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

PERSONNEL AND READINESS

NOV 21 2019

The Honorable James M. Inhofe
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The enclosed report is in response to section 711(c) of the John S. McCain National Defense Authorization for Fiscal Year 2019 (Public Law 115–232), which requires a report on the feasibility of the Defense Health Command (DHC) as a superseding organization to the Defense Health Agency (DHA).

In developing our response, we conducted an independent review of 50+ years of available studies and analysis on the organization of military medicine and the Military Health System. Our assessment included four options suggested by this independent analysis. However, we believe that the feasibility of transitioning to a DHC is better considered once the current set of transitions are completed in 3 to 5 years, when we can better define the desired outcomes to be met by a DHC, to include the performance gaps and risks resulting from the in-process changes in responsibilities between the DHA and the Military Departments.

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

Sincerely,

James N. Stewart
Assistant Secretary of Defense for Manpower and Reserve Affairs, Performing the Duties of the Under Secretary of Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member

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

PERSONNEL AND READINESS

NOV 21 2019

The Honorable Adam Smith
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

The enclosed report is in response to section 711(c) of the John S. McCain National Defense Authorization for Fiscal Year 2019 (Public Law 115–232), which requires a report on the feasibility of the Defense Health Command (DHC) as a superseding organization to the Defense Health Agency (DHA).

In developing our response, we conducted an independent review of 50+ years of available studies and analysis on the organization of military medicine and the Military Health System. Our assessment included four options suggested by this independent analysis. However, we believe that the feasibility of transitioning to a DHC is better considered once the current set of transitions are completed in 3 to 5 years, when we can better define the desired outcomes to be met by a DHC to include the performance gaps and risks resulting from the in-process changes in responsibilities between the DHA and the Military Departments.

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

Sincerely,

James N. Stewart
Assistant Secretary of Defense for Manpower and Reserve Affairs, Performing the Duties of the Under Secretary of Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable William M. "Mac" Thornberry
Ranking Member

Response to Section 711(c) of the John S. McCain National Defense Authorization Act for Fiscal Year 2019 (Public Law 115-232)

Report to Congressional Armed Services Committees

Report on the Feasibility of Establishing a Command as a Superseding Organization to the Defense Health Agency

November 2019

The estimated cost of this report or study for the Department of Defense (DoD) is approximately $239,000 for the 2019 Fiscal Year. This includes $20,000 in expenses and $219,000 in DoD labor.

Generated on 2019Aug22 RefID: 9-3DB2BD8

Executive Summary

Section 711 of the John S. McCain National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2019 (Public Law 115–232) directed the Secretary of Defense (SECDEF) to submit a report on the feasibility of a command, to be called the Defense Health Command (DHC), to supersede the Defense Health Agency (DHA).

The Department chartered a team of senior military medical and line leaders (study team, Appendix C). As a part of the study effort, the Johns Hopkins University Applied Physics Laboratory (JHU/APL) conducted an independent assessment of the literature involving reorganization of the Military Health System (MHS) and developed and assessed organizational options for a DHC. JHU/APL reviewed MHS organizational studies extending back to 1948 and from these and relevant subject matter expert interviews developed four archetype command constructs with the purpose of providing a set of options that would cover the decision space of relevant authorities and responsibilities for a DHC. The JHU/APL report, *Defense Health Command: Organizational Options and Assessment*, is provided in Appendix B. This independent assessment informed this report produced by the study team in response to congressional direction.

A clear determination of DHC feasibility is problematic at this point in time. Both the JHU/APL independent study and the work of the study team determined that the primary challenge in assessing the feasibility of a DHC is identifying and agreeing upon the key challenge(s) or problem(s) this reorganization is meant to address. Further complicating the assessment is the transition of the DHA, as directed in public law and pending legislation, as that transition would need to be completed and assess the effectiveness of the new MHS design and identify the need for further authorities. The study team and the JHU/APL independent assessment noted that the DHA is still maturing into its newly assigned responsibilities. The potential constructs have been assessed for pros, cons, and mitigations, but the weighting of these risks and benefits requires agreement on the desired outcomes of the transition to a DHC.

The study team was able to define several organizational constructs for a DHC. The study team noted that, while all constructs were technically feasible, determining the value or risk/benefits for the cost of a particular construct was dependent on a clear understanding of the issue to be solved and the desired outcomes for a DHC. Without this understanding, it was not possible to come to a clear recommendation. Moreover, given the additional authorities already being transitioned to the DHA, the study team suggests that, once these authorities have been fully transitioned, the need for and, ultimately the feasibility of a transition to a DHC would be better considered after maturation of the DHA's authorities and responsibilities in three to five years.

One key area for consideration during a follow-on review in three to five years by Department leadership is the role the follow-on DHC is expected to play in the provision of medical forces to combatant commands. JHU/APL identified three possibilities for the assignment of title 10 authorities (including all authorities remain with the separate Services) and relevant examples of how each might be achieved in practice. Another area is the need to define the structure for providing command authority to the Commander, DHC through a revised reporting chain.

Introduction and Issue Addressed

This report responds to section 711 of the John S. McCain NDAA for FY 2019 (Public Law 115–232). Specifically, this report addresses the feasibility of a command, to be called the DHC, to serve as a superseding organization to the DHA. Exact text of the congressional direction for this report is provided in Appendix A.

The questions addressed here are:

1. What are the available options for a Defense Health Command?
2. Which options are feasible, meaning what are the risks and benefits of these options?

Background

The MHS is a complex healthcare organization serving 1.4 million Active Duty personnel, 331,000 reserve personnel, and a total of 9.4 million beneficiaries. The MHS is comprised of 190K military (Active Duty, reserve, and Guard) and 46K civilian personnel[1] in four distinct and interrelated Army, Navy, and Air Force medical components, and the DHA. Continuous operation of the MHS sustains military medicine and supports the Department of Defense (DoD) mission through the three interrelated missions of the MHS:

1. Provide a medically ready force,
2. Provide a ready medical force,
3. Provide a medical benefit to all eligible beneficiaries.

This MHS team is currently responsible for the lowest disease non-battle injury rate and the highest survival rate in recorded conflict.

The MHS has been undergoing near continuous change since the formation of the DHA in 2013. Currently, DHA is in the process of assuming "administration and management" of the Department's medical treatment facilities (MTFs) as directed in NDAA for FY 2017[2]. The DHA's focus is on delivery of health care in MTFs with support from the Services. The Services are focusing on readiness with DHA in a supporting role. DHA additionally has been directed to incorporate elements of Research and Development (R&D) and Public Health functions from the Services.[3] The development of the DHA's expanded R&D and Public Health functions are mandated to be completed by September 30, 2022.

As summarized in the attached report, *Defense Health Command: Organizational Options and Assessment* (Appendix B), the organizational structure of the MHS has been studied more than 18 times since 1948. Despite many recommendations for centralization, these studies have resulted in few reorganizations. The creation of the Defense Health Program in 1992, the formation of the DHA in 2013, and section 702 of the NDAA for FY 2017 (Public Law 114–

[1] Health Manpower Personnel Data System FY 2018 Report, Tables A2, C2, R2.
[2] Title 10, United States Code, section 1073c.
[3] Title 10, United States Code, section 1073c.

328) serve as notable exceptions. A bibliography of the available studies, including those used in the attached report, is provided in Appendix D.

A review of these studies produced several key findings. First, the studies were mixed in their findings of whether the readiness and benefits missions of the MHS are compatible or in tension with one another. Some studies supported the assessment that the two missions are inextricably linked, some did not. Previous studies consistently found that command structures were indeed feasible given the legislative and regulatory landscape at the time. Finally, nearly all studies found that some centralization of decision-making authority was desirable. Further details on the studies can be found in the section entitled "Looking Back: A History of Defense Health Organizational Studies" in the Appendix B attached report.

Organization of this Study

A team of senior military medical leaders conducted the study. The full list of the leadership team is provided in Appendix C. The main challenge set forth for the study team was the concept of feasibility. This report first details that challenge, then lays out the two-step approach in developing a thorough response to the congressional direction. Following this, the results are presented along with a discussion of key findings. Lastly, the study team's recommendations are provided.

Discussion on the Concept of Feasibility

At its core, feasibility of an option supports decisions made by appropriate leadership based on the risks and benefits of each option. Based on this understanding of feasibility the task of the study team was to provide sufficient facts and analysis to DoD leaders for option selection.

Fundamental to this process is the question of what problem an assessment is seeking to solve. The options presented here all have pros and cons associated with them. The weighting of those pros and cons depends on the value placed on the metrics as determined by the desired outcome. Throughout the course of this study there was consensus within the study team on the need for a desired end state that would drive the development of a DHC. The study team believes determination of that desired end state is best done after the DHA has had time to mature in its present role.

Defining the desired outcome also requires an assessment of the current capabilities of the DHA within the MHS. DHA is in transition of responsibilities. The DHA has yet to fully exercise its authorities and demonstrate its capability along all dimensions of its new responsibilities. This suggested to the study team that a reasonable solution to the yet-to-be-identified desired outcome may be to complete the transition of the DHA and reassess gaps in authorities and capabilities that might be addressed by a DHC construct after completion of the transition.

Approach

The study team contracted with JHU/APL to: a) provide an independent review and assessment of MHS organizational studies; and b) develop and analyze potential options for a DHC. Following the receipt of the JHU/APL study, the study team commenced with the development of the feasibility assessment. Both steps of the approach are described in more detail below.

The JHU/APL study team conducted a review of what was available from the preceding 70 years of studies relevant to centralizing the Department's medical system. As this is the first study conducted after the reassignment of authorities and responsibilities to the DHA, the baseline of comparison for many of the alternative constructs is now arguably different, and includes the consolidation of shared services within the DHA and the plan for DHA management of the MTFs. This literature review led to the key findings presented above in the background section. It also informed the development of the four alternative constructs analyzed. JHU/APL also conducted key stakeholder interviews to fully understand the present and future planned construct of the MHS as detailed in their report.

Based on the findings of the comprehensive literature review and subject matter expert interviews with 28 key stakeholders within the MHS, the JHU/APL study team identified 28 previously considered constructs relevant to a DHC. These constructs binned into four main types: unified medical commands (UMC), defense agencies, single-Service commands, and models that combine both an agency and a command. Based on these types, JHU/APL identified four archetype models: two versions of the UMC, a single-Service model, and a joint agency and command. The two UMC models are a Special Operations Command (SOCOM)-like model and a Transportation Command (TRANSCOM)-like model.

Simultaneous with the identification of the four archetypes, the JHU/APL team identified the option space of key authorities required for command and control (C2) of the MHS. The eight identified authorities determined who, between the Services and the considered construct or current DHA, had authority over aspects of administrative control (ADCON) (generally residing with the Service except portions of the man, train, and equip (MTE) duty were provided to the UMC in the SOCOM-like model) and operational control (OPCON) both at the MTFs and when embedded with operational units. These authorities were mapped to the four archetype constructs to provide detailed descriptions of how each construct would interact with the Services in a manner which spanned the decision space.

The JHU/APL study team then assessed these four constructs for the pros and cons of their adoption and implementation, along with possible mitigations for the cons. This assessment was aided by further input from the study team and from the Surgeons General (SGs) and Vice Chiefs of the Services, along with the Vice Chairman of the Joint Staff and the DHA Director.

Upon receipt of the JHU/APL organizational options and assessment, the study team commenced with the feasibility assessment of those options. As described in the previous section "Discussion on the concept of feasibility", the study leadership identified that the pros and cons for each of the options, as identified by JHU/APL, demonstrate that no proposed DHC construct was a clear "winner." Additionally, weighting of the pros and cons required some agreement as to what the desired outcomes the DHC transition was to meet. This question has yet to be

answered. Furthermore, the study team noted that the relationship of the DHA and Services had continued to develop throughout the process, most recently with the release of the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) memorandum[4] that defined relative roles between the Services and DHA for healthcare delivery in non-MTF environments along with non-healthcare readiness requirements. This stabilization, and expected future maturing of the DHA, will require new consideration of the pros and cons as presented by JHU/APL.

Results

The study team reviewed four constructs for a potential DHC: a SOCOM-like UMC, a TRANSCOM-like UMC, a single-Service command, and a split agency and command construct. These constructs were chosen as a result of the literature review. For each of these options, eight authorities were aligned to the construct or the Services in a way that spanned the decision space. These eight authorities and responsibilities for the Services or the commander of the construct were:

1. MTE type 1 (recruiting, promotion, etc.) (ADCON)
2. MTE type 2 (specialty selection and training)
3. Force provision to Combatant Commands
4. MTF management
5. OPCON of MTF personnel (assigned)
6. OPCON of medical personnel assigned to operational units
7. R&D
8. Management of purchased care contracts

Additionally, the immediate superior for the DHC in each construct was identified. The study team analyzed the UMC constructs as though they were new functional combatant commands accountable to the SECDEF; however, it also noted that the analysis of pros and cons is not substantially impacted by establishing a sub-unified command under an existing combatant command. Additionally, the single-Service construct analysis is only minimally changed to allow for consideration of a new separate medical service, although this latter option has potentially higher implementation and transition costs.

A set of common criteria was developed from the independent literature review that allowed for comparison of the alternatives developed. These criteria included:

- Clear decision authority – assessment depended on interviewee's background and was hampered by a lack of data on the relationship between command and control, discipline, and command roles for each of the Service medical elements and other MHS organizations.

[4] USD(P&R) memorandum, "Alignment of Operational and Installation Specific Medical Functions and Responsibilities with Section 7092 of the National Defense Authorization Act for Fiscal Year 2017, and Sections 711 and 712 of the John S. McCain National Defense Authorization Act for Fiscal Year 2019," dated March 27, 2019.

- Stakeholder integration – only UMCs had positive consideration, while all four constructs had many cons reported for this feature.

- Medical readiness of the force – individual medical readiness measures should be collected over time to establish a baseline and determine trends arising from the changes in the organization of the medical force.

- Operational medical support – there is a strong trust component arising from working, training, and deploying with the same individuals over the course of a tour that should be factored into the consideration of organizational structure.

- Ready and deployable medical force – requires a substantive and agreed upon definition with supporting data collection.

- High quality care to beneficiaries – most respondents felt there would be no anticipated impact to beneficiary care.

- Impact on medical personnel – command constructs were thought to disconnect the medical personnel from their service, thus losing the shared cultural understanding.

- Cost savings via reduced duplication – cost savings require that the duplicated elements be eliminated, which is not guaranteed in the process of reorganization.

- Cost and ease of implementation – the single-Service model causes the most disruption, though any change at the moment continues to inject chaos into a system in the midst of major transition.

- Enhance interoperability – most respondents agreed that standardization would improve interoperability between the Services.

Summary of the Constructs Assessed[5]

UMC (TRANSCOM-like)

This command construct would manage military health related missions, to include direct and purchased care, without changing title 10-related MTE functions currently managed by individual Services.

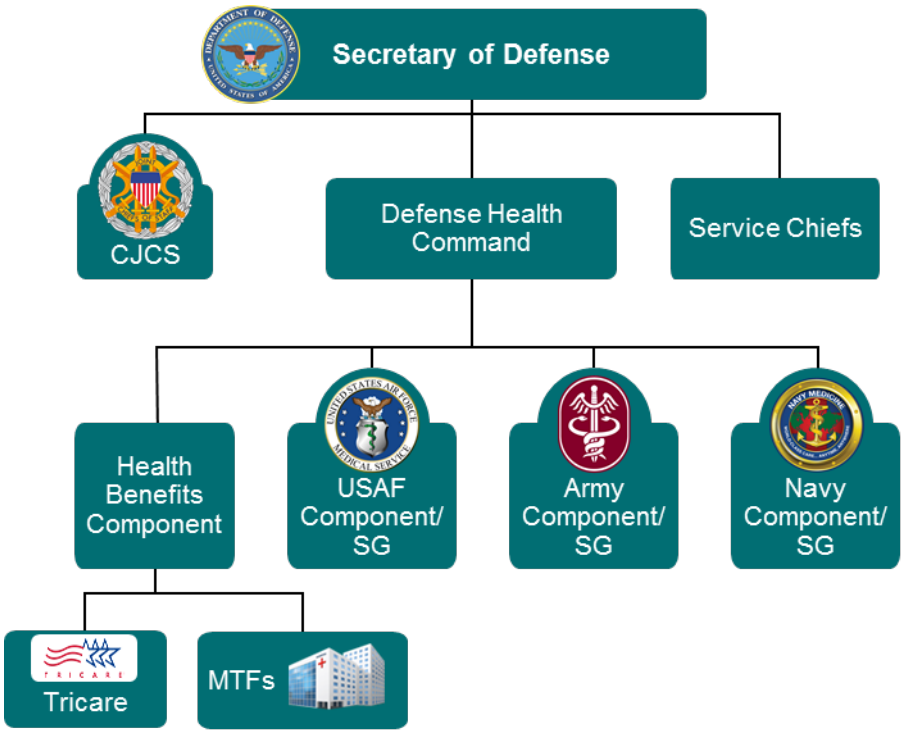


Figure 1. Unified Medical Command (TRANSCOM-like)

Key Roles and Responsibilities

1. Manage MTFs to include associated infrastructure
2. Manage direct and purchased health care for beneficiaries
3. Develop military medical readiness priorities and requirements

Characteristics and Authorities

The DHC[6] under this construct would report directly to the SECDEF and would be supported by Service component commands. The DHC would develop military medical readiness priorities and requirements in coordination with Service SGs. The Health Benefits Component Commander would be responsible for setting priorities and requirements for the military health mission, to include direct and purchased care contracts and MTF management. The Command

[5] Details of each construct can be found in the attached independent report.
[6] For clarity of language, and in keeping with the requirements of the NDAA for FY 2019, the study team refers to the specific new command as the DHC and to the generalized construct as the UMC.

would also manage MTFs to include on-base clinics, associated infrastructure, and other related assets.

Each of the Services would remain responsible for title 10 related MTE functions for medical personnel. Through the Service component structure, it would support the DHC by addressing overall mission and staffing requirements. The Services maintain ADCON of medical personnel and the DHC Commander would assume OPCON for those personnel assigned to MTFs. Additionally, the Services remain responsible for addressing both the requirements of the DHC and other combatant command mission requirements through the joint planning and force generation processes.

The DHP would be allocated to the DHC and align to key missions as defined and prioritized by the commander. These missions would include purchased and direct care, as well as readiness related missions that stem from the MTFs and Service specific requirements embedded units and capabilities.

Table 1. Authorities (TRANSCOM-Like)

Authority	Services	Construct
MTE Type 1 (Recruiting, promotion, etc.)(ADCON)	X	
MTE Type 2 (Specialty selection and training)	X	
Force provision to CCMD	X	
MTF Management		X
OPCON of MTF Personnel (Assigned)		X
OPCON of Embedded Personnel (Assigned)	X	
R&D		X
Management of purchased care contracts		X
Immediate Superior		SECDEF/Existing Combatant Commander

Table 2. TRANSCOM-Like – Evaluation of Criteria

Criteria	Pros	Cons
Clear decision authority	• Clearly defined authority, C2 MHS elevated to joint level • Alignment of Services in component structure	• No complete unity of command • Challenges with dealing with components • Risks to line control of expeditionary capabilities
Stakeholder integration	• Service control of force provision • Component representation • Consistent with Joint world approach	• Separation of requirements across Services • Disconnect between centralized bureaucracy and Service needs
Medical readiness of the force	• OPCON of garrison care • Standardized approach to readiness • Service focus on readiness	• Loss of Service-unique line mission readiness support
Operational medical support	• Service-specific focus • Standardized approach • Common set of joint requirements	• Requirements decentralized to Service; leads to stovepipes • Challenge of managing 4 sets of requirements
Ready and deployable medical force	• Standardized requirements • Service-specific requirements met • Services focus on readiness	• Challenge of managing components • Discounting of Service-specific approaches and needs
High quality care to beneficiaries	• Standardization of care and management • Authority to direct personnel throughout the system	• Components prioritize themselves over benefit care
Impact on medical personnel	• Increased retention via more diverse opportunities • Connection to components	• Potential for inconsistent support and development of personnel
Cost savings via reduced duplication	• Significant savings via headquarters reduction	• Increased cost due to training and equipping redundancies across Services
Cost and ease of implementation	• Congressional interest • Easy sell to Services	• Stand-up and re-organization costs likely high • Difficult sell to Services
Enhance interoperability	• Increased interoperability via standardized policy and requirements	• Decreased interoperability due to inconsistent training and equipping

UMC (SOCOM-like)

This command construct would manage and provide health capabilities to combatant commanders, manage health benefit missions, and execute some title 10 MTE functions currently managed by individual Services. There is a danger in the use of the SOCOM analogy that each reader may focus on a different aspect of what makes SOCOM a unique functional combatant command. The study team uses the term "SOCOM-like" to capture a force provision function and a MTE function of the UMC. The team does not provide the exact delineation of MTE functions between the UMC and the Services, noting simply that such a line can and would be drawn.

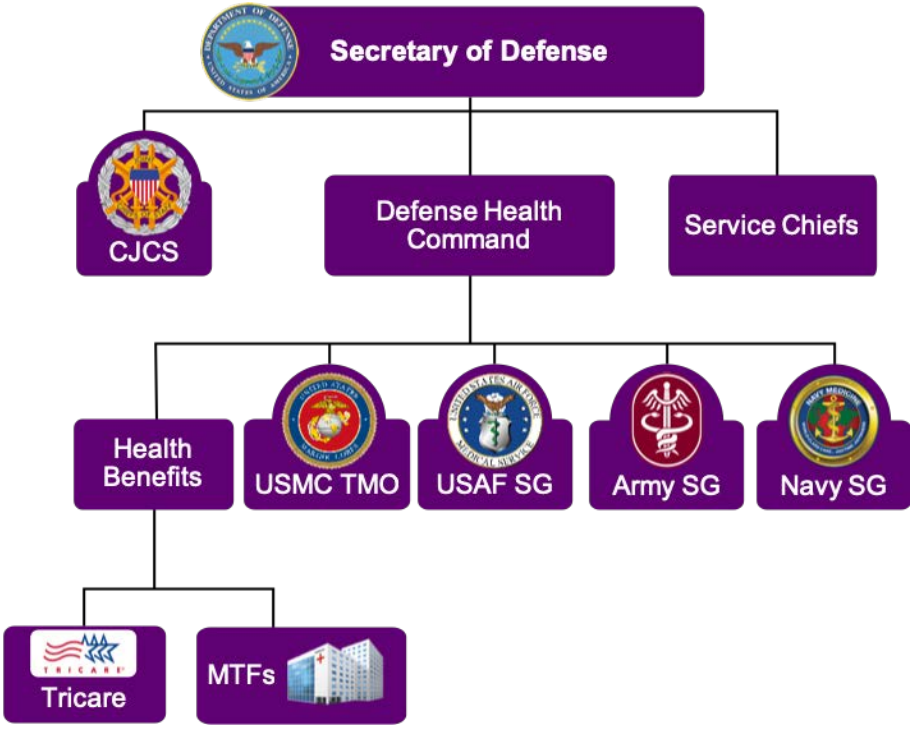


Figure 2. Unified Medical Command (SOCOM-like)

Key Roles and Responsibilities

1. Manage MTFs to include associated infrastructure
2. Manage direct and purchased health care for beneficiaries
3. Develop military medical readiness priorities and requirements
4. Plan and manage some title 10 MTE functions for medical personnel

Characteristics and Authorities

The DHC under this construct would report directly to the SECDEF and would be supported by Service component commands. The Health Benefits Commander would be responsible for setting priorities and requirements for the military healthcare mission, to include direct care and

purchased care contracts and MTF management. The Command would also manage MTFs to include on-base clinics, associated infrastructure, and other related assets.

Each of the Services would remain responsible for some title 10-related MTE functions and associated ADCON for medical personnel. However, the DHC would also assume responsibility for some title 10 functions, such as specialty training and selection. The DHC Commander would assume OPCON for those personnel assigned to MTFs and the authority to address medical related mission requirements from other combatant commanders. Services remain responsible for coordinating and supporting the DHC Commander to address combatant command mission requirements through the joint planning and force generation processes, with The Medical Officer of the United States Marine Corps (USMC) fulfilling a role similar to the Service SGs.

The DHP would be allocated to the DHC and align to key missions as defined and prioritized by the commander. These missions would include purchased and direct care, as well as readiness-related missions that stem from the MTFs and Service-specific requirements embedded units and capabilities.

Table 3. Authorities (SOCOM-Like)

Authority	Services	Construct
MTE Type 1 (Recruiting, promotion, etc.)(ADCON)	X	
MTE Type 2 (Specialty selection and training)		X
Force provision to CCMD		X
MTF Management		X
OPCON of MTF Personnel (Assigned)		X
OPCON of Embedded Personnel (Assigned)	X	
R&D		X
Management of purchased care contracts		X
Immediate Superior		SECDEF

Table 4. SOCOM-Like – Evaluation of Criteria

Criteria	Pros	Cons
Clear decision authority	Unity of command Clearly defined authority, C2 MHS elevated to joint level	Lose C2: Accountability is best managed by Services Inefficiencies from ADCON/OPCON split
Stakeholder integration	Unity of effort	Military Department (MILDEPS) disconnected Disconnect between centralized bureaucracy and Service needs
Medical readiness of the force	OPCON of garrison care Standardized approach to readiness Service focus on readiness	Challenge of managing 4 sets of readiness requirements Loss of Service-unique line mission readiness support
Operational medical support	Service-specific focus Standardized approach Common set of joint requirements	None
Ready and deployable medical force	Centralized title 10 authorities Joint approach to care Services focus on readiness	Discounting of Service-specific approaches and needs
High quality care to beneficiaries	Standardization of care and management Authority to direct personnel throughout the system	None
Impact on medical personnel	Clearer lines of command Increased retention via more diverse opportunities	Disconnect from components Potential for inconsistent support and development of personnel
Cost savings via reduced duplication	Significant savings via headquarters reduction	Unclear costs of integrating the personnel process (duty status, deployability) between Services and command
Cost and ease of implementation	Reduced redundancies Congressional interest	Stand-up and re-organization costs Air Force: formal re-alignment of personnel
Enhance interoperability	Standardized train and equip across personnel	None

Single-Service Command

The single-Service command construct would shift the management of defense health resources, personnel, and facilities under a single selected Service. The selected Service would manage defense medical missions, including MTFs and readiness related activities and requirements. The JHU/APL study team does not make a recommendation of which Service is the preferred for medical personnel, but do note that all three [USMC is exempted] had champions for why each made the most sense.

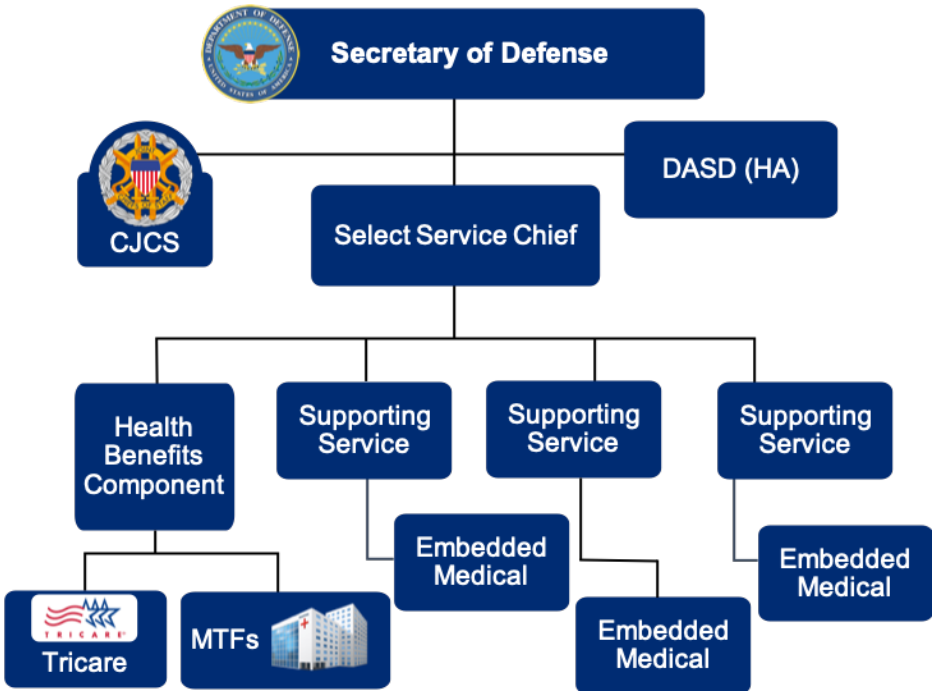


Figure 3. Single-Service Command Construct

Key Roles and Responsibilities

1. Manage MTFs to include associated infrastructure
2. Manage direct and purchased health care for beneficiaries
3. Develop military medical readiness priorities and requirements
4. Plan and manage title 10 MTE functions for medical personnel

Characteristics and Authorities

The selected Service would assume responsibility for all Defense Health-related activities and requirements, to include MTF management, readiness missions, and direct and purchased care. The selected Service would support the medical requirements and missions of the other Services and coordinate with them to ensure their individual mission requirements are sustainably addressed. The medical command element within the selected Service would report to the Service Chief and would be supported by the other Services through a component structure, for handling those personnel who choose to specialize in a sister-Service's operational medicine.

The selected Service, in coordination with the Chairman of the Joint Chiefs of Staff and the supporting Services, would be responsible for addressing defense medical missions, including emergent combatant command mission requirements. The selected Service would assume ADCON and OPCON of medical personnel with the exception of those assigned to specific embedded units within the other Services. Additionally, medical personnel assigned to operational environments would shift to the OPCON of the receiving command. Title 10 MTE functions for medical personnel remains with the managing Service.

The DHP would support the requirements developed and programmed by the selected managing Service, to include those associated with MTF management, personnel, and managed and purchased care.

Table 5. Authorities (Single-Service)

Authority	Services	Construct
MTE Type 1 (Recruiting, promotion, etc.)(ADCON)		X
MTE Type 2 (Specialty selection and training)		X
Force provision to CCMD		X
MTF Management		X
OPCON of MTF Personnel (Assigned)		X
OPCON of Embedded Personnel (Assigned)	X	X
R&D		X
Management of purchased care contracts		X
Immediate Superior		Service Secretary

Table 6. Single-Service Command – Evaluation of Criteria

Criteria	Pros	Cons
Clear decision authority	• Clearly defined authority, C2 • Paraphrasing one interviewee, this is the most efficient way to create an integrated system	• Challenge to handle other Service specific requirements • Variations of different Service force structures • Lose C2: Accountability is best managed by Services
Stakeholder integration	• None	• No Service buy-in • No natural integration in providing direct support to Services
Medical readiness of the force	• Standardized approach to readiness • Service focus on readiness	• Inter-Service discrepancies in readiness definition • Recent agreement that Services are responsible for readiness
Operational medical support	• Centralized title 10 authorities • Standardized knowledge, skills, and abilities (KSAs), currency, and support for deployments	• Potential bias from lead Service • Lack of link to meet non-lead Service requirements
Ready and deployable medical force	• Greater joint opportunities • Standardized KSAs, currency, and support • Services focus on readiness	• Potential bias from lead Service • Lack of link to meet non-lead Service requirements
High quality care to beneficiaries	• Unified health care delivery • Standardization to maximize care delivery	• Coordination in places with no multi-service market • Continuity of management
Impact on medical personnel	• Increased retention via more diverse opportunities • Playing field leveled across MHS in the long term	• Potential bias from lead Service • Culture change for Service medics • Potential for inconsistent support and development of personnel
Cost savings via reduced duplication	• Significant savings via reduced redundancy	• Need for Service liaisons
Cost and ease of implementation	• None	• Long lead time to implement • High implementation costs • Service resistance
Enhance interoperability	• Standardized train and equip across personnel	• Potential bias from lead Service • Loss of unique understanding and trust with other Services

UMC and DHA

This construct would divide the management of military medical missions between a command element for readiness-related missions and an agency responsible for the administration and management of direct and purchased care.

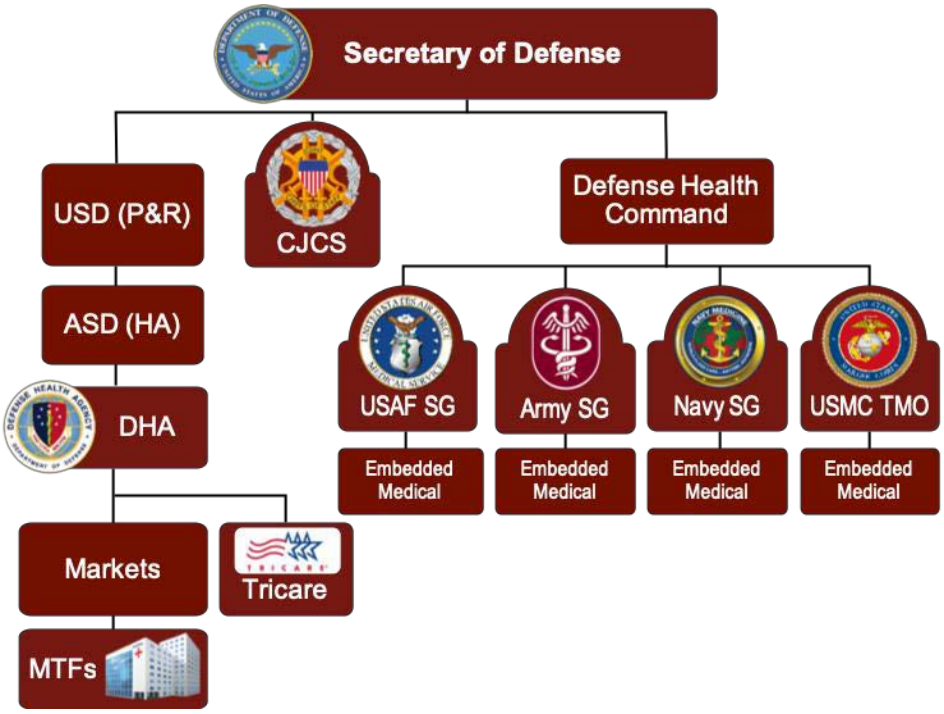


Figure 6. Unified Medical Command and Defense Health Agency

The split construct was previously considered in the studies the team reviewed. The conclusions suggested that this construct would allow for focused management of the health care and readiness missions. However, the prior studies noted that, in splitting the defense health mission between two separate entities, any efficiencies realized or potentially realized would likely be negated.

Key Roles and Responsibilities

1. Manage military medical missions through tailored command and agency components
2. Manage direct and purchased health care for beneficiaries with a focused DHA
3. Manage operational medical missions and readiness focused functions with a DHC

Characteristics and Authorities

This construct would divide the overall defense medical missions between the command element and an agency. The agency would primarily manage direct and purchased care, to include TRICARE and manage MTFs to include clinics and other infrastructure. The agency element would report to the Assistant Secretary of Defense for Health Affairs (ASD(HA)) and USD(P&R).

The command element would have responsibility for managing readiness-related missions and

addressing emergent combatant command mission requirements in coordination with the agency and Services. Contrasting the agency element, the DHC would report directly to the SECDEF and would be supported by the Services through a Service component structure.

Each of the Services would retain the title 10 MTE functions for their respective medical personnel. However, the command element assumes some specific training responsibility for medical personnel, and the agency retains tactical control of personnel assigned to MTFs.

The DHP would be split between the command element and agency based on their resource needs. For example, the agency would receive resources supporting TRICARE management while the command element would receive those resources associated with readiness related missions and some MTE requirements.

Alternatives to this construct could consider creating a separate medical Service rather than implementing a component model or utilizing a single-Service construct.

Table 7. Authorities (UMC and DHA)

Authority	Services	Agency	Command
MTE Type 1 (Recruiting, promotion, etc.)(ADCON)	X		
MTE Type 2 (Specialty selection and training)			X
Force provision to CCMD			X
MTF Management		X	
OPCON of MTF Personnel (Assigned)			X
OPCON of Embedded Personnel (Assigned)	X		
R&D		X	
Management of purchased care contracts		X	
Immediate Superior		ASD(HA)	SECDEF

Table 8. UMC and DHA Construct – Evaluation of Criteria

Criteria	Pros	Cons
Clear decision authority	• Clear authority over benefit mission • R&D placement aligned to policy ASD(HA)	• No unity of command • Benefit and readiness missions are intertwined • Lose C2: Accountability is best managed by Services
Stakeholder integration	• None	• Increased stove piping • Requirement for a separate medical service • No accounting for Service-specific needs
Medical readiness of the force	• Service focus on readiness • Command structure for managing defined readiness	• Increased difficulty in maintaining readiness • Absence of Service culture in benefit delivery • Competing priorities
Operational medical support	• Service control in support of mission sets	• Diminished support • DHA support for UMC only during contingency ops
Ready and deployable medical force	• Service focus on readiness • Command structure for managing defined readiness	• Increased difficulty in maintaining readiness • Discounting of Service-specific approaches and needs • Competing priorities
High quality care to beneficiaries	• Improved care due to complete focus • DHA ability to find efficiencies	• No way to leverage the system to solve challenges
Impact on medical personnel	• Potential for more opportunities • Joint career enhancement opportunities	• Decreased retention if no full-time MTF opportunities • Challenges in rotating between distinct missions
Cost savings via reduced duplication	• Reduction in direct and purchased care • Differentiation of costs between missions • DHA ability to find efficiencies	• Increased requirements

Cost and ease of implementation	• Service buy-in	• High cost of implementation of two Headquarters (HQs)
Enhance interoperability	• None	• Increased layer of bureaucracy to navigate • No perceived change to interoperability

Discussion:

The study team did not reach agreement on which construct is best for the department. The study team determined that a full assessment of the criteria would require clear definition and delineation of medical readiness, readiness of medical forces responsibilities, and maturation of DHA's new authorities to allow for rigorous collection of data needed to show how each construct may or may not contribute to improvements along these dimensions. The study team also determined that the lack of defined problem(s) to solve within the MHS hindered the evaluation of constructs. Furthermore, its analysis showed that the maturation of DHA's execution of acknowledged authorities and responsibilities is not necessarily accelerated by changing to a command construct, nor is command status necessarily required for DHA to carry out its currently assigned responsibilities. The study team observed there has not been enough time for the DHA and the other components of the MHS to complete their current transition and for the DHA to mature into its role as a Combat Support Agency to allow for a better informed assessment of whether there is a need for additional authorities.

A key variable raised in the comparison of the command constructs is the designation of the force provider role for medical personnel. The study team assessed three options for the Title 10 functions of manning, training, and equipping medical personnel: a) entirely a responsibility of the Services (TRANSCOM-like UMC); b) entirely with a single Service command (single-Service command); and c) split between the Services and the command (SOCOM-like UMC). All options have their strengths and weaknesses; similarly, all options have examples of how this can be done successfully.

At this point in time, an objective comparison of alternative command constructs lacked quantitative data on the effects of the present planned changes. Collection of relevant data starts first with agreed upon definitions for the scoping of metrics. This is especially important for tracking a medically ready force and a ready medical force. With appropriate supporting data, models can be generated to provide insight on how the alternative constructs can reasonably be expected to impact relevant metrics. In the current assessment, the study team noted that different senior leaders' opinions on whether or not a particular construct was viewed as improving readiness or being detrimental to readiness depended on their perspectives and understanding of the desired outcome as provided in the attached report at Appendix B. This observation suggests a clear statement of the desired outcomes the DHC is intended to meet would be integral to successful evaluation and transition.

