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

PERSONNEL AND
READINESS

NOV 25 2

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(c)(3) of the National Defense Authorization Act for Fiscal Year (FY) 2013 (P.L. 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 deliver periodic reports on the progress of the development of the plan. Enclosed is the third of the three directed reports.

This third submission addresses the current status of the reform efforts, with respect to each shared service the Secretary will implement during FY 2014, a timeline for such implementation, and detailed business case analyses. It also includes an update regarding the status of major reform efforts and details regarding how we will monitor and measure success in achieving the seven objectives described in previous reports. A similar letter is being sent to the Chairpersons of the other congressional defense committees.

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

NOV 25 2013

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

Dear Madam Chairwoman:

The enclosed report responds to section 731(c)(3) of the National Defense Authorization Act for Fiscal Year (FY) 2013 (P.L. 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 deliver periodic reports on the progress of the development of the plan. Enclosed is the third of the three directed reports.

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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

NOV 25 2013

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

Dear Mr. Chairman:

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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

NOV 25 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 report responds to section 731(c)(3) of the National Defense Authorization Act for Fiscal Year (FY) 2013 (P.L. 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 deliver periodic reports on the progress of the development of the plan. Enclosed is the third of the three directed reports.

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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 Adam Smith
Ranking Member

Response to Congressional Defense Committees

Third 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 $3,600.00. This includes $600.00 in expenses and $3,000.00 in DoD labor.

(Generated on 25 October 2013; Reference ID: C-31CC2DF)

Introduction

This is the third of three responses to section 731 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2013. In our first report to the congressional defense committees, dated March 15, 2013, we identified our reform efforts and provided detailed goals, milestones and schedules for implementing the Defense Health Agency (DHA), the enhanced multi-Service markets (eMSMs), and the National Capital Region (NCR) Directorate. In our second report, dated June 27, 2013, we provided our strategic objectives, success measures, and business case analyses for four of the initial ten identified shared services.

For this third report, section 731(c)(3) requires that we provide specific information for each shared service to be implemented in FY14. In the June report, we described our overall approach to each shared service using a common business case analysis (BCA) and business process re-engineering (BPR) plan strategy. In this report, and using this strategy, we provide the results of our assessments for the remaining six shared services to be implemented in FY14: Pharmacy, Medical Education and Training, Medical Research and Development, Budget and Resource Management, Contracting, and Public Health.

In addition to the required reporting, we provide a status update on our activities, progress, and plans since our last report submission. We describe the new governance structure that supports system integration, and allows us to aggressively pursue our goal of improving the value of the healthcare and health promotion services we deliver. This new structure also makes it possible to set enterprise-wide measurement targets and provides a forum for monitoring performance. We have already begun to set performance targets where we have reliable data, and those targets are included in this report. We also describe our plan for developing additional performance metrics and targets over time as baseline data becomes available. Specifically, we describe overall targets for cost reductions achieved with full implementation of shared services and enhanced multi-Service market (eMSM) plans. We recognize that metrics, measures and targets will continue to evolve as we measure progress towards meeting the strategic objectives outlined below. Through our established MHS Governance process, we will assess and refine metrics, measures and targets to drive the changes we are working to achieve. Finally, we describe how we intend to re-engineer the system to promote learning, innovation, and continuous improvement.

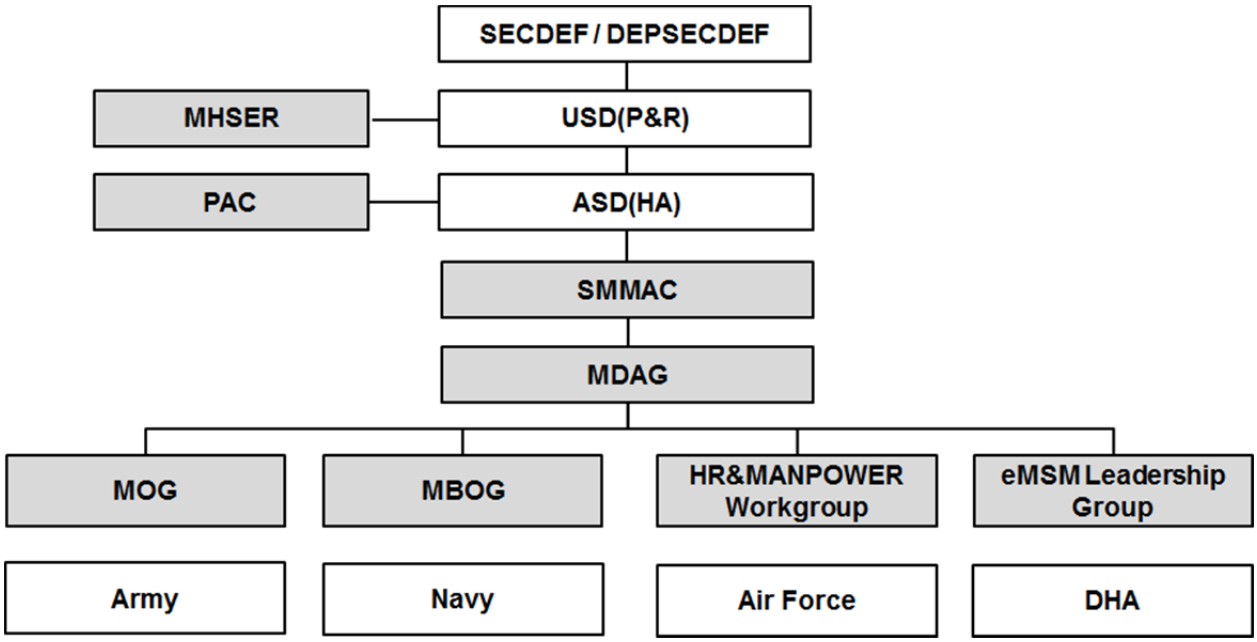
Status of Major Reform Efforts

We begin this third response to section 731 with a description of our new governance structure, a status update on our activities since the June report, and performance measures.

Governance Structure

In our June report, we described our goal of an integrated health care delivery system. Central to that vision is the need to reform our governance or decision-making process to drive performance and system improvement. To that end, we have established, by charter, several groups to provide advice and assistance, illustrated in Figure 1.

Figure 1: MHS Governance Structure



The Military Health System Executive Review (MHSER) serves as a senior-level forum for Department of Defense (DoD) leadership input into the strategic, transitional, and emerging issues facing the Military Health System (MHS), the Defense Health Program (DHP) and the DoD. The MHSER informs the Office of the Secretary of Defense (SECDEF) and Office of the Deputy Secretary of Defense (DEPSECDEF) on performance, challenges, and direction of the MHS. The MHSER is chaired by the Under Secretary of Defense (Personnel and Readiness) [USD(P&R)], and includes the Principal Deputy Under Secretary of Defense (Personnel and Readiness), Assistant Secretary of Defense (Health Affairs) [ASD(HA)], Service Vice Chiefs, Military Department Assistant Secretaries for Manpower and Reserve Affairs, Assistant Commandant of the Marine Corps, Director of Program Analysis and Evaluation, Principal Deputy Under Secretary of Defense (Comptroller), Director of the Joint Staff, and Surgeons General (as ex-officio members).

The Senior Military Medical Action Council (SMMAC) is the highest governing body in the MHS. The SMMAC is chaired by the ASD(HA), and includes the Principal Deputy Assistant Secretary of Defense (Health Affairs) [PDASD(HA)], Military Department Surgeons General, DHA Director, Joint Staff Surgeon, and other attendees as required. The SMMAC presents enterprise-level guidance and operational issues for decision-making by the ASD(HA).

Reporting to the SMMAC is the Medical Deputies Action Group (MDAG), which ensures that actions are coordinated across the MHS and are in alignment with strategy, policies, directives, and initiatives of the MHS. The MDAG is chaired by the PDASD(HA), and includes the Deputy Surgeons General, DHA Deputy Director, and a Joint Staff Surgeon Representative.

Reporting to the MDAG are four supporting governing bodies:

- The Medical Operations Group (MOG) consists of the senior healthcare operations directors of the Service Medical Departments, the DHA Director of Healthcare Operations, and a Joint Staff Surgeon representative, with the chairmanship rotating among these members. The MOG carries out MDAG assigned tasks and provides a collaborative and transparent forum supporting enterprise-wide oversight of direct and purchased care systems focused on sustaining and improving the MHS integrated delivery system.
- The Medical Business Operations Group (MBOG) consists of the senior resource managers of the Service Medical Departments and the DHA Director of Business Operations, with the chairmanship rotating among these members. The MBOG provides a collaborative and transparent forum for providing resource management input to the MDAG on direct and purchased care issues and initiatives focused on sustaining and improving the MHS integrated delivery system.
- The Human Resources and Manpower Workgroup (HR&MANPOWER WG) consists of the senior human resources and manpower representatives from the Service Medical Departments and the DHA, with the chairmanship rotating among these members. The HR&MANPOWER WG supports centralized, coordinated policy execution, and guidance for development of coordinated HR and manpower policies and procedures for the MHS.
- The eMSM Leadership Group consists of the six eMSM Market Managers, with the chairmanship rotating among these members. The eMSM Leadership Group provides a collaborative and transparent forum for eMSM Managers to discuss clinical and business issues, policies, performance standards, and opportunities that relate to the strategic imperatives and operational performance of the eMSMs.

Finally, the ASD(HA) is supported and advised by the Policy Advisory Council (PAC), composed of the Deputy Assistant Secretaries of Defense (Health Affairs), the DHA Deputy Director, the Deputy Surgeons General, and a representative of the Joint Staff. The PAC provides a forum for supporting MHS-wide policy development and oversight in a unified manner.

In addition to a new governance structure for shared decision making, we have established a yearly MHS strategic planning session during which the previous year's performance will be reviewed and new targets set, where appropriate, for each of our seven objectives. The first of these strategic planning sessions was held in early September 2013. Together, the MHS leadership reviewed and confirmed the seven objectives detailed in this report, and directed the further development of specific performance dashboards for each of these objectives, along with timelines for completion.

Defense Health Agency

At the time of the last report, the DHA Director had been nominated and confirmed by the Senate. We also provided an initial DHA organizational structure (Attachment 1). The mapping of TRICARE Management Activity (TMA) functions to that new DHA organizational structure is complete and all shared services functional leads identified. On August 19, 2013, we held an orientation day for TMA employees and provided TMA leadership with training materials to

help them guide their staffs through the transition. We also established an intranet site for posting key messages and other information. TMA employees can use this site to submit questions and concerns. We initiated the various human resources requirements to move relevant personnel from TMA and the Services into the DHA.

Business case analyses (BCA) for ten initial shared services were completed; five of these shared services achieved initial operational capability in the DHA on October 1, 2013. The BCAs for four of these shared services (Facility Planning, Medical Logistics, Health Information Technology, and TRICARE Health Plan) were provided in the June report. The fifth shared service's BCA (Pharmacy) is provided in this report. We included Pharmacy as an initial operating shared service because of the opportunity to achieve early and significant resource savings. On August 21, 2013, we conducted a Rehearsal of Concept drill where a Concept of Operations (CONOPS) for each of these initial five shared services was presented to and approved by the Surgeons General, Health Affairs (HA) and DHA leadership.

DoD Directive (DoDD) 5136.01, "Assistant Secretary of Defense for Health Affairs (ASD(HA))," was reissued to reflect changes to responsibilities and functions, relationships and authorities resulting from previous decisions regarding MHS reform. Additionally, DoDD 5136.13, "Defense Health Agency (DHA)," was developed to codify the establishment of the DHA and the previous decisions regarding its assigned responsibilities and functions, relationships, and authorities. Both directives were signed by the Deputy Secretary of Defense on September 30, 2013.

