

Additional Cost Analysis supporting the 2011 MHS Governance Task Force Report

This document provides additional analysis regarding estimated cost savings for 12 military health system (MHS) governance options contained in the 2011 Department of Defense (DoD) Military Health System (MHS) Governance Task Force report. This analysis was informed by, and extends, the methods used in the 2006 analysis performed by the Center for Naval Analyses (CNA) in support of the 2006 MHS Governance work group.¹

Goals:

- Provide a rough estimate of the cost savings, if any, to be achieved by 12 governance options considered by the 2011 DoD MHS Governance Task Force, based on estimated staffing sizes and associated personnel costs (see footnote) of those options
- Ensure that the sizing of the options resulted in organizations that could reasonably meet mission requirements

Assumptions:

- Current staffing can be used as a benchmark for staffing consolidated headquarters entities.
- External benchmarks can be used to validate the staffing of consolidated headquarters entities, paying close attention to mission and scope differences.
- The organizational constructs used by the Military Services could be adapted to cover a larger MHS-wide scope.
- Current MHS management headquarters are sized to accomplish individual missions through component-specific processes.
- The missions of the management headquarters are similar for each component, but the scope and processes are variable.

¹ It is important to note that this cost analysis uses estimated staffing sizes as its basis for estimating the costs and/or savings associated with each option. However, the largest cost elements in military healthcare are in the direct and civilian healthcare systems, not in administrative and management headquarters. The potential cost savings to be obtained through the consolidation and standardization of shared services and the adoption of common business and clinical processes to reduce variation and assure rapid adoption of knowledge and technology dwarf the savings to be achieved by any reductions in headquarters manpower. To generate estimates of the cost savings stemming from a governance structure that better promotes efficient management of the direct and civilian healthcare systems would be a time- and labor-intensive process, and would be inherently imprecise.

ENCLOSURE 4

Results:

Below are the estimated number of personnel for each of the options considered using the “most efficient” organization, the change in personnel from the current as-is structure, and an estimate of the additional cost or savings for each option. (In these estimates, the personnel savings from shared services are estimated to be 330, as opposed to 566 as contained in the Task Force report, because of a correction to the equation for the “economies of scale” estimate from the 2006 CNA analysis.) To develop these cost estimates, the average cost per civilian employee for the TRICARE Management Activity, with a grade structure that would most likely be similar to any of these organizations, was applied to the change in personnel. These results are point estimates and actual costs/savings will depend on the final implementation, both in terms of the change in the number of personnel and in the cost per employee. Therefore, these estimates should be used in a relative sense for comparing options rather than in an absolute sense to adjust budgets given the uncertainties in the estimates.

MHS Governance Options (ref: MHS Governance Task Force Technical Volume)	Personnel Estimate (FTEs) without Shared Services FTE Savings	Estimated Personnel (FTEs) with Shared Services FTE Savings	Additional (+)/ Reduced (-) Personnel (FTEs) from “As Is” (Option A)	Net Cost (+) or Net Savings (-) (\$M/year)
Option A: Current MHS Governance Structure	6136	---	---	---
Option B: Defense Health Agency, Geographical Model	6314	5,984	-152	-\$21.4
Option C: Defense Health Agency with Service MTFs	6136	5,806	-330	-\$46.5
Option D: Unified Medical Command, Geographical Model	7546	7,216	+1,080	+\$152.3
Option E: Unified Medical Command with Service Components	7910	7,580	+1,444	+\$203.6
Option F: Unified Medical Command - HR 1540 Section 711 Model	8160	7,830	+1,694	+\$238.8
Option G: Single Service, Geographic Model	5796	5,466	-670	-\$94.4
Option H: Single Service with Components	5796	5,466	-670	-\$94.4
Option I: Split UMC and Military-Led DHA Geographic Hybrid	8160	7,830	+1,694	+\$238.8
Option J: Unified Medical Command with components and DHA Hybrid	8064	7,734	+1,598	+\$225.3
Option K: Single Service Hybrid with a Unified Medical Command	8160	7,830	+1,694	+\$238.8
Option L: DHA Hybrid with MTFs placed under the Agency	5846	5,516	-620	-\$87.4

ENCLOSURE 4

Additional information about the approach to sizing and cost estimation used in the 2011 Task Force report and this supporting analysis is in Part 2 of Volume II of the Task Force's report.

Comparison of 2011 Task Force analysis to 2006 CNA analysis:

- The 2011 analysis was conducted over several months, while the 2006 CNA study took approximately 2 years, including data collection, validation, analysis, and coordination of results.
- The 2011 analysis addressed a larger and more diverse set of options (12) than the 2006 analysis (3) with a higher risk of proposing an organizational size that would not be able to meet mission needs.
- The 2011 analysis was benchmarked against DoD Service medical organizations; the 2006 study benchmarks included commercial, non-healthcare entities. As a result, the 2011 analysis provided both a range and a "most efficient" organizational construct based on real-world Service organizations.
- The 2011 analysis benchmarked the Unified Medical Command (UMC) sizing to active Combatant Commands and developed alternative approaches to UMC headquarters sizing based on current organizational structures and missions.
- The 2006 study used an average of the Service and TMA staffing for the various functions. The 2011 study did not use averages, but used values directly derived from the Services' medical departments' headquarters staffing.
- The 2006 study assumed that the Service Surgeons General would be absorbed into the UMC; the 2011 study kept the Service SGs separate.
- The 2011 study assessed sensitivity of the options by using the range of Service medical organizations as the inputs. The 2006 study used an additional 20% redundancy factor to assess sensitivities of the options.
- Both the 2011 and 2006 studies used an "economies of scale" approach to assess the savings for shared and common services.