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

MAR 0 2 2012

The Honorable Daniel K. Inouye
Chairman
Subcommittee on Defense
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Pursuant to section 716(a)(2) of the National Defense Authorization Act for Fiscal Year (FY) 2012, "The Review of the Military Health System," the Department of Defense (DoD) provides the enclosed report.

The report consists of four enclosures. Enclosures 2 and 3 contain the two volumes of the Department's internal Task Force on Military Health System (MHS) Governance. This Task Force was established on June 14, 2011 by the Deputy Secretary of Defense to inform deliberations within the Department on the issue. The Task Force conducted a review of the governance of the MHS and provided a report containing an evaluation of options for the governance of MHS as a whole, for the governance of multi-Service medical markets, and for the governance of the National Capital Region health system. The Task Force delivered its report to the Deputy Secretary of Defense on September 15, 2011.

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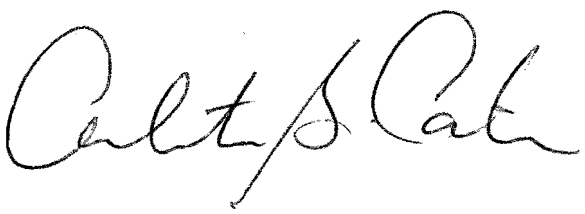

Enclosures:
As stated

cc:
The Honorable Thad Cochran
Vice Chairman

DEPUTY SECRETARY OF DEFENSE
1010 DEFENSE PENTAGON
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MAR 0 2 2012

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The Honorable Thad Cochran
Vice Chairman

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

MAR 0 2 2012

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

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As stated

cc:
The Honorable John McCain
Ranking Member

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

MAR 0 2 2012

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

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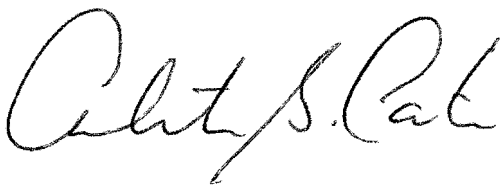

Enclosures:
As stated

cc:
The Honorable Adam Smith
Ranking Member

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

MAR 0 2 2012

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

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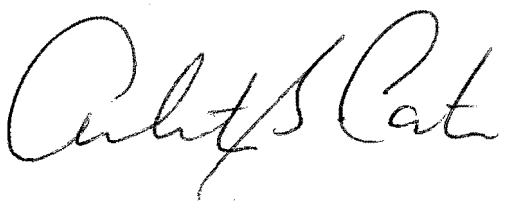

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As stated

cc:
The Honorable Norman D. Dicks
Ranking Member

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

MAR 0 2 2012

The Honorable Jim Webb
Chairman
Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510

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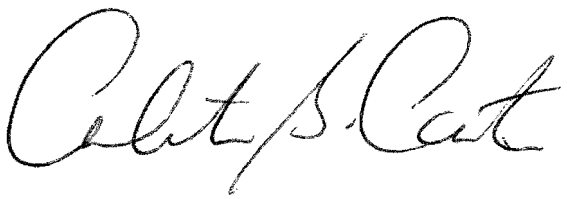

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cc:
The Honorable Lindsey Graham
Ranking Member

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1010 DEFENSE PENTAGON
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The Honorable Joe Wilson
Chairman
Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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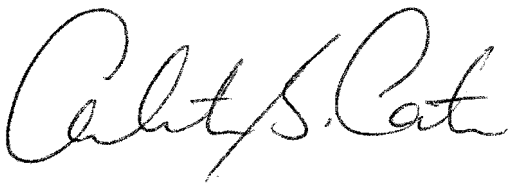

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cc:
The Honorable Susan A. Davis
Ranking Member

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

MAR 0 2 2012

The Honorable C.W. Bill Young
Chairman
Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

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As stated

cc:
The Honorable Norman D. Dicks
Ranking Member

ENCLOSURE 1

Military Health System Governance Statement of Intent

On June 14, 2011, the Deputy Secretary of Defense established an internal task force to conduct a review of the governance of the Military Health System (MHS) and to provide a report containing an evaluation of options for the governance on the MHS as a whole, for the governance of multi-Service medical markets, and for the governance of the National Capital Region (NCR) health system. The conclusions of the Task Force were delivered to the Deputy Secretary on September 15, 2011. The report, delivered in two volumes, includes the Task Force's terms of reference; the options reviewed with their strengths, weaknesses, and estimated manpower cost savings; the criteria used to evaluate the many options considered; and a set of recommendations from the Task Force.

Subsequent to the receipt of the Task Force Report of September 15, 2011, the Deputy Secretary of Defense, Chairman of the Joint Chiefs of Staff, the Military Department Secretaries and Service Chiefs, and other senior officials of the Department reviewed the work of the Task Force and considered a variety of other pertinent factors, including the following:

- Although the ability to control healthcare expenditures is an important element in evaluating possible changes to medical governance, it is only one of several, to include ease of implementation, the effect on the delivery of healthcare in garrison and the field, and ability to field trained and ready medical forces.

- The largest cost elements in healthcare are in the direct and civilian healthcare systems, not in areas such as administrative and management headquarters. Any change in governance must create an enhanced capability to better control these costs through the expansion of shared services and the adoption of common business and clinical processes to reduce variation and assure rapid adoption of knowledge and technology. Any change that results only in headquarters manpower reductions would not produce a significant impact on cost control.

- A large-scale change in governance could be disruptive and create unintended and unexpected consequences in an enterprise engaged in direct combat service support. Any changes to current medical governance, including governance for multi-Service markets or for shared medical services among the Military Departments (e.g., health information technology, training, and logistics) must be carefully considered for impact to the operational mission. An option for changes in medical governance selected for near-term implementation does not preclude possible further organizational realignment of the MHS in the future, informed by additional experience and insight.

Based on these and other considerations, and building on the options developed by the Task Force, the Department arrived at its final position for changes to the existing governance of the MHS, as summarized below:

1. **Establish a Defense Health Agency.** The TRICARE Management Activity (TMA) would be transitioned to a Defense Health Agency (DHA), an agency of the Department of Defense under the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) and operating under the authority, direction, and control of the Assistant Secretary of Defense for

Health Affairs (ASD(HA)). The DHA would be designated a Combat Support Agency, with oversight by the Chairman of the Joint Chiefs of Staff (CJCS) in accordance with DoD Directive 3000.06, "Combat Support Agencies." The DHA would assume responsibility for the functions currently undertaken by TMA, except for such functions that are determined to be assigned to the ASD(HA). In addition, the DHA would assume responsibility for shared services, functions, and activities in the MHS, including but not limited to the TRICARE Health Plan, pharmacy programs, medical education and training, medical research and development, health information technology, facility planning, public health, medical logistics, acquisition, budget and resource management, and other common business and clinical processes. The position of Director, DHA, would be a general or flag officer in the grade of Lieutenant General or Vice Admiral and published on the Joint Duty Assignment List (JDAL) in accordance with DoD Instruction 1300.19, "DoD Joint Officer Management Program." Responsibility for the management and allocation of the Defense Health Program (DHP) budget would continue to reside with the ASD(HA). The actions described in this paragraph would build on, and supersede, the provisions related to the MHS Support Activity in the March 14, 2011, Secretary of Defense memorandum entitled "Track Four Efficiency Initiatives Decisions."

The target dates for the attainment of initial operating capability and full operational capability for the DHA; the shared services and other functions and activities for which the DHA would have responsibility; the potential use of a single financial accounting system for allocation and tracking of DHP funds; and the military, civilian, and contractor staffing levels for the Office of the ASD(HA) and the DHA would be among the items addressed in an implementation plan.

Rationale: This action would allow the Department to enhance its ability to create and expand shared services to create common business and clinical practices under the leadership of a three-star general or flag officer. At the same time, this action would accomplish these objectives without large-scale changes to the MHS (such as creating a Unified Medical Command or converting to a single-Service delivery system), which would require a massive reorganization that could unduly disrupt current command and control structures and create unintended and unexpected consequences in a large enterprise engaged in direct combat service support. While this action would not preclude subsequent decisions by the Department to implement more sweeping changes in the future, the DHA described above would be an appropriate next step to improve MHS governance and provide a structure to rein in healthcare costs.

2. **Appoint multi-Service market managers with enhanced authorities.** In each geographic medical market determined to be a multi-Service market due to overlapping catchment areas, a market manager would be appointed with the mission to create and sustain a cost-effective, coordinated, and high-quality health care system in that area. The market manager in each such market would have the authority to, among other things, manage and allocate the budget for the market, direct the adoption of common clinical and business functions for the market, and direct the movement of workload and workforce between or among the medical treatment facilities (MTFs) in the market. The market manager for a market would be

selected by the Military Department or Departments designated as lead for that market. The actions described in this paragraph would not apply to the NCR, which is covered in paragraph 3 below.

The target date(s) for the establishment of multi-Service Market Managers, the specific authorities and responsibilities of the Market Managers, the geographic medical markets designated as multi-Service markets, and the Military Department or Departments designated as lead(s) for each market would be among the items addressed in an implementation plan.

Rationale: There is great opportunity to better control costs in Multi-Service markets through stronger local control of resources, business and clinical processes, and workforce under a long term business plan. Empowering a designated Market Manager with specific mission goals coupled with enhanced authorities will accomplish this for these important health regions.

3. **Create a National Capital Region Medical Directorate in the newly established DHA.** After such time as the transition of TMA to the Defense Health Agency has begun, the authority, direction, and control over the NCR health system, to include the Walter Reed National Military Medical Center (WRNNMC), the Fort Belvoir Community Hospitals (FBCH), and all other military medical treatment facilities that are determined to reside within the NCR market, would be assigned to the "NCR Medical Directorate," a subordinate organization of the Defense Health Agency and successor to JTF CAPMED. The position of Director, NCR Medical Directorate, would be filled by a general or flag officer in the grade of Major General or Rear Admiral (Upper Half) and will be published on the JDAL. The directors of the WRNMMC, the FBCH, and the other MTFs in the NCR Medical Directorate would be selected by the USD(P&R) (or, if delegated, the ASD(HA); Director, DHA; or Director, NCR Medical Directorate) from nominees provided by the Military Departments. Military personnel for the WRNMMC, the FBCH, and the other MTFs within the NCR Medical Directorate would be provided by the Military Departments according to manning documents maintained by the DHA.

   The target date for the transfer of the of the NCR system to the authority, direction, and control of the NCR Medical Directorate, and the determination of the MTFs that reside within the NCR market and therefore will be assigned to the NCR Medical Directorate, would be among the items addressed in an implementation plan.

   Until such time as the actions described above are executed, JTF CAPMED would retain its existing missions and authorities, and all previously issued guidance pertaining to JTF CAPMED would remain in effect. During this period, the JTF CAPMED commander would continue to report to the Deputy Secretary of Defense.

   Rationale: There currently are two notably different regional governance models in the MHS, namely a cross-Service market management model, best exemplified by the San Antonio Military Health System, and a singular authority model, employed by JTF CAPMED. Both models have proven successful to date in their respective regions and, because they are still in their early stages of development and execution, both should be allowed to continue to exist and be improved. The changes described in paragraph 2 would

improve upon the cross-Service market management model; similarly, the changes described in paragraph 3 would improve JTF CAPMED and continue it in a modified form with an appropriate reporting and supervisory structure. In doing so, the Department would, among other things, obtain greater insight, based on actual outcomes, that may inform considerations of more significant transformations of the military health system governance in the future.

To make the Department's intent a reality will require in-depth planning. To that end, the Under Secretary of Defense for Personnel and Readiness and the Chairman of the Joint Chiefs of Staff will stand up a planning team to develop an implementation plan to accomplish the changes described above. The Department intends to begin execution of these changes after the provisions of Section 716 of the National Defense Authorization Act for Fiscal Year 2012 have been fulfilled. In addition, this planning team will support the work to be performed by the Comptroller General pursuant to Section 716 and will develop other products, as necessary, to support this intent.

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DEPARTMENT OF DEFENSE

TASK FORCE ON MILITARY HEALTH SYSTEM GOVERNANCE

Volume 1

Final Report

September 29, 2011

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Executive Summary

For the past six decades, the Department of Defense (DoD) has undertaken numerous studies concerning the governance of the Military Health System (MHS). Performed by both internal and external boards, commissions, task forces, and other entities, a number of these studies recommended dramatic changes in the organizational structure of military medicine. Despite these recommendations, the DoD introduced change in its management and oversight of the MHS in an incremental manner.

Since 2001, the MHS has undergone significant transformation – both in the United States and abroad. Advances in strategy, training, technology, and greater interoperability have helped save lives and prevent both illness and injury at a level never before witnessed in combat medicine. At home, the MHS is just completing the implementation of the 2005 Base Realignment and Closure (BRAC) requirements, producing a military health care delivery environment far different from what existed just 10 years ago. Also, overall trends in American medicine coupled with increases in both beneficiaries and health benefits in military medicine, drove MHS costs from $19 billion in 2001 to $53 billion in 2011. The dual imperatives of ensuring superb medical support for current and future military operations and instituting enduring health care cost containment measures require that the DoD continue this momentum of military health transformation. The DoD needs to operate the most efficient health system possible, elevating cost containment as a priority objective and increasing unity of effort as an implementation capability.

It is in this environment that on June 14, 2011, the Deputy Secretary of Defense established an internal Task Force, consisting of representatives from the Military Departments, the Joint Staff, and the Office of the Secretary of Defense (OSD) to conduct this review of the current governance of the MHS. The Task Force was directed to evaluate options for the long-term governance of the MHS as a whole and the governance of multi-Service health care markets, to include the National Capital Region (NCR) and to provide a report within 90 days detailing the relative strengths and weaknesses of each option evaluated as well as recommendations for governance.

Operating from the Deputy Secretary's tasking memorandum and Terms of Reference, the Task Force developed, assessed, and refined numerous variations of five potential organizational models for the MHS as a whole: a Unified Medical Command (UMC), a Defense Health Agency (DHA), management by one or more Military Departments, a hybrid model incorporating elements of the other models, and an "As Is" option. The Task Force also developed and evaluated options for the governance of multi-Service markets (MSMs) in general, as well as options for the governance of the National Capital Region military health system in particular.

The Terms of Reference enumerated several criteria for the Task Force to use in evaluating the governance models. The Task Force further refined and expanded these criteria to consist of the following:

- **Sustain a medically ready Active Duty (AD)/Reserve Component (RC) through high quality integrated health care.**
  The alternative should maintain or enhance the ability to provide medically ready warfighters.
- **Maintain a trained and ready deployable medical force.**
  The alternative should sustain the training necessary to meet all clinical and other requirements needed to provide a fully trained and current deployable medical force.
- **Provide high quality, integrated medical care to non-AD/RC beneficiaries.**
  The alternative should maintain or enhance the ability of the system to sustain the current high quality of health care that it provides at the current levels of integration between the Services as well as the private sector.
- **Achieve significant cost savings through reduction in duplication and variation.**
  The alternative should result in a reduction of the system operating costs.
- **Afford dispute resolution process and clear decision authority with clear accountability.**
  The alternative should provide clear decision authority and dispute resolution at the lowest appropriate level, including clear lines of accountability.
- **Offer ease of implementation.**
  The alternative should be implementable taking into account Title 10 equities; short-term costs and long-term savings; and decisions required inside and outside of the DoD.
- **Enhance interoperability.**
  The alternative should facilitate interoperability among the Services.

Based on its internal deliberations, the Task Force selected a set of models to develop in greater detail for each of the three decision areas of (1) overall MHS governance; (2) multi-Service market governance; and (3) NCR governance. These are summarized below.

OVERALL MHS GOVERNANCE MODELS

The Task Force developed the following five models for the governance of the overall MHS. (Note that these models describe overall MHS governance, and do not necessarily incorporate the governance of multi-Service markets, or of the National Capital Region. MSM and NCR governance are considered separately in the sections that follow.)

- **MHS Option 1: As Is – Current Structure.** The current functions, responsibilities, and reporting relationships of the Military Departments and the TRICARE Management Activity (TMA) would be maintained (with possible modification to reporting relationships in multi-Service markets and in the National Capital Region, as described below). Specifically, the direct care system of 56 hospitals, 363 medical clinics, and 282 dental clinics would continue to be operated by the three Military Departments; TMA would manage the TRICARE health plan and lead collaborative efforts on selected shared support services; the Assistant Secretary of Defense for Health Affairs (ASD(HA)) would retain MHS-wide policy and budgetary authority.

- **MHS Option 2: A Defense Health Agency (DHA) with Medical Treatment Facilities (MTFs) Remaining in the Military Departments.** A Defense Health Agency would be established (replacing TMA) to consolidate a far broader set of shared health care support services. MHS-wide shared services activities include (but are not limited to): the

TRICARE Health Plan; pharmacy programs; medical education and training; medical research and development; health information technology; facility planning; public health; medical logistics, acquisition, and other common business and clinical processes. As conceived by the Task Force, the DHA would be led by a 3-Star general or flag officer who reports to the Assistant Secretary of Defense (Health Affairs), and could be designated a Combat Support Agency (CSA), to fulfill support functions for joint operating forces across the range of military operations, and in support of combatant commanders executing military operations. The Chairman of the Joint Chiefs of Staff oversees the planning and execution of each CSA's combat support missions and, among other responsibilities, provides military advice and planning guidance to the CSAs and the combatant commanders in the preparation of their operational plans.

- **MHS Option 3: A Defense Health Agency with Medical Treatment Facilities Placed under the Authority, Direction, and Control of the Agency.** A Defense Health Agency would be established with the functions and reporting relationships described above. Additionally, all military medical treatment facilities would be transferred to the DHA and would operate under its authority, direction, and control. The Military Departments would continue to own all military personnel and be responsible for organizing, training, and equipping their deployable military medical forces. Personnel requirements of the Services' operational forces needed for deployment and/or training would be requested through the Director, DHA.

- **MHS Option 4: A Unified Medical Command (UMC) with Service Components.** A tenth unified combatant command (U.S. Medical Command) would be established, led by a 4-Star general or flag officer, and reporting directly to the Secretary of Defense. Medical forces would be provided by Service Components, but the UMC would be responsible for overall direction and leadership of the Military Health System. Components would establish subordinate medical command structures to manage the medical treatment facilities. This option for a Unified Medical Command would include a Unified Medical Command Headquarters and a subordinate Joint Health Support Command to manage shared services as well as the TRICARE Health Plan. The proposed structure of this Unified Medical Command is depicted in Figure 8 and Table 8. Services maintain control of their deployable forces with force generation responsibilities. The U.S. Medical Command would have operational control of the garrison forces that would be identified through a Joint Table of Distribution (JTD) or Joint Manning Document (JMD). The ASD(HA) would continue in a policy role.

- **MHS Option 5: A Single Service - One Military Department Secretary Assigned Responsibility for the Management of the MHS.** One Military Department Secretary would be assigned responsibility for the management of the MHS. All MTFs would be transferred to the authority, direction, and control of the designated Military Department (e.g., if Navy is the designated Service, all hospitals and clinics would become Navy medical facilities). Each Military Department would continue to be responsible for organizing, training, and equipping its deployable military medical forces, but this would occur through assignment to operational platforms in medical treatment facilities run by the designated Military Department Secretary. The medical treatment facilities would be run by the designated Military Department, and would be staffed by personnel from all of

the Military Departments. The designated Military Department would operate the TRICARE health plan and would have control over the Defense Health Program (DHP). The ASD(HA) would retain policy authority within the MHS.

MULTI-SERVICE MARKET GOVERNANCE MODELS

The Task Force identified 14 multi-Service markets (MSMs)—those markets where more than one Military Department delivers health care services to the entire population (governance models for the National Capital Region are considered separately in the following section). For these markets, the Task Force considered six governance models described below.

- **MSM Option 1: Informal MSM Management.** Under this option, the responsibilities of the existing multi-Service market managers would be limited to the most basic elements of informally coordinating activities between medical commanders in a market. MTF commanders could meet and share information on an ongoing basis, but there would be no requirement to formally collaborate. This model would essentially eliminate multi-Service market governance and any central coordinating role in a market. This would effectively allow MSMs to run on their own as the respective local MTF commanders deem necessary.

- **MSM Option 2: Existing MSM Management.** Multi-Service market managers would be designated with responsibilities to create a unified one-year business plan and facilitate the adoption of common business and clinical practices. This is the current practice in most stateside regions, based on the existing TRICARE governance policy, and would now be expanded to overseas MSMs.

- **MSM Option 3: Enhanced MSM Management.** The authorities of the multi-Service market managers would be expanded to include responsibility for developing a five-year unified business plan, budget authority for the entire market, establishing common workload accounting processes, driving common clinical and business practices, and the authority to direct personnel to work in other locations within the market on a short-term basis. This expanded set of authorities is based on experiences derived from three of the largest MSMs: National Capital Region; San Antonio, Texas; and the Tidewater Area, Virginia.

- **MSM Option 4: Single Service – One Military Department Secretary Assigned Responsibility for the MHS.** Each identified multi-Service market, and the medical treatment facilities within it, would be assigned to a particular Military Department and thereby become a single-Service market. In a notional example, the Hawaii MSM would be designated as a Navy market, and all medical treatment facilities in the Hawaii MSM would become Navy facilities. Command and control of the market would be aligned under the Department of the Navy, and all business and clinical processes in the market would follow Navy procedures. Medical personnel would be assigned to the facilities in the market by their owning Service to meet beneficiary and clinical currency demands. This approach would solve the MSM governing issue by definition, as there would no longer be multi-Service markets, only large, multi-facility single-Service markets.

- **MSM Option 5: Executive Agent.** Each multi-Service market would be established as an entity of the Military Departments involved and assigned to a particular Military Department Secretary, who would operate the market as an Executive Agent on behalf of the multiple Departments involved. The major facilities could be either multi-Service facilities or "owned" by a single Service. The individual MTFs within the market would become multi-Service staffed facilities (and, as such, the market would remain "multi-Service"). An executive board of major stakeholders could be established to protect equities and promote a multi-Service management perspective. The day-to-day operation of the multi-Service market would subject to the policy direction of the ASD(HA) as informed by the executive board. The Executive Agent would have budgetary and other authorities to direct single business and clinical processes throughout the market.

- **MSM Option 6: Military Command.** Each multi-Service market would be established as a Joint military command. The market commander would exercise command authority over the military medical treatment facilities within the market. These medical treatment facilities would no longer be Service-run, but would be subordinate Joint commands under the market area command. This is similar to the model currently in place in the National Capital Region.

NATIONAL CAPITAL REGION (NCR) GOVERNANCE MODELS

Because of the unique nature of the existing model of governance in the National Capital Region, the Task Force separately considered governance models for this region. The six models developed by the Task Force are summarized below.

- **NCR Option 1: As Is – Current Structure Reports to Secretary of Defense/Deputy Secretary of Defense.** The Joint Task Force National Capital Region Medical (JTF CAPMED) would remain in place, reporting to the Secretary of Defense/Deputy Secretary of Defense. The medical treatment facilities currently directed by the JTF CAPMED would operate as subordinate Joint commands with the manning, budgetary, and organizational arrangements directed to-date by the Deputy Secretary.

- **NCR Option 2: JTF CAPMED Reports to a Combatant Commander.** The JTF CAPMED would remain in place, with the characteristics described in the preceding paragraph, but would report to the Commander, U.S. Northern Command (NORTHCOM), or another designated Combatant Command (COCOM) Commander.

- **NCR Option 3: NCR Reports to a Defense Health Agency.** Responsibility for management of the NCR medical market would be transferred to the DHA described in the "Overall MHS Governance Models" section above (provided that such an agency is established), and the NCR medical treatment facilities would operate under the agency's authority, direction, and control. In general, these medical treatment facilities would operate with the manning, budgetary, and organizational arrangements directed to-date by the Deputy Secretary. If the Defense Health Agency is not adopted for purposes of overall MHS governance, then the NCR market and medical treatment facilities would be transferred to the existing TRICARE Management Activity.

- **NCR Option 4: NCR Reports to an Executive Agent.** The NCR Health System would be established as an entity of the three Military Departments. Day-to-day operational and administrative activities are supported by one of the Military Department Secretaries assigned as the Executive Agent. The Walter Reed National Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH) would be multi-Service facilities, not owned by a single Service. An executive board of major stakeholders could be established to protect equities and promote a multi-Service management perspective. The day-to-day operation of the NCR Health System would be subject to the policy direction of the ASD(HA) as informed by the executive board. Multi-Service staffing facilities would be sustained through agreements between the Services. This option would disestablish JTF CAPMED as a joint command but maintain a similar multi-Service management structure.

- **NCR Option 5: NCR Reports to a Single Service.** All medical treatment facilities in the NCR would be assigned to a particular Military Department Secretary, consistent with the MSM "Single Service" option above.

- **NCR Option 6: Enhanced MSM Management.** The Joint Task Force National Capital Region Medical would be disestablished and an NCR Market Management Office would be established with the characteristics described as "Enhanced MSM Management" in the "Multi-Service Market Governance Models" section above. The medical treatment facilities would continue to be staffed by personnel from all three Military Departments. The medical treatment facilities would be operated by the Military Departments that have historically operated them (i.e., Fort Belvoir Community Hospital would be an Army Hospital; Walter Reed National Military Medical Center, a Navy Medical Center).

A more complete description of each of these models, as well as the Task Force's assessment of their relative strengths and weaknesses is contained in the respective sections to follow: MHS Governance, Multi-Service Market Governance, and National Capital Region Governance.

TASK FORCE RECOMMENDATIONS

The members of the Task Force reached a consensus on the following general points:

- There is an opportunity to accelerate the adoption and implementation of more efficient, common clinical and business processes through reengineered and more streamlined shared services.
- There is an obligation in the current fiscal environment to more rapidly implement and effectively manage efficiencies than the current organizations are likely to do.
- There is an opportunity to provide a more coherent, cohesive, and effective long-term governance model for the MHS.

The Task Force reached its recommendations on specific governance models for each of the three decision areas – MHS Governance, MSM Governance, and NCR Governance – through a series of discussions and votes among the Task Force members. The voting process is described on page 24 of this report. The model receiving a majority or plurality of the members' first place

votes constituted the Task Force's recommendations. Where there was a significant difference of views among Task Force members, the minority views are noted.

The Task Force's recommendations on specific governance models are the following:

- **Overall MHS Governance: MHS Option 2 – A Defense Health Agency (DHA) with Medical Treatment Facilities (MTFs) Remaining with the Military Departments**

  Establish a Defense Health Agency that would be focused on consolidating and delivering a broader set of shared health services, and implementing common clinical and business processes. MTFs would remain under the respective Military Departments. The Task Force recommends the DHA be designated as a Combat Support Agency for its combat support mission responsibilities, which would include oversight by the Chairman, Joint Chiefs of Staff. This recommendation builds upon the decision by the Secretary of Defense in March 2011 to establish a Military Health System Support Activity and expand the delivery of shared services throughout the MHS.

  The majority (five of nine members) of the Task Force favored this option. The minority was split as follows: DHA with MTFs placed under the Agency (two members); Unified Medical Command with Service Components (one member); and Single Service (one member). Results of this vote are depicted in Table 14 on page 46 of this report.

- **Multi-Service Market Governance: MSM Option 3 – Enhanced MSM Management**

  Introduce enhanced MSM manager authorities for multi-Service medical markets in the DoD, to include providing budgetary and short-term personnel management authority to the market manager. The majority (seven of nine members) of the Task Force favored this option. The minority was split as follows: single Service (one member); Executive Agent (one member). Results of this vote are depicted in Table 28 on page 58 of this report.

- **National Capital Region Governance: NCR Option 6 – Enhanced MSM Management**

  Transition JTF CAPMED to a market management office with enhanced MSM manager authorities, similar to the model that would be applied in all other MSM markets based on the MSM governance recommendation. The medical treatment facilities would continue to be staffed by personnel from all three Military Departments, and common clinical and business processes would be maintained. The medical treatment facilities would be operated by the Military Departments that have historically operated them (i.e., Fort Belvoir Community Hospital would be an Army Hospital; Walter Reed National Military Medical Center would be a Navy Medical Center).

  The majority (five of nine members) of the Task Force favored this option. The minority was split as follows: NCR MTFs report to DHA (two members); NCR MTFs report to an Executive Agent (one member); and JTF CAPMED "As Is" Current Structure reports to Secretary of Defense/Deputy Secretary of Defense (one member). Results of this vote are depicted in Table 42 on page 70 of this report.

If these recommendations are adopted, the Task Force believes that implementation actions could begin during Fiscal Year (FY)12 with full implementation by the end of FY13 (although the Army expressed concern that this timetable is overly aggressive). A brief implementation plan for these recommendations is contained in the conclusion of this report. The Task Force recommends the immediate establishment of an implementation team, led by a senior OSD official, that would further delineate the specific milestones, concepts of operations, and detailed execution plans. The Task Force further recommends that the proposed MHS governance model be permitted sufficient time, following implementation, to be fully evaluated in its ability to achieve expected outcomes in terms of clear and measurable criteria for performance improvement, agility, and efficiency.

The Task Force members express their gratitude for the opportunity to serve in this vital capacity. The MHS is a unique and indispensable asset in the country's overall national security strategy. The performance of the MHS, especially over the last 10 years of war, has been historic and its operations exemplified by increasing joint activity and interoperability. We believe that the options and recommendations put forward in this report provide a pathway to a stronger and enduring governance model for the system, while maintaining the incredible performance of a military health system whose primary mission is to prepare for and go to war.

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Purpose of Study

On June 14, 2011, the Deputy Secretary of Defense established a Task Force, consisting of representatives from the Military Departments, the Joint Staff, and the Office of the Secretary of Defense (OSD), to conduct a review of the current governance of the Military Health System (MHS). The Task Force was directed to evaluate options for the long-term governance of the MHS as a whole and the governance of multi-Service markets (MSMs), to include the National Capital Region (NCR), and, within 90 days, to provide a report with an assessment of the relative strengths and weaknesses and recommendations among the options evaluated.

In his memorandum establishing the Task Force, the Deputy Secretary noted that the pending conclusion of the consolidation of military medical facilities in the National Capital Region in fulfillment of the Base Realignment and Closure (BRAC) statutory obligation afforded the Department of Defense (DoD) a timely opportunity to consider both the NCR governance and larger MHS governance issues.

In addition, the Deputy Secretary of Defense stated that the consideration of these issues should be informed by the "long-term fiscal challenges the nation faces" and the need to "ensure the MHS is organized in a way that curtails expenses and achieves savings to the greatest extent possible in meeting its deeply important mission."

Included with the tasking memorandum were the Terms of Reference that identified the Task Force's objectives and scope, methodology (to include minimum inclusive criteria), the membership, and final deliverables. The memorandum and Terms of Reference are provided as Appendix 1 to this report.

Task Force and Deliverables

Group Composition

The Deputy Secretary of Defense named Dr. Peach Taylor (Deputy Assistant Secretary of Defense (Health Affairs) for Force Health Protection and Readiness) and Major General (Dr.) Doug Robb, Joint Staff Surgeon, to serve as co-chairs of the Task Force. Other members of the review group were directed to consist of one representative at the 1- or 2-Star general or flag officer or comparable Senior Executive Service level designated by the Secretaries of the Military Departments, the Chairman of the Joint Chiefs of Staff, the Under Secretary of Defense (Comptroller), the Under Secretary of Defense for Personnel and Readiness, and the Director, Cost Assessment and Program Evaluation. A representative from the Marine Corps was subsequently added to the Department of the Navy delegation.

The Task Force membership is listed in Table 1.

Name	Organization	Position	Alternate
Dr. Peach Taylor	Co-Chair	Deputy Assistant Secretary of Defense (Force Health Protection and Readiness)	Mr. Allen Middleton
Maj Gen (Dr.) Doug Robb	Co-Chair	Joint Staff Surgeon	COL James Rice
BGen W. Mark Faulkner	Office of the Chairman of the Joint Chiefs of Staff	Vice Director for Logistics (J-4)	COL James Rice
Mr. Charles Milam	OUSD/ Personnel and Readiness	Principal Director, Military Community and Family Policy	Ms. Carolee Van Horn
Ms. Anne McAndrew	OUSD/Comptroller	Director, Military Personnel and Construction Directorate	Mr. Kevin Lannon
Dr. Jerry Pannullo	Director/Cost Assessment and Program Evaluation (CAPE)	Director, Economic and Manpower Analysis Division	Mr. Michael Strobl Dr. Garrett Summers
BG (Dr.) Tom Thomas	Secretary of the Army	Assistant Surgeon General	Mr. Rich Beauchemin
RADM Karen Flaherty	Secretary of the Navy	Deputy Surgeon General	Mr. Jerry LaCamera
BGen Robert Hedelund	Marine Corps	Director, Marine and Family Programs	Ms. Kerry Lewis
Maj Gen (Dr.) Tom Travis	Secretary of the Air Force	Deputy Surgeon General	Brig Gen Michael Miller
Task Force Advisors			
Mr. Jonathan Lee	Office of the Deputy Secretary of Defense	Special Assistant to the Deputy Secretary of Defense	None
Mr. John Casciotti	Office of General Counsel	Associate Deputy General Counsel (Health Affairs)	None
Ms. Bethany Bassett	OASD/Legislative Affairs	Team Chief for Personnel and Readiness	LTC AnnMarie Amaral
Ms Jennifer Cole	Office of Director, Administration and Management	Organization and Management Planning	Mr. Tedd Ogren

Table 1. Members, Alternates, and Advisors of the DoD Task Force on MHS Governance

Deliverables

The Task Force was directed to include an evaluation of at least the following four models for MHS governance, where primary authority would be vested in:

1. A Defense Agency/DoD Field Activity
2. A Unified Military Command
3. One or more Military Department Secretaries
4. A hybrid model incorporating features of the other three options

The Task Force also developed and evaluated options for the governance of MSMs, as well as options for the governance of the National Capital Region military health system in particular. Each model was to be evaluated based on criteria specified in the Terms of Reference, as well as any other criteria the Task Force determined appropriate. The Terms of Reference included a template for the Task Force to use to describe each option. This template included:

- The entity or entities having authority, direction, and control of the MHS as a whole;
- The head of this entity and reporting chain to the Secretary of Defense;
- The management, including supervisory chain(s), of individual medical treatment facilities (MTFs);
- The management, including supervisory chain(s) of multi-Service medical markets;
- The authority, direction, and control for mission and administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities;
- The budgetary authority among OSD, the Military Departments, and/or joint entities;
- The policy making authority among OSD, the Services, and/or joint entities;
- The management of purchased care and other functions currently performed by the TRICARE Management Activity;
- The management of support services such as information technologies and systems, medical logistics, business functions, medical construction and facility operations, research and development, education and training, and other related functions; and
- The roles of the Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Surgeons General, and any other senior leaders in the MHS options considered.

Approach

In order to effectively analyze options and provide a recommendation for governance models for the overall MHS, MSMs, and the NCR, the Task Force utilized a three-tiered approach outlined in Figure 1.

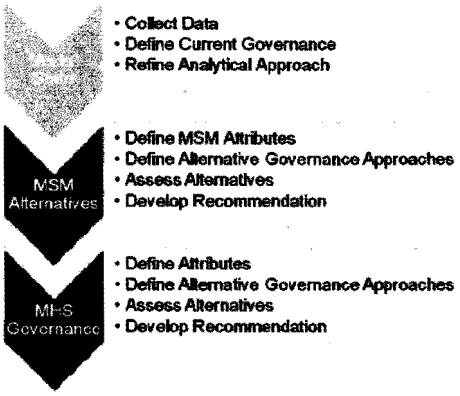


Figure 1. Approach for Analyzing Governance Model Options

By focusing initially on collecting data and defining the "As-Is" state of the MHS, the Task Force was informed on the current environment and complexities of the MHS. This in-depth overview set the stage for the analysis of the MSM and NCR governance options.

Following the MHS review, the Task Force identified and analyzed the current MSMs located in the United States and overseas. The Task Force reviewed the existing MSM manager authorities and the processes (e.g., DoD policies, local memorandums of agreement / memorandums of understanding (MOAs/MOUs)) by which they execute their missions. This review was informed by presentations from MSM leaders, including representatives from San Antonio, the Tidewater area, and the Kaiserslautern Military Community. Additionally, the Commander, Joint Task Force National Capital Region Medical (JTF CAPMED), presented information to the Task Force on both his command and MSM responsibilities.

Finally, the Task Force analyzed various MHS and MSM governance options. Because of some unique impacts of the NCR market and its existing governance structures, NCR governance options were separately developed and considered. In accordance with the Terms of Reference, the Task Force assessed the strengths and weaknesses of each option. The Task Force expanded the Terms of Reference criteria to guide the evaluation of each governance option. The Task Force then, through a series of deliberations and votes, developed recommendations for the governance structure for each of the three areas: overall MHS governance, MSM governance, and NCR governance.

Criteria for Evaluation

The Task Force added two additional evaluation criteria to those in the Terms of Reference to allow for a more comprehensive analysis of the various options. The Task Force developed a weighting scheme to reflect the relative importance of the criteria, and used these weighted criteria to guide the evaluation of the MHS, MSM, and NCR governance options. The final seven criteria used by the Task Force are provided Table 2.

	Criteria	Weighting
1*	**Sustain a medically ready Active Duty (AD)/Reserve Component (RC) through high quality integrated health care.** The alternative should maintain or enhance the ability to provide medically ready warfighters.	25%
2*	**Maintain a trained and ready deployable medical force.** The alternative should sustain the training necessary to meet all clinical and other requirements needed to provide a fully trained and current deployable medical force.	23%
3*	**Provide high quality, integrated health care to non-AD/RC beneficiaries.** The alternative should maintain or enhance the ability of the system to sustain the current high quality of health care that it provides at the current levels of integration between the Services as well as the private sector.	21%
4*	**Achieve significant cost savings through reduction in duplication and variation.** The alternative should result in a reduction of the system operating costs.	17%
5	**Provide dispute resolution process and clear decision authority with clear accountability.** The alternative should provide clear decision authority and dispute resolution at the lowest appropriate level, including clear lines of accountability.	6%
6	**Ease of implementation.** The alternative should be implementable taking into account Title 10 equities, short term costs and long-term savings, and decisions required inside and outside of the DoD.	5%
7*	**Enhance interoperability.** The alternative should facilitate interoperability among the Services.	3%

Table 2. Criteria for Evaluating MHS, MSM, and NCR Governance Options
(*) Indicates criteria already outlined in the Terms of Reference

Development and Selection of Options

The Task Force developed and evaluated a series of options for MHS Governance using a detailed investigation of organizational alternatives as shown in Figure 2. The Task Force evaluated various combinations of the building blocks resulting in the development of a set of alternatives for further consideration.

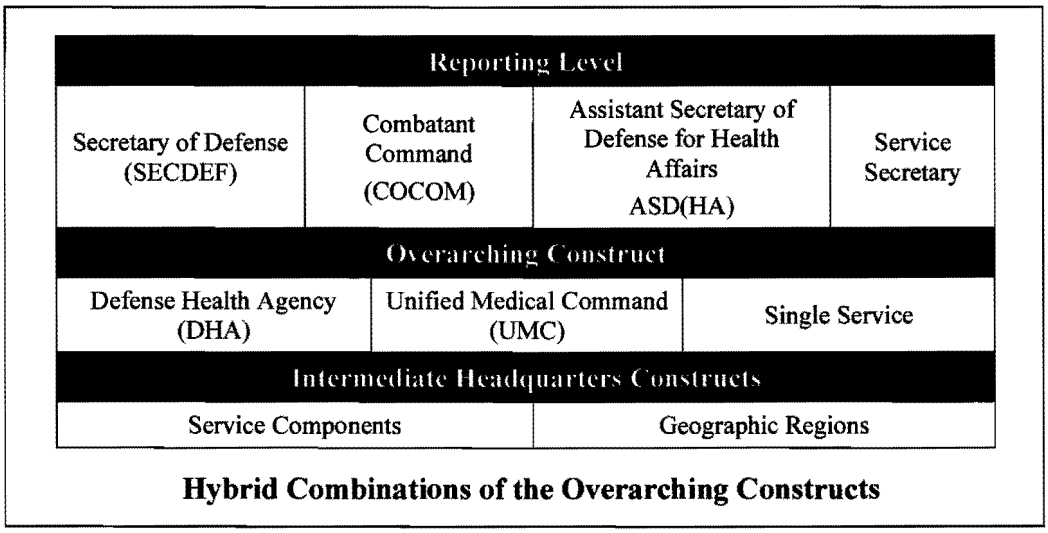


Figure 2. Building Blocks Used for Development of MHS Governance Alternatives

The Task Force narrowed the multiple options by applying the seven evaluation criteria in a series of votes. Each option was evaluated on a 1-5 scale with the higher number (5) indicating "strongest" application of the criteria and the lowest number (1) reflecting the "weakest." Each vote was normalized through the identification of the "As Is" option as all "3s" to which all of the other alternatives in the vote were compared. As an example, Figure 3 depicts one of the voting sheets the Task Force used to evaluate one of the organizational options.

CRITERIA	WT	SCORING	As Is	DHA 2/ Hybrid 1	UMC 2	DHA 1/ Hybrid 2	SS Option 2
1. Medically Ready AD/RC through high quality integrated health care The alternative should maintain or enhance the ability to provide medically ready warfighters.	25%	1 = Weakest 2 = Weaker 3 = Neutral 4 = Stronger 5 = Strongest	3				
2. Maintain training & ready deployable medical force The alternative should sustain the training necessary to meet all clinical and other requirements needed to provide a fully trained/current deployable medical force	23%	1 = Weakest 2 = Weaker 3 = Neutral 4 = Stronger 5 = Strongest	3				
3. Provide high quality, integrated healthcare to non-AD/RC beneficiaries The alternative should maintain or enhance the ability of the system to sustain the current high quality of healthcare that it provides at the current levels of integration between services as well as private sector.	21%	1 = Weakest 2 = Weaker 3 = Neutral 4 = Stronger 5 = Strongest	3				
4. Achieve significant cost savings through reduction in duplication and variation Alternative should result in a reduction of the system operating costs.	17%	1 = Weakest 2 = Weaker 3 = Neutral 4 = Stronger 5 = Strongest	3				
5. Dispute resolution and clear decision authority with clear accountability Alternative should provide clear decision authority and dispute resolution at the lowest appropriate level, including clear lines of accountability.	6%	1 = Weakest 2 = Weaker 3 = Neutral 4 = Stronger 5 = Strongest	3				
6. Ease of implementation Alternative should be implementable taking in to account Title 10 equities; short term costs, long term savings; and decisions required inside/outside of the DoD.	5%	1 = Weakest 2 = Weaker 3 = Neutral 4 = Stronger 5 = Strongest	3				
7. Enhance interoperability Alternative should facilitate interoperability among Services.	3%	1 = Weakest 2 = Weaker 3 = Neutral 4 = Stronger 5 = Strongest	3				

Figure 3. Sample Voting Sheet for Assessing Organizational Models

Analysis of the voting results indicated that some voters, rather than arraying the alternatives from weakest to strongest, tended to score their preferred choice as strongest ("5") and all other alternatives as weakest ("1"). This was particularly evident in the later voting that determined the final options for the MHS, MSM, and NCR governance constructs. In those cases, the votes were both scored and ranked for each voting member.

Estimate of Staffing Requirements

In support of the Terms of Reference criteria to evaluate options based on the potential to achieve significant cost savings through reduction in duplication and variation, the Task Force collected data on the organizational structure and staffing levels (military, civilian, and contractor) of the existing headquarters, intermediate command, and field activities of Health Affairs (HA), TRICARE Management Activity (TMA), the offices of the Surgeons General, and the JTF CAPMED. The purpose was to develop a baseline of existing headquarters staffing and to provide an initial analysis of whether the options under consideration offered greater or lesser efficiencies in overall headquarters staffing.

Our analysis was based on, and extended parts of, a similar analytical model performed by the Center of Naval Analyses in support of the 2006 MHS Governance work group. The Task Force recognized the highly preliminary nature of the data presented here. The 90-day review period did not allow for a more rigorous approach, but rather a "rough order of magnitude" estimate of staffing increases or reductions based on the organizational construct being considered. The preliminary findings suggested that the Defense Health Agency with medical treatment facilities, Defense Health Agency without medical treatment facilities, and single-Service models would achieve a similar savings in Full Time Equivalents (FTEs) while the Unified Medical Command shows a growth in FTEs required.

A high-level description of the initial baseline estimates is provided in Appendix 5 to this report. Nonetheless, it is the consensus of the Task Force that a more comprehensive analysis should be undertaken by those responsible for implementing recommendations put forward by this Task Force and accepted by the Deputy Secretary of Defense.

MHS Governance Background

Since the Department of Defense was first established in 1947, the issue of MHS governance has been the subject of multiple studies, internal and external Task Forces, and recommendations from Congress, Defense Boards, and independent think tanks. The historical record shows that more than 15 studies have been performed. Table 3 below summarizes the key studies performed over the last 30 years that informed the Task Force's deliberations.

Year	Study	Requester	Author	Recommendation	Outcomes
2006	Unified Medical Command Working Group	Deputy Secretary of Defense	Internal Working Group	Unified Medical Command (UMC)	Deputy Secretary of Defense Memo (Nov 2006) directed further consolidation, but not UMC
2006	Defense Business Board	Deputy Secretary of Defense	External Board	Unified Medical Command	
2003	RAND Report	Under Secretary of Defense for Personnel and Readiness (USD P&R)	The RAND Corporation	Modify current structure to unify health plan management	Establishment of multi-Service market responsibilities and authorities.
2000	Defense Medical Oversight Committee (DMOC)	Chairman, DMOC	Internal Team with KPMG LLP	Unified Medical Command	Not implemented
1991	DoD Organization of DoD Medical Care	Deputy Secretary of Defense	Office of the Secretary of Defense, Director of Administration and Management (OSD DA&M)	Single leader (did not specify UMC or a Defense Health Agency)	Establishment of Defense Health Program (DHP)
1983	Defense Health Agency Feasibility Study	Senate Armed Services Committee	SRA International, Inc.	Defense Health Agency	None

Table 3. Summary of MHS Governance Studies, 1983-Present

Although many of the various task forces and study groups recommended major organizational realignments, the Department of Defense did not implement these overarching recommendations. Instead, the Department implemented a number of important policy and program changes that have incrementally increased the interoperability and jointness of both combat and peacetime health care delivery.

Another critical factor that led to these studies and many programmatic changes in the Department was the many efforts to control the increase in health care costs. In particular, over the last 10 years, the Department has experienced significant growth in health care costs –

increases driven principally by four factors: (1) new and expanded health care benefits, particularly TRICARE For Life, which offered new benefits for Medicare-eligible military retirees and retired family members; (2) an increased number of overall military beneficiaries, as military end-strengths were increased for combat operations; (3) increases in the utilization of services on a per capita basis, particularly behavioral health, orthopedic and emergency room services; and (4) general health care inflation consistent with the rest of American society as new technology, financial incentives, and an aging population all serve as inflationary influences.

The focus on governance, in this respect, is to create a system that is both more efficient in terms of headquarter size, but more importantly, that is more agile, has greater unity of effort, and can rapidly and comprehensively implement cost-effective approaches to health care delivery. Figure 4 highlights the relative budget size of the headquarters function as compared to other major components of the Defense Health Program (DHP).

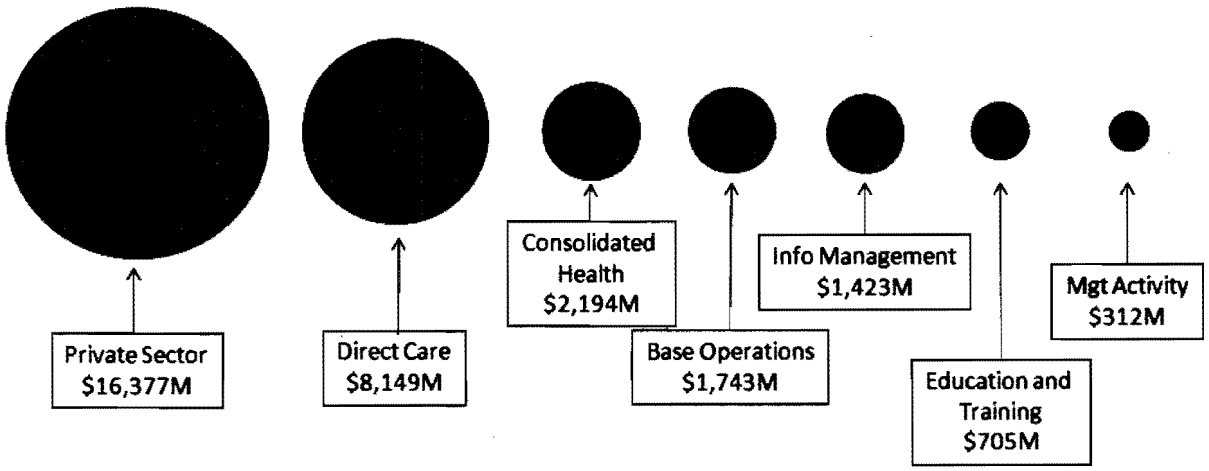


Figure 4. Relative Size of Defense Health Program (DHP) Budget Activity Groups

The Task Force role was to develop effective governance constructs for the MHS, MSM, and NCR that can influence and shape a more cost-effective and efficient delivery of direct and purchased health care.

