

DEPARTMENT OF DEFENSE
TASK FORCE ON MILITARY HEALTH
SYSTEM GOVERNANCE



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Part 1. Development of Governance Options

Introduction

On June 14, 2011, the Deputy Secretary of Defense established an internal Task Force consisting of representatives from the Military Departments, the Joint Staff, and the Office of the Secretary of Defense (OSD) to conduct a review of the current governance of the Military Health System (MHS). The Task Force Terms of Reference (TOR) directed the team to evaluate options for the long-term governance of the MHS as a whole and the governance of multi-Service markets (MSMs), to include the National Capital Region (NCR). The team was also directed to provide a report within 90 days detailing the relative strengths, weaknesses, and barriers of each option evaluated, as well as recommendations for governance.

Outline

The purpose of this section is to provide:

- The methodology used to build and analyze governance structure options for the MHS, MSM, and NCR
- The voting methodology, MHS construct results, and voting results
- Discussion of the various methods employed by the Task Force and the final MHS, MSM, and NCR recommendations that were made in the full MHS Task Force report delivered to the Deputy Secretary of Defense on September 29, 2011

Methodology

For the MHS-wide analysis, the Task Force sought to understand the components that comprise the MHS and what specific attributes are required to run those components.

The Task Force began its inquiry with several over-arching briefings defining the current organizational structure, personnel requirements, and funding processes within the Office of the Secretary of Defense (Health Affairs), the TRICARE Management Activity, and within the individual Service Medical Departments. The Task Force received briefings from several MSM managers explaining what defines an MSM, what authorities are given to an MSM manager, and what additional MSM authorities would provide greater flexibility and opportunities for efficiencies within MSMs.

Following the review of MSMs, the Task Force evaluated the larger MHS governance options with the understanding that the MHS recommendations would drive recommendations for the MSMs, including the NCR.

To build the various MHS organizational constructs for analysis and consideration, the Task Force developed the Evaluation Framework (Figure 1) to help define and describe each construct option and the authorities prescribed to each, using the objectives and scope outlined in the TOR. Once the organizational construct options were developed, the Task Force identified the strengths, weaknesses, barriers, and mitigation strategies for each option. Each option was evaluated against the criteria established by the Task Force.

MSMs were separately addressed and evaluated, independent of the larger MHS Governance model. Although an MSM, the National Capital Region organizational options were also separately evaluated.

Please note that the tables reflecting TOR objectives, scope and strengths, weaknesses and barriers were constructed for initial Task Force review and analysis of each option. Expanded tables for the final options included in the Final Task Force Report were revised to reflect additional Task Force discussion and deliberations.



Figure 1. Evaluation Framework for MHS, MSM, and NCR Governance Options

MHS Governance Options Identified by the Task Force

- Option A: Current MHS Governance Structure
- Option B: Defense Health Agency, Geographic Model
- Option C: Defense Health Agency with Service Military Medical Treatment Facilities (MTFs)
- Option D: Unified Medical Command, Geographic Model
- Option E: Unified Medical Command with Service Components
- Option F: Unified Medical Command - HR 1540 Section 711 Model
- Option G: Single Service, Geographic Model – One Military Department Secretary Assigned Responsibility for the MHS
- Option H: Single Service with Components
- Option I: Split UMC and Military-Led DHA Geographic Hybrid Model
- Option J: UMC with Components and DHA Hybrid

- Option K: Single Service Hybrid with a Unified Medical Command
- Option L: Defense Health Agency Hybrid with MTFs placed under the Agency
- Option M: Defense Health Agency Hybrid with Regional MTFs

MHS Governance Option A: Current MHS Governance Structure

The Task Force reviewed the current governance structure of the MHS to lay a foundation for comparing options (Figure 2).

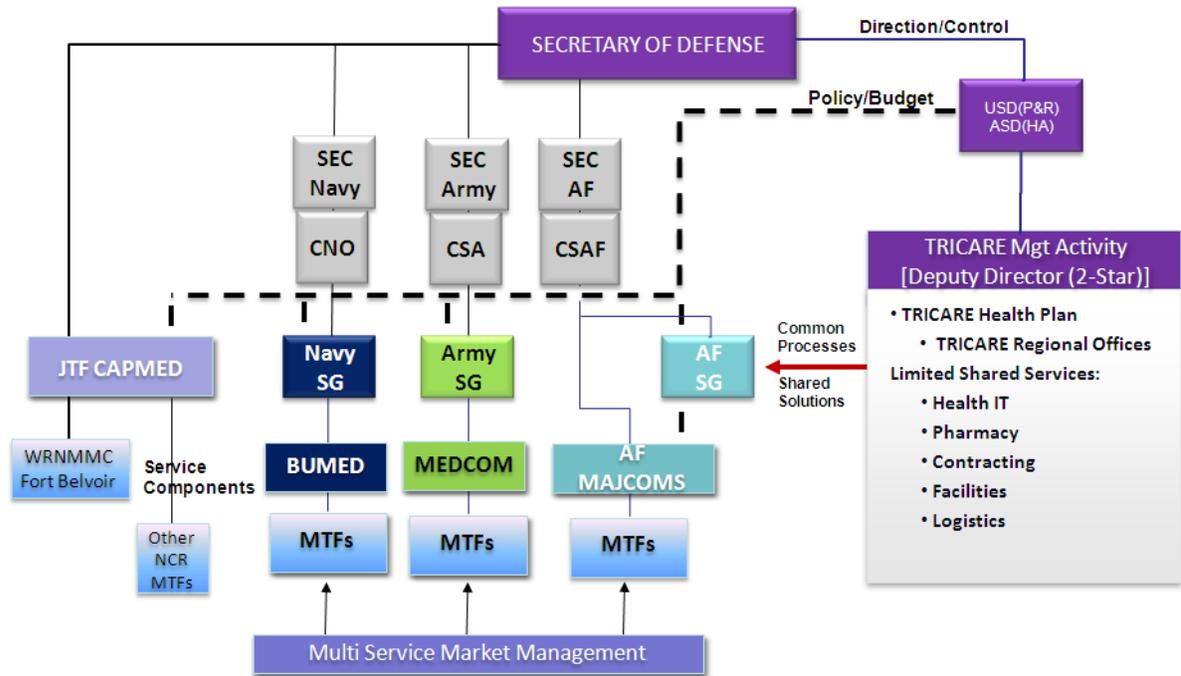


Figure 2. MHS Governance Option A: Current MHS Governance Structure

TOR Objectives and Scope of MHS Governance Option A: As Is - Current Structure

Item	TOR Objectives and Scope	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The ASD(HA) is responsible for all authority, direction, and control of policy and resources of the MHS as a whole, consistent with DoD Directive 5036.01.
2	Head of entity or entities, and the reporting chain to the Secretary of Defense.	Military Department reporting chains remain as they currently exist with Service Surgeons General reporting to their Service Chiefs who report to their Military Department Secretaries who report to the Secretary of Defense.
3	Management and supervisory chains of MTFs.	MTF commanders report through their established Military Department chains of command.
4	Management and supervisory chains of multi-Service markets.	Based on the selection for MSM governance (see Section, “multi-Service market Governance” further in this report).

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Item	TOR Objectives and Scope	Outcome
5	The authority, direction, and control for mission/administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities.	The authority, direction, and control over MHS personnel reside within the Military Departments.
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	The DHP is sustained, and authority over the DHP resides with the ASD(HA).
7	The policymaking authority among OSD, the Services, and/or joint entities.	The ASD(HA) establishes and directs policy. The Services execute policy.
8	Management of purchased care and other functions currently performed by the TRICARE Management Activity.	The TMA Director (currently dual-hatted by the ASD(HA)) manages purchased care and other TMA functions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education and training, and other shared services, related functions.	Shared services activities, including but not limited to this listing, are delivered through a collaborative process between the ASD(HA) and the Military Departments.
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	<p>The ASD(HA) exercises the responsibilities outlined in DoD Directive 5136.01, “Assistant Secretary of Defense for Health Affairs”, and as Director, TRICARE Management Activity.</p> <p>The Military Departments are responsible for management and oversight of their military medical personnel, medical readiness programs, and health care delivery within their respective medical treatment facilities. The Military Department Secretaries are responsible for assigning duties to their respective Surgeons General, organizing their medical forces, and executing policy. Would execute policies established by and under the direction of ASD(HA).</p>
11	Effect on the Guard and Reserve forces.	No effect on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 1. TOR Objectives and Scope of MHS Governance Option A: As Is - Current Structure

Strengths, Weaknesses, and Barriers of MHS Governance Option A: As Is - Current Structure

Strengths of As Is - Current Structure	
<ul style="list-style-type: none"> • Ease of Implementation: This organizational construct remains as it is, without any organizational upheaval. 	
Weaknesses of As Is - Current Structure	
<ul style="list-style-type: none"> • Lines of Authority: Does not establish undivided MHS authority, direction, and control over entire system. • Enhance Interoperability: This option fails to take advantage of consensus opportunities to more rapidly implement common clinical and business processes across the system. • Achieve Significant Cost Savings through Reduction in Duplication and Variation: Fails to introduce a broader set of shared services that can be delivered more efficiently to the end customer. 	
Barriers to As Is - Current Structure	Mitigation Strategies for As Is - Current Structure
<ul style="list-style-type: none"> • There are no barriers to implementation 	<ul style="list-style-type: none"> • None

Table 2. Strengths, Weaknesses, and Barriers of MHS Governance Option A: As Is - Current Structure

MHS Governance Option B: Defense Health Agency, Geographic Model

This option would establish a Defense Health Agency (DHA) to replace TMA focused on consolidating and delivering a far broader set of shared health care support services than exist today. MHS-wide shared services activities would include, but are not limited to: the TRICARE health plan; pharmacy programs; medical education and training; medical logistics; facility planning; health information technology; medical research and development; health information technology; facility planning; public health; acquisition; and other common clinical and business processes.

The DHA could be led by a 3-Star general or flag officer who would report to the Assistant Secretary of Defense (Health Affairs). The DHA could be designated as a Combat Support Agency (CSA) with periodic CJCS review of its combat support mission execution effectiveness. The MTFs would be transferred to the DHA and would operate under its authority, direction, and control. The Military Departments would continue to own all military personnel and be responsible for organizing, training, and equipping their deployable military medical forces. Personnel requirements of the Services’ operational forces needed for deployment and/or training would be requested through the DHA Director. MSMs and the NCR are addressed in this option as a part of the DHA. Service intermediate headquarters would be reduced to a single, DHA-run set of regional headquarters.

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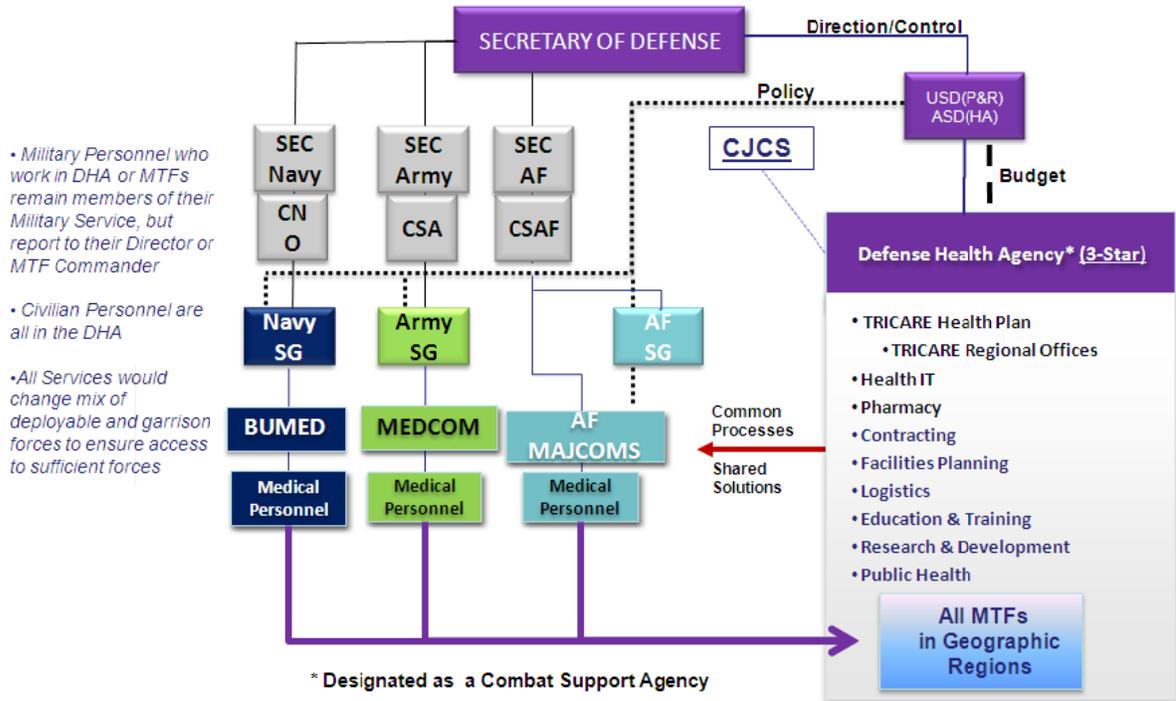


Figure 3. MHS Governance Option B: DHA, Geographic Model

TOR Objectives and Scope of MHS Governance Option B: DHA, Geographic Model

Item	TOR Objectives and Scope	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The Defense Health Agency would have control of the MHS.
2	Head of entity or entities, and the reporting chain to the Secretary of Defense.	The ASD(HA), USD (P&R) would report to the Secretary of Defense, or you could establish a USD(HA) to report to the Secretary of Defense. The 3-Star DHA Director would report to ASD(HA) or CJCS
3	Management and supervisory chains of MTFs.	MTF Directors would report to Regional Directors (or Components) who would report to the Defense Health Agency. The NCR could be a single market.
4	Management and supervisory chains of multi-Service markets.	All MSMs would have a single Director and report to the Director of Healthcare Operations.
5	The authority, direction, and control for mission/administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities.	The DHA would manage the peacetime medical mission and the designated Service chain of command would have administrative control. Deployed forces would be assigned to the receiving Service.
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	DHA, through ASD(HA), would be responsible for the planning, programming, budget and execution (PPBES) for facility and beneficiary healthcare delivery.
7	The policymaking authority among OSD, the Services, and/or joint entities.	OSD would have broad policy and guidance as well as execution and operational policy development and implementation. The Services would designate the readiness requirements.

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Item	TOR Objectives and Scope	Outcome
8	Management of purchased care and other functions currently performed by the TRICARE Management Activity.	The DHA would manage purchased care and other TMA functions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education and training, and other shared services, related functions.	This would be a single system based on the requirements of the DHA.
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	<p>The ASD(HA)/DHA would have policy and oversight, provide advice to the Secretary of Defense, and oversee beneficiary care.</p> <p>The Military Departments' Secretaries and Chiefs would provide the readiness requirements to the DHA.</p> <p>The Military Departments' Service Surgeon's General would advise the Service Chiefs on readiness issues.</p>
11	Effect on the Guard and Reserve forces.	No effect is anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 3. TOR Objectives and Scope of MHS Governance Option B: DHA, Geographic Model

Strengths, Weaknesses, and Barriers of MHS Governance Option B: DHA, Geographic Model

Strengths of a DHA, Geographic Model	
<ul style="list-style-type: none"> • Lines of Authority: This organizational construct would have clear lines of authority and there would be central control of the MTFs. • Enhance Interoperability: This option would allow for single processes for key functions. 	
Weaknesses of a DHA, Geographic Model	
<ul style="list-style-type: none"> • Dispute Resolution: Key issues would be elevated quickly to the highest levels. • Ease of Implementation: This option would be more of a "civilianized" model which may be difficult to implement in the current military structure. It may also reduce command leadership opportunities and professional growth. 	
Barriers to a DHA, Geographic Model	Mitigation Strategies for a DHA, Geographic Model
<ul style="list-style-type: none"> • Centralization of readiness support platforms under a civilian agency. • Some required Service assets not under Service control (e.g. Army Professional Fill Forces). • Split medical forces for garrison and deployments. 	<ul style="list-style-type: none"> • None.

Table 4. Strengths, Weaknesses, and Barriers of MHS Governance Option B: DHA, Geographic Model

MHS Governance Option C: Defense Health Agency with Service MTFs

This option would establish a Defense Health Agency to replace TMA focused on consolidating and delivering a far broader set of shared health care support services than exist today. MHS-wide shared services activities include, but are not limited to: the TRICARE health plan; pharmacy programs; medical education and training; medical logistics; facility planning; health information technology; medical research and development; health information technology; facility planning; public health; acquisition; and other common clinical and business processes.

The DHA could be led by a 3-Star general or flag officer who would report to the Assistant Secretary of Defense (Health Affairs). The DHA could be designated as a Combat Support Agency (CSA) with periodic CJCS review of its combat support mission execution effectiveness. MSMs and the NCR are not inherently addressed in this option.

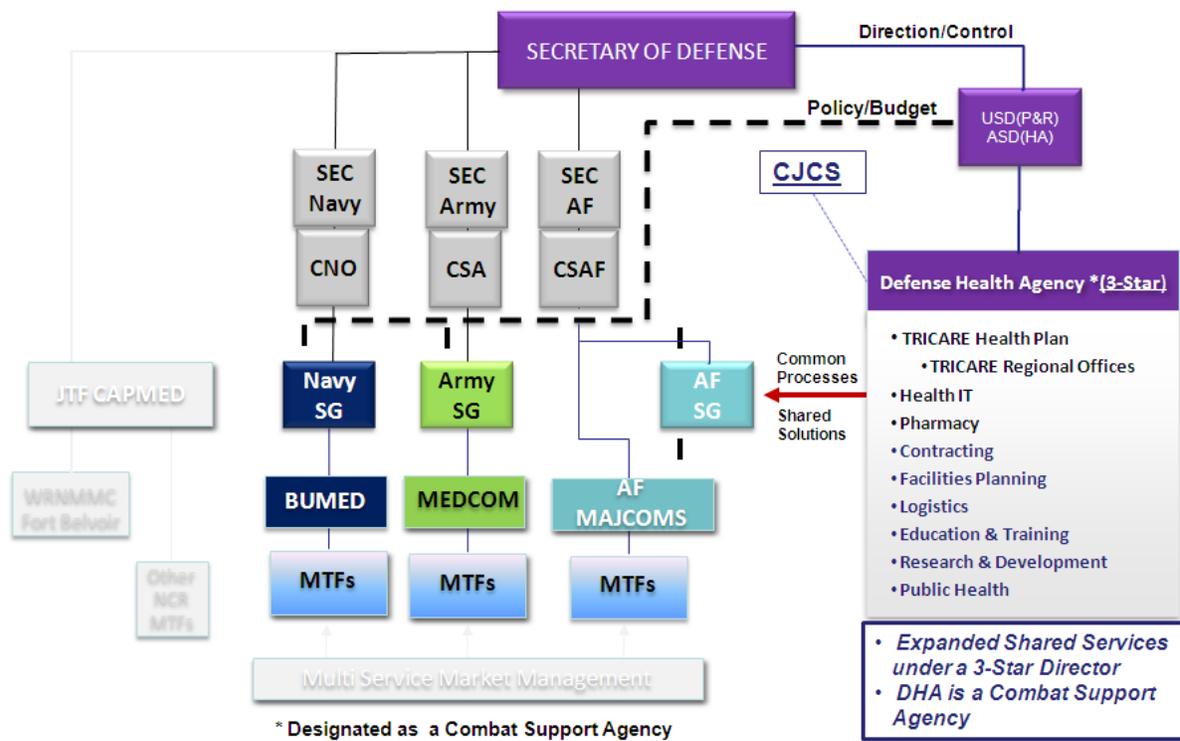


Figure 4. MHS Governance Option C: DHA with Service MTFs

TOR Objectives and Scope of MHS Governance Option C: DHA with Service MTFs

Item	TOR Objectives and Scope	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The Defense Health Agency would have authority, direction, and control for the shared and consolidated services. The Services would have authority, direction, and control for the MTFs and personnel.
2	Head of entity or entities, and the reporting chain to the Secretary of Defense.	The DHA would report through the ASD(HA) to the Secretary of Defense.
3	Management and supervisory chains of MTFs.	MTFs would be managed through the Service chain of command to the Service Secretary.
4	Management and supervisory chains of multi-Service Markets.	The MSMs would be assigned to a Service and report through the Service chain of command. JTF CAPMED would have to transition to this structure.
5	The authority, direction, and control for mission/administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities	The Services would operate the garrison and deployed health care system. The DHA would provide the shared and consolidated services.
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	OSD would be responsible for PPBES for the DHP. The Services would be responsible for PPBES for the personnel and readiness platforms.
7	The policymaking authority among OSD, the Services, and/or joint entities.	OSD would have broad policy and guidance, execution and operational policy development and implementation, and shared and consolidated services policies. The Services would designate the readiness requirements.
8	Management of purchased care and other functions currently performed by the TRICARE Management Activity.	The DHA would manage purchased care and other TMA functions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education and training, and other shared services, related functions.	The DHA would manage the peacetime health care systems. The Services would manage the readiness related services.
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	The ASD(HA)/DHA would have policy and oversight, advise the Secretary of Defense, and oversee the beneficiary care. The Military Departments' Secretaries and Chiefs would provide the readiness requirements. The Military Departments' Service Surgeon's General would manage the MTFs and implement common practices and systems.
11	Effect on the Guard and Reserve forces.	No effect is anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 5. TOR Objectives and Scope of MHS Governance Option C: DHA with Service MTFs

Strengths, Weaknesses, and Barriers of MHS Governance Option C: DHA with Service MTFs

Strengths of DHA with Service MTFs	
<ul style="list-style-type: none"> • Lines of Authority: This option would be a Military-led DHA and would eliminate the ASD(HA) dual-hatting. The Services would control the garrison and deployed health care. • Enhance Interoperability: The DHA would be focused on the shared and consolidated services. • Ease of Implementation: This would require minimal change to the current Service organizational structure. 	
Weaknesses of DHA with Service MTFs	
<ul style="list-style-type: none"> • Enhance Interoperability: This option would eliminate the Joint Hospitals in the NCR as well as San Antonio. • Ease of Implementation: This option would require JTF CAPMED to transition to a different construct. The Services' cultures could limit the implementation of common services and processes. 	
Barriers to DHA with Service MTFs	Mitigation Strategies for DHA with Service MTFs
<ul style="list-style-type: none"> • None. 	<ul style="list-style-type: none"> • None.

