

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

MAR -9 2016

The Honorable John McCain
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

This report is in response to House Report 113-446, pages 168-169, accompanying H.R. 4435, the National Defense Authorization Act for Fiscal Year 2015, which requested the Department of Defense submit detailed information on the Military Health System (MHS) implementation plan regarding the Defense Health Agency's staffing requirements, cost estimates, and performance measures.

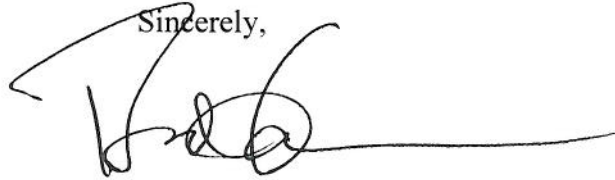
As we stated in our March 25, 2015, interim response, we have ensured the information provided is consistent with changes we are making as a result of the recent MHS review of safety, quality, and access. In addition, the strategic objectives in the 2013 Reports to Congress on MHS Governance Reform are now incorporated in the MHS Performance Dashboard. The Performance Dashboard will support the MHS Health Benefit Delivery Concept of Operations (CONOPS), currently in development under the sponsorship of the Navy and with guidance from the Joint Staff. The CONOPS and Performance Dashboard are in coordination within the Department. Upon acceptance by the Joint Requirements Oversight Council in 2016, the MHS will forward to your office a copy of the MHS Health Benefit Delivery CONOPS.

The MHS also is using a new Partnership for Improvement steering committee to provide a formal performance management approach with solid analytics support for the dashboard. With this performance management capability, MHS leaders are able to monitor MHS-wide core measures for the purpose of driving system-level improvements in the areas identified in the MHS Review.

In the enclosed report, please note Appendix A provides a crosswalk of the 2013 strategic objectives, MHS Review items, and the corresponding measures on the MHS Performance Dashboard. The report also provides an update on cost savings from the shared services, as well as manpower requirements and an update on Medical Education and Training.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families. A similar letter is being sent to the House of Representatives Armed Services Committee.

Sincerely,

A handwritten signature in black ink, appearing to read 'Brad Carson', with a long horizontal line extending to the right.

Brad Carson
Senior Advisor to the Under Secretary of
Defense for Personnel and Readiness,
Performing the Duties of the Principal
Deputy Under Secretary of Defense for
Personnel and Readiness

Enclosure:
As Stated

cc:
The Honorable Jack Reed
Ranking Member



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

MAR -9 2016

The Honorable William M. "Mac" Thornberry
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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Sincerely,



Brad Carson

Senior Advisor to the Under Secretary of
Defense for Personnel and Readiness,
Performing the Duties of the Principal
Deputy Under Secretary of Defense for
Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

Response to House Report 113-446, pages 168–169, accompanying H.R. 4435, the National Defense Authorization Act for Fiscal Year 2015



Report on Implementation Plans for the Defense Health Agency

The estimated cost of this report or study for the Department of Defense is approximately \$14,000 in Fiscal Years 2015 - 2016. This includes \$4,430 in expenses and \$9,700 in DoD labor.

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Executive Summary

As requested in House Report 113-446, pages 168–169, accompanying H.R. 4435, the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2015, this submission provides a fourth Report to Congressional Defense Committees on Military Health System (MHS) Governance Reform. Information requested includes more detailed information on:

- performance measures;
- cost savings from the implementation of shared services;
- the number of personnel working at headquarters;
- and the goals of the medical and education and training shared service.

This report includes the requested information, as well as a description of the new MHS performance management system named the Partnership for Improvement (P4I) (page 27) and an update on the status of the development of strategic documents.

Part One (page 7) of this report provides performance measures, baseline data, and plans for improvement for each of the seven MHS strategic objectives from the three previous reports to Congress. Over the past two years, the MHS has conducted an in-depth review of performance, which resulted in some changes to the portfolio of measures. It also resulted in a collaborative planning effort and a commitment to becoming a high reliability organization (HRO).

The Chairman of the Joint Chiefs of Staff recently signed the Joint Concept for Health Services, which specifies the strategic requirements for health support of the National Security Strategy. The MHS then drafted the MHS Health Benefit Delivery Concept of Operations (CONOPS) that will serve as the operational approach to describe how the MHS will deliver the TRICARE benefit to all eligible beneficiaries in a manner that optimally supports the operational requirements of Combatant Commanders. The MHS Health Benefit Delivery CONOPS was coordinated with the Military Departments' Medical Departments and will be entering formal staffing with the Department of Defense (DoD) Joint Requirements Oversight Council in 2016. Upon completion of the approval process, it will be forwarded to the appropriate congressional committees.

As part of the comprehensive effort to become an HRO, the MHS developed and deployed the P4I. Part of that effort resulted in an enterprise performance dashboard. The measures in that dashboard replace some of the measures in the 2013 reports to Congress and represent a natural evolution to more useful and meaningful performance measures. (Please see appendix A for a list of the original strategic objectives and measures with a crosswalk to the new P4I enterprise dashboard measures.)

Part Two (page 32) of this report provides an explanation of the expected sources of cost savings from the implementation of the original 10 shared service Business Process Reengineers (BPR) plans, including estimates of cost savings for each product line within the respective shared service. As of this writing the shared services are evolving into enduring Enterprise Support Activities that support the Military Departments' Medical Departments, and promote greater efficiency across the Department.

On October 1, 2015, the DHA achieved full operating capability; the Agency is fully capable of carrying out its mission and assigned responsibilities. The Agency's high-level goals in the next year are to fortify relationships with the Military Departments' Medical Departments; better define and strengthen its role as a Combat Support Agency; and optimize DHA operations. Enterprise Support Activities (ESAs) will play a large part in achieving these goals. As ESAs improve, the Military Departments' Medical Departments should experience better service delivery while the enterprise achieves cost savings. Over the next year, MHS will enhance measures of quality and service for the ESAs. For this report the focus is on the achievement of predicted cost savings.

For the reporting period of October 2013 to September 2015, the projected savings from shared service process improvement initiatives was \$467.70M and actual savings was \$712.92M.

Part Three (page **53**) of this report is a baseline assessment of the number of military and civilian personnel requirements/spaces pre-DHA (September 2013) and for DHA this past spring (March 2015). The DHA Manpower and Organization division is currently working to provide the number and cost of headquarters personnel within the MHS (both DHA and Services), as part of a larger DoD initiative to better define and account for management headquarters functions.

Finally, Part Four (page **54**) of this report provides an update on the implementation of the Medical Education and Training shared service as specifically requested in GAO report 073114. This shared service has a robust course of action to consolidate DHA and Service eLearning products. As of this writing, DHA currently is in the process of better defining the scope of its role in Medical Education and Training.

Introduction

In 2013, the DoD provided three full submissions and one supplemental submission to the Congressional Defense Committees regarding the reform of the MHS. These reports established a vision and seven strategic objectives (see figure 1) for the MHS and provided details on several major components of the reform including:

- the standup of the DHA focused on shared services and other support services needed for an integrated delivery system;
- the shift to an integrated delivery model particularly in six large multi-Service Markets;
- and the establishment of the DHA National Capital Region (NCR) Directorate with authority, direction, and control over the Walter Reed National Military Medical Center and Fort Belvoir Community Hospital, and their subordinate clinics.

As requested this fourth submission focuses on implementation plans for the DHA, and provides information about the seven strategic objectives listed below, personnel levels in the DHA, and specifics concerning the Medical Education and Training shared service.

Figure 1: Strategic Objectives

Objectives from 2013 Reports to Congress on MHS Governance Reform
1. Promote more effective and efficient health care operations through enhanced enterprise-wide shared services.
2. Deliver more comprehensive primary care and integrated health services using advanced patient-centered medical homes.
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.
4. Match personnel, infrastructure, and funding to current missions, future missions, and population demand.
5. Establish more inter-Service standards / metrics, and standardize processes to promote learning and continuous improvement.
6. Create enhanced value in military medical markets using an integrated approach specified in 5-year business performance plans.
7. Align incentives with health and readiness outcomes to reward value creation.

Over the past two years, in the context of continuing efforts to implement governance reform, the MHS conducted an in-depth review of performance. This review resulted in a collaborative strategic planning effort, a commitment to becoming an HRO, and a much-improved enterprise-wide performance management system called the P4I.

The Chairman of the Joint Chiefs of Staff recently signed the Joint Concept for Health Services which specifies the strategic requirements for health support of the National Security Strategy. The MHS then drafted the MHS Health Benefit Delivery Concept of Operations (CONOPS) that will serve as the operational approach to describe how the MHS will deliver the TRICARE benefit to all eligible beneficiaries in a manner that optimally supports the operational requirements of Combatant Commanders. The MHS Health Benefit Delivery CONOPS was coordinated with the Military Departments' Medical Departments and will be entering formal

staffing with the Department of Defense (DOD) Joint Requirements Oversight Council in 2016. Upon completion of the approval process it will be forwarded to congressional committees.

As part of the comprehensive effort to become an HRO, the MHS developed and deployed an enterprise-wide performance management system called the P4I. Part of that effort resulted in an enterprise performance dashboard. The measures in that dashboard replace some of the measures in the 2013 reports to Congress, but represent a natural evolution to more useful and meaningful performance measures. (Please see appendix A for a list of the original strategic objectives and measures with a crosswalk to the new P4I enterprise dashboard measures.)

As requested, and in light of the recent advances described above, this report focuses on the four areas outlined in House Report 113-446, pages 168–169, accompanying H.R. 4435, the NDAA for FY 2015:

- (1) Performance measures for each objective and shared service that are clear, quantifiable, objective, and include a baseline assessment of current performance, and if such information has not yet been developed, a timeline for developing and submitting such measures in the future;
- (2) An explanation of the potential sources of cost savings from the implementation of its shared services projects, including estimates of cost savings for each product line within the respective shared services;
- (3) A baseline assessment of the current number of military, civilian, and contractor personnel currently working within the MHS headquarters and an estimate for DHA at full operating capability, including estimates of changes in contractor full-time equivalents; and
- (4) An explanation of the purpose and goals of the Medical Education and Training shared service with regard to its role in improving the cost efficiency of delivering training, including the challenges it will address, the practices it will put in place to address these challenges, and the resulting cost savings.

Part One: Performance Measures for Shared Services and Strategic Objectives

In the third submission from the 2013 Reports to Congress on MHS Governance Reform under section 731 of the NDAA for FY 2013, DHA provided core and driver performance measures for each of seven objectives. The report noted that, “metrics, measures, and targets will continue to evolve....” and that “we will assess and refine metrics, measures, and targets to drive the changes we are working to achieve.” The following is an update on the performance measures for each objective. For instances where the measures are still being developed, a timeline for further development is provided.

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

The core performance measure for this objective is Total Net Savings from the Implementation of Shared Services. For FY14, baseline performance (i.e., projected net savings) was \$126.7M (including both Defense Health Program (DHP) and Medicare Eligible Retiree Health Care Fund (MERHCF) dollars). Actual performance (i.e., actual net savings) was \$238.1M. For FY 2015, projected savings were \$341.0M (DHP and MERHCF) and actual savings were \$474.8M. Details for each shared services savings are presented in Figure 2 below.

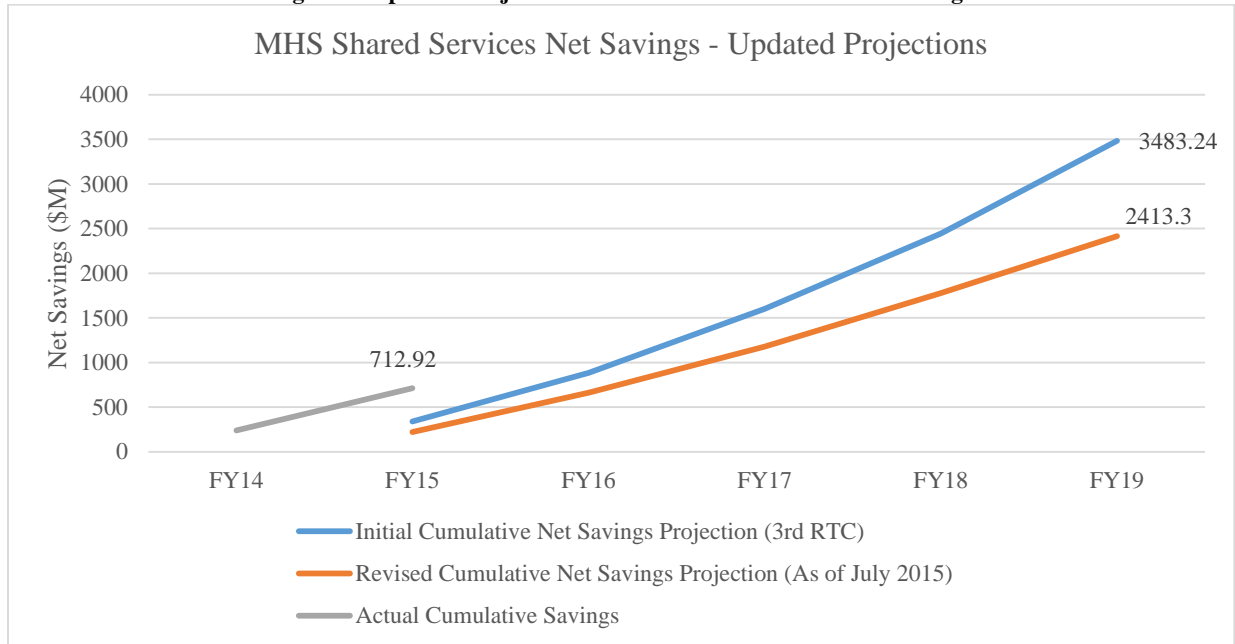
Figure 2: Projected and Actual Performance by Shared Service for FY14 and FY15

Shared Service	Process Improvement Project	FY14 Savings Forecast	FY14 Savings Actual	FY15 Savings Forecast	FY15 Savings Actual
Facilities	Facilities Portfolio Management	(\$18.40M)	(\$3.13M)	\$6.10M	\$1.00M
	Facility Requirements Planning		(\$0.50M)		\$3.95M
	Design, Construction, and Initial Outfitting & Transition		(\$0.50M)		\$24.88M
	Facility Operations		(\$0.50M)		\$0.00M
Medical Logistics	S1 - Supply purchasing standardization management	(\$5.68M)	\$4.98M	\$7.05M	\$7.60M
	S3 – Voluntary Incentive Purchase Agreement (VIPA) savings		\$4.57M		\$5.74M
	S4 -- Electronic Catalog (ECAT) ordering for orthopedic implants		\$5.10M		\$11.61M
	S5 – VA Remote Ordering Entry System		\$0.88M		\$0.88M
	E2 - Medical Equipment Information Assurance standardization		\$3.61M		\$2.03M
Health IT	BCA 1 – Re-engineering of IT Management	(\$22.00M)	\$1.40M	(\$11.24M)	\$1.66M
	BCA 2 – IT Infrastructure Rationalization		\$4.98M		\$31.22M

Shared Service	Process Improvement Project	FY14 Savings Forecast	FY14 Savings Actual	FY15 Savings Forecast	FY15 Savings Actual
	BCA 3 – Software Application Portfolio Rationalization		\$20.72M		\$10.06M
Health Plan	Tricare Service Center closure	\$25.46M	\$3.40M	\$85.20M	\$31.40M
	Other Health Insurance (OHI) discovery		(\$1.00M)		\$4.21M
Pharmacy	Retail Rx to Mail Order/MTF conversion (including TRICARE for Life (TFL) pilot)	\$160.48M	\$74.80M	\$208.09M	\$149.20M
	Brand to generic conversions		\$39.90M		\$51.60M
	Formulary Management		\$100.30M		\$153.70M
Budget and Resource Management	Armed Forces Billing and Collection Utilization Solution (ABACUS) Implementation	\$4.88M	(\$19.83M)	\$42.60M	(\$15.27M)
	Common Cost Accounting		(\$1.04M)		\$0.00M
Contracting	Strategic Multiple Award Task Order Development – Q Services, R Services	(\$5.70M)	No net savings	\$3.70M	(\$0.70M)
Research, Dev. and Acq. (RDA)	Redirection of Extramural Funding; Future DHA RDA structure development	\$0.00	No net savings	\$0.54M	No net savings
Medical Education and Training	Modeling and Simulation contract consolidation; eLearning software application rationalization	(\$0.00M)	No net savings	(\$0.00M)	No net savings
Public Health	TBD	(\$12.34M)	No net savings	(\$1.00M)	No net savings
TOTAL		\$126.70M	\$238.14M	\$341.00M	\$474.78M

Figure 3 below includes updated projected savings from FY 2015 – 2019 for each of the 10 original shared services in comparison to the original projected savings. The adjustments are based on sound rationale: potential new opportunities, obstacles to savings maximization, and other factors. For example, some of the shared services have greater implementation costs, which reduced their net savings projections. Although actual savings have exceeded projections in the first two years, these savings have been primarily derived from the first five shared services to reach IOC, and the second five shared services have taken extra time to activate and begin work on the approved business process re-engineering plans.

Figure 3: Updated Projections for DHA Shared Services Net Savings



As of this writing, the shared services are evolving into enduring ESAs that support the effectiveness of the Military Departments' Medical Departments and promote enterprise efficiency. The Defense Health Agency's goals in the next year are to fortify relationships with the Military Departments' Medical Departments; better define and strengthen its role as a Combat Support Agency; and optimize DHA operations. The continuously improving ESAs will play a large part in achieving these goals.