Current Structure of MHS Governance

The Task Force reviewed the current structure and state of the MHS to lay a foundation for comparing options. The organization and governance structure of the MHS is depicted in Figure 5 (the current governance of multi-Service markets and of the National Capital Region is discussed separately in the sections below).

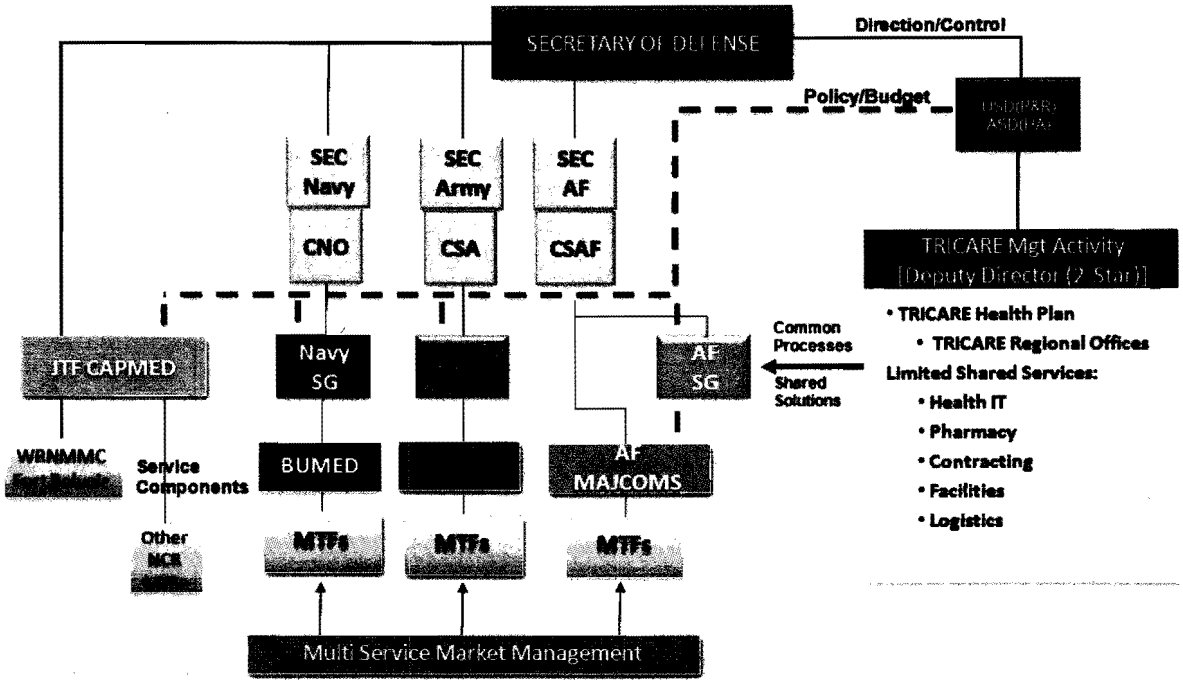


Figure 5. Current Structure of MHS Governance

The Assistant Secretary of Defense for Health Affairs (ASD(HA)) reports to the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) and serves as the senior medical advisor to the Secretary of Defense. The ASD(HA) is provided with considerable authorities that are unique within the Department.

According to DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs," subject to the authority, direction, and control of the USD(P&R), the ASD(HA): "shall exercise authority, direction and control over DoD medical and dental personnel authorizations and policy, facilities, programs, funding, and other resources in the Department of Defense." The DoD Directive clarifies this authority to state that the ASD(HA) "may not direct a change in the structure of the chain of command within a Military Department or with respect to medical personnel assigned to that command." The ASD(HA) is responsible for creating and submitting a unified medical budget. As a major part of this requirement, the Defense Health Program (DHP) is a separate appropriation in the Defense budget, with the ASD(HA) responsible for allocating funds to the Military Departments for their respective medical systems, as well as to the TRICARE Management Activity (TMA). In addition to these authorities, the ASD(HA) is currently dual-hatted as the Director, TMA.

The Secretaries of the Military Departments establish their own organizational and reporting chains for their respective health systems. Other than the National Capital Region, the Military

Departments each manage their own medical treatment facilities, the commanders of which report through their respective chains to the Military Department Secretary. The Army and Navy have vested their Surgeons General with command authorities through intermediate headquarters over the MTF commanders. The Surgeon General of the Air Force serves as the senior medical advisor to the Chief of Staff and Secretary of the Air Force; MTF commanders do not report to the Air Force Surgeon General, but rather directly to their local line commanders.

Each of the Military Departments assigns their medical personnel to Table of Organization and Equipment (TOE) or Table of Distribution and Allowance (TDA) requirements/authorizations documents. The TOE documents prescribe the wartime mission, organizational structure, and personnel and equipment requirements for a military unit. The TDA documents prescribe the organizational structure and personnel and equipment requirements of a military unit for which there is no TOE. The Army has traditionally placed a much higher number of their personnel in TOE (wartime) organizational structures, even in stateside locations, while the Navy and Air Force placed fewer of their stateside active duty forces into TOE organizations. Instead, upon deployment, the TDA forces are assigned to TOE units. The distinction between TOE and TDA forces becomes important in the governance discussion as the assignment of both TOE and TDA forces creates differing command relationships, particularly in medical treatment facilities, as the TOE forces are almost always assigned and led through Service-specific chains of command. TOE forces may be "embedded" within a TDA unit, but their reporting structures don't follow the TDA chain of command.

In 2003, following the consolidation of TRICARE Regions and the award of new TRICARE contracts, the Under Secretary of Defense for Personnel and Readiness issued a policy memorandum on TRICARE governance (see Appendix 2). This memorandum identified 11 multi-Service markets (MSMs) in the United States (it did not address MSMs in overseas locations); identified the single senior market manager in these MSMs; stipulated the process and appeal route for resolving disputes within the Services; and outlined the business planning process in these markets. The current governance of multi-Service markets is discussed further in the section titled "Multi-Service Market Governance" later in the report.

In 2007, an additional medical organizational structure and new reporting chain was established with the creation of the Joint Task Force National Capital Region Medical (JTF CAPMED) to manage the delivery of health services in the NCR market and to oversee the execution of the BRAC-directed transitions (see Appendix 3). The command includes the two post-BRAC inpatient medical facilities in the NCR, the Walter Reed National Military Medical Center (WRNMMC), and Fort Belvoir Community Hospital (FBCH), as well as several other clinics in the region. The two inpatient medical facilities are Joint Commands assigned to the JTF, with the JTF Commander reporting to the Secretary of Defense through the Deputy Secretary of Defense, a unique reporting relationship within the MHS. The current governance of the National Capital Region is discussed further in the National Capital Region Governance section of the report.

The ASD(HA) closely coordinates policy and programming decisions with the Military Departments and the Commander, JTF CAPMED, through a structured policy review and decision-making process.

In March 2011, the Secretary of Defense, as part of a Department-wide organizational efficiency review, directed the ASD(HA) to rename and reorganize the TRICARE Management Activity to become the MHS Support Activity. This re-organization was intended to separate and formalize

the TMA functional responsibilities that extend well beyond TRICARE Health Plan activities and drive greater efficiency in the delivery of shared services in the MHS. The pertinent sections of this memorandum are provided as Appendix 4. The specific actions to implement this reorganization have not yet been executed, pending decisions on the broader governance issues being considered by the Task Force.

It is important to note that the Task Force agrees that a great opportunity exists to accelerate the process for a shared services model across a range of common MHS activities. These activities include, but are not limited to: medical education and training, medical logistics, facility planning and construction, health information technology, medical research and development, public health, acquisition, and other common clinical and business processes. A more detailed evaluation and plan for delivering shared services is recommended.

Options for Future MHS Governance

The Task Force considered multiple variations of organizational models for overall governance of the MHS. A detailed description of each organizational variation is provided in Volume II, Appendix 1, to be delivered at a later date. After evaluating all of these models, the Task Force selected the following five MHS governance options to develop for further consideration. These options are described in detail below, to include reporting chains, responsibilities, and authorities as required by the Terms of Reference.

MHS Option 1: As Is - Current Structure

The current functions, responsibilities, and reporting relationships of the Military Departments and the TRICARE Management Activity (TMA) would be maintained as described below. Modification to reporting relationships in multi-Service markets and in the National Capital Region is possible. Specifically, the direct care system of 56 hospitals, 363 medical clinics, and 282 dental clinics would continue to be operated by the three Military Departments; TMA would manage the TRICARE health plan and lead collaborative efforts on selected shared support services; the Assistant Secretary of Defense for Health Affairs (ASD(HA)) would retain MHS-wide policy and budgetary authority.

Elements and Authorities of MHS Option 1: As Is - Current Structure

Item	TOR Elements	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The ASD(HA) would be responsible for all authority, direction, and control of policy and resources of the MHS as a whole, consistent with DoD Directive 5036.01.
2	Head of entity or entities, and the reporting chain to the Secretary of Defense.	Military Department reporting chains would remain as they currently exist with Service Surgeons General reporting to their Service Chiefs who would report to their Military Department Secretaries who would report to the Secretary of Defense.
3	Management and supervisory chains of MTFs.	MTF commanders would report through their established Military Department chains of command.
4	Management and supervisory chains of multi-Service markets.	Based on the selection for MSM governance (see Section, "Multi-Service Market Governance" further in this report).
5	The authority, direction, and control for mission/administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities	The authority, direction, and control over MHS personnel would reside within the Military Departments.
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	The DHP would be sustained, and authority over the DHP would reside with the ASD(HA).
7	The policymaking authority among OSD, the Services, and/or joint entities.	The ASD(HA) would execute policy.
8	Management of purchased care and other functions currently performed by the TRICARE Management Activity.	The Director, TMA (currently dual-hatted by the ASD(HA)) would manage purchased care and other TMA functions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education and training, and other shared services, related functions.	Shared services activities, including but not limited to, this listing would be delivered though a collaborative process between the ASD(HA) and the Military Departments.
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	The ASD(HA) would continue the responsibilities outlined in DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs," and as Director, TRICARE Management Activity. The Military Departments would continue to be responsible for management and oversight of their military medical personnel, medical readiness programs, and health care delivery within their respective medical treatment facilities. The Military Department Secretaries would be responsible for assigning duties to their respective Surgeons General and organizing their medical forces.
11	Effect on the Guard and Reserve forces.	No effect would be anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 4. Elements and Authorities of MHS Option 1: As Is - Current Structure

Strengths, Weaknesses, and Barriers of MHS Option 1: As Is - Current Structure

Strengths of As Is - Current Structure	
• **Ease of Implementation:** This organizational construct remains as it is, without any organizational upheaval.	
Weaknesses of As Is - Current Structure	
• **Lines of Authority:** Does not establish undivided MHS authority, direction, and control over entire system. • **Enhance Interoperability:** This option fails to take advantage of consensus opportunities to more rapidly implement common clinical and business processes across the system. • **Achieve Significant Cost Savings through Reduction in Duplication and Variation:** Fails to introduce a broader set of shared services that can be delivered more efficiently to the end customer.	
• There are no barriers to implementation	• None

Table 5. Strengths, Weaknesses, and Barriers of MHS Option 1: As Is - Current Structure

MHS Option 2: A Defense Health Agency (DHA) with Medical Treatment Facilities (MTFs) Remaining in the Military Departments

A Defense Health Agency would be established (replacing TMA) and would be focused on consolidating and delivering a far broader set of shared health care support services. MHS-wide shared services activities include, but are not limited to: the TRICARE health plan; pharmacy programs; medical education and training; medical logistics; facility planning; health information technology; medical research and development; health information technology; facility planning; public health; acquisition; and other common clinical and business processes. The Task Force recommends the DHA be led by an 3-Star general or flag officer who reports to the Assistant Secretary of Defense (Health Affairs) and that the DHA be designated a Combat Support Agency to fulfill support functions for joint operating forces across the range of military operations, and in support of combatant commanders executing military operations. The Chairman of the Joint Chiefs of Staff oversees the planning and execution of each CSA's combat support missions and, among other responsibilities, provides military advice and planning guidance to the CSAs and the combatant commanders in the preparation of their operational plans.

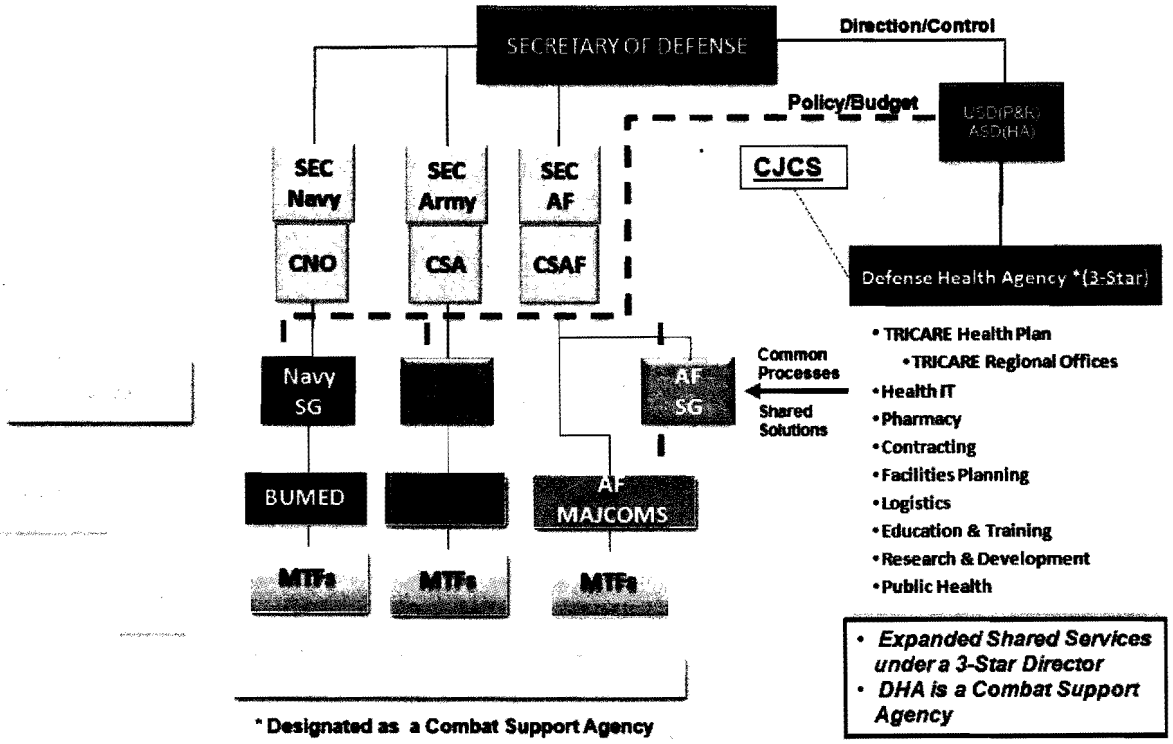


Figure 6. MHS Option 2: Defense Health Agency (DHA) with Medical Treatment Facilities (MTFs) Remaining in the Military Departments

The Military Departments would retain ownership and oversight of their respective medical treatment facilities (MTFs). The specific authorities, responsibilities, and reporting relationships of the DHA are provided below in Table 6.

Elements and Authorities of MHS Option 2: A Defense Health Agency with Medical Treatment Facilities (MTFs) in Military Departments

Item	TOR Elements	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The ASD(HA) would be responsible for all authority, direction, and control of policy and resources of the MHS as a whole, consistent with DoD Directive 5036.01.
2	Head of entity or entities, and the reporting chain to the Secretary of Defense.	Component reporting chains would remain as they currently exist with Service Surgeons General reporting to their Service Chiefs who would report to their Military Department Secretaries who would report to the Secretary of Defense. The Director, Defense Health Agency (DHA), would report to the ASD(HA) who would report to the USD (P&R) who would report to the Secretary of Defense.
3	Management and supervisory chains of MTFs.	MTF commanders would report through their established Military Department chain of command.
4	Management and supervisory chains of multi-Service markets.	Based on the option selected for MSM governance (see Section, "Multi-Service Market Governance" further in this report).
5	The authority, direction, and control for mission and administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities.	The authority, direction, and control over MHS personnel would reside within the Military Departments, except for those assigned directly to the DHA.
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	The DHP would be sustained, and authority over the DHP would reside with the ASD(HA). The Service Surgeons General and the DHA would develop their own DHP inputs to ASD(HA).
7	The policymaking authority among OSD, the Services, and/or joint entities.	The ASD(HA) would execute policy through the Director, DHA.
8	Management of purchased care and other functions currently performed by the TRICARE Management Activity.	The Director, DHA, would assume control of TRICARE contracts and all other TMA functions, with the exception of select financial management activities which would migrate to the OASD(HA).
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education and training, and other shared services and related functions.	All shared services activities, including but not limited to, this listing would be delivered under the authority, direction and control of the Director, DHA.
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	The ASD(HA) would retain most responsibilities outlined in DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs," and would supervise the Director, DHA. The Military Departments would continue to be responsible for management and oversight of their military medical personnel, medical readiness programs, and health care delivery within their respective medical treatment facilities. The Military Department Secretaries would be responsible for assigning duties to their respective Surgeons General and organizing their medical forces. The Director, DHA, would assume all responsibilities currently

Item	TOR Elements	Outcome
		outlined in DoD Directive 5136.12 "TRICARE Management Activity", and would have the authority to issue program guidance regarding medical research and development, health information technology, military medical logistics, military medical construction, medical education and training, and all other responsibilities as provided by the Secretary of Defense.
11	Effect on the Guard and Reserve forces.	No effect is anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 6. Elements and Authorities of MHS Option 2: Defense Health Agency with Medical Treatment Facilities (MTFs) in Military Departments

Strengths, Weaknesses, and Barriers of MHS Option 2: Defense Health Agency with Medical Treatment Facilities (MTFs) in Military Departments

Strengths of a Defense Health Agency with MTFs in Military Departments	
• **Achieve Significant Cost Savings through Reduction in Duplication and Variation:** The DHA would be focused on the most common theme emphasized by the Task Force - implementation of an organizational model that would accelerate implementation of shared services, identify and proliferate common clinical and business practices, and consider entirely new approaches to delivering shared activities. A single clinical and business system would allow for significant savings. • **Ease of Implementation:** This organizational construct would retain those elements of the existing MHS governance structure that do not require major organizational upheaval (as would any Unified Medical Command model or more comprehensive DHA option). Would place a general or flag officer, of any medical corps, as the director, creating a fourth military-led entity of the MHS. • **Readiness Mission:** The establishment of the DHA as a Combat Support Agency would provide a means for line oversight of the MHS and DHA activities through the Chairman, Joint Chiefs of Staff – ensuring readiness missions and line priorities would remain paramount. • **Other:** This organizational option, while building upon existing structures, also would have the advantage of serving as a potential platform for assessment of future governance constructs.	
Weaknesses/Barriers of Defense Health Agency with MTFs in Military Departments	
• **Lines of Authority:** Would not establish undivided MHS authority, direction, and control over the entire system, and would add complexity to the coordination of deployments between Services and the DHA.	
• **Other:** Would require an approach for Health Affairs to oversee and manage its financial and internal control responsibilities at the same time that dual-hatting is eliminated.	• Appropriate modifications to OSD/Health Affairs staffing levels, in light of enhanced oversight mission, would be explored.

Table 7. Strengths, Weaknesses, and Barriers of MHS Option 2: Defense Health Agency with Medical Treatment Facilities (MTFs) in Military Departments

MHS Option 3: A Defense Health Agency with Medical Treatment Facilities (MTFs) placed under the Agency

A Defense Health Agency would be established with the functions and reporting relationships described in the DHA option above. Additionally, all MTFs would be transferred to the DHA and would operate under its authority, direction, and control. The Military Departments would continue to own all military personnel and be responsible for organizing, training, and equipping their deployable military medical forces. Personnel requirements of the Services' operational forces needed for deployment and/or training would be requested through the Director, DHA.

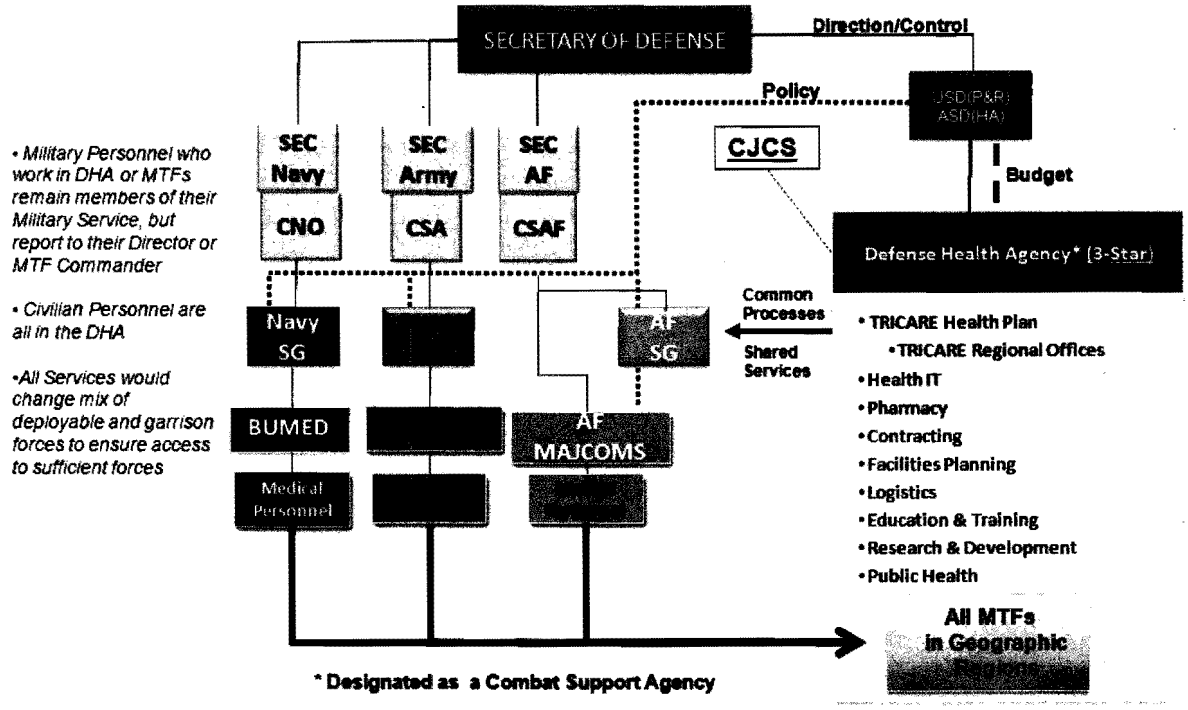


Figure 7. MHS Option 3: Defense Health Agency with Medical Treatment Facilities (MTFs) placed under the authority, direction, and control of the Agency

Elements and Authorities of MHS Option 3: Defense Health Agency with Medical Treatment Facilities (MTFs) under the Agency

Item	TOR Elements	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The Director, DHA, would be responsible for authority, direction, and control of the MHS. ASD(HA) would have an oversight and policy role. Military Departments would be responsible for the size and capabilities of the active duty medical forces.
2	Head of entity or entities, and reporting chain to the Secretary of Defense.	Component reporting chains for headquarters and TOE-assigned military personnel would remain as they currently exist. Service Surgeons General would continue reporting to their Service Secretaries who would report to the Secretary of Defense, but overall reporting chains would be changed for garrison care. The Director, DHA reports to the ASD(HA), who reports to the

Item	TOR Elements	Outcome
		USD (P&R), reporting to the Secretary of Defense.
3	Management and supervisory chains of MTFs.	MTF commanders would report through intermediate commands established by the Director, DHA.
4	Management and supervisory chains of multi-Service markets.	As all medical treatment facilities would be operated by the DHA, vice the Services, the concept of multi-Service markets would no longer be applicable.
5	The authority, direction, and control for mission and administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities.	The Director, DHA, would have authority, direction, and control over MHS personnel assigned to the medical treatment facilities within rules established with the Military Department Secretaries. TOE forces would report through Service structures.
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	Authority over the DHP would reside with the Director, DHA, with oversight from ASD(HA).
7	The policymaking authority among OSD, the Services, and/or joint entities.	The ASD(HA), subject to the authority, direction, and control of USD (P&R), would be the senior policy authority in the MHS. Director, DHA, would execute policy through the DHA structure. Policy matters would be coordinated with the Director, DHA, and Military Department Secretaries.
8	Management of purchased care and other functions currently performed by TMA.	The Director, DHA, would assume control of TRICARE contracts and all other TMA functions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education/training, and other shared services and related functions.	The Director, DHA, would control all shared and common functions.
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	The ASD(HA) would retain policy-making activities, and would supervise the Director, DHA. The Service Components would continue to be responsible for management and oversight of their medical readiness programs. The Director, DHA, would assume budgetary control of the DHP and all responsibilities currently outlined in DoD Directive 5136.12, "TRICARE Management Activity," and would have the authority to issue program guidance regarding medical research and development, health information technology, military medical logistics, military medical construction, medical education and training, and all other responsibilities as provided by the Secretary of Defense. The Director, DHA, would also have overall supervision of all medical treatment facilities.
11	Effect on the Guard and Reserve forces.	No effect is anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 8. Elements and Authorities of MHS Option 3: Defense Health Agency (DHA) with Medical Treatment Facilities (MTFs) under the Agency

Strengths, Weaknesses, and Barriers of MHS Option 3: Defense Health Agency with Medical Treatment Facilities (MTFs) under the Agency

Strengths of a DHA with MTFs under the Agency	
• **Dispute Resolution/Lines of Authority/Accountability:** Would place management of all medical treatment facilities under one authority (Director, DHA), albeit at the expense of long-standing practice of management by Military Departments. The Director, DHA, would report directly to the ASD(HA). • **Achieve Significant Cost Savings Through Reduction in Duplication and Variation:** As with Option 2, the DHA would be focused on the most common theme emphasized by the Task Force – an organizational model that would accelerate implementation of shared services models that identify and proliferate best practices and consider entirely new approaches to delivering shared activities. Further, placement of medical treatment facilities under the DHA would allow for even more rapid implementation of unified clinical and business systems, which could create significant savings. • **Other:** Would align management of purchased care (TRICARE) and direct care (medical treatment facilities) under one entity, creating potential for greater coordination and cost-effective distribution of resources between the two sources of care.	
[illegible]	
• **Medical Readiness:** Concerns were expressed that an organization this large with this many authorities could jeopardize Services priorities. A comprehensive DHA could reduce command and leadership development opportunities. • **Dispute Resolution/Lines of Authority/Accountability:** This model may elevate management disputes to the highest levels of the DoD, as local line command disputes with the DHA command structure may need to be adjudicated at the level of the Secretary of the Military Department /ASD(HA) level. • **Ease of Implementation:** Moving all medical treatment facilities to the DHA would be a major reorganization. • **Other:** Could mix the DHA mission between support of MHS-wide functions and direct operation of hospitals and clinics. The Military Department's representatives on the Task Force believed that operation of the direct care system is a Military Department responsibility.	
[illegible]	[illegible]
• Would require increase or transfer of personnel into OSD manpower levels for Health Affairs to accommodate the migration of financial management/oversight personnel from the field activity to OSD.	• Appropriate modifications to OSD/Health Affairs staffing levels, in light of enhanced oversight mission, would be explored.

Table 9. Strengths, Weaknesses, and Barriers of MHS Option 3: Defense Health Agency with MTFs under the Agency

MHS Option 4: Unified Medical Command (UMC) with Service Components

A tenth unified combatant command (U.S. Medical Command) would be established, led by a 4-Star general or flag officer and reporting directly to the Secretary of Defense. Medical forces would be provided by Service Components, but the Unified Medical Command would be responsible for overall direction and leadership of the Military Health System. Components would establish subordinate medical command structures which would manage the medical treatment facilities. This option for a Unified Medical Command would include a Unified Medical Command Headquarters and a subordinate Joint Health Support Command to manage shared services as well as the TRICARE Health Plan. The proposed structure of this Unified Medical Command is depicted in Figure 8. Services maintain control of their deployable forces (TOE) with force generation responsibilities. The U.S. Medical Command would have operational control of the garrison (TDA) forces that would be identified through a Joint Table of Distribution (JTD) or Joint Manning Document (JMD). The ASD(HA) would continue to have a policy role.

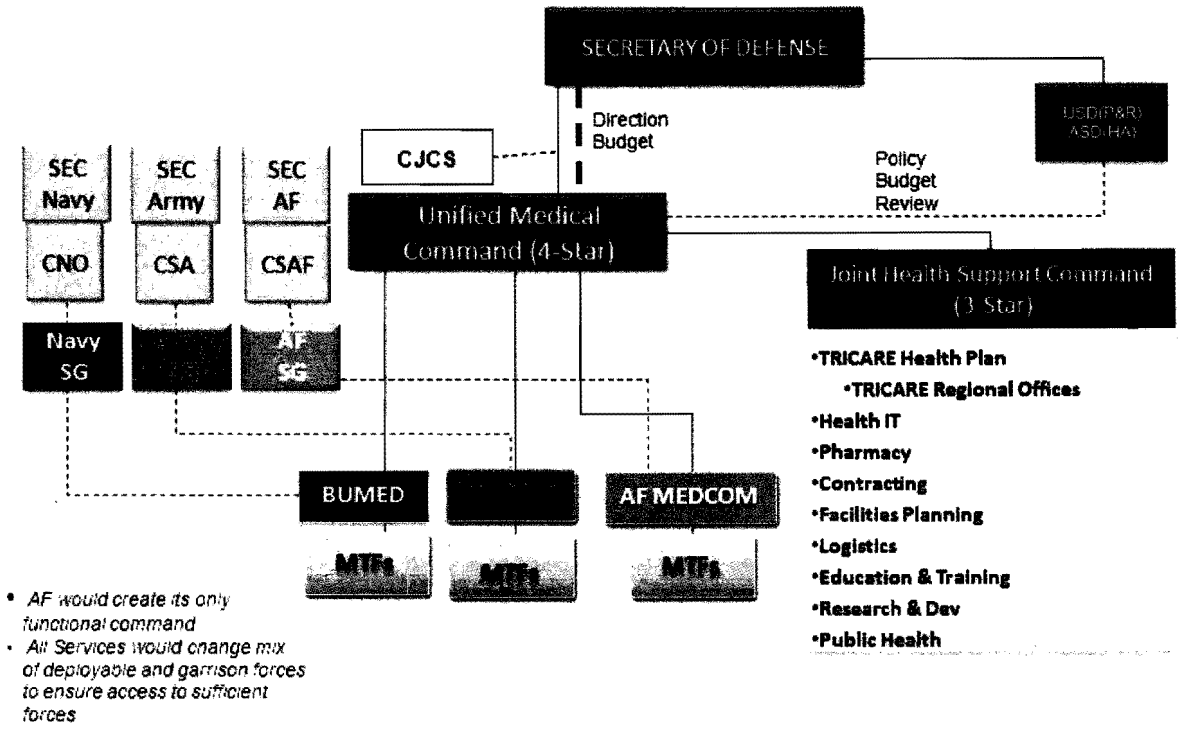


Figure 8. MHS Option 4. Unified Medical Command with Service Components

Elements and Authorities of MHS Option 4: Unified Medical Command with Service Components

Item	TOR Elements	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The Commander, U.S. Medical Command, would be responsible for authority, direction, and control of the MHS as a whole through its components.

Item	TOR Elements	Outcome
2	Head of entity or entities, and reporting chain to the Secretary of Defense.	The Commander, U.S. Medical Command, would report directly to the Secretary of Defense.
3	Management and supervisory chains of MTFs.	MTF commanders would report through their components to the U.S. Medical Command.
4	Management and supervisory chains of multi-Service markets.	The Commander, U.S. Medical Command, would designate the Market manager. Supervisory chains would continue through their Service Components. Larger, complex entities like the NCR may report outside component chains.
5	Authority, direction, and control for mission/ administrative support matters over MHS personnel among OSD, Military Departments, and/or joint entities.	The authority, direction, and control over assigned MHS personnel would reside within the Service Components of the U.S. Medical Command, who report to the UMC commander.
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	Authority over the DHP would reside with the Commander, U.S. Medical Command.
7	The policymaking authority among OSD, the Services, and/or joint entities.	The ASD(HA), subject to the authority, direction and control of the USD (P&R), would be the senior policy authority within the MHS. Policy matters would be coordinated with the UMC commander and Military Departments.
8	Management of purchased care and other functions currently performed by the TRICARE Management Activity.	The Commander, U.S. Medical Command, would assume control of TRICARE contracts and all other TMA functions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education/training, and other shared services/related functions.	The Commander, U.S. Medical Command would be responsible for managing and directing shared and common functions through the subordinate Joint Health Support Command.
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	The ASD(HA) responsibilities would be delineated in an updated DoD Directive focused only on policy-making activities. The Service Components would continue to be responsible for management and oversight of their military medical personnel and medical readiness programs. The Service Secretaries would be responsible for assigning duties to their respective Surgeons General and organizing their medical forces. The Unified Command Plan (UCP) would establish the missions and responsibilities for the UMC, which should include responsibilities currently outlined in DoD Directive 5136.12, "TRICARE Management Activity," and would have the authority to issue operational and program guidance regarding medical research/development, health information technology, medical logistics, medical construction, medical education and training.
11	Effect on the Guard and Reserve forces.	No effect is anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 10. Elements and Authorities of MHS Option 4: Unified Medical Command with Service Component

Strengths, Weaknesses, and Barriers of MHS Option 4: Unified Medical Command with Service Components

Strengths of a Unified Medical Command with Service Components	
• **Dispute Resolution/Lines of Authority/Accountability:** Clear lines of authority would be established. • **Achieve Significant Cost Savings Through Reduction in Duplication and Variation:** There would be central control of common business and clinical processes, and implementation would be achieved more readily with command and control throughout the medical structure to ensure compliance. • **Ease of Implementation:** JTF CAPMED, if retained in its current form, could be addressed as a Region directly reporting to the Commander, U.S. Medical Command.	
Weaknesses of a Unified Medical Command with Service Components	
• **Achieve Significant Cost Savings Through Reduction in Duplication and Variation:** In any UMC model that maintains Service Components (the common model for all unified commands), the overall management headquarters overhead would increase above "As Is" and all other organizational models. • **Dispute Resolution/Lines of Authority/Accountability:** The current structure of civilian authority over components of the MHS (the ASD(HA) and Military Department Secretaries) would not be maintained; the first civilian official in the authority chain would be the Secretary of Defense. • **Ease of Implementation:** This action would represent a significant departure in governance for all existing organizations (Health Affairs, TMA, Military Department Secretaries, Military Service Chiefs, Service Medical Departments). For the Air Force, this includes creating a medical component command for operation of Air Force medical treatment facilities; the Navy would need to redesign how garrison billets are mapped to operational requirements.	
• **Medical Readiness:** Would alter the process for deployment of forces. • **Other:** A new Unified Command would have to be established by the President of the United States.	• It is understood that the establishment of the UMC would require a disciplined implementation with major changes in all activities.

Table 11. Strengths, Weaknesses, and Barriers of MHS Option 4: Unified Medical Command with Service Components

MHS Option 5: Single Service – One Military Department Secretary Assigned Responsibility for the MHS

One Military Department Secretary would be assigned responsibility for the management of the MHS. Military medical treatment facilities would be transferred to the authority, direction and control of the designated Military Department (e.g., if Navy is the designated Service, all hospitals and clinics would become Navy medical facilities). Each Military Department would continue to be responsible for organizing, training and equipping its deployable military medical (TOE) forces, but this would occur through assignment to operational platforms in medical treatment facilities run by the designated Military Department Secretary. The medical treatment facilities would be run by the designated Military Department, and would be staffed by personnel from all of the Military Departments. The designated Military Department would operate the TRICARE health plan and would have control over the Defense Health Program. The Assistant Secretary of Defense for Health Affairs (ASD(HA)) would retain policy authority within the MHS. This option is depicted inFigure 9.

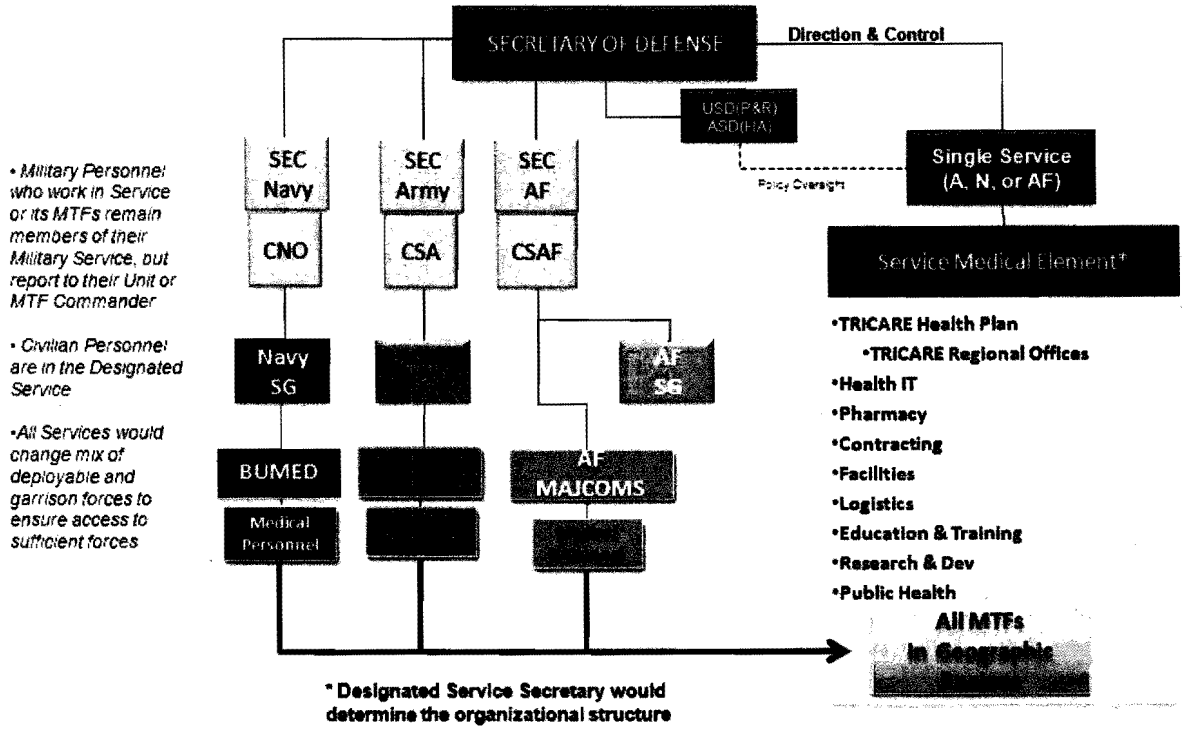


Figure 9. MHS Option 5: Single Service

Elements and Authorities of MHS Option 5: Single Service

Item	TOR Elements	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The designated Military Department Secretary would be responsible for the management and oversight of the MHS.
2	Head of alternative and reporting chain to the Secretary of Defense.	The designated Military Department Secretary would establish a medical organizational model as they determine is best suited to manage the MHS (likely with geographic or regional intermediate headquarters). The leader of the medical organization would report to the Military Department Secretary. The Military Department Secretary would report to the Secretary of Defense.
3	Management and supervisory chains of MTFs.	MTF commanders would report through the organizational model that the designated Military Department Secretary has put into place, through the Military Department chain of command. There may be an intermediate command structure put in to place by the Military Department Secretary based on geographic or functional mission considerations.
4	Management and supervisory chains of multi-Service markets.	There would be no multi-Service markets. All MSMs would function under one Service.
5	The authority, direction, and control for mission and administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities.	The Military Department Secretary would have authority, direction, and control over MHS TDA personnel assigned to the medical treatment facilities. TOE forces would report through their separate Service structures.
6	The budgetary authority for the Defense Health Program among OSD, the Military Departments and/or joint entities.	Authority over the DHP would reside with the designated Military Department Secretary.
7	The policymaking authority among OSD, the Services, and/or joint entities.	The ASD(HA), subject to the authority, direction and control of the USD(P&R), would serve as the senior medical advisor to the Secretary of Defense, and retains policy authority within the MHS. The designated Military Department Secretary would execute ASD(HA) policy directives.
8	Management of purchased care and other functions currently performed by the TRICARE Management Activity.	The designated Military Department Secretary would assume control of TRICARE contracts and all other TMA functions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education and training, and other shared services and related functions.	Medical shared services activities would move to the single designated Military Department Secretary.
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	The ASD(HA) would retain most responsibilities as delineated in an updated DoD Directive and focused on policy-making activities. The Service Components would be responsible for identifying their requirements for medical support to the designated Military Department Secretary. The designated Military Department Secretary would assume all responsibilities currently outlined in DoD Directive 5136.12, "TRICARE Management Activity," and would have the authority to issue operational and program guidance regarding

Item	TOR Elements	Outcome
		medical research and development, health information technology, military medical logistics, military medical construction, medical education and training, and all other responsibilities as provided by the Secretary of Defense.
11	Effect on the Guard and Reserve forces	No effect is anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 12. Elements and Authorities of MHS Option 5: Single Service

Strengths, Weaknesses, and Barriers of MHS Option 5: Single Service

Strengths of a Single Service	
• **Dispute Resolution/Lines of Authority/Accountability:** Clear lines of authority and chain of command from Secretary through the MTF commander would be established. • **Achieve Significant Cost Savings Through Reduction in Duplication and Variation:** With shared services, there would be one set of business and clinical processes and implementation would be achieved more readily with command and control in a single Service. It also would eliminate the issues that arise with multi-Service markets. This option would create the most significant savings in headquarters overhead of any organizational option.	
Weaknesses of a Single Service	
• **Medical Readiness:** With medical personnel still "owned" by their Components, a requirement for coordination between Service Chiefs and Military Department Secretaries on readiness and personnel issues would remain. • **Ease of Implementation:** There is no known precedent or example where this approach has been tested in other military medical organizations worldwide. The Navy/USMC medical support model does not have the mission for all of the DoD; however, it is representative of how a Single Service model could work. Additionally, this option would entail a large scale reorganization to include re-mapping of Service medical personnel to operational platforms. • **Dispute Resolution/Lines of Authority/Accountability:** Issues would be adjudicated at a higher level (Military Department Secretary).	
Barriers	**Mitigations**
• There would be a need to overcome perceptions of bias toward the facilities serving the forces of the designated Military Department Secretary, and the level at which these issues would need to be adjudicated.	• Management controls and oversight processes would need to be transparent.

Table 13. Strengths, Weaknesses, and Barriers of MHS Option 5: Single Service

Task Force Voting Results: MHS Governance

Vote	MHS Option 1: As Is - Current Structure		[redacted]	MHS Option 3: DHA with MTFs placed under the Agency		MHS Option 4: UMC with Service Components		MHS Option 5: Single Service	
	Raw Score	Ranked Score		Raw Score	Ranked Score	Raw Score	Ranked Score	Raw Score	Ranked Score
A	3	3		3.5	2	2.75	4	2.52	5
B	3	3		2	4	5	1	1	5
C	3	2		1.89	4	1.75	5	2.92	3
D	3	2		1	4	1	4	1	4
E	3	4		3.12	2	3.03	3	2.09	5
F	3	4		3.24	3	3.25	2	3.25	1
G	3	4		3.35	1	2.93	5	3.32	2
H	3	4		4.21	1	2.53	5	3.42	3
I	3	4		3.67	2	3.01	5	3.49	3
Average	**3**	**3.33**		**2.89**	**2.56**	**2.81**	**3.78**	**2.56**	**3.44**

Table 14. Task Force Voting Results for MHS Governance

Note: Raw Score Scale: (1) weakest and (5) strongest based on the application of the weighted criteria.
Ranked Score derived from the raw score and ordered from first (1) to last (5).

Task Force Recommendation:

The Task Force recommends implementation of MHS Option 2 - Establish a Defense Health Agency with MTFs remaining with the Military Departments. This Defense Health Agency would be focused on consolidating and delivering a broader set of shared health services, and implementing common clinical and business processes. This recommendation builds upon the direction in Secretary Gates' March 2011 memorandum that directed greater shared services within the MHS.

The Task Force recommends the DHA be designated as a Combat Support Agency for its combat support mission responsibilities, which would include oversight by the Chairman, Joint Chiefs of Staff.

The Task Force further recommends that the Director, Defense Health Agency, be a 3-Star general or flag officer, providing comparability with the Service Surgeons General, and to provide senior military oversight of the DHA.

The majority (five of nine members) of the Task Force favored this option. The minority was split as follows: DHA with MTFs placed under the Agency (two members); Unified Medical Command with Service Components (one member); and Single Service (one member).

Multi-Service Market Governance

Background

The MHS engaged in numerous efforts over the past 25 years to manage the delivery and coordination of health services in geographic "market" areas with medical treatment facilities from more than one Military Department. Numerous past MHS Governance studies sought to address these multi-Service markets (MSMs). In most previous studies, weaknesses in the governance structure within these markets have been cited as the leading reason for a sub-optimized direct care system.

One underlying concern is that in the absence of a formal process to manage these Service-run medical facilities, there may be both unnecessary duplication of services (inefficiency) and missed opportunities for greater collaboration and sharing. This could result in sub-optimization of medical skills (for graduate medical education, ongoing maintenance of provider competency and currency, and enlisted skills training) and the sub-optimization of direct care system capacity. Various pilot projects have aimed to improve the process by which the combined medical capabilities of the local Army, Navy, and Air Force medical treatment facilities are better integrated to optimize the direct care delivery systems, and ensure available capacity is optimized before health care is referred to the private sector through TRICARE.

The most recent OSD policy direction regarding MSM management is the Under Secretary of Defense for Personnel and Readiness memorandum, dated November 4, 2003, which designated the responsibilities and authorities of market managers to include coordinating activities regarding common appointing, referral management, capacity and workload planning, and development of a consolidated business plan. This memorandum is provided in Appendix 2. The initial implementation of the MSM concept resulted in a consolidation of the MSMs under varying models for executing the MSM authorities. This implementation has demonstrated examples of success in the delivery of health care in certain markets. It was clear from the comments received from several current market managers that more authorities are needed in order for market management to achieve the next level of efficiency and effectiveness.

Consistent with the direction in the Terms of Reference for the Task Force to recommend a way ahead for management of MSMs, the Task Force addressed questions related to the mission, responsibilities, authorities, locations, and reporting structure of the MHS, as well as whether multiple variations of MSM governance should persist. The following questions guided the discussion on governance options and responsibilities of the MSM communities:

1. Does the "value" created by the MSMs outweigh the costs in creating, staffing, and sustaining an MSM office?

2. What missions, responsibilities, and authorities should a MSM manager have? To whom is a multi-Service market manager responsible?

3. What are the locations where MSMs need to be established?

4. Of the models that exist today to manage MSMs, should the Department continue to allow multiple variations of MSM management models?

Identification of Multi-Service Markets

The Task Force reviewed the November 2003 USD (P&R) policy memorandum on TRICARE Governance to understand the multi-Service markets identified, and to determine if the market listings were still current and comprehensive.

The Task Force determined that two of the markets in the 2003 memorandum could be removed from consideration: (1) Fort Jackson/Shaw Air Force Base (AFB), South Carolina – as the down-sizing from hospital to clinic at Shaw AFB reduced the "catchment area" and the two installations no longer had overlapping service areas; and (2) San Diego, California – as this is a single-Service market managed entirely by Navy Medicine.

The Task Force also identified four overseas markets for inclusion in the multi-Service market definition: (1) Kaiserslautern Military Community, Germany; (2) Guam; (3) Okinawa, Japan, and (4) Osan Community, South Korea with the relocation of the 121 Army hospital from Seoul.

Table 15 represents the current multi-Service markets for which all subsequent organizational options and recommendations will pertain (other than for the NCR, which is considered separately in the section on National Capital Region Governance further in the report).

[illegible]	Army	Navy	Air Force
U.S. MSMs			
National Capital Region	Hospital	Hospital	Clinic
Tidewater, VA	Clinic	Hospital	Hospital
Puget Sound, WA	Hospital	Hospital	Clinic
Colorado Springs, CO	Hospital		Clinic
San Antonio, TX	Hospital		Clinic
Oahu, HI	Hospital	Clinic	Clinic
Fort Bragg/Pope, NC	Hospital		Clinic
Anchorage, AK	Clinic		Hospital
Mississippi Gulf Region, MS		Clinic	Hospital
Naval Hospital Charleston / Charleston AFB, SC		Hospital	Clinic
Fairbanks, AK	Hospital		Clinic
Overseas MSMs			
Okinawa, Japan		Hospital	Clinic
Kaiserslautern , Germany	Hospital		Clinic
Osan Community, South Korea	Hospital		Clinic
Guam		Hospital	Clinic

Table 15. United States and Overseas MSMs

Options for MSM Governance

A number of models were considered to enhance the integration of military medical care in MSMs. Through a series of discussions with representatives from existing MSM organizational models, the Task Force outlined six broad MSM constructs for consideration:

1. Informal MSM Management
2. Existing MSM Management
3. Enhanced MSM Management
4. Single Service MSM Management
5. Executive Agent MSM Management
6. Command Authority

The attributes and authorities as well as the strengths, weaknesses, and barriers to each model are elaborated below.

MSM Option 1: Informal Multi-Service Market Management

This option presents the case that the value of the MSM offices are low, and that reducing this overhead cost will outweigh the value of coordination. Under this option, the responsibilities of the existing MSM managers would be limited to the most basic elements of informally coordinating activities between medical commanders in a market. MTF Commanders could meet and share information on an ongoing basis, but there would be no requirement to formally collaborate. This model for governance would essentially eliminate MSM governance and any central coordinating role. This would effectively allow MSMs to run on their own as the respective local MTF Commanders deem necessary.