Table 6. Strengths, Weaknesses, and Barriers of MHS Governance Option C: DHA with Service MTFs

MHS Governance Option D: Unified Medical Command, Geographic Model

This option would require a tenth unified combatant command (Unified Medical Command) be established, led by a 4-Star general or flag officer, and reporting directly to the Secretary of Defense. The UMC Commander would have authority, direction, and control over the MHS, with the UMC Commander reporting to the Secretary of Defense as a Combatant Command (COCOM) force provider. The UMC Commander would assume control of TRICARE contracts. PPBES authority, execution authority, operational control of forces assigned, staffing would be through a Joint Table of Distribution (JTD) that includes the MTFs. The UMC Commander would have COCOM authorities and control of the MTFs through the JTDs. All assigned forces would be TDA forces.

This option for a UMC would include a Joint Medical Operations Command (JMOC) to manage shared services as well as the TRICARE Health Plan. The TRICARE Regional Offices (TROs) would be assigned to and support the UMC regions. Service Intermediate Headquarters structure is changed to a single regional HQ approach to manage MTFs. MSMs and the NCR would be addressed within this option.

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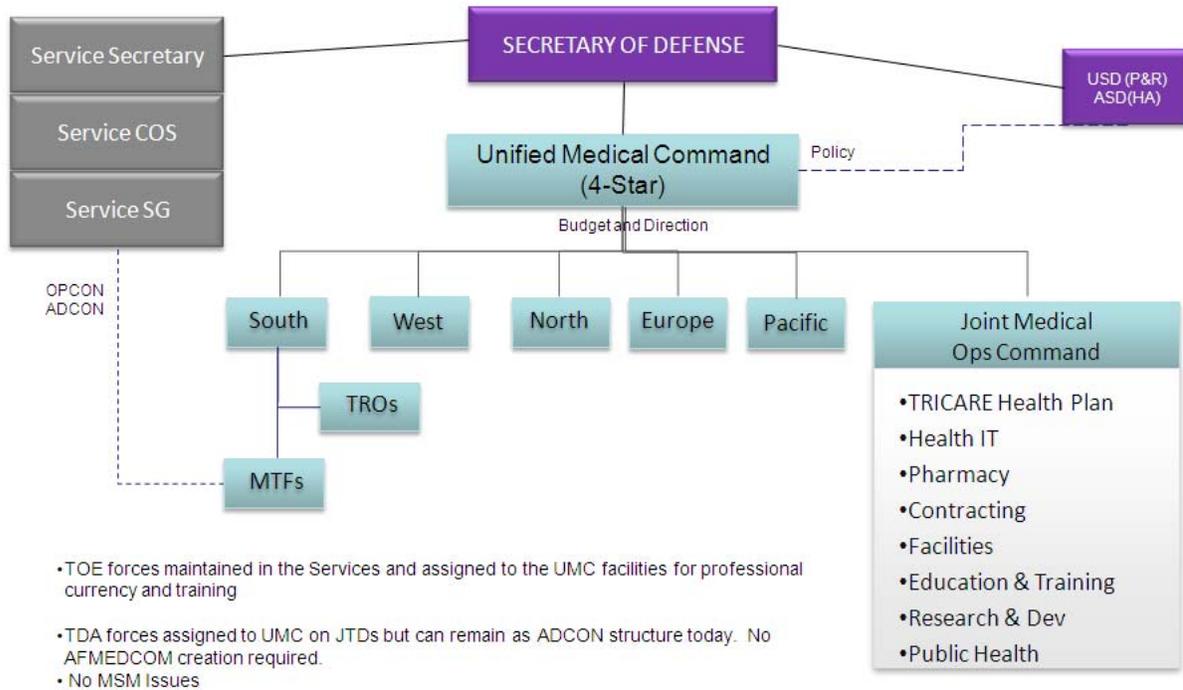


Figure 5. MHS Governance Option D: UMC, Geographic Model

TOR Objectives and Scope of MHS Governance Option D: UMC, Geographic Model

Item	TOR Objectives and Scope	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The Unified Medical Command would have authority, direction, and control of the MHS.
2	Head of entity or entities, and the reporting chain to the Secretary of Defense.	The UMC Commander would report to the Secretary of Defense as a COCOM force provider.
3	Management and supervisory chains of MTFs.	The MTF commander would report through regional commanders to the UMC Commander.
4	Management and supervisory chains of multi-Service markets.	MSMs would be organized as single management entity in a region with a single JTD.
5	The authority, direction, and control for mission/administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities	The UMC Commander would have COCOM authorities and control of the MTF personnel through JTDs. All assigned forces would be TDA forces. The UMC Commander would also have shared services authority. The Military Departments would be responsible for assigning TOE forces to the UMC that are off-JTDs. An alternative would be for the Military Departments to have ADCON and UCMJ authorities per a decision by the UMC Commander.
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	The ASD(HA) would have policy review and oversight. The UMC Commander would have PPBES authority for healthcare delivery and shared services.

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Item	TOR Objectives and Scope	Outcome
7	The policymaking authority among OSD, the Services, and/or joint entities.	<p>The ASD(HA) would have broad policy direction.</p> <p>OSD would have PPBES review.</p> <p>The UMC Commander would have execution authority, OPCON of JTD and TACON of non-JTD forces assigned, and shared services.</p> <p>The Military Departments would be responsible for developing and equipping TOE forces.</p>
8	Management of purchased care and other functions currently performed by the TRICARE Management Activity.	The UMC Commander would assume control of TRICARE contracts. The TRICARE Regional Offices (TROs) would be assigned to regions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education and training, and other shared services, related functions.	The UMC Commander would control shared and common functions under the Joint Medical Operations Command (JMOC). The Medical Education Training Campus (METC) would be reassigned to the UMC and funded through the DHP for medical education and training.
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	<p>The ASD(HA) provides overall policy oversight, advice to the OSD staff, and PPBES review for the Defense Health Program.</p> <p>The Military Departments' Secretaries and Service Chiefs would have PPBES review, OPCON of TOE forces, and ADCON for TDA forces assigned to the UMC.</p> <p>The Military Departments' Service Surgeon's General would advise the Secretaries and Chiefs.</p> <p>The UMC Commander would have COCOM and PPBES execution authority.</p>
11	Effect on the Guard and Reserve forces.	No effect is anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 7. TOR Objectives and Scope of MHS Governance Option D: UMC, Geographic Model

Strengths, Weaknesses, and Barriers of MHS Governance Option D: UMC, Geographic Model

Strengths of a UMC, Geographic Model	
<ul style="list-style-type: none"> • <u>Dispute Resolutions and Lines of Authority:</u> This organizational construct would have clear lines of authority and there would be central control of the MTFs. The shared services (i.e. E&T, R&D, HIT, logistics) would be centrally managed. The TROs would be aligned with the MTFs in the same chain of command. • <u>Enhance Interoperability:</u> This option would focus the development of common business processes. • <u>Ease of Implementation:</u> The JTDs would eliminate any MSM issues because the UMC would control the MSMs. • <u>Achieve Significant Cost Savings Through Reduction in Duplication and Variation:</u> Reduction in overhead personnel would be relative to the current MHS structure. • Services would focus on deployable forces with the UMC as the platform for medical professional force development and benefit delivery. 	
Weaknesses of a UMC, Geographic Model	
<ul style="list-style-type: none"> • <u>Enhance Interoperability:</u> Some required Service assets would not be under Service control (PROFIS, AF UTCs); sourcing from UMC. • <u>Ease of Implementation:</u> This would be a massive change for the way the DoD does business. TDA and TOE forces would be split. An alternative is to embed TOE in a JTD in the UMC. • <u>Lines of Authority:</u> This would be a major change for the Service Surgeon's General. • <u>Achieve Significant Cost Savings Through Reduction in Duplication and Variation:</u> The Command may be focused on effectiveness over costs. 	
Barriers to a UMC, Geographic Model	Mitigation Strategies for a UMC, Geographic Model
<ul style="list-style-type: none"> • Splitting garrison and deployable forces. • The Service Surgeon's General roles would change. • The Air Force would have to create TOE forces • Integration of common processes and equipment with Service readiness assemblages. • No Service buy-in. • Managing real estate disputes regarding timing of recapitalization. 	<ul style="list-style-type: none"> • Ensure PROFIS forces OPCON to Service. • Role of HA and Service Secretaries in PPBES oversight. • Services develop Command and Control for deployable forces, with the Air Force being most affected. • Develop processes for identifying deployable and garrison forces. • Have detailed implementation planning. • The JMOC could establish an integration process.

Table 8. Strengths, Weaknesses, and Barriers of MHS Governance Option D: UMC, Geographic Model

MHS Governance Option E: Unified Medical Command with Service Components

This option would require a tenth unified combatant command (Unified Medical Command) be established, led by a 4-Star general or flag officer, and reporting directly to the Secretary of Defense. Medical forces would be provided by Service Components, but the Unified Medical Command would be responsible for overall direction and leadership of the Military Health System. Components would maintain intermediate headquarters structures to manage the medical treatment facilities. This option for a Unified Medical Command would include a Unified Medical Command Headquarters and a subordinate Joint Health Support Command to manage shared services as well as the TRICARE Health Plan. Services maintain control of their deployable forces (TOE) with force generation responsibilities. The U.S. Medical Command would have operational control of the garrison (TDA) forces that would be identified through a Joint Table of Distribution (JTD) or Joint Manning Document (JMD). The ASD(HA) would continue to have a policy role. MSMs and the NCR would be addressed with in this option through the UMC.

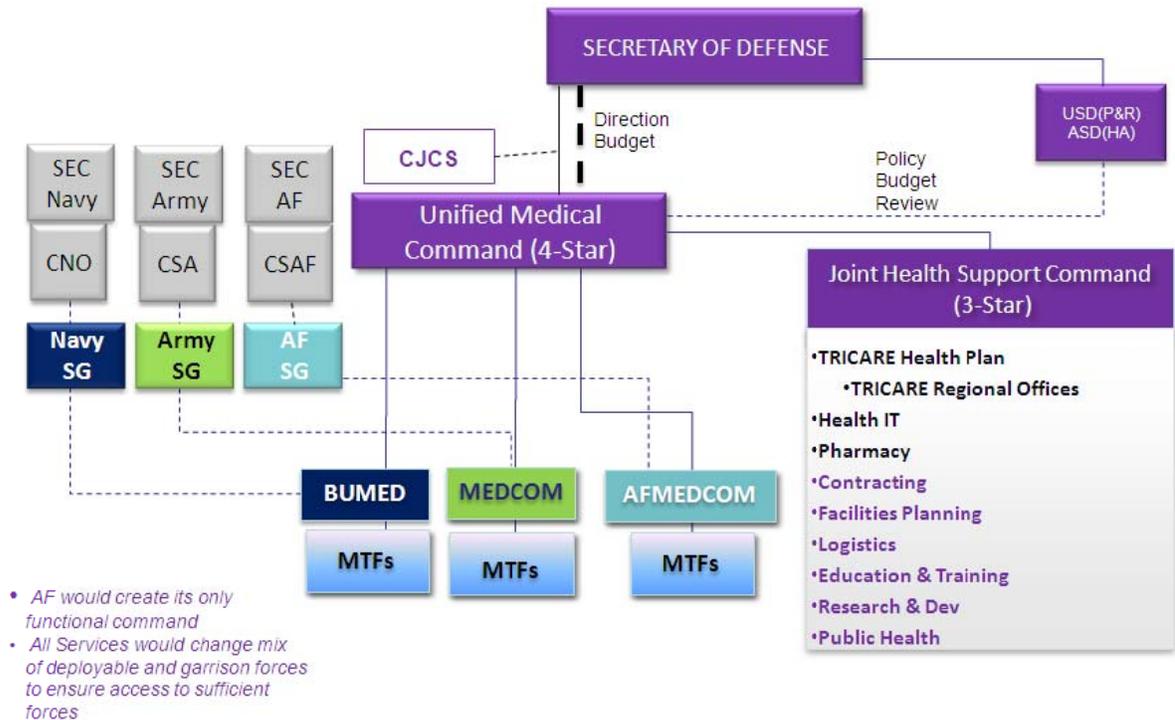


Figure 6. MHS Governance Option E: UMC with Service Components

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TOR Objectives and Scope of MHS Governance Option E: Unified Medical Command with Service Components

Item	TOR Objectives and Scope	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The UMC Command would be responsible for authority, direction, and control of the MHS through its components.
2	Head of entity or entities, and reporting chain to the Secretary of Defense.	The UMC Commander would report directly to the Secretary of Defense.
3	Management and supervisory chains of MTFs.	MTF commanders would report through their components to the US Medical Command.
4	Management and supervisory chains of multi-Service markets.	The UMC Commander would designate the Market Manager. Supervisory chains would continue through their Service Components. Larger, complex entities like the NCR may report outside component chains.
5	Authority, direction, and control for mission/administrative support matters over MHS personnel among OSD, Military Departments, and/or joint entities.	The authority, direction, and control over assigned MHS personnel would reside within the Service Components of the U.S. Medical Command, who would report to the UMC commander.
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	Authority over the DHP would reside with the UMC Commander.
7	The policymaking authority among OSD, the Services, and/or joint entities.	The ASD(HA), subject to the authority, direction, and control of the USD (P&R), would be the senior policy authority within the MHS. Policy matters would be coordinated with the UMC Commander and Military Departments.
8	Management of purchased care and other functions currently performed by the TRICARE Management Activity.	The UMC Commander would assume control of TRICARE contracts and all other TMA functions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education/training, and other shared services/related functions.	The UMC Commander would be responsible for managing and directing shared and common functions through the subordinate Joint Health Support Command.
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	<p>The ASD(HA) responsibilities would be delineated in an updated the DOD Directive focused only on policy-making activities.</p> <p>The Service Components would continue to be responsible for management and oversight of their military medical personnel and medical readiness programs. The Service Secretaries would be responsible for assigning duties to their respective Surgeons General and organizing their medical forces.</p> <p>The Unified Command Plan (UCP) would establish the missions and responsibilities for the UMC, which could include responsibilities currently outlined in the DoDDirective 5136.12, TRICARE Management Activity, and would have the authority to issue operational and program guidance regarding medical research/development, health information technology,</p>

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Item	TOR Objectives and Scope	Outcome
		medical logistics, medical construction, medical education, and training.
11	Effect on the Guard and Reserve forces.	No effect is anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 9. TOR Objectives and Scope of MHS Governance Option E: UMC with Service Components

Strengths, Weaknesses, and Barriers of MHS Governance Option E: Unified Medical Command with Service Components

Strengths of a UMC with Service Components	
<ul style="list-style-type: none"> • <u>Dispute Resolution/Lines of Authority/Accountability:</u> Clear lines of authority would be established. • <u>Achieve Significant Cost Savings Through Reduction in Duplication and Variation:</u> There would be central control of common business and clinical processes, and implementation would be achieved more readily with command and control throughout the medical structure to ensure compliance. • <u>Ease of Implementation:</u> JTF CAPMED, if retained in its current form, could be addressed as a Region directly reporting to the Commander, U.S. Medical Command. 	
Weaknesses of a UMC with Service Components	
<ul style="list-style-type: none"> • <u>Achieve Significant Cost Savings Through Reduction in Duplication and Variation:</u> In any UMC model that maintains Service Components (the common model for all unified commands), the overall management headquarters overhead would increase above “As Is” and all other organizational models. • <u>Dispute Resolution/Lines of Authority/Accountability:</u> The current structure of civilian authority over components of the MHS (the ASD(HA) and Military Department Secretaries) would not be maintained; the first civilian official in the authority chain would be the Secretary of Defense. • <u>Ease of Implementation:</u> This action would represent a significant departure in governance for all existing organizations (Health Affairs, TMA, Military Department Secretaries, Military Service Chiefs, Service Medical Departments). For the Air Force, this includes creating a medical component command for operation of Air Force medical treatment facilities; the Navy would need to redesign how garrison billets are mapped to operational requirements. 	
Barriers to a UMC with Service Components	Mitigation Strategies for a UMC with Service Components
<ul style="list-style-type: none"> • <u>Medical Readiness:</u> Would alter the process for deployment of forces. • <u>Other:</u> A new Unified Command would have to be established by the President of the United States. 	<ul style="list-style-type: none"> • It is understood that the establishment of the UMC would require a disciplined implementation with major changes in all activities.

Table 10. Strengths, Weaknesses, and Barriers of MHS Governance Option E: UMC with Service Components

MHS Governance Option F: Unified Medical Command - HR 1540 Section 711 Model

This option, derived from the House Armed Services Committee entitled HR 1540 Section 711 Model, would require a tenth unified combatant command (US Medical Command) be established, led by a 4-Star general or flag officer, and reporting directly to the Secretary of Defense. Medical forces would be provided by Service Components, but the Unified Medical Command would be responsible for overall direction and leadership of the Military Health System. Components would maintain intermediate headquarters structures to manage the MTFs. This option for a Unified Medical Command would include a Unified Medical Command Headquarters and a subordinate Healthcare Command to manage the Service Components and NCR and San Antonio MSMs; a Modernization, Doctrine, and Personal Development Command to manage R&D and E&T, and a Defense Health Agency to manage healthcare support, shared services, private sector care, health IT, and facilities. Services maintain control of their deployable forces (TOE) with force generation responsibilities. Service Surgeon's General would be dual-hatted within the UMC structure.