The current legislative-directed MHS transitions were in progress during the course of this assessment. With additional time towards building maturity and developing the necessary

relationships between the agency and the Services, the Department may identify issues that suggest a command construct may be needed within the MHS. Based on this finding, a prudent recommendation would be to readdress this issue in three to five years, first as an assessment of the state of the MHS and then possibly as a follow-on review of how implementing a command construct may improve upon possible issues unearthed in that assessment.

Recommendations:

Although the creation of a DHC is feasible, it is not recommended at this time based on a number of factors discussed above.

Allow MHS as a whole, the time to mature and to stabilize following realignment of responsibilities.

Reassess the state of the MHS in three to five years to determine if agreed upon problems resident within the MHS are remediable by a change in governance and whether further consolidation of authorities and potentially the addition of force provision would improve performance of the MHS. This reassessment would ideally require a clear objective statement of the desired end state. Additionally, this reassessment should delineate how changes to healthcare delivery and readiness support to Services and Combatant Commanders would be facilitated by the DHC transition. The study should also estimate the costs and benefits of the transition (to include staffing requirements) as well as barriers.

Appendix A:

Subtitle B—Health Care Administration

SEC. 711. IMPROVEMENT OF ADMINISTRATION OF THE DEFENSE HEALTH AGENCY AND MILITARY MEDICAL TREATMENT FACILITIES.

(c) REPORT ON FEASIBILITY OF SUPERSEDING ORGANIZATION FOR

DHA.—

(1) REPORT REQUIRED.—Not later than 270 days after the

date of the enactment of this Act, the Secretary of Defense shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report on a study, conducted by the Secretary for purposes of the report, of the feasibility of establishing a command, to be called the Defense Health Command, as a superseding organization to the Defense Health Agency.

(2) ELEMENTS.—If the Secretary determines in the report under paragraph (1) that a command as a superseding organization to the Defense Health Agency is feasible, the report shall include the following:

(A) A description of the required responsibilities of the commander of the command.

(B) A description of any current organizations that support the Defense Health Agency to be included in the command.

(C) A description of any authorities required for the leadership and direction of the command.

(D) Any other matters in the connection with the establishment, operations, and activities of the command that the Secretary considers appropriate.

Appendix B: The attached report: *Defense Health Command: Organizational Options and Assessment*.

JOHNS HOPKINS
APPLIED PHYSICS LABORATORY



DEFENSE HEALTH COMMAND

Organizational Options and Assessment

Joshua Mueller | Reid Smith | Jonathon Cosgrove | Grant Sutton | Kathleen Reedy | W. Sam Lauber
Rodney Yerger | Kevin Ray

DEFENSE HEALTH COMMAND

Organizational Options and Assessment

Program Manager: John Barnes

Project Leads: Joshua Mueller, Reid Smith

Authors: Jonathon Cosgrove, Grant Sutton, Kathleen Reedy, W. Sam Lauber, Rodney Yerger, Kevin Ray

Contributions from: Alan Brown, Amy Haufler, M. Oliver Luen, Guillermo Pinczuk, Kristen Ryan

The following material and analysis is intended for informational purposes only and not to provide legal advice. The hypothetical command construct options are employed only as tools to facilitate the analysis and communication of concepts. This analysis does not instruct readers on what actions to take. Rather, it illustrates the dimension and nature of change that could be required. Readers with questions about how the information addressed here applies to their particular circumstances should consult their legal officers or legal counsel. Readers cannot rely on this writing as legal advice.

Furthermore, the section identifying policy and legal implications intends to provide a perspective on the scope and type of changes likely required for each organizational option. It does not, however, intend to specify all the possible statutory and regulatory steps that would be required to execute each option. As a result, the analysis behind it does not constitute an exhaustive appraisal of all the applicable rules, regulations, statutes, and policies. Rather, the research sought to highlight major changes and significant obstacles.

June 2019
Task #: VQC21

Contents

Figures v
Tables v

Summary S-1

Introduction 1

Brief History of MHS 1
Perceived Problems and Desired End State 2
Key Analytic Questions 2
Study Approach 3
Roadmap of the Document 6

Looking Back: A History of Defense Health Organizational Studies 6

70 Years of Studies 7
Common Themes and Trends 14

Developing a Baseline 18

DHA Establishment and Modification 18
Problems Highlighted in Interviews 19
Organizational Construct Baseline 20

Alternative Organizational Constructs 22

Unified Medical Command (TRANSCOM-like) 24
Unified Medical Command (SOCOM-like) 30
Single-Service Command 36
Unified Medical Command and Defense Health Agency 42

Overarching Assessment Findings 48

Response Trends 48

Clear Decision Authority 49

Stakeholder Integration 49

Readiness 50

Operational Medical Support 51

Beneficiary Care 51

Impact on Personnel 52

Cost Savings 52

Cost and Ease of Implementation 53

Interoperability 53

Final Findings 54

Appendix A. Lists of Interviewees 60

Appendix B. Interview Questions 63

Appendix C. Timeline of Major Statutory, Policy, and Regulatory Changes to Military Health Governance 70

Appendix D. Additional Background Studies 79

Appendix E. Task B Deliverable Slide Deck 84

Appendix F. Vignettes 108

References 112

Abbreviations and Acronyms 117

About the Authors 120

Figures

Figure 1. Previous Governance Studies 8
Figure 2. Defense Health Agency Construct (Baseline) 18
Figure 3. Unified Medical Command (TRANSCOM-like) 25
Figure 4. Unified Medical Command (SOCOM-like) 31
Figure 5. Single-Service Command Construct 37
Figure 6. Unified Medical Command and Defense Health Agency 42

Tables

Table 1. Summary of Findings and Organizational Constructs from Previous Key Studies[a] 9
Table 2. Authority Distribution in MHS for Planned DHA Construct 21
Table 3. Construct Assessment Criteria 24
Table 4. Authorities (TRANSCOM-Like) 26
Table 5. TRANSCOM-Like Construct Primary Pros, Cons, and Mitigations 27
Table 6. TRANSCOM-Like Construct Pros and Cons (Full List) 28
Table 7. Authorities (SOCOM-Like) 32
Table 8. SOCOM-Like Construct Primary Pros, Cons, and Mitigations 33
Table 9. SOCOM-Like Construct Pros and Cons (Full List) 34
Table 10. Authorities (Single-Service) 38
Table 11. Single-Service Command Construct Primary Pros, Cons, and Mitigations 39
Table 12. Single-Service Command Construct Pros and Cons (Full List) 40
Table 13. Authorities (UMC and DHA) 44
Table 14. UMC and DHA Construct Primary Pros, Cons, and Mitigations 45
Table 15. UMC and DHA Construct Pros and Cons (Full List) 45
Table A-1.Interviewees for Background and Options Development 60
Table A-2.Interviewees for Options Assessment 61
Table C-1.Timeline of Legislative Actions[a] 71
Table F-1.Vignette 1 Authorities. 108
Table F-2.Vignette 2 Authorities. 110
Table F-3.Vignette 3 – Alternative Constructs. 111

This page intentionally left blank.

Summary

The 2019 National Defense Authorization Act section 711(c) requires a "Report on [the] feasibility of [a] superseding organization for [the Defense Health Agency] (DHA)" [1]. Accordingly, the Office of the Assistant Secretary of Defense for Health Affairs (ASD(HA)) asked the Johns Hopkins University Applied Physics Laboratory to conduct a preceding baseline study identifying, compiling, reviewing, and assessing previous available studies and analyses that have addressed the organization, authorities, and responsibilities of the Department of Defense's (DoD's) medical functions. This baseline study supports the research for the final Feasibility Report to be conducted by ASD(HA).

After reviewing 70 years of Military Health System (MHS) governance studies and conducting semi-structured interviews with 36 of key stakeholders, the study team identified four key themes and 28 previously identified organizational options. Key themes identified were inconsistencies in the relationship between readiness and benefits missions, agreed upon feasibility of command structures at the time of study, desirability of centralized decision making authority in the MHS, and recognition of the decision making capabilities of the ASD(HA). These themes and the example organizational constructs guided the development of command organizations for the MHS for this assessment.

The study team developed four command constructs using a combined top-down and bottom-up approach. Previously identified organizational structures were binned to provide example organization charts. Simultaneously, the study team identified 8 key authorities for efficient operation of the MHS. The team mapped these authorities to the binned constructs to produce four archetype command organizations for the MHS. Those constructs are:

1. Unified Medical Command (UMC) (modeled on Transportation Command),
2. UMC (modeled on Special Operations Command),
3. Single-Service Command, and
4. Split agency and UMC.

To assess the four command organizational options, the study team identified and defined 10 assessment criteria:

1. Clear decision authority – provides clear demarcations of authority (including accountability), for budgeting policy, command and control, personnel, etc.
2. Stakeholder integration – provides for clear integration with other stakeholders
3. Medical readiness of the force – maintains or enhances the ability to provide medically ready warfighters
4. Operational medical support – ensures that the services have highly effective operational medical support and the medical-line relationships that this requires
5. Ready and deployable medical force – sustains the training necessary to meet all requirements needed to provide a fully trained and current deployable medical force
6. High quality care to beneficiaries – maintains or enhances the ability of the system to sustain the current high quality of health care that it provides
7. Impact on medical personnel – maintains or enhances the retention and promotion rates of medical personnel
8. Cost savings via reduced duplication – reduces duplication, resulting in cost savings for system operations
9. Cost and ease of implementation – is implementable taking into account Title 10 equities; short-term costs and long-term savings; and decisions required inside and outside of the DoD
10. Enhance interoperability – facilitates interoperability amongst the Services

Command options were assessed along these dimensions by the study leadership team, Service Vice Chiefs and Surgeons General, the DHA Director, and other DoD senior leadership. Pros, cons, and mitigations were identified for each option. The UMC constructs modeled on Transportation Command and Special Operations Command were rated positively for their ability to integrate stakeholders. The single-Service model was consistently cited as having the greatest potential for cost savings but with the greatest scope of statutory change and impact on personnel. However, the study found that no one construct emerged as universally superior to the others.

Opinions varied widely about which would be preferable, and every construct had at least one assessment that said it was overall unfeasible or undesirable. This lack of consistency suggests that further assessment and consensus-building will be necessary in order to establish the optimal organizational structure for the Military Health System.

Though there was no overarching agreement about which construct was most appropriate, the assessment of the options yielded several overarching findings that may indicate where and why there are points of disagreement. These findings should help to shape further assessment and consensus efforts. For instance, respondents' backgrounds influenced their receptiveness to certain constructs, with those having DHA or Joint medical experience tending to be more favorable to a Command construct and those with primarily Service-oriented backgrounds preferring other options. This trend was most present when assessing the constructs for clear decision authority and impacts on readiness. Many of these findings were directly associated with the overall input for each assessment criteria, including:

1. Clear decision authority – assessment depended on interviewee's background and was hampered by a lack of data on the relationship between command and control, discipline, and command roles for each of the Service medical elements and other MHS organizations
2. Stakeholder integration – only UMCs had positive consideration, while all four constructs had many cons reported for this feature
3. Medical readiness of the force – individual medical readiness measures should be collected over time to establish a baseline and determine trends arising from the changes in the organization of the medical force
4. Operational medical support – there is a strong trust component arising from working, training, and deploying with the same individuals over the course of a tour that should be factored into the consideration of organizational structure
5. Ready and deployable medical force – requires a substantive and agreed upon definition with supporting data collection
6. High quality care to beneficiaries – most respondents felt there would be no anticipated impact to beneficiary care
7. Impact on medical personnel – command constructs were thought to disconnect the medical personnel from their service, thus losing the shared cultural understanding

8. Cost savings via reduced duplication – cost savings require that the duplicated elements be eliminated, which is not guaranteed in the process of reorganization
9. Cost and ease of implementation – the single-Service model causes the most disruption, though any change at the moment continues to inject chaos into a system in the midst of transition
10. Enhance interoperability – most respondents agreed that standardization would improve interoperability between the services.

Finally, several themes were identified throughout the course of study that crosscut the proposed constructs. Foremost among these was the lack of clear definitions for key concepts, such as readiness. Next, the lack of supporting data hampered quantifiable comparisons. The lack of supporting data and clear definitions led to inconsistent assessments of the constructs by senior leaders, where the same features of a construct appeared as both a pro and a con along the same assessment criteria. Finally, DHA has not had the time to prove itself as a Combat Support Agency capable of carrying out the responsibilities assigned to it. Clarity and recognition of key authorities can facilitate this growth, but do not necessarily require a reorganized command construct.

Introduction

The 2019 National Defense Authorization Act (NDAA), Subtitle B-Healthcare Administration, Section 711 contains actions for the "Improvement of Administration of the Defense Health Agency and Military Treatment Facilities" [1]. Actions called for in this section include

1. Transfer of Military Treatment Facilities (MTF) administration to Director, Defense Health Agency (DHA) before 30 Sep 2021
2. Further delineation of authorities Director, DHA will have to enable MTF oversight
3. Restrictions on MTF closure
4. Clarification of DHA role in supporting medical readiness requirements of military installations

This same section called for a "Report on [the] feasibility of [a] superseding organization for DHA," that is specifically to look at a Command as the superseding organization [1]. That study will be conducted by Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)). To support the feasibility study, OASD(HA) requested the Johns Hopkins University Applied Physics Laboratory (JHU/APL) conduct a preceding study to develop Command organizational options and to assess their impact on DHA post-consolidation.

This section briefly discusses the history of the Military Health System (MHS), indicates the perceived problems and desired end state of the MHS, and describes this study's key analytic questions and approach.

Brief History of MHS

The history of the MHS is captured in Refs [2], [3], and [4]. The MHS began with health support to Active Duty Service members in combat in World War I and II and their recovery after. In 1956, Congress passed the *Dependents Medical Care Act* that established care for Active Duty dependents, retirees, and their dependents [2][3]. In 1966, Congress passed the *Military Medical Benefits Amendments* that created the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) system, allowing coverage of medical care for retirees and dependents in civilian hospitals outside of MTFs [2][3]. In 1973, the draft was ended, and the military moved to an All-Volunteer Force (AVF), which gradually changed the military and dependent population—on average in the AVF, service members were older, married, and had

more dependents [4]. Additionally, over time, the number of retirees increased. In 1995/6, CHAMPUS was replaced by TRICARE and the triple option [2]. In 2013, DHA was established, and in 2017, as part of the 2017 NDAA, Congress decreed that administration of MTFs would transfer to DHA, and that to accomplish this new responsibility, it would have a professional staff [5].

Perceived Problems and Desired End State

In the text of the 2019 NDAA that called for a study on Command organizations to replace DHA, no specific problem was indicated that would be addressed by establishing a Command. However, the preamble to the Senate report on Title VII of the 2017 NDAA, *Health Care Provisions*, discussed the issues with the MHS and the desired end state, at least as of 2016 when it was drafted.

The issues documented include

1. "The military health system, designed decades ago, has increasingly emphasized delivering peacetime healthcare at the expense of strengthening operational medical force readiness.
2. "Bloated medical headquarters staffs--over 12,000 persons strong--have failed to take quick action on what needs to be fixed.
3. "The current stove-piped military health system command structure leads to inevitable turf wars … paralyzing decision-making and stifling healthcare innovation.
4. "Total cost to provide healthcare services in military treatment facilities is greater than the cost of providing the same types of services in the private sector" [6].

The desired end state was articulated as "a high-performing integrated health system that gives beneficiaries what they need and deserve: the right care at the right time in the right place" [6].

Key Analytic Questions

Three analytic questions guided this analysis

1. What authorities are required for the efficient operation of the MHS?
2. How can lines of authority be clarified and which organizational structures best enforce that clarification?

3. How does the organizational structure affect key aspects of the Military Health System?

The study team addressed the first question by examining the missions, functions, and tasks of the MHS (DHA, ASD(HA), Service Medical organizations), trying to identify the primary functions that must be carried out in the MHS. That set of functions is captured in the tables shown for each organizational option, including DHA. The authority of organizational components to carry-out each function distinguishes each organizational option.

The second question informed the winnowing of the organizational options and the construction of the option details. To clarify lines of authority, no single authority was given to two entities. Authorities are assigned to the Services or the construct for each option, so as to provide options that span the decision space. Further details on this approach are provided in the Study Approach sub-section below.

The third question informed the assessment of the options. For each, its impact on various attributes of MHS was assessed using subject matter expert (SME) input.

Study Approach

The study team took a multi-method approach to answer each of the above questions. First, the team reviewed relevant published reports, policy, and doctrine that addressed organizational options and requirements for the MHS. Second, the team conducted expert, semi-structured interviews with an initial round of 28 key stakeholders, selected through a combination of nominations from the study leadership team and relevant SMEs already known to JHU/APL (see Appendix A for the full list of offices interviewed). The interviews elicited feedback on the primary objectives and functions of the MHS, as well as opinions on the most efficient organizational approaches for achieving those aims (see Appendix B for the baseline interview protocol). The interviews were de-identified and then coded using a combination of inductive and deductive techniques and analyzed using the qualitative analysis software, Dedoose™.

The study team developed organizational options using a combination of top-down and bottom-up approaches in order to fully describe example archetypes. In the top-down approach, the developed organizational options are informed by both the initial literature review and interviews with stakeholders identified in Table A-1. The space of available options was constrained to those models that have been previously studied and to options that are specifically command constructs, as required for the Feasibility Study called out in the 2019 NDAA. From approximately 28 different

organizational models, the study team binned the previously considered organizations into four main types. Using the term model for the generalized organizational structure and later using the term construct for the specific organizational structure, the team defined an archetype for the model. Aiding in identifying the bins were criteria provided by interviews with the House and Senate Armed Services Committees: the need for a centralized decision-making authority, oversight and visibility into the MTFs, and efficiencies in the headquarters staffs. The four models are: Agency models, Unified Medical Command (UMC) models, single-Service models, and models with both an agency element and a command element. All previous studies were completed prior to the existence of the DHA; the current MHS is considered an agency model. The study team did not consider agency models here because of the 2019 NDAA requirement to study commands, with the exception of highlighting important findings for the current system. From the remaining three models, the team developed four constructs by describing two types of UMC.

In conjunction with the top-down approach, which identified the main types of constructs previously considered, a bottom-up analysis of the authorities required for efficient operation of the MHS was performed. The study team identified the following key authorities: administrative control (ADCON) of medical personnel, operational control (OPCON) of personnel at MTFs, OPCON of embedded forces, management of MTFs, management of purchased care contracts, and force provision to combatant commands (CCMDs). The options for who has each of these authorities presents another means of spanning the decision space. These authorities were identified through a thorough literature review and in SME interviews. These authorities were mapped to the example constructs derived from the literature in order to present four specific organizational command constructs for the MHS (the team detailed two different types of UMC).

The four options that were developed and describe are: a Special Operations Command (SOCOM)-like version of a UMC, a Transportation Command (TRANSCOM)-like version of a UMC, a single-Service Command, and a split Agency and Command construct. Two types of UMC are considered in-order to capture important considerations of a command as a force provider. The study team noted that these commands can exist as either a new Functional Combatant Command, like TRANSCOM, SOCOM, or Cyber Command (CYBERCOM), or as a sub-unified command under one of the existing CCMDs. Additionally, the considerations for a single-Service construct (all medical units transferred into one of the existing Services) also apply, along with other start-up costs, to a separate-Service (completely new medical Service) construct. Finally, the decision was made to model the split Command as a SOCOM-like command as this gives the most distinction between archetypes. However, it should be acknowledged that the split construct can also be applied to a

TRANSCOM-like command and a single-Service command. Each construct is described in detail in the Alternative Command Constructs section.

Costs were assessed for each of the four identified command organizational options. The scope of the assessment was limited to the calculation of rough of order of magnitude manpower changes from the planned Military Health Organization DHA model baseline described in the Alternative Command Constructs section. The cost of manpower was calculated using FY2018 Department of Defense (DoD) Military Personnel Composite Standard Pay Rates plus locality pay adjustments for military Full-Time Equivalents (FTEs) and using 2018 Office of Personnel Management Civilian Salary Rates plus DoD Civilian Personnel Fringe Benefits Rates for civilian FTEs.

In order to assess the projected manpower impacts of the identified command organizational options, the billet-level detail of the DHA model baseline was categorized by functions leveraging an approach taken by the Center for Naval Analysis (CNA) in their *Cost Implications of a Unified Medical Command* study [7]. These functional categories are:

1. Healthcare Operations
2. Comptroller
3. Information Technology (IT)
4. Education and Training
5. Research and Development (R&D)
6. Logistics
7. Strategic Planning
8. Human Capital Management
9. Force Health Protection
10. General Headquarters

Each functional category was assessed within each command organizational option for efficiencies and redundancies against the baseline. Note that DHA controls the Military Health Service IT systems and will maintain this control under each command organizational option; therefore, no additional efficiencies were estimated for the IT functional category. Standard economies of scale factors were applied to

those functional categories highlighted above[1]. Impact sensitivity was tested by applying an additional redundancy factor to those same areas.

Using a short-answer survey, the study team solicited feedback from the study leadership team and initial pool of interviewees about the pros and cons of each organizational option based on the stated criteria. In addition, the study team conducted a second round of unstructured interviews with additional stakeholders as identified by the study leadership team (see Appendix A) to ask for high-level assessments of the options. This feedback was coded thematically using an inductive approach. Finally, the team combined the options and their assessments into an organized format and made note of any over-arching themes that emerged from the data analysis.

Roadmap of the Document

First, a review of the studies on MHS governance is provided, along with a summary of findings. The following chapter discusses DHA and how a baseline for comparing organizational options against was constructed. After the DHA baseline chapter, the four organizational options are presented, along with their assessment. Next the study team presents overarching findings for the MHS in response to the assessment criteria. Finally, the report closes with additional findings and conclusions that arose external to the specific organizational constructs.

Looking Back: A History of Defense Health Organizational Studies

The structure and direction of the health mission have been a persistent topic of organizational and policy consideration since the genesis of the modern United States (U.S.) Defense enterprise after World War II. Commissions, panels, studies, committees, task forces, and reviews have all taken up the issue between 1948 and 2012. This prior work contains valuable insights that inform this report's development and analysis of organizational options. To inform this effort, previous available studies addressing the organization, authorities, and responsibilities of the Department's medical functions were compiled and reviewed. A timeline of major statutory and policy shifts was also developed to check assumptions and inform any contemporary consideration of past recommendations (see Figure 1and Appendix C).

[1] Using the same methodology as the CNA study, a production function (A=(P/C)^(1/e), where A is administrative output, P is personnel, C is a constant, and e is economies of scale) was used to estimate the reduction in personnel using an economy of scale factor of 0.80, which was derived from studying historical mergers of hospitals as well as other industries. The percent personnel reduction that was applied to each function varied based on the number of organizations that were potentially merging.

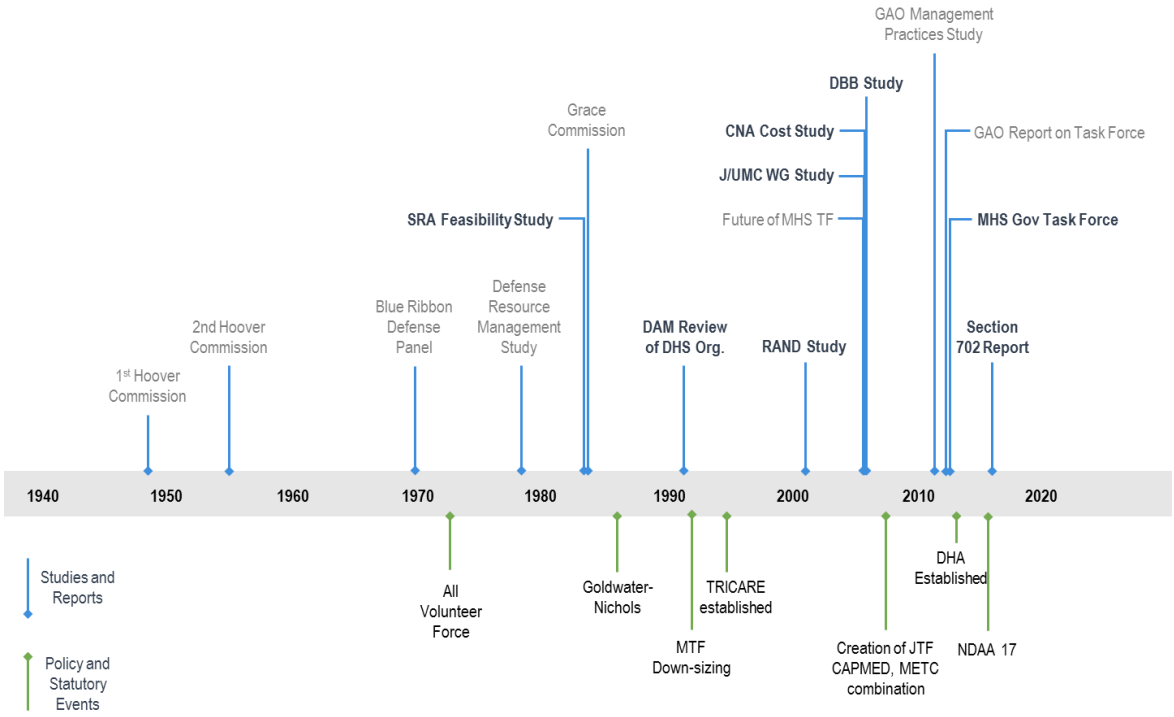
Further supporting documentation for this section is found in Appendix D and Appendix E.

70 Years of Studies

An early major proposal for the centralization of the MHS was published by the Commission on Organization of the Executive Branch of the Government – commonly known as the First Hoover Commission, because it was led by former President Herbert Hoover in 1949. Citing deficiencies in the contemporary structure,[2] the Commission recommended "the establishment of a United Medical Administration [consolidating most Federal]… medical care, medical research, and public health" – to include military hospitals in the United States [8]. While "control of medical policy in the armed services [would] be exercised by the Secretary of Defense (SECDEF)," the Administration would need to "give constant attention to necessary measures for national defense," and would consult an advisory board of Surgeons General and the Administrator of Veterans' Affairs [8].

However, "little fundamental improvement in Federal medical services" occurred in the six years after the First Hoover Commission, so a second commission under the same name (known as the Second Hoover Commission) delivered a report in 1955 [9]. After affirming the findings of the previous report, the Second Hoover Commission offers a second solution: "In the absence of unification, regionalization can offer the best solution" [9]. Under regionalization, responsibility for medical care in the United States would be distributed between the three Services "in such a way that the nationwide proportion of the total responsibility… assumed by each of the three departments would not be materially altered" [9]. This modification, in the view of the commission, would constitute "a much more closely coordinated pattern" for the military health system in the United States [9]. No changes to the organizational structure of the MHS were made following these recommendations.

[2] Noted deficiencies at the time include (but are not limited to) "no central supervision," operation "under diverse policies," "No one has responsibility for an over-all plan," "Failure to Utilize Capacity," "Varied Quality of Service," and "Lack of Clear Policy on Beneficiaries" [8].



Studies in bold are considered key studies for the purposes of this report because they address the organization, authorities, and responsibilities of the MHS in-depth.

Figure 1. Previous Governance Studies

In 1969, the Blue Ribbon Defense Panel was chartered by President Richard Nixon and Secretary of Defense Melvin R. Laird "to study the entire organization, structure, and operation of the Department of Defense" [10]. The panel notes at the time that "significant economies" were possible in the "medical, dental and hospital services" of the department, as well as other "common non-combatant functions," through consolidation as a defense agency, or alternatively under a Military Department designated "as 'Executive Agent' to perform such functions for all military services" [10].

No significant reorganizations occurred following the 1969 Blue Ribbon Defense panel, and so, in 1979, the Defense Resource Management Study (DRMS) was commissioned by Secretary of Defense Harold Brown. The DRMS was tasked to perform a "searching organizational review" of five resource management topics, one of which was the "military health care system" [11]. Although it reviews the organization, functions, and authorities of the MHS, the DRMS "discusses, but makes no major recommendations on, the organization of the health care system" [11]. Despite admitting that "[t]he DRMS has not taken up the consolidation question," the DRMS nevertheless "opts for the current decentralized system" [11]. Instead of any

organizational changes, the DRMS calls "for a more concerted effort… stronger leadership and more aggressive management" by SECDEF, ASD(HA), and "the Assistant Secretary of Defense (Manpower, Reserve Affairs, and Logistics)" [11]. No changes to the MHS organizational structure were made.

When asked in 1982 by the Senate Armed Services Committee (SASC) to study a proposed DHA construct, DoD contracted Systems Research and Applications Corporation (SRA) and Delphic Concepts Inc. to perform the study. The "Defense Health Agency Feasibility Study" evaluated the proposal and developed it in detail to address "functions, organizations, and the relationship of the DHA to the [ASD(HA)], the Joint Chiefs of Staff… and the Surgeons General" [12]. Under the DHA construct proposed at the time, "The Military Departments would be responsible for mobilization, military personnel, and certain related items such as career development, in-service training and education, and the war reserve materiel assets" [12]. Overall, after considering efficiencies and savings against potential problems and issues, the study determined at the time that the DHA model described by the SASC was "both feasible and desirable," but not without problems [12].

Table 1. Summary of Findings and Organizational Constructs from Previous Key Studies[a]

Source	Options Considered	Findings and Recommendation(s)[b]
SRA *DHA Feasibility Study* (1983)	• Only assessed the Defense Health Agency model as described in a proposal out of SASC at the time.	DHA proposal "feasible and desirable," but not without problems. **Recommendation**: Distribute study to community of interest for comment.
DAM *Review of the DoD Organization for Health Care (*1991)	• UMC to serve as a force provider to the CCMDs. The model is based on United States Special Operations Command (SOCOM). • A Defense Health Agency • Strengthening the authorities of ASD-HA.	No ASD(HA) has elected to exert his full authority or to implement the internal organizational restructuring required for greater involvement in program management. **Recommendation**: Centralized health command
RAND *Reorganizing the Military Health System (*2001)	• Status Quo: 2 Organizations tailored to the two MHS missions, readiness and benefits; • Modified status quo: Separated MTFs and TRICARE;	Insufficient evidence to predict the necessity or effectiveness of establishing a joint command to direct the restructured TRICARE organization and other military medical activities. **No Recommendation**: "we do not recommend one specific option in this report" [12]; Depends on how objectives are **valued**.

Source	Options Considered	Findings and Recommendation(s)[b]
	• Joint Command w/ Service Components; • Joint Command w/ Service and TRICARE components; • Joint Command w/ Readiness and TRICARE components	• Abstract: Modify the current (as of 2001) system organization to unify health-plan management and separate it from MTF management.
J/UMC *Joint/Unified Medical Command Working Group* (2006)	• UMC • Two Distinct Commands: (1) Joint Medical Command; (2) Joint Healthcare Command • Single Service	Split Command models are inherently less efficient, likely less effective, and violate the principle of unity of command. Single-Service model is simple, efficient, effective, and could be done without a change to the law. Unified Command provides unity of command and effectiveness, but has higher headquarters overhead than the single service model. **Recommendation**: Support for UMC proposal.
CNA *Center for Naval Analysis Cost Implications Study* (2006)	• Single Medical Command • Medical Command and Health Care Command • Single-Service	Most savings likely realized under a single-Service model; Split medical command and healthcare command likely the highest cost; Eliminating military, civilian, & contractor billets required to realize savings. **No Recommendation**
DBB *Defense Business Board Study* (2006)	• UMC • Existing Structure w/ greater centralized control	Costs to deliver this mission unsustainable – duplication and incompatibility of equipment key cost drivers. **Recommendations**: Establish a UMC; Adopt Industry Best Practices; and Use existing governance framework.
Task Force *MHS Government Task Force* (2011)	• Twelve models other than current structure considered[c] • Includes big and small versions of DHA, a UMC, and a single-Service model.	Some centralization of shared services will be beneficial. Costs of adding command structure outweigh the benefits. **Recommendation**: "Small" DHA Model with Service retention of MTFs.

[a] Key studies are those that provided significant detail on the organization, authorities, and responsibilities of prospective models for governing the Department's medical function. Other studies discussed in the body of this section also provide insight into the governance of the MHS and inform the analysis.

[b] More detail on findings and recommendations provided in the body of this section.

[c] 2011 Task Force Models: A - Current MHS Governance Structure; B - Defense Health Agency, Geographic Model; C - Defense Health Agency with Service MTFs; D - Unified Medical Command, Geographic Model; E - Unified Medical Command with Service Components; F - Unified Medical Command - HR 1540 Section 711

Model; G – Single-Service, Geographic Model – One Military Department Secretary Assigned Responsibility for the MHS; H – Single-Service with Components; I - Split UMC and Military-Led DHA Geographic Hybrid Model; J - UMC with Components and DHA Hybrid; K – Single-Service Hybrid with a Unified Medical Command; L - Defense Health Agency Hybrid with MTFs placed under the Agency; and M - Defense Health Agency Hybrid with Regional MTFs.

During the same period as the SRA study, the President's Private Sector Survey on Cost Control (PPSSCC), chaired by J. Peter Grace and known as the Grace Commission, was established by President Ronald Reagan to "identify opportunities for increased efficiency" and "suggest… managerial operating improvements," among other issues across the government through thirty-six different task forces [13]. The PPSSCC "Report on Federal Hospital Management" concluded that centralized management and administration of the MHS "could save at least $225 million annually" at the time of the report [14]. Notably, the PPSSCC describes reasons why consolidation of shared medical services had not yet been adopted by 1983, noting significant cultural obstacles. The traditions of Service autonomy meant that the "development of individual hospital systems within which each armed service [was] entangled in this autonomous tradition," and fell within "the perceived mission" of each Service, making centralization of shared services difficult [14]. Nevertheless, due to a lack of direction and consistency in the management structure at the time, the task force recommends the establishment of a centralized health entity to manage the MHS, alongside the establishment of "more authority and direction from OASD-HA." However, this did not lead to any significant reorganization of the MHS [14].

In 1990, the Deputy Secretary of Defense asked the Director of Administration and Management (DAM) to conduct "a study to determine the optimum organization of medical functions within the [DoD]" in order to both provide combat and peacetime medical services "at the lowest feasible cost to the taxpayer" [15]. To do this, the DAM considered three different organizational options: a unified U.S. Medical Command (MEDCOM), a DHA, and strengthening the role of ASD(HA). The study found that despite being "one of the strongest charters among OSD staff activities… no ASD(HA) has elected to exert [their] full authority..." DAM also found that the benefits and readiness missions were too closely connected to be separately managed, going so far as recommending that integration of the two be institutionalized [15]. The recommended MEDCOM would have budget authority and assume both the benefits and readiness missions, with the Service Surgeons General serving as component commanders. Structural changes to the organization of the MHS were not adopted [15].

RAND, after being initially tasked with assessing the organization and cost of DoD's TRICARE program, focusing on civilian-managed options, took on a broader scope of research after the passage of the 2000 NDAA, which requested a study on expanded

joint medical operations to include "an assessment of the merits and feasibility of establishing a joint command" [13]. In order to assess the merits and feasibility at the time, RAND considered five alternative organizational structures: The current structure at the time, a modification of the current structure that would "unify health-plan management in TRICARE and separate it from MTF management," and three different iterations of a joint command [13]. The first joint command option had three component commands, each responsible for MTFs, TRICARE management, and medical readiness in each Service. The second joint command option had service and TRICARE components, where each service component was responsible for the MTFs and medical readiness. The third joint command option had readiness and TRICARE components, the latter of which would be responsible for both TRICARE and the MTFs. The study found that there was insufficient evidence to predict the necessity or effectiveness of establishing a joint command. Although the body of the report states that the authors "do not recommend one specific option in this report," instead recommending "that DoD leadership consider the relative importance" of objectives when selecting any specific joint command structure, the abstract for the report asserts that "[t]he authors recommend modification of the current system organization to unify health-plan management in TRICARE and separate it from military treatment facility management" [13].

Chartered by the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) to develop an implementation plan for a Joint Medical Command in accordance with the 2004 Program and Budget Decision (PBD) 753, the Joint/UMC Working Group (J/UMCWG) sought to respond to the PBD while addressing Joint Force health protection/operational medicine, force generation, and beneficiary care. Starting broad, the J/UMCWG began with eight different models for the structure of the Joint Medical Command, which were then narrowed down to three courses of action (COAs) that were assessed. COA 1 presented a SOCOM-like UMC model that held responsibility for both operational medicine and healthcare. COA 2 proposed split commands, one a UMC responsible for readiness and the other a Joint/Unified Healthcare Command addressing beneficiary care. Finally, COA 3 envisioned a single-Service model similar to Navy medical support to Marines. The J/UMCWG found that the single-Service model of COA 3 was simple, efficient, and effective, but also noted significant concerns about resource liability for the chosen Service and disenfranchisement of the other Services. Ultimately, the J/UMCWG recommended the UMC model in COA 1. After the J/UMCWG's analysis was conducted, a fourth COA was added that allowed for a civilian-controlled health agency model, prefiguring the DHA [16].

Supporting the efforts of the J/UMCWG, which was charged in 2006 with developing a plan for a Joint Medical Command, the Bureau of Medicine and Surgery (BUMED)

asked the CNA to "estimate the cost implications of various configurations of a [UMC]" [7]. In "Cost Implications of a Unified Medical Command," the authors at CNA examined the costs and savings associated with three different UMC structures. First, a single medical command, where "the Services and [Tricare Management Activity] are unified under a single command" and "funding flows directly to the unified commander and does not go to the Army or Navy Surgeon General (SG) or to the Air Force line" [7]. Second, a healthcare command that "would cover the [MTFs] and the purchased care contracts," with a separate medical command that "would cover all other functions" [7]. Third, a single medical service, where "one Service provides the medical function for the other three" [7]. Assuming "proper execution and clear command and control," CNA's estimation of costs over the long run concluded that the most potential savings are found in a single medical service, with a single medical command option in second [7]. The CNA did not offer a recommendation, compare the options with a DHA, or note which structure would be more effective, but did note that clear command and control would be essential to realize the savings of a UMC.

Another 2006 effort was conducted by the Defense Business Board (DBB), who were tasked by the Deputy Secretary of Defense to assess an MHS "governance framework in keeping with the Defense Enterprise Planning and Management Framework and… identify key best practices for delivery of the overall military health care mission" [17]. Having considered the establishment of a UMC and augmenting the existing structure with greater centralized control, the DBB recommended immediate establishment of a UMC, which would take on "shared services, non-battlefield medicine (Level III care and above), and associated funding," and outsourcing the TRICARE Management Activity "once the agency has been re-aligned" [17]. Levels I and II, as well as "Service-specific medical capabilities and needs for mission continuity" would remain under Service control. Policy control, budget accountability, and oversight of all MHS activities would rest with ASD(HA) [17]. However, the DBB recommended continued use of the existing MHS governance framework of enterprise planning models and methodologies. Finally, the DBB recommended the adoption of several private industry best practices in defense medicine, including the combination of shared services, enhanced coordination with Veterans Affairs, and the alignment of "investment, manpower and resources to ensure implementation, accountability, and transparency" [17]. While the J/UMCWG fourth option was adopted as department policy following these three studies, the lack of a transition leadership team and changes in department leadership led to no organizational changes being adopted.

