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

PERSONNEL AND READINESS

MAR 31 2017

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

Dear Mr. Chairman:

This is an interim response to section 702 of the National Defense Authorization Act for Fiscal Year 2017 (Public Law 114–328), concerning "Reform of Administration of the Defense Health Agency (DHA) and Military Medical Treatment Facilities." The Department is committed to working with Congress to improve the Military Health System (MHS).

Section 702 directs a major transformation of the MHS, including the transfer of certain authorities and control from the Military Departments to DHA. Substantial challenges are inherent in implementing major reform such as that required by this legislation, not the least of which is maintaining "a ready medical force and a medically ready force." As the attached report conveys, progress is well underway to implement the statutory requirements included in section 702 while continuing to work on how best to harmonize roles and responsibilities of the DHA and the Military Departments.

We will provide more detail on the Course of Action selected no later than June 30, 2017, and a final report on March 01, 2018. Thank you for your continued support of the MHS.

Sincerely,

A. M. Kurta
Performing the Duties of the 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

PERSONNEL AND READINESS

MAR 31 2017

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

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Sincerely,

A. M. Kurta
Performing the Duties of the Under Secretary of Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

Report to the Armed Services Committees of the Senate and House of Representatives

Plan to Implement Section 1073c of Title 10, United States Code

Interim Report – Preliminary Draft
31 March 2017

Required by: Section 702(e)(1) of the National Defense Authorization Act for Fiscal Year 2017, Public Law 114–328

The estimated cost of this report or study for the Department of Defense (DoD) is approximately $65,000. This includes $5,000 in expenses and $60,000 in DoD labor.

INTRODUCTION

This report is in response to section 702 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2017 (Public Law 114–328), which requires the Secretary of Defense to "submit to the congressional defense committees a report containing (A) a preliminary draft of the plan developed under subsection (d)(1); and (B) any recommendations for legislative actions the Secretary determines necessary to carry out the plan." The plan includes the following information as prescribed by statute:

"(A) How the Secretary will carry out subsection (a) of such section 1073c.
(B) Efforts to eliminate duplicative activities carried out by the elements of the Defense Health Agency and the military departments.
(C) Efforts to maximize efficiencies in the activities carried out by the Defense Health Agency.
(D) How the Secretary will implement such section 1073c in a manner that reduces the number of members of the Armed Forces, civilian employees who are full-time equivalent employees, and contractors relating to the headquarters activities of the military health system, as of the date of the enactment of this Act."

The Secretary fully supports Congress' intent to drive fundamental reform of healthcare within the Department of Defense (DoD). Recent progress toward a more integrated and efficient healthcare delivery system has positioned the Military Health System (MHS) for more dynamic transformation. Implementation of the NDAA provisions will accelerate MHS' progress towards developing an operating model that reduces total management costs, supports improved and efficient delivery of healthcare at military medical treatment facilities (MTFs) and enhances the Services' readiness capabilities.

Following a comprehensive evaluation of a number of courses of action (COAs), the Department decided that implementing a Component Model, under which the Defense Health Agency (DHA) Director administers each MTF through Service-led intermediary commands, best balances Section 702 requirements while managing risks to readiness. In the section below, the Department details the process used to develop COAs, describes the Component Model, and provides a thorough explanation for why the Secretary approved this COA.

The Department will submit a second Interim Report to Congress by June 30, 2017, to provide additional detail on how the DHA will administer the MTFs through the Component Model, including an assessment of the opportunity to maximize efficiencies and eliminate unnecessary duplicative activities under the new structure. The Department will submit the final report on time on March 1, 2018, with full detail on how the Department intends to implement the Component Model beginning October 1, 2018.

PRELIMINARY DRAFT IMPLEMENTATION PLAN

(A) How the Secretary will carry out subsection (a) of such section 1073c.

In December 2016, the Department convened a Work Group bringing together representatives from the Office of the Assistant Secretary of Defense for Health Affairs (ASD(HA)), the DHA, the Service Medical Components, and the Joint Staff to assess COAs for meeting the requirements of Section 702.

The expanded DHA functions in relation to the administration and management of the MHS will include the following responsibilities and accompanying authorities to ensure they are accomplished.

