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

PERSONNEL AND READINESS

OCT 29 2017

The Honorable Thad Cochran
Chairman
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The enclosed interim report is in response to section 703 of the National Defense Authorization Act for Fiscal Year 2017 (Public Law 114–328), "Military Medical Treatment Facilities." Section 703 requests the Department to submit an update to the Military Health System (MHS) Modernization Study, to address the restructuring or realignment of military treatment facilities.

Section 703 directs a comprehensive transformation of the MHS by including standardization of the way that we determine capabilities in our medical centers, hospitals, and ambulatory care centers. We are proceeding with two parallel efforts that we will address together in the final report to Congress: the development of capability criteria responsive to section 703(a) in the legislation and completion of the MHS Modernization Study update. Linking these efforts will provide both the facility capability framework as well as the scope of the implementation plan required in section 703(d). Progress is well underway, but the complexities of the analysis require additional time for data collection and model application, as well as receipt of results from work in progress.

This interim report describes the methodology for applying the facility-level criteria and for updating the MHS Modernization Study. The Department initiated efforts to enhance the MHS Modernization Study model and refresh the data for the model. In addition, the report discusses the progress to refine and apply the criteria for medical centers, and collect the data necessary to apply the criteria for hospitals and ambulatory care centers. We will provide our final report in January 2018.

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

Sincerely,

AM Kurta

A. M. Kurta
Performing the Duties of the Under Secretary of Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Patrick J. Leahy
Vice Chairman

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

PERSONNEL AND READINESS

OCT 2 [illegible] 2017

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

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A. M. Kurta
Performing the Duties of the Under Secretary of Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member

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

PERSONNEL AND READINESS

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

OCT 2 5 2017

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AM Kurta

A. M. Kurta
Performing the Duties of the Under Secretary of Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

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

PERSONNEL AND READINESS

OCT 29 2017

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

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A. M. Kurta
Performing the Duties of the Under Secretary of Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Nita M. Lowey
Ranking Member

Section 703 of the National Defense Authorization Act for Fiscal Year 2017, (Public Law 114-328) "Military Medical Treatment Facilities"

Interim Report

The estimated cost of this report or study for the Department of Defense is approximately $782,000.00 in Fiscal Year 2017. This includes $77,000 in expenses and $705,000 in Department of Defense labor.
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Introduction

This interim report provides the Department's progress on section 703 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2017 (Public Law (P.L.) 114-328), requesting the Secretary of Defense, in collaboration with the Secretaries of the Military Departments, to complete three primary lines of effort:

- Define a framework for applying criteria for medical centers, hospitals, and ambulatory care centers (ACCs) specified in 10 U.S.C. § 1073d.
- Update the Military Health System (MHS) Modernization Study no later than 270 days after enactment.[1]
- Provide an implementation plan to identify future facility designations and describe planned changes to facility capability sets.

The Department is using this effort to implement a more readiness-focused approach to military medical treatment facility (MTF) capabilities. Much progress has been made but, given the broad scope of the effort, additional time for careful consideration and analysis is necessary to complete the requirements of section 703 (c), "Update of Study." The Department continues to collect and validate data required for updating its MHS Modernization Study models. In addition, the completion of the section 703(c) update requires inputs from other sections of the NDAA for FY 2017, including but not limited to, sections 706, 708, 717, 721, 725, and 749. The Department anticipates providing the updated MHS Modernization Study, specified in section 703(c), in January 2018.

The following seven operating principles inform the effort:[2]

1. Readiness is the primary mission. The Department will ensure a ready medical force and a medically ready force.
2. The Services are ultimately responsible for this readiness and will be supported by the Defense Health Agency (DHA).
3. DHA is responsible for the health benefit and is supported by the Services, which will use this as a means to enable and sustain readiness.
4. The Direct Care System will be the first choice to meet the readiness requirements.
5. DHA creates healthcare direction, policies, and procedures for the Direct Care System.
6. DHA is the single source budgeting authority for the Direct Care System.
7. All Active Duty medical personnel are tied to operational force requirements.