The cumulative net savings of \$712.9M from October 2013 to September 2015 (cited above) were achieved through a set of shared services Process Improvement (PI) initiatives. As part of the design and analysis process, each shared service developed a Business Case Analysis and a Business Process Reengineering Plan that described the opportunities for cost savings and performance improvement in each shared service, as well as a discrete set of projects needed to achieve cost savings and improvement.

Additional detail on the full portfolio of Shared Services PI initiatives, and estimated savings is provided in Part Two of this report. Also included is an explanation of any changes in project savings. It must be noted that the projected savings were for discreet projects that focused on improving existing operations. Unexpected environmental changes could, however, change total overall cost of operations (e.g., compound pharmacy expenditures). These external impacts, either positive or negative, on the original cost projections were not included in the adjustments to the original saving projections.

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

In the third submission dated October 25, 2013 in response to section 733 of NDAA for FY 2013, DHA proposed as the core measure the percent of total health care delivered in primary care. Subject matter experts were unable to define the algorithm for this measure. During this time, however, the MHS conducted a comprehensive review of safety, quality, and access in the MHS and established baseline performance in key areas. This work resulted in a core set of 30 enterprise-wide standard measures of performance for the entire MHS. This MHS Performance Dashboard, and its alignment to the MHS Quadruple Aim and strategic objectives, is shown in figure 4 below.

Figure 4

MHS Performance Dashboard

Report as of 24 SEPT 2015



STRATEGIC ALIGNMENT		PERFORMANCE MEASURE	DEV. STATUS	MHS PERFORMANCE	THRESHOLDS			AS OF	DATA ENTRY		
AIM	OBJECTIVE				RED	GREEN	BLUE				
Readiness	Medically Ready Force (PLS1)	Individual Medical Readiness (IMR)	I	87%		<75%	≥85%	90%	Jun 15	Sept 15	
	Ready Medical Force (PLS2)	TBD	---	---		---	---	---	---	---	
Better Health	Healthy People (PLS3)	TBD	---	---		---	---	---	---	---	
	Improve Healthy Behaviors (IP5)	HEDIS Cancer Screening Index	I	63%		50%	70%	90%	May 15	Sept 15	
Better Health	Improve Clinical Outcomes and Consistent Patient Experience (PLS4)	▼ Risk Adjusted Mortality (All Cause)	E	.82		TBD	TBD	TBD	Mar 15	Sept 15	
		Inpatient: Recommend Hospital (Satisfaction)	I	75%		<71%	≥73%	≥75%	Mar 15	Sept 15	
		Overall Satisfaction w/Healthcare (Outpatient)	I	94%		Service Specific	Service Specific	Service Specific	Mar 15	Sept 15	
Better Health	Improve Safety (IP9)	▼ **HAI (CLABSI)	I	14		N/A	N/A	0	Jun 15	Sept 15	
		▼ **PSI 5 - Retained Surgical Item or Unretrieved Device Fragment Count (Per Year)	I	11		N/A	N/A	0	Dec 14	Jun 15	
		▼ National Surgical Quality Improvement Program (NSQIP) (30 Day) All Case Morbidity Index	I	82% of MTFs green		10th percentile	11th - 89th percentile	90th percentile	Dec 14	Sept 15	
		CAUTI		14		TBD	TBD	TBD	Jun 15	Sept 15	
		Wrong Site Surgery		11		TBD	TBD	TBD	Jun 15	Sept 15	
		**HEDIS Diabetes Index	I	54%		50%	70%	90%	May 15	Sept 15	
Better Care	Improve Condition-Based Quality Care (IP7)	**HEDIS Appropriate Care Index (Low Back Pain, Pharyngitis, URI)	I	47%		50%	70%	90%	May 15	Sept 15	
		▼ NPIC Post-Partum Hemorrhage*	E	3.9%		2σ above NPIC avg (3.3%)	within 2σ of NPIC avg. (3.3%)	2σ below NPIC avg (3.3%)	Dec 14	Sept 15	
		▼ NPIC Vaginal Deliveries w/Coded Shoulder Dystocia Linked to a Newborn ≥ 2500 grams w/Birth Trauma*	I	10.9%		2σ above NPIC avg (12.5%)	within 2σ of NPIC avg. (12.5%)	2σ below NPIC avg (12.5%)	Dec 14	Sept 15	
		HEDIS (30-Day) Mental Health Follow-Up	I	79%		50th percentile (74%)	75th percentile (81%)	90th percentile (85%)	May 15	Sept 15	
		▼ HEDIS All Cause Readmission	E	1.45		50th percentile (0.79)	75th percentile (0.73)	90th percentile (0.68)	Nov 14	Jun 15	
		ORYX Transition of Care Index (Asthma, VTE, Inpt Psy(2))	I	50%		60%	75%	100%	Sept 14	Jun 15	
Better Care	Improve Comprehensive Primary Care (IP8)	AHRQ Prevention Quality Indicator (PQI) Index	I	94%		70%	80%	90%	Dec 14	Sept 15	
		PCM Continuity	I	56%		55%	65%	81%	Jul 15	Sept 15	
		PCM Empanelment	E	<1,100.1		<1,100.1	1,100.1	>TBD	May 15	Sept 15	
		▼ Primary Care Leakage	I	25.2%		>24%	24% to > 20%	≤ 20%	May 15	Sept 15	
		▼ **Avg. No. of Days to Third Next Available Future Appointment (Primary Care)	I	7.6d		>7d	7.0d	2.2d	Aug 15	Sept 15	
		▼ **Avg. No. of Days to Third Next Available 24 Hour Appointment (Primary Care)	I	1.7d		>1d	1.0d	0.8d	Aug 15	Sept 15	
Better Care	Optimize & Standardize Access & Other Care Support Processes (IP10)	**Percent of Direct Care Enrollees in Secure Messaging	I	37%		<50%	≥50%	≥60%	July 15	Sept 15	
		**Satisfaction with Getting Care When Needed (Service Surveys)	I	86%		Service Specific	Service Specific	Service Specific	Mar 15	Sept 15	
Lower Cost	Improve Stewardship (PLS5)	▼ PMPM	I	\$370 10.6%		>2.8% yearly growth	2.8% to > 0% yearly growth	≤ 0% yearly growth	Mar 15	Sept 15	
		▼ Total Purchased Care Cost	E	\$-47.7M -2.5%		Service Specific	Service Specific	Service Specific	Dec 14	Mar 15	
		▼ Private Sector Care Cost per Prime Enrollee	I	\$194 17.3%		>2.8% yearly growth	2.8% to > 0% yearly growth	≤ 0% yearly growth	Mar 15	Sept 15	
		OR Utilization	E								
		**Total Enrollment	I	3.58M 0.1%		<0% yrly growth	0% to < 5% yrly growth	≥ 5% yrly growth	Aug 15	Sept 15	
		▼ Pharmacy Percent Retail Spend	I	54.7%		>40%	40% to > 35%	≤35%	Apr 15	Sept 15	
		Productivity Targets	I	93%		Service Specific	Service Specific	Service Specific	Jun 15	Sept 15	

Measures for Objective 3

Measures for Objective 2

▼ Lower is better

**Indicates Process Improvement Priority

Indicates measure under development

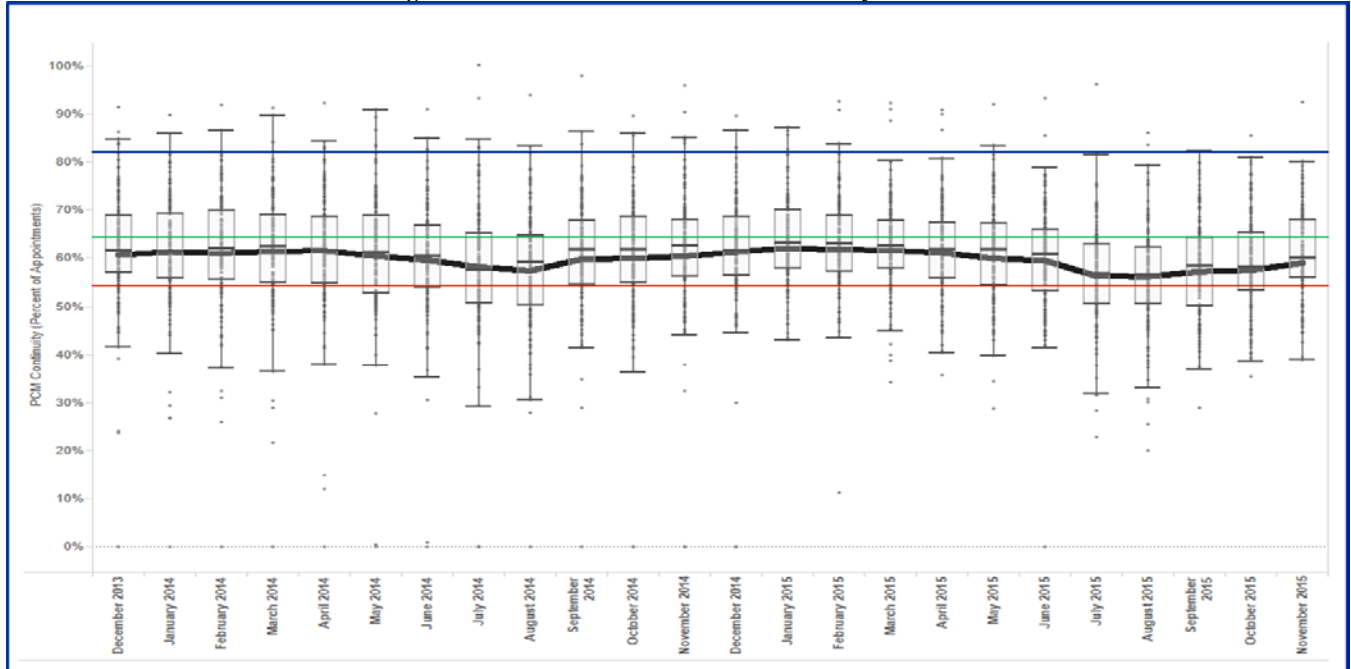
Developmental Status: A = Accountability; I = Improvement; E = Exploratory
*NPIC calculates + provides the MHS w/ MHS, Service + MTF status relative to the NPIC database average

Seven measures from this dashboard apply directly to primary care and have become the primary measures of performance for Objective 2.

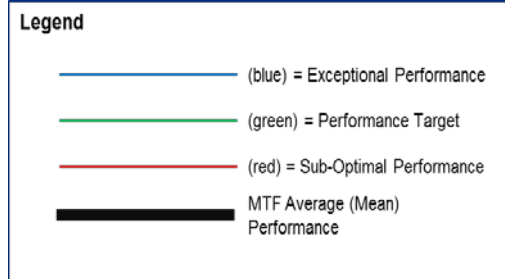
- **PCM Continuity**
- PCM Empanelment (In Development)
- **Primary Care Leakage**
- **Average Number of Days to Third Next Available Future Appointment (Primary Care)**
- **Average Number of Days to Third Next Available 24-Hour Appointment (Primary Care)**
- **HEDIS Cancer Screening Index**
- **MHS Acute Conditions Composite (low back pain, pharyngitis, URI) formerly HEDIS Appropriate Care Index (Low Back Pain, Pharyngitis, Upper Respiratory Infection (URI))**

PCM Continuity is measured as the percent of appointments where an enrollee is seen by his or her primary care manager (PCM). PCM Continuity is a critical component of the Patient Centered Medical Home (PCMH) model of care because a continuous relationship between an enrollee and his/her PCM often leads to higher quality, more integrated/coordinated care, a more proactive, preventive focus on health, and lower unnecessary healthcare utilization and reduced healthcare costs. High PCM continuity is statistically correlated with higher patient satisfaction and better access. Figure 5 below shows the performance of the Military Health System.

Figure 5: MHS Performance – PCM Continuity



From December 2013 through November 2015, PCM Continuity was relatively stable but reflected some seasonable variation during summer staff turnover, as well as variation in military treatment facility (MTF) performance. Current average performance at approximately 60% reflects a nearly 50% improvement as compared to 2011*, prior to full-scale implementation of the PCMH model. We will continue to monitor this measure to ensure the improvements resulting from PCMH are sustained.

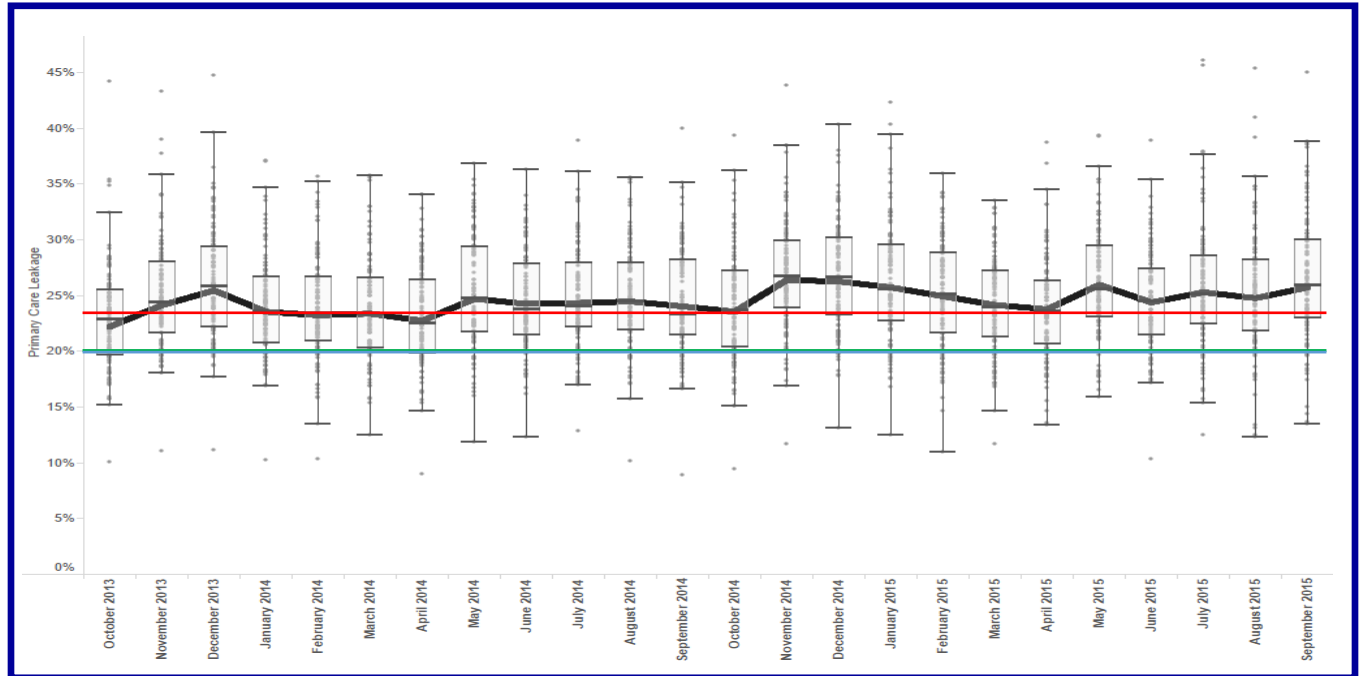


NOTE: Where possible, data is presented as a “box and whisker” graph. Definitions for the components of a “box and whisker” chart can be found in Appendix B.

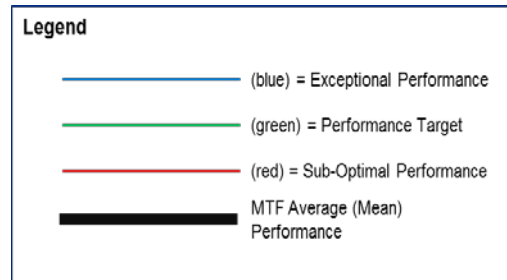
* While not shown in this chart, data from 2011 is available upon request

Primary Care Leakage is the percentage of recapturable primary care workload (relative value units (RVUs)) that is done outside of the beneficiary’s enrollment site. It includes primary care, urgent care and some emergency room care delivered in direct care (DC) settings and in private sector care (PSC). The Primary Care Leakage measure is intended to help assess whether patients have access to timely and convenient care within the direct care system. Figure 6 below shows the performance of the Military Health System.

Figure 6: MHS Performance – Primary Care Leakage



Primary care leakage has been relatively stable between 20% and 25%. There is variability in MTF performance as well as seasonal variation during the winter holidays and summer personnel turnover. In March, 2015, MHS Leadership designated access as one of four P4I process improvement priorities.