The 2007 final report of the Task Force on the Future of Military Health Care briefly commented on issues of the "Command and Control Structure to Manage the Military Health System," but in light of vigorous, ongoing debate at the time, the Task Force

decided it was "premature to make additional recommendations" [18]. However, the Task Force commented on past efforts and recent reports, noting that the findings of the 2001 RAND report "appear to have some merit," and reiterated recommendations given by the Government Accountability Office (GAO) to "Develop Metrics by Which to Assess the Success of Military Health System Transformation" [18].

Established by the Deputy Secretary of Defense in June 2011, the Task Force on Military Health System Governance submitted their final report in September of that same year. 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," including recommendations and details on "the relative strengths and weaknesses of each option evaluated" [19]. The Task Force concluded that there were opportunities to adopt and implement more efficient, common processes in streamlined shared services, as well as provide a "coherent, cohesive, and effective long-term governance model for the MHS" [19]. Out of the numerous models considered, the Task Force recommended a DHA model where the Services retain control of the MTFs. This was favored over the establishment of a UMC at the time in light of the costs associated with setting up a command structure, which they found outweighed the benefits. [19] However, it is important to note that a report by the GAO was critical of the final report, concluding that the Task Force did not adequately assess the costs and savings of the organizational options originally considered [20]. The findings of this Task Force directly led to the creation of the DHA [20].

Common Themes and Trends

In this review of the literature and studies on MHS organization and governance, several recurring themes and common trends are evident. While none of the themes across past studies are unanimous, they illuminate the key issues at the core of this study.

Relationship Between the Readiness and Benefits Missions

First, a persistent point of discussion over years of studies has been *the relationship between the readiness and benefits missions of the MHS*. At least one study held these missions in tension, concluding that each mission was better served by governance solutions that would be detrimental to the other. In justifying their decision not to take up the question of MHS consolidation, the DRMS contemplates that it "may well be another question which the two missions pull in opposite directions" [11]. When one has "the benefit mission solely or primarily in mind," the DRMS argues, "consolidation, perhaps even the creation of a single, unified DoD health care agency, seems attractive" [11]. However, the DRMS report immediately counters this claiming

"with the readiness mission primarily in mind, the current decentralized system, more closely linked to the deploying forces, seems better" [11]. While this study cannot necessarily affirm or contradict the DRMS' assumptions about the suitability of different governance models to the readiness and benefits missions, it is clear that a singular focus on cost efficiencies can create a bias toward centralization solutions (see Blue Ribbon Defense Panel and CNA).

Other studies, however, viewed the two missions as inseparably linked. The DAM study argued that "the peacetime/benefit mission is closely related to medical readiness," complimenting it by providing "a pool of physicians and other health care professional and support personnel trained in the complete range of medical specializations" and "as a part of the total compensation package required to attract the force needed to perform the wartime mission" [15]. The Grace Commission likewise assumed this symbiotic relationship, describing the readiness and benefits missions as "mutually supportive," despite acknowledging tensions between the types of care required, each drawing "on a limited [MHS] budget" [14]. Although it is clear to the Grace Commission that the MHS "requires peacetime patients to maintain the skills of professional and supporting staffs for the readiness mission," they nevertheless acknowledge the "dichotomy between the types of services demanded by each mission… [can cause] a shortage of specialists needed by each to be optimally effective" [14].

Prior Feasibility of Command Structures

Second, while it is important to note each study was operating under their own time, circumstances, and definitions that may not be applicable today, *studies prior to the establishment of the DHA have consistently found UMC structures to be feasible given the statutes and directives in place at the time*. However, not all studies that found a UMC to be feasible concluded that one was desirable. Additionally, the creation of the DHA may impact the calculus used in determining feasibility. When the 1991 DAM review of DoD health care organization assessed DHA and UMC[3] models, the UMC was found to have both greater advantages and fewer disadvantages. They concluded that while a DHA "possesses most of the same advantages" of a UMC, it would entail a greater "reduction in military involvement in medical readiness planning and operations than would be the case" with a UMC [15]. In 2006, the DBB also recommended the immediate establishment of a UMC [17]. However, the DBB did not compare the UMC option with that of a DHA as was done in the DAM assessment.

[3] In the DAM report, this model is discussed as a U.S. Medical Command (MEDCOM).

The 2001 RAND study considered three separate UMC models, but did "not recommend one specific option" [13]. Although the study did not directly comment on the feasibility of each model, the authors found at the time that it was "impossible to know whether it would manage the system more effectively and maintain medical-line relationships important for readiness" unless a UMC was established [13].

Similarly, the 2011 Task Force on MHS Governance considered UMC models alongside DHA and other options. Although the final report did not comment directly on the feasibility of a UMC, the Task Force concluded that the costs of adding a command structure outweighed the benefits, and instead recommended a DHA model [19].

Desirability of a Central Decision Making Authority in MHS

Prior to the establishment of the DHA, *studies almost unanimously saw the centralization of MHS decision making authority as desirable*. The prospect of centralized leadership of the MHS debuted as early as the 1949 1st Hoover Commission when it recommended centralization of nearly all federal medical activity, including military hospitals in the U.S., under a Unified Medical Administration [8]. Despite opposing centralization, the DRMS nevertheless asserted that "stronger leadership and more aggressive management… [is] clearly warranted" [11]. The DHA feasibility study by SRA praised the centralization in the model examined as affording "opportunities for substantial improvements both in the efficiency of [the MHS][4] and the readiness of military medical support for wartime" [12]. The Grace Commission recommended that "[DoD] should… place management authority and governance of the [MHS] and its dual mission into a central health agency," arguing that "continuous, repetitive evaluation… that concentrates on the adherence to mission, quality of care, and professional development can only be accomplished from a central source of management authority" [14]. The RAND study pointed out the need for "[c]lear assignment of responsibility within the MHS and possibly a single authority" [13]. The DAM argued that DoD "must have a single accountable individual to provide medical support and ensure medical readiness," and that any savings from a structural change "will depend on the degree to which the system is placed under the management of a single, central authority" [15].

[4] SRA used the term Military Healthcare System and the initialism MHCS as was common at the time. For the purposes of clarity, the study team adopted consistent use of MHS to refer to the widest aperture of military health care functions.

By the time of the 2011 MHS Governance Task Force, whether or not a governance model afforded a "dispute resolution process and clear decision authority with clear accountability" was imposed as one of the evaluation criteria [19].

Prior to the establishment of the DHA, the separate question of *combining shared services also enjoyed widespread, though not unanimous, support* (1st Hoover, 2nd Hoover, Blue Ribbon, SRA, Grace, DAM, J/UMCWG, DBB, Task Force). In contrast, the DRMS recommended keeping the shared services decentralized, albeit with more assertive leadership out of the Office of the Secretary of Defense (OSD). However, this DRMS recommendation was made without taking "up the consolidation question" for consideration [11].

ASD(HA) Capacity for Centralized Decision-Making

Finally, related to the desirability of centralized decision-making authority in the MHS, several studies addressed the issue of *ASD(HA)'s authorities for centralized decision-making*. Some studies concluded that ASD(HA) had not exercised the full scope of their given authorities for centralized decision-making, but others disagreed and recommended strengthening the authorities, to include reorganizing the Service medical departments, held by ASD(HA). "Although widely recognized as one of the strongest charters among OSD staff activities, [the DAM argued at the time,] no ASD(HA) has elected to exert his full authority or to implement the internal organizational restructuring required for greater involvement in program management" [15]. Likewise, as already noted above, the DRMS concluded that "stronger" and "more aggressive management" by ASD(HA) was warranted, leaving as an open question, what this looks like in practice [11].

However, the Grace Commission disagreed, and recommended strengthening the office. Despite ASD(HA) formally having significant authorities over both the benefits and readiness missions, the Commission argued that a combination of delegation to the three Services and office vacancies "diluted the formal and informal authority inherent in this position," leaving the MHS "without any true central direction that would enable it to efficiently and effectively accomplish its mission" [14]. The 2nd Hoover Commission also argued that ASD(HA) at the time could be strengthened if the Surgeons General across the Services "were each to be given a reasonable comparable span of control, with adequate authority and budgetary control to carry out his responsibility" [9].

Developing a Baseline

The DHA is still evolving and maturing, with its responsibilities and authorities having been set and modified three times in the past five years. This section discusses the establishment of DHA and subsequent modifications, the issues highlighted in interviews, and how the planned DHA will be used as a baseline.

DHA Establishment and Modification

The MHS, as depicted in Figure 2 below, will have six organizations governing healthcare: OASD(HA), DHA, three Services, and the Joint Staff. Responsibilities for the primary functions of the MHS are split among these organizations, with some overlap in responsibility and possibly authorities, which may be clarified as DHA matures.

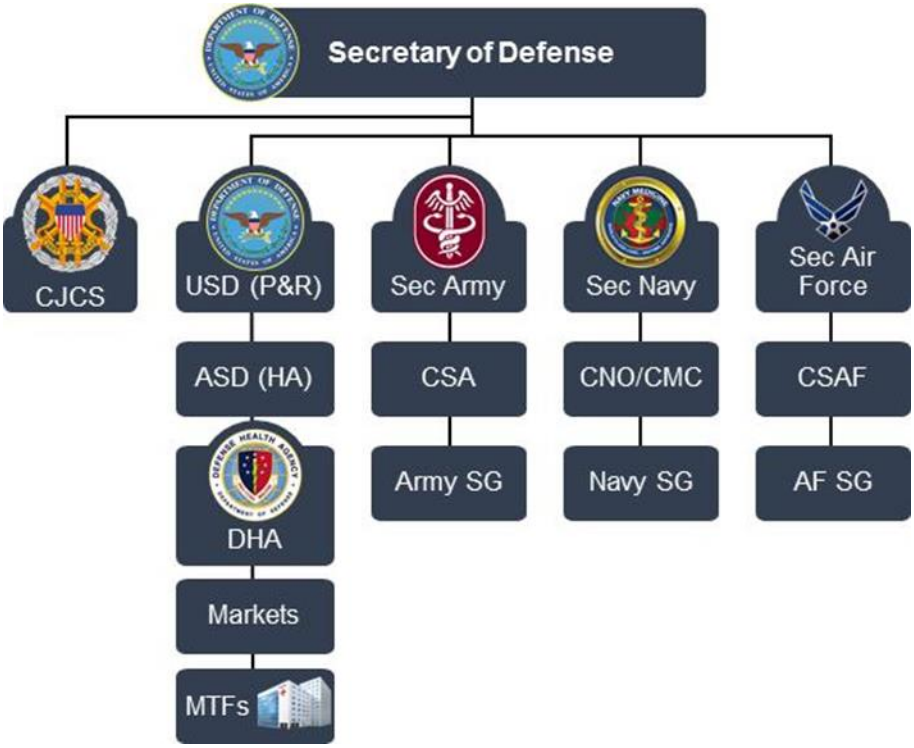


Figure 2. Defense Health Agency Construct (Baseline)

DoD Directive (DoDD) 5136.13, [21] formally established DHA as a Combat Support Agency (CSA), in accordance with DoDD 3000.06 [22]. As per the Establishing Directive, DHA took over management of shared services, including information management and information technology, medical education and training, medical research and development, facility planning, public health, pharmacy, logistics,

acquisition, and budget. DHA manages and executes the Defense Health Program (DHP) appropriation, and TRICARE. The agency prepares and submits requirements to fund health and medical activities. In addition, DHA was designated manager of the National Capital Region (NCR) MTF market. Of note, the Directive stipulates that, "the Director, DHA, must ensure that all OSD and DoD Components and non-DoD federal agencies with equity in a DHA publication are given the opportunity to coordinate when such publication is written, changed, or revised," which could be the foundational requirement for consensus decision-making among DHA and the three service Surgeons General [21].

The 2017 NDAA and the subsequent USD(P&R) Section 702 report added to DHA's responsibilities and authorities [5], [23]. First, the law required the transfer of the management of all MTFs to DHA over a two-year timeframe (later extended), including setting administrative policy and procedure, policy for provision of care, and budgetary oversight [5]. Further, for each MTF, DHA will construct and disseminate a DHA MTF Joint Table of Distribution (JTD) and will address, with the MTF Director, its capacity to address both readiness and healthcare delivery [23].

The 2019 NDAA, particularly Section 712, clarified some of the authorities with respect to supporting operational readiness. The statute stipulated that DHA was to provide venues for personnel to obtain skills needed for operational medicine and to ensure that staffing at those venues supports operational readiness requirements [1]. The Joint Staff's role is to validate those operational readiness requirements articulated by the Global Combatant Commanders. The Service Surgeons General have a myriad of tasks in support of operational readiness. These include:

1. Assigning personnel to MTFs who will then be under MTF Director operational control,
2. Ensuring medical and dental personnel and unit readiness for deployment, including logistical support, and
3. Conducting Force Development, including operational medical capabilities, a clarification of typical Service man-train-equip responsibilities.

Problems Highlighted in Interviews

Interviewees raised numerous problems with the MHS, including that it lacks a singular decision-making authority, lacks standardized policy, and grants overlapping authorities to separate entities. However, it was widely recognized that DHA is still evolving to address authorities and responsibilities granted in statute in

recent years. Accordingly, it is possible that some of the issues indicated in interviews and in the Senate's preamble to the 2017 NDAA, see Ref. [5], could be addressed without additional statutory changes, a conclusion the study team addresses in the Final Findings section.

Organizational Construct Baseline

The baseline, modeled on the planned DHA, is an integrated CSA capable of managing and supporting medical readiness goals and health care functions for the DoD. The planned transfer of MTFs currently managed by the individual Services will adjust some of the authorities and business practices that currently manage the MHS [24].

Key Roles and Responsibilities

1. Leads the MHS integration of readiness and health to deliver the Quadruple Aim: increased readiness, better health, better care, and lower cost [25]

Characteristics and Authorities

This section discusses the characteristics and authorities of DHA once DHA, as planned, has matured. Table 2 below shows the distribution of authorities in the MHS with the planned DHA construct.

The Defense Health Agency reports to ASD(HA). The agency will manage MTFs, to include clinics and other infrastructure, and has operational control of personnel assigned to MTF. In addition, DHA manages direct and purchased care, to include TRICARE, and will oversee research and development.

The Services remain responsible for Title 10-related man, train, and equip (MTE) functions, including recruiting, promotion, and discipline, as part of administrative control. In addition, Services are responsible for specialized medical training, including Service-specific needs. The Services will continue to provide forces to the Combatant Commanders in response to Joint Staff-validated operational requirements. Although the Services retain operational control and budgetary authority for medical forces assigned to operational units, their operational control over medical forces assigned to MTFs is disputed and overlaps with authorities granted to DHA in the 2019 NDAA [1].

OASD (HA) will continue to oversee the Defense Health Program (DHP), which funds medical related missions and requirements across the DoD; DHP management aid

will continue to be provided by DHA. The DHP supports readiness and health care missions through MTF funding and TRICARE management.

Table 2. Authority Distribution in MHS for Planned DHA Construct

Authority	Services	DHA (planned construct)
Man, Train, Equip Type 1 (recruiting, promotion, etc.) (ADCON)	**X**	
Man, Train, Equip Type 2 (specialty selection and training)	**X**	
Force provision to Combatant Commands	**X**	
MTF Management		**X**
OPCON of MTF personnel (assigned)	**X**	**X**
OPCON of medical personnel assigned to operational units	**X**	
Research and Development		**X**
Management of purchased care contracts		**X**
Immediate Superior		**ASD (HA)**

Cost Basis

For cost analysis, the baseline consists of the military and civilian FTE staffing levels for the DHA and Service Medical Department Headquarters and Intermediate Management Organizations (IMO), which aligns to the manpower footprint represented in the 2017 NDAA, Section 702 implementation report [24].

The details of the manpower baseline were constructed from data mined from Service Medical Manpower Zero Based Review documentation, the DHA Joint Table of Distribution file, and the FTE staffing totals in the Section 702 implementation report [24]. This existing manpower footprint was then converted to the planned manpower baseline by taking a 10% reduction against the Service Medical Department Headquarter (HQ)/IMO staffing levels following planned transfers to DHA, which aligns to the guidance in the Section 702 implementation report.

The cost of manpower was calculated using FY2018 DoD Military Personnel Composite Standard Pay Rates plus locality pay adjustments for military FTEs and

using 2018 Office of Personnel Management Civilian Salary Rates plus DoD Civilian Personnel Fringe Benefits Rates for civilian FTEs. The DHA baseline is $936M and 6,640 FTEs.

Alternative Organizational Constructs

Using the review of previously conducted studies and reviewing available information on the planned DHA Construct, the study team identified four alternative command constructs to organize and manage the defense medical readiness and health care missions. The four alternative constructs include: (1) a UMC with authorities similar to the U.S. Transportation Command; (2) a UMC with expanded authorities, to some extent analogous to U.S. Special Operations Command; (3) management of military medical mission by a single Service; and (4) a split construct with a command element focused on readiness related missions and an agency responsible for purchased and direct care missions.

These options represent a cross-section of the primary options previously considered or studied. With these constructs, the team highlight the different operational characteristics associated with different authority paradigms. To assess these constructs, the team distilled a series of ten assessment criteria (Table 3) from the key research studies listed in the previous chapter. The team then asked stakeholders, including the Study Leadership Team, Service Vice Chiefs and Surgeons General, Vice Chairman Joint Chiefs of Staff (VCJCS), Joint Staff Surgeon, and DHA Director to provide input into the pros and cons of each criterion. *Given that the constructs are all notional and are being compared against a baseline organization that is still in the process of settling out after the changes from the 2017 NDAA and given the short timeline for the study, there is not currently sufficient data to make concrete statements about many of the criteria. The assessments of the constructs are therefore more exploratory in nature, relying on input from subject matter experts about the pros and cons of each option and identifying key themes that point to opportunities for more formal data collection and analysis as the current baseline stabilizes.* Where relevant, this SME input was supplemented with findings from previous reports, though most of those reports pre-dated the 2017 NDAA and so were not always directly relevant. These assessments include an initial table that notes the highest consequence pros and cons provided by feedback, as well as a more complete table of pros and cons for each criteria as detailed by the respondents.

In addition to the pros and cons, the study team conducted an assessment of the expected costs associated with each construct, as well as an overview of any legal or policy changes that would be required to enact the construct. With regards to policy,

across all the organizational options, 10 U.S. Code (U.S.C.) 125 limits executive authority regarding certain functions, powers, or duties established by statute: "… a function, power, or duty vested in the Department of Defense, or an officer, official, or agency thereof, by law may not be substantially transferred, reassigned, consolidated, or abolished" [26]. The 2017 and 2019 NDAAs amended the U.S.C. to vest the DHA with a number of functions, powers, and duties by law. Changes, then will all require some level of statute adjustment.

The study team must also note that the following material and analysis is intended for informational purposes only and not to provide legal advice. The hypothetical command construct options are employed only as tools to facilitate the analysis and communication of concepts. This analysis does not instruct readers on what actions to take. Rather, it illustrates the dimension and nature of change that could be required. Readers with questions about how the information addressed here applies to their particular circumstances should consult their legal officers or legal counsel. Readers cannot rely on this writing as legal advice.

Furthermore, the paragraphs in this section identifying policy and legal implications intends to provide a perspective on the scope and type of changes likely required for each organizational option. It does not, however, intend to specify all the possible statutory and regulatory steps that would be required to execute each option. As a result, the analysis behind it does not constitute an exhaustive appraisal of all the applicable rules, regulations, statutes, and policies. Rather, the research sought to highlight major changes and significant obstacles.

Table 3. Construct Assessment Criteria

Criteria	Descriptions
Clear decision authority	Provide clear demarcations of authority (including accountability), for budgeting, policy, C2, personnel, etc.
Stakeholder integration	Integrate with other stakeholders
Medical readiness of the force	Maintain or enhance the ability to provide medically ready warfighters
Operational medical support	Ensure that the services have highly effective operational medical support and the medical-line relationships that this requires
Ready and deployable medical force	Sustain the training necessary to meet all requirements needed to provide a fully trained and current deployable medical force
High quality medical care to beneficiaries	Maintain or enhance the ability of the system to sustain the current high quality of health care that it provides
Impact on medical personnel	Maintain or enhance the retention and promotion rates of medical personnel
Cost savings via reduced duplication	Reduce duplication, resulting in cost savings for system operations
Cost and ease of implementation	Be implementable taking into account Title 10 equities; short-term costs and long-term savings; and decisions required inside and outside of DoD
Enhance interoperability	Facilitate interoperability amongst the Services

Unified Medical Command (TRANSCOM-like)

This command construct would manage military health related missions, to include direct and purchased care, without managing Title 10-related MTE functions currently managed by individual Services.

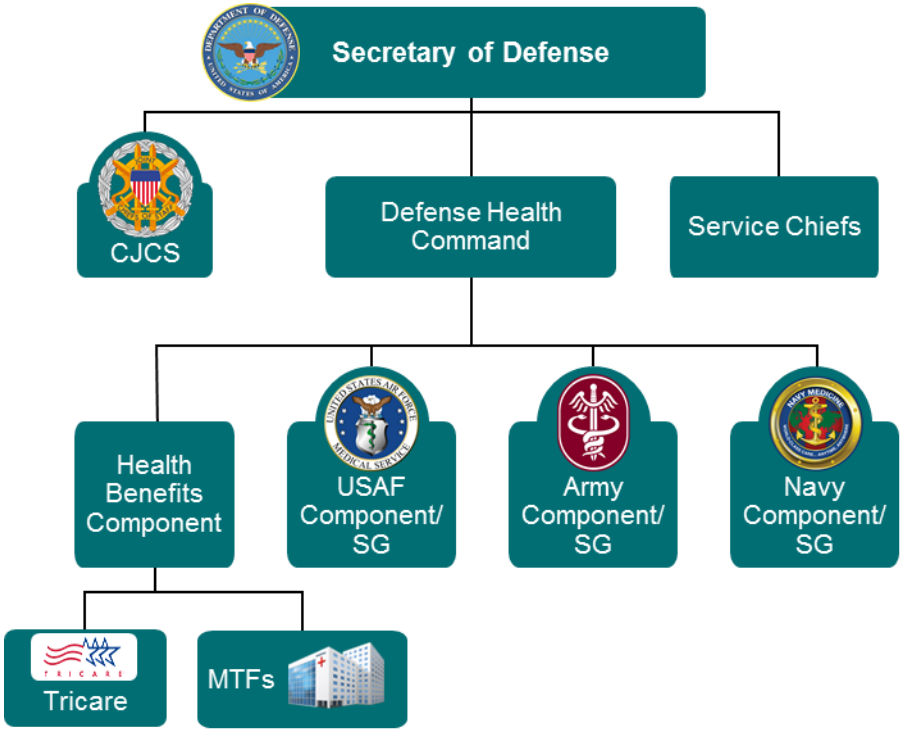


Figure 3. Unified Medical Command (TRANSCOM-like)

Key Roles and Responsibilities

1. Manage medical treatment facilities to include associated infrastructure
2. Manage direct and purchased health care for beneficiaries
3. Develop military medical readiness priorities and requirements

Characteristics and Authorities

The Defense Health Command[5] (DHC) under this construct would report directly to the Secretary of Defense and would be supported by Service component commands. The Health Benefits Component Commander would be responsible for setting priorities and requirements for the military health mission, to include direct and purchased care contracts and medical treatment facility management. The Command would also manage MTFs to include on-base clinics, associated infrastructure, and other related assets.

[5] For clarity of language, and in keeping with the requirements of the 2019 NDAA, the study team refers to the specific new command as the DHC and to the generalized construct as the UMC.

Each of the Services would remain responsible for Title 10 related MTE functions for medical personnel. Through the Service component structure, they would support the DHC by addressing overall mission and staffing requirements. The Services maintain administrative control of medical personnel and the DHC Commander would assume OPCON for those personnel assigned to MTFs. Additionally, the Services remain responsible for addressing both the requirements of the DHC and other combatant command mission requirements through the joint planning and force generation processes.

The DHP would be allocated to the DHC and align to key missions as defined and prioritized by the commander. These missions would include purchased and direct care, as well as readiness related missions that stem from the MTFs and Service specific requirements embedded units and capabilities.

Table 4. Authorities (TRANSCOM-Like)

Authority	Services	Construct
MTE Type 1 (Recruiting, promotion, etc.)(ADCON)	X	
MTE Type 2 (Specialty selection and training)	X	
Force provision to CCMD	X	
MTF Management		X
OPCON of MTF Personnel (Assigned)		X
OPCON of Embedded Personnel (Assigned)	X	
R&D		X
Management of purchased care contracts		X
Immediate Superior		SECDEF/Existing Combatant Commander (CCDR)

Formal Stakeholder Assessment

Overall, this concept was considered to have strong, but not entirely clear, lines of authority, with concerns expressed over whether it would be well suited to maintaining readiness and beneficiary care. Table 5 highlights the study team's assessment of the highest impact pros and cons of the TRANSCOM-like construct. This

assessment is informed by SME input and the literature review. The team also identified potential mitigation opportunities for the identified cons. In one instance, different respondents listed the same general assessment as either a pro or a con, depending on the perspective of their experience or their organization.

Table 5. TRANSCOM-Like Construct Primary Pros, Cons, and Mitigations

Pro or Con	Possible Mitigation Strategies
Pro: Provides a clear unity of command, while allowing Services to retain greater control of their personnel via a component structure.	
Pro/Con: Services have greater control over meeting mission-specific readiness requirements, at the risk of stovepiping.	Ensure the UMC has visibility into readiness requirements within and across Services to reduce stovepiping.
Con: There are challenges associated with managing components, including the potential to prioritize Services over the benefits mission.	Look to successful models of componency for lessons learned. Identify and clearly delineate the role of the benefits mission within the UMC and for readiness of the medical force.
Con: Respondents were mixed about having the SECDEF as the immediate superior to the Commander UMC while Service secretaries set training requirements.	Make a sub-unified command, where a parent CCMD (e.g. TRANSCOM) would be in the chain of command.

Table 6 provides a more complete overview of the pros and cons respondents provided for this construct. As in the previous table, different stakeholders occasionally viewed the same point as a pro or a con, depending on their perspectives. These points of contradiction highlight institutional and cultural challenges the MHS is currently facing in building consensus on key issues and point to spaces that need specific focus by the medical community before a full assessment can occur. These areas of concern tend to focus around issues of authority and readiness, as well as more abstract elements such as whether or not the Services would buy into this model, and are addressed more fully in the Overarching Assessment Findings section.

Table 6. TRANSCOM-Like Construct Pros and Cons (Full List)

Criteria	Pros	Cons
Clear decision authority	• Clearly defined authority, command and control • MHS elevated to joint level • Alignment of Services in component structure	• No complete unity of command • Challenges with dealing with components • Risks to line control of expeditionary capabilities
Stakeholder integration	• Service control of force provision • Component representation • Consistent with Joint world approach	• Separation of requirements across Services • Disconnect between centralized bureaucracy and Service needs
Medical readiness of the force	• Operational control of garrison care • Standardized approach to readiness • Service focus on readiness	• Loss of Service-unique line mission readiness support
Operational medical support	• Service-specific focus • Standardized approach • Common set of joint requirements	• Requirements decentralized to Service; leads to stovepipes • Challenge of managing 4 sets of requirements
Ready and deployable medical force	• Standardized requirements • Service-specific requirements met • Services focus on readiness	• Challenge of managing components • Discounting of Service-specific approaches and needs
High quality care to beneficiaries	• Standardization of care and management • Authority to direct personnel throughout the system	• Components prioritize themselves over benefit care
Impact on medical personnel	• Increased retention via more diverse opportunities • Connection to components	• Potential for inconsistent support and development of personnel
Cost savings via reduced duplication	• Significant savings via headquarters reduction	• Increased cost due to training and equipping redundancies across Services
Cost and ease of implementation	• Congressional interest • Easy sell to Services	• Stand-up and re-organization costs likely high • Difficult sell to Services
Enhance interoperability	• Increased interoperability via standardized policy and requirements	• Decreased interoperability due to inconsistent training and equipping

Cost Impacts

This command structure results in the following efficiencies and redundancies as compared against the baseline:

1. R&D / Strategic Planning: Efficiencies driven by single command structure
2. Comptroller / Education & Training: No efficiencies expected as these responsibilities remain with services
3. General HQ: Additional staff estimated as the Title 10 responsibilities remain with the services requiring additional coordination
4. Human Capital Management: No efficiencies expected as ADCON control remains with services
5. Logistics: Efficiencies already implemented with MTF transfer to DHA

For assumed redundancies of 0-20%, these changes result in an expected 2-5% increase in costs when compared to baseline. This equates to an annual cost increase of $19-$47M. Total manpower (FTEs) under this construct range from 6,785 to 6,994.

Policy Impacts

Congress has vested power in the Executive Branch to establish combatant commands. The statute, located at 10 U.S.C. §161 specifically grants that power to the President. According to that statute, the Secretary of Defense would need direction from the President to commence establishing a command using his or her authority through a DoDD. Commands created by DoDD are established by the President, through the SECDEF, with the advice and assistance of Chairman of the Joint Chiefs (10 U.S.C. 161). This is how TRANSCOM was created. President Ronald Reagan issued National Security Decision Directive 219 implementing the recommendations of the Blue Ribbon Commission on Defense Management. Specifically, President Reagan wrote, "…the Secretary of Defense will take those steps necessary to establish a single Unified Command to provide global air, land, and sea transportation" [27].

The SECDEF then issued DoDD 5158.04, later canceled and reissued as DoDD 5158.04 [28]. In that directive, the SECDEF identified and explained the relationships of the Commander of TRANSCOM with heads of DoD Components, directors of defense agencies, the services, and the larger DoD. The language used is clear and direct about the authorities and relationships amongst and between these agencies. The DoDD establishing the DHA also identifies responsibilities and relationships, but it does not vest the DHA with the kinds of authorities and relationships that DoDD 5158.04

grants TRANSCOM. Accordingly, the provisions in DoDD 5136.13 establishing the DHA would need rewriting to reflect the language found in TRANSCOM's directive better as is appropriate for a UMC. Also, regulatory references to the DHA would need to be changed to UMC as the superseding organization. Were Congress to require changes to a UMC that is established by the Executive, it would require amending and reissuing the directive.

Even though the Executive can establish a command by directive, 10 U.S.C. §125 prohibits substantially transferring, reassigning, consolidating, or abolishing functions, duties, and powers vested in the DoD or its agencies, such as DHA, by statute. It does provide that the DoD may organize itself to maximize efficiency, including transferring, reassigning, consolidating, or abolishing functions, powers, or duties vested in the DoD. However, the statute has an important exception: "a function, power, or duty vested in the Department of Defense, or an officer, official, or agency thereof, by law may not be substantially transferred, reassigned, consolidated, or abolished" by the DoD [26]. In other words, the Executive through the DoD cannot undo or change what Congress has directed by statute. Any changes to the DHA must comport with this provision.

Unified Medical Command (SOCOM-like)

This unified command construct would manage and provide health capabilities to combatant commanders, manage health benefit missions, and execute some Title 10 MTE functions currently managed by individual Services. There is a danger in the use of the SOCOM analogy that each reader may focus on a different aspect of what makes SOCOM a unique functional combatant command. The study team uses SOCOM-like to capture a force provision function and a MTE function of the UMC. The team does not provide the exact delineation of MTE functions between the UMC and the Services, noting simply that such a line can and would be drawn.

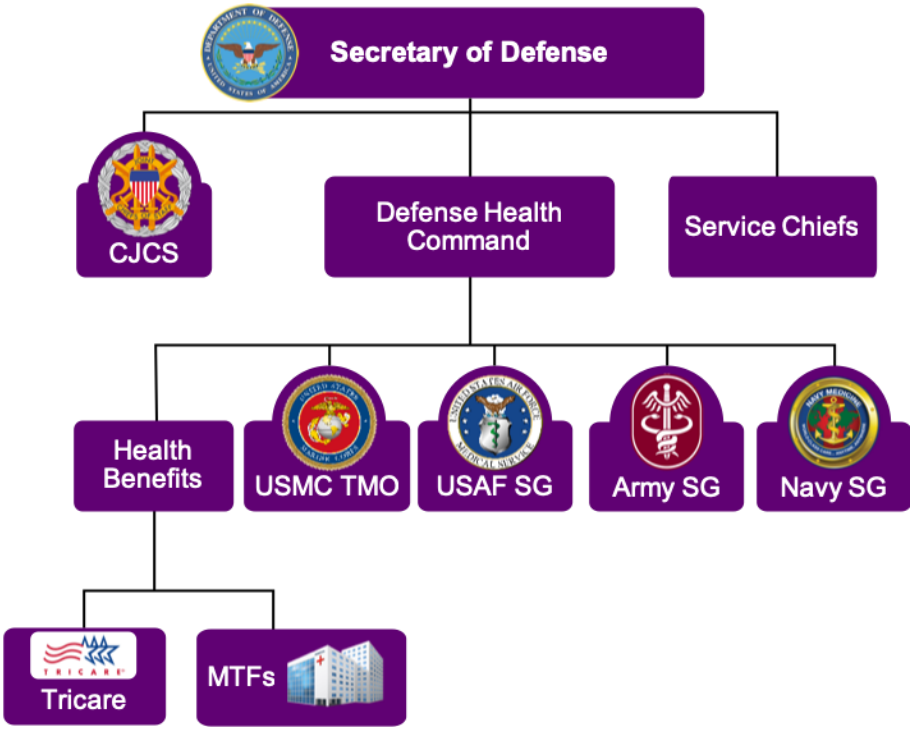


Figure 4. Unified Medical Command (SOCOM-like)

Key Roles and Responsibilities

1. Manage medical treatment facilities to include associated infrastructure
2. Manage direct and purchased health care for beneficiaries
3. Develop military medical readiness priorities and requirements
4. Plan and manage some Title 10 MTE functions for medical personnel

Characteristics and Authorities

The DHC under this construct would report directly to the Secretary of Defense and would be supported by Service component commands. The Health Benefits Commander would be responsible for setting priorities and requirements for the military healthcare mission, to include direct care and purchased care contracts and medical treatment facility management. The Command would also manage MTFs to include on-base clinics, associated infrastructure, and other related assets.

Each of the Services would remain responsible for some Title 10-related MTE functions and associated administrative control for medical personnel. However, the DHC would also assume responsibility for some Title 10 functions, such as specialty training and selection. The DHC Commander would assume OPCON for those personnel assigned to MTFs and the authority to address medical related mission requirements from other combatant commanders. Services remain responsible for coordinating and supporting the DHC Commander to address combatant command mission requirements through the joint planning and force generation processes, with The Medical Officer (TMO) of the United States Marine Corps (USMC) fulfilling a role similar to the Service SGs.

The DHP would be allocated to the DHC and align to key missions as defined and prioritized by the commander. These missions would include purchased and direct care, as well as readiness related missions that stem from the MTFs and Service specific requirements embedded units and capabilities.

Table 7. Authorities (SOCOM-Like)

Authority	Services	Construct
MTE Type 1 (Recruiting, promotion, etc.)(ADCON)	X	
MTE Type 2 (Specialty selection and training)		X
Force provision to CCMD		X
MTF Management		X
OPCON of MTF Personnel (Assigned)		X
OPCON of Embedded Personnel (Assigned)	X	
R&D		X
Management of purchased care contracts		X
Immediate Superior		SECDEF

Formal Stakeholder Assessment

Respondents widely ranked the SOCOM-like construct as having the strongest command construct for providing clear lines of authority and was not seen to diminish beneficiary care. Table 8 highlights the pros this construct has in providing

clear authority and a standardized approach to readiness and benefits, as well as concerns that Service-specific requirements might be de-prioritized.

Table 8. SOCOM-Like Construct Primary Pros, Cons, and Mitigations

Pro or Con	Possible Mitigation Strategies
Pro: This provides unity of command with clear lines of authority, a Joint approach, and standardized readiness requirements.	
Pro: Integrated readiness and benefits missions allows a single organization to take an enterprise view of the MHS.	
Con: Service- and mission-specific readiness requirements may be lost or undervalued.	Clearly delineate mission-specific requirements for readiness of the force and each role of care across and within the Services. Ensure these requirements are met.
Con: Respondents were mixed about having the SECDEF as the immediate superior to the Commander UMC and responsible for all medical training.	Make a sub-unified command, where a parent CCMD [e.g., Northern Command (NORTHCOM)] would be in the chain of command.

The full list of the pros and cons provides more nuance to some of the considerations above (Table 9). The benefit of being more Joint in nature was raised across several points, but there was a great deal of concern that Service-specific readiness and mission support would be lost in this construct. In interviews, respondents emphasized that the distinct missions within each Service generate very different readiness requirements and that maintaining those requirements is important. Others noted, though, that such a model could maintain all four sets of readiness requirements, but that the interoperability and standardization across the Services would be a benefit. Of the constructs, this one received the fewest number of cons, and so had the highest pro-to-con ratio. It was also more favorable to those who had Joint medical experience or had worked at DHA than to those who had served primarily in Service medical billets.

Table 9. SOCOM-Like Construct Pros and Cons (Full List)

Criteria	Pros	Cons
Clear decision authority	• Unity of command • Clearly defined authority, C2 • MHS elevated to joint level	• Lose C2: Accountability is best managed by Services • Inefficiencies from ADCON/OPCON split
Stakeholder integration	• Unity of effort	• Military Department (MILDEPS) disconnected • Disconnect between centralized bureaucracy and Service needs
Medical readiness of the force	• Operational control of garrison care • Standardized approach to readiness • Service focus on readiness	• Challenge of managing 4 sets of readiness requirements • Loss of Service-unique line mission readiness support
Operational medical support	• Service-specific focus • Standardized approach • Common set of joint requirements	• None
Ready and deployable medical force	• Centralized Title 10 authorities • Joint approach to care • Services focus on readiness	• Discounting of Service-specific approaches and needs
High quality care to beneficiaries	• Standardization of care and management • Authority to direct personnel throughout the system	• None
Impact on medical personnel	• Clearer lines of command • Increased retention via more diverse opportunities	• Disconnect from components • Potential for inconsistent support and development of personnel
Cost savings via reduced duplication	• Significant savings via headquarters reduction	• Unclear costs of integrating the personnel process (duty status, deployability) between Services and command
Cost and ease of implementation	• Reduced redundancies • Congressional interest	• Stand-up and re-organization costs • Air Force: formal re-alignment of personnel
Enhance interoperability	• Standardized train and equip across personnel	• None

Cost Impacts

This command structure results in the following efficiencies and redundancies as compared against the baseline:

1. Comptroller / R&D / Education & Training / Strategic Planning / General HQ: Efficiencies driven by transfer of most Title 10 responsibilities (MTE) to a single command structure
2. Human Capital Management: No efficiencies expected as ADCON control remains with services
3. Logistics: Efficiencies already implemented with MTF transfer to DHA

For assumed redundancies of 0-20%, these changes result in an expected 11-17% decrease in costs when compared to baseline. This equates to an annual cost decrease of $105-$158M. Total manpower (FTEs) under this construct range from 5,882 to 5,493. For a 20% assumed redundancy, the increased cost savings come from a further reduction in the total manpower; the smaller workforce size (5,493) is provided second to maintain consistency with the reported range of assumed redundancies.

