



August 2023

DEFENSE HEALTH CARE

DOD Should Reevaluate Market Structure for Military Medical Treatment Facility Management

Accessible Version

GAO Highlights

Highlights of [GAO-23-105441](#), a report to congressional committees

Why GAO Did This Study

The National Defense Authorization Act for Fiscal Year 2017 mandated sweeping reforms to the military health system, including transitioning military medical treatment facilities to DHA. These facilities deliver health care to service members to ensure their medical readiness. The facilities also provide essential on-the-job training for active-duty medical providers, and care for service members' families, retirees, and other eligible beneficiaries.

The joint explanatory statement accompanying the Consolidated Appropriations Act for Fiscal Year 2021 includes a provision for GAO to review the transition. This report examines (1) the status of the transition of facilities to DHA management, and the extent to which DHA has (2) addressed any transition-related staffing challenges and (3) identified cost savings and assessed efficiency initiatives.

GAO reviewed DOD reports and briefings and analyzed data on medical headquarters personnel numbers and budgetary resources, both before and after the transition. GAO interviewed DOD officials from six market offices and six facilities selected on the basis of market establishment date, patients served, and location.

What GAO Recommends

GAO recommends that DOD (1) reevaluate its market structure for facility management and (2) establish performance goals for reform initiatives and monitor savings. DOD concurred with the first recommendation and partially concurred with the second. GAO continues to believe the second recommendation is warranted, as discussed in the report.

View [GAO-23-105441](#). For more information, contact Brenda S. Farrell at (202) 512-3604 or FarrellB@gao.gov.

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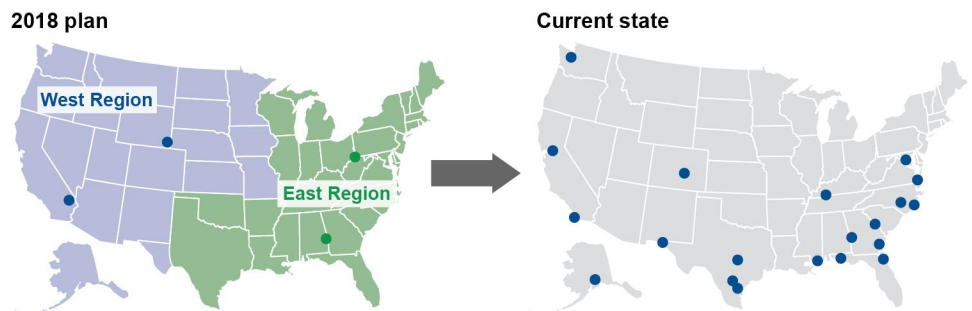
DOD Should Reevaluate Market Structure for Military Medical Treatment Facility Management

What GAO Found

In November 2022, the Department of Defense (DOD) completed its multiyear transition of military medical treatment facilities from the military departments—the Army, the Navy, and the Air Force—to the Defense Health Agency (DHA). This means DHA is responsible for the management and administration of about 700 facilities (including dental clinics) in the United States and overseas. DOD accomplished the transition with a series of steps following a 2019 plan. For example, DHA grouped facilities into 36 markets in the United States and two regions overseas and established 22 offices to manage them. DHA relies on the military departments to provide active-duty personnel to staff the facilities and the offices, and augments them with civilian employees and contractors.

DHA is working to mitigate staffing shortfalls at the military medical treatment facilities that predated the transition. For example, DHA and the military departments agreed on a process to staff military personnel to all facilities in 2024 and beyond. However, DOD has not studied and validated the number of personnel required to staff the market and regional offices. The estimate of over 1,400 personnel for the 22 offices could be higher than needed and exceeds expected budgetary and personnel resources. DHA has faced difficulties staffing these offices with military and civilian personnel in the first years of operations. Yet, DOD has not reevaluated the efficiency of the current structure since adopting it in 2019 to replace the 2018 plan. The 2018 plan would have established two U.S. regions with two offices each, compared with the 2019 plan's 20 offices to manage 36 markets (see fig.). Until DOD reevaluates the efficiency of the market structure and updates personnel requirements, DOD may risk not accomplishing its vision for an integrated health delivery system that efficiently uses available personnel and budgetary resources.

Changes to DHA's Management Structure for Military Medical Treatment Facilities



Source: GAO presentation of Department of Defense & Defense Health Agency (DHA) information; MapResources. | GAO-23-105441

Note: The two DHA overseas regions did not change after 2018 and so are not shown here.

DOD officials stated that the transition may lead to savings in future years as DHA matures its managerial capabilities, but GAO found that the extent to which DOD has realized or will realize savings is unclear. For example, in fiscal year 2022, DHA began 10 initiatives reforming clinical and business processes to save over \$1.6 billion by fiscal year 2026. However, DOD

officials were unable to identify performance goals to track execution of the initiatives. Without doing so, DOD may not know whether the initiatives are achieving intended cost savings.

Contents

GAO Highlights		ii
	Why GAO Did This Study	ii
	What GAO Recommends	ii
	What GAO Found	ii
Letter		1
	Background	4
	DOD Has Completed the Transition of MTFs to DHA’s Management, with Continued Military Department Support for Some Functions	10
	DHA Faces Challenges Providing Personnel Needed to Staff MTFs and Market and Regional Offices	17
	DHA Is Working to Identify Future Efficiencies and Cost Savings, but Is Not Tracking Achievement of Efficiency Initiatives Underway	33
	Conclusions	40
	Recommendations for Executive Action	41
	Agency Comments and Our Evaluation	41
Appendix I: Objectives, Scope, and Methodology		44
Appendix II: Comments from the Department of Defense		48
Appendix III: GAO Contact and Staff Acknowledgments		52
	GAO Contact	52
	Staff Acknowledgments	52
Related GAO Products		53
Table		
	Table 1: Numbers of Military and Civilian Personnel Required for Defense Health Agency Market and Regional Management Offices, Fiscal Year 2023 through Fiscal Year 2027	25
Figures		
	Changes to DHA’s Management Structure for Military Medical Treatment Facilities	ii
	Figure 1: Organizational Structure of the Military Health System	5

Figure 2: Market and Regional Structure for Military Medical Treatment Facility Management	13
Figure 3: Defense Health Program Operation and Maintenance Amounts, Fiscal Year 2016 through Fiscal Year 2023	35
Data table for Figure 3: Defense Health Program Operation and Maintenance Amounts, Fiscal Year 2016 through Fiscal Year 2023	35

Abbreviations

ASD(HA)	Assistant Secretary of Defense for Health Affairs
DHA	Defense Health Agency
DOD	Department of Defense
MTF	medical treatment facility

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August 21, 2023

Congressional Committees

In 2016, Congress initiated sweeping military health system reforms, including a requirement for the transfer of hospitals, medical centers, and clinics (collectively referred to as military medical treatment facilities, or MTFs) from the military departments to a then-3-year-old organization called the Defense Health Agency (DHA).¹ These MTFs deliver health care to service members to help ensure their medical readiness, and provide essential on-the-job training for military medical providers. The MTFs also deliver health care to service members' families, retired service members and their families, dependent survivors, and certain reserve component members and their families. The Senate and House Armed Services Committees cited the need to create a more efficient oversight structure for the MTFs that would lower costs while improving beneficiary care.² With the enactment of the National Defense Authorization Act for Fiscal Year 2017, the President and Congress set in motion one of the largest reorganizations in the history of the Department of Defense (DOD). The Surgeons General of the Army and the Air Force have called the transition "extremely difficult" and "a complicated merger of four cultures."³

From March 2017 through June 2018, DOD provided the Senate and House Armed Services Committees with three interim reports and a final

¹Pub. L. No. 114-328, § 702 (2016), codified as amended at 10 U.S.C. § 1073c. For the purposes of this report, we use the term military medical treatment facilities (MTFs) to include dental clinics.

²S. Rep. No. 114-255, at 183 (2016) and H.R. Rep. No. 114-840, at 1066 (2016) (Conf. Rep.).

³Lieutenant General R. Scott Dingle, U.S. Army, and Lieutenant General Dorothy A. Hogg, U.S. Air Force, *Defense Health Program (DHP)*, testimony before the House Appropriations Committee Subcommittee on Defense, 116th Cong., 2nd sess., March 5, 2020.

report on its plans for executing the MTF transition.⁴ Our prior work assessed these plans and is discussed later in this report. In August 2019, DHA completed its final plan for implementing the MTF transition, which remained current throughout our review.⁵ The 2019 plan described in detail the multiyear transition of the MTFs to DHA through the end of fiscal year 2021, including the phased divestiture of military department responsibilities.

The management approach described in the plan divided MTFs in the United States into groups called markets based on geographic proximity and facility type. According to the plan, a market is a group of MTFs that operate as a system, sharing patients, health care providers, functions, budgets, and a market office for management, across facilities. Outside the United States, the plan divided MTFs into two regions (one for the Indo-Pacific and one for Europe), with one regional office to manage each region. The 2019 plan further established the functions and structure of the market and regional offices, along with the responsibilities of personnel in the market and regional offices and DHA headquarters.

The joint explanatory statement accompanying the Consolidated Appropriations Act for Fiscal Year 2021 includes a provision for us to review the status and various aspects of the transition, including the ongoing role of the military departments and any plans to achieve savings

⁴Department of Defense, *Report to the Armed Services Committees of the Senate and House of Representatives, Plan to Implement Section 1073c of Title 10, United States Code, Interim Report – Preliminary Draft* (Mar. 31, 2017); Department of Defense, *Report to the Armed Services Committees of the Senate and House of Representatives, Plan to Implement Section 1073c of Title 10, United States Code, Second Interim Report* (June 30, 2017); Department of Defense, *Report to the Armed Services Committees of the Senate and House of Representatives, Preliminary Draft Plan to Implement 1073c of Title 10, United States Code, Interim Report* (Mar. 31, 2018); and Department of Defense, *Report to the Armed Services Committees of the Senate and House of Representatives, Final Plan to Implement Section 1073c of Title 10, United States Code, Final Report* (June 30, 2018). We reported on DOD's first two interim reports in September 2017 and on DOD's final plan in October 2018. See GAO, *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*, [GAO-17-791R](#) (Washington, D.C.: Sept. 29, 2017); and *Defense Health Care: DOD Should Demonstrate How Its Plan to Transfer the Administration of Military Treatment Facilities Will Improve Efficiency*, [GAO-19-53](#) (Washington, D.C.: Oct. 30, 2018).

⁵Defense Health Agency, *Plan 3: Implementation Plan for the Complete Transition of Military Medical Treatment Facilities to the Defense Health Agency*, Version 6.0 (August 12, 2019).

and efficiencies.⁶ This report examines (1) the status of DOD's transition of the MTFs to DHA management, and the extent to which DHA has (2) addressed any transition-related challenges with staffing the MTFs and DHA's management organizations and (3) identified cost savings associated with the transition and assessed the effectiveness of efficiency initiatives.

For objective one, we reviewed DHA's August 2019 implementation plan, DOD briefings, and other documentation on actual milestones accomplished related to the transition. We also analyzed DHA's personnel data for fiscal years 2018 and 2023, and the military departments' medical headquarters personnel data for fiscal years 2017 and 2022, for before and after the MTF transition.

For objective two, to understand staffing challenges, we interviewed personnel from a non-generalizable sample of six market offices and six MTFs that we selected to reflect a range in market establishment dates, number of patients served, and geographic locations. We reviewed DOD medical headquarters studies and our prior work on the MTF transition and medical personnel. Further, we analyzed data on personnel requirements, authorizations, and staffing for DHA's headquarters and market and regional offices, and compared DHA's process for determining requirements with DOD guidance.⁷ To identify changes to implementation plans, we compared DOD's June 2018 report to Congress with DHA's August 2019 plan.

For objective three, we reviewed DOD budget documents for fiscal year 2016 through fiscal year 2023 to identify trends over time in nominal and real dollars, and to identify any resource changes that DOD expected and attributed to the MTF transition. We reviewed DOD's June 2018 report to Congress and other documents about the MTF transition to identify financial goals. We compared information about DOD's processes to

⁶166 Cong. Rec. H2858 (daily ed. Dec. 21, 2020). The joint explanatory statements accompanying the Consolidated Appropriations Acts for fiscal years 2022 and 2023 similarly included provisions for us to review the status and various aspects of the transition. 168 Cong. Rec. H2156 (daily ed. Mar. 9, 2022); 168 Cong. Rec. S7819 (daily Ed. Dec. 20, 2022). In April 2020, the Deputy Secretary of Defense approved a pause in the transition of MTFs to DHA due to the COVID-19 pandemic; in turn, we began our work for this review in October 2021.