Methodology

In December 2016, the Department established a senior-level workgroup comprised of Service and DHA representatives, chaired by the Deputy Assistant Secretary of Defense for Health Readiness Policy and Oversight, to conduct the update of the MHS Modernization Study. This

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[1] The Department submitted the MHS Modernization Study Team Report to Congress in May 2015 in response to section 713 of the Carl Levin and Howard P. 'Buck' McKeon NDAA of FY 2015 (P.L. 113-291)

[2] The Senior Military Medical Advisory Committee developed the seven operating principles to inform the Department's efforts to address NDAA FY 2017.

workgroup has met weekly to develop the methodology for applying the facility-level criteria provided in P.L.114-328 and updating the MHS Modernization Study. In order to establish a transparent, comprehensive, data-driven approach, the workgroup engaged the DHA and Services' analytical communities with contract support to build the analytics infrastructure. Throughout this process, the workgroup coordinated with other teams tasked with addressing interrelated sections of P.L. 114-328, including sections 706, 708, 717, 721, 725, and 749.

The workgroup carefully considered multiple methodologies for applying the legislative requirements of section 703(a). Each potential methodology was reviewed for accuracy as well as validity, and adjusted as needed by the analytical communities of the Services and the DHA before the workgroup recommended the outline below. The workgroup engaged the DHA TRICARE Regional Offices (TROs) to assess the ability of the purchased care network to accommodate healthcare workload currently performed in MHS hospitals and ACCs. In partnership with the TROs and the analytical communities, the workgroup defined the initial business rules and approach for the hospital and ACC assessments. The workgroup will integrate the analysis of network capability and capacity into the final hospital and ACC decision frameworks.[3]

At the direction of the workgroup, the DHA began refreshing the data and enhancing the MHS Modernization Study model. This included developing and validating a model that reflects a clinical-readiness focus absent from the original MHS Modernization Study approach. All model methodologies and results are under review by the Services' analytical communities for accuracy and validity.[4]

In order to define the analytical scope, the Department limits the analysis to the following:

- MTFs in the 50 United States[5]
- MTF clinical functions, excluding:
  - Base support functions[6] (examples include: occupational and environmental health, food protection, aerospace medicine, and animal medicine)
  - Dental care
- Demand needed to support the uniformed medical force
- Patient workload available to the MTFs, including the Department of Veterans Affairs (VA) and civilians[7]
- Authorized medical force structure[8]
- Graduate Medical Education (GME) and Graduate Dental Education (GDE) requirements[9]

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[3] As was done previously, any decisions include a detailed assessment of market conditions.
[4] The updated MHS Modernization Study will include a refresh to the MHS Modernization Study Team Report (Part II of the MHS response to section 713(c) of P.L. 113-291, dated May 29, 2017)
[5] Per section 725(c) of P.L. 114-328
[6] Second interim report to Congress on section 1073c, Title 10, USC
[7] Including inputs from section 717 of P.L. 114-328.
[8] This will be different from the personnel requirements outlined in the report responding to section 721 of P.L. 114-328.
[9] From the workgroup tasked with addressing section 749 of P.L. 114-328.

Discussion of Progress

Level of effort (LOE) #1: Develop Framework to Apply Section 703 Facility Criteria

The Department made substantive progress in refining and applying the criteria for medical centers, and is collecting the data necessary to apply the criteria for hospitals and ACCs.

Application of Medical Center Criteria

The following provides an overview of the application of medical center criteria to current state inpatient MTFs[10]:

- Population: The Department uses two concepts to define populations centered on a MTF. A 40-mile-radius catchment area, centered on an inpatient facility, defines its beneficiary population. A 20-mile-radius Provider Requirement Integrated Specialty Model (PRISM) area, centered on an outpatient-only facility, defines its beneficiary population. In cases where the PRISM of an outpatient-only clinic overlaps with an inpatient MTF catchment area, the beneficiary populations are consolidated into a single healthcare market with the outpatient-only facilities serving as referral sources for the inpatient facilities.
- Referrals: Referrals include all specialty workload within an MTF performed on anyone not enrolled to that MTF. Internal referrals to specialty care on beneficiaries enrolled to the MTF are included.
- Trauma Capabilities: For the purposes of the section 703 analysis, the Department defines a Combat Casualty Care Team (CCCT) as including the following specialties: anesthesiology, critical care/trauma medicine, emergency medicine, general surgery, and orthopedic surgery. For the purpose of this assessment, an MTF is considered to have trauma capabilities if that MTF performed sufficient direct care workload in the five CCCT specialties.[11]
- Tertiary Care: In the MHS, tertiary care is often associated with addressing the complex, specialized needs of trauma patients beyond the core trauma specialties of the CCCT. Therefore, an MTF is considered to have tertiary care capabilities if that MTF performed sufficient direct care workload in the 20 specialties required by the American College of Surgeons (ACS) at Level I or Level II trauma centers, in excess of CCCT.[12]
- GME Programs: Medical centers serve as a key training platform for uniformed providers. Our approach includes both graduate medical and dental programs.