Enhanced Multi-Service Markets

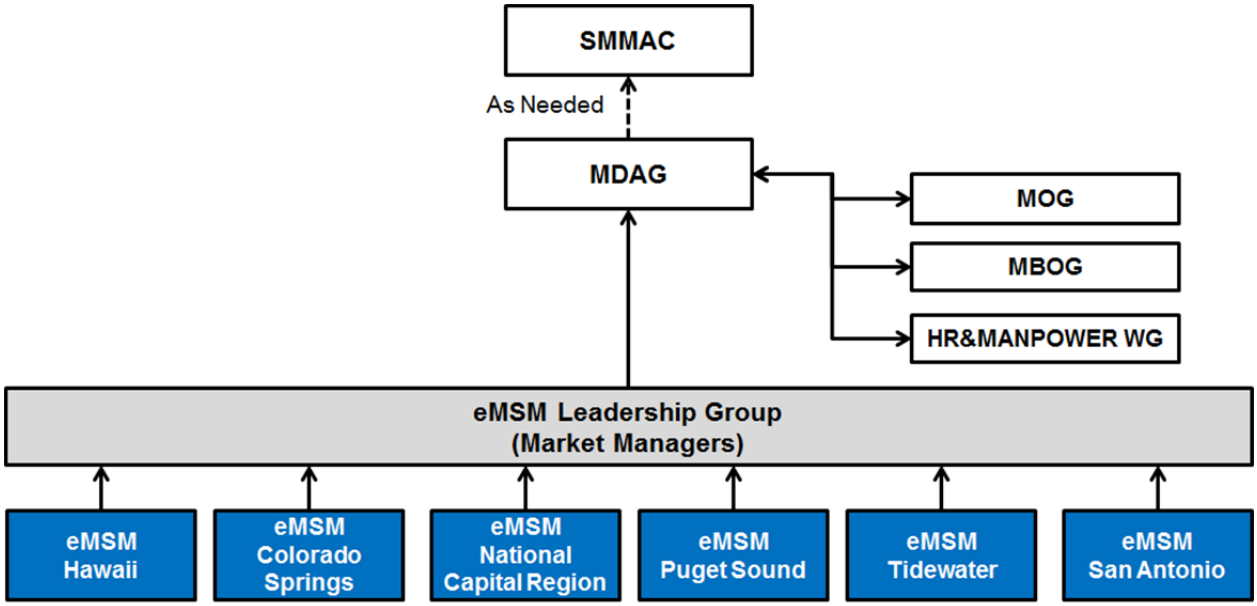
Updated business plans for the six eMSMs were submitted and reviewed in July 2013. Subsequently, a CONOPS was drafted and approved by the MDAG that outlines the roles, responsibilities, authorities, and functions of the eMSMs. A common dashboard for eMSM performance reporting has been created.

The new eMSM Leadership Group, composed of the six eMSM Market Managers has been formed as described above. The MOG will review and assess eMSM performance based on the common dashboard and will report its assessment of eMSM progress to the MDAG. The MDAG will support the oversight and accountability function for the eMSMs to address issues and ensure that eMSMs are meeting performance targets. The Services will hold their MTF's accountable to meet performance goals of the eMSM business plan.

Challenges and issues that cannot be resolved at the individual market level or at the eMSM Leadership Group level are raised to the MDAG for resolution. At the request of the eMSMs, the MDAG can task the MOG, MBOG, and HR&MANPOWER WG to help address specific issues or challenges raised by the eMSMs.

A schematic of the eMSM governance structure is shown in Figure 2.

Figure 3: Governance Structure for eMSM Planning and Execution



National Capital Region Directorate

The NCR Director assumed duties on October 1, 2013. The Joint Task Force National Capital Region Medical Command (JTF CAPMED), in anticipation of standing up the NCR Directorate, participated in performance planning along with the other five eMSMs, subject to the same governance process and metrics. Staffing realignment for the NCR Directorate is complete (see next section).

Update on Defense Health Agency and National Capital Region Directorate Staffing

A detailed accounting, including specific duties and responsibilities, for all personnel being transferred from both TMA and the Services into the DHA has been developed. Table 1 provides updated staffing numbers for the DHA and the NCR Directorate on October 1, 2013.

Table 1: Estimated Defense Health Agency Staffing at IOC[1]

Category	Directorate/Division/Function	No.[2]
Shared Services	Medical Logistics	40
	Facilities Planning	47
	TRICARE Health Plan	293
	Health IT	805
	Pharmacy	44
	Public Health	5
	Contracting	73
	Education and Training	1
	Budget and Resource Management	80
	Research and Development	1
	Sub-Total	**1,389**
Headquarters Related Functions	DHA Front Office	2
	DHA Chief of Staff /Administration & Management	93
	DHA Special Staff Support	39
	National Capital Region Directorate (HQ)	42
	Sub-Total	**176**
Other Non-Shared Services Organizations	Component Acquisition Executive (CAE) to include DHSS and DHCS Program Offices	115
	Clinical Support	65
	Comptroller	10
	DoD/VA Interagency Program Office	85
	General Counsel	45
	Program Integrity	16
	Readiness	33
	Warrior Care	7
	Sub-Total	**376**
DHA TOTAL		**1,941**

[1] Notes on DHA staffing table:

- National Capital Region (NCR) Headquarters (HQ) figures do not reflect Walter Reed National Military Medical Center (WRNMMC), Fort Belvoir Community Hospital (FBCH), and Joint Pathology Center (JPC) positions.
- Education and Training and R&D reflect that the Directorate Directors have been identified.
- Special Staff includes Program Integration, DoD/VA Sharing, Strategic Communications, Office of Strategy Management, Defense Health Board, and Chief Human Capital Officer.
- Warrior Care transferred from Defense Human Resources Activity (DHRA) to DHA at the start of FY14
- Component Acquisition Executive (CAE) includes Defense Health Clinical Systems (DHCS) and Defense Health System Support (DHSS).

[2] Numbers above reflect civilian positions and uniformed services on hand strength.

Performance Measures Update

During the September 4-5, 2013, MHS Strategic Planning Session, proposed measures were reviewed. The MHS Strategic Planning Team is in the process of coordinating and finalizing both measures and respective performance targets. The MDAG and the SMMAC will review and approve the proposed measures and targets, after which they will be published in the 2014 MHS Strategic Plan. We will use a single data repository for collecting performance data, along with a single performance dashboard, for leadership performance reviews. We will submit a copy of the 2014 MHS Strategic Plan to our congressional committees in December 2013.

Strategic Objectives Update

In the March 2013 report, we outlined the following MHS strategic vision and seven supporting objectives:

> "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."

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 five-year business performance plans.
7. Align incentives with health and readiness outcomes to reward value creation.

In the June 2013 report, we described each objective and provided the expected system improvements, clinical and business practice standardizations, and resource reductions that each objective will achieve. We also provided performance measures by which we will document our progress. In the sections that follow, we provide an update on each of the seven objectives, including the specification of core and driver performance measures for each objective.

Objective 1: Promote more effective and efficient health care operations through enhanced enterprise-wide shared services.

We have completed the BCA and BPR plans with SMMAC approval for seven shared services, including an assessment of the level of risk based on the probability of achieving savings. We

are in the process of finalizing the BCA and BPR plans for SMMAC decision for the remaining three shared services. Four of these BCAs were provided in the June report: Facilities Planning, Medical Logistics, Health IT, and TRICARE Health Plan. These shared services became operational in the DHA on October 1, 2013. Additionally, the Pharmacy shared service, included in this report, accelerated its implementation timeline and began operations at IOC. These five shared services have detailed BPR plans which identify and prioritize key business processes requiring redesign or reengineering in order to implement the functional design and achieve the identified level of savings.

Following approval of both the BCAs and BPR plans, the five shared services underwent a series of transition planning activities in preparation for IOC. A CONOPS was approved for each shared service. The CONOPS describes the scope of services provided, the resources required to begin operations, accountability and mechanisms for dispute resolution, and performance reporting requirements. Appendices to the CONOPS, Coordinated Operations Standards (COSs), were developed and further describe the roles and responsibilities of the DHA and Services.

All five CONOPS and the COS appendices were reviewed with the Services' human resources, operations, and finance communities to identify issues and mitigate risks in operationalizing the shared service. The CONOPS and COSs appendices were then reviewed and approved by the Surgeons General and confirmed by the DHA Director.

The five remaining of the initial 10 shared services (Public Health, Medical Education and Training, Contracting, Research and Development, and Budget and Resource Management) will undergo a similar process over the coming year prior to beginning operations in the DHA.

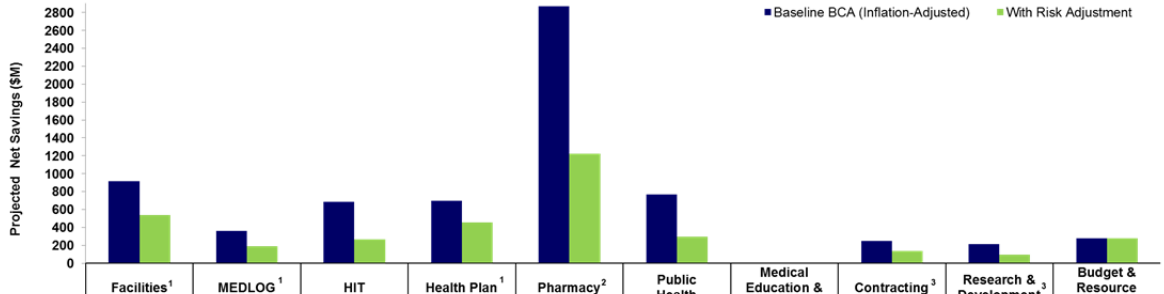
Core Measure: Total cost savings achieved through implementation of shared services.

Driver Measures:

- Cost savings from each shared service.
- Measures of cost, quality, speed, and customer satisfaction for each shared service. These measures are described in the shared service sections that follow and will be used to populate shared service dashboards and service level agreements.

Based on the BCAs for all ten shared services, the savings estimates (baseline and risk-adjusted) are shown in the figures below. Figure 3 shows the total savings (FY15-19) for each individual shared service and Figure 4 shows the cumulative savings over that same period of time.

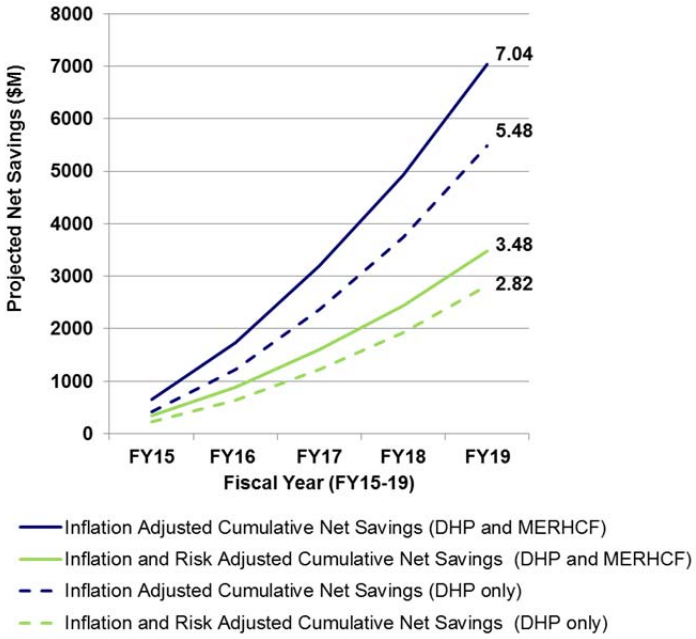
Figure 2: Cumulative Net Savings by Shared Service, FY15-19 (Baseline and Risk-Adjusted)



	Facilities[1]	MEDLOG[1]	HIT	Health Plan[1]	Pharmacy[2]	Public Health	Medical Education & Training[1]	Contracting[3]	Research & Development[3]	Budget & Resource Management[4]
Baseline BCA (Inflation-Adjusted)	915.13	358.21	688.00	694.90	2870.87	767.66	5.07	250.62	212.60	279.43
With Risk Adjustment	537.44	189.02	265.02	456.31	1224.36	293.06	5.07	135.81	97.69	279.43

[1] Shared service savings have been updated since the second Report to Congress due to additional refinement of business case analyses.
[2] Pharmacy shared service savings estimates reflect $566.06M in savings from the Defense Health Program (DHP) and $658.30M in savings from the Medicare Eligible Retirement Health Care Fund (MERHCF).
[3] At the time of this report, implementation costs for both Contracting and Research & Development have not been confirmed. All projected savings are gross savings without implementation costs.
[4] The B&RM shared service enables data transparency and specifically targets additional reimbursements, credited to the MTFs, which cannot be decremented from the DHP budget.

Figure 3: Cumulative Net Savings, All 10 Shared Services, FY15-19 (Baseline and Risk-Adjusted)



For discussion of the six remaining shared services, we have followed a format similar to our June 2013 report. We have included the purpose of the shared service, the product lines that will be consolidated, the scope of responsibilities within the shared service, projected savings and implementation costs, the timeline for implementation, and the measures we will use to assess performance.

1.0 PHARMACY

DoD Pharmacy provides outpatient, inpatient, and clinical pharmacy services to the MHS and its 9.7 million beneficiaries. It refers to a distinct set of capabilities needed to provide high-quality, affordable and accessible pharmaceutical care through direct care and purchased care points of service. Pharmacy accounts for approximately $7.3 billion in annual operating costs and over 4,400 FTEs across the MHS, with drug costs accounting for nearly 96 percent of pharmacy spending.

1.1 Purpose

The Pharmacy shared services strategy builds upon the activities of the Pharmacy Operations Directorate (POD), previously part of TMA. The strategy is centered on improving pharmacy operations and resource allocation through a series of standardization initiatives, greater accountability for performance measures, and policy and legislative changes. Pharmacy shared services will facilitate agile, responsive, data-based decision-making regarding the delivery and accessibility of pharmacy services by establishing standards and business rules to decrease variation in staffing, drug purchasing, formulary management, and pharmacy automation purchasing across outpatient pharmacies within the direct care system. Included in this strategy is the redirection of maintenance medication refills from high cost retail pharmacies to lower cost home delivery or Military Treatment Facility (MTF) pharmacies.

