in the MHS will likely instigate a challenge to the structure from the military medical establishment. The naysayers will engage in a variety of derailing arguments to prevent implementation, ranging from the legislative to the practical incentives of such a policy. The DOD already implements incentive pay structures for aviation and warfare specialties so that personnel remain proficient in their chosen profession (e.g., eligibility based on minimum flight hours per year). Why is the medical enterprise exempt from similar requirements? Under this policy change, the DOD would also demonstrate a respect for taxpayer resources by directly linking military medical specialty pay to the readiness of the providers.

Improve Utilization and Management of the Reserve Medical Force

Policy Recommendation 3: Improve accession and management of reserve component medical forces to supplement active component specialties unable to remain current in MTFs.

For many highly skilled medical professionals in the reserve components of the Army, Navy or Air Force, maintaining medical currency is not a problem. For the most part, the civilian practices of these reserve medical personnel have significantly greater volumes of higher acuity cases than do their active-duty peers working in MTFs. Rather than trying to sustain select active-duty medical specialties in MTFs with limited caseload, an IDA report suggests that the MHS should consider moving some of those trauma, surgical or critical-care support requirements to the reserve medical force. This third policy initiative would selectively shift medical personnel from the active force to the reserve component for specialties that have limited case demand inside MTFs.

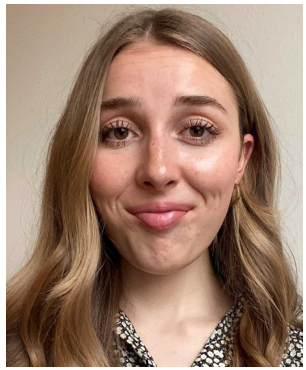
Military-civilian partnerships with Level 1 trauma centers provide excellent platforms to identify and engage critical-care personnel whose skills are essential in combat-casualty care. With only a single Level 1 trauma center in all of the DOD, medical personnel assigned to MTFs have limited opportunities to experience the types of medical trauma generated in combat operations. The DOD already sends active-duty critical-care providers to many external Level 1 trauma centers through military-civilian partnerships and could expand these existing programs to provide accession pathways for civilian providers to become reserve component members available to the DOD during times of mobilization. By using reserve component members in lieu of, or as a supplement to, active-duty providers, the DOD will gain access to physicians whose practice experience is more robust and relevant to combat-casualty care – and at a fraction of the cost of maintaining a full-time active force that is ill-prepared for contingency operations.

Start Now!

Making policy changes to how the DOD delivers care in MTFs will be difficult. Previous administrations have repeatedly failed to fundamentally affect leadership accountability, provider incentives or specialty mismatches. Such changes are necessary to deliver responsive beneficiary care in MTFs. By failing to address the fundamental causes of ineffective MTF utilization, the MHS continues to move services to purchased care, where the incentive structure is more responsive to patient needs. As these shifts from MTFs to purchased care continue, the DOD pays twice: once to preserve inefficient MTFs with few incentives or structures responsive to beneficiary needs, and again for the purchased-care services that beneficiaries eventually seek as they opt out of MTFs. Numerous additional policy changes will be necessary to reform MTF care delivery. The three discussed here – ensuring reliable leadership continuity, aligning provider incentives to maintain medical readiness and improving utilization of the reserve-component medical force – can set the foundation for improving MTF management. The alternative is to continue allowing military medical leadership to suboptimize down the path of least resistance and highest cost.

Research Spotlight #3

PRIORITIZING A VALUE-BASED MILITARY HEALTH SYSTEM PURCHASED-CARE MODEL

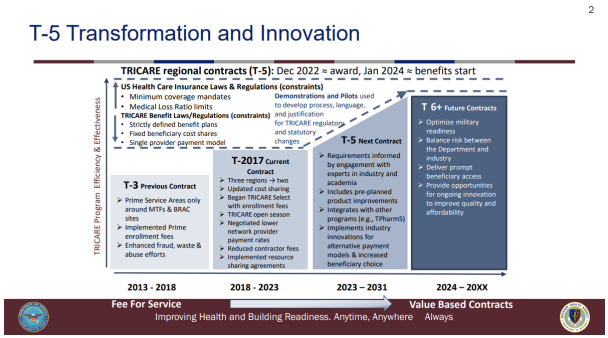


Mallory B. Thompson

What Happened to "Next Generation"?

The new Department of Defense (DOD) TRICARE purchased-care T-5 contracts, which came into effect on January 1, 2025, are yet another attempt in a multidecade-long struggle to improve the "delivery, quality, and cost" of TRICARE purchased-care services. The T-5 contract transition included two main changes: TriWest Healthcare Alliance will replace Health Net Federal Services, LLC as the West Region contract; and six states from the East Region contract are now part of the West Region contract. In addition, the Defense Health Agency (DHA) also implemented a swath of vague improvements, incentives and demonstrations in the new contracts. Despite these changes, many elements of these next generation contracts lag behind private sector health care best practices (i.e., value-based care, risk-sharing models, competitive contracts, etc.) and are only an incremental step towards reforming the growing purchased-care benefit.