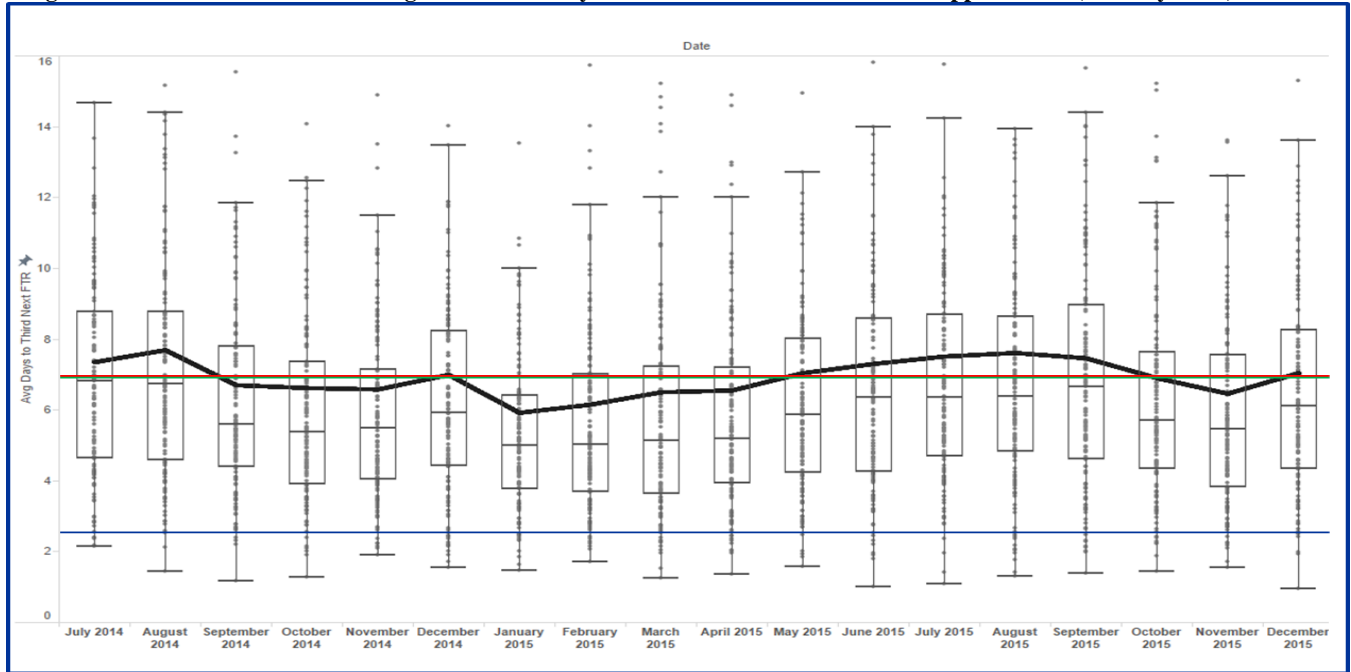


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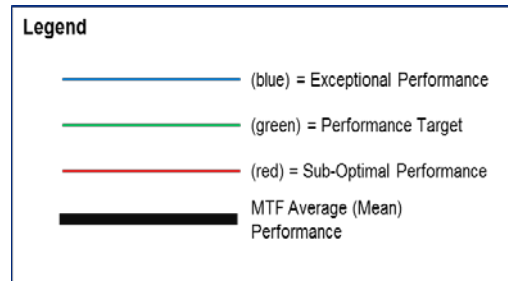
Average Number of Days to Third Next Available Future Appointment (Primary Care)

reflects the ability of a clinic to maintain availability of a future appointment for routine health issues. The MHS wants to ensure that patients will have at least three appointment options within seven days for a routine issue. Figure 7 below shows the performance of the enterprise.

Figure 7: MHS Performance – Average Number of Days to Third Next Available Future Appointment (Primary Care)



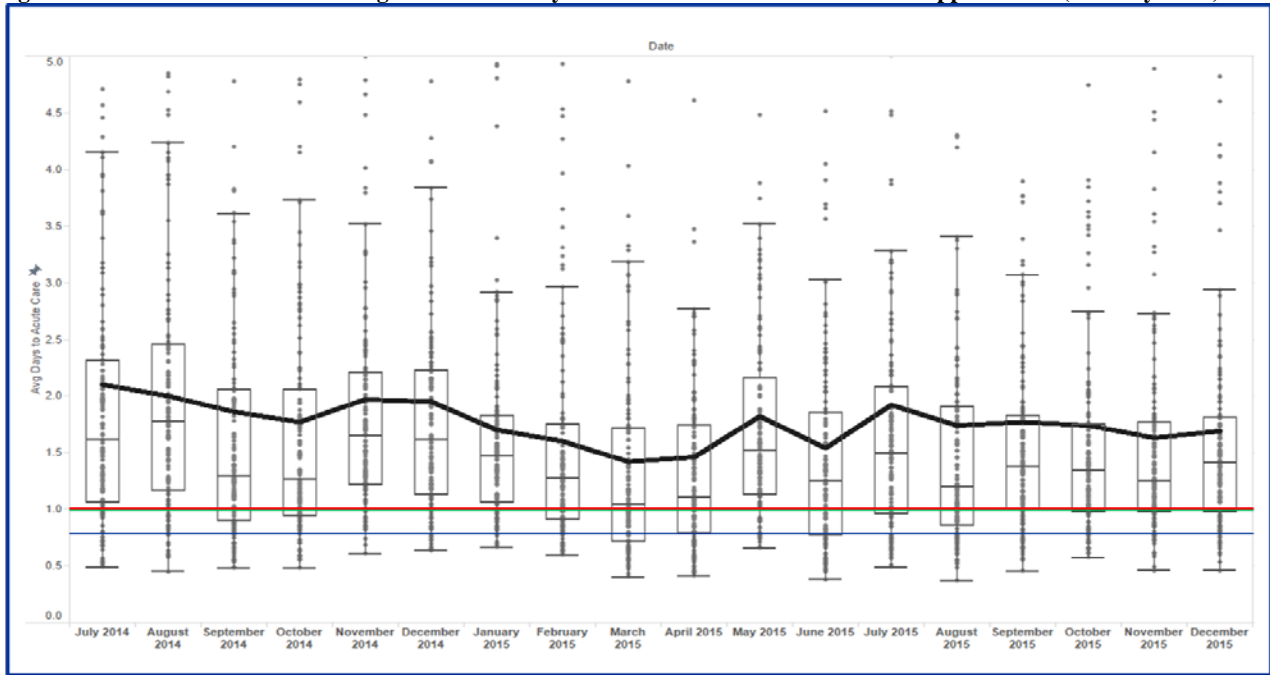
On average, during the period from July 2014 through December 2015, the MHS met the target of 7 days for availability of routine future appointments. There was, however, variation in performance across MTFs and seasonal variation that affect patient experience. In March 2015, MHS Leadership designated access as one of four P4I process improvement priorities.



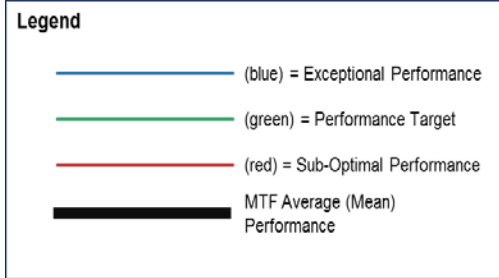
NOTE: Where possible, data is presented as a “box and whisker” graph. Definitions for the components of a “box and whisker” chart can be found in Appendix B.

Average Number of Days to Third Next Available 24 Hour Appointment (Primary Care) reflects the ability of a clinic to maintain availability of an acute appointment for urgent health issues. The MHS wants to ensure that patients will have at least three appointment options within 24 hours for an urgent issue. Figure 8 below shows the performance of the enterprise.

Figure 8: MHS Performance – Average Number of Days to Third Next Available 24 Hour Appointment (Primary Care)



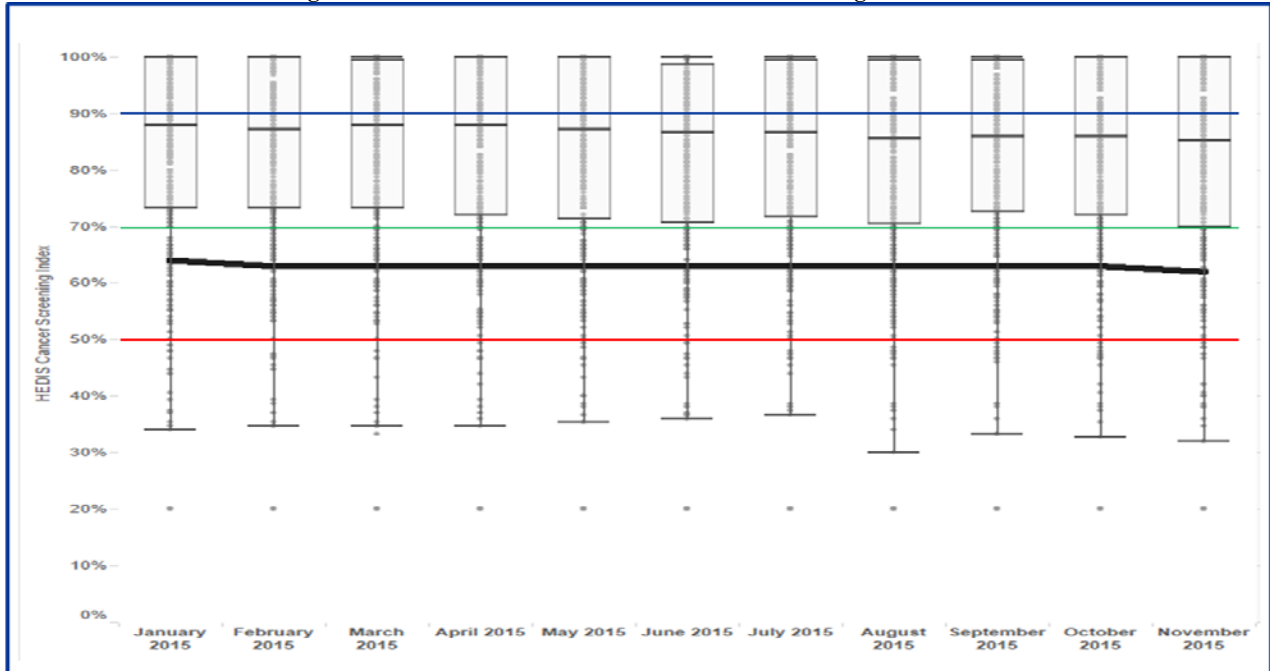
In July 2014 it took 2.1 days on average to find three available urgent appointments for primary care in an MTF. By December 2015, that number declined to 1.8 days. In addition, the amount of variation across MTFs went down by 33% as indicated by a reduction in interquartile range. In March, 2015, MHS Leadership designated access as one of four P4I process improvement priorities and placed special emphasis on simplifying appointing processes, offering alternatives to face to face visits (e.g., secure e-mail) and increasing availability of primary care providers.



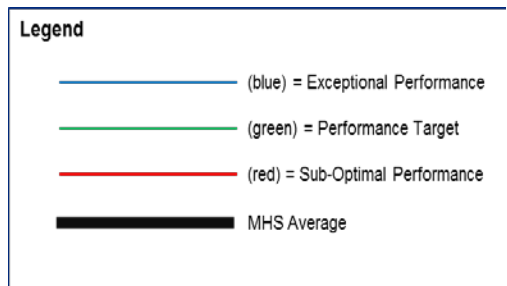
NOTE: Where possible, data is presented as a “box and whisker” graph. Definitions for the components of a “box and whisker” chart can be found in Appendix B.

HEDIS Cancer Screening Index The index measures performance for nationally recognized evidence based-preventive screening measures including breast cancer screening, cervical cancer screening and colorectal cancer screening. Improved scores indicate higher rates of appropriate screening that can result in early detection of cancer, reduced healthcare needs, and lower rates of death from cancer. Figure 9 below shows the performance of the enterprise.

Figure 9: MHS Performance – HEDIS Cancer Screening Index



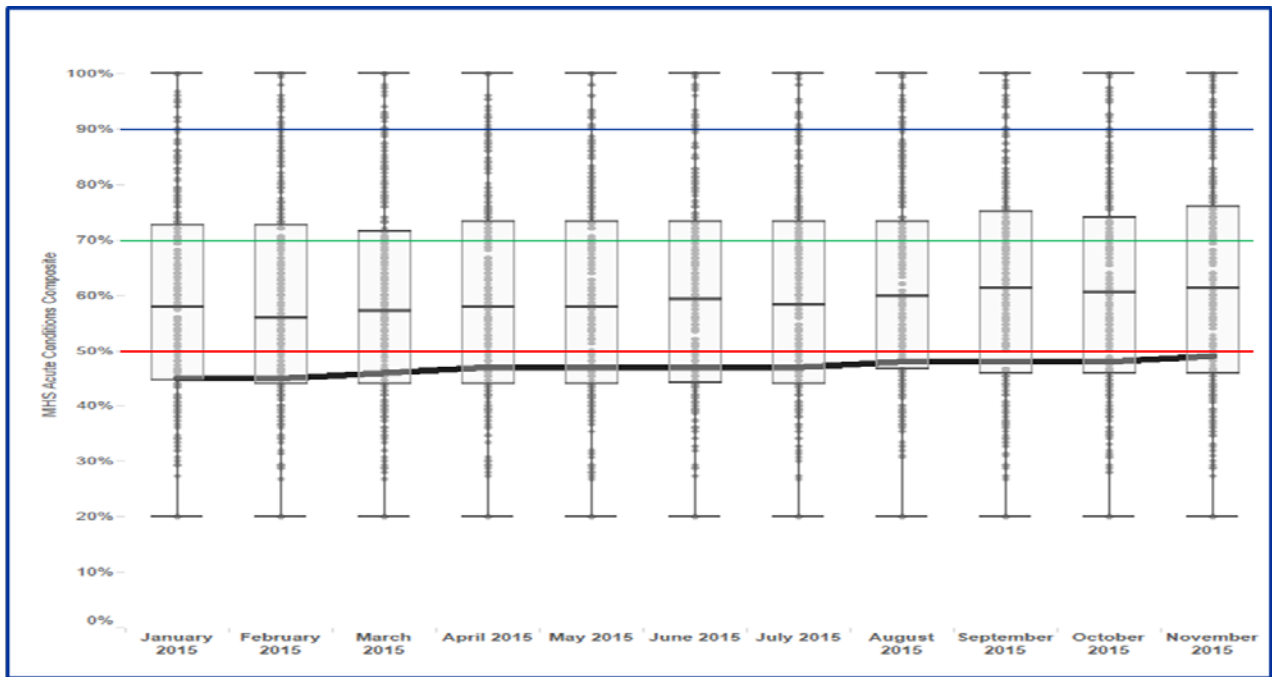
During CY 2015, MTF averages for this measure exceeded the MHS target but overall MHS performance did not meet enterprise target because the average was lowered due to lower documented performance for patients enrolled to a private sector primary care manager. To address this, the MHS will consider additional performance incentives for indicators of quality (e.g., HEDIS measures) as part of a value based purchasing strategy.



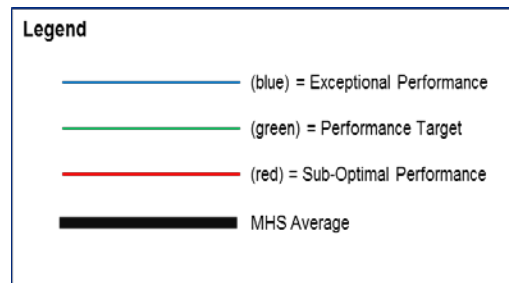
NOTE: Where possible, data is presented as a “box and whisker” graph. Definitions for the components of a “box and whisker” chart can be found in Appendix B.

MHS Acute Conditions Composite (Low Back Pain, Pharyngitis, URI) –This index measures three acute-care focused areas: appropriate use of imaging studies for low back pain, use of antibiotics for upper respiratory infection (URI), and treatment of pharyngitis with antibiotics and strep test. These three common acute care services have well established evidence based guidelines and this measure indicates MHS adherence to the guidelines which have been shown to improve outcomes and lower costs by eliminating unnecessary treatment or testing. Figure 10 below shows the performance of the enterprise.

Figure 10: MHS Performance – MHS Acute Conditions Composite (Low Back Pain, Pharyngitis, URI)



Between January and November 2015, average MHS performance increased by about 5% but variability across MTFs remained constant. In March, 2015, MHS Leadership designated improvement in quality outcomes as one of four P4I process improvement priorities and placed special emphasis on this measure of acute condition management.



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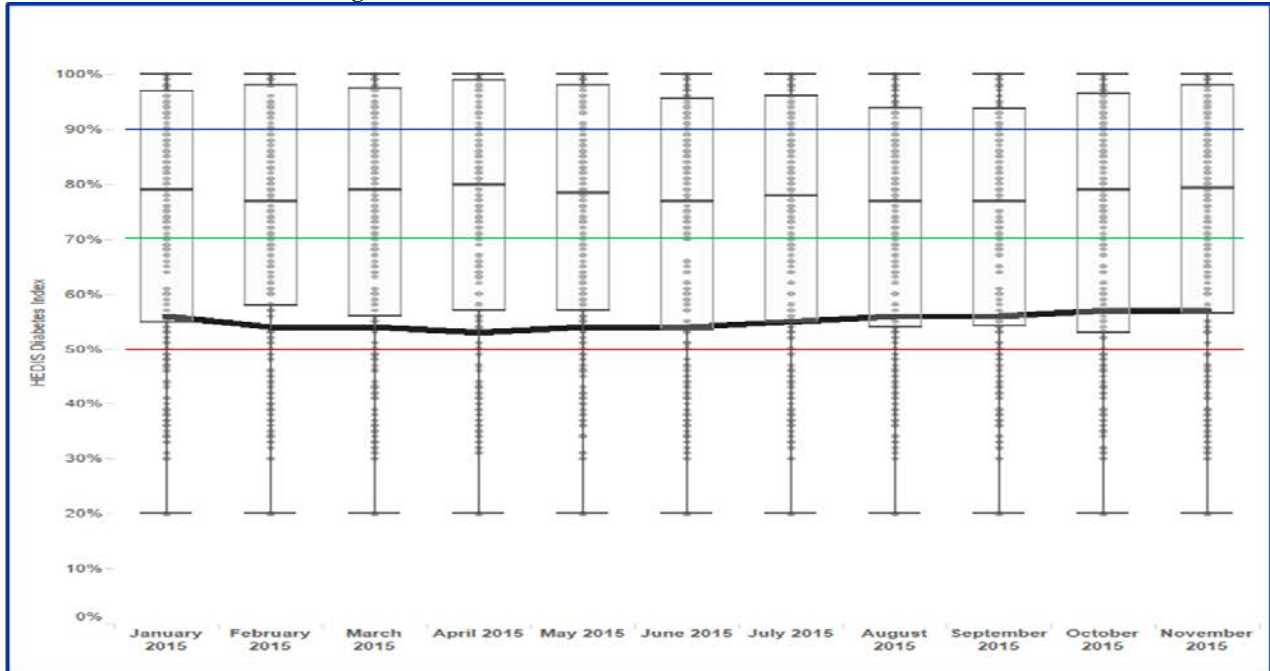
Objective 3: Coordinate care over time and across treatment settings to improve outcomes in the management of chronic illness, particularly for patients with complex medical and social problems.