Policy Impacts

To create SOCOM, Congress directed the President by statute at 10 U.S.C. § 167 to establish through the Secretary of Defense with the advice and assistance of the Chairman of the Joint Chiefs of Staff (CJCS) a unified combatant command for special operations. This exhibits that Congress has the authority under Article I of the Constitution to legislate a command into existence. It also demonstrates the pragmatism and practice that while Congress directs the creation of a command, it leaves the details to the executive branch. Technically, however, Congress could also legislate the details of a command. In the case of SOCOM, Congress did set a limited number of clear requirements for the command, including grade of commander, authority of the combatant commander, command activities and missions, and intelligence and special activities. These sections of the statute alternately prescribe duties the command must undertake and activities the command may not undertake. These provisions also clearly outline the special operations combatant command's relationships with geographic combatant commanders and military departments, such as who is responsible for training, acquisition, recruiting, and readiness to name a few. Any statute intending to establish a unified medical command would want to include similarly explicit definitions of relationships and responsibilities.

It bears noting that Congress can also legislate changes to a command that it directs to be established. For instance, the changes made to DHA's mission and the military health system in the 2017 and 2019 NDAAs did precisely that in the context of a CSA. Like with the statute establishing a command, it would likely again take the practical form of Congress instructing the executive to institute a new requirement in the way it determines best.

The current DoD Directive establishing the DHA does not define duties and relationships as clearly as the statute directing the establishment of SOCOM. Specifically, paragraphs 5.a.(15) to 5.b. would need rewriting to more clearly establish and articulate the duties, activities, authorities, and responsibilities of a UMC in the model of SOCOM. Paragraphs 5.a.(1) to 5.a.(14) would require less rewriting as they more clearly outline the benefits mission of DHA. However, they would have to be rewritten to incorporate the changes required by the 2017 and 2019 NDAAs. If Congress were to make further changes in later NDAAs, those changes can be implemented in the U.S.C. by Congress and implementation carried out by the Executive.

Taking the approach of establishing a command by statute would comport with 10 U.S.C. §125. That statute provides that the DoD may organize itself to maximize efficiency, including transferring, reassigning, consolidating, or abolishing functions, powers, or duties vested in the DoD. However, the statute has an important exception: "a function, power, or duty vested in the Department of Defense, or an officer, official, or agency thereof, by law may not be substantially transferred, reassigned, consolidated, or abolished" by the DoD [26]. In other words, the Executive through the DoD cannot undo or change what Congress has directed by statute. Any changes to the DHA must comport with this provision.

Single-Service Command

The single-Service command construct would shift the management of defense health resources, personnel, and facilities under a single selected Service. The selected Service would manage defense medical missions including medical treatment facilities and readiness related activities and requirements. The JHU/APL study team does not make a recommendation of which Service is the preferred for medical personnel, but do note that all three [USMC is exempted] had champions for why each made the most sense.

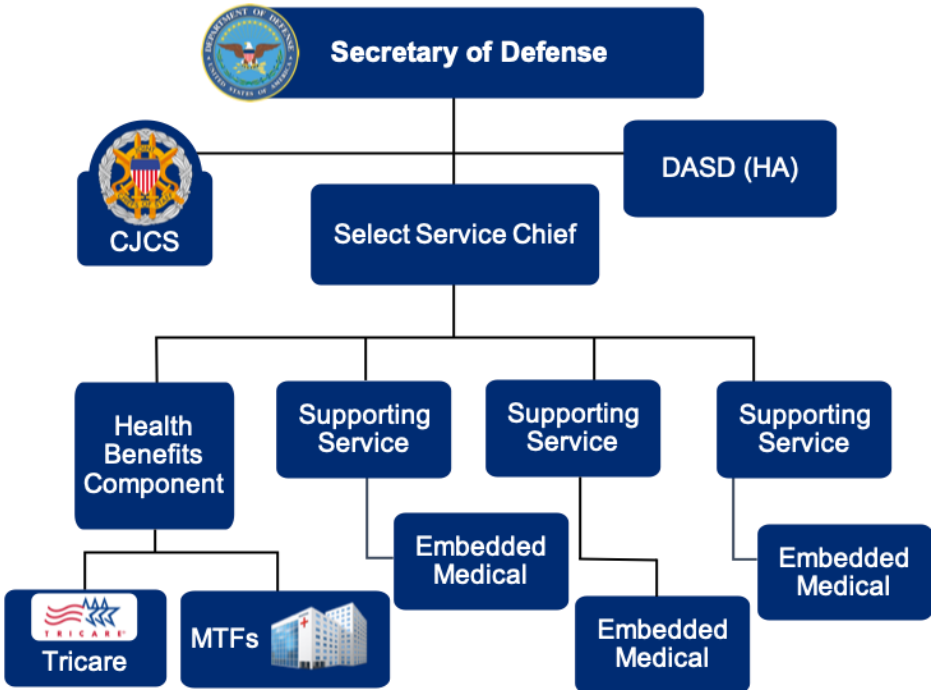


Figure 5. Single-Service Command Construct

Key Roles and Responsibilities

1. Manage MTFs to include associated infrastructure
2. Manage direct and purchased health care for beneficiaries
3. Develop military medical readiness priorities and requirements
4. Plan and manage Title 10 MTE functions for medical personnel

Characteristics and Authorities

The selected Service would assume responsibility for all Defense Health-related activities and requirements, to include MTF management, readiness missions, and direct and purchased care. The selected Service would support the medical requirements and missions of the other Services and coordinate with them to ensure their individual mission requirements are sustainably addressed. The medical command element within the selected Service would report to the Service Chief and would be supported by the other Services through a component structure, for handling those personnel who choose to specialize in a sister-Service's operational medicine.

The selected Service, in coordination with the CJCS and the supporting Services, would be responsible for addressing defense medical missions including emergent

combatant command mission requirements. The selected Service would assume administrative and operational control of medical personnel with the exception of those assigned to specific embedded units within the other Services. Additionally, medical personnel assigned to operational environments would shift to the operational control of the receiving command. Title 10 MTE functions for medical personnel remains with the managing Service.

The DHP would support the requirements developed and programmed by the selected managing Service, to include those associated with MTF management, personnel, and managed and purchased care.

Table 10. Authorities (Single-Service)

Authority	Services	Construct
MTE Type 1 (Recruiting, promotion, etc.)(ADCON)		X
MTE Type 2 (Specialty selection and training)		X
Force provision to CCMD		X
MTF Management		X
OPCON of MTF Personnel (Assigned)		X
OPCON of Embedded Personnel (Assigned)	X	X
R&D		X
Management of purchased care contracts		X
Immediate Superior		Service Secretary

Formal Stakeholder Assessment

The single-Service construct has been previously considered and is widely considered to be the most efficient or having the most potential for cost savings. Additionally, previous studies concluded that this option would likely provide the most clarity of command for medical missions. Respondents were more cautious, however, noting that while this construct provides strong unity of requirements, it does so at the potential cost of Service culture and Service-specific requirements, as well as care in remote locations.

Table 11. Single-Service Command Construct Primary Pros, Cons, and Mitigations

Pro or Con	Possible Mitigation Strategies
Pro: Paraphrasing one interviewee, this is the most efficient way to create an integrated system, by providing unity of command with clear lines of authority, and standardized readiness requirements.	
Con: Service- and mission-specific readiness requirements, as well as Service culture, may be lost or under-valued.	Clearly delineate mission-specific requirements for readiness and each Role of care. Find opportunities to develop Service culture for medical personnel.
Con: Coordination in remote MTFs without multi-service markets might be insufficient.	Ensure Service takes an enterprise view in balancing all aspects of the readiness and benefits missions, or find non-military alternatives.
Con: Having one Service Secretary as the superior to the Commander UMC and responsible for all of training was seen as potentially introducing a Service bias.	Implement a Separate Service Construct, where a new Service Secretary would be appointed solely for this service.

As with previous constructs, some respondents appreciated the standardized approaches to readiness the single-Service construct would create. There was some disagreement about the impact on command and control (C2) and on personnel, with some suggesting that more variation in assignments such an option would afford would help with retention, while others were concerned that people who join the military to be a part of a specific Service would be less likely to choose a medical path. The main concern that appeared across several criteria, though, was that a single-Service construct would create bias against the culture and mission-specific requirements of the other Services. As noted above, a separate Service model might alleviate that concern, but the approach would still need to be carefully considered.

Table 12. Single-Service Command Construct Pros and Cons (Full List)

Criteria	Pros	Cons
Clear decision authority	• Clearly defined authority, C2 • Paraphrasing one interviewee, this is the most efficient way to create an integrated system	• Challenge to handle other Service-specific requirements • Variations of different Service force structures • Lose C2: Accountability is best managed by Services
Stakeholder integration	• None	• No Service buy-in • No natural integration in providing direct support to Services
Medical readiness of the force	• Standardized approach to readiness • Service focus on readiness	• Inter-Service discrepancies in readiness definition • Recent agreement that Services are responsible for readiness
Operational medical support	• Centralized Title 10 authorities • Standardized KSAs, currency, and support for deployments	• Potential bias from lead Service • Lack of link to meet non-lead Service requirements
Ready and deployable medical force	• Greater joint opportunities • Standardized KSAs, currency, and support • Services focus on readiness	• Potential bias from lead Service • Lack of link to meet non-lead Service requirements
High quality care to beneficiaries	• Unified health care delivery • Standardization to maximize care delivery	• Coordination in places with no multi-service market • Continuity of management
Impact on medical personnel	• Increased retention via more diverse opportunities • Playing field leveled across MHS in the long term	• Potential bias from lead Service • Culture change for Service medics • Potential for inconsistent support and development of personnel
Cost savings via reduced duplication	• Significant savings via reduced redundancy	• Need for Service liaisons
Cost and ease of implementation	• None	• Long lead time to implement • High implementation costs • Service resistance
Enhance interoperability	• Standardized train and equip across personnel	• Potential bias from lead Service • Loss of unique understanding and trust with other Services

Cost Impacts

This command structure results in the following efficiencies and redundancies as compared against the baseline:

1. Most functions are estimated to have redundancies due to the authorities going under a single command

For assumed redundancies of 0-20%, these changes result in an expected 17-28% decrease in costs when compared to baseline. This equates to an annual cost savings of $157-$263M. Total manpower (FTEs) under this construct range from 5,528 to 4,781. As with the SOCOM-like construct, the smaller workforce size (4,781) is provided second to maintain consistency with the reported range of assumed redundancies.

Policy Impacts

This construct would require significant statutory and regulatory changes to Service responsibilities. Currently, each service handles the administration and support of its personnel, including but not limited to recruiting, training, pay, advancement, and education. In this construct all the medical personnel across the services would fall under one service. Accordingly, all the responsibilities currently administered by each service for medical personnel as personnel of that service would have to be transferred over to the selected Service. This would also implicate service budgets.

Such a change also implicates civilian personnel that support services. Statute 10 U.S.C. §126 provides that the Secretary of Defense can, in the context of civilian personnel, transfer a "function, power, or duty or an activity" from one department or agency to another within the Department of Defense [26]. Regarding funding such a change, the appropriations that the Secretary of Defense determines are available and needed may be used for the purposes of their original appropriation. Regarding relationships between service personnel changes MTFs, 10 U.S.C. § 1073d requires that the Secretary of Defense ensure that all covered beneficiaries maintain access to healthcare services through TRICARE if a restructure, realignment, or modification to a MTF eliminates access to health care. It is, therefore, the responsibility of the Secretary of Defense to ensure that if moving all medical personnel into one service eliminates access to healthcare at a MTF, it be available to beneficiaries through TRICARE.

While 10 U.S.C. § 126 provides for transferring a function, power, or duty or activity of a department or agency for civilian purposes, 10 U.S.C. §125 addresses the same for military personnel, departments, and agencies. It provides that the DoD may

organize itself to maximize efficiency, including transferring, reassigning, consolidating, or abolishing functions, powers, or duties vested in the DoD. However, the statute has an important exception: "a function, power, or duty vested in the Department of Defense, or an officer, official, or agency thereof, by law may not be substantially transferred, reassigned, consolidated, or abolished" by the DoD [26]. In other words, the Executive through the DoD cannot undo or change what Congress has directed by statute. Any changes to the DHA must comport with this provision.

Unified Medical Command and Defense Health Agency

This construct would divide the management of military medical missions between a command element for readiness related missions and an agency responsible for the administration and management of direct and purchased care.

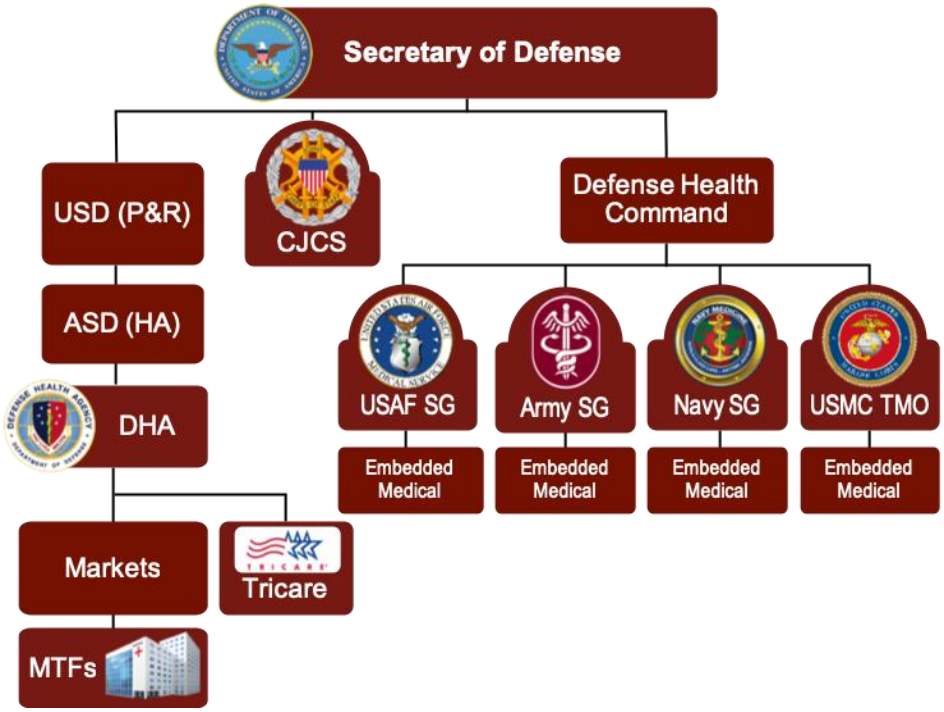


Figure 6. Unified Medical Command and Defense Health Agency

The split construct was previously considered in the studies the team reviewed. The conclusions suggested that this construct would allow for focused management of the health care and readiness missions. However, the prior studies noted that splitting the defense health mission between two separate entities, any efficiencies realized or potentially realized would likely be negated by this approach.

Key Roles and Responsibilities

1. Manage military medical missions through tailored command and agency components
2. Manage direct and purchased health care for beneficiaries with a focused DHA
3. Manage operational medical missions and readiness focused functions with a DHC

Characteristics and Authorities

This construct would divide the overall defense medical missions between the command element and an agency. The agency would primarily manage direct and purchased care, to include TRICARE and manage medical treatment facilities to include clinics and other infrastructure. The agency element would report to the ASD(HA) and the Undersecretary of Defense for Personnel and Readiness.

The command element would have responsibility for managing readiness-related missions and addressing emergent combatant command mission requirements in coordination with the agency and Services. Contrasting the agency element, the DHC would report directly to the Secretary of Defense and would be supported by the Services through a Service component structure.

Each of the Services would retain the Title 10 MTE functions for their respective medical personnel. However, the command element assumes some specific training responsibility for medical personnel, and the agency retains tactical control of personnel assigned to MTFs.

The DHP would be split between the command element and agency based on their resource needs. For example, the agency would receive resources supporting TRICARE management while the command element would receive those resources associated with readiness related missions and some MTE requirements.

Alternatives to this construct could consider creating a separate medical service rather than implementing a component model or utilizing a single-Service construct.

Table 13. Authorities (UMC and DHA)

Authority	Services	Agency	Command
MTE Type 1 (Recruiting, promotion, etc.)(ADCON)	X		
MTE Type 2 (Specialty selection and training)			X
Force provision to CCMD			X
MTF Management		X	
OPCON of MTF Personnel (Assigned)			X
OPCON of Embedded Personnel (Assigned)	X		
R&D		X	
Management of purchased care contracts		X	
Immediate Superior		ASD(HA)	SECDEF

Formal Stakeholder Assessment

The split construct was previously considered in the studies we reviewed. The conclusions suggested that this construct would allow for focused management of the health care and readiness missions. However, the prior studies noted that splitting the defense health mission between two separate entities, any efficiencies realized or potentially realized would likely be negated by this approach. The respondents for this study generally thought this construct provided the highest quality of beneficiary care, but potentially at the cost of meeting Service needs and maintaining the readiness of the medical force. Several emphasized that while the current MTF structure alone is not sufficient for meeting readiness needs, nor is relying entirely on partnerships with civilian institutions, and this construct would make the necessary integration with the MTFs more challenging.

Table 14. UMC and DHA Construct Primary Pros, Cons, and Mitigations

Pro or Con	Possible Mitigation Strategies
Pro: The benefit mission will improve due to being the DHA's sole focus and the DHA's ability to find efficiencies.	
Pro: The Services and a single command structure will be devoted to readiness.	
Con: Separate commands risks losing the cultural and practical ties between the readiness and benefits missions.	Cleary delineate the readiness requirements fulfilled by the MTFs and ensure those ties and the related authorities are in place to enable readiness.
Con: Respondents were mixed about having the SECDEF directly oversee all readiness and training issues for the UMC.	Create a sub-unified command with a parent CCMD in the chain of command for the UMC or remove the command structure for the Service side.

In general, the respondents' cons largely outweighed the pros in their responses to this construct along the criteria. Though respondents largely approved of the Service control of readiness in Command, they seemed to suggest that the disassociating the two elements and its negative impacts both operationally and culturally outweigh those pros.

Table 15. UMC and DHA Construct Pros and Cons (Full List)

Criteria	Pros	Cons
Clear decision authority	• Clear authority over benefit mission • R&D placement aligned to policy (ASD(HA))	• No unity of command • Benefit and readiness missions are intertwined • Lose C2: Accountability is best managed by Services
Stakeholder integration	• None	• Increased stovepiping • Requirement for a separate medical service • No accounting for Service-specific needs

Criteria	Pros	Cons
Medical readiness of the force	• Service focus on readiness • Command structure for managing defined readiness	• Increased difficulty in maintaining readiness • Absence of Service culture in benefit delivery • Competing priorities
Operational medical support	• Service control in support of mission sets	• Diminished support • DHA support for UMC only during contingency ops
Ready and deployable medical force	• Service focus on readiness • Command structure for managing defined readiness	• Increased difficulty in maintaining readiness • Discounting of Service-specific approaches and needs • Competing priorities
High quality care to beneficiaries	• Improved care due to complete focus • DHA ability to find efficiencies	• No way to leverage the system to solve challenges
Impact on medical personnel	• Potential for more opportunities • Joint career enhancement opportunities	• Decreased retention if no full-time MTF opportunities • Challenges in rotating between distinct missions
Cost savings via reduced duplication	• Reduction in direct and purchased care • Differentiation of costs between missions • DHA ability to find efficiencies	• Increased requirements
Cost and ease of implementation	• Service buy-in	• High cost of implementation of two HQs
Enhance interoperability	• None	• Increased layer of bureaucracy to navigate • No perceived change to interoperability

Cost Impacts

This command structure results in the following efficiencies and redundancies as compared against the baseline:

1. No efficiencies expected to DHA staff as command structure is similar to baseline
2. Comptroller / R&D / Education & Training / Strategic Planning: Efficiencies to service staffs driven by transfer of some responsibilities to a single command structure
3. General HQ: Additional staff estimated as the ADCON and OPCON responsibilities remain with the services requiring additional coordination

For assumed redundancies of 0-20%, these changes result in an expected 0-1% increase in costs when compared to baseline. This equates to an annual cost increase of $4-$9M. Total manpower (FTEs) under this construct range from 6,671 to 6,742.

Policy Impacts

The issues regarding establishing a command that were discussed previously would also apply in this scenario. Unlike in those scenarios, this approach would require separating the portions of the DHA Directive that deal with the benefits mission and the readiness of medical forces mission. It would then require new or reissuance of statutes and directives. Congress can direct establishment of a Unified Medical Command or the President can require its creation, and the President has authority under 10 U.S.C. § 191 to "provide for the performance of a supply or service activity that is common to more than one military department by a single agency of the Department of Defense" [26]. Even though a DoD directive already exists establishing the DHA, it would have to be assessed, amended, and reissued. Another option would be to cancel the existing directive and issue a new one that more clearly explains the DHA's authorities and relationships with other DoD elements, including the services, and in this scenario especially the newly established Unified Medical Command.

Recall that 10 U.S.C. §125 places an important limitation on the DoD's ability to organize its elements: the DoD cannot substantially transfer, reassign, consolidate, or abolish a function, power, or duty vested in the DoD or an agency thereof. The 2017 and 2019 NDAAs imposed functions and duties on the DHA, which is a defense agency. Accordingly, for functions and duties currently assigned to the DHA by statute Congress would need to write legislation to substantially transfer, reassign, consolidate, or abolish them. For instance, the functions, duties, and powers vested in

the DHA by 10 U.S.C. § 1073c, Administration of DHA and military medical treatment facilities, would require a statute by Congress to change; 10 U.S.C. § 125 prohibits the DoD from doing that alone.

Overarching Assessment Findings

In addition to offering insight into the specific constructs, several themes emerged from the responses and input the study team received. This section addresses some of those overarching findings and their implications.

Response Trends

One of the major themes that arose in interviews was that a respondent's background often had a large influence on whether or not they more generally supported the concept of the DHA being superseded by a command or even the DHA having the level of responsibility it was granted in the 2017 NDAA. Respondents with DHA or Joint medical experience tended to be more favorable overall toward a Command construct and the current DHA organization. Respondents with primarily Service medical experience tended to be more Service-oriented and more cautious about whether a Command or the current DHA organizational structure could meet authority or readiness needs. These differing perspectives led to some of the discrepancies noted in the options assessment sections in the previous section, Alternative Organizational Constructs.

In numerous cases, individuals with primarily Service medical experience suggested that this issue is partly due to a lack of trust in the DHA to function effectively and meet the needs of all stakeholders. It was not that they openly distrusted the organization, but that building such institutional trust takes time, and the DHA has not yet had the opportunity to fully implement its new responsibilities or work through the inevitable challenges organizational change engenders. Respondents suggested that the question of whether to further alter the MHS by creating a command is a premature one, as it is too early to tell whether and how the DHA will ultimately be able to meet stakeholder needs.

However, personal experience was not the only element that had an impact on the discrepancies in the responses. Numerous respondents noted that asking about whether a particular organizational concept could adequately meet readiness needs, for instance, was unanswerable because no two organizations had a consistent definition of what readiness entails. Interviewees said that this gap is partly due to the fact that readiness has multiple meanings in the medical context (see below), but

also to readiness requirements and measurements being unclear and different within and across different aspects of the MHS. Coordination is currently on-going to address that definition gap, but its current status means there is no ready way to assess current or notional constructs against these criteria. Respondents suggested that for this and some of the other assessment criteria, it would be best to wait until a more standardized definition is developed with clear metrics before making such an assessment, which the study team has therefore included here as a recommendation.

Clear Decision Authority

One of the primary points of disagreement on whether the various constructs provided options for clear decision authority was over C2. Respondents with primarily Service medical experience felt strongly that accountability and C2 over personnel is best managed by the Services directly and any construct that limits that control will have a negative impact. Conversely, other respondents thought that some of the constructs offered increased C2, along with clearer lines of authority. Several respondents, however, suggested that because the DHA's current set of authorities is not clear to all involved and because the constructs as presented are strategic in nature, it might be useful to host a tabletop exercise with key stakeholders to map authorities down to a much more tactical level and use that to better assess options for alternatives. While still qualitative, this approach would allow stakeholders to have direct input into identifying, defining, and shaping the authorities they feel are essential for their organizations.

In addition, to better assess whether a given construct might provide clear decision authority, future studies would need information and data on the relationship between C2, discipline, and command roles for each of the Service medical elements and other MHS organizations. These data should ideally provide a historical and current perspective in order to establish a baseline and possible trend lines. If necessary, similar data from other low-density military specialties could be used to provide comparisons.

Stakeholder Integration

Only the TRANSCOM- and SOCOM-like constructs received any positive input for their ability to integrate stakeholders, and each of those options also had numerous perceived cons. The aforementioned tabletop exercise might help to clarify some of these relationships and how different constructs would manage them.

Readiness

The two readiness criteria (medical readiness of the force and readiness of the medical force) were easily the most complicated and divisive portion of the assessment. Though they are broken out in the assessment, respondents repeatedly reported that the two are inherently intertwined, which prompted them to be cautious about the split service construct. As noted above, respondents also identified that defining readiness is complex and not necessarily standardized between the elements of the MHS. Some saw the potential for such standardization as being one of the benefits of a command model, but others worried that doing so would lose the Service- and mission-specific components of readiness that might be unique within certain medical communities.

To get around this challenge of definitions, this study team recommends the key stakeholders within the MHS work to develop clear definitions of both readiness of the medical force and medical readiness of the force within and across the Services. Doing so would enable more objective measures and analysis insights, as data about readiness could then be more directly measured and compared. Measures such as Individual Medical readiness and rates of prevalence and counseling for obesity, tobacco cessation success, and routine wellness and screenings would provide an initial baseline for medical readiness of the force as noted in other studies [19].

More complicated is defining measuring the readiness of the medical force. MTF utilization rates and graduate medical education rates have been suggested as metrics in the past [19], but could be broadened substantially. For instance, the primary tie between the beneficiary portion of the MHS and the readiness portion is that medical forces use experience in MTFs to maintain their professional skills. However, as multiple interviewees noted, MTFs are necessary, but not sufficient for maintaining the full range of required skills, mainly because they often do not provide enough opportunities to work in trauma. The Air Force, in particular, cited partnerships with various civilian medical institutions to supplement their readiness needs, which are also necessary but not sufficient for achieving full readiness. When assessing options for the MHS, it would be useful to have standardized data on the levels of utilization, necessity, and sufficiency of relying on MTFs and civilian institutions for achieving readiness. Such data, though, would have to account for any changes due to the MTF consolidation under the DHA, and so past data may not be entirely reliable for forecasting future performance. Additionally, location would have to be accounted for, as the remoteness of some MTF locations that might lack access to local civilian care alternatives may be inherently more or less efficient at helping to meet readiness standards due to that limitation. There may also be a range of Service- or mission-specific readiness metrics. These various roles should be

concisely and consistently defined to improve comparison between the Services, as should manning requirements and fill rates of medical personnel to highlight gaps in the force.

Operational Medical Support

As with readiness, there were some discrepancies in the assessments of the impacts of the various constructs on operational medical support, primarily in the form of a divide between whether respondents thought a more standardized and Joint approach to care was better or worse than that responsibility resting fully in the hands of the Services. The disagreements on this appeared to depend on culture and experience more than other variables, and apart from measuring rates of operational care, most metrics related to these criteria would likely be the same as those for readiness.

One major point that was raised in relation to operational medical support, though, was that it also has a strong trust component. Interviewees stressed that it is imperative for a unit to trust their embedded medical personnel, which they stated is largely derived from exposure and experience to those personnel. Consistently working, training, and deploying with the same individuals over the course of a tour allows the medical force to have better relationships with their team, improving trust and ultimately the quality of care in the field. While trust is notoriously difficult to measure, there have been efforts to measure trust in patient-physician relationships [29], and it might be possible to implement a similar metric for the MHS and develop correlations between that trust and quality of care. Doing so would allow the Services to establish whether or not there is a strong case for organizational constructs that would provide operational medical support based on relationship-building.

Beneficiary Care

In general, most respondents thought that the various constructs would not have major impacts on beneficiary care, with the exception of the split service construct. Many of the pros they listed about standardization and identifying efficiencies via reducing redundancies are likely to also be accomplished through the consolidation of the MTFs under the DHA. The only major concern raised was for quality of care in remote locations if a more centralized model would wind up de-prioritizing such locations. To best assess the impacts on beneficiary care, the study team recommends conducting a baseline assessment of care and efficiencies once the consolidation under DHA has been finalized, both in major markets and in remote locations. That could then be combined with metrics for quality of care such as rates of routine wellness and screening, surgery errors, hospital readmission, access and wait times,

satisfaction with care, prevalence and counseling for obesity, and tobacco cessation programs to provide a holistic measurement of beneficiary care provision and how organizational change might impact it [19], [30].

Impact on Personnel

Changing the organizational structure has the potential to affect medical personnel and their outlook for accession, retention, and promotion. Assessment respondents were fairly consistent in that they considered command structures to be positive for personnel as it might offer them opportunities to work in more diverse setting and to serve in Joint billets. They were concerned, though, that various command constructs would disconnect personnel from their Services, provide inconsistent support, or deny them access to the Service culture they joined. Historical and current data on medical accession, retention, and promotion rates and manning requirements and fill rates under various organizational modes in the past might help to forecast the impacts of future changes on personnel. These data could be analyzed against personnel who had more billets in Joint or diverse environment settings to see if there is a correlation between the two.

Cost Savings

With the exception of the split construct, respondents considered each of the other three options to be likely to involve significant cost savings particularly through reductions in headquarters requirements. Some respondents did note, though, that the TRANSCOM-like construct might increase costs through the need for components to maintain separate train and equip capabilities in addition to the command structure. However, though cost and personnel reductions are generally expected in the case of the development of and consolidation under a command, SOCOM's initial stand-up proved to be an exception to that case. A 1990 GAO report showed that there was actually an increase in staff authorizations at both the Command and at component headquarters in the years following its creation in 1987 [31]. Similarly, the Canadian armed forces reversed its decision to unify partly due to a lack of financial savings, combined with deleterious effects in operational effectiveness, flexibility, and rapid decision-making. Conversely, the German Joint Medical Service was able to achieve cost reductions following the unification of disparate medical services by limiting redundancies. However, doing so required strong centralization with a single point of accountability combined with financial control, something only strongly replicated in the single-Service construct presented here. Even so, the 2006 CNA report cautions that there are numerous other institutional, organizational, and cultural issues that can lead mergers to fail and, additionally, the German model does not have to account for the provision of beneficiary care [7].

To best measure and predict cost savings, a post-MTF consolidation baseline would need to be established, and then historical and current data would need to be collected on shared services, health care operations, infrastructure, IT, personnel, short vs long-term savings, per capita costs, military health construction rates, and use rates of facilities. In addition, the staffing of existing HQs, intermediate commands, and field activities of Health Affairs, TRICARE management, and surgeons general officers will provide additional baseline information [19], [20], and [30].

Cost and Ease of Implementation

In the TRANSCOM-like and SOCOM-like constructs, respondents noted that implementation costs would be somewhat offset by being able to use current DHA facilities and services as a starting point for creating any headquarters. These two constructs were also seen as having the highest levels of Congressional buy-in, which would make for an easier decision, though Air Force respondents cautioned that the SOCOM-like construct would require a formal realignment of Air Force personnel, since they currently operate under a different model than the other Services. Respondents were divided as to whether the single-Service construct would be more or less palatable for the Services, and also noted there would be high expenses involved with preparing one service (or a new service) to be responsible for all medical forces. The split construct was largely perceived as having among the highest implementation costs, as it would require standing up two headquarters, only one of which would likely leverage current DHA elements. Data on moving costs, construction costs, IT, and personnel severance will help further inform the impacts of implementing a command.

Interoperability

Most respondents agreed that the various command structures would increase medical interoperability between the Services due to standardization, but were concerned that increase would come at the cost of maintaining Service-specific requirements. Interoperability is notoriously difficult to measure [32], but some methods are available that might be leveraged to derive metrics and data that would be relevant to the medical community [33]. In addition to those, the concise and consistent description of requirements for all medical roles would help improve assessments and rates of interoperability.

Final Findings

The Military Health System is unique in the U.S. in terms of its scale and its combination of direct care, purchased care, research and development, and command and control. This strength provides the flexibility for efficiencies where possible, while maintaining surge capacity and capabilities to be ready for the risks associated with war. A study of the organizational options should not lose sight of the importance of maintaining these strengths when seeking ways in which the system could be improved.

The study team does not make any recommendations in this report, nor can it safely be said that one organizational option is strictly dominant on all metrics. As shown in the section Alternative Organizational Constructs there are pros and cons to each option. However, through the course of this analysis and interviews, several themes were identified that do not pertain to any individual construct. These themes apply as much to the current DHA in the flux of the transition prescribed in the 2017 NDAA as they do to any of the proposed constructs.

Finally, a central challenge of a military health system is how do we project the battlefield needs of medical care? The fact that this is a difficult problem should not dissuade the U.S. from using the tools at its disposal to make progress towards an ever-improving system of care and readiness. This study serves as the first exploration of the question of organization of the MHS in the wake of the disruptions of the creation of the DHA and the transfer of MTFs with the 2017 NDAA. The study team aims here to provide guidance to the Services and DHA on how they can improve data-collection efforts in support of future analysis of possible changes to the system, so that these assessments can supplement expert opinion with quantitative evidence.

Is this the right time?

A common theme among interviewees was that DHA has not been given enough time to mature. Similar points to this refrain included criticisms of introducing more uncertainty into a system that is already in upheaval and comparisons to the Defense Logistics Agency, which has had over 40 years to demonstrate success and earn the Service's trust. Time itself is unlikely to resolve the churn in the MHS, and so valid questions remain on how to make that time productive and stabilizing.

First, the results presented in this analysis compare the expectations of what DHA will look like when the transition of MTFs is completed to four notional command constructs. There are therefore, necessarily, large error bars on any transition from the DHA as it existed at the time of study to each of the four command organizational

options. Given the disruption of the current transition, any subsequent detailed analysis of the best organizational structure for the MHS should be conducted after the transition of the MTFs to DHA. This delay allows for the system to stabilize and enables detailed identification of relevant authorities and responsibilities that may be impacted by a transition. System stabilization also allows for identification of new challenges and issues that may be addressed by the command constructs identified here that do not present in the current system.

Organizational maturity of DHA is not solely a reflection on the agency, but is also a function of the Department and Services adjusting their processes in response to DHA authorities and responsibilities. Essentially, the full system has not yet adjusted to the perturbations of DHA formation in 2013 and transition of MTF management beginning in 2017. As identified in the Overarching Assessment Findings section, this was expressed initially as a lack of trust in the Agency before being restated as a systemic problem of which DHA is also a victim. It should be noted however, that upon further questioning this was clarified as an issue of time to build trust and not a function of Agency action or an expression of distrust. Interviewees noted that the DHA has been given a monumental task and that successful performance of that task may negate some of the pressures to consider further organizational change.

Finally, the time to maturity is not an existential function, but a question of productive effort towards a well-defined goal. A challenge for the DHA is that repeated organizational churn and the accompanying chaos of uncertainty threaten to continue to delay full integration and maturity. Interviewees noted that there is a constant drumbeat of new proposed organizational structures and news reports of a merger between DHA and VA [34]. This can create a sense that the plan and direction are unsettled and therefore there is benefit in stalling to ensure efforts at change are not wasted.

What is the right question?

In addition to the question of whether the timing was right for an analysis of organizational options, nearly every interviewee and questionnaire respondent noted that it is unclear what questions this analysis was attempting to answer. On similar lines, concern was expressed as to whether the question of command vs. agency adequately captures organizational incentives related to readiness, beneficiary care, and risk management. The study team addresses both themes here.

“What problem are we trying to fix?” was a consistent feature of the study team’s interactions with stakeholders, while the answers varied widely. Some thought costs were the driving factor behind the 2019 NDAA call for a study of command options,

others clarity of authority, and still others concerns about readiness and lethality. The title of the section provides little insight into the motivations, calling simply for a "report on [the] feasibility of superseding organization for DHA" [1]. There was no clear or consistent answer across stakeholders, in no small part because, as mentioned, the MHS is currently in a state of flux as it continues to evolve after the changes of the 2017 NDAA. Having a more clearly articulated driving force behind any organizational assessment will better allow respondents and stakeholders to make informed inputs into the process, and will help define the right metrics for assessment and ultimately allow decision-makers to appropriately weight the various criteria used in the analysis.

Additionally, there were numerous other concerns that factors external to the system can impact any given construct; it is not clear whether the driving forces behind the analysis emphasizes or acknowledges these concerns. For instance, an Agency director and a Commander both would face similar incentive structures for balancing efficiency and risk management within the MHS as a whole. This issue is different than the question of underlying problem we solve with a command construct, instead focusing on whether questions about organizational structure address the right MHS challenges.

Recurring concerns related to the balance of risk and efficiency were the maintenance of medical care capabilities and hospital bed capacities in the event of a future peer-to-peer conflict. It was noted that militaries by their nature are inefficient, and while some efficiency gains can be desired, where and how decisions are being made is opaque to most people. These concerns cannot be fully separated from the lack of clarity in lines of authority, as respondents were as concerned about knowing who makes the decisions as they were about what pressures and incentives guided those decisions. The command organizations presented here do not address these concerns, and we note them here as a focus for future MHS reform analysis.

Where do we need clarity?

Interviewees invariably lamented a lack of clarity in the assigned responsibilities of DHA as a source of concern. Three features of the current system were commonly discussed as requiring clarity and agreement: OPCON of personnel assigned to MTFs, decision-making authority within the MHS, and the definition of readiness. The first two of these are addressed by the command constructs, though neither necessitates a Command structure. The lack of a detailed and agreed upon definition or set of metrics for readiness hinders the evaluation of command organizational constructs. Additionally, it was noted that the three services do not share a consistent definition of MTF, and that this label provides a false sense of homogeneity of treatment

facilities within a Service, let alone across Services. The study team notes that clear definitions are not addressed through an organizational construct.

When discussing preferences of Agency vs. Command, the JHU/APL team asked as a follow-up whether this distinction is required to address the authorities presented in each of the constructs, particularly in clarifying the OPCON of personnel assigned to MTFs. Thus, while changing from an Agency to a Command would provide clarity with regards to this authority, it is not a necessary condition. Senior leaders agreed that OPCON of personnel assigned to MTFs could be delegated to DHA as an Agency. The primary concern among senior leaders was that Service internal processes were correctly arranged to ensure the right number of personnel are assigned or embedded in units and attached to MTFs. An example of this is the reverse-Professional Filler System (PROFIS) process now used by the Army.

The assignment of personnel to an MTF would be more easily facilitated by two changes and would be enhanced by a third requirement. First, medical tours of duty would follow the model of line officers, for example, sea and shore tours in the Navy. Thus, medical tours would likely alternate between operational tours assigned to a unit with training stints at MTFs, where the MTF has Tactical Control (TACON) but not OPCON of personnel. Second, the agency or command would need forces to be assigned to it for duty in MTFs. A recurring theme from DHA interviewees and from some service members is the need for a Joint Duty Assignment List (JDAL) for the DHA. This list would provide more protections for personnel assignments to MTFs than the current JTD process as described in the 702 Implementation report [23]. Finally, use of a JDAL would be enhanced by removing the joint duty exemption for medical personnel.