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[10] Current state is based on FY 2016 data from the MHS Management and Analysis Reporting Tool (M2).

[11] Until a readiness metric is available, sufficient workload is defined as having performed sufficient work Relative Value Units (wRVUs) in direct care facilities to support 80% of a provider in that specialty. A single provider's workload is defined as 40 percent of the FY 2012 Medical Group Management Association median wRVU by specialty. The wRVUs are standard factors defined by Centers for Medicare and Medicaid Services and provide a relative measure of the level of professional time, skill, training, and intensity to provide a given clinical service. This workload is not limited to only beneficiary care. The workgroup notes that this does not directly translate into an ACS-certified or state-designated trauma center.

[12] Tertiary Care Specialties: cardiology, gastroenterology, infectious disease, internal medicine, nephrology, obstetrics/gynecology, ophthalmology, otorhinolaryngology, pulmonary disease, radiology, urology, cardiac/thoracic surgery, neurological surgery, plastic surgery, vascular surgery, physical/rehabilitation medicine, audiology and speech, physical/occupational therapy, dietician, and social work. Adapted from the ACS' Committee on Trauma manual, "Resources for the Optimal Care of the Injured Patient 2014"

Therefore, a medical center market must support at least two resident GME or GDE programs.

After developing a quantitative approach to the medical center criteria, the Department evaluated the MHS's current inpatient markets using FY 2016 MTF performance and shown in Table 1. We are working to finalize the analysis of potential demand within each market to add to this historical performance.

Application of Hospital/ACC Criteria

The Department has made progress in developing hospital and ACC criteria, and has developed a standard framework for the analysis of the ability of the purchased care network to accommodate the workload of direct care hospitals and ACCs. The TROs are populating this network ability framework with an expected completion in fall 2017.

The Department is finalizing its approach to evaluate cost effectiveness and is including both internal and external analyses[13] to inform the cost-effectiveness approach. Once complete, the cost-effectiveness and availability-in-the-local-healthcare-market criteria will be integrated into a decision framework for applying the section 703 requirements, which will inform future hospital and ACC designation decisions. Medical capability will be retained as needed to support the assigned active duty force where necessary.

LOE #2: Update the MHS Modernization Study

In updating the MHS Modernization Study, the Department is developing alternatives that better describe the ability of the MHS to sustain clinical readiness. The use of provider productivity (an economic measure) has been effective in increasing MTF enrollment and utilization, but is an inadequate measure of clinical readiness. Expeditionary competency and currency is of the greatest importance to the Department. Provider productivity was chosen in the original MHS Modernization Study due to the lack of consensus on a measure of clinical readiness. In the update, the Department will implement a more readiness-focused analytic tool adapted from a clinical-community-driven assessment of the knowledge, skills, and abilities (KSAs) necessary to accomplish the expeditionary clinical mission. This product was initially developed by the general surgery community with the support of the ACS. It facilitates an assessment of surgical workload at the individual and higher levels against a defined set of KSAs related to expeditionary practice. This innovative approach promises to provide a more direct assessment of a market's ability to sustain clinical readiness.[14] The Department expanded this effort to include all specialties in the CCCT. As this is a long-term effort, the modernization update will be based on the results for the CCCT, and will present the plan for expanding the KSA approach to additional specialties within the MHS. A model that applies this KSA-based analysis construct is awaiting final development of specialty-related benchmarks. The Services and the DHA are working together to refine the KSA work via proof-of-concept projects in four locations. The data gained from these projects is expected to be completed in late fall 2017 and will serve to inform Service-developed implementation plans.

