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

PERSONNEL AND
READINESS

MAR 15 2013

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

Dear Mr. Chairman:

The enclosed report responds to section 731 of the National Defense Authorization Act for Fiscal Year 2013 (Public Law HR 4310), which requires the Secretary of Defense to develop a detailed plan for Reform of the Administration of the Military Health System and to deliver periodic reports on the progress of the development of the plan.

Attached is the first of three required reports. This first report describes the goals of the reform effort, including goals with respect to improving clinical and business practices, cost reductions, and personnel reductions achieved by establishing the Defense Health Agency, carrying out shared services, and modifying the Governance of the National Capital Region. The report also includes a detailed schedule of activities that are part of the reform effort.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families.

Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable James M. Inhofe
Ranking Member

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

PERSONNEL AND
READINESS

MAR 15 2013

The Honorable Barbara A. Mikulski
Chairwoman
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Madam Chairwoman:

The enclosed submission is pursuant to section 731 of the National Defense Authorization Act for Fiscal Year 2013 (Public Law 112-239), which requires the Secretary of Defense to develop a detailed plan for reform of the administration of the Military Health System and to submit to the congressional defense committees three updates on its progress.

This first submission, pursuant to subsection (c)(1), describes the goals of the reform effort, including goals with respect to improving clinical and business practices, achieving cost and personnel reductions by establishing the Defense Health Agency, carrying out shared services, and modifying the governance of the National Capital Region. The response also includes a detailed schedule of activities that are part of the reform effort.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families. A similar letter is being submitted to the other congressional defense committees.

Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable Richard C. Shelby
Vice Chairman

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

PERSONNEL AND
READINESS

MAR 15 2013

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

Dear Mr. Chairman:

The enclosed submission is pursuant to section 731 of the National Defense Authorization Act for Fiscal Year 2013 (Public Law 112-239), which requires the Secretary of Defense to develop a detailed plan for reform of the administration of the Military Health System and to submit to the congressional defense committees three updates on its progress.

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Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable Nita M. Lowey
Ranking Member

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

PERSONNEL AND
READINESS

MAR 15 2013

The Honorable Kirsten E. Gillibrand
Chairwoman
Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Madam Chairwoman:

The enclosed submission is pursuant to section 731 of the National Defense Authorization Act for Fiscal Year 2013 (Public Law 112-239), which requires the Secretary of Defense to develop a detailed plan for reform of the administration of the Military Health System and to submit to the congressional defense committees three updates on its progress.

This first submission, pursuant to subsection (c)(1), describes the goals of the reform effort, including goals with respect to improving clinical and business practices, achieving cost and personnel reductions by establishing the Defense Health Agency, carrying out shared services, and modifying the governance of the National Capital Region. The response also includes a detailed schedule of activities that are part of the reform effort.

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Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable Lindsey Graham
Ranking Member

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

PERSONNEL AND
READINESS

MAR 15 2013

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

Dear Mr. Chairman:

The enclosed submission is pursuant to section 731 of the National Defense Authorization Act for Fiscal Year 2013 (Public Law 112-239), which requires the Secretary of Defense to develop a detailed plan for reform of the administration of the Military Health System and to submit to the congressional defense committees three updates on its progress.

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Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable Susan A. Davis
Ranking Member

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

PERSONNEL AND
READINESS

MAR 15 2013

The Honorable Richard J. Durbin
Chairman
Subcommittee on Defense
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The enclosed submission is pursuant to section 731 of the National Defense Authorization Act for Fiscal Year 2013 (Public Law 112-239), which requires the Secretary of Defense to develop a detailed plan for reform of the administration of the Military Health System and to submit to the congressional defense committees three updates on its progress.

This first submission, pursuant to subsection (c)(1), describes the goals of the reform effort, including goals with respect to improving clinical and business practices, achieving cost and personnel reductions by establishing the Defense Health Agency, carrying out shared services, and modifying the governance of the National Capital Region. The response also includes a detailed schedule of activities that are part of the reform effort.

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Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable Thad Cochran
Vice Chairman

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

PERSONNEL AND
READINESS

MAR 15 2013

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

Dear Mr. Chairman:

The enclosed submission is pursuant to section 731 of the National Defense Authorization Act for Fiscal Year 2013 (Public Law 112-239), which requires the Secretary of Defense to develop a detailed plan for reform of the administration of the Military Health System and to submit to the congressional defense committees three updates on its progress.