Elements and Authorities of MSM Option 1: Informal Multi-Service Market Management

Item	TOR Elements	Outcome
1	Management and supervisory chains of MTFs.	MTF commanders would report through their Component organizations (however the Components determine is the best organizational model for their Service).
2	Management and supervisory chains of multi-Service markets.	There would be no designated MSM. The frequency and intensity of coordination of activities is entirely subject to the preferences of local commanders. Supervisory chains for the MTF commanders would continue as their Service Component directs.
3	The authority, direction, and control for mission and administrative support matters over MSM personnel.	The authority, direction, and control over MSM personnel would reside within Service Components.
4	The budgetary authority for the Defense Health Program (DHP) within the MSM.	The DHP would be distributed through the Military Departments to the individual medical treatment facilities within an MSM.
5	Management of MSM-specific shared services and related functions.	The MTF commanders would be responsible for coordinating activities regarding, referral management, capacity, and workload planning.

Table 16. Elements and Authorities of MSM Option 1: Informal MSM Management

Strengths, Weaknesses, and Barriers of MSM Option 1: Informal MSM Management

Strengths of Informal MSM Management	
• **Ease of Implementation:** Would be little change to current structures; although MTF commanders in a market would not be obligated to sustain formal planning and coordination processes, it is likely that most commanders would sustain the coordination activities already in place (e.g., referral management processes).	
Weaknesses of Informal MSM Management	
• **Achieve Significant Cost Savings Through Reduction in Duplication and Variation:** Would not focus on optimization of services within a medical market; success and implementation of common processes would be reliant on local leaders. • **Enhance Interoperability:** Could reverse the successes in existing MSM offices, including the NCR.	
• None.	• None.

Table 17. Strengths, Weaknesses, and Barriers of MSM Option 1: Informal MSM Management

MSM Option 2: Existing Multi-Service Market Management

This option would maintain the MSM authorities as specified in the 2003 USD (P&R) policy memo. Multi-Service market managers would be designated with responsibilities to create a unified one-year business plan and facilitate the adoption of common business and clinical practices. This is the current practice in most stateside regions, based on the existing TRICARE Governance policy, and would now be expanded to overseas MSMs. Both the San Diego and Fort Jackson/Shaw Air Force Base markets would no longer be deemed multi-Service markets. All other authorities and responsibilities would remain without change.

Elements and Authorities of MSM Option 2: Existing MSM Management

Item	TOR Elements	Outcome
1	Management and supervisory chains of MTFs.	MTF commanders would report through Military Departments.
2	Management and supervisory chains of multi-Service markets.	The designated MSM managers would have responsibilities for coordinating business plans and leading a collaborative process within their markets, consistent with the direction in the USD(P&R) November 2003 memorandum and with the memorandums of agreement established within their market. Supervisory chains for the MSM manager would continue as their Service Component directs.
3	The authority, direction, and control for mission and administrative support matters over MSM personnel.	The authority, direction, and control over MSM personnel would reside within Service Components.
4	The budgetary authority for the Defense Health Program (DHP) within the MSM.	The DHP would be distributed through the Military Departments to the individual medical treatment facilities within an MSM.
5	Management of MSM-specific shared services and related functions.	The senior market manager would be responsible for coordinating activities regarding common appointing, referral management, capacity and workload planning, and development of a consolidated business plan.

Table 18. Elements and Authorities of MSM Option 2: Existing MSM Management

Strengths, Weaknesses, and Barriers of MSM Option 2: Existing MSM Management

Strengths of Existing MSM Management	
• **Ease of Implementation:** This option would require very little organization change.	
Weaknesses of Existing MSM Management	
• **Achieve Significant Cost Savings Through Reduction in Duplication and Variation:** Although some markets have created common business and clinical practices (to include referral management), most locations report being limited by the lack of budgetary authority. • **Dispute Resolution/Lines of Authority/Accountability:** While allowing for coordination, this model would have no forcing mechanism. This means that the market would function effectively until an MTF commander decided that cooperating was no longer in his or her best interest. There would be no guarantees of long-term consistency or governance improvement. This model has shown to be heavily personality dependent on success, although the 2003 policy letter has specific dispute resolution through the relevant Service SGs and ultimately, if needed to ASD(HA).	
• Implementation in those regions without formal MSM offices (e.g., overseas).	• Would require initial training and support for new MSMs.

Table 19. Strengths, Weaknesses, and Barriers of MSM Option 2: Existing MSM Management

MSM Option 3: Enhanced Multi-Service Market Management

The authorities of the multi-Service market managers would be expanded to include responsibility for developing a five-year unified business plan, budget authority for the entire market, establishing common workload accounting processes, driving common clinical and business practices, and the authority to direct personnel to work in other locations within the market on a short-term basis. This expanded set of authorities is based on experiences derived from three of the largest MSMs: National Capital Region,; San Antonio, Texas; and the Tidewater area, Virginia.

Elements and Authorities of MSM Option 3: Enhanced Multi-Service Market Management

Item	TOR Elements	Outcome
1	Management and supervisory chains of MTFs.	MTF commanders would report through their Component organizations (however the Components determine would be the best organizational model for their Service).
2	Management and supervisory chains of multi-Service markets.	The designated MSM managers would have additional responsibilities and authorities. They would develop a unified business plan for the market covering a five year period; be empowered to develop and implement common business and clinical processes throughout the market; use a common workload accounting process; establish a single credentialing process and system; have direct budget authority for all medical treatment facilities in the market; and have authority to re-direct personnel within the market for short-term (less than six months) reassignment. Supervisory chains for the MSM manager would continue through their Service chains as their Service Component directs. Dispute resolution would continue as in the past to the Service SGs and to ASD(HA), as needed.
3	The authority, direction, and control for mission and administrative support matters over MSM personnel.	The authority, direction, and control over MSM personnel would reside within Military Departments, although the market manager would have the authority to direct short-term reassignment of personnel as demand for health care in that market dictates.
4	The budgetary authority for the Defense Health Program (DHP) within the MSM.	DHP would be distributed directly from OSD to the MSM manager.
5	Management of MSM-specific shared services and related functions.	The senior market manager would be responsible for coordinating and directing common activities to include: common appointing, referral management, capacity/workload planning, and development of a consolidated business plan. This change has the potential for significant savings in the direct care and purchased care sectors.

Table 20. Elements and Authorities of MSM Option 3: Enhanced MSM Management

Strengths, Weaknesses, and Barriers of MSM Option 3: Enhanced MSM Management

Strengths of Enhanced MSM Management	
• **Achieve Significant Cost Savings Through Reduction in Duplication and Variation:** Would address the weaknesses that were identified by current multi-Service market managers by providing them with certain enhanced authorities. It would allow for market management to be driven in a timelier and more effective manner by the market leader, a change with the potential for significant savings in the direct care and private sector care systems. o A five-year business plan would require local commanders to take the long view on what they hope to achieve in terms of investments and market recapture. o The markets would determine their market management office resources; staff would come from internal sources, but would be dedicated to market manager responsibilities. o A single budget authority would incentivize all MTFs to seek market optimization opportunities. • **Enhance interoperability:** The market manager would have authority to direct adoption of local clinical and business processes (such as credentialing, referral management, financial management processes) that would provide for a more seamless experience for both patients and staff in the market.	
Weaknesses of Enhanced MSM Management	
• **Dispute Resolution/Lines of Authority/Accountability:** Full command and control authorities would not be in place, and a dispute resolution process that requires inter-Service cooperation persists; Services would forfeit some budgetary control for MTFs under their authority and control.	
• MHS leadership must design a new process for directing budgets to market managers, and the process for implementing shared service approaches. • MSM Management Offices with proper staffing, development, and capabilities are needed to run this complex set of tasks.	• Implementation Team must design business processes that ensure transparency and clarity of responsibilities. • Market managers could leverage commercial and U.S. Government expertise to develop market staff with deep expertise in the management of healthcare systems.

Table 21. Strengths, Weaknesses, and Barriers of MSM Option 3: Enhanced MSM Management

MSM Option 4: Single Service

Each identified MSM, and the medical treatment facilities within it, would be assigned to a particular Military Department and thereby become a Single Service market. In a notional example, the Hawaii MSM would be designated as a Navy market, and all medical treatment facilities in the Hawaii MSM would become Navy facilities. Command and control of the market would be aligned under the Department of the Navy, and all business and clinical processes in the market would follow Navy procedures. Medical personnel would be assigned to the facilities in the market by their owning Service to meet beneficiary and clinical currency demands. This approach would solve the MSM governing issue by definition, as there would no longer be multi-Service markets, only large, multi-facility single-Service markets.

Elements and Authorities of MSM Option 4: Single Service

Item	TOR Elements	Outcome
1	Management and supervisory chains of MTFs.	MTF commanders would report through the Service designated to lead that market.
2	Management and supervisory chains of MSMs	The market would no longer be "multi-Service."
3	The authority, direction, and control for mission and administrative support matters over MSM personnel.	The authority, direction, and control over MSM personnel would reside with the designated Service.
4	The budgetary authority for the Defense Health Program (DHP) within the MSM.	The DHP appropriation would be distributed through the Military Department for those markets in which the Military Department serves as Single Service.
5	Management of MSM-specific shared services and related functions.	The Senior Service official in the market would be responsible for directing the activities of the subordinate medical treatment facilities in his/her chain of command.

Table 22. Elements and Authorities of MSM Option 4: Single Service

Strengths, Weaknesses, and Barriers of MSM Option 4: Single Service

Strengths of MSM Single Service	
• **Achieve Significant Cost Savings Through Reduction in Duplication and Variation:** This option permits rapid implementation of common processes and approaches within the market.	
Weaknesses of MSM Single Service	
• **Ease of Implementation:** There would be complexities in establishing a Single Service similar to an EA. Transfer of medical treatment facilities and other medical campuses, as well as MOA process to place personnel within another Service's organization, would be complex. • **Achieve Significant Cost Savings Through Reduction in Duplication and Variation:** Would create a high degree of variation in market management approaches across the MHS, as processes will be Service-specific.	
• Process for selecting the Service lead may be difficult to adjudicate.	• Implementation Team must design business processes that ensure transparency and clarity of responsibilities.

Table 23. Strengths, Weaknesses, and Barriers of MSM Option 4: Single Service

MSM Option 5: Executive Agent

Each multi-Service market would be established as an entity of the Military Departments involved and assigned to a particular Military Department Secretary, who would operate the market as an Executive Agent on behalf of the multiple Departments involved. The major facilities could be either multi-Service facilities or "owned" by a single Service. The individual MTFs within the market would become multi-Service staffed facilities (and, as such, the market would remain "multi-Service"). An executive board of major stakeholders could be established to protect equities and promote a multi-Service management perspective. The day-to-day operation of the multi-Service market would subject to the policy direction of the ASD(HA) as informed by the executive board. The Executive Agent would have budgetary and other authorities to direct single business and clinical processes throughout the market.

Elements and Authorities of MSM Option 5: Executive Agent

Item	TOR Elements	Outcome
1	Management and supervisory chains of MTFs.	The market manager would have mission and budgetary control over the medical treatment facilities within the market area. The major facilities could be either multi-Service facilities or "owned" by a single Service.
2	Management and supervisory chains of multi-Service markets.	Supervisory chains for the MSM manager/Executive Agent would continue as their Executive Agent directs.
3	The authority, direction, and control for mission and administrative support matters over MSM personnel.	The authority, direction, and control over MSM personnel would reside within the Executive Agent, subject to policy direction of the ASD(HA) as informed by an executive oversight board.
4	The budgetary authority for the Defense Health Program (DHP) within the MSM.	The DHP would be distributed through the Military Department of each market's Executive Agent to the market EA, and subsequently to each MTF within an MSM.
5	Management of MSM-specific shared services and related functions.	Appointing, referral management, credentialing, business planning, and other activities in the market would be directed by the designated Executive Agent.

Table 24. Elements and Authorities of MSM Option 5: Executive Agent

Strengths, Weaknesses, and Barriers of MSM Option 5: Executive Agent

Strengths of MSM Executive Agent	
• **Ease of Implementation:** There is a well-designed process for establishing Executive Agents, and would leverage existing Service budget processes. • **Dispute Resolution/Lines of Authority/Accountability:** This option shares similarities with the Single Service model, and would allow the Executive Agent to direct common processes and approaches within the market.	
Weaknesses of MSM Executive Agent	
• **Ease of Implementation:** There are complexities in establishing the Executive Agent, and would require Secretary of Defense decision to establish the Executive Agent and/or alter of the Executive Agent. Additionally, ODA&M has indicated that the entire DoD process for Executive Agent designation may need to be reviewed. • **Enhance Interoperability:** Would create a high degree of variation in market management approaches as processes would be Service-specific based on which Service is the Executive Agent of a particular market.	
• Process for selecting the Executive Agent may be difficult to adjudicate.	• Implementation Team must develop Executive Agent selection processes that use common, transparent criteria.

Table 25. Strengths, Weaknesses, and Barriers of MSM Option 5: Executive Agent

MSM Option 6: Command Authority

Each multi-Service market would be established as a Joint military command. The market commander would exercise command authority over the medical treatment facilities within the market. These MTFs would no longer be Service-run, but would be subordinate Joint commands under the market area command. This is similar to the current model in the NCR.

Elements and Authorities of MSM Option 6: Command Authority

Item	TOR Elements	Outcome
1	Management and supervisory chains of MTFs.	MTF commanders would report to the Market Commander.
2	Management and supervisory chains of multi-Service markets.	The Market Commander would report to the Secretary of Defense, or a Combatant Commander.
3	The authority, direction, and control for mission and administrative support matters over MSM personnel.	The authority, direction, and control over the MSM would reside with the Market Commander.
4	The budgetary authority for the Defense Health Program (DHP) within the MSM.	The DHP would be distributed directly to the Market Commander.
5	Management of MSM-specific shared services and related functions.	The Market Commander would be responsible for directing all activities and processes within their area.

Table 26. Elements and Authorities of MSM Option 6: Command Authority

Strengths, Weaknesses, and Barriers of MSM Option 6: Command Authority

Strengths of MSM Command Authority	
• **Dispute Resolution/Lines of Authority/Accountability:** Command authority would allow rapid implementation of common processes and approaches within the market. • Command authority and Joint Manning Documents (JMDs) would allow for allocation and reassignment of personnel within the market as needed.	
Weaknesses of MSM Command Authority	
• **Achieve Significant Cost Savings Through Reduction in Duplication and Variation:** Higher overhead costs unless resources would be removed from other Service command and intermediate command offices. • **Other (Organizational) Alignment:** This option only appears to be an effective alternative if it is aligned with a larger MHS Governance decision to direct a unified command.	
• **Ease of Implementation:** It would require transformation of market and MTFs from Service leads to joint market commands. • **Medical Readiness:** Alters process for the deployment of forces through the global force manpower allocation process.	• MHS leadership would need to work closely with Military Departments to institute a sophisticated dispute adjudication process. • MHS leadership would need to establish a process that allows for timely escalation of issues if the joint commands fail to support deployment requirements.

Table 27. Strengths, Weaknesses, and Barriers of MSM Option 6: Command Authority

Task Force Voting Results: MSM Governance

Vote	MSM Option 1: Informal MSM Management		MSM Option 2: Existing MSM Management		[redacted]	MSM Option 4: Single Service		MSM Option 5: Executive Agent		MSM Option 6: Command Authority	
	Raw Score	Ranked Score	Raw Score	Ranked Score		Raw Score	Ranked Score	Raw Score	Ranked Score	Raw Score	Ranked Score
A	2.86	3	3	2		2.73	4	2.66	5	2.12	6
B	2	5	3	2		1	4	1	6	2	3
C	2.5	4	3	2		2.46	5	2.78	3	1.69	6
D	3	3.5	3	3.5		2	5	4	2	1	6
E	1.87	5	3	2		2.49	3	2	2	2.32	4
F	2.43	6	3	3		2.99	4	3.04	1.5	2.82	5
G	3	4.5	3	4.5		3.41	1	2.75	2.75	3.07	3
H	1.89	6	3	5		3.67	3	3.73	2	3.44	4
I	2.38	6	3	5		3.72	3	3.78	2	3.27	4
Average	**2.4**	**4.8**	**3**	**3.2**		**2.7**	**3.6**	**2.9**	**2.9**	**2.4**	**4.6**

Table 28. Task Force Voting Results for MSM Governance

Note: Raw Score Scale: (1) weakest and (5) strongest based on the application of the weighted criteria.
Ranked Score derived from the raw score and ordered from first (1) to last (6).

Task Force Recommendation:

The Task Force recommends MSM Option 3 – Enhanced Multi-Service Market Management. This option would introduce enhanced MSM manager authorities for MSMs in the DoD, to include providing budgetary and short-term personnel management authority to the market manager, instituting common clinical and business practices in the market, and other authorities as listed below. The majority (seven of nine members) of the Task Force favored this option.. The minority was split as follows: Single Service (one member); Executive Agent (one member).

Authorities in these markets would be the same regardless of the size of the market in order to limit the variance in governance across the MHS. Resources to staff the MSM offices would transfer from within the markets. The designated market manager would determine the size of the MSM office.

These enhanced authorities would expand the responsibilities from those specified in the 2003 USD (P&R) memo, and would address the concerns and issues highlighted to the Task Force by serving MSM managers. The Task Force recommends the following MSM responsibilities.

- **Core Mission:** MSMs, in which more than one Service operates medical facilities in overlapping service areas, must plan for and deliver health care in a manner that optimizes the market over the individual medical facilities. A single MSM manager would be designated by policy directive. The Task Force's recommendation for designated MSM managers is found in Table 29.

- MSM management activities must create and sustain a local market healthcare delivery system that enhances the patient experience of care, sustains or enhances quality of care, responsibly manages the costs of care across the medical treatment facilities and private

sector care, and sustains graduate medical education, training and readiness capabilities. The market manager would carry out the following mission-essential tasks.

1. Create and sustain a **unified business operation** with **common business processes** centered on the requirements to run an integrated medical system. This includes:
    a. A five year **unified business plan** that is more than the consolidation of individual MTF plans
    b. A single (or common) **financial management process** which allows movement of funds to highest priority/impact clinical and business operations by the designated market manager
    c. One **workload accounting system** for the entire market area to ensure the alignment of appropriate incentives
    d. **Civilian personnel processes**, which are as seamless as possible, reduce inter-MTF competition for resources and allow flexible staffing
    e. Common **medical logistics, information technology, and contracting operations** where practical
    f. The establishment of **common business processes across the enterprise**
2. Create and sustain a unified **clinical operation with common clinical processes** that seeks to optimize the military medical system and enhance the patient experience.
    a. A single **referral management system** that allows for timely referrals to medical treatment facilities or rapidly identifies the absence of military medical capacity or capability and refers the patient to the most effective private sector provider
    b. A health care environment which optimizes teaching staff, patient care exposure, and research opportunities for the Service directed readiness platforms as well as education and training programs, while maintaining excellent patient access and quality of care
    c. A **credentialing and privileging process** that allows for providers to move easily between facilities in the market
    d. A single responsible authority for **market relationships** and coordination with the local civilian, government, and inter-agency health communities

3. Ensure **unified planning and programs** will facilitate the maximum use of the market for **medical readiness training**, pre- and post-deployment support, disability evaluation determination, wounded warrior care, and supporting civilian-military and interagency interactions such as local emergency response.

The Task Force recommends the market manager be determined as identified in Table 29 below, with some markets having a permanent market manager, and other markets having a rotational leader. The staff in the multi-Service market offices, however, would be permanent and drawn from the respective Services in that market.

U.S. Based MSMs	Market Manager
National Capital Region	Rotate Army / Navy
Tidewater, VA	Navy
Puget Sound, WA	Army
Colorado Springs, CO	Rotate Air Force / Army
San Antonio, TX	Rotate Air Force / Army
Oahu, HI	Rotate Navy / Army
Fort Bragg / Pope, NC	Army
Anchorage, AK	Air Force
Mississippi Gulf Region, MS	Air Force
Naval Hospital Charleston / Charleston AFB, SC	Navy
Fairbanks, AK	Army
Overseas Based MSMs	**Market Manager**
Okinawa, Japan	Navy
Kaiserslautern, Germany	Army
Osan Community, South Korea	Army
Guam	Navy

Table 29. Recommended MSM Manager Designation

National Capital Region (NCR) Governance

Background

NCR health care governance was transformed in 2007 with the establishment of the Joint Task Force National Capital Region Medical (JTF CAPMED). This organization was established to (1) ensure effective and efficient delivery of military health care within the NCR TRICARE sub-regional Joint Operations Area (JOA) using all available medical resources in the JOA; and to (2) oversee the consolidation and realignment of military health care resources within the JOA in accordance with BRAC obligations. The JTF CAPMED has successfully accomplished these missions of meeting the complex and challenging BRAC transformations while maintaining the highest levels of care for all beneficiaries. As the BRAC actions are nearing completion, the Task Force was asked to assess whether the JTF CAPMED governance model should serve as an enduring construct.

Following completion of all BRAC activities, the NCR will include the largest medical center in the Department of Defense staffed by personnel from all the Services, the Department's only medical school, and one of the largest military community hospitals also staffed by all the Services. Thus, the NCR hosts a significant portion of the Department's medical resources and is a critical component in the maintenance and projection of medical capabilities for all three Service medical departments through the NCRs Graduate Medical Education (GME), clinical currency, and clinical research capacities.

Options for NCR Governance

Through a deliberative discussion and down-select process, applying the weighted criteria, the Task Force assessed the following seven options for NCR governance. These options are described in detail, to include reporting chains, responsibilities, and authorities as required by the Terms of Reference.

NCR Option 1: As Is - Current Structure Reports to Secretary of Defense/Deputy Secretary of Defense

The JTF CAPMED would remain in place, reporting to the Secretary of Defense/Deputy Secretary of Defense. The medical treatment facilities currently directed by the JTF CAPMED would operate as subordinate Joint commands with the manning, budgetary, and organizational arrangements directed to date by the Deputy Secretary. Staffing of military personnel would be through Joint Tables of Distribution (JTDs) and the assigned forces would be under the operational control of the JTF.

Elements and Authorities of NCR Option 1: As Is - Current Structure

Item	TOR Elements	Outcome
1	Management and supervisory chains of NCR MTFs.	Two MTF commanders, Walter Reed National Military Medical Center and Fort Belvoir Community Hospital, would report to the NCR JTF Commander.
2	Management and supervisory chains of the NCR.	The NCR JTF Commander would report to the Secretary/Deputy Secretary of Defense.
3	The authority, direction, and control for mission and administrative support matters over NCR personnel.	The authority, direction, and control over the NCR would reside with the JTF Commander.
4	The budgetary authority for the Defense Health Program (DHP) within the NCR.	The DHP would be distributed directly to the NCR JTF Commander to redistribute to assigned forces.
5	Management of NCR-specific shared services and related functions.	The NCR JTF Commander would be responsible for directing all activities and processes within the assigned Joint Operations Area (JOA). Shared services and other efficiencies would be implemented by command authorities through JTF developed processes.

Table 30. Elements and Authorities of NCR Option 1: As Is - Current Structure

Strengths, Weaknesses, and Barriers of NCR Option 1: As Is - Current Structure

Strengths of Current NCR Structure	
• Neither the NCR organizations nor the authorities of JTF CAPMED would be impacted. • JTF CAPMED leadership would be well integrated into MHS governance.	
[illegible]	
• Would continue the unique status of the NCR by operating outside of the traditional management of medical treatment facilities through the Services. • Would retain NCR as the fourth medical component to the MHS garrison service delivery (Army, Navy, Air Force). • **Dispute Resolution/Lines of Authority/Accountability:** When dispute resolution is needed, would require JTF CAPMED to go directly to senior levels within the DoD. Would create ambiguity between the responsibilities of the JTF CAPMED Commander and the Military Department Surgeons General. • **Achieve Significant Cost Savings Through Reduction in Duplication and Variation:** Would require the largest staffing of all of the current MSMs, partly due to its budget authorities that other MSMs do not possess, and partly due to the Joint Staff organizational models required in joint operations.	
• None.	• None.

Table 31. Strengths, Weaknesses, and Barriers of NCR Option 1: As Is - Current Structure

NCR Option 2: JTF CAPMED Reports to a Combatant Commander (COCOM)

The Joint Task Force National Capital Region Medical would remain in place, with the characteristics described in the preceding paragraph, but would report to the Commander, U.S. Northern Command (NORTHCOM), or another designated Combatant Command (COCOM) Commander. This assumes the COCOM does not alter the current authorities and related organizational structure.

Elements and Authorities of NCR Option 2: JTF CAPMED Reports to a COCOM

Item	TOR Elements	Outcome
1	Management and supervisory chains of NCR MTFs.	Two MTF commanders, Walter Reed National Military Medical Center and Fort Belvoir Community Hospital, would report to the NCR JTF Commander.
2	Management/supervisory chains of NCR	The NCR JTF Commander would report to COCOM Commander.
3	The authority, direction, and control for mission and administrative support matters over NCR personnel.	The authority, direction, and control over the NCR would reside with the NCR JTF Commander.
4	The budgetary authority for the Defense Health Program (DHP) within the NCR.	The DHP would be distributed directly to the NCR JTF Commander to redistribute to assigned forces, but would be overseen by the COCOM Commander.
5	Management of NCR-specific shared services and related functions.	The NCR JTF Commander would be responsible for directing all activities and processes within the assigned AREA. Shared services and other efficiencies would be implemented by command authorities through NCR JTF developed processes.

Table 32. Elements and Authorities of NCR Option 2: JTF CAPMED Reports to a COCOM

Strengths, Weaknesses, Barriers of NCR Option 2: JTF CAPMED Reports to a COCOM

Strengths of JTF CAPMED Reporting to a COCOM	
• Neither the NCR organizations nor the authorities of JTF CAPMED would necessarily be impacted. • Would require the reporting chain of the JTF CAPMED to move to a level below the Secretary of Defense level.	
Weaknesses of JTF CAPMED Reporting to a COCOM	
• Would continue the unique status of the NCR by operating outside of the traditional management of medical treatment facilities through the Services. • There would be no precedent for direct COCOM oversight of health care delivery and not within the current mission sets of COCOM. • **Achieve Significant Cost Savings Through Reduction in Duplication and Variation:** This would require additional billets to be added to the COCOM for oversight. • Would retain the NCR as the fourth medical component to MHS garrison service delivery (Army, Navy, Air Force).	
Barriers to JTF CAPMED Reporting to a COCOM	**Challenges to JTF CAPMED Reporting to a COCOM**
• COCOM Commanders willingness to accept the NCR medical mission. • The learning curve for COCOM personnel to understand and indoctrinate MHS governance processes.	• May require a staff increase for the COCOM office for oversight responsibilities of the JTF. • A training program would need to be introduced to assist a COCOM staff with taking in this added responsibility; likely managed through the COCOM Surgeon's office.

Table 33. Strengths, Weaknesses, and Barriers of NCR Option 2: JTF CAPMED Reports to a COCOM

NCR Option 3: NCR MTFs Report to a Defense Health Agency

Responsibility for management of the NCR medical market would be transferred to the Defense Health Agency described in the MHS Governance section above (provided that such an agency is established), and the NCR medical treatment facilities would operate under the agency's authority, direction and control. In general, these medical treatment facilities would operate with the manning, budgetary, and organizational arrangements directed to date by the Deputy Secretary. (If the Defense Health Agency is not adopted for purposes of overall MHS governance, then the NCR market and medical treatment facilities would be transferred to the existing TRICARE Management Activity.)

Elements and Authorities of NCR Option 3: NCR MTFs Report to a DHA

Item	TOR Elements	Outcome
1	Management and supervisory chains of NCR MTFs.	Walter Reed National Military Medical Center and Fort Belvoir Community Hospital, and potentially the other NCR medical facilities, would report to the Director, DHA.
2	Management and supervisory chains of the NCR.	The NCR market manager may be one of the two MTF commanders and would report to the Director, DHA.
3	The authority, direction, and control for mission and administrative support matters over NCR personnel.	The Director, DHA, who reports directly to the ASD(HA), would have authority, direction and control for mission and administrative support matters over NCR personnel.
4	The budgetary authority for the Defense Health Program (DHP) within the NCR.	The Director, DHA, who reports directly to the ASD(HA), would have budgetary authority for the NCR.
5	Management of NCR-specific shared services and related functions.	The Director, DHA, would be responsible for shared services.

Table 34. Elements and Authorities of NCR Option 3: NCR MTFs Report to a Defense Health Agency

Strengths, Weaknesses, and Barriers of NCR Option 3: NCR MTFs Report to a DHA

Strengths of the NCR MTFs Reporting to a DHA
• **Ease of Implementation:** Would sustain current NCR organization and authorities, including decision to place WRNMMC and FBCH civilians under TMA. • Would better align rank of market manager with rest of MHS: NCR market manager can revert to a 2-Star general or flag officer, reporting to a 3-Star general or flag medical officer with equivalent rank to the Service Surgeons General. • Would provide a "test bed" for a more rapid implementation of solutions to include common business and clinical process re-engineering in which the organizational entity responsible for shared services is integrated with MTFs. • **Dispute Resolution/Lines of Authority/Accountability:** Would remove division of authorities among multiple military Services, by placing all under the authority, direction, and control of the DHA. • Would align under a designated Combat Support Agency, ensuring Chairman of the Joint Chiefs of Staff (CJCS) involvement. • **Achieve Significant Cost Savings Through Reduction in Duplication/Variation:** Could achieve savings by aligning management of NCR private sector care (in TRICARE Regional Office North) with direct care via the NCR Director.
Weaknesses of the NCR MTFs Reporting to a DHA

• Would require an additional mission for DHA to provide health care delivery, which traditionally has been a Service responsibility, and which may distract DHA from successful implementation of shared services aspect of its mission.
• **Dispute Resolution/Lines of Authority/Accountability:** Potential to create conflicting priorities and distract Director, DHA, from shared service delivery.
  o Would continue the situation in which four entities (the three Military Departments and DHA) have responsibilities for the garrison direct care mission.
  o Could create a perception of budgetary conflicts of interest in distribution of DHP funds between DHA and Service hospitals, stemming the fact that Director, DHA, reports to ASD(HA).

• Would require the DHA to develop oversight capabilities for the NCR. • Could foster a complex environment by absorbing health delivery mission and oversight of JTF/NCR market.	• DHA would need to establish a dedicated officer and institute an oversight process that comports with the expectations of various accreditation organizations. • Health Affairs would establish processes to ensure transparency and protect against perceptions of conflicts of interest.

Table 35. Strengths, Weaknesses, Barriers of NCR Option 3: NCR MTFs Report to a Defense Health Agency

NCR Option 4: NCR MTFs Report to an Executive Agent

The NCR Health System would be established as an entity of the three Military Departments, day to day operational and administrative activities are supported by one of the Military Department Secretaries assigned as the Executive Agent. The Walter Reed National Military Medical Center (WRNMMC) and Fort Belvoir Community Hospital (FBCH) would be multi-Service facilities, not owned by a Single Service. An executive board of major stakeholders could be established to protect equities and promote a multi-Service management perspective. The day-to-day operation of the NCR Health System is subject to the policy direction of the ASD(HA) as informed by the executive board. Multi-Service staffing facilities would be sustained through agreements between the Services. This option would disestablish JTF CAPMED as a joint command but maintain a similar multi-Service management structure.

Elements and Authorities of NCR Option 4: NCR MTFs Report to an Executive Agent

Item	TOR Elements	Outcome
1	Management and supervisory chains of NCR MTFs.	Identified commanders would report through their chain of command to the Military Department Secretary/Executive Agent.
2	Management and supervisory chains of the NCR.	The NCR market manager would report through the Executive Agent chain of command.
3	The authority, direction, and control for mission and administrative support matters over NCR personnel.	The day-to-day management and execution responsibilities over the NCR would reside with the market manager and the Executive Agent, subject to policy direction of the ASD(HA) as informed by an executive oversight board.
4	The budgetary authority for the Defense Health Program (DHP) within the NCR.	The DHP would be distributed directly to the Executive Agent to redistribute to assigned forces.
5	Management of NCR-specific shared services and related functions.	The Executive Agent, through the NCR market manager, would be responsible for directing all activities and processes, subject to oversight by an executive board and the ASD(HA).

Table 36. Elements and Authorities of NCR Option 4: NCR MTFs Report to an Executive Agent

Strengths, Weaknesses, Barriers of NCR Option 4: NCR MTFs Report to Executive Agent

Strengths of NCR MTFs Reporting to an Executive Agent	
• **Dispute Resolution/Lines of Authority/Accountability:** Would establish one Service responsible for the delivery of healthcare in the NCR. • Would allow current organization and authorities in the NCR to remain in place under the Executive Agent of the designated Service. • Would retain multi-Service hospitals, staffed by personnel from all Services and commanders from any Service.	
Weaknesses of NCR MTFs Reporting to an Executive Agent	
• **Ease of Implementation:** There are a number of complexities involved in establishing an Executive Agent (policy, and chartering process; establishing MOUs between Executive Agent and other Military Departments). • May induce some staff growth in designated Services to manage new responsibilities.	
• The process of selecting Military Department to assume control of the NCR. • Assuring proper Wounded, Ill and Injured (WII) priorities across all Services.	• Establishment of executive oversight board with representation from MHS leadership. • Establish Memorandums of Understanding with all Services over policies and procedures for managing WII matters.

Table 37. Strengths, Weaknesses, and Barriers of NCR Option 4: NCR MTFs Report to an Executive Agent

NCR Option 5: NCR MTFs Report to a Single Service

All medical treatment facilities in the NCR would be assigned to a particular Military Department Secretary, consistent with the MSM Single-Service Model option above.

Elements and Authorities of NCR Option 5: NCR MTFs Report to a Single Service

Item	TOR Elements	Outcome
1	Management and supervisory chains of NCR MTFs.	MTF commanders would report through the designated Service chain of command.
2	Management and supervisory chains of the NCR.	The NCR market manager would report through the designated Service chain of command.
3	The authority, direction, and control for mission and administrative support matters over NCR personnel.	The authority, direction, and control over the NCR would reside with the NCR market manager.
4	The budgetary authority for the Defense Health Program (DHP) within the NCR.	The DHP would be distributed through the designated Service to the NCR market manager to redistribute to NCR facilities.
5	Management of NCR-specific shared services and related functions.	The NCR market manager would be responsible for directing all activities and processes in accordance with designated Service processes and policies.

Table 38. Elements and Authorities of NCR Option 5: NCR MTFs Report to a Single Service

Strengths, Weaknesses, Barriers of NCR Option 5: NCR MTFs Report to a Single Service

Strengths of NCR MTFs Reporting to a Single Service	
• **Dispute Resolution/Lines of Authority/Accountability:** One Service would be responsible for the delivery of health care in the NCR. • Would be easier to implement single business and clinical processes across the region.	
Weaknesses of NCR MTFs Reporting to a Single Service	
• Could be a perceived loss of Wounded, Ill and Injured Service members care priorities from losing Service(s). • May induce some staff growth in the designated Service to manage new responsibilities.	

• Selecting a Service to assume control of the NCR.
• Setting up the necessary organizational relationships, including:
  o Transferring MTFs and medical campuses to the designated Service
  o Establishing the MOUs for assignment of personnel from other Services
	• Implementation Team would need to work with the Department leadership on the best approach to select a Service lead.
	• Implementation Team would need to develop detail Concept of Operations for assignment of transfer of property and process for assigning personnel.

Table 39. Strengths, Weaknesses, and Barriers of NCR Option 5: NCR MTFs Report to a Single Service

NCR Option 6: Enhanced MSM Management

The JTF CAPMED would be disestablished and an NCR Market Management Office would be established with the characteristics described as "Enhanced MSM Management" in the "Multi-Service Market Governance Models" section above. The MTFs would continue to be staffed by personnel from all three Military Departments. The MTFs would be operated by the Military Department that has historically operated them (i.e., Fort Belvoir Community Hospital would be an Army Hospital; Walter Reed National Military Medical Center would be a Navy Medical Center). A stand-alone NCR market manager would be named, and would be rotated on a set periodic basis between the Army and Navy, and the market manager would report through their Service chain of command.

Elements and Authorities of NCR Option 6: Enhanced MSM Management

Item	TOR Elements	Outcome
1	Management and supervisory chains of NCR MTFs.	MTF commanders would report to Service chains of command.
2	Management and supervisory chains of the NCR.	The NCR market manager would rotate between the Services and would report through their Service chain of command.
3	Authority, direction, and control for mission and administrative support matters for NCR personnel	The authority, direction, and control over the NCR would remain with the parent Service of individual MTFs.
4	The budgetary authority for the Defense Health Program (DHP) within the NCR.	The DHP would be distributed directly to the NCR market manager to redistribute to assigned forces.
5	Management of NCR-specific shared services and related functions.	The NCR market manager would be responsible for directing all activities and processes within the assigned AREA.

Table 40. Elements and Authorities of NCR Option 6: Enhanced MSM Management

Strengths, Weaknesses, and Barriers of NCR Option 6: Enhanced MSM Management

Strengths of an Enhanced MSM	
• **Dispute Resolution/Lines of Authority/Accountability:** Would align the NCR with the other MSMs, creating consistency among the Services and missions. • **Achieve Significant Cost Savings Through Reduction in Duplication and Variation:** Could reduce current JTF CAPMED overhead by more than 100 staff positions. • **Enhance Interoperability:** Would retain certain JTF authorities: budget, workload accounting, ability to move workload/personnel within the market, sustain and implement further clinical and business process.	
Weaknesses of an Enhanced MSM	
• Could create the perception that there is reduced value in seeing Joint solutions in the NCR. • Relies on the effectiveness of an "enhanced" multi-Service market office governance model, vice command authority, to drive change across command structures.	
• Would require re-evaluation of various NCR organizational personnel decisions made to date, including: Military personnel (multi-Service staffing through MOU vice Joint Tables of Distribution); Civilian personnel (currently under TMA); OPCON with Services, vice NCR medical commander.	• Implementation Team responsible for developing a detailed Concept of Operations that outlines specific, sequential steps to create new organizational and manning documents. • Pursue personnel decisions with bias toward least impactful approach.

Table 41. Strengths, Weaknesses, and Barriers of NCR Option 6: Enhanced MSM Management

Task Force Voting Results: NCR Governance

Vote	NCR Option 1: As Is - Current Structure Reports to Secretary of Defense/ Deputy Secretary of Defense		NCR Option 2: JTF CAPMED Reports to a Combatant Commander (COCOM)		NCR Option 3: NCR MTFs Report to a Defense Health Agency		NCR Option 4: NCR MTFs Report to an Executive Agent		NCR Option 5: NCR MTFs Report a Single Service	
	Raw Score	Ranked Score	Raw Score	Ranked Score	Raw Score	Ranked Score	Raw Score	Ranked Score	Raw Score	Ranked Score
A	3	3	2	6	3	2	2.17	5	2.82	4
B	3	1	2	3	2	4	2	5	1	6
C	3	3	1	5	1	6	3	2	2.4	4
D	3	4	3	3	1	6	4	2	2	5
E	3	5	1.99	6	3.65	2	3	4	3.45	3
F	3	5	3.01	4	3.06	3	3.52	1	3.52	2
G	3	2	2.69	6	3.25	1	2.72	4	2.7	5
H	3	2	2.6	6	4.23	1	2.92	3	2.92	4
I	3	3	2.48	6	3.11	2	2.94	5	2.95	4
Average	**3**	**3.1**	**2.31**	**5**	**2.70**	**2.9**	**2.92**	**3.4**	**2.64**	**4.1**

Table 42. Task Force Voting Results for NCR Governance

Note: Raw Score Scale: (1) weakest and (5) strongest based on the application of the weighted criteria.
Ranked Score derived from the raw score and ordered from first (1) to last (6).

Task Force Recommendation:

The Task Force recommends NCR Option 6 – Enhanced MSM Management for governance of the NCR health system. JTF CAPMED would be disestablished and would be replaced with a market management office with enhanced MSM manager authorities, similar to the model that would be applied in all other MSM markets based on the MSM Governance recommendation. The MTFs would continue to be staffed by personnel from all three Military Departments, and common clinical and business processes would be maintained. The MTFs would be operated by the Military Departments that have historically operated them (i.e., Fort Belvoir Community Hospital would be an Army Hospital; Walter Reed National Military Medical Center, a Navy Medical Center).

The majority (five of nine members) of the Task Force favored this option. The minority was split as follows: NCR MTFs report to DHA (two members); NCR MTFs report to an Executive Agent (one member); and JTF CAPMED "As Is" Current Structure reports to Secretary of Defense/Deputy Secretary of Defense (one member).

Summary of Task Force Recommendations

The members of the Task Force reached a consensus on the following general points:

- There is an opportunity to accelerate the adoption and implementation of more efficient, common clinical and business processes through reengineered and more streamlined shared services.
- There is an obligation in the current fiscal environment to more rapidly implement and effectively manage efficiencies than the current organizations are likely to do.
- There is an opportunity to provide a more coherent, cohesive, and effective long-term governance model for the MHS.

The Task Force reached its recommendations on specific governance models for each of the three decision areas – MHS Governance, MSM Governance, and NCR Governance – through a series of discussions and votes among the Task Force members. The model receiving a majority or plurality of the members' first place votes constituted the Task Force's recommendations. Where there was a significant difference of views among Task Force members, the minority views are noted.

This summarizes the Task Force's overall major recommendations for the MHS as a whole, in multi-Service markets in general, and for the National Capital Region specifically.

- **Overall MHS Governance: MHS Option 2 – A Defense Health Agency with Medical Treatment Facilities Remaining with the Military Departments.**

  Establish a Defense Health Agency that would be focused on consolidating and delivering a broader set of shared health services, and implementing common clinical and business processes. Medical treatment facilities would remain under the respective Military Departments. The Task Force recommends the DHA be designated as a Combat Support Agency for its combat support mission responsibilities, which will include oversight by the Chairman, Joint Chiefs of Staff. This recommendation builds upon the decision by the Secretary of Defense in March 2011 to establish an MHS Support Activity and expand the delivery of shared services throughout the MHS.

- **Multi-Service Market Governance: MSM Option 3 – Enhanced MSM Management.**

  Introduce enhanced MSM manager authorities for multi-Service medical markets in the DoD, to include providing budgetary and short-term personnel management authority to the market manager as described previously.

- **National Capital Region Governance: NCR Option 6 – Enhanced MSM Management.**

  Disestablish the JTF CAPMED and establish it as a market management office with enhanced MSM manager authorities, similar to the model that would be applied in all other MSM markets based on the MSM Governance recommendation. The MTFs would continue to be staffed by personnel from all three Military Departments, and common clinical and business processes would be maintained. The MTFs would be operated by the Military Departments that have historically operated them (i.e., Fort Belvoir

Community Hospital would be an Army Hospital; Walter Reed National Military Medical Center, a Navy Medical Center).

The Task Force offers these recommendations with the acknowledgement that while these represent majority views of the Task Force members, they do not represent unanimous views. The Task Force further recognizes that, while the Task Force submitted these recommendations in keeping with the original tasking, the Task Force also attempted to portray the full range of options available to the Department leadership for consideration as objectively and thoroughly as the timeline would allow.

Implementation (Concept of Operations) Plan

This section describes an approach for the implementation of the Task Force's recommendations, should one or more of these recommendations be selected. This approach is also generally applicable, with some modifications, should one or more of the other options presented in this report be adopted.

Upon selection of the governance decisions for the MHS as a whole, in multi-Service markets, and in the National Capital Region, the Task Force recommends that the Deputy Secretary of Defense direct the establishment of an Implementation Team. This Team would be tasked to develop a more detailed Concept of Operations (CONOPS) for the tasks, responsibilities, and resources required to implement the governance decisions. The Task Force further recommends the Deputy Secretary of Defense name a DHA Program Executive Officer (PEO) to coordinate activities across the Department in the execution of the governance decisions.

In addition, the Task Force recommends the DSD establish an Executive Advisory Committee (EAC) to review and advise the PEO and DSD. Members of this Committee would include representatives from USD (P&R), ASD(HA), Joint Staff, Military Department Secretaries, Comptroller, CAPE, DA&M, Deputy Chief Management Officer (DCMO), Office of the General Counsel (OGC), and Office of Legislative Affairs (OLA). The CONOPS should be completed in six (6) months beginning in October 2011. Tasks should include the development of measures for tracking and assessing the outcomes from this re-organization. The measures would permit DoD leaders to assess the performance of the new organization in meeting the stated objectives of the reorganization four to five years after implementation.

If these recommendations are accepted, the Task Force believes that implementation actions could begin during FY12. The Task Force suggests that aggressive implementation could result in completion of activities by the end of FY14; the Implementation Team should work out the final timeline for implementation of any decisions made relative to this study. The Army views this timetable to be overly aggressive. The timelines below represent notional milestones that the Task Force believes are achievable in the near to medium term.

- **October 2011:** Establish and charter an Implementation Team with a Program Executive Officer and Program Specific Study Teams to assess the means and extent by which shared services will be organized and directed, and all other activities resulting from the Deputy Secretary of Defense's decision(s).
- **April 2012:** The Implementation Team will present a detailed Concept of Operations for the stand-up of the Defense Health Agency and the enhanced multi-Service market

responsibilities; the approach for consolidating and delivering shared services; and the process to disestablish the JTF CAPMED.

- **October 2012:** Reach Initial Operating Capability (IOC) for the Defense Health Agency and appoint a 3-Star general or flag officer to lead the DHA and establish the enhanced multi-Service markets. Disestablish the JTF CAPMED.
- **October 2013:**
  - Full Operating Capability (FOC) reached for the DHA.
- **October 2013-2018**: Allow for a five-year period to operate the DHA and e-MSM constructs before formal evaluation.

The Task Force recommends the immediate establishment of an Implementation Team, led by a senior OSD official that would further delineate the specific milestones, concepts of operations, and detailed execution plans. The Task Force further recommends that the proposed MHS Governance model be permitted sufficient time, following implementation, to be fully evaluated in its ability to achieve expected outcomes in terms of clear and measurable criteria for performance improvement, agility and efficiency.

The Task Force members wish to express appreciation for the opportunity to serve in this vital capacity. The MHS is a unique and indispensable asset in the country's overall national security strategy. The performance of the MHS, especially over the last 10 years of war, has been historic and its operations exemplified by increasing joint activity and interoperability. We believe that the options and recommendations put forward in this report provide a pathway to a stronger and enduring governance model for the system, while maintaining the incredible performance of a military health system whose primary mission is to prepare for and go to war.

Appendices

1. June 14, 2011, Deputy Secretary of Defense Memorandum with Terms of Reference
2. November 14, 2003, Under Secretary of Defense (Personnel and Readiness) Memorandum, "TRICARE Governance Plan"
3. September 12, 2007, Deputy Secretary of Defense Memorandum, "Establishing Authority for Joint Task Force – National Capital Region/Medical (JTF CAPMED) and JTF CAPMED Transition Team"
4. March 14, 2011, Secretary of Defense Memorandum, "Organizational Efficiencies" (Pertinent Elements)
5. High-Level Description of the Staffing Estimation Method
6. Side-By-Side Comparisons of each MHS Governance Option depicting TOR Criteria and Strengths and Weaknesses
7. MHS Task Force Report Acronyms

Appendix 1. June 14, 2011, Deputy Secretary of Defense Memorandum with Terms of Reference

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

JUN 14 2011

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS
CHAIRMAN OF THE JOINT CHIEFS OF STAFF
UNDER SECRETARY OF DEFENSE (COMPTROLLER)
UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS
DIRECTOR, COST ASSESSMENT AND PROGRAM EVALUATION

SUBJECT: Review of Governance Model Options for the Military Health System

With the pending completion of the consolidation of medical facilities and functions in the National Capital Region (NCR) mandated by the Base Realignment and Closure (BRAC) statutory process, the governance of military health care in the NCR is an issue that requires consideration and decision. This present need for a decision regarding the post-BRAC governance of military health care in the NCR provides an opportunity to address the desired end-state governance of the entire Military Health System (MHS). Furthermore, in light of the considerable long-term fiscal challenges the nation faces, and the comprehensive review established by the Secretary of Defense to inform future decisions about spending on national security, we must ensure that the MHS is organized in a way that curtails expenses and achieves savings to the greatest extent possible in meeting its deeply important mission.

I am therefore directing Dr. Peach Taylor, Deputy Assistant Secretary of Defense (Health Affairs/Force Health Protection and Readiness), and Major General (Dr.) Doug Robb, Joint Staff Surgeon, to serve as co-chairs of a small review team and provide me, within 90 days, a report that includes their recommendation for the governance of the MHS as a whole and in multi-Service medical markets, to include the NCR. To ensure a full consideration of these issues, the report will be considered by the Deputy's Advisory Working Group prior to my final decision on this subject.

The Secretaries of the Military Departments, the Chairman of the Joint Chiefs of Staff, the Under Secretary of Defense (Comptroller), the Under Secretary of Defense for Personnel and Readiness, and the Director, Cost Assessment and Program Evaluation will each provide to me by June 20, 2011, with a nominee, at the 1-star or 2-star level, or a comparable Senior Executive Service official, to serve as a member of this review team.

The terms of reference for this review are attached. By copy of this memorandum, all Department of Defense components will fully cooperate in the execution of this review and be responsive to all requests for information or other support.