⁷Department of Defense Directive 1100.4, *Guidance for Manpower Management* (Feb. 12, 2005).

track cost savings with criteria from GAO's *Business Process Reengineering Assessment Guide*.⁸

For all three objectives, we interviewed various DOD officials across components of the military health system. We provide further details on our scope and methodology in appendix I.

We conducted this performance audit from October 2021 to August 2023 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.

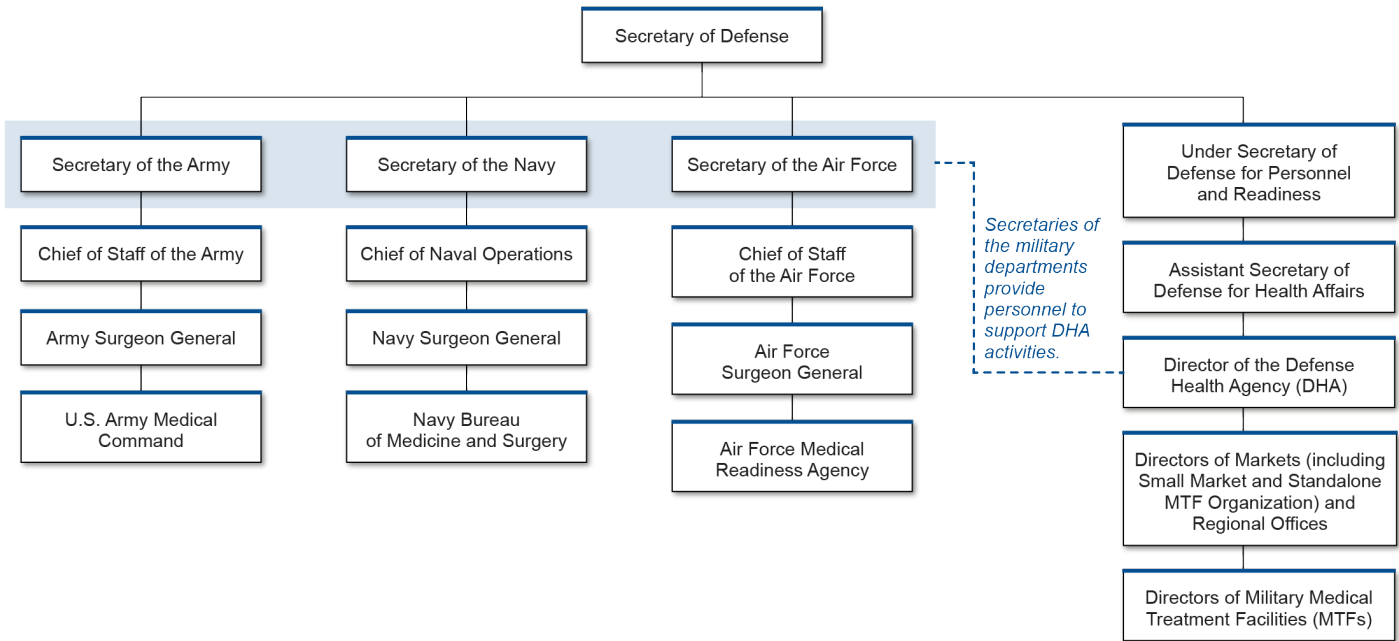
Background

Key Roles and Responsibilities in the Military Health System

The military health system is a complex enterprise. DHA is responsible for health care delivery, and the responsibility for medical readiness is shared among the military departments—the Army, the Navy, and the Air Force—and DHA. The Office of the Secretary of Defense provides oversight of the military health system. Figure 1 illustrates the hierarchy of responsibilities executed within the military health system.

⁸GAO, *Business Process Reengineering Assessment Guide—Version 3*, [GAO/AIMD-10.1.15](#) (Washington, D.C.: May 1997).

Figure 1: Organizational Structure of the Military Health System



Source: GAO analysis of Department of Defense information. | GAO-23-105441

The Under Secretary of Defense for Personnel and Readiness is the principal staff assistant and advisor to the Secretary of Defense for health-related matters, and, in that capacity, develops policies, plans, and programs for health and medical affairs.⁹

The Assistant Secretary of Defense for Health Affairs (ASD(HA)) serves as the principal advisor to the Under Secretary of Defense for Personnel and Readiness for all DOD health-related policies, programs, and activities.¹⁰ The ASD(HA) has the authority to develop policies; conduct analyses; issue guidance; provide advice and make recommendations to the Secretary of Defense, the Under Secretary of Defense for Personnel and Readiness, and others; and provide oversight on matters pertaining to the military health system.

Further, the Office of the ASD(HA) prepares and submits a DOD unified medical program budget for the military health system, which totaled

⁹Department of Defense Directive 5124.02, *Under Secretary of Defense for Personnel and Readiness (USD(P&R))* (June 23, 2008).

¹⁰Department of Defense Directive 5136.01, *Assistant Secretary of Defense for Health Affairs (ASD(HA))* (Sept. 30, 2013) (incorporating change 1, effective Aug. 10, 2017).

\$55.8 billion for the fiscal year 2023 budget request.¹¹ The Defense Health Program budget makes up the largest portion of the unified medical program budget, accounting for \$36.9 billion of the \$55.8 billion fiscal year 2023 budget request. In particular, the Defense Health Program Operation and Maintenance appropriation funding provides for worldwide medical and dental services to active-duty service members and other eligible beneficiaries through the direct care system of MTFs and private sector care from civilian medical providers through the TRICARE Health Program.

The Director of DHA functions under the authority, direction, and control of the ASD(HA). As such, the Director manages, among other things, the execution of policies issued by the ASD(HA) and the Defense Health Program appropriation.¹² The Director of DHA is also responsible for the TRICARE Health Program. In December 2016, the National Defense Authorization Act for Fiscal Year 2017 expanded the role of DHA by directing the transfer of responsibility for the administration of each MTF from the military departments to DHA.¹³ Specifically, the Director of DHA is responsible for budgetary matters, information technology, health care administration and management, administrative policy and procedure, and military medical construction, among other things. The John S. McCain National Defense Authorization Act for Fiscal Year 2019 further expanded the responsibilities of DHA, establishing additional requirements for the MTF transition, and mandating the reorganization of public health and medical research and development capabilities from the military departments to DHA, among other things.¹⁴

In addition, the Director of DHA coordinates with the Joint Staff Surgeon to ensure the Director most effectively carries out the responsibilities of DHA as a combat support agency.¹⁵ The Director is also responsible for ensuring the MTFs deliver high-quality care, meeting the military

¹¹The DOD unified medical program consists of the Defense Health Program appropriation, the medical military construction appropriation, military personnel funds for military personnel supporting the military health system, and the estimated payments to the DOD Medicare-Eligible Retiree Health Care Fund.

¹²Department of Defense Directive 5136.13, *Defense Health Agency (DHA)* (Sept. 30, 2013) (incorporating change 1, Mar. 2, 2022).

¹³10 U.S.C. § 1073c(a)(1). Initially, the transfer of responsibilities to DHA was to occur by October 1, 2018. However, in August 2018, Congress amended 10 U.S.C. § 1073c to require this transition occur by September 30, 2021. Pub. L. No. 115-232, § 711 (2018).

¹⁴Pub. L. No. 115-232, § 711 (2018).

¹⁵10 U.S.C. § 1073c(d).

departments' health care requirements, and providing the necessary clinical workload to meet the military department's medical readiness requirements, including the requirements of the senior military operational commanders of the military installations.

The Secretaries of the military departments coordinate with the ASD(HA) to develop certain military health system policies, standards, and procedures and provide military personnel and other authorized resources to support the activities of DHA, among other things. They are also responsible for ensuring the readiness of military personnel and providing military personnel and authorized resources in support of the combatant commanders and DHA.

Each military department maintains one or more medical headquarters organizations, which are responsible for developing and maintaining the readiness of medical personnel. These include the U.S. Army Medical Command and the Medical Center of Excellence within the U.S. Army Training and Doctrine Command, the Navy Bureau of Medicine and Surgery, and the Air Force Medical Readiness Agency. The Surgeon General of each respective military department leads the medical organization and serves as the principal advisor to the Secretary of the military department concerning all health and medical matters of the military department.

MTF Role in Supporting Health Care Delivery and Military Readiness

According to DOD Instruction 6000.19, the primary purpose of MTFs is to support the readiness of the military services.¹⁶ In particular, the guidance states that the size, type, and location of MTFs must further this readiness objective. Further, each MTF must spend most of its resources supporting wartime skills, development and maintenance for military medical personnel, or the medical evaluation and treatment of service members. To that end, MTFs serve as training and readiness platforms for active-duty medical providers in two respects. First, according to a DOD report, 22 MTFs host graduate medical and dental education programs for physicians and dentists, along with other training and

¹⁶Department of Defense Instruction 6000.19, *Military Medical Treatment Facility Support of Medical Readiness Skills of Health Care Providers* (Feb. 7, 2020).

education programs for medical providers.¹⁷ Second, day-to-day patient care at MTFs helps maintain the clinical skills and readiness of medical providers.

In fiscal year 2022, there were more than 700 MTFs in the United States and overseas supporting health care delivery and military readiness. These facilities vary in size and capabilities from small clinics to ambulatory surgery centers, hospitals, and medical centers. MTF workforces include health care providers such as physicians (both primary and specialty care providers), nurses, and enlisted specialists who assist with medical procedures, as well as administrative and support personnel. In fiscal year 2022, DOD's MTF workforces included approximately 49,000 active-duty military personnel, augmented by about 46,000 federal civilian employees and an estimate of about 14,500 contractor personnel.

History of DHA

DOD created DHA as a solution to address congressional and departmental concerns about inefficiencies and rising costs in the military health system. For example, after the House Armed Services Committee noted in 2010 that DOD had not yet developed a comprehensive plan to enhance quality, efficiencies, and savings in the military health care system, DOD studied options for military health system governance structures.¹⁸ On the basis of this study's findings, the department chose to pursue the formation of DHA as a combat support agency, to be led by a

¹⁷Under Secretary of Defense for Personnel and Readiness, *Section 749 of the National Defense Authorization Act for Fiscal Year 2017 (Public Law 114-328): Report on Oversight of Graduate Medical Education Programs of Military Departments* (July 13, 2018).

¹⁸House Armed Services Committee Print, 111th Cong., Legislative Text and Joint Explanatory Statement accompanying Pub. L. No. 111-383 (Dec. 2010).

three-star General or Flag Officer who would report to the ASD(HA).¹⁹ According to a DOD report, this approach would allow DOD to create shared services and common business and clinical practices under one leader without large-scale changes.²⁰ DHA would not take over MTF administration and management from the military departments under this approach.

DHA replaced the TRICARE Management Activity, which was a field activity reporting to the ASD(HA) that had responsibility for managing TRICARE and the Uniformed Medical Program budget, among other responsibilities. DOD Directive 5136.13, issued on September 30, 2013, disestablished the TRICARE Management Activity and transferred appropriate functions to DHA.

When DHA officially began operations on October 1, 2013, its responsibilities were limited compared with its current responsibilities. DHA was established to manage shared services of the military health system; the Defense Health Program appropriation; TRICARE; enhanced multiservice markets of MTFs; and the MTFs in the National Capital Region, including the Walter Reed National Military Medical Center and the Fort Belvoir Community Hospital (renamed as the Alexander T. Augusta Military Medical Center in May 2023). The National Defense Authorization Acts for Fiscal Years 2017 and 2019 further expanded DHA's missions. For example, in addition to the management and administration of the MTFs, DHA has assumed responsibility for the Joint Trauma System and graduate medical education oversight. DHA is also undergoing a multiyear process to assume, by 2026, the operations of the military departments' public health centers and programs and the Army's medical research and development programs.

¹⁹DOD also considered alternatives to DHA, including variations based on (1) a unified functional combatant command, to be led by a four-star General or Admiral who would report to the Secretary of Defense, and (2) single service governance structures that would place overall control of the military health system under one designated military department Secretary, who would report to the Secretary of Defense. In the Army, the Air Force, and the Marine Corps, the general officer ranks serve above the rank of Colonel and include the following: Brigadier General (one star), Major General (two stars), Lieutenant General (three stars), and General (four stars). In the Navy, the equivalent ranks, called "Flag Officers," serve above the rank of Captain and include the following: Rear Admiral Lower Half (one star); Rear Admiral Upper Half (two stars); Vice Admiral (three stars); and Admiral (four stars).