- DHA will be responsible for the administration of each MTF, including budgetary matters, information technology, health care administration and management, administrative policy and procedure, military medical construction, and other appropriate matters.
- DHA will be responsible for establishing priorities for health care administration and management; policies, procedures and direction for the provision of direct care at MTFs; priorities for budgeting; matters with respect to the provision of direct care at MTFs; policies procedures, and direction for clinic management and operations at MTFs; and priorities for information technology at and between MTFs.
- DHA will be responsible for policy, procedures, and direction of budgetary matters and financial management with respect to the provision of direct care across the MHS.
- DHA will be responsible for policy, procedures, and direction of health care administration in the MTFs.
- DHA will be responsible for policy, procedures, and direction of clinical quality and process improvement, patient safety, infection control, graduate medical education, clinical integration, utilization review, risk management, patient experience, and civilian physician recruiting.
- DHA Director shall coordinate with the Joint Staff Surgeon to ensure DHA will carry out responsibilities as a Combat Support Agency under 10 U.S.C. 193 in the most effective manner.
- DHA Director will be responsible for meeting the operational needs of the commanders of combatant commands as it relates to DHA's responsibility as a Combat Support Agency.
- DHA Director will be responsible for coordinating with the military departments to ensure staffing at MTFs supports readiness requirements for members of the armed forces and health care personnel.
- Each Surgeon General will serve as the chief medical advisor to the DHA Director on matters pertaining to military health readiness requirements and safety of members of his or her Service.

To further guide this assessment process, senior military medical leadership published the following seven operating principles to inform the process, consistent with the new law, while maintaining organizational focus and momentum:

1. Readiness is the primary mission. The Department will ensure a ready medical force and a medically ready force.
2. The Services are ultimately responsible for this readiness and will be supported by the DHA.
3. The DHA is responsible for the health benefit and is supported by the Services, which will use this as a means to enable and sustain readiness.
4. The Direct Care System (DCS) will be the first choice to meet the readiness requirements.
5. The DHA creates healthcare direction, policies and procedures for the DCS.
6. DHA is the single source budgeting authority for the DCS.
7. All Active Duty medical personnel are tied to operational force requirements.

Additionally, throughout the assessment process the Department invested significant time in determining how best to synchronize roles and responsibilities of the DHA and the Military Departments where the statute describes overlapping responsibilities. These include synchronizing the DHA's responsibilities as a Combat Support Agency and the responsibilities of the Surgeons General to recruit, organize, train, and equip members of the military service concerned. Another area for synchronizing responsibilities relates to MTF commanders, who have duties under a military chain of command, which runs up through a Military Service and Department, and under a chain of authority to the DHA, a Defense Agency under 10 U.S.C. 191.

After first identifying several potential COAs, the Work Group provided three COAs for consideration by the Combatant Commands and the Services. For each COA, the Work Group produced three artifacts: 1) a high-level organizational structure describing how the DHA Director administers each MTF, 2) a description of the MTF Commander's reporting relationships, and 3) a description of how uniformed, civilian, and contractor personnel are allocated and assigned to MTFs.

As a result of the subsequent staffing process, the Department identified two viable COAs; the Department also determined that additional information was required before a final COA selection could be made, and the Work Group reconvened to conduct a more thorough analysis.

