

Military Health System Governance Statement of Intent

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

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

- Although the ability to control healthcare expenditures is an important element in evaluating possible changes to medical governance, it is only one of several, to include ease of implementation, the effect on the delivery of healthcare in garrison and the field, and ability to field trained and ready medical forces.
- The largest cost elements in healthcare are in the direct and civilian healthcare systems, not in areas such as administrative and management headquarters. Any change in governance must create an enhanced capability to better control these costs through the expansion of shared services and the adoption of common business and clinical processes to reduce variation and assure rapid adoption of knowledge and technology. Any change that results only in headquarters manpower reductions would not produce a significant impact on cost control.
- A large-scale change in governance could be disruptive and create unintended and unexpected consequences in an enterprise engaged in direct combat service support. Any changes to current medical governance, including governance for multi-Service markets or for shared medical services among the Military Departments (e.g., health information technology, training, and logistics) must be carefully considered for impact to the operational mission. An option for changes in medical governance selected for near-term implementation does not preclude possible further organizational realignment of the MHS in the future, informed by additional experience and insight.

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

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

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

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

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

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

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

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

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

3. **Create a National Capital Region Medical Directorate in the newly established DHA.**

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

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

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

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

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

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