1.2 Consolidated Services

The DHA POD will deliver and centrally manage funding for enterprise-wide pharmacy programs, services, and initiatives. The POD will also be responsible for leading the strategy, management, and oversight of pharmacy operations across the enterprise.

1.3 Shared Services Scope of Responsibilities

(1) Corporate strategy, program governance, and communications. The POD will be responsible for establishing and monitoring strategic plans and initiatives for DoD pharmacy operations. The POD will support a collaborative governance process to coordinate and advocate for enterprise-wide pharmacy programs and initiatives to promote joint interoperability, efficiency, effectiveness and responsiveness in support of the MHS mission.

The POD will be responsible for centrally managing funding for enterprise-wide pharmacy activities and will oversee the planning, programming, budgeting, and execution of resources for all DoD pharmacy components. Funding mechanisms and structures for pharmacy operations will be standardized across the enterprise.

The POD will put in place the appropriate communication channels to support engagement of key stakeholders prior to and after the establishment of strategic plans and initiatives.

(2) Standardization, operational excellence, and pharmacy data analytics. The POD will consolidate contracts, develop uniform business rules, and standardize and reengineer pharmacy operations management processes to reduce costs, improve performance, and enable the MHS to operate more efficiently as an integrated health system. Moreover, the

POD will implement metrics, standards, and formalized performance reporting structures alongside the implementation of shared services to:

- Monitor strategy execution.
- Support evaluation of deployed and potential initiatives intended to improve the delivery and/or accessibility of pharmacy services.
- Inform future standardization, business process reengineering, and operational efficiency activities.

1.4 Cost Reductions

Implementing the Pharmacy shared service has the potential to save approximately $2.9B ($1.2B risk-adjusted) over five years. As shown in the table below, the Pharmacy savings come from both DHP-appropriated funds as well as appropriations from the Medicare Eligible Retiree Health Care Fund (MERHCF). Potential savings are contingent upon the following key changes to existing policy:

- The Uniform Formulary Final Rule will be revised to defer classification of newly approved Food and Drug Administration (FDA) innovator drugs as non-formulary prior to DoD Pharmacy & Therapeutic (P&T) Committee review.
- The pharmacy benefit structure for the under 65 retiree population will be adjusted to mirror the benefit structure of the TRICARE for Life (TFL) pilot project.
- OASD(HA) will develop policy to define the reporting structure and controls of pharmacy resources at MTFs, as well as to allow the POD to level contract resources across the MHS.
- A legislative proposal will be considered to enable establishment of direct care outpatient pharmacy central fill sites that have the ability to mail prescriptions to beneficiaries without copay costs to beneficiaries.

Savings are expected to result from implementation of the TFL pilot project. We propose reinvesting a portion of such savings, beginning in FY14 and through FY19, toward (1) developing an IT solution to automate uniform drug purchasing rules and reduce variation in drug purchasing practices across MTF pharmacies, and (2) procuring contracted pharmacy personnel to augment increased workloads at MTF outpatient pharmacies resulting from the redirection of maintenance medication refills. Such investments will enable further realization of projected savings through FY19.

We anticipate savings to be achieved in FY14 and FY15, and thereafter, through increased MTF pharmacy adherence to standardized drug purchasing practices, decreased drug costs resulting from the redirection of maintenance medication refills, and consolidation of pharmacy automation requirements and contracts. We also anticipate cost avoidance as a result of formulary management decisions made by the P&T Committee. If forecasted cost savings and avoidance for FY14 and FY15 are achieved, we propose reinvesting additional program dollars in establishing at least one new direct care pharmacy site and one direct care outpatient pharmacy central fill site, beginning in FY16. Investment costs may increase over time if direct care pharmacy workloads grow more significantly than estimated and/or if more sites are approved for development. Investment costs should be re-evaluated prior to FY16 programming.

Savings were risk-adjusted using the following methodology: Subject matter experts assessed the likelihood of achieving the savings by scoring each savings opportunity as having a high, medium, or low risk level. Low risk corresponded to a 100 percent probability of achieving the savings, medium risk corresponded to a 50 percent probability of achieving the savings, and high risk corresponded to a 10 percent probability of achieving the savings. Savings were then multiplied by the appropriate probability factor to calculate the risk-adjusted estimate.

For the Pharmacy shared service only, several implementation costs are variable, rather than fixed, and are directly proportional to the projected savings that can be achieved. As a result, these costs are displayed below from two perspectives: "Unadjusted" - where the costs are associated with savings potential without factoring in risk; and "Adjusted" – where the costs are associated with savings potential and have been adjusted for risk.

Pharmacy Projected Net Savings, FY 15-19 ($M)[3]								
			FY14	FY15	FY16	FY17	FY18	FY19
Gross Savings	Annual Gross Savings		$1,386.20	$1,790.00	$1,973.17	$2,162.19	$2,356.84	$2,549.27
	Annual Risk Adjusted Gross Savings		$ 693.15	$ 900.38	$ 941.27	$ 981.03	$1,018.50	$1,054.96
	Cumulative Gross Savings (FY15-19)		-	$1,790.00	$3,763.17	$5,925.36	$8,282.20	$10,831.47
	Cumulative Risk Adjusted Gross Savings (FY15-19)		-	$ 900.38	$1,841.64	$2,822.67	$3,841.17	$4,896.14
Implementation Costs[4]	Total Annual Implementation Costs	Unadj.	$1,064.62	$1,383.83	$1,482.13	$1,584.96	$1,695.15	$1,811.16
		Adj.	$ 532.67	$ 692.28	$ 711.48	$ 732.46	$ 755.53	$ 780.03
	IT Cost, Annual		$ 0.62	$ 0.63	$ 0.64	$ 0.65	$ 0.67	$ 0.68
	Contractor Support Cost, Annual[5]	Unadj.	$ 35.37	$ 45.97	$ 46.75	$ 47.64	$ 48.64	$ 49.71
		Adj.	$ 17.69	$ 22.98	$ 23.37	$ 23.80	$ 24.30	$ 24.70
	Personnel Severance, Annual		$ -	$ -	$ -	$ -	$ -	$ -
	Personnel Relocation, Annual		$ -	$ -	$ -	$ -	$ -	$ -
	Military Construction, Annual		$ -	$ -	$ -	$ -	$ -	$ -

[3] Future year savings and implementation costs have been inflated to "then year" dollars using inflation rates from the OSD Comptroller FY 14 "Green Book".

[4] Several implementation costs are dependent on the level of savings achieved (i.e. the anticipated costs vary with the savings). For these cost categories, the "Unadj" line provides the estimated cost for the unadjusted savings scenario, while the "Adj" line provides the estimated cost for risk-adjusted savings scenario.

[5] Accounts for contracted pharmacy personnel costs required to augment increased MTF outpatient pharmacy workloads.

Pharmacy Projected Net Savings, FY 15-19 ($M)[3]								
			FY14	**FY15**	**FY16**	**FY17**	**FY18**	**FY19**
	Other, Annual[6]	Unadj.	$1,028.63	$1,337.23	$1,434.74	$1,536.67	$1,645.85	$1,760.77
		Adj.	$ 514.37	$ 668.67	$ 687.46	$ 708.01	$ 730.56	$ 754.64
	Cumulative Implementation Costs (FY15-19)	Unadj.	-	$1,383.83	$2,865.96	$4,450.92	$6,146.07	$7,957.23
		Adj.	-	$ 692.28	$1,403.76	$2,136.22	$2,891.75	$3,671.78
Net Savings[7]	Annual Net Savings (DHP)		$ 135.48	$ 164.25	$ 216.00	$ 267.43	$ 315.12	$ 353.09
	Annual Net Savings (MERHCF)		$ 186.10	$ 241.93	$ 275.03	$ 309.80	$ 346.58	$ 385.03
	Annual Net Savings (Consolidated)		**$ 321.58**	**$ 406.17**	**$ 491.03**	**$ 577.23**	**$ 661.69**	**$ 738.11**
	Annual Risk Adjusted Net Savings (DHP)		$ 67.48	$ 87.18	$ 103.87	$ 117.30	$ 125.91	$ 131.79
	Annual Risk Adjusted Net Savings (MERHCF)		$ 93.00	$ 120.91	$ 125.92	$ 131.27	$ 137.05	$ 143.15
	Annual Risk Adjusted Net Savings (Consolidated)		**$ 160.48**	**$ 208.09**	**$ 229.79**	**$ 248.57**	**$ 262.97**	**$ 274.94**
	Cumulative Net Savings (DHP: FY15-19)		-	$ 164.25	$ 380.25	$ 647.68	$ 962.79	$1,315.88
	Cumulative Net Savings (MERHCF: FY15-19)		-	$ 241.93	$ 516.96	$ 826.76	$1,173.33	$1,558.36
	Cumulative Net Savings (Consolidated: FY15-19)		**-**	**$ 406.17**	**$ 897.21**	**$1,474.44**	**$2,136.13**	**$2,874.24**
	Cumulative Risk Adjusted Net Savings (DHP: FY15-19)		-	$ 87.18	$ 191.05	$ 308.36	$ 434.27	$ 566.06
	Cumulative Risk Adjusted Net Savings (MERHCF: FY15-19)		-	$ 120.91	$ 246.83	$ 378.10	$ 515.15	$ 658.30

[6] The majority of "other" costs account for the cost and volume of drugs moving from retail pharmacy points of service to direct care and mail order outpatient pharmacies. These costs are not new investments, rather, they are dollars previously spent on drugs dispensed at retail pharmacies that will need to be programmed for increased direct care and mail order outpatient pharmacy drug inventories.

[7] The lower cost estimates ("Adj") are deducted from the Risk Adjusted Savings (Annual/Cumulative) to calculate the Risk Adjusted Net Savings (Annual/Cumulative) while the cost estimates ("Unadj.") are deducted from the Savings (Annual/Cumulative) to calculate the Net Savings (Annual/Cumulative).

Pharmacy Projected Net Savings, FY 15-19 ($M)[3]						
	FY14	FY15	FY16	FY17	FY18	FY19
Cumulative Risk Adjusted Net Savings (Consolidated: FY15-19)	-	$ 208.09	$ 437.88	$ 686.45	$ 949.42	$1,224.36

1.5 Timeline

- As of July 17, 2013, the BPR Plan for Pharmacy shared services was approved by the SMMAC.
- On August 21, 2013, the CONOPS and organizational structure at IOC for Pharmacy shared services was complete.
- On October 1, 2013, Pharmacy shared services began implementation under the authority of the DHA.
- By February 1, 2014, the POD will have identified the three Service billets to be integrated into the DHA.

1.6 Pharmacy Measures

The following initial measures will be developed and monitored via an enterprise-level dashboard, which will provide the POD with the capability to monitor progress of initiatives and improvements included in the BPR plan. The measures are listed by objectives of the Pharmacy shared services initiatives. These measures may be adjusted or refined following IOC.

Redirect the Filling of Beneficiary Prescriptions for Maintenance Medications to Lower Cost Pharmacy Points of Service:

- The number of maintenance medication refills filled at all points of service by catchment area and the distribution of medication refills by enrollment status.
- MTF outpatient pharmacy, retail pharmacy, and mail order pharmacy market shares by catchment area and the distribution of market shares by enrollment status.
- Net cost to the government of the pharmacy benefit per member per year by catchment area and the distribution by enrollment status.
- MTF outpatient pharmacy staffing variance against the POD's universal MTF outpatient pharmacy staffing standard.
- Percentage of civilian provider prescriptions e-prescribed and filled at MTFs.

Increase MTF Outpatient Pharmacy Compliance with Centralized Drug Purchasing Rules:

- Percentage of prescriptions filled as generic when generic is identified as a preferred agent, per MTF outpatient pharmacy.
- Percentage of compliance with purchasing drugs via national contracts, per MTF outpatient pharmacy.

Savings from DoD P&T Committee Formulary Management Decisions:

- Annual projected cost-avoidance estimate for a formulary course of action selected, compared to a baseline formulary status for each class review completed.
- Cumulative annual cost-avoidance estimate of all classes reviewed at each quarterly P&T meeting.

Decrease Spending on Decentralized Pharmacy Automation Contracts:

- Percentage of MTF pharmacies' adherence to purchasing pharmacy automation maintenance products and services via centralized contracts.
- Percentage of MTF pharmacies' adherence to purchasing pharmacy automation products and services via centralized contracts.

2.0 PUBLIC HEALTH

Public Health is a critical component of military medicine. The discipline employs systematic processes to promote health, and manage population and individual health risks, in order to field a fit and medically ready force, as well as to improve and sustain the health of DoD populations. Military Public Health is comprised of 10 product lines: Deployment Health, Health Surveillance, Occupational and Environmental Health, Health Risk Communication and Public Health Emergency Response, Clinical Preventive Medicine, Radiation Health, Health Promotion, Public Health Laboratories, Entomology, and Food/Water Safety and Sanitation. In FY 2012, Public Health had total annual costs and resources of $1.2 billion and 9,159 FTEs, respectively.[8] This represents 2.4 percent of total costs to the MHS and 6.9 percent of FTEs. A significant portion of the public health budget, in particular occupational and environmental health, is driven by regulatory requirements.