Similar to Objective 2 (Primary Care), the MHS Review has informed an update to the measures for Objective 3. Six measures from the enterprise dashboard apply directly to condition-based care and have become the primary measures of performance for Objective 3. The measures below are being used to assess both safety and quality of condition based care.

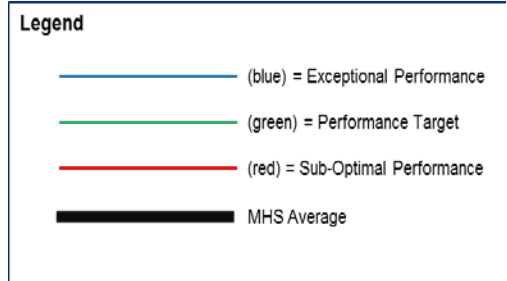
- **Healthcare Effectiveness Data and Information Set (HEDIS) Diabetes Index**
- **National Perinatal Information Center (NPIC) Postpartum Hemorrhage**
- **NPIC Vaginal Deliveries with Coded Shoulder Dystocia linked to a Newborn ≥ 2500 grams with Birth Trauma**
- **HEDIS (30-Day) Mental Health Follow-Up**
- **HEDIS All Cause Readmission**
- **Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicator (PQI) Index**

Healthcare Effectiveness Data and Information Set (HEDIS) Diabetes Index consists of two measures that indicate aspects of appropriate care for diabetic patients age 18-75. Specifically, the index reflects both appropriate screening of long term blood sugar control and success in maintaining healthy blood sugar levels. Figure 11 below shows the performance of the enterprise.

Figure 11: MHS Performance –HEDIS Diabetes Index



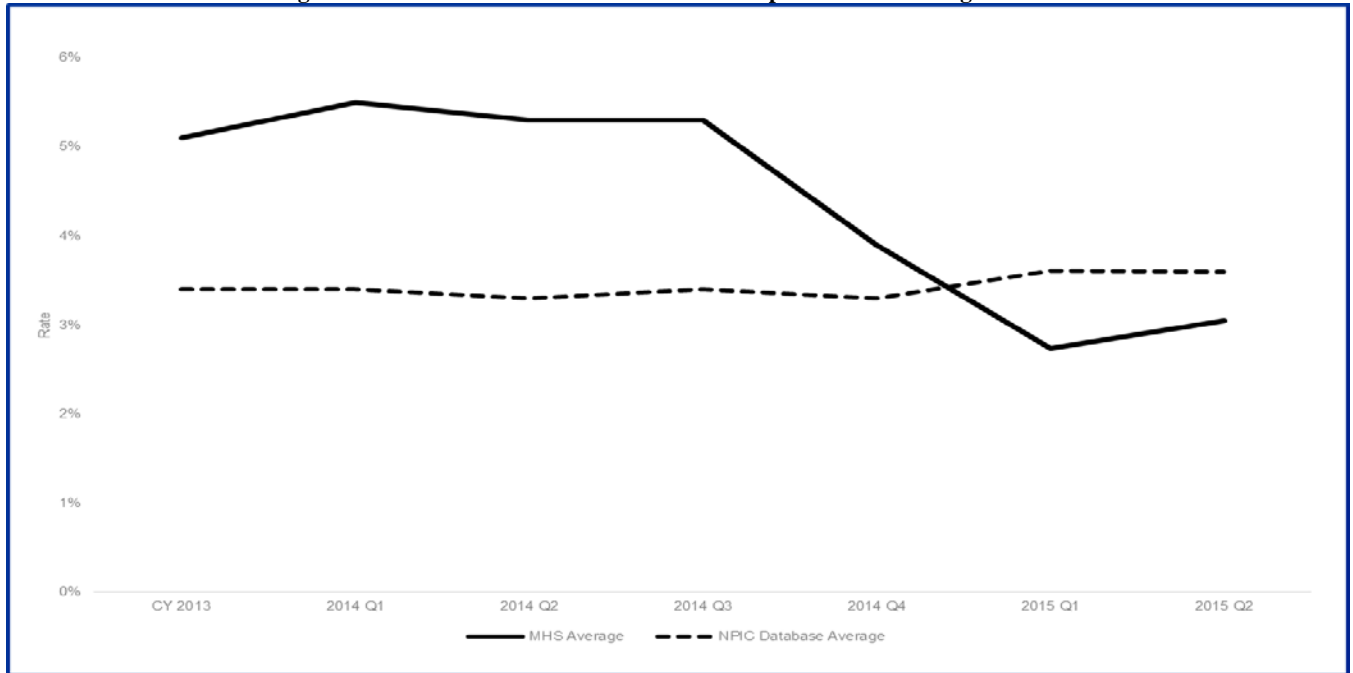
During CY 2015, MTF averages for this measure exceeded the MHS target but overall MHS performance did not meet enterprise target because the average was lowered due to lower documented performance for patients enrolled to a private sector primary care manager. To address this, the MHS will consider additional performance incentives for indicators of quality (e.g., HEDIS measures) as part of a value based purchasing strategy. In March, 2015, MHS Leadership designated improvement in quality outcomes as one of four P4I process improvement priorities and placed special emphasis on this measure of chronic illness management.



NOTE: Where possible, data is presented as a “box and whisker” graph. Definitions for the components of a “box and whisker” chart can be found in Appendix B.

NPIC Postpartum Hemorrhage measures maternal blood loss at or after delivery. Excessive blood loss can result in harm, suffering, or even death and is therefore an indicator of safe and appropriate care during childbirth. Figure 12 below shows the performance of the enterprise. Please note that the data for this measure would be erroneously represented in a box and whisker format, and for this reason the information is displayed as a run chart against the NPIC database average.

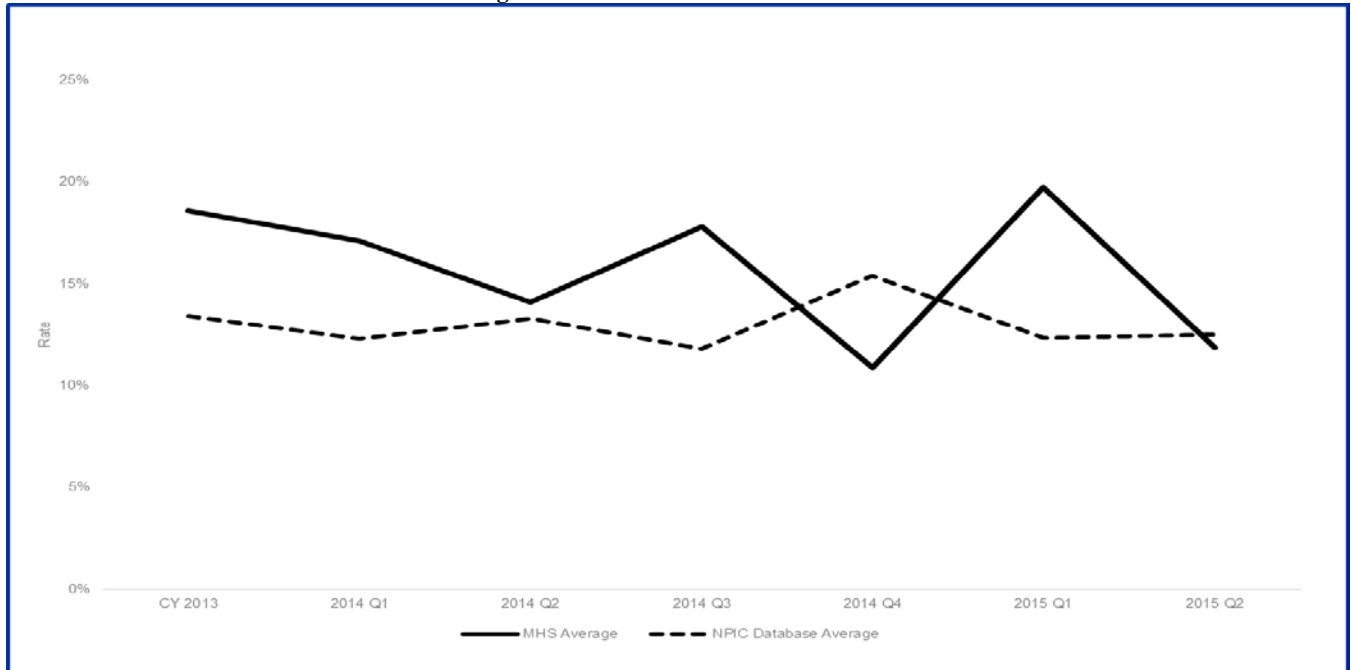
Figure 12: MHS Performance -- NPIC Post Postpartum Hemorrhage



The rate of documented postpartum hemorrhage in the MHS improved from 5% to less than 3% between the last quarter of 2013 and the second quarter of 2015. MHS performance is now above the National Perinatal Information Center benchmark for this measure.

NPIC Vaginal Deliveries with Coded Shoulder Dystocia linked to a Newborn ≥ 2500 grams with Birth Trauma is a measure that reflects the proportion of mothers with vaginal delivery that had a shoulder dystocia code on their record as well as a birth trauma code on their baby's record. This measure is one indicator of safe and effective management of pregnancy and delivery. Figure 13 below shows the performance of the enterprise. Please note that the data for this measure would be erroneously represented in a box and whisker format, and for this reason the information is displayed as a run chart against the NPIC database average.

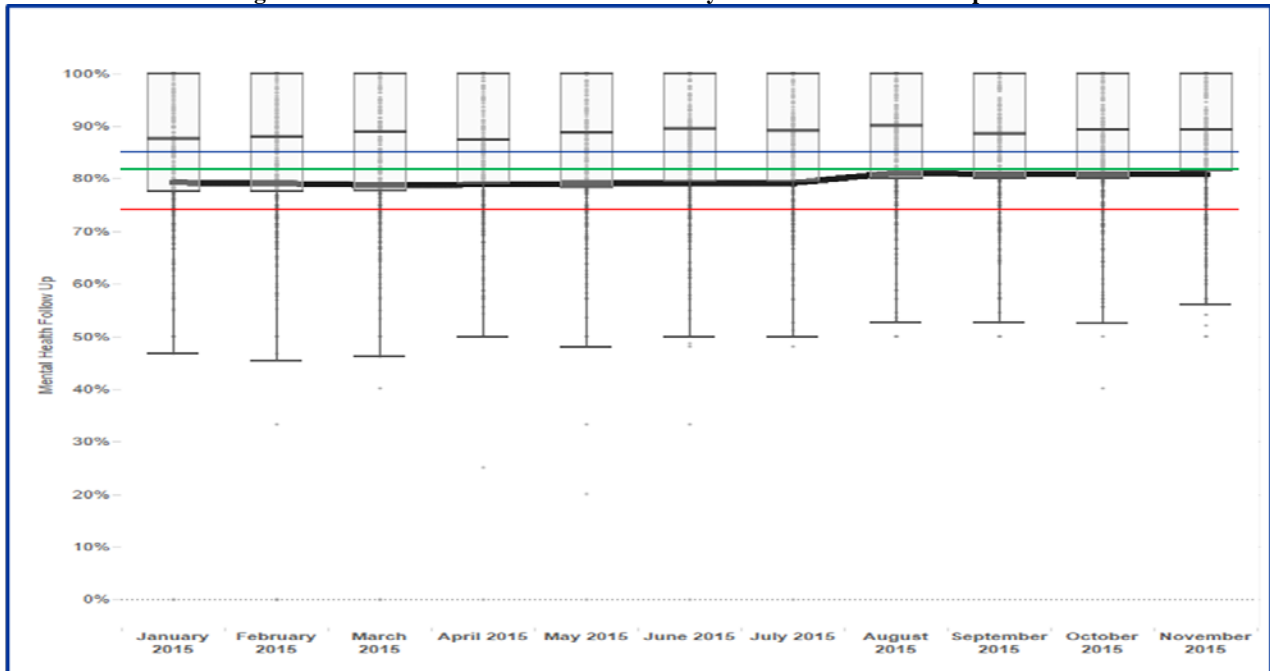
Figure 13: MHS Performance – NPIC Vaginal Deliveries with Coded Shoulder Dystocia linked to a Newborn ≥ 2500 grams with Birth Trauma



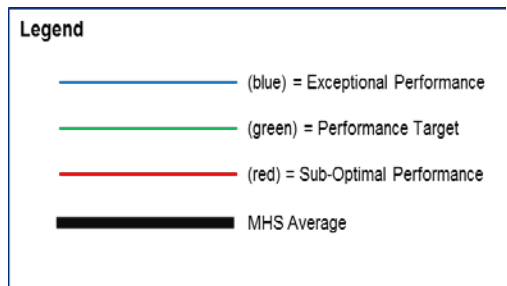
Although there has been variability in performance over the period from late 2013 through the first half of 2015, there have been two quarters when the MHS enterprise performance exceeded the National Perinatal Information Center benchmark.

HEDIS 30 Day Mental Health Follow Up measures the percentage patients age 6 or older who had an encounter with an appropriate provider within 30 days of discharge from an inpatient mental health facility. This measure is an indicator of success in providing a safe, seamless transition from inpatient to outpatient care. Figure 14 below shows the performance of the enterprise.

Figure 14: MHS Performance -- HEDIS 30 Day Mental Health Follow Up



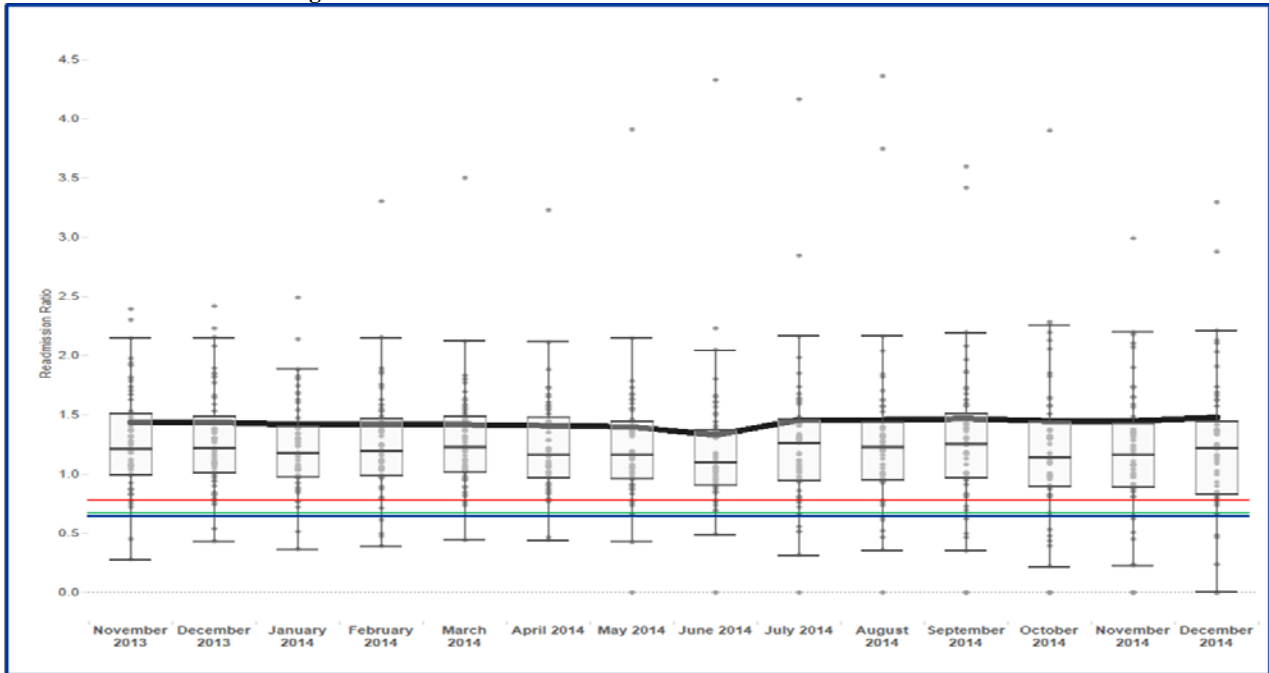
From January to November 2015 the MHS increased average performance on this measure by approximately 20% and reduced variation across MTFs by almost 20% (as indicated by a reduced interquartile range). This improvement reflects efforts to improve integration of services across inpatients and outpatient care settings and across direct and private sector care settings.