This first submission, pursuant to subsection (c)(1), describes the goals of the reform effort, including goals with respect to improving clinical and business practices, achieving cost and personnel reductions by establishing the Defense Health Agency, carrying out shared services, and modifying the governance of the National Capital Region. The response also includes a detailed schedule of activities that are part of the reform effort.

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Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable Peter J. Visclosky
Ranking Member

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

PERSONNEL AND
READINESS

MAR 15 2013

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

Dear Mr. Chairman:

The enclosed submission is pursuant to section 731 of the National Defense Authorization Act for Fiscal Year 2013 (Public Law 112-239), which requires the Secretary of Defense to develop a detailed plan for reform of the administration of the Military Health System and to submit to the congressional defense committees three updates on it progress.

This first submission, pursuant to subsection (c)(1), describes the goals of the reform effort, including goals with respect to improving clinical and business practices, achieving cost and personnel reductions by establishing the Defense Health Agency, carrying out shared services, and modifying the governance of the National Capital Region. The response also includes a detailed schedule of activities that are part of the reform effort.

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Sincerely,

Jessica L. Wright
Acting

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

Response to Congress
First Submission under Section 731 of the National Defense Authorization Act for Fiscal Year 2013

Plan for Reform of the Administration of the Military Health System

The estimated cost of report or study for the Department of Defense is approximately $3,380 for the 2013 Fiscal Year. This includes $600 in expenses and $2,780 in DoD labor.

(Generated on 5 March 2013; Reference ID: 7-3B32E05)

Introduction

The Military Health System (MHS) provides health care to over 9.7 million beneficiaries worldwide using a direct care system of military hospitals and clinics and a contracted network of private sector providers. In addition, the MHS provides coordinated activities specifically directed to the care of our Nation's warfighters – in and out of designated combat areas. This unique system is currently managed through a policy and oversight function at the level of the Office of the Secretary of Defense (OSD), three Service-led medical departments, and a field activity centered on the TRICARE health care plan.

The MHS is dedicated to improving the health of the population it serves, along with the quality and outcomes of the health care it provides. In 2009, the MHS adopted overall system performance aims of force readiness, population health, quality health care, and cost management. This Quadruple Aim, represented in Figure 1, is our strategic performance measurement framework to measure and improve the value that the MHS creates for its customers and various stakeholders.

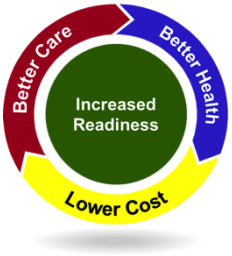


Figure 1. The MHS Quadruple Aim

Recent reviews of MHS performance identified opportunities for improvement in both efficiency and effectiveness. Other health systems facing similar challenges have moved to more highly integrated delivery structures. By integrating a health care delivery system, preventive and curative services can be better coordinated across the continuum of care, fragmentation and practice variation can be minimized, capital and technology can be used more efficiently, and unnecessary utilization of resources can be reduced.

This approach has already proven successful in the MHS. Over almost 12 years of war, our ability to deliver highly integrated combat casualty care has demonstrated a clear benefit to wounded, ill, or injured Service members and timely support for Combatant Commanders. The result of this enhanced integration saved lives and created an interdependence of Service capability on the battlefield. By reorganizing peacetime healthcare operations using the principles that worked so well in combat, the MHS can achieve higher levels of quality improvement, improve consumer responsiveness, and deliver greater value for the military community.

In 2011, then-Deputy Secretary of Defense William Lynn established an internal task force to conduct a review of the governance of the MHS. The task force identified cost containment, greater integration, and increased unity of effort as priority objectives for the MHS. This report concluded that optimal governance would support medically ready forces through high quality integrated health care and achieve cost savings through reduction in duplication and variation. It

also noted the need for clear decision authority and accountability. Following extensive consultations among the Deputy Secretary of Defense, Chairman of the Joint Chiefs of Staff, Military Department Secretaries and Service Chiefs, and other officials of the Department, a report was submitted to Congress outlining the Department's position on reforms that should be made to the governance of the MHS.