Attachment:
As stated

cc:
General Counsel of the Department of Defense
Assistant Secretary of Defense for Legislative Affairs
Director, Administration and Management

TERMS OF REFERENCE

Review of Governance Model Options for the Military Health System

These Terms of Reference (TOR) establish the objectives of the review directed by the Deputy Secretary of Defense to identify a governance model for the Military Health System (MHS) as a whole and in multi-Service medical markets (to include the National Capital Region (NCR)).

Background

On 12 September 2007, the Deputy Secretary of Defense established the Joint Task Force National Capital Region Medical (JTF-CAPMED) with a mission to (1) ensure effective and efficient delivery of world-class health care within the NCR and (2) oversee the consolidation and realignment of military health care in accordance with the Base Realignment and Closure (BRAC) statutory process. With the pending completion of the consolidation of medical facilities and functions in the NCR mandated by BRAC, the governance of military health care in the NCR is an issue that requires consideration and decision.

Outside the NCR, the MHS continues under a mix of governance by the military departments and by the Office of the Secretary of Defense. Military departments separately manage medical treatment facilities (MTFs) without DoD-wide direct management oversight. Within the Office of the Secretary of Defense, the Assistant Secretary of Defense for Health Affairs establishes health care policy, exercises budgetary authority over the MHS through the Defense Health Program (DHP) appropriation account, and administers beneficiary purchased care through the TRICARE Management Activity (TMA). In recent years, there have been numerous recommendations from both within and outside of the Department of Defense for increased jointness in the governance of the MHS to better achieve the missions of the MHS and to do so in a more cost-effective manner. In addition, the Secretary's March 14, 2011, Track Four Efficiency Initiatives Decisions Memorandum directed that the "MHS Support Activity" would replace the TRICARE Management Activity and have four divisions: Uniformed Services University of the Health Sciences, TRICARE Health Plan, Health Management Support, and Shared Services. Furthermore, in light of the considerable long-term fiscal challenges the nation faces, and the comprehensive review established by the Secretary of Defense to inform future decisions about spending on national security, we must ensure that the MHS is organized in a way that curtails expenses and achieves savings to the greatest extent possible in meeting its deeply important mission.

The present need for a decision regarding the post-BRAC governance of military health care in the NCR provides an opportunity to address the desired end-state governance of the entire MHS to best promote the effective and cost-efficient achievement of the MHS mission, potentially to involve a major system-wide reorganization.

Objectives and Scope

The review will analyze options and provide a recommendation for a governance model for the MHS as a whole and in multi-Service medical markets (to include the NCR). In the event the review does not

reach a consensus among all members, the co-chairs shall present their recommendation as well as the alternative recommendation(s) of the other members of the review group. The analysis of each option should address all of the aspects below:

- The entity or entities having authority, direction, and control of the MHS as a whole (e.g., joint medical command; defense health agency or activity; Military Departments).

- The head of this entity or entities, and the reporting chain between such head and the Secretary of Defense.

- The management, including supervisory chain(s), of individual MTFs (e.g., jointly; by particular Military Departments). The review should include a specific recommendation regarding the MTFs currently under JTF-CAPMED.

- The management, including supervisory chain(s), of multi-Service medical markets (e.g., jointly; through a designated Military Department lead for the market; through coordination among the Military Departments in the market). The review should include a specific recommendation for the management of the NCR market, currently managed by JTF-CAPMED.

- The authority, direction and control for mission and administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities.

- The budgetary authority for the Defense Health Program among OSD, the Military Departments, and/or joint entities.

- The policymaking authority among OSD, the Services, and/or joint entities.

- Management of purchased care and other functions currently performed by the TRICARE Management Activity.

- Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education and training, and other shared services and related functions.

- Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.

Methodology

The review will assess the options based on their fulfillment of the following criteria and such other criteria as the review determines necessary:

- Provision of high-quality, integrated medical care for Service members and eligible beneficiaries.

- Maintenance of a trained and ready deployable medical force to support combatant commanders.

- Achievement of significant cost-savings through, for example, elimination of redundancies, increased interoperability, and other means of promoting cost-efficient delivery of care.

No option may be recommended that might interfere with the successful completion of the NCR medical recommendation under the Base Realignment and Closure Act by the September 15, 2011, deadline.

Review Group Membership

The co-chairs of the review will be Dr. Peach Taylor, Deputy Assistant Secretary of Defense (Force Health Protection and Readiness), Office of the Assistant Secretary of Defense (Health Affairs), and Major General (Dr.) Doug Robb, Joint Staff Surgeon. Other members of the review group will consist of one representative at the 1- or 2-star general or flag officer or comparable Senior Executive Service level designated by each of the Secretaries of the Military Departments, the Chairman of the Joint Chiefs of Staff, the Under Secretary of Defense (Comptroller), the Under Secretary of Defense for Personnel and Readiness, and the Director, Cost Assessment and Program Evaluation. The review group shall meet on call of the co-chairs and as often as necessary to submit its report in a timely manner. The review shall have access to any information in the Department as the review determines necessary to accomplish its mission. All Department of Defense components will fully cooperate in the execution of this review and be responsive to all requests for information or other support.

Deliverables

The review will provide its report to the Deputy Secretary of Defense not later than 90 days from the issuance of these Terms of Reference. The report will be coordinated with the General Counsel of the Department of Defense, the Assistant Secretary of Defense for Legislative Affairs, and the Director, Administration and Management. The report shall include the following:

- At least four options for MHS governance, including but not limited to MHS governance models where primary authority is vested in: (1) a Defense Agency/ Field Activity; (2) a Joint Military Command; (3) one or more Military Department Secretaries; and (4) a hybrid model incorporating features of the other three options.

- An explanation of each option considered with regard to the aspects of governance listed in "Objectives and Scope," above, and an analysis of each option with regard to those aspects.

- Analysis of the strengths and weaknesses of each option based on the criteria listed in "Methodology" above, and any other criteria determined by the review to be relevant. This analysis should include an estimate of the cost-savings, if any, to be achieved by each option compared to current governance.

- A recommendation for the governance of the MHS as a whole and in multi-Service medical markets (to include the NCR). In the event the review does not reach a consensus recommendation among all members, the co-chairs shall present their recommendation as well as the alternative recommendation(s) of the other members of the review group.

- A timeline and process for implementing the recommended governance model for the MHS as a whole and in multi-Service medical markets (to include the NCR).

The report will be considered by the Deputy's Advisory Working Group (DAWG) prior to a final decision by the Deputy Secretary of Defense on its recommendations. The DAWG may also convene to discuss the progress of the review efforts prior to the completion of the report, as determined appropriate by the Deputy Secretary of Defense.

Appendix 2. November 14, 2003, Under Secretary of Defense (Personnel and Readiness) Memorandum, "TRICARE Governance"

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

JAN 20 2004

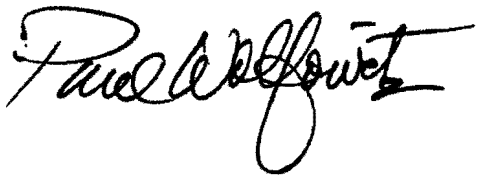
MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

SUBJECT: TRICARE Governance Plan

References: (a) Memorandum of the Under Secretary of Defense for Personnel and Readiness, Subject: "TRICARE Governance," October 22, 2003.
(b) DoD Directive 5136.12, "TRICARE Management Activity (TMA)," May 31, 2001.

I direct immediate execution of the TRICARE Governance Plan attachment to reference (a) as a key component of the Department's transformation of the Military Health System to achieve our vision for an improved, accountable, integrated and sustainable health care system for our military eligible beneficiaries. Corresponding revisions to the TRICARE Management Activity charter (reference (b)) regarding TRICARE Regional Office responsibilities and staffing identified in the Plan are also directed.

Time is of the essence in establishing the organizational framework identified in the Plan in order to have the appropriate staff in place to administer the new TRICARE contracts and to participate in the formal business planning process. Therefore, you are authorized to execute the Plan and to initiate appropriate revisions to reference (b) for conformance to the approved Plan.



OSD 00564-04

TAB A

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

OCT 2 2 2003

PERSONNEL AND READINESS

MEMORANDUM FOR SECRETARY OF THE ARMY
SECRETARY OF THE NAVY
SECRETARY OF THE AIR FORCE

SUBJECT: TRICARE Governance

The recent announcement of the award of new TRICARE contracts greatly improves the administration of TRICARE. We will reduce the number of health care services contracts from seven to three, and reduce the number of TRICARE regions from eleven to three. We will improve accountability for patient satisfaction. The contracts also offer new incentives for military medical commanders to optimize the direct care system which directly supports readiness and can be less costly.

Given these significant changes in the TRICARE program structure and the new performance incentives, the Assistant Secretary of Defense (Health Affairs) and the Service Surgeons General developed a joint governance plan by which they will establish performance objectives, monitor performance, and resolve problems should disagreements occur within the various components of the military health system. The TRICARE Governance Plan is attached.

This plan reflects a reasoned and balanced approach to managing the military health benefit with military medical readiness as the first priority, supported by a health delivery system that focuses on joint decision-making and effective resource allocation. With the close involvement of the Service Secretaries, the defense leadership will continue to monitor the performance of military medicine through the Military Health System Executive Review structure.

David S. C. Chu

Attachment:
TRICARE Governance Plan

cc:
Vice Chiefs of Staff
ASD (HA)
Assistant Secretaries (M&RA)

TRICARE Governance Plan

Table of Contents

October 2003

I. Executive Summary

The magnitude of the resources involved in providing the TRICARE health benefit and the demands being placed on military health care to support contingency operations require an effective and efficient management structure for delivering and coordinating care in the military health system. The TRICARE governance model distinguishes TRICARE health plan management from health care delivery. Health plan management includes: establishing worldwide Defense health policy; establishing and managing the overall health benefit; determining the annual budget; contracting for global or national health care services; and allocating funds to the Services and to DoD health care contractors.

This TRICARE Governance Plan establishes the overall organizational construct, regional office responsibilities and staffing plan, market manager responsibilities, and the business planning requirements and process. The major elements of this plan establish:

1. *Regional Organization:*
   a. There will be three TMA TRICARE Regional Offices (TROs) aligned with three TRICARE regional contracts in the United States.
   b. There will be an Overseas TRICARE Regional office, headquartered in the TRICARE Management Activity with subordinate three overseas area offices.
   c. The TRICARE Alaska Office is a satellite office of the TRO-West.

2. *Regional Directors.* Regional Directors have knowledge of all assets, costs, and expenditures and can make recommendations to the Services regarding the flow of dollars and staffing in their respective regions. Regional Director positions will be filled by a military flag officer or a Senior Executive Service (SES) civilian.

3. *Market Managers.* Market management is a key responsibility for the Senior Market Managers, MTF Commanders, and for the three TRO Regional Directors. Senior market managers are responsible for developing a single, integrated business plan for their respective markets.

   a. There are eleven (11) large health care delivery markets
      (1) North Region: National Capital Region; Tidewater, VA; Fort Bragg/Pope AFB, NC.
      (2) South Region: Charleston Naval Hospital/AFB Clinic, SC; Fort Jackson/Shaw AFB, SC; Biloxi, MS; San Antonio, TX.
      (3) West Region: Colorado Springs, CO; San Diego, CA; Puget Sound, WA; State of Hawaii.

   b. In markets in which more than one Service military treatment facility (MTF) is present, referred to as multiple service markets, the Surgeons General will designate a Senior Market Manager. The Senior Market Manager will be responsible for coordinating the development of a single business plan representing all the MTFs located within the respective multiple service market.

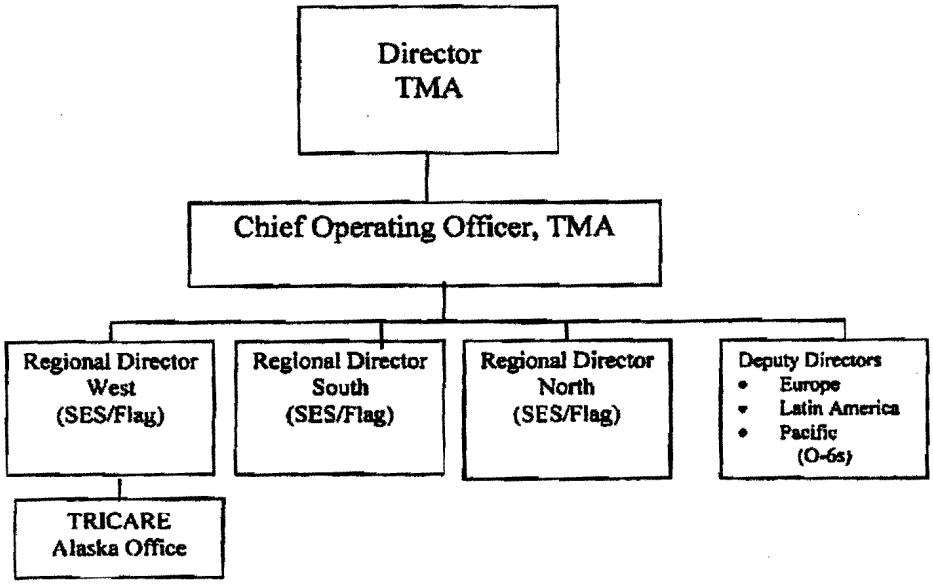
4. *Business Plans.* A regionally integrated business plan developed prior to the year of execution is the management tool to provide accountability at all levels in the MHS for both the direct care and purchased health care delivery. The Regional Director is responsible for the development and implementation of the regional business plan.

5. *Problem Resolution.* The TRICARE Management Activity. Chief Operating Officer communicates with the Surgeons General regarding any unresolved issues in the MTF or Multi-Market Service business plans. A lack of agreement between a Service and the TRICARE Management Activity (TMA) regarding the development and execution of the business plan should be resolved at the TRICARE Advisory Committee (TAC) and, if necessary, the issue can be brought forward to the Senior Military Medical Advisory Council (SMMAC) for decision by the Assistant Secretary of Defense (Health Affairs). Disputes between MTFs in a multi-service market will be adjudicated through the chains of command of the involved Services.

II. TRICARE Regional Offices

1. *TRICARE Organizational Relationships.* The TRICARE Regional Offices represent the new management organization for managing regional contractors and overseeing an integrated health care delivery system in the three United States-based TRICARE regions. The TROs are designated TRICARE Regional Office-North, TRICARE Regional Office-South and TRICARE Regional Office-West. The new management organization for the TRICARE Overseas program will include a TRICARE Overseas Regional Office based at TMA with subordinate overseas offices. After adequate staffing and funding for civilian personnel for the TROs is transferred from the existing Lead Agents or Service medical departments, TMA will assume responsibility for ongoing management, staffing and funding of these offices. Military staff provided to the Regional Offices may continue to be provided through the current Service processes for providing military manpower to the Lead Agents. Each United States-based TRICARE regional office will be led by a Regional Director, reporting to and operating under the authority, direction, and control of the TMA Chief Operating Officer (COO).

Chart 1



2. *Responsibilities of the Regional Director.* Within each region the Regional Director is the health plan manager. They have visibility of both the contract and direct care assets, and coordinate with the Services to develop an integrated health plan. Specific responsibilities include:

a. Management of the TRICARE contracts for all eligible MHS beneficiaries in the region. This responsibility includes:

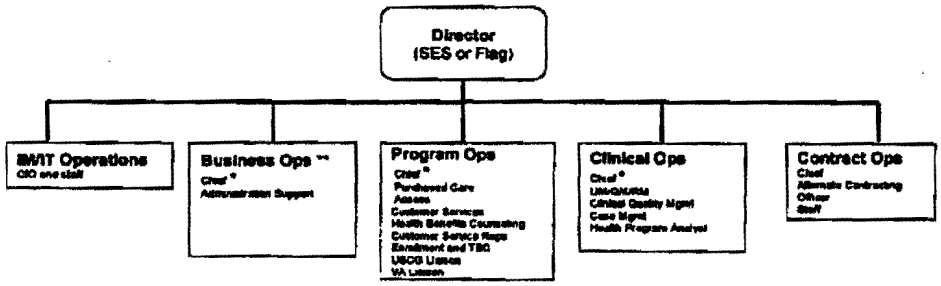
- ensuring network quality and adequacy including provider issues
- monitoring customer satisfaction outcomes
- managing TRO customer service issues
- coordinating appointing and referral management policies
- addressing enrollment issues
- contracting and fiscal management functions
- establishing and coordinating regional marketing and education functions
- overseeing contractor credentialing
- developing TRICARE Maximum Allowable Charge (TMAC) waiver packages
- approving resource sharing agreements entered into between the contractor and the MTF under the auspices of the new contract
- ensuring contract support for MTF optimization
- approving memorandums of understanding with the contractor(s)
- serving as the fee determination official for the Health Care Services and Administration contract
- other delegated functions.

b. Provision of support to the military medical treatment facility (MTF) Commanders in their delivery of health care services for MTF-enrolled beneficiaries; for the management of health care services for beneficiaries not enrolled to MTFs; supporting the MTF Commanders in their efforts to optimize health care services in the MTFs; and other assistance as required to support both MTF and remote areas to meet regional strategic planning goals and the annual business plan objectives.
c. Development of business plans for non-MTF areas (e.g., BRAC sites), remote areas, and those areas in which a Service Surgeon General requests Regional Director support.
d. Integration of MTF and remote business plans into a single, regional business plan for submission to TMA prior to the start of each fiscal year, and subsequent monitoring of performance against the business plans.
e. Funding of regional initiatives to optimize and improve the delivery of health care, through dedicated resources and a disciplined and open business case planning/approval process. Opportunities for investment capital can be initiated by the Regional Director, a single MTF Commander or by a Senior Market Manager on behalf of the MTFs in a multiple service market.
f. Chair of the TRICARE Regional Advisory Committee

3. *TRICARE Regional Office Organization and Staffing.* For the three US-based regions, the TRICARE Regional Office organizational chart is provided (Chart 2). These offices will each be supported with sixty (60) persons including one US Coast Guard liaison and one representative from the Department of Veterans Affairs for each office. During the transition from the current contracts to the new TRICARE contracts, some Lead Agent office staff will migrate to the TROs and some will be retained by the Services. TRO staff should operate under the authority, direction and control of the Regional Director. Civilian staffing will be maintained under TMA manning documents while military staffing (except Regional Directors if Flag Officer) will be classified as detailed assets and remain on Service manning documents. If the Services wish to move military personnel to TMA manning documents, they may.

Chart 2

TRICARE Regional Office Organization Chart



* One of these three Chiefs will be selected to function as Director in the absence of incumbent

**Responsible for Business Operations and functions of Office of the Director

4. *Overseas Regions.* Although overseas locations are not served by a Managed Care Support Contractor, the TRICARE Overseas programs require continued management presence.

a. The overseas offices will be established as follows:
   - ❑ TRICARE Europe in Sembach, Germany.
   - ❑ TRICARE Pacific in Okinawa. Japan
   - ❑ TRICARE Latin America/Canada in Fort Gordon, Georgia.

b. Each overseas area will have an office with a military (0-6) Deputy Director, TRO. The overseas Deputy Directors shall operate under the authority, direction and control of the TMA, Chief Operating Officer and will be supported by the Overseas Regional Office. Civilian staffing will be maintained under TMA manning documents while military staffing will remain on Service manning documents.

c. Each overseas area will form an Executive Steering Committee consisting of Combatant and Component Surgeons to provide a forum for communication and to address issues that affect health care delivery for their beneficiaries.

5. *TRICARE Alaska Office.* The TRICARE Alaska Office (TAO) is a satellite of the TRICARE West Region. Funding and authorities will come from current Lead Agent resources.

6. Regional Business Planning Process. Utilizing the business plans (see Section IV) that have been approved and submitted by the Surgeons General for all multiple service market areas and by the Services for their single MTFs, the Regional Director develops the regional business plan for health care delivery by integrating the TRO regional non-MTF business plan with the single

and multi MTF business plans. *(Chart 3)*. The Regional Director has knowledge of all assets, costs, and expenditures and is able to make recommendations to the Services regarding the flow of dollars and staffing throughout the region. The Regional Director monitors MTF performance in accordance with the business plans and communicates with MTF Commanders, and if necessary with Service headquarters, when deviations from the plan are noted. Within the region, the Regional Director accomplishes the market management for the areas without MTFs and for smaller MTFs, when requested by a Surgeon General.

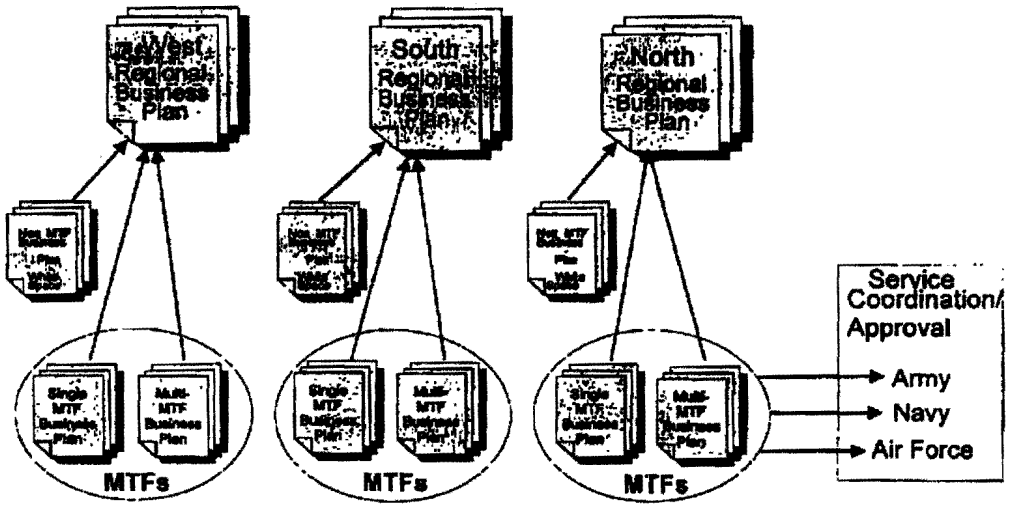


Chart 3: Regional Business Plan Review Process

III. Market Management

TRICARE Markets. A TRICARE market is a significant density of TRICARE users and is designated in the new TRICARE contracts as Prime Service Areas. The TRICARE contractor will develop provider networks in these Prime Areas that include, but not restricted to, the forty-mile radius around MTFs, Base Realignment and Closure (BRAC) sites and any additional sites proposed by the contractor. The TMA and the services have defined 182 Prime Service Areas across the United States where the Managed Care Support Services contractors are required to develop a Prime provider network.

1. *Multiple Service Markets.* Multiple service markets are those Prime Areas in which more than one Service military treatment facility is present, and significant beneficiary health care costs exist.
   a. There will be eleven large markets (See Table 1). Thirteen markets are multiple service markets. Although San Diego only has one Service with a medical presence, it ranks third in terms of beneficiaries served (337,641) and expends 5 percent of the total purchased care and direct care dollars in the MHS and thus merits equivalent attention. These 13 markets account for approximately 31 percent of the total eligible TRICARE population and approximately 44 percent of the purchased and direct care dollars expended.
   b. The title Senior Market Manager applies to the MTF Commander designated by the Surgeons General to be the market manager for each of the 13 multi-service markets.
   c. In multiple service markets, the Senior Market Manager will be responsible for coordinating the development of a single, integrated business plan. This includes integrated plans for appointing services, resource sharing (among the Services and with contractor support), optimization initiatives and DoD/VA sharing opportunities.
   d. The Senior Market Manager leads a collaborative process to develop a consolidated business plan for the market and to jointly work resource issues. The Senior Market Manager is empowered to make recommendations concerning short-term operational decisions to address unanticipated changes in staffing and/or demand for patient care services. This includes recommendations to temporarily reassign staff within the market. Recommendations agreed upon by the MTF Commanders may be implemented locally. Disputes between MTFs in a multi-service market will be adjudicated through the chains of command of the involved Services and in accordance with the dispute resolution process outlined in Section V.

Table 1: Multiple Service Market Areas/ Senior Market Managers

Multiple Service Market Areas			
Region	Market	Service	Senior Market Manager
North	National Capital Area	Army	Walter Reed Army Medical Center
North	Tidewater, VA	Navy	Portsmouth Naval Medical Center
North	Ft Bragg/Pope AFB, NC	Army	Womack Army Medical Center
South	Naval Hospital Charleston/ Charleston AFB, SC	Navy	Naval Hospital Charleston
South	Ft Jackson/Shaw AFB, SC	Army	Moncrief Army Hospital
South	Mississippi Delta	Air Force	Keesler USAF Medical Center
South	San Antonio, TX	Air Force	Wilford Hall Medical Center
West	Colorado Springs, CO	Air Force	USAF Academy Hospital
West	San Diego, CA	Navy	San Diego Naval Medical Center
West	Puget Sound, WA	Army	Madigan Army Medical Center
West	Hawaii	Army	Tripler Army Medical Center
West	Anchorage, Alaska	Air Force	Elmendorf AFB Hospital
West	Fairbanks, Alaska	Army	Bassett Army Community Hospital

2. *Service Responsibilities.* The Surgeons General will approve business plans for their individual MTFs and for the multiple service markets designated as their responsibility. The Services are also responsible for resourcing MTFs in accordance with the approved business plan.

3. *MTF Commander Responsibilities.* The Services will determine the size, resources, organizational alignment and staffing to accomplish MTF market management functions at the MTFs and for those MTFs who are Senior Market Managers. The MTF Commander is responsible for the following activities:

a. Develop and submit the business plan for the market.
b. Develop and implement joint programs in multiple service market areas.
c. Identify and develop sharing initiatives with the Veterans Health Administration
d. Manage the care of all MTF Prime enrollees under Revised Financing.

e. Support and participate in regional activities as requested, assign Point(s) of Contact for the managed care contractor within the market, and develop Memorandums of Understanding with the managed care contractor as required in the contracts.

IV. Business Planning

1. The business planning process is the key element for the integration of the direct care system with purchased care. Annual business plans, developed by MTF Commanders and multi-service market managers, will be integrated into regional business plans by the Regional Directors and will serve as the cornerstone of TRICARE health plan management. The objective for the business planning process is to achieve optimal utilization of the DHP resources and provide management accountability at every level of the MHS.

2. A fundamental principle of the business planning and operational monitoring process is that the Regional Directors, Services and TMA will conduct operations with complete financial and workload visibility. Progress will be monitored based on pre-established performance goals.

3. The business planning process will:
   a. Document the accountability and responsibility for the scope of care provided by each MTF.
   b. Account for staffing and funding, and establish productivity and financial objectives with TMA.
   c. Establish the direct care system capability and capacity with analysis of market demands and opportunities. Opportunities that require investment capital, optimization funding, or requirements to meet critical medical needs will be identified in the business plan.

4. All Service designated MTFs will develop a business plan. For outpatient MTFs there are two options:
   a. A stand alone business plan;
   b. The facility may be incorporated into the business plan of a parent MTF.

5. The MTF Commander is responsible and accountable for the delivery of the TRICARE health benefit to the population enrolled to the MTF. Additionally, the MTF Commander will include in the business plan the provision of care to selected beneficiaries to maintain readiness skills and clinical competency, and to maximize utilization of the facility after the needs of TRICARE Prime enrollees have been met.

6. Revised financing provides the MTF Commander with the incentives to closely manage total health care utilization and cost for their enrollees. MTFs in the United States will operate under revised financing rules, with funds identified for non-active duty purchased care and for active duty supplemental care costs.

V. Policy, Business Planning and Problem Resolution Process

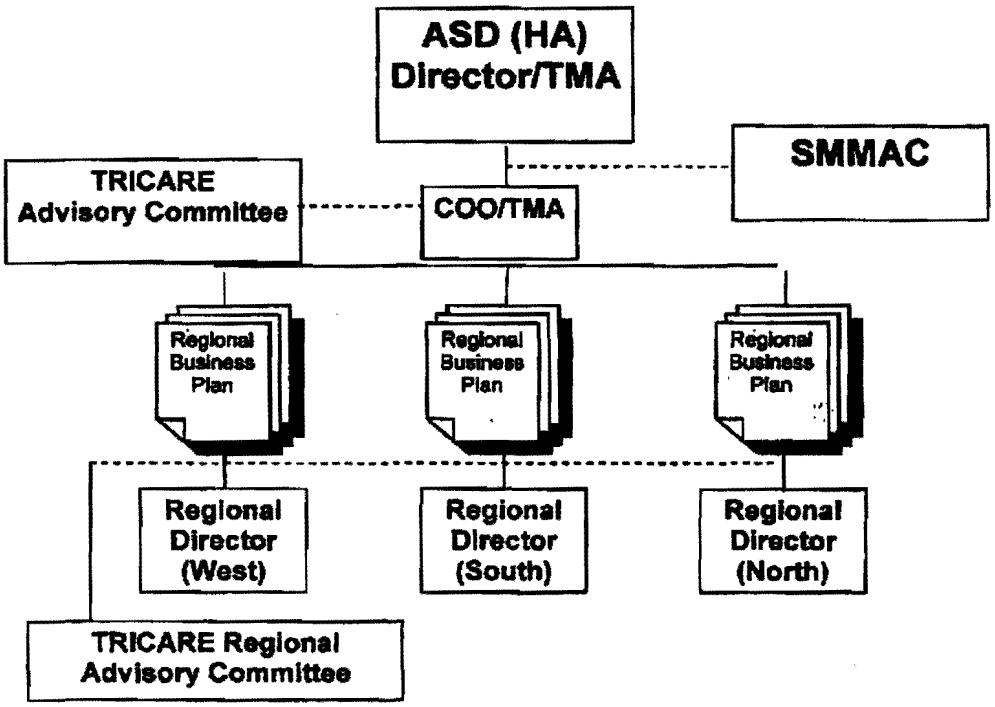
1. Business Plan Approval and Execution. During the development and execution of the regional business plan the Regional Director will directly communicate and coordinate with MTF Commanders and, if necessary, with the Services to reconcile any concerns. The goal is to mutually agree if the plan as submitted by the Services needs to be changed. Assuming consensus, the consolidated plan will be reviewed and approved by the TAC. Issues concerning the business plan that cannot be resolved between the Regional Director and the Services will be referred to the COO to work with the Deputy Surgeons General for resolution.

2. TRICARE Regional Advisory Committee (TRAC). The TRAC will review the annual regional business plans and periodically assess the regional business plan's performance. The TRAC will serve as a forum to identify and resolve regional issues prior to bringing them to the attention of the TRICARE Advisory Committee (TAC) or COO. The membership will include: the Regional Director, the representative MTF Commanders and/or Intermediate Commands/Services and the Managed Care Support Contractor. The SMMAC will review the composition of the regional TRACs periodically to ensure uniformity of Service representation.

3. *TRICARE Advisory Committee (TAC).* The TRICARE Advisory Committee (TAC) will be chaired by the TMA, COO with membership to include the TMA Chief Medical Officer, TMA Chief Financial Officer, TMA Chief Information Officer, and the three Deputy Surgeons General. The TAC will approve and periodically evaluate the regional health plans. The TAC also is available to identify and resolve issues prior to bringing them to the attention of the TMA Director.

4. Regional business plan issues that are not resolved by the TAC will be presented for review by the Senior Military Medical Advisory Council (SMMAC) and resolution by the ASD(HA) in his role as program manager for all medical resources.

Chart 4


ASD (HA)
Director/TMA
SMMAC
TRICARE
Advisory Committee
COO/TMA
Regional
Business
Plan
Regional
Business
Plan
Regional
Business
Plan
Regional
Director
(West)
Regional
Director
(South)
Regional
Director
(North)
TRICARE Regional
Advisory Committee

TAB B

B

Department of Defense
DIRECTIVE

31 May 2001
NUMBER 5136.12

DA&M

SUBJECT: TRICARE Management Activity (TMA)

References: (a) Title 10, United States Code
(b) DoD Directive 5136.11, "Defense Medical Programs Activity," October 26, 1992 (hereby canceled)
(c) DoD Directive 5105.46, "TRICARE Support Office," July 31, 1997 (hereby canceled)
(d) DoD Directive 5136.1, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," May 27, 1994
(e) through (h), see enclosure 1

1. PURPOSE

Pursuant to the authority vested in the Secretary of Defense under reference (a) establishes TRICARE Management Activity (TMA) with the mission, organization, responsibilities, functions, relationships, and authorities as described herein. The TMA replaces the Defense Medical Programs Activity (reference (b)), and the TRICARE Support Office (TSO) (reference (c)), which are hereby disestablished. All references in DoD Directive 5136.1 (reference (d)) or any other DoD issuance (except the Defense Federal Acquisition Regulation Supplement (DFARS)) (reference (e)) to active functions or authorities of the "Office of CHAMPUS" or "OCHAMPUS" shall be understood to be references to functions and authorities of the TMA (successor to TSO, which was previously known as the Office of CHAMPUS). All references in the DFARS to active functions or authorities of the "Office of CHAMPUS" shall be understood to be references to the functions and authorities of the TMA Directorate of Acquisition Management and Support.

2. APPLICABILITY

This Directive applies to the Office of the Secretary of Defense, the Military Departments, the Chairman of the Joint Chiefs of Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the Department of Defense (hereafter referred to collectively as "the DoD Components"). This Directive also applies to the Coast Guard when it is not operating as a Military Service in the Navy, the Commissioned Corps of the Public Health Service, and the National Oceanic and Atmospheric Administration under agreements with the Departments of Transportation and Health and Human Services.

3. DEFINITIONS

Terms used in this Directive are defined in enclosure 2.

4. MISSION

The mission of the TMA is to:

4.1. Manage TRICARE;

4.2. Manage and execute the Defense Health Program (DHP) Appropriation and the DoD Unified Medical Program; and

4.3. Support the Uniformed Services in implementation of the TRICARE Program and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

5. ORGANIZATION

The TMA is hereby established as a DoD Field Activity of the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) and shall operate under the authority, direction, and control of the Assistant Secretary of Defense for Health Affairs (ASD(HA)). It shall consist of:

5.1. A Director appointed by and reporting to the ASD(HA).

5.2. The Directorate of Acquisition Management and Support (AM&S), which shall operate as the primary contracting activity in support of the TMA mission.

5.3. Such additional subordinate organizational elements as are established by the Director, TMA, within authorized resources.

6. RESPONSIBILITIES AND FUNCTIONS

6.1. The Assistant Secretary of Defense for Health Affairs, under the Under Secretary of Defense for Personnel and Readiness, in accordance with DoD Directive 5136.1 (reference (d)), shall:

6.1.1. Execute the Department's medical mission, which is to provide, and to maintain readiness to provide, medical services and support to members of the Armed Forces during military operations, and to provide medical services and support to members of the Armed Forces, their dependents, and others entitled to DoD medical care.

6.1.2. Exercise authority, direction, and control over all DoD medical and dental personnel, facilities, programs, funding, and other resources within the Department of Defense.

6.2. The Director, TMA, under the authority, direction, and control of the ASD(HA), shall:

6.2.1. Organize, direct, and manage the TMA and all assigned resources.

6.2.2. Manage the execution of policy issued by the ASD(HA), pursuant to reference (d), in the administration of all DoD medical and dental programs authorized by reference (a). Issue program direction for the execution of policy within the MHS to the Surgeons General of the Army, Navy, and Air Force. When issued to the Military Departments, program direction shall be transmitted through the Secretaries of those Departments.

6.2.3. Serve as the program manager for TRICARE health and medical resources, supervising and administering TRICARE programs, funding, and other resources within the Department of Defense. The Director, however, may not direct a change in the structure of the chain of command within a Military Department with respect to medical personnel and may not direct a change in the structure of the chain of command with respect to medical personnel assigned to that command.

6.2.4. Prepare and submit, together with and pursuant to policy guidance of the ASD(HA) and with Service input, for the Department's planning, programming, and budgeting system (PPBS), the DoD Unified Medical Program and budget to provide resources for all health and medical activities within the Department of Defense. Support the ASD(HA)'s presentation and justification of the DoD Unified Medical Program and budget throughout the PPBS process, including representations before the Congress.

6.2.5. Manage and execute the DHP and DoD Unified Medical Program accounts, including Military Department execution of allocated funds, in accordance with instructions issued by the ASD(HA), fiscal guidance issued by the Under Secretary of Defense (Comptroller), and applicable law.

6.2.6. Exercise oversight, management, and program direction of information management/information technology systems and programs as necessary to manage TRICARE and support the ASD(HA) in administration of all medical and dental programs authorized by reference (a).

6.2.7. Develop such technical guidance, regulations, and instructions as required to manage TRICARE and to support the ASD(HA) in administration of all medical and dental programs authorized by reference (a).

6.2.8. Support the conduct of studies and research activities in the healthcare area to assist the ASD(HA), and others, as necessary, in support of their responsibilities and to support the management and implementation of health policies for the MHS issued by the ASD(HA).

6.2.9. Contract for managed care support, dental support, other health programs, claims processing services, studies and research support, supplies, equipment, and other services necessary to carry out the TRICARE and support the MHS.

6.2.10. Collect, maintain, and analyze data appropriate for the preparation of budgets, fiscal planning, and as otherwise needed to carry out TRICARE.

6.2.11. Provide beneficiary and customer support and information services.

6.2.12. Exercise oversight and program direction over each TRICARE Regional Office (TRO), to include defining the roles, functions, and responsibilities of the Lead Agents, to ensure consistent implementation and management of MHS policies and the uniform health benefit.

6.2.13. Issue, through the head of the contracting activity (HCA), administrative contracting officer warrants, as the HCA deems appropriate, to TRO staff pursuant to a memorandum of agreement entered into between the HCA and each TRO Lead Agent for administration of TRICARE contracts

6.2.14. Provide comments and recommendations to the appropriate official in the evaluation and rating of each TRO Lead Agent, consistent with applicable Service regulations.

6.2.15. Perform such other functions as the ASD(HA) may prescribe.

6.3. The Secretaries of the Military Departments shall:

6.3.1. Establish and staff a TRO for geographical areas designated by the ASD(HA). The TRO shall be provided the authority and staff necessary to ensure consistent implementation and management of MHS policies and the uniform health benefit within the geographical area.

6.3.1.1. The TRO shall be headed by a Lead Agent (a senior military officer) who shall be the focal point for health services within the geographical region with responsibility for development and execution of an integrated plan for the delivery of health care. While the Lead Agent shall be under the operational control of, and be responsible to, his/her respective Military Department, the Lead Agent shall be subject to the oversight and program direction of the TMA Director in the implementation and management of MHS policies and the uniform health benefit.

6.3.1.2. A Lead Agent Director, operating under the authority, direction, and control of the TRO Lead Agent, shall manage the TRO. The Lead Agent Director shall be responsible, in collaboration with Military Treatment Facility commanders, for development and execution of an integrated plan for the delivery of health care within the geographical region. Selection and appointment of each TRO Lead Agent Director shall be made in coordination with and approval of the Director, TMA.

6.3.2. Provide, on a reimbursable basis, such facilities, physical security, logistics, and administrative support as required for effective TMA operations. Reimbursements for inter-service support and services shall be made in accordance with DoD Instruction 4000.19 and DoD Directive 1400.16 (references (f) and (g)).

6.4. The Director, Defense Legal Services Agency, shall provide legal advice and services for the TMA.

7. RELATIONSHIPS

7.1. The Director, TMA, shall:

7.1.1. Ensure that the DoD Components are kept fully informed concerning TMA activities with which they have collateral or related functions.

7.1.2. Use established facilities and services of the Department of Defense and other Federal Agencies, whenever practicable, to avoid duplication and to achieve an appropriate balance of modernization, efficiency, and economy of operations.

7.1.3. Maintain appropriate liaison, consultation and coordination with other governmental and non-governmental agencies, as required, to exchange information and advice on programs in the fields of assigned responsibility.

7.1.4. Work collaboratively with the Military Departments, through the Surgeons General, to ensure an integrated and standardized TRICARE health care delivery system.

7.2. The Heads of DoD Components shall coordinate with the Director, TMA, as appropriate, on matters relating to TMA operations, functions, and responsibilities.

8. AUTHORITIES

8.1. The Director, TMA, is specifically delegated authority to:

8.1.1. Obtain from other DoD Components, consistent with the policies and criteria of the DoD Directive 8910.1 (reference (h)), information, advice, and assistance necessary to carry out TMA programs and activities.

8.1.2. Communicate directly with appropriate representatives of the DoD Components, other Executive Departments and Agencies, and members of the public, as appropriate, on matters related to TMA programs and activities. Communications to the Commanders of the Combatant Commands shall be transmitted by the ASD(HA), through the Chairman of the Joint Chiefs of Staff.

8.1.3. Exercise oversight and management of Executive Agents designated to perform TRICARE activities. Exercise oversight, program direction, and funding execution of Executive Agents designated to perform activities related to TRICARE activities.

8.1.4. Exercise the administrative authorities contained in enclosure 3.

9. ADMINISTRATION

9.1. The Secretaries of the Military Departments shall assign military personnel to the TMA in accordance with approved authorizations and established procedures for assignment to joint duty.

9.2. Administrative support for Headquarters, TMA and the TMA field elements may be provided by the DoD Components through interservice support agreements in accordance with DoD Instruction 4000.19 and DoD Directive 1400.16 (references (f) and (g)).

10. EFFECTIVE DATE

This Directive is effective immediately.

Paul Wolfowitz
Deputy Secretary of Defense

Enclosures – 3
E1. Reference, continued
E2. Definitions
E3. Delegations of Authority

E1. ENCLOSURE 1

REFERENCES, continued

(e) Defense Federal Acquisition Regulation Supplement (current edition)
(f) DoD Instruction 4000.19, "Interservice and Intergovernmental Support," August 9, 1995
(g) DoD Directive 1400.16, "Inter-departmental Civilian Personnel Administration Support," October 30, 1970
(h) DoD Directive 8910.1, "Management and Control of Information Requirements," June 11, 1993
(i) Title 32, Code of Federal Regulations, Part 199, "Civilian Health and Medical Programs of the Uniformed Services (CHAMPUS)"

E2. ENCLOSURE 2

DEFINITIONS

E2.1.1. Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The DoD civilian sector health care program operated under the authority of 32 CFR part 199 (reference (i)).

E2.1.2. TRICARE. The DoD medical and dental programs operating pursuant to chapter 55 of 10 U.S.C. (reference (a)), under which medical and dental services are provided to DoD health care beneficiaries. (The term "TRICARE" includes all activities described in the definition of the term "TRICARE Program" at 10 U.S.C. 1072(7) (reference (a)).

E2.1.3. Armed Forces. The Army, Navy, Air Force, Marine Corps, and Coast Guard.

E2.1.4. Uniformed Services. Includes the Armed Forces, the Commissioned Corps of the National Oceanic and Atmospheric Administration, and the Commissioned Corps of the Public Health Service.

E2.1.5. DoD Military Health System (MHS). The DoD medical and dental programs, personnel, facilities, and other assets operating pursuant to chapter 55 of 10 U.S.C. (reference (a)), by which the Department of Defense provides:

E2.1.5.1. Health care services and support to the Armed Forces during military operations, and

E2.1.5.2. Health care services and support under TRICARE to members of the Armed Forces, their family members, and others entitled to DoD medical care.

E2.1.6. Defense Health Program (DHP) Appropriation. A single appropriation consisting of operation and maintenance and other procurement funds designed to finance the non-military personnel requirements of the MHS.

E2.1.7. DoD Unified Medical Program. A combination of the DHP appropriation, the medical military construction appropriation, and the military personnel funds to reimburse the military personnel appropriations of the three Military Departments for military personnel supporting the MHS.

E2.1.8. TRICARE Regional Office (TRO). The office charged with ensuring consistent implementation and management of MHS policies and the uniform health benefit within a geographical area designated by the ASD(HA).

E2.1.9. Director, TMA. The official appointed by, and reporting to, the ASD(HA), with responsibilities, functions, and authorities set forth in this Charter. The term "Director" includes any other recognized organizational title, such as "Executive Director."

E3. ENCLOSURE 3

DELEGATIONS OF AUTHORITY

E3.1.1. Pursuant to the authority vested in the Secretary of Defense, and subject to the authority, direction, and control of the Secretary of Defense, the USD(P&R), the ASD(HA), and in accordance with DoD policies, Directives, and Instructions, the Director, TMA, or in the absence of the Director, the person acting for the Director, is delegated authority as required in the administration and operation of the TMA to:

E3.1.1.1. Exercise the powers vested in the Secretary of Defense by 5 U.S.C. 301, 302(b), 3101, 4103, 4302, and 5107 on the employment, direction, and general administration of TMA civilian personnel.

E3.1.1.2. Fix rates of pay of wage-rate employees exempted from the Classification Act of 1949 by 5 U.S.C. 5102 on the basis of rates established under the Federal Wage System. In fixing such rates, the Director, TMA, shall follow the wage schedule established by the DoD Wage Fixing Authority.

E3.1.1.3. Administer oaths of office to those entering the Executive Branch of the Federal Government or any other oath required by law in connection with employment therein, in accordance with 5 U.S.C. 2903, and designate in writing, as may be necessary, officers and employees of the TMA to perform this function.

E3.1.1.4. Establish a TMA Incentive Awards Board, and pay cash awards to, and incur necessary expenses for, the honorary recognition of civilian employees of the Government whose suggestions, inventions, superior accomplishments, or other personal efforts, including special acts or services, benefit or affect the TMA, in accordance with 5 U.S.C. 4503, Office of Personnel Management (OPM) regulations, and DoD 1400.25-M, Chapter 400, Subchapter 451.

E3.1.1.5. Maintain an official seal and attest to the authenticity of official TMA records under that seal.

E3.1.1.6. Establish advisory committees and employ temporary or intermittent experts or consultants, as approved by the Secretary of Defense, for the performance of TMA functions consistent with 10 U.S.C. 173; 5 U.S.C. 3109(b); and DoD Directive 5105.4.

E3.1.1.7. In accordance with Executive Order 10450, "Security Requirements for Government Employment," April 27, 1953; Executive Order 12333, "United States Intelligence Activities," December 4, 1981; and Executive Order 12968, "Access to Classified Information," August 4, 1995; and DoD Directive 5200.2, as appropriate:

E3.1.1.7.1. Designate any position in the TMA as a "sensitive" position.

E3.1.1.7.2. Authorize, in case of emergency, the appointment of a person to a

sensitive position in the TMA for a limited period of time and for whom a full field investigation or other appropriate investigation, including National Agency Check, has not been completed.

E3.1.1.7.3. Initiate personnel security investigations and, if necessary, in the interest of national security, suspend a security clearance for personnel assigned, detailed to, or employed by the TMA. Any action under this paragraph shall be taken in accordance with procedures prescribed in DoD 5200.2-R.

E3.1.1.8. Act as the agent for the collection and payment of employment taxes imposed by Chapter 21 of the Internal Revenue Code of 1954, as amended; and, as such agent, make all determinations and certifications required or provided for under the Internal Revenue Code of 1954, as amended (26 U.S.C. 3122), and the "Social Security Act," as amended (42 U.S.C. 405(p)(1) and 405(p)(2)), with respect to TMA employees.

E3.1.1.9. Authorize and approve:

E3.1.1.9.1. Temporary duty travel for military personnel assigned or detailed to the TMA in accordance with Joint Federal Travel Regulations, Volume 1.

E3.1.1.9.2. Travel for TMA civilian personnel in accordance with Joint Travel Regulations, Volume 2.

E3.1.1.9.3. Invitational travel to non-DoD personnel whose consultative, advisory, or other highly specialized technical services are required in a capacity that is directly related to, or in connection with, TMA activities, in accordance with Joint Travel Regulations, Volume 2.

E3.1.1.9.4. Overtime work for TMA civilian personnel in accordance with 5 U.S.C. Chapter 55, Subchapter V, and applicable OPM regulations.

E3.1.1.10. Approve the expenditure of funds available for travel by military personnel assigned or detailed to the TMA for expenses incident to attendance at meetings of technical, scientific, professional, or other similar organizations in such instances when the approval of the Secretary of Defense, or designee, is required by 37 U.S.C. 412, and 5 U.S.C. 4110 and 4111.

E3.1.1.11. Develop, establish, and maintain an active and continuing Records Management Program, pursuant to 44 U.S.C. 3102 and DoD Directive 5015.2.

E3.1.1.12. Utilize the Government Purchase Card for making micro-purchases of material and services, other than personal services, for the TMA, when it is determined more advantageous and consistent with the best interests of the Government.

E3.1.1.13. Authorize the publication of advertisements, notices, or proposals in newspapers, magazines, or other public periodicals, as required for the effective administration and operation of the TMA, consistent with 44 U.S.C. 3702.

E3.1.1.14. Establish and maintain, for the functions assigned, an appropriate publications

system for the promulgation of common supply and service regulations, instructions, and reference documents, and changes thereto, pursuant to the policies and procedures prescribed in DoD 5025.1-M.

E3.1.1.15. Enter into support and service agreements with the Military Departments, other DoD Components, or other Government Agencies, as required, for the effective performance of TMA functions and responsibilities.

E3.1.1.16. Enter into and administer contracts, through the TMA Directorate of Acquisition Management and Support or through a Military Department, a DoD contract administration services component, or other Federal Agency, as appropriate, for supplies, equipment, and services required to accomplish the mission of the TMA. The Director, AM&S, shall be the head of the contracting activity. To the extent that any law or Executive Order specifically limits the exercise of such authority to persons at the Secretarial level of the Department, such authority shall be exercised by the appropriate Under Secretary or Assistant Secretary of Defense.