Requiring medical officers to achieve similar joint experience to other officers can be achieved within a command or agency construct. The desire for more joint experience, and for requiring joint experience and joint credit for medical officers of flag rank, was a common theme from Service line and Service medical officers. During the interviews, the study team also noted that there was a significantly different tone and view taken towards the DHA and the MHS enterprise by those officers with experience within the DHA. It was noted that 20% of a medical officer's time is in duties that could qualify as joint. Joint experience could be facilitated by assigning medical personal to MTFs traditionally associated with other Services. This is most easily done during a tour assigned to an MTF, since tours assigned or embedded in line units would be at Service specific bases and therefore MTF attachment would be within traditional Service-aligned facilities.

A separate clarity issue raised by multiple interviewees was the need to identify a clear decision-making authority and to ensure that authority is recognized. This was the goal for the study as identified by the Senate Armed Services Committee staff. It was clear from interviews, however, that the fundamental tension to resolving this issue rests in whether one thinks the readiness and benefit missions are separable or necessarily integrated. Interviewees who voiced an opinion that readiness and benefit care are and must be integrated also felt like DHA had clear authority to be the lead decision-maker for the MHS. Those who felt readiness and beneficiary care are separable expressed a desire for DoD leadership to interpret statute and draw clear lines of authority.

The question of who has decision-making authority, and therefore the ability to move beyond consensus decision making, is tied-up in the definition of readiness. One challenge voiced by several Service line leaders is that readiness tends to take on an ever-expanding definition. The narrowest view of readiness is that it is merely the requirements as delivered by the combatant commands. The most expansive definition includes family benefits as a feature of readiness, building on the idea that a military member who has lingering concerns about her dependent's healthcare is not ready to deploy. The study team discussed in detail the lack of clarity around readiness in the previous section on Overarching Assessment Findings.

What data provides support for future assessments?

As the first study of MHS organizational constructs in the wake of the seismic events of creating the DHA and the 2017 NDAA transfer of MTFs to DHA management, this study is by necessity somewhat exploratory. One outcome of this work is that the process of developing assessment criteria highlighted important gaps in data which would need to be rectified in order to provide informed, factual bases for comparisons of organizational constructs. The study team identified several types of data that would aid in future assessments, which is summarize below.

1. Formalized metrics of medical C2 for all MHS elements
2. Force medical-readiness metrics, following the development of a clear and agreed upon readiness definition
3. Medical force readiness metrics, both enterprise and service-level, also following the development of a clear and agreed upon readiness definition
4. Metrics for trust of medical care

5. Medical accession, retention and promotion rates and manning requirement under various organizational modes
6. Stable post-MTF consolidation baseline for cost comparisons

Cross-cutting MHS improvements

Finally, there are two features of the constructs, and of the current DHA, which strengthen the MHS that deserve attention. The first is the combination of MTF management and purchased care management within the same organization. This feature is maintained in each of the options developed here. The integration of direct and purchased care is an identified strength of DHA that will facilitate cost-savings and better beneficiary care. The other feature of these constructs or of a DHA with clarified and recognized authorities is that the agency or the command is able to use those authorities proactively and not merely reactively.

In each option developed for this study, the management of the MTFs and of purchased care was aligned to the same entity. This facilitates an integrated approach to healthcare delivery for service members and beneficiaries that leverages all available options. This integration is achieved through an enterprise view of the military health system, as is currently held by the DHA. As MTF management transitions to the DHA, it will be important to develop metrics and measures of success with regards to market-based healthcare delivery. Successful integration of direct and purchased care must be a data-driven process, and several respondents pointed to the fact that DHA is well-suited to identify, collect, and analyze this data.

Finally, there is a benefit of clear authorities and responsibilities in the MHS that may not be readily apparent in this analysis. The vignettes provided in Appendix F were identified as limited by their reactionary design. While the goal in presenting the vignettes was to help provide clarity to the identified authorities, this was a criticism of the vignettes shared here to further highlight potential improvements in the MHS. Clear and recognized authority provides leaders with the freedom to be proactive in manpower assignment and training across the enterprise. Regardless of organizational construct, this flexibility may lead to an outcome that is strictly dominant along all metrics.

Appendix A. Lists of Interviewees

Table A-1. Interviewees for Background and Options Development

Category	Interviewee	Status
Background	Lt Gen Douglas J. Robb (Ret. USAF)	Interviewed
	Lorraine Breen	Declined
	Allen Middleton	Interviewed
	Lt Gen George P. Taylor (Ret. USAF)	Interviewed
	Kathleen Miller	Interviewed
	HASC	Interviewed
	SASC / Al Edwards	Interviewed
	John Casciotti	Interviewed
Service Medical	CAPT Michael Malanoski (Ret. USN)	Interviewed
	MG Jeffrey Clark, USA	Interviewed
	CAPT Steve Blivin, USN	Interviewed
	MG Patrick Sargent, USA	No Response
	Col John Andrus, USAF	Interviewed
	Maj Gen Robert Miller, USAF	Interviewed
Service Line	RDML Philip Sobeck, USN	Interviewed
	BGen David Maxwell, USMC	Interviewed
	BG Jill Faris, USA	Interviewed
	COL Anne Hessinger, USA	Interviewed
	CAPT Daryl Daniels, USN	Interviewed
	Steven Pietruszka	Interviewed

Joint Staff	CAPT Adam Poling (Ret. USN)	Interviewed
	LTC Jian Guan, USA	Declined
DHA	Maj Gen Lee Payne, USAF	Interviewed
	Barclay Butler	Interviewed
	Jeff Zottola	Interviewed
	Brig Gen Sharon Bannister, USAF	Interviewed
	Pat Flanders	Interviewed
	Patrick Grady	Interviewed
	MG Ronald Place, USA	Interviewed
Health Affairs	RADM David Smith (Ret. USN)	Interviewed
	Col Mark Hamilton (Ret. USAF)	Interviewed

Table A-2. Interviewees for Options Assessment

Category	Interviewee	Status/Form
Background	Lt Gen Douglas J. Robb (Ret. USAF)/ Allen Middleton	Written Feedback
	Lorraine Breen	No Response
	Lt Gen George Peach Taylor (Ret. USAF)	Written Feedback
	HASC	Written Feedback
	SASC	No Response
Service Medical	CAPT Michael Malanoski (Ret. USN)	No Response
	MG Jeffrey Clark, USA	Written Feedback
	CAPT Steve Blivin, USN	No Response
	MG Patrick Sargent, USA	No Response
	Maj Gen Robert Miller, USAF	Written Feedback

Service Line	RDML Philip Sobeck, USN	Written Feedback
	BGen David Maxwell, USMC	No Response
	BG Jill Faris. USA	No Response
	COL Anne Hessinger, USA	FORSCOM Presentation
	LtGen Chiarotti, USMC	Cancelled Interview
Joint Staff	CAPT Adam Poling (Ret. USN)	Interviewed
	LTC Jian Guan, USA	No Response
DHA	Maj Gen Lee Payne, USAF	No Response
	Barclay Butler	No Response
	Jeff Zottola	Written Feedback
	VADM Raquel Bono, USN	Interviewed
	Brig Gen Sharon Bannister, USAF	Interviewed
Health Affairs	RADM David Smith (Ret. USN)	No Response
	Col Mark Hamilton (Ret. USAF)	No Response
Senior Leaders	Lt Gen Dorothy Hogg, USAF	Interviewed
	RADM Colin Chinn, USN	Interviewed
	VADM Forrest Faison, USN	Interviewed
	RDML Gayle Schaffer, USN	Declined
	VCNO	Interviewed
	VCOS Army	Interviewed
	VCOS Air Force	Interviewed
	Vice Commandant	No Response
	VCJCS	Interviewed

Appendix B. Interview Questions

Front Matter for the Interviewer

1. Provide interviewee with informed consent form, if not sent by email. Review the form to highlight that this interview is confidential, details will be anonymized to the organization level, and that they are free to not answer any questions or end the interview at any time.
2. Provide an overview of the study and its intent.
3. Once established, include details of the various options and the impacts any changes are likely to have on the particular organization.

Interviewee Details

4. Date/Time:
5. Organization:
6. Position:

Organizational Background

7. Where does your office/organization fit into the broader MHS?
   - **[Prompt interviewee to diagram this out on paper—for each of the below, use the diagram to identify various roles, responsibilities, authorities, and formal and informal LOCs]**
8. Please describe your org/office's relations to others within and across the MHS.
   - Formal Relations: (command and policy authority, budgetary authority, etc.)
   - Informal Relations: (advising, dotted line relationships, etc.)
9. What organizations do you think you should engage with but don't, and why not?
10. What functions and roles is your office or organization responsible for?
11. What authorities/policies guide those functions?
    - Can we get a copy?
12. How have these relationships, roles, and authorities changed in the wake of the 2017 and 2019 NDAAs?

13. How do medical personnel fit in your organization with respect to the MHS process?
    - Are you a producer or customer of medical personnel?
    - Do you have control over medical personnel and if so, what kind?

Big Picture

14. From your organization's perspective, what are the major challenges with the current MHS setup?
    - What drives those challenges?
        - E.g. Organizational issues, legal/policy issues, manpower, etc.
    - What might some potential solutions to those challenges include?
        - E.g. Reorganization, change in authorities, etc.
    - What would be required to enable any such changes?
        - E.g. Policy changes, authorities, C2, resourcing processes, etc.
15. Given that MHS governance has been addressed numerous times, what do you think the biggest hurdles have been in getting to a better solution?
    - Are there any lessons learned from previous attempts at reorganization that you think we should take away?
16. One of the considerations is whether the MHS should be unified as a Command or an Agency.
    - In your opinion, how would those options be organized and what would be different about them?
    - What do you think are the relative strengths or weaknesses of one versus the other…
        - Specifically for your organization?
        - For the MHS as a whole?
    - What impact would a change from an Agency to a Command have on your organization?

HQ/Leadership Team

17. Transition
    - What sort of timeline would be feasible for a transition?
18. What do you envision would be the major impacts of a transition from an Agency to a Unified Medical Command?
    - How would you measure some of those impacts?

19. What are the major sources of cost within the MHS?
    - How might some of those costs change with a move to a UMC?
    - Are there alternative methods for reducing costs?

Efficiency

20. How is efficiency measured across the MHS?
21. How is efficiency measured in your organization with respect to the medical process?
22. How might a shift to a unified medical command improve or impede your organization's efficiency?
    - Why do you think so?
    - How would you measure this?
23. Is there a need for some redundancy within or across the MHS?
    - If so, where and why?

Interoperability

24. What is your current assessment of interoperability of medical forces?
    - Do you have any current measures of that interoperability?
25. How do you think those interoperability would change if MHS were to move to a Command structure?
    - Overall, would such a reorganization be beneficial or detrimental?

Budgets (if not covered)

26. How does the money flow with respect to medical services in your organization?
27. Who has responsibility for the budgetary process in your organization?
28. What are some of the major budgetary challenges you face in terms of…
    - Process?
    - Allocations?
    - Spending?
29. What other organizations does yours interact with in terms of the budget process?

30. What are the major sources of costs in terms of medical service provision in your organization?
    - Can we get any current measurements or statistics for those costs?
    - How do you think those costs would change if MHS were to move to a Command structure?
        - Overall, would such a reorganization be beneficial or detrimental to your operations?
31. Do you interact with the service secretaries, surgeons general, ASD(HA), and/or DHA in terms of budgetary processes?
    - If so, can you please describe that process?
        - What are the major strengths and challenges in this process?
        - How have you mitigated some of those challenges?
        - How might a reorganization impact those relations?

Education and Training

32. How is medical training and education currently handled in your service/organization?
    - What are the strengths and weaknesses of this current setup?
33. Who sets medical education and training requirements?
    - How centralized are these?
34. What is the role of the DHA in training and education currently?
35. What role do they play in graduate medical education (e.g. fellowships)?
36. What potential positive or negative impacts might a change in MHS organizational structure have on education and training?
    - How might any negative impacts be avoided or mitigated?

Force Provision

37. Please walk us through force provision of medical personnel and your organization's role in that process.
    - Where and how are requirements for medical personnel generated?
    - Where should they be generated, in your opinion and why?
38. How are decisions made about personnel mix in the provision of medical personnel (e.g. AC, Reserve, civilian, contractor)?
    - Are there options to change that mix?
    - What advantages and disadvantages do certain mixes have?

39. What are the major force provision challenges your organization faces?
    - How do you mitigate those challenges?
    - How might organizational restructuring of the MHS alter this process and add or remove challenges?
40. How would a change in organization to a Command impact force provision?
    - Overall, would such a change be beneficial or detrimental to your operations?

HR Concerns

41. What are some of the major HR-related concerns with respect to medical personnel?
    - Accessions
    - Promotions
    - Retention
42. How do you measure or track any such issues?
    - How do you reduce them?
43. Where do policies and authorities regarding HR issues originate?
44. What do you consider the potential implications of a UMC might be on HR aspects of medical personnel?
    - Overall, would such a change be beneficial or detrimental?

Surgeon General-Specific

45. What is the role of the Surgeon General in relation to your organization?
    - What authorities or responsibilities do they have?
    - How formal or informal are those?
46. Where are the divisions of responsibilities and authorities between the Surgeon General and other medical organizations in your service?
    - What policies or authorities drive that?
        - Can we get a copy?
    - How is this relationship changing after the 2017 NDAA?
    - What are the strengths and weaknesses of those changes?

47. What is the role of the Joint Surgeon General?
    - How does your organization interact with the Joint Surgeon, if at all?
    - How might this role change if the DHA becomes a Unified Medical Command?
    - How should it change, in your opinion?

Medical 'Customers' (e.g. Line-Side)

48. How do medical personnel fit into your organization?
    - How does this vary in garrison versus deployed environments?
    - Include: roles of personnel, command authorities, billeting, etc.
49. How do you generate and validate requirements for numbers of medical personnel?
50. Deployments
    - How often does this unit deploy?
51. How do you utilize or engage with MTFs?
    - How close is the closest one to your base/post?
    - Are there formal authorities between your unit and the MTFs?
52. How do you think any organizational changes to the MHS might impact your operations?
    - How would you measure any such impacts?
    - What are some of your major concerns about a consolidation in authorities and responsibilities of medical personnel?

Readiness

53. Where do the requirements for readiness originate?
54. How are your medical personnel involved in readiness?
    - Their own readiness?
    - The readiness of the unit?
55. Who is responsible for medical readiness in your unit and in what ways?
    - Medical readiness of forces?
    - Readiness of medical personnel?
56. How do you measure readiness in your unit?
    - Medical readiness of forces?
    - Readiness of medical personnel?

57. What are your major readiness concerns and challenges?
    - How do you mitigate them?
    - How might a change in organizational structure impact readiness in your organization?
58. How do you think moving to a Command structure might impact readiness?
    - How would you measure any such impacts?
    - What are some of your major concerns about a consolidation in authorities and responsibilities on readiness?

Benefits Provision

59. Is your organization at all involved in the provision of benefits?
60. If so, what are your main challenges when interacting with the MHS?
61. Are there alternative organizational constructs that would make providing benefits easier?
    - What would they look like?
    - Why would they be better?

Clinical Concerns and MTFs

62. How do you currently measure quality of care for both military personnel and beneficiaries?
    - Do you have any current measures or statistics that we could have?
63. How might different organizational options impact clinical processes and outcomes?
64. How would you measure any such changes?
    - How might any detrimental effects be mitigated?

Wrap Up

65. Are there any other considerations that we should be asking about in these interviews?
66. Can you recommend anyone else we should be talking to about this or related topics?

Appendix C. Timeline of Major Statutory, Policy, and Regulatory Changes to Military Health Governance

Legislative Actions

The Congress' actions toward the DHA can be characterized as being in fits and starts since the 1980s with increased detail in the 2017 and 2019 NDAAs.

The 1980s saw two requests for feasibility studies on establishing a DHA and two directives from Congress to establish a DHA. None of these provisions became law. The first mention of a defense health agency occurred in a Senate Bill in 1982 seeking a feasibility study on establishing a DHA. Another Senate Bill in 1983 repeated this request. In 1985, a House Resolution directed the Assistant Secretary of Defense to consolidate the health care systems of the services (excluding the Coast Guard) to be administered in policy and operation by a DHA. The resolution gave that task to the Assistant Secretary of Defense, who with the Surgeons General of the services were responsible for ensuring defense readiness was met. Finally, in 1986, an amendment to a House Resolution also established a DHA to consolidate the health care systems of all the services, to be administered by the Surgeons General. This resolution's language was subsequently reduced to requesting studies from the SECDEF, each service and the Joint Chiefs of Staff on the organizational structure of the military health care system.

The 1990s saw no legislative movement on the question.

The 2000s only saw the Base Realignment and Closure (BRAC) legislation creating the National Capital Region.

Serious movement on the question began again in 2010. House Resolution 5136 authorized the president to establish a unified command for medical operations, to include a DHA. This language made it to the Senate but no mention of UMC or DHA survived into the final bill that became law. The next year, in 2011, Congress expressly prohibited the SECDEF from restructuring or reorganizing the military health system until after completing a report that assessed the organizational options developed by a task force previously. Further, that report by the SECDEF had to be reviewed by the Comptroller General and 180 days had to pass from that review's completion before any action could be taken. In the 2013 NDAA, the action Congress requires of the SECDEF moves from conducting reports to developing plans [35]. Specifically, the Congress tasked the SECDEF with developing a detailed plan to reform the governance of the military health system as described in the Deputy Secretary of

Defense memorandum from March 2012. Six months later, the Dep. Sec. of Defense issued DoD Directive 5136.13 establishing the Defense Health Agency. Until passage of the 2017 NDAA in December 2016, Congress only instructs DHA to serve as senior medical advisor to the Armed Services Retirement Home and to report on non-DoD hospitals in arrears. Then, the 2017 and 2019 speak in great detail as to what DHA must do, how it is to operate, and how it is to interact with the Surgeons General of the services.

Table C-1. Timeline of Legislative Actions[a]

[a] **Bold** = Important information within the Relevance box; Grey text = Did not pass into law

Date	Name	Relevance
1980s		
September 1982	S. Bill 2936: Uniformed Services Pay Act of 1982	Directed SECDEF to conduct feasibility study on establishing a DHA for the SASC within 180 days. (never left committee)
April-May 1983	S. Bill 989 Omnibus Military Personnel Act of 1983	Same as S.B. 2936 (made it to Senate floor and put on calendar)
1984	*Department of Defense Authorization Act, 1984,* Public Law 98-94, cited in "The Evolution of the Military Health Care System: Changes in Public Law and DOD Regulations," CNA, p. 30 [3].	**CHAMPUS given statutory authority by Congress to reimburse hospitals for inpatient care** at a predetermined fixed rate per discharge based on a diagnosis-related-group (DRG) system through the Prospective Payment System (PPS).
February 1985	House Resolution (H.R.) 1136: A bill to consolidate the medical health care systems of the armed services to be administered in policy and operation solely by the Defense Health Agency.	Consolidates the medical health care systems of the services (minus CG) to be administered in policy and operation solely by the DHA. ASD to organize DHA. Prescribes two offices: policy and operation, and defense readiness, to be administered by ASD and Surgeon Generals of the services. [referred to subcommittee on investigations by the House Armed Services Committee (HASC)]

Date	Name	Relevance
June 1985	H.Amdt. 169 to H.R. 1872 (DoD Authorization Act, 1986)	To establish the DHA to administer policy and operation of medical health care systems for all the services, to be administered by the Surgeons General. (amendment passed by voice vote in the Committee – larger Res. passed the house and was incorporated (amended) into S.Bill 1160 as an amendment) **Establishment of DHA appears to have been reduced to directing SECDEF to submit a report to Congress on the organizational structure of the military health-care delivery system.** Outlines goals to be accomplished by that system. Requires separate studies by secretary of each military dept. and Joint chiefs.
October 1986	P.L. 99-433 – Goldwater Nichols	
1987	"The Evolution of the Military Health Care System: Changes in Public Law and DOD Regulations," CNA, p. 41 [3].	Dependents' Dental Program implemented.
1988	"The Evolution of the Military Health Care System: Changes in Public Law and DOD Regulations," CNA, p. 41 [3].	Changes to provider reimbursement methods, including the implementation of CHAMPUS DRGs and the beginning of MTF third-party billing for inpatient care. Catastrophic caps established.
1990s		
2000s		
September 2007	BRAC legislation Defense Base Closure and Realignment Act of 1990, as amended through FY 05 Authorization Act: https://www.brac.gov/docs/BRAC05Legislation.pdf	Directed creation of the National Capital Region

Date	Name	Relevance
May 2010	H.R. 5136: NDAA FY2011	**Established ASD-Health Affairs**. Authorizes president to establish unified command for medical operations, headed by commander, and provides subordinate commands to UMC, including a DHA. Requires Secretary to develop and submit to defense and appropriations committees a plan to establish the UMC and DHA. (passed House and read twice by Senate, and placed on Senate legislative calendar under general orders. Told to see H.R. 6523 that became P.L. 111-383 on 1/7/2011, but the defense health command does not appear in that statute).
December 2011	H.R. 1540 – P.L. 112-81, Sec. 716 – NDAA 2012	SECDEF prohibited from restructuring or reorganizing military health system until 120 days after date on which report submitted by SECDEF is reviewed by comptroller general to congressional defense committees. Report to assess the options developed by the task force for cost, goals achieved, readiness, quality of care, beneficiary satisfaction, cost savings. Comptroller General review also prescribed: analyze strengths and weaknesses of each option, cost estimates for each option, cost savings estimates. Review to be done within 180 after SECDEF report submitted.
March 2012	Deputy Secretary of Defense Memorandum – Planning for Reform of the Governance of the Military Health System	Describes BRAC consolidation of medical facilities and functions in NCR prompting review of medical health system, and cites internal task force to review governance leading to NDAA FY12 section 716 report on reforms to the MHS.
January 2013	H.R. 4310 - NDAA FY13, sect. 731	Requires detailed plan from SECDEF to reform to governance of the military health system described in DepSecDef memo from March 2012. Prescribes elements to include in the plan: improve clinical and business practices, cost reductions, infrastructure reductions, and personnel reductions by establishing DHA and modifying governance of NCR; metrics; personnel levels; initial operating capability details; timelines and business cases for shared services to be implemented. (became P.L. 112-239 on January 2, 2013).
September 2013	DoDD 5136.13 – Defense Health Agency	**Establishes DHA and defines roles and responsibilities.**

Date	Name	Relevance
October 2014	DepSecDef Memo – Military Health System Action Plan for Access, Quality of Care, and Patient Safety	Identifies and tasks DHA with improving access, quality of care, and patient safety. Includes developing specific plan to implement necessary changes, including organizational and infrastructure.
December 2014	H.R. 3979 – NDAA FY 15, Sect. 721, sect. 728	721: Deputy Director of DHA designated senior medical advisor to the Armed Services Retirement Home 728: Requires SECDEF to brief armed services committees on process used by DHA to collect payments from hospitals outside DoD, and provide a list of each hospital more than 90 days arrears in payments (became P.L. 113-291) Section 723 of S.B. 2410 required a DoD-wide strategy for contracting for health care professionals for DoD, to include responsibilities of each military department and DHA, but this appears not to have survived into the NDAA
October 2016	H.R. 6132 - National Trauma Care System Act	Requires SECDEF create plan to establish joint trauma system within the DHA for armed service members and those eligible for care at MTFs (referred to subcommittee on military personnel, nothing since then)
NDAA FY 2017		
December 2016	NDAA FY2017: Section 702	Amended Chapter 55 of Title 10 of U.S.C. The new text called for the **administration of the MTFs to be the responsibility of the Director of the DHA by 10/1/2018**
December 2016	NDAA FY2017: Section 702	The new text also called on the SecDef **to establish a professional staff within DHA**. To do so, the SecDef **must appoint a DHA Assistant Director and Deputy Assistant Directors**
December 2016	NDAA FY2017: Section 702	The new text also called on the DHA Director to coordinate with the Joint Staff Surgeon to ensure the director most effectively carries out responsibilities of the DHA as a Combat Support Agency; in this regard, the **DHA Director is to ensure that the DHA meets the operational requirements of the CCMD commanders, and coordinates with military departments to ensure that MTFs support readiness requirements**

Date	Name	Relevance
December 2016	NDAA FY2017: Section 702	Surgeon General Responsibilities and Roles The new text also discusses the role of the Surgeon General of the Army. Specifically, the SG serves as the principal medical advisor to the Secretary of the Army and the Chief of Staff of the Army; the SG of the Army also serves as the chief medical advisor of the Army to the DHA Director; and under the authority of the Secretary of the Army, shall recruit, equip and train (among other duties) the medical personnel within the Army. Amended Section 5137 of Title 10 to specify procedures for the appointment of the Surgeon General of the Navy, and the duties of the SG, including with respect to the DHA director. The text is similar to that for the SG of the Army Amended Section 8036 of Title 10 to specify procedures for the appointment of the Surgeon General of the Air Force, and the duties of the SG, including with respect to the DHA director. The text is similar to that for the SG of the Army
December 2016	NDAA FY2017: Section 703	Amended Chapter 55 of Title 10 of the U.S.C. with new text that **called on the SecDef to maintain MTFs** (Medical Centers, Hospitals and Ambulatory Care Facilities), and specifies the roles of those facilities.
December 2016	NDAA FY2017: Section 703	This section also notes that the SecDef may not restructure the infrastructure of the MTFs or alter medical benefits from them unless similar benefits can be obtained through TRICARE (purchased care)
December 2016	NDAA FY2017: Section 705	**Transfers solicitation and awards of contracts** for acquisition of managed care support services from DHA to the Office of the Under Secretary of Defense for Acquisition, Technology and Logistics
December 2016	NDAA FY2017: Section 705	Calls on SecDef to submit a report to Congress on implementing a Joint Trauma System within DHA, and then to implement the plan
December 2017	NDAA FY2018: Section 715	This section amended section 705 of NDAA FY2017 by noting that **acquisition of managed care support services under TRICARE is now the responsibility of the Undersecretary of Defense for Acquisition and Sustainment,** who are responsible for (1) decisions related to such acquisition; (2) approving the acquisition strategy; and (3) conducting pre-acquisition, pre-award and post-award acquisition reviews

Date	Name	Relevance
NDAA FY 2019		
August 2018	NDAA FY2019: Section 711	Amended section 1073c of Title 10 of the U.S.C. The pre-existing text of 1073c noted that **the DHA Director would take control of the administration of MTFs by 10/1/2018. NDAA FY2019 pushed this back to 9/30/2021**
August 2018	NDAA FY2019: Section 711	Inserts a new paragraph in section 1073c of Title 10, which indicates that **once the DHA Director exercises his/her responsibility over MTFs, she/he will also (1)** serve as the primary rater of the performance of commanders/directors of MTFs; **(2)** direct and control any intermediate organizations between DHA and MTFs; **(3)** determine scope of medical treatment at MTFs to meet medical requirements; **(4)** determine workforce requirements at MTFs and direct joint manning at MTFs & intermediate organizations; **(5)** address personnel staffing shortages at MTFs and **(6)** select among service recommendations for commanders or directors of MTFs
August 2018	NDAA FY2019: Section 711	Calls on SecDef to establish a **timeline for each Secretary of a military department to transition the administration of an MTF to the DHA** Director consistent with the data specified above (9/30/2021)
August 2018	NDAA FY2019: Section 711	Section 711 further elaborated the CSA activities of the DHA, by noting that the Director of the DHA must meet the military medical readiness requirements of the senior military operational commanders of the military installations
August 2018	NDAA FY2019: Section 711	**Places a restriction on the ability of the SecDef to close an MTF or downsize any medical center, hospital or ambulatory care center** unless the SecDef submits a report to Congress detailing the methodology used in making such a recommendation
August 2018	NDAA FY2019: Section 711	Calls on the SecDef to establish, by 9/30/2022 a subordinate organization within DHA called Defense Health Agency Research & Development. It will comprised Army Medical Research and Material Command, and potentially other medical research organizations
August 2018	NDAA FY2019: Section 711	Calls on the SecDef to establish another subordinate organization, the Defense Health Agency Public Health, comprising the Army Public Health Command, the Navy-Marine Corps Public Health Command, the Air Force public health programs, and other related defense health activities considered appropriate

Date	Name	Relevance
August 2018	NDAA FY2019: Section 711	**Requirement for report on feasibility of superseding organization for DHA,** to include: description of required responsibilities of commander of such a command; description of any current organizations that support DHA to be included in the command; description of any authorities required for the leadership and direction of the command; and any other matters.
August 2018	NDAA FY2019: Section 712	This section discusses the organization of the MHS, and notes that the organizational framework of the MHS will not contain more than 2 defense health regions within the Continental United States (CONUS). Each region will have a leader selected by the DHA Director, at a level no higher than major general or rear admiral.
August 2018	NDAA FY2019: Section 712	Section 712 also notes that Outside the Continental United States (OCONUS) will not have more than 2 defense health regions.
August 2018	NDAA FY2019: Section 712	Section 712 also calls on the DHA director to work with military departments **to ensure that staffing at MTFs meets readiness requirements** for Armed Forces personnel and medical personnel
August 2018	NDAA FY2019: Section 712	Calls on the DHA Director to coordinate with the CJCS, through the Joint Surgeon General, **to meet the requirements of DHA functioning as a Combat Support Agency** (consistent with Section 193 of Title 10 of U.S.C.)
August 2018	NDAA FY2019: Section 712	Calls on DHA Director, based on readiness requirement of CCMD commanders validated by the Joint Chiefs of Staff (JCS), **to validate demand/supply requirements for medical/dental staff at MTFs**; in coordination with Surgeons General of Armed Forces, provide "currency workload" for uniformed medical/dental staff at MTFs to maintain skill levels [1]; and identify alternative training and clinical practice sites if workload at MTFs is insufficient
August 2018	NDAA FY2019: Section 712	Section 712 also elaborated on the role of Surgeons General within the Armed Forces. Specifically, it indicated that they have **responsibility for assigning medical and dental personnel to MTFs for training, and such personnel will be under the OPCON of commanders of such MTFs**, subject to the authority and direction of the Director of the DHA
August 2018	NDAA FY2019: Section 712	**Surgeons General are also responsible for the readiness for operational deployment of medical/dental teams, and to provide for the logistical support of such teams**

Date	Name	Relevance
August 2018	NDAA FY2019: Section 712	**Surgeons General are also responsible for the readiness for operational deployment of medical/dental teams, and to provide for the logistical support of such teams**
August 2018	NDAA FY2019: Section 712	Surgeons General are also **responsible for the mobilization and demobilization of medical/dental forces**; also, in conjunction with the appropriate military department secretary, the Surgeons General are **responsible for ensuring that the operational medical force readiness organizations of the Armed Forces support the readiness responsibilities of the DHA Director.**
August 2018	NDAA FY2019: Section 712	Surgeons General also ensure that uniformed medical personnel receive training and clinical practice opportunities through DHA programs and activities, and through other avenues identified as appropriate
September 2018	Deputy Secretary of Defense Memorandum – Implementing Congressional Direction for Reform of the Military Health System	Directs implementation of the MHS organizational reform required by section 1073c of Title 10, effective October 1, 2018.

Appendix D. Additional Background Studies

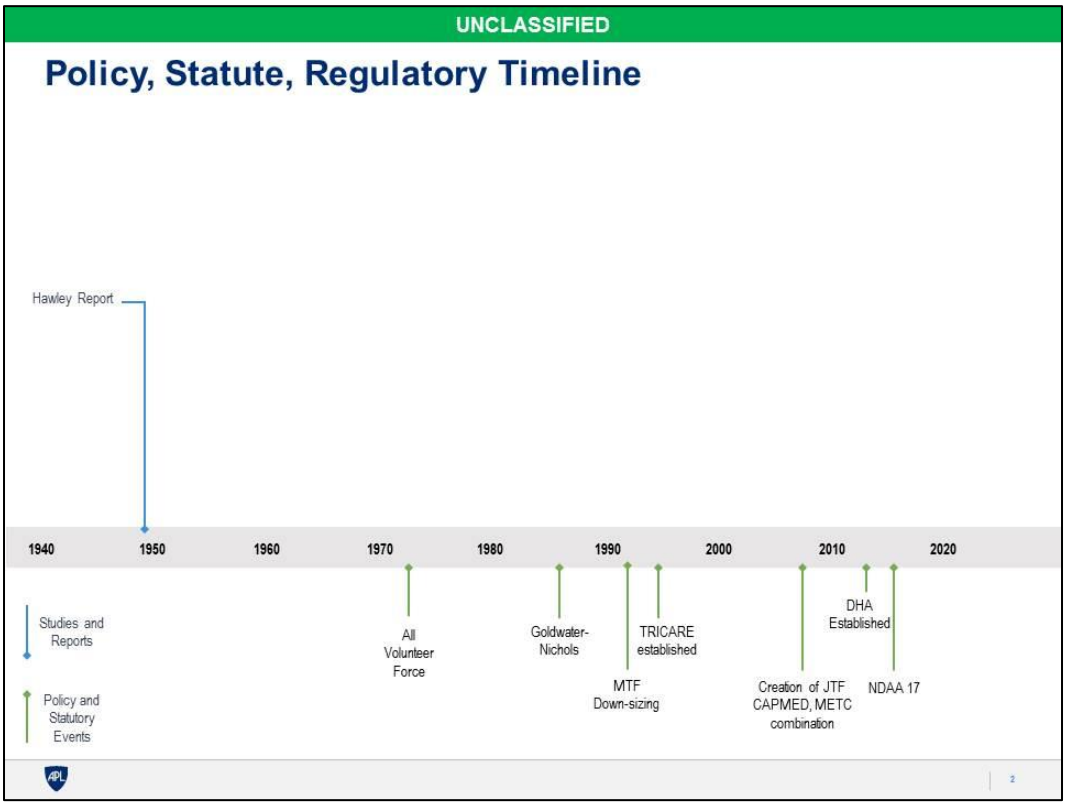
Subsequent to the completion of Task B, the study team received copies of the 1947 Hawley Report and the 1975 Military Healthcare Study.[6] These studies are not included in the Task B deliverable or in the section Looking Back: A History of Defense Health Organizational Studies section of this report as they were not received in time to inform the Task C development of command organizational options. We include them in this appendix for thoroughness, and note that the findings and recommendations of these studies are consistent with the study team's conclusions in Task B. Of note, the Hawley Report recommended the sharing of services across the three military departments and the 1975 Military Healthcare Study recommended there be some coordinating body for CONUS delivery of healthcare. While neither recommends a Unified Medical Command, this topic was explicitly analyzed by either study.

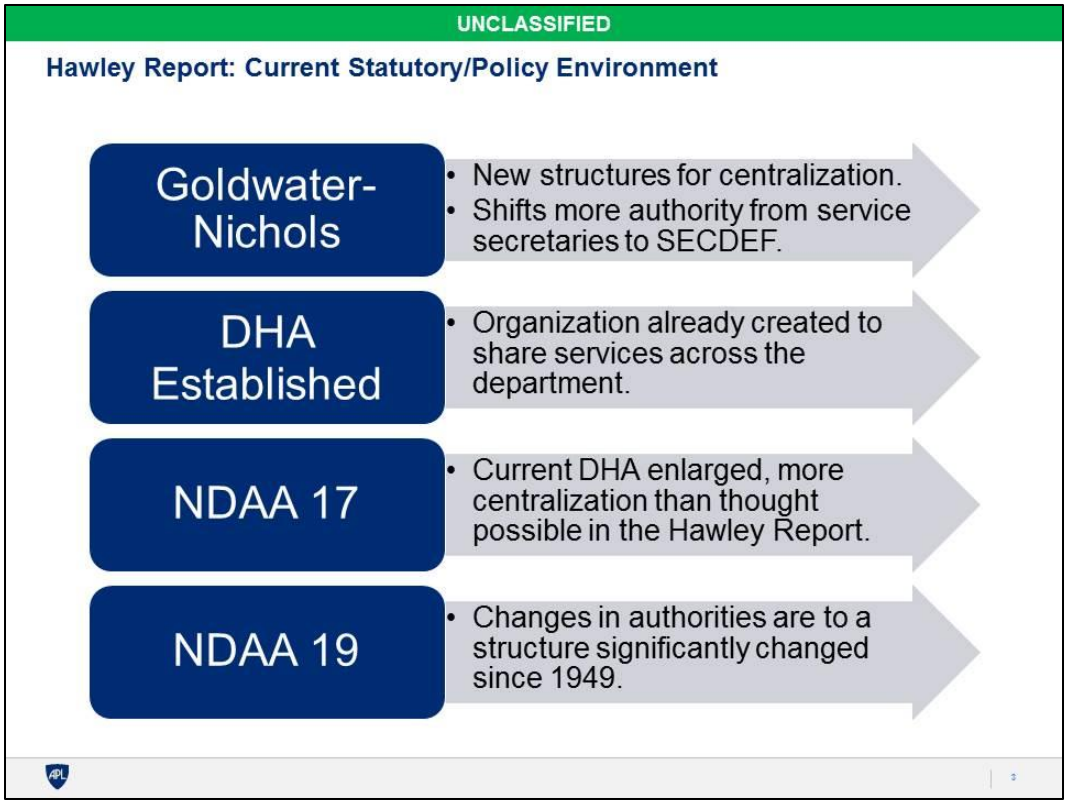
[6] The study team also received a slide deck for the OSD(HA) Office of Transformation Study. However, no findings or recommendations were made in this source document and so the team did not include it here. It should be noted that this study was performed jointly with the Joint Unified Medical Command Working Group, a report the study team analyzed in depth for the purposes of the organizational options development in Task C.

