

September 2012

# DEFENSE HEALTH CARE

## Additional Analysis of Costs and Benefits of Potential Governance Structures Is Needed



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## Why GAO Did This Study

Over the past decade, the cost of the MHS has grown substantially and is projected to reach nearly \$95 billion by 2030 according to the Congressional Budget Office. As health care costs consume an increasingly large portion of the defense budget, current DOD leadership and Congress have recognized the need to better control these costs. Section 716 of the National Defense Authorization Act for Fiscal Year 2012 required DOD to submit a report analyzing potential MHS governance options under consideration, and also required GAO to submit an analysis of these options. In response to this mandate, GAO determined the extent to which DOD's assessment provides complete information on cost implications and the strengths and weaknesses of potential MHS governance options. To conduct this review, GAO analyzed DOD's governance report along with supporting documents, and interviewed Task Force members.

## What GAO Recommends

GAO recommends that DOD develop (1) a comprehensive cost analysis for its potential MHS governance options, (2) a business case analysis and strategy for implementing its shared services concept, and (3) more complete analyses of the options' strengths and weaknesses. DOD concurred with developing a business case analysis for its shared services concept. DOD did not concur with the other 2 recommendations, stating that further analysis would not alter its conclusions. GAO disagrees and believes that more comprehensive analysis will help to distinguish the differences among the costs and benefits of the options.

View [GAO-12-911](#). For more information, contact Brenda S. Farrell at (202) 512-3604 or [farrellb@gao.gov](mailto:farrellb@gao.gov).

## DEFENSE HEALTH CARE

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## What GAO Found

The Department of Defense's (DOD) assessment of potential governance options for its Military Health System (MHS) did not provide complete information on the options' total cost impact and their strengths and weaknesses. As part of DOD's assessment, it identified 13 potential governance options for the MHS and included a limited analysis of the options' estimated costs savings and their strengths and weaknesses. All of the options would create a shared services concept to consolidate common services, such as medical logistics, acquisition, and facility planning, under the control of a single entity. DOD selected an option that would create a defense health agency to, among other things, assume the responsibility for creating and managing shared services, and leave the long-standing military chain of command intact with the services in control of the military hospitals. The National Defense Authorization Act (Act) for Fiscal Year 2012 required DOD to submit a report to congressional committees that would, among other things, estimate the cost savings and analyze the strengths and weaknesses of each option. Using key principles derived from federal guidance, including cost estimating and economic analysis documents, GAO determined that DOD could have provided more information on cost implications and strengths and weaknesses in its report to Congress. Specifically, DOD did not (1) estimate implementation costs and comprehensive cost savings; (2) include a business case to support consolidating common services; or (3) include supporting quantitative data in its analysis of the options' strengths and weaknesses.

- DOD's cost analysis for its potential MHS governance options was limited in that it did not include implementation costs and only estimated personnel costs savings based on some potentially flawed assumptions, such as not using representative salaries to estimate personnel savings.
- DOD did not develop a business case analysis and an implementation strategy for its proposed shared services concept. A business case analysis would, among other things, define the services to be consolidated, cost to implement and efficiencies to be achieved and could support DOD's assertion that implementing shared services could achieve efficiencies. DOD approved a shared services concept two other times since 2006, but it has yet to develop a business case analysis that would provide a data-driven rationale for implementing the concept.
- DOD used a qualitative process with input from internal experts to assess the strengths and weaknesses of the potential governance structures. However, it did not balance this support with quantitative data as its criteria for assessing the strengths and weaknesses specified.

DOD officials stated that they did not provide comprehensive cost estimates or quantitative analysis of the options because an internal 90-day deadline to report back to the Deputy Secretary of Defense did not allow enough time. However, the act requiring DOD to report to Congress was enacted subsequent to DOD's own internal assessment and did not establish a specific deadline. As a result, DOD could have taken time to conduct a more comprehensive analysis before submitting its report.

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## Abbreviations

BRAC	Base Realignment and Closure
DOD	Department of Defense
MHS	Military Health System
JTF CapMed	Joint Task Force National Capital Region Medical

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United States Government Accountability Office  
Washington, DC 20548

September 26, 2012

### Congressional Committees

Over the past decade, the cost of the Department of Defense's (DOD) Military Health System (MHS) has grown substantially. DOD's fiscal year 2013 budget request for health care is almost \$50 billion,<sup>1</sup> and is projected to reach about \$95 billion by 2030.<sup>2</sup> Historical growth rates in the MHS have been significantly higher than the corresponding rates in the national economy. For example, from 2006 to 2011, DOD experienced annual growth rates of 6.2 percent for purchased care and contracts and 5.2 percent for direct care and administration, compared with a national rate of 3.3 percent.<sup>3</sup> As health care consumes an increasingly larger portion of the defense budget, DOD leadership recognizes the need to reduce duplication, overhead, and operate the most efficient health system possible. Under the current structure, the responsibilities and authorities for the management of the MHS and the medical services it provides to over 9.7 million beneficiaries are distributed among several organizations. Several past DOD studies have suggested that realigning the MHS governance structure could help control the increase in health care costs.

Congressional leaders also have raised questions regarding rising military health costs and the MHS governance structure. For example, the House Armed Services Committee's Print accompanying the Ike Skelton National Defense Authorization Act for Fiscal Year 2011<sup>4</sup> noted that DOD

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<sup>1</sup> DOD's fiscal year 2013 budget request of \$48.7 billion for its Unified Medical Budget includes \$32.5 billion for the Defense Health Program, \$8.5 billion for military medical personnel, \$1.0 billion for military construction, and \$6.7 billion set aside for the Medicare-Eligible Retiree Health Care Fund. The total excludes overseas contingency operations funds and certain transfers.

<sup>2</sup> Congressional Budget Office, *Long-term Implications of the 2013 Future Years Defense Program*, Pub. No. 4458, July 2012.

<sup>3</sup> The national rate refers to the comparable composite category of hospital care and physician and clinical services.

<sup>4</sup> The Ike Skelton National Defense Authorization Act for Fiscal Year 2011 Pub. L. No. 111-383 (2010) was not accompanied by a conference report. In lieu of a formal conference report and joint explanatory statement, House Committee on Armed Services Print No. 5 (December 2010) was reported to show congressional intent and maintain legislative history.

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had not yet developed a comprehensive plan to enhance quality, efficiencies, and savings in the MHS, and it encouraged the Secretary of Defense to evaluate the potential operational, organizational, and financial benefits of a unified medical command. For the past 6 decades, DOD and Congress have undertaken many studies to attempt to determine the governance structure of the MHS, with many of these studies recommending major organizational realignments. However, for several years, GAO has highlighted a range of long-standing issues surrounding the MHS and its efforts to reorganize its governance structure. In 2005, we identified DOD's health care system as an example of a key challenge facing the U.S. government in the 21st century and an area in which DOD could improve delivery of services by combining, realigning, or otherwise changing selected support functions to achieve economies of scale.<sup>5</sup> Additionally, in our March 2011 report on opportunities to reduce potential duplication in government programs, we noted that realigning DOD's military medical command structures and consolidating common functions could increase efficiencies and significantly reduce costs.<sup>6</sup>

In June 2011, the Deputy Secretary of Defense established a Task Force to review various options for changes to the overall governance structure of the MHS and of its multi-service medical markets and to provide a report back within 90 days.<sup>7</sup> The Task Force submitted a report to the Deputy Secretary of Defense in September of 2011. Further, the National Defense Authorization Act for Fiscal Year 2012 required DOD to submit a report to the congressional defense committees to include a description of the alternative MHS governance structures developed and considered by the Task Force; the goals to be achieved by restructuring or reorganization and the principles upon which the goals are based; a description of how each option would affect readiness, quality of care, and beneficiary satisfaction; an explanation of the costs of each potential option considered; an analysis of the strengths and weaknesses of each

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<sup>5</sup> GAO, *21st Century Challenges: Reexamining the Base of the Federal Government*, [GAO-05-325SP](#) (Washington, D.C.: Feb. 2005).

<sup>6</sup> GAO, *Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue*, [GAO-11-318SP](#) (Washington, D.C.: Mar. 1, 2011).

<sup>7</sup> Deputy Secretary of Defense Memorandum, *Review of Governance Model Options for the Military Health System* (Jun. 14, 2011). Multi-service medical markets are areas in which more than one DOD component provides military health care services.

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option; and an estimate of the cost savings, if any, to be achieved by each option compared to the MHS in place on December 31, 2011. No deadline for DOD's report was included in the statutory language. Additionally, we were required to submit a subsequent report to the congressional defense committees within 180 days from the date DOD issued its report (March 2, 2012) reviewing, among other things, the cost implications and strengths and weaknesses of DOD's potential governance structures.<sup>8</sup> In response to this mandate, we determined the extent to which (1) DOD's preferred governance option, and the other options presented in its report, change the current structure of the MHS; (2) DOD developed a cost analysis of its potential MHS governance options; and (3) DOD's assessment of the strengths and weaknesses of its potential governance options is well supported and data-driven.

To determine how DOD's preferred governance option and the other options presented in its report would change the current structure of the MHS, we obtained and reviewed the current MHS governance structure including identifying key changes that have occurred since 1991 by reviewing relevant legislative materials and DOD directives, as well as interviewing knowledgeable DOD officials. We then compared the current governance structure with each of the potential options by using the terms of reference from the Task Force report. To determine the extent to which DOD has developed a cost analysis of its potential MHS governance options, we reviewed DOD's analysis using key principles we derived from cost estimating and budgeting guidance.<sup>9</sup> To apply those principles, we reviewed DOD's report, interviewed Task Force members concerning

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<sup>8</sup> National Defense Authorization Act for Fiscal Year 2012, Pub. L. No. 112-81, § 716 (2011). The act also prohibits the Secretary of Defense from restructuring or reorganizing the MHS until 120 days after we submit our report.

<sup>9</sup> We reviewed numerous federal guidance documents related to cost estimating, accounting standards, economic analysis, and budgeting and identified key principles that we believe can be applied to the evaluation of cost savings estimates. The guidance documents we reviewed include: *GAO Cost Estimating and Assessment Guide, GAO-09-3SP* (Washington, D.C.: Mar. 2, 2009); Office of Management and Budget Circular No. A-11, *Preparation, Submission and Execution of the Budget* (Aug. 2011, superseded by an August 2012 issuance); Federal Accounting Standards Advisory Board, *Statement of Federal Financial Accounting Standards 4* (June 2011); Department of Defense Instruction 7041.3, *Economic Analysis for Decisionmaking* (Nov. 7, 1995); and Department of Defense Financial Management Regulation 7000.14-R, Volume 4, Chapter 22, *Cost Finding* (May 2010). Although each of these documents may not apply to these circumstances as a legal matter, we believe that they collectively contain broad themes that can be applied to evaluating cost analyses.

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their analysis, and identified broad cost categories that should be considered in the course of implementing DOD's governance transformation. We were unable to rely on DOD's cost savings estimates because the estimates and their supporting data were insufficient in the key data elements needed to completely and accurately develop them as discussed in the findings section of this report. Finally, to determine the extent to which DOD's assessment of the strengths and weaknesses of its potential governance options is well-supported and data driven, we obtained and reviewed the Task Force's supporting documents including meeting minutes, briefing slides, and the voting template for the criteria and process used to formulate the strengths and weaknesses of the options. We also interviewed Task Force officials regarding their involvement in the process and how they formulated their assessments. For each of our objectives, we limited our review to the potential overall governance structures that the Task Force presented in its report. We did not specifically review the proposed changes to DOD's multi-service medical markets or to the governance structure in place within the National Capital Region as presented in the Task Force report because we determined these proposed changes were outside the scope of our mandate. We conducted this performance audit from March 2012 through September 2012 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. For details on our scope and methodology, see appendix I.

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## Background

The MHS is a complex organization that provides health services to its beneficiaries across a range of care venues, from the battlefield to traditional hospitals and clinics at stationary locations. The current management of this large health system is spread over several organizations in order to meet its two-fold mission of ensuring servicemember readiness and delivering beneficiary care. Over the years many studies have been conducted to assess potential changes to the governance structure of the MHS.

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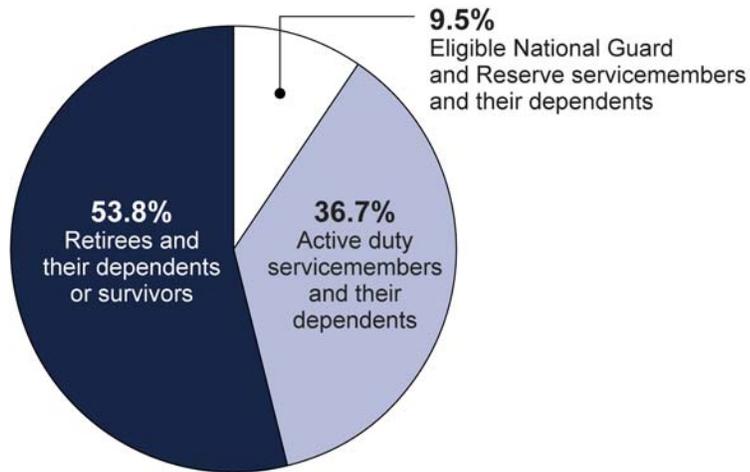
## Current Governance Structure of DOD's Military Health System

DOD operates its own large, complex health system that employs almost 140,000 military, civilian, and contract personnel who work in medical facilities throughout the world to provide health care to approximately 9.7 million beneficiaries.<sup>10</sup> Operationally, the MHS has two missions: supporting wartime and other deployments, known as the readiness mission, and providing peacetime care, known as the benefits mission. The readiness mission provides medical services and support to the armed forces during military operations, including deploying medical personnel and equipment throughout the world, and ensures the medical readiness of troops prior to deployment. The benefits mission provides medical services and support to members of the armed forces, retirees, and their dependents. Beneficiaries fall into several different categories: (1) active duty servicemembers and their dependents, (2) eligible National Guard and Reserve servicemembers and their dependents, and (3) retirees and their dependents or survivors. As of May 2012, active duty servicemembers and their dependents represented 36.7 percent of the beneficiary population, eligible National Guard and Reserve servicemembers and their dependents represented 9.5 percent, and retirees and their dependents or survivors made up the remaining 53.8 percent. See figure 1.

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<sup>10</sup> In addition to approximately 9.7 million beneficiaries, DOD also provides care and, in some cases, rehabilitation for veterans as part of its coordination with the Department of Veterans Affairs on health care services.

