



DEPUTY SECRETARY OF DEFENSE  
1010 DEFENSE PENTAGON  
WASHINGTON, DC 20301-1010

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

JUN 30 2017

Dear Mr. Chairman:

This is the second 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.

Section 702 directs a major transformation of the Military Health System, including the transfer of certain authorities and control from the Military Departments to the Defense Health Agency. 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 enclosed 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 Defense Health Agency and the Military Departments.

A final report is due in March 2018. Thank you for your continued support of the Military Health System.

A handwritten signature in black ink, appearing to read "R. M. ...", written over a light blue horizontal line.

Enclosure:  
As stated

cc:  
The Honorable Jack Reed  
Ranking Member





DEPUTY SECRETARY OF DEFENSE  
1010 DEFENSE PENTAGON  
WASHINGTON, DC 20301-1010

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

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Enclosure:  
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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

Second Interim Report  
30 June 2017

**In Response To:** 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 is the second Interim Report 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.”

On March 31, 2017, the Department communicated its intent to implement a Component Model, under which the Director, Defense Health Agency (DHA) Director administers each military treatment facility (MTF) through Service-led Components, to meet section 702 requirements while mitigating risks to readiness, which remains the top priority.

The Secretary is confident the Component Model provides the opportunity for the Department to provide DHA the ability to meet its responsibilities to execute its mission of administration and management over the MTFs while providing the Surgeons General the ability to meet their responsibilities to recruit, organize, train, and equip the medical personnel of each Military Department. The Secretary views the implementation of the Component Model by October 1, 2018, as a major step in reforming the Military Health System (MHS) to more efficiently support the Department’s readiness and healthcare delivery missions and expects Department efforts will continue beyond that date.

In this report, the Department provides a more detailed description of how the Component Model will operate, including a review of DHA and Military Department responsibilities and how the Department will meet readiness and healthcare delivery requirements. Additionally, this report includes a detailed description of the process the Department will use to plan the transition to the Component Model. This report does not address requirements included in NDAA for FY 2017 sections beyond section 702; the Department understands other NDAA for FY 2017 sections will impact section 702 implementation and will address necessary integration through the Program Management Office (PMO) established by the Assistant Secretary of Defense for Health Affairs (ASD(HA)). The Department will deliver the Final Report to Congress on March 1, 2018, which

will describe how the Department will implement the transformation of the MHS to meet the statutory requirements of section 1073c and ensure the Director, DHA has the ability to administer each MTF by October 1, 2018.

## **PRELIMINARY DRAFT IMPLEMENTATION PLAN**

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

In the Preliminary Draft Interim Report delivered on March 31, 2017, the Department confirmed the Secretary's decision to implement a Component Model to address the requirements of section 1073c. The Secretary directed a work group with representatives from the Military Departments, the Office of the ASD(HA), the Joint Staff, Office of the Deputy Chief Management Officer (DCMO), and the DHA to continue the development of the Component Model to comply with all specifications of the statute and achieve the Congressional intent. That intent is clearly articulated in the Congressional Conference Committee report accompanying the final version of NDAA for FY 2017:

“After careful study and deliberation, the conferees conclude that a single agency responsible for the administration of all MTFs would best improve and sustain operational medical force readiness and the medical readiness of the Armed Forces, improve beneficiaries' access to care and the experience of care, improve health outcomes, and lower the total management cost of the military health system.”

As with the preliminary draft, the following seven operating principles informed progress:

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 will be the first choice to meet the readiness requirements.
5. The DHA creates healthcare direction, policies and procedures for the Direct Care System.
6. The DHA is the single source budgeting authority for the Direct Care System.
7. All Active Duty medical personnel are tied to operational force requirements.

### **Concept of Operations**

Under the Component Model, the DHA will serve as the headquarters bringing the direct and purchased care into a single integrated healthcare system, and the Director, DHA shall be responsible for the administration of each MTF through Service-led Intermediary Component Commands (herein after referred to as Component Commands) and Service-led MTFs (herein after referred to as MTFs), including with respect to (A) budgetary matters; (B) information technology; (C) health care administration and management; (D) administrative policy and procedure; (E) military medical construction; (F) other MTF operations as provided in 10 U.S.C., section 1073c; and (G) any other matters the Secretary of Defense determines appropriate. This

report will not address all DHA responsibilities; it only addresses responsibilities related to section 702.

