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September 29, 2017

The Honorable John McCain  
Chairman  
The Honorable Jack Reed  
Ranking Member  
Committee on Armed Services  
United States Senate

The Honorable Mac Thornberry  
Chairman  
The Honorable Adam Smith  
Ranking Member  
Committee on Armed Services  
House of Representatives

**Defense Health Reform: Steps Taken to Plan the Transfer of the Administration of the Military Treatment Facilities to the Defense Health Agency, but Work Remains to Finalize the Plan**

The Department of Defense’s (DOD) Military Health System (MHS) provides health care to more than 9 million beneficiaries, including service members, retirees, and their family members, through the direct and purchased care systems. Military treatment facilities (MTFs) are part of the direct care system.<sup>1</sup> In September 2013, DOD established the Defense Health Agency (DHA) to assume management responsibility for numerous functions of the MHS, among other things.<sup>2</sup> DHA also exercises authority, direction, and control over the MTFs in the National Capital Region—the Walter Reed National Military Medical Center, the Fort Belvoir

<sup>1</sup>The direct care system, which represents health care facilities and medical support organizations owned by DOD and managed by the Services’ respective Surgeons General, includes military hospitals, ambulatory care clinics, and dental clinics (i.e., MTFs), among other facilities. Through regional contracts, TRICARE administers the purchased care system, which comprises a civilian network of hospitals and providers.

<sup>2</sup>As part of our continuing assessment of opportunities to reduce duplication and achieve cost savings across the federal government, we recommended in 2012, prior to the creation of the DHA, that DOD (1) develop an overall monitoring process across its portfolio of health care initiatives for overseeing progress and identifying accountable officials, and (2) fully implement management dashboards and detailed implementation plans for its health care initiatives. DOD implemented the first recommendation but, as of March 2017, had not yet fully implemented the second. Specifically, DOD has not fully developed performance metrics and cost estimates for each of the initiatives. See *2012 Annual Report: Opportunities to Reduce Duplication, Overlap and Fragmentation, Achieve Savings, and Enhance Revenue*, [GAO-12-342SP](#) (Washington, D.C.: Feb 28, 2012) and *Defense Health Care: Applying Key Management Practices Should Help Achieve Efficiencies within the Military Health System*, [GAO-12-224](#) (Washington, D.C.: Apr 12, 2012). Further, we have issued multiple reports on defense health care reform specific to DHA. For example, in fiscal year 2014 we recommended that—in order to provide decision makers with more complete information on the planned implementation, management, and oversight of DOD’s newly created DHA—DOD should monitor implementation costs to assess whether the shared services projects are on track to achieve projected net cost savings. DOD concurred with this recommendation and has taken steps to implement some of the changes; as a result, we have identified financial savings. See *Defense Health Care Reform: Additional Implementation Details Would Increase Transparency of DOD’s Plans and Enhance Accountability*, [GAO-14-49](#) (Washington D.C.: Nov 6, 2013).

Community Hospital, and the Joint Pathology Center.<sup>3</sup> The National Defense Authorization Act (NDAA) for Fiscal Year 2017 amended Chapter 55 of title 10, United States Code, to include a new section; “1073c Administration of Defense Health Agency and military medical treatment facilities.” According to the section, the Director of the DHA, beginning October 1, 2018, shall be responsible for the administration of each MTF, including with respect to budgetary matters, information technology, and health care administration and management, among other things.<sup>4</sup> Further, the House Conference Report accompanying the NDAA for Fiscal Year 2017 noted that the creation of a single agency responsible for all MTFs would best improve and sustain readiness, reduce costs, and increase efficiency.<sup>5</sup> Currently, the MTFs—which consist of approximately 680 hospitals and clinics—are under the direction and control of the services.<sup>6</sup> According to DHA officials, the Fiscal Year 2017 budget request includes over \$8 billion for the MTFs.<sup>7</sup>