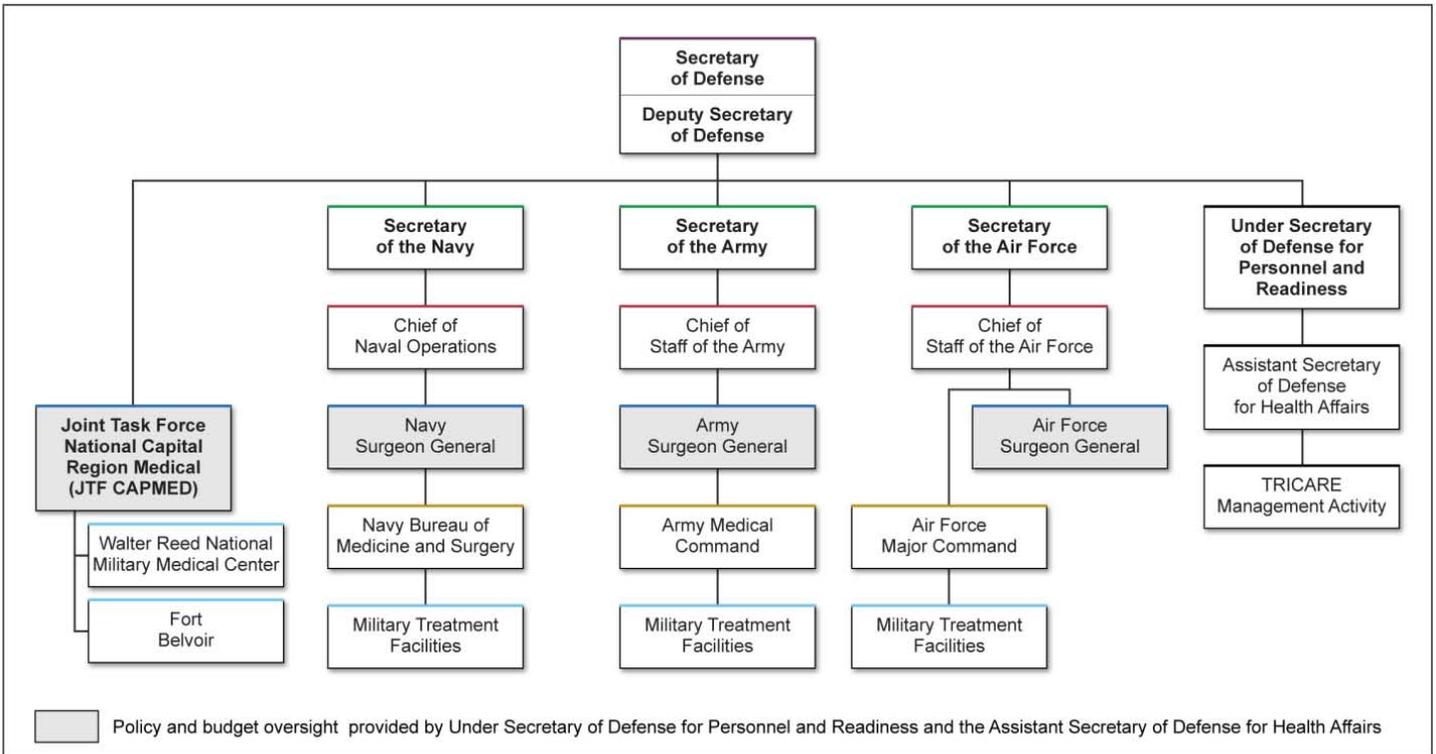
**Figure 1: Distribution of Beneficiaries as of May 2012**



Source: GAO analysis of DOD data.

Reporting to the Under Secretary of Defense (Personnel and Readiness), the Assistant Secretary of Defense (Health Affairs) is the principal advisor for all DOD health policies, programs, and force health protection activities. The Assistant Secretary of Defense (Health Affairs) issues policies, procedures, and standards that govern management of DOD medical programs and has the authority to issue DOD instructions, publications, and directive-type memorandums that implement policy approved by the Secretary of Defense or the Under Secretary of Defense (Personnel and Readiness). As the Director of the TRICARE Management Activity, the Assistant Secretary of Defense (Health Affairs) is also responsible for awarding, administering, and overseeing approximately \$24.4 billion in fiscal year 2012 funding for DOD's purchased care network of private sector civilian primary and specialty care providers. Additionally, the Assistant Secretary of Defense (Health Affairs) integrates the military departments' budget submissions into a unified medical budget that provides resources for MHS operations; however, the military services have direct command and control of the military hospitals and their medical personnel. See figure 2 for the current organizational structure of the MHS.

**Figure 2: Governance Structure of the MHS as of August 2012**



Source: DOD.

The care of the eligible beneficiary population is also spread across the Army, the Navy, and the Air Force, which deliver care at 56 inpatient facilities and hundreds of clinics. Both the Army and the Navy have medical commands headed by surgeons general. The Army's portion of the fiscal year 2012 Unified Medical Budget's funding is approximately \$11.8 billion, and it manages 24 of the 56 inpatient facilities. Additionally, the Navy's portion of the fiscal year 2012 Unified Medical Budget funding was approximately \$6.4 billion. It manages 19 of the 56 inpatient facilities and provides medical support to the Marine Corps. Additionally, the Air Force's portion of the fiscal year 2012 Unified Medical Budget's funding is approximately \$6.6 billion, and it manages 13 of the 56 inpatient clinics. The Air Force Surgeon General serves as medical advisor to the Air Force Chief of Staff and as functional manager of the Air Force Medical Service. Air Force hospitals and their personnel do not report to the Air Force Surgeon General, but directly to local line commanders. Each military department also recruits, trains, and funds its own medical

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personnel to administer the medical programs and provide medical services to beneficiaries.

Specifically for the management of Military Treatment Facilities within the National Capital Region and the execution of related Base Realignment and Closure (BRAC) actions in that area, an additional medical organizational structure and reporting chain was established in 2007.<sup>11</sup> This structure is known as the Joint Task Force National Capital Region Medical, and its Commander reports to the Secretary of Defense through the Deputy Secretary of Defense. The two inpatient medical facilities in the area, Walter Reed National Military Medical Center and Fort Belvoir Community Hospital, were directed by the Deputy Secretary of Defense in January 2009 to become joint commands.<sup>12</sup>

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## Studies of Governance Structures for DOD's Military Health System

As early as March 1949, the following recommendation was presented to the Secretary of Defense:

"The Joint Chiefs of Staff recommend unanimously that the Secretary of Defense immediately institute studies and measures intended to produce, for the support of the three fighting services, a completely unified and amalgamated (single) Medical Service."<sup>13</sup>

As noted in DOD's 2011 Task Force report, a long series of studies have addressed the issue of DOD's health care organization. Performed by both internal and external boards, commissions, task forces, and other entities, a number of these studies have recommended dramatic changes in the organizational structure of military medicine. See figure 3 for a timeline of MHS governance studies.

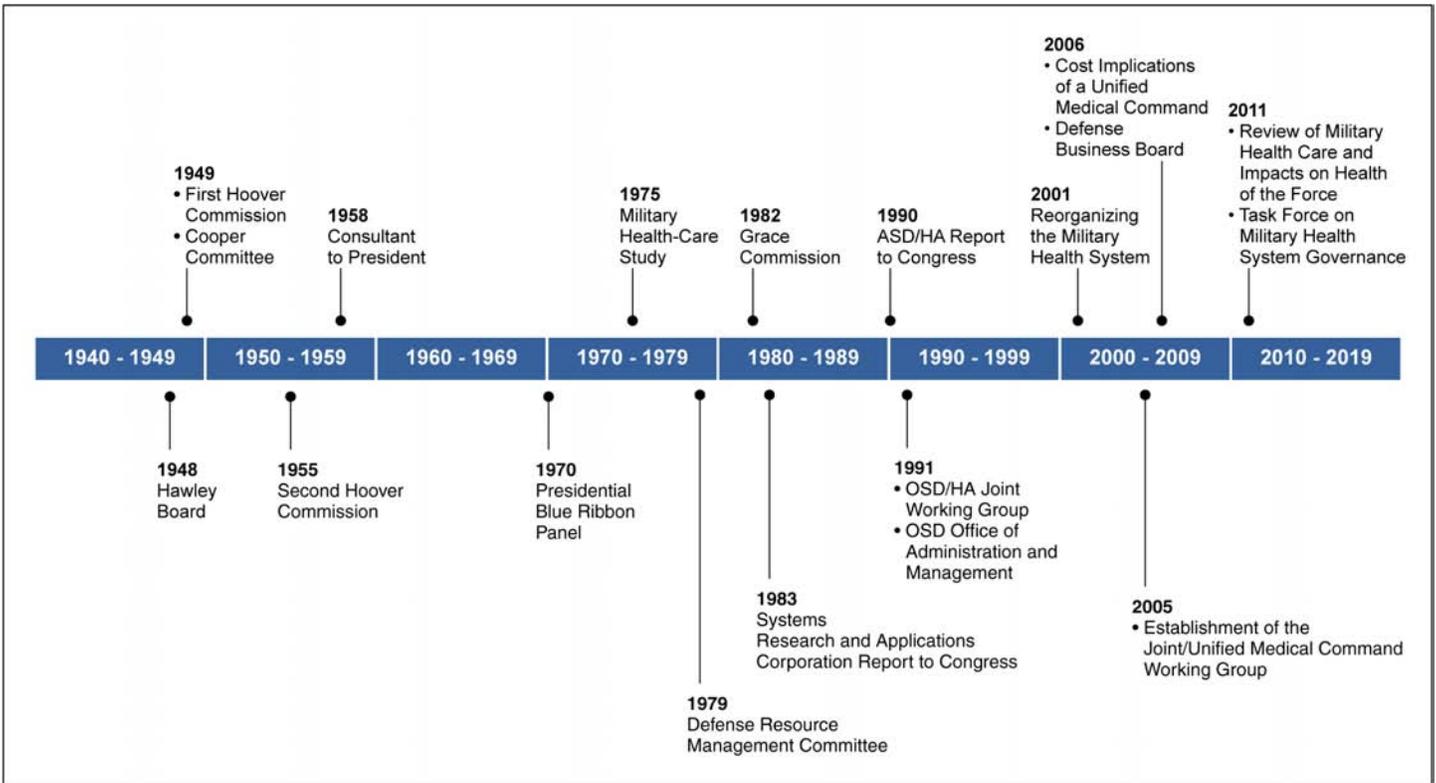
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<sup>11</sup> The 2005 BRAC Commission recommended that certain patient care activities at Walter Reed Army Medical Center in Washington, D.C., be relocated to the National Naval Medical Center in Bethesda, Maryland, and to a new community hospital at Fort Belvoir, Virginia.

<sup>12</sup> According to DOD, as of August 2012, these hospitals were operating on an interim manning document.

<sup>13</sup> Department of Defense, *Review of the Department of Defense Organization for Health Care*, March 1991.

**Figure 3: Timeline of Military Health System Governance Studies**



Source: GAO analysis of DOD information.

Although many of these studies favored a unified system or a stronger central authority to improve coordination among the services, major organizational change has historically been resisted by the military services in favor of the retention of their respective independent health care systems. In 1995, we reported that interservice rivalries and conflicting responsibilities, hindered improvement efforts,<sup>14</sup> and noted that the services' resistance to changing the way military medicine is organized is based primarily on the grounds that each service has unique medical activities and requirements.

<sup>14</sup> GAO, *Defense Health Care: Issues and Challenges Confronting Military Medicine*, GAO/HEHS-95-104 (Washington, D.C.: Mar. 22, 1995).

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## Overview of DOD's 2011 Task Force and Its Potential Governance Options

In June 2011, with the pending completion of the consolidation of medical facilities and functions in the National Capital Region undertaken by DOD in response to 2005 BRAC Commission recommendations, the Deputy Secretary of Defense recognized that a final decision concerning the governance of military health care in the capital region needed to be made. This need for a decision provided an opportunity to address the desired end-state governance structure of the entire MHS. Furthermore, in light of the considerable, long-term fiscal challenges the nation faces, and the 2010 comprehensive review established by the then-Secretary of Defense to inform future decisions about spending on national security, the Deputy Secretary of Defense wrote that it was important to ensure that MHS was organized in a way that curtails expenses and achieves savings to the greatest extent possible in meeting its mission.

As a result, in June of 2011, the Deputy Secretary of Defense established an internal task force to conduct a review of the current governance structure of the MHS. The Task Force was directed to evaluate options for the long-term governance of the MHS as a whole and for the governance of multi-service medical markets, to include the National Capital Region and to provide a report within 90 days detailing the relative strengths and weaknesses of each option evaluated as well as recommendations. The Deputy Secretary of Defense designated the co-chairs of the Task Force as the Deputy Assistant Secretary of Defense (Force Health Protection and Readiness) and the Joint Staff Surgeon. The Task Force also contained representatives from the military services,<sup>15</sup> the Joint Chiefs of Staff, the DOD Comptroller, the Cost Assessment and Program Evaluation Office, and the Under Secretary of Defense (Personnel and Readiness). In addition to this membership, the co-chairs included representatives from the Office of the Deputy Secretary of Defense, the DOD Office of General Counsel, Legislative Affairs, and Administration and Management as advisors to the Task Force.

*Potential Governance Structures*—DOD's report, submitted to the Deputy Secretary of Defense in September of 2011 and later to Congress in response to section 716 of the National Defense Authorization Act for Fiscal Year 2012, presented 13 potential governance structures for the

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<sup>15</sup> The Task Force subsequently added a representative from the Marine Corps to the Department of the Navy delegation.

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overall MHS, with other options for governance of multi-service medical markets and the National Capital Region. The potential options were variations of the following three governance structures:<sup>16</sup>

- The **defense health** agency governance structures would create a combat support agency led by a 3-star flag officer (Lieutenant General or Vice Admiral) who would report to the Assistant Secretary of Defense (Health Affairs). This agency would be focused on consolidating and delivering a set of shared health care support services. DOD presented variations of a defense health agency which would (1) leave management of the Military Treatment Facilities with the military services, (2) place the management of the Military Treatment Facilities under the control of the defense health agency, or (3) create hybrid structures by pairing the agency with other options such as a unified medical command.
- The **unified medical command** governance structures would create a unified functional combatant command led by a 4-star flag officer (General or Admiral) who would report to the Secretary of Defense. The command would exercise direction and control over the entire MHS but would do so either through (1) service components, (2) geographic regions, (3) a subordinate health care command, or (4) various hybrid governance structures pairing the unified medical command with other options such as a designated single service structure.
- Finally, the **single service** governance structures would place overall control of the MHS under one designated military department Secretary, who would report to the Secretary of Defense. However, each of the services would continue to organize, train, and equip their respective forces. The Military Treatment Facilities report to the designated military department Secretary through a variety of local and regional commands combinations.

