UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

The Honorable Carl Levin
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

JUN 27 2013

Dear Mr. Chairman:

The enclosed report responds to section 731(c)(2) of the National Defense Authorization Act for Fiscal Year (FY) 2013 (Public Law 112-239), which requires the Secretary of Defense to develop a detailed plan for Reform of the Administration of the Military Health System (MHS) and to deliver periodic reports on the progress of the development of the plan. Enclosed is the second of the three required reports.

This second report describes the status of the reform efforts, the metrics the MHS will use to evaluate the achievement of the objectives identified in the first report, as well as an explanation of the purpose and improvements made by each objective. The report also contains the personnel levels required for the Defense Health Agency and the National Capital Region Medical Directorate and the status of our planning activities for implementing shared services in FY14, which includes the business case analyses and timeline for implementation.

A similar letter is being sent to the other congressional defense committees.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families.

Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable James M. Inhofe
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

The Honorable Barbara A. Mikulski
Chairwoman
Committee on Appropriations
United States Senate
Washington, DC 20510

JUN 27 2013

Dear Madam Chairwoman:

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Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable Richard C. Shelby
Vice Chairman

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

The Honorable Harold Rogers
Chairman
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

JUN 27 2013

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Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable Nita M. Lowey
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

The Honorable Howard P. "Buck" McKeon
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

JUN 27 2013

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Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

Response to Congressional Defense Committees

**Second Submission under Section 731 of the**
**National Defense Authorization Act for Fiscal Year 2013**

# Plan for Reform of the Administration of the Military Health System

**The estimated cost of report or study for the Department of Defense is approximately $3,400 for the 2013 Fiscal Year. This includes $600 in expenses and $2,800 in DoD labor.**

**(Generated on 10 Jun 2013; Reference ID: F-1752E0F)**

## Introduction

This is the second of three responses to section 731 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2013, which affirmed the Department of Defense (DoD) blueprint for the Military Health System's governance reforms. In our first report to the Congressional Defense Committees, dated March 15, 2013, we listed detailed goals to be achieved while carrying out the defined reforms, along with milestones and schedules for implementing the Defense Health Agency (DHA), the enhanced multi-Service markets (eMSM), and the National Capital Region (NCR) Directorate reforms.

In this second response, section 731 requires that we provide the metrics associated with every goal, addressing the associated purpose, objective, and improvements of each. Section 731 also requires specific information for each shared service implemented during FY 2013. The Department of Defense (DoD) will not implement any shared services during FY 2013. However, in this response, we provide the status of our planning activities for implementing shared services in FY 2014, including the business case analysis and business process re-engineering methodologies used to assess each shared service. We also provide the business case analyses for 4 of the 10 shared services (Medical Logistics, Facility Planning, Health Information Technology, and TRICARE Health Plan). These four shared services will be implemented in stages beginning in FY 2014, with the other six implemented between October 1, 2013 (DHA Initial Operating Capability, IOC) and September 30, 2015 (DHA Full Operating Capability). In our next response to section 731, due September 30, 2013, we will provide the completed business case analyses (BCA) for the remaining six shared services, along with a status update regarding our readiness for IOC.

In response to the Report accompanying the House Armed Services Committee version of NDAA for FY 2014[1], we have included more information on how the goals were defined and how they relate to the DHA. We will provide the other requested information in the form of a supplemental report as required in the Report.

Since our last report was prepared, the Deputy Secretary of Defense issued formal guidance for implementation of MHS Governance Reform, with the concurrence and support of the Joint Chiefs of Staff. This memorandum is attached to this report (Attachment 1).[2]

We begin this response to section 731 with a review and status of our three major reform efforts and then address each of the seven objectives outlined in our March 15, 2013, response.

## Status of Major Reform Efforts

The following is a description of the progress that the DoD has made to: 1) create a DHA, 2) develop eMSMs, and 3) establish an NCR Medical Directorate. We have met significant milestones, outlined in our March response, for each of these three reforms, and consistent with the actions specified in the Deputy Secretary of Defense's March 11, 2013, memorandum.

[1] Per the House Armed Services Committee mark of the NDAA for FY 2014 for the June Report to Congress.
[2] Deputy Secretary of Defense 11 March 2013 Memo, Implementation of Military Health System Governance Reform.

**Defense Health Agency**

In his March 2012 memorandum on Military Health System (MHS) Governance, the Deputy Secretary of Defense noted that there are "opportunities to realize savings in the MHS through the adoption of common clinical and business processes and the consolidation and standardization of various shared services." The organizational structure we selected to drive this change is the DHA, which will accelerate implementation of shared services with common clinical and business practices. Furthermore, the DHA will enable improved enterprise-wide measurement of outcomes, rapid adoption of proven practices, reduction in unwarranted variation, and improvement in the coordination of care across time and treatment venues. To ensure accountability for meeting combatant commanders' needs, the DHA will be designated as a Combat Support Agency and led by a flag or general officer with the rank of Lieutenant General or Vice Admiral. In the third response to section 731, we will describe our proposed performance improvement cycle and the interdependent roles of the DHA and Service Medical Departments supported by our modified governance structures.

The movement toward enterprise consolidation and integration of shared services has been endorsed by others over the years. The Defense Health Board's Task Force on the Future of Military Health Care stated in its 2007 report: "Although consolidation and centralization are occurring at service level, fragmentation still exists at the MHS enterprise level."[3] The Government Accountability Office has stated, the "lack of coordination across the acquisition function results in redundancy, inconsistency, and an inability to leverage resources to meet common or shared requirements."[4] The Defense Business Board called for a shared service approach and stated that "the Department may not be fulfilling its obligations under public law requiring consolidation of shared services."[5]

Other pressure to reform the MHS has come from Congress, the Budget Control Act of 2011, and Department-initiated efficiencies. As the Department adjusts all budgets to reach the targets set by Congress through sequestration, the MHS must do its part to achieve administrative and clinical efficiencies through smart business reengineering. In addition, the Department has issued several manpower reduction mandates and we believe the MHS restructuring will allow prudent personnel reductions without sacrificing key mission activities.

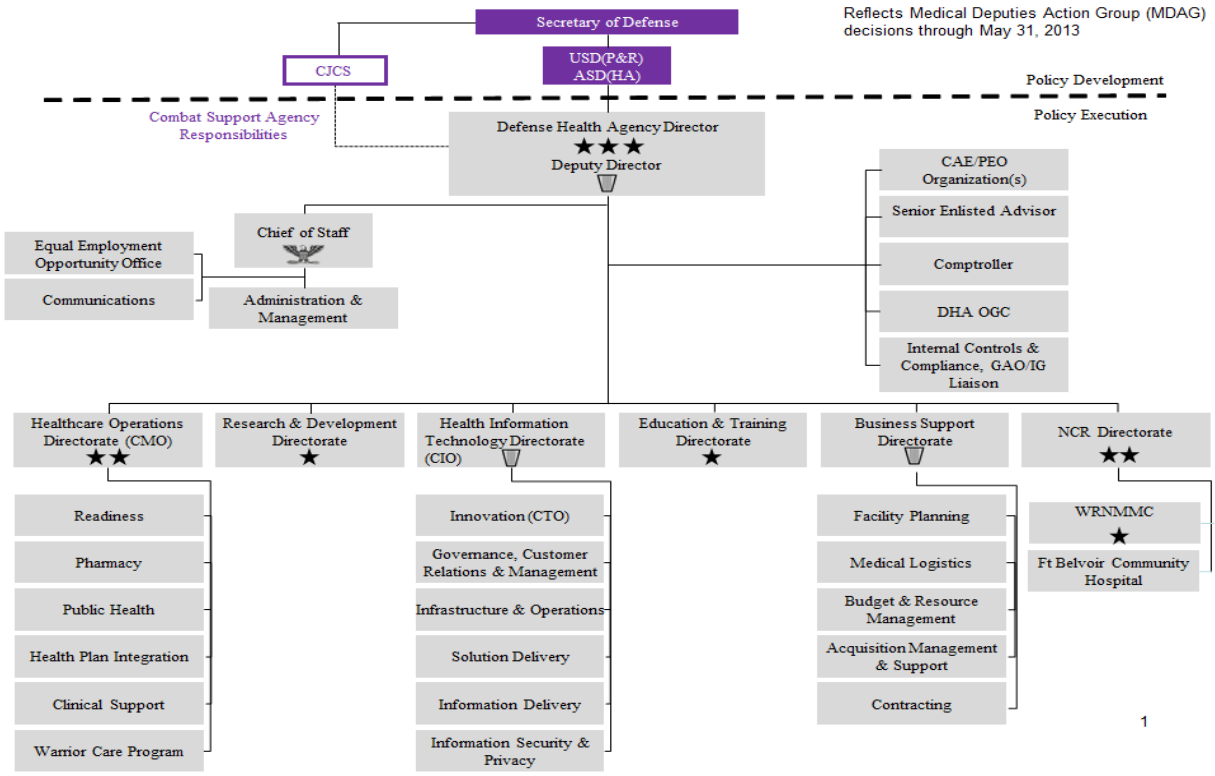
Progress to Date

The DHA Director has been confirmed by the Senate. A draft of the DHA Charter is in Department coordination. Figure 1 below shows a proposed DHA organizational structure and the TRICARE Management Activity (TMA) functional mapping to this proposed structure is nearly finished. We completed initial business case analyses for four of the shared services and work is proceeding on the remaining six. On October 1, 2013, the first four shared services will begin staged implementation within the DHA. In addition, all shared services will have

[3] Task Force on the Future of Military Health Care Final Report, December 2007.
[4] Framework for Assessing the Acquisition Function at Federal Agencies. GAO-05-218G. September 2005. See www.gao.gov/new.items/d05218g.pdf.
[5] Defense Business Board. Report to the Secretary of Defense, Military Health System – Governance, Alignment and Configuration of Business Activities Task Group Report, Report FY06-5. September 2006.

individuals identified who will be accountable for monitoring the cost and performance of their respective areas, as well as completing implementation of the shared service within the DHA. Creation of the DHA requires decoupling of the current "dual hat" structure of Health Affairs/TMA. Beginning October 1, 2013, Health Affairs (HA) will be responsible for policy and oversight, and the DHA will support the execution of policy, manage the TRICARE health plan, manage the NCR, and provide shared services. In doing so, the DHA will support the Services in execution of their medical missions.

**Figure 1: Proposed DHA Organizational Chart**




## Enhanced Multi-Service Markets

A key feature of a better integrated health care delivery system is the coordination of care and resources across a variety of service delivery sites and activities, as well as the ability to redistribute services to best address population needs. For the MHS, we took a step in this direction in 2003 when the Under Secretary of Defense for Personnel and Readiness signed a memorandum designating responsibilities and authorities for multi-service markets (MSM). These responsibilities and authorities included common appointing, referral management, capacity and workload planning, and a consolidated business plan. The initial implementation of the MSM concept demonstrated some level of success. To reach the next level of efficiency and effectiveness, and promulgate the best practices from the existing MSMs, additional authorities are being implemented along with a more robust governance structure to ensure quality improvements and enhanced value creation.