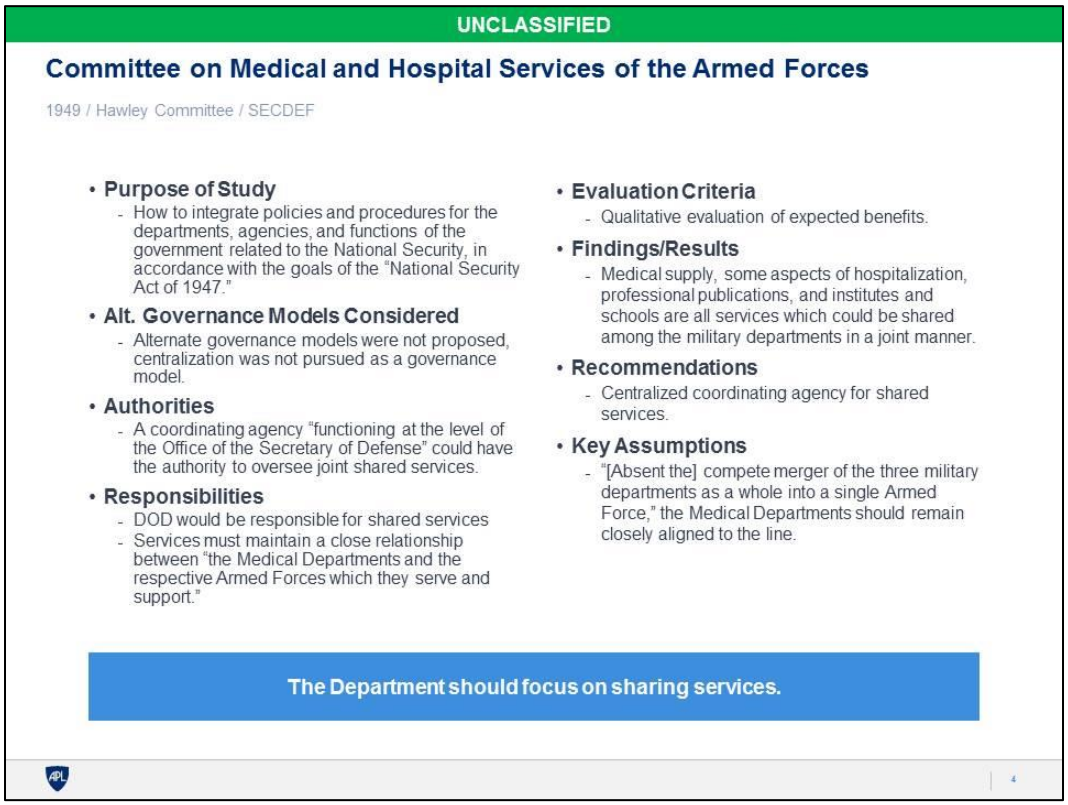
UNCLASSIFIED

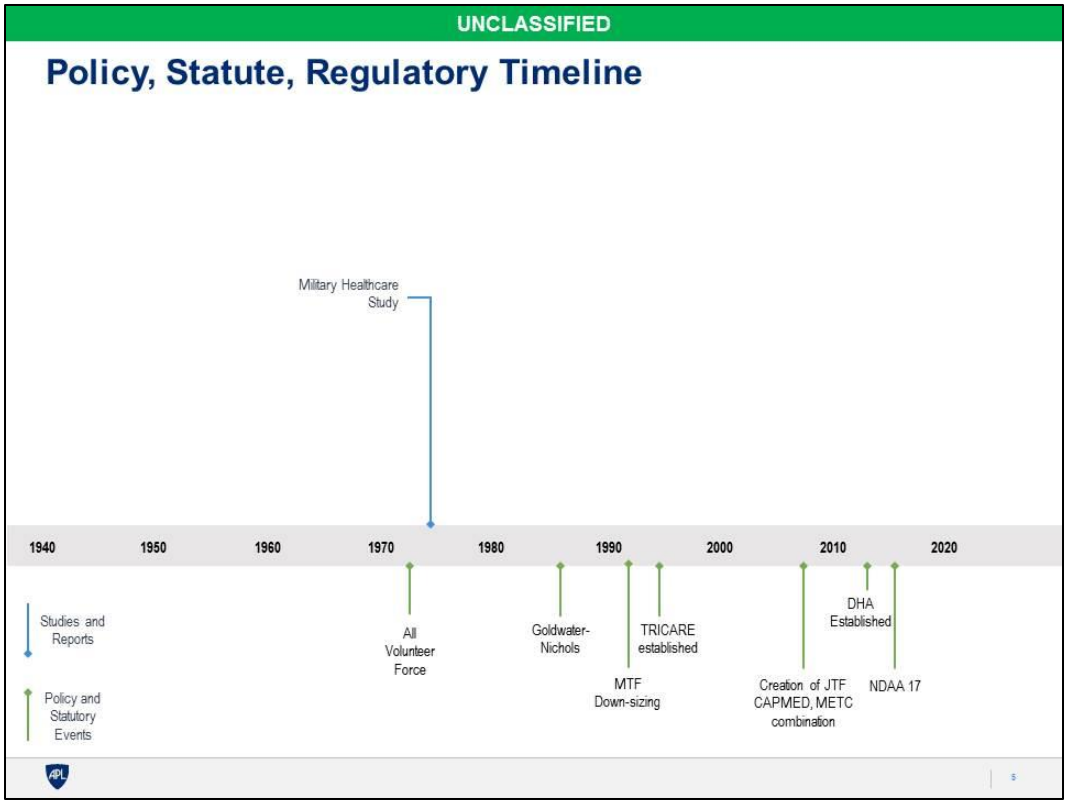
Year	COMMISSION AND/OR STUDY	Study / Doc in Hand	Reviewed
1948	HAWLEY BOARD	Yes	☑
1949	COOPER COMMITTEE	No	☒
1949	FIRST HOOVER COMMISSION	Yes	☑
1955	SECOND HOOVER COMMISSION	Yes	☑
1958	CONSULTANT TO PRESIDENT	No	☒
1970	PRESIDENTIAL BLUE RIBBON PANEL	Yes	☑
1975	MILITARY HEALTHCARE STUDY	Yes	☑
1979	DEFENSE RESOURCE MANAGEMENT COMMITTEE	Yes	☑
1982	GRACE COMMISSION *	Yes	☑
	Prioritization: 1983-Present		
1983	SRA DHA FEASIBILITY STUDY	Yes	☑
1990	ASD(HA) JOINT WORKING GROUP	No	☒
1991	OSD OFFICE OF ADMINISTRATION AND MANAGEMENT	Yes	☑
1996	MHS 2020	Yes	☑
2001	USD(P&R) RAND STUDY	Yes	☑
2001	DEFENSE MEDICAL OVERSIGHT COUNCIL	No	☒
2006	OSD(HA) OFFICE OF TRANSFORMATION	No	☒
2006	CNA UMC COST IMPLICATIONS STUDY	Yes	☑
2006	DEFENSE BUSINESS BOARD	Yes	☑
2006	JOINT UNIFIED MEDICAL COMMAND WORKING GROUP	Yes	☑
2011	MHS TASK FORCE	Yes	☑
2012	GAO REPORT ON TASK FORCE (GAO-12-911)	Yes	☑
2012	GAO MANAGEMENT PRACTICES STUDY (GAO-12-224)	Yes	☑
2018	702 IMPLEMENTATION REPORT (JUNE 2018)	Yes	☑

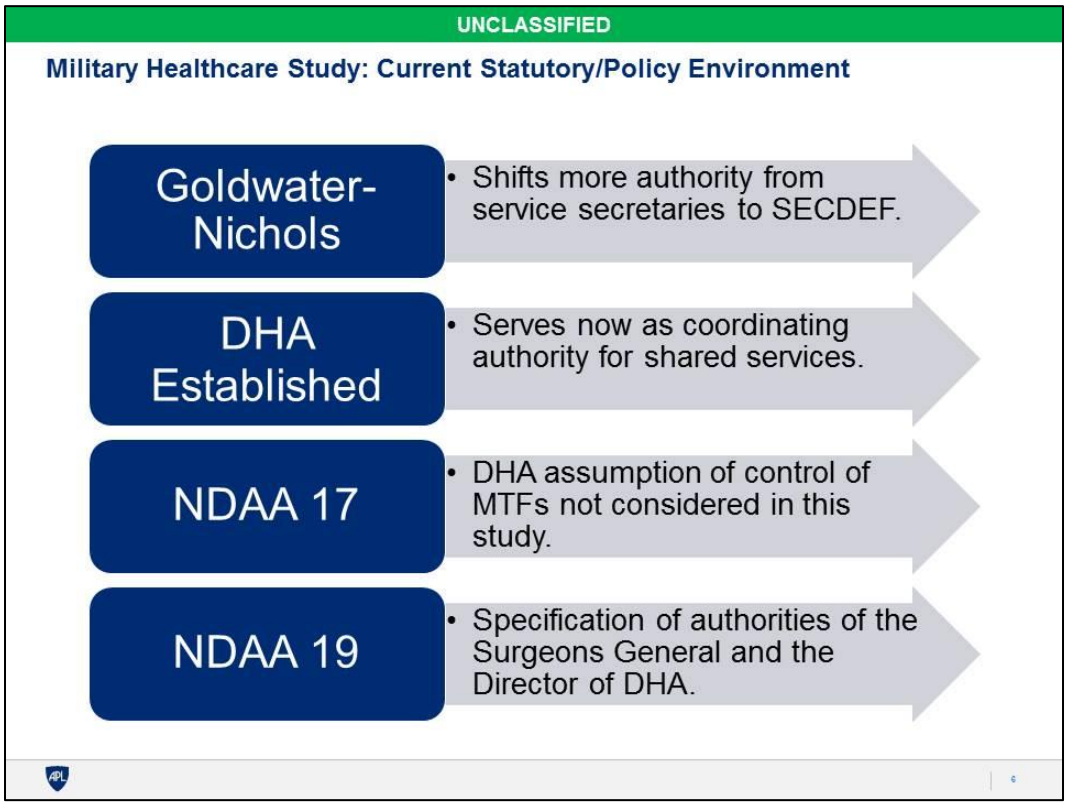
* The Grace Commission report notes a list of "21 studies on [the organization and management of the Military Health Care System] completed" between 1949 and 1979 in the DRMS Supporting Papers. (pp. 64-65) This is higher than the number of studies we knowof for this period, but we did not have a copy of this list.




UNCLASSIFIED
Hawley Report: Current Statutory/Policy Environment
Goldwater-Nichols
• New structures for centralization.
• Shifts more authority from service secretaries to SECDEF.
DHA Established
• Organization already created to share services across the department.
NDAA 17
• Current DHA enlarged, more centralization than thought possible in the Hawley Report.
NDAA 19
• Changes in authorities are to a structure significantly changed since 1949.


UNCLASSIFIED
Committee on Medical and Hospital Services of the Armed Forces
1949 / Hawley Committee / SECDEF
• Purpose of Study
- How to integrate policies and procedures for the departments, agencies, and functions of the government related to the National Security, in accordance with the goals of the "National Security Act of 1947."
• Alt. Governance Models Considered
- Alternate governance models were not proposed, centralization was not pursued as a governance model.
• Authorities
- A coordinating agency "functioning at the level of the Office of the Secretary of Defense" could have the authority to oversee joint shared services.
• Responsibilities
- DOD would be responsible for shared services
- Services must maintain a close relationship between "the Medical Departments and the respective Armed Forces which they serve and support."
• Evaluation Criteria
- Qualitative evaluation of expected benefits.
• Findings/Results
- Medical supply, some aspects of hospitalization, professional publications, and institutes and schools are all services which could be shared among the military departments in a joint manner.
• Recommendations
- Centralized coordinating agency for shared services.
• Key Assumptions
- "[Absent the] compete merger of the three military departments as a whole into a single Armed Force," the Medical Departments should remain closely aligned to the line.
The Department should focus on sharing services.


UNCLASSIFIED
Policy, Statute, Regulatory Timeline
Military Healthcare Study
1940
1950
1960
1970
1980
1990
2000
2010
2020
Studies and Reports
Policy and Statutory Events
All Volunteer Force
Goldwater-Nichols
MTF Down-sizing
TRICARE established
Creation of JTF CAPMED, METC combination
DHA Established
NDAA 17


UNCLASSIFIED
Military Healthcare Study: Current Statutory/Policy Environment
Goldwater-Nichols
• Shifts more authority from service secretaries to SECDEF.
DHA Established
• Serves now as coordinating authority for shared services.
NDAA 17
• DHA assumption of control of MTFs not considered in this study.
NDAA 19
• Specification of authorities of the Surgeons General and the Director of DHA.

UNCLASSIFIED

Report of the Military Healthcare Study

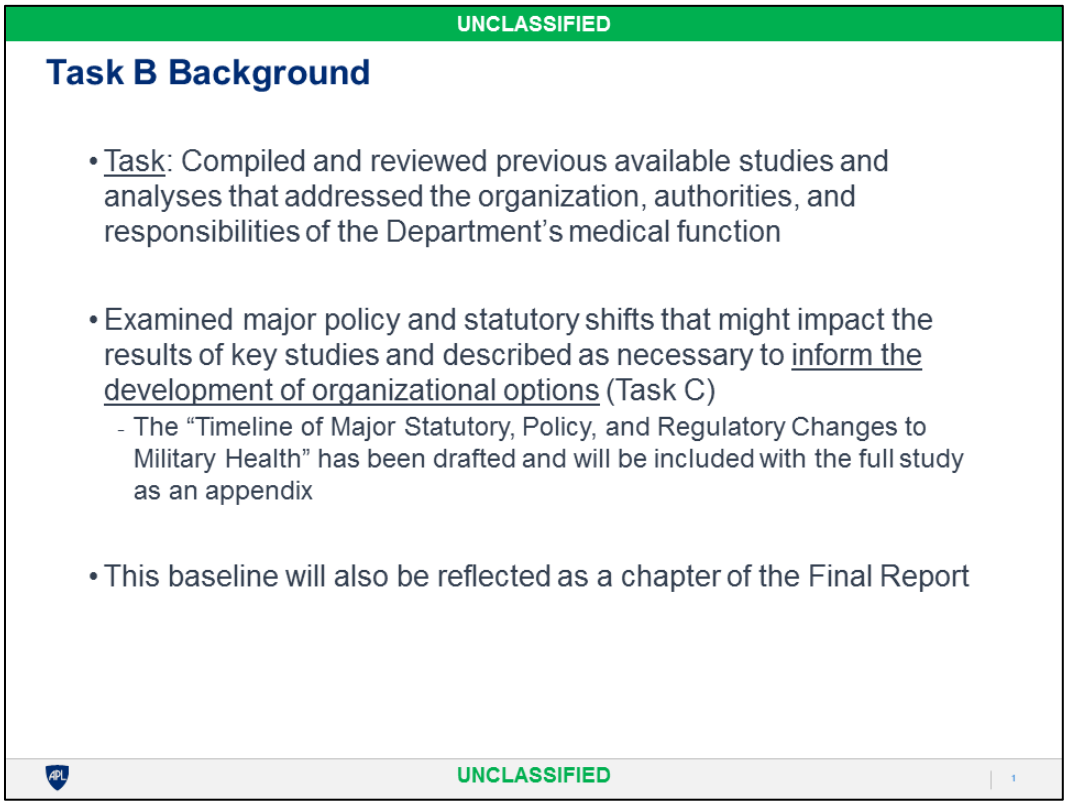
1975 / Military Healthcare Study / DOD, Department of Health, Education, and Welfare, OMB

- **Purpose of Study**
  - Comprehensive overview of the MHS in the face of national healthcare system changes and the shift to the all volunteer force.
- **Alt. Governance Models Considered**
  - Alternate governance models were not proposed, a centralized authority "to plan and allocate resources, and monitor the management of health care delivery in CONUS" is recommended.
- **Authorities**
  - The proposal for centralized authority subjected to the existing statutory authorities.
- **Responsibilities**
  - Coordinating entity is proposed with authorities and responsibilities subordinate to those of the services.
- **Evaluation Criteria**
  - Qualitative evaluation of expected benefits along with quantitative analysis of the cost split between direct and purchased care.
- **Findings/Results**
  - Most finding relate to the interaction of CHAMPUS and direct care, which changed with the creation of TRICARE.
- **Recommendations**
  - Centralization of plans and resources is recommended. This may be accomplished through the DHP.
  - Recommends a resource allocation based on the size of the market.
- **Key Assumptions**
  - Study focuses first on readiness of the Armed Forces, with subsequent forces added for benefit care in remote environments.

Some degree of coordination is desired.

Appendix E. Task B Deliverable Slide Deck

The slides presented here are selected from the final revised deliverable representing the work of Task B (Develop a Baseline of Prior Work), which is also informed by the content of Appendix C (Timeline of Major Statutory, Policy, and Regulatory Changes to Military Health). See the section Looking Back: A History of Defense Health Organizational Studies for the formal presentation of this review.



UNCLASSIFIED

Year	COMMISSION AND/OR STUDY	Study / Doc in Hand	Reviewed
1948	HAWLEY BOARD	No	☒
1949	COOPER COMMITTEE	No	☒
1949	FIRST HOOVER COMMISSION	Yes	☑
1955	SECOND HOOVER COMMISSION	Yes	☑
1958	CONSULTANT TO PRESIDENT	No	☒
1970	PRESIDENTIAL BLUE RIBBON PANEL	Yes	☑
1975	MILITARY HEALTHCARE STUDY	No	☒
1979	DEFENSE RESOURCE MANAGEMENT COMMITTEE	Yes	☑
1982	GRACE COMMISSION *	Yes	☑
	Prioritization: 1983-Present		
1983	SRA DHA FEASIBILITY STUDY	Yes	☑
1990	ASD(HA) JOINT WORKING GROUP	No	☒
1991	OSD OFFICE OF ADMINISTRATION AND MANAGEMENT	Yes	☑
1996	MHS 2020	Yes	☑
2001	USD(P&R) RAND STUDY	Yes	☑
2001	DEFENSE MEDICAL OVERSIGHT COUNCIL	No	☒
2006	OSD(HA) OFFICE OF TRANSFORMATION	No	☒
2006	CNA UMC COST IMPLICATIONS STUDY	Yes	☑
2006	DEFENSE BUSINESS BOARD	Yes	☑
2006	JOINT UNIFIED MEDICAL COMMAND WORKING GROUP	Yes	☑
2011	MHS TASK FORCE	Yes	☑
2012	GAO REPORT ON TASK FORCE (GAO-12-911)	Yes	☑
2012	GAO MANAGEMENT PRACTICES STUDY (GAO-12-224)	Yes	☑
2018	702 IMPLEMENTATION REPORT (JUNE 2018)	Yes	☑

* The Grace Commission report notes a list of "21 studies on [the organization and management of the Military Health Care System] completed" between 1949 and 1979 in the DRMS Supporting Papers. (pp. 64-65) This is higher than the number of studies we knowof for this period, but we did not have a copy of this list.

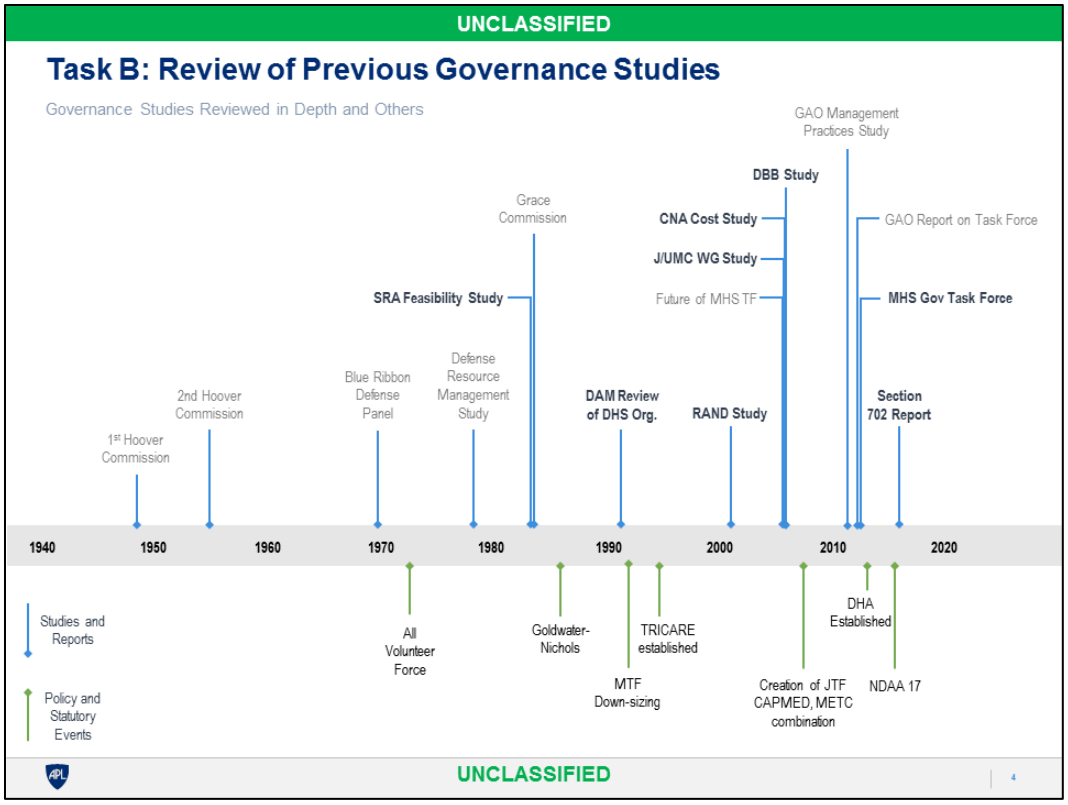
UNCLASSIFIED

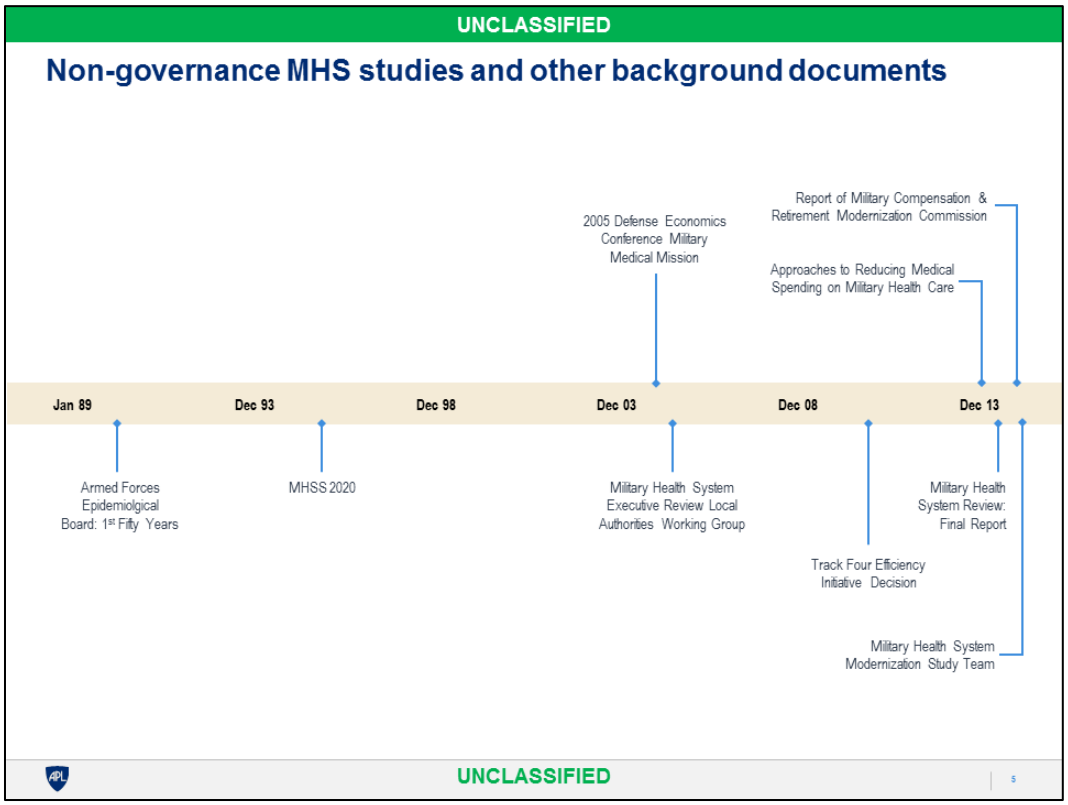
UNCLASSIFIED

Which studies and analyses were most informative?

- All studies and analyses we secured were reviewed, informing the baseline and outcomes of Task B
- We have focused on studies that address these subjects **in-depth**
  - SRA (1983), DAM (1991), RAND (2001), CNA (2006), DBB (2006), J/UMC (2006), and the MHS Task Force (2011)
  - Also includes the final 702 Implementation Report (June 2018) as vital baseline for current future of DHA organization
- Some documents, studies, and analyses provided less detail on organization, authorities, and responsibilities

UNCLASSIFIED


UNCLASSIFIED
Task B: Review of Previous Governance Studies
Governance Studies Reviewed in Depth and Others
GAO Management Practices Study
DBB Study
Grace Commission
CNA Cost Study
GAO Report on Task Force
J/UMC WG Study
SRA Feasibility Study
Future of MHS TF
MHS Gov Task Force
Defense Resource Management Study
Blue Ribbon Defense Panel
2nd Hoover Commission
DAM Review of DHS Org.
RAND Study
Section 702 Report
1st Hoover Commission
1940
1950
1960
1970
1980
1990
2000
2010
2020
DHA Established
All Volunteer Force
Goldwater-Nichols
TRICARE established
MTF Down-sizing
Creation of JTF CAPMED, METC combination
NDAA 17
Studies and Reports
Policy and Statutory Events
UNCLASSIFIED


UNCLASSIFIED
Non-governance MHS studies and other background documents
Report of Military Compensation & Retirement Modernization Commission
2005 Defense Economics Conference Military Medical Mission
Approaches to Reducing Medical Spending on Military Health Care
Jan 89
Dec 93
Dec 98
Dec 03
Dec 08
Dec 13
Armed Forces Epidemiolgical Board: 1st Fifty Years
MHSS 2020
Military Health System Executive Review Local Authorities Working Group
Military Health System Review: Final Report
Track Four Efficiency Initiative Decision
Military Health System Modernization Study Team
UNCLASSIFIED

UNCLASSIFIED

Task B: Summary of findings and organizational constructs from key studies *

Source	Options Considered	Findings/Recommendation(s) [a]
SRA *DHA Feasibility Study* (1983)	• Only assessed the Defense Health Agency model as described in a proposal out of SASC at the time.	• DHA proposal "feasible and desirable," but not without problems. **Recommendation**: Distribute study to community of interest for comment.
DAM *Review of the DOD Organization for Health Care* (1991)	• Unified Medical Command to serve as a force provider to the CCMDs. The model is based on USSOCOM. • A Defense Health Agency • Strengthening the authorities of ASD-HA.	• No ASD(HA) has elected to exert his full authority or to implement the internal organizational restructuring required for greater involvement in program management. **Recommendation**: Centralized health command
RAND *Reorganizing the Military Health System* (2001)	• Status Quo: 2 Organizations tailored to the two MHS missions, readiness and benefits; • Modified status quo: Separated MTFs and TRICARE; • Joint Command w/ Service Components; • Joint Command w/ Service and TRICARE components; • Joint Command w/ Readiness and TRICARE components	• Insufficient evidence to predict the necessity or effectiveness of establishing a joint command to direct the restructured TRICARE organization and other military medical activities. **No Recommendation**: "we do not recommend one specific option in this report" (p. 75); Depends on how objectives are **valued**. • Abstract: Modify the current (as of 2001) system organization to unify health-plan management and separate it from MTF management.
J/UMC *Joint/Unified Medical Command Working Group* (2006)	• Unified Medical Command • Two Distinct Commands: (1) Joint Medical Command; (2) Joint Healthcare Command • Single Service	• Split Command models are inherently less efficient, likely less effective, and violate the principle of unity of command. • Single Service model is simple, efficient, effective, and could be done without a change to the law. • Unified Command provides unity of command and effectiveness, but has higher headquarters overhead than the single service model. **Recommendation**: Support for Unified Medical Command proposal.
CNA *Center for Naval Analysis Cost Implications Study* (2006)	• Single Medical Command • Medical Command and Health Care Command • Single Service	• Most savings likely realized under a single-service model; • Split medical command and healthcare command likely the highest cost; • Eliminating military, civilian, & contractor billets required to realize savings. **No Recommendation**
DBB *Defense Business Board Study* (2006)	• Unified Medical Command • Existing Structure w/ greater centralized control	• Costs to deliver this mission unsustainable – duplication and incompatibility of equipment key cost drivers. **Recommendations**: • Establish a Unified Medical Command; • Adopt Industry Best Practices; and • Use existing governance framework.
Task Force *MHS Government Task Force* (2011)	• Twelve models other than current structure considered.[b] Includes big and small versions of DHA, a UMC, and a single service model.	• Some centralization of shared services will be beneficial. Costs of adding command structure outweigh the benefits. **Recommendation**: "Small" DHA Model with Service retention of MTFs.

* More details on each key study, options considered, and their findings/recommendations provided in the backup slides of this deliverable.

UNCLASSIFIED

6

UNCLASSIFIED

Common themes and trends

- **Relationship between the readiness and benefits missions**
  - Some studies held these missions in tension (DRMS)
  - Others viewed the two missions as inseparably linked (DAM, Grace)
  - Focus on cost savings can create a bias toward centralization (CNA, Blue Ribbon)
- **Prior to the establishment of the DHA, DHC structures have been consistently found to be feasible given the statute and directives at the time of the study**
  - Desirability has varied; recommended at times (DAM, DBB), but not consistently (RAND, Task Force)
- **Desirability of a single, assertive, decision making authority in MHS** (DBB, DAM, DRMS, SRA, 1st Hoover, 2nd Hoover, Grace)
  - Prior to the establishment of the DHA, the separate question of combining shared services also enjoyed widespread support (SRA, DAM, J/UMC, DBB, Task Force, 1st Hoover, Blue Ribbon, Grace), though not unanimous (DRMS).
- **ASD(HA) possesses significant authorities for centralized decision making.**
  - Some studies conclude ASD(HA) does not exercise the full scope of their given authorities (DAM, DRMS), while others recommend strengthening the authorities held by ASD(HA) (Grace)
  - The 2nd Hoover Commission noted that ASD(HA) could be strengthened by making authorities/budgetary controls of SGs equitable

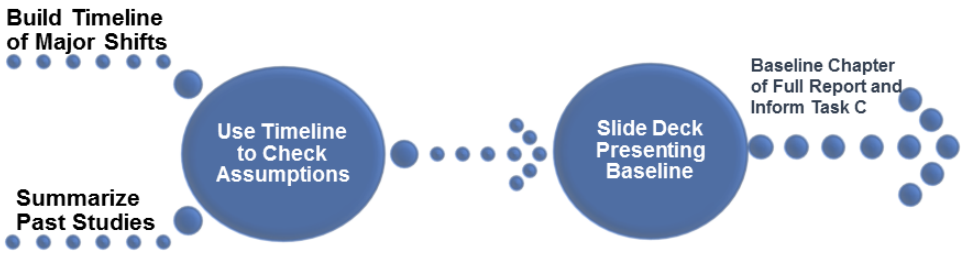
UNCLASSIFIED

7

UNCLASSIFIED

Task B: Process for Creating a Baseline of Previous Studies

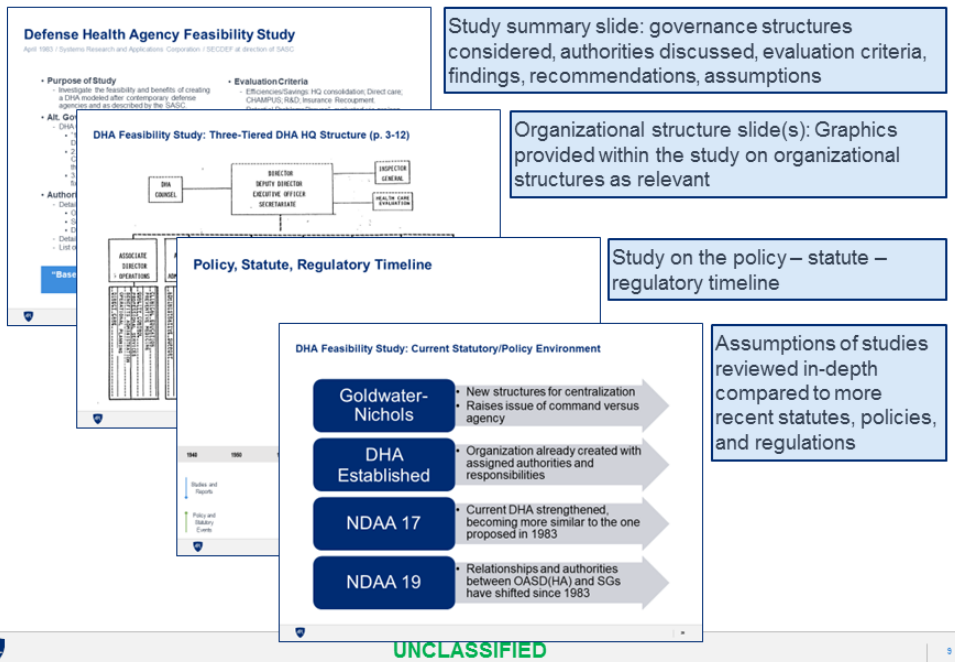
- Collect and review past studies on the organization of defense health.
- Build a timeline of policy-statute-regulation shifts that could impact applicability of past studies.
- Use the timeline to check study assumptions and inform option development (Task C) of caveats attached to any organizational options.



UNCLASSIFIED

UNCLASSIFIED

Task B: Study Summary Template



Study summary slide: governance structures considered, authorities discussed, evaluation criteria, findings, recommendations, assumptions

Organizational structure slide(s): Graphics provided within the study on organizational structures as relevant

Study on the policy – statute – regulatory timeline

Assumptions of studies reviewed in-depth compared to more recent statutes, policies, and regulations

UNCLASSIFIED

UNCLASSIFIED

Defense Health Agency Feasibility Study

April 1983 / Systems Research and Applications (SRA) Corporation / SECDEF at direction of SASC

- **Purpose of Study**
  - Investigate the feasibility and benefits of creating a DHA modeled after contemporary defense agencies and as described by the SASC.
- **Alt. Governance Model Considered**
  - DHA Organizational Structure with 3 Levels:
    - "1. A management headquarters, with Director and supporting staff;
    - 2. A set of Regional Commanders for the Continental U.S. and the major overseas theaters; and
    - 3. The personnel and other resources of the fixed military medical facilities worldwide…"
- **Authorities and Responsibilities**
  - Details DHA mission and following responsibilities:
    - ASD(HA) supervisor responsibilities
    - Surgeons General
    - DHA Director and Subordinate Commanders
  - Detailed list of 14 DHA functions w/sub-bullets.
  - List of functions to stay with services on p. 3-29.
- **Evaluation Criteria**
  - Efficiencies/Savings: HQ consolidation; Direct care; CHAMPUS; R&D; Insurance Recoupment.
  - Potential Problems/"Issues" evaluated via pro/con
- **Findings/Results**
  - Study finds DHA proposal as described by SASC to be "feasible and desirable," but not without problems. (p. 5-34)
- **Recommendations**
  - "that this report be circulated to the JCS, the Military Departments and the steering committee members… for comments and that those comments be incorporated… before the report is submitted to [SECDEF]." (p. 5-34)
- **Key Assumptions**
  - Only considered DHA option as described by SASC.
  - No in-depth look at implementation steps.
  - Did not consider Services/beneficiary receptivity.
  - Data for direct care efficiencies.