See appendix II for a more detailed description of DOD's potential governance options.

*Task Force Voting Process*—Through the course of 20 formal meetings, the Task Force members evaluated 13 potential overall governance

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<sup>16</sup> These three structures are in addition to the current MHS structure, which the Task Force included in the 13 options presented in the report.

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structures by first establishing criteria for evaluation and developing a system to weight the criteria to reflect their relative importance. After formulating criteria, the Task Force discussed each potential governance structure in detail. Following discussion, the individual Task Force members voted on the governance structures by scoring them according to the criteria. The member score was then adjusted by the weights established by the Task Force, and the governance structures were ranked according to the final, weighted score. The Task Force held five voting rounds on the governance options throughout the 90 days allotted to the review process (rather than holding a single vote at the end of the review). Using this method, the Task Force evaluated the potential structures in “head-to-head” voting rounds, until the governance option that the Task Force believed was the highest ranking was determined.

*Task Force Results*—The Task Force provided the Deputy Secretary of Defense with a report and a recommendation as to which course of action to follow for changing the governance structure of the overall MHS, the multi-service medical markets, and specifically, the National Capital Region. For the overall MHS, the Task Force’s recommendation was to pursue the formation of a defense health agency which would consolidate common shared services<sup>17</sup> in support of the three military departments and to leave the medical components of the military departments as they are currently. The rationale for this action, according to the Task Force report, would allow DOD to create shared services, common business and clinical practices under one leader without large-scale changes to the MHS at this time. According to the Task Force report, pursuing this preferred option would not preclude subsequent decisions by the Department to implement more sweeping changes in the future and was considered an appropriate incremental next step to improving MHS governance and providing a structure to rein in healthcare costs.

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<sup>17</sup> According to DOD a shared services concept is a combination of common services performed across the medical community, such as medical logistics, facility planning, medical education and training, health information technology, and medical research and development.

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## DOD's Preferred Option Generally Retains Command Structures and Includes a Shared Service Concept

DOD's preferred option would create a defense health agency that would assume the responsibility for shared services in the MHS with military hospitals remaining under the control of the services while other potential options represent larger scale changes. In addition, DOD's preferred option would include implementing a shared services concept, which was common to all of its governance options; however, DOD did not develop a business case analysis that would provide a data-driven rationale for implementing the concept.

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## DOD's Preferred Option Creates a New Agency but Maintains Established Military Chains of Command

DOD's preferred option creates a defense health agency that would report to the Assistant Secretary of Defense (Health Affairs) and would consolidate and deliver shared services in the MHS while services would maintain control of their military hospitals. DOD presented a wide range of governance structures in its report, such as creating another unified functional combatant command or establishing a single service in charge of all medical operations. However, DOD's preferred option does not require complex changes in long-established military chains of command like some other structures would. As discussed earlier, currently the Army, the Navy, and the Air Force manage their own personnel, hospitals, and medical operations. The Assistant Secretary of Defense (Health Affairs) exercises authority, direction, and control over the policies and resources of the MHS, but does not have command and control over the military hospitals or over the respective military departments' medical personnel. Over the years, DOD has shifted certain responsibilities and authorities among various MHS officials, as seen in the establishment of the Assistant Secretary of Defense (Health Affairs) authority over the Defense Health Program in 1991 and the TRICARE Management Activity in 1998, both of which remain part of the current MHS. In 1991, the Defense Health Program was established as the result of a study of governance options for the MHS to address concerns about recurring funding crises and concerns over the inconsistent distribution of health care services and benefits among the different military departments. In 1992, Department of Defense Directive 5136.1 assigned responsibility for the program to the Assistant Secretary of Defense (Health Affairs). Later, the TRICARE Management Activity was created to reduce duplication within management of the MHS and transfer the direct management of several functions away from the Assistant Secretary of Defense (Health Affairs) to allow that position to concentrate on major policy and Defense Health Program related issues and initiatives. Together, all of these entities and their responsibilities have evolved into the current MHS governance structure.

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The Task Force reviewed multiple versions of three basic governance structures—defense health agency, unified medical command, and single service. The options' primary differences from the current structure of the MHS occur mainly in three particular areas of roles and responsibilities—overall control, budgetary authority, and control of personnel. DOD's preferred governance option is a defense health agency with military hospitals remaining under the control of the military services. The unified medical command options would assign the services' medical assets to a functional combatant command. Lastly, the single service options would assign these assets to a single military service. Figure 4 summarizes variations of these three structures and the current structure as it has evolved over the years, while figure 5 presents a number of hybrid models also considered by the Task Force, such as an option which includes a unified medical command sharing responsibilities with a defense health agency.

**Figure 4: Summary of Differences in Governance Elements for the Potential Defense Health Agency, Unified Medical Command, and the Single Service Governance Structures**

Options	Overall control <i>Determines dispute resolution and lines of accountability</i>	Budgetary authority <i>Determines the organizational entity with budgetary authority for the Defense Health Program</i>	Control of personnel <i>Management and supervisory chains of Military Treatment Facilities</i>	Control of personnel <i>Control over Military Health System (MHS) mission personnel</i>
<b>Current model</b>				
Current Military Health System Governance Structure	Assistant Secretary of Defense (Health Affairs)	Assistant Secretary of Defense (Health Affairs)	Military departments	Military departments
<b>Defense Health Agency models</b>				
<b>Preferred option</b> Defense Health Agency with Military Treatment Facilities Under the Services	Assistant Secretary Defense (Health Affairs)	Assistant Secretary Defense (Health Affairs)	Military departments	Military departments
Defense Health Agency – Geographic Model	Defense Health Agency, the Director of the Defense Health Agency reports to the Assistant Secretary of Defense (Health Affairs)	Defense Health Agency	Defense Health Agency	<ul style="list-style-type: none"> <li>• Defense Health Agency (peacetime medical mission)</li> <li>• Military Departments (deployed forces and administrative control)</li> </ul>
Defense Health Agency Hybrid with Medical Treatment Facilities placed under the Agency	Defense Health Agency, but Assistant Secretary of Defense (Health Affairs) would have an oversight and policy role. Military Departments would be responsible for the size and capabilities of the active duty medical forces.	Defense Health Agency, with oversight from Assistant Secretary of Defense (Health Affairs)	Military departments	Defense Health Agency
Defense Health Agency Hybrid with Regional Military Treatment Facilities	Assistant Secretary of Defense (Health Affairs), Combatant Command, or Designated Service Secretary	Assistant Secretary of Defense (Health Affairs), Combatant Command, or Designated Service Secretary	Military departments through regional enhanced Multi-Service Market offices	No information provided in Task Force report
<b>Unified Medical Command models</b>				
Unified Medical Command – Geographic Model	Unified Medical Command	Unified Medical Command	Unified Medical Command	Unified Medical Command
Unified Medical Command with Service Components	Unified Medical Command	Unified Medical Command	Unified Medical Command	Unified Medical Command
Unified Medical Command – HR 1540	Unified Medical Command	<ul style="list-style-type: none"> <li>• Unified Medical Command</li> <li>• Military departments (planning, programming, budget, and execution over the wartime forces)</li> </ul>	Unified Medical Command	<ul style="list-style-type: none"> <li>• Unified Medical Command (force provider authorities)</li> <li>• Military departments (wartime forces)</li> </ul>
<b>Single service models</b>				
Single Service – Geographic Model	Military department	Military department	Military department	Military department
Single Service with Service Components	Military department	Military department	Military department	Military department

Source: GAO analysis of DOD information.

**Figure 5: Summary of Differences in Governance Elements for the Potential Hybrid Governance Structures**

Options	Overall control <i>Determines dispute resolution and lines of accountability</i>	Budgetary authority <i>Determines the organizational entity with budgetary authority for the Defense Health Program</i>	Control of personnel <i>Management and supervisory chains of Military Treatment Facilities</i>	Control of personnel <i>Control over Military Health System (MHS) mission personnel</i>
Hybrid models				
Unified Medical Command and Defense Health Agency – Geographic Model	<ul style="list-style-type: none"> <li>Unified Medical Command (wartime forces)</li> <li>Defense Health Agency (peacetime medical personnel)</li> </ul>	<ul style="list-style-type: none"> <li>Assistant Secretary of Defense (Health Affairs) (review)</li> <li>Defense Health Agency (execution)</li> <li>Unified Medical Commander (execute Defense Health Program funding to support medical readiness)</li> <li>Military departments (planning, programming, budget, and execution inputs for Service-funded forces)</li> </ul>	Defense Health Agency	<ul style="list-style-type: none"> <li>Unified Medical Command (wartime forces in the Military Treatment Facilities)</li> <li>Military departments (administration control)</li> </ul>
Unified Medical Command with Service Components and Defense Health Agency	<ul style="list-style-type: none"> <li>Unified Medical Command (operational control over all forces and the Military Treatment Facilities and serve as a force provider)</li> <li>Defense Health Agency (operational control over assigned personnel)</li> </ul>	<ul style="list-style-type: none"> <li>Assistant Secretary of Defense (Health Affairs)</li> <li>Defense Health Agency (program and budget execution authority for shared and consolidated services)</li> <li>Unified Medical Command (Defense Health Program funding to the Components and Military Treatment Facility health care delivery system)</li> <li>Military departments (planning, programming, budget, and execution input for Service-funded forces)</li> </ul>	Unified Medical Command	<ul style="list-style-type: none"> <li>Defense Health Agency (shared and consolidated services)</li> <li>Unified Medical Command (operational control of forces and Military Treatment Facilities)</li> <li>Military departments (administration control)</li> </ul>
Single Service with a Unified Medical Command	<ul style="list-style-type: none"> <li>Military department (peacetime beneficiary health care system for the MHS)</li> <li>Unified Medical Command (deployable mission and leverage single service run Military Treatment Facilities for clinical currency)</li> </ul>	<ul style="list-style-type: none"> <li>Military department (planning, programming, budget, and execution for Military Treatment Facility beneficiary delivery requirements)</li> <li>Unified Medical Command (provide forces to the designated service; have planning, programming, budget, and execution for readiness equipment; and deploy forces)</li> </ul>	Military department	<ul style="list-style-type: none"> <li>Military department (tactical control)</li> <li>Unified Medical Command (wartime and medical facility forces)</li> </ul>

Source: GAO analysis of DOD information.

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- *Overall control* – determines policy making authority, dispute resolution, and lines of accountability. Under the current MHS structure, the Assistant Secretary of Defense (Health Affairs) exercises authority, direction, and control of policy and resources, but DOD noted that in practice, this structure fails to take advantage of consensus opportunities to more rapidly implement common business processes. DOD’s preferred option of a defense health agency with military hospitals remaining under the control of the services would establish a military-led combat support agency organized under the Assistant Secretary of Defense (Health Affairs) that would have authority, direction, and control of shared services, health plan management, other strategic areas, while another version of this option would assign the proposed defense health agency control of military hospitals. The unified medical command options would place authority, direction, and control of the MHS with a functional combatant commander, along with direct responsibility for execution of health care services. This option would mark a departure from the current separation of these responsibilities among the three military services. The single-service options would assign responsibility for the MHS as a whole to a designated military service Secretary who would also command all military hospitals— a departure from the current arrangement of split responsibility between the Assistant Secretary of Defense (Health Affairs) and the military departments. Under all options, the Assistant Secretary of Defense (Health Affairs) would retain a policy-making role.
  - *Budgetary authority* – determines the organizational entity or entities with responsibility over the Defense Health Program appropriation. In 2007, the Defense Health Board stated in its report, *Task Force on the Future of Military Health Care*,<sup>18</sup> that the MHS does not function as a fully integrated health care system and this lack of integration diffuses accountability for fiscal management and results in misalignment of incentives. The current governance structure vests overall budgetary authority with the Assistant Secretary of Defense (Health Affairs), who allocates funds to the services to execute their respective budgets. The Assistant Secretary of Defense (Health Affairs) does not have command and control over the military hospitals or over the respective military departments’ medical

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<sup>18</sup> Defense Health Board, *Task Force on the Future of Military Health Care* (December 2007).

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personnel. DOD's preferred option of a defense health agency with military hospitals remaining under the control of the services would not alter this aspect of the current governance structure. An alternative potential option of a defense health agency with the military hospitals under the agency's control would assume direct control of the Defense Health Program appropriation. Like the latter option, the unified medical command options would consolidate budgetary authority with a single official, a functional combatant commander, along with direct responsibility for the execution of health care, and would mark a departure from the current separation of these responsibilities. Similarly, the single-service options would streamline budgetary authority by vesting all such authority with a designated military service Secretary.

- *Personnel control* – determines which entity has management and supervisory responsibility over the personnel working within the MHS. Historically, military services have exercised command and control over their own medical personnel, and Task Force members told us that control over the medical personnel was a sensitive issue in their discussions. DOD's preferred option of a defense health agency with military hospitals remaining under the control of the services would allow the services to maintain control over their own personnel. An alternative potential option of a defense health agency with the military hospitals under the agency's control would allow the agency to take control of personnel not assigned to deployable units. The unified medical command options vary on the level of authorities retained over personnel, as some options assign control of all forces to the unified medical command, and others assign control of only some personnel to the unified medical command. The single service options provide some level of control of all personnel to the designated single military service in charge of the MHS, with variations of this option related to the assignment of the deployable medical personnel assigned to their respective military services.

DOD's potential governance options would have different effects on multi-service medical market governance, which is the management of medical care in a geographic area where more than one service operates Military Treatment Facilities through a common business plan and coordination of resources. For example, a single service option would make such coordination unnecessary, while it still might be required under a unified medical command. In its report, DOD cites the main weakness of the current governance of multi-service markets as the failure to fully leverage the medical capabilities across service boundaries in a given market to achieve efficiencies. According to DOD officials, DOD's

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preferred option of a defense health agency would allow the department to implement an enhanced management structure for the multi-service medical markets that would drive such efficiencies while avoiding complex changes to long-established military chains of command. According to DOD's report, the authorities of the multi-service market managers would be expanded to include responsibility for developing a 5-year business plan, budgetary authority for the entire medical market, and the authority to direct personnel to work in other locations within the market on a short-term basis, among other authorities. However, DOD's current effort is not its first attempt at improving multi-service medical market governance. As its report notes, DOD has experimented with different approaches to multi-service medical markets over the past 25 years, including the 2003 establishment of Senior Market Managers responsible for coordinating the development of a single business plan for all Military Treatment Facilities in each such market. In 2006, the Deputy Secretary of Defense approved the implementation of an alternative to wholesale changes in the structure of the MHS, which included seven targeted governance initiatives. Among other things, the initiatives included the establishment of governance structures for two multi-service medical markets, San Antonio and the National Capital Region, as well as the creation of governance structures that consolidate command and control of military treatment facilities in other multi-service medical markets.<sup>19</sup> As we reported in 2012, DOD established these structures in San Antonio and the National Capital Region, but had made no changes to the governance structures of other multi-service markets.<sup>20</sup> Several senior DOD officials noted that while they recognize there are efficiencies to be gained in multi-service markets, they expressed reservations concerning the details of DOD's plans for reforming such markets. One senior DOD official highlighted challenges that may arise in their operation, such as the control of medical personnel to support deployments and other missions and coordination of market business plans with the services' priorities.