Progress to Date

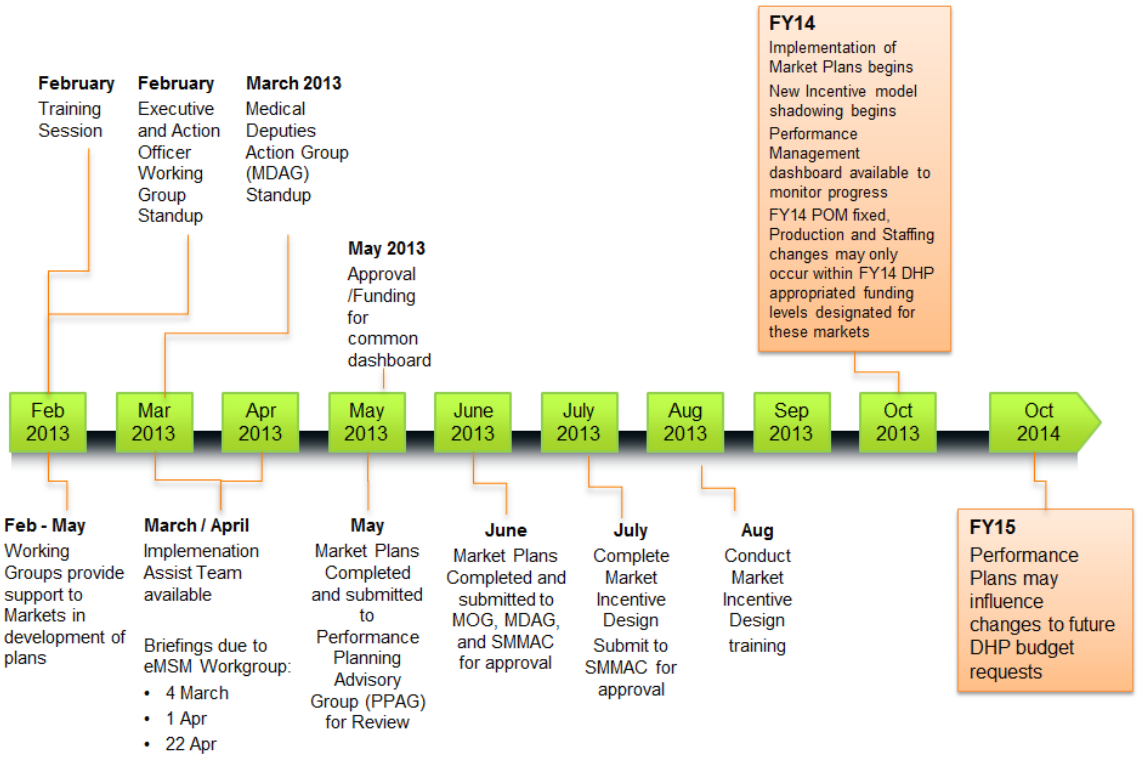
Since the last report, the MHS has conducted intensive planning for the rollout of the eMSMs. The six markets designated as eMSMs by the Deputy Secretary of Defense are Colorado Springs, Hawaii, National Capital Area, Puget Sound, San Antonio, and Tidewater; together they account for 53 percent of the direct care inpatient volume and 39 percent of the eligible population within catchment areas. Market managers for each location have been specified and their future roles and responsibilities have been codified and approved. Since the eMSM managers will be accountable for performance of military treatment facilities operated by more than one military Service, a new governance structure with representation from the three Services and the DHA has been implemented to provide oversight for the planning, implementation, and execution of 5-year business performance plans.[6] The internal functional structure of the eMSM offices has also been finalized.

In May, each eMSM submitted an initial 5-year business performance plan using a standard template that specified core components (Attachment 2). These draft plans were reviewed by a multidisciplinary team of experts and by the Medical Deputies Action Group[7] (MDAG), and are under revision with final plans due July 1, 2013. Additionally, MHS leaders have agreed on standard performance measures for all eMSMs and the new governance structure will monitor these measures. The figure below shows the progress achieved and implementation milestones.

[6] All new governance structure will be defined in the third report on MHS governance reform, along with the responsibilities and composition, as well as how they related to one another.

[7] The MDAG is a new committee consisting of the Deputy Surgeons General, a DHA representative, the Joint Staff Surgeon, and chaired by the Principal Deputy Assistant Secretary of Defense for Health Affairs (PDASD/HA). It is accountable to the Senior Military Medical Action Council.

**Figure 2: eMSM Business Performance Planning Timeline**




## National Capital Region Directorate

The creation of the NCR Directorate and disestablishment of the Joint Task Force National Capital Region Medical Command (JTF CAPMED) signals a significant change in the MHS following the completion of the Defense Base Realignment and Closure Commission NCR recommendations. The NCR Director is designated as an eMSM Manager and, as such, will be given the appropriate authorities required to manage the NCR medical market according to the principles and guidelines established by the eMSM initiative. Additionally, the NCR Director will exercise authority, direction, and control over the Walter Reed National Military Medical Center and Fort Belvoir Community Hospital, and their subordinate clinics.

Progress to Date

The NCR Director has been identified, and will assume duties on October 1, 2013. As an interim step to the placement of the NCR Directorate within the DHA, the Deputy Secretary of Defense has delegated day-to-day oversight and management of JTF CAPMED to the Assistant Secretary of Defense (ASD) HA. The JTF CAPMED, in anticipation of the NCR Directorate, is participating in performance planning along with the other five eMSMs, and will be evaluated using the same governance process and metrics. Staffing realignment for the NCR Directorate is nearly complete (see next section).

## Defense Health Agency and National Capital Region Directorate Staffing

The Defense Health Program (DHP) 2014 Budget Request reflected a reduction in funded civilian personnel. While some of this reduction will occur by attrition, it is our intent to avoid across-the-board allocations of civilian personnel reductions, and instead reduce overall staffing through the disciplined implementation of business and clinical processes. These collective reform efforts will be instrumental in guiding the DHP-funded civilian personnel reductions to the DHP 2014 Budget Request requirements.

The table below provides an estimate of staff at IOC (October 1, 2013) and includes JTF CAPMED personnel available to staff the DHA NCR Directorate. Neither TMA nor JTF CAPMED will exist as of October 1, 2013. In addition, on that date, the DHA will include Army, Navy, and Air Force military and civilian personnel for the first four shared services (Medical Logistics, Facility Planning, Health Information Technology, and TRICARE Health Plan Support). We will submit a revised estimated staffing level chart in our September 2013 response once the remaining BCAs and business process reengineering (BPR) plans are completed.

| **Preliminary Defense Health Agency Staffing at IOC[8]** | |
|---|---|
| | **Estimated Authorizations** |
| **Defense Health Agency (Overall)** | **1,081** |
| **Defense Health Agency** | **1,039** |
| **National Capital Region Directorate (HQ)** | **42** |

## Strategic Vision, Objectives, and Measures

In the March 2013 response to section 731, we provided seven objectives that support the MHS strategic vision, restated below.

> "The integrated Military Health System delivers a coordinated continuum of preventive and curative services to eligible beneficiaries and is accountable for health outcomes and cost while supporting the Services' warfighter requirements."

The strategic vision and the seven objectives were derived, and subsequently endorsed, by the MHS leadership, including the Surgeons General of the Military Departments. Together they reflect our joint approach to MHS reforms that ensure military readiness by improving the care and health of our beneficiaries with cost-effective strategies. In addition, in our March 2013 response we outlined a new vision for the MHS – one of improved system integration. We provided evidence from private sector health care organizations illustrating the performance advantage of such a strategy.

[8] These estimates exclude Uniformed Services University of the Health Sciences (USUHS) personnel.

What do we mean by "improved integration" and why is the DHA critical to its achievement? Integrated health services can be interpreted in a variety of ways. For the MHS this means bringing together joint support functions and strategies into a new enterprise-focused organizational structure. When we can see and manage across the enterprise in a more unified way, we will be able to optimize the health status and readiness of our entire population more efficiently. The DHA is critical to this strategy and our efforts to eliminate redundancy, reduce variation, and create the conditions for learning and continuous improvement. Other successful organizations such as Kaiser Permanente have created shared services and used similar structures to achieve standardization, drive down costs, and improve performance.[9]

This strategy is the natural and necessary evolution of the MHS that will make us better, stronger, and more relevant to the future; a future with more constrained resources and where the medical response to future military engagements is "joint."

In the sections that follow, we discuss each of the seven objectives and the metrics to help us achieve our strategic vision. We believe that the DHA is the structural organization to drive the change we desire.

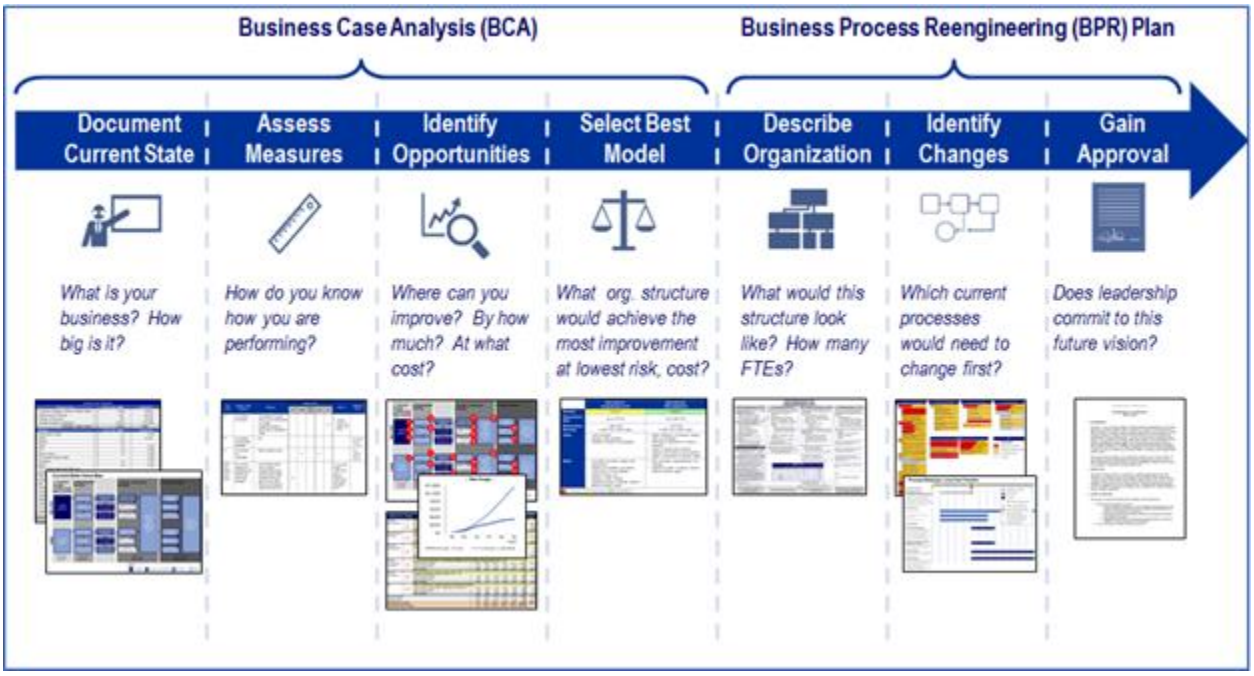
**Objective 1: Promote more effective and efficient health care operations through enhanced enterprise-wide shared services.**

Sharing common services is a proven method to reduce variation and eliminate redundant processes within an organization to deliver cost-savings and improve performance. Examples include centralizing financial processes, information technology, human resources, procurement, research and development, legal services, and marketing. Consolidating services has been successful for governments and private industry.[10,11]

At IOC, the DHA will assume management responsibility for shared services, functions, and activities of the MHS and its common business and clinical processes, starting with the 10 services identified in the Deputy Secretary of Defense's March 2012 memo and listed again here for reference: the TRICARE Health Plan, pharmacy programs, medical education and training, medical research and development, health information technology, facility planning, public health, medical logistics, acquisition, and budget and resource management. Services will be shared in a variety of ways. Some will place all shared service personnel within the DHA; others will have critical service components remaining in the Military Medical Departments. In order to determine how the DHA will assume management responsibility for each shared service, we first determine the "value proposition" and quantify the opportunities through the development of a business case analysis, followed by a business process reengineering plan for each approved BCA. This process is illustrated in Figure 3 below, followed by a brief discussion of each step.