²⁰DOD, *Task Force on Military Health System Governance - Final Report* (Sept. 29, 2011). DOD provided the report to Congress in 2012 in response to a mandate from the National Defense Authorization Act for Fiscal Year 2012.

Our prior work has monitored the progress of DHA since its establishment and made recommendations to improve DHA's performance, some of which DHA has implemented, as discussed below. A list of these reports is included at the end of this report.

DOD Has Completed the Transition of MTFs to DHA's Management, with Continued Military Department Support for Some Functions

DOD completed the transition of MTFs to DHA-led management and administration in November 2022 with a series of steps that realigned resources from the military departments and expanded DHA's management structure. DHA continues to leverage support from the military departments, including the provision of military personnel to staff the MTFs. In addition, we found that, with the transition complete, DHA is focusing on steps to improve the capabilities of its new management structure and standardize operations across the MTFs.

DOD Completed Medical Resource Transfers and Realigned Management Organizations

In November 2022, DOD completed its multiyear transition of MTFs from the military departments to DHA's management and administration. At that time, the official transfer of all MTF resources—including civilian personnel, property, and systems—from the control of the military departments to that of DHA was completed. DOD's completion of these resource transfers was preceded by implementation delays both within and outside the department's control. For example, the COVID-19 pandemic began soon after DHA established its first four markets in the United States. The Deputy Secretary of Defense approved a pause in the transition of MTFs to DHA in April 2020, which allowed DHA to prioritize the pandemic response efforts.²¹ The pause was lifted in November 2020. In August 2020, the Secretaries of the military departments and the Chiefs of Staff, Chiefs, and Commandant of the respective military services issued a memorandum to the Secretary of Defense describing concerns about the transition of the MTFs and service capabilities to

²¹Under Secretary of Defense for Personnel and Readiness Memorandum, *Transition of Military Medical Treatment Facilities from Military Departments to the Defense Health Agency during the COVID-19 Response* (March 31, 2020).

DHA.²² The memorandum requested a blanket suspension of all transition activities. In November 2020, the Secretary of Defense responded with a memorandum directing the Under Secretary of Defense for Personnel and Readiness to continue implementation of the August 2019 transition plan.²³

Notwithstanding the challenges of the COVID-19 pandemic and initial military department resistance, DOD accomplished the transition of MTF management and administration with a series of key steps since the issuance of its 2019 implementation plan. These steps included (1) changes to MTF personnel and policies, and resource alignment; (2) the creation and staffing of 22 market and regional offices to handle management and administrative activities for the MTFs; (3) expansion of DHA's headquarters management staff to oversee markets and regions; and (4) a corresponding restructure and realignment of the military departments' medical headquarters organizations, which facilitated DHA's expansion.

Changes to MTF personnel and policies, and resource alignment.

Each of DOD's approximately 700 MTFs in the United States and overseas now reports to DHA after having reported to its respective parent military department prior to the transition. Specifically, each MTF reports to a DHA market office in the United States or a regional office overseas. Personnel working in an MTF report to an active-duty military MTF Director, who is dual-hatted as the MTF's military Service Commander.²⁴ In that capacity, Service Commanders are responsible for ensuring that uniformed medical providers assigned to their MTF meet medical readiness requirements determined by the military departments.

The scope of the transition did not include changing the number and types of MTFs, the health care services each of them provides, or the required numbers of health care providers. However, DHA expects that Directors of markets and regions will redistribute resources between or

²²Memorandum for the Secretary of Defense, *Military Medical Health System Reform* (Aug. 5, 2020).

²³Secretary of Defense Memorandum, *Guidance on Military Medical Health System Reform* (Nov. 9, 2020).

²⁴Under Secretary of Defense for Personnel and Readiness Memorandum, *Authorities and Responsibilities of Military Treatment Facility Leaders, Service Leaders and the Military Medical Departments* (Feb. 21, 2018); Under Secretary of Defense for Personnel and Readiness Memorandum, *Construct for Implementation of Section 702* (May 22, 2018).

among MTFs, as needed, to meet the demand for health care services and the readiness needs of medical personnel. This could include pooling budgetary resources across MTFs to launch broad initiatives, or moving civilian medical providers between MTFs within the market or region, as discussed later in this report.

With regard to staffing, military personnel remain affiliated with their parent service and the military departments allocate them to DHA for MTF duty. They may be reassigned for operational missions as needed. Most, but not all, civilian personnel working in the MTFs (approximately 44,000) transferred employment from the military departments to DHA.²⁵ These employees are now categorized as DOD civilian employees and they perform the same jobs they had prior to the transition. Likewise, DHA is now responsible for MTF service contracts covering health care delivery and operations, including contractor personnel performing such work, and for MTF property and equipment items, such as facility leases and vehicles.²⁶

The MTFs are now responsible for implementing standardized DHA policies, guidance, information technology systems, and procedures across the range of health care delivery and administrative functions in place of those of their former parent military department. These changes were phased in over time. For example, policies regarding clinical quality that were provided by the military departments have been replaced with a DHA procedures manual. Additionally, each MTF is now responsible for submitting an annual performance plan to its market or regional office, which then consolidates the submissions into a single plan.²⁷ DHA headquarters personnel are then responsible for approving the plans, monitoring their implementation, and holding the market and region Directors accountable for the performance of the MTFs under their authority.

²⁵MTF personnel who did not transfer employment include military department personnel in support of readiness functions, such as substance use disorder clinical care. A DHA official explained that, in fiscal year 2023, DOD was identifying employees whose employment was transferred by mistake, or should have been transferred but were not. As such we opted to round the total number of employees transferred down to 44,000 as a conservative approximation.

²⁶For fiscal year 2022, DOD reported that there were approximately 14,500 full-time equivalent contractor personnel working in its MTFs.

²⁷These plans are submitted in accordance with a process that DHA calls Quadruple Aim Performance Process. The "Quadruple Aim" refers in turn to DOD's goals for the military health system for better health, better care, lower costs, and improved readiness.

Creation of market and regional offices. DHA grouped most MTFs into 36 markets and two regions overseas and established 22 management organizations—market and regional offices—to lead them and provide shared support functions. Specifically, there is one office for each of 19 large markets, and one office for each of two overseas DHA regions. Another market office, called the Small Market and Stand-Alone MTF Organization, manages 17 small and dispersed markets, and 40 isolated “parent” MTFs and their surrounding clinics across the United States. Each of these market offices is generally colocated with the largest parent MTF in the market. Figure 2 shows the organizational structure for the market and regional offices, their locations, and reporting relationship to DHA leaders.

Figure 2: Market and Regional Structure for Military Medical Treatment Facility Management



- ★ Led by one-star General or Admiral
- ★★ Led by two-star General or Admiral

Source: GAO analysis of Defense Health Agency information. | GAO-23-105441

Notes: Unless indicated by stars, a market Director is generally an O-6 military officer (i.e., a Colonel or Captain). Market offices are generally colocated with the largest parent military medical treatment facility (MTF) in the market (i.e., large MTFs—such as community hospitals—that are connected to

smaller surrounding clinics). The 40 standalone MTFs is the count of parent MTFs to which smaller, surrounding clinics are connected. For the purpose of this report, “MTFs” includes dental treatment facilities.

The staff of each market and regional office are responsible for: (1) managing health services delivery, (2) managing administrative operations (including performance planning), and (3) supporting military readiness requirements. Generally, each market office is led by an O-6 military officer. For four of the largest markets—the National Capital Region, Tidewater, San Antonio, and San Diego—and the Small Market and Stand-Alone MTF Organization, DHA appointed, and the military departments assigned, a one or two-star General or Admiral to lead each of them. The leader of DHA Region Europe is a one-star General, and the leader of DHA Region Indo-Pacific is a two-star General. The leaders of these 22 market and regional offices are to be supported by permanent staffs of mostly civilian employees. According to DHA officials, none of the new market office personnel were transferred from the military departments. Further, they stated that DHA headquarters personnel were temporarily staffed to fill vacant market office positions while DHA completed hiring actions for permanent DOD civilian staff.

DHA headquarters expansion. DHA reorganized and expanded its headquarters as it took on increasing levels of responsibility from the military departments for the MTFs. DHA’s military and DOD civilian workforces grew by 1,748 authorized personnel (from 2,271 to 4,019 authorized personnel) from fiscal year 2018 through fiscal year 2023. Most of these authorized personnel additions (1,169) were transferred from the military departments’ medical headquarters. According to DHA officials, the agency has also hired employees to help meet its requirements for staff that exceeded the number of personnel who transferred from the military departments’ medical headquarters.

The majority of the civilian employees DHA received from the military departments to support its headquarters were transferred to perform the same job duties they performed as military department civilians prior to the transition. Such personnel included attorneys, program managers, and budget and management analysts, among others. The other 126 civilian employees from the military departments were designated as “management-directed reassignments,” allowing DHA to place these employees in roles they qualified for within DHA headquarters despite their new roles being different from the jobs they performed prior to the transition.

Military departments’ medical headquarters restructure and realignment. As part of transitioning MTF management and administration to DHA, the military departments restructured and

realigned their medical headquarters to focus on overseeing and supporting medical readiness. These changes were informed by a March 2019 memorandum from the Office of the Under Secretary of Defense for Personnel and Readiness that clarified the specific division of responsibilities for MTF functions between DHA for health care delivery and the military departments for operational, readiness, and installation support functions.²⁸ For example, the memorandum directed military departments to retain 38 MTF-supported readiness functions, such as aeromedical evacuation and patient movement, and drug demand reduction and testing.

The military departments have accomplished their pivot toward readiness and installation support focus in part by providing personnel to DHA to support the health care delivery mission. The remaining personnel were realigned to focus on the medical readiness mission. The Army also funded some additional personnel for its medical headquarters in support of readiness requirements, such as education and training, force health protection, and telecommunications, among other positions. However, U.S. Army Medical Command's personnel authorizations decreased by about 31 percent from fiscal year 2017 through fiscal year 2022, according to our analysis of the data. In fiscal year 2023, the command completed the transition from four regional health commands to four medical readiness commands. Similarly, the Air Force's medical headquarters authorized personnel decreased by about 32 percent from fiscal year 2017 through fiscal year 2022, during which time the Air Force reorganized its medical headquarters by eliminating the Air Force Medical Operations Agency and the Air Force Medical Support Agency and creating the Air Force Medical Readiness Agency. The Navy's medical headquarters personnel decreased by about 36 percent from fiscal year 2017 through fiscal year 2022. The Navy has substantially reorganized the structure of its medical headquarters, the Bureau of Medicine and Surgery, to refocus on operational readiness and to mirror the fleet's organization, according to Navy officials.

²⁸Office of the Under Secretary of Defense for Personnel and Readiness Memorandum, *Alignment of Operational and Installation-Specific Medical Functions and Responsibilities with Section 702 of the National Defense Authorization Act for Fiscal Year 2017, and Sections 711 and 712 of the John S. McCain National Defense Authorization Act for Fiscal Year 2019* (Mar. 27, 2019).

DHA Continues to Leverage Support from Military Departments for MTFs and Is Working to Improve Its Management Capabilities

DHA requires permanent support from the military departments to administer and manage the MTFs through their provision of active-duty military personnel to staff the MTFs and, to a comparably smaller extent, staff the market and regional offices and DHA headquarters. Given that DOD guidance provides that the MTFs should be the primary venue by which military medical providers develop and sustain their skills, the military departments likewise require DHA's support to assign providers to MTFs with enough demand for their skills from patient encounters.²⁹ Military providers generally make up a substantial portion of the total staffing for MTFs, augmented by civilians and contractor personnel. As discussed later in this report, DHA and the military departments have faced challenges in meeting MTF staffing requirements due in part to overall shortages of military personnel and difficulty predicting their availability for MTF duties.

Beyond military personnel staffing, DHA continues to leverage some other military department support to the MTFs. Specifically, the Army and the Air Force will provide DHA with continued support to operate certain functions across the MTFs.³⁰ For example:

- DHA has executed memorandums of agreement with the Army Civilian Human Resources Agency—an organization that also provides support to other DOD components for their civilian workforces, in addition to the Army's civilian employees. The Civilian Human Resources Agency will provide civilian workforce management support to DHA for the MTFs, markets, and regional offices, including recruiting and staffing, employee benefits programs counseling, and employee and management relations, among others.
- The Army Health Contracting Activity will continue to provide contracting support to DHA to support MTF staffing.

²⁹DOD Instruction 6000.19. Other venues for medical providers' skills sustainment include civilian medical facilities under partnership arrangements with DOD, as well as deployments and predeployment training in operational platforms like field hospitals, hospital ships, battalion aid stations, and others.