In March 2012, the Deputy Secretary of Defense summarized the task forces report and directed Department leadership to develop an implementation plan that would include establishment of a Defense Health Agency (DHA) with responsibility for shared services, functions and activities of the MHS, enhanced management of multi-Service markets, and transition of control of the National Capital Region (NCR) health system to the DHA. (Appendix A)

We have begun implementation planning for the changes outlined in the Deputy's memorandum. Specifically, we are developing business case analyses for each of the initially identified shared services: the TRICARE Health Plan, pharmacy programs, medical education and training, medical research and development, health information technology, facility planning, public health, medical logistics, acquisition, and budget and resource management. We are identifying the changes needed for the development of a DHA, including necessary organizational changes, some of which will be defined following each shared service business case analysis. We have identified 6 multi-Service medical markets to be designated for enhanced authorities and are in the process of developing the 5-year business performance plans, along with the financial management scheme, that will govern the implementation and monitor the performance of these markets. Finally, we are planning for the transition of Joint Task Force National Capital Medical (JTF CAPMED) to the NCR Medical Directorate within the DHA.

Achieving Greater System Integration

There is a clear performance advantage to achieving more integration as demonstrated by leading health systems in the private sector. The Journal *Health Affairs* recently reported on a number of examples where integrated health systems were able to improve outcomes and reduce costs through standardization of clinical processes.[1] Kaiser Permanente implemented standard practice guidelines in a program called Healthy Bones, resulting in a 30 percent reduction in hip fractures for an at risk population. The Hospital Corporation of America achieved better adherence to evidence-based practices in perinatal care and achieved $50 million in savings. In a third example, ThedaCare Health System's use of standardized inpatient care unit design and operation of reduced hospital length of stay, medical errors, and inpatient costs by 25 percent, while improving patient satisfaction.

The MHS has always had a fundamental level of integration. It has a common mission, a unified budget, a worldwide hospital and outpatient clinic system led by the Army, Navy, and Air Force Medical Departments, a health plan (TRICARE), and partially integrated health care support functions. However, it has not always been fully aligned to maximize and share common business practices and approaches to the delivery of health care. By better aligning financial management, information technology, strategic planning, quality improvement, analytics and

[1] Delos M. Cosgrove, Ten Strategies to Lower Costs, Improve Quality, and Engage Patients: The View from Leading Health System CEOs, Health Affairs, February 2013; 32:2; 321-327.

decision support, and other common and shared activities, the MHS can better meet the readiness demands of the Department by matching services, capacity, and capability to meet a common need. We have recently defined our strategic vision for an integrated MHS.

> **"**The integrated Military Health System delivers a coordinated continuum of preventive and curative services to eligible beneficiaries and is accountable for health outcomes and cost while supporting the Services' warfighter requirements."

By adopting the principles of system accountability, continuous innovation, access to appropriate care, information continuity, and well-managed and coordinated care, the MHS can achieve system-wide improvements. In his March 2012 memorandum on MHS Governance, the Deputy Secretary of Defense noted that there are "opportunities to realize savings in the MHS through the adoption of common clinical and business processes and the consolidation and standardization of various shared services." To achieve these outcomes, the Deputy Secretary of Defense directed two major actions to promote greater system integration. The first is to establish a DHA that will assume responsibility for enterprise-wide shared services, activities, and functions of the MHS and its common business and clinical processes (hereafter "shared services"). The second is to establish enhanced governance and 5-year business performance plans in major markets to optimize resources and the delivery of care across treatment sites within geographic areas. These two changes will support integration at the enterprise and local market level respectively.

The Objectives of Reorganization

Our overarching strategic goal – to achieve greater system integration– is supported by seven subordinate objectives that can best be achieved by re-engineering how we do business. We will also improve governance to ensure unity of purpose and shared pursuit of performance goals. The specific changes to the design of the system along with enhanced accountability will enable continuous performance improvement and reduce the projected cost growth of the Defense Health Program. As we develop our business case analyses for each change, we will add new measures or refine existing measures to ensure we are tracking the achievement of our stated goal and the objectives listed below.