[9] Daniels, Dick, Presentation to DoD on Kaiser Permanente Shared Services, May 2013.
[10] Kaplan, Robert S., and David P. Norton. "Creating Synergies through Shared Services." *The Strategy-focused Organization: How Balanced Scorecard Companies Thrive in the New Business Environment*. Boston, MA: Harvard Business School, 2001.
[11] Federal Information Technology Shared Services Strategy, Office of Management and Budget, May 2012.

**Figure 3: Shared Services Process**




Step 1: For each defined shared service, using subject matter experts from Office of the Secretary of Defense (OSD), TMA, and the Services, the current state is carefully documented, including identification of the customers, product lines, enablers, available measures, baseline annual costs, and the number of personnel performing activities specific to that shared service. Then, the annual costs are validated through a council composed of the cost assessment and program evaluation experts from TMA and the Service Medical Departments.

Step 2: For each specific service, function, or activity under evaluation, current performance metrics are identified, confirmed by managers, and compared to existing industry standards. If measurement gaps are identified, a plan to develop appropriate measures is created. Included in these measures are cost, quality, timeliness, and customer satisfaction.

Step 3: Once the current state and measures of effectiveness have been identified, the team looks for performance improvement and cost reduction opportunities, which are documented. Initiatives are developed around each of these opportunities along with the identification of the resources necessary to fully realize the identified potential. The team also develops a plan for adapting existing measures or developing new measures for each of these opportunities.

Step 4: The final step in the business case analysis effort for each shared service is the development of an operating model that describes the extent of integration into the DHA. Each shared service work group is asked to examine at least four options: 1) consolidation of all operations under the DHA; 2) consolidation under a lead Service; 3) integrated management with limited consolidation of operations in the DHA (for example, shared measures of cost and performance for a given shared service); and 4) outsourcing to an external service provider. Each team is encouraged to examine a hybrid combination of these alternatives.

At the completion of this work, the team determines the preferred course of action and presents the business case analysis to a steering committee for validation and then to the MDAG for decision and approval. Once a course of action is determined, the expert working group begins the business process reengineering plan. We do not expect approval of each business case the first time through the process and have, in fact, sent the teams back to do additional analysis or to consider other alternative courses of action (CoA).

Step 5: The business process reengineering begins with the approved CoA and development of a functional design. This design work identifies resourcing, geographical considerations (if any), and required policy changes. In this more detailed planning, the team considers exactly which functions become DHA responsibilities, along with the attendant resources.

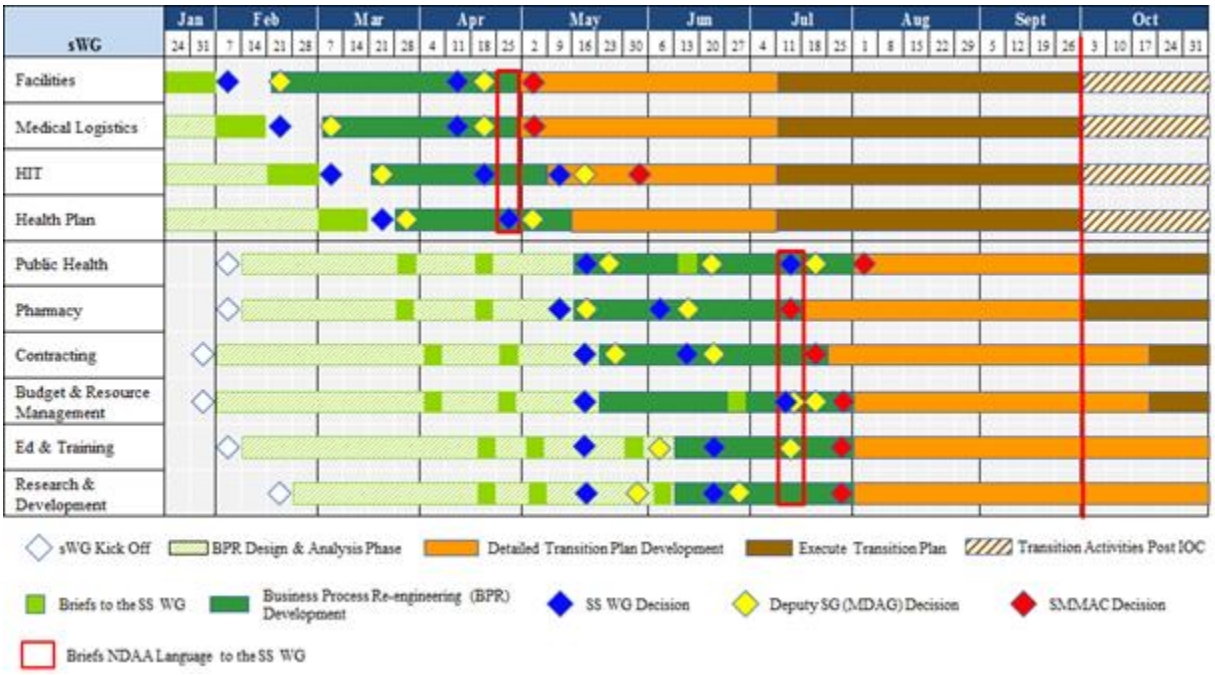
Step 6: The specific process changes to implement the functional design are determined and scoped accordingly. Each identified process change is categorized according to the level of change required (from "little" to "significant," or "new process"), and prioritized and classified as to importance relative to performance and cost. This information is put into a schedule for process redesign implementation. Along with these changes, a coordinated concept of operations is developed through collaboration among the business process/shared service "supplier" and the "customers" that specifies the scope of services provided, a defined dispute resolution process, accountability for cost and performance, and defined performance reporting requirements.

Step 7: The coordinated plan is presented the MDAG and Senior Military Medical Action Council for approval to proceed with implementation.

We will have a single accountable leader for each shared service within the DHA who will be responsible for monitoring performance improvement plans and have authority to oversee corrective actions directed by senior MHS leadership. The creation of a single leader with enhanced authority and accountability to carry out these improvements is made possible by the establishment of the DHA.

To date, we have several shared services complete the business case analysis and process reengineering plans. In the next section, we discuss the shared services initially identified for major implementation action in FY 2014 (Medical Logistics, Facility Planning, Health Information Technology, and TRICARE Health Plan) and how the processes described above were used to identify business processes for improvement, along with potential cost, infrastructure, and personnel savings associated with moving the shared service within the DHA structure. Figure 4 provides the shared services schedule as of June 1, 2013.

**Figure 4: Notional Shared Services Schedule**




## Measures:

The overall purpose or goal of this objective is to "realize savings in the MHS through the adoption of common clinical and business processes and the consolidation and standardization of various shared services."[12] The specific measures of success for this particular objective include: 1) reduction of redundancies; 2) decrease in process variation; 3) improved efficiency; and 4) achievement of cost savings.

While we are still working through the business case analyses and process reengineering plans for the shared services to be implemented in FY 2014 and beyond, in this report we provide the business case analyses of four shared services and an update on the progress of the additional six shared services. We have included the purpose of the integration, the services that will be consolidated, the scope of responsibilities within the shared service, preliminary savings estimates and implementation costs (based on the business case analyses we have performed), the timeline for implementation, and the measures we will use to assess performance following implementation.

## 1.0 MEDICAL LOGISTICS

Medical Logistics (MEDLOG) refers to a distinct set of capabilities required to meet the Services' medical materiel requirements for force health protection and health care delivery in both garrison and theater. MEDLOG encompasses a connected series of life-cycle management activities from identification and validation of requirements through acquisition, fielding,

[12] Deputy Secretary of Defense, March 2012 Memo: "Planning for Reform of the Governance of the Military Health System"

sustainment, and ultimate retrograde or disposal. In FY 2011, MEDLOG represented a $2.3 billion line of business, not including pharmaceutical supplies.

## 1.1 Purpose

The MEDLOG shared services will standardize clinical demand signals for medical supplies, equipment, and aseptic cleaning (that is, housekeeping services), and establish DHA oversight of compliance with best purchasing practices across the MHS. Implementation will leverage the well-established Defense Medical Logistics (DML) governance framework and build on DML shared services for medical materiel standardization and strategic acquisition that enable electronic commerce and lean distribution. Improving critical processes will increase efficiency, reduce purchase costs, and improve responsiveness to clinical requirements while laying a foundation for greater reengineering in business processes and supporting information technology enablers.

## 1.2 Consolidated Services

MEDLOG shared services will improve product standardization and optimize contracting and sourcing strategies in support of military treatment facility (MTF) operations. The DHA will provide performance and compliance oversight of MEDLOG product line execution by the Services.

## 1.3 Shared Services Scope of Responsibilities

**(1) Corporate management over joint medical logistics initiatives.** The DHA will have responsibility and oversight of materiel standardization and other shared services described in DoD Instruction 6430.02, "Defense Medical Materiel Program." The Defense Medical Logistics Proponent Committee will link DHA governance to the Services' management of MEDLOG functions and provide a collaborative forum for development of joint business solutions, information system requirements, and performance standards. The DHA will also leverage and strengthen the MHS strategic partnership with the Defense Logistics Agency (DLA), the DoD Executive Agent for Medical Materiel. The DHA, in coordination with the Services and DLA, will develop business process reengineering initiatives to realize enterprise capabilities beyond IOC for support of global healthcare delivery and medical materiel readiness.

**(2) Standards, metrics, and compliance oversight.** The DHA will develop standards and metrics to improve visibility and reliability of performance data in order to uniformly assess MEDLOG performance and enable governance to take corrective action and monitor results. In coordination with the DHA Health Care Operations Directorate, it will develop measures to ensure MEDLOG product lines remain responsive to clinical demand triggers and ensure that efficiency initiatives do not compromise the safety and quality of patient care. Several initial measures are identified in the relevant section below.