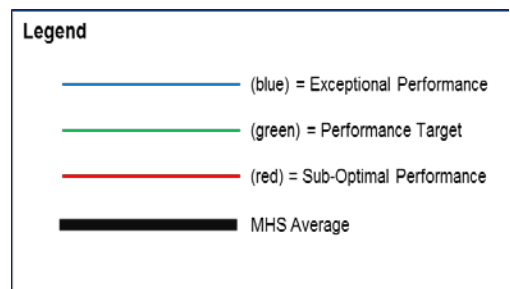
NOTE: Where possible, data is presented as a “box and whisker” graph. Definitions for the components of a “box and whisker” chart can be found in Appendix B.

HEDIS All Cause Readmission assesses the number of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days for members 18 years of age and older in direct care. The measure excludes maternal and perinatal patients. Reducing the rate of unplanned readmissions is another indicator of effective coordination of care between inpatient and outpatient care and across direct and private sector care venues.

Figure 15: MHS Performance –HEDIS All Cause Readmission



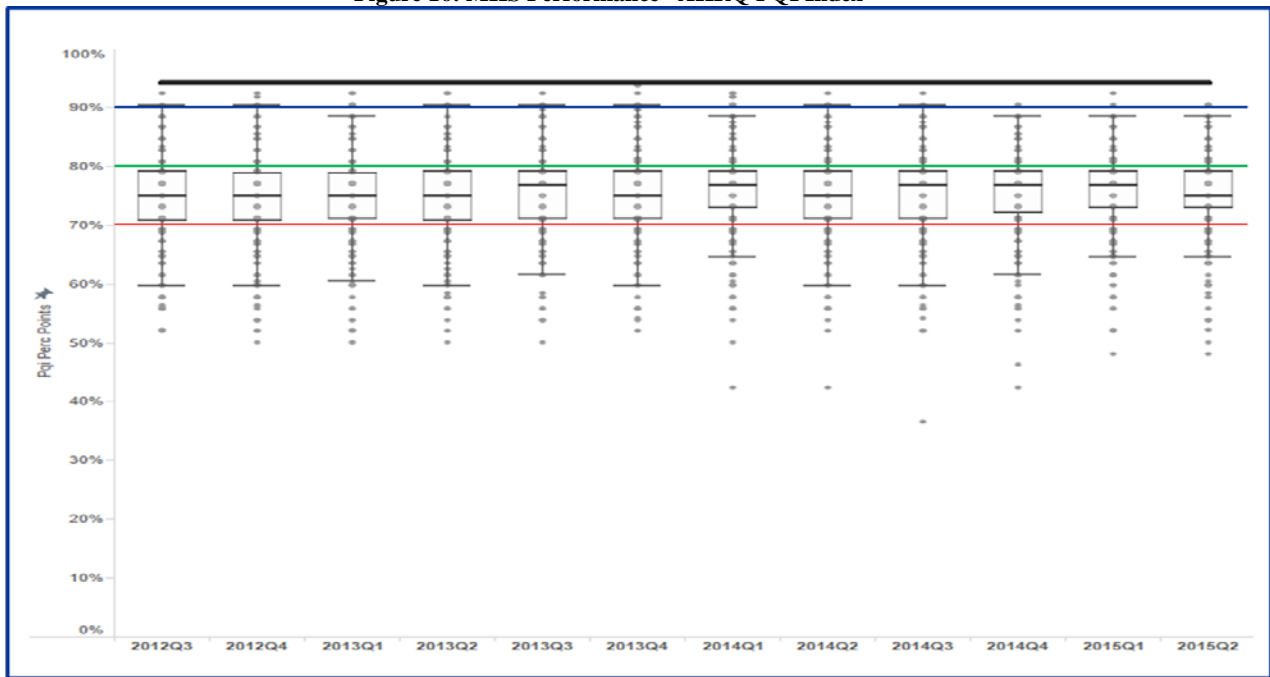
Between November 2013 and December 2014, documented MHS performance revealed an enterprise average rate of readmission that was over 50% higher than national benchmarks and increasing variability in performance across MTFs. In 2015, MHS leadership conducted a study of specific causes of elevated readmission rates in the MHS and created mitigation plan to reduce unwarranted readmissions.



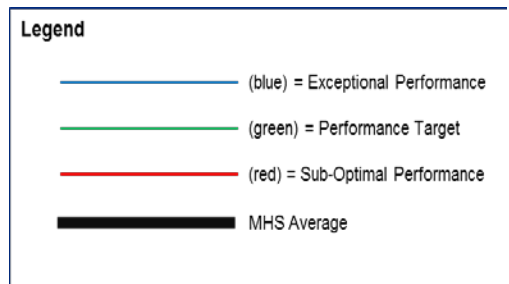
NOTE: Where possible, data is presented as a “box and whisker” graph. Definitions for the components of a “box and whisker” chart can be found in Appendix B.

Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicator (PQI) Index is a set of measures developed by AHRQ that can be used with hospital inpatient discharge data to identify quality of care for ambulatory care sensitive conditions. This indicator reflects the rate at which patients with selected chronic illnesses require inpatient hospitalization; better performance is one indicator of success keeping people with chronic illness from requiring hospitalization. Figure 16 below shows the performance of the enterprise.

Figure 16: MHS Performance –AHRQ PQI Index



From June 2012 through June of 2015, MHS average performance on this measure has remained high and variation in performance across MTFs has decreased.

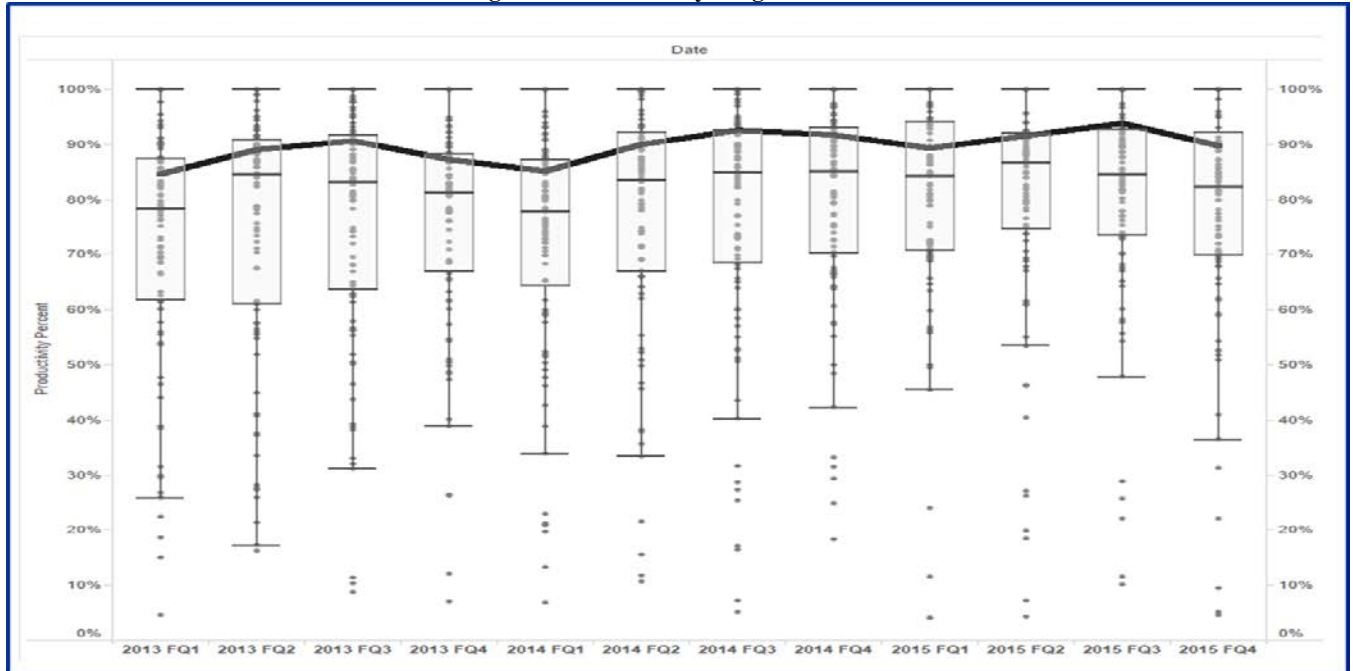


NOTE: Where possible, data is presented as a “box and whisker” graph. Definitions for the components of a “box and whisker” chart can be found in Appendix B.

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

The core measure for this objective is Productivity Targets for workload measured in Relative Value Units (RVUs). The targets were set using benchmarks established by the Medical Group Management Association (MGMA). The MHS has set a goal of achieving 40% of the MGMA median by FY18. Figure 17 below shows performance on this measure. The targets are Service and specialty specific, but the MHS goal is for at least 75% of providers to meet productivity targets by FY2018.

Figure 17: Productivity Targets



From the beginning of FY2013 through the end of FY 2015 the percentage of providers meeting targets has increased by approximately 5% on average. During this time productivity has shown a decline during the winter holiday season. There is also variation across providers but, this is declining based on analysis of interquartile range over time. As efforts to redistribute personnel to meet population demand for services proceed along with efforts to improve MTF efficiency, productivity should continue to increase.

Legend
 MTF Average (Mean) Performance

NOTE: Where possible, data is presented as a “box and whisker” graph. Definitions for the components of a “box and whisker” chart can be found in Appendix B.

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

In January 2015, the MHS updated an enterprise-wide performance dashboard and established the P4I as a formal performance management system. The P4I is guided by a steering committee with governance oversight and is responsible for developing inter-Service standards/metrics and supporting appropriate standardization of processes to enable learning and continuous improvement. This is part of an overall commitment by the MHS to achieve higher reliability particularly in safety, quality and access, consistent with the findings and recommendations from the MHS Review.

The MHS has replaced the milestones set out in the 2013 reports to Congress with the milestones for the P4I, including the deployment of an enterprise-wide performance management system that includes the common standards and measures described below.

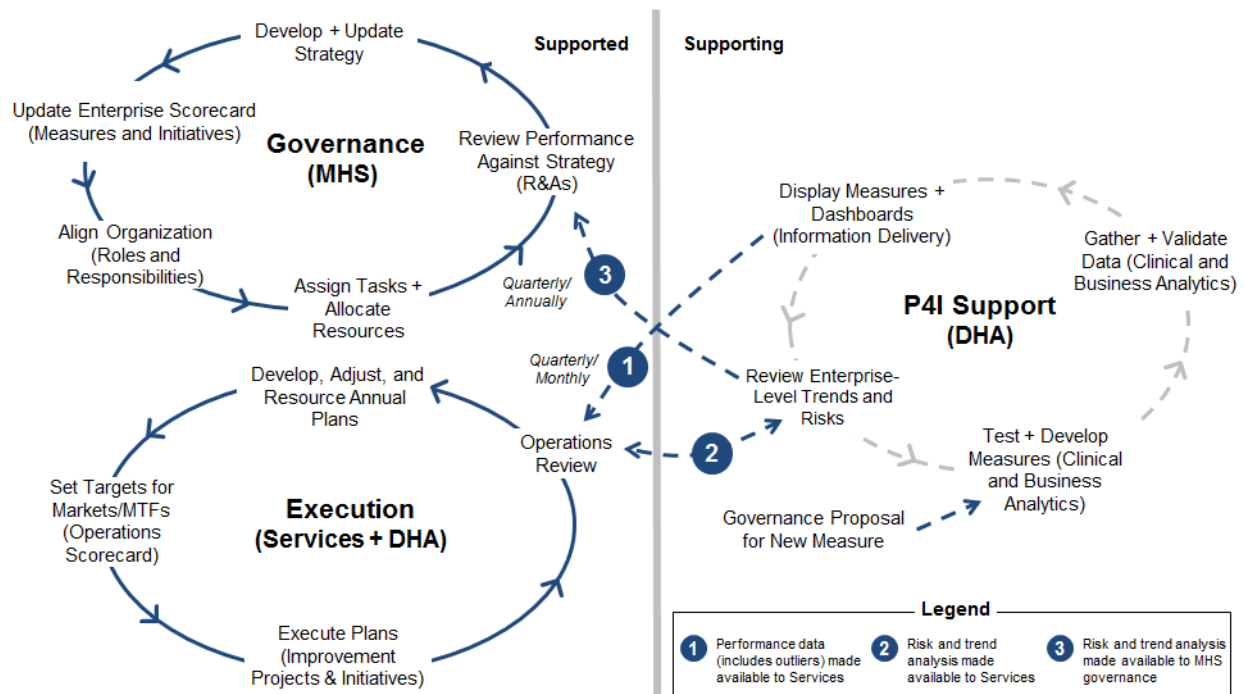
The updated milestones and measures of success for this objective were:

- Establishment of P4I with initial operating capability (IOC) of January 1, 2015.
- Release of an initial set of performance measures covering all areas of the MHS Review (Quality, Safety, Access) as part of IOC capability of the P4I.
- A report that clearly demonstrates the P4I capability to enable system-wide improvement in all areas addressed in the MHS Review by July 15, 2015.
- A balanced set of measures across the Quadruple Aim aligned with the Strategy Map with thresholds for each measure by December 1, 2015.

All the items above have been addressed by the Military Health System.

On January 1, 2015, the MHS achieved IOC for the P4I. The operating concept for the P4I has three interdependent parts as depicted in figure 18 below. The overarching principle is DHA operates in support of the Military Departments' Medical Departments and MHS Governance. It monitors performance, provides enterprise-level analysis, and supports improvement, but, with the exception of the NCR and Shared Services, execution is the responsibility of the Military Departments' Medical Departments.

Figure 18: Partnership for Improvement Operating Concept



The DHA supports the Services in executing their plans and supports MHS governance in achieving alignment of activities. The system supports enterprise learning and improvement.

The processes located in the right circle are the responsibilities of the DHA. The DHA develops standard performance measures as directed by MHS Governance and in collaboration with the Services. The DHA collects, validates, and distributes performance information to the Services and the National Capital Region Directorate within the DHA. This supports the lower circle. The DHA also provides analysis on enterprise trends and risks to MHS Governance. This supports the upper circle.

The lower circle is the responsibility of the Military Departments’ Medical Departments and DHA (specifically the NCR Directorate), which use the information provided by the DHA P4I Support function to develop strategy, allocate resources and analyze, review, and improve the performance of Markets, MTFs, and other operations under their authority, direction, and control.

The top circle is the responsibility of the MHS Governance structure. MHS Governance is responsible for setting the enterprise strategy and for providing oversight of performance. MHS Governance uses the information provided by the DHA to review enterprise performance, adjust the MHS strategy, and allocate resources to close performance gaps.

The initial measures identified for inclusion in the P4I are a fraction of the measures Services/MTFs need to manage the complex MHS. New measures will be requested by the Services and DHA and developed by the DHA in accordance with a standard process agreed to by all components of the MHS. In addition, those measures no longer thought to be relevant by the Services and DHA will be removed. The Services and DHA also may choose to create and

monitor additional measures that are either Service-specific or needed to support improvement efforts.

On January 1, 2015, the MHS deployed 30 enterprise measures as part of IOC for the P4I. The measures are aligned to the MHS Strategy as shown in figure 4, the MHS Performance Dashboard.

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

In 2013, the MHS shifted to an integrated planning and management model for six of its largest markets where more than one Military Department operates an MTF. The six markets designated by the Deputy Secretary of Defense are Colorado Springs, Hawaii, National Capital Region, Puget Sound, San Antonio, and Tidewater; these are known as Enhanced Multi-Service Markets (eMSMs). Beginning in FY14, the eMSMs transitioned to an integrated performance measurement and planning process using a common set of measures. The nine measures applicable to the FY15 eMSM business plans are provided below. These measures are included in the MHS Performance Dashboard described earlier. The transition to the full set of measures on the MHS Performance Dashboard is ongoing.

The core measures for this objective are:

- Per Member Per Month (PMPM) Growth Rate
- Total Purchased Care Cost
- Private Sector Care Cost Per Prime Enrollee
- Prime Enrollment
- Percent Retail Pharmacy Spend
- Primary Care Leakage
- Overall Satisfaction with Healthcare - Inpatient
- Overall Satisfaction with Outpatient Access (Able to Get Care When Needed)
- Productivity Targets

At the time this report was drafted, FY 2015 data for market performance was not available in central systems due to ongoing upgrades in the enterprise dashboard. The data will be available in market specific dashboards beginning in May 2016. In the interim, data on the Colorado Springs, Hawaii, Puget Sound, San Antonio, and Tidewater market, is available through individual Military Departments' Medical Departments.

Working with the market authorities, the MHS can demonstrate that the enterprise is better together than apart in these vital markets. The eMSMs provide a natural climate in which to share information, more fully integrate with purchased care, and replicate good performance across the enterprise. As the MHS works to continue on the path to high reliability, the eMSMs will continue to use a business planning process that can drive quality and safety standards for the enterprise.

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

There is lack of consensus across the MHS and across US healthcare as to the ideal set of incentives to drive value. Consequently, the Military Departments' Medical Departments are piloting different pay-for-value models. These experiments will inform the MHS strategy for incentives in the future. MHS leaders also are developing approaches for pilot testing value-based purchasing for TRICARE contracts in collaboration with other federal agencies.

Part Two: Potential Sources of Cost Savings from Shared Services Projects

This section provides a more thorough explanation of the potential sources of cost savings from the implementation of shared services projects.

Total Projected Savings. In the third report to the Congressional Defense Committees submitted on October 25, 2013, DHA projected \$3.48B in savings from shared services projects from FY 2015 – 2019 (Defense Health Program (DHP) and Medicare Eligible Retiree Health Care Fund (MERHCF)). In July of 2015, DHA adjusted the savings projections based on new opportunities, obstacles to savings maximization, and other factors. Although the projections for total savings decreased as of that point in time, the DHA shared services are actively working to identify additional opportunities to make up the difference. These savings will be realized through a variety of projects that capture cost efficiencies from consolidating and standardizing the 10 shared service functions across the enterprise.