As reported in the March 31, 2017, Interim Report, the expanded DHA functions in relation to the administration and management of the MHS will, consistent with the detailed statutory specifications, include the following responsibilities and accompanying authorities to ensure they are accomplished.

- The 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.
- Each MTF commander will be responsible for ensuring the readiness of the members of the armed forces and civilian employees of the MTF and for furnishing the health care and medical treatment provided at the MTF. The DHA will provide policy, oversight, and direction to carry out these MTF commander responsibilities.
- The DHA (acting through the Assistant Director for Health Care Administration) 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.
- The DHA (acting through the Deputy Assistant Director for Information Operations) will be responsible for policy, management, and execution of information technology operations at and between MTFs.
- The DHA (acting through the Deputy Assistant Director for Financial Operations) 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.
- The DHA (acting through the Deputy Assistant Director for Health Care Operations) will be responsible for policy, procedures, and direction of health care administration in the MTFs.
- The DHA (acting through the Deputy Assistant Director for Medical Affairs) 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.
- The DHA Director shall coordinate with the Joint Staff Surgeon (JSS) to ensure DHA will carry out responsibilities as a Combat Support Agency (CSA) under 10 U.S.C. 193 in the most effective manner.
- The DHA Director and the Military Departments will be responsible for meeting the operational needs of the commanders of combatant commands.
- The 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.



Additionally, the responsibilities of the Surgeons General include the following:

- Each Surgeon General will serve as the chief medical advisor to the Director, DHA on matters pertaining to military health readiness requirements and safety of members of his or her Service.
- Each Surgeon General will serve as the principal advisor to the Secretary of the Military Department concerned of all health and medical matters of the armed service(s) under the authority of that Secretary, including strategic planning and policy development relating to such matters.
- Each Surgeon General will recruit, organize, train, and equip medical personnel of the military service concerned.

The Secretary anticipates the rationalization and consolidation of responsibilities from the Service Medical Departments to the DHA, as it relates to administration of the MTFs, will result in opportunities to achieve additional reductions in programmed management headquarters activities and has set a goal of achieving a 25 percent reduction in programmed management headquarters activities (Program Element Code 0807798). The MHS currently operates the MTFs through multiple agency and command structures, including Service Medical Departments, multiple Regional Commands (Army and Navy), the Air Force Medical Operations Agency, five enhanced Multi-Service Markets (eMSMs), and the National Capital Region Medical Directorate. As the Department rationalizes and consolidates MTF administration and management, the Department will work to streamline and eliminate unwarranted duplicative activities carried out within these management structures.

Under the Component Model, the Military Departments and DHA will be mutually supportive of both readiness and healthcare delivery missions and both the Services and DHA will have significant roles in ensuring readiness remains the number one priority and the MTFs are prepared to accomplish both missions. The DHA will take full responsibility for the health care operations at each MTF, and the DHA together with the Military Departments will establish three Component Commands – one aligned to each Military Department to serve as the integration point for healthcare delivery and military personnel readiness missions at each MTF. Each of these has two roles – one as a Component of the DHA responsible to the DHA Director for MTF health care operations and the other as a military command under the command and control of the chain of command under the Secretary of the Military Department concerned. While the term “Component Command” is used throughout this implementation plan, the term is used in reference to its dual roles and is not intended to imply a specific organizational construct. The military command relationship with each MTF will be determined by the Military Department concerned. Under the Department’s concept of operations, the leader of each Component Command will be “dual-hatted,” serving under the authority, direction and control of the Director of the DHA for MTF health care operations and also reporting through the Military Department chain of command as the Commander of a Service command. The DHA and the Military Departments will have the

***Integrated Readiness & Healthcare Delivery***

In the future, the Department will empower the Director of the DHA to manage and administer the MTFs across the enterprise while maintaining the Military Department’s ability to ensure readiness through the dual-hatting of Component Commands.

responsibility for implementing appropriate DHA headquarters management and military command structures to perform this integration function within each Component Command's unique mission and capabilities. The Services will rely on funding approved by the DHA to operate the Component Commands. The Component Commands will be accountable to the DHA and to the Military Departments and have responsibility for healthcare operations at each MTF and for readiness of the uniformed and civilian personnel within each MTF. As a matter of authorities, section 1073c provides some overlapping responsibilities for readiness-related functions for both DHA and the Military Departments. As a concept of operations, the DHA has responsibility for budgetary matters in the administration of the MTFs as it related to the Defense Health Program (DHP), and the Military Departments have the lead role for readiness and resource management of Military Department appropriations with respect to the administration of MTFs, including military personnel appropriations.