E3.1.1.17. Establish and maintain appropriate property accounts for the TMA and appoint Boards of Survey, approve reports of survey, relieve personal liability, and drop accountability for TMA property contained in the authorized property accounts that has been lost, damaged, stolen, destroyed, or otherwise rendered unserviceable, in accordance with applicable laws and regulations.

E3.1.1.18. Promulgate the necessary security regulations for the protection of property and places under the jurisdiction of the Director, TMA, pursuant to DoD Directive 5200.8.

E3.1.1.19. Lease property under the control of the TMA, under terms that will promote the national defense or that will be in the public interest, pursuant to 10 U.S.C. 2667.

E3.1.1.20. Exercise the authority delegated to the Secretary of Defense by the Administrator of the General Services Administration for the disposal of surplus personal property.

E3.1.2. The Director, TMA, may redelegate these authorities as appropriate, with the approval of the ASD (HA) and in writing, except as otherwise specifically indicated above or as otherwise provided by law or regulation.

Appendix 3. September 12, 2007, Deputy Secretary of Defense Memorandum, "Establishing Authority for Joint Task Force – National Capital Region/Medical (JTF CAPMED) and JTF CAPMED Transition Team"

Appendix 4. March 14, 2011, Secretary of Defense Memorandum, "Organizational Efficiencies" (Pertinent Elements)

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

SEP 12 2007

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS
CHAIRMAN OF THE JOINT CHIEFS OF STAFF
UNDER SECRETARIES OF DEFENSE
CHIEFS OF SERVICES
COMMANDERS OF THE COMBATANT COMMANDS
ASSISTANT SECRETARIES OF DEFENSE
GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE
DIRECTOR, ADMINISTRATION AND MANAGEMENT
DIRECTOR, PROGRAM ANALYSIS AND EVALUATION
DIRECTORS OF THE DEFENSE AGENCIES

SUBJECT: Establishing Authority for Joint Task Force - National Capital Region/Medical (JTF CapMed) and JTF CapMed Transition Team (Unclassified)

The 2006 Quadrennial Defense Review provided strategies to improve the management, performance, and efficiency of the Military Health System (MHS). These strategies included elimination of redundant command structures, alignment of resource streams, and provision of clear lines of authority and responsibility for local decision making.

Effective 14 Sep 07, I am establishing JTF CapMed under the command of RADM John Mateczun, MC, USN, as delineated in Annex A and B. JTF CapMed will (1) ensure the effective and efficient delivery of world-class military healthcare within the NCR Tricare Sub-region (JOA) using all available military healthcare resources within this JOA, and (2) oversee the consolidation and realignment of military healthcare within the JOA in accordance with the Base Realignment and Closure Act (BRAC) Business Plan 169 and 173E. JTF CapMed will also conduct such other missions as may be assigned to improve the management, performance, and efficiency of the MHS.

Upon receipt of this memorandum, the current NCR Multiple Service Market Office (MSMO) and the NCR Medical BRAC Integration Office will merge to form the Transitional Element (TE) of JTF CapMed. RADM Mateczun will establish the Joint Table of Distribution (JTD) for the JTF Headquarters. Services will provide additional or alternate staffing as requested by the transition team or JTF.

I have tasked the Under Secretary of Defense for Personnel and Readiness and Vice Chairman, Joint Staff to oversee this effort within the Department. Tab A provides authorities, guidance, and immediate tasks to establish JTF CapMed. Tab B identifies the military units assigned to JTF CapMed.

Attachments:
As stated

TAB A

Final as of Signature Date

AUTHORITIES AND GUIDANCE FOR ESTABLISHING
JOINT TASK FORCE NATIONAL CAPITOL REGION MEDICAL (JTF CapMed)

1. **ESTABLISHMENT**. JTF CapMed will achieve Initial Operational Capable (IOC) not later than 1 October 2007 and Fully Operational Capable (FOC) not later than 30 September 2008.

a. JTF CapMed will be a fully functional Standing Joint Task Force reporting directly to the Secretary of Defense (SECDEF) through the Deputy Secretary of Defense (DEPSECDEF).

b. The commander of JTF CapMed will be an O-9 Medical Department Officer vested with appropriate authorities and reporting relationships as specified below. This position will be a position of importance and responsibility under section 601 of Title 10, United States Code.

c. The Commander of JTF CapMed will act as the senior medical officer in the JOA with responsibility for the effective and efficient delivery of world-class military healthcare in the NCR. The Commander will organize staff and reporting organizations to execute his/her mission. The Commander shall have the authority to compile budgets for the units assigned to JTF CapMed and distribute and direct resources as needed within the JOA to accomplish mission objectives. The Commander shall directly supervise the JTF Component Commanders within the JOA. The Commander shall forward risks and issues to the Co-Chairs of the Overarching Integrated Product Team for the Transition of Medical Activities in the National Capital Region (NCR OIPT) as necessary to ensure the effective execution of the JTF CapMed mission.

2. **MISSIONS AND RELATED AUTHORITIES**. The mission and authorities of JTF CapMed are as follows:

a. Oversee, manage, and direct all health care delivery by military medical units within the JOA and ensure the military medical readiness of personnel in the JOA.

b. Oversee, manage, and distribute resources to military health care assets within the JOA.

c. Develop a Joint NCR transition plan and oversee BRAC Business Plan 169 and 173E implementation and related military construction (MILCON) projects.

d. Coordinate the scheduling and funding of clinical and non-clinical work with Services, MHS BRAC Program Integration Office, US Army Corps of Engineers and NAVFAC.

e. Develop and maintain interagency and private partnerships.

f. Other tasks as assigned.

3. **JTF CAPMED LOCATION.** The Commander, National Naval Medical Center, Bethesda, Maryland shall provide or arrange for the administrative and logistic support of the headquarters of JTF CapMed.

4. **RESOURCES AND PERSONNEL.** JTF CapMed will be resourced by the Commands, Services, and MHS to ensure the successful implementation of its assigned missions, as indicated below.

a. The Commander, JTF CapMed will establish the JTD for the JTF Headquarters (HQ). Initial joint staffing will be provided by MSMO and BRAC Medical Integration Office staff. Services will take immediate steps to identify and assign military personnel to fill the JTF CapMed Headquarters Joint Table of Distribution (JTD) to meet mission requirements; Services will fill these positions prior to funding the billets.

b. The Commander, JTF CapMed will have Tactical Control (TACON) of the military medical units assigned or attached to the JTF (TAB B). The Services will retain operational and administrative control of the personnel assigned to JTF CapMed. The Services may assign and reassign personnel within the JTF CapMed JOA in support of their military medical units.

c. Operational and Maintenance funding. ASD (HA) shall identify and provide funds to support the HQ Staff of JTF CapMed and provide resources for the delivery of military health care within the JOA.

TAB B

JTF CapMed Military Medical Units

Army:

Walter Reed Army Medical Center, Washington, DC

- Dunham HC, Carlisle, PA
- Barquist AHC, FT Detrick, MD
- Kirk AHC, Aberdeen Proving Ground, MD
- Kimbrough AHC, FT Mead, MD
- Fairfax FHC, Fairfax, VA
- Woodbridge FHC, Woodbridge, VA
- Andrew/Rader FHC, FT Meyer, VA
- DeWitt ACH, FT Belvoir, VA
- Pentagon HC, Arlington, VA

Air Force:

Malcolm Grow MC, Andrews AFB, MD

- Bolling AFB 579 HC, Washington, DC
- 11th MDG Flight Medicine Clinic, Pentagon

Navy:

National Naval Medical Center, Bethesda, MD

- NHC Quantico, Quantico, VA
- Pax River HC, Patuxent River, MD
- NMC Naval Academy, Annapolis, MD
- NHC USUHS, Bethesda, MD
- NHC Carderock, Anacostia, MD
- NHC/DC Lakehurst, Lakehurst, NJ
- NHC/DC NAF Washington, DC
- NHC/DC Willow Grove, PA
- NHC Mechanicsburg, PA
- NHC/DC Dahlgren, VA
- NHC/DC Indian Head, MD
- NHC NRL, Washington, DC
- Tri-Serv Dental Clinic, Pentagon
- NHC Philadelphia Naval Bus Ctr, PA
- NHC/DC Washington Navy Yard, DC
- NHC/DC Earle, NJ
- NHC/DC Sugar Grove, WV

Appendix 5. High-Level Description of the Staffing Estimation Method

Estimate of Staffing Requirements

In support of the TOR criteria to evaluate options based on the potential to achieve significant cost savings through reduction in duplication and variation, the Task Force collected data on the organizational structure and staffing levels (military, civilian, and contractor) of the existing headquarters, intermediate command and field activities of Health Affairs, the TRICARE Management Activity (TMA), the offices of the Surgeons General, and the JTF CAPMED. The purpose was to develop a baseline of existing headquarters staffing and to provide an initial analysis of whether the options under consideration offered greater or lesser efficiencies in overall headquarters staffing. The analytic support team for the Task Force projected the potential staffing requirements for the MHS governance options. The details and tables that support this analysis are available in a separate volume. This report contains a review of the staffing analysis, along with the strengths and weaknesses of this approach. The key assumptions that guided the analysis were:

- For each component, the missions are similar but scope and processes are variables,
- Service management HQs are sized to accomplish their medical mission through the Service specific processes and in the Service operational environment, and

Current staffing can be used as a benchmark for staffing of consolidated HQ entities

Our analysis was based on, and extended parts of, a similar analytical model performed by the Center of Naval Analyses in support of the 2006 MHS Governance work group. Using the organizational charts and inputs from all organizations, the data were aligned by Higher Headquarters level and by functional category as shown in Figure A5-1 and Table A5-1.

	Air Force	Army	Navy	HA/TMA
Higher HQs	Air Force Surgeon General (AFSG)	Office of the Surgeon General (OTSG)	Navy Surgeon General (NSG)	Assistant Secretary of Defense (ASD), Health Affairs (HA)
Support Functions	Air Force Medical Operations Agency (AFMOA) / Air Force Medical Support Activity (AFMSA)	Army Medical Command (MEDCOM)	Bureau of Medicine & Surgery (BUMED) / Naval Medical Support Command (NMSC)	TRICARE Management Activity (TMA)
Regional HQs	Major Commands (MAJCOMs)	Regions	Regions	TRICARE Regional Offices (TROs)
Military Treatment Facilities	Not Included In This Analysis			

Figure A5-1. Higher Headquarters Construct

Level	Air Force	Army	Navy	HA	TMA	Total
Higher HQ	105	128	128	45	0	406
Support Agencies	831	705	532	0	2,649	4,717
Regions	156	504	195	0	158	1,013
Total	1,092	1,337	855	45	2,807	6,136

Table A5-1. Higher Headquarters Staffing

Function	Air Force	Army	Navy	HA	TMA	Total
Command	99	247	46	45	84	521
Contracting & Acquisition	15	0	0	0	138	153
Education & Training	1	3	12	0	7	23
Human Resources	47	89	62	0	48	246
Installations	17	38	26	0	6	87
IT	267	119	54	0	1,327	1,767
Logistics	92	71	10	0	0	173
Operations	301	104	229	0	220	854
Plans & Programs	21	164	82	0	16	283
PSC	0	4	0	0	440	444
RDT&E	85	0	155	0	3	243
Readiness	72	8	11	0	189	280
Resource Mangement	75	146	142	0	331	694
Specialty	0	344	26	0	0	370
Total	1,092	1,337	855	45	2,807	6,136

Table A5-2. Higher Headquarters Staffing by Function

The analysis was divided into two parts. The first part included the estimate of potential staff requirements for the development of shared services; the second half of the analysis estimated management headquarters requirements.

Part 1: Shared Services

All MHS Governance options proposed include a shared services construct. This construct was similar in each of the options and, therefore, a single analysis was conducted to estimate the size

of this element. The analysis adopted that of the Center for Naval Analyses[1] (CNA) by using an "economies of scale" approach based on the construct, i.e., the combination of two similar work elements will result in an output level that is marginally greater than the sum of the individual outputs due to scale efficiencies. This approach was used to estimate the staffing for the shared services component and Table A5-2 lists the functions considered for shared services. Due to the short time available for this Task Force to complete its work, no estimate was made of the savings from such items of consolidated contracts and other common business processes. The details of the shared services in terms of the functions involved and the level of consolidation should be developed further as part of the implementation of any governance changes.

Part 2: Higher Headquarters

The management headquarters construct used is given above in Figure A5-1, with each level analyzed separately.

Higher Headquarters. Representing the direct support offices of the ASD(HA) and the Surgeons General, this headquarters level was allocated a value of 100 personnel for each component for the analysis. Neither the TRICARE Management Activity nor any of the Service support activities is included in this allocation.

Unified Medical Command. To address the Unified Medical Command, we evaluated the JTF CAPMED staffing with expansion to an MHS-wide scope and compared this result to existing Combatant Commands staffing levels as a benchmark.

The estimated JTF CAPMED end-state staffing requirement is ~150 personnel to manage ~10% of the MHS operations. Extending this estimate linearly to the entire MHS suggests that approximately 1,500 staff would be needed to manage the entire system. Evaluation of Combatant Command staffing, shown in Table A5-3, suggests that UMC staffing could range from 2,000-3,000 personnel to oversee and direct the activities of over 130,000 personnel assigned and $53B in resources. A conservative estimate of the UMC staffing of 1,750 was used as the midpoint between the JTF staffing estimate and the lower end of the Combatant Command staffing benchmark. Although comparisons offer a reasonable estimate for staffing, the Task Force recognizes that a detailed concept plan or business case analysis is required to accurately determine the manpower requirements for a Unified Medical Command.

	AFRICOM	CENTCOM	EUCOM	JFCOM	NORTHCOM	PACOM	SOCOM	SOUTHCOM	STRATCOM	TRANSCOM	Joint Staff
TOTAL	2,695	5,801	3,788	5,703	2,412	5,371	6,209	2,563	6,021	2,601	2,252

*Data is all approved funded authorizations (FY11) as of 1 Aug JTD/JTMD.

Table A5-3. Combatant Command Joint Table of Distribution Authorizations

Intermediate Headquarters. This level represents the Regional Headquarters for the Army and Navy and the Major Command Medical Staffs for the Air Force. The TMA

[1] E. Christensen, CDR D Farr, J. Grefer, and E Schaefer, "Cost Implications of a Unified Medical Command," Center for Naval Analyses, CRM D0013842.A3, May 2006.

TRICARE Regional Offices (TROs) were not included as they were deemed to provide a unique and focused function centered on contractor performance that was different from the Services' regional and Major Command Medical Headquarters. In order to address the differences in organizational approach and command environment between the Services, a metric was developed that was normalized to the operations and maintenance (O&M) budget from the FY12 President's Budget. This metric was developed by reducing the size of the headquarters element by the estimated FTE savings based on shared services. As the shared services analysis addressed the shared services staffing estimate, removal of shared services from the management headquarters avoided double counting of those personnel. Initially, the intermediate headquarters staffing FTEs were reduced by the FTEs in functions that would be addressed as shared services. This reduced headquarters staffing was divided into the Defense Health Program (DHP) provided O&M budget for that Service to produce a metric showing the amount of O&M resources executed on a per capita basis of the numbers of people in the Headquarters element. This metric was used to estimate the staffing for Regional Headquarters in the options. By dividing the metric into the total DHP O&M executed by the Services, an estimate of the non-shared services intermediate staffing levels was obtained.

Support Elements. All Services include a support element for their management headquarters. Management headquarters include the Army's Medical Command (MEDCOM); the Navy Bureau of Medicine and Surgery (BUMED) and Naval Medical Support Command (NMSC); the Air Force Medical Operations Agency (AFMOA) and the Air Force Medical Support Agency (AFMSA). These elements provide key staffing for the daily common operational requirements for each Service medical organization. The analysis utilized the same approach for this level of command as in the intermediate headquarters.

Staffing Requirements. The final impact on staffing requirements for a governance option was estimated by adding the results for the shared services and the intermediate headquarters, less projected saving. These results were determined as ranges, shown in Figure A5-2. This figure shows the range of potential changes that is available from the model and the data provided. Clearly, the optimum result will lie between these two extremes and be dependent on the particular option assessed. For example, the Single Service option and the DHA with MTFs are very similar analytically and therefore any differences between them will depend on differences in the efficiencies found in the support and Intermediate HQ areas.

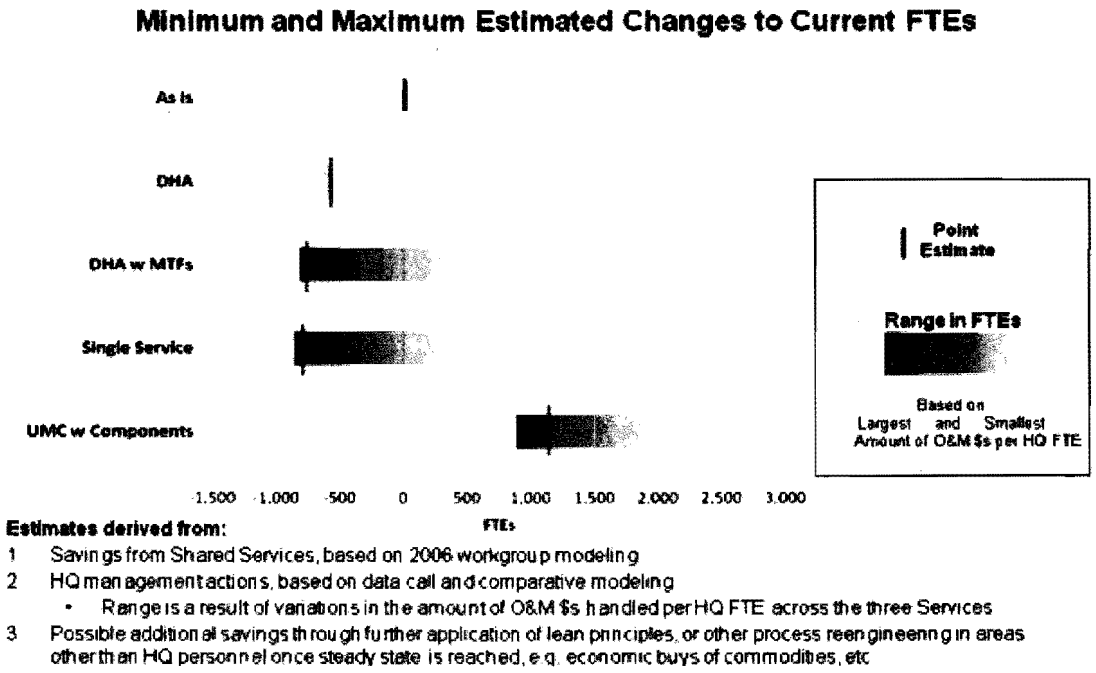


Figure A 5-2. Estimated Defense Health Program Funded Minimum and Maximum HQ Staffing Changes

Strengths and Weaknesses of the Analysis

The Task Force recognizes the highly preliminary nature of the data presented here. The 90-day review period did not allow for a more rigorous approach, but rather a "rough order of magnitude" estimate of staffing increases or reductions based on the organizational construct being considered. As such, the DHA with MTFs, DHA without MTFs, and single-Service models achieve a similar savings in FTEs while the UMC shows a growth in FTEs required. Given the similarity in the range of "rough order of magnitude" present in both DHA models and the single-Service model, caution should be used in basing preference in one model over the others, solely on FTE funded staffing reductions. No allocations of personnel reductions should be considered until a more detailed analysis is completed initially, the intermediate headquarters staffing FTEs were reduced by the FTEs in functions that would be addressed as shared services. This reduced headquarters staffing was divided into the Defense Health Program (DHP) provided O&M budget for that Service to produce a metric showing the amount of O&M resources executed.

Multiple assumptions were made to facilitate this analysis to include the use of the O&M calibrated metric as a method for scaling the size of the intermediate headquarters and support activities. This type of metric has potential for wide variations depending on the mission and functions of an organization and how much leveraging of other service and line resources occurs. It is not a credible predictor of staffing requirements. As the analysis included only DHP O&M resources, it did not include an assessment of the non-DHP, Service-level resources that are used to support the management of a Service Medical Department. The extent that a particular medical department leverages its owning Service processes and systems to reduce its DHP requirements clearly varied among the Services and should be addressed in a detailed assessment

of the overall savings for a particular option. The analysis did not include any allocation of requirements by component due to the differences in the staffing and operational environments between the components. Any allocation of reductions in particular should be informed by a more detailed analysis that would address the differences in the way the different components staff the various functions. This would avoid penalizing components that already have highly efficient processes potentially to the point of reducing their ability to deliver the needed functional outputs.

For the Unified Medical Command, there is interplay between the UMC staff and the support and intermediate headquarters staff that cannot be easily modeled without a more detailed analysis, therefore the UMC estimate is on the low end of the typical COCOM staff size. The estimate of the staffing requirements for the UMC is in the range of other COCOM staffs and indicates that a UMC may not provide significant savings as stated previously.

Appendix 6. Side-By-Side Comparisons of each MHS Governance Option depicting TOR Criteria and Strengths and Weaknesses

MHS Governance

MHS Governance Options
TOR Elements Side-by-Side Comparison

	TOR Elements	MHS Option 1: As Is Current Structure	MHS Option 2: A Defense Health Agency (DHA) with Medical Treatment Facilities (MTFs) remaining in the Military Departments	MHS Option 3: A Defense Health Agency (DHA) with Medical Treatment Facilities (MTFs) placed under the authority, direction and control of the Agency	MHS Option 4: Unified Medical Command (UMC) with Service Components	MHS Option 5: Single Service – one Military Department Secretary assigned responsibility for the MHS
1	**Entity having authority, direction and control of MHS as a whole.**	The ASD(HA) would be responsible for all authority, direction, and control of policy and resources of the MHS as a whole, consistent with DoD Directive 5036.01.	The ASD(HA) would be responsible for all authority, direction, and control of policy and resources of the MHS as a whole, consistent with DoD Directive 5036.01.	The Director, DHA would be responsible for authority, direction, and control of the MHS. ASD(HA) would have an oversight and policy role. Military Departments would be responsible for the size and capabilities of the active duty medical forces.	The Commander, US Medical Command, would be responsible for authority, direction, and control of the MHS as a whole through its components.	The designated Military Department Secretary would be responsible for the management and oversight of the MHS.
2	**Head of entity or entities, and the reporting chain to the Secretary of Defense.**	Military Department reporting chains would remain as they currently exist with Service Surgeons General reporting to their Service Chiefs who would report to their Military Department Secretaries who would report to the Secretary of Defense.	Component reporting chains would remain as they currently exist with Service Surgeons General reporting to their Service Chiefs who would report to their Military Department Secretaries who would report to the Secretary of Defense. The Director, Defense Health Agency (DHA) would report to the ASD(HA) who would report to the USD (P&R) who would report to the Secretary of Defense.	Component reporting chains for headquarters and TOE-assigned military personnel would remain as they currently exist. Service Surgeons General would continue reporting to their Service Secretaries who would report to the Secretary of Defense, but overall reporting chains would be changed for garrison care. The Director, DHA would report to the ASD(HA), who would report to the USD (P&R), who would report to the Secretary of Defense.	The Commander, US Medical Command, would report directly to the Secretary of Defense.	The designated Military Department Secretary would establish a medical organizational model as they determine is best suited to manage the MHS (likely with geographic or regional intermediate headquarters). The leader of the medical organization would report to the Military Department Secretary. The Military Department Secretary would report to the Secretary of Defense.
3	**Management and Supervisory Chains of MTFs.**	MTF commanders would report through their established Military Department chains of command.	MTF commanders would report through their established Military Department chain of command.	MTF commanders would report through intermediate commands established by the DHA Director.	MTF commanders would report through their components to the US Medical Command.	MTF commanders would report through the organizational model that the designated Military Department Secretary has put into place, through the Military Department chain of command. There may be an intermediate command structure put in to place by the Military Department Secretary based on geographic or functional mission considerations.
4	**Management and Supervisory Chains of Multi-Service Markets.**	Based on the selection for MSM governance (see Section, "Multi-Service Market Governance" further in this report).	Based on the option selected for MSM governance (see Section, "Multi-Service Market Governance" further in this report).	As all medical treatment facilities would be operated by the DHA, vice the Services, the concept of Multi-Service Markets would no longer be applicable.	The Commander, US Medical Command, would designate the Market Manager. Supervisory chains would continue through their Service Components. Larger, complex entities like the NCR may report outside component chains.	There would be no Multi-Service Markets. All MSMs would function under one Service.
5	**The authority, direction, and control for mission and administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities.**	The authority, direction, and control over MHS personnel would reside within the Military Departments.	The authority, direction, and control over MHS personnel would reside within the Military Departments, except for those assigned directly to the DHA.	The Director, DHA would have authority, direction, and control over MHS personnel assigned to the medical treatment facilities within rules established with the Military Department Secretaries. TOE forces would report through their Service structures.	The authority, direction, and control over assigned MHS personnel would reside within the Service Components of the US Medical Command, who report to the UMC commander.	The Military Department Secretary would have authority, direction, and control over MHS TDA personnel assigned to the medical treatment facilities. TOE forces would report through their separate Service structures.
6	**The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.**	The DHP would be sustained, and authority over the DHP would reside with the ASD(HA).	The DHP would be sustained, and authority over the DHP would reside with the ASD(HA). The Service Surgeons General and the DHA would develop their own DHP inputs to ASD(HA).	Authority over the DHP would reside with the Director, DHA with oversight from ASD(HA).	Authority over the DHP would reside with the Commander, US Medical Command.	Authority over the DHP would reside with the designated Military Department Secretary.

MHS Governance Options
TOR Elements Side-by-Side Comparison

	TOR Elements	MHS Option 1: As Is Current Structure	MHS Option 2: A Defense Health Agency (DHA) with Medical Treatment Facilities (MTFs) remaining in the Military Departments	MHS Option 3: A Defense Health Agency (DHA) with Medical Treatment Facilities (MTFs) placed under the authority, direction and control of the Agency	MHS Option 4: Unified Medical Command (UMC) with Service Components	MHS Option 5: Single Service – one Military Department Secretary assigned responsibility for the MHS
7	**The policymaking authority among OSD, the Services, and/or joint entities.**	The ASD(HA) would execute policy.	The ASD(HA) would execute policy through the Director, DHA.	The ASD(HA), subject to the authority, direction and control of USD (P&R), would be the senior policy authority within the MHS. The Director, DHA would execute policy through the DHA structure. Policy matters would be coordinated with the Director, DHA, and Military Department Secretaries.	The ASD(HA), subject to the authority, direction and control of the USD (P&R), would be the senior policy authority within the MHS. Policy matters would be coordinated with the UMC Commander and Military Departments.	The ASD(HA), subject to the authority, direction and control of the USD (P&R), would serve as the senior medical advisor to the Secretary of Defense, and retains policy authority within the MHS. The designated Military Department Secretary would execute ASD(HA) policy directives.
8	**Management of purchased care and other functions currently performed by the TRICARE Management Activity.**	The Director, TMA (currently dual-hatted by the ASD(HA)) would manage purchased care and other TMA functions.	The Director, DHA would assume control of TRICARE Contracts and all other TMA functions, with the exception of select financial management activities which would migrate to the OASD(HA).	The Director, DHA would assume control of TRICARE contracts and all other TMA functions.	The Commander, US Medical Command, would assume control of TRICARE contracts and all other TMA functions.	The designated Military Department Secretary would assume control of TRICARE contracts and all other TMA functions.
9	**Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education and training, and other shared services and related functions.**	Shared services activities, including but not limited to, this listing would be delivered though a collaborative process between the ASD(HA) and the Military Departments.	All shared services activities, including but not limited to, this listing would be delivered under the authority, direction and control of the Director, DHA.	The Director, DHA would control shared and common functions.	The Commander, US Medical Command would be responsible for managing and directing shared and common functions through the subordinate Joint Health Support Command.	Medical shared services activities would move to the single designated Military Department Secretary.
10	**Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.**	The ASD(HA) would continue the responsibilities outlined in DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs", and as Director, TRICARE Management Activity. The Military Departments would continue to be responsible for management and oversight of their military medical personnel, medical readiness programs, and health care delivery within their respective medical treatment facilities. The Military Department Secretaries would be responsible for assigning duties to their respective Surgeons General and organizing their medical forces.	The ASD(HA) would retain most responsibilities outlined in DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs", and would supervise the DHA Director. The Military Departments would continue to be responsible for management and oversight of their military medical personnel, medical readiness programs, and health care delivery within their respective medical treatment facilities. The Military Department Secretaries would be responsible for assigning duties to their respective Surgeons General and organizing their medical forces. The Director, DHA would assume all responsibilities currently outlined in DoD Directive 5136.01TRICARE Management Activity, and would have the authority to issue program guidance regarding medical research and development, health information technology, military medical logistics, military medical construction, medical education and training, and all other responsibilities as provided hy the Secretary of Defense.	The ASD(HA) would retain policy-making activities, and would supervise the DHA Director. The Service Components would continue to be responsible for management and oversight of their medical readiness programs. The Director, DHA would assume budgetary control of the DHP and all responsibilities currently outlined in DoD Directive, 5136.12, TRICARE Management Activity, and would have the authority to issue program guidance regarding medical research and development, health information technology, military medical logistics, military medical construction, medical education and training, and all other responsibilities as provided by the Secretary of Defense. The Director, DHA, would also have overall supervision of all medical treatment facilities.	The ASD(HA) responsibilities would be delineated in an updated DoD Directive and focused only on policy-making activities. The Service Components would continue to be responsible for management and oversight of their military medical personnel and medical readiness programs. The Service Secretaries would be responsible for assigning duties to their respective Surgeons General and organizing their medical forces. The Unified Command Plan (UCP) would establish the missions and responsibilities for the UMC, which should include responsibilities currently outlined in DoD Directive 5136.12, TRICARE Management Activity, and would have the authority to issue operational and program guidance regarding medical research and development, health information technology, military medical logistics, military medical construction, medical education and training.	The ASD(HA) would retain most responsibilities as delineated in an updated DoD Directive and focused on policy-making activities. The Service Components would be responsible for identifying their requirements for medical support to the designated Military Department Secretary. The designated Military Department Secretary would assume all responsibilities currently outlined in DoD Directive, 5136.12, TRICARE Management Activity, and would have the authority to issue operational and program guidance regarding medical research and development, health information technology, military medical logistics, military medical construction, medical education and training, and all other responsibilities as provided by the Secretary of Defense.
11	**Effect on the Guard and Reserve forces.**	No effect would be anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.	No effect would be anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.	No effect would be anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.	No effect would be anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.	No effect would be anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

MSM Governance

MSM Governance Options
TOR Elements Side-by-Side Comparison

	TOR Elements	MSM Option 1: Informal Multi-Service Market Management	MSM Option 2: Existing Multi-Service Market Management	MSM Option 3: Enhanced Multi-Service Market Management	MSM Option 4: Single Service	MSM Option 5: Executive Agent	MSM Option 6: Command Authority
1	**Management and Supervisory Chains of MTFs.**	MTF commanders would report through their Component organizations (however the Components determine is the best organizational model for their Service).	MTF commanders would report through their Military Departments.	MTF commanders would report through their Component organizations (however the Components determine would be the best organizational model for their Service).	MTF commanders would report through the Service designated to lead that market.	The Market Manager would have mission and budgetary control over the medical treatment facilities within the market area. The major facilities could be either multi-Service facilities or "owned" by a single Service.	MTF commanders would report to the Market Commander.
2	**Management and Supervisory Chains of Multi-Service Markets.**	There would be no designated MSM. The frequency and intensity of coordination of activities is entirely subject to the preferences of local commanders. Supervisory chains for the MTF commanders would continue as their Service Component directs.	The designated MSM Managers would have responsibilities for coordinating business plans and leading a collaborative process within their markets, consistent with the direction in the USD (P&R) November 2003 memorandum and with the Memorandums of Agreement established within their market. Supervisory chains for the MSM Manager would continue as their Service Component directs.	The designated MSM Managers would have additional responsibilities and authorities. They would develop a unified business plan for the market covering a five year period; be empowered to develop and implement common business and clinical processes throughout the market; use a common workload accounting process; establish a single credentialing process and system; have direct budget authority for all medical treatment facilities in the market; and have authority to re-direct personnel within the market for short-term (less than six months) reassignment. Supervisory chains for the MSM Manager would continue through their Service chains as their Service Component directs. Dispute resolution would continue as in the past to the Service SGs and to ASD(HA), as needed.	The market would no longer be "multi-Service."	Supervisory chains for the MSM Manager/Executive Agent would continue as their Executive Agent directs.	The Market Commander would report to the Secretary of Defense, or a Combatant Commander.
3	**The authority, direction, and control for mission and administrative support matters over MSM personnel.**	The authority, direction, and control over MSM personnel would reside within Service Components.	The authority, direction, and control over MSM personnel would reside within Service Components.	The authority, direction, and control over MSM personnel would reside within Military Departments, although the Market Manager would have the authority to direct short-term reassignment of personnel as demand for health care in that market dictates.	The authority, direction and control over MHS personnel would reside with the designated Service.	The authority, direction, and control over MSM personnel would reside within the Executive Agent, subject to policy direction of the ASD(HA) as informed by an executive oversight board.	The authority, direction, and control over the MSM would reside with the Market Commander.
4	**The budgetary authority for the Defense Health Program (DHP) within the MSM.**	The DHP would be distributed through the Military Departments to the individual medical treatment facilities within an MSM.	The DHP would be distributed through the Military Departments to the individual medical treatment facilities within an MSM.	The DHP would be distributed directly from OSD to the Market Manager.	The DHP appropriation would be distributed through the Military Department for those markets in which the Military Department serves as Single Service.	The DHP would be distributed through the Military Department of each market's Executive Agent to the Market EA, and subsequently to each MTF within an MSM.	The DHP would be distributed directly to the Market Commander.
5	**Management of MSM-specific shared services and related functions.**	The MTF commanders would be responsible for coordinating activities regarding, referral management, capacity, and workload planning.	The Senior Market Manager would be responsible for coordinating activities regarding common appointing, referral management, capacity and workload planning, and development of a consolidated business plan.	The Senior Market Manager would be responsible for coordinating and directing common activities to include: common appointing, referral management, capacity and workload planning, and development of a consolidated business plan. This change has the potential for significant savings in the direct care and purchased care sectors.	The Senior Service official in the market would be responsible for directing the activities of the subordinate medical treatment facilities in his/her chain of command.	Appointing, referral management, credentialing, business planning, and other activities in the market would be directed by the designated Executive Agent.	The Market Commander would be responsible for directing all activities and processes within the Area of Responsibility (AOR).

NCR Governance

NCR Governance Options
TOR Elements Side-by-Side Comparison

	TOR Elements	NCR Option 1: As Is Current Structure Reports to Secretary of Defense Deputy Secretary of Defense	NCR Option 2: JTF CAPMED Reports to a Combatant Commander (COCOM)	NCR Option 3: NCR Reports to a Defense Health Agency	NCR Option 4: NCR Medical Treatment Facilities Report to an Executive Agent	NCR Option 5: NCR Reports to a Single Service	NCR Option 6: Enhanced MSM Management
1	**Management and Supervisory Chains of NCR MTFs.**	Two MTF commanders, Walter Reed National Military Medical Center and Ft. Belvoir Community Hospital, would report to the NCR JTF Commander.	Two MTF commanders, Walter Reed National Military Medical Center and Ft. Belvoir Community Hospital, would report to the NCR JTF Commander.	Walter Reed National Military Medical Center and Ft. Belvoir Community Hospital, and potentially the other NCR medical facilities, would report to the Director, DHA.	Identified commanders would report through their chain of command to the Military Department Secretary/Executive Agent.	MTF commanders would report through the designated Service chain of command.	MTF commanders would report to Service chains of command.
2	**Management and Supervisory Chains of the NCR.**	The NCR JTF Commander would report to the Secretary/Deputy Secretary of Defense.	The NCR JTF Commander would report to the COCOM Commander.	The NCR Market Manager may be one of the two MTF commanders and would report to the Director, DHA.	The NCR Market Manager would report through the Executive Agent chain of command.	The NCR Market Manager would report through the designated Service chain of command.	The NCR Market Manager would rotate between the Services and would report through their Service chain of command.
3	**The authority, direction, and control for mission and administrative support matters over NCR personnel.**	The authority, direction, and control over the NCR would reside with the JTF Commander.	The authority, direction, and control over the NCR would reside with the NCR JTF Commander.	The Director, DHA, who reports directly to the ASD(HA), would have authority, direction and control for mission and administrative support matters over NCR personnel.	The day-to-day management and execution responsibilities over the NCR would reside with the Market Manager and the Executive Agent, subject to policy direction of the ASD(HA) as informed by an executive oversight board.	The authority, direction, and control over the NCR would reside with the NCR Market Manager.	The authority, direction, and control over the NCR would remain with the parent Service of individual MTFs.
4	**The budgetary authority for the Defense Health Program (DHP) within the NCR.**	The DHP would be distributed directly to the NCR JTF Commander to redistribute to assigned forces.	The DHP would be distributed directly to the NCR JTF Commander to redistribute to assigned forces, but is overseen by the COCOM Commander.	The Director, DHA, who reports directly to the ASD(HA), would have budgetary authority for the NCR.	The DHP would be distributed directly to the Executive Agent to redistribute to assigned forces.	The DHP would be distributed through the designated Service to the NCR Market Manager to redistribute to NCR facilities.	The DHP would be distributed directly to the NCR market manager to redistribute to assigned forces.
5	**Management of NCR-specific shared services and related functions.**	The NCR JTF Commander would be responsible for directing all activities and processes within the assigned Joint Operations Area (JOA). Shared services and other efficiencies would be implemented by command authorities through JTF developed processes.	The NCR JTF Commander would be responsible for directing all activities and processes within the assigned AOR. Shared services and other efficiencies would be implemented by command authorities through NCR JTF developed processes.	The Director, DHA would be responsible for shared services.	The Executive Agent, through the NCR Market Manager, would be responsible for directing all activities and processes, subject to oversight by an executive board and the ASD(HA).	The NCR Market Manager would be responsible for directing all activities and processes in accordance with designated Service processes and policies.	The NCR Market Manager would be responsible for directing all activities and processes within the assigned AOR.

Appendix 7. MHS Task Force Report Acronyms

Acronym	Definition
AOR	Area of Responsibility
ASD	Assistant Secretary of Defense
BRAC	Base Realignment and Closure
CAPE	Cost Assessment and Program Evaluation
CJCS	Chairman of the Joint Chiefs of Staff
COCOM	Combatant Command
CONOPS	Concept of Operations
CSA	Chief of Staff, Army/Combat Support Agency
DA&M	Director of Administration and Management
DCMO	Deputy Chief Management Officer
DHA	Defense Health Agency
DHP	Defense Health Program
DMOC	Defense Medical Oversight Committee
DoD	Department of Defense
EAC	Executive Advisory Committee
eMSMO	Enhanced Multi-Service Market Office
FBCH	Fort Belvoir Community Hospital
FOC	Full Operating Capability
FTE	Full Time Equivalent
GME	Graduate Medical Education
HA	Health Affairs
IOC	Initial Operating Capability
JMD	Joint Manning Document
JOA	Joint Operations Area
JTD	Joint Table of Distribution
JTF CAPMED	Joint Task Force National Capital Region Medical
MHS	Military Health System
MHSSA	Military Health System Support Activity
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MSM	Multi-Service Market
MTF	Medical Treatment Facilities

Acronym	Definition
NCR	National Capital Region
NORTHCOM	United States Northern Command
OGC	Office of the General Counsel
OLA	Office of Legislative Affairs
OSD	Office of the Secretary of Defense
P&R	Personnel and Readiness
PEO	Program Executive Officer
SECDEF	Secretary of Defense
TDA	Table of Distribution and Allowance
TMA	TRICARE Management Activity
TOE	Table of Organization and Equipment
UCP	Unified Command Plan
UMC	Unified Medical Command
USD	Under Secretary of Defense
WII	Wounded, Ill and Injured
WRNMMC	Walter Reed National Military Medical Center

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DEPARTMENT OF DEFENSE

TASK FORCE ON MILITARY HEALTH SYSTEM GOVERNANCE

Volume 2

Technical Supplement

December 7, 2011

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Part 1. Development of Governance Options

Introduction

On June 14, 2011, the Deputy Secretary of Defense established an internal Task Force consisting of representatives from the Military Departments, the Joint Staff, and the Office of the Secretary of Defense (OSD) to conduct a review of the current governance of the Military Health System (MHS). The Task Force Terms of Reference (TOR) directed the team to evaluate options for the long-term governance of the MHS as a whole and the governance of multi-Service markets (MSMs), to include the National Capital Region (NCR). The team was also directed to provide a report within 90 days detailing the relative strengths, weaknesses, and barriers of each option evaluated, as well as recommendations for governance.

Outline

The purpose of this section is to provide:

- The methodology used to build and analyze governance structure options for the MHS, MSM, and NCR
- The voting methodology, MHS construct results, and voting results
- Discussion of the various methods employed by the Task Force and the final MHS, MSM, and NCR recommendations that were made in the full MHS Task Force report delivered to the Deputy Secretary of Defense on September 29, 2011

Methodology

For the MHS-wide analysis, the Task Force sought to understand the components that comprise the MHS and what specific attributes are required to run those components.

The Task Force began its inquiry with several over-arching briefings defining the current organizational structure, personnel requirements, and funding processes within the Office of the Secretary of Defense (Health Affairs), the TRICARE Management Activity, and within the individual Service Medical Departments. The Task Force received briefings from several MSM managers explaining what defines an MSM, what authorities are given to an MSM manager, and what additional MSM authorities would provide greater flexibility and opportunities for efficiencies within MSMs.

Following the review of MSMs, the Task Force evaluated the larger MHS governance options with the understanding that the MHS recommendations would drive recommendations for the MSMs, including the NCR.

To build the various MHS organizational constructs for analysis and consideration, the Task Force developed the Evaluation Framework (Figure 1) to help define and describe each construct option and the authorities prescribed to each, using the objectives and scope outlined in the TOR. Once the organizational construct options were developed, the Task Force identified the strengths, weaknesses, barriers, and mitigation strategies for each option. Each option was evaluated against the criteria established by the Task Force.

MSMs were separately addressed and evaluated, independent of the larger MHS Governance model. Although an MSM, the National Capital Region organizational options were also separately evaluated.

Please note that the tables reflecting TOR objectives, scope and strengths, weaknesses and barriers were constructed for initial Task Force review and analysis of each option. Expanded tables for the final options included in the Final Task Force Report were revised to reflect additional Task Force discussion and deliberations.

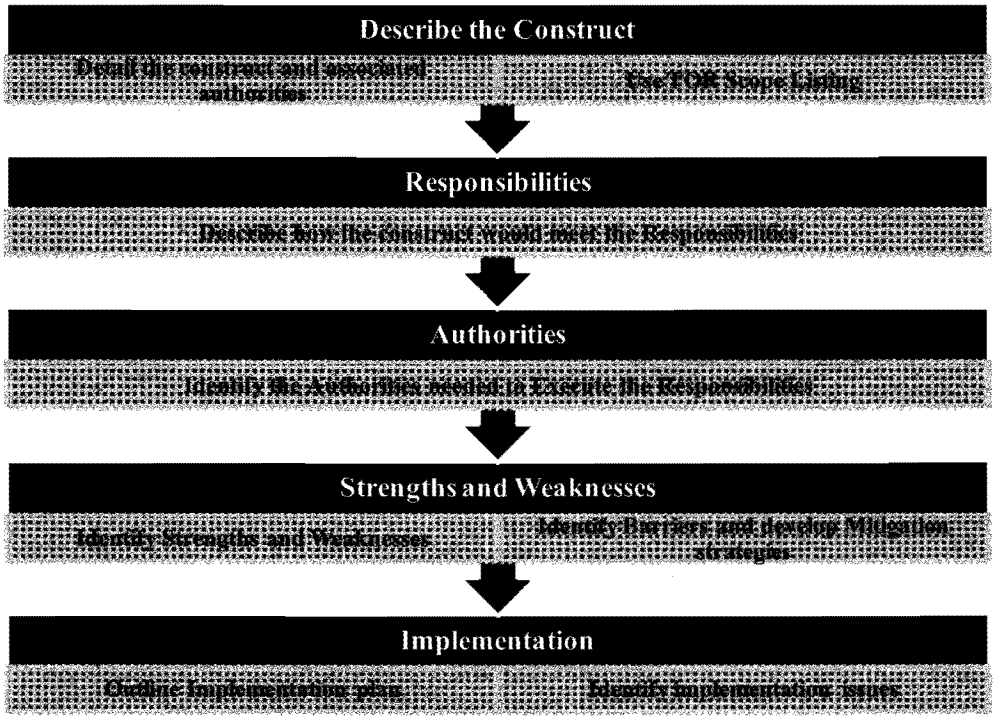

Figure 1. Evaluation Framework for MHS, MSM, and NCR Governance Options

MHS Governance Options Identified by the Task Force

- Option A: Current MHS Governance Structure
- Option B: Defense Health Agency, Geographic Model
- Option C: Defense Health Agency with Service Military Medical Treatment Facilities (MTFs)
- Option D: Unified Medical Command, Geographic Model
- Option E: Unified Medical Command with Service Components
- Option F: Unified Medical Command - HR 1540 Section 711 Model
- Option G: Single Service, Geographic Model – One Military Department Secretary Assigned Responsibility for the MHS
- Option H: Single Service with Components
- Option I: Split UMC and Military-Led DHA Geographic Hybrid Model
- Option J: UMC with Components and DHA Hybrid

- Option K: Single Service Hybrid with a Unified Medical Command
- Option L: Defense Health Agency Hybrid with MTFs placed under the Agency
- Option M: Defense Health Agency Hybrid with Regional MTFs

MHS Governance Option A: Current MHS Governance Structure

The Task Force reviewed the current governance structure of the MHS to lay a foundation for comparing options (Figure 2).

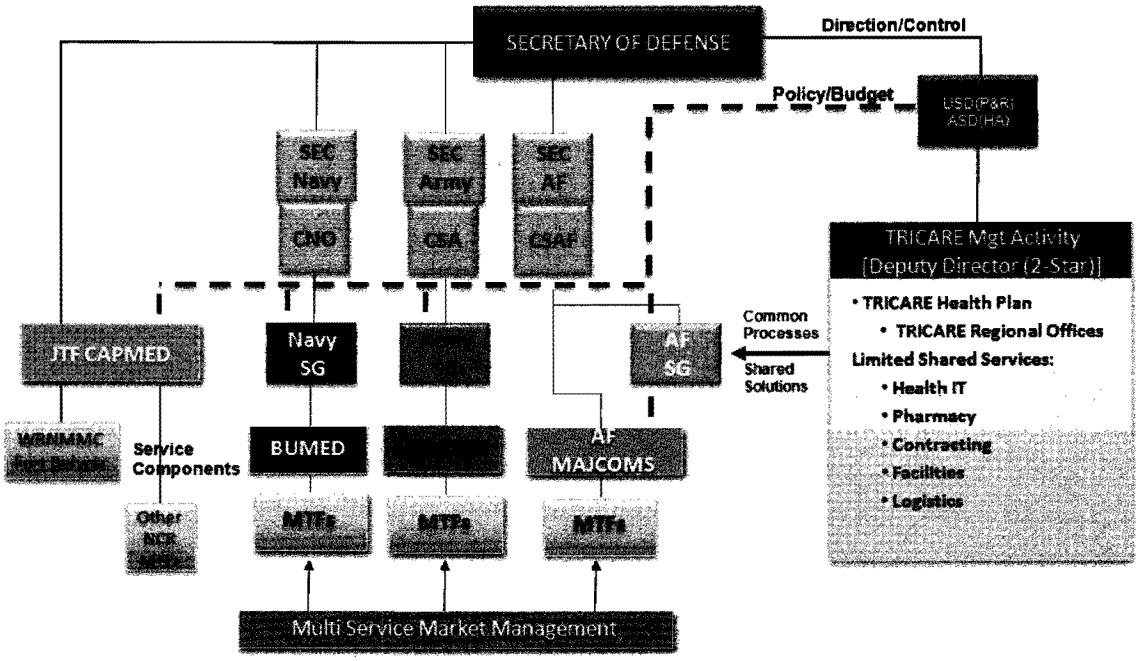

Figure 2. MHS Governance Option A: Current MHS Governance Structure

TOR Objectives and Scope of MHS Governance Option A: As Is - Current Structure

Item	TOR Objectives and Scope	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The ASD(HA) is responsible for all authority, direction, and control of policy and resources of the MHS as a whole, consistent with DoD Directive 5036.01.
2	Head of entity or entities, and the reporting chain to the Secretary of Defense.	Military Department reporting chains remain as they currently exist with Service Surgeons General reporting to their Service Chiefs who report to their Military Department Secretaries who report to the Secretary of Defense.
3	Management and supervisory chains of MTFs.	MTF commanders report through their established Military Department chains of command.
4	Management and supervisory chains of multi-Service markets.	Based on the selection for MSM governance (see Section, "multi-Service market Governance" further in this report).