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<sup>19</sup> Action Memorandum for the Deputy Secretary of Defense, *Joint/Unified Medical Command (J/UMC) Way Ahead* (Nov. 27, 2006).

<sup>20</sup> GAO, [GAO-12-224](#), *Applying Key Management Practices Should Help Achieve Efficiencies within the Military Health System*, [GAO-12-542](#) (Washington, D.C.: Apr 12, 2012).

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## DOD Did Not Present a Business Case Analysis for Its Shared Services Concept

DOD did not present a business case analysis for proceeding with its shared services concept<sup>21</sup> common to all of the proposed governance structures, including an estimate of costs to merge shared services functions, operational savings to be accrued, or the likely timeframe in which this service consolidation would achieve savings. As we have previously reported, a business-case analysis can provide a data-driven rationale for why an agency is undertaking a consolidation initiative, such as a shared services concept since consolidation is beneficial in some situations and not in others, and so a case-by-case analysis is necessary.<sup>22</sup> DOD has twice proposed this shared services concept in the past, which would consolidate areas such as information technology, contracting, and public health under one entity. DOD first proposed implementation of a shared services concept in 2006 as part of a series of seven different incremental governance initiatives adopted as an alternative to wholesale changes in the structure of the MHS. Specifically, implementation of the initiative would have created a Joint Military Health Service Directorate under a joint senior flag officer reporting to the Assistant Secretary of Defense (Health Affairs), a structure not unlike DOD's preferred option of a Defense Health Agency for its current review of MHS governance. At the time, we recommended that DOD needed to demonstrate a sound business case, including an analysis of benefits, costs, and risks, for proceeding with its seven initiatives, and DOD concurred with our recommendation.<sup>23</sup> Further, we later reported that DOD had not developed such estimates, and the Assistant Secretary of Defense (Health Affairs) had not provided guidance on how and when to complete these initiatives.<sup>24</sup> In 2012, we also reported that in the prior calendar year, DOD approved a plan to reorganize the TRICARE Management Activity and establish a shared services division with a new Military Health System Support Activity as part of the former Secretary of

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<sup>21</sup> According to DOD a shared services concept is a combination of like common services across the medical community, such as medical logistics, facility planning and construction, health information technology, and medical research and development.

<sup>22</sup> GAO, *Streamlining Government: Questions to Consider When Evaluating Proposals to Consolidate Physical Infrastructure and Management*, [GAO-12-542](#) (Washington, D.C.: May 23, 2012).

<sup>23</sup> GAO, *Defense Health Care: DOD Needs to Address the Expected Benefits, Costs, and Risks for Its Newly Approved Medical Command Structure*, [GAO-08-122](#) (Washington, D.C.: Oct. 12, 2007).

<sup>24</sup> [GAO-11-318SP](#). [GAO-12-224](#).

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Defense's effort to increase efficiencies and reduce costs with the department.<sup>25</sup> As a result of this effort, DOD reduced the fiscal year 2012 Defense Health Program budget request anticipating the establishment of the Military Health System Support Activity, but the initiative was put on hold pending the results of the Task Force report.

In addition to a data-driven analysis, our body of work on organizational mergers, acquisitions, and other transformations has shown that agencies should apply essential change management practices such as active, engaged leadership of top leaders and a dedicated implementation team to ensure the continued attention needed for a transformation to be sustained and successful, among others.<sup>26</sup> We reported in 2012 that in the implementation of its 2006 governance initiatives, including efforts to establish a shared services directorate, DOD did not establish an effective and ongoing communication strategy, did not establish a dedicated implementation team, and top leadership did not provide the sustained direction needed to maintain progress.<sup>27</sup> Moreover, we also have previously reported on the challenges that other federal agencies have faced in attempting to specifically implement shared services. For example, in December 2005, the Department of Homeland Security (DHS) halted its eMerge<sup>2</sup> program, which was expected to integrate financial management systems across the entire department and address financial management weaknesses, after DHS had spent about \$52 million, according to officials.<sup>28</sup> We noted our concern that moving forward, DHS did not have a fully developed financial management strategy and plan for the integration of its financial management systems and shared services, such as information technology hosting, business process services, and application management services.

DOD's report does not estimate the costs to implement a shared services concept or an implementation timeline. Also, while DOD estimated a projected savings of 330 full-time personnel equivalents for implementing

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<sup>25</sup> [GAO-12-224](#).

<sup>26</sup> GAO, *Highlights of a GAO Forum: Mergers and Transformation: Lessons Learned for a Department of Homeland Security and Other Federal Agencies*, [GAO-03-293SP](#) (Washington, D.C.: Nov. 14, 2002).

<sup>27</sup> [GAO-12-224](#).

<sup>28</sup> GAO, *Homeland Security: Departmentwide Integrated Financial Management Systems Remain a Challenge*, [GAO-07-536](#) (Washington, D.C.: June 21, 2007).

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this concept, it did not estimate potential savings from consolidating common services. According to DOD officials, DOD's preferred option of a defense health agency is a significant change for the MHS because it would allow the department to implement shared services in order to drive the adoption of common business and clinical practices and achieve efficiencies while not requiring complex changes to long-established military chains of command. However, under the current governance structure, the Assistant Secretary of Defense (Health Affairs) has the broad authority that could allow for the implementation of shared support services across the MHS. As noted above, DOD has developed proposals to exercise such authority in the past, but such proposals have never been implemented. Further, DOD has not developed a business case analysis for its shared services concept since it was first proposed in 2006. Until DOD develops a more detailed business case analysis, it lacks a data-driven rationale and a strategy for proceeding with the implementation of this concept.

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## DOD's Cost Analysis of Its Potential MHS Governance Options Was Limited

DOD took certain steps to develop a cost analysis for its potential MHS governance options, but we found it to be limited because it (1) did not include an estimate of implementation costs, (2) reflected only personnel cost savings, and (3) was based on some potentially flawed assumptions. DOD initiated a review of potential governance structures to assess possible changes that it anticipated could result in improved effectiveness and cost savings within the MHS. To aid its assessment, DOD included many internal stakeholders from across the department in the Task Force to solicit varying opinions and perspectives in the deliberations. As part of this process, the Task Force used a number of methods to develop estimates of the required number of full-time equivalent positions for the headquarters of each potential governance structure. To develop its cost savings estimates, the Task Force then translated these estimates of the number of required personnel into costs by multiplying the number of full-time equivalent positions by an average salary for civilian employees. The Task Force did not attempt to estimate savings other than in the area of headquarters personnel. Based on key principles we derived from cost

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estimating and budgeting guidance,<sup>29</sup> we identified two elements needed to ensure a reasonable basis for cost savings estimates: (1) inclusion of all significant costs and key assumptions and (2) use of reliable data. However, several aspects of DOD's cost analysis fell short of these principles for the following reasons.

- *DOD did not estimate implementation costs.* The Task Force's report does not include an estimate of implementation costs for any of its 13 governance options. We have previously reported that, in some instances, up-front investments are needed to yield longer-term savings.<sup>30</sup> The results of the implementation of the 2005 BRAC recommendations provide useful insight concerning the effect of implementation costs on the net impact of major transformations. For example, the estimate of the 20-year net present value<sup>31</sup> for the relocation of medical command headquarters changed from a projected net savings of \$316.3 million to a net cost of \$105.9 million. According to officials, projected increases are the result of the decision to lease a building, as opposed to the original plan to renovate an existing building or build a new facility.<sup>32</sup> Over the course of BRAC implementation, DOD's one-time implementation costs

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<sup>29</sup> We reviewed numerous federal guidance documents related to cost estimating, accounting standards, economic analysis, and budgeting and identified key principles that we believe can be applied to the evaluation of cost savings estimates. The guidance documents we reviewed include: *GAO Cost Estimating and Assessment Guide, GAO-09-3SP*; Office of Management and Budget Circular No. A-11, *Preparation, Submission and Execution of the Budget* (Aug. 2011, superseded by an August 2012 issuance); Federal Accounting Standards Advisory Board, *Statement of Federal Financial Accounting Standards 4* (June 2011); Department of Defense Instruction 7041.3, *Economic Analysis for Decisionmaking* (Nov. 7, 1995); and Department of Defense Financial Management Regulation 7000.14-R, Volume 4, Chapter 22, *Cost Finding* (May 2010). Although each of these documents may not apply to these circumstances as a legal matter, we believe that they collectively contain broad themes that can be applied to evaluating cost analyses.

<sup>30</sup> [GAO-12-542](#).

<sup>31</sup> Net present value is a financial calculation that accounts for the time value of money by determining the present value of future savings minus up-front investment costs over a specific period of time. Determining net present value is important because it illustrates both the up-front investment costs and long-term savings in a single amount. In the context of BRAC implementation, net present value is calculated for a 20-year period from 2006 through 2025.

<sup>32</sup> GAO, *Military Base Realignments and Closures: Updated Costs and Savings Estimates from BRAC 2005*, [GAO-12-709R](#) (Washington, D.C.: Jun. 29, 2012).

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increased 53 percent, from the \$21 billion originally estimated by the BRAC Commission to about \$32.2 billion,<sup>33</sup> while the 20-year net present value of savings decreased 72 percent, from \$35.6 billion originally estimated by the BRAC Commission to \$9.9 billion.<sup>34</sup> The Cost of Base Realignment and Closure Model provides a number of implementation cost categories that may be relevant to health care reorganization, including personnel severance, moving costs, and military construction. Military construction costs are particularly important, as our analysis of the implementation of the 2005 BRAC recommendations found that such expenses were largely responsible for the overall increase in implementation costs. Task Force officials told us that they did not attempt to develop implementation cost estimates for the various options, and that they intend to develop an implementation cost estimate only for DOD's preferred option as part of the implementation process. Similarly, in the course of the 2006 review of possible changes to MHS governance, DOD approved seven initiatives to improve medical governance without conducting a comprehensive cost-benefit analysis. GAO recommended that DOD needed to demonstrate a sound business case, including an analysis of benefits, costs, and risks, for proceeding with its preferred medical governance concept, and DOD concurred. However, in 2011, we reported that DOD had not developed such estimates.<sup>35</sup>

- *DOD restricted its estimates to personnel savings.* DOD's cost analysis of potential savings for its governance options was limited to changes in headquarters personnel levels and excluded other possible areas of savings. By limiting its analysis of savings for all of the governance options to changes in headquarters personnel levels, DOD's savings estimates do not consider the impact of headquarters reorganization on the larger health system. In its 2006 report on MHS governance,<sup>36</sup> CNA's Center for Naval Analyses presented additional areas of potential savings which the 2011 Task Force report did not explore. Although CNA's estimates are 6 years old and do not reflect such changes in the MHS as the consolidation of health care in the

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<sup>33</sup> Calculation and amounts in 2005 constant dollars.

<sup>34</sup> [GAO-12-709R](#).

<sup>35</sup> [GAO-11-318SP](#).

<sup>36</sup> CNA Center for Naval Analyses, *Cost Implications of a Unified Medical Command*, 2006.

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National Capital Region, the study provides several categories for potential savings beyond headquarters personnel. For example, health care operations savings could be accrued through administrative consolidation between large medical facilities which perform responsibilities on behalf of smaller clinics in the same geographic area. CNA reported that by bridging current service administrative boundaries which require the smaller clinics to report to larger facilities of the same service, potential savings could be accrued by designating a single facility in a geographic area to perform technical, legal, and administrative functions on behalf of all nearby clinics, regardless of service affiliation. In addition, governance reorganization may provide an opportunity to reduce infrastructure costs, and as the CNA report notes, the timeline for realizing cost savings could influence the amount of possible short- and long-term savings. The difference in the areas of cost savings considered and methodological approaches could explain the varying results of CNA and DOD's analyses. For example, DOD estimated a net cost increase for a unified medical command option, while CNA estimated a net cost savings for the same option in its 2006 study. As noted earlier, although DOD's preferred option assumes that DOD would achieve some personnel efficiencies due to greater use of shared services, DOD did not estimate the operational savings it expects, such as savings from consolidated contracts.

- *DOD used several potentially flawed assumptions in estimating headquarters personnel savings.* DOD used several potentially flawed assumptions in estimating its headquarters personnel savings, and therefore it cannot be assured that DOD's methods to estimate such savings produced reliable results. First, DOD estimated the size of a unified medical command by using Joint Task Force National Capital Region Medical (JTF CapMed) headquarters as an example of a unified medical command on a small scale. DOD estimated that given this command performs 10 percent of MHS operations with 150 personnel, a unified medical command would require a minimum of 1,500 personnel. However, DOD did not present evidence that 150 personnel is the most efficient number of staff for JTF CapMed, and the assumption concerning the relationship between the number of staff at JTF CapMed and a unified medical command is questionable because economies of scale could create efficiencies, therefore requiring fewer personnel. Moreover, the report assumes such economies of scale in its estimate of personnel savings from shared services functions. Second, DOD used the services' execution of the Defense Health Program's Operations and Maintenance budget to determine the most efficient staffing requirements for service support

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and regional commands. While these commands currently execute only their respective services' portion of the budget, DOD estimated the number of full-time equivalents each of these commands would require if charged with executing the entire budget. However, in its report, DOD undermines the credibility of this method by citing numerous weaknesses, and characterized this approach as "not a credible predictor of staffing requirements." Third, DOD determined the cost of the potential options' personnel requirements by multiplying an average of TRICARE Management Activity civilian compensation by the number of staffing requirements. However, this figure excluded military personnel, whose compensation is markedly different from that of civilian personnel.

Task Force officials stated that the internal 90-day deadline required by the Deputy Secretary of Defense for the Task Force to complete its report did not allow for a detailed analysis of implementation costs or a more thorough review of possible cost savings, and that this time period also limited the practicality of more detailed analysis. However, the National Defense Authorization Act for Fiscal Year 2012, which required a report on MHS governance options to be submitted to the congressional defense committees, was passed approximately 3 months after the Task Force completed its review and contained no specific deadline for DOD to submit its report. DOD chose to submit the report developed by the Task Force in response to the Deputy Secretary of Defense's direction, along with an additional cost analysis in response to the statutory requirement. However, DOD could have conducted additional analysis before submitting its report to the congressional defense committees.