The MTFs and MSMs would be managed by market-level MTF Commanders, either through components or regional commanders, and the MTF Commanders would report to a Healthcare Command. Selected MSMs, to include JTF CAPMED and San Antonio, would be led by a 2-Star general who would report to the Healthcare Command.

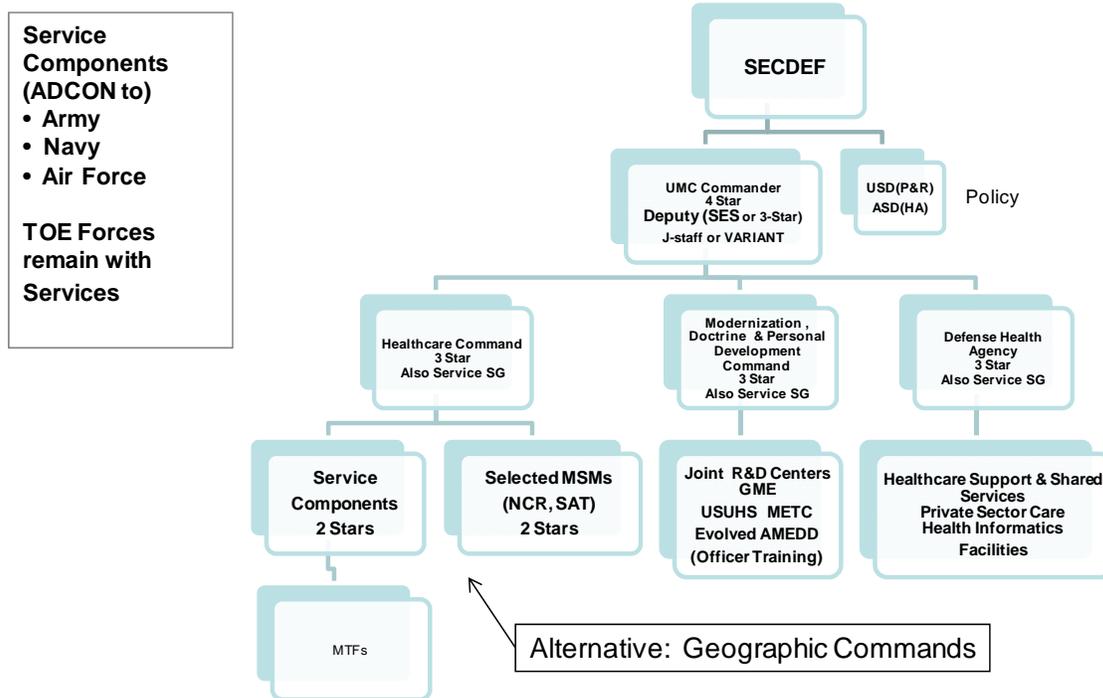


Figure 7. MHS Governance Option F: Unified Medical Command - HR 1540 Section 711 Model

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TOR Objectives and Scope of MHS Governance Option F: Unified Medical Command - HR 1540 Section 711 Model

Item	TOR Objectives and Scope	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The Unified Medical Command would have authority, direction, and control of the MHS.
2	Head of entity or entities, and reporting chain to the Secretary of Defense.	The UMC Commander would report through a COCOM to the Secretary of Defense.
3	Management and supervisory chains of MTFs.	The MTFs would be managed by MTF commanders, either through components or regional commanders, to a Healthcare Command.
4	Management and supervisory chains of multi-Service markets.	The MSMs would be managed by market level commanders with the MTFs reporting through components or stand-alone regions to a Healthcare Command led by a 3-Star.
5	Authority, direction, and control for mission/administrative support matters over MHS personnel among OSD, Military Departments, and/or joint entities.	The UMC Commander would have full COCOM authorities. The Military Departments would retain TOE forces.
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	The USD (P&R) would have policy review and oversight. The UMC Commander would have PPES authority. The Military Departments would have PPBES over the TOE forces.
7	The policymaking authority among OSD, the Services, and/or joint entities.	The USD (P&R) would provide broad policy and direction. The UMC Commander would have PPBES authority, UMCJ operational authority, and OPCON of forces. The Healthcare Command would be led by a 3-Star who would control doctrine, E&T, and R&D. The Military Departments would be responsible for developing and equipping the TOE forces.
8	Management of purchased care and other functions currently performed by the TRICARE Management Activity.	The UMC Commander would assume all TMA functions under the 3-Star led DHA.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education/training, and other shared services/related functions.	The UMC Commander would manage these functions under the DHA and the 3-Star led Modernization, Doctrine, and Personnel Development Command.
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	The ASD(HA) would become a DASD(HA) for overall policy oversight and advice to the OSD staff. The Military Departments' Secretaries and Service Chiefs would have PPBES and control of TOE forces. The Military Departments' Service Surgeon's General would advise the Secretaries and Chiefs and serve as

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Item	TOR Objectives and Scope	Outcome
		commanders in the UMC. The UMC Commander would have COCOM and full PPBES authority.
11	Effect on the Guard and Reserve forces.	No effect is anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 11. TOR Objectives and Scope of MHS Governance Option F: UMC - HR 1540 Section 711 Model

Strengths, Weaknesses, and Barriers of MHS Governance Option F: Unified Medical Command - HR 1540 Section 711 Model

Strengths of a UMC - HR 1540 Section 711 Model	
<ul style="list-style-type: none"> • <u>Dispute Resolution/Lines of Authority/Accountability:</u> Clear lines of authority would be established as well as central management of shared services (i.e. E&T, R&D, HIT, logistics). MTFs would be centrally controlled. • <u>Enhance Interoperability:</u> Allows for JTF CAPMED to be easily inserted into this construct as a regional or sub-regional command. Common business processes would be implemented across the MTFs. • <u>Ease of Implementation:</u> The Service Component execution would minimize organizational change. 	
Weaknesses of a UMC - HR 1540 Section 711 Model	
<ul style="list-style-type: none"> • <u>Achieve Significant Cost Savings Through Reduction in Duplication and Variation:</u> The Command would likely be focused more on effectiveness over costs. • <u>Dispute Resolution/Lines of Authority/Accountability:</u> Some required Service assets would not be under Service control (i.e. PROFIS). There would be civilian oversight for budget located at the Secretary of Defense level which would bypass OSD PSA. • <u>Enhance Interoperability:</u> TDA and TOE medical forces would be split. • <u>Ease of Implementation:</u> This would require all three Services to significantly change, with the biggest impact on the Air Force. • Dual-hatted SGs could face perception issues from home Service and UMC. 	
Barriers to a UMC - HR 1540 Section 711 Model	Mitigation Strategies for a UMC - HR 1540 Section 711 Model
<ul style="list-style-type: none"> • Service cultures and values and adoption of consolidated systems and processes. • Changing roles of the SGs. • Changes in the processes for the deployment of forces. • Component MTF construct will require separate MSM decision. 	<ul style="list-style-type: none"> • Ensure PROFIS forces OPCON to Service. • Develop a role for HA and Service Secretaries in POM oversight. • Create a DMOC-like entity. • Sustain core Service organizational structures. • Ensure there is clear implementation planning. • Make a decision on the MSMs.

Table 12. Strengths, Weaknesses, and Barriers of MHS Governance Option F: UMC - HR 1540 Section 711 Model

MHS Governance Option G: Single Service, Geographic Model – One Military Department Secretary Assigned Responsibility for the MHS

This option would assign one Military Department Secretary to have the authority, direction, and control of the MHS and would report directly to the Secretary of Defense. Each Military Department would continue to be responsible for organizing, training and equipping its deployable military medical (TOE) forces, but this would occur through assignment to operational platforms in medical treatment facilities run by the designated Military Department Secretary. The MTFs would be run by the designated Military Department, and would be staffed by personnel from all of the Military Departments. The designated Military Department would operate the TRICARE health plan and would have control over the Defense Health Program. The Assistant Secretary of Defense for Health Affairs (ASD(HA)) would retain policy authority within the MHS. The MSMs and NCR would be addressed in this option as single Service markets.

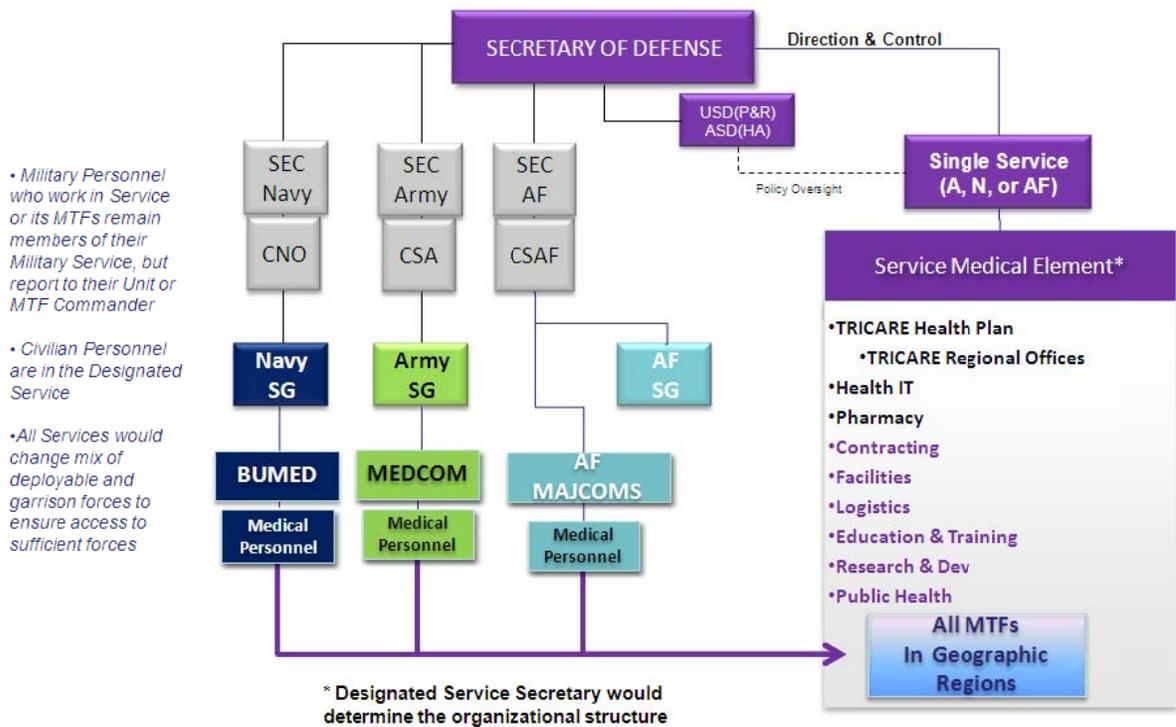


Figure 8. MHS Governance Option G: Single Service, Geographic Model

TOR Objectives and Scope of MHS Governance Option G: Single Service, Geographic Model

Item	TOR Objectives and Scope	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The designated Military Department Secretary would be responsible for the management and oversight of the MHS.
2	Head of alternative and reporting chain to the Secretary of Defense.	The designated Military Department Secretary would establish a medical organizational model that is best suited to manage the MHS (likely with geographic or regional intermediate headquarters). The leader of the medical organization would report to the Military Department Secretary. The Military Department Secretary would report to the Secretary of Defense.
3	Management and supervisory chains of MTFs.	MTF commanders would report through the organizational model that the designated Military Department Secretary has put into place, through the Military Department chain of command. There may be an intermediate command structure put in to place by the Military Department Secretary based on geographic or functional mission considerations.
4	Management and supervisory chains of multi-Service markets.	There would be no multi-Service markets. All MSMs would function under one Service.
5	The authority, direction, and control for mission and administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities.	The Military Department Secretary would have authority, direction, and control over MHS TDA personnel assigned to the medical treatment facilities. TOE forces would report through their separate Service structures.
6	The budgetary authority for the Defense Health Program among OSD, the Military Departments and/or joint entities.	Budgeting authority over the DHP would reside with the designated Military Department Secretary.
7	The policymaking authority among OSD, the Services, and/or joint entities.	The ASD(HA), subject to the authority, direction, and control of the USD(P&R), would serve as the senior medical advisor to the Secretary of Defense, and retains policy authority within the MHS. The designated Military Department Secretary would execute ASD(HA) policy directives.
8	Management of purchased care and other functions currently performed by the TRICARE Management Activity.	The designated Military Department Secretary would assume control of TRICARE contracts and all other TMA functions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education and training, and other shared services and related functions.	Medical shared services activities would be developed and implemented by the designated Military Department Secretary.

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Item	TOR Objectives and Scope	Outcome
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	The ASD(HA) would retain policy-making activities. The Service Components would be responsible for identifying their requirements for medical support to the designated Military Department Secretary. The designated Military Department Secretary would assume all responsibilities currently outlined in the DoDDirective, 5136.12, TRICARE Management Activity, and would have the authority to issue operational and program guidance regarding medical research and development, health information technology, military medical logistics, military medical construction, medical education and training, and all other responsibilities as provided by the Secretary of Defense.
11	Effect on the Guard and Reserve forces.	No effect is anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 13. TOR Objectives and Scope of MHS Governance Option G: Single Service, Geographic Model

Strengths, Weaknesses, and Barriers of MHS Governance Option G: Single Service, Geographic Model

Strengths of a Single Service, Geographic Model	
<ul style="list-style-type: none"> • <u>Dispute Resolution/Lines of Authority/Accountability:</u> Clear lines of authority and chain of command from Secretary through the MTF commander would be established. • <u>Achieve Significant Cost Savings Through Reduction in Duplication and Variation:</u> With shared services, there would be one set of business and clinical processes and implementation would be achieved more readily with command and control in a single Service. It also could eliminate the issues that arise with multi-Service markets. This option would create the most significant savings in headquarters overhead of any organizational option. 	
Weaknesses of a Single Service, Geographic Model	
<ul style="list-style-type: none"> • <u>Medical Readiness:</u> With medical personnel still “owned” by their Components, a requirement for coordination between Service Chiefs and Military Department Secretaries on readiness and personnel issues would remain. • <u>Ease of Implementation:</u> There is no known precedent or example where this approach has been tested in other military medical organizations worldwide. The Navy/USMC medical support model does not have the mission for all of the DOD; however, it is representative of how a Single Service model could work. Additionally, this option would entail a large scale reorganization to include re-mapping of Service medical personnel to operational platforms. • <u>Dispute Resolution/Lines of Authority/Accountability:</u> Issues would be adjudicated at a higher level (Military Department Secretary). 	
Barriers to a Single Service, Geographic Model	Mitigation Strategies for a Single Service, Geographic Model
<ul style="list-style-type: none"> • There would be a need to overcome perceptions of bias toward the facilities serving the forces of the designated Military Department Secretary, and the level at which these issues would need to be adjudicated. 	<ul style="list-style-type: none"> • Management controls and oversight processes would need to be transparent.

Table 14. Strengths, Weaknesses, and Barriers of MHS Governance Option G: Single Service, Geographic Model

MHS Governance Option H: Single Service with Components

This option would assign one Military Department Secretary to have the authority, direction, and control of the MHS and would report directly to the Secretary of Defense. Each Military Department would continue to be responsible for organizing, training and equipping its deployable military medical (TOE) forces, but this would occur through assignment to operational platforms in medical treatment facilities run by the Defense Healthcare System. The MTFs would be run by the designated Military Department's component commands in the Defense Healthcare System. The Defense Healthcare System would also manage the TRICARE Plan, the TROs and shared services. The Assistant Secretary of Defense for Health Affairs (ASD(HA)) would retain policy authority within the MHS through an updated the DoDDirective. The MSMs and NCR are addressed in this option as single Service markets under the Defense Healthcare System.

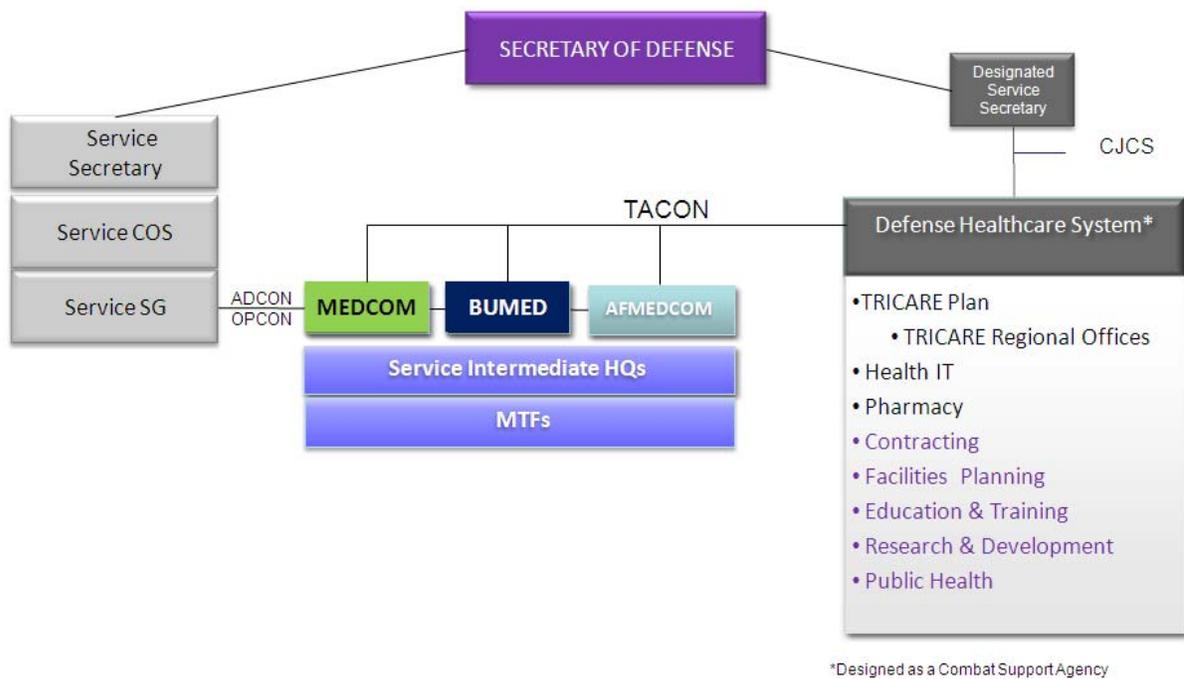


Figure 9. MHS Governance Option H: Single Service with Components

TOR Objectives and Scope of MHS Governance Option H: Single Service with Components

Item	TOR Objectives and Scope	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The Service Secretary/4 Star Commander would run the beneficiary health care delivery system. The Components would provide staff and manage readiness.
2	Head of entity or entities, and reporting chain to the Secretary of Defense.	The designated Service Secretary would report to the Secretary of Defense.
3	Management and supervisory chains of MTFs.	MTFs would be managed by Service MTF commanders who would report to Service Regional Commanders

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Item	TOR Objectives and Scope	Outcome
		who would report to the designated Service Component Commander who would report to the designated Service Secretary. The NCR would be a single Service market or a separate regional command.
4	Management and supervisory chains of multi-Service markets.	All MSMs would be managed by a single Service.
5	Authority, direction, and control for mission/administrative support matters over MHS personnel among OSD, Military Departments, and/or joint entities.	The designated Service chain of command would have TACON over the personnel assigned. TOE and TDA forces would be assigned to the designated Service for currency with OPCON to the parent Service through the components.
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	OSD would have policy oversight. The designated Service would have PPBES for MTF delivery requirements. The other Services would provide forces to the designated Service, have PPBES for the readiness equipment, and deploy forces.
7	The policymaking authority among OSD, the Services, and/or joint entities.	OSD would have broad policy and guidance and provide input into the SPG. The designated Service would have execution and operational policy development and implementation. The other Services would develop readiness requirements and platforms and deploy forces.
8	Management of purchased care and other functions currently performed by the TRICARE Management Activity.	The designated Service Secretary would manage purchased care and other TMA functions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education/training, and other shared services/related functions.	These functions would be a single system based on the processes of the designated Service.
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	The ASD(HA) would have policy and oversight and provide advice to the Secretary of Defense. The Military Departments' Secretaries and Chiefs would oversee beneficiary care and maintain the readiness mission. The Military Departments' Service Surgeon's General would oversee the readiness of forces and the deployed mission and monitor the performance of the designated Service.
11	Effect on the Guard and Reserve forces.	No effect is anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 15. TOR Objectives and Scope of MHS Governance Option H: Single Service with Components

Strengths, Weaknesses, and Barriers of MHS Governance Option H: Single Service with Components

Strengths of a Single Service with Components	
<ul style="list-style-type: none"> • Dispute Resolution/Lines of Authority/Accountability: Clear lines of authority would be established as well as central control of the MTFs and MSMs. Service readiness assets would be under Service control. • Achieve Significant Cost Savings Through Reduction in Duplication and Variation: There would be single processes for key functions. 	
Weaknesses of a Single Service with Components	
<ul style="list-style-type: none"> • Dispute Resolution/Lines of Authority/Accountability: This option would create a need for coordination of issues between the Service Secretaries. • Enhance Interoperability: This would split the readiness and garrison care system. 	
Barriers to a Single Service with Components	Mitigation Strategies for a Single Service with Components
<ul style="list-style-type: none"> • Selection of the Service responsible for all DoD medical care. • Transfer of medical forces and civilians to the designated Service. • Changing the role of the ASD(HA) to policy oversight. 	<ul style="list-style-type: none"> • None.