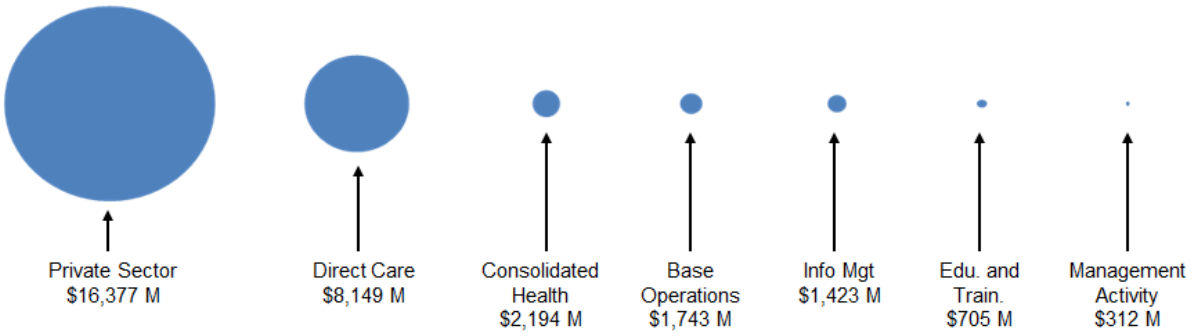
1. Promote more effective and efficient health care operations through enhanced enterprise-wide shared services.
2. Deliver more comprehensive primary care and integrated health services using advanced patient-centered medical homes.
3. Coordinate care over time and across treatment settings to improve outcomes in the management of chronic illness, particularly for patients with complex medical and social problems.
4. Match personnel, infrastructure, and funding to current missions, future missions, and population demand.
5. Establish more inter-Service standards / metrics, and standardize processes to promote learning and continuous improvement.
6. Create enhanced value in military medical markets using an integrated approach specified in 5-year business performance plans.
7. Align incentives with health and readiness outcomes to reward value creation.

Achievement of these goals will translate to better clinical and business practices and reduce cost, infrastructure, and personnel.

Managing Health Care Cost

Enhanced integration will help the Department control costs by improving the efficiency and effectiveness of health care delivery. In Fiscal Year (FY) 2001 the cost of delivering health care was $19 billion and represented 6 percent of total Defense spending. In FY 2012, the cost of health care was $51.4 billion or 9.7 percent of Defense spending. The Congressional Budget Office believes that growth will continue and has projected that the Department will spend $65 billion in FY 2017. Some cost increase is beyond the Department's control (such as health care inflation and legislatively-directed changes in the health benefit). However, other costs can be better managed through improvements in internal clinical and business practices – particularly in the cost of delivering health care in both direct care and purchased care sectors. Furthermore, by making changes in our governance structure, we will be better able to manage costs across all health care delivery venues, including purchased care.

The various health care expense domains, or budget allocation groups, are shown in Figure 2 along with their associated costs. The actual costs consumed by headquarters – personnel, infrastructure, contracting – are modest in comparison to the combined costs of health care delivered in our purchased care and direct care systems. While we will reduce the overall size of headquarters through this reorganization, the true value of shared support services will result from common clinical and business practices that create savings through continuous improvement in health care delivery. While the common practices will be implemented throughout the system, they will have particularly significant impact in our large multi-Service markets.



MHS Appropriations by Budget Activity Group (Operations & Maintenance Funding, FY12). Size of Activity corresponds to width of circle.

Figure 2. Defense Health Program Costs by Major Budget Activity

Major Governance Milestones and Program Schedule

Each activity defined in the Deputy Secretary of Defense's March 2012 memorandum is listed below, along with accomplishments to date and plans for full implementation. Our over-arching goal of creating a more integrated system has been used to prioritize and plan the implementation of the changes described below.

Establish a DHA. A series of actions has commenced to ensure a DHA is established and achieves Initial Operating Capability (IOC) by October 1, 2013.

- By June 1, 2013, the Department will have identified and recommended a DHA Director in the grade of Lieutenant General or Vice Admiral. The nomination package will thereafter be forwarded to the U.S. Senate for consideration.
- By July 1, 2013, the designation of the DHA as a Combat Support Agency (CSA) in accordance with Department of Defense Directive 3000.06, "Combat Support Agencies," will be included in the proposed DHA Charter Directive. This CSA designation ensures that the DHA remains focused on the primary mission of medical readiness, and is responsive to the Combatant Commanders through a formal oversight process established by the Chairman, Joint Chiefs of Staff.
- By July 1, 2013, we will prepare and have coordinated a Charter Directive for the DHA for the Deputy Secretary of Defense's approval.
- By July 1, 2013, the Assistant Secretary of Defense for Health Affairs (ASD (HA)) will provide the Deputy Secretary of Defense with a detailed plan for implementing a shared services model within the MHS. The Deputy Secretary of Defense initially identified 10 functions that will be included as shared services: Medical Logistics; Facility Planning; TRICARE Health Plan; Health Information Technology; Pharmacy Programs; Education & Training; Research & Development; Public Health; Acquisition; and Budget & Resource Management.