Item	TOR Objectives and Scope	Outcome
5	The authority, direction, and control for mission/administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities.	The authority, direction, and control over MHS personnel reside within the Military Departments.
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	The DHP is sustained, and authority over the DHP resides with the ASD(HA).
7	The policymaking authority among OSD, the Services, and/or joint entities.	The ASD(HA) establishes and directs policy. The Services execute policy.
8	Management of purchased care and other functions currently performed by the TRICARE Management Activity.	The TMA Director (currently dual-hatted by the ASD(HA)) manages purchased care and other TMA functions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education and training, and other shared services, related functions.	Shared services activities, including but not limited to this listing, are delivered through a collaborative process between the ASD(HA) and the Military Departments.
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	The ASD(HA) exercises the responsibilities outlined in DoD Directive 5136.01, "Assistant Secretary of Defense for Health Affairs", and as Director, TRICARE Management Activity. The Military Departments are responsible for management and oversight of their military medical personnel, medical readiness programs, and health care delivery within their respective medical treatment facilities. The Military Department Secretaries are responsible for assigning duties to their respective Surgeons General, organizing their medical forces, and executing policy. Would execute policies established by and under the direction of ASD(HA).
11	Effect on the Guard and Reserve forces.	No effect on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 1. TOR Objectives and Scope of MHS Governance Option A: As Is - Current Structure

Strengths, Weaknesses, and Barriers of MHS Governance Option A: As Is - Current Structure

Strengths of As Is - Current Structure	
• **Ease of Implementation:** This organizational construct remains as it is, without any organizational upheaval.	
Weaknesses of As Is - Current Structure	
• **Lines of Authority:** Does not establish undivided MHS authority, direction, and control over entire system. • **Enhance Interoperability:** This option fails to take advantage of consensus opportunities to more rapidly implement common clinical and business processes across the system. • **Achieve Significant Cost Savings through Reduction in Duplication and Variation:** Fails to introduce a broader set of shared services that can be delivered more efficiently to the end customer.	
Barriers to As Is - Current Structure	**Mitigation Strategies for As Is - Current Structure**
• There are no barriers to implementation	• None

Table 2. Strengths, Weaknesses, and Barriers of MHS Governance Option A: As Is - Current Structure

MHS Governance Option B: Defense Health Agency, Geographic Model

This option would establish a Defense Health Agency (DHA) to replace TMA focused on consolidating and delivering a far broader set of shared health care support services than exist today. MHS-wide shared services activities would include, but are not limited to: the TRICARE health plan; pharmacy programs; medical education and training; medical logistics; facility planning; health information technology; medical research and development; health information technology; facility planning; public health; acquisition; and other common clinical and business processes.

The DHA could be led by a 3-Star general or flag officer who would report to the Assistant Secretary of Defense (Health Affairs). The DHA could be designated as a Combat Support Agency (CSA) with periodic CJCS review of its combat support mission execution effectiveness. The MTFs would be transferred to the DHA and would operate under its authority, direction, and control. The Military Departments would continue to own all military personnel and be responsible for organizing, training, and equipping their deployable military medical forces. Personnel requirements of the Services' operational forces needed for deployment and/or training would be requested through the DHA Director. MSMs and the NCR are addressed in this option as a part of the DHA. Service intermediate headquarters would be reduced to a single, DHA-run set of regional headquarters.

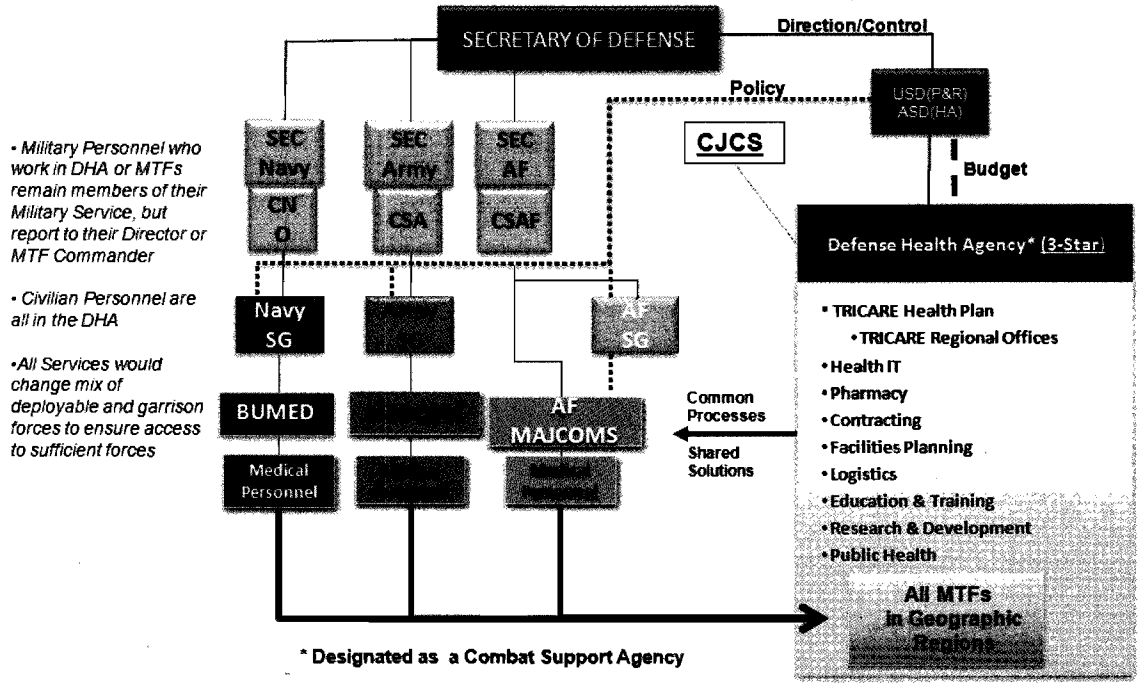

Figure 3. MHS Governance Option B: DHA, Geographic Model

TOR Objectives and Scope of MHS Governance Option B: DHA, Geographic Model

Item	TOR Objectives and Scope	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The Defense Health Agency would have control of the MHS.
2	Head of entity or entities, and the reporting chain to the Secretary of Defense.	The ASD(HA), USD (P&R) would report to the Secretary of Defense, or you could establish a USD(HA) to report to the Secretary of Defense. The 3-Star DHA Director would report to ASD(HA) or CJCS
3	Management and supervisory chains of MTFs.	MTF Directors would report to Regional Directors (or Components) who would report to the Defense Health Agency. The NCR could be a single market.
4	Management and supervisory chains of multi-Service markets.	All MSMs would have a single Director and report to the Director of Healthcare Operations.
5	The authority, direction, and control for mission/administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities.	The DHA would manage the peacetime medical mission and the designated Service chain of command would have administrative control. Deployed forces would be assigned to the receiving Service.
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	DHA, through ASD(HA), would be responsible for the planning, programming, budget and execution (PPBES) for facility and beneficiary healthcare delivery.
7	The policymaking authority among OSD, the Services, and/or joint entities.	OSD would have broad policy and guidance as well as execution and operational policy development and implementation. The Services would designate the readiness requirements.

Item	TOR Objectives and Scope	Outcome
8	Management of purchased care and other functions currently performed by the TRICARE Management Activity.	The DHA would manage purchased care and other TMA functions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education and training, and other shared services, related functions.	This would be a single system based on the requirements of the DHA.
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	The ASD(HA)/DHA would have policy and oversight, provide advice to the Secretary of Defense, and oversee beneficiary care. The Military Departments' Secretaries and Chiefs would provide the readiness requirements to the DHA. The Military Departments' Service Surgeon's General would advise the Service Chiefs on readiness issues.
11	Effect on the Guard and Reserve forces.	No effect is anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 3. TOR Objectives and Scope of MHS Governance Option B: DHA, Geographic Model

Strengths, Weaknesses, and Barriers of MHS Governance Option B: DHA, Geographic Model

Strengths of a DHA, Geographic Model	
• **Lines of Authority:** This organizational construct would have clear lines of authority and there would be central control of the MTFs. • **Enhance Interoperability:** This option would allow for single processes for key functions.	
Weaknesses of a DHA, Geographic Model	
• **Dispute Resolution:** Key issues would be elevated quickly to the highest levels. • **Ease of Implementation:** This option would be more of a "civilianized" model which may be difficult to implement in the current military structure. It may also reduce command leadership opportunities and professional growth.	
Barriers to a DHA, Geographic Model	**Mitigation Strategies for a DHA, Geographic Model**
• Centralization of readiness support platforms under a civilian agency. • Some required Service assets not under Service control (e.g. Army Professional Fill Forces). • Split medical forces for garrison and deployments.	• None.

Table 4. Strengths, Weaknesses, and Barriers of MHS Governance Option B: DHA, Geographic Model

MHS Governance Option C: Defense Health Agency with Service MTFs

This option would establish a Defense Health Agency to replace TMA focused on consolidating and delivering a far broader set of shared health care support services than exist today. MHS-wide shared services activities include, but are not limited to: the TRICARE health plan; pharmacy programs; medical education and training; medical logistics; facility planning; health information technology; medical research and development; health information technology; facility planning; public health; acquisition; and other common clinical and business processes.

The DHA could be led by a 3-Star general or flag officer who would report to the Assistant Secretary of Defense (Health Affairs). The DHA could be designated as a Combat Support Agency (CSA) with periodic CJCS review of its combat support mission execution effectiveness. MSMs and the NCR are not inherently addressed in this option.

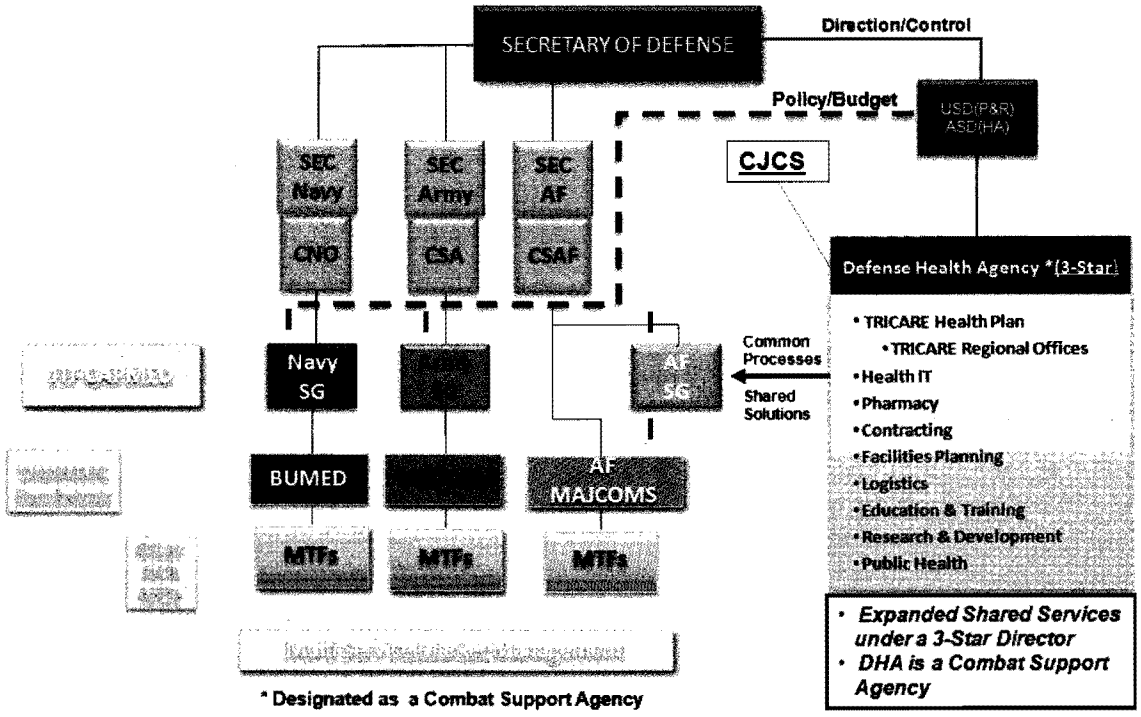

Figure 4. MHS Governance Option C: DHA with Service MTFs

TOR Objectives and Scope of MHS Governance Option C: DHA with Service MTFs

Item	TOR Objectives and Scope	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The Defense Health Agency would have authority, direction, and control for the shared and consolidated services. The Services would have authority, direction, and control for the MTFs and personnel.
2	Head of entity or entities, and the reporting chain to the Secretary of Defense.	The DHA would report through the ASD(HA) to the Secretary of Defense.
3	Management and supervisory chains of MTFs.	MTFs would be managed through the Service chain of command to the Service Secretary.
4	Management and supervisory chains of multi-Service Markets.	The MSMs would be assigned to a Service and report through the Service chain of command. JTF CAPMED would have to transition to this structure.
5	The authority, direction, and control for mission/administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities	The Services would operate the garrison and deployed health care system. The DHA would provide the shared and consolidated services.
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	OSD would be responsible for PPBES for the DHP. The Services would be responsible for PPBES for the personnel and readiness platforms.
7	The policymaking authority among OSD, the Services, and/or joint entities.	OSD would have broad policy and guidance, execution and operational policy development and implementation, and shared and consolidated services policies. The Services would designate the readiness requirements.
8	Management of purchased care and other functions currently performed by the TRICARE Management Activity.	The DHA would manage purchased care and other TMA functions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education and training, and other shared services, related functions.	The DHA would manage the peacetime health care systems. The Services would manage the readiness related services.
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	The ASD(HA)/DHA would have policy and oversight, advise the Secretary of Defense, and oversee the beneficiary care. The Military Departments' Secretaries and Chiefs would provide the readiness requirements. The Military Departments' Service Surgeon's General would manage the MTFs and implement common practices and systems.
11	Effect on the Guard and Reserve forces.	No effect is anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 5. TOR Objectives and Scope of MHS Governance Option C: DHA with Service MTFs

Strengths, Weaknesses, and Barriers of MHS Governance Option C: DHA with Service MTFs

Strengths of DHA with Service MTFs	
• **Lines of Authority:** This option would be a Military-led DHA and would eliminate the ASD(HA) dual-hatting. The Services would control the garrison and deployed health care. • **Enhance Interoperability:** The DHA would be focused on the shared and consolidated services. • **Ease of Implementation:** This would require minimal change to the current Service organizational structure.	
Weaknesses of DHA with Service MTFs	
• **Enhance Interoperability:** This option would eliminate the Joint Hospitals in the NCR as well as San Antonio. • **Ease of Implementation:** This option would require JTF CAPMED to transition to a different construct. The Services' cultures could limit the implementation of common services and processes.	
Barriers to DHA with Service MTFs	**Mitigation Strategies for DHA with Service MTFs**
• None.	• None.

Table 6. Strengths, Weaknesses, and Barriers of MHS Governance Option C: DHA with Service MTFs

MHS Governance Option D: Unified Medical Command, Geographic Model

This option would require a tenth unified combatant command (Unified Medical Command) be established, led by a 4-Star general or flag officer, and reporting directly to the Secretary of Defense. The UMC Commander would have authority, direction, and control over the MHS, with the UMC Commander reporting to the Secretary of Defense as a Combatant Command (COCOM) force provider. The UMC Commander would assume control of TRICARE contracts. PPBES authority, execution authority, operational control of forces assigned, staffing would be through a Joint Table of Distribution (JTD) that includes the MTFs. The UMC Commander would have COCOM authorities and control of the MTFs through the JTDs. All assigned forces would be TDA forces.

This option for a UMC would include a Joint Medical Operations Command (JMOC) to manage shared services as well as the TRICARE Health Plan. The TRICARE Regional Offices (TROs) would be assigned to and support the UMC regions. Service Intermediate Headquarters structure is changed to a single regional HQ approach to manage MTFs. MSMs and the NCR would be addressed within this option.

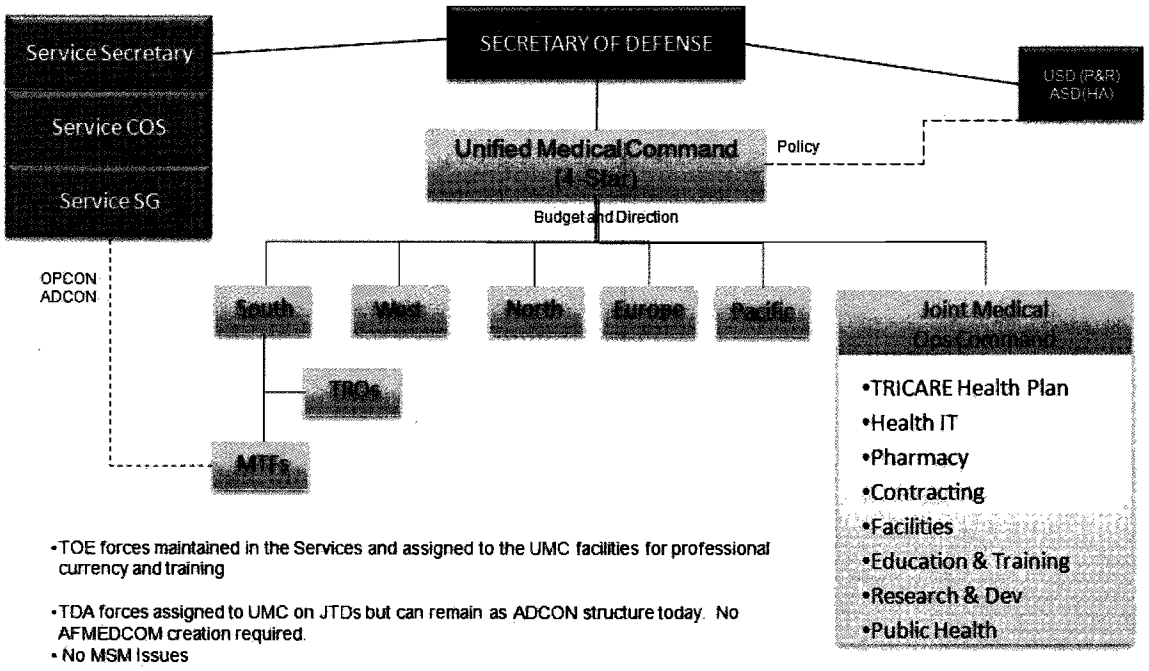

Figure 5. MHS Governance Option D: UMC, Geographic Model

TOR Objectives and Scope of MHS Governance Option D: UMC, Geographic Model

Item	TOR Objectives and Scope	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The Unified Medical Command would have authority, direction, and control of the MHS.
2	Head of entity or entities, and the reporting chain to the Secretary of Defense.	The UMC Commander would report to the Secretary of Defense as a COCOM force provider.
3	Management and supervisory chains of MTFs.	The MTF commander would report through regional commanders to the UMC Commander.
4	Management and supervisory chains of multi-Service markets.	MSMs would be organized as single management entity in a region with a single JTD.
5	The authority, direction, and control for mission/administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities	The UMC Commander would have COCOM authorities and control of the MTF personnel through JTDs. All assigned forces would be TDA forces. The UMC Commander would also have shared services authority. The Military Departments would be responsible for assigning TOE forces to the UMC that are off-JTDs. An alternative would be for the Military Departments to have ADCON and UCMJ authorities per a decision by the UMC Commander.
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	The ASD(HA) would have policy review and oversight. The UMC Commander would have PPBES authority for healthcare delivery and shared services.

Item	TOR Objectives and Scope	Outcome
7	The policymaking authority among OSD, the Services, and/or joint entities.	The ASD(HA) would have broad policy direction. OSD would have PPBES review. The UMC Commander would have execution authority, OPCON of JTD and TACON of non-JTD forces assigned, and shared services. The Military Departments would be responsible for developing and equipping TOE forces.
8	Management of purchased care and other functions currently performed by the TRICARE Management Activity.	The UMC Commander would assume control of TRICARE contracts. The TRICARE Regional Offices (TROs) would be assigned to regions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education and training, and other shared services, related functions.	The UMC Commander would control shared and common functions under the Joint Medical Operations Command (JMOC). The Medical Education Training Campus (METC) would be reassigned to the UMC and funded through the DHP for medical education and training.
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	The ASD(HA) provides overall policy oversight, advice to the OSD staff, and PPBES review for the Defense Health Program. The Military Departments' Secretaries and Service Chiefs would have PPBES review, OPCON of TOE forces, and ADCON for TDA forces assigned to the UMC. The Military Departments' Service Surgeon's General would advise the Secretaries and Chiefs. The UMC Commander would have COCOM and PPBES execution authority.
11	Effect on the Guard and Reserve forces.	No effect is anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 7. TOR Objectives and Scope of MHS Governance Option D: UMC, Geographic Model

Strengths, Weaknesses, and Barriers of MHS Governance Option D: UMC, Geographic Model

Strengths of a UMC, Geographic Model	
• **Dispute Resolutions and Lines of Authority:** This organizational construct would have clear lines of authority and there would be central control of the MTFs. The shared services (i.e. E&T, R&D, HIT, logistics) would be centrally managed. The TROs would be aligned with the MTFs in the same chain of command. • **Enhance Interoperability:** This option would focus the development of common business processes. • **Ease of Implementation:** The JTDs would eliminate any MSM issues because the UMC would control the MSMs. • **Achieve Significant Cost Savings Through Reduction in Duplication and Variation**: Reduction in overhead personnel would be relative to the current MHS structure. • Services would focus on deployable forces with the UMC as the platform for medical professional force development and benefit delivery.	
Weaknesses of a UMC, Geographic Model	
• **Enhance Interoperability:** Some required Service assets would not be under Service control (PROFIS, AF UTCs); sourcing from UMC. • **Ease of Implementation:** This would be a massive change for the way the DoDdoes business. TDA and TOE forces would be split. An alternative is to embed TOE in a JTD in the UMC. • **Lines of Authority:** This would be a major change for the Service Surgeon's General. • **Achieve Significant Cost Savings Through Reduction in Duplication and Variation**: The Command may be focused on effectiveness over costs.	
Barriers to a UMC, Geographic Model	**Mitigation Strategies for a UMC, Geographic Model**
• Splitting garrison and deployable forces. • The Service Surgeon's General roles would change. • The Air Force would have to create TOE forces • Integration of common processes and equipment with Service readiness assemblages. • No Service buy-in. • Managing real estate disputes regarding timing of recapitalization.	• Ensure PROFIS forces OPCON to Service. • Role of HA and Service Secretaries in PPBES oversight. • Services develop Command and Control for deployable forces, with the Air Force being most affected. • Develop processes for identifying deployable and garrison forces. • Have detailed implementation planning. • The JMOC could establish an integration process.

Table 8. Strengths, Weaknesses, and Barriers of MHS Governance Option D: UMC, Geographic Model

MHS Governance Option E: Unified Medical Command with Service Components

This option would require a tenth unified combatant command (Unified Medical Command) be established, led by a 4-Star general or flag officer, and reporting directly to the Secretary of Defense. Medical forces would be provided by Service Components, but the Unified Medical Command would be responsible for overall direction and leadership of the Military Health System. Components would maintain intermediate headquarters structures to manage the medical treatment facilities. This option for a Unified Medical Command would include a Unified Medical Command Headquarters and a subordinate Joint Health Support Command to manage shared services as well as the TRICARE Health Plan. Services maintain control of their deployable forces (TOE) with force generation responsibilities. The U.S. Medical Command would have operational control of the garrison (TDA) forces that would be identified through a Joint Table of Distribution (JTD) or Joint Manning Document (JMD). The ASD(HA) would continue to have a policy role. MSMs and the NCR would be addressed with in this option through the UMC.

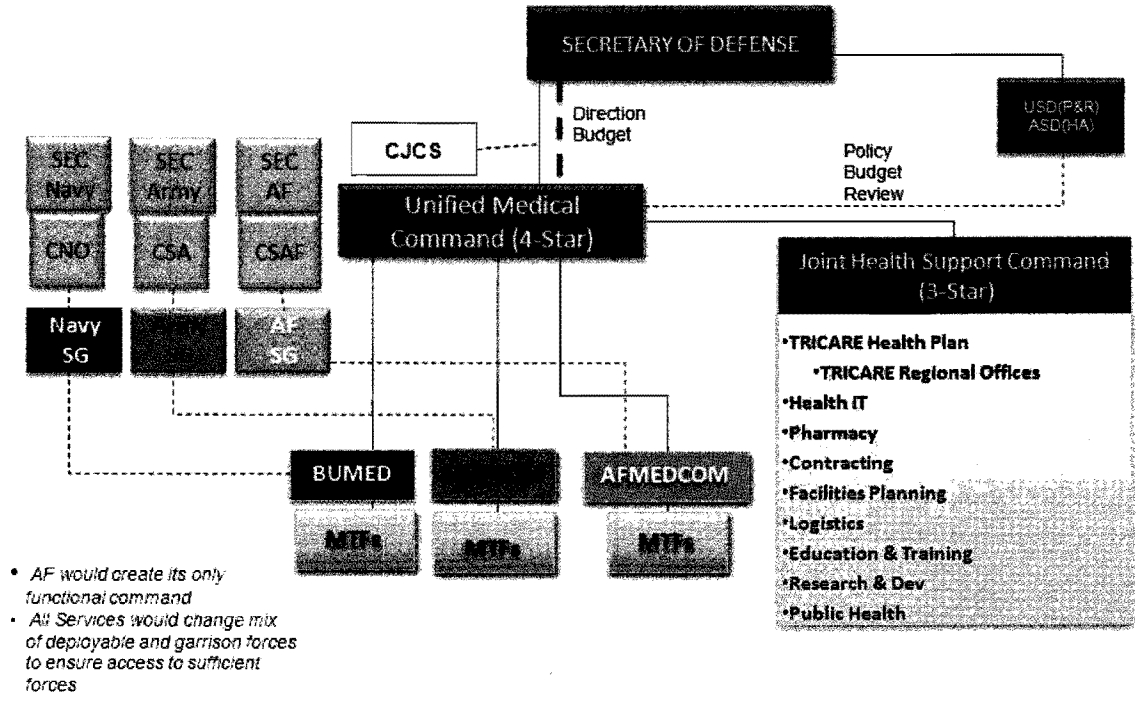

Figure 6. MHS Governance Option E: UMC with Service Components

TOR Objectives and Scope of MHS Governance Option E: Unified Medical Command with Service Components

Item	TOR Objectives and Scope	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The UMC Command would be responsible for authority, direction, and control of the MHS through its components.
2	Head of entity or entities, and reporting chain to the Secretary of Defense.	The UMC Commander would report directly to the Secretary of Defense.
3	Management and supervisory chains of MTFs.	MTF commanders would report through their components to the US Medical Command.
4	Management and supervisory chains of multi-Service markets.	The UMC Commander would designate the Market Manager. Supervisory chains would continue through their Service Components. Larger, complex entities like the NCR may report outside component chains.
5	Authority, direction, and control for mission/ administrative support matters over MHS personnel among OSD, Military Departments, and/or joint entities.	The authority, direction, and control over assigned MHS personnel would reside within the Service Components of the U.S. Medical Command, who would report to the UMC commander.
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	Authority over the DHP would reside with the UMC Commander.
7	The policymaking authority among OSD, the Services, and/or joint entities.	The ASD(HA), subject to the authority, direction, and control of the USD (P&R), would be the senior policy authority within the MHS. Policy matters would be coordinated with the UMC Commander and Military Departments.
8	Management of purchased care and other functions currently performed by the TRICARE Management Activity.	The UMC Commander would assume control of TRICARE contracts and all other TMA functions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education/training, and other shared services/related functions.	The UMC Commander would be responsible for managing and directing shared and common functions through the subordinate Joint Health Support Command.
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	The ASD(HA) responsibilities would be delineated in an updated the DOD Directive focused only on policy-making activities. The Service Components would continue to be responsible for management and oversight of their military medical personnel and medical readiness programs. The Service Secretaries would be responsible for assigning duties to their respective Surgeons General and organizing their medical forces. The Unified Command Plan (UCP) would establish the missions and responsibilities for the UMC, which could include responsibilities currently outlined in the DoDDirective 5136.12, TRICARE Management Activity, and would have the authority to issue operational and program guidance regarding medical research/development, health information technology,

Item	TOR Objectives and Scope	Outcome
		medical logistics, medical construction, medical education, and training.
11	Effect on the Guard and Reserve forces.	No effect is anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 9. TOR Objectives and Scope of MHS Governance Option E: UMC with Service Components

Strengths, Weaknesses, and Barriers of MHS Governance Option E: Unified Medical Command with Service Components

Strengths of a UMC with Service Components
• **Dispute Resolution/Lines of Authority/Accountability:** Clear lines of authority would be established. • **Achieve Significant Cost Savings Through Reduction in Duplication and Variation:** There would be central control of common business and clinical processes, and implementation would be achieved more readily with command and control throughout the medical structure to ensure compliance. • **Ease of Implementation:** JTF CAPMED, if retained in its current form, could be addressed as a Region directly reporting to the Commander, U.S. Medical Command.
Weaknesses of a UMC with Service Components
• **Achieve Significant Cost Savings Through Reduction in Duplication and Variation:** In any UMC model that maintains Service Components (the common model for all unified commands), the overall management headquarters overhead would increase above "As Is" and all other organizational models. • **Dispute Resolution/Lines of Authority/Accountability:** The current structure of civilian authority over components of the MHS (the ASD(HA) and Military Department Secretaries) would not be maintained; the first civilian official in the authority chain would be the Secretary of Defense. • **Ease of Implementation:** This action would represent a significant departure in governance for all existing organizations (Health Affairs, TMA, Military Department Secretaries, Military Service Chiefs, Service Medical Departments). For the Air Force, this includes creating a medical component command for operation of Air Force medical treatment facilities; the Navy would need to redesign how garrison billets are mapped to operational requirements.

Barriers to a UMC with Service Components	Mitigation Strategies for a UMC with Service Components
• **Medical Readiness:** Would alter the process for deployment of forces. • **Other:** A new Unified Command would have to be established by the President of the United States.	• It is understood that the establishment of the UMC would require a disciplined implementation with major changes in all activities.

Table 10. Strengths, Weaknesses, and Barriers of MHS Governance Option E: UMC with Service Components

MHS Governance Option F: Unified Medical Command - HR 1540 Section 711 Model

This option, derived from the House Armed Services Committee entitled HR 1540 Section 711 Model, would require a tenth unified combatant command (US Medical Command) be established, led by a 4-Star general or flag officer, and reporting directly to the Secretary of Defense. Medical forces would be provided by Service Components, but the Unified Medical Command would be responsible for overall direction and leadership of the Military Health System. Components would maintain intermediate headquarters structures to manage the MTFs. This option for a Unified Medical Command would include a Unified Medical Command Headquarters and a subordinate Healthcare Command to manage the Service Components and NCR and San Antonio MSMs; a Modernization, Doctrine, and Personal Development Command to manage R&D and E&T, and a Defense Health Agency to manage healthcare support, shared services, private sector care, health IT, and facilities. Services maintain control of their deployable forces (TOE) with force generation responsibilities. Service Surgeon's General would be dual-hatted within the UMC structure.

The MTFs and MSMs would be managed by market-level MTF Commanders, either through components or regional commanders, and the MTF Commanders would report to a Healthcare Command. Selected MSMs, to include JTF CAPMED and San Antonio, would be led by a 2-Star general who would report to the Healthcare Command.

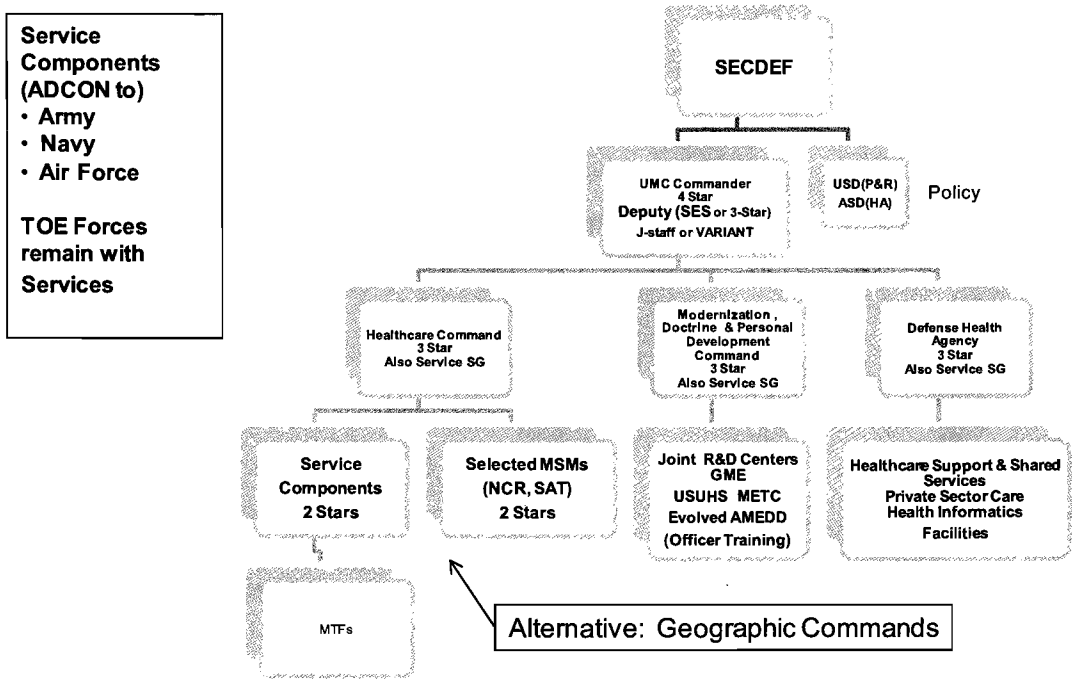

Figure 7. MHS Governance Option F: Unified Medical Command - HR 1540 Section 711 Model

TOR Objectives and Scope of MHS Governance Option F: Unified Medical Command - HR 1540 Section 711 Model

Item	TOR Objectives and Scope	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The Unified Medical Command would have authority, direction, and control of the MHS.
2	Head of entity or entities, and reporting chain to the Secretary of Defense.	The UMC Commander would report through a COCOM to the Secretary of Defense.
3	Management and supervisory chains of MTFs.	The MTFs would be managed by MTF commanders, either through components or regional commanders, to a Healthcare Command.
4	Management and supervisory chains of multi-Service markets.	The MSMs would be managed by market level commanders with the MTFs reporting through components or stand-alone regions to a Healthcare Command led by a 3-Star.
5	Authority, direction, and control for mission/ administrative support matters over MHS personnel among OSD, Military Departments, and/or joint entities.	The UMC Commander would have full COCOM authorities. The Military Departments would retain TOE forces.
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	The USD (P&R) would have policy review and oversight. The UMC Commander would have PPES authority. The Military Departments would have PPBES over the TOE forces.
7	The policymaking authority among OSD, the Services, and/or joint entities.	The USD (P&R) would provide broad policy and direction. The UMC Commander would have PPBES authority, UMCJ operational authority, and OPCON of forces. The Healthcare Command would be led by a 3-Star who would control doctrine, E&T, and R&D. The Military Departments would be responsible for developing and equipping the TOE forces.
8	Management of purchased care and other functions currently performed by the TRICARE Management Activity.	The UMC Commander would assume all TMA functions under the 3-Star led DHA.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education/training, and other shared services/related functions.	The UMC Commander would manage these functions under the DHA and the 3-Star led Modernization, Doctrine, and Personnel Development Command.
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	The ASD(HA) would become a DASD(HA) for overall policy oversight and advice to the OSD staff. The Military Departments' Secretaries and Service Chiefs would have PPBES and control of TOE forces. The Military Departments' Service Surgeon's General would advise the Secretaries and Chiefs and serve as

Item	TOR Objectives and Scope	Outcome
		commanders in the UMC. The UMC Commander would have COCOM and full PPBES authority.
11	Effect on the Guard and Reserve forces.	No effect is anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 11. TOR Objectives and Scope of MHS Governance Option F: UMC - HR 1540 Section 711 Model

Strengths, Weaknesses, and Barriers of MHS Governance Option F: Unified Medical Command - HR 1540 Section 711 Model

Strengths of a UMC - HR 1540 Section 711 Model	
• **Dispute Resolution/Lines of Authority/Accountability:** Clear lines of authority would be established as well as central management of shared services (i.e. E&T, R&D, HIT, logistics). MTFs would be centrally controlled. • **Enhance Interoperability:** Allows for JTF CAPMED to be easily inserted into this construct as a regional or sub-regional command. Common business processes would be implemented across the MTFs. • **Ease of Implementation:** The Service Component execution would minimize organizational change.	
Weaknesses of a UMC - HR 1540 Section 711 Model	
• **Achieve Significant Cost Savings Through Reduction in Duplication and Variation:** The Command would likrly be focused more on effectiveness over costs. • **Dispute Resolution/Lines of Authority/Accountability:** Some required Service assets would not be under Service control (i.e. PROFIS). There would be civilian oversight for budget located at the Secretary of Defense level which would bypass OSD PSA. • **Enhance Interoperability:** TDA and TOE medical forces would be split. • **Ease of Implementation:** This would require all three Services to significantly change, with the biggest impact on the Air Force. • Dual-hatted SGs could face perception issues from home Service and UMC.	
Barriers to a UMC - HR 1540 Section 711 Model	**Mitigation Strategies for a UMC - HR 1540 Section 711 Model**
• Service cultures and values and adoption of consolidated systems and processes. • Changing roles of the SGs. • Changes in the processes for the deployment of forces. • Component MTF construct will require separate MSM decision.	• Ensure PROFIS forces OPCON to Service. • Develop a role for HA and Service Secretaries in POM oversight. • Create a DMOC-like entity. • Sustain core Service organizational structures. • Ensure there is clear implementation planning. • Make a decision on the MSMs.

Table 12. Strengths, Weaknesses, and Barriers of MHS Governance Option F: UMC - HR 1540 Section 711 Model

MHS Governance Option G: Single Service, Geographic Model – One Military Department Secretary Assigned Responsibility for the MHS

This option would assign one Military Department Secretary to have the authority, direction, and control of the MHS and would report directly to the Secretary of Defense. Each Military Department would continue to be responsible for organizing, training and equipping its deployable military medical (TOE) forces, but this would occur through assignment to operational platforms in medical treatment facilities run by the designated Military Department Secretary. The MTFs would be run by the designated Military Department, and would be staffed by personnel from all of the Military Departments. The designated Military Department would operate the TRICARE health plan and would have control over the Defense Health Program. The Assistant Secretary of Defense for Health Affairs (ASD(HA)) would retain policy authority within the MHS. The MSMs and NCR would be addressed in this option as single Service markets.

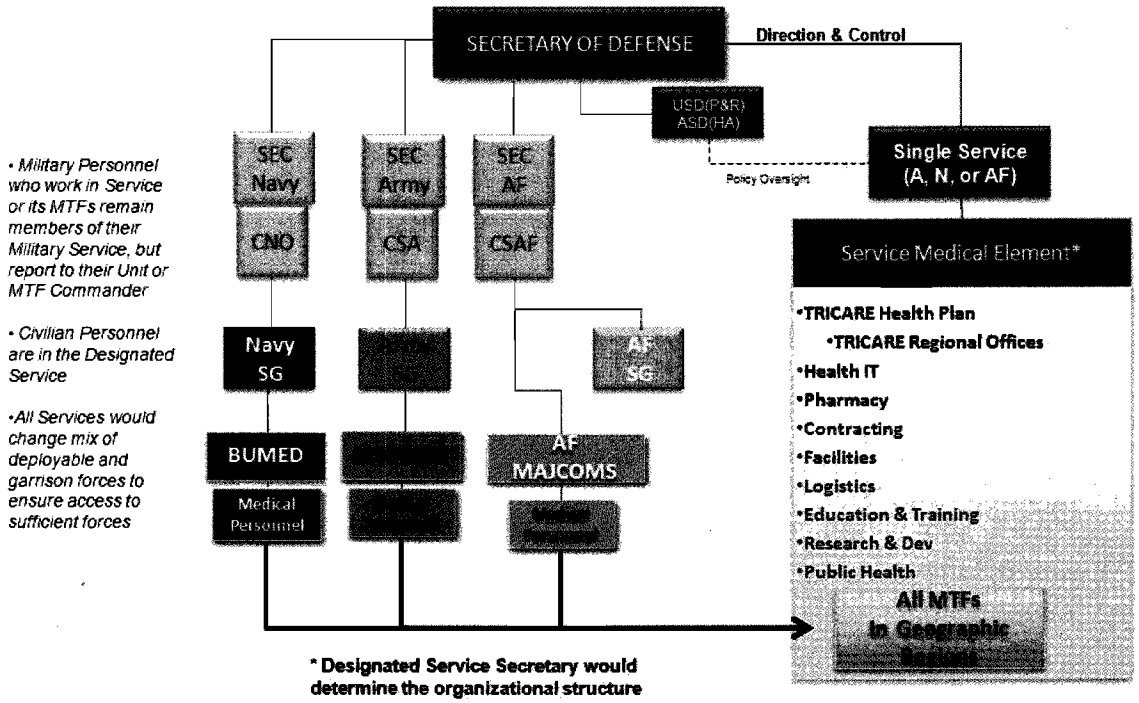

Figure 8. MHS Governance Option G: Single Service, Geographic Model

TOR Objectives and Scope of MHS Governance Option G: Single Service, Geographic Model

Item	TOR Objectives and Scope	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The designated Military Department Secretary would be responsible for the management and oversight of the MHS.
2	Head of alternative and reporting chain to the Secretary of Defense.	The designated Military Department Secretary would establish a medical organizational model that is best suited to manage the MHS (likely with geographic or regional intermediate headquarters). The leader of the medical organization would report to the Military Department Secretary. The Military Department Secretary would report to the Secretary of Defense.
3	Management and supervisory chains of MTFs.	MTF commanders would report through the organizational model that the designated Military Department Secretary has put into place, through the Military Department chain of command. There may be an intermediate command structure put in to place by the Military Department Secretary based on geographic or functional mission considerations.
4	Management and supervisory chains of multi-Service markets.	There would be no multi-Service markets. All MSMs would function under one Service.
5	The authority, direction, and control for mission and administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities.	The Military Department Secretary would have authority, direction, and control over MHS TDA personnel assigned to the medical treatment facilities. TOE forces would report through their separate Service structures.
6	The budgetary authority for the Defense Health Program among OSD, the Military Departments and/or joint entities.	Budgeting authority over the DHP would reside with the designated Military Department Secretary.
7	The policymaking authority among OSD, the Services, and/or joint entities.	The ASD(HA), subject to the authority, direction, and control of the USD(P&R), would serve as the senior medical advisor to the Secretary of Defense, and retains policy authority within the MHS. The designated Military Department Secretary would execute ASD(HA) policy directives.
8	Management of purchased care and other functions currently performed by the TRICARE Management Activity.	The designated Military Department Secretary would assume control of TRICARE contracts and all other TMA functions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education and training, and other shared services and related functions.	Medical shared services activities would be developed and implemented by the designated Military Department Secretary.

Item	TOR Objectives and Scope	Outcome
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	The ASD(HA) would retain policy-making activities. The Service Components would be responsible for identifying their requirements for medical support to the designated Military Department Secretary. The designated Military Department Secretary would assume all responsibilities currently outlined in the DoDDirective, 5136.12, TRICARE Management Activity, and would have the authority to issue operational and program guidance regarding medical research and development, health information technology, military medical logistics, military medical construction, medical education and training, and all other responsibilities as provided by the Secretary of Defense.
11	Effect on the Guard and Reserve forces.	No effect is anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 13. TOR Objectives and Scope of MHS Governance Option G: Single Service, Geographic Model

Strengths, Weaknesses, and Barriers of MHS Governance Option G: Single Service, Geographic Model

Strengths of a Single Service, Geographic Model	
• **Dispute Resolution/Lines of Authority/Accountability:** Clear lines of authority and chain of command from Secretary through the MTF commander would be established. • **Achieve Significant Cost Savings Through Reduction in Duplication and Variation:** With shared services, there would be one set of business and clinical processes and implementation would be achieved more readily with command and control in a single Service. It also could eliminate the issues that arise with multi-Service markets. This option would create the most significant savings in headquarters overhead of any organizational option.	
Weaknesses of a Single Service, Geographic Model	
• **Medical Readiness:** With medical personnel still "owned" by their Components, a requirement for coordination between Service Chiefs and Military Department Secretaries on readiness and personnel issues would remain. • **Ease of Implementation:** There is no known precedent or example where this approach has been tested in other military medical organizations worldwide. The Navy/USMC medical support model does not have the mission for all of the DOD; however, it is representative of how a Single Service model could work. Additionally, this option would entail a large scale reorganization to include re-mapping of Service medical personnel to operational platforms. • **Dispute Resolution/Lines of Authority/Accountability:** Issues would be adjudicated at a higher level (Military Department Secretary).	
Barriers to a Single Service, Geographic Model	**Mitigation Strategies for a Single Service, Geographic Model**
• There would be a need to overcome perceptions of bias toward the facilities serving the forces of the designated Military Department Secretary, and the level at which these issues would need to be adjudicated.	• Management controls and oversight processes would need to be transparent.

Table 14. Strengths, Weaknesses, and Barriers of MHS Governance Option G: Single Service, Geographic Model

MHS Governance Option H: Single Service with Components

This option would assign one Military Department Secretary to have the authority, direction, and control of the MHS and would report directly to the Secretary of Defense. Each Military Department would continue to be responsible for organizing, training and equipping its deployable military medical (TOE) forces, but this would occur through assignment to operational platforms in medical treatment facilities run by the Defense Healthcare System. The MTFs would be run by the designated Military Department's component commands in the Defense Healthcare System. The Defense Healthcare System would also manage the TRICARE Plan, the TROs and shared services. The Assistant Secretary of Defense for Health Affairs (ASD(HA)) would retain policy authority within the MHS through an updated the DoDDirective. The MSMs and NCR are addressed in this option as single Service markets under the Defense Healthcare System.

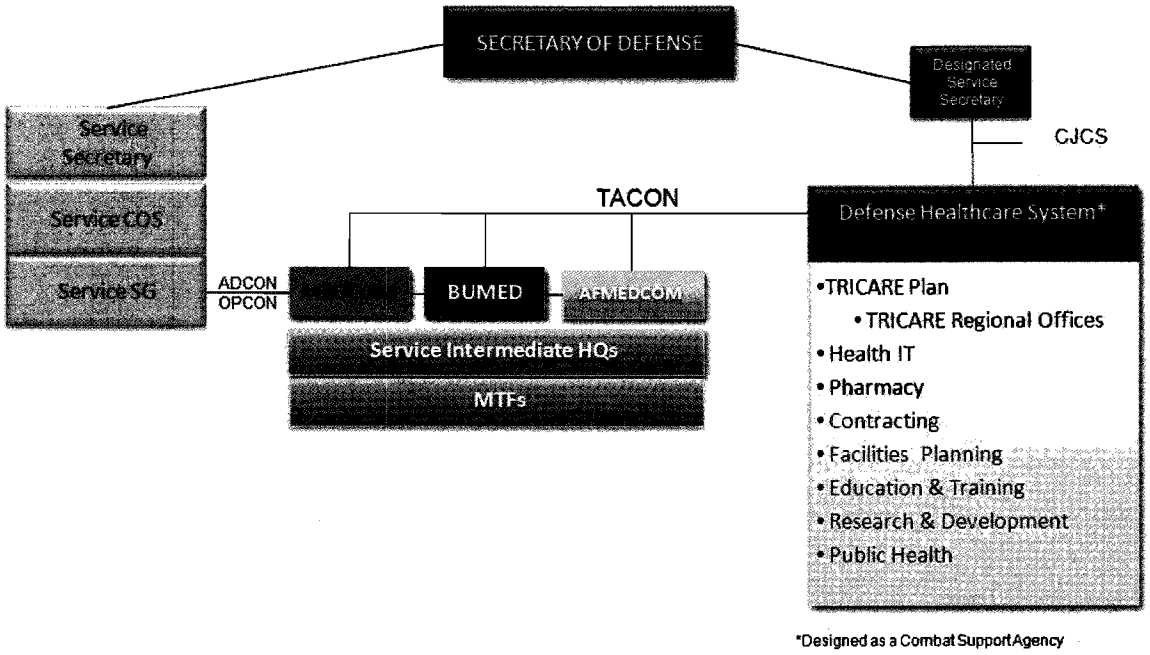

Figure 9. MHS Governance Option H: Single Service with Components

TOR Objectives and Scope of MHS Governance Option H: Single Service with Components

Item	TOR Objectives and Scope	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The Service Secretary/4 Star Commander would run the beneficiary health care delivery system. The Components would provide staff and manage readiness.
2	Head of entity or entities, and reporting chain to the Secretary of Defense.	The designated Service Secretary would report to the Secretary of Defense.
3	Management and supervisory chains of MTFs.	MTFs would be managed by Service MTF commanders who would report to Service Regional Commanders

Item	TOR Objectives and Scope	Outcome
		who would report to the designated Service Component Commander who would report to the designated Service Secretary. The NCR would be a single Service market or a separate regional command.
4	Management and supervisory chains of multi-Service markets.	All MSMs would be managed by a single Service.
5	Authority, direction, and control for mission/ administrative support matters over MHS personnel among OSD, Military Departments, and/or joint entities.	The designated Service chain of command would have TACON over the personnel assigned. TOE and TDA forces would be assigned to the designated Service for currency with OPCON to the parent Service through the components.
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	OSD would have policy oversight. The designated Service would have PPBES for MTF delivery requirements. The other Services would provide forces to the designated Service, have PPBES for the readiness equipment, and deploy forces.
7	The policymaking authority among OSD, the Services, and/or joint entities.	OSD would have broad policy and guidance and provide input into the SPG. The designated Service would have execution and operational policy development and implementation. The other Services would develop readiness requirements and platforms and deploy forces.
8	Management of purchased care and other functions currently performed by the TRICARE Management Activity.	The designated Service Secretary would manage purchased care and other TMA functions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education/training, and other shared services/related functions.	These functions would be a single system based on the processes of the designated Service.
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	The ASD(HA) would have policy and oversight and provide advice to the Secretary of Defense. The Military Departments' Secretaries and Chiefs would oversee beneficiary care and maintain the readiness mission. The Military Departments' Service Surgeon's General would oversee the readiness of forces and the deployed mission and monitor the performance of the designated Service.
11	Effect on the Guard and Reserve forces.	No effect is anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 15. TOR Objectives and Scope of MHS Governance Option H: Single Service with Components

Strengths, Weaknesses, and Barriers of MHS Governance Option H: Single Service with Components

Strengths of a Single Service with Components	
• **Dispute Resolution/Lines of Authority/Accountability:** Clear lines of authority would be established as well as central control of the MTFs and MSMs. Service readiness assets would be under Service control. • **Achieve Significant Cost Savings Through Reduction in Duplication and Variation:** There would be single processes for key functions.	
Weaknesses of a Single Service with Components	
• **Dispute Resolution/Lines of Authority/Accountability:** This option would create a need for coordination of issues between the Service Secretaries. • **Enhance Interoperability:** This would split the readiness and garrison care system.	
Barriers to a Single Service with Components	**Mitigation Strategies for a Single Service with Components**
• Selection of the Service responsible for all DoD medical care. • Transfer of medical forces and civilians to the designated Service. • Changing the role of the ASD(HA) to policy oversight.	• None.