Given the concerns outlined above, DOD has not comprehensively assessed the net costs of the various governance options. As we reported in 2007, such information is critical to making data-informed decisions about the structure of the MHS, especially in light of the nation's current fiscal challenges.<sup>37</sup> Past transformation experiences, such as the BRAC process, and prior reports on MHS governance, such as the 2006 CNA study, could provide a starting point for DOD in the consideration of possible implementation costs, cost savings areas, and methods of estimating such cost data. DOD has selected its preferred structure, a Defense Health Agency with the Military Treatment Facilities remaining under the services, without the benefit of an inclusive cost analysis which

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<sup>37</sup> [GAO-08-122](#).

explores these areas. Table 1 provides possible implementation cost and cost savings categories from BRAC and the 2006 CNA study and available estimates for DOD's preferred defense health agency governance option as provided in their report.

**Table 1: Possible Implementation Cost and Cost Savings Categories for DOD's Preferred Defense Health Agency Governance Structure**

Category	Cost/Savings (dollars, millions per year)
<b>Implementation Costs</b>	
Personnel severance	Not estimated
Moving	Not estimated
Military construction	Not estimated
Information technology	Not estimated
<b>Total Implementation Costs</b>	<b>Not estimated</b>
<b>Cost Savings</b>	
Shared Services	Not estimated <sup>a</sup>
Health care operations	Not estimated
Reduced Infrastructure	Not estimated
Personnel	\$46.5 <sup>b</sup>
<b>Total Cost Savings</b>	<b>Not estimated</b>
<b>Net Cost/Savings</b>	<b>Not estimated</b>

Source: GAO analysis and DOD MHS governance cost estimates.

<sup>a</sup> These savings should include the net of any implementation costs and anticipated savings associated with the creation of the shared services part of the Defense Health Agency.

<sup>b</sup> We determined that this cost savings estimate is not reliable because DOD did not use estimating methods which produced reliable results.

Prior attempts to proceed with MHS reorganization without the benefit of reliable estimates of implementation costs and cost savings demonstrate the effects of such an approach. In 2007, DOD did not conduct a comprehensive cost-benefit analysis, including an analysis of benefits, costs, and risks, for proceeding with its preferred medical governance concept at that time, which consisted of seven different incremental governance initiatives.<sup>38</sup> At the time, DOD concurred with our recommendation that they develop such an analysis, but we reported in

<sup>38</sup> [GAO-08-122](#).

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2011 that it had not done so.<sup>39</sup> Additionally, in 2012, we reported that DOD had documented estimated financial savings for only one of those seven governance initiatives while at least one other one had an estimated cost increase.<sup>40</sup> In the absence of an inclusive and reliable cost analysis, DOD's current effort may produce similar results.

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## DOD Limited Its Assessment of the Options' Strengths and Weaknesses to a Qualitative Process

DOD used a qualitative process to support its assessment of the strengths and weaknesses of the 13 potential governance options presented in its report, but did not balance this support with quantitative data. We recognize the use of quantitative data is a key component of study quality, and DOD's criteria calls for assessing the options based on quantitative data. Also, DOD did not mention in its report some of the criteria it identified as most important for assessing the governance options because they asserted that no option that adversely affected these two criteria would be recommended.

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## DOD's Assessment Gathered Significant Qualitative Information from Internal Stakeholders, but Did Not Provide Support for the Quantitative Elements Included in Its Criteria

DOD used a deliberative and qualitative approach to assess the strengths and weaknesses of the 13 potential governance structures presented in its report that included developing and applying criteria to each of the 13 governance options it developed.<sup>41</sup> In establishing the MHS review, the Deputy Secretary of Defense prescribed that the review should assess potential governance options based on their fulfillment of the following criteria:

- Provision of high-quality, integrated medical care for servicemembers and eligible beneficiaries;
- Maintenance of a trained and ready deployable medical force to support combatant commanders;

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<sup>39</sup> [GAO-11-318SP](#).

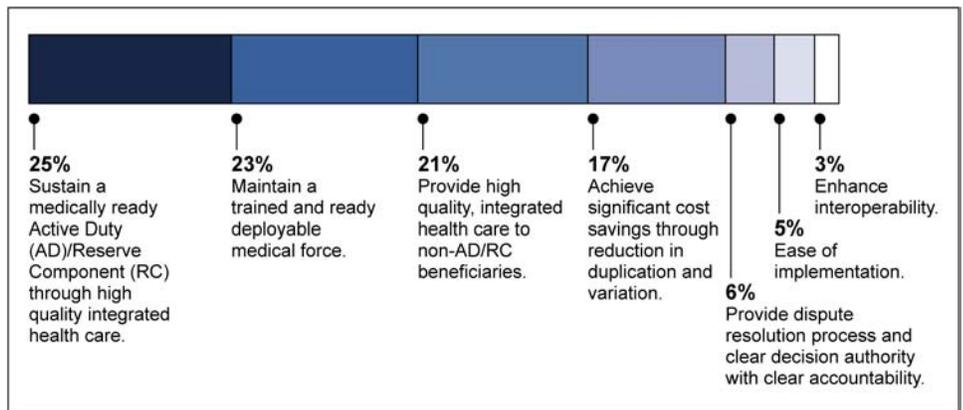
<sup>40</sup> [GAO-12-224](#).

<sup>41</sup> Qualitative methods include collecting data through interviews, focus groups, document or literature reviews, and observation, and analyzing data by discerning, examining, comparing, and contrasting meaningful patterns or themes in qualitative data. Quantitative methods typically involve collecting quantifiable data or other information, and may include the use of probability sampling using various forms of statistical analysis to generalize results. Evaluations using mixed methods employ a combination of qualitative and quantitative data collection and analysis techniques.

- Achievement of significant cost-savings through, for example, elimination of redundancies, increased interoperability, and other means of promoting cost-efficient delivery of care.

The Deputy Secretary of Defense noted that the Task Force members could consider additional criteria in their review. As such, the Task Force members collectively decided to split the criteria provided by the Deputy Secretary of Defense into separate criteria and add two new criteria, for a total of seven criteria used to assess the MHS governance options (see Figure 6). The Task Force members also collectively defined each of the criteria and added a weight to each based on their expert opinion of the relative importance of the criteria.

**Figure 6: Criteria Used to Assess MHS Governance Options**



Source: DOD Task Force Report.

The definitions of the seven criteria used by DOD—while mostly qualitative—included elements for certain criteria that called for quantitative data. For example,

- DOD defined the Ease of Implementation criterion as “The alternative should be implementable taking into account Title 10 equities,<sup>42</sup> short-term costs and long-term savings, and decisions required inside and

<sup>42</sup> DOD’s Task Force report did not define Title 10 equities. Title 10 of the United States Code contains the organic law governing the Armed Forces of the United States and providing for the organization of the Department of Defense, including the military departments and the Reserve Components.

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outside of the DOD.”

- DOD defined the Achieve Significant Cost Savings through Reduction in Duplication and Variation criterion as “The alternative should result in a reduction of the system operating costs.”

As we have previously reported, the quality of assessments can be strengthened by using a mixed approach that includes both qualitative and quantitative information to remove concerns about bias in one data source.<sup>43</sup> DOD’s review obtained a great deal of qualitative information from stakeholders and internal experts and used this information to support its assessment of the strengths and weaknesses of the governance options, but it did not balance this assessment with quantitative data. Specifically DOD’s assessments of the strengths and weaknesses did not provide data to support the quantitative elements specified in its own criteria as indicated in the following two examples.

- DOD did not attempt to estimate the range of either short- or long-term costs or savings data associated with the governance structures in the 14 instances where Ease of Implementation was listed either as a strength or a weakness. Instead, the DOD report cited qualitative information such as “this action would represent a significant departure in governance for all existing organizations” or “this will entail a large scale reorganization to include re-mapping of service medical personnel to operational platforms and there is no known precedent or example where this approach has been tested in other military medical organizations worldwide” as support for the assessment of this criterion. As one leading industry official told us, statements about how hard it would be to change and that the change would be too disruptive to actually implement is not sufficient evidence for avoiding necessary change.
- DOD did not provide cost data as support for the 11 instances where Achieve Significant Cost Savings through Reduction in Duplication and Variation was listed as a strength or a weakness. During the Task Force meetings, members expressed concern that no business case was presented for the governance options, and that the support presented for the assessment of strengths and weaknesses were

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<sup>43</sup> GAO, *Designing Evaluations: 2012 Revision*, [GAO-12-208G](#) (Washington, D.C.: Jan. 12, 2012).

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“descriptive statements.” According to the meeting minutes, it was understood by the Task Force that “deeper analytical work will be required following the submission of the report.”

Furthermore, DOD’s report listed the Medical Readiness criterion as a weakness for five options but did not provide supporting examples or quantitative data for this assessment. DOD defined Medical Readiness as “The alternative should maintain or enhance the ability to provide medically ready warfighters.” As support for the assessments where this criterion was listed as a weakness, DOD stated that coordination between Service Chiefs and Military Department Secretaries would be required under governance options where medical personnel were still “owned” by their service components. For governance options that included a split between unified medical command and military-led defense health agency, DOD stated that these structures would effectively split the readiness sustainment between the higher command and the services, thereby making the development and sustainment of the medical readiness forces more complex. However, DOD did not specifically identify the types of complexities or provide supporting examples in which such organizational issues have resulted in a negative impact on medical readiness. In July 2010, we reported that the services’ collaborative planning efforts regarding requirements determination for medical personnel working in fixed military treatment facilities have been limited, and recommended that DOD develop and implement cross-service medical manpower standards for common medical capabilities.<sup>44</sup> DOD did not address how the potential governance structures they presented would affect such issues. Similarly, DOD did not discuss or provide support for how the governance structures would impact the other MHS priorities—population health, experience of care, and per capita cost—even though quantitative data that measure the performance of these priorities for the current governance structure are available.<sup>45</sup>

In addition, DOD’s assessment of the strengths and weaknesses was often unclear. Specifically, 10 of the 13 assessments of governance options listed at least one criterion as support for both a strength and a

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<sup>44</sup> GAO, *Military Personnel: Enhanced Collaboration and Process Improvements Needed for Determining Military Treatment Facility Medical Personnel Requirements*, [GAO-10-696](#) (Washington, D.C.: July 29, 2010).

<sup>45</sup> Department of Defense, *2012 MHS Stakeholder’s Report*.

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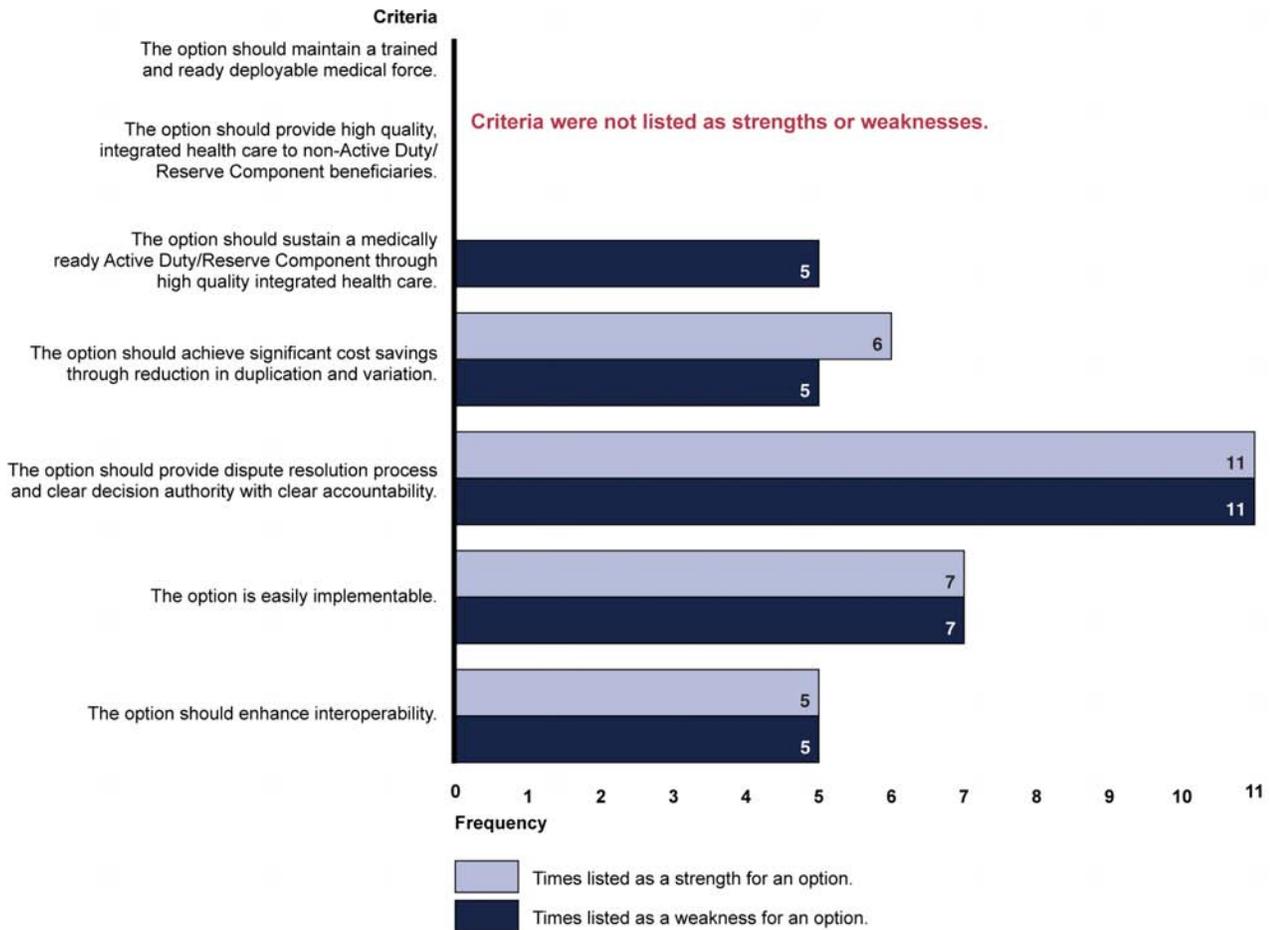
weakness, without coming to a conclusion as to whether the criterion was a strength or a weakness on balance. For example, in its assessment of its preferred governance option (Defense Health Agency with Service Medical Treatment Facilities), DOD listed the Enhance Interoperability criterion as both a strength and a weakness for the option without coming to a final conclusion as to the net effect of this assessment. Task Force members we met with told us that for options where the same criterion was listed as both a strength and a weakness, each Task Force member would make their own judgment as to which was a more important characteristic and vote accordingly – taking into account the perspective of their organization or service and the weighting of the criteria. This approach to assessing the strengths and weaknesses of the options illustrates the subjective nature of DOD’s analysis, and highlights an area where additional support, specifically quantitative data, would have improved the clarity and robustness of DOD’s conclusions about the strengths and weaknesses of the governance options.