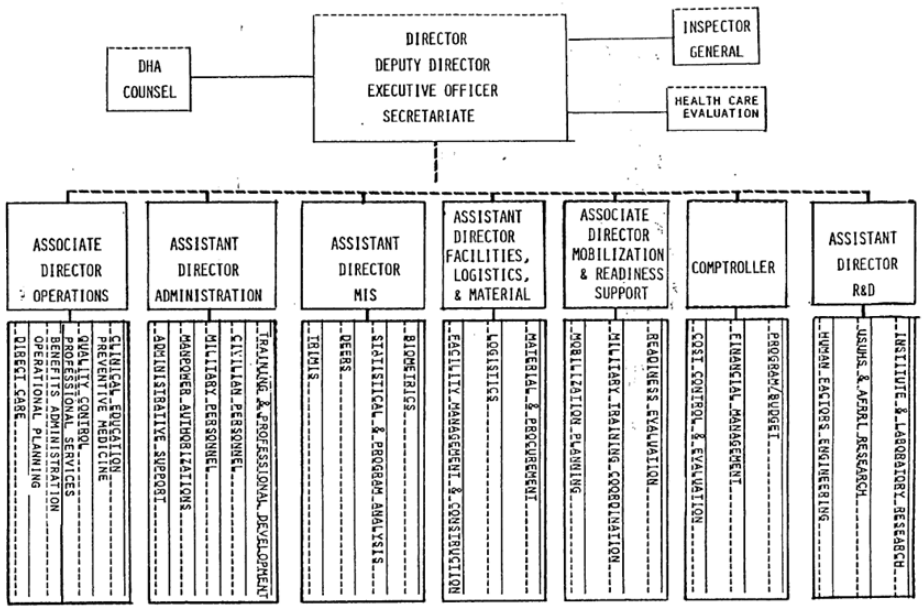
"Based on this analysis, the proposed DHA appears to be both feasible and desirable, but it will not be without problems" (p. 5-34)

UNCLASSIFIED

10

UNCLASSIFIED

Three-Tiered DHA HQ Structure (SRA, p. 3-12)

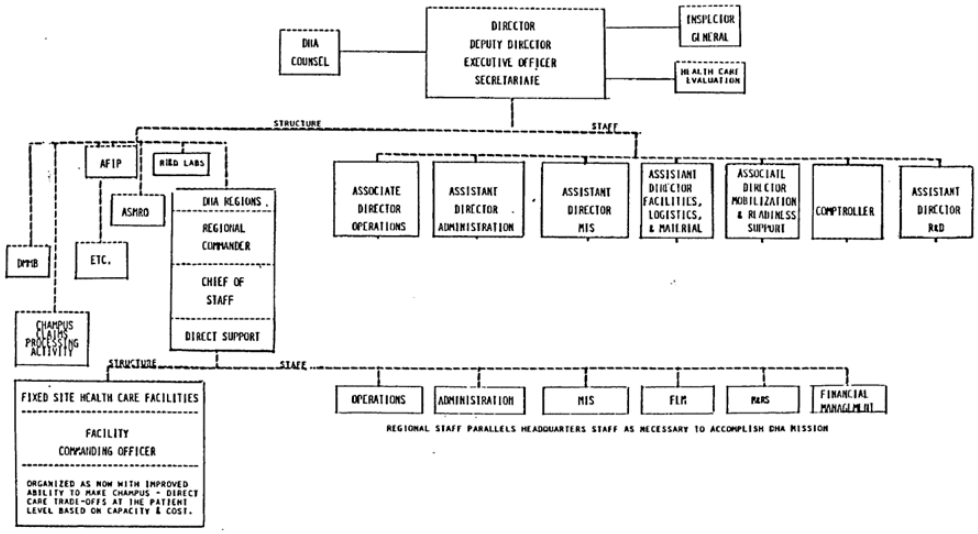


UNCLASSIFIED

11

UNCLASSIFIED

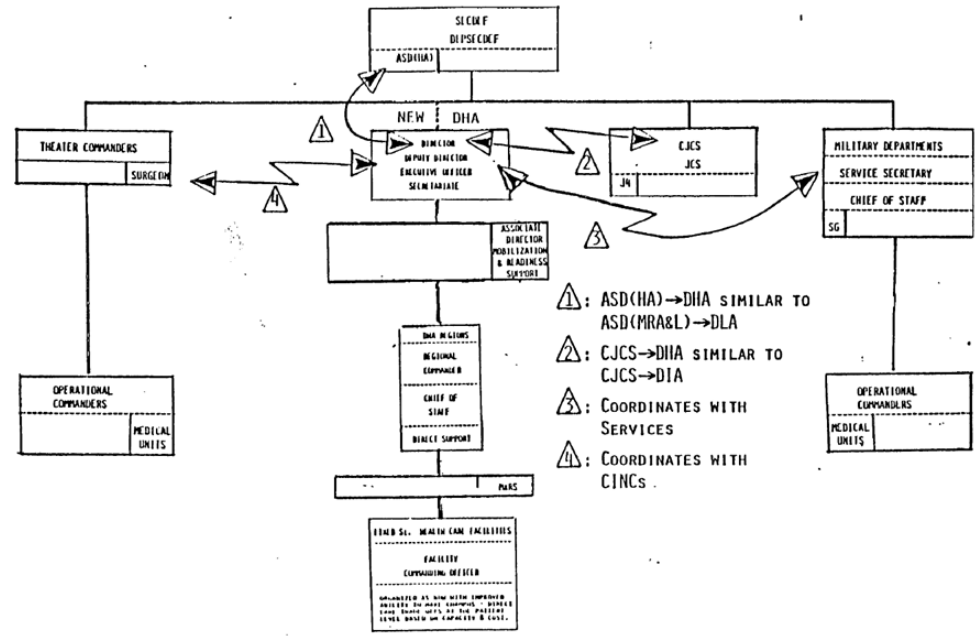
DHA Detailed Organization Chart (SRA, p. 3-14)



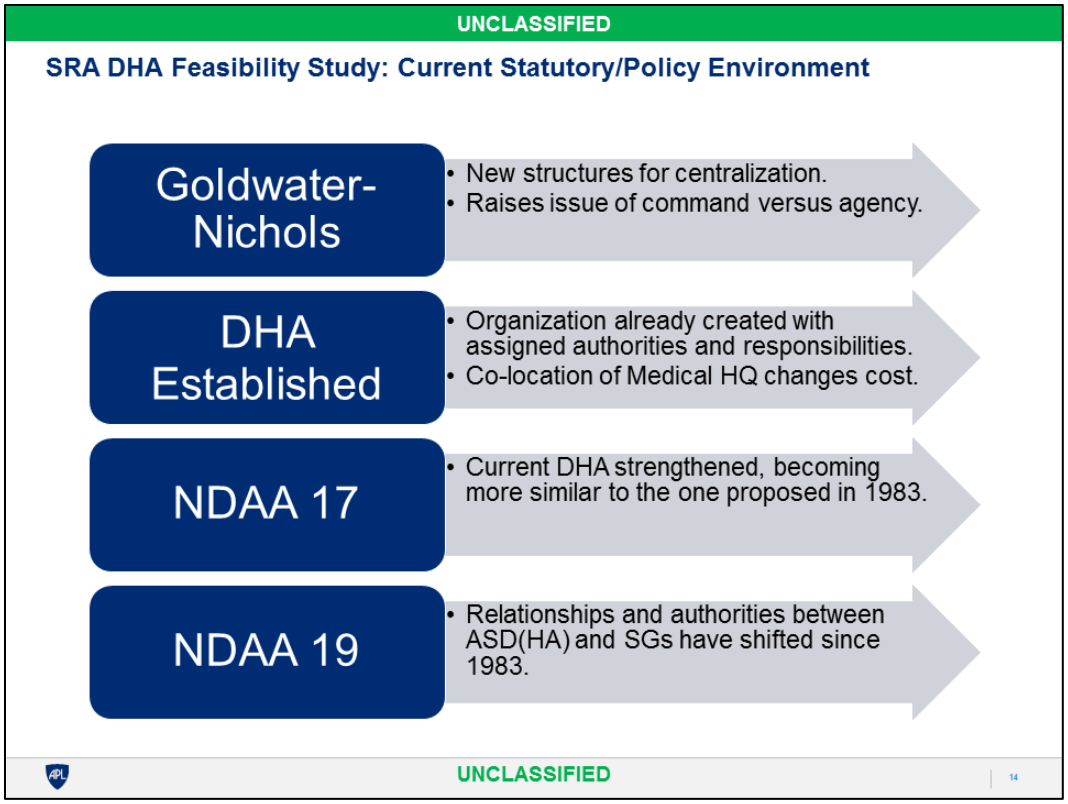
UNCLASSIFIED

UNCLASSIFIED

DHA Director's Relationships Within DoD (SRA, p. 3-15)



UNCLASSIFIED


UNCLASSIFIED
SRA DHA Feasibility Study: Current Statutory/Policy Environment
Goldwater-Nichols
• New structures for centralization.
• Raises issue of command versus agency.
DHA Established
• Organization already created with assigned authorities and responsibilities.
• Co-location of Medical HQ changes cost.
NDAA 17
• Current DHA strengthened, becoming more similar to the one proposed in 1983.
NDAA 19
• Relationships and authorities between ASD(HA) and SGs have shifted since 1983.
UNCLASSIFIED
14


UNCLASSIFIED
Review of the Department of Defense Organization for Health Care
1991 / Director of Administration and Management / Deputy SECDEF
• Purpose of Study
- How to achieve both the readiness and the benefits mission while also achieving cost savings.
• Alt. Governance Models Considered
- Unified Medical Command to serve as a force provider to the CCMDs. The model is based on USSOCOM.
- A DHA is considered as well as strengthening the authorities of ASD(HA).
• Authorities
- UMC: Budget authority granted to the command, with services having first cut. SGs absorbed into UMC.
- ASD(HA): Retain existing roles, functions, and responsibilities; Departments retain budget prep.
- DHA: CSA answering to ASD(HA); Director responsible for integrating readiness and peacetime missions.
• Responsibilities
- Medical Command would assume both the benefits and readiness mission with the Service Surgeons General serving as component commanders.
• Evaluation Criteria
- Qualitative evaluation of expected benefits.
• Findings/Results
- In addition to the benefits and readiness missions, it should be noted that a third mission exists of integrating the prior two missions and this must be institutionalized.
- "Although widely recognized as one of the strongest charters among OSD staff activities, because other officials do not have similar delegations, no ASD(HA) has elected to exert his full authority or to implement the internal organizational restructuring required for greater involvement in program management." (p. 9)
• Recommendations
- Centralized health command
• Key Assumptions
- The deployable force is now a joint force, and so joint medical provision is the best way to meet readiness requirements.
Benefits and readiness are too closely connected to be separately managed.
UNCLASSIFIED
15

UNCLASSIFIED

Review of DoD Org. of Health Care: Current Statutory/Policy Environment

DHA Established

- Current DHA is similar to proposed model (owns MTFs).
- However, SGs not dual-hatted as proposed.
- Co-location of Medical HQ.

NDAA 17

- Makes the current DHA more similar to this proposal.

NDAA 19

- Impacts role of SGs relative to DHA.

UNCLASSIFIED

16

UNCLASSIFIED

Reorganizing the Military Health System: Should There Be a Joint Command?

2001 / Susan Hosek and Gary Ceccine (RAND) / OSD

- **Purpose of Study**
  - Considered five alternative organizational structures for impact on health care and readiness. It also examined civilian managed-care systems.
- **Alt. Governance Models Considered**
  1. Status quo.
  2. Modification of current structure.
  3. Joint Command with Service Components.
  4. Joint Command with Service and TRICARE Components.
  5. Joint Command with Readiness and TRICARE Components.
- **Evaluation Criteria**
  - Based on study of success in private sector: (p. 71)
    - "Clear assignment of responsibility within the MHS and possibly a single authority
    - A coherent TRICARE health-plan management structure with designated local area managers
    - Assignment of authority over resources and other decisions, consistent with the assignment of responsibility
    - Strong accountability and incentives
    - Mechanisms that ensure that the services have highly effective operational medical support and the medical-line relationships that this requires
    - Clear assignment of responsibility, resources, and authority for readiness and mechanisms for coordinating with peacetime health-care delivery"
- **Findings/Results (see next slide)**
  - There is insufficient evidence to predict the necessity or effectiveness of establishing a joint command to direct the restructured TRICARE organization and other military medical activities.
  - The outcome of a regional test then underway could better inform that question.
- **Recommendations**
  - Abstract says: Modify the current (as of 2001) system organization to unify health-plan management in TRICARE and separate it from MTF management.
  - Recommendations section says: "we do not recommend one specific option in this report" (p. 75); Depends on how objectives are valued.
- **Key Assumptions**
  - That criteria drawn from the private sector are appropriate/apt
  - Status quo organizational model – changed by NDAAs
  - That definition of medical readiness suffices

"Unless a joint command is established, it is impossible to know whether it would manage the system more effectively." (p. 75)

UNCLASSIFIED

17

UNCLASSIFIED

RAND: Examining the Alternatives

Page 70 of Reorganizing the Military Health System by RAND Corporation (2001).

Table 6.1

Management Structure in Organizational Alternatives

	Current Structure: Number 1	Modified Current Structure: Number 2	MEDCOM Service Compo-nents: Number 3	MEDCOM Service, TRICARE Compo-nents: Number 4	MEDCOM Readiness, TRICARE Compo-nents: Number 5
Single MHS authority			✓	✓	✓
TRICARE management organization		✓		✓	✓
Combined MTF and TRICARE management			✓		
Service-based organization for readiness	✓	✓	✓	✓	✓
Service command of readiness, MTFs	✓	✓			

UNCLASSIFIED

UNCLASSIFIED

RAND Study: Current Statutory/Policy Environment

CAPMED/NCR
- Study referenced a regional experiment taking place that could provide data.
- Potential needed data possibly comes out of NCR experience.

DHA Established
- Obviates the non-command options; Changes the analysis to a comparison with command structures.
- Authorities now clearly defined.
- Co-location of Medical HQ.

NDAA 17
- Status quo now includes the MTFs under the control of the DHA.
- Has altered the services' equity positions.

NDAA 19
- Organizational model now more clearly defined as Congress tightly prescribes duties and structure of DHA.

UNCLASSIFIED

UNCLASSIFIED

Cost Implications of a Unified Medical Command

May 2006 / Eric Christensen, CDR DeAnn Farr, James Grefer, and Elizabeth Schaefer (CNA) / BuMed

- **Purpose of Study**
  - "[E]stimate the cost implications of various configurations of a unified medical command." (p. 1)
- **Alt. Governance Model(s) Considered**
  - The study estimated savings and costs by function to examine three different unified medical command structures: (p. 1)
    - (1) A single medical command,
    - (2) a medical command and a healthcare command, and
    - (3) a single medical service.
- **Authorities and Responsibilities**
  - Org. charts differentiate between "Operational control," "Combatant Command Authority," "Policy and oversight," and "Command relationships determined by JFC." (pp. 7-9)
  - USSOCOM model for single medical service. (p.9)
- **Evaluation Criteria**
  - Cost over "the long run," meaning the "steady state after a [UMC] would be fully implemented." (pp. 2, 105) Does not count transition costs.
- **Findings/Results**
  - Most savings found in a single medical service.
  - A single medical command comes in second.
  - A medical command and a healthcare command offers the smallest potential savings.
  - In all cases, savings are greater when eliminating military as well as civilian/contractor personnel.
- **Recommendations**
  - N/A; Only examined costs, not effectiveness.
- **Key Assumptions**
  - Numerous cost estimation assumptions.
  - Clear command and control.
  - 20% redundancy.
  - Does not compare any command structures to centralization within a Defense Health Agency.

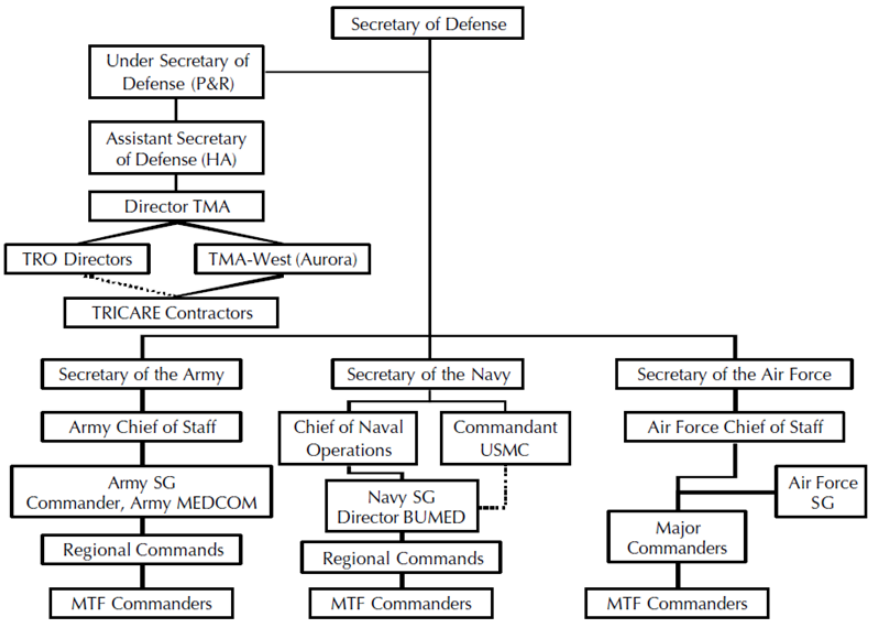
Does not compare a command structure to centralization within a Defense Health Agency.

UNCLASSIFIED

20

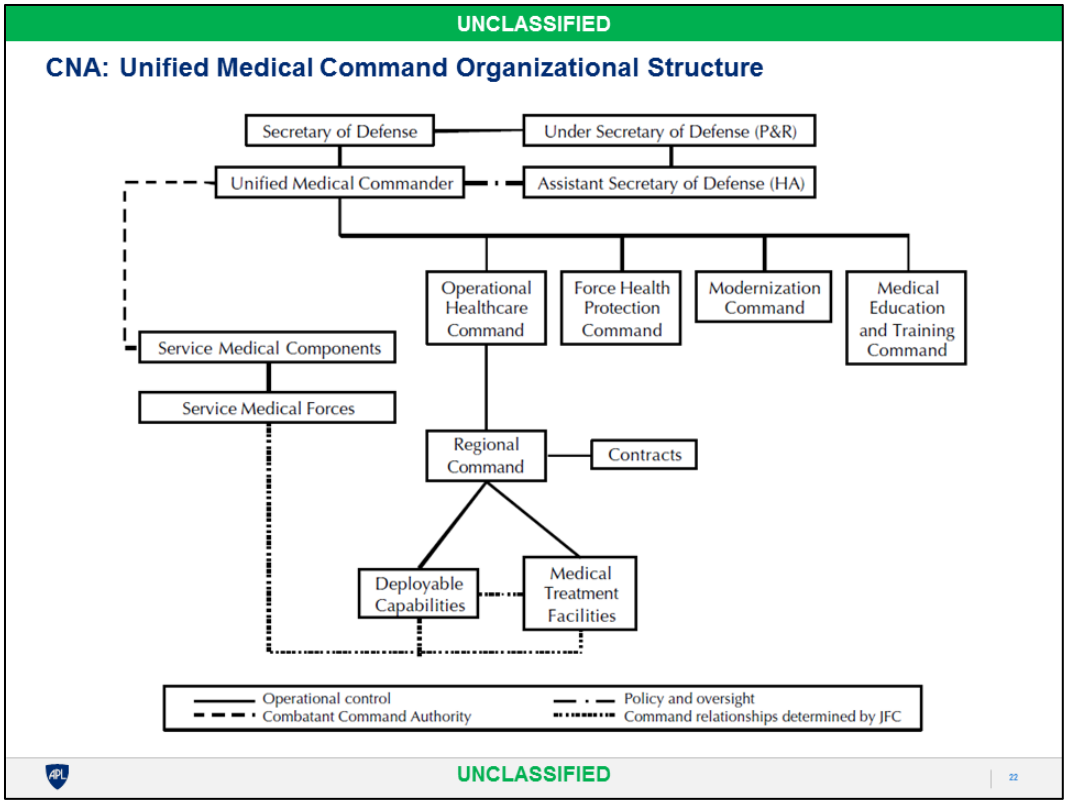
UNCLASSIFIED

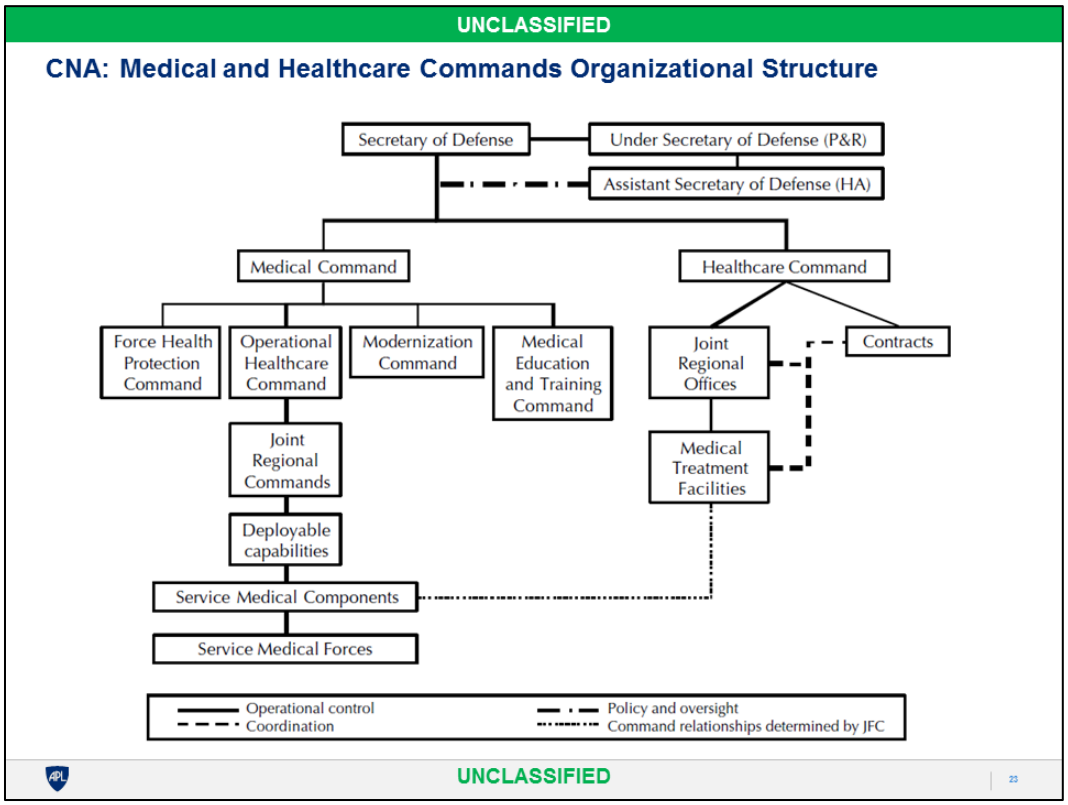
CNA: Status Quo (2006) Organizational Structure



UNCLASSIFIED

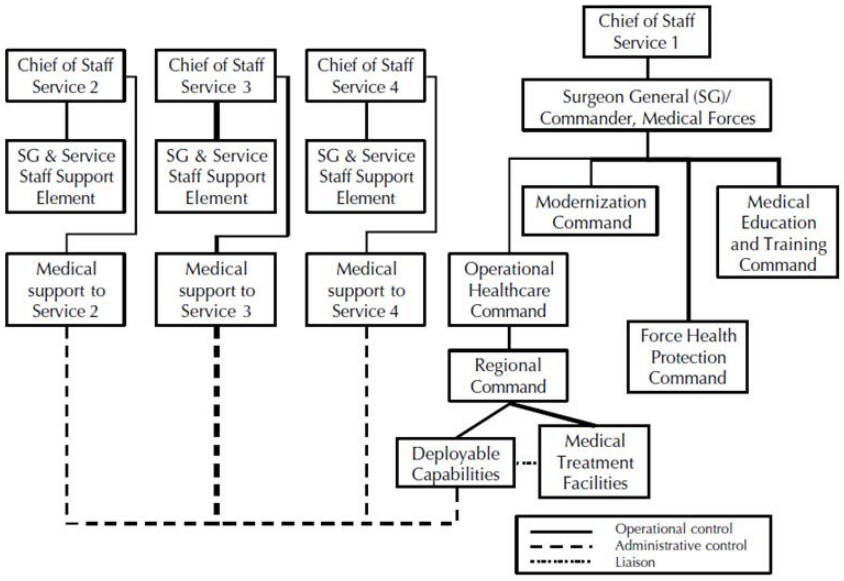
21


UNCLASSIFIED
CNA: Unified Medical Command Organizational Structure
Secretary of Defense
Under Secretary of Defense (P&R)
Unified Medical Commander
Assistant Secretary of Defense (HA)
Operational Healthcare Command
Force Health Protection Command
Modernization Command
Medical Education and Training Command
Service Medical Components
Service Medical Forces
Regional Command
Contracts
Deployable Capabilities
Medical Treatment Facilities
Operational control
Combatant Command Authority
Policy and oversight
Command relationships determined by JFC
UNCLASSIFIED
22


UNCLASSIFIED
CNA: Medical and Healthcare Commands Organizational Structure
Secretary of Defense
Under Secretary of Defense (P&R)
Assistant Secretary of Defense (HA)
Medical Command
Healthcare Command
Force Health Protection Command
Operational Healthcare Command
Modernization Command
Medical Education and Training Command
Joint Regional Offices
Contracts
Joint Regional Commands
Medical Treatment Facilities
Deployable capabilities
Service Medical Components
Service Medical Forces
Operational control
Coordination
Policy and oversight
Command relationships determined by JFC
UNCLASSIFIED
23

UNCLASSIFIED

CNA: Single Service Organizational Structure



UNCLASSIFIED

UNCLASSIFIED

CNA Cost Implications Study: Current Statutory/Policy Environment

DHA Established

- Co-location of Medical HQ changes costs.
- Potential savings likely far less than the numbers as they stood at the time of the study (2006 no longer baseline).

NDAA 17

- Status quo now includes the MTFs under the control of the DHA.
- Has altered the services' equity positions.

NDAA 19

- Organizational model now more clearly defined as Congress tightly prescribes duties and structure of DHA.

UNCLASSIFIED

UNCLASSIFIED

Military Health System – Governance, Alignment and Configuration of Business Activities Task Group Report

September 2006 / Defense Business Board (DBB) / Dep. SECDEF (Gordon England)

- **Purpose of Study**
  - Assess and provide an independent and objective assessment to DoD for a MHS governance framework consistent with the Defense Enterprise Planning and Management Framework
  - Identify key best practices for delivery of the overall military health care mission.
- **Alt. Governance Model(s) Considered**
  - Unified Medical Command
  - Existing structure with greater centralized control
- **Authorities**
  - ASD(HA): Holds policy control, budget accountability, and oversight of all MHS activities.
  - Service Medical: DBB implies that Services control some funding.
- **Responsibilities**
  - Move shared services, non-battlefield medicines (Level III up) and associated funding into UMC
  - Maintain battlefield medicine (Level I and II) within the services, along with service-specific medical capabilities.
  - Realign TMA to function alongside UMC and streamline its management functions to focus on policy and oversight of health plan management.
- **Evaluation Criteria**
  - Cost
  - Unity of Effort/Command
- **Findings/Results**
  - UMC is feasible within Title 10.
  - Military medicine seen as strategic national asset, and health diplomacy can help win hearts and minds.
  - Costs to deliver this mission unsustainable – duplication and incompatibility of equipment.
- **Recommendations**
  - Establish a Unified Medical Command
    - Begin implementation in January 2007
  - Adopt industry best practices for defense medicine
    - Combine like shared services across the medical community
  - Use existing governance framework
    - Support MHS strategic plan regarding the linking of shared services to core processes
    - Establish feedback loops for civilian healthcare benefit management activities
- **Key Assumptions**
  - Health diplomacy was salient in 2006 (i.e. Iraq, Afghanistan, Indonesian tsunami). Less so today (although may be salient if U.S. competes with China on soft-power terms), but cost concerns remain.
  - TMA exists, which is no longer the case.

UNCLASSIFIED

26

UNCLASSIFIED

DBB Governance Study: Current Statutory/Policy Environment

DHA Established

- TMA disestablished as functions are transferred to the DHA.
- DBB presumed a reformed TMA working alongside the UMC.
- Co-location of Medical HQ changes cost.

NDAA 17

- DHA Operates MTFs: Non-battlefield medicine in DHA, not UMC.
- Any consolidation within DHA, not UMC.
- DHA as CSA: Not a force generator. Must meet readiness & operational requirements.

NDAA 19

- Organizational model now more clearly defined as Congress tightly prescribes duties and structure of DHA.
- Consolidation of Research & Development and Public Health under DHA.

UNCLASSIFIED

27

UNCLASSIFIED

Joint/Unified Medical Command (J/UMC) Working Group

November 2006 / J/UMC Working Group / Chartered by USD(P&R) and DJS

- **Purpose of Study/Background**
  - Called for in PBD 753 (Jan 2005) with no problem indicated.
  - Identified these problems to solve: Joint Force Health Protection/Operational Medicine issues, Force Generation Issues, and Beneficiary Care issues
- **Alt. Governance Model(s) Considered**
  - 8 models winnowed down to 3. 4th added by HA/P&R after analysis completed.
  - 3 original options: SOCOM-like functional Command; Split Commands over operational mission and benefits mission; Single Service over all.
  - 4th option: Civilian controlled health agency type model.
- **Authorities**
  - Sufficient detail for 3 or 8. COCOM, OPCON, ADCON, TACON in each setting: deployed (service-embedded and joint), garrison (service-embedded), and MTFs.
- **Responsibilities**
  - Partial, but a lot. Policy oversight, management of infrastructure and purchased care, training, recruiting and promotion
- **Evaluation Criteria**
  - Effectiveness and Efficiency (details in notes)
- **Findings/Results**
  - Split Command models are inherently less efficient, likely less effective, and violates the principle of unity of command.
  - Single Service model is simple, most efficient and effective, and could be done without a change to the law.
  - Unified Command provides unity of command, stipulates unity and effectiveness, but has higher headquarters overhead than the single service model.
- **Recommendations**
  - Support for Unified Medical Command proposal.
- **Key Assumptions**
  - JS is Global Force Manager; JFCOM is Global Force Provider
  - New HQ would have to be built for COAs 1,2
  - Joint business procedures and IM/IT systems
- **Notes**
  - 4th COA added after analysis was conducted—no documentation of decision or 4th COA

UNCLASSIFIED

28

UNCLASSIFIED

J/UMC WG: Authorities/Responsibilities Tables for 3 COAs (1/2)

COA 1: Joint / Unified Medical Command

Authority or Responsibility	Services	UMC	Health Affairs
Healthcare policy and oversight			X
Recruiting, initial entry training, promotion, professional development	X		
Medical training	Sustainment training	X	
Operational control of organic level 1 and 2 health assets	X		
Operational control of Theater-level medical organizations		X	
Operational control of MTFs and clinics		X	
COCOM authority over Component medical orgs in a non-deployed setting		X	
Management of purchased care contracts		X	
Managements of MTF infrastructure		X	

COA 2: Joint / Unified Medical Command and Joint/Unified Healthcare Command

Authority or Responsibility	Services	MED CMD	HC CMD	Health Affairs
Healthcare policy and oversight				X
Recruiting, intial entry training, promotion, professional development	X			
Medical training	Sustainment training	X		
Operational control of organic level 1 and 2 health assets	X			
Operational control of Theater-level medical organizations		X		
Operational control of MTFs and clinics			X	
Management of purchased care contracts			X	
Managements of MTF infrastructure			X	

Note about COA 2 table: Indicates MTFs are OPCON to HC CMD—not quite. Deployable providers remain OPCON to Medical CMD, and provided to HC CMD via an MOA and can be removed when needed.

UNCLASSIFIED

29

UNCLASSIFIED

J/UMC WG: Authorities and Responsibilities for COA 3 (2/2)

COA 3: Single Service-Based Medical System			
Authority or Responsibility	**Other Services**	**Single Service**	**Health Affairs**
Healthcare policy and oversight			X
Recruiting, intial entry training, promotion, professional development		X	
Medical training		X	
Operational control of organic level 1 and 2 health assets	X		
Operational control of Theater-level medical organizations		X	
Operational control of MTFs and clinics		X	
Administrative control of all medical personnel		X	
Management of purchased care contracts		X	
Managements of MTF infrastructure		X	

UNCLASSIFIED

30

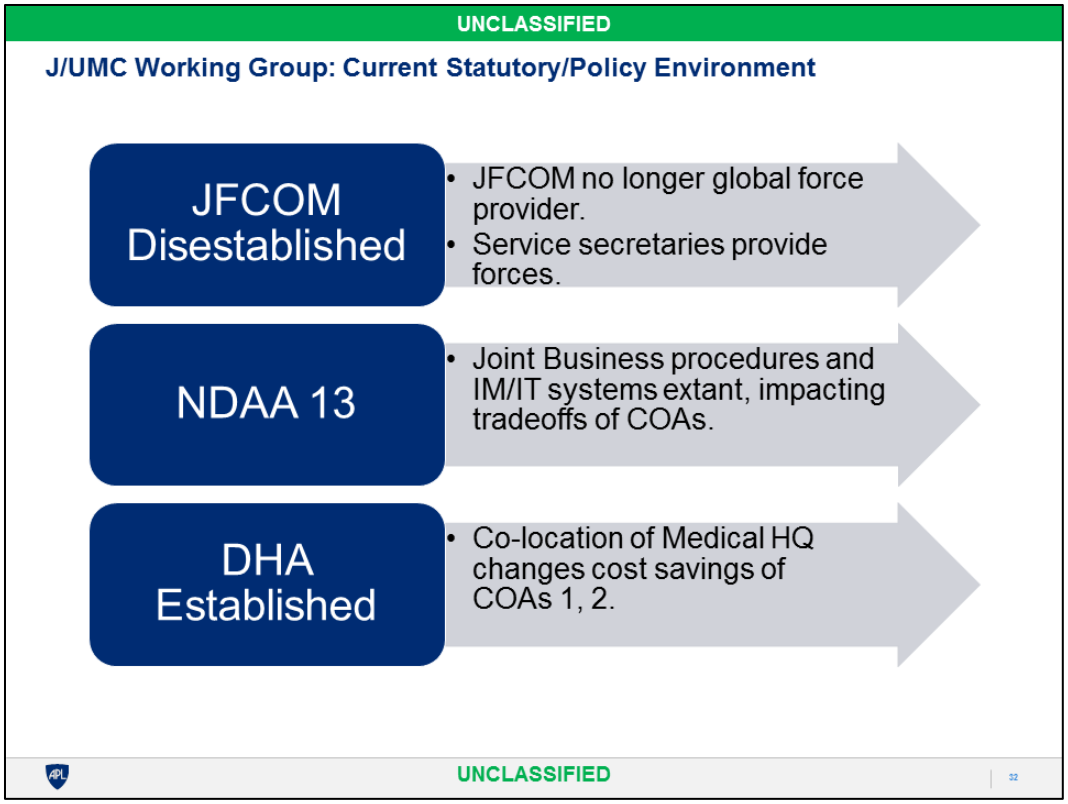
UNCLASSIFIED

Evaluation Table and Pros and Cons

Measure	COA 1: Unified Command	COA 2: Dual Commands	COA 3: Single Service
Effectiveness			
Maintain clear lines of authority	+++	+	+++
Promote interoperable and interdependent processes, common standards, and resource sharing	++	+	+++
Support Joint and Service-unique requirements	+++	+	++
Balance the operational and benefits mission	+++	+/-	+++
Efficiency			
Eliminate layers of command and duplication	++	+/-	+++
Reduce cost of benefit mission delivery	++	+	+++
Potential annual cost savings	$334M	$271M	$407M
Pros	Uses existing Unified Command structure, Joint responsibility for operational med & h/c, strong links between medics and Services	Healthcare-focused command develops h/c program mgmt expertise	Greatest potential for standardization, does not require new HQ, streamlined option, simplifies planning
Cons	Line commanders may perceive as reduced support, requires estab. of new HQ, requires estab. of joint business and IM/IT procedures	Responsibility for med & h/c split, deployment sourcing and readiness issues require coord btwn Svcs & Commands	Resource liability for Service, potential disenfranchisement of other Services, transitions personnel to another Service

UNCLASSIFIED

31


UNCLASSIFIED
J/UMC Working Group: Current Statutory/Policy Environment
JFCOM Disestablished
• JFCOM no longer global force provider.
• Service secretaries provide forces.
NDAA 13
• Joint Business procedures and IM/IT systems extant, impacting tradeoffs of COAs.
DHA Established
• Co-location of Medical HQ changes cost savings of COAs 1, 2.
UNCLASSIFIED


UNCLASSIFIED
DoD Task Force on MHS Governance and Supplement
September 2011 / DoD Task Force (Dr. Taylor and MG Robb) / DoD
• Purpose of Study
- To evaluate for the SECDEF alternative MHS governance models, later addition of a report to Congress including a cost analysis.
• Alt. Governance Models Considered
- Twelve models considered including big and small versions of DHA, a UMC, and a single service model.
• Authorities
- Elements and authorities discussed for each of the ten models.
- No clear discussion of the relationship of DHA director to the Service SGs
• Responsibilities
- Each proposed alternative structure enumerated the responsibilities that would be transferred from the current Service run model and then was evaluated against the status-quo.
• Evaluation Criteria
- Stakeholder engagement and voting based on a qualitative assessment.
- The Supplement added a cost analysis, though we note that this was found to be insufficient by the GAO (GAO-12-911).
• Findings/Results
- Some centralization of shared services will be beneficial. Costs of adding command structure outweigh the benefits.
• Recommendations
- Small DHA with Service retention of MTFs.
• Key Assumptions
- TF relied on the 2006 CNA report for personnel estimates.
- Large changes in headquarters sizing would require process changes in order to minimize impact on effectiveness.
Small DHA is the preferred option. Services retain readiness and healthcare provision.
UNCLASSIFIED

UNCLASSIFIED

Task Force on MHS Governance: Current Statutory/Policy Environment

DHA Established
- 2013 directive created small DHA.
- DHA designated as a CSA by SECDEF in 2013.
- Co-location of Medical HQ.

NDAA 17
- Shifting of MTFs transitions the small DHA into a big DHA.

NDAA 19
- Research and Development centralization in DHA.

UNCLASSIFIED

UNCLASSIFIED

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

June 30, 2018 / DoD / Congress

- **Purpose of Report**
  - Implementation plan submitted to Congress by the DoD regarding integration of the MHS.
- **Governance Models Discussed**
  - Five Implementation Phases (0 through 4) to strengthen DHA enterprise activities and the standardization of processes across MTFs. (p. 3)
- **Authorities and Responsibilities**
  - Oversight Councils will "focus on high-level, MHS-wide policy and budgetary matters," rather than both policy and management issues. (p. 5)
    - As opposed to past governance bodies, which saw an often "sclerotic decision-making process that has the effect of demoralizing staff and other stakeholders." (p. 5)
  - "Functions unique to Service-specific operational readiness matters will continue to be executed by the Services. Matters that have both Service and DHA equity will be resolved by ASD(HA) with the advice and assistance of an updated MHS Governance model." (p. 5)
- **Evaluation Criteria**
  - N/A
- **Findings/Results**
  - N/A
- **Recommendations**
  - Legislation that would "grant the ability to implement title 10 U.S.C. §1073c under a phased-in approach as well as grant the Secretary the authority to waive specific requirements of title 10 U.S.C. §1073c if the Secretary determines such waiver is necessary for implementation feasibility or military health readiness." (p. 1)
- **Key Assumptions**
  - N/A

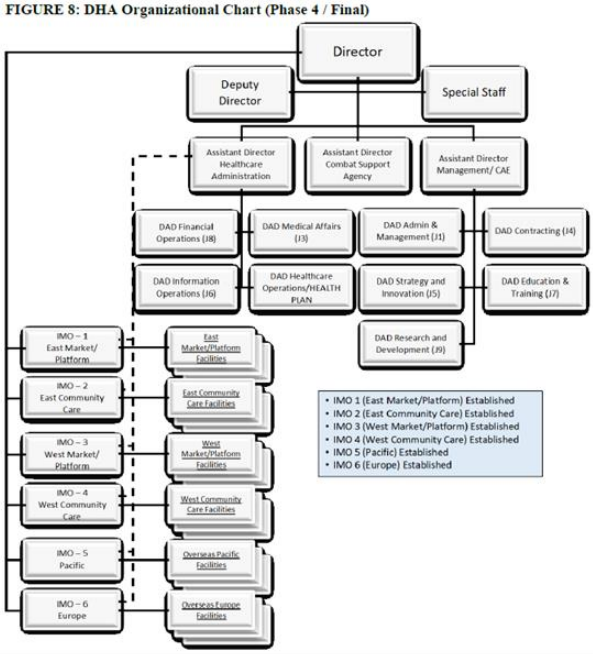
"MHS Governance will shift its focus from consensus-driven bodies…to a smaller, more streamlined set of oversight councils" (p. 5)

UNCLASSIFIED

UNCLASSIFIED

Section 702 Implementation Report: Currently Planned Final DHA Org Chart

FIGURE 8: DHA Organizational Chart (Phase 4 / Final)



UNCLASSIFIED

UNCLASSIFIED

Reorganization of Federal Medical Activities (First Hoover Commission)

March 1949 / The Commission on Organization of The Executive Branch of the Government / Congress

- **Purpose of Study**
  - As part of an overall review of how the Executive Branch was organized, the Hoover Commission reviewed all Federal medical activities.
- **Alt. Governance Model Considered**
  - A Unified Medical Administration to consolidate most Federal medical care, research, and public health. *Including military hospitals in the U.S.*
    - Did not consider a non-Cabinet level solution.
  - Military medical services would remain intact, each retaining one training and research center and all overseas hospitals.
- **Authorities**
  - Administrator reports to POTUS; Supported by Advisory Board of the 3 Surgeons General and the Administrator of Veterans' Affairs.
    - Dissents to advisory role of the Board.
- **Responsibilities**
  - Most U.S. functions, facilities, and personnel transferred to the United Medical Administration.
- **Evaluation Criteria**
  - Itemized deficiencies of status quo structure.
- **Findings/Results**
  - List of advantages of proposed Administration.
- **Key Recommendations**
  - Advisory Board of Surgeons General and VA.
  - "control of medical policy in the armed services should be exercised by the [SECDEF]." (p. 27)
  - New Administration "should give constant attention to necessary measures for national defense." (p. 28)
- **Key Assumptions**
  - Government medical care must be "the highest quality which can be sustained by the best possible organization of the strictly limited human resources available." (p. ix)
  - Commission to recommend a Cabinet Department embracing health, education, and security. (p. ix)

"[T]he Commission recommends the establishment of a United Medical Administration [consolidating most Federal]…medical care, medical research, and public health." (p. 2)

UNCLASSIFIED

UNCLASSIFIED

Federal Medical Services (Second Hoover Commission)

February 1955 / Commission on Organization of The Executive Branch of the Government – Medical Services Task Force / Congress

- **Purpose of Study**
  - Due to waste and lack of improvement since first Commission, Task Force performed a basic investigation into the Federal medical services.
- **Alt. Governance Model Considered**
  - "A regional pattern in which… Responsibility for medical care for the three Services could be assigned to the Service with the major interest in each region of the United States." (p. 25)
- **Authorities and Responsibilities**
  - Status quo responsibilities and authorities of the Surgeons General too varied.
  - ASD(HA) coordination would be strengthened if SGs "were each to be given a reasonable comparable span of control, with adequate authority and budgetary control to carry out his responsibility." (pp. 26-27)
- **Evaluation Criteria**
  - Included cost, staffing, average daily occupied beds, unused beds, and other metrics.
- **Findings/Results**
  - "[E]vidence of duplication and waste in the Defense Department medical services." (p. 23)
- **Recommendations**
  - Modify "the medical and hospital services of the three Armed Services… into a much more closely coordinated pattern…" (p. 27)
  - SECDEF "develop recommendations for revision of the Selective Service Act to effect maximum utilization of medical personnel." (p. 28)
  - "[S]trengthen the Armed Services training program for interns and residents, for other physicians and dentists on active duty, and for reserve officers not on active duty…" (p. 29)
- **Key Assumptions**
  - Selective Service as driver for medical staffing.