³⁰According to Navy officials, the Navy has not provided additional support to DHA since September 2022.

- DHA, the Air Force, and the Space Force, executed a memorandum of agreement for continued base operations support for Air Force-affiliated MTFs transitioned to DHA. Based on the terms of the memorandum, the Air Force and Space Force are expected to work with DHA to correctly identify needed support, uphold local support agreements, and address any changes to services provided until 2030.

As DHA headquarters officials collaborate with military department counterparts on supporting the MTFs, we likewise found that market and regional office staff are working with DHA headquarters staff to improve and expand their management and administration capabilities. Toward that end, a transition management office and subject matter experts from DHA headquarters have provided training and other support to market and regional office staff as they develop their capability to perform responsibilities defined in the August 2019 implementation plan. In addition, according to DHA officials, DHA's Assistant Director for Healthcare Administration and Deputy Assistant Directors hold biweekly meetings with the market and regional office staff to monitor their performance. DHA officials stated that they anticipate the large market offices will reach their full maturity, or capability levels, by the end of fiscal year 2023. At that time, according to milestones outlined in the implementation plan, the market and regional offices should be fully staffed and executing their management responsibilities.

DHA Faces Challenges Providing Personnel Needed to Staff MTFs and Market and Regional Offices

Our review found that DHA faces challenges mitigating shortfalls of military medical personnel in MTFs. These challenges predate the transition because of factors such as deployments and training. In addition, personnel requirements for the market and regional offices that manage the MTFs are not linked to workload information and may exceed expected budgetary resources. DHA has also faced challenges in staffing these offices. However, DHA has not yet reevaluated the organizational structure of the market and regional offices to help mitigate challenges identifying personnel requirements and providing staff.

DHA Has Faced Challenges Mitigating Shortfalls of Military Medical Personnel in the MTFs

Military Medical Personnel Shortfalls Predate the Transition

On the basis of our review of DOD documents, our prior reports, and interviews with DHA officials from headquarters, market offices, and MTFs, we found that DHA has faced challenges mitigating persistent shortfalls of MTF personnel—including military medical providers who are needed to keep health care services and departments operational. Military personnel are a critical component of the MTFs' workforce mix, which also includes civilian employees, augmented by contractor personnel. MTF personnel shortfalls occur when military medical personnel are ordered by their military department to attend training, to deploy, or to rotate to another duty assignment before a replacement is provided, among other reasons. For example, officials from Naval Hospital Jacksonville stated that expected shortages in their military provider staffing levels jeopardized their ability to provide 24/7 emergency room services in the summer of 2022 and the summer of 2023. The officials attributed the provider shortages to permanent change-of-station assignments, retirements, and operational support commitments outside the MTF. Officials stated that they were able to continue 24/7 emergency services by using military providers from other MTFs on a temporary basis despite Navy-wide shortages of such providers.

These shortfalls predate the MTF transition, as discussed further below. However, officials from DHA headquarters and market offices told us that they are concerned the shortfalls may have worsened since the transition in light of the military departments' primary focus shifting to readiness. These officials stated that they believe the readiness-related duties, such as deployments and duty assignments outside the MTFs, have reduced the availability of personnel assigned to the MTFs. For example, MTF and market officials explained that, in fiscal year 2021, the Department of the Navy realigned 803 authorized military medical personnel positions at MTFs to primary assignments with Marine Corps battalions, which limits their availability to the MTFs as full-time staff members. DHA headquarters officials told us that they estimate that enlisted medical personnel, in particular, are unavailable to their assigned MTF approximately 40 percent of the time while they are tasked with military department- or installation-specific readiness duties.

DOD's budget requests for the Defense Health Program have cited military personnel shortfalls generally, or deployments in support of

COVID-19, as a reason MTFs did not meet performance goals for health care delivery in fiscal years 2019 and 2020. According to DHA officials, the COVID-19 pandemic contributed to shortfalls in military personnel at MTFs due to deployments in support of U.S. pandemic response efforts. However, based on our prior work, shortages of military personnel have been a long-standing issue that precedes the transition and COVID-19 pandemic. In February 2018, we reported that all of the service components that employ physicians (i.e., the active and reserve components of the Army, the Navy, and the Air Force) were below authorizations (funded positions) to varying degrees in a number of their physician specialties in fiscal year 2011 through fiscal year 2015.³¹ Specifically, for fiscal year 2011 through fiscal year 2015, each component was consistently below 80 percent of authorizations in 19 physician specialties, 11 of which were designated as being critically short wartime specialties. We reported that, according to Office of the ASD(HA) and service officials, national shortages in certain physician specialties make it difficult to obtain fully qualified physicians in both the military and civilian sectors. In 2009 we reported that all of the components were below their overall physician authorizations for 1 or more years from fiscal year 2001 through fiscal year 2007.³²

On the basis of DOD documents we reviewed, we found that senior leaders—including the Deputy Secretary of Defense, the Under Secretary of Defense for Personnel and Readiness, and the ASD(HA)—have recognized the challenges posed by military medical personnel shortfalls in the MTFs, and the need to address them. Further, DOD is working to identify the magnitude of the shortfalls and the relative contribution of various root causes, as discussed below.

³¹GAO, *Military Personnel: Additional Actions Needed to Address Gaps in Military Physician Specialties*, [GAO-18-77](#), (Washington, D.C.: Feb. 28, 2018). “Funded” positions are those positions to which appropriated amounts have been allocated. Funded positions are also sometimes referred to as billets authorized. Although neither our current review nor our prior work analyzed overall medical personnel data relative to authorizations after fiscal year 2015, our prior work has described anecdotal accounts of shortfalls in such personnel and the effects thereof. See GAO, *Defense Health Care: Additional Information and Monitoring Needed to Better Position DOD for Restructuring Medical Treatment Facilities*, [GAO-20-371](#) (Washington, D.C.: May 29, 2020); and *Defense Health Care: Additional Assessments Needed to Better Ensure an Efficient Total Workforce*, [GAO-19-102](#) (Washington, D.C.: Nov. 27, 2018).

³²GAO, *Military Personnel: Status of Accession, Retention, and End Strength for Military Medical Officers and Preliminary Observations Regarding Accession and Retention Challenges*, [GAO-09-469R](#) (Washington, D.C.: Apr. 16, 2009).

DHA Has Taken Steps to Help Mitigate Shortfalls of Military Medical Personnel

DHA has taken several steps to help mitigate shortfalls of military medical personnel in MTFs by authorizing markets and regions to move civilian providers between facilities, coordinating with the military departments on processes to fill vacancies, planning to use a new oversight mechanism, and establishing a new human capital process.

Authorizing markets and regions to move civilian providers. First, DHA established that each market and regional office will be responsible for, among other things, directing the movement of civilian medical personnel between or among the MTFs it oversees.³³ In doing so, the offices can help ensure that the patient demand for health care services matches the available supply of services from MTF medical personnel. More specifically, according to DHA officials, moving civilian medical personnel dynamically among MTFs can help mitigate the effect of vacancies that have occurred since before the transition to DHA. DHA's dynamic staffing approach toward civilian medical personnel in MTFs is also part of its plan to improve MTF efficiency within markets and regions by maximizing the availability of MTF health care services. In turn, maximizing MTF health care services can help DHA avoid the financial cost of paying for patients' private-sector civilian health care in the TRICARE network when MTF services are unavailable. Otherwise, the practice of referring patients to private-sector care is a mitigation strategy that MTFs employ when patient demand exceeds MTF staffing.

In January 2023, all but six of the 20 market offices and one of two regional offices reported to DHA that they were fully capable of leveraging their authority to move civilian personnel among MTFs as needed. According to a DHA official who oversees the markets' capability assessments, the limitations were attributed to staffing shortages and the challenge of managing the MTFs' workforce mix of DOD civilian employees, military department civilian employees (i.e., those retained by military departments for readiness functions), and military personnel. The DHA official explained that these challenges are not actually impediments to the markets' ability to move their civilian employees.

Coordinating with the military departments on processes to fill vacancies. Despite the markets' authority over civilian medical

³³Defense Health Agency Administrative Instruction 5136.03, *Delegation of Authority and Assignment of Responsibility for Administration and Management of Direct Care* (Nov. 3, 2022).

personnel, and their ability to move them among MTFs to meet patient demand, officials we interviewed from selected market offices stated that shortfalls in military personnel may continue to pose a challenge in MTF management. This is because the military departments retain the authority and responsibility for assigning military personnel to MTFs, and deploying them from MTFs. Although DHA provides the day-to-day direction to military personnel working in MTFs through a dual-hatted MTF Director working both for DHA and the military departments, the military departments have command and control of those personnel.³⁴ To address this challenge, DHA has established a process to coordinate with the military departments on filling vacancies temporarily with military providers. Specifically, if an MTF needs a temporary military provider to fill a vacancy that the market or regional office cannot fill internally, the MTF or its market or regional office is to submit a “Manning Assistance Request” to its respective military department. If the military department cannot support the request, DHA headquarters may request support from the other military departments, or assess the feasibility of potential voluntary civilian personnel support.

Planning for a new oversight mechanism. Since the transition of MTFs to DHA, DOD leaders have identified the need to address staffing shortfalls in the MTFs by improving military medical personnel staffing predictability, availability, and accountability. Specifically, in August 2022, the Office of the Under Secretary of Defense for Personnel and Readiness established a means for the Office of the ASD(HA) to obtain and review military medical personnel data from the military departments on a recurring basis.³⁵ According to a memorandum describing the process, the goal of this effort is to measure and monitor MTF staffing levels, military personnel support to the MTFs, and clinical readiness levels of military medical providers. According to officials from the Office of the ASD(HA) and DHA, this new oversight mechanism may help them understand the causal factors behind those shortages and then address them. For example, officials explained that in time, the data could help show whether military provider shortfalls are the result of recruiting or retention challenges, more assignments of medical personnel to positions outside the MTFs, additional duties for military personnel training outside the MTFs, all of these factors, or others.

³⁴Under Secretary of Defense for Personnel and Readiness Memorandum, *Authorities and Responsibilities of Military Treatment Facility Leaders, Service Leaders and the Military Medical Departments* (Feb. 21, 2018); DOD Directive 5136.13.

³⁵Under Secretary of Defense for Personnel and Readiness, *Transparency of Military Medical Personnel and Clinical Readiness Data* (Aug. 8, 2022).

Establishing a new human capital process. DHA headquarters officials told us that they too had concerns over MTF staffing shortfalls and attributed the shortfalls to problems with the predictability and availability of military personnel filling MTF positions for their usual 2-year assignments. To address this challenge, according to DHA officials, DHA established its human capital distribution framework—a process by which DHA communicates to the military departments the number and type of military medical personnel that need to be assigned at each MTF 1 year in the future. This process began in 2021 for a limited number of MTFs and personnel types assigned to MTFs in the summer of 2022, according to a DHA official. A DHA official explained that, through biannual conferences with the military department officials around June and December each year, they reach agreement on the numbers of military personnel that will be available for assignments by location, and identify locations where the expected supply of personnel will not meet demand. DHA uses this process to project the number of military, civilian, and contractor staff available by location, and whether it will need to leverage TRICARE network providers or additional contractor staff.

DHA officials believe the new framework will improve their oversight of military personnel assignments and availability, and expect this to be fully implemented by the summer of 2023 for staffing decisions that will apply across all MTFs in 2024 and beyond. According to a DHA senior leader, the human capital distribution framework will also help address a statutory requirement from the John S. McCain National Defense Authorization Act for Fiscal Year 2019, which mandated that the DHA Director (1) coordinate with the military departments to ensure that staffing at MTFs supports readiness requirements for military medical personnel and other service members, and (2) validate supply and demand requirements for medical and dental services at each MTF.³⁶

GAO Previously Recommended Improvements to DHA's MTF Workforce Planning

In November 2018, as DOD was planning to carry out the transition of MTFs to DHA, we reported that the military departments faced challenges implementing their workforce mix of military, civilian, and contractor personnel in the MTFs.³⁷ Specifically, we found that a number of challenges, including lengthy hiring and contracting processes and

³⁶Pub. L. No. 115-232, § 712 (2018), as amended by Pub. L. No. 116-92, § 712 (2019).