Table 16. Strengths, Weaknesses, and Barriers of MHS Governance Option H: Single Service with Components

MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model

This option would establish a tenth unified command (Unified Medical Command), led by a 4-Star general or flag officer who would report directly to the Secretary of Defense as a Combatant Commander. The UMC would have OPCON over all assigned forces and MTFs and would also manage a subordinate Joint Medical Operations Command (JMOC) that would manage E&T, R&D, and Public Health. A Defense Health Agency would also be established to manage beneficiary delivery, the TRICARE plan, and TROs, and shared services. The readiness and deployed mission would be focused in the UMC. The ASD(HA) would have budget control and would report through USD (P&R) to the Secretary of Defense. The DHA Director would have OPCON over assigned TDA personnel and would report directly to ASD(HA). MTFs would be managed by Regional Directors through the DHA but the NCR Commander would have OPCON over forces assigned to the NCR joint facilities. Service intermediate headquarters would be reduced to a single, DHA-run set of regional headquarters. The UMC would maintain OPCON over their designated TOE forces assigned for currency maintenance to the DHA-run MTFs. This alternative addresses the MSMs and NCR as regions or sub-regions within the DHA.

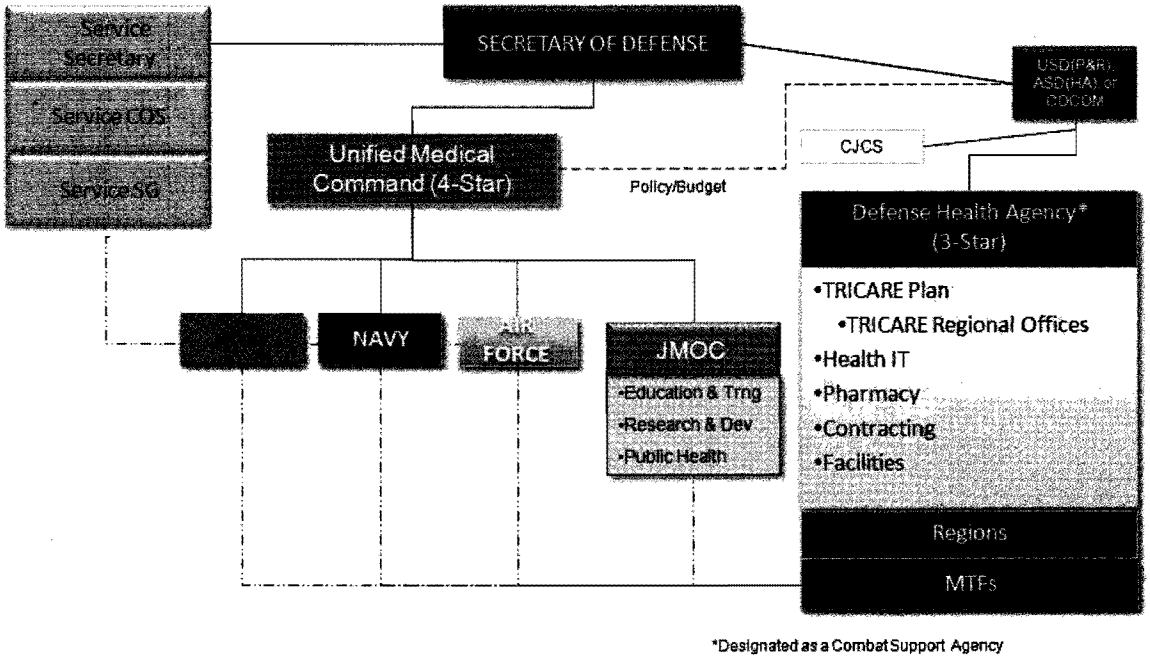

Figure 10. MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model

TOR Objectives and Scope of MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model

Item	TOR Objectives and Scope	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The ASD(HA) would have budget control. The UMC Commander would have OPCON over TOE forces. The DHA Director would have OPCON over assigned TDA personnel and would report directly to ASD(HA).
2	Head of entity or entities, and reporting chain to the Secretary of Defense.	The ASD(HA) would report through USD(P&R) to the Secretary of Defense. The DHA Director would report to the ASD(HA). The UMC Commander would report directly to the Secretary of Defense.
3	Management and supervisory chains of MTFs.	The MTFs would be managed by Regional Directors through components to the DHA.
4	Management and supervisory chains of multi-Service markets.	MSMs would be organized under the DHA, JTF CAPMED would be disestablished.
5	The authority, direction, and control for mission and administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities.	The ASD(HA) would have policy and budgetary review and oversight. The DHA Director would have control over shared and consolidated services and the MTF health care delivery system.

Item	TOR Objectives and Scope	Outcome
		The UMC Commander would have OPCON of TOE forces in the MTFs. The Military Departments would have ADCON and UCMJ authorities.
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	The ASD(HA) would have budgetary policy and review and would present and defend the DoD health budget to the PPBES. The DHA Director would have program and budget execution authority for shared and consolidated services and the MTF health care delivery system. The UMC Commander would execute DHP funding to support medical readiness. The Military Departments would have PPBES inputs for Service- funded forces.
7	The policymaking authority among OSD, the Services, and/or joint entities.	The ASD(HA) would have broad policy direction and would present and defend the PPBES. The DHA Director would have execution of shared and consolidated services and the MTF healthcare delivery system. The UMC Commander would assign medical TDA and TOE forces to the MTFs to support beneficiary healthcare delivery, line forces medical readiness, and clinical currency for medical forces. The Services would be responsible for readiness doctrine and equipment.
8	Management of purchased care and other functions currently performed by TMA.	The DHA would manage purchased care and TMA functions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education/training, and other shared services and related functions.	The DHA Director would be responsible for the development and implementation of common processes and systems to meet cost-efficiency, clinical, operational, and MTF health care delivery system requirements. The UMC Commander would be responsible for the JMOC readiness-related research, education and development and public health.
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	The ASD(HA) would provide strategic policy and PPBES oversight. The Military Departments' Secretaries and Service Chiefs would provide readiness requirements to the UMC Commander. The Military Departments' Service Surgeon's General would develop Service requirements and represent Service equities. There could be potential dual-hatting as Component Commanders.

Item	TOR Objectives and Scope	Outcome
		The DHA Director would develop common processes and systems to meet operational, clinical and cost-effectiveness goals for the MHS and MTF healthcare delivery system.
11	Effect on the Guard and Reserve forces.	No effect is anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 17. TOR Objectives and Scope of MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model

Strengths, Weaknesses, and Barriers of MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model

Strengths of a Split UMC and Military-Led DHA Geographic Hybrid Model	
• **Dispute Resolution/Lines of Authority/Accountability:** This option would align Command and Control (C2) forces under a Military chain of command. It would also align the ASD(HA)'s role to policy and oversight with execution delegated to the Military DHA Director. It would focus healthcare delivery in the DHA (efficiency) and medical readiness in the UMC (effectiveness). • **Achieve Significant Cost Savings Through Reduction in Duplication and Variation:** This option would centralize responsibilities for shared and common processes and systems.	
Weaknesses of a Split UMC and Military-Led DHA Geographic Hybrid Model	
• **Medical Readiness:** Service readiness functions would be located in the UMC. • **Dispute Resolution/Lines of Authority/Accountability:** The UMC Commander would report directly to the Secretary of Defense. It could be difficult to adjudicate disagreements between the UMC and DHA at the DSD level.	
Barriers to a Split UMC and Military-Led DHA Geographic Hybrid Model	**Mitigation Strategies for a Split UMC and Military-Led DHA Geographic Hybrid Model**
• A decision on common processes and functions under the control of the DHA Director. • JTF CAPMED would be disestablished.	• Service line could fund medical readiness equipment to meet unique Service requirements. • Sustain the core Service organizational structures. • Implement and alternative MSM construct.

Table 18. Strengths, Weaknesses, and Barriers of MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model

MHS Governance Option J: UMC with Components and DHA Hybrid

This alternative divides the shared services between the DHA and UMC. Shared services retained within the UMC would be those that predominately support force readiness. Shared services in the Agency would support beneficiary health care delivery and clinical quality. The ASD(HA) would have budgetary control over the MHS, reporting through USD (P&R) to the Secretary of Defense. The UMC Commander would have OPCON over all forces and MTFs and would report directly to the Secretary of Defense. The DHA Director would have OPCON over assigned personnel and would report directly to the ASD(HA). The MTFs would be managed through Components to the UMC Commander. Service intermediate headquarters structure would be retained. The MSMs would be addressed by the UMC Commander, potentially as separate regions reporting directly to the UMC Commander or to a component.

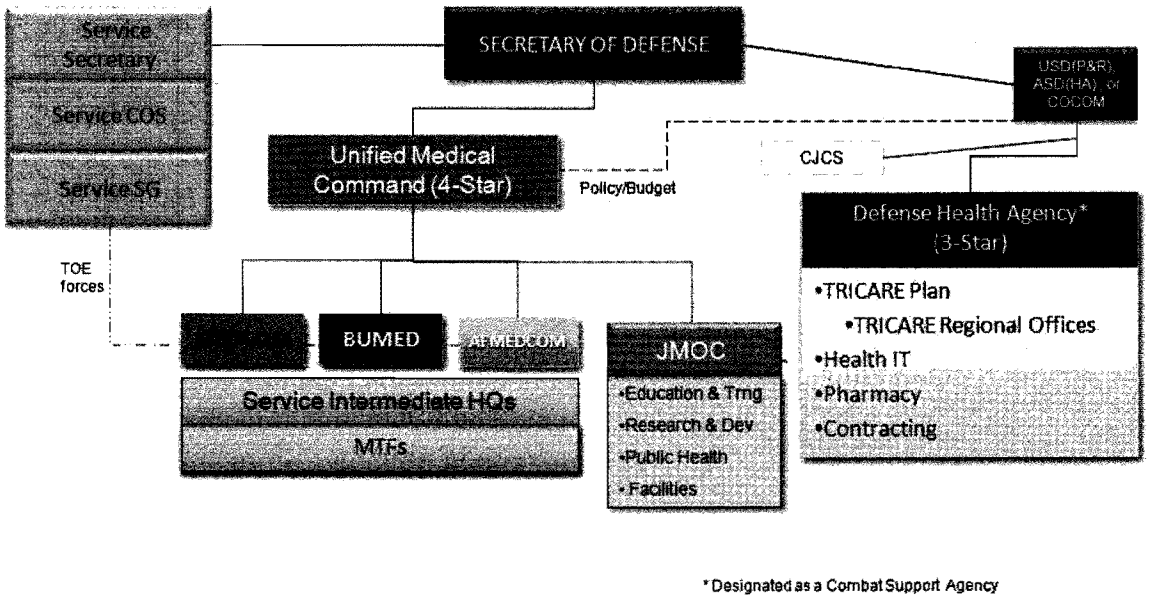

Figure 11. MHS Governance Option J: UMC with Components and DHA Hybrid

TOR Objectives and Scope of MHS Governance Option J: UMC with Components and DHA Hybrid

Item	TOR Objectives and Scope	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The ASD(HA) would have budgetary control over the MHS. The UMC Commander would have OPCON over all forces and MTFs and serve as a force provider. The DHA Director would have OPCON over assigned personnel.
2	Head of entity or entities, and reporting chain to the Secretary of Defense.	The ASD(HA) would report through the USD(P&R) to the Secretary of Defense. The DHA Director would report to the ASD(HA).

Item	TOR Objectives and Scope	Outcome
		The UMC Commander would report directly to the Secretary of Defense.
3	Management and supervisory chains of MTFs.	The MTFs would be managed by MTF Directors through components to the UMC Commander.
4	Management and supervisory chains of multi-Service markets.	There are two options for the MSMs. Option 1 is to manage the MSMs through Service Components. Option 2 is to have the MSMs report directly to the UMC Commander.
5	The authority, direction, and control for mission and administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities.	The ASD(HA) would have policy and budgetary review and oversight. The DHA Director would have control over shared and consolidated services. The UMC would have OPCON of forces and MTFs. The Military Departments would have ADCON and UCMJ authorities.
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	The ASD(HA) would have budgetary policy and review and also present and defend the DoD health budget to the PPBES. The DHA Director would have program and budget execution authority for shared and consolidated services. The UMC Commander would provide DHP funding to the Components and MTF health care delivery system. The Military Departments would have PPBES input for Service- funded forces.
7	The policymaking authority among OSD, the Services, and/or joint entities.	The ASD(HA) would have broad policy direction and would present and defend the PPBES. The DHA Director would execute shared and consolidated services. The UMC Commander would have policymaking authority over the MTFs and the medical forces. The Services would be responsible for readiness doctrine and equipment.
8	Management of purchased care and other functions currently performed by TMA.	The DHA would manage purchased care and other TMA functions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education/training, and other shared services and related functions.	The DHA Director would be responsible for the development and implementation of common processes and systems to meet cost-efficiency, clinical, operational requirements and MTF health care delivery system. The UMC Commander would be responsible for the JMOC readiness related research, education and development and public health, and facilities as well as

Item	TOR Objectives and Scope	Outcome
		the healthcare delivery system.
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	The ASD(HA) would have strategic policy and PPBES oversight. The Military Departments' Secretaries and Service Chiefs would provide readiness requirements to the UMC Commander. The Military Departments' Service Surgeon's General would develop Service requirements and represent Service equities. They could possibly dual-hat as Component Combatant Commanders. The DHA Director would develop common processes and systems to meet operational, clinical and cost-effectiveness goals for the MHS and MTF health care delivery system. The UMC Commander would run the health care system and be the force provider to meet COCOM operational requirements.
11	Effect on the Guard and Reserve forces.	The Guard and Reserve forces would remain aligned with their respective Service but may require access to the UMC MTFS for readiness training prior to deployment.

Table 19. TOR Objectives and Scope of MHS Governance Option J: UMC with Components and DHA Hybrid

Strengths, Weaknesses, and Barriers of MHS Governance Option J: UMC with Components and DHA Hybrid

Strengths of a UMC with Components and DHA Hybrid	
• **Dispute Resolution/Lines of Authority/Accountability:** This option would align Command and Control (C2) forces under a Military chain of command. It would also align the ASD(HA)'s role to policy and oversight with execution delegated to the UMC Commander and DHA Director. • **Ease of Implementation:** This option would maintain Service structures as Component Commands in the UMC. It would also support the JTF CAPMED construct.	
Weaknesses of a UMC with Components and DHA Hybrid	
• **Medical Readiness:** Service readiness functions would be located in the UMC. • **Dispute Resolution/Lines of Authority/Accountability:** The UMC Commander would report directly to the Secretary of Defense. It could be difficult to adjudicate disagreements between the UMC and DHA at the DSD level. • **Achieve Significant Cost Savings:** The execution of the shared services and common processes would require UMC Combatant Command agreement.	
Barriers to a UMC with Components and DHA Hybrid	**Mitigation Strategies for a UMC with Components and DHA Hybrid**
• A decision on common processes and functions under the control of the DHA Director.	• The Service line could fund medical readiness equipment to meet unique Service requirements. • Sustain the core Service organizational structures.

Table 20. Strengths, Weaknesses, and Barriers of MHS Governance Option J: UMC with Components and DHA Hybrid

MHS Governance Option K: Single Service Hybrid with a Unified Medical Command

This alternative divides the shared services between a single service-run Defense Healthcare System and UMC. Shared services retained within the UMC would be those that predominately support force readiness. Shared services in the Defense Healthcare System would support beneficiary health care delivery and clinical quality. The designated Military Department Secretary of the Defense Healthcare System would have budgetary control over the MHS, reporting directly to the Secretary of Defense. The UMC Commander would have OPCON over all assigned forces. The MTFs would report through Regional Commanders to the designated Service to the Secretary of Defense. All MSMs, including the NCR, would be single Service. MSMs and NCR would be resolved in this construct without further decisions. Service intermediate headquarters would be reduced to a single set of regional headquarters.

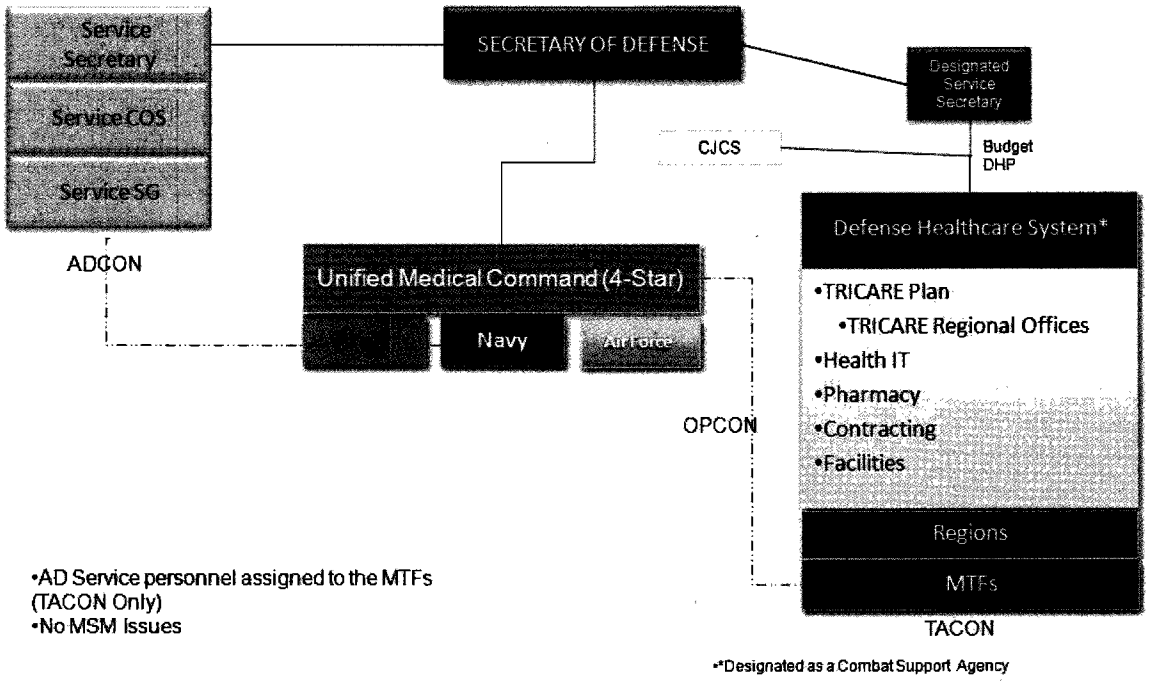

Figure 12. MHS Governance Option K: Single Service Hybrid with a Unified Medical Command

TOR Objectives and Scope of MHS Governance Option K: Single Service Hybrid with a Unified Medical Command

Item	TOR Objectives and Scope	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The designated Service Secretary would run the peacetime beneficiary health care system for the MHS. The Components would provide staff to the UMC. The UMC Commander would manage the deployable mission and leverage single service run MTFs for clinical currency.
2	Head of entity or entities, and reporting chain to the Secretary of Defense.	DHA through the designated Service to the Secretary of Defense. UMC Commander directly to the Secretary of Defense.
3	Management and supervisory chains of MTFs.	MTFs would be managed by MTF commanders who would report to Regional Commanders who would report to the designated Service Medical Commander who would then report to the Service Secretary. The NCR would be a single Service market.
4	Management and supervisory chains of multi-Service markets.	All MSMs would be single Service.
5	The authority, direction, and control for mission and administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities.	The designated Service chain of command would have TACON. TOE and TDA forces would be assigned to the designated Service facilities for currency with OPCON to the UMC.
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	OSD would have policy oversight. The designated Service would have planning, programming, budget, and execution for MTF beneficiary delivery requirements. The UMC Commander would provide forces to the designated Service, have PPBES for readiness equipment, and deploy forces.
7	The policymaking authority among OSD, the Services, and/or joint entities.	OSD would have broad policy and guidance with input into the SPG. The designated Service would have execution and operational policy development and implementation. The UMC Commander would develop readiness requirements and platforms and deploy forces. The Services would have ADCON to forces assigned to the UMC.
8	Management of purchased care and other functions currently performed by TMA.	The designated Service Secretary would manage purchased care and other TMA functions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education/training,	This would be a single system based on the processes of the designated Service.

Item	TOR Objectives and Scope	Outcome
	and other shared services and related functions.	
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	The ASD(HA) would have policy and oversight and provide advice to the Secretary of Defense. The Military Departments' Secretaries and Chiefs would oversee beneficiary care and maintain ADCON to the assigned forces. The Military Departments' Service Surgeon's General would oversee readiness of forces and deployed mission and monitor the performance of the designated Service.
11	Effect on the Guard and Reserve forces.	No effect is anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 21. TOR Objectives and Scope of MHS Governance Option K: Single Service Hybrid with a Unified Medical Command

Strengths, Weaknesses, and Barriers of MHS Governance Option K: Single Service Hybrid with a Unified Medical Command

Strengths of a Single Service Hybrid with a Unified Medical Command	
• **Dispute Resolution/Lines of Authority/Accountability:** This option would establish clear lines of authority for ADCON, OPCON, and TACON of forces with each being vested in a different structure. It would also create central control of the MTFs. • **Ease of Implementation:** In this option, the MSMs are addressed and joint facilities would be maintained. • **Enhance Interoperability:** This option would allow for single processes for key functions.	
Weaknesses of a Single Service Hybrid with a Unified Medical Command	
• **Medical Readiness:** This would split the readiness and garrison care systems. • **Dispute Resolution/Lines of Authority/Accountability:** This option would create different responsible agents for ADCON, TACON, and OPCON of forces.	
Barriers to a Single Service Hybrid with a Unified Medical Command	**Mitigation Strategies for a Single Service Hybrid with a Unified Medical Command**
• Selection of the Service responsible for all DoD medical care. • Transfer of medical forces and civilians to the designated Service. • Separating control elements (ADCON, OPCON and TACON) to different responsible agents.	• None.

Table 22. Strengths, Weaknesses, and Barriers of MHS Governance Option K: Single Service Hybrid with a Unified Medical Command

MHS Governance Option L: Defense Health Agency Hybrid with Medical Treatment Facilities (MTFs) placed under the Agency

This option would establish a Defense Health Agency replacing TMA and focused on consolidating and delivering a far broader set of shared health care support services. MHS-wide shared services activities include, but are not limited to: the TRICARE health plan; pharmacy programs; medical education and training; medical logistics; facility planning; health information technology; medical research and development; health information technology; facility planning; public health; acquisition; and other common clinical and business processes.

The DHA could be led by a 3-Star general or flag officer who would report to the Assistant Secretary of Defense (Health Affairs). The DHA could be designated as a Combat Support Agency (CSA) with periodic CJCS review of its combat support mission execution effectiveness. The MTFs would transfer to the DHA and would operate under its authority, direction, and control. The Military Departments would continue to own all military personnel and be responsible for organizing, training, and equipping their deployable military medical forces. Service medical personnel would be assigned to DHA-run MTFs to maintain readiness and clinical currency. MSMs and the NCR are addressed in this option as a part of the DHA. Service intermediate headquarters would reduce to a single, DHA-run set of regional headquarters.

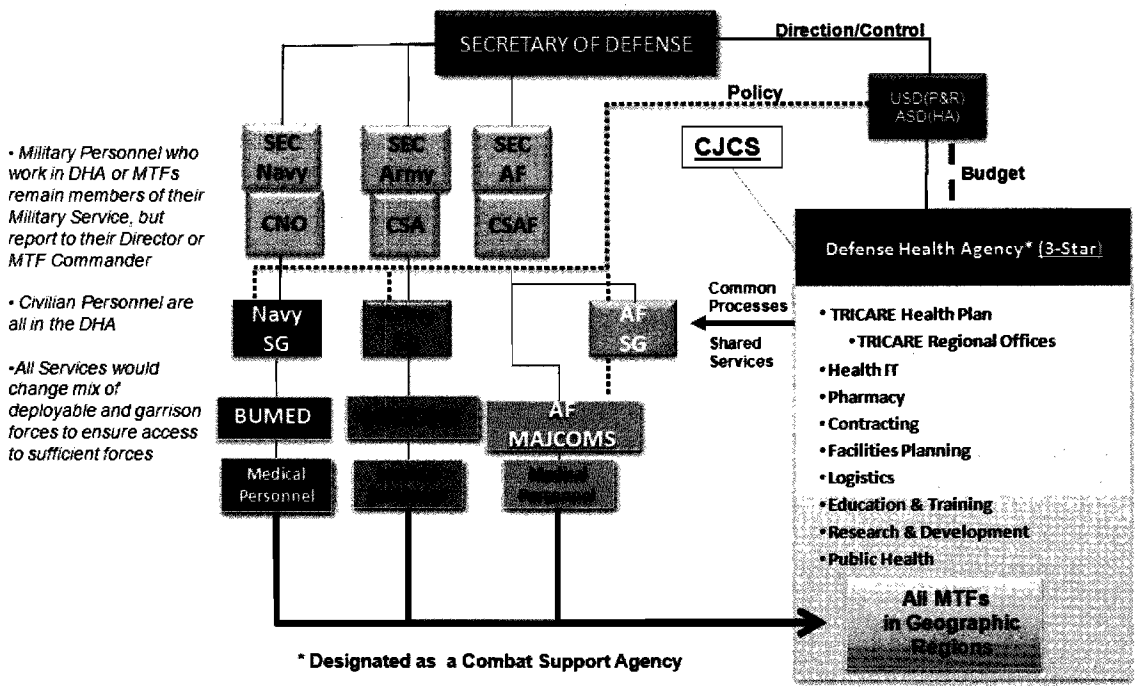

Figure 13. MHS Governance Option L: DHA Hybrid with Medical Treatment Facilities (MTFs) placed under the authority, direction, and control of the Agency

TOR Objectives and Scope of MHS Governance Option L: Defense Health Agency Hybrid with Medical Treatment Facilities (MTFs) under the Agency

Item	TOR Objectives and Scope	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The DHA Director would be responsible for authority, direction, and control of the MHS. ASD(HA) would have an oversight and policy role. Military Departments would be responsible for the size and capabilities of the active duty medical forces. Military medical forces are assigned to the DHA for professional currency maintenance.
2	Head of entity or entities, and reporting chain to the Secretary of Defense.	Component reporting chains for headquarters and TOE-assigned military personnel would remain as they currently exist. Service Surgeons General would continue reporting to their Service Secretaries who would report to the Secretary of Defense, but overall reporting chains would be changed for garrison care. The DHA Director would report to the ASD(HA), who would report to the USD (P&R), reporting to the Secretary of Defense.
3	Management and supervisory chains of MTFs.	MTF commanders would report through intermediate commands established by the DHA Director.
4	Management and supervisory chains of multi-Service markets.	As all medical treatment facilities would be operated by the DHA, vice the Services, the concept of multi-Service markets would no longer be applicable.
5	The authority, direction, and control for mission and administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities.	The Director, DHA would have authority, direction, and control over MHS personnel assigned to the medical treatment facilities within rules established with the Military Department Secretaries. TOE forces would report through Service structures.
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	Authority over the DHP would reside with the Director, DHA with oversight from ASD(HA).
7	The policymaking authority among OSD, the Services, and/or joint entities.	The ASD(HA), subject to the authority, direction, and control of USD (P&R), would be the senior policy authority in the MHS. The DHA Director would execute policy through the DHA structure. Policy matters would be coordinated with the Director, DHA, and Military Department Secretaries.
8	Management of purchased care and other functions currently performed by TMA.	The DHA Director would assume control of TRICARE contracts and all other TMA functions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education/training, and other shared services and related functions.	The DHA Director would control all shared and common functions.
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military	The ASD(HA) would retain policy-making activities, and would supervise the DHA Director. The Service Components would continue to be

Item	TOR Objectives and Scope	Outcome
	Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	responsible for management and oversight of their medical readiness programs and TOE forces. The DHA Director would assume budgetary control of the DHP and all responsibilities currently outlined in the DoDDirective, 5136.12, TRICARE Management Activity, and would have the authority to issue program guidance regarding medical research and development, health information technology, military medical logistics, military medical construction, medical education and training, and all other responsibilities as provided by the Secretary of Defense. The DHA Director would also have overall supervision of all medical treatment facilities.
11	Effect on the Guard and Reserve forces.	No effect is anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 23. TOR Objectives and Scope of MHS Governance Option L: DHA Hybrid with Medical Treatment Facilities (MTFs) under the Agency

Strengths, Weaknesses, and Barriers of MHS Governance Option L: DHA Hybrid with Medical Treatment Facilities (MTFs) under the Agency

Strengths of a DHA Hybrid with MTFs under the Agency	
• **Dispute Resolution/Lines of Authority/Accountability:** Would place management of all medical treatment facilities under one authority (Director, DHA), albeit at the expense of long-standing practice of management by Military Departments. The DHA Director would report directly to the ASD(HA). • **Achieve Significant Cost Savings Through Reduction in Duplication and Variation:** The DHA would be focused on the most common theme emphasized by the Task Force – an organizational model that would accelerate implementation of shared services models that identify and proliferate best practices and consider entirely new approaches to delivering shared activities. Further, placement of medical treatment facilities under the DHA would allow for even more rapid implementation of unified clinical and business systems, which could create significant savings. • **Other:** Would align management of purchased care (TRICARE) and direct care (medical treatment facilities) under one entity, creating potential for greater coordination and cost-effective distribution of resources between the two sources of care.	
Weaknesses of a DHA with MTFs under the Agency	
• **Medical Readiness:** Concerns were expressed that an organization this large with this many authorities could jeopardize Services priorities. A comprehensive DHA could reduce command and leadership development opportunities. • **Dispute Resolution/Lines of Authority/Accountability:** This model may elevate management disputes to the highest levels of the DoD, as local line command disputes with the DHA command structure may need to be adjudicated at the level of the Secretary of the Military Department /ASD(HA) level. • **Ease of Implementation:** Moving all medical treatment facilities to the DHA would be a major reorganization. • **Other:** Could mix the DHA mission between support of MHS-wide functions and direct operation of hospitals and clinics. The Military Department's representatives on the Task Force believed that operation of the direct care system is a Military Department responsibility.	
Barriers to a DHA with MTFs under the Agency	**Migration Strategies for a DHA with MTFs under the Agency**
• Would require increase or transfer of personnel into OSD manpower levels for Health Affairs to accommodate the migration of financial management/oversight personnel from the field activity to OSD.	• Appropriate modifications to OSD/Health Affairs staffing levels, in light of enhanced oversight mission, would be explored.

Table 24. Strengths, Weaknesses, and Barriers of MHS Governance Option L: DHA Hybrid with MTFs under the Agency

MHS Governance Option M: Defense Health Agency Hybrid with Regional MTFs

The ASD(HA), COCOM, or Service Secretary would report directly to the Secretary of Defense and would manage the shared services of the MHS through the DHA. The Service Secretaries would manage the Services and Medical Operations Support Command (MOSC). The MOSC would be created to run those shared services that are required to support medical readiness and deployed forces. Shared services supporting beneficiary health care delivery would be located in the Agency. The regional MSM structure would expand with all MTFs reporting to the MSMs, including the NCR, which would report directly to their respective Service. Services would maintain their current intermediate headquarters structure. This alternative was offered by a member of the Task Force without a detailed analysis.

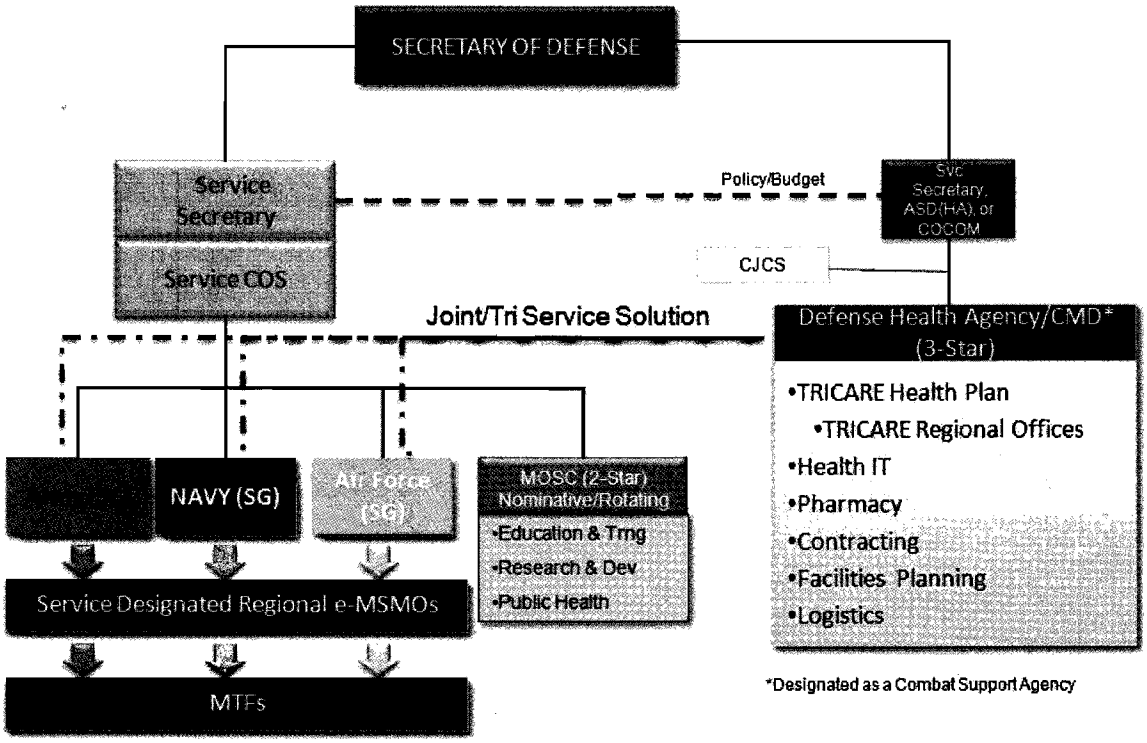

Figure 14. MHS Governance Option M: Defense Health Agency Hybrid with Regional Medical Treatment Facilities (MTFs)

Voting Structure

The Task Force narrowed down the multiple construct options described by applying the seven evaluation criteria in a series of votes, as seen in Figure 15 below. The run-off bracket voting style was developed in order to allow the Task Force to objectively compare options and helped to structure the questions that each Task Force member was voting on. The voting results of each option are detailed later in this report. The voting process used a Likert-type scale of 1 (weakest) to 5 (strongest) to rate the options against the criteria in each voting flight. The votes were examined by both weighted score as well ranked weighted score in the final four votes.

In order to normalize the votes across the nine voting members, one of the options was chosen by the co-chairs to serve for comparison purposes. This was intended to allow the voters to rate each option in the flight against the same baseline; thereby rating each option as better or worse than the baseline option. This was necessary in order to ensure comparability of the votes. In each case, the baseline for the vote was predetermined to score as "3s" for the criteria.

Each vote and selected option is listed in Table 25. The votes were also weighted and ranked by weighted score. This provided two different views of the Task Force Member's views: one relating to the relative merit of each option considered and one relating to the members ranking of the options. This allowed the Task Force to better assess the options and each members views.

Vote 4 was unique and consisted of four separate sub-votes with the first three votes focusing on the desired governance and reporting structure for the NCR. Vote 4d addressed governance all of the U.S.-based (i.e. CONUS) and Overseas-based (i.e. OCONUS) MSMs. The Task Force members further voted on the Service that would be lead, by Market, for the case of eMSM and Executive agent governance models. This was done to provide a complete assessment of the relevant governance issues for the eMSM and EA models. The majority of the Task Force members recommended each MSM to be an eMSM but the Service who would manage the MSM varied among the Task Force members.

The September 29, 2011 MHS Task Force report delivered to the Secretary of Defense provides greater detail on the MSM and NCR options.

	Vote	Selected Option
1a	• MHS Governance Option E: UMC with Service Components; • MHS Governance Option F: Unified Medical Command - HR 1540 Section 711 Model; or • MHS Governance Option J: UMC with Components and DHA Hybrid	**MHS Governance Option E: UMC with Service Components**
1b	• MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model or • MHS Governance Option K: Single Service Hybrid with a Unified Medical Command	**MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model**
2a	• MHS Governance Option E: UMC with Service Components or • MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model	**MHS Governance Option E: UMC with Service Components**
2b	• MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model; • MHS Governance Option J: UMC with Components and DHA Hybrid; or • MHS Governance Option M: Defense Health Agency Hybrid with Regional MTFs	**MHS Governance Option M: Defense Health Agency Hybrid with Regional MTFs**
2c	• MHS Governance Option G: Single Service, Geographic Model – One Military Department Secretary Assigned Responsibility for the MHS or • MHS Governance Option H: Single Service with Components	**MHS Governance Option H: Single Service with Components**
Final Single Service Vote	• MHS Governance Option H: Single Service with Components • MHS Governance Option K: Single Service Hybrid with a Unified Medical Command	**MHS Governance Option H: Single Service with Components**
3a	• MHS Governance Option E: UMC with Service Components; • MHS Governance Option M: Defense Health Agency Hybrid with Regional MTFs; or • MHS Governance Option K: Single Service Hybrid with a Unified Medical Command	**MHS Governance Option E: UMC with Service Components**

3b	• MHS Governance Option D: Unified Medical Command, Geographic Model or • MHS Governance Option L: Defense Health Agency Hybrid with Medical Treatment Facilities (MTFs) placed under the Agency	**MHS Governance Option L: Defense Health Agency Hybrid with Medical Treatment Facilities (MTFs) placed under the Agency**
4a	• The current NCR structure of JTF CAPMED reporting to the Secretary of Defense; • A Northern Command (NORTHCOM); • An enhanced MSM structure (eMSM); • HA/TMA; • A Single Service; or • An Executive Agent (EA)	**An enhanced MSM structure (eMSM)**
4b	• The current NCR structure of JTF CAPMED reporting to the Secretary of Defense; • A Northern Command (NORTHCOM); • An enhanced MSM structure (eMSM); • A DHA; • A Single Service; or • An Executive Agent (EA)	**An enhanced MSM structure (eMSM)**
4c	• A minimal MSM; • The current NCR structure of JTF CAPMED reporting the Secretary of Defense; • An enhanced MSM structure (eMSM); • An Executive Agent (EA); • A Single Service; or • A Command Authority	**An enhanced MSM structure (eMSM)**
4d	• MSM Type, Manager, EA Designation	**See Results in Table 33**
5	• The current "As-Is" MHS structure; • DHA 2/ Hybrid 1 (DHA with MTFS Remaining in the Military Departments); • UMC Option 2 (Component); • DHA 1/ Hybrid 2 (DHA with MTFs under the DHA); or • Single Service Option 2 (Component)	**DHA 2/ Hybrid 1 (DHA with MTFS Remaining in the Military Departments)**

Table 25. MHS Task Force Votes and Selected Options

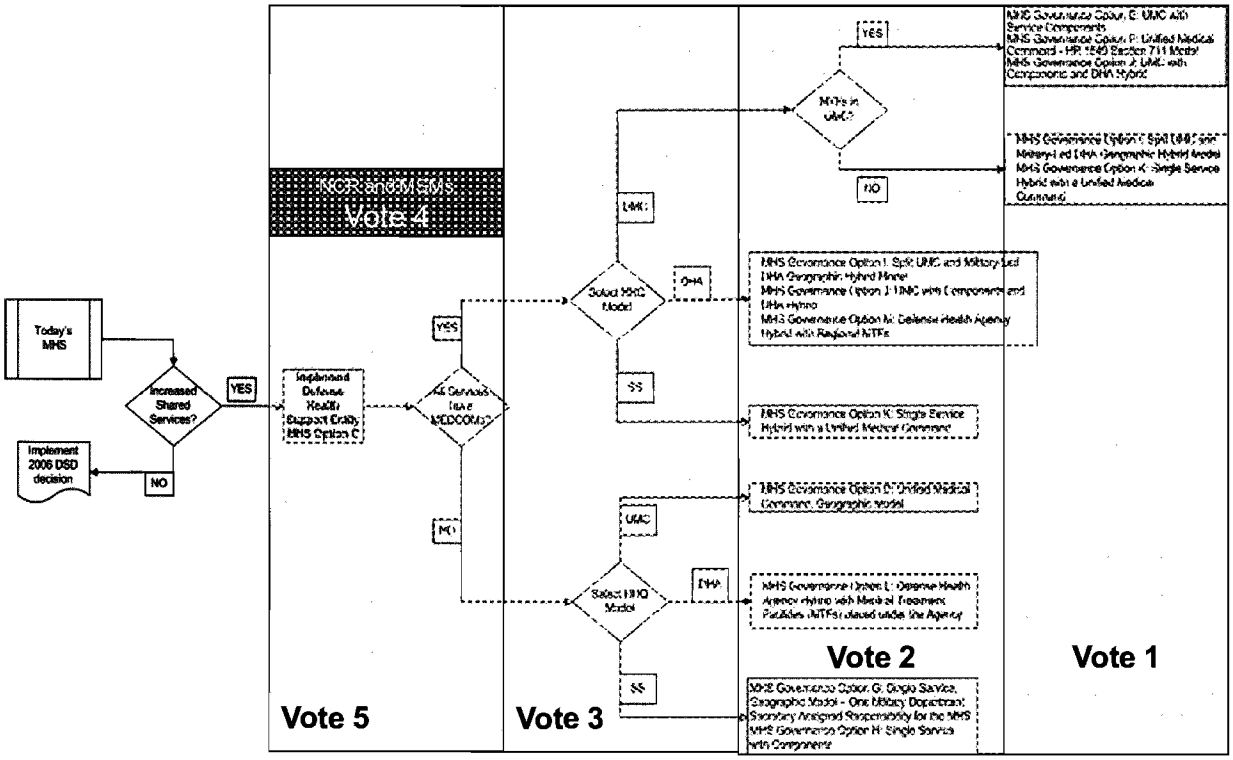

Figure 15. MHS Task Force Voting Construct

Voting Results

Based on the voting construct, the voting results are below. The voter identities have been sanitized for this report.