Savings By Individual Shared Services. As of September 30, 2015, all 10 of the shared services reached full operating capability and are in various stages of maturity, with some on track to meet or exceed savings targets and others reevaluating business case analyses or redefining their essential product lines. The original business process re-engineering (BPR) plans that each shared service developed included a portfolio of improvement projects across one or more product lines.

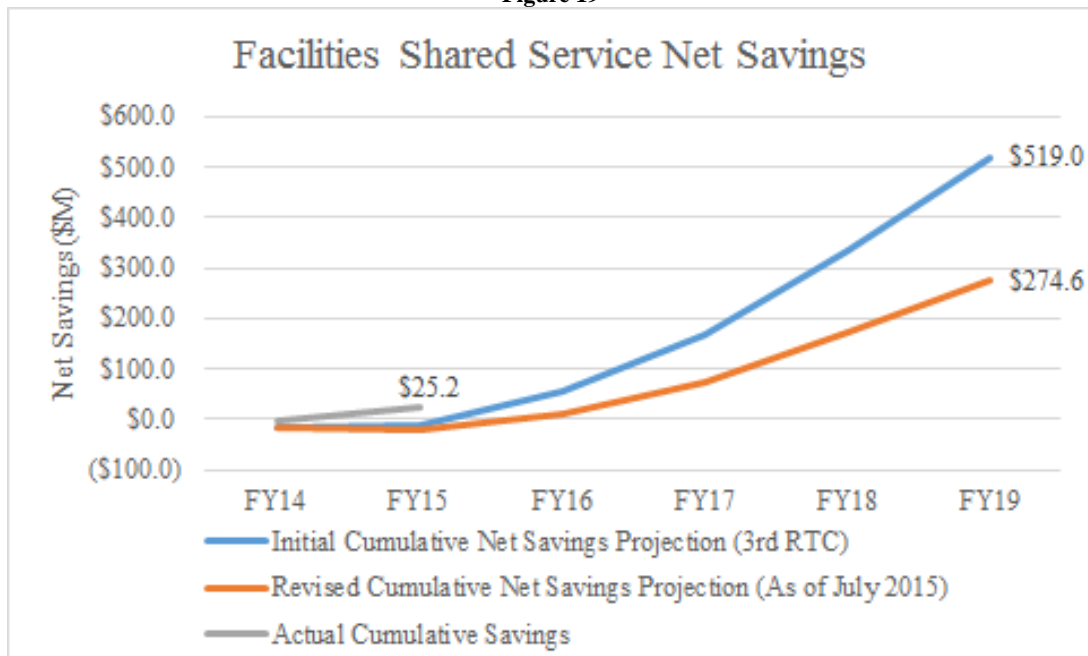
The projects ranged in scope from simple process re-design to enterprise-wide business process reengineering.

While FY 2014 was considered a startup year for shared services, several projects were initiated and completed in FY 2014. Initial results from BPR efforts are encouraging: MHS shared services achieved \$238.1M in savings in FY 2014 against a forecast of \$126.7M. Savings were primarily derived from the first 5 shared services that reached IOC on October 1, 2013 (Facilities, Medical Logistics, Health Plan, Pharmacy, and Health IT). In FY 2015, the shared services achieved \$478.8M in savings against a projection of \$341.0M. Actual savings reflected the results of initiatives, projects, activities, and operational changes. Investment costs are included in the savings reports for all shared services.

Facilities. Facilities will evolve the current business model toward more of a central portfolio management function. Savings are focused on making better investment decisions upstream in the facilities planning process so that downstream costs in construction, restoration, operations, and maintenance are better aligned to the needs of the MHS and its beneficiaries.

Facilities Savings: The initial projected savings target for Facilities from FY 2014 – 2019 was \$519.0M. For FY 2014, Facilities was projected to require a net investment of \$18.4M, but the actual net investment was \$4.6M. For FY 2015, Facilities originally projected savings of \$6.1M and actually achieved \$29.8M in savings. Investments costs include tools, training, studies, and contractor costs. Original and updated savings projections for Facilities are depicted in figure 19 below.

Figure 19



Update on Projected Net Savings: Facilities has updated its forecast from 2014 – 2019 from \$519.0M to \$274.6. Facilities conducted several process improvement projects in FY 2014 and FY2015, and as a result has better information for savings projections than the assumptions that were in the original BCA. In addition, top-line decrements were made to the Military Construction (MILCON), restoration & modernization, and initial outfitting & transition (IO&T) budgets over the next five years that will affect the potential savings opportunities that were originally identified. Facilities is still evaluating additional opportunities for savings, specifically in the area of programming oversight for IO&T.

Detail on Updated Facilities Savings: Facilities is working on establishing and strengthening enterprise standards as well as standardizing business processes to help decrease variance across the entire facilities business. Facilities has cost savings projects that span all four of its major product lines: Portfolio Management; Requirements Planning; Design, Construction, & Initial Outfitting and Transition (IO&T); and Facility Operations. A breakdown of the original

projected savings (currently being updated) by product line is presented in the following paragraphs.

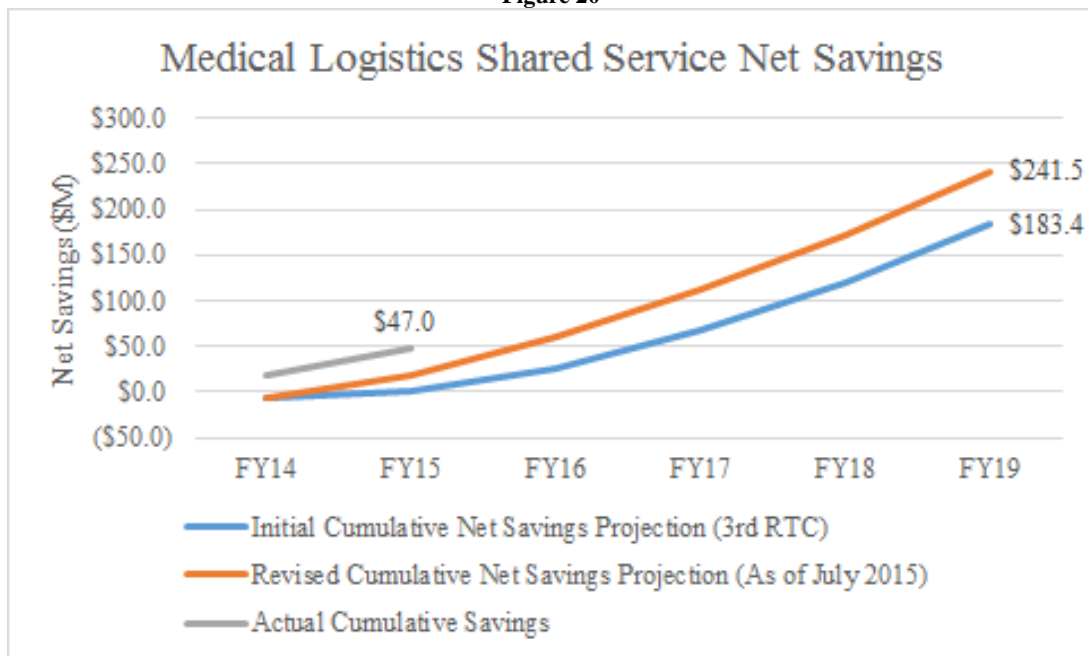
- *Portfolio Management (\$64.9M investment)* – The portfolio management product line has several functions including maintaining visibility across the entire MHS facilities inventory, measuring performance, overseeing the MHS facilities program and budget, and integrating with external demand signals to provide initial analysis of potential facilities investments. The net investments in this product line are related to gaining better asset visibility across the enterprise through implementation of new systems. Processes will be centralized in order to provide an enterprise review of all investments in MILCON or large restoration and modernization (RM) projects.
- *Requirements Planning (\$95.4M)* – The requirements planning product line within Facilities is where the shared services conducts analysis and evaluation of potential solutions and building options. A healthcare requirements analysis compares local market options for brick-and-mortar facilities. Requirements analyses produce the documentation needed to secure capital funds and to begin the design process. Savings potential exists in not only re-engineering the healthcare requirements analysis (HCRA) process to streamline the number of studies and reduce re-work but also in reducing the current number of square feet built each year, resulting in both MILCON and operations and maintenance (O&M) cost reductions.
- *Design, Construction, and IO&T (\$229.0M)* – The third product line for facilities is the actual design, construction and outfitting of facilities. Savings in this product line will come from standardizing design processes, enhancing construction management, and utilizing best practices to standardize IO&T across the MHS portfolio.
- *Facilities Operations (\$15.1M)* – Facilities operations include everything necessary to run a facility after construction. While this function will remain with the Services moving forward, there are still several opportunities for efficiencies. Potential savings are derived from opportunities to standardize operational procedures and processes and improve project management for small RM projects that are conducted after initial MILCON.

Implementation Costs: The primary costs for Facilities improvement activities are related to implementation of an automated system that will allow better visibility into the status of buildings across the MHS enterprise. For FY 2014, these costs were significantly lower than forecasted in the original business case due to funding that ending up occurring at the end of FY 2013. Although implementation costs for Facilities may end up shifting between the years, total implementation costs should not increase.

Medical Logistics (MEDLOG). DHA MEDLOG works with the DHA Clinical Support Division and Service leadership to standardize the demand signal for medical supplies, health care technology, and MEDLOG services (specifically housekeeping).

MEDLOG Savings: The projected savings for MEDLOG from FY 2014 – 2019 was originally \$183.4M. For FY 2014, a net investment of \$5.7M was projected but MEDLOG actually realized \$19.1M in net savings. While MEDLOG expected FY 2014 to be an investment year, savings were realized in both medical supply management and health care technology management product lines. For FY2015, MEDLOG realized \$27.9M in savings against a projection of \$7.1M. Initial and updated projected savings for MEDLOG are in figure 20 below.

Figure 20



Update on Projected Net Savings: MEDLOG has increased its savings projections for 2014 – 2019 from \$183.4M to \$241.5M. The increase in savings projections is a result of additional initiatives in supply chain management. MEDLOG is also analyzing additional opportunities for savings in medical equipment standardization and strategic sourcing.

Detail on Updated MEDLOG Savings: MEDLOG savings are expected to come in conjunction with a shift from coordinating improvements across the enterprise to establishing the DHA role for corporate/enterprise management and compliance with Defense Medical Logistics strategies. MEDLOG has cost savings projects that span all three of its product lines: Supply Management, Health Care Technology Management, and Services (primarily housekeeping). A breakdown of projected savings by product line is presented in the following paragraphs.

- *Supply Management (\$176.5M)* – Savings in the Supply Management product line will derive from projects that address standardizing medical consumable supplies across the enterprise in order to reduce the number of types of items being purchased. In conjunction, MEDLOG will focus on influencing the channels where local purchases occur in order to maximize cost effectiveness

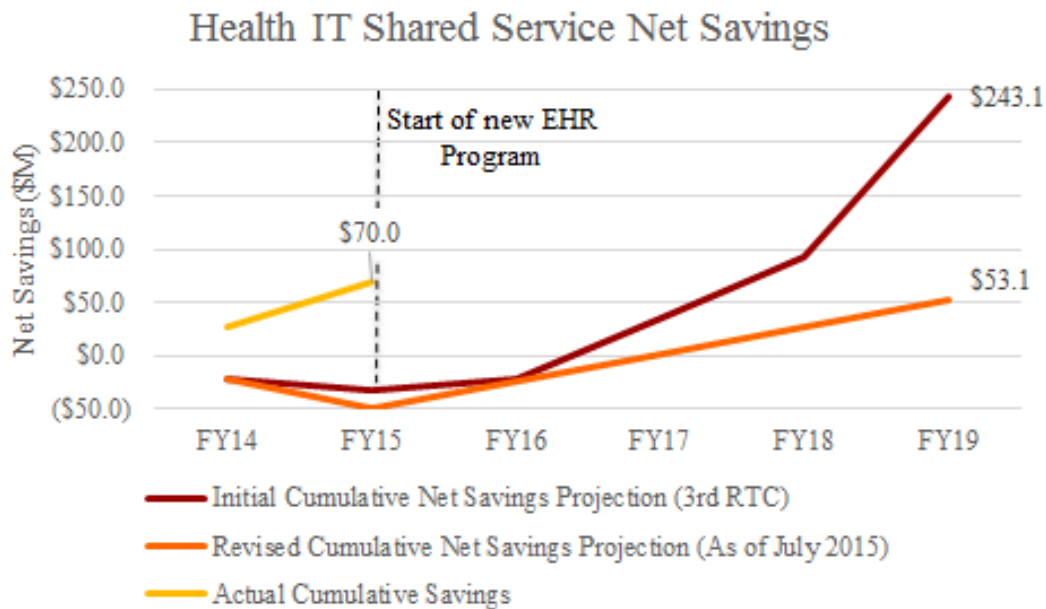
- *Health Care Technology Management (\$62.7M)* – In the area of Health Care Technology Management, which involves most of the medical equipment utilized at MTFs, savings projections are focused on gaining efficiencies through better coordination and integration across the entire lifecycle – planning future equipment requirements, procuring current equipment requirements, and maintaining equipment upon purchase.
- *Services (\$2.3M)* – The Services product line is focused on standardizing the acquisition of enabling services performed at MTFs across the enterprise.

Implementation Costs: The primary drivers of implementation costs for MEDLOG are related to IT investments that will enhance operations within the medical supplies and healthcare technology product lines. Implementation costs in FY 2014 were exactly as projected, and implementation costs for the next five years are not expected to change from the original projections.

Health IT (HIT). HIT aims to create an integrated HIT environment in support of an integrated MHS, with standardized IT infrastructure and applications down to the desktop.

HIT Savings: The initial projected savings for Health IT from FY 2014 – 2019 were \$243.1M. For FY 2014, a net investment of \$22.0M was projected but HIT actually realized \$27.1M in net savings. HIT realized savings across all of its product lines and made minimal investments in FY 2014. For FY2015, HIT realized \$42.9M in savings against a projected net investment of \$11.2M. An overall year-on-year summary of the original and updated projected savings for HIT are in figure 21 below.

Figure 21



Update on Projected Net Savings: Health IT has updated its forecast from FY14-19 from \$243.1M to \$53.1M. HIT is actively reassessing the original business case projections based on updated information. The acquisition by the Department of Defense of a new electronic health record (EHR) is expected to impact the original projections of both savings and costs around IT infrastructure and applications. When the original BCA was conducted for HIT, the requirements and timeline for the EHR program had not been established. Now that these have been confirmed, HIT is reassessing the original set of savings projects and re-baselining its business case analysis. Once this exercise is complete, Health IT will look to identify additional savings opportunities to meet or exceed original savings targets.

Detail on Updated HIT Savings: Savings in HIT are focused on centralizing/consolidating many of the core Health IT processes as well as reducing redundancies in the IT environment across the MHS. HIT operations transitioned under the management of DHA between IOC and FOC according to predetermined milestones. HIT has savings projects in three major areas: Re-engineering of IT Management, Infrastructure Consolidation, and Application Rationalization. A breakdown of the original projected savings (currently being updated) by initiative is presented in the following paragraphs.

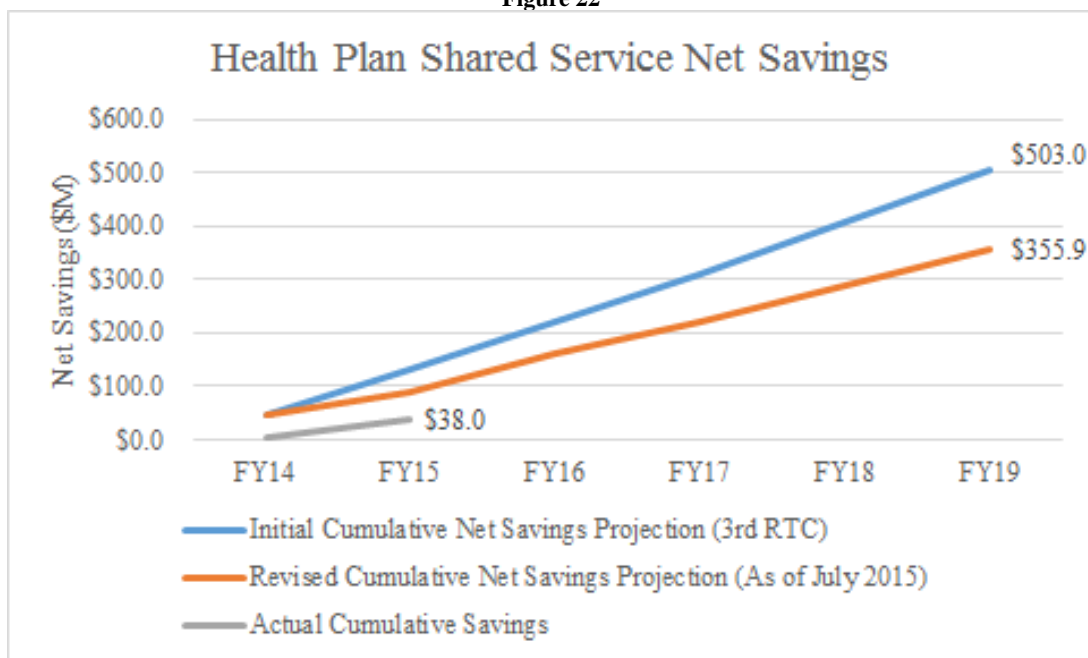
- *Re-engineering of IT Management (\$28.3M)* – For this major initiative, HIT will transition and consolidate IT management under the DHA while reengineering management processes. Savings will result from several projects that will reduce redundancy and maximize available resources to provide overall IT management for the MHS.
- *Infrastructure Consolidation (\$11.7M)* – HIT has identified several projects to consolidate and standardize IT infrastructure down to the desktop. This will be done across seven different functions and result in reduced IT infrastructure costs in the long-term.
- *Application Rationalization (\$13.1M)* – The major savings initiative for HIT was originally the rationalization of the software application portfolio within the MHS. This includes both clinical and non-clinical applications as well as garrison and theater applications. Applications will be segregated into product lines and evaluated for sustainment and alignment with other major application acquisitions. Emphasis will be placed on the increased use of commercial off-the-shelf products. Because several software applications were aligned with the implementation of the EHR, original savings projections in this product line were significantly adjusted.