### ***Major Functions***

The Department has identified the major functions required to operate the MTFs and support readiness requirements. For each function, the Department's concept of operations has designated primary responsibility to either the DHA or the Military Departments.

The Director, DHA will have primary responsibility for:

1. Healthcare Administration and Management
2. Healthcare Delivery
3. Administrative Policies and Procedures
4. Budgetary Matters
5. Military Medical Construction
6. Information Technology
7. Resource management of the DHP appropriation for the MTFs as allocated by the DHP appropriation manager

The Military Departments will have primary responsibility for:

1. Identification of Operational Requirements
2. Recruit, Organize, Train and Equip Medical Personnel
3. Provide Ready Medical Forces
4. Enable Medically Ready Forces
5. Military Department Directed Activities

Military Department-directed installation and command support functions separate from direct healthcare activities are traditionally performed under the direction of the medical departments of each Service. Examples of such activities may include, but are not limited to:

- Occupational Health
- Environmental Health
- Substance Abuse Programs
- Food Protection
- Family Advocacy
- Aerospace Physiology



- Aerospace Medicine
- Bioenvironmental Engineering
- Nuclear Power and other Personnel Reliability Programs
- Animal Medicine

Many such activities are performed by more than a single Service; in those situations, given the unique missions of the Medical Departments, the management and delivery of these activities vary widely. The processes required to fund, manage, and execute Military Department-directed activities will be provided in the Final Report on March 1, 2018. The Department anticipates creating business rules under which the DHA and the Military Departments establish policies and procedures for these activities when the DHA funds the activities via the DHP. The Military Departments and DHA will work iteratively to agree on programmatic funding of the identified activities which have significant budgetary impact; the Component Commanders will have flexibility to respond to changing requirements during execution, within DHA controls.

***How the DHA will manage and administer MTFs***

The DHA will direct enterprise-wide programs that support the efficient, innovative, collaborative, and standardized delivery of healthcare at the MTFs in order to support readiness requirements, improve healthcare safety, quality, and access, and to more efficiently manage the resources committed to healthcare delivery. The DHA and the Component Commands will execute two major administration and management lines of effort (LOEs) related to the delivery of healthcare at MTFs: 1) Build healthcare delivery capability; and 2) Manage MTFs within geographic markets.<sup>1</sup>

**LOE #1: Build Healthcare Delivery Capability**

The DHA will assume responsibility for managing and administering an established, global MTF network. To ensure the MHS continues to effectively and efficiently meet both readiness and healthcare delivery requirements, the DHA will collaborate with the Military Departments to continually review healthcare delivery requirements and capabilities at the MTFs.

The Military Departments and the Combatant Commands (CCMDs) are responsible for determining readiness requirements for Service Members (Medically Ready Force) and for operational medicine functions (Ready Medical

**Standardized MTF Workforce Process**  
 While responding to Military Department-specific readiness requirements and local market conditions, the DHA will plan, program and prescribe standardized MTF workforce strategies which reduce performance variation across the MHS.

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<sup>1</sup> The term “markets” within this report is used as a generic term for the geographic area in which each MTF operates.

Force).<sup>2</sup> The Military Departments will communicate those requirements to the Service Surgeons General, who retain responsibility for recruiting, organizing, training, and equipping Service medical personnel. The Surgeons General will advise the Director, DHA on how they intend to organize and will work with the DHA to best position their medical personnel and determine which healthcare services are needed to support the Military Departments' readiness requirements.

The DHA is responsible for building MTF capabilities that optimally support the operational and readiness requirements of the CCMDs and the Military Departments. In addition to the requirements established by the CCMDs, the Military Departments and their Surgeons General, the DHA will assess the ability of the private sector to support healthcare requirements to determine the type and volume of geographic delivery services each MTF must deliver.<sup>3</sup> The DHA will also consider the capabilities provided by existing or planned military-civilian partnerships within specific markets.<sup>4</sup> In those healthcare markets served by MTFs aligned to more than one Component Command, the DHA will eliminate unwarranted duplication and increase efficiency across the market without adversely impacting readiness levels.