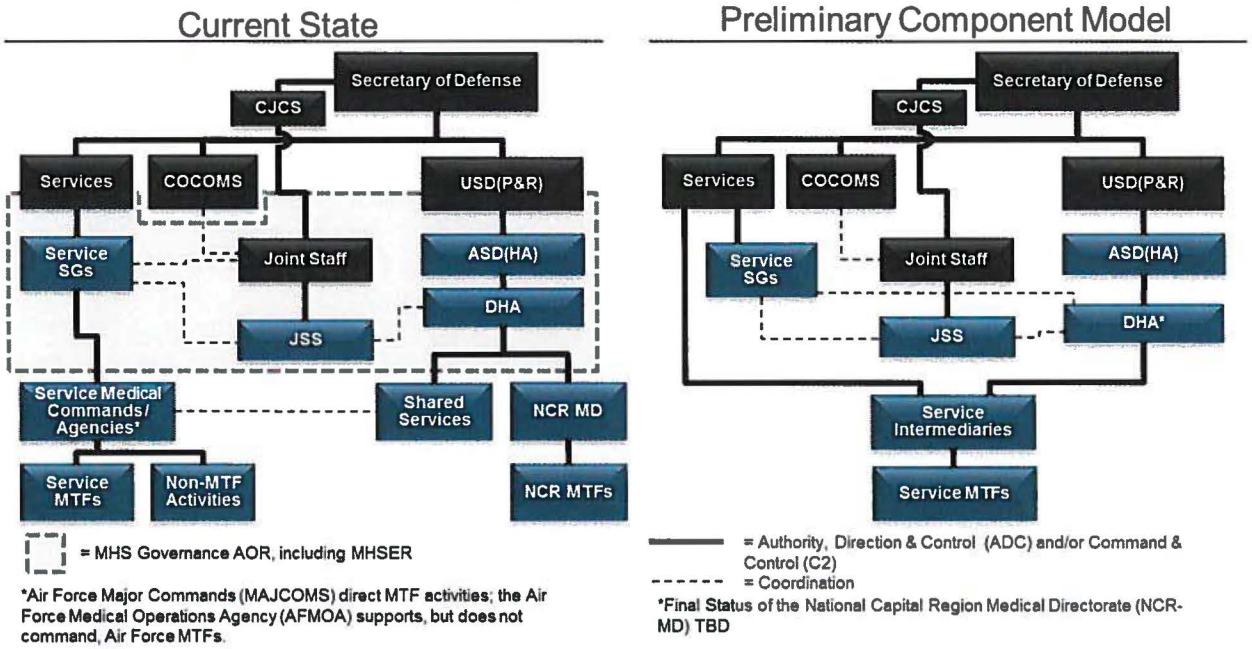
Joint Staff/Joint Operational Planning Process

The Department augmented the Work Group with Joint Staff planners to support a detailed evaluation of the models. A Joint Staff planner led the Work Group members through a modified, but formal, version of the Joint Operational Planning Process (JOPP) to further define and evaluate the COAs. In line with the JOPP, the Work Group defined the problem; established an end state; identified facts, assumptions, constraints, and limitations; defined functions and tasks relevant to the challenge; developed complete descriptions of the COAs, to include pros, cons, and risks; and validated and evaluated the COAs.

Component Model Description

Under the Component Model, the Director of the DHA shall be responsible for the administration of each MTF through Service-led intermediary commands and Service-led MTFs. The Service-led intermediary commands are accountable to the DHA for MTF functions that are under DHA's direction. The Services work with the DHA to establish MTFs that meet the requirements of the Combatant Commands and the Services, and the Services assign uniformed personnel to positions within Service-commanded intermediaries and MTFs in order to meet readiness and healthcare requirements. The Service Surgeons General retain responsibility for recruiting, organizing, training, and equipping Service medical personnel. The DHA is responsible for coordinating with the military departments to ensure that the staffing at the MTFs supports readiness requirements for members of the armed forces and health care personnel. The Services and DHA have accountability for ensuring personnel are trained to meet clinical readiness requirements.

Task Organization for the Administration and Management of MTFs



COA Evaluation and Findings

The Work Group arrived at two major findings following the evaluation of COAs: 1) the COAs are not distinguishable in regards to the management structure required to support the delivery of healthcare within the MTFs, and 2) The Component Model offers less risk in transition to the new paradigm, particularly as it relates to maintaining a ready medical force.

- **No distinguishable difference in the delivery of healthcare at the MTFs**. In all COAs evaluated by the Department, DHA retains complete responsibility for healthcare delivery at the MTFs and the Services retain responsibility for providing uniformed personnel to deliver healthcare at the MTFs. In all cases, under the direction of the DHA, unity of effort is achieved in MTF operations and significant opportunities are created to standardize clinical expertise and processes. Finally, in all cases, the Department eliminates the need to continue to operate the current MHS Governance structure, which is focused on mediating issues of

MTF administration and management; in place of Governance, roles and responsibilities are more clearly defined and the need for consensus-driven decision making is removed.