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**DOD’s Assessment Did Not Provide Supporting Information for Two of the Criteria It Identified as Most Important**

DOD weighted its criteria according to relative importance but DOD’s assessment of strengths and weaknesses did not mention two of the three criteria weighted as most important. As noted earlier, DOD assigned various weights to the seven criteria used to assess the governance options as shown in figure 6. The DOD report stated that the weighting system was developed to reflect the relative importance of the criteria. However, two of the top three criteria with the greatest assigned weight—Trained and Ready Medical Force and Quality Beneficiary Care—were not mentioned in DOD’s assessment of the strengths and weaknesses. See figure 7.

**Figure 7: Frequency that the Criteria Were Listed as a Strength or Weakness for Potential Governance Structures**



Source: GAO analysis of DOD data.

DOD officials told us that these two criteria were not discussed in the report because the Task Force members agreed that each governance option presented in the report would meet both of these criteria. However, DOD did not provide an explanation or justification as to how each governance option would satisfy the two criteria in question. The officials added that there was a general understanding among the Task Force members that no option that adversely affected these two criteria would be recommended. However, five of DOD’s options presented medical readiness of the active duty force, a related and similarly important concept, as a weakness. Because DOD’s report does not discuss the criteria they identified as the most important for their assessment of the strengths and weaknesses—including providing support for why each

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option equally satisfied the Trained and Ready Medical Force and Quality Beneficiary Care criteria—DOD and Congress lack assurance that these criteria were sufficiently considered in DOD’s assessment. As a result, decision makers may not have well-supported, data-driven information about the strengths and weaknesses of the potential MHS governance options.

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## Conclusions

Transforming the governance structure of the MHS represents a potential opportunity to implement more efficient ways of doing business while maintaining a ready and trained medical force as well as continuing to meet the needs of military personnel, retirees, and their dependents. Reliable and comprehensive information, including implementation and other associated costs, is needed to provide a data-driven rationale for why DOD may be undertaking consolidation initiatives, and a clearly presented business-case or cost-benefit analysis can justify the benefits of such action. DOD has repeatedly studied options to transform its governance structure, but has relied on implementing “interim steps” or incremental changes toward an unknown final governance structure, often without the benefit of a clear understanding of the costs and benefits of its actions. DOD risks repeating this pattern without full knowledge of the costs, strengths, and weaknesses of each of the options. As DOD moves forward with its plans to transform its governance structure, it is imperative that officials benefit from full and complete information to be assured that they choose the best alternative and that their efforts yield necessary improvements and achieve maximum efficiencies.

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## Recommendations for Executive Action

To provide decision makers with more complete information on the total cost impact of the various governance structures to help determine the best way forward, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to:

- Develop a comprehensive cost analysis for the MHS governance structures including estimates of implementation costs and cost savings in additional areas such as health care operations and infrastructure changes as well as an improved estimate of personnel savings,
- Develop a business case analysis and strategy for the implementation of its shared services concept,

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- Improve its evaluation of the potential governance structures' strengths and weaknesses by including quantitative data when available, and a specific assessment of the degree to which the options meet the criteria Trained and Ready Medical Force and Quality Beneficiary Care.

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## Agency Comments and Our Evaluation

In written comments provided in response to our draft report, DOD concurred with one of our recommendations and did not concur with the remaining two recommendations. DOD's written comments are reprinted in appendix III of this report.

In concurring with our recommendation that DOD develop a business case analysis and a strategy for the implementation of its shared services concept, DOD agreed, but on the premise that it can and should occur in the context of its ongoing implementation planning effort for the creation of a defense health agency. DOD reiterated that all of the potential governance options under consideration include a shared services concept and noted that as part of its implementation planning, it will ascertain which shared services, functions, and activities will be consolidated. Additionally, DOD stated it will produce a detailed implementation timeline for the transfer of each such service to the defense health agency. We agree this effort to identify which services will be consolidated and to develop a timeline for the migration of these services is important. DOD states that shared services and common business practices will realize savings, but we are concerned that DOD is moving forward in implementing its shared services concept without knowledge of implementation costs or an estimated return on its investment. Further, with respect to DOD's governance decisions on the multi-service markets and the National Capital Region, DOD states that our recommendations for additional analysis did not apply to these reforms. We did not include these specific areas in our recommendation because the potential governance options for the multi-service markets and the National Capital Region were outside the scope of our mandated review. As a result, we did not address the extent to which DOD's reform plans for the multi-service markets and the National Capital Region may or may not require additional analysis. However, several senior DOD officials noted during the course of our review that while they recognize efficiencies could be gained in multi-service markets, they expressed reservations concerning the details of DOD's plans for reforming such markets.

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In its non-concurrence with our recommendation that DOD develop a comprehensive cost analysis for the MHS governance structures, including (1) estimates of implementation costs, (2) cost savings in additional areas such as health care operations and infrastructure changes, and (3) and an improved estimate of personnel savings, DOD noted that it recognizes that a more detailed and comprehensive cost analysis of governance options could be undertaken. However, DOD states that further cost analysis will not help to materially distinguish among the options. We disagree with DOD and believe that more comprehensive cost analysis will help to distinguish the differences among the costs and benefits of the options. First, DOD did not estimate implementation costs for any of its 13 governance options. As we reported, significant implementation costs are a key element of a comprehensive cost analysis, as illustrated in the case of the Base Realignment and Closure (BRAC) process, in which DOD's one-time implementation costs increased 53 percent over the BRAC Commission's original estimate. Second, we continue to believe that further analysis of cost savings areas beyond personnel cost savings, such as health care operations or reduced infrastructure, could help DOD to materially distinguish among the governance options. Third, DOD's estimate of personnel cost savings used several potentially flawed assumptions, and as a result, we determined DOD's estimate to be unreliable. In its decision to move forward with implementation of the defense health agency, DOD not only lacks any estimate of implementation costs and cost savings in areas such as healthcare operations and reduced infrastructure, but also reliable estimates of personnel cost savings. DOD also stated in its non-concurrence that its decision to affect incremental change through the implementation of a defense health agency enjoys the consensus of the most senior military leaders. However, the decision for this option is based on incomplete and potentially flawed data. Absent such information, we continue to believe that DOD lacks a sound basis upon which to make its decision about the future of MHS governance.

In its non-concurrence with our recommendation that DOD include quantitative data as available in its assessment of the strengths and weaknesses of the potential overall governance structures and conduct a specific assessment of the degree to which the options meet the criteria for Trained and Ready Medical Force and Quality Beneficiary Care, DOD stated that the work of the MHS governance task force provided DOD senior leaders with sufficient information to make decisions among near-term medical governance reform options based on a variety of criteria, many of which are inherently qualitative in nature and would not significantly benefit from the sort of quantitative data we recommended

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that DOD include. However, DOD's own criteria for the assessment of the potential governance structures called for the inclusion of quantitative information, as we reported. Further, DOD's response to our draft report did not specifically address the portion of our recommendation that a specific assessment of the degree to which the potential governance options meet the criteria Trained and Ready Medical Force and Quality Beneficiary Care—two of the three most important criteria according to DOD task force members. Without inclusion of these criteria coupled with the lack of quantitative data, it remains unclear how DOD senior leaders have sufficient information to make decisions regarding near- and long-term medical governance reform options. Therefore, we believe our recommendation that DOD improve its evaluation of the potential governance structures' strengths and weaknesses by including quantitative data in its assessment and to determine the impact on a trained and ready medical force and the quality of beneficiary care remains valid.

In its comments, DOD noted that it is committed to the MHS governance changes agreed to by the Department leadership in 2012 that are presented in its report in response to Section 716 of the National Defense Authorization Act for Fiscal Year 2012. As we noted, Section 716 required DOD to submit a report to the congressional defense committees to include, among other things, a description of the alternative MHS governance options developed and considered by the Task Force; an analysis of the strengths and weaknesses of each option; and an estimate of the cost savings, if any, to be achieved by each option. DOD stated that to undertake the additional evaluation we recommended would not only be time-consuming but also inherently speculative and imprecise, and that additional analysis would not alter its conclusion about which governance reforms to pursue in the near term. We are not suggesting that DOD not reap the benefits of certain desirable, near-term reforms, such as the development of a business-case analysis for its shared services followed by its implementation, and we recognize that implementing these near-term reforms can provide some insight into the potential benefits of further transformation efforts. As we noted in our report, under the current governance structure, the Assistant Secretary of Defense (Health Affairs) has the broad authority that could allow for the implementation of shared support services across MHS, and DOD has had an opportunity to develop a supporting business case analysis since this concept was first proposed in 2006. However, given the complex and costly nature of MHS, we continue to believe that changes to its overall governance should be well thought out and analyzed to ensure that there are significant, measurable benefits before being implemented. In

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addition, the need to improve the evaluation of potential governance options by considering critical information such as the cost of DOD's reforms, their possible cost savings, and a thorough discussion of the options' strengths and weaknesses would benefit DOD's decision-making process. DOD has repeatedly studied options to transform its governance structure, but has relied on implementing "interim steps" or incremental changes toward an unknown final governance structure, often without the benefit of a clear understanding of the costs and benefits of its actions. Prior attempts to proceed with MHS reorganization without the benefit of such information demonstrate the effects of such an approach. In 2007, DOD did not conduct a comprehensive cost-benefit analysis, including an analysis of benefits, costs, and risks, for proceeding with its preferred medical governance concept at that time, which consisted of seven different incremental governance initiatives. At the time, DOD concurred with our recommendation that they develop such an analysis, but we reported in 2011 that it had not done so. We reiterate that DOD risks repeating this pattern if it does not develop full knowledge of the costs, strengths, and weaknesses of each of the options under consideration.

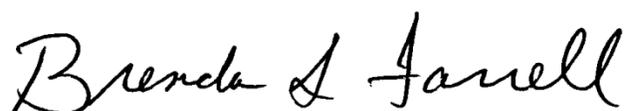
DOD noted that it is currently planning for the implementation of its governance reforms, and that it expects the defense health agency to reach an initial operating capability by 2013, with full operating capability within 2 years. We will continue to monitor DOD's efforts to reform MHS governance.

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We are sending copies of this report to interested congressional committees, the Secretary of Defense, the Deputy Secretary of Defense, the Under Secretary of Defense for Personnel and Readiness, the Assistant Secretary of Defense (Health Affairs), the Surgeon General of the Air Force, the Surgeon General of the Army, and the Surgeon General of the Navy. In addition, the report is available at no charge on the GAO website at <http://www.gao.gov>.

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If you or your staff have any questions regarding 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 IV.

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

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*List of Committees*

The Honorable Carl Levin  
Chairman  
The Honorable John McCain  
Ranking Member  
Committee on Armed Services  
United States Senate

The Honorable Daniel K. Inouye  
Chairman  
The Honorable Thad Cochran  
Ranking Member  
Subcommittee on Defense  
Committee on Appropriations  
United States Senate

The Honorable Howard P. "Buck" McKeon  
Chairman  
The Honorable Adam Smith  
Ranking Member  
Committee on Armed Services  
House of Representatives

The Honorable C.W. Bill Young  
Chairman  
The Honorable Norman D. Dicks  
Ranking Member  
Subcommittee on Defense  
Committee on Appropriations  
House of Representatives

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# Appendix I: Scope and Methodology

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To determine how the Department of Defense's (DOD) preferred governance option, and the other options presented in its report, changes the current structure of the MHS, we first obtained documentation describing key changes in the Military Health System (MHS) governance structure since 1991 by reviewing relevant DOD directives, legislation, and interviewing knowledgeable DOD officials. Using this as the basis for what constitutes the current MHS governance system, we then reviewed DOD's description of each of the proposed changes to the current governance options in the Task Force report. Upon review of all of the historical as well as proposed changes to the MHS governance structure, we identified three common governance elements among them all: the overall control of policy-making authority, budgetary authority, and control of medical personnel. As a guide for developing our comparison of the changes, we used these elements to describe the differences among the various governance options and key changes that have shaped the current structure. We defined these three governance elements to encompass the following activities:

- Overall Control of Policy-Making Authority: Who controls the overall MHS? Who heads its various entities? Who reports to the Secretary of Defense? What is the command and control structure? Who establishes MHS policy for the Office of the Secretary of Defense, the Services, and joint entities? What are the roles of senior leaders?
- Budgetary Authority: Who controls the Defense Health Program appropriation?
- Control of Personnel: Who manages and supervises the Military Treatment Facilities and multi-service medical markets? Who controls the MHS mission and administrative support personnel among the Office of the Secretary of Defense, the Military Departments, and/or joint entities?

To review DOD's shared services concept, we reviewed the information presented in DOD's report and interviewed DOD officials concerning their analysis of this concept. We compared this information to our prior work on business case analyses in the context of management consolidations,<sup>1</sup> and leveraged our prior work on efforts by DOD and other federal

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<sup>1</sup> [GAO-12-542](#).

agencies to establish shared services to provide context for DOD's current efforts.<sup>2</sup>

To determine the extent to which DOD has developed a cost analysis of its potential MHS governance options, we reviewed DOD's cost assessments for its governance options using key principles we derived from cost estimating and budgeting guidance. Specifically, we reviewed numerous federal guidance documents related to cost estimating, accounting standards, economic analysis, and budgeting and identified key principles that we believe can be applied to the evaluation of cost savings estimates. The guidance documents we reviewed include GAO Cost Estimating and Assessment Guide, [GAO-09-3SP](#); Office of Management and Budget Circular No. A-11, Preparation, Submission and Execution of the Budget (Aug. 2011, superseded by an August 2012 issuance); Federal Accounting Standards Advisory Board, Statement of Federal Financial Accounting Standards 4 (June 2011); Department of Defense Instruction 7041.3, Economic Analysis for Decisionmaking (Nov. 7, 1995); and Department of Defense Financial Management Regulation 7000.14-R, Volume 4, Chapter 22, Cost Finding (May 2010). Although each of these documents may not apply to these circumstances as a legal matter, we believe that they collectively contain broad themes that can be applied to evaluating cost analyses. To apply these key principles, we interviewed Task Force members concerning the extent to which they attempted to estimate implementation costs and reviewed the cost savings presented in DOD's report. We identified broad cost categories that should be considered in the course of implementing DOD's governance transformation by leveraging prior GAO work on the implementation costs of major transformations and consolidations, such as the Base Realignment and Closure (BRAC) process, and CNA's report, Cost Implications of a Unified Medical Command.<sup>3</sup> In reviewing DOD's cost savings estimate, we interviewed officials concerning their estimating methods and reviewed supporting documentation, noting where we identified shortcomings in the Task Force's approach. We were unable to rely on DOD's cost savings estimates because the estimates and their supporting data were insufficient in the key data elements needed to completely and accurately develop them as discussed in the findings section of this report.