The Military Departments and DHA, working through the Component Commands, are responsible for the placement of Service personnel at the MTFs in accordance with Service generated readiness requirements and the capabilities established by the DHA. Per section 1073c requirements, the Director, DHA will be responsible for coordinating with the Military Departments to ensure staffing at the MTFs supports readiness requirements. The Military Departments will be responsible for balancing personnel assignments between the direct care system and other military assignments, and Surgeons General are responsible for ensuring personnel are trained to meet clinical and operational readiness requirements. The DHA will collaborate with the Military Departments to determine the manpower mix of civilian and contractor personnel necessary to fill staffing requirements beyond those filled with uniformed personnel.

The DHA will have responsibility for establishing supporting capabilities at each MTF in line with its assigned functions of healthcare administration, budgetary matters, military medical

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<sup>2</sup> NDAA for FY 2017, section 721, "Authority to Convert Military Medical and Dental Positions to Civilian Medical and Dental Positions," will impact how the Military Departments make these determinations. The Department is working to comply with this requirement in parallel with efforts to meet the requirements of Section 702.

<sup>3</sup> NDAA for FY 2017, section 703, "Military Medical Treatment Facilities," requires the "Secretary of Defense, in consultation with the Secretaries of the Military Departments, [to] maintain [MTFs] describe in subsections (b), (c), and (d)." The Department is working to meet the requirements of section 703 in parallel with the Department's efforts to comply with section 702. Throughout implementation of section 702 requirements, the Department will ensure all responsibilities, functions, and processes detailed in this report are harmonized with the Department's implementation of section 703.

<sup>4</sup> NDAA for FY 2017, section 706, "Establishment of High Performance Military-Civilian Integrated Health Delivery Systems," provides guidance to establish partnerships through memoranda of understanding or contracts by January 1, 2018. The Department is working to meet the requirements of section 706 in parallel with the requirements of section 702.

construction, information technology, and other MTF operations for which the DHA has responsibility. The DHA resource management processes under the Component Model are described in more depth in a later section of this report. The DHA will also have responsibility to resource designated Military Department directed activities within the MTF.

**Unified MTF Administration & Management**

Under the component model, the DHA will have authority, direction and control over each MTF. For the first time, a single leader within the Department will have the authority to manage healthcare delivery at the enterprise level.

The Department will consolidate and rationalize common clinical and business functions into a single, jointly-staffed DHA headquarters under an approved Joint Manning Document (JMD). The JMD will ensure the DHA is staffed by senior leaders who understand and are invested in meeting the unique requirements of the Military Departments and the MHS. The DHA will establish standard policies, procedures, and reporting requirements for the management of direct care at MTFs. The Department expects that the DHA will establish enterprise-wide policies and procedures

incrementally; each MTF will continue to operate under policies and procedures established by its current Military Department until superseded by DHA issuances. The DHA will rationalize established Department practices and policies among the three Services and provide MTFs common direction. The DHA Issuances will serve as the official policy and procedure under which the MTFs will operate under the Component Commands.

The DHA will direct enterprise-wide programs that support the efficient, innovative, and standardized delivery of healthcare at the MTFs, including initiatives related to the MHS' ongoing journey to high reliability, the implementation of telehealth services, and the implementation of a Joint Trauma System (JTS).<sup>5</sup>

The DHA will establish a system of metrics and measurements to evaluate healthcare delivery efficiency and performance. The MHS has already established an enterprise-wide measurement program – Partnership For Improvement (P4I) – and the Department expects the DHA to build on the foundation laid by P4I. The DHA will use information reported through this system to evaluate MTF performance. The DHA will work through the Component Commands to identify the root cause of performance issues and direct, through the Component Commands, corrective actions as appropriate. The Department describes the relationship between the DHA and Component Commands in more depth below.

**Reduced Unwarranted Duplication**

In the future, the Department will use a single set of metrics to evaluate the performance of the direct care system. Currently, each Military Department collects Military Department-specific performance metrics in addition to those rolled into P4I.