2.1 Purpose

By February 1, 2014, the Public Health shared service of the DHA will manage the deployment health and the health surveillance product lines, including the Armed Forces Health Surveillance Center (AFHSC). It will also manage the DoD Veterinary Service Activity and the Military Vaccine Agency (MILVAX),[9] both of which involve services currently provided by the Secretary of the Army as a DoD Executive Agent.[10,11] The Public Health shared service will reengineer business processes to standardize and consolidate operations of these functions and increase efficiency. The Director of the Public Health shared service will design, monitor, and analyze metrics for these and all other public health product lines, and will conduct value stream analyses for the remaining product lines. These analyses will form the basis of recommendations for the future state DHA structure that will streamline and consolidate additional product lines.

[8] FY12 FTEs include 1,828 FTEs responsible for deployment health-related clinical activities occurring at the installation level.

[9] Integrated organization with the Vaccine Health Care Network; pre-decisional new organization name is DoD Immunization Health Care Center.

[10] Health surveillance product line includes Services' health surveillance assets combined with the Armed Forces Health Surveillance Center; does not include the health surveillance capabilities in non-DHP organizations.

[11] Deployment health product line includes Individual Medical Readiness, periodic health assessments and deployment health assessments.

Establishing consolidated and centralized governance for all appropriate public health product lines will garner cost savings by eliminating unnecessary redundancy and enhancing opportunities to implement standardized processes in a continuously improving organization.

2.2 Consolidated Services

Initially, the Deployment Health (to include deployment health assessments, individual medical readiness and deployment health execution guidance), and Health Surveillance product lines will be consolidated under the DHA, optimizing them and ensuring standardization across the military services. Consolidation of Health Surveillance will enable improved control and prioritization of data requests for information and analysis; streamlined data capture, data use, and analytic approach; and centralized oversight and management of DoD databases and epidemiologic resources. Consolidation of Deployment Health will enable optimization of the timing, frequency, content, and delivery method of health assessments and individual medical readiness tracking. DoD veterinary services and all immunization services will also be consolidated under the DHA, though this will represent a less significant change, as they already operate under DoD Executive Agent management arrangements.

2.3 Shared Services Scope of Responsibilities[12]

(1) Oversight, management, and execution responsibilities above the regional level for Health Surveillance. The AFHSC and military Services' health surveillance functions will be consolidated and managed as a single product line within the Public Health shared service. The Chief of Health Surveillance will provide and manage implementation and execution guidance; assign and manage customer requests; gather and analyze health surveillance data; interpret data and report if necessary; assess overall quality of health surveillance products; innovate and implement best practices; conduct program management; and maintain the DoD Serum Repository.

(2) Oversight and management of Deployment Health. The Chief of Deployment Health within the Public Health shared service will provide and manage deployment health implementation and execution guidance; facilitate adoption of Deployment Health guidance through Line liaisons; monitor and oversee compliance rates; identify best practices and opportunities to standardize across DoD; develop IT requirements in coordination with the DHA requirements management cell; manage Reserve and Guard-specific issues; serve as program experts for internal and external customers; communicate and implement standardized policies and programs; and align DHA plans with HA strategic and business plans. Execution-level responsibilities for Deployment Health will remain with the Services.

(3) Oversight and management of the DoDVSA. All current DoD Veterinary Service Activity (DoDVSA) functions will move to the DHA Public Health Division. The Chief of DoDVSA will provide oversight and advocacy for the congressionally mandated DoD veterinary service mission; conduct international, tri-Service and federal-level veterinary strategic planning and policy guidance development; maintain situational awareness of worldwide veterinary service

[12] At the time of this report, the MDAG has not approved the CONOPS and the number of FTEs moving into the shared services has not been confirmed.

operations; coordinate and advise the Office of the Secretary of Defense; and coordinate veterinary requirements and actions with DoD Combatant Commands (COCOMs) and Army Service Component Commands (ASCCs). In the future, it is anticipated the Food/Water Safety and Sanitation product line will be integrated with the DoDVSA.

(4) Oversight and management of the DoD immunizations health care functions. All current joint immunization health care functions, presently administered by MILVAX, will move to the DHA Public Health Division. The Chief of Immunizations will integrate and coordinate DoD and Military Services' vaccine policies and information; issue implementation and execution guidance; provide expert clinical and consultation services to support immunization healthcare policy and practice; support population vaccine safety surveillance and research; deliver quality immunization healthcare information, educational resources/tools, and training services; conduct public health investigations, surveillance, and clinical studies and research related to immunization healthcare; advocate for evidence-based practice improvements in immunization healthcare; promote excellence in immunization standards of practice; and develop and implement communication strategies and activities.

2.4 Cost Reductions

Implementation of the Public Health shared service has the potential to save $767.66M ($293.06M risk-adjusted) over five years, as shown in the table below. These savings estimates are derived from analysis of two of the ten public health product lines: Deployment Health and Health Surveillance. Cumulative implementation costs for these product lines will be $48.09M.

Up to $735.89M ($287.8M risk-adjusted) of these savings will be in direct care costs – achieved by streamlining the deployment health process, resulting in a reduction in associated clinical encounters. Reducing the frequency of unnecessary deployment health clinical encounters can be used to increase access for other patient needs. To realize these savings, several changes to legislation and tri-Service deployment health policies will be required. Implementation costs of $15.5M include modification of the electronic Periodic Health Assessments (PHAs) and medical readiness tracking systems. The remaining $31.77M ($5.27M) in public health costs, results from consolidation of health surveillance activities through implementation of process improvements and the optimization and realignment of health surveillance activities and databases. Implementation costs of $32.56M include IT and contract support. Additional savings will likely be garnered pending further analysis and potential incorporation of additional public health functions in the DHA.

Public Health Projected Net Savings, FY 15-19 ($M)*							
		FY14	FY15	FY16	FY17	FY18	FY 19
Gross Savings	Annual Savings	$ 0.10	$ 20.20	$ 125.05	$ 214.53	$ 223.26	$ 232.72
	Annual Risk Adjusted Savings*	$ 0.10	$ 10.68	$ 57.81	$ 87.28	$ 90.78	$ 94.60
	Cumulative Savings (FY15-19)	-	$ 20.20	$ 145.25	$ 359.77	$ 583.03	$ 815.76
	Cumulative Risk Adjusted Savings (FY15-19)*	-	$ 10.68	$ 68.49	$ 155.77	$ 246.55	$ 341.15

Public Health Projected Net Savings, FY 15-19 ($M)*							
		FY14	**FY15**	**FY16**	**FY17**	**FY18**	**FY 19**
Implementation Costs	Total Annual Implementation Costs	$ 12.45	$ 11.68	$ 10.59	$ 15.48	$ 5.34	$ 5.00
	IT Cost, Annual	$ 7.50	$ 7.42	$ 6.23	$ 9.03	$ 2.94	$ 2.68
	Contractor Support Cost, Annual	$ 4.95	$ 4.26	$ 4.36	$ 6.45	$ 2.40	$ 2.32
	Personnel Severance, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Personnel Relocation, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Military Construction, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Other, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Cumulative Implementation Costs (FY15-19)	-	$ 11.68	$ 22.27	$ 37.75	$ 43.09	$ 48.09
Net Savings	**Annual Net Savings**	$ (12.34)	$ 8.52	$ 114.46	$ 199.05	$ 217.92	$ 227.72
	Annual Risk Adjusted Net Savings*	$ (12.34)	$ (1.00)	$ 47.22	$ 71.80	$ 85.44	$ 89.60
	Cumulative Net Savings (FY15-19)	-	$ 8.52	$ 122.98	$ 322.03	$ 539.95	$ 767.66
	Cumulative Risk Adjusted Net Savings (FY15-19)*	-	$ (1.00)	$ 46.22	$ 118.02	$ 203.46	$ 293.06

*See Section 1.4 (Pharmacy) for an explanation of the risk-adjustment methodology.

2.5 Timeline

- As of September 1, 2013, the BPR plan for the Public Health shared service was completed.
- On October 1, 2013, the Director of DHA identified a Chief for the Public Health division and a proposed organizational structure.
- By February 1, 2014, a CONOPS will be developed for the Public Health Division.
- On February 1, 2014, the Public Health Division will begin implementation under the authority of the DHA.

2.6 Public Health Measures

Preliminary metrics were developed to aid the Chief of the Public Health Division in monitoring execution, implementation success and savings attributed to the reengineered, streamlined and consolidated processes for Deployment Health and Health Surveillance. Additional measures for all remaining product lines will be developed and implemented after IOC.

Deployment Health:

- Percentage of active duty who complete the required components of the Health Assessment at the required time.
- Percentage of health assessment referrals with a documented provider encounter within the required timeframe.
- Percentage of MTFs utilizing standardized deployment health process.
- Percentage of total force medically ready.

Health Surveillance:

- Percentage of appropriate, identified data sources utilized by the Health Surveillance product line in the DHA (denominator: will establish the baseline of identification).
- Percentage of time that primary health surveillance information systems are off-line.
- Percentage of products completed within the appropriate timeframe.
- Percentage of finished products of high quality, as rated by requestor.

3.0 MEDICAL EDUCATION & TRAINING

Note: At the time of this report, the SMMAC had not approved the Medical Education & Training BPR plan which impacts sections 3.2-3.5.

Medical Education and Training (MET) enables a ready, capable, and qualified medical professional force to carry out the military mission and support the delivery of health care services. There are four medical education and training product lines: Federal Academic Health Education & Training,[13] Force Development and Sustainment,[14] Academic Review and Development,[15] and Academic and Administrative Support Activities.[16] In FY12, total costs and resources were $693.5M and 3,780 FTEs, respectively.

3.1 Purpose

By October 1, 2014, the Director of MET will design, monitor, and analyze metrics for all MET product lines and functions. Additionally, the Director will manage the development of an enterprise-wide learning management solution and support standardization and consolidation contracts for modeling and simulation products and services.

3.2 Consolidated Services

Initially, consolidation of service will occur in the Academic Review & Development and Academic & Administrative Support Activities product lines. Two-sub product lines of Academic Review & Development, eLearning and Modeling & Simulation, will be established

[13] Includes: undergraduate programs, graduate programs, and professional certification
[14] Includes: MHS leader development, operational training, GME, GDE, officer training, and enlisted training
[15] Includes: Health Care Interservice Training Review Organization (HC ITRO), curriculum development, curriculum management, innovative modalities (eLearning, and modeling & simulation)
[16] Includes: administration of tuition payment, CE granting, conference approval & package development, and Graduate Medical Education Specialty Board (GMESB) scheduling & support

under the DHA. Centralized DHA support will enhance coordination efforts to move toward a joint Learning Management System (LMS). Additional benefits of a shared LMS include interoperability across the Services and the ability to develop and provide shared course offerings. Standardized and consolidated modeling and simulation products and services will offer the same benefits as well as reduce overall spend through optimized strategic sourcing. MET administrative functions will also be consolidated in the DHA to enhance the timeliness and delivery of support to academic development and delivery.

3.3 Shared Services Scope of Responsibilities

The MET Directorate scope of responsibilities includes the following services:

Medical Education and Training Campus (METC)
(1) Oversee and manage the METC. Manage personnel from the Services currently aligned to METC. Utilize current governance to identify opportunities for improvement in delivery and management of enlisted MET. Collaborate with other federal health academic centers to optimize all MET.

Force Development & Sustainment Training
(2) Oversee and manage the Defense Medical Readiness Training Institute (DMRTI). Manage personnel currently aligned to DMRTI. Utilize the Services and the Joint Staff to identify opportunities for improvement in delivery and management of operational MET.

(3) Oversee and manage the Joint Medical Executive Skills Institute (JMESI). Manage personnel currently aligned to JMESI. Utilize current governance to identify opportunities for improvement in delivery and management of MHS leader development. Collaborate with the Services to optimize MHS leader development.

(4) Additional Force Development & Sustainment Training responsibilities. Utilize current or newly charted working groups to determine future opportunities to expand product lines in the MET Directorate.

Academic Review & Development
(5) Oversee eLearning and direct LMS standardization. Monitor requirements from the Services. Serve as liaison between the Services, DHA MET shared services and DHA Health IT shared service. Utilize current or newly chartered working groups to establish and manage updates to an enterprise-wide LMS. Identify opportunities for sharing curriculum across the Services. Coordinate joint curriculum development and trainings when Service requirements are similar.

(6) Oversee medical modeling and simulation and manage contract spending. Monitor medical modeling and simulation requirements from the Services. Serve as a liaison between the Services, DHA MET Directorate, DHA Director, DHA Contracting Division and other entities, as required, to standardize modeling & simulation products and consolidate related contracts. Identify opportunities for resource sharing across the Services. Coordinate joint curriculum development and trainings when Service requirements are similar.

(7) Additional Academic Review & Development responsibilities. Utilize current or newly chartered working groups to determine future opportunities to expand product lines in the MET Directorate.