## 1.4 Cost Reductions

Implementing the MEDLOG shared service has the potential to save approximately $353 million ($132 million risk-adjusted) over 6 years as shown in the table below. To achieve savings, we will first need to invest in a standard enterprise catalog of medical supplies and equipment and upgrades to existing information technology (IT) systems to allow real time reporting and reduce off-catalog purchases. Subsequently, we anticipate that the MEDLOG shared service begins to realize savings by increased procurement of standardized products and enterprise level contracting for high cost products and services.

Savings were risk-adjusted using the following methodology. Subject matter experts assessed the likelihood of achieving the savings by scoring each savings opportunity as having a high, medium, or low risk level. Low risk corresponded to a 100 percent probability of achieving the savings, medium risk corresponded to a 50 percent probability of achieving the savings, and high risk corresponded to a 10 percent probability of achieving the savings. Savings were then multiplied by the appropriate probability factor to calculate the risk-adjusted estimate.

| **Medical Logistics Projected Net Savings, FY14-FY19 ($M)[13]** | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | **FY14** | **FY15** | **FY16** | **FY17** | **FY18** | **FY 19** |
| **Savings** | Annual Savings | $0 | $22 | $56 | $81 | $98 | $115 |
| | Annual Risk Adjusted Savings* | $0 | $9 | $22 | $33 | $40 | $47 |
| | Cumulative Savings | $0 | $22 | $78 | $158 | $256 | $372 |
| | Cumulative Risk Adjusted Savings* | $0 | $9 | $32 | $65 | $105 | $151 |
| **Implementation Costs** | Total Annual Implementation Costs | $5.7 | $5.8 | $4.0 | $1.2 | $1.2 | $1.3 |
| | IT Cost, Annual | $5.3 | $4.5 | $2.1 | $0.0 | $0.0 | $0.0 |
| | Contractor Support Cost, Annual | $0.0 | $0.2 | $0.4 | $0.7 | $0.7 | $0.7 |
| | Personnel Severance, Annual | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 |
| | Personnel Relocation, Annual | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 |
| | Military Construction, Annual | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 |
| | Other, Annual | $0.4 | $1.1 | $1.5 | $0.5 | $0.6 | $0.6 |
| | Cumulative Implementation Costs | $5.7 | $11.5 | $15.5 | $16.7 | $17.9 | $19.2 |
| **Net Savings** | **Annual Net Savings** | **($6)** | **$16** | **$52** | **$79** | **$97** | **$114** |
| | **Annual Risk Adjusted Net Savings*** | **($6)** | **$4** | **$18** | **$32** | **$39** | **$46** |
| | **Cumulative Net Savings** | **($6)** | **$10** | **$62** | **$141** | **$238** | **$353** |
| | **Cumulative Risk Adjusted Net Savings*** | **($6)** | **($2)** | **$16** | **$48** | **$87** | **$132** |

[13] Future year savings and implementation costs have been inflated to "then year" dollars using inflation rates from the OSD Comptroller FY14 "Green Book".

## 1.5 Timeline

- By July 1, 2013, the BPR Plan for the MEDLOG shared service will be complete.
- By July 1, 2013, a Transition Plan will be developed for the MEDLOG shared service.
- By September 1, 2013, the Department will have identified the DHA MEDLOG Director and a proposed organization structure.
- Beginning October 1, 2013, the MEDLOG shared service will begin implementation under the authority of the DHA.

## 1.6 MEDLOG Measures

The MEDLOG community has a mature measurement capability, but lacks some enterprise-wide standard measures. The following specific measures will be developed and included in an enhanced dashboard related to improvements included in the BPR plan. The measures have been aligned with the three primary product lines referenced in section 1.1 – medical supplies, equipment, and aseptic cleaning (that is, housekeeping services).

- Percentage of procurement of standardized products (Enterprise wide, by MTF)
- Percentage purchased by e-commerce (prime vendor, electronic catalog; Enterprise wide, by MTF)
- Total cost reduction (spend and percentage) achieved through joint requirements analysis
- Total cost reduction (spend and percentage) achieved through equipment group purchases
- Total cost reduction (spend and percentage) of DoD service maintenance contracts
- Ratio of total DoD contract maintenance costs to total DoD Biomedical Equipment Technicians working in MTFs
- Cost per square foot cleaned (housekeeping)
- Number of patient complaints for housekeeping

# 2.0 FACILITY PLANNING

The MHS is a large, complex provider and payer organization, with more than 1,000 medical facilities valued at approximately $33 billion. They represent a significant annual investment of about $4 billion, approximately half of which is for military construction (MILCON) and half is for managing, planning, and operating MHS medical buildings.

## 2.1 Purpose

Facilities are a long-term investment in the strategy of any healthcare organization. They are investments in specific markets, based on an estimate of a 30 year projection of health care demands. They also create the safe environment where health care providers interact with one another and their patients. For the MHS, they are also an investment in future military capacity, built with the readiness mission and force size in mind. The MHS must link brick-and-mortar investments to a holistic vision of the future demand and strategy. For this reason, it is critical that the MHS has a rationalized demand signal that is centrally and strategically incorporated into enterprise facility planning requirements.

This facility planning shared services transformation will achieve this vision. It will evolve the current business model – one where each Service manages its own facilities portfolio and identifies its own individual needs for facilities – into a central portfolio management function, which will tie the MHS's future readiness and health requirements to building investment decisions across the portfolio. This approach better tailors investment decisions to meet future needs, and may allow the organization to build and operate less space while better meeting the mission. Additionally, the DHA will establish and strengthen enterprise standards, standard business processes, and performance measurement functions, which will help decrease variance across the entire facilities business. Decreased variance will decrease the cost of designing, constructing, initially outfitting, and operating the MHS's facilities, while maintaining or improving quality.

## 2.2 Consolidated Services

To set standards and performance measures across the entire facilities portfolio, the facility planning shared service will consolidate the "upstream" functions in the facilities lifecycle. Specifically, this shared service will centralize the corporate management and budget of the entire MHS facilities portfolio and requirements planning activities for large construction projects, which includes MILCON and large restoration and modernization projects. Additionally, in order to decrease variance and costs in design and construction, the facility planning shared service will consolidate MILCON design and construction oversight. Lastly, in order to decrease variation, decrease cost, and improve performance across the system, the facility planning shared service will consolidate standards and program management for the more "downstream" functions which occur once a building is already built, including initial outfitting and transition of building activation, and operations and maintenance. The Services will execute these "downstream" functions, but their execution will be consistent with standards and guidance set by the facility planning shared service.

## 2.3 Shared Services Scope of Responsibilities

**(1) Corporate management over the facilities portfolio.** The facility planning shared service will maintain visibility across the entire MHS facilities inventory. This visibility will allow the enterprise to better understand and monitor the utilization and condition of its assets. The facility planning shared service will use data to improve performance by managing metrics, analyzing data, identifying best practices and suboptimal performance, and using this information to improve asset management. Given the dynamic nature of healthcare, the facility planning shared service will consistently compare the healthcare demand to the state of the inventory, identify opportunities to improve the value of the portfolio, and prioritize, in coordination with the Service Medical Departments, potential investments.

The facility planning shared service will link to, translate, and execute external demand signals that are critical to produce a high quality, cost-effective facilities portfolio. The facility planning shared service will:

- Set standards, develop metrics, and track performance across the entire MHS facilities business;

- Develop training to help consistently implement these standards;
- Coordinate activities within the MHS facilities business (for example, between the Services and the DHA) and with external groups (for example, with the Department of Veterans Affairs);
- Oversee the entire MHS facilities program and budget;
- Coordinate MHS facilities contracts;
- Conduct research and innovation activities;
- Oversee philanthropic efforts; and
- Provide a robust knowledge base of subject matter experts (for example, architects, Joint Commission accreditation experts, interior designers, et cetera) accessible to all MHS facility stakeholders.

**(2) Requirements planning.** For all of the Service Medical Departments, the facility planning shared service will develop standard methodologies for predicting and quantifying healthcare requirements for brick-and-mortar facilities.[14] Where there is an opportunity to increase MHS facility portfolio value, the facility planning shared service will develop and compare potential solutions. More specifically, the facility planning shared service will conduct periodic health care requirements analyses for all planning factors likely to lead to MILCON or large restoration and modernization (RM) projects. These requirements analyses will produce the documentation needed to secure capital funds and to begin the design process.

**(3) Design and construction oversight.** The facility planning shared service will be responsible for the executive management of major design and construction, to include new MILCON as well as large RM projects. As part of this oversight, the facility planning shared service will develop project-specific support agreements with the Design and Construction Agents, and track Agent performance by monitoring both cost and quality. While the Services maintain responsibility for outfitting, transitioning, and activating individual projects, the facility planning shared service will set standards, monitor performance, help establish joint regional and global contracts, and perform other activities as necessary to achieve standardization.

**(4) Standards and program management for facility operations.** The facility planning shared service will oversee facility operation processes to reduce process variance and promulgate best business practices. The facility planning shared service will develop standards for operations and maintenance, track the use of standards through performance metrics, provide training on the execution of standards, facilitate the use of best practices, and provide program management for enterprise-wide programs, such as energy and sustainability. Some of the identified measures are provided below.

## 2.4 Cost Reductions

Implementing the facility planning shared service has the potential to save approximately $1.1 billion ($590 million risk-adjusted) over 6 years. To realize these savings, we will first need an investment to support standardization of business processes and IT improvements that allow for full data visibility across the portfolio, as well as additional BPR efforts to standardize the

[14] Service-unique requirements may be accommodated by an exception process.

manner in which the facilities portfolio is built, outfitted, activated, and then operated and maintained. The subsequent savings will accrue as the facility planning shared service tailors investments for the quantity and type of new hospitals and clinics; this has the potential to appropriately reduce the current number of square feet operated and built each year. These efforts will, in turn, decrease MILCON costs, as well as annual operating and maintenance costs. Future savings will accrue over time as reflected in the table below.

| Facility Planning Projected Net Savings, FY14-FY19 ($M)[15] | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | **FY14** | **FY15** | **FY16** | **FY17** | **FY18** | **FY 19** |
| **Savings** | Annual Savings | $23 | $64 | $181 | $245 | $345 | $382 |
| | Annual Risk Adjusted Savings* | $4 | $33 | $98 | $139 | $196 | $217 |
| | Cumulative Savings | $23 | $86 | $267 | $512 | $857 | $1,239 |
| | Cumulative Risk Adjusted Savings* | $4 | $37 | $135 | $274 | $470 | $688 |
| **Implementation Costs** | Total Annual Implementation Costs | $21.9 | $22.7 | $21.4 | $14.1 | $8.5 | $8.7 |
| | IT Cost, Annual | $12.8 | $15.3 | $17.7 | $10.9 | $6.0 | $6.1 |
| | Contractor Support Cost, Annual | $8.6 | $7.4 | $3.7 | $3.3 | $2.5 | $2.6 |
| | Personnel Severance, Annual | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 |
| | Personnel Relocation, Annual | $0.6 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 |
| | Military Construction, Annual | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 |
| | Cumulative Implementation Costs | $21.9 | $44.6 | $66.0 | $80.1 | $88.6 | $97.3 |
| **Net Savings** | **Annual Net Savings** | **$1** | **$41** | **$160** | **$231** | **$337** | **$373** |
| | **Annual Risk Adjusted Net Savings*** | **($18)** | **$11** | **$77** | **$125** | **$188** | **$209** |
| | **Cumulative Net Savings** | **$1** | **$42** | **$201** | **$432** | **$769** | **$1,142** |
| | **Cumulative Risk Adjusted Net Savings*** | **($18)** | **($8)** | **$69** | **$194** | **$382** | **$590** |

*See the section 1.4 (MEDLOG) for an explanation of the risk-adjustment methodology.