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<sup>5</sup> NDAA for FY 2017, section 707, “Joint Trauma System,” directs the Department to establish a JTS within the DHA. The Department is addressing requirements under section 702 in parallel with requirements for section 707, and will ensure implementation plans for both requirements are mutually reinforcing.

Through the DHA's Health Information Technology (HIT) Enterprise Support Activity (ESA), the DHA will continue to standardize and rationalize the IT environment across the Direct Care System. The DHA will leverage the ongoing deployment of MHS GENESIS (the new electronic health record (EHR)) to drive clinical and business process standardization across the MTFs. The DHA, working with the Services, will develop and implement enterprise standards for EHR workflows, content, and system configuration to support the transition to MHS GENESIS. The DHA will coordinate all HIT ESA Defense Business Systems with the Office of the DCMO to obtain approval of all covered Defense Business Systems within the Defense Health Portfolio including MHS Genesis. This process will standardize the healthcare experience for both patient and provider and lead to an overall reduction in variation across the system.

### **LOE #2: Manage MTFs within geographic markets**

The Department will continue to leverage evidence-based management techniques to support readiness requirements, improve healthcare safety, quality, and access, and to more efficiently manage the resources committed to healthcare delivery. The Director, DHA will have the authority to establish market teams within the DHA headquarters, responsible for assessing market conditions and executing actions to improve performance. The Component Model will build on the successes of the eMSMs while addressing challenges. The DHA may direct actions which include adjusting healthcare services offered by specific MTFs (with attendant resource implications), implementing partnerships with other health systems, and the establishment of new programs or initiatives. The Department's plan for implementing MHS-wide management functions to optimize the system will include:

- Manage and allocate the budget;
- Establish standards for clinical and business functions;
- Optimize readiness to deploy medically ready forces and ready medical forces;
- Plan and program for the optimization of the workload at all MTFs;
- Integrate the movement of workload and workforce between or among MTFs in the respective market area, in coordination with Components;
- Maximally integrate the direct and purchased care systems;
- Delivery of patient-centered care;
- Establish military-civilian integrated delivery systems through partnerships with local, regional health systems; and
- Incorporate leading practices into the daily operations of MTFs to eliminate variability in health outcomes and to improve the quality of health services.

As the DHA has a coordination role in balancing capacity and readiness, the DHA will work through the Component Commands to ensure resources necessary for each MTF to achieve its assigned readiness mission. If operational readiness optimization requirements conflict with MTF optimization opportunities, the DHA and the Components will prioritize readiness optimization as risks are weighed across the mission in DHP resource allocation.

## **Governance and Reporting Relationships**

The Department recognizes the inherent challenge of balancing the consistent delivery of healthcare within the MTFs and the ability to maintain and operationalize both a ready medical force and medically ready force. Under the Component Model, Component Commanders serve as the integration point to address competing demands of readiness, healthcare delivery, and cost savings.

As such, the Secretary has determined that the Component Commander should be dual-hatted, reporting to their respective Service and to the Director, DHA. The Commander will work under the authority, direction, and control of the Director, DHA for matters related to the effective and efficient operation of the MTFs. The Director, DHA will provide formal input to the Military Department on the Component Commander's performance. In parallel, the Component Commander will report to Service leadership on all command and control matters related to maintaining readiness. It is the Department's concept of operations and expectation that the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) (or designee) and the Military Department Secretary (or designee) will evaluate the performance of the component head against established duties, responsibilities and performance standards at least annually. The MHS plan for selecting Component Commanders will be consistent with existing authorities for Service Chiefs to manage their General/Flag Officers filling Service billets. The Services will consult formally with the USD (P&R) (or designee). To maintain consistency with the statutory responsibilities of the Director, DHA and the chain-of-command responsibilities of the Military Departments, the Component Model maintains the authority of both the Director, DHA and the Service concerned to control their respective "hat." Using a well-established model within the Department, if "hat" changes are required, this control will be executed with discussions between the DHA and the respective Military Department as needed. Any unresolved issues will be elevated through governance.

All MTFs will function under the command and control of their chain of command and under the management control of the DHA, both through the Component Commands. The DHA will have authority, direction, and control for the delivery of MTF healthcare operations and all other functions assigned to the Director, DHA as listed in the Concept of Operations above.