Section 702 of the NDAA for Fiscal Year 2017 requires that the Secretary of Defense develop an implementation plan that includes, among other requirements, how the Secretary will carry out the transfer of the administration of the MTFs and eliminate duplicative activities.<sup>8</sup> The act requires that DOD’s implementation plan include the following elements: (A) how the Secretary will carry out subsection (a) of section 1073c of title 10 of the United States Code (i.e., how DHA will take administrative responsibility of the MTFs); (B) efforts to eliminate duplicative activities carried out by the elements of the DHA and military departments; (C) efforts to maximize efficiencies in the activities carried out by the DHA; and (D) how the Secretary will implement section 1073c in a manner that reduces the number of members of the armed forces, civilian employees who are full-time equivalent employees, and contractors relating to the headquarters activities of the military health system, as of the date of the enactment of the act. Section 1073c of title 10 of the United States Code is reproduced in the enclosure.<sup>9</sup>

DOD provided Congress with two interim reports concerning the department’s preliminary draft of the implementation plan: the first on March 31, 2017, and the second on June 30, 2017. Section 702 of the NDAA for Fiscal Year 2017 also includes a provision for us to review the department’s interim report on the preliminary draft of the implementation plan, as well as to

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<sup>3</sup> DHA also has authority, direction, and control over subordinate clinics of the Walter Reed National Military Medical Center and the Fort Belvoir Community Hospital. Department of Defense, Directive 5136.13, *Defense Health Agency (DHA)* (Sept. 30, 2013).

<sup>4</sup> Pub. L. No. 114-328, § 702 (2016).

<sup>5</sup> H.R. Conf. Rep. No. 114-840, at 1066 (2016).

<sup>6</sup> As required by section 702 of Public Law 114-328, effective October 1, 2018, DHA shall be responsible for the administration of all MTFs, including the MTFs currently within its authority.

<sup>7</sup> DHA’s May 2017 report to Congress estimated direct care expenditures for Fiscal Year 2017 would be approximately \$17 billion representing the largest portion of the department’s total estimate of \$52.6 billion for the Unified Medical Program. The estimated direct care expenditures for Fiscal Year 2017 include MTFs. DHA, *Evaluation of the Tricare Program, Fiscal Year 2017 Report to Congress, Access, Cost, and Quality Data through Fiscal Year 2016*, (May 2017).

<sup>8</sup> The interim report on the department’s preliminary draft of the implementation plan was due by March 1, 2017, and the final report on the implementation plan is due by March 1, 2018.

<sup>9</sup> These four elements will hereinafter be referred to as “element (A),” “element (B),” “element (C),” and “element (D),” respectively.

review the final version of the implementation plan, which is due by March 1, 2018. In this report we describe the status of DOD's efforts in developing the preliminary draft of the implementation plan to address the requirements of identifying how the DHA will (1) take administrative responsibility of the MTFs and (2) eliminate duplicative activities, maximize efficiencies in the activities it carries out, and reduce headquarters staff.

We reviewed and compared DOD's March 2017 and June 2017 interim reports on the department's preliminary draft of the implementation plan to Congress with the requirements in section 702 of the NDAA for Fiscal Year 2017. Specifically, we reviewed DOD's interim reports for information concerning each of the implementation plan requirements and the status of those activities. In addition, we reviewed DOD's planning documents, such as memorandums and a draft Deliverables Work Plan about implementation efforts from the work group (hereinafter referred to as the 702 Work Group) established by the Deputy Secretary of Defense to lead the changes related to section 702.<sup>10</sup> To obtain information and details beyond the March and June 2017 interim reports about DOD's actions and planning efforts to address the requirements in section 702 of the NDAA for Fiscal Year 2017, we interviewed members of the 702 Work Group, including the Chair and primary members from organizations within DOD: the DHA; the Deputy Chief Management Officer; the Army Medical Command, the Office of the Surgeon General; the Navy Bureau of Medicine and Surgery; the Air Force Medical Service; and the Joint Staff Surgeon.