Implementation Costs: In coordination with the updated business case analysis (as discussed in above), HIT will re-evaluate both the amount and timing of implementation costs for its savings projects over the next five years.

Health Plan. The TRICARE Health Plan provides oversight for the major purchased care contracts as well as proactive updates and information to the Services and information about benefit changes and potential issues.

Health Plan Savings The initial projected savings for Health Plan from FY 2014 – 2019 were \$503.0M. For FY 2014, savings were projected to be \$47.9M; however Health Plan achieved \$2.4M savings at for the year. Although Health Plan began execution on both of the primary savings initiatives in FY 2014, savings were delayed due to contract negotiations for modifications related to the closure of Tricare Service Centers (TSCs). For FY 2015, Health Plan achieved \$35.6M in savings versus a projection of \$40.9M. An overall year-on-year summary of the initial and updated projected savings for Health Plan are shown in figure 22 below.

Figure 22



Update on Projected Net Savings: The TRICARE Health Plan has updated its forecast from FY14-19 from \$503.0M to \$355.9M. Based on the results of actual contractual negotiations with vendors on the Managed Care Support Contracts (MCSCs) related to the closure of the Tricare Service Centers, Health Plan reduced the forecast over the six-year period. For the Other Health Insurance (OHI) initiative, projections were reduced due to delays in awarding the support contract as well as the fact that fewer policies were discovered than had been forecasted. Health Plan is evaluating additional savings opportunities with changes to the next generation of MCSCs as well as revisions to the dental contracts.

Detail on Updated TRICARE Health Plan Savings: As reported in the second Report to the Congressional Defense committees, the TRICARE Health Plan has identified two major programs in which savings are projected to occur. First, the TRICARE Health Plan will close TRICARE Service Centers (TSCs) that are contractor-operated, face-to-face customer service areas primarily located within MTFs. Customers will be provided greater access to information

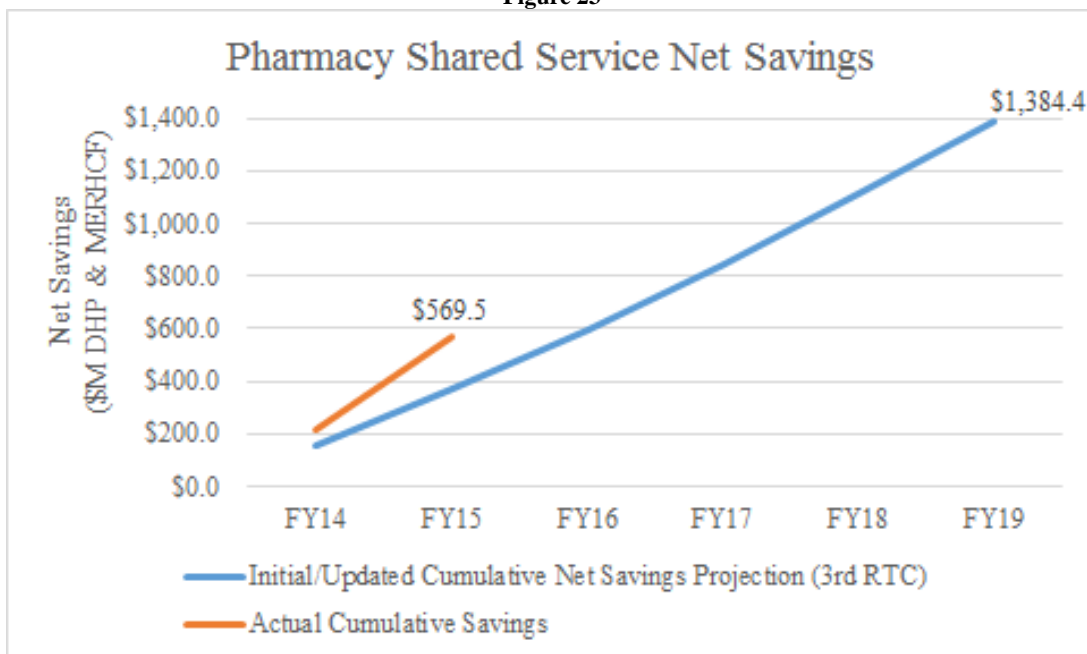
through toll-free call centers and internet resources. Savings are projected to result from reducing the TSC staffing requirement from existing contracts. Second, the Health Plan will invest in a centralized other health insurance (OHI) contract to increase the efficiency of OHI discovery and enable substantial cost avoidance for purchased care and provide the foundation for third-party collections for direct care. Together these two initiatives are projected to save the enterprise \$355.9M by FY 2019.

Implementation Costs: The primary drivers of implementation costs for Health Plan are contracted-related costs for both of its initiatives. Although overall gross savings for Health Plan may be delayed, implementation costs are not expected to vary significantly from the original business case analysis projections.

Pharmacy. The Pharmacy strategy is centered on improving pharmacy operations and resource allocation. Central to this strategy is the redirection of select refills from high cost points of service (retail pharmacies) to lower cost points of service (home delivery or MTF pharmacies) as well as more effective management of the DoD Formulary.

Pharmacy Savings: The projected savings for Pharmacy from FY 2014 – 2019 are \$1384.4M. For FY 2014, Pharmacy net savings were projected to be \$160.0M (including both DHP and MERHCF dollars). Pharmacy realized savings of \$215.0M in savings in FY 2014 and \$354.5M in savings in FY 2015 against a projection of \$208.1M. Pharmacy has exceeded savings projections largely due to a more effective implementation across the pharmacy enterprise. Savings projections and risk estimates were based on the historical rate of adoption of recommendations for standardization, uniform metrics and process improvements. Coming together as a shared, or enterprise, activity under the MHS Governance process that now includes the DHA has been foundational to more effective initiative implementations and reduction of barriers to adoption. Pharmacy savings are depicted in figure 23 below:

Figure 23



Update on Projected Net Savings: For the \$1384.4M in net savings projected for FY14-19, Pharmacy is currently updating the original business case assumptions but has not yet made final decisions on any updates to the original projection. The Pharmacy Enterprise faced an extraordinary issue during FY 2014- FY 2015: an explosion of cost and utilization of compounded prescriptions. Through the work of the Pharmacy Work Group, enterprise solutions were developed and implemented. The results have maintained beneficiary access to clinically and economically appropriate compound prescriptions while reducing cost by 98%. There are also over 100 Federal investigations of compound pharmacies, marketing companies and physicians for potentially fraudulent activity around the \$1.6B in compound expenditures by DoD prior to the new criteria implemented by DoD. The excess cost of compound

pharmaceuticals was not included in our initial or revised projections since it was outside the original scope of the Pharmacy business process reengineering plan.

Detail on Projected Pharmacy Savings: The DHA Pharmacy shared service has established the following priorities (1) redirect beneficiary prescriptions for maintenance medications from retail to mail order and MTF points of service through policy and new business rules; (2) increase MTF outpatient pharmacy compliance with centralized drug purchasing rules; and (3) decrease spending on decentralized pharmacy automation contracts. Accordingly, Pharmacy has cost savings projects that span three product lines: Policy Guidance and Business Rule Development; Formulary Management; and Pharmacy Automation. A summary of the original projected savings (currently being updated) by product line is presented in the following paragraphs.

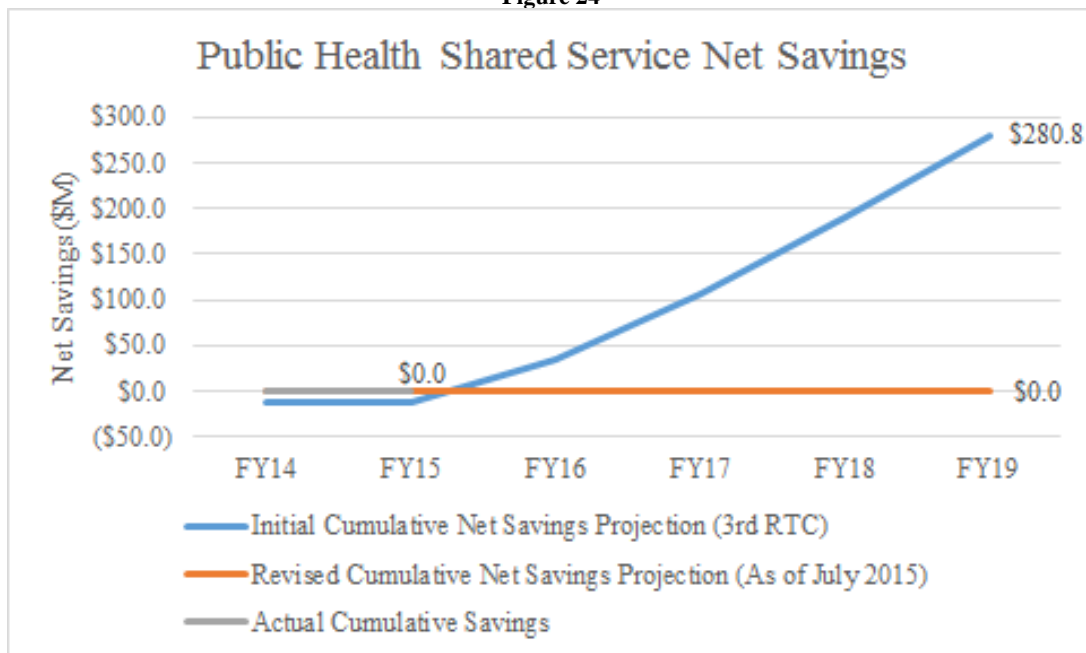
- *Policy Guidance and Business Rule Development (\$846.7M)* – The projects in this product line are focused on implementing new policies and business rules across the enterprise to influence which channel beneficiaries are able to use for select medications, as well as how MTF pharmacies purchase drugs. Channel management efforts are projected to result in significant savings, as beneficiaries will be re-directed from retail pharmacies to more cost-effective points of service (MTF or mail order) for certain maintenance medication refills.
- *Formulary Management (\$354.0M)* – The projects in this product line focus on enhancing decision-making and communicating updates to the DoD Uniform Formulary to prevent unnecessary or unwise spending on drugs that have not been evaluated for their clinical or cost effectiveness. In addition, Pharmacy will develop a new process for evaluating new drugs that are available but not yet approved by the FDA. Savings are derived from the cost avoidance of no longer purchasing non-formulary drugs.
- *Pharmacy Automation (\$23.7M)* – The projects in this product line are focused on enhancing the acquisition of pharmacy automation systems which is currently decentralized, with overlapping requirements and inflated automation purchasing and maintenance costs. Projected savings are expected to result from creating uniform requirements, developing a central acquisition strategy, and enhancing the monitoring of automation contract utilization.

Implementation Costs: Implementation Costs for Pharmacy in FY2014 and FY2015 were significantly lower than expected in the original business case. This is primarily due to the TFL Pilot. Forecasted implementation costs included the costs of buying drugs and increasing pharmacy personnel in the MTFs based on the number of prescriptions that were moved to MTFs from the retail point of service. Pharmacy over-estimated the number of select maintenance refills that ended up in MTFs as a result of the TFL Pilot and had significantly lower costs for contracted pharmacy personnel. As Pharmacy updates the projections for FY16-19, FY15 actual data will likely lead to lower estimates of implementation costs. Other forecasted implementation costs are not expected to change.

Public Health. Public Health is focused on standardizing processes to promote health and manage population and individual health risks in order to field a fit and medically ready force. At IOC, DHA Public Health assumed responsibility for 3 areas: Deployment Health, Immunization Healthcare (MILVAX-VHCN), and the DoD Veterinary Services Activity (DoDVSA). A fourth area, Health Surveillance, was to be integrated into the Division at IOC but was delayed due to administrative issues. Health Surveillance was integrated into the Division in August 2015.

Public Health Savings: The projected savings for Public Health from FY 2014 – 2019 were \$280.8M. For FY 2014, Public Health was to require a net investment of \$12.3M and FY 2015 was projected to include an additional investment of \$1.0M. Due to implementation delays, no investments (or savings) have yet been reported by Public Health. The initial and revised Public Health savings are depicted in figure 24 below:

Figure 24



Update on projected Net Savings: Public Health has updated its forecast from FY14-19 from \$280.8M to \$0.0M. Public Health is currently re-assessing all savings calculated in its original BCA. The Public Health Division has identified changes within the external enabling environment that will significantly impact the MHS’ ability to generate proposed savings tied to the Deployment Health product line which was projected to account for almost all of the \$280.8M. Specifically, FY2015 NDAA language requiring an “annual mental health face-to-face visit for all Service members” would nullify cost savings derived from Public Health Assessment optimization initiatives envisioned under the direction of the Public Health Division. In addition, potential savings from the Health Surveillance Branch were delayed when there was a two year delay in the transition of this organization into the DHA.

Across the MHS enterprise, military Public Health is comprised of 10 product lines: Deployment Health; Health Surveillance; Occupational and Environmental Health; Health Risk

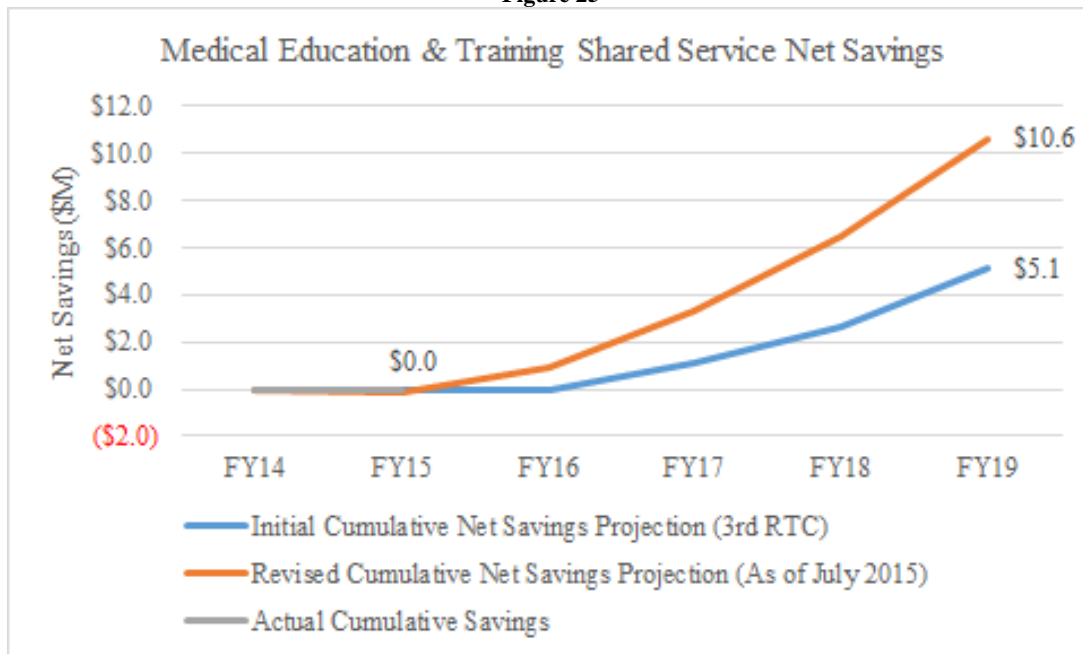
Communication and Public Health Emergency Response; Clinical Preventive Medicine; Radiation Health; Health Promotion; Public Health Laboratories; Entomology; and Food/Water Safety and Sanitation. When initially evaluating potential savings feasible through shared services, Public Health focused on only those product lines that would be integrated into the DHA at IOC: Deployment Health and Health Surveillance. Due to the complications from the NDAA directive, Public Health has initiated a series of business case analyses to identify new opportunities for efficiencies and costs savings. As of the writing of this report, Public Health has teams actively conducting new business case analyses on the Deployment Health, Food safety, Hearing Health, Public Health laboratories, and Immunization product lines.

Implementation Costs: Due to the fact that Public Health is updating all of its original business case projections, it is expected that implementation costs will need to be updated accordingly.

Medical Education and Training. The DHA Education and Training Directorate will focus on supporting the DHA shared service for education and training in the areas of clinical, operational, and leadership human capital development across the MHS Enterprise. The Education and Training Directorate has two main focus areas: research to advance patient care and creation of innovative training platforms to meet evolving healthcare requirements in war and peace time environments. Education and Training supports the Services and enables a ready, capable, and qualified medical professional force to carry out the military mission including the delivery of health care services.