## 2.5 Timeline

- By July 1, 2013, the BPR Plan for the facility planning shared service will be complete.
- By July 1, 2013, the Transition Plan will be developed for the facility planning shared service.
- By September 1, 2013, the Department will have identified the DHA Facility Planning Functional Lead and a proposed organization structure.

[15] Future year savings and implementation costs have been inflated to "then year" dollars using inflation rates from the OSD Comptroller FY14 "Green Book"

- Beginning October 1, 2013, the Facility Planning shared service will begin to execute implementation under the authority of the DHA.

### 2.6 Facility Planning Measures

The Facilities community has mature measurement capabilities, but lacks some enterprise-wide standard measures of facility condition and functionality. The following specific measures will be developed and included in an enhanced dashboard related to improvements included in the business process reengineering plan.

- Savings achieved vs. savings projected
- Facility Condition Index
- Facility Functionality Index
- Asset Productivity Index
- Percentage of projects performed within cost and schedule
- Customer Satisfaction Survey with facility environment

## 3.0 HEALTH INFORMATION TECHNOLOGY

MHS Health Information Technology (HIT) provides the right information to the right people at the right time in support of military health care operations. Approximately 230,000 MHS users depend on IT services delivered through several DoD organizations, including TMA and each of the Service Medical Departments. IT services are provided across many venues—56 military hospitals and 360 clinics, expeditionary settings, TMA headquarters and regional offices, Services' headquarters and intermediate commands, the Uniformed Services University of the Health Sciences, and patients and families.

### 3.1 Purpose

HIT provides the critical infrastructure and software for an integrated delivery system and is a key enabler of all seven strategic objectives for the MHS governance reforms. For example, HIT supports data collection to measure and improve the cost and performance of shared services and enterprise-wide population heath initiatives. HIT enables new provider-patient communication methods for our Patient Centered Medical Homes and access to patient health data for 24/7 delivery of care anywhere in the world. HIT aids health system planners in collecting system data for forecasting the demand for health services so that the right infrastructure can be built and personnel can be distributed in the best interest of the enterprise. HIT enables system wide efforts to implement inter-Service standards and processes, and data collection to increase the overall measurement capacity of the system. HIT assists the eMSMs in implementing a standard set of performance measures and targets, and collecting the necessary data needed to quantify opportunities to recapture care. HIT enables new forms of incentives and reimbursement mechanisms by allowing the enterprise to link rewards to value creation in a fair and equitable manner, based on consistent and authoritative sources of data.

A fragmented, disjointed HIT platform will promote a fragmented, disjointed health system. On the other hand, a unified, integrated set of HIT shared services, driven by the need for decisional

information, can accelerate our system integration efforts. Because of the enterprise-wide need for these capabilities, the MHS has selected a fully consolidated operating model for HIT.

### 3.2 Consolidated Services

The future state operating model for HIT is one where all services—IT management, infrastructure, and applications—will be consolidated and placed under the management of the DHA, creating a single point of accountability for the delivery of HIT services to MHS customers and tightly integrated to the functional/operating components of the MHS. This model will be implemented over time, beginning with the consolidation and reengineering of IT management functions. Infrastructure will be consolidated and brought under the management of the DHA in a stepwise fashion that minimizes mission risk and disruption of service to end users. Applications will be consolidated and transitioned on a product-line-by-product-line basis.

### 3.3 Shared Services Scope of Responsibilities

**(1) Management services.** The HIT shared service will consolidate and reengineer all IT management services with a focus on customer service optimization. This effort includes IT governance, strategy, enterprise architecture, portfolio management, requirements management, business process reengineering, relationship management, and program management. Today, IT management services are provided by TMA, Army Medicine, Navy Medicine, Air Force Medical Service, and JTF CAPMED. In the future state, the DHA will be the single provider of these services.

**(2) Infrastructure services.** The HIT shared service will consolidate all IT infrastructure services over time. The infrastructure services to be consolidated include network operations, communications and messaging, end user support, identity management, information assurance, testing and evaluation, and engineering services. Today, infrastructure services are provided by TMA, Army Medicine, Navy Medicine, Air Force Medical Service, JTF CAPMED, and other DoD organizations. In the future state, all HIT related infrastructure services will be under the management of the DHA.

**(3) Application services.** The HIT shared service will rationalize all applications across the entire MHS portfolio. This includes all garrison and deployed MHS systems. In the future state, all MHS applications will be under the management of the DHA.

### 3.4 Cost Reductions

Implementing the HIT shared service has the potential to save approximately $672 million ($243 million risk-adjusted) over 6 years. This will require 3 years of targeted investment in hardware, software, and services in order to consolidate the infrastructure and application portfolio (for example, analysis and planning to determine optimal sequencing, migration of application functionality and data, end-user training). The subsequent savings result from elimination of redundancy and standardization of IT infrastructure, increased use of commercial off-the-shelf products, and the elimination of redundant or low value IT applications with high sustainment

costs. The HIT shared service is projected to provide net savings as product lines are consolidated, reaching steady state in FY 2019.

| Health IT Projected Net Savings, FY14-FY19 ($M)[16] | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | **FY14** | **FY15** | **FY16** | **FY17** | **FY18** | **FY 19** |
| **Savings** | Annual Savings | $13 | $66 | $121 | $177 | $181 | $300 |
| | Annual Risk Adjusted Savings* | $6 | $33 | $61 | $89 | $91 | $150 |
| | Cumulative Savings | $13 | $79 | $201 | $378 | $559 | $859 |
| | Cumulative Risk Adjusted Savings* | $6 | $40 | $100 | $189 | $279 | $429 |
| **Implementation Costs** | Total Annual Implementation Costs | $28.4 | $44.4 | $48.7 | $31.0 | $33.8 | $0.0 |
| | IT Cost, Annual | $26.5 | $30.0 | $40.3 | $13.9 | $13.1 | $0.0 |
| | Contractor Support Cost, Annual | $0.0 | $14.4 | $8.4 | $17.1 | $20.7 | $0.0 |
| | Personnel Severance, Annual | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 |
| | Personnel Relocation, Annual | $1.8 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 |
| | Military Construction, Annual | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 |
| | Cumulative Implementation Costs | $28.4 | $72.8 | $121.5 | $152.5 | $186.3 | $186.3 |
| **Net Savings** | **Annual Net Savings** | **($16)** | **$22** | **$73** | **$146** | **$147** | **$300** |
| | **Annual Risk Adjusted Net Savings*** | **($22)** | **($11)** | **$12** | **$58** | **$57** | **$150** |
| | **Cumulative Net Savings** | **($16)** | **$6** | **$79** | **$225** | **$373** | **$672** |
| | **Cumulative Risk Adjusted Net Savings*** | **($22)** | **($33)** | **($21)** | **$36** | **$93** | **$243** |

*See the Section 1.4 (MEDLOG) for an explanation of the risk-adjustment methodology.

## 3.5 Timeline

- By July 1, 2013, the BPR Plan for the HIT shared service will be complete.
- By July 1, 2013, the Transition Plan will be developed for the HIT shared service.
- By September 1, 2013, MHS will have identified the DHA Director of HIT and a proposed organization structure.
- Beginning October 1, 2013, the HIT shared service will begin implementation under the authority of the DHA.

[16] Future year savings and implementation costs have been inflated to "then year" dollars using inflation rates from the OSD Comptroller FY14 "Green Book"

### 3.6 Health IT Measures

The Health IT community has a mature measurement capability, but will create an enhanced dashboard to track the measures of cost, quality, timeliness, process excellence, and customer satisfaction specifically related to improvements included in the BPR plan. A measure of strategic alignment is included to track success in delivering maximal value for the IT investment.

- Total IT costs as a percentage of revenue
- Percentage of IT spending allocated to delivering new capabilities (Operating Expense vs. Capital Expense)
- Percentage of software releases deployed on time
- Percentage of software releases deployed with all promised capability
- Number of failure incidents with business impact
- Number of critical production software defects identified
- Alignment of IT with MHS strategic initiatives
- End-user satisfaction with MHS applications

## 4.0 TRICARE HEALTH PLAN

TRICARE Health Plan refers to a specific collection of functions and capabilities, rules, and procedures that enable the DoD and the Services to deliver healthcare to eligible beneficiaries. TRICARE Health Plan policy governs access to services under the direct care and purchased health care segments of the integrated delivery system. The Health Plan establishes the rules and procedures under which the MHS delivers health care services, acquires purchased care services, conducts benefits determinations, coordinates care, and administers the health care program. As the central entity of the MHS integrated delivery system, the DHA will ensure that the TRICARE Health Plan optimally supports the direct care and purchased care systems by synchronizing business and clinical process.

### 4.1 Purpose

The current TRICARE Health Plan support functions will transition to a shared services model within the DHA. The TRICARE Health Plan shared service will support the MHS integrated health delivery system and the purchase of health care services contracts. The TRICARE Health Plan shared service will execute the requirements determined by the integrated health delivery system, and provide assurance that those requirements are purchased and implemented effectively. In addition to the shift to a shared services model, two initiatives have been developed to improve the efficiency of providing customer service and increase appropriate reimbursement for delivered health services. These two initiatives have the potential to achieve cost savings for the MHS of up to $147 million ($97 million risk-adjusted) per year in FY 2019, and up to $787 million ($503 million risk-adjusted) over 6 years.

## 4.2 Consolidated Services

At IOC, current TMA executed TRICARE Health Plan support activities will shift into the DHA. Additionally, two consolidation and business process reengineering initiative will begin implementation. The TRICARE Service Center (TSC) initiative will improve customer service efficiency by eliminating expensive walk-in service centers located at every MTF and providing greater access to information through current toll-free call centers and readily available internet resources. These options are available 24/7 worldwide and more than 80 percent less expensive per encounter compared to the TSCs. Since both the TSCs and the toll-free call centers are part of the current managed care support contracts, this initiative requires modifying these contracts.