Academic & Administrative Support Activities

(8) Oversee and manage administrative and support activities. Manage administrative support activities, to include: continuing education credit granting, conference approval package development, Graduate Medical Education Specialty Board (GMESB) scheduling and support, tuition payment and scholarship payment processing. Determine future opportunities to expand product lines in the MET Directorate.

3.4 Cost Reductions

Initial implementation of the MET shared service has the potential to save $5.07M over five years as shown in the table below. This savings estimate is derived from analysis of an initiative to standardize and consolidate contracts for modeling and simulation products and services. Implementation costs will be incurred by DHA Contracting. Subsequent savings will result from optimization of strategic sourcing strategies for modeling and simulation contract spend. The MET Directorate will also collaborate with the HIT Directorate to establish an enterprise-wide LMS. Estimated savings for this initiative are included in the HIT IT application portfolio rationalization initiative.

Medical Education and Training Projected Net Savings, FY 15-19 ($M)*							
		FY14	**FY15**	**FY16**	**FY17**	**FY18**	**FY 19**
Gross Savings	Annual Savings	$ -	$ -	$ -	$ 1.05	$ 1.55	$ 2.47
	Annual Risk Adjusted Savings*	$ -	$ -	$ -	$ 1.05	$ 1.55	$ 2.47
	Cumulative Savings (FY15-19)	-	$ -	$ -	$ 1.05	$ 2.60	$ 5.07
	Cumulative Risk Adjusted Savings (FY15-19)*	-	$ -	$ -	$ 1.05	$ 2.60	$ 5.07
Implementation Costs	Total Annual Implementation Costs	$ -	$ -	$ -	$ -	$ -	$ -
	IT Cost, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Contractor Support Cost, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Personnel Severance, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Personnel Relocation, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Military Construction, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Other, Annual	$ -	$ -	$ -	$ -	$ -	$ -

Medical Education and Training Projected Net Savings, FY 15-19 ($M)*							
		FY14	**FY15**	**FY16**	**FY17**	**FY18**	**FY 19**
	Cumulative Implementation Costs (FY15-19)	$ -	$ -	$ -	$ -	$ -	$ -
Net Savings	**Annual Net Savings**	$ -	$ -	$ -	$ 1.05	$ 1.55	$ 2.47
	Annual Risk Adjusted Net Savings*	$ -	$ -	$ -	$ 1.05	$ 1.55	$ 2.47
	Cumulative Net Savings (FY15-19)	-	$ -	$ -	$ 1.05	$ 2.60	$ 5.07
	Cumulative Risk Adjusted Net Savings (FY15-19)*	-	$ -	$ -	$ 1.05	$ 2.60	$ 5.07

*See Section 1.4 (Pharmacy) for an explanation of the risk-adjustment methodology.

3.5 Timeline

- On October 1, 2013, the BPR plan for the MET shared service was completed.
- On October 1, 2013, the Director of DHA identified the MET Director and a proposed organizational structure.
- By January 1, 2014, a Transition Plan will be developed for the MET shared service.
- By June 30, 2014, the MET shared service will begin implementation under the authority of the DHA.

3.6 MET Measures

Preliminary metrics were developed to aid the DHA MET Director in monitoring execution, implementation success and savings attributed to the reengineered, streamlined and consolidated processes for the proposed cost saving initiatives. Additional measures for all remaining product lines and functions will be developed and implemented after IOC.

eLearning: Learning Management Systems:

- Cost per course.
- Cost per student.
- Percent of courses that are Joint versus Service-specific.
- Average turnaround time to put a course on the system.
- Required training compliance rates.

Modeling & Simulation (Contract Spending):

- Cost per course.
- Cost per student.
- Percent of contracts that are Joint vs. Service-specific.

- Percent of medical modeling and simulation requirements managed by the Joint project office.
- Percent of modeling and simulation platforms using MHS governance approved modeling and simulation protocols.
- Percent of modeling and simulation platforms using MHS governance approved assessment tools.
- Percent of modeling and simulation platforms using MHS governance approved performance metrics (number trained, assessment responses, etc.).
- Number of training programs or procedures transitioned from using live animals to employing a modeling and simulation modality.

4.0 CONTRACTING

Note: At the time of this report, the MDAG had not approved the Contracting BPR plan which impacts sections 4.2-4.5.

Contracting describes a very broad capability of the Government to incur mutually binding legal relationships obligating the seller to furnish supplies or services[17] and the buyer to pay for them. Contracting encompasses a connected series of lifecycle management activities linking the requirement with contract award, administration, and closeout.

4.1 Purpose

The Contracting shared service is an effort to centralize the strategy for acquisition of goods and services to meet the needs of shared services and common functions and business lines. In May 2013, the Government Accountability Office stated: "The Department of Defense (DOD) does not have a consolidated agency-wide acquisition strategy for medical services. In the absence of such a strategy, contracting for health care professionals is largely fragmented." The Contracting shared services effort, therefore, aims to reduce variation, redundancy, and cost while improving the efficiency of operations. Shared services will improve efficiency within core processes associated with acquisition planning and program management as well as contract execution and management.

4.2 Consolidated Services

As of the time of preparation of this report in September 2013, the scope of contracting shared services is proposed to initially be limited to medical services contracting. Medical services contracting is the procurement of health care services to support the medical mission capability of operational forces and the DoD beneficiary population. Contracting shared services will begin with Medical Services (Product Service Code Q) and continue to cover Professional, Administrative and Management Support Services (Product Service Code R). Other DHA functions considering centralized contracting strategies include the management of hospital housekeeping services (Product Service Code S) and Automated Data Processing and Telecommunications (Product Service Code D). An analysis currently underway to quantify the

[17] Contracting, as discussed in this report, does not include construction contracting.

scope and the range of contracting offices currently managing other services will determine the eventual full scope of the contracting shared services effort.

In FY2011, medical contracting comprised $3.3B in DoD spending for Q and R services alone. Contracts and associated manpower considered within the purview of the health plans business line (e.g., TRICARE Managed Care Support Contracts; dental contracts; pharmacy contracts, and Designated Provider contracts) are excluded since they are addressed in a prior report.

4.3 Shared Services Scope of Responsibilities

(1) Acquisition Planning and Program Management. The DHA will assert responsibility for acquisition and program management within the contracting function. An Oversight and Performance Management Committee (OPMC) will link DHA governance to the Services' leadership and provide a forum for cross-Service collaboration on acquisition strategies. The OPMC will develop acquisition strategies, standardize requirements, review waiver requests to use strategic contracting vehicles for Service-specific needs, and report contract execution metrics and contractor performance. In addition, the OPMC will benchmark DHA and Service contracting activities and measure progress toward savings goals.

(2) Contract Execution, Management and Administration. If required as part of an acquisition strategy, the DHA will award strategic contracts for use across the enterprise in order to eliminate redundancy and reduce variation in contract cost and quality of services. Although award of task and delivery orders at the Service and Agency level will remain with end users' contracting offices, the DHA will ensure that the awards are consistent with the terms and conditions of the contracts and that contractor performance evaluation is completed in a timely manner. The DHA will also develop metrics leveraging standard procurement systems to produce and monitor performance data.

(3) Assistance Services. Contracting shared services may also cover awarding Research and Development Grants/Cooperative Agreements to support the ongoing research and development mission of the DHA and the Services. The scope of assistance services will be finalized after further evaluation.

4.4 Cost Reductions

Initial implementation of contracting shared services has the potential to save up to $250.62M ($135.81M risk-adjusted) over five years as shown in the table below. To achieve savings, an initial investment may be required to support additional manpower needed to establish organic contracting oversight and operations within the DHA and prepare information technology systems for contracting shared services. The level of investment required is still under review. Because the majority of medical contracting is carried out by either standalone contracts or Service-specific contracts, the timing of the savings will depend on when contracted services are re-competed through joint, multiple award contracts (MAC) awarded by the DHA. Subject matter experts identified a significant risk to identified savings if the Services' contracting offices do not use the centralized contracts due to Service-specific "wants" or because small business program goals are not attainable through shared services. As a component of

performance management efforts, the DHA will enumerate the loss of the spend to these types of requirements in order to understand contract cost variations resulting from these types of requirements.

Contracting Projected Net Savings, FY 15-19 ($M)*							
		FY14	**FY15**	**FY16**	**FY17**	**FY18**	**FY 19**
Gross Savings	Annual Savings	$ 2.35	$ 4.23	$ 3.76	$ 27.38	$ 49.39	$ 165.85
	Annual Risk Adjusted Savings*	$ 2.35	$ 3.75	$ 3.76	$ 16.29	$ 26.87	$ 85.14
	Cumulative Savings (FY15-19)	-	$ 4.23	$ 7.99	$ 35.38	$ 84.77	$ 250.62
	Cumulative Risk Adjusted Savings (FY15-19)*	-	$ 3.75	$ 7.51	$ 23.80	$ 50.67	$ 135.81
Implementation Costs	Total Annual Implementation Costs	$ -	$ -	$ -	$ -	$ -	$ -
	IT Cost, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Contractor Support Cost, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Personnel Severance, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Personnel Relocation, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Military Construction, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Other, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Cumulative Implementation Costs (FY15-19)	-	$ -	$ -	$ -	$ -	$ -
Net Savings	**Annual Net Savings**	$ 2.35	$ 4.23	$ 3.76	$ 27.38	$ 49.39	$ 165.85
	Annual Risk Adjusted Net Savings*	$ 2.35	$ 3.75	$ 3.76	$ 16.29	$ 26.87	$ 85.14
	Cumulative Net Savings (FY15-19)	-	$ 4.23	$ 7.99	$ 35.38	$ 84.77	$ 250.62
	Cumulative Risk Adjusted Net Savings (FY15-19)*	-	$ 3.75	$ 7.51	$ 23.80	$ 50.67	$ 135.81

*See Section 1.4 (Pharmacy) for an explanation of the risk-adjustment methodology.

4.5 Timeline

The proposed timeline for establishing the DHA contracting shared service is March 1, 2014.

4.6 Contracting Measures

The contracting community has mature measurement capacity but lacks enterprise-wide standard measures. The following specific contracting measures will be developed and included in an enhanced dashboard to track improvements described in the contracting BPR plan. Contracting performance measures have been aligned with the three primary business lines referenced in section 4.3.

- Number of End Items: Number of unique end items by product line that are sourced through strategic MACs. For example, a joint performance work statement for a board certified primary care physician would be an example of a strategically sourced end item.
- Percent use of MACs: Total number of MACs divided by total spend (by product line).
- Number of Strategic Vehicles on Schedule: Describes progress toward sourcing enterprise strategic vehicles in terms of timeliness. The vehicles must hit execution milestones in order to be considered "on schedule."
- Percent of Waivers Approved: Total number of approved waivers divided by total number of waivers requested.
- Task Order Procurement Administrative Lead Time: Time from receipt of complete requirement and funding to award of task order.
- MAC Overall Fill Rates: Calculated by dividing the number of filled positions by the number of required positions.
- MAC on Time Fill Rate: Calculated by dividing the number of FTEs that started on time by the total number of FTEs required.
- Contracting Officer Representative (COR) Percentage: Percentage of Task Orders awarded with current, trained COR identified.
- Extensions and Bridges Awarded: Number of extensions and bridge contracts awarded.
- Percent of Small Business Spending: Volume of work awarded to small business (by product line).
- Contractor Performance Assessment Reporting System (CPARS) Compliance: Number of CPARS completed/Total number of CPARS required.
- Contract Closeout: Number of open task orders following the end of the contract ordering period.

5.0 RESEARCH AND DEVELOPMENT

Note: At the time of this report, the MDAG had not approved the Research & Development BPR plan which impacts sections 5.2-5.5.

Medical Research, Development and Acquisition (RDA) is directed toward developing products and medical knowledge to prevent and/or correct any human condition that would impair or preclude a Service or joint force from achieving its objectives across the range of operations and responsibilities. RDA develops solutions in response to the medical needs of the warfighter and provides a robust Science and Technology base designed to prevent technological surprise. RDA encompasses a connected series of investigations and developmental process activities from basic research, materiel and non-materiel solution analysis, technology development, and engineering manufacturing. The RDA enterprise goal is to ensure the transition of medical technologies and clinical products to the field (deployed or in garrison), and the translation of

empirically-based knowledge products into clinical practice and policy. The significance of the RDA function is described in the Force Health Protection CONOPS.

The DHP and Service-specific RDA function supports nine coordinated and integrated research areas: Medical Simulations and Health IT Services, Human Performance, Force Health Protection, Infectious Diseases, Military Operational Medicine, Combat Casualty Care, Radiation Health Effects, Clinical Medicine and Rehabilitation, and Congressional Special Interest (CSI) National Programs.

5.1 Purpose

The RDA shared service will execute specific activities to improve RDA coordination, process efficiency, and output quality across the enterprise. Process improvement initiatives to move RDA toward a more shared service will produce greater operational efficiency particularly in the areas of requirements generation, advanced development management, and research protections. Additionally, an RDA shared services model that matches investments with intramural capabilities and expertise will reduce research costs allowing the program to recapture funds that can be reinvested into additional research programs.