We conducted this performance audit from May 2017 to September 2017 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

### **DOD Has Taken Steps to Address How It Plans to Transfer the Administrative Responsibility for the Military Treatment Facilities, but Significant Work Remains to Finalize the Implementation Plan**

In the March 2017 and June 2017 interim reports, DOD summarizes roles and responsibilities at a high level to address how DHA will take administrative responsibility of the MTFs (i.e., element (A)), but a significant amount of work remains to complete the implementation plan by March 1, 2018—the due date of the department's final report on its planned implementation. For example, DOD identified the major functions required to operate the MTFs and also identified two lines of effort that explain how DHA will manage and administer the MTFs.<sup>11</sup> However, our review of the August 2017 draft Deliverables Work Plan found that a significant amount of work is still needed to complete the implementation plan for how the reform will be accomplished. For example, the draft Deliverables Work Plan showed that the work group still needed to define readiness functions, define the organizational structure, and define the governance structure, among other things. According to the draft Deliverables Work Plan, some of this work is not scheduled to begin until September 2017, and some of these items will not be complete until December 2017. Additionally, most of the primary members of the 702 Work Group stated that the work on the implementation plan needed for element (A) (i.e., how DHA will take

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<sup>10</sup>The 702 Work Group includes senior officials from organizations within DOD, such as from the Office of the Assistant Secretary of Defense for Health Affairs, the DHA, service medical components, and Joint Staff, among others. There are multiple members of the 702 Work Group; however, only some are primary members.

<sup>11</sup>According to DOD's June 2017 interim report, the lines of effort are (1) building health care delivery capability and (2) managing the MTFs in geographic markets.

administrative responsibility of the MTFs) is not complete. Specifically, primary members stated that the department has a significant amount of work remaining to understand how it will address and accomplish the requirements for element (A). Members also stated that the 702 Work Group has yet to define the component model structure (i.e., the administrative model the department will use to achieve DHA reform requirements for section 702) in sufficient detail needed to establish the future state of the DHA.<sup>12</sup>

Regarding the appointment of DHA positions—such as the Assistant Director for Health Care Administration—to provide policy, oversight, and direction to carry out subsection (a) of section 1073c of title 10 of the United States Code, neither the March 2017 nor June 2017 interim reports provided information about this requirement. In August 2017, a DHA official and the 702 Work Group Chair provided us with an update on the status of appointing these DHA positions. According to these officials, position descriptions and recruitment actions for a Senior Executive Service career appointee have been approved for the positions of Assistant Director for Health Care Administration and Deputy Assistant Director for Financial Operations and are underway. These officials added that they expect recruitment will start in August 2017 for those two positions and that remaining positions will likely be sourced from the DHA, service civilians, or military senior leaders through the consolidation of service functions.

### **DOD Has Taken Steps to Address How It Plans to Eliminate Duplication, Maximize Efficiencies, and Reduce Staff, but Specific Details Remain under Development**

The department's March 2017 and June 2017 interim reports include information about eliminating duplicative activities, maximizing efficiencies in the activities carried out by the DHA, and reducing headquarters staff (i.e., elements (B), (C), and (D)), but specific details related to these elements are under development. According to both interim reports, details related to elements (B), (C), and (D) will not be available until the department issues its final report on the implementation plan on March 1, 2018. Specifically, the June 2017 interim report stated that in order for the department to eliminate duplicative activities, maximize efficiencies, and reduce headquarters staffing across the MHS, it must first complete an analysis by comparing “future state” requirements under the component model with “current state” resources. Further, according to an August 2017 draft Deliverables Work Plan, the 702 Work Group has begun efforts to define the future state of the DHA under the component model. Specifically, the 702 Work Group has begun to conduct reengineering efforts on six major functions and plans to define long-term plans related to DHA efficiencies, among other things.<sup>13</sup> A primary member of the 702 Work Group told us that much of the work related to, for example, how the department will eliminate duplicative activities carried out by the DHA and the MTFs and maximize efficiencies in the activities carried out by the DHA was not complete.

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<sup>12</sup>In its March 2017 interim report, DOD revealed the selection of the component model as the administrative model it will use to achieve the DHA reform requirements specified in section 702. Although dental clinics are part of the MTFs, the 702 Work Group Chair told us that the 702 Work Group, as of August 2017, had not yet included dental clinics in the scope of implementation planning efforts.