    - We will phase-in the shared services infrastructure between the time of IOC, October 1, 2013, and when full operating capability is achieved October 1, 2015. We will begin with reengineering clinical and business processes in Medical Logistics, Facility Planning, TRICARE Health Plan, and Health Information Technology at the start of FY 2014.
    - By July 1, 2013, Business Process Reengineering plans for these four shared services will be completed. The plans will include projected cost savings and performance improvements, personnel reductions, implementation costs, organizational design, performance measures, and necessary changes to accountabilities and authorities.
    - By September 1, 2013, the ASD (HA) will appoint an individual in each of the ten initial shared service areas within the DHA; these ten individuals will be accountable for the cost and performance of their respective areas and will have the authority to drive improvements in shared services across the enterprise.
    - By September 30, 2013, Business Process Reengineering plans for Pharmacy Programs, Education and Training, Research and Development, Public Health, Acquisitions, and Budget and Resource Management will be completed. The

plans will include projected cost savings and performance improvements, personnel reductions, implementation costs, organizational design, performance measures, and necessary changes to accountabilities and authorities.

- By October 1, 2013, we will begin implementation of shared services under the authority of the DHA. This effort will improve integrated health service delivery by providing a common, standardized approach to those services; reduced overhead to manage the services; and service delivery expectations for the supporting and supported organizations.

Establish Multi-Service Market Business Planning Process

- By July 1, 2013, 5-year business performance plans will be completed for each enhanced Multi-Service Market, including the NCR. The market level (specifically, Prime Service Areas surrounding military medical hospitals and clinics) is where substantial improvements in clinical and business processes will occur, and where major reductions in cost through standardized processes and recapture of private sector care are most achievable. Each market will have yearly targets for recapture of private sector health care and performance targets tied to the Quadruple Aim. The performance plans will specify how improvements in clinical and business practices will result in cost reductions, infrastructure reductions, and personnel reductions.

Disestablish JTF CAPMED / Establish NCR Medical Directorate

- By October 1, 2013, we will establish the NCR Medical Directorate within the DHA, replacing the existing JTF CAPMED. This transition will sustain the joint organizational structure for the two inpatient medical facilities in the NCR, and also clarify accountability for comprehensive market management, and allow the MHS to reduce the intermediate headquarters overhead for managing the market.

Conclusion

Over the next several months, the Department will have completed a series of actions to prepare for the establishment of the DHA. Our next submission to the congressional defense committees will outline our progress and preparedness for stand-up of the new organization at the start of FY 2014, identify the metrics we will use to evaluate the achievement of each objective we have outlined and the projected personnel levels required for the DHA and the NCR Medical Directorate. It will also outline in greater specificity how shared services will be organized and managed by the Department under this new construct.

Appendix A

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

MAR 0 2 2012

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS
CHAIRMAN OF THE JOINT CHIEFS OF STAFF
UNDER SECRETARIES OF DEFENSE
DEPUTY CHIEF MANAGEMENT OFFICER
DIRECTOR, COST ASSESSMENT AND PROGRAM EVALUATION
DIRECTOR, OPERATIONAL TEST AND EVALUATION
GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE
INSPECTOR GENERAL OF THE DEPARTMENT OF DEFENSE
ASSISTANT SECRETARIES OF DEFENSE
DEPARTMENT OF DEFENSE CHIEF INFORMATION OFFICER
ASSISTANTS TO THE SECRETARY OF DEFENSE
DIRECTOR, ADMINISTRATION AND MANAGEMENT
DIRECTOR, NET ASSESSMENT
DIRECTORS OF THE DEFENSE AGENCIES
DIRECTORS OF THE DOD FIELD ACTIVITIES

SUBJECT: Planning for Reform of the Governance of the Military Health System

The transformations that have occurred in the Military Health System (MHS) over the past years, including the consolidation of medical facilities and functions in the National Capital Region (NCR) mandated by the Base Realignment and Closure (BRAC) process, have provided the Department with an opportunity to consider changes to the governance of the MHS to ensure that it is organized in an effective and cost-efficient manner.