The Department will establish governance committees to provide advice and assistance to decision makers to adjudicate issues that cannot be resolved through established relationships within the DHA and Component Commands. A primary level of governance will bring together the Director, DHA, the Military Department Surgeons General and the Joint Staff Surgeon. Within this body, the Military Department Surgeons General will fulfill their mandated role to serve as chief medical advisors to the Director of the DHA, and the Director of the DHA will have decision-making authority on MTF healthcare operations. The higher level governance committee will bring together senior representatives from the Military Departments and the Office of the Secretary of Defense to review enterprise-level performance and provide advice and assistance to adjudicate select issues which cannot be resolved at a lower level. An annual evaluation of performance of the DHA and the Services support of the DHA will be conducted. The Director, DHA is under the authority, direction, and control of the ASD(HA). The ASD(HA) is under the authority, direction, and control of the USD(P&R). The USD(P&R) is under the authority, direction, and control of the Secretary and Deputy Secretary of Defense.

MTF Commanders will work primarily through the Component Commands to DHA leadership. Service MTF and Component Commanders will consult, as appropriate, with DHA and Service stakeholders (e.g., Service line units, installation commanders, and other strategic partners). The Director, DHA has the authority over healthcare operations within the MTFs and the understanding that military readiness is the overall priority. Should the Director, DHA determine additional consultation is necessary or should the Surgeons General or other relevant commanders within the Military Departments have concerns with decisions made by the Director of the DHA, issues may be elevated through the Governance structure for adjudication.

### **Request for Forces (RFF) Processes**

The Secretary is confident the Component Model addresses the readiness requirements of the CCMDs and the Military Departments. The Component Model concept of operations minimizes risk by assigning the Military Departments primary responsibility for military personnel readiness and the DHA responsibility for supporting the Military Departments and combatant commanders' readiness requirements. The Department has identified a process for how the RFF process will work under two separate scenarios:

**Global Force Management (GFM) Process:** Working with guidance from the GFM Board, CCMDs submit RFFs to the Joint Staff. The Joint Staff, in coordination with the Joint Force Provider, validates the request, determines a sourcing solution and issues orders through Military Department channels to the MTF.

The MTF Commander will evaluate the MTF's ability to support the requirement and its impact on healthcare delivery. If the MTF can mitigate the healthcare delivery impact internally, the MTF provides the required capabilities and no further action is required. If the MTF Commander determines the impact on healthcare delivery cannot be mitigated at the local level, the MTF Commander will engage the Component Command which will plan and execute mitigation plans which could include the shifting of resources within or between the Component MTFs. If the Component Commander is unable to address the requirement, the issue will be elevated to the Director, DHA. The DHA will evaluate additional options, including contracting for additional support within the MTF, arranging for cross-component support, or leveraging private sector support through the Managed Care Support Contracts.

**Other Mission Requirements:** Beyond CCMD driven requirements, the MTFs must respond to requests for support from the Military Departments and Installations. For routine or predictable requirements, such as training exercises or other deployments, the Component Command will mitigate healthcare delivery operations impacts through annual forecasts and updates as appropriate to support MTF planning efforts. Short notice and installation requests will be routed directly to MTF Commanders for action. Each MTF Commander will determine how best to support the requirements, and, as with the GFM process, the MTF Commander will elevate requests to the Component Commander and the DHA leadership when responding to the request will have impacts on healthcare delivery beyond the MTF Commander's ability to mitigate with organic resources.

### **Resource Management and Execution Processes**

The consolidation and rationalization of resources and oversight for MTF healthcare operations

will improve operational cohesion and financial coherence through:

- Standardization of processes and achievement of economies of scale;
- Improved financial transparency;
- Added fidelity to methodologies used for workload accounting;
- Reduced unwarranted duplication in day-to-day healthcare operations;
- Increased purchasing power while decreasing operating costs;
- Optimized revenue cycle management; and
- Maximized commonality, reuse, interoperability, efficiencies, and effectiveness of healthcare resources.

ASD(HA), as the DHP appropriation manager, will allocate funding for both the direct and purchased care systems to the DHA. The DHA, in turn, will allocate budgets for each MTF through the Component Commands using Funding Allocation Documents. The MTFs will execute funding in support of the healthcare delivery mission as directed by DHA.