<sup>13</sup>According to an August 2017 draft Work Stream Proposal, defining the “future state” is one of the three work streams that will provide material information contributing to the development of the implementation plan. The two other work streams are to conduct a baseline analysis of the “current state” and develop an operational construct to be in place on October 1, 2018. The Office of the Assistant Secretary of Defense for Health Affairs also issued several memorandums appointing the leads for each of the work streams on August 4, 2017.

The department is also conducting a review of the programmed management headquarters activities.<sup>14</sup> The terms of reference accompanying an April 2017 Deputy Secretary of Defense memorandum states that two of the desired outcomes of this review are to develop opportunities to reduce headquarters-related activities and to submit a comprehensive plan to reduce these activities by 25 percent.<sup>15</sup> The 702 Work Group Chair told us that the 25 percent goal was not based on analysis completed by the 702 Work Group. Rather, the Chair said that the 25-percent target was mutually agreed upon by the Assistant Secretary of Defense for Health Affairs and the Deputy Chief Management Officer in developing the terms of reference attached to the April 2017 Deputy Secretary of Defense memorandum; the goal was set at the lower end of expected savings with the understanding that the final report would contain better estimates. Because much of the department's work related to elements (B), (C), and (D) remain to be completed, it is too soon to fully assess how the department's efforts to address these elements will eliminate duplicative activities, maximize efficiencies, or reduce headquarters staffing. Therefore, we are not making any recommendations at this time concerning DOD's implementation plan. We will continue to monitor the department's efforts and provide a detailed review of the final implementation plan.

### Agency Comments

We provided a draft of this report to DOD for review and comment. DOD did not have any comments on the draft.

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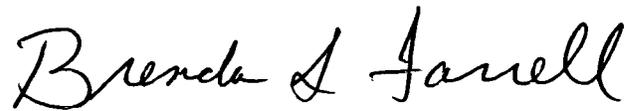
We are sending copies of this report to the appropriate congressional committees, the Secretary of Defense, the Assistant Secretary of Defense (Health Affairs), DOD's Deputy Chief Management Officer, the Defense Health Agency Director, the Surgeon General of the Army, the Surgeon General of the Navy, and the Surgeon General of the Air Force. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

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<sup>14</sup>Since 2012, we have reported on the prior growth in DOD's headquarters-related activities, the difficulties of accounting for the resources, functions, and costs associated with headquarters activities, and the department's efforts to pursue reductions in headquarters staff. In July 2017, we found that DOD's projected cost savings estimate was unreliable because DOD-provided documentation, when compared with best practices for cost estimates, was not sufficiently detailed to support the estimate. According to DOD's internal assessment, the \$5.3 billion in cost savings identified in DOD's May 2015 *Plan for Streamlining DOD Management Headquarters: Section 904 Initial and Status Report to Congress* were "not auditable" because the baseline for reductions had not been established, among other reasons. We recommended that DOD develop reliable cost savings estimates that include detailed information and documentation. DOD partially concurred with this recommendation and has not implemented it. See *Defense Efficiency Initiatives: DOD Needs to Improve the Reliability of Cost Savings Estimates*, [GAO-17-724](#) (Washington, D.C.: July 24, 2017).

<sup>15</sup>See Deputy Secretary of Defense Memorandum and the attached Terms of Reference, *Military Health System Reform*, (Apr. 27, 2017).

If you or your staff have questions concerning this report, please contact me at (202) 512-3604 or [farrellb@gao.gov](mailto:farrellb@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report include Lori Atkinson, Assistant Director; Edward W. Anderson, Jr.; Alexandra E. Gonzalez; Rebecca Guerrero; Mae Jones; and Amber Sinclair.

A handwritten signature in black ink that reads "Brenda S. Farrell". The signature is written in a cursive, flowing style.