Table 16. Strengths, Weaknesses, and Barriers of MHS Governance Option H: Single Service with Components

MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model

This option would establish a tenth unified command (Unified Medical Command), led by a 4-Star general or flag officer who would report directly to the Secretary of Defense as a Combatant Commander. The UMC would have OPCON over all assigned forces and MTFs and would also manage a subordinate Joint Medical Operations Command (JMOC) that would manage E&T, R&D, and Public Health. A Defense Health Agency would also be established to manage beneficiary delivery, the TRICARE plan, and TROs, and shared services. The readiness and deployed mission would be focused in the UMC. The ASD(HA) would have budget control and would report through USD (P&R) to the Secretary of Defense. The DHA Director would have OPCON over assigned TDA personnel and would report directly to ASD(HA). MTFs would be managed by Regional Directors through the DHA but the NCR Commander would have OPCON over forces assigned to the NCR joint facilities. Service intermediate headquarters would be reduced to a single, DHA-run set of regional headquarters. The UMC would maintain OPCON over their designated TOE forces assigned for currency maintenance to the DHA-run MTFs. This alternative addresses the MSMs and NCR as regions or sub-regions within the DHA.

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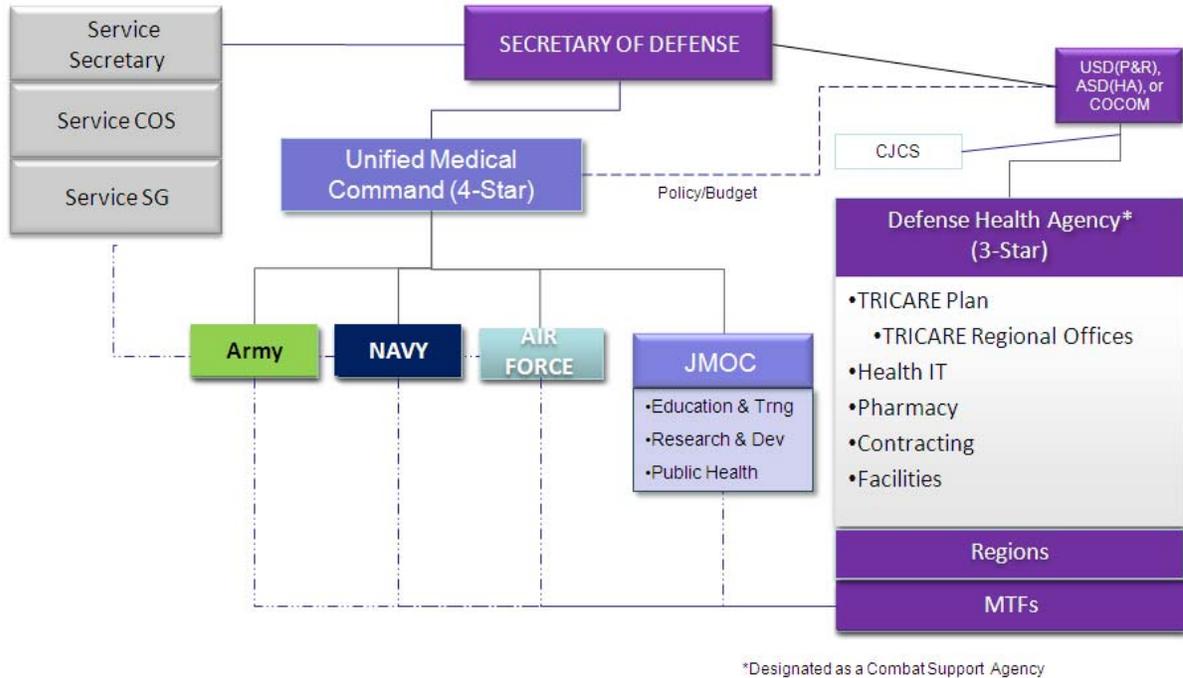


Figure 10. MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model

TOR Objectives and Scope of MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model

Item	TOR Objectives and Scope	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	<p>The ASD(HA) would have budget control.</p> <p>The UMC Commander would have OPCON over TOE forces.</p> <p>The DHA Director would have OPCON over assigned TDA personnel and would report directly to ASD(HA).</p>
2	Head of entity or entities, and reporting chain to the Secretary of Defense.	<p>The ASD(HA) would report through USD(P&R) to the Secretary of Defense.</p> <p>The DHA Director would report to the ASD(HA).</p> <p>The UMC Commander would report directly to the Secretary of Defense.</p>
3	Management and supervisory chains of MTFs.	The MTFs would be managed by Regional Directors through components to the DHA.
4	Management and supervisory chains of multi-Service markets.	MSMs would be organized under the DHA, JTF CAPMED would be disestablished.
5	The authority, direction, and control for mission and administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities.	<p>The ASD(HA) would have policy and budgetary review and oversight.</p> <p>The DHA Director would have control over shared and consolidated services and the MTF health care delivery system.</p>

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Item	TOR Objectives and Scope	Outcome
		<p>The UMC Commander would have OPCON of TOE forces in the MTFs.</p> <p>The Military Departments would have ADCON and UCMJ authorities.</p>
6	<p>The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.</p>	<p>The ASD(HA) would have budgetary policy and review and would present and defend the DoD health budget to the PPBES.</p> <p>The DHA Director would have program and budget execution authority for shared and consolidated services and the MTF health care delivery system.</p> <p>The UMC Commander would execute DHP funding to support medical readiness.</p> <p>The Military Departments would have PPBES inputs for Service- funded forces.</p>
7	<p>The policymaking authority among OSD, the Services, and/or joint entities.</p>	<p>The ASD(HA) would have broad policy direction and would present and defend the PPBES.</p> <p>The DHA Director would have execution of shared and consolidated services and the MTF healthcare delivery system.</p> <p>The UMC Commander would assign medical TDA and TOE forces to the MTFs to support beneficiary healthcare delivery, line forces medical readiness, and clinical currency for medical forces.</p> <p>The Services would be responsible for readiness doctrine and equipment.</p>
8	<p>Management of purchased care and other functions currently performed by TMA.</p>	<p>The DHA would manage purchased care and TMA functions.</p>
9	<p>Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education/training, and other shared services and related functions.</p>	<p>The DHA Director would be responsible for the development and implementation of common processes and systems to meet cost-efficiency, clinical, operational, and MTF health care delivery system requirements.</p> <p>The UMC Commander would be responsible for the JMOC readiness-related research, education and development and public health.</p>
10	<p>Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.</p>	<p>The ASD(HA) would provide strategic policy and PPBES oversight.</p> <p>The Military Departments' Secretaries and Service Chiefs would provide readiness requirements to the UMC Commander.</p> <p>The Military Departments' Service Surgeon's General would develop Service requirements and represent Service equities. There could be potential dual-hatting as Component Commanders.</p>

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Item	TOR Objectives and Scope	Outcome
		The DHA Director would develop common processes and systems to meet operational, clinical and cost-effectiveness goals for the MHS and MTF healthcare delivery system.
11	Effect on the Guard and Reserve forces.	No effect is anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 17. TOR Objectives and Scope of MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model

Strengths, Weaknesses, and Barriers of MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model

Strengths of a Split UMC and Military-Led DHA Geographic Hybrid Model	
<ul style="list-style-type: none"> • <u>Dispute Resolution/Lines of Authority/Accountability:</u> This option would align Command and Control (C2) forces under a Military chain of command. It would also align the ASD(HA)'s role to policy and oversight with execution delegated to the Military DHA Director. It would focus healthcare delivery in the DHA (efficiency) and medical readiness in the UMC (effectiveness). • <u>Achieve Significant Cost Savings Through Reduction in Duplication and Variation:</u> This option would centralize responsibilities for shared and common processes and systems. 	
Weaknesses of a Split UMC and Military-Led DHA Geographic Hybrid Model	
<ul style="list-style-type: none"> • <u>Medical Readiness:</u> Service readiness functions would be located in the UMC. • <u>Dispute Resolution/Lines of Authority/Accountability:</u> The UMC Commander would report directly to the Secretary of Defense. It could be difficult to adjudicate disagreements between the UMC and DHA at the DSD level. 	
Barriers to a Split UMC and Military-Led DHA Geographic Hybrid Model	Mitigation Strategies for a Split UMC and Military-Led DHA Geographic Hybrid Model
<ul style="list-style-type: none"> • A decision on common processes and functions under the control of the DHA Director. • JTF CAPMED would be disestablished. 	<ul style="list-style-type: none"> • Service line could fund medical readiness equipment to meet unique Service requirements. • Sustain the core Service organizational structures. • Implement an alternative MSM construct.

Table 18. Strengths, Weaknesses, and Barriers of MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model

MHS Governance Option J: UMC with Components and DHA Hybrid

This alternative divides the shared services between the DHA and UMC. Shared services retained within the UMC would be those that predominately support force readiness. Shared services in the Agency would support beneficiary health care delivery and clinical quality. The ASD(HA) would have budgetary control over the MHS, reporting through USD (P&R) to the Secretary of Defense. The UMC Commander would have OPCON over all forces and MTFs and would report directly to the Secretary of Defense. The DHA Director would have OPCON over assigned personnel and would report directly to the ASD(HA). The MTFs would be managed through Components to the UMC Commander. Service intermediate headquarters structure would be retained. The MSMs would be addressed by the UMC Commander, potentially as separate regions reporting directly to the UMC Commander or to a component.

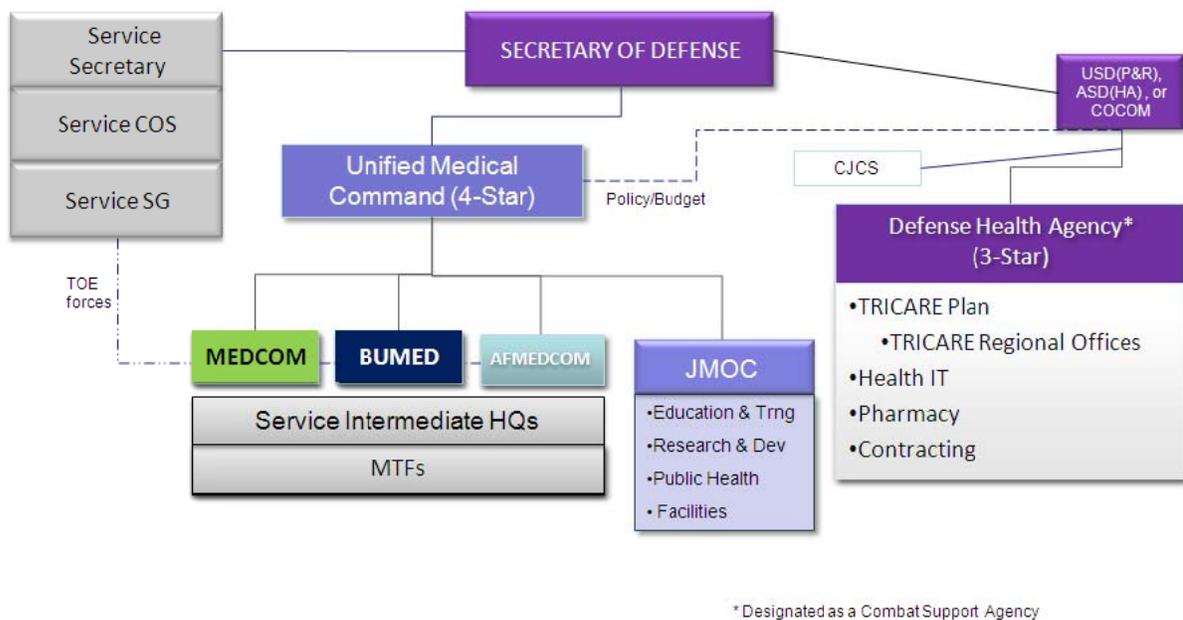


Figure 11. MHS Governance Option J: UMC with Components and DHA Hybrid

TOR Objectives and Scope of MHS Governance Option J: UMC with Components and DHA Hybrid

Item	TOR Objectives and Scope	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	<p>The ASD(HA) would have budgetary control over the MHS.</p> <p>The UMC Commander would have OPCON over all forces and MTFs and serve as a force provider.</p> <p>The DHA Director would have OPCON over assigned personnel.</p>
2	Head of entity or entities, and reporting chain to the Secretary of Defense.	<p>The ASD(HA) would report through the USD(P&R) to the Secretary of Defense.</p> <p>The DHA Director would report to the ASD(HA).</p>

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Item	TOR Objectives and Scope	Outcome
		The UMC Commander would report directly to the Secretary of Defense.
3	Management and supervisory chains of MTFs.	The MTFs would be managed by MTF Directors through components to the UMC Commander.
4	Management and supervisory chains of multi-Service markets.	There are two options for the MSMs. Option 1 is to manage the MSMs through Service Components. Option 2 is to have the MSMs report directly to the UMC Commander.
5	The authority, direction, and control for mission and administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities.	<p>The ASD(HA) would have policy and budgetary review and oversight.</p> <p>The DHA Director would have control over shared and consolidated services.</p> <p>The UMC would have OPCON of forces and MTFs.</p> <p>The Military Departments would have ADCON and UCMJ authorities.</p>
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	<p>The ASD(HA) would have budgetary policy and review and also present and defend the DoD health budget to the PPBES.</p> <p>The DHA Director would have program and budget execution authority for shared and consolidated services.</p> <p>The UMC Commander would provide DHP funding to the Components and MTF health care delivery system.</p> <p>The Military Departments would have PPBES input for Service- funded forces.</p>
7	The policymaking authority among OSD, the Services, and/or joint entities.	<p>The ASD(HA) would have broad policy direction and would present and defend the PPBES.</p> <p>The DHA Director would execute shared and consolidated services.</p> <p>The UMC Commander would have policymaking authority over the MTFs and the medical forces.</p> <p>The Services would be responsible for readiness doctrine and equipment.</p>
8	Management of purchased care and other functions currently performed by TMA.	The DHA would manage purchased care and other TMA functions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education/training, and other shared services and related functions.	<p>The DHA Director would be responsible for the development and implementation of common processes and systems to meet cost-efficiency, clinical, operational requirements and MTF health care delivery system.</p> <p>The UMC Commander would be responsible for the JMOC readiness related research, education and development and public health, and facilities as well as</p>

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Item	TOR Objectives and Scope	Outcome
		the healthcare delivery system.
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	<p>The ASD(HA) would have strategic policy and PPBES oversight.</p> <p>The Military Departments' Secretaries and Service Chiefs would provide readiness requirements to the UMC Commander.</p> <p>The Military Departments' Service Surgeon's General would develop Service requirements and represent Service equities. They could possibly dual-hat as Component Combatant Commanders.</p> <p>The DHA Director would develop common processes and systems to meet operational, clinical and cost-effectiveness goals for the MHS and MTF health care delivery system.</p> <p>The UMC Commander would run the health care system and be the force provider to meet COCOM operational requirements.</p>
11	Effect on the Guard and Reserve forces.	The Guard and Reserve forces would remain aligned with their respective Service but may require access to the UMC MTFs for readiness training prior to deployment.

Table 19. TOR Objectives and Scope of MHS Governance Option J: UMC with Components and DHA Hybrid

Strengths, Weaknesses, and Barriers of MHS Governance Option J: UMC with Components and DHA Hybrid

Strengths of a UMC with Components and DHA Hybrid	
<ul style="list-style-type: none"> • Dispute Resolution/Lines of Authority/Accountability: This option would align Command and Control (C2) forces under a Military chain of command. It would also align the ASD(HA)'s role to policy and oversight with execution delegated to the UMC Commander and DHA Director. • Ease of Implementation: This option would maintain Service structures as Component Commands in the UMC. It would also support the JTF CAPMED construct. 	
Weaknesses of a UMC with Components and DHA Hybrid	
<ul style="list-style-type: none"> • Medical Readiness: Service readiness functions would be located in the UMC. • Dispute Resolution/Lines of Authority/Accountability: The UMC Commander would report directly to the Secretary of Defense. It could be difficult to adjudicate disagreements between the UMC and DHA at the DSD level. • Achieve Significant Cost Savings: The execution of the shared services and common processes would require UMC Combatant Command agreement. 	
Barriers to a UMC with Components and DHA Hybrid	Mitigation Strategies for a UMC with Components and DHA Hybrid
<ul style="list-style-type: none"> • A decision on common processes and functions under the control of the DHA Director. 	<ul style="list-style-type: none"> • The Service line could fund medical readiness equipment to meet unique Service requirements. • Sustain the core Service organizational structures.

Table 20. Strengths, Weaknesses, and Barriers of MHS Governance Option J: UMC with Components and DHA Hybrid

MHS Governance Option K: Single Service Hybrid with a Unified Medical Command

This alternative divides the shared services between a single service-run Defense Healthcare System and UMC. Shared services retained within the UMC would be those that predominately support force readiness. Shared services in the Defense Healthcare System would support beneficiary health care delivery and clinical quality. The designated Military Department Secretary of the Defense Healthcare System would have budgetary control over the MHS, reporting directly to the Secretary of Defense. The UMC Commander would have OPCON over all assigned forces. The MTFs would report through Regional Commanders to the designated Service to the Secretary of Defense. All MSMs, including the NCR, would be single Service. MSMs and NCR would be resolved in this construct without further decisions. Service intermediate headquarters would be reduced to a single set of regional headquarters.