"In the absence of unification, regionalization can offer the best solution." (p. 25)

UNCLASSIFIED

UNCLASSIFIED

Report of the Blue Ribbon Defense Panel

July 1970 / Blue Ribbon Defense Panel & the National Technical Information Service / POTUS and SECDEF

- **Purpose of Study**
  - A broad overview of the entire organization, structure, and operation of the DoD.
- **Alt. Governance Models Considered**
  - Medical functions only briefly noted as advisably centralized into a Defense Agency.
    - "There exist… innumerable non-combatant functions common to more than one Service. Among such functions for which Defense Agencies have not been created, but where significant economies might result from consolidation, are… (2) Medical, dental and hospital services." (p. 42)
  - "An alternative to the Defense Agency for consolidation of common non-combatant functions is the designation of one Military Department as 'Executive Agent' to perform such functions for all military services… For a comparatively small function, this mechanism has… advantages." (p. 42)
- **Authorities and Responsibilities**
  - N/A
- **Evaluation Criteria**
  - N/A
- **Findings/Results**
  - N/A
- **Recommendations**
  - Consider establishment of a Defense Agency for the medical, dental, and hospital services.
- **Key Assumptions**
  - N/A

The Blue Ribbon Defense Panel did not consider or examine organizational models, authorities, or responsibilities for Military Health with any sort of depth.

UNCLASSIFIED

UNCLASSIFIED

Defense Resource Management Study

February 1979 / Donald B. Rice / Requested by POTUS and SECDEF

- **Purpose of Study**
  - Commissioned by SECDEF at request of POTUS to conduct a "searching organizational review" of five resource management issues. (p. v)
- **Alt. Governance Model Considered**
  - None: "discusses, but makes no major recommendations on, the organization of the health care system" (p. 80)
  - Despite not considering alternative models, "With respect to the organization of DoD health care, the DRMS opts for the current decentralized system." (p. xv) Answers question without asking!
- **Authorities**
  - No new or different authorities proposed.
  - Notes statutory ASD(HA) authorities and SGs.
- **Responsibilities**
  - Makes sharp distinction between the Readiness and Benefit missions; Separate sections.
  - No new or different responsibilities proposed.
  - Reviews status quo functions of Surgeons General.
  - Absence of explicit assignment of Benefits mission.
- **Evaluation Criteria**
  - N/A: Did not evaluate organizational options.
- **Findings/Results**
  - Focus = Bed capacity for early wartime scenario and improvements to CHAMPUS benefit.
- **Recommendations**
  - Try Harder: *"the DRMS opts for a more concerted effort to pursue both missions through the current, decentralized system."* (pp. 111-112)
  - *"… stronger leadership and more aggressive management by the Secretary of Defense, the Assistant Secretary of Defense (Health Affairs) and the Assistant Secretary of Defense (Manpower, Reserve Affairs, and Logistics) are clearly warranted."* (p. 112)
- **Key Assumptions**
  - Divided governance between Services is better for the Readiness mission than consolidation.

"The DRMS has not taken up the consolidation question" (p. 111)

UNCLASSIFIED 40

UNCLASSIFIED

President's Private Sector Survey on Cost Control

Spring/Fall 1983 / Grace Commission / White House

- **Purpose of Study**
  - This study is part of the Grace Commission authorized by President Reagan to focus on waste and inefficiency in the U.S. government. The specific report here focused on the need for a central authority should be created for the management of the medical branches of the three services.
- **Alt. Governance Model Considered**
  - This analysis proposes consolidation of shared functions; the study notes that operation of each service's hospital system is a perceived mission of the service.
- **Authorities**
  - There is not sufficient detail on the types of authorities this centralization would have over military Service Medical.
- **Responsibilities**
  - Consolidation of facility planning and graduate medical education.
- **Evaluation Criteria**
  - Simple cost analysis: no rigorous methodology or explanation provided
- **Findings/Results**
  - Shifting to a centralized authority will save $225M per year.
- **Recommendations**
  - Create a centralized authority, starting with strengthened ASD(HA), but also through Congressional legislation.
- **Key Assumptions**
  - Military health has dual missions of benefits (peacetime) and readiness, and while ASD(HA) is nominally responsible for both they have delegated readiness to Service Medical.

"Begin to establish more authority and direction from OASD-HA" (p. 79)

UNCLASSIFIED 41

UNCLASSIFIED

Grace Commission: Reasons why consolidation had not been adopted by 1983… (pp. 64-65)

The DRMS "recommendations regarding the consolidation of the three Military Medical Departments under a single management structure and organization have not been adopted. Several reasons can be given for this:"

- "Each military service is a contiguous unit that fosters and breeds loyalty both to the individual armed service and the Nation. Certain unavoidable codes of personal conduct, based on tradition and autonomy, remain sacrosanct to this day and prevent any true consolidation of operations or services except in an emergency. **The development of individual hospital systems within each armed service is entangled in this autonomous tradition**."
- "The **perceived mission** of each armed service **extends to its hospital system** and the services it is designed to supply."
- "Only in the last two years has Congress acknowledged the health benefits, or 'peacetime,' mission of the DoD hospital system. Only recently has it begun to show an interest in a consolidated hospital system for DoD."
- "There has been a **lack of standardization in staffing, accounting and other operational aspects** of the three armed service hospital systems. This situation is gradually changing due to uniform methodologies discussed and recommended in this Report."
- "There have been some efforts, however, to implement other recommendations pertinent to the coordination and integration of health delivery among the military services."
- "In 1973, the three Military Medical Departments initiated… [CONUS]-wide Tri-Service Regionalization. This effort appears to focus on reactive events rather than participating in the identification of active initiatives that would have a positive effect on long-term problems and planning."
- "In 1975, the 'DoD/HEW/OMB Military Health Care Study' recommended the creation of 'a central entity within DoD to serve as a coordinating mechanism for planning and allocating resources and to oversee health care delivery in CONUS.' The DoD health Council was created as a result in December 1976."

UNCLASSIFIED

42

UNCLASSIFIED

MHSS 2020

1996 -97 / Mr. Charles Monfort (MHSS Strategic Planning & DASD (PPC) Health Affairs) and RADM Rowley (Senior Advisor)

- **Purpose of Study**
  - A structured exploration of the possible 21st century futures of military health using four broad planning scenarios. "MHSS 2020 was chartered to create an ongoing process that explores long term visioning and strategic MHSS requirements." (p. 1-2)
- **Alt. Governance Models Considered**
  - No specific governance models were considered but working groups discussed and analyzed trends and forecasted possibilities of future military health.
  - Integrated groups forecast more specific stories of how the future of military health might unfold in four scenarios.
- **Authorities and Responsibilities**
  - N/A
- **Evaluation Criteria**
  - The study used "plausible futures," "trends," and "scenarios" in present, mid, and long-term to focus the discussions on specific topics and potential future environments. (pp. 2-5 to 2-6)
- **Findings/Results**
  - MHSS 2020 resulted in four products: MHSS Future Scenarios book; Semantic Model for capturing ideas; a Non-linear dynamic model for simulating military health over a 25-year period; an online Health Futures Repository; and 200 trained military health futurists.
- **Recommendations (p. 8-2)**
  - "Make aspects of 'health promotion, wellness, self-care, and healthy communities' THE military medical mission"
  - "Promulgate Health Operations Other Than War as one of THE primary readiness tools for advancing national policy"
  - "Define US medical readiness operations by their global scope and concentrate on fully supporting and medically leading international coalition forces"
  - "Market MHSS strategic long-range and near-term planning processes and products at all levels."
  - "Ensure that all information and communication technologies are platform independent, inter-operable, **standardized**, and fully accessible throughout the MHSS."
- **Key Assumptions**
  - Military health will see continued movement toward an integrated defense health organization, and there will be a much larger role for health operations other than war in term of critical importance and frequency.

No specific governance models were considered, but recommendations were offered based on projected trends in military health.

UNCLASSIFIED

43

UNCLASSIFIED

Task Force on the Future of Military Health Care: Final Report

December 2007 / Dr. Wilensky, Gen. Corley (USAF), et al / SECDEF

- **Purpose of Study**
  - "[A]ssess and recommend changes that would help sustain the military health care services" on "an array of topics..." (Cover Letter and p. P1)
- **Alt. Governance Model Considered**
  - None.
  - Discussed "Command and Control Structure to Manage the Military Health System," but in light of vigorous debate and recent GAO reports, decided it was "premature to make additional recommendations," and only reiterated one given by the GAO. (p. ES12)
- **Authorities and Responsibilities**
  - N/A
- **Evaluation Criteria**
  - N/A
- **Findings/Results**
  - Reviewed recent studies/command structures:
    - RAND: "appear to have some merit." (p. 113)
- **Recommendations**
  - Echoed the GAO.
  - "Develop Metrics by Which to Assess the Success of Military Health System Transformation." (pp. ES12, 116)
- **Key Assumptions**
  - N/A

"the Task Force believes it is premature to make additional recommendations." (p. 116)

UNCLASSIFIED 44

UNCLASSIFIED

Defense Health Care: Applying Key Management Practices Should Help Achieve Efficiencies within the Military Health System

April 2012 / U.S. Government Accountability Office (GAO) / Congressional Committees

- **Purpose of Study**
  - Review DoD efforts to slow rising health care costs by changing selected clinical, business, and management practices.
- **Alt. Governance Model(s) Considered**
  - Two sets of governance initiatives:
    - Measures approved by the Deputy SECDEF in 2006 (driven by BRAC and CNA study).
    - Initiatives approved by the Senior Military Advisory Council in 2011.
- **Authorities**
  - N/A
- **Responsibilities**
  - N/A
- **Evaluation Criteria**
  - 2006 Initiatives
    - Steps Taken
    - Outcomes Achieved
    - Potential Additional Opportunities
  - 2011 Initiatives
    - Dashboard Approved?
    - Implementation Plan Approved?
    - Estimated Net Savings
- **Findings/Results**
  - Almost no realized savings from initiatives
  - Significant progress required on 2011 initiatives.
- **Recommendations**
  - N/A
- **Key Assumptions**
  - Reliability of DoD data.
  - Progress on initiatives since 2012?

UNCLASSIFIED 45

UNCLASSIFIED

Defense Health Care: Additional Analysis of Costs and Benefits of Potential Governance Structures Is Needed

September 2012 / U.S. Government Accountability Office (GAO) / Congress (NDAA FY 2012, Section 716)

- **Purpose of Study**
  - Analyzed the congressionally mandated DoD report on alternative governance structures.
- **Alt. Governance Model(s) Considered**
  - This report considers and assesses the analysis done by the DoD Task Force, not alternative models.
  - It recapitulates the options considered by the Task Force in Appendix II.
- **Authorities and Responsibilities**
  - N/A
- **Evaluation Criteria**
  - Whether the DoD performed a sufficiently thorough analysis of the costs. (see third Finding/Result)
  - Identified three common governance elements among historical proposals to changing MHS organization:
    - Overall control of policy making authority
    - Budgetary authority
    - Control of medical personnel
- **Findings/Results**
  - DoD lacks full knowledge and assessment of the strengths and weaknesses of each organizational option.
  - DoD preferred outcome is the DHA structure without control over the MTFs.
  - The DoD is unable to support its decision with quantitative data.
- **Recommendations**
  - SECDEF direct the ASD(HA) to develop a comprehensive cost analysis for the MHS governance structures.
  - DoD develop a business case analysis and strategy for its shared services concept.
  - Improve evaluation of governance structures with quantitative data when available, and assessing the degree to which options meet the criteria Trained and Ready Medical Force and Quality Beneficiary Care.
- **Key Assumptions**
  - Baseline organizational structure remains the same.
  - Structure of the Air Force regarding the Surgeon General's role remains the same.
  - These assumptions appear to be changed by NDAA 2017 but if answered in the negative they do not impact the recommendation.

The DoD's 2011 Task Force on reforming the Military Health System did not adequately assess the costs and savings of the organizational options it considered.

UNCLASSIFIED

46

UNCLASSIFIED

References

- Alphonso Maldon, Jr., et al, *Report of the Military Compensation and Retirement Modernization Commission: Final Report*, January 29, 2015.
- CAPT David Smith (USN), et al, "Military Health System Executive Review (MHSER) Local Authorities Working Group," Final Report, January 2005.
- Congressional Budget Office, *Approaches to Reducing Federal Spending on Military Health Care*, CBO, Pub. No. 4282, January 2014.
- David J. Smith, et al, "Report on Military Health System Modernization: Response to Section 713 of the Carl Levin and Howard P. 'Buck' McKeon National Defense Authorization Act for Fiscal Year 2015 (P.L. 113-291)," Military Health System Modernization Study Team, May 29, 2015.
- Defense Business Board, "Military Health System – Governance, Alignment and Configuration of Business Activities Task Group Report," Report FY06-5, September 2006.
- Department of Defense, "Final Plan to Implement Section 1073c of Title 10, United States Code: Final Report," June 30, 2018.
- Director of Administration and Management, "Review of the Department of Defense Organization for Health Care," Directorate for Organizational and Management Planning, March 1991.
- Donald B. Rice, et al, "Defense Resource Management Study: Final Report," Defense Organization Committee, February 1979.
- Eric W. Christensen, CDR DeAnn J. Farr, James E. Grefer, and Elizabeth Schaefer, "Cost Implications of a Unified Medical Command," CRM D0013842.A3, Center for Naval Analyses, May 2006.
- George P. Taylor, Jr., Maj Gen Douglas Robb (USAF), et al, "Task Force on Military Health System Governance Final Report," Department of Defense, September 29, 2011.
- Gilbert W. Fitzhugh, et al, "Report to The President and the Secretary of Defense on the Department of Defense by the Blue Ribbon Defense Panel," AD-A013 261, July 1, 1970.
- Government Accountability Office, "Defense Health Care: Additional Analysis of Costs and Benefits of Potential Governance Structures Is Needed," GAO-12-911, September 2012.
- Government Accountability Office, "Defense Health Care: Applying Key Management Practices Should Help Achieve Efficiencies within the Military Health System," GAO-12-224, April 2012.
- Herbert Hoover, et al, "Reorganization of Federal Medical Activities," Letter from the Chairman, Commission on Organization of the Executive Branch of the Government, House Document No. 128 (81st Congress, 1st Session), March 21, 1949.
- Herbert Hoover, et al, "Federal Medical Services," A Report to the Congress by the Commission on Organization of the Executive Branch of the Government, House Document No. 99 (84th Congress, 1st Session), February 1955.
- J. Peter Grace, et al, "President's Private Sector Survey on Cost Control: Report on Federal Hospital Management," Federal Hospital Management Task Force, August 31, 1983.
- Jerry Pannullo, et al, "2005 Defense Economics Conference: Perspectives on the Military Medical Mission," jointly sponsored by Office of the Secretary of Defense Program Analysis and Evaluation and Institute for Defense Analyses, September 22, 2005.
- Joint/Unified Medical Command Working Group, May 2006.
- Maya Anton, et al, *MHSS 2020: Envisioning Tomorrow to Focus Today's Resources*, US Army Medical Department Center and School, 1996.
- "Military Health System Review," Final Report to the Secretary of Defense, August 29. 2014.
- Richard W. Hunter and Benjamin R. Baker, "Defense Health Agency Feasibility Study," Systems Research and Applications Corporation, April 22, 1983.
- Robert Gates, "Track Four Efficiency Initiatives Decisions," Office of the Secretary of Defense, OSD 02974-11, March 14, 2011.
- Susan D. Hosek and Gary Cecchine, *Reorganizing the Military Health System: Should There Be a Joint Command?*, MR-1350-OSD, RAND National Defense Research Institute, 2001.
- Theodore E. Woodward, M.D., *The Armed Forces Epidemiological Board: Its First Fifty Years*, Center of Excellence in Military Medical Research and Education, July 20, 1990.

UNCLASSIFIED

47

Appendix F. Vignettes

Vignette 1: African Command (AFRICOM) Urgent Need

AFRICOM has indicated an urgent need for medical capability to the Joint Staff, who has validated that urgent need. Who provides the forces to meet the medical capability need? Who do they coordinate with? Who all has authorities that are relevant to addressing this issue?

This vignette provides information on the authorities to move personnel. It is not meant to make any statement on the other ways in which such a gap could be covered. For instance, use of contractors and civilian personnel would likely be among the first options used in any situation. However, that discussion does not illuminate the question of authorities.

Table F-1. Vignette 1 Authorities.

Authorities	UMC (SOCOM Construct)	UMC (TRANSCOM Construct)	Single-Service Construct (SSC)	Split Command / Agency Construct
Force Provision	UMC is Force Provider (FP) and receives validated request and will staff it	Services are FP and would receive request and staff it	SSC is FP and receives request and staffs it	UMC is FP and receives request and staffs it
OPCON of personnel	UMC would staff request from personnel assigned to MTFs and would select according to internal business rules for readiness, currency, proficiency	Services will either (a) staff from embedded medical personnel according to internal business rules, or (b) coordinate with UMC to staff from personnel assigned to MTFs	SSC would staff request from personnel assigned to MTFs and would select according to internal business rules for readiness, currency, proficiency	UMC has OPCON of personnel in MTFs and staffs request from MTFs

Authorities	UMC (SOCOM Construct)	UMC (TRANSCOM Construct)	Single-Service Construct (SSC)	Split Command / Agency Construct
Managing MTFs	UMC would level-load MTFs post-staffing to address second/third order effects through Temporary Additional Duty/Temporary Duty (TAD/TDY) processes	UMC would level-load MTFs post-staffing to address second/third order effects through TAD/TDY processes	SSC would level-load MTFs post-staffing to address second/third order effects through TAD/TDY processes	Agency must level-load MTFs post-staffing to address second/third order effects – through contracting or coordination with UMC

Vignette 2: MTF Urgent Need

An MTF has an urgent, short-term staffing need that must be addressed, and none of the MTFs within its same market can cover the gap. Who addresses it? Who do they coordinate with? Who all has authorities that are relevant to addressing this issue?

This vignette provides information on the authorities to move personnel. It is not meant to make any statement on the other ways in which such a gap could be covered. For instance, use of contractors and civilian personnel would likely be among the first options used in any situation. However, that discussion does not illuminate the question of authorities.

Table F-2. Vignette 2 Authorities.

Authorities	UMC (SOCOM Construct)	UMC (TRANSCOM Construct)	Single-Service Construct (SSC)	Split Command / Agency Construct
Manages MTFs	UMC maintains situational awareness on needs of MTFs, develops business rules for staffing accordingly	UMC maintains situational awareness on needs of MTFs, develops business rules for staffing accordingly	SSC maintains situational awareness on needs of MTFs, develops business rules for staffing accordingly	Agency maintains situational awareness on needs of MTFs, develops business rules for staffing accordingly, must coordinate with UMC for urgent staffing need
OPCON of personnel	UMC has authorities and responsibilities to address urgent needs and level-load after through TAD/TDY processes	UMC has authorities and responsibilities to address urgent needs and level-load after through TAD/TDY processes	SSC has authorities and responsibilities to address urgent needs and level-load after through TAD/TDY processes	UMC has the authority to address urgent needs and level-load after, based on requests from the Agency, through TAD/TDY processes

Vignette 3: Black Swan Event

The purpose of this vignette is different from the two previous. Here the team is not the clarifying authority, but rather offers alternatives to the proposed constructs that change the immediate superior while maintaining all the remaining lines of authority.

A highly visible, politically sensitive event (not identified here, but a recent historical example would be the 2006-07 Walter Reed Wounded Warrior Incident) has occurred related to military medicine. Questions of concern: Who replies to a White House inquiry? Who is testifying before Congress? What alternative constructs maintain the key findings of the authorities' analysis while increasing flexibility in how the construct is operationalized?

Table F-3. Vignette 3 – Alternative Constructs.

Authorities	UMC (SOCOM Construct)	UMC (TRANSCOM Construct)	Single-Service Construct	Split Command / Agency Model
Proposed construct	SECDEF is the immediate superior to the Commander UMC. SECDEF is also responsible for all of medical training.	SECDEF is the immediate superior to the Commander UMC. Service secretaries set training requirements and could be answerable for events related to training.	Selected Service Secretary is the immediate superior to the Commander UMC. Selected Service Secretary is also responsible for all of medical training.	Agency answers to ASD(HA); for any incident at MTFs, ASD(HA) is immediate superior. For readiness and training related issues, SECDEF oversees the UMC
Alternative leadership model	Sub-unified command Parent CCMD would be in chain of command.	Sub-unified command Parent CCMD (possibly TRANSCOM) would be in chain of command.	Separate-Service Model New Service Secretary would be appointed solely for this service.	Sub-unified command Parent CCMD would be in chain of command for the UMC. No change to Agency leadership structure.

References

[1] John S. McCain National Defense Authorization Act for Fiscal Year 2019, Pub. L. 115-232 (codified as amended in scattered sections of 10 U.S.C.).

[2] Dorrance, K.A., S. Ramchandani, N. Neil, & H. Fisher "Leveraging the Military Health System as a Laboratory for Healthcare Reform." *Military Medicine* 178, No. 2 (2013, February): 142-154.

[3] Dolfini-Reed M and J Jebo. "The Evolution of the Military Healthcare System: Changes in Public Law and DoD Regulations." CNA Research Memorandum (CRM), CRM D0000437.A3/Final. 2000, July.

[4] RAND. "The Evolution of the All-Volunteer Force." Research Brief RB9195. 2006.

[5] National Defense Authorization Act for Fiscal Year 2017, Pub. L. No. 114-328, 130 Stat. 2000 (codified as amended in scattered sections of 10 U.S.C.).

[6] National Defense Authorization Act for Fiscal Year 2017, Senate Report, S. Rep. No. 114-255, at 173-177 (2016)

[7] Christensen, Eric W., DeAnn J. Farr, James E. Grefer, and Elizabeth Schaefer, "Cost Implications of a Unified Medical Command" [CRM D0013842.A3], Arlington, VA: Center for Naval Analyses, 2006 May.

[8] U.S. Congress. House of Representatives Commission on Organization of the Executive Branch of the Government (1949), "*Reorganization of Federal Medical Activities: A Report to Congress*" by Herbert Hoover (House Document No. 128) 81st Congress, 1st Session, Washington D. C.: U.S. Government Printing Office, 1949, March 21.

[9] U.S. Congress. House of Representatives Commission on Organization of the Executive Branch of the Government (1955), Federal Medical Services: A Report to the Congress by Hoover, Herbert (House Document No. 99) 84th Congress, 1st Session, Washington D. C.: U.S. Government Printing Office, 1955, February.

[10] Fitzhugh, Gilbert W., Martha E. Peterson, Leona P. Thurman, William Blackie, George Champion, William P. Clements, John M. F'uke, et. al, "Report to The President and the Secretary of Defense on the Department of Defense by the Blue Ribbon Defense Panel," (AD-A013 261), Washington D. C.: DoD, 1970, July 1.

[11] Rice, Donald B., Stephen M. Drezner, Charles L. Trozzo, "*Defense Resource Management Study: Final Report*," Washington D. C.: Government Printing Office, 1979, February.

[12] Hunter, Richard W. and Benjamin R. Baker, "Defense Health Agency Feasibility Study," Fairfax, VA: Systems Research and Applications Corporation, 1983, April 22.

[13] Hosek, Susan D. and Gary Cecchine, *Reorganizing the Military Health System: Should There Be a Joint Command?* [MR-1350-OSD], Santa Monica, CA: RAND National Defense Research Institute, 2001. Retrieved from https://www.rand.org/pubs/monograph_reports/MR1350.html.

[14] Grace, J. Peter, & Federal Hospital Management Task Force, "*President's Private Sector Survey on Cost Control: Report on Federal Hospital Management*," Washington D. C.: Government Printing Office, 1983, August 31.

[15] Director of Administration and Management, "Review of the Department of Defense Organization for Health Care," Washington D. C.: Directorate for Organizational and Management Planning, 1991, March.

[16] Kelley, Joseph, David N. Tornberg, and Darrel Porr, *J/UMC Working Group Report.* [For Official Use Only] Restrictions removed per email conversation with Dr. Mark Hamilton June 24, 2019. Washington, D. C.: Department of Defense, 2005, December 16.

[17] Defense Business Board, "Military Health System – Governance, Alignment and Configuration of Business Activities Task Group Report" [Report FY06-5], Washington D. C.: DoD, 2006, September. Retrieved from https://dbb.defense.gov/Reports/

[18] Department of Defense Task Force, "*The Future of Military Health Care: Final Report*," Washington D. C.: DoD, 2007, December.

[19] Department of Defense, "Task Force on Military Health System Governance, *Final Report*," Washington D. C.: DoD, 2011, September 29. [For Official Use Only] Restrictions removed per email conversation with Dr. Mark Hamilton June 24, 2019.

[20] Government Accountability Office, "*Defense Health Care: Additional Analysis of Costs and Benefits of Potential Governance Structures Is Needed*" [GAO-12-911], Washington D. C. GAO, 2012, September.

[21] Department of Defense, "Defense Health Agency" [DoD Directive 5136.13.] Washington D. C. DoD, 2013, September 30.

[22] Department of Defense, "Combat Support Agencies" [DoD Directive 3000.06.] Washington D. C. DoD, 2013, June 27.

[23] Wilkie, Robert, L. USD (P&R) Memorandum. "Construct for Implementation of Section 702." May 22, 2018.

[24] Wilkie, Robert, L. *Final Plan to Implement Section 1073c of Title 10, United States Code, Final Report*. Washington D.C.: DoD, 2018, June 30.

[25] "Defense-Health-Agency," *Health.mil*. https://www.health.mil/About-MHS/OASDHA/Defense-Health-Agency. Accessed on March 02, 2019.

[26] 10 U.S.C. §§ 125, 126, 161, 167, 191, 1073d.

[27] The White House, National Security Decision Directive 219, Implementation of the Recommendations of the President's Commission on Defense Management, 1986 April 1.

[28] Department of Defense, "United States Transportation Command (USTRANSCOM)" [DoD Directive 5158.04.] Washington D.C. DoD, 2007, July 27.

[29] Anderson, L. A., R. F. DeVelus, B. Boyles, & J. R. Feussner, "Patients' Perceptions of their Clinical Interactions: Development of the Multidimensional Desire for Control Scales." *Health Education Research* 4, No. 3 (1989, September): 383–397. https://doi.org/10.1093/her/4.3.383.

[30] Military Health System. *2012 MHS Stakeholders' Report, The MHS: Healthcare to Health. Health.mil.* Accessed on March 4, 2019: https://www.health.mil/Reference-Center/Reports/2012/12/31/2012-MHS-Stakeholders-Report.

[31] General Accounting Office, *Defense Reorganization: DoD's Efforts to Streamline the Special Operations Command (NSIAD-91-24BR)*, Washington, D.C.: GAO, 1990 November.

[32] Hura, M., G. W. McLeod, E. V. Larson, J. Schneider, D. Gonzales, D. M. Norton, J. Jackobs, et al., *Interoperability: A Continuing Challenge in Coalition Air Operations*, Santa Monica: RAND Corporation, 2000.

[33] Ford, T.C. *Interoperability Measurement*. Dissertation. Wright-Patterson Air Force Base, OH: Air Force Institute of Technology, 2008 August.

[34] Levinson, R. & M. Howard. "VA, Pentagon to Team on Health Services Contract (corrected)," *Bloomberg.government.gov*, 2019 February 4. Retrieved from https://about.bgov.com/news/va-pentagon-to-team-on-health-services-contract/.

[35] National Defense Authorization Act for Fiscal Year 2013, Pub. L. 112-239, 126 Stat. 1631 (codified as amended in scattered sections of 10 U.S.C.).

This page intentionally left blank.

Abbreviations and Acronyms

ADCON	Administrative Control
AFRICOM	African Command
ASD	Assistant Secretary of Defense
AVF	All-Volunteer Force
BGen	Brigadier General
BRAC	Base Realignment and Closure
BUMED	Bureau of Medicine
C2	Command and Control
CAPT	Captain
CCDR	Combatant Commander
CCMD	Combatant Command
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CJCS	Chairman of the Joint Chiefs of Staff
CNA	Center for Naval Analysis
COA	Course of Action
COL	Colonel
CONUS	Continental United States
CRM	CNA Research Memorandum
CSA	Combat Support Agency
CYBERCOM	Cyber Command
DAM	Director of Administration and Management
DBB	Defense Business Board
DHA	Defense Health Agency
DHC	Defense Health Command
DHP	Defense Health Program
DoD	Department of Defense
DoDD	DoD Directive
DRG	Diagnosis Related Group
DRMS	Defense Resource Management Study
FORSCOM	Army Forces Command
FP	Force Provider
FTE	Full-Time Equivalents
FY	Fiscal Year

GAO	Government Accountability Office
H.R.	House Resolution
HA	Health Affairs
HASC	House Armed Services Committee
HQ	Headquarter
IMO	Intermediate Management Organizations
IT	Information Technology
J/UMC	Joint Unified Medical Command
J/UMCWG	Joint Unified Medical Command Working Group
JCS	Joint Chiefs of Staff
JDAL	Joint Duty Assignment List
JHU/APL	Johns Hopkins University Applied Physics Laboratory
JTD	Joint Table of Distribution
LTG	Lieutenant General (Army)
LtGen	Lieutenant General (USMC)
MEDCOM	Medical Command
MGen	Major General
MHS	Military Health System
MILDEP	Military Department
MTE	Man Train and Equip
MTF	Military Treatment Facilities
NCR	National Capital Region
NDAA	National Defense Authorization Act
NSAD	National Security Analysis Department
NSIAD	National Security and International Affairs Division
OASD	Office of the Assistant Secretary of Defense
OCONUS	Outside the Continental United States
OPCON	Operational Control
OSD	Office of the Secretary of Defense
P&R	Personnel and Readiness
PBD	Program and Budget Decision
PPS	Prospective Payment System
PPSSCC	President's Private Sector Survey on Cost Control
PROFIS	Professional Filler System
R&D	Research and Development
RDML	Rear Admiral

SASC	Senate Armed Services Committee
SECDEF	Secretary of Defense
SG	Surgeon General
SME	Subject Matter Expert
SOCOM	Special Operations Command
SRA	Systems Research and Applications
SSC	Single-Service Construct
TACON	Tactical Control
TAD/TDY	Temporary Additional Duty/Temporary Duty
TMO	The Medical Officer
TRANSCOM	Transportation Command
U.S.	United States
U.S.C.	United States Code
UMC	Unified Medical Command
UMCWG	UMC Working Group
USAF	United States Air Force
USD	Under Secretary of Defense
USMC	United States Marine Corps
VADM	Vice Admiral
VCJCS	Vice Chairman Joint Chiefs of Staff
VCNO	Vice Chief of Naval Operations
VCOS	Vice Chief of Staff

About the Authors

Joshua Mueller is a Senior National Security Analyst in the National Security Analysis Department at JHU/APL. For this project he served as project lead and can be reached at (Joshua.Mueller@jhuapl.edu). Josh graduated as valedictorian from the U.S. Naval Academy in 2004 with a B.S. in Physics, after which he served nine years as a submarine officer. He has Master's Degrees in Philosophy, Politics, and Economics from the University of Oxford (2006) and the Technology and Policy Program at the Massachusetts Institute of Technology (2015). He earned his Ph.D. in 2018 from MIT in Engineering Systems for work on renewable energy and electricity storage.

(Valoris) Reid Smith is a member of the Senior Professional Staff at JHU/APL. She has conducted analysis of real-world operations and readiness for the Navy and Joint Forces for more than a decade and holds a Ph.D. in Physics from the University of Texas at Austin. Reid was lead author on the Introduction and Baseline sections of the report. She can be contacted at valoris.smith@jhuapl.edu.

Jonathon Cosgrove is an analyst at JHU/APL, and served as the task lead and primary author for the "Looking Back: A History of Defense Health Organizational Studies" section of this report. Over six years, he has led and contributed to numerous studies tackling national security, policy, and organizational issues. Jonathon holds an M.A. in Statecraft and National Security Affairs from the Institute of World Politics (IWP) and a B.A. in Political Science from Geneva College. He can be contacted by phone at 240-228-7427, or email at jonathon.cosgrove@jhuapl.edu.

Grant Sutton is a senior national security analyst at JHU/APL where he serves as a project lead and contributor to a variety studies related to readiness, force structure, and emergent Department of Defense issues and challenges. Prior to joining JHU-APL, he served as a senior analyst and project manager for the Government Accountability Office (GAO) within the Defense Capabilities and Management division. He holds advanced degrees in National Security Studies and International Policy from the California State and George Washington universities, along with a bachelor's degree in political science from the University of California. He led the development of alternative organizational options for this report and can be reached at grant.sutton@jhuapl.edu and (240)592-2383.

Kathleen Reedy (PhD, University of Edinburgh) is a senior anthropologist and the supervisor of the Counterforce Analysis section in APL's National Security Analysis Department, as well as a lecturer at Johns Hopkins University. She has spent over a decade working on national security challenges, including two deployments with the

US Army, teaching for the US Air Force, and conducting numerous policy and organizational culture studies for the DOD. Dr. Reedy led the options assessment and interview development and analysis for this report and can be reached at kathleen.reedy@jhuapl.edu.

W. Sam Lauber holds a law degree from the University of Maryland and performs analysis at APL on the intersections of technology, operations, law, and policy. In this effort, he researched the relevant statutes, directives, and policies, as well as assessed, without providing legal advice, the legislative and policy implications of organizational changes to the Defense Health Agency. You can contact him by email at William.lauber@jhuapl.edu, or by phone at 240-228-0432.

Kevin Ray is a senior cost analyst in the National Security Analysis Department at JHU/APL and has been conducting cost analysis for the Department of Defense for over ten years. He has a B.S in Mechanical Engineering from Georgia Institute of Technology and an international MBA from Vlerick Business School as well as a Certified Cost Estimator/Analyst (CCEA) certification from ICEAA. Kevin worked on the personnel requirements and cost analysis of each of the alternative organizational constructs and can be contacted at kevin.ray@jhuapl.edu.

Rodney Yerger is a senior analyst at JHU/APL, leading a team that provides affordability analysis and assessments for DoD/government sponsors. Previously, he spent 10 years as a civilian supervisory program analyst on the staff of the Chief of Naval Operations and also served in the U.S. Navy as a surface warfare officer. He holds a M.S. in Cost Estimating and Analysis from the Naval Postgraduate School, a MBA from the University of Maryland, and a B.S. in Mechanical Engineering from the U.S. Naval Academy.

This page intentionally left blank.

JOHNS HOPKINS
APPLIED PHYSICS LABORATORY

Appendix C: Study team members:

David Smith MD, MS, CPE, SES, Deputy Assistant Secretary of Defense (Heath Readiness Policy & Oversight), Chair

Lee Payne MD, CFS, Maj Gen, USAF, Assistant Director for Combat Support, Defense Health Agency

Jeffrey Clark MD, MG, USA, Deputy Surgeon General of the Army for Operations

Robert Miller MD, CFS, Maj Gen, USAF, Director Air Force Medical Services Agency

Michael Malanoski MD, SES, Executive Director, BUMED

Barclay Butler, PhD, SES, Assistant Director for Health Care Administration, Defense Health Agency

Jill Faris, BG, USANG, Army, G3,5,7

Douglas J. Robb MD, CFS, Lt Gen (Ret), USAF Uniformed University of the Health Care Sciences

Steven Blivin, CAPT, MC, USN, Deputy Director, Health Services HQMC

Mark Hamilton PhD, Study Executive Secretary

Appendix D: Bibliography:

[1] Christensen, Eric W., DeAnn J. Farr, James E. Grefer, and Elizabeth Schaefer, "Cost Implications of a Unified Medical Command" [CRM D0013842.A3], Arlington, VA: Center for Naval Analyses, 2006 May.

[2] U.S. Congress. House of Representatives Commission on Organization of the Executive Branch of the Government (1949), "*Reorganization of Federal Medical Activities: A Report to Congress*" by Herbert Hoover (House Document No. 128) 81st Congress, 1st Session, Washington D.C.: U.S. Government Printing Office, 1949, March 21.

[3] U.S. Congress. House of Representatives Commission on Organization of the Executive Branch of the Government (1955), Federal Medical Services: A Report to the Congress by Hoover, Herbert (House Document No. 99) 84th Congress, 1st Session, Washington D. C.: U.S. Government Printing Office, 1955, February.

[4] Fitzhugh, Gilbert W., Martha E. Peterson, Leona P. Thurman, William Blackie, George Champion, William P. Clements, John M. F'uke, et. al, "Report to The President and the Secretary of Defense on the Department of Defense by the Blue Ribbon Defense Panel," (AD-A013 261), Washington D.C.: DoD, 1970, July 1.

[5] Rice, Donald B., Stephen M. Drezner, Charles L. Trozzo, "*Defense Resource Management Study: Final Report*," Washington D.C.: Government Printing Office, 1979, February.

[6] Hunter, Richard W. and Benjamin R. Baker, "Defense Health Agency Feasibility Study," Fairfax, VA: Systems Research and Applications Corporation, 1983, April 22.

[7] Hosek, Susan D. and Gary Cecchine, *Reorganizing the Military Health System: Should There Be a Joint Command?* [MR-1350-OSD], Santa Monica, CA: RAND National Defense Research Institute, 2001. Retrieved from https://www.rand.org/pubs/monograph_reports/MR1350.html.

[8] Grace, J. Peter, & Federal Hospital Management Task Force, "*President's Private Sector Survey on Cost Control: Report on Federal Hospital Management*," Washington D.C.: Government Printing Office, 1983, August 31.

[9] Director of Administration and Management, "Review of the Department of Defense Organization for Health Care," Washington D. C.: Directorate for Organizational and Management Planning, 1991, March.

[10] Kelley, Joseph, David N. Tornberg, and Darrel Porr, *J/UMC Working Group Report.* For Official Use Only. Washington, D. C.: Department of Defense, 2005, December 16.

[11] Defense Business Board, "Military Health System – Governance, Alignment and Configuration of Business Activities Task Group Report" [Report FY06-5], Washington D. C.: DoD, 2006, September. Retrieved from https://dbb.defense.gov/Reports/

[12] Department of Defense Task Force, "*The Future of Military Health Care: Final Report*," Washington D. C.: DoD, 2007, December.

[13] Department of Defense, "Task Force on Military Health System Governance, *Final Report*," Washington D. C.: DoD, 2011, September 29. For Official Use Only.

[14] Government Accountability Office, "*Defense Health Care: Additional Analysis of Costs and Benefits of Potential Governance Structures Is Needed*" [GAO-12-911], Washington D. C. GAO, 2012, September.