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<sup>2</sup> [GAO-07-536](#) and [GAO-12-224](#).

<sup>3</sup> [GAO-12-542](#).

To determine the extent to which DOD's assessment of the strengths and weaknesses of its potential governance options is well-supported and data-driven, we obtained and analyzed Task Force documents including meeting minutes, briefing slides, and voting templates. We then used this analysis to determine the criteria and process used to formulate the strengths and weaknesses of the options. We then assembled a list of the 78 strengths and weaknesses cited in the task force report and used a semi-structured interview process to collect information from Task Force officials regarding the process and inputs used to formulate each assessment. We then conducted a content analysis of the information provided by the officials to identify and categorize the inputs that the officials cited as contributing to the assessments of strengths and weaknesses. The categorization of the information was conducted by one analyst and confirmed by a second analyst to ensure the analysis was adequately supported by the evidence. In addition, we interviewed officials from one multi-service market and a health administration expert to obtain their opinions on the process used by DOD to formulate the strengths and weaknesses.

For each of our objectives, we limited our review to the potential overall governance structures that the Task Force presented in its report. We did not specifically review the proposed changes to DOD's multi-service medical markets or to the governance structure in place within the National Capital Region as presented in the Task Force report because we determined that these proposed changes were outside the scope of our mandate. We conducted this performance audit from March 2012 through September 2012 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.

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# Appendix II: Detailed Description of the Potential Governance Structures and DOD's Assessment of Their Strengths and Weaknesses

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DOD's task force report provided the following detailed description, cost savings estimates,<sup>1</sup> and strengths and weaknesses of the governance structures<sup>2</sup> it identified as potential options for its Military Health System (MHS). As we noted earlier in our report, we found DOD's cost savings estimates to be unreliable because the estimates and their supporting data were insufficient in the key data elements needed to completely and accurately develop them. As a result, using DOD's data as presented below may lead to an incorrect or unintentional result.

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## Defense Health Agency Governance Structures

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### Defense Health Agency with Military Treatment Facilities under the Services

DOD's preferred option would create a new defense health agency that would assume the responsibilities of the TRICARE Management Activity and additional possible areas of savings known as shared services. The new agency would be a combat support agency headed by a 3-star general or flag officer who would report to the Assistant Secretary of Defense (Health Affairs), but with oversight from the Chairman of the Joint Chiefs of Staff. The services would maintain their surgeons general, service support commands, and intermediate headquarters.

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<sup>1</sup> We determined DOD's cost savings estimates to be unreliable.

<sup>2</sup> These structures are in addition to the current MHS structure, which the Task Force included in the 13 options presented in the report.

**Appendix II: Detailed Description of the Potential Governance Structures and DOD's Assessment of Their Strengths and Weaknesses**

DOD's Estimate of Projected Net Savings: \$46.5 million per year.

**DOD's Assessment of Strengths**

- Lines of Authority: The services control the hospital and deployed health care; eliminates the Assistant Secretary of Defense role as the Director of the TRICARE Management Activity.
- Enhance Interoperability: The defense health agency would be focused on the shared and consolidated services.
- Ease of Implementation: This would require minimal change to the current service organizational structure.

**DOD's Assessment of Weaknesses**

- Enhance Interoperability: Eliminates the Joint Hospitals in the National Capital Region as well as San Antonio.
- Ease of Implementation: This option would require the Joint Task Force National Capital Region Medical to transition to a different structure. The services' cultures could limit the implementation of common services and processes.

**Defense Health Agency with Military Treatment Facilities Placed under the Agency**

Similar to the previous option, this structure would create a defense health agency combat support agency led by a 3-star general or flag officer, but would place Military Treatment Facilities under the authority, direction, and control of the agency. Military personnel not assigned to a deployable unit would be under the direction of the defense health agency, but the services would continue to own their personnel, and all civilian personnel would be under the direction of the agency.

DOD's Estimate of Projected Net Savings: \$87.4 million per year.

**DOD's Assessment of Strengths**

- Dispute Resolution/Lines of Authority/Accountability: Management of all medical treatment facilities under one authority (Director, Defense Health Agency); the Defense Health Agency Director would report directly to the Assistant Secretary of Defense (Health Affairs).
- Achieve Significant Cost Savings Through Reduction in Duplication and Variation: The defense health agency would be focused on the most common theme emphasized by the Task Force – an organizational model that would accelerate implementation of shared services models that identify and proliferate best practices and consider entirely new approaches to delivering shared activities. Further, placement of medical treatment facilities under the defense health agency would allow for even more rapid implementation of unified clinical and business systems, which could create significant savings.
- Other: Would align management of purchased care (TRICARE) and direct care (Medical Treatment Facilities) under one entity, creating potential for greater coordination and cost-effective distribution of resources between the two sources of care.

**DOD's Assessment of Weaknesses**

- Dispute Resolution/Lines of Authority/Accountability: This model may elevate management disputes to the highest levels of the DOD, as local line command disputes with the defense health agency command structure may need to be adjudicated at the level of the Secretary of the Military Department /Assistant Secretary of Defense (Health Affairs) level.
- Medical Readiness: Concerns were expressed that an organization this large with this many authorities could jeopardize services priorities. A comprehensive defense health agency could reduce command and leadership development opportunities.
- Ease of Implementation: Moving all medical treatment facilities to the defense health agency would be a major reorganization.
- Other: Could mix the defense health agency mission between support of MHS-wide functions and direct operation of hospitals and clinics. The Military Department's representatives on the Task Force believed that operation of the direct care system is a Military Department responsibility.

Weaknesses of a DHA with MTFs under the Agency

Defense Health Agency – Geographic Model

This option would create a Defense Health Agency to exercise authority, direction, and control over the Military Treatment Facilities. However, service intermediate headquarters would be replaced by a single defense health agency-run organization.

DOD's Estimate of Projected Net Savings: \$21.4 million per year.

DOD's Assessment of Strengths	DOD's Assessment of Weaknesses
<ul style="list-style-type: none"> <li>• Lines of Authority: This organizational construct would have clear lines of authority and there would be central control of the Military Treatment Facilities.</li> <li>• Enhance Interoperability: This option would allow for single processes for key functions.</li> </ul>	<ul style="list-style-type: none"> <li>• Dispute Resolution: Key issues would be elevated quickly to the highest levels.</li> <li>• Ease of Implementation: This option would be more of a "civilianized" model which may be difficult to implement in the current military structure. It may also reduce command leadership opportunities and professional growth.</li> </ul>

Unified Medical Command Governance Structures

Unified Medical Command with Service Components

A unified medical command with service components option would create a tenth combatant command led by a 4-star general or flag officer, with forces supplied by service components. Service intermediate headquarters would manage the Military Treatment Facilities, but personnel not assigned to deployable units would be assigned to the unified medical command. A Joint Health Support Command would manage the TRICARE health plan and shared services.

**Appendix II: Detailed Description of the Potential Governance Structures and DOD's Assessment of Their Strengths and Weaknesses**

DOD's Estimate of Projected Net Cost: \$203.6 million per year.

**DOD's Assessment of Strengths**

- Dispute Resolution/Lines of Authority/Accountability: Clear lines of authority would be established.
- Achieve Significant Cost Savings Through Reduction in Duplication and Variation: There would be central control of common business and clinical processes, and implementation would be achieved more readily with command and control throughout the medical structure to ensure compliance.
- Ease of Implementation: Joint Task Force National Capital Region Medical, if retained in its current form, could be addressed as a region directly reporting to the Commander, U.S. Medical Command.

**DOD's Assessment of Weaknesses**

- Dispute Resolution/Lines of Authority/Accountability: The current structure of civilian authority over components of the MHS (the Assistant Secretary of Defense (Health Affairs)) and Military Department Secretaries) would not be maintained; the first civilian official in the authority chain would be the Secretary of Defense.
- Achieve Significant Cost Savings Through Reduction in Duplication and Variation: In any unified medical command structure that maintains service Components (the common model for all unified commands) the overall management headquarters overhead would increase above "As Is" and all other organizational models.
- Ease of Implementation: This action would represent a significant departure in governance for all existing organizations (Assistant Secretary of Defense (Health Affairs), TRICARE Management Activity, Military Department Secretaries, Military Service Chiefs, Service Medical Departments). For the Air Force, this includes creating a medical component command for operation of Air Force medical treatment facilities; the Navy would need to redesign how garrison billets are mapped to operational requirements.

**Unified Medical Command, Geographic Model**

This structure would create a tenth combatant command for medical care. However, the unified medical command commander would exercise control over personnel and the Military Treatment Facilities. Service intermediate headquarters would be replaced by a single organization.

DOD's Estimate of Projected Net Cost: \$152.3 million per year.

**Appendix II: Detailed Description of the Potential Governance Structures and DOD's Assessment of Their Strengths and Weaknesses**

<b>DOD's Assessment of Strengths</b>	<b>DOD's Assessment of Weaknesses</b>
<ul style="list-style-type: none"> <li>Dispute Resolutions and Lines of Authority: This organizational structure would have clear lines of authority and there would be central control of the Military Treatment Facilities. The shared services (i.e. education and training, research and development, health information technology, logistics) would be centrally managed. The TRICARE Regional Offices would be aligned with the Military Treatment Facilities in the same chain of command.</li> <li>Enhance Interoperability: This option would focus the development of common business processes.</li> <li>Ease of Implementation: The Joint Table of Distributions would eliminate any multi-service market issues because the unified medical command would control the multi-service markets.</li> <li>Achieve Significant Cost Savings Through Reduction in Duplication and Variation: Reduction in overhead personnel would be relative to the current MHS structure. Services would focus on deployable forces with the unified medical command as the platform for medical professional force development and benefit delivery.</li> </ul>	<ul style="list-style-type: none"> <li>Lines of Authority: This would be a major change for the Service Surgeons General.</li> <li>Enhance Interoperability: Some required service assets would not be under service control — sourcing would be from the unified medical command.</li> <li>Ease of Implementation: This would be a massive change for the way the DOD does business. Hospital based and wartime medical forces would be split. An alternative is to embed deployable wartime forces in a Joint Table of Distribution in the unified medical command.</li> <li>Achieve Significant Cost Savings through Reduction in Duplication and Variation: The Command may be focused on effectiveness over costs.</li> </ul>

**Unified Medical Command, HR 1540<sup>3</sup>**

This option would create a tenth combatant command for medical care with forces supplied by service components. Subordinate service commands would manage the Military Treatment Facilities, but within the framework of a Healthcare Command led by a 3-star general or flag officer to manage the service components.

DOD's Estimate of Projected Net Cost: \$238.8 million per year.

<sup>3</sup> H.R. 1540, which became the National Defense Authorization Act for Fiscal Year 2012, Pub. L. No. 112-81 (2011), when initially passed by the House, contained a provision (sec. 711) that would have required the establishment of a unified medical command. That provision was not ultimately enacted, and was replaced by section 716 during conference.

**Appendix II: Detailed Description of the Potential Governance Structures and DOD's Assessment of Their Strengths and Weaknesses**

DOD's Assessment of Strengths	DOD's Assessment of Weaknesses
<ul style="list-style-type: none"> <li>• Dispute Resolution/Lines of Authority/Accountability: Clear lines of authority would be established as well as central management of shared services (i.e. education and training, research and development, health information technology, logistics). Military Treatment Facilities would be centrally controlled.</li> <li>• Enhance Interoperability: Allows for Joint Task Force National Capital Region Medical to be easily inserted into this structure as a regional or sub-regional command. Common business processes would be implemented across the Military Treatment Facilities.</li> <li>• Ease of Implementation: The service component execution would minimize organizational change.</li> </ul>	<ul style="list-style-type: none"> <li>• Achieve Significant Cost Savings Through Reduction in Duplication and Variation: The Command would likely be focused more on effectiveness over costs.</li> <li>• Dispute Resolution/Lines of Authority/Accountability: Some required service assets would not be under service control. There would be civilian oversight for budget located at the Secretary of Defense level which would bypass the Office of the Secretary of Defense Principal Staff Assistant.</li> <li>• Enhance Interoperability: Hospital based and unit based medical forces would be split.</li> <li>• Ease of Implementation: This would require all three services to significantly change, with the biggest impact on the Air Force.</li> <li>• Dual-hatted surgeons general could face perception issues from home service and the unified medical command.</li> </ul>

## Single Service Governance Structures

### Single Service with Service Components

A single military service Secretary would be assigned all headquarters management functions, such as management of the TRICARE health plan and shared services. The designated service also would control a Defense Healthcare System agency that would include the service component commands, which in turn would command the Military Treatment Facilities.

DOD's Estimate of Projected Net Savings: \$94.4 million per year.

DOD's Assessment of Strengths	DOD's Assessment of Weaknesses
<ul style="list-style-type: none"> <li>• Dispute Resolution/Lines of Authority/Accountability: Clear lines of authority would be established as well as central control of the Military Treatment Facilities and multi-service markets. Service readiness assets would be under service control.</li> <li>• Achieve Significant Cost Savings Through Reduction in Duplication and Variation: There would be single processes for key functions</li> </ul>	<ul style="list-style-type: none"> <li>• Dispute Resolution/Lines of Authority/Accountability: This option would create a need for coordination of issues between the service Secretaries.</li> <li>• Enhance Interoperability: This would split the warrior and beneficiary care systems.</li> </ul>

## Single Service, Geographic Model

Under this structure, a single military service Secretary would be assigned all headquarters management functions, such as management of the TRICARE health plan and shared services. In addition, the designated service would command all of the Military Treatment Facilities, while all services would remain responsible for providing personnel.

DOD's Estimate of Projected Net Savings: \$94.4 million per year

### DOD's Assessment of Strengths

- Dispute Resolution/Lines of Authority/Accountability: Clear lines of authority and chain of command from Secretary through the Military Treatment Facilities commander would be established.
- Achieve Significant Cost Savings Through Reduction in Duplication and Variation: With shared services, there would be one set of business and clinical processes and implementation would be achieved more readily with command and control in a single service. It also could eliminate the issues that arise with multi-service markets. This option would create the most significant savings in headquarters overhead of any organizational option.