DHA Education and Training Savings: The projected savings for DHA Education and Training from FY 2014 – 2019 were \$5.1M. For FY 2014, a small investment of \$30K was projected and was made. No net savings were projected for FY 2015 and no savings were reported for FY 2015. Medical Education and Training initial and revised projected savings are depicted in figure 25 below:

Figure 25



Update on projected Net Savings: Medical Education and Training has updated its forecast from FY14-19 from \$5.1M to \$10.6M. Additional savings have been identified around reducing user fees for e-Learning platforms across the enterprise. DHA Education and Training is still evaluating the full scope of responsibilities, and once this has been determined, exploration will begin to determine if there are additional savings opportunities available.

Detail on projected DHA Education and Training Savings: The savings estimate for Education and Training is derived from analysis of an initiative to standardize and consolidate contracts for learning management systems (LMS) and medical modeling and simulation products and services. Consolidation of the multiple LMS systems within DHA will provide the following benefits and savings: a) a single source for MHS Online training, leading to more accurate training reports for the staff; b) elimination of the costs associated with sustaining multiple

systems across the MHS; and c) a system with ease of use and access via Common Access Card (CAC)/Personal Identity Verification (PIV).

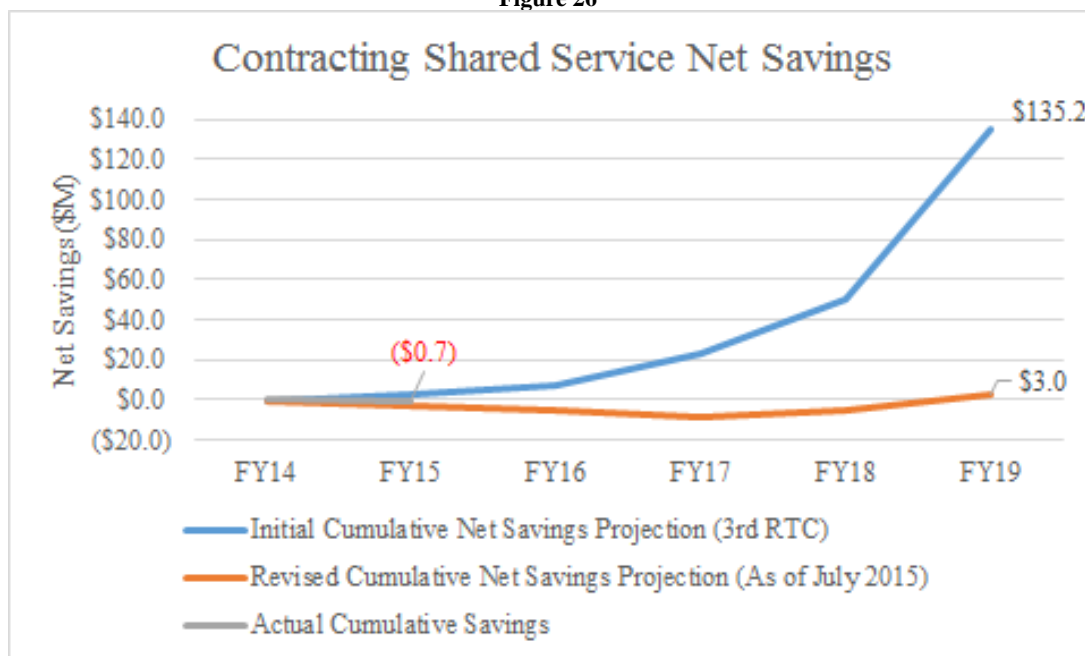
The DHA Education and Training Directorate is in the early stages of consolidating across the MHS enterprise medical modeling and simulation efforts. Standardization of medical modeling and simulation affords the opportunity to advance evidence-based treatment modalities, and promotes the implementation of innovative learning technologies. As DHA and the Services continue to work together, there will be greater transparency of all products across the MHS. As common lines of efforts are identified and coordinated, the shared service will eliminate redundancies and generate economies of scale and efficiencies.

Implementation Costs: No additional costs for were required in FY 2015.

Contracting. Contracting assumed responsibility for corporate management and compliance oversight of joint contracting initiatives and is in the process of developing strategic contracts for shared requirements. The DHA will transition from being a buying activity to being a buying agency, thus taking responsibility for all components of the contracting life-cycle.

Contracting Savings: The projected savings for Contracting from FY 2014 – 2019 were originally \$135.2M. For FY 2014, Contracting net savings were projected to be a net investment of \$0.63M. Due to the fact that Contracting reached IOC on March 1, 2014, and a significant amount of leadership time was spent on establishing a new organization, no net savings were reported in FY 2014. Contracting reported a net investment of \$0.7M for FY 2015 against an initial projection of \$3.7M. Original and updated projected savings are depicted in figure 26 below:

Figure 26



Update on Projected Net Savings: Contracting has updated its forecast from FY14-19 from \$135.2M to \$3.0M. Contracting is anticipating a slower transition to the strategic vehicles than was initially forecasted, eliminating almost all of the initial projected savings. It is expected, however, that in FY 2020 the strategic contracting vehicles will be utilized to the highest extent possible and annual savings will be around \$34.0M from that point forward. In addition, the Contracting shared service is now developing a standard process for exploring and developing strategic sourcing initiatives across the MHS.

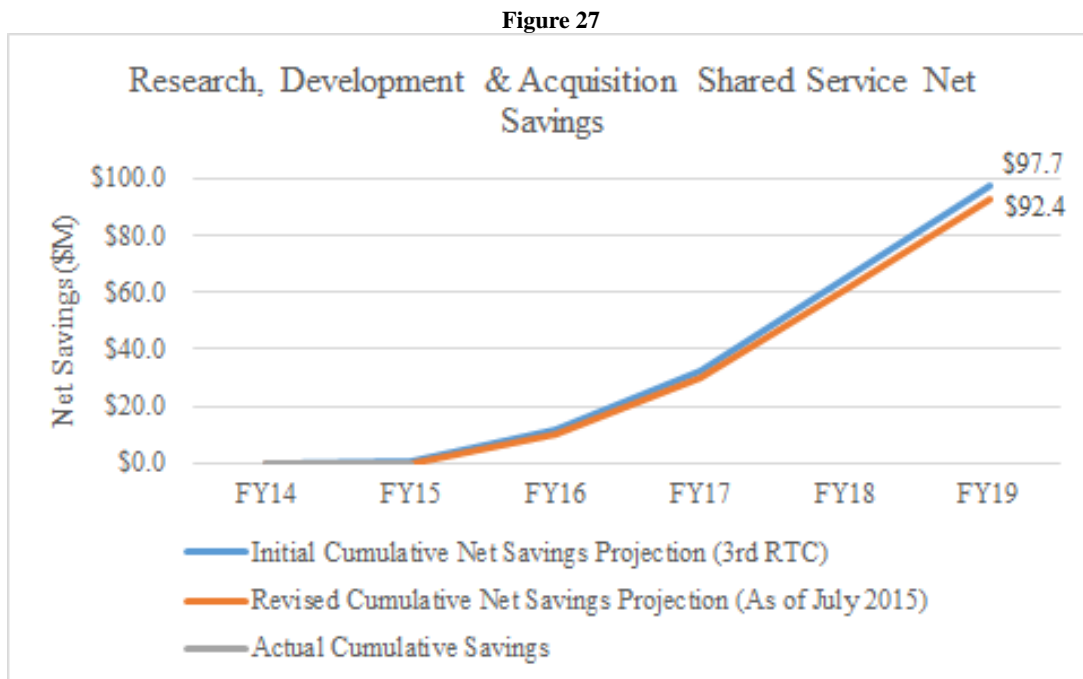
Detail on Projected Contracting savings: The Contracting shared services effort aims to reduce variation, redundancy, and cost while improving the efficiency of operations. Savings are primarily focused on consolidating requirements and using strategic sourcing vehicles for services contracts. Savings from Contracting are forecasted to primarily come from the development of Multiple Award Task Orders (MATOs) for Product Service Code Q (Medical Services) in support of the MTFs and Product Service Code R (Professional, Administrative, and

Management Support Services) in support of all parts of the organization. While these savings are specifically attributed to the Contracting function, Contracting is also an enabler for savings proposed by several other shared services. Contract rationalization and centralization is a common component among many savings initiatives.

Implementation Costs: Implementation costs were not included in the original forecast of savings for Contracting, although they were calculated after the third Report to Congressional Defense Committees was submitted in October 2013. The primary driver for costs will be contracted personnel to support the civilian and military staff in establishing the new contracting vehicles and standardizing processes as appropriate. The updated net savings projections for Contracting will include both gross savings as well as a detailed forecast of implementation costs.

Research and Development. Medical Research and Development is directed toward developing products and medical knowledge to prevent and/or correct any human condition that would impair or preclude a Service or joint force from achieving its objectives across the range of operations and responsibilities. The vision of the Medical Research and Development enterprise is to advance collaborative, innovative medical research and development to improve military community health and save lives on and off the battlefield.

Research and Development Savings: The initial projected savings for Medical Research and Development from FY 2014 – 2019 were \$97.7M. For FY 2014 and FY2015, Medical Research and Development did not forecast any net savings and none were realized. Original and updated projected savings are depicted in figure 27 below:



Updated Projected Net Savings: Research and Development has updated its forecast from FY14-19 from \$97.7M to \$92.4M. The MHS decided that all savings achieved for Medical Research and Development would be re-invested into additional research. After reaching FOC on October 1, 2015, Medical Research and Development established several initiatives to achieve its mission to implement best practices to responsibly design, prioritize, and integrate medical research, development, and acquisition programs across the continuum of care. The original savings projections were adjusted due to the discovery that two process improvement initiatives were not going to achieve the original savings intended. As Research and Development establishes its role across the MHS enterprise, DHA will work with the Services to identify additional opportunities for efficiencies and cost savings.

Detail on Projected Medical Research and Development savings: The BPR initiatives for Medical Research and Development were: a cost reinvestment initiative to move more funding from extramural (academia and industry) research efforts to intramural (DoD laboratories) efforts; and the consolidation of 2 commands that were executing the largest percentage of the

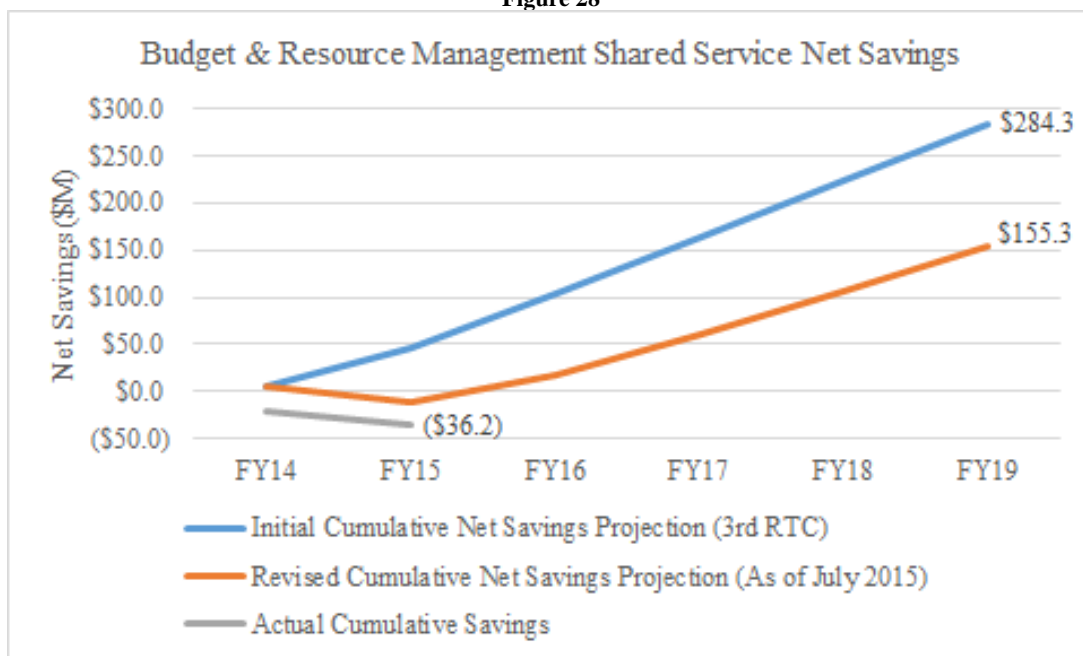
DHP Research, Development, Testing and Evaluation (RDT&E) funding. The original estimated total savings from the initiatives were \$92M, and \$2M, respectively. The consolidation of the 2 commands was completed and the savings will be used for additional research. The reinvestment initiative has begun, with FY 2016 being the first full fiscal year in which the Agency can track the percentage of funds that have shifted to the intramural labs.

Implementation Costs: Medical Research and Development did not estimate any implementation costs in its original business case analysis. As appropriate, implementation costs will be included with any new initiatives that are identified through future business case analyses.

Budget and Resource Management. Budget and Resource Management (B&RM) will support a collaborative process to coordinate and advocate for DoD-wide budget and resource management programs and initiatives in order to promote the utilization of budgeted funds in a cost-effective manner, increased reimbursements, and improved financial transparency of expenditures made in support of the MHS.

Budget and Resource Management Savings: The initial projected savings for Budget and Resource Management from FY 2014 – 2019 were \$284.3M. For FY 2014, B&RM net savings were projected to be \$4.9M; however these estimates did not include the acquisition-sensitive costs of technology. B&RM actually realized a net investment of \$20.9M for the first year. For FY 2015, B&RM made an investment of \$15.3M against a projection of \$42.6M in savings. Initial and updated projected savings for Budget and Resource Management are depicted in figure 28 below:

Figure 28



Update on Projected Net Savings: B&RM has updated its forecast from FY14-19 from \$284.3M to \$155.3M. While the projects for B&RM are not cost reduction strategies, the associated benefits in the form of additional revenue for the MHS were not realized in FY2014 and FY 2015. B&RM Shared Services adjusted their projected net savings from FY 2014-2019 for three primary reasons. First, the implementation costs for ABACUS (an automated system to support improved revenue cycle management) were acquisition sensitive at the time of the 3rd report to the Congressional committees and were not included in the cumulative net savings estimate of \$284.3M. Upon contract award, these costs were included in all projections. Second, there were several delays in the development process of ABACUS that extended the deployment schedule, thereby delaying the potential to garner savings in FY 15. Third, the delays also increased the costs associated with maintaining legacy systems. As a result, the revised B&RM projections were reduced to \$155.3M.

Detail on Projected B&RM Savings: Although portrayed as savings, the benefits from Budget and Resource Management are actually enhanced medical reimbursements and will result in additional “revenue” for the MHS as well as enhanced data transparency. The Budget and Resource Management projects are in the Accounting and Financial Integrity product line.

Going forward, the MHS will implement a common cost accounting structure that is anticipated to support identification of future savings by effectively and efficiently producing enterprise-wide resource comparisons. In addition, the MHS will implement a new medical billing and collection solution that will increase collections and reduce demands on manpower.

Implementation Costs: At this point, the delays in the deployment of the billing and collection solution will require additional investment costs in both the development of the solution as well as extending the lifecycle of legacy systems.

Part Three: Baseline Assessment of the Number of Military, Civilian, and Contractor Personnel Working in MHS Headquarters and Estimate at FOC

In June 2013 in the DHA's second Report to Congressional Defense Committees as required by Section 731 of the NDAA for FY 2013, the initial estimate provided for anticipated DHA civilian staffing at IOC was 1,081. This estimate was based on preliminary counts of "faces" and was categorized as either DHA (1,039) or NCR Directorate (42). Between June and October 2013, a more detailed analysis was performed on projected DHA staffing levels. In the third Report to Congressional Defense Committees, submitted in October 2013, we reported anticipated staffing of 1,941 at IOC, which included both civilian and military. These numbers included, for the first time, estimates for the Shared Services that would reside in the DHA.

To manage the increased manpower dynamics associated with the DHA and Service activity, the DHA Manpower & Organization (M&O) was established in July, 2014 as a Special Staff Office under the DHA Chief of Staff. The M&O Division plays a critical role in the DHA standup through standardized manpower management and programming activities. With the establishment of M&O, the DHA numbers being reported can be tracked back to the program of record from the Corporate Information System (CIS), Inventory of Contracts for Services (ICS), and Concept of Operation Documents.

The following are the military and civilian personnel requirements/spaces pre-DHA (September 2013) and for DHA this past spring (March 2015), excluding NCR.

- The DHA Initial Operating Capability (October 1, 2013) numbers updated to the program of record are 390 military and 899 civilians.
- The DHA Full Operational Capability (October 1, 2015), the numbers are 391 military; 1,492 civilians; and 2,571.5 contract full-time equivalents. The Services also track this information.

Part Four: Explanation of the Purpose and Goals of the Medical Education and Training Shared Service with regard to Improving Cost Efficiency

The Medical Education and Training shared service identified estimated cost savings from improvement opportunities in its Innovative Teaching and Learning product line, which includes eLearning and Modeling and Simulation. The shared service exceeded its initial savings goals related to eLearning and has developed a robust course of action to continue consolidation of the DHA and Services eLearning products. Medical Modeling and Simulation savings are not scheduled to be realized until fiscal year 2017. In the interim, the DHA commissioned a Joint Capabilities Integration and Development Systems (JCIDS) study to determine the overall direction of Medical Modeling and Simulation. The Shared Service is working through MHS governance to resolve issues related to responsibilities and authorities for Education and Training to facilitate identification of future opportunities that reduce/eliminate redundancies and those lines of effort that improve efficiencies across the MHS.

Appendix A: Report to Congressional Defense Committees Objectives and Corresponding MHS Performance Dashboard Measures

See enclosed Excel spreadsheet.

Appendix B: Key to Box and Whisker Graphs