The second consolidation initiative involves contracting with a single, centralized service to identify beneficiaries with Other Health Insurance (OHI). By earlier identification of OHI, we can improve coordination of benefits with other insurance companies and reduce MHS payment for services that should have been paid by OHI. A centralized contract will more accurately identify of beneficiaries with OHI rather than relying on the current self-reported method.

## 4.3 Shared Services Scope of Responsibilities

The TRICARE Health Plan shared service scope of responsibilities includes the following services:

**(1) Develop market, product, and health care services acquisition strategy.** Develop product strategy by translating statutory requirements and policy directives into operational changes, and recommend statutory modifications to change or add products based on the changing health care environment or program/initiative performance. Develop health care services acquisition strategy to support the integrated health delivery system. Conduct continuous improvement and modifications, as needed, to coordinate of care between the purchased care and direct care systems.

**(2) Perform pricing and risk management evaluations.** Determine prices based on statutory requirements (entitlements) or actuarial methods (voluntary programs). Perform program, contract, or initiative risk analysis and develop and execute mitigation plans, ensuring appropriate integration of care between direct and purchased care systems.

**(3) Develop and maintain the civilian provider network**. Establish network through contracts with Managed Care Support Contractors (MCSC) to meet access standards and complement MTF capabilities. Incentivize provider recruitment based on cost and health outcomes. Ensure that patient information is appropriately transferred between direct care and purchased care systems.

**(4) Educate beneficiaries.** Develop and distribute understandable program educational materials to beneficiaries to guide program selection decisions and to encourage active participation of beneficiaries in their own health care decisions.

**(5) Enroll and administer members**. Enroll eligible beneficiaries into TRICARE plans, maintain the plans (for example, Prime, Extra, and Standard), update all enrollee information as necessary and collect appropriate fees and cost shares. Improved enrollment processes will specifically support the patient-centered medical home (PCMH) along with other market and MTF level initiatives.

**(6) Administer benefits and process claims**. Administer benefits within the health plan, process claims and claims exceptions, review claims against contractual performance standards, collect TRICARE encounter data records, and collect third party payments.

**(7) Service customers**. Provide customer service activities through a variety of media channels in accordance with best industry standards and strategies, in addition to managing the prime travel benefit program. Maintain a single beneficiary website to convey information about the health benefit and perform surveys to determine beneficiary and provider satisfaction.

**(8) Perform data management, contract oversight, and decision support**. Produce key performance measurements specific to the health plan and monitor using a Performance Management Review type approach, and provide oversight for managed care support contracts.

### 4.4 Cost Reductions

The two initiatives can achieve a cost savings of up to $787 million ($503 million risk-adjusted) over 6 years as shown in the table below. Implementation costs are for increasing capacity of existing call centers, and for establishing a commercial contract for obtaining information on beneficiaries with other health insurance. However, these costs are offset by potential savings. Savings are realized from no longer exercising the TSC contract line item in the managed care support contracts and by requiring other insurers to serve as the primary payor in cases where a beneficiary has identified OHI information.

| TRICARE Health Plan Projected Net Savings, FY14-FY19 ($M)[17] | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | **FY14** | **FY15** | **FY16** | **FY17** | **FY18** | **FY 19** |
| **Savings** | Annual Savings | $113 | $139 | $143 | $147 | $152 | $157 |
| | Annual Risk Adjusted Savings* | $68 | $93 | $96 | $100 | $103 | $107 |
| | Cumulative Savings | $113 | $253 | $396 | $543 | $695 | $852 |
| | Cumulative Risk Adjusted Savings* | $68 | $161 | $258 | $357 | $461 | $568 |
| **Implementation Costs** | Total Annual Implementation Costs | $20.1 | $8.1 | $8.5 | $8.9 | $9.4 | $9.9 |
| | Contractor Support Cost, Annual | $12.1 | $4.1 | $4.3 | $4.5 | $4.8 | $5.0 |
| | IT Support Cost, Annual | $7.8 | $3.8 | $4.0 | $4.2 | $4.4 | $4.6 |
| | Personnel Support Costs, Annual | $0.2 | $0.2 | $0.2 | $0.2 | $0.2 | $0.3 |
| | Personnel Severance, Annual | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 |
| | Personnel Relocation, Annual | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 |
| | Other Implementation Costs | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 | $0.0 |
| | Cumulative Implementation Costs | $20.1 | $28.2 | $36.7 | $45.7 | $55.1 | $64.7 |
| **Net Savings** | **Annual Net Savings** | **$93** | **$131** | **$135** | **$138** | **$143** | **$147** |
| | **Annual Risk Adjusted Net Savings*** | **$48** | **$85** | **$88** | **$91** | **$94** | **$97** |
| | **Cumulative Net Savings** | **$93** | **$224** | **$359** | **$497** | **$640** | **$787** |
| | **Cumulative Risk Adjusted Net Savings*** | **$48** | **$133** | **$221** | **$312** | **$406** | **$503** |

*See the Section 1.4 (MEDLOG) for an explanation of the risk-adjustment methodology.

## 4.5 Timeline

- By July 1, 2013, the BPR Plan for Health Plan shared service will be complete.
- By July 1, 2013, a Transition Plan will be developed for the Health Plan shared service.
- By September 1, 2013, the Department will have identified the DHA TRICARE Health Plan Functional Lead and a proposed organization structure.
- Beginning October 1, 2013, the Health Plan shared service will begin implementation under the authority of the DHA.

[17] Future year savings and implementation costs have been inflated to "then year" dollars using inflation rates from the OSD Comptroller FY14 "Green Book"

## 4.6 TRICARE Health Plan Measures

The following measures have been developed to monitor the performance of the TSC and OHI initiatives. A broader set of Health Plan measures will be included in the September 2013 report.

- TRICARE Service Centers
  - Time to resolve customer services issues
  - Satisfaction with customer service
  - Cost per customer service incident
  - MCSCs' compliance with performance standards (index measure of customer service performance )
- Other Health Insurance Information
  - Projected vs. achieved OHI purchased care cost savings
  - Percent change in the number of claims processed with OHI

**Progress to Date with the Additional Six Shared Services**

The status of the additional six shared services to begin implementation in FY 2014 and beyond (Pharmacy, Acquisition, Public Health, Medical Research and Development, Medical Education and Training, and Budget and Resource Management) is described below. While many of the BCAs are complete, they have not yet been through the entire governance process for approval. We expect that these will be approved in the near future and provided in the September 2013 response.

- **Pharmacy:** We have completed the BCA, which focuses on a number of pharmacy benefit channel management and process improvement initiatives. The largest savings will come from reducing retail refills (driving volume to MTF and mail order points of service) and stronger formulary management. The Pharmacy shared service is expected to implement a DHA governed operating model where the DHA develops and enforces uniform business rules, establishes centralized contract vehicles for automation of products and services, and provides headquarters policy execution and compliance oversight. Centralized distribution of resources via a central fund is considered a critical enabler to realizing projected savings, and is currently under discussion.
- **Acquisition:** We have completed the BCA, which focuses on developing and implementing strategic Multiple Award Task Orders that will be used throughout the MHS to consolidate ordering to better leverage DoD buying power, strategically manage the vendor base, reduce process time, and lower overall contract costs. The design of the operating model for the Acquisition shared service is in progress.
- **Public Health:** We have completed the BCA, which focuses on optimizing deployment health processes (particularly the periodic health assessment) and centralizing and consolidating health surveillance functions. The Public Health shared service is expected to transition three Public Health Executive Agencies (Veterinary Services Activity, Military Vaccine Agency and Immunizations, and the Armed Forces Health Surveillance Center) under the management of the DHA, as well as oversight functions for

Deployment Health. The DHA will monitor metrics for all Public Health product lines and will potentially take on additional management responsibilities for these areas pending further analysis after IOC.

- **Research and Development:** We have completed the BCA, which focuses on redirection of extramural funding to reduce expenditures on overhead costs and consolidation of funding lines into a single appropriation. The design of the operating model for the Research and Development shared service is in progress.
- **Education and Training:** We have initiated the BCA, which focuses on creating a governance structure to support common education and training platforms to ensure efficiency and standardization, where common education and training requirements exist. The design of the operating model for the Education and Training shared service is in process.
- **Budget and Resource Management:** We have initiated the BCA, which focuses on implementing a common cost accounting structure and standards and standardizing and consolidating Uniform Business Office functions across the Services. The design of the operating model for the Budget and Resource Management shared service is in progress.

**Objective 2: Deliver more comprehensive primary care and integrated health services using advanced patient-centered medical homes.**

Over the past 3 years, the MHS has reengineered primary care by implementing the PCMH model in the direct care system. However, implementation has been Service-specific and has resulted in significant clinical and business process variation, along with different metrics. The overall success of our PCMH initiative, and ability to reach MHS enterprise targets for improvement, depends on the rapid identification and dissemination of best practices, standardized processes and measures, and the ability to accelerate learning and system-wide improvements.

Only a centralized function, like the DHA, can coordinate across all three Services to measure enterprise-wide success. In addition, performance enablers, in the form of shared services, will be organized within the DHA. For example, information technology, standardized facilities, logistics, education, and training are critical components to our ability to meet the metrics for this objective. The Health Care Operations Directorate within the DHA will monitor enterprise performance with appropriate measures applied consistently across the Services. This allows for the identification of top performers and rapid process improvements to design the next generation of comprehensive primary care services.

Finally, in systems that have successfully optimized primary care, the need for specialty and inpatient services has declined. This creates the need to appropriately reallocate resources across the enterprise. The DHA will monitor system-wide changes and recommend redistribution of resources to achieve greater enterprise-wide efficiencies.

**System Improvements:** We will improve health and health outcomes for patients enrolled in PCMH. In order to measure our effectiveness, we will monitor access to services, effective provider communication, patient and provider satisfaction with PCMH, and per capita costs.

Furthermore, for each of our PCMH groups, we will seek external PCMH certification as validation of our progress.

**Clinical and Business Practices**: The MHS Tri-Service Workflow group is standardizing processes and documentation for the management of high frequency clinical encounters for low back pain, evaluation of metabolic syndrome and depression, among others. The MHS has developed standard business processes for appointments and referral management. In addition, lessons learned from first generation PCMH implementation in the MHS have resulted in innovations such as enhanced patient communication using secure messaging and improved access through alternatives to traditional office visits. The pace and scope of improvement has been limited by the lack of a central entity that can drive rapid dissemination of proven practices.

The Director of Health Care Operations at the DHA will accelerate the pace of process standardization, and the learning and improvement process under revised governance, working with directors of health care operations from the Service Medical Departments to implement standard business rules.

**Cost Reductions:** A study of MHS PCMH implementation by the Center for Naval Analyses found significant positive impact on various cost and utilization metrics at three implementation sites.[18] Utilization of inpatient services, emergency room (ER), and urgent care services was significantly lower, and all sites had decreases in per member per month costs for both family medicine and pediatric clinics. Based on these observations, using the DHA to monitor, evaluate, and promulgate PCMH successes across the MHS should result in better health for our beneficiaries at a lower overall cost.