Vote 1a: - MHS Governance Option E: UMC with Service Components
- MHS Governance Option F: UMC - HR 1540 Section 711 Model
- MHS Governance Option J: UMC with Components and DHA Hybrid

Vote 1b: - MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model
- MHS Governance Option K: Single Service Hybrid with a Unified Medical Command

VOTE 1a			
Voter		MHS Governance Option F	MHS Governance Option J
A	3	3.04	3.28
B	3	1	2
C	3	2.41	2.89
D	3	1	2
E	3	2.39	2.61
F	3	2.75	2.75
G	3	2.57	2.78
H	3	2.66	2.51
I	3	2.89	3.25
OVERALL		20.71	24.07
Average		2.3	2.7

VOTE 1b		
Voter		MHS Governance Option K
A	3	3
B	3	1
C	3	3.21
D	3	1
E	3	2.86
F	3	2.95
G	3	3.11
H	3	2.89
I	3	2.7
OVERALL		22.72
Average		2.5

Table 26. Vote 1a and 1b Results

Vote 2a: - MHS Governance Option E: UMC with Service Components
- MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model

Vote 2b: - MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model
- MHS Governance Option J: UMC with Components and DHA Hybrid
- MHS Governance Option M: Defense Health Agency Hybrid with Regional MTFs

Vote 2c: - MHS Governance Option G: Single Service, Geographic Model – One Military Department Secretary Assigned Responsibility for the MHS
- MHS Governance Option H: Single Service with Components

VOTE 2a		
Voter		MHS Governance Option I
A	3	2.49
B	3	1
C	3	2.89
D	3	1
E	3	2.05
F	3	2.46
G	3	2.98
H	3	2.03
I	3	2.89
OVERALL		19.79
Average		2.20

VOTE 2b			
Voter	MHS Governance Option I	MHS Governance Option J	
A	3	3.08	3.1
B	3	4	5
C	3	2.17	3.8
D	3	5	4
E	3	3.61	2.33
F	3	3	3.73
G	3	3.02	3.19
H	3	3.11	3.14
I	3	3.14	3.48
OVERALL	27	30.13	
Average	3	3.35	

VOTE 2c		
Voter	MHS Governance Option G	
A	3	2.51
B	3	4
C	3	3.24
D	3	4
E	3	3.21
F	3	2.71
G	3	2.83
H	3	3.39
I	3	3.21
OVERALL	27.00	
Average	3.00	

Table 27. Vote 2a, 2b, and 2c Results

Final Single Service Vote: - MHS Governance Option H: Single Service with Components
- MHS Governance Option K: Single Service Hybrid with a Unified Medical Command

Final Single Service Vote		
Voter		MHS Governance Option K
A	3	2.06
B	3	1
C	3	2.72
D	3	1
E	3	1.77
F	3	2.78
G	3	2.6
H	3	2.09
I	3	2.69
OVERALL		18.71
Average		2.08

Table 28. Final Single Service Vote Results

Vote 3a: - MHS Governance Option E: UMC with Service Components
- MHS Governance Option M: Defense Health Agency Hybrid with Regional MTFs
- MHS Governance Option K: Single Service Hybrid with a Unified Medical Command

Vote 3b: - MHS Governance Option D: Unified Medical Command, Geographic Model
- MHS Governance Option L: Defense Health Agency Hybrid with Medical Treatment Facilities (MTFs) placed under the Agency
- MHS Governance Option H: Single Service with Components

VOTE 3a			
Voter		MHS Governance Option M	MHS Governance Option K
A	3	3.53	2.91
B	3	2	1
C	3	3.99	1.7
D	3	2	1
E	3	2.41	2.2
F	3	2.99	2.26
G	3	3.17	2.86
H	3	1	1
I	3	3.37	2.81
OVERALL		24.46	17.73
Average		2.72	1.97

VOTE 3b			
Voter	MHS Governance Option D		MHS Governance Option H
A	3	2.38	3.36
B	3	4	1
C	3	3.48	2.89
D	3	4	1
E	3	3.4	1.89
F	3	2.99	2.93
G	3	3.17	2.77
H	3	5	4
I	3	3.05	2.94
OVERALL	27		22.78
Average	3		2.53

Table 29. Vote 3a and 3b Results

Vote 4a: - JTF – NCR MSM in MHS Governance Option A: Current MHS Governance Structure

Vote 4a: JTF - NCR MSM in MHS Governance Option A: Current MHS Governance Structure						
Voter	SECDEF	NORTHCOM		JS/J3/DJ4	Single Service	EA
A	3	2.23	3.52	2.97	2.89	2.29
B	3	3	2	2	1	1
C	3	1	5	2	2.4	3
D	3	3	5	1	2	4
E	3	2.25	3.17	2	2.96	2.86
F	3	3.01	2.94	3.06	3.52	3.52
G	3	2.64	3.12	2.89	3.15	2.75
H	3	2.6	3.14	2.75	2.92	2.92
I	3	2.48	3.43	2.89	3.15	2.98
OVERALL	27	22.21		21.56	23.99	25.32
Average	3	2.47		2.40	2.67	2.81

Vote 4a: JTF - NCR MSM in MHS Governance Option A: Current MHS Governance Structure (RANKED)						
Voter	SECDEF	NORTHCOM		JS/J3/DJ4	Single Service	EA
A	2	6	1	3	4	5
B	1	2	3	4	5	6
C	3	6	1	5	4	2
D	4	3	1	6	5	2
E	2	5	1	6	3	4
F	5	4	6	3	2	1
G	3	6	2	4	1	5
H	2	6	1	5	4	3
I	3	6	1	5	2	4
OVERALL	25	44		41	30	32
Average	2.8	4.9		4.6	3.3	3.6

Table 30. Vote 4a Results

Vote 4b: - JTF – NCR MSM in MHS Governance Option C: Defense Health Agency with Service MTFs

Vote 4b: JTF - NCR MSM in MHS Governance Option C: Defense Health Agency with Service MTFs						
Voter	SECDEF	NORTHCOM		DHA	Single Service	EA
A	3	2	3.13	3	2.82	2.17
B	3	2	3	2	1	2
C	3	1	5	1	2.4	3
D	3	3	5	1	2	4
E	3	1.99	3.65	4.09	3.45	3
F	3	3.01	2.94	3.06	3.52	3.52
G	3	2.69	2.91	3.25	2.7	2.72
H	3	2.6	2.75	4.23	2.92	2.92
I	3	2.48	3.17	3.11	2.95	2.94
OVERALL	27	20.77		24.74	25.75	26.27
Average	3	2.31		2.75	2.86	2.92

Vote 4b: JTF - NCR MSM in MHS Governance Option C: Defense Health Agency with Service MTFs (RANKED)						
Voter	SECDEF	NORTHCOM		DHA	Single Service	EA
A	3	6	1	2	4	5
B	1	3	2	4	6	5
C	3	5	1	6	4	2
D	4	3	1	6	5	2
E	5	6	2	1	3	4
F	5	4	6	3	2	1
G	2	6	3	1	5	4
H	2	6	5	1	4	3
I	3	6	1	2	4	5
OVERALL	28	45		26	37	31
Average	3.1	5.0		2.9	4.1	3.4

Table 31. Vote 4b Results

Vote 4c: MSM Alternatives

Vote 4c: MSM Alternatives						
Voter	Min MSMO	Today's MSM		EA	Single Service	Command Authority
A	2.86	3	3.44	2.66	2.73	2.12
B	2	3	3	1	1	2
C	2.5	3	5	2.78	2.46	1.69
D	3	3	5	4	2	1
E	1.87	3	3.81	2	2.49	2.32
F	2.43	3	3.04	3.04	2.99	2.82
G	3	3	3.15	2.75	3.41	3.07
H	1.89	3	4.95	3.73	3.67	3.44
I	2.38	3	4.22	3.78	3.72	3.27
OVERALL	21.93	27		25.74	24.47	21.73
Average	2.4	3.0		2.9	2.7	2.4

Vote 4c: MSM Alternatives (RANKED)						
Voter	Min MSMO	Today's MSM		EA	Single Service	Command Authority
A	3	2	1	5	4	6
B	5	2	1	6	4	3
C	4	2	1	3	5	6
D	3.5	3.5	1	2	5	6
E	5	2	1	2	3	4
F	6	3	1.5	1.5	4	5
G	4.5	4.5	6	2.75	1	3
H	6	5	1	2	3	4
I	6	5	1	2	3	4
OVERALL	45	29		26.25	32	41
Average	4.8	3.2		2.9	3.6	4.6

Table 32. Vote 4c Results

Vote 4d: MSM Type, Manager, and EA Designation

Market	MSM Type	If e/MSM: Manager	If an EA: EA will be:
National Capital Area	eMSM (4) - Aligned Under DHA (3) - Command Authority (1) -eMSM/EA (1)	Rotate (5) - Army (1) -Army/Navy Rotate (2) - No opinion (1)	Army (6) -Navy (1) - Army (1) - No opinion (1)
Tidewater, VA	eMSM (8) - eMSM/EA (1)	Navy (8) - No opinion (1)	Navy (8) - No opinion (1)
Puget Sound, WA	eMSM (8) -eMSM/EA (1)	Army (7) -Army/Navy Rotate (1) - No opinion (1)	Army (8) - No opinion (1)
Colorado Springs, CO	eMSM (8) -eMSM/EA (1)	Rotate (6) -Do Not Rotate, Pick One (1) - Air Force (1) - No opinion (1)	Army (6) -Air Force (2) - No opinion (1)
San Antonio, TX	eMSM (8) -eMSM/EA (1)	Rotate (6) -Do Not Rotate, Pick One (1) - Air Force (1) - No opinion (1)	- Air Force (7) - Army (1) - No opinion (1)
Fort Bragg/Pope, NC	eMSM (8) -eMSM/EA (1)	Army (8) - No opinion (1)	Army (8) No opinion (1)
Mississippi Delta	eMSM (8) -eMSM/EA (1)	Air Force (8) - No opinion (1)	Air Force (8) No opinion (1)
Naval Hospital Charleston/ Charleston AFB, SC	eMSM (8) -eMSM/EA (1)	Navy (8) - No opinion (1)	Navy (8) No opinion (1)
	OCONUS MSMs		
Anchorage, AK	eMSM (8) -eMSM/EA (1)	Air Force (8) - No opinion (1)	Air Force (8) No opinion (1)
Fairbanks, AK	eMSM (8) -eMSM/EA (1)	Army (8) - No opinion (1)	Army (8) No opinion (1)
Oahu, HI	eMSM (8) -eMSM/EA (1)	Army/Navy (5) - Do Not Rotate, Pick One (1) -Army/Navy Rotate (1) - Navy (1) - No opinion (1)	Army (6) -Navy (2) - No opinion (1)
Okinawa, Japan	eMSM (8) -eMSM/EA (1)	Navy (8) - No opinion (1)	Navy (8) - No opinion (1)
Kaiserslautern , Germany	eMSM (8) -eMSM/EA (1)	Army (8) - No opinion (1)	Army (8) - No opinion (1)
Osan Community, South Korea	eMSM (8) -eMSM/EA (1)	Army (8) - No opinion (1)	Army (8) - No opinion (1)
Guam	eMSM (8) -eMSM/EA (1)	Navy (8) - No opinion (1)	Navy (8) - No opinion (1)

Table 33. Vote 4d Results

Vote 5, Final Vote: - MHS Governance Option A: Current MHS Governance Structure
- MHS Governance Option C: Defense Health Agency with Service MTFs
- MHS Governance Option E: UMC with Service Components
- MHS Governance Option L: Defense Health Agency Hybrid with Medical Treatment Facilities (MTFs) placed under the Agency
- MHS Governance Option H: Single Service with Components

Vote 5: Final Vote					
Voter	MHS Governance Option A		MHS Governance E	MHS Governance Option L	MHS Governance Option H
A	3	3.81	2.75	3.5	2.52
B	3	4	5	2	1
C	3	4.67	1.75	1.89	2.92
D	3	5	1	1	1
E	3	3.84	3.03	3.12	2.09
F	3	2.95	3.25	3.24	3.25
G	3	3	2.93	3.35	3.32
H	3	3.69	2.53	4.21	3.42
I	3	3.91	3.01	3.67	3.49
OVERALL	27		25.25	25.98	23.01
Average	3		2.81	2.89	2.56

Vote 5: Final Vote (RANKED)					
Voter	MHS Governance Option A		MHS Governance E	MHS Governance Option L	MHS Governance Option H
A	3	1	4	2	5
B	3	2	1	4	5
C	2	1	5	4	3
D	2	1	4	4	4
E	4	1	3	2	5
F	4	5	2	3	1
G	4	3	5	1	2
H	4	2	5	1	3
I	4	1	5	2	3
OVERALL	30		34	23	31
Average	3.333333333		3.78	2.56	3.44

Table 34. Vote 5, Final Vote Results

Detailed Voting Results

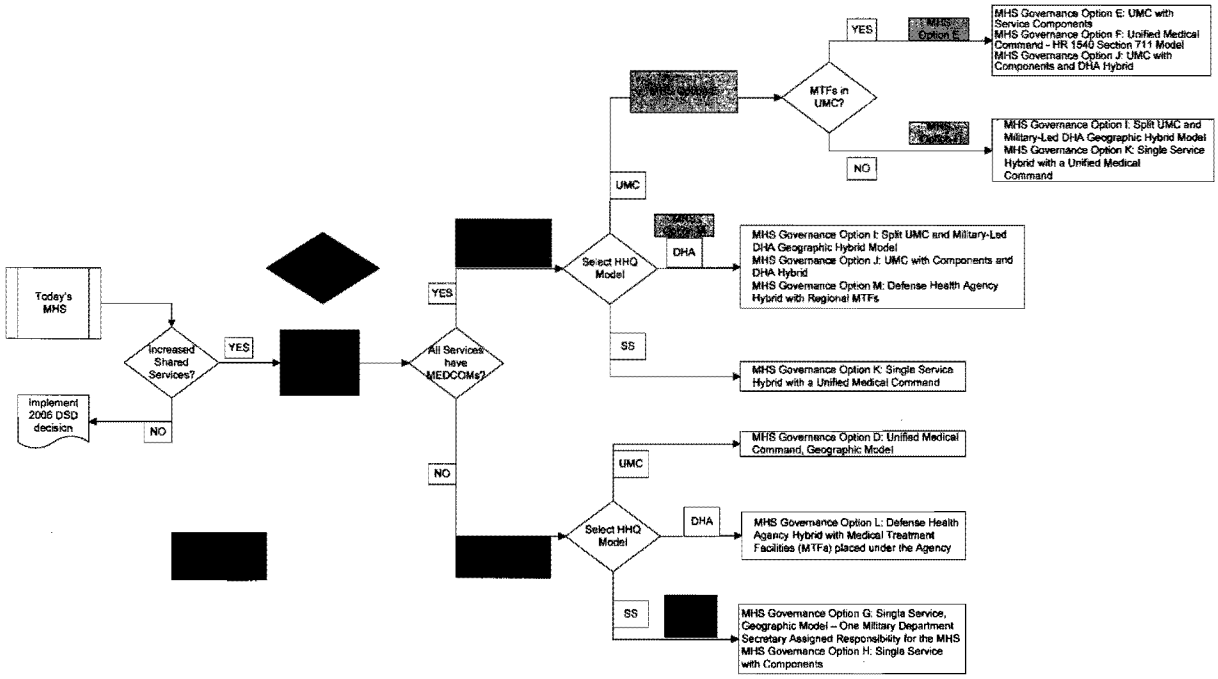

Figure 16. MHS Task Force Voting Results

Note: Voting bracket results read from right to left.

Part 2. Management Headquarters and Shared Services Sizing Analysis

Introduction

Given the rapid 90-day time period to conduct this analysis, the Task Force used the 2006 "Cost Implications of a Unified Medical Command"[1] study as a starting point in the cost analysis of the governance options. The intent of analyzing the management headquarters is to identify opportunities for creating efficiencies across the Military Health System (MHS). The objectives of this analysis are shown below:

- Establish a baseline of existing management headquarters personnel across the three Service medical headquarters, Health Affairs (HA), and TRICARE Management Activity (TMA)
- Determine a rough order of magnitude estimate of the total number of management headquarters personnel required to operate each organizational construct being considered by the Task Force using standardized analytics and assumptions

The following assumptions supported this analysis:

- Current MHS management headquarters are sized to accomplish individual missions through component-specific processes
- The missions of the management headquarters are similar for each component, but the scope and processes are variable
- Large changes in headquarters sizing would require process changes to achieve greater efficiencies without reducing effectiveness
- Current staffing can be used as a benchmark for staffing consolidated headquarters entities
- In select cases, (UMC) external benchmarks can be used to validate the staffing of consolidated headquarters entities, paying close attention to mission and scope differences
- The organizational constructs used by the Services could be adapted to cover a larger MHS-wide scope; scalability does not include any related non-medical Service-provided support

Methodology

The analysis was addressed in two parts: Management Headquarters and Shared Services. The total savings for an alternative was estimated by adding together the costs or savings from both the management headquarters and the shared services.

[1] E. Christensen, CDR D Farr, J. Grefer, and E. Schaefer, "Cost Implications of a Unified Medical Command", Center for Naval Analyses, CRM D0013842.A3, May 2006.

Management Headquarters

A simplified analytical approach was taken to design a hierarchal organizational construct of the existing MHS. Current organizational charts and personnel information (including type, military/civilian/contractor, and associated office name) for the three Service medical departments, HA, and TMA were provided to the Task Force and evaluated to determine similar levels of management headquarters personnel across all components.

As shown in Figure 17 below, the Higher Headquarters level of personnel represent the direct support offices of the Service Surgeons General and the Assistant Secretary of Defense for Health Affairs (ASD(HA)). Personnel allocated to the Support Functions level perform common daily operational requirements for the support elements of the Service medical headquarters and TMA. The intermediate headquarters level of personnel includes the Army and Navy Regional Headquarters as well as the Air Force Major Commands (MAJCOMs) and TRICARE Regional Offices (TROs). Not included in this analysis are the MTF personnel, considered to be outside the scope of the Task Force Terms of Reference (TOR). JTF CAP MED was included as a part of the assessment of the UMC alternatives. Initial responses to the data call required further explanation to normalize the data to make the results comparable. In spite of the efforts of the Services and the Task Force analysis team, it is likely that some Service-specific differences in the approach to the data remained in the final data set. However, the Services and the analysis team allowed that the final data set was sufficient for the level of analysis undertaken to support the Task Force deliberations.

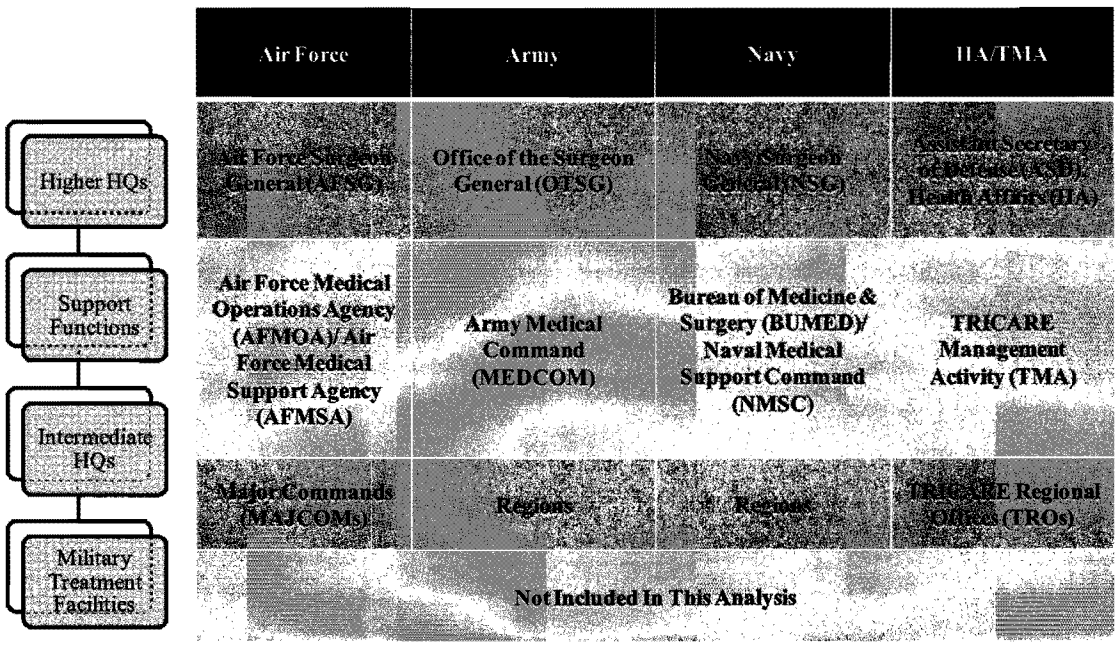

Figure 17. MHS Management Headquarters Construct

MHS management headquarters personnel were also subdivided by functional category based on an assessment of the organizational structures, nomenclature, and Service input. The functional groupings were determined by recognizing that personnel perform similar work

functions across all components (e.g., AFMSA/SG8Y Financial Management and BUMED Budget Support were both categorized into a Resource Management functional grouping since the nature of work is comparable). This analysis extends a similar analysis of common functions developed to support the deliberations on locating the staffs being co-located in the BRAC-directed Defense Health Headquarters (DHHQ). Below are the characteristics of each functional grouping:

- Command: Leadership and support staff
- Education and Training: Professional development and sustainment
- Human Resources: Personnel management
- Installations: Infrastructure management
- Information Technology (IT): Medical systems development, implementation and sustainment
- Contracting and Acquisition – acquisition of services and materials through commercial sources
- Logistics: Supply chain management
- Operations: Mission execution
- Plans and Programs: Program analysis and development
- Private Sector Care: Non-direct care system management
- Research, Development, Test, and Evaluation (RDT&E): Modernization planning and development
- Readiness: Sustainment and deployment of medical forces in support of operational needs
- Resource Management: Budget development and execution
- Specialty: Specialized functions uncommon across components

Coinciding with the development of the MHS management headquarters framework in Figure 17 and functional groupings, a database was created that included all the personnel information submitted to the Task Force To ensure the database represented an accurate account of management headquarters personnel, stakeholders from each component were given the opportunity to review and validate information as well as provide updated information, as needed. The Task Force analysis recognized that the staffing of headquarters functions was changing in response to a number of requirements to achieve added efficiencies and effectiveness. As revised information was incorporated into the database, the updates were distributed to these stakeholders as well as the Task Force members for further confirmation. In order to allow the analysis to go forward, the data represents the staffing as of August 1, 2011.

The database was comprised of an identifier (abbreviation of the MHS management headquarters level), office name, component, functional grouping, level, and total number of personnel by type (military/civilian/contractor); additional comments provided to the Task Force were incorporated into the database as notes. Table 35 provides a snapshot of the database. Once all stakeholders and Task Force members validated the contents of the database, it was finalized and used for analysis.

						Authorized Total Personnel				
Identifier	DUIC Name	Office Name	Service	Function	Level	Military	Civilian	Contractors	Total	Notes
AFSG		AF/SG	Air Force	Command	SG	17	4		21	HAF/SG and support staff are all MHQ LAF-Funded to Goldwaters-Nichols ceiling
AFSG		AF/SG3 - Healthcare Operations	Air Force	Operations	SG	5	1	1	7	HAF/SG and support staff are all MHQ LAF-Funded to Goldwaters-Nichols ceiling
AFSG		AF/SG3X - Medical Operations Center	Air Force	Readiness	SG	9	0		9	HAF/SG and support staff are all MHQ LAF-Funded to Goldwaters-Nichols ceiling
AFSG		AF/SG3P - Aerospace Operations	Air Force	Human Resources	SG	6	4		10	HAF/SG and support staff are all MHQ LAF-Funded to Goldwaters-Nichols ceiling
AFSG		AF/SGL	Air Force	Command	SG	2	8		10	HAF/SG and support staff are all MHQ LAF-Funded to Goldwaters-Nichols ceiling
AFSG		AF/SG8 - Strategic Medical Plans, Programs & Budget	Air Force	Plans & Programs	SG	3	0	1	4	HAF/SG and support staff are all MHQ LAF-Funded to Goldwaters-Nichols ceiling
AFSG		AF/SG8F - Health Facilities	Air Force	Installations	SG	2	0		2	HAF/SG and support staff are all MHQ LAF-Funded to Goldwaters-Nichols ceiling
AFSG		AF/SG8P - Programming	Air Force	Plans & Programs	SG	5	3		8	HAF/SG and support staff are all MHQ LAF-Funded to Goldwaters-Nichols ceiling

Table 35. Database Sample

The analytical approach determined that the development of an estimate for the various building blocks used by the Task Force to develop alternative governance constructs for the MHS would allow a flexible and rapid way to compare personnel costs. A fundamental issue with developing the sizing of the building blocks, given the short duration of the study period, was the need to validate that the sizing used was executable in practice. There being no opportunity to provide the detailed mission and tasks analysis that this would require, the analysis chose to assume that the organizational constructs used by the Services could be adapted to cover a larger, MHS-wide scope. Assuming scalability of this nature does not include any related non-medical Service support as this was not included in the model.

Another aspect of this approach is that it assures that the models for the various headquarters levels are based on functioning Service constructs that are currently addressing the organizational and operational requirements of running large military healthcare delivery systems. Inspection of the organizational constructs and the analytical framework for the data (Higher Headquarters, Support Agency, Intermediate Headquarters) revealed that the analytical framework could be used as the foundation for the sizing estimates.

Inherent in this analysis was the need to address the manpower to operate large headquarters functions such as the Defense Health Agency and the Unified Medical Command. In these cases, the estimate would include some, or all, of the support agency manpower, depending on the construct.

Higher Headquarters

Based on analysis of the database, the higher headquarters functions were allocated 100 personnel per headquarters for the Service SGs, and ASD(HA). This allows a total of 400 personnel assigned to the four headquarters units where all are included in the alternative.

Support and Intermediate Headquarters

To determine a rough order of magnitude estimate of the total number of management headquarters personnel required to operate each organizational construct under consideration by the Task Force, both the existing Support Agencies and Intermediate Headquarters personnel requirements were calibrated to identify the personnel requirements necessary to efficiently operate the MTFs.

In order to provide an estimate of relative manpower requirements for the alternatives developed by the Task Force, a metric was developed for both the Support Agency and the Intermediate Headquarters levels of management headquarters. To generate this metric, those personnel that would be considered in the shared services evaluation were removed from the management headquarters manpower data. This provided a level of manpower that was deemed to be related to the execution and control of direct healthcare delivery. Normalizing this data across the Services required the development of a metric that would relate the manpower to an operational parameter. Of the several that were considered, this analysis determined that using Operating and Maintenance (O&M) funding provided by the Defense Health Program (DHP) was the best parameter to use based on commonality, accuracy, and availability of data. Dividing the number of personnel by the O&M executed by that Service provided a metric that described the number of management headquarters Full Time Equivalents (FTEs) per dollar of O&M distributed (Equation 2). This was used to estimate the manpower requirements for MHS-wide Support Agencies and Intermediate Headquarters by multiplying the metric by the total O&M distributed to the Services (Equation 2). These metrics were developed for all three Services and used to determine the manpower estimates for the various Task Force alternatives.

Equation 1. DHP O&M Distributed to Service A / (Intermediate Headquarters Manpower – Shared Services Manpower) = Support Agency Metric for Service A

Equation 2. Support Agency Metric for Service A * Total DHP O&M Distributed to the Services = Estimate of the Support Agency Manpower for the MHS based on Service A

Selecting Sizing Estimates to Use for Governance Alternatives

The analysis developed a set of guidelines to use in selecting the sizing estimate to use for a particular construct. For the Support Agencies in the alternatives, the median of the three estimates was used. The median was used instead of the mean to maintain the connection of the estimate to an operating Service organizational system. Inspection of the data indicated that the mean would represent an organizational approach different from the Services. This suggests that using the mean without further analysis of the organizational structure(s) it represents, would risk proposing an un-executable functional structure. In specific cases where there was only single or no Service components in an alternative (e.g. Single Service, UMC with Geographic Regions) the smallest Support Agency and/or Intermediate Headquarters sizing was used assuming that, given a clean slate to develop these functions, the most efficient approach for the DHP would be taken. The details of the sizing estimates are given in the results section.

Defense Health Agency and Unified Medical Command

The Defense Health Agency (DHA) was deemed to consist predominately of shared services, essentially replacing TMA. In the case that the DHA would include all of the MTFs, the addition of Intermediate Headquarters and a slight increase in the Command element was used to estimate the sizing. The DHA was assumed to have a smaller mission and task element than the UMC and the UMC staffing estimate was not used in the DHA with MTFs model.

The Unified Medical Command (UMC) estimated personnel requirement was based on both the Joint Task Force National Capital Region (JTF CAPMED) estimated end-state personnel requirement as well as current Combatant Command personnel requirements. The JTF CAPMED end-state personnel requirement is estimated to be approximately 150 personnel for managing 10% of the MHS operations. By multiplying the JTF CAPMED personnel requirement by 10, 1,500 personnel are estimated as required to manage 100% of the MHS operations. Additionally, review of the Combatant Command personnel requirements shown in Table 36, could lead to concluding that the UMC could require between 2,000 and 3,000 personnel. By taking the midpoint between the JTF CAPMED end-state personnel requirement and the lower-end of the Combatant Command personnel requirements, a conservative estimate of the UMC was determined to be 1,750 personnel.

JTD	AFRICOM	CENTCOM	EUCOM	JFCOM	NORTHCOM	PACOM	SOCOM	SOUTHCOM	STRATCOM	TRANSCOM	Joint Staff
TOTAL	2,695	5,801	3,788	5,703	2,412	5,371	6,209	2,563	6,021	2,601	2,252

* Data is all approved funded authorizations (FY11) as of 1 Aug JTD/JTMD.

Table 36. COCOM Personnel Authorizations

A Combat Support Agency (CSA) was included in some of the potential MHS governance options to fulfil support functions for joint operating forces across components. An estimate of 50 personnel was used for the CSA based on current CSA staffing requirements.

Shared Services

The shared services personnel requirements identified by the Task Force were developed by estimating the savings associated with consolidating management headquarters personnel performing similar functions. To estimate the shared services personnel requirements, the Task Force used the same "economies of scale" approach as in the 2006 study; initially developed by the Center for Naval Analyses (CNA). As all MHS governance options considered by the Task Force included a shared services element, one calculation was used for this analysis throughout. The calculation used the sum of all components personnel allocated to the TRICARE Plan, TROs, IT, Pharmacy, Contracting and Acquisition, Facility Planning (mentioned above as Installations), Education and Training, Research and Development, and Logistics.

Results

DHP-funded Management Headquarters Personnel

By filtering the data provided, subsets of information were analyzed to gain insights into how MHS management headquarters personnel are currently organized. In particular, the total number of personnel assigned to each level, functional grouping, and shared service were evaluated by component, as shown in Table 37, Table 38, and Table 39.

Level	Service A	Service B	Service C	HA	TMA	Total
Higher HQ	105	128	128	45	0	406
Support Agencies	831	705	532	0	2,649	4,717
Regions	156	504	195	0	158	1,013
Total	1,092	1,337	855	45	2,807	6,136

Table 37. MHS Management Headquarters Personnel by Level

Function	Service A	Service B	Service C	HA	TMA	Total
Command	99	247	46	45	84	521
Contracting & Acquisition	15	0	0	0	138	153
Education & Training	1	3	12	0	7	23
Human Resources	47	89	62	0	48	246
Installations	17	38	26	0	6	87
IT	267	119	54	0	1,327	1,767
Logistics	92	71	10	0	0	173
Operations	301	104	229	0	220	854
Plans & Programs	21	164	82	0	16	283
PSC	0	4	0	0	440	444
RDT&E	85	0	155	0	3	243
Readiness	72	8	11	0	189	280
Resource Management	75	146	142	0	331	694
Specialty	0	344	26	0	0	370
Total	1,092	1,337	855	45	2,807	6,136

Table 38. MHS Management Headquarters Breakdown by Function

Function	Service A	Service B	Service C	TMA	Total
Contracting & Acquisition	15	0	0	0	15
Education & Training	1	3	12	0	16
Facility Planning	17	38	26	0	81
Health IT	267	119	54	0	440
Logistics	92	71	10	0	173
Pharmacy	0	2	0	0	2
Research & Development	85	0	155	0	240
TRICARE Plan	0	0	0	2,649	2,649
TROs	0	0	0	158	158
Total	477	233	257	2,807	3,774

Table 39. Shared Services

Estimating the Intermediate Headquarters and Support Agency Sizing

Table 40 and Table 41 show the development and application of the metric for Intermediate Headquarters and Support Agencies, respectively.

Intermediate Headquarters Personnel Calibration	Service A	Service B	Service C
FY2011 DHP O&M Appropriation Amount	$2,297	$6,588	$3,195
Total Intermediate Headquarters Level Personnel	156	504	195
Shared Services* Personnel (included in the Intermediate Headquarters Level)	0	58	75
Total Intermediate Headquarters Personnel less Shared Services*	156	446	120
Service Intermediate Headquarters Level Metric (O&M funding per person)	$14.72	$14.77	$26.63
Calibrated Service Intermediate Headquarters Level Metric	821	818	454

Table 40. Intermediate Headquarters Calculation

Support Level Personnel Calibration	Service A	Service B	Service C
FY2011 DHP O&M Appropriation Amount	$2,297	$6,588	$3,195
Total Support Level Personnel	831	705	532
Shared Services* Personnel (included in the Support Level)	383	68	157
Total Support Level Personnel less Shared Services*	448	637	375
Service Support Level Metric (O&M funding per person)	$5.13	$10.34	$8.52
Calibrated Service Support Level Metric	2,355	1,168	1,418

Table 41. Support Level Personnel Calculation

Sizing Estimate for Management Headquarters

As shown in Table 42 below the personnel requirements of each MHS governance option considered was calculated, to include the minimum and maximum number of FTEs, and the differences between the as-is MHS governance construct was provided for each option to illustrate potential personnel savings.

For the case of DHA with MTFs in Military Departments option, the command and control elements of the Military Services medical departments are unchanged. This leads to a single point on the chart that describes the estimated staffing for this option. Discussion with the military departments suggested that this situation did not accurately present the option as the error in the data call would, at a minimum, result in a range of values. After deliberations, the military departments and the analytical team agreed to a ±10% variance to highlight the data accuracy of the analysis and underlying data. As the ranges for the other options were well beyond this 10% variance, it is not visible in Figure 18.

Construct	Estimated Personnel Count	Difference	%	Steps Taken To Arrive At The Estimated Personnel Count	Estimated Personnel Count (Minimum)	Difference	Estimated Personnel Count (Maximum)	Difference
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Single Service, Geographic Model	5,796	-340	-5.54%	**Sum:** **(1)** Service SG = **100** **(2)** ASD (HA) = **100** **(3)** Shared Services (TMA, TROs, IT, Pharmacy, Contracting, Facilities Planning, Education & Training, Research & Development, Logistics) = **3,774** **(4)** "Most Efficient" *Calibrated* Regional HQ [820 (AF), 818 (Army), 454 (Navy)] = **454** (Navy) **(5)** "Most Efficient" *Calibrated* Support Services [2,356 (AF), 1,168 (Army), 1,509 (Navy)] = **1,168** (Army)	5,796	-340	7,351	1,214
Single Service with Components	5,796	-340	-5.54%	**Sum:** **(1) ASD(HA) = 100** **(2)** Service SG = **100** **(3)** Defense Healthcare System (TMA, TROs, IT, Pharmacy, Contracting, Facilities Planning, Education & Training, Research & Development, Logistics) = **3,774** **(4)** "Most Efficient" *Calibrated* Regional HQ [820 (AF), 818 (Army), 454 (Navy)] = **454** (Navy) **(5)** *Calibrated* Support Level (excluding Shared Services) = **1,418**	5,796	-340	7,251	1,114
Hybrid 2: DHA with MTFs placed under the authority, direction, and control of the Agency	5,846	-290	-4.73%	**Sum:** **(1) ASD(HA) = 100** **(2)** Service SG = **100** **(3)** Defense Healthcare System (TMA, TROs, IT, Pharmacy, Contracting, Facilities Planning, Education & Training, Research & Development, Logistics) = **3,774** **(4)** "Most Efficient" *Calibrated* Regional HQ [820 (AF), 818 (Army), 454 (Navy)] = **454** (Navy) **(5)** *Calibrated* Support Level (excluding Shared Services) = **1,418**	5,846	-290	7,401	1,264
UMC Geographic Model	7,546	1,410	22.97%	**Sum:** **(1)** Service SG = **100** **(2)** USD (P&R) ASD (HA) = **100** **(3)** UMC (average of the estimate of 1,500-2,000) = **1,750** **(4)** Joint Medical Ops Command (TMA, IT, Pharmacy, Contracting, Facilities Planning, Education & Training, Research & Development, Logistics) = **3,443** **(5)** "Most Efficient" *Calibrated* Regional HQ [820 (AF), 818 (Army), 454 (Navy)] = **454** (Navy) **(6)** "Most Efficient" Calibrated Support Services [2,356 (AF), 1,168 (Army), 1,509 (Navy)] = **1,168** (Army)	7,546	1,410	9,101	2,964
Hybrid 3: Split UMC and Military-Led DHA Geographic Model	8,160	2,024	32.98%	**Sum:** **(1)** Service SG = **100** **(2)** ASD (HA) = **100** **(3)** UMC (average of the estimate of 1,500-2,000) = **1,750** **(4)** Defense Health Agency (TMA, TROs, IT, Pharmacy, Contracting, Facilities Planning) = **3,518** **(5)** JMOC (Education & Training, Research & Development,Logistics) = **256** **(6)** *Calibrated* Regional HQ [Median(820 (AF), 818 (Army), 454 (Navy))] = **818** **(7)** *Calibrated* Support Level (excluding Shared Services) [Median(2,356 (AF), 1,168 (Army), 1,509 (Navy))] = **1,509**	7,546	1,410	9,101	2,964
Hybrid S: Single Service with UMC	8,160	2,024	32.98%	**Sum:** **(1)** Service SG = **100** **(2)** Designated Service Secretary = **100** **(3)** UMC (average of the estimate of 1,500-2,000) = **1,750** **(4)** Defense Healthcare System (TMA, TROs, IT, Pharmacy, Contracting, Logistics) = **3,518** **(5)** JMOC (Education & Training, Research & Development, Public Health) = **256** **(6)** *Calibrated* Regional HQ [Median(820 (AF), 818 (Army), 454 (Navy))] = **818** **(7)** *Calibrated* Support Level (excluding Shared Services) [Median(2,356 (AF), 1,168 (Army), 1,509 (Navy))] = **1,509**	7,546	1,410	9,101	2,964

Construct	Estimated Personnel Count	Difference	%	Steps Taken To Arrive At The Estimated Personnel Count	Estimated Personnel Count (Minimum)	Difference	Estimated Personnel Count (Maximum)	Difference
UMC - HR 1S40 Section 711 Model	8,160	2,024	32.98%	**Sum:** **(1)** Service SG = **100** **(2)** USD (P&R) ASD (HA) = **100** **(3)** UMC (average of the estimate of 1,500-2,000) = **1,750** **(4)** Healthcare Command = **100** **(5)** Modernization Doctrine & Personal Development Command / Defense Health Agency / Joint R&D Centers / Healthcare Support & Shared Services (TMA, TROs, IT, Pharmacy, Contracting, Facilities Planning, Education & Training, Research & Development, Logistics) = **3,774** **(6)** *Calibrated* Regional HQ [Median(820 (AF), 818 (Army), 454 (Navy))] = **818** **(7)** *Calibrated* Support Level (excluding Shared Services) [Median(2,356 (AF), 1,168 (Army), 1,509 (Navy))] = **1,509**	7,646	1,510	9,201	3,064
UMC with Service Components	7,910	1,774	28.91%	**Sum:** (1) ASD (HA) = **100** (2) Service SG = **100** **(3)** UMC (average of the estimate of 1,500-2,000) = **1,750** **(4)** Joint Medical Ops Command (PSC, TROs, IT, Pharmacy, Contracting, Facilities Planning, Education & Training, Research & Development, Logistics) = **3,774** **(5)** *Calibrated* Regional HQ [Median(820 (AF), 818 (Army), 454 (Navy))] = **818** **(6)** "Most Efficient" *Calibrated* Support Services [2,356 (AF), 1,168 (Army), 1,509 (Navy)] = **1,168** (Army)	7,546	1,410	9,101	2,964
Hybrid 1: DHA with MTFs Remaining in the Military Departments	6,136	0	0.00%	**No change to the Management Headquarters Staffs**	6,136	0	6,136	0
Hybrid 6: DHA with Regional MTFs	6,314	178	2.90%	**Sum:** **(1)** ASD (HA) or COCOM or SVC Secretary = **100** **(2)** Service SG = **100** **(3)** Defense Health Agency (TMA, TROs, IT, Pharmacy, Contracting, Facilities Planning) = **3,518** **(4)** MOSC (Education & Training, Research & Development, Logistics) = **256** **(5)** As-Is Regional HQ (exluding Shared Services & TMA) = **722** **(6)** *Calibrated* Support Level (excluding Shared Services) [Median(2,356 (AF), 1,168 (Army), 1,509 (Navy))] = **1,509**	6,216	80	6,530	394
Hybrid 4: UMC with DHA with Components	8,064	1,928	31.42%	**Sum:** **(1)** Service SG = **100** **(2)** ASD (HA) = **100** **(3)** UMC = **1,750** **(4)** Defense Health Agency (TMA, TROs, IT, Pharmacy, Contracting) = **3,473** **(5)** JMOC (Education & Training, Research & Development, Logistics, Facilities Planning) = **337** **(6)** As-Is Regional HQ = **722** **(7)** *Calibrated* Support Level (excluding Shared Services) [Median(2,356 (AF), 1,168 (Army), 1,509 (Navy))] = **1,509**	7,966	1,830	8,280	2,144

Table 42. MHS Governance Options Personnel Calculations

Sizing Estimate for the Shared Services

Table 43 shows the estimated personnel reductions of the shared services grouping. As described above in the Methodology section, this analysis applied the same "economies of scale" approach used in the 2006 study to account for savings associated with consolidating similar management headquarters functions. The values shown in the below columns labelled 'Number of Organizations Merging' and 'Reduction in Personnel' are the same values used to estimate personnel reductions in the 2006 study.

Shared Service	2011 Total As-Is Personnel Requirement	Number of Organizations Merging*	Reduction in Personnel (as % of cost without merger)*	Personnel Reductions*	2011 Total Personnel Requirement*
Contracting & Acquisition	153	3	20%	31	122
Education & Training	23	4	24%	6	17
Facility Planning	87	4	24%	21	66
Health IT	1,767	4	24%	424	1,343
Logistics	173	3	20%	35	138
Research & Development	243	3	20%	49	194
Total	2,446			566	1,880

* Based on the 2006 Study

Table 43. Shared Services Personnel Reductions

Range of Estimates for Task Force Options

Figure 18 shows the results of a sensitivity analysis of the five task Force options. This analysis was developed by varying the size of the Intermediate Headquarters and Support Agencies by using the maximum and minimum as determined by the metric. For the "As Is" option, there is no variance and only shows the current authorizations. For the DHA without MTFS the only difference from the "As Is" option is the enhanced shared services function. The analysis included a 10% variance around the point estimate after to account for the variance in the manpower data provided.

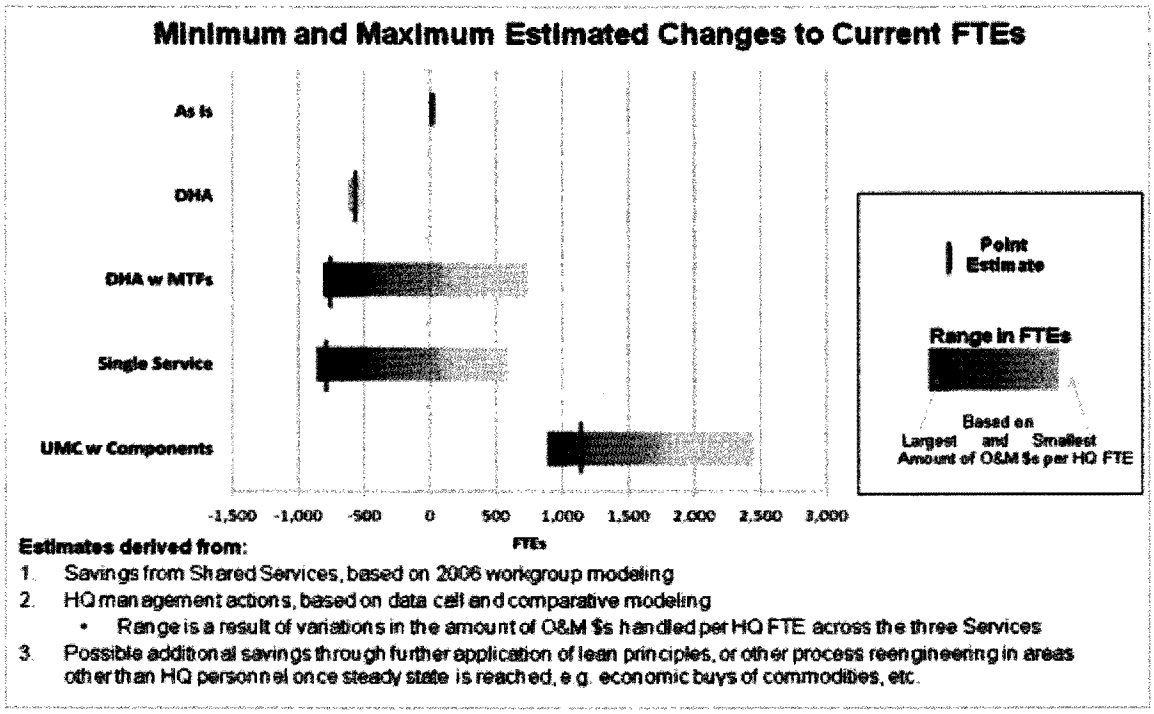

Figure 18. Estimated DHP Funded Minimum and Maximum Headquarters Staffing Changes

Excursion analysis

During the management review of the Task Force results and recommendations an excursion analysis was performed that alternatively addressed the sizing of the DHA and UMC. TRANSCOM Headquarters was determined to be the most similar to the UMC as a functional COCOM with daily mission elements requirements. This UMC manpower was also assumed to include all of the Support Agency manpower for the MHS. The Intermediate headquarters remained at the minimal level as a result of keeping the Component structure in the UMC. The results are shown in Table 44.

		DHA		UMC	
Management Level	As Is	w/o MTFs	with MTFs	Regions	Components
DHA/UMC HHQ	0	1168	1445	2601	2601
Service SGs and HA HHQ	406	406	346	346	346
Service IHQ/Geog Region HQ	735	735	454	454	818
Support Agencies	1221	0	0	0	0
Combat Support Agency	0	50	100	0	0
Total	2362	2359	2345	3401	3765

Table 44. Additional Benchmarking Analysis Using TRANSCOM

An additional alternative included the assumption that the DHA and UMC would absorb all of the Support Agency personnel from the services. This would allow the maximum available offset for the growth in the HQ size in these two alternatives. Table 45 below provides the results of this excursion analysis.

		DHA		UMC		
Management Level	As Is	w/o MTFs	with MTFs	Regions	Components	Comments
DHA/UMC Higher HQ	0	1168	1445	2918	2918	UMC is a median number among the COCOMs (see chart below), offset from the Support Agency migration from Svcs to UMC.
Service SGs and ASD(HA) High	406	406	346	346	346	Core SG and HA support functions; SGs/HA may or may not retain programming (-60FTEs)
Service IHQ/Geog Region HQ	735	735	454	454	818	Reduction from elimination of overlapping IHQs; UMC: Increases due to Retaining and Standardizing IHQ across Services Components HQ
Support Agencies	1221	0	0	0	0	Support Agencies of the Services migrate to the UMC and DHA
Combat Support Agency	0	50	100	0	0	
Total	2362	2359	2345	3718	4082	

Notes:

1. JTF CAPMED J-Staff authorizations are 157. NCR has approximately 8-10% of the MHS workload, including GME, but not including R&D, E&T, Public Health. Therefore 1750 is thought to a be a good estimate of scaling up to a UMC
2. DHA, operating within the OSD will not require the overhead of a UMC as it participates in the UCP, multiple interface requirements across the COCOMs, four-star support, etc.

Table 45. Maximum Offset for Projected DHA and UMC Headquarters Growth

Appendix A. Acronym List

Acronym	Definition
AOR	Area of Responsibility
ASD	Assistant Secretary of Defense
BRAC	Base Realignment and Closure
CAPE	Cost Assessment and Program Evaluation
CJCS	Chairman of the Joint Chiefs of Staff
COCOM	Combatant Command
CONOPS	Concept of Operations
CSA	Chief of Staff, Army/Combat Support Agency
DA&M	Director of Administration and Management
DCMO	Deputy Chief Management Officer
DHA	Defense Health Agency
DHP	Defense Health Program
DMOC	Defense Medical Oversight Committee
DoD	Department of Defense
EAC	Executive Advisory Committee
eMSMO	Enhanced multi-Service market Office
FBCH	Fort Belvoir Community Hospital
FOC	Full Operating Capability
FTE	Full Time Equivalent
GME	Graduate Medical Education
HA	Health Affairs
IOC	Initial Operating Capability
JMD	Joint Manning Document
JOA	Joint Operations Area
JTD	Joint Table of Distribution
JTF CAPMED	Joint Task Force National Capital Region Medical
MHS	Military Health System
MHSSA	Military Health System Support Activity
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding

Acronym	Definition
MSM	multi-Service market
MTF	Medical Treatment Facilities
NCR	National Capital Region
NORTHCOM	United States Northern Command
OGC	Office of the General Counsel
OLA	Office of Legislative Affairs
OSD	Office of the Secretary of Defense
P&R	Personnel and Readiness
PEO	Program Executive Officer
SECDEF	Secretary of Defense
TDA	Table of Distribution and Allowance
TMA	TRICARE Management Activity
TOE	Table of Organization and Equipment
UCP	Unified Command Plan
UMC	Unified Medical Command
USD	Under Secretary of Defense
WII	Wounded, Ill and Injured
WRNMMC	Walter Reed National Military Medical Center

4

Additional Cost Analysis supporting the 2011 MHS Governance Task Force Report

This document provides additional analysis regarding estimated cost savings for 12 military health system (MHS) governance options contained in the 2011 Department of Defense (DoD) Military Health System (MHS) Governance Task Force report. This analysis was informed by, and extends, the methods used in the 2006 analysis performed by the Center for Naval Analyses (CNA) in support of the 2006 MHS Governance work group.[1]

Goals:

- Provide a rough estimate of the cost savings, if any, to be achieved by 12 governance options considered by the 2011 DoD MHS Governance Task Force, based on estimated staffing sizes and associated personnel costs (see footnote) of those options
- Ensure that the sizing of the options resulted in organizations that could reasonably meet mission requirements

Assumptions:

- Current staffing can be used as a benchmark for staffing consolidated headquarters entities.
- External benchmarks can be used to validate the staffing of consolidated headquarters entities, paying close attention to mission and scope differences.
- The organizational constructs used by the Military Services could be adapted to cover a larger MHS-wide scope.
- Current MHS management headquarters are sized to accomplish individual missions through component-specific processes.
- The missions of the management headquarters are similar for each component, but the scope and processes are variable.

[1] It is important to note that this cost analysis uses estimated staffing sizes as its basis for estimating the costs and/or savings associated with each option. However, the largest cost elements in military healthcare are in the direct and civilian healthcare systems, not in administrative and management headquarters. The potential cost savings to be obtained through the consolidation and standardization of shared services and the adoption of common business and clinical processes to reduce variation and assure rapid adoption of knowledge and technology dwarf the savings to be achieved by any reductions in headquarters manpower. To generate estimates of the cost savings stemming from a governance structure that better promotes efficient management of the direct and civilian healthcare systems would be a time- and labor-intensive process, and would be inherently imprecise.

Results:

Below are the estimated number of personnel for each of the options considered using the "most efficient" organization, the change in personnel from the current as-is structure, and an estimate of the additional cost or savings for each option. (In these estimates, the personnel savings from shared services are estimated to be 330, as opposed to 566 as contained in the Task Force report, because of a correction to the equation for the "economies of scale" estimate from the 2006 CNA analysis.) To develop these cost estimates, the average cost per civilian employee for the TRICARE Management Activity, with a grade structure that would most likely be similar to any of these organizations, was applied to the change in personnel. These results are point estimates and actual costs/savings will depend on the final implementation, both in terms of the change in the number of personnel and in the cost per employee. Therefore, these estimates should be used in a relative sense for comparing options rather than in an absolute sense to adjust budgets given the uncertainties in the estimates.

MHS Governance Options (ref: MHS Governance Task Force Technical Volume)	Personnel Estimate (FTEs) without Shared Services FTE Savings	Estimated Personnel (FTEs) with Shared Services FTE Savings	Additional (+)/ Reduced (-) Personnel (FTEs) from "As Is" (Option A)	Net Cost (+) or Net Savings (-) ($M/year)
Option A: Current MHS Governance Structure	6136	---	---	---
Option B: Defense Health Agency, Geographical Model	6314	5,984	-152	-$21.4
Option C: Defense Health Agency with Service MTFs	6136	5,806	-330	-$46.5
Option D: Unified Medical Command, Geographical Model	7546	7,216	+1,080	+$152.3
Option E: Unified Medical Command with Service Components	7910	7,580	+1,444	+$203.6
Option F: Unified Medical Command - HR 1540 Section 711 Model	8160	7,830	+1,694	+$238.8
Option G: Single Service, Geographic Model	5796	5,466	-670	-$94.4
Option H: Single Service with Components	5796	5,466	-670	-$94.4
Option I: Split UMC and Military-Led DHA Geographic Hybrid	8160	7,830	+1,694	+$238.8
Option J: Unified Medical Command with components and DHA Hybrid	8064	7,734	+1,598	+$225.3
Option K: Single Service Hybrid with a Unified Medical Command	8160	7,830	+1,694	+$238.8
Option L: DHA Hybrid with MTFs placed under the Agency	5846	5,516	-620	-$87.4

Additional information about the approach to sizing and cost estimation used in the 2011 Task Force report and this supporting analysis is in Part 2 of Volume II of the Task Force's report.

Comparison of 2011 Task Force analysis to 2006 CNA analysis:

- The 2011 analysis was conducted over several months, while the 2006 CNA study took approximately 2 years, including data collection, validation, analysis, and coordination of results.
- The 2011 analysis addressed a larger and more diverse set of options (12) than the 2006 analysis (3) with a higher risk of proposing an organizational size that would not be able to meet mission needs.
- The 2011 analysis was benchmarked against DoD Service medical organizations; the 2006 study benchmarks included commercial, non-healthcare entities. As a result, the 2011 analysis provided both a range and a "most efficient" organizational construct based on real-world Service organizations.
- The 2011 analysis benchmarked the Unified Medical Command (UMC) sizing to active Combatant Commands and developed alternative approaches to UMC headquarters sizing based on current organizational structures and missions.
- The 2006 study used an average of the Service and TMA staffing for the various functions. The 2011 study did not use averages, but used values directly derived from the Services' medical departments' headquarters staffing.
- The 2006 study assumed that the Service Surgeons General would be absorbed into the UMC; the 2011 study kept the Service SGs separate.
- The 2011 study assessed sensitivity of the options by using the range of Service medical organizations as the inputs. The 2006 study used an additional 20% redundancy factor to assess sensitivities of the options.
- Both the 2011 and 2006 studies used an "economies of scale" approach to assess the savings for shared and common services.