³⁷[GAO-19-102](#).

federal civilian hiring freezes, affected DOD's ability to use federal civilians and contractors to fill MTF positions. As a result, military department officials told us at the time that when personnel gaps arose, MTFs sometimes discontinued some services at MTFs due to patient safety concerns. Additionally, at that time senior MTF officials told us that military personnel often must work additional hours or be borrowed from other facilities. However, obtaining a temporary military provider from another MTF may take longer than before the transition, as previously discussed. In November 2018, we reported that, despite DHA being poised to assume MTF management responsibilities and the challenges associated with them, DHA did not have a strategic total workforce plan, as called for in key principles for effective strategic workforce planning and consistent with federal regulations.³⁸

As a result, we recommended that the DHA Director develop a strategic total workforce plan which includes the following, among other things: (1) tailored human capital strategies, tools, and metrics by which to monitor and evaluate progress toward reducing personnel gaps and (2) integration of human capital strategies with acquisition plans, such as DOD's acquisition strategy for health care services at DOD's MTFs. DOD concurred with the recommendation, but has not yet implemented it, citing the ongoing military health system reforms as the reason.

In November 2018, we also reported that DHA and the military departments had not clearly identified how they would manage the assignment of military personnel to MTFs and mitigate the effect of deployments of military medical personnel on MTF operations.³⁹ We found that planning for the transition by DHA and the military departments had not included the development of policies and procedures for the management of military personnel. This planning was not consistent with one of the leading practices for interagency collaboration in our prior work to establish compatible policies, procedures, and other means to operate across agency boundaries.⁴⁰ As a result, we recommended that DHA and the military departments develop policies and procedures for management of military personnel, including agreement on specific roles and responsibilities for the military departments and DHA in this process.

³⁸GAO, *Human Capital: Key Principles for Effective Strategic Workforce Planning*, [GAO-04-39](#) (Washington, D.C.: Dec. 11, 2003) and 5 C.F.R. § 250.204 (2017).

³⁹[GAO-19-102](#).

⁴⁰GAO, *Results-Oriented Government: Practices That Can Help Enhance and Sustain Collaboration among Federal Agencies*, [GAO-06-15](#) (Washington, D.C.: Oct. 21, 2005).

DOD concurred with this recommendation, but has not fully implemented it, citing ongoing military health system reforms as the reason.

We continue to believe that fully implementing these two recommendations on MTF workforces and military personnel management would help DOD mitigate long-standing challenges with attaining the right mix of available personnel to staff the MTFs. In turn, this would help DHA's market and regional offices as they oversee MTF staffing and rely upon the flexibility of their federal civilian workforces to fill gaps, as needed and when possible. Until DOD implements these recommendations, DHA may continue to face shortfalls in personnel that challenge MTF operations.

Personnel Requirements for Market and Regional Offices May Be Too Large and DHA Has Faced Difficulties Staffing Them

On the basis of our review of DOD data and reports, and interviews with officials from DHA and the military departments, we found that the number of personnel required to conduct the work of the market and regional offices has not been studied and validated. However, the current estimate of over 1,400 personnel across the 22 offices may be higher than what is needed to support the offices' workloads, and the number exceeds expected budgetary and personnel resources. Furthermore, DHA has faced difficulties identifying staff to assign to the market and regional offices in their first years of operations.

Personnel Requirements for Market and Regional Offices Are Not Linked to Workload Information and May Exceed Expected Budgetary Resources

In its 2019 implementation plan for the MTF transition, DHA identified the estimated number of personnel required for each of its market and regional offices by the time they are considered fully mature in their administrative and managerial capabilities. The estimate totaled 1,943 military and civilian personnel, according to the implementation plan. The required number of personnel for each office would vary based on the characteristics and functions of the market. Our review of DHA's May 2023 data showed that the numbers have decreased since the 2019 plan to 1,458 required personnel.

According to DHA officials, they expect that the required number of personnel for each office may evolve over time with greater precision as

the necessary workload, skills, and job qualifications become clearer. Nevertheless, the implementation plan states that the number of personnel should remain within 15 percent of DHA’s estimate, which would range from 1,652 to 2,234 required personnel if applied to all market and regional offices. To identify these updated requirements, training documents from DHA headquarters instructed the market offices to arrange their own structure by using guidance regarding functions and types of positions that will likely be needed. For example, according to the training documents, DHA headquarters expects that each market office will require a Chief of Staff with support from various special staff, such as legal and public affairs staff. In addition, DHA expects dual-hatted market positions may include advisors from the MTFs in various clinical communities, such as primary care and behavioral health.

Market office officials stated that they planned to examine and update their personnel requirements. They explained that their workload was evolving based on the administrative needs of the MTFs they support, and DHA’s expectations about market tasks were changing. However, the required personnel estimated for each of these offices substantially exceeds the number of personnel that are funded through at least 2027. Specifically, 1,041 of the current estimate of 1,458 required personnel are unfunded over that time period (see table 1).

Table 1: Numbers of Military and Civilian Personnel Required for Defense Health Agency Market and Regional Management Offices, Fiscal Year 2023 through Fiscal Year 2027

Market or region	Number of required personnel, unfunded	Number of required personnel, funded	Total personnel required (funded and unfunded)
Alaska Market	58	11	69
Augusta Market	0	3	3
Central North Carolina Market	69	4	73
Central Texas Market	1	2	3
Coastal Mississippi Market	57	4	61
Coastal North Carolina Market	61	4	65
Colorado Market	60	11	71
Defense Health Agency Region - Europe	103	42	145
Defense Health Agency Region - Indo-Pacific	165	54	219
El Paso Market	0	3	3
Florida Panhandle Market	48	20	68
Jacksonville Market	58	3	61
Low Country Market	0	3	3

Letter

National Capital Region Market	38	44	82
Puget Sound Market	36	50	86
San Antonio Market	67	10	77
San Diego Market	62	16	78
Sacramento Market	0	3	3
Small Market and Stand-Alone Military Medical Treatment Facility Organization	124	82	206
Southwest Kentucky Market	0	3	3
Southwest Georgia Market	0	3	3
Tidewater Market	34	42	76
Total	1,041	417	1,458

Source: GAO analysis of Defense Health Agency (DHA) data and information. | GAO-23-105441.

Notes: The data were reported current as of May 2023. Numbers of required and authorized personnel were missing from DHA data for the following four market offices: Augusta, El Paso, Southwest Kentucky, and Southwest Georgia. A DHA official provided the numbers of required and authorized personnel in the table for these markets. The official explained that markets were missing from the data set because each of them supports a single military service and the market offices were created by using personnel from the military medical treatment facilities (MTFs). As a result, the required and authorized personnel from those market offices are documented in data sets for the MTFs.

A series of DOD-wide studies of DHA’s personnel requirements had methodological limitations. For example, a 2022 DOD report on a “zero-based review” study of required and authorized personnel for medical headquarters (including those of DHA and the military departments) calculated 9,169 total personnel required for DHA’s headquarters and market and regional offices. However, the report did not break out separately the number of personnel required at the market and regional offices. The report also described methodology limitations, such as the absence of personnel workload data (i.e., the output of staff performing work in medical headquarters functions). In an independent study of medical headquarters personnel requirements that DOD commissioned in 2021, the authors estimated that the requirements for the market and regional offices should range from 627 to 1,339 personnel. However, this study was similarly limited by the lack of available workload data. Instead, these estimates for the personnel requirements of the market and regional offices were modeled based on benchmark assumptions, including the staffing levels of the Veterans Health Administration networks and those of the San Antonio Market Office.

In October 2018, as the MTF transition began, we reported on challenges that DOD has faced with understanding DHA headquarters personnel requirements and composition. We found that, until DOD validates headquarters-level personnel requirements and conducts a comprehensive review that considers the least costly mix of personnel

(i.e., the composition of military, federal civilian, and contractor personnel), DOD will not be well positioned to reduce or better manage duplication and improve efficiencies.⁴¹ DOD concurred with both recommendations, but has not implemented them as of August 2023. In its most recent update on the status of the recommendations, DOD stated that its 2022 zero-based review of medical headquarters personnel, discussed above, constituted a validation of requirements. We disagree because DOD noted in its 2022 zero-based review that a detailed evaluation of personnel workload was not possible given the timeline and methodology limitations for the review.

DHA Has Faced Challenges Staffing Market and Regional Offices

With regard to providing staff to fill its estimated personnel requirements for market and regional offices, a DHA planning document for the transition explains that vacancies will be filled incrementally, with coordination between the offices and DHA headquarters. To that end, the DHA Director appointed a military Director of each office. Many Market Directors are dual-hatted as MTF Directors. Four Directors are dual-hatted in positions for their respective military department's medical headquarters organization, including the Directors of the San Diego and Tidewater Markets, Small Market and Stand-Alone MTF Organization, DHA Region Europe. DHA expected the market Directors to assemble their initial office staff, generally by assigning responsibilities to MTF staff on a temporary basis. For some market offices, DHA provided civilian employees from its headquarters on a temporary basis to augment the temporary staff from the MTFs until permanent market staff were onboard, according to DHA officials.

Across the six selected markets that we reviewed in detail, we found that the numbers and types of market office staff varied. DHA officials expressed concern about the overall number of staff on hand relative to the expected workload, as well the number of federal civilian staff they could hire in the future or military personnel to be assigned by the military departments. The Central North Carolina Market, which was among the first established in January 2020, did not have permanent market office staff to assist its dual-hatted director, according to market office officials. Likewise, officials from the San Diego and Jacksonville market offices told us they were supported by military personnel from the MTFs who were contributing their time on a collateral basis.

⁴¹[GAO-19-53](#).

For all markets, DHA officials stated that they are working to recruit and hire permanent, full-time civilian staff. However, market office staff and DHA headquarters officials told us that hiring has been slow for a variety of reasons, such as competition in the labor market. Meanwhile, as they await new civilian employees, market office officials explained that their staffing is limited. Officials from two of the offices stated that they relied upon a “coalition of the willing” from the MTF to support market office tasks. Further, some market office officials explained that the ability to permanently staff military personnel to market positions is uncertain for reasons previously discussed—namely, the military departments retain command and control of their personnel and prioritize their assignments across various MTF and non-MTF related requirements. In particular, officials noted that the Army would not assign military personnel in support of market office responsibilities, other than the market Directors who were already appointed.

DHA’s staffing plan for market and regional offices also notes that some market staff should comprise shared personnel from across the MTFs, whereby functions should be consolidated for legal support, resource management, and information technology, among other possibilities. The officials from three of six selected market offices we interviewed described plans or efforts to identify such consolidation opportunities across the MTFs to support the market. However, those opportunities had not been implemented because the market offices were reviewing options or waiting for DHA headquarters input, according to officials.

Meanwhile, DHA headquarters officials told us they have assisted markets in identifying consolidation opportunities for their market staff. Specifically, according to DHA’s Chief Financial Officer, for the past few years he has assisted market offices with identifying consolidation opportunities across MTFs in their resource management personnel. For example, leveraging advice from the U.S. Army Medical Command, he identified a consolidation opportunity for the resource management functions between the MTFs at Fort Knox and Fort Campbell in Kentucky. He stated that this consolidation and others planned will yield civilian personnel savings, and that he expects to continue assisting other markets in identifying such opportunities. Notably, however, the MTFs at Fort Knox and Fort Campbell are not aligned to the same market, which could complicate the further consolidation and sharing of budgetary and

personnel resources between organizations and physical locations that are separated by about 160 miles.⁴²

Like the market and regional offices, DHA's headquarters has faced staffing shortfalls relative to its authorized personnel levels, and relative to requirements estimated in the 2022 zero-based medical headquarters review. These shortfalls exist despite DHA having received 1,169 military and civilian personnel transferred from the military departments' medical headquarters over the course of the transition, as discussed earlier in this report. Our analysis of DHA's personnel and staffing data found that at least 16 offices within its headquarters perform work directly related to health care delivery in the MTFs, and therefore received transfers of personnel from the military departments. However, all of those offices had fewer personnel than they were authorized at the beginning of fiscal year 2023. Specifically, the offices had 576 vacant positions relative to the 2,913 they were authorized (about 20 percent). Of these, 355 positions were expected to be filled through pending hiring actions, but as of October 2022 the staff were not yet on board. In particular, the offices of the Deputy Assistant Directors for Administration and Management and Financial Operations would have 72 (about 23 percent) and 35 (about 9 percent) fewer personnel than authorized, respectively, after the onboarding of new employees.

DOD's 2022 report on medical headquarters identified an estimated, overall shortfall of 513 DHA personnel across its headquarters and market and regional offices relative to the 9,169 required personnel that the study team estimated with its own methodology. However, the DOD study team recommended that DHA should resource its personnel shortfall internally rather than request additional personnel resources. In August 2022, the Deputy Secretary of Defense endorsed this recommendation. According to DHA officials, this means that they will look for opportunities to realign workloads among MTFs, market and regional offices, and headquarters.