**Infrastructure Reductions:** This initiative will not immediately reduce infrastructure. However, over time, by improving comprehensive primary care the need for more intensive specialty, ER and inpatient services can be reduced which could lead to a reduction in the associated facility overhead, maintenance, and replacement costs.

**Personnel Reductions**: This initiative will not result directly in personnel reductions, but by reengineering care delivery to focus on lower cost venues of care, we may see reductions in inpatient staffing in the years to come.

**Measures:** The MHS has developed and deployed a PCMH dashboard that will continue to improve as this care delivery model matures. To monitor the specific objective of delivering more comprehensive and integrated care, the DHA will monitor the following measures for TRICARE Prime enrollees:

i. Healthcare Effectiveness Data and Information Set (HEDIS) preventive measures
ii. HEDIS measures of adherence to evidence-based guidelines for chronic illness management
iii. Access to care
iv. Satisfaction with provider communications

[18] Linda M. Pikulin • Eric W. Christensen • CDR Jamie Lindly; FY12 Medical Home Port Evaluation; Center for Naval Analysis, DRM-2012-U-001777-Final September 2012

v. Satisfaction with health care
vi. Primary care staff satisfaction
vii. Percentage of primary care clinics with external PCMH certification
viii. Percentage usage of standard forms for treatment of lower back pain, depression, and metabolic syndrome
ix. Time to third available appointment
x. Percentage of enrollees using secure messaging
xi. Number of standard business rules
xii. Bed days per year per 1,000 enrollees
xiii. Emergency room visits per year per 100 enrollees
xiv. Per member per month health care cost

**Objective 3: Coordinate care over time and across treatment settings to improve outcomes in the management of chronic illness, particularly for patients with complex medical and social problems.**

Effective clinical integration means that individuals receive appropriate interventions in a coordinated, seamless manner. This is particularly true for patients with chronic illnesses. Unfortunately, many patients are left to navigate a confusing healthcare system alone and, as a result, those with chronic illnesses may not receive the care they need. Recently, the Institute of Medicine identified gaps in care coordination as a central contributor to suboptimal care and rising costs.[19]

Similar to Objective 2 regarding PCMH, the DHA is critical to achieving our objective of coordinated care. We will know if we are successful by collecting and disseminating enterprise-wide clinical outcomes metrics that demonstrate improved management of individuals with chronic illnesses. Central to this effort is the clinical and business process reengineering that will need to take place to ensure that standards are described and promulgated across the Services for optimal case management. Much of this coordination should take place in our PCMHs. However, we believe that the improvement in care, outcomes, and potential cost savings for those with chronic conditions needs a specific focus and effort. The DHA will also afford the opportunity to work with our MCSCs to ensure that best practices are identified and promulgated across both the direct and purchase care sectors of the MHS.

By our September 2013 response to section 731, we will provide the status of our progress on reengineering those clinical and business systems necessary to achieve this objective. We will provide the initial set of agreed to standards that demonstrate our commitment to optimal management of individuals with chronic medical conditions.

**System Improvements:** We will improve outcomes for patients with chronic illness and for those with complex medical and social problems. In order to measure our effectiveness, we will monitor outcomes for high frequency or high cost illnesses such as cancer, depression, diabetes, cardiovascular disease, and hypertension. Other integrated delivery systems show that adherence

[19] IOM (Institute of Medicine). 2013. Best care at lower cost: The path to continuously learning health care in America. Washington, DC: The National Academies Press.

to evidence-based care reduces the need for inpatient services, ER visits, and complex procedures while reducing death and disability. In our September 2013 response we will provide more detail on the measures of effectiveness we will use to monitor outcomes for these clinical conditions.

**Clinical and Business Practices:** Success will require standard, reliable implementation of illness-specific care pathways involving multidisciplinary care teams. In addition, we will focus on the coordination of care especially for post-hospitalization transitions or transfers between providers. In our September 2013 response we will provide the timeline for the implementation and monitoring of care pathways for the five conditions listed above and measures for monitoring our care coordination success, as well as a description of our continuous process improvement methods.

**Cost Reductions:** The Institute of Medicine has reported that the two largest sources of excess cost in health care are the provision of unnecessary services and inefficiently delivered services. One major opportunity to eliminate unnecessary services is to optimize and coordinate care for people with chronic illness. Sources of waste in our current operations include unnecessary readmissions, duplicate tests, excessive emergency room visits, and medical errors. This objective has great promise for cost reductions in the long-term, but until baseline data are collected on actual experience with our patient population, we cannot estimate any cost savings with precision. By our September report, we will define what data are required, the extent to which the data exists in our current information system platforms, a strategy to add missing data elements, and the methodology that we will use to define our baseline for this important objective. In addition, we will provide target dates for the completion of this work.

**Infrastructure Reductions:** This objective is not expected to yield a reduction in infrastructure in the short-run, but other countries and large health systems have seen a decreased need for inpatient beds when chronic illness is managed effectively. Initially, we will monitor inpatient occupancy where these initiatives are fully implemented to assess whether we can achieve similar change. There may be potential for infrastructure reductions in the long-run.

**Personnel Reductions:** This objective is not expected to yield a reduction in personnel in the near-term but should reduce cost by making care more efficient and effective. There may be potential for personnel reductions in the long-run.

**Measures:**

i. Performance on HEDIS chronic illness measures for diabetes, cardiovascular disease, and mental illness
ii. Per capita cost for management of selected chronic illnesses (diabetes, asthma, depression, posttraumatic stress disorder)
iii. Bed days per year per 1,000 enrollees, stratified by identified chronic illnesses
iv. Emergency room visits per year per 100 enrollees, stratified by identified chronic illnesses
v. Number of individuals with greater than 10 providers or more than 20 prescriptions, stratified by identified chronic illnesses

vi. Percentage usage of standard forms for treatment of lower back pain, depression, and metabolic syndrome
vii. Number defined clinical care pathways
viii. Readmission rate following hospitalization where chronic illness is the primary diagnosis for both initial and readmission hospitalizations
ix. Medication error rate, stratified by identified chronic illnesses

**Objective 4: Match personnel, infrastructure, and funding to current missions, future missions, and population demand.**

At the end of any conflict, the DoD readjusts personnel and resources. The MHS, a Force-supporting function, mirrors these changes. With the end of operations in Afghanistan, we have an opportunity to restructure the MHS to create the necessary framework to deliver appropriate and contemporary care for the next conflict, wherever and whenever it might occur. Prior to creating this framework, however, we need to understand where we are today as a result of 12 years of war.

In FY 2013, the ASD(HA) established the MHS modernization study – a collaborative effort of OSD/HA and the Service Medical Departments – to assess our current portfolio of hospitals and clinics and to determine if changes are needed to improve readiness, enhance quality of care, and reduce health care costs. This study includes four components to identify requirements for uniformed medical personnel; personnel productivity benchmarks; beneficiary demands for care; and business practices to facilitate efficient and effective health care delivery. This study will identify opportunities to reallocate resources to more efficiently produce a medically ready force and a ready medical force.

The DHA is essential to providing the supporting services aligned with the new strategic framework for these system resets. Facility planning, medical logistics, and education and training will play essential roles in the MHS modernization following the study; these are all shared services within the DHA. Furthermore, DHA will support the Services with capabilities that enable a more rapid response to future combatant commander requirements for medical assets.

**System Improvements:** Through redistribution of personnel to better match supply with health service demand, we will increase the efficiency of the system as a whole. This will yield higher productivity for our professional staff and lower unit costs for health services. In addition, we will see an increase in the currency or medical preparedness of the health team when they are more fully employed at sites with high demand for health care.

**Clinical and Business Practices:** Appropriately matched facility and personnel capabilities are the focus of this objective. In coordination with the implementation of the facility planning shared service, the DHA will assume responsibility for standardizing the processes for strategic portfolio management, health care requirements analysis, and facilities design and construction, as described above.

**Cost Reductions:** By redistributing resources to better match supply with health care demand, we will be able to more efficiently use available capacity and reduce the unit cost of providing health services. As we create more productive hospitals and clinics, particularly in eMSMs, we will be able to bring more care into our hospitals and reduce reliance on private sector care. This will result in two areas cost reduction:

- Reduction in the cost of operating the direct care system of hospitals and clinics as a result of focused reductions in inpatient capabilities where appropriate; and
- Reduction in the cost of purchased care through increased use of military medical treatment facilities, particularly in eMSMs.

**Infrastructure Reductions:** The results of the modernization study should identify those infrastructure assets where it is not possible to operate in a cost-effective manner and where there are safe alternatives for care provision. The magnitude of these potential reductions is unknown at present.

**Personnel Reductions:** Until the study is completed, any proposals for reduction or realignment of personnel are unknown.

**Measures:**

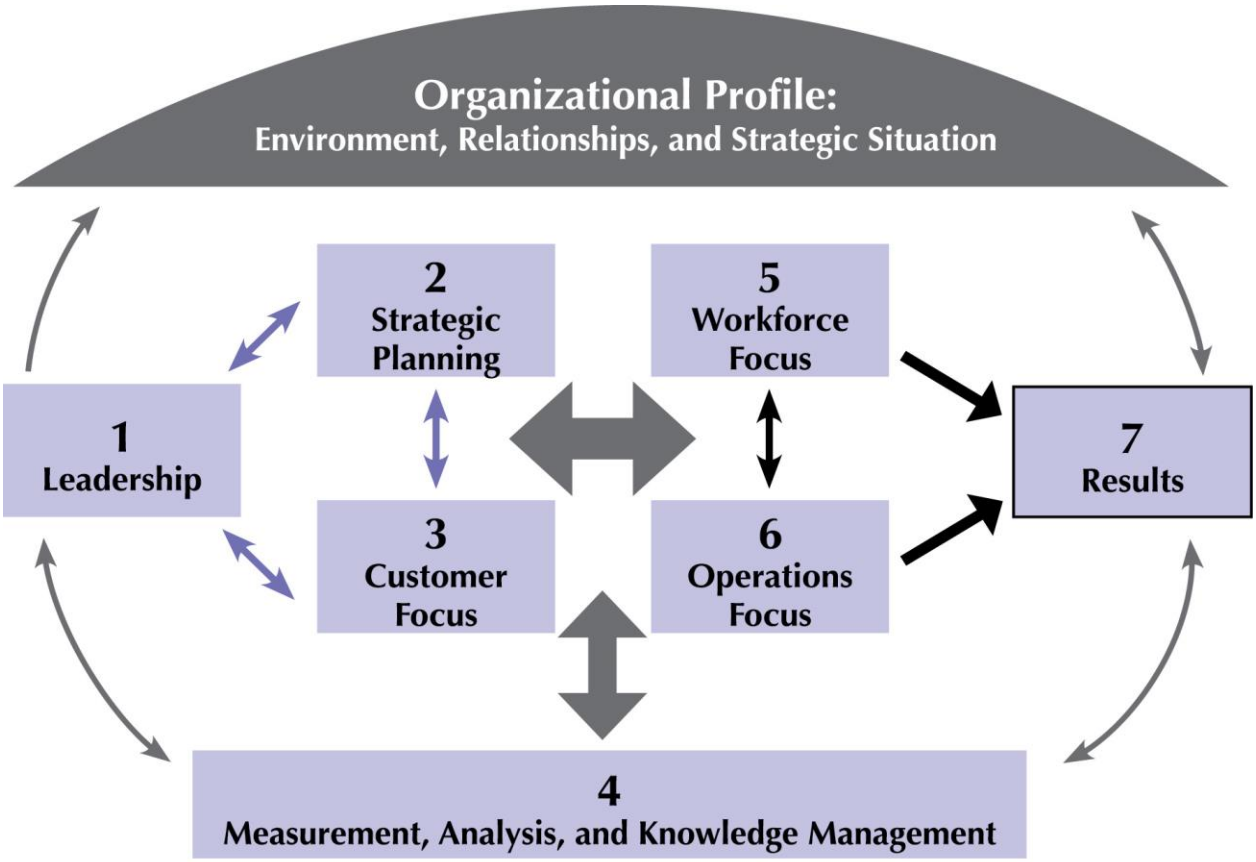
i. Number of square feet of facilities that will be reduced based on decisions to re-mission military medical treatment facilities
ii. Amount of purchased care in eMSMs
iii. Market share in eMSMs
iv. Utilization of staffed inpatient capacity
v. Relative value unit (RVU) per provider per month
vi. Cost per RVU
vii. Cost per relative weight product
viii. Cost per prescription
ix. Direct care market share