Brenda S. Farrell  
Director, Defense Capabilities and Management

Enclosure

## Enclosure: Section 1073c of Title 10, United States Code

The National Defense Authorization Act for Fiscal Year 2017 amended Chapter 55 of title 10, United States Code, to include a new section: § 1073c *Administration of Defense Health Agency and military medical treatment facilities*. Section 1073c reads as follows:

### Figure 1: Section 1073c. Administration of Defense Health Agency and Military Medical Treatment facilities

- (a) Administration of military medical treatment facilities.
  - (1) Beginning October 1, 2018, the Director of the Defense Health Agency shall be responsible for the administration of each military medical treatment facility, including with respect to--
    - (A) budgetary matters;
    - (B) information technology;
    - (C) health care administration and management;
    - (D) administrative policy and procedure;
    - (E) mili[t]ary medical construction; and
    - (F) any other matters the Secretary of Defense determines appropriate.
  - (2) The commander of each military medical treatment facility shall be responsible for--
    - (A) ensuring the readiness of the members of the armed forces and civilian employees at such facility; and
    - (B) furnishing the health care and medical treatment provided at such facility.
  - (3) The Secretary of Defense shall establish within the Defense Health Agency a professional staff to provide policy, oversight, and direction to carry out subsection (a). The Secretary shall carry out this paragraph by appointing the positions specified in subsections (b) and (c).
- (b) DHA Assistant Director.
  - (1) There is in the Defense Health Agency an Assistant Director for Health Care Administration. The Assistant Director shall--
    - (A) be a career appointee within the Department; and
    - (B) report directly to the Director of the Defense Health Agency.
  - (2) The Assistant Director shall be appointed from among individuals who have equivalent education and experience as a chief executive officer leading a large, civilian health care system.
  - (3) The Assistant Director shall be responsible for the following:
    - (A) Establishing priorities for health care administration and management.
    - (B) Establishing policies, procedures, and direction for the provision of direct care at military medical treatment facilities.
    - (C) Establishing priorities for budgeting matters with respect to the provision of

direct care at military medical treatment facilities.

**(D)** Establishing policies, procedures, and direction for clinic management and operations at military medical treatment facilities.

**(E)** Establishing priorities for information technology at and between the military medical treatment facilities.

**(c)** DHA Deputy Assistant Directors.

**(1)** **(A)** There is in the Defense Health Agency a Deputy Assistant Director for Information Operations.

**(B)** The Deputy Assistant Director for Information Operations shall be responsible for policies, management, and execution of information technology operations at and between the military medical treatment facilities.

**(2)** **(A)** There is in the Defense Health Agency a Deputy Assistant Director for Financial Operations.

**(B)** The Deputy Assistant Director for Financial Operations shall be responsible for the policy, procedures, and direction of budgeting matters and financial management with respect to the provision of direct care across the military health system.

**(3)** **(A)** There is in the Defense Health Agency a Deputy Assistant Director for Health Care Operations.

**(B)** The Deputy Assistant Director for Health Care Operations shall be responsible for the policy, procedures, and direction of health care administration in the military medical treatment facilities.

**(4)** **(A)** There is in the Defense Health Agency a Deputy Assistant Director for Medical Affairs.

**(B)** The Deputy Assistant Director for Medical Affairs shall be responsible for policy, procedures, and direction of clinical quality and process improvement, patient safety, infection control, graduate medical education, clinical integration, utilization review, risk management, patient experience, and civilian physician recruiting.

**(5)** Each Deputy Assistant Director appointed under paragraphs (1) through (4) shall report directly to the Assistant Director for Health Care Administration.

**(d)** Certain responsibilities of DHA Director.

**(1)** In addition to the other duties of the Director of the Defense Health Agency, the Director shall coordinate with the Joint Staff Surgeon to ensure that the Director most effectively carries out the responsibilities of the Defense Health Agency as a combat support agency under section 193 of this title.

**(2)** The responsibilities of the Director shall include the following:

**(A)** Ensuring that the Defense Health Agency meets the operational needs of the commanders of the combatant commands.

**(B)** Coordinating with the military departments to ensure that the staffing at the military medical treatment facilities supports readiness requirements for members of the armed forces and health care personnel.

**(e) Definitions.** In this section:

- (1)** The term "career appointee" has the meaning given that term in section 3132(a)(4) of title 5.
- (2)** The term "Defense Health Agency" means the Defense Agency established pursuant to Department of Defense Directive 5136.13, or such successor Defense Agency.

Source: Pub. L. No. 114-328, § 702 (2016)| GAO-17-791R

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