In the event there is a healthcare delivery resourcing issue at an MTF which the MTF Commander cannot resolve locally, the MTF Commander will elevate the issue to the respective Component Commander who, with the Director, DHA, will determine the appropriate resourcing solution. The Director, DHA will have the flexibility to move healthcare delivery funding between Component Commands or to direct a Component Commander to shift funding between MTFs to solve such challenges. Examples of potential resourcing issues include:

- Issues which could be addressed within a Component Command: Balancing funding to address differences between budgeted and actual expenses. For example, the Army Component Commander could redirect utility funding from the Weed Army Community Hospital at Ft Irwin to Madigan Army Medical Center (MAMC) when Weed's heating and cooling costs are below budgeted levels while the reverse is true at MAMC.
- Issues which would need elevation to the DHA: Responding to operational requirements that significantly impact healthcare delivery operations and require additional funding to which the Component Commander does not control. For example, if the USNS Mercy is deployed on short-notice, Naval Medical Center San Diego could face a significant shortage in uniformed providers and support staff – requiring a significant increase in contractor staffing to meet healthcare delivery demands. In this situation, the DHA might need to shift resources from across the entire Direct Care System to meet the new requirement.

As allocated by the ASD(HA), the DHA and the Military Departments will maintain oversight and control of those DHP financial resources supporting both Service medical readiness requirements and the organizing, training, and equipping of military medical personnel.

### **CSA Responsibilities**

As mandated in NDAA for FY2017 section 702, the JSS will be a principal coordinator for the Military Departments with the DHA in its role as a CSA. To support Chairman of the Joint



Chiefs of Staff (CJCS) responsibilities, the JSS will facilitate integration between the Joint Staff, Service Surgeons General, and the ASD(HA) to guide the DHA's CSA responsibilities in support of the Military Departments and CCMDs. This will be accomplished through periodic meetings between the principals as well as subordinate functional work groups. This also will include liaison and routine staff coordination by the DHA with the Office of the JSS. The biennial CSA Review Team will evaluate DHA progress toward readiness-prioritized resource management in accordance with the Joint Strategy Review and the CJCS Risk Assessment.

### **Plan of Action and Milestones (POA&M) to develop Final Plan by March 1, 2018**

Under the direction of the ASD(HA), senior leaders from the DHA and the Military Departments are working together to develop a detailed plan for implementing the structures and processes described above. The ASD(HA) has engaged the DCMO to provide subject matter experts to guide this planning process, and, together, the planning team is working from a DCMO-provided organizational transformation methodology. The DCMO built the methodology on leading process improvement principles, and, at its foundation, are Lines of Business around which the team will define capabilities, processes and resources.

The ASD(HA) has chartered the Section 702 Implementation Planning Team, and the Planning Team has built a POA&M designed to provide overarching milestones, key components, and a means to address implementation risks as the Department works to provide Congress a Final Report on March 1, 2018. The table highlights critical milestones leading up to the delivery of the Final Report.

### **Phase I: 1 June – 30 September: Define and Measure Future State Lines of Business (LOBs) for the DHA:**

- Within the DHA, define, organize and prioritize Future State LOBs and related functions prescribed by NDAA for 2017 section 702.
- Define capabilities and establish measures associated with LOBs.
- Define future state supporting processes based on the functions prescribed by NDAA for FY 2017 section 702.
- Measure current state resources based on scoped LOBs, capabilities, and processes.

### **Phase II: 1 October – 31 December: Analyze Lines of Business within the Current State**

- Analyze current state resources at the DHA and Military Departments for transition to future state LOBs.
- Recommend current state resources for transition to future state LOBs.
- In comparing Future State requirements to Current State resources, identify and document eliminated duplicative activities, efficiency maximization at the DHA, and reduced HQ staffing across MHS headquarters.

### **Phase III: 1 January – 28 February: Design Organization Structure and Develop Implementation Plan**

- Design future state organizational structure aligned to LOBs.
- Determine Doctrine, Organization, Training, Materiel, Leadership and Education, Personnel, Facilities and Policy actions.
- Identify and define risks to implementation.

### **Future Phases: Organizational Transformation at the Component Command Level and below**

- Build Component Command functions that support the DHA.
- Build MTF functions that support the DHA.