⁴²The MTF at Fort Knox (Ireland Army Health Clinic) is the parent MTF within the Central Kentucky Market, which is a small market aligned with the Small Market and Stand-Alone MTF Organization. The MTF at Fort Campbell (Blanchfield Army Community Hospital) is the parent MTF and market office headquarters of the Southwest Kentucky Market—a large market reporting directly to DHA. The 160-mile measurement is the driving distance between Fort Campbell and Fort Knox, but the distance from outlying clinics could be smaller or larger.

DHA Has Not Reevaluated Its Market-Based Structure to Help Mitigate Challenges with Identifying Personnel Requirements and Providing Staff

Despite the aforementioned challenges with determining the correct level of required personnel for the market and regional offices, and providing military and federal civilian personnel to staff the offices, DOD has not reevaluated the overall design of its market-based structure. For example, according to officials from the Office of the ASD(HA) and DHA, DOD has not considered whether the missions of the markets and regions, and the workload of their office staff, could be accomplished by a structure with fewer market offices to achieve efficiencies in their personnel levels. Since DHA's 2019 transition plan, DOD has held the 22 market and regional offices as a fixed assumption in carrying out the transition despite evidence that the design may be resource intensive. Based on estimates from an independent study in 2021, discussed previously in this report, DHA's personnel requirements for the markets and regional offices may be about 40 to 200 percent higher than needed. The 2022 zero-based review similarly concluded that the design of the markets and regions was "suboptimal," although reevaluating their organizational construct was not within the scope of the study. Likewise, some officials we interviewed from Office of the ASD(HA), DHA headquarters, and the military departments stated that the overall structure of the markets and regions may be larger than needed, including the number of offices and estimated personnel required for each.

We also found that the structure may be larger than, and inconsistent with, the structure specified in the John S. McCain National Defense Authorization Act for Fiscal Year 2019. Specifically, section 712 mandated that there should not be more than two DHA regions in the continental United States, and not more than two regions outside the continental United States.⁴³ Further, section 712 specified that each DHA region within the United States should be led by a commander or director who is a member of the armed forces and not higher than a major general or rear admiral. DHA established two overseas regions, consistent with the statute. According to a DHA senior leader, DHA considers the continental United States and all of its markets to be a single region, although it does not use the term "region" in its organizational structure. However, we found that the structure of the largest U.S. markets parallels that of the overseas regions in terms of the number and types of MTFs,

⁴³Pub. L. No. 115-232, § 712 (2018), as amended by Pub. L. No. 116-92, § 712 (2019).

the population of beneficiaries served, and the leadership and staffing framework. For example, the National Capital Region Market and the DHA Region Indo-Pacific oversee about the same number of MTFs and patients, and are led by a two-star General or Admiral. A previously proposed organizational framework for DHA, as outlined in a June 2018 report to Congress, would have created an eastern region and a western region in the United States, with two management organizations aligned to each region.⁴⁴ In 2019, DOD replaced that design with the current market structure.⁴⁵

According to DOD Directive 1100.4, *Guidance for Manpower Management*, it is DOD policy that existing structures (along with policies and procedures) shall be periodically evaluated to ensure efficient and effective use of personnel resources.⁴⁶ Additionally, personnel requirements are driven by workload and shall be established at the minimum levels necessary to accomplish mission and performance objectives. However, DOD has not reevaluated DHA's market-based organizational structure, such as the number and size of the market and regional offices, or assessed the workloads within the market and regional offices for several reasons. First, DHA officials explained to us that the structure is new and differs substantially from the structures of the military departments' medical headquarters, which also managed other medical functions before and after the transition—now referred to as medical readiness functions.⁴⁷ Because of the new structure, according to officials, it will take more time to understand the required workloads of market and regional office staff and refine the division of responsibilities

⁴⁴Department of Defense, *Report to the Armed Services Committees of the Senate and House of Representatives, Final Plan to Implement Section 1073c of Title 10, United States Code, Final Report* (June 30, 2018).

⁴⁵In April 2019, DOD provided a report to the Senate and House Armed Services Committees that informed them of significant revisions to the plan reported in June 2018 and described the market construct. In the report, DOD stated that statutory amendments subsequent to the June 2018 report necessitated revisions to the plan, and that DOD approved other changes to the plan. Department of Defense, *Report to Armed Services Committees, Section 712 of the John S. McCain National Defense Authorization Act for Fiscal Year 2019 (Public Law 115-232), "Organizational Framework of the Military Healthcare System to Support the Medical Requirements of the Combatant Commands"* (Apr. 17, 2019). The market construct is described in detail in the August 2019 implementation plan, which remained current through the time of our review and is discussed throughout this report.

⁴⁶DOD refers to personnel as "manpower." Department of Defense Directive 1100.4, *Guidance for Manpower Management* (Feb. 12, 2005).

⁴⁷DHA has managed the MTFs in the National Capital Region since 2013, when the agency was first established.

between them and DHA headquarters personnel. To that end, DHA plans to review the personnel requirements of the market offices in fiscal year 2025, and those of various DHA headquarters components in fiscal year 2024 through 2026. According to DHA officials, this timeline will allow for the market offices and reporting relationships to mature, while they first prioritize reviewing MTF personnel requirements.

However, according to DHA officials, the future review of personnel requirements will not reevaluate the number and size of markets. Moreover, investing the limited personnel resources of DHA headquarters staff to evaluate the requirements of an uncertain structure could be inefficient. According to DHA headquarters officials, in fiscal year 2023 they had 14 full-time civilian staff with which to evaluate the personnel requirements of more than 700 MTFs, 22 market and regional offices, and DHA headquarters. They added that this number of staff is fewer than each individual military medical department had to evaluate its respective medical personnel requirements prior to the transition.

Further, we identified two other reasons that contributed to DOD having not reevaluated the market-based structure. The first is momentum behind the 2019 implementation plan. On the basis of our review of DOD documents and interviews with DHA and military department officials, we found that DOD has prioritized the success of its 2019 implementation plan by focusing on improving the management and administrative capabilities of the markets and regional offices, expecting they would continue to grow in staffing levels and efficiency through the end of DHA's performance plan cycle in 2026. However, increased staffing levels are not guaranteed given the challenges in DHA's ability to fully staff its MTFs, market and regional offices, and headquarters. DHA headquarters was unable to provide us complete data on the total number of civilian and military personnel filling its authorized market and regional office positions.

A second factor is DHA's management of competing priorities as the agency assumes the military departments' programs for public health and medical research and development pursuant to a statutory mandate, among other areas of mandated growth.⁴⁸ Officials from the Office of the ASD(HA) and DHA stated that expected budgetary and personnel

⁴⁸10 U.S.C. § 1073c(e). Section 1073c of title 10, U.S. Code, states that DHA Research and Development shall also be comprised of any other medical research organizations and activities of the armed forces as the Secretary of Defense considers appropriate. DHA Public Health is to be comprised of Army Public Health Center, the Navy—Marine Corps Public Health Center, Air Force public health programs, and any other related defense health activities that the Secretary of Defense considers appropriate.

resources in the Defense Health Program have not grown over time commensurate with the growth of DHA's mission. As discussed later in this report, budgetary resources for the Defense Health Program have remained fairly constant since at least fiscal year 2016, and DOD leaders have continued to apply budget constraints for future years that DHA must operate within by further reducing operating costs during a period of rising inflation. As a result, DHA officials have underscored the need to find every available efficiency. However, until DOD prioritizes a reevaluation of the organizational approach for DHA's market-based management structure, including the possible consolidation under DHA headquarters of some or all management activities currently vested with market offices, it will risk allocating personnel and budgetary resources to a design that is not efficient or effective. Further, until DOD uses the conclusions from such an evaluation to study and validate workloads and personnel requirements, DHA may risk not accomplishing its vision for an integrated health system that efficiently uses resources and lowers costs.

DHA Is Working to Identify Future Efficiencies and Cost Savings, but Is Not Tracking Achievement of Efficiency Initiatives Underway

Now that the transition of MTFs is complete, DHA officials stated that they will look to improve stewardship of budgetary resources across the MTFs through financial management initiatives. However, officials noted that this may take time as new processes and resource management systems are implemented and as DHA staff gain experience with using them. For example, fiscal year 2022 was the first year in which DHA assumed financial management responsibilities for the MTFs from the military departments through its Direct Care Financial Management Division, which it established for that purpose. Also in fiscal year 2022, DHA implemented a new "Integrated Resourcing" system to allocate funding to the MTFs, monitor their use of funding, and make adjustments based on actual performance over the fiscal year. Although DHA's standardized process for developing budgets for each of the MTFs began in fiscal year 2020, according to DHA officials, they are working with MTF and market staff to train them on improving their inputs to that process and the level of detail of the submissions they provide.

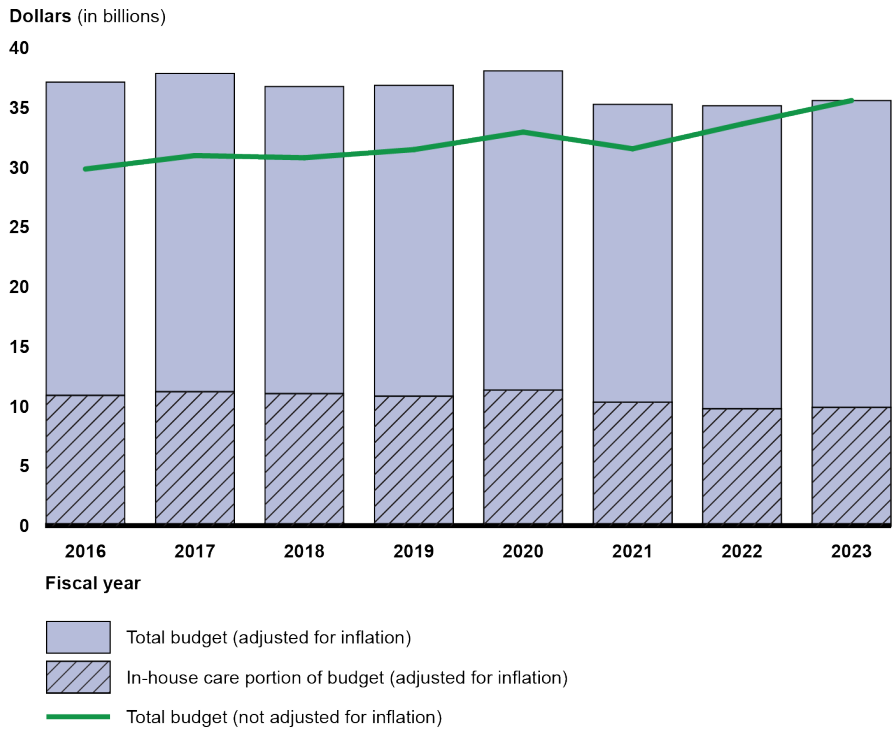
In addition to possible efficiencies in the allocation of budgetary resources to the MTFs, DHA officials noted that future efficiencies in administration and management staffing are possible through the consolidation of

functions across locations, thereby reducing the number of staff who perform those functions. However, officials noted that such opportunities are unknown and will take time to identify after DHA achieves maturity in its management activities, such as by identifying additional opportunities for the consolidation of shared functions and staff across MTFs within and across markets.

Moreover, officials from DHA emphasized that the military health system has already achieved net savings in the overall Defense Health Program budget over the last 10 years by slowing its growth relative to inflation. Our analysis of the Defense Health Program budget over time, and specifically the portions that fund MTF operations, confirmed that the budget has remained generally constant when adjusted for inflation (see fig. 3).⁴⁹

⁴⁹The Defense Health Program Operation and Maintenance appropriation funding provides for worldwide medical and dental services to active-duty service members and other eligible beneficiaries, as well as veterinary services, specialized services for the training of medical personnel, occupational and industrial health care, and operating costs of DHA and its management headquarters. This appropriation also funds costs associated with the private sector care component of TRICARE, which provides for health care benefits to eligible beneficiaries, including active and retired service members and their families, dependent survivors, certain reserve component members and their families, and certain other eligible groups. The Defense Health Program operation and maintenance funding is divided into seven major areas, or budget activity groups, including "In-House Care," which funds health care services and pharmaceuticals in military medical treatment facilities in the United States and overseas.