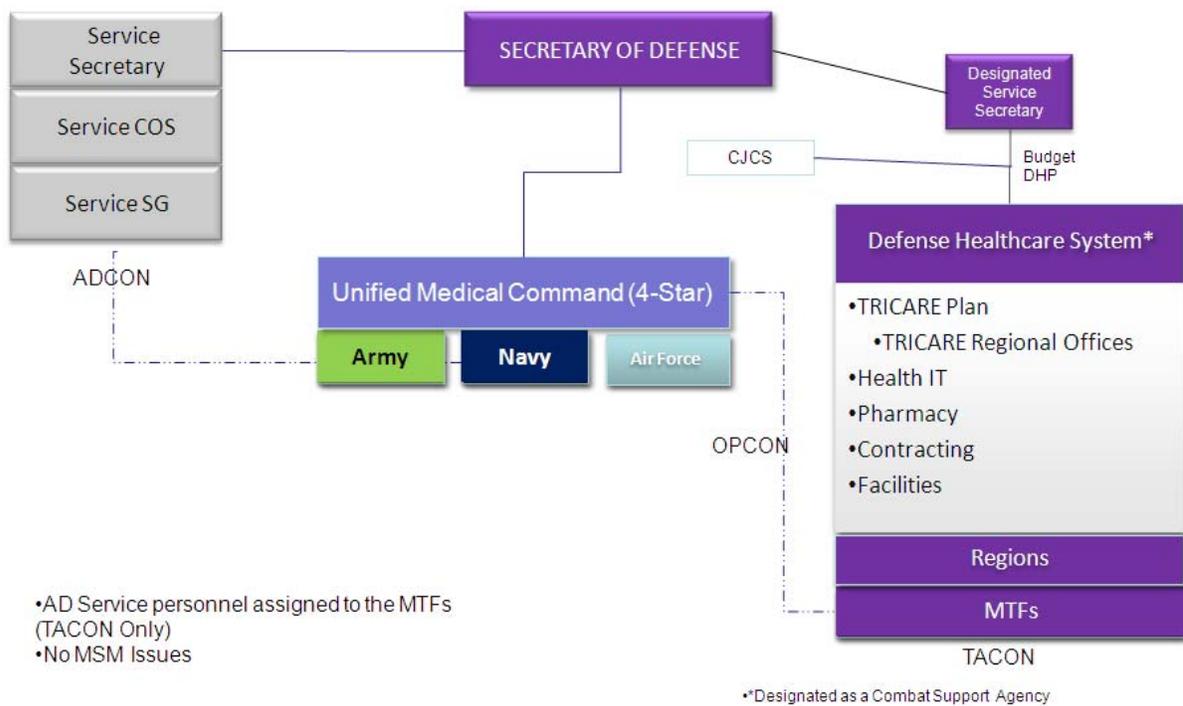


Figure 12. MHS Governance Option K: Single Service Hybrid with a Unified Medical Command

TOR Objectives and Scope of MHS Governance Option K: Single Service Hybrid with a Unified Medical Command

Item	TOR Objectives and Scope	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	<p>The designated Service Secretary would run the peacetime beneficiary health care system for the MHS.</p> <p>The Components would provide staff to the UMC.</p> <p>The UMC Commander would manage the deployable mission and leverage single service run MTFs for clinical currency.</p>
2	Head of entity or entities, and reporting chain to the Secretary of Defense.	<p>DHA through the designated Service to the Secretary of Defense.</p> <p>UMC Commander directly to the Secretary of Defense.</p>
3	Management and supervisory chains of MTFs.	MTFs would be managed by MTF commanders who would report to Regional Commanders who would report to the designated Service Medical Commander who would then report to the Service Secretary. The NCR would be a single Service market.
4	Management and supervisory chains of multi-Service markets.	All MSMs would be single Service.
5	The authority, direction, and control for mission and administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities.	<p>The designated Service chain of command would have TACON.</p> <p>TOE and TDA forces would be assigned to the designated Service facilities for currency with OPCON to the UMC.</p>
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	<p>OSD would have policy oversight.</p> <p>The designated Service would have planning, programming, budget, and execution for MTF beneficiary delivery requirements.</p> <p>The UMC Commander would provide forces to the designated Service, have PPBES for readiness equipment, and deploy forces.</p>
7	The policymaking authority among OSD, the Services, and/or joint entities.	<p>OSD would have broad policy and guidance with input into the SPG.</p> <p>The designated Service would have execution and operational policy development and implementation.</p> <p>The UMC Commander would develop readiness requirements and platforms and deploy forces.</p> <p>The Services would have ADCON to forces assigned to the UMC.</p>
8	Management of purchased care and other functions currently performed by TMA.	The designated Service Secretary would manage purchased care and other TMA functions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education/training,	This would be a single system based on the processes of the designated Service.

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Item	TOR Objectives and Scope	Outcome
	and other shared services and related functions.	
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.	<p>The ASD(HA) would have policy and oversight and provide advice to the Secretary of Defense.</p> <p>The Military Departments' Secretaries and Chiefs would oversee beneficiary care and maintain ADCON to the assigned forces.</p> <p>The Military Departments' Service Surgeon's General would oversee readiness of forces and deployed mission and monitor the performance of the designated Service.</p>
11	Effect on the Guard and Reserve forces.	No effect is anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.

Table 21. TOR Objectives and Scope of MHS Governance Option K: Single Service Hybrid with a Unified Medical Command

Strengths, Weaknesses, and Barriers of MHS Governance Option K: Single Service Hybrid with a Unified Medical Command

Strengths of a Single Service Hybrid with a Unified Medical Command	
<ul style="list-style-type: none"> • Dispute Resolution/Lines of Authority/Accountability: This option would establish clear lines of authority for ADCON, OPCON, and TACON of forces with each being vested in a different structure. It would also create central control of the MTFs. • Ease of Implementation: In this option, the MSMs are addressed and joint facilities would be maintained. • Enhance Interoperability: This option would allow for single processes for key functions. 	
Weaknesses of a Single Service Hybrid with a Unified Medical Command	
<ul style="list-style-type: none"> • Medical Readiness: This would split the readiness and garrison care systems. • Dispute Resolution/Lines of Authority/Accountability: This option would create different responsible agents for ADCON, TACON, and OPCON of forces. 	
Barriers to a Single Service Hybrid with a Unified Medical Command	Mitigation Strategies for a Single Service Hybrid with a Unified Medical Command
<ul style="list-style-type: none"> • Selection of the Service responsible for all DoD medical care. • Transfer of medical forces and civilians to the designated Service. • Separating control elements (ADCON, OPCON and TACON) to different responsible agents. 	<ul style="list-style-type: none"> • None.

Table 22. Strengths, Weaknesses, and Barriers of MHS Governance Option K: Single Service Hybrid with a Unified Medical Command

MHS Governance Option L: Defense Health Agency Hybrid with Medical Treatment Facilities (MTFs) placed under the Agency

This option would establish a Defense Health Agency replacing TMA and focused on consolidating and delivering a far broader set of shared health care support services. MHS-wide shared services activities include, but are not limited to: the TRICARE health plan; pharmacy programs; medical education and training; medical logistics; facility planning; health information technology; medical research and development; health information technology; facility planning; public health; acquisition; and other common clinical and business processes.

The DHA could be led by a 3-Star general or flag officer who would report to the Assistant Secretary of Defense (Health Affairs). The DHA could be designated as a Combat Support Agency (CSA) with periodic CJCS review of its combat support mission execution effectiveness. The MTFs would transfer to the DHA and would operate under its authority, direction, and control. The Military Departments would continue to own all military personnel and be responsible for organizing, training, and equipping their deployable military medical forces. Service medical personnel would be assigned to DHA-run MTFs to maintain readiness and clinical currency. MSMs and the NCR are addressed in this option as a part of the DHA. Service intermediate headquarters would reduce to a single, DHA-run set of regional headquarters.

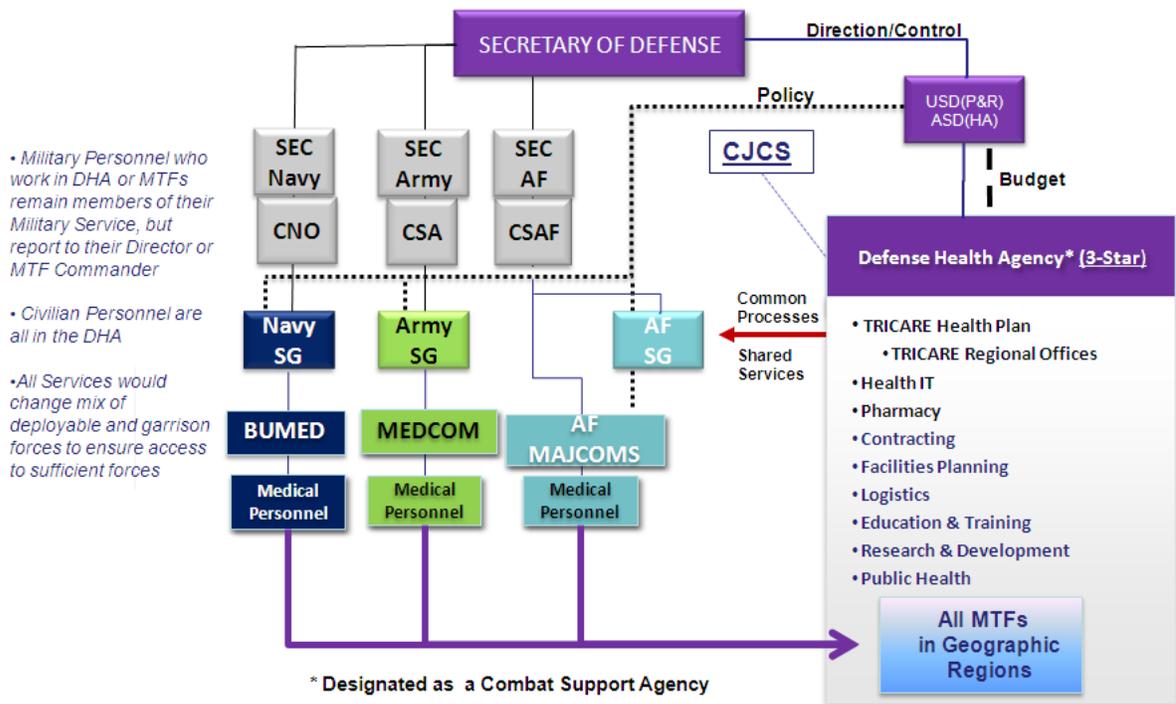


Figure 13. MHS Governance Option L: DHA Hybrid with Medical Treatment Facilities (MTFs) placed under the authority, direction, and control of the Agency

TOR Objectives and Scope of MHS Governance Option L: Defense Health Agency Hybrid with Medical Treatment Facilities (MTFs) under the Agency

Item	TOR Objectives and Scope	Outcome
1	Entity having authority, direction, and control of MHS as a whole.	The DHA Director would be responsible for authority, direction, and control of the MHS. ASD(HA) would have an oversight and policy role. Military Departments would be responsible for the size and capabilities of the active duty medical forces. Military medical forces are assigned to the DHA for professional currency maintenance.
2	Head of entity or entities, and reporting chain to the Secretary of Defense.	Component reporting chains for headquarters and TOE-assigned military personnel would remain as they currently exist. Service Surgeons General would continue reporting to their Service Secretaries who would report to the Secretary of Defense, but overall reporting chains would be changed for garrison care. The DHA Director would report to the ASD(HA), who would report to the USD (P&R), reporting to the Secretary of Defense.
3	Management and supervisory chains of MTFs.	MTF commanders would report through intermediate commands established by the DHA Director.
4	Management and supervisory chains of multi-Service markets.	As all medical treatment facilities would be operated by the DHA, vice the Services, the concept of multi-Service markets would no longer be applicable.
5	The authority, direction, and control for mission and administrative support matters over MHS personnel among OSD, the Military Departments, and/or joint entities.	The Director, DHA would have authority, direction, and control over MHS personnel assigned to the medical treatment facilities within rules established with the Military Department Secretaries. TOE forces would report through Service structures.
6	The budgetary authority for the Defense Health Program (DHP) among OSD, the Military Departments and/or joint entities.	Authority over the DHP would reside with the Director, DHA with oversight from ASD(HA).
7	The policymaking authority among OSD, the Services, and/or joint entities.	The ASD(HA), subject to the authority, direction, and control of USD (P&R), would be the senior policy authority in the MHS. The DHA Director would execute policy through the DHA structure. Policy matters would be coordinated with the Director, DHA, and Military Department Secretaries.
8	Management of purchased care and other functions currently performed by TMA.	The DHA Director would assume control of TRICARE contracts and all other TMA functions.
9	Management of information technologies and systems, medical logistics, business functions, medical construction and facility operations, management support functions, readiness planning, medical research, education/training, and other shared services and related functions.	The DHA Director would control all shared and common functions.
10	Roles of Assistant Secretary of Defense for Health Affairs, Military Department Secretaries, Service Chiefs, Military	The ASD(HA) would retain policy-making activities, and would supervise the DHA Director. The Service Components would continue to be

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Item	TOR Objectives and Scope	Outcome
	<p>Department Surgeons General, a Joint Commander (if any), a Defense Agency or Field Activity Director (if any), and any other senior leaders in the MHS option being considered.</p>	<p>responsible for management and oversight of their medical readiness programs and TOE forces. The DHA Director would assume budgetary control of the DHP and all responsibilities currently outlined in the DoDDirective, 5136.12, TRICARE Management Activity, and would have the authority to issue program guidance regarding medical research and development, health information technology, military medical logistics, military medical construction, medical education and training, and all other responsibilities as provided by the Secretary of Defense. The DHA Director would also have overall supervision of all medical treatment facilities.</p>
<p style="text-align: center;">11</p>	<p>Effect on the Guard and Reserve forces.</p>	<p>No effect is anticipated on the Guard and Reserve forces, and they would remain aligned with their respective Service.</p>

Table 23. TOR Objectives and Scope of MHS Governance Option L: DHA Hybrid with Medical Treatment Facilities (MTFs) under the Agency

Strengths, Weaknesses, and Barriers of MHS Governance Option L: DHA Hybrid with Medical Treatment Facilities (MTFs) under the Agency

Strengths of a DHA Hybrid with MTFs under the Agency	
<ul style="list-style-type: none"> • <u>Dispute Resolution/Lines of Authority/Accountability:</u> Would place management of all medical treatment facilities under one authority (Director, DHA), albeit at the expense of long-standing practice of management by Military Departments. The DHA Director would report directly to the ASD(HA). • <u>Achieve Significant Cost Savings Through Reduction in Duplication and Variation:</u> The DHA would be focused on the most common theme emphasized by the Task Force – an organizational model that would accelerate implementation of shared services models that identify and proliferate best practices and consider entirely new approaches to delivering shared activities. Further, placement of medical treatment facilities under the DHA would allow for even more rapid implementation of unified clinical and business systems, which could create significant savings. • <u>Other:</u> Would align management of purchased care (TRICARE) and direct care (medical treatment facilities) under one entity, creating potential for greater coordination and cost-effective distribution of resources between the two sources of care. 	
Weaknesses of a DHA with MTFs under the Agency	
<ul style="list-style-type: none"> • <u>Medical Readiness:</u> Concerns were expressed that an organization this large with this many authorities could jeopardize Services priorities. A comprehensive DHA could reduce command and leadership development opportunities. • <u>Dispute Resolution/Lines of Authority/Accountability:</u> This model may elevate management disputes to the highest levels of the DoD, as local line command disputes with the DHA command structure may need to be adjudicated at the level of the Secretary of the Military Department /ASD(HA) level. • <u>Ease of Implementation:</u> Moving all medical treatment facilities to the DHA would be a major reorganization. • <u>Other:</u> Could mix the DHA mission between support of MHS-wide functions and direct operation of hospitals and clinics. The Military Department’s representatives on the Task Force believed that operation of the direct care system is a Military Department responsibility. 	
Barriers to a DHA with MTFs under the Agency	Mitigation Strategies for a DHA with MTFs under the Agency
<ul style="list-style-type: none"> • Would require increase or transfer of personnel into OSD manpower levels for Health Affairs to accommodate the migration of financial management/oversight personnel from the field activity to OSD. 	<ul style="list-style-type: none"> • Appropriate modifications to OSD/Health Affairs staffing levels, in light of enhanced oversight mission, would be explored.

Table 24. Strengths, Weaknesses, and Barriers of MHS Governance Option L: DHA Hybrid with MTFs under the Agency

MHS Governance Option M: Defense Health Agency Hybrid with Regional MTFs

The ASD(HA), COCOM, or Service Secretary would report directly to the Secretary of Defense and would manage the shared services of the MHS through the DHA. The Service Secretaries would manage the Services and Medical Operations Support Command (MOSC). The MOSC would be created to run those shared services that are required to support medical readiness and deployed forces. Shared services supporting beneficiary health care delivery would be located in the Agency. The regional MSM structure would expand with all MTFs reporting to the MSMs, including the NCR, which would report directly to their respective Service. Services would maintain their current intermediate headquarters structure. This alternative was offered by a member of the Task Force without a detailed analysis.

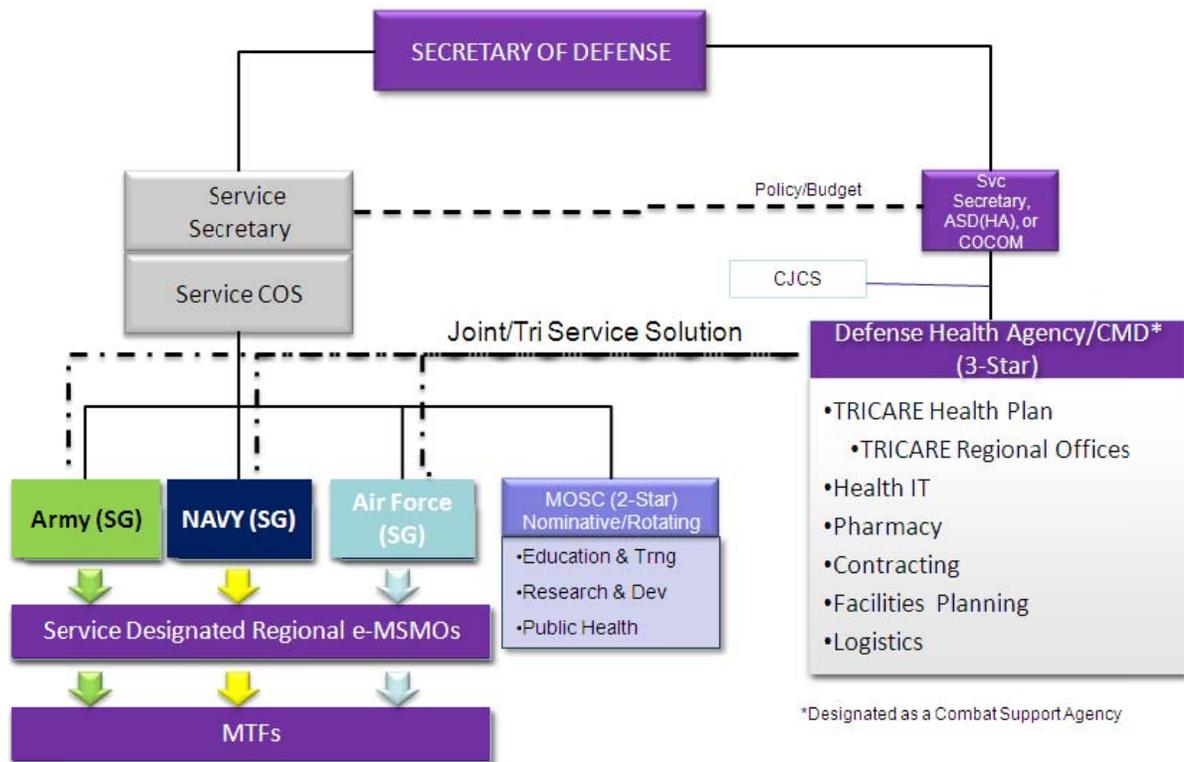


Figure 14. MHS Governance Option M: Defense Health Agency Hybrid with Regional Medical Treatment Facilities (MTFs)

Voting Structure

The Task Force narrowed down the multiple construct options described by applying the seven evaluation criteria in a series of votes, as seen in Figure 15 below. The run-off bracket voting style was developed in order to allow the Task Force to objectively compare options and helped to structure the questions that each Task Force member was voting on. The voting results of each option are detailed later in this report. The voting process used a Likert-type scale of 1 (weakest) to 5 (strongest) to rate the options against the criteria in each voting flight. The votes were examined by both weighted score as well ranked weighted score in the final four votes.

In order to normalize the votes across the nine voting members, one of the options was chosen by the co-chairs to serve for comparison purposes. This was intended to allow the voters to rate each option in the flight against the same baseline; thereby rating each option as better or worse than the baseline option. This was necessary in order to ensure comparability of the votes. In each case, the baseline for the vote was predetermined to score as “3s” for the criteria.

Each vote and selected option is listed in Table 25. The votes were also weighted and ranked by weighted score. This provided two different views of the Task Force Member’s views: one relating to the relative merit of each option considered and one relating to the members ranking of the options. This allowed the Task Force to better assess the options and each members views.