### **Summary of Risks and Plans for Mitigation**

The Department has identified mitigation strategies for three major risks:

- 1) Beyond section 702, the Department is addressing a significant number of additional requirements included in title VII of the NDAA for FY 2017, including a number of requirements with direct bearing on administering and managing the MTFs. In light of the suspense dates established by Congress, there is a risk that plans for implementing the requirements of separate sections will be in conflict. To mitigate this risk, the ASD(HA) has established a PMO to guide collaboration across the teams charged with implementing the various title VII requirements.
- 2) More than nine million beneficiaries rely on the healthcare services provided by the MHS, and the Department cannot afford reductions or gaps in service during the required transition of responsibilities to the DHA. The DHA and the Military Departments are working collaboratively to build and implement a deliberate process developed to mitigate any risk to healthcare delivery services.
- 3) The MHS will continue to prioritize providing a ready medical force and a medically ready force to the CCMDs and the Military Departments. The DHA and the Military Departments will continually evaluate readiness levels and capabilities throughout the transition process to ensure the Military Medical Departments can continue to meet their operational requirements.

### **(B) Efforts to eliminate duplicative activities carried out by the elements of the Defense Health Agency and the Military Departments**

Each Military Department currently has its own clinical and business functions related to policy, policy analysis, compliance and management activities which dictate how the specific Component Command 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. As detailed in the Concept of Operations above, the Department anticipates many of these responsibilities will shift

to the DHA in the future. This process should result in a significant reduction in unwarranted duplicative activities dedicated to administering and managing the MTFs.

As the POA&M indicates, the Department will commit significant resources to planning these transitions in responsibility, and the associated transition of resources, over the coming months. The Department will 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 Defense Health Agency**

As the Department reduces unwarranted duplicative activities and centralizes responsibilities within the DHA, efficiencies will be captured through two primary means:

- **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.

As the Final Report is prepared per the process described in the POA&M above, the Department expects to identify economies of scale and leading practice efficiencies in each of the areas of responsibility delineated in NDAA for FY 2017 section 702:

- **Budgetary Matters:** As listed above, the centralization of budgetary authority for MTF healthcare operations will lead to improved financial transparency, increased fidelity for workload accounting, increased purchasing power, improved accounting for revenue cycle management, and greater standardization in programming, planning, budgeting and execution. Each of these improvements will increase efficiency as variances in the system will become easier to identify and the DHA can direct corrective measures across the Direct Care System.
- **Information Technology:** As part of the initial stand-up of the DHA and other related Governance reforms, the Department created the HIT ESA within DHA in 2013. The Department expects the DHA to further rationalize and standardize HIT functions related to the delivery of healthcare as planning for and executing NDAA for FY 2017 section 702 requirements continue. The rationalization and standardization process should continue to produce efficiencies in the provision of technology support across the MTFs.
- **Healthcare Operations:** 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.

- **Administrative Policy and Procedure:** As with Budgetary Matters and Health Care Administration and Management, the Department expects the DHA to identify best in class processes to guide the execution of administrative policy within MTFs.
  - **Military Medical Construction:** The Department established the Facilities Planning ESA in parallel with the creation of the HIT ESA in 2013, and the current DHA Facilities Division already plays a leading role in planning and executing Military Medical Construction requirements. Going forward, the Department will continue to capture additional efficiencies from planning and executing an enterprise-wide approach to building, improving and maintaining the Direct Care System's physical infrastructure.
- (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 for FY 2017 section 702 requirements. The Department expects to capture reductions in the total personnel through the elimination of unwarranted 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 healthcare operations responsibilities from the Service Medical Departments to the DHA and a subsequent rationalization of staff remaining in each Component Command.

The MHS will identify potential reductions in headquarters-related personnel resulting from implementation. The Department intends to redirect savings resulting from realized efficiencies, eliminated unwarranted duplicate activities, and reduced headquarters staffing, for existing medical readiness requirements to receive priority in the disposition of future savings adjudication. The Department will 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 of the NDAA for 2017 requirements. Through this process, the DHA and Military Departments may uncover opportunities to achieve greater results that are only possible through additional legislative actions. At this time, the Department is not proposing any such recommendations 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.