**Objective 5: Establish more inter-Service standards / metrics, and standardize processes to promote learning and continuous improvement.**

We need common standards, processes, and measures to clearly document system improvements and to realize our strategic vision. To that end, we will create the necessary analytic infrastructure within the DHA to support learning, innovation, and system improvements. One component of this infrastructure will monitor strategic, tactical, and operational performance. Another component will drive continuous process improvement. Success to date has been limited by four separate measurement efforts by the Services and TMA, compromising inter-Service comparisons and enterprise-level improvement efforts. The DHA, for the first time, creates a structure to enable standard measurement, full visibility of enterprise-wide system performance, and coordinated process improvement efforts.

Measurement is essential to the improvement of any organization – we tend to improve what we measure. Understanding how measurement fits and contributes to performance excellence has been a driving force behind some of the notable efforts in improving business performance in this country. As illustrated below in
Figure 5, measurement drives all business process improvement efforts.

**Figure 5: Measures and the Organizational Profile**




From Baldrige Performance Excellence Program, *2013, 2013–2014 Health Care Criteria for Performance Excellence* (Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology, http://www.nist.gov/baldrige/publications/hc_criteria.cfm).

A focus on MHS enterprise measurement does not require investment in new information technology solutions, but a commitment to using common data, with transparent assumptions about use of that data and the use of common and consistent business rules across the enterprise. This will allow us to focus on solving the problems the data identifies rather than contesting the analysis. It will allow us to use business data to support clinical care and clinical data to support business needs. To drive this synergistic change, we will locate clinical, business, and quality analysts in the DHA Healthcare Operations Directorate.

We are in the process of establishing the new, joint analytic cell within the DHA. The work needed to identify the organizational structure for this effort, along with staffing from the Services and existing TMA assets, is underway. While creating this permanent structure within the DHA, we have created a "Council of CAPES" (Cost Assessment and Program Evaluation)

that supports our current reform efforts with analytics to drive process standardization and improvement in shared services. In our September 2013 response to section 731, we will provide more detail of the organizational structure for this effort.

**System Improvements:** As noted above, the improvements in specified processes will be documented using common measures. These process improvements will yield improved outcomes as specified in each shared service business case analysis. In addition, standard business and clinical measures, and performance dashboards will be used by the eMSMs to track improvement in accordance with their 5-year business performance plans.

**Clinical and Business Practices:** We have a variety of data capture and storage capabilities in TMA and in the Services. In order to more rapidly implement our enterprise-wide measurement effort, we will standardize how data are captured, organized, displayed, and used to support decisions in both clinical and business settings. We will standardize processes involved in performing analytic functions. Through our current shared service efforts, we have standardized the MHS approach for planning business process reengineering and performance improvement in the future. We will use this same process to examine other areas where services can be more efficiently and effectively shared. This consolidation of analytic capability does not imply that the Services will be unable to perform necessary analytics to support their unique Service requirements, but it does mean that the data will be standard across the enterprise, along with the necessary business rules for use.

**Cost Reductions:** This effort will likely result in some near-term savings due to the elimination of redundant reporting and analytic capabilities; larger savings will come when managers at all levels use improved performance measures to make more-informed decisions. This will be reflected in the successful accomplishment of shared services reengineering plans and eMSM 5-year business performance plans. The magnitude of these potential cost savings is unknown at present, and will require the formation of the analytic infrastructure to initially capture baselines.

**Infrastructure Reductions:** No immediate infrastructure reductions are anticipated as a result of this activity. By our September 2013, response to section 731, we will have estimates of any infrastructure reductions that might occur due to this effort.

**Personnel Reductions:** We do not anticipate any personnel reductions that are directly associated with this objective.

**Measures:**

i. Number of processes that have been standardized as part of the business process reengineering process for shared services
ii. Number of standard measures developed and deployed for use in the eMSMs
iii. Number of best practices identified and disseminated as part of the business performance plan review process
iv. Number of standard business rules approved and implemented across the MHS
v. Percentage of business plan targets achieved
vi. Percentage of shared service targets achieved

**Objective 6: Create enhanced value in military medical markets[20] using an integrated approach specified in 5-year business performance plans.**

The purpose of this objective is to increase value (for example, readiness, health, healthcare) and lower costs in six of our largest medical markets where we have more than one Service operating a hospital or clinic (Colorado Springs, Hawaii, National Capital Area, Puget Sound, San Antonio, and Tidewater). This will be accomplished through integrated planning, resource management, and care delivery. Each market will have its own 5-year business performance plan, will establish baseline performance, and will set annual targets across a standard set of measures aligned to the Quadruple Aim. The difference between the baseline and target performance represents the increased value that the markets will create over time. The status of these activities is covered in an earlier section of this response to section 731.

The DHA will provide an essential integrating function for these six markets. By leveraging the governance and accountability structure provided by the DHA and the Services, along with the ability to use selected shared services, the market managers are better poised to achieve success. The DHA is also where the integration of the direct and purchased care sectors comes together in a single governance structure, making it easier for market managers to coordinate cross-sector functions. Finally, the DHA will support the transformation to integrated markets by designing incentives and reimbursement mechanisms that promote competition based on value and by developing standard performance dashboards that are common to all markets.

**System Improvements:** Each market will have quantitative performance improvement targets in its 5-year business performance plan for a standard set of market performance measures (please see the measures section below for the set of measures). These improvement targets will be provided in our September 2013 response to section 731.

**Clinical and Business Practices:** The 5-year business performance plans will have tailored improvement initiatives that describe the business and clinical process changes each market will implement in order to achieve its cost savings and performance improvement goals. The MHS will use business plan reviews to identify best practices and disseminate proven practices as standard processes. A summary of business performance plans for all six eMSMs will be provided in our September 2013 response to section 731.

**Cost Reductions:** The shift to market-focused performance plans under the authority and direction of the new eMSM governance structure will facilitate optimized use of existing market resources, which will result in lower costs. All markets will have goals for reducing private sector healthcare costs by maximizing the use of total MTF capacity and capability in the market. The methods we will use to monitor costs for each eMSM will be provided in our September 2013 response to section 731.

**Infrastructure Reductions:** No overall infrastructure reductions are anticipated; however, each 5-year business performance plan will describe how the market will use existing infrastructure to meet demands. These plans will be tightly integrated with the results of the MHS modernization study described in Objective 4 and with the facilities shared service effort.

[20] Defined as eMSMs

**Personnel Reductions:** Each 5-year business performance plan will describe how the market will optimize the use of personnel to meet demands. The plans will identify reductions and investments in personnel based on business case analysis.

**Measures:** The markets will be evaluated using a standard set of measures aligned to the Quadruple Aim: readiness, health, health care, and cost. At the time of this report, the initial set of eMSM performance measures include:

i. No show rate
ii. Operating room utilization rate
iii. Number of enrollees per primary care manager
iv. Unfilled appointment rate
v. Bed days per 1,000 enrollees
vi. Inpatient occupancy rate
vii. Percent retail pharmacy
viii. Right of first refusal take rate
ix. Total relative value units per 100 enrollees
x. Total purchased care ($)
xi. Average daily patient load
xii. Percentage of the total force medically ready to deploy
xiii. HEDIS preventive measures
xiv. HEDIS measures of adherence to evidence-based guidelines for chronic illness management (diabetes, cardiovascular disease)
xv. Primary care third available appointment
xvi. Primary care manager continuity
xvii. ER utilization rate
xviii. Per member per month health care costs
xix. Percentage of performance targets met by eMSMs

**Objective 7: Align incentives with health and readiness outcomes to reward value creation.**

Until now, we have aligned incentives with volume rather than with value. Successful transformation of the health care delivery system requires appropriate alignment of incentives with desired outcomes. Currently, the MHS funds military medical treatment facilities based on historical resource requirements adjusted for clinical productivity. Recently, the military Services successfully piloted programs that provide incentives for improved health and readiness outcomes. This experience has enabled the MHS to develop a more comprehensive program for internal reimbursement and performance incentives that will be tested in FY 2014 and implemented in FY 2015. The program will include partial capitation for primary care and a set of performance incentives tied to measures of health and readiness outcomes. This program supports the transition from "pay for volume" to "pay for value."

The DHA will implement and monitor incentives based on standard measures, which requires standard actionable information in useable scoreboards and dashboards. The DHA will be

responsible for serving as the source of reliable, unbiased information for local, regional, and central headquarters leaders through the new analytic framework previously described.

In our September 2013 response to section 731, we will provide the details associated with the FY 2014 test of this new reimbursement system, along with plans for full implementation in FY 2015.

**System Improvements:** This objective supports almost all of the other objectives by integrating the activities of managers at all levels with the priorities for value creation – improved readiness, better health, better care, and lower cost. The effects of this objective will be an improvement in organizational alignment and resultant improvement in organizational efficiency.

**Clinical and Business Practices:** We will reengineer the process of providing internal funding so that we will have consistent financial incentives across the Service Medical Departments. Efforts to standardize performance measures and dashboards as part of Objective 5 are critical for success. These reengineered processes will be described in our September 2013 response.

**Cost Reductions:** Since the purpose of this objective is to align financial incentives with desired outcomes, we expect to see overall improvement in system performance including reduction in per capita cost of care. It will be difficult, however, to attribute savings directly to this effort.

**Infrastructure Reductions:** No infrastructure reductions are directly associated with this objective.

**Personnel Reductions:** No personnel reductions are directly associated with this objective.

**Measures:**

i. Successful achievement of milestones implementing new health and readiness incentive measures and primary care sub-capitation model in FY 2014.
ii. Implementation of value-based financing of military medical treatment facilities and eMSMs in FY 2015.