In the 2017 National Defense Authorization Act (NDAA), Congress explicitly required that DOD "develop and implement [a] value-based incentive" purchased-care program by the beginning of 2018 and identified 13 elements that needed to be included in order to improve patient care. In 2020, the Government Accountability Office (GAO) reported that DOD had only "partially implemented six of the 13" required NDAA elements. DHA's consistent rebuttal was that the incoming T-5 contracts would address the shortcomings identified in the GAO report. However, now in 2025, the DHA's T-5 contracts still seem far from the value-based vision laid out in the 2017 NDAA. Based on the DHA's official T-5 Contract Overview Briefing, while the T-5 contracts do include some value-based improvements, the changes are incremental and only in a testing phase. Furthermore, in the figure below, it's clear that fully value-based contracts won't become a reality until an unidentified year after 2031.



DHA T-5 Transformation and Innovation Model, TRICARE (T-5) Contract Overview Brief to the Defense Health Board (2023)

The Customer Is Always Right: The Benefits of Value-Based Care

Value-based care is typically defined as a health care model where providers are compensated based on the quality, rather than the quantity, of the care that they provide. According to the American Hospital Association, in 2024, about 60% of private sector health care payments in the United States were tied to value and quality. Unlike the fee-for-service (FFS) model the DHA currently follows, value-based care models aim to shift the incentive structure away from "providing more" to "providing better." This patient-centered health care model prioritizes coordination, integration, quality and preventative care. Civilian network providers would be held accountable for providing timely and effective care, leading to benefits like better patient outcomes, reduced long-term health care costs, proactive patient engagement and better care-coordination among providers.

Despite clear direction from Congress, the DHA's purchased-care T-5 contracts still fail to incorporate best practices; an IDA report indicates that they are non-risk-bearing, noncompetitive, inflexible and inefficient. In order to directly address these deficiencies, the DHA should implement a risk-sharing health care model, increase competition and flexibility among providers, and consider creating a joint purchased-care support contract between the DOD and the Veteran Health Administration (VHA).

Take a Chance on Me: Establishing a Risk-sharing Care Model

In contrast to these value-based best practices, DHA follows a FFS-purchased health care model where providers charge DOD for individual services and are evaluated based on volume – as opposed to quality – of the services provided. As a result of this moral hazard, third-party administrators, who develop the community provider networks for the TRICARE contracts, are incentivized to negotiate low-fee schedules with providers in order to boost their own profit margins. This practice is analogous to cost-plus contracting in other defense acquisitions. Low-fee schedules (currently indexed to Medicare rates) disincentivize providers to prioritize TRICARE patients; instead, they encourage providing more services rather than the right services. Simply forcing third-party administrators to adjust the fee schedule is unlikely and probably ineffective in the long run. Rather, the DHA should implement value-based, risk-and fee-sharing practices to ensure that TRICARE network participants offer quality care to beneficiaries. Some of these practices could include requiring that providers assume the cost of readmitted patients, requiring extended appointment times (so doctors get to know their patients better), and implementing a capitated payment system. IDA research indicates that beyond the patient-related benefits of these changes, previous value-based, risk-sharing care practices could lower annual TRICARE costs by anywhere from $400 million to $1.5 billion.

No Progress without Competition: Improving TRICARE Competition and Flexibility

The DHA should also prioritize increasing competition and flexibility in future TRICARE contracts by allowing more contractors to bid for and participate in the contracts in order to provide better, more accessible care to beneficiaries. Most large federal health care programs, such as Medicare Part C, Medicare Part D and the Federal Employees Health Benefit Program, follow the model of having multiple contractors compete for their health plans in a given market area. In contrast, the current T-5 contracts feature only two contractors (or third-party administrators), TriWest and Humana, under a winner-takes-all contracting approach.

According to an IDA report, when beneficiaries have choice, carriers must compete for their business by offering a desirable benefit at a competitive price while also correcting problems and simplifying processes. Ultimately, with increased competition, if a plan fails to offer what the beneficiaries want, it is driven from the market with no DOD intervention required.

Thus, greater contract competition, when coupled with a risk-sharing model, is a patient-first health care approach that can help provide TRICARE beneficiaries with more robust, individualized and accessible care.

The Best of Both Worlds: Considering a Joint DOD-VHA Purchased-Care Support Contract

The DHA should also consider creating a joint purchased-care contract and fee schedule with the VHA in order to improve efficiency and the long-term health of care-for-service members. As mentioned in a previous IDA Health Watch article, combining the DOD's and VHA's health services under similar third-party administrators would likely allow both systems to "harness shared resources," affording beneficiaries with a wider range of service options. Since many service-related injuries and conditions may manifest after service or later in life, a joint support contract, in conjunction with a risk-sharing payment model, could hold providers more accountable to offering preventative and value-based care. This could ensure the longevity of service member health. In 2024, the DOD and VHA implemented a common electronic health record (EHR) system so that physicians could view a patient's full medical history. A joint and simplified purchased-care network is a natural extension to greater care coordination between departments.

Conclusion

The Secretary of Defense recently identified private sector health care as one of 17 priority expansion areas. Expanding purchased care in the absence of simultaneous reform of the contract structure would further entrench the inefficiencies and moral hazard of the existing construct. With the renewed attention to defense acquisition reform, DHA has an opportunity to innovate and lean in to congressional reform.