Vote 4 was unique and consisted of four separate sub-votes with the first three votes focusing on the desired governance and reporting structure for the NCR. Vote 4d addressed governance all of the U.S.-based (i.e. CONUS) and Overseas-based (i.e. OCONUS) MSMs. The Task Force members further voted on the Service that would be lead, by Market, for the case of eMSM and Executive agent governance models. This was done to provide a complete assessment of the relevant governance issues for the eMSM and EA models. The majority of the Task Force members recommended each MSM to be an eMSM but the Service who would manage the MSM varied among the Task Force members.

The September 29, 2011 MHS Task Force report delivered to the Secretary of Defense provides greater detail on the MSM and NCR options.

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Vote		Selected Option
1a	<ul style="list-style-type: none"> • MHS Governance Option E: UMC with Service Components; • MHS Governance Option F: Unified Medical Command - HR 1540 Section 711 Model; or • MHS Governance Option J: UMC with Components and DHA Hybrid 	MHS Governance Option E: UMC with Service Components
1b	<ul style="list-style-type: none"> • MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model or • MHS Governance Option K: Single Service Hybrid with a Unified Medical Command 	MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model
2a	<ul style="list-style-type: none"> • MHS Governance Option E: UMC with Service Components or • MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model 	MHS Governance Option E: UMC with Service Components
2b	<ul style="list-style-type: none"> • MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model; • MHS Governance Option J: UMC with Components and DHA Hybrid; or • MHS Governance Option M: Defense Health Agency Hybrid with Regional MTFs 	MHS Governance Option M: Defense Health Agency Hybrid with Regional MTFs
2c	<ul style="list-style-type: none"> • MHS Governance Option G: Single Service, Geographic Model – One Military Department Secretary Assigned Responsibility for the MHS or • MHS Governance Option H: Single Service with Components 	MHS Governance Option H: Single Service with Components
Final Single Service Vote	<ul style="list-style-type: none"> • MHS Governance Option H: Single Service with Components • MHS Governance Option K: Single Service Hybrid with a Unified Medical Command 	MHS Governance Option H: Single Service with Components
3a	<ul style="list-style-type: none"> • MHS Governance Option E: UMC with Service Components; • MHS Governance Option M: Defense Health Agency Hybrid with Regional MTFs; or • MHS Governance Option K: Single Service Hybrid with a Unified Medical Command 	MHS Governance Option E: UMC with Service Components

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3b	<ul style="list-style-type: none"> • MHS Governance Option D: Unified Medical Command, Geographic Model or • MHS Governance Option L: Defense Health Agency Hybrid with Medical Treatment Facilities (MTFs) placed under the Agency 	MHS Governance Option L: Defense Health Agency Hybrid with Medical Treatment Facilities (MTFs) placed under the Agency
4a	<ul style="list-style-type: none"> • The current NCR structure of JTF CAPMED reporting to the Secretary of Defense; • A Northern Command (NORTHCOM); • An enhanced MSM structure (eMSM); • HA/TMA; • A Single Service; or • An Executive Agent (EA) 	An enhanced MSM structure (eMSM)
4b	<ul style="list-style-type: none"> • The current NCR structure of JTF CAPMED reporting to the Secretary of Defense; • A Northern Command (NORTHCOM); • An enhanced MSM structure (eMSM); • A DHA; • A Single Service; or • An Executive Agent (EA) 	An enhanced MSM structure (eMSM)
4c	<ul style="list-style-type: none"> • A minimal MSM; • The current NCR structure of JTF CAPMED reporting the Secretary of Defense; • An enhanced MSM structure (eMSM); • An Executive Agent (EA); • A Single Service; or • A Command Authority 	An enhanced MSM structure (eMSM)
4d	<ul style="list-style-type: none"> • MSM Type, Manager, EA Designation 	See Results in Table 33
5	<ul style="list-style-type: none"> • The current "As-Is" MHS structure; • DHA 2/ Hybrid 1 (DHA with MTFS Remaining in the Military Departments); • UMC Option 2 (Component); • DHA 1/ Hybrid 2 (DHA with MTFS under the DHA); or • Single Service Option 2 (Component) 	DHA 2/ Hybrid 1 (DHA with MTFS Remaining in the Military Departments)

Table 25. MHS Task Force Votes and Selected Options

TASK FORCE ON MILITARY HEALTH SYSTEM GOVERNANCE

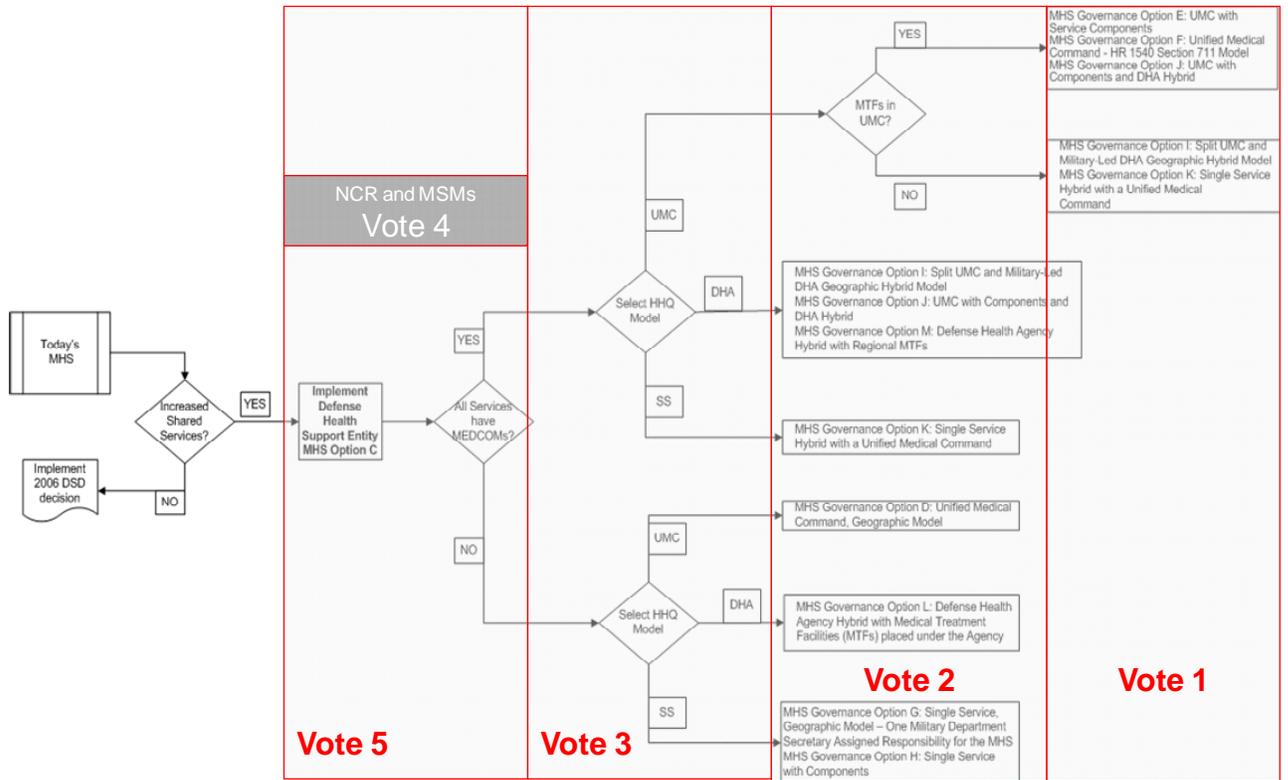


Figure 15. MHS Task Force Voting Construct

Voting Results

Based on the voting construct, the voting results are below. The voter identities have been sanitized for this report.

- Vote 1a:** - MHS Governance Option E: UMC with Service Components
 - MHS Governance Option F: UMC - HR 1540 Section 711 Model
 - MHS Governance Option J: UMC with Components and DHA Hybrid

- Vote 1b:** - MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model
 - MHS Governance Option K: Single Service Hybrid with a Unified Medical Command

VOTE 1a				VOTE 1b		
Voter	MHS Governance Option E	MHS Governance Option F	MHS Governance Option J	Voter	MHS Governance Option I	MHS Governance Option K
A	3	3.04	3.28	A	3	3
B	3	1	2	B	3	1
C	3	2.41	2.89	C	3	3.21
D	3	1	2	D	3	1
E	3	2.39	2.61	E	3	2.86
F	3	2.75	2.75	F	3	2.95
G	3	2.57	2.78	G	3	3.11
H	3	2.66	2.51	H	3	2.89
I	3	2.89	3.25	I	3	2.7
OVERALL	27	20.71	24.07	OVERALL	27	22.72
Average	3	2.3	2.7	Average	3.0	2.5

Table 26. Vote 1a and 1b Results

TASK FORCE ON MILITARY HEALTH SYSTEM GOVERNANCE

Vote 2a: - MHS Governance Option E: UMC with Service Components
 - MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model

Vote 2b: - MHS Governance Option I: Split UMC and Military-Led DHA Geographic Hybrid Model
 - MHS Governance Option J: UMC with Components and DHA Hybrid
 - MHS Governance Option M: Defense Health Agency Hybrid with Regional MTFs

Vote 2c: - MHS Governance Option G: Single Service, Geographic Model – One Military Department Secretary Assigned Responsibility for the MHS
 - MHS Governance Option H: Single Service with Components

VOTE 2a			VOTE 2b				VOTE 2c		
Voter	MHS Governance Option E	MHS Governance Option I	Voter	MHS Governance Option I	MHS Governance Option J	MHS Governance Option M	Voter	MHS Governance Option G	MHS Governance Option H
A	3	2.49	A	3	3.08	3.1	A	3	2.51
B	3	1	B	3	4	5	B	3	4
C	3	2.89	C	3	2.17	3.8	C	3	3.24
D	3	1	D	3	5	4	D	3	4
E	3	2.05	E	3	3.61	2.33	E	3	3.21
F	3	2.46	F	3	3	3.73	F	3	2.71
G	3	2.98	G	3	3.02	3.19	G	3	2.83
H	3	2.03	H	3	3.11	3.14	H	3	3.39
I	3	2.89	I	3	3.14	3.48	I	3	3.21
OVERALL	27	19.79	OVERALL	27	30.13	31.77	OVERALL	27.00	29.10
Average	3	2.20	Average	3	3.35	3.53	Average	3.00	3.23

Table 27. Vote 2a, 2b, and 2c Results

Final Single Service Vote: - MHS Governance Option H: Single Service with Components
 - MHS Governance Option K: Single Service Hybrid with a Unified Medical Command

Final Single Service Vote		
Voter	MHS Governance Option H	MHS Governance Option K
A	3	2.06
B	3	1
C	3	2.72
D	3	1
E	3	1.77
F	3	2.78
G	3	2.6
H	3	2.09
I	3	2.69
OVERALL	27.00	18.71
Average	3.00	2.08

Table 28. Final Single Service Vote Results

TASK FORCE ON MILITARY HEALTH SYSTEM GOVERNANCE

- Vote 3a:** - MHS Governance Option E: UMC with Service Components
 - MHS Governance Option M: Defense Health Agency Hybrid with Regional MTFs
 - MHS Governance Option K: Single Service Hybrid with a Unified Medical Command

- Vote 3b:** - MHS Governance Option D: Unified Medical Command, Geographic Model
 - MHS Governance Option L: Defense Health Agency Hybrid with Medical Treatment Facilities (MTFs) placed under the Agency
 - MHS Governance Option H: Single Service with Components

VOTE 3a			
Voter	MHS Governance Option E	MHS Governance Option M	MHS Governance Option K
A	3	3.53	2.91
B	3	2	1
C	3	3.99	1.7
D	3	2	1
E	3	2.41	2.2
F	3	2.99	2.26
G	3	3.17	2.86
H	3	1	1
I	3	3.37	2.81
OVERALL	27	24.46	17.74
Average	3	2.72	1.97

VOTE 3b			
Voter	MHS Governance Option D	MHS Governance Option L	MHS Governance Option H
A	3	2.38	3.36
B	3	4	1
C	3	3.48	2.89
D	3	4	1
E	3	3.4	1.89
F	3	2.99	2.93
G	3	3.17	2.77
H	3	5	4
I	3	3.05	2.94
OVERALL	27	31.47	22.78
Average	3	3.50	2.53

Table 29. Vote 3a and 3b Results

TASK FORCE ON MILITARY HEALTH SYSTEM GOVERNANCE

Vote 4a: - JTF – NCR MSM in MHS Governance Option A: Current MHS Governance Structure

Vote 4a: JTF - NCR MSM in MHS Governance Option A: Current MHS Governance Structure						
Voter	SECDEF	NORTHCOM	eMSM	HA/TMA	Single Service	EA
A	3	2.23	3.52	2.97	2.89	2.29
B	3	3	2	2	1	1
C	3	1	5	2	2.4	3
D	3	3	5	1	2	4
E	3	2.25	3.17	2	2.96	2.86
F	3	3.01	2.94	3.06	3.52	3.52
G	3	2.64	3.12	2.89	3.15	2.75
H	3	2.6	3.14	2.75	2.92	2.92
I	3	2.48	3.43	2.89	3.15	2.98
OVERALL	27	22.21	31.32	21.56	23.99	25.32
Average	3	2.47	3.48	2.40	2.67	2.81

Vote 4a: JTF - NCR MSM in MHS Governance Option A: Current MHS Governance Structure (RANKED)						
Voter	SECDEF	NORTHCOM	eMSM	HA/TMA	Single Service	EA
A	2	6	1	3	4	5
B	1	2	3	4	5	6
C	3	6	1	5	4	2
D	4	3	1	6	5	2
E	2	5	1	6	3	4
F	5	4	6	3	2	1
G	3	6	2	4	1	5
H	2	6	1	5	4	3
I	3	6	1	5	2	4
OVERALL	25	44	17	41	30	32
Average	2.8	4.9	1.9	4.6	3.3	3.6

Table 30. Vote 4a Results

TASK FORCE ON MILITARY HEALTH SYSTEM GOVERNANCE

Vote 4b: - JTF – NCR MSM in MHS Governance Option C: Defense Health Agency with Service MTFs

Vote 4b: JTF - NCR MSM in MHS Governance Option C: Defense Health Agency with Service MTFs						
Voter	SECDEF	NORTHCOM	eMSM	DHA	Single Service	EA
A	3	2	3.13	3	2.82	2.17
B	3	2	3	2	1	2
C	3	1	5	1	2.4	3
D	3	3	5	1	2	4
E	3	1.99	3.65	4.09	3.45	3
F	3	3.01	2.94	3.06	3.52	3.52
G	3	2.69	2.91	3.25	2.7	2.72
H	3	2.6	2.75	4.23	2.92	2.92
I	3	2.48	3.17	3.11	2.95	2.94
OVERALL	27	20.77	31.55	24.74	23.76	26.27
Average	3	2.31	3.51	2.75	2.64	2.92

Vote 4b: JTF - NCR MSM in MHS Governance Option C: Defense Health Agency with Service MTFs (RANKED)						
Voter	SECDEF	NORTHCOM	eMSM	DHA	Single Service	EA
A	3	6	1	2	4	5
B	1	3	2	4	6	5
C	3	5	1	6	4	2
D	4	3	1	6	5	2
E	5	6	2	1	3	4
F	5	4	6	3	2	1
G	2	6	3	1	5	4
H	2	6	5	1	4	3
I	3	6	1	2	4	5
OVERALL	28	45	22	26	37	31
Average	3.1	5.0	2.4	2.9	4.1	3.4

Table 31. Vote 4b Results

TASK FORCE ON MILITARY HEALTH SYSTEM GOVERNANCE

Vote 4c: MSM Alternatives

Vote 4c: MSM Alternatives						
Voter	Min MSMO	Today's MSM	eMSM	EA	Single Service	Command Authority
A	2.86	3	3.44	2.66	2.73	2.12
B	2	3	3	1	1	2
C	2.5	3	5	2.78	2.46	1.69
D	3	3	5	4	2	1
E	1.87	3	3.81	2	2.49	2.32
F	2.43	3	3.04	3.04	2.99	2.82
G	3	3	3.15	2.75	3.41	3.07
H	1.89	3	4.95	3.73	3.67	3.44
I	2.38	3	4.22	3.78	3.72	3.27
OVERALL	21.93	27	35.61	25.74	24.47	21.73
Average	2.4	3.0	4.0	2.9	2.7	2.4

Vote 4c: MSM Alternatives (RANKED)						
Voter	Min MSMO	Today's MSM	eMSM	EA	Single Service	Command Authority
A	3	2	1	5	4	6
B	5	2	1	6	4	3
C	4	2	1	3	5	6
D	3.5	3.5	1	2	5	6
E	5	2	1	2	3	4
F	6	3	1.5	1.5	4	5
G	4.5	4.5	6	2.75	1	3
H	6	5	1	2	3	4
I	6	5	1	2	3	4
OVERALL	43	29	14.5	26.25	32	41
Average	4.8	3.2	1.6	2.9	3.6	4.6

Table 32. Vote 4c Results

TASK FORCE ON MILITARY HEALTH SYSTEM GOVERNANCE

Vote 4d: MSM Type, Manager, and EA Designation

Market	MSM Type	If e/MSM: Manager	If an EA: EA will be:
National Capital Area	eMSM (4) - Aligned Under DHA (3) - Command Authority (1) - eMSM/EA (1)	Rotate (5) - Army (1) - Army/Navy Rotate (2) - No opinion (1)	Army (6) - Navy (1) - Army (1) - No opinion (1)
Tidewater, VA	eMSM (8) - eMSM/EA (1)	Navy (8) - No opinion (1)	Navy (8) - No opinion (1)
Puget Sound, WA	eMSM (8) - eMSM/EA (1)	Army (7) - Army/Navy Rotate (1) - No opinion (1)	Army (8) - No opinion (1)
Colorado Springs, CO	eMSM (8) - eMSM/EA (1)	Rotate (6) - Do Not Rotate, Pick One (1) - Air Force (1) - No opinion (1)	Army (6) - Air Force (2) - No opinion (1)
San Antonio, TX	eMSM (8) - eMSM/EA (1)	Rotate (6) - Do Not Rotate, Pick One (1) - Air Force (1) - No opinion (1)	- Air Force (7) - Army (1) - No opinion (1)
Fort Bragg/Pope, NC	eMSM (8) - eMSM/EA (1)	Army (8) - No opinion (1)	Army (8) No opinion (1)
Mississippi Delta	eMSM (8) - eMSM/EA (1)	Air Force (8) - No opinion (1)	Air Force (8) No opinion (1)
Naval Hospital Charleston/ Charleston AFB, SC	eMSM (8) - eMSM/EA (1)	Navy (8) - No opinion (1)	Navy (8) No opinion (1)
OCONUS MSMs			
Anchorage, AK	eMSM (8) - eMSM/EA (1)	Air Force (8) - No opinion (1)	Air Force (8) No opinion (1)
Fairbanks, AK	eMSM (8) - eMSM/EA (1)	Army (8) - No opinion (1)	Army (8) No opinion (1)
Oahu, HI	eMSM (8) - eMSM/EA (1)	Army/Navy (5) - Do Not Rotate, Pick One (1) - Army/Navy Rotate (1) - Navy (1) - No opinion (1)	Army (6) - Navy (2) - No opinion (1)
Okinawa, Japan	eMSM (8) - eMSM/EA (1)	Navy (8) - No opinion (1)	Navy (8) - No opinion (1)
Kaiserslautern, Germany	eMSM (8) - eMSM/EA (1)	Army (8) - No opinion (1)	Army (8) - No opinion (1)
Osan Community, South Korea	eMSM (8) - eMSM/EA (1)	Army (8) - No opinion (1)	Army (8) - No opinion (1)
Guam	eMSM (8) - eMSM/EA (1)	Navy (8) - No opinion (1)	Navy (8) - No opinion (1)