To inform deliberations within the Department on this important issue, on June 14, 2011, Deputy Secretary Lynn established an internal task force to conduct a review of the governance of the MHS and to provide a report containing an evaluation of options for the governance of the MHS as a whole, for the governance of multi-Service medical markets, and for the governance of the NCR health system. The task force was co-chaired by Dr. George Peach Taylor, Jr., Deputy Assistant Secretary of Defense for Force Health Protection and Readiness, and Major General (Dr.) Doug Robb, Joint Staff Surgeon, and consisted of representatives from each of the Military Departments, the Joint Staff, and the Offices of the Under Secretary of Defense for Personnel and Readiness, Under Secretary of Defense (Comptroller), and Director, Cost Assessment and Program Evaluation. The task force delivered its report on September 15, 2011, and I thank the task force co-chairs, members, and staff for their diligent and thoughtful work on this very important and complex matter.

Subsequent to the delivery of the task force report, section 716 of the National Defense Authorization Act for Fiscal Year 2012 was enacted. Section 716 prohibits the Department from restructuring or reorganizing the MHS until the Department and the Comptroller General of the United States have each provided a specified report to the congressional defense committees, and

after a specified waiting period has elapsed. The Department has since completed and delivered its report as required by section 716. Included in this report was a description of the Department's position on reforms that should be made to the governance of the MHS. This position builds on the options developed by the task force and was arrived at through extensive consultations that have taken place over the past months among the Deputy Secretary of Defense, Chairman of the Joint Chiefs of Staff, Service Secretaries and Chiefs, and other senior officials of the Department. It is summarized below:

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

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

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

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

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

3. **National Capital Region:** After such time as the transition of TMA to the DHA described in paragraph 1 has begun, the authority, direction, and control over the NCR health system, to include the Walter Reed National Military Medical Center (WRNMMC), the Ft. Belvoir Community Hospital (FBCH), and all other military medical treatment facilities that are determined to reside within the NCR market, will be assigned to the "NCR Medical Directorate," a subordinate organization of the DHA and successor to Joint Task Force National Capital Region Medical (JTF CAPMED). The position of Director, NCR Medical Directorate, will be filled by a general or flag officer in the grade of Major General or Rear Admiral (Upper Half) and will be published on the JDAL. The directors of the WRNMMC, the FBCH, and the other MTFs in the NCR Medical Directorate will be selected by the USD(P&R) (or, if delegated, the ASD(HA), Director, DHA, or Director, NCR Medical Directorate) from nominees provided by the Military Departments. Military personnel for the WRNMMC, the FBCH, and the other MTFs within the NCR Medical Directorate will be provided by the Military Departments according to manning documents maintained by the DHA.

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

The reforms described in the paragraphs above are based on a belief that there are opportunities to realize savings in the MHS through the adoption of common clinical and business processes and the consolidation and standardization of various shared services. They are also informed by a recognition that there currently are two notably different regional governance models in the MHS, namely a cross-Service market management model, best exemplified by the San Antonio Military Health System, and a singular authority model, employed by JTF CAPMED. Both models have proven successful to date in their respective regions, and, as they are still in their early stages of development and execution, both should be allowed to continue to exist and be improved upon. The modifications described in paragraphs 2 and 3 above will, respectively, enhance the effectiveness of the cross-Service market management model and provide an appropriate reporting and supervisory structure for the singular authority model. Improving these two models and allowing them both to continue in modified form in their respective regions will, among other things, provide the Department with

greater insight, based on actual outcomes, that may inform considerations of more significant transformations of MHS governance in the future.

To ensure that the Department maintains momentum on this very important issue, I direct the Under Secretary of Defense for Personnel and Readiness and the Chairman of the Joint Chiefs of Staff to stand up a planning team to develop an implementation plan for the governance changes described above. The implementation team will be led by two Implementation Program Co-Directors, designated by the USD(P&R) and the CJCS, respectively, and will include representatives from the Military Services, the Joint Staff, and relevant components of the Office of the Secretary of Defense. The implementation plan will be submitted to the Deputy Secretary of Defense for approval so that the Department is prepared to begin execution of these changes once the provisions of section 716 have been fulfilled. In addition, this planning team will support the work to be performed by the Comptroller General pursuant to section 716.