Figure 3: Defense Health Program Operation and Maintenance Amounts, Fiscal Year 2016 through Fiscal Year 2023



Source: GAO analysis of Department of Defense budget documents. | GAO-23-105441

Data table for Figure 3: Defense Health Program Operation and Maintenance Amounts, Fiscal Year 2016 through Fiscal Year 2023

Fiscal Year	Enacted In-House Care Budget Total (adjusted by inflation)	Enacted Defense Health Program Budget Total (adjusted by inflation)	Enacted Defense Health Program Budget Total (not adjusted by inflation)
2016	10.9196	37.1537	29.8739
2017	11.2298	37.8772	30.9999
2018	11.0654	36.7921	30.8181
2019	10.8596	36.8804	31.4972
2020	11.368	38.09	32.9639
2021	10.3668	35.2897	31.5681
2022	9.80204	35.16964	33.6408
2023	9.91917	35.60917	35.6091

Source: GAO analysis of Department of Defense budget documents. | GAO-23-105441

Notes: Amounts were adjusted for inflation using fiscal year 2023 dollars. The amounts for fiscal year 2023 are estimated because this fiscal year was not yet complete. The Defense Health Program Operation and Maintenance appropriation funding provides for worldwide medical and dental services to active-duty service members and other eligible beneficiaries, as well as veterinary services, specialized services for the training of medical personnel, occupational and industrial health care, and

operating costs of the Defense Health Agency and its management headquarters. This appropriation also funds costs associated with the private sector care component of TRICARE, which provides for health care benefits to eligible beneficiaries, including active and retired service members and their families, dependent survivors, certain reserve component members and their families, and certain other eligible groups. The Defense Health Program Operation and Maintenance funding is divided into seven major areas, or budget activity groups, including "In-House Care," which funds health care services and pharmaceuticals in military medical treatment facilities in the United States and overseas.

Nevertheless, DHA officials stated that some level of future savings will be possible as they standardize administrative activities and health care delivery practices across the MTFs through process improvement initiatives. Further, officials explained that, although future efficiencies in the operating costs of the MTFs (e.g., facilities, personnel, equipment, and supplies associated with hospitals and clinics) are possible, these will take time to identify and implement. According to officials, they are targeting opportunities to reduce costs in larger, multiservice markets by consolidating common administrative activities.⁵⁰ In contrast, they noted that cost-saving opportunities in small, single-service markets and standalone MTFs will be limited. This is because the largest opportunities for cost reductions were already implemented over the past decade, including through enterprise shared services that DHA began implementing soon after its establishment. DOD claimed more than \$2.5 billion in savings from the shared services implementation from fiscal year 2014 through fiscal year 2017.

We found that DOD planned for and began reducing its medical headquarters personnel in fiscal year 2020, attributing this action directly to the transition and expected personnel efficiencies. These reductions were described in DOD's June 2018 report to Congress on its transition

⁵⁰Multiservice markets contain MTFs affiliated with more than one military service.

implementation plan.⁵¹ Specifically, DOD began reducing all medical headquarters personnel levels (military departments and DHA) by 10 percent in fiscal year 2020 relative to the 6,948 personnel authorized in fiscal year 2018. We recommended in October 2018 that DOD should address a lack of clarity in how it would achieve its plan to grow DHA's staffing and concurrently apply a 10-percent reduction by validating headquarters-level personnel requirements and identifying the least costly mix of military, civilian, and contractor personnel to meet the validated requirements.⁵² DOD concurred but has not yet implemented the recommendations. Given that DOD had not validated its required personnel or its mix of personnel prior to the reduction, it is not clear whether its goal was enabled by the transition or was carried out despite the concurrent growth in DHA's staffing level.

In addition to personnel reductions and related cost reductions that DOD attributed to the MTF transition in fiscal year 2020, we found that DOD reduced the Defense Health Program budgets for fiscal years 2020, 2021, and, to a smaller extent, 2022, to account for expected savings from the MTF transition. We identified the following examples of expected decreases to budgetary resources in the Defense Health Program budget requests for operation and maintenance:

- **Fiscal year 2022.** DOD planned a \$5.83 million reduction in its Management Activities and Consolidated Health Support budget activity groups. This included a decrease of 108 contractor personnel that DOD attributed to the ongoing consolidation of services at DHA, and decreasing advisory and assistance services contracts due to the MTF transition. DOD's budget request stated that realigning those

⁵¹DOD's June 2018 plan further stated that DHA would experience incremental growth in staffing during the MTF transition until it had full responsibility for all MTFs—a milestone reached in November 2022. DOD, *Report to the Armed Services Committees of the Senate and House of Representatives, Final Plan to Implement Section 1073c of Title 10, United States Code, Final Report* (June 30, 2018). In October 2018, we reported that DOD's plans were unclear in its June 2018 report as to how it would achieve the goal of reducing headquarters-level personnel by 10 percent. [GAO-19-53](#). Specifically, DOD's plan stated that DHA would experience personnel growth during each phase of the transition, but that DOD expected to reduce headquarters-level personnel by 10 percent by 2021. The plan also described efforts to reduce medical headquarters personnel and commensurate budgetary resources that predated the enactment of the National Defense Authorization Act for Fiscal Year 2017 and were then accelerated upon the legislation's enactment. The report stated that DOD had already programmed a 25-percent reduction in all medical headquarters personnel, commensurate with a \$202.5 million reduction in the Defense Health Program budget. The relationship between these personnel reductions and the MTF transition is unclear, however, given that they were already planned before Congress mandated the transition.

⁵²[GAO-19-53](#).

resources would help fund civilian personnel increases to support the transition, and cited a requested increase of 149 civilians.

- **Fiscal year 2021.** DOD decreased its budget request by more than \$32.2 million in Management Activities and Consolidated Health Support budget activity groups for reductions to headquarters overhead, including some civilian and contractor personnel associated with the transition.
- **Fiscal year 2020.** DOD identified an approximately \$53.5 million budget decrease for its In-House Care, Management Activities, and Education and Training budget activity groups. These reductions were related to requirements for travel, supplies, and other contract costs to implement reforms in support of the transition, including eliminating duplicative activities between DHA and the military departments' medical headquarters.

In DOD's June 2018 report to Congress on its implementation plan for the transition of MTFs to DHA, the department described its plans to implement 10 military health system reform initiatives related to clinical and business processes. The report noted that the transition of MTFs to DHA would facilitate these initiatives and generate savings of approximately \$760 million annually by fiscal year 2023. We found on the basis of our interviews with officials from the Office of the ASD(HA) and DHA that the initiatives were first implemented in fiscal year 2022.

Likewise, the corresponding savings projections were first incorporated into the Defense Health Program budget for fiscal year 2022. For the first 2 years of implementation in fiscal years 2022 and 2023, DOD estimated savings of about \$310 million and \$321 million, respectively. According to DOD's estimates, the total savings would exceed \$1.6 billion by fiscal year 2026. According to DHA and Office of the ASD(HA) officials, these dollar amounts were reduced from the topline Defense Health Program budget, based on the expectation that they can be achieved during the budget years. However, the officials were unable to identify the actual amounts saved in these specific reform areas relative to the projections.

DHA's past experience with implementing cost-savings initiatives has been successful, and our prior work made previous recommendations that helped improve its estimates for net savings and its monitoring of those savings over time. Specifically, in November 2013, 1 month after DHA officially began operations, we reported that some key details of a sound business case were missing from DOD's cost-savings estimates

for implementing its shared services.⁵³ For example, we found that by not providing a detailed quantitative analysis regarding the sources of cost savings, DOD's aggregated cost-savings estimates obscured the relative size, cost, and potential uncertainties or risks associated with forming a shared service. As a result, we recommended that DOD provide Congress with a more-thorough explanation of the potential sources of cost savings and then monitor implementation costs to assess whether the shared services projects achieved projected net cost savings or if corrective actions were needed. DOD concurred with the two recommendations and implemented them. Moreover, DHA reported, and we verified, financial savings of more than \$1.4 billion from the first 3 years of shared services implementation from fiscal year 2014 through fiscal year 2016. DOD continued to track its savings relative to projected estimates in the implementation of shared services, and reported in June 2018 that its actual, cumulative financial savings had exceeded \$2.3 billion by fiscal year 2017.

DHA officials stated that the current reform initiatives that started in fiscal year 2022 are not yet trackable to determine the actual savings achieved. According to GAO's *Business Process Reengineering Assessment Guide*, as part of an agency's business case for implementing a new process, it should have established specific performance goals for the reengineered process.⁵⁴ These goals should include a mixture of intermediate goals to be met at various stages during the implementation phase, as well as ultimate performance goals for the process after it has been fully implemented and institutionalized. The intermediate goals are particularly important because the agency should be able to start showing a return on investment in the early stages of implementation.

However, DHA officials were unable to identify specific performance goals for the 10 transition-related reform initiatives other than projected savings identified in the Defense Health Program. On the basis of our interviews with DHA officials, we found that this is because the execution of these initiatives spans many lines of accounting across DHA's markets and MTFs. Financial management systems and reporting for the MTFs had varied among the military departments prior to the transition. Officials stated that it will take time to accomplish the financial management standardization needed to monitor the actual savings from the initiatives.

⁵³GAO, *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).

⁵⁴[GAO/AIMD-10.1.15](#).

As DHA continues its financial management improvement projects to facilitate tracking and oversight of the transition-related clinical and business reform initiatives, it will be important to establish performance goals that can help ensure the initiatives are on track to achieve the intended benefits for efficiency of operations. Without establishing performance goals and monitoring the results in relation to projected savings, DOD may not know whether the initiatives work as intended. Moreover, if the initiatives do not meet or exceed the projected savings, DOD may have to make unexpected tradeoffs by reducing other operating costs to meet the budget controls of the Defense Health Program.

Conclusions

Nearly 10 years after its establishment, DHA's mission, responsibilities, and authority have expanded substantially within the military health system. In assuming the military departments' administration and management responsibilities for the MTFs, in particular, DHA accomplished a number of challenging milestones. The agency accepted the transfer of personnel, property, and systems associated with approximately 700 total facilities worldwide; standardized and replaced necessary policies; and established new and expanded management structures. However, work remains for DHA and military departments to address service member staffing issues in the MTFs, along with market and regional offices. Without reevaluating the organizational approach and required personnel for the market offices, DHA may not have enough personnel to accomplish its vision for an integrated health delivery system. In doing such a reevaluation, DHA may also be better positioned to achieve efficiencies in health care delivery and management.

DOD has successfully controlled the growth of the Defense Health Program budget through various cost-savings initiatives over the past decade. DHA plans to continue this progress and achieve savings and efficiency goals from the MTF transition through its clinical and business process reform initiatives. However, until DHA establishes performance goals and monitors the results in relation to projected savings, it may not know whether the initiatives work as intended and risks making unexpected tradeoffs by reducing other operating costs to meet its budget controls.

Recommendations for Executive Action

We are making the following two recommendations to DOD:

The Secretary of Defense should ensure that the Deputy Secretary of Defense, in coordination with the Under Secretary of Defense for Personnel and Readiness, prioritizes a reevaluation of its organizational approach for DHA's market-based management structure, including the possible consolidation under DHA headquarters of some or all management activities currently vested with market offices, and use the conclusions to study and validate workloads and personnel requirements. (Recommendation 1)

The Secretary of Defense should ensure that the Under Secretary of Defense for Personnel and Readiness establishes performance goals for its transition-related clinical and business reform initiatives, and then monitors the results in relation to projected savings. (Recommendation 2)

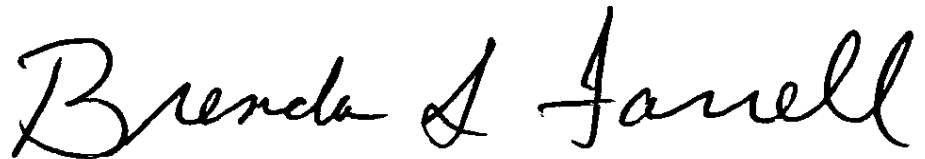
Agency Comments and Our Evaluation

We provided a draft of this report to DOD for review and comment. In its written comments, reproduced in appendix II, DOD concurred with our first recommendation and partially concurred with the second recommendation. Regarding recommendation two, DOD noted that virtually all transition-related clinical and business reform initiatives are completed and that strategic plans for DHA and the military health system have identified new initiatives with overarching goals, which also include processes to closely monitor resource utilization—both personnel and funds. However, our recommendation was specific to the 10 clinical and business reform initiatives that began in fiscal year 2022 and are ongoing. As we noted in our report, DHA officials were unable to identify the actual amounts saved relative to the projected savings because the initiatives are not yet trackable. Thus, we continue to believe that it will be important for DHA to establish performance goals that can help ensure the 10 initiatives are on track to achieve the intended benefits for efficiency of operations. Without doing so, and monitoring the results in relation to projected savings, DOD may not know whether the initiatives work as intended. Finally, DOD provided technical comments on the draft report, which we incorporated as appropriate.