5.2 Consolidated Services

While all Services maintain medical RDA capabilities, only the Army possesses all of the necessary product lines and enablers required to manage and execute full life-cycle development of medical products. This diverse set of medical product RDA capabilities is what led the ASD(HA) to direct the Army to serve as manager of the DHP Research, Development, Testing and Evaluation (RDT&E) portfolio. As a result, RDA within the military is already largely joint, managed through a series of joint program committees. These committees are designed to increase inter-Service coordination and cooperation as well as reduce unnecessary duplication of efforts and enhance efficiency.

As of the time of report preparation in September 2013, the eventual scope of RDA shared services is envisioned to reduce overlap among the Services in administrative and management functions. The outcome will improve research coordination through joint research programs, create operational efficiencies, and reduce costs by aggregating funding around joint intramural research programs and streamlining intramural laboratory structure. As of FY11, the total value of medical research activities across all Services was $1.7 B, which includes approximately $0.5 B of CSI funding. The RDA shared services at IOC will not include Service investments, nor Defense Advanced Research Projects Agency or Office of the Assistant Secretary of Defense (Research and Engineering) investments, but will include the DHP RDA funding portfolio of approximately $1.2 B.

5.3 Shared Services Scope of Responsibilities

The scope of this shared service will be finalized once the BPR plan is approved by the MDAG and SMMAC.

5.4 Cost Reductions

Structural changes in how the DHP research program is managed and executed will provide limited savings. However, initiatives to improve RDA shared service processes for managing RDT&E investments and reducing overhead expenses associated with the execution of the program have the potential to recapture up to $212.6 M (risk adjusted to $97.7 M) in RDA investment over a five year period. These funds could be reinvested into additional research. An initial cost assessment indicates that the implementation of process improvement initiatives would not require additional funding.

Research, Development, and Acquisition Projected Net Savings, FY 15-19 ($M)*							
		FY14	**FY15**	**FY16**	**FY17**	**FY18**	**FY 19**
Gross Savings	Annual Savings	$ -	$ 0.54	$ 26.24	$ 46.74	$ 68.78	$ 70.30
	Annual Risk Adjusted Savings*	$ -	$ 0.54	$ 10.97	$ 21.18	$ 32.15	$ 32.86
	Cumulative Savings (FY15-19)	-	$ 0.54	$ 26.77	$ 73.52	$ 142.30	$ 212.60
	Cumulative Risk Adjusted Savings (FY15-19)*	-	$ 0.54	$ 11.50	$ 32.68	$ 64.83	$ 97.69
Implementation Costs	Total Annual Implementation Costs	$ -	$ -	$ -	$ -	$ -	$ -
	IT Cost, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Contractor Support Cost, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Personnel Severance, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Personnel Relocation, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Military Construction, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Other, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Cumulative Implementation Costs (FY15-19)	-	$ -	$ -	$ -	$ -	$ -
Net Savings	**Annual Net Savings**	$ -	$ 0.54	$ 26.24	$ 46.74	$ 68.78	$ 70.30
	Annual Risk Adjusted Net Savings*	$ -	$ 0.54	$ 10.97	$ 21.18	$ 32.15	$ 32.86
	Cumulative Net Savings (FY15-19)	-	$ 0.54	$ 26.77	$ 73.52	$ 142.30	$ 212.60
	Cumulative Risk Adjusted Net Savings (FY15-19)*	-	$ 0.54	$ 11.50	$ 32.68	$ 64.83	$ 97.69

*See the Section 1.4 (Pharmacy) for an explanation of the risk-adjustment methodology.

5.5 Timeline

As noted in the beginning of this section, the BPR plan has not been approved. Timeline and milestones will be part of the BPR plan.

5.6 Research and Development Measures

The following metrics will be developed and included in an enhanced dashboard related to improvements included in the BPR plan.

Requirements Generation

- Number of requirements approved by the Joint Requirements Oversight Council.
- Number of Initial Capabilities Documents, Capabilities Development Documents for Medical Products (joint or Service-specific).

Advanced Development, including materiel solutions and translation of Medical Knowledge (e.g., best Practice, clinical practice guidelines and policy)

- Number of milestone decisions successfully completed.
- Number of active product Integrated Product Teams.
- Number of products fielded.
- Number of products transitioned.
- Number of Investigational New Drug applications.
- Number of Investigational Device Exemption applications.
- Number of New Drug Applications.
- Number of knowledge-products fielded (Clinical Practice Guidelines, Training, etc.).

Redirection of Extramural Funding

- Ratio of extramural to intramural investments.
- Percent of obligations and disbursements to extramural and intramural activities.
- Total number of FTEs supporting extramural programs.

6.0 BUDGET AND RESOURCE MANAGEMENT (B&RM)

B&RM works to promote the cost-effective use of program and budgeted funds, increased reimbursements and improved financial transparency and utilization in support of the MHS. B&RM encompasses financial management activities including cost accounting and billing to other health insurance (OHI) providers as well as inter-agency entities. The FY12 operating costs for its product lines were $300 million, to include cost accounting and billing for healthcare reimbursement.

6.1 Purpose

As an enabler, the B&RM shared services will support the development and dissemination of a common cost accounting data structure, standards, and guidance, and establish an ability to monitor and track compliance with a standardized financial information structure through the development of a data warehouse. Adoption will enable the MHS to better compare financial performance, and serve as a necessary stepping stone to enterprise-wide financial data transparency. Further, the B&RM shared services will monitor the progress of a Tri-Service initiative to implement a new web-based commercial-off-the-shelf medical billing software solution called the Armed Forces Billing and Collection Utilization Solution (ABACUS). ABACUS will replace manually-intensive legacy systems, promote cleaner claims, enhance discovery of OHI data, improve denials management, reduce delinquent debt and enable transparency of medical billing activities across the MHS enterprise. The program will compel compliance with 10 U.S.C. 1095 and 32 CFR 220 (law/regulations governing the Third Party Collections Program), 10 U.S.C. 1079b and 32 CFR 108/728 (law/regulations governing the Medical Services Accounts Program), 42 U.S.C. 2651 (law governing the Medical Affirmative Claims Program) and 31 U.S.C. 3711-16 and 31 CFR 900-904 (law/regulations governing the Debt Collection Improvement Act).

6.2 Consolidated Services

B&RM shared services will adopt common cost accounting structures, standards and guidance as well as monitor the Tri-Service effort to optimize billing and collections activities through implementation of a new billing solution. The DHA will provide compliance oversight of common structure compliance and billing execution by the Services.

6.3 Shared Services Scope of Responsibilities

(1) Management of Common Cost Accounting Initiatives. As members of the Common Cost Accounting Structure Governance Board, the DHA and the Services, will advise and make recommendations on the development and distribution of a common cost accounting structure, standards, and guidance. The DHA will also assist, monitor and track compliance with the published structure and standards in order to uniformly assess common cost accounting performance and take corrective action, if necessary. Further, the DHA and the Services will develop data warehouse requirements and implement a joint solution to consolidate financial data storage and reporting capabilities and further enterprise-wide transparency.

(2) Monitoring of Billing Solution Implementation. The DHA Uniform Business Office (UBO) will set policy and provide program oversight for the MHS's three health care cost recovery programs in addition to the overall revenue cycle direction. As the lead of the UBO Advisory Working Group, the DHA, in collaboration with the Services, will monitor the progress of the billing solution implementation. The DHA UBO, in collaboration with the Services, will develop new standards, refine existing guidance, and monitor new reporting metrics to track the results of medical billing activities. Following implementation, the DHA UBO will evaluate a range of governance models – including centralized, regionalized and contracted models – to determine the optimal construct for the MHS UBO functions. Once a model is selected and approved, the DHA, in collaboration with the Services, will implement the new governance structure.

6.4 Cost Reductions

While the initiatives proposed by B&RM are not cost reduction strategies, they are focused on enhancing data transparency and improving medical reimbursements across the enterprise, which will positively impact all MHS Components, including the DHA and shared services. Implementing a common cost accounting structure and a data warehouse with a reporting interface may indirectly achieve future savings by effectively and efficiently producing enterprise-wide resource comparisons, identifying best practices, and enabling further robust analyses to target new opportunities to reduce costs.

Implementation of ABACUS will improve the MTFs' ability to bill and collect from billable self-pay patients, third-party insurers, and supported federal agencies. Improvements in the revenue cycle business processes coupled with the technology investment is projected to yield greater reimbursements ($279.43M by FY19) through more timely and increased collections, increased billable encounters, and the ability to collect on more claims. This initiative specifically targets additional reimbursements, credited to the MTF, which cannot be used to defray DHP budget projections.[18]

Budget and Resource Management Projected Net Reimbursements, FY 15-19 ($M)							
		FY14	FY15	FY16	FY17	FY18	FY 19
Gross Savings	Annual Savings	$ 6.02	$ 43.65	$ 58.84	$ 59.95	$ 61.21	$ 62.56
	Annual Risk Adjusted Savings*	$ 6.02	$ 43.65	$ 58.84	$ 59.95	$ 61.21	$ 62.56
	Cumulative Savings (FY15-19)	-	$ 43.65	$ 102.49	$ 162.44	$ 223.65	$ 286.21
	Cumulative Risk Adjusted Savings (FY15-19)*	-	$ 43.65	$ 102.49	$ 162.44	$ 223.65	$ 286.21
Implementation Costs	Total Annual Implementation Costs	$ 1.14	$ 1.05	$ 1.39	$ 1.42	$ 1.45	$ 1.48
	IT Cost, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Contractor Support Cost, Annual	$ 1.14	$ 1.05	$ 1.39	$ 1.42	$ 1.45	$ 1.48
	Personnel Severance, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Personnel Relocation, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Military Construction, Annual	$ -	$ -	$ -	$ -	$ -	$ -

[18] Per 10, U.S.C. 1095(g), MTF budgets cannot be decremented by the amount of their third party collections program. Collections received from third-party payers are "credited to the appropriation supporting the maintenance and operation of the facility and shall not be taken into consideration in establishing the operating budget of the facility."

Budget and Resource Management Projected Net Reimbursements, FY 15-19 ($M)							
		FY14	**FY15**	**FY16**	**FY17**	**FY18**	**FY 19**
	Other, Annual	$ -	$ -	$ -	$ -	$ -	$ -
	Cumulative Implementation Costs (FY15-19)	-	$ 1.05	$ 2.44	$ 3.86	$ 5.31	$ 6.79
Net Savings	**Annual Net Savings**	$ 4.88	$ 42.60	$ 57.45	$ 58.54	$ 59.77	$ 61.08
	Annual Risk Adjusted Net Savings*	$ 4.88	$ 42.60	$ 57.45	$ 58.54	$ 59.77	$ 61.08
	Cumulative Net Savings (FY15-19)	-	$ 42.60	$ 100.05	$ 158.58	$ 218.35	$ 279.43
	Cumulative Risk Adjusted Net Savings (FY15-19)*	-	$ 42.60	$ 100.05	$ 158.58	$ 218.35	$ 279.43

6.5 Timeline

- On July 26, 2013, the BPR Plan for the B&RM Division was approved by the MDAG.
- On August 28, 2013, the BPR Plan for the B&RM Division was approved by the SMMAC.
- On October 1, 2013, the Director of DHA identified a Chief for the B&RM Division and a proposed organizational structure.
- By February 1, 2014, a CONOPS will be developed for the B&RM Division.
- On February 1, 2014, the B&RM Division will begin implementation under the authority of the DHA.

6.6 B&RM Measures

The B&RM community has a mature measurement capability. The following specific measures will be developed and included in an enhanced dashboard related to improvements included in the BPR Plan. The measures have been aligned with the two primary initiatives referenced in section 6.1 – common cost accounting and the ABACUS billing solution.

- Percentage of accounting transactions adhering to common cost accounting standards, structures and guidance.
- Revenue goals, actual billed and collected by UBO function.
- Number of claims billed and collected by UBO function.
- Accounts receivable, outstanding revenue, and other underpayment/bad debt measures.

Progress on the Remaining Six Objectives

The MHS is committed to transparency and accountability; for each of the remaining objectives (2-7), we will discuss our core measure of success, explain our rationale for choosing that measure, and then describe a set of "driver" measures that will be monitored to track improvement. Some of the driver measures are directly aligned with one part of the Quadruple

Aim, allowing us to demonstrate how our objectives support our high-level strategic goals. In many cases, the driver measures have been monitored for some time, baseline data has been established and performance targets set. For each objective, the combination of the core measure and the subordinate "driver" measures will make up a dashboard which will be used in performance reviews.

Development of the dashboards is underway; we are in the process of setting targets for each measure. To complete this work, we must develop and test standard algorithms and gather baseline data. In the interim, we are using available measures to set targets for interim goals and accelerate the process of achieving documented performance improvement. As noted above, we have already set five-year goals for cost savings in all shared services and all eMSMs.

In addition, we have supplied additional information regarding the objectives as outlined in our second report on section 731, dated June 30, 2013.

Objective 2: Deliver more comprehensive primary care and integrated health services using advanced patient-centered medical homes (PCMHs).