[13] Lurie, Philip M., "Comparing Costs of Military Treatment Facilities with Private Sector Care," Institute for Defense Analyses Paper NS P-5262, February 2016

[14] This is separate and distinct from the Services' KSA work for the purposes of managing force readiness and assignments.

The update to the Provider Demand Model (PDM) used in the original MHS Modernization Study is awaiting input on the number of uniformed medical specialists that need to be sustained. Other Provider Staffing models are under investigation by the Services to support readiness. The PDM will inform how much workload is available in a given market to sustain the Services' own clinical providers for those specialties where KSAs have not been developed. As such, the Services may utilize PDM data to inform their implementation plans.

LOE #3: Develop the Implementation Plan

Each Military Department will construct an implementation plan for the section 703(d) implementation report to Congress in January 2018. In overseeing force readiness, the Military Departments will identify future facility designations by applying the new facility decision framework, while balancing long-term readiness needs with the cost of delivering the health care benefit. The update to the MHS Modernization Study will inform, but not drive, these decisions. The implementation report will describe all facility realignments, elaborating on how capability sets will change and justifying all changes. The plan will identify any initiatives the Military Departments plan to implement to achieve the future state, potentially including military-civilian partnerships, DoD and VA partnerships, and regionalization of the direct care system. Any exceptions to the facility decision framework will be detailed in the implementation plan.

Conclusion

The key aim of the Department is to support the dual readiness mission of maintaining a ready medical force and a medically ready force. Through the responses to section 703, the Secretary continues progress towards enhancing the utility of MHS MTFs to support readiness.
Section 703 provides a strategic opportunity to reevaluate the MTF's balance between readiness and benefit missions.

During the course of the work to date, the Department has concluded the following:

- The Services will allocate uniformed personnel to meet readiness and MTF needs.
- Where healthcare demand is insufficient to meet benchmarks for the Department's uniformed specialty providers, partnerships with the VA or civilian organizations (as per P.L. 114-328 sections 706, 708, and 717) may be employed to support medical force clinical readiness.
- Given the complexities of allocating multi-Service market (MSM) healthcare demand to individual Service MTFs, the study update will be at the MHS level rather than the Service-specific level.
- MHS inpatient facilities serve as key readiness generating platforms. If a hospital is required to meet the medical force readiness mission, the MHS will continue to operate the hospital.

The Department will use these conclusions as key assumptions underlying the analysis in the final MHS Modernization update report.

Table 1: Markets Evaluated Against Medical Center Criteria[15]