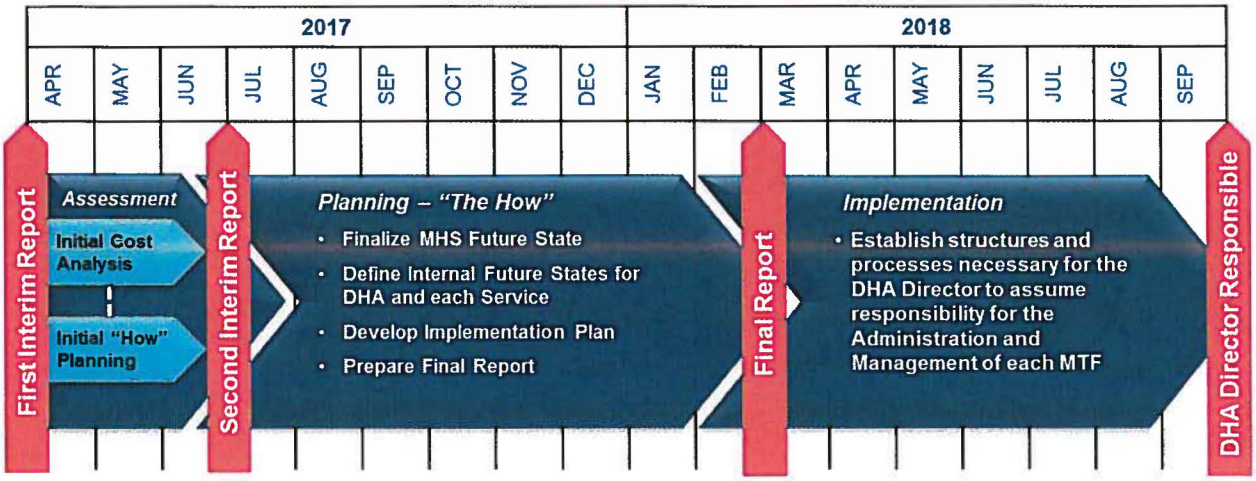
- **The Component Model maintains the Department's ability to provide a ready medical force.** The Work Group determined that, as opposed to the Component Model, all other COAs could result in a loss of synchronization between readiness and healthcare delivery at the headquarters and intermediary levels. While the Work Group assumes the Services and DHA would be able to implement policies and business processes to mitigate this risk under other COAs, the Work Group members recognize that policies cannot account for all scenarios and, as a result, an MTF Commanders could be put in a position where they would be required to balance demands from the Services and demands from the DHA. By placing responsibility with the MTF Commanders, the Department would introduce variability in how different MTFs manage readiness requirements. Conversely, under the Component Model, readiness and healthcare delivery synchronization can be managed through the Service intermediary commands, which would have greater flexibility in allocating resources to meet competing demands. Given the Department's ability to deliver healthcare within the MTFs is not impacted by differences between the COAs, and there are substantially fewer risks to readiness in the adoption of the Component Model, the Department has decided to move forward with planning efforts necessary to implement the Component Model by October 1, 2018.

The realignment to the Component Model will be published in a revision of DoD Directive 5136.13, "Defense Health Agency (DHA)," September 30, 2013. The current Directive established part of the DHA's mission to exercise management responsibility for shared services, functions, and activities of the MHS and its common business and clinical processes; and to exercise authority, direction, and control over the National Capital Region Medical Directorate and its MTFs, as directed by the ASD(HA). As directed by the NDAA, and as described in the Component Model, this set of responsibilities will be significantly changed.

The revised DoD directive will also recognize each Surgeon General will serve as an advisor to the Director of the DHA and, that under the authority, direction, and control of the Secretary of the Military Department concerned, will recruit, organize, train, and equip medical personnel of the military service. The revised directive will also confirm the commanders of MTFs will be accountable through the Service intermediary commands to the Director of the DHA for operations within the MTFs.