### DOD's Assessment of Weaknesses

- Medical Readiness: With medical personnel still "owned" by their service components, a requirement for coordination between Service Chiefs and Military Department Secretaries on readiness and personnel issues would remain.
- Ease of Implementation: There is no known precedent or example where this approach has been tested in other military medical organizations worldwide. The Navy/US Marine Corps medical support model does not have the mission for all of the DOD; however, it is representative of how a single service model could work. Additionally, this option would entail a large scale reorganization to include re-mapping of service medical personnel to operational platforms.
- Dispute Resolution/Lines of Authority/Accountability: Issues would be adjudicated at a higher level (Military Department Secretary).

## Hybrid Governance Structures

### Unified Medical Command with Service Components and Defense Health Agency

This option would create a tenth combatant command led by a 4-star general or flag officer, with forces supplied by service components, and service commands charged with management of the Military Treatment Facilities. However, shared services would be split, with the unified medical command in charge of readiness-focused areas and a defense health agency charged with beneficiary health care and clinical quality.

DOD's Estimate of Projected Net Cost: \$225.3 million per year.

**Appendix II: Detailed Description of the Potential Governance Structures and DOD's Assessment of Their Strengths and Weaknesses**

DOD's Assessment of Strengths	DOD's Assessment of Weaknesses
<ul style="list-style-type: none"> <li>• Dispute Resolution/Lines of Authority/Accountability: This option would align command and control forces under a military chain of command. It would also align the Assistant Secretary of Defense (Health Affairs) role to policy and oversight with execution delegated to the unified medical command commander and the defense health agency director.</li> <li>• Ease of Implementation: This option would maintain service structures as component commands in the unified medical command. It would also support the Joint Task Force National Capital Region Medical structure.</li> </ul>	<ul style="list-style-type: none"> <li>• Medical Readiness: Service readiness functions would be located in the unified medical command.</li> <li>• Dispute Resolution/Lines of Authority/Accountability: The unified medical command commander would report directly to the Secretary of Defense. It could be difficult to adjudicate disagreements between the unified medical command and the defense health agency at the Deputy Secretary of Defense level.</li> <li>• Achieve Significant Cost Savings: The execution of the shared services and common processes would require unified medical command and defense health agency agreement.</li> </ul>

**Unified Medical Command and Defense Health Agency, Geographic Model**

Similar to the above, this option would pair a tenth combatant command with a defense health agency with shared services divided between the two organizations. However, the defense health agency through Regional Directors, not service components, would manage the Military Treatment Facilities.

DOD's Estimate of Projected Net Cost: \$238.8 million per year.

DOD's Assessment of Strengths	DOD's Assessment of Weaknesses
<ul style="list-style-type: none"> <li>• Dispute Resolution/Lines of Authority/Accountability: This option would align command and control forces under a military chain of command. It would also align the role of the Assistant Secretary of Defense (Health Affairs) to policy and oversight with execution delegated to the unified medical command commander and defense health agency director.</li> <li>• Achieve Significant Cost Savings: The execution of the shared services and common processes would require unified medical command combatant command agreement.</li> </ul>	<ul style="list-style-type: none"> <li>• Medical Readiness: Service readiness functions would be located in the unified medical command.</li> <li>• Dispute Resolution/Lines of Authority/Accountability: The unified medical command commander would report directly to the Secretary of Defense. It could be difficult to adjudicate disagreements between the unified medical command and defense health agency at the Deputy Secretary of Defense level.</li> </ul>

**Single Service with a Unified Medical Command**

Similar to the above two options, this option would pair a tenth combatant command with another organization, a Defense Healthcare System in charge of all of the Military Treatment Facilities managed by one military service. Shared services also would be divided between the two organizations.

DOD's Estimate of Projected Net Cost: \$238.8 million per year.

**Appendix II: Detailed Description of the Potential Governance Structures and DOD's Assessment of Their Strengths and Weaknesses**

**DOD's Assessment of Strengths**

- Dispute Resolution/Lines of Authority/Accountability: This option would establish clear lines of authority for administrative, operational, and tactical control of forces with each being vested in a different structure. It would also create central control of the Military Treatment Facilities.
- Ease of Implementation: In this option, the multi-service markets are addressed and joint facilities would be maintained.
- Enhance Interoperability: This option would allow for single processes for key functions.

**DOD's Assessment of Weaknesses**

- Medical Readiness: This would split the warrior care and the beneficiary care systems.
- Dispute Resolution/Lines of Authority/Accountability: This option would create different responsible agents for administrative, operational, and tactical control of forces.

**Defense Health Agency Hybrid with Regional Military Treatment Facilities**

The defense health agency would be led by a 3-star general or flag officer who would report directly to either a Service Secretary, the Assistant Secretary of Defense (Health Affairs) or a combatant commander. The agency would control the TRICARE health plan. Additionally, a Medical Operations Support Command would be created to control the education and training, research and development, and public health. Finally, the individual military departments would continue to manage the Military Treatment Facilities, albeit through Service designated regional enhanced multi-service market offices instead of their current medical commands.

DOD's Estimate of Projected Cost/Saving: None presented.

**DOD's Assessment of Strengths**

- None provided.

**DOD's Assessment of Weaknesses**

- None provided.

# Appendix III: Comments from the Department of Defense



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON  
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

SEP 14 2012

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

Dear Ms. Farrell:

Thank you for the opportunity to comment on the draft Government Accountability Office (GAO) report, GAO-12-911. Military Health System (MHS) governance reform is a priority issue for the Department of Defense (DoD) and we very much appreciate GAO's thoughtful assessment.

The Department's specific comments on the three recommendations contained in the draft GAO report are provided in the attached. Our points of contact are Dr. Michael Dinneen (Functional) at 703-681-8063 and Mr. Gunther Zimmerman (Audit Liaison) at 703-681-4360.

Sincerely,

  
Jonathan Woodson, M.D.

Attachment:  
As stated

GAO DRAFT REPORT DATED AUGUST 23, 2012  
GAO-12-911 (GAO CODE 351719)

**“DEFENSE HEALTH CARE: ADDITIONAL ANALYSIS OF COSTS AND  
BENEFITS OF POTENTIAL GOVERNANCE STRUCTURES IS NEEDED”**

**DEPARTMENT OF DEFENSE COMMENTS  
TO THE GAO RECOMMENDATIONS**

The Department of Defense is committed to the military health system (MHS) governance changes agreed to by Department leadership in 2012 and explained in enclosure 1 of the Department’s report in response to Section 716 of the National Defense Authorization Act. These near-term reforms will realize savings through common business processes and shared services, and will provide valuable information to improve management of our shared medical markets. These reforms will also provide information, based on actual experience and outcomes that will be used to inform future MHS governance decisions. The Department is currently undertaking detailed implementation planning for its intended medical governance reforms, and is on track to achieve an initial operating capability of the new Defense Health Agency by 2013, with full operating capability within two years.

The Department extensively reviewed the work of its internal task force and prior studies of governance options and arrived at an informed consensus among the Department’s civilian and uniformed leadership both regarding this approach and that improved efficiency in the military health system is an urgent priority. While the Department does not concur with proposals that would delay implementation of these near-term reforms, it is undertaking detailed cost analyses as part of the implementation planning process. Furthermore, the implementation of these near term reforms will result in additional information and insight, based on actual experience and outcomes that can inform future consideration by the Department and the Congress of potential more significant transformations to MHS governance.

**RECOMMENDATION 1:** The GAO recommends that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to develop a comprehensive cost analysis for the MHS governance structures including estimates of implementation costs and cost savings in additional areas such as health care operations and infrastructure changes as well as an improved estimate of personnel savings.

**DoD RESPONSE:** DoD recognizes that a more detailed and comprehensive cost analysis of military health system (MHS) governance structures could be undertaken; however, the Department does not believe that doing so would materially enhance its ability to select among potential governance options, or that it would alter its conclusion about which governance reforms it should pursue in the near term. Furthermore, to the extent that the GAO recommendation might suggest that DoD should defer the implementation of its intended near-term reform to MHS governance until further cost analysis is completed, the Department does not agree, because doing so would unduly delay the Department from realizing the benefits of these needed reforms.

As described in Enclosure 1 of the report provided to the congressional defense committees as directed by section 716 of the National Defense Authorization Act for 2012, DoD intends to transition the TRICARE Management Activity (TMA) to a “Defense Health Agency” that will, among other things, assume responsibility for shared services, functions, and activities in the MHS. This decision was informed by the work of the Department’s internal task force on MHS governance and was arrived at after extensive discussion among the senior most leaders of the Department, including the Deputy Secretary of Defense, the Chairman of the Joint Chiefs of Staff, and the Military Department Secretaries and Service Chiefs. As such, this option has the consensus of the senior leaders representing the various components of the Department involved in the medical mission and achieves important objectives sought in medical governance reform – one of which is the potential to achieve cost savings. Further cost analysis as recommended by the GAO will not help to materially distinguish among the MHS governance options developed by the Task Force, all of which are predicated on the concept of consolidating shared services and functions that are currently performed separately by each of the Military Departments.

DoD does intend to undertake additional cost analysis of its intended medical governance change, to include cost savings in the areas specified in the GAO’s recommendation, in the context of the implementation planning effort directed by the Deputy Secretary of Defense (as described in Enclosure 1 of DoD’s section 716 report). This effort is already well underway, and is targeted to achieve interim operating capability for the Defense Health Agency by 2013 and full operating capability within two years. To undertake the cost analysis recommended by the GAO for each of the medical governance options developed by the Task Force would be a time- and labor-intensive process that, if required to be undertaken prior to proceeding with any MHS governance reforms, would significantly delay the implementation of these needed and beneficial reforms. As the GAO report notes, MHS governance reform has been studied numerous times

before, and has yet to result in the implementation of a significant redesign to the system. In the context of the past and the projected future of the MHS, DoD sees this incremental MHS governance reform – around which there is consensus within the Department and which is on track for execution in the near term – as beneficial, and preferable to deferring any reform for another study.

**RECOMMENDATION 2:** The GAO recommends that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to develop a business case analysis and strategy for the implementation of its shared services concept.

**DoD RESPONSE:** DoD agrees that a business case analysis and strategy for the implementation of its shared services concept should be undertaken; this will be done in the context of the ongoing implementation planning effort. As described above, DoD’s intended governance change (and, indeed, all of the changes considered by the task force) is predicated on the concept of consolidating shared services and functions. In the context of implementation planning, the Department will ascertain, based on this business case analysis, precisely which shared services, functions, and activities will be consolidated among the Military Departments and transferred to the Defense Health Agency. This process will also produce detailed implementation timelines for the transfer of each such service to the Defense Health Agency. As such, the Department agrees with the recommendation, but on the premise that it can and should occur in the context of the ongoing implementation planning effort.

Additionally, DoD agrees with GAO that the recommendations for additional analysis do not involve the reforms to the Multi-Service Markets (MSMs) or the National Capital Region (NCR), which the GAO considered outside the scope of its review mandate. Thus, DoD will continue to pursue its reform plans for the MSMs and the NCR (as described in Enclosure 1 of DoD’s section 716 report), which are part of the current implementation planning effort.

**RECOMMENDATION 3:** The GAO recommends that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to improve its evaluation of the potential governance structures’ strengths and weaknesses by including quantitative data when available, and a specific assessment of the degree to which the options meet the criteria *Trained and Ready Medical Force* and *Quality Beneficiary Care*.

**DoD RESPONSE:** For similar reasons expressed in the response to recommendation 1, DoD does not support an indefinite deferral of the Department’s intended near-term MHS governance reform for a new study to develop potential quantitative data to inform a reconsideration of options already

considered at length by DoD senior leaders. The work of the MHS governance task force provided DoD senior leaders with sufficient information to make decisions among near-term medical governance reform options based on a variety of criteria, many of which are inherently qualitative in nature and would not significantly benefit from the sort of quantitative data recommended by the GAO. To this end, the Department also does not agree with the proposed title of the draft GAO report, to the extent that it suggests that additional analysis of costs and benefits is needed before useful, albeit incremental, reforms are put into place in the near term.

Even as it works to implement these near-term reforms, DoD does intend to continue to study options for potential further, more significant transformations to MHS governance in the future. Importantly, as described in Enclosure 1 of DoD's section 716 report, the Department's intended near-term MHS governance reforms – including the consolidation of shared services into one entity, the enhancement of authorities of managers in multi-Service medical markets, and the improvements to the singular authority model currently in place in the NCR (and unique in the MHS) – will provide the Department with actual experience to evaluate the efficacy of these different governance models. In doing so, the Department will not only reap the benefits of these desirable near-term reforms, but will also obtain greater insight, based on actual results and outcomes that can inform the evaluation of potential more significant transformations in the future. To undertake the additional evaluation recommended by the GAO at this time, prior to the implementation to any near-term changes to shared services, multi-service market management, and the National Capital Region, would not only be time-consuming but also inherently speculative and imprecise.

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# Appendix IV: GAO Contact and Staff Acknowledgments

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## GAO Contact

Brenda S. Farrell, (202) 512-3604 or farrellb@gao.gov

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## Staff Acknowledgments

In addition to the contact named above, Lori Atkinson, Assistant Director; Edward Anderson, Jr., Rebecca Beale, Grace Coleman, Foster Kerrison, Charles Perdue, Carol Petersen, Terry Richardson, Adam Smith, and Karen Nicole Willems made key contributions to this report.

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# Related Products

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GAO, *Defense Health Care: Applying Key Management Practices Should Help Achieve Efficiencies within the Military Health System*, [GAO-12-224](#) (Washington, D.C.: April 12, 2012).

GAO, *2012 Annual Report: Opportunities to Reduce Duplication, Overlap and Fragmentation, Achieve Savings, and Enhance Revenue*, [GAO-12-342SP](#) (Washington, D.C.: Feb. 28, 2012).

GAO, *Follow-up on 2011, Status of Actions Taken to Reduce Duplication, Overlap, and Fragmentation, Save Tax Dollars, and Enhance Revenue*, [GAO-12-453SP](#) (Washington, D.C.: Feb. 28, 2012).

GAO, *Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue*, [GAO-11-318SP](#) (Washington, D.C.: Mar. 1, 2011).

GAO, *Defense Health Care: DOD Needs to Address the Expected Benefits, Costs, and Risks for Its Newly Approved Medical Command Structure*, [GAO-08-122](#) (Washington, D.C.: Oct. 12, 2007).

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