As noted in the June report, we began implementation of PCMHs across the MHS in a Service-specific manner three years ago. We agreed to adopt National Committee for Quality Assurance (NCQA) standards and have achieved level two or three NCQA recognition in 181 of our 435 PCMH clinics; we are on track to attain the highest level of NCQA recognition at 100 percent of our primary care sites by the end of CY15. As noted in our earlier report, we have documented improvement in measures of emergency room utilization, access, satisfaction, and quality at our more mature PCMH locations and we expect to see those results spread across the MHS. All of these measures reflect the achievement of our ultimate goal of providing more comprehensive primary care services, enabling us to shift some management of chronic illness into primary care, thereby reducing utilization of high cost inpatient and specialty services. Our core measure for this objective will monitor the shift to primary care, and the driver measures will allow us to identify how this has been accomplished so that we can focus improvement efforts where they will make the most impact.

Core Measure: Percent of total health care delivered in primary care. At this time, approximately one third of non-institutional healthcare services are delivered via primary care. By December 2013, we will set a three-year goal to increase the proportion of care done in PCMHs.

Driver Measures: The chart below shows the current set of driver measures for objective two along with current and target performance, where established.

Table 2: Driver Measures for Objective 2

No.	Measure Name	Date to Define Measure and Baseline (Status)	Current Performance	Target Performance
1	Healthcare Effectiveness Data and Information Set (HEDIS) Preventive Measures (Breast Cancer Screen, Cervical Cancer Screen, Colorectal Cancer Screen, Well-Child Visits), Direct Care Enrollees	--	Between 50th and 75th Percentile	90th Percentile (by end of FY15)
2	HEDIS Measures of Adherence to Evidence Based Guidelines for Chronic Illness (Cardiovascular, Diabetic & Mental Health Care), Direct Care Enrollees	--	Between 25th and 50th Percentile	90th Percentile (by FY15)
3	Satisfaction with Getting Timely Care	--	76%	83% (by end of FY14)
4	Satisfaction with Provider Communications	--	TBD	TBD
5	Satisfaction with Healthcare	--	62%	64% (by end of FY14)
6	Primary Care Staff Satisfaction	--	62%	65% (by end of FY14)
7	Number of Practices Achieving Level 2/3 NCQA PCMH Recognition (Out of 435 Total)	--	60%	100% (by end of CY15)
8	% Use of Approved Clinical Practice Guidelines (e.g., low back pain, depression, metabolic syndrome)	Nov 2013	TBD	TBD
9	Third Available Acute	--	60%	75% (by end of FY16)
10	# Enrollees in Secure Messaging	Nov 2013	607,000 Registered	TBD
11	Bed Days Per Year Per 1,000 Enrollees (↓)	Nov 2013	TBD	TBD
12	Emergency Room Visits Per 100 Enrollees Per Year (↓)	--	45	26 (by end of FY16)
13	Percent of Time Enrollees Sees Primary Care Manager	--	60%	70% (by end of FY16)
14	% of Total MTF Enrollee Primary Care RVUs Delivered by OTHER than the PCMH (↓)	--	23%	20% (by end FY16)
15	Annual Percent Increase in Per Member Per Month (PMPM) Healthcare Costs	Nov 2013	4.5%	TBD*

(↓) denotes that lower is better.
*This target is reset annually based on the average civilian sector premium increase.

Additional information promised in the second report to Congressional Defense Committees: None.

Objective 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.

In our June report, we described the need to coordinate care beyond the walls of our PCMHs, and we have begun to use the term "medical neighborhood" to describe the structure for managing patients with chronic illness or those with complex medical and social problems. The NCQA has recently developed a set of standards for Patient Centered Specialty Practices (PCSP) similar to the standards for PCMH implementation.[19] The standards specify requirements to:

- Enhance coordination between primary care and specialty care.
- Strengthen relationships between primary care clinicians and clinicians outside the primary care specialties.
- Improve the experience of patients accessing specialty care.
- Align requirements with processes demonstrated to improve quality and eliminate waste.
- Have practices use clinical performance measurement and results to demonstrate improvement.
- Identify requirements appropriate for various specialty practices seeking recognition for excellent care integration with the medical home.
- Align with the Centers for Medicare & Medicaid Services proposed Measures of Meaningful Use.

Our implementation of "medical neighborhoods" will focus on those conditions where there is the greatest need for coordination and improvement such as behavioral health, cardiovascular care, musculoskeletal injuries and management of diabetes. We will also focus on coordinating the care for all wounded warriors, especially those in the disability evaluation system. This approach has already had a profound impact on value in other integrated health systems. For instance, compared with regional averages, patients at Virginia Mason's multidisciplinary Spine Clinic miss fewer days of work (4.3 vs. 9 per episode), and need fewer physical therapy visits (4.4 vs. 8.8). The clinic has also reduced utilization of MRI scans by 23%. This approach has resulted in better outcomes at lower cost.[20] The MHS is already achieving improved results in coordinated care for wounded warriors and through the efforts of the Defense Centers of Excellence; this objective will build on that foundation to accelerate the implementation of proven practices across the enterprise.

The ultimate goal of having a coordinated medical neighborhood is to achieve better outcomes for chronic and complex illness; the core measure for this objective will be a composite measure of healthcare outcomes. We are working now to develop standard measures and standard data capture beginning with behavioral health so that we can establish baselines and targets.

Core Measure(s):

- Functional outcomes for patients with chronic illness.
- Functional outcomes for patients with complex medical and social problems.
- Cost per patient per year for those with specified chronic illnesses.

[19] Standards and Guidelines for PCSP Recognition, National Committee on Quality Assurance, Item # 30023-321-13, July 29, 2013.

[20] "The Strategy that Will Fix Health Care", Michael Porter and Thomas Lee, Harvard Business Review, October 2013.

All three of these measures are in active development. By March 2014, we will have established baseline data for cost measures and at least two functional outcomes measures for high frequency chronic illnesses.

Table 3: Driver Measures for Objective 3

No.	Measure Name	Date to Define Measure and Baseline (Status)	Current Performance	Target Performance
1	HEDIS chronic illness measures for diabetes, cardiovascular disease, and mental illness	--	Between 50th and 75th Percentile	90th Percentile (by end of FY15)
2	Per capita cost for management of selected chronic illnesses (diabetes, asthma, depression, PTSD)	Baseline data available March 2014	-	-
3	Bed days per year per 1,000 enrollees, stratified by identified chronic illnesses	Data source identified, Baseline data March 2014	-	-
4	Emergency room visits per year per 100 enrollees, stratified by identified chronic illnesses	Data source identified, Baseline data March 2014	-	-
5	Percentage usage of standard forms for treatment of lower back pain, depression, and metabolic syndrome	Forms use now being monitored, baseline use established, target set by December 2013	-	-
6	Number defined clinical care pathways	24 Clinical Practice Guidelines (CPGs) established, 18 incorporated in standard forms, 15 additional in development, target will be established December 2013	-	-
7	Readmission rate following hospitalization where chronic illness is the primary diagnosis for both initial and readmission hospitalizations	Data source identified, measure created, baseline data March 2014	-	-

Additional information promised in our second report in June, 2013:

- Status of our progress on reengineering those clinical and business systems necessary to achieve this objective:
  - As noted in the description of Objective 5 (below), we will begin implementation of an analytics shared service within the Health Care Operations Directorate of the DHA tasked with developing the measures and dashboards required to track the success of this objective.
  - At the September 2013 MHS Strategic Planning offsite, the ASD(HA) tasked a group to develop a plan for implementation of this objective and associated initiatives including the "Medical Neighborhood". The team will deliver an initial report to the MDAG by November 15, 2013.

- Details on the measures of effectiveness we will use to monitor outcomes for the initial set of clinical conditions:
    - The set of clinical outcomes measures for behavioral health has been established and will be implemented in 2014. We will use the Patient Health Questionnaire (PHQ-9) for depression, the PTSD Checklist for PTSD, the AUDIT-C for alcohol abuse and the Generalized Anxiety Disorder – 7 (GAD-7) for GAD.
    - Measures for low back pain, metabolic syndrome, and 17 other clinical conditions have been incorporated in tri-Service Workflow Forms now in use across the MHS.
    - Additional measures of effectiveness are being created for the 15 CPGs now in development.

- Timeline for the implementation and monitoring of care pathways for the five conditions listed above (in our second report) and measures for monitoring our care coordination success, as well as a description of our continuous process improvement methods:

    - The timeline for implementation of care pathways for depression, diabetes, cardiovascular disease, and hypertension will be part of the report on Objective 3 implementation due November 15, 2013 to the MDAG.
    - The MHS, along with the entire Department of Defense, has adopted Lean Six Sigma as the tool set for Continuous Process Improvement.

Objective 4: Match personnel, infrastructure, and funding to current missions, future missions, and population demand.

This objective aims to align the MHS more closely with mission demands by readjusting the global distribution of personnel as well as the capacity and capability of fixed facilities. Once complete, we will have matched capability to mission requirements within each market and for the enterprise as a whole, and we will have repositioned personnel to work in facilities where there exists sufficient demand for health services so that both the personnel and the facilities will be operating at a high level of efficiency.

Core Measure(s):

- Percent fill of validated operational readiness personnel requirements. By October 2015, we will complete a full medical readiness review, an analysis that will establish our wartime medical personnel requirements aligned to the National Security Strategy. Based on this, our target is to fill 100 percent of these requirements by 2017.
- Percent of critical wartime specialists meeting targets for productivity. We will set targets for provider productivity by specialty by 3rd quarter FY14; our overall target is for 100 percent of providers to meet productivity targets by the end of CY15.
- Percent utilization of staffed inpatient beds. Our target for this measure is 60% by 2015.

Driver Measures:

1. Milestones for completing the modernization study and its implementation:
    a. By October 2013, complete Modernization study.

b. By December 2013, identify Service recommended changes to capability and capacity of military treatment facilities, considering Line Service mission changes, for inclusion into the FY15 President's Budget Submissions.
c. From FY15 through FY19, the Services will implement changes to capability and capacity as identified in the FY15 President's Budget submission.
d. From FY15 through FY19, the Services will develop and execute proposals to align personnel resources within MTFs and markets, and to determine the appropriate force mix to ensure mission and readiness requirements are met, maximize clinical experiences, and increase market share and recapture for implementation.
e. By October 2015, complete update to medical readiness review of wartime personnel requirements.

2. Measures of the effect of the modernization study and its implementation:
    a. Percent of providers meeting productivity standards by specialty.
    b. Percent fill of wartime requirements by specialty.
    c. Average daily patient load for major hospitals by specialty.
    d. Market share of specialty ambulatory care by specialty.
    e. Market share of inpatient care by specialty.
    f. Purchased care costs by market.
    g. PMPM costs by market.
    h. Change in size of inpatient facilities (square feet).
    i. Number of total personnel in each market (military, civilian and contractor).

Additional information promised in the second report to Congressional Defense Committees: None.

Objective 5: Establish more inter-Service standards / metrics, and standardize processes to promote learning and continuous improvement.

Objective 5 creates the foundational infrastructure so that the MHS will be a learning organization that employs both evidence-based medicine and evidence-based management. In the past, improvement efforts have been hampered by the inability to compare performance and the inability to disseminate proven practices. To correct this, we will proceed in a stepwise manner, focusing first on standardizing the most important strategic measures and then defining and documenting core business processes. In addition, we will implement a consistent MHS approach for enterprise improvement so that we can have a common language to use in educating our workforce to excel in the science of improvement. The DHA will serve as the hub of activity, coordinating standardization efforts and providing support for education and execution. To achieve success, we are implementing an analytics shared service within the DHA and we are improving the support structure for performance improvement activities. Our driver measures for this objective track the establishment of the improvement infrastructure, the accomplishment of standardization and the achievement of performance gains. Since this objective enables improvement gains that will result from optimized business and clinical processes, the core measure of success will be the number of proven practices documented in an enterprise library and used as the basis of best practice dissemination. Another, indirect measure

of success will be the achievement of targets specified in both the shared service business process reengineering plans and the enhanced MSM business performance plans.

Core Measure: Number of proven practices identified and verified. Note: We have implemented a "Council of Cost Analysis and Program Evaluation (CAPE) functions" from the DHA and the Services (Council of CAPEs) to conduct internal reviews of BCAs and business process improvement results. This group will "certify" that a process improvement effort has been appropriately documented and has resulted in a "proven practice".

Driver Measures:

1. Milestones for completing the implementation of learning organization infrastructure within the DHA and across the MHS:
    a. By November 2013, deploy initial set of standard measures for eMSMs.
    b. By November 2013, deploy MHS enterprise dashboard with initial set of standard measures.
    c. By January 2014, deploy seven objective dashboards with initial set of core and driver measures.
    d. By January 2014, approve implementation plan for MHS Analytics as a shared service.
    e. By March 2014, agree on single approach and brand for MHS performance improvement.
    f. By June 2014, approve implementation plan for performance improvement support infrastructure.
    g. By June 2014, implement standard performance improvement training for MTF and shared service leadership teams.
    h. By June 2014 establish repository of standard measures, standard processes, evidence-based practices and CPGs.