Follow-On Efforts

As stated in the Introduction, the Department will continue assessment and planning efforts over the coming months with the intent of delivering a second Interim Report to Congress by June 30, 2017. The Department will conduct a cost analysis to assess the opportunity to maximize efficiencies and eliminate unnecessary duplicative activities under the Component Model. In parallel, the Department will continue work to more fully define how the Component Model will operate. Subsequent to delivery of the second Interim Report, the Department will dedicate resources to plan implementation requirements. Following submission of the Final Report on March 1, 2018, the Department will execute the implementation plan with a goal of establishing the structures and processes necessary for the DHA Director to assume responsibility for the administration and management of each MTF on October 1, 2018.



The Department has established a Program Management Office (PMO) under the direction of the ASD(HA) to ensure the Department implements Title VII-A of NDAA-17 (and closely related sections) in a coordinated and reinforcing manner. The PMO will play a key role over the coming months in coordinating progress addressing Section 702 with progress addressing other NDAA section that impact or are impacted by Section 702 implementation.

(B) Efforts to eliminate duplicative activities carried out by the elements of the DHA and the military departments

The Department's initial cost analysis will include identification of unnecessary, potentially-duplicative activities that could be eliminated as the Department executes the plan to implement the new operating model. Each Service currently has its own clinical and business functions related to policy, policy analysis, compliance and management activities which dictate how the specific component delivers healthcare in its MTFs. These activities and associated resources are dedicated to prescribing policies such as clinical processes; patient safety programs; lab and pharmacy procedures; and budget, accounting, and procurement operations. The Department will highlight initial opportunities to streamline duplicative activities in the second Interim Report in June 2017, and provide further detail on the activities identified for elimination in the Section 1073c Final Report due on March 1, 2018.

(C) Efforts to maximize efficiencies in the activities carried out by the DHA

During the process of identifying unnecessary duplicative activities for elimination, standardizing policies and procedures, and reducing the role of MHS Governance in MTF administration and management, the DHA will capture efficiencies in three primary ways:

- **Realizing Economies of Scale:** As operational procedures are standardized, the DHA, in coordination with the Services, will seek to uncover opportunities to realize additional operational efficiencies.
- **Implementing Leading Practices:** The DHA, in coordination with the Services, will propagate business and clinical practices that result in the best health outcomes and consume resources most efficiently.

- **Improving Healthcare Delivery:** The DHA, in coordination with the Services, will achieve a better and more consistent experience of care by continuing work toward common clinical quality and process improvement priorities, improving patient safety by implementing standardized processes and procedures across all MTFs, and taking a streamlined approach to functions such as: clinical integration, utilization review, and risk management.

The MHS will identify specific efficiencies to be gained during implementation. The Department will highlight initial opportunities to gain efficiencies in the second Interim Report in June 2017, and provide further detail on those opportunities in the Section 1073c Final Report due on March 1, 2018.

(D) How the Secretary will implement such section 1073c in a manner that reduces the number of members of the Armed Forces, civilian employees who are full-time equivalent employees, and contractors relating to the headquarters activities of the military health system, as of the date of the enactment of this Act

The Department will reduce the total number of service members, civilian employees and contractors relating to headquarters activities as the MHS implements the NDAA Section 702 requirements. The Department expects to capture reductions in the total personnel through the elimination of unnecessary duplication and the capture of efficiencies described in Sections (B) and (C). The most significant opportunity for a reduction in headquarters-related activities will occur as a result of the transition of MTF administration and management responsibilities from the Service Medical Departments to the DHA and a subsequent rationalization of staff remaining in each Component.

The MHS will identify potential reductions in headquarters-related personnel resulting from implementation. The Department will highlight initial opportunities to reduce headquarters-level personnel in the second Interim Report in June 2017, and provide further detail on the reductions in the Section 1073c Final Report due on March 1, 2018.

RECOMMENDATIONS FOR LEGISLATIVE ACTIONS

The Department is taking a deliberate and collaborative approach to all of the Title VII NDAA requirements, including the establishment of a PMO under the direction of the ASD(HA). At this time, the Department is not proposing any legislative recommendations concerning Section 702, but will continue to consider this over the course of the coming year as plans are finalized.

CONCLUSION

The Secretary fully supports MHS reform and has directed the Department to take determined action to see that it is implemented effectively and efficiently. He is also committed to full visibility with members of Congress and will continue to communicate with appropriate committees on the Department's progress on this most important initiative.