Table 33. Vote 4d Results

TASK FORCE ON MILITARY HEALTH SYSTEM GOVERNANCE

- Vote 5, Final Vote:** - MHS Governance Option A: Current MHS Governance Structure
 - MHS Governance Option C: Defense Health Agency with Service MTFs
 - MHS Governance Option E: UMC with Service Components
 - MHS Governance Option L: Defense Health Agency Hybrid with Medical Treatment Facilities (MTFs) placed under the Agency
 - MHS Governance Option H: Single Service with Components

Vote 5: Final Vote					
Voter	MHS Governance Option A	MHS Governance Option C	MHS Governance E	MHS Governance Option L	MHS Governance Option H
A	3	3.81	2.75	3.5	2.52
B	3	4	5	2	1
C	3	4.67	1.75	1.89	2.92
D	3	5	1	1	1
E	3	3.84	3.03	3.12	2.09
F	3	2.95	3.25	3.24	3.25
G	3	3	2.93	3.35	3.32
H	3	3.69	2.53	4.21	3.42
I	3	3.91	3.01	3.67	3.49
OVERALL	27	34.87	25.25	25.98	23.01
Average	3	3.87	2.81	2.89	2.56

Vote 5: Final Vote (RANKED)					
Voter	MHS Governance Option A	MHS Governance Option C	MHS Governance E	MHS Governance Option L	MHS Governance Option H
A	3	1	4	2	5
B	3	2	1	4	5
C	2	1	5	4	3
D	2	1	4	4	4
E	4	1	3	2	5
F	4	5	2	3	1
G	4	3	5	1	2
H	4	2	5	1	3
I	4	1	5	2	3
OVERALL	30	17	34	23	31
Average	3.333333333	1.89	3.78	2.56	3.44

Table 34. Vote 5, Final Vote Results

Detailed Voting Results

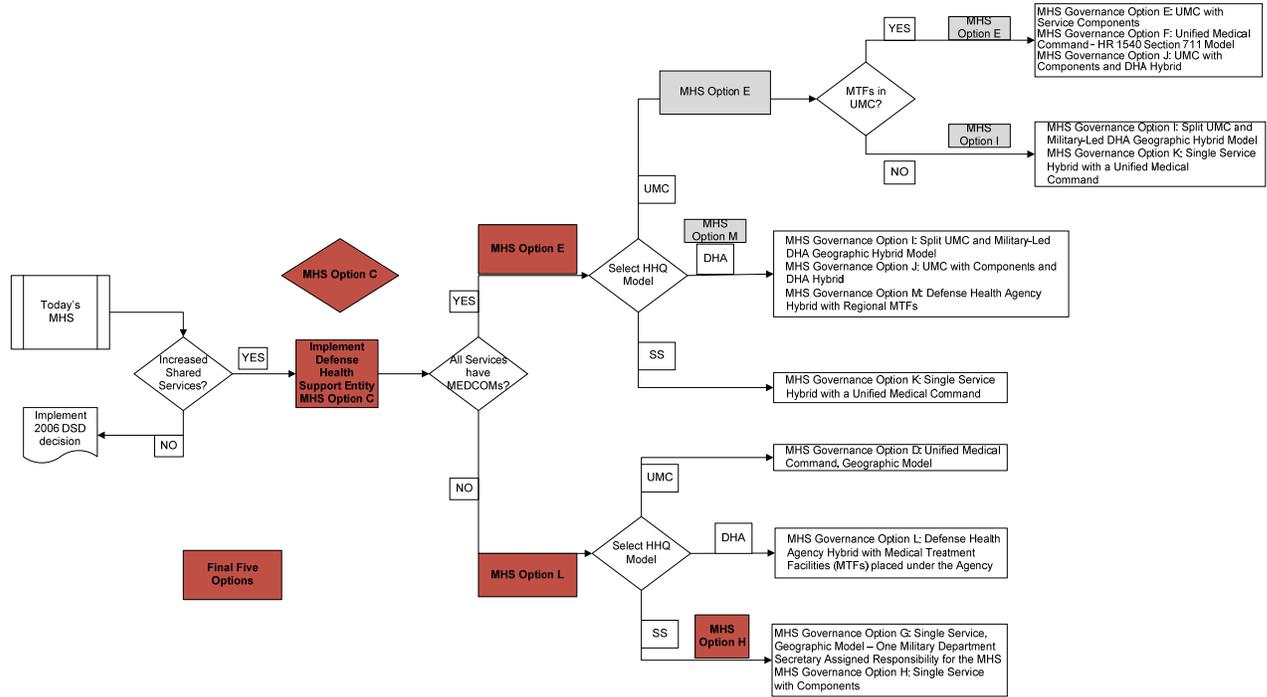


Figure 16. MHS Task Force Voting Results
Note: Voting bracket results read from right to left.

Part 2. Management Headquarters and Shared Services Sizing Analysis

Introduction

Given the rapid 90-day time period to conduct this analysis, the Task Force used the 2006 "Cost Implications of a Unified Medical Command"¹ study as a starting point in the cost analysis of the governance options. The intent of analyzing the management headquarters is to identify opportunities for creating efficiencies across the Military Health System (MHS). The objectives of this analysis are shown below:

- Establish a baseline of existing management headquarters personnel across the three Service medical headquarters, Health Affairs (HA), and TRICARE Management Activity (TMA)
- Determine a rough order of magnitude estimate of the total number of management headquarters personnel required to operate each organizational construct being considered by the Task Force using standardized analytics and assumptions

The following assumptions supported this analysis:

- 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
- Large changes in headquarters sizing would require process changes to achieve greater efficiencies without reducing effectiveness
- Current staffing can be used as a benchmark for staffing consolidated headquarters entities
- In select cases, (UMC) 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 Services could be adapted to cover a larger MHS-wide scope; scalability does not include any related non-medical Service-provided support

Methodology

The analysis was addressed in two parts: Management Headquarters and Shared Services. The total savings for an alternative was estimated by adding together the costs or savings from both the management headquarters and the shared services.

¹ E. Christensen, CDR D Farr, J. Grefer, and E. Schaefer, "Cost Implications of a Unified Medical Command", Center for Naval Analyses, CRM D0013842.A3, May 2006.

Management Headquarters

A simplified analytical approach was taken to design a hierarchal organizational construct of the existing MHS. Current organizational charts and personnel information (including type, military/civilian/contractor, and associated office name) for the three Service medical departments, HA, and TMA were provided to the Task Force and evaluated to determine similar levels of management headquarters personnel across all components.

As shown in Figure 17 below, the Higher Headquarters level of personnel represent the direct support offices of the Service Surgeons General and the Assistant Secretary of Defense for Health Affairs (ASD(HA)). Personnel allocated to the Support Functions level perform common daily operational requirements for the support elements of the Service medical headquarters and TMA. The intermediate headquarters level of personnel includes the Army and Navy Regional Headquarters as well as the Air Force Major Commands (MAJCOMs) and TRICARE Regional Offices (TROs). Not included in this analysis are the MTF personnel, considered to be outside the scope of the Task Force Terms of Reference (TOR). JTF CAP MED was included as a part of the assessment of the UMC alternatives. Initial responses to the data call required further explanation to normalize the data to make the results comparable. In spite of the efforts of the Services and the Task Force analysis team, it is likely that some Service-specific differences in the approach to the data remained in the final data set. However, the Services and the analysis team allowed that the final data set was sufficient for the level of analysis undertaken to support the Task Force deliberations.

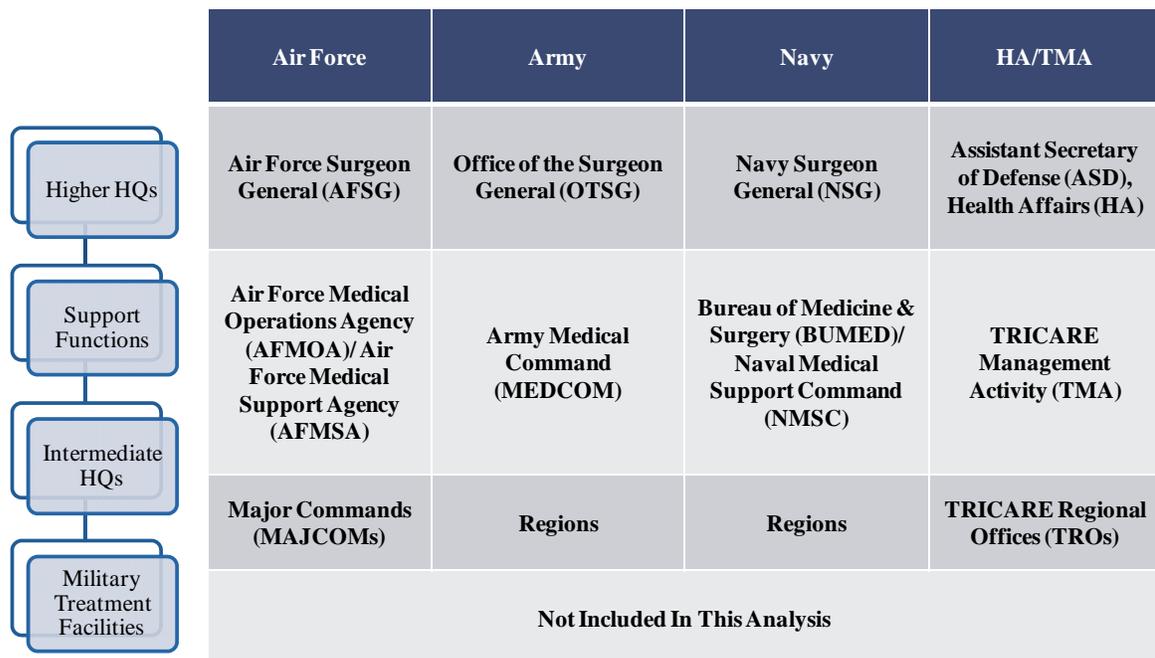


Figure 17. MHS Management Headquarters Construct

MHS management headquarters personnel were also subdivided by functional category based on an assessment of the organizational structures, nomenclature, and Service input. The functional groupings were determined by recognizing that personnel perform similar work

functions across all components (e.g., AFMSA/SG8Y Financial Management and BUMED Budget Support were both categorized into a Resource Management functional grouping since the nature of work is comparable). This analysis extends a similar analysis of common functions developed to support the deliberations on locating the staffs being co-located in the BRAC-directed Defense Health Headquarters (DHHQ). Below are the characteristics of each functional grouping:

- Command: Leadership and support staff
- Education and Training: Professional development and sustainment
- Human Resources: Personnel management
- Installations: Infrastructure management
- Information Technology (IT): Medical systems development, implementation and sustainment
- Contracting and Acquisition – acquisition of services and materials through commercial sources
- Logistics: Supply chain management
- Operations: Mission execution
- Plans and Programs: Program analysis and development
- Private Sector Care: Non-direct care system management
- Research, Development, Test, and Evaluation (RDT&E): Modernization planning and development
- Readiness: Sustainment and deployment of medical forces in support of operational needs
- Resource Management: Budget development and execution
- Specialty: Specialized functions uncommon across components

Coinciding with the development of the MHS management headquarters framework in Figure 17 and functional groupings, a database was created that included all the personnel information submitted to the Task Force. To ensure the database represented an accurate account of management headquarters personnel, stakeholders from each component were given the opportunity to review and validate information as well as provide updated information, as needed. The Task Force analysis recognized that the staffing of headquarters functions was changing in response to a number of requirements to achieve added efficiencies and effectiveness. As revised information was incorporated into the database, the updates were distributed to these stakeholders as well as the Task Force members for further confirmation. In order to allow the analysis to go forward, the data represents the staffing as of August 1, 2011.

The database was comprised of an identifier (abbreviation of the MHS management headquarters level), office name, component, functional grouping, level, and total number of personnel by type (military/civilian/contractor); additional comments provided to the Task Force were incorporated into the database as notes. Table 35 provides a snapshot of the database. Once all stakeholders and Task Force members validated the contents of the database, it was finalized and used for analysis.

TASK FORCE ON MILITARY HEALTH SYSTEM GOVERNANCE

Identifier	DUIC Name	Office Name	Service	Function	Level	Authorized Total Personnel				Notes
						Military	Civilian	Contractors	Total	
AFSG		AF/SG	Air Force	Command	SG	17	4		21	HAF/SG and support staff are all MHQ LAF-Funded to Goldwaters-Nichols ceiling
AFSG		AF/SG3 - Healthcare Operations	Air Force	Operations	SG	5	1	1	7	HAF/SG and support staff are all MHQ LAF-Funded to Goldwaters-Nichols ceiling
AFSG		AF/SG3X - Medical Operations Center	Air Force	Readiness	SG	9	0		9	HAF/SG and support staff are all MHQ LAF-Funded to Goldwaters-Nichols ceiling
AFSG		AF/SG3P - Aerospace Operations	Air Force	Human Resources	SG	6	4		10	HAF/SG and support staff are all MHQ LAF-Funded to Goldwaters-Nichols ceiling
AFSG		AF/SGL	Air Force	Command	SG	2	8		10	HAF/SG and support staff are all MHQ LAF-Funded to Goldwaters-Nichols ceiling
AFSG		AF/SG8 - Strategic Medical Plans, Programs & Budget	Air Force	Plans & Programs	SG	3	0	1	4	HAF/SG and support staff are all MHQ LAF-Funded to Goldwaters-Nichols ceiling
AFSG		AF/SG8F - Health Facilities	Air Force	Installations	SG	2	0		2	HAF/SG and support staff are all MHQ LAF-Funded to Goldwaters-Nichols ceiling
AFSG		AF/SG8P - Programming	Air Force	Plans & Programs	SG	5	3		8	HAF/SG and support staff are all MHQ LAF-Funded to Goldwaters-Nichols ceiling

Table 35. Database Sample

The analytical approach determined that the development of an estimate for the various building blocks used by the Task Force to develop alternative governance constructs for the MHS would allow a flexible and rapid way to compare personnel costs. A fundamental issue with developing the sizing of the building blocks, given the short duration of the study period, was the need to validate that the sizing used was executable in practice. There being no opportunity to provide the detailed mission and tasks analysis that this would require, the analysis chose to assume that the organizational constructs used by the Services could be adapted to cover a larger, MHS-wide scope. Assuming scalability of this nature does not include any related non-medical Service support as this was not included in the model.

Another aspect of this approach is that it assures that the models for the various headquarters levels are based on functioning Service constructs that are currently addressing the organizational and operational requirements of running large military healthcare delivery systems. Inspection of the organizational constructs and the analytical framework for the data (Higher Headquarters, Support Agency, Intermediate Headquarters) revealed that the analytical framework could be used as the foundation for the sizing estimates.

Inherent in this analysis was the need to address the manpower to operate large headquarters functions such as the Defense Health Agency and the Unified Medical Command. In these cases, the estimate would include some, or all, of the support agency manpower, depending on the construct.

Higher Headquarters

Based on analysis of the database, the higher headquarters functions were allocated 100 personnel per headquarters for the Service SGs, and ASD(HA). This allows a total of 400 personnel assigned to the four headquarters units where all are included in the alternative.

Support and Intermediate Headquarters

To determine a rough order of magnitude estimate of the total number of management headquarters personnel required to operate each organizational construct under consideration by the Task Force, both the existing Support Agencies and Intermediate Headquarters personnel requirements were calibrated to identify the personnel requirements necessary to efficiently operate the MTFs.

In order to provide an estimate of relative manpower requirements for the alternatives developed by the Task Force, a metric was developed for both the Support Agency and the Intermediate Headquarters levels of management headquarters. To generate this metric, those personnel that would be considered in the shared services evaluation were removed from the management headquarters manpower data. This provided a level of manpower that was deemed to be related to the execution and control of direct healthcare delivery. Normalizing this data across the Services required the development of a metric that would relate the manpower to an operational parameter. Of the several that were considered, this analysis determined that using Operating and Maintenance (O&M) funding provided by the Defense Health Program (DHP) was the best parameter to use based on commonality, accuracy, and availability of data. Dividing the number of personnel by the O&M executed by that Service provided a metric that described the number of management headquarters Full Time Equivalents (FTEs) per dollar of O&M distributed (Equation 2). This was used to estimate the manpower requirements for MHS-wide Support Agencies and Intermediate Headquarters by multiplying the metric by the total O&M distributed to the Services (Equation 2). These metrics were developed for all three Services and used to determine the manpower estimates for the various Task Force alternatives.

Equation 1. DHP O&M Distributed to Service A / (Intermediate Headquarters Manpower – Shared Services Manpower) = Support Agency Metric for Service A

Equation 2. Support Agency Metric for Service A * Total DHP O&M Distributed to the Services = Estimate of the Support Agency Manpower for the MHS based on Service A

Selecting Sizing Estimates to Use for Governance Alternatives

The analysis developed a set of guidelines to use in selecting the sizing estimate to use for a particular construct. For the Support Agencies in the alternatives, the median of the three estimates was used. The median was used instead of the mean to maintain the connection of the estimate to an operating Service organizational system. Inspection of the data indicated that the mean would represent an organizational approach different from the Services. This suggests that using the mean without further analysis of the organizational structure(s) it represents, would risk proposing an un-executable functional structure. In specific cases where there was only single or no Service components in an alternative (e.g. Single Service, UMC with Geographic Regions) the smallest Support Agency and/or Intermediate Headquarters sizing was used assuming that, given a clean slate to develop these functions, the most efficient approach for the DHP would be taken. The details of the sizing estimates are given in the results section.

Defense Health Agency and Unified Medical Command

The Defense Health Agency (DHA) was deemed to consist predominately of shared services, essentially replacing TMA. In the case that the DHA would include all of the MTFs, the addition of Intermediate Headquarters and a slight increase in the Command element was used to estimate the sizing. The DHA was assumed to have a smaller mission and task element than the UMC and the UMC staffing estimate was not used in the DHA with MTFs model.

The Unified Medical Command (UMC) estimated personnel requirement was based on both the Joint Task Force National Capital Region (JTF CAPMED) estimated end-state personnel requirement as well as current Combatant Command personnel requirements. The JTF CAPMED end-state personnel requirement is estimated to be approximately 150 personnel for managing 10% of the MHS operations. By multiplying the JTF CAPMED personnel requirement by 10, 1,500 personnel are estimated as required to manage 100% of the MHS operations. Additionally, review of the Combatant Command personnel requirements shown in Table 36, could lead to concluding that the UMC could require between 2,000 and 3,000 personnel. By taking the midpoint between the JTF CAPMED end-state personnel requirement and the lower-end of the Combatant Command personnel requirements, a conservative estimate of the UMC was determined to be 1,750 personnel.

JTD	AFRICOM	CENTCOM	EUCOM	JFCOM	NORTHCOM	PACOM	SOCOM	SOUTHCOM	STRATCOM	TRANSCOM	Joint Staff
TOTAL	2,695	5,801	3,788	5,703	2,412	5,371	6,209	2,563	6,021	2,601	2,252

* Data is all approved funded authorizations (FY11) as of 1 Aug JTD/JTMD.

Table 36. COCOM Personnel Authorizations

A Combat Support Agency (CSA) was included in some of the potential MHS governance options to fulfil support functions for joint operating forces across components. An estimate of 50 personnel was used for the CSA based on current CSA staffing requirements.

Shared Services

The shared services personnel requirements identified by the Task Force were developed by estimating the savings associated with consolidating management headquarters personnel performing similar functions. To estimate the shared services personnel requirements, the Task Force used the same "economies of scale" approach as in the 2006 study; initially developed by the Center for Naval Analyses (CNA). As all MHS governance options considered by the Task Force included a shared services element, one calculation was used for this analysis throughout. The calculation used the sum of all components personnel allocated to the TRICARE Plan, TROs, IT, Pharmacy, Contracting and Acquisition, Facility Planning (mentioned above as Installations), Education and Training, Research and Development, and Logistics.

Results

DHP-funded Management Headquarters Personnel

By filtering the data provided, subsets of information were analyzed to gain insights into how MHS management headquarters personnel are currently organized. In particular, the total number of personnel assigned to each level, functional grouping, and shared service were evaluated by component, as shown in Table 37, Table 38, and Table 39.