2. Measures of the effect of the clinical and business standardization:
    a. Number of standard business rules approved and implemented across the MHS.
    b. Number of standard measures developed and deployed for use in the eMSMs.
    c. Number of standard clinical and business processes (documented).
    d. Number of validated improvements (as determined by Council of CAPEs).
    e. Number of best practices identified and disseminated as part of the business performance plan review process.

Additional information promised in our second report:

- More details on organizational structure of the "joint analytics cell" in DHA:
    - In August 2013, the MDAG approved the concept for a shared Analytics cell under Health Care Operations in the DHA. The core functions of the cell will include:

        - Establishment of functional requirements for information systems that will support measurement and improvement activities.
        - Development of a comprehensive array of performance standards and metrics including management dashboards at all levels of the organization.
        - Support for performance monitoring and analysis.
        - Development of new measures.
        - Performance of ad-hoc analyses and studies.
    - The MDAG directed that a detailed implementation plan for Analytics as a shared service be completed no later than 90 days after the appointment of the DHA Director of Health Care Operations.
- Infrastructure reductions due to this effort:
    - At this time, estimates of infrastructure changes are not possible as the development of requirements for support of analytics and performance improvement is not complete.

Objective 6: Create enhanced value in military medical markets using an integrated approach specified in five-year business performance plans.

As explained in our second report, one of the primary reasons for the establishment of the DHA is to provide support for operations in hospitals and clinics through the provision of shared services. The DHA also supports the MTFs by providing guidance in the development of, as well as oversight for, the five-year business performance plans. When successful in all of these activities, the value produced by the MTFs and clinics will increase, particularly in the larger multi-Service markets where improved integration can result in more efficient and effective operations. Our ultimate goal is to increase the value produced in each of the major markets by increasing readiness, improving the health of the population, improving healthcare outcomes and reducing costs. The immediate focus, however, is to reduce our reliance on purchased care and achieve real cost savings by increasing the productivity of our hospitals and clinics. Bringing more care into our facilities will enhance readiness by ensuring that our health care teams remain highly productive and maintain their clinical skills. Therefore, our core measure is focused on cost reduction while our driver measures reflect all of the elements of our value equation.

Core Measure: Reduction in purchased care expenses and reduction in the rate of increase in per member (enrollee) per month expenses.

Driver Measures:

1. Readiness
    a. Individual medical readiness (IMR).
    b. Provider productivity – wRVU/Provider.
2. Health
    a. Functional Health Status.
    b. Health risks [smoking rate, % obese (BMI>30), activity level].
    c. Illness burden.
    d. HEDIS Preventive Measures (cancer screening, well child visits).
3. Care
    a. Outcome measures by specialty (behavioral health, cardiovascular disease, etc.).

b. Rate of preventable injury (preventable infections, birth injuries, falls, etc.).
c. Access to care (third available acute appointment, satisfaction with access).
d. Efficiency (occupancy rate, OR utilization rate, unfilled appointment rate).
e. Disease management (HEDIS measures for cardiovascular disease, diabetes and mental health).
f. Patient centeredness (PCM continuity, satisfaction with care).

4. Cost
   a. Market share (inpatient/outpatient).
   b. ER utilization rate.
   c. Healthcare utilization rate (RVU/1000 enrollees, bed days/1000 enrollees).
   d. Pharmacy cost (% retail pharmacy and % home delivery).

Additional information promised in the second report to Congressional Defense Committees: In the second report we committed to a summary of the performance improvement initiatives and quantitative performance improvement targets in the five-year business performance plans for all six eMSMs. The total estimated savings across the markets is $1,019 M with total investment costs of $75 M over the five-year planning horizon as shown in Table 4.

Table 4: Cost Savings and Investments for 5-Year eMSM Plans

eMSM	Initiative	5-Year Savings Potential	Investment Required
NCR	Outpatient Recapture	$165.00	$0.00
	Inpatient Recapture	$106.00	$0.00
	ED/UC Reduction	$20.00	$0.00
	OR Recapture	$37.00	$0.00
	TOTAL ($M)	**$328.00**	**$0.00**
San Antonio	SAMMC ED Transfer Cell	$112.00	$0.00
	Enrollment Recapture	$47.40	$2.80
	Pharmacy Recapture	$43.90	$0.00
	Behavioral Health Recapture	$30.50	$0.00
	Orthopedics Recapture	$4.00	$0.00
	TOTAL ($M)	**$237.80**	**$2.80**
Tidewater	Reducing ED Utilization	$23.80	$0.00
	Primary Care and Enrollment Optimization	$37.60	$0.00
	Referral Management/Specialty Care Optimization	$65.50	$0.12
	Pharmacy Optimization	$96.10	$13.60
	Inpatient Recapture	$14.40	$3.70
	TOTAL ($M)	**$237.40**	**$17.42**
Colorado Springs	Expand Inpatient Capability	$10.80	$2.70
	Expand OR Capacity	$24.30	$9.90
	Radiology Optimization	$4.80	$0.90
	Physical Therapy Expansion	$7.00	$1.50
	Management of High Utilizers	$43.10	$0.00
	Retail Pharmacy Recapture	$18.00	$2.70
	TOTAL ($M)	**$108.00**	**$17.70**

eMSM	Initiative	5-Year Savings Potential	Investment Required
Puget Sound	Active Duty Residential Treatment Facility (RTF)	$23.10	$17.80
	Network to MTF Inpatient Transfer	$18.30	$0.46
	Specialty Care Recapture	$14.10	$3.90
	Optimize Appointing Process/Increase Outpatient Capacity-Recapture	$14.00	$0.00
	Ancillary Services Recapture	$25.90	$13.70
	TOTAL ($M)	**$95.40**	**$35.86**
Hawaii	Electroconvulsive Therapy (ECT)	$1.40	$0.28
	Army PT Staffing (Return to Baseline)	$2.50	$0.00
	Air Force PT Staffing Model	$1.00	$1.00
	PT Position Review for GS11-GS12 (Stabilization)	$0.30	$0.11
	DoD Urgent Care Center	$7.50	$0.25
	TOTAL ($M)	**$12.70**	**$1.64**
ALL eMSMs	**GRANT TOTAL ($M)**	**$1,019.30**	**$75.42**

In the second report, we were also asked to describe the methods we will use to monitor performance for the eMSMs. A description of this can be found earlier in this report.

Objective 7: Align incentives with health and readiness outcomes to reward value creation.

This objective is foundational and required to achieve alignment of effort across the MHS. As noted in the June report, our current internal eMSM funding process primarily rewards the production of health services, not value creation.

The Service Medical Departments and TMA have experimented with modifications to reward outcomes and value creation, but we have not implemented a consistent set of incentives that truly reflect our Quadruple Aim value equation, and we have not agreed on a single approach that could be applied across all three Services. Thus, the first step in this objective is to agree on a set of measures, and implement them universally. In addition, we will need to communicate with our staff and educate them so they can understand both the mechanics of the new reward system and the strategic rationale for each of the measures. Once we have aligned incentives with the Quadruple Aim and provided sufficient training, our team will align their daily activities and generate increased measurable value for the MHS. We will track our success in meeting milestones for implementing the incentives, communicating the changes, and educating our people regarding the new eMSM funding program. The true measure of success, however, will be improved outcomes in health and readiness at lower cost.

Core Measure: Increased value in health and readiness outcomes demonstrated by improvement on the MHS enterprise dashboard core measures.

Driver Measures:

1. Milestones for implementing the new eMSM funding system:
    a. By October 2013, establish measures and rates for pay for value model.

b. By October 2013, begin shadow year for incentive plan for enhanced Multi-Service Markets (eMSMs).
c. By December 2013, begin conducting quarterly review of performance and virtual payment under pay for value model.
d. Develop and execute education plan for market and MTF leaders at all levels by March 31, 2014.
e. By October 2014, begin funding eMSMs according to pay for value model.

2. Measures of the effect of the new eMSM funding system:
    a. Improvement on specific measures of readiness, health, healthcare and cost associated with financial rewards. The final list of incentive measures will be specified by November 1, 2013.

Additional information promised in the second report to Congress: In the June report we promised to provide:

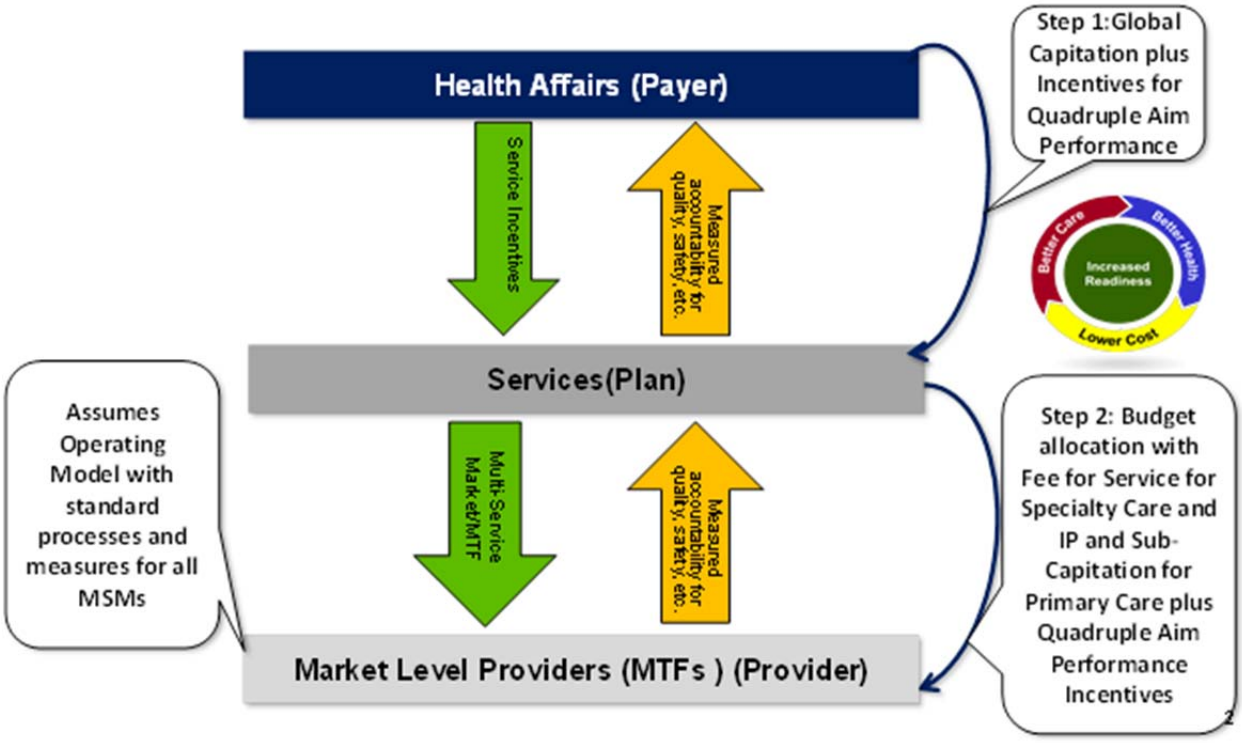
- Details associated with the FY14 test of this new eMSM funding system, along with plans for full implementation in FY15.
- Description of the reengineered process for providing internal funding so that we will have consistent financial incentives across the Service Medical Departments.

Specifics of the eMSM funding system: The chart below is a graphical depiction of the proposal for funds distribution from HA to the Services and then from the Services to the enhanced markets.

- The first layer shows the movement of funds from HA to the Services. By providing pre-payment to the Services for all care of enrollees, we are creating an incentive to optimize health and reduce unneeded tests, procedures and visits. By providing additional performance incentives for improved readiness, better health (health status), better care (satisfaction with plan) and lower costs (PMPM), we are supporting alignment with mission success.
- The second layer shows the proposed approach for financing the enhanced MSMs and includes the following features:
    - Fee-for-service for specialty care and inpatient: this approach will reward efforts to increase production and to focus on private sector care recapture.
    - Sub-capitation for primary care: this is intended to support the transition to the PCMH which has a reduced emphasis on visit-based care.
    - Performance incentives aligned with Quadruple Aim outcomes.

We have limited the number and complexity of incentive measures to focus on strategic priorities, but we have included measures that align with all four aspects of the Quadruple Aim. The final list of measures including financial rewards will be complete by November 1, 2013 so that we can “shadow” the eMSM funding program in FY14 and implement in FY15.

Figure 4: Overview of MHS Pay for Value Model (Aligning Reimbursement and Financial Incentives to Generate Value)



Clinical and Business Practices: We will reengineer the process of providing internal funding to the eMSMs so that we will have consistent financial incentives across markets. In FY14, we will "shadow" the performance of the eMSMs and calculate the level of funding they would have received. Based on what we learn, we will make adjustments to the program before going "live" in October 2014. During that time we will create a mechanism to allocate incentive funds directly to a multi-Service market so that the market can distribute those funds internally to optimize performance.

Attachment 1 – Proposed DHA Organizational Chart at IOC