Market Information	Medical Center Criteria				
MSM Market Name/MTF Name	Population	Referrals	Tertiary Care	Trauma Capabilities	GME/GDE Programs
	Beneficiaries in Catchment Area Plus	*Total Referral Encounters*	*ACS Trauma Specialties (out of 20)*	*CCCT Specialties (out of 5)*	*Number of Programs*
NATIONAL CAPITAL REGION	**500,830**	**728,859**	**19**	**5**	**68**
WALTER REED NATL MIL MED CNTR		*450,059*	*19*	*5*	*66*
FT BELVOIR COMMUNITY HOSP-FBCH		*278,800*	*15*	*3*	*2*
TIDEWATER	**470,033**	**527,416**	**20**	**5**	**18**
AF-H-633rd MED GRP LANG-EUSTIS		*71,009*	*13*	*5*	*1*
NMC PORTSMOUTH		*456,407*	*20*	*5*	*17*
SAN DIEGO	**411,045**	**651,492**	**19**	**5**	**28**
NH CAMP PENDLETON		*160,953*	*12*	*5*	*4*
NMC SAN DIEGO		*490,539*	*19*	*5*	*24*
PUGET SOUND	**308,659**	**356,858**	**19**	**5**	**26**
AMC MADIGAN-LEWIS		*295,752*	*19*	*5*	*26*
NH BREMERTON		*50,156*	*10*	*4*	*0*
SAN ANTONIO	**246,043**	**619,744**	**20**	**5**	**39**
AMC BAMC-FSH		*619,744*	*20*	*5*	*39*
FORT BRAGG	**203,859**	**354,072**	**15**	**5**	**6**
AMC WOMACK-BRAGG		*354,072*	*15*	*5*	*6*
HAWAII	**188,871**	**415,830**	**20**	**5**	**16**
AMC TRIPLER-SHAFTER		*415,830*	*20*	*5*	*16*
COLORADO SPRINGS	**177,998**	**186,790**	**14**	**5**	**1**
ACH EVANS-CARSON		*186,790*	*14*	*5*	*1*
NMC CAMP LEJEUNE	**173,000**	**197,779**	**13**	**5**	**3**
JACKSONVILLE	**164,360**	**128,713**	**13**	**5**	**1**
NH JACKSONVILLE		*128,713*	*13*	*5*	*1*
AMC DARNALL-HOOD	**159,237**	**313,845**	**13**	**5**	**5**
AMC WILLIAM BEAUMONT-BLISS	**119,628**	**300,076**	**18**	**5**	**5**
AF-MC-60th MED GRP-TRAVIS	**117,722**	**92,475**	**20**	**5**	**7**
ACH BLANCHFIELD-CAMPBELL	**109,401**	**186,141**	**12**	**4**	**1**
AF-H-96th MED GRP-EGLIN	**103,678**	**95,432**	**19**	**4**	**2**
ACH WINN-STEWART	**95,942**	**141,901**	**11**	**4**	**0**
AF-MC-99th MED GRP-NELLIS	**91,853**	**55,822**	**16**	**5**	**4**
ACH MARTIN-BENNING	**91,411**	**145,578**	**13**	**4**	**2**
AMC EISENHOWER-GORDON	**77,248**	**188,615**	**19**	**5**	**9**
NH PENSACOLA	**70,799**	**48,741**	**13**	**3**	**0**
AF-MC-88th MED GRP-WRIGHT-PAT	**69,103**	**61,082**	**18**	**5**	**7**
ANCHORAGE, AK	**56,373**	**68,907**	**13**	**4**	**0**
AF-H-673rd-ELMENDORF		*68,907*	*13*	*4*	*0*
ACH IRWIN-RILEY	**55,752**	**132,903**	**8**	**4**	**0**
MISSISSIPPI DELTA	**55,684**	**56,680**	**15**	**4**	**4**
AF-MC-81st MED GRP-KEESLER		*56,680*	*15*	*4*	*4*
AF-H-366th MED GRP-MT HOME	**46,466**	**3,911**	**6**	**1**	**0**
ACH LEONARD WOOD	**42,640**	**89,788**	**9**	**5**	**0**
NH TWENTYNINE PALMS	**39,406**	**32,829**	**6**	**5**	**0**
ACH KELLER-WEST POINT	**36,412**	**28,717**	**9**	**4**	**1**
ACH BAYNE-JONES-POLK	**30,195**	**56,327**	**7**	**4**	**0**
FAIRBANKS, AK	**28,959**	**48,698**	**8**	**5**	**0**
ACH BASSETT-WAINWRIGHT		*48,698*	*8*	*5*	*0*
ACH WEED-IRWIN	**14,753**	**14,379**	**5**	**3**	**0**

[15] VA-DoD partnership at James A Lowell HFCC was excluded. Evaluation within each market is based on FY 2016 performance of Inpatient MTFs and associated civilian-DoD external resource sharing agreements, not market potential, which will be evaluated in the MHS Modernization Study Update. Source: M2 for FY 2016.

Appendix A – Acronyms

ACC	Ambulatory Care Center
ACS	American College of Surgeons
CCCT	Combat Casualty Care Team
DHA	Defense Health Agency
FY	Fiscal Year
GDE	Graduate Dental Education
GME	Graduate Medical Education
KSAs	Knowledge, Skills, and Abilities
LOE	Level of effort
M2	MHS Management and Analysis Reporting Tool
MHS	Military Health System
MSM	Multi-Service Market
MTF	Military Medical Treatment Facility
NDAA	National Defense Authorization Act
P.L.	Public Law
PDM	Provider Demand Model
PRISM	Provider Requirement Integrated Specialty Model
TRO	Tricare Regional Office
VA	Department Of Veterans Affairs
wRVU	Work Relative Value Unit