Level	Service A	Service B	Service C	HA	TMA	Total
Higher HQ	105	128	128	45	0	406
Support Agencies	831	705	532	0	2,649	4,717
Regions	156	504	195	0	158	1,013
Total	1,092	1,337	855	45	2,807	6,136

Table 37. MHS Management Headquarters Personnel by Level

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Function	Service A	Service B	Service C	HA	TMA	Total
Command	99	247	46	45	84	521
Contracting & Acquisition	15	0	0	0	138	153
Education & Training	1	3	12	0	7	23
Human Resources	47	89	62	0	48	246
Installations	17	38	26	0	6	87
IT	267	119	54	0	1,327	1,767
Logistics	92	71	10	0	0	173
Operations	301	104	229	0	220	854
Plans & Programs	21	164	82	0	16	283
PSC	0	4	0	0	440	444
RDT&E	85	0	155	0	3	243
Readiness	72	8	11	0	189	280
Resource Management	75	146	142	0	331	694
Specialty	0	344	26	0	0	370
Total	1,092	1,337	855	45	2,807	6,136

Table 38. MHS Management Headquarters Breakdown by Function

Function	Service A	Service B	Service C	TMA	Total
Contracting & Acquisition	15	0	0	0	15
Education & Training	1	3	12	0	16
Facility Planning	17	38	26	0	81
Health IT	267	119	54	0	440
Logistics	92	71	10	0	173
Pharmacy	0	2	0	0	2
Research & Development	85	0	155	0	240
TRICARE Plan	0	0	0	2,649	2,649
TROs	0	0	0	158	158
Total	477	233	257	2,807	3,774

Table 39. Shared Services

Estimating the Intermediate Headquarters and Support Agency Sizing

Table 40 and Table 41 show the development and application of the metric for Intermediate Headquarters and Support Agencies, respectively.

Intermediate Headquarters Personnel Calibration	Service A	Service B	Service C
FY2011 DHPO&M Appropriation Amount	\$2,297	\$6,588	\$3,195
Total Intermediate Headquarters Level Personnel	156	504	195
Shared Services* Personnel (included in the Intermediate Headquarters Level)	0	58	75
Total Intermediate Headquarters Personnel less Shared Services*	156	446	120
Service Intermediate Headquarters Level Metric (O&M funding per person)	\$14.72	\$14.77	\$26.63
Calibrated Service Intermediate Headquarters Level Metric	821	818	454

Table 40. Intermediate Headquarters Calculation

Support Level Personnel Calibration	Service A	Service B	Service C
FY2011 DHPO&M Appropriation Amount	\$2,297	\$6,588	\$3,195
Total Support Level Personnel	831	705	532
Shared Services* Personnel (included in the Support Level)	383	68	157
Total Support Level Personnel less Shared Services*	448	637	375
Service Support Level Metric (O&M funding per person)	\$5.13	\$10.34	\$8.52
Calibrated Service Support Level Metric	2,355	1,168	1,418

Table 41. Support Level Personnel Calculation

Sizing Estimate for Management Headquarters

As shown in Table 42 below the personnel requirements of each MHS governance option considered was calculated, to include the minimum and maximum number of FTEs, and the differences between the as-is MHS governance construct was provided for each option to illustrate potential personnel savings.

For the case of DHA with MTFs in Military Departments option, the command and control elements of the Military Services medical departments are unchanged. This leads to a single point on the chart that describes the estimated staffing for this option. Discussion with the military departments suggested that this situation did not accurately present the option as the error in the data call would, at a minimum, result in a range of values. After deliberations, the military departments and the analytical team agreed to a $\pm 10\%$ variance to highlight the data accuracy of the analysis and underlying data. As the ranges for the other options were well beyond this 10% variance, it is not visible in Figure 18.

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Construct	Estimated Personnel Count	Difference	%	Steps Taken To Arrive At The Estimated Personnel Count	Estimated Personnel Count (Minimum)	Difference	Estimated Personnel Count (Maximum)	Difference
As-Is	6,136	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Single Service, Geographic Model	5,796	-340	-5.54%	Sum: (1) Service SG = 100 (2) ASD (HA) = 100 (3) Shared Services (TMA, TROs, IT, Pharmacy, Contracting, Facilities Planning, Education & Training, Research & Development, Logistics) = 3,774 (4) "Most Efficient" <u>Calibrated</u> Regional HQ [820 (AF), 818 (Army), 454 (Navy)] = 454 (Navy) (5) "Most Efficient" <u>Calibrated</u> Support Services [2,356 (AF), 1,168 (Army), 1,509 (Navy)] = 1,168 (Army)	5,796	-340	7,351	1,214
Single Service with Components	5,796	-340	-5.54%	Sum: (1) ASD(HA) = 100 (2) Service SG = 100 (3) Defense Healthcare System (TMA, TROs, IT, Pharmacy, Contracting, Facilities Planning, Education & Training, Research & Development, Logistics) = 3,774 (4) "Most Efficient" <u>Calibrated</u> Regional HQ [820 (AF), 818 (Army), 454 (Navy)] = 454 (Navy) (5) <u>Calibrated</u> Support Level (excluding Shared Services) = 1,418	5,796	-340	7,251	1,114
Hybrid 2: DHA with MTFs placed under the authority, direction, and control of the Agency	5,846	-290	-4.73%	Sum: (1) ASD(HA) = 100 (2) Service SG = 100 (3) Defense Healthcare System (TMA, TROs, IT, Pharmacy, Contracting, Facilities Planning, Education & Training, Research & Development, Logistics) = 3,774 (4) "Most Efficient" <u>Calibrated</u> Regional HQ [820 (AF), 818 (Army), 454 (Navy)] = 454 (Navy) (5) <u>Calibrated</u> Support Level (excluding Shared Services) = 1,418	5,846	-290	7,401	1,264
UMC Geographic Model	7,546	1,410	22.97%	Sum: (1) Service SG = 100 (2) USD (P&R) ASD (HA) = 100 (3) UMC (average of the estimate of 1,500-2,000) = 1,750 (4) Joint Medical Ops Command (TMA, IT, Pharmacy, Contracting, Facilities Planning, Education & Training, Research & Development, Logistics) = 3,443 (5) "Most Efficient" <u>Calibrated</u> Regional HQ [820 (AF), 818 (Army), 454 (Navy)] = 454 (Navy) (6) "Most Efficient" <u>Calibrated</u> Support Services [2,356 (AF), 1,168 (Army), 1,509 (Navy)] = 1,168 (Army)	7,546	1,410	9,101	2,964
Hybrid 3: Split UMC and Military-Led DHA Geographic Model	8,160	2,024	32.98%	Sum: (1) Service SG = 100 (2) ASD (HA) = 100 (3) UMC (average of the estimate of 1,500-2,000) = 1,750 (4) Defense Health Agency (TMA, TROs, IT, Pharmacy, Contracting, Facilities Planning) = 3,518 (5) JMOC (Education & Training, Research & Development, Logistics) = 256 (6) <u>Calibrated</u> Regional HQ [Median(820 (AF), 818 (Army), 454 (Navy))] = 818 (7) <u>Calibrated</u> Support Level (excluding Shared Services) [Median(2,356 (AF), 1,168 (Army), 1,509 (Navy))] = 1,509	7,546	1,410	9,101	2,964
Hybrid 5: Single Service with UMC	8,160	2,024	32.98%	Sum: (1) Service SG = 100 (2) Designated Service Secretary = 100 (3) UMC (average of the estimate of 1,500-2,000) = 1,750 (4) Defense Healthcare System (TMA, TROs, IT, Pharmacy, Contracting, Logistics) = 3,518 (5) JMOC (Education & Training, Research & Development, Public Health) = 256 (6) <u>Calibrated</u> Regional HQ [Median(820 (AF), 818 (Army), 454 (Navy))] = 818 (7) <u>Calibrated</u> Support Level (excluding Shared Services) [Median(2,356 (AF), 1,168 (Army), 1,509 (Navy))] = 1,509	7,546	1,410	9,101	2,964

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Construct	Estimated Personnel Count	Difference	%	Steps Taken To Arrive At The Estimated Personnel Count	Estimated Personnel Count (Minimum)	Difference	Estimated Personnel Count (Maximum)	Difference
UMC - HR 1540 Section 711 Model	8,160	2,024	32.98%	Sum: (1) Service SG = <u>100</u> (2) USD (P&R) ASD (HA) = <u>100</u> (3) UMC (average of the estimate of 1,500-2,000) = <u>1,750</u> (4) Healthcare Command = <u>100</u> (5) Modernization Doctrine & Personal Development Command / Defense Health Agency / Joint R&D Centers / Healthcare Support & Shared Services (TMA, TROs, IT, Pharmacy, Contracting, Facilities Planning, Education & Training, Research & Development, Logistics) = <u>3,774</u> (6) <i>Calibrated</i> Regional HQ [Median(820 (AF), 818 (Army), 454 (Navy))] = <u>818</u> (7) <i>Calibrated</i> Support Level (excluding Shared Services) [Median(2,356 (AF), 1,168 (Army), 1,509 (Navy))] = <u>1,509</u>	7,646	1,510	9,201	3,064
UMC with Service Components	7,910	1,774	28.91%	Sum: (1) ASD (HA) = <u>100</u> (2) Service SG = <u>100</u> (3) UMC (average of the estimate of 1,500-2,000) = <u>1,750</u> (4) Joint Medical Ops Command (PSC, TROs, IT, Pharmacy, Contracting, Facilities Planning, Education & Training, Research & Development, Logistics) = <u>3,774</u> (5) <i>Calibrated</i> Regional HQ [Median(820 (AF), 818 (Army), 454 (Navy))] = <u>818</u> (6) "Most Efficient" <i>Calibrated</i> Support Services [2,356 (AF), 1,168 (Army), 1,509 (Navy)] = <u>1,168</u> (Army)	7,546	1,410	9,101	2,964
Hybrid 1: DHA with MTFs Remaining in the Military Departments	6,136	0	0.00%	No change to the Management Headquarters Staffs	6,136	0	6,136	0
Hybrid 6: DHA with Regional MTFs	6,314	178	2.90%	Sum: (1) ASD (HA) or COCOM or SVC Secretary = <u>100</u> (2) Service SG = <u>100</u> (3) Defense Health Agency (TMA, TROs, IT, Pharmacy, Contracting, Facilities Planning) = <u>3,518</u> (4) MOSC (Education & Training, Research & Development, Logistics) = <u>256</u> (5) As-Is Regional HQ (excluding Shared Services & TMA) = <u>722</u> (6) <i>Calibrated</i> Support Level (excluding Shared Services) [Median(2,356 (AF), 1,168 (Army), 1,509 (Navy))] = <u>1,509</u>	6,216	80	6,530	394
Hybrid 4: UMC with DHA with Components	8,064	1,928	31.42%	Sum: (1) Service SG = <u>100</u> (2) ASD (HA) = <u>100</u> (3) UMC = <u>1,750</u> (4) Defense Health Agency (TMA, TROs, IT, Pharmacy, Contracting) = <u>3,473</u> (5) JMOC (Education & Training, Research & Development, Logistics, Facilities Planning) = <u>337</u> (6) As-Is Regional HQ = <u>722</u> (7) <i>Calibrated</i> Support Level (excluding Shared Services) [Median(2,356 (AF), 1,168 (Army), 1,509 (Navy))] = <u>1,509</u>	7,966	1,830	8,280	2,144

Table 42. MHS Governance Options Personnel Calculations

Sizing Estimate for the Shared Services

Table 43 shows the estimated personnel reductions of the shared services grouping. As described above in the Methodology section, this analysis applied the same "economies of scale" approach used in the 2006 study to account for savings associated with consolidating similar management headquarters functions. The values shown in the below columns labelled 'Number of Organizations Merging' and 'Reduction in Personnel' are the same values used to estimate personnel reductions in the 2006 study.

Shared Service	2011 Total As-Is Personnel Requirement	Number of Organizations Merging*	Reduction in Personnel (as % of cost without merger)*	Personnel Reductions*	2011 Total Personnel Requirement*
Contracting & Acquisition	153	3	20%	31	122
Education & Training	23	4	24%	6	17
Facility Planning	87	4	24%	21	66
Health IT	1,767	4	24%	424	1,343
Logistics	173	3	20%	35	138
Research & Development	243	3	20%	49	194
Total	2,446			566	1,880

* Based on the 2006 Study

Table 43. Shared Services Personnel Reductions

Range of Estimates for Task Force Options

Figure 18 shows the results of a sensitivity analysis of the five task Force options. This analysis was developed by varying the size of the Intermediate Headquarters and Support Agencies by using the maximum and minimum as determined by the metric. For the “As Is” option, there is no variance and only shows the current authorizations. For the DHA without MTFS the only difference from the “As Is” option is the enhanced shared services function. The analysis included a 10% variance around the point estimate after to account for the variance in the manpower data provided.

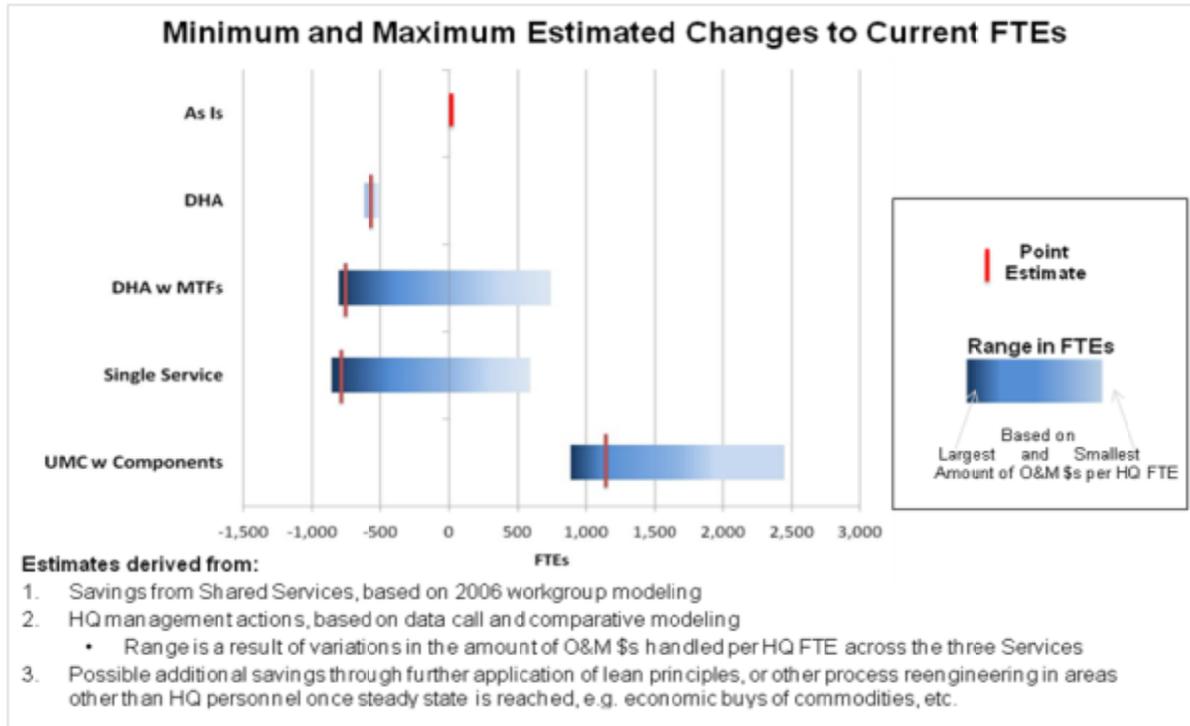


Figure 18. Estimated DHP Funded Minimum and Maximum Headquarters Staffing Changes

Excursion analysis

During the management review of the Task Force results and recommendations an excursion analysis was performed that alternatively addressed the sizing of the DHA and UMC. TRANSCOM Headquarters was determined to be the most similar to the UMC as a functional COCOM with daily mission elements requirements. This UMC manpower was also assumed to include all of the Support Agency manpower for the MHS. The Intermediate headquarters remained at the minimal level as a result of keeping the Component structure in the UMC. The results are shown in Table 44.

Management Level	As Is	DHA		UMC	
		w/o MTFs	with MTFs	Regions	Components
DHA/UMC HHQ	0	1168	1445	2601	2601
Service SGs and HA HHQ	406	406	346	346	346
Service IHQ/Geog Region HQ	735	735	454	454	818
Support Agencies	1221	0	0	0	0
Combat Support Agency	0	50	100	0	0
Total	2362	2359	2345	3401	3765

Table 44. Additional Benchmarking Analysis Using TRANSCOM

An additional alternative included the assumption that the DHA and UMC would absorb all of the Support Agency personnel from the services. This would allow the maximum available offset for the growth in the HQ size in these two alternatives. Table 45 below provides the results of this excursion analysis.

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Management Level	As Is	DHA		UMC		Comments
		w/o MTFs	with MTFs	Regions	Components	
DHA/UMC Higher HQ	0	1168	1445	2918	2918	UMC is a median number among the COCOMs (see chart below), offset from the Support Agency migration from Svcs to UMC.
Service SGs and ASD(HA) High	406	406	346	346	346	Core SG and HA support functions; SGs/HA may or may not retain programming (-60FTEs)
Service IHQ/Geog Region HQ	735	735	454	454	818	Reduction from elimination of overlapping IHQs; UMC: Increases due to Retaining and Standardizing IHQ across Services Components HQ
Support Agencies	1221	0	0	0	0	Support Agencies of the Services migrate to the UMC and DHA
Combat Support Agency	0	50	100	0	0	
Total	2362	2359	2345	3718	4082	

Notes:

1. JTF CAPMED J-Staff authorizations are 157. NCR has approximately 8-10% of the MHS workload, including GME, but not including R&D, E&T, Public Health. Therefore 1750 is thought to be a good estimate of scaling up to a UMC
2. DHA, operating within the OSD will not require the overhead of a UMC as it participates in the UCP, multiple interface requirements across the COCOMs, four-star support, etc.

Table 45. Maximum Offset for Projected DHA and UMC Headquarters Growth

Appendix A. Acronym List

Acronym	Definition
AOR	Area of Responsibility
ASD	Assistant Secretary of Defense
BRAC	Base Realignment and Closure
CAPE	Cost Assessment and Program Evaluation
CJCS	Chairman of the Joint Chiefs of Staff
COCOM	Combatant Command
CONOPS	Concept of Operations
CSA	Chief of Staff, Army/Combat Support Agency
DA&M	Director of Administration and Management
DCMO	Deputy Chief Management Officer
DHA	Defense Health Agency
DHP	Defense Health Program
DMOC	Defense Medical Oversight Committee
DoD	Department of Defense
EAC	Executive Advisory Committee
eMSMO	Enhanced multi-Service market Office
FBCH	Fort Belvoir Community Hospital
FOC	Full Operating Capability
FTE	Full Time Equivalent
GME	Graduate Medical Education
HA	Health Affairs
IOC	Initial Operating Capability
JMD	Joint Manning Document
JOA	Joint Operations Area
JTD	Joint Table of Distribution
JTF CAPMED	Joint Task Force National Capital Region Medical
MHS	Military Health System
MHSSA	Military Health System Support Activity
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding

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Acronym	Definition
MSM	multi-Service market
MTF	Medical Treatment Facilities
NCR	National Capital Region
NORTHCOM	United States Northern Command
OGC	Office of the General Counsel
OLA	Office of Legislative Affairs
OSD	Office of the Secretary of Defense
P&R	Personnel and Readiness
PEO	Program Executive Officer
SECDEF	Secretary of Defense
TDA	Table of Distribution and Allowance
TMA	TRICARE Management Activity
TOE	Table of Organization and Equipment
UCP	Unified Command Plan
UMC	Unified Medical Command
USD	Under Secretary of Defense
WII	Wounded, Ill and Injured
WRNMMC	Walter Reed National Military Medical Center