We are sending copies of this report to the appropriate congressional committees, the Secretary of Defense, the Under Secretary of Defense for Personnel and Readiness, the Assistant Secretary of Defense for

Health Affairs, the Director of DHA, and the Secretaries of the Army, the Navy, and the Air Force. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-3604 or 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 are listed in appendix III.

A handwritten signature in black ink that reads "Brenda S. Farrell". The signature is written in a cursive style with a large, prominent "B" and "F".

Brenda S. Farrell
Director, Defense Capabilities and Management

List of Committees

The Honorable Jack Reed
Chairman

The Honorable Roger Wicker
Ranking Member
Committee on Armed Services
United States Senate

The Honorable Jon Tester
Chair

The Honorable Susan Collins
Ranking Member
Subcommittee on Defense
Committee on Appropriations
United States Senate

The Honorable Mike Rogers
Chairman

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

The Honorable Ken Calvert
Chair

The Honorable Betty McCollum
Ranking Member
Subcommittee on Defense
Committee on Appropriations
House of Representatives

Appendix I: Objectives, Scope, and Methodology

This report examines (1) the status of the Department of Defense (DOD) transition of military medical treatment facilities (MTFs) to Defense Health Agency (DHA) management, and the extent to which DHA has (2) addressed any transition-related challenges with staffing the MTFs and DHA's management organizations and (3) identified cost savings associated with the transition and assessed the effectiveness of efficiency initiatives.

For objective one, to understand the status of the MTF transition, we reviewed DHA's August 2019 implementation plan for the transition, which remained current through the time of our review, to identify planned milestones and time frames. We also reviewed DOD briefings and other documentation on actual milestones accomplished related to the transition, including the transfer of personnel, property, and systems from the military departments to DHA. We corroborated our understanding of transition steps and progress with officials from DHA and the military departments' medical headquarters organizations, including the U.S. Army Medical Command, the Navy Bureau of Medicine and Surgery, and the Air Force Medical Readiness Agency.

In addition, we analyzed DHA's personnel data for fiscal years 2018 and 2023, and the military departments' medical headquarters personnel data for fiscal years 2017 and 2022, to compare changes over time, before and after the transition. We assessed the reliability of the data sources by interviewing responsible DOD officials, reviewing the data for outliers and missing values, and comparing the data with similar data reported in other DOD sources. We determined the data were sufficiently reliable for our purposes to describe the changes to personnel required and funded over the time period.¹

For objective two, to understand any challenges related to the MTF transition and their effect on MTF operations, we interviewed personnel from a non-generalizable sample of six market offices and six MTFs that we selected for a range of market establishment dates and number of patients served, and variation in military service affiliations and

¹"Funded" personnel, or funded positions, are those positions to which appropriated amounts have been allocated. Funded positions are also sometimes referred to as billets authorized.

geographic locations to ensure a range of perspectives. The selected locations included the following:

- Alaska Market Office, Joint Base Elmendorf-Richardson, Alaska
- Central North Carolina Market Office, Fort Liberty, North Carolina
- Hawaii Market Office, Honolulu, Hawaii²
- Jacksonville Market Office, Jacksonville, Florida
- San Diego Market Office, San Diego, California
- Small Market and Stand-Alone MTF Organization, San Antonio, Texas
- 4th Medical Group, Seymour Johnson Air Force Base, North Carolina
- 15th Medical Group, Joint Base Pearl Harbor-Hickam, Hawaii
- 88th Medical Group, Wright-Patterson Air Force Base, Ohio
- Bassett Army Community Hospital, Fort Wainwright, Alaska
- Naval Hospital Jacksonville, Jacksonville, Florida
- Naval Hospital Camp Pendleton, Camp Pendleton, California

In addition to interviews with market office and MTF personnel, we reviewed the findings and recommendations of DOD studies of medical headquarters personnel levels, and our prior work on the MTF transition and medical personnel. Further, we analyzed personnel requirements, authorizations, and staffing data for DHA's headquarters, and market and regional offices to identify the extent to which required positions were filled. We assessed the reliability of DHA data sources by interviewing responsible DHA officials, reviewing the data for outliers and missing values, and comparing the data with similar data reported in other DOD sources. We determined the data on personnel authorized were sufficiently reliable for our purposes to describe staffing levels and vacancies for DHA headquarters, and differences between required and authorized personnel for market and regional offices. However, DHA's staffing data for the market and regional offices were incomplete, and therefore we did not include the data in our report.

We compared DOD's June 2018 report to Congress on implementation plans for the MTF transition with DHA's August 2019 plan to identify

²The Hawaii Market has since become part of the Indo-Pacific Region.

changes, and discussed the changes with DHA officials.³ We also compared DOD's personnel requirement determinations for the market and regional offices with criteria from DOD Directive 1100.4, *Guidance for Manpower Management*.⁴

For objective three, to assess the extent to which DOD has identified cost savings associated with the transition and assessed the effectiveness of its efficiency initiatives, we reviewed DOD's budget documents for fiscal year 2016 through fiscal year 2023 to identify overall amounts for operation and maintenance funding within the Defense Health Program. We selected this time frame to observe trends over time, and fiscal year 2016 served as a baseline with which to compare the more recent years because it was prepared and submitted before section 1073c of title 10, U.S. Code—the MTF transition mandate—was enacted. We also reviewed the budget documents to identify any funding changes that DOD attributed to the transition of MTFs to DHA. We assessed trends over time in the Defense Health Program operation and maintenance budgets in both nominal and real dollars to account for any effects from inflation.

We also reviewed DOD's June 2018 report to Congress on implementation plans for the MTF transition, the August 2019 implementation plan, memorandums, and other documents on the MTF transition to identify whether any financial goals had been documented. We interviewed officials from the Office of the Assistant Secretary of Defense for Health Affairs and DHA about processes in place to track the execution of expected cost savings relative to goals, comparing these processes with criteria from GAO's *Business Process Reengineering Assessment Guide*.⁵

We conducted this performance audit from October 2021 to August 2023 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

³Department of Defense, *Report to the Armed Services Committees of the Senate and House of Representatives, Final Plan to Implement Section 1073c of Title 10, United States Code, Final Report* (June 30, 2018); Defense Health Agency, *Plan 3: Implementation Plan for the Complete Transition of Military Medical Treatment Facilities to the Defense Health Agency*, Version 6.0 (August 12, 2019).

⁴Department of Defense Directive 1100.4, *Guidance for Manpower Management* (Feb. 12, 2005).

⁵GAO, *Business Process Reengineering Assessment Guide—Version 3*, [GAO/AIMD-10.1.15](#) (Washington, D.C.: May 1997).

**Appendix I: Objectives, Scope, and
Methodology**

the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II: Comments from the Department of Defense



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

June 28, 2023

Ms. Brenda S. Farrell
Director, Defense Capabilities and Management
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Farrell:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) draft report GAO-23-105441, "DEFENSE HEALTH CARE: DOD Should Reevaluate Market Structure for Medical Treatment Facility Management" dated June 1, 2023 (GAO Code 105441)

Attached is DoD's proposed response to this report. My point of contact is CDR Stephen Lewis, who can be reached at stephen.l.lewis.mil@health.mil.

Sincerely,

MULLEN, SEIL
EEN, MARIE. 1
519853007

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Date: 2023.06.28
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Lester Martínez-López, M.D., M.P.H.

Attachments:
As stated

**GOVERNMENT ACCOUNTABILITY OFFICE DRAFT REPORT DATED JUNE 1, 2023
GOVERNMENT ACCOUNTABILITY OFFICE -23-105441 (GOVERNMENT
ACCOUNTABILITY OFFICE CODE 105441)**

**“DEFENSE HEALTH CARE: DoD Should Reevaluate Market Structure for Medical
Treatment Facility Management”**

**DEPARTMENT OF DEFENSE COMMENTS
TO THE GOVERNMENT ACCOUNTABILITY OFFICE RECOMMENDATION**

RECOMMENDATION 1: The Secretary of Defense should ensure that the Deputy Secretary of Defense, in coordination with the Under Secretary of Defense for Personnel and Readiness (USD(P&R)), prioritizes a reevaluation of its organizational approach for the Defense Health Agency’s (DHA) market-based management structure, including the possible consolidation under DHA headquarters of some or all management activities currently vested with Market offices, and use the conclusions to study and validate workloads and personnel requirements.

DoD RESPONSE: DoD concurs with this recommendation. DoD is presently reevaluating DHA’s Market-based management structure.

RECOMMENDATION 2: The Secretary of Defense should ensure that the USD(P&R) establishes performance goals for its transition-related clinical and business reform initiatives, and then monitors the results in relation to projected savings.

DoD RESPONSE: DoD partially concurs. Virtually all transition-related clinical and business reform initiatives are completed: The DHA has issued administrative instructions and procedural instructions that standardize the means by which DHA manages military medical treatment facilities (MTFs). Leaders are identified and in place at all management tiers of the DHA. Military Health System and DHA Strategic Plans, respectively, have identified new initiatives with the overarching goals of improving readiness, clinical outcomes, patient safety, and patient experience. These plans will also include processes to closely monitor resource utilization – both personnel and funds.

Text of Appendix II: Comments from the Department of Defense

June 28, 2023

Ms. Brenda S. Farrell

Director, Defense Capabilities and Management

U.S. Government Accountability Office

441 G Street, NW

Washington, DC 20548

Dear Ms. Farrell:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) draft report GAO-23-105441, "DEFENSE HEALTH CARE: DOD Should Reevaluate Market Structure for Medical Treatment Facility Management" dated June 1, 2023 (GAO Code 105441)

Attached is DoD's proposed response to this report. My point of contact is CDR Stephen Lewis, who can be reached at stephen.l.lewis.mil@health.mil.

Sincerely,

Digitally signed by MULLEN.SEILEEN.MAR

Lester Martínez-López, M.D., M.P.H.

Attachments:

As stated

GOVERNMENT ACCOUNTABILITY OFFICE DRAFT REPORT
DATED JUNE 1, 2023 GOVERNMENT ACCOUNTABILITY
OFFICE -23-105441 (GOVERNMENT ACCOUNTABILITY OFFICE
CODE 105441)

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Appendix III: GAO Contact and Staff Acknowledgments

GAO Contact

Brenda S. Farrell at (202) 512-3604 or FarrellB@gao.gov

Staff Acknowledgments

Vincent Balloon (Assistant Director), Melissa Blanco (Analyst in Charge), Alexandra Gonzalez, Simon Hirschfeld, Mae Jones, David Jones, Ron La Due Lake (retired), Nathan Parmeter, Amber Sinclair, Jordan Tibbetts, and Jaya Walker made key contributions to this report.

Related GAO Products

Defense Health Care: Actions Needed to Define and Sustain Wartime Medical Skills for Enlisted Personnel. [GAO-21-337](#). Washington, D.C.: June 17, 2021.

Defense Health Care: Additional Information and Monitoring Needed to Better Position DOD for Restructuring Medical Treatment Facilities. [GAO-20-371](#). Washington, D.C.: May 29, 2020.

Defense Health Care: DOD Should Collect and Use Key Information to Make Decisions about Incentives for Physicians and Dentists. [GAO-20-165](#). Washington, D.C.: January 15, 2020.

Defense Health Care: Additional Assessments Needed to Better Ensure an Efficient Total Workforce. [GAO-19-102](#). Washington, D.C.: November 27, 2018.

Defense Health Care: DOD Should Demonstrate How Its Plan to Transfer the Administration of Military Treatment Facilities Will Improve Efficiency. [GAO-19-53](#). Washington, D.C.: October 30, 2018.

Military Personnel: Additional Actions Needed to Address Gaps in Military Physician Specialties. [GAO-18-77](#). Washington, D.C.: February 28, 2018.

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. [GAO-17-791R](#). Washington, D.C.: September 29, 2017.

Defense Health Care Reform: DOD Needs Further Analysis of the Size, Readiness, and Efficiency of the Medical Force. [GAO-16-820](#). Washington, D.C.: September 21, 2016.

Defense Health Care Reform: Actions Needed to Help Ensure Defense Health Agency Maintains Implementation Progress. [GAO-15-759](#). Washington, D.C.: September 10, 2015.

Military Health System: Sustained Senior Leadership Needed to Fully Develop Plans for Achieving Cost Savings. [GAO-14-396T](#). Washington, D.C.: February 26, 2014.

Defense Health Care Reform: Additional Implementation Details Would Increase Transparency of DOD's Plans and Enhance Accountability. [GAO-14-49](#). Washington, D.